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Towards Europeanisation through the proportionality test? The impact of free movement law on medical professional discipline

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Abstract

Medical doctors can exercise their free movement rights to escape the control of professional regulation at the national level. This "darker side" of free movement of doctors has received a lot of attention. This article will show that the free movement provisions play an increasingly important role in medical disciplinary cases. The application of free movement law can make a positive contribution to the protection of patient safety. However, disciplinary tribunals are unfamiliar with the structure of arguments based on the free movement provisions. While the case law on free movement of patients has encouraged a process of internationalisation of medical standards, free movement of doctors has not yet led to a similar process of Europeanisation of medical professional rules. Nevertheless, the proportionality test requires that disciplinary tribunals engage in a process of comparison between their own rules and the rules in other Member States.

1 | INTRODUCTION

In 2010, it was reported that Dr Daniel Ubani, who had been convicted of gross negligence manslaughter in the United Kingdom after he had injected a patient with an overdose of a certain drug, was able to continue practising as a doctor in Germany.[1] In 2013, the German authorities discovered that Dr Ernst Jansen Steur, who had been labelled "Dr Frankenstein" in the Netherlands, was still practising as a neurologist in Germany despite the fact that he had relinquished his registration in the Netherlands.[2] Several Dutch patients had brought cases against him after he had given them false diagnoses. These stories provide extreme examples, but they vividly illustrate some of the problems caused by free movement of doctors in the EU.

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[1]'Doctor Daniel Ubani unlawfully killed overdose patient', *The Guardian*, 4 February 2010. Available at https://www.theguardian.com/society/2010/feb/04/doctor-daniel-ubani-unlawfully-killed-patient (accessed 7 June 2020).

[2]'Prozess gegen niederlandischen Skandal-Arzt Ernst J. beginnt', *Der Spiegel*, 3 November 2013. Available at https://www.spiegel.de/panorama/justiz/prozess-gegen-niederlaendischen-skandal-arzt-ernst-j-beginnt-a-931335.html (accessed 7 June 2020).

Free movement law creates opportunities for both doctors and national healthcare systems. Doctors are able to work in countries where the working conditions are more favourable and national healthcare systems are able to attract doctors with a particular kind of expertise.[3] At the same time, free movement makes it more difficult to control the quality of healthcare provided by doctors. Because EU law has harmonised the mutual recognition of professional qualifications of doctors,[4] national regulators are restricted in their ability to verify the competences of doctors who are exercising their free movement rights. Incompetent or even dangerous doctors could rely on free movement to escape the disciplinary rules in their home Member States. This "darker side"[5] of free movement of doctors has received an increasing amount of attention in the last decade and has led to new rules on the exchange of information about disciplinary sanctions between national regulators. From 2016, national regulators have to use an EU-wide Alert System to warn regulators in other Member States if the ability of doctors to practise has been restricted.[6]

Medical professional discipline plays an important role in guaranteeing the quality of care provided by doctors. It constitutes one of the most important tools to prohibit doctors from practising or to restrict their ability to practise. As an area of law, it has not received a lot of academic attention from EU lawyers.[7] However, free movement law has an impact on medical professional discipline at the national level. The aim of this paper is to analyse the interaction between medical professional discipline and free movement law. It will be argued that the free movement provisions play an important role in protecting the ability of Member States to guarantee and promote patient safety in the EU.

A key role in promoting the quality of healthcare is played by the proportionality test. In the absence of harmonisation or mutual recognition of medical professional standards, the proportionality test requires that disciplinary tribunals engage in a process of comparison between their national disciplinary rules and the disciplinary rules or judgments in other Member States. Although there is no mutual recognition in the field of medical professional discipline, the proportionality test requires that disciplinary tribunals engage with the substance of the judgments of disciplinary tribunals in other Member States. The result would be more frequent judicial dialogues between national tribunals in the field of medical professional discipline. An important role in facilitating these judicial dialogues should be played by the Court of Justice of the European Union (CJEU), which has to provide more guidance on how medical disciplinary tribunals have to apply the proportionality test.

The structure of this paper is as follows. In section 2, the interaction between free movement law and medical professional discipline will be introduced. The focus will be on the role of the free movement provisions, the Professional Qualifications Directive and the CJEU's judgment in *Konstantinides*.[8] Section 3 will analyse case law from Germany, the UK and the Netherlands to investigate to what extent and in what type of cases doctors relied on free movement law. In section 4, the role of the proportionality test in medical disciplinary cases will be discussed in more detail. Section 5 will make a comparison between free movement of doctors and free movement of patients to consider whether the case law on free movement of doctors leads to a process of "deprofessionalisation" of doctors and Europeanisation of medical professional standards. Finally, section 6 will show how the judicial dialogues required by the proportionality test can lead to a bottom-up process of Europeanisation of medical professional discipline. These judicial dialogues would encourage Member States to analyse and learn from medical professional standards in other Member States. This process would improve patient safety and the quality of care provided by medical doctors across the EU.

[3]M. Peeters, M. McKee and S. Merkur, 'EU Law and Health Professionals', in E. Mossialos et al. (eds.), *Health Systems Governance in Europe: The Role of European Union Law and Policy* (Cambridge University Press, 2010), 589.
[4]Directive 2005/36/EC on the recognition of professional qualifications, OJ L 255, 30.9.2005, at 22–142.
[5]T. Hervey and J. McHale, *European Union Health Law* (Cambridge University Press, 2015), 130.
[6]Article 56a of Directive 2013/55/EU amending Directive 2005/36/EC on the recognition of professional qualifications, OJ L 354, 28.12.2013, p. 132–170.
[7]But see Hervey and McHale, above, n. 5, 148–150, and Peeters et al., above, n. 3, 619–620. For an earlier perspective, see H. Roscam Abbing, 'The right of the patient to quality of medical practice and the position of migrant doctors within the EU' (1997) 4 *European Journal of Health Law*, 347.
[8]Case C-475/11, *Kostas Konstantinides*, ECLI:EU:C:2013:542.

2 | THE INTERACTION BETWEEN MEDICAL PROFESSIONAL DISCIPLINE AND FREE MOVEMENT LAW

2.1 | A short introduction to medical professional discipline

In all EU Member States, access to the medical profession is regulated and the use of the title "medical doctor" is reserved to doctors who are registered and who are authorised to practise medicine as a doctor with basic training, a GP or a specialist. The fact that doctors have to be registered not only gives them the right to practise medicine, it also means that they have to comply with the relevant medical professional standards. These professional standards are laid down by the Member States at the national level. In doing so, some Member States provide a more dominant role to the State (which means that standards will be laid down in legislation), whilst others rely more on self-regulation by the medical profession.[9] There are different mechanisms to enforce compliance with medical professional standards. Patients can bring a claim in negligence – or in contract, if they were treated privately – against their doctor if they feel that their treatment fell below the required professional standards.[10] Public authorities can revoke the licence of hospitals or clinics through administrative law.[11] In extreme cases, criminal law can be used if the behaviour of doctors fell so significantly below the expected professional standards that the application of criminal law would be justified.[12] Each of these mechanisms involves different actors and seeks to protect different aims (compensation for harm, protection against harm, deterrence, etc).

Another important mechanism that is used to enforce professional standards is medical professional discipline. The aim of medical professional discipline is to protect the quality of healthcare provided to patients. As such, professional discipline falls somewhere between civil and criminal law.[13] The aim is not to "punish" bad doctors or to compensate aggrieved patients – the focus is on improving the quality of healthcare in a more general way. If doctors fail to comply with medical professional standards, disciplinary proceedings can be brought against them. By way of example, in the UK, the Medical Practitioners Tribunal Service (MPTS) hears a few hundred cases brought against doctors each year.[14] Various other cases are settled before the hearing stage, and interim sanctions might have been imposed in the meantime. In the Netherlands, in 2018, the five Regional Medical Disciplinary Tribunals received around 2000 complaints, of which around 500 resulted in a hearing.[15]

The way in which medical professional discipline is organised varies significantly across the EU.[16] Nevertheless, a number of common characteristics can be identified. Disciplinary cases can be brought directly by patients or by a healthcare regulator. For example, in the UK, all disciplinary cases are brought by the General Medical Council (GMC), the public regulator that is responsible for maintaining professional standards for doctors.[17] Although a case might have started with a complaint from an individual patient, the regulator is ultimately responsible for bringing proceedings. In the Netherlands, medical professional discipline has more of a private character. Cases are usually

[9]Hervey and McHale, above, n. 5, 131. See also B. van Leeuwen, *European Standardisation of Services and its Impact on Private Law* (Hart Publishing, 2017), 86–91.

[10]For the UK perspective, see J. Herring, *Medical Law and Ethics* (Oxford University Press, 2019), 102–147.

[11]J. Healy, *Improving Healthcare Quality and Safety: Reluctant Regulators* (Ashgate, 2011), ch. 4.

[12]O. Quick, *Regulating Patient Safety: The End of Professional Dominance* (Cambridge University Press, 2017), 108–127.

[13]This 'in-between position' of professional discipline can most clearly be observed in arguments about the applicable standard of proof in medical disciplinary cases, and in arguments about the applicability of the *ne bis in idem* rule to disciplinary proceedings. For the UK perspective, see D. Gomez, *Regulation of Healthcare Professionals* (Sweet and Maxwell, 2019). For the Dutch perspective, see J. Legemaate and J. Dute, *Handboek Gezondheidsrecht* (Boom, 2017), 65–70.

[14]For figures for the period 2013–2017, see General Medical Council, *Fitness to Practise Statistics 2017*. Available at https://www.gmc-uk.org/-/media/documents/fitness-to-practise-statistics-report-2017_pdf-76024327.pdf (accessed 7 June 2020).

