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Meeting Report

International Association of Medical Regulatory Authorities' 13th International Conference on Medical Regulation October 6-9, 2018 – Dubai, United Arab Emirates AAOE Representative: Anna Z. Hayden, DO, Immediate Past President

I. Conference Chair: Humayun J. Chaundry, DO, CEO and President, Federation of State Medical Boards (FSMB), United States of America (USA)
   a. Attendees: Over 1,000 representatives from over 40 different countries.
   b. Theme: Empowering regulation via innovation and evidence.
   c. Breakout sessions: Innovative regulation models, medical workforce, safe practice and quality, and medical education.

II. October 7, 2018
   a. Plenary Session: "Regulation in the Age of Acceleration" – Kevin Fong, MD, United Kingdom (UK)
      i. Dr. Fong presented a historical perspective on the oldest human alive today, 122-year-old Jeanne Calmut (France). During her lifetime, humans explored Antarctica (1912), developed the atomic bomb (1940s), climbed Mount Everest (1953) and explored the moon (1969).
      ii. We hope that technology will evolve to improve safety and patient care. "Technology is not about building better people; it is about building a better system to stop errors from happening."
      iii. Technology is neutral; it can help us or hurt us. Artificial intelligence (AI) and big data is our future. AI can help us apply clinical knowledge to arrive at a diagnosis; however, AI machines learn real world biases. For example, an AI program was programmed to review medical school applicants and select those that the human selection committee likely accepted. Bias was not written into the AI program, but the program detected and "learned" the selection committee's biases related to applicant gender, race and exam scores. Technology and science are a foundation, but AI requires human involvement. There will be a need to regulate AI, especially since no data in the digital world is secure.
   b. Breakout Session: Workshop: "Reducing the Impact and Stress of Regulatory Complaints" – Ms. Anna Rowland, General Medical Council, UK
      i. Discussed the negative impact that disciplinary hearings can have on physicians and advocated for a compassionate administrative complaint process. Regulators should receive training on mental health issues, coordinate communication, and provide a single point of contact as well as a counselor for each physician. The implementation cost to the UK's National Health Service was minimal.
      ii. Another speaker discussed how complaints are digitalized and taxonomized, which improves accuracy and data sharing.
      iii. Between January 2011 and December 2015, Canadian researchers collected data on complaints by age, gender, medical school, practice dynamics and coverage. Previous complaints were coded to help predict future complaints. Complaints were classified as:
         1. Physicians in GME programs - 5% of patient complaints

2. Physicians outside of GME programs - 25%
3. Male physicians received 1.7% fewer complaints than females
4. Physicians working in labs, pediatrics and anesthesiology received fewer complaints
5. OB/GYN and surgery received the most complaints
6. Solo practices received less complaints due to social isolation
7. Physician-professors under 50 received 22% fewer complaints; no protective effect was observed for physician-professors over 50.

