Health Professions Council – 9 December 2010

Reports from Council representatives at external meetings

Executive Summary and Recommendations

Introduction
The attached feedback forms have been received from Anna van der Gaag, Neil Willis, Keith Ross, Diane Waller and John Donaghy, reporting back from meetings at which they represented the HPC.

Decision
The Council is requested to note the documents.

Background information
None

Resource implications
None

Financial implications
The cost for attendance at conferences/meetings has been incorporated into the Council annual budget.

Background papers
None

Appendices
Copies of feedback forms

Date of paper
29 November 2010

Chair's Report on the IAMRA Conference 'Best Practices in Medical Regulation' Philadelphia, USA, September 2010

Introduction

IAMRA is the International Association of Medical Regulatory Authorities, providing a forum for the development of new approaches to regulation and to promote high standards in medical education, licensure and other regulatory activities. The conference attracted delegates from 33 countries, 90 organisations, with a large representation from the US and Canada. This was the 9th IAMRA conference. HPC has been a partner organisation since 2004. Presentations can be found at: http://iamra.com/conference_presentations-2010.asp

Day 1

The session included presentations from US, UK, Netherlands, Denmark, and Australia.

Ian Frank described the 'competent authority' model of assessment used in Australia which uses a combination of online assessments and OSCE assessment of clinical skills. Key characteristics of the model is that it does not rely on mutual recognition agreements and is not assessing equivalency but 'competence' Since 2007, 4,400 applications have been received and 61% have been eligible to proceed. 40% have completed the assessment to full licensure.

Paul Kavanagh from the Irish Medical Council described their new professional competence framework, which has many similarities with HPC's own CPD standards. All doctors are expected to take part in local appraisal and clinical governance, as well as undertaking CME courses run by the Colleges. The Council is proposing to assesses only those doctors who have identified performance issues/recognised concerns (no details yet on how this will happen). Unlike the GMC, the Irish Medical Council is not planning to introduce any additional assessment for all doctors. Paul Kavanagh quoted a recent report from the EU on medical revalidation, which concluded that 'there are many outstanding questions on the effectiveness of assessment systems'.

Lourens Kooij from the WETBIG in the Netherlands talked about the Dutch approach to the assessment of doctors trained overseas. Their test includes mandatory language testing, and they support the GMC's position on mandatory testing for EA applicants. There was some disquiet from the audience, particularly those from African nations, when asked by HPC South Africa why doctors in Holland could not make use of interpreters as European doctors do in Africa.

Stephen Schabel, Professor of Radiology, Medical University of South Carolina described the benefits of formal assessment in medical regulation. His argument was that 'we trust no-one' and therefore formal objective assessment of each doctor applying to work in the US was essential. Medical school transcripts, letters of recommendation, patient testimonials could not be relied upon as assessments of competence. Standardised formal testing was the only 'real data' allowable. USMLE (US medical licencing exam) is made up of three parts – a science exam a clinical knowledge test and a test of independent practise (includes section on communication skills and professionalism). This test applies nationally, although there are other assessments which occur at state level as well, and of course these vary in content from state to state. There was an interesting debate about the advantages of this system – creates uniformity – reliable, objective – but also criticism – bias towards those who are good at multiple choice exams (tend to be

male, and risk takers), encourages sameness in US doctors and discouraged diversity, and cannot test everything necessary to be a good doctor.

Bruce McIntyre from Rhode Island Medical Board described his approach to assessing prior convictions and medical history – this has been an issue in the past and Rhode Island now have mandatory self declaration on questions about past history/mental health/substance misuse. Introducing this approach has been challenging, as it risks legal action by doctors if judged too intrusive.

Joan Wehrle and Richard Whitehouse from the Ohio State medical Board presented the most innovative paper of the day on engaging medical students in debate on 'professionalism' and regulation. Ohio has 8 medical schools, the Board has 61,000 registrants, an income of 8.6 million and 87 FTE staff.

