Medical Council OF NEW SOUTH WALES

Annual Report 2011

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Contents

Access to the Medical Council of New South Wales

Address	Building 45 Gladesville Hospital Off Punt Road, Gladesville NSW 2111
Telephone	(02) 9879 2200
Facsimile	(02) 9816 5307
E-mail	mcnsw@mcnsw.org.au
Website	www.mcnsw.org.au
Hours of Business	9.00 am to 5.00 pm
Mail	The Executive Officer Medical Council of New South Wales PO Box 104 GLADESVILLE NSW 1675 DX 22808 GLADESVILLE

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> about the **Council**

The Medical Council of New South Wales (the Council) was established on 1 July 2010 with the commencement of the National Registration and Accreditation Scheme (the Scheme) for health professionals. Through the Scheme, responsibility for registering health practitioners and accrediting educational programs, transferred from State and Territory authorities to National Boards. Health professionals now no longer need to hold multiple registrations in the same profession and uniform registration standards apply across all jurisdictions. The National Boards are supported by the Australian Health Practitioner Regulation Agency (AHPRA) which has an office in each State and Territory, including New South Wales (NSW).

NSW did not adopt the regulatory part of the Scheme which handles complaints and notifications about practitioners. Instead, the co-regulatory environment in NSW was maintained and the NSW Medical Board was replaced by the Council. The Council, together with the Health Care Complaints Commission (HCCC), continue to be responsible for dealing with complaints about the professional performance, conduct and health of medical practitioners who practise in NSW.

> aims and **objectives**

The Council is a statutory body established pursuant to the *Health Practitioner Regulation National Law (NSW)* to exercise the powers and functions imposed on it by the Law.

The object of the *Health Practitioner Regulation National Law (NSW)* (the Law), which created the Council, is to establish the National Registration and Accreditation Scheme. The objects of the 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;
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;
c. to facilitate the provision of high quality education and training of health practitioners;
d. to facilitate the rigorous and responsive assessment of overseas-trained health practitioners;
e. to facilitate access to services provided by health practitioners in accordance with the public interest;
f. to enable the continuous development of a flexible, responsive and sustainable Australian health workforce;
g. to enable innovation in the education of, and service delivery by, health practitioners.

The Council is one of 10 NSW Health Professional Councils established under the *Health Practitioner Regulation National Law (NSW)* to manage complaints about the performance, conduct and health of practitioners who are registered under the Law and who practise in NSW. The staff of the Health Professional Councils Authority (HPCA) provides secretariat support to the 10 NSW Health Professional Councils who administer the NSW Health Professional Regulatory Scheme.

Medical Council
OF NEW SOUTH WALES

PO Box 104 Gladesville NSW 1675
DX: 22808 Gladesville
Telephone: (02) 9879 2200
Facsimile: (02) 9816 5307
www.mcnsw.org.au

22 November 2011

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

CONFIDENTIAL

Dear Minister,

I have the pleasure of forwarding to you the first Annual Report of the Medical Council of New South Wales for the year ending 30 June 2011.

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*.

The Council was granted a one month extension of time to 30 November 2011 to submit this Report under section 13 (3) of the *Annual Reports (Statutory Bodies) Act 1984*. The approval was given on the understanding that this is the Council's first report since the establishment of the National Registration and Accreditation Scheme, which has impacted the timely submission of the financial statements and annual report.

I 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

Enclosure

> president's **report**

More than a year has passed since national registration commenced on 1 July 2010. At the same time, the Medical Council of New South Wales (the Council) replaced the NSW Medical Board as the body responsible for regulatory activities in NSW concerning a medical practitioner's performance, health or conduct.

The unique co-regulatory environment in NSW has been maintained through the continued relationship between the Council and the Health Care Complaints Commission (HCCC) with respect to the assessment and management of complaints. This relationship continues to be effective and to uphold the public's confidence in the complaint handling functions of both agencies.

Since 1 July 2010, the national Medical Board of Australia, through its administrative agency, the Australian Health Practitioner Regulation Agency (AHPRA), has been responsible for the registration of medical practitioners in Australia and the accreditation of courses for study.

The Council has forged a strong working relationship with the Medical Board of Australia. Two members of the Council are also members of this National Board. This provides a valuable and effective means of communicating to the National Board the views of the Council, on behalf of NSW registrants. The National Board has commenced the task of developing consistent standards and policies to govern the practice of medicine throughout Australia, and the Council has been involved in communicating its views in relation to the adoption and implementation of these policies.

This relationship is mirrored at state level in the liaison between the Council, through its administrative staff of the Health Professional Councils Authority (HPCA), and the staff at the AHPRA. Both organisations work closely in order to ensure effective communication and the exchange of information concerning registration and regulatory matters in a timely and efficient manner.

While the Council has seen some changes in its administrative structure since the commencement of national registration, the transition has been relatively seamless with regard to the management of regulatory matters in NSW.

The introduction of the *Health Practitioner Regulation National Law (NSW)* on 1 July 2010 has seen many of the procedures remain unchanged for dealing with a performance, health or conduct complaint. In NSW, the more serious complaints are investigated and, if appropriate, prosecuted by the HCCC. Complaints that concern a medical practitioner's performance or health are managed through the non-disciplinary pathways available to the Council, including Performance Assessments and Impaired Registrants Panels. The Council remains strongly committed to both the Health Program and the Performance Program, which are vital tools in maintaining professional standards, through remedial, non-punitive and broad-based assessment and review.

The year has seen a steady increase in the activity of the Council with a greater number of mandatory reports made in relation to medical practitioners as compared to last year. This increase indicates that health professionals, employers and education providers are all aware of their obligations to report notifiable conduct. This advances public protection by ensuring that the Council can take appropriate action in response to any issues of concern identified as a result of a mandatory notification.

There has also been an increase in the number of times the Council has been required to exercise its power to take immediate action against medical practitioners, either by suspending or imposing conditions on their registration. This reflects the Council's view that, where necessary, early interim action should be taken to protect the health or safety of the public, while the complaint is investigated or otherwise managed by the Council or the HCCC.

While medical students were registered in NSW prior to the commencement of the national scheme, medical students are now registered nationally by the AHPRA. During the year, the Council has seen a number of health notifications made in relation to students and is managing their health issues through its non-disciplinary Health Program.

Following the commencement of national registration, the Council has experienced a change in the way it performs its functions although many of its procedures have remained unchanged. The Council has welcomed a new Executive Officer and, more recently, a new Medical Director to meet the challenges of a new era. In spite of the level of change experienced during the reporting year, the work of the Council continues to be conducted with a high level of proficiency across a spectrum of difficult and complex matters.

The Council looks forward to continuing to maintain high standards of medical practice in NSW and improving the regulatory environment for medical practitioners and the public in NSW.

Peter Procopis
President

> year in **summary**

The following table gives an overview of the Medical Council's activities in the three major areas of Professional Conduct, Performance and Health, and a three-year historical comparison.

	2008/09	2009/10	2010/11
Professional Conduct			
Complaints assessed	1268	1279	1407
Professional Standards Committees concluded	18	16	14
Medical Tribunals concluded	19	19	18
Counselling Interviews finalised	18	25	30
Section 66 (*Medical Practice Act*) Inquiries conducted (including s66AB proceedings)	45	47	11
Section 150 proceedings (including s150A and s150C proceedings)	-	-	49
Health			
Medical Practitioners in Health Program	146	122	111
Entrants to Program	30	28	29
Impaired Registrants Panels convened	61	43	46
Council Review Interviews	276	263	242
Performance			
Medical Practitioners in Performance Program	54	65	79
Entrants to Program	24	32	31
Assessments concluded	19	20	26
Performance Review Panels concluded	11	10	11
Retired as a result of participation	5	5	4
Performance Interviews concluded	43	67	32
Exit from Program	15	21	17

> 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 Council) consists of 20 part-time members appointed by the Governor.

Members of the Council, their qualifications, term of appointment and nominating body for the period 1 July 2010 to 30 June 2011 are listed below. During this period, six ordinary meetings and one extraordinary meeting were held. Attendances at these Council Meetings 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) [6]

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, Royal College of Pathologists of Australasia nominee (current term: 1.7.2010 – 30.6.2012) [5]

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) [6]

Mr Antony Carpentieri, LLB (UTS), Ministerial nominee (current term: 1.7.2010 – 30.6.2012) [6]

Dr Kerry Chant, MBBS (UNSW), FAFPHM, MHA (UNSW), MPH (UNSW), Department of Health nominee (current term: 1.7.2010 – 30.6.2012) [3]

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) [6]

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) [5]

Associate Professor Rodney James McMahon, MBBS (Sydney), Flt Lt (ret), DRCOG, DRANZCOG, IDD (Hons) MMED FAIM, FRACGP, Royal Australian College of General Practitioners nominee (current term: 1.7.2010 – 30.6.2012) [4]

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) [5]

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) [5]

Dr Gregory Joseph Stewart, MBBS, MPH (Sydney), FRACMA, FAFPHM, Ministerial nominee (current term: 1.7.2010 – 30.6.2012) [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) [5]

Dr Choong-Siew Yong, MBBS (Sydney), FRANZCP, Australian Medical Association nominee (current term: 1.7.2010 – 30.6.2012) [6]

Council members generally serve on one or more of the Council's Committees, including the Conduct Committee, Health Committee, Performance Committee, Executive Committee and Corporate Governance and Audit Committee (see table next page).

The 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 performance assessors:

Dr G Abouyanni, Dr K Arnold, Dr K Atkinson, Dr A Bean, Dr M Bennett, Dr R Benson, Dr C Berglund, Dr F Black, Dr P Bland, Dr L Boshell, Dr J Branch, Dr D L Brash, Dr J Brown, Dr P J Burn, Dr G Burton, Dr R Chapman-Konarska, Dr D Child, Dr A Christie, Dr C Clarke, Ms A Collier, Dr J Curotta, Dr G P Curtin, Dr R Davies, Dr V De Carvalho, Ms A Deveson, Dr M Diamond, Dr G Dore, Dr K Edwards, Dr S Ehsman, Ms G Ettinger, Dr R Fisher, Dr R Ford, Dr M Friend, Dr M Giuffrida, Dr A Glass, Dr M Gleeson, Em Prof W Glover, Dr P R Gordon, Dr A Gould, Ms A Gray, Dr R Halliwell, Dr N Harris, Dr J Hawkins, Dr J Hely, Dr M Higgins, Ms J Houen, Dr S Howle, Dr D Hunt, Dr K Hutt, Dr K Ilbery, Mr D Jackett, Dr W Jammal, Dr M Jarrett,

Dr W A C Johnston, Dr G Kaye, Ms M Kelly, Mr R Kelly, Dr J Kendrick, Dr E Kertesz, Ms H Kiel, Dr J King, Dr L King, Dr R King, Prof P Klineberg, Dr E Kok, Dr B Kotze, Dr P Langeluddecke, Prof H Lapsley, Dr V Lele, Dr K Lovric, Dr J Mair, Dr S Mares, Dr M McGlynn, Dr P McInerney, Dr A Meares, Dr S Messner, Dr P Morse, Dr M Mulligan, Dr J Ng, Dr N O'Connor, Dr B Parsonage, Dr H Pedersen, Dr C Peisah, Dr A Pethebridge, Dr J Phillips, Dr T Poon, A/Prof R Rae, Dr S Renwick, Dr J Riley, Ms D Robinson, Dr J Rodney, Dr I Rotenko, Dr J Sammut, Dr A Samuels, Dr P Schofield, Dr D Semmonds, Mr R Smith, Dr R Spark, Dr G Steele, Dr G Stewart, Dr I Stewart, Dr D Storey, Dr E Summers, Dr V Sutton, Dr I Symington, Dr G Tang, Dr S-H Toh, Dr E Tompsett, Dr V Tran, Dr P Truskett, Dr P Tucker, Dr F Varghese, Dr J Vaughan, Dr A Virgona, Ms A Walker, Dr M Walker, A/Prof R Walsh, Dr J Warden, Dr B Westmore, Dr P C Wijeratne, Dr J M Wright, Dr M Wroth, Dr G Yeo.

