ANNUAL REPORT 2005

The New South Wales Medical Board

NEW SOUTH WALES MEDICAL BOARD

Annual Report 2005

ACCESS TO THE BOARD

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CHARTER

The Medical Practice Act 1992 establishes the New South Wales Medical Board as an incorporated statutory body. Its functions are defined under Section 132:

(1) The Board has and may exercise the functions conferred or imposed on it by or under this or any other Act.

(2) In addition, the Board has the following functions:

(a) to promote and maintain high standards of medical practice in New South Wales;

(b) to advise the Minister on matters relating to the registration of medical practitioners, standards of medical practice and any other matter arising under or related to this Act or the regulations;

(c) to publish and distribute information concerning this Act and the regulations to registered medical practitioners and other interested persons;

(d) to provide counselling services for registered medical practitioners and medical students.

The functions referred to in section 132(1) relate to:

- the registration of medical practitioners;
- the handling of complaints and notifications concerning
  - professional conduct
  - impairment
  - performance
- miscellaneous provisions concerning the practice of medicine, unqualified persons, and advertising.

AIMS AND OBJECTIVES

The Medical Practice Act 1992 sets out the scope of the Board's responsibilities and functions regarding the registration of medical practitioners and the administration of the disciplinary and health system in relation to those practitioners.

The principal aim of the Medical Board is to ensure that the people of New South Wales receive the highest possible standard of medical care through the fair and effective administration of these functions. This aim is achieved by ensuring that appropriate standards of entry onto the Register are maintained, and that instances of misconduct, incompetence or impairment are dealt with appropriately and rapidly.

Through a process of regular evaluation of current practices and continual development of new approaches to its responsibilities, the Board believes that its objective of benefiting both the public and the medical profession can be achieved.

NEW SOUTH WALES MEDICAL BOARD
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THE OFFICE OF THE PRESIDENT

25 August 2005

The Hon Mr John Hatzistergos
Minister for Health
NSW Department of Health
Locked Mail Bag 961
North Sydney NSW 2059

Dear Minister

I have the pleasure of forwarding to you the Annual Report of the New South Wales Medical Board for the year ending 30 June 2005.

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.

I trust that the Report clearly demonstrates the Board's commitment to ensuring that it meets its charter of protecting the public of NSW through efficient and effective administration of the Medical Practice Act 1992.

Yours sincerely

P G Procopis
President

Enclosure

PRESIDENT'S REPORT

The New South Wales model for regulation of the medical profession, and particularly its co-regulatory character involving both the Medical Board and the Health Care Complaints Commission, was established as a result of the Chelmsford scandal of the 1980s. In the last two years, this system and some of the basic principles underlying it have been subjected to intense scrutiny as a result of the Camden/Campbelltown Inquiry. While the Board emerged from the Inquiry with its reputation enhanced, the long term impact of legislative and cultural change flowing from the recommendations of the Inquiry remains to be seen.

After problems with the management of complaints about health services in South West Sydney became a public issue in December 2003, eighteen months of intensive work and significant change involving the Health Care Complaints Commission, the Board, the Area Health Service, and the doctors and public in the Area, ensued. By 30 June 2004, the Special Commission of Inquiry had issued an interim report, and was contemplating the release of a final report in July 2004. A significant number of matters had been referred by the Area and the Director-General, either directly to the Board for consideration of Performance Assessment or to the Health Care Complaints Commission for investigation, and Judge Ken Taylor AM RFD had been appointed Interim Health Care Complaints Commissioner.

During the period July to December 2004, the majority of the Camden/Campbelltown matters referred to the Board were finalised and, similarly, the required statutory consultation on the outcome of the matters under investigation by the Health Care Complaints Commission was undertaken. In order to facilitate this, the Board convened several special meetings to deal with the volume of material it was required to consider.

Following the release of the Final Report of the Special Commission of Inquiry on 30 July 2004, a number of legislative changes flowing from the report were proposed, and the Board was actively involved in negotiations leading to the passing of the Health Legislation Amendment Act in December. Of particular note to the Board was the Walker Inquiry's strong endorsement of the Board's Performance Program.

The provisions of the amending legislation, which substantially commenced on 1 April 2005, principally relate to procedural shortcomings which were identified by the Special Commission of Inquiry, though they also have amended or clarified a number of significant features of the co-regulatory model.

While several matters are still to be concluded before the Medical Tribunal and Professional Standards Committees, the overwhelming impression from the last two years' detailed examination of Camden/Campbelltown is of a system under stress, where mismatches between the complexity of cases and the experience and supervision of medical staff resulted in poor decision-making and some tragic clinical outcomes. This is confirmed by the majority of individual cases considered by the Board. At the root of the Special Commission of Inquiry's criticisms of the Health Care Complaints Commission was its failure to find an appropriate balance between examination of systems issues and individual accountability. The tension between these two sometimes competing objectives is well understood by the Board, and the long term impact of the Inquiry will be carefully monitored from the perspective of the co-regulatory model.

Progress on the national agenda has been a regular feature of the Board's Annual Reports for a considerable period, but developments during the last twelve months suggest that the pace may be quickening, and that in the not too distant future doctors with unconditional registration will be able to practise anywhere within Australia with minimum red tape. A number of committees and working parties under Commonwealth auspices are working to achieve this, and the New South Wales Medical Board has promoted and supported these initiatives at both philosophical and practical levels.

The registration of medical practitioners is at the core of the Board's activities. National workforce issues have dominated the agenda for several years, with growing concern at the lack of medical services in areas of need, and scrutiny of mechanisms to assess doctors recruited to work in these areas. The Board's area of need program was developed in 1999 and remains one of the few models which insists upon clinical assessment of all applicants for area of need positions. During the period covered in this report, Queensland has had its area of need program called into question by the Bundaberg Hospital case, and this has provided an opportunity for the Board to review and strengthen its processes.

Introduction of consistent national English language skill requirements and strengthened Certificate of Good Standing processes are further steps designed to address possible vulnerabilities in the system.

The data in the Annual Report shows that the Health and Performance Programs continue to develop steadily. The Performance Program has achieved a number of significant instances of remediation and reskilling, to the benefit of both the doctor concerned and the public. The Program was strongly endorsed in the Special Commission of Inquiry Final Report, and while a recent legal challenge has necessitated some procedural changes, overall the Supreme Court decision provided valuable support for the underpinning philosophy of the program.

On 31 December 2004, Professor Brian McCaughan stood down as the Board's President, having held that position since October 1999. His presidency was marked by significant change at the Board and in its environment. The 2000 amendments to the Medical Practice Act included the introduction of Australia's first Performance Program. The indemnity crisis of 2002-2003 and

the Camden/Campbelltown Inquiry of 2003-2004 were of major importance to the Board. Professor McCaughan's political skills and commonsense guided it through these issues, ensuring that its purpose to protect the public was not in any way jeopardised, and its reputation as a progressive and adaptable regulatory authority enhanced. Brian took on the presidency with great energy and enthusiasm, and his willingness to challenge received wisdom meant that his contribution both at the local level and on the national scene has been far-reaching.

During the year, Dr Jamal Rifi took up a position on the Board as the nominee of the Community Relations Commission, replacing Dr Joachim Schneeweiss, while Drs Robyn Napier and Choong-Siew Yong replaced Drs Julian Lee and Bruce Kinghorn as the nominees of the AMA.

The Board noted with great sadness the death in May 2005 of Dr Bernie Amos, a long-serving member and President between 1983 and 1989. Bernie was largely responsible for the current shape of the Board, and its development into an independent self-governing body in the co-regulatory model. Bernie's death marked the end of a long and highly successful career of a man who gave an enormous amount to medicine, the Board and the health system in Australia.

During the year, Anne Scahill, the Deputy Registrar of the Board, left to take a position at the University of Sydney after seven years of valuable service.

Professional regulation is an important and high-stakes undertaking. It is subjected to frequent and often trenchant scrutiny and criticism, and it is vital that the Board is able to maintain the proper balance between the competing interests so as to ensure that its duty of public protection is met, while at the same time it achieves this within a constructive and positive framework. Tensions will inevitably emerge between the regulators and the regulated, as well as between different bodies involved in these activities in a co-regulatory model, and it is vital that these do not obscure the overriding purpose of the system. The last year has seen a number of issues which have tested these relationships. They have remained strong, but the Board must ensure that this continues into the future.

Peter Procopis
President

YEAR IN REVIEW

The following tables give an overview of the Board's activities in the four major areas of Registration, Professional Conduct, Performance and Health, and a three year historical comparison.

	2002/03	2003/04	2004/05
Number of Registrants by Category			
Category of Registration			
General (unconditional)	21590	21798	22307
Interns	478	487	479
AMC registrants undertaking supervised training	91	94	150*
Postgraduate Trainees	889	1082	1193
General Practice Trainees	163	185	200
Area of Need	192	217	247
Conditional Specialists	426	511	624
Specialist Trainees	16	21	15
Retired/Non Practising	1380	1563	1625
Other	256	53	249
Total Registrants	**25481**	**26011**	**27089**
Student Registrants	**2495**	**2209**	**2716**
Professional Conduct			
Complaints received	1129	1030	1080
PSCs concluded	12	11	19
Medical Tribunals concluded	27	19	35
Counselling Interviews	22	12	15
Section 66 Inquiries	29	34	18
Health			
Doctors in Health Program	131	131	126
Entrants to Program	48	40	37
IRPs convened	55	50	48
Board Review Interviews	169	210	211
Performance			
Doctors in Performance Program	36	33	42
Notifications	21	21	22
Entrants to Program	15	19	17
Assessments undertaken	16	13	10
PRPs concluded	11	4	7
Retired as a result of participation	3	2	2
Section 26 Interviews	36	31	18

*Increase in number of AMC graduates registered at 30/07/2005 in main due to mid year allocation commencing in June instead of August.

