Welcome

We gather at a time of great change in medical practice and patient expectation. We regulate a profession that itself is changing and, we ourselves need to evolve to meet the challenges of 21st century healthcare.

If professional regulation is to protect patients and improve standards, it must work more closely with the profession, employers, educators and patient groups. It must also recognise the different and developing pressures in today's medical practice. We hope this conference will help us all in meeting that challenge.

Wherever you come from, whatever your contribution to, or interest in, patient safety, you are most welcome to the 11th international conference on medical regulation. The General Medical Council (GMC) and the International Association of Medical Regulatory Authorities (IAMRA) are delighted you have joined us in London. This is the largest IAMRA Conference, with 400 participants from more than forty countries around the world. It is a testament to the growing interest in and importance of medical regulation.

The theme of the conference is *Evaluating risk and reducing harm to patients*. We hope the programme will provide you with a wide variety of topics of interest and that you will feel able to take part in the discussions and debates with speakers and panellists. Above all, we want this to be an interactive conference where your experience and perspective matters, whether you are a speaker or panellist, or a workshop, abstract or poster presenter or indeed an attendee.

We have one afternoon dedicated to the *Fundamentals of medical regulation*. This part of the programme is designed to deal with the practical challenges we all face on a daily basis. In designing this session, we have asked everyone attending the conference to tell us the one fundamental issue with which they are grappling – from the responses, this looks set to be a stimulating and exciting session which will enable us all to share our experience of what works and what does not.

On behalf of the IAMRA, the 2014 Programme Planning Committee and the GMC, thank you for coming and taking part in what we hope will be a memorable event. We want this to be an interactive, productive and stimulating session during which we can all share and learn from each other and thereby contribute to patient safety and good medical practice around the world.

If you have any queries or need any help please ask one of the conference team or contact one of us. We hope you have a great time!

Best wishes,

Philip Pigou
Chair, IAMRA 2012–2014
Chief Executive, Medical Council of New Zealand

Niall Dickson
Chair, IAMRA 2014 – 2016
Chief Executive, General Medical Council (UK)

Thank you

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We would also like to thank the IAMRA Programme Planning Committee for their support in delivering the conference.

Programme Planning Committee

- Chair, Niall Dickson, IAMRA and General Medical Council (UK)
- Dr Alexander Jäkel, German Medical Association (Germany)
- Dr André Jacques, Collège des médecins du Québec (Canada)
- Harry Cayton CBE, Professional Standards Authority for Health and Social Care (United Kingdom)
- Dr Humayun Chaudhry, IAMRA and Federation of State Medical Boards (United States)
- Dr Joanna Flynn, IAMRA and Medical Board of Australia (Australia)
- Josephine Mwakutuya, IAMRA and Medical and Dental Practitioners Council (Zimbabwe)
- Marc Seale, Health and Care Professions Council (United Kingdom)
- Philip Pigou, IAMRA and Medical Council of New Zealand (New Zealand)
- Roxanne Huff, IAMRA Secretariat
- Shane Carmichael, General Medical Council (United Kingdom)
- Tanja Schubert, General Medical Council (United Kingdom)
- Tina Sâpec, Medical Chamber of Slovenia (Slovenia)

Map 1
Conference floor plan
200 Aldersgate

Map 2
200 Aldersgate and surrounding area

Agenda at a glance

TUESDAY 09 SEPTEMBER 2014

13:00 **Registration and welcome lunch**

14:00 **IAMRA General Assembly**
Premium

17:00 **Walk to Drapers' Hall**

17:30 **Conference opening reception**
Drapers' Hall

Dr Daniel Poulter MP, Parliamentary Under Secretary of State for Health (UK)
Prof Sir Peter Rubin, Chair, General Medical Council (UK) 2012–2014
Philip Pigou, outgoing Chair, IAMRA 2012–2014
Niall Dickson, Chair, IAMRA 2014–2016

19:30 **End of the day**

Agenda at a glance

For details on the individual breakout sessions please see page 49

WEDNESDAY 10 SEPTEMBER 2014

07:30 **Registration opens**

08:00 BREAKFAST SESSIONS

Including sessions sponsored by:

- Health Foundation (UK)
- Royal College of Physicians of London

09:00 KEYNOTE PANEL

In whose interest do we regulate?

Chaired by Fergus Walsh, British Broadcasting Corporation (UK)

Premium

Prof Maureen Edmondson, Patient and Client Council (Northern Ireland)
James Titcombe, Care Quality Commission (England)
Audrey Birt, Health and Social Care Alliance (Scotland)
Dr Jon Thomas, Federation of State Medical Boards (USA)
Philip Pigou, Chair, IAMRA 2012–2014
Dr Eli Kwasi Atikpui, Medical and Dental Council of Ghana

10:30 **Break**

11:00 BREAKOUT SESSIONS

12:00 **Poster exhibition opening**

Galleria

Prof Jane Dacre, Royal College of Physicians of London

12:30 **Lunch**

13:30 KEYNOTE PANEL

Different approaches to health professional regulation across the world

Chaired by Fergus Walsh, British Broadcasting Corporation (UK)

Premium

Carrie Yam, Chinese University of Hong Kong
Prof Frank Montgomery, German Medical Association
Prof Sir Peter Rubin, General Medical Council (UK)
Prof Sian Griffiths, Chinese University of Hong Kong
Else Smith, Danish Health & Medicines Authority

14:30 BREAKOUT SESSIONS

15:30 **Break**

16:00 BREAKOUT SESSIONS

17:00 **End of the day**

Bus transfer from conference venue to House of Lords

Please note this event is only available to those who have pre-booked their place.

18:30 **Parliament reception**

Sponsored by The Lord Patel KT

House of Lords

Dr Sarah Wollaston MP, Chair, Health Select Committee (UK)
Prof Sir Peter Rubin, Chair, General Medical Council (UK)

20:30 **Bus transfer to conference venue**

Agenda at a glance

For details on the individual breakout sessions please see page 93

THURSDAY 11 SEPTEMBER 2014

07:30 **Registration opens**

08:00 BREAKFAST SESSIONS

Including sessions sponsored by:

- Medical Protection Society (UK)
- Federation of State Medical Boards (USA)

09:00 KEYNOTE SPEECH

The art of harm-reduction – lessons from the world of regulatory practice

Premium

Prof Malcolm Sparrow, Harvard University (USA)

10:00 KEYNOTE PANEL

How to better identify harms and the concentration of risk

Chaired by Fergus Walsh, British Broadcasting Corporation (UK)

Premium

Prof Malcolm Sparrow, Harvard University (USA)
Dr Marie Bismarck, University of Melbourne (Australia)
Prof Sir Mike Richards, Care Quality Commission (England)
Karina Raaijmakers, Clear Conduct (the Netherlands)

11:00 **Break**

11:30 BREAKOUT SESSIONS

12:30 **Lunch**

13:30 – 17:00 FUNDAMENTALS OF MEDICAL REGULATION

Chaired by Harry Cayton CBE
Professional Standards Authority for Health and Social Care (UK)
In partnership with PA Consulting

13:30 OPENING SPEECH

Right touch regulation

Premium

Harry Cayton CBE
Professional Standards Authority for Health and Social Care (UK)

OPENING PANEL

Prof Malcolm Sparrow, Harvard University (USA)
Dr Margaret Mungherera, World Medical Association
Elliot Rose, PA Consulting

14:30 BREAKOUT SESSIONS

15:15 **Break**

15:45 BREAKOUT SESSIONS

16:30 CLOSING PANEL

Premium

Prof Malcolm Sparrow, Harvard University (USA)
Dr Margaret Mungherera, World Medical Association
Elliot Rose, PA Consulting

17:00 **End of the day**

18:00 **Boat transfer to Greenwich**

Departs from Temple Pier, Victoria Embankment

Please note this event is only available to those who have pre-booked their place.

19:00 **Conference dinner**

Sponsored by:

- Educational Commission for Foreign Medical Graduates (USA)
- PA Consulting

Cutty Sark, Greenwich

Sir Ranulph Fiennes, explorer, fundraiser and author

22:30 **Boat transfer to central London**

Arrives at Temple Pier, Victoria Embankment

Agenda at a glance

For details on the individual breakout sessions please see page 125

FRIDAY 12 SEPTEMBER 2014

07:30 **Registration opens**

08:00 BREAKFAST SESSIONS

Including sessions sponsored by:

- British Medical Association (UK)
- Health Foundation (UK)

09:00 KEYNOTE PANEL

How to maintain trust in the profession?

Chaired by Fergus Walsh, British Broadcasting Corporation (UK)

Premium

Baroness O'Neill of Bengarve CH CBE FBA, Equalities and Human Rights Commission (UK)
Sir Robert Francis QC, Mid Staffordshire NHS Foundation Trust Public Inquiry and President of the Patients Association (UK)

10:00 **Break**

10:30 KEYNOTE PANEL

The future of medical regulation: challenges and opportunities

Chaired by Niall Dickson, IAMRA

In partnership with KPMG

Premium

Dr Humayun Chaudhry, Federation of State Medical Boards (USA)
Dr Joanna Flynn, Australian Medical Board
Prof Mochichi Mokgokong, Health and Professions Council of South Africa
Dr Ramadan Ibrahim, Dubai Health Authority (United Arab Emirates)
Prof Kieran Walshe, Manchester Business School (UK)
Dr Margaret Mungherera, World Medical Association (United Arab Emirates)
Albert van der Zeijden, patient speaker (the Netherlands)
Claire Warnes, KPMG

12:00 **Closing session**

13:00 **End of conference**

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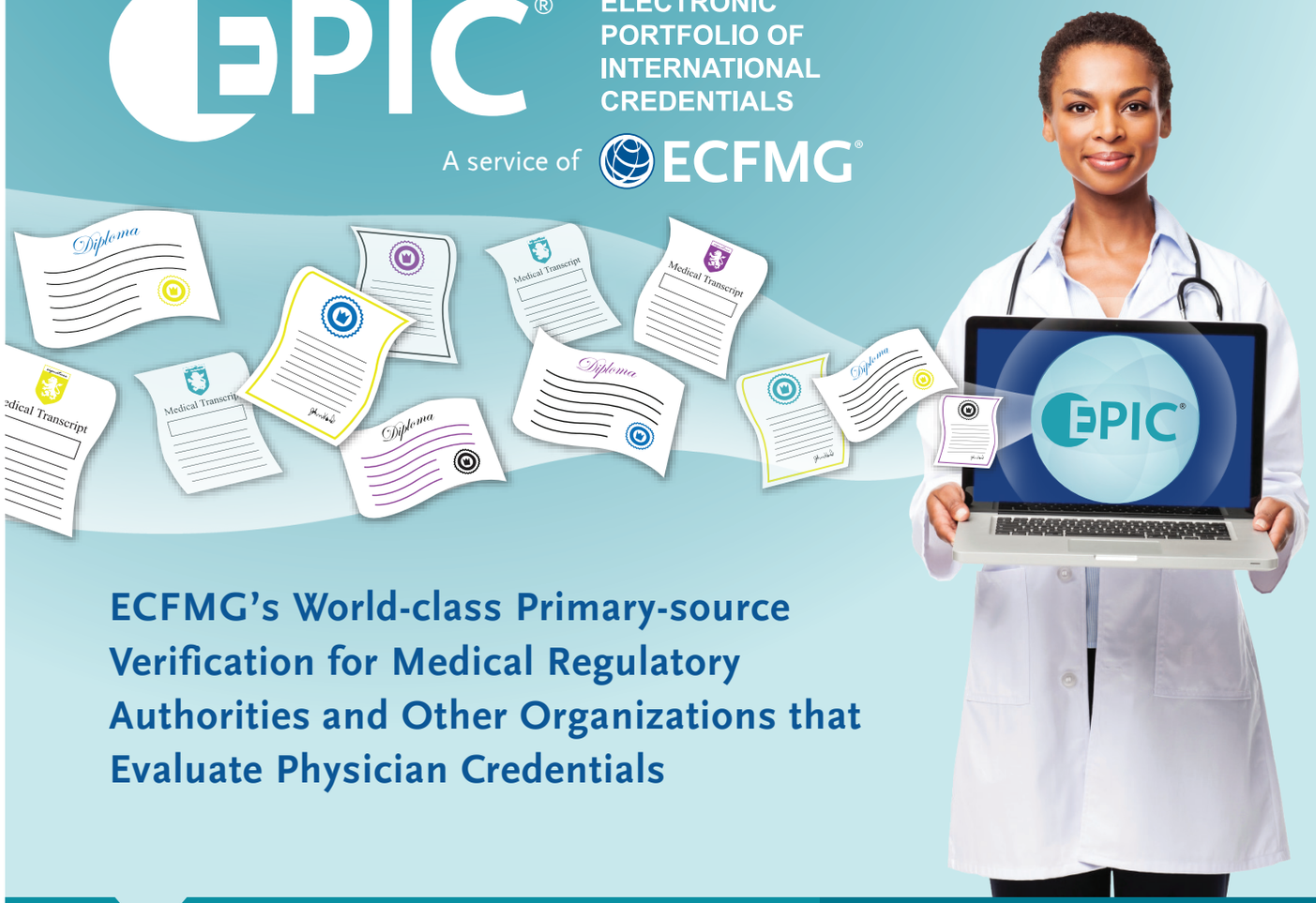

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Please join us for a special lunch session about EPIC® on Thursday, September 11.

Stop by our booth to learn more about how EPIC® can meet your needs.

Dr Eli Kwasi Atikpui

Dr Eli Kwasi Atikpui is the Registrar/Chief Exectutive Officer of the Medical and Dental Council, Ghana.

Dr Eli Kwasi Atikpui obtained his BSc (Human Biology) and MBChB in 1983 and 1985 respectively from the Kwame Nkrumah University of Science and Technology, Kumasi, Ghana. He gained his Masters in Public Health and Post Graduate Diploma in Health Management, Planning and Policy in 1993 and 2004 respectively from the Nuffield Institute for Health Services, University of Leeds, United Kingdom. He is currently a Law Student at the Ghana Institute of Management and Public Administration (GIMPA), Accra Ghana.

He is a professional medical practitioner with 29 years of intensive and extensive clinical and managerial skills at various levels of the health sector in Ghana. He has been the Registrar/Chief Executive Officer of the Medical and Dental Council, a governmental agency charged with the responsibility of maintaining standards in the training and practice of medicine and dentistry in Ghana, since August, 1998.

He has also worked as a Medical Administrator at the National, Regional and District Levels of the country. He has been a facilitator and resource person at various workshops on ethics, medical jurisprudence, public health policy, district health systems and institutional care. He is a part-time lecturer in Epidemiology and Health Care Management at the School of Administration, University of Ghana, Legon. He has authored several articles on health policy, management and regulation.

Dr Atikpui among others is a Board Member, College of Health, Kintampo, a member of the IAMRA Management Committee, Ghana-Yale Partnership for Global Health Initiative and Member, University of Ghana Hospital Implementation Committee.

Audrey Birt

Audrey Birt MSc, BSc, RGN, Dip HV, Dip Gestalt in Organisations, Cert in Coaching Practice

Coach and consultant in health and social care

Audrey is an independent coach and consultant and health activist with a particular interest in health and social care and authentic leadership. She has extensive senior executive experience and was previously the Director for Scotland of Breakthrough Breast Cancer having set the charity up in Scotland and the National Director for Diabetes UK Scotland. Audrey is the Chair of the Health and Social Care Alliance and was a founder member.

She is an Associate Consultant with Oasis School of Human Relations and is conducting research into workplaces and leadership of the future. Audrey's professional background is nursing, having worked as a nurse manager and in service redesign. She works as a coach and consultant across the third and public sectors. She has an interest in gestalt in organisations and in mindfulness. She is a regular blogger covering leadership, health and social care as well as her personal experience of breast cancer. She is currently writing a book about her experience both professional and personal.

Dr Marie Bismarck

Dr Marie Bismark is a public health physician and health lawyer, who leads the Law and Public Health Group at the University of Melbourne. Her research focuses on the role of the patient voice in improving the quality and safety of healthcare.

Marie has previously worked as a doctor in a number of New Zealand hospitals, served as a legal adviser to the New Zealand Health and Disability Commissioner, and been a solicitor with a leading New Zealand law firm. In 2004–2005 she completed a Harkness Fellowship in Health Care Policy at Harvard University.

In addition to her academic role, Marie serves as a non-executive director on the boards of a number of health sector companies, including GMHBA Health Insurance, Summerset retirement villages, and the Young and Well Cooperative Research Centre. She has published widely on no-fault compensation, patient safety and healthcare complaints resolution. Marie and her husband Matthew have three teenage children.

Harry Cayton CBE

Harry Cayton CBE is Chief Executive of the Professional Standards Authority for Health and Social Care, the statutory body which oversees the regulation and registration of health and care professions in the UK.

From 2001–2007 he was National Director for Patients & the Public at the Department of Health following 20 years in the voluntary sector, latterly as Chief Executive of the Alzheimer's Society. He is Chair of the Patient & Public Involvement Advisory Group of the Commission on Human Medicines, a trustee of Comic Relief, and advisor to several charities. He was made an OBE in 2002 for services to people with dementia and a CBE in 2014 for services to health and regulation reform.

Dr Humayun Chaudhry

President and Chief Executive Officer

Federation of State Medical Boards

Dr Humayun 'Hank' Chaudhry is the President and CEO of the Federation of State Medical Boards (FSMB). He was previously Commissioner of Health Services for Suffolk County, New York, overseeing the ninth largest health department in the United States.

He is board-certified in internal medicine and is a clinical associate professor of internal medicine at the University of Texas Southwestern Medical School and clinical associate professor of preventive medicine at Stony Brook University School of Medicine in New York. Dr Chaudhry graduated in 1991 from the New York Institute of Technology College of Osteopathic Medicine and has Masters degrees from New York University and Harvard School of Public Health.

He completed a residency in internal medicine at Winthrop-University Hospital in Mineola, New York, where he was chief medical resident, and served as a flight surgeon in the United States Air Force Reserve, rising to the rank of Major. He is the primary author of *Fundamentals of Clinical Medicine*, a medical textbook published by Lippincott Williams & Wilkins in 2004, and a co-author with David Johnson of *Medical Licensing and Discipline in America*, published in 2012 by Lexington Books. He became a Master of the American College of Physicians in 2013.

Prof Jane Dacre

Jane Dacre was elected president of the Royal College of Physicians of London in April 2014

She is an honorary consultant physician and rheumatologist at the Whittington hospital in North London, Professor of Medical Education and Director of UCL Medical School in London. She was also the medical director of Membership of the Royal Colleges of Physicians of the United Kingdom until December 2013 and prior to that academic vice president of the Royal College of Physicians of London.

She was a GMC council member, and chaired the GMC Education and Training Committee (2008–2012) and leads a research programme in medical education focussing on assessment.

She was the clinical lead for the development of the first Clinical Skills Centre in the UK, and was a co-author of the GALS screen. Professor Dacre has been instrumental in the development, implementation and evaluation of assessment systems in medicine.

