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Perceptions and Practices of Evidence-Based Medicine among Medical professionals in South India

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Introduction

Clinical expertise refers to the clinician's cumulated experience, education and clinical skills. The patient brings to the encounter his or her own personal and unique concerns, expectations, and values. The best evidence is usually found in clinically relevant research that has been conducted using sound methodology. Evidence-Based Practice requires new skills of the clinician, including efficient literature searching, and the application of formal rules of evidence in evaluating the clinical literature.

Objectives

To find out the perceptions and practices of EBM among medical professionals in the region and identifying the facilitators and barriers to the adoption of EBM.

Methodology

This cross sectional study was conducted for a period of 2 months among 188 Medical Faculties involved in patient care, in a tertiary care teaching hospital associated with Kasturba Medical College (Manipal University), Mangalore in Southern India.
Permission from the Institutional Ethics Committee was obtained to carry out the research study. The study participants were selected using simple random sampling. Data collection was done using a questionnaire adapted from the one developed by McColl et al. It consisted of five sections, sources of information being utilized during their clinical decision-making; their perception of EBM; their familiarity and use of electronic EBM sources; their knowledge of methodological terminology used in EBM; and their self-rated confidence in EBM skills.

Data Analysis

The data analysis was done using SPSS version 11.5, statistical test. Student t test was used and a $p<0.05$ was considered statistically significant.

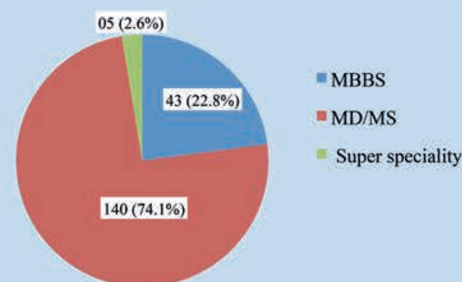
Results

A hundred and thirty two participants (69.8%) were males and fifty six (29.6%) were females. Majority of them agreed that EBM should be taught in school, helps clinical decision making, improves patient care, patient outcomes, brings about quick knowledge update. When asked about the difficulty of EBM application in daily practice, most replied a neutral response of "don't know". Most of the professionals opined that without a firm grasp on the techniques of Evidence-Based Medicine, it will be a tough task to start incorporating a new methodology into their practice.

Table 1. Familiarity of doctors to EBM sources and their use of electronic EBM sources

Familiarity and use of electronic EBM sources	Work experience <5 years Mean (SD)	>5 years Mean (SD)	P value
Pubmed/Medline journal	3.44 (0.632)	3.43 (0.695)	0.862
Evidence-Based Medicine	2.60 (0.847)	2.86 (0.940)	0.054
Clinical evidence	2.65 (1.002)	2.98 (0.950)	0.025
Cochrane database of Systematic Review	2.37 (1.018)	2.49 (0.959)	0.433
The American College of Physician journal club	2.30 (0.863)	2.16 (0.952)	0.296
Up to date	2.46 (1.169)	2.44 (1.148)	0.902

Fig 1 Specialty wise distribution of the study subjects (n=188)



The self-rated confidence in EBM skills for most professionals, both with experience < 5 years and more than five years was Good.

Conclusions

An important thing to consider is the incorporation of EBM skills /in a day-to day scenario right from creating awareness about the electronic EBM sources to removing the hindrances to EBM in order to incorporate it on a regular basis.

Acknowledgement

Manipal University, India

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Perceptions and practices of evidence based medicine among medical professionals in South India
Unnikrishna B, Rekha T, Mithra P, Kumar N, Holla R, Darshan BB, Kulkarni V
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TRACKING DOCTORS' KNOWLEDGE AND ATTITUDES TOWARDS THE STATUTORY DUTY TO MAINTAIN PROFESSIONAL COMPETENCE:

A MEDICAL COUNCIL SURVEY OF DOCTORS IN IRELAND

Gráinne Behan, Fergal McNally

Medical Council of Ireland

Comhairle na nDochtúirí Leighis
Medical Council

Professional Competence
Reaching for Improvement

Background:

In May 2011, the scope of professional medical regulation in Ireland was extended to include a legal duty on all doctors to maintain their professional competence.

The Medical Council sought to better understand and track doctors' attitudes and knowledge towards this new duty and determine if Council's support to doctors in meeting this statutory duty was effective.

Approach:

A random, independent, sample of 1000 doctors from the Medical Council's register of medical practitioners were asked to complete a web-based survey before (in November 2010 = T1) and after (in September 2011 = T2) the introduction of the new regulatory arrangements.

A similar survey was conducted in June 2013 (T3) to help identify changing trends in doctors' awareness, attitudes and knowledge towards this duty.

Results:

Doctors' awareness of the detailed requirements of the statutory duty increased year on year; rising from 42% of doctors being aware of requirements at T1, to 94% in T3. (Figure 1).

Doctors' self-confidence in their ability to meet the requirements of the new statutory duty fell between T1 and T2 (suggesting that for some doctors the new duties were harder to meet than they anticipated) before rising at T3. (Figure 2).

The number of doctors stating that structural factors supported them in pursuing requirements for the maintenance of professional competence increased over time. For example, at T2, 47% of doctors felt there was access to tools, documents and guides to support them maintaining professional competence compared to 61% at T3. (Figure 3).

Conclusions:

Doctors' awareness of the duty to maintain professional competence improved post introduction of regulatory arrangements.

Although confidence to maintain competence fell post inception, this then increased and results suggest that support from Medical Council and Postgraduate Training Bodies was effective in helping doctors maintain professional competence.

Figure 1:

- Participants in the 2013 survey were more aware in the types and amounts of activities required to maintain professional competence.

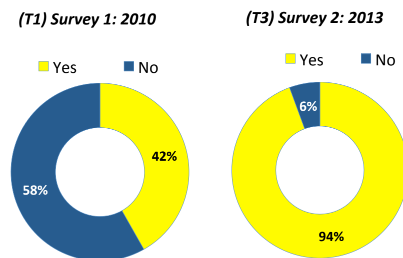


Figure 1:
I am aware of the types and amounts of activities that I am required to do to maintain my professional competence.

Figure 2:

- The survey reported a decrease in confidence in meeting professional competence requirements in T2 before rising again in T3.

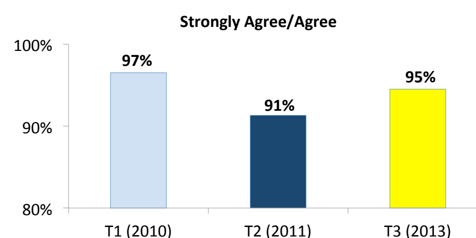


Figure 2:
I am confident that I can meet requirements to maintain my professional competence.

Figure 3:

- An increase in participants in T3 agreed that there was access to a range of support mechanisms to support doctors to maintain professional competence.

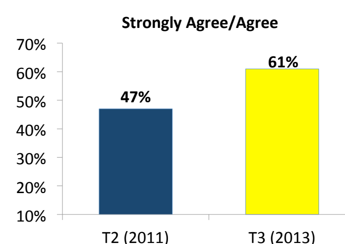


Figure 3:
There is access to tools, documents and guides to support me to pursue standards for maintenance of professional competence

Acknowledgements:

We thank the doctors who participated in the surveys. Postgraduate training bodies play a key role in providing advice to doctors in relation to professional competence requirements and we are grateful for their support.

The studies were directed and overseen by the Medical Council's former Professional Competence Committee and we would like to thank the past members and former Chair, Dr David O'Keeffe for advice and encouragement. Finally we would like to thank Dr Paul Kavanagh, Director of Professional Development and Practice and Mr Simon O' Hare, Research Manager for their assistance.

Choosing the right path to improve patient safety in Ireland - Medical Council strategy development

Authors: Lorna Farren, Caroline Spillane
Medical Council of Ireland

Background: A clear and coherent strategy is essential in underpinning the work of an effective regulator. The Medical Council developed its first formal statement of strategy for implementation between 2010-2013. For its second strategy, for the period 2014-2018, the objective was to ensure the creation of an effective five year plan for the organisation that enhanced patient safety by drawing on the views and experience of the public, the medical profession and partner organisations.

Approach: The development of the statement of strategy followed internal consultation with staff, former and current Council members. To ensure the views of external audiences were captured, research was conducted with approximately 1,000 members of the public and 700 doctors. A detailed consultation plan was also implemented to measure feedback from over 40 partner organisations.

Results: The Medical Council's statement of strategy for 2014 to 2018 was launched in March and has been operationalised through the 2014 business plan.

The need for leadership within the Irish health system was a key theme emerging from the consultation process.

The Council's vision is:
"Providing leadership to doctors in enhancing good professional practice in the interests of patient safety"

Six strategic objectives have been set, reflecting the key issues which emerged from internal and external consultation processes. To ensure confidence of all partners in the Council's work, a detailed programme of metrics have been established which will measure progress over the next five years.

Conclusions: To enhance patient safety and reduce risk, an effective strategy is pivotal. The process focused on transparency and engagement, principles that are fundamental to an effective regulator.

The relationships built during the process will assist in the implementation of the strategy as it addresses many of the issues raised by partner organisations, patients and doctors.

Figure 1: The Medical Council's Strategy Wheel

Figure 2: Medical Council Values

Acknowledgements:
The Medical Council would like to thank the 700 doctors, 1,000 members of the public and representatives of over 40 partner organisations who informed the development of the strategy by providing open and honest feedback.

Caring for others more than for themselves? Doctors' health experiences in Ireland

Authors: Dr Paul Kavanagh, Ms Caroline Spillane, Mr Simon O'Hare, Ms Lorna Farren, *Medical Council of Ireland;* Prof Hannah Mc Gee, Dr Mary Clarke, *Royal College of Surgeons in Ireland*

Background: Like their patients, doctors may experience difficulties with their physical and mental health that can impact on their ability to practise. The health and wellbeing of doctors is therefore an important consideration for medical regulators given its implications for the safety of doctors and their patients. The Medical Council has sought to better understand doctors' health and the implications for patient safety through a quantitative survey of registered doctors.

Approach: Doctors' attitudes and experiences relating to their own health were measured through a simple random sample of 2,500 Medical Council registrants in 2013 (response rate 28%) using questions previously used to measure population health and wellbeing in Ireland (SLAN)*. To better understand the relative burden of mental health difficulties among doctors, the prevalence of mental health difficulties was compared with an age, gender and educational class matched sample from the general population.

Results: The majority of doctors rated their health as being excellent or very good, and the vast majority rated their quality of life as very good or good. The prevalence of possible mental health difficulties among doctors was however greater than the prevalence in a comparable sample of the general population. Younger doctors and doctors working greater numbers of hours per week were more likely to report possible mental health difficulties than the general sample. An important theme emerging was that health indicators were generally poorer among younger doctors, doctors in training and doctors working a greater number of hours per week.

Conclusions: The results provide a snapshot of the quality of health of doctors in Ireland, and point to areas requiring further research. Since the study was cross sectional in nature, further work would be required to confirm that the issues highlighted are firm trends.

The Council will this year publish a position statement on doctors' health based on these findings, while questions on health were an important component of a recent survey of trainee doctors to build up more data on this issue. The Council has also been working with partner organisations to highlight the issues raised by the research.

Figure 1: Doctors reporting their health as Excellent/Very Good by age

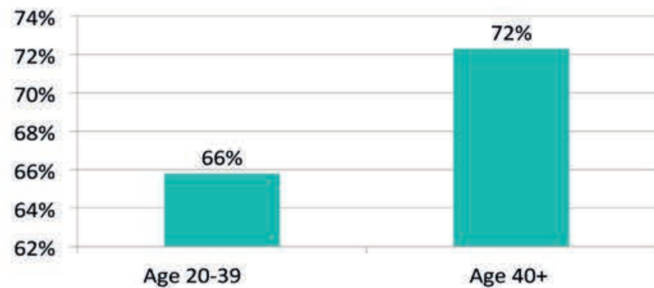


Figure 2: Doctors' descriptions of their quality of life by age

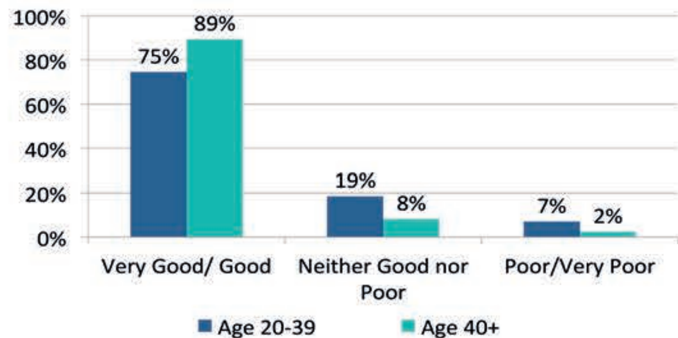
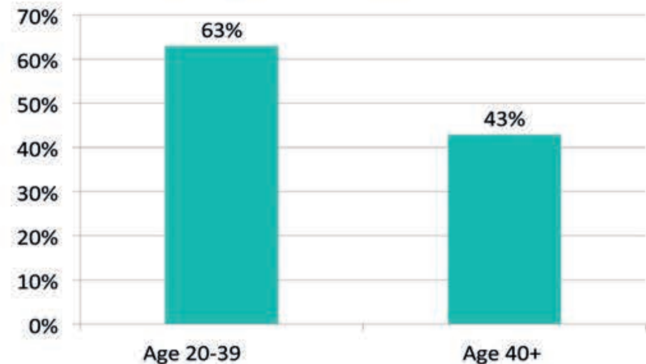


Figure 3: Doctors reporting a low score for Positive Mental Health (Energy and Vitality)**



Acknowledgements:
The Medical Council would like to thank the doctors who participated in this survey.

