KINGSTON, AUSTRALIA
MAJOR SHIFTS IN MEDICAL EDUCATION IN AUSTRALIA

Medical education in Australia is dynamic and going through a period of unprecedented change, according to the Australian Medical Council (AMC).

Announcing the outcome of its medical school accreditation reviews and other decisions made at its Annual General Meeting on 25 November 2005, AMC President Dr. Joanna Flynn said the volume of change under way in medical education was reflected in the AMC's medical school accreditation program.

In 2004, the AMC accredited three new medical schools. In 2005, the AMC reviewed the progress of these schools, agreed to assess the plans for another new medical school, and the plans by one established school to offer its medical course in Malaysia in 2007.

In 2004-2005, the AMC also reviewed Australia's first three graduate-entry medical programs, which were introduced in 1995-96, and continue to produce quality graduates.

"The changes are being driven by increased collaboration and better cross-fertilization of ideas between schools – ensuring all schools are improving to meet the quality of the best," Dr. Flynn said.

She also stated that, since its inception, the AMC had deliberately not stipulated what direction medical education in Australia should take. Instead, it had consciously fostered an environment of collaboration between universities and active peer review, to maximize best practice across medical schools.

"The level of innovation we see now and the diversity of approach to medical education in Australia demonstrates the value of this approach," Dr Flynn said.

Before the Council meeting, the Minister for Health and Ageing, The Honorable Tony Abbott MP, advised the AMC that a case had been made for the recognition of the new specialties of pain medicine and palliative medicine. As a result, the AMC considered the education and training programs available for doctors who wish to train in the new specialties. The AMC has advised the Minister on the accreditation of training programs in both specialties.

The AMC also confirmed it had submitted its report to the Minister on an application by the Australian College of Rural and Remote Medicine (ACRRM) for recognition of rural and remote medicine as a distinct specialty. The report will be published on the AMC's website after the Minister has considered the report and released his decision about ACRRM's application.

AMC accreditation is mandatory for all university medical schools, which must meet explicit accreditation standards. The accreditation process involves detailed analysis of the proposed curriculum and medical school resources, rigorous review of clinical training opportunities and visits from clinical and community based assessment teams.

General trends identified in 2004 were carried through to the 2005 accreditation process – including a greater focus on student directed learning, increased breadth of clinical experience beginning from first year and more emphasis on communication skills training.

All medical schools reviewed during 2005 received positive assessments from an AMC Assessment Team. Detailed Accreditation Reports are available on the AMC website (www.amc.org.au). A range of strengths is detailed in each report and in all cases opportunities for improvement were identified in order to promote continuous improvement.

In summary:

- The University of Notre Dame Australia (UNDA) is a new medical school. The AMC reviewed the first year of the program (implemented in 2005) and the University's plans for Years 2 and 3 of the course. The AMC commended UNDA on its progress and collaboration with the University of Western Australia concerning clinical placements for students.

- The University of Tasmania is beginning a new five-year program, reflecting a complete turnaround in curriculum and approach. The AMC congratulated the medical school's leadership, the staff commitment and the support of a wide range of other stakeholders, including the State and Commonwealth health departments, for the successful redevelopment of the course.
- The Australian National University Medical School is now implementing Year 2 of its four-year program, which developed from a clinical school of the University of Sydney. The AMC found the ANU program to have strong community support, backed by support from ACT Health for staffing and capital development. Particularly commended are the population health resources available to the school.
- The University of Auckland Medical School is a well established and well regarded school. It has implemented a major curriculum renewal strategy in the last three years. The AMC has commended the commitment of the University, the staff and clinical teachers to a high quality medical course relevant to the health care needs of the communities of New Zealand, the Pacific and beyond.
- The University of Queensland and The University of Sydney are both older established schools which are now graduating students from their graduate entry four-year programs. The implementation of the programs in these schools, together with Flinders University, marks the beginning of the current period of diversification, and collaboration between medical schools.

Reprinted from the Australian Medical Council website.

