COMMISSION OF INQUIRY NO. 1 OF 2005
MEDICAL BOARD OF QUEENSLAND

This is the annexure marked "**JPO-17"** mentioned and referred to in the Statement of **JAMES PATRICK O'DEMPSEY** dated this 17th day of May 2005.

REPORT ON

6TH INTERNATIONAL CONFERENCE

ON MEDICAL REGULATION

DUBLIN, IRELAND

21-24 APRIL 2004

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Day 1 Plenary Session: Introduction, Welcome and Official Opening

In opening the conference, the three speakers (Professor Gerard Bury, President Medical Council of Ireland; Dr Lloyd Toft, Chairman, International Association of Medical Regulatory Authorities; and Mr Ian Callanan, President, Irish Society for Quality and Safety in Health Care) each stressed a number of points. These were as follows:

- The International Association of Medical Regulatory Authorities ('IAMRA') had increased in relevance given the growth of membership, the increase in attendance at the conference and the diversity of countries represented. In this regard, 42 countries were represented at the conference as per the attached (1) attendance list.

- This increase in both membership and attendance could be related to the increased mobility of the medical profession, globalisation and the growth in free trade agreements.

- The conference would address issues relevant to such mobility, explore IAMRA initiatives such as the medical passport, investigate possible relationships with other international organisations and explore contemporary issues in relation to medical regulation.

Following the introduction and welcome, the conference was formally opened by Mr Brian Cowen, Minister for Foreign Affairs. In his opening speech, the Minister:

- endorsed the collaboration between regulatory authorities through IAMRA;

- advised that a new bill was soon to be introduced to the Irish Parliament which would include competence/fitness to practice mechanisms for initial and ongoing registration; and

- indicated that 15 European Union Directives for mutual recognition were to be reduced to one mutual recognition Directive to further enhance mobility and simplicity of registration within the European Union.

Comment

The new European Union Directive may have registration implications for applicants from those countries.

Recommendation 1

It is recommended that a copy of the Directive be sought and placed before the Registration Advisory Committee for review.

Day 1 Plenary Session: Medical Regulation from the WHO Perspective

Mr Hugh Mercer, WHO representative, in outlining the World Health Organisation's perspective, advised that:

- At the beginning of the third millennium, health systems and services continue to seek a balanced way to deliver high quality care and concentrate on the needs of the poor.

- This challenge is reflected in the goals set by the United Nations Millennium Summit in September 2000. Six of the eight goals relate directly or indirectly to health development to attack the direct consequences of poverty. These goals are concerned with health outcomes of the poor, but to a large extent they need the support and intervention of human resources. These human resources must be technically skilled to deliver the needed preventive and curative services when and where needed.

- Human Resources for Health ('HRH') one of the most essential components of the health system, is increasingly recognised as a crucial element if health systems and health services are to improve. During the recent WHO regional committee meetings, Ministers of Health from many countries strongly identified HRH as a significant and confounding constraint to achieving their health policies. The World Health Assembly in 2002 also identified HRH as a major challenge to health development.

- A broader group of governments, providers in the public and private sector, and civil society have increasingly advocated scaling up major health interventions as a way to achieve the Millennium Development Goals. This same broader constituency is also becoming aware that the means to deliver these health interventions are not present in many of the countries most in need. While concerted efforts have been made to improve access to medicines for developing countries, this has not been the case for human resources.

- New pressures have emerged during the last decades. Health gains and increased longevity in developed countries attract a substantial number of health workers from developing countries to look after the increasing long term and other care needs of aging populations. But the skills and numbers of health workers are not optimally distributed, both geographically and between different professions and countries. Educational and training models persist in providing health skills that no longer match the health needs of the populations to be served, in particular the poor. Moreover, the increasing toll of HIV/AIDS is directly affecting service capacity and staff in terms of morbidity, prolonged absence, mortality and low morale among those remaining in the services who face an ever-increasing workload in high burdened countries.

- This scenario is typical of many countries whose health and HRH systems are at a crossroads in their development. WHO is developing and providing tools for assessing HRH needs and planning, and providing evidence and best practices that can define policy options for development of human resources as well as methods, guidelines and tools devised for planning, education and improvement of the performance of health workers. WHO is also addressing many of the HRH issues including: migration,

imbalances, education for health professionals and working conditions of the public health workforce.

