Marie McInerney reported on the 12th International Conference on Medical Regulation in Melbourne, from September 20-23, 2016, for the Croakey Conference News Service.

Croakey is a social journalism project for public health based in Australia.  
http://croakey.org
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Conference preview: What are the big issues in international medical regulation?

The 12th International Conference on Medical Regulation was held in Melbourne, hosted by the Medical Board of Australia (MBA) and the Australian Health Practitioner Regulation Agency (AHPRA).

It was the biggest and most diverse gathering of the International Association of Medical Regulatory Associations (IAMRA) yet, with more than 450 delegates coming from 42 countries.

Journalist Marie McInerney reported on the discussions for the Croakey Conference News Service. In the article below, she previewed some of the issues to be showcased at the conference.

Marie McInerney writes:

Many of the issues canvassed at the 12th International Conference on Medical Regulation have been writ large in headlines across Australia over the past year or more.

The conference was held in Melbourne amid continuing investigations into a number of tragic and distressing failures in care across the country. They include allegations of serial sexual abuse against a Melbourne neurologist which sparked a review of Australia's chaperone system, the tragic deaths of babies at Bacchus Marsh Hospital, a fatal oxygen mix-up in New South Wales and incorrect chemotherapy doses in South Australia.

Croakey has also reported on continuing debate about the role and performance of the Australian Health Practitioner Regulation Agency (AHPRA) since state-based medical boards were rolled into one big national register of all health practitioners six years ago.
Medical Board of Australia (MBA) chair Dr Joanna Flynn said the conference was a valuable opportunity for regulators from across the globe to talk about challenges and successes of regulation in various and varying jurisdictions and how they can better predict “where the next iceberg is”.

Sessions like ‘Physicians behaving badly’ focused on a range of practitioner issues, from dishonesty and fitness to practise through to a timely workshop being conducted by the Royal Australasian College of Surgeons after its investigation upheld whistleblower claims that discrimination, bullying and sexual harassment are rife among surgeons.

But the conference also focused on the crossover between individual “adverse events” with systems issues like Australia has seen in some of the issues outlined above, and most alarmingly in the United Kingdom’s Mid Staffs scandal.

“There’s an emerging question, particularly in the UK, here, and in some Canadian provinces about how do you link up what is happening in the health system in terms of standards and quality and what might be regarded as adverse events… and the systems issues,” said Flynn.

“A practitioner might say ‘yes, that went wrong, but it’s not my fault, this or that other aspect of the system didn’t support me to do a good job or give me resources, or sometimes I may have been pressured to do things cheaply or didn’t have enough time’,” she said.

“On the other hand, the broader community, understandably and appropriately, is less and less tolerant of either side of that regulatory divide … saying ‘that’s not our problem’.”

This has been a big issue in the UK in the past five years, post Mid Staffordshire, she said, where there was plenty of data about a poorly performing system with poorly performing practitioners and questions of quality control, governance and compassion which raised the big question: “why didn’t people join those dots up and do something about it?”

It’s led to demands that regulators be more proactive, seeking to prevent harm before it occurs at the systemic level but also to identify areas of risk among different groups of medical practitioners, at different points in their careers, in different specialties, and/or where they work. These are expected to be big topics at the conference.

Community standards

Community standards and expectations were also a major theme, including a plenary discussion hosted by ABC broadcaster Geraldine Doogue on ‘Shaping an old profession for a new society – what does the community need/want/expect?’.

The panelists at another plenary included Professor Ron Paterson, who is leading AHPRA’s chaperoning review and public health physician and health lawyer Dr Marie Bismark whose research focuses on the patient voice in improving the quality and safety of care.

It’s recognition, Flynn says, of the dramatic shift in medical regulation in recent decades, from what was once a “very sheltered business” but is now subject to huge scrutiny by government, the public and media, as well as criticism from within.
It is, she said, really important to hear from strong voices in the community and also to share experiences across regulators in different countries about what is working well and what is not.

Some of those experiences, she says, will point to the need for better practice, others to the need for legislative change and better linkage of data. They are live issues in Australia, where health insurance and medical indemnity funds often have more data about which doctors are complained about than regulators, including issues like whether a doctor under investigation may previously been part of a legal process that was settled.

Flynn said Australian regulators are also currently lobbying the Council of Australian Health Ministers about changing laws so practitioners under investigation have to reveal everywhere they work, not just a primary “employer”, and to address “a deficiency” in law about how much regulators can tell complainants at the end of a complaint process.

“If we didn’t do something that led to a restriction on a doctor’s registration, it can feel from their point of view like we’re saying ‘you gave us a complaint, we did something with it, we’re not telling you what it is, and we did nothing in the end’, which is pretty seriously unsatisfactory for people who complain,” Flynn said.

**Global and emerging challenges**

The conference focused strongly on global challenges, particularly around the growing mobility of medical practitioners.

A plenary session on the issues was chaired by Professor Vivian Lin, from the World Health Organization’s Regional Office for the Western Pacific, looking at education, registration and cultural issues for medical practitioners who move between nations and continents. It raised ethical questions around the globalising workforce, including much reported claims that there are more Malawian doctors in Birmingham than in Malawi.

Other sessions looked at the regulatory challenges involved in large-scale public health emergencies like Ebola, war and major movements of refugees. Lin also reported back on a regional workshop held in the lead up to the conference on regulation issues in the Western Pacific.

Martin Fletcher, CEO of AHPRA, said the conference raised opportunities for the more well developed regulatory jurisdictions to support others but he said there are also lessons to be learnt from non-Western nations, particularly “questioning of assumptions that underpin what we do”.

An example, he said, is guest speaker Professor Ducksun Ahn, Vice-President of the World Federation for Medical Education, on how regulation in Korea is informed by Confucian values.

Fletcher said global challenges sessions will not just consider the mobility of the workforce, but also the increasing mobility of patients travelling overseas – particularly for dental and cosmetic care. One session included a presentation on “how being a regulator helped make Dubai a hub for medical tourists”.

Martin Fletcher
The conference highlighted particular emerging “hot topics”, including challenges around cosmetic surgery and telemedicine. And it explored the regulatory implications of the decision early this year of Canada’s Supreme Court of Canada to allow doctor-assisted suicide across the country under certain circumstances.

Frustrations and perceptions

Fletcher acknowledges that Australia’s regulation system is “not perfect”, but he says it is strong and well functioning and the fact that we have a national, multi-professional scheme “in itself creates opportunities that other countries can only dream about”.

An example, he says, is the US where First Lady Michelle Obama fought for years to streamline licensing for various groups of military spouses, including many medical practitioners, who faced different rules and requirements each time they moved.

But he said it can be frustrating from his perspective that some debate about regulation is “not as well informed as it could be” and also that privacy and natural justice restrictions mean AHPRA sometimes has to respond in public “with one hand tied behind our back”.

“What tends to get reported are these cases that raise concerns and end up being the lens by which everything is viewed,” he said. “I think there is a real challenge and opportunity for us to do more to raise public awareness and understanding.”

Fletcher pointed to this video below featuring one of the conference’s guest speakers – Dan Faulkner, deputy registrar of the College of Physicians and Surgeons of Ontario – about the misconceptions faced by regulators. In it Faulkner says:

One (misconception) is held by a small but vocal contingent of the doctors we license, and another by a small but vocal contingent of the general public. Ironically enough, these two perceptions are diametrically opposed to one another.”
What keeps you awake at night? And other burning questions for medical regulators

IAMRA leaders future, current and past in Melbourne: Mungherera, Chaudhry, Dickson, Pigou and Lefebvre

Marie McInerney writes:

On the first day of the 12th International Medical Regulation Conference in Melbourne, delegates were urged to work “upstream” so they can prevent harm from occurring to patients and the health system, not just manage it when harm is caused.

Welcoming 450 participants – a record number – from more than 42 countries, International Association of Medical Regulatory Authorities (IAMRA) chair Niall Dickson told the opening session that regulators were finding themselves under pressure in a “turbulent world”.

Healthcare had “belatedly woken up” to the challenge of safety, and was attempting to adapt to a more demanding and transparent world, he said.

Health professions were also changing and were more than ever on the move, working across jurisdictions and other boundaries.

“Like the profession we regulate, more is expected from us,” Dickson told the biennial conference.

