Medical Council
OF NEW SOUTH WALES

Annual Report 2013

Annual Report 2013

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> about the **medical council of new south wales**

The Medical Council of New South Wales (the Medical Council) is a statutory authority established to manage complaints and notifications in relation to conduct, performance and health matters about registered medical practitioners in New South Wales (NSW). It also manages notifications and complaints about health and conduct matters relating to registered students training in NSW.

The Medical Council undertakes its regulatory functions in partnership with the Health Care Complaints Commission (HCCC), which is a separate statutory authority, established under the *Health Care Complaints Act 1993*.

The Medical Council is one of 14 health professional councils in NSW. The Health Professional Councils Authority (HPCA) provides secretariat and corporate services to the NSW councils to assist them in carrying out their regulatory responsibilities.

> **charter**

The Medical Council is a statutory body constituted under the *Health Practitioner Regulation National Law (NSW).* The Medical Council exercises the powers, authorities, duties and functions conferred on it by the *Health Practitioner Regulation National Law (NSW).* The object of the *Health Practitioner Regulation National Law (NSW)* is to establish the National Registration and Accreditation Scheme (the National Scheme). The objectives of the National Scheme are:

a) to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered; and
b) to facilitate workforce mobility across Australia by reducing the administrative burden for health practitioners wishing to move between participating jurisdictions or to practise in more than one participating jurisdiction; and
c) to facilitate the provision of high quality education and training of health practitioners; and
d) to facilitate the rigorous and responsive assessment of overseas-trained health practitioners; and
e) to facilitate access to services provided by health practitioners in accordance with the public interest; and
f) to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners.

> aims and **objectives**

The purpose of the Medical Council is to act in the interests of the public by ensuring that registered medical practitioners are fit to practise and medical students are fit to have contact with members of the public while they undertake approved programs of study. In the exercise of functions under the *Health Practitioner Regulation National Law (NSW),* the protection of the health and safety of the public must be the Medical Council's paramount consideration.

The Medical Council manages a range of programs, services and procedures to achieve its purpose. As a result, members of the public can be assured that registered medical practitioners are required to maintain suitable and appropriate standards of conduct and professional performance.

Medical Council
OF NEW SOUTH WALES

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23 October 2013

The Hon Jillian Skinner MP
Minister for Health
Minister for Medical Research
Level 31 Governor Macquarie Tower
1 Farrer Place
SYDNEY NSW 2000

CONFIDENTIAL

Dear Minister,

I have the pleasure of forwarding to you the Annual Report of the Medical Council of New South Wales for the year ending 30 June 2013.

The report has been prepared in accordance with the provisions of the *Annual Reports (Statutory Bodies) Act 1984* and the *Public Finance and Audit Act 1983*.

We trust that this Report clearly demonstrates the Medical Council's commitment to ensuring that it meets its charter of protecting the people of NSW through efficient and effective administration of the *Health Practitioner Regulation National Law (NSW)*.

Yours sincerely,

P G Procopis
President

G J Kesby
Deputy President

Enclosure

> president's **report**

It is now three years since the commencement of the National Registration and Accreditation Scheme. In that time, the Medical Council of NSW has adjusted to change while also responding to and managing an increased workload of complaints against practitioners and associated regulatory activity.

Complaints against NSW medical practitioners continued to increase this year. There was a significant increase in the number of matters referred to the Medical Council following assessment of the complaint with the Health Care Complaints Commission (HCCC). This reflects the Medical Council's view that it is important to take action in response to conduct which may not necessarily require investigation or prosecution, but which still represents a departure from acceptable standards. Activity in the Medical Council's Performance Program also continued to rise during the year with a substantial increase in the number of complaints managed and finalised. Again this is illustrative of the Medical Council's view that it is important to consider and, if appropriate, take action in response to unsatisfactory performance that may not necessarily require investigation or prosecution, but which still represents a departure from accepted standards.

In order to respond to this increased activity and to ensure that it remains an effective, innovative and robust regulator, the Medical Council identified a number of strategic initiatives that it will start in the next financial year. This will include: the establishment of ongoing and effective communication with key stakeholder groups; evaluating the effectiveness of the Medical Council's programs to identify areas for improvement and to inform quality assurance review; and reviewing internal processes and delegations to improve decision-making.

An example of the Medical Council's support of quality assurance review is its participation in the Australian Research Council Linkage Grant Research being undertaken by the University of Sydney. This research will examine the national registration of health practitioners and undertake a comparative study of the complaints and notification models under the national and NSW systems. The research commenced this year, and the Medical Council, together with a number of other NSW health professional councils, is a partner to the research along with the Australian Health Practitioner Regulation Agency and the HCCC.

The year saw change in the membership of the Medical Council with seven new members being appointed by the Governor. The appointment of these new members ensured that the Medical Council benefited from new perspectives into its activities and decision-making. The new membership of the Medical Council also resulted in a change of membership throughout its Health, Performance, Conduct and Corporate Governance committees.

The year also saw the NSW Government announce changes to the structure of the Health Professional Tribunals with the creation of a new NSW Civil and Administrative Tribunal (NCAT) which is due to commence on 1 January 2014. The NCAT will assume responsibility over the Medical Tribunal. Once NCAT commences, Medical Tribunals will no longer be held in the District Court or presided over by a District Court Judge. The Medical Council has worked closely with the Attorney-General and Justice Department to ensure that many of the unique features which exist within the current structure of the Medical Tribunal are retained. This will ensure that the Medical Tribunal continues to effectively exercise its protective jurisdiction and take appropriate action against medical practitioners who are found guilty of professional misconduct.

Throughout the year, the Medical Council continued to develop and update policies relevant to its regulation of medical practitioners in NSW. This included updating its policy on the use of chaperones following allegations of sexual misconduct and its protocol on urine drug testing, and developing new guidelines on publishing decisions to a third party following a performance panel.

The Medical Council also endorsed a number of corporate governance policies, which replaced a number of previous policies. These included an updated *Code of Conduct for Members* and *Conflict of Interest* and *Gifts and Benefits* policies.

The Medical Council also provided comment and submissions on a range of policies issued by the Medical Board of Australia, including a policy explaining social media and professional obligations and proposed changes to the *Medical Practice: A Code of Conduct for Doctors in Australia.*

The Council's success in continuing to manage increasing complaint numbers would not be possible without the considerable contribution made by its members and hearing members. These medical practitioners and community representatives contribute their time and expertise to assist the Council in discharging its legislative responsibility of ensuring public protection.

On behalf of the Council, I look forward to continuing to meet the challenges ahead and in guiding the Medical Council so that it continues to effectively and efficiently regulate medical practitioners in NSW and protect the public.

Peter Procopis
President

> year in **summary**

The following table gives an overview and a three-year comparison of the Medical Council's activities in its three major areas of activity: professional conduct, performance and health. The table includes information relating to the Medical Council's role in monitoring compliance with conditions on a practitioner's registration following a performance, conduct or health outcome. The table also provides information as to the number of registered medical practitioners whose principal place of practice is NSW[1].

Table 1: Year in summary

	2010/11	2011/12	2012/13
Professional conduct			
Complaints assessed	1,407	1,508	1,696
Professional Standards Committees finalised	14	17	10
Medical Tribunal complaints finalised	18	22	27
Medical Tribunal appeals and review applications finalised	6	4	5
Conduct Interview and Counselling finalised	30	19	36
Section 66 proceedings / s66AB proceedings finalised (under previous Medical Practice Act)	11	-	-
Section 150 proceedings finalised (including section 150A and section 150C proceedings)	49	53	45[2]
Health			
Medical practitioners in Health Program	111	122	118
Entrants to Program	29	29	21
Impaired Registrants Panels conducted	46	64	48
Board / Medical Council Review Interviews conducted	242	234	226
Performance			
Medical practitioners in Performance Program	79	70	97
Entrants to Program	31	25	40
Performance Assessments conducted	25*	22	10
Re-Assessments conducted	2*	3	15
Performance Review Panels conducted	10*	12	12
Performance Interviews conducted	25*	69	77
Exit from Program	17	22	13
Monitoring			
New cases – Health Program	19	37	25
New cases – Performance Program	4	8	3
New cases – Conduct Program	34	31	31
Total cases completed	73	81	57
Total active cases	232	227	239
Registration			
Medical practitioners in NSW	27,686	28,972	30,333
Medical students in NSW		5,800	5,853
Total number of medical practitioners in Australia	88,293	91,648	95,690

[1]Data concerning registration numbers for medical practitioners who have a principal place of practice as NSW or students training in NSW has been obtained from the Australian Health Practitioner Regulation Agency annual reports 2011/12 and 2012/13.
[2]Data for 2012/13 includes matters where practitioners consented to the imposition of conditions or suspension under section 41P of the *Health Practitioner Regulation National Law (NSW).*
* Reported in 2010/11 as matters "concluded" which accounts for the variation from the figures as reported in that year.

> structure of the **medical council** and the health professional councils authority

Membership of the Medical Council of NSW

On 1 July 2012 the Governor of NSW appointed seven new members and reappointed 12 existing members to the Medical Council following the expiry of the terms of some previous appointments. The Medical Council now comprises 19 part-time members, one less than the previous composition as there is no longer a nominee from the Ministry of Health.

All members have been appointed for a period of three years to 30 June 2015, except for the nominees from the Royal Australasian College of Medical Administrators, the Royal College of Pathologists of Australasia, and the Royal Australian and New Zealand College of Radiologists. The nominees from these three Colleges have been appointed for 18 months to 31 December 2013.

These changes are the result of the continuing consultation and review of the composition of the Medical Council by the Minister for Health.

Membership of the Medical Council is prescribed in Part 2 of Schedule 1A of the *Health Practitioner Regulation (New South Wales) Amendment (Health Professional Councils) Regulation 2012.* Part 2 of Schedule 5C of the *Health Practitioner Regulation National Law (NSW)* prescribes the positions of the President and Deputy President.

Membership includes six female members, one member with a disability, and six members with a culturally diverse background.

Members of the Medical Council, their qualifications, term of appointment and nominating body for the period 1 July 2012 to 30 June 2013 are listed below. During this period, six ordinary meetings were held. Attendances at these Medical Council meetings are recorded in square brackets.

Professor Peter George Procopis AM, President, MBBS (Sydney), FRACP, Royal Australasian College of Physicians nominee (current term: 1.7.2012 – 30.6.2015) [5]

Dr Greg Kesby, Deputy President, MBBS Hons (UNSW), BSc Hons (UNSW), PhD (Cambridge), FRANZCOG, DDU, CMFM, Royal Australian and New Zealand College of Obstetricians and Gynaecologists nominee (current term: 1.7.2012 – 30.6.2015) [5]

Associate Professor Stephen Adelstein, MB BCh (Wits), PhD (Sydney), FRACP, FRCPA, FFSc (RCPA) Royal College of Pathologists of Australasia nominee (current term: 1.7.2012 – 31.12.2013) [3]

Professor Belinda Bennett, B Ec. LLB (Macquarie), LLM SJD (Wisconsin), FAICD, Legal Member nominated by the Minister (current term: 1.7.2012 – 30.6.2015) [5]

Dr Roger Gregory David Boyd, MBBS (Sydney), MBA (Geneva), MHP (UNSW), FRACMA, AFCHSM, Royal Australasian College of Medical Administrators nominee (current term: 1.7.2012 – 31.12.2013) [5]

Mr Antony Carpentieri, LLB (UTS) Hons, Ministerial nominee (current term: 1.7.2012 – 30.6.2015) [4]

Mr Michael Christodoulou AM, Community Relations Commission nominee (current term: 1.7.2012 – 30.6.2015) [6]

Dr Bruce David Doust, BSc(Med), MBBS (Sydney), LLB (Macquarie,) FRANZCR, Royal Australian and New Zealand College of Radiologists nominee (current term: 1.7.2012 – 31.12.2013) [6]

Professor Anthony Andrew Eyers, MBBS (Sydney), FRACS, FRCS, Master of Bioethics (Monash), Royal Australasian College of Surgeons nominee (current term: 1.7.2012 – 30.6.2015) [5]

Professor Cheryl Anne Jones, MBBS Hons 1 (UTas), FRACP (Paediatrics), PhD (Sydney), Universities nominee (current term: 1.7.2012 – 30.6.2015) [4]

Ms Rosemary Eva Kusuma, BSW (Sydney), Ministerial nominee (current term: 1.7.2012 – 30.6.2015) [5]

Dr Alix Genevieve Magney, BA Sociology (Hons), PhD Sociology (UNSW), Ministerial nominee (current term: 1.7.2012 – 30.6.2015) [6]

Mr Jason Masters, BEc. (Flinders), GAICD, CFIAA, CRMA, CGEIT, CFE, JP, Ministerial nominee (current term: 1.7.2012 – 30.6.2015) [5]

Associate Professor Rodney James McMahon, MBBS (Sydney), Flt Lt (ret), DRCOG, DRANZCOG, IDD (Hons) MMED FAIM, FRACGP, Royal Australian College of General Practitioners nominee (current term: 1.7.2012 – 30.6.2015) [5]

Dr Robyn Stretton Napier, MBBS (Sydney), Australian Medical Association nominee (current term: 1.7.2012 – 30.6.2015) [5]

Dr Julian Parmegiani, MBBS (Hons) (UNSW), FRANZCP, Royal Australian & New Zealand College of Psychiatrists nominee (current term: 1.7.2012 – 30.6.2015) [6]

Ms Lorraine Poulos, RN (SVH), Grad Cert HSM (ECU), Ministerial nominee (current term: 1.7.2012 – 30.6.2015) [5]

Clinical Associate Professor Richard George Walsh, MBBS (Sydney), FANZCA, Ministerial nominee (current term: 1.7.2012 – 30.6.2015) [6]

Dr Choong-Siew Yong, MBBS (Sydney), FRANZCP, Australian Medical Association nominee (current term: 1.7.2012 – 30.6.2015) [5]

Medical Council members generally serve on two or more committees, including the Conduct Committee, Health Committee, Performance Committee, Executive Committee and Corporate Governance Committee. The committees are established pursuant to section 41(F)

of the *Health Practitioner Regulation National Law (NSW)* to assist the Medical Council in the exercise of its functions. Committee members need not be members of the Medical Council. (See Table 2 for details of the composition of the committees.)

The Medical Council acknowledges the invaluable contribution of the following members of the profession and the public who serve as members of Medical Tribunals, Professional Standards Committees, Impaired Registrants Panels, Performance Review Panels, urgent Inquiries, interview panels, committees, and in a variety of other capacities, including as auditors and performance assessors:

Dr G Abouyanni, Dr S Allnutt, Dr H An, Dr P Anderson, Dr K Arnold, Dr C Barnes, Dr A Bean, A/Prof C Benness, Dr R Benson, Dr C Berglund, Dr H Bittar, Dr L Boshell, Dr D L Brash, Dr G Buckland, Dr C Clarke, Ms A Collier, Dr C Commens, Dr S Cowap, Dr M Cox, Dr G P Curtin, A/Prof M da Cruz, Dr J Davidson, Dr R Davies, Dr V de Carvalho, Dr M Diamond, Dr A Dilley, Dr G Dore, Dr S Dorney, Dr K Edwards, Ms G Ettinger, Dr P Fishburn, Dr R Fisher, Dr J Fogarty, Dr R Ford, Dr M Friend, Dr S Gani, Dr M Gardner, Dr M Giuffrida, Dr A Glass, Dr M Gleeson, Dr P R Gordon, Dr A Gould, Ms A Gray, Dr G Herkes, Dr M Higgins, Dr A Holdgate, Ms J Houen, Dr S Howle, Dr K Ilbery, Dr W Jammal, Dr M Jarrett, Ms M Kelly, Mr R Kelly, Dr J Kendrick, Dr E Kertesz, Dr A Keshava, Dr M Khadra, Ms H Kiel, Dr L King, Prof P Klineberg, Dr E Kok, Dr P Langeluddecke, Prof H Lapsley, Dr V Lele, Dr R Lyneham, Dr J Mair, Dr L Macken, Prof B McCaughan, Dr M McGlynn, Dr A Meares, Dr S Messner, Dr P Morse, Dr J Ng, Dr N O'Connor, Dr B Parsonage, Dr A Pethebridge, Dr J Phillips, A/Prof R Rae, Dr J Raleigh, Dr W Reid, Ms D Robinson, Dr J Rodney, Dr I Rotenko, Prof D Rowe, Dr J Sammut, Dr A Samuels, Dr D Semmonds, Mr R Smith, Dr R Spark, Dr J Spies, Prof A Spigelman, Dr E Stafford, Dr I Stewart, Dr D Storey, Dr J Sullivan, Dr K Sundquist, Dr V Sutton, Dr I Symington, Dr S-H Toh, Dr E Tompsett, Dr V Tran, Dr P Truskett, Dr F Varghese, Dr A Virgona, Dr A Walker, Dr M Walker, Dr B Westmore, Dr P C Wijeratne, Dr J M Wright, Dr M Wroth, Dr G Yeo.

Executive Officer

Mr Ameer Tadros is the Executive Officer of the Medical Council of NSW under section 41Q of the *Health Practitioner Regulation National Law (NSW).*

Senior Officers

Jeanette Evans
Director
Health Professional Councils Authority

Ameer Tadros BA/LLB (ANU) MALP (Sydney)
Assistant Director, Medical
Health Professional Councils Authority,
Executive Officer, Medical Council of NSW

David Rhodes B Soc Stud, Grad Cert in Health Management
Assistant Director, Allied Health, Nursing and Midwifery
Health Professional Councils Authority

Iain Martin B Ec (Syd), Dip Law (LPAB)
Assistant Director, Legal
Health Professional Councils Authority

Tim Burke BBus FCA, FCPA, FCSA, FCIS
Assistant Director, Finance and Shared Services
Health Professional Councils Authority

Dr Joanna Hely BMed, Dip RANZCOG, MHA, FRACMA
Medical Director
Health Professional Councils Authority (to 31.5.2013)

Miranda St Hill BA LLB (Monash)
Legal Director, Medical
Health Professional Councils Authority

Table 2: Medical Council of NSW committees 2012/13

CONDUCT	HEALTH	PERFORMANCE	EXECUTIVE	CORPORATE GOVERNANCE
Chair **G Kesby**	**Chair** **C-S Yong**	**Chair** **R McMahon**	**Chair** **P Procopis**	**Chair** **B Bennett**
S Adelstein	R Boyd	B Bennett	B Bennett	S Adelstein
B Bennett	A Carpentieri	B Doust	G Kesby	R Boyd
A Carpentieri	M Christodoulou	A Eyers	R McMahon	M Christodoulou
A Eyers	B Doust	C Jones	C-S Yong	R Kusuma
C Jones	R Kusuma	G Kesby		J Masters
A Magney	R Napier	A Magney		P Procopis
J Masters	J Parmegiani	R Napier		
R McMahon	L Poulos	J Parmegiani		
P Procopis	P Procopis	L Poulos		
R Walsh		P Procopis		
C-S Yong		R Walsh		
M Walker		J Sammut		
		E Tompsett		

Remuneration

The members of the Medical Council are remunerated as follows:

- President $43,266 per annum
- Deputy President/Committee Chair $27,038 per annum
- Members $12,978 per annum

Medical Tribunal

The NSW Medical Tribunal is established under section 165 of the *Health Practitioner Regulation National Law (NSW)* and comprises four members. The Chairperson or Deputy Chairperson of the Medical Tribunal is a Judge of the Supreme Court, a Justice of the Industrial Relations Commission or Judge of the District Court of NSW. For each Medical Tribunal hearing, the three other members are appointed by the Medical Council.

Chairperson:

- The Honourable Justice R O Blanch – Chief Judge (current term: 1.7.2010 – 9.5.2014)

Deputy Chairpersons:

- His Honour Judge R H Solomon (retired 26.9.2012)
- Her Honour Judge H G Murrell SC (reappointment: 6.12.2012 – 6.12.2019)
- Her Honour Judge A S Balla (current term: 1.7.2010 – 24.6.2015)
- His Honour Judge P Johnstone (current term: 1.7.2010 – 24.6.2015)
- The Honourable Justice A F Backman (current term: 1.7.2010 – 23.9.2015)
- The Honourable Justice C G Staff (current term: 1.7.2010 – 23.9.2015)
- His Honour Judge A M Colefax SC (current term: 22.9.2010 – 21.9.2017)
- His Honour Judge M A Elkaim SC (current term: 22.9.2010 – 21.9.2017)
- His Honour Judge S L Walmsley SC (current term: 2.10.2010 – 1.10.2017)
- Her Honour Judge L Flannery SC (current term: 5.12.2012 – 4.12.2019)
- His Honour Judge P I Lakatos SC (current term: 5.12.2012 – 4.12.2019)
- His Honour Judge P G Mahony SC (current term: 5.12.2012 – 4.12.2019)
- His Honour Judge L A Levy SC (current term: 5.12.2012 – 4.12.2019)

Health Professional Councils Authority

The Health Professional Councils Authority (HPCA) provides shared executive and corporate services to the 14 NSW health professional councils, including the Medical Council, to support their regulatory responsibilities.

