

Working in SWEDEN

Information for doctors from EU/EEA countries

Swedish Medical Association
National Board of Health and Welfare

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Legal aspects on the recognition of diplomas

a) Directive 93/16/EEC

The basic principle of free movement of persons, as laid down in the Treaty of Rome, would not by itself guarantee migrating doctors the right to exercise the medical profession in other Member States. Therefore, the major purpose of the Medical Directive of the European communities – 93/16/EEC – is to *facilitate* free movement of doctors within the European Union. What is said hereinafter about Member States is equally applicable to the EEA States Norway, Iceland and Liechtenstein.

The Medical Directive 93/16/EEC is in fact a consolidated version of the older Directives of 1975 and 1986 with later amendments. The Directive provides for the mutual recognition of medical qualifications on basic level as well as postgraduate level. Member States are obliged to harmonize their medical training systems in order to comply with the minimum requirements laid down in the Directive. However, nothing prevents Member States from placing their respective qualifications on a higher level. In fact, this is often the case.

In order to be eligible to benefit under the Directive the migrating doctor must be a *national* of a Member State and hold a medical qualification awarded on completion of *training* in a Member State. If these two conditions are met, the competent authority of the host Member State cannot refuse recognition and has no option to make individual assessment of the contents of training completed by the applicant. Sweden is probably the only Member State that does not maintain the nationality requirement for doctors residing in

Sweden, but this policy has no legal consequence in relation to other Member States.

The principle of automatic recognition is expressed in the Medical Directive in terms of listed qualifications under the Article in question. Thus, under Article 3 a number of basic medical qualifications are listed in the language of the Member State of training. This makes it possible for the competent authorities to identify qualifications that have to be recognized without any further evaluation, even without translation into the language of the host Member State in question. As for medical specialties, the relevant qualifications are listed under Articles 5 and 7.

In addition to basic medical qualifications and specialist qualifications the Medical Directive contains a section with provisions on specific training in general practice. According to these provisions the right to establish general practice under the social security scheme of a Member State is subject to the possession of an additional diploma as referred to in Article 30. This applies to the Member State of origin as well as the host Member State. Thus the principle of mutual and automatic recognition is extended to general practitioners and the relevant qualifications have been published in the Official Journal.

The training required for an Article 30 diploma varies to a greater extent between the Member States than the other medical qualifications. It must also be emphasized that a general practitioner in the meaning of the Directive must not be confused with a specialist in Family Medicine. The specialty Family Medicine seems to be a qualification mainly in the Nordic States and does not appear among the specialties listed under Article 5 or 7, at least not so far.

b) Recommendation 75/367/EEC

Sweden has decided to comply with a recommendation adopted by the Council of the European Communities with the objective to make it possible to perform postgraduate medical practice in another Member State than that of undergraduate training. This could be an opportunity for graduated doctors who need some kind of pre-registration service in order to gain the qualification listed under Article 3 of the Directive.

The relevant clinical practice available in Sweden is either the internship programme (“AT-block”) of at least 18 months’ duration or short-time medical appointments as *locum tenens* in a subordinate position. However, it must be noted that in order to be eligible for these appointments the applicant must have passed a language test following a formal decision of the National Board of Health and Welfare. It is up to the competent authority in the Member State of origin to take such clinical practice into account for recognition.

Administrative procedure

In Sweden the National Board of Health and Welfare is the competent authority under the Medical Directive. The Board is responsible for issuing medical qualifications and for maintaining the Swedish medical register for all qualifications on the three levels referred to in the above.

A migrating doctor seeking recognition in Sweden should approach the Board in order to acquire the necessary application

form. In addition to the application form the following documents must be submitted:

- 1 evidence of qualification as listed in the Directive presented in copies verified by an authority in Sweden or in the Member State of origin
- 2 certificate of good standing with the competent authority in the Member State of origin or last residence. This certificate must not be older than three months and be presented in original. This requirement is not applicable to migrating doctors from a Nordic State
- 3 curriculum vitae (not compulsory)

When the National Board of Health and Welfare has made the formal assessment, the applicant will become fully registered and the licence to practise medicine will be issued. At the same time the migrant doctor will be furnished with information emphasizing the necessity of good knowledge of the Swedish language and the relevant medical legislation and how to obtain such knowledge in terms of suitable courses. Nothing prevents the employer (county council) to make proof of linguistic and legal competence a requirement for a medical appointment.

Medical education and training

Medical education and training is organized in three phases: medical school, basic clinical training and specialist training.

Basic undergraduate medical education takes 5 1/2 years (at least 40 weeks of full time studies per year).

After graduation follows a compulsory training programme (internship) of at least 18 months. This first stage of clinical training comprises surgery (3–6), internal medicine (3–6), psychiatry (three months) and family medicine (six months). The doctor's knowledge and skills are assessed by the senior colleagues and tested in a written and practical examination. After successful completion of this programme the doctor obtains his licence to practise (full registration), which is granted by the National Board of Health and Welfare.