Health Professional Councils Authority - Senior Officers

Jeanette Evans
Director, Health Professional Councils Authority

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

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

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

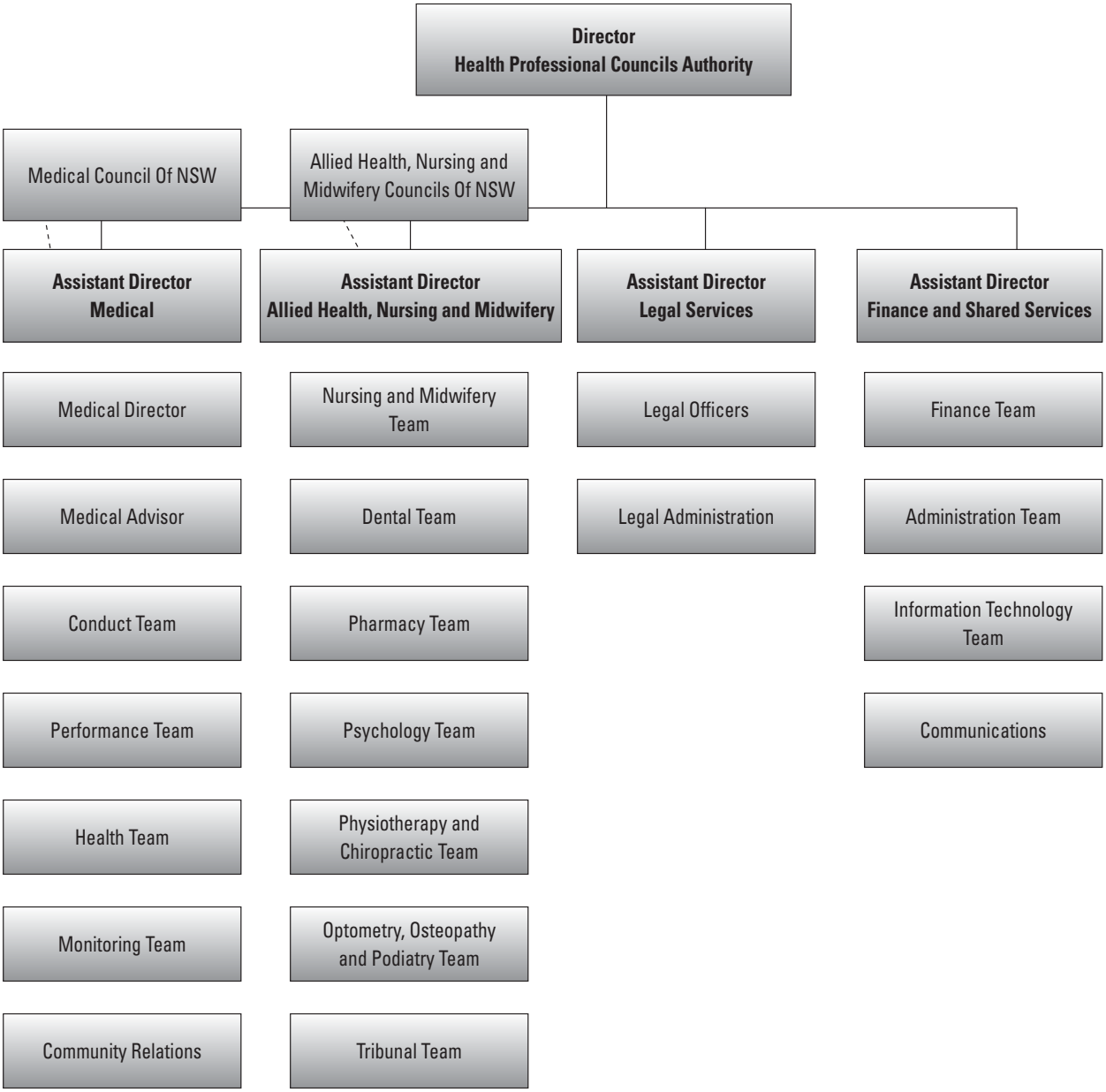
Dr Alison Reid B Med Sc, MBBS (Tas.), MHA, FAFPHM
Medical Director, Health Professional Councils Authority (to 17.12.2010)

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

Medical Council of NSW Committees 2010 - 2011

CONDUCT	HEALTH	PERFORMANCE	EXECUTIVE	CORPORATE GOVERNANCE & AUDIT
Chair	**Chair**	**Chair**	**Chair**	**Chair**
G Kesby	**K Wilhelm**	**G Stewart**	**P Procopis**	**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	D Smith	C-S Yong
R McMahon	R Kusuma	G Kesby	G Stewart	
R Napier	L Poulos	R McMahon	K Wilhelm	
P Procopis	P Procopis	F J Palmer		
D Smith	A Spigelman	P Procopis		
K Sundquist	C-S Yong	K Sundquist		
		C-S Yong		
R Walsh		F Black		
		J Hely		
		E Tompsett		
		R Walsh		

Health Professional Councils Authority Organisation Chart as at June 2011



Management and administration

Shared services of the Health Professional Councils Authority (HPCA) is an administrative unit of the Health Administration Corporation (HAC). It was established on 1 July 2010 to provide 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 it to fulfil its statutory role 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 to meet their legislative and policy requirements as statutory bodies (see organisational chart previous page).

On behalf of the Councils, the HPCA liaises with the Australian Health Practitioner Regulation Agency regarding financial, registration and reporting matters; with the Health Care Complaints Commission on complaints management issues; and with the Department of Health on human resources and providing advice and responses to the Minister for Health and the Director-General on regulatory matters and appointments.

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

> management & **activities**

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

> national registration

This is the first Annual Report of the Medical Council of New South Wales (the Council) which came into existence on 1 July 2010. On 30 June 2010, the NSW Medical Board ceased to exist and responsibility for the registration of medical practitioners passed to the Medical Board of Australia.

The Medical Board of Australia and the nine other National Boards are responsible for registering health practitioners and for deciding the requirements for registration. The National Boards also develop and approve standards, codes and guidelines for their respective health profession and approve accredited programs of study which provide the necessary qualifications for registration in a health profession.

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

The AHPRA was established by virtue of the *Health Practitioner Regulation National Law (NSW)* in NSW. The AHPRA's functions include providing administrative assistance and support to the National Boards, and their Committees, in exercising their functions. In consultation with the National Boards, the AHPRA also develops and administers procedures for the purpose of ensuring the efficient and effective operation of the National Boards.

At 30 June 2011, there were 27,686 registered medical practitioners (excluding students) whose principal place of practice was in NSW. This represents 32% of the total number of medical practitioners registered under the National Registration and Accreditation Scheme across Australia. Data for the current reporting year is supplied by the AHPRA.

> professional **conduct**

2010-2011 **in summary**

- → 1424* complaints were received by the Medical Council of New South Wales (the Council) and the Health Care Complaints Commission (HCCC) in 2010/11.
- → Of the 1407 complaints assessed, 930 (67%) were declined, 90 (6%) were referred for investigation by the HCCC, and 227 (16%) were referred to the Council.
- → More than half (62%) of investigated complaints (55 matters) were then referred to the Director of Proceedings (DP) to determine whether a complaint should be prosecuted before a disciplinary body.
- → During the year, the Medical Tribunal made determinations on complaint matters against 18 practitioners which resulted in four practitioners being de-registered (or an order made that they not be re-registered). Two practitioners were suspended (the first practitioner for one year with additional conditions imposed and the second practitioner for six months who was additionally reprimanded and had conditions imposed). Eight practitioners were reprimanded and had conditions imposed on their registration, two practitioners had conditions imposed only and two practitioners received a reprimand only.
- → 14 Professional Standards Committee (PSC) hearings were finalised during the period, resulting in 11 practitioners having unsatisfactory professional conduct findings made against them. Of these, nine were reprimanded, two were cautioned and one practitioner had conditions imposed without reprimand or caution. In total, 10 practitioners had conditions imposed, two were reprimanded only and in two matters, the Committee found that the conduct did not amount to unsatisfactory professional conduct and no action was taken.
- → 55 urgent Council proceedings to take action to protect the public were held this year, as well as five proceedings to review orders imposed under these provisions. As a result of the urgent proceedings, 15 practitioners were suspended, 28 had conditions imposed on their registration and two practitioners removed their name from the Register or requested to be moved to the non-practising category of registration prior to proceedings being held. Eight matters resulted in no further action being taken. The proceedings to review orders resulted in the conditions being lifted in one matter, one practitioner having registration conditions altered and three practitioners having suspensions affirmed.

Overview

Regulatory proceedings and processes have been conducted this year in accordance with both the *Medical Practice Act* and the *Health Practitioner Regulation National Law (NSW)*. Although the *Medical Practice Act* was repealed from 30 June 2010, there was a tail of matters caught by the transition provisions that were dealt with under the *Medical Practice Act* during the reporting year. The provisions of the *Health Practitioner Regulation National Law (NSW)* that relate to the regulation of medical practitioners are strongly modelled on the *Medical Practice Act* and this has resulted in little change to the way proceedings have been conducted in this reporting year. The biggest change has been the impact for the Council in having to interface with the Australian Health Practitioner Regulation Agency (AHPRA) to ensure the results of proceedings are accurately reflected on the online public Register.

There was a rise in the number of complaints received in 2010/11 (1424) compared to the previous reporting year (1249).

Forty-seven notifications (compared to 13** in 2009/10 and eight in 2008/09) were expressed to have been made in accordance with the mandatory reporting provisions of the *Health Practitioner Regulation National Law (NSW)*, which require any registered health practitioner, employer or education provider to report a colleague, employee or student who appears to have committed reportable misconduct. The *Health Practitioner Regulation National Law (NSW)* requires mandatory notifications to be made to the AHPRA, and, in NSW, the AHPRA forwards these to the Council and the HCCC for appropriate action. No complaint has yet been made that a practitioner who was under an obligation to make such a notification has not done so.

During the year there was an increase in the proportion of matters declined (56% to 67%). Referrals to the Council dropped slightly (17% to 16%), and the proportion of matters referred to the HCCC for investigation also dropped (9% to 6%).

Of the 90 matters investigated (compared with 120 last year), the proportion which resulted in referral to the Director of Proceedings (DP), for her to assess whether disciplinary proceedings were warranted, remained at the same level as recent years (62% in 2009/10 and in 2010/11). Last year, 18 of the investigated matters related to one practitioner.

Of the 90 matters investigated by the HCCC, the proportion referred back to the Council for action, such as disciplinary counselling or consideration in a Health or Performance pathway, rose from 17% last year to 22% this year.

* The Australian Health Practitioner Regulation Agency and National Boards' Annual Report 2010/11 reports the total complaints/notifications received for medical practitioners in NSW as 1455. This has been incorrectly reported and the figure is 1495 (being 1424 complaints and 71 health notifications received in 2010/11).

** Incorrectly reported as 10 in the NSW Medical Board Annual Report 2010

There was a decrease in the number of matters dealt with by the Medical Tribunal. Thirty-two practitioners were the subject of matters referred to the Medical Tribunal (down from 42 in 2009/10), 22 of which were complaints prosecuted by the HCCC. The remainder consisted of appeals and review applications. One of the appeals (subsequently withdrawn) was an appeal against a Medical Board of Australia decision to refuse to register a medical practitioner.

The number of matters where urgent interim suspension or imposition of conditions by the Council was considered to be appropriate under section 150 of the *Health Practitioner Regulation National Law (NSW)* (or section 66 of the *Medical Practice Act*) continued to rise (from 26 in 2007/08, to 40 in 2008/09, 47 in 2009/10 and to 52 this year). The number of urgent interim proceedings held during the year is dependent on the nature and type of matter which comes to the Council's attention from various sources. The number of practitioners suspended this year as a result of these hearings was 15 (19 practitioners were suspended last year). Two practitioners elected to surrender their registration in lieu of attending such proceedings. An additional eight proceedings resulted in no urgent interim action being taken by the Council. Although no urgent interim action was taken, two practitioners were referred to the Performance Program and two continued to be monitored as they were already subject to urgent interim conditions operating from previous proceedings.

The increase in the number of proceedings has had a significant impact on the workload of the Council's Legal, Monitoring and Conduct teams.

In line with legislative requirements, decisions of the Medical Tribunal and PSCs are published in full on the Council's website. The Council also makes available relevant decisions from other courts and tribunals.

A list of de-registered and suspended practitioners was maintained on the former NSW Medical Board's website up until 30 June 2010. From 1 July 2010, a search can be made on the AHPRA website for health practitioners whose registration has been cancelled by an adjudication body under the *Health Practitioner Regulation National Law (NSW)*.

The complaints handling process

See Appendix 18 of this Annual Report for a summary of complaints bodies and processes.

Assessment of complaints

During 2010/11, the Council and the HCCC received 1424 complaints (including notifications from the AHPRA that were deemed to be complaints) about medical practitioners. The Council and the HCCC completed an assessment of 1407 complaints (up from 1279 in the previous year). The most common outcome of assessment was to decline to deal with the complaint (67%), followed by referral to the Medical Council (16%). Six percent were referred to the HCCC for investigation (down from 9% in the previous year).

Both the Council and the HCCC can accept complaints from any source about medical practitioners. Legislation requires the Council and the HCCC to consult on the assessment of each complaint. This consultation occurs weekly. In most cases, prior to the assessment of a complaint, the HCCC prepares an assessment brief, confirming with the complainant the issues to be considered and obtaining the practitioner's response to the complaint.

In general, the HCCC has 60 days from receipt of a complaint to complete the assessment. The HCCC is also required to notify the Council of a complaint as soon as practicable. This allows the Council to review each complaint received and ensure that complaints which appear to warrant urgent interim action to protect the public can be dealt with by the Council under section 150 of the *Health Practitioner Regulation National Law (NSW)*.

At assessment, a complaint may be declined if it falls outside the Council's or HCCC's jurisdiction, does not relate to health care, or does not raise clinical issues of sufficient seriousness. In some instances, a complaint is declined at assessment as the parties have subsequently resolved the matter. This occurred in 3% of complaints declined in the period, down from 8% in the previous year.

The Council considers that a complaint should be referred to the HCCC for disciplinary investigation when 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 Council for consideration through the Performance or Health Programs, or through conciliation or assisted resolution with a complaints resolution officer at the HCCC.

The following table illustrates the trends in complaints assessment for the past three years.

Outcome of complaint assessments (%)

	2008/09	2009/10	2010/11
	n = 1268	n = 1279	n = 1407
Investigation	10	9	6
Refer to the Medical Council	19	17	16
Refer to another person or body	1	1	1
Conciliation	5	4	10
Direct resolution	12	13	n/a
Decline to deal with	53	56	67

The following table shows the types of complaints lodged over the past three years. During this reporting period, complaints concerning clinical competence continued to dominate as the main area of complaint. This category includes allegations about incorrect or inadequate treatment or clinical advice, misdiagnosis and complications following treatment.

Type of complaint (%)

	2008/09	2009/10	2010/11
	n = 1268	n = 1279	n = 1407
Clinical competence	54	57	55
Communication	18	15	15
Conduct	24	23	23
Practice administration	4	5	7

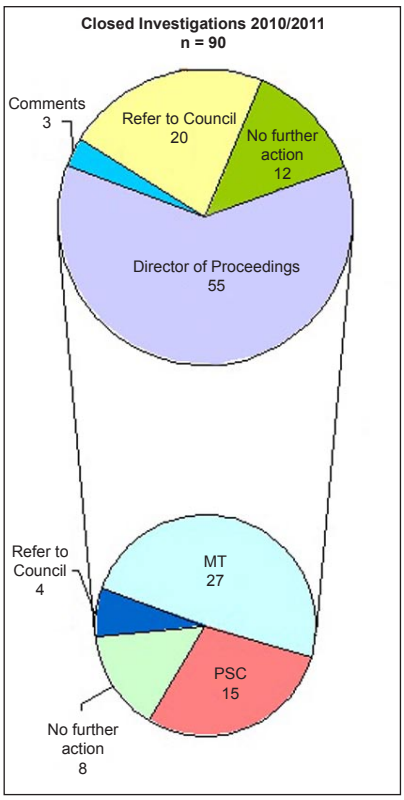
Complaints investigated by the Health Care Complaints Commission (HCCC)

During the year, 90 complaints were referred to the HCCC for investigation, compared to 120 in the previous year. These complaints were referred on the basis that they appeared to the Council or the HCCC, at the time of assessment, to raise a significant issue of public health or safety or provide grounds for disciplinary action against a practitioner. In this period, 90 investigations were finalised, compared to 143 in the previous reporting year. Outcomes of the investigations during the year included:

- 12 cases (13%) were terminated and no further action was taken against the practitioner (down slightly from 14% last year);
- 3 cases (3%) required comments to be made in the form of a letter from the HCCC to the practitioner (down from 7% last year);
- 20 cases (22%) referred the practitioner to the Council for it to take appropriate action, up from 17% last year. Such action may include disciplinary counselling in the form of a letter or interview or referral of the matter for consideration of a Health or Performance pathway;
- 55 cases (62%) were referred to the DP to determine whether a complaint ought to be prosecuted before a disciplinary body, either a PSC or the Medical Tribunal (the same proportion as last year).