ALBERTA, CANADA

PROFESSIONALISM: A KEY MESSAGE IN COLLEGE OF PHYSICIANS AND SURGEONS OF ALBERTA PRESENTATIONS

College of Physicians and Surgeons of Alberta (CPSA) Council President Dr. Gordon Arnett recently took center stage in Calgary as one of several guest speakers at the 9th Annual Glen Edwards Day Lectures.

Put on by the University of Calgary's Faculty of Medicine, the lectures focused on Issues in Patient Safety and attracted more than 200 people, including orthopedic surgeons, residents and allied health professionals interested in musculoskeletal injuries.

Dr. Arnett's 20-minute presentation began with a review of the College's mission statement and how it plays a key role in ensuring and enhancing patient safety. "Our mission is to serve the public and guide the profession," he noted. "Ensuring our members are clinically competent and meet professional standards is an absolute necessity in ensuring patient safety."

The concept of professionalism was the central focus of the presentation and is also a key component of Dr. Arnett's speeches for the 2005 CPSA Regional Tour. In both instances, he outlines scenarios that help physicians understand the link between professionalism and patient safety. These include:

- The need for disclosure. When harm occurs – the CMA's medical code of ethics clearly outlines the physician's responsibility for full disclosure to the patient and the family. This approach is fully supported by the CPSA.
- The need for physicians to be clear in their communications with patients, colleagues and co-workers.

Unnecessary delays in treatment, prescription mistakes, lack of follow up – all of these can be caused by poor communication and go against the basic tenet of professionalism – to put the patient's needs before one's own.

Dr. Arnett's speech also touched on the College's complaints process, and how the approach to complaint resolution is similar to the approach being touted for the patient safety movement. Our ultimate goal for the complaints process is not to punish or blame, but to improve the quality of medicine available in Alberta. "By focusing on education and quality improvement, we allow physicians to learn from their mistakes," notes Dr. Arnett in his presentation. "In fact, many voluntarily make changes to their practice, or agree to take additional training to address concerns that were raised during the complaints process."

MOVING FROM PAPER TO ONLINE DATA: STREAMLINING THE CPSA ACCREDITATION PROCESS

For more than 25 years, the College has accredited medical laboratories and diagnostic imaging facilities throughout

Alberta. With the more recent inclusion of neurophysiology, pulmonary and nonhospital surgical facilities, more than 700 diagnostic and treatment facilities are accredited by the College every four years.

Accreditation activities are currently managed with a variety of paper-based systems. To create a more efficient process to collect and collate data, and to monitor and guide the quality of care in these facilities, the College is moving to an electronic platform that will store information from the accreditation process and enable more meaningful and timely data analysis. This platform will also streamline the accreditation process for facilities, inspectors and the College.

The College is collaborating with HealthMetrx Canada of Vancouver in the development of this digital accreditation platform (DigitalAP). It is a multi-phase project encompassing the full scope of accreditation activities, including the preassessment phase, on-site reporting, the post-assessment phase, and comprehensive standards management. With the success of DigitalAP in province-wide pilots and laboratory assessments in the Peace Country Region and Calgary Health Regions, the College has made a five-year commitment to manage the accreditation process using DigitalAP.

During the next two years, pilot projects will be introduced for diagnostic imaging, pulmonary, cardiac stress testing, neurophysiology and non-hospital surgical facilities requiring accreditation. For more information on the digital accreditation platform or the pilot projects, please contact Ms. Barb Unger, Manager of the Quality of Care Department at (780) 970-6249, (800) 320-8624, ext. 249 or by e-mail at bunger@cpsa.ab.ca.

COMPLAINT ISSUE: ADVERTISING COSMETIC SERVICES

A woman attended a dermatologist regarding excessive facial hair growth. According to the patient, she was reassured by the physician she could expect permanent hair reduction from the treatments.

After several treatments, she expressed dissatisfaction with the results. The physician provided additional treatments free of charge. Despite the extensive treatment received, both at her cost (approximately $1,800) and at the physician's expense (approximately $900), the patient was dissatisfied with the results. When she confronted the physician, she was told that there was adequate improvement. Some time after these clinical encounters, she received a newsletter from the physician's office stating:

- I was the first doctor in (city) involved in laser hair removal. I am the only one with two sophisticated units – Lumenis' Lightsheer and Palomar's Estelux IPL system. These are recognized as being the best in the industry. That's why I offer a guarantee – permanent hair reduction or your money refunded. I am the only one in (city) bold enough to make this claim.