As Croakey’s conference preview outlined, the conference was held amid investigations into a number of tragic and distressing failures in care across Australia. Other countries have similar experiences, not least the United Kingdom’s Mid Staffs scandal.
Dickson quoted Medical Board of Australia chair Dr Joanna Flynn as saying the sector needs to move from being “philosopher regulators” – considering ethics and values – to also becoming “scientific regulators, where data, once the detritus of our operations, can help us develop a more risk based approach to regulation that seeks to prevent harm”.

“We all know the regulators’ challenge is to make sure patients are safe and to maintain the trust of the public while forging positive and ongoing relationships with the profession,” he said.

“This isn’t easy and is becoming more complex as expectations rise and regulators find themselves in firing line when services are seen to fail or are unsafe.”

It was a continuing theme through presentations and discussions yesterday, following a brief official opening from Health Minister Sussan Ley.

Ley hailed Australia’s national and multi-professional registration and accreditation scheme, but said it was an ongoing project that requires “ongoing vigilance” across jurisdictions and professions.

She particularly welcomed delegates from Pacific nations, saying the region needs to enhance its ties “to increase mobility and portability” of health qualifications and to share education and health services.

Instead of keynotes, the concurrent sessions were topped and tailed by interactive panel plenary sessions, with delegates asked on arrival to fill in a postcard – in five words or less – “what keeps you awake at night?”

The opening session provided a smorgasbord for conference participants to choose from, presenting three real-life case studies from Australia, Canada, and Kenya that outlined tragic abuses and regulatory nightmares.

They included a shocking case of a woman who died in childbirth due to a doctor being under the influence of alcohol, and a complex and long-running case of a psychiatrist who was ultimately jailed for sexual abuse and suspended, after a decade of varying alerts and complaints that authorities determined could not be substantiated.

It was an interactive session, with delegates asked to vote via a conference app on how high they judged the risks to patient and public safety in each case, and what action should come next.

There was much agreement, but also significant variation on a number of key matters, like when and whether to alert police, and whether investigations should or could go into another country.

For some, talking afterwards, the session highlighted how easy it is to know what to do after an event – to use the “retrospectoscope” as one put it, and that “nothing is black or white”.

What keeps you awake at night? And other burning questions for medical regulators

#IAMRA2016
For others, it revealed continuing gaps and failures, and alarming signs the system was still more rooted in protecting practitioners than patients and the public good.

Conflicting views also were aired in the following panel discussion, particularly around whether some offences are “so heinous” that a medical practitioner should never be given permission to practise again.

Daniel Yumbya, CEO of Kenya’s Medical Practitioners and Dentists Board, argued passionately that regulators had to accept, as the wider society does when someone is released from jail, that those who have been punished have “done their time”.

However, Susan Hughes, Member of the Medical Council of New Zealand, said she believed there were some offences that made medical practitioners not fit to practise again.

She was particularly concerned about practitioners who use their office as an opportunity to indecently assault their patients.

“The first thing we teach children is that actions have consequences,” she said. “There’s an enormous distinction to be made between doctors who offend outside and within the profession.”

Hughes also saw an important gap in a Canadian case, where an investigation was closed when a complainant “failed to attend” an appointment to discuss a complaint about “fondling”.

“You’ve got to be focused on where power sits in this,” she said. “The doctor is all powerful.”

Regulators needed to have a more complainant-centred mechanism, “where you go to them, allow them to tell their story, because it’s so challenging for them to be confronted by suits.”

She said: “Never lose sight of the power differential between patient and doctor. If they’ve done it once and denied it, how would you have the confidence they won’t do it again?”

Issues of honesty and insight into wrongdoing were also themes, with one delegate pointing to the prevalence of lies in the case studies, and proposing that “dishonesty might not just be treated as an act but as a state of mind”.

The room also discussed the power differential within health groups, sparked when delegates considered whether or not a nurse should have intervened with the drunken doctor to avert the mother’s death.

“If the system does not allow your nurse to stop the doctor working, then you must fix your system,” Yumbya said.
However, how to determine responsibility in more “equal” team-based care was also raised as an emerging issue for countries, like the United States, that don’t currently have multi-professional regulatory bodies.

Another delegate raised concerns about the reliance on certification from hospitals and medical practices for medical practitioners in “areas of need”, such as rural and remote regions, where it is very difficult to recruit and retain doctors. “So practitioners, owners may want to be more supportive of a doctor because it’s so hard to get another one there,” was one comment.

“What keeps you awake at night? And other burning questions for medical regulators #IAMRA2016

“Do we think chaperones are appropriate in this day and age?”

New Zealand Law Professor Ron Patterson said that’s the first question underlying a review into chaperoning that he is leading for AHPRA, in the wake of a case where a Melbourne neurologist is alleged to have continued to sexually assault patients even with a chaperone in the room.

Urging health and regulatory groups to make submissions to the inquiry, Patterson said he was hearing two responses to the question: some who felt it was an antiquated concept from a bygone era; and others who said it was a critical tool to be able to use between taking no action and suspending a practitioner.

There was similar division in the room. Some questioned whether chaperoning was at all appropriate ethically, given the need for trust and informed consent for patients (who often don’t know the chaperone’s role and rarely the reasons for their presence).

For others, the question was how to make sure the chaperoning process protects patients while managing procedural fairness for practitioners.

More conference news and views, from the Twittersphere

![Image of a presentation at IAMRA2016 conference]
What keeps you awake at night? And other burning questions for medical regulators

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“Conference News Service”
From a workshop on “mastering the media”

@AHPRA @WePublicHealth • 19h
‘The number one objective for @AHPRA is protecting the public’. Anita Rivera speaks on building trust through stakeholder engagement
What keeps you awake at night? And other burning questions for medical regulators

#IAMRA2016

Community expectations and needs

ABC presenter Geraldine Doogue presented a session: Shaping an old profession for a new society – What does the community need/want/expect?
You can track Croakey's coverage of the conference here.


@AHPRA @WePublicHealth · 17h
Powerful discussions on shaping an old profession for a new society @IAMRA2016 @GeraldineDoogue @AlanKirkland EK Yeoh, H. Oetter & K. Murphy

Michael Greco @CEO_POAustralia · 18h
Interesting distinction... 'disease' is what medical profession grapple with whereas patients try to make sense of 'illness' #IAMRA2016
You can track Croakey’s coverage of the conference here.

What keeps you awake at night? And other burning questions for medical regulators

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From Uganda to China, how do the global challenges of medical regulation vary?

There is no one-size-fits-all approach to medical regulation, and models need to accommodate local cultural, economic and health system differences, according to speakers yesterday at the 12th International Medical Regulation Conference in Melbourne.

Journalist Marie McInerney profiles some of the issues for regulators spanning countries across Asia and Africa.

Marie McInerney writes:

Ugandan health leader Dr Margaret Mungherera says it’s impossible to try to take the Western model of medical regulation and “plonk” it into other regions like Africa.

That’s particularly so, she said, with Africa still suffering an unabated “brain drain” of doctors to richer nations that helps weaken its health systems and patient safety.

Mungherera is a psychiatrist, president of the Ugandan Medical and Dental Practitioners Council and a former president of the World Medical Association – the first African woman elected to the role.

In 2014, during her tenure, she helped fight moves by Ugandan president Yoweri Museveni to force doctors to report gay patients, putting them at huge risk in the nation where homosexuality is illegal. She saw it as a professional and ethical duty to speak out against harm.
“The most important thing is that health professionals know what their obligations are, whether dealing with POWs [prisoners of war] or gay people,” she said. “We said this is unacceptable as a profession.”

Mungherera was speaking at the biennial conference of medical regulators in a plenary panel session on global challenges in medical education and professional regulation.

The session focused on non-Western regions, particularly across Asia and Africa.

It raised a range of cultural issues, from how regulators can help address gender inequality and gay discrimination through to what Western health regulation could or should learn from values like Confucianism and the deeper connections with family and community in other cultures.

Korean Professor Ducksan Ahn, Vice President of the World Federation for Medical Education, highlighted the “sharp contrast” of Confucian principles around the perfectibility of a person with the Christian teaching of original sin and belief in the fallibility of human beings.

The panel also talked about the role and risks of traditional medicine and healing, and of the struggle to put patient safety on the agenda in countries that lack outspoken consumer organisations and have either a government controlled media or completely unregulated media that airs unchecked claims of medical cures and alarms.

“Systems evolve in cultural contexts….you can’t take a model and just imprint it around the world,” said session chair, Dr Vivian Lin from the World Health Organisation’s Western Pacific Office.

“By understanding the diversity of history, culture and political systems, all the regulators can learn and be more reflective about why things work in some places and not in others.”