The programme consists of:

1. A game show style quiz about regulation (based on the Jeopardy game show)
2. Students have the opportunity to observe fitness to practise hearings, with a briefing beforehand and discussions afterwards
3. Presentations on issues such as communication, boundary issues, medico legal issues at medical school.

This combination of different approaches has significantly increased student's knowledge and interest in regulation and its relevance to their lives as doctors. There is also made a short DVD about the programme and its benefits.

The programme was prompted by the Papadakis study, which found links between performance at medical school and later disciplinary history. Ohio decided to take a proactive approach – low cost, highly successful and now being adopted in other states.

Day 2

This session began with an overview from the GMC and College of Surgeons and Physicians of Alberta on post licensure QA programmes. GMC view was that the public expect doctors to be regularly checked to see if they are up to date. Patient expectations have changed the landscape and regulators need to respond to these external changes.

Alberta has a well established post licensure QA processes in place for doctors. This includes review of:

1. Prescribing practises
2. CME/CPD records
3. Health status
4. Inspection of facilities where required
5. PAR – physician assessment review – a 360 appraisal every 5 years by patients and peers.

In the future regulators need to take account of the growth of team based care, growth in medical technology and the increase in patients with long term conditions who are knowledgeable about their care. These developments will all influence the requirements on doctors. The remainder of the day was spent in small group workshops discussing registration processes, disciplinary procedures and quality assurance initiatives.

Workshop 1 Registration processes

The following stories illustrate the wide variation in regulatory practises across the world.

Zimbabwe – Poor practise in resource poor countries

Doctors arrive in Zimbabwe with voluntary organisations for short periods. Sometimes they have no documentation/verification with them, but are permitted to work in the country, often because their organisation has some connection with a local political leader. Most recently there was a doctor who came in with no documentation – he worked as part of a cleft lip and palate team. He administered anaesthesia (without adequate qualifications as it turned out), and this led to the death of several patients. He was never disciplined for this, and left the country without being held accountable.

US – fear of litigation drives decision making

Each state has its own Medical Board with its own registration process. There is an expectation that many doctors will have had law suits against them during the course of their careers, and so doctors moving from state to state often carry a history with them. Full disclosure for example about performance as a medical student, is variable across the US, and the Canadian regulators talked of 'difficulties' getting information from US medical schools. Fear of legal action is common. The US is heavily dependent upon the USMLE, the national exam for all doctors – on the basis that 'we trust no-one'.

Canada

Personal relationships across the regulatory world are important in Canada. Registrars will 'lift the phone' to colleagues in other states as well as in the US to obtain information on doctors seeking registration from outside their own state, in addition to seeking full disclosure and verification of documentation.

Australia

There has traditionally been little movement of doctors between states, and up until recently each state had its own regulatory system. (see day 1 and 3 for more details on the Australian system).

The workshop concluded that good practise in registration should be underpinned by the following principles

1. Verification of id and qualifications from the source institution should be routinely available
2. The ideal would be an international database that all countries can access so that doctors 'struck off' in one jurisdiction can no longer practise in another.
3. Regulators need to share information through direct communication where appropriate
4. There should be a 'leaning towards' full disclosure of information on past history
5. Letters of good standing could be 'harmonised' so that they contain standard information.

The group were very interested in HPC's 4 'additional' checks on registrants from overseas and in particular the databases we use in the Netherlands for checking ID.

Workshop 2 Fitness to Practise processes

This workshop also revealed variations in practise across the globe. In Dominica and Iraq there is no formal complaints process for doctors other than through the courts. In Iraq, this has caused difficulties especially as the courts have little or no understanding of medical practises and are therefore not equipped to make informed judgements. In Australia, a complaint is dealt with via three 'pathways' –

1. Disciplinary
2. Underperformance
3. Health

The last two are non disciplinary procedures but all are referred to a Board to determine whether there is a case to answer and then referred on to a tribunal.