In the same newsletter, the physician also made statements implying that his/her clinic met or exceeded international standards of excellence in Photo Rejuvenation, Botox and Liposuction. The physician happily reported to patients that "in many areas of my practice, we are leading the way."

The complainant suggested that physicians hold a position of trust in society and should not be allowed to make claims and not honor them.

The physician responded that the patient had olive skin with some dark and coarse hairs, as well as some light and fine hairs. It was felt that some reduction in her hair growth could be achieved. The physician indicated that at no time was she misled as to what to expect but rather she was educated about what was possible and not possible in her case. The physician provided the College with a copy of the guarantee offered to the patient stating:

- If there has been NO visible improvement after completing the recommended eight-treatment program, you will receive a full refund or a free package to treat that area again.

The College in its investigation recognized that complete hair loss may not be a reasonable expectation, particularly in patients with darker complexion and light fine hairs. It was noted that the patient signed a consent that clearly lists the potential for a 20 percent incidence of no permanent hair loss. Furthermore, the physician offered the patient free packages of treatment when the results were suboptimal from her perspective. As a result, the College was unable to support the patient's claim that the physician acted unprofessionally and without compassion in the provision of her care.

Our review of the physician's newsletter found it to be aggrandizing and self promoting. From the College's per-

spective, advertising to the public should be factual, easily understandable and dignified. A practitioner should not make false or misleading promises or compare him/ herself to others directly, indirectly or by innuendo to any other practitioner, clinic or facility.

Discussions were held with the physician about the ethics of advertising. The physician agreed that the statements in the newsletter were unprofessional and committed to put in place a rigorous review process for future newsletters and promotional materials in order to ensure compliance with the College bylaws. In addition, the physician will issue an apology in his/her newsletter in which he/she undertakes in future advertising to meet the high ethical standard the public expects of the medical profession.

Reprinted from issues 119, 120 and 121 of *The Messenger*, published by the College of Physicians and Surgeons of Alberta.

LONDON, ENGLAND

GMC OPENS NORTHERN IRELAND OFFICE

The General Medical Council regulates more than 3,000 doctors in Northern Ireland and is to open its first ever Northern Ireland office before the end of the year.

The GMC has appointed Alan Walker as Head of Northern Ireland Affairs to provide a local focus to its operations from December 2005. This fulfills the promise made by GMC 12 months ago to review its arrangements in Northern Ireland.

"We are delighted that Alan has accepted the post of Head of Northern Ireland Affairs," said Professor Sir Graeme Catto, President of the GMC. "Given his background in representing the interests of Northern Ireland, we are certain that the skills he will bring to the role will support the GMC's commitment to ensuring the differing health issues in the devolved nations are effectively addressed. We are committed to actively participating in the development of Northern Ireland health policy and look forward to having a permanent presence locally."

The decision to open a new office followed consultation with key stakeholders, who overwhelmingly supported the establishment of a GMC presence in Northern Ireland. This will be the fifth GMC office, supplementing offices in London, Manchester, Edinburgh and Cardiff. The Northern Ireland office will establish and maintain links with the Northern Ireland Assembly and other key stakeholders and decision makers in the health sector including consumers and their representatives.

"I look forward to taking up this new role with the GMC and engaging with all stakeholders within the health sector," said Alan Walker, the new Head of Northern Ireland Affairs at the GMC, "including those representing the 1.7 million health service users. I will seek to ensure the voice of Northern Ireland is heard and communicated. This will better enable the GMC to monitor health care issues across the United Kingdom and respond to the changing health agenda in Northern Ireland. It will also mean that we can further our work on patient and public involvement in Northern Ireland, ensuring that medical regulation is a partnership between the public and the medical profession."