Focus on Africa

Mungherera provided the context for challenges to medical regulation in Africa: with 11 per cent of the global population, it accounts for 40 per cent of women who died from childbirth related conditions and 67 per cent of HIV patients.

She said widespread and ongoing conflict is one of the big issue from outside of the health sector that impacts on regulation – “of our 54 nations, we have 7 countries coming out of conflict, 7 countries in conflict, and 7 about to go in conflict”.

She listed other issues: poverty, unregulated traditional and complementary medicines, corruption, an unregulated media (often reporting ‘cures’ without evidence), a public unaware of its rights, and its “human resource crisis”. “I’m not talking numbers, but quality and motivation of health workers. “

“You lose the highly qualified health professions, the academics who are supposed to be the ones in charge of policies of medical schools, training and mentoring of young professionals,” she said. “It has definitely affected the qualify of (medical) education.”
There is good news, she said. “We have hope, determination.” And there have been recent alliances built between regulators and other medical stakeholders.

But she said too many medical schools and doctors think regulation is there “to improve their lives” and self regulation lessens the quality of training on human rights and ethics.

Stronger medical education is also needed, Mungherera says, to address the lack of patient autonomy for women in countries where they have little stature and fewer rights.

“We need to get health professionals to understand that patients are autonomous, whether they are wives or daughters. Some health professionals tend to consult with husbands about care, talk to them before the patient themselves,” she said.

“That needs a lot of training, not just in medical schools but through continual professional development.”

And she said, it is time for better African leadership. It’s a call she made in 2014 as WMA President in response to slow local responses to the Ebola outbreaks. She said then:

“Developing leadership capacity should therefore be the main emphasis of any effort aimed at to strengthening health systems and reducing Africa’s disease burden.”

At the conference she quoted a Malawi proverb:

**Western Pacific**

Dr Vivian Lin also reported back to the conference on a regional workshop held in Melbourne in the days before for the WHO West Pacific region, which includes the ASEAN nations, Australia and New Zealand and stretches from Mongolia to the Pacific Islands.

Lin said it was clear the region needs a “paradigm shift” in medical regulation – pointing to the lack of investment in China, which has eight million doctors but only three people in the national body responsible for policy and regulation.

She welcomed having the IAMRA conference in the region – opening up awareness for many regional delegates of regulatory issues and practices.

Lin said the region faces huge challenges on the “demand side”: a rapidly ageing population, a non-communicable disease “crisis” in the Pacific nations, some of the highest suicide rates in the world (particularly for women in China), and a growing middle class with rising expectations.
Alongside that, many countries have a tradition of respect for authority, compliance to government and doctors, and an unwillingness to speak up about unhappiness with the system until grievances build up, with rising violence against health workers in countries like China and Vietnam.

Due to poverty, conflict and other issues, many health systems are not well designed and still operate in the era of ‘walk in walk out’ acute care. There is little primary health care and the dominance of hospitals has led to perverse financial incentives for hospitals and doctors overserving to earn revenue, while only 11 countries have explicit medical accreditation systems.

Regulation strength varies enormously across the region, she said, with Western style models in former British colonies while others are dominated by the profession. Others are government run, where “professionalism has yet to develop because it’s not really in the traditional culture.”

The WHO’s most important objective, she said, is to achieve universal health coverage in all countries, providing affordable access to quality health services.

“We need a regulatory system that can assure its safety,” she said.

**Traditional healing**

The session, and other parts of the conference, also talked about the ongoing challenge to medical regulators of traditional medicine and healing.

Lin noted that 15 years ago Victoria became the first jurisdiction outside of China to regulate Chinese medicine, and the profession is now fully regulated by AHPRA. Countries like Korea and Taiwan have separate licences, while Japan has a more integrated system, where doctors can specialise in traditional medicine as part of their degree.

Lin pointed to many risks with untested traditional healing practices such as in the Pacific where herbs are used to treat diabetic patients have resulted in infection and many amputations.

But she said regulators had to appreciate that traditional medicine is “a form of primary health care” in many nations. What’s needed, she said, is regulation.

Mungaherera agreed: “(Traditional healers) are better communicators than us, they know the social and cultural issues. But it has to be evidence-based, we have to make sure of public safety because we do have quacks.

“It must be regulated because, if anything, it is the health care we know (in Africa), everything else is foreign! People respect it more than they do Western medicine.”
From the Twitterverse

More coverage of the session, *Global challenges in medical education and professional regulation.*

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**From Uganda to China, how do the global challenges of medical regulation vary?**

You can track Croakey's coverage of the conference here.

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From Uganda to China, how do the global challenges of medical regulation vary?

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Healthcare regulators urged to give patients a greater stake

Poster from New Zealand: Potential of restorative approaches to complaints

Marie McInerney writes:

Consumers who lodged complaints about doctors to Australia’s healthcare regulators were “generally unhappy” about the process because they were seen and treated as an “informant” rather than a participant with a stake in the outcome, according to new research findings.

Professor Merrilyn Walton, the former head of New South Wales’ Health Care Complaints Commission, and members of her team presented interim findings of the research at the 12th International Medical Regulation Conference in Melbourne.

The research and other reviews have already led to changes in Australian Health Practitioner Regulation Agency (AHPRA) processes, and will strengthen calls for national law reform to enable complainants to be given more information about the results of their complaints.

Croakey has been asked to not include specific figures until the research publication, expected in early 2017, but Walton said generally complainants reported that the processes were too slow, they didn’t get enough information, and the outcomes were way short of what had been expected, if they got to hear about them at all.

“Of those (the majority) that don’t continue on to some formal serious outcome, the complainants don’t understand why, they’re not given that information, there’s no transparency around the decision making,” she said.
The in-depth study is one of five research projects being conducted by Walton and her team at the University of Sydney, funded by an Australian Research Council Linkage Grant in partnership with AHPRA and two New South Wales bodies that manage complaints in that state: the Health Professional Councils Authority (HPCA) and the NSW Health Care Complaints Commission.

It has taken place in the context of major scrutiny of Australia’s regulation system (see the slide at the bottom of this article).

The much-awaited consumer research surveyed every complainant or notifier whose cases were completed by those bodies between 1 July 2013 to 30 June 2014. They were asked about their expectations and experiences, why they had made their complaint, what happened, and what they would like to see changed about the process.

For confidentiality reasons, complainants were invited to join the survey by the agency involved, but were able to respond directly to the researchers if they preferred.

**Whose stories are being heard?**

Walton, who is Professor of Medical Education (Patient Safety) at the Sydney School of Public Health at the University of Sydney and a member of AHPRA’s management committee, said the issue is not confined to Australia.

Most medical regulation systems across the globe were designed so that consumers or complainants “step aside” once a complaint or notification is received, while the medical practitioner remains more fully involved, she said.

“They were just generally very unhappy about the little information they were provided, the outcomes they would expect but didn’t receive, but also they think that the weight of their story, the narrative of what happened to them, wasn’t a major consideration,” Walton said.

The findings underlined similar issues raised at other sessions at the conference that consumers often felt their issues were “ unanswered or unaddressed” and ongoing accusations that regulators act more often to protect the profession than the public.

One presentation heard that the disconnect can just come down to medico-legal terms. The Northern Territory Board of the Medical Board of Australia reported on its analysis of “No Further Action” findings to complaints, which account for about 70 per cent of cases.

Some may follow serious investigation and may have already involved education, training and/or internal restrictions for the practitioner, but they are read as “No Action At All” by consumers, Board Chair Dr Charles Kirkland told delegates.

**Shifting the balance of power**

Walton said the research team had been providing the results as they came in to the regulators, which were already taking steps to resolve issues, such as speeding up resolution of complaints. However, much of what they can reveal to complainants is currently restricted by law.

AHPRA Chief Executive Martin Fletcher told Croakey the research would point the way to additional reforms, but he said AHPRA had already made improvements in the years since the processing of the complaints that were studied as part of the research.
These improvements included tracking feedback from consumers through the process, the pilot of a Notification Liaison Officer in Victoria (which may be rolled out nationally), the establishment of a Community Reference Group, and setting out recommendations to Australia’s Health Ministers on law reform so complainants can be given more information.

“It’s often very important to have a front-end conversation with a notifier, to clarify what they are expecting and what we can do as a regulator,” he said. “We’ve not solved the whole problem but we’ve made good progress.”

The conference heard that national regulators have varied but increasing public and consumer representation on their boards – ranging from 4 out of 28 on Hong Kong’s regulator, to making up one-third in Canada, and a lay majority in Ireland.

