You show me yours and I'll show you mine—medical mobility and regulatory cooperation

Details of disciplinary action taken against doctors who work abroad are often difficult to track down, so it can be tempting for doctors with something to hide to try and conceal their history. *Richard Marchant* offers his view on the challenges facing medical regulators

The challenge

Dr A is a clever, resourceful, and well travelled physician who has practised medicine around the world. He is also a serial liar and fraudster. On his CV he claims qualifications he was never awarded and lists posts he has not held. He also omits to mention certain appointments that he has held and countries where he has worked. One of his favourite scams is to steal the identities of other doctors who are no longer practising. He then uses their good standing to enable him to continue working. By maintaining several different identities simultaneously he can try to ensure that, if one identity is uncovered, there are others he can fall back on.

Dr A is not typical. The vast majority of doctors are doing a good job in difficult circumstances and want to contribute positively to the healthcare system in which they work. But the damage that can be done by the minority who are unfit to practise their profession, but move easily between jurisdictions, can be disproportionate to their numbers. Patients may be harmed, confidence in the profession damaged, and trust in the regulatory system shaken. The challenge for medical regulators worldwide is to find effective mechanisms for facilitating the mobility of the majority who wish to move, while preventing the dangerous minority from putting patients at risk.

The drive for free movement

In 2004 the GMC (General Medical Council) granted more than 12 500 new full registrations to doctors. Of these, 19% were from the EEA (European Economic Area) and 44% were international graduates. Despite the expansion in the number of UK medical schools, it seems likely that we will continue to register significant numbers of non-UK graduates. Indeed, the enlargement of the European Union (EU) in 2004 coincided with the GMC registering 650 more doctors from Europe than in 2003, and the thrust of recent EU legislation has been to remove barriers to the free movement of professionals and services.

Slipping through the net: more international cooperation is needed

We showed you ours

The GMC has long been alert to the need to share details of disciplinary action it has taken, but the flow of information has tended to be one way. While we have adopted policies for proactively notifying our international partners of sanctions we have imposed on a doctor's registration, reciprocity has been rare. There are various reasons for this—different perceptions about what information should be exchanged and with whom and when it should be shared, different regulatory systems with different priorities, concerns about data protection and proportionality, and fear of information overload. Even within Europe, although regulators are usually willing to respond to specific requests for information, there is little proactive cooperation.

Pressure for change

A number of developments now provide an opportunity for more effective international collaboration. The recently adopted directive on the recognition of professional qualifications,[1] although aimed at facilitating professional mobility, will balance this with a duty for regulators to exchange information on serious matters that may affect an individual's right to practise his or her profession. So regulators will have to review their ways. The Dutch presidency of the EU in 2004 helped to focus minds when it held a conference in Amsterdam on the obstacles to successful information sharing. The baton has now been picked up by the United Kingdom, which took over the EU presidency in July. Using the theme of patient safety, the *Healthcare Professionals Crossing Borders*[2] project has brought together stakeholders from across the EU to work on practical initiatives to improve cooperation between regulators. Preliminary results will be known in the autumn.

IAMRA and the international experience

These issues are not unique to Europe, so it is worth looking at what we can learn from others. The International Association of Medical Regulatory Authorities (IAMRA) was established in 2000. Its purpose is to support medical regulators worldwide in protecting the public interest by promoting high standards for medical education, licensure, and regulation, and facilitating the exchange of information. It has a membership of 73 regulators from 30 countries and is supporting policy analysis, research, and sharing of best practice across a range of regulatory activities. Two areas are relevant to the present discussion—the development of a fast track credentials system (FTCS) and the sharing of information about doctors' fitness to practise.

FTCS

For many years, medical regulators have required doctors who wish to practise in their territory to provide certificates of their good standing issued in the countries where they have been practising. These confirm that an individual is not subject to disciplinary proceedings in those countries. But it is difficult to guard against the use by doctors of fraudulent certificates. Even where the system works well, the transmission of documents from ▶

one country to another can be slow, meaning that doctors' registration may be delayed. To address this problem, two IAMRA members, the GMC and the Medical Council of New Zealand, began piloting the electronic exchange of encrypted data directly between regulators. The GMC has since begun to operate the same system with a number of EU regulators.