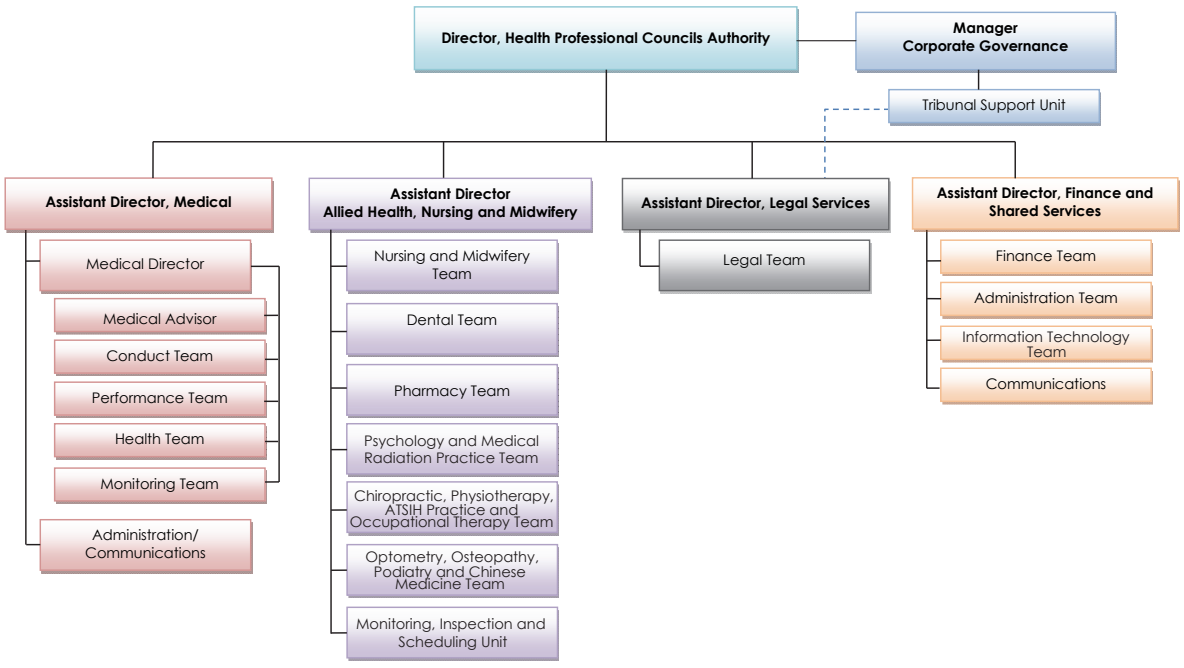
On behalf of the councils, the HPCA liaises with:

- AHPRA regarding financial, registration and reporting matters,
- the HCCC on notifications (complaints) management, and
- the Ministry of Health on human resources and providing advice and responses to the Minister for Health and the Director-General on regulatory matters and appointments.

This coordinated approach provides efficiencies through shared services that would be costly for small bodies, like the councils, to implement on their own. It also allows councils to direct their attention to protection of the public by concentrating on their core regulatory functions.

The Medical Council and the HPCA have signed a three-year service level agreement (SLA) effective from 1 July 2012. The SLA articulates the services the HPCA provides and key performance indicators against which performance is assessed annually. It provides certainty and a shared understanding for the Medical Council and the HPCA on the range and quality of services provided.

Chart 1: Health Professional Councils Authority organisation chart (June 2013)



> regulatory **activities**

- **National registration**
- **Professional conduct**
- **Health**
- **Performance**
- **Monitoring**

> national **registration**

Health practitioners, including medical practitioners, are registered to practise their profession under the National Registration and Accreditation Scheme (the National Scheme). Through the introduction in 2010 of the National Scheme, responsibility for registering and regulating health practitioners and accrediting education programs transferred from State and Territory authorities to National Boards.

The National Boards are supported by the Australian Health Practitioner Regulation Agency (AHPRA), which has an office in each State and Territory including in NSW.

Further information about the Medical Board of Australia can be obtained from the Australian Health Practitioner Regulation Agency (AHPRA) website at www.ahpra.gov.au.

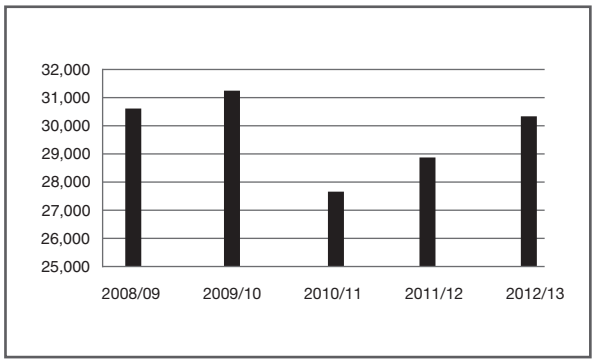
NSW did not adopt the regulatory part of the National Scheme which involves the management of complaints and notifications about health practitioners. Instead, the co-regulatory environment that existed in NSW prior to the commencement of the National Scheme was maintained. As a result, the NSW health professional Councils and the Health Care Complaints Commission continue to be responsible for assessing and managing complaints about the professional performance, conduct and health of practitioners, including medical practitioners, and about the health and conduct of medical students in NSW.

Registrations in NSW

At 30 June 2013, there were 30,333 medical practitioners whose principal place of practice was in NSW. This represents approximately 31.7% of the total number of 95,690 medical practitioners registered under the National Scheme across Australia. There are 5,853 students registered to undertake approved programs of study in NSW. This represents approximately 30.1% of the total number of 19,434 medical students registered under the National Scheme across Australia. Data for the current reporting year has been provided by AHPRA.

Chart 2 below provides information about the number of registered medical practitioners in NSW from 2008/09 to 2012/13. Following the commencement of the National Scheme, there was a fall in the number of medical practitioners whose principal place of practice is recorded as NSW when compared to practitioners who were registered with the former NSW Medical Board. The fall is due to medical practitioners who were registered previously in both NSW and their home State or Territory now only being required to hold one registration nationally.

Chart 2: Registered medical practitioners in NSW



> professional **conduct**

2012/13 snapshot

- → 1,677 complaints against medical practitioners were received by the Medical Council and the HCCC in 2012/13.
- → 1,696 complaints were jointly assessed by the Medical Council and HCCC, of which 1,033 (61%) were discontinued and 82 (5%) were referred for investigation by the HCCC. Three hundred and eighty-three were referred to the Medical Council – an increase of 41% from the previous year.
- → The Medical Council received 87 reports of notifiable conduct (up from 72 in the previous reporting year), the majority of which related to professional conduct issues. Six mandatory notifications were referred for investigation following initial assessment by the Medical Council and the HCCC.
- → The Medical Tribunal made determinations on 27 complaint matters against 26 practitioners which resulted in 11 practitioners having their registration cancelled or being disqualified from being registered. One practitioner was suspended. The remaining 14 practitioners were subject to orders made by the Tribunal.
- → 10 Professional Standards Committee decisions were handed down. Eight practitioners had unsatisfactory professional conduct findings made against them and consequential orders were made.
- → The Medical Council considered exercising its powers to take urgent interim action to protect the public under section 150 on 40 occasions. As a result of these urgent proceedings, 10 practitioners were suspended, 27 practitioners had conditions imposed on their registration and no action under section 150 was taken in relation to three practitioners. An additional four practitioners surrendered their registration.

Introduction

In NSW, complaints concerning medical practitioners and medical students are handled in a co-regulatory model in conjunction with the Health Care Complaints Commission (HCCC). Management of complaints received is one of the ways the Medical Council acts to protect the public, by ensuring registered medical practitioners practise in a competent and ethical way.

Any person may complain to either body about the conduct of a medical practitioner or medical student. In addition, health practitioners and employers are obliged to report misconduct or impairment of a medical practitioner that falls under mandatory notification provisions of the *Health Practitioner Regulation National Law (NSW).* The Australian Health Practitioner Regulation Agency (AHPRA) can also receive complaints and notifications about medical practitioners. Where such complaints relate to matters in NSW, AHPRA forwards these to the Medical Council and the HCCC for assessment and management. (The Medical Council also notifies AHPRA of all complaints it receives and when the management of complaints is finalised).

The Medical Council and the HCCC consult on initial assessment and subsequent handling of all complaints. Consultation to assess complaints occurs weekly. Consultation also occurs at various stages during a HCCC investigation and prior to any prosecution of a complaint before a disciplinary body.

When a complaint is made the following may occur, depending on the facts of the complaint and the extent of available evidence:

- The Medical Council may take immediate interim action under section 150 of the *Health Practitioner Regulation National Law (NSW).* Section 150 empowers the Medical Council to suspend or to impose conditions on a practitioner's registration if the Medical Council is satisfied such action is appropriate to protect the life or physical or mental health of any person or if the action is otherwise in the public interest;
- After assessment, a complaint may require further investigation by the HCCC. Following completion of this further investigation by the HCCC, a complaint may be:
  - referred to the Director of Proceedings for a determination as to whether to prosecute the complaint before a Professional Standards Committee (PSC) or a Medical Tribunal;
  - referred for comments to be made to the practitioner;
  - terminated;
  - referred to the Medical Council for appropriate action. A referral of a complaint to the Medical Council may result in a medical practitioner being interviewed or counselled in relation to his/her conduct. The practitioner might also be dealt with in the Medical Council's Health or Performance program.

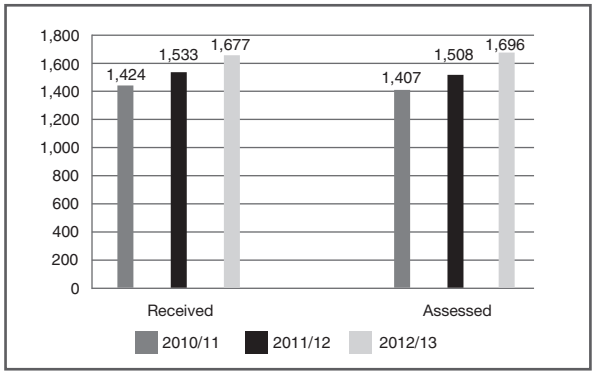
Further information about making a complaint and complaints management processes is available in the 'Doctors' performance, conduct and health' section of the Medical Council website www.mcnsw.org.au.

Complaints and notifications

Complaints received

In 2012/13, the Medical Council and the HCCC received 1,677 complaints, up from 1,533 in the previous year (a 9.4% increase). This increase is consistent with increasing numbers of complaints received and assessed over recent years (see **chart 3**).

Chart 3: Complaints received and assessed from 2010/11 to 2012/13



During this reporting year, complaints concerning clinical competence continued to dominate as the main area of complaint. Complaints concerning communication have increased by 4% compared to last year, while complaints about conduct decreased by 7%. Table 3 shows the types of complaints assessed over the past three reporting periods.

Table 3: Type of complaint (%) 2010/11 to 2012/13

	2010/11 n=1,407	2011/12 n=1,508	2012/13 n=1,696
Clinical competence	55	57	60
Communication	15	10	14
Conduct	23	27	20
Practice administration	7	6	6

Complaints assessed

During the reporting year, the Medical Council and the HCCC together assessed 1,696 complaints (up from 1,508 in the previous year). This included 14 complaints received prior to 30 June 2012, but which were assessed in 2012/13.

At assessment a complaint may be discontinued if it falls outside the Medical Council's or HCCC's jurisdiction, if it does not relate to health care, or if it does not raise sufficiently serious issues. In some instances, a complaint is discontinued at assessment because the parties have resolved the matter prior to assessment.

The Medical Council considers that a complaint should be referred to the HCCC for disciplinary investigation if there is evidence of unethical, reckless, wilful or criminal behaviour in either clinical or non-clinical domains. In all other circumstances, public protection can be achieved through the application of non-disciplinary and educative responses. Options include referring complaints to the Medical Council for consideration through its health or performance programs, or referring complaints to conciliation or assisted resolution with a complaints resolution officer at the HCCC. Information concerning the Medical Council's non-disciplinary health and performance programs appears elsewhere in this Annual Report.

Table 4 illustrates the trends in complaint assessments over the past three reporting years.

Table 4: Outcomes of complaint assessments (%) 2010/11 to 2012/13

	2010/11 n=1,407	2011/12 n=1,508	2012/13 n=1,696
Investigation	6	6	5
Refer to the Medical Council	16	18	22
Refer to another person or body	1	2	2
Resolution*	10	9	10
Decline to deal with	67	65	61

**Resolution includes referral of a complaint for conciliation or direct resolution with a complaints resolution officer at the HCCC.*

There has been an increase in the number of complaints referred to the Medical Council following complaint assessment in this reporting year: 373 complaints were referred to the Medical Council as compared to 265 in the previous reporting year – a 41% increase. This has resulted in an increase in the Council's professional conduct work. This is best illustrated by the 89% increase in the number of medical practitioners who have been counselled/interviewed in 2012/13, up from 19 in 2011/12 to 36 in 2012/13.

The number of complaints referred for conciliation or direct resolution has also increased in this reporting year (161 matters, as compared to 136 in 2011/12 and 140 in 2010/11).

Mandatory notifications

Notifications received

Division 2 of the *Health Practitioner Regulation National Law (NSW)* sets out the requirements for reporting notifiable conduct to AHPRA. Where the conduct has occurred in NSW, AHPRA forwards the mandatory notification to the Medical Council and the HCCC.

Notifiable conduct is defined in section 140 of the *Health Practitioner Regulation National Law (NSW).* It requires registered health practitioners, education providers and employers of a registered medical practitioner to make a report if they have formed a reasonable belief that another registered medical practitioner has:

1. practised the profession while intoxicated by alcohol or drugs
2. engaged in sexual misconduct in connection with the practice of the medical practitioner's profession
3. placed the public at risk of substantial harm in the medical practitioner's practice of the profession because the medical practitioner has an impairment
4. placed the public at risk of harm because the medical practitioner has practised the profession in a way that constitutes a significant departure from accepted professional standards.

In 2012/13, the Medical Council received 87 mandatory notifications (up from 72 in the previous reporting year). **Table 5** illustrates the trend of increasing numbers of mandatory notifications lodged over the past three reporting years.

Table 5: Number of mandatory notifications received 2010/11 to 2012/3

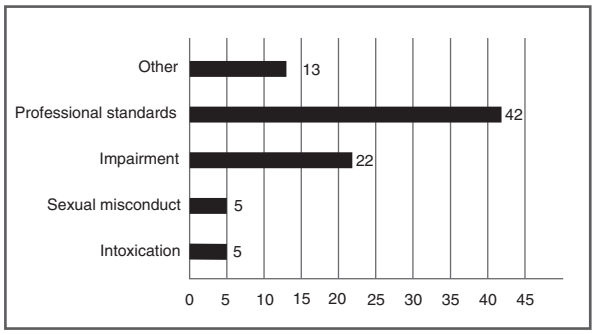
	2010/11	2011/12	2012/13
Number of mandatory notifications received	47	72	87

Reasons for the increase in mandatory notifications since 1 July 2010 are likely to be due to an increased awareness of reporting obligations by health practitioners and employers. Under the provisions of the *Health Practitioner Regulation National Law (NSW),* the obligation to report notifiable conduct extends to all health practitioners, employers and education providers. Prior to the commencement of the National Scheme, only medical practitioners were subject to mandatory reporting requirements.

The 87 notifications received have been categorised into the four grounds of notifiable conduct, and into a fifth category that represents instances where the notifier believed he or she was reporting a mandatory notification, but the issues raised in the notification did not fall within one of the grounds of notifiable conduct set out in the *Health Practitioner Regulation National Law (NSW).* These notifications are assessed as complaints. As can be seen from **Chart 4**, professional standards comprise the largest category of notifiable conduct and impairment the second largest. Together these two categories represent 74% of the total number of matters which have triggered an obligation to report notifiable conduct.

Mandatory notifications about professional standards usually relate to matters concerning diagnosis, treatment, prescribing and communication. Mandatory notifications about impairment usually relate to matters concerning psychiatric illness, drug or alcohol abuse and cognitive impairment.

Chart 4: Mandatory notifications received 2012/13



Notifications assessed

The Medical Council and the HCCC assessed 87 mandatory notifications during this reporting period. Three of these mandatory notifications were from different notifiers but related to the same medical practitioner. **Table 6** illustrates the assessment outcomes: a significant proportion of the mandatory notifications were referred to the Medical Council's health, performance or conduct programs. Six mandatory notifications (7%) were referred for investigation by the HCCC.

Table 6: Outcome of mandatory notifications assessed 2012/13

Investigation	6 (7%)
Refer to the Medical Council	51 (59%)
Refer to another person/body	7 (8%)
Resolution	2 (2%)
Decline to deal with	21 (24%)
TOTAL	**87**

Of the mandatory notifications referred to the Medical Council, 27 (52%) were referred to the Health Program. The majority of these matters related to psychiatric illness or drug abuse. This follows a similar trend to that of the previous reporting year. Seventeen mandatory notifications (33%) were referred to the Performance Program. The majority of these matters related to treatment, diagnosis and prescribing.

Investigations

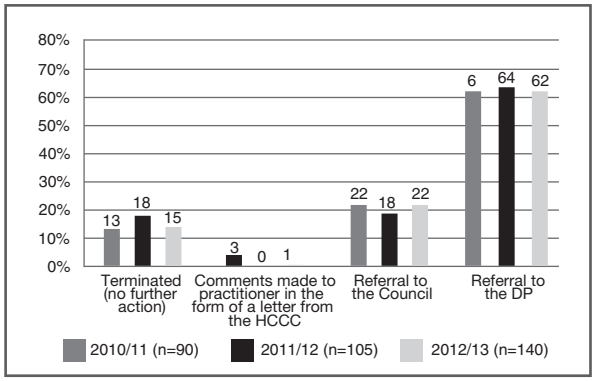
Complaints are referred for investigation by the HCCC when, at the time of assessment, the information before the Medical Council or the HCCC appears to raise significant issues of public health or safety, or if substantiated, would provide grounds for disciplinary action against the medical practitioner or involves gross negligence on the part of the medical practitioner. In 2012/13, 82 complaints were referred to the HCCC for investigation (down from 90 complaints referred in the previous reporting year).

Investigation outcomes

The HCCC is required to consult with the Medical Council before deciding what action to take following the completion of the investigation; however the final decision concerning the appropriate outcome rests with the HCCC. During this reporting year, 140 investigations were finalised, a significant increase from 105 investigations in the previous reporting year.

Section 39(1) of the *Health Care Complaints Act 1993* identifies the outcomes available to the HCCC at the completion of its investigation. This includes referral of a matter to the Medical Council or to the HCCC Director of Proceedings (DP), comments being made to the practitioner in the form of a letter from the HCCC, or termination of the matter and no further action being taken. **Chart 5** provides a three-year comparison of outcomes of investigations.

Chart 5: Investigation outcomes: 2010/11 to 2012/13 by outcome category



Matters referred to the Medical Council

The courses of action available to the Medical Council following referral of a practitioner at the conclusion of a HCCC investigation includes disciplinary counselling or referral of the practitioner for consideration through the Medical Council's Health or Performance programs.

As **Table 7** illustrates, of the 31 investigated matters referred to the Medical Council in 2012/13:

- 15 investigations resulted in practitioners being referred to disciplinary counselling;
- 5 investigations resulted in practitioners being counselled by comments in a letter;
- 4 investigations resulted in the practitioner being referred to the Performance Program;
- 6 investigations resulted in the Medical Council referring the matter to AHPRA (as the medical practitioner had surrendered his/her registration); and
- no further action was taken in one matter as the medical practitioner had surrendered his/her registration.

Table 7: Outcomes of HCCC-investigated matters referred to Medical Council 2012/13

Disciplinary counselling	15
Counselling by comments/letter	5
Performance Program	4
Refer to AHPRA	6
No further action	1
TOTAL	**31**

Matters referred to the Director of Proceedings

Upon referral of an investigation to the Director of Proceedings (DP), the DP considers whether or not the complaint should be prosecuted before a disciplinary body. The DP is required to consult with the Medical Council prior to making such a determination, although the final determination rests with the DP. Section 90B of the *Health Care Complaints Act 1993* sets out the functions of the DP and section 90C of the *Health Care Complaints Act 1993* identifies the relevant criteria the DP must take into account when making a determination as to whether or not to prosecute a complaint before a disciplinary body. The criteria include the protection of the health and safety of the public, the seriousness of the alleged conduct and the likelihood of proving the alleged conduct.

In 2012/13, the DP made the determinations as set out in **Table 8.**

Table 8: DP determinations 2012/13

	Number of investigations	Number of practitioners
Not to prosecute a complaint	8	3
Referred a complaint to a Professional Standards Committee	18	18
Referred to a Medical Tribunal	67	23
TOTAL	**93**	**44**

In the reporting period the DP determined not to prosecute eight complaints before a disciplinary body because there was insufficient evidence. This involved three practitioners and no further action was taken with respect to these investigations. In some instances more than one complaint against an individual practitioner was prosecuted before a Medical Tribunal.