GMC STATEMENT CONCERNING STUDENTS OF U.K.-BASED OVERSEAS MEDICAL SCHOOLS WORKING IN NHS HOSPITALS

The GMC has issued a fact sheet to the NHS hospitals who may be offering attachments to students from overseas medical schools based in the UK. The fact sheet sets out the GMC position on accrediting the degrees from certain UK based overseas medical schools, following an investigation into the links they claim to have with overseas universities.

Offering Clinical Placements

This fact sheet provides information for NHS and other medical institutions considering clinical placements for medical students. All fact sheets on the GMC website are for guidance only; they do not carry legal force. The information they contain will change from time to time and you will always be able to find the current version on our website. This fact sheet was most recently updated in November 2005.

Introduction

There are 27 UK medical schools that are recognized by the GMC. The medical education delivered at these medical schools complies with the curriculum set by the GMC. Additionally the medical education undertaken at these medical schools is quality assured by the General Medical Council. We have oversight of the curriculum and we set and monitor standards in basic medical education. This covers both undergraduate education and, more recently,

the first year of foundation program training. A medical degree from one of these medical schools, subject to our other registration requirements, is recognized for the purposes of registration with the GMC.

Clinical Placements

All medical students undertake clinical placements as part of their medical education. Clinical placements in the UK ensure that student education reflects the changing patterns of health care and provides them with working experience in a variety of environments including hospitals, general practices and community medical services.

The arrangements for clinical placements are coordinated at local level between the medical schools and the hospitals or other settings providing clinical placements.

Organizations offering clinical placements should ensure that the students are studying at one of the 27 UK based medical schools listed above.

Private UK and Non-U.K.-Based Medical Colleges

We are aware that there are some private, UK and non-UK based, medical colleges offering medical courses. These colleges do not fall within the GMC's jurisdiction and are not supervised or quality assured in any way by the GMC. Any organization considering providing clinical placements for the students from such colleges should assure itself about the medical education provision and the quality assurance arrangements. The GMC is unable to provide a quality assurance role and organizations are therefore strongly recommended to undertake thorough investigations and take appropriate advice before providing clinical placements for such students.

GMC LEADS ON INFORMATION SHARING PROPOSALS

The General Medical Council has endorsed the proactive approach to information exchange that was agreed to at an international conference in November 2005.

More than 130 delegates from health care regulators, health ministries and professional bodies from the majority of EU countries attended the conference in Scotland with the objective of developing ways of working together and sharing of fitness to practice information.

The aim of the conference was to look at ways of ensuring patient safety while still allowing health care professionals to exercise their right to freedom of movement across Europe. The GMC has been at a the forefront of sharing information, and is taking a proactive and consistent approach. By other member states agreeing to join the GMC in sharing information, there is the opportunity to receive better information than has happened in the past from fellow regulators.

Council gave its endorsement to the project to take forward the agreement on improved information sharing reached at the Edinburgh conference. The objectives of the project (which the GMC will lead) will include encouraging and supporting the implementation in all member states of the Agreement. The project will have added impetus because from September 2007 a European Directive will require member states to "exchange information regarding disciplinary action or criminal sanctions which are likely to have consequences" for people likely to engage in professional services.

"The vast majority of doctors are competent and conscientious professionals who do a good job," said GMC President Sir Graeme Catto. "However, public protection demands that we have systems in place to identify the small minority who may present a risk to patients and prevent them from taking up practice. We have to get the systems right for information exchange between European nations. We welcome increased mobility for the medical profession but we also have to ensure no discrepancies exist between levels of regulation for UK registered doctors and their European colleagues."

Reprinted from the General Medical Council website.