**SLÁN 2007: Survey of Lifestyle, Attitudes and Nutrition in Ireland. Mental Health and Social Well-being Report, Department of Health and Children*
***Low scores based on those who were below the mean of matched controls from Slán*

Medical Workforce Intelligence – the start and end point for medical education and training in Ireland?

Comhairle na nDochtúirí Leighis
Medical Council

Authors: Paul Kavanagh, Lorna Farren and Caroline Spillane
Medical Council of Ireland

Background: The medical workforce is a cornerstone of a strong health system. High quality intelligence is necessary to continually plan, develop and maintain a medical workforce to meet health system needs. Understanding the medical workforce can help better inform the work of the medical regulator; it can also enable the medical regulator to inform health system design in favour of good professional practice and patient safety. To address this, the Medical Council has re-used data from its annual registration retention process to develop medical workforce intelligence for Ireland.

Approach: The Medical Council maintains a register of doctors who are legally entitled to practise medicine in Ireland. Each year it invites doctors to apply to retain registration. In response to a need to monitor maintenance of competence and ensure continuing fitness to practice, in 2012, this process was comprehensively re-designed to collect data about doctors current practise. Responses were linked with registration data and the final dataset was analysed to identify current number, inflows, outflows and key trends in the medical workforce in Ireland.

Results: The number and age-profile of the medical workforce in Ireland appear sustainable. However, deeper analyse highlights some challenges:

- ***Age-patterning of outflows*** underlines the challenge Ireland faces in retaining domestically trained doctors **(Figure 1)**.
- The ***high dependence on international medical graduates*** raises questions about sustainability and equity of workforce planning **(Figure 2)**.
- ***Skill-mix varies*** significantly across practice areas and ***specialisation is growing*** in the absence of a clear strategic policy framework **(Figure 3)**.
- The ***feminisation*** of the medical workforce and ***variation in work practice*** are important developments which require a response to ensure all doctors are enables to contribute equitably to the health system **(Figure 4).**

Conclusions: Routine administrative data collected from registration processes can be innovatively re-used to directly and indirectly enhance medical regulation. This project provided the Medical Council with a clear and comprehensive view of the medical workforce which it regulates. This better informs strategic policy in education and training, registration and maintenance of competence. It also provides the Medical Council with a platform to engage with the health system to ensure that medical workforce planning and management fosters good practice and promotes patient safety. The response to the report was positive and annual reports are now underway.

Figure 1: Exit rate 2012 per age group (doctors who graduated from Irish medical schools only)

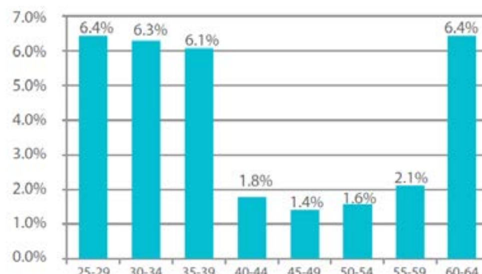


Figure 2: Trend in proportion of doctors registered, Irish versus other medical schools, 2008-2012

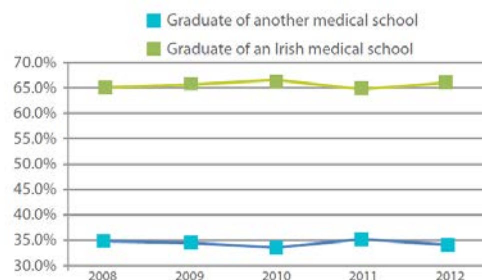


Figure 3: Proportion of doctors registered in the Specialist division at year end, 2008-2012

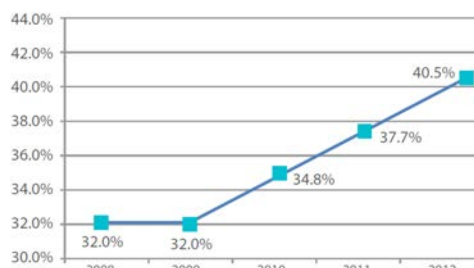
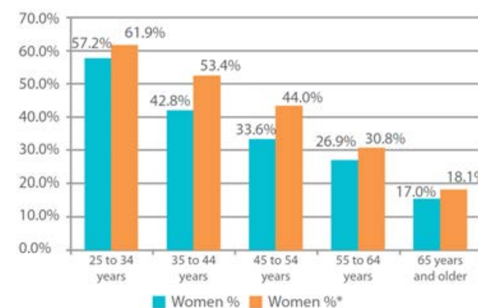


Figure 4: Proportion of female doctors in each age group



**Graduates of Irish medical schools only*

Acknowledgements:
Emma Cassidy and Sarah Lane who contributed to the analysis of data and development of this report. Philip Brady, Head of Registration, led the Medical Council team that managed the annual application retention process.

"Your training counts" A national trainee experience survey of doctors in Ireland

Authors: Simon O'Hare, Paul Lyons, and Paul Kavanagh
Medical Council of Ireland

Background:
In April 2014 the Medical Council of Ireland launched its first National Trainee Experience Survey – "Your Training Counts" (YTC). YTC aimed to identify environmental factors perceived by trainees to be positively or negatively affecting their experiences of postgraduate education and training; helping us understand how learning environments that enable good professional practice are created and maintained.

Developing the Trainee Experience Survey:
To start the process we reviewed different theories of how people learn (e.g. behaviourism; constructivism; relational learning). Through doing this we identified a variety of theoretically-grounded educational values and approaches that we considered as core to achieving high quality medical education and training (e.g. structured feedback, role modelling, team-based approaches to problem solving, relationships between trainer/facilitator and trainee).

Next we considered a variety of validated instruments that measure learning environments. We assessed which instruments were best fits for what we valued in different learning theories, and ultimately refined our choices down to two - the Postgraduate Hospital Educational Environment Measure (PHEEM) and the Dutch Residency Educational Climate Test (D-RECT).

To get wider perspectives on our thoughts we consulted with the profession – outlining the learning theories that informed our approach and the instruments we thought were best fits.

Feedback from the profession demonstrated a preference for D-RECT and a desire for the trainee experience survey to consider a wider range of topics:

"The home/work/life balance to limit the risk of burnout"

"What we don't get asked about is our working conditions"

"Special attention should be paid to ... trainees mental and physical health and workplace bullying"

Acknowledgements: *To everyone who helped create, shape, raise awareness of and administer this important piece of research – thank you!*

Adjusting the instrument:
After deciding to use it in the main body of YTC, we adjusted D-RECT for use in Ireland with Professor Fedde Scheele (who helped create D-RECT) helping with language/concept mapping. Simultaneously, we sought other validated instruments to help capture some of the additional themes recommended by trainees, resulting in new additions to the survey on:

- preparedness, transitions, career intentions and emigration (Goldacre et al);
- energy levels and engagement in work (Utrecht Work Engagement Scale);
- health (SF-12 by RAND);
- wellbeing (the Short Depression-Happiness Scale Joseph et al); and,
- undermining, bullying and harassment (the General Medical Council UK).

Administering the survey
The survey was constructed in-house (massive thanks must go to Grainne Behan for constructing the survey) and hosted online from late April to mid-July. 3000 trainees (interns and doctors in specialist training programmes) were invited to participate, via email. Reminder emails were issued every two weeks. Participation was entirely voluntary.

To raise awareness of the survey a communication strategy was developed and delivered (including articles in the press, social media presence from our partner organisations, and YouTube clips by the Medical Council's Vice President Dr Audrey Dillon). The survey attracted a response rate of 55%.

Survey data is currently being prepared for analysis and we anticipate sharing the results (and findings from a validation process being conducted by University College Cork) from October 2014 onwards.

Conclusions
We are delighted to have delivered our first National Trainee Experience Survey. We believe it has been enriched by acting on consultation feedback from the profession and by our supportive partnerships with other organisations (in particular the Royal College of Surgeons in Ireland and the D-RECT team in the Netherlands).

We look forward to sharing the results in the near future and, more importantly, using those results to share good practice and guide quality improvement activities, so that training experiences, learning environments and, ultimately, patient outcomes in Ireland are enhanced.

Innovation of Korean Medical Licensing Examination For Competency Based Evaluation

Mikyoung Yim, Ducksun Ahn, Myunghyun Chung
(National Health Personnel Licensing Examination Board, Korea)

Background

Toward more relevant and valid evaluation for Medical License

- NHPLEB(National Health Personnel Licensing Examination Board) has been trying to develop valid and competency based licensing exam.

KMLE(Korean Medical Licensing Examination) is licensing exam for primary physician and it has 78 years history.

- KMLE has been reformed several times to be a competency based evaluation through innovative tasks. Currently this exam consists of written test and OSCE. Medical school graduates should pass two steps of test to receive medical License.

Design and Methods

Reforming Written test and Clinical Skill test were needed

- The purpose of medical licensing exam is to evaluate that examinee has sufficient knowledge, skills and attitude as a primary physician. Thus, the licensing examination needs to evaluate all these three domains.
- In early days, KMLE was just written test with plenty of items evaluating factual knowledge. That was not enough to evaluate qualified primary physician. Reforming written test and adopting OSCE were conducted to make KMLE competence based test.

Result

The innovative tasks for competency based test were as follows;

First, the subjects of exam were reformed through job analysis. The first reform in 1995 reduced 15 subjects to 7 key subjects according to educational curriculum. Since 2002 currently 3 subjects which are basic, clinical medicine and medical law are selected focusing on general practitioner's duty.

Second, medical licensing exam reformed as two steps of test which means OSCE was started since 2009. OSCE consists of 6 stations for SP encounter and 6 stations for clinical skill test. It evaluates examinee's clinical performance ability and attitude.

Third, written test is being revised efficiently and effectively. The number of test item is decreased but the high quality problem solving items and R type items are increased.

Clinical Skill Test; OSCE

Clinical Skill Test using Standard Patient

The clinical skill test was first introduced to Korea in 2009 and this was the first test of its kind to be introduced in Asia. It is an advanced test to assess the examinee's attitudes and knowledge of patients using standardized patients. The test also assesses the basic technical skill required by a qualifying doctor by observing their use of medical equipment and devices when treating patients

N of items		time	score allocation	total score
12 items	6 patient encounters	10 min	100 per item	600
	6 procedure skills	5 min	50 per item	300

Test procedure	Upon the start and finish bell, examinee will move between 12 test stations and perform the given tasks. The procedure and the outcome of their performance will be assessed
Test contents	History taking, Physical examination, Physician and patient interaction, Attitude toward patients, and Basic technical skill
Test format	Clinical skill test using standardized and simulated patients and models

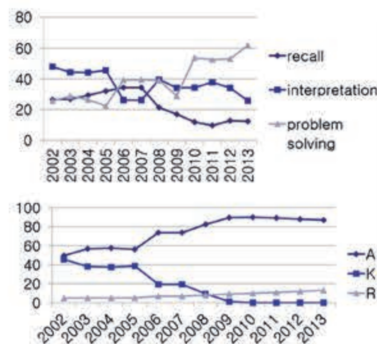
Accomplishment

- Strengthen Medical Education
- Improve Clinical Performance Ability
- Balanced Evaluation For Competency

Written test ; Subject Reform

Period	N of Subject	Subject	Characteristics
Before 1994	15	Internal Medicine Surgery Obstetrics and Gynecology Pediatrics Neuroscience Psychiatry Dermatology Urological Science Ophthalmology Studies ENT Radiology Clinical Pathology Anesthesiology Preventive Medicine Medical Health Legislation	Medical School Curriculum based subject Factual knowledge evaluation dominated A, K type items
1995-2001	7	Internal Medicine Surgery Pediatrics Obstetrics and Gynecology Psychiatry Preventive Medicine Medical Health Legislation	Clinical science based subject Job analysis Clinical case centered and Problem based items are developed
2002-present	3	Medicine 1(Basic medicine) Medicine 2(Clinical medicine) Medical Health Legislation	Integrated subject R type items adopted

Written test ; Item development



K type is dismissed now and R type items increased up to 13%(2013) from 5%. (2002)
In Knowledge level, Recall items are decreased from 26%(2002) to 12%(2013). Interpretation items are decreased from 48%(2002) to 26%(2013). Problem solving items are increased up to 62%(2013 from 25%(2002)

Accomplishment

- Clinical case centered and problem based items are increased.
- Test evaluates clinical knowledge such as clinical reasoning and problem solving include academic knowledge.

Discussion

Innovative works has been enhanced qualification for licensure. Through the national medical exam, we can evaluate examinee's various domains of ability. Data analysis shows that some high achiever in written test failed in OSCE. Survey result shows that the adoption of Clinical skill test in licensing exam improved the quality of medical school education and student's performance ability.

Change of Medical School's Educational environment	Before OSCE		After OSCE	
	Yes(%)	No(%)	Yes(%)	No(%)
Own Clinical skill education center	65.9	34.1	97.6	2.4
Communication skill education and exercise	73.2	26.8	97.6	2.4
Education program using SP	46.3	53.7	85.4	14.6
Medical ethics education	87.8	12.2	100.0	-
SP encounter test	75.6	24.4	100.0	-
Procedural skill test	78.0	22.0	100.0	-

2013 score	OSCE fail	
	Written pass	Written fail
mean	298	213
SD	20.4	23.5
min	240	123
max	330	239

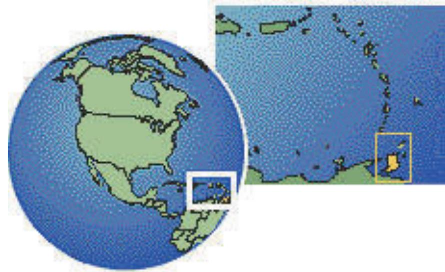
Conclusion

National evaluation system has been developed by medical society and NHPLEB step by step. Innovative works has been enhanced qualification for licensure. Other challenges still exist. Written test will be replaced by computer based test. Medical Ethics may be included as essential items in the test. Hybrid item of OSCE and increasing exam time per station are subjects under investigation. Although reforming is in progress, we hope KMLE may become a good model for other countries.

