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Meeting Report

**International Association Medical Regulatory Authorities Meeting
September 20-23, 2016 - Melbourne, Australia**

The International Association Medical Regulatory Authorities (IAMRA) held its biennial meeting on September 20-23, 2016 in Melbourne, Australia. More than 500 regulators from more than 46 countries attended the meetings, including leaders from The American Osteopathic Association, National Board of Osteopathic Medical Examiners, National Board of Medical Examiners, Federation of State Medical Boards, and various United States (US) state medical and osteopathic medical boards. Many poster programs were displayed, with a focus being on incorporating science and research into the regulation of medicine. The General Members Assembly elected Humayun Chaudhry, DO to serve as Chair for a two-year term (2016-2018). Dr. Chaudhry is the first physician from the United States of America to serve as IAMRA Chair, as well as, the first DO to do so.

IAMRA originated from a forum that was held in 1994 in Washington, DC, and was initially funded by a US Department of Health and Human Services grant. IAMRA's vision is to ensure that patients around the world are treated and cared for by a safe and competent physician. They encourage best practices among medical regulatory authorities worldwide through scientific, educational and collaborative activities. IAMRA has members from every region of the world, including medical regulatory authorities, medical schools, professional colleges and regulators of other health professions.

The global impact for regulation is seen not only in memberships, but also in responses to recent Zika and Ebola outbreaks challenging health systems around the world. Diseases travel as well as physicians travel, and targeted recruitment of medical doctors continues. Higher pay, improved quality of life, safety and security for their families creates an atmosphere that allows for mobility of the medical school graduate. Each step of a physician's career, from graduating from medical school, completing certifications exams, establishing credentialing and licensure requirements, and maintaining competency through licensure renewal/revalidation is global. Data sharing worldwide is critical to IAMRA's vision and mission that every patient be treated safely. Presentations from speakers represented various countries, and were very informative. I have chosen to highlight several that I found to be of particular interest.

Canada recently passed the "Carter Decision" which allows for, "medication assistance in dying". Prior to this, the Canadian criminal code stated it was unconstitutional to assist patients in death. Upon further review, they determined that their code was not actually giving the patient a fundamental right of choice, as patient autonomy is a fundamental right in Canada. Canada has two forms of euthanasia (clinician administered) or physician assisted suicide (patient administered). Criteria includes a competent adult (>18 years old) entitled to public health care, clear consent to terminate life, grievous and irremediable medical condition, and experience enduring suffering that is intolerable.

Australia reported on experiences with its Lyme Disease epidemic. Complaints regarding some questionable treatment practices have been an issue recently. It was also noted that there have

been 12 cardiac arrests associated with cosmetic procedures. After years of study, Australians recently issued *Guidelines for Registered Medical Practitioners Who Perform Cosmetic Medical and Surgical Procedures*.

Representatives from the United Kingdom discussed “risk-based regulation” and mandatory revalidation for licensure. They provided an overview of their campaign to reduce harm based on risk. This includes, “collecting information on harm in a systematic manner, and then identifying hotspots of risk that are amendable to a regulatory response.” The example provided, was the higher than usual complaints for surgeons in the 60 - 75 years old age group. As a result, this group is investigated closely by the regulatory agency. They described two styles of regulation; the “soft” is compliance assistance, focusing on preventative partnerships with problem solving. The “hard” style is enforcement, which includes a reactive, adversarial and incident driven response.

The General Members Assembly updated its bylaws, streamlining its classes of membership to either member or partner. The Management Committee was expanded from eight to twelve members, all IAMRA officers including Chair , Chair-elect, Secretary, Immediate Past Chair and eight members at large (six regional and two non-regional). The regions are:

- Africa
- Asia
- Australasia Pacific
- Europe
- Central and North America
- South America

This expansion was considered because of membership growth. Three resolutions were passed. These included an IAMRA Statements on Accreditation, Continued Competency, and Facilitating the Professional Development of Faculty through Short-term International Placements. In addition, Margaret Mungherera, MD of Uganda was elected Chair-elect.

Overall, the IAMRA conference was very informative. The pre-conference organization and post conference follow up was excellent, with ample time for networking with the Victorian Ministry of Health and a dinner social at Melbourne Conservatorium of Music. The Australians were a gracious host with their attitude of “no worries mate”. The next IAMRA meeting is scheduled for Dubai, the United Arab Emirates in 2018.

Respectfully submitted,



Anna Z. Hayden, DO
President