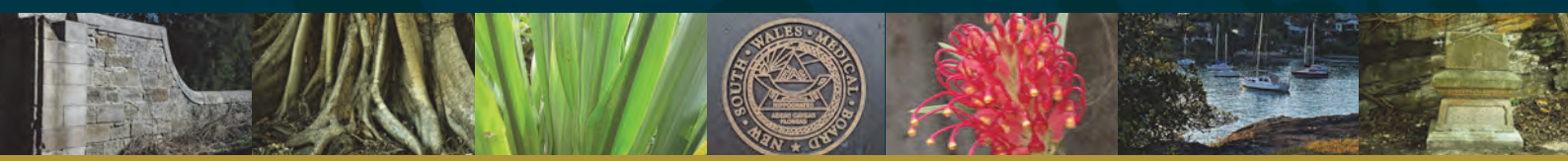
Medical Council
OF ★ NEW ★ SOUTH ★ WALES

Annual Report 2012



Annual Report 2012

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ISSN 1839-5430

> 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 about conduct, performance and health matters concerning 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 10 health professional councils operating 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 pursuant to the *Health Practitioner Regulation National Law (NSW)*. The Medical Council exercises the powers, authorities, duties and functions imposed on it by the *Health Practitioner Regulation National Law (NSW)*. The object of *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 *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 proper and appropriate standards of conduct and professional performance.

Medical Council
OF NEW SOUTH WALES

PO Box 104 Gladesville NSW 1675
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23 October 2012

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,

We have the pleasure of forwarding to you the Annual Report of the Medical Council of New South Wales for the year ending 30 June 2012.

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 the 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**

The year has seen the Medical Council of NSW (the Medical Council) consolidate its role within the National Scheme's operation in NSW and continue to effectively manage its health, conduct and performance programs in the face of increasing complaint numbers.

The increase in complaints and notifications made against NSW medical practitioners is in keeping with recent trends over the past five years. This in turn has led to an increase in the Medical Council's regulatory activities. The number of complaints prosecuted before a Medical Tribunal or Professional Standards Committee remains substantial as does the incidence of taking interim immediate action, either by imposing conditions or suspending a practitioner.

There is an increased awareness of mandatory reporting obligations which has resulted in an increase in these types of notifications. While NSW introduced mandatory reporting obligations in 2008, the current national definitions as to what constitutes notifiable conduct are different and the obligation to report extends to all registered health practitioners, their employers and education providers. Partly as a result of this increased awareness, more health notifications were received this year and the Medical Council convened more Impaired Registrants Panels than in previous years. Given the ongoing national discussion concerning the funding of doctors' health advisory services and the role of the National Board and the Medical Council in managing impaired practitioners, the Medical Council recognises the importance of maintaining its non-disciplinary Health Program. The Medical Council continues to receive a large proportion of notifications from impaired practitioners self-notifying their illness. One of the reasons why a significant proportion of medical practitioners are prepared to self-notify to the Medical Council is the success of the Health Program, which the profession and stakeholders recognise as supportive in many respects.

The activity of the Medical Council's Performance Program is at an unprecedented level and reflects the Medical Council's continued commitment to managing complaints through a non-disciplinary and remedial pathway where appropriate. The Medical Council conducted almost three times as many performance interviews this year when compared to last year, which is an indication of the Performance Committee's view that such interviews are an effective means of obtaining additional information when a complaint raises concerns about a practitioner's professional performance. Although a performance assessment may be an outcome following such an interview, there continue to be occasions where practitioners are referred for a health assessment. This outcome reinforces the view that many factors influence and affect a practitioner's performance and a practitioner's health may be one factor which may cause professional performance to be unsatisfactory.

The Medical Council also experienced change this year with respect to its audit responsibilities following the introduction of a direction by NSW Treasury requiring agencies like the Medical Council to establish an independent internal audit and risk committee. While the Medical Council was provided with an exemption from this requirement because of its size and budget, the Health Professional Councils Authority, on behalf of all of the NSW health professional councils, established an independent internal audit and risk committee to oversee the Medical Council's performance in relation to audit and risk management and compliance. The Medical Council's Executive Officer and a Medical Council member attend these meetings to provide ongoing liaison between this Committee and the Medical Council with respect to these functions. The Medical Council's Governance Committee continues to function and consider governance issues.

There were a number of minor amendments made to the *Health Practitioner Regulation National Law (NSW)* in the reporting year. The most significant was an amendment reinforcing the philosophy that in the exercise of functions by the Medical Council, the protection of the health and safety of the public must be the paramount consideration. This philosophy underpinned the former NSW Medical Board's approach to regulation in NSW and is viewed by the Medical Council as a significant amendment which clarifies the objective and guiding principle of the Law as it operates in NSW.

During the year, the Medical Council embarked on financial analysis and commissioned external review into its budget and future cash reserve position so as to ensure that it maintained adequate provisions to fund its regulatory activities over the coming years. The review resulted in an increase in the registration fee payable by NSW medical practitioners for the coming year. For a number of years in the lead-up to the National Scheme, the former NSW Medical Board had intentionally kept the registration fees artificially low by drawing on its reserves to fund operating costs. Despite the increase, NSW practitioners will continue to pay less for their medical registration than their interstate colleagues.

Since the commencement of the National Scheme, the Medical Council has been operating at a loss, despite substantial cost saving measures in the face of increasing complaint numbers. In part, the operating loss has been caused by a decrease in the number of medical practitioners whose principal place of practice is NSW. This is because many medical practitioners who were registered previously in NSW as well as in their home state or territory, are now only required to hold one registration nationally. There is no cross-subsidisation of other health professions in the National Scheme or in NSW, so the registration fees of NSW medical practitioners only fund the regulation by the Medical Council of the medical profession in NSW and registration costs by AHPRA.

Throughout the year, the Medical Council continued to develop new policies and other initiatives which were relevant to, or associated with, its regulatory functions. The Medical Council, for example, developed a policy on data access and use for research purposes. Throughout the year, the Medical Council has also been actively involved in national initiatives, including providing advice and feedback to the Medical Board of Australia arising from the Board's consultation into a number of policies and guidelines. This has included guidelines on technology based consultations, the use of chaperones following allegations of sexual misconduct, the review into the definition of 'practice', and funding external doctors' health programs. Where appropriate, the Medical Council endorses the Medical Board of Australia's guideline or policy so that it applies to all registered medical practitioners, including NSW practitioners. There may however be exceptions where a national policy or guideline is not able to be applied in NSW, in light of the different provisions that operate in NSW concerning performance, conduct and health matters.

The Medical Council commences the new financial year with a smaller composition of 19 members, including seven new members. The appointment of new members ensures that the Medical Council continues to benefit from a broad spectrum of expertise and results in new input and perspective into its activities and decisions.

The Medical Council farewelled a number of its longstanding members on 30 June 2012. The retirement of Dr Kerry Chant, Dr Sue Ieraci, A/Professor John Palmer, Dr Denis Smith, Professor Allan Spigelman, Dr Greg Stewart, Dr Kendra Sundquist and Professor Kay Wilhelm from the Medical Council represents a loss of nearly 90 years of combined regulatory experience. All of these members contributed greatly to the work of the former NSW Medical Board and the Medical Council over the years and guided the Medical Council through a number of difficult and complex challenges following transition to the National Scheme. Each member willingly dedicated time and energy that made a large contribution to developing and implementing programs and initiatives to improve and enhance the regulation of the medical profession in NSW.

The Medical Council looks forward to continuing in its role as a recognised leader, at the forefront of medical regulation both nationally and internationally over the coming 12 months.

Peter Procopis
President

> year in **summary**

Table 1 provides 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 from the past three years relating to the Medical Council's role in monitoring compliance with conditions on practitioners' 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

	2009/10	2010/11	2011/12
Professional conduct			
Complaints assessed	1,279	1,407	1,508
Professional Standards Committees finalised	16	14	17
Medical Tribunals complaints finalised	20	18	22
Medical Tribunal appeals and review applications finalised	11	6	4
Counselling interviews finalised	25	30	19
Section 66 proceedings / s66AB proceedings finalised (under previous Medical Practice Act)	47	11	-
Section 150 proceedings finalised (including section 150A and section 150C proceedings)	-	49	53
Health			
Medical practitioners in Health Program	122	111	122
Entrants to Program	28	29	29
Impaired Registrants Panels conducted	43	46	64
Board / Medical Council Review Interviews conducted	263	242	234
Performance			
Medical practitioners in Performance Program	65	79	70
Entrants to Program	32	31	25
Performance Assessments conducted	26*	25*	22
Re-Assessments conducted	3*	2*	3
Performance Review Panels conducted	11*	10*	12
Performance Interviews conducted	57*	25*	69
Exit from Program	21	17	22
Monitoring			
New cases – Health Program	35	19	37
New cases – Performance Program	8	4	8
New cases – Conduct Program	40	34	31
Total cases completed	60	73	81
Total active cases	248	232	227
Registration			
Medical practitioners in NSW	31,425	27,686	28,972
Medical students in NSW			5,800
Total number of medical practitioners in Australia	82,895	88,293	91,648

[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 2010/11 and 2011/12.

* Reported in 2009/10 and 2010/11 as matters 'concluded' which accounts for the variation from the figures reported in those years.

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

Membership of the Medical Council of NSW

The Medical Council of New South Wales (the Medical Council) consists of 20 part-time members appointed by the Governor.

Membership of the Medical Council and the positions of the President and Deputy President are prescribed pursuant to Parts 1 and 2 of Schedule 5C of the *Health Practitioner Regulation National Law (NSW)*.

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

The current term of office for all Medical Council members commenced on 1 July 2010, following their transition as members of the former NSW Medical Board, and expired on 30 June 2012.

New appointments to the Medical Council will occur following this reporting period, effective from 1 July 2012. The size of the Medical Council will reduce from 20 members to 19 members with the composition not changing, except for the Department of Health nominee who will no longer be eligible for appointment to the Council.

Members of the Medical Council, their qualifications, term of appointment and nominating body for the period 1 July 2011 to 30 June 2012 are listed below. During this period, six ordinary meetings were held. Attendances at these Medical Council are recorded in square brackets.

Clinical Associate Professor Peter George Procopis AM, President, MBBS (Sydney), FRACP, Royal Australasian College of Physicians nominee (current term: 1.7.2010 – 30.6.2012) [5]

Dr Gregory John Kesby, Deputy President, MBBS (UNSW), BSc Hons (UNSW), PhD (Cambridge), FRANZCOG, DDU, CMFM, Royal Australian and New Zealand College of Obstetricians and Gynaecologists nominee (current term: 1.7.2010 – 30.6.2012) [6]

Dr Stephen Adelstein, MB BCh (Wits), PhD (Sydney), FRACP, FRCPA, FFs, (RCPA), Royal College of Pathologists of Australasia nominee (current term: 1.7.2010 – 30.6.2012) [6]

Professor Belinda Bennett, B Ec. LLB (Macquarie), LLM SJD (Wisconsin), GAICD, Legal Member nominated by the Minister (current term: 1.7.2010 – 30.6.2012) [5]

Mr Antony Carpentieri, LLB (UTS), Ministerial nominee (current term: 1.7.2010 – 30.6.2012) [4]

Dr Kerry Chant, MBBS (UNSW), FAFPHM, MHA (UNSW), MPH (UNSW), Department of Health nominee (current term: 1.7.2010 – 30.6.2012) [0]

Mr Michael Christodoulou AM, Community Relations Commission nominee (current term: 1.7.2010 – 30.6.2012) [6]

Professor Anthony Andrew Eyers, MBBS (Sydney), FRACS, FRCS, Master of Bioethics (Monash), Royal Australasian College of Surgeons nominee (current term: 1.7.2010 – 30.6.2012) [3]

Dr Susan Ieraci, MBBS (Sydney), FACEM, Ministerial nominee (current term: 1.7.2010 – 30.6.2012) [5]

Ms Rosemary Eva Kusuma, BSW (Sydney), Ministerial nominee (current term: 1.7.2010 – 30.6.2012) [6]

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: 1.7.2010 – 30.6.2012) [3]

Dr Robyn Stretton Napier, MBBS (Sydney), Australian Medical Association nominee (current term: 1.7.2010 – 30.6.2012) [5]

Clinical Associate Professor Frederick John Palmer, M.Litt (New England), MB ChB (Sheffield) MD (Sheffield), BA (New England), MRCP (London), DMRD (London), FRANZCR, FRCR (London), Royal Australian and New Zealand College of Radiologists nominee (current term: 1.7.2010 – 30.6.2012) [5]

Ms Lorraine Poulos, RN (SVH), Grad Cert HSM (ECU), Ministerial nominee (current term: 1.7.2010 - 30.6.2012) [3]

Dr Denis Andrew Smith, MBBS (Sydney), MHP, FRACMA, Royal Australasian College of Medical Administrators nominee (current term: 1.7.2010 – 30.6.2012) [5]

Professor Allan David Spigelman, MBBS (Sydney), FRACS, FRCS, MD, Universities nominee (current term: 1.7.2010 – 30.6.2012) [3]

Dr Gregory Joseph Stewart, MBBS, MPH (Sydney), FRACMA, FAFPHM, Ministerial nominee (current term: 1.7.2010 – 30.6.2012) resigned 24.1.2012 [3]

Dr Kendra Sundquist, Ed.D (UTS), MHlth.Sc. (Ed) (Sydney), RN, MCNA, Ministerial nominee (current term: 1.7.2010 – 30.6.2012) [6]

Professor Kathleen Anne Wilhelm AM, MBBS (UNSW), MD, FRANZCP, Royal Australian & New Zealand College of Psychiatrists nominee (current term: 1.7.2010 – 30.6.2012) [6]

Dr Choong-Siew Yong, MBBS (Sydney), FRANZCP, Australian Medical Association nominee (current term: 1.7.2010 – 30.6.2012) [4]

Medical Council members generally serve on one or more of the Medical Council's 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 *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 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 H An, Dr P Anderson, Dr K Arnold, Dr B Bailey, Dr A Bean, A/Prof C Benness, Dr R Benson, Dr C Berglund, Dr H Bittar, Dr F Black, Dr P Bland, Dr L Boshell, Dr J Branch, Dr D L Brash, Dr J Briedis, Dr G Buckland, Dr R Chaseling, Dr C Clarke, Ms A Collier, Dr M Cox, Dr G P Curtin, A/Prof M da Cruz, Dr R Davies, Dr V de Carvalho, Dr M Diamond, Dr G Dore, Dr K Edwards, Ms G Ettinger, Dr R Fisher, Dr R Ford, Dr M Friend, Ms G Furness, Dr S Gani, Dr M Giuffrida, Dr A Glass, Dr M Gleeson, Dr P R Gordon, Dr A Gould, Dr A Gray, Ms A Gray, Dr J S Harbison, Dr N Harris, A/Prof B Haylen, Dr G Herkes, Dr M Higgins, Dr R Hislop, Dr A Holdgate, Dr M Hollands, Ms J Houen, Dr S Howle, Dr K Ilbery, Dr W Jammal, Dr M Jarrett, Dr W A C Johnston, Ms M Kelly, Mr R Kelly, Dr J Kendrick, Dr E Kertesz, Dr A Keshava, Ms H Kiel, Dr L King, Prof P Klineberg, Dr E Kok, Dr P Langeluddecke, Prof H Lapsley, Dr V Lele, Dr K Lovric, Dr M Lowy, Dr R Lyneham, Dr J Mair, Dr S Mares, Dr M McGlynn, Dr S Messner, Dr P Morse, Dr J Ng, Dr N O'Connor, Dr B Parsonage, Dr R Payten, Dr H Pederson, Dr A Pethebridge, Dr J Phillips, Dr T Poon, 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, Dr D Storey, Dr J Sullivan, Dr E Summers, Dr V Sutton, Dr I Symington, Dr S-H Toh, Dr E Tompsett, Dr V Tran, Dr P Truskett, Dr P Tucker, Dr F Varghese, Dr A Virgona, Dr A Walker, Dr M Walker, A/Prof R Walsh, Dr B Westmore, Dr P C Wijeratne, Dr J M Wright, Dr M Wroth, Dr G Yeo, Dr I Zetler.