National Health Personnel Licensing Examination Board

Innovation of Korean Medical Licensing Examination for competency based evaluation

Mikyoung Yim, Ducksun Ahn, Myunghyun Chung
National Health Personnel Licensing Examination Board (Korea)



THE MEDICAL BOARD OF TRINIDAD AND TOBAGO… Challenges even after 200 YEARS

Much has happened since 1814 and the existing Medical Board Act (1960) with rules and regulations as stipulated in this Act and as enacted by Parliament.

Although two-hundred years old, MBTT is still evolving as it aims to introduce and maintain acceptable international standards in regulating the medical profession.

The major challenges currently facing the MBTT are:

- Introducing mandatory Continuing Professional Development (CPD) for licence renewal in accordance with a proposed amendment of the MBTT Act. This is outstanding despite the fact that CPD for continuing registration has been proposed since 1996.
- Deregistration of medical practitioners who have not paid their annual retention fees. The total number of registered medical practitioners is 3121 of which only 2245 (72%) are in financial good standing while 876 (28%) have not paid but legally may continue to practice.
- Financing of legal responses to ensure adequate representation in addressing complaints against doctors, particularly since the income of MBTT derives solely from registration fees.

OET
OCCUPATIONAL ENGLISH TEST

The impact and relevance of the Occupational English Test (OET) for the medical and nursing workplace

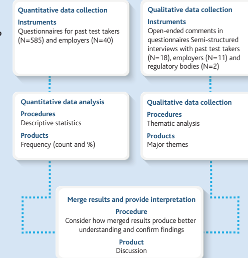
1. About OET

- It is a screening test of English communication skills for doctors and nurses.
- It is recognised by over 30 regulatory healthcare bodies and councils internationally and has been used for medical registration in Australia since the 1980s. It is available in 28 countries around the world, up to 10 times a year (rising to 12 times a year in 2 time zones from 2015), see www.occupationalenglishtest.org
- As a result of extensive and in-depth research into the linguistic needs and practices of doctors and nurses:
  - OET is a test of English for Specific Purposes (ESP) designed to meet the specific needs of doctors and nurses.
  - OET Speaking and Writing tests are profession-specific.
  - OET Reading and Listening tests are not profession-specific, but are firmly grounded in the healthcare domain.

2. Research questions and a mixed methods design

1. What is the intended impact of using an ESP test, i.e. OET, when assessing the language ability of healthcare professionals?
2. Is OET an appropriate language examination for the health sector in terms of its construct validity (i.e. content, skills/abilities assessed)?
3. Are OET test-takers perceived as ready for the workplace in terms of their English language ability and their confidence in using English in a healthcare context?

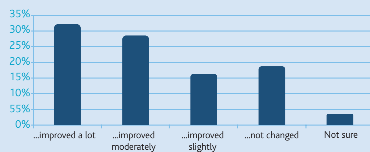
The research participants: 603 past OET test takers, 51 colleagues/supervisors, 2 representatives of the healthcare regulatory bodies in Australia.



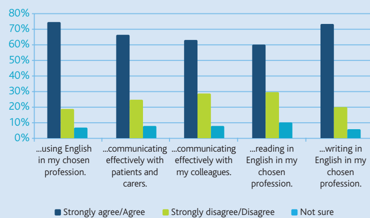
3. Key findings

1 Preparation for OET impacts positively on OET test-takers' language ability and on their confidence in using English.

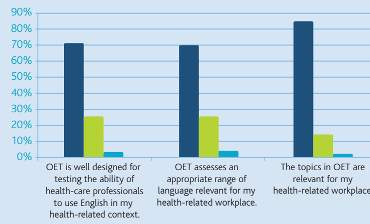
As a result of preparing for OET, my ability to use English in my health-related context has...



Preparing for OET has made me feel confident about...



2 In the eyes of test-takers, employers and healthcare regulatory bodies, the major strength of OET is its relevance for the healthcare (medical and nursing) context in terms of topics, language, tasks, scenarios and the language ability/skills required to address tasks.



Test-takers' perspectives

As a test relevant to specific healthcare professions, OET has a positive impact on its test-takers. OET test-takers believe that:

a) Preparation for OET prepares them for language-mediated tasks in their profession.
b) Interesting and relevant topics in OET allow them to engage more with test preparation and OET tasks.
c) Familiarity with terminology and content reduces their anxiety during written and spoken tasks.

Perspectives from the workplace

On the task of writing a letter using case notes as input:
'We do those all day every day.' (A senior doctor)
Writing a discharge letter is 'very very appropriate.'
(A senior nurse)

On a Listening task:
'The dialogue is actually very, very relevant.' (A senior doctor)

The perspectives of the interviewed regulatory healthcare bodies

'Speaking as an employer, sure you would have to have more confidence in someone who could pass the English language test that was related to the industry in which they were going to go and work.'

'...If testing is congruent with practice, that's terrific.'

On Speaking tasks: 'They are relevant. I think they are appropriate.'

3 OET test-takers are able and effective users of English in their workplace.

Test-takers' perspectives

'As an employee (nurse) in a hospital you are expected to function almost at a hundred percent from day one, meaning that you are expected to understand both patients and staff, the latter often speaking very fast and with lots of abbreviations. Preparing for the OET helped a lot.' (A nurse)

'It helped me to communicate with patients and workmates effectively and correctly, because I have gained a lot of good communication styles in a very professional and elegant way.' (A physician)

'OET helped me in gaining communication skills with patients and other health professionals. Now I can use some expressions in calming patients and showing empathy, which I knew but never used before.' (A nurse)

Perspectives from the workplace

The employees/colleagues who have taken OET...	Percentage agreement
... use English effectively in their health-related workplace.	93%
... communicate well with their patients.	68%
... communicate well with their colleagues.	83%
... understand well what they are told by their colleagues.	83%
... understand well what they are told by their patients.	65%*
... perform well at the writing tasks in their health-related workplace.	83%
... understand well what they read in their health-related workplace.	80%

*The most common feedback focuses on employees' ability to understand idioms and slang.

4. Summary

- Preparing for OET has a positive effect on OET test-takers' language ability and confidence.
- OET successfully simulates many relevant aspects of the medical and nursing workplaces for which it is used as an entry requirement. Its validity for these contexts is confirmed in the eyes of test-takers, their workplace supervisors and the interviewed healthcare regulatory bodies.
- OET test-takers are perceived as effective communicators who can communicate on both technical and emotional matters and be easily understood by patients.

5. Looking forward

OET rests on a large body of research and an up-to-date research agenda. As part of continuous improvement, a programme of OET revision is being established. The following revisions are already taking place:

- The Speaking test construct has been expanded to bring it in line with the best practice in clinical communication, as encapsulated in the Calgary-Cambridge Guides. The speaking assessment criteria have been enhanced and are currently at the trialling stage, but OET is not intended to replace tests of clinical skills.
- The Listening test will include more representation of professional-professional communication to complement the current emphasis on professional-patient communication. New task types and item writer guidelines are at the development stage.

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9

The impact and relevance of Occupational English Test (OET) for the medical and nursing workplace

Dr Ivana Vidakovic
Cambridge English Language Assessment (UK)

Exploring associations between fitness to practise and hospital data sets

General Medical Council

Introduction

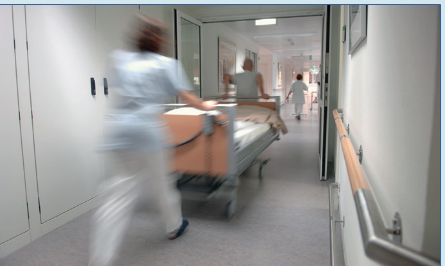
Last year we explored the associations between core quality metrics used across acute NHS hospitals in England and our own fitness to practise data on the number of:

- complaints made about doctors
- complaints that were serious enough to trigger investigation
- warnings and restrictions placed on doctors from that hospital.

We found associations between the proportion of doctors with warnings and restrictions, hospital mortality rates, and staff perceptions.

We also found associations between trainee doctors' perceptions of the quality of clinical supervision, hospital mortality and patient experience.

We found that working extra hours, readmission rates, MRSA rates, and never events (patient safety incidents that shouldn't happen if correct procedures are followed) did not have strong associations with our data.



What did we find?

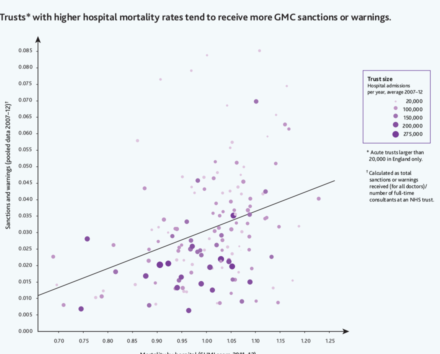
Wide variation

- Even taking into account wide-ranging patient characteristics, death rates vary considerably across acute NHS hospitals in England.
- Fitness to practise statistics show even greater variation, with some trusts having more than ten times as many consultants receiving sanctions and warnings, compared to others.

Hospital mortality

- Further analysis is needed to understand fully the relationship between fitness to practise statistics and mortality rates.
- Though there are many contributing factors, mortality may help us identify hospitals where there are higher numbers of doctors that are not fit to practise and are not being reported.

Trusts* with higher hospital mortality rates tend to receive more GMC sanctions or warnings.

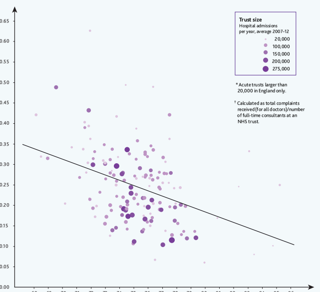


Staff engagement and patient experience

There are associations with our professional practice statistics and different measures of staff engagement and patient experience. Though long hours and poor support from immediate management are often cited, they are not associated with fitness to practise complaints, investigations or outcomes.

The trusts where doctors are subject to a high number of complaints are not always those with the most doctors who go on to receive sanctions and warnings. This suggests that some complaints might be driven as much by the patient's experience as by the doctor's departure from *Good medical practice*.

Trusts* scoring higher for patient experience in the CQC Patient Survey tend to receive fewer complaints.



The strongest associations with the number of doctors who received a sanction or warning are whether staff would recommend their friends and family to the hospital. And how many of the staff at each hospital feel that their role makes a difference to patients.

	All complaints	Complaints that were investigated	Investigated complaints that resulted in a sanction or a warning
Summary hospital level mortality indicator	*	0.07	0.12
NHS staff survey (Eng): family/friends average	0.15	0.17	0.07
NHS staff survey (Eng):% agreeing that their role makes a difference to patients	*	0.04	0.07
NHS staff survey (Eng): % having a well structured appraisal	*	0.04	0.05
Staff sickness days per full time equivalent	*	0.04	0.03
National training survey: working beyond competence or experience question	0.04	0.05	0.03
National training survey: quality of care question	0.16	0.17	0.03
CQC patient survey: positive patient experience	0.15	0.09	*
NHS staff survey (Eng): Work pressure felt by staff	0.04	0.06	*
NHS staff survey (Eng): effective team working	0.03	*	*
NHS staff survey (Eng): % working extra hours	*	*	*
NHS staff survey (Eng): support from immediate managers	*	*	*

Conclusions

Our exploratory findings demonstrate associations between the likelihood of a doctor to progress through our fitness to practise proceedings and other indicators of the wellbeing of NHS trusts in England. They make a compelling case for medical regulators to collaborate with health system regulators to identify risks to patient safety, and to explore whether these results can be generalised internationally.

Fitness to practise proceedings were associated with mortality rates as well as staff and patient perceptions at the hospital level, but they were not related to other risks in the system, including readmission rates, MRSA rates, and never events. It is unclear why this is the case.

There are many questions around what is driving the associations, such as whether the way the hospital is organised is driving the associations between mortality, staff and patient experience, and a higher propensity for doctors to be investigated.

A note on the data

R-squared values, ranging from 0-1, express how far the variation in one measure is explained by the other. They were derived using ordinary least squares regression models. A * was placed where the chance of the association happening if the two measures were not related was at least 5%. Only acute NHS hospitals with more than 20,000 admissions from England were studied, and Mid Staffordshire was excluded.

Working with doctors Working for patients

The GMC is a charity registered in England and Wales (1089278) and Scotland (SC037750)

Bridging the gap: local support for medical regulation in the UK

General Medical Council

GMC liaison services

Our liaison services cover the four countries of the UK. Together, they help us improve how we work with our key interest groups – in particular patients, the medical profession, medial educators and health organisations – and increase their understanding of our work and its value. The feedback we receive through these teams can alert us to trends, good practice and concerns relating to professional practise and patient safety. It can also help us to shape our policy and processes to the rapidly changing and complex world of healthcare delivery across the UK.

The services enable local decision making and relationship building and are part of our commitment to being both a proactive, listening organisation and relevant to the doctors and environments we regulate – as well as to the patients in whose interest we regulate.

These local services also provide support and insight to our office-based colleagues which can enable us to intervene at an earlier stage – before panel hearings or serious sanctions against doctors or formal regulatory action to address concerns about the training of doctors are needed. See below to find out more about our three local liaison services.

