What are the global challenges facing regulation?

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Introduction

It is a great privilege to address you this morning — and let me say at the outset how grateful the world community of medical regulators is for the steadfast and loyal support given by the FSMB to the International Association of Medical Regulatory Authorities.

IAMRA has grown and developed thanks to the administrative skill and to the wise policy guidance of the FSMB leadership and staff over many years.

It is a privilege too to give this eponymous lecture in honour of Bryant Galusha, a distinguished paediatrician and medical educator and it is a special honour for me because he did so much to establish and take forward the notion of a national medical licensing examination for the United States.

In the UK today we are exploring, some would say not before time, the idea a national licensing assessment and it has been enormously helpful to be able to draw on your now considerable experience with the USMLE.

Bryant Galusha, your 67th Federation President, was a key figure in helping create the current system. A member of the North Carolina Board of Medical Examiners (now the North Carolina Medical Board) he was elected to the Federation Licensing Examination Board in 1976, and was committee chairman when the idea that evolved into FLEX I-FLEX II emerged. He was both an ardent supporter and effective spokesman and the adoption of this program in 1981 was a pivotal moment in Federation history and indeed in the development of medical education in the US.

I think you owe him a great deal — and in the UK we too are grateful to this pioneer in medical assessment as we embark on our important journey to create our own medical licensing assessment.

This morning I’d like to reflect on the state of medical regulation. It’s not a topic to everyone’s taste and there are plenty within and beyond the profession who regard us regulators with the enthusiasm normally reserved for funeral directors or taxmen.

A past President of the GMC, anxious to curry favour with the profession, decided to send congratulatory letters out whenever a physician won a prestigious award. That year a British doctor won the Nobel Prize for science but the response from the great man was disappointing:
“Dear President”, he wrote, “this morning I was looking forward to the day ahead when I came down to breakfast to be confronted by an envelope propped up against the cereal packet with the dreaded letters ‘GMC’ embossed upon it – I thought my career was at an end. Thank you for ruining my day — please never write to me again”.

I suspect regulation may always be something of a thankless task. Fear of disciplinary action though remains a potent feature of medical regulation and in the past I suspect we have not paid enough attention to its corrosive effect. I will return to that.

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**The Origins of Medical Regulation**

Now I am a great believer in the maxim that, if you don’t know where you’ve come from, you probably don’t know where you are and almost certainly don’t know where you are going.

Medical regulation, like medicine itself, is a social construct, subject to constant change and influenced strongly by the historical, social, political and cultural context in which it operates. After hearing the fascinating insights yesterday from Charlie Cook on your impending presidential race I can see why many might be regarding the future with some trepidation.

I have no idea what awaits us all with the presidential race and I don’t want to alarm you, but as far as I am aware only one country has abolished medical regulation and that was the Pinochet dictatorship in Chile — which believed that *caveat emptor* was sufficient protection for all consumers, including patients. But I am sure none of your candidates for presidency would go that far!

Medical regulation is largely a nineteenth century creation and I want to suggest that we could well see a rather different model emerge in the twenty-first century compared to what was experienced in the nineteenth and twentieth centuries.

The need for regulation, given the potential risks of medicine, has long been recognised — Hippocrates may not have used the words ‘do no harm’ but that is what he meant by requiring physicians to ‘abstain from all intentional wrong-doing and harm’.

As early as the 1400s, petitions were made to England’s Henry V asking that only those with appropriate qualifications should be allowed to practise medicine. It did not work because they did not have enough qualified physicians — so we have obviously made a lot of change there!¹

In the UK it took us until 1858 to create the GMC, and that was after 18 years of parliamentary debate and 17 earlier Bills — it makes the impasse on Capitol Hill look fleeting. All this to create a single register for doctors whatever field of medicine they intended to pursue.

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Incidentally the tidying up of 1858 coincided with three other very useful household innovations — the pencil eraser, ironing board and dustpan also all appeared in 1858.

As in other countries, this was an attempt to distinguish between practitioners who were products of the Enlightenment who based their practice on knowledge and understanding of science, and those who made it up as they went along.