In Saskatoon, Canada, complaints are dealt with either via a disciplinary or an education track. The disciplinary track involves a hearing and the outcomes can be reprimand, fine, suspension or striking off.

In Ontario, the complaint is assessed by the Executive and then referred on to a Committee. The outcome is no action/ caution or suspension.

In Zimbabwe, an Investigation Committee decides whether to pursue a complaint and typically will interview the doctor and the complainant before recommending to the Executive that the case be heard. The panel is made up of Members of the Council and members of the profession. The sanctions are fine, suspension, erasure or admonishment.

Problems with systems

Besides the obvious resource driven issues, a number of stories emerged during the discussions which illustrated specific problems

1. Lack of follow up across jurisdictions

Canada

A medical doctor of high standing in his local community, Dr 'A' was accused of raping two young patients. He was DNA tested and found not guilty of the offenses. He moved to another jurisdiction, and after some time was again accused of rape. He was again admonished. However, the family of the patient hired an investigator, who eventually found out that the doctor had persuaded another patient to supply him with blood, and he had switched this patient's sample for his own during the police investigations. He was found guilty, served a two year sentence, and left the US to return to his home country of South Africa, where he began practising again as a doctor.

2. Regulation and Alternative and complementary treatments

Canada

A doctor offered alternative vitamin treatment to a terminally ill patient and his family, offering them this treatment as a cure for cancer. The doctor charged the family 30,000 dollars and the patient died within a month.

This doctor was struck off the register because he failed the 'alternative but respected view' test ie, he offered an alternative treatment, but did not demonstrate honesty or integrity to the patient or his family. In Ontario, doctors are not penalised for offering alternative treatments so long as they are offering genuine choice to the patient and are explaining all the options to them. The charge was considered exploitative, and the treatment was sold to the patient on the promise of a cure, which was dishonest.

The workshop concluded that good practise in dealing with complaints should be underpinned by the following principles

1. Ensure process is as timely as possible
2. Keep complainant informed
3. Aim for consistency with flexibility
4. Not all complaints are the same and each requires individual discretion on how they are managed
5. The continuum from disciplinary action to 'educational' action should determine the degree of transparency (health/impairment case less in public than conduct case)

There were no examples of mediation being used, other than in Alberta, but there was a lot of interest in the work HPC is doing to explore this. Many regulators agreed that a triage approach would allow mediation to have a place early on in the process, as well as offering a 'lessons learned/restorative option at the end of the process. In New Zealand, where there is a no blame compensation culture, mediation would provide a valuable progression.

Day 3

Joanna Flynn Australian Medical Board
This paper began with a story of negligence and malpractice that changed the way Australia delivers medical regulation.

Dr Patel applied to work in an area of need in Bundaberg, Queensland. His papers were reviewed the day he arrived from the US. He had a disciplinary record in 2 US jurisdictions, but when he submitted the paperwork he omitted the second page of the application, which went unnoticed by the Registration Office of the Queensland Board. He began working in April 2003 and by June 2003 a nurse raised concerns about his practise. These were ignored. There were 20 complaints from patients over the next 2 years. In April 2005 Patel resigned and left Australia. In November, 16 charges were brought against him including manslaughter and fraud. In August 2010 he was sentenced to 7 years in jail. He is appealing the decision and his case will be heard in November 2010.

Patel registered but omitted to tell the Board about his previous history and restrictions on his practise. In 1984 he had been disciplined during his residency for harassing patients and failures in record keeping. In 2000 the Oregon Medical Board had disciplined him for gross negligence.

Largely in response to this case, Australia introduced a new regulatory system – a single cross professional registration board. Before July 2010, there were 8 states with 85 boards and 66 pieces of legislation. Since July 2010, there is one national scheme and a single piece of legislation governing 10 professional boards. There is a national on line register. The new system includes mandatory CPD, student registration and mandatory professional indemnity insurance.