STRUCTURE OF THE BOARD AND SECRETARIAT

MEMBERSHIP OF THE NEW SOUTH WALES MEDICAL BOARD

The Medical Board consisted of 20 part-time members appointed by the Governor.

Members of the Board, their qualifications and nominating body, for the period 1 July 2004 to 30 June 2005 are listed below. During this period six ordinary meetings were held. Attendances at these Board Meetings are recorded in square brackets.

A/Professor Peter George Procopis, President from 1 January 2005, Deputy President 1 October 2004 – 30 December 2004, AM, MBBS (Sydney), FRACP, Royal Australasian College of Physicians nominee [6]

A/Professor Brian Charles McCaughan President MBBS (Sydney), FRACS, Ministerial nominee [3] (resigned 30/12/2004)

A/Professor Michael Robert Fearnside, Deputy President from 1 June 2005, MBBS (Sydney), MS (Sydney), FRACS, Royal Australasian College of Surgeons nominee [5]

A/Professor Richard Alan Vickery Benn, B.Sc (Med) (Sydney) MBBS (Sydney), FRACP, FRCPA, Royal College of Pathologists of Australasia nominee [6]

Dr Susan Ieraci, MBBS (Sydney), FACEM, Ministerial nominee [5]

Dr Bernard Raymond Kelly, AM, MBBS (Sydney), FRACGP, BSc, Royal Australian College of General Practitioners nominee [6]

Ms Maria Kelly, B.Pharm. (Sydney), Dip Ed (NSW), Grad Cert Bioethics (UTS), Ministerial nomineee [5]

Dr Bruce Kinghorn, MBBS (Sydney), FRACGP, Australian Medical Association nominee [1] (term expired 30/09/2004)

Professor Helen Madeleine Lapsley, BA (Auckland), MEc (Sydney), FCHSE, Ministerial nominee [5]

Dr Julian Hertzl Lee, MBBS (Sydney), FRACP, FCCP, Australian Medical Association nominee [1] (term expired 30/09/2004)

Ms Julie McCrossin, LLB (NSW), BA (Sydney), Dip Ed (Sydney), Grad Dip Adult Education (UTS), Ministerial nominee [6]

Dr Robyn Napier, MBBS (Sydney), Australian Medical Association nominee (appointed 1 October 2004) [5]

A/Professor Frederick John Palmer, M.Litt (New England), MB ChB (Sheffield) MD (Sheffield), BA (New England), MRCP (London), DMRD (London), FRACR, FRCR (London), Royal Australasian College of Radiologists nominee [5]

Ms Diane Robinson, LLB (Sydney), BA (Sydney), Ministerial nominee (Legal) [6]

Dr Denis Andrew Smith, MBBS (Sydney), MHP, FRACMA, Royal Australian College of Medical Administrators nominee [6]

Professor Allan David Spigelman, MBBS (Sydney), FRACS, FRCS, MD, Universities nominee [5]

Dr Gregory Joseph Stewart, MBBS, MPH (Sydney), FRACMA, FAFPHM, Department of Health nominee [5]

Dr Kendra Sundquist, Ed.D (UTS), MHlth.Sc.(Ed) (Sydney), RN, MCNA, Ministerial nominee [6]

Dr Ian Kenneth Symington, MBBS (Sydney), FRANZCOG, FRCOG, Royal Australian and New Zealand College of Obstetricians and Gynaecologists nominee [4]

A/Professor Kathleen Anne Wilhelm, MBBS (New South Wales), MD, FRANZCP Royal Australian & New Zealand College of Psychiatrists nominee [5]

Dr Choong-Siew Yong, MBBS (Sydney), FRANZCP, Australian Medical Association nominee (appointed 1 October 2004) [4]

All Board members served on one or more of the Board's Standing Committees, including the Registration Committee, Conduct Committee, Health Committee, Performance Committee, Corporate Governance Committee, and various sub-committees established to deal with ad hoc matters throughout the year.

The Board 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, interview panels, Committees, etc.

Dr A Abrahams, Dr I Alexander, Dr S Allnutt, Dr K Arnold, Dr P Arnold, Dr K Atkinson, Dr A Badam, Dr S Benjamin, Dr J Bell, Dr B Bennett, Dr C Berglund, Dr F Black, Dr P Bland, Dr J Branch, Dr D Brash, Dr J Brown, Dr P Burn, Dr F H Burns, Dr R Carroll, Dr M Carlton, Dr I Chaussivert, Dr D Child, Dr C Clifton, Ms A Collier, Dr Crawford, Ms A Deveson, Dr M Diamond, Dr J Donsworth, Dr G Dore, Prof S Dorsch, Dr J Dudley, Dr K Edwards, Dr L Edwards, Ms G Ettinger, Dr A Eyers, Dr R Fisher, Dr D Floate, Dr T French, Dr M Friend, Dr P Friend, Dr R Gertler, Dr M Giuffrida, Dr A Glass, Dr M Gleeson, Prof W Glover, Dr R Gordon, Dr A Gould, Ms A Gray, Dr R Gyaneshwar, Prof J Ham, Dr N Harris, Dr J Hely, Dr N Hiramanek, Dr M Hollands, Prof J Horvath, Dr S Howle, Ms J Houen, Dr D Hunt, Dr S Huntsman, Dr K Hutt, Dr K Ilbery, Mr D Jackett, Dr M Joseph, Dr C Karalaris, Mr R Kelly, Dr J Kendrick, Dr E Kertesz, Dr G Kesby, Dr L King, Dr R King, Prof P Klineberg, Dr E Kok, Dr B Kotze, Ms R Kusuma, Dr P Langeluddecke, Dr C Lauer, Dr V Lele, Dr I Lorentz, Dr J Lovric, Dr R Lyneham, Dr S Mares, Dr P McInerney, Dr R McMahon, Prof P McNeill, Dr A Meares, Dr S Messner, Dr P Morse, Dr R Mulder, Ms M L Napier, Dr J Ng, Dr N O'Connor, Dr M Pasfield, Dr C Peisah, Dr A

Pethebridge, Dr J Phillips, Dr S Phillipson, Dr R Pillemer, Dr S Porges, Dr P Purches, Dr K Ramsay, Dr W Reid, Dr S Renwick, Dr G Rickarby, Dr J Rodney, Dr C Robinson, Dr I Rotenko, Dr A Samuels, Dr D Saunders, Dr R Seidler, Mr R Smith, Dr R Spark, Dr J Spies, Dr S Spring, Dr G Steele, Dr J Stevenson, Dr I Stewart, Dr J Sullivan, Dr D Sutherland, Dr V Sutton, Prof C Tennant, Dr S Toh, Dr S Tomas, Dr J Trollor, Dr P Tucker, Dr M Vamos, Dr F Varghese, Dr M Vukasovic, Ms A Walker, Prof R Walsh, Dr J Warden, Dr B Westmore, Dr J Wilkinson, Dr R Wilson, Dr J Woodforde, Dr M Wright, Dr M Wroth, Dr P Wyllie, Dr G Yeo.

New South Wales Medical Board Committees 2005

CONDUCT
Chair: P Procopis
B Kelly
M Kelly
K Sundquist
I Symington
K Wilhelm

HEALTH
Chair: K Wilhelm
P Procopis
M Kelly
H Lapsley
D Smith
K Sundquist
C Yong

PERFORMANCE
Chair: R Benn
P Procopis
M Fearnside
S Ieraci
B Kelly
J McCrossin
D Robinson
A Spigelman
G Stewart
I Symington

REGISTRATION
Chair: S Ieraci
P Procopis
R Benn
H Lapsley
J McCrossin
R Napier
J Palmer
J Rifi
D Smith
A Spigelman