Employer Liaison Service

The challenge in bridging the gap between local delivery and oversight is especially evident when concerns are raised about a doctor and their fitness to practise is investigated. In 2006, following a number of high profile medical events in the UK, the Chief Medical Officer recommended that we establish a mechanism to improve information sharing between systems of local management and national regulation. The work that followed tested and refined an approach that would eventually be rolled out across the UK as the Employer Liaison Service.

The Employer Liaison Service facilitates closer working between ourselves and healthcare providers, predominately around fitness to practise and revalidation. Specifically, we aim to work with healthcare providers to improve patient safety and ensure higher standards of medical practice.
We do this by:

- improving the understanding of our fitness to practise procedures, including raising awareness of patient safety issues and our thresholds for referral
- improving the quality of referrals and supporting evidence given to us when concerns are raised about a doctor
- encouraging thorough local investigation, performance management and clinical governance in the handling of underperforming doctors, in order to support low level concerns to be resolved locally
- providing advice and support on revalidation
- working with other agencies, including systems regulators, on quality initiatives to develop a mutual understanding around key themes and emerging trends in poor performance.

The success of the Employer Liaison Service goes beyond issues affecting the individual doctor. Additional benefits, both operational and strategic, have emerged from this model of proactively working with healthcare providers.

3,977
Ad-hoc contacts seeking advice and support.

847
Healthcare organisations linking to the service.

3,533
Meetings with linked organisations.

18
Employer liaison advisers supported by a centralised 11 strong support team.

As well as feedback on our internal processes and key functions, the service has also led to new opportunities to contribute to wider patient safety debates and initiatives across healthcare.

We work with partner organisations through active participation in local and regional forums. This gives the health system a shared view of risks to quality through sharing information, early warnings where risks of poor quality are identified and consequent opportunities to work together to drive improvement.

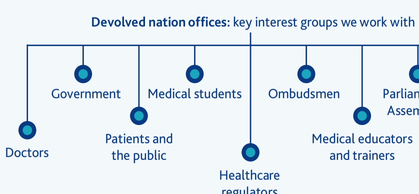
Our Employer Liaison Service lets us contribute to the delivery of high quality care and patient safety. This is because of close partnership working, sharing information appropriately, using the information of others to enhance our own understanding and, on occasion, following up on GMC-related concerns.

Devolved nation offices

Our devolved offices make sure that we fulfil our statutory role as a UK-wide regulator, and continue to be a relevant, physical presence in Northern Ireland, Scotland and Wales. Teams are based in Belfast, Edinburgh and Cardiff and promote our work to key interest groups in each country. They were set up between 2003 and 2005 to help us respond to political devolution in the UK – ensuring our approach to regulation remains appropriate in all four countries, which increasingly have different health policies and structures.

The offices provide us with up-to-date, relevant, intelligence and guidance on local sensitivities, which helps us to shape our regulatory actions appropriately. The offices also increase the awareness of the professional standards and guidance we produce among the profession and patients in each country.

Key interest groups get a single point of local contact, communications that are tailored to their needs, the chance to influence our work and an opportunity to engage with on us on local joint working opportunities.



Regional Liaison Service

Our Regional Liaison Service was set up to give us greater understanding of and contact with local interest groups within England, building on the successful model of local engagement developed by our devolved offices. The team of eight regional liaison advisers dedicate their time to working with groups of doctors, medical students, educators and patient groups to:

- promote the GMC, increasing partners understanding of our work
- promote and explain the ethical standards and guidance for professional practise we produce
- Improve the GMC's understanding of the concerns and needs of doctors, patients and medical students
- consult on changes to GMC policies and processes.

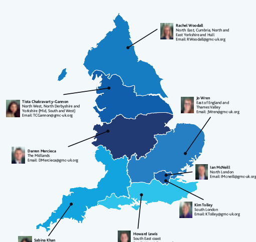
The team is remotely based across England and works closely with our Employer Liaison Service colleagues to provide outreach services to healthcare Environments in England – be that the hospital, GP surgery or education environments.

The team has received strong feedback from doctors and medical educators that suggests our explanation of standards and guidance is helping them to reflect on their practice and change it when they need to. Since its launch in 2013, the Regional Liaison Service has met with over 25,000 doctors, 15,000 medical students. Meanwhile, we've also worked directly with local patient groups, to explain the role of the GMC – particularly our work on setting standards and handling complaints.

We've spent a lot of time explaining revalidation and reflective practice, but have also been able to facilitate learning on ethical issues such as end of life care, use of social media, how to raise concerns as well as core topics like consent, confidentiality and good medical practice.

96%
of doctors said working with the Regional Liaison Service to understand GMC standards and guidance helped them to reflect on their practices.

77%
of doctors said after a Regional Liaison Service session they would change their practice.



Working with doctors Working for patients

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Making sure all doctors have the necessary knowledge of English to practise safely in the UK
Jo Nicholas, Sara Kovach Clarke
General Medical Council (UK)

Making sure all doctors have the necessary knowledge of English to practise safely in the UK

General Medical Council

Voicing our concerns

In 2010 we began voicing our concerns that European doctors were allowed to register with a licence to practise medicine in the UK without being asked for evidence of their English language knowledge. This has been a long-standing requirement for doctors trained outside the European Union.

In 2013 the UK Government consulted on new powers for the GMC. This year we implemented these legislative changes across the organisation to make sure that all doctors have the necessary knowledge of English to practise safely in the UK.

'This is an important milestone in creating better, safer care for patients. Everyone has a right to expect to be treated by doctors who can communicate effectively in English and this will help us achieve this. European law does not yet allow us to check every doctor but that reform will come and this is a vital first step.'

Niall Dickson, Chief Executive of the GMC

'For the first time ever, we have a full system of checks in place to prevent doctors working in the NHS who do not have the necessary knowledge of English from treating patients. This is a huge step forward for patient safety. I am pleased to have played my part in making this happen.'

Dr Dan Poulter, Health Minister

Top five European countries of medical qualification for doctors registered with the GMC

Ireland	Greece	Germany	Italy	Romania
4,038	3,290	3,243	3,239	2,256

The knowledge of English to practise safely in the UK

Seeking evidence that a European doctor is able to communicate in English before granting a licence

Previously, if European doctors had a recognised medical qualification from a medical school based in a member state of the European Economic Area or Switzerland, we were required by law to grant registration and a licence to practise. We weren't allowed to do any further assessment or testing, or ask these doctors for any evidence of their language skills.

This change means that:

- we can ask for evidence of a European doctor's ability to communicate in English if concerns about this emerge during the registration process
- we will refuse to grant a licence if a doctor is unable to demonstrate that they have the necessary knowledge of English
- we will recognise their qualifications by continuing to grant registration.

Our evidence requirements

We will consider evidence of knowledge of English only if it:

- is recent (less than two years old at the point of application)
- clearly shows the doctor can read, write and interact with patients, relatives and healthcare professionals in English
- can be verified by us through contact with recognised medical institutions, regulators or other official bodies.

We routinely accept:

- a valid International English Language Testing System certificate that meets our criteria
- a letter or certificate from the institution where the doctor qualified that confirms all of the course, including clinical activities, were taught and examined solely in English, and at least 75% of any clinical interaction was conducted in English (if the primary medical qualification is more than two years old at the point of application we also need employer references).

Dealing with concerns about a doctor's knowledge of English

Previously, serious complaints about a doctor's communication skills, including knowledge of English, have been categorised as performance concerns.

This change means that:

- where a doctor's inability to speak, write, read or understand English means they are unable to treat patients safely, we can clearly state this as the reason their fitness to practise is impaired
- as part of the information gathering process, the registrar and panels will have a new power to require doctors to undergo a language assessment if we need evidence of their language skills for us to make a decision about their fitness to practise medicine in the UK
- if a doctor's language skills do not improve sufficiently or they are unwilling to agree the necessary action, the case may be referred to a fitness to practise panel to consider if action is necessary to protect the public.

In such cases, indefinite suspension would be the most serious outcome available to us in dealing with concerns about a doctor that relate solely to their knowledge of English.

Responsibilities of healthcare organisations and responsible officers

Healthcare organisations have always had responsibilities to make sure that the doctors who work for them are competent for their role. This includes being assured of a doctor's English language ability.

In April 2013 these responsibilities were made explicit in legislation for responsible officers based in England. Local arrangements are also in place in Northern Ireland, Scotland and Wales.

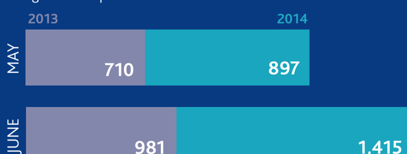
These responsibilities will continue to exist in future, but will be strengthened by our ability to ask for evidence of European doctors' English language ability when concerns arise during our registration process.

Key changes we introduced in summer 2014

- We introduced a reference to English knowledge in our core guidance *Good medical practice*.
- We increased the minimum score accepted on a recognised academic English language test.
- We changed the law so that we can refuse to grant a licence to any doctor unable to demonstrate that they have the necessary knowledge of English.
- We established a new ground of 'impairment' where there are issues with a doctor's ability to speak, read, write or understand English, and introduced English language assessments into our investigations of these concerns.

Implementation trends

We received an increase in applications for registration with a licence to practise from European doctors in the two months before our changes were implemented.



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Engaging patients during a fitness to practise investigation

General Medical Council

Background

We launched our Patient Information Service pilot in 2012 with the aim of providing improved communication with patients, their relatives or other members of the public who have raised a complaint about a doctor's fitness to practise medicine.

Aim

The objective of the pilot was to facilitate communication with patients to improve our understanding of concerns and their understanding of the investigation process.

Pilot target

The pilot was designed to involve 100 face-to-face meetings with patients, to provide sufficient data for meaningful evaluation. This target was reached in March 2014 and a decision was made to continue holding meetings until the final report from the independent evaluators was received in July 2014.

Location

We have offices in both Manchester and London with a Patient Information Officer based in each office. Patients who live in the North West and Greater London regions of the UK were invited to participate in the pilot. A telephone meeting was offered to those unable to travel to the offices

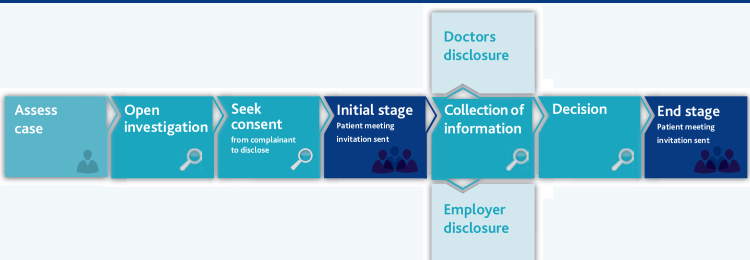
The meetings

Two types of meeting are offered:

- an initial stage meeting held soon after the investigation has opened, and
- an end stage meeting held following the conclusion of the investigation or after a panel hearing has taken place.

The meetings are an opportunity to:

- ensure that we have fully understood the matter the person is complaining about
- improve the public's understanding of our role and function
- explain our processes of investigation and what they can expect
- explain the possible outcomes that we can reach at the end of our investigation
- provide information about other organisations that may be able to assist.



AS OF JUNE 2014 WE HAVE HELD:

Initial stage meetings

167 in person | **92** via phone

End stage meetings

64 in person | **35** via phone

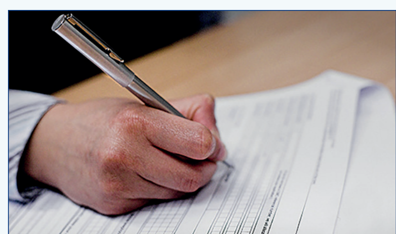
Role of the Patient Information Officer

- Arranging, facilitating and conducting the meetings.
- Liaising with Investigation staff before and after the meetings.
- Writing to the patient after the meeting to ensure they know what to expect.
- Answering internal and external queries about the meetings.

Feedback from the independent evaluation

The evaluation report shows that the vast majority of feedback in relation to patient meetings is positive.

- Complainants were positive about the opportunity to meet with us.
- It is clear from comments received that the meetings build rapport with complainants and reduce their feeling of isolation. The meetings help complainants to understand our role and purpose and our investigation process.
- Some complainants raised concerns about the end stage meetings that seems to arise largely from their unhappiness with our decision on the case, rather than from the meetings themselves, although we are looking at ways to improve this part of the process.



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13

Engaging patients during a fitness to practise investigation

Rachel Procter (author), Patient Meetings Pilot team: Rachel Procter and Cristina Diaz (Patient Information Officers), Lyndsey Dodd and Eleanor Davy (project team), Anna Rowland (project sponsor), *General Medical Council (UK)*

Continuously improving our regulatory functions and operations: the journey so far

General Medical Council

Finding ways to improve our work

As an organisation, we constantly need to change. Continuous improvement is about supporting our staff to deliver a better and more efficient service for patients, doctors and others who rely on us and the work we do.

We introduced our continuous improvement programme in 2004 following the Shipman and Neal public enquiries, when we faced increased scrutiny about our role in protecting patients. The aim was to constantly question our processes and to find ways to improve them.

Why do we need continuous improvement in the GMC?

- We owe it to the public to do the best job we can.
- We owe it to doctors to use their fees efficiently and effectively.
- We want to do more with what we've got (or with less).
- We need to keep up with demand for our services.

Our approach to continuous improvement

- Our improvement teams work across teams and directorates, with support from senior management.
- We've introduced a suggestion scheme so that anyone can highlight improvement opportunities.
- We're training, coaching and mentoring staff members.

CONTINUOUS**IMPROVEMENT**

Director of Resources and Quality Assurance, Neil Roberts, awards a member of staff his completion certificate at a recent Continuous Improvement Project Leaders course.