The lessons learned from Dr Patel have been translated into a new multi professional more 'joined up' system of regulation – 'a framework to maintain trust.'

Workshop 3 Quality Assurance Programmes post licensure
As with the other two topics, there was huge variation in the regulatory bodies and their approach to this area. Canada was acknowledged as the most 'advanced' in its 'post licensure quality assurance programmes, and Alberta and Ontario in particular were seen as leaders in this area of regulation. The Canadian system is dependent upon the Medical Colleges for CPD programmes and in general terms Canadian regulators tend to insist that doctors enrol in one of these programmes rather than running their own QA programme. In Ontario, the regulator takes a more 'risk based' approach, and has mandatory peer assessment for all doctors over the age of 70 years.

Australia also has a monitoring role with older doctors, wheras in the US, the Boards are more cautious because they risk being sued for discrimination unless they have clear reasons for pursuing any kind of monitoring of competence.

My sense was that much of the work in QA was driven by costs. In the US, doctors are charged around $175 per year by their State Medical Boards and a percentage of this fee income goes to the state not to the regulator. In Canada, the fee is on average around $1400 per year, and none of this fee income goes to the state.

The workshop concluded that good practise in quality assurance post registration should be underpinned by the following principles;

1. Personal responsibility for lifelong learning is key
2. QA schemes should be evidence based
3. QA schemes should be outcomes focused
4. They should be regular and linked to registration

Day 4

CHRE presentation from Douglas Bilton and Christine Braithwaite

Figures for 2009/10

CHRE Review of All Fitness to Practise Cases

Total reviewed	1835
Total closed after review	1536
Transcripts requested	201
Learning points given	77
Cases discussed at case meeting	8
Advice to regulatory body	6
Referred to High Court	2

Of these 1835 cases, 501 were GMC, 742 were NMC and 335 were HPC.

Christine gave a description of the CHRE process for applying 'right touch regulation'

- Identify the problem
- Quantify the risks
- Get as close to the problem as possible
- Focus on the outcome
- Use regulation only when necessary
- Keep it simple
- Check for unintended consequences

- Review and respond to change

She used this framework to described how CHRE had concluded that health care support workers worked in managed environments under supervision and therefore do not require regulation. Similarly, she used podiatric surgeons as an example of extended scope of practice – covered by HPC and therefore no additional 'regulation' necessary for this group.

Douglas Bilton announced the forthcoming launch of the CHRE International Observatory

- Launch in 2011 via new webpage
- An international resource for regulators
- Providing evidence on good practise
- 54 members to date

CHRE is now offering to performance review regulators worldwide and had recently completed a review of the NZ Regulator (report on the CHRE website in Oct 2010).

The remainder of the session was a plenary, during which the facilitators of the workshops presented their good practise findings

On complaints, the facilitators concluded that:

- Regulators need to be proportionate about how they manage complaints but not put roadblocks in the way of complainants
- Be accessible to the public
- An international database for disciplinary history was desirable but not achievable given different culture and countries approach to privacy.

On QA post registration (revalidation):

- There will continue to be a tension between professional ethic and regulatory imposition
- Self reflective practise amongst all doctors is the goal
- QA needs to be proportionate and risk based
- It needs to develop risk based indicators
- QA needs to tackle variation in clinical quality that we know exists amongst doctors – sub optimal care is more common that we think
- QA may need to be different for newly qualified doctors versus experienced doctors
- It needs to use technology
- It needs to be kept separate from the disciplinary function
- It will redefine what we mean by professional regulation (GMC view)

Conclusions

This was a good conference. HPC's poster (entitled; 'Measuring compliance to CPD standards in a multi professional context) was well received and there was a lot of interest both from regulators from many different parts of the world. HPC's work on CPD is unique, I think – there were no other reports of a similar system at the conference. The Canadian model of QA includes CPD assessment as well as peer assessment, prescribing patterns, 360 feedback but is more costly and therefore could only work in some settings. There was still a lot of ambivalence amongst the US regulators about revalidation – in part cost driven but also still questioning the need for it, given that the US Medical Colleges have a strong CPD infrastructure. Patient feedback was not seen as a necessary addition to existing CME processes.