But Walton said the role of consumers in the complaints process is lagging behind the huge changes seen in the role of consumers in health care over the past five to ten years, where most parts of the system recognise the importance of engaging patients not only in their own health care but in broader systems improvement.

Walton said the early question to emerge from her work was: How does Australia’s medical regulation system shift so it gives equal weight to the narrative and experience of complainants as it does to medical service providers?

**Motivated by concern for others**

Presenting a breakdown of the research, PhD candidate Suzanne Pierce said most complaints were about care and treatment (such as that it was inadequate, or diagnoses were wrong), followed by conduct (aggressive, unprofessional, inappropriate), medication, and then about responses to first complaints – often none or hostile.

Interestingly, and this too was a common theme at the conference, the research found that most people made formal complaints because they felt what happened to them was wrong, unfair, unjust or unsafe – but also because they wanted to make sure it didn’t happen to someone else.

They were not only looking for specific redress for the practitioner involved – such as disciplinary action, supervision and monitoring – but also to influence system change, including where some thought the practitioner was rorting the system. And what they most wanted for themselves was an apology, acknowledgement, and explanation.

The reality was far different: the majority did not believe or did not know whether their issues were addressed (around 60 per cent of complaints resulted in ‘No Further Action’), nor whether they had resulted in any improvements to practice or the system.

If there was an apology, it was often considered not sincere or sufficient, or that it came from “someone else”, not the practitioner in question.

Walton said the next step will be to consider recommendations, such as: “Do we show them the doctor’s reports, do we have face-to-face interviews, how do we involve them in an investigation and, at the end of it, what role do they have in terms of restorative justice?”
Inviting complainants to present

The conference also heard of initiatives in other jurisdictions trying to address similar issues, including where there is face-to-face contact between complainants and the General Medical Council in the United Kingdom at the beginning and end of an investigation.

GMC chief executive Niall Dickson told the conference these initiatives have been “an enormous success”, although he hinted to unhappiness with the results of investigations by observing that the meetings at the start were “fantastic”, and those at the end “slightly less so”.

Kathleen Haley, Executive Director of the Oregon Medical Board in the United States, described a “wake up call” it had got 20 or so years ago, when a gynaecologist had been found to have sexually violated more than 100 patients. The Board invited all of the patients to come in, at their convenience, and tell their stories. Many did.

“From that point on, whenever there is an issue of credibility, whether it be sexual misconduct or something else, one of these ‘he said she said’ issues, we invite the complainants to come in and tell the Board their story,” she said.

It’s been, she said, both moving and effective although she said the board probably lacked the resources to expand that to broader complaints.

Haley said her Board was also constantly revising its communication tools, to see if they were “patient friendly”.

But the whole basis of regulatory communication may have to change, according to Alan Kirkland, CEO of CHOICE, who talked at another session about consumer frustrations with systems that are still based around written complaints and lengthy legal processes.

It is counter to the way that consumers expect businesses these days to respond to complaints, he said.

“They want much more human engagement, and that’s going to be an enormous challenge for complaints regulators,” he said.
Towards proactive medical regulation – preventing fires as well as putting them out

Marie McInerney writes:

Earlier this year the United Kingdom’s medical regulator took the “nuclear threat option” and threatened to remove junior doctors – who make up one-third of staff – from a leading London hospital if it did not address concerns about under-staffing and risks to patient safety.

The move forced the North Middlesex University Hospital Trust in London to inject a “huge input of resources, borrowing staff from other hospitals, to try to deal with the crisis that could have caused harm to patients”, Professor Terence Stephenson, chair of the General Medical Council (GMC), told the 12th International Medical Regulation Conference.

The GMC has now put almost 80 sites under what it calls its “enhanced monitoring system”. This means “undertaking active monitoring of the trainee environment to ensure they and patients are being kept safe”, according to a spokesman. Here, for example, is its notification about concerns with the Emergency Department at the North Middlesex University Hospital Trust.

UK media have reported the move as part of efforts to prevent a repeat of the Mid Staffordshire scandal in which shocking standards of care in the early 2000s resulted in hundreds of patient deaths and “appalling and unnecessary suffering”.

Media reports said the GMC had put hospitals on notice this year after “finding alarming levels of bullying, handover systems so poor that desperately ill patients got ‘lost’ and left at risk of serious harm during weekends, unmanageable workloads and bed shortages in intensive care.”

They quoted GMC chief executive Niall Dickson as saying: “We are here to protect patients, not doctors… We are not part of the medical establishment, as we might have been seen in the past.”

Speaking about the action against the North Middlesex University Hospital Trust, which had argued that the GMC couldn’t “use the trainee tail to wag the system dog”, Stephenson told the conference: “We said we had ‘the nuclear threat option’.”

He was speaking during a plenary session on risk-based regulation, which discussed growing (but contested) moves by regulators to use research and data so they are not just responding to unsafe practice or casting their prevention work too widely, but can predict risk and prevent harm in the first place.
It’s also known, session chair Dr Anna van der Gaag quipped, as: “Find the doctor before the lawyer does”.

The session also heard from research being done by Dr Marie Bismark, as part of a risk-based regulation collaboration with the Australian Health Practitioners Regulation Agency (AHPRA), that identified past behaviour as a major predictor for future complaints, and tracked different impairments in doctors across their lives and careers.

Digging deeper into coronial data as part of the collaboration, Bismark also published research recently in the Medical Journal of Australia showing that the risk of dying by suicide for women working in medicine was more than twice that in other professions (more about her work follows below).

Stephenson explained that the GMC differs from many other national regulators – and therefore had greater fire power in its move against the North Middlesex University Hospital Trust – after taking on responsibility for the quality of training of junior doctors in 2010 in the wake of the Mid Staffordshire scandal.

He outlined three examples where the GMC uses the “shed loads” of data gathered from its annual survey of around 55,000 postgraduate and undergraduate trainees, which attracts a response rate of around 95 per cent and is the biggest training survey in the world.

He said medical trainees are the “canaries in the coal mine” for health care – their experiences acting as red flags to system or team failures.

Stephenson said the GMC last year launched a “very targeted proportionate intervention” in 12 different hospitals – six departments of surgery and six of obstetrics and gynaecology – in response to “persistent, egregious” reporting by trainees of bullying and harassment. See some case studies here about the action, and more about the way the GMC gathers risk information.

He said: “All the evidence shows us that departments where there is bullying and harassment are dangerous for patients and bad for doctors so we went into those, in partnership with hospitals, to try to prevent this deteriorating situation where either harm would come for patients and doctors and there would be ‘fitness to practice’ issues.”

A third example was where the GMC provides a “Welcome to the UK Practice” free half-day learning session to help doctors new to the UK to understand cultural and ethical issues in practice. It was, he said, preventive action that should be the responsibility of hospitals.

“But if they’re not doing it, we will,” he said. “A cent spent on prevention is worth a dollar spent on cure.”

Not a crystal ball

While some regulators like AHPRA have adopted risk-based regulation as a guiding strategy, concerns were expressed at the conference about it being a “probabilistic model” that risks antagonising huge numbers of medical practitioners with the “false positives”.

Responding to such concerns, Dr Marie Bismark, from the Centre for Health Policy at the School of Population and Global Health at Melbourne University, said she looks on data as “a red flag, not as a crystal ball”.

She said an understanding of risk factors can “help to triage notifications (and) identify practitioners and notifications that merit a closer look.”
She pointedly compared risk-based regulation with other screening programs “that doctors are very familiar with”, such as for cardiovascular conditions and bowel cancer. Equally, she said, there was “no point doing it unless we have an evidence-based intervention that will make a difference.”

Bismark outlined three case examples from her research work, which is being funded by AHPRA and the National Health and Medical Research Council, to illustrate the benefits of using data to “confirm intuitions, dispel myths, and reveal the unknown”.

She said analysis of 19,000 patient complaints in Australia shows that around three per cent of doctors account for 49 per cent of complaints.

“So Gerry Hickson [a US expert on poor physician practice] is right: there is a medico-legal cloud over all doctors, but it certainly rains more heavily on some than others,” she said.

The study is confirming the now accepted evidence that older male medical practitioners, and particularly surgeons, are most likely to attract complaints from patients or their peers.

But Bismark said that one other factor predicts complaints more than any other: past behaviour.

After two years of follow up, a doctor with one previous complaint has around a 20 percent chance of another complaint. By five years, it’s 40 percent. After two years of follow-up, a doctor with five previous complaints has around an 80 percent chance of another complaint. By five years, it’s more than 90 percent.