[15]See Tuchtcolleges voor de Gezondheidszorg, *Jaarverslag 2018*. Available at https://magazines.tuchtcollege-gezondheidszorg.nl/jaarverslagen/2018/01/index (accessed 7 June 2020).

[16]I. Risso-Gill, 'Assessing the Role of Regulatory Bodies in Managing Health Professional Issues and Errors in Europe' (2014) 26 *International Journal for Quality in Health Care*, 348–349.

[17]The GMC is responsible for supervising all doctors who provide medical care in the UK, whether in the NHS or in private practice.

brought directly by individual patients.[18] Although it is possible for the public regulator to bring a case, it will only do so in extreme cases.[19] The private character of medical disciplinary proceedings in the Netherlands makes it more difficult to focus on the improvement of the quality of healthcare, because the reasons why patients bring disciplinary proceedings – such as wanting compensation or vengeance – are not necessarily directly linked to the general improvement of the quality of care provided by doctors.[20]

An important characteristic of medical professional discipline is that doctors are judged by their fellow professionals. Therefore, some of the judges will always have a medical background. These judges are assisted by lay judges or judges with a legal background. The tribunal is responsible for assessing whether the doctor's actions have fallen below the required medical professional standards. Although the sanctions that disciplinary tribunals can impose are different across the Member States, the "catalogue" of disciplinary sanctions is usually similar. The lowest sanction is to impose a warning or reprimand, which indicates that the doctor's actions have fallen only just below the expected professional standards. In more serious cases, conditions can be imposed on a doctor's practice. A doctor's right to practise can also be temporarily suspended. The most serious sanction is to "erase" or "strike off" a doctor from the medical register. In such cases, the doctor will no longer be entitled to practise medicine. Overall, although there is diversity in the professional standards that doctors have to comply with, there is significantly more convergence in the sanctions that can be imposed by disciplinary tribunals across the EU.[21]

2.2 | The moving doctor, medical professional discipline and free movement law

The fact that doctors are registered to practise means that they are subject to medical professional discipline, and that they have to comply with the relevant professional standards. For doctors who want to practise in another Member State from the one where they qualified, the EU has adopted Directive 2005/36/EC on the recognition of professional qualifications ("the Professional Qualifications Directive").[22] In simple terms, it provides that medical doctors who are qualified in a Member State have the right to have their qualifications recognised in other Member States and to practise as a doctor without having to complete additional training. Although the EU has regulated *access* to the medical profession through the Professional Qualifications Directive, the *conditions* under which medical doctors work in another Member State after they have moved are regulated only to a very limited extent.[23] The scope and impact of the Professional Qualifications Directive will be analysed in more detail below, but one of its important characteristics is that Member States remain responsible for the organisation of medical professional discipline.[24] Therefore, Member States remain free to subject doctors to medical professional discipline and to adopt medical professional standards at the national level. The Professional Qualifications Directive imposes an obligation on Member States to exchange information about disciplinary sanctions taken against doctors if their right to practise has been restricted or suspended.[25] However, EU law does not directly regulate the *substance* of medical professional discipline.

[18]In the Netherlands, the claimant must have a direct interest in bringing the case. This is usually the patient or their family, but it could also be a colleague of the doctor.

[19]If a patient has died because of the alleged failure to comply with the relevant professional standards, there is a strong presumption that proceedings will be brought by the public regulator. Another type of case where proceedings are often brought by the regulator is where a doctor had a sexual relationship with a patient. In such cases, the patient does not necessarily want to start disciplinary proceedings.

[20]Legemaate and Dute, above, n. 13, 583. See also R. van Leeuwen and B. Schudel, 'Tuchtrecht gaat over betere zorg' (2018) 23 *Medisch Contact*, 32.

[21]Risso-Gill, above, n. 16, 355.

[22]Directive 2005/36/EC on the recognition of professional qualifications, OJ L 255, 30.9.2005, at 22–142.

[23]M. Peeters, 'Free Movement of Medical Doctors: The New Directive 2005/36/EC on the Recognition of Professional Qualifications' (2005) 11 *European Journal of Health Law*, 386, 387.

[24]Articles 5 and 6 of the Professional Qualifications Directive. See also recital 8.

[25]Article 56 of the Professional Qualifications Directive.

There are essentially three types of "moving doctors" who exercise their free movement rights to practise in another Member State ("the host Member State") from the one where they qualified ("the home Member State"). First, a doctor can find employment in another Member State on a permanent basis and rely on Article 45 TFEU – the right to work freely in another Member State. Second, a doctor can establish himself or herself in another Member State as a self-employed medical practitioner. Self-employed doctors in another Member State rely on Article 49 TFEU – the right to freedom of establishment. Finally, doctors can provide services in another Member State on a temporary basis without permanently establishing themselves in that Member State. In such cases, doctors are exercising their right to freely provide services in another Member State under Article 56 TFEU.

The relationship between the moving doctor and medical professional discipline can be different depending on the type of moving doctor involved. Doctors who are employed or self-employed in another Member State are working there on a permanent basis. As a result, they will have to register and they will be subject to medical professional discipline in the host Member State.[26] They might also still be subject to medical professional discipline in their home Member State. However, this would only be the case if they continued to be registered as a doctor in the home Member State. The decision to keep the registration in the home Member State would be a voluntary decision made by the doctor – it is possible to be registered in multiple Member States. Since Member States are encouraged to exchange information about continuing professional development,[27] it is possible for doctors to maintain their registration in a Member State where they are not actually working. If disciplinary sanctions are imposed on a doctor by the host Member State, the home Member State could decide to recognise these sanctions or to take action as a result of the disciplinary proceedings in the host Member State. In such cases, the doctor would be subject to a double regulatory burden. After all, both the host and the home Member State could impose sanctions against the doctor. This double burden could be regarded as a restriction on free movement.

For doctors who are providing services in another Member State on a temporary basis, the situation is different. Service providers always continue to be registered in their home Member State. The question whether they should also be registered in the host Member State is regulated by the Professional Qualifications Directive. Article 5(3) of the Directive provides that the service provider shall be subject to "professional rules of a professional, statutory or administrative nature which are directly linked to professional qualifications" in the host Member State. This includes "disciplinary provisions which are applicable in the host Member State to professionals who pursue the same profession in that Member State". Article 6 of the Directive makes it possible to require service-providing doctors to register in the host Member State on a temporary basis to make it possible to apply disciplinary provisions to them.[28] For these doctors, the double regulatory burden is imposed by the host Member State. However, the Professional Qualifications Directive expressly allows this double burden in the circumstances set out in Article 5(3). The relationship between Article 5(3) of the Directive and Article 56 TFEU will be analysed below.

It is possible for moving doctors to claim that disciplinary proceedings brought against them constitute a restriction on their free movement rights – whether under Article 45, Article 49 or Article 56 TFEU. In doing so, the doctor would be using free movement law as a "shield" to disciplinary proceedings. Two different types of free movement arguments can be made. The first would be for a doctor to argue that a double regulatory burden is imposed by the fact that disciplinary proceedings are brought in two Member States. This would be an argument *in abstracto* – the application of a second set of disciplinary rules would be regarded as a restriction on free movement. The substance of the disciplinary provisions would not be relevant. This argument could be made by service

[26]For established doctors, registration requirements are not even expressly regulated by the Professional Qualifications Directive.
[27]Amendments to Articles 22 and 56 introduced by Directive 2013/55/EU.
[28]Article 6(a) of the Professional Qualifications Directive.

providers against the host Member State, or by employed or self-employed doctors against their home Member State. It would be particularly relevant in cases where the home Member State automatically recognises a disciplinary sanction that has been imposed by the host Member State. A second free movement argument could be to submit that the way in which disciplinary proceedings are brought against doctors constitutes a restriction of their free movement rights. This would not be an abstract claim, but it would be based on the *substance* of the disciplinary provisions applied against them. This second type of claim can be made by all types of moving doctors and can be invoked against the home or host Member State. For example, a doctor can argue that disciplinary provisions in the host Member State discriminate against non-national doctors, or deter doctors from exercising their free movement rights. Alternatively, doctors could claim that disciplinary proceedings brought in the home Member State deter them from exercising their free movement rights, or discriminate against doctors who have exercised their free movement rights.

The analysis of *Konstantinides* below shows that the CJEU does not accept the abstract double burden argument.[29] The fact that doctors are subject to medical professional discipline in different Member States does not in itself constitute a restriction on free movement. However, the CJEU is prepared to scrutinise the way in which disciplinary provisions are applied to moving doctors. This approach will be analysed in the next sub-section.

2.3 | The Professional Qualifications Directive and its interaction with Article 56 TFEU: *Konstantinides*

There have hardly been any cases before the CJEU where a doctor who had moved to another Member State relied on free movement law to challenge disciplinary proceedings in the host or home Member State. The only exception is *Konstantinides.* Dr Konstantinides was a Greek urologist who travelled to Germany for one or two days per month to perform complicated surgery in a private clinic in Darmstadt. After a patient had complained about the high fees for his treatment, the regional German professional association decided to bring disciplinary proceedings against Dr Konstantinides. It argued that he had breached the relevant disciplinary rules in two ways.[30] First, Dr Konstantinides had charged an excessive price for the treatment. Second, he had advertised his services in Germany as being provided by a German and European "Institute". This created the perception of a permanent infrastructure with a link to scientific research. According to the profession association, this was misleading and likely to confuse patients. In his defence, Dr Konstantinides' principal submission was that the Professional Qualifications Directive prevented the German association from bringing disciplinary proceedings against him in Germany. Such proceedings would have to be brought in Greece.[31] This was essentially the abstract double burden argument outlined above. The German disciplinary tribunal submitted a number of preliminary questions about the interaction between the Professional Qualifications Directive and medical professional discipline to the CJEU.