Professor Dacre won the Medicine & Healthcare Category for the 2012 Women in the City Woman of Achievement Award and was named on the Health Service Journal's inaugural list of 50 inspirational women in Healthcare in 2013.

Professor Dacre is married with three children.

Niall Dickson

Chief Executive and Registrar, General Medical Council

Chair of IAMRA (2014-2016)

Niall Dickson joined the General Medical Council as Chief Executive and Registrar in January 2010.

He is responsible for the day to day running of the GMC and reports directly to the Chair of Council, Professor Sir Peter Rubin. Niall joined the GMC from The King's Fund, the leading independent think tank and development organisation, where he was Chief Executive for six years (2004–2009).

He began his career in teaching before taking up posts in national voluntary organisations involved with older people. He was Editor of *Therapy Weekly* for the allied health professions and then of *Nursing Times*.

He moved to the BBC in 1988 as Health Correspondent, became Chief Social Affairs Correspondent and then, in 1995, Social Affairs Editor, focussing mainly on Radio 4's Today programme and the Ten O'clock News on BBC 1.

Niall is a member of the Department of Health's National Quality Board.

He is the Chairman of the Leeds Castle Foundation. His honorary awards include being a Fellow of the Royal College of Physicians of London and a Fellow of the Royal College of General Practitioners.

Prof Maureen Edmondson

Maureen Edmondson is Chair of the Patient Client Council and of the Northern Ireland Advisory Committee of OFCOM – the UK communications regulator.

A food scientist by training and experience she worked for Mars Incorporated until 2000 where she was responsible for International Scientific Affairs. Maureen served six years as Northern Ireland Board Member for the Food Standards Agency and Chair of the Northern Ireland Food Advisory Committee. Passionate about character in leadership, she has served with The Trinity Forum and now chairs The Renaissance Forum.

Maureen studied at Queen's University gaining her doctorate in food studies. She has been appointed President Elect for the Professional Institute of Food Science and Technology of which she is a Fellow. Maureen received an OBE in 2008 for public service. She is married to Doug who is a barrister and lives in Northern Ireland.

Sir Ranulph Fiennes

In 1984 the Guinness Book of Records ***described Sir Ranulph Fiennes as the 'World's Greatest Living Explorer'.***

He was awarded the Sultan of Oman's Bravery Medal in 1970, the Explorers Club of New York Medal in 1983, the Royal Scottish Geographical Society's Livingstone Gold Medal in 1983, the Royal Geographical Society's Founder's Medal in 1984, and both he and his late wife received the Polar Medal in 1987.

In 1993 he was awarded an OBE for 'human endeavour and charitable services'.

Sir Ranulph has, through his expeditions, raised large amounts of money for charities. He has led 22 major expeditions to remote parts of the world including both Poles.

In 2003, only 3½ months after suffering a massive heart attack and double bypass operation, he ran seven marathons on seven continents in seven days.

In 2004 he came second in the International North Pole Marathon and, in 2005, he raised £2m through his ascent to within 300 metres of the Everest summit ridge for the British Heart Foundation's new research MRI scanner. In March 2007, he climbed the North Face of the Eiger and raised £1.8m for Marie Curie Cancer Care's delivering Choice Programme. Also in 2007 Winner of ITV's Greatest Britons 2007 Sport Award and in May 2008, climbed Everest (Nepal-side) to within 400m from the summit. In May 2009 he successfully summited Everest, raising nearly £3m for Marie Curie Cancer Care. To date he has raised over £14 million for UK charities.

He has authored 18 books including the UK bestseller (*Times* and *Telegraph*) in 1991 *The Feather Men*, and in 2003 the top selling biography (*Times*) of Captain Scott. His latest book *My Heroes* was published in 2011. Also in 2011 *The Feather Men* was released as a major motion picture *Killer Elite* (www.killerelite.com).

Dr Joanna (Jo) Flynn AM MBBS, MPH, HonDMedSc, FRACGP, DRANZCOG

Jo is a general practitioner in West Brunswick, an inner suburb of Melbourne where she has worked for over twenty years.

Jo is a general practitioner in West Brunswick, an inner suburb of Melbourne where she has worked for over 20 years.

In August 2009 she was appointed the Inaugural Chair of the Medical Board of Australia and she continues in that role.

From 2000 to 2008 she was President of the Medical Practitioners Board of Victoria and was President of the Australian Medical Council from 2003 to 2008. Jo was first appointed to the Victorian Medical Board in 1989.

She has been involved in medical education and accreditation in a number of roles for over 25 years.

She has been Chair of the Board of Eastern Health, one of Melbourne's largest public health services, since July 2009.

In June 2012 she was appointed Chair of the Independent Advisory Council for the Personally Controlled Electronic Health Record (PCEHR).

She was elected to the IAMRA Management Committee as a Member at Large in 2012.

Jo was made a Member of the Order of Australia in June 2011 for services to medical administration and the community and in 2012 the University of Melbourne conferred on her an Honorary Doctorate of Medical Science.

Sir Robert Francis QC

Sir Robert Francis QC has been a barrister since 1973 and remains in practice at Serjeants Inn Chambers, 85 Fleet Street, London EC4Y 1AE of which he is a former head. He became a Queen's Counsel in 1992. He is a governing Bencher of the Honourable Society of the Inner Temple and a former chairman of its Education and Training Committee. He was knighted in 2014 for services to healthcare and patients.

He specialises in medical law, including medical treatment and capacity issues, clinical negligence, in which he is instructed by claimants and defendants, and professional discipline. He has taken part in many leading cases in these fields.

He has been involved in many healthcare related inquiries including homicide inquiries. He chaired inquiries into the care and treatment of Michael Stone, convicted of killing members of the Russell family, and, the care and treatment of two patients in Broadmoor following a homicide there. He appeared for parties at the Bristol Royal Infirmary Inquiry, the Royal Liverpool Children's Inquiry, and the Neale Inquiry. He chaired the Independent Inquiry into the Care provided by the Mid-Staffordshire NHS Foundation Trust, and subsequently the Mid-Staffordshire NHS Foundation Trust Public Inquiry, the report of which was published in February 2013.

He has acted as legal assessor or adviser to various statutory committees, is a Recorder [part-time circuit judge] and sits as a Deputy High Court Judge. He is a past Chairman of the Professional Negligence Bar Association and is a consultant editor of the Medical Law Reports. He is co-author of Medical Treatment Decisions and the Law (Francis & Johnston: Butterworths 2001, 2nd edition 2009). In 2013 he was appointed the honorary President of the Patients Association, and in 2014 a Commissioner and non-executive director of the Care Quality Commission. He is a trustee of the Point of Care Foundation and the Prostate Cancer Research Centre.

Prof Sian Griffiths, OBE, JP

Emeritus Professor at The Chinese University of Hong Kong

Visiting Professor at Imperial College London

Sian Griffiths was President of the UK Faculty of Public Health before moving in 2005 to be Director of the School of Public Health and Primary Care and become Founding Director of the Centre for Global Health at the Chinese University of Hong Kong following her co-chairing of the HKSAR Government's inquiry into the 2003 SARS epidemic. Now based in the UK she remains Senior Adviser on International Academic Development to the Vice Chancellor at CUHK. In the UK she is providing advice to the UK Government as Healthcare Sector Specialist for Hong Kong in Healthcare UK, is Associate Board member for Public Health England and chairs their Global Health Committee and is Visiting Professor at the Institute of Global Health Innovation at Imperial College, London.

She was made JP by the HKSAR government in 2010 for her contribution to health in Hong Kong. In 2012 she was named Professional of the Year in the AMCHAM Women of Influence Awards. She has recently edited the Routledge Handbook of Global Public Health in Asia and is finalising a report for the HKSAR government on professional regulation.

Dr Ramadan Ibrahim

Ramadan qualified as a physician from The Royal College of Surgeons in Ireland in 2001 and he specialised in gastroenterology from Queen Mary University, UK.

During his studies in the UK, he was exposed to work in the clinical governance unit where he found himself attached to that field which serves the patients in broader terms. After achieving the specialisation degree, he came back to UAE and worked as a gastroenterologist with the interest of establishing clinical governance in Dubai. After one year and half, he succeeded to establish the office and was assigned to lead it.

Currently, he is the director of the health regulation department in Dubai health authority and medical tourism project; with the continuum of his previous responsibilities. This department manages all health regulation components including inspection of healthcare facilities, registration of facilities and professionals, clinical governance activities and customer care across Dubai in both governmental and private sectors, the department also is responsible for dictating all polices and standards in healthcare and continuously updates them.

Ramadan opted to further study and did his Masters degree in the field of Business Administration. He chose Zayed University In Abu Dhabi to fulfil this goal as part time for a total duration of 2 years. He was also chosen among 500 applicants to enrol in Sheikh Mohd Bin Rashid leadership program.

Outside his busy schedule, Ramadan also keeps a list of hobbies. He enjoys swimming, canoeing, reading newspapers, and travelling. Ramadan is also interested in learning different languages. In addition to Arabic which is his mother tongue he speaks fluent English and some Urdu to accommodate the growing multicultural Dubai.

Prof Mochichi Mokgokong

Professor Mochichi Samuel Mokgokong is a medical practitioner and President of the Health Professions Council of South Africa. He has been Professor and Chief Specialist at the Department of Neurosurgery, University of Pretoria since 2008.

Prof Mokgokong has a dedicated interest in primary healthcare and has been working in the public sector for almost 35 years. One of Prof Mokgokong's career highlights was the separation of Craniopagus Siamese Twins. He presented a paper entitled *Separation of Craniopagus Twins (The South African Experience)* at the 13th World Congress of Neurological Surgery in 2005.

Prof Frank Montgomery

President German Medical Association

Prof Frank Ulrich Montgomery, a radiologist from Hamburg, was elected President of the German Medical Association (GMA) in 2011. Before assuming this position, he had been Vice-President of the GMA since 2007 and a member of the Executive Board between 1987 and 2002, and again from 2006. He continues to work as a consultant radiologist at the University Hospital in Hamburg.

Prof Montgomery was Chairman of the Marburger Bund, the professional organisation of the hospital-based and employed physicians of Germany, from 1989 until 2007. He currently serves as treasurer of the World Medical Association (WMA) and the Standing Committee of European doctors (CPME).

Born in 1952, Frank Ulrich Montgomery graduated from Hamburg University in 1979 after studying medicine in Hamburg and Sydney. His main political interests are the financing of healthcare and structural issues related to healthcare organisations. He is also very committed to all ethical matters concerning the medical profession.

Prof Montgomery is married to a general practitioner with whom he has two children.

Dr Margaret Mungherera

Dr Margaret Mungherera is a Ugandan medical doctor working as Senior Consultant Psychiatrist at Mulago National Referral Hospital in Kampala, Uganda.

She has chaired and been a member of boards of several nonprofit organisations and has received several national awards. In 2005 she was appointed member of the Public Universities Visitation Committee by HE the President of Uganda and was specifically tasked with chairing the Medical and Veterinary Schools Sub-Committee. She is also currently serving her third term as a Ministry of Education appointee on the governing Council of a rural government university, Gulu University, where she chairs the Appointments Board.

Dr Mungherera has been the only woman to serve as President of the Uganda Medical Association. During her term in office, she was at the forefront of a regional East African collaboration of national medical associations and regulatory bodies which harmonised Continuing Professional Developing (CPD) systems, educational curriculum for medical and dental students and interns with subsequent reciprocal recognition of graduates. She continues to represent her national medical association on the national regulatory body where she chairs the Ethics and Discipline Committee. She is the current President of the World Medical Association and is the second African to be elected into this position since this global professional body was formed in 1947. She has spearheaded a capacity building initiative for African national medical associations aimed at strengthening their advocacy roles in issues around medical education, CPD, brain drain, social determinants of health, research and publication.

Baroness O'Neill of Bengarve
CH CBE FBA

Onora O'Neill combines writing on political philosophy and ethics with a range of public activities. She comes from Northern Ireland and has worked mainly in Britain and the US.

She was Principal of Newnham College, Cambridge from 1992–2006, President of the British Academy from 2005–9, chaired the Nuffield Foundation from 1998–2010, has been a crossbench member of the House of Lords since 2000 (Baroness O'Neill of Bengarve).

She currently chairs the UK's Equality and Human Rights Commission and is on the board of the Medical Research Council. She lectures and writes on justice and ethics, accountability and trust, justice and borders, as well as on the future of universities, the quality of legislation and the ethics of communication, including media ethics.

The Lord Patel KT

Lord Patel graduated from the University of St Andrews (MB ChB 1964) and since qualifying continued to work in Scotland, including more than 30 years at Ninewells Hospital and Medical School.

His academic and clinical interests were in the field of high-risk obstetrics. He has published on pre-term labour, foetal growth retardation and obstetric epidemiology. He is a Fellow of the Academy of Medical Sciences and the Royal Society of Edinburgh, honorary fellow of several royal colleges in the UK, Ireland and overseas, and honorary doctorates in the UK and overseas. In 2006 Lord Patel was appointed Chancellor of the University of Dundee.

Lord Patel received a knighthood in 1997 and currently sits in the House of Lords having been elevated to the peerage as Baron Patel, of Dunkeld in Perth and Kinross in 1999. Lord Patel is currently a member of various committees in the House of Lords including the Science and Technology Committee, the Procedure Committee and the Affordable Childcare Committee. In 2010 Lord Patel became a Knight of The Most Ancient and Most Noble Order of the Thistle which represents the highest honour in Scotland.

In 2010 Lord Patel led a General Medical Council review of the Future Regulation of Medical Education and Training, making recommendations that would inform future policy developments by the GMC. Lord Patel was also a member of the GMC Council, 1998–2003.

Philip Pigou

Chief Executive, Medical Council of New Zealand

Chair of IAMRA 2012–2014

Philip Pigou has been the Chief Executive of the Medical Council of New Zealand since November 2005 and became the Chair of International Association of Medical Regulatory Authorities in October 2012.

Philip has a law degree and a postgraduate Diploma in Business.

He has a background in strategy and change management, introducing a strategic programme in the Medical Council. He has also led some major initiatives in primary health care in New Zealand.

Dr Daniel Poulter MP

Parliamentary Under Secretary of State for Health

Dan Poulter was appointed Parliamentary Under Secretary of State at the Department of Health in September 2012.

He is the Conservative MP for Central Suffolk and North Ipswich (2010–).

Member of the Health Select Committee (2011–2012)

Before entering politics, Dan worked as an NHS hospital doctor specialising primarily in obstetrics, gynaecology and women's health. He continues to practise medicine as an NHS hospital doctor on a part-time basis.

Dan studied law at Bristol University and has a degree in medicine from Guy's, King's and St Thomas' School of Medicine. He has helped to set up medical and lifestyle advice clinics for the homeless and people with drug and alcohol misuse problems.

The minister is responsible for health at the Department of Health. Responsibilities include:

- nursing and midwifery
- maternity services
- health education & training
- children's health
- NHS workforce
- NHS estates
- NHS security management
- allied health professions.

Karina Raaijmakers
MSc LLM

Partner, Clear Conduct and Assistant Professor Erasmus University Rotterdam

Karina Raaijmakers studied law and economics at Erasmus University Rotterdam. She started her career at the The Netherlands Authority for the Financial Markets (AFM) in 2007. After a career as (senior) regulator she was promoted in 2010 to become manager of a regulatory team.

Additionally she was part of a team that implemented the risk-based approach in the regulatory practice of the AFM. Karina joined Clear Conduct, a specialised strategic consulting firm that aims to improve regulatory strategy and practice, in 2012. She is assistant professor in governance and financial regulation at Erasmus University Rotterdam and co-editor of a Dutch regulatory journal.

Prof Sir Mike Richards

Sir Mike Richards was appointed as the First Chief Inspector of Hospitals for England at the Care Quality Commission (CQC) in July 2013.

He has been asked to lead a new programme of inspections across acute hospitals, mental health services, community services and ambulance services both in the NHS and in the independent sector.

The new inspection programme involves a radically new approach for the CQC with large teams of clinicians, patients, carers and CQC inspectors visiting NHS Trusts. Each inspection will lead to a rating for service: outstanding, good, requires improvement or inadequate.

Prior to joining the CQC Mike was Director for Reducing Premature Mortality at NHS England (2013–14) and National Cancer Director at the Department of Health (1999–2013). Prior to these appointments Mike was a consultant and Reader in Medical Oncology at Guy's and St Thomas' NHS Trust (1986–1995) and Professor of Palliative Medicine (1995–1999).

Mike was appointed CBE in 2001 and Knight Batchelor in 2010.

Elliot Rose

Elliot is a member of PA's Management group and delivers information management strategies and systems for clients.

He has over 20 years' experience of working across both the private and public sectors. He has led enterprise wide projects to deliver systems to manage regulatory, statutory and legal compliance. Elliot specialises in the regulatory aspects of information management and has worked with a number of health regulators including the General Medical Council, Nursing and Midwifery Council and General Dental Council.

Prof Sir Peter Rubin

Chair, General Medical Council

Sir Peter Rubin is Professor of Therapeutics and Consultant Physician at the Queen's Medical Centre, Nottingham. His clinical interests have been in high blood pressure and also in the medical disorders of pregnancy. He was Dean of the Faculty of Medicine and Health Sciences at Nottingham from 1997–2003; a non-Executive Director of Nottingham Health Authority from 1998–2002; and led the development of the Nottingham Vet School, which is the first new Vet School in the UK for over half a century.

Since 2009 he has been Chair of the General Medical Council. He chaired the GMC Education Committee 2002–2008; the Postgraduate Medical Education and Training Board 2005–2008; and was a member of the Board of the Higher Education Funding Council for England 2003–09, chairing the Higher Education Funding Council for England / DH Dental Joint Implementation Group. He has also chaired a number of committees for the Medical Research Council.

Else Smith

Else Smith, MD, PhD, was appointed Director General of the Danish Health and Medicines Authority in March 2012.

From January 2011 she served as Chief Executive Officer at the National Board of Health and from 2004–2011 she held a position as Director of the National Centre for Health Promotion and Disease Prevention at the National Board of Health. She is an expert on public health medicine and has held numerous public and scientific lectures and has contributed to and peer-reviewed a number of international journals. From 1989–2003 she worked at Statens Serum Institut with responsibilities on surveillance and research of infectious diseases.

Dr Else Smith is, among others, chairman of the National Danish Pandemic Group and the National Cancer Steering Group. She represents Denmark in several international fora, including the World Health Organisation, and she is a Committee Member of the Management Board of the European Centre for Disease Prevention and Control (ECDC) and Member of the European Medicines Agency's (EMA) Management Board.

Prof Malcolm Sparrow

Malcolm K Sparrow is Professor of the Practice of Public Management at Harvard's John F Kennedy School of Government.