Bismark said her second example busts the myths put forward by some that the introduction of mandatory reporting of concerns about doctors in Australia “would open the floodgates” to nurses, midwives and other practitioners unfairly levelling accusations of poor practice.

She quoted one doctor who wrote to a newspaper to express his indignation:

*I liken a nurse reporting a physician to someone who plays a little chess deciding to report to authorities the likes of an international grand master for their choice of opening moves*.

Rather, she said, her analysis of more than 800 mandatory reports found that nurses are more likely to make reports about other nurses, doctors about other doctors and so on.
In fact, she said, inter-professional reports are so rare that there should be concern that “even though nurses are very well placed to be able to identify poorly performing doctors, there appear to be significant barriers to coming forward to regulators with those concerns”.

Her final case study was to illustrate the importance of digging deeper after preliminary analysis of AHPRA data found very little difference in the level of notifications of physical or mental impairment, including substance abuse or dependence, between older and younger doctors.

When researchers looked more closely, they found “strikingly different” patterns of health impairment concerns along the life course: with mental health issues dominating the picture among new graduates, moving to a pattern of alcohol and drug misuse in middle age, and then, finally, a “sharp increase” in cognitive decline and physical illness over the age of 65.

**Focus on bullying and discrimination**

In response to a question, Bismark said that potential links between patient complaints and concerns with bullying, harassment and discrimination in the health professions was “a really ripe area for exploration” by regulators in the context of patient safety.

In separate sessions, the conference delegates heard of work being done by the Royal Australasian College of Surgeons after an expert review found discrimination, bullying and sexual harassment were rife among surgeons in Australia and New Zealand, as well as a culture of fear and reprisal that made it “career suicide” to make a complaint.

RACS CEO David Hillis said the organisation was getting some “push back” from hospitals and its fellows against the Action Plan it has launched to drive cultural change in the profession, saying he still often hears comments that trainees in particular have to “toughen up”.

“I’d say it’s the consultants who need to learn how to cope with the stress and their workload,” he said, adding that major cultural deficits are a link between revelations about the profession in Australia and New Zealand and medical scandals like at MidStaff in the UK.

The RACS review was sparked by the revelations of Melbourne neurosurgeon Caroline Tan whose career was derailed after she spoke out about sexual assault. It revealed “a profound lack of leadership and ownership” of the problem and little confidence that medical colleges, universities, hospital human resources departments or medical regulators would address it, Hillis said.

“I get confronted by outright denial or grief reactions from members of the medical profession who say ‘it doesn’t happen in my patch’. But it does, and it particularly occurs in surgery,” he said.

He acknowledged that it’s very difficult for senior clinicians to learn how to take a stand: “You spend 30 years walking past it, how do you suddenly say to your colleague, ‘You can’t say that, that’s sexual harassment’.” But he said role modelling has a profound impact.

The RACS vision for change is not only a commitment to a safe workplace and learning environment for the profession, but that every patient has a right to expect their health care is not being compromised by discrimination, bullying and sexual harassment, he said.
The RACS announced last week that it had signed its first Action Plan agreement with a tertiary education partner – the University of Otago Medical School in New Zealand. Health organisations committed to the plan so far include Ramsay Health, Monash Health, St Vincent’s Health and Metro South Health in Queensland.

**Prevention, partnership and problem solving**

Chairing a session on risk-based regulation, Dr Anna van der Gaag, Chair of the UK’s Health and Care Professions Council, recalled a rallying cry from Harvard University’s Professor Malcolm Sparrow at the 2014 IAMRA conference, when he urged delegates to think beyond the “traditional style of enforcement” in regulation.

Instead of being reactive, adversarial and incident-driven, he urged prevention, partnership and problem-solving to find more innovative forms of risk reduction and harm prevention.

AHPRA CEO Martin Fletcher said Sparrow had been hugely influential for AHPRA’s work on becoming a risk-based regulator, trying to move from “just holding rich data” to actually learning from it, while respecting how sensitive it is. That has led APHRA to invest in staff skills not traditionally held by a regulator: in statistics, epidemiology, research and maths.

Van der Gaag said most regulators were more comfortable with traditional approaches: setting standards, keeping a medical register, and investigating complaints.

“But there is much less focus by us on the impact of complaints on those who are involved, why they arise in first place, what can be done to prevent then, and indeed why there are fewer complaints from certain groups…the young, old, and people with disabilities,” she said.

“*Are we like firefighters in the station waiting for fires to break out, or working with our communities to reduce the risk of fire breaking out in first place?*”

See also Marie Bismark’s blog post from the 2014 IAMRA conference on the seven qualities of highly effective regulators.

These are: 1. Clarity about purpose; 2. Agility to use the right regulatory tool for the purpose; 3. Trustworthy; 4. A willingness to question, a desire to learn, and an openness to new evidence; 5. The humility to recognise that none of us operate alone, that there is much to be learnt from others, and that there are some problems that regulation alone cannot solve; 6. The ability to make fair, independent and unbiased decisions; 7. Proactive – they look upstream for opportunities to prevent harm before it occurs.
More reports from the Twittersphere

**RACSurgeons @RACSurgeons · 22h**
Panel discussion on ensuring an accessible & non-retaliatory complaints/ feedback process. #IAMRA2016 @AHPRA

Graeme Campbell and Cathy Ferguson

**RACSurgeons @RACSurgeons · 23h**
Cathy Ferguson FRACS addressing #AMRA2016 on discrimination: "The standard you walk by is the standard you accept"

**Humayun Chaudhry @FedMed1 · 20h**
Dr David Hills: Knowles Report (2015) said "teaching by humiliation in medical education is widespread" #AMRA2016

Towards proactive medical regulation – preventing fires as well as putting them out #IAMRA2016

“Conference News Service”
Towards proactive medical regulation – preventing fires as well as putting them out #IAMRA2016

**Katr Leslie @katy_skier · 22h**
Low empathy narcissistic behaviour is a system problem that can be changed #IAMRA2016 @RACSurgeons

**David Hillis @dhillis1957 · 22h**
Change the systems in health both in VIC and elsewhere #IAMRA2016 @RACSurgeons @JillHennessyMP @GortonM

**RACSurgeons @RACSurgeons · 20h**
David Hillis on key components of tackling discrimination: Respect, reflection, resilience, relationality, relentless leadership #IAMRA2016

**Cathy Ferguson @cathymferguson · 20h**
Physician behaviour - Concept of the regulator as the guard dog and the College as the guide dog #IAMRA2016 @RACSurgeons

**Catherine Hughes @_CateHughes · 20h**
No innocent bystanders - but how to start standing up to what you’ve spent years learning to walk past? #IAMRA2016

**RACSurgeons @RACSurgeons**
Cathy Ferguson FRACS addressing #IAMRA2016 on discrimination: “The standard you walk by is the standard you accept”
Focus on listening

You Retweeted

Joel Kirsh @joelakirk - 4h
Terence Stephenson of @gmcuk explaining importance of trainee surveys in focusing regulators’ attention #IAMRA2016

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Marie McInerney @mariemcinerney - 4h
We tell medical students to listen to patients on health, we say listen to trainees on hospital systems: UK #IAMRA2016

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Catherine Hughes @_CateHughes - 4h
Are we looking at data on how OHS treat each other - any correlation between bullying behaviours and risk of patient complaints? #IAMRA2016

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Catherine Hughes @_CateHughes - 4h
Key tip of the day: listen - people are telling us where problems are if we could only hear. #IAMRA2016

Marie McInerney @mariemcinerney
We tell medical students to listen to patients on health, we say listen to trainees on hospital systems: UK #IAMRA2016
Watch these leading experts discuss the latest issues in medical regulation and patient safety

Nearly 500 people from more than 40 countries attended the 12th International Conference on Medical Regulation in Melbourne.

You can watch Croakey’s interviews with some of the presenters and delegates at the conference in the post below and track our coverage of the conference here.

**Dr Vivian Lin** talked to Croakey about the global and regional challenges in medical regulation, with a focus on social, political and cultural issues across the Western Pacific region.

Lin is Director of Health Systems at the World Health Organisation’s Western Pacific Regional Office. She said the region needs a “paradigm shift” in medical regulation to face big challenges on the “demand side” (including a rapidly ageing population and non-communicable disease “crisis”), undeveloped primary care, issues with traditional healing, and a tradition of respect for authority that can stop poor practice being addressed.

