THE DOCTOR IN FREE MOVEMENT LAW: EXPERTISE, DUTY, AND ACCOUNTABILITY

I. INTRODUCTION

In comparison with free movement of patients, free movement of doctors in the internal market has not received the same amount of attention in the academic literature – certainly not from EU lawyers.[1] This is surprising, because free movement of doctors is a much less recent "phenomenon" than free movement of patients. In the 1970s, the EU already adopted legislation to provide for mutual recognition of professional qualifications of medical doctors.[2] Moreover, the adoption of the Professional Qualifications Directive in 2005 resulted in a significant number of cases brought by doctors.[3] In 2013, after some "scandals" with doctors who had moved to another Member State to escape accountability in their home Member State,[4] the EU made a number of amendments to the Professional Qualifications Directive to improve patient safety and strengthen the accountability of doctors in the internal market.[5] This response emphasised concerns about the negative effects of free movement of doctors. At the same time, free movement of doctors can be an important "tool" to share medical expertise in the internal market and to improve the quality of care provided to patients in the EU.[6]

Against this background, the aim of this article is twofold. First, the article will provide a "characterisation" of the doctor in free movement law. The aim is to identify the characteristics of the doctors who relied on free movement law in the case law before the CJEU. In what kind of professional setting did doctors rely on free movement law, and what was the purpose of their reliance on free movement law? Is free movement law primarily relied on against supervisory authorities, or does it have a direct impact on the patient-doctor relationship? Second, the article will analyse the interaction between free movement law and the concept of medical professionalism.[7] As one of the traditional professions, doctors are expected to comply with high professional standards in providing medical care to their patients. What is the impact of free movement law on medical professionalism? The exercise of free movement rights by patients has regularly been criticised on the basis that it would encourage a process of consumerism.[8] Because of its economic focus, and because medical treatment is regarded as a "regular" service under Article 56 TFEU, free movement law has the potential to transform patients into consumers. Does

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[1] See, for some exceptions, T. Hervey and J. McHale, *European Union Health Law: Themes and Implications* (CUP, 2015), 127-155; M. Peeters, M. McKee and S. Merkur, 'EU law and health professionals' in R. Baeten, E. Mossialos and T. Hervey (eds.), *Health Systems Governance in Europe: The Role of EU Law and Policy* (CUP, 2010), 589-634; B. van Leeuwen, 'Towards Europeanisation through the Proportionality Test: The Impact of Free Movement Law on Medical Professional Discipline' (2020) 26 *ELJ* 61. For a broader and interdisciplinary perspective, see J. Buchan, M. Wismar, I. Glinos and J. Bremmer (eds.), *Health Professional Mobility in a Changing Europe* (WHO, 2014).

[2] Directive 75/962/EEC concerning the mutual recognition of diplomas, certificates and other evidence of formal qualifications in medicine, including measures to facilitate the effective exercise of the right of establishment and freedom to provide services.

[3] Directive 2005/36/EC on the recognition of professional qualifications.

[4] T. Hervey and J. McHale, above n 1, 130.

[5] Directive 2013/55/EU and the new Article 53 of the Professional Qualifications Directive (added by Directive 2013/55/EU amending Directive 2005/36/EC on the recognition of professional qualifications).

[6] M. Peeters et al., above n 1, 589.

[7] E. Freidson, *Profession of Medicine: A Study of the Sociology of Applied Knowledge* (The University of Chicago Press, 1970). For a recent perspective, see O. Quick, *Regulating Patient Safety: The End of Professional Dominance?* (CUP, 2017).

[8] C. Newdick, 'Citizenship, Free Movement and Health Care: Cementing Individual Rights by Corroding Solidarity' (2006) 43 *CML Rev* 1645.

free movement law have a similar impact on doctors? If this were the case, free movement law could potentially result in a process of *deprofessionalisation* of medical doctors.

The methodology of this article is to provide an empirical analysis of the case law of the CJEU. All 26 cases in which doctors relied on free movement law before the CJEU have been identified. Each of these cases has been "coded" on the basis of four questions which are directly linked to the relationship between free movement law and medical professionalism. The empirical nature of the analysis means that the focus is on the factual patterns of cases – the legal reasoning of the CJEU is not analysed in detail. Questions such as the extent to which free movement law requires public authorities to engage in a substantive comparison of qualifications obtained in different countries, or the extent to which the CJEU has developed the role of the proportionality test in free movement of doctors cases are not addressed. The focus is on the "empirical reality" of the case law: the setting in which the case takes place, the purpose of the reliance on free movement law, and the relationship between the doctor's reliance on free movement law and the concept of medical professionalism.

The analysis will show that the doctor in free movement law is a much more homogenous character than the patient in free movement law.[9] Almost all the cases were about the recognition of qualifications, or about how the provisions of the Professional Qualifications Directive should be implemented at the national level. As such, the case law has focussed on the *expertise* of medical doctors in the internal market. The concept of expertise is one of the core foundations of medical professionalism.[10] The case law of the CJEU has placed this concept in a transnational perspective. This is the direct result of the adoption of the Professional Qualifications Directive, which has combined mutual recognition of professional qualifications with harmonisation of the training requirements for medical doctors. However, the focus of the Directive is primarily on *quantitative* harmonisation: it lays down how many years of training doctors must complete before they can qualify in a certain medical specialty.[11] The Directive does not say very much about the *substance* of medical training. Although certain standards on medical training are laid down at the European level by medical professional associations,[12] this quantitative focus of the Directive has been a particular concern to medical professional associations.

As a result, many of the free movement cases were brought by collective groups of doctors or professional associations. This is another important difference with the case law on free movement of patients, which has had more of an individual focus. Patient associations have not been very active in bringing free movement cases.[13] Furthermore, in most free movement of doctors cases, the motive to bring the case was to *defend* medical professionalism, or to defend a particular interpretation of medical professionalism in the internal market. As such, many of the cases were defensive exercises by the medical profession against the potential of deprofessionalisation through the application of free movement law.

Despite the general focus on professional qualifications, some of the recent cases have brought free movement law "into the treatment room". These cases focussed directly on the patient-doctor relationship. Although the number of cases is low, these cases show that the application of free

[9] See B. van Leeuwen, 'The Patient in Free Movement Law: Medical History, Diagnosis and Prognosis' (2019) 21 *CYELS* 162, 175.
[10] E. Freidson, above n 7, 12-22.
[11] Articles 24-28 of the Professional Qualifications Directive.
[12] In particular, by the European Union of Medical Specialists. See https://www.uems.eu/uems-activities/harmonization-of-medical-training.
[13] B. van Leeuwen, above n 9, 185-186.

movement law could potentially pose a risk to medical professionalism. Free movement law could have an impact on the doctor's duty of care towards their patients, and on the doctor's accountability towards their patients. Moreover, these cases also show that free movement law is more regularly relied on before national courts which do not necessarily have a lot of expertise in the field of free movement law – such as criminal courts or disciplinary tribunals. This makes it important that non-specialised courts ensure that they are familiar with the structure of free movement cases, and that they continue to engage in a dialogue with the CJEU.

The structure of this article will be as follows. In section II, the concept of medical professionalism will be introduced in more detail. It will be placed in the legal context of the internal market. Three core characteristics of medical professionalism will be provided: the concepts of expertise, duty, and accountability. Section III will set out the methodology of the empirical analysis. The empirical analysis itself will be provided in section IV. The case law of the CJEU is analysed in chronological order. The next three sections (sections V, VI and VII) make a more precise link between the empirical analysis and the concepts of expertise, duty, and accountability. The conclusion in section VIII provides a characterisation of the doctor in free movement law. It will provide a conclusion on the relationship between free movement law and medical professionalism in the case law of the CJEU.

II. MEDICAL PROFESSIONALISM IN THE INTERNAL MARKET

The concept of medical professionalism is one of the core concepts of medical practice. The foundation of the concept is that doctors enjoy a significant degree of autonomy in the organisation and delivery of medical treatment.[14] This autonomy – or position of dominance – has been challenged from different directions in the last decades. The delivery of medical treatment is regulated more strictly, and self-regulation is no longer the primary source of regulation of the work of medical doctors.[15] As a result, doctors have to engage much more regularly with external parties, such as national supervisory authorities. The autonomy of the medical profession is also challenged by patients. The patient-doctor relationship has become less hierarchical, because patients have access to more information about their (potential) diagnosis or treatment options.[16] Furthermore, most national healthcare systems facilitate patients in seeking a second opinion if they disagree with the diagnosis or treatment plan provided by their treating doctor. Free movement of patients has played a role in this process, because it potentially extends the number of treatment options beyond the borders of a patient's home Member State.[17] All of these developments have resulted in a process of rebalancing of power in the patient-doctor relationship. As a result, today's medical professionalism requires doctors to take a patient-centred approach to the provision of medical care.[18]

Three core characteristics of medical professionalism will be taken as the starting point of the analysis: the concepts of expertise, duty, and accountability. Each of these dimensions of medical professionalism has a self-standing "existence", but they are also cumulative in the sense that they build on each other. The foundation of medical professionalism is that doctors possess a very

[14] E. Freidson, above n 7, 137-157.
[15] O. Quick, above n 7, 52-57
[16] See M. Wolfensberger and A. Wrigley, *Trust in Medicine: Its Nature, Justification, Significance and Decline* (CUP, 2019), 187-193.
[17] T. Hervey and J. McHale, above n 1, 81-83.
[18] J. Herring, K. Fulford, M. Dunn and A. Handa, 'Elbow Room for Best Practice? Montgomery, Patients' Values, and Balanced Decision-Making In Person-Centred Clinical Care' (2017) 25 *Medical Law Review* 582. See also S. Delacroix, 'Professional Responsibility: Conceptual Rescue and Plea for Reform' (2022) 42 *CJLS* 1, 14-16.

specific and high level of skill and *expertise*, which distinguishes them from other professions in the healthcare sector. Based on this level of expertise, doctors have to comply with a high *duty of care* towards their patients. In particular, they always have to act in the best interests of the individual patient. Finally, medical professionalism requires that doctors can be held *accountable* for the care provided to patients. From a legal perspective, this could be in private law, in medical professional discipline, or even in criminal law. Each of these concepts will now be directly linked to the legal context in which free movement of doctors takes place.