The main question for the CJEU was whether the disciplinary proceedings in this case fell within the scope of Article 5(3) of the Professional Qualifications. If they did, it was argued that the disciplinary proceedings would be explicitly protected by that provision and would not constitute a restriction on free movement. Article 5(3) provides that:

"Where a service provider moves, he shall be subject to professional rules of a professional, statutory or administrative nature which are directly linked to professional qualifications, such as the definition of the profession, the use of titles and serious professional malpractice which is directly and specifically linked to consumer protection and safety, as well as disciplinary provisions applicable in the host Member State to professionals who pursue the same profession in that Member State".

[29]Case 475/11, *Konstantinides*, above, n. 8, para. 49.
[30]Ibid., paras. 22–26.
[31]Ibid., para. 27.

The CJEU held that "the object and purpose" of the Professional Qualifications Directive dictated that disciplinary rules would only be covered by Article 5(3) if they were "directly linked to the actual practice of medicine and failure to observe them harms the protection of patients".[32]

This is a restrictive interpretation of Article 5(3), which ignores the fact that the term "such as" appears to provide a non-exhaustive list of examples of professional rules. Furthermore, the CJEU decided to make a direct link between the last part of Article 5(3) on disciplinary provisions, and the previous part on serious malpractice directly linked to consumer protection and safety.[33] According to the CJEU, doctors would be subject to disciplinary rules in the host Member State only if these rules were directly linked to consumer protection and safety. This interpretation of Article 5(3) appears to be heavily influenced by recital 8 of the Professional Qualifications Directive.[34] However, a more convincing interpretation of the wording of Article 5(3) would be that the part on disciplinary provisions is separate and not restricted to rules that are specifically linked to consumer protection and safety. This would suggest that service-providing doctors are subject to all disciplinary rules in the host Member States.

Furthermore, the CJEU seems to assume that Article 5(3) provides a "safe haven" to disciplinary provisions that are directly linked to the actual practice of medicine.[35] However, Article 5(3) only provides that service providers "are subject to" disciplinary provisions in the host Member State. It does not in any way deal with the *substance* of these disciplinary provisions. In other words, Article 5(3) rules out a double burden argument, but it does not rule out a substantive argument. It could still be argued that *the way in which* disciplinary provisions – whether linked to the actual provision of medicine or not – are applied to service providers constitutes a restriction of Article 56 TFEU.

After concluding that Article 5(3) of the Professional Qualifications Directive was not applicable to this case, the CJEU proceeded to analyse the case under Article 56 TFEU.[36] Interestingly, neither Dr Konstantinides nor the German disciplinary tribunal had raised the possibility of a challenge of the German disciplinary provisions under Article 56 TFEU. The CJEU also rejected the double burden argument under Article 56 TFEU.[37] However, the application of the German rules on prices could constitute a restriction on free movement – in particular, if the rules lacked any flexibility. Such a lack of flexibility could have a deterrent effect on doctors from other Member States.[38] It was for the referring court to determine whether this was the case. If it found a restriction, this restriction could still be justified if it pursued a legitimate objective and was proportionate. The CJEU also held that the German rule that prohibited misleading or unprofessional advertising constituted a restriction on free movement, which could be justified on the grounds of public health and consumer protection if the application of the rule was proportionate.[39] Again, this assessment had to be made by the national court.

Overall, *Konstantinides* shows that moving doctors can rely on free movement law to challenge disciplinary proceedings against them. Whilst the CJEU dismissed the double burden argument, the *substance* and the *application* of disciplinary provisions to doctors from other Member States can be reviewed under the free movement provisions. The intensity of that review will depend on the intensity of the proportionality review, which, in *Konstantinides*, was left to the national court. In section 3, we will analyse the impact of *Konstantinides* in Germany. Furthermore, we will look at the extent to which doctors rely on free movement law before national courts in the UK and the Netherlands. However, before this analysis is conducted, the impact of Directive 2013/55/EU will be discussed.

[32]Ibid., paras. 38–39.
[33]Ibid., para. 40.
[34]Ibid., paras. 37–38.
[35]Ibid., para. 36.
[36]Ibid., para. 43.
[37]Ibid., para. 48.
[38]Ibid., para. 49.
[39]Ibid., paras. 51–52.

2.4 | Directive 2013/55/EU and the new Alert Mechanism

It is clear from the Professional Qualifications Directive that Member States remain free to determine the disciplinary rules that are applicable to medical doctors and to subject doctors from other Member States to those rules. Medical professional discipline remains a national competence without any kind of European harmonisation.[40] Nevertheless, *Konstantinides* showed that the application of disciplinary rules to moving doctors can be reviewed under the free movement provisions. The risk of leaving medical professional discipline entirely to individual Member States is that doctors might be able to "escape" the reach of national disciplinary systems by simply moving to another Member State. If a doctor has been prohibited from practising in one Member State, they could still try to practise as a doctor in another Member State. The possibility of free movement not only provides an opportunity for Member States to attract good doctors, it also poses a serious risk that "rotten apples" will exercise their free movement rights to escape sanctions imposed in the home or host Member State. In the last decade, this negative dimension of free movement of doctors has received more attention by EU policy makers and has resulted in the adoption of a number of EU instruments.

Article 56(2) of the Professional Qualifications Directive provided that "[t]he competent authorities of the host and home Member State shall exchange information regarding disciplinary action or criminal sanctions taken or any other serious, specific circumstances which are likely to have consequences for the pursuit of activities under this Directive".[41] This obligation to exchange information did not prove to be sufficient to prevent doctors against whom disciplinary sanctions had been adopted in one Member State from continuing to practise in other Member States. Moreover, the precise scope of the obligation to exchange information was unclear.[42] Because of the lack of EU competence in this field, there is no automatic recognition of disciplinary sanctions. The question of how Member States respond to a disciplinary sanction imposed by another Member State is determined entirely at the national level. However, with the increase of free movement of doctors in the last decades,[43] it is important that Member States exchange information about serious disciplinary sanctions against doctor on a continuous basis.

Against this background, Directive 2013/55/EU was adopted to provide more substance to the obligation to exchange information in the Professional Qualifications Directive. The main change for medical professional discipline was that it introduced an Alert Mechanism.[44] The new Article 56(a) provides that "the competent authorities of a Member State shall inform the competent authorities of all other Member States about a professional whose pursuit on the territory of that Member State of the following professional activities in their entirety or parts thereof has been restricted or prohibited, even temporarily, by national authorities or courts". This information is exchanged through the Internal Market Information (IMI) system, which is a general IT system for public authorities of the Member States to exchange information relating to the functioning of the internal market.[45] In 2015, the Commission adopted Implementing Regulation 2015/983 to provide more detailed rules on the application of the Alert Mechanism.[46] The Alert Mechanism has been in force since January 2016. In 2018, the Commission published a Staff Working Document in which it evaluated the functioning of the Alert Mechanism.[47] Since January 2016, 4,286 alerts had been sent by Member State public authorities concerning disciplinary sanctions taken against doctors – a bit more than 30% of all alerts sent through the Alert Mechanism.[48] The United Kingdom

[40]See Article 168(7) TFEU.
[41]Article 56(2) of the Professional Qualifications Directive.
[42]Recital 29 of the preamble of Directive 2013/55/EU.
[43]See I. Glinos, 'Health Professional Mobility in the European Union: Exploring the Equity and Efficiency of Free Movement' (2015) 119 *Health Policy*, 1,529.
[44]Article 56(a)(1) of the Professional Qualifications Directive.
[45]Article 56(a)(2) of the Professional Qualifications Directive.
[46]Commission Implementing Regulation (EU) 2015/983 on the procedure for issuance of the European Professional Card and the application of the alert mechanism pursuant to Directive 2005/36/EC, OJ L 159, 25.6.2015, at 27–42.
[47]European Commission, 'Assessment of stakeholders' experience with the European Professional Card and the Alert Mechanism procedures', SWD(2018) 90 final.
[48]Ibid., 17.

had submitted the majority of all alerts in the EU (67.5%, for all professions covered by the Alert Mechanism) and ten Member States had not yet sent any alerts.[49] A significant majority (79%) of the public authorities that used the Alert Mechanism was satisfied with how it worked.[50]

The Alert Mechanism helps Member States to identify doctors against whom disciplinary sanctions have been adopted. However, the *impact* of this exchange of information is not regulated by EU law. In some Member States, a sanction imposed by another Member State may lead to an investigation into the question whether the doctor should still be allowed to practise. In other Member States, national law might provide for the automatic recognition of disciplinary sanctions imposed by other Member States. The increased exchange of information between Member States through the Alert Mechanism makes it more likely that action will be taken by one Member State as a result of disciplinary sanctions imposed by another Member State. This is where free movement law plays an important role. Doctors can argue that the automatic recognition of foreign sanctions breaches their free movement rights. Alternatively, they can submit that the non-recognition of a foreign sanction creates an obstacle to free movement. In both scenarios, free movement law would be relied on as a defence to disciplinary proceedings – in a similar way to *Konstantinides*. This type of recognition cases will be analysed in more detail in the next section.

3 | FREE MOVEMENT LAW AS A "SHIELD" TO MEDICAL DISCIPLINARY PROCEEDINGS

The previous section focused on developments at the European level. The aim of this section is to investigate whether and to what extent doctors rely on free movement law in medical disciplinary proceedings before national courts or tribunals, and what impact free movement law arguments have on disciplinary proceedings. Although *Konstantinides* is still the only case before the CJEU in which disciplinary proceedings against doctors were challenged under free movement law,[51] it is possible that such challenges are frequently made at the national level. Furthermore, *Konstantinides* could provide an incentive for doctors to rely on free movement law. Cases in three Member States will be analysed to investigate the role of free movement law in medical disciplinary cases.[52] As a starting point, we will look at what happened when *Konstantinides* returned to Germany after the CJEU's judgment. The next step will be to analyse the role of free movement law in appeals to disciplinary sanctions in the UK. Finally, we will discuss the role of free movement law in Dutch cases on the automatic recognition of disciplinary sanctions imposed by other Member States.