But here, not for the first or last time, you were ahead of us. The New Jersey Medical Society, chartered in 1766, was developed to "form a program embracing all the matters of highest concern to the profession: regulation of practice; educational standards for apprentices; fee schedules; and a code of ethics."² Not a million miles from where we are today!

By 1806 the first licensing laws were passed in the US — in New York — the Medical Practices Act. This allowed the state to license practitioners, which meant that only licensed physicians could recover their fees in courts. Unlicensed practitioners were fined $25.00³.

Incidentally the first female registrant on the UK’s medical register was Elizabeth Blackwell, a graduate of Geneva University in the US and also the first woman to receive a medical degree in the US⁴.

And just to complete the picture and demonstrate that others were very much around this topic, in 1838 the Sydney gazette called for urgent legislation to guard against quackery:

“Surely it is the duty of the Legislature to prevent uneducated ignorant men tampering with human life... adding I am sure unfairly - the Colony swarms with individuals calling themselves Surgeons” - Sydney Gazette 1838.

The first model of medical regulation

The essence of the regulatory model that emerged from all this was self-regulation. It was based on the notion that medicine was an autonomous profession mastered and practised by individuals — or rather by men. The business of regulation was to confine entry to that profession to those with the right education and training and then, unless they behaved badly, to leave them alone to practise their profession. It was based too on an assumption that all doctors were competent and that intervention was really only required when they misbehaved and let the side down.

The effect was to create a system that was essentially reactive, with contact between regulator and regulated limited — for most physicians it was confined to the point when they joined the register and the point when they left it, usually when they died. In addition,

for a few, there was the one off catastrophic contact usually focussed on some form of misconduct.

For many of us, our legislation and much of what we do today is still predicated on assumptions and activities that would be recognised by the pioneers of medical regulation.

But the model was always based on a compact — an unwritten agreement between politicians, patients and profession. It was, and is, only sustainable as long as the three parties are more or less aligned.

The compact under pressure

Through the twentieth century, by different degrees and in different ways, in different jurisdictions that model came under scrutiny. In some places today it survives with less challenge but in the English speaking world in particular there has been pressure to change, not least as patients have become more assertive and less deferential.

The claim — not always fair — was that unfettered, self-regulation too often placed the interests of the profession over the interests of patients.

I think the most honest advocate of this approach was one John Marshall, President of the GMC in 1889, who warned his Council that they 'should not seem over-anxious to be at work since the spreading abroad of the shortcomings of any erring members of our honourable profession is a proceeding to be carefully restrained within precise limits'. In other words don't wash your dirty linen in public!

Over the last twenty years in many countries we have seen major public enquiries that have highlighted the danger individual incompetent practitioners could pose to patient safety and which have exposed the limitations of relying on regulators who only responded after significant harm to patients had come to light.

And among regulators themselves there has been a growing realisation that the competence and health of practitioners matters as much as misconduct and that it ought to be possible to describe what good should look like, rather than simply describing what not to do. In the UK this was the transition from the Blue Book which listed the things doctors should not do to our current core guidance Good Medical Practice.

And of course regulation in developed countries, particularly at the end of the twentieth and the start of this century, has been subject to seismic movements that have affected the whole healthcare landscape.

I want to touch on four major challenges which, as regulators around the world, we now face — I could have talked about how we deal with social media, the challenge of opioid prescribing, the over-prescribing of antibiotics, managing conflicts of interests, physician

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shortages and much else so these four are by no means exhaustive — you will doubtless have your own preferences.

The challenge of a safety critical industry

I want to begin with the belated but growing recognition that we are dealing with a safety critical industry.

The 2000 seminal report from the Institute of Medicine (IOM) in Washington To Err is Human, resonated around the world. It placed healthcare in the US ten years behind other safety-critical industries\(^7\) and exposed an iatrogenic death rate that was both unacceptable and largely avoidable — the third leading cause of death in the US, after heart disease and cancer\(^8\).

Similar work in the UK and Australia, among others, highlighted a system that lacked transparency and was too often characterised by unacceptable variation.