- The improvement of medical education and practice has been a part of WHO's mandate since its foundation. The challenge for accomplishing this in the 21st century is to create relevant, effective medical regulatory systems that can address the dynamics of global and rapidly changing medical practice environments, technologies and health care delivery systems. International co-operation and collaboration is the key to enhancing the role of medical regulatory authorities as the primary vehicle for public protection in health care.

- IAMRA is a natural partner for this activity given its constitution and purpose and WHO proposes an extension to the collaboration by entering into an agreement for the assessment of medical regulatory systems worldwide and to examine the evidence required by WHO, IAMRA and other partners to support national authorities on HRH toward the improvement of national health systems.

- The preparatory steps toward the development of a common strategy and a joint project on the assessment of medical regulatory systems worldwide are as follows:

  Objectives

  To produce an updated review of the regulatory practices in countries looking at the production, recruitment, maintenance and migration of medical graduates.

  To identify existing gaps in the regulation and management of medical graduates as part of the health workforce of each country.

  Methodology

  The project will be developed through:

  (a) Review of the literature (including a description of regulatory interventions in the health sector and ones that specifically address the medical profession).

  (b) Identification of models of regulation in each region.

  (c) Identification of gaps (areas with no regulation).

  (d) Interviews with regional key informers in education, professional associations and health service authorities.

Day 1 Plenary Session: Performance Assessment of Physicians

Professor Paul Finucane, Medical Council of Ireland, took the opportunity to overview the establishment and purpose of the International Performance Assessment Coalition ('IPAC'). He indicated that the focus on performance assessment had grown out of a number of problems, being that: (a) there was no obligation for registrants to demonstrate maintenance of

competence; (b) the processes for identifying and intervening when a registrant was potentially incompetent were poorly developed; and (c) regulatory bodies had been working in isolation to address these problems and had missed opportunities in collaboration.

To address these problems, IPAC was established and, through a number of meetings, has now identified that there is a rich diversity of approaches to the problems and a commonality of approaches has been developed, particularly in the categorisation of assessment processes. He described three levels of assessment, being as follows:

Level 1 An assessment process targeting the registrant population or a representative sample of that population (largely a quality assurance activity).

Level 2 An assessment process targeting 'at risk' groups.

Level 3 An assessment process targeting specific individuals.

The concept of performance assessment is anchored in Level 3 assessments and he indicated that the ongoing issues to be addressed by IPAC were: (a) how best to screen for those in need of Level 3 assessments; (b) recruitment and training of assessors; (c) ensuring consistency of assessment standards; (d) how best to assess communication skills; and (d) linking the assessment process to remediation.

Comment

Recency of practice requirements in the *Medical Practitioners Registration Act 2001* could be characterised as a Level 1 assessment. However, there are no processes directly enabled by the Act or the *Health Practitioners (Professional Standards) Act 1999* to initiate a performance assessment on receipt of a complaint. The lack of a non adversarial process for dealing with issues of competence is problematic. Given AHMC's recent approval of inclusion of a non adversarial performance assessment pathway, it would be timely to raise this issue in discussions with the Legislative Projects Unit and following that with the AMA and Colleges.

Professor Finucane jointly published an article in Academic Medicine Volume 78, Number 8/August 2003 entitled *A Comparison of Performance Assessment Programs for Medical Practitioners in Canada, Australia, New Zealand, and the United Kingdom.* A copy of that article is available at request from Mr O'Dempsey.

Recommendation 2

It is recommended that Mr O'Dempsey raise this issue with the Legislative Projects Unit to explore the process whereby a non adversarial pathway for addressing issues of competence could be included in the *Health Practitioners (Professional Standards) Act 1999.*

Day 1 Plenary Session: Medical Passports

Ms Sue Ineson, CEO, Medical Council of New Zealand, provided a report of the Working Group on Medical Passports. In this regard she advised that:

- In June 2002, the Management Committee of IAMRA established a working group to develop a system by which the migration of medical practitioners between participating jurisdictions could be facilitated through international co-operation.

- The goal of the working group was to develop a system to increase ease of movement of competent medical practitioners; that is, to develop a fast track method to process applications for medical practitioners who meet or exceed 'gold standard' practice requirements of the International Passport.

- In its beginning stages the working group determined that for an international medical passport system to be successfully devised, IAMRA would serve as the facilitating organisation, compiling and streamlining the use of existing resources, rather than create new registration procedures. Additionally, the group began considering the technology that could be used, such as 'smart card' technology, a verification system linked to a database to validate the identity, core credentials and other qualifications of those seeking mobility from country to country.