Executive Officer

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

Senior Officers of the HPCA

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 RACOG, MHA, FRACMA
Medical Director
Health Professional Councils Authority

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

Table 2: Medical Council of NSW Committees 2011/12

CONDUCT	HEALTH	PERFORMANCE	EXECUTIVE	CORPORATE GOVERNANCE [3]
Chair **G Kesby**	**Chair** **C-S Yong[1]**	**Chair** **R McMahon[2]**	**Chair** **P Procopis**	**Chair** **B Bennett**
B Bennett	S Adelstein	B Bennett	B Bennett	R Kusuma
A Carpentieri	M Christodoulou	A Carpentieri	G Kesby	P Procopis
A Eyers	S Ieraci	A Eyers	R McMahon[2]	C-S Yong
R McMahon	R Kusuma	G Kesby	D Smith	
R Napier	L Poulos	F J Palmer	G Stewart[2]	
P Procopis	P Procopis	P Procopis	K Wilhelm[1]	
D Smith	A Spigelman	G Stewart[2]	Dr C-S Yong[1]	
K Sundquist	K Wilhelm[1]	K Sundquist		
		C-S Yong		
R Walsh		F Black		
		E Tompsett		
		R Walsh		

[1] Dr C-S Yong replaced Professor K Wilhelm as Chair of the Health Committee and member of the Executive Committee after Professor Wilhelm resigned from these positions on 20 December 2011
[2] A/Professor R McMahon replaced Dr G Stewart as Chair of the Performance Committee and member of the Executive Committee after Dr Stewart resigned from the Medical Council on 24 January 2012
[3] Formerly the Corporate Governance and Audit Committee

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 or 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 (appointed to 9 May 2014)

Deputy Chairpersons:

- His Honour Judge R H Solomon – appointed to 26 September 2012
- Her Honour Judge H G Murrell SC – appointed to 6 December 2012
- Her Honour Judge A S Balla – appointed to 24 June 2015
- His Honour Judge P Johnstone – appointed to 24 June 2015
- The Honourable Justice A F Backman – appointed to 23 September 2015
- The Honourable Justice C G Staff – appointed to 23 September 2015
- His Honour Judge A M Colefax SC – appointed to 21 September 2017
- His Honour Judge M A Elkaim SC – appointed to 21 September 2017
- His Honour Judge S L Walmsley SC – appointed to 1 October 2017
- His Honour Judge A F Garling – appointed to 21 September 2017 (retired 30 June 2012)
- The Honourable Justice T M Kavanagh – appointed to 1 March 2018 (retired 30 June 2012)
- The Honourable Justice F Marks – appointed to 1 March 2018 (retired 30 June 2012)

Health Professional Councils Authority

The Health Professional Councils Authority (HPCA) is an administrative unit of the Health Administration Corporation (HAC) which provides shared secretariat and corporate services to the NSW health professional councils to support their regulatory responsibilities.

The HPCA currently supports 10 Councils:

- Chiropractic Council of New South Wales
- Dental Council of New South Wales
- Medical Council of New South Wales
- Nursing and Midwifery Council of New South Wales
- Optometry Council of New South Wales
- Osteopathy Council of New South Wales
- Pharmacy Council of New South Wales
- Physiotherapy Council of New South Wales
- Podiatry Council of New South Wales
- Psychology Council of New South Wales

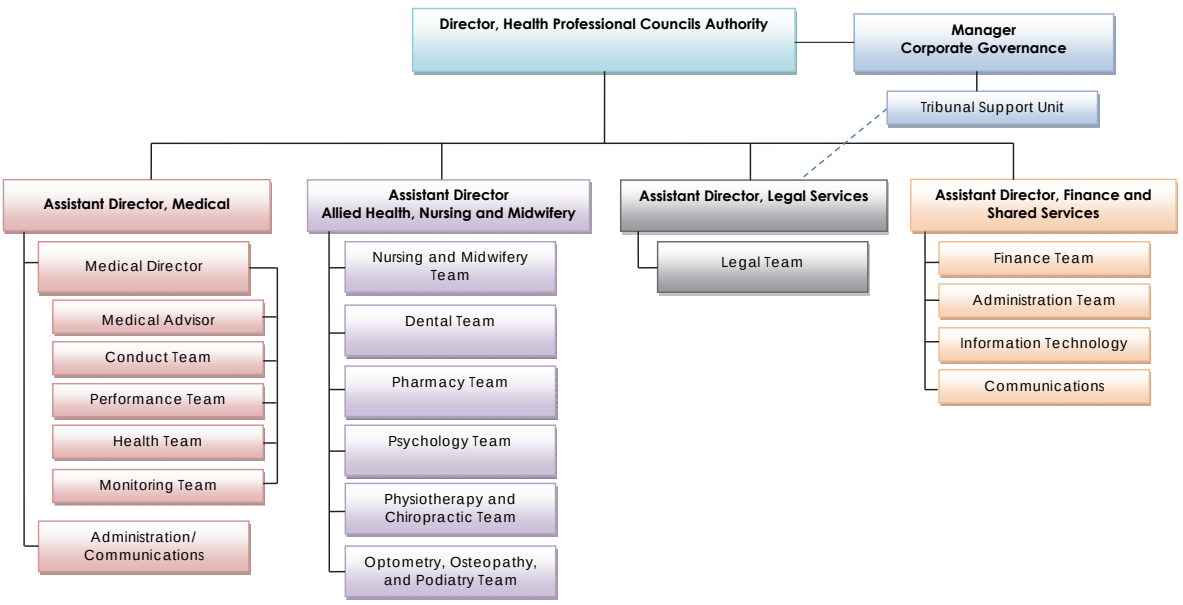
Each Council's Executive Officer and support staff provide secretariat services to enable the Councils to fulfil their statutory responsibilities in regulating NSW health practitioners. In addition, the HPCA coordinates shared administrative, financial, legal and policy services across all of the Councils to assist them in meeting their legislative and policy requirements as statutory bodies.

On behalf of the Councils, the HPCA liaises with the Australian Health Practitioner Regulation Agency (AHPRA) regarding financial, registration and reporting matters; with the Health Care Complaints Commission (HCCC) in relation to the assessment and management of complaints; and with the Ministry of Health on human resource matters and to provide 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.

A service level agreement (SLA) between the Councils and the HPCA has been developed for implementation from 1 July 2012, which articulates the services the HPCA provides and identifies key performance indicators against which to assess performance. The SLA provides certainty and a shared understanding for the Councils and the HPCA on the type and quality of services provided.

Chart 1: Health Professional Councils Authority organisation chart (June 2012)



> management & **activities**

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

> national registration

Health practitioners, including medical practitioners, are registered 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.

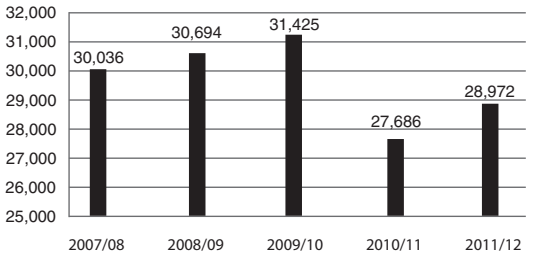
NSW did not adopt the regulatory part of the National Scheme which involves the management of complaints and notifications about health practitioners. Instead, the co-regulatory environment that existed in NSW prior to the commencement of the National Scheme was maintained. As a result, the NSW health 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 2012, there were 28,972 practitioners whose principal place of practice was in NSW. This represents approximately 32% of the total number of 91,648 medical practitioners registered under the National Scheme across Australia. There are 5,800 students registered to undertake approved programs of study in NSW. This represents approximately 31% of the total number of 18,712 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 2007/08 to 2011/12. 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**

2011-2012 in summary

- → 1,533 complaints were received by the Medical Council and the HCCC in 2011/12.
- → Of the 1,508 assessed complaints, 978 (65%) were declined, 94 (6%) were referred for investigation by the HCCC, and 265 (18%) were referred to the Medical Council.
- → More than half (64%) of investigated complaints (67 matters) were referred to the Director of Proceedings (DP) following conclusion of the investigation, to determine whether a complaint should be prosecuted before a disciplinary body.
- → The Medical Tribunal made determinations on complaint matters against 22 practitioners which resulted in three practitioners having their registration cancelled or being disqualified from being registered because they were not registered at the time of the hearing. Two practitioners were suspended. The remaining 17 practitioners were subject to orders made by the Tribunal, including the imposition of conditions, the issuing of a reprimand or a caution, or a combination of these orders. In addition, the Medical Tribunal heard two appeals and two review applications.
- → 17 Professional Standards Committee (PSC) decisions were handed down. Fourteen practitioners had unsatisfactory professional conduct findings made against them and consequential orders were made. Two matters were terminated because they appeared serious enough to warrant referral to the Medical Tribunal. One matter resulted in no orders being made as the conduct did not amount to unsatisfactory professional conduct.
- → 46 proceedings were held where the Medical Council considered if it should take urgent interim action to protect the public (section 150 proceedings). As a result, 11 practitioners were suspended, an additional nine practitioners surrendered their registration either prior to the proceedings being held or before the proceedings were finalised. An additional seven proceedings were held to review urgent interim action that had been previously taken by the Medical Council. One of these resulted in conditions being lifted, one matter resulted in conditions being altered and the suspensions were either affirmed or were lifted and replaced with conditions in the other cases.

The complaints handling process

Assessment of complaints overview

The Medical Council of NSW (Medical Council) and the Health Care Complaints Commission (HCCC) accept written complaints from any source about medical practitioners. Notifications received by the Australian Health Practitioner Regulation Agency (AHPRA) about medical practitioners, where the conduct occurred in NSW, are forwarded to the Medical Council and the HCCC for assessment and management. Information about complaints received is exchanged between the Medical Council and the HCCC as soon as practicable. This allows the Medical Council to review each complaint received and ensures that complaints which appear to warrant urgent interim action to protect the public can be dealt with by the Medical Council promptly under section 150 of the *Health Practitioner Regulation National Law (NSW).*

Legislation requires the HCCC to consult with the Medical Council on the assessment of each complaint. This consultation occurs weekly. The HCCC is required to process the complaint from receipt to assessment within 60 days.

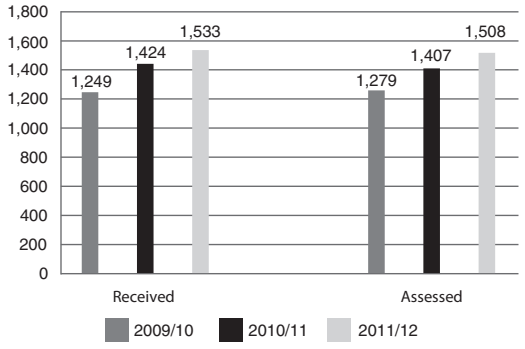
(See appendix 13 for a detailed summary of complaints bodies and processes.)

Complaints received

In 2011/12, the Medical Council and the HCCC received 1,533 complaints (up from 1,424 in the previous year – a 7% increase).

The number of complaints received and assessed over recent years continues to increase. Chart 3 illustrates complaints received and assessed over the past three reporting years.

Chart 3: Complaints received and assessed from 2009/10 to 2011/12



Complaint assessment outcomes

In 2011/12, the Medical Council and the HCCC assessed 1,508 complaints (up from 1,407 in the previous year). Section 12 of the *Health Care Complaints Act 1993* requires the HCCC to consult with the Medical Council prior to determining the assessment outcome of a complaint. **Table 3** illustrates the trends in complaint assessments over the past three reporting years.

At assessment, a complaint may be declined 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 clinical issues of sufficient seriousness. In some instances, a complaint is declined at assessment as the parties have resolved the matter after the complaint was lodged.

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 such as referring complaints to the Medical Council for consideration through the Performance or Health Programs, or to conciliation or assisted resolution with a complaints resolution officer at the HCCC.

Table 3: Outcomes of complaint assessments (%) 2009/10 to 2011/12

	2009/10 n = 1,279	2010/11 n = 1,407	2011/12 n = 1,508
Investigation	9	6	6
Refer to the Medical Council	17	16	18
Refer to another person or body	1	1	2
Resolution*	17	10	9
Decline to deal with	56	67	65

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

There has been no significant change in complaint assessment outcomes in this reporting year as compared to the previous reporting years. The number of complaints referred to another person or body has increased in this reporting year from the previous reporting years (38 matters, as compared to 14 and 13 in previous years). This is due to a number of matters being referred to AHPRA as the issue identified in the complaint concerns conduct which is no longer within the Medical Council's or HCCC's jurisdiction (such as complaints about advertising or the use of protected titles).

Type of complaints assessed – all complaints

Table 4 shows the types of complaints assessed over the past three reporting periods.

Table 4: Type of complaint (%) 2009/10 to 2011/12

	2009/10 n = 1,279	2010/11 n = 1,407	2011/12 n = 1,508
Clinical competence	57	55	57
Communication	15	15	10
Conduct	23	23	27
Practice administration	5	7	6

During this reporting year, complaints concerning clinical competence continued to dominate as the main issue raised in the complaint. Complaints concerning communication have decreased by 5% and complaints concerning conduct have increased by 4% from the previous reporting year.

Mandatory notifications assessed

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 any mandatory notification to the Medical Council and the HCCC. In 2011/12, the Medical Council received 72 mandatory notifications (up from 47 in the previous reporting year). **Table 5** illustrates the trend in mandatory notifications lodged over the past three reporting years.

Table 5: Number of mandatory notifications received 2009/10 to 2011/12

	2009/10	2010/11	2011/12
Number of mandatory notifications received	13	47	72

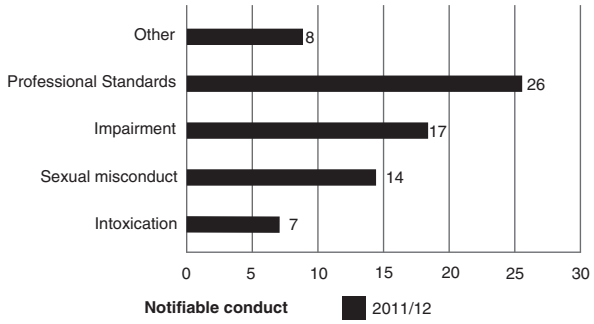
Reasons for the increase in mandatory notifications since 1 July 2010 are due to the different definitions of what constitutes notifiable conduct under the mandatory reporting requirements that existed prior to 1 July 2010 as compared to the current definition. An additional reason is that prior to 1 July 2010, only medical practitioners were subject to mandatory reporting requirements under the now repealed *Medical Practice Act 1992*, whereas the current obligations extend to all health practitioners, employers and education providers.

Notifiable conduct is defined in section 140 of the *Health Practitioner Regulation National Law (NSW)*. The 72 notifications received by the Medical Council have been categorised into the five grounds for notifiable conduct which are illustrated in **Chart 4**. The categories represent circumstances where the notifier 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
5. other - the notifier believed he or she were reporting a mandatory notification, but the issues raised in the mandatory notification did not fall within one of the grounds of notifiable conduct set out in section 140 of the *Health Practitioner Regulation National Law*. These notifications are assessed as complaints.

Chart 4: Mandatory notifications received 2011/12



Sixty-seven mandatory notifications were assessed by the Medical Council and the HCCC during this reporting period (a number of the 72 mandatory notifications received were from different notifiers but related to the same medical practitioner). **Table 6** illustrates the assessment outcomes of these mandatory notifications. A comparison with Table 3 demonstrates that a higher proportion of mandatory notifications are referred for investigation and a significantly higher proportion are referred to the Medical Council to consider taking health, performance or conduct action as compared to complaints. Conversely, a much lower proportion of mandatory notifications are assessed as decline to deal with (that is, not requiring any action) as compared to complaints.

Table 6: Outcome of mandatory notifications assessed 2011/12

	2011/12 n = 67
Investigation	9 (13%)
Refer to the Medical Council	38 (57%)
Refer to another person/body	3 (4%)
Resolution	0
Decline to deal with	17 (25%)

Of the mandatory notifications referred to the Medical Council, more than half (53%) were referred to the Health Program.

Notifying AHPRA

The Medical Council notifies AHPRA of all complaints received and when complaints are finalised.

Complaints investigated by the HCCC

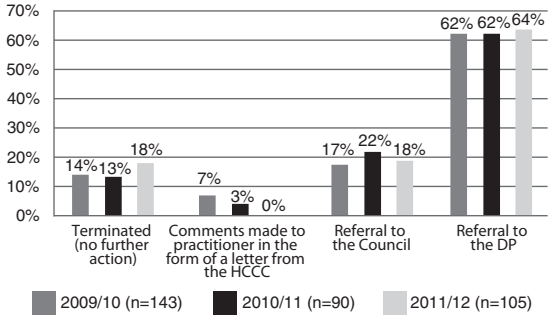
Complaints are referred for investigation when, at the time of assessment, the information before the Medical Council or the HCCC appears to raise significant issues of public health or safety, or if substantiated, would provide grounds for disciplinary action against the medical practitioner or involves gross negligence on the part of the medical practitioner. In 2011/12, 94 complaints were referred to the HCCC for investigation (up 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, 105 investigations were finalised (up from 90 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 and include: referral of a matter to the Medical Council or to the HCCC Director of Proceedings, 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 the investigation outcomes.