The HCCC is required to consult with the Council before deciding what action to take following the completion of an investigation, although the final decision on the outcome rests with the HCCC.

The following chart illustrates investigation outcomes for the reporting period and the outcome of matters referred to the DP.



Complaints referred to the DP

During the reporting year, 55 finalised investigations (62%) led to a referral to the DP. Upon referral of a matter, the DP is required to determine whether a matter should be prosecuted before a disciplinary body. The DP is required to consult with the Council, but the final determination rests with the DP.

In 2010/11, the DP referred 27 cases concerning 22 practitioners to the Medical Tribunal (down from 28 practitioners last year) and 16 cases concerning 15 practitioners to a PSC (down from 19 last year).

Of the matters the DP determined not to prosecute, no further action was taken in relation to eight practitioners (as the practitioners were no longer registered or de-registered by the Medical Tribunal) and four practitioners were referred back to the Council. The Council directed three of these practitioners to attend counselling and one practitioner was referred to the Health Program.

Complaints remaining under investigation

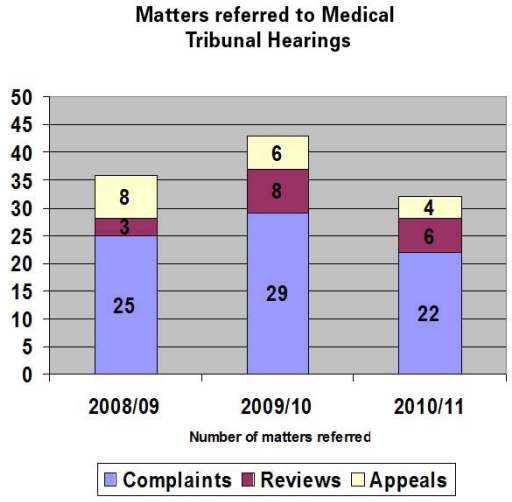
At 30 June 2011, the HCCC reported that 92 practitioners were currently under investigation (down from 112 in the previous year) and 52 matters were with the DP for consideration of possible disciplinary action (up from 38).

Disciplinary hearings

Referral to the Medical Tribunal

In addition to the complaint matters against 22 practitioners referred by the DP, four appeals and six review applications were also referred to the Medical Tribunal. Two of the appeals and two of the review applications were later withdrawn by the appellant/applicant prior to the hearing. The Council made no direct referrals pursuant to section 150(3)(b) of the *Health Practitioner Regulation National Law (NSW)* (which requires the Council to refer any contravention of critical compliance orders on a doctor's registration) this reporting year.

One of the appeals referred to the Medical Tribunal (and then withdrawn) was an appeal against a decision made by the Medical Board of Australia to refuse to register a medical practitioner. Such appeals replace those previously lodged against registration decisions made by the NSW Medical Board. Although the Medical Board of Australia will now be the respondent in registration appeals, the Council has a responsibility for referring these appeals and for appointing the Medical Tribunal hearing members.



Matters commenced in the Medical Tribunal 2010/11

In the year under review, 21 matters (including complaints, appeals, restorations and review applications) were commenced in the Medical Tribunal. This compares with 42 in 2009/10, and 33 matters in 2008/09.

The following table profiles the types of matters commenced in the Tribunal in the last three years.

Matters commenced in the Tribunal

	2008/09	2009/10	2010/11
Complaints			
Boundary Crossing	5	8	8
Prescribing	7	8	5
Breach Conditions	2	4	0
Treatment	1	3	3
Competence/impairment	0	0	0
Fraud	1	2	0
Hygiene	0	1	0
Criminal matter	3	0	0
Section 65 referral (MPA)	2	1	0
Section 149D referral (HPRNL)			
Section 63 recommendation (MPA)	1	0	0
Section 146D recommendation (HPRNL)			
Section 66(2)(b) referrals (MPA)	0	1	0
Section 150(2)(b) referral (HPRNL)			
Appeals			
PSC	1	1	0
Registration	4	4	1
Conditions/suspension	2	1	0
PRP	0	0	0
Board/Council decision	1	0	0
Restorations	3	3	2
Review of conditions	0	5	2
Total matters commenced in the Medical Tribunal	**33**	**42**	**21**

Note: MPA – *Medical Practice Act*
HPRNL – *Health Practitioner Regulation National Law (NSW)*

Matters finalised in the Medical Tribunal

The Medical Tribunal determined matters in the following categories:

	2008/09	2009/10
Complaints	19	18
Section 66(2)(b) referral / section 150(2)(b)	1	0
Appeals	7	1
Reviews	4	5
Total	31	24*

* An additional six matters were lodged with the Tribunal (four appeals and two reviews) however these were withdrawn and did not proceed.

Medical Tribunal matters outstanding

As at 30 June 2011, 39 matters referred to, or lodged in, the Medical Tribunal in this or previous years await determination. This is the same number outstanding as last year, year ending 30 June 2010, while there were 31 outstanding matters in the year ended 30 June 2009.

Complaints

Heard/part-heard

As at 30 June 2011, two matters have been heard and are awaiting judgment.

Listed for hearing and to be listed for hearing

As at 30 June 2011, 10 matters have been listed for hearing and 23 are yet to be listed for hearing.

Appeals

As at 30 June 2011, there are three appeals outstanding in the Medical Tribunal. Of these, two are awaiting hearing dates and one appeal has been stood over generally.

Reviews

As at 30 June 2011, one application for review of a de-registration order or the imposition of conditions has been lodged in the Medical Tribunal and remains outstanding. It is yet to be listed for hearing.

The Medical Tribunal decisions listed in the following table are published in full on the Council's website (subject to any relevant non-publication directions or orders not to publish that are made by the Medical Tribunal) at www.mcnsw.org.au . A practitioner's current registration status is available by searching the on-line Public Register on the AHPRA's website at www.ahpra.gov.au . A search of the AHPRA website can also be made for the details of cancelled health practitioners, that is practitioners whose registration has been cancelled by order of an adjudication body under the *Health Practitioner Regulation National Law (NSW)*.

Medical Tribunal decisions 2010/11

Judgment date	Practitioner	Tribunal Outcome
COMPLAINTS PROSECUTED BY THE HEALTH CARE COMPLAINTS COMMISSION		
02/07/2010	Richard Arthur Allen	Reprimanded
27/08/2010	Yolande Lucire	Conditions imposed
30/09/2010	Gordon Christopher Howe	Conditions imposed
07/10/2010	Gopal Chandra Mukherjee	Not to be re-registered for two years
15/10/2010	Ray Woods	Reprimanded and conditions imposed
20/10/2010	Swapan Chowdhury	Reprimanded and conditions imposed
02/11/2010	Satya Pal Bhatia	Reprimanded. Now non-practising
30/11/2010	Robert Leslie Sims	Not to be re-registered for one year
07/12/2010	Bao-Quy Nguyen-Phuoc	Reprimanded and conditions imposed
14/12/2010	John Gerard Holmes	Suspended for one year and conditions imposed
15/12/2010	Chi-Quan Benjamin Ly	Reprimanded and conditions imposed
17/12/2010	Timothy Tristan Tang-Tat Wong	Not to be re-registered for two years
15/02/2011	Basavaraj Vastrad	Reprimanded and orders
24/02/2011	Elizabeth Mary Millard	Suspended for six months, reprimanded and conditions imposed
30/03/2011	Joseph Patrick Nicholas	Reprimanded and conditions imposed
15/04/2011	Kinga Maria Gorondy-Novak	Reprimanded and conditions imposed
21/04/2011	Stamatios Ktenas	Reprimanded and conditions imposed
05/05/2011	Victor King	De-registered. Not to apply for review for 18 months (Decision under appeal)
APPEALS*		
19/10/2010	A Practitioner (name suppressed)	Appeal partially successful. Conditions altered.

* Three further appeals, two lodged prior to 1 July 2010 and one in this period, were withdrawn during the period and did not proceed.
An additional appeal was lodged concerning a decision by the Medical Board of Australia, but this appeal was also withdrawn and did not proceed.

REVIEW APPLICATIONS FOR RESTORATION TO THE REGISTER*		
15/10/2010	Jason Jefferson Martin	Restored with conditions
25/03/2011	Enn Vilo	Application dismissed
16/05/2011	Naresh Parajuli	Restored with conditions

* Two further Review applications for Restoration to the Register were lodged, but withdrawn and did not proceed.

APPLICATIONS FOR REVIEW OF CONDITIONS		
28/02/2011	Ghee Hong Michael Tan	Application successful. Conditions lifted
14/03/2011	Vipal Kumar Mehta	Application successful. Conditions lifted

Sample Medical Tribunal decisions

Readers can use the web links provided to read the full Medical Tribunal decisions related to these case summaries.

Relationship with patient

Patient A consulted the general practitioner from mid 1991 until late 2006 and then on four occasions in late 2008 and early 2009. In late 1998, after undertaking a pap smear in his rooms, the practitioner had sexual intercourse with Patient A. From late 1998 until early 2008, the practitioner engaged in an inappropriate personal and sexual relationship with Patient A when a regular and continuous therapeutic relationship existed for most of that period.

The practitioner admitted the particulars of the complaint and that he had engaged in unsatisfactory professional conduct which amounted to professional misconduct. The Medical Tribunal found the practitioner's conduct constituted professional misconduct within the meaning of section 37 of the *Medical Practice Act*. He was suspended for 12 months and had Practice and Health Conditions imposed on his registration.
Read more.

Inappropriate prescribing and record keeping plus breach of registration conditions

In 2006, the practitioner admitted to prescribing Schedule 8 and Schedule 4D medications in large quantities on demand, including to patients who were on the methadone program. The Council imposed urgent interim conditions on his registration to protect the public. These prohibited him from possessing, supplying, administering or prescribing Schedule 8 and Schedule 4D medications. When the practitioner subsequently breached these conditions, the Council suspended his registration, again as an urgent interim measure.

In 2010, the HCCC prosecuted a complaint in the Medical Tribunal in relation to the practitioner's:

- → Conviction in 2007 for 63 counts of making false or misleading statements in court proceedings in relation to fraudulent claims against Medicare Australia for services he had not provided;
- → Prescribing which demonstrated that his practice of medicine was significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience, and was improper or unethical;
- → Inadequate record keeping in contravention of both the Medical Practice Regulation and the Poisons and Therapeutic Goods Regulation;
- → Breach of conditions.

The practitioner admitted all the particulars of the complaints and that his conduct amounted to professional misconduct. The Medical Tribunal noted that the practitioner's conduct included multiple breaches of his conditions, despite the intervention from the NSW Medical Board on a number of occasions and his entry into the Impaired Registrants Program in 2008. The Medical Tribunal found that the practitioner either could not or would not comply with his conditions over an extended period of time. The practitioner was deregistered and ordered not to apply for re-registration for two years from October 2010.
Read more.

Referral to a Professional Standards Committee (PSC)

In total, the DP referred 16 matters to a PSC and 14 PSC Inquiries were held in relation to matters referred in this or the preceding year. PSC Inquiries are open to the public at the premises of the Institute of Arbitrators & Mediators Australia at Level 9, 52 Phillip Street, Sydney. Details of impending public Inquiries are published on the Council's website.

Due to the legislative change in November 2009, which entitled the parties to a PSC Inquiry to be legally represented (previously parties were entitled to be assisted but not represented), legal representation has now become the norm.

Fourteen PSC Inquiries were finalised during the reporting year, resulting in 11 practitioners having unsatisfactory professional conduct findings made against them. One matter was withdrawn and in two matters, no orders were made because it was found that the complaint did not amount to unsatisfactory professional conduct.

The PSC decisions listed in the table on the following page are published in full on the Council's website (subject to any relevant non-publication directions or orders not to publish made by the PSC) at www.mcnsw.org.au.
Prior to changes in the legislation in 2008 which resulted in public PSC hearings and publication of PSC decisions, such decisions were confidential.

PSC decisions 2010/11

Decision date	Practitioner	Outcome
01/07/2010	Dr D	No further action
13/07/2010	Dr Geoffrey Laurence Brooke-Cowden	No further action
21/09/2010	Dr Paramalingam Lingathas	Reprimanded. Conditions imposed
18/10/2010	Dr Kurt Kaiser	Reprimanded. Conditions imposed
21/10/2010	Dr Sergio Staraj	Reprimanded
28/10/2010	Dr Michael Gerd Hugo Wiegand	Reprimanded. Conditions imposed
23/11/2010	Dr Dror Schmuelly	Cautioned. Conditions imposed
29/11/2010	Dr Ricardo Al Khouri	Cautioned. Conditions imposed
24/12/2010	Dr Surendranath Vithalrao Rananavare	Reprimanded. Conditions imposed
25/01/2011	Dr Satya Dev Atreya	Reprimanded. Conditions imposed
04/04/2011	Dr Biing-Lin Yin	Reprimanded
28/04/2011	Dr Michael John Forster Hunter	Reprimanded. Conditions imposed
13/05/2011	Dr Glenn Allan Taylor	Reprimanded. Conditions imposed
25/05/2011	Dr Geoffrey Robert Tyler	Conditions imposed

Referral to a counselling interview

During the year, 26 practitioners were referred to the Council for counselling (24 in 2009/10) and 30 practitioners, whose matters were referred to the Council in either this or the previous period, were counselled. A referral to counselling occurs on the basis that a practitioner's apparent departure from acceptable standards is not considered so significant as to warrant referral to the DP, but it still raises concerns that need to be addressed. Counselling provides an opportunity for a practitioner to reflect upon the issues raised within the context of their practice and to critically examine suggestions for improvements to their practice. The Council also invited three practitioners to attend the Council for an interview to discuss concerns that had come to the Council's attention.