EXECUTIVE
Chair: M Fearnside
P Procopis
H Lapsley
K Wilhelm
R Benn
S Ieraci

GOVERNANCE & AUDIT
Chair: H Lapsley
P Procopis
I Symington
D Smith
K Sundquist

NON-BOARD COMMITTEE MEMBERS 2005

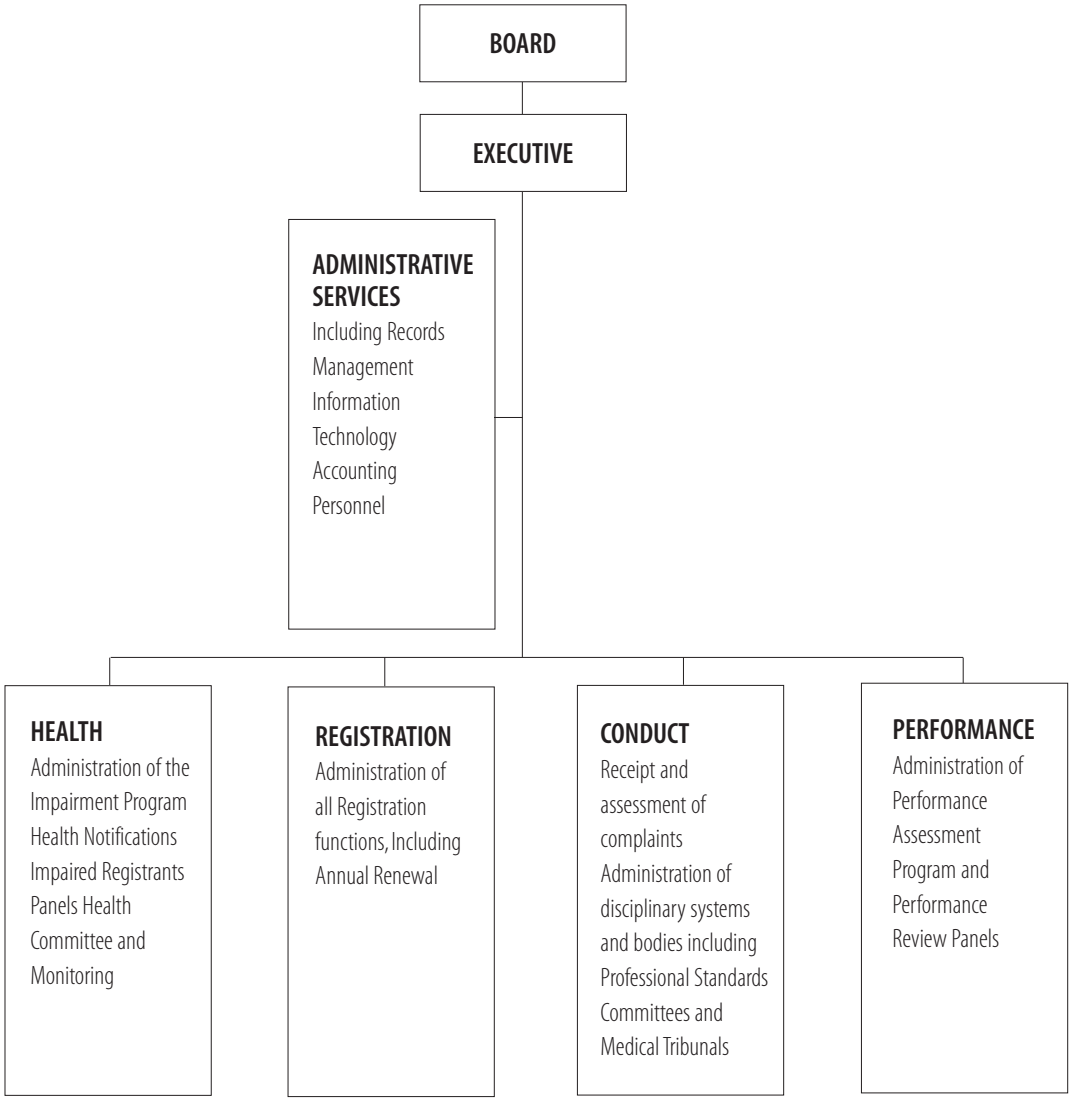
F Black
Y Saleh
R Walsh

F Black
Y Saleh
R Walsh

J Hely
M Hollands

P Browne
S Chan
J Hely
P Klineberg

NSW MEDICAL BOARD ORGANISATIONAL CHART 2005



ACTIVITIES

Management-related activities undertaken by the Board during the year have included:

Human Resources

Overview

In March 2005 the Board appointed Ms Joy Walker as Manager, Administration. The core functions of this role are to oversee the Board's human resources, IT activities, assets, administrative functions, assist the Registrar, senior staff and employees with staff matters.

An organisational restructure followed the resignation of Anne Scahill, Deputy Registrar from 1998 to 2005. The restructure has involved the creation of the position of Director of Legal Services to oversee the Board's legal functions and the Legal Team.

During 2004-2005 year there have been seven new employees recruited for various roles within the Board.

Staff Development

Staff have attended a wide range of relevant training courses, seminars and in-house activities.

In-house sessions have been held with staff in relation to Dealing with Psychiatric Illness, Training for Hearing Members, Risk Management – Self Assessment Tool.

Staff have attended a wide range of external courses.

Sick Leave

	2001/02	2002/03	2003/04	2004/05
Days lost	198	177	265	183
Per person average	5.7	5.5	7.5	4.9

Equal Opportunity Employment

All staff are employed by the Board in accordance with EEO principles, and a breakdown showing the various categories is as follows:

Total Staff	Male	Female	Aboriginal/Torres Strait Islander	NESB
39	3	36	0	7

Five females and one male are in management positions.

Occupational Health and Safety

Appropriate fire safety and emergency evacuation programs are in place and are regularly reviewed. Wardens attend two training sessions per annum, and conduct regular evacuation exercises. Management and staff are committed to ensuring a safe workplace without risk to health for all employees. New occupational health and safety policies were finalised during the year and discussed with staff and managers. There were no work-related injuries reported during the year. There were no prosecutions under the Occupational Health and Safety Act during the year.

In April 2005 the formal process of establishing OH&S representatives for each floor was implemented and in June 2005 the relevant accredited training for the four Consultation Committee members was undertaken and completed.

Executive Officers

The Board employs one SES level 2 and one SES level 1 officer, one of whom is female. This situation has changed since the previous year with the resignation of the Deputy Registrar, Ms Anne Scahill on 27 May 2005.

Overseas Travel

The Board funded Dr Alison Reid's travel to the United Kingdom to attend the International Physician Coalition in London in June 2005.

Insurance and Risk Management

The Corporate Governance and Audit Committee monitors and reviews the Board's risk management activities each year. The Corporate Governance Better Practice review was undertaken at its meeting held 18 May 2005. Through Treasury Managed Fund and the GIO partnership, the Board commenced a risk management review using the Self Assessment Tool developed by TMF-GIO and this review will continue during the 2005-06 year.

Workers Compensation Insurance with Treasury Managed Fund GIO is to be transferred to Allianz Workers Compensation, which was awarded the Workers Compensation No. 3 portfolio at the end of the 2005 financial year.

Privacy Report

The Board collects and retains information, including personal and health information about medical practitioners and patients, in the course of exercising its functions under the Medical Practice Act. It deals 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.

The Board is required to maintain a register of all medical practitioners in New South Wales and to make the information on the register publicly available. The Board makes allowances for registered medical practitioners to have their registered address suppressed on the Register in accordance with Section 58 of the Privacy and Personal Information Protection Act 1998. A number of medical practitioners have asked the Board to suppress such details.

Consultants

Consultancies equal to or more than $30,000

Consultant	Cost $	Title/Nature
Information Technology		
Red River Solutions	75,100	Software development
Red River Solutions	121,775	Support and consultancy
Sub-total	196,875	
Electronic Document Management Project		
HLB Mann Judd	37,308	Consultancy
Sub-total	37,308	
Total consultancies equal to or more than $30,000	**234,183**	

Consultancies less than $30,000

During the year 2004-05 other consultants were engaged in the following areas:		
Internal Audit Bureau	1,645	Finance and accounting
Internal Audit Bureau	6,350	Transition to AEIFRS
Palm Consulting Group	5,776	Strategic Planning workshop
Jill Wawn & Associates	5,200	Human Resources
Total consultancies less than $30,000	**18,611**	
Total Consultancies	**252,794**	

Ethnic Affairs Priority Statement

The Board's primary function is the administration of the provisions of the Medical Practice Act, 1992, and it flows from this that a key priority in relation to Ethnic Affairs is to ensure that the provisions of the Act are administered fairly and consistently. The Act prescribes acceptable qualifications for the purposes of registration, and the Board is clearly bound by these requirements, regardless of the ethnicity of applicants. The Board is, however, able to grant discretionary registration, and it is in this area that it has focused its attention to ensure equal treatment, regardless of country of origin or training.

Progress and achievements in the year under review have included the following:

- ➔ Continuing development of policies to facilitate access to area of need and postgraduate training positions.
- ➔ Between July 2004 and June 2005, 38 practitioners were approved for GP area of need positions, 34 for RMO/CMO positions and 42 for specialist positions. These practitioners are overseas-trained doctors from a range of countries such as Colombia, Egypt, India, Iraq, Pakistan, Syria, the Philippines, Nigeria, Switzerland, Russia and Bangladesh.
- ➔ Continued support for the Postgraduate Medical Council orientation course designed to assist AMC graduates prior to their entering teaching hospitals for their requisite period of supervised training.
- ➔ Increasing the number of Panel members from non-English speaking backgrounds sitting on Professional Standards Committees, Medical Tribunals, Impaired Registrants Panels, Performance Review Panels, conducting peer audits and Board Reviews.
- ➔ Presentation at Information Sessions for overseas-trained doctors.
- ➔ Membership of the Department of Health/Australian Doctors Trained Overseas Association Liaison Committee.

Strategies identified for the forthcoming year include the following:

- Continuing exploration of ways to include greater ethnic diversity on Board Committees, hearing panels and peer audits.
- Continued review of policies in relevant areas, and promotion of national uniformity in relation to these policies.
- Participation in Australian Medical Council discussions concerning enhancement of the support provided to practitioners trained overseas to orient them to Australian practice.

Promotions, Publications and Presentations

The Board's website has become its primary means of communicating with the public and the profession, and the site is updated regularly to reflect legislative and policy changes, and to provide electronic interface with inquirers and registrants.

The Board Newsletter is sent bi-annually to all registrants, and issues covered in the most recent newsletters have included:

- Self-reporting of impairment
- Issuing of sickness certificates
- Pecuniary interests and patients
- Mandatory professional indemnity insurance requirements
- The Camden-Campbelltown Inquiry
- Introduction of a new category of registration for limited prescribing and referral
- Amendments to guidelines for medico-legal consultations
- English language skills requirements for registration
- Cosmetic surgery
- Complementary health care policy
- Kickbacks and professional misconduct.

Board members and secretariat speak at seminars, conferences and meetings on a wide range of issues, including Performance Assessment, the Medical Practice Act amendments, general practitioner training, professional indemnity insurance requirements, area of need registration and overseas-trained doctors.

Waste Reduction and Purchasing Plan (WRAPP)

The Board's Waste Reduction and Purchasing Plan (WRAPP) was developed in conjunction with the previous Environmental Protection Agency 1998, now the Department of Environment and Conservation (NSW). The Board regularly monitors its compliance with the Plan, with its major features being reduction in generation of waste by use of electronic communications, use of recycled materials and staff education in relation to these matters.