Continuous improvement timeline

2004
- Increased scrutiny and pressure on the GMC to improve performance following public enquiries (Shipman, Neal).
- Limited quality assurance.
- Over-reliant on paper.

2005
- Fitness to Practise and Registration directorates introduce Quality Assurance and Project Management teams.
- Change Management and Business Improvement teams set up.

2006–2007
- We adopt Lean/Six Sigma/Total Quality Management approach to continuous improvement.
- Director of Resources commissions a five day course to train a group of staff in continuous improvement.

2008–2009
- Registration and Resources launch its directorate-wide programme and roll out a bespoke course to train staff in continuous improvement.
- Over 250 staff have received basic training and over 50 project leaders have been trained.

2010–2011
- Focus on the customer, automation and improving our online capability.
- Implement a number of continuous improvement projects, delivering in excess of £100,000 savings.
- Complete merger with the Postgraduate Medical Education Training Board.
- Introduce the licence to practise.

2012
- Fitness to Practise directorate launches their directorate-wide improvement programme and a local continuous improvement framework – starting with an overall review of the fitness to practise process.
- Five projects have been completed so far, with around £100,000-worth of staff time saved.

2013–2014
- Registration and Revalidation directorate start a service review programme to provide assurance that teams are doing the right things, for the right reasons and then address the gaps.
- Improvement approaches continue to develop across the organisation.

Some examples of our continuous improvement projects

Local process improvements to increase our efficiency and improve the quality of our services.
For example, redesigning our direct debit form used by doctors to pay their annual retention fee, had the following impact.

Number and percentage of fees calls to our Contact Centre

	July 2005	July 2006	Change
	24	18	20% ▼

	August 2005	August 2006	Change
	31	17	41% ▼

- We relocated our adjudication and certification functions from London to Manchester.
- We cut the annual retention fee from £420 in March 2012 to £390 now.
- We've cut down the amount of paper we use by using more electronic communication methods.
- We've become better at using technology – for example, by digitally recording hearings.
- We've introduced visual management to keep staff informed – for example by showing the number of current fitness to practise hearings on a digital dashboard.
- We've made £17.6 million of efficiency savings.
- We've worked to simplify and standardise our procedures.
- We introduced flow charts to give staff across teams a better understanding of our processes. The example below shows our process for reviewing fitness to practise restrictions.

Staff members on the first Continuous Improvement Project Leaders course, November 2008.

Where next?

- We'll rebrand our suggestion scheme to *Tell us your problem* – to help us to get at root causes.
- We'll look at getting accreditation against an international quality standard.
- We'll continue to roll out the programme across the organisation. Some leading organisations in this field have been on their continuous improvement journey for over 40 years. We have a way to go!

Working with doctors Working for patients

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Continuously improving our regulatory functions and operations: the journey so far
Registration and Revalidation business improvement team, Resources and Quality Assurance finance improvement team, Fitness to Practise Lean review team, Communications team, *General Medical Council (UK)*

15

Welcome to UK practice: an introduction to the guidance and support we give to doctors new to the medical register

Kim Tolley, Sunil Kapur, Ian McNeill, Mary Morgan-Hyland, Nico Kirkpatrick, Maria Walsh and Gareth Williams

General Medical Council (UK)

Welcome to UK practice: an introduction to the guidance and support we give to doctors new to the medical register

General Medical Council

Why is the programme needed?

We developed the Welcome to UK practice programme in response to our report *The state of medical education and practice in the UK 2011*. It found:

'A variation in the standards of medical practice displayed by doctors new the practice in the UK. Research undertaken on behalf of the GMC and evidence gathered also suggests variation in the application of legal, ethical and professional standards as set out in Good medical practice. *These standards include, but are not limited to communication, teamwork and understanding professional relationships'.*

A recent study by Bhat, Ajaz and Zaman (2014) supports these concerns. It says that doctors in training reported that:

'Inductions conducted at their individual trusts were generic and not tailored to support their particular needs, and there was an expectation that doctors were already familiar with the overall healthcare system in the United Kingdom and how the different services were integrated'.

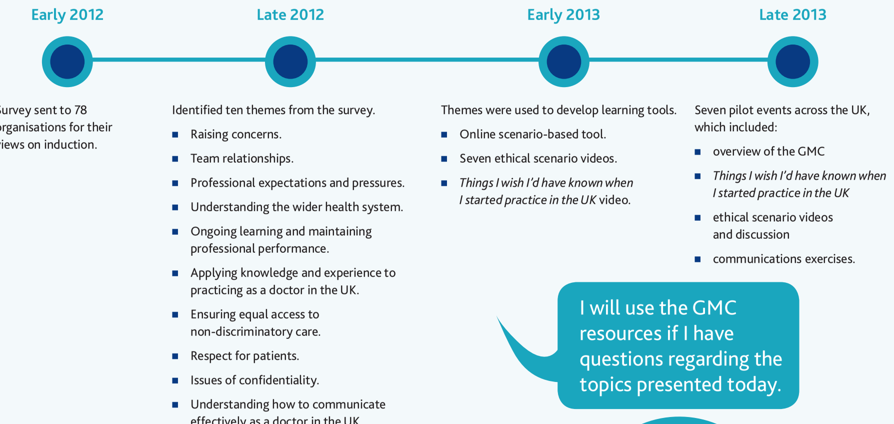
Online scenario-based tool

Our anonymous on-line self-assessment scenario-based tool is designed to help doctors check their knowledge of our core guidance *Good medical practice* and see how they apply it to real situations. It also shows where to find further information and advice. The tool contains 16 case studies that explore ethical challenges in different clinical scenarios.

The online tool has been visited 5,000 times since its launch by doctors from 19 countries and has had positive feedback.

> A brilliant tool in better understanding *Good medical practice* in action and it has been a very informative experience going through all the themes.

Stages of development of the Welcome to UK practice programme



Early 2012

Survey sent to 78 organisations for their views on induction.

Late 2012

Identified ten themes from the survey.

- Raising concerns.
- Team relationships.
- Professional expectations and pressures.
- Understanding the wider health system.
- Ongoing learning and maintaining professional performance.
- Applying knowledge and experience to practicing as a doctor in the UK.
- Ensuring equal access to non-discriminatory care.
- Respect for patients.
- Issues of confidentiality.
- Understanding how to communicate effectively as a doctor in the UK.

Early 2013

Themes were used to develop learning tools.

- Online scenario-based tool.
- Seven ethical scenario videos.
- *Things I wish I'd have known when I started practice in the UK* video.

Late 2013

Seven pilot events across the UK, which included:

- overview of the GMC
- *Things I wish I'd have known when I started practice in the UK*
- ethical scenario videos and discussion
- communications exercises.

> I will use the GMC resources if I have questions regarding the topics presented today.

Testing the Welcome to UK practice events

We delivered seven pilot events to 320 doctors in late 2013. The aim of these pilots was to understand how we can develop the programme to deliver our messages to doctors new to practice.

The first phase of the pilots showed us that the original interactive videos worked well. The second phase allowed us to test our new ideas and identify ways to maximise the impact of these events with the most doctors.

During the pilot events we showed the film, *Things I wish I had known when I started practice in the UK*, which shows doctors sharing their personal challenges and experiences of starting practice in the UK.

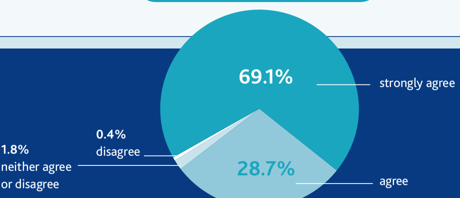
We also used ethical scenario videos, which explore key elements of our standards and explanatory guidance. Each scenario shows a clinical situation which was then discussed by the group. During the discussions the group was shown how the relevant parts of our guidance applied to the clinical situation. Each of the ethical scenario videos has a second part, which gives a suggested outcome.

All of these learning tools aim to be interactive and seek to bring our guidance to life.

> I think the GMC should continue offering this day. It has been one of the most interesting courses/educational days I have ever attended.

> A great way to meet other doctors and learn from their experiences.

At the end of the pilot events doctors were asked if the day had 'improved their awareness of issues related to the GMC ethical guidance?'



What next for the programme?

We are working with partners to hold further pilot events across the UK, as well as looking at how many organisations might want to use the programme and how it might be progressed in the future.

If you have any questions about the Welcome to UK practice programme or would like to be involved, please contact the team at **WelcomeUK@gmc-uk.org**.

Working with doctors Working for patients

The GMC is a charity registered in England and Wales (1089278) and Scotland (SC037750)

National training surveys: our annual survey of doctors in training

General Medical Council

Why do we survey doctors in training?

We register doctors to practise medicine in the UK. We protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine and in medical education and training.

Each year, we run a survey of all doctors in postgraduate medical training in the UK (around 55,000 doctors, with a response rate of over 95% since 2012). The results of the survey give us a reliable source of evidence the perspective that doctors in training have of their training environment and the quality of their training.

The survey gives a snapshot of the quality of medical education and training at a national level. The survey also generates a unique dataset of the training pathway and progression of UK doctors in training.

How does the survey work?

Respondents complete the survey online. Their answers are logged on our in-house systems, which allows survey responses to be automatically stored against the doctors' records held by the GMC.

We calculate scores for every medical training provider in the UK for 12 different areas, including overall satisfaction, clinical supervision, induction, and handover.

The 2014 survey involved the following key stages.

- We collect data from postgraduate deans on doctors in training and their training location. We also check to make sure that all locations are approved training sites.
- Doctors in training confirm their training information and complete the survey. This year, they could do this over a seven week period, beginning from 26 March 2014.
- We releas the survey results to postgraduate deans and medical royal colleges using our web-based reporting tool. The results password protected – deans and royal colleges could see the results one month before they were released to the public, so they could investigate concerns locally.
- We publish the survey results on our website, approximately eight weeks after the survey closes. The results can be viewed by training programme and by training provider.

This was the third year that we had run the survey ourselves. It meant that we've been able to offer more useful reports than ever before.

- Our online tool includes aggregated reports, which combine up to three years of survey results. They are designed for sites and specialties that do not generate reports each year because there are less than three doctors in the training posts at one time.
- Our trend reports, which show three years of results side by side, to give an overview of how perceptions of training have improved, deteriorated or remained constant over time. They let postgraduate deans see where their quality improvement strategies are working and which areas need further work. We have identified the sites with three years of poor results and are working with postgraduate deans to investigate them and take action.
- The survey also gives doctors in training the chance to raise any concerns they have about patient safety.

What the survey shows

In 2014, 53,077 doctors in training completed the survey out of 54,068 who were eligible, giving a response rate of 98.2%.

The doctors in training surveyed were:

- doctors in training in the first (F1) and second (F2) year of the Foundation Programme
- core doctors in training
- higher specialty doctors in training, including specialist registrar and general practitioner doctors in training
- fixed term specialty training appointment doctors in training.

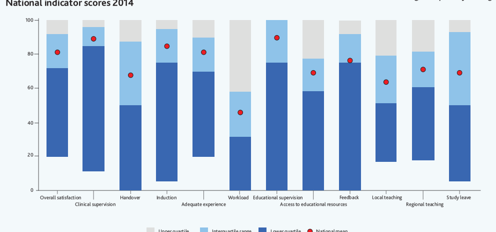
All UK surgery doctors in training by training level

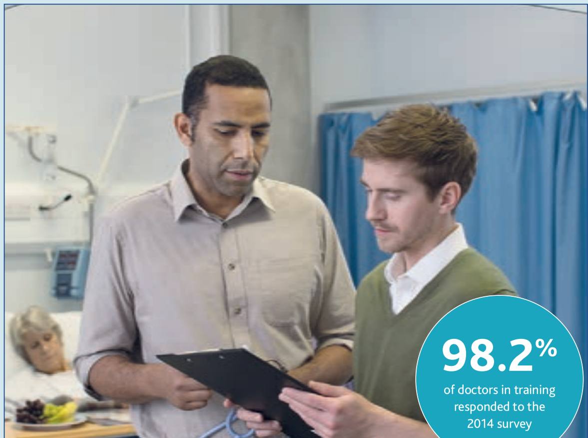
	CT1/ST1	CT2/ST2	ST3	ST4	ST5	ST6	ST7	ST8	Total
Core	795	813							
Cardiothoracic			58	29	15	10	7	5	124
General	2	10	337	280	237	235	206	137	1,444
Oral and maxillofacial surgery			39	35	24	35	10		143
Ear, nose and throat			101	70	76	56	43	29	375
Paediatric	4	5	29	18	32	21	15	12	136
Trauma and orthopaedic	39	45	301	183	183	213	186	122	1,272
Urology			103	69	67	60	56		355
Total	841	875	1,052	727	704	701	588	328	5,816

The survey identified variation across training posts, for example, in the overall satisfaction of training, with general practice posts (including Foundation doctors) having the highest average score of 88.6, and surgical posts (including Foundation doctors) with the lowest with a score of 77.1.

National indicator scores 2014

CT= Core training, ST= Speciality training





98.2% of doctors in training responded to the 2014 survey

Conclusion

Our 2014 survey had one of the highest response rates of any of our previous surveys of doctors in training. The results were shared with postgraduate deans and medical royal colleges to take action only four weeks after the survey closed.

The survey is well established and deeply embedded in the quality assurance systems of regional (Postgraduate Deans) and local (trusts, boards, hospitals, practices) training providers. Postgraduate Deans are required to respond to the results each year, and to publish action plans where poor results indicate problems.