Section 150 proceedings – Urgent action to protect the public

The Council must exercise its powers to either suspend a practitioner's registration or to impose conditions upon the practitioner's registration where it is satisfied that such action is appropriate for the protection of the public's health or safety or is otherwise in the public interest. Such action is an interim measure only. Where the Council takes action under section 150 of the *Health Practitioner Regulation National Law (NSW)*, the matter must be referred to the HCCC for investigation (except in cases of impairment). The HCCC is to investigate the matter and, if it is appropriate to do so, refer a complaint to a Professional Standards Committee, Medical Tribunal or consult with the Council to refer the practitioner to an Impaired Registrants Panel. Section 150 proceedings are the equivalent of section 66 proceedings under the repealed *Medical Practice Act*.

There were 55 practitioners referred to section 150 proceedings during the reporting period and two of these practitioners were referred to two separate section 150 proceedings in that time. The Council conducted eight section 66 proceedings (in addition to three review of orders proceedings) during the year under the *Medical Practice Act*. The Council also conducted 47 section 150 proceedings and two reviews of orders proceedings, under the *Health Practitioner Regulation National Law (NSW)*. This compared with 47 proceedings (and seven reviews) during the previous reporting year. Fifteen practitioners were suspended during this reporting period as a result of the Council exercising its powers under section 150. Twenty-eight medical practitioners had conditions imposed on their registration. Two practitioners voluntarily requested to be moved to the non-practising category. Eight matters did not require urgent interim action.

Of these eight, three continued with conditions that were already operating and two were referred to the Performance Committee. During this reporting period, three practitioners requested a review of an order made under section 66 and two under section 150. Of these, three practitioners had their application dismissed and suspensions affirmed, one had conditions removed and one practitioner's conditions were altered.

The Council exercises the section 150 power under the *Health Practitioner Regulation National Law (NSW)* in a variety of circumstances, including where a practitioner:

- has been charged with serious criminal matters (particularly if arising within the practice of medicine);
- suffers from a serious impairment and demonstrates little or no insight into the extent of the problem and the risk posed to the public;
- has continued to recklessly prescribe drugs in a manner which is dangerous and is likely to cause harm, despite previous warnings or counselling;
- has breached conditions imposed on his/her registration.

Disciplinary hearings snapshot

Medical Tribunal matters and outcomes

Eighteen complaints were determined by the Medical Tribunal in 2010/11 and related to issues of boundary crossing, prescribing, treatment, breach of conditions and fraud. These Medical Tribunals resulted in four practitioners being de-registered (or an order made that they not be re-registered). Two practitioners were suspended (the first for one year with additional conditions imposed and the second for six months who was additionally reprimanded and had conditions imposed). Eight practitioners were reprimanded and had conditions imposed on their registration, two practitioners had conditions imposed only and two practitioners received a reprimand only. Copies of the Medical Tribunal decisions are available on the Council's website www.mcnsw.org.au

Professional Standards Committee matters and outcomes

Fifteen practitioners were referred to a PSC during 2010/11 and 14 hearings were held (including those referred from the previous year). One matter was referred and subsequently withdrawn. The PSC Inquiries related to patient management, prescribing, diagnosis and treatment, clinical error, competence, record keeping, impairment and boundary crossing. Twelve practitioners had unsatisfactory professional conduct findings made against them, of whom seven were also reprimanded and had registration conditions imposed. One practitioner who had a finding of unsatisfactory professional conduct was cautioned. In two matters the complaint was dismissed or no orders were made. Copies of the PSC decisions are available on the Council's website www.mcnsw.org.au

Section 150 proceedings and outcomes

Fifty-five practitioners were referred to section 150 proceedings under the *Health Practitioner Regulation National Law (NSW)*. The Council conducted 60 urgent interim proceedings in total: eight section 66 proceedings and three reviews of orders imposed under section 66 (of the *Medical Practice Act*); and 47 section 150 proceedings as well as two reviews of orders imposed under section 150 of the *Health Practitioner Regulation National Law (NSW)* during the year. Proceedings related to issues of prescribing, drug use, boundary crossing, criminal charges and convictions, impairment, capacity to practise, treatment, and breach of conditions. Fifteen practitioners were suspended, 28 had conditions imposed on their registration, one was referred for a performance assessment and eight matters resulted in no urgent action being taken. Three section 150 proceedings were not finalised during the reporting period. Two practitioners who would otherwise have been the subject of section 150 proceedings surrendered their registration or requested to be moved to the non-practising category of registration.

> health

2010-2011 **in summary**

- → 71 notifications were made to the Health Program, compared with 57 and 79 notifications in the previous two reporting years.
- → 30% of notifications were made by colleagues, 23% were self-notified, and 28% were made by treating practitioners or as a result of a hospital admission. Nineteen per cent came from other sources.
- → 46 Impaired Registrants Panels were convened and related to psychiatric illness (67%), drug addiction (13%), alcohol addiction (17%) and cognitive problems (3%).
- → There were 111 participants in the Program and 16 practitioners exited the Program in the reporting year.
- → Ethyl Glucuronide (EtG) testing was introduced to monitor abstinence from alcohol.
- → The Health Program Handbook was significantly updated.

Overview

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

The Health Program had been operating under the provisions of the *Medical Practice Act* since 1992 and transferred to the *Health Practitioner Regulation National Law (NSW)* on 1 July 2010. It is the longest established health program in Australia. Since its inception, more than 235 practitioners have successfully exited the Program, having fulfilled the Council's monitoring requirements.

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 Council becomes aware of impaired practitioners through notifications and self-notifications as well as through its dealings with practitioners in its Performance and Conduct Sections.

The reporting year has seen an increase in the number of mandatory reports concerning impaired practitioners. 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 has been reinforced under the new *Health Practitioner Regulation National Law (NSW).* An additional requirement introduced under 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 Council, there is a profound professional and ethical obligation to do so.

The average age of impaired practitioners at the time of notification to the Council is 42 years. Almost 90% of Health Program participants remain in practice and, if it is assumed that they continue to practise until they are 60 years old, program participants can be expected to contribute a total of more than 8000 working years to the medical workforce after the notification to the Council. In the absence of the Health Program, many of these working years would have been lost to the community.

An overview of the activities of the Health Committee is as follows:

		2008/09	2009/10	2010/11
Notifications to Health Program		79	57	71
Impaired Registrants Panel reports endorsed:	Psychiatric Illness	37	33	31
	Alcohol	7	2	8
	Drug	15	8	6
	Physical	2	0	0
	Cognitive	Not Reported	Not Reported	1
	Total	**61**	**43**	**46**
Review Interviews held		276	263	242
Exits from the Program		17	17	16
Participants in Program as at 30 June		146	122	111

Notifications

Notifications by source	**2008/09**	**2009/10**	**2010/11**
	n=79	n=57	n=71
Colleagues (including employers)	16	10	21
Self-notifications	30	25	16
University	2	1	4
Council Committee	2	1	4
Treating practitioner/hospital admission	13	15	20
Other	16	5	6
Total	**79**	**57**	**71**

While self-notifications have previously been the largest source of notifications to the Health Program, currently the largest source is colleagues, including employers. This may be a reflection of mandatory reporting requirements introduced in 2008.

Cross-referral from other Council Committees indicates an increasing awareness that underlying health problems may be manifested as unsatisfactory professional performance or unsatisfactory professional conduct.

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 Council. The Health Committee will then review this report and decide whether to convene an Impaired Registrants Panel (IRP).

In the 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 remain in safe practice. This year, 29 practitioners entered the program with 63% of IRPs concluding with the practitioner agreeing to conditions being placed on his or her registration. Seven per cent of IRPs resulted in no further action being taken, 26% were adjourned, and in 4%, other action was taken. There are a range of reasons for an IRP being adjourned, including to seek further information or to allow the practitioner to seek further treatment or support, particularly if they are very unwell at the time of the initial IRP.

Under the provisions of the *Health Practitioner Regulation National Law (NSW)*, the AHPRA is required to notify the 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 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 drugs or alcohol can expect to be monitored by the Council for a minimum of three years. Practitioners with 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 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 Council with useful feedback about the administration of the Program.

In the year ending 30 June 2011, a total of 16 practitioners exited the Health Program. These practitioners all had their conditions lifted and returned to full registration. The 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 unconditionally. 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%.

Chronic Relapsing Illness Authorisation

In the previous reporting year, the Health Committee introduced a process which enables it to exit practitioners with chronic relapsing illnesses, such as Bipolar Disorder and Eating Disorders, from the Health Program with confidence that the 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. In the current reporting year, this process was extended to allow some practitioners to be subject to a Chronic Relapsing Illness Authorisation rather than enter the Health Program. In these cases, the practitioner would be assessed by a Council-appointed practitioner but not necessarily attend an IRP or enter the Health Program.

A practitioner is asked to complete an authority allowing treating practitioners to advise the 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 Council of any change in treating practitioners.

There are currently over 50 practitioners subject to a Chronic Relapsing Illness Authorisation.

The Health Committee has found this to be an extremely valuable tool, and participants welcome the opportunity to return to unconditional registration, or to enter the Health Program. In the reporting year, one practitioner has returned to the Health Program as a direct result of authorising his treating practitioner to contact the Council.

Health Program Handbook

During the reporting year, the Health Program Handbook was substantially revised and updated to reflect changes to the legislation and the Program. The Handbook provides information about the Program and is designed to assist participants during their involvement with the Council. A new section has been included which provides a range of resources and reading material on mental health and other health and career-related references.

Ethyl Glucuronide (EtG) testing

During the reporting year, the Health Committee introduced Ethyl Glucuronide (EtG) testing to monitor abstinence from alcohol. EtG is a biomarker test that detects the presence of ethyl glucuronide in urine samples and is used to monitor alcohol consumption in practitioners who are prohibited from drinking alcohol by way of a condition on their registration.

Medical students

The impairment provisions of the *Health Practitioner Regulation National Law (NSW)* also apply to medical students. The primary objective of the Program as it applies to medical students is public protection. A clear secondary objective is ensuring that the student's transition into the medical workforce is assisted and supported.

Early notification is seen as essential in supporting the impaired student, and planning his or her transition to internship.

There were eight medical students notified to the Council during 2010/11. Four of these notifications were made by universities, and three as a result of hospital admissions. There were no self-notifications in the reporting period.

As at 30 June 2011, there were three interns and two medical students involved in the Health Program. Two of these interns were notified to the Council after they commenced their internship.

Conclusion

The strengths of the Council's Health Program include:

- → its focus on regulation 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 nature;
- → its cautious, long term monitoring of impaired practitioners;
- → its flexible integration with all other Council activities such that every decision about a practitioner is made in full knowledge of their health status.

> performance

2010-2011 **in summary**

- → The Health Care Complaints Commission (HCCC) referred 208 complaints to the Medical Council of New South Wales (the Council) as performance matters.
- → 61 complaints were referred for a Performance Interview compared to 57 in the previous year, reflecting the increasing trend to use an interview as an alternative to Performance Assessment or as an intermediate step in decisions to conduct an assessment.
- → 26 Performance Assessments were conducted as well as two Re-Assessments.
- → 11 Performance Review Panels were held.

Overview

The Council aims to ensure that medical practitioners are fit to practise, and its Performance Program, introduced in NSW in October 2000 (the first in Australia), is central to this aim. The Program complements the Council's Conduct and Health pathways by providing a means of dealing with medical practitioners who are neither impaired nor have engaged in professional misconduct, but for whom the Council has concerns about the standard of their clinical performance.

The Program ensures education and retraining where inadequacies are identified, with public protection paramount at all times. A Performance Assessment (PA) is broad-based and is not limited to the particulars of the matter that triggered the assessment. The assessment is conducted in the medical practitioner's practice and the contribution of system issues to his/her performance difficulties can also be considered.

The professional performance of a registered medical practitioner is defined to be unsatisfactory if it is below the standard reasonably expected of a practitioner of an equivalent level of training or experience. In addition, the Medical Board of Australia's "Good Medical Practice: A Code of Conduct for Doctors in Australia" sets out relevant expectations of registered medical practitioners in its document.

Many factors influence a medical practitioner's performance. Once poor performance has been identified, the Council may implement a range of means to support improvement, including education and mentoring, as well as public protection measures, such as supervision and limits on practice.

Program activity

There were a total of 31 new entrants to the Performance Program in the current reporting year.

An overview of the Performance Program activity in 2010/11 compared with previous years follows.

Complaints

Under the co-regulatory model, the Council and the HCCC are required to consult on the action to be taken in regard to complaints received by either body or referred by the Australian Health Practitioner Regulation Agency (AHPRA). This has been upheld with the implementation of the *Health Practitioner Regulation National Law (NSW)*. In 2010/11, 208 complaints were referred to the Council from the HCCC as performance matters.

Outcomes of complaints

The Performance Program provides a timely mechanism by which complaints can be managed and resolved with an appropriate intervention. The Council may consider a range of actions in response to performance matters that come to the Council's attention. In 2010/11, 182 complaints were considered by the Council.

The following table reports the outcomes of complaints referred to the Council by the HCCC:

Outcome of complaints referred to the Council by the HCCC

	2008/09	2009/10	2010/11
No further action	99	73	63
Letter of apology to patient	11	9	2
Board/Council letter	34	42	42
Performance Interview	54	57	61
Performance Assessment	13	8	5
Section 140B/Section 40P – consent to conditions	1	0	0
Section 66/Section 150 proceedings	0	0	2
Refer to Health Committee	2	0	0
Refer to Conduct Committee	1	1	4
Refer to HCCC for investigation	4	0	0
HCCC for resolution/conciliation	4	4	3
Total	**223**	**194**	**182**

Of the 32 Performance Interviews concluded in the year, 14 resulted in no further action, as the Council was satisfied that the issues of concern had been adequately addressed in the interview. A further 15 resulted in Performance Assessments and three were referred to the disciplinary pathway.