Chart 5: Investigation outcomes 2009/10 to 2011/12 by outcome category



Matters referred to the Medical Council at conclusion of HCCC investigation

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

Table 7 illustrates that of the 19 investigated matters referred to the Medical Council in 2011/12:

- 15 investigations resulted in 13 practitioners being referred to disciplinary counselling
- one investigation resulted in the practitioner being referred to the Performance Program, and
- three investigations resulted in the Medical Council taking no further action as the medical practitioners had surrendered their registration.

Table 7: Outcomes of HCCC investigated matters referred to the Medical Council 2011/12

	Number of investigations n = 19	Number of practitioners n = 17
Counselling	15	13
Performance Program	1	1
No further action	3	3

Matters referred to the Director of Proceedings on conclusion of HCCC investigation

Upon referral of an investigation to the HCCC 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, however 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 2011/12, the DP made the following determinations, as set out in **Table 8**.

Table 8: DP determinations 2011/12

	Number of investigations n = 67	Number of practitioners n = 44
Not to prosecute a complaint	18 (27%)	10 (23%)
Referred a complaint to a Professional Standards Committee	19 (28%)	13 (30%)
Referred a complaint to a Medical Tribunal	30 (45%)	21 (47%)

In the reporting period, the DP determined not to prosecute a complaint before a disciplinary body for the following reasons:

- the medical practitioner had surrendered his or her registration (11 investigations/six practitioners)
- the medical practitioner was not registered as his or her registration had already been cancelled by the Medical Tribunal (two investigations/ two practitioners), and
- there was insufficient evidence to prosecute the matter (five investigations/ two practitioners). (These matters were subsequently referred to the Medical Council by the HCCC. The Medical Council resolved to counsel both practitioners.)

Notifying AHPRA

The Medical Council liaises 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 2012, the HCCC reported that 59 practitioners were currently under investigation (down from 92 practitioners in the previous reporting year).

Open matters with the DP

At the conclusion of the reporting year, 62 matters involving 28 practitioners were with the DP awaiting consideration of possible disciplinary action (up from 52 matters in the previous reporting year).

Referral to a counselling interview

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 for counselling in the following circumstances:

- at the completion of an investigation by the HCCC
- following a determination by the DP not to prosecute a complaint, and
- following a referral to the Medical Council at 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 either not significant enough as to warrant referral to the DP or prosecution before a disciplinary body, but still significant enough to raises 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 in the reporting year.

Table 9: Medical practitioners referred and counselled/interviewed in 2011/12

	Practitioners referred n = 27	**Practitioners counselled/ interviewed** n = 19
Counselling	22	15
Interview	5	4

Disciplinary hearings

Overview

Section 150 proceedings

In the 2011/12 reporting year, the Medical Council exercised its urgent interim powers (to suspend or to impose conditions on a medical practitioner's registration) under section 150 of the *Health Practitioner Regulation National Law (NSW)* on 46 occasions. This was fewer than the 55 occasions in 2010/11 and 47 occasions in 2009/10. The numbers of such hearings has remained at a significantly high level since the 2009/10 reporting year. 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.

In this reporting year, nine practitioners elected to surrender their registration prior to section 150 proceedings being held or before the proceedings were completed. In the previous reporting year, only two practitioners surrendered their registration prior to section 150 proceedings being held or before the proceedings were completed.

In this reporting year, no practitioner transferred to the non-practising category of registration when section 150 proceedings were contemplated. Since the commencement of the National Registration and Accreditation Scheme, fewer practitioners elect to transfer their registration to the non-practising category prior to section 150 proceedings being held or before the proceedings are completed. This is because transfer from the general category of registration to the non-practising category now requires the Medical Board of Australia to consider the application and determine whether the practitioner is eligible to be granted non-practising registration. Transfer to the non-practising category is no longer a feasible option available to practitioners who are facing urgent interim action proceedings. In contrast, a medical practitioner can elect to surrender his/her registration. The Medical Board of Australia must give immediate effect to such a request. This course of action is more likely to result in the urgent interim action proceedings no longer being necessary.

Professional Standards Committee hearings

The number of Professional Standards Committee (PSC) hearings finalised has not varied significantly during the last three reporting years, with 17 matters being finalised during this reporting period, compared to 14 in 2010/11 and 16 in 2009/10.

Medical Tribunal

The number of complaint matters finalised in the Medical Tribunal increased slightly this year (22 this reporting period compared with 18 in 2010/11 and 20 in 2009/10). The number of matters finalised in relation to appeals to the Tribunal and applications for review to the Tribunal have decreased to four in this reporting period as compared to six 2010/11 and 11 in 2009/10. There has been no significant change in the number of matters withdrawn or terminated over the past three years. **Table 10** illustrates the concluded Tribunal matters over the past three reporting years.

Table 10: Concluded Medical Tribunal hearings 2009/10 to 2011/12

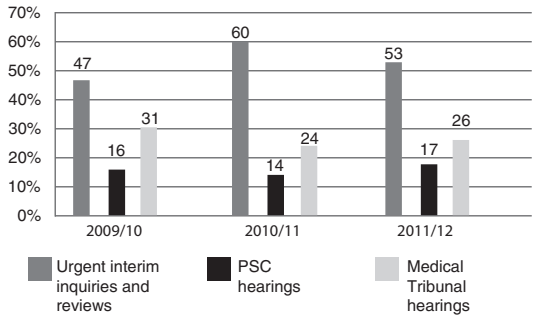
	Complaint matters	**Appeal matters**	**Applications for review and restoration applications**
2009/10	20	7 (and 3 withdrawn)	4 (and 2 withdrawn)
2010/11	18 (and 1 terminated)	1 (and 2 withdrawn)	5 (and 2 withdrawn)
2011/12	22 (and 3 withdrawn)	2	2 (and 2 withdrawn/ terminated)

Three Medical Tribunal complaint matters in this reporting period concerned medical practitioners practising without approved professional indemnity insurance (see decisions at **Table 12** relating to Dr Denise Perroux, Dr Peng Seng Chan and Dr Il-Song Lee which can be found at the Medical Council website at www.mcnsw.org.au. (There were no such cases in the previous two reporting years.) All medical practitioners are required to be insured in accordance with the *Health Care Liability Act 2001 (NSW)* and to practise without professional indemnity insurance constitutes unsatisfactory professional conduct. In relation to these three matters, the Medical Tribunal found two registered medical practitioners and one previously registered medical practitioner guilty of unsatisfactory professional conduct for failing to hold professional indemnity insurance. Two of these registered medical practitioners were reprimanded by the Tribunal. The Tribunal also ordered that their registration be suspended for a specified period of time, after which their registration would be subject to conditions. An appeal by one practitioner against his

suspension was dismissed by the Court of Appeal. The practitioner who was previously registered was also reprimanded and the Tribunal ordered that conditions be imposed, should an application for registration be made in the future. The Tribunal noted that one function of its orders was 'to deter other doctors who might be tempted to practise without professional indemnity insurance'.

Chart 6 provides a comparison of the total number of section 150 inquiries and reviews, PSC hearings, and Medical Tribunal hearings (of complaints, appeals and restoration matters) that have been finalised over the past three reporting years.

Chart 6: Section 150 inquiries and reviews, PSC and Medical Tribunal hearings finalised 2009/10 to 2011/12



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. A practitioner's registration can either be suspended, or conditions imposed on their registration. Any action taken is an interim public protective measure. Following any Medical Council action under section 150, the matter must be referred to the HCCC for investigation. 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).

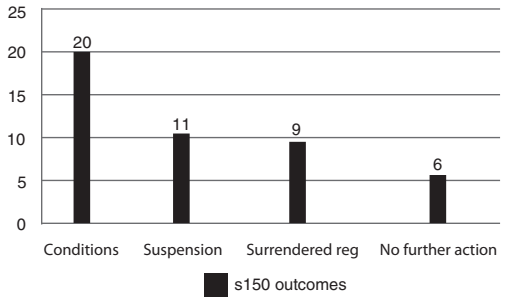
Triggers for convening section 150 proceedings can include:

- 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.

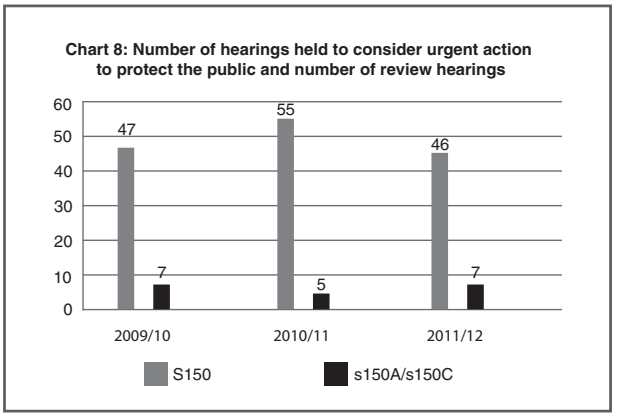
Section 150 proceedings represent a significant proportion of the workload of the Medical Council's professional conduct and legal staff, due to the urgent nature of the proceedings together with the number of times proceedings are held. Section 150 proceedings are usually held within two to four weeks of a matter being identified as raising sufficient concern to warrant proceedings being held.

In the reporting year, the Medical Council conducted 46 section 150 proceedings. As a result of these proceedings, the registration of 11 practitioners was suspended, and 20 practitioners had conditions imposed on their registration (as illustrated in **Chart 7**). On nine occasions, the Medical Council decided to convene section 150 proceedings, however the practitioners surrendered their registration prior to the proceedings being held or before the proceedings 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. Six proceedings resulted in no urgent action being taken by the Medical Council, however in three of those matters, recommendations were made.

Chart 7: Outcomes of section 150 proceedings 2011/12



In addition to the section 150 proceedings held during the reporting year, seven section 150A or section 150C review hearings were also conducted. These types of hearings review orders previously imposed by the Medical Council under section 150. (This compares with five review hearings in 2010/11 and seven review hearings during the 2009/10 year.) One review resulted in all interim conditions being lifted. Two reviews resulted in previous suspensions being affirmed. Three review hearings resulted in suspensions being lifted and conditions being imposed instead, and one review resulted in a change to the previous conditions. (Two of these reviews concerned the same practitioner, whose suspension was affirmed on the first occasion and lifted with conditions being imposed on the second.). **Chart 8** shows a comparison of the numbers of urgent hearings and review hearings held over the past three years.



(Note: equivalent hearings were held under sections 66 and 66 AB of the repealed Medical Practice Act 1992 and are included in the total numbers of hearings for 2009/10 and 2010/11.)

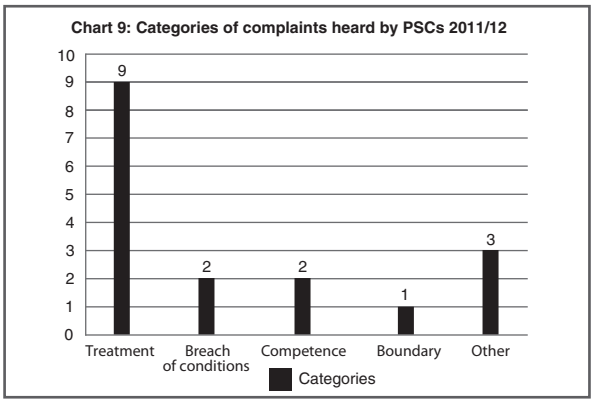
Professional Standards Committees

A Professional Standards Committee 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.

In the 2011/12 reporting year, 17 Professional Standards Committee (PSC) inquiries were finalised in relation to complaints prosecuted by the HCCC. The Medical Council assists the hearing process by appointing PSC members, providing a legal officer and administrative support staff to assist the PSC, and monitoring compliance with any orders and conditions that are made by a PSC.

PSC inquiries are open to the public and are held at the premises of the Institute of Arbitrators and Mediators Australia at Level 9, 52 Phillip Street, Sydney. 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.

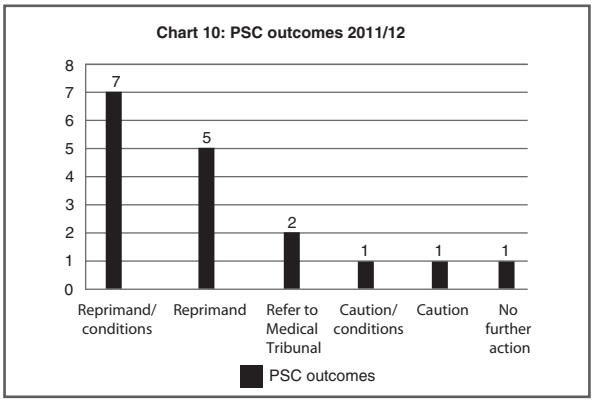
The categories of complaints which were considered by PSCs during the 2011/12 year varied, with clinical treatment being the most prevalent. **Chart 9** illustrates the categories of complaints heard by PSCs during this reporting period.



In the reporting year, PSCs found the practitioner guilty of unsatisfactory professional conduct in 14 of the 17 inquiries that were finalised.

In one PSC, where the practitioner was not guilty of unsatisfactory professional conduct, the Committee found the factual matters proven, but that the conduct did not amount to unsatisfactory professional conduct. Two PSC inquiries were terminated when the Committee reached the view that the complaint, if substantiated, may provide grounds for the suspension or cancellation of the medical practitioner's registration. Under these circumstances, a PSC inquiry must be terminated and the complaint referred to the Medical Tribunal.

Chart 10 illustrates the various orders made by PSCs in the reporting year following a finding that the complaint was found proven.



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 11: PSC decisions 2011/12

Decision date	Practitioner	Outcome
5/07/2011	Hassan Salloum	Reprimand and conditions
19/07/2011	Vasil Tulevski	Caution
25/08/2011	Dr T	No orders made
14/09/2011	Peter Slezak	Reprimand
29/09/2011	Nadi Hanna	Reprimand
5/10/2011	Tat Tiong	Referred to Medical Tribunal
31/10/2011	Michael Quach	Reprimand and conditions
11/11/2011	Ashraf Selim	Reprimand and conditions
22/11/2011	MD Jaodad Hasan	Reprimand and conditions
23/12/2011	David Ellis	Reprimand and conditions
13/02/2012	Terrence Hillier	Reprimand and conditions
1/03/2012	Yolande Lucire	Reprimand
20/03/2012	Peter Slezak	Caution and conditions
5/04/2012	Robyn Pogmore	Referred to Medical Tribunal
23/04/2012	Anthony Jebb	Reprimand
30/04/2012	Richard Townsend	Reprimand and conditions
20/06/2012	Joachim Fluhrer	Reprimand

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 or 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 monitors 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.

Medical Tribunal complaints

Twenty-five complaints were referred to the Medical Tribunal in the reporting year. Twenty-two complaints were referred by the Director of Proceedings (DP) of the HCCC (relating to 30 investigations concerning 21 practitioners), two complaints were referred by Professional Standards Committees, and the Court of Appeal remitted one complaint to the Tribunal to make orders in relation to the Tribunal's original findings (where this decision was delivered in the previous 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.

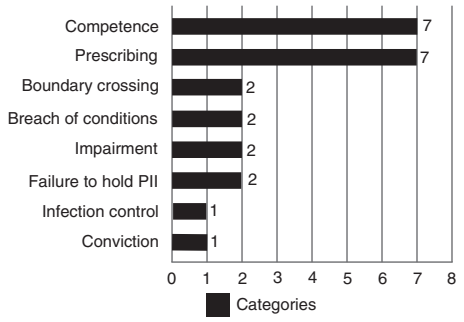
The Medical Tribunal finalised 22 hearings in relation to 24 complaints during the reporting year. Two practitioners were the subject of two complaints and the two complaints were heard concurrently. Three complaints were withdrawn as the three practitioners had surrendered their registration in the period between referral of the complaint to the Tribunal and the anticipated hearing date.