- In order to determine the resources already in existence and to prepare for implementation of a pilot project, the working group undertook extensive research addressing multiple issues including: (a) determining and defining the elements of a passport system; (b) analysing the standards used for those elements by different jurisdictions; (c) determining the technical requirements for transmitting the appropriate information from one authority to another; (d) addressing privacy issues and establishing specific protocols for exchanging confidential information and ensuring the information is verified; and (e) identifying protocols for evaluating medical graduates who are refugees and whose information is more difficult to obtain.

- To aid their research the group developed three surveys that were circulated to medical regulatory authorities worldwide to identify: (a) communication and technical capabilities; (b) the different variations of core credentials verification; and (c) policies and procedures for those with refugee or asylum status.

- The working group is currently studying the results of these surveys and information gathered from other research to determine how the information can be of most value in the creation of a medical passport system. The working group has also produced a business plan for developing the medical passport project, with the objective being to pilot the project by the end of 2005 or the beginning of 2006.

- The working group envisages that the medical passport system will function electronically, with core elements of the passport being 'pulled' by the jurisdiction wanting to register the doctor(s) from another jurisdiction. These core elements will include: (a) a unique identifier; (b) a medical degree from an institution listed on the WHO's World Directory of Medical Schools or in the International Medical Education Directory of the

Foundation for Advancement of International Medical Education and Research; (c) a licence for practising medicine in the medical practitioner's home country; (d) names and details of three work related referees/references that can be verbally checked; (e) a current 'gold standard' Certificate of Good Standing from all jurisdictions worked throughout their entire career; (f) passage of a screening exam and/or one of an acceptable group of entry examinations; and (g) an agreement to waiver of privacy allowing the regulatory authority to investigate any matter relevant to registration/ licensure.

- Although much has been accomplished since the establishment of the working group, many objectives still need to be completed to prepare for the launching of a pilot for testing the medical passport system. These objectives include: (a) agreeing on a process and protocols for allocation of unique identifiers; (b) developing a world coding system for medical schools; (c) defining protocols for a 'gold standard' verification system; (d) expanding the current trial between the Medical Council of New Zealand and the General Medical Council for the electronic exchange of information; (e) developing and delivering electronically an evaluating or screening exam of knowledge and skill; (f) agreeing on standards acceptable for current exams from English speaking countries; (g) determining how to utilise a system for registering refugees; and (h) developing and maintaining a web-based directory for storing and updating information pertinent to each jurisdiction that is collected by the working group so the data is readily available.

Comment

While some progress has been made, it is believed that the working party is optimistic of developing a pilot project prior to 2006. However, we should continue to support the work of the group as it may enhance the registration processes, particularly those for special purpose registration.

Day 1 Plenary Session: Information Exchange

Mr Finlay Scott, Chief Executive and Registrar, General Medical Council, provided a report of the Working Group on the International Exchange of Information on Physicians. In this regard he advised that:

- In June 2002, the Management Committee of IAMRA determined that this working group, established the previous year, would continue its work toward developing a co-ordinated system for the electronic exchange of information.

- In the beginning stages of its work, the working group discussed many issues about the practicality of creating a co-ordinated system for the exchange of such information. The group agreed that there can be a conflict between a regulatory authority's need to obtain information from foreign regulators and its willingness or ability to provide such

information to regulators who request it. This was identified as a fundamental obstacle to effective international communication. The working group also identified a number of further obstacles, being that: (a) regulators may take different approaches to disclosure of fitness to practice findings; (b) criminal convictions and allegations may not be pursued or proven; (c) there is no standardised terminology to describe actions that have been or may be take; (d) it may not be clear who to contact in another country to request or provide information; and (e) there may be legal obstacles to the disclosure of personal data.

- Given these obstacles, the group determined that the best way to make progress would be to start on a small scale, harnessing the commitment of those organisations within IAMRA's membership who are willing to make changes and to provide an example for others.

- The working group considered two models for implementing the exchange of information, being: (a) the routine provision of information on fitness to practise outcomes; and (b) the provision of information in response to a request for data regarding an individual doctor seeking registration. Both models are currently being piloted and the working group will evaluate the progress of the project against its aims in the coming months. If the results are encouraging, the group plans to invite other authorities to participate.