Legal Change

The most significant legislative change affecting the Board is encompassed in the provisions of the Health Legislation Amendment Act, 2004, and the Health Registration Legislation Amendment Act, 2004. These Acts were passed by NSW Parliament in October 2004, and came into effect on 1 March 2005.

The legislation principally deals with issues raised by the Special Commission of Inquiry into Campbelltown and Camden Hospitals, and the principal amendments affected both the Medical Practice Act and the Health Care Complaints Act.

The Medical Practice Act has been amended to more clearly distinguish acts or omissions which constitute unsatisfactory professional conduct as defined in Section 36 from acts or omission which may constitute evidence of unsatisfactory performance under Section 86. The Board's obligation to notify doctors of complaints received has been transferred entirely to the HCCC, and the requirement for a statutory declaration to be prepared before referring a complaint to a disciplinary hearing has been deleted. The Act has made it explicit that Board members may not be appointed to sit on a Medical Tribunal or a Professional Standards Committee, while limited rights of representation by an adviser (other than a barrister or solicitor) have been introduced to Professional Standards Committees.

Amendments to the Health Services Act require CEOs of public health organisations to notify the Board of suspected professional misconduct or unsatisfactory professional conduct on the part of an employee or visiting practitioner.

The Health Care Complaints Act has been substantially amended. The objects of the Act have been restated to focus on receipt and assessment of complaints, and investigating and prosecuting serious complaints. A new assessment hierarchy has been established which makes it clear that if a matter is referred to the Board at initial assessment, the Commission has no further role to play in that matter. The Commission has a general power to undertake ongoing review of matters with a view to reassessing them, and failure to comply with requests for further information can lead to a complaint of unsatisfactory professional conduct. Statutory declarations are no longer required to commence an investigation, and a new office of the Director of Proceedings has been created with the aim of independently assessing proposed references to a disciplinary hearing prior to referring matters to the Medical Tribunal or Professional Standards Committee.

Corporate Governance and Audit Committee

The Corporate Governance and Audit Committee met twice during the year. Issues considered included risk assessment and management, budgetary process review, safety of Board members and staff, confidentiality of Board proceedings, the Camden/Campbelltown Inquiry and Board self-evaluation.

Freedom of Information

This year has seen fewer requests for information under the Freedom of Information Act, 1989 (NSW) compared to last year. The Board responds promptly and openly to all applications under the provisions of the Act.

The Medical Board has Statements of Affairs on each of the following:

- ➔ Medical Board
- ➔ Medical Tribunal
- ➔ Professional Standards Committees
- ➔ Impaired Registrants Panel
- ➔ Performance Review Panel

During the year 1 July 2004 to 30 June 2005, the NSW Medical Board received five enquiries about applying for documents held by the Board. Members of the public and practitioners are regularly informed by the Board secretariat that consideration should be given to making an application under the Act in appropriate circumstances. Information was provided informally to some enquirers.

The Board received and processed eleven applications for access to documents under the Act within the required timeframe. This compares with fifteen applications in 2003/2004 and six applications in 2002/2003. The Board provides practitioners with information sought from their personal files unless FOI exemptions apply.

This year, the Board complied with requests from five practitioners to access all or some of the information on their files. Of these, one practitioner was provided with approximately 200 documents. One of these applications was still to be completed as at the end of this reporting period.

In addition, five applications received in the previous reporting year were finalised.

Three patients sought access to information on medical practitioner files against whom they had made a complaint.

The Board received a full and a partial transfer of two applications made under Freedom of Information from two other government departments.

In the reporting period, one application was received for an internal review of the Board's decision. There have been no appeals filed in the Administrative Appeals Tribunal of NSW.

REVIEW OF OPERATIONS

REGISTRATION

Overview

The overall number of registered practitioners continues to grow, with an increase of 2.8% over the previous year, bringing the total at 30 June 2005 to 27,089. Practitioners registered to work in area of need positions have increased in the last year from 217 to 247, postgraduate trainees from 1,082 to 1193, and overseas trained specialists from 511 to 624.

In May 2005 the Minister approved a new category of registration at a reduced fee called Limited Prescribing and Referral to facilitate those practitioners who have retired from practice and wish to utilise the Health Care Liability exemption from holding professional indemnity insurance. Until that time practitioners were required to hold full registration and pay the full fee to be able to undertake such limited practice.

A number of policies were reviewed and modified during the year, including:

- ➔ English language proficiency
- ➔ Certificates of good standing
- ➔ Waiver of supervised training
- ➔ Area of need supervision
- ➔ Progression of interns and AMC supervised trainees to general registration

While most interns and AMC graduates are able to progress to general registration after 1 year of supervised training, a small number require additional terms and support to reach the required level of performance. The degree and area of deficit varies, but most registrants are able to satisfactorily complete their internship / supervised training with additional terms. There must, however be a realistic limit to the time required to satisfactorily complete an internship or supervised training. To facilitate the management of intern registration, a set of principles and guidelines has been developed, outlining the steps required for underperforming interns and supervised trainees.

This is based on the Board approving up to two 6 month extensions of internship/supervised training, during which the registrant must demonstrate substantial progress towards general registration. If not, registration will not be renewed.

During the year the Board conducted 15 interviews of interns and supervised trainees who had been referred to the Board as not progressing satisfactorily during the period of their internship or supervised training.

The Registration Committee has considered an increasing number of applications for registration from practitioners who have been away from clinical practice for a number of years, highlighting the need for a policy and process to consider such applications. This will be addressed in the coming year.

During the year the Board conducted 107 panel assessments for Area of Need GP and non-specialist hospital positions. Of these, 72 applicants were assessed as suitable for the specific position while 35 (30 GP and 5 RMO/CMO) were unsuccessful. While the Board to date has the most stringent requirements of all Australian Boards for registration of overseas trained doctors, the Registration Committee undertakes an ongoing assessment of the Board's Area of Need program at a case by case and overall level. A number of additional documents are now required to complete the registration process, and after the completion of a review in the second half of 2005, a refinement of processes will be undertaken.

During the year 61 Area of Need registrants moved to other categories of registration based on successfully completing AMC examinations or assessments. 31 transferred to Conditional Specialist, 22 to General registration and 8 to AMC supervised training.

Registration Workflow

General Registration

General registration is granted to applicants who meet all requirements for unconditional registration. For administrative purposes, applicants for general registration are separated into various categories. The following table details the number of registration approvals in each category for this year and previous years.

The different pathways to general registration are defined as follows:

	2002/03	2003/04	2004/05
Internship complete	365	430	432
General registration	138	129	134
Re-registration	327	556	492
Mutual recognition	619	757	773
AMC complete	99	118	105
Total	1548	1990	1936

➔ Internship Complete

Applicants who hold primary medical qualifications conferred by Australian and New Zealand universities accredited by the Australian Medical Council who have completed their internship.

➔ General Registration

Applicants who hold primary medical qualifications conferred by Australian

and New Zealand universities who are first-time registrants in NSW, who have completed an internship and are not eligible for registration under mutual recognition legislation.

→ Re-registration

Restoration to the Register after lapse for non-payment of the annual registration fee.

→ Mutual Recognition

Applicants who have become registered by virtue of current general registration in a participating State under the Mutual Recognition Act, 1992 regardless of primary qualification.

→ AMC Complete

Applicants who have completed the Australian Medical Council examinations and the required period of supervised training.

Conditional Registration

Conditional registration is granted to applicants who do not meet the requirements for general registration. The following table details the number of applicants granted initial registration in each category for this year and previous years.

	2002/03	2003/04	2004/05
Interns	477	460	463
AMC graduates	71	80	95
Postgraduate Trainees – Initial application	786	799	848
General Practice trainees – Initial application	121	154	152
Unmet areas of need – Initial application	146	113	114
Overseas trained specialists	124	98	154
Specialist assessment	12	6	1
Academic appointments	5	0	1
Temporary Board discretion	16	18	6
Medical exchange	1	0	0
TOTAL	**1759**	**1728**	**1834**

The categories of conditional registration are defined as follows:

→ Interns

Recent graduates of Australia and New Zealand Universities registered to undertake 12 months training as an Intern.

→ Australian Medical Council Graduates

Holders of primary medical qualifications from universities outside Australia and New Zealand who have completed the Australian Medical Council examinations and are undertaking 12 months' supervised training. This will normally commence at intern level, although accelerated progress may be approved in appropriate circumstances.

→ Postgraduate Trainees

International medical graduates undertaking a period of postgraduate training.

→ General Practice Training Program

A reciprocal arrangement exists between training programs in the United Kingdom and the Royal Australian College of General Practitioners which allows UK family practice trainees to work in approved and accredited hospitals in terms which are accredited for general practice training. The majority of terms and training that occurs in these hospitals relates to either Obstetrics/Gynaecology, Accident and Emergency, General Paediatrics and Palliative Care.

→ Unmet Areas of Need

Registrants practising in a position of need as declared by NSW Health. All applicants are assessed by an independent assessment panel to ensure that their training, experience and communication skills are suitable for the position.

→ Specialists

Overseas-trained specialists whose training and experience is the equivalent of local specialists, as assessed by the relevant college. Registration is limited to the appropriate specialty.

→ Overseas-trained Specialists Assessment

Overseas trained specialists who have been assessed by the relevant College and are required to undertake further top-up experience, up to a maximum of two years.

→ Academic Appointments

Overseas qualified medical practitioners filling academic positions in New South Wales. Registration, when granted, is by virtue of and during the tenure of the appointment only.

→ Public Interest

(i) Temporary Board Discretion
Conditional registration for applicants spending a minimal amount of time in New South Wales, for example, assisting in an operation, participating in a seminar.