There are 30 complaint matters that have been referred to the Medical Tribunal that are yet to be determined. Twenty-eight complaints are either part-heard or yet to commence. Of these, the Tribunal made findings in relation to the complaint in two matters but a decision concerning protective orders was pending. An additional two hearings in relation to complaints were heard, but the decisions were not delivered in the reporting year.

Nature of complaint matters determined by the Medical Tribunal

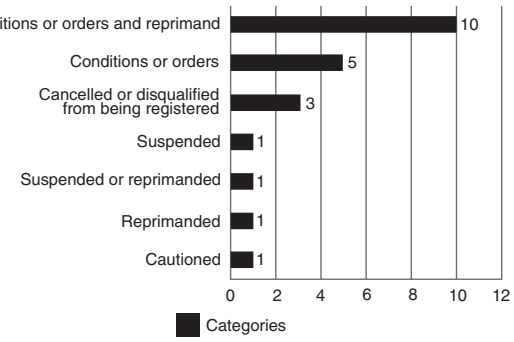
Competency of medical practitioners and the appropriateness of prescribing were the main issues identified in the complaints finalised by the Medical Tribunal in the reporting year. **Chart 11** illustrates the nature of complaint matters determined by the Tribunal.

Chart 11: Issues raised in the complaints determined by the Medical Tribunal 2011/12



In the reporting year, the Medical Tribunal found 22 practitioners guilty of unsatisfactory professional conduct and/or the more serious professional misconduct, with findings in relation to the complaints proven either in full or in part. Orders were made in respect of each of the 22 subject practitioners with the details illustrated in **Chart 12**.

Chart 12: Medical Tribunal determinations (complaint matters) 2011/12



Three practitioners had their registration cancelled by the Tribunal or were disqualified from re-registering for a specified period. Two practitioners were suspended (one of whom was also reprimanded). One practitioner was reprimanded, and one practitioner received a caution. The remaining 15 practitioners had conditions imposed on their registration, or orders made, with 10 of these practitioners being issued with a reprimand in addition to the imposition of conditions or orders.

Medical Tribunal decisions listed in the following table are published in full on the Medical Council's website at www.mcnsw.org.au (subject to any relevant non-publication directions).

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 by the Tribunal.

Table 12: Medical Tribunal decisions in relation to complaints 2011/12

Judgment Date	Practitioner	Tribunal decision
26/07/2011	John Frederick McKenzie	Registration cancelled. May not apply for review for 3 years
30/05/2011	Richard Francis Gorman (2 complaints)	Registration cancelled. May not apply for review for 3 years
23/06/2011	Malay Kanti Halder	Caution
3/08/2011	Angelo Joseph Mazzaferro	Conditions
5/09/2011	Peng Seng Chan	Registration suspended for 3 months then Conditions
9/08/2011	John Richard Bathurst Edwards	Reprimanded and conditions
19/09/2011	Andrew Philip Pembroke	Conditions
18/07/2011	Il-Song Lee	Registration suspended for 10 weeks, reprimanded and conditions
4/10/2011	Daniel Hameiri	Reprimanded, fined and order made for an audit
15/08/2011	Denise Perroux	Reprimanded and conditions
10/10/2011	Michael William Zacharia	Reprimanded, fined and conditions
1/02/2012	Michael Tsouroutis	Reprimanded
13/02/2012	Tat Kong Joseph Tiong	Reprimanded and conditions
16/04/2012	Neil John Schultz	Disqualified from being registered. May not apply for review for 18 months
20/02/2012	Katherine Eva Nemeth	Conditions
6/03/2012	Roland Alexander Kocmut Von Marburg	Conditions
15/05/2012	Margaret Siu-Ying Tung	Reprimanded and conditions
22/06/2012	Dr A (name suppressed until 14/4/2015)	Conditions
22/06/2012	Anne Christine Amigo	Reprimanded and conditions
28/6/2012	Leonard Niranjan Philipiah	Reprimanded and suspended with conditions imposed when the suspension ends
28/06/2012	Carolyn Giselle Cooke (2 complaints)	Reprimanded and conditions
28/06/2012	A Esin Dalat Ozme	Reprimanded and orders

Medical Tribunal appeals

Two appeals were referred to the Medical Tribunal in the reporting year. One appeal from the previous year was outstanding at the beginning of the reporting year.

Two appeals were finalised by the Tribunal in the reporting year. The first appeal was against conditions imposed by an Impaired Registrants Panel (IRP), and the second appeal against conditions imposed by the Medical Council under section 150 of the *Health Practitioner Regulation National Law (NSW).* Both appellants were unsuccessful in their appeals, although the appeal against the IRP conditions did result in some alteration to the original conditions. The Medical Council appeared as the respondent in both of these appeals. One appeal matter is yet to be finalised.

Table 13: Medical Tribunal appeal decisions 2011/12

Judgment date	Practitioner	Tribunal decision
12/03/2012	Impaired registrant	Conditions altered
30/03/2012	Paramalingam Lingathas	Appeal dismissed

Medical Tribunal applications for review

Eight applications for review were referred to the Medical Tribunal in the reporting year. One application for review was outstanding from the previous reporting year.

Two applications for review were finalised by the Tribunal in the reporting year. The first review concerned a practitioner who sought a review of conditions previously imposed by a Professional Standards Committee. The second review was an application for review of a previous order made by the Medical Tribunal to cancel registration (also known as a 'restoration application'). Two applications were withdrawn or terminated. There were five matters concerning applications for restoration which were yet to be finalised at the end of the reporting year.

In one of the finalised matters, the practitioner's conditions were altered in accordance with an agreement between the parties that was approved by the Tribunal. In the other matter, the Tribunal made a re-instatement order that included the imposition of conditions on the practitioner's registration. The Medical Council appeared as the respondent in both applications.

Table 14: Medical Tribunal application for review decisions 2011/12

Judgment date	Practitioner	Tribunal decision
30/03/2012	Paramalingam Lingathas	Conditions altered
03/05/2012	Bruce Desmond Litchfield	Restored with conditions

> health

2011-2012 **in summary**

- → 99 notifications were made to the Health Program in the reporting year, compared with 71 and 57 notifications in the previous two reporting years.
- → 31% of notifications were made by colleagues, 19% were self-notified, 10% were referred from AHPRA and 20% were made by treating practitioners or as a result of a hospital admission. Twenty per cent of notifications came from other sources.
- → 64 Impaired Registrants Panels were conducted and considered issues related to psychiatric illness (58%), drug addiction (20%), alcohol addiction (16%) and cognitive problems (6%).
- → There were 122 participants in the Health Program and 20 practitioners exited the Program in the reporting year.

Overview

The primary purpose of the Health Program of the Medical Council is to protect the public while maintaining impaired practitioners in practice, but only if it is safe to do so. A guiding principle under which the Health Program operates is that restrictions are only placed on a medical practitioner's practice if they are necessary to ensure that health services are provided safely and are of appropriate quality.

The Health Program was first established in 1993 under the provisions of the (now repealed) *Medical Practice Act 1992* and continues to operate under the *Health Practitioner Regulation National Law (NSW)* that was enacted in 2010. The Medical Council's Health Program is the longest established health program in Australia.

Since its inception, more than 270 practitioners have successfully exited the Health Program, having fulfilled the Medical Council's monitoring requirements. Almost 90% of Health Program participants remain in practice as conditions are imposed and then monitored and complied with, which ensures the public is protected. If impaired practitioners were unable to continue to practise, then many years of training and expertise would be lost to the community.

The impairment provisions within the *Health Practitioner Regulation National Law (NSW)* also apply to medical students. The primary objective of the Health Program as it applies to medical students is public protection by ensuring students undertake training safely and within appropriate limitations. A secondary objective is to ensure that the student's transition into the medical workforce is assisted and supported. Early notification is seen as essential in supporting the impaired student, including planning his or her transition to internship.

As confidence in the Health Program has grown over the years, so has the profession's willingness to come forward with information about impaired practitioners. The Medical Council becomes aware of impaired practitioners through notifications and self-notifications as well as through its dealings with practitioners in its Performance and Professional Conduct programs.

Since 2008, NSW has been subject to a mandatory reporting requirement in relation to practitioners who are reasonably believed to have been practising while intoxicated through consumption of drugs or alcohol and this obligation has been reinforced through the *Health Practitioner Regulation National Law (NSW)*. An additional requirement introduced through the *Health Practitioner Regulation National Law (NSW)* is to report a practitioner who places the public at risk of substantial harm in the practitioner's practice of the profession because the practitioner has an impairment. All medical practitioners should be aware of their statutory obligations in this regard. In all other circumstances, although there is no legal obligation for practitioners to notify the Medical Council about practitioners with health problems, there is a profound professional and ethical obligation to do so.

Health Program process

When a notification indicates that a practitioner may be impaired, according to its statutory definition, the practitioner will be assessed by a Council-appointed practitioner, often a psychiatrist, who will prepare a report for the Medical Council. The process of assessment by a practitioner completely independent of the subject practitioner's treating relationships is a key feature of the Medical Council's Health Program and maintains the confidentiality of treating relationships. The Health Committee will then review the report from the Medical Council-appointed practitioner and decide whether to convene an Impaired Registrants Panel (IRP).

In the Medical Council's experience, most impaired practitioners can continue to practise, subject to appropriate limitations. As a consequence, the most common outcome of an IRP is that conditions are placed on the practitioner's registration. IRPs are non-disciplinary and are designed to encourage impaired practitioners to seek treatment for their impairment and safely remain in practice.

Under the provisions of the *Health Practitioner Regulation National Law (NSW)*, the Australian Health Practitioner Regulation Agency (AHPRA) is required to notify a practitioner's employer of the conditions imposed on the practitioner's registration.

The conditions that are placed on a practitioner's registration are tailored to address the practitioner's particular circumstances and type of impairment. Practitioners with a drug addiction are generally required to attend an appropriate specialist (usually a psychiatrist) for treatment, undertake urine drug testing according to the Medical Council's protocol, attend a Council-appointed practitioner for monitoring, and surrender an authority to prescribe drugs of addiction. Practitioners who have abused alcohol will also need to attend for ongoing treatment and undertake regular blood or urine testing. Practitioners suffering from a psychiatric illness must attend a treating psychiatrist and comply with treatment.

Practitioners are monitored over an extended period of time. Practitioners whose impairment relates to drug addiction or alcohol abuse can expect to be monitored by the Medical Council for a minimum of three years. Practitioners with a psychiatric illness may remain in the Health Program for an extended period, although the intensity of their monitoring is varied according to the stability of their illness.

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.

In recent years, the Health Committee has introduced the Chronic Relapsing Illness Authority (CRIA). A CRIA enables it to exit from the Program practitioners with illnesses, such as bipolar disorder and eating disorders, with confidence that the Medical Council will be informed if the practitioner becomes unwell or is not compliant with treatment. Previously, stable practitioners were often maintained on the Program with conditional registration in case of a relapse of their illness. A CRIA is also used in some cases as an alternative to entry to the Health Program. In these cases, the practitioner is assessed by a Council-appointed practitioner but will not necessarily attend an IRP or enter the Health Program. Presently, there are more than 50 practitioners subject to a CRIA.

A practitioner is asked to complete a CRIA allowing 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.

The practitioner also undertakes to notify the Medical Council of any change in treating practitioners. The Health Committee has found the use of a CRIA to be an extremely valuable tool, and participants welcome the opportunity to return to unconditional registration, or not to enter the Health Program.

Program activity

In the year ending 30 June 2012, there were 99 health notifications received about practitioners, including one medical student notified to the Medical Council as a result of a hospital admission. There were 64 IRPs held during the reporting year and 56 IRP reports endorsed by the Health Committee. Twenty-nine practitioners entered the program during the reporting year.

Table 15: Source of health notifications 2009/10 to 2011/12

Notifications by source	2009/10 n=57	2010/11 n=71	2011/12 n=99
Colleagues (including employers)	10	21	30
Self-notifications	25	16	19
University	1	4	0
Council committee	1	4	4
Treating practitioner/hospital	15	20	20
AHPRA	Not reported	Not reported	10
Other	5	6	16
Total	**57**	**71**	**99**

Of the 64 IRPs held in the reporting year, 69% recommended that the practitioner agree to conditions being placed on his or her registration. Twelve per cent of IRPs resulted in no further action being taken, 11% were adjourned, and in 8%, some other type of action was taken. 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.

During 2011/12, a total of 20 practitioners exited the Health Program following an exit interview. These practitioners had all of their conditions lifted and returned 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. As in previous years, the relapse rate remained below 5%.

Details of the source of health complaints/notifications which were considered by the Health Committee in the reporting year and a comparison over the last two reporting years appear at **Table 15**. There has been an increase in the number of health notifications that have been received from colleagues including employers in the reporting year. This is due to the increased awareness of mandatory reporting obligations while the increase in the last two reporting years is likely to reflect the broadening of the current mandatory reporting obligations to all registered health practitioners and employers. Included in this reporting year are notifications received from AHPRA, when a practitioner discloses an impairment at the time of registering or renewing his or her registration.

Details of the nature of the impairment considered by an IRP in the reporting year and a comparison over the past two reporting years appears at **Table 16**.[1] Psychiatric illness continues to be the largest type of impairment considered by IRPs. There has been an increase in the number of IRPs where the nature of the impairment is either alcohol abuse or drug use. This may be a reflection of the increased awareness of mandatory reporting obligations. It may also be due to an increased awareness of practitioners' obligations to report criminal charges and convictions for driving whilst under the influence of alcohol. The increase in the number of matters relating to cognitive impairment reflects the continued awareness that unsatisfactory professional performance or unsatisfactory professional conduct may be caused by an underlying health problem (also evidenced by the cross-referrals from other Council Committees in **Table 15**).

Table 16: Nature of impairment considered by IRPs 2009/10 to 2011/12

	2009/10	2010/11	2011/12
Psychiatric illness	33	31	37
Alcohol	2	8	13
Drug	8	6	10
Physical	0	0	0
Cognitive	Not reported	1	4
Total	**43**	**46**	**64**

As can be seen from **Table 17**, the overall activity of the Health Program has been consistent with previous years, with an increase in the number of IRPs and Exit Interviews held and a slight decrease in the number of Review Interviews held in the reporting year. The increase in the number of IRPs held reflects the increased number of health notifications received in the reporting year and the increase in the number of IRPs held under section 152K of the *Health Practitioner Regulation National Law (NSW).* These IRPs are held following a request by a practitioner to ease or remove conditions or lift a suspension. The number of Health Program participants has remained steady over the past three reporting years.

Table 17: Health Program activity 2009/10 to 2011/12

Hearings	2009/10	2010/11	2011/12
IRP	43	46	64
Review interviews	263	242	234
Exit interviews	17	16	20
Participants in Program as at 30 June	122	111	122

Case studies

Case study – Notification with outcome of no further action

Dr X is a 35-year-old specialist medical practitioner about whom a notification was received regarding the temporary withdrawal of clinical privileges at the hospital at which he worked. The concerns related to his behaviour, work performance and health, specifically alleged erratic behaviours, psychomotor agitation and lack of insight. The matter was referred to the Medical Council and Dr X underwent a Medical Council-appointed practitioner (CAP) assessment by a psychiatrist. The CAP identified no major psychiatric illness and recommended the notification was likely to be related to a work-place dispute. The matter proceeded to an IRP which found no evidence of impairment and recommended that it was not appropriate for Dr X to enter the Health Program. Dr X suggested that he complete a communication skills course and the IRP were supportive of this. No further action was taken by the Medical Council following consideration of the IRP report.

Case study – Exiting the Health Program

Dr X is a 54-year-old medical practitioner who made a self-notification to the then Medical Board regarding his alcohol dependence that had culminated in a drink-driving charge. He underwent a Board-nominated practitioner assessment by a psychiatrist, who identified a long history of alcohol dependence. However it was also noted that since the notification, the practitioner had committed to lifelong abstinence and had engaged with a treating team of a general practitioner, psychiatrist and drug and alcohol specialist. The matter proceeded to an IRP, which found that Dr X had an impairment. Conditions were placed on his registration to ensure regular review by his treating practitioners, abstinence monitoring with urine and blood testing, and regular reviews initially by the former Medical Board and then the Medical Council. Dr X remained on the Health Program and his conditions, with which he remained compliant, were eased over time. He attended an Exit Interview approximately two years after the IRP was held, at which he remarked how the Health Program assisted him in achieving his goals of remaining abstinent, improving his fitness and his practice. Dr X exited the Health Program.