3.1 | Disciplinary proceedings against service providers in the "host" Member State: The impact of *Konstantinides* in Germany

The message given by the CJEU to the German disciplinary tribunal ("the *Berufsgericht*") in *Konstantinides* was clear: it was for the national court to determine whether the German rules on prices for medical treatment constituted a restriction of Article 56 TFEU, whether they could be justified and whether they were proportionate.[53] The issue whether they constituted a restriction had to be determined by looking at the flexibility of the rules and their impact on foreign doctors who wanted to provide medical services in Germany. The *Berufsgericht* found that the German rules did not provide any indication to Dr Konstantinides as to the appropriate price for the treatment that he provided,

[49]Ibid., 20.

[50]Ibid., 38. In March 2019, the Commission announced that it had initiated infringement proceedings against fourteen Member States because they had not (correctly) implemented the Alert Mechanism. See https://europa.eu/rapid/press-release_IP-19-1479_en.htm (accessed 7 June 2020).

[51]Disciplinary proceedings against lawyers have more regularly 'made it' to the CJEU. For an interesting recent example on Greek rules preventing monks from practising as a lawyer, see Case C-431/17, *Monachos Eirinaios*, ECLI:EU:C:2019:368.

[52]Germany was selected to investigate what happened after the CJEU's judgment in *Konstantinides*. The UK and the Netherlands were selected because they have different approaches to the recognition of disciplinary sanctions imposed by other Member States. Moreover, the decisions of disciplinary tribunals in the UK and the Netherlands are easily accessible online.

[53]Case 475/11, *Konstantinides*, above, n. 8, para. 58.

because it was not a kind of treatment that was already provided in Germany.[54] This uncertainty about the correct price – or range of prices – made it more likely that disciplinary proceedings would be brought against foreign doctors because they had charged prices that were considered excessive under the German rules. As such, it deterred foreign doctors from providing medical services in Germany and constituted a restriction of Article 56 TFEU.[55] The *Berufsgericht* did not discuss or analyse the potential ground of justification for this restriction. It simply held that it was not necessary to apply the German disciplinary rules to foreign doctors since it was sufficient for patients to rely on private law to challenge the price arrangement between doctor and patient.[56] In other words, patients could bring a contractual claim against their doctor and it was not necessary for medical professional discipline to be involved.

The *Berufsgericht*'s assessment of the restriction and proportionality was a joint assessment under German constitutional law and EU law.[57] It adopted a very broad-brush approach and did not follow the structure suggested by the CJEU (restriction, ground of justification and proportionality). As a result, the German professional association was unable to apply the German rules on prices to Dr Konstantinides, and it will be unable to apply these rules to foreign service-providing doctors in the future. The application of the free movement provisions made it impossible for the German professional association to apply a particular medical disciplinary rule to foreign service-providing doctors. Three observations should be made. First, the *Berufsgericht* did not follow the guidance provided by the CJEU. It did not engage in a detailed analysis of the proportionality of the restriction and it did not even identify a ground of justification. The most likely explanation is that the *Berufsgericht* was not used to dealing with free movement cases, and that it decided to base its judgment primarily on German constitutional law. Second, this broad-brush approach worked out in favour of the service-providing doctor. The *Berufsgericht* might have adopted a defensive approach to prevent any future challenges to the German professional rules. Consequently, the German disciplinary rules had to give way without too much consideration of their purpose or effect. Third, the *Berufsgericht*'s finding that the application of the German rules to foreign doctors was not necessary because private law provided a sufficiently effective remedy failed to take the aim of medical professional discipline into account. Medical professional discipline is not about providing compensation to patients – its primary aim is to improve the quality of healthcare provided by doctors. From that perspective, it is at least doubtful whether a private law action constitutes an effective alternative to disciplinary proceedings. A private law action does not necessarily seek to achieve the same general aim as disciplinary proceedings.

The *Berufsgericht* adopted a similar approach to the German rule that prohibited misleading advertising. The CJEU had found that this rule restricted Dr Konstantinides' right to freely provide services in Germany.[58] However, the *Berufsgericht* did not analyse the potential ground of justification and the proportionality of the restriction. It only held that Dr Konstantinides had breached the rules by giving the impression that he provided his services in a research-active institute with a permanent infrastructure.[59] He was reprimanded for this breach.

3.2 | Disciplinary proceedings against established doctors in the "host" Member State: The UK perspective

The UK was one of the Member States with a very high percentage of EU doctors.[60] It was also a Member State with a high number of medical disciplinary proceedings brought before the MPTS.[61] This is confirmed by the high number

[54] *VG Giessen*, Judgment of 11 March 2015–21 K 1976/13.GI.B, para. 33.
[55] Ibid., para. 34.
[56] Ibid.
[57] Ibid., para. 31.
[58] Case 475/11, *Konstantinides*, above, n. 8, para. 56.
[59] *VG Giessen*, Judgment of 11 March 2015, above, n. 54, paras. 36–38.
[60] R. Young, 'A Major Destination Country: The United Kingdom and its Changing Recruitment Policies', in M. Wismar et al. (eds.), *Health Professional Mobility and Health Systems* (WHO, 2011), 295–336. The high number of EU doctors in the UK has received a lot of attention after Brexit. See British Medical Association, *The Impact of Leaving the EU on Patients* (Brexit Briefing).
[61] See General Medical Council, above, n. 14.

of alerts submitted by the UK through the Alert Mechanism.[62] A search of all MPTS decisions did not reveal any cases in which arguments based on free movement law had been made. Therefore, we decided to go one level higher in the judicial hierarchy and to investigate all appeals against decisions of the MPTS to the High Court (Administrative Court) over a period of a bit more than ten years.[63] Between 1 January 2009 and 1 July 2019, 428 appeals were brought. In forty of these cases, the appeal was brought by a doctor with a medical qualification from another EU Member State. Because the nationality of the doctor could not always be ascertained, all forty cases were included in the analysis. These forty doctors were all working in the UK on a permanent basis – either as employed doctors in the National Health Service or in private practice. In only two of the forty cases did the doctor raise an explicit argument based on free movement law.[64] These arguments were based either on the free movement provisions or on the Professional Qualifications Directive. Because this was a very low number, all forty cases were analysed to discover whether any doctors had made arguments that were substantively based on free movement law, although no express mention was made of the free movement provisions or the Professional Qualifications Directive. The test to identify a "substantive free movement argument" was whether the doctor had argued that they had been discriminated against based on their nationality, or whether the disciplinary proceedings made it less attractive or more difficult for them to practise as a doctor in the host or home Member State. Another six cases were identified and included in the analysis.

There is no clear pattern in the eight appeals in which (substantive) free movement arguments were raised. Nevertheless, they can be divided into three categories. The first category contains two cases about the way in which the MPTS took sanctions imposed by the home Member State into account in proceedings in the UK (the host Member State).[65] These cases will be analysed in more detail below. A second category contains two cases about disciplinary proceedings which had been conducted in the absence of a foreign doctor, who worked in their home Member State at the time of the proceedings.[66] Their argument was essentially that more should have been done by the GMC to ensure that the doctor could have been present during the proceedings. In both cases, the free movement arguments were dismissed because the registered addresses of the doctors were known and they could or should have been aware of the proceedings against them. The third category of cases is a residual category and contains four cases in which a variety of free movement arguments were made. In one case, a Dutch doctor unsuccessfully argued that the disciplinary proceedings brought against him were the result of a conspiracy against EU doctors in the UK after Brexit.[67] In a second case, a German doctor claimed that a requirement for EU doctors to register with the Care Quality Commission in the UK constituted a restriction of his free movement rights.[68] In fact, no such requirement existed. In the third case, a doctor complained about the alert that the GMC had circulated through the IMI system after he had been erased from the medical register in the UK.[69] His argument was that the alert contained incorrect and misleading information, which damaged his reputation and made it more difficult for him to practise as a doctor elsewhere. The judge found that the alert contained no incorrect or misleading information. In a fourth and final case, a Romanian doctor complained that the length of the disciplinary proceedings brought against her – she was still waiting for the final hearing of her case – had a negative impact on her ability to practise elsewhere in the EU.[70] She also argued that it was unclear what language requirements she had to comply with. Both arguments were dismissed until the final hearing.[71]

[62]European Commission, above, n. 47, 20.

[63]Westlaw was used for this search and the search term to identify relevant cases was 'General Medical Council' as a party to the case.

[64]*R (on the application of Alhy) v. General Medical Council* [2011] EWHC 2277 (Admin) and *R (on the application of Waghorn) v. General Medical Council* [2012] EWHC 3427 (Admin).

[65]*Alhy* and *Fopma v. General Medical Council* [2018] EWHC 714 (Admin).

[66]*Gerstenkorn v. General Medical Council* [2009] EWHC 2682 (Admin) and *General Medical Council v. Adeogba and Visvardis* [2016] EWCA Civ 162.

[67]*IJsselmuiden v. General Medical Council* [2018] EWHC 1199 (Admin).

[68]*Waghorn v. General Medical Council* [2014] EWHC 1214 (Admin).

[69]*Madu v. General Medical Council* [2017] EWHC 3163 (Admin).

[70]*General Medical Council v. Curca* [2013] EWHC 4482 (Admin).

[71]Unfortunately, the final hearing before the MPTS was not reported.