Performance Assessments

Performance Assessment (PA) is one of the approaches that the Council may take in response to a concern about a practitioner's performance. In a small number of cases (five in 2010/11), the decision to hold a Performance Assessment is based on the triggering complaint alone. In the majority of cases, the practitioner has attended a Performance Interview or is involved in another Council process prior to referral to a PA.

The following table reports the source of matters considered for PA.

Source of matters referred for Performance Assessment

	2008/09	2009/10	2010/11
Council Committee (Health, Conduct)	5	6	9
Referred because of an imposed condition	4	2	5
Complaint originating from:			
i. Patient or relative of patient	10	22	13
ii. Employer	1	2	3
iii. Colleague	6	3	4
iv. Other	2	2	1
Total	**28**	**37**	**35**

The following table reports the professional background of medical practitioners considered for PA. As expected, general practitioners make up the majority, reflecting their proportionate number in the medical workforce.

Practice area of medical practitioners referred for Performance Assessment

	2008/09	2009/10	2010/11
Anaesthetist	1	1	0
Cosmetic proceduralist	n/a	2	0
General practitioner	14	20	27
Hospital Non-Specialist	n/a	n/a	3
Obstetrician & gynaecologist	2	4	2
Ophthalmologist	1	0	0
Physician	1	2	1
Psychiatrist	4	1	0
Surgeon	5	6	2
Total	**28**	**36**	**35**

Performance Assessments conducted

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

Once the report of a PA is received, a number of options are available to the Performance Committee. When the 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 and advise the practitioner during the assessment. More formal counselling can occur when there are more significant performance issues that do not require the Council to order remediation, but that need to be drawn to the practitioner's attention. If remediation is required, or if there are issues of public protection, then a Performance Review Panel is convened.

In 2010/11, 25 PAs commenced, 26 PAs were finalised (concluded), and two practitioners retired or changed to non-practising registration prior to an assessment being undertaken. The following table summarises the outcomes of the finalised and cancelled assessments.

Performance Assessment outcomes

	2008/09	2009/10	2010/11
Retired or non-practising before having PA	3	3	2
Section 66/section 150	2	1	4
No further action	5	7	4
Counselling	0	2	3
Consent to conditions under section 140B/section 41P	1	1	3
Performance Review Panel	11	9	12
Total	**22**	**23**	**28**

Performance Review Panels

A Performance Review Panel (PRP) is convened if the PA concludes that the practitioner's professional performance is unsatisfactory and orders requiring remediation are likely. The practitioner concerned has an opportunity to respond to the assessment findings and make submissions about any likely orders. In circumstances in which there is ongoing concern, the Panel may impose conditions on a practitioner's registration. Conditions may relate to remediation or public protection or both.

Remediation orders may include the practitioner's attendance at courses, spending time observing another medical practitioner or engaging in additional Continuing Professional Development activities.

Orders imposed for public protection may include limitation of the scope of practice or a requirement for supervision.

The following table reports the outcomes of PRPs held and completed during the reporting period.

Performance Review Panel (PRP) outcomes

		2008/09	2009/10	2010/11
PRP completed		11	10	11
Outcome:	no orders	0	1	1
	remediation orders	7	3	4
	protective orders	11	9	7

On one occasion, both in this reporting year and the previous year, a medical practitioner was able to demonstrate that conditions did not need to be imposed as the practitioner has rectified the deficiencies identified following the PA.

Conditions may be removed after the practitioner has satisfactorily completed any remediation or has been re-assessed. The performance of two practitioners was re-assessed in 2010/11.

Conclusion

The range of options that is available to the Performance Committee in response to a complaint or notification reflects the spectrum of performance difficulties that present to the Council. The increasing use of the Performance pathway is an indication of its success and points to a significant shift in the balance of non-disciplinary and disciplinary approaches to matters that come to the Council's attention.

The strengths of the Council's Performance Program include:

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

As the initiator of Performance Assessment in Australia and an acknowledged international leader in this field, the Council remains committed to continuing this innovative and effective program and seeks to build upon its strengths and integrity.

> monitoring

2010-2011 **in summary**

- → The compliance of 232 medical practitioners with conditions on their registration was under active monitoring by the Medical Council of New South Wales (the Council) as at 30 June 2011.
- → 57 new cases were referred to the Council's Monitoring Section during the year and 73 became inactive during the year.
- → Of the latter 73 cases, 17 were transferred to other States, eight were suspended or de-registered, 12 either failed to renew or changed their registration to non-practising, and 36 completed all conditions satisfactorily.

The Council's Monitoring Program is responsible for the monitoring of compliance with all Practice Conditions resulting from an outcome of the Performance, Conduct or Health pathways.

Monitoring of compliance with Health Conditions on a practitioner's registration, except for any drug testing and alcohol testing requirements, is the responsibility of the Health Program Section and is undertaken primarily through the practitioner's regular assessment by Council appointed practitioners and attendance at Council Review Interviews.

The monitoring process

For each new Monitoring Program case, the responsible Program Officer makes initial contact with the practitioner to detail and clarify all compliance requirements. An action schedule covering all active conditions is then established and regularly updated. Subsequent monitoring activity includes:

- → the 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 (27 in this reporting year) and referral of audit reports to the responsible Committee;
- → where applicable, requests for and review of data from Medicare Australia or from NSW Health Pharmaceutical Services to check on the practitioner's prescribing or patient consultation restrictions;
- → preparing submissions for the appropriate Committee agenda on questions of satisfactory compliance with a condition, variation or removal of a condition, or breach of a condition;
- → follow up on Committee resolutions which may range from removal of all conditions to the lodging of a complaint with the Health Care Complaints Commission (HCCC);
- → liaison with the HCCC on cases where conditions are in effect while a complaint is under investigation and providing periodic updates on the practitioner's compliance history;
- → maintenance of ongoing contact with the practitioner and on occasion with third parties such as an employer or a 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. Others 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. Hearing members responsible for the drafting of conditions are encouraged to discuss the monitorability of conditions proposed, as the chosen wording can have considerable impact 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 that regard.

System enhancements

During this reporting year, the Program welcomed the implementation of new capabilities built into the Monitoring Management Module within the Council's database of registrants. The developments include an electronic check of Medicare data and comprehensive data recording, including custodian details (supervisors, mentors, notifiers and assessors) and employment locations in respect of all practitioners with conditions requiring approvals by the Council.

Drug and alcohol testing

Throughout the reporting year, the Program has continued to receive and record urine drug testing (UDT) results through the automated electronic system link between PaLMS Toxicology Unit and the Council's database, a highly successful innovation first introduced in 2009/2010. Blood alcohol testing (CDT) results continue to be received and recorded manually. In the current reporting year a new alcohol testing regime based on urine samples, Ethyl Glucuronide (EtG), was offered by Concord Hospital and accepted by the Council for use in conjunction with conditions requiring total alcohol abstinence. The CDT testing remains for cases of limited alcohol consumption.

Critical compliance conditions

Critical compliance provisions, whereby a practitioner faces suspension as an immediate consequence of non-compliance with a condition so designated, were first introduced into the *Medical Practice Act* in 2008 and have been mirrored in the *Health Practitioner Regulation National Law (NSW)*. At the beginning of the reporting year there were two active cases subject to critical compliance conditions. A third practitioner, de-registered by the Medical Tribunal during the previous year for failure to comply, had his registration (including his critical compliance conditions) restored by the Tribunal in October 2010 and in June 2011. A fourth practitioner became subject to a critical compliance condition, one of several conditions imposed by a Professional Standards Committee decision. That practitioner subsequently moved to non-practising registration. As of 30 June 2011, the Monitoring Program was dealing with a total of three practitioners with active critical compliance conditions on their registration. The mandatory nature of such conditions as well as the consequence of a breach is routinely explained in detail to the medical practitioner.

In summary

As at 30 June 2011, there was a total of 232 cases under active monitoring by the Program, a net decrease of 16 in the total as at 30 June 2010. The totals according to sole or primary source of conditions are as follows:

Sole or primary source of conditions	New cases in 2010-11	New cases in 2009-10	Total active cases 2010-11	Total active cases 2009-10
Health Program	**19**	35*	**97**	102
Performance Program	**4**	8	**19**	20
Conduct Program	**34**	40*	**116**	126
Total	**57**	**83**	**232**	**248**

*Incorrectly reported as 30 new cases (from Health) and 37 (from Conduct) in the NSW Medical Board Annual Report 2010

The Monitoring Program continues to provide strength to the 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 Council's Committees and Legal Section when non-compliance or breach of conditions has become an issue;
- providing advice to legal officers assisting determining bodies on the monitorability of proposed conditions;
- 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 comprises the statement of financial position as at 30 June 2011, 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.

Auditor's Opinion

In my opinion, the financial statements:

- give a true and fair view of the financial position of the Council as at 30 June 2011, and of its financial performance 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 and fair presentation of the financial statements 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 the 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 controls relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal controls. 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 that 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 any 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 role by the possibility of losing clients or income.

Peter Barnes
Director, Financial Audit Services

21 November 2011
SYDNEY

MEDICAL COUNCIL OF NEW SOUTH WALES

STATEMENT BY MEMBERS OF THE COUNCIL

FOR YEAR ENDED 30 JUNE 2011

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 2011 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

17 November 2011

> statement of comprehensive income

FOR THE YEAR ENDED 30 JUNE 2011

	Notes	2011
		$
Expenses		
Personnel services	3	(3,486,537)
Other operating expenses	4	(4,634,003)
Total Expenses		(8,120,540)
Revenue		
Registration fees		6,449,431
Other revenue		87,350
Interest revenue	5	184,922
Total revenue		6,721,703
Gain/(Loss) on disposal of assets		-
Surplus/(Deficit) for the year		(1,398,837)
Other comprehensive income		-
Total comprehensive income for the year		**(1,398,837)**

The accompanying notes form part of these financial statements.

> statement of financial position

AS AT 30 JUNE 2011

	Notes	2011
		$
ASSETS		
Current Assets		
Cash and cash equivalents	6	1,382,161
Receivables	7	253,529
Total Current Assets		**1,635,690**
Non-Current Assets		
Leasehold improvements	8	1,851,926
Motor Vehicles	8	22,668
Plant and Equipment	8	89,611
Furniture and fittings	8	5,605
Intangibles	8	992,981
Total Non-Current Assets		**2,962,791**
Total Assets		**4,598,481**
LIABILITIES		
Current Liabilities		
Payables	10	1,098,634
Fees in advance		2,017,646
Provisions	11	267,966
Total Current Liabilities		**3,384,246**
Non-Current Liabilities		
Fees in advance		46,258
Total Non-Current Liabilities		**46,258**
Total Liabilities		**3,430,504**
Net Assets		**1,167,977**
EQUITY		
Accumulated Funds		1,167,977
Total Equity		**1,167,977**

The accompanying notes form part of these financial statements.

> statement of changes in equity

FOR THE YEAR ENDED 30 JUNE 2011

Total Accumulated Funds	**Notes**	**2011**
		$
Balance at 1 July 2010		-
Transfer in of net assets due to restructure	17	3,710,779
Payment to Department of Health (As part of arrangement of structure)	17 (a) (i)	(1,143,965)
Restated transfer balance as at 1 July 2010		2,566,814
Surplus/(Deficit) 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 2011

	Notes	2011
		$
Cash Flows from Operating Activities		
Payments		
Suppliers and employees		(7,810,563)
Total Payments		**(7,810,563)**
Receipts		
Receipts from members		5,735,824
Interest received		179,327
Total Receipts		**5,915,151**
Net Cash Flows from Operating Activities	**12**	**(1,895,412)**
Cash Flows from Investing Activities		
Purchases of plant and equipment		(363,389)
Net Cash Flows from Investing Activities		**(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		**1,382,161**
Opening cash and cash equivalents		-
Closing cash and cash equivalents	6	**1,382,161**

The accompanying notes form part of these financial statements.

> notes to and forming part of **the financial statements**

FOR THE YEAR ENDED 30 JUNE 2011

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 Council was established under Part 5A 41B of the *Health Practitioner Regulation National Law (NSW) No 86a.*

These financial statements have been authorised for issue by the Council on 21 November 2011.

The *Medical Practice Act 1992* was repealed on 1 July 2010. As a result the New South Wales Medical Board was abolished on the same day. In accordance with the *Health Practitioner Regulation National Law (NSW) No 86a*, the assets and liabilities of the Board were transferred to the newly established Medical Council of New South Wales as equity.

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

The financial statements are general purpose financial statements which have been prepared in accordance with applicable Australian Accounting Standards and Interpretations (which include Australian Equivalents to International Financial Reporting Standards (AEIFRS)), and the requirements of the Public Finance and Audit Act and Regulation and the Treasurer's Directions. The financial statements have been prepared on the basis of historical cost.

Judgements, key assumptions and estimations that management has made are disclosed in the relevant notes to the financial statements.

All amounts are rounded to the nearest dollar and are expressed in Australian currency.

c. Statement of Compliance
The Council's financial statements and notes comply with Australian Accounting standards, which include Australian Accounting Interpretations.

d. 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. The former registration Boards in NSW were all abolished and registration and accreditation functions became the responsibility of the new National Boards established under the National scheme. 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 *Health Practitioner Regulation National Law (NSW)* the complaints element of the registration fees payable during 2011 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 *Health Practitioner Regulation National Law (NSW)*, shall receive fees on a monthly basis from the Australian Health Practitioner Regulation Agency (AHPRA) being the agreed NSW complaints element for the 2011 registration fee.

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

Interest income is recognised as it is accrued, taking into account the effective yield on the financial asset as set out in AASB 139 *Financial Instruments: Recognition and Measurement.*

e. Accounting for the Goods and Services Tax (GST)
Income, expenses and assets are recognised net of the amount of GST, except where that amount of GST incurred is not recoverable from the Australian Taxation Office (ATO). In these circumstances the GST is recognised as part of the cost of acquisition of the asset or as part of an item of the expense.