(ii) Medical Exchange
Conditional registration for applicants on an educational exchange, with College support.

Practitioners Removed from the Register

The following table details the number of registrants removed from the Register for the 2004/05 year and previous years.

	2002/03	2003/04	2004/05
Deceased	88	56	48
At own request	746	792	408
Non-payment of registration fee	704	996	1000
Term of conditional registration expired	416	666	764
Other	131	73	0
Withdrawal	63	52	54
Declined	16	16	27
Medical Tribunal	5	7	4
Total	**2169**	**2658**	**2305**

PROFESSIONAL CONDUCT

Overview

The major issue for the Board in the previous reporting year was the Special Commission of Inquiry into Camden-Campbelltown Hospitals (SCI) announced in December 2003. Changes in personnel and strategic direction at the HCCC followed the announcement of the Inquiry and, as the Board had anticipated, the impact of these changes on the Board and the overall complaints system have been more significant during this reporting year. Strategies adopted by the HCCC included a backlog reduction strategy and focus on complaints that had been outstanding for several years, as well as dealing with the issues raised by the Commission's earlier investigation into Camden/Campbelltown Hospitals.

By the end of the reporting year, the HCCC had finalised the investigations of the complaints identified as constituting the backlog of outstanding investigations, with the exception of one matter. In the period under review, 356 investigations were finalised, an increase of 230% on the previous year.

The SCI made a number of recommendations for legislative change, both to the Health Care Complaints Act and the Medical Practice Act. Amendments to the legislation commenced on 1 March 2005 and the effects of the amendments on the process of initial assessment of complaints are discussed later in this report. Of particular note is the establishment of the position of the Director of Proceedings, appointed by the HCCC but independent of the HCCC. Should the HCCC consider that a matter may warrant referral to a Professional Standards Committee or the Medical Tribunal at the conclusion of investigation, it consults the Board with a recommendation that the matter be referred to the Director of Proceedings. The Director of Proceedings then makes a determination as to whether a complaint ought to be prosecuted and if so, before which disciplinary body. Similarly to the requirement that the HCCC consult with the Board prior to deciding on an appropriate outcome for an investigation, the Director of Proceedings must consult with the Board before determining whether or not a complaint ought to be prosecuted before a disciplinary body.

Previously the HCCC could finalise an investigation by referring the practitioner to the Board for counselling. A further amendment to the Health Care Complaints Act provides that the HCCC may now finalise an investigation by referring the practitioner to the Board and in addition to disciplinary counselling, the Board may determine to deal with that practitioner through the Health or Performance programs.

For the year ending 30 June 2005, 1080 complaints received against medical practitioners were jointly considered by the Board and the HCCC, and an assessment made as to the appropriate way to deal with each complaint. The Board and the HCCC referred 19% of complaints to the HCCC for investigation, this being the second most common assessment after declining to deal with complaints, and an increase of 6% from the previous year.

Once an investigation is completed, the HCCC must consult with the Board before deciding what action to take. Options include:

- ➔ to terminate an investigation and take no further action against the practitioner;
- ➔ that the HCCC make comments in a letter to the practitioner;
- ➔ to refer the practitioner to the Board for action under the Medical Practice Act; or
- ➔ refer the matter to the Director of Proceedings who will determine whether a complaint ought to be referred to a disciplinary hearing.

Of the 356 investigations closed in the period under review, the most common outcome was that no further action was required (47%). A total of 19 complaints against 18 practitioners was finalised by referral to Professional Standards Committees (PSC). Additionally, a total of 65 investigations involving 35 medical practitioners was finalised by referral to the Medical Tribunal.

Seven appeals were lodged in the Medical Tribunal, three against decisions of Professional Standards Committees and four against decisions of the Board following its consideration of applications for registration as a medical practitioner in New South Wales. Four practitioners applied to the Medical Tribunal for review of de-registration orders made by previous Tribunals, and two practitioners applied to the Tribunal to have conditions imposed upon their registration reviewed.

The Board also conducted seven Schedule 1 Inquiries into registration applications.

The Complaint Handling Process

The following data details complaints received during the year.

Type of Complaint			%
	2002/03 n=1129	2003/04 n=1030	2004/05 n=1080
Clinical Competence	45	47	53
Communication	20	18	17
Conduct	27	28	22
Practice Administration	8	7	8

Clinical competence continues to dominate as the main area of complaint, with issues raised including misdiagnosis, incorrect clinical advice and complications following procedures. Complaints concerning conduct include inappropriate prescribing, medical records, medical reports and certificates.

A small proportion (3% of the total) allege assault or boundary crossing by the practitioner.

Assessment of Complaints

Both the HCCC and the Board can receive complaints against medical practitioners. The Board and the HCCC, at a weekly Assessment Committee meeting, assess complaints received by either body. Changes to consultation and assessment procedures, introduced by the HCCC following the SCI, are still being worked through.

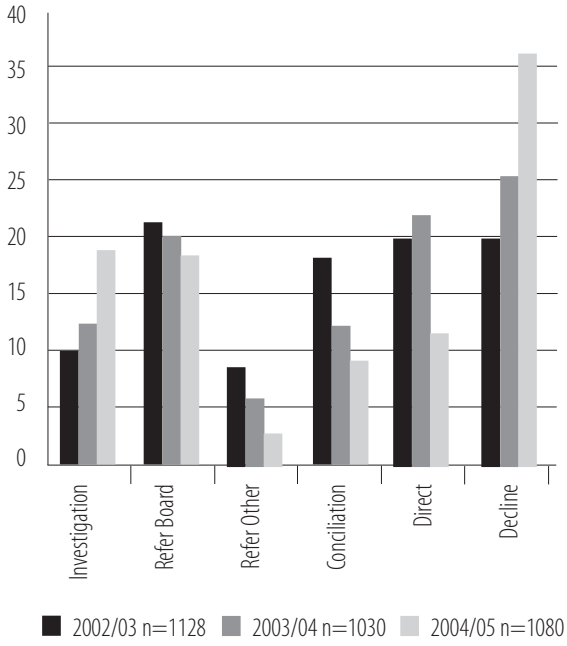
It was the previous practice of the HCCC to submit complaints received by it to the next weekly Assessment Committee meeting with the Board. Following amendments to the Health Care Complaints Act commencing on 1 March 2005, it now conducts an analysis of the issues raised in the complaint and confirms it has correctly identified those issues with the complainant prior to making an assessment of the complaint.

In response to the Board's concern that it was not being immediately notified of complaints, the HCCC now sends copies as they are received for the purposes of notification rather than consultation and assessment. This enables the Board to review each matter and to determine whether a complaint raises such serious issues that the Board ought to consider whether urgent action is necessary to protect the life or physical or mental health of any person. As this process of notification to the Board did not commence for some months after the HCCC changed its process, some complaints received by the HCCC during the reporting year have not yet been assessed and will be reflected in the figures for the next reporting year.

This initial assessment of the 1080 complaints that were assessed during the year resulted in the following actions:

- ➔ referral to investigation by the HCCC – 19%
- ➔ referral to another person or body such as the Pharmaceutical Services Branch for investigation – 3%
- ➔ referral to the Board – 18%
- ➔ referral to the Health Conciliation Registry for conciliation – 9%
- ➔ direct resolution between the practitioner and the complainant – 13%
- ➔ declining to deal with the complaint – 38%

The chart below illustrates trends in initial assessment for the last three years.



Of note is the significant increase in the number of matters that the Board and HCCC have declined to deal with, and the increase in matters referred for investigation by the HCCC. The HCCC has conducted more extensive pre-assessment enquiries during the year and therefore matters that may have otherwise been referred to the Board, the Health Conciliation Registry or for direct resolution have been declined on the basis of the additional information available at the time of assessment. Prior to the change to its assessment process, which formally commenced from 1 March 2005, the HCCC would submit such complaints to the weekly Assessment Committee meeting with a recommendation that additional information be sought prior to making an assessment. Matters that would previously have been referred to an Area Health Service for investigation are now investigated by the HCCC itself, and this combined with the 4% of the total number of complaints assessed that were referred for investigation as a result of the Camden-Campbelltown Inquiry, has contributed to the increase in matters referred for investigation by the HCCC. Investigation must be undertaken if either the Board or the HCCC require it.

The Board considers that investigation (with a view to disciplinary action should a complaint be substantiated) is only appropriate in matters where 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 and professional standards maintained through the application of non-disciplinary and educative responses. This conceptual framework will continue to be used by the Board when assessing new complaints received.

Complaints investigated by the HCCC

The number of complaints referred to the HCCC for investigation was 205. These complaints were referred on the basis that, on initial consideration, they appeared to one or both parties to the assessment to raise a significant issue of public safety, or to provide grounds for disciplinary action against a medical practitioner. At the completion of investigation, the HCCC consults with the Board's Conduct Sub-Committee on its proposed outcomes for the investigation. The final decision on outcome rests with the HCCC, after the required consultation.

The number of investigations closed this year was 356, compared with 155 closed in the previous year. In March 2004, 207 complaints against medical practitioners were identified by the HCCC as constituting the backlog of outstanding investigations. As at 30 June 2005 only one of these complaints remained under investigation. The Board had anticipated a significant increase in the numbers of matters referred to disciplinary hearing as a consequence of the HCCC's backlog reduction strategy, and budgeted accordingly.

The majority of the complaints closed following investigation by the HCCC were closed without referral to a disciplinary hearing (59%). This figure includes matters where the HCCC made comments to the practitioner. These investigations were terminated because they were either unsubstantiated or did not warrant disciplinary action or, in the case of some matters that had been under investigation for an extended period, because disciplinary action was no longer appropriate given the passage of time.