Here’s our conference report on the session where she spoke.

**Dr Gyikua Plange-Rhule** from the Medical and Dental Council of Ghana talks about the issues facing regulators in her country, including traditional healing concerns and workforce shortages that mean rural communities think “it’s better to have a bad doctor than no doctor at all”.

A paediatrician who studied law after getting involved in medical regulation, she said that if she had a bucket of money, she would spend it on better medical education and lifelong professional development.
Sydney University School of Public Health Professor Merrilyn Walton talks about research into consumer expectations and experiences in Australia’s medical regulation system.

The in-depth study, that has already informed change at the Australian Health Practitioners Regulation Agency, found consumers who lodged complaints about doctors were generally unhappy about the process because they were seen and treated as an “informant” rather than a participant with a stake in the outcome, including bringing about broader system improvement.

You can also read our story about the research.

Canadian regulator Dr Heidi Oetter, Registrar of the College of Physicians and Surgeons of British Columbia, talks about the implications for medical regulation of Canada’s landmark Supreme Court ruling that legalised medically-assisted deaths. She also discusses medical regulation in relation to cultural safety issues in health care for the First Nations, Inuit and Métis people of Canada.

Dr Margaret Mungherera is Vice Chair of the Uganda Medical and Dental Practitioners Council and former President of the World Medical Association, the first African woman to hold the position. In that role, she helped to fight moves by Uganda’s President to force doctors to inform on gay patients.

She talks here about the range of social, political and cultural challenges in Africa for patient safety and sustainable health care. Dr Mungherera was elected the chair-elect of the International Association of Medical Regulatory Authorities, to take up the role in 2018.

You can also read our story here on the global challenges session at which she presented.

Quickchat: Fleur-Ange Lefebvre, Chief Executive Officer of the Federation of Medical Regulatory Authorities of Canada, reviews Day 1 at IAMRA2016.
Quickchat: **Kieran Murphy**, Past President of the Medical Council of Ireland, talks about regulatory issues in Europe, Ireland and the UK, and a session he chaired on ‘health, impairment and fitness to practice’.

Quickchat: **Kathleen Haley**, Executive Director of the Oregon Medical Board, talks to Croakey after addressing a plenary session on ‘What keeps me awake and the challenges ahead?’ She talks about what her Board has done to try to “hear the stories” of patients in some complaints processes, sparked by a wake-up call when one practitioner sexually abused 100 patients.

Quickchat: Incoming chair of the International Association of Medical Regulatory Authorities (IAMRA) **Dr Humayun (Hank) Chaudhry**, a graduate of the Harvard School of Public Health, talks about his priorities for medical regulation.
Calls for a regulatory crackdown on the “wild west” of cosmetic surgery. Plus, how is medically assisted death working out in Canada?

Cosmetic surgery is the new “wild west.”

Slide shown by Dr Tim Papadopoulos at the conference

Concerns about the safety and quality of cosmetic surgery were highlighted at the 12th International Medical Regulation Conference.

Another issue flagged during a session on emerging issues for medical regulators around the world was the implications of a landmark Canadian Supreme Court decision in 2015 to legalise medically-assisted deaths.

Journalist Marie McInerney reports below on the “emerging issues” session.

Marie McInerney writes:

Cosmetic surgery in Australia is “the new wild west”, leaving a trail of victims who are scarred for life, according to a leading Australian specialist plastic surgeon.

Dr Tim Papadopoulos called for Australian authorities to stamp down on inadequate regulation that allows any registered medical practitioner to describe themselves as a cosmetic surgeon when they may only have done a weekend course in breast implants.

“Patients are screaming out for help,” he told the conference in a presentation titled: ‘Bad things happen when good people do nothing: how unscrupulous exploitation of loopholes harmed unsuspecting patients in 2016’.
“The botched jobs, shattered dreams and the trail of destruction is fixed by plastic surgeons with the taxpayer picking up the tab,” said Papadopoulos, who is President of the Australasian Society of Aesthetic Plastic Surgery (ASAPS) and a member of the Australian Society of Plastic Surgeons.

 Asked whether such comments could be seen as turf protection by plastic surgeons, Papadopoulos said such accusations are “a very convenient distraction to gloss over the appalling lack of basic patient safety”.

“What we’re trying to do is protect the public from improperly trained, self-regulated GPs who do not have the appropriate knowledge, experience, nor skills to perform surgery at such a high level,” he said.

His comments follow growing public and regulator concern over risks to public safety, including from so-called “backyard beauticians” who perform cosmetic surgical procedures in homes or hotels.

Former NSW Health Care Complaints Commissioner Professor Merrilyn Walton, who chaired a New South Wales Ministerial Inquiry into Cosmetic Surgery more than 15 years ago, has written of concerns that cosmetic surgery is not a recognised branch of medicine, so operators are only required to have a general medical degree.

Papadopoulos outlined three cases of concern, including one that prompted the Health Care Complaints Commission to issue a warning of a “real risk to public health and safety” from non-registered practitioners who advertise through social media platforms and perform cosmetic surgery service in facilities with little, if any, infection control measures.

The Commission outlined the complaint from a woman who underwent a double eyelid suture procedure in a Sydney apartment, saying:

*The treatment caused bruising and scarring to the patient and damage to her eyelids. The Commission’s investigation has so far determined that the practitioner who carried out the surgery is not registered as a medical practitioner in Australia and was not qualified to conduct the surgery. Upon executing a search warrant at the premises, Commission staff located a number of prescription-only medications that had been illegally imported into Australia. This included Botulinum toxin (Botox) and hyaluronic acid injection preparations (Dermal fillers).*

The practitioner was later banned, and NSW Health urged her customers to see their GP for blood tests because of the risk of infections for blood borne viruses.

Papadopoulos also referred to a tragic 2013 case – the death of a 75-year-old nursing home resident following liposuction stem cell procedure to treat dementia.

In its investigation, the New South Wales Deputy State Coroner said the case bore “some of the troubling hallmarks of “quack” medicine: “desperate patients, pseudo-science and large amounts of money being charged for unproven therapies”.

Papadopoulos welcomed new laws announced in New South Wales in June that will require cosmetic surgery to be performed in accredited and licensed facilities. But he said more still needs to be done.

He is particularly concerned that practitioners should not be able to operate and describe themselves as cosmetic surgeons unless, like him, they had completed surgical training equivalent to that required for fellows of the Royal Australasian College of Surgeons.
Currently, he said, GPs can do just a weekend course or workshop in cosmetic surgery.

“Almost anything goes,” he said. “We must impose stronger regulation over who can perform surgical procedures and drive unscrupulous and dangerous operators out of the profession.”

The Medical Board of Australia earlier this year issued guidelines on cosmetic medical and surgical procedures that include cooling off periods for adults and minors (including a mandatory evaluation by a psychiatrist, GP or psychologist for under 18s), and a requirement for emergency facilities when sedation, anaesthesia or analgesia are used. They come into effect on 1 October.

Asked by Croakey about the concerns raised by Papadopoulos, a spokeswoman for the Board pointed to detailed discussion on the issue on page 24 of the Regulation Impact Statement and said it regulates by title and not by scope of practice. She said the recognition of a speciality comes via a detailed Australian Medical Council process, with recent examples including sexual health medicine and sports medicine.

“The Board reviews all policies, codes and guidelines on a 3-5 year schedule and we will consider whether the new (cosmetic surgery) guidelines have been effective in better protecting patients in the context of that scheduled review,” she said.

Medically assisted death in Canada

Dr Heidi Oetter says the introduction of medically assisted death for terminally ill people in Canada is the biggest social change she expects to see in her lifetime.

Yet the head of the College of Physicians and Surgeons of British Columbia says authorities have managed to “navigate the regulatory framework quite seamlessly” since February 2015, when the Supreme Court struck down the country’s law that banned doctor-assisted death.
That’s not to say that there is not continuing controversy around the laws. Some critics say they don’t go far enough and will prevent people with degenerative conditions, such as multiple sclerosis, from seeking assisted suicide. Others, including individuals and religious groups, remain totally opposed and have launched legal challenges.

Dr Trevor Theman, Registrar of the College of Physicians and Surgeons of Alberta, told the conference that polls show around 70 per cent of Canadians are in favour of the new laws. Surveyed doctors had expressed similar levels of support on the right as individuals to have assisted death, but were less ready to be the one to assist a patient’s death, he said.