Receivables and payables are stated with the amount of GST included.

Cash flows are included in the statement of cash flow on a gross basis. The GST components of cash flows arising from investing and financing activities, which is recoverable from, or payable to, the ATO are classified as operating cash flows.

f. Insurance

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

g. Assets

i. Acquisitions of Assets

All acquisitions of assets controlled by the Council are initially recorded at cost. 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 specific 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 as assets and revenues at their fair value at the date of acquisition.

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

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

ii. Capitalisation Thresholds

The Health Professional Councils Authority (HPCA) acquires all assets on behalf of the Council. Assets that cost over $5,000 at the time of purchase by the HPCA are to be capitalised. These capitalised assets costs are then allocated to the Council using an appropriate allocation method.

iii. Impairment of Property, Plant and Equipment

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

iv. 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.

h. Intangibles

Intangible assets that are acquired have finite useful lives and are measured at cost less accumulated amortisation and accumulated impairment losses.
Fair value is the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms-length transaction.

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 recognises intangible assets only if it is probable that future economic benefits (synonymous with the notion of service potential) will flow to the Council 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 Council's intangible assets, the assets are carried at cost less any accumulated amortisation.

The Council's intangible assets are amortised using the straight line method over a period of two to 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.

i. Depreciation and Amortisation
Depreciation and amortisation is provided for on a straight-line basis for all depreciable assets and amortisable intangible 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%
Furniture and Fittings 20%
Motor Vehicles 18%
Leasehold Improvements 1.70% - 4%

Amortisation rates used are as follows:
Software 25%

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

k. Payables
These amounts represent liabilities for goods and services provided to the Council and other amounts, including interest. 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.

l. Provision for Personnel Services
Personnel services are acquired from the Health Administration Corporation.

Liabilities for salaries and wages (including non-monetary benefits), annual leave and paid sick leave that fall due wholly within 12 months of the reporting date 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.

Liabilities for annual leave are recognised and measured as the amount unpaid at the reporting date at current pay rates in respect of employees' service up to that date including appropriate oncosts.

Annual leave benefits, payable later than 12 months, have been measured at the present value of estimated cash flows to be made for those benefits in accordance with AASB 119 *Employee Benefits*.

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 benefits accrued in the future.

The outstanding amount of payroll tax, workers compensation and superannuation guarantee contributions, which are consequential to employment, are recognised as expenses where the employee entitlements 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.

m. Provision for Make Good
Provisions include the Council's proportionate liability of the estimated make good liability of the Medical Council of New South Wales, discounted to today's present value.

n. Equity Transfers
The transfer of net assets between NSW public sector agencies is designated as a contribution by owners by NSW Treasury Policy and Guidelines Paper TPP 09-3 and recognised as an adjustment to 'Accumulated Funds'. This treatment is consistent with Australian Interpretation 1038 Contributions by Owners Made to Wholly-Owned Public Sector Entities.

Transfers arising from an administrative restructure between Government departments are recognised at the amount at which the asset was recognised by the transferor Government department immediately prior to the restructure. In most instances this will approximate fair value. All other equity transfers are recognised at fair value.

o. Adoption of New and Revised Accounting Standards
A number of new standards, amendments to standards and interpretations are effective for annual periods beginning after 1 July 2011, and have not been applied in preparing these financial statements. None of these these are expected to have a significant effect on the financial statements of the Medical Council of New South Wales, except for AASB 9 Financial Instruments, which becomes mandatory for the 2014 financial statements and could change the classification and measurement of financial assets. The Council does not plan to adopt this standard early and the extent of the impact has not been determined.

2. EQUITY ACCUMULATED FUNDS

The accumulated funds include all current year funds and the transfer of net assets of the abolished Board due to the restructure.

3. PERSONNEL SERVICES

Personnel services are acquired from the Health Administration Corporation and the cost is calculated as follows:

	2011
	$
Salaries and wages	2,951,652
Superannuation	261,754
Payroll taxes	272,667
Workers compensation insurance	464
	3,486,537

4. 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 Health Professional Councils Authority, 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 Health Administration Corporation. Staff are employed in the Government Service and are listed in Chapter 1A of the *Public Sector Employment and Management Act 2002*. The Health Administration Corporation continues to pay for the staff and associated oncosts.

Details of transactions managed on behalf of the Council through the Health Administration Corporation are detailed below:

	Notes	2011
		$
(i) Personnel services		
Personnel services	3	3,486,537
(ii) Other operating expenses		
Council fees		264,921
Sitting fees		1,407,210
Funding contributions		57,888
Fee for services		879,756
Rent and other building expenses		61,139
Medical Tribunal fees		643,612
Postage and communication		107,327
Printing and stationery		92,371
General administration expenses		245,639
Travel and accommodation		76,826
Depreciation and amortisation	8-9	476,714
Equipment and furniture		11,953
Contracted labour		285,647
Auditor's remuneration		23,000
Total expenditure		**4,634,003**
Total operating expenses		**8,120,540**

5. INTEREST

	2011
	$
Interest revenue	35,413
TCorp Hour Glass cash facility	149,509
	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 cheques fees, and charges applicable to overseas drafts.

	2011
Weighted Average Interest Rate	4.43 %

6. CURRENT ASSETS – CASH AND CASH EQUIVALENTS

	2011
	$
Cash at bank**	229,941
Cash on hand	1,011
TCorp Hour Glass cash facility	575,523
Cash at bank - held by HPCA*	575,686
	1,382,161

** managed by the Health Professional Councils Authority, an administrative unit of the Health Administration Corporation.

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

7. CURRENT ASSETS – RECEIVABLES

	2011
	$
Prepayments	3,343
Interest receivable	6,595
Other receivables	49,254
Trade receivables	194,337
	253,529

No receivables are considered impaired.
The trade receivables include monies that AHPRA has collected from registrants as at 30 June 2011 and has remitted the monies to HPCA in July 2011.

8. NON-CURRENT ASSETS – PROPERTY, PLANT AND EQUIPMENT

	Leasehold Improvements	Motor Vehicles	Furniture & Fittings	Plant & Equipment	Total
	2011	2011	2011	2011	2011
	$	$	$	$	$
Year ended 30 June 2011					
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 - fair value					
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 property, plant and equipment at the beginning and end of the current reporting period is set out below:

	Leasehold Improvements	Motor Vehicles	Furniture & Fittings	Plant & Equipment	Total
	2011	2011	2011	2011	2011
	$	$	$	$	$
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	(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

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

	Intangibles	Total
	2011	2011
	$	$
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. CURRENT LIABILITIES – PAYABLES

	2011
	$
Accrued personnel services	239,990
Trade and other payables	858,644
	1,098,634

11. CURRENT LIABILITIES – PROVISIONS

	2011
Current	**$**
Personnel services	267,966
	267,966

12. RECONCILIATION OF CASH FLOWS FROM OPERATING ACTIVITIES TO NET COST OF SERVICES

	2011
	$
Net cash used on operating activities	(1,398,837)
Depreciation and amortisation	476,714
Changes in assets and liabilities:	
Decrease/(Increase) in receivables	(218,529)
Decrease/(Increase) in prepayments	(588,022)
Increase/(Decrease) in payables	(12,704)
Increase/(Decrease) in provisions	(154,034)
Net Cash Flows from Operating Activities	(1,895,412)

13. 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**
			2011
Class:			**$**
Cash and Cash Equivalents	6	N/A	1,382,161
Receivables [1]	7	Loans and receivables (at amortised cost)	200,932

Financial Liabilities	**Note**	**Category**	**Carrying Amount**
			2011
Class:			**$**
Payables [2]	8	Financial liabilities (measured at amortised cost)	1,098,634

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

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 Board has minimal exposure to interest rate risk from its holdings in interest bearing financial assets. The Board 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.

14. COMMITMENTS

i. Operating lease commitments

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

	2011
	$
Less than 1 year	33,000
Between I and 5 years	132,000
Greater than 5 years	266,000
Total (including GST)	431,000

i. Capital commitments

There is no capital expenditure contracted for at balance date.

15. RELATED PARTY TRANSACTIONS

The Council has only one related party, being the Health Professional Councils Authority (HPCA), an administrative unit of 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. All accounting transactions are carried out by HPCA on behalf of the Council.

16. CONTINGENT LIABILITIES AND CONTINGENT ASSETS

There are no material unrecorded contingent assets and liabilities as at 30 June 2011.

17. EQUITY TRANSFERS

As a result of the commencement of the *Health Practitioners Regulation National Law (NSW) No. 86a*, assets and liabilities of New South Wales Medical Board were transferred to the newly establish 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.

Comparative disclosures are required by TPP09-03 to facilitate a comparison of the operating results and financial position to the previous year.

The comparative Statement of Comprehensive Income of the Council set out below includes adjustments to align the prior year's comparatives to the functions transferred to the Council.

Statement of Comprehensive Income	**30 June 2010***	**Comparative Adjustments**		**Total**
	$	**$**		**$**
Fees	8,487,000	(1,709,705)	(1)	6,777,295
Other income	263,000			263,000
Interest Revenue	364,000			364,000
Personnel services expense	(4,897,000)	1,176,611	(2)	(3,720,389)
Other expenses	(7,240,000)			(7,240,000)
Deficit for the Year	**(3,023,000)**	**(533,094)**		**(3,556,094)**

(* per prior year statutory accounts)

Adjustments:

1. Adjustment to recognise fee revenue relating to registration function not transferred to new Council.
2. Adjustment to recognise expenses relating to registration function not transferred to new Council.

> notes to and forming part of **the financial statements**

FOR THE YEAR ENDED 30 JUNE 2011

The comparative Statement of Financial Position at 30 June 2010 acquired by the Council on 1 July 2010 is set out below.

Statement of Financial Position	**30 June 2010***
	$'000
CURRENT ASSETS	
Cash and cash equivalents	5,454
Trade and other receivables	35
Leasehold improvements	1,955
Motor Vehicles	25
Furniture and fittings	8
Plant and Equipment	135
Intangibles	953
TOTAL CURRENT ASSETS	8,565
NON-CURRENT ASSETS	
TOTAL NON-CURRENT ASSETS	-
TOTAL ASSETS	8,565
CURRENT LIABILITIES	
Trade and other payables	1,111
Fees in Advance	3,321
Make Good provisions	-
Short-term provisions	422
TOTAL CURRENT LIABILITIES	4,854
NON-CURRENT LIABILITIES	
TOTAL NON-CURRENT LIABILITIES	-
TOTAL LIABILITIES	4,854
NET ASSETS	3,711
EQUITY	
Accumulated Funds	3,711
TOTAL EQUITY	**3,711**

(* per prior year statutory accounts, that were prepared with a rounding to the nearest $'000)

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 Australian Health Practitioner Regulation Agency 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.

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
FOI	Freedom of Information
GIPA Act	Government Information (Public Access) Act
HCCC	Health Care Complaints Commission
HPCA	Health Professional Councils Authority
IRP	Impaired Registrants Panel
MPA	*Medical Practice Act*
MT	Medical Tribunal
PA	Performance Assessment
PRP	Performance Review Panel
PSC	Professional Standards Committee

Appendix 2: Human resources

Employees

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

As at 30 June 2011, there were 89 permanent full-time and 11 temporary full-time positions at the HPCA, of which 36 full-time equivalent positions provided secretariat support directly to the Medical Council.

The HPCA adopts NSW Department of Health personnel policies and practices and ensures that staff have access to these policies through the Department of Health internet and intranet.

Learning and development

A priority for the HPCA in 2010/11 has been to ensure that all staff receive appropriate induction to the Department of Health and their roles as public sector employees, in particular those staff who transferred from the previously independent Registration Boards.

Staff participated in the Department of Health Orientation Program, which included familiarisation with the structure and functions of the Department of Health Code of Conduct and discussion of conflict of interest and fraud prevention issues.

The Department's Coaching and Performance System (CAPS) has been introduced to identify skills needs and is assisting staff and managers to align individual staff strengths with organisational goals. All staff have access to the Department's learning and development program to support their training needs and professional development. During the year, staff attended a range of courses, including Outlook 2007, Time Management, Preparation of Committee Agendas and Minutes Course, Policy Writing Course, High Performance Memory Training, Work Cover NSW Occupational Health and Safety Consultation Course, and Government Information (Public Access) Training Courses.

A learning and development program is also being developed to address the information and training needs of secretariat staff and members of Council, Committees, Panels and Tribunals. The program will focus on developing knowledge of the Law, and Council's regulatory responsibilities and processes to protect the public. It will comprise in-house training and use of external expertise.

Legal Officers attend Continuing Legal Education seminars as part of the mandatory requirement for renewal of Practising Certificates issued by the Law Society.

Staff also have access to the Department of Health's Employee Assistance program. Converge International provides confidential, professional counselling services to staff and their immediate families.

Industrial Relations policies and practices

The HPCA maintained a harmonious industrial environment throughout the year. There were no industrial disputes and the transition of staff from the NSW Medical Board, and secondment of former registration staff to the Australian Health Practitioner Regulation Agency (AHPRA), was achieved through extensive consultation and open communication. The HPCA implements the NSW Department of Health industrial relations policies and practices.

Appendix 3: Equal Employment Opportunity

The Health Professional Councils Authority (HPCA) has a strong commitment to equal employment opportunity (EEO) and recruits and employs staff on the basis of merit. This provides a diverse workforce and a workplace culture where people are treated with respect.

The Medical Council of NSW also implements EEO principles and anti-discrimination practices in its activities and the membership of its committees and adjudicating bodies to ensure access and equity regarding representation and participation in the Medical Council activities.

Total Staff	Male	Female	Aboriginal/Torres Straigh Islander	NESB
2010/11				
36	1	35	0	6
2009/10				
53	5	48	0	5

Appendix 4: Occupational Health and Safety

In accordance with the *Occupational Health and Safety Act 2000 (NSW)* and the *Occupational Health and Safety Regulation 2001 (NSW)*, the Health Professional Councils Authority (HPCA) maintains its commitment to the health, safety and welfare of staff and visitors to the workplace.