The remaining 41% of investigations closed were referred for disciplinary action following consultation between the Board and the HCCC. Of these actions, 65 were referred to the Medical Tribunal, 19 to Professional Standards Committees and 31 to counselling. From 1 April 2005 to 30 June 2005, 31 investigations have been concluded by referral to the Director of Proceedings and of these, one has been referred to a Professional Standards Committee and five have been referred to the Medical Tribunal within the reporting year.

Some practitioners had a number of complaints which were referred to a disciplinary hearing at the completion of the investigation, but which constituted only one formal complaint against the practitioner. The 65 investigations closed by referral to the Medical Tribunal equate to the referral of complaints against 35 practitioners to the Medical Tribunal, and the 19 investigations closed by referral to Professional Standards Committees equates to the referral of 18 practitioners. It should be noted that six of the 35 complaints against medical practitioners referred to the Medical Tribunal had not been formally referred as they were awaiting finalisation of the particulars of the complaints.

One investigation was finalised by referral of the practitioner to the Board's Performance Program.

Investigations Arising from the Inquiry into Camden and Campbelltown Hospitals

Of the 205 complaints referred for investigation in this year, 43 arose from the HCCC's previous investigation into Campbelltown and Camden Hospitals. Including those matters referred for investigation in the previous reporting year, 70 incidents concerning medical practitioners were referred for investigation following the Special Commission of Inquiry into Campbelltown and Camden Hospitals. Some practitioners were the subject of more than one investigation and these 70 incidents equate to investigations concerning 48 medical practitioners.

As at 30 June 2005, the HCCC had concluded its investigation and consulted with the Board on 66 of the 70 incidents. The table below details the outcomes of these investigations by incident and by medical practitioner. Where a medical practitioner had multiple investigations and with varying outcomes, the most serious finding against that practitioner has been reported.

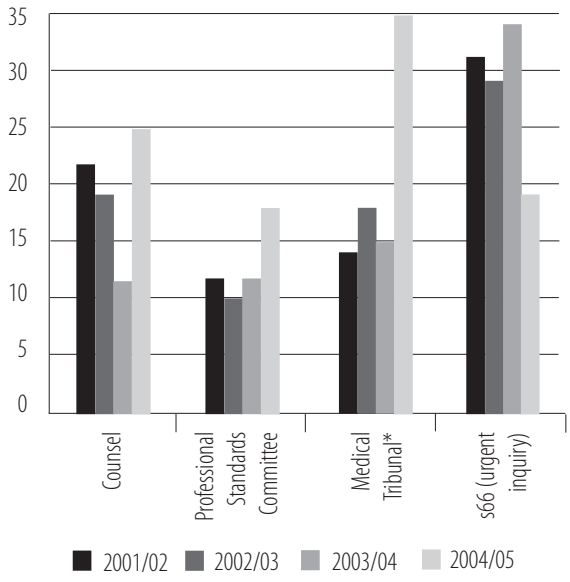
Outcome of investigation	Incident n = 70	Practitioner n = 48
No further action	35	20
Comments	15	15
Counselling	7	3
Professional Standards Committee	2	2
Medical Tribunal	4	4
Referral to Director of Proceedings	3	3
Remaining under investigation	4	1

Complaints remaining under investigation

At 30 June 2005, the HCCC reported 138 complaints currently under investigation.

Disciplinary Hearings

The following graph illustrates the numbers of practitioners referred to disciplinary hearings during the last three periods:



* The total for Medical Tribunals refers to practitioners against whom a complaint has been referred. It does not include Appeals filed in the Tribunal, or applications to the Medical Tribunal for review of conditions imposed or an order for de-registration made by a previous Tribunal.

Counselling

In the year under review, 31 investigations were finalised by the referral of 25 practitioners to the Board for counselling. Counselling occurs when there are issues of concern, which may constitute a recognised departure from accepted standards of practice, or where the Board requires to assure itself that the practitioner is aware of accepted standards of practice and conduct. 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.

Some matters that constituted part of the HCCC's backlog of outstanding investigations were finalised by referral to counselling because of the passage of time, and may have warranted referral to a Professional Standards Committee or Medical Tribunal if the investigation had been concluded earlier.

Professional Standards Committee

In the year ending 30 June 2005, the HCCC referred complaints in relation to 18 practitioners to a Professional Standards Committees, and 19 Professional Standards Committees were held.

Since the year 2000, most complaints concerning professional standards have been dealt with in the Performance Program, leaving those where the practitioner's conduct raises significant issues of public health and safety to be referred to Professional Standards Committees. The Board considers whether the conduct was reckless, unethical, wilful or criminal in initially determining which path will be followed.

Section 93 Application for review of conditions

One Section 93 review of conditions imposed by a Professional Standards Committee was held during the year.

Section 66 Inquiries – Urgent action to protect the public

The Medical Board must exercise its powers to either suspend a practitioner for a limited period (up to eight weeks) or impose conditions upon their registration where it is reasonably satisfied that such action is necessary for the protection of the public's health or safety. Such action is an interim measure only. Suspension for a period of greater than eight weeks requires the approval of the Chairperson or a Deputy Chairperson of the Medical Tribunal. Where the Board takes action under section 66, the matter must be referred to the HCCC for investigation (except in cases of impairment). The Commission is to investigate the matter and refer a complaint to a Professional Standards Committee, Medical Tribunal or consent to refer the practitioner to an Impaired Registrant's Panel.

The Medical Board has conducted 18 Section 66 Inquiries in this year and one review of orders imposed under section 66 (compared with ten reviews conducted in the previous reporting year).

The Board has exercised this power in a variety of circumstances, including where practitioners:

- ➔ have been charged with serious criminal matters (whether arising within or outside the practice of medicine)
- ➔ suffer from a serious impairment and demonstrate little or no insight into the extent of their problem and the risk they pose to the public
- ➔ have continued to recklessly prescribe drugs in a manner which is dangerous and likely to cause harm, despite previous warnings or counselling.

Schedule 1 Inquiries

The Board referred 12 applications for registration to a Schedule 1 Inquiry. When the Board is not satisfied as to the eligibility of an applicant for registration, it must conduct an Inquiry into the application. The Inquiry may grant or refuse registration or may determine that registration be granted subject to the imposition of conditions. Three applications were withdrawn following referral to an Inquiry and two are to convene in the next reporting year.

The Board also refers applications for re-registration to such an Inquiry if there are issues of health, character or competence that may affect the applicant's fitness to practise medicine.

MEDICAL TRIBUNAL

Matters commenced in Tribunal 2004/2005

In the year under review, 48 matters were commenced in the Medical Tribunal of New South Wales. This compares with 18 matters in 2003/04 and 27 in 2002/03.

The table below profiles the matters commenced in the Tribunal in the last three years.

Complaints	2002/03	03/04	04/05
Sexual misconduct	6	3	8
Prescribing	2	7	13
Breach conditions	3	1	3
Treatment	1	1	9
Competence/Impairment	4	2	2
Fraud	2	1	0
Appeals			
PSC	0	1	3
Registration	2	0	4
Conditions/suspension	2	0	0
Restoration	3	2	4
Review of Conditions	2	0	2
Total	27	18	48

Matters Finalised in the Tribunal 2004/2005

The Tribunal determined matters in the following categories.

1. Complaints	20
2. Appeals	6
3. Reviews	8
Total	**34**

The table below shows the outcome of 20 complaints determined by the Tribunal in 2004/2005.

COMPLAINTS

Sexual Misconduct/ Boundary Crossing	
Chatterjee, B (076531)	Reprimand, fine
Cheng, ESP(208962)	Reprimand, fine
Jones, RS (235110)	Not to be re-registered, no review 5 years
Rivera, D (339342)	De-registration
Tse, B (332201)	Reprimand
Breach Conditions	
Bills, RM (208828)	Dismissed
Lindsey, PH (59085)	Not to be re-registered, no review 2 years
Michael, A (200653)	De-registered, no review 2 years
Prakash, KV (92615)	De-registered, no review 2 years
Reeves, GS (165159)	De-registered, no review 3 years
Breach Policy	
Ma, WKW (334212)	Reprimand, conditions
Prescribing	
Barratt, GI (008373)	Reprimand, conditions
Devsam, JA (275623)	Reprimand, fine, conditions
Hamad, GMT (027467)	Reprimand, conditions
Joseph, A (026513)	Withdrawn, undertaking to remove name
Roehrich, E (187762)	Conditions
Tsouroutis, M (183406)	Conditions, no review 2 years
Competence	
Lindsay, DC (248911)	Reprimand
Conviction/impairment	
Corbett, PH (179993)	Reprimand

Matters Outstanding

As at 30 June 2005, 34 matters referred to or filed in the Tribunal in this or previous years await determination. This compares with 25 in the year ended 30 June 2004 and 24 in the year ended 30 June 2003.

Complaints

Heard/part-heard

One matter has been heard and awaits judgment.

Listed for hearing and to be listed for hearing

Four matters have been listed for hearing before December 2005 and 25 are yet to be listed for hearing.

Appeals

An appeal on a point of law arising in a Professional Standards Committee has been referred to the Tribunal and is listed for hearing before December 2005. An appeal against a decision of a Professional Standards Committee has been referred to the Tribunal and is yet to be listed for hearing.

Reviews

Two applications for review of a de-registration order have been lodged in the Tribunal and remain outstanding. One is listed for hearing before December 2005 and one is yet to be listed for hearing.