Next steps: understanding the perspective of trainers

In autumn 2014 we will pilot a survey of trainers, which will provide evidence on whether they think the training environments support them in their trainer role. We've been working for some time to increase the recognition and support for doctors who make a significant contribution to medical training as part of their professional role. In 2012, following consultation, we published *Recognising and approving trainers: the implementation plan* which details arrangements and a timetable for recognising undergraduate and postgraduate trainers. Over time, the survey of trainers will help us understand how the implementation plan has been delivered across the UK.

Authors: Kirsty White, Head of Planning, Research and Development,
Paul Clayton, Survey Development Manager, Nick di Paolo, Survey Analyst (GMC Surveys Team).

Working with doctors Working for patients

The GMC is a charity registered in England and Wales (1089278) and Scotland (SC037750)

‘Coaching and Mentoring’

- a prerequisite for the doctor of today and tomorrow

Dr Rebecca Viney, Professor John Howard, Ms Beryl De Souza,

Coaching and Mentoring

In addition to increasing depth and knowledge needed to work in their chosen specialty. It is becoming more important that the skills of mentoring and coaching are needed in the everyday life of a doctor. This concept is endorsed by the GMC as important for doctors to deliver safe, effective and efficient care to patients as soon as they start a new job.

Coaching and mentoring have been used in the commercial sector for many years and are increasingly being used in the NHS with patients, colleagues, teams, in management and for leadership. The development of local and national schemes to train mentors and coaches for health care professionals is supported by the National Health Service by initiatives such as the London Deanery Coaching and Mentoring Service.

Defining coaching and mentoring

When defining coaching and mentoring the terms should be differentiated from other development roles such as patronage, appraisal, educational supervision or line management.
It is not teaching, telling, advising or instructing. Neither is it counselling or therapy although the process of coaching and mentoring may identify the need for this. The precise definitions and use of the terms coaching and mentoring vary. However those offering will need to demonstrate a common set of core skills and qualities.

Qualities needed in a coach or mentor [1]

- **High level of self awareness**
- **Genuine interest in others**
- **Open and approachable style**
- **Humility**
- **Integrity**
- **Confidentiality**

Core skills needed to be a coach or mentor [1]

Active listening
This is the ability to engage with and respond to what the person being coached or mentored is saying, attending to what is being said, and managing distractions.

Observation
The person being coached or mentored will at times display much of what they are thinking or feeling through body language. It is therefore essential that the coach or mentor is able to notice this and in particular to react appropriately when there is a mismatch between what is being said and the non-verbal cues that are being displayed.

Questioning
This is the ability to use questions to help the person being coached or mentored to develop their thinking and to explore the issue or topic in depth.

Challenge
The coach or mentor needs to be able to challenge the thinking of the person being coached or mentored, and this may be done through questioning but also through observation and comment.

Feedback
Providing specific and constructive feedback is a necessary part of helping the person being coached or mentored to develop.

Reflection
The coach or mentor needs to practise reflection and to foster a reflective perspective in the person being coached or mentored.

Mentoring and Coaching

We recommend to allow for resilience and sustaining of the working life of a doctor there should be coaching and mentoring training embedded at medical school and throughout the training grades.

Reference [1] Viney R, Harris D. Coaching and mentoring. In: Bhugra D, Ruiz P, Gupta S, eds. Leadership in psychiatry. Wiley-Blackwell, 2013:126-36.

Dr Rebecca Viney: rviney@nhs.net | Beryl De Souza: bds@dr.com

Situational judgement tests for overseas medics

What are they?

- Measure non-academic professional attributes
- Challenging, real-life situations
- Candidates asked to make judgements

What can they assess?

Cultural differences

You are reviewing a routine drug chart for a patient with rheumatoid arthritis during an overnight shift. You notice that your consultant has inappropriately prescribed methotrexate 7.5mg daily instead of weekly.

Rank in order the following actions in response to this situation (1= Most appropriate; 5= Least appropriate)

A Ask the nurses if the consultant has made any other drug errors recently

B Correct the prescription to 7.5mg weekly

C Leave the prescription unchanged until the consultant ward round the following morning

D Phone the consultant at home to ask about changing the prescription

E Inform the patient of the error

Average candidate ranking as 'most appropriate'
- UK
- South East Asia

Case study

- UKCAT launched a computer-based test University admissions test measuring cognitive ability in 2007.
- Recognised a need to measure potential behaviours of medical candidates within real medical settings.
- In 2012, they added an SJT to test integrity, team working and perspective taking.
- This helps universities make better decisions about suitability of candidates to enter into medical profession.

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ALWAYS LEARNING PEARSON

One size does not fit all – a right-touch approach to assuring continuing fitness to practise

Dinah Godfree, Policy Adviser **IAMRA Conference 2014**

Abstract

With the UK General Medical Council's recent introduction of revalidation for doctors in the UK, the question of how a professional regulator can assure the continuing fitness to practise (FtP) of its registrants is a live debate both within the UK and internationally. At the Professional Standards Authority, we have applied the principles set out in our landmark paper *Right-touch regulation* to this question. This poster explains how an intelligent and proportionate continuing fitness to practise model should be based on a sound understanding of the type and prevalence of a range of risk factors connected to the professional group in question.

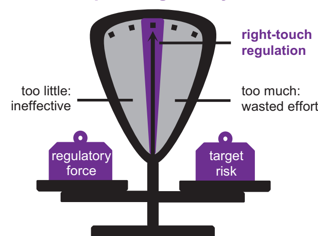
What is right-touch regulation?

A set of principles for developing regulatory policy

Regulation should:

- be proportionate, consistent, targeted, transparent, accountable, agile, and outcome-focused
- be based on a sound understanding of the risks it needs to address
- share the risks with other agencies: people, professionals, employers, commissioners, the law, and other regulators
- look for existing solutions before introducing new ones
- apply the appropriate level of regulatory force.

Figure 1: The concept of regulatory force



Professional Standards Authority, August 2010. *Right-touch regulation.*

What is continuing fitness to practise?

How do I know that my healthcare professional is **up-to-date and fit to practise**?

Regulators should be able to provide assurances of the continuing fitness to practise of their registrants

Focus on the outcome:
compliance with the regulator's core standards of competence and conduct

- Fitness to practise data suggests that conduct breaches arise in a large proportion of fitness to practise cases:
  - GMC: in 2012, 46% of complaints were neither about clinical care, nor about clinical care combined with communication. Complaints concerning probity almost always reached the threshold for investigation.[1]
  - GDC: 1/3 of issues considered by its fitness to practise committees in 2013 related to conduct.[2]

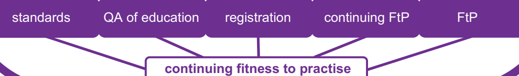
1 General Medical Council, 2014. *The State of Medical Education and Practice in the UK, 2013.*
2 General Dental Council, 2014. *Annual report and accounts 2013.*

- Compliance with CPD requirements may be necessary but is not in itself a demonstration of continuing fitness to practise.

Be clear about the purpose:
periodic re-affirmation of continued fitness to practise

Quality control vs. quality improvement
It is important to be clear about the purpose of assuring continuing fitness to practise. For regulators to be able to answer the patient's question above, they must have some means of checking their registrants' compliance with core standards – you could call this outcome-focused 'quality control'. However, this does not preclude the pursuit of quality *improvement*, which can be achieved through the intelligent application of quality control mechanisms.
The primary role of continuing fitness to practise should be to reaffirm that registrants continue to meet the core standards of competence and behaviour.

All the regulatory functions contribute to these aims



Applying right-touch regulation principles to continuing fitness to practise

- **Understanding the risks**
  This involves looking at the factors that might be associated with professional failings in continuing practise in terms of context and activity, and possible impact on conduct and competence.

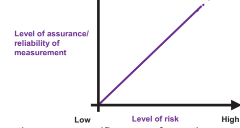
Table 1: Some risk factors associated with continuing fitness to practise for health and care professionals

Risk factor (*source*)		Authority's interpretation
Context	**Effectiveness of clinical governance mechanisms (*GOC*)**	What measures are in place to manage risk and learn from mistakes
	Effectiveness of qualifying training (*HCPC*)	How well the course has taught skills, knowledge and professionalism
	Frequency of practise (*PSNI, TAS*)	If practitioner is well-versed in his/her field, e.g. returners to practise, practitioners in predominantly management roles
	Level of autonomy (*TAS*)	Extent to which practice is monitored and practitioners able to practise independently
	Level of isolation (*GOC*)	Level of interaction with other practitioners (linked to practice context)
	Level of support (*PSNI*)	Quantity and quality of appraisals, learning opportunities, etc to which registrant has access
	Practice context (*GOC, GOsC, TAS*)	Whether in private practice, NHS or non-NHS managed environments, or domiciliary
	Time since qualification (*GOC, NCAS, TAS*)	Length of time since practitioner qualified
	Workload (*PSNI*)	Pressure on practitioners to become more efficient; increased stress
Activity	**Complexity of task (*GOC, TAS*)**	Complexity of diagnosis, procedure or treatment; including management of issues related to the service user such as compliance with treatment
	Emotional and psychological engagement (*PSA*)	Extent to which intervention poses an emotional and/or psychological risk to the service user
	Level of responsibility (*TAS*)	Whether responsible for service user safety, how many responsible for; vulnerability and/or severity of condition
	Likelihood and severity of treatments side-effects (*GCC*)	Extent to which practitioner manages risky side-effects
	Medical invasiveness (*TAS*)	Whether the intervention requires invasive medical treatment
	Rate of evolution of techniques (*GOC*)	Level of need for ongoing training and learning
	Sexual invasiveness (*GOsC*)	Whether the intervention requires undressing and/or contact with intimate areas

CHRE: although it did not feature in any of the literature reviewed, this risk factor has been added by the authors, on the basis that if medical and sexual invasiveness can be said to result in heightened risks for service users, so too can psychological or emotional 'invasiveness'.
GCC: Europe Economics, February 2010. *Report to the General Chiropractic Council.* General Chiropractic Council.
GOC: Europe Economics, March 2010. *Risks in the Optical Profession, Final Report*. General Optical Council.
GOsC: KPMG, 2011. *How do osteopaths practise? Executive summary.* General Osteopathic Council.
HCPC (then HPC): Health Professions Council, October 2008. *Continuing Fitness to Practise, Towards an evidence–based approach to revalidation.* Health Professions Council.
NCAS: National Clinical Assessment Service, September 2009. *NCAS Casework, The first eight years.* National Clinical Assessment Service.
PSNI: University of Manchester, June 2011. *Assessing Risk Associated with Contemporary Pharmacy Practice in Northern Ireland, Executive Summary of the Final Report*. Pharmaceutical Society of Northern Ireland
TAS: HM Government, February 2007. *Trust, Assurance and Safety – The Regulation of Health Professionals in*

- **Determining what level of risk you should and can mitigate**
  You should determine the extent to which you are willing to compromise on the **reliability** of your mechanisms for determining whether a practitioner continues to be fit to practise, based on an assessment of the level and type of risk you feel you can and should be mitigating – and what risks you are prepared to tolerate. **Reliability** can be improved by reducing the numbers of false negatives (incorrect 'fails') and false positives (incorrect 'passes').
- **Developing a response that is proportionate to the level of risk you want to mitigate**
  The **severity and prevalence** of a risk, and your decisions about what risks you are prepared to tolerate should guide decisions about the regulatory force that is needed. We find it helpful to think of the range of possible responses as sitting on a **risk-based continuum (fig. 2)**.

Figure 2: How levels of risk drive levels of assurance



- **Targeting your response**
  You can use the information derived from identifying risks to develop mechanisms that focus on the higher risk practice areas or groups.
- **Developing a response that addresses the type of risk,** for example:

⇒ **Tailoring evidence requirements** to collect information on a specific area of practice or conduct, and to improve practice in these areas (e.g. gathering information on how one-to-one consultations are carried out to identify and root out sub-standard practice)
⇒ **Using evidence collection or assessment methods** that address identified risks (e.g. requiring peer review of performance to address problem of isolated practice).

Some examples from the UK

General Medical Council (*introduced 2012*)

- **Five year** cycle
- Based on **regular appraisals** against core guidance, *Good medical* practice including **reflection and discussion** of:
  1. Continuing professional development (CPD)
  2. Quality improvement activity
  3. Significant events
  4. Feedback from colleagues
  5. Feedback from patients
  6. Review of complaints and compliments.
- GMC decision to revalidate based on:
  - a **recommendation** from a **'responsible officer'** (usually medical director) that the doctor is up to date and fit to practise based on a doctor's appraisals over the last five years and other information drawn from their organisation's clinical governance systems
  - further checks by the GMC to ensure there are no other concerns.

General Osteopathic Council (*draft framework*)

Three year cycle with **90 hours** of CPD (including 45 hours of learning with others).Three mandatory elements:

- **objective activity** to inform CPD and practice (e.g. patient feedback), peer observation, clinical audit or case-based discussion
- CPD in **communication and consent**
- CPD in all four **themes of the Osteopathic Practice Standards** (communication and patient partnership, knowledge, skills and performance, safety and quality).

Cycle completed by '**Peer Discussion Review**' of CPD, practice, and patient care; compliance with the scheme.

General Optical Council (*introduced 2013*)

- **Three year** cycle
- Points-based requirements – minimum per cycle. Points reflect:
  - the level of **engagement with peers** or experts, and
  - the extent to which the **activity supports reflection** (e.g. peer discussion and clinical skills Continuing Education and Training (CET) carry more points than attendance at lectures.
- Registrants expected to spread their CET activity throughout 3 year cycle with a min of 6 points / year (the points requirement is calculated *pro rata* for registrants who join mid-year)
- A minimum of half the points must be achieved through interactive CET.