A. Expertise in the internal market

First, the foundation of medical professionalism is the expertise which is possessed by doctors. This expertise is primarily based on their extensive training. The training to become a basic doctor takes six years, and the additional training to qualify in a medical specialty could take another four to six years.[19] In the context of the internal market, the Professional Qualifications Directive has introduced automatic mutual recognition of professional qualifications of doctors. This automatic recognition is based on the co-ordination of minimum training requirements. The Directive covers both permanent establishment in another Member State,[20] and the temporary provision of services by doctors in another Member State.[21]

The focus of the Directive is primarily on *access* to the medical profession in other Member States – it does not regulate the *exercise* of the medical profession in another Member State.[22] The provision of medical care itself is not directly regulated by the Directive. This is linked to Article 168(7) TFEU, which provides that the EU does not have the competence to harmonise the delivery of health services and medical care. Because of the Directive's focus on access to the profession, the Treaty provisions continue to have an important role when it comes to restrictions on free movement in the exercise of the profession. Article 45 TFEU could be relied on by doctors who are employed in another Member State, while Article 49 TFEU would be applicable to self-employed doctors. Article 56 TFEU could be relied on by doctors who provide services in another Member State on a temporary basis. The Directive requires that Member States automatically recognise the qualifications of doctors who trained and qualified in another Member State. This recognition is automatic and based on the harmonisation of the minimum training requirements of doctors. Supervisory authorities in the Member States are not allowed to carry out detailed checks of the qualifications – they must accept that a doctor who has qualified as a doctor in another Member State is good enough to practise medicine in their country.

The Professional Qualifications Directive could be considered a threat to medical professionalism because of its quantitative approach to the harmonisation of the substance of medical training. The Directive has harmonised the minimum training requirements for doctors with basic training, doctors with specialist training and general medical practitioners in the EU. For each of these groups, the Directive provides for a minimum period of training. If a doctor satisfies these basic criteria, the Member State must recognise their professional qualifications – there is no discretion to refuse recognition. Although the Directive expressly refers to "minimum training requirements",[23] it does not in fact constitute minimum harmonisation. It is not possible for Member States to impose higher requirements on doctors from other Member States. Once a

[19] Articles 24-25 of the Professional Qualifications Directive.
[20] Articles 24-30 of the Professional Qualifications Directive.
[21] Articles 5-7 of the Professional Qualifications Directive.
[22] This is linked to the legal bases of the Directive: Articles 46 (workers), 53 (establishment) and 62 TFEU (services).
[23] Chapter III of the Professional Qualifications Directive.

doctor from another Member State satisfies the minimum training requirements, their qualification must be accepted. It would be possible for Member States to increase their own training requirements, but this would not have a direct impact on their ability to refuse to recognise the qualifications of doctors from other Member States. With such a system, it becomes very important to determine what the minimum level of training across the EU should be. This is why European professional associations of doctors play an important role in the adoption of European standards on medical training for different specialties.[24]

B. Duty of care in the internal market

Second, the next foundation of medical professionalism is the concept of duty. The high level of expertise of doctors is "translated" into a number of duties imposed on doctors. The doctor's duty of care towards their patients has traditionally been laid down in the Hippocratic oath.[25] The doctor's primary duty is towards their patient: the patient's interests should always be put first.[26] Moreover, the duty imposed by medical professionalism means that doctors should not be affected by external factors or influences in providing medical care to patients. Financial gain should never be a motive to provide a particular treatment. This aspect of medical professionalism has come under pressure with the rise of private healthcare, because medical treatment is provided in a professional setting which is inherently more focussed on profit-making than public healthcare systems.[27] Finally, the concept of duty requires that doctors recognise their own limitations, and that they only carry out procedures for which they possess the required level of skills and expertise.

The concept of duty of care, which focusses on the doctor's duties in the patient-doctor relationship, is not directly regulated by the Professional Qualifications Directive. Nevertheless, the Directive does have an indirect effect on the patient-doctor relationship. One important example is the Directive's emphasis on language requirements. The recent amendments to the Directive have increased the ability of supervisory authorities to verify the language requirements of doctors who seek to practise in another Member State.[28] Language skills are fundamentally important to the patient-doctor relationship, and to the ability of patients to provide informed consent.[29] As such, the Directive's increased emphasis on language requirements helps to protect medical professionalism in a transnational context.

In a broader sense, free movement of doctors could put the doctor's duty towards their patients at risk, because free movement rights are based on the exercise of economic activity. Free movement law could encourage doctors to act like entrepreneurs rather than medical professionals. This argument should be dismissed in so far as the free movement of workers under Article 45 TFEU is concerned. Although it is true that doctors must receive remuneration to be able to rely on Article 45 TFEU, this is not in any way different from a doctor who works in their home Member State. This would be different in the field of free movement of establishment, because doctors who are relying on Article 49 TFEU are self-employed. As such, they are not only

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[24] See https://www.uems.eu/about-us/presentation. See also, by way of practical example, T. Lerut, D. Van Raemdonck and G. Massard, 'Why do we need harmonization in thoracic surgery: a view from above by the European Union of Medical Specialists' (2021) 13 *Journal of Thoracic Disease* 2021.

[25] H. Teff, *Reasonable Care: Legal Perspectives on the Doctor-Patient Relationship* (OUP, 1994), 72-76. See also K. Oxtoby, 'Is the Hippocratic oath still relevant to practising doctors today?' (2016) 355 *British Medical Journal* 6629.

[26] Ibid., 74-76.

[27] M. Wolfensberger and A. Wrigley, above n 16, 193-196.

[28] Recital 26 of Directive 2013/55/EU and the new Article 53 of the Professional Qualifications Directive (added by Directive 2013/55/EU amending Directive 2005/36/EC on the recognition of professional qualifications).

[29] S. Merkur, 'Policy responses facilitating mobility or negating its negative effects: national, EU and international instruments' in J. Buchan et al. (eds.), above n 1, 301-324.

financially independent – they are also responsible for ensuring that they make sufficient financial profit. In these circumstances, in making decisions about the proposed treatment for a patient, a doctor could be influenced by financial considerations in such a way that it would put medical professionalism at risk. However, again, this development would not be significantly different from self-employed doctors who are working in their home Member State. The impact of profit-making as a motive would be similar for these doctors without free movement law playing a significant role in this process.

The free movement provision which is most likely to put the doctor's duty to their patients at risk is Article 56 TFEU. This is primarily because of the temporary nature of the freedom of services. If a doctor provides services to patients in another Member State on a temporary basis and returns to their home Member State shortly after the treatment, this makes it more difficult to guarantee consistency in the treatment of the patient. It is difficult for the doctor to provide after-care to a patient after having returned to their home Member State. Furthermore, it is more difficult for doctors to assess the clinical situation of their patient from a distance.

C. Accountability in the internal market

Third, the final foundation of medical professionalism is that doctors are held accountable for their actions in the exercise of their duty of care towards patients. Historically, because of the status of doctors in society and the autonomy of the medical profession, the extent to which doctors were held accountable was limited.[30] This has changed significantly in the last decades. Doctors now have to be prepared to account for their actions in a plethora of legal (and non-legal) fora. First, doctors are increasingly held liable in private law. The most likely avenue for patients to seek compensation from their doctors is tort law. If a patient has been treated in a private clinic, and there is a contractual relationship with their doctor or the clinic, patients can also bring an action in contract law. Second, proceedings may be brought against doctors in public or administrative law. This can relate to the licensing of clinics or hospitals.[31] At the individual level, professional discipline is the most common way in which proceedings might be brought against a doctor.[32] Article 5(3) of the Professional Qualifications Directive provides that doctors who are providing services in another Member State are subject to professional discipline in the host Member State. Similarly, doctors who establish themselves in another Member State on a permanent basis – whether on the basis of Article 45 or 49 TFEU – have to register and become subject to professional discipline in the host Member State. Third, doctors are increasingly held liable in criminal law.[33] The application of criminal law is reserved for the most serious cases of medical failure, in which the doctor's actions have fallen seriously below the standards that could be expected from a doctor. In these cases, it is no longer only the individual patient to whom the doctor is held responsible – the doctor is held accountable to society.

In the literature, one of the key risks which has been identified is that doctors are able to rely on free movement law to "escape" disciplinary sanctions imposed in one host Member State by moving to another Member State where they could continue to practise without any restrictions.[34]

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[30] O. Quick, above n 7, 30-34.
[31] Ibid., 78-82.
[32] Ibid., 69-75.
[33] See M. Karazarian, *Criminal Medical Ma'practice: A Comparative Perspective* (Routledge, 2021). See also A. McCall Smith, 'Criminal Negligence and the Incompetent Doctor' (1993) 1 *Medical Law Review* 336; A. Mullock, 'Gross Negligence (Medical) Manslaughter and the Puzzling Implications of Negligent Ignorance: Rose v R [2017] EWCA Crim 1168' (2018) 26 *Medical Law Review* 346.
[34] M. Peeters, M. McKee and S. Merkur, above n 1, 589.

As such, free movement law could facilitate "bad doctors" in their attempts to escape accountability.[35] The automatic recognition of qualifications under the Professional Qualifications Directive makes it more difficult for Member States to investigate the qualifications of doctors who qualified in another Member State. In the last decade, Member States have come to understand that there is a real risk to patient safety if incompetent doctors can continue to move freely between Member States. For that reason, in 2013, several changes were made to the Professional Qualifications Directive, including the introduction of an Alert Mechanism.[36] This mechanism requires Member States to be more pro-active in the exchange of information about service providers whose right to practise in the home Member State has been restricted. The creation of the Alert Mechanism was a response to several medical scandals, in which doctors had been able to move to another Member State to continue working after they had been banned from practising in their home Member State. It was clear that the lack of adequate information exchange between supervisory authorities in the Member States made it easier for doctors to do this. As a result, this could lead to a real risk to patient safety. The new Article 56a of the Professional Qualifications Directive requires that "[t]he 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".

The improved exchange of information between national supervisory authorities under the Alert Mechanism established by Directive 2013/55/EU has resulted in a higher number of disciplinary proceedings brought against doctors who exercised their free movement rights.[37] The public supervisory authorities of the Member States must inform other Member States if restrictions have been placed on a doctor's ability to practise, or if a doctor has been suspended from practising or struck off the medical register. Although the *effect* of the exchange of information is not regulated by EU law, the exchange of information leads to more intense dialogues between the Member States on how professional discipline can serve to protect the quality of care provided by doctors and guarantee patient safety.[38] As such, it has also improved the accountability of doctors who work in a transnational context.