Case study – Health Program participant with relapsing illness

Dr X is a 48-year-old female medical practitioner who first came to the attention of the former Medical Board following a notification from her employer regarding performance concerns and depression. 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 and supervised 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 X attended a second IRP, when further notifications were received and her conditions were adjusted. A third IRP was held following a relapse of her depression at which time the Medical Council-appointed practitioner (CAP) assessment identified that she was displaying signs of possible hypomania and poor insight. She was not working at that time and it was identified that she was not

[1] Reported in 2009/10 and 2010/11 as details of the nature of the impairment as endorsed by an IRP; however the type of impairment in an endorsed IRP decision and that considered by an IRP are the same activity.

attending her treating practitioners. At this third IRP, further conditions on her registration were recommended, however she refused to agree to these further conditions. As a result, the Medical Council conducted section 150 proceedings where the recommended conditions were imposed on her registration. These conditions included a requirement that her future employers must be made aware of her practice conditions, that she not return to practice until she had been cleared by her treating practitioners, and that her treating practitioners forward regular reports to the Medical Council to confirm her attendance for treatment. Dr X remains in the Health Program.

Conclusion

The strengths of the Medical Council's long established and accepted Health Program include:

- → its focus on regulation and public protection with treatment provided independently
- → its acceptance by the profession as a consistent program that achieves its public protection goals in a fair and objective way
- → its structured but non-disciplinary approach
- → its cautious, long term monitoring of impaired practitioners, and
- → its flexible integration with all other Medical Council activities, so that every decision about a practitioner is made in full knowledge of their health status.

> performance

2011-2012 **in summary**

- → The HCCC referred 235 complaints to the Medical Council as performance matters and 233 complaints had outcomes in this reporting year.
- → 69 Performance Interviews were conducted, which is approximately three times as many as in the previous reporting year and 62 Performance Interviews had outcomes in this reporting year.
- → 22 Performance Assessments were conducted in the reporting year and three Re-Assessments were conducted in the reporting year.
- → 12 Performance Review Panels were conducted during the reporting year.
- → There were 25 practitioners who entered the Performance Program in 2011/12, with a total of 70 practitioners who either required a Performance Assessment, have been subject to a Performance Assessment or have had conditions imposed by a Performance Review Panel and are being monitored by the Medical Council's Monitoring Program.

Overview

The Medical Council aims to ensure that medical practitioners are fit to practise and its Performance Program is pivotal to this aim. The Performance Program was introduced in NSW in October 2000 (known then as the Performance Assessment Program) and was the first of its kind in Australia. In August 2003, the Performance Committee commenced dealing with complaints about a practitioner's performance, having previously been dealt with by the Conduct Committee with all other complaints.

The Performance Program complements the Medical Council's Health and Professional Conduct programs by providing a means of dealing with medical practitioners who are neither impaired nor have engaged in professional misconduct, but for whom the Medical Council has concerns about the standard of their professional performance and has decided a Performance Assessment is required. Professional performance of a registered medical practitioner is defined as the knowledge, skill or judgment possessed and applied by the practitioner in the practice of medicine. The professional performance of a registered medical practitioner is defined as being unsatisfactory if it is below the standard reasonably expected of a practitioner of an equivalent level of training or experience. The Medical Board of Australia's *Good Medical Practice: A Code of Conduct for Doctors in Australia* sets out relevant expectations for registered medical practitioners.

The 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 Council's Monitoring Program.

Program activity

A practitioner is considered to be a participant in the Performance Program once a decision to hold a PA is made. Twenty-five practitioners entered the Performance Program in the reporting year, with a total of 70 participants within the Program at 30 June 2012.

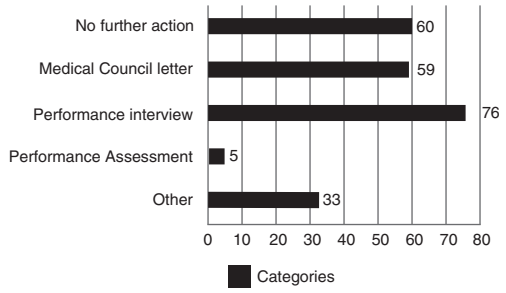
Complaints

Under the co-regulatory model in New South Wales, the Medical Council and the Health Care Complaints Commission (HCCC) are required to consult on the action to be taken in response to complaints received by either body, or referred by the Australian Health Practitioner Regulation Agency (AHPRA). The HCCC referred 235 complaints to the Medical Council as performance matters during the current reporting year (which is a 13% increase from the previous reporting year).

Outcomes of complaints

The Medical Council may consider a range of actions in response to performance matters that come to its attention. In 2011/12, the Medical Council's Performance Committee determined outcomes in relation to 233 performance complaints. The complaint outcomes are summarised in **Chart 13**. The most common outcome following initial consideration of the complaint and the practitioner's response is either no further action, a Medical Council letter or a PINT.

Chart 13: Outcomes of complaints considered by the Performance Committee in 2011/12



* Other outcomes include apology, resolution, and referral elsewhere (section 150 Inquiry, Conduct or Health committee or referral to the HCCC)

Performance Interviews (PINT)

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 in 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 following the PINT. Other outcomes available to the Medical Council following a PINT are referral to a PA, referral to a disciplinary pathway or referral to a Council-appointed Practitioner (CAP) assessment which may include neuropsychometric testing or psychiatrist assessment. This reflects an awareness by the Medical Council that performance issues may be indicative of early or mild cognitive impairment or mental health issues.

PINTs held

During 2011/12 reporting year, 69 PINTs were conducted as a result of 73 complaints. A practitioner may attend a PINT that has been triggered by more than one complaint. The total number of PINTs conducted in this reporting year is approximately three times as many when compared to the 2010/11 reporting year when 25 PINTs were conducted. [1] The increase in the number of PINTs conducted continues to reflect the Performance Committee's view that a PINT is an effective means of obtaining additional information when a complaint raises concerns about a practitioner's professional perormance.

In the 2011/12 reporting year, the Performance Committee made decisions in relation to 62 PINTs. These outcomes are summarised in **Table 18**. 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 (69 in the 2011/12 reporting year) and the number of PINTs with outcomes reported in Table 18 (62 PINTs for 62 medical practitioners in relation to 66 complaints).

Table 18: PINT outcomes 2011/12

		2011/12
No further action	(for 47 complaints)	44 doctors
Referral to medical assessment	(for 4 complaints)	4 doctors
Medical assessment and PA	(for 4 complaints)	3 doctors
PA	(for 9 complaints)	9 doctors
Referral to disciplinary pathway	(for 2 complaints)	2 doctors
Total	**(for 66 complaints)**	**62 practitioners**

Case study – PINT members recommend PA and neuropsychometric testing

Dr X is a 71-year-old medical practitioner. A complaint was received by the HCCC alleging that Dr X was inappropriate, rude and offensive in his communication with a female patient regarding her weight. As a result of this, the patient subsequently experienced an episode of depression with thoughts of self-harm. 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 take an appropriate history or conduct a physical examination of the patient, nor did he elaborate on any emotional issues surrounding the patient's weight. The PINT members also expressed concern regarding his concrete and rigid thinking, and his unprofessional and inappropriate response concerning the complaint and queried whether these matters indicated that the practitioner may have an impairment. The PINT members recommended a PA be undertaken and that Dr X attend for neuropsychometric testing.

Performance Assessment (PA)

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. During 2011/12, two PAs were held at the Medical Council premises because the medical practitioners were primarily working in locum positions, making an on-site assessment impractical. In these cases, the assessment was limited to a general interview regarding the medical practitioner's practice and a detailed scenario-based 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.

PAs referred

In the 2011/12 reporting year, the Performance Committee decided that a PA should be conducted for 25 practitioners. **Table 19** provides a breakdown of the practice areas of the medical practitioners referred to a PA. As expected, general practitioners make up the majority (76%), reflecting their proportionate number in the medical workforce.

[1] The 2010/11 Annual Report reported that 32 Performance Assessments were concluded in that reporting year. The 2010/11 Annual Report did not report on the number of Performance Interviews held in that year, which was 25.

Table 19: Practice area of medical practitioners referred for a PA 2011/12

	2011/12
General practitioner	19
Obstetrician & gynaecologist	1
Physician	3
Psychiatrist	1
Surgeon	1
Total	**25**

PAs conducted

There were 22 PAs and three re-assessments conducted in 2011/12 reporting year.

In the reporting year, the Performance Committee considered 22 PA reports (from PAs conducted in this and the previous reporting year). The outcomes of the PA reports appear below in **Table 20**. In the reporting year, the Performance Committee also considered 11 matters where a decision was previously made to hold a PA and this decision was either:

- rescinded or the PA could not be held
- a complaint was referred to the HCCC and assessed for investigation, or
- the PA was held, but the PA findings warranted urgent immediate action by the Council under section 150 of the Act.

Specifically, the decision to hold a PA was rescinded in relation to three medical practitioners, four medical practitioners retired, surrendered their registration or transferred to the non-practising category of registration before having the PA and four medical practitioners were either referred to the HCCC for investigation or the Medical Council conducted section 150 proceedings.

In relation to the three re-assessments held in the 2011/12 reporting year, the outcome was no further action for one practitioner and a PRP for the other two practitioners.

Table 20: PA outcomes 2011/12

	2011/12
No further action	4
Counselling	0
Consent to conditions or re-assessment under Section 41P	6
Performance Review Panel	12
Total	**22**

Case study – PA finds unsatisfactory professional performance and recommends a PRP

Dr X is a 61-year-old medical practitioner. A complaint was received by the HCCC following an investigation into the care of an elderly nursing home patient, who underwent a below knee amputation as a result of complications arising from a diabetic foot ulcer. The investigation found that Dr X failed to examine the patient's foot and failed to actively manage the ulcer. The matter was referred to the Medical Council and Dr X was required to attend a PINT. The PINT members expressed concerns about Dr X's management of the case and his general clinical practice. The matter was referred to a PA that was conducted at Dr X's consulting rooms and at a nursing home he attended. The assessors considered that while Dr X had good rapport with his patients and a good working relationship with his staff, his professional performance was unsatisfactory in the areas of basic clinical skills, patient management skills and medical records. The matter was referred to a PRP to review Dr X'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 the 2011/12 reporting year, the Performance Committee decided to refer six practitioners to attend neuropsychometric testing by a clinical neuropsychologist due to concerns about cognitive impairment and two practitioners were 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 a practitioner's performance to be unsatisfactory.

Performance Review Panel (PRP)

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 determines the matter should be referred to a PRP. The Panel, which consists of three members, 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 2011/12

	2011/12
No further action	0
Re-Assessment only	3
Conditions and re-assessment	7
Rescinded after hearing 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.

Twenty-two practitioners exited the Performance Program during the 2011/12 reporting year.

Case study – PRP finds professional performance unsatisfactory and conditions imposed

Dr X is a 59-year-old medical practitioner. A complaint was received by the HCCC by the by the son of an elderly female resident of a low-level care hostel. He alleged that Dr X failed to provide adequate medical care for his mother who was later diagnosed with a urinary tract infection requiring intensive care unit admission for septicaemia. Dr X had consulted the resident in the capacity of a locum for her usual general practitioner. The complainant also alleged that Dr X failed to respond to his correspondence identifying concerns with his mother's management. The matter was referred to the Medical Council and the outcome was a PINT. The PINT members expressed concern regarding Dr X's long working hours and multiple practice locations, his clinical judgment and failure to diagnosis a seemingly apparent urinary tract infection at the time of his review, his poor medical records, and his failure to respond to the complainant in a timely and appropriate manner. The matter proceeded to a PA and it was considered that Dr X's professional performance was unsatisfactory in the areas of basic clinical skills, patient management skills, and interaction and communication with patients. A PRP was held at which concern was raised regarding Dr X's overall cursory approach to clinical history taking and examination of patients, lack of patient-centred approach to consultations, and failure to adequately explain management advice to patients. His medical records were acknowledged as deficient. Dr X agreed with the concerns raised by the Panel and outlined the changes he had already made to his practice to amend these deficiencies. It was found that Dr X's professional performance was unsatisfactory and conditions were imposed on his registration including a restriction in his work hours and patient numbers, a requirement to undertake an observership with another general practitioner, followed by being observed by that general practitioner, and undertaking a clinical communication program.

Conclusion

The range of options that are available to the Performance Committee in response to a complaint or notification reflects the spectrum of performance difficulties that present to the Medical Council. The use of the non-disciplinary and remedial Performance Program continues to increase over recent times, reflecting the value of an alternative approach to the disciplinary pathway. Increasingly, the Performance Program is also detecting underlying health issues, such as cognitive impairment, which impact on a practitioner's professional performance.

The strengths of the Performance Program include:

- its acceptance by the profession as a fair and objective process
- its non-disciplinary and remedial focus, and
- its broad-based outcomes that result in lasting improvement in the practitioner's performance.

As the initiator of PAs in Australia and an acknowledged international leader in this field, the Medical Council remains committed to continuing this innovative and effective program and seeks to build upon the Program's strengths and integrity.

> monitoring

2011-2012 **in summary**

- → The compliance of 227 medical practitioners with conditions imposed on their registration was subject to active monitoring by the Medical Council as at 30 June 2012.
- → 76 new cases were referred to the Council's Monitoring Program during this reporting year.
- → 81 cases were closed during the reporting year.

The Medical Council's Monitoring Program is responsible for monitoring a practitioner's compliance with conditions on his/her registration, following a Performance, Conduct or Health outcome.

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

Health conditions, which are not published on the register, are conditions which regulate a medical practitioner's treatment. Usually these will be adjunct conditions relating to activities that occur outside of the practitioner's workplace and include monitoring activities, such as urine drug testing, alcohol testing or hair testing. 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 shared between the Health and Monitoring programs, with the latter responsible for conditions relating to drug and alcohol testing. The Health Program monitors the remainder of health conditions.

Under the provisions of the *Health Practitioner Regulation National Law (NSW)*, AHPRA is required to notify a practitioner's employer of the conditions imposed on the practitioner's registration.

Monitoring process

For each new Monitoring Program case, the responsible program officer makes initial contact with the practitioner to specify and clarify all compliance requirements. An action schedule covering all active conditions is then established and regularly updated. Subsequent monitoring activity depends on the conditions themselves and may include:

- processing of approvals by delegates of the appropriate Committee, for example, to approve employment positions, supervisors, mentors and courses
- the design and provision of reporting templates to reporting practitioners, the assessment of reports as they are received, and referral to the appropriate Committee if concerns are indicated
- arranging of audits, for example of medical records, (13 in this reporting year), and referral of audit reports to the appropriate Committee
- requesting and reviewing data from Medicare Australia or from NSW Health, Pharmaceutical Services to review the practitioner's prescribing or patient consultation restrictions
- reviewing results received from pathology services relating to health conditions including urine drug testing (UDT) and alcohol monitoring (Carbohydrate deficient transferrin [CDT]) for conditions relating to limited alcohol consumption, and Ethyl Glucuronide (EtG) for conditions relating to abstinence, and liaising with practitioners when positive results are received or failure to attend to testing is documented
- monitoring any critical compliance conditions imposed by a Medical Tribunal, whereby a practitioner faces suspension as an immediate consequence of non-compliance with a condition designated as a critical compliance condition (five practitioners in this reporting year)
- preparing submissions for the appropriate Medical Council committee agenda on questions of satisfactory compliance with a condition, variation or removal of a condition, or breach of a condition
- following up on Medical Council committee resolutions, which range from removal of all conditions to the lodging of a complaint with the Health Care Complaints Commission (HCCC)
- liaising with the HCCC in respect of cases where conditions are in effect while a complaint is under investigation and providing periodic updates on the practitioner's compliance history, and
- maintaining ongoing contact with the practitioner and, on occasions, with third parties such as an employer or supervisor, to facilitate and optimise compliance wherever possible.

The level, complexity and duration of monitoring activity will vary considerably over the range of cases administered by the Program. Some cases may require no more than a periodic letter to confirm the practitioner's circumstances. Other cases require more frequent contact and scrutiny. The efficiency and effectiveness of the monitoring function overall is dependent to a considerable degree on the quality and relevance of the conditions themselves. The HCCC which seeks orders before adjucation bodies including the imposition of conditions and hearing members who are responsible for the drafting of conditions are encouraged to discuss any proposed conditions with the Monitoring Program. This is because the chosen wording can have a considerable affect on the practitioner's ability to comply and on the Program's ability to monitor compliance. A Conditions Bank developed by the Program provides a resource for all hearing members and panellists in this regard.