For good reason, the quality and safety movement has been more focussed on systemic than individual failing, but perhaps there has been a tendency to underestimate the role that professional regulation can play in helping to ensure that every healthcare professional is both committed to a safety culture and can align themselves with and embrace a complex interdependent system.

Healthcare is entirely dependent on the competence of individual practitioners — indeed arguably it relies more on that skill and competence, the more sophisticated and effective the system becomes.

My chairman when I was at The King’s Fund health think tank in London was the paediatric nephrologist Sir Cyril Chantler. In a Lancet article some years ago he observed that ‘Medicine used to be simple, ineffective and relatively safe. It is now complex, effective and potentially dangerous\(^9\)

The notion that medicine was ever safe is certainly challengeable but the fact that it is now complex effective and potentially dangerous is surely not in dispute.

The potential to do good has of course increased but so too has the capacity to do harm — the family physician who missed a potential breast cancer diagnosis might have made little difference to the prognosis a generation ago, today that could be the difference between life and death for that patient.

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I know many argue that the airline analogy is overdone — pilots deal with machines not people, they operate in a highly tuned and well maintained piece of equipment, not a garage for mending broken aircraft, and the levels of uncertainty between the two industries are not comparable — to name but a few differences.

But then consider what we do tolerate in our system. Many hospitals around the world rely heavily on locum physicians — now just imagine you are boarding your return flight from this conference and behind you are two cabin crew. Just then a figure rushes past pulling on his uniform — ”who’s that?” asks one cabin crew member. ”That is the locum pilot” replies the other. ”Ever seen him before?” ”No”. ”Does the airline know anything about his ability?” ”No”. ”What’s his flying record?” ”Not sure, but I think he got his licence twenty years ago”. ”Has he been checked since then?” ”Don’t know”. ”Has he ever flown this type of aircraft before?” ”Don’t know”. Well I don’t know about you, but I would be heading back to the terminal building.

And in many healthcare systems — not only here and in Canada — there is of course recognition that ongoing oversight of individual competency of highly trained professionals performing high risk roles is essential.

And there is also a point where safety of individual practitioners and the safety of the system meet — in the science of Human factors. This then is not just about more safety inspectors, or even understanding safety theory, but about learning from when things go wrong and fostering changes in professional and organisational culture.

We have come a long way since To Err is Human, but a recent review by the Health Foundation concluded that:

”The safety culture in the industries reviewed in this report may be more mature than the current safety culture in healthcare, with patient safety still being a recent and emerging discipline in many jurisdictions”.

The question for medical regulation is how far do we see ourselves as part of this developing agenda not just as bystanders or responders but in helping to shape it?

The growth of system regulation

The safety movement has also spawned a new set of players with which professional regulators are having to come to terms. The realisation by payers — whether governments or insurers — that quality and safety cannot simply be assured by reliance on those who run the service. This has led to a vast array of system regulators and accreditation schemes

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designed to provide assurance that patients are being protected and that funders are securing value for money. So whether the healthcare system is funded privately, by co-payment, national insurance or socialised, various approaches and organisations have sprung up to monitor, inspect, rate and sometimes close healthcare services.

Increasing interest in cost, quality and measurement has meant that in addition to voluntary accreditation, such as that provided by the Joint Commission (JCAH) in the US, there are now a host of new arrivals on the regulatory scene looking at quality, safety and effectiveness of the organisations and systems in which doctors work.

The relationship between these new kids on the block and professional regulation looks set to become increasingly significant. In some jurisdictions, especially smaller countries, the functions are governmental and even combined into one organisation. I will return to this, but it strikes me that unless professional regulation sees itself as part of this wider system in some form or another, it risks being seen as increasingly irrelevant to that system. More practically, if there is the potential to analyse data and trends and thereby to understand risk, the opportunity to share intelligence lies before us.

The end of deference and the changing nature of trust

One of the founding purposes of regulation was to reinforce the trust patients have in doctors — recognition that trust is not just a crucial component of the patient-doctor relationship, the literature is clear that it has recognised healing qualities of its own.


At a superficial level there is little to worry about — although in the US physicians may not rank as high as nurses or pharmacists, they are still the third most trusted profession.