III. METHODOLOGY OF THE EMPIRICAL ANALYSIS

The next step is to provide an empirical analysis of all cases before the CJEU in which medical doctors relied on free movement law. The empirical nature of the analysis means that the focus is not on the reasoning of the CJEU. Rather, the focus is on the characteristics of the doctors who relied on free movement law: the public or private setting in which healthcare was provided, the doctor's professional training, and the impact of free movement law on the patient-doctor relationship. In identifying all the cases before the CJEU in which medical doctors relied on free movement law, a broad interpretation of the concept of free movement law has been adopted. Cases in which doctors relied on Article 45 TFEU, Article 49 TFEU, Article 56 TFEU, the Professional Qualifications Directive and its predecessors are included in the analysis. Moreover, one case in which the doctor relied on the Citizens' Rights Directive[39] was included.[40] In some

[35] See T. Hervey and J. McHale, above n 1, 130.
[36] Article 56a of Directive 2013/55/EU.
[37] B. van Leeuwen, above n 1, 69.
[38] Ibid., 79-80.
[39] Directive 2004/38/EC on the rights of citizens of the Union and their family members to move and reside freely within the territory of the Member States.
[40] Case C-229/07, *Meyer*, ECLI:EU:C:2008:29.

cases, doctors relied on the Unfair Commercial Practices Directive[41] or the E-commerce Directive.[42] There were also a number of VAT cases.[43] These cases were only included if there was a link to the exercise of free movement rights. In other words, the doctor had to have exercised free movement rights or had to argue that their free movement rights had been infringed.

A more inclusive approach was adopted for cases brought on the basis of the Professional Qualifications Directive. For this Directive, wholly internal cases were included in the analysis. This is because the Directive has a clear link to medical professionalism. It was often relied on by doctors against their Member State of qualification without these doctors having exercised free movement rights. In these cases, the source of the rights relied on by the doctor was still based on free movement law. Moreover, these cases usually involved an analysis of the training, qualifications, and remuneration of doctors.

Three additional methodological choices were made in determining the scope of the concept of "doctor". First, paramedical professions were excluded. Even though most paramedical professions share a significant number of characteristics with doctors, one of the foundations of medical professionalism is that, as a result of their lengthy training, the level of expertise of doctors should be distinguished from the expertise of paramedical professions. Furthermore, the scope of their work is narrower than that of doctors.[44] As a result, cases before the CJEU which were brought by nurses, physiotherapists or other paramedical professions were excluded.[45] Second, cases brought by dentists were included in the analysis, while pharmacists were excluded.[46] There are good reasons for doing so. Dentists must undertake the same amount of training as medical doctors. Furthermore, while it might be argued that dentists are inherently more focussed on aesthetics than doctors, the nature of the patient-dentist relationship is similar to the patient-doctor relationship. Finally, the professional regulation (including professional discipline) of dentists is very similar to the regulatory framework for medical doctors. This is different for pharmacists. Many free movement cases brought by pharmacists were in fact brought by commercial pharmacies.[47] Third, cases brought by medical professional associations have been included. This is primarily because there is a strong link between the work of medical professional associations and the concept of medical professionalism. Moreover, these cases are not fundamentally different from the cases in which groups of doctors collectively relied on free movement law. As we will see below, there was a significant number of group actions brought by a collective of doctors.[48]

The search was conducted by using the case law database of CURIA, the website of the CJEU. The advanced search form was used.[49] As a starting point, we searched for all cases in which the Professional Qualifications Directive was referred to in the grounds of the judgment. The same

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[41] Directive 2005/29/EC concerning unfair business-to-consumer commercial practices in the internal market.
[42] See, for example, Case C-356/16, *Wamo and Van Mol*, ECLI:EU:C:2017:809.
[43] See, for example, Case C-172/03, *Heiser*, ECLI:EU:C:2005:130.
[44] E. Freidson, above n 7, 69-70.
[45] Case C-108/96, *Mac Quen and others*, ECLI:EU:C:2001:67; Case C-54/88, *Nino*, ECLI:EU:C:1990:340; Case C-61/89, *Bouchoucha*, ECLI:EU:C:1990:343; Case C-294/00, *Gräbner*, ECLI:EU:C:2002:442; Case C-84/06, *Antroposana*, ECLI:EU:C:2007:535, Case C-575/11. *Nasupoulos*, ECLI:EU:C:2013:430.
[46] See, for example, C-570/07, *Blanco Perez*, ECLI:EU:C:2010:300; C-367/12, *Sokoll-Seebacher*, ECLI:EU:C:2014:68.
[47] See, for example, C-169/07, *Hartlauer*, ECLI:EU:C:2009:141.
[48] Case C-98/95, *Bertini*, ECLI:EU:C:1986:246; Case C-69/96 to C-79/96, *Garofalo*, ECLI:EU:C:1997:492; Case C-93/97, *Fédération Belge*, ECLI:EU:C:1998:375; Case C-131/97, *Carbonari*, ECLI:EU:C:1999:98; Case C-371/97, *Gozza*, ECLI:EU:C:2000:526; Case C-10/02, *Fasciolo*, ECLI:EU:C:2004:271; Case C-452/09, *Iaia*, ECLI:EU:C:2011:323; Case C-492/12, *Conseil national de l'ordre des médecins,* ECLI:EU:C:2013:576; Case C-940/19, *Chirurgiens-dentists de France*, ECLI:EU:C:2021:135.
[49] https://curia.europa.eu/juris/recherche.jsf?language=en.

exercise was conducted for its predecessors, Directive 75/362/EEC[50] and Directive 93/16/EEC.[51] Since the scope of the Professional Qualifications Directive does not only regulate medical doctors, separate searches were conducted for each of the Directive's articles which were directly linked to medical doctors.[52] Moreover, a search was conducted for cases in which reference was made to Directive 2013/55/EU, which made various updates to the Professional Qualifications Directive and which introduced the Alert Mechanism.[53] After these searches based on the relevant pieces of legislation, some more general searches were conducted. The search terms used for these searches were general terms used for the medical professions, such as "medical doctor" and "doctor". Furthermore, a final search was conducted for certain common medical professions, using the search terms "surgeon" and "general practitioner".

A total number of 26 relevant cases was identified.[54] These cases have been divided in five groups, based on the period in which the CJEU's judgment was delivered. Because certain cases were brought by professional associations or collective groups of doctors, it is not possible to specify the totalnumber of doctors who relied on free movement law before the CJEU. In all cases, the doctors relied on free movement to challenge national rules which regulated access to and the exercise of the medical profession. Because the first Doctors Directive was already adopted in the 1970s, the cases span over a period of more than forty years. Most of the cases were based on the Professional Qualifications Directive or its predecessors. As a result, unsurprisingly, most cases focussed on professional qualifications and access to the profession. It is only in the last ten years or so that cases were brought in which doctors relied on free movement law in situations that focussed on the patient-doctor relationship.[55]

Some limitations of the methodology should be identified. The cases that reach the CJEU might not be sufficiently representative of the *type of doctors* who rely on free movement law. Moreover, they might be the more complicated cases, in which national courts felt that they required assistance from the CJEU. As such, the cases might not be entirely representative of the *type of legal issues* that are raised by cases in which doctors relied on free movement law. Despite these methodological reservations, it is argued that a holistic analysis of the case law on free movement of doctors before the CJEU provides an interesting and meaningful representation of the kind of issues that are raised by doctors who rely on free movement law.

In the sections below, four questions are answered for each case. These questions are directly linked to the three core characteristics of medical professionalism introduced above. The answers

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[50] Directive 75/962/EEC concerning the mutual recognition of diplomas, certificates and other evidence of formal qualifications in medicine, including measures to facilitate the effective exercise of the right of establishment and freedom to provide services.

[51] Directive 93/16/EEC to facilitate the free movement of doctors and the mutual recognition of their diplomas, certificates and other evidence of formal qualifications.

[52] Articles 21, 23, 24, 25, 26, 27, 28 and 30 of the Professional Qualifications Directive.

[53] Article 56a of Directive 2013/55/EU.

[54] Case C-246/80, *Broekmeulen*, ECLI:EU:C:1981:218; *Bertini*, above n 48; Case C-131/85, *Gül*, ECLI:EU:C:1986:200; Case C-319/92, *Haim*, ECLI:EU:C:1994:47; Case C-71/93, *Van Poucke*, ECLI:EU:C:1994:120; Case C-443/93, *Vougioukas*, ECLI:EU:C:1995:394; Case C-15/96, *Schöning-Kougebetzopoulou*, ECLI:EU:C:1998:3; *Garofalo*, above n 48; *Fédération Belge*, above n 48; *Carbonari*, above n 48; *Gozza*, above n 48; Case C-238/98, *Hocsman*, ECLI:EU:C:2000:440; Case C-16/99, *Espelding*, ECLI:EU:C:2000:445; Case C-136/00, *Danner*, ECLI:EU:C:2002:558; C-110/01, *Tennah-Durez*, ECLI:EU:C:2003:357; Case C-204/01, *Klett*, ECLI:EU:C:2002:634; *Fasciolo*, above n 48; *Meyeur*, above n 40; *Iaia*, above n 48; Case C-475/11, *Konstantinides*, ECLI:EU:C:2013:542; *Conseil national de l'ordre des médicins*, above n 48; Case C-339/15, *Vanderborght*, ECLI:EU:C:2017:335; Case C-419/16, *Simma Feder-piel*, ECLI:EU:C:2017:997; Case C-675/17, *Preindl*, ECLI:EU:C:2018:990; *Chirurgiens-dentistes de France*, above n 48; Case C-634/20, *A*, ECLI:EU:C:2022:149.

[55] *Konstantinides*, above n 54; and *Vanderborght*, above n 54.

to the questions are provided in a table. In addition, a short narrative is included for each case to provide more information about the doctor's background, their motivation for relying on free movement law and the potential impact of free movement law on the patient-doctor relationship.

The first question is whether the doctor was working in a public or private healthcare environment. As was explained above, private practice could potentially pose a threat to medical professionalism, because medical treatment is provided in a setting which is inherently more profit-focussed than public healthcare systems. The aim of this question is to investigate whether free movement law is more regularly relied on by doctors who work in a private healthcare environment.

The second question is whether the reliance on free movement law is linked to the doctor's medical training or professional qualifications. This is directly related to another foundation of medical professionalism: the concept of expertise. It includes cases that focussed on the training of medical doctors and cases that were about access to the medical profession.

For the third question, we analysed whether the doctor's reliance was directly linked to the quality of care provided to patients. In other words, was the doctor's reliance on free movement law linked to the patient-doctor relationship? The aim of this question is to analyse to what extent free movement law has a direct impact on the doctor's duty to their patients.

The fourth and final question is whether the doctor was using free movement law as a "shield" to prevent them from being held liable in legal proceedings. Was free movement law being relied on as a defence to exclude or limit the possibility of liability in tort or contract law, in medical professional discipline, or in criminal law? This question is directly based on the third foundation of medical professionalism: the concept of accountability.

In the next section, these questions will be answered for each case. In addition, a narrative will be provided for all 26 cases. The cases have been divided in sub-groups in chronological order.