Once the doctor has got his licence to practise, he is entitled to apply for a post to start his specialist training. The specialist training has a duration of minimum five years and is carried out in a salaried position with medical responsibility.

There are currently 62 recognized specialties in Sweden (see **Appendix A**). For each of these specialties there is an official description of the training objectives in terms of required knowledge, skills and attitudes. These descriptions have been made by the various Specialist societies (within the Swedish Medical Association and the Swedish Society of Medicine) and are authorized by the National Board of Health and Welfare. The junior doctor is entitled to have an individual training programme, specifying the required practical training in various departments together with additional theoretical education. He/she is also entitled to have a personal tutor (a recognised specialist) who will give professional guidance during the specialist training.

The head of the department (clinical medical director) has the ultimate responsibility for the specialist training. He/she also has the legal responsibility to assess when the doctor has achieved the training objectives set up for the specialist training and thus should be recognized as a specialist. The head of the department states

his/her opinion by issuing an official certificate. The National Board of Health and Welfare will then – upon application – grant the doctor the formal qualification as a specialist.

Clinical skill and theoretical knowledge is evaluated continually through the whole period of specialist training. Thus the doctor is not required to take a formal final examination before being granted qualification as a specialist. However, some Specialist societies have introduced voluntary examinations.

The Swedish Medical Association, in cooperation with the Swedish Society of Medicine, runs a programme to review and evaluate the quality of training in different departments all over the country. Participation is voluntary.

Continuing medical education is not formalized. There is, however, a variety of courses, seminars etc available, mainly organized by the various Specialist societies.

Working conditions

Sweden has a decentralized health and medical care system. The role of the Government is mainly limited to providing the legal framework and supervising that medical care is safe, of good quality and equitably distributed. Financial and operative responsibility rests almost totally with the county councils. These regional bodies have an independent and powerful position with their own right to levy taxes. They run some 90 hospitals – including all university hospitals – and over 900 health centers. Medical care in Sweden has traditionally been hospital-orientated, and the number of hospital beds has been high by international standards. In later years, however, primary care and other kinds of ambulatory care

have expanded, and the number of hospital beds has been reduced considerably.

The dominant position of the county councils is also reflected in the employment situation. About 90 per cent of all physicians are employed in the county council sector. The remainder work as university teachers, private practitioners, in occupational health and the pharmaceutical industry. The establishment of private practice under the social security scheme is possible only with the consent of the county council concerned.

It should particularly be noted that in Sweden also general practitioners usually are salaried employees, not private entrepreneurs, as is the case in many European countries. They have the qualification as specialist in Family Medicine. All training posts for junior doctors are likewise salaried positions in the county councils' health care.

Posts for physicians are advertised in the Swedish Medical Journal (Läkartidningen) and official publications. As a main rule physicians are employed in a position for an indefinite period. There are exceptions to this rule, notably the internship period, and at the university hospitals, where a contract period of six years is common. Employment as *locum tenens* is, of course, for a definite period.

Salaries and general terms of employment are negotiated between the Federation of County Councils and the Swedish Medical Association. However, the central collective agreements leave considerable room for local negotiations between the individual county council and the local branch of the Swedish Medical Association.

Working hours are partly regulated in law, and partly in collective agreements. The working week is in principle 40 hours. In addition most specialities have night and week-end duty, which is compensated with money, free time or a combination of both. The retirement age is 65 years.

A large majority (90-95 per cent) of the Swedish doctors are members of the Swedish Medical Association. As has already been mentioned, the Swedish Medical Association represents its members in collective bargaining about salaries, working hours, working conditions etc, but the Association is also deeply involved in a wide range of professional issues, e.g. medical education, medical ethics, health care politics, quality assurance and international relations.

Labour market situation

The number of Swedish physicians has increased steadily and rapidly. During the period 1970-1998 the figure almost trebled: from slightly over 10.000 to about 28.000. There is now one doctor for every 330 inhabitants. Two thirds are specialists (including specialists in Family Medicine).

The six medical faculties admit about 900 new students every year. The Government and Parliament have commissioned the faculties to graduate a minimum of 740 new doctors annually. In addition there is an influx every year of some 100 doctors from non-EU countries, who are granted residence permit for political, humanitarian or family reasons.

In the middle of the 1990's there was a tendency towards a surplus of physicians. Particularly, there was keen competition for posts for

specialist training, and many young doctors had to be content with temporary employment as *locum tenens*.

The picture changed in late 1998, and a certain shortage of specialists was felt in several specialities, e.g. anaesthesiology and psychiatry. The principal factors behind this change were that the county councils increased their demand for specialists, that physicians from Denmark and Norway working in Sweden returned to their native countries, and that Swedish doctors sought occupation abroad, especially in the booming Norwegian health sector. The demand for junior doctors also increased considerably: the number of new training posts advertised in 1998 increased twofold.