The presentation of particular note was from Ohio – the ‘Partners in Professionalism’ paper which described an innovative approach to engaging students in regulation. The Canadians lead the way in revalidation/QA programmes as we know from the Ontario visit, and if we were to go down that road there is much to be gained from their model, especially the use of online tools and peer assessment.

It was somewhat disappointing that there were not more presentations from developing nations, and that the majority of the papers were very US centric. There were also few research papers, ie papers from academics that have been carrying out studies of regulation, and performance of doctors, such as Papakadis and her colleagues. However, the HPC raised its profile at this conference, which was important, and established new networks with regulators in other countries.

Name of Council Member	**Neil Willis**
Title of event	**CHRE Four Country Conversations**
Date of event	**22 October 2010**
Approximate attendance at event	**10**

Issues of Relevance to HPC

The CHRE organises meetings in all four countries (www.chre.org.uk/public/271/) to inform the public of their role and obtain feedback from the public and registrants both on their views and knowledge of regulation issues and how to improve or refine the data they present. The venues were Manchester, Glasgow, Cardiff, Belfast and London and all the meetings were held in October.

Following introductions from the three CHRE staff and the attendees present, the program for the day was outlined which included the listed powerpoint presentations followed by general discussion and a question and answer session;

Presentations

1. What we found in the Performance Review this year.
2. Getting your views on two projects
   a) Measuring regulators' work
   b) How regulators involve patients and the public
3. Creating a single point of contact for complaints
4. What are our plans for continued work with patients and the public?

The main findings of the Performance Review were outlined with examples from a number of regulators generally focusing on improvements and presented in a positive manner.

Measuring regulators work

CHRE is looking for suggestions on how the work of the regulators could be compared and agreed that as the regulators had different rules and regulations direct comparison may be difficult but it would be easier to compare fitness to practice outcomes than some other aspects, any data collected will be referenced to the CHRE standards.
Views were sought on how best the work of the regulators, once measured, could be presented. Data extracted from the Fitness to Practice annual reports of five regulators, including the tables from the HPC annual report were circulated to determine which was the preferred format. The consensus from this non representative group was that pie charts, good use of colours and good labelling with the minimal use of abbreviations were important factors when presenting data.

Creating a single point of contact for complaints.

How and where to complain was seen as an area for improvement and there was strong agreement within the group that this was a problem. It was felt that there was insufficient information as to whether complaints should be referred to individuals, line managers, employers, professional bodies, statutory regulatory bodies, MPs or other authorities in the UK and EEC. Once again no general conclusions can be drawn because of the small numbers in the group and also

because some were interested in “single issues” regarding the treatment of a family member mainly by a doctors or a nurses. It is worth noting that a significant number of attendees were associated with Community Health Councils. Suggestions included possibly making advice available from the Citizens Advice Bureau or specifically in Wales from the online Portal.

CHRE will be producing a bimonthly newsletter to which patient groups can submit articles and has also set up a Public Stakeholder network which anyone can join either by completing a form or by clicking the “keep in touch” button on the homepage of the CHRE website (www.chre.org.uk). They will be e-mailing those signed up with alerts as consultations and new information becomes available.

The future of the CHRE was queried following the governments statement that funding was being withdrawn. The Director of Policy and External Relations informed the group that the CHRE will be funded through a levy on the registrants of the nine statutory bodies but it would not compromise their position as they would report to Parliament through the Privy Council. The CHRE currently has a budget of £2.3m.

What happens next

In addition to measuring the work of the regulators the CHRE is also engaged in determining how the regulators involve patients and public in their work.