Notifying AHPRA

The Medical Council communicates with AHPRA to ensure an alert is placed on its system in matters where the HCCC or the DP determines to take no further action because the medical practitioner has surrendered his/her registration or when a medical practitioner

is not registered as his/her registration had already been cancelled by the Medical Tribunal. This ensures that in the event that the medical practitioner seeks registration in the future, the outcome of the investigation can be taken into account when considering the suitability of the medical practitioner to hold registration.

Complaints remaining under investigation

Open investigations
At 30 June 2013 the HCCC reported that 62 practitioners were currently under investigation (up from 59 practitioners in the previous reporting year).

Open matters with the DP
At the conclusion of the reporting year, 40 matters involving 34 practitioners were with the DP awaiting consideration of possible disciplinary action (down from 62 matters at the same time in the previous reporting year).

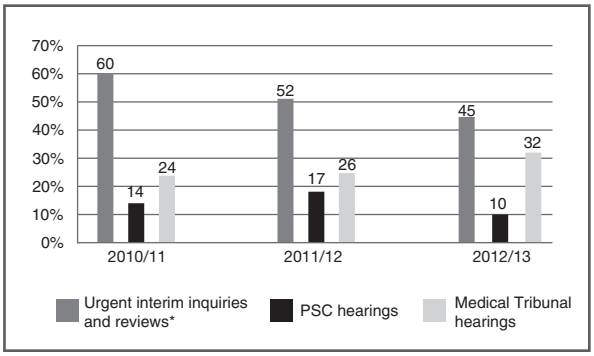
Disciplinary proceedings

The *Health Practitioner Regulation National Law (NSW)* establishes a number of disciplinary procedures and bodies of inquiry to deal with complaints that a medical practitioner may have engaged in unsatisfactory professional conduct or professional misconduct. These include:

- disciplinary counselling
- the use of the Medical Council's powers to take urgent interim action to protect the public (section 150 proceedings)
- Professional Standards Committee hearings
- Medical Tribunal hearings.

Chart 6 below provides an overview of the total number of section 150 proceedings and reviews, PSC hearings, and Medical Tribunal hearings (of complaints, appeals and review matters) that have been finalised over the past three reporting years.

Chart 6: Section 150 proceedings and reviews, PSC and Medical Tribunal hearings finalised 2010/11 to 2012/13



** The total for 2012/13 includes practitioners that have consented to conditions or suspensions under section 41P of the Health Practitioner Regulation National Law (NSW) in lieu of urgent interim inquiries*

Counselling interviews

Section 145B of the *Health Practitioner Regulation National Law (NSW)* provides that the Medical Council may direct a medical practitioner to attend counselling. A medical practitioner may be referred to counselling or interview in the following circumstances:

- at the completion of an investigation by the HCCC;
- following a determination by the DP not to prosecute a complaint; or
- following completion of the assessment of a complaint under section 25B of the *Health Care Complaints Act 1993.* (In relation to this type of referral, the Medical Council may determine that counselling is not warranted and resolve to invite the medical practitioner to attend the Medical Council for an interview to discuss any concerns that have come to the Medical Council's attention.)

A referral to counselling usually occurs because a practitioner's apparent departure from acceptable standards is considered to be not significant enough as to warrant referral to the DP or prosecution before a disciplinary body, but still significant enough to raise concerns that require counselling. Counselling provides an opportunity for the practitioner to reflect upon the issues raised within the context of his/her practice and to critically examine suggestions for improvements to his/her practice.

Table 9 illustrates the number of practitioners referred and the number of practitioners who were counselled/interviewed by the Medical Council. There were 41 practitioners referred to counselling/interview, which is a 52% increase from 27 referred during 2011/12. There was a significant increase in the number of practitioners referred for interview or counselling, up by 89% from 19 to 36. This reflects the Medical Council's view that it is important to take action in response to conduct which may not necessarily require investigation or prosecution, but which still represents a departure from accepted standards.

Table 9: Medical practitioners referred and counselled/interviewed in 2012/13

	Practitioners referred	Practitioners counselled/ interviewed
Counselling	32	27
Interview	9	9
TOTAL	**41**	**36**

Section 150 proceedings – urgent interim action to protect the public

The Medical Council must exercise its powers under section 150 of the *Health Practitioner Regulation National Law (NSW)* when it is satisfied that such action is appropriate for the protection of the health or safety of any person or persons or it is otherwise in the public interest. As a result of such action, a practitioner's registration can be suspended or conditions can be imposed on their registration. Any

action taken is only an interim public protective measure. Following any Medical Council action under section 150, the matter must be referred to the HCCC for investigation or, alternatively, subject to consultation between the Medical Council and the HCCC, the matter may be referred to an Impaired Registrants Panel (if the practitioner is impaired) or a Performance Assessment (if a condition is imposed requiring a Performance Assessment).

Section 150 proceedings represent a significant proportion of the workload of the Health Professional Councils Authority (HPCA) professional conduct and legal staff who support the activities of the Medical Council. This is due to the urgent nature of the proceedings together with the large volume of proceedings held. Section 150 proceedings are usually held within two to four weeks of a matter being identified as raising sufficient concern to warrant proceedings being held.

The number of urgent interim proceedings held is dependent on the nature and type of concern which comes to the Medical Council's attention from a variety of sources. Triggers for convening section 150 proceedings may include:

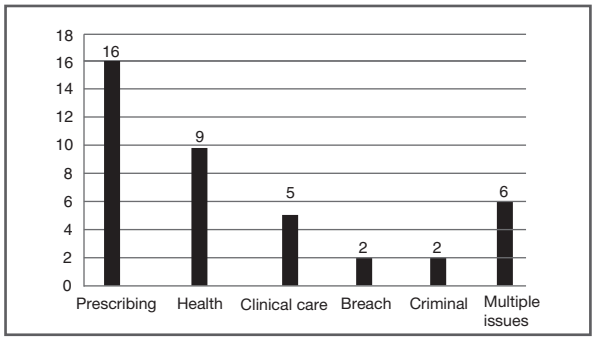
- a practitioner being charged with serious criminal offences (particularly if arising within the practice of medicine)
- a practitioner suffering from a serious impairment and demonstrating little or no insight into the extent of his/her problem and the potential or actual risk posed to the public
- a practitioner recklessly prescribing drugs in a manner which is dangerous and is likely to cause harm, despite previous warnings or counselling, or
- a practitioner breaching conditions imposed on his/her registration.

Section 150 – breakdown of proceedings

In 2012/13, the Medical Council exercised its urgent immediate action powers to protect the public on 40 occasions. This included matters where conditions were imposed or a suspension ordered following an Inquiry and matters where the powers were exercised with the consent of the practitioner under section 41P of the *Health Practitioner Regulation National Law (NSW).*

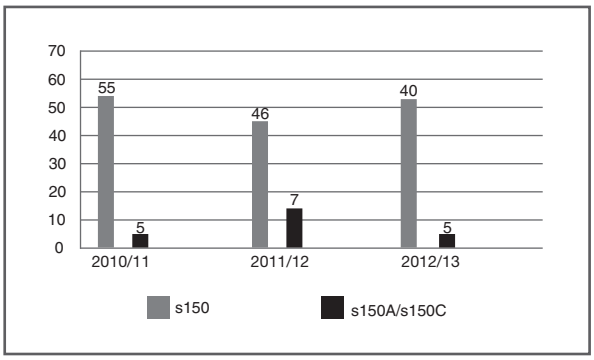
Chart 7 illustrates the categories of matters that initiated section 150 proceedings during this reporting period.

Chart 7: Categories of triggers for section 150 proceedings finalised in 2012/13



The Medical Council concluded 40 section 150 proceedings, including one matter which was finalised from the preceding year. This was fewer than the 46 occasions in 2011/12 and 55 occasions in 2010/11. **Chart 8** provides a comparison in the number of matters with the past two years.

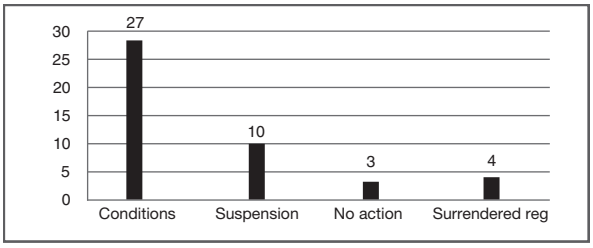
Chart 8: Numbers of occasions the Council considered urgent action to protect the public and number of reviews



(Note: 1. Equivalent hearings were held under sections 66 and 66AB of the repealed Medical Practice Act 1992 and are included in the total numbers of hearings for 2010/11.
2. Data for 2012/13 includes matters where practitioners consented to the imposition of conditions or suspension under section 41P).

As a result of these proceedings, the registration of 10 practitioners was suspended and 27 practitioners had conditions imposed on their registration (as illustrated in **Chart 9**). Three proceedings resulted in no urgent action being taken by the Medical Council. An additional hearing did not have the outcome finalised by the end of the reporting period.

Chart 9: Outcomes of section 150 proceedings 2012/13



On an additional four occasions, the Medical Council resolved to convene section 150 proceedings, however the practitioners surrendered their registration prior to the proceedings being held or before they were completed. This obviated the need for any urgent interim action to be taken by the Medical Council in order to protect the public and illustrates the important public protective effect that section 150 proceedings can have. On two occasions resolutions to convene section 150 proceedings were rescinded due to the Medical Council's consideration of further information provided by the practitioner.

Consent to conditions or suspension under section 41P

Under section 41P of the *Health Practitioner Regulation National Law (NSW),* the Medical Council can, with the consent of the practitioner or student, exercise its section 150 powers to suspend or impose conditions in lieu of convening related proceedings. In this reporting period, seven practitioners consented to the imposition of conditions on their registration and one practitioner consented to the suspension of his/her registration in lieu of convening section 150 proceedings. Six of these matters were in relation to the practitioners' prescribing. Two of these matters were in relation to the practitioners' impairment.

Section 150A and 150C reviews

In addition to the section 150 proceedings held during the reporting year, five section 150A or section 150C reviews were also conducted. These applications relate to the review of orders previously imposed by the Medical Council under section 150. The number of reviews this year has not changed significantly when compared with the seven review hearings in 2011/12 and five review hearings during 2010/11.

Three reviews were considered without the practitioner appearing before the review Inquiry in person. One of these reviews resulted in a change to the conditions and two reviews resulted in no changes to the practitioner's conditions. Two reviews were considered by an Inquiry where the practitioner attended in person and neither resulted in changes to the practitioner's conditions. A further two applications for review were lodged but were withdrawn prior to the Inquiry being held.

Professional Standards Committees

A Professional Standards Committee (PSC) is established under section 169 of the *Health Practitioner Regulation National Law (NSW)* and comprises four members. The Chairperson is an Australian lawyer who is appointed by the Medical Council. The Medical Council also appoints the other Committee members who include two registered medical practitioners and a person who is not registered in the same profession from a panel of persons nominated by the Minister for Health.

The HPCA provides a legal officer and administrative support staff to assist the PSC and monitors compliance with any orders and conditions that are imposed by the PSC.

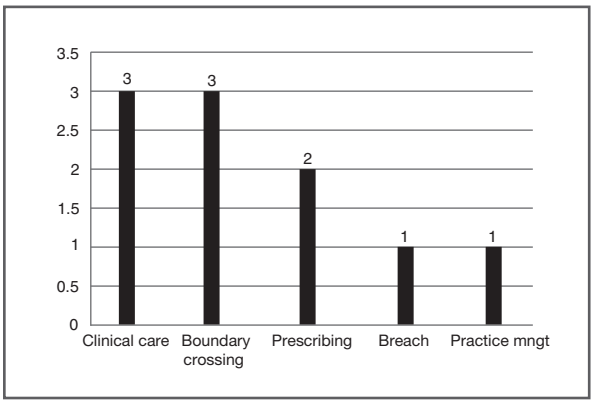
PSC inquiries are open to the public and are held in the Old Medical Council Building (Building 54A) at the former Gladesville Hospital, Gladesville. Details of upcoming PSC inquiries are published on the Medical Council's website. In almost all PSC matters, the parties are legally represented by a solicitor and more often than not by a barrister.

PSC inquiries

In the 2012/13 reporting year, 10 Professional Standards Committee (PSC) inquiries were finalised in relation to complaints prosecuted by the HCCC, compared to 17 in 2011/12 and 14 in 2010/11. Six PSC inquiries were heard but were yet to be finalised by the end of 2012/13. An additional 11 matters were referred to PSCs but were yet to be heard within the reporting period.

The categories of complaints which were considered by PSCs that were finalised during 2012/13 varied, with clinical care and boundary crossing being the most prevalent. **Chart 10** illustrates the categories of complaints heard by PSCs during this reporting period.

Chart 10: Categories of complaints heard by PSCs in 2012/13

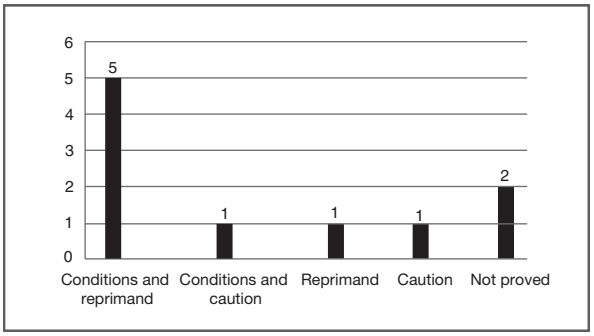


PSC outcomes

In the reporting year, PSCs found the practitioner guilty of unsatisfactory professional conduct in eight of the 10 inquiries that were finalised. Two practitioners were found not guilty of unsatisfactory professional conduct. An additional PSC inquiry was adjourned and the practitioner was referred to a section 150 inquiry.

Chart 11 illustrates the orders made by PSCs in the reporting year.

Chart 11: PSC outcomes in 2012/13



The following is a list of PSC decisions concerning medical practitioners for the reporting period, which are published in full on the Medical Council's website at www.mcnsw.org.au (subject to any relevant non-publication directions).

Table 10: PSC decisions 2012/13

Decision date	Practitioner	Outcome
17/08/2012	Gregory Maxwell McCarten	Reprimand and conditions
23/08/2012	Mark Christopher James Craddock	Reprimand and conditions
19/09/2012	William Douglas Wade	Reprimand
19/11/2012	Artin Jebejian	Reprimand and conditions
18/02/2013	Nada Kolak	Reprimand and conditions
13/03/2013	Anoop Sankaranarayanan	Caution
13/03/2013	Dr B	Not proved
05/06/2013	Arunendu Bahadur Singh	Reprimand and conditions
21/06/2013	Thomas Tjung Kwong Tjeuw	Cautioned and conditions

Medical Tribunals

The NSW Medical Tribunal is established under section 165 of the *Health Practitioner Regulation National Law (NSW)* and comprises four members. The Chairperson or Deputy Chairperson of the Medical Tribunal is a Judge of the Supreme Court, a Justice of the Industrial Relations Commission or Judge of the District Court of NSW.

The Medical Council appoints the non-judicial members to sit on all Medical Tribunal hearings, appeals and review hearings, and staff of the HPCA monitor compliance with any orders and conditions that are imposed by a Tribunal. While complaints before the Tribunal are prosecuted by the HCCC, the Medical Council is a party (respondent) to review hearings and certain appeals which are lodged in the Tribunal. Medical Tribunal hearings are open to the public and are held at either the District Court or the Industrial Relations Commission.

Table 11 illustrates the concluded Tribunal matters over the past three reporting years.

Table 11: Concluded Medical Tribunal hearings 2010/11 to 2012/13

	Complaint matters	Appeal matters	Applications for review/ restoration applications
2010/11	18 (and 1 terminated)	1 (and 2 withdrawn)	5 (and 2 withdrawn)
2011/12	22 (and 3 withdrawn)	2	2 (and 2 withdrawn/terminated)
2012/13	27 (and 2 withdrawn)	1 (and 2 withdrawn)	4 (and 3 withdrawn/terminated)

The NSW Civil and Administrative Tribunal (NCAT) will commence operation in January 2014. It is proposed that from its commencement, NCAT will assume responsibility for the matters currently dealt with by the NSW Medical Tribunal. (See the 'President's report' in this annual report for more information.)

Medical Tribunal complaint hearings

Twenty-three complaints (two of which related to the same practitioner) were referred to the Medical Tribunal in the reporting year.

Following referral of a complaint to the Medical Tribunal Registry, a number of directions hearings are held and then a hearing date will be allocated by the Chairperson of the Tribunal. The Tribunal's decision may be delivered at the completion of the hearing or reserved and delivered at a later date. Consequently, complaints that are referred to the Medical Tribunal are generally unlikely to be finalised within the same reporting year.

The number of complaint matters finalised in the Medical Tribunal increased again this year (27 compared with 22 in 2011/12 and 18 in 2010/11). Two further complaints were withdrawn. One of the complaints withdrawn by the HCCC was subsequently referred to a PSC and the other complaint was withdrawn due to the practitioner surrendering his/her registration.

There are 28 complaint matters that have been referred to the Medical Tribunal that are yet to be determined. Of these, four have been adjourned indefinitely and six have been set down for hearing in the second half of 2013. In one matter the Tribunal has made findings in relation to the complaint and the matter is scheduled for further hearing in relation to the protective orders.

Medical Tribunal complaint hearing outcomes

In all of the 27 complaints finalised against 26 practitioners, the Tribunal found the practitioner guilty of unsatisfactory professional conduct and/or professional misconduct.

The number of matters finalised in relation to appeals to the Tribunal and applications for review to the Tribunal remained constant, with five in this reporting period as compared to four in 2011/12 and six in 2010/2011. A further seven matters were withdrawn, or terminated by the Medical Tribunal this year.

In these complaint cases, the Tribunal made findings in relation to the complaints either being proven in full or in part. Protective orders were made in respect of each of the 26 subject practitioners with the details illustrated in **Chart 12**. Eight practitioners had their registration cancelled by the Tribunal and three were disqualified from re-registering for a specified period or until specified criteria were met. This is an increase on last year's total of three practitioners who either had their registration cancelled or disqualified. Two of the cancelled practitioners were also prohibited from providing health services generally. One practitioner was suspended with conditions imposed while one practitioner was reprimanded. Thirteen practitioners were issued with a reprimand in addition to the imposition of conditions or orders and of these practitioners, three were also fined.

Chart 12: Medical Tribunal determinations (complaint matters) 2012/13

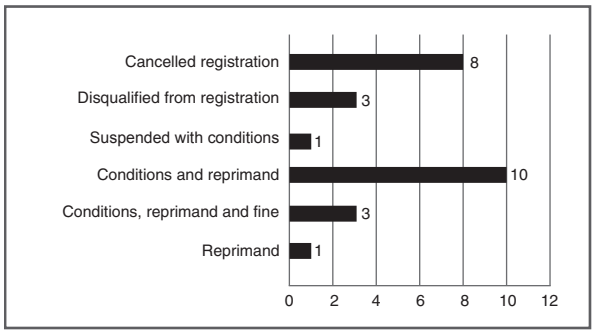
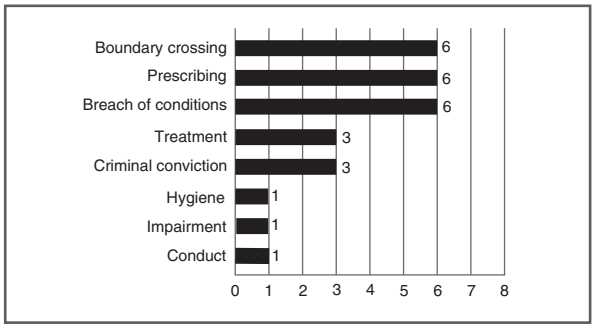


Chart 13: Medical Tribunal determinations (complaint issues) 2012/13



Boundary crossing, prescribing issues and breach of conditions were the main categories identified in the complaints finalised by the Medical Tribunal in the reporting period. **Chart 13** illustrates the nature of complaints matters determined by the Tribunal.

Medical Tribunal decisions listed in the following table are published in full on the Medical Council's website (subject to any relevant non-publication directions) at www.mcnsw.org.au. In matters where no judgment was handed down, the orders have been published. A practitioner's current registration status, including the details of any published conditions, is available from AHPRA's website at www.ahpra.gov.au. A search of the AHPRA website can also be made for the details of medical practitioners whose registration has been cancelled.