An Occupational Health and Safety Committee is in place, and hazard monitoring and mitigation is undertaken continuously. Membership of the Committee is being reviewed and terms of reference are being prepared. Select staff attended the first aid and fire warden training.

Appendix 5: Disability plans

The Medical Council of NSW supports the NSW Government's Disability Policy Framework and the Principles outlined in Schedule 1 of the *Disability Services Act 1993*. The Health Professional Councils Authority maintains a range of strategies to implement these requirements including:

- workplace assessment and adjustments to support staff and members of the Medical Council of NSW and its adjudicating bodies with a disability;
- assistance from external providers to prepare and coordinate return to work plans for staff with work related injuries and/or temporary disabilities;
- provision of ergonomic furniture and equipment for all staff including those requiring workplace adjustment;
- access to disabled washrooms, including access for clients and others participating in Medical Council of NSW business, hearings and Tribunals;
- a TTY service available for the hearing impaired;
- installation of a hearing loop in Tribunal hearing rooms.

Appendix 6: Insurance and risk management activities

Insurance

The Medical Council's insurance activities are conducted by the Health Professional Councils Authority (HPCA) through the NSW Department of Health's insurance cover through the NSW Treasury Managed Fund, and include:

- Legal liability – public liability, professional indemnity, product liabililty;
- Comprehensive Motor Vehicle Insurance Policy;
- Public/Liability Insurance Policy;
- Personal Accident Policy.

Risk management

Identification of risk for the HPCA and the Medical Council has been a priority during the year. A risk register has been prepared and an internal audit plan developed for implementation from 2011/12, which will focus on the HPCA's shared services.

NSW Treasury has granted the Medical Council an exemption from the Internal Audit and Risk Policy (TPP09-05) on the grounds that it is a small agency for which the administrative and cost burden of full compliance would be prohibitive.

In November 2010, the Internal Audit Bureau (IAB) undertook a high level review of the HPCA's governance and policy processes. A comprehensive policy framework has been developed and ongoing monitoring of compliance and reporting is being implemented. The framework enables compliance risks to be managed and supports all of the 10 NSW Health Professional Councils in meeting these obligations.

Other risk management activities include:

- regular preventative maintenance programs on plant and equipment;
- security entry and alarm system in place for access to the HPCA and the Medical Council of NSW premises;
- computer system Disaster Recovery Plan;
- back-up and off-site storage of computer data.

During 2011/12, the HPCA will establish an audit and risk committee with NSW Health Professional Councils participation, with an independent Chair and representative membership.

Appendix 7: Medical Council Financial Management

Financial Management

The Health Professional Councils Authority (HPCA) provides financial management services to the Medical Council of NSW including the payment of accounts, budget preparation and monitoring and coordination of regular financial reporting to the Medical Council.

HPCA staff work with the Australian Health Practitioner Regulation Agency (AHPRA) on behalf of the Medical Council to consider practitioner fees and the regulatory component of those fees paid to the Medical Council to enable it to undertake its regulatory functions.

During 2011/12, the HPCA will work with the 10 NSW Health Professional Councils to develop an overall funding model to ensure the equitable distribution of shared costs and staffing resources across all the NSW Health Professional Councils.

Format

The accounts of the Medical Council of NSW's administrative operations, as well as Education and Research activities, together with the independent auditor's report are set out in this Annual Report.

Performance

The accounts in respect of the Council's administrative operating expenditure for the year show expenditure of $8,162,841.

Budget

The budget in respect of the administrative operation for the period 1 July 2011 to 30 June 2012 is as follows:

Revenue	
Fees	7,641,119
Less Operating Costs	
Bank charges	1,113
Labour costs	3,501,205
Occupancy costs	86,904
Subsistence and transport	58,987
Sitting fees	1,651,920
Council fees	317,457
Funding contribution	150,000
Computer services	203,760
Fees for services	240,552
Legal fees	400,000
Medical consultancy fees	244,400
Medical Tribunal funding	669,352
Postage and communications	123,588
Printing and stationery	123,608
Room hire	30,839
Miscellaneous	75,288
Temporary labour	162,240
Total Operating Costs	8,041,214
Gross Profit/(Loss)	(400,095)
Other Income/Expenses	
Depreciation	(554,232)
Interest received	110,979
Operating Profit/(Deficit)	**(843,348)**

Accounts payable performance report

The consolidated accounts payable performance report for the HPCA is as shown below:

Aged analysis at the end of each quarter

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	3,156,302	31,173	25,789	16,382	0
December	1,151,215	839,503	-218	248	0
March	1,454,399	7,080	0	1,645	0
June	1,282,574	1,001	0	-34	0

Accounts paid on time within each quarter

Quarter	Accounts paid on time			Total amount paid
	Target %	Actual %	$	
September	100.00	97.70	3,156,302	3,229,647
December	100.00	57.80	1,151,215	1,990,748
March	100.00	99.40	1,454,399	1,463,124
June	100.00	99.90	1,282,574	1,283,542

Investment Performance

The Medical Council of NSW, through a Special Interest Arrangement with the Commonwealth Bank of Australia, earned an average of 4.25% p.a on its daily bank balances. In addition, an average rate of interest of 4.43% was earned on investments held in a Cash Deposit Account.

The Medical Council of NSW's externally managed funds were held in Treasury Corporation's Hour Glass Cash Facility. An average return of 5.37% was achieved for the current financial year.

Significant Issues Audit

Response to Audit Report Findings

The Council provides the following response to significant issues identified by the Audit Office of NSW in the audit of the Council's financial statements, in accordance with section 7(1)(iia) of the *Annual Report (Statutory Bodies) Act 1984*:

Financial statements submitted late

The financial statements were due for submission to the Audit Office on 11 August 2011. The financial statements were instead submitted on 16 August 2011, five days after the statutory deadline. NSW Treasury subsequently granted the Council an extension to 18 August 2011.

Recognition and Disclosure inadequacies

Following the abolition of the New South Wales Medical Board on 1 July 2010, its assets and liabilities were transferred to the Medical Council of New South Wales. As a restructured entity the Council was required to present comparative accounts. One of the large accounting firms was engaged to assist the Council with preparation of the accompanying disclosure notes and financial statements for this first year. Specifically the firm was engaged to provide accounting advisory services in relation to certain transactions being:

1. Letter of advice regarding the accounting and disclosure implications of the restructuring of the Council on 1 July 2010; and
2. Accounting assistance in relation to various year-end matters including disclosure review of the Council's financial statements as at 30 June 2011; accounting treatment of building leases including related make good provisions; and review of cash flow disclosures in the 2011 financial statements in respect of specific transactions.

The Audit Office was not satisfied that the disclosure notes prepared by the accounting firm met required accounting standards in respect to the accounting and disclosure implications of the establishment of the Council on 1 July 2010. The accounting firm subsequently amended the equity transfer disclosure note to the Audit Office's satisfaction.

The auditors also identified nine instances of monetary misstatements. They are for amounts between $1,863 and $74,775. The misstatements have been corrected in the financial statements as approved by the Council and published in this Annual Report.

The HPCA is currently reviewing processes to improve the quality of the 2012 financial statements.

Use of cash from other Councils to finance operations of other Councils
During its first financial year the HPCA followed the practice put in place by the former Health Professionals Registration Boards, whereby cash received by the HPCA on behalf of the Councils has been held in a common account. A full reconciliation was conducted at the end of the financial year. In future the HPCA will reconcile cash on a quarterly basis and seek formal approval under section 10 of the *Public Authorities (Financial Arrangements) Act 1987* if over the course of a financial year cash is required to finance operations of another Council.

Recognition of Assets
The 10 health professional councils share and jointly pay for a common secretariat, premises (with the exception of the Medical Council) and a range of assets. The costs are apportioned across the Councils and the Councils with fewer registrants contribute comparatively smaller amounts to the overall costs. Where the total value of an asset is more than $5,000, and where the Councils collectively meet the cost of a single asset, the asset is consistently capitalised although the portion a smaller Council contributes to that asset may be less than $5,000. The Audit Office has noted that amounts of less than $5,000 are being recognised in financial statements. However it would be incorrect to simultaneously capitalise and expense the same assets across different statutory accounts. The only other alternative available to the Council is to recognise all assets, including items over $5,000 as expenses in the financial statements. This would also be deemed to be a misstatement. The HPCA on behalf of the 10 health professional councils, including the Medical Council, will seek approval from the Chief Financial Officer of the Ministry for Health to vary the accounting policy for the treatment of shared assets.

Amortisation of intangible assets
In line with the comments made by the external auditors intangible assets will be amortised over a longer period of time.

The need for a Service Level Agreement
The Council and the HPCA agree with comments by the external auditor about the need to establish relevant service level agreements and will act on this advice.

Appendix 8: Legal change

During the reporting period, the NSW Parliament passed a number of minor amendments to 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)

Amendments made by the *Statute Law (Miscellaneous Provisions) Act (No 2) 2010*:

- An amendment to the definition of "protected report" in section 138(1) of the *Health Practitioner Regulation National Law (NSW)* to address an oversight that inadvertently omitted reports prepared under section 152B from the definition.
- A consequential transitional amendment was also required in Schedule 5A.
- Amendments made by the *Health Services Amendment (Local Health Networks) Act 2010:*
- Amendments were made to clauses 6(2)(i), 7(2)(a), 8(2)(a) and 9(2)(a) of Schedule 5C of the *Health Practitioner Regulation National Law (NSW)* to reflect the replacement of Area Health Services with Local Health Networks.

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

- Amendments were made to 6(2)(i), 7(2)(a), 8(2)(a) and 9(2)(a) of Schedule 5C of the *Health Practitioner Regulation National Law (NSW)* to reflect the replacement of Local Health Networks with Local Health Districts.

Health Practitioner Regulation (New South Wales) Regulation 2010

Amendments made by the *Statute Law (Miscellaneous Provisions) Act (No 2) 2010*:

- An amendment was made to clause 17(1)(b) to amend an incorrect cross reference to the NSW Trustee and Guardian Act 2009.

Amendments made by the *Health Practitioner Regulation (New South Wales) Amendment (Savings and Transitional) Regulation 2010:*

- Amendments of a savings and transitional nature were made as follows:
  - amendment of clause 22(2)(b) to ensure that a delegation made by a Board under a repealed Act continues in force under the *Health Practitioner Regulation National Law (NSW)* until 1 January 2013;
  - insertion of clause 23 which provides that a registered health practitioner may apply for a review of conditions imposed on the health practitioner's registration by a Board under a repealed Act (ie a repealed NSW health professional registration Act) or by a Council;

- insertion of clause 24 which provides that if, immediately before the commencement of the *Health Practitioner Regulation National Law (NSW),* a Board had started but not completed dealing with a complaint about a registered health practitioner by an inquiry under a repealed Act, the inquiry is to continue under the repealed Act but is to be conducted by the relevant Council.

Amendments made by the *Statute Law (Miscellaneous Provisions) Act 2011:*

- An amendment was made to clause 21 to correct an incorrect reference to "authorised officer" with the correct term "authorised person".

- Amendments were made to clauses 24(3) and (5) to correct typographical errors by replacing the term "this Law" with "the Law".

Amendments made by the *Health Practitioner Regulation (New South Wales) Amendment (Savings and Transitional) Regulation 2011:*

- Clause 25 was inserted in the Regulation in order to address concerns about possible defects in the appointments of some members of any State Boards of the National Boards.

Significant judicial decisions

There were no significant judicial decisions affecting the Medical Council of NSW or users of its services in the last reporting year.

Appendix 9: Departures from Subordinate Legislation Act

The *Subordinate Legislation Act 1989* requires that before any principal statutory rule is made, the responsible Minister must ensure that a number of requirements are met, including that a regulatory impact statement is prepared and made publicly available. There were no departures by the Council from the Subordinate Legislation Act during 2010/11.

Appendix 10: Multicultural Policies and Services Program

The Medical Council of NSW applies the NSW Government's Principles of Multiculturalism and ensures that information and services are available to meet the diverse language needs of the people of NSW.

The Medical Council of NSW and the Health Professional Councils Authority (HPCA) websites provide advice on how to access translating and interpreting services in 19 languages for people making an enquiry or a complaint about a medical practitioner. A number of HPCA staff are also able to provide assistance in translating and interpreting in a range of languages.

Responsibility for the registration and accreditation of overseas trained medical practitioners rests with the Medical Board of Australia. The Medical Council of NSW supports the National Board's commitment to providing opportunities for overseas trained health practitioners to be registered and practise in Australia. The following strategies are in place to address the Principles of Multiculturalism:

- ensuring the use of ethnic media to disseminate the Medical Council information if required;
- promoting a culturally diverse workforce, membership of Committees and participation in the Medical Council's regulatory activities;
- maintaining ongoing commitment to the Principles of Multiculturalism and the requirements of relevant legislation and Government policy.

Appendix 11: Promotion

The Medical Council of NSW did not fund any overseas travel for any staff of the Health Professional Councils Authority.

The Medical Council's former Medical Director attended conferences in Philadelphia held by the International Physician Assessment Coalition (in conjunction with the Coalition for Physician Enhancement), where she was also a presenter, and the International Association of Medical Regulatory Authorities on 26 September 2010 to 1 October 2010.

Appendix 12: Waste Reduction and Purchasing Policy

The Health Professional Councils Authority (HPCA) manages implementation of the NSW Government's Waste Reduction and Purchasing Policy (WRAPP) on behalf of the Medical Council of NSW. During the year, the Medical Council of NSW maintained efforts to reduce waste, recycle paper products, consumables and equipment, and to purchase resources with recycled content, with the following results:

- 100% of secure paper destruction is recycled into cardboard;
- recycling facilities are easily accessible and utilised by staff for paper, cardboard, cans, glass and plastic bottles;
- 100% of toner cartridges are sent for recycling;
- garden refuse is recycled on site.

The following waste avoidance strategies are in place:

- increased use of email for communication;
- practitioners and the public are referred to the Medical Council website for access to publications and other information as an alternative to providing hard copy documents;
- inclusion of "Please consider the environment before printing" note on email communication.

Appendix 13: Use of consultants

The 10 NSW Health Professional Councils 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 Health Professional Councils Authority (HPCA).