CASE STUDIES

PROFESSIONAL STANDARDS COMMITTEES

Competence

➔ *Inappropriate prescribing*

A career medical officer working in an emergency department, faced two complaints. The first complaint alleged that he prescribed 500mg of methadone to a patient; the second that following a paracetamol overdose, he administered 22.5g of parvolex for a three year old, 15kg patient, being ten times the recommended dose. The Committee found the complaints proven, reprimanded the practitioner and imposed a condition on his registration requiring him to only work in an emergency department when there was a senior medical officer present and prohibiting him from being the senior member in charge.

➔ *Changing a patient's medication without consulting the specialist*

The complaint alleged that the general practitioner failed to take an adequate cardiac history, failed to arrange for appropriate investigations and failed to consult with the patient's specialist prior to ceasing the patient's medication. The complaint further alleged that the practitioner subsequently attended the patient's funeral and addressed the congregation in circumstances where she disclosed confidential information about the patient and made inappropriate comments. The Committee found the complaint proven, reprimanded the practitioner and directed that she attend a course on appropriate communication.

➔ *Failure to obtain consent and communicate postoperatively*

A specialist obstetrician and gynaecologist faced a complaint that he inappropriately performed sub mucous fibroid resection, inappropriately performed a partial or complete endometrial ablation to treat intra-operative bleeding when he did not have the patient's consent, and failed to inform the patient of this prior to her discharge and/or during subsequent consultations. The Committee found the complaint proven, cautioned the practitioner and imposed a condition prohibiting him from performing operative hysteroscopy until he had been accredited by the Royal Australian College of Obstetricians and Gynaecologists.

➔ *Failure to appreciate acute abdomen*

An intern faced a complaint that he failed to appreciate the severity of the patient's illness, failed to consult with a more senior member of the hospital staff, failed to arrange for appropriate investigations, inappropriately diagnosed and treated the patient for constipation and inappropriately discharged the patient from hospital. The patient had presented at the emergency department complaining of severe abdominal pain and the patient was found to have acute appendicitis. The Committee found the complaint proven, reprimanded the practitioner, and ordered that he undertake an appropriate communication course and the Emergency Life Support course conducted by the Australasian Society of Emergency Medicine.

Conduct and Competence

➔ *Prescribing pethidine to wife*

A general practitioner faced a complaint alleging he inappropriately treated his wife by supplying and administering pethidine for a period exceeding two months without applying for the relevant authority and that he issued prescriptions for pethidine in the names of other persons in order to obtain pethidine for her. The Committee found the complaint proven, reprimanded the practitioner and directed that his registration be subject to conditions including the withdrawal of his Schedule 8 prescribing authority, that he work under supervision, that he be prohibited from treating family members and that he undertake a course on clinical skills in drug and alcohol medicine.

➔ *Medicare Fraud*

At the time of the incident, the general practitioner was an approved pathology practitioner who was convicted of eighteen offences of making false statements to the Health Insurance Commission. The Committee found the complaint proven and reprimanded the practitioner. It directed that, although he was not currently registered in New South Wales, should the practitioner be reregistered, then he be subject to conditions requiring him to complete a course on ethics.

➔ *Failure to physically examine patient and altering medical records*

A general practitioner faced a complaint alleging that when the patient presented with symptoms of stomach pains, nausea, recent dry retching and pallour, the practitioner failed to physically examine the patient, incorrectly told the patient he had a virus and failed to obtain and record a proper clinical history, including a history regarding the patient's diabetes. The complaint further alleged that the practitioner subsequently made additions to the patient record which were not contemporaneous. The practitioner acknowledged her error of judgment in altering the records. The Committee found all the particulars of the complaint proven, and cautioned the practitioner.

➔ *Self-administration of nitrous oxide*

It was alleged that the medical practitioner had on two occasions whilst on duty as a registrar, self-administered nitrous oxide. The practitioner admitted to the particulars of the complaint and admitted that his actions amounted to unsatisfactory professional conduct. The Committee found the complaint admitted and proven, and reprimanded the practitioner.

➔ *Inappropriate relationship with patient and inadequate records*
The complaint against the general practitioner related to a period when he was undertaking postgraduate training in psychiatry and was employed as a psychiatric registrar. The complaint alleged that he breached the professional doctor-patient relationship by giving the patient his private phone number, telephoning the patient at her home, giving the patient personal items and by taking the patient for a drive at night and driving the patient home. The complaint further alleged that the practitioner failed to maintain adequate clinical records. The practitioner admitted that he breached the professional doctor-patient relationship and that he failed to maintain adequate clinical records. The Committee found the complaint proven in that the practitioner demonstrated a lack of judgment and care in the practice of medicine, reprimanded the practitioner, and imposed conditions on his registration, limiting him to work only in a group general practice under supervision.

➔ *Leaving operating theatre and refusing a request to attend*
The medical practitioner was employed as a visiting medical officer general practitioner with privileges in anaesthetics. It was alleged that he left anaesthetised patients on the table while he lifted weights and had on one occasion refused a request to attend a patient. Further complaints concerned non-compliance with infection control policies and alleged inappropriate behaviour in theatre. The Committee found the particulars of the complaint proven, and imposed conditions on the practitioner's registration requiring him to familiarise himself with the NSW Department of Health's policy on infection control, work for a period of time with an experienced anaesthetist and subsequently enter into a mentorship arrangement with the anaesthetist to review specific cases or any clinical incidents.

SECTION 93 APPLICATION – REVIEW OF PROFESSIONAL STANDARDS COMMITTEE CONDITIONS

Following a request by a practitioner to have conditions imposed by a Professional Standards Committee removed, a Committee was constituted pursuant to Section 93 of the Medical Practice Act 1992. Section 92 of the Medical Practice Act provides that a person may apply to the appropriate review body for a review of conditions and Section 93 details which body is to consider that application.

The Section 93 Review Committee considered an application by the general practitioner to remove the remaining conditions from her registration. These conditions included a prohibition on performing circumcisions and requiring certain pre-conditions to be met when she was undertaking procedures.

The Review Committee noted that the events took place between 1993 and 1995 and that the practitioner had since stopped practising in the areas that gave rise to these complaints. The Review Committee accepted a statutory declaration concerning limiting her future practice and acknowledging that any breach would lead to further action. Accordingly the Review Committee removed the remaining conditions on her registration.

SECTION 66 INQUIRIES – EMERGENCY IMPOSITION OF CONDITIONS

➔ *Aggravated sexual assault*
The Board was advised that a cosmetic surgeon had been charged by the police with the offence of aggravated sexual assault. The patient alleged that whilst incapacitated by a substance injected by the doctor, she was sexually assaulted. The Inquiry imposed conditions on the practitioner, requiring a female registered nurse to be present during any examination of a patient.

➔ *Aggravated indecent assault*
The Board was advised that a general practitioner had been charged with two counts of aggravated indecent assault arising from the practitioner's practice of medicine. The Inquiry concluded that there was sufficient concern to impose conditions pending further investigation. The practitioner was required to have an adult third person present whilst examining any female patient. Further concerns relating to the practitioner's practice were referred to the Board's Performance Committee.

➔ *Inappropriate physical examination of children*
The Board received an investigation carried out by an Area Health Service into the practice of a consultant paediatrician. The investigation reported allegations consisting of four separate complaints of inappropriate physical examination of children. The Inquiry considered that the practitioner's response demonstrated a lack of awareness of the sensitivity that a child or parent might experience when performing a physical examination on sensitive areas of the body, without an adequate explanation. The Inquiry imposed a condition on the practitioner requiring him to complete an appropriate communication course.

➔ *Charged with possession of child pornography*
An ophthalmologist was charged by the police with the offence of possessing child pornography. At the Inquiry, the practitioner stated he had downloaded images from an internet site and had stored these on his computer. The practitioner also stated that since these events, he had consulted a psychiatrist for depression. The Inquiry imposed conditions requiring a third person to be present during any consultation with children under the age of 16, and health conditions requiring the practitioner to continue to consult with his treating psychiatrist and be reviewed by a Board-nominated psychiatrist.

➔ *Performance and management of patients as a locum casual medical officer*

A general practitioner had previously appeared before a Performance Review Panel following a performance assessment, which found that he was below the standard reasonably expected of a practitioner of an equivalent level of training or experience in general practice medicine. Information was subsequently received by the Board raising concerns about his standard of clinical performance and management of patients whilst employed as a locum medical officer at a district hospital. The Inquiry imposed further conditions on the practitioner's registration, including prohibiting him from undertaking any employment in a public or private hospital, that he work under supervision and further health conditions to address his possible impairment.

➔ *Prescribing*

Following an investigation by the Pharmaceutical Services Branch, restrictions were placed on the general practitioner's ability to prescribe Schedule 8 drugs. Despite these restrictions, the practitioner continued to prescribe these drugs. The Inquiry determined that, in the interest of protecting the health and safety of the public, the practitioner should be suspended pending further investigation.

➔ *Self-administration of propofol*

The Board received notification alleging that the practitioner had self-administered propofol whilst employed on night shift as a locum ICU Registrar. At the Inquiry, the practitioner admitted to a history of intravenous propofol use. The Inquiry suspended the practitioner and determined to refer him to an Impaired Registrants Panel upon expiry of his period of suspension.

➔ *Self-administration and breach of conditions*

The Board received notification that the practitioner was using intranasal cocaine. He was referred to an Impaired Registrants Panel who placed conditions on his registration, including the condition to attend for thrice weekly urine drug testing. Subsequent results were positive for cocaine. The Inquiry noted that the practitioner had a severe impairment in the form of cocaine abuse/dependency and considered that the practitioner must be suspended for the safety of the public until his rehabilitation was further progressed.

➔ *Impairment*

A medical practitioner advised the Board of her concerns about a colleague. The general practitioner was assessed by a Board-nominated psychiatrist and neuropsychologist. The neuropsychometric testing revealed a decline in cognitive functioning and the Board-nominated psychiatrist concluded that the results would render the practitioner's clinical practice potentially unsafe. At the commencement of the Inquiry, the practitioner voluntarily removed his name from the Register of Medical Practitioners.