The most interesting cases from the UK were the two cases where disciplinary sanctions had been imposed in the doctor's home Member State. These sanctions then led to disciplinary proceedings in the UK. The UK does not automatically recognise sanctions imposed by other Member States. However, they can lead to an investigation by the GMC, which may decide to bring disciplinary proceedings.[72] In both cases, the primary argument of the doctors was that the MPTS should have taken the outcome of disciplinary proceedings in the home Member State into account in deciding what sanction should be imposed in the UK. In *Alhy*, a French doctor had been convicted of two offences in relation to the death of his patients in France. One of these offences was gross negligence manslaughter; the other was non-assistance to a person in danger.[73] He received a suspended prison sentence and was banned from working as a surgeon in France for three years. He was not banned from working as a doctor with basic training. Dr Alhy failed to declare these sanctions to the GMC. Disciplinary proceedings were brought against him in the UK and he was erased from the medical register. Dr Alhy's argument was that Article 56(2) of the Professional Qualifications Directive required that the MPTS give reasons as to why it imposed a significantly higher sanction (erasure) than the French authorities had imposed (suspension as a surgeon, but he could continue to work as a doctor with basic training).[74] He submitted that the host Member State was under "a duty to explain and justify" why they had taken a different approach.[75] The High Court held that there was no hierarchy between sanctions imposed by the home and host Member State.[76] The MPTS would assess the case on the basis of the relevant disciplinary rules in the UK. Although the sanctions imposed in France were likely to be taken into account in the proceedings in the UK, there was no obligation under the Professional Qualifications Directive to justify why the MPTS had imposed a different sanction from the French authorities.[77]

Similarly, in *Fopma*, a Dutch surgeon had been convicted of sexual assault of a minor in the Netherlands. He received a suspended prison sentence.[78] No disciplinary sanctions were imposed in the Netherlands. After his conviction, he moved to the UK and registered as a surgeon with the GMC. He did not declare his previous conviction in the Netherlands. Years later, the GMC became aware of his Dutch conviction and disciplinary proceedings were brought against him. After a hearing before the MPTS, he was erased from the medical register. Dr Fopma argued that the MPTS should have taken into account the fact that no disciplinary sanctions had been imposed in the Netherlands in reaching its decision.[79] Shortly after his conviction in the Netherlands, the Dutch authorities had decided that no disciplinary proceedings would be brought against him because he had made a commitment that he would no longer work as a doctor in the Netherlands. Moreover, after the MPTS had imposed the sanction of erasure, the Dutch authorities decided that Dr Fopma did not have to be struck off in the Netherlands. Although Dutch law provides for the automatic recognition of foreign sanctions, in this case, the Dutch authorities relied on the hardship clause – which will be discussed in more detail below – to depart from the principle of automatic recognition. The High Court held that the decision of the Dutch authorities not to bring disciplinary proceedings had been based on different considerations, since Dr Fopma had always been honest with the Dutch authorities.[80] Moreover, Dr Fopma had made a commitment not to work as a doctor in the Netherlands. Therefore, the factual background to the decision in the Netherlands was different. In any event, the MPTS was under no obligation to follow or to attach particular weight to the decision of the Dutch regulator.[81]

In both cases, the doctors complained about the lack of recognition of disciplinary proceedings in the home Member State. The doctors did not claim that the same sanction should be imposed in the host Member State – they

[72]See General Medical Council, *The European Alert Mechanism: Sending Alerts on Doctors with Restrictions or Prohibitions on their Practice* (May 2018).
[73]*Alhy*, above, n. 64, paras. 12–13.
[74]Ibid., para. 18.
[75]Ibid., para. 32.
[76]Ibid., para. 43.
[77]Ibid., para. 48.
[78]*Fopma*, above, n. 65, para. 5.
[79]Ibid., para. 55.
[80]Ibid., paras. 64–68.
[81]Ibid., para. 69.

were not arguing for mutual recognition – but they argued that the disciplinary tribunal in the host Member State had to consider and investigate the sanction imposed by the home Member State. They did not criticise the double burden caused by regulatory proceedings in two Member States, but they submitted that there was an obligation to justify why a different sanction should be imposed in the host Member State. Although the judges in both cases held that there was no such obligation, they did in fact attempt to justify the imposition of a more severe sanction in the UK. In *Fopma*, the judge closely investigated the reasons why the Dutch authorities had not taken any disciplinary action against Dr Fopma and distinguished these from the circumstances in the UK.[82] In *Alhy*, the judge refused to look into the circumstances of the French sanction, but also found that Dr Alhy had shown a clear lack of insight and had failed to declare his conviction in the UK.[83]

Although Article 56 TFEU was not expressly relied on in either case, the doctors could have used it as a frame for their argument. A lack of recognition of a disciplinary sanction imposed in the doctor's home Member State and the imposition of a potentially more severe sanction in the host Member State constitutes a restriction on free movement, because it could prevent the doctor from practising in the host Member State. Even if the more severe sanction fell short of erasure, it would still make it more difficult or less attractive for doctors to practise in the host Member State. Such a restriction on free movement can be justified on the ground of the protection of patient safety and the quality of healthcare. However, for the restriction to be proportionate, the host Member State would be under an obligation to explain why it is necessary to impose a more severe sanction than the home Member State. This "duty to engage" with the decision of the home Member State is directly based on the free movement provisions. Free movement law requires that disciplinary tribunals engage with the sanction imposed by the home Member State, and explain and justify why a different sanction should be imposed in the host Member State. This will be analysed in more detail in section 4.

3.3 | Disciplinary proceedings in the "home" Member State: Mutual recognition of disciplinary sanctions in the Netherlands

In the Netherlands, foreign disciplinary sanctions adopted against doctors are automatically recognised.[84] This is not explicitly restricted to sanctions imposed by EU Member States. The recognition is automatic and the Minister of Health is not allowed to reconsider the decision of the foreign tribunal – i.e. to verify whether the decision taken abroad was correct. However, the Minister is required to look into the circumstances of that decision, and it is open to the Minister of Health to rely on a so-called "hardship clause" to refuse to recognise the foreign sanction.[85] Recognition should be refused if patient safety is not at risk and if the sanction abroad was imposed for conduct which would not lead to a disciplinary sanction in the Netherlands.[86]

In 2014, the Dutch Council of State – one of the courts of last instance for administrative appeals in the Netherlands – heard an appeal against the decision of the Minister of Health to strike off a doctor who had been erased by the GMC in the UK.[87] The reason for the erasure in the UK was that the doctor had used a controversial kind of stem cell therapy on patients with multiple sclerosis and Hodgkin's disease. The Council of State found that this treatment – whilst controversial – was not prohibited in the Netherlands at the time. No disciplinary action had been taken against the doctor in the Netherlands. As a result, it could not be argued by the Minister of Health that patient safety was at risk.[88] Because the conduct for which the doctor had been struck off in the UK was lawful in

[82] Ibid., paras. 64–69.
[83] *Alhy*, above, n. 64, paras. 46–48.
[84] Article 7.e. of the *Wet op de beroepen in de individuele gezondheidszorg* - 'Wet BIG' (Individual Healthcare Professions Act).
[85] Article 7(a)(1) of *Wet BIG*.
[86] *Memorie van Toelichting* (TK 2009–2010, 32,261, no. 3, p. 11).
[87] Judgment of the *Raad van State* of 17 September 2014, ECLI:NL:RVS:2014:3414.
[88] Ibid., para. 7.1.

the Netherlands, the Minister was under a duty to rely on the hardship clause to refuse to recognise the sanction imposed by the UK.

In 2015, the Council of State heard another appeal by a Dutch doctor who had been struck off in the UK, and who had automatically been struck off in the Netherlands because of the UK sanction.[89] The doctor had been required to complete a medical assessment in the UK, which had revealed that his professional skills were seriously deficient. He subsequently failed to comply with the conditions that had been imposed on his practice. Therefore, the MPTS had decided that erasure was the only appropriate sanction. The doctor argued that the Dutch Minister of Health was under an obligation to verify whether the sanction in the UK had been correctly imposed. According to the doctor, the Dutch legislation on automatic recognition was in breach of Article 56(2) of the Professional Qualifications Directive. The Council of State rejected this argument, because Article 56(2) only provides for an exchange of information between Member State authorities.[90] It did not require a full investigation or reconsideration of the sanction imposed by another Member State. Secondly, the doctor submitted that the system of automatic recognition constituted a breach of free movement law, because disciplinary sanctions could be adopted against Dutch doctors who were working in another Member State without these doctors being given the chance to defend themselves before a Dutch disciplinary tribunal.[91] The risk that a doctor would automatically lose his right to practise in the Netherlands because of a sanction imposed abroad made it less attractive for Dutch doctors to exercise their free movement rights. The Council of State accepted that the automatic recognition could constitute a restriction, since the doctor would no longer be able to practise in his home country, and, as a result, lose his right to work in other Member States.[92] However, this restriction could be justified on the ground of the protection of the safety of patients. Doctors who are not sufficiently capable should not be allowed to treat patients. This aim can only be achieved by prohibiting them from practising as doctors. Therefore, the appeal of the Dutch doctor was dismissed.[93]

Although it might seem counterintuitive to free movement lawyers, the Dutch cases show that the automatic recognition of disciplinary sanctions adopted by another Member State can also constitute a restriction on free movement. The free movement provisions might require that the automatic recognition of disciplinary sanctions imposed by another Member State is justified or even denied. Consequently, there has to be a degree of flexibility in the application of national rules on automatic recognition of foreign sanctions. In the Netherlands, this flexibility is provided by the hardship clause, which makes it possible for the Minister of Health to refuse to provide automatic recognition to a foreign sanction. The exercise of discretion under this hardship clause is controlled by free movement law.