He is Faculty Chair of the school's executive program 'Strategic Management of Regulatory and Enforcement Agencies.' Professor Sparrow's recent publications include:

- *The Character of Harms: Operational Challenges in Control* (Cambridge University Press, 2008)
- *The Regulatory Craft: Controlling Risks, Solving Problems, and Managing Compliance* (Brookings Press, 2000)
- *License to Steal: How Fraud Bleeds America's Health Care System* (Westview Press, 2000)

He served 10 years with the British Police Service, rising to the rank of Detective Chief Inspector. He has conducted internal affairs investigations, commanded a tactical firearms unit, and has extensive experience with criminal investigation. His research interests include regulatory and enforcement strategy, fraud control, corruption control, and operational risk management.

He is also a patent-holding inventor in the area of computerised fingerprint analysis and is dead serious at tennis. He holds an MA in mathematics from Cambridge University, an MPA from the Kennedy School, and a PhD in Applied Mathematics from Kent University at Canterbury.

Dr Jon Thomas, MD, MBA

Immediate Past Chair, Federation of State Medical Boards

Dr Thomas was appointment by Governor Ventura to the Minnesota Board of Medical Practice in 2001. He rose in the ranks and joined the Complaint Review Committee; the Taskforce on Maintenance of Competency; and the Work-study Group on Controlled Substances. He was elected secretary, vice president, and president twice. During this time he also served nationally on the Finance and Nominating committees of the Federation of State Medical Boards.

He has also served on the Senior Management Team of United Hospital, has been Secretary/Treasure, Vice-Chief, and was the 2012–2013 Chief of Staff. These appointments were precipitated and aided by his involvement with the Minnesota Task Force on the Maintenance of Competency, the State Policy and Planning Committee, and the Minnesota Medical Practice Act Work Group.

After achieving local success, Dr Thomas was elected to the national Board of Directors of the Federation of State Medical Boards. While on the Board he served as the Chair of Governance Committee and on the Executive Committee, and in 2013 was elected the Chair of the Federation. In this capacity, he travelled nationally and Internationally to engage health care professionals about medical regulation.

Jon resides in Vadnais Heights, Minnesota with his wife, Professor Duchess Harris, and their three children.

James Titcombe

A former project manager in the nuclear industry, now an advisor in Safety for the Care Quality Commission. James has campaigned for improvements in patient safety since the preventable death of his baby son in 2008 and is passionate about the need for an honest and open culture in the NHS.

Fergus Walsh

Fergus Walsh is the British Broadcasting Corporation's Medical Correspondent. His reports are seen globally via BBC World News. Fergus also reports for Panorama, the world's longest-running investigative TV programme.

Fergus joined the BBC in 1984. In the late '80s he was the BBC's Legal and Home Affairs Correspondent covering issues such as crime, terrorism and miscarriages of justice.

For much of the past 20 years he has concentrated on health and science. Fergus has reported from around the world on topics such as stem cells, genetics, obesity, HIV/AIDS, malaria, TB, swine flu, population growth, and cloning. In 2007 he gave evidence to Parliament during the scrutiny of the Human Tissue and Embryos Bill.

He is a firm supporter of the importance of medical volunteers and has taken part in several patient trials. He has had all his genes sequenced, his brain, heart and other vital organs scanned for television reports, and taken part in a number of medial trials.

Prof Kieran Walshe

Professor of Health Policy and Management, University of Manchester, UK

Kieran Walshe is an academic and researcher at Manchester Business School with a longstanding interest in healthcare regulation, as well as wider interests in researching organisational performance and quality in healthcare; and knowledge mobilisation and evidence based decision making in health policy and management.

He has undertaken research on regulation and performance for the Department of Health, Economic and Social Research Council, Commission for Health Improvement, Healthcare Commission, and Care Quality Commission and has been involved in advising regulatory agencies in the UK and internationally.

He was a non-executive member of the Council for Healthcare Regulatory Excellence from 2003 to 2008, and was involved in the reforms of health professions regulation enacted at that time. He is also associate director of the National Institute for Health Research health services and delivery research programme, editor of the Sage journal *Health Services Management Research*, a board member of the European Health Management Association.

Claire Warnes

Partner, KPMG, Head of Healthcare Regulation and Professional Standards

Claire leads a dedicated team at KPMG focusing on healthcare regulation and professional standards. She has extensive experience in the regulation of doctors, nurses and midwives, with a particular interest in revalidation. She also works closely with quality and system regulators across health and social care to improve regulatory effectiveness and design and evaluate regulatory policy.

Passionate about improving public service, Claire has a strong interest in compassionate leadership in healthcare and the role of regulation to stimulate this. She is working closely, in a consortium led by KPMG, with the NHS Leadership Academy to design and deliver the one of the largest ever leadership development programmes across a healthcare system.

In a 20 year career, Claire has led large change programmes for clients in the public sector including defence, security, higher and further education and criminal justice. Prior to joining KPMG in 2001, Claire worked for the Higher Education Funding Council for England and the European Commission.

She is a graduate of Cardiff University with a degree in European Studies with French and has an MBA from the University of Wales. She is a Fellow of the University of Worcester.

Dr Sarah Wollaston MP

Chair of the Health Select Committee (June 2014–)

Member of the Health Select Committee (July 2010–)

Conservative Member of Parliament for Totnes (2010–)

A GP in rural Devon for 16 years, Dr Wollaston has a medical degree from Guy's Hospital. She has also worked as a police forensic medical examiner, an examiner for the Royal College of General Practitioners, a GP trainer for Peninsula Medical School and a teacher of doctors in training at the Exeter Postgraduate Centre.

One of three medical doctors who joined the Conservative benches in 2010, Dr Wollaston was the first parliamentary candidate to be selected by a postal ballot of all constituents, regardless of party membership.

In June 2014, she was elected chair of the Health Select Committee, which examines the policy, administration and expenditure of the Department of Health. The Committee of MPs also calls the General Medical Council and other regulators before them for annual accountability hearings.

Carrie Yam

Research Associate at the Jockey Club School of Public Health and Primary Care, The Chinese University of Hong Kong.

Ms Yam obtained her MPhil degree in Statistics from the University of Hong Kong in 2002. She joined the Jockey Club School of Public Health and Primary Care at the Chinese University of Hong Kong as a Research Associate in 2007, and is mainly responsible for implementing and managing the conduct of funded projects for the Government and other international and local institutions.

She has extensive experience and considerable knowledge and skills in quantitative and qualitative research methods. Her research interests include regulation of health systems and policy studies as well as health services evaluation.

Albert van der Zeijden

After a study of psychology and pedagogy, he was a teacher and director of a teachers college until 1980. Until 1988, he was a member and chairman of the board of a teacher training college.

In 1980 he was diagnosed with Crohns' disease and enkylosing spondylitis (Bechterews disease). In 1990 he had open heart surgery after a heart attack and since 2005 he has had an Implantable Cardio Defibrillator after a heart arrest.

Since 1982, Mr van der Zeijden is active as a board member of patients' organisations. His involvement with patients' organisations is at a national as European and international level.

At present he represents the International Alliance of Patients' Organizations (IAPO)at the European medicines Agency EMA), as well as being a board member for Forum Gastein (EHFG) and Health First Europe (HFE).

As such he is a member of numerous boards, committees and working parties for organisations including:

- The Scientific Committees' Working Party with Patients' and Consumers' Organisations (PCWP) of the European Medicines Agency (EMA)
- The Pharmaceutical Risk Assessment Committee PRAC) of EMA
- The Dutch National Platform Patients' and Industry (Platform PI)
- The Dutch Agency for the registration of side effects of medicines Lareb.

Wednesday 10 September 2014

BREAKOUT SESSIONS

08:00–09:00

Welcome to IAMRA breakfast – by invitation only
Versatile

Sponsored session: Asymmetry of influence: the role of regulators in patient safety
by Health Foundation (UK)
Impressive 1

Douglas Bilton, Professional Standards Authority for Health and Social Care (UK)

Sponsored session
by Royal College of Physicians of London
Impressive 2

- **The Future Hospital Programme**
- **What stops us learning from clinical incidents?**
- **Organisational support for doctors**
- **The importance of reliable data**

Dr Anita Donley, Prof Jane Dacre, Dr Mark Temple, Dr Kevin Stewart, Dr Sian Williams and Prof John Williams, Royal College of Physicians of London

Oral presentations: Patients' rights
Innovative

- **The patient's right to know**
  Don Malcolmson, Medical Board of Australia
- **Medical regulation, social media and generation Alpha**
  Dr Stephen Bradshaw, Medical Board of Australia

11:00–12:00

Workshop: Medical regulation needs insightful practice
Energetic

Dr Douglas Murphy and Dr Ellie Hothersall, University of Dundee (UK)

Workshop: The communications conundrum – from trust us to tell us
Impressive 2

Kelly Eby, College of Physicians and Surgeons of Alberta (Canada)
Jill Hefley, College of Physicians and Surgeons of Ontario (Canada)
Susan Prins, College of Physicians and Surgeons of British Columbia (Canada)

11:00–12:00 Workshop: **Public and patient priorities and values: changing the focus of professional practice and regulation**
Innovative

Fionnula Flannery, General Medical Council (UK)

11:00–12:00 Oral presentations: **Supporting doctors and feedback**
Versatile

- **Offering emotional support to doctors going through fitness to practise procedures – a pilot project**
  Dr Mike Peters, British Medical Association (UK)
- **Should doctors have a right to silence?**
  Andrew Forbes, Lander & Rogers Lawyers (Australia)
- **Feedback from patients: potential and pitfalls in measuring health professionals' performance**
  Dr Anna van der Gaag, Health and Care Professions Council (UK)

Oral presentations: **Fitness to practise and complaints processes**
Chaired by His Honor, David Pearl, Medical Practitioners Tribunal Service (UK)
Permium

- **Enhancing processes for a more effective and transparent handling of complaints**
  Caroline Spillane, Medical Council of Ireland
- **Getting off the conveyor belt: saving time and money with ADR and pre-hearing conferences**
  Irwin Fefergrad, Royal College of Dental Surgeons of Ontario (Canada)
- **If the panel thinks fit: review hearings and current impairment in fitness to practise proceedings**
  Simon Wiklund, Professional Standards Authority for Health and Social Care (UK)

11:00–12:00 Oral presentations: **Professional standards**
Impressive 1

- **What do the public and doctors think about good professional practice – mind the gap!**
  Lorna Farren, Medical Council of Ireland
- **Evaluating what professional regulation can do to encourage professionals to deliver the 'duty of candour'**
  Amy Smith, Professional Standards Authority for Health and Social Care (UK)

14:30–17:00 **Oral presentations: Different approaches to revalidation/recertification/ maintenance of licensure around the world**

Chaired by Una Lane, General Medical Council (UK)

Premium

- **Should patients and the public have a (direct) role in regulating doctors?**
  Dr Julian Archer, Peninsula Schools of Medicine and Dentistry (UK)
- **Revalidation: The journey so far…**
  Rhian Rajaratnam, General Medical Council (UK)
- **Developing a framework for continuing fitness to practise for the UK osteopathic profession**
  Tim Walker, General Osteopathic Council (UK)
- **Implementing a framework for maintenance of licensure (MOL) for the US osteopathic medical profession**
  Dr Humayun Chaudhry, Federation of State Medical Boards (USA)
- **A system for physician performance enhancement in Canada**
  Dr André Jacques, Federation of Medical Regulatory Authorities of Canada
- **Maintaining and improving standards: recertification in New Zealand**
  Philip Pigou, Medical Council of New Zealand
- **Continuing professional development (CPD) in medicine – a way to quality healthcare delivery**
  Dr Abdulmumini Ibrahim, Medical and Dental Council of Nigeria

14:30–15:30 **Oral presentations: The accreditation of medical regulation**
Impressive 2

- **The World Federation for Medical Education (WFME) recognition of accreditation agencies: overview and updates**
  Prof David Gordon, World Federation for Medical Education
- **Strategies for regulation of accreditation, monitoring and standardisation of training programmes**
  Prof Zafar Ullah Chaudhry, College of Physicians and Surgeons Pakistan
- **The registration of physicians worldwide: one school's opportunities and challenges for its diverse graduates**
  Margaret Lambert, St George's University (Grenada, West Indies)

14:30–15:30 **Workshop: Experience of Asian Pacific countries in the healthcare professional regulation**
Led by the Chinese University of Hong Kong
Energetic

Prof E K Yeoh, Prof Sian Griffiths and Carrie Yam,
Chinese University of Hong Kong

Workshop: Accreditation of continuing professional education as a strategic asset to licensure
Impressive 1

Dr Murray Kopelow and Kate Regnier, Accreditation Council for Continuing Medical Education (USA)
Jennifer Gordon and Craig Campbell, Royal College of Physicians and Surgeons of Canada

Workshop: In the kitchen of the Dutch Health Care Inspectorate: handling concerns and complaints
Innovative

Edzo van Slooten, Marijke Prims, Arjeh Stofkooper and Paul Zwietering,
Dutch Health Care Inspectorate

16:00–17:00 **Oral presentations: Medical regulation in Australia**
Chaired by Dr Joanna Flynn, Medical Board of Australia
Impressive2

- **Background to the Australian National Registration and Accreditation Scheme**
  Dr Joanna Flynn, Medical Board of Australia
- **Evolving models of professional regulation: insights from health practitioner regulation in Australia**
  Prof Belinda Bennett, Queensland University of Technology and Medical Board of Australia
- **The development of a regulatory philosophy for the Australian National Registration and Accreditation Scheme – what is it and why is it important?**
  Dr Joanne Katsoris, Australian Health Practitioner Regulation Agency
- **HealthGov: ideas and evidence to underpin effective health workforce regulation at the national level**
  Prof Stephanie Short, University of Sydney (Australia)
- **Workforce and safety – friends or foes? Balancing public safety and medical workforce pressures in Australia**
  Chris Robertson, Australian Health Practitioner Regulation Agency

16:00–17:00 **Workshop: The interface between health professionals and healthcare organisations regulation: lessons from the UK and the Netherlands**
Innovative

Prof Kieran Walshe, Manchester Business School (UK)
Marijke Prins, Dutch Health Care Inspetorate
Michael Shepherd, Care Quality Commission (England)

Workshop: Assessing clinical competency with standardised patients: an invitation for ongoing dialogue
Impressive 1

Dr Kim Edward LeBlanc, Clinical Skills Evaluation Collaboration (USA)

Workshop: Developing the state of medical education and practice in the UK
Energetic

Paul Buckley, General Medical Council (UK)

Wednesday 10 September | 08:00–09:00

Session sponsored by Health Foundation (UK)

Asymmetry of influence: the role of regulators in patient safety

Douglas Bilton, Research and Knowledge Manager, Professional Standards Authority for Health and Social Care (UK)

This session will examine the relationship between regulators and those they regulate, and the impact this can have on patient safety.

Wednesday 10 September | 08:00–09:00

Session sponsored by Royal College of Physicians of London

08:00 **Welcome and overview of session**

Prof Jane Dacre (President), Royal College of Physicians of London and Dr Anita Donley (Clinical Vice President)

08:05 **The Future Hospital Programme**

Dr Mark Temple, Royal College of Physicians of London

08:15 **What stops us learning from clinical incidents?**

Dr Kevin Stewart, Royal College of Physicians of London

08:30 **Organisational support for doctors**

Dr Sian Williams, Royal College of Physicians of London

08:45 **The importance of reliable data**

Prof John Williams, Royal College of Physicians of London

09:00 **Closing comments**

Dr Anita Donley, Royal College of Physicians of London

Wednesday 10 September | 08:00–09:00

Patients' rights

The patient's right to know

Don Malcolmson, Medical Board of Australia

Patients' expectations have changed from being an accepter of doctors' orders to being an active partner in a therapeutic relationship.

In Australia, GPs are the 'gatekeepers' for specialists' referrals.

The Australian Health Practitioner Regulation Agency (AHPRA) maintains an online searchable register of doctors. Details displayed include registration conditions, undertakings and reprimands.

AHPRA circulates a monthly newsletter to doctors that contains links to panel, tribunal and court decisions. Panel decisions are deidentified.

Doctors who practise privately in Australia are regarded as carrying on a business covered by consumer protection legislation. Australian Consumer Law (ACL) prohibits false or misleading representations in connection with the supply of goods or services.

Under the ACL, a GP's conduct is misleading if representations about the specialist are inaccurate, or the overall impression conveyed is likely to mislead the patient. A representation may arise out of conduct, including silence.

Many patients lack the time, energy or desire to seek out registration details of specialists, and rely on GP advice.

A key issue for GPs is knowledge of the specialists' registration. When referring patients, how many practitioners routinely check the publicly available records of the specialist? Even if the record is checked, is there sufficient information to enable the patient to make an informed decision as to choice of specialist? Is there a duty on a referring practitioner to check and advise the patient of any conditions?

Is there a duty on the Regulator to advise practitioners of specialists whose registration is restricted?

Even though disclosure may cause distress to the practitioner, this does not mean that disclosure would be unfair. Rather, the relevant question is whether there is a legitimate public safety interest in disclosure? There is a balance to be struck between the rights of the individual practitioners and the public expectation of safety, competency and currency.

Wednesday 10 September | 08:00–09:00

Patients' rights (cont)

Medical regulation, social media and generation Alpha

Dr Stephen Bradshaw, Medical Board of Australia

Advertising is permissible under the national law in Australia. However, testimonials are prohibited. This has resulted in an interesting range of views, discussion and tension. When do testimonials become advertising and especially testimonials on third party sites over which the practitioner may have very little control? These third party sites may be quite helpful to a patient's decision making but equally may be misleading to the public and harmful to the practitioner.

Modern technology and social media with Facebook, Twitter, LinkedIn and YouTube to name just a few has transformed the communication landscape. Modern regulators empowered to protect the public now have to weigh up the use of social media to better inform the public whilst at the same time putting a check on the unfettered promotional advertising that maybe misleading rather than informative.

At the same time modern medical practice with ease of internet access and the 'now' culture has resulted in information and medical access being required at the click of a keystroke. The results of investigations and inquiries are now required 24 hours a day. This has led to the burgeoning of online help sites and the greater use of telemedicine on a global scale.

Who is responsible to check these sites and their accuracy and thus their ability to protect the public? If there are detectable medical practitioners responsible for the information on these sites then who is responsible for the registration and the standards of these practitioners knowing they may well be 20 thousand kilometres away, in an opposite time zone and a completely different language and culture to the geographical area of the patient.

Wednesday 10 September | 11:00–12:00

Workshop

Medical regulation needs insightful practice

Dr Douglas Murphy, University of Dundee (UK)

The workshop shares a concept (insightful practice) which puts forward a robust basis to inform medical revalidation decisions for UK general (family) practitioners and has since been adopted by University of Dundee to underpin its system of professional remediation and final decisions on outcomes of training in medical undergraduates identified as causing concern.* Insightful practice is defined as 'professional engagement with, insight into and appropriate action in response to a suite of credible independent and contextually appropriate feedback on performance, in order to minimise harm, protect patients and improve healthcare'.* Delegates will have the opportunity to reflect and discuss their reflections on the presented system in small groups and further share their opinions at a plenary session.