Activity

The activity of the Monitoring Program in the reporting year is summarised in **Table 22**. As at 30 June 2012, there were a total of 227 cases under active monitoring by the Program, a net decrease of five in total as compared to 30 June 2011.

Table 22: Monitoring activity 2011/12

Primary source of conditions	New cases in 2011/12	Closed cases in 2011/12*	Total active cases in 2011/12
Health Program	37	36	98
Performance Program	8	7	20
Conduct Program	31	38	109
Total	**76**	**81**	**227**

*Closed cases refer to practitioners who have satisfactorily complied with conditions, who were suspended, failed to renew their registration, were no longer working in medical practice or moved out of NSW so that monitoring was transferred to another state or territory.

Case study – monitoring conditions following a finding of unsatisfactory professional conduct by a Medical Tribunal

Dr X is a 49-year-old medical practitioner who came to the attention of former Medical Board after a complaint was received alleging he was inappropriately prescribing benzodiazepines to drug-dependent persons. Conditions were imposed on his registration following a Medical Tribunal hearing which found Dr X guilty of unsatisfactory professional conduct. These conditions included a withdrawal of Schedule 4D and Schedule 8 drug prescribing rights for two years, requirements for a mentor, a medical records audit, professional guidance, limited work hours and numbers of patients per day, and continuing professional development.

Dr X was monitored by the Medical Council and his conditions were adjusted over the years. He remained compliant with his conditions and those relating to the professional mentor, medical records audit and professional guidance were removed. The remainder of his conditions were to remain in place with a view to consideration of removal after the specified expiration time was reached. Dr X continues to be monitored by the Monitoring Program.

Conclusion

The Monitoring Program continues to provide strength to the Medical Council's authority in relation to the various outcomes from disciplinary and non-disciplinary bodies and committees by:

- → ensuring compliance by practitioners with conditions on registration and follow-up when difficulties or non-compliance occurs
- → alerting the Medical Council's committees and legal section when non-compliance or breach of conditions has become an issue
- → providing advice to the HCCC, hearing members and legal officers assisting adjudication bodies concerning the wording and ability to objectively monitor proposed conditions, and
- → providing information and advice to assist practitioners in meeting the requirements of conditions imposed on their registration.

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 2012, 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 2012, 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 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.

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.

Peter Boulous CA
Director Financial Audit Services

19 October 2012
SYDNEY

MEDICAL COUNCIL OF NEW SOUTH WALES

STATEMENT BY THE MEMBERS OF THE COUNCIL

FOR THE YEAR ENDED 30 JUNE 2012

Pursuant to section 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 2012 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

19 October 2012

> statement of comprehensive income

FOR THE YEAR ENDED 30 JUNE 2012

	Notes	2012	2011
		$	$
Expenses Excluding Losses			
Operating expenses			
Personnel services	2(a)	(2,803,012)	(3,486,537)
Other operating expenses	2(b)	(3,104,733)	(2,730,300)
Depreciation and amortisation	2(c)	(521,089)	(476,714)
Other expenses	2(d)	(1,588,849)	(1,426,989)
Total Expenses Excluding Losses		(8,017,683)	(8,120,540)
Revenue			
Registration fees		7,159,539	6,449,431
Other revenue		97,449	87,350
Interest revenue	4	92,235	184,922
Total Revenue		7,349,223	6,721,703
Gain/(Loss) on disposal	5	6,210	-
Net Result		(662,250)	(1,398,837)
Other Comprehensive Income		-	-
Total Comprehensive Income		(662,250)	(1,398,837)

The accompanying notes form part of these financial statements.

> statement of financial position

AS AT 30 JUNE 2012

	Notes	2012	2011
		$	$
ASSETS			
Current Assets			
Cash and cash equivalents	6	1,098,069	1,382,161
Receivables	7	141,216	253,529
Total Current Assets		1,239,285	1,635,690
Non-Current Assets			
Plant and equipment	8		
Leasehold improvements		1,748,897	1,851,926
Motor vehicles		20,464	22,668
Furniture and fittings		3,114	5,605
Other		42,128	89,611
Total Plant and equipment		1,814,603	1,969,810
Intangible assets	9	653,918	992,981
Total Non-Current Assets		2,468,521	2,962,791
Total Assets		3,707,806	4,598,481
LIABILITIES			
Current Liabilities			
Payables	10	1,247,883	1,366,600
Fees in advance	11	1,954,196	2,017,646
Total Current Liabilities		3,202,079	3,384,246
Non-Current Liabilities			
Fees in advance	11	-	46,258
Total Non-Current Liabilities		-	46,258
Total Liabilities		3,202,079	3,430,504
Net Assets		505,727	1,167,977
EQUITY			
Accumulated funds		505,727	1,167,977
Total Equity		505,727	1,167,977

The accompanying notes form part of these financial statements.

> statement of changes in equity

FOR THE YEAR ENDED 30 JUNE 2012

	Notes	Accumulated Funds
		$
Balance at 1 July 2011		1,167,977
Changes in accounting policy		-
Correction of errors		-
Restated Total Equity		1,167,977
Net Result for the Year		(662,250)
Other comprehensive income		-
Balance at 30 June 2012		505,727
Balance at 1 July 2010		-
Transfer in of net assets due to restructure	17	3,710,779
Payment to Ministry of Health	17	(1,143,965)
Restated transfer balance as at 1 July 2010		2,566,814
Net Result for the Year		(1,398,837)
Other comprehensive income		-
Balance at 30 June 2011		1,167,977

The accompanying notes form part of these financial statements.

> statement of cash flows

FOR THE YEAR ENDED 30 JUNE 2012

	Notes	2012	2011
		$	$
Cash Flows from Operating Activities			
Payments			
Personnel services		(2,873,199)	(3,640,571)
Other		(4,766,165)	(4,169,992)
Total Payments		(7,639,364)	(7,810,563)
Receipts			
Receipts from registration fees		7,179,742	5,648,474
Interest received		95,142	179,327
Other		100,997	87,350
Total Receipts		7,375,881	5,915,151
Net Cash Flows from Operating Activities	15	(263,483)	(1,895,412)
Cash Flows from Investing Activities			
Proceeds from sale of plant and equipment		24,485	-
Purchases of plant and equipment		(45,094)	(363,389)
Net Cash Flows from Investing Activities		(20,609)	(363,389)
Cash Flows from Financing Activities			
Proceeds from restructure of previously abolished Board	17	-	5,454,000
Australian Health Practitioner Regulation Agency as per Government Gazette No 90	17	-	(669,074)
Payment to NSW Department of Health (owner) as per Government Gazette No 90	17	-	(1,143,965)
Net Cash Flows from Financing Activities		-	3,640,961
Net Increase/(Decrease) in Cash		(284,092)	1,382,161
Opening cash and cash equivalents		1,382,161	-
Closing Cash and Cash Equivalents	6	1,098,069	1,382,161

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 2012 have been authorised for issue by the Council on 19 October 2012.

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)
- the requirements of the *Public Finance and Audit Act 1983* and Regulation and
- the Financial Reporting Directions published in the Financial Reporting Code for NSW General Government Sector Entities or issued by the Treasurer.

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. 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.

d. 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.

e. 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.

Under Section 26A of the Law, the complaints element of the registration fees payable during 2012 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 2012 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.

f. Personnel Services

All employees of the Council reside with the Ministry of Health (MOH). Staff costs are shown in the Statement of Comprehensive Income as personnel services in the financial statements of the Council. Provisions in the Statement of Financial Position represent amounts payable to the MOH in respect of personnel services.

g. Interest Revenue

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

h. Assets

i. Acquisitions 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.

The cost of assets recognised in the financial statements has been calculated based on the benefits expected to be derived by the Council.

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 arm's length transaction.

Where payment for an item is deferred beyond normal credit terms, its costs are 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 $887.

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.

i. 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), annual 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.

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

k. 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.

Comparative amounts, where applicable (in Notes 2b and 2d), are reclassified for the purpose of comparability with the current year figures.

l. New Australian Accounting Standards issued but not yet effective
There are no new Accounting Standards applicable this financial year.

2. EXPENSES EXCLUDING LOSSES

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

	2012	2011
	$	$
	2,409,691	
Salaries and wages (including recreation leave)		2,951,652
Superannuation	230,789	261,754
Payroll taxes	151,640	272,667
Workers compensation insurance	10,892	464
	2,803,012	3,486,537

EXPENSES EXCLUDING LOSSES (continued)

b. Other operating expenses include the following:

	2012	2011
	$	$
Auditor's remuneration	23,000	23,000
Rent and building expenses	92,910	105,910
Council fees	293,699	264,921
Sitting fees	1,302,901	1,407,210
Medical Tribunal fees	660,669	643,612
Contracted labour	731,554	285,647
	3,104,733	2,730,300

c. Depreciation and amortisation expense

	2012	2011
	$	$
Depreciation		
Motor vehicles	7,099	7,619
Furniture and fittings	2,491	2,490
Other	47,483	45,450
	57,073	55,559
Amortisation		
Leasehold improvements	103,029	103,030
Intangible assets	360,987	318,125
	464,016	421,155
Total Depreciation and Amortisation	521,089	476,714

d. Other expenses

	2012	2011
	$	$
Funding contributions	136,994	57,888
Subsistence and transport	56,751	76,826
Fees for service	1,087,228	899,277
Postage and communication	85,723	107,327
Printing and stationery	94,530	87,631
Equipment and furniture	1,883	11,953
General administration expenses	125,740	186,087
	1,588,849	1,426,989

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

The Council's accounts are managed by the Health Administration Corporation. Executive and administrative support functions are provided by the HPCA, which is an administrative unit of the Health Administration Corporation. The Health Administration Corporation 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 Health Administration Corporation are detailed above in notes 2 to 10.

4. INTEREST REVENUE

		2011
	$	$
Interest revenue from financial assets not at fair value through profit or loss	64,102	35,413
TCorp Hour Glass cash facility	28,133	149,509
	92,235	184,922

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 Health Administration Corporation. 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.

	2012	2011
	%	%
Weighted Average Interest Rate	3.65	4.43

5. GAIN/(LOSS) ON DISPOSAL

	2012	2011
	$	$
Plant and equipment		
Net book value disposed during the year	(18,275)	-
Proceeds from sale	24,485	-
Total Gain on Disposal	6,210	-

6. CASH AND CASH EQUIVALENTS

	2012	2011
	$	$
Cash at bank and on hand**	240,853	230,952
TCorp Hour Glass cash facility	603,656	575,523
Cash at bank - held by HPCA*	253,560	575,686
	1,098,069	1,382,161

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

** Managed by the HPCA, an administrative unit of the Health Administration Corporation.

7. RECEIVABLES

	2012	2011
	$	$
Prepayments	22,116	3,343
Other receivables	54,534	49,254
Interest receivable	3,688	6,595
Trade receivables	64,426	194,337
Less: Allowance for impairment	(3,548)	-
	141,216	253,529
Movement in the allowance for impairment		
Balance at 1 July	-	-
Amounts written off during the year	-	-
Amounts recovered during the year	-	-
Increase/(decrease) in allowance recognised in profit or loss	3,548	-
Balance at 30 June	3,548	-

Trade receivables have been considered for impairment.
The trade receivables include monies that AHPRA has collected from registrants as at 30 June 2012 and has remitted the monies to HPCA in July 2012.

8. PLANT AND EQUIPMENT

	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 current reporting period is set out below:

	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)
Depreciation expense	(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

	Leasehold Improvements	Motor Vehicles	Furniture & Fittings	Other	Total
	$	$	$	$	$
At 1 July 2010					
Transfer of net assets due to restructure	1,954,956	24,810	8,095	135,061	2,122,922
Net Carrying Amount	1,954,956	24,810	8,095	135,061	2,122,922
At 30 June 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

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:

	Leasehold Improvements	Motor Vehicles	Furniture & Fittings	Other	Total
	$	$	$	$	$
Year ended 30 June 2011					
Net carrying amount at start of year	1,954,956	24,810	8,095	135,061	2,122,922
Additions	-	5,477	-	-	5,477
Disposals	-	-	-	-	-
Depreciation expense	(103,030)	(7,619)	(2,490)	(45,450)	(158,589)
Net Carrying Amount at End of Year	1,851,926	22,668	5,605	89,611	1,969,810

9. INTANGIBLE ASSETS

	Software Work in Progress	Software	Total
	$	$	$
At 1 July 2011			
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			
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	-	-	-
Amortisation	-	(360,987)	(360,987)
Net Carrying Amount at End of Year	3,409	650,509	653,918

	Software Work in Progress	Software	Total
	$	$	$
At 1 July 2010			
Transfer of net assets due to restructure	-	953,194	953,194
Net Carrying Amount	-	953,194	953,194
At 30 June 2011			
Gross carrying amount	-	1,860,903	1,860,903
Accumulated amortisation and impairment	-	(867,922)	(867,922)
Net Carrying Amount	-	992,981	992,981

	Software Work in Progress	Software	Total
	$	$	$
Year ended 30 June 2011			
Net carrying amount at start of year	-	953,194	953,194
Additions	-	357,912	357,912
Disposals	-	-	-
Amortisation	-	(318,125)	(318,125)
Net Carrying Amount at End of Year	-	992,981	992,981

10. PAYABLES

	2012	2011
	$	$
Personnel services - Ministry of Health	437,769	507,956
Trade and other payables	810,114	858,644
	1,247,883	1,366,600

11. FEES IN ADVANCE

	2012	2011
Current	$	$
Fees in advance	1,954,196	2,017,646
	1,954,196	2,017,646

	2012	2011
Non-Current	$	$
Fees in advance	-	46,258
	-	46,258

Unearned revenue from NSW Regulatory Fees received on behalf of the Council by the HPCA from the AHPRA.

12. COMMITMENTS FOR EXPENDITURE

i. Capital Commitments
There is no capital expenditure contracted for at balance date.

ii. Operating Lease Commitments
Future non-cancellable operating lease rentals not provided for and payable:

	2012	2011
	$	$
Not later than one year	33,640	33,000
Later than one year and not later than five years	134,561	132,000
Later than five years	241,649	266,000
Total (including GST)	409,851	431,000

13. RELATED PARTY TRANSACTIONS

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

The Council's accounts are managed by the Health Administration Corporation. 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 2012.

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

	2012	2011
	$	$
Net Result	(662,250)	(1,398,837)
Depreciation and amortisation	521,089	476,714
Allowance for impairment	3,548	-
(Decrease)/Increase in receivables	108,765	(218,529)
Increase/(Decrease) in fees in advance	(109,708)	(588,022)
Increase/(Decrease) in payables	(118,717)	(12,704)
Increase/(Decrease) in provisions	-	(154,034)
Net gain/(loss) on sale of plant and equipment	(6,210)	-
Net cash used on operating activities	(263,483)	(1,895,412)

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.

i. Financial Instrument Categories

Financial Assets	**Note**	**Category**	**Carrying Amount 2012**	**Carrying Amount 2011**
Class			**$**	**$**
Cash and Cash Equivalents	6	N/A	1,098,069	1,382,161
Receivables [1]	7	Loans and receivables (measured at amortised cost)	64,566	200,932

Financial Liabilities	**Note**	**Category**	**Carrying Amount 2012**	**Carrying Amount 2011**
Class			**$**	**$**
Payables [2]	10	Financial liabilities (measured at amortised cost)	1,247,883	1,366,600

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).

ii. 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.

iii. 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.

iv. 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.

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. EQUITY TRANSFERS

As a result of the commencement of the Law, assets and liabilities of New South Wales Medical Board were transferred to the newly established Medical Council of New South Wales on 1 July 2010, and the former New South Wales Medical Board was abolished.

The establishment of the Council and the transfer of assets and liabilities referred to above was classified as a restructure of administrative arrangements and accounted for in accordance with NSW Treasury's Accounting Policy: Contribution by owners made to wholly owned Public Sector Entities (TPP09-03) as a contribution by owners. Assets and liabilities were transferred at book values at 30 June 2010 per transferor entities as these book values were considered reasonable approximations of fair value to the Council, with a net credit to Equity of $3,710,779.

Transactions and adjustments recognised on 1 July 2010 as a result of the restructure were as follows:

The *New South Wales Government Gazette No 90*, dated 2 July 2010 ordered that the Council make the following payments:

i). An amount of $1,143,965 to the NSW Department of Health in respect of an unrecorded liability for the Council's contribution towards the national registration implementation costs. This was treated as a transaction with owners and debited to Equity, and subsequently paid on 2 September 2010; and

ii). An amount of $669,074 to the AHPRA being the estimated registration fees component of total fees received in advance by the former Board as at 30 June 2010. This amount was reclassified from Fees in Advance to Trade and Other Payables, and subsequently paid on 14 March 2011.