In conclusion

- There are many possible responses to the challenge of assuring continuing fitness to practise, revalidation is just one of them.
- Continuing fitness to practise mechanisms should enable a regulator to reaffirm periodically its registrants' continued fitness to practise, in relation to both conduct and competence.
- Compliance with CPD requirements is not in itself a demonstration of continuing fitness to practise.
- Regulators need to know the types, severity and prevalence of the risks presented by the professions they regulate in order to develop measures that are proportionate and targeted. They should consider risk factors linked with context as well as activity.
- Regulators also need to make a judgment about the levels of risk they can and should respond to and what they are prepared to tolerate.
- Approaches taken should be both intelligent and agile, making use of existing mechanisms where possible, and adapting in response to intelligence about their effectiveness and impact.

For the full report, *An approach to assuring continuing fitness to practise based on right-touch regulation principles,* and references, please visit: www.professionalstandards.org.uk

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Royal College of Physicians

Marie Curie Cancer Care

Let's talk about end of life care

Authors: Kevin Stewart[1], Janet Husk[1], John Ellershaw[2] and Helen Mulholland[2]
1: Royal College of Physicians 2: Marie Curie Palliative Care institute Liverpool

Introduction

In England half of all deaths occur in acute hospitals. Public concern about quality of care for dying patients has focussed on poor communication by clinicians with patients and families and the provision of artificial nutrition and hydration. Regulators and professional bodies recommend that clinicians actively engage patients and families in discussion about end of life care.

Methods

A national clinical audit of the quality of care of patients who died in hospital in England was undertaken with the aim of contributing to learning to improve the care for patients dying in hospitals and the support given to their families. The audit was led by the Royal College of Physicians in partnership with the Marie Curie Palliative Care Institute, Liverpool and a consortium of professional and patient groups. Funding was provided by Marie Curie Cancer Care and Public Health England.

Local clinical teams entered data into an online database for 50 consecutive patients who died during May 2013 making this the national audit data set. Those who died unexpectedly were excluded.

Data were analysed and care provided was compared against national standards.

A subset of hospitals distributed questionnaires to bereaved family members after 3 months.

Results

Organisational data was submitted by 150 NHS hospital trusts. Data on 6580 patients were submitted by 149 hospitals in England (90% of those eligible).

Patients who died had a mean age of 82 years and 51% were female. 23% had a diagnosis of cancer; other common diagnoses were cardiac and respiratory conditions, stroke and dementia.

Questionnaires were distributed to 2313 family members in a subset of 36 hospitals; 858 (37%) were returned.

- 87% of patients had documented evidence that the clinicians recognised they were in the last hours or days of life; this was communicated to 46% of those patients who were thought capable of having such discussions. Communication was recorded with family members in 93% of cases.
- Discussion about artificial nutrition and hydration occurred in 17% of those thought capable of having the discussion. Regarding hydration this discussion was documented with relatives and friends in 36% of cases and for nutrition this was 29%.
- 24% of bereaved relatives reported feeling excluded from decisions about the care and treatment for their family member.

Table 77: Key outcome measures – section F: overall impressions: National (n=858)

	%	n
29a. How much of the time was s/he treated with respect and dignity in the last 2 days of life? – By doctors (n=815)		
Always	66	(535)
Most of the time	13	(105)
Some of the time	8	(63)
Never	3	(25)
Don't know	11	(87)
29b. How much of the time was s/he treated with respect and dignity in the last 2 days of life? – By nurses (n=823)		
Always	70	(577)
Most of the time	16	(131)
Some of the time	9	(76)
Never	3	(21)
Don't know	2	(18)
30. Overall, in your opinion, were you adequately supported during his/her last 2 days of life? (n=802)		
Yes	76	(610)
No	24	(192)
31. How likely are you to recommend our trust to friends and family? (n=820)		
Extremely likely	40	(328)
Likely	28	(232)
Neither likely or unlikely	16	(132)
Unlikely	4	(32)
Extremely unlikely	8	(64)
Don't know	4	(32)

Comment

There appears to be widespread reluctance by hospital doctors in England to discuss decisions about care at the end of life with patients and their families despite regulatory and professional recommendations to do so.

For the full report: http://www.rcplondon.ac.uk/resources/national-care-dying-audit-hospitals

STANDARDS FOR THE STRUCTURE AND CONTENT OF CLINICAL INCIDENT REPORTS

Alexis Lewis, John Williams and Harold Thimbleby

Methods applied

Method	Finding
Systematic literature review	Well documented barriers to clinical incident reporting
Reporting requirements	Diversity in local and national requirements for investigation and analysis
Comparison of current reporting forms	Forms are long, diverse, complicated and do not match national requirements
Interviews with staff	"By the time you get to the bottom of the form you are losing the will to live!"
Workshops with staff and patients	The development of a simplified content for the report form

A single reporting process is in development which will conform to the Academy of Medical Royal Colleges' standards for the structure and content of patient records.

The science of bespoke testing

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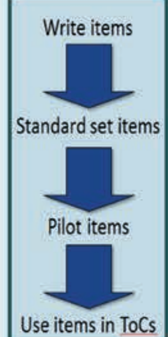
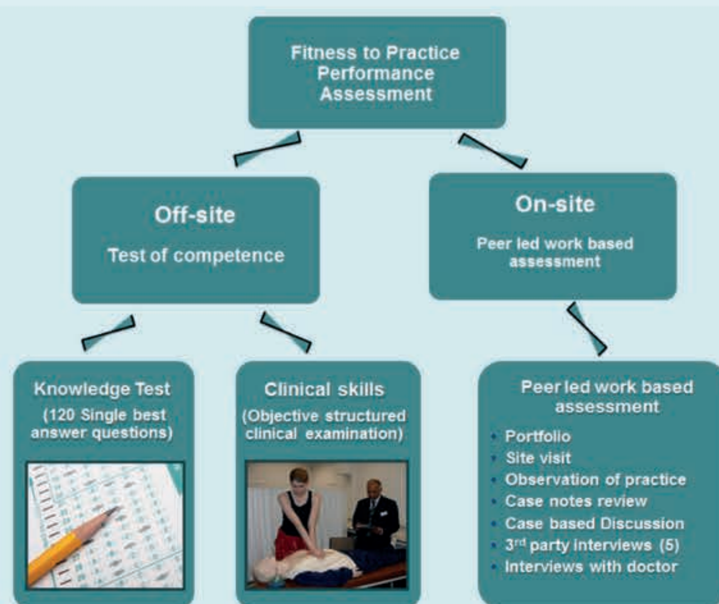
Delivering the GMC Test of Competence for Fitness to Practice Processes

The increasing specialisation of clinical medicine poses a significant challenge when developing fair, valid, and reliable tests of knowledge and skills, particularly for single candidates. University College London Medical School (UCLMS) has developed an extensive validated bank of assessment tools for a range of clinical specialties, which can be tailored to an individual doctor. UCLMS has been supporting the GMC Fitness to Practice (FtP) Directorate for the last ten years, developing and delivering Tests of Competence (ToCs) for doctors referred to the GMC

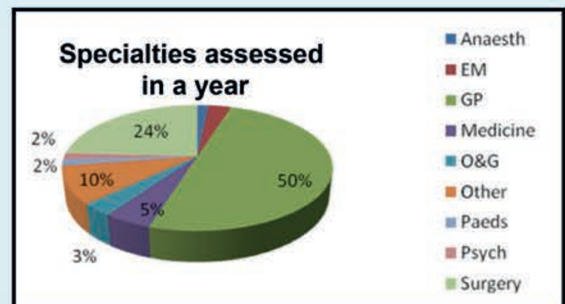


Assessing the doctors



The FtP performance assessment consists of an "on-site" evaluation led by the GMC assessment team. The "off-site" assessment is the ToC which consist of a written knowledge test and an assessment of clinical skills in OSCE format, including practical, interpersonal and communication skills.

Over the last five years we have delivered in excess of 300 ToCs averaging 5 cases a month.



Tailoring the Test of Competence

When collating an assessment for an individual doctor, we review the portfolio doctors that are invited to complete. We focus on areas that describe the doctor's work to ensure that the assessment is relevant to them.

The balance of items used in ToCs reflects the individual doctor's daily practice and training grade, whilst also spanning the breadth of the Good Medical Practice blueprint.

We have developed relationships with the Medical Royal Colleges and specialist organisations to access additional test material when necessary.

Reviewing the portfolio:

- qualifications
- professional employment record
- special interest declarations
- typical weekly timetable
- future plans

Conclusion

All doctors undergoing a ToC have a bespoke assessment relevant to their current clinical practice.

Reference: Dacre, Jane, et al. "The development of a new method of knowledge assessment: Tailoring a test to a doctor's area of practice." *Acad Med* 84.8(2009):1003-1007.

Osteopathic Continuous Certification (OCC)

Ensuring Physician Competency and Patient Safety Through Establishment of an Osteopathic Physician Certification and Evaluation Program

S Scheinthal, DO[1], JM Wieting, DO[1], C Gross, MA, CAE

[1] American Osteopathic Association

ABSTRACT

The American Osteopathic Association's Bureau of Osteopathic Specialists (BOS), under the auspices of the AOA Board of Trustees, has the authority to mandate policies and requirements for the 18 approved specialty certifying boards of the AOA, and it is dedicated to establishing and maintaining the standard of excellence for certification of osteopathic physicians (DOs). The BOS has implemented Osteopathic Continuous Certification (OCC) as a validation process for AOA board-certified DOs to ensure currency, competency and quality patient care in their specialty area. This mandate confirms that rather than being a single event, certification should be a continuous, lifelong process.

As of January 2013, all boards implemented the OCC process, which requires each AOA-certified osteopathic physician with a time-limited certificate to participate in the five components of the OCC process, including Practice Performance Assessment & Improvement.

WHAT IS OSTEOPATHIC MEDICINE?

Doctors of Osteopathic Medicine, or DOs, apply the philosophy of treating the whole person (a holistic approach) to the prevention, diagnosis and treatment of illness, disease and injury using conventional medical practice such as drugs and surgery, along with manual therapy (Osteopathic Manipulative Medicine or OMM). Outside the United States, "osteopathic medicine" is often used interchangeably with "osteopathy."

OSTEOPATHIC MEDICINE IN THE UNITED STATES – SOME FACTS:
(As of December 2013)

Number of U.S. Osteopathic Physicians: 82,146

Number of U.S. Osteopathic Medical Schools: 30 schools in 42 locations

Number of Students in Osteopathic Medical Schools: 23,071 ***(22% of all medical students)***

OSTEOPATHIC BOARD CERTIFICATION AND OSTEOPATHIC CONTINUOUS CERTIFICATION (OCC)

BOARD CERTIFICATION: AN ESSENTIAL CREDENTIAL FOR US PHYSICIANS

Although board certification of physicians is a voluntary process in the United States, the majority of hospitals, insurance companies and health care management organizations make it a requirement for physicians to have hospital staff privileges and obtain reimbursement for services rendered. To that end, osteopathic physicians begin the board certification process through a capstone examination immediately after completing their residency training or just prior to the completion of their residency training to ensure their ability to practice is not impeded and to begin the OCC process.

Board certification protects the public by ensuring that the certificant has completed a program of study or practice in their specialty and have passed a rigorous exam process that has been psychometrically evaluated for validity and reliability.

THE OSTEOPATHIC DIFFERENCE IN CERTIFICATION

For the past 75 years (since 1939), the American Osteopathic Association (AOA), through its official certifying body, the Bureau of Osteopathic Specialists (BOS), and its eighteen member certifying boards has offered board certification for osteopathic physicians. Currently, the AOA offers 87 certifications in specialty, subspecialty and areas of added qualifications ranging from Family Medicine, Internal Medicine and Surgery to Cardiology, Sports Medicine and Geriatrics.

The BOS' Standards Review Committee ensures that the osteopathic board certification process meets the standard of excellence required by the public, regulators, and the medical profession, and that the certifying boards comply with the Guidelines for AOA Certification Examination Standards.

Osteopathic certification is built upon job-task analyses of osteopathic physicians practicing in each specialty or subspecialty. Evaluation can include written, oral and clinical assessments to ensure that the physician practices to a benchmark of excellence and not just to one of minimal competency.

OSTEOPATHIC CONTINUOUS CERTIFICATION

Implemented in January 2013, OCC replaced the former recertification process for AOA diplomates with time-limited certifications. The previous recertification process provided only a snapshot of a physician's certification at a given point of time. OCC provides ongoing input to the specialty certifying board and to the physician based on actual clinical practice as compared to national benchmarks.

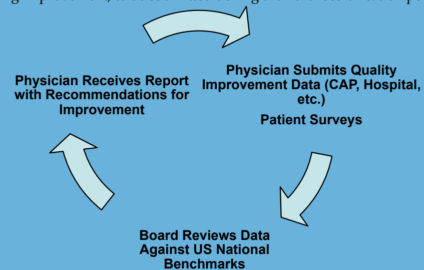
OCC requirements include:

- **Component 1: Unrestricted License to Practice**
  Must hold a valid, unrestricted license to practice medicine in one of the 50 states, territories or Canada. In addition, must adhere to the AOA's Code of Ethics.
- **Component 2: Lifelong Learning / Continuing Medical Education**
  Must fulfill a minimum of 120 hours of CME credit during each three-year CME cycle — though some certifying boards have higher requirements. Of these 120+ CME credit hours, a minimum of 50 credit hours must be in the specialty area of certification.
- **Component 3: Cognitive Assessment**
  Requires provision of one (or more) psychometrically valid and proctored examinations that assess a physician's specialty medical knowledge, as well as core competencies in the provision of health care.
- **Component 4: Practice Performance Improvement and Assessment**
  Physicians must engage in continuous quality improvement through comparison of personal practice performance measured against US national standards for their medical specialty.
- **Component 5: Continuous AOA Membership**
  Membership in good standing through the AOA serves to establish a foundation of commitment to lifelong learning through basic CME requirements.