The UK’s Ipsos Mori¹³ report which has monitored confidence in different professions for decades continues to show medics leading the field.¹⁴ And globally, doctors are said to be the third most trusted profession¹⁵ but we all know and recognise that the nature of that trust is changing — deference is on the wane, respect has to be earned and patients as consumers are more likely to know more or think they know more than in the past.

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As with all these issues it is possible to overstate the case here — no matter who were are, which of us, when we are horizontal, feeling ill, frightened and staring at neon lights above us, feel there is equivalence of knowledge and power with the health practitioners who are treating us?

Traditionally professional regulators were more or less invisible to consumers — but the challenge going forward must surely be to make sure that the standards we set make clear that physicians are expected to cope with a very different set of expectations from patients and that undergraduate and ongoing education reflect the partnership working that increasingly characterises the physician-patient relationship.

The other side of this coin is a profession that increasingly seems to feel under siege — medical morale in my country has been described as the lowest it has ever been for at least the last 30 years — and I have little doubt that today that is true.

The stress referred to yesterday among medical students by the Surgeon General extends throughout the profession in many parts of the world. The causes are many and varied and they manifest themselves in many ways — we are currently experiencing unprecedented industrial action by NHS doctors in training in England which, this week for the first time ever, included withdrawal of emergency cover. It is a tragedy, the last chapter of which is not yet written, but we know the damage will be significant and long-lasting.

As regulators many of us are working with a profession that has always operated in a stressful environment — that is the nature of the job — but how we conduct our business effectively in this environment, knowing that sometimes we are the cause of additional stress ourselves, represents a key challenge.

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**Redrawing professional boundaries**

The final challenge I want to allude to is around traditional professional boundaries — whether it be newer roles such as nurse practitioners, physician associates, or the constantly changing boundaries between established professions — what distinguishes one profession from another or one speciality within a profession? Professions are social constructs and medicine’s success has been its ability to evolve.

The boundaries around medicine are constantly changing — regulation can be an impediment or a catalyst for change — and from time-to-time it may involve us revisiting what we mean by a doctor or physician, not to protect territory, but to enable us to foster and develop the next generation of practitioners.

Based on work led by Sir John Tooke, the *British Medical Journal* published a definition in 2008 based on a consensus of medical and healthcare organisations — it talked about “the doctor’s frequent role as head of the healthcare team and commander of considerable clinical resource requires that greater attention is paid to management and leadership skills
regardless of specialism. An acknowledgement of the leadership role of medicine is increasingly evident. But interestingly the report observed there was nothing doctors do which no one else could do — it was the combination of skills and knowledge which marked them out. And perhaps the greatest of these characteristics was the ability to manage uncertainty.

And alongside that there was much greater emphasis on the need for teamwork, how to lead and how to follow in teams.

More than ever those of us with education responsibilities must be confident that it is less about what medical students and doctors in training know now and more about their ability to acquire and use knowledge going forward, less about their lone mastery of specialty than their skill in accessing and interpreting knowledge and applying it within a team.

We need what someone once described as thinking-doers — not those who can paint by numbers but those who can adapt to a world that will have changed more in the next thirty years than it has in the last fifty.

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**The future of professional regulation**

So where does this leave professional regulation in the twenty-first century? I want to leave you with three major areas with potential for all of us to transform the way we work and then a reflection on the nature of what may become a series of new compacts between politicians, the profession and patients for the future of medical regulation.

**Managing complaints better**

The first area where many of us struggle is in the management of complaints.

In the UK, the number of complaints to the GMC from patients nearly doubled between 2007 and 2012. Data from the Republic of Ireland and France also suggests that complaints made to medical regulators have also increased in recent years.

With better access to the regulator (i.e. through the internet and availability of data) this rise is at least likely to be sustained if not to continue. Regulators are starting to turn their attention to how well they handle complaints — the growing volume has made this an operational imperative as well as a societal one.

Complainants often leave dissatisfied — often they don’t understand the role of the regulator, they are understandably angry and frustrated when the complaint does not meet

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17 Regan de Bere, S. et al, Understanding the rise in Fitness to Practise complaints from members of the public, Plymouth University Peninsula Schools of Medicine. January 2014.

some arbitrary legal threshold. The process is often lengthy and damaging, not just to the complainant but also to the doctor. Unsurprisingly, in many jurisdictions, all this has a negative impact on the reputation of the regulatory agency with both patients and physicians.