However, about 100 doctors still receive unemployment benefits from their organization's unemployment funds, and some 600 doctors are registered as job-seeking at the national unemployment bureaus; many of these are foreign physicians.

After a period of financial constraint, the county councils started spending again in 1998, but the long-term perspective remains uncertain. If the present demand for doctors is upheld or increased, a shortage of trained specialists will occur in the period 2005-2015, when large numbers of doctors born in the 1940's are expected to retire. If they choose to retire before the official retirement age of 65, and/or the present migration trends continue, Sweden may experience a lack of specialists as early as in the first years of the new millennium.

Medical responsibility and professional ethics

A doctor who is practising the medical profession in Sweden – either in an employed position or as a self-employed private practitioner – is subject to the supervision of the National Board of

Health and Welfare. The doctor is obliged to exercise the medical profession in accordance with the scientific development and reliable experience. The exact definition of these concepts is complicated, changing over time and not available in terms of legislation.

It is extremely important (as has already been mentioned) that the migrant doctor becomes well acquainted with current regulations and administrative provisions governing the professional duties. The definition of the concepts “scientific development and reliable experience” must be derived from such provisions, as well as from individual decisions of the Medical Responsibility Board.

If a practising doctor fails in his professional duty – intentionally or negligently – and the fault is more than trivial, disciplinary sanctions may be imposed by the Medical Responsibility Board after notification from the National Board of Health and Welfare or the patient concerned. In serious cases the licence to practise may be revoked and the doctor removed from the medical register.

The Swedish Medical Association has issued a code of medical ethics which is in conformity with international ethical declarations adopted by the World Medical Association.

The code of ethics states *inter alia* that the doctor must act in accordance with the scientific development and reliable experience, and continually strive to expand his/her knowledge. The physician's prime objective is to promote the health and well-being of his/her patient. He/she must respect the patient's right to integrity and autonomy. The physician must not let his/her relation to the patient be influenced by religious or political convictions, nationality, race or position in society.

Medical indemnity

All patients, in public as well as in private care, are covered by an insurance (“Patient Insurance”) paid by the county councils and other care providers. The insurance gives the patient economic compensation for injuries that occur in connection with medical examination, treatment and care. It operates on a no-fault principle, i. e. the patient does not have to prove that the injury is due to negligence on the part of the physician or other personnel. The requirement is that the relation of cause and effect between treatment and damage is established, and that damage is not a “normal” risk of the medical procedure in question. The doctor responsible for the treatment is obliged to inform the patient, if he/she considers that damage has occurred, and also to assist the patient in applying for compensation.

It is, however, recommended that doctors also have a private liability insurance as a complement. The premiums for a private liability insurance are low, since the Patient Insurance covers almost all cases of demands for compensation.

Medical specialties in Sweden

The official designations in Council Directive 93/16/EEC are used.

Specialties not listed in Council Directive 93/16/EEC are referred to in italics and marked with *

- **Surgical Specialties**

- General surgery
- Orthopaedics
- Urology
- Paediatric surgery
- Hand surgery**
- Plastic surgery
- Neurological surgery
- Thoracic surgery
- Anaesthetics
- Obstetrics and gynaecology
- Gynaecological oncology**
- Oto rhino laryngology
- Phoniatrics**
- Audiology**
- Ophthalmology

- **Internal Medicine Specialties**

- General (internal) medicine
- Cardiology
- Gastro-enterology
- Endocrinology
- Renal diseases
- Respiratory medicine
- General haematology
- Allergology

Rheumatology
Occupational medicine
Geriatrics

- **Paediatric Specialties**

Paediatrics
*Child & adolescent allergology**
*Child & adolescent neurology**
*Child & adolescent cardiology**
*Neonatology**

- **Family Medicine***

- **Psychiatric Specialties**

Psychiatry
*Forensic psychiatry**
Child Psychiatry

- **Radiological Specialties**

Diagnostic radiology
*Neuroradiology**
*Child & adolescent radiology**

- **Clinical Laboratory Specialties**

*Transfusion medicine**
*Coagulation & bleeding disorders**
Immunology
Microbiology-bacteriology
*Clinical virology**
*Clinical physiology**
Clinical neurophysiology
Biological chemistry
Pharmacology
*Clinical genetics**

Pathological anatomy
*Clinical cytology**
*Forensic medicine**

- **Community Medicine**

- **Industrial Health***

- **Student Health***

- **Dermatology-venereology**

- **Neurology**

- **Communicable diseases**

- **Physiotherapy**

- **Radiotherapy**

- **Nutrition***

- **Pain management***

- **Nuclear Medicine (Not yet notified by Sweden.)**

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