- Extensive research had been undertaken by Mr Ian Frank on behalf of the working group regarding the use of unique physician identifiers to assure proper identification of physicians on whom information is being transmitted. A set of draft principles for implementation of a unique identifier have been placed before IAMRA for consideration. When endorsed, the working group on the International Exchange of Information on Physicians and the working group on medical passports will collaborate to further expand the development of the unique identifier.

Comment

The work undertaken by Mr Ian Frank is the basis for the unique identifier being implemented as a component of the Australian Index of Medical Practitioners. As such, Queensland and Australia are well placed in implementation of this initiative.

It will be important to review the outcomes of the pilot projects currently being undertaken by this working group in order that we can consider whether to participate in any proposed model.

Recommendation 3

That Mr O'Dempsey maintain a watching brief on the pilots, evaluate their outcomes and provide a submission to the Board on such outcomes.

Day 1 Plenary Session: Collaboration for Patient and Professional Safety

Ms Emily O'Reilly, Ireland's Ombudsman and Information Commissioner, provided an overview of her organisation's role and collaborative relationship with health services and health regulatory bodies. This is a newly established statutory authority which has the role and responsibilities similar to both the Queensland Health Rights Commission and the Queensland Ombudsman/Information Commissioner.

Comment

No detail of Ms O'Reilly's presentation is provided as Queensland has a rich and extensive history of such collaborative relationships given the Health Rights Commission was established in 1992 and Freedom of Information was provided for in legislation in the same year.

Day 1 Concurrent Session: Co-Regulation in New South Wales

Dr David Thomas, School of Public Health and Community Medicine, University of New South Wales, provided a paper describing the medical disciplinary system in New South Wales as one based on a model of co-regulation. His description lacked both depth and breadth but did raise the relevant question as to whether peer review of professional practice is a sine qua non for medical disciplinary systems.

Day 1 Concurrent Session: Revalidation

Ms Amanda Watson, Registration Manager, General Medical Council, provided an overview of the legislative changes to introduce a 'revalidation' process for registration in the United Kingdom. Currently medical practitioners in the United Kingdom are registered for life however, from 2005, they will be required to apply for a licence to practise each five years. Ms Watson indicated that: (a) this new approach was designed to enhance public confidence that registrants stay fit to practice; (b) each five years when applying for the licence to practise, the applicant will be required to undergo a revalidation process; and (c) the revalidation process is anchored in the Council's publication entitled *Good Medical Practice* as workplace appraisals are linked directly to the requirements detailed in this publication.

The revalidation process requires every doctor applying for re-licensure to: (a) provide the Council with a description of practice which is used to confirm identity and the appropriateness of the supporting documentation; (b) evidence to show they are taking action to keep up-to-date; and (c) evidence to prove there are no significant unresolved concerns in the employment setting.

It is the Council's intention to stagger introduction of revalidation process in order to do one fifth of the register (40,000) revalidations annually. No additional resources have been planned to meet this workload as Council is of the view that efficiency savings in other areas of its operations will fund the anticipated workload.

Day 1 Concurrent Session: Competence Assurance - the Irish Approach

In addressing this issue Professor Paul Finucane, Medical Council of Ireland, addressed the questions why, what and how. In relation to why he indicated that there was: (a) a perceived public need for increased accountability ensuing from the high profile disasters in the United Kingdom; (b) an increasing threat to the status of the profession flowing from rapid erosion of public competence in all professions; (c) a desire on the part of the Council to remain abreast of international best practice standards; (d) the view that introducing competence assurance processes was consistent with the role of the Council; and (e) a need to introduce a proactive approach in addition to the reactive approach provided by the complaints investigation mechanism.

In relation to the what, he indicated that the Council was introducing Level 1 and Level 3 assessment activities. In this regard the: (a) Level 1 assessments required each registrant on applying for renewal of registration to provide evidence of CME of 50 hours, the outcomes of a clinical audit and the outcomes of peer review; and (b) Level 3 assessments modelled on the performance assessment approach introduced by the College of Physicians of Quebec.

In relation to the how, Professor Finucane advised that the: (a) Council had delegated responsibility for the Level 1 assessments to the post graduate training bodies for day to day administration while retaining responsibility for all aspects of the Level 3 assessment; (b) approach was being introduced through a model of persuasion rather than dictation and introduction was to be phased in over a three to five year period; and (c) introduction of the approach was based on an engagement plan (consultation) and an explanation plan.