Table 12: Medical Tribunal decisions in relation to complaints 2012/13

Judgment Date	Practitioner	Tribunal Decision
03/07/2012	Anthony Constantine Bosnich	Reprimanded, conditions imposed and fined
19/07/2012	Andrew Robert Small	Reprimanded and conditions imposed
01/08/2012	Peter Edwin Jones	Reprimanded, conditions imposed and fined
22/08/2012	Antony Underwood	Reprimanded and conditions imposed
31/08/2012	Thomas Murai Fiay	Registration cancelled
14/09/2012	Robert Darlow Smith	Registration cancelled
17/09/2012	James Alexander Justin Woolcock	Reprimanded and conditions imposed
18/10/2012	Renato Di Mascio	Reprimanded and conditions imposed
07/11/2012	Roman Hasil	Reprimanded and conditions to be met prior to applying for re-registration
14/12/2012	Kiro Ristevski	Registration cancelled and reprimanded
14/12/2012	Rasha Howari	Registration cancelled
25/01/2013	Andrew John Snell	Reprimanded and not to apply for re-registration for 18 months
06/02/2013	Victor King	Registration cancelled and not to apply for 12 months
22/02/2013	Aron Kondasinghe Sudath	Registration cancelled and not to apply for 24 months
22/02/2013	Reddall Ernest Leslie	Reprimanded and conditions imposed
01/03/2013	Guy Kingsley Herron	Reprimanded and conditions imposed
11/03/2013	Peter Sau Onn Chang	Reprimanded and conditions imposed
08/04/2013	Hugh Stewart Paterson	Reprimanded and conditions imposed
12/04/2013	Riju Chandra Ramrakha	Reprimanded and conditions imposed
18/04/2013	David Justin Moss	Suspended for 6 months and conditions imposed
22/04/2013	Mohammed Mofizur Rahman	Registration cancelled and not to apply for 96 months
15/05/2013	Ian Robert Hutchins	Reprimanded
17/05/2013	John Philip Rolleston	Registration cancelled, not to apply for 48 months and prohibited from providing health services generally
22/05/2013	Christopher Michael Maendel	Reprimanded and conditions imposed
06/06/2013	Robyn Lesley Pogmore	Registration cancelled, not to apply for 12 months and prohibited from providing health services generally
21/06/2013	Saeid Saedlounia	Reprimanded, conditions imposed and fined

Medical Tribunal appeals

No appeals were referred to the Medical Tribunal in the reporting year. Three appeals from the previous year were outstanding at the beginning of the year and have now concluded. There are no outstanding appeals.

The Tribunal heard an appeal against the Medical Board of Australia's decision to refuse an application for registration. The appeal was dismissed and the applicant ordered to pay costs. An appeal against conditions imposed by a Performance Review Panel (PRP), and an appeal against the Medical Board of Australia's decision not to grant general registration were withdrawn by the applicants.

Table 13: Medical Tribunal appeal decisions 2012/13

Judgment date	Practitioner	Tribunal decision
09/11/2012	Geoffrey Ian Barratt	Appeal dismissed

Medical Tribunal applications for review

Two applications for review were referred to the Medical Tribunal in the reporting year. Five applications for review were outstanding from the previous reporting year. All review matters were concluded and there are no outstanding reviews. The Medical Council appears as the respondent in these applications.

All of the seven applications for review finalised by the Tribunal in the reporting year related to applications for review of cancellation orders. Four applicants were successful in their applications (reinstated) and were registered subject to conditions. One application was struck out and two applicants withdrew their applications.

Table 14: Medical Tribunal application for review decisions 2012/13

Judgment date	Practitioner	Tribunal decision
04/07/2012	Steven Anthony Goodman	Reinstated with conditions
16/08/2012	Melvin Kesavan Muralidharan	Reinstated with conditions
12/12/2012	Rajesh Baddipudi Samson Dinakar	Reinstated with conditions
19/04/2013	John Andrew Balafas	Reinstated with conditions

Review of Medical Tribunal orders

Under section 163A of the *Health Practitioner Regulation National Law (NSW),* a practitioner may apply to the Medical Council for a review of an order that conditions be imposed on the practitioner's registration. In 2012/13, three practitioners applied for a review of an order imposing conditions on their registration. Two of these practitioners were seeking a review of an order concerning the imposition of conditions made by the Medical Tribunal. One practitioner sought a review of an order made by a PSC after changing his principal place of practice.

> health

2012/13 **snapshot**

- → 90 notifications were made to the Health Program, compared with 99 in 2011/12 and 71 notifications in 2010/11.
- → 19% of notifications were made by colleagues, 6% were self-notified, 16% were referred from AHPRA and 19% were made by treating practitioners or as a result of a hospital admission. 27% of notifications came from other sources.
- → 48 Impaired Registrants Panels were conducted and considered issues related to psychiatric illness (46%), drug addiction (25%), alcohol addiction (17%) and cognitive problems (8%).
- → Twenty-one practitioners entered and 13 practitioners exited the Program.
- → There were 118 participants in the Health Program.

Overview

A medical practitioner's health is one area that may impact on his or her capacity to practise medicine safely and effectively. Among its range of programs and services aimed at ensuring all medical practitioners in NSW are fit to practise medicine, the Medical Council has a long established Health Program that enables it to deal with impaired medical practitioners and medical students in a constructive and non-disciplinary manner.

The Health Program aims to protect the public while at the same time allowing participants with health problems to remain in active practice or training, if it is safe to do so. The Health Program is designed to be non-disciplinary and non-adversarial and is conducted under the provisions of the *Health Practitioner Regulation National Law (NSW).*

Impairment has a specific, statutory definition. A medical practitioner is impaired if they have a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect their capacity to practise medicine, or for a student, the student's capacity to undertake clinical training. Illness does not necessarily equate to impairment. If an impaired practitioner is insightful and practises within their residual capacity, then they are not necessarily impaired for the Medical Council's purposes.

The Health Program manages medical practitioners suffering from psychiatric illness, problems with alcohol abuse or the self-administration of addictive drugs, cognitive impairment and occasionally, physical illness.

Obligations to notify

The Medical Council through its Health Program receives self-notifications from practitioners and third party notifications including colleagues, employers, treating practitioners, and from AHPRA.

The *Health Practitioner Regulation National Law (NSW)* requires registered health practitioners, education providers and employers of a registered medical practitioner to make a report to AHPRA about certain types of misconduct committed by another registered medical practitioner. Notifiable conduct includes practitioners who are reasonably believed to have been practising while intoxicated through consumption of drugs or alcohol, or to have placed the public at risk of substantial harm in the practitioner's practice of the profession because the practitioner has an impairment (for further information on mandatory notifications activity, see the 'Professional Conduct' section of this Annual Report).

In all other circumstances, although there is no legal obligation for practitioners to notify AHPRA or the Medical Council about practitioners with health problems, there is a strong professional and ethical obligation to do so.

How the Program operates

When a notification is received which raises a legitimate concern about possible impairment, the medical practitioner will be assessed by a Medical Council-appointed practitioner (CAP) to determine the extent and nature of their impairment. The CAP's role is to make an independent assessment about the nature and extent of the impairment and whether participation in the Health Program is appropriate. The medical practitioner will meet with two members of the Medical Council's Impaired Registrants Panel (IRP) and agree on the action necessary to protect the public. The most common outcome is conditions on the medical practitioner's registration, although on occasions, it may be necessary for the medical practitioner to be suspended for a period of time.

Conditions on registration are tailored to address the practitioner's particular circumstances and type of impairment. Under the provisions of the *Health Practitioner Regulation National Law (NSW),* AHPRA is required to notify the practitioner's employer of the conditions imposed on the practitioner's registration.

The Medical Council's Health Committee monitors these conditions, which may include urine drug testing, regular reviews and assessments. Medical practitioners are expected to comply with their conditions of registration so as to assure the Medical Council that they pose no risk to the public. As the medical practitioner demonstrates progress in rehabilitation and recovery, the conditions on their registration are gradually eased. While return to unconditional practice is a goal of the program, some medical practitioners, for example those with recurring psychiatric illness may remain on the program indefinitely, albeit with low level, occasional review by the Medical Council.

The Health Committee also utilises a Chronic Relapsing Illness Authority (CRIA), which allows treating practitioners to advise the Medical Council if there is any concern about the practitioner's health or if the practitioner is non-compliant with treatment, or terminates treatment against advice. This has been useful in replacing the need for some practitioners to remain on the Health Program despite being

stable. A CRIA is also used in some cases as an alternative to entry to the Health Program. Presently, there are approximately 66 practitioners subject to a Chronic Relapsing Illness Authorisation.

The Health Committee requires Health Program participants to attend an exit interview prior to leaving the Program. The interview serves to focus attention on the practitioner's insight, learning and relapse prevention strategies. It also provides the Medical Council with useful feedback about the administration of the Program.

Program activity

Notifications

In the year ending 30 June 2013, the Medical Council received 90 health notifications about practitioners, including 10 medical students. **Table 15** details the source of these notifications and a comparison over the past two reporting years. This year has seen an increase in health complaints/notifications made to the Medical Council by AHPRA. This may occur when a practitioner makes a declaration that he/she is impaired at the time of the initial application for registration or renewal of registration, a process managed by AHPRA. In most of these cases, the practitioner is already in the Health Program and is subject to conditions and monitoring by the Medical Council.

There have been fewer notifications received from employers when compared with last year, although the number is consistent with the number received in 2010/11. Notifications categorised as received from "Other" were made by other regulatory agencies, such as the Health Care Complaints Commission, Pharmaceutical Services of the Ministry of Health, overseas regulatory authorities or other NSW health professional councils.

Table 15: Source of notifications 2010/11 to 2012/13

Notifications by source	2010/11	2011/12	2012/13
Colleagues (including employers)	21	30	19
Self-notifications	16	19	6
University	4	0	1
Medical Council committee	4	4	2
Treating practitioner/hospital admission	20	20	19
AHPRA	Not reported	10	16
Other	6	16	27
Total	**71**	**99**	**90**

Impaired Registrant Panels

There were 48 Impaired Registrants Panels (IRPs) held during the reporting year and 40 IRP reports endorsed by the Health Committee. Six IRPs were convened under section 152K of the *Health Practitioner Regulation National Law (NSW)* which are held following a request by a practitioner to ease or remove conditions or lift a suspension. Twenty-one practitioners entered the program during the reporting year.

Of the 48 IRPs held in the reporting year, 71% recommended that the practitioner agree to conditions being placed on his/her registration, 12% resulted in no further action being taken, 6% were adjourned and some other type of action was taken in the remaining 11%. There are a range of reasons for an IRP being adjourned, including to obtain further information or to allow the practitioner to seek further treatment or support, particularly if they are significantly unwell at the time of the initial IRP.

The details of the nature of impairments considered by an IRP in this and the previous two reporting years appear at **Table 16**. Psychiatric illness continues to be the largest type of impairment considered by IRPs, although this year there was a 40% decrease in these types of matters. There was a 20% increase in the number of IRPs where the nature of the impairment was drug use. This may be a reflection of the increased awareness of mandatory reporting obligations.

The number of matters relating to cognitive impairment has remained steady and reflects the continued awareness that unsatisfactory professional performance or conduct may be caused by an underlying health problem.

Table 16: Nature of impairment considered by IRPs 2010/11 to 2012/13

	2010/11	2011/12	2012/13
Psychiatric illness	31	37	22
Alcohol	8	13	8
Drug	6	10	12
Physical	0	0	2
Cognitive	1	4	4
Total	**46**	**64**	**48**

Review and exit

One of the ways that the Medical Council monitors an impaired practitioner is through regular review interviews. Following the IRP, conditions will require the practitioner to be reviewed by the Medical Council-appointed practitioner (CAP). The CAP will provide the Medical Council with a report on the impaired practitioner's progress and make any recommendations about the easing of conditions. This report is then considered by a Review Interview which provides the Medical Council with an opportunity to examine the practitioner's progress, compliance with conditions and make any recommendations about varying or easing conditions of registration. The frequency of such reviews varies depending on the practitioner's health, progress and level of compliance with conditions. The Medical Council conducted 226 Review Interviews in 2012/13, which was consistent with the number in the previous reporting period.

During 2012/13, a total of 13 practitioners exited the Health Program returning to general registration without conditions. The Medical Council was satisfied that these practitioners had actively sought to manage their impairment, were willing and able to take responsibility for their own health and were safe to practise without conditions. In view of the rehabilitative focus of the Program, this is regarded as a positive and encouraging outcome.

In addition to Health Program participants being monitored, there are practitioners who are also subject to conditions on their registration relating to their health but who are not participants in the Program. This is because the conditions were imposed through another process rather than a Health Program IRP, such as a Medical Tribunal or urgent section 150 proceedings. At the time of reporting there are 15 practitioners in this category being monitored by the Medical Council.

The overall activity of the Health Program is similar to previous years (see **Table 17**), with the number of participants in the Program and number of Review Interviews remaining stable. There has been a slight decrease in the number of IRPs and Exit Interviews held in the reporting year.

Table 17: Health Program activity 2010/11 to 2012/13

Hearings	2010/11	2011/12	2012/13
IRPs	46	64	48
Review interviews	242	234	226
Exit interviews	16	20	13
Participants in Program as at 30 June	111	122	118

The Medical Council's *Health Program Participant Handbook* is available on the website and provides detailed information about the program and assists doctors with their involvement in it.

Case studies

Case study – Notification with outcome of no further action

Dr W is a 34-year-old male medical officer who first came to the attention of the Medical Council following a mandatory notification received from a psychiatry registrar. This stated that Dr W presented to the hospital's emergency department with police under section 22 of the *Mental Health Act 2007*. The police had been contacted by Dr W's ex-wife when she became concerned for his well-being after suggestions of self-harm. Dr W admitted he had previously considered overdose but denied current suicidal intent. He reported a several week history of low mood and distress secondary to protracted relationship stressors with his ex-wife. Dr W was diagnosed with an acute on chronic situational crisis and was later discharged. The Health Committee resolved that Dr W may have an impairment under section 152B of the *Health Practitioner Regulation National Law (NSW)* and ordered Dr W to undergo an examination by a Medical Council-appointed practitioner (CAP). The CAP concluded Dr W did not suffer from impairment according to the statutory definition of impairment. The Health Committee considered the report from the CAP and resolved no further action to be taken.

Case study – Notification without Program entry

Dr X is a 55-year-old male pathologist who self-notified in relation to a charge being dismissed under the *Mental Health (Forensic Provisions) Act 1990*. Dr X was discharged on the condition that he attend for treatment. The Health Committee requested further information about the matter and was advised that Dr X had been charged with "possession of an illegal substance or a prohibited substance". The Committee resolved that Dr X may have an impairment under section 152B of the *Health Practitioner Regulation National Law (NSW)* and that he undergo an examination by a Medical Council-appointed practitioner (CAP). The CAP opined that Dr X did not suffer from an impairment. The Health Committee resolved that Dr X be requested to sign a Chronic Relapsing Illness Authorisation (CRIA), which authorises his treating practitioners to notify the Medical Council if Dr X is non-compliant with treatment, terminates treatment against advice, or if there is any concern about his mental state.

Case study – Health Program participant with relapsing illness

Dr Y is a 42-year-old female general practitioner who first came to the attention of the former Medical Board following a self-notification regarding her bipolar affective disorder. She underwent a Board-nominated practitioner assessment by a psychiatrist and an IRP was conducted which found that she had an impairment. Conditions were placed on her registration, requiring her to practise only in an approved position, to attend treating practitioners, to take medication as prescribed, to obtain a mentor, and to attend for regular Board and later Medical Council reviews. Dr Y attended a second IRP in order for a supervision condition to be included on her registration following a relapse in her condition. Dr Y suffered a number of relapses in her health over the approximately five years following the IRP. Dr Y remains subject to practice and health conditions which enable the Medical Council to closely monitor her progress through her treating practitioners, clinical supervisors and mentors. Dr Y remains in the Health Program.

Case study – Exiting the Health Program

Dr Z is a 47-year-old male surgeon who made a self-notification to the then Medical Board regarding his excessive alcohol intake. He underwent a Board-nominated practitioner assessment by a psychiatrist, who identified a serious alcohol problem. The matter proceeded to an IRP, which found that Dr Z had an impairment. Conditions were placed on his registration to ensure regular review by his treating practitioners, abstinence monitoring with blood testing, and regular reviews initially by the former Board. Dr Z remained on the Health Program and his conditions, with which he remained compliant, were eased over time. He attended an Exit Interview approximately three years after the IRP was held and subsequently exited the Health Program. Approximately three years after exiting, Dr Z self-notified to the Board that he had relapsed with alcohol consumption. He underwent a Board-nominated practitioner assessment by a psychiatrist who recommended his re-entry into the Health Program. An IRP held subsequent to his assessment found that Dr Z was impaired and conditions were placed on his registration to ensure regular review by his treating practitioners, abstinence monitoring with blood testing, and regular reviews initially by the Board. He attended an Exit Interview approximately four years after the second IRP was held and subsequently exited the Health Program. On exiting, Dr Z signed a Chronic Relapsing Illness Authorisation which authorises his treating practitioners to notify the Medical Council if Dr Z is non-compliant with treatment, terminates treatment against advice, or if there is any concern about his mental state.

Conclusion

The Medical Council's Health Program provides a clear and well-defined process for initial assessment and ongoing management of medical practitioners with impairment. The Council's program focuses on regulation with independent assessment, which is distinct from treating relationships. The Health Program relies on the combination of independent opinion and regular in-person review interviews with the impaired practitioner. This provides a sound basis on which to judge whether a practitioner's health is, or may be, having an impact on his/her professional performance or whether a practitioner should be referred for disciplinary measures because of non-compliance with conditions.

> performance

2012/13 **snapshot**

- → Following assessment, the HCCC referred 264 complaints to the Medical Council as performance matters. Three hundred and four performance matters had outcomes.
- → 77 Performance Interviews were conducted (a 12% increase on the previous reporting year), and 73 Performance Interviews had outcomes.
- → 10 Performance Assessments were conducted and 15 re-assessments were conducted.
- → 12 Performance Review Panels were conducted.
- → There were 40 practitioners who entered the Performance Program with a total of 97 practitioners who either: required a Performance Assessment, were subject to a Performance Assessment, or had conditions imposed by a Performance Review Panel and were being monitored by the Medical Council.

Overview

The Performance Program is a pivotal part of the Medical Council's activities to ensure the health and safety of the public is protected and registered medical practitioners are fit to practise. Introduced in October 2000, it represents the culmination of intensive research, consultation and development. The Program is designed to complement the conduct and health streams by providing an alternative pathway for dealing with practitioners who are neither impaired nor guilty of professional misconduct, but for whom the Medical Council has concerns about the standard of their clinical performance. The Program is designed to provide an avenue for education and retraining where inadequacies are identified, while at all times ensuring that the public is adequately protected. It is designed to address patterns of practice rather than one-off incidents unless the single incident is demonstrative of a broader problem.

The professional performance of a registered medical practitioner is considered to be unsatisfactory if it is below the standard reasonably expected of a practitioner of an equivalent level of training or experience. In addition, the Medical Board of Australia publication *Good Medical Practice: A Code of Conduct for Doctors in Australia* sets out its expectations of registered medical practitioners. The causes of poor performance are many and varied. Professional isolation and inattention to continuing professional development are common contributing factors. On occasions, medical practitioners present with adequate knowledge, but an inability to apply it in their day to day practice. This may be due to external 'distracters' such as illness and financial stress which may affect practitioner performance in the short or longer term.

The Medical Council's Performance Committee has a number of tools available to determine whether a practitioner's professional performance is satisfactory, including the Performance Interview (PINT), Performance Assessment (PA) and Performance Review Panel (PRP). Once performance has been found to be unsatisfactory, there is a range of means available to support improvement, including education and observation of another practitioner's practice, as well as public protection measures, such as supervision and limits on practice. These measures may be imposed on the practitioner as conditions on his/her registration and compliance with the conditions is monitored by the Medical Council's Monitoring Program.

Program activity

Forty practitioners entered the Performance Program in the reporting year and a total of 97 participants were in the Program at 30 June 2013. (A practitioner is considered to be a participant in the Performance Program once a decision to hold a Performance Assessment (PA) is made).

Complaints

The Medical Council and the HCCC jointly assess all complaints received about the practice of medicine in NSW. Following this joint assessment, a matter related to a practitioner's professional performance may be referred to the Medical Council for consideration of a performance assessment. This decision may be made when the Medical Council and the HCCC agree that there has been a departure from acceptable standards but the matter does not warrant investigation or requires disciplinary proceedings. Complaints referred to the Medical Council for consideration of a performance assessment are managed in the Performance Program, which is non-disciplinary and works within a framework of early intervention and, if required, remediation.

The HCCC referred 264 complaints to the Medical Council as performance matters during the current reporting year (which is a 12% increase from the previous reporting year when 235 complaints were referred, and a 45% increase from 2010/11 when 182 complaints were referred to the Medical Council). This increased activity in the Performance Program is consistent with the increased trend in complaint numbers. It illustrates the Medical Council's view that it is important to take action in response to unsatisfactory performance that may not necessarily require investigation or prosecution but which still represents a departure from accepted standards.