18. EVENTS AFTER THE REPORTING PERIOD

There are no events after the reporting period to be included in the financial statements as of 30 June 2012.

End of audited financial statements

> appendices

Appendix 1: List of Shortened Forms

AHPRA	Australian Health Practitioner Regulation Agency
AHWMC	Australian Health Workforce Ministerial Council
AMC	Australian Medical Council
CAP	Council-appointed Practitioner
CRIA	Chronic Relapsing Illness Authorisation
DP	Director of Proceedings
GIPA Act	Government Information (Public Access) Act 2009
HCCC	Health Care Complaints Commission
HPCA	Health Professional Councils Authority
IRP	Impaired Registrants Panel
MOH	Ministry of Health
MT	Medical Tribunal
PA	Performance Assessment
PINT	Performance Interview
PRP	Performance Review Panel
PSC	Professional Standards Committee
S150	Section 150 of the Health Practitioner Regulation National Law (NSW)
SLA	Service level agreement

Appendix 2: 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 2012, there were 89 permanent full-time and nine temporary full-time positions at the HPCA, of whom 24 FTE and 10 temporary FTE staff provided secretariat support directly to the Medical Council.

The HPCA adopts NSW Ministry of Health personnel policies and practices and ensures that staff have access to these policies through the Ministry intranet. During the reporting year, all staff signed the new NSW Health Code of Conduct and had the opportunity to discuss it at staff meetings. The HPCA also commissioned a review of its organisational structure to determine the best allocation of staffing resources and opportunities to streamline some services that are shared across all of the health professional councils.

Learning and development

The HPCA continues to provide learning and development opportunities for staff that are aligned with Council and corporate priorities, and that meet staff individual training needs, as identified through the Coaching and Performance System (CAPS).

During the year, members of the Occupational Health and Safety Committee received training in the requirements of the *Work Health and Safety Act (NSW) 2011* and the *Work Health and Safety Regulation (NSW) 2011*, which came into effect on 1 January 2012. Selected staff attended courses on the GIPA Act, privacy management and public interest disclosure provisions; writing procedures and policy documents and Ministerial correspondence; staff selection techniques, DISC behavioural profiling, career coaching and fundamentals of project management. The introduction of the Monitoring and Complaints system (MaCS) for case management included intensive training, development of procedure manuals and ongoing support following implementation.

The Medical Council aims to ensure that staff and members understand the provisions of the *Health Practitioner Regulation National Law (NSW)* and its administration. Priorities for 2012/13 include induction of members joining the Medical Council from 1 July 2012 and a focus on developing knowledge of the *Health Practitioner Regulation National Law (NSW)* and the Medical Council's regulatory responsibilities and processes to protect the public. Legal information sessions for staff are being developed as part of an ongoing program of continuous learning and education.

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*. The Council has endorsed an internal reporting policy and has provided a report to the NSW Ombudsman's online reporting tool. Staff and Council members are aware of this policy and information is available on the requirements and processes for making and managing disclosures.

There were no public interest disclosures made by staff or Council members during the year:

Table 23: Public interest disclosures January 2012-June 2012

	January 2012 – June 2012
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
Local government pecuniary interest contravention	0
Number of PIDs finalised	0

Note: The number of PIDs finalised only refers to PIDs that have been received since 1 January 2012.

Industrial relations policies and practices

The HPCA implements the NSW Ministry of Health industrial relations policies and practices, and maintained a harmonious industrial environment throughout the year.

Appendix 3: 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 disability services; equal employment opportunity; multicultural policies and services program; occupational health and safety and waste management. The Medical Council last reported on these provisions in the 2010/11 Annual Report and will next report in 2013/14.

The Medical Council continues to meet its compliance obligations with regard to each of these matters and is committed to implementing the relevant policy requirements.

Appendix 4: 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 includes:

- 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 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 Council has appropriate internal audit and risk management practices in place in line with the core requirements of TPP09-05, in particular:

- the HPCA has established a Health Professional Councils Audit and Risk Committee comprising three members, with a majority of independent members and an independent chair
- developed an Audit and Risk Committee charter consistent with the content of the 'model charter'
- established and maintained an enterprise risk management process including a Risk Register and three year rolling internal audit plan, which covers the operation of all of the Councils

Due to the Councils' small budgets the HPCA has not established a specific Chief Audit Executive role. To meet this requirement, IAB is commissioned to undertake the internal audits nominated in the internal audit plan and the HPCA Manager, Corporate Governance provides the secretariat to the Audit and Risk Committee and ensures that audit outcomes and risk management activities are regularly reported to and monitored by the Committee.

Since its inception in January 2012, the Audit and Risk Committee reviewed the 2011/2012 Risk Register, monitored internal audits and reviews and the Council's financial and management reports.

During the year the HPCA paid particular attention to implementing the recommendations arising from the Audit Office of NSW audit of the 2010/2011 financial statements. In addition, the HPCA updated the risk register, developed a fraud risk assessment tool and initiated work on a business continuity plan.

The IAB conducted an internal audit of the financial controls over payments to Council, committee and panel members. The audit found no evidence of fraud but recommended a number of policy and control measures to improve internal processes and the development of a policy and procedures. All of the review's recommendations were accepted and are being addressed.

A proposed audit of information and records management was postponed to enable the scope to be revised to focus on the content and accessibility of records. This review will be rescheduled during 2013 and development of a business continuity plan has been initiated.

Information management and systems

A priority this year was to improve information systems and the management of information, which is one of the Medical Council's key assets. This has enabled information to be more readily shared and has improved the accuracy, reliability and security of corporate and regulatory information.

Documentation of an IT disaster recovery plan has begun and will be completed as part of the business continuity plan.

Appendix 5: Medical Council financial management

Financial management

The HPCA provides financial management services to the Medical Council including the payment of accounts, budget preparation and monitoring and coordination of regular financial reporting to the Medical Council. The HPCA staff work with the AHPRA on behalf of the Medical Council to determine practitioner fees and the regulatory component of those fees paid to the Medical Council to enable it to undertake its regulatory functions.

A new model for the allocation of costs across the health professional councils is being developed to ensure the equitable distribution of shared costs and staffing resources across all councils. It will be implemented from 2013 once the impact of the methodology across the 13 councils has been tested.

Format

The accounts of the Medical Council's administrative operations, together with the independent auditor's report, are set out in the Financial Statements included in this Annual Report.

Performance

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

Table 24: Accounts performance

Revenue	$7,349,223
Operating expenditure	$8,017,683
Net Profit/(loss)	($622,250)
Net cash reserves (cash and cash equivalents minus current liabilities)	($2,104,010)

Budget 2012/13

Table 25: Budget in respect of administrative operations for 1 July 2012-30 June 2013

The budget in respect of the administrative operation for the period 1 July 2012 to 30 June 2013 is as follows:

Revenue	10,349,390
Operating expenditure	(8,362,650)
Net Profit/(Loss)	1,986,740

The 2012/13 budget is subject to revision.

Investment performance

The Medical Council, through a Special Interest Arrangement with the Commonwealth Bank of Australia, earned an average of 3.65% p.a. on its daily bank balances. The Medical Council's externally managed funds were held in Treasury Corporation's Hour Glass Cash Facility. An average return of 4.8% was achieved for the current financial year.

Payments performance

The Medical Council's accounts are managed by the Health Administration Corporation. The HPCA is in the process of identifying small business suppliers as required by NSW Treasury Circular TC11/21. The consolidated accounts payable performance report for the HPCA is as shown below:

Table 26: Accounts payable performance report

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
	$	$	$	$	$
September	1,932,856	1,094	0	74	0
December	2,007,267	23,963	0	0	0
March	1,152,270	0	0	0	0
June	1,437,800	31,854	0	0	0

Quarter	Accounts paid on time			Total amount paid
	Target %	Actual %	$	
September	100.00	99.90	1,932,856	1,934,024
December	100.00	98.80	2,007,267	2,031,229
March	100.00	100.00	1,152,270	1,152,270
June	100.00	97.80	1,437,800	1,469,654

Measure	Sept	Dec	Mar	Jun
All Suppliers				
Number of accounts due for payment	116	122	132	108
Number of accounts paid on time	113	92	131	107
Actual percentage of accounts paid on time (based on number of accounts)	97.4	75.4	99.2	99.1
Dollar amount of accounts due for payment	1,934,024	2,031,230	1,152,359	1,469,654
Dollar amount of accounts paid on time	1,932,856	2,007,267	1,152,270	1,437,800
Actual percentage of accounts paid on time (based on $)	99.9	98.8	100	97.8
Number of payments for interest on overdue accounts				
Interest paid on overdue accounts				

Measure	Sept	Dec	Mar	Jun
Small business suppliers				
Number of accounts due for payment				
Number of accounts paid on time				
Actual percentage of accounts paid on time (based on number of accounts)				
Dollar amount of accounts due for payment				
Dollar amount of accounts paid on time				
Actual percentage of accounts paid on time (based on $)				
Number of payments for interest on overdue accounts				
Interest paid on overdue accounts				

Appendix 6: Legal change

During the reporting period, the NSW Parliament passed a number of minor amendments to the *Health Practitioner Regulation National Law (NSW)*, and the Governor made an order which amended sections 41B and 165 of the *Health Practitioner Regulation National Law (NSW)*. In the same reporting period, the Governor approved a number of amendments to the *Health Practitioner Regulation (New South Wales) Regulation 2010*.

Health Practitioner Regulation National Law (NSW)

1. Amendments made by the *Health Services Amendment (Local Health Districts and Boards) Act 2011* (commenced 1 July 2011):

Amendments were made to Schedule 5C of the *Health Practitioner Regulation National Law (NSW)* to reflect the replacement of Local Health Networks with Local Health Districts.

2. Amendments made by the *Health Legislation Amendment Act 2012* (commenced 21 June 2012):

An amendment was made to section 6A of the *Health Practitioner Regulation (Adoption of National Law) Act 2009* to remove impaired registrants panels from the definition of 'adjudication body'.

The following amendments were made to the *Health Practitioner Regulation National Law (NSW)*:

- Inclusion of section 3A which provides that in exercising a function under a NSW provision of the *Health Practitioner Regulation National Law (NSW)*, public protection is the paramount consideration
- Inclusion of section 143A which provides that a mandatory notification made to AHPRA is to be taken as a complaint for the purposes of Part 8 of the *Health Practitioner Regulation National Law (NSW)* and for the purposes of the Health Care Complaints Act 1993
- Amendments to a range of sections to clarify that a Council may refer a person for psychological counselling in addition to medical and other types of counselling
- Amendments to a range of sections to provide that where a committee, panel or Tribunal is required to include a lay person that person is to be someone who has never been registered as a practitioner or student in the relevant profession
- Amendment to section 159 to clarify that an appeal to the Tribunal from a decision by the Council is a hearing *de novo*
- Amendment to section 163 to provide that the Chairperson of the Tribunal may determine in a particular case that the Council is the 'appropriate review body'
- Amendment to section 163A to provide that a disciplinary order of a Council may be reviewed
- Amendment of section 163B to clarify that a practitioner who receives a 'reinstatement order' from the Tribunal must still meet the registration requirements of the National Board
- A range of minor consequential amendments flowing from the above amendments were also made, and
- Amendment to section 41B to include the Aboriginal and Torres Strait Islander Health Practitioner Council, the Chinese Medicine Council, the Medical Radiation Practice Council and the Occupational Therapy Council in the table of Councils established by that section.

3. Amendments made by the *Health Practitioner Regulation National Law (NSW)* Amendment (Health Professions) Order 2012 (commenced 1 July 2012):

- Amendment was made to section 41B to include the Aboriginal and Torres Strait Islander Health Practitioner Council of New South Wales, the Chinese Medicine Council of New South Wales, the Medical Radiation Practice Council of New South Wales and the Occupational Therapy Council of New South Wales in the table of Councils established by that section.

- Amendment was made to section 165 to include the Aboriginal and Torres Strait Islander Health Practitioner Tribunal of New South Wales, the Chinese Medicine Tribunal of New South Wales, the Medical Radiation Practice Tribunal of New South Wales and the Occupational Therapy Tribunal of New South Wales in the table of Tribunals established by that section.

Health Practitioner Regulation (New South Wales) Regulation 2010

1. Amendments made by the *Statute Law (Miscellaneous Provisions) Act 2011* (commenced 8 July 2011):

An amendment to clause 24 of a savings and transitional nature.

2. *Health Practitioner Regulation (New South Wales) Amendment (Savings and Transitional) Regulation 2011* (commenced 22 July 2011):

An amendment of a savings and transitional nature to ensure that a person who became a member of a State Board of the National Board by virtue of the transitional provisions in the National Law did not cease to hold that office due to the expiry of their former term of office as a member of the local registration board.

3. *Health Practitioner Regulation (New South Wales) Amendment Regulation 2012*

An amendment to insert Clause 3A to the Regulation, setting out the membership of the four new Professional Councils established on 1 July 2012 (commenced 3 February 2012).

A consequential amendment to Clause 4 of the Regulation flowing from the insertion of Clause 3A (commenced 1 July 2012).

4. *Health Practitioner Regulation (New South Wales) Amendment (Health Professional Councils) Regulation 2012* (commenced 1 July 2012):

Amendments to include Clause 4A and Schedules 1A and 1B to the Regulation to provide for the membership of the Dental, Medical, Nursing and Midwifery, Pharmacy, Physiotherapy and Psychology Councils.

Appendix 7: Promotion of the Medical Council's activities / Overseas travel

No HPCA staff or Medical Council members undertook overseas travel during the reporting year.

The Medical Council maintains a website which is updated on a regular basis (www.mcnsw.gov.au) and is the principal medium for disseminating information to practitioners and students. The Medical Council's Annual Report for 2011 and Annual Reports for previous years of the former Medical Board of NSW, are accessible on the website.

Appendix 8: Use of consultants and other external costs

The 10 health professional councils together commissioned three consultancies to assist with the transition to the new regulatory regime and the distribution of financial and shared services being provided through the HPCA.

The Medical Council made the following contribution to these consultancies:

Table 27: Contribution to consultancies

	No. of consultants	Cost inc. GST $
Financial management	3	$ 13,822
Governance	3	$ 9,047
Administration	2	$ 11,067
Information management and systems	1	$ 1,168
	9	**$ 35,104**

Printing cost incurred in the production of the Annual Report is **$2267.80.**

Appendix 9: 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, service delivery and processes.

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 complaints or investigations concerning medical practitioners. Included were complaints made against a former staff member and current staff member, which were made to another organisation, and a complaint concerning whether publication of information by the Medical 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 if necessary, procedures were reviewed and amended.

Appendix 10: 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: www.mcnsw.org.au

In accordance with section 7(3) of the GIPA Act, the Medical Council conducted a review of its proactive release of information. As a result of this review, the Medical Council's website has been modified to provide enhanced access to the policies and guidelines of the Medical Council and related agencies. Additionally, the Medical Council has introduced a mechanism so that the publication of key documents is considered at the time of endorsement.

All newly created and revised key documents are gradually being assessed to determine whether they should be published on its website in accordance with the requirements of the GIPA Act. At its meeting on 4 October 2011, the Medical Council of NSW resolved to adopt the Health Professional Councils Authority's Policy Management Framework. This framework provides practical guidance with respect to the development of future policies, guidelines, procedures and position statements.

Access to information held by the Medical Council was available by either searching the Medical Council's website or by contacting the Medical Council. On receipt of requests for information, staff assess and decide whether the information requested is readily available, could be disclosed as part of a proactive release of information, could be disclosed through informal release, or if a formal access application was required. The application fee for a formal GIPA Act application was $30.

During the period 1 July 2011 to 30 June 2012, the Medical Council received 10 formal access applications for information (three from the same applicant), compared to two in the preceding year. One application was withdrawn, six were determined and three applications remained under consideration at the end of the reporting period.

During this period, two applicants sought a review of the Medical Council's decision, one by the Information Commissioner and one by the Administrative Decisions Tribunal.

Assistance for any matter concerning the GIPA Act is available by contacting a Right to Information Officer at the Medical Council.