And of course managing complaints about doctors consumes a large proportion of the resources allocated to medical regulators (59% of the GMC’s annual budget of $154 million is spent on managing complaints\(^\text{19}\)).

Yet the regulatory action taken by most authorities, while vitally important, is still small in scale — in our case 63 doctors were removed last year from a register of 270,000. If you include advice, we took action against fewer than 1000 doctors yet the law required us to investigate nearly three times that number\(^\text{20}\).

It is an area where medical regulators are finding new ways to improve the customer experience of making complaints\(^\text{21}\) and exploring ways to reduce the stress on doctors through less legalistic correspondence, mediation and consensual disposal.

### Managing increased mobility

Most of us are faced with unprecedented levels of professional mobility, whether as unwilling exporters of one of our most precious assets, the professionals we have helped to train, or as importers of those who have been trained by others, or both.

We are just beginning to understand more about the impact of movement — the fact that doctors, even from relatively similar cultures, can struggle in unfamiliar environments and systems. While aspects of clinical knowledge may be transferable, perhaps we should view physicians more as if they were delicate flowers — as such simply uprooting them and sticking them back in the ground somewhere else will be no guarantee that they will thrive and survive.

There is now mounting evidence from here, from Canada, Australia and the UK of differential attainment by doctors who have come from overseas and this persists even when there are robust and effective licensing assessments which all must pass.

We are in the early stages of understanding this, as well as differential attainment among doctors differentiated by factors including by gender and ethnicity.

With growing mobility it is surely incumbent on us as regulators to understand this issue — to gather the data to describe what is happening in practice and in education, to subject it to analysis and of course to help the system devise means to mitigate difference while fiercely guarding standards.

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As the organisations responsible for admitting overseas physicians, how far do we have a duty to help them overcome some of the cultural barriers they face when moving to work in unfamiliar social and environmental environments?

Employers must all have an interest in making sure that the physicians they take on are competent and fit to undertake the duties to which they have been assigned, but is there a role here for us too — as catalysts if not providers? In Ireland they have developed a ‘Safe Start’ programme and the GMC has rolled out a small intervention ‘Welcome to UK Practice’ mainly aimed at new practitioners from overseas. These may not solve the problem but they send a powerful signal both to new doctors joining the register and to the system itself of the need to support new arrivals.

Mobility of course is fuelled by shortages of doctors though too often it transfers the problem from richer to poorer countries. The challenges here in the US in filling posts in family medicine, psychiatry and remote and rural areas are replicated throughout the world.

As regulators, assuming we are not simply the agencies of government or of the profession, our principal focus will be on maintaining standards while helping the system to meet the needs of patients within our jurisdiction.

To give an idea of the scale of this, Brazil’s ‘Programa Mais Médicos’ (More Doctors Programme) is a federal government program to expand the number of physicians in underserved regions of the country, such as the interior counties and the suburbs of the main cities.

Twenty-two out of 27 states in Brazil have less than two physicians per 1,000 inhabitants. About 8% of doctors in the country work in cities with less than 50,000 people, which makes up approximately 90% of Brazil.

The challenge of course is to be the guardian of standards while encouraging practical solutions.

And then there is the challenge of the exporter nations. Almost 60,000 Indian physicians practice in the US, UK, Canada, and Australia — a workforce equal to 10% of the physicians in India. It is the largest émigré physician workforce in the world.

For whatever reason, internal attempts to address this and the major gaps in healthcare in India have not succeeded. One obvious solution — the development of new clinicians such as nurse practitioners and physician assistants — has met with resistance from the regulator and the professional body.

The circumstances in each jurisdiction will demand different judgements but the principle must surely be what is best for patients, not what is best for doctors.

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The United Nations Commission for Trade and Development (UNCTAD) has estimated that each migrating African professional represents a loss of US$ 184,000\(^2\). The UK has 270,000 registered medical practitioners for a population of 60 million; for a population of 45 million Kenya has fewer than 8,000 practising physicians.