c. Breakout Session: "Sexual Behaviors Sexual behaviors between Health and Care Practitioners Where Does the Boundary Lie?" - Ms. Daisy Blench, Professional Standards Authority, UK
    i. In risk-based regulatory models, medical practitioners, nurses and midwives in high-risk categories must revalidate to prove their skills are up-to-date and they remain fit to practice.
    ii. Survey of behaviors, settings (social vs. professional) and other factors. Survey also looked at the role that team culture and shared norms play in legitimizing behavior.
    iii. Prior to 1978, medical practitioners who were accused of disgraceful or dishonest conduct by professional brethren of good repute were convicted of a felony or misdemeanor for "infamous conduct." In 1978, the "infamous conduct" language was replaced with "professional misconduct." The *McCandless vs. GMC* case (1996) established that seriously negligent work is professional misconduct; poor professional performance, however, does not.
d. Plenary Session: "The Late Career Physician: Possibilities, Perils, and the Role of Regulatory Authorities" - Barbara Schneidman, MD, USA
    i. Dr. Schneidman discussed the effects of aging, including loss of physical or mental capacity, on "late career" physicians (> 65 years old). She also cited the example of Dr. Shigeaki Hinohara, who died at age 105 and continued to work well into his late 80s. He popularized Japan's practice of annual medical checkups. In Japan, the retirement age is 75 years old, and many physicians there practice competently into their 70s and 80s. Some report satisfaction with this practice, but others cite concerns about financial security and a belief that retirement is seen as a quick prelude to the end of one's life as reasons for their reluctance to retire.
    ii. Today in the US, 30% of the physician workforce is older than 60. There are no national standards related to ability to practice, unless a required peer review occurs in the re-credentialing process. Individuals that are between 65 and 70 must have a visual exam in order to renew their driver's licenses. The role of health screening, peer reporting and review for physician credentials and privileges vary by country and there are no accepted guidelines for making this judgment. Many hospitals oppose setting a minimum age for mandatory testing. Dr. Schneidman stressed the importance of physicians having their own annual wellness exams.
e. Plenary Session: "Medical Regulation of Doctors in Training: A Case Study"
    i. In *Dr. Bawa-Garba vs. GMC*, a junior pediatrics resident (Dr. Hadiza Bawa-Garba) returned to training after a 14-month maternity leave. Her physician supervisor instructed her not to contact him except in the case of an emergency. She was the most senior junior physician on duty when a six-year old boy with Downs' syndrome was admitted to the hospital with viral gastroenteritis, therefore she was responsible for supervising

the other clinicians on the care team. The boy passed away from septic shock on the day of admission. At the inquest, Dr. Bawa-Garba and two nurses were charged with gross malpractice and neglect that fell below the standard of care. Dr. Bawa-Garba was convicted of manslaughter and lost her medical license. She filed an appeal and won back her ability to practice medicine. This case raised many issues within the National Health Service regarding supervision of doctors-in-training.

III. October 8, 2018

a. Plenary Session: "Doctors, Patients, Sex and Chaperones: Rethinking Medical Regulation" – Ron Paterson, JD, Professor, University of Auckland, New Zealand

i. A good physician-patient relationship involves trust, and a power imbalance often exists. If the physician is unable to be objective and sexualizes a patient, the following may occur:

1. An inappropriate exam (assault);
2. A sexual relationship with a patient/former patient; or
3. Misconduct in private life, such as viewing child pornography.

ii. Often state laws/regulations require chaperones during intimate examinations. A review of 36 physicians convicted of rape between 2005 and 2015 found that none were banned from practice. By not requiring disclosure to patients, current systems do not allow for informed consent. Chaperones are inadequate. Australia has phased out the term "mandated chaperones" in favor of the term "practice monitors." Others argue for "gender specific restrictions" that would prohibit physicians from seeing anyone at all of another gender. Ontario, Canada has a zero tolerance policy for sexual misconduct, and physicians who violate the policy must give up their licenses for a period of five years.

iii. The panel acknowledged the importance of physician education on zero tolerance, how to discuss and respect sexual boundaries, and advocated for physician training, access to resources, revised organizational sexual boundary policies and license suspensions for physicians who commit violations.

b. Breakout Session: "Physician Wellness, Aging and Burnout" – Ms. Diane Meldi, MBA, Executive Director, National Association of Medical Staff Services, USA

i. The discussion covered credentialing of practitioners, professionalism, and interpersonal communication skills. Data collected from late career physicians in 2015 showed that 23% of practicing physicians were over 65 years old. Clinicians that are 65-75 years old should voluntarily undergo annual physical exams. Often there is reduced hearing and a need to evaluate neurological function. Organizations should explore how medical practice can be adapted to facilitate continued involvement by late career physicians. Encourage physicians to utilize resources for work-life balance. Physicians may have an excessive devotion to work and spend less time on leisure, family and friends. Compulsiveness and perfectionism can lead to estrangement from friends and family. Physicians may experience loss of enthusiasm, increased cynicism, disengagement, depression, drug and alcohol use, suicidal ideation, economic and/or personal stressors, irritation, cognitive impairment and preoccupation with physical problems.