IV. THE EMPIRICAL ANALYSIS

A. The period of 1981-1995

Case number	**Doctor's name**	**Private practice?**	**Training?**	**Quality of care?**	**Shield?**
C-246/80	Broekmeulen	NO	YES	NO	NO
C-98/85	Bertini	NO	YES	NO	NO
C-131/85	Gül	NO	NO	NO	NO
C-319/92 and C-424/97	Haim	YES	YES	NO	NO
C-71/93	Van Poucke	YES	NO	NO	NO
C-443/93	Vougioukas	NO	NO	NO	NO

Dr Broekmeulen was a Dutch national who had trained as a doctor in Belgium. After having completed his studies in Belgium, he was authorised to practise medicine in the Netherlands. However, when he applied to be registered as a general practitioner in the Netherlands, his application was rejected on the ground that he had not completed an additional one year of training

as a general practitioner.[56] A similar requirement was imposed on Dutch doctors who had obtained the qualification of basic doctor in the Netherlands. However, with his Belgian qualification, he did not have to undertake any additional training before he could work as a general practitioner. On this basis, he argued that the Netherlands could not impose any additional requirements on him – even though he was a Dutch national.[57] The CJEU agreed and held that the Dutch authorities had to recognise the professional qualification obtained by Dr Broekmeulen in Belgium.[58] As a result, he should be allowed to practise as a general practitioner in the Netherlands.

Bertini was a joined case in which several Italian doctors challenged their dismissal by local health authorities. The case before the national court focussed on the contractual relationship between doctors and their employers, the local health authorities. The CJEU noticed that the context of these cases was a professional environment in which a large number of young doctors were looking for work in Italy, and the fact that Italian universities did not restrict access to degrees in medicine in any way – there was no *numerus clausus* system.[59] The Italian courts asked the CJEU whether Article 3(c) EEC and Article 57(3) EEC required that Member States adopted a *numerus clauses* system to limit admission to the degree of medicine at Italian universities. The CJEU provided a short and clear answer: "no provision of Community law requires the Member States to limit the number of students admitted to medical faculties by introducing a numerus clausus system".[60]

Dr Gül was a Cypriot national, married to a British national, who was resident in Germany. He had trained as a doctor in Turkey. He was allowed to register as a doctor in Germany on a temporary basis to be able to train as a specialist in anaesthetics. This registration was conditional on Dr Gül returning to his home country – or another developing country – after the completion of his training.[61] However, after he had completed his training, he applied for permanent authorisation to practise medicine in Germany. In doing so, he relied on the fact that his wife was working as a hairdresser in Germany, and that their children were British nationals residing in Germany.[62] The German authorities rejected his application, because he was not a national of a Member State. The maximum amount of training he was allowed to do in Germany was four years. As a result, he was required to return to his home country. The CJEU relied on Regulation 1612/68 to establish that Dr Gül had a right of residence in Germany based on his British wife's right, and that this right should include his ability to access the medical profession under the same conditions as German nationals.[63]

Mr Haim was an Italian national who had qualified as a dentist in Turkey. He practised as self-employed dentist in Germany. Later, his Turkish diploma was recognised in Belgium as equivalent to the Belgian qualification for dentists. He then started to work in Belgium in the public healthcare system. In 1988, Mr Haim applied to the Association of German Dentists be registered as a dentist under the German social security system. His application was refused because he had not completed a training period of at least two years. The Association argued that Mr Haim's Turkish qualification could not be recognised, because it had been obtained in a non-Member State.[64] It was not sufficient for the Belgian authorities to have recognised his qualifications as equivalent.

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[56] *Broekmeulen*, above n 54, para 5.
[57] Ibid., paras 24-26.
[58] Ibid., para 27.
[59] *Bertini*, above n 48, para 4.
[60] Ibid., para 12.
[61] *Gül*, above n 54, para 3.
[62] Ibid., para 4.
[63] Ibid., para 7.
[64] *Haim*, above n 54, para 8.

Mr Haim brought two cases against the Association.[65] The first one focussed on the substantive issue: was the refusal of the German authorities a breach of Mr Haim's right to freely establish himself in Germany under Article 49 TFEU? The CJEU found that the Association was not required to recognise Mr Haim's Turkish qualification solely on the basis that the Belgian authorities had found the qualification to be equivalent to the Belgian qualification.[66] However, the CJEU also held that, because Belgium had recognised Mr Haim's qualification as equivalent, the German Association was under an obligation to carry out a substantive assessment to establish to what extent Mr Haim had already acquired the necessary expertise as a dentist.[67] It could not automatically reject his application.

Van Poucke is one of the few cases which did not involve the recognition of professional qualifications. Dr Van Poucke was a Belgian national who had two jobs: he was employed as a military doctor in Belgium and he worked as a self-employed doctor in the Netherlands. Because he was self-employed in the Netherlands, he was asked to pay contributions to the Belgian fund for the social insurance of self-employed persons.[68] Dr Van Poucke argued that this requirement was a restriction of his free movement rights – in particular, of his rights under Regulation 1408/71.[69] The CJEU held that, because he was self-employed in the Netherlands, the Belgian authorities were entitled to treat Dr Van Poucke as self-employed under the Regulation.[70]

A similar kind of scenario could be observed in *Vougioukas*. Dr Vougioukas was a Greek national who had worked as a doctor in German hospitals for a period of five years. When Dr Vougioukas was about to retire, he applied to the Greek social security institution for the five-year period that he practised in Germany to be taken into account in calculating his pension entitlements in Greece. If this period could not be taken into account, Dr Vougioukas was not yet entitled to a retirement pension. His application was rejected on the basis that the period of work in Germany did not fall within one of the categories of service that could be taken into account in calculating Dr Vougioukas' pension entitlements.[71] The CJEU held that refusal to take into account his German work experience this constituted a breach of his rights under Article 45 TFEU, if equivalent experience obtained in Greece was taken into account in calculating his pension entitlements.[72]

B. The period of 1998-2000

Case number	**Doctor's name**	**Private practice?**	**Training?**	**Quality of care?**	**Shield?**
C-15/96	Schöning-Kougebetopoulou	NO	YES	NO	NO
C-69/96 to C-79/96	Garofalo	NO	YES	NO	NO
C-93/97	Fédération Belge	NO	YES	NO	NO
C-131/97	Carbonari	NO	YES	NO	NO
C-371/97	Gozza	NO	YES	NO	NO

[65] *Haim*, above n 54, and Case C-424/97, *Haim*, ECLI:EU:C:2000:357.
[66] *Haim*, above n 54, paras 19-22.
[67] Ibid., paras 27-28.
[68] *Van Poucke*, above n 54, para 3.
[69] Ibid., para 4.
[70] Ibid., paras 20-26.
[71] *Vougioukas*, above n 54, para 6.
[72] Ibid., paras 39-44.

C-238/98	Hocsman	YES	YES	NO	NO

Dr Schöning-Kougebetopoulou was a Greek national who was working in Hamburg as a specialist doctor in the public healthcare system. When she applied for a higher salary group based on her previous experience as a specialist doctor, the German authorities rejected her application and refused to take her six-year experience as a specialist doctor in Greece into account in calculating the number of years she had worked as a medical specialist.[73] This was despite the fact that her experience in Greece was in the same specialty and that her work was comparable to the work in Germany. Dr Schöning-Kougebetopoulou argued that this rejection constituted indirect discrimination on the ground of nationality and breached Article 45 TFEU.[74] The CJEU agreed and held that Germany could not rely on the public service exception in Article 45(4) TFEU.[75]

Garofalo was a joined case brought by a number of Italian doctors against the Italian Ministry of Health. As such, the case did not concern any cross-border movement – it was a group of Italian doctors who relied on Directive 86/457/EEC against the Italian State.[76] The case concerned the recognition of qualifications of general practitioners. Doctors with basic training were allowed to practise as a general practitioner in certain Member States. In other Member States, they would first have to complete an additional period of training as a general practitioner. From January 1995, amendments to the Directive meant that general practitioners *always* had to complete an additional period of training.[77] However, at the same time, the Directive recognised that certain doctors had already acquired the right to practise as a general practitioner without obtaining an additional qualification. Dr Garofalo and the other claimants were all Italian nationals who were practising as general practitioners in Italy. Furthermore, they had obtained a specific qualification as a general practitioner in Italy. They brought a case against the Ministry of Health to prevent a number of other doctors without an additional qualification in general medicine from being registered as general practitioners in Italy.[78] As such, the case focussed on the interpretation and the scope of the concept of acquired rights under Directive 86/457/EEC. The CJEU held that Italy had to recognise the acquired rights of doctors without an additional period of training who had been allowed to practise as a general practitioner before January 1995.[79]

In *Fédération Belge*, the Belgian Federation of Doctors' Associations brought a case against the Flemish Government about the implementation of Directive 93/16/EEC on the free movement of doctors and the mutual recognition of their diplomas. Again, the case was about general practitioners. Directive 93/16/EEC required general practitioners to complete six years of training as a basic doctor and two years of training as a general practitioner. The Flemish Government had implemented this in such a way that students studying for the basic medicine degree could already complete one year of training as a general practitioner *during* their training as a basic doctor.[80] This resulted in discrimination between doctors trained in the Flemish region and doctors trained in other regions. The Federation argued that the way in which the Flemish Government had implemented the Directive was in breach of Directive 93/16/EEC.[81] However, the CJEU

[73] *Schöning-Kougebetopoulou*, above n 54, para 6.
[74] Ibid.
[75] Ibid., paras 22-28.
[76] Directive 86/457/EEC on specific training in general medical practice.
[77] *Garofalo*, above n 48, paras 3-4.
[78] Ibid., paras 11-13.
[79] Ibid., para 20.
[80] *Fédération belge*, above n 48, para 18.
[81] Ibid., para 19.

disagreed and held that it was open to Member States to integrate the training as a general practitioner into the training as a basic doctor – it was not necessary that trainees had already qualified as a basic doctor before they started their training.[82]

Carbonari was another Italian case in which a group of Italian doctors brought proceedings against the Italian Ministry of Health. The claimants had all completed their training as a basic doctor in Italy and were registered as training to be specialists in different specialties with the University of Bologna. The doctors claimed that, based on Directive 82/76/EEC, they were entitled to appropriate remuneration during their specialist training.[83] They did not receive any remuneration even though they were in full-time training. In this case, the key issue was whether the doctors' entitlement to appropriate remuneration was a directly effective right which could be relied on in proceedings before the Italian national courts. The issues were almost identical in *Gozza*. This case was brought by a number of graduates in medicine and surgery from the University of Padua. They also applied to receive retrospective remuneration for their training as a surgeon. The case focussed on the relevant criteria in determining the appropriate remuneration for doctors who had been in part-time rather than full-time training.[84] Another issue was which specialties were covered by the obligation to provide remuneration.[85] In both cases, the CJEU held that the provisions of the Directive were sufficiently clear and precise. However, they were not unconditional, because the Directive did not regulate which national authority was made responsible to provide the remuneration. Therefore, the provisions were not directly effective. However, the duty of consistent interpretation meant that national courts were under an obligation to give effect to the provisions of the Directive on the basis of the national legislation.[86]

Dr Hocsman was an Argentine national who trained as a doctor in Buenos Aires. The Spanish authorities recognised his Argentinian qualification as equivalent to a Spanish medical qualification. In 1982, he completed his training as a urologist in Spain. Four years later, after he had obtained Spanish nationality, he was formally allowed to practise as a urologist in Spain. In 1990, Dr Hocsman moved to France to practise in that country. He applied to be registered as a doctor in France. However, the French authorities rejected his application on the ground that he had obtained his basic qualification in a non-Member State.[87] As such, the factual scenario was essentially similar to *Haim*, and the CJEU held that the French authorities were required to make a substantive comparison of the Argentinian and French qualifications.[88] Dr Hocsman's application could not be rejected without such a substantive assessment.