Let us never forget the benefits that come from migration, in terms of sharing knowledge, developing expertise and advancing the art and science of medicine, not to mention individual freedom — as such it is a benign force and should be encouraged. But, as regulators, while recognising the positive impact of professionals moving around the world sharing and gaining experience and supporting the individual freedom that represents, is there a case also for doing what we can to encourage our own jurisdictions to produce enough doctors for our own needs without the need to plunder the world for other people's?

At the same time we have seen welcome efforts to assure quality of those doctors who cross jurisdictional boundaries within larger groups of regulators as in the European Union, in Canada or here in the US. In Europe — we have made great progress in terms of being allowed to test language and smaller steps in sharing information between regulators. Sizeable challenges remain with a system in which freedom of movement is sacrosanct but the latest EU legislation is overall a sign of progress and there is a greater willingness than ever among European regulators to work together.

The progress reported yesterday by the Interstate Medical Licensure Compact\(^2\) is a good example of breaking down unnecessary barriers to movement while also making sure Medical Boards can share information about doctors on their registers. With freedom of movement of physicians must come freedom of movement of information.

Finally, the growing movement of doctors has been accompanied by the growing movement of medical students and the exponential growth of medical schools — itself fuelled by the shortage of doctors in many parts of the world and by the lucrative nature of private medical education.

We all face the challenge of effective accreditation when new schools are springing up at an extraordinary rate — the plans being developed by WFME and ECFMG to accredit the accreditors, while not without challenges, marks an important step to bring this ‘wild west’ aspect of our work under some form of order and control.

**Embracing the digital revolution**

Finally, as regulators we must embrace the digital revolution and recognise that this will not only change the way we deliver our functions but that it may also change what we do, who we are and how we are seen.

We have already seen that the digital revolution has reduced the asymmetry of knowledge between physician and patient. From being seen as the omnipotent master of knowledge,


\(^2\) [http://www.licenseportability.org/](http://www.licenseportability.org/)
the physician becomes the partner and navigator — helping the patient understand the choices he or she can make.

The digital revolution is also changing the way physicians think and work — it is exposing variation of performance in institutions, within specialties, and among individual clinicians. In so doing it will in turn drive further demands for transparency at all levels.

And for us one of the greatest opportunities lies in our ability to convert operational data — once the relatively useless byproduct of our regulatory processes — into something that informs and provides insight for us, the profession and the systems in which physicians work.

Data will become the new currency of regulation. As one participant observed at the IAMRA London conference, we have for most of our histories been or attempted to be philosopher regulators – so we must also become scientific regulators.

The data we collect not only tells us about the profession — its numbers and make-up and its changing demographic — but also the information we hold about educational attainment, disciplinary histories, the impact of stress and ill health, all this has enormous potential to make us better regulators, to understand trends and critically to identify risk. It can also be useful to a wide range of other agencies from those providing undergraduate and postgraduate education, to hospitals and primary care organisations wanting to understand how better to manage and support their medical workforce and to system regulators.

A key challenge here will be around joining up the information from other parts of the healthcare regulatory landscape to piece together a full picture and start to develop risk-based approaches.

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**Towards a new compact?**

I suspect we are moving and indeed need to move towards a new compact between regulators, the public and the profession.

If it were ever acceptable for us simply to work down-stream and fish bodies out of the river then it is surely not acceptable now. As you have demonstrated at this meeting, the modern regulator must be concerned with more than discipline when, in many cases, the path to remediation is difficult or impossible to traverse — in addition therefore we must start to learn to work upstream to prevent harm in the first place.

The move will be away from a traditional reactive model rooted in ‘minimum standards’, where we only act when something goes wrong and are only interested in things which are “illegal”, and toward an approach which is also interested in preventing harms, before these behaviours/processes become “illegal” — stopping the bodies falling into the river — being the fence at the top of the cliff, rather than the ambulance at the bottom.
Professor Malcolm Sparrow\textsuperscript{26} in his work at Harvard has developed what he terms 'Regulatory Craftsmanship' in the current age. He points out that we will be expected to be:

(a) \textit{vigilant}, able to spot emerging threats early, pick up on precursors and warning signs, use our imagination to work out what could happen, and to do these things even before much harm is done.