Background

The public both deserve and demand that those who provide care for patients are accountable and provide safe and effective healthcare. To achieve this, healthcare teams need their multi-disciplinary membership to have and maintain their individual standards of professionalism throughout their career. Problems should be highlighted as early as possible to allow intervention, support and remediation.

This is not simple – there are problems.

Measurement of professionals may be interpreted only in terms of performance management, aimed to achieve organisational goals, or to identify 'bad apples,' rather than support individuals and teams to enhance and maintain their expertise. The multitude of professional work-roles and circumstances found in healthcare would appear to require a multitude of different validated tools, thus threatening the feasibility of measurement. In addition, measurement may be interpreted as purely 'hoop jumping' and face-to face appraisal's capacity to offer a robust recommendation on revalidation decisions has been questioned.* Lastly, those identified as causing concern need a system of remediation which is fair, supportive and protects patients.

The workshop's presented system is designed to meet these challenges. It is designed to allow the early identification of professionals who are in danger, or have wandered 'off track' in their level(s) of professionalism and offers an early opportunity for remediation. Importantly, the presented system is facilitated by peer discussion to help promote professionals' insight, protect their patients and set objectives for improvement in standards of healthcare.

* Murphy et al. *Insightful Practice: a reliable measure for medical revalidation. BMJ Qual Saf* 2012;21:649–656.

The workshop is divided into three parts

Part 1 (15 minutes) – A presentation covering the research, development and experience in the use of 'insightful practice' to date.

Part 2 (20 minutes) – Small group marking and discussion of provided subject scenarios to illustrate the application of 'insightful practice' to evaluate the variation in the professionalism of subjects' responses to their suite of provided feedback. In addition, following review of individuals' data, delegates will be asked whether they feel able to recommend scenario subjects as fit to practice without referral for further consideration by others.

Part 3 (25 minutes) – A plenary discussion will allow delegates to share their thoughts on the potential adaptation and applicability of the presented system to their own work contexts. It is hoped that the workshop will promote ongoing interest and possible future partnerships for its further development.

Wednesday 10 September | 11:00–12:00

Workshop

The communications conundrum – from trust us to tell us

Kelly Eby, College of Physicians and Surgeons of Alberta (Canada)
Jill Hefley, College of Physicians and Surgeons of Ontario (Canada)
Susan Prins, College of Physicians and Surgeons of British Columbia (Canada)

Over the past 10–15 years, communications in the world of medical regulation have undergone a revolutionary transformation – from one-way messages with an authoritarian attitude to interactive media and more conversational tone. Despite many innovative approaches to communicating with the public and the profession, challenges remain for the medical regulator. How do we engage busy practitioners in decisions that will impact their practice? How do we change public perception and increase public trust when the media is the prime source of information to the public about regulatory activities and actions?

This workshop will explore some of the innovative ways Canadian regulators are addressing these issues, including a discussion on how social media is changing the landscape and opening gateways to enhanced dialogue with the profession and the public. We'll not only talk about how we communicate, but what we communicate and why.

We'll also explore what the future might hold for regulators as the pressure from media, the public and government to be more transparent ever increases.

How do we meet these challenges? Join us for an interactive and no-holds-barred discussion facilitated by three regulatory communications professionals who face these challenges daily.

Wednesday 10 September | 11:00–12:00

Workshop

Public and patient priorities and values: the changing focus of confidentiality concerns in professional practice and regulation

Fionnula Flannery, General Medical Council (UK)

Public concerns about standards of care are greatest where patients are at their most vulnerable. This includes elderly patients with complex healthcare needs, patients who are at risk of serious harm or pose a risk to others or situations when individual doctors cannot control access to patient records.

The GMC (UK) has published or is developing guidance for doctors, to provide clarity about expected professional practice in these areas. We know that regulators and professional bodies in other countries are grappling with similar issues. In 2014-15 we are revising our guidance on patient confidentiality issues.

Respect for patient confidentiality is fundamental to trust between doctors and patients and a universal touchstone in medical practice. However setting regulatory standards in this area raises difficult questions about the balance between protecting and sharing information whether for the benefit of individual patients, or the wider population. In the UK public support for sharing information eg to support joined-up patient services or a 'public good' such as research into new cancer treatments, may not be matched by individual willingness to disclose personal data. There is considerable debate about the risks posed by, for example, shared electronic records accessible beyond the healthcare team, and transfers of information to support cross-border care. In updating *Confidentiality* (2009), we will be exploring different models of consent and approaches to disclosure without consent; and the relative weight to be attached to community and individual interests.

We know there are a wide range of approaches to these issues in other countries and we see great benefit in sharing our experience and learning from other IAMRA participants.

Authors

Fionnula Flannery, Sharon Burton, Suzanne Fuller and Catherine Thomas, *General Medical Council (UK)*

Wednesday 10 September | 11:00–12:00

Supporting doctors and feedback

Offering emotional support to doctors going through fitness to practise procedures – a pilot project

Dr Mike Peters, British Medical Association (UK)

The Doctor Support Service offers a unique service in the UK to support doctors going through the General Medical Council (GMC) fitness to practise procedures. This pilot service has been commissioned by the GMC and is now in its second year, it is delivered on behalf of the GMC by the Doctors for Doctors Unit of the British Medical Association (BMA).

Having your fitness to practise investigated can be a very stressful experience and some doctors find it particularly difficult. The Doctor Support Service provides doctors going through fitness to practise procedures with an independent source of emotional support. The service is open to any doctor whether or not they are a BMA member and is free of charge. It is confidential and although funded by the GMC is independent of it. The GMC has commissioned externally independent evaluation of the Doctor Support Service. This has shown that the service is valued by those who have used it.

The support is primarily delivered over the telephone by a trained Doctor Supporter. If invited to do so that Doctor Supporter can attend a hearing to be with the doctor during what is often a very stressful part of the process. The service does not offer legal advice nor does it deal with any medical issues the doctor may have.

Over 200 doctors have used the service and data will be presented showing the profile of the doctors receiving support looking at specialty, reasons for GMC involvement, ethnicity, their age range and whether they are obtaining medico-legal representation.

Wednesday 10 September | 11:00–12:00

Supporting doctors and feedback

Should doctors have a right to silence?

Andrew Forbes, Lander & Rogers Lawyers (Australia)

Should a practitioner have a right to be silent during an investigation or disciplinary process? Is it time to evaluate any right that might exist in the context of reducing harm to patients?

When facing serious allegations of misconduct, a practitioner might refuse to answer those allegations, or provide documents claiming:

- self-incrimination privilege; or
- penalty privilege.

The right to claim privilege is seen as a basic right in criminal or civil proceedings where the penalty might be a jail term of imprisonment or significant fine. But privilege might be claimed in disciplinary proceedings before professional boards or tribunals.

If the claim for privilege is available, the person may remain silent when asked to answer a question that may expose them to a penalty or sanction. Privilege may also be claimed when the answer to a question, or the provision of a document, might expose the person to a criminal or civil sanction in another proceeding, for example, exposure to a conviction under drugs misuse legislation.

Attempts are being made to simplify proceedings to achieve quick, efficient and economic outcomes. However, when an accused practitioner is permitted to claim privilege, the disciplinary process might be frustrated or the regulator put to the time and expense of a protracted legal proceeding.

Is it in the patient's, or the public's, interest to allow a practitioner to abstain from fully engaging in a disciplinary process by claiming a right to silence? Should the right to claim privilege be abrogated, for example, by the legislature overriding any right to claim privilege?

This presentation proposes to explore when a practitioner might have a right to silence. It also proposes to explore whether this basic legal right should be abrogated in the interests of achieving effective and efficient regulation for the protection of the public and maintaining the standards of the profession.

Wednesday 10 September | 11:00–12:00

Supporting doctors and feedback

Feedback from patients: potential and pitfalls in measuring health professionals' performance

Dr Anna van der Gaag, Health and Care Professions Council (UK)

Across the globe, patients are becoming more active participants in the design and delivery of health care. This is a welcome development, which is likely to transform the ways in which health care is delivered over coming decades. This paper explores the strengths and weaknesses of professional regulators seeking feedback on health professionals' performance as part of competence assessment. It will draw on the findings of a literature review of patient feedback tools and on empirical research exploring the use of such measures.

The Health and Care Professions Council commissioned Picker Europe to conduct an independent review on the use of feedback tools in health and social care. The researchers used a combination of paper based reviews and delphi consultations and found a wide variety of measures in use, some with good validation data and others with very little. The tools included standard questionnaires, supported conversations and storytelling, and covered a range of areas including communication, respect for privacy, and competence in developing therapeutic relationships.

The key recommendation from the review was that regulators and practitioners should exercise caution in the application and interpretation of standard questionnaires, as they may not be appropriate tools with which to obtain feedback. Patients with long-term disabilities, neurological, sensory or communication impairments will need different types of tools to suit their needs and context. More recent empirical research with people with learning disabilities confirms this conclusion. Professional regulators' initiatives to involve patients must be authentic, inclusive and evidence based, and should avoid the risk of being tokenistic. More research is required on the long-term impact and effectiveness of feedback tools in measuring performance.

Wednesday 10 September | 11:00–12:00

Fitness to practise and complaints processes

Enhancing processes for a more effective and transparent handling of complaints

Caroline Spillane, Medical Council of Ireland

Objectives

The handling of complaints in a proportionate and targeted manner is a core component of the Medical Council's work, and is central in maintaining the confidence of the public and doctors. To ensure that complaints processes are optimally designed to be robust, fair and appropriately transparent, a review and revision of procedures for the handling of complaints was conducted between 2012 and 2013.

Methods

Complaints received by the Medical Council are investigated by the Medical Council's Preliminary Proceedings Committee (PPC), which determines if there is a case to refer a complaint for a fitness to practise inquiry; or it may give an opinion to the Medical Council that no further action should be taken, a complaint could be resolved by mediation, or the complaint could be referred to another body. Complaints to the Medical Council have increased in recent years, with approximately 400 received per year compared to approximately 300 per year in 2008. A comprehensive review of procedures of the Preliminary Proceedings Committee was undertaken, resulting in significant revisions and enhancements in 2012 and 2013.

Results

Revisions to procedures for the handling of complaints have included:

- The introduction of on-site assessments where concerns have been raised about a doctor's ongoing performance.
- The appointment of additional investigative expertise, as six case officers were appointed and highly trained, becoming the first ever graduates of a Certified Investigator Training Programme with the Chartered Institute of Arbitrators in Ireland.
- Improved linkages with patient support groups, to make complainants aware of such resources if they are required.
- Revision of online materials, including the development of video guides, online complaints forms and the publication of procedures.

Conclusion

Revised procedures are more robust, ensuring appropriate transparency while also supporting complainants and doctors involved in the process.

Authors

Caroline Spillane and William Kennedy, *Medical Council of Ireland*

Wednesday 10 September | 11:00–12:00

Fitness to practise and complaints processes

Getting off the conveyor belt: saving time and money with ADR and pre-hearing conferences

Irwin Fefergrad, Royal College of Dental Surgeons of Ontario (Canada)

The odds are the financial, social and emotional costs of resolving disputes escalates the longer it takes to reach a decision. For both complainant and member, justice delayed is justice denied.

Regulators need to actively look for ways to increase the timeliness of their process, while ensuring quality outcomes.

Alternative dispute resolution (ADR) is an effective problem-solving tool that offers a flexible framework to deal effectively with many issues that do not involve serious practices deficiencies. Complaints involving poor communication skills, inaccurate or poor documentation, rude behaviour, confidentiality breaches, or conflict of interest are naturals for ADR.

While ADR is not suitable for all complaints, it is usually much faster than the normal complaints process.

It is a no risk option as, if for some reason, the ADR process does not result in a negotiated settlement, the complaint is processed in the usual way through the normal complaints process.

Pre-hearing conferences are a fast-track way to identify and simplify issues before a discipline hearing, and possibly even reach a settlement without the necessity of an actual full proceeding.

Pre-hearing conferences allow both parties in advance of the proceeding to speed the process along by identifying and simplifying the issues, agreeing upon facts or evidence, the length of the hearing, and even the settlement of issues.

A pre-hearing conference presider, who is a dentist, is designated by the chair of the Discipline Committee from the governing Council or is a former member of the Discipline Committee. A public member of Council is also appointed to assist the presider.

Both counsel and their clients attend the pre-hearing conference. Any agreement reached, except for procedural matters, is then approved by the Discipline Committee.

Wednesday 10 September | 11:00–12:00

Fitness to practise and complaints processes (cont)

If the panel thinks fit – review hearings and current impairment in fitness to practise proceedings

Simon Wiklund, Professional Standards Authority for Health and Social Care (UK)

The 5th Shipman Inquiry Report recommended that review hearings be held in all cases where suspension or conditional registration has been imposed, that evidence for review hearings be gathered by specially appointed case examiners, that registrants undergo an objective assessment of fitness to practise and that where assessments reveal that registrants do not meet the required standard, steps should be taken to protect patients by removing registrants from practice.

All nine of the regulators overseen by the Professional Standards Authority in the United Kingdom now have mechanisms allowing review hearings while regulators in many other jurisdictions do not.

Review hearings can provide an opportunity to assess the fitness of registrants to return to practise, but it is unclear whether these hearings adequately address the Shipman Inquiry Report recommendations or protect the public interest.

Guidance from the High Court on review hearings was provided in the decision of Abrahaem v GMC which suggests panels must consider whether the concerns raised in the original impairment finding have been sufficiently addressed to the panel's satisfaction. However, little practical advice for panels on the procedure to follow is provided by case law or legislation.

Considering the purpose of review hearings and concept of current impairment raises questions about whether further guidance should be provided to review panels. An examination of case law concerning impairment and review hearings as well as the regulators' guidance will highlight issues around the proper basis for review decisions and suggests that following the existing guidance on finding impairment at substantive hearings would address some of the Shipman recommendations and ensure protection of the public interest.

Exploring the neglected area of review hearings can provide practical assistance to panels on the approach to be taken at these hearings and reinforce their importance in evaluating risk and reducing harm to patients.

Wednesday 10 September | 11:00–12:00

Professional standards

What do the public and doctors think about good professional practice – mind the gap!

Lorna Farren, Medical Council of Ireland

Objectives

Professionalism is a key theme in the reform of medical education and training internationally. As the medical regulatory authority, the Medical Council sets clear expectations on what it means to be a good doctor in Ireland. To inform its work, the Medical Council has explored the attitudes of the public and doctors in Ireland to good professional practice.

Methods

Public attitudes were measured through annual surveys conducted with a nationally representative quota sample of 1,000 adults 2011–2013 conducted by a market research company. Doctors' attitudes were measured through a simple random sample of 2,500 Medical Council registrants in 2013 (response rate 28%). The content of both questionnaires were informed by similar public and profession surveys conducted in other jurisdictions to enable comparability.

Results

Public trust in the medical profession in Ireland is high and 94% report satisfaction with their experience of doctors. The public is also positive about experiences of aspects of professionalism including effective communication and shared decision making. While the public has confidence that doctors engage in activities to ensure patient safety and healthcare quality, attitudes and reported behaviours of doctors and comparison with international counterparts highlight that this is an areas where medical professionalism could be further developed in Ireland.

Conclusion

Understanding public and doctors' views on good professional practice is necessary for fostering professionalism. Gaps between public expectations and doctors' attitudes and practices warrant particular attention if trust is to be maintained.

Authors

Lorna Farren, Dr Mary Clarke, Dr Paul Kavanagh, Prof Hannah McGee, Simon O'Hare and Caroline Spillane, *Medical Council of Ireland*

Wednesday 10 September | 11:00–12:00

Professional standards (cont)

Evaluating what professional regulation can do to encourage professionals to deliver the 'duty of candour'

Amy Smith, Professional Standards Authority for Health and Social Care (UK)

This presentation considers the need for professional regulators to evaluate the nature of a risk: in particular its amenability to management by regulation. Drawing on the Authority's recent work on candour as an example and the principles of 'right-touch regulation', the presentation explores how to evaluate the ability of regulatory tools to mitigate a specific threat to patient safety or public trust in a profession.

There are various reasons why healthcare professionals may find it difficult to tell patients and their families about mistakes in their care. Consideration is given to what UK professional regulators can do to overcome these and encourage professionals to deliver the Francis Inquiry recommendation that 'any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it'.

Wednesday 10 September | 14:30–17:00

Different approaches to revalidation/recertification/ maintenance of licensure around the world

Should patients and the public have a (direct) role in regulating doctors?

Dr Julian Archer,
Peninsula Schools of Medicine and Dentistry (UK)

Revalidation, the new form of medical regulation of UK doctors, aspires to be a mechanism to improve patient care, by encouraging doctors to maintain their clinical knowledge and skills, professional attitudes, and behaviours through ongoing assessment and as such shares common practices and goals with medical regulation in many other jurisdictions. One key feature of revalidation is the stated, but not yet fully operationalised requirement, for patient and public involvement (PPI). Our recent research for the NHS Revalidation Support Team found a lack of clarity about the place and purpose of PPI in revalidation. We identified a PPI typology featuring three distinct populations – patient, public, lay – each with different insights, spheres of potential engagement and expertise.

Drawing on our programme of research we explore whether in its current form PPI is included to satisfy demands for a patient voice, to make the regulatory system potentially more transparent, or simply as a token gesture. Although there are marked regional variations in operationalisation, currently there are two main ways in which revalidation explicitly draws on PPI; first, individual patient feedback that is included as part of the evidence in the doctor's appraisal portfolio leading to revalidation and second, lay representation on a variety of panels and boards. The presentation will raise questions about how patients, the public and lay people might get more involved in medical regulation.

Authors

Dr Julian Archer, Dr Samantha Regan de Bere and Dr Suzanne Nunn, *Plymouth University, Peninsula Schools of Medicine and Dentistry (UK)*

Wednesday 10 September | 14:30–17:00

Different approaches to revalidation/recertification/ maintenance of licensure around the world (cont)

Revalidation: The journey so far…

Rhian Rajaratnam, General Medical Council (UK)

The General Medical Council (GMC) introduced medical revalidation in December 2012 following significant debate and consultation. It is the first system of its kind in the world to use local annual work-based appraisals and a network of responsible officers as a basis for regular checks on doctors' fitness to practise.

With over 230,000 doctors now participating in revalidation, we will share our experience of implementing the biggest change to medical regulation in the UK in over 150 years including how we worked with key stakeholders, emerging data and trends and feedback from those directly involved in making it work.

Looking ahead, we will also share our plans for evaluating this ground-breaking initiative.

Authors

Rhian Rajaratnam and Philip Finn, *General Medical Council (UK)*

Wednesday 10 September | 14:30–17:00

Different approaches to revalidation/recertification/ maintenance of licensure around the world (cont)

Developing a framework for continuing fitness to practise for the UK osteopathic profession

Tim Walker, General Osteopathic Council (UK)

The General Osteopathic Council (GOsC) regulates approximately 4,900 osteopaths in the UK practising primarily in independent (and often sole) practice.

The GOsC has sought to develop an approach to assuring continuing fitness to practise that is proportionate and effective, while acknowledging the environmental and clinical risks present in osteopathy.