C. The period of 2000-2004

Case number	Doctor's name	Private practice?	Training?	Quality of care?	Shield?
C-16/99	Erpelding	NO	YES	NO	NO
C-136/00	Danner	YES	NO	NO	NO
C-110/01	Tennah-Durez	NO	YES	NO	NO
C-204/01	Klett	YES	YES	NO	NO

[82] Ibid., paras 33-38.
[83] *Carbonari*, above 49, paras 19-20.
[84] Ibid., paras 29-42.
[85] Ibid., paras 24-28.
[86] *Carbonari*, paras 47-50; and *Gozza*, para 45.
[87] *Hocsman*, above n 54, para 18.
[88] Ibid., paras 35-36.

C-10/02	Fascicolo	NO	YES	NO	NO

Dr Erpelding was an Austrian national who had trained as a doctor in Austria. He subsequently completed his specialisation in internal medicine and was authorised to practise as a specialist in internal medicine in Austria. In 1991, he applied for authorisation to work as a specialist in internal medicine in Luxembourg, which was duly granted.[89] In 1993, the Austrian authorities granted Dr Erpelding the title of specialist in internal medicine with a specialisation in cardiology. The Luxembourg authorities allowed him to use this title in Luxembourg. However, when Dr Erpelding applied to the Luxembourg authorities in 1997 to be allowed to use the title of cardiologist, because he no longer worked in general internal medicine, his application was refused.[90] This was because the speciality of cardiology was not recognised as a separate specialty in Austria. Dr Erpelding submitted that the Austrian qualification was essentially similar to the qualification of cardiologist in Luxembourg and that his qualification should be recognised on that basis.[91] The Court disagreed: mutual recognition was only required for specialties recognised by the Directive, and Dr Erpelding did not possess an Austrian qualification as a cardiologist.[92]

Dr Danner was a German and Finnish national. He worked in Germany as a doctor until 1977, when he established himself as a doctor in Finland. While resident in Finland, he continued to pay contributions to two German pension insurance schemes for doctors in Germany. One of these schemes was in fact compulsory for all doctors working in the area of Berlin. Dr Danner continued to pay contributions to this scheme because he had to do so if he wanted to receive a pension in case of invalidity.[93] Moreover, by continuing to pay contributions he increased his pension entitlements. The case before the CJEU focussed on the extent to which Dr Danner should be allowed to deduct the contributions to pension schemes in Germany from his taxable income in Finland.[94]

Dr Tennah-Durez was an Algerian national who qualified as a doctor in Algeria. After she had obtained Belgian nationality, she completed the final year of training as a basic doctor in Belgium. The Belgian authorities recognised the six years of training Dr Tennah-Durez had completed in Algeria. After two additional years of training as a general practitioner, she was authorised to work as a general practitioner in Belgium. When she registered to practise as a general practitioner in France on a permanent basis, the French authorities asked for additional information from the Belgian authorities.[95] The Belgian authorities replied that the majority of Dr Tennah-Durez' training had been undertaken in a non-Member State. As a result, she had not received the majority of her training in a Member State. Dr Tennah-Durez was subsequently removed from the French register of general practitioners. Her appeal was upheld at first instance, because the French tribunal found that Dr Tennah-Durez had completed the required number of hours of training.[96] However, this decision was reversed on appeal. The key issue before the CJEU was to what extent the training which Dr Tennah-Durez had received in Algeria should be taken into account in assessing her request for recognition of her Belgian qualification in France. The CJEU held that France had to accept Dr Tennah-Durez's Belgian qualification. Because the qualification had been

[89] *Erpelding*, above n 54, para 12.
[90] Ibid., paras 14-15.
[91] Ibid., para 16.
[92] Ibid., paras 22-27.
[93] *Danner*, above n 54, para 17.
[94] Ibid., para 22.
[95] *Tennah-Durez*, above n 54, paras 22-24.
[96] Ibid., para 26.

provided by a Member State, the "location" of some of the training was no longer relevant and did not provide a ground to the French authorities to refusal recognition of the qualification.[97]

Dr Klett was a German national who completed his training as a doctor in Germany. He also obtained a PhD in Medicine from the University of Hamburg. He was authorised to practise as a basic doctor in Germany on a self-employed basis. In 1995, about twenty years after completing his training as a doctor, Dr Klett applied for admission to a specialised course in dentistry at the University of Graz in Austria. After several legal proceedings, the Austrian authorities rejected his application on the ground that he did not have a degree in general medicine conferred by an Austrian university.[98] Moreover, the authorities argued that a qualification in medicine did not give any rights to doctors in Member States "where there was special training for dentists and where dentistry is an independent profession".[99] The CJEU agreed and held that Dr Klett did not have a right to be admitted to a dentistry course in Austria when his original qualification was not provided by Austria.[100]

Fascicolo was another Italian case about general practitioners. Under the Italian healthcare system, in deciding whether and which doctors were authorised to practise, the authorities classified and ranked doctors using a points-based system.[101] This was necessary because the Italian system relied on quota for doctors – only a certain number of doctors was allowed to practise in a particular region. Doctors with specialist training in general medicine were awarded 12 points and 0.2 points for each month of practice. If there was a particular shortage of doctors, doctors without the specialist training in general medicine could apply to be on the register, and they would be awarded the same number of points, if they had obtained equivalent previous experience. In the region of Puglia, because there was a shortage of doctors, the authorities allowed doctors without specialist training to practise as a general practitioner. However, it refused to award them the 12 points.[102] This decision was overturned after legal proceedings which ultimately reached the Italian Council of State. However, the authorities in Puglia still refused to award points for the years before the decision of the Council of State. Similarly to *Carbonari* and *Gozza*, the case focussed on the concept of acquired rights. The CJEU held that the points-based system was compatible with Directive 93/16/EC.[103]

D. The period of 2008-2013

Case number	Doctor's name	Private practice?	Training?	Quality of care?	Shield?
C-229/07	Mayeur	NO	YES	NO	NO
C-452/09	Iaia	NO	YES	NO	NO
C-475/11	Konstantinides	YES	NO	YES	YES
C-492/12	Conseil national de l'ordre des médecins	NO	YES	NO	NO

[97] Ibid., paras 64-70.
[98] *Klett*, above n 54, para 12.
[99] Ibid.
[100] Ibid., paras 34-41.
[101] *Fasciolo*, above n 48, paras 12-13.
[102] Ibid., paras 16-17.
[103] Ibid., paras 36-45.

Dr Mayeur was a Peruvian national who had trained as a doctor in Peru. She qualified as a basic doctor in 2002 and started training as a cardiac surgeon in France a few months later. In 2005, she married a French national, and in 2006 her Peruvian qualification was recognised as equivalent by the authorities in Spain.[104] After this process of recognition, Dr Mayeur applied for authorisation to practise medicine in France. This request for authorisation was refused by the French authorities. Dr Mayeur appealed that decision and argued that, following the judgment in *Hocsman*, she had a right under the Citizens' Rights Directive for her Peruvian qualifications to be taken into account in the assessment by the French authorities.[105] However. the CJEU held that because Dr Mayeur's husband had not moved between Member States, it was not possible for her to rely on the Citizens' Rights Directive.[106]

Iaia was another Italian case following from *Carbonari* and *Gozza*. In this case, a group of doctors who had trained as a specialist doctor at the University of Pisa brought a claim against the Italian State to recover the amount of remuneration which they should have received during their training. The case did not focus on the substantive rights under Directive 82/76, but rather focussed on the remedial aspects. Italian law provided that there was a five-year limitation period for this kind of claim.[107] The question for the CJEU was whether such a limitation period was compatible with the principles of effectiveness and equivalence under EU law. It found that a reasonable limitation period was permitted under EU law. This was the case even if the Member State had not implemented a directive correctly – except when the Member State was responsible for the delay in bringing the action.[108]

Dr Konstantinides was a Greek national who qualified as a doctor in Athens in 1981. After having worked in the Athens University Hospital for a number of years, he established his own Andrology Institute Athens. He was registered to practise as a doctor in Greece. Between 2006 and 2010, Dr Konstantinides visited Germany for one or two days per month to carry out highly specialised surgical operations in a private clinic in Darmstadt.[109] All other organisational and clinical aspects were organised by the clinic. In August 2007, after a successful operation, one of Dr Konstantinides' patients complained about the amount of fees he had been charged.[110] This resulted in the regional professional association bringing disciplinary proceedings against Dr Konstantinides in Germany. He was charged with two counts of professional misconduct. First, it was alleged that he had charged fees in breach of the applicable professional rules, because they were excessive.[111] Dr Konstantinides claimed that the fees had been agreed with the patient. Second, the professional association accused him of engaging in unprofessional advertising, because he had used the terms "German Institute" and "European Institute" on his website.[112] This created the impression of a permanent hospital infrastructure, even though he only provided services on a temporary basis.

Dr Konstantinides argued that, because he was a temporary service provider in Germany, under Article 5(3) of the Professional Qualifications Directive, no disciplinary proceedings could be

[104] *Mayeur*, above n 40, para 8.
[105] Ibid., para 9.
[106] Ibid., paras 18-20.
[107] *Iaia*, above n 48, para 10.
[108] Ibid., paras 17-21.
[109] *Konstantinides*, above n 54, para 21.
[110] Ibid., para 22.
[111] Ibid., paras 23-24.
[112] Ibid., para 25.

brought against him in Germany.[113] However, the CJEU held that Article 5(3) did not stop Dr Konstantinides from being subject to professional discipline in Germany. The application of the German disciplinary rules still had to be assessed under Article 56 TFEU. The CJEU provided a strong indication that the German rules on professional advertising could be justified on the basis of the promotion of public health and consumer protection.[114] The CJEU also found that the German rules on the appropriate fees lacked flexibility, which meant that they could deter doctors from other Member States from exercising their free movement rights (because it was not clear which tariffs could lawfully be adopted under the German rules).[115] It was for the national court to determine whether there was a restriction of Article 56 TFEU, and whether this restriction could be justified.