The Medical Council is required to report its activity annually in accordance with section 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 28: Number of GIPA applications – type of applicant and outcome

Number of applications by 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	1	0	0	0	0	0	0
Members of Parliament	0	0	0	0	0	0	0	0
Private sector business	0	1	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	0	0	0	0	0	0	0
Members of the public (other)	0	4	0	0	0	0	0	1

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

Table 29: Number of GIPA applications – type of application and outcome

Number of applications by 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	0	0	0	0	1
Access applications that are partly personal information applications and partly other	0	4	0	0	0	0	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 30: Invalid applications

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

Table 31: 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	4
Cabinet information	0
Executive Medical Council information	1
Contempt	0
Legal professional privilege	2
Excluded information	1
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 32: Other public interest considerations against disclosure

Other public interest considerations against disclosure: matters listed in table to section 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	2
Business interests of agencies and other persons	0
Environment, culture, economy and general matters	0
Secrecy provisions	1
Exempt documents under interstate Freedom of Information legislation	0

Table 33: Timeliness

Timeliness	
	Number of applications
Decided within the statutory timeframe (20 days plus any extensions)	5
Decided after 35 days (by agreement with applicant)	1
Not decided within time (deemed refusal)	0
Total	6

Table 34: 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	0	0	0
Review by Information Commissioner*	0	0	0
Internal review following recommendation under section 93 of Act	0	0	0
Review by ADT	0	0	0
Total	0	0	0

* The Information Commissioner does not have the authority to vary decisions, but can make recommendations to the original decision-maker.

Table 35: 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	2
Applications by persons to whom information the subject of access application relates (see section 54 of the Act)	0

Appendix 11: 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*.

Three complaints about breach of privacy were received by the Medical Council in this reporting period. All three were made by the same practitioner (one on behalf of the practitioner's child). The Medical Council conducted internal reviews in relation to each complaint within the required statutory timeframes and in accordance with Part 5 of the *Privacy and Personal Information Protection Act 1998*.

One complaint is still unresolved, in that at the time of reporting, it is the subject of an external review in the Administrative Decisions Tribunal, with the Privacy Commissioner having filed a Notice of Representation.

A privacy management plan will be developed in 2012/13.

Appendix 12: Policies and publications

The Medical Council's website is a key means of communicating with the public and with practitioners. Under the 'Resources' tab, the Medical Council provides copies of policies, guidelines, position statements, and links to policies of the Medical Board of Australia and the HPCA. Copies of policies and guidelines rescinded by the Medical Council are now also available on the website.

Other publications available under the 'Resources' tab of the website include: previous annual reports, newsletters to the profession, and a copy of the Health Program Handbook.

Decision of Medical Tribunals, Professional Standards Committees and other relevant courts and Tribunals, as well as information about the Medical Council's processes and programs, are published under different headings on the Medical Council's website.

Appendix 13: Overview of complaints bodies and processes

In relation to complaints, the Medical Council's Professional Conduct section operates under the provisions contained in the *Health Practitioner Regulation National Law (NSW)* and the *Health Care Complaints Act 1993*. The bodies, persons or entities that deal with complaints against medical practitioners are:

- ***The Medical Council:*** The Medical Council's role in relation to complaints is to consult with the HCCC on the assessment and management of a complaint, to take relevant action under the *Health Practitioner Regulation National Law (NSW)*, to appoint medical and lay members to sit on relevant inquiries, and to monitor any conditions or restrictions on a medical practitioner's practice of medicine.

- ***The Health Care Complaints Commission (HCCC)***: The HCCC's role in relation to complaints is to investigate and prosecute complaints in relation to medical practitioners and to consult with the Medical Council as to the course and outcome of a complaint.

- ***The Director of Proceedings (DP) at the HCCC***: The role of the DP is to independently assess whether a matter should be prosecuted, to prosecute matters before a Professional Standards Committee or Medical Tribunal, and to consult with the Medical Council in relation to prosecutions.

- ***A Professional Standards Committee (PSC)***: PSCs are independent bodies of inquiry established under the *Health Practitioner Regulation National Law (NSW)* to deal with complaints that a medical practitioner may have engaged in unsatisfactory professional conduct.

- ***A Medical Tribunal (Tribunal)***: The Tribunal is an independent body of inquiry established under the *Health Practitioner Regulation National Law (NSW)*, and chaired by a Judge of the District Court of NSW or a Justice of the Industrial Relations Commission, to determine serious complaints that a medical practitioner may have engaged in professional misconduct or unsatisfactory professional conduct. The Tribunal also has a role in determining appeals against decisions of the Medical Council or a PSC and conducting reviews of cancellation orders.

- ***The Australian Health Practitioner Regulation Agency (AHPRA) and the Medical Board of Australia (the National Board)***: These national bodies deal with registration and regulation of health practitioners Australia-wide, except in NSW where they only deal with registration. The *Health Practitioner Regulation National Law (NSW)* requires mandatory notifications and notification of certain other relevant events to be made to AHPRA. Notifications that might require some regulatory action in NSW are forwarded to the Medical Council and the HCCC for assessment and appropriate action.

Any person can make a complaint about a registered medical practitioner. Each complaint is assessed by the HCCC in consultation with the Medical Council. Consultation occurs at various stages during the investigative stage 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 degree of evidence available:

- The Medical Council may take immediate 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 any 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 PSC or a Tribunal
  - referred for comments
  - 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.

Appendix 14: Sections 150 and 150A proceedings case studies

The Medical Council is required to take action under section 150 of the *Health Practitioner Regulation National Law (NSW)* by either suspending a practitioner's registration or imposing conditions, if it is satisfied it is appropriate to so for the protection of the life or safety of any person or if it is otherwise in the public interest to do so.

Practitioners can seek a review of such a decision by making an application under section 150A of the *Health Practitioner Regulation National Law (NSW)*. The Medical Council can also shorten or terminate a suspension, or alter or remove conditions that have been imposed under section 150 by conducting proceedings under section 150C of the *Health Practitioner Regulation National Law (NSW)*.

If the Medical Council takes any action under section 150, the matter that triggered the proceedings must either be referred to the HCCC for investigation as a complaint or be referred to an Impaired Registrants Panel Inquiry or a Performance Assessment (subject to consultation and agreement with the HCCC).

The Medical Council has conducted 46 urgent interim proceedings under section 150 and seven proceedings to review orders imposed under section 150A or Section 150C during the reporting year.

Summaries of some of the matters considered by the Medical Council appear below.

A case where three section 150A review applications were made before a suspension under section 150 was eventually lifted

A general practice registrar, with a history of involvement in the Health Program since 2003, was suspended in October 2010 under section 150 of the *Health Practitioner Regulation National Law (NSW)*. The Medical Council was satisfied the practitioner had not been complying with conditions that had been imposed following Impaired Registrant Panel inquiries and subsequent review interviews. The Medical Council also referred a complaint of breach of conditions to the HCCC for investigation. The suspension was a public protective interim measure pending either disposal of the complaint or a review by the Medical Council that resulted in the suspension being lifted.

Reviews of the suspension order were sought by the practitioner in March 2011 (in the previous reporting period), August 2011 and February 2012.

In March 2011, the Medical Council concluded that the suspension could not be lifted because the practitioner displayed a very concerning pattern of behaviour through a lack of truthfulness, lack of engagement with his/her treating practitioners, lack of insight into his/her actions (and the potential consequences) and a disregard for ethical and professional responsibilities.

In August 2011, although the Medical Council delegates were impressed with the practitioner's efforts and significant improvements in presentation, they concluded that the suspension could not be lifted as they continued to be concerned by a lack of balance in work/study/family responsibilities; no formal proposal about intended work and supervision arrangements; and their difficulty in accepting the practitioner's assurances of truthfulness and commitment without clear evidence of sustained compliance of random urine drug testing (UDT) and of sustained engagement with his/her treating practitioners.

At the review hearing in February 2012, the practitioner emphasised an intention to accept ongoing responsibility for future compliance with conditions. Corroborative documentation from treating practitioners was provided. Random UDT results confirmed there were no positive results, and no dilute samples.

The delegates were impressed with the practitioner's efforts to address their previous recommendations. In light of the demonstrated sustained compliance with random UDT and engagement with his/her treating practitioners and progress in attitude and behaviour, the delegates concluded that it was appropriate to lift the suspension and impose Practice and Health Conditions on the practitioner's registration.

Concerns about surgical performance did not warrant urgent interim action, but did warrant performance assessment

In 2010 and 2011, two notifications were received concerning adverse clinical outcomes in five patients who had undergone advanced laparoscopic surgery, together with a further adverse surgical event. In May 2011, a patient complained that the practitioner had recommended hysterectomy and oophorectomy (removal of ovaries), however a second opinion advised this was not necessary. As a result of these notifications, the Medical Council referred the practitioner for a performance assessment. However in June 2011, further information was received alleging the practitioner had performed an oophorectomy on a patient, in contravention of the practitioner's surgical privilege restrictions. Following receipt of this further complaint, the Medical Council convened section 150 proceedings.

During the proceedings, the practitioner submitted s/he was not currently performing complex procedures, and therefore not posing a risk to patients. S/he attributed her/his current situation to the occurrence of recent complications and the medico-political situation at the notifying private hospitals. S/he said s/he took on difficult surgical cases which necessarily resulted in higher complication rates.

The delegates also had before them an independent report which recommended that the practitioner have surgical privileges restored. The delegates considered the practitioner to be isolated, but had

displayed insight into the nature of his/her isolated practice. They also considered that the concerns raised regarding the practitioner's practise of medicine did not amount to immediate concern regarding patient safety. The delegates concluded that while the concerns before the delegates did not engage the provisions of section 150, nevertheless, there remained issues regarding the practitioner's clinical performance. The delegates recommended that the practitioner's performance be assessed as a matter of priority, but took no urgent action under section 150.

Action taken because of alcohol dependence

A general practitioner, with ongoing involvement in the Health Program as a result of alcohol dependence, became the subject of section 150 proceedings when, contrary to conditions on his/her registration, s/he resumed drinking and failed to attend for twice-weekly EtG testing. The practitioner had also disclosed two alcohol-related criminal charges when renewing his/her registration with AHPRA.

The practitioner disclosed to the Medical Council's delegates that s/he was now cognisant of the importance of complying with the conditions on his/her registration and had ceased drinking alcohol and commenced taking Antabuse shortly prior to the proceedings. Nevertheless, the delegates suspended the practitioner's registration, with a view to having him/her focus entirely on his/her health and demonstrate a sustained commitment to abstinence. The delegates made a number of recommendations to the practitioner about matters s/he should attend to before seeking to have the suspension of his/her registration lifted. The practitioner's registration was subsequently lifted four months later, on the recommendation of an Impaired Registrants Panel.

Ongoing clinical issues impacting on professional performance

A specialist physician at a regional hospital, with previous involvement in the Performance Program in 2002, came to the Medical Council's attention when a notification was made about the practitioner's clinical practice. Section 150 proceedings were convened. The practitioner agreed that the clinical records were scant with no documented history, examination findings, diagnosis or overall patient management plan. There were numerous retrospective entries in the clinical records, and entries made without examining the patient. Of concern to the delegates was the practitioner's strong reliance on test results, which delayed ward rounds, patient examination and communication with the patient's family. In one case, the practitioner had failed to attend a young male patient who presented with shortness of breath and lacking oxygen. The delegates considered how little the practitioner's professional performance had changed since 2002.

The delegates noted evidence that the hospital had subsequently imposed practice conditions and that there were supportive hospital colleagues. However, the delegates considered that additional interim practice conditions were needed including: restricting any change in the location/nature of the practitioner's work; close supervision and reporting by a senior colleague at the hospital and maintaining a patient log for all patients admitted under the practitioner's care for submission to the Medical Council. The practitioner was required to notify the hospital's Director of Medical Services of these conditions.

Appendix 15: Matters in other jurisdictions

New South Wales Court of Appeal

Lucire v Parmegiani & Anor [2012] NSWCA 86

In a decision delivered on 20 April 2012, the New South Wales Court of Appeal considered an appeal by Dr Lucire from a District Court decision to summarily dismiss her claim for damages for alleged defamation. (Dr Lucire alleges that a letter which Dr Parmegiani wrote to the then Medical Board of NSW concerning Dr Lucire's conduct, was defamatory. The District Court held that the defence of absolute privilege applied to Dr Lucire's allegation that Dr Parmegiani's letter of complaint was defamatory, and dismissed the defamation claim.)

The Medical Council had appeared as an intervenor in the District Court hearing, on the question of immunity from action for defamation. The Medical Council was a respondent to Dr Lucire's appeal.

The Court of Appeal held that the defence of absolute privilege in the *Defamation Act 2005 (NSW)* attaches to communications made for the purpose of dealing with a complaint once the complaint has been made, and not to the making of a complaint itself. Individuals who made complaints prior to 1 July 2010 have a qualified protection against being sued, subject to their complaint being made in good faith, under section 47 of the *Medical Practice Act 1992* and section 96 of the *Health Care Complaints Act 1993*.

The above decision is available on the Medical Council's website at www.mcnsw.org.au

SUPREME COURT NEW SOUTH WALES

Katelaris v Medical Council of New South Wales (formerly New South Wales Medical Board) [2012] NSWSC 282 and Andrew John Katelaris v Medical Council of New South Wales (formerly New South Wales Medical Board) (No. 2) [2012] NSWSC 617

In 2005, the Medical Tribunal de-registered Dr Andrew Katelaris. The Medical Tribunal dismissed an application for a review of the de-registration order in 2009, and in April 2011, the Court of Appeal declined to allow Dr Katelaris to bring an appeal out of time.

In December 2011, Dr Katelaris sought damages in the Supreme Court against the Medical Council. The claim alleges that the conditions imposed by the former Board on his registration in 2003 to protect

the public were "….to unreasonably harass a practitioner where no such threat exists…" and imposing those conditions constitutes the tort of misfeasance in public office. The claim for damages is being vigorously defended by the Medical Council. While there have been two judgments of the Supreme Court relating to this claim during this reporting period, the substantive matter is yet to be heard.

The above decisions are available on the Medical Council's website at www.mcnsw.org.au

Bar-Mordecai v Attorney General of New South Wales 12012) NSWSC 453

Mr Bar-Mordecai is seeking a review of a de-registration order made by the Medical Tribunal in 2000. As a declared vexatious litigant, the Supreme Court must grant Mr Bar-Mordecai leave before any proceedings can be commenced in the Medical Tribunal. Leave was granted by the Supreme Court, subject to a number of strict conditions and the matter is listed for hearing in the Medical Tribunal in October 2012. Prior applications for review of the 2000 order were dismissed by the Medical Tribunal in 2006 and 2009.

The above decision is available on the Medical Council's website at www.mcnsw.org.au

Criminal prosecutions by the Medical Council

Two holding out matters were finalised in this reporting period.

(As a result of legislative change from July 2010, responsibility for such prosecutions now rest with the Medical Board of Australia and the Australian Health Practitioner Regulation Agency.)

In one, a former specialist physician in private practice was prosecuted by the Medical Council for falsely holding himself out as a registered medical practitioner while unregistered and in breach of the *Medical Practice Act 1992*. The practitioner's name was removed from the Register of Medical Practitioners in June 2009 for administrative reasons, but after his name was removed, he continued to practise while unregistered and uninsured.

The former practitioner entered a plea of guilty in relation to the charge of holding himself out as person able to perform a medical service between August 2009 and February 2010, in which time he gave medical advice, performed blood pressure tests and took urine samples. While unregistered, he issued prescriptions for medications for more than 300 patients.

The Magistrate cautioned that his failure to hold professional indemnity insurance could have had 'very serious consequences' for the patients involved. However the Magistrate considered that this case was different from those cases where a person held themselves out as registered after their registration was cancelled by the Medical Tribunal or where a person "practised" with no medical training.

The practitioner was given a section 10 bond to be of good behaviour for a period of 18 months.

The second matter concerned a conviction in the Local Court in relation to three charges of holding out under the *Medical Practice Act 1992* (reported in 2010/11 Annual report) which was stood over for sentence.

In August 2011, the practitioner was sentenced to section 9 bonds on the first two charges, and a term of imprisonment for nine months with a non-parole period of five months in respect of the third charge. The practitioner appealed to the NSW District Court on the severity of sentence. The sentence was maintained but the non-parole period was reduced to two months.

In reducing the sentence, the judge noted that the practitioner should have the benefit of the amendment under the new legislative scheme. That is, that there is no longer a term of imprisonment imposed for the equivalent holding out offence under the *Health Practitioner Regulation National Law (NSW)*.

Appendix 16: Index of tables

Appendix 17: Index of charts

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

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