FROM THE INTERNATIONAL ASSOCIATION OF MEDICAL REGULATORY AUTHORITIES
2006 INTERNATIONAL CONFERENCE

Preparations for the International Association of Medical Regulatory Authorities' (IAMRA) 7th International Conference on Medical Regulation, scheduled for Nov. 14-16, 2006, in Wellington, New Zealand, are underway. The conference will be held at the Wellington Convention Centre, with satellite meetings of other groups taking place on Nov. 9-11, prior to the conference opening. The Medical Council of New Zealand is hosting the conference and has established a subcommittee of four council members who are overseeing the conference managers and the

development of the educational program, "Medical Regulation: Global Issues – Shared Solutions." The council has been in consultation with IAMRA`s Biennial Conference Advisory Group to identify keynote speakers and interesting topics, and to discuss other items necessary to plan a successful event. The first call for abstracts will take place this month. For additional information about the conference, including the Provisional program, or to submit expressions of interest in receiving registration information when it becomes available, the following link can be accessed: www.iamra2006.co.nz. Letters of invitation can be obtained from the IAMRA Secretariat and the Medical Council of New Zealand as part of the necessary documentation some of you will need to facilitate preparations for your participation at the conference. The council can be contacted at:

Medical Council of New Zealand
IAMRA Conference
Level 13, Mid City Tower
139 – 143 Willis Street
P.O. Box 11 649
Wellington
Tel: 64-4-381-6777/Fax: 64-4-385-8902
E-mail: ineson@paradise.net.nz

JOINT PROJECT WITH THE WORLD HEALTH ORGANIZATION

IAMRA's joint project with the World Health Organization (WHO) is progressing. A questionnaire was developed by the two organizations for gathering and documenting information about medical regulatory practices worldwide, the results of which will be used to identify gaps in regulatory systems that could be affecting the development of an adequate national health workforce. The questionnaire was distributed to medical regulators worldwide, and 57 regulators in 36 countries responded. The responses have been collated and a report is being developed for inclusion in the *2006 World Health Report*, which is due to be published on April 7. Additionally, documentation of this project and other official papers regarding IAMRA has been submitted to WHO in order that IAMRA's official relationship with WHO as a non-governmental organization (NGO) can be finalized. Recognition should be obtained by April 2006.

FAST TRACK CREDENTIALS SYSTEM

Serious discussion continues regarding the development of a successful Fast Track Credentials System whereby regulators can electronically exchange important physician information and ease the migration of competent physicians from one country to another. Several projects are in progress testing various elements that will ultimately be enhanced, combined and expanded to create the foundation for this system.

Electronic Exchange of Certificates of Good Standing

The Medical Council of New Zealand (MCNZ) and the General Medical Council (GMC) in the United Kingdom are forwarding an extension of the electronic Certificates of Good Standing (CGS) to each other verifying individual physicians by exchanging details on birth date, gender, photograph and passport number at the time the CGS is exchanged. Additionally, the group involved in the exchange of CGSs has expanded to include Ireland, New Delhi, South Africa and South Australia. Several jurisdictions in Canada and Australia have indicated their interest in being part of the exchange. Questions were included in the WHO-IAMRA questionnaire to assist in the research and assessment of CGS verification.

MCNZ and GMC to Improve Credentials Verification

This project has been broken down into six stages and stage one has been agreed to:

Stage 1: Additional information to be exchanged with the doctor's consent to help verify the individual's identity.
Stage 2: Verifying identity of doctors who have entered New Zealand or the UK who are not New Zealand or UK graduates.
Stage 3: Verifying identity of New Zealand and UK graduates – in New Zealand this will require agreement with medical schools to get useful photographs.
Stage 4: Work history verification – continue to investigate systems to extend information reliably on places and length of time a doctor has worked, and his/her position.
Stage 5: Bilateral agreement on English testing.
Stage 6: Bilateral acceptance of entry examinations, e.g., PLAB and NZREX.

In the future, mutual access at certain levels of each body's registration database is a possibility so that a direct check of credentials could be made from the primary source.

Exchange of Disciplinary Information

Those in discussion have agreed that a global solution for storing and exchanging disciplinary information is unlikely at this time due to the many challenges that would have to be overcome. Instead, it will be more effective to find mul-

tiple and even regional solutions, and to continue developing ideas such as the implementation of privacy waivers and collection of licensure information at the point of registration so that information can eventually be targeted to where it is most useful. A session at the IAMRA conference is being planned to discuss this issue and share ideas.