Comment

More detail on this approach is available from the Council's website (www.medicalcouncil.ie) and has been referred to the recency of practice project officer for review with the view to including a description of the approach in the draft discussion paper. Of particular interest is the approach taken for consultation as an essential part of preparing the ground for introduction of the competence assurance requirements. However, it should be noted there are no sanctions against doctors who fail to meet the requirements and the requirements are only placed on medical specialists in Ireland.

Day 1 Concurrent session: Registration of Overseas Trained Doctors in New Zealand - the Challenges

Dr Deborah Read gave an overview of the topic. Overseas trained doctors in New Zealand have several pathways to registration in New Zealand similar to Australia. Temporary Visa doctors must work with a supervisor for a minimum of three years and are given a period of probation. Supervisors in the workforce are required to provide quarterly reports on the doctor's progress. Cultural awareness programs are emphasized but many OTDs feel they are not given enough information especially with reference to the New Zealand health care system and prescription medications available in New Zealand.

NZ has a similar English Language test to that recently adopted in Queensland.

Interestingly NZ has an electronic exchange of certificates of good standing with the UK for registration which seems to work quite well and avoids a lot of the problems associated with the time differences. Of course this is simplified with language and cultural similarities and would not work everywhere.

Day 1 Concurrent Session: Integration of International Medical Graduates in Canada

Canada had a 10% reduction in medical school intakes in 1990-91 and is now having to deal with that problem. 23% of their practising doctors are international medical graduates. There were no real differences to the Australian experience elucidated.

Day 1 Concurrent Session: The New Zealand Competence Programme and Future Development of Screening

Dr John Campbell discussed the competence review process. He emphasized the separation of the competence and disciplinary processes which is something we have considered in Queensland.

They assure that the competence assessment is comprehensive, constructive and private. There is no prosecution associated with the process and there is no feedback to the complainant. The review costs in the order of $NZ4000.00 and is undertaken by a team of 3 (2 doctors and 1 public member) It is usually completed within 2 months.

Jim--do we have details of this for comparison with the NSW programme? An interesting pint is that they have not been able to identify any group sufficiently to justify targeted screening e.g. doctors over a certain age. Do we know if NSW has come to similar conclusions?

Day 1 Concurrent session: A Proposal of a Model for Supporting the Evolution of a National Continuing Medical Education System

Murray Kopelow discussed the relationship between knowledge, competence and performance and how all three need to be evaluated. He has discovered that there is substantial equivalence between the programs available and proposed the possibility of transferring CME credits within the EU.

Jim do we have any proposal for recognition of CME credits obtained in other countries in our recency of practice discussions

Day 1 Plenary Session: Clinical Performance Indicators

Dr J Mainz, European Society for Quality and Safety in Healthcare, in his plenary session provided an overview of the National Indicators Project being undertaken in Denmark. While of interest in terms of clinical pathways and use of data generated to improve health systems, there was no direct relevance to medical regulation. For those interested in further exploring this project, information is available from www.nip.dk .

Day 2 Plenary Session: Medical Education - A Vehicle for Change in Medical Practice

Dr John Norcini, President and Chief Executive Officer, Foundation for Advancement of International Medical Education and Research ('FAIMER'), in addressing this question advised that:

- Continuing medical education is a vehicle for change in practice under certain circumstances, being as follows: (a) the learner and the educator must have access to data on the learner's practice; (b) learning best occurs in the context of patient care; (c) education must be short and focused on relevant aspects of practice; and (d) social interaction must be present in order for learning to occur.

- Regulatory authorities should encourage practice based learning as part of any re-validation process introduced for renewal of registration and/or licences to practise.

- While regulatory authorities do not have a role to play in formal training for practitioners, they should all utilise a licensing or certifying exam to ensure that such training prepared applicants to a minimum standard for registration.

Day 2 Plenary Session: Accreditation – A Vehicle for Change in Medical Practice

Dr Hans Karle, President, World Federation for Medical Education ('WFME'), in addressing this question advised that:

- To ensure that competencies of medical doctors are globally applicable and transferable, readily accessible and transparent, documentation of the levels of quality of educational institutions and their programs is essential.

- The *World Directory of Medical Schools* published by WHO was never intended for a purpose other than a listing and qualitative considerations were explicitly excluded.

- WFME, in its position paper 1998 suggested that a world register of medical schools be developed, aiming to constitute a roster of quality assurance in medical education institutions, and indicating specifically that institutions included had attained globally accepted and approved standards for medical education programs.