Outcomes of complaints

The Medical Council may consider a range of actions in response to performance matters that come to its attention, including that:

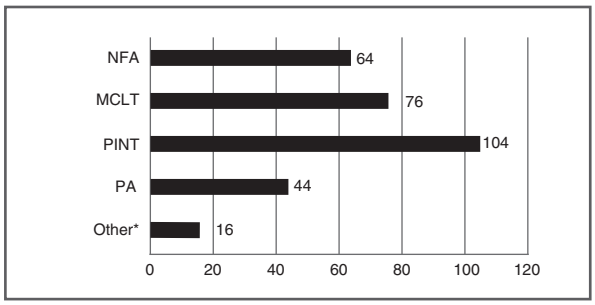
- no further action be taken as the medical practitioner's response to the issues is satisfactory;
- a letter be sent from the Medical Council to the medical practitioner drawing attention to particular performance issues;
- the medical practitioner should attend a Performance Interview (PINT) where the issues raised by the complaint can be further explored;
- the medical practitioner should undergo a detailed Performance Assessment.

Other outcomes include an apology to the complainant, direct resolution or conciliation between the practitioner and complainant, or referral elsewhere (such as to the HCCC for investigation or to the Medical Council's conduct or health programs).

In 2012/13 the Medical Council's Performance Committee determined outcomes in relation to 304 performance complaints. This is a 30% increase from the 233 complaints considered in the previous reporting year and a 67% increase from the 182 complaints considered in 2010/11. Again this trend illustrates the Council's view that it is important to consider and, if appropriate, take action in response to unsatisfactory performance that may not necessarily require investigation or prosecution but which still represents a departure from accepted standards.

The complaint outcomes following initial consideration of the complaint and the practitioner's response are summarised in **Chart 14**. The most common outcome is no further action, a Medical Council letter, or a PINT.

Chart 14: Outcomes of complaints considered by the Performance Committee in 2012/13



Performance Interviews

Where a complaint raises concern about a medical practitioner's professional performance but does not immediately reach the threshold for a Performance Assessment (PA), the Performance Committee may hold a Performance Interview (PINT). This is an informal interview, during which issues raised by the complaint and the medical practitioner's response, as well as any broader issues regarding the practitioner's practice, are explored. In the majority of cases, matters raised by the complaint can be addressed at a PINT, with appropriate advice and counselling given to the medical practitioner so that no further action is taken by the Medical Council. Other outcomes available to the Medical Council following a PINT are referral to a PA, referral to a disciplinary pathway, or referral to a Medical Council-appointed practitioner (CAP) assessment which may include neuropsychometric testing or psychiatrist assessment.

PINTs held

During the 2012/13 reporting year, 77 PINTs were conducted as a result of 85 complaints. (A practitioner may attend a PINT that has been triggered by more than one complaint). The increase in the total number of PINTs from 69 in the previous reporting year reflects the Performance Committee's continuing view that a PINT is an effective means of obtaining further information when a complaint raises concerns about a practitioner's professional performance.

The Performance Committee made decisions in relation to 73 PINTs. A number of PINT reports were yet to be considered by the Performance Committee by the end of the reporting year, accounting for the discrepancy in the number of PINTs conducted (77 in 2012/13) and the number of PINTs with outcomes (73 PINTs for 73 medical practitioners in regard to 77 complaints).

These outcomes following the PINTs are summarised in **Table 18** below. There has been an increase in the number of PAs which have been recommended following a PINT with 22 recommendations for a PA, up from 9 in 2011/12.

Table 18: PINT outcomes

	2011/12	2012/13
No further action	44	48
Referral to medical assessment	4	2
Referral to medical assessment and PA	3	
PA	9	22
Referral to disciplinary pathway	2	1
Total	**62**	**73**

Case study - PINT

Dr X is a 69-year-old female general practitioner. A complaint was received by the HCCC alleging that Dr X failed to examine a patient who had attended the practice two weeks earlier. It was further alleged that Dr X failed to review the details of the previous presentation. The patient then attended a different practice from where she was subsequently admitted to a hospital. The matter was referred to the Medical Council and following consideration of the issues raised in the complaint and the practitioner's response, the Performance Committee determined to hold a PINT. The PINT members were concerned that Dr X did not record any observations of the patient in her clinical records and did not include any information about clinical findings, examination or follow up arrangements, or the advice given to the patient. The PINT members also expressed concern regarding her responses to questions including her inability to recall the details of the issues raised by the complaint. The PINT members recommended a PA be undertaken and that Dr X attend for neuropsychometric testing. Dr X attended neuropsychometric testing which showed no evidence of impairment. The Performance Committee considered the results following neuropsychometric testing and resolved that the PA should proceed.

Performance Assessment

A Performance Assessment (PA) is one of the mechanisms available to the Medical Council in response to a concern about a practitioner's professional performance. The practitioner's complaint history is taken into consideration. In a small number of cases, the decision to hold a

PA is based on the triggering complaint alone. However, in the majority of cases, the practitioner has attended a PINT or is involved in another Medical Council process prior to referral to a PA.

PAs are usually conducted in the practitioner's environment by two or three practitioners familiar with the practitioner's area of practice. The assessment is broad-based and is not limited to the particulars of the matter that triggered the assessment. Multiple assessment tools are used, including the observation of consultations and procedures, a review of records and a clinical practice interview.

Once the PA report is received, a number of options are available to the Performance Committee. When the performance assessors do not identify performance deficiencies, no further action is taken in relation to the practitioner. In cases where minor concerns are raised, the assessors may counsel the practitioner and provide advice and recommendations during the assessment. More formal counselling can occur when there are more significant performance issues that still need to be brought to the practitioner's attention, but do not require remediation or limitations in practice. A Performance Review Panel (PRP) is conducted if remediation or limitations in practice appear to be required, or if there are issues of public protection.

Referrals to PA

In the 2012/13 reporting year, the Performance Committee decided that a PA should be conducted for 40 practitioners. This is an increase from 25 practitioners in 2011/12. **Table 19** provides a breakdown of the practice areas of the medical practitioners referred to a PA. General practitioners as in previous years make up the majority (57%), reflecting their proportionate number in the medical workforce.

Table 19: Practice area of medical practitioners referred for a PA in 2012/13

	2012/13
Anaesthetist	2
Dermatologist	2
General practitioner	23
Hospital non-specialist	1
Obstetrician & gynaecologist	1
Pathologist	2
Physician	1
Psychiatrist	2
Radiologist	1
Surgeon	5
Total	**40**

PAs conducted

There were 10 PAs conducted in 2012/13 and 15 re-assessments during the reporting year.

The Performance Committee considered 17 PA reports (from PAs conducted in this and the previous reporting year). The outcomes of the PA reports appear below in **Table 20**. The Performance Committee also considered five matters where a decision was previously made to hold a PA and it did not go ahead because:

- it was rescinded or the PA could not be held, or
- the practitioner changed his/her registration to non-practising or surrendered his/her registration or failed to renew his/her registration and was therefore no longer registered, or
- the practitioner moved to another state so his/her principal place of practice (PPP) was not NSW and the matter referred to the Medical Board of Australia/AHPRA to consider undertaking a performance assessment.

The decision to hold a PA was rescinded in relation to one medical practitioner, four medical practitioners retired, surrendered their registration or transferred to the non-practising category of registration before having the PA, or changed their PPP and one medical practitioner consented under section 41P to a re-assessment instead of attending a Performance Review Panel (PRP).

In relation to the 15 re-assessments held in 2012/13, the outcome was no further action for one practitioner, counselling for two practitioners and a PRP for six practitioners. Of these six, three required neuropsychometric testing by a clinical neuropsychologist prior to the PRP.

Table 20: PA outcomes in 2012/13

	2012/13
No further action	1
Performance Review Panel	16
Total	**17**

Case study – PA

Dr Y is a 70-year-old male general practitioner. A complaint was received by the HCCC alleging that a patient went to see Dr Y complaining of severe pain in her right side. Dr Y diagnosed her as suffering gallstones after sending her for an x-ray and ultrasound. The patient was admitted later that day to hospital where she was diagnosed with pneumonia following an x-ray. The matter was referred to the Medical Council and Dr Y was required to take part in a PA which was conducted at Dr Y's consulting rooms. The assessors considered that while Dr Y had a pleasant manner, he failed to take a detailed and relevant clinical history from his patients. His examination technique was also found to be unsatisfactory and his advice and clinical judgement was outdated or incorrect. The assessors found his professional performance was unsatisfactory in the areas of basic clinical skills, clinical judgement, patient management skill, prescribing skills, communication and medical records. The matter was referred to a PRP to review Dr Y's professional performance.

Medical Assessment

On occasions, the Performance Committee will require a medical practitioner to be assessed by a Medical Council-appointed practitioner. This occurs when the complaint, or additional information obtained by the Medical Council indicates that the practitioner has or may have an impairment.

In 2012/13, the Performance Committee decided to refer nine practitioners to attend neuropsychometric testing by a clinical neuropsychologist due to concerns about cognitive impairment and one practitioner was referred to an assessment by a Medical Council-appointed psychiatrist.

These referrals reinforce the Medical Council's view that many factors influence and affect a practitioner's performance and a practitioner's health may be one factor which may cause unsatisfactory performance.

Performance Review Panel

A Performance Review Panel (PRP) is held if, as a result of a PA, the Performance Committee considers that the practitioner's professional performance is unsatisfactory and should be referred to a PRP. The Panel, which consists of three members, one not being a registered medical practitioner, considers the areas believed by the PA assessors to be unsatisfactory, as well as the medical practitioner's submissions. Where a PRP makes a finding of unsatisfactory professional performance, it may impose conditions on a practitioner's registration. Such conditions may relate to remediation, for example completion of appropriate courses, or public protection, such as limitation on the scope of practice, or both. The Panel may also make a direction for a performance re-assessment.

PRPs held

During the reporting year, 12 PRPs were held. The outcomes of the PRPs are summarised in **Table 21** below.

Table 21: PRP outcomes in 2012/13

	2011/12
No further action	0
Re-assessment only	4
Conditions and re-assessment	6
Changed to non-practising before PRP commenced	1
Decision pending	1
Total	**12**

Conditions that are imposed by a PRP may be removed after the practitioner has satisfactorily completed any remediation or after the practitioner has been subject to a performance re-assessment at which the practitioner demonstrates satisfactory performance.

Thirteen practitioners exited the Performance Program during the reporting year.

Case study - PRP

Dr Z is a 37-year-old male general practitioner who also undertook casual locum emergency department work. A complaint was received by the HCCC from his employer who raised concerns in relation to Dr Z's clinical management and judgement arising from a number of adverse patient outcomes. The matter was referred to the Medical Council and it was determined that Dr Z be required to undergo a PA. As Dr Z was working occasional locums and the issues raised by the complaint occurred when he was working in a hospital, the PA took place by way of a structured interview. Following the PA, the assessors considered that Dr Z's professional performance was unsatisfactory in the areas of clinical judgment, patient management skills (treatment / advice) and prescribing skills. A PRP was held at which it was found that Dr Z demonstrated deficiencies in clinical judgment, patient management and prescribing. Moreover, the PRP found that Dr Z lacked training and experience in certain areas and that he had failed to take any specific remedial action to address these deficiencies. The PRP found that Dr Z's professional performance was unsatisfactory and conditions were imposed on his registration including that he only work in a hospital setting under supervision, that he undertake further education and that if he is working in general practice that he is to meet with a supervisor to review his clinical judgment and patient management skills.

Conclusion

The Medical Council's Performance Program has seen a substantial increase in activity in the reporting year. It is difficult to precisely indicate why there is a significant increase in the number of PAs being ordered by the Medical Council. It may reflect a greater awareness of the need to take action in response to unsatisfactory professional performance. Decisions about whether to take action continued to be effective. Consistent with previous years, each PA held has resulted in a finding of unsatisfactory professional performance.

The Medical Council assessed or reassessed 25 practitioners in the year. It also decided that a PA should be conducted on 40 practitioners. The Medical Council increased its resources towards the end of the reporting year in order to schedule more PAs and reassessments in the next financial year. The Medical Council expects that this will ensure that it continues to respond to concerns about a practitioner's professional performance in a robust and timely way.

> monitoring

2012-2013 **snapshot**

- → 296 medical practitioners were subject to conditions monitored by the Medical Council in this reporting period.
- → 59 practitioners were referred to the Medical Council's Monitoring Program during this reporting year.
- → 57 practitioners no longer required monitoring during the reporting year.
- → At 30 June 2013, 239 practitioners were subject to conditions monitored by the Medical Council.

Overview

The Monitoring Program is responsible for monitoring compliance with orders and conditions imposed on a medical practitioner's registration, following a Performance, Conduct or Health outcome, including an urgent interim action. Further information about these processes can be found in the relevant sections in this annual report.

Orders and conditions are imposed on a practitioner's registration only if it is necessary in order to protect the public. This can be achieved by:

- placing limitations on a practitioner's practice of medicine. For example, restricting the type of procedure(s) a practitioner may perform or limiting the number of patient consultations per day;
- setting in place conditions aimed at remediating the medical practitioner. For example, requiring a practitioner to undertake specific courses or participate in supervision; and/or
- ensuring practitioners attend for treatment in order to manage an impairment so they can practise safely. This may include engaging in treatment or participating in alcohol or drug testing.

The Medical Council differentiates conditions imposed on practitioners' registration into practice conditions and health-related conditions. The Program monitors compliance with all practice conditions. These conditions are published on the public register, which is available through the Australian Health Practitioner Regulation Agency (AHPRA) website at www.ahpra.gov.au. Published conditions may relate to a practitioner's work arrangements, such as where and in what capacity a practitioner may work, for how many hours per day or week, and whether supervision is required and, if so, at what level.

Health conditions are not usually published on the register. These conditions regulate a practitioner's treatment and will be adjunct conditions relating to activities that occur outside of the practitioner's workplace. They may include monitoring activities, such as urine drug screening, alcohol testing or hair testing and requirements to engage in treatment. These conditions also specify the review cycle undertaken by the Medical Council, including the frequency of review by the Medical Council-appointed practitioner and interview by the Medical Council. Monitoring of compliance with health conditions is the combined responsibility of the Health and Monitoring Programs, with the latter being responsible for conditions relating to drug and alcohol testing. The Health Program monitors the remainder of health conditions.

Monitoring process

Following the imposition of conditions on a practitioner's registration, a monitoring program officer makes initial contact with the practitioner and advises of all compliance requirements, including whether adherence to a particular Medical Council Policy or Protocol is required. An action schedule covering all conditions is then established and regularly updated.

Depending on the case, information regarding compliance may be obtained from the practitioner themselves, external organisations such as Medicare or Pharmaceutical Services and/or independent third parties such as Council-appointed practitioners, supervisors, auditors or testing laboratories.

Council Committees are responsible for decisions regarding applications and submissions to vary or lift condition(s), any approvals required by the practitioner's conditions and/or any actions required following a breach of a condition. Program staff prepare a brief which includes relevant information to inform the Committees and also action outcomes following a Committee resolution.

All changes to a practitioner's conditions are communicated by Program staff to AHPRA so that the public register can be amended accordingly.

The level, complexity and duration of monitoring activity vary considerably over the range of conditions being monitored by the Program. Some conditions may require no more than a periodic letter to request confirmation of the practitioner's circumstances. Other cases require more frequent contact and scrutiny, such as an analysis of data from Medicare to determine compliance with a specific condition, for example a restriction prohibiting the prescription of Schedule 8 drugs or reviewing drug or alcohol testing results.

The Program has developed a Conditions Bank as a resource which outlines standard conditions. These conditions are consistent with the Medical Council's Policies and Protocols and are readily able to be monitored. Program staff are also available to provide assistance on a case-by-case basis should these standard conditions require amendment to reflect a practitioner's particular circumstances.

Monitoring activity

The activity of the Program in the reporting year is summarised in **Table 22**. As at 30 June 2013 there were 239 practitioners being monitored by the Program, an increase of two practitioners since 30 June 2012.

Table 22: Monitoring activity in 2012/13

Primary source of conditions	Total number of practitioners monitored at 30 June 2012	Number of new* practitioners monitored 2012/13	Number of practitioners no longer monitored 2012/2013	Total number of practitioners monitored at 30 June 2013
Health Program	108	25	26	107
Performance Program	21	3	3	21
Conduct Program	108	31	28	111
Total	**237**[3]	**59**	**57**	**239**

*A new practitioner is defined as a practitioner who was not subject to conditions at the time of the imposition of conditions. If a practitioner was already subject to conditions on their registration and further conditions were imposed, this is not deemed to be a new practitioner.

Table 23 lists the reasons monitoring was no longer required during the reporting period.

Table 23: Reasons for closure of monitoring cases 2012/13

Reason for closure	Number of practitioners
Conditions lifted	23
Registration surrendered/Failure to renew registration	17
Principal Place of Practice changed (other than NSW)	6
Registration suspended	4
Registration cancelled by the Medical Tribunal	3
Practitioner deceased	3
Moved to non-practising registration	1
TOTAL	**57**

The state or territory office responsible for monitoring a practitioner's conditions is determined by the practitioner's principal place of practice.

Of the practitioners no longer requiring monitoring, the median length of time the practitioner was subject to conditions was three years. One practitioner whose case was closed following exit from the Health Program had been subject to conditions for 18 years.

Table 24 lists the number of practitioners subject to a particular condition or order as at 30 June 2013. (A practitioner may be subject to one or more of the conditions/orders listed.)

Table 24: Practitioners subject to conditions, by type, at 30 June 2013

Condition/Order	Number of practitioners
Urine Drug Testing (UDT)	26
Ethyl Glucuronide (EtG) Testing	15
Carbohydrate-Deficient Transferrin (CDT) testing	14
Chaperone	6
Education course	14
Mentor	21
Supervision	74
Audit	23

Audits

Twenty-three audits were conducted in 2012/13. Audits are conducted by registered medical practitioners who practice in the same or similar field to the practitioner subject to the audit condition. The most common form of audit condition is a medical records audit. This type of audit is imposed to monitor whether the practitioner's:

- standard of creating and maintaining records is in compliance with the appropriate regulations or standards; and/or;
- is complying with other conditions imposed on their registration, for example an audit may be used to monitor a condition requiring a practitioner to seek a second opinion before undertaking a specific procedure.

[3] The breakdown and total number of practitioners monitored as at 30 June 2012 differs from the number reported in the 2011/12 Annual Report following data cleansing.

Table 25 lists the outcomes of the audits conducted in this period.

Table 25: Audit outcomes

Outcome	Number
Further audit required	14
Audit satisfactory (condition requiring audit lifted)	7
Other action (such as urgent interim action, refer a complaint to HCCC)	2
TOTAL	**23**

Critical compliance

A Medical Tribunal or Professional Standards Committee may direct that a specific order or condition is a 'critical compliance condition'. A breach of a critical compliance condition or order results in the immediate suspension of a practitioner's registration. Seven practitioners were subject to at least one critical compliance order or condition during the reporting period. There were no breaches identified of any critical compliance condition or order in this period.

Policies and protocols

The Council's Urine Drug Testing Protocol was revised in the reporting period. The Protocol was updated and also includes specific information regarding:

- who can supervise the collection of the specimen;
- the requirements when an approved supervisor is temporarily unavailable; and
- a requirement for the supervisor to establish the identification of the participant prior to each collection.

Council policies and protocols are available at www.mcnsw.org.au

Case study – Monitoring a practitioner's compliance

Dr A was subject to conditions following urgent interim action proceedings in July 2008. The conditions restricted Dr A's prescribing of Schedule 8 and Schedule 4D drugs and required Dr A to undergo an audit. A complaint was referred to the Health Care Complaints Commission. The complaint was ultimately prosecuted before a Medical Tribunal.

Dr A's practice was audited, which found that Dr A's medical records complied with the relevant Regulations and the then NSW Medical Board resolved to lift this condition in January 2009.

The Medical Tribunal subsequently imposed conditions restricting Dr A's prescribing of Schedule 8 and Schedule 4D drugs, required completion of education courses concerning prescribing and required mentoring by a senior general practitioner approved by the then Board.

Dr A was compliant with all conditions imposed, completing the education courses as stipulated. Dr A's condition restricting prescribing of Schedule 8 and 4D drugs was lifted in May 2012 and the remaining mentor condition was lifted in this reporting period.

> management and administration

Human resources

Employees
Section 41C (2) of the *Health Practitioner Regulation National Law (NSW)* prescribes that a health professional council cannot employ staff. The Health Professional Councils Authority (HPCA) staff who support the Medical Council are employed under Chapter 1A of the *Public Sector Employment and Management Act 2002.*

As at 30 June 2013 the HPCA employed 97 permanent full-time equivalent (FTE) staff and two temporary FTE staff, of whom 35 FTE staff provided secretariat support directly to the Medical Council.

Learning and development
Learning and development opportunities are available to staff to ensure that they have the skills and knowledge to support the Council's core business and the HPCA's organisational priorities. Individual staff training needs are identified through the Coaching and Performance System (CAPS).

Staff attended training sessions on:

- GIPA, privacy management and public interest disclosure provisions
- Writing procedures and policy documents, and minute taking
- Dealing with difficult complainants
- Fundamentals of project management.

Public Interest Disclosures
The Medical Council is subject to the provisions of the *Public Interest Disclosures Act 1994* and the reporting requirements of the *Public Interest Disclosures Regulation 2011*. Staff and Medical Council members comply with the policy and information is available on the requirements and processes for making and managing disclosures. The Council provides six-monthly reports to the NSW Ombudsman and Ministry of Health.