Key Decisions Taken

This meeting was for information from CHRE and feedback from the groups and as such was not a decision making forum

Name of Council Member	**Keith Ross**
Title of event	**Scottish Government Regulation Conference**
Date of event	**26/27 October 2010**
Approximate attendance at event	**100+**

Issues of Relevance to HPC

Whole conference was relevant to HPC. The morning of Day 1 focussed on revalidation – initially the progress being made on medical revalidation. This was followed by presentations from GOC, HPC and NMC and question and answer panel discussion. The afternoon focussed on Professionalism and Transparency with presentations from GDC and NHS QIS (Scotland) The final part of the day was a facilitated discussion in small groups of a case study to highlight issues related to the threshold for referral to a regulatory body. Day 2 started with presentations on Protection of Vulnerable Groups and progress with the Scottish scheme. This was followed by a presentation by CHRE on Models of Assurance for the Public, by HPC on Regulation of new Professional Groups, by Heads of Workforce Policy and Planning in Wales and NI on Models of Assurance, and by NMC on their research into regulation for nursing assistants. The afternoon focussed on advanced practice and regulation of support workers in Scotland.

The conference was well attended by employers, Scottish Government Health Directorates, and all UK regulators. There were representatives of a number of HPC's professions and prospective professions. It was an excellent opportunity for networking and making contacts.

Key Decisions Taken

This was not a decision making event.

Name of Council Member	**Diane Waller**
Title of event	**Group Psychotherapy for our evidence-based times**
Date of event	**12th November 2010**
Approximate attendance at event	**200**

Issues of Relevance to HPC

Another opportunity to meet and discuss with a specialist section within the psychotherapy profession. Group analysis/group psychotherapy is a specialist training at Master's level delivered at very few centres within the UK. The Group Analytic Society is a learned society which support members throughout the UK and also has an international membership. Graduates are normally UKCP members. The conference had a focus on service users' perspectives. The programme included three presentations from users of mental health/psychotherapy services who all supported the need for more research into the psychological therapies in general and group psychotherapy in particular. The service users spoke about their experiences in different settings, including a famous but now closed therapeutic community.

They addressed the importance of including service users (patients in this context) in the design and implementation of research and that this should be more than paying 'lip service' to such inclusion. Thinking about our discussion at Council, concerning HEIs and other training providers involving service users' perspectives in their programmes, I was once again reminded of the complexity of that term across all our different professions. Whereas within this conference, the term clearly meant 'patients'. It was even suggested that a return to this word might be welcome due to misunderstandings around 'service user'.

One of the papers delivered by a service user: Are we researching what matters to service users? This was particularly clear in the context of mental health provision as the presenter stated that the concerns of researchers could often differ from those of the people who actually experienced the provision.

Key Decisions Taken

Not a decision making event. Participants were generally accepting of the need for more research in this specialist area but were worried about the emphasis on quantitative research (as in NICE guidelines) and argued for the inclusion of qualitative studies as being more appropriate to a process-oriented modality such as group analysis. This is a common concern across the psychotherapies, including the arts therapies.

Name of Council Member	**John Donaghy**
Title of event	**JRCALC committee meeting**
Date of event	**11th November 2010**
Approximate attendance at event	**16**

Issues of Relevance to HPC

The Joint Royal College Ambulance Liaison Committee (JRCALC) are the clinical advisors for the paramedic profession, they advise on clinical issues and are currently produce paramedic National Clinical Guidelines (NCG) used throughout the UK by ambulance services and paramedics, in conjunction with the College of Paramedics (COP) they form the basis of our clinical scope of practice.

The meeting on the 11th November discussed a number of issues relating to clinical guidelines and the production of the new 2011 NCG due in April/May. I gave an update of the work of the HPC and the abolition of the GSCC which was noted.

Some discussion took place around the role of the Emergency care Practitioner (ECP) and if this is currently annotated on the HPC register. The chair was pleased to see representation from the College of Paramedics (CoP), HPC, DOH and UNISON.

Key Decisions Taken
No key decisions taken affecting regulation or HPC.