In *Conseil national de l'ordre des médecins*, the National Council of the Association of Doctors brought proceedings against the French Ministry of Education for the annulment of an order which created a common (joined) training course for postgraduate students in medicine and dentistry. The outcome of the course would be the award of a diploma in "specialised oral surgery". The National Council argued that this course was incompatible with the provisions of the Professional Qualifications Directive. This argument was based on the ground that the new course introduced courses within the area of specialist medicine which would now become accessible to postgraduate students in dentistry.[116] As a result, the course would lead to the creation of a new profession that was common to doctors and dentists. The CJEU held that the creation of a specialist training course was not prohibited so long as the course did not make it possible for practitioners without basic training as a doctor to practise as a doctor, or for practitioners without basic training as a dentist to practise as a dentist.[117]

E. The period of 2017-2022

Case number	**Doctor's name**	**Private practice?**	**Training?**	**Quality of care?**	**Shield?**
C-339/15	Vanderborght	YES	NO	YES	YES
C-419/16	Simma Federspiel	YES	YES	NO	YES
C-675/17	Preindl	YES	YES	NO	NO
C-940/19	Chirurgiens-dentistes de France	NO	YES	NO	NO
C-634/20	A	NO	YES	NO	NO

Mr Vanderborght was a Belgian dentist who worked in private practice in Belgium. Criminal proceedings were brought against him after a complaint by the Flemish Association of Dentists. It was alleged that, for a period of more than ten years, he had advertised his dental services in breach of the relevant Belgian legislation.[118] He had created a website to inform patients of the treatments provided in his clinic. On this website, he showed photos of the results of his

[113] Ibid., para 27.
[114] Ibid., paras 54-57.
[115] Ibid., paras 49-53.
[116] *Conseil national de l'ordre des médecins*, above n 48, paras 25-26.
[117] Ibid., paras 36-45.
[118] *Vanderborght*, above n 54, para 13.

treatments. This kind of information could not be provided under the Belgian legislation. Mr Vanderborght had also posted several advertisements in local newspapers.[119] His defence to the criminal proceedings was that the complete prohibition on advertising constituted a restriction of Articles 49 and 56 TFEU. Even though there was no actual cross-border element, the CJEU found that Mr Vanderborght could provide services to non-nationals.[120] On that basis, the case came within the scope of Article 56 TFEU. The CJEU held that the complete prohibition did not comply with the proportionality test, because less restrictive measures were available – it was not necessary to impose an absolute prohibition on advertising, which was enforced through criminal proceedings.[121]

Simma Federspiel is the most recent case in the series of Italian cases focussing on the remuneration of doctors during their specialist training. Dr Simma Federspiel was an Italian national who had trained as a medical specialist in neurology and psychiatry at the University of Innsbruck from 1992 to 2000. During this eight-year period, she had received a bursary from the Province of Bolzano, in which she was also resident. After the completion of her training, she moved to Austria, where she practised as a neurologist and psychiatrist. According to the CJEU, it was not clear whether she was working in private practice in Austria.[122] One of the conditions for receiving the bursary was that Dr Simma Federspiel would work for the public health services of the Province of Bolzano for at least five years over a 10-year period, within 10 years of the date of qualifying for the specialisation.[123] If she did not do this, she would have to repay 70% of the bursary together with interest. Dr Simma Federspiel had moved to Austria immediately after the completion of her training and had never worked in the Province of Bolzano. As a result, the Province asked her to repay 70% of the amount of the bursary received, which, together with interest, amounted to almost EUR 120,000.[124] Dr Simma Federspiel argued that the Italian rules on repayment of the bursary constituted a restriction of her rights under Article 45 TFEU.[125] Because it was not clear whether Dr Simma Federspiel was employed or self-employed, the CJEU decided to assess her case under Article 45 TFEU and Article 49 TFEU. There was no doubt that the Italian rules constituted a restriction on free movement. The key question, which the CJEU left to the national court to answer, was whether the Italian rules complied with the proportionality test.[126]

Dr Preindl was an Austrian national who had qualified as a dentist in Austria. His Austrian qualification was recognised as equivalent to the Italian dentist qualification by the Italian Ministry of Health. About a year later, he submitted his Austrian degree in "Doktor der Gesamten Heilkunde" to be recognised as a surgeon in Italy. The Austrian professional association had certified this qualification as equivalent to a degree in basic medicine. However, when the Italian Ministry investigated the degree, it discovered that the diploma could be obtained after only 15 months of training.[127] As such, it fell significantly short of the minimum amount of training of six years. However, the Austrian association confirmed that Dr Preindl had studied for the dental and

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[119] Ibid., paras 14-15.
[120] Ibid., paras 55-56.
[121] Ibid., paras 71-75.
[122] *Simma Feder.piel*, above n 54, para 34. A Google search suggests that she works in her own private practice: https://www.medicus-online.at/aek/dist/praxis-1375-O1.html.
[123] Ibid., para 12.
[124] Ibid., para 16.
[125] Ibid., paras 17-19.
[126] Ibid., paras 45-51.
[127] *Preindl*, above n 54, paras 14-16.

basic doctor qualification at the same time.[128] In Italy, this kind of concurrent training was prohibited. As a result, the Italian Ministry still refused to recognise the qualification. Dr Preindl then brought proceedings in Italy claiming that his Austrian qualification should be recognised as equivalent to the Italian qualification. The CJEU agreed: Member States were not allowed to refuse to recognise qualifications which had been awarded on the competition of partially concurrent training.[129]

In *Chirurgiens-dentistes de France*, the French Association of Dental Surgeons (with a number of other professional associations) brought an action against the French Ministry of Health for the annulment of an order which had sought to implement the amendments made to the Professional Qualifications Directive by Directive 2013/55/EU. The professional associations argued that this order unlawfully included the professions of doctor, dental surgeon, midwife and nurse in the scope of the concept of "partial access" to the profession under the Professional Qualifications Directive.[130] The concept of partial access had been introduced by Directive 2013/55/EU to enable Member States to provide partial access to professionals whose scope of activities was significantly narrower than the scope of activities undertaken by professionals with the same qualification in the host Member State. Partial access would only be allowed if the differences between the professional activity were so significant that the professional would be required to complete the full programme of education and training in the host Member State.[131] The French professional associations argued that the professions of doctor (and the other professions represented by the associations) should be excluded from the partial access mechanism under the amended Professional Qualifications Directive. The case turned on the interpretation of the term "professionals" and the distinction between the term "professions" and "professionals" in the Professional Qualifications Directive. The CJEU held that, while professionals (individuals) with the required qualifications enjoyed automatic recognition, the same was not true for the professions in the general sense. This distinction was based on a deliberate choice which had been made in the legislative process leading to the adoption of Directive 2013/55/EU.[132]

Finally, in the case of *A*, a Finnish national had completed her bachelor's degree in medicine at the University of Edinburgh. Under the UK rules, this qualification meant that A had a restricted right to practise as a doctor in the UK, and she was registered as a "provisionally registered doctor with a licence to practise" in the UK.[133] This entitled her to work in a postgraduate programme. After having finished her degree in Edinburgh, A returned to Finland and applied for authorisation to work as a doctor in Finland based on her UK qualification. However, A was unable to provide a certificate of experience, which was required in the UK to have the unrestricted right to practise as a doctor. Because she did not have this certificate, the Finnish supervisory agency suggested that she apply for a temporary licence to practice for three years.[134] In those three years, A could then either complete a professional traineeship in Finland in accordance with UK guidelines, so that she would be able to obtain an unrestricted right to practise in the UK (which would subsequently allow her to practise in Finland), or complete special training in general medicine in Finland.

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[128] Ibid., para 17.
[129] Ibid., paras 26-32.
[130] *Chirurgiens-dentistes de France*, above n 48, paras 13-15.
[131] Article 4f of the Professional Qualifications Directive.
[132] *Chirurgiens-dentistes de France*, above n 48, paras 21-27.
[133] *A*, above n 54, para 14.
[134] Ibid., para 16.

A chose the second option, which did not lead to automatic recognition of her professional qualification under the Professional Qualifications Directive. However, A's problem remained that she had not obtained the full qualification to practise as a basic doctor in UK, and after her training in general medicine the Finnish authorities still refused to recognise this. A brought proceedings before the Finnish Court and claimed that this constituted a restriction of her rights under Articles 45 and 49 TFEU.[135] She argued that, even if she was not entitled to automatic recognition under the Directive, the Finnish authorities still had to make a substantive and individual comparison between the training A had received in the UK and the required training in Finland. In particular, it was disproportionate to refuse to require A to complete three years of additional training in Finland, when the Finnish equivalent only required an additional four months of extra training to obtain the right to practise.[136] The CJEU held that Articles 45 and 49 TFEU required that A's expertise was assessed on an individual basis. It was not proportionate to provide that all holders of a qualification obtained in another Member State had to choose between the same options – the potential outcomes should be based on an individual and detailed assessment of the circumstances of A's case.[137]

V. THE EXPERTISE AND QUALIFICATIONS OF THE MOVING DOCTOR

One of the main findings of the empirical analysis is that most of the cases in which doctors relied on free movement law focussed on their training and qualifications. In 20 out of the 26 cases, the focus was on the doctor's training and qualifications. These cases were usually brought on the basis of the Professional Qualifications Directive. The cases brought on the basis of the free movement provisions in the TFEU usually involved a doctor who had obtained qualifications in a non-Member State. The strong emphasis on expertise means that the focus of the cases was not on the patient-doctor relationship. As will be discussed in more detail below, the only cases which had a direct impact on the patient-doctor relationship were *Konstantinides* and *Vanderborght*.[138] Although an important component of these cases was that the doctors claimed that they possessed a particular kind – or level – of expertise, the restrictions on advertising were based on professional standards or expectations on how doctors should behave towards their (prospective) patients.