ii. Stressors on today's physicians include the pressure to produce more accurate diagnoses, decrease automation, financial stress, the threat of malpractice claims, time constraints, rules, regulations and expectations.
iii. 46% of physicians in the US experience symptoms of burnout, and burnout costs the US healthcare system $3.4 billion annually, in addition to numerous patient lives. The following specialties report more burnout: emergency medicine, critical care medicine, internal medicine, neurology, family medicine, and surgery. There needs to be increased awareness so that burnout can be detected and addressed early. The following resources and individuals help address burnout: the Maslach Burnout Inventory, the Shirom-Melamed Burnout Questionnaire, the Copenhagen Burnout Inventory and the 9-item Bergen Burnout Inventory.
iv. We have a duty to help address late career physician burnout. There is no standard approach/commitment among regulatory authorities to address physician burnout. There is a lack of resources to help physicians-in-training and international medical graduates cope with personal issues that interfere with training and impact morale and overall wellbeing. Women are impacted more greatly, and additionally experience increased structural barriers. Negative attitudes from seniors and high workloads lead to burnout among physicians-in-training.

c. Breakout Session: "Building a Culture of Respect in Surgery" – John Biviano, MBA, Royal Australasian College of Surgeons, Australia
i. The discussion focused on the bullying, discrimination and sexual harassment issues surrounding the culture of surgeons. Forty-nine percent of fellows experienced it, 63% of the trainers are bullied, 30% of females suffered sexual harassment. The prevalence survey got input from all members. Public apology launched. Every patient has a right to expect that their surgeon be at his or her best. Surgeons have a responsibly to lead culture change, launch a campaign for respect and collaboration.

d. Plenary Session: "Regulating the Prescribing of Opioids in the Face of a Public Health Crisis" – Karen Mazurek, MD, Canada
i. Between January 2016 and March 2018, 8,000 Canadians died from apparent overdoses, 94% of which were accidental. Research into the deaths determined that the root cause of this crisis was the introduction of Oxycontin by Purdue Pharma in 1996. In 2007, several lawsuits were filed against Purdue for its aggressive marketing practices, and the company was ordered to pay fines.
ii. Canada is a major opioid consumer. In 2016, 50,0000 Canadian patients received prescriptions for opioids. Although effective peer-to-peer interventions called DOME 5000 exist for high-risk patients, they are costly at $2,200 per physician. Regulators and physicians should form a coordinated response to this crisis, to reduce the stigma and provide safer, more effective treatment by (in part) increasing naloxone availability/prescribing.

IV. October 9, 2018

a. Plenary Session: "Upholding Healthcare Quality in a Refugee Situation: The Case of Jordan" – Ms. Salma Jaouni, MPA, CEO, Health Care Accreditation Council (HCAC), Jordan
i. 1.4 million Syrians fled to Jordan during their civil war, challenging the country's healthcare system to care for a greatly expanded population

while upholding quality. At the height of the crisis, refugees comprised 30% of the country's population and 90% of them lived outside of camps, in Jordanian towns and cities. The country's healthcare system struggled to combat the diseases encountered among Syrian refugees, including diarrhea, chicken pox, scabies, hepatitis A, cutaneous leishmaniasis, 128 cases of tuberculosis and 30 cases of acute flaccid paralysis.

ii. In addition, physicians saw:
    1. War-related injuries: bullet wounds, burns and amputations
    2. Mental health issues: Post-traumatic stress disorder, depression, anxiety, schizophrenia
    3. Diabetes, hypertension, renal failure, phenylketonuria, cancer, thalassemia

iii. The HCAC is the Arab region's only independent not-for-profit organization that aims at improving the quality of health and social care services and promoting safer care through accreditation and consultation. Accreditation in Jordan has improved healthcare, reduced staff turnover, and improved patient satisfaction through the implementation of regulatory monitoring, improved oversight of equipment, the promulgation of clinical guidelines and certification. HCAC measures data and analyzes health outcomes and shares this information with Jordan's Ministry of Health.