In both Dutch cases, the automatic recognition of a disciplinary sanction imposed in the UK made it less attractive or even impossible for the doctors to exercise their free movement rights. If the doctors lost their right to practise in their home Member State, they would no longer be able to practise in other Member States because their free movement rights are based on the qualifications obtained in their home Member State. This automatic recognition of foreign sanctions can be justified on the ground of the protection of patient safety. However, the proportionality test still requires that Member States verify whether automatic recognition is suitable and necessary to serve its purpose – i.e. to protect the safety of patients. This is why Dutch law makes a connection between the hardship clause and patient safety. The Minister of Health has to exercise her discretion under the hardship clause if patient safety is not at risk. In the 2014 case, because the treatment provided by the doctor was allowed under Dutch law, the Minister of Health was held to be under a duty to exercise her discretion to refuse to recognise the sanction. Although no express reference was made to the free movement provisions, the role of free movement law

[89] Judgment of the *Raad van State* of 16 December 2015, ECLI:NL:RVS:2015:3818.
[90] Ibid., para. 5.2.
[91] Ibid., para. 6.
[92] Ibid., para. 6.1.
[93] Ibid. Another recent judgment of the Council of State dealt with a case that involved disciplinary proceedings in three Member States. The UK decided to erase a doctor after he had been struck off in Germany, and the Netherlands then automatically recognised the sanction imposed by the UK. See Judgment of the *Raad van State* of 6 February 2019, ECLI:NL:RVS:2019:345.

was explicitly recognised in the 2015 case. As a result, disciplinary tribunals – or regulators – are forced to engage in a comparison between the disciplinary rules in the home and host Member State. This comparative exercise is essentially similar to what is required in cases where there is a lack of recognition of foreign sanctions (such as in the UK).

4 | FREE MOVEMENT LAW AS A "FRAME" IN MEDICAL DISCIPLINARY PROCEEDINGS

Although the disciplinary rules and the factual circumstances of the cases in Germany, the UK and the Netherlands were different, some general conclusions can be drawn. In all three Member States, doctors either expressly or impliedly relied on free movement law as a defence to disciplinary proceedings. This defence forced the disciplinary tribunals to consider national disciplinary rules from the perspective of free movement law. The free movement provisions provided a "frame" for judicial reasoning.[94] It did not matter whether the case was about the substance of disciplinary rules applied to foreign doctors in the host Member State (*Konstantinides*), about the lack of recognition of foreign sanctions in the host Member State (*Alhy* and *Fopma*) or about the automatic recognition of foreign sanctions by the home Member State (the Dutch cases). The application of disciplinary rules to foreign doctors or to national doctors who had exercised their free movement rights constituted a restriction on free movement, which had to be justified and proportionate. This structure of free movement law – i.e. restriction, justification and proportionality – can be identified in a number of cases. However, the level of detail of the analysis differed across the Member States and across the different cases. Moreover, in most cases, the national courts did not look beyond the provisions of the Professional Qualifications Directive. They ignored the possibility of reviewing national disciplinary rules directly under Article 56 TFEU. The aim of this section is to "dissect" the free movement frame in medical disciplinary cases and to analyse how the proportionality test can be applied to protect patient safety and the quality of healthcare.

From the aftermath of *Konstantinides* in Germany, it can be seen that the disciplinary tribunal was unfamiliar and uncomfortable with detailed arguments based on free movement law. Although the *Berufsgericht* was willing to engage with EU law and even made a preliminary reference to the CJEU, it did not conduct a detailed assessment of the justification and the proportionality of the restriction. Instinctively, one could argue that this unfamiliarity makes it less likely that free movement arguments by doctors are successful. However, in *Konstantinides*, the *Berufsgericht* clearly erred on the side of caution by not applying the German professional rule to foreign doctors. The court's unfamiliarity with free movement law worked to the advantage of the foreign doctor. The consequence of the cautious approach adopted by the disciplinary tribunal was that free movement law provided a shield to disciplinary proceedings. Article 56 TFEU prevented the German professional association from applying a particular disciplinary rule to foreign doctors. From the perspective of the quality of healthcare and the reputation of the medical profession in Germany, this conclusion is concerning. The ability of Member States to set their own medical professional standards and to apply them on their territory was restricted without a detailed assessment of the suitability and necessity of these rules.

Konstantinides shows that it is very important for national regulators to provide detailed information about the aims of disciplinary rules. This information is necessary to enable disciplinary tribunals to review the suitability and necessity of the rules under the proportionality review. The more information is provided, the easier it becomes for disciplinary tribunals to engage in a detailed proportionality review of the restriction. Such a detailed review is necessary to strike the right balance between the doctor's right to move freely between Member States and the ability of Member States to enforce their own medical disciplinary rules to protect patient safety and the quality of

[94]For a general analysis of the application of the proportionality test under Article 56 TFEU in the healthcare sector, see W. Gekiere, R. Baeten and W. Palm, 'Free Movement of Services in the EU and Healthcare', in E. Mossialos et al. (eds.), above, n. 3, 482–493. See also Hervey and McHale, above, n. 5, 150–152.

the medical profession. This level of detail has to be provided by the regulators that are defending the disciplinary rules. The broad-brush approach adopted in *Konstantinides* did not help the German regulator to defend its disciplinary rules.

The case law in the UK and the Netherlands shows that the most complicated free movement arguments are made in cases where the disciplinary systems of two Member States interact. Although the concept of mutual recognition was not explicitly referred to, these cases raised important questions about the lack of recognition or the automatic recognition of disciplinary sanctions imposed by other Member States. The decision whether to (automatically) recognise sanctions imposed by other Member States remains a choice that is made at the national level. However, this does not mean that free movement law is not applicable.[95] This applies both to non-recognition and automatic recognition of foreign sanctions. In both scenarios, the exercise of non-recognition or automatic recognition is controlled by free movement law. As a result, disciplinary tribunals should analyse these cases under Article 56 TFEU. They cannot focus exclusively on the provisions of the Professional Qualifications Directive, because the Directive does not regulate the *substance* and the *impact* of the application of medical disciplinary rules. Although this would not necessarily require a significant amount of additional reasoning, the analysis of the justification and proportionality of (the application of) disciplinary rules has to be more detailed and more explicit.

In particular, disciplinary tribunals are under an obligation to explain why it is necessary to impose a more severe sanction in the host Member State. As part of this exercise, they have to engage in a comparison between the disciplinary rules – and the judgments of disciplinary tribunals – in the home and host Member State. There is no presumption that the host Member State adopts the same sanction as the home Member State, but if a more severe sanction is adopted, the free movement provisions require that the host Member State justify why a stricter sanction should be imposed, and establish that this sanction is necessary to achieve its aim. The justification for a more severe sanction could be that the disciplinary rules in the host Member State are different or that the factual background to the decision is different. *Fopma* provides a good example. No disciplinary sanctions had been adopted against Dr Fopma in the Netherlands. An important aspect of the proceedings in the UK was that Dr Fopma had not declared his Dutch conviction to the GMC. The justification for imposing the sanction of erasure was that Dr Fopma had not been honest to the regulator. Therefore, to protect the integrity of the medical profession, it was necessary for Dr Fopma to be struck off. The restriction of Dr Fopma's free movement rights could be justified on that basis.

Overall, it is clear that free movement law plays an increasingly important role in medical disciplinary proceedings. Despite the lack of EU competence in this area, free movement law requires Member States to justify the application of national disciplinary rules in cases with a cross-border dimension. At the same time, the role of free movement law has not yet been "crystallised". The way in which national disciplinary tribunals and courts have dealt with free movement arguments is rather primitive. They do not always conduct their assessment in the framework of Article 56 TFEU. This makes it more difficult to conduct a detailed analysis of the justification and the proportionality of the disciplinary rules. Although Member States are granted a broad margin of discretion in deciding what kind of measures are necessary to protect the health of patients,[96] they have to make their decisions on the basis of evidence.[97] A more detailed application of the proportionality test is not only necessary to protect the free movement rights of doctors in an effective way, but also to ensure that Member States continue to be able to apply their national rules on medical professional discipline.[98] The aftermath of *Konstantinides* has highlighted the

[95]Despite the lack of competence of the EU to adopt harmonisation in a certain sector or field, this does not protect national rules from being reviewed under the free movement provisions. This has been a consistent line of case law in the sectors such as healthcare, education and social. See Case C-158/96, *Kohll*, ECLI:EU:C:1998:171, paras. 17–20.

[96]See J. Zglinski, 'The Rise of Deference: The Margin of Appreciation and Decentralised Judicial Review in Free Movement Law' (2018) 55 CMLR 1341, 1357–1359.

[97]N. Nic Shuibhne and M. Maci, 'Proving Public Interest: The Growing Impact of Evidence in Free Movement Law' (2013) 50 CMLR 965, 987–989. The importance of evidence has recently been emphasised by the CJEU in two free movement of goods cases: see Case C-333/14, *Scotch Whisky Association*, ECLI:EU:C:2015:845 and Case C-148/15, *Deutsche Parkinson Vereinigung*, ECLI:EU:C:2016:776

[98]Gekiere, Baeten and Palm, above, n. 94, 488. For an early analysis of the impact of the proportionality test on medical cases, see T. Hervey, 'Buy Baby: The European Union and Regulation of Human Reproduction' (1998) 17 *Oxford Journal of Legal Studies*, 207, 224–225.

risk that disciplinary tribunals disregard certain disciplinary rules because they fear that they cannot be justified under free movement law. This misunderstanding of how free movement law should be applied can potentially undermine the ability of Member States to protect patient safety and to promote the quality of healthcare at the national level. As a result, it is important that medical disciplinary tribunals receive more guidance on how the proportionality test should be applied. This will be analysed in more detail in section 6.