Exam Review Working Group

IAMRA's Exam Review Working Group has been reviewing the standards of differing registering/licensing exams used by six jurisdictions including Australia, Canada, Ireland, New Zealand, the United Kingdom and the United States (USMLE and COMLEX). The group is trying to determine if it would be possible for the jurisdictions to bi-laterally or multilaterally accept each others' examinations for overseas trained doctors entering these jurisdictions. The group's research has included reviewing the stated purpose of the various exams and assessing the examination construction process. The group has also examined the level and scope of the entry requirements, examination formats, scope of the exam (for equivalency in coverage of areas of medicine), equivalency in assessment standards (for both basic knowledge and clinical skills) and pass rates. Additionally, the group has been studying mechanisms used to set examination standards and determining if outcomes of the examinations can be linked to future performance by examinees. The working group will develop a matrix of how the exams work, document their research in an international journal focusing on best practices, and forward the information to the jurisdictions for their use in determining if agreements are possible.

Medical Regulation Thesaurus

A "thesaurus" of medical regulatory terms has been drafted and distributed to all regulators listed in the international directory. The purpose of the thesaurus is to enhance communication between regulators so that varied usage of terms is understood across jurisdictions. In order to ensure the thesaurus is a valuable tool, regulators have been asked to report any differences they see in the way the words are defined in their jurisdictions, which will then be included in the document as a means of comparison. Upon completion, the thesaurus will be forwarded to IAMRA membership for their use and posted on IAMRA's website.

QUESTIONNAIRE FROM THE FINANCE AND DEVELOPMENT COMMITTEE

The Finance and Development Committee produced and distributed a questionnaire that was specifically designed for feedback from IAMRA members on benefits they hope to gain by being a member of IAMRA. The responses will be considered by the Management Committee as they prepare an organizational business plan for the next two to three years, and will be presented to IAMRA membership for approval at the Members General Assembly in 2006.

BYLAWS COMMITTEE EVALUATION

The Bylaws Committee has begun its evaluation of the organization's bylaws, including recommendations submitted by membership for amendments to the document and recommendations for improving IAMRA's dues structure. A draft report will be forwarded to IAMRA members next spring for comment. All comments will be considered by the committee for incorporation into the bylaws and for reconstruction of the dues structure. A final report will be developed and submitted to the Management Committee for approval, and then presented to IAMRA members for approval at the Members General Assembly.

IAMRA WEBSITE EXPANSION

IAMRA's website is being expanded so that it can be used by members as an active resource in their efforts to research standards, policies and systems of medical regulators worldwide and learn about new developments in medical regulation. A message board has been activated so that members can communicate with each other in forum discussions. Additionally, documents from all IAMRA committee and working group meetings and Members General Assemblies are being posted in the Members Only section, and the international directory is being modified to contain jurisdiction-specific information, to be accessible to members only. The Management Committee encourages members to place the IAMRA website link onto their own websites to increase accessibility by regulators and the public. The URL is http://www.iamra.com.

WELLINGTON, NEW ZEALAND

CONSULTATION PAPER – PATHWAY TO REGISTRATION WITHIN A VOCATIONAL SCOPE FOR INTERNATIONAL MEDICAL GRADUATES

The Medical Council of New Zealand (Council) has identified the need to review the pathway to registration within a vocational scope of practice for international medical graduates. In anticipation of changes to the current path-

way, the Council has prepared a consultation document suggesting possible changes. The Council is consulting various stakeholders, including the vocational branch advisory bodies.

The Council is seeking comment on this paper, and welcomes your responses to the questions asked in the document. In particular, the Council is interested in your views on alternative methods of assessing a doctor's competence as a specialist in a particular scope of practice and their suitability for registration within a vocational scope of practice.

The Council would appreciate any comments you or your organization might be able to offer on the consultation paper. The paper can be downloaded in Adobe Reader PDF at: http://www.mcnz.org.nz/Default.aspx?tabid=1199. Please send your response to Joan Crawford, Registration Manager, at the Council office or by e-mail to regsupport@mcnz.org.nz by Feb. 20, 2006.

LET US HEAR FROM YOU

Would you like for information from your board to be considered for publication in the *Journal*? If so, e-mail articles and news releases to Edward Pittman at epittman@fsmb.org or send via fax to (817) 868-4098.