In discussing the relationship between the free movement cases and the concept of expertise, the focus will be on three aspects. First, it should be noted that almost half of the expertise-focussed cases (9 out of 20) were collective actions – brought either by an ad-hoc group of doctors or by a (national) medical professional association. Most of the Italian cases were brought by collectives of doctors who had all graduated from the same universities.[139] Similarly, the French and Belgian medical professional associations were particularly active in bringing cases.[140] This collective element is not surprising in cases which focussed on the training and professional qualifications of doctors. After all, it is likely that a significant number of doctors have obtained the same type of qualifications and, therefore, find themselves in the same legal position as their colleagues. The case law before the CJEU shows that doctors are good at mobilising collectives to protect their professional interests. A particularly important role is played by medical professional associations. They provide an important organisational structure in which doctors can get together and collectively protect their expertise and interests. This increasingly involves an element of "external

[135] Ibid., para 19.
[136] Ibid., para 20.
[137] Ibid., paras 42-47.
[138] *Konstantinides*, above n 54; and *Vanderborght*, above n 54.
[139] *Bertini*, above n 48; *Garofalo*, above n 48; *Carbonari*, above n 48; *Gozza*, above n 48; *Fasciolo*, above n 48.
[140] *Fédération Belge*, above n 48; *Conseil national de l'ordre des médecins,* above n 48; *Chirurgiens-dentists de France*, above n 48.

representation", where doctors have to engage with national supervisory authorities in setting and enforcing professional standards.[141] The cases before the CJEU brought by professional associations usually involved a conflict between medical professional associations and national supervisory authorities, or the Ministry of Health. They showed that the professional medical associations were willing to take on cases on behalf of a certain specialty or sub-group of doctors in their Member State.

The second aspect follows directly from the analysis above. An important feature of a significant number of the collective cases was that the aim was to *defend* medical professionalism. All three cases brought by professional associations involved an attempt by the medical profession to defend their own ability to define the required level of training or expertise of general practitioners or medical specialists. All cases focussed on the interpretation of the Professional Qualifications Directive. The fear of the professional associations was that the Directive could lead to a process of deprofessionalisation through over-reliance on the quantitative aspects of medical training. In *Fédération Belge*, the Belgian medical professional association was concerned about a course which combined training as a basic doctor with the training as a general practitioner. This effectively meant that doctors would require fewer years of training before they could practise as a general practitioner in Flanders.[142] Similarly, in *Conseil national de l'ordre des médecins*, the French association was worried about the creation of a new medical specialty which would require less training than the existing specialties.[143] Finally, in *Chirurgiens-dentistes*, the French association was worried that the possibility of partial access to a profession would result in doctors with insufficient expertise being allowed to practise medicine in France.[144] Each of these cases could be seen as an example of the protection of medical professionalism. There was no obvious cross-border or transnational dimension. The cases involved a defensive exercise by the medical profession against national supervisory authorities based on a perceived risk that the Professional Qualifications Directive could be interpreted in such a way that doctors with less or insufficient expertise would be allowed to practise in certain areas of medicine.

A similar kind of "defensive" medical professionalism could be observed in *Garofolo* – a case which was not brought by a professional association, but by an ad-hoc group of doctors. These doctors tried to prevent the Italian authorities from allowing certain doctors to register as general practitioners in Italy without having completed an additional period of training as a general practitioner.[145] The doctors who had brought the action had all completed additional training. The key question was whether EU law allowed or required that the other doctors could register as general practitioners based on acquired rights under the old Directives. This action took place against the background of an Italian healthcare system in which access to the medical profession was strictly controlled by quota.[146] From this perspective, it was unsurprising that the general practitioners did not want to facilitate less-qualified entrants to be entered on the register. The aim of the collective was to defend a particular interpretation of medical professionalism (i.e. that general practitioners should complete additional training and cannot only be basic doctors). By the time this case was brought before the CJEU, this interpretation had already been accepted through

[141] O. Quick, above n 7, 52-67; M. Wolfensberger and A. Wrigley, above n 16, 177-184.
[142] *Fédération belge*, above n 48, para 18.
[143] *Conseil national de l'ordre des médecins*, above n 48, paras 25-26.
[144] *Chirurgiens-dentistes de France*, above n 48, paras 13-15.
[145] *Garofalo*, above n 48, paras 11-13.
[146] *Bertini*, above n 48, para 4.

revisions to the relevant directive. It is no longer possible to practise as a general practitioner without having completed an additional period of training after the training as a basic doctor.

Third, the case law shows how free movement law requires national supervisory authorities to place the concept of medical expertise in a *comparative* and *transnational* perspective. The cases which did *not* involve automatic recognition of professional qualifications provide the clearest example of this. In cases like *Haim* and *Tennah-Durez*, the doctors' initial qualification had been obtained in a non-Member State.[147] These qualifications had been recognised by one Member State, after which the doctors moved on to practise in another Member State. Because of the absence of an EU qualification, the "final destination countries" were under no obligation to automatically recognise the qualifications of the doctors. However, because the qualifications had previously been recognised by another Member State, the minimum obligation imposed by the free movement provisions was that the supervisory authorities had to engage in a substantive assessment of the qualifications obtained in the non-Member State.[148] This assessment would involve an analysis of the basis on which the qualifications were recognised in the other Member State, and the extent to which the qualifications were substantially similar to the qualifications that could be obtained in the destination country.

As such, the concept of expertise is placed in an international perspective. The expertise of medical doctors can no longer be assessed exclusively on the basis of national interpretations of expertise. National authorities have to engage with the substance of the training and qualifications in other countries. The outcome of this assessment is not determined by free movement law. The only obligation imposed by the free movement provisions is that the substantive comparison takes place. Foreign qualifications cannot automatically be rejected. It should be emphasised that this obligation only arises when the doctor's case falls within the scope of application of the free movement provisions.[149] This could be because the doctor has the nationality of a Member State and is seeking to work in another Member State (*Haim*), because the doctor has obtained the nationality of a Member State after having worked there for a certain period of time (*Hocsman*), or because, even though the doctor does not have the nationality of an EU Member State, they can rely on a derived free movement right based on the exercise of free movement rights by a family member under the Citizens' Rights Directive (*Mayeur*).

VI. THE IMPACT OF FREE MOVEMENT LAW ON THE DOCTOR'S DUTY OF CARE TOWARDS THEIR PATIENTS

As a starting point, it should be noted that only two out of 26 cases (*Konstantinides* and *Vanderborght*) were linked to the quality of care provided by doctors to their patients. The duties of doctors towards their patients did not feature prominently in the case law. This is not surprising in light of the fact that the secondary law adopted by the EU is focussed almost exclusively on *access* to the medical profession.[150] Furthermore, in *Konstantinides* and *Vanderborght*, the doctor's reliance on free movement law was not directly linked to the treatment provided to patients. These cases were not about the doctor's competence or skills. Rather, the cases focussed on some of the ancillary aspects of medical treatment: the fees and the advertising of medical treatment. Nevertheless, these aspects are still important to the patient-doctor relationship.

[147] *Haim*, above n 54, para 6; *Tennah-Durez*, above n 54, para 20.
[148] *Tennah-Durez*, above n 54, paras 75-81.
[149] *Mayeur*, above n 40, paras 18-20.
[150] See the Opinion of AG Cruz Villalón in *Konstantinides*, above n 54, ECLI:EU:C:2013:51, para 28.

In both cases, the doctors relied on Article 56 TFEU. It could be argued that Article 56 TFEU is the most "dangerous" free movement provision from the perspective of medical professionalism. This is primarily because of the temporary nature of the provision of services, which could be particularly problematic in cases where the doctor moves between Member States (such as in *Konstantinides*). The empirical analysis confirms the potential danger posed by Article 56 TFEU. However, it is risky to identify this danger on the basis of only two cases. In *Vanderborght*, Article 56 TFEU could be relied on only because of the possibility that Dr Vanderborght *might* be treating patients from other Member States.[151] The case did not involve cross-border movement of the doctor. Nevertheless, the impact of advertising on patients in a cross-border context is important and might be different from advertising directed towards patients in the home Member State.

In *Konstantinides*, the temporary nature of the doctor's stay in Germany had a more significant impact on his duty towards his patients. In particular, one of the main complaints of the German professional association was that Dr Konstantinides had created an impression of permanency – through his reference to a research institute – which was not justified on the basis of a number of short monthly visits to the German clinic.[152] Overall, a large majority of cases involved doctors who relied on Article 45 TFEU or Article 49 TFEU. All of these cases involved permanent establishment in another Member State – even if, in *Van Poucke*, the doctor was working on a permanent basis in two Member States.[153] The empirical analysis confirms that permanent establishment cases are less likely to have a direct impact on the patient-doctor relationship.

Another potential risk to medical professionalism could be the private nature of the medical treatment provided. A private healthcare environment might make it more likely that doctors are driven by economic considerations in making decisions about the medical treatment of their patients. As such, Article 49 TFEU could be argued to pose more of a risk to medical professionalism than Article 45 TFEU. This risk is not confirmed by the empirical analysis. Only 9 out of the 26 cases involved doctors who were working in private practice. A number of these cases were about dentists (*Haim*, *Klett* and *Preindl*), who are likely to be self-employed in most Member States. Other cases, like *Simma Federspiel*, were about doctors who had their own independent solo practice. At the same time, both *Konstantinides* and *Vanderborght* focussed on the quality of care provided by doctors who were working in private clinics. Furthermore, profit-making was directly relevant in *Konstantinides*, in which it was alleged that the doctor had charged excessive fees. In both cases, advertising played an important role. It was argued that the advertising conducted by the doctors was in breach of national law – either through a criminal law prohibition (*Vanderborght*) or through medical disciplinary law (*Konstantinides*). Again, advertising is likely to play a role in a private healthcare environment, in which doctors are more likely to treat their patients as consumers.

Konstantinides and *Vanderborght* show that a clear link can be made between the concept of medical professionalism and the concept of consumerism. In effect, it means that patients are acting more like consumers in the treatment process, and that they want to be able to exercise a degree of choice over whom they are treated by, and what sort of treatment they will receive. The empirical analysis of the free movement of doctors cases shows that consumerism is not just "one-way traffic" from patients to doctors. Patients are an important "driver" of this process of consumerism. For example, free movement of patients could result in consumerism to the extent

[151] *Vanderborght*, above n 54, paras 55-56.
[152] *Konstantinides*, above n 54, para 25.
[153] *Van Poucke*, above n 54, para 3.

that it increases patient choice in the internal market.[154] However, it is not just the patient who is in the "driving seat" - consumerism is a mutual process that takes place directly in the patient-doctor relationship.[155] *Konstantinides* and *Vanderborght* show that doctors might be able to "induce" consumerism – in particular, through their emphasis on advertising. This kind of doctor-induced consumerism of medical treatment is most likely to take place in a private healthcare setting. Similarly, it is more likely to be relevant in areas of medicine with a strong focus on aesthetics, such as dentistry. Although the CJEU was (suspiciously) quiet about the nature of the treatment provided by Dr Konstantinides,[156] based on the information in the judgment and the Advocate General's Opinion, it seems likely that the treatment provided by Dr Konstantinides was heavily focussed on aesthetics. This focus on advertising and aesthetics poses risks to the concept of medical professionalism. At the same time, an increased emphasis on consumerism could also lead to new or additional types of legal accountability of doctors, such as cases in contract law or complaint procedures.