5 | COMPARING FREE MOVEMENT OF DOCTORS WITH FREE MOVEMENT OF PATIENTS

This section will analyse the broader impact of free movement law on medical professional discipline through a comparison with the case law on free movement of patients. While the number of free movement cases in medical professional discipline is low, a significant number of free movement of patients cases have reached the CJEU. What parallels can be drawn between free movement of patients and doctors, and what lessons can be learnt from the case law on free movement of patients? Two dimensions will be highlighted. First, by focusing on individual free movement rights, it has been argued that the case law on free movement of patients has led to a process of "consumerisation" of the patient. Second, the case law on free movement of patients has encouraged a process of internationalisation of quality standards for medical treatment. This section will analyse to what extent free movement law has a similar impact on medical professional discipline.

A regular criticism of the case law on free movement of patients is that the CJEU has favoured an approach based on individual patient rights over the ability of Member States to adopt their own rules on patient entitlements under national healthcare systems.[99] Free movement law has encouraged a process of consumerisation of the patient. Although this argument can be criticised for a lack of nuance,[100] it is clear that the case law provides a central role to the individual rights of patients.[101] The question is to what extent the literature on the consumerisation of patients can be applied to free movement of doctors. Does the impact of free movement law also lead to a highly individualised perspective on the rights of individual healthcare providers? If this were the case, the application of free movement law to medical professional discipline could lead to a process of deprofessionalisation[102] if doctors were able to rely on free movement law to prevent national disciplinary rules from being applied to them. This would be concerning if moving doctors were increasingly motivated by economic or commercial considerations.[103]

The cases analysed in this article do not show such a tendency. Dr Konstantinides could certainly be regarded as an entrepreneur – the doctor equivalent of the "consumer patient". His fees and advertising for treatments created the impression of a commercially driven medical professional. Because the German court held that the German rules on prices could not be applied to foreign doctors, it could even be argued that free movement law encouraged a process of deprofessionalisation of medical doctors. However, it should be emphasised that the decision not to apply the German rules to moving doctors was a decision made by the German disciplinary tribunal. This decision was not in any way imposed or encouraged by the CJEU. On the contrary, the CJEU was respectful of the German disciplinary rules, which could be justified if they were proportionate to their aim. The CJEU was willing to provide a broad margin of discretion to Member States in the field of medical professional discipline and protected the ability of Member States to uphold medical professional standards through the proportionality test.[104] As has been argued

[99]C. Newdick, 'Citizenship, Free Movement and Health Care: Cementing Individual Rights by Corroding Social Solidarity' (2006) 43 CMLR 1645.
[100]Hervey and McHale, above, n. 5, 73–97. See also F. De Witte, 'The Constitutional Quality of the Free Movement Provisions: Looking for Context in the Case Law on Article 56 TFEU' (2017) 42 ELR 313, 329–331 and M. Flear, 'Developing Euro-Biocitizens through Migration for Healthcare Services' (2007) 14 *Maastricht Journal of European and Comparative Law*, 239, 251–252. For an empirical rebuttal, see B. van Leeuwen, 'The Patient in Free Movement Law: Medical History, Diagnosis and Prognosis' (2019) 21 *Cambridge Yearbook of European Legal Studies*, 162.
[101]See A. de Ruijter, *EU Health Law and Policy* (Oxford University Press, 2019), 169–174. See also S. Greer and T. Sokol, 'Rules for Rights: European Law, Health Care and Social Citizenship' (2014) 20 *European Law Journal*, 66.
[102]See E. Freidson, *Profession of Medicine: A Study of the Sociology of Applied Knowledge* (University of Chicago Press, 1988).
[103]See O. Quick, above, n. 12, 16–18.
[104]See Zglinski, above, n. 96, 1347.

above, this requires a detailed analysis of the proportionality of the rules. The outcome in *Konstantinides* could have been avoided if the national court had conducted a more detailed proportionality review. The Dutch cases show that, when free movement law is applied to medical disciplinary cases, sufficient respect is paid to national disciplinary rules. Moreover, the doctors who relied on free movement law did not do so for commercial motives. As a result, it cannot be concluded that the application of free movement law in disciplinary proceedings has led to a process of deprofessionalisation of medical doctors.

Returning to the case law on patients, in *Kohll*[105] and *Decker*,[106] the CJEU established that patients have a right to receive medical treatment in another Member State if this treatment is covered by their home Member State's healthcare system or health insurance. If the medical treatment abroad involves a stay in hospital, Member States can impose a requirement that patients apply for prior authorisation. Prior authorisation can be refused if "the same or equally effective treatment" is available in the home Member State.[107] The requirement to obtain prior authorisation constitutes a restriction on free movement, which can be justified on the ground of the protection of the financial balance of the home Member State's social security system.[108] As a result, in order to establish whether a patient has a right to receive medical treatment abroad, national authorities or courts have to assess whether the treatment abroad is more effective than what can be provided in the home Member State – while still being covered by the patient's health insurance or healthcare system. This is not mutual recognition in the traditional sense of the word – the right to free movement of patients is based on the *differences* between national healthcare systems.[109] The rules developed by the CJEU have now been codified in the Cross-Border Healthcare Directive.[110]

Although the EU does not have the competence to harmonise the entitlements of patients under national healthcare systems,[111] free movement law requires that Member States engage in a detailed comparison between the types of medical treatments available and that they identify the differences between them. In *Geraets-Smits*, the CJEU held that this comparison has to be conducted on the basis of "international medical science".[112] In deciding whether an equally effective medical treatment is available in the home Member State, national courts or regulators cannot only consider national medical standards – they have to consider international scientific standards. This obligation leads to a process of Europeanisation or internationalisation of medical standards, because Member States are forced to determine the entitlements of patients in free movement cases on the basis of international standards.[113]

A similar kind of obligation could be imposed by the CJEU in the field of medical professional discipline. In *Konstantinides*, the CJEU could have held that in justifying the application of German disciplinary rules to Dr Konstantinides, the German professional association and courts had to take into account international standards on medical professional discipline. In deciding whether the application of the German disciplinary rules to Dr Konstantinides was suitable and necessary, the CJEU could have required the national court to assess whether these rules were in line with international or European standards on medical professional discipline. The CJEU did not impose such an obligation. This was probably because there are very few international or European standards on medical professional discipline.[114] Disciplinary rules are still primarily adopted at the national level. They are based on social, cultural and ethical considerations, which may be divergent across the EU. This is different for quality standards for medical treatment, which have become more internationalised in the last decades.[115] A significant

[105]Case C-158/96, *Kohll*, ECLI:EU:C:1998:71.
[106]Case C-120/95, *Decker*, ECLI:EU:C:1998:167.
[107]Case C-157/99, *Geraets-Smits and Peerbooms*, ECLI:EU:C:2001:404, para. 103.
[108]Ibid., para. 97.
[109]K. Nicolaidis, 'Mutual Recognition: Promise and Denial, from Sapiens to Brexit' (2017) 70 *Current Legal Problems*, 227, 255–256.
[110]Directive 2011/24/EU on the application of patients' rights in cross-border healthcare, OJ L 88, 4.4.2011, at 45–65.
[111]Article 168(7) TFEU.
[112]C-157/99, *Geraets-Smits*, paras. 94–98.
[113]B. van Leeuwen, 'The Doctor, The Patient and EU Law: The Impact of Free Movement Law on Quality Standards in the Healthcare Sector' (2016) 41 ELR 638, 642–644.
[114]See Risso-Gill, above, n. 16, 348.
[115]D. Sackett et al., 'Evidence Based Medicine: What It Is and What It Isn't' (1996) 71 *British Medical Journal*, 312.

number of evidence-based quality standards in the medical sector is adopted at the international level, and most national standards are based on the same international scientific evidence. Such an international source of standards does not exist in the field of medical professional discipline.

Nevertheless, the application of free movement law to medical professional discipline could indirectly encourage a process of Europeanisation of medical professional discipline. This would be through an obligation to compare disciplinary rules and judgments. The proportionality test requires Member States to justify the application of an additional set of disciplinary rules to doctors who have exercised their free movement rights. In doing so, they are required to engage with the disciplinary rules or decisions in other Member States. Even if there are very few international or European standards on medical professional discipline, this process of comparison could encourage Member States to learn from each other and to reconsider the aims or effectiveness of existing disciplinary rules. This could ultimately lead to the development of European standards in this field.

6 | EUROPEANISATION THROUGH PROPORTIONALITY: JUDICIAL DIALOGUES ON MEDICAL PROFESSIONAL DISCIPLINE

The analysis in the previous sections has shown that there has not been any harmonisation or mutual recognition of medical professional standards at the European level. This reflects the fact that the EU does not have the competence to harmonise the delivery of healthcare services.[116] So far, harmonisation at the European level has focused on the recognition of professional qualifications and the exchange of information through the Alert Mechanism. Nevertheless, through the application of the proportionality test in free movement cases, a more subtle – or softer[117] – form of Europeanisation is introduced.[118] The role of the principle of proportionality is to engage medical disciplinary tribunals in a comparative exercise. In reaching their decision in disciplinary cases with a free movement dimension, tribunals have to investigate the rules and decisions in other Member States. The focus of this investigation is initially on identifying the differences between Member States – differences that justify the imposition of a different or more severe sanction. Ultimately, however, this comparative exercise would not be limited to identifying differences between Member States – it would also lead to a more explicit and conscious dialogue on the similarities of medical disciplinary rules in different Member States. As a result, the judicial dialogues between national medical disciplinary tribunals would lead to a bottom-up process of Europeanisation of medical professional standards.[119]

It should be emphasised that the comparative exercise required by the proportionality test is not outcome-based – it does not determine a particular kind of outcome. Member States do not have to automatically recognise the sanctions adopted by other Member States. If the proportionality test is applied in the way that has been suggested in this article, the focus is on the *process* through which disciplinary tribunals reach their decision.[120] It would require a detailed assessment of the factual background to, and the substantive reasons for, the disciplinary sanction imposed by another Member State.[121] There is no expectation that a similar outcome will be reached, but the disciplinary tribunal has to explain why it is necessary to impose a more severe sanction or why a foreign

[116]See Article 168(7) TFEU.