(b) \textit{nimble}, flexible enough to organise ourselves quickly and appropriately around each emerging risk, rather than being locked into patterns of practice constructed around the risks of a preceding decade, and

(c) \textit{skillful}, masters of the entire intervention toolkit, and adept at creating new approaches when existing methods turn out to be irrelevant or insufficient to suppress a risk.

To do this we will need to be more sophisticated in our understanding of professional practice, have a more sophisticated approach to the capture and analysis of data allowing us to spot trends and patterns of risk and harm and we will need to develop a new language to explain how we might apply this risk/harms based approach to regulation, recognising that ours is a human and inevitably risky business.

I suspect we are at the early stages of understanding where this will take us — we need to identify interventions that help to reduce harm or help to flag issues early. If we can get them to work, this is where systems for assuring continuing competence can come into their own – Revalidation in the UK, Canada and Australia, Maintenance of Licensure in US.

Secondly, in the new world the medical board is not a remote body for the physician to engage with as little as possible. Instead, from the day the would-be doctor arrives at medical school to the day she or he retires from practice, there needs to be an ongoing and, for the vast majority of practitioners, a positive and active relationship with their regulator. This is about developing a dialogue with the profession as a whole and with the individual clinician around ethics and professionalism and areas of risk. In response to Hank’s question yesterday about the levels of understanding of what medical boards do, I think you reflected a strong desire to take this forward.

And thirdly, while doing all this, we need to make sure we continue to get the basics of regulation right — guarding our registers effectively and making sure that those who practise, practise safely remains fundamental.

And last — alongside this questioning everything we do to make sure it is effective and not adding to the burden of front line clinical care — regulation in all walks of life is paved with good intentions but is often victim to the law of unintended consequences.

We need to understand where we fit into the wider healthcare landscape and to remember that regulation is only effective at every level of the pyramid.

As the chair of one of the UK’s many enquiries pointed out, the eyes and ears of practitioners are the most potent safety devices on any healthcare system.

And, as we develop a new compact, how do we balance the need for greater assurance and accountability while fostering and preserving the trust that lies at the heart of good medical practice? As the philosopher Onora O’Neill observed, excessive demands of accountability on professionals by the likes of regulators, auditors, and employers can undermine the trust and professionalism it is intended to promote27.

There is no easy answer to this but at least applying the principle of subsidiarity should go some way to addressing it — by which I mean that decisions are best taken at the most local level possible, compatible with them being effective. The point was made strongly in your context yesterday around state rather than federal based regulation.

Interestingly, the FSMB’s six attributes for regulators to retain their relevan28y fit beautifully into the framework of a new compact — a world in which the regulator is concerned with physician engagement, public participation, communication, transparency, innovation and collaboration.

Creating a global community

I am going to leave you with a plea — the rich diversity of the debate you have here needs to be shared with the rest of the world — IAMRA is expanding and we hope to have more than 100 members by our meeting in Melbourne.

We do not have a model of regulation we seek to impose or even promote but we are passionate that medical regulation — and indeed health professional regulation more widely — is a positive force and one that every day protects patients and helps to drive improvements in medical education and practice.

We believe too that, as a community of medical regulators, we will be stronger and we have much to learn from each other — including of course support by more experienced and better resourced regulators for those that manage on tiny funds or are just starting out — but also that even the best resourced and longest established can learn from those who are thinking this stuff through for the first time.

We are clear this is about protecting patients not doctors, but we also believe that effective regulation is one of the greatest assets such a high risk profession can have.

Like the US President, I will be standing down later this year — my term leading IAMRA will be at an end. But, unlike the US president, I know who will succeed me.

And I have to say I have complete confidence as Hank Chaudhry takes over. I very much hope you will support him in this role and that many more of you will join the International Association of Medical Regulatory Authorities and bring your considerable expertise to our deliberations.

Our world is smaller, the challenges we face are similar — it makes sense to support each other in this international regulatory community. I hope you will come on board and start by joining us in Melbourne.

ENDS