VII. ESCAPING ACCOUNTABILITY THROUGH FREE MOVEMENT LAW

Free movement law was relied on as a "shield" to limit or avoid liability in only three out of 26 cases: *Simma Federspiel*, *Konstantinides* and *Vanderborght*. Two of these cases were already discussed above in the context of the doctor's duties in the patient-doctor relationship. There is a close link between the concepts of duty and accountability. Moreover, in each of the three cases, the doctor relied on the free movement provisions in the TFEU – not on the Professional Qualifications Directive. In *Konstantinides*, the doctor relied on Article 5(3) of the Professional Qualifications Directive.[157] However, the CJEU decided to assess his case under Article 56 TFEU. In *Simma Federspiel*, the doctor relied on Articles 45 and 49 TFEU in her defence, while *Vanderborght* focussed on Article 56 TFEU. The aim of this section will be to analyse *where* and *to whom* the doctors were being held accountable, and what the impact of free movement was on their attempt to restrict liability.

Even though only three cases focussed on the concept of accountability, each case involved a different type of accountability before a different type of national court. The three main types of accountability of doctors identified above were private law (tort law or contract law), professional discipline and criminal law. Although *Simma Federspiel* was not strictly a contractual case, it did have an important contractual dimension. Dr Simma Federspiel brought a case to challenge the decision of the regional authorities in Bolzano that she should pay a very significant part of the funding which she had received for her training as a neurologist and psychiatrist. As such, she was seeking judicial review of a decision of a public authority. Nevertheless, the focus was on the interpretation of the provision in the (quasi-)contractual agreement between the regional authorities and Dr Simma Federspiel, according to which she would have to repay 70% of her funding if she did not work in the Bolzano region for at least five years in the ten years after she had obtained her specialist qualification.

In addition to the contractual nature of the case, another interesting feature was that there was also a direct link to the concept of duty of care. However, while the concept of duty has so far primarily been analysed as the duty of care owed by a doctor towards their patients, in *Simma*

[154] B. van Leeuwen, above n 9, 175.
[155] E. Jackson, 'Challenging the Comparison in Montgomery Between Patients and 'Consumers Exercising Choices' (2021) 29 *Medical Law Review* 595.
[156] *Konstantinides*, above n 54, para 21.
[157] Ibid., para 27.

Federspiel, the issue focussed on a doctor's duty – and solidarity – towards their national healthcare system. In this case, the duty had been laid down in the agreement between the doctor and the national healthcare system. It was based on the principle of solidarity: "if we pay for your training, we are entitled to expect you to make a contribution to our healthcare system". In moving to Austria immediately after she had completed her training, Dr Simma Federspiel had not sufficiently appreciated the duty she owed towards her national healthcare system.

In *Konstantinides*, Dr Konstantinides was held accountable before a German disciplinary tribunal. As such, this was a professional discipline case, which was brought by the regional medical professional association in the German region where he was working. The case was to a significant extent based on professional standards which had been laid down by the professional association itself. In his Opinion, Advocate General Cruz Villalón had briefly addressed the question of whether a medical disciplinary tribunal could be regarded as a "court of tribunal" for the purposes of the preliminary reference procedure under Article 267 TFEU.[158] This was not the first time that such a question came before the CJEU: the early case of *Broekmeulen* already addressed the question to what extent professional committees or tribunals could engage with the CJEU through the preliminary reference procedure.[159]

In *Konstantinides*, the CJEU provided guidance to national disciplinary tribunals on how they should assess whether national rules or conduct complied with the free movement provisions. In doing so, the CJEU has enabled individual doctors to confront supervisory authorities or healthcare systems with professional standards or qualifications from other Member States. Medical disciplinary tribunals tend to be composed of a combination of lawyers and doctors.[160] These tribunals do not necessarily possess a significant amount of expertise in the field of free movement law. Free movement law requires that these tribunals take a comparative approach to medical professional standards – in the same way that supervisory authorities have to adopt a comparative approach to professional qualifications obtained by doctors. Furthermore, free movement law has required a process of *evaluation* of medical professional standards and rules in a cross-border and European context – in particular, through the proportionality test.[161]

Finally, *Vanderborght* involved the criminal liability of a doctor. Dr Vanderborght had to defend his actions before a criminal court in Brussels. The nature of the complaint against him was substantially not very different from the advertising complaint brought against Dr Konstantinides. However, the main difference was that the Belgian prohibition on advertising had been laid down in national criminal law. In German law, it was a matter of professional discipline only – criminal law did not get involved.

Overall, in all three cases, the doctors were not held directly accountable to patients. Patients played no visible role in the proceedings. This confirms that most of the cases were primarily concerned with the relationship between doctors, medical professional associations and national healthcare systems. The only exception was *Konstantinides*. Although the patient was not directly involved in the case, the proceedings had started with a complaint from one of Dr Konstantinides' patients, which had triggered an investigation by the professional association.[162] Therefore,

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[158] Opinion of AG Cruz Villalón in *Konstantinides*, above n 150, paras 14-22.
[159] *Broekmeulen*, above n 54, paras 8-17.
[160] For a comparative perspective, see H. de Vries et al., *International Comparison of Ten Medical Regulatory Systems* (RAND, 2009). See also I. Rosso-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.
[161] B. van Leeuwen, above n 1, 75-77.
[162] *Konstantinides*, above n 54, para 22.

indirectly, Dr Konstantinides was also held accountable to his patients. As such, *Konstantinides* provides an example of medical professional associations taking responsibility for defending and enforcing medical professionalism against their members. This includes the indirect representation of patients by taking up complaints submitted by them. This "prosecutorial function" confirms the important role of medical professional associations in protecting medical professionalism.[163]

VIII. CONCLUSION

In comparison with free movement of patients, the overall picture for doctors is more homogenous. The doctor who relies on free movement law is usually concerned about medical training or professional qualifications. The free movement provisions are relied on in cases against national supervisory authorities or Ministries of Health. Doctors do not regularly rely on free movement law in situations which are directly linked to the quality of care provided to patients. In a large majority of cases, free movement law was relied on to defend medical professionalism. The case law shows a strong tendency on the part of doctors to defend the expertise and training component of medical professionalism – in particular, by challenging national interpretations or applications of the Professional Qualifications Directive.

In only three out of 26 cases was the doctor's aim to limit or avoid liability by relying on the free movement provisions. *Konstantinides* and *Vanderborght* are the cases in which medical professionalism was most clearly under threat. In *Konstantinides*, this was because the doctor charged extremely high fees and engaged in unprofessional advertising. In *Vanderborght*, the allegation was also that the doctor had engaged in unlawful advertising. In both cases, the doctor relied on Article 56 TFEU. Moreover, it is important to note that these cases are more recent – both cases were decided in the last decade. Although the number of cases is too low to draw reliable consequences, these two cases could indicate that it has become more common for doctors to try to rely on free movement to restrict liability in a cross-border context.

Overall, it is possible to make a distinction between three different types of doctor in free movement law.[164] Each of these types is linked to the different characteristics of medical professionalism: expertise, duty, and accountability. The first and most common type of doctor in free movement law is "the concerned doctor". These doctors were seeking to defend medical professionalism based on a perceived threat to medical professionalism caused by the way in which national authorities interpreted the Professional Qualifications Directive. The cases did not usually have a cross-border dimension – they were about doctors complaining against their own national supervisory authorities. The only case in which there was something like a cross-border dimension was *Fédération Belge*, in which the national professional association was unhappy with a competitive advantage given to doctors who had been trained in another region in the same country.[165] However, no borders were crossed between Member States. The concerned doctors were not particularly concerned about free movement of doctors. They were usually concerned about the impact of the Professional Qualifications Directive on the required level of training or expertise of doctors. They always acted as a collective. They regarded themselves as defending their specialty against a process of deprofessionalisation caused by the application or implementation of the Professional Qualifications Directive.

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[163] E. Freidson, above n 7, 96.

[164] See also I. Glinos and J. Buchan, 'Health professionals crossing the EU's internal and external border: a typology of health professional mobility and migration' in J Buchan et al. (eds.), above n 1, 129-152.

[165] *Fédération Belge*, above n 48, para 19.

The second type of doctor is "the multi-qualified doctor". This is a doctor who has obtained qualifications and expertise in different countries, which usually include a non-Member State. The aim of their reliance on free movement law was to encourage the Member State in which the doctor was working to take into account the recognition of expertise acquired in a non-Member State in deciding whether or to what extent the doctor should be allowed to practice medicine. Similarly to the concerned doctor cases, the aim of the multi-qualified doctors was to defend medical professionalism. In their cases, they were trying to force the national authorities to adopt a transnational or comparative perspective on the qualifications of doctors. Decisions on the recognition of qualifications could not be taken based on an exclusively national perspective on the required expertise of doctors. In all cases, the multi-qualified doctors were seeking to have previous qualifications or expertise taken into account.

Finally, the third type of doctor is "the entrepreneurial doctor". This doctor poses the most significant risk to the concept of medical professionalism. This is because the doctor is relying on the free movement provisions to limit their liability and accountability for conduct directly linked to the patient-doctor relationship. As a result, there is a direct link between the concepts of accountability and duty. The doctors were held accountable – in professional discipline or criminal law – for conduct towards their (prospective) patients. Although this category only includes two cases, these cases confirm that doctors are more likely to act as entrepreneurs in a private healthcare setting. In *Vanderborght*, it should be noted that the national restriction on advertising was very strict, since it was almost absolute in nature.[166] From this perspective, the fact that a doctor tried to challenge it should not immediately be regarded as an example of deprofessionalisation. Nevertheless, it is clear that the entrepreneurial doctor is willing to rely on free movement law to limit or avoid liability. The risks for medical professionalism depend on whether these doctors are successful in their attempts, and on whether or to what extent national healthcare systems or public supervisory authorities are allowed to restrict the free movement rights of doctors to defend medical professionalism.

To conclude, the empirical analysis shows that the exercise of free movement rights by doctors is most strongly linked to the expertise and qualifications of doctors. Overall, the reliance on free movement law does not pose a risk to medical professionalism. On the contrary – in many of the cases, doctors were defending medical professionalism. The main risk to medical professionalism that has been identified comes from recent cases in which doctors were seeking to rely on free movement to restrict their liability in medical professional discipline or criminal law. Although the number of cases is low, the cases show that free movement of doctors cases will more regularly be decided by national courts with less experience in the structure and substance of free movement law – such as disciplinary tribunals or criminal courts. This makes it important that non-specialised courts ensure that they are familiar with the structure of free movement cases, and that they continue to engage in a dialogue with the CJEU.[167]

[166] *Vanderborght*, above n 54, paras 11-12.
[167] See also B. van Leeuwen, above n 1, 79-80.