A 2015 survey of 1,400 doctors by the Canadian Medical Association found 29 per cent of its members would consider providing “medical aid in dying” if requested by a patient, but 63 per cent would refuse. However, around 70 per cent supported their own right as individuals to choose medically assisted death.

The Supreme Court’s landmark Carter decision, as it is known, makes Canada one of the few countries that permits assisted death, alongside Switzerland, the Netherlands, Albania, Colombia and Japan, and some states of the United States.

It gave the government 12 months to amend Canadian laws to implement the decision.

Media reports say that more than 100 Canadians, including novelist WP Kinsella, have died with the assistance of medical practitioners since the new law took effect in June.

In its ruling, the Supreme Court declared that the previous prohibition on assisted death:

...deprives some individuals of life, as it has the effect of forcing some individuals to take their own lives prematurely, for fear that they would be incapable of doing so when they reached the point where suffering was intolerable. The rights to liberty and security of the person, which deal with concerns about autonomy and quality of life, are also engaged. An individual's response to a grievous and irremediable medical condition is a matter critical to their dignity and autonomy."

The Court explicitly said its ruling would not “compel” physicians to provide assistance, but said that the constitutional rights of patients and physicians would need to be reconciled.

Oetter said regulators had spent the last year developing professional standards to comply with legislation and also the professional and ethical expectations of physicians who would be involved in assisted death or were going to be conscientious objectors.

“We’ve been very clear with physicians that even if they may have moral or other objections to providing assistance in dying they have an obligation to their patient to make sure they have enough information to make an informed decision about their health care,” she said.

“Most importantly, they must not abandon their patient or ask the patient to justify their belief or impose their own belief systems on patients,” she said.

She said laws refer to medically assisted death to recognise that healthcare is not just provided by physicians, and to therefore guide and protect the role also of nurses, pharmacists, and family members who support the decision.
“It hasn’t been a difficult process,” Oetter said, saying all relevant agencies had come together to work on the landmark changes. “It wasn’t being for or against medical assistance in dying: it was about what is in the public interest, what does patient safety look like and what kind of ethical and professional standards do we bring to that?

“We kind of got it right in a short period of time,” she said.

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Calls for a regulatory crackdown on the “wild west” of cosmetic surgery. Plus, how is medically assisted death working out in Canada?
In the brave new world of medical regulation, there are many questions to be answered

Humayun Chaudhry talking about the future of medical regulation

Some of the complex and pressing issues facing medical regulators around the world are profiled in Marie McInerney’s final report below.

Marie McInerney writes:

Four years ago, former Radio National broadcaster Julie McCrossin was working together with senior federal health department executives at an international health forum in Canberra that she was helping to facilitate.

Two days later, she found herself unable to speak. This was due to a traumatic intubation during a biopsy that confirmed she had stage four throat cancer.

Now in remission, McCrossin shared her story with conference delegates to make the point to regulators and others involved in the health system that it is “absurd” to talk about “them” and “us”.

“Any one of us can slip through that membrane (to become the patient),” she said, launching an intense interactive session challenging regulators to say what action would be needed, where they lived, to ensure they would get safe, quality health care if they were the patient.
It was a session designed to ask as many questions as it answered, but it prompted the ready admission from UK General Medical Council chair Dr Terence Stephenson that most doctors know “who they wouldn’t want to be treated by” – who they wouldn’t let treat family or their dog.

“I’ve always been troubled that the public doesn’t know that,” he said.

For many of the delegates, it was access to information about the practitioner and the treatment that they would be after.

But even if we did have more transparency of data and health information, McCrossin asked, how do we ensure the very vulnerable are “deadset safe”? What about those with low health literacy, who aren’t fluent in the main language where they live, who lack a sense that they have any agency or power, who live in more remote areas, and are often very sick, she asked.

And, said New Zealand GP Dr Jonathan Fox, the value of information about the practitioner and the treatment that they would be after.

He asked: “What about the patient who doesn’t have choice?”

**Improving complaint processes**

At the start of the three-day conference, organisers polled the nearly 500 delegates at the conference on what keeps them awake at night.

The results were reported back on the final day.

Over half of those who responded said they worried whether or not regulation was protecting the public adequately. About a quarter worried about “things I don’t know”, practices and behaviours of doctors that they didn’t know about, or not having enough “intelligence” to be effective.

One in five worried about making the wrong decision – either failing to protect a patient or harming a doctor by putting them through an unnecessary complaints process.

The findings underlined what one presenter described as a “weakness in the current system” – that the process can be a negative experience for both the practitioner, who feels stressed, and unfairly or unjustly subjected to a notification, and the patient, equally often very vulnerable and stressed, who feels the regulator “protects its own”.

The conference heard about new approaches put in place by the General Medical Council in the UK to balance public safety with the needs of ill or vulnerable doctors, after a review of cases found that up to 28 doctors had died by suicide between 2005 and 2013 while being investigated by the GMC.

The review showed that many of the doctors who suicided suffered from a recognised mental disorder, most commonly depressive illness, bipolar disorder and personality disorder, while a number also had drug and/or alcohol addictions.

The GMC’s Anna Rowland told the conference that mental health specialist Professor Louis Appleby had been enlisted to identify what changes could be made to GMC processes. Croakey readers can find out more here about those changes, including recognition of the need to act earlier, more sensitively and to focus better on treatment.

Rowland said the aim was to provide “sensitive handling” while ensuring patient protection.
There were also many discussions on how to make the system work better for patients and other complainants, including adopting restorative justice processes that put patient and practitioner in the same room to come to an understanding and response – “a move from a reporting system to a learning system”, as one presenter put it.

Currently regulators in Australia are restricted in what they can tell patients about an investigation but one session discussed whether even just warmer communications, thanking them for their complaint and saying that it may not have resulted in punishment but that it would help to improve practice or systems, might make a big difference.

**More voices in the room?**

US regulator Kathleen Haley, CEO of the Oregon Medical Board, told a plenary session that one issue that “snaps my mind awake at 3am” is the makeup of her board, which she thinks of as “a big dinner party”.

She worries: *Are they the right people at the table? Do they come from diverse backgrounds of experience and geographic place? Do we have the right tools? Do we mentor members who are brand new?*

Most regulatory boards now have public and consumer representatives, but one speaker recalled a leading regulator being aghast not so long ago at the very notion, before being slightly mollified by the thought that it would be acceptable, “perhaps if they had a PhD”.

Interesting questions were raised in other sessions about consumer representation – such as whether community board members agree with the public or their fellow regulators in an outcry over perceived regulator failure, and whether growing level of public representation was producing different judgments on cases and/or having an impact on public confidence.

Such questions also highlighted for Croakey some gaps in the program. While there were many consumer representatives of regulatory bodies speaking and presenting, some of these issues could have been more deeply explored with a dedicated patient voice and/or session, at least an opportunity for complainants to highlight ‘best’ and ‘worst’ practice in regulation.

Interestingly, this article – *“Nothing about us without us”—patient partnership in medical conferences* – was published in the British Medical Journal just before the conference, saying that involvement in academic medical conferences “is an important step to bring patients closer to the conversations driving the future of healthcare” and to widen research agendas.

Given the strong presence there of regulators from Canada, the US, New Zealand and Australia, it would also have been interesting to hear, from regulators and from Indigenous organisations and patients, about the role of medical regulation in cultural competence and safety.

Talking about what keeps him awake at night, outgoing IAMRA chair Niall Dickson referred to the UK’s *Mid Staffs scandal* where he said it was not the professions, community organisations, or hospital board that were making enough noise about the problems – but the families of patients who were the “canaries in the coalmine”.

In the brave new world of medical regulation, there are many questions to be answered

**#IAMRA2016**
“A bad doctor is better than no doctor at all”

For Dr Gyikua Plange-Rhule from the Medical and Dental Council of Ghana, it was a revelation to come to the conference and discover that other regulators are as unpopular as she sometimes is.

“We get told ‘all you care about is attacking doctors’,” she told Croakey. While she said it is good in some ways that Ghana is not as “quick to pounce” on complaints as are Western regulators and media, there are problems when workforce shortages and cultural attitudes to doctors still produce the view that “a bad doctor is better than no doctor”.

She often hears criticism of sanctions against doctors, even if it’s resulted in the death of a patient, that it “won’t bring them back”.