PRACTICE PERFORMANCE ASSESSMENT & IMPROVEMENT

Below is a general chart on the process of practice performance assessment and improvement.

The physician submits information to the board based on his or her current practice. The data is reviewed against US national standards for patient care, and the physician receives a report with recommendations for improvement. At that time, the physician makes a plan for ongoing improvement, to be submitted during the next recertification period.



STANDARDS FOR OCC COMPONENT 4

The Standards Review Committee has established specific standards for each practice performance assessment activity.

1. Data from a minimum of 10 patient charts extracted for a designated condition, disease or procedure.
2. All patient data information submitted by the diplomate must be from patients treated by the diplomate, rather than from other physicians in a group practice.
3. The diplomate provides the extracted patient data to his/her Specialty Certifying Board in a specified electronic format.
4. Diplomate data will be compared to accepted US national benchmarks. These benchmarks must be identified and included with the Board's submission to the Standards Review Committee for validation and approval.
5. Benchmarks and associated criteria must be clearly defined prior to the diplomate engaging in the process. Some specialty certifying boards must establish benchmarks based upon accepted standards of care, as US national benchmarks may not exist for the specialty.
6. Specialty certifying board provides the findings and comments to the diplomate.
7. If the diplomate did not meet benchmarks, a remediation plan is developed.
   a. If remediation is necessary, the diplomate will engage in a remediation program as specified or approved by the Board. The remediation must be completed with appropriate evidence submitted within the time frame established by the Board.
   b. After a specified period of time, the diplomate extracts patient data from a minimum of 10 new charts again.
8. An analysis of improvement or maintaining of benchmarks is performed.

All data is confidential and only published in aggregate format, and chart data may be audited for verification. All activities are reviewed and approved by the SRC and ultimately reported to the AOA Board of Trustees.

American Osteopathic Association

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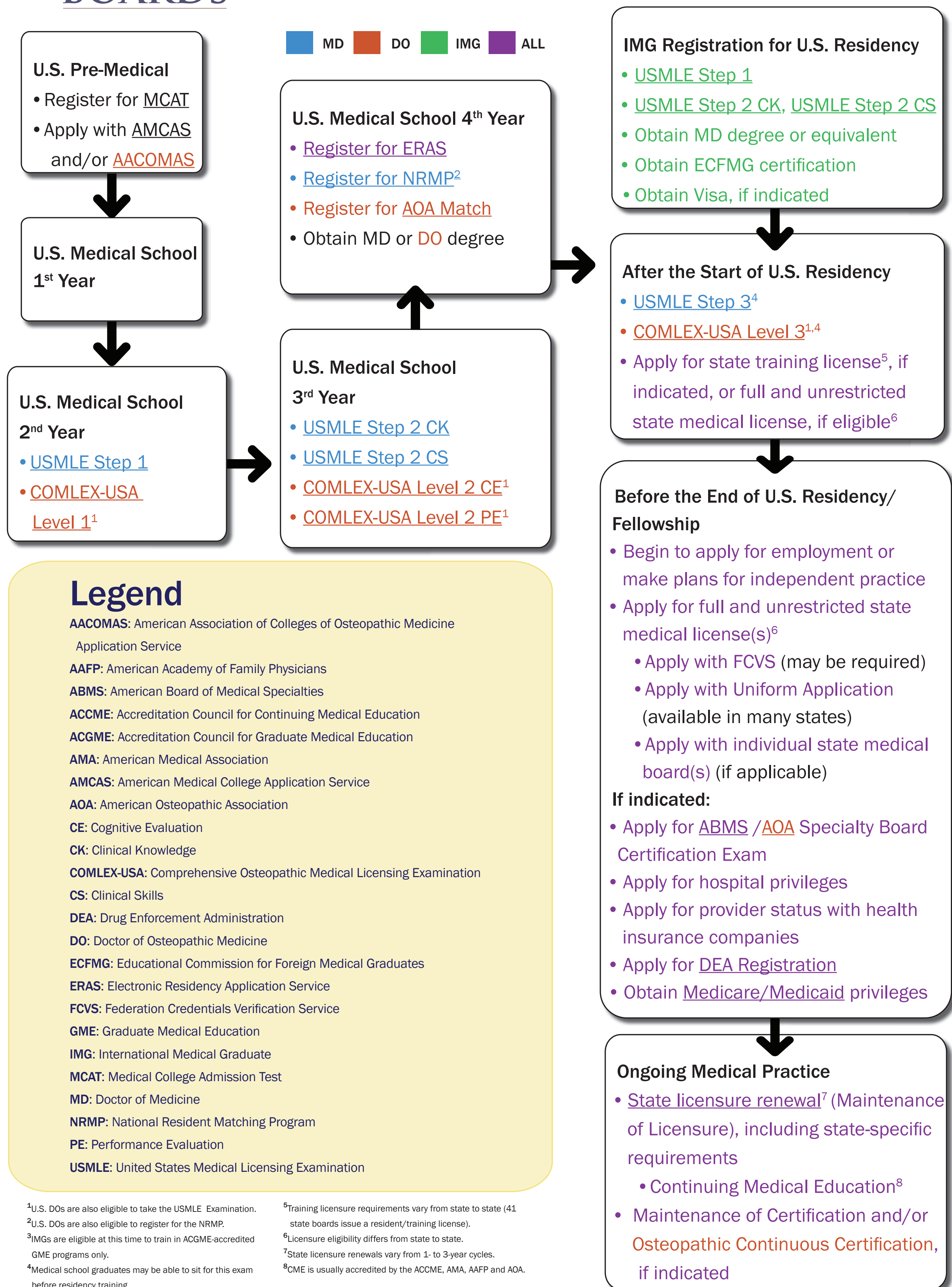
Federation of STATE MEDICAL BOARDS

PATHWAY TO MEDICAL PRACTICE IN THE U.S.



Pathway to medical practice in the US.
Dr Humayun Chaudhry, Mike Dugan, Kevin Caldwell, David Hooper, Amy Gerald
Federation of State Medical Boards (USA)

TRAINING THE GLOBAL PHYSICIANS: THE SGU SCHOOL OF MEDICINE APPROACH

Calum N.L. Macpherson, PhD | St. George's University, Grenada

INTRODUCTION

Students from over 85 countries with different models of education, instructional backgrounds, languages, and cultural traditions enroll in SGU's MD program. The challenges to this wonderfully diverse student population center around helping students through the transition from a possibly one-culture saturation environment to an extremely diverse environment where their culture is present but not dominant. It helps them to learn efficiently and become intelligent, responsive, culturally aware and compassionate doctors in an intense, rigorous medical school curriculum with a large student body. Historically, the ultimate success rate of international students on a campus is sporadic at best.

SOLUTION

An articulated, institutionally shared mission of internationalism is key for the success of an internationally diverse student body. From the initial point of contact, during the admission process, throughout the academic program, and after graduation, each student is counseled by staff that has a thorough understanding of different cultures and academic models, and is able to support a variety of potential challenges that the student may face, to ensure that each student is connected with the appropriate support services in order to facilitate their transition both culturally and academically, enhance their skill set, and, in general, support their progress through the program and beyond.

Admission

- Understanding of different academic backgrounds and cultural perspectives

Student Organizations

- Run by the Student Government Organization; funded by the Dean of Students budget
- SGU fosters and funds a wide range of student clubs, many of which are cultural, religious, national and ethnic in structure, but whose focus is to engage and embrace all others for cross-cultural awareness

Department of Educational Services

- Full student support office of 25 staff trained to help international students succeed
- Introduction to a US-style education, with educational expectations
- Aid in understanding and conquering the MCQ
- Help in English communication skills
- Training in successful group study habits
- Time management skills
- Cross-cultural management skills

Office of Professional Licensing

- Knowledgeable in the ever-changing demands of the qualifications and documentation required for licensing and registration in 50 US states, Canada, the United Kingdom, and many other countries

Office of the Dean and Clinical Studies

- Help students with visa issues to US and UK
- Aid students in seeking clinical electives in home and other countries

Office of Regulatory Data and Information

- Liaises with accreditation and medical regulatory bodies filing submissions and monitoring change
- Submits applications to registration/licensing agencies in countries from which our students come and from which they are seeking registration as doctors

Dean of Students

- Culturally competent staff
- Dedicated Assistant Dean of Students for international students.
- Culture and background assessed when assigning faculty advisors

Office of Career Guidance and Student Development

- Guides students through clinical, boards and other steps to the right postgraduate training
- Develop counselors for international students

Counseling Services

- Aware of specific cultural perspectives on homesickness and immersion into cultural diversity
- Proactive, culture specific personal counseling

CONCLUSION

In order for an institution of higher learning to be successful in the recruitment, retention, and graduation of students from diverse countries and cultures, all offices within the institution must support the mission and dedicate and train staff in cross-cultural needs for academic and professional success.

CONTACT

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DECENTRALISATION OF INTERNSHIP BY THE MEDICAL AND DENTAL PRACTITIONERS' COUNCIL OF ZIMBABWE (MDPCZ)

Josephine Mwakutuya BMGT (HR) MBA

The Medical and Dental Practitioners Council of Zimbabwe whose tenure has been from 2010 and ending in 2015 was faced with an increasing number of junior resident medical officers from the College of Health Sciences as its throughput increased over the years. The increased residents had to be absorbed somehow.

The Council resolved to identify and upgrade five Provisional and District hospitals from ten Provinces where these Junior Resident Medical Officers (JRMOs) could undertake their internship away from the traditional Teaching Units (TUs) which were becoming congested.

The strategy was to:

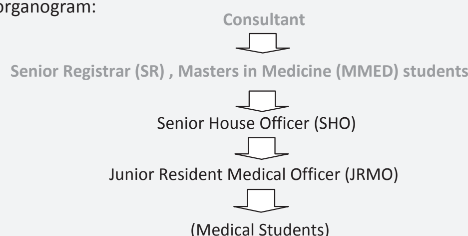
- Broadly to reduce harm to patients as is the theme of the 11th biennial edition of the conference
- Specifically enhance quality of medical standards
- Meet the growing output of medical graduates
- Guaranteeing best practice in a growth background

Challenges on the JRMO training included:

- Overcrowded 10-15 JRMOs per unit
- The ideal setup is 4 JRMOs per unit
- There was then compromise on the quality of the JRMO produced alongside virtues of excellence , motivation and best practice
- In the year 2000 the throughput was 150 JRMOs and in 2013 it shot up to 299
- This is against a background that another faculty has since been established in the country

The background of the challenges on the scene included:

- Shrinking space at traditional Teaching Units (TUs)
- General resource constraints with the associated negative impact on the limited Designated Health Institutions (DHIs)
- "Unbaked" products of internship
- Distorted population ratios per medical practitioner
- The growing patient population and the burden of the same
- The structure of traditional Teaching Units (TUs) assumed the following organogram:



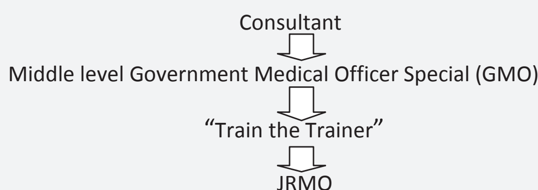
The Medical and Dental Practitioners' Council of Zimbabwe has since responded to these challenges in the increase of JRMOs by:

- Adopting a concept of decentralisation of internship
- By identifying and accrediting suitable peripheral institutions
- Five such institutions equipped with optimal material and human capital resources were found in 10 Provinces.
- The limitation however was that complete rotations in all disciplines were not possible.
- Therefore twinning arrangements were put into place
- It is also envisaged that experiences from the five units be shared at a consultative forum
- Inter-alia here and there teething problems have necessitated "re-strategy"

The new model which is co-existing with the traditional Teaching Units (TUs) still offers comprehensive services that include:

- Acute intake rota, medicine and psychiatry.
- Post take rounds.
- Grand rounds.
- Emergency and electric surgical/orthopaedic lists
- Gynaecology and Obstetrics
- Anaesthesia
- Internal Medicine

CO-EXISTING NEW MODEL



The government medical officer featured in the decentralisation programme since 2011. This is a medical cadre who would have completed a 2 year general medical education programme and rotated sufficiently in surgery obstetrics and gynaecology and in some cases anaesthesia. In other words the medical practitioner is a graduate "train the trainer". They are:

- Generally effective mentors for mentees
- Complimenting Consultants effectively
- In the majority posted to Provisional and District hospitals
- Are good candidates for specialisation later

From the 10 Provinces they are five Teaching Units (TUs) accommodating 140 JRMOs.

The monitoring and evaluation is being achieved through:

- Interval and Adhoc inspections in loco by sub-committees of the Education and Liason Committee (ECL).
- Pilot assessment forms are in place.
- Log books are universal for all interns.
- Feedback forms are in place.
- Inter-alia there is always room for systems improvement.

The benefits of this exercise include:

- Decongestion achieved at traditional Teaching Units.
- Mentees report good exposure as they are apprenticed.
- Invariably senior surgeons in the outskirts are apparently versatile.
- The majority of folk who are rural are served.
- Professionalism and ethics not only prevail comparably but also are maintained.

In conclusion MDPCZ is satisfied with the paradigm shift which it is happy to share with those in similar settings as theirs. Besides there is indication that there is less harm to patients. And indeed the quality of public health delivery is enhanced. Against this background of success, Council has resolved to copying and pasting the same programme on the SHO (MMED) graduate deployment.

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