The GOsC's 2012 revalidation pilot involved testing costs and benefits of using tools such as patient and peer feedback, clinical audit and structured reflection and methods of assessment and engagement. Building on the results and lessons from the pilot, the GOsC has developed a new continuing fitness to practise framework built around reflection, objective evidence and regular peer review.

This new approach has been partly founded on the principle of 'formative space' suggesting that professionals are more likely to behave in accordance with standards if they have a forum in which to discuss standards and their performance in practice.

Through this work the GOsC hopes to:

- facilitate a shift in culture in the osteopathic professions to one of objective and continuous improvement in a constructive, verifiable and credible manner
- facilitate demonstration of patient safety and enhanced quality of care to the public.

The presentation will also highlight common goals and learning in the development of continuing competence schemes for osteopathic physicians in the United States and osteopaths in the UK despite the differing professional contexts.

Authors

Tim Walker and Fiona Browne,
General Osteopathic Council (UK)

Wednesday 10 September | 14:30–17:00

Different approaches to revalidation/recertification/ maintenance of licensure around the world

Implementing a framework for maintenance of licensure (MOL) for the US osteopathic medical profession

Dr Humayun Chaudhry, Federation of State Medical Boards (USA)

The Federation of State Medical Boards (FSMB) is the organisation that represents the 70 state medical and osteopathic boards of the United States and its territories. Collectively, these boards license and regulate 878,194 physicians, including 63,045 osteopathic physicians (DO) who have the right to practise the full scope of osteopathic medicine across all specialties of medicine and surgery.

The FSMB's House of Delegates in 2010 adopted a framework for Maintenance of Licensure (MOL), a form of continued professional development, by which all licensed physicians would be required by state boards to demonstrate proficiency in three specific components (reflective self-assessment, knowledge and skills, and practice performance) in their area of practice every five to six years. Unlike the UK model for continuing competency of physicians, the MOL framework will likely involve self-reported completion of activities by physicians and periodic random audits for verification.

For osteopathic physicians, the FSMB has recommended that participation in the American Osteopathic Association's Osteopathic Continuous Certification (OCC) program for specialty certified physicians should substantially meet any state's MOL requirements but should not be mandated for licensure. This past year, the FSMB identified a wide range of continuing medical education and CPD activities that osteopathic physicians, like allopathic (MD) physicians, already engage in which could meet a state's MOL requirements.

The FSMB is working with several organisations and state medical and osteopathic boards to better understand how physicians stay current in their area of practice and to determine what resources state boards have available to them to implement MOL in the month and years ahead.

The presentation will highlight the origins of MOL, including some of the opportunities and challenges of implementing a reasonable CPD system that recognises a physician's commitment to lifelong learning while avoiding an undue burden for physicians and state boards or a negative impact on patient care delivery.

Authors

Dr Humayun Chaudhry, Frances Cain and Mark Staz, *Federation of State Medical Boards (USA)*

Wednesday 10 September | 14:30–17:00

Different approaches to revalidation/recertification/ maintenance of licensure around the world

A system for Physician Performance Enhancement in Canada

Dr André Jacques, Federation of Medical Regulatory Authorities of Canada

The Federation of Medical Regulatory Authorities of Canada (FMRAC) multi-stakeholder Working Group on Physician Performance Enhancement (PPE) is developing a pan-Canadian strategy for physician performance enhancement to assist:

- all practising physicians in identifying opportunities for improvement
- all medical regulatory authorities in identifying physicians who may benefit from focused assessment and enhancement
- all stakeholder organisations in identifying their roles and responsibilities in PPE.

The group is developing a system and framework for PPE that is defined a life-long quality improvement and assurance system that has a demonstrable, positive impact on the quality of patient care, and is feasible and sustainable. The PPE System will:

- help physicians identify their own relevant learning needs that can be addressed through education and can help improve the quality of patient care and safety
- encompass all CanMEDS and CanMEDS-FM roles and competencies (medical expert, collaborator, communicator, manager, scholar, professional and health advocate)
- include the four dimension of a physician's practice (clinical, administrative, educational or research-based).

The FMRAC Revalidation Principles will apply and the PPE System will be fair, relevant, inclusive, transferable and formative. The PPE System involves and sets expectations of all the stakeholders: practising physicians themselves, medical regulatory authorities, certifying colleges, health care institutions, faculties of medicine, governments (federal and provincial) and others (medical associations, specialty societies, assessment organisations, etc.). The PPE System will be supported through effective advocacy and allocation of appropriate resources from all stakeholders for broad and individual physician learning needs.

The framework described will be a work-in-progress and delegate feedback will be welcome; currently, it is tentatively based on a three by three grid (the three levels of assessment / enhancement X step-wise approach (questions for physicians, data required, enhancement activities). FMRAC hopes that this will serve as a model for integration, funding and coordination of PPE activities.

Authors

André Jacques and Fleur-Ange Lefebvre, *Federation of Medical Regulatory Authorities of Canada*

Wednesday 10 September | 14:30–17:00

Different approaches to revalidation/recertification/ maintenance of licensure around the world (cont)

Maintaining and improving standards: recertification in New Zealand

Philip Pigou, Medical Council of New Zealand

In 1897 the Lancet described New Zealand as …

'… a happy home for every kind of unfeathered quack.' Lancet 1897 (1): 490

Since 1897, we have had significant lapses in the self-regulation of doctors. It is common for colleagues of doctors to be aware of another doctor's competence or conduct issues well before the Council becomes aware. This risks both patient harm and the likely success of any future rehabilitation or re-education of the doctor.

Today doctors working in New Zealand are respected for the high standard of care they provide. However the expectations have increased and patients are more questioning of the medical advice they receive. The medical profession, regulators, medical colleges and others involved in the setting of standards need to take the lead in providing assurance to the public and patients that their trust and confidence in doctors is warranted.

The Medical Council of New Zealand (MCNZ) developed a strategy in 2008 for more robust recertification requirements for doctors. This has included the implementation of professional development plans, regular practice review, multi-source feedback etc. We have been implementing these through both the inpractice recertification programme (for general scope doctors) and through college programmes (for vocationally registered doctors).

This presentation will describe the strategies the Council has adopted in maintaining and improving standards. This will include describing the recertification programmes in New Zealand, the expectations the Council has of colleges in identifying and managing poor performers, the critical relationships between the Council and employers, and the challenges in implementation.

Authors

Philip Pigou and Valencia van Dyk,
Medical Council of New Zealand

Wednesday 10 September | 14:30–17:00

Different approaches to revalidation/recertification/ maintenance of licensure around the world (cont)

Continuing professional development (CPD) in medicine – a way to quality healthcare delivery

Dr Abdulmumini Ibrahim, Medical and Dental Council of Nigeria

Background/introduction

CPD in medicine is a process of ensuring that knowledge is continually updated, in order to be in tune with current trends in the practice of medicine for the ultimate benefit of the patient.

The Medical and Dental Council of Nigeria (MDCN) introduced this programme in 2008 and later made it compulsory for practitioner in 2011. The programme has guidelines in respect of activities practitioners are expected to participate and obtain credit in.

The paper addresses the successes, challenges and the impact of the programme since its inception.

Methodology

Response from the practitioners was assessed through their annual license renewal forms. The doctors' returned application forms are carefully examined to detect compliance with the CPD guidelines. A random sample of 100 was analysed out of 28,000 financial members who submitted their licensing forms.

Based on submissions made by doctors in their forms, the outcome was analysed to see which CPD activities interest practitioners the most.

Results

The study showed a greater response to the CPD programme, it motivated the practitioners to buy into it without prejudice to sanctions to be applied to defaulters.

Also the study compared cases of professional negligence reported against doctors before and after the programme was introduced, showing a significant difference.

Discussion

Factors responsible for greater participation in CPD programme includes penalty for non renewal of annual license, sanctions, pressure from employers, and ethically related issues.

Conclusion/recommendation

Introduction of CPD by the MDCN as a way of compelling the practitioners to give their best to the patient has greatly impacted positively on the healthcare delivery. This is indicated by improvement in health indices.

Authors

Dr Abdulmumini Ibrahim and Dr Victor Gbenro, *Medical and Dental Council of Nigeria*

Wednesday 10 September | 14:30–15:30

The accreditation of medical regulation

The World Federation for Medical Education recognition of accreditation agencies: overview and updates

Prof David Gordon, World Federation for Medical Education (USA)

Background

Accreditation is frequently viewed as a powerful tool for quality control and improvement of medical education programs, yet accreditation practices vary considerably worldwide. The World Federation for Medical Education (WFME), with assistance from the Foundation for Advancement of International Medical Education and Research (FAIMER), has developed and implemented a global program of recognition of agencies accrediting medical schools.

Methods

The WFME Recognition Program consists of criteria that must be met by the agency seeking recognition. First, an accrediting agency seeking recognition completes an application documenting how the agency meets the criteria. Next, an ad-hoc WFME team reviews the agency's application, observes a site visit of one medical school, and observes the agency's decision making meeting. The WFME team subsequently writes a report documenting the agency's compliance with the recognition criteria. The agency has the opportunity to respond to the report before it is finalised. Lastly, the WFME Recognition Committee debates the final report and makes a recognition decision.

Results

Currently the Caribbean Accreditation Authority for Education in Medicine and other Health Professions (CAAM-HP), the Association for Evaluation and Accreditation of Medical Education Programs (TEPDAD), Turkey, and the United States Liaison Committee on Medical Education (LCME) / Committee on the Accreditation of Canadian Medical Schools (CACMS) have all undergone the WFME recognition process. The WFME Recognition Committee made positive decisions to officially recognise each of these agencies for a period of ten years.

Conclusions

The goal of the WFME Recognition Program is to enhance the quality of accreditation systems globally, which will improve medical education and health care worldwide. As of 2023, the Educational Commission for Foreign Medical Graduates (ECFMG) will require WFME recognition of agencies accrediting the schools of international graduates seeking training positions in the United States. Additional accreditation agencies are encouraged to participate in this quality improvement process.

Authors

Prof David Gordon,
World Federation for Medical Education
Dr Marta van Zanten, *Foundation for Advancement of International Medical Education* and Research *(USA)*

Wednesday 10 September | 14:30–15:30

The accreditation of medical regulation (cont)

Strategies for regulation of accreditation, monitoring and standardisation of training programmes

Prof Zafar Ullah Chaudhry, College of Physicians and Surgeons Pakistan

The objective of the presentation is to discuss the strategies and instruments used for accreditation, monitoring and standardisation of training programmes of the College of Physicians and Surgeons Pakistan.

The presentation will describe the structures and processes being used at the College of Physicians and Surgeons Pakistan for regulation of accreditation, monitoring and standardisation of training programmes. In this regard, several tools and quality assurance mechanisms have been adopted, adapted or created by the College after experimenting with these tools for several years. The presentation will explain some of these innovative but indigenous tools such as Structured Visual Curriculum Display (SVCD) charts and E-log system, which allow trainees to acquire given competencies in the prescribe timelines, enter their day to day work; the mentors to validate the work of their trainees; and the College to generate a quarterly electronic report on the performances of both the trainees and their mentors.

Authors

Prof Zafar Ullah Chaudhry and Dr Siraj Haque, *College of Physicians and Surgeons Pakistan*

Wednesday 10 September | 14:30–15:30

The accreditation of medical regulation (cont)

The registration of physicians worldwide: one school's opportunities and challenges for its diverse graduates

Margaret Lambert, St George's University (Grenada, West Indies)

In 2014, medicine is truly a global profession. Physicians may train in different countries at stages in their education, and practice in yet another country. More medical schools, as part of their mission, are educating nationals from throughout the world, not just from their own country or region. Many of these nationals wish to return to their home country for licensure and practice after completion of medical training.

St George's University School of Medicine in Grenada has a particularly diverse student body. SGUSOM is accredited by the Caribbean Accreditation Authority for Education in Medicine and other Health Professions (CAAM-HP), the first health accrediting body in the world to be recognised by the World Federation of Medical Education.

Founded in 1976, SGUSOM has had over 21,000 MD graduates who have practiced in over 50 countries. Its student body is 30 percent non-US citizens, with a total number of 85 countries represented. As a result, SGUSOM graduates seek licensure/registration in many different countries.

This presentation will focus on the opportunities and challenges of a global student body seeking licensure/regulation around the world. Using the experience of SGUSOM graduates, we will explore how regulatory bodies can assure protection of the public through reasonable licensure/registration standards, while simultaneously ensuring the free flow of well-trained physicians from globally accredited medical schools.

We would propose a 'validated accreditation model' that would allow for regulatory bodies to 'recognise/accept' 'foreign' medical schools meeting these standards. After meeting this baseline international standard, graduates of such schools would then be able to seek to satisfy the examination and other licensure requirements in that jurisdiction.

We believe this approach would allow jurisdictions to protect the public interest while facilitating the much-needed global movement of well-trained physicians.

Authors

Margaret Lambert and Stephen Seeling,
St George's University (Grenada, West Indies)

Wednesday 10 September | 14:30–15:30

Workshop

Experience of Asian Pacific countries in the healthcare professional regulation

Prof E K Yeoh, Prof Sian Griffith and Carrie Yam, Chinese University of Hong Kong

This workshop will follow on from the Panel Session on 'Different approaches to healthcare professional regulation and models of regulatory accountability across the world', in which Carrie Yam will describe the results of work by the Chinese University of Hong Kong (CUHK) on medical regulatory systems across the world. This workshop will provide an opportunity for an in-depth discussion about the current practices of regulation of healthcare professionals in different countries focusing on the Asian Pacific countries.

As part of the healthcare reform process, in 2012 the Hong Kong SAR government commissioned the CUHK group to review healthcare professional regulatory systems across the world. Ten key messages emerged from this review which were that:

1. Reform of regulation is to protect patients and improve quality of care.
2. Legislative change is needed to reform structures.
3. Policy and organisation for overarching common principles of governance is emerging.
4. Moving towards self regulation in partnership.
5. Lay representation is becoming the norm.
6. Relationships with governments and regulation of standards by healthcare system and institutional regulators (providers) vary.
7. Compulsory Continuing Professional Development is the norm.
8. Emerging emphasis is on both detecting and dealing with poor performance and improving quality of care.
9. Greater separation and clarity of these roles is occurring.
10. Overseas graduates are admitted in different ways.

Whilst many countries are undergoing reform of regulation of their healthcare professions, often triggered by scandals and political interests, a comparison between the practices between the Asian and Western countries is interesting. Asian countries are more likely to have a stronger degree of government oversight, and with less lay representation in the regulatory council/ boards. Continuous professional development is more likely to be compulsory for healthcare professionals in the West to maintain their professional competence. Advances towards regular assessment of performance for upholding standards of practice and early detection of poor performance are exemplified by the launch of revalidation in UK and recertification in US.

This workshop will invite participants to share issues and experience of regulating healthcare professionals with a focus in the Asian Pacific region, and discuss with a wider audience as a platform for knowledge transfer and learning lessons for different countries.

Wednesday 10 September | 14:30–15:30

Workshop

Accreditation of continuing professional education as a strategic asset to licensure

Dr Murray Kopelow and Kate Regnier,
Accreditation Council for Continuing Medical Education (USA)
Jennifer Gordon and Dr Craig Campbell,
Royal College of Physicians and Surgeons of Canada

In most jurisdictions, professional expectations for continuing professional education (CPE) co exist with expectations for attaining and maintaining licensure. This workshop will explore the ways accreditation and accredited CPE, including interprofessional education, can support and enhance the achievement of professional standards through the quality assurance of the medical education and training available to those in practice.

Goal

To foster collaboration between licensure and CPE.

The workshop will include:

1. Discussion on the diverse approaches to CPE/ continuing professional development (CPD) in support of licensure requirements, around the world.

2. The exploration of the different ways CPE/ CPD and licensure interact around the world.

3. Group participation in identifying opportunities for inter-national and intra-national collaboration between education and licensure over projects specifically designed to evaluate risk and reduce harm to patients. (using case-studies of existing collaborations).

4. Exploring how accreditation and licensure can promote the evolution of interprofessional education in support of interprofessional collaborative practice.

The planning of the workshop will be a collaborative project of the newly formed 'International Academy of CME/CPD Accreditation' and will include the input of CME/CPD leaders from existing and developing accreditation systems of the UK, South Africa, Qatar, Oman, Australia, Hong Kong, Germany, Canada and the United States.

Wednesday 10 September | 14:30–15:30

Workshop

In the kitchen of the Dutch Health Care Inspectorate: handling concerns and complaints

Edzo van Slooten, Marijke Prins, Arjeh Stofkooper and Paul Zwietering, Dutch Health Care Inspectorate

How does the Dutch Health Care Inspectorate handle complaints and concerns? How do they assess and judge complaints and concerns raised? What does their assessment framework look like? After a short introduction to the Dutch system of health care, the role of the Dutch Health Care Inspectorate and the way it gathers information, weighs this information and acts will be explained to you.

An inspector will present this process to you and will then interactively lead you through several example complaints, eg a professional with a possible addiction, and by doing so explain the Dutch way of handling complaints on possibly impaired professionals.

Wednesday 10 September | 16:00–17:00

Medical regulation in Australia

Background to the Australian National Registration and Accreditation Scheme

Dr Joanna Flynn, Medical Board of Australia

In July 2010, Australia established a new national system for the regulation of health practitioners across 14 professions. The Medical Board of Australia oversees the regulation of medical practitioners nationally. The Australian Health Practitioner Regulation Agency works in partnership with the Board to administer the regulatory system.

Authors

Dr Joanna Flynn,
Medical Board of Australia
Martin Fletcher,
Australian Health Practitioner Regulation Agency

Wednesday 10 September | 16:00–17:00

Medical regulation in Australia (cont)

Evolving models of professional regulation: insights from health practitioner regulation in Australia

Prof Belinda Bennett, Queensland University of Technology and Medical Board of Australia

Legal developments around health practitioner regulation in Australia provide a unique opportunity to consider and evaluate a number of differing regulatory models, comparing profession-specific with cross-profession approaches, and state/territory-based regulation with national regulation. Three regulatory models will be analysed in the paper:

- the state and territory-based framework that existed in Australia prior to 2010
- the proposals for a national model and the national model introduced in 2010
- the co-regulatory model developed in New South Wales and more recently in Queensland.

This paper evaluates the relative strengths and weaknesses of the various models and considers the challenges of developing responsive regulatory systems for contemporary health practitioner regulation.

Authors

Prof Belinda Bennett,
Queensland University of Technology and Medical Board of Australia
Dr Fleur Beauport,
Independent Researcher
Prof Terry Carney, Prof Mary Chiarella, Dr Patrick Kelly, Dr Claudette Satchell and Prof Merrilyn Walton, *University of Sydney (Australia)*

Wednesday 10 September | 16:00–17:00

Medical regulation in Australia (cont)

The development of a regulatory philosophy for the Australian National Registration and Accreditation Scheme – what is it and why is it important?