- As a basis for this register, the WFME has developed global standards for all three phases of medical education, being: (a) basic medical education; (b) post graduate medical education; and (c) continuing professional development.

- The three sets of global standards are in different stages of implementation, but the Executive Council of WFME has formally adopted all.

- WHO and WFME have entered into a strategic partnership to pursue a long term work plan which will result in: (a) a shared database that will include up-to-date experience in implementing quality improvement processes in medical schools; (b) access, via the database, to information on specific schools and, in particular, to a description of their approach to quality improvement; (c) promoting twinning between schools and other

institutions in processes to foster innovative education; (d) means to update the management of medical schools; (e) identification and analysis of innovations in medical education in order to help define appropriate lines of work for each WHO region; (f) assistance to institutions or national/regional organisations and agencies in developing and implementing reform programs or establishing recognition/accreditation systems; and (g) a review of good practices in medical education that can serve as examples and as a source of further innovation.

- Extension of the strategic partnership is also currently being explored to include FAIMER and the further development of IMED as the primary source of data on medical schools, their accreditation and the basis of that accreditation.

Day 2 Concurrent Session: The International Medical Directory

James Hallock, MD, Education Commission for Foreign Medical Graduates, in providing an overview of the *International Medical Education Directory* ('IMED') advised that:

- FAIMER had developed a resource database for medical regulatory authorities entitled IMED which contained a listing of all Medical Schools recognised by the appropriate government agency in the country where the school is located.

- IMED was available through the Internet in two versions, one for the general public (free of cost) and one for institutions and agencies such as medical boards (at a cost of US$500 per annum).

- IMED currently included 1800 entries and such entries were only included on the database after consideration by the Advisory Board (the Australian Medical Council holds membership on this Board).

- Increasingly, physicians are migrating across jurisdictional borders to pursue graduate medical education and licensure and IMED provides accurate, up-to-date information about international medical schools to enable decisions to be made, particularly in relation to registration.

- The IMED website provides, in searchable format, the medical school contact information, university affiliation, degree awarded, year instruction began, language of instruction, curriculum duration, entrance requirement and enrolment.

Comment

While registration staff currently access the public version of IMED, an assessment should be made of the institutional version to establish its usefulness in contributing data to the registration decision-making process. Use of the institutional version, particularly given the direction of establishing IMED as the primary source of information about international medical schools, can only value add to the registration decision-making process.

Recommendation 4

It is recommended that the Deputy Registrar investigate the use of the institutional version of IMED and provide an assessment report of such use to the Registration Advisory Committee.

Day 2 Concurrent Session: Collecting, Electronically Storing and Sharing Physician Disciplinary Information

Mr Tim Knettler, Vice President, Federation of State Medical Boards of the United States ('FSMB'), in his presentation advised that:

- FSMB has collected and centralised, physician disciplinary information for the last 40 years and such information is collected from: (a) all 70 US Medical Boards; (b) England, New Zealand, Australia and Canada; (c) the US Department of Health and Human Services; (d) the US Drug Enforcement Agency; and (e) the US Department of Defence.

- As a service to the Boards in the US and with any other regulatory authority who has entered into a written agreement with FSMB, FSMB will: (a) provide data centre searches for history of disciplinary action for research purposes; (b) undertake searches upon particular registrant disciplinary history; (c) provide daily disciplinary alert reports by email; and (d) undertake special audits of disciplinary outcomes (in this regard they are able to provide reports on disciplinary sanctions applied for particular categories of unsatisfactory professional conduct).

Comment

Access to the database maintained by FSMB and the services provided would value add not only to registration decision-making processes but also to investigations and disciplinary actions, particularly at Tribunal level.

Recommendation 5

It is recommended that Mr O'Dempsey investigate the establishment of a written agreement between FSMB and the Board and prepare a submission on the outcomes of that investigation for the Board's consideration.

Day 2 Concurrent Session: A Collaborative Approach to the Management of Impaired Practitioners

In his presentation Dr Patrick McNamara, College of Physicians and Surgeons of Ontario, advised that:

- A significant part of the College's mandate is to ensure that doctors practise medicine safely and are not impaired by physical or mental illness which might impact on their abilities.

- The *Regulated Health Professions Act of Ontario*, which governs the College, sets out a formal legal framework for the College to investigate issues related to physician health and, as such, the process is lengthy, formal and often confrontational.