b. Breakout Session: "Telemedicine/Telehealth – Credentialing to Ensure Competence" - Ms. Susan DuBois, Immediate Past President, National Association of Medical Staff Services, USA

i. Telemedicine refers to clinical diagnosis and management. Telehealth encompasses a wide range of disciplines including dentists and counselors, and includes diagnosis, management and education. Telemedicine and telehealth improve patient access to care via better care coordination, reductions in unnecessary costs and continuous patient monitoring.

ii. In 2018, Intermountain Healthcare launched the first "virtual" hospital, called "Connect Care Pro." Medical teams provide telehealth programs to all 21 Intermountain hospitals in Utah and Idaho, with the goal of allowing patients to stay in smaller hospitals closer to home and avoiding unnecessary transfers, while providing access to critical specialty services. Intermountain Healthcare has had more than 51,972 visits since 2013.

iii. The Joint Commission sets accreditation standards for telemedicine for Joint Commission-accredited hospitals and ambulatory health care organizations offering direct-to-patient telehealth services. If the originating site hospital is Joint Commission-accredited, the only way that hospital can use credentialing by proxy is if the distant site is also Joint Commission-accredited. Other standards involve credentialing and privileging, approved scopes of practice, delegation agreements to a distant site, peer review, ongoing and focused use of advanced practice clinicians, resident and fellows, and bylaws rules and regulations.

iv. The provider must be licensed in the state where the patient is located, which is the "originating site." Federal and state privacy laws apply to telemedicine and telehealth, and there are concerns regarding the increased number of persons with access to protected health information. Compliance, legal considerations, billing/collections, prescribing,

documentation, medical records, informed consent, malpractice converge and outpatient services are all considerations in telehealth.

c. Breakout Session: "Regulating Reflection: Exploring Global Concepts in Assessing Professional Practice" – Laura Knight, MD and Ann Griffin, MD, University College London, UK
    i. Global medical travel (medical tourism) is a widely regulated industry, with potential economic benefits, as well as challenges, including the strain on locals' access to care.
    ii. Australia and Canada rely heavily on medical tourism. Australia has the highest physician-to-patient ratio in the world, in contrast to New Zealand, due to differences of land, resources, environmental degradation, economic diversity and health care inequalities.
d. Panel and General Discussion: "The Social, Professional and Regulatory Landscape for Doctors of the Future"
    i. Regulate the medical profession with an eye towards the landscape for future physicians:
        1. Foster confidence in medicine
        2. Technology can help improve medicine
        3. Doctors need to utilize machines, and be a "friend to their patients"
        4. Medical schools are implementing curriculum changes to address the world's changing needs
        5. Despite the advent of AI, the human touch and smiles are still important

V. Conference Summary
    a. The IAMRA conference was very informative. Sub-themes of the conference included innovative regulatory models, medical workforce issues, safe practice, improving quality and medical education. There were numerous sessions on aging physicians and physician wellness. There were plenty of opportunities for networking throughout the conference, as well as a social program highlighting the culture of Dubai. Sponsorship from multiple stakeholders included: Saudi German Hospitals, Aster DM Healthcare Limited (the largest private integrated healthcare service provider network), the Federation of State Medical Boards, the Educational Commission for Foreign Medical Graduates, VPS Healthcare (integrated healthcare service provider,) NMC (owner and manager of 200 health care facilities), ProMetric (a testing and assessment resource), MedSU Medical Support Union, OET (Occupational English Test) and Al Zahra Hospital.

Respectfully submitted,
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Immediate Past President, AAOE