There were no public interest disclosures (PIDs) made by staff or Medical Council members during the year.

Table 26: Public interest disclosures July 2012-June 2013

	2012/13
Number of public officials who made PIDs	0
Number of PIDs received	0
Of PIDs received, number primarily about:	
Corrupt conduct	0
Maladministration	0
Serious and substantial waste	0
Government information contravention	0
Number of PIDs finalised	0

Exemptions from the reporting provisions

As a small statutory body, the Medical Council is exempt from certain reporting provisions and provides a triennial report in relation to:

- multicultural policies and services programs
- disability services
- equal employment opportunity
- occupational health and safety, and
- waste management (WRAPP).

The Medical Council last reported on these provisions in the 2010/11 Annual Report and will next report in 2013/14. The Medical Council continued to meet its compliance obligations with regard to each of these matters and remains committed to implementing the relevant policy requirements.

Insurance and risk management activity

Insurance
The Medical Council's insurance activities are conducted by the HPCA through the NSW Ministry of Health's insurance cover with the NSW Treasury Managed Fund, and include:

- legal liability – public liability, professional indemnity, product liability
- comprehensive motor vehicle insurance policy
- personal accident policy for volunteer workers
- property coverage, and
- workers' compensation.

Audit and risk management
NSW Treasury has granted the Medical Council an exemption from the Internal Audit and Risk Management Policy for the NSW Public Sector (TPP09-05) on the grounds that it is a small agency for which the administrative and cost burden of full compliance would be prohibitive. However the Medical Council has appropriate internal audit and risk management practices in place in line with the core requirements of TPP09-05.

In 2012/13, the HPCA Audit and Risk Committee continued to review and monitor the Risk Register, discussed and monitored internal audits and reviews, and received high level summaries on the Medical Council's financial reports. On the Committee's advice the HPCA established the role of Chief Audit Executive, which is fulfilled by the HPCA Assistant Director, Legal.

During the year the HPCA implemented the recommendations of the Audit Office of NSW 2011/12 Management Letter, developed a business continuity management framework and commissioned a review of the 2012/13 budget process following the identification of certain errors and omissions in some budget line items. These matters have been addressed and monitored through the 2013/14 budget development process.

The business continuity management framework comprises a policy, Business Continuity Plan and procedures. Members of the Recovery Team have received training and been issued with documents and resources in case of an emergency. Documentation of an IT disaster recovery plan has been initiated and will be completed during 2013/14.

Audits
IAB is commissioned to undertake the internal audits nominated in the internal audit plan. The IAB conducted an internal audit of the HPCA's Workforce Management Framework, which identified the need for a more consistent approach to performance monitoring, and improved turnaround times on recruitment activity. All of the review's recommendations were accepted and are being addressed.

A review of monitoring of practitioners with orders and/or conditions on their registration commenced in June 2013.

Information management and systems
Further improvements have been achieved in information management, control and reporting. System modifications have been made to the case management system (MaCS), to improve usability and reporting. The MaCS user group guides priorities and contributes to user testing. Staff received ongoing training and support as changes are implemented and the accuracy and reliability of reporting is improving.

The TRIM records management system has been further embedded in practice. The Business Classification Scheme was reviewed and is being modified to address the specific needs of the Medical Council. Training has been a focus and priorities developed to promote the use of TRIM to meet State Records compliance requirements.

Promotion/ overseas visits

The Medical Council funded the former Medical Director's attendance at conferences in Ottawa on 2-5 October 2012 followed by a meeting with the Office of Professional Medical Conduct, Albany, New York on 9 October 2012. The conferences in Ottawa were held by the International Association of Medical Regulatory Authorities, the International Physician Assessment Coalition and the Coalition for Physician Enhancement.

Use of consultants and other external costs

The health professional Councils together commissioned six consultancies related to Council business process improvement, system improvements and the ongoing development of the HPCA's shared services to Councils. The Medical Council also managed one consultancy to develop a communications strategy.

The Council made the following contribution to these consultancies:

Table 27: Contribution to consultancies

Service Provided	Number	Cost inc. GST $
Administration	2	6,475.40
Communications	1	4,620.00
Council business processes	1	11,923.29
Financial management	1	4,704.59
Information management and systems	2	12,177.26
Total	**7**	**39,900.54**

Costs incurred in the production of the Annual Report were $817.01

Business process improvement

Through the course of several reviews (including of Council business planning processes), risk assessment and the 2011/12 Council Satisfaction Survey a number of Councils and the HPCA identified the need to embark on a project to analyse selected core processes and to develop maps and procedure documents to guide work processes and decision making. A consultant was engaged to undertake the project.

The purpose of process mapping is to optimise efficiency and provide support tools to staff and Councils and to help manage workflow and assist with sound decision-making.

The consultants in consultation with staff are working on process maps for the management of correspondence, handling notifications and immediate action, and refinement of the business classification scheme for records management.

Consumer response

The Medical Council acknowledges that the trust and confidence of the public are essential to its role and values all forms of feedback. Complaints regarding the administrative processes of the Medical Council can be made by members of the public or external organisations about the Medical Council's activities, staff or service delivery.

In the reporting year, the Medical Council received a small number of complaints about its processes from the public and members of the medical profession. These complaints primarily related to dissatisfaction with the outcome of the complaints or investigations concerning medical practitioners. Included were complaints made against a former staff and current staff member which were made to

another organisation and a complaint concerning whether publication of information by the Council on its website was defamatory. Additionally, a stakeholder group sought the Medical Council's response in relation to issues arising from the practice and procedure of Professional Standards Committees. Complaints were referred to the appropriate area for investigation and resolution, and where necessary, procedures were reviewed and amended.

Activity under the Government Information (Public Access) Act 2009

The Medical Council is committed to the principles of the *Government Information (Public Access) Act 2009* (GIPA Act) and makes available, free of charge on its website, a large range of publications, documents and information that form part of the Medical Council's open access information and pro-actively released information. Details are contained in the Agency Information Guide on the Medical Council's website.

Open access and pro-active release
In accordance with the obligations in s 7(3) of the GIPA Act, the Medical Council continually publishes information on the Council website such as publicly available decisions, handbooks and newsletters. The Medical Council has a mechanism to ensure that the publication of key documents is considered at the time of endorsement. All newly created and revised key documents are assessed to determine whether they should be published on the Medical Council's website in accordance with the requirements of the GIPA Act.

The Agency Information Guide was updated and is accessible on the website.

Review of pro-active release program
The Medical Council reviewed its program for the release of government information to identify the type of information that can be made publicly available.

The Medical Council releases all new and revised policies and other information publicly on the website. In addition, the Medical Council reviewed the program and the policy register including monitoring the completion and approval of relevant information.

New and revised policies and documents released on the Medical Council website are:

- Medical Council Annual Report 2012
- Code of Conduct for Members
- Conflict of Interest Policy
- Gifts and Benefits Policy
- Reporting Corrupt Conduct
- Public Interest Disclosure Policy
- Chaperone Policy
- Cost responsibility for a Performance Re-assessment
- Providing Performance Review Panel decisions to third parties
- Doctors in training and Performance
- Urine Drug Screening Protocol.

Number of access applications received
During the period 1 July 2012 to 30 June 2013, the Medical Council received 14 formal access applications for information (11 different applicants), compared to 10 in the preceding year. Two invalid applications were received which subsequently became valid applications. Determinations were made for 11 applications and three applications remained under consideration at the end of the reporting period. All of the applications received were determined either within the statutory timeframe or with an extended timeframe agreed by the applicant.

Number of refused applications for Schedule 1 information - Clause 7(c)
Of the 11 applications determined in the period, the Medical Council released documents to 10 of the applicants. In nine of these 10 applications, the application was refused in part because the information requested was information referred to in Sch 1 of the GIPA Act. One decision was made to refuse to deal with part of the application under s 60(1)(a) of the GIPA Act. The Medical Council made one decision to refuse an application as a whole under s 60 (1)(c) of the GIPA Act.

The overriding secrecy laws in regards to the *Health Care Complaints Act 1993 (NSW)* was the most applied conclusive presumption of overriding public interest against disclosure under Sch 1 of the GIPA Act. The categories of individual rights, judicial processes and natural justice were the most applied public interest considerations against disclosure that the Council relied on under s 14 of the GIPA Act.

During this period, five access applicants sought a review of the Medical Council's decision - three applications for internal review by the Medical Council, one by the Information Commissioner and one by the Administrative Decisions Tribunal (the ADT). Four of these were determined in the period and one remains under review. In each of the four reviews completed, the Medical Council's decision was in the main confirmed, with only a small amount of additional information being released to the applicant. The ADT review is a publicly available decision (see *AIN and Medical Council of NSW [2013] NSWADT 112* in Appendix 3 of this report).

The Medical Council's 2012/13 GIPA statistics are reported in Appendix 2 of this report.

Privacy management

The Medical Council is subject to the provisions of the *Privacy and Personal Information Protection Act 1998* and the *Health Records and Information Privacy Act 2002.*

The Council has adopted the NSW Health Privacy Management policy pending development of a specific privacy management plan. A number of staff attended privacy awareness training conducted by the Office of the Information and Privacy Commissioner.

No complaints were received during the reporting period.

Two complaints about breach of privacy, received by the Medical Council in the previous reporting period, remain outstanding. Both were made by the same practitioner. These two complaints remain in progress in the NSW Administrative Decisions Tribunal and are set down for mediation in the latter half of 2013.

Financial management

The HPCA provides financial management services to the Council including the payment of accounts, budget preparation and monitoring and coordination of regular financial reporting to the Council.

In signing a Service Level Agreement, the Medical Council endorsed a revised cost allocation methodology for the distribution of shared costs across all Councils. The methodology is largely based on Council activity and provides a formula to apportion shared services staff, facilities and other resources. The methodology will be reviewed in 2013/14 to ensure that it is equitable and is the best means of cost allocation.

Format
The accounts of the Medical Council's administrative operations, as well as education and research activities, together with the independent auditor's report, are set out in the Financial Statements included in this Annual Report.

Performance
The Council's account performance as reported in the Financial Statements is as follows:

Table 28: Accounts performance

Operating expenditure	$7,750,884
Revenue	$10,141,437
Net profit/(loss)	$2,394,142
Net cash reserves (cash and cash equivalents minus current liabilities)	$633,417

Budget
The budget in respect of the administrative operation for the period 1 July 2013 to 30 June 2014 is as follows:

Table 29: Budget 2013/14

Revenue	$11,595,121
Operating expenditure	$9,519,446
Net profit/(loss)	$2,075,675

Investment performance
The Medical Council, through a Special Interest Arrangement with the Commonwealth Bank of Australia earned an average of 3.09% p.a. on all bank account balances.

Payments performance
The Medical Council's accounts are managed by the Health Administration Corporation. The consolidated accounts payable performance report for all 14 Councils is as shown below:

Table 30: Payments performance 2012/13

Quarter	Current (within due date) $	Less than 30 days overdue $	Between 30 to 60 days overdue $	Between 60 to 90 days overdue $	More than 90 days overdue $
All suppliers					
September	1,201,178	620	0	218	0
December	1,106,321	26,167	0	165	0
March	1,310,988	1,225	0	657	0
June	1,758,606	4,583	141	1,758	0
Small business suppliers					
September	426,997	620	0	218	0
December	255,185	11,203	0	165	0
March	501,058	1,225	0	657	0
June	678,088	3,106	0	706	0

Measure	Sept	Dec	Mar	June
All suppliers				
Number of accounts due for payment	158	130	130	198
Number of accounts paid on time	156	105	128	177
% of accounts paid on time (based on number of accounts)	98.7	80.8%	98.5	89.4
$ amount of accounts due for payment	1,202,016	1,132,653	1,312,870	1,765,088
$ amount of accounts paid on time	1,201,178	1,106,321	1,310,988	1,758,606
% of accounts paid on time (based on $)	99.9	97.7	99.9	99.6
Number of payments for interest on overdue accounts	0	0	0	0
Interest paid on overdue accounts	0	0	0	0

Measure	Sept	Dec	Mar	June
Small business suppliers				
Number of accounts due for payment	141	112	120	170
Number of accounts paid on time	139	96	118	156
% of accounts paid on time (based on number of accounts)	98.6	85.7	98.3	91.8
$ amount of accounts due for payment	427,835	266,553	502,940	681,900
$ amount of accounts paid on time	426,997	255,185	501,058	678,088
% of accounts paid on time (based on $)	99.8	95.7	99.6	99.4
Number of payments for interest on overdue accounts	0	0	0	0
Interest paid on overdue accounts	0	0	0	0

The HPCA is confirming relevant details with our small business suppliers in accordance with Treasury Circular TC11/21.

MEDICAL COUNCIL OF NEW SOUTH WALES

YEAR ENDED 30 JUNE 2013

STATEMENT BY MEMBERS OF THE COUNCIL

Pursuant to s 41C(1B) *Public Finance and Audit Act 1983*, and in accordance with the resolution of the members of the Medical Council of New South Wales, we declare on behalf of the Council that in our opinion:

1. The accompanying financial statements exhibit a true and fair view of the financial position of the Medical Council of New South Wales as at 30 June 2013 and financial performance for the year then ended.

2. The financial statements have been prepared in accordance with the provisions of Australian Accounting Standards, Accounting Interpretations, the *Public Finance and Audit Act 1983*, the *Public Finance and Audit Regulation 2010*, and the Treasurer's Directions.

Further, we are not aware of any circumstances which would render any particulars included in the financial statements to be misleading or inaccurate.

President

Deputy President

22 October 2013

INDEPENDENT AUDITOR'S REPORT

Medical Council of New South Wales

To Members of the New South Wales Parliament

I have audited the accompanying financial statements of the Medical Council of New South Wales (the Council), which comprise the statement of financial position as at 30 June 2013, the statement of comprehensive income, statement of changes in equity and statement of cash flows, for the year then ended, notes comprising a summary of significant accounting policies and other explanatory information.

Opinion

In my opinion, the financial statements:

- give a true and fair view of the financial position of the Council as at 30 June 2013, and of its financial performance and its cash flows for the year then ended in accordance with Australian Accounting Standards
- are in accordance with section 41B of the *Public Finance and Audit Act 1983* (the PF&A Act) and the Public Finance and Audit Regulation 2010.

My opinion should be read in conjunction with the rest of this report.

The Council's Responsibility for the Financial Statements

The members of the Council are responsible for the preparation of the financial statements that give a true and fair view in accordance with Australian Accounting Standards and the PF&A Act, and for such internal control as the members of the Council determine is necessary to enable the preparation of financial statements that give a true and fair view and that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

My responsibility is to express an opinion on the financial statements based on my audit. I conducted my audit in accordance with Australian Auditing Standards. Those Standards require that I comply with relevant ethical requirements relating to audit engagements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Council's preparation of the financial statements that give a true and fair view in order to design audit procedures appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Council's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by the members of the Council, as well as evaluating the overall presentation of the financial statements.

I believe the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.

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My opinion does *not* provide assurance:

- about the future viability of the Council
- that it has carried out its activities effectively, efficiently and economically
- about the effectiveness of its internal control
- about the security and controls over the electronic publication of the audited financial statements on any website where they may be presented
- about other information which may have been hyperlinked to/from the financial statements.

Independence

In conducting my audit, I have complied with the independence requirements of the Australian Auditing Standards and other relevant ethical pronouncements. The PF&A Act further promotes independence by:

- providing that only Parliament, and not the executive government, can remove an Auditor-General
- mandating the Auditor-General as auditor of public sector agencies, but precluding the provision of non-audit services, thus ensuring the Auditor-General and the Audit Office of New South Wales are not compromised in their roles by the possibility of losing clients or income.

C J Giumelli
Director, Financial Audit Services

24 October 2013
SYDNEY

> statement of comprehensive income

FOR THE YEAR ENDED 30 JUNE 2013

	Notes	2013	2012
		$	$
Expenses Excluding Losses			
Operating expenses			
Personnel services	2(a)	(2,768,509)	(2,803,012)
Other operating expenses	2(b)	(3,331,786)	(3,104,733)
Depreciation and amortisation	2(c)	(490,363)	(521,089)
Other expenses	2(d)	(1,160,226)	(1,588,849)
Total Expenses Excluding Losses		**(7,750,884)**	**(8,017,683)**
Revenue			
Registration fees		9,868,189	7,159,539
Interest revenue	4	162,184	92,235
Other revenue		111,064	97,449
Total Revenue		**10,141,437**	**7,349,223**
Gain/(Loss) on disposal/additions	5	3,589	6,210
Net Result		**2,394,142**	**(662,250)**
Other Comprehensive Income		-	-
Total Comprehensive Income		**2,394,142**	**(662,250)**

The accompanying notes form part of these financial statements.

> statement of financial position

AS AT 30 JUNE 2013

	Notes	2013	2012
		$	$
ASSETS			
Current Assets			
Cash and cash equivalents	6	5,116,721	1,098,069
Receivables	7	163,892	141,216
Total Current Assets		**5,280,613**	**1,239,285**
Non-Current Assets			
Plant and equipment	8		
Leasehold improvements		1,645,867	1,748,897
Motor vehicles		16,202	20,464
Furniture and fittings		11,191	3,114
Other		120,202	42,128
Total Plant and equipment		1,793,462	1,814,603
Intangible assets	9	317,568	653,918
Total Non-Current Assets		**2,111,030**	**2,468,521**
Total Assets		**7,391,643**	**3,707,806**
LIABILITIES			
Current Liabilities			
Payables	10	1,481,087	1,247,883
Fees in advance	11	3,002,217	1,954,196
Total Current Liabilities		**4,483,304**	**3,202,079**
Non-Current Liabilities			
Fees in advance	11	8,470	-
Total Non-Current Liabilities		**8,470**	**-**
Total Liabilities		**4,491,774**	**3,202,079**
Net Assets		**2,899,869**	**505,727**
EQUITY			
Accumulated funds		2,899,869	505,727
Total Equity		**2,899,869**	**505,727**

The accompanying notes form part of these financial statements.

> statement of changes in equity

FOR THE YEAR ENDED 30 JUNE 2013

	Notes	Accumulated Funds
		$
Balance at 1 July 2012		505,727
Changes in accounting policy		-
Correction of errors		-
Restated Total Equity at 1 July 2012		**505,727**
Net Result for the Year		2,394,142
Other comprehensive income		-
Balance at 30 June 2013		**2,899,869**
Balance at 1 July 2011		1,167,977
Changes in accounting policy		-
Correction of errors		-
Restated Total Equity at 1 July 2011		**1,167,977**
Net Result for the Year		(662,250)
Other comprehensive income		-
Balance at 30 June 2012		**505,727**

The accompanying notes form part of these financial statements.

> statement of cash flows

FOR THE YEAR ENDED 30 JUNE 2013

	Notes	2013	2012
		$	$
Cash Flows from Operating Activities			
Payments			
Personnel services		(2,913,151)	(2,873,199)
Other		(4,060,175)	(4,766,165)
Total Payments		**(6,973,326)**	**(7,639,364)**
Receipts			
Receipts from registration fees		10,856,634	7,179,742
Interest received		152,485	95,142
Other		112,142	100,997
Total Receipts		**11,121,261**	**7,375,881**
Net Cash Flows from Operating Activities	**15**	**4,147,935**	**(263,483)**
Cash Flows from Investing Activities			
Proceeds from sale of plant and equipment		-	24,485
Purchases of plant and equipment and intangible assets		(129,283)	(45,094)
Net Cash Flows from Investing Activities		**(129,283)**	**(20,609)**
Net Increase/(Decrease) in Cash		4,018,652	(284,092)
Opening cash and cash equivalents		1,098,069	1,382,161
Closing Cash and Cash Equivalents	**6**	**5,116,721**	**1,098,069**

The accompanying notes form part of these financial statements.

> notes to **the financial statements**

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

a. Reporting Entity

The Medical Council of New South Wales (the Council) as a not-for-profit reporting entity with no cash generating units, performs the duties and functions contained in the *Health Practitioner Regulation National Law (NSW) No 86a* (the Law).

These financial statements for the year ended 30 June 2013 have been authorised for issue by the Council on 22 October 2013.

b. Basis of Preparation

The Council has adopted the going concern basis in the preparation of the financial statements.

The Council's financial statements are general purpose financial statements and have been prepared in accordance with:

- applicable Australian Accounting Standards (which include Australian Accounting Interpretations), and
- the requirements of the *Public Finance and Audit Act 1983* and Regulation.

The financial statements have been prepared on the basis of historical cost.

Judgements, key assumptions and estimations management has made are disclosed in the relevant notes to the financial statements.
All amounts are rounded to the nearest dollar and are expressed in Australian currency.

c. Statement of Compliance

The financial statements and notes comply with Australian Accounting Standards, which include Australian Accounting Interpretations.

d. Significant Accounting Judgments, Estimates and Assumptions

Effective from 1 July 2012, the Health Professional Councils Authority (HPCA) introduced an agreed cost sharing arrangement for the distribution of pooled costs between health professional Councils. This was a change from the cost sharing arrangements from prior years.