[117]See S. Greer and B. Vanhercke, 'The Hard Politics of Soft Law: The Case of Health', in E. Mossialos et al. (eds), above, n. 3, 186–230.

[118]See T. Hervey, 'The Role of the European Court of Justice in the Europeanization of Communicable Disease Control: Driver or Irrelevant' (2012) 37 *Journal of Health Politics, Policy and Law*, 977.

[119]On Europeanisation through EU law, see F. Snyder (ed.), *The Europeanisation of Law: The Legal Effects of European Integration* (Hart Publishing, 2000). On Europeanisation through the case law of the CJEU, see A. Vauchez, 'The Transnational Politics of Judicialization: *Van Gend en Loos* and the Making of EU Polity' (2009) 19 *European Law Journal*, 1.

[120]B. van Leeuwen, 'Euthanasia and the Ethics of Free Movement Law: The Principle of Recognition in the Internal Market' (2018) 19 *German Law Journal*, 1417, 1430–1432.

[121]National disciplinary tribunals have to engage with the substance of the decision made in the other Member State. As such, a focus on the process is not the same as a procedural proportionality test, as proposed by Floris de Witte: F. de Witte, 'Sex, Drugs and EU Law: The Recognition of Moral and Ethical Diversity in the EU' (2013) 50 CMLR 1545, 1570–1575.

sanction should automatically be recognised. As such, tribunals are required to accentuate and make explicit the differences in medical professional standards.

This process for conducting the proportionality test provides sufficient room for Member States to adopt different approaches to medical professional discipline. It focuses on the interaction in working towards a decision – not on the outcome. As a result, Member States can continue to adopt their own definitions of how patient safety should be protected and how the quality of care provided by medical doctors can best be guaranteed. National courts would remain in control of the outcome of the proportionality assessment.[122] For example, in the UK cases, the imposition of a more severe sanction in the UK was justified because the medical doctors had been dishonest. They had not been dishonest in their home Member State. Similarly, in one of the Dutch cases, the Netherlands took a more tolerant approach (at the time) to an experimental kind of stem cell therapy. Therefore, the UK's sanction of erasure should not be automatically recognised. Free movement law does not require that these differences are eliminated, but free movement law requires that the differences are identified and justified.

For this process of Europeanisation of medical professional discipline to be effective, disciplinary tribunals should engage more regularly in a judicial dialogue with tribunals in other Member States.[123] An important role in facilitating this would be played by the CJEU.[124] At the moment, *Konstantinidis* is still the only preliminary reference made by a medical disciplinary tribunal – there is practically no judicial dialogue between medical disciplinary tribunals and the CJEU. This is primarily because medical disciplinary tribunals and lawyers lack experience in free movement law. Therefore, tribunals and lawyers should be encouraged to establish a more regular dialogue with the CJEU.[125] The focus of this interaction would be on how the proportionality test should be conducted and what weight should be given to the judgments of disciplinary tribunals in other Member States.

In effect, since the free movement provisions require disciplinary tribunals to take into account the decisions of tribunals in other Member States, the CJEU would act as a "facilitator" of a more regular dialogue between national disciplinary tribunals. This would help the Member States to adopt a more coordinated perspective on medical professional discipline in the EU.[126] If disciplinary tribunals engage more regularly on the substance of medical disciplinary rules, this judicial dialogue could eventually lead to a learning process.[127] Through their investigation into the approaches of other Member States, Member States can identify approaches or professional standards in other Member States that are more effective in protecting patient safety.[128] In other words, the proportionality test encourages Member States to learn from each other and to adopt examples of best practice.[129] Whether such a learning process would eventually lead to a process of Europeanisation of medical professional discipline – e.g., through harmonisation, co-regulation or self-regulation – remains to be seen.[130] However, it is important that a more regular dialogue takes place between disciplinary tribunals on the substance of medical professional discipline.

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[122]See C. Rieder, 'Courts and EU Health Law and Policies', in T. Hervey, C.A. Young and L.E. Bishop (eds.), *Research Handbook on EU Health Law and Policy* (Edward Elgar, 2017), 60–81. See also J. Zglinski, above, n. 96, 1369.

[123]See W. van Gerven, 'Bringing (Private) Laws Closer to Each Other at the European Level', in F. Cafaggi (ed.), *The Institutional Framework of European Private Law* (Oxford University Press, 2006). Van Gerven argued for an 'open method of convergence' through dialogues between national courts – a bottom-up process of Europeanisation that would be driven by the judiciary.

[124]See T. Tridimas, 'The ECJ and the National Courts: Dialogue, Co-operation and Instability', in D. Chalmers and A. Arnull (eds.), *The Oxford Handbook of European Union Law* (Oxford University Press, 2015), 403–430.

[125]For other examples of judicial dialogues between specialised tribunals and the CJEU, see C. Kilpatrick, 'Community or Communities of Courts in European Integration? Sex Equality Dialogues between UK Courts and the ECJ' (1998) 4 *European Law Journal*, 21, and H. Micklitz, *The Politics of Judicial Co-operation* (Cambridge University Press, 2005), ch. 3.

[126]See W. van Gerven, 'Harmonization of Private Law: Do We Need It?' (2004) 41 CMLR 505, 518–520. Van Gerven used the term 'cross-fertilisation' between national courts and the CJEU.

[127]For a similar learning process as a result of free movement of patients, see Van Leeuwen, above, n. 100, 182–183.

[128]For the analysis of a similar process through the application of the competition provisions in the healthcare sector, see J. van de Gronden and E. Szyszczak, 'Introducing Competition Principles into Health Care Through EU Law and Policy: A Case Study of the Netherlands' (2014) 22 *Medical Law Review*, 238.

[129]On Europeanisation through learning, see C. Sabel and J. Zeitlin, 'Learning from Difference: The New Architecture of Experimentalist Governance in the EU' (2008) 14 *European Law Journal*, 271.

[130]See Hervey and McHale, above, n. 5, 154–155 and 547.

7 | CONCLUSION

Although it cannot be denied that the exercise of free movement rights by doctors has a "darker side",[131] free movement law is not just part of the problem – it is part of the solution. Free movement law does not simply disrupt the ability of Member States to protect the integrity and quality of their healthcare systems. This orthodox view, which continues to emphasise the destabilising impact of free movement law on the healthcare sector, is based on an abstract approach to the role of free movement law.[132] It is not based on the empirical reality in the case law. This applies to the impact of free movement of doctors and free movement of patients.[133] Free movement law is not only about economic or market integration – it is just as much about the protection of non-economic public interests in the internal market.[134] Negative integration[135] through the free movement provisions puts these public interests – such as patient safety and the quality of the medical profession – in a transnational and comparative perspective.

A more sophisticated approach is required to ensure that free movement law reinforces the ability of Member States to promote patient safety and quality of healthcare. This article has shown how a detailed approach to the proportionality test leads to a process of interaction between national disciplinary tribunals. These judicial dialogues would not lead to the elimination of national differences or a race to the bottom in the healthcare sector. Rather, they would encourage Member States to analyse medical professional rules in other Member States, and to adopt a more co-ordinated approach to medical professional discipline. Such a bottom-up process of Europeanisation of the decision-making processes of disciplinary tribunals could ultimately lead to a learning process, where Member States would discover through free movement law how to learn from medical professional rules or approaches in other Member States.[136]

A number of challenges have to be overcome before this approach can be successful. First, medical disciplinary lawyers and tribunals have to become more aware of the impact of free movement law on medical professional discipline. They should establish a more regular dialogue with the CJEU to receive more guidance on how the proportionality test should be applied. Free movement lawyers should contribute to the debate by showing – and reassuring – medical lawyers how free movement law can be applied to protect patient safety and the quality of healthcare. If they do not do this, there is a risk that disciplinary tribunals will follow the approach adopted by the German disciplinary tribunal in *Konstantinides*. This superficial and inconsistent approach to the application of free movement law should be avoided. It creates the erroneous impression that free movement law is the cause of the problem. However, the real problem is not *that* free movement law is applied to medical disciplinary cases, but rather *how* free movement law is applied.

Finally, judicial dialogues in the field of medical professional discipline are now more important than ever. After Brexit, the UK will no longer be part of the Alert Mechanism. The Withdrawal Agreement provides that the UK will continue to have access to the IMI for a period of nine months after the end of the transitional period.[137] Since the UK employs a high number of EU doctors and imposes a high number of disciplinary sanctions on an annual basis, it is crucial that the EU and the UK adopt clear and detailed rules on the exchange of information about disciplinary sanctions in a future trade agreement.

[132]Although their overall approach to the impact of EU law on the healthcare sector is nuanced, Hervey and McHale, above, n. 5, at 131, still argue that 'the problem with EU law in this context is that it is not the aim of the EU provisions to protect patients or to ensure high-quality, cost-effective care.' Similarly, at 155, they conclude that free movement law 'complicates and disrupts the traditional understanding of a professional role founded on an ethic of public service, which includes a duty of care to individual patient/consumers'. For a similar view, see A. de Ruijter, above, n. 101, 176–178.

[133]Van Leeuwen, above, n. 113, 654.

[134]Van Leeuwen, above, n. 120, 1,425–1,428.

[135]See S. Weatherill, *The Internal Market as a Legal Concept* (Oxford University Press, 2017), 5–9.

[136]Van Leeuwen, above, n. 100, 182–183.

[137]Article 29 of the Agreement on the withdrawal of the United Kingdom of Great Britain and Northern Ireland from the European Union and European Atomic Energy Community, OJ L 384I, 12.11.2019, at 1–177.

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