Dr Joanne Katsoris, Australian Health Practitioner Regulation Agency

By mid-2012, 14 National Boards covering more than 15 professions and governed by a single piece of legislation replaced 97 state-based Boards. Recognising that regulatory decision making is complex and contextual, we have resisted developing algorithms for decision makers. Rather, we have developed a regulatory philosophy or principles for decision-making across the Scheme to support consistent and effective decision making.

Wednesday 10 September | 16:00–17:00

Medical regulation in Australia (cont)

HealthGov: ideas and evidence to underpin effective health workforce regulation at the national level

Prof Stephanie Short, University of Sydney (Australia)

Since 2009 HealthGov has been auspiced by the University of Sydney where the international network provides: collaborative research with regulators and professionals; facilitating the internationalisation of research and international linkages; improving techniques of research design and management; providing opportunities to network with other governance researchers and practitioners; improving communication of results to wide audiences; and strengthening this research area and enhancing future viability.

Authors

Prof Stephanie Short and Kanchan Marcus, *University of Sydney (Australia)*

Wednesday 10 September | 16:00–17:00

Medical regulation in Australia (cont)

Workforce and safety – friends or foes? Balancing public safety and medical workforce pressures in Australia

Chris Robertson, Australian Health Practitioner Regulation Agency

Australian legislation governing the Medical Board of Australia and Australian Health Practitioner Regulation Agency's operations is relatively unique in adding the potentially conflicting objectives of ensuring public safety while also improving access to health services and enabling a flexible, responsive and sustainable health workforce. In addition there are very few legislative constraints on scope of practice with just three explicit practice restrictions in the Australian legislation.

This presentation will outline the context of the broader workforce development objectives in the Australian scheme and illustrate the developing thinking, issues and legal challenges arising from the early experience within this new model.

Wednesday 10 September | 16:00–17:00

Workshop

The interface between health professionals and healthcare organisations regulation: lessons from the UK and the Netherlands

Prof Kieran Walshe, Manchester Business School (UK)
Marijke Prins, Dutch Health Care Inspectorate
Michael Shepherd, Care Quality Commission (England)

This workshop is focused on the interface and interactions between the regulation of healthcare professions and the regulation of healthcare services and organisations. In most countries there is a long and complex history to healthcare regulation, which has resulted in the development and evolution of regulatory arrangements which vary in important respects such as their governance and accountability, scope and intensity of oversight, methods for regulatory direction, measurement and enforcement, and professional and societal acceptability. International and interprofessional comparisons provide us with an opportunity to learn from such variation about the determinants of regulatory effectiveness.

This workshop is concerned with the interface between the regulation of health services and organisations (hospitals, clinics, care homes, primary care practices, etc) and the regulation of professionals (doctors, nurses, therapists etc) and seeks to explore three main questions: what are the reasons for and consequences of separate or integrated regulatory arrangements for these two domains; what are the main areas, forms and functions of interaction between them and how are they enacted in different systems; and how might some current and future regulatory developments (for example, revalidation for health professionals, or increased employer responsibility for professional oversight) lead to a need for greater regulatory integration.

These issues will be explored through three short presentations which will first compare and contrast the development of health profession and healthcare organisations regulation, and then offer two country case studies – the Netherlands, which has an integrated regulator of services and professionals (Inspectie voor de Gezondheidszorg, the Dutch Healthcare Inspectorate), and England which has a regulatory agency for health and social care services (the Care Quality Commission) and nine separate health professions regulators (General Medical Council, Nursing and Midwifery Council, Health Professions Council etc).

Wednesday 10 September | 16:00–17:00

Workshop

Assessing clinical competency with standardised patients: an invitation for ongoing dialogue

Dr Kim Edward LeBlanc, Clinical Skills Evaluation Collaboration (USA)

The purpose of this workshop is to foster an informational exchange among entities in countries administering similar assessments, or planning similar assessments, with an eye toward improving these kinds of evaluations for the future. The Clinical Skills Evaluation Collaboration, a partnership between the Educational Commission for Foreign Medical Graduates (ECFMG) and the National Board of Medical Examiners (NBME), based in Philadelphia PA, USA has been administering the United States Medical Licensing Examination (USMLE) Step 2 CS since June 2004. The USMLE examinations assist State Medical Boards to determine eligibility for licensure of all individuals applying for a medical licence in the United States.

The examinees must take a history, perform a physical examination, develop differential diagnoses, and provide recommendations for further diagnostic studies for 12 standardised patient encounters.

This examination requires substantial training of the standardised patients, extensive staff, standardised patient trainers, and six different facilities situated across the country for administration. We engage a large group of academic medical faculty members from across the US for the development of relevant cases and scoring rubrics following the standard of medical care. All of the post-encounter patient notes are scored by trained, board-certified, practising physician note raters. Psychometricians participate in scoring the exams to insure the reliability of every administration. We are in the developmental stages of the assessment of more advanced communication skills, and are researching the introduction of additional simulated pathology to the examination for enhanced realism. This brings about both practical and psychometric considerations worthy of discussion. After a brief presentation regarding the United States Medical Licensing Examination Step 2 Clinical Skills, participants will be asked to share information about current examinations, plans for future examinations, and ideas for enhancing the current state of the enhancement of clinical skills. Plans for continuing the dialogue will be discussed.

Wednesday 10 September | 16:00–17:00

Workshop

Developing the state of medical education and practice in the UK

Paul Buckley, General Medical Council (UK)

Over the last three years the General medical Council (GMC) has developed a new public policy product to help explore what we and others know about the UK's doctor population, the environments they work in and their education. Published annually, the state of medical education and practice report seeks to:

- use GMC and other data to provide a picture of the medical profession in the UK and to identify some of the challenges it faces
- promote discussion and debate about some of the practical steps we and others could take in better supporting doctors and improving patient care.

The authors draw on the GMC's data and the data of others to try and understand more about how doctors' professional lives and how standards of practice can be improved. Previous editions have examined complaints to the GMC to see if we can understand more about them and whether they can help us identify areas of risk within medical practice. The GMC has also explored how variability in practice might be affected by the environment doctors work in.

This workshop will examine how the GMC goes about developing this product and some of the challenges faced by a regulator in seeking to draw on a wide range of data to inform public debate. During the session participants will examine what has worked and what has not. We will look at how the GMC has organised itself to deliver this work and how it has been received by key interest groups across the UK. We will seek to learn lessons from other regulators attending IAMRA.

Link to the *State of Medical Education and Practice in the UK 2013* report: www.gmc-uk.org/somep

Authors

Paul Buckley and Luke Bruce,
General Medical Council (UK)

Thursday 11 September 2014

BREAKOUT SESSIONS

08:00–09:00 **Sponsored session: Should regulators hold the profession to account or should the regulator encourage the profession to be accountable?**
by Medical Protection Society (UK)
Impressive 1

Dr Letticia Mojo, Health Professions Council of South Africa
Caroline Spillane, Medical Council of Ireland
Dr Liliane Field, Medical Protection Society (UK)
Dr Robert Hendry, Medical Protection Society (UK)
Anthony Omo, General Medical Council (UK)

Sponsored session: Introduction to the Federation of State Medical Boards (FSMB) and networking breakfast
by Federation of State Medical Boards (USA)
Energetic

Donald Polk, Humayun Chaudhry and Gregory Snyder,
Federation of State Medical Boards (USA)

Oral presentations: Professionalism
Innovative

- **Designing professionalism induction e-Learning for international medical graduates**
  Sue Roff, University of Dundee (UK)
- **Promoting professionalism and professional behaviours for health care students and professionals: a case study**
  Fiona Browne, General Osteopathic Council (UK)

Oral presentations: Education and training
Versatile

- **Training our new doctors: ensuring a quality training experience**
  Andrew Connolly, Medical Council of New Zealand
- **The value of licensure, specialty certification, revalidation and accreditation in medicine: challenges and opportunities**
  Dr Jack (John) Boulet, Educational Commission for Foreign Medical Graduates (USA)

11:30–12:30 **Workshop: Risk identification, risk assessment and risk mitigation: the three main steps of healthcare regulatory practice**
Impressive 1

Karina Raaijmakers, Clear Conduct (the Netherlands)
Ian Leistikow, Dutch Healthcare Inspectorate

Workshop: Migration and integration: regulating overseas trained doctors
Impressive 2

Andrea Callender, General Medical Council (UK)

Workshop: Understanding risk: towards an evidence based approach to regulatory policy development
Versatile

Guy Rubin and Claire Herbert, General Dental Council (UK)

Workshop: Unprofessional behaviour and the risks to patient safety
Energetic

Dr Kevin Stewart, Royal College of Physicians of London

Oral presentations: Using data to identify risks and improve regulatory effectiveness
Premium

- **Complaints against physicians: a study of the prevalence of communication issues as a basis for complaints**
  Dr Aaron Young, Federation of State Medical Boards (USA)

- **Overview of research methods for evidenced-based regulation: an Australian case study**
  Prof Merrilyn Walton, University of Sydney and Australian Health Practitioners Regulation Agency

- **Can evidence gathered from practice be used for research? The Professional Standards Authority's 'Section 29' database**
  Douglas Bilton, Professional Standards Authority for Health and Social Care (UK)

Oral presentations: Fitness to practise and risk
Innovative

- **Disciplined doctors: does sex of a doctor matter?**
  Emily Unwin, University College London (UK)

- **Tests of competence: unfair to long standing doctors?**
  Dr Leila Mehdizadeh, University College London (UK)

14:30–15:15 **Workshop: Risk based regulation: what can we learn from other regulated sectors?**
Impressive 1

Elliot Rose and Robert Bowen, PA Consulting

Workshop: Collaboration and consensus building in developing a common application for medical registration
Energetic

Kate Reed, College of Physicians and Surgeons of Alberta (Canada)
Pierre Lemay, Medical Council of Canada

Workshop: Protecting the public? An analysis of complaints and disciplinary proceedings against doctors in Australia and New Zealand
Impressive 2

Dr Katie Elkin, Office of the Health and Disability Commissioner (New Zealand)

Oral presentation: Fundamentals of medical regulation – international experiences (1)
Innovative

- **Safeguarding patients: where we were and where we are now: sharing Dubai's experience**
  Dr Ramadan Ibrahim, Dubai Health Authority (United Arab Emirates)
- **Establishing a system of postgraduate medical education in Pakistan**
  Prof Zafar Ullah Chaudhry, College of Physicians and Surgeons of Pakistan

Oral presentations: Fundamentals of medical regulation – international experiences (2)
Premium

- **Compulsory criminal record checks for health practitioners in Australia**
  Dr Joanne Katsoris, Australian Health Practitioner Regulation Agency
- **The pressure to recognise foreign medical qualifications – emerging global trends**
  Prof Lesleyanne Hawthorne, University of Melbourne (Australia)

15:45–16:30 **Workshop (repeated): Risk based regulation: what can we learn from other regulated sectors?**
Impressive 1

Elliot Rose and Robert Bowen, PA Consulting

Workshop (repeated): Protecting the public? An analysis of complaints and disciplinary proceedings against doctors in Australia and New Zealand
Impressive 2

Dr Katie Elkin, Office of the Health and Disability Commissioner (New Zealand)

Workshop: Primary-source verification of physician credentials: real-world challenges and real-world solutions
Energetic

Kara Corrado and Tracy Gill,
Educational Commission for Foreign Medical Graduates (USA)

Oral presentations: Public registers
Innovative

- **Good practice for setting up and managing public registers**
  Dr Humayun Chaudhry, IAMRA Physician Information Exchange Working Group
- **Developing the register**
  Niall Dickson, General Medical Council (UK)

Oral presentations (repeated): Fundamentals of medical regulation – international experiences (2)
Premium

- **Compulsory criminal record checks for health practitioners in Australia**
  Dr Joanne Katsoris, Australian Health Practitioner Regulation Agency
- **The pressure to recognise foreign medical qualifications – emerging global trends**
  Prof Lesleyanne Hawthorne, University of Melbourne (Australia)

Thursday 11 September | 08:00–09:00

Session sponsored by Medical Protection Society (UK)

Should regulators hold the profession to account or should the regulator encourage the profession to be accountable?

Dr Letticia Mojo, Health Professions Council of South Africa
Caroline Spillane, Medical Council of Ireland
Dr Liliane Field and Dr Robert Hendry, Medical Protection Society (UK)
Dr Robert Hendry, Medical Protection Society (UK)
Anthony Omo, General Medical Council (UK)

The nature and purpose of healthcare regulation will be the focus of this session. In recent years, and in many countries, there has been a renewed focus on the role of regulators and how they can best ensure compliance and most importantly, patient safety.

Key questions will be debated, including whether regulators can act as a barrier to an open medical profession, how a culture of accountability might be created, as well as what impact criminal sanctions may have when trying to create openness. We will also seek to address the role of a blame culture and where the balance lies.

On the panel will be a Medical Protection Society medicolegal expert who will share their thoughts and experience on these questions. This session is open to all and we look forward to welcoming you to take part in this important debate.

Thursday 11 September | 08:00–09:00

Session sponsored by Federation of State Medical Boards (USA)

Introduction to the Federation of State Medical Boards (FSMB) and networking breakfast

Donald Polk, Humayun Chaudhry and Gregory Snyder,
Federation of State Medical Boards (USA)

08:00–08:15 **Opening remarks**

Donald Polk, DO, Chair, FSMB Board of Directors
Humayun Chaudhry, DO, MACP, FSMB President and CEO
Gregory Snyder, MD, FSMB Board of Directors, Chair, FSMB Workgroup on International Collaboration

8:15–9:00 **Breakfast and attendee networking**

Thursday 11 September | 08:00–09:00

Professionalism

Designing professionalism induction e-Learning for international medical graduates

Sue Roff, University of Dundee (UK)

Background

Overseas graduates compose 20–25% of the medical workforce in countries such as the UK, USA, Australia and Canada. Some have difficulty in understanding and meeting elements of the professionalism standards of their new work culture. Regulators who license international medical graduates may find it helpful to develop inexpensive e-learning in order to both evaluate risk and reduce potential harm to patients by using the software properties to provide 'calibrated feedback loops for formative learning' of professionalism in its cultural context.

Aims

The presentation aims to show how dialogic e-learning can be delivered (increasingly inexpensively) by combining the principles of formative calibrated feedback loops with design strategies from the field of progress testing for the formative learning and potentially summative assessment of understanding core elements of professionalism in new cultural contexts.

Methods

Responses to the Dundee Polyprofessionalism online resources from medical students in Saudi Arabia, Egypt, Pakistan and Scotland indicating different understandings of the importance of some core elements of health care professionalism will be reported. It will be demonstrated how the feedback analytics of online software including Articulate and Bristol Online Surveys can facilitate cost-efficient dialogic learning within and between communities of practice, creating a learning organisation of the whole health care team by promoting reflective learning through iterative creation of formative calibrated feedback loops.

Results

Iterative calibration from the software analytics are used to provide the 'feedback loop' that is essential to formative learning.

Conclusions

Data from online learning programmes can be used to monitor and promote individual professional development and organisational culture changes in health team professionalism among students, trainees and registrants as part of CPD, revalidation and quality assurance of work-based learning and assessment. The process is demonstrated in relation to induction of International Medical Graduates.

Thursday 11 September | 08:00–09:00

Professionalism (cont)

Promoting professionalism and professional behaviours for health care students and professionals: a case study

Fiona Browne, General Osteopathic Council (UK)

Background

Osteopathy is a regulated health profession in the United Kingdom. Osteopaths are trained to degree level and practise primarily in the independent sector usually without teams and employers, once registered. In such a context, how might the regulator work with educational institutions and osteopaths to ensure that professional guidance is embedded and interpreted appropriately informed by patients and other health professionals as well as the osteopathic profession?

Objectives

- To identify professional values and norms and support appropriate contextual professional behaviours.
- To provide feedback to support learning.
- To put in place strategies to better align values, norms, behaviours and standards in partnership with educational institutions and others.

Methods

We adapted and field tested situational judgement scenarios for undergraduate students and facilitated group learning. We developed and piloted e-learning tools for registrants with automated feedback supporting learning. We analysed data to evaluate risk and reduce harm to patients.

Results

Data will be presented, both from osteopathic students and other healthcare students and delegates invited to evaluate areas of risk where further guidance or other interventions may be necessary. We will discuss how the results have been used to facilitate dialogic learning with osteopathic students to enable them to better inform contextual professional behaviours.

Take home messages

- Collecting data from osteopaths and other health professionals could help to bring norms together across different professions and patients.
- E-learning can be used to facilitate dialogic learning in communities of practice such as osteopathy, by providing feedback and reflective learning.
- Dialogue can help to evaluate risks to professionalism.
- Active regulation: working supportively with individuals and organisations can help us to develop strategies to support coordinated approaches to implementation of guidance and lapses in professional norms, behaviour and standards. This provides potential opportunities to address risks before they harm patient care.

Authors

Sue Roff, *Education Consultant*
Marcus Dye, Alan Stewart, Tim Walker, Pria Lakhani and Kellie Green,
General Osteopathic Council (UK)

Thursday 11 September | 08:00–09:00

Education and training

Training our new doctors: ensuring a quality training experience

Andrew Connolly, Medical Council of New Zealand

New Zealand is changing the way doctors are trained in the first two years following graduation. A doctor's first two postgraduate years (PGY1 and PGY2) are a crucial link that bridge the gap between medical school and vocational training.

In 2011 the Medical Council of New Zealand (MCNZ) began consultation with the profession and stakeholders about the problems with the existing model of prevocational training, and what changes need to be made to address these.

As a result the MCNZ focused on improving the quality of prevocational training with changes to:

- the structure of prevocational training
- the curriculum framework and learning outcomes for each of PGY1 and PGY2
- elements of assessment – tracking, assessing and recording skills and knowledge via an e-portfolio
- supervision requirements and training and support for supervisors
- accreditation of services who provide training.

This presentation will explore the issues and drivers behind the need for change to prevocational medical education and the purpose and objectives for the first two postgraduate years, and present key features of a new prevocational training framework. The features include structural change, the implementation of a curriculum framework, well defined learning outcomes for the end of both PGY1 and PGY2, an e-portfolio model for tracking, assessing and recording skills and knowledge for each intern, and the setting of standards for training providers and clinical attachments to ensure high quality training.

Authors

Andrew Connolly and Joan Crawford,
Medical Council of New Zealand

Thursday 11 September | 08:00–09:00

Education and training (cont)

The value of licensure, specialty certification, revalidation and accreditation in medicine: challenges and opportunities

Dr Jack (John) Boulet, Educational Commission for Foreign Medical Graduates (USA)

The licensing and revalidation (or recertification) of physicians and the accreditation of undergraduate, graduate, and continuing medical education programs are believed to be important for safeguarding patients. Although regulation of the medical profession is mandated in most countries and jurisdictions around the world, the process by which physicians become licensed, and maintain their licenses, is quite varied and subject to different quality standards. With respect to educational programs, there has been a recent push to expand accreditation activities. Here too, the quality standards on which medical schools are evaluated can vary from one area of the world to another.