These indirect costs are shown as part of the Council's statement of comprehensive income under the following expense line items:

1. Personnel services
2. Contracted labour
3. Depreciation and amortisation

e. Insurance

The Council's insurance activities are conducted through the NSW Treasury Managed Fund Scheme of self-insurance for Government entities.
The expense (premium) is determined by the Fund Manager based on past claim experience.

f. Accounting for the Goods and Services Tax (GST)

Income, expenses and assets are recognised net of the amount of GST, except that:

- the amount of GST incurred by the Council as a purchaser that is not recoverable from the Australian Taxation Office is recognised as part of the cost of acquisition of an asset or as part of an item of expense, and
- receivables and payables are stated with the amount of GST included.

Cash flows are included in the statement of cash flows on a gross basis. However, the GST components of cash flows arising from investing and financing activities which are recoverable from, or payable to, the Australian Taxation Office are classified as operating cash flows.

g. Income Recognition

Income is measured at the fair value of the consideration or contribution received or receivable.

The National Registration and Accreditation Scheme for all health professionals commenced on 1 July 2010. NSW opted out of the complaint handling component of the National scheme and the health professional Councils were established in NSW effective from 1 July 2010 to manage the complaints function in a co-regulatory arrangement with the NSW Health Care Complaints Commission (HCCC).

Under s 26A of the Law, the complaints element of the registration fees payable during 2013 by NSW health practitioners was decided by the Council established for that profession subject to approval by the Minister for Health.

The Council, under the Law, receives fees on a monthly basis from the Australian Health Practitioner Regulation Agency (AHPRA) being the agreed NSW complaints element for the 2013 registration fee.

Fees are progressively recognised as income by the Council as the annual registration period elapses. Fees in advance represent unearned income at balance date.

h. Personnel Services

The Ministry of Health (MOH) being the employer charges the Council for personnel services relating to the provision of all employees. Staff costs are shown in the Statement of Comprehensive Income as personnel services in the financial statements of the Council. Amounts owing for personnel services in the Statement of Financial Position represent amounts payable to the MOH in respect of personnel services.

i. Interest Revenue

Interest revenue is recognised using the effective interest method as set out in AASB 139 *Financial Instruments: Recognition and Measurement.*

j. Assets

i. Acquisition of Assets

The cost method of accounting is used for the initial recording of all acquisitions of assets controlled by the Council. Cost is the amount of cash or cash equivalents paid or the fair value of the other consideration given to acquire the asset at the time of its acquisition or construction or, where applicable, the amount attributed to that asset when initially recognised in accordance with the requirements of other Australian Accounting Standards.

Assets acquired at no cost, or for nominal consideration, are initially recognised at their historical cost at the date of acquisition.

Fair value is the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms-length transaction.

Where payment for an item is deferred beyond normal credit terms, its cost is the cash price equivalent, i.e. the deferred payment amount is effectively discounted at an asset-specific rate.

ii. Capitalisation Thresholds

The Health Professional Councils Authority (HPCA) acquires all assets on behalf of the Council. Shared use assets that cost over $5,000 at the time of purchase by the HPCA are capitalised. These capitalised shared use assets are then allocated to the Council using an appropriate allocation method. The minimum capitalisation threshold limits applied to the Council for the asset are $1,678 (2011/2012 - $916).

iii. Impairment of Plant and Equipment

As a not-for-profit entity with no cash generating units, AASB 136 *Impairment of Assets* effectively is not applicable. AASB 136 modifies the recoverable amount test to the higher of fair value less costs to sell and depreciated replacement cost. This means that, where an asset is already measured at fair value, impairment can only arise if selling costs are material. Selling costs for the entity are regarded as immaterial.

iv. Depreciation of Plant, Equipment and Leasehold Improvements

Depreciation and amortisation is provided for on a straight-line basis for all depreciable assets so as to write off the amounts of each asset as it is consumed over its useful life to the Council.

Depreciation and amortisation methods, useful lives and residual values are reviewed at each reporting date and adjusted if appropriate.

Depreciation rates used are as follows:

Plant and equipment 20% - 25%
Furniture and fittings 16% - 20%
Motor vehicles 25% - 29%
Leasehold improvements 1.7% - 4%

v. Revaluation of Plant and Equipment

There has been no revaluation on any of the Council's plant and equipment as they are non-specialised assets. Non-specialised assets with short useful lives are measured at depreciated historical cost as a surrogate for fair value.

vi. Maintenance

Day-to-day servicing costs or maintenance are charged as expenses as incurred, except where they relate to the replacement of a component of an asset, in which case the costs are capitalised and depreciated.

vii. Intangible Assets

The Council recognises intangible assets only if it is probable that future economic benefits will flow to the entity and the cost of the asset can be measured reliably. Intangible assets are measured initially at cost. Where an asset is acquired at no or nominal cost, the cost is its fair value as at the date of acquisition.

All research costs are expensed. Development costs are only capitalised when certain criteria are met.

The useful lives of intangible assets are assessed to be finite.

Intangible assets are subsequently measured at fair value only if there is an active market. As there is no active market for the entity's intangible assets, the assets are carried at cost less any accumulated amortisation.

Intangible assets are tested for impairment where an indicator of impairment exists. If the recoverable amount is less than its carrying amount, the carrying amount is reduced to recoverable amount and the reduction is recognised as an impairment loss.

The Council's intangible assets are amortised using the straight line method over a period of four years. In general, intangible assets are tested for impairment where an indicator of impairment exists. However, as a not-for-profit entity with no cash generating units, the Council is effectively exempted from impairment testing.

viii. Loans and Receivables

Loans and receivables are recognised initially at fair value, usually based on the transaction cost or face value. Subsequent measurement is at amortised cost using the effective interest method, less an allowance for any impairment of receivables. Short-term receivables with no stated interest rate are measured at the original invoice amount where the effect of discounting is immaterial. An allowance for impairment of receivables is established when there is objective evidence that the Council will not be able to collect all amounts due. The amount of the allowance is the difference between the assets carrying amount and the present value of the estimated future cash flows, discounted at the effective interest rate. Bad debts are written off as incurred.

k. Liabilities

i. Trade and Other Payables

These amounts represent liabilities for goods and services provided to the Council and other amounts. Payables are recognised initially at fair value, usually based on the transaction cost or face value. Subsequent measurement is at amortised cost using the effective interest method. Short-term payables with no stated interest rates are measured at the original invoice amount where the effect of discounting is immaterial.

ii. Personnel Services – Ministry of Health

Personnel services are acquired from the MOH. As such the MOH accounting policy is below.

Liabilities for salaries and wages (including non-monetary benefits), recreation leave and paid sick leave that are due to be settled within 12 months after the end of the period in which the employees render the service are recognised and measured in respect of employees' services up to the reporting date at undiscounted amounts based on the amounts expected to be paid when the liabilities are settled.

Unused non-vesting sick leave does not give rise to a liability as it is not considered probable that sick leave taken in the future will be greater than the benefits accrued in the future.

The outstanding amounts of payroll tax, workers' compensation insurance premiums and fringe benefits tax, which are consequential to employment, are recognised as liabilities and expenses where the employee benefits to which they relate have been recognised.

All employees receive the Superannuation Guarantee Levy contribution. All superannuation benefits are provided on an accumulation basis - there are no defined benefits. Contributions are made by the entity to an employee superannuation fund and are charged as an expense when incurred.

l. Equity

Accumulated Funds

The category 'Accumulated Funds' includes all current and prior period funds.

m. Comparative information

Except when an Australian Accounting Standard permits or requires otherwise, comparative information is disclosed in respect of the previous period for all amounts reported in the financial statements.

n. Cash and cash equivalents

Cash and cash equivalent assets in the statement of financial position would normally comprise cash on hand, cash at bank and short-term deposits and include deposits in the NSW Treasury Corporation's Hour-Glass cash facility, other Treasury Corporation deposits (less than 90 days) and other at-call deposits that are not quoted in the active market.

Bank overdrafts are included within liabilities.

o. Adoption of New and Revised Accounting Standards

A number of new standards, amendments to standards and interpretations are effective for annual periods beginning after 1 July 2013, and have not been applied in preparing these financial statements. None of these are expected to have a significant effect on the financial statements of the Council.

NSW Treasury issued NSWTC13/02 circular which states none of the new or revised Standards of Interpretations are to be adopted early.

List of new standards that are relevant to the Council are as follows:
a) AASB 9 Financial Instruments (2010), AASB 9 Financial Instruments (2009)
b) AASB 13 Fair Value Measurement (2011)

2. EXPENSES EXCLUDING LOSSES

a. Personnel services expenses

Personnel services expenses are acquired from the MOH and comprise the following:

	2013	2012
	$	$
Salaries and wages (including recreation leave)	2,362,006	2,409,691
Superannuation	238,041	230,789
Payroll taxes	158,777	151,640
Workers compensation insurance	9,685	10,892
	2,768,509	**2,803,012**

b. Other operating expenses

	2013	2012
	$	$
Auditor's remuneration	21,430	23,000
Rent and building expenses	111,348	92,910
Medical Tribunal expenses	675,000	660,669
Council fees	303,458	293,699
Sitting fees	1,338,897	1,302,901
Contracted labour	881,653	731,554
	3,331,786	**3,104,733**

c. Depreciation and amortisation expense

	2013	2012
	$	$
Depreciation		
Motor vehicles	7,901	7,099
Furniture and fittings	4,356	2,491
Other	31,690	47,483
	43,947	**57,073**
Amortisation		
Leasehold improvements	103,030	103,029
Intangible assets	343,386	360,987
	446,416	**464,016**
Total Depreciation and Amortisation	**490,363**	**521,089**

d. Other expenses

	2013	2012
	$	$
Subsistence and transport	84,921	56,751
Funding contributions	42,653	136,994
Fees for service	670,785	1,087,228
Postage and communication	81,773	85,723
Printing and stationery	116,484	94,530
Equipment and furniture	2,550	1,883
General administration expenses	161,060	125,740
	1,160,226	**1,588,849**

3. EXPENDITURE MANAGED ON BEHALF OF THE COUNCIL THROUGH THE HEALTH ADMINISTRATION CORPORATION

The Council's accounts are managed by the Health Administration Corporation (HAC). Executive and administrative support functions are provided by the HPCA, which is an administrative unit of the HAC. The HAC has determined the basis of allocation of material costs to the Council.

Salaries and associated oncosts are paid by the MOH. The MOH continues to pay for the staff and associated oncosts. These costs are reimbursed by the Council to the MOH.

Details of transactions managed on behalf of the Council through the HAC are detailed above in notes 2 to 10.

4. (a) INTEREST REVENUE

	2013	2012
	$	$
Interest revenue from financial assets not at fair value through profit or loss	160,493	64,102
TCorp Hour Glass investment facility	1,691	28,133
	162,184	**92,235**

The interest received was paid under a Special Interest Arrangement with the bank which applied to all daily balances of bank accounts administered on behalf of all health professional Councils by the HAC. In addition to daily balances receiving interest at a rate revised each week, the bank also waived normal bank fees payable such as transaction fees, dishonoured cheque fees and overseas draft fees.

	2013	2012
	%	%
Weighted Average Interest Rate	3.092	3.65

(b) OTHER REVENUE

	2013	2012
	$	$
Legal fee recoveries	72,677	
Other revenue	38,386	97,449
	111,063	**97,449**

5. GAIN/(LOSS) ON DISPOSAL/ ADDITIONS

	2013	2012
	$	$
Plant and equipment		
Net book value disposed/acquired during the year	3,640	(18,275)
Proceeds from sale/acquisition costs	-	24,485
	3,640	6,210
Intangible assets		
Net book value disposed/acquired during the year	51	-
Proceeds from sale/acquisition costs	-	-
Total Gain/(Loss) on Disposal/Additions	**3,589**	**-**

Included in the above Gain/(Loss) on Disposal/Additions for 2013 is an adjustment arising from the Council's decision to acquire an increased portion of its share of the opening carrying values of the pooled assets located at Level 6, 477 Pitt Street, Sydney for no charge.

This adjustment was necessary as the HPCA introduced a revised cost sharing arrangement with the agreement of all the health professional Councils for the distribution of costs of depreciation of the pooled assets between all the health professional Councils effective from 1 July 2012 - refer Note 1.d.

This adjustment has the effect of deferring the depreciation on the portion of the fixed assets that were acquired as future depreciation will be higher under the revised distribution of depreciation costs.

6. CASH AND CASH EQUIVALENTS

	2013	2012
	$	$
Cash at bank and on hand	247,142	240,853
TCorp Hour Glass investment facility	5,347	603,656
Cash at bank - held by HPCA*	4,864,232	253,560
	5,116,721	**1,098,069**

* This is cash held by the HPCA, an administrative unit of the HAC, on behalf of the Council for its operating activities.

Cash and cash equivalent assets in the statement of financial position would normally comprise cash on hand, cash at bank and short-term deposits and include deposits in the NSW Treasury Corporation's Hour-Glass cash facility, other Treasury Corporation deposits (less than 90 days) and other at-call deposits that are not quoted in the active market. Bank overdrafts are included within liabilities.

7. RECEIVABLES

	2013	2012
	$	$
Prepayments	21,865	22,116
Other receivables	(543)	54,534
Interest receivable	13,387	3,688
Trade receivables	131,110	64,426
Less: Allowance for impairment	(1,927)	(3,548)
	163,892	**141,216**

Movement in the allowance for impairment	
Balance at 1 July 2012	3,548
Amounts written off during the year	-
Amounts recovered during the year	(1,716)
Increase/(decrease) in allowance recognised in profit or loss	95
Balance at 30 June 2013	**1,927**

Trade receivables have been considered for impairment.

The trade receivables include monies that AHPRA has collected from registrants as at 30 June 2013 and has remitted the monies to HPCA in July 2013.

Analysis of Trade Debtors Overdue	**$**		
2013	**Total**	**Past due but not impaired**	**Considered impaired**
< 3 months overdue	5,806	-	-
3-6 months overdue	2,772	-	-
> 6 months overdue	2,851	924	1,927
2012			
< 3 months overdue	1,848	-	-
3-6 months overdue	1,221	-	-
> 6 months overdue	3,548	-	3,548

Notes

1. Each column in the table represents the 'gross receivables'.

2. The ageing analysis excludes statutory receivables that are not past due and not impaired.

8. PLANT AND EQUIPMENT

The Council has an interest in plant and equipment used by all health professional Councils. Plant and equipment is not owned individually by the council. The amounts recognised in the financial statements have been calculated based on the benefits expected to be derived by the Council.

	Work in Progress Software / Hardware	**Leasehold Improvements**	**Motor Vehicles**	**Furniture & Fittings**	**Other**	**Total**
	$	**$**	**$**	**$**	**$**	**$**
At 1 July 2012						
Gross carrying amount	-	3,615,799	23,170	341,632	491,143	4,471,744
Accumulated depreciation and impairment	-	(1,866,902)	(2,706)	(338,518)	(449,015)	(2,657,141)
Net Carrying Amount	-	**1,748,897**	**20,464**	**3,114**	**42,128**	**1,814,603**
At 30 June 2013						
Gross carrying amount	109,764	3,615,799	27,769	354,065	491,143	4,598,540
Accumulated depreciation and impairment	-	(1,969,932)	(11,567)	(342,874)	(480,705)	(2,805,078)
Net Carrying Amount	**109,764**	**1,645,867**	**16,202**	**11,191**	**10,438**	**1,793,462**

Reconciliation

A reconciliation of the carrying amount of each class of plant and equipment at the beginning and end of the current reporting period is set out below:

	Work in Progress Software / Hardware	Leasehold Improvements	Motor Vehicles	Furniture & Fittings	Other	Total
	$	$	$	$	$	$
Year Ended 30 June 2013						
Net carrying amount at start of year	-	1,748,897	20,464	3,114	42,128	1,969,810
Additions	109,764	-	-	12,433	-	23,170
Disposals	-	-	-	-	-	23,170
Other [1]	-	-	3,639	-	-	(18,275)
Depreciation	-	(103,030)	(7,901)	(4,356)	(31,690)	(160,102)
Net Carrying Amount at End of Year	**109,764**	**1,645,867**	**16,202**	**11,191**	**10,438**	**1,814,603**

	Work in Progress Software / Hardware	Leasehold Improvements	Motor Vehicles	Furniture & Fittings	Other	Total
	$	$	$	$	$	$
At 1 July 2011						
Gross carrying amount	-	3,615,799	40,176	341,632	491,143	4,488,750
Accumulated depreciation and impairment	-	(1,763,873)	(17,508)	(336,027)	(401,532)	(2,518,940)
Net Carrying Amount	-	**1,851,926**	**22,668**	**5,605**	**89,611**	**1,969,810**
At 30 June 2012						
Gross carrying amount	-	3,615,799	23,170	341,632	491,143	4,471,744
Accumulated depreciation and impairment	-	(1,866,902)	(2,706)	(338,518)	(449,015)	(2,657,141)
Net Carrying Amount	-	**1,748,897**	**20,464**	**3,114**	**42,128**	**1,814,603**

Reconciliation

A reconciliation of the carrying amount of each class of plant and equipment at the beginning and end of the prior reporting period is set out below:

	Work in Progress Software / Hardware	Leasehold Improvements	Motor Vehicles	Furniture & Fittings	Other	Total
	$	$	$	$	$	$
Year Ended 30 June 2012						
Net carrying amount at start of year	-	1,851,926	22,668	5,605	89,611	1,969,810
Additions	-	-	23,170	-	-	23,170
Disposals	-	-	(18,275)	-	-	(18,275)
Other	-	-	-	-	-	-
Depreciation	-	(103,029)	(7,099)	(2,491)	(47,483)	(160,102)
Net Carrying Amount at End of Year	-	**1,748,897**	**20,464**	**3,114**	**42,128**	**1,814,603**

1. Other includes:

a. Adjustments required to opening balances due to the implementation of agreed Cost Allocation Methodology as at 1 July 2012.

9. INTANGIBLE ASSETS

The Council has an interest in plant and equipment used by all health professional Councils. Plant and equipment is not owned individually by the council. The amounts recognised in the financial statements have been calculated based on the benefits expected to be derived by the Council.

	Software Work in Progress	Software	Total
	$	$	$
At 1 July 2012			
Cost (gross carrying amount)	3,409	1,879,419	1,882,828
Accumulated amortisation and impairment	-	(1,228,910)	(1,228,910)
Net Carrying Amount	**3,409**	**650,509**	**653,918**
At 30 June 2013			
Cost (gross carrying amount)	10,495	1,882,005	1,892,500
Accumulated amortisation and impairment	-	**(1,574,932)**	(1,574,932)
Net Carrying Amount	**10,495**	**307,073**	**317,568**

	Software Work in Progress	Software	Total
	$	$	$
Year Ended 30 June 2013			
Net carrying amount at start of year	3,409	650,509	653,918
Additions	7,086	-	7,086
Disposals	-	-	-
Other[1]	-	(50)	(50)
Amortisation	-	(343,386)	(343,386)
Net Carrying Amount at End of Year	**10,495**	**307,073**	**317,568**

	Software Work in Progress	Software	Total
	$	$	$
At 1 July 2011			
Cost (gross carrying amount)	-	1,860,903	1,860,903
Accumulated amortisation and impairment	-	(867,922)	(867,922)
Net Carrying Amount	**-**	**992,981**	**992,981**
At 30 June 2012			
Cost (gross carrying amount)	3,409	1,879,419	1,882,828
Accumulated amortisation and impairment	-	(1,228,910)	(1,228,910)
Net Carrying Amount	**3,409**	**650,509**	**653,918**

	Software Work in Progress	Software	Total
	$	$	$
Year Ended 30 June 2012			
Net carrying amount at start of year	-	992,981	992,981
Additions	3,409	18,515	21,924
Disposals	-	-	-
Other	-	-	-
Amortisation	-	(360,987)	(360,987)
Net Carrying Amount at End of Year	**3,409**	**650,509**	**653,918**

1. Other includes:

a. Adjustments required to opening balances due to the implementation of agreed Cost Allocation Methodology as at 1 July 2012.

10. PAYABLES

	2013	2012
	$	$
Personnel services - Ministry of Health	293,127	437,769
Trade and other payables	1,187,960	810,114
	1,481,087	**1,247,883**

11. FEES IN ADVANCE

	2013	2012
Current	$	$
Registration fees in advance	3,002,217	1,954,196
	3,002,217	**1,954,196**

	2012	2011
Non-Current	$	$
Registration fees in advance	8,470	-
	8,470	**-**

Registration fees in advance is the unearned revenue from NSW Regulatory Fees received on behalf of the Council by the HPCA from the AHPRA.