- In an effort to address these issues, the College developed a collaborative relationship with the Ontario Medical Association to employ a more appropriate approach in keeping with the illness model related to physician impairment. The result of this was the Physician Health Program ('PHP').

- PHP provides for the assessment, referral for treatment, monitoring and advocacy for physicians with substance abuse problems, major mental health issues and will shortly include those physicians who are positive in blood borne pathogens and performing high risk procedures.

- The agreement between the College and PHP requires mandatory annual reports to the College and a relapse reporting protocol.

Comment

The establishment of such a program was explored in the Siggins Miller Report and rejected by the Minister. However, there may be strategic opportunities in the future to look at introduction of such a model and a watching brief will be maintained for such opportunities.

Day 2 Concurrent Session: Primary Source Verification – Best Practices

In their presentation, Tim Knettler and Stephen Seeling provided an overview of the outcomes of the IAMRA Working Group on Medical Passports' research into the use of primary source verification and advised of the 'gold standard' being established for verification history. This 'gold standard' is as follows:

- The identity of the applicant is verified by at least two documents (passport, birth certificate, photo identification card) signed by an IAMRA registering body or certificate from an external verification agency such as ECFMG, EIS.

- The original primary degree is sighted and verified at source by the issuing institution or an IAMRA registering body or external verifying agency.

- The medical licence or registration certificate from all jurisdictions worked throughout the applicant's entire career is verified at source by registering jurisdictions or external verifying agency.

- Documents substantiating post graduate medical training are verified at source.

- Examination results are verified at source.

- An affidavit is provided by the applicant that the information is true and this affidavit is witnessed by a public notary, consulate official or magistrate.

Day 2 Concurrent Session: Five Years After: The Alberta Physician Achievement Review Program

Alberta has a Level 1 program which is a 3 stage model:-
a) Profession wide screening
b) Physicians at risk
c) Individual assessments.

The aims of the program are that it is mandatory, comprehensive, educational, performed at arms length and is reliable, valid and credible.

The licensing authority has statutory authority to undertake these assessments every 5 years. They are performed by an outside contractor and a committee and subcommittee deal with the results. A Director of Practice Improvement, who is a doctor, controls the program. It is a comprehensive program consisting of several domains including technical knowledge and skill, psych-social management, communication ability, collegiality and office management. Feedback is given to the physician.

The bottom 10% are reviewed by the Committee with possible telephone follow-up and the bottom 2% are reviewed by the Director with an interview and probable practice visit

As with similar programs the Alberta program is totally separated from the disciplinary program.

Whilst more comprehensive and resource intensive than we are contemplating in Queensland it would be useful to review all the available programs worldwide.

Day 2 Concurrent Session: The Inter-rater Reliability of Evaluation of Physicians' Performance in a Peer Assessment Program

Dr Andre Jacques et al discussed the use of a peer inter-evaluation reliability assessment which is currently being undertaken. This project is not yet completed. Quebec has 6 full-time physicians who travel to undertake evaluations "on the spot." They use 4 quality criteria: record keeping, clinical investigations, diagnostic accuracy and treatment. The only positive finding so far is that better results are achieved by the inspector who actually visits the practice rather than one who just reviews the charts. Whilst interesting there was little relevance to the Queensland situation as this is obviously a much more intensive program than we will be undertaking.

Day 2 Concurrent session: The Monitoring and Enhancement of Physician's Performance: the Pathological Report of Breast Cancer Surgery

Various criteria were evaluated in the pathologists' reporting of breast cancer surgery and deficiencies addressed by educative means. One pathologist who was not reporting much breast cancer pathology retired. A follow-up study showed an improvement in all criteria at all hospitals. The program is to be extended to cover other aspects of medical practice. Once again whilst interesting there was no relevance to the Queensland situation.

Day 2 Concurrent Session: Deborah Coleman from the GMC Explored the Relationships Between Ethical Guidance and Fitness to Practice Decisions

The GMC has recently replaced the "Blue Book" with a publication entitled "Good Medical Practice." The aim of this was to make the document more user-friendly and to update the ethical advice to physicians registered with the GMC.

The GMC faces similar challenges to all other regulatory bodies to encourage registrants to read their publications and it is difficult to know how to measure "market penetration."

The publications are available on the GMC website.

Day 2 Concurrent Session: Electronic Exchange of Certificates of Good Standing

Sue Ineson and Amanda Watson from New Zealand discussed the exchange of information between the UK and New Zealand. This topic has been dealt with earlier in this report.