The Medical Council of NSW made the following contribution to these consultancies:

Engagements costing less than $50,000

Service Provided	Number	Cost incl GST
Financial management	2	$14,854
Governance / administration	1	$ 1,974
TOTAL	**3**	**$16,828**

Appendix 14: Consumer response

During 2010/11, the Medical Council of NSW received a small number of complaints about its processes from the public and members of the profession. These largely related to dissatisfaction with the outcome of complaints or investigations concerning medical practitioners but also included complaints about the publication of decisions and whether those decisions complied with non-publication directions, and a complaint about the professionalism of a staff member. A complaint was also made against a former NSW Medical Board member alleging a failure to declare a conflict of interest. Complaints were referred to the appropriate area for investigation and prompt resolution, and the Medical Council's policies and procedures were reviewed and amended where necessary.

Appendix 15: Government Information (Public Access)

The *Government Information (Public Access) Act 2009 (GIPA Act)* came into effect on 1 July 2010 replacing the former *Freedom of Information Act 1989*. The GIPA Act creates rights to information that are designed to meet community expectations of more open and transparent Government.

The Medical Council of NSW is committed to the principles of the GIPA Act and makes available, through 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 Publication Guide on the Medical Council's website.

In accordance with section 7(3) of the GIPA Act, the Medical Council conducted a review with respect to the proactive release of information. As a result of this review, the Medical Council's website has been modified to provide enhanced access to the decisions of the adjudication bodies convened under the *Health Practitioner Regulation National Law (NSW)* and other Courts and Tribunals, as well as access to the policies and guidelines of the Medical Council.

All newly created and revised key documents are gradually being assessed to determine whether they should be published on the Medical Council's website in accordance with the requirements of the GIPA Act.

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 by the Medical Council for information, staff would assess and decide whether the information requested was 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 2010 to 30 June 2011, the Medical Council received two formal access applications for information. One of these applications was invalid, in part because the application included a request for the disclosure of information referred to in schedule 1 of the GIPA Act.

These applications were determined within statutory timeframes. During this period, no applicants sought a review of the Medical Council's decision by either the Medical Council or the Information Commissioner.

During the reporting period, one outstanding application received under the FOI Act, was finalised. There was a reduction in the number of formal GIPA applications received in the reporting year (two), compared with formal FOI applications received in the preceding year (five).

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 *Government Information (Public Access) Amendment Regulation 2010.* The statistical reports that follow correspond to schedule 2 of the *Government Information (Public Access) Amendment Regulation 2010.*

Table A: 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	1	0	0	0	0	0	0	0
Members of Parliament	0	0	0	0	0	0	0	0
Private sector business	0	0	0	0	0	0	0	0
Not for profit organisations or community groups	0	0	0	0	0	0	0	0
Members of the public (application by legal representative)	1	0	0	0	0	0	0	0
Members of the public (other)	0	0	0	0	0	0	0	0

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

Table B: 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)	2	0	0	0	0	0	0	0
Access applications that are partly personal information applications and partly other	0	0	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 C: 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)	1*
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

* Part of one of the applications received was invalid.

Table D: Conclusive presumption of overriding public interest against disclosure: matters listed in Schedule 1 to Act	
	Number of times consideration used*
Overriding secrecy laws	0
Cabinet information	0
Executive Council information	0
Contempt	0
Legal professional privilege	0
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 E.

Table E: 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	0
Law enforcement and security	0
Individual rights, judicial processes and natural justice	0
Business interests of agencies and other persons	0
Environment, culture, economy and general matters	0
Secrecy provisions	0
Exempt documents under interstate Freedom of Information legislation	0

Table F: Timeliness	
	Number of applications
Decided within the statutory timeframe (20 days plus any extensions)	2
Decided after 35 days (by agreement with applicant)	0
Not decided within time (deemed refusal)	0
Total	2

Table G: 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. The data in this case indicates that a recommendation to vary or uphold the original decision has been made by the Information Commissioner.

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

Appendix 16: Privacy management

The Medical Council of NSW collected and retained information, including personal and health information about medical practitioners and patients, in the course of exercising its functions under the *Health Practitioner Regulation National Law (NSW)*. It dealt with the collection, use, disclosure, security and quality of this information in accordance with the *Privacy and Personal Information Protection act 1998* and the *Health Records and Information Privacy Act 2002* as well as the confidentiality provisions in the *Health Practitioner Regulation National Law (NSW)* itself.

The Medical Council is no longer required to maintain a register of medical practitioners in New South Wales. Responsibility for maintaining the Register now rests with the Australian Health Practitioner Regulation Agency (AHPRA).

No applications for internal review under Part 5 of the *Privacy and Personal Information Protection act 1998* were received during the reporting period.

The Medical Council regularly reviewed its compliance with the relevant legislation and its procedures and policies were amended where necessary.

Appendix 17: Policies and publications

The Medical Council of NSW's website is one of its key means of communicating with the public and the profession. It has been a busy year, due to implementing changes flowing from the transition to the new national scheme from 1 July 2010, as well as the changes flowing from the repeal of the *Freedom of Information Act 1989 (NSW)* and the commencement of the *Government Information (Public Access) Act 2009 (GIPA Act)*. The use of the site has been significant in disseminating legislative and policy information.

The Medical Council has successfully complied with requirements under the GIPA Act, such as the timely approval of its Publication Guide by the Information Commissioner and the Guide's subsequent publication and review.

Appendix 18: Overview of complaints bodies and processes

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

- The ***Medical Council of NSW:*** The Medical Council's role in relation to complaints is to consult with the Health Care Complaints Commission (HCCC) on the course and outcome 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 inquires, 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 and prosecute matters before a Professional Standards Committee or Medical Tribunal and to consult with the Council in relation to the proposed course of action.
- ***Professional Standards Committee*** (PSC): PSCs are independent bodies of inquiry set up 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 New South Wales or a Commissioner 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 de-registration 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 the AHPRA, and such notifications in NSW that might require some regulatory action 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 health or safety 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 DP 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 19: Section 150 and s150A proceedings case studies

The Medical Council of NSW 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 health 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 of the *Health Practitioner Regulation National Law (NSW)*, the matter that triggered the proceedings must either be referred to the Health Care Complaints Commission (HCCC) for investigation as a complaint, or be referred to an Impaired Registrants Panel Inquiry (subject to consultation and agreement with the HCCC).

The Medical Council has conducted 55 urgent interim proceedings under section 150 of the *Health Practitioner Regulation National Law (NSW)* (and section 66 of the now repealed *Medical Practice Act*) and five proceedings to review orders imposed under section 150A of the *Health Practitioner Regulation National Law (NSW)* (and section 66AB of the now repealed *Medical Practice Act*)) during the reporting year.

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

Conditions not sufficient to effectively protect the public in some circumstances

A registrar, with a history of involvement in the Health Program since 2003, was suspended under section 150 of the *Health Practitioner Regulation National Law (NSW)* in October 2010 for non-compliance with conditions. The matter was referred to the Health Care Complaints Commission (HCCC) for investigation.

The practitioner sought a review of the suspension order under section 150A of the *Health Practitioner Regulation National Law (NSW)* in March 2011. Although the practitioner confirmed re-engagement with treating practitioners and compliance with random urine testing since the suspension, the Council was also provided with a number of documents from the ongoing HCCC investigation which showed the practitioner had not been truthful to previous Medical Council hearings and had practised medicine despite the suspension.

The decision to suspend was affirmed.

Clinical incident of concern reveals cognitive decline

A general practitioner came to the Medical Council's attention when the NSW Ambulance Service complained that a patient had been rendered unconscious when the practitioner injected morphine, an incorrect dose having been prescribed by the practitioner. The Medical Council was not satisfied by the practitioner's response to the complaint when interviewed. A neuropsychological assessment was arranged and section 150 proceedings were convened.

The delegates noted evidence that the general practitioner suffered from a degree of cognitive impairment which would cause difficulties in managing new or unusual situations. Conditions were imposed, limiting the number of patients the practitioner may see, and restricting the practitioner to seeing current patients only.

Subsequently, the Medical Council became aware of evidence that the pharmacist who had dispensed the morphine prescription had raised concerns about the dosage with the practitioner, who nevertheless confirmed that the dosage prescribed was correct. The delegates then considered whether it would be appropriate to suspend the practitioner's registration pursuant to section 150C, but determined that the conditions previously imposed provided adequate interim public protection.

Mandatory notification from a treating psychiatrist triggers section 150 proceedings

The Medical Council received a mandatory notification from the treating psychiatrist of a general practitioner, indicating that the practitioner had disclosed an incident of boundary crossing with a patient some 15 years earlier. Shortly before the notification was made, the practitioner had been the subject of disciplinary orders, having been found guilty of unsatisfactory professional conduct in relation to the practitioner performing an inappropriate breast examination and in relation to medical records. Section 150 proceedings were convened. Conditions were placed on the general practitioner's registration, including additional health conditions and a requirement that female patients over the age of 13 be seen only in the presence of a chaperone.

Suspension warranted by history and presentation

A general practitioner, with ongoing involvement in the Medical Council's Health and Performance Programs, was assessed by a neuropsychologist who concluded the practitioner had serious deficits which would detrimentally affect the practitioner's practice of medicine.

Section 150 delegates also noted the practitioner demonstrated borderline non-compliance with previous conditions, and at the hearing, there were concerns about the practitioner's presentation, in that the practitioner appeared more tangential than on previous occasions.

The delegates concluded the practitioner was demonstrating a lack of mental capacity to practise medicine which further conditions could not adequately address. The practitioner was suspended with immediate effect.

Long term prescribing issues results in conditions being imposed

A general practitioner, with a history of entering the Medical Board's Health Program in 2002, and exiting in 2006 sought restoration of an authority to prescribe Schedule 8 drugs. On receipt of the application, NSW Health Pharmaceutical Services conducted an audit of pharmacies in the area, which indicated the practitioner had been prescribing long term benzodiazepines (Schedule 4D medications) to patients, some of whom were on the methadone program.

At section 150 proceedings, the delegates found the practitioner to be isolated and somewhat naive. They considered that the practitioner was motivated to remedy the identified practice deficiencies and did not intend to prescribe Schedule 4D medications in future. The delegates also noted the medical records were unsatisfactory.

In circumstances where the practitioner admitted that medical record keeping was below standard, and where the practitioner (given the past history) ought to have been especially aware of prescribing issues, the delegates concluded conditions were required and that the practitioner's medical and prescribing records be audited, and that the practitioner's Schedule 4D and Schedule 8 authorities remain withdrawn. The delegates also considered that the practitioner ought to review clinical decision making, particularly in the identification of drug seeking patients and treatment decisions, and imposed a condition requiring the practitioner to consult a mentor.

No urgent interim action warranted

A surgeon was the subject of section 66 proceedings after three complaints, relating to the surgeon's care of patients, were brought to the Medical Council's attention. All three patients had peritonitis caused by leaks or bowel perforation. The surgeon did not attend the first hearing owing to illness and the proceedings were adjourned for approximately six weeks. In the interim, conditions were imposed restricting the facilities, in which the surgeon could perform bariatric surgery, to those in an Intensive Care Unit or High Dependency Unit with ventilatory support and requiring the surgeon to first obtain a second opinion on the appropriateness of performing the surgery. At the second hearing, the delegates were satisfied that the surgeon had the training and experience to perform bariatric surgery safely and the conditions were removed from the surgeon's registration.

Appendix 20: Matters in other jurisdictions

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

SUPREME COURT (COURT OF APPEAL)

O'Sullivan v Medical Council of NSW 2010/345057 NSWSC

On 22 September 2010, Dr Brendan O'Sullivan filed an application in the Supreme Court (Court of Appeal) seeking leave to appeal an Administrative Decisions Tribunal summary dismissal decision made against him on 22 September 2010. (See O'Sullivan v Medical Council of NSW [2010] NSW ADTAP 64, below.)

On 22 March 2011, the Supreme Court (McColl JA and Handley JA) determined, in an oral judgment, that the applicant had identified "no arguable ground of appeal." An order for costs was made in the Medical Council's favour.

ADMINISTRATIVE DECISIONS TRIBUNAL

O'Sullivan v NSW Medical Board (No. 2) [2010] NSWADT 188

On 22 March 2010. the Administrative Decisions Tribunal, on application by the former Medical Board, dismissed a claim lodged by Dr Brendan O'Sullivan that the Board had discriminated against him and had victimised him in 2008 (as reported in the 2010 Annual Report). On 8 July 2010, the Administrative Decisions Tribunal delivered a decision that Dr O'Sullivan was to pay the Medical Board's costs of those proceedings on a party/party basis.

O'Sullivan v Medical Council of NSW [2010] NSW ADTAP 64

On 22 March 2010, the Administrative Decisions Tribunal, on application by the former Medical Board, dismissed a claim lodged by Dr Brendan O'Sullivan that the Board had discriminated against him and had victimised him in 2008 (as reported in the 2010 Annual Report). Dr Brendan O'Sullivan appealed the dismissal and, on 22 September 2010, the Appeal Panel of the Administrative Decisions Tribunal granted leave for him to appeal the Administrative Decisions Tribunal's decision, but refused leave for the appeal to extend to the merits of the decision. The Appeal Panel then dismissed Dr Brendan O'Sullivan's appeal on the basis that his grounds for appeal were extremely weak and ordered him to pay the Medical Council's costs.

LOCAL COURT

Zarcadas – criminal prosecution by Medical Council

Ms Nora Zarcadas was prosecuted by the Medical Council of NSW for falsely holding herself out as a medical practitioner in breach of the *Medical Practice Act*. On 26 May 2011, Ms Zarcadas entered a plea of guilty in relation to the three charges. The charges related to her holding herself out as a medical practitioner in public hospitals and providing medical advice to members of the public who believed she was a medical practitioner; asserting she was a medical graduate, which resulted in a job offer from her general practitioner; and attending on an intimate procedure in a public hospital on the basis she was a medical practitioner. The offender's matter was listed for sentence in the next reporting period.

There is no published decision as at 30 June 2011 and the outcome is being appealed by Ms Zarcadas.