From Africa to rural New Zealand and Australia, this was a big issue across the conference – where patients, communities and health administrations overlook poor performance and behaviour because a doctor or other practitioner will be too difficult to replace. (Uganda, for example, has just 5,000 doctors for 40 million people, compared to around 100,000 for half that many people in Australia)

While most regulatory systems have clear ways to act when something is definitely wrong (assaulting a patient, prescribing the wrong drug), there are also questions about what to do with general negligence or under-performance (such as not suggesting a relevant test/screen, not using the latest evidence-based treatment guidelines, not addressing co-morbidities etc).

A Northern Territory study presented to the conference of regulatory cases that did not lead to sanctions or other action found that most were about clinical care, were not frivolous, and involved harm or poor outcomes for patients. But they found that while the treatment was “not ideal, not perfect”, it still usually fell “within reasonable standard”.

Some regulators see the answer in peer review, common practice in the UK and New Zealand, where doctors in clinical groups get together – in a supportive, non-punitive environment – to discuss relevant details of their practice (for example, GPs in the same region get together and review each others’ prescribing rates), to help the poorer doctors to improve their practice.

It’s what the UK’s GMC hopes its controversial new revalidation system will help address, particularly by getting “360 degree feedback” on doctors from a mixture of medical and non-medical colleagues. (Critics of revalidation say it is a cumbersome tick-box exercise, that was introduced without evidence of effectiveness and only highlighted lack of accountability by regulators themselves. A review is underway.)

But the issue also raises international reporting issues. One Zambian delegate called for international reporting of bad doctors. “If they are a bad doctor in New Zealand, they are a bad doctor in Zambia,” he said.

Finally, incoming IAMRA chair Dr Humayun (Hank) Chaudhry, who has a public health background, sounded a warning on the “dangers of unintended consequences” in regulation.

He cited the case of cardiac surgeons in New York State whose ‘death rates’ for coronary bypass surgery were released to the public annually, in a bid by health officials to stamp out poor performance. It famously saw mortality rates fall, but prompted concerns that some surgeons were turning away severely ill patients for fear a death would hurt their rankings.
Reflections from some participants

1. What was the most important takeaway message from the conference? Why was it the most important?

Dr Margaret Mungherera, Vice Chair of the Uganda Medical and Dental Practitioners Council, former President of the World Medical Association, IAMRA chair elect

The most important message I took away is the need to build public trust and confidence in the regulatory system. This is because access to health services depends on the quality of the health services. The quality of a service is measured by how efficient, effective, patient centered and to what degree patient safety is assured. So the building of public trust and confidence in the services is therefore important.

Mark Bodycoat, Community member, Medical Board of Australia

There is a great deal of interest and energy in the medical profession and among medical regulators worldwide in setting, attaining and achieving high standards of practice and, by doing so, achieving the best possible outcomes for patient safety. Because there are significant differences in the scope and maturity of the regulatory systems represented at IAMRA, there are wide variations in the abilities of the regulators to establish and maintain the systems required to do this. Australia’s medical regulatory system is amongst the best in the world, and offers high standards of patient safety, but we need to continue to try to improve it.

John Stubbs, Community Member, New South Wales Board of the Medical Board of Australia

I was delighted to hear how well we do things here in Australia – and I was not aware of that before. We can continue to improve but from most of the overseas delegates I learnt we are really at the forefront of international regulation. In some ways I am not surprised as we ‘really punch well above our weight’ in the international health scene – and regulation is part of that.
2. What would you have liked to hear more about? Why?

**Dr Margaret Mungherera**, Vice Chair of the Uganda Medical and Dental Practitioners Council, former President of the World Medical Association, IAMRA chair elect

> I would have liked to hear more from experiences in resource-constrained countries in Africa, South America and Asia. How have they innovatively and creatively overcome the challenges in medical regulation?

> I would have loved to hear more from members of the general public other than journalists (as well as the session led by Julie McCrossin, ABC TV and radio broadcaster Geraldine Doogue hosted a plenary session on ‘Shaping and old profession for a new society: what does the community need/want/expect’). And more presentations in the workshops from Africa and Asia.

**Mark Bodycoat**, Community member, Medical Board of Australia

> There is a lot of work going on to maintain and improve standards of practice, but the public doesn’t always know much about it. Patients, the ultimate users and the intended beneficiaries of this work, tend to trust that there is a good system in place and that they are in fact protected from poor practice and its effects.

> But they often don’t know what is actually going on, or HOW they are protected or what THEY can do if they get poor service or outcomes. Because they trusted “the system” they often feel let down, disempowered and angry in these circumstances. There is a substantial need for greater information for health consumers and for the continued and expanded inclusion of their voice in regulatory planning.

**John Stubbs**, Community Member, New South Wales Board of the Medical Board of Australia

> Nothing more really – there were really interesting and engaging speakers, excellent plenaries and facilitators. Extremely well organised!

3. How will what you heard there change the way you work?

**Dr Margaret Mungherera**, Vice Chair of the Uganda Medical and Dental Practitioners Council, former President of the World Medical Association, IAMRA chair elect

> I intend to promote a dialogue between our medical regulatory body and the public. And to use the Melbourne presentations to promote discussions on assessing competency of doctors at different stages in their career.

**Mark Bodycoat**, Community member, Medical Board of Australia

> I will continue to work with my colleagues on the Consumer Reference Group, on the Medical Board and in AHPRA to see that the work we do is as inclusive as is reasonably possible of the health consumer voice and to build on the healthy appetite for inclusion that already exists amongst those bodies.
John Stubbs, Community Member, New South Wales Board of the Medical Board of Australia

I will be really mindful of the practitioner – we do address the issue of public safety, but in a number of ways, clinicians bear the brunt. We must use good evidence, some rat cunning and our combined skills as a board or committee to achieve best outcomes for all.

From the Twitterverse

Julie McCrossin @JulieMcCcrossin · Sep 22
Some patients are too sick or voiceless to be "canaries in the coal mine" on safety. We need safe systems @IAMRA2016

A couple of canaries

www.targetingcancer.com.au
www.beyondfive.org.au

Julie McCrossin @JulieMcCcrossin · Sep 22
Who needs to co-operate with medical regulators to keep patients safe? @cancerNSW @TargetingCancer @HCNSW @IAMRA2016

Who needs to co-operate & communicate?

• Employers, public and private
• Politicians & public servants
• Health co-workers & peers
• Patient visitors & pastoral care workers & volunteers
• Patients and families
• Insurers
• Universities
• Medical Colleges
• Complaints bodies
• Patient Support & advocacy groups
• Media
You can track Croakey’s coverage of the conference here.

In the brave new world of medical regulation, there are many questions to be answered.

#IAMRA2016

Marie McInerney @marie mcinerney - Sep 22

#IAMRA2016: Audience Q: Heard a lot about regulator worry 4 physician wellbeing, not complainants. Why this doesn’t keep you awake at night?

Marie McInerney @marie mcinerney - Sep 22

Biggest #IAMRA2016 challenges: Mungherera: strength of the health system, human resource crisis, legal and policy env, nbuilding public trust

IAMRA 2016 @IAMRA2016 - Sep 22

@maureenboon on #transparency and building #publictrust, ‘Don’t tell me to trust you….tell me why I should.’ #IAMRA2016

Marie McInerney @marie mcinerney - Sep 22

Dickson: what role should regulators play to shape and supply the medical workforce of the future? #IAMRA2016

John Gimpel @JohnGimp - Sep 22

IAMRA passes powerful statements on import of med school accreditation and assuring continuing competence #IAMRA2016 @NBOME @AOAforDOs

Marie McInerney @marie mcinerney - Sep 22

Insurer delegate says we’ve ‘forgotten about supporting the doctors here, they’re under siege, culture of blame & punishment’. #IAMRA2016

Marie McInerney @marie mcinerney - Sep 22

#IAMRA2016 GP says much talk of patient safety predicated on having choice: ‘even in NZ, Aust, many don’t’. Recs UK peer review system
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#IAMRA2016
In the brave new world of medical regulation, there are many questions to be answered.

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In the brave new world of medical regulation, there are many questions to be answered.
Thanks to all who helped share the #IAMRA2016 news

• More than 5.5 million Twitter impressions
• 279 participants on Twitter

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@croakeyblog 91
@isra2016 83
@ahpra 82
@theamb 60
@ADK 49
@nborne 48
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@ketaminh 40,525
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@jurylady6 31,418
@fmsa 27,941

The Numbers
5,505,876 Impressions
1,227 Tweets
279 Participants
3 Arg Tweets/Retweet
4 Arg Tweets/Participant

#IAMRA2016 Participants

Croakey Conference News Service

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• Editing by Melissa Sweet
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In the brave new world of medical regulation, there are many questions to be answered