Given the perceived importance of oversight in medicine, both at the individual practitioner and medical school levels, it is important to describe and discuss the regulatory practices employed throughout the world. In this paper, we document current issues in regulation, provide a brief summary of research in the field, and discuss the need for, and design of, investigations to better quantify relationships between regulatory activities and patient outcomes. Well-designed studies can yield important information to support the validity regulatory activities, including any associated competency assessments, and provide quality assurance data to guide improvement efforts.

For licensure, revalidation and accreditation, several studies have linked specific processes to quality indicators. Nevertheless, additional evaluations should be conducted across the medical education and practice continuum to better understand the relationships between regulatory activities and patient outcomes. The value of accreditation, licensure, and revalidation programs around the world, including the effectiveness of specific protocols employed in these diverse systems, needs to be better quantified and disseminated. Through this process, 'best practices' can be formulated and shared amongst regulatory and accreditation bodies, thus promoting higher quality education and medical practice.

Authors

Dr Jack Boulet,
Education Commission for Foreign Medical Graduates (USA)
Dr Dale Dauphinee, Amy Opalek and Dr Marta van Zanten,
Foundation for Advancement of International Medical Education and Research (USA)

Thursday 11 September | 11:30–12:30

Workshop

Risk identification, risk assessment and risk mitigation: the three main steps of healthcare regulatory practice

Karina Raaijmakers, Clear Conduct (the Netherlands)
Ian Leistikow, Dutch Healthcare Inspectorate

This workshop focuses on the three main steps of regulatory practice in the context of healthcare regulation: risk identification, risk assessment and risk mitigation. It will give an insight into the ongoing development within the Dutch Healthcare Inspectorate on how to choose which healthcare risks to focus on and how to monitor the effect of interventions. In this interactive workshop attendees will experience what it's like to define and rate healthcare risks that differ in size and shape. In addition, we will pay attention to monitoring the effectiveness of regulatory practice.

Thursday 11 September | 11:30–12:30

Workshop

Migration and integration: regulating overseas trained doctors

Andrea Callender, General Medical Council (UK)

Doctors, like other healthcare professionals, are constantly crossing national and regional boundaries on a global scale. The reasons for their migration are varied and sometimes complex. For example, in 2006 the World Health Organisation (WHO) estimated that there was a shortage of more than 4.3 million health professionals across the world.

What most overseas trained doctors have in common is the need to quickly adapt and embrace the frequently challenging transition to practising a different environment with its own ethical and social norms.

Doctors on the move bring with them valuable skills and competences as well as varying levels of experience of working in different professional contexts and to different standards. For example, research indicates that qualifying outside of the UK can be a 'risk factor' for a doctor being involved in the General Medical Council's fitness to practise procedures. Some international medical graduates are more likely to perform less well on exams and assessments at different stages of their medical education and training in the UK.

The debate is evolving to look at what interventions, regulatory or otherwise, may be needed to support overseas trained doctors to practise safely in their chosen settings. This interactive workshop will explore approaches and lessons learnt in regulating these cohorts of international doctors through two questions:

- Is there a role for the professional regulator to help integrate overseas trained doctors into clinical practice in their chosen environment?
- Are there regulatory interventions that are proving to be effective in supporting doctors who qualify elsewhere?

Thursday 11 September | 11:30–12:30

Workshop

Understanding risk: towards an evidence based approach to regulatory policy development

Guy Rubin and Claire Herbert, General Dental Council (UK)

This workshop will draw upon recent research carried out by the General Dental Council (GDC) to argue that understanding and evaluating risk provides a valuable framework for policy development in professional regulation. It enables regulators to (i) analyse and understand potential root causes or contributory factors associated with poor performance and can (ii) contribute to developing policies, including for continuing fitness to practise.

The workshop will present three case studies from recent GDC commissioned independent research studies and explains the value of taking an evidence based approach to risk in developing proportionate regulation policy. The paper defines risk in dentistry and analyses risk in relation to four categories of potential risk factors or risk: clinical, competence, conduct, and context. It considers how professional healthcare regulators may understand risk and potential risk factors in the context of patient safety.

It goes on to draw lessons, for others, from the work carried out so far and concludes by acknowledging opportunities for regulators (both systems and professional) to share experience and findings in this area.

The context of this includes the recent increased focus on the value and importance of proactively understanding and evaluating risk in healthcare, and in professional healthcare regulation. For example, the Department of Health England's *Trust, Assurance and Safety* (2007) stated that the frequency and intensity of revalidation should be proportionate to the level of risk. The UK's Council for Healthcare Regulatory Excellence (now PSA) published *Right-touch regulation* (2012) noting that proportionate regulation requires regulators to quantify risk in balancing regulatory needs with requirements. In 2013, the *Final Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* in the UK – the Francis Report – recommended that professional regulators should take a more proactive approach to detecting and preventing harm to patients.

Thursday 11 September | 11:30–12:30

Workshop

Unprofessional behaviour and the risks to patient safety

Dr Kevin Stewart, Royal College of Physicians of London

Most doctors behave to the highest professional standards, but a small number do not. Those who display unprofessional behaviour tend to do so recurrently and often go unchallenged, except in the most extreme or serious cases. Doctors perceived as of high value to their organisations are least likely to be challenged. Around 5% of doctors account for over 70% of incidents.

In North America disruptive and unprofessional behaviour has recently received increased attention from regulators and clinical leaders following a clear demonstration of a link with medical errors and safety incidents. Individuals who display unprofessional behaviour have also been shown to be at high risk of becoming the subject of litigation.

A range of factors may predispose to unprofessional behaviour including illness (physical or psychiatric), personality disorder, stress and drug or alcohol dependency. Behaviours may be a manifestation of doctors' family, relationship or financial difficulties. Individuals with poor influencing or communication skills are often implicated especially if there are inadequate organisational systems for dealing with complaints or concerns.

Disruptive behaviour has also been demonstrated by nurses and managers but it is the behaviour of doctors which has been most closely linked with patient harm. Various programs have been developed to deal with this and most have a moderate degree of success.

Workshop description

In this interactive workshop we shall briefly review the international literature and present some unpublished UK work. This will be followed by a 30 minute small group case-based discussion when delegates will be split into groups of four to six. The final feedback session will incorporate discussion of approaches to dealing with individuals displaying unprofessional behaviour.

Learning objectives

By the end of this session participants will:

- Understand the spectrum of behaviours which can be regarded as unprofessional.
- Understand how this can contribute to errors and safety incidents and foster an unsafe environment.
- Understand some other effects of this behaviour.
- Be familiar with some approaches for dealing with this.

Authors

Dr Kevin Stewart and Dr Anita Donley,
Royal College of Physicians of London

Thursday 11 September | 11:30–12:30

Using data to identify risks and improve regulatory effectiveness

Complaints against physicians: a study of the prevalence of communication Issues as a basis for complaints

Dr Aaron Young, Federation of State Medical Boards (USA)

Medical boards in the United States take actions against the licenses of thousands of physicians each year. Many actions originate as a complaint reported by a patient or their family. Anecdotal evidence suggests that communication issues are a primary reason for physician complaints, but quantitative studies have yet to examine this assertion. This presentation seeks to advance the discussion by focusing on research examining the complaints received by a medical board to determine if communication is a primary reason for complaints against physicians.

Using data from 2002–2012, our research focused on one jurisdiction as a case study to examine complaints against physicians. An analysis of this data reveals that communication issues are consistently the most prevalent reason for complaints against physicians, accounting for more than one in five of all complaints. These results are discussed in light of their implications for the field of medicine as it seeks to improve patient care.

Authors

Dr Aaron Young, Phil Davignon and David Johnson, *Federation of State Medical Boards (USA)*

Thursday 11 September | 11:30–12:30

Using data to identify risks and improve regulatory effectiveness (cont)

Overview of research methods for evidenced-based regulation: an Australian case study

Prof Merrilyn Walton, University of Sydney and Australian Health Practitioners Regulation Agency

Regulatory models to regulate medical practice and methods to develop policies have historically been developed opportunistically or reactively to community and professional concerns. While the theories and regulatory philosophies underpinning health regulation are now part of the regulatory dialogue there is yet to be a body of research to help governments and regulators design regulatory systems that deliver cost effective and safe regulation. To date there has been little research into regulation. Obtaining the evidence for best practice regulation in complaints management and decision making in disciplinary processes was one of the major reasons for the Australian Research Council awarding a one million dollar Linkage grant to the University of Sydney and its linkage partners – Australian Health Practitioners Regulation Agency (AHPRA), the Professional Health Councils (New South Wales) and the New South Wales (NSW) Health Care Complaints Commission. This research will provide the first comparative analysis of the national and NSW approaches to the management of complaints/notifications about health professionals. The research consists of the following five studies:

1. Comparative analysis of health complaints data
2. Complaint journeys – comparing and contrasting the way in which complaints move through the relevant handling systems.
3. Attitudes and decision making characteristics of key personnel and quasi-judicial decision makers
4. Experience of complainants/notifiers with the system of complaint management
5. Models of complaint handling and/regulation.

This oral presentation will cover the aims and methods selected for the five studies including the challenges associated with undertaking large-scale research with involving different regulatory authorities.

Authors

Prof Merrilyn Walton, *University of Sydney and Australian Health Practitioners Regulation Agency*
Prof Belinda Bennett, *Queensland University of Technology and Medical Board of Australia*
Prof Terry Carney, Dr Patrick Kelly and Dr Claudette Shapelle, *University of Sydney (Australia)*

Thursday 11 September | 11:30–12:30

Using data to identify risks and improve regulatory effectiveness (cont)

Can evidence gathered from practice be used for research? The Professional Standards Authority's 'Section 29' database

Douglas Bilton, Professional Standards Authority for Health and Social Care (UK)

The UK Professional Standards Authority for Health and Social Care reviews all of the outcomes of the final fitness to practise committees of the nine professional regulators whose work it oversees. The Authority can refer those decisions to court if it considers they are unduly lenient and do not protect the public, a power which comes from Section 29 of the National Health Service Reform and Health Care Professions Act 2002.

As a result of a decade of reviewing these outcomes, the Authority has a database of around 16,000 cases from a wide range of different professional groups and settings, and has begun to explore the potential research uses of this data. The data includes details of the individual's profession, a summary of the allegation made against them, an account of the panel's deliberation of the evidence, the sanction (if any) ultimately applied, and an account of the panel's reason for applying that sanction.

The Authority has begun to explore the potential of the database to provide fresh insights into, for example, the circumstances in which professional misconduct occurs and whether we could learn from the data to prevent misconduct occurring in future. It has commissioned an academic centre to take forward an initial assessment of the database, looking at the quality and consistency of the data, and advising on the range of research that it could support.

The Authority's Research and Knowledge Manager will present the emerging findings, and will reflect in more general terms on the use of evidence for research that has initially been gathered for a different purpose.

Thursday 11 September | 11:30–12:30

Fitness to practise and risk

Disciplined doctors: does sex of a doctor matter?

Emily Unwin, University College London (UK)

Background

The General Medical Council (GMC) has been receiving an increasing number of complaints about doctors' fitness to practise since 2007. Developing a better understanding of who receives sanctions on their medical registration and the factors associated with receiving sanctions is needed to enable the profession to better support doctors and maintain the health and safety of patients.

Summary of work

A cross-sectional study was used to examine the association between doctors' sex and receiving sanctions on their medical registration. The population of interest were doctors who were practising in the United Kingdom and were listed in the GMC's List of Registered Medical Practitioners (LRMP) database. Binary logistic regression modelling, controlling for confounders, described the association between doctor's sex and sanctions (warning, undertakings, conditions, suspension or erasure from the medical register) on a doctor's medical registration. Confounding variables included years since primary medical qualification, world region of primary qualification and specialty.

Summary of results

Female doctors were less likely to receive sanctions against their medical registration, compared to male doctors (OR 0.37, 95% CI: 0.33–0.41).

Conclusion

The results suggest that female doctors have reduced odds of receiving sanctions on their medical registration when compared to their male colleagues, however it is not clear why women are less likely to receive sanctions when compared to men. Exploring the possible reasons for this sex difference in professional performance is required. We discuss the potential theories to explain the differences between the sexes.

Authors

Emily Unwin, Prof Jane Dacre, Dr Clare Wadlow and Katherine Woolf, *University College London (UK)*

Thursday 11 September | 11:30–12:30

Fitness to practise and risk (cont)

Tests of competence: unfair to long standing doctors?

Dr Leila Mehdizadeh, University College London (UK)

Background

In the UK, a General Medical Council Fitness to Practise (FtP) investigation may involve a test of competence (ToC) for doctors with performance concerns. Concern has been raised about the suitability of the ToC format for doctors who qualified before the introduction of single best answer (SBA) and OSCE assessments.

Summary of work

A retrospective cohort design was used to determine an association between year of primary medical qualification (PMQ) and doctors' ToC performance. Performance of 95 general practitioners under FtP investigation was compared with that of 376 controls. We analysed performance on knowledge test, OSCE overall, and three individual OSCE stations using Pearson's correlation and regression models.

Summary of results

On average, FtP doctors performed worse on all ToC outcomes compared to control doctors. The earlier they qualified the less well they performed, except for physical examination skills. The control group remained mostly consistent irrespective of PMQ year. PMQ year predicted exam performance more strongly in FtP doctors than controls, even when controlling for gender, ethnicity and qualification region. Further analysis showed that controls who qualified before the introduction of SBA and OSCE assessments still outperform their peers under investigation.

Conclusions

Results suggest that ToC format does not disadvantage long standing doctors. We discuss findings in relation to the FtP procedures and recent controversy regarding underperformance in ethnic minority doctors and international medical graduates taking postgraduate exams in the UK. This study should be extended with more doctors who were recent graduates under FtP investigation, more who were earlier graduates in the control group and who are working in a variety of hospital specialties. Future work should also look at whether PMQ year still predicts ToC performance when the age of doctors, years in clinical practice and specialty are controlled for.

Authors

Dr Leila Mehdizadeh, Prof Jane Dacre and Dr Alison Sturrock, *University College London (UK)*

Thursday 11 September | 14:30–15:15, and at 15:45–16:30

Workshop

Risk based regulation: what can we learn from other regulated sectors?

Elliot Rose and Robert Bowen, PA Consulting

This workshop will look at different regulated sectors and organisations in order to understand ways in which risk based regulation has been adopted and their relevance for medical regulation. We will also discuss what some of the general risks medical regulators may need to address and how they could be managed better.

Thursday 11 September | 14:30–15:15

Workshop

Collaboration and consensus building in developing a common application for medical registration

Kate Reed, College of Physicians and Surgeons of Alberta (Canada)
Pierre Lemay, Medical Council of Canada

Protecting the public by ensuring only competent and ethical physicians are registered and permitted to practise medicine is a cornerstone of medical self-regulation. When Canada introduced a national mutual recognition agreement with the aim of increasing medical workforce mobility, it became essential for the 13 provincial medical regulatory authorities (MRAs) to understand how each registers physicians to minimise risk to the public they serve. After negotiating common registration criteria, the MRAs collaborated with the Medical Council of Canada to develop a common application for medical registration in any Canadian jurisdiction.

Other collaborators were Canada's 17 medical schools, all of the country's postgraduate training institutions, and the national speciality certification bodies. The process involved analysis and comparison of the 13 different application forms before achieving consensus on the inclusion of common questions regarding the candidate's identity, primary medical degree, postgraduate training, specialty certifications, medical licences, and practice history.

Source-verified information is fed into the system to pre-populate certain fields, and each MRA also includes unique questions on professional conduct and health issues to satisfy jurisdictional requirements. Candidates from within Canada and around the world enter the secure online portal to complete the application and submit it to any number of the provincial MRAs. This workshop would be of interest and benefit to any medical regulatory authority developing or redeveloping the content of its application forms, considering an online application process, or involved in reciprocity agreements with other jurisdictions.

Thursday 11 September | 14:30–15:15

Fundamentals of medical regulation – international experiences (1)

Safeguarding patients: where we were and where we are now: sharing Dubai's experience

Dr Ramadan Ibrahim, Dubai Health Authority (United Arab Emirates)

Thirty years ago physicians in Dubai were practising without a medical license. A decade ago there was no medical laws. Five years ago physicians were obtaining their healthcare professional license without verification of their certificate/experience or the need for good standing certificate. Till recently there were no proper health policies or regulations in place. Medical error was unreported and not investigated.

Today and after establishing the health regulation department (HRD) in DHA, the licensing process has transformed into a safer and more robust one in Dubai. All physicians in Dubai are licensed, including those working in the governmental sector (started only five years ago). Medical liability and other laws related to practising medicine have been developed. Add to that, a local decree in relation to regulating medical practice was issued at the end of 2012. An appeal and medical practice committee has been formed. MoUs have been signed with national and international governmental bodies and authorities in order to simplify licensing process and ensure patients' safety. A contract is signed with a specialised company to do primary source verification for professional and experience certificate of doctors. Policies and regulations were set for medical specialties and subspecialties. Clinical audit and on site physician and facility assessment have been introduced. A vigorous electronic system for reporting mortality cases in healthcare facilities has been developed. A proper system put in place to report and review medical complaint. HRD has developed in collaboration with the executive council in Dubai several KPIs to monitor healthcare professional's performance in order to ensure patients' safety and provide best quality of care. Mental and physical assessment for senior doctors is well established and linked to licensure renewal. Add to that the bi annual checkup for all doctors to assess their physical fitness to practice. And the cycle of improvement continues in Dubai.

Authors

Dr Ramadan Ibrahim and Dr Layla Al Marzouqi, *Dubai Health Authority (United Arab Emirates)*

Thursday 11 September | 14:30–15:15

Fundamentals of medical regulation – international experiences (1) (cont)

Establishing a system of postgraduate medical education in Pakistan

Prof Zafar Ullah Chaudhry, College of Physicians and Surgeons of Pakistan

The objectives of the presentation are:

- Describe the Milestones in establishing a system of Post Graduate Medical Education in Pakistan
- Challenges met and solutions used to meet those challenges
- Project present training Network.

The presentation will identify the needs that led to the establishment of the College of Physicians and Surgeons Pakistan and will highlight milestones of its progress. It will briefly describe its existing training system and network within the country comprising 178 accredited institutions with 17,748 trainees under supervision of 2,756 mentors, and also its fellowship training programs in several overseas countries.

Authors

Prof Zafar Ullah Chaudhry and Dr Siraj Haque, *College of Physicians and Surgeons of Pakistan*

Thursday 11 September | 14:30–15:15, and at 15:45–16:30

Fundamentals of medical regulation – international experiences (2)

Compulsory criminal record checks for health practitioners in Australia

Dr Joanne Katsoris, Australian Health Practitioner Regulation Agency

Since 2010, criminal record checks have been a mandatory part of the registration process for Australian health practitioners. Practitioners must have a criminal record check when they apply for registration. This is now being extended to include international criminal history checks. Practitioners are also obliged to declare changes to their criminal history at renewal of registration and to inform the Board if they are charged with an offence punishable by 12 months imprisonment or are convicted or found guilty for an offence punishable by imprisonment.