Day 2 Concurrent Session: Public Enquiries

Deborah Coleman from the GMC discussed the fact that disciplinary bodies in the UK can now act on disciplinary procedures in another jurisdictions. Previously the whole case would have to be retried in the UK. The case of Dr Neale was quoted who was removed from the register in Canada but managed to register to practice in the UK. With the increasing exchange of information between jurisdictions hopefully these incidents will become less frequent.

Day 2 Concurrent Session: The Retention of Sensitive Information Regarding Disciplinary Proceedings

This address was given by Andrew Forbes from Phillips Fox in Brisbane and discussed the legislative requirements for the retention of confidential information in various jurisdictions. Currently in Queensland this time is 10 years. He emphasized the fact that confidential information should only be used when it is relevant and that procedural fairness should be implemented at all times.

Day 2: IAMRA General Meeting

The IAMRA General Meeting was held over two hours and a copy of the report of the meeting will be available in due course. Significant outcomes of the meeting included the following:

- The budgets for 2005 and 2006 were approved.
- It was agreed that IAMRA would be established as an incorporated non profit organisation under Texas (US) state law. Following such agreement, the IAMRA Articles of Incorporation and By-laws were approved and a copy of these are available on request.

- Professor Thanyani J Mariba, President, Health Professionals Council of South Africa, was elected as Chair of IAMRA for a two year period.

- Dale L Austin, Senior Vice President and Chief Operating Officer, FSMB, was elected unopposed as the Deputy Chair for a two year period.

It was noted that the Management Committee would be responsible for progressing the initiatives ensuing from the workshops to be held on Day 3 of the Conference.

Day 3 Plenary Session: Medical Mobility, an Australian Perspective

Dr John Herron, Australian Ambassador to Ireland, provided an enjoyable presentation on the history of medical mobility in the context of Australia's geographic problems. He particularly stressed that medical mobility is a reality, a right of individual medical practitioners, and was of benefit to the development of the profession. No further detail is provided of this presentation given the Board's knowledge of the Australian perspective.

Day 3 Plenary Session: Feedback from Workshops

Workshops were the primary focus of Day 3, with all delegates attending one of three workshops about: (a) future directions for IAMRA; (b) prevention, detection and treatment of impaired physicians; and (c) medical regulation in 2014.

The outcomes of each workshop were as follows:

<u>Future Directions for IAMRA</u>

1. To develop strategic partnerships with related organisations such as: (a) WHO; (b) FAIMER and the WFME; and (c) the regional meetings of medical regulatory authorities which are in existence in the European Union, Southern Africa, and the Middle East.

2. To enhance IAMRA's relevance for developing countries by understanding their needs, providing relevant functional and material support and to assist in maintaining and improving standards of medical regulation.

3. To continue the development of the bi-annual conference by ensuring themes of relevance to areas of special need and to provide funding assistance for attendance.
4. To maintain a focus on medical regulation and not be diverted from this focus by the needs of other organisations.

5. To continue to refine the Articles of Incorporation and By-laws to ensure IAMRA remains a democratic organisation.

<u>Prevention, Detection and Treatment of Impaired Physicians</u>

1. To develop an internationally accepted definition of impairment. The definition is to include or capture behavioural issues and those with blood borne viruses.

2. In terms of detection: (a) to ensure there is a legal responsibility on registrants to report suspected impairment; (b) to ensure there are programs for education of medical students in relation to the risks of impairment and how to manage these risks; and (c) to ensure there is registration of medical students.

3. In terms of prevention: (a) to focus on lifeline education for the management of impairment risks; and (b) to introduce level 1 and level 3 assessment programs.

4. In terms of support: (a) to develop best practice guidelines for assessment, treatment and monitoring; and (b) to develop a framework for support of those who treat impaired doctors.

Regulation 2004

1. To enhance patient involvement in regulation given that increased public literacy has increased public expectations in relation to safe and competent care, increased the need for accountability and decreased public awe of the medical profession.

2. To address the changing scope of medical practice, particularly its implication for breaking down professional silos.

3. To identify the risks and benefits of medical migration and address these consistent with the individual rights of the doctor and the rights of the society which has funded their education.

4. To address the need for increased accountability of medical regulators by ensuring processes are transparent, efficient and responsive to society.

5. To address conflicts between the role of medical regulators and the demands placed on them by medical workforce issues (and international trade agreements).