12. COMMITMENTS FOR EXPENDITURE

a. Capital Commitments

Aggregate capital expenditure for the acquisition of computers and software at Building 45 Gladesville Hospital Gladesville contracted for at balance date and not provided for:

	2013	2012
	$	$
Not later than one year	57,424	-
Later than one year and not later than five years	-	-
Total (including GST)	**57,424**	**-**

b. Operating Lease Commitments

Future non-cancellable operating lease rentals not provided for and payable:

	2013	2012
	$	$
Not later than one year	61,784	33,640
Later than one year and not later than five years	283,110	134,561
Later than five years	578,556	241,649
Total (including GST)	923,450	409,851

13. RELATED PARTY TRANSACTIONS

The Council has only one related party, being the HPCA, an administrative unit of the HAC.

The Council's accounts are managed by the HAC. Executive and administrative support functions are provided by the HPCA. All accounting transactions are carried out by the HPCA on behalf of the Council.

14. CONTINGENT LIABILITIES AND CONTINGENT ASSETS

There are no material unrecorded contingent assets and liabilities as at 30 June 2013.

15. RECONCILIATION OF NET RESULT TO CASH FLOWS FROM OPERATING ACTIVITIES

	2013	2012
	$	$
Net result	2,394,142	(662,250)
Depreciation and amortisation	490,363	521,089
Allowance for impairment	1,621	3,548
Increase/(Decrease) in receivables	(24,297)	108,765
Increase/(Decrease) in fees in advance	1,056,491	(109,708)
Increase/(Decrease) in payables	233,204	(118,717)
Net gain/(loss) on sale of plant and equipment	(3,589)	(6,210)
Net cash used on operating activities	**4,147,935**	**(263,483)**

16. FINANCIAL INSTRUMENTS

The Council's main risks arising from financial instruments are outlined below, together with the Council's objectives, policies and processes for measuring and managing risk. Further quantitative and qualitative disclosures are included throughout the financial statements.

The Council has overall responsibility for the establishment and oversight of risk management and reviews and agrees on policies for managing each of these risks.

a. Financial Instrument Categories

Financial Assets	**Note**	**Category**	**Carrying Amount 2013**	**Carrying Amount 2012**
Class			**$**	**$**
Cash and Cash Equivalents	6	N/A	5,116,721	1,098,069
Receivables [1]	7	Loans and receivables (measured at amortised cost)	142,027	64,566

Financial Liabilities	**Note**	**Category**	**Carrying Amount 2013**	**Carrying Amount 2012**
Class			**$**	**$**
Payables [2]	10	Financial liabilities (measured at amortised cost)	1,481,087	1,247,883

Notes:
1. Excludes statutory receivables and prepayments (i.e. not within scope of AASB 7).
2. Excludes statutory payables and unearned revenue (i.e. not within scope of AASB 7).
3. There are no financial instruments accounted for at fair value.

b. Credit Risk

Credit risk arises when there is the possibility of the Council's debtors defaulting on their contractual obligations, resulting in a financial loss to the Council. The maximum exposure to credit risk is generally represented by the carrying amount of the financial assets (net of any allowance for impairment).

Credit risk arises from the financial assets of the Council, including cash, receivables, and authority deposits. No collateral is held by the Council. The Council has not granted any financial guarantees.

Cash

Cash comprises cash on hand and bank balances held by the Council and the HPCA on behalf of the Council. Interest is earned on daily bank balances. The TCorp Hour Glass cash facility is discussed in paragraph (iv) below.

Receivables - Trade Debtors

All trade debtors are recognised as amounts receivable at balance date. Collectability of trade debtors is reviewed on an ongoing basis. Debts which are known to be uncollectible are written off. An allowance for impairment is raised when there is objective evidence that the entity will not be able to collect all amounts due. This evidence includes past experience, and current and expected changes in economic conditions and debtor credit ratings. No interest is earned on trade debtors. The Council is not materially exposed to concentrations of credit risk to a single trade debtor or group of debtors.

c. Liquidity Risk

Liquidity risk is the risk that the Council will be unable to meet its payment obligations when they fall due. The HPCA on behalf of the Council continuously manages risk through monitoring future cash flows and maturities planning to ensure adequate holding of high quality liquid assets.

The liabilities are recognised for amounts due to be paid in the future for goods or services received, whether or not invoiced. Amounts owing to suppliers (which are unsecured) are settled in accordance with the policy set out in Treasurer's Direction 219.01. If trade terms are not specified, payment is made no later than the end of the month following the month in which an invoice or a statement is received. Treasurer's Direction 219.01 allows the Minister to award interest for late payment.

All payables are current and will not attract interest payments.

d. Market Risk

Market risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in the market prices. The Council's exposure to market risk is primarily through price risks associated with the movement in the unit price of the TCorp Hour Glass facilities. The Council has no exposure to foreign currency risk and does not enter into commodity contracts.

The TCorp Hour Glass investment facilities are held for strategic rather than trading purposes. The Council has no direct equity investments. Investment in the Hour Glass facilities limits the Council's exposure to risk, as it allows diversification across a pool of funds, with different investment horizons and a mix of investments.

e. Interest Rate Risk

The Council has minimal exposure to interest rate risk from its holdings in interest bearing financial assets. The Council does not account for any fixed rate financial instruments at fair value through profit or loss or as available-for-sale. Therefore, for these financial instruments, a change in interest rates would not affect profit or loss or equity. A reasonably possible change of +/- 1% is used, consistent with current trends in interest rates. The basis will be reviewed annually and amended where there is a structural change in the level of interest rate volatility.

17. EVENTS AFTER THE REPORTING PERIOD

There are no events after the reporting period to be included in the financial statements as of 30 June 2013.

End of audited financial statements

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Appendix 1: Legal change

Health Practitioner Regulation National Law (NSW)

During 2012/13 the NSW Parliament passed two minor amendments to the *Health Practitioner Regulation National Law (NSW).* Amendments were made by the *Health Legislation Amendment Act 2013.* Those amendments are:

1. The inclusion of section 150D (4A) to provide that notwithstanding sections 150D(3) and (4), the Health Care Complaints Commission is not required to investigate a complaint that is referred to it following the taking of immediate action under section 150 if the matter that is the subject of the complaint is being, or has been, investigated as, or as part of, another complaint to the Commission.

2. Amendment of section 152J(b) to provide that a practitioner's consent is required before the Medical Council suspends his or her registration following the recommendation of an impaired registrants panel. The amendment clarifies that, in keeping with the cooperative and remedial nature of the Health Program, both suspension and conditions on registration following an impaired registrants panel require the practitioner's consent.

3. Amendment of clause 11 of Schedule 5C to provide that the appointment of a person as an acting member of a Council or of a member as the acting President of a Council is by the Minister for Health rather than by the Governor.

Health Practitioner Regulation (New South Wales) Regulation 2010

The Governor approved amendments to the *Health Practitioner Regulation (New South Wales) Regulation 2010* concerning the composition of certain health professional councils.

Amendments were made by the *Health Practitioner Regulation (New South Wales) Amendment (Health Professional Councils) Regulation 2012.* They comprised minor amendments to the membership composition of the Dental Council, Medical Council, Nursing and Midwifery Council, Pharmacy Council, Physiotherapy Council and Psychology Council.

Appendix 2: GIPA statistics 2012/13

The Medical Council is required to report its activity annually in accordance with s 125 of the GIPA Act and clause 7 of the Regulations. The statistical reports that follow correspond to Schedule 2 of the *Government Information (Public Access) Amendment Regulation 2010.*

Table 31: Number of GIPA applications - type of applicant and outcome

	Access granted in full	Access granted in part	Access refused in full	Information not held	Information already available	Refuse to deal with application	Refuse to confirm/ deny whether information is held	Application withdrawn
Media	0	0	0	0	0	0	0	0
Members of Parliament	0	0	0	0	0	0	0	0
Private sector business	0	0	0	0	0	0	0	0
Not for profit organisations or community groups	0	0	0	0	0	0	0	0
Members of the public (application by legal representative)	0	2	0	0	0	0	0	0
Members of the public (other)	0	7	0	2	1	1	0	0

* More than one decision can be made in respect of a particular access application. If so, a recording must be made in relation to each such decision. This also applies to Table 29.

Table 32: Number of GIPA applications – type of application and outcome

	Access granted in full	Access granted in part	Access refused in full	Information not held	Information already available	Refuse to deal with application	Refuse to confirm/ deny whether information is held	Application withdrawn
Personal information applications*	0	0	0	0	0	0	0	0
Access applications (other than personal information applications)	0	2	0	1	0	0	0	0
Access applications that are partly personal information applications and partly other	0	7	0	1	1	1	0	0

* A personal information application is an access application for personal information (as defined in clause 4 of Schedule 4 to the Act) about the applicant (the applicant being an individual).

Table 33: Invalid applications

Invalid applications	
Reason for invalidity	**No of applications**
Application does not comply with formal requirements (s 41 of the Act)	2
Application is for excluded information of the agency (s 43 of the Act)	0
Application contravenes restraint order (s 110 of the Act)	0
Total number of invalid applications received	2
Invalid applications that subsequently became valid applications	2

Table 34: Presumption of overriding public interest

Conclusive presumption of overriding public interest against disclosure: matters listed in schedule 1 to Act	
	Number of times consideration used*
Overriding secrecy laws	7
Cabinet information	0
Executive Council information	0
Contempt	1
Legal professional privilege	2
Excluded information	2
Documents affecting law enforcement and public safety	0
Transport safety	0
Adoption	0
Care and protection of children	0
Ministerial code of conduct	0
Aboriginal and environmental heritage	0

* More than one public interest consideration may apply in relation to a particular access application and, if so, each such consideration is to be recorded (but only once per application). This also applies in relation to Table 32.

Table 35: Other public interest considerations against disclosure

Other public interest considerations against disclosure: matters listed in table to s 14 of Act	Number of occasions when application not successful
Responsible and effective government	1
Law enforcement and security	0
Individual rights, judicial processes and natural justice	8
Business interests of agencies and other persons	2
Environment, culture, economy and general matters	0
Secrecy provisions	0
Exempt documents under interstate Freedom of Information legislation	0

Table 36: Timeliness

Timeliness	Number of applications
Decided within the statutory timeframe (20 days plus any extensions)	8
Decided after 35 days (by agreement with applicant)	3
Not decided within time (deemed refusal)	0
Total	11

Table 37: Applications reviewed – by type of review and outcome

Number of applications reviewed under Part 5 of the Act (by type of review and outcome)	Decision varied	Decision upheld	Total
Internal review	1	0	1
Review by Information Commissioner*	1	0	1
Internal review following recommendation under s 93 of Act	1	0	1
Review by ADT	1	0	1
Total	4	0	4

* The Information Commissioner does not have the authority to vary decisions, but can make recommendations to the original decision-maker. The data in this case indicates that a recommendation to vary or uphold the original decision has been made by the Information Commissioner.

Table 38: Applications for review – by type of applicant

Applications for review under Part 5 of the Act (by type of applicant)	Number of applications for review
Applications by access applicants	4
Applications by persons to whom information the subject of access application relates (see s 54 of the Act)	0

Appendix 3: Legal matters in other jurisdictions

Andrew John Katelaris v Medical Council of New South Wales (formerly New South Wales Medical Board) (No. 2) [2012] NSWSC 617

In 2011/12 it was reported that Dr Katelaris had commenced a claim for damages in the Supreme Court of New South Wales against the Medical Council. The claim by Dr Katelaris alleged that the conditions to protect the public, which the former New South Wales Medical Board imposed on his registration in 2003, constituted the tort of misfeasance in public office.

In September 2012 the Supreme Court dismissed the claim with gross sum costs awarded to the Medical Council.

AIN and Medical Council of NSW [2013] NSWADT 212

This was an external review by the Administrative Decisions Tribunal (ADT) of a decision made by the Medical Council under the *Government Information (Public Access) Act 2009.*

Some 2,000 documents had been released in response to a GIPA request. This review concerned the 139 documents the Medical Council had decided to withhold from release.

The ADT decision includes discussion of:

- conclusive presumptions against disclosure of information which were found to exist (legal professional privilege in relation to both external and internal advice, and the Medical Council holding information obtained from the Health Care Complaints Commission as part of joint exercise of functions conferred by the *Health Care Complaints Act 1993*)
- whether reasonable searches were conducted by the Medical Council (the Council conceded that its processes were not perfect, however the Tribunal was satisfied there were no further searches the Council could reasonably undertake to attempt to locate additional documents)
- whether serious allegations made by AIN (the applicant, a medical practitioner) precluded the Medical Council from asserting legal professional privilege, which the Tribunal found they did not. (Section 125 of the *Evidence Act 1995* outlines circumstances in which client legal privilege may be lost through misconduct.)

The Medical Council's decision was affirmed by the Tribunal, other than in relation to nine documents which the Tribunal decided should be released with some redactions.

Glossary of terms

Adjudication Body	A term used in the *Health Practitioner Regulation National Law (NSW)* to describe the decision making bodies, including: Tribunals, Courts, Professional Standards Committees, Councils, and Performance Review Panels
Caution	A formal outcome of disciplinary proceedings that is intended to act as a deterrent to a practitioner not to repeat specified conduct
Complainant	A person whose correspondence to any of the following is dealt with as a complaint under the *Health Practitioner Regulation National Law (NSW)*, and the *Health Care Complaints Act*: • Health Professional Councils Authority (HPCA) • Health Care Complaints Commission (HCCC) • Australian Health Practitioner Regulation Agency (AHPRA)
Conciliation	A process conducted by the HCCC with a view to a complainant and the subject/s of a complaint negotiating a resolution
Condition	Text attached to a practitioner's registration which imposes restrictions or obligations on the practitioner
Conducted	A matter has been conducted when an Adjudication Body or review/interview panel has received some or all of the evidence (by oral hearing and/or written submissions), but the matter is adjourned or not yet completed, in that the outcome and/or the written reasons have not been handed down
Closed	A complaint/notification is closed when there is a final outcome regarding the matters raised in or by the complaint/notification. (Closure may occur on initial assessment of a complaint by the Council and HCCC, or may not occur until the completion of the hearing of a matter before an adjudication body.)
Director of Proceedings	Following investigation of a complaint by the HCCC, if it appears disciplinary action may be warranted, the HCCC's Director of Proceedings is the person responsible for independently determining whether a complaint should be prosecuted. Prior to reaching this decision, the DP is required to consult with the Medical Council
Endorsed	Under the *Health Practitioner Regulation National Law (NSW)*, Impaired Registrant Panels make recommendations for the Medical Council to consider. If the Council accepts the recommendations, they are considered to be endorsed and are put into effect. Similarly, a Performance Interview or Performance Assessment can make recommendations to the Council following an interview or assessment. Again, if accepted, the recommendations are considered to be endorsed, and are put into effect
Exiting Health Program	A practitioner who participates in the Health Program is described as exiting the program at the point where the Medical Council decides conditions relating to a practitioner's health are no longer necessary and health goals have been met. Exiting the Health program includes the practitioner attending an exit interview with the Council
Exiting Performance Program	A practitioner who participates in the Performance Program is described as exiting the program at the point where the Medical Council decides conditions relating to a practitioner's performance are no longer necessary and health goals have been met.
Finalised	A matter is finalised when there is a final outcome that can be described or measured by its effect, for example when an adjudication body delivers its findings and any orders and hands down its written reasons for decision
Impaired Registrants Panel (IRP)	An inquiry convened to enquire into impairment matters that come to the attention of the Medical Council. The Panel consists of two or three members appointed by the Council from a pool of doctors and lay members who are experienced in working with practitioners experiencing problems with their health

Impairment	As defined by the *Health Practitioner Regulation National Law (NSW),* in relation to a person, means the person has a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect— (a) for a registered health practitioner or an applicant for registration in a health profession, the person's capacity to practise the profession; or (b) for a student, the student's capacity to undertake clinical training— (i) as part of the approved program of study in which the student is enrolled or (ii) arranged by an education provider
Interim Immediate Action	The suspension of a practitioner's registration or the imposition of conditions as an interim protective measure by the Council
Mandatory notification	A statutory obligation on registered health practitioners, employers of registered health practitioners and education providers to inform the relevant National Board of 'notifiable conduct', as defined under section 140 of the *Health Practitioner Regulation National Law (NSW)*
National Boards	Bodies appointed by the Ministerial Council with responsibility for the registration and regulation of health professionals. Functions are in the public interest and as set out in the *Health Practitioner Regulation National Law.* The Medical Board of Australia is the National Board for the medical profession
Notifiable conduct	Is defined in section 140 of the *Health Practitioner Regulation National Law (NSW).* It consists of practising the profession while intoxicated by alcohol or drugs, engaging in sexual misconduct, placing the public at risk of substantial harm because the practitioner has an impairment, or placing the public at risk of harm by practising in a way that constitutes a significant departure from accepted professional standards
Reprimand	A formal outcome of disciplinary proceedings consisting of a chastisement for conduct or a formal rebuke
Notification	Information or complaint about the performance, conduct or health of a medical practitioner made by another health practitioner, employer, education provider or another party
Open	A complaint/notification remains open until such time as a final outcome or decision has been made by the Council and HCCC or other adjudication body. This decision disposes of the matter
Preliminary assessment	When the Medical Council and HCCC meet following the receipt of a complaint or notification to determine the most appropriate way to manage and respond to the issues identified in the complaint or notification
Professional misconduct	Defined in section 139E of the *Health Practitioner Regulation National Law (NSW).* A complaint of professional misconduct is more serious than a complaint of unsatisfactory professional conduct
Professional performance	Professional performance of a registered health practitioner is a reference to the knowledge, skill or judgment possessed and applied by the practitioner in the practice of the practitioner's health profession
Unsatisfactory professional conduct	Has several definitions in sections 139B and 139C of the *Health Practitioner Regulation National Law (NSW).* The most common definitions being 1) conduct that is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience, and 2) conduct that is improper or unethical that relates to the practice or purported practice of the practitioner's profession. A complaint of professional misconduct is more serious than a complaint of unsatisfactory professional conduct
Unsatisfactory Professional Performance	The professional performance of a registered health practitioner is unsatisfactory if it is below the standard reasonably expected of a practitioner of an equivalent level of training or experience

Glossary of monitoring terms

Drug and alcohol testing conditions

Urine testing

Urine testing is the main monitoring and rehabilitation tool utilised by the Medical Council. Urine testing may be a requirement for practitioners or medical students with a history of substance and/or alcohol abuse or about whom concerns have been identified regarding possible self administration of prescribed or illicit substances. Two types of urine testing are utilised the Council:

1. Urine drug testing

Drugs routinely tested for include cannabis, opiates (morphine and codeine), cocaine, amphetamine and benzodiazepines. In addition, specimens are tested for pethidine and tramadol. In certain cases, conditions may also require specimens to be tested for additional drugs (such as zolpidem (Stilnox), propofol and fentanyl).

2. Ethyl Glucuronide (EtG) Testing

Ethyl Glucuronide (EtG) is a specific and sensitive biomarker of ethanol consumption. EtG is a metabolite of alcohol that is much more slowly eliminated from the body than alcohol itself. It is the best marker currently available to monitor abstinence from alcohol and has been adopted by the Medical Council for use in circumstances where abstinence is required.

Blood testing

A practitioner or medical student may be required to undertake Carbohydrate-Deficient Transferrin (CDT) testing where the presenting health problem is related to the harmful use of alcohol. The test is designed to identify excess consumption or harmful use of alcohol.

Chaperone

From time-to-time the Council becomes aware of a medical practitioner facing criminal charges in the nature of sexual assault. In addition, complaints alleging serious sexual misconduct may be made which may not result in criminal charges. As well as referring a complaint to the Health Care Complaints Commission for investigation, the Council's usual practice is to seek information about the nature of the practitioner's practice of medicine and to obtain any available information about the matter and other relevant criteria, in order to consider whether or not urgent interim action should be taken.

Mentor

This type of condition is most commonly imposed when a practitioner has been absent from clinical practice for some period of time, has encountered difficulties in their practice or suffers from a condition which affects or might affect their practice of medicine.

A practitioner is usually required to nominate a mentor who will be approved by the Council. The mentor may be required to report to the Council and to confirm that they have acted as mentor for a period of time or to notify the Council of significant difficulties experienced by the subject practitioner.

Supervisor

Supervision conditions may be imposed on a practitioner's registration for some or all of the following reasons:

- Monitoring compliance with conditions.
- Monitoring capacity to practise medicine safely.
- Monitoring performance.
- Providing the Medical Council with regular feedback on these matters.
- Providing peer support for the supervised practitioner.

Audit

An audit is an assessment of a practitioner's clinical practice by an independent body, namely an auditor appointed by the Council. Practitioners are required to undergo an audit of their clinical practice as a result of a hearing by a determining authority such as a Professional Standards Committee, Performance Review Panel, Section 150 proceedings, or the Medical Tribunal. The purpose of an audit varies from case to case, but is likely to include one or more of the following:

- Assessment of compliance with conditions or orders;
- Assessment of aspects of clinical performance; and/or
- Assessment of aspects of practice accommodation / facilities / equipment.

Critical Compliance

A Medical Tribunal or Professional Standards Committee may direct that a specific order or condition is a critical compliance condition. A breach of a critical compliance condition or order results in the immediate suspension of a practitioner's registration.

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