In 2012/13, the Australian Health Practitioner Regulation Agency, on behalf of the Medical Board of Australia, requested 60,053 practitioner criminal record checks. Of the 60,053 practitioners, 3,284 (5%) indicated that the practitioner had a criminal history. Action was taken in 29 cases (0.05% of the total criminal checks) as a result of the check. Two applications were refused where the criminal history was a factor in the decision and in 27 cases, conditions were imposed or undertakings were entered into.

Criminal record checks come at a significant financial cost without much yield. This presentation will discuss the process for undertaking criminal history checks, how the Boards deal with the information and will explore whether it's worth the effort.

Thursday 11 September | 14:30–15:15, and at 15:45–16:30

Fundamentals of medical regulation – international experiences (2) (cont)

The pressure to recognise foreign medical qualifications – emerging global trends

Prof Lesleyanne Hawthorne, University of Melbourne (Australia)

The scale of skilled migration has grown phenomenally in the past two decades. In an age of transnationalism, growing numbers of medical professionals are born in one country, educated in other/s, and leverage off their skills to secure professional integration anywhere in the world. This process poses major challenges to regulatory bodies. Temporary medical migrants now dominate skilled migration flows to a range of countries. Many immediately start work, with few initially willing to invest in securing full recognition. Regulatory systems are further required to accommodate the return-migration of citizens qualified overseas; the presence of expatriates; and the placement of international students – all derived from highly diverse source countries. The question increasingly asked is whether regulatory systems designed centuries back remain fit for purpose in the 21st century? Or do they lack the agility to manage contemporary labour flows? Within this context, the use of partial or limited recognition to practice is increasing.

Employers seek flexible and responsive accreditation systems, relevant to health sector needs and contemporary migration modes. Regulatory bodies are being forced to adjust – spurred by the scale of migration in regulated fields, growth of temporary flows, and national/regional reform agendas. Governments are urging change, with the aim of improving efficiency and social justice outcomes. This paper defines global factors driving regulatory change, based on recent research completed by the author for the US Migration Policy Institute and the World Health Organisation (2012–14).

Thursday 11 September | 14:30–15:15, and at 15:45–16:30

Workshop

Protecting the public? An analysis of complaints and disciplinary proceedings against doctors in Australia and New Zealand

Dr Katie Elkin, Office of the Health and Disability Commissioner (New Zealand)

The professional regulation of doctors is commonly justified as necessary for the protection of the public. However, the degree to which regulatory decision-making is actually consistent with public protection considerations is unclear. The impact of other influences, such as the wider public interest in ensuring an adequate supply of doctors in the workforce, is also unknown. This workshop presents empirical analyses that we undertook to explore these questions.

The first study is an analysis of the 485 determinations made by medical tribunals between 2000 and 2009 in the four most populous states of Australia and in New Zealand. The nature of the misconduct at issue is analysed according to a new typology that is more refined than previous typologies and, for the first time, considers misconduct according to both its type and the underlying reason for that misconduct. Disciplinary sanctions imposed by the tribunals are explored in some detail, with removal from practice given special attention due to the unique role of that sanction in protecting the public.

The results lead us to question whether the potential for rehabilitation is being weighted too heavily by the tribunals, and whether this may indicate that other considerations (such as doctor supply and the doctor's own interests) are being allowed to obscure the primary goal of public protection.

The second study investigates 5,323 complaints made to medical boards in Victoria and Western Australia. Again, the characteristics of the doctors concerned are analysed, with particular attention paid to how those characteristics appear at different stages of the complaints and disciplinary process. A focus of the second study is doctor country of training, which is considered in a more nuanced way than ever before. Due to the regulatory response to doctor shortage in Australia, this doctor characteristic is of contemporary significance, including in relation to what it reveals of the tension between public protection and the wider public interest. The increased risk of complaints and disciplinary proceedings among international medical graduates suggests that more may need to be done in ensuring that the approach to the registration, support and supervision of such doctors does not expose the public to risk.

As well as being instructive as to the priorities and operation of the complaints and disciplinary system, the knowledge gained through the empirical studies may be useful to regulators in furthering their public protection agendas. In summary, the results indicate that the risk of being subject to complaints and/or disciplinary action is particularly elevated for doctors who: are male; specialise in obstetrics/gynaecology, psychiatry or general practice; obtained their primary medical qualification overseas; hold general registration; and have previously come to the negative attention of the regulator. The first study shows that sexual misconduct, illegal or unethical prescribing, and inappropriate or inadequate treatment are the most common issues leading to disciplinary action. This increased knowledge may move regulators closer to being able to proactively identify of 'at risk' doctors and behaviours, thus allowing them to target training, support and interventions towards such doctors and concerns.

Please note that the majority of the results from the analyses described above were published in the Medical Journal of Australia in 2011, the British Medical Journal Quality and Safety or Medical Journal of Australia in 2012, or in the Journal of Law and Medicine.

Authors

Dr Katie Elkin,
Office of the *Health and Disability Commissioner (New Zealand)*
Dr Matthew Spittal,
University of Melbourne (Australia)
Prof David Studdert, *Stanford University (USA)*
David Elkin

Thursday 11 September | 15:45–16:30

Workshop

Primary-source verification of physician credentials: real-world challenges and real-world solutions

Kara Corrado and Tracy Gill,
Educational Commission for Foreign Medical Graduates (USA)

Evaluating the authenticity of credentials related to a physician's medical education, training, and registration/licensure are critical to determining whether that physician is qualified to provide safe and effective patient care. Primary-source verification – verifying the credential directly with the issuing institution – is the gold standard in the evaluation of credentials, and an integral part of a licensing authority's mission to the public. However, this process can present many challenges. Throughout its more than three decades of primary-source verifying physician credentials, the Educational Commission for Foreign Medical Graduates (ECFMG) has succeeded in addressing these issues while maintaining the integrity and rigor of its primary-source verification process. The result is a process that has evolved to mitigate challenges, to maximise efficiency, and to adjust to a continually changing world.

During this workshop, ECFMG presenters will explore some of the real-world challenges the organisation has faced when seeking to verify the authenticity of physician credentials and discuss strategies it has developed in response to these challenges. Challenges to be discussed include the time it takes to receive and process credentials and verifications; foreign policy restrictions; dealing with cultural differences; data accessibility; and working with special cases.

At the end of this workshop, participants will be able to:

- Define primary-source verification
- Identify some of the core challenges faced during primary-source verification
- Understand the need for a verification process that is both rigorous and flexible
- Identify solutions for addressing core challenges

Attendees will be invited to ask questions, discuss their own experiences, and identify issues and solutions associated with the verification of physician credentials.

Thursday 11 September | 15:45–16:30

Public registers

Good practice for setting up and managing public registers

Dr Humayun Chaudhry,
IAMRA Physician Information Exchange Working Group

One of IAMRA's highest priorities is the efficient and effective exchange of information between medical regulatory authorities about the physicians that they register, in the interest of public protection. With this in mind, the Physician Information Exchange (PIE) Working Group was formally established on January 31, 2007 and is overseen by IAMRA's Management Committee.

Great strides have been made in improving information sharing among IAMRA members through the exchange of Certificates of Good Standing (CGS) and equivalents, the use of bilateral memoranda of understanding, and the adoption by members at the 2012 Members General Assembly of an IAMRA Statement of Intent on Proactive Information Sharing, which was developed to encourage medical regulatory authorities to share information about physicians whose practice may put patients at risk. Several IAMRA members have become signatories or endorsers of this statement, and those that have not are encouraged to do so, if they are able.

The PIE Working Group has also developed a document to provide guidance to medical regulators about the development and maintenance of public registers, a document which is being put forth as a resolution at IAMRA's Member General Assembly. IAMRA members are encouraged to use the information outlined in these guidelines for information sharing if they choose to develop public registers, to the extent permitted by applicable privacy legislation and other procedural rules.

In 2013, the PIE Working Group surveyed the IAMRA membership to determine which medical regulatory authorities have public registers. This information is being developed into a resource that will be made available on the new IAMRA website by the end of 2014.

Thursday 11 September | 15:45–16:30

Public registers (cont)

Developing the register

Niall Dickson, General Medical Council (UK)

This General Medical Council (GMC) is undertaking a review of its online medical register, the list of registered medical practitioners (LRMP). Since the LRMP was introduced in 2006, we have witnessed a 'revolution' in the proliferation and publication of heath information, bringing increased levels of openness and transparency. This is both influencing, and is influenced by, a growing demand for health related data – leading to increased 'patient activation' and improvement activity on the part of providers and practitioners. Against this context, and with greater access to information on a doctor's scope of practice, the GMC is undertaking a programme of work to explore how its online register can be redeveloped to both meet this demand and help improve standards within the medical profession.

The purpose of this session is to introduce the GMC's work in this area and to pose the following questions for consideration:

- Who are the key users of an online register and can a single product meet the needs and requirements of all interested parties?
- Should a register serve as a reference point or should it serve as a tool to stimulate improvement – can an online register of medical practitioners ever serve as a consumer tool?
- Should an online register serve as a historical record or should it reflect current practice?
- How should the information be presented to ensure it is both meaningful and accessible to all parties?
- What are the core principles that should underpin the design of an effective online register? Should the content draw solely on verifiable information collected by the regulator or could it also include information submitted by patients and registrants?

Friday 12 September 2014

BREAKOUT SESSIONS

08:00–09:00 **Sponsored session: Supporting doctors who are under pressure**
by British Medical Association (UK)
Impressive 1

Dr Mark Porter and Dr Mike Peters, British Medical Association (UK)

Sponsored session: Revalidation – how is it affecting practice?
by Health Foundation (UK)
Impressive 2

Richard Taunt, Health Foundation (UK)
Dr Julian Archer and Dr Marie Bryce,
Peninsula Schools of Medicine and Dentistry (UK)

Oral presentations: Assessment
Innovative

- **Assessment within the framework of medical regulation: blending public, private and professional interests in a decentralised system of independent audit**
  David Johnson, Federation of State Medical Boards (USA)
- **How technology assists the screening of medical practitioners**
  Ian Frank, Australian Medical Council
- **Five year review of OSCE for the 2nd part of licensing examination in South Korea**
  Prof Ducksun Ahn, National Health Professional Licensing Examination Board (South Korea)

Oral presentations: Registration and international medical graduates
Energetic

- **Challenges of registration: from training to practice**
  Faten Yousef, Dubai Health Authority (United Arab Emirates)
  (presenting on behalf of Khawla Al Mansoori, Dubai Health Authority)
- **Which medical migrants should be prioritised? The merits of international medical graduates compared to international students qualified in Australia**
  Prof Lesleyanne Hawthorne, University of Melbourne (Australia)

Friday 12 September | 08:00–09:00

Session sponsored by British Medical Association (UK)

Supporting doctors who are under pressure

Dr Mark Porter and Dr Mike Peters, British Medical Association (UK)

Doctors are facing increasing demands and expectations. These can lead to a perfect storm of pressures, under which the doctor starts to demonstrate performance issues and finds themselves before the regulator. The regulatory process then increases the pressures.

We will look at a study, using validated health questionnaires, on the impact of complaints on the physical and psychological health of doctors, and whether exposure to a complaint makes doctors practice more defensively. The session will conclude by considering how the system can be improved to minimise and damage to those going through the complaints process.

Friday 12 September | 08:00–09:00

Session sponsored by Health Foundation (UK)

Revalidation – how is it affecting practice?

Richard Taunt, Health Foundation (UK)
Dr Julian Archer and Dr Marie Bryce, Peninsula Schools of Medicine and Dentistry (UK)

Dr Julian Archer and Dr Marie Bryce from Peninsula Schools of Medicine and Dentistry will present an overview of an ongoing Health Foundation programme of research that seeks to understand the impact of revalidation and fitness to practise procedures on doctors and their patients in the UK.

Friday 12 September | 08:00–09:00

Assessment within the framework of medical regulation: blending public, private and professional interests in a decentralised system of independent audit

David Johnson, Federation of State Medical Boards (USA)

This presentation addresses the role of assessment within the overall context of medical regulation citing the framework used in the United States, which provides an independent audit function for a decentralised system blending public, private and professional interests.

The authors begin with the concept of independent audit as one approach for assuring physician preparedness to practice medicine, drawing upon the explication of the concept by Donald Melnick (Medical Teacher, 2009).

The presentation examines assessment in three spheres of activity (medical education; accreditation; licensure) that operate independently yet complementary to each other in the framework of US medical regulation.

The presentation identifies how the public, private and professional sectors are blended within each of the three spheres identified above. For example, medical education is an endeavour conducted by both public and private institutions. Accreditation of these schools is a 'voluntary' endeavor conducted by a private entity (Liaison Committee on Medical Education) comprised of the profession (American Medical Association) and medical educators (Association of American Medical Colleges). Licensure decisions are the responsibility of each state licensing board, which typically draw upon expertise from both the public and professional sector.

The authors work with the United States Medical Licensing Examination® (USMLE®) and draw from the program's attempt to blend public, private and professional elements into all facets of test design, delivery, and reporting. The authors discuss USMLE as a key marker across the continuum of medical education even though its primary function remains serving the assessment needs of US medical regulatory bodies.

The presentation touches upon the successes of this framework for medical regulation as well as the challenges inherent in such an approach. The authors hope to encourage an ongoing dialogue about the perspectives represented in medical regulation and to benefit from the varied experiences of the IAMRA community.

Authors

David Johnson,
Federation of State Medical Boards (USA)
Dr Gerry Dillon,
National Board of Medical Examiners (USA)

Friday 11 September | 08:00–09:00

Assessment (cont)

How technology assists the screening of medical practitioners

Ian Frank, Australian Medical Council

Formal assessment and examination have been part of the medical regulatory process since its inception. Assessments in medicine are used in a variety of ways, including to:

- Credential completion of a medical course or unit of training
- Establish fitness for licensure
- Screen those trained outside a specific regulatory system
- Monitor performance of licenced practitioners.

Although in recent years there have been significant advances in testing technology and science, assessment of the medical profession for regulatory purposes has changed little, with a heavy reliance on MCQs for the testing of knowledge and OSCEs to evaluate clinical skills. Valid and efficient delivery of high stakes assessments continues to present a challenge for all examining and regulatory bodies in medicine.

This presentation will focus on how technology can facilitate the screening of medical practitioners for patient safety purposes, including licensure, focussing on two case studies from the Australian Medical Council:

- Advances in statistical analysis and computer-administered testing resulting in Computer-adaptive MCQ assessments tailored to the ability of the individual, with greater test integrity and efficiency of test administration.
- Improved defensibility and quality assurance in clinical OSCE testing through the use of CCTV and advanced (mobile computer) tablet technology, opening the way to remote scoring of clinical examinations and more efficient use of examiner time.

In the face of increasing pressure to defend assessment outcomes, the growing demand for testing and the increased competition for clinical and examination resources, advances in testing technology will have an ever more important role to play in ensuring patient safety.

Friday 11 September | 08:00–09:00

Assessment (cont)

Five year review of OSCE for the 2nd part of licensing examination in South Korea

Prof Ducksun Ahn, National Health Professional Licensing Examination Board (South Korea)

Since 1991, large scale high stake OSCE has been successfully used for medical license testing in Canada. It was the consensus among Korean medical educators that the implementation of a clinical skill test at the national level could improve the deficient clinical skill education very effectively. Therefore the strategy of implementing OSCE as a second component of national licensure examination was chosen to drive the improvement of clinical skill education for Korean students. Furthermore, the medical school accreditation program installed new standards, which included mandating the clinical skill examination as well as communication skill education during clerkship training. Since 2000, National Health Personnel Licensing Examination Board initiated basic research on the feasibility of performance assessment and subsequently organised various committees to generate test content and structure a large scale OSCE. Also, a mock test was done annually to volunteers from various medical schools since 2006, where the entire system for the clinical skill test could be thoroughly vetted.

The first clinical skill test was carried out over the course of three months from September to early December at the OSCE center in NHPLEB in 2009. The 12-station OSCE measures the proficiency of clinical skills using mannequins, models and various equipment as well as systematically trained standardised patients. For the last five years, the OSCE at the national licensing examination level was done without serious problems and the outcome of this examination will be presented and discussed.

Authors

Prof Ducksun Ahn, Dr Myunghyun Jung and Mikyung Yim, *National Health Professional Licensing Examination Board (South Korea)*

Friday 11 September | 08:00–09:00

Registration and international medical graduates

Challenges of registration: from training to practice

Faten Yousef, Dubai Health Authority (United Arab Emirates) (presenting on behalf of Khawla Al Mansoori, Dubai Health Authority)

Dubai has developed rapidly in many fields in the last 10 years. This attracted people all over the world to choose Dubai for establishing their business. One of the major areas Dubai focuses on is the health care sector. Currently, Dubai has more than 26 thousand licensed health care professionals coming from more than 75 countries. While Dubai is challenging to be the choice of business destination and striving to ensure quality in nearly every aspect of the services provided, a system was needed to evaluate different qualifications and training programs while ensuring that the quality is not compromised at any cost.

In 2009, Dubai Health Authority announced its 'Health care Professionals licensing Requirements manual' which includes the tier system. This system classifies qualification from different countries into three levels based on selected standards such as: the country and institution from which the certificate/qualification was awarded, the level of international recognition of the certificate/qualification, and the duration and content of study, with special emphasis on the presence or absence of clinical practice/practical training as relevant to the type of licensure requested.

The real challenge in implementing the system comes from lack of information and communication barriers from some of the countries we have applicants from.

Authors

Khawla Essa Saeed Al Mansoori,
Dubai Health Authority (United Arab Emirates)

Friday 11 September | 08:00–09:00

Registration and international medical graduates (cont)

Which medical migrants should be prioritised? The merits of international medical graduates compared to international students qualified in Australia

Prof Lesleyanne Hawthorne, University of Melbourne (Australia)

Australia is one of few nations with an explicit policy to import migrant health professionals. Recent trends include the devolution of the temporary resident pathway; removal of the cap on international student enrolments; the impact of bilateral/multilateral agreements on the recognition of foreign qualifications; and the introduction of more flexible strategies to secure medical registration. While the goal of workforce self-sufficiency has been set for 2025, this is unlikely to be achieved. By 2011 47% of Australians with medical degrees were overseas-born. A quarter had arrived in the previous five years. International medical graduates (IMGs) are now derived from an unprecedented array of source countries. Despite dramatic escalation in domestic student training in the past decade, the scale of medical migration shows no signs of abating (with an additional 12,000 medical migrants approved in the past three years).

Based on analysis of a wide range of databases, this paper asks which source of medical migrants Australia should prioritise – temporary sponsored IMGs, permanent skilled migrants, or former international medical students qualified in Australia? Improved understanding of the characteristics of medical migrants has become critical, including the workforce outcomes for different cohorts, and their potential population health impacts. Key issues related to quality assurance and medical regulation are raised, of relevance to a wide range of OECD immigrant-receiving countries.