Meanwhile, the GMC/New Zealand project is being extended to include other countries and support the electronic transmission of a wider range of information (including qualifications, date of birth, sex, photograph, and passport number) intended to enable the host regulator swiftly and confidently to verify the credentials of a migrating doctor. In future, it will not be so easy for Dr A to ply his trade across the world.

Sharing of fitness to practise information

But providing information in response to a request is only half the answer. If Dr A does not tell you where he has been, you may not know who to ask for information. Further, doctors often maintain registration in two or more countries simultaneously, making it easy for them to move between jurisdictions without having to undergo the checks of their good standing that would be made at the point of entry to the register. Regulators must therefore be more proactive in the way they engage with others to ensure that those who are unfit to practise cannot use their professional mobility to flee one jurisdiction only to put patients at risk in another.

A central database containing details of disciplinary sanctions imposed is sometimes offered as the solution. IAMRA's experience shows that, although technically feasible, it is unreliable if regulators are unwilling to post information on the database. It is also poor at targeting information to where it is most likely to be useful. IAMRA is now looking at how regulators can adopt an approach based on risk assessment to disseminate information more accurately to those who most need to know.

Conclusion

There is unlikely to be a single, global solution to these issues. Rather, a series of regional answers that take account of local factors is the more likely way forward. The experience of IAMRA suggests some options.

STEFAN ROUSSEAU/PA/EMPICS

Richard Neale, the gynaecologist who practised in Britain after losing his licence in Canada, was erased from the register in 2000

What IAMRA illustrates more generally is the benefit of greater international collaboration between regulators. This is not confined to rooting out rogue physicians. Other IAMRA projects include a comparison of international licensing examinations (such as the Professional and Linguistic Assessment Board (PLAB) test) to establish whether they could be mutually recognised across jurisdictions, and support for the development of regulation in countries from the developing world. IAMRA's 7th International Conference on Medical Regulation in New Zealand in 2006 will provide opportunities for regulators to share best practice. The developments now taking place under the UK presidency of the EU provide an opportunity for European regulators to establish some best practice of their own. ■

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1 *Directive on the recognition of professional qualifications adopted on 6 June 2005 by the Council of the European Union.*
2 Department of Health. *Healthcare professionals crossing borders. UK presidency patient safety initiative.* London: DoH, 2005.

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Off the wall solutions for on the ball doctors

Problem: How does one establish what doctors are really worth?

Solution: Float doctors on the stock market

Establishing the true value of doctors is an incredibly complex affair, and all stakeholders, be they patients, colleagues, managers, or politicians, will have different ways of measuring a doctor's worth. **solutions.doc** believes the best way to determine the value of doctors is to float them on the stock market, and let the market decide. The idea of simplifying the complex issue of "value" down to a share price has great appeal. This has, after all, been used to establish the value of most other aspects of life.

Thus, if patients are grateful for what their doctor has done, rather than baking them a cake, they could buy shares. In order to help decide what a doctor's share price should be, we fully advocate having full access to the doctor's CV, as well as publicising data from audit, performance in league tablets, etc. In fact, this is the only situation in which audit data and league tables might be of any use.

The advantages are obvious. When determining how much to pay doctors, managers can simply look at share prices and pay them accordingly—performance related pay in its most elegant form. When trying to decide which doctor to appoint to a post, we suggest simply picking the one highest in the Doctors' FTSE, again providing doctors with a real incentive to perform well and increase their market value.

As the money invested would be ploughed into the NHS, buying shares in doctors would almost offer an alternative to private health insurance. Patients could develop an investment portfolio in areas that match the diseases they think will affect them as they get older. Naturally, those who have invested in the health service in this way would be able to exert influence on how individual doctors or departments operate, as well as being offered preferential treatment. Supporting the NHS in this way would, quite literally, pay dividends. ■

solutions.doc (An independent think tank of two practising NHS doctors)
(V Mohan and A O'Brien)