➔ *Alcohol abuse*

The practitioner had participated in the Impaired Registrants Program over a number of years as a result of her impairment from alcohol abuse. The Inquiry was convened following notification that the practitioner had been convicted of a drink-driving offence and had breached conditions imposed upon her registration. The Inquiry suspended the practitioner and determined to refer her to an Impaired Registrants Panel upon expiry of this period of suspension.

➔ *Breach of conditions*

The practitioner had participated in the Impaired Registrants Program over a number of years as a result of substance abuse, which included the self-administration of morphine and pethidine. Advice was received alleging a failure to comply with his conditions of registration, together with concerns about the practitioner's clinical performance. The Inquiry concluded that there was insufficient evidence to demonstrate that any action was necessary in order to protect the life or the physical or mental health of any person. The Inquiry determined to take no further action and noted that the practitioner's existing health and employment conditions would remain.

SCHEDULE 1 INQUIRIES INTO APPLICATIONS FOR REGISTRATION

The Board conducted eleven Schedule 1 Inquiries into applications for registration in the year under review. One further application that was referred to an inquiry was withdrawn by the applicant before being heard.

➔ *Recovery from psychiatric illness*

A practitioner who trained overseas and who had last worked in NSW in the 1990s applied for re-registration in NSW. He included in his application evidence of his psychiatric illness for approximately ten years, but also evidence that he had made a full recovery, had insight into his illness and had been well for the last 18 months with no relapse. He travelled to Australia for the Inquiry, which found that his mood state appeared to be normal, that he was fully compliant with medication, and that he had insight into his illness. The concern was to create a safety net in case of any future relapse. The Inquiry concluded that he was eligible to be re-registered with conditions regarding supervision of his practice of medicine and ongoing monitoring of his health.

➔ *AMC graduate unable to complete period of supervised training on the basis of his unsatisfactory work performance*

An AMC graduate was conditionally registered and commenced supervised training in 2003. The supervising hospital reported problems with his

performance. The Board had him assessed by a neuro-psychologist, who reported the practitioner had cognitive weaknesses.

A practitioner's entitlement to registration as an AMC graduate is overridden by Section 13 of the Act, which provides that the Board must not register a person unless satisfied they are competent to practise medicine. A Schedule 1 Inquiry was held, which ordered that the practitioner remain registered, but with conditions that he satisfactorily complete a further short period as a supervised trainee before the Board could determine what further periods of conditional registration may be required.

➔ *Practitioner suspended overseas seeks restoration*

An Australian graduate worked in several countries for periods of several years at a time, including Australia.

In 2001 three complaints were prosecuted in the NSW Medical Tribunal which resulted in conditions being placed on his NSW registration.

In 2004 the practitioner was fined and suspended from practising medicine for 6 months by the Singapore Medical Council, and the NSW Board removed the practitioner's name from the NSW Register on the basis of the suspension in Singapore.

After the Singapore suspension expired, the practitioner applied to be restored to the NSW Register.

Having heard evidence as to the practitioner's medical practice since restoration in Singapore, and his competence to practise medicine, the Schedule 1 Inquiry determined that the practitioner be re-registered in NSW subject to the same conditions that were imposed by the Medical Tribunal in 2001.

➔ *Intern unsuccessful in his application to move to general (unsupervised) registration*

Having spent far more than the usual one year as an intern, a practitioner applied to have his conditional registration changed to full registration.

Despite 10 years of hospital practice in his country of graduation, he took nine years to complete the last four years of medical training at a NSW university. He was then not successful in demonstrating he could practise unsupervised, despite having spent 18 months at one Sydney teaching hospital as an Intern, and a further three years at another Sydney teaching hospital, also as an Intern.

The Inquiry heard evidence that neither experience nor input from hospital staff had been able to bring the practitioner to a standard where he could practise unsupervised.

The Inquiry ordered that the practitioner's application for general registration should be refused.

The Inquiry noted that it did not have the power to withdraw conditional registration from interns/supervised trainees. It ordered conditions relating to the practitioner's performance and review be imposed on his continuing registration as an Intern.

MEDICAL TRIBUNAL

A. Complaints determined by Tribunal 2004/2005

Sexual Misconduct/Boundary Crossing

Badal Chatterjee, a general practitioner, was found to have given a patient a massage without clinical justification and touched her breasts and buttocks in 2000. At the time of the sexual misconduct (in 2000) the practitioner was 63 and the patient 23 years of age. At the hearing the practitioner raised a number of issues about the patient's mental condition and character, but the Tribunal preferred the patient's evidence. The Tribunal noted that there was little evidence of insight or a willingness to accept all the responsibilities of medical practice, and it regarded as particularly reprehensible the manner in which the practitioner dealt with the patient in his response to the complaint. He was found guilty of professional misconduct, severely reprimanded and fined $13,750.

Elvin Suet Pang Cheng, general practitioner, admitted that he had inappropriate sexual contact with a patient in his rooms on five occasions after he failed to deal appropriately with his patient's sexualised behaviour. He experienced sexual gratification and so colluded in an interaction, which became more sexualised as time went on. The patient told the practitioner that she had a video of his conduct with her and would make a complaint to the Health Care Complaints Commission unless he made a payment of $300,000. The practitioner complained to the Police about the attempted extortion. The patient was charged and convicted and given a suspended prison sentence. In both the District Court and in the Court of Criminal Appeal, an order was made suppressing the name of the practitioner in the patient's trial on the basis of protecting his identity as a victim of attempted blackmail. It was argued before the Tribunal that to allow the practitioner's name to be published in association with the disciplinary proceedings would have the effect of completing the threat made to him, i.e. expose his sexual misconduct with her to the community and damage his reputation and standing.
In dismissing the application, the Deputy Chairperson noted the principle that justice is administered in open court with some exceptions, such as attempted extortion, as follows:

> "Proceedings before a Medical Tribunal brought under the Medical Practice Act are not punitive but are for the protection of the community and of the reputation and standing of the medical profession. It is inherent in the requirement to protect the public that information about a practitioner be readily available to enable a potential patient, should he/she so wish, to enquire if the practitioner had been the subject of an order under the Act

or to make a complaint about the practitioner. In this case it would be inconsistent with the purpose of the Act to make an order which suppressed the name of the practitioner".

The Tribunal declined to suppress the name of the practitioner.

The Police made the complaint about the practitioner to the Health Care Complaints Commission. The Tribunal found that although the practitioner knew that his contact was outside the boundaries of proper professional conduct, he allowed it to continue. The Tribunal formed the view that there was little risk of the practitioner re-offending having regard to his developing insight and his positive and appropriate steps to address the factors which contributed to his misconduct. Nonetheless, the conduct of the practitioner was a grave breach of the trust and power, which is a consequence of his right to practise. The conduct deserved to be denounced to protect the standing and reputation of the profession. The Tribunal found him guilty of professional misconduct. He was severely reprimanded and fined $10,000.

Roger Stephen Jones was a career medical officer in a psychiatry unit, who faced a complaint that he had inappropriate relationships with two patients from 1995 to 1998. Prior to the commencement of the proceedings in 2003 he removed his name from the Register. The Tribunal was terminated in 2004, prior to its decision, because of the illness of the Deputy Chairperson. A newly constituted Tribunal determined the matter. The practitioner denied sexual impropriety or that he had engaged in an inappropriate relationship with either patient. The Tribunal was particularly critical of his dealings with one patient, whom he threatened to lock up in an institution and to administer shock therapy. The Tribunal found that he has used the title psychiatrist to refer to his professional skills, capacities and training when he was not a psychiatrist nor had he obtained the necessary training to become a psychiatrist. The Tribunal found the practitioner guilty of professional misconduct and ordered that he not be re-registered, with no review of its order for five years. The practitioner remains registered in the United Kingdom. The Board has informed the General Medical Council, which is investigating the matter.

Darwin Rivera passed the Australian Medical Council examination and was conditionally registered to undertake 12 months supervised hospital training in 2000. He faced a complaint that he examined two patients' genitals without clinical justification and inappropriately rubbed one patient's clitoris, anus and legs. The Tribunal accepted the evidence of the patients after making all possible allowances for the fact that English was not the practitioner's first language. The Tribunal found that the two sets of allegations from totally unrelated persons had sufficient similarities to assist it to draw the inference to the requisite standard that the acts alleged did occur in relation to the second patient. The Tribunal noted that he has not practised as a doctor since September 2000. He was found guilty of professional misconduct and his name was removed from the register.

Bernard Hing Yat Tse, general practitioner, faced a complaint that he had used his position as a medical practitioner to establish an improper relationship in circumstances where he had a close personal relationship with his friend's wife. It was accepted that the sexual relationship developed from the social contact and not from her consultations with him as a general practitioner. The Tribunal found the complaint proved and that he was guilty of unsatisfactory professional conduct. He was reprimanded.

Breach of Conditions

Ross Maynard Bills, general practitioner has had conditions on his registration relating to his health for a number of years. He failed to fully comply with these conditions and, as a consequence, the Board referred a complaint to the Health Care Complaints Commission. The Tribunal considered that the contravention of this condition did not amount to unsatisfactory professional conduct and that the existing conditions remained appropriate. The complaint was dismissed.

Peter Howard Lindsey, general practitioner, has had conditions on his registration relating to his health for a number of years. In 1992, a PSC imposed conditions on his registration. As a result of his breaches of his conditions he came before a Tribunal in 1996, and again in 2000. He was given "a last opportunity to avoid de-registration by retaining him on the register with significant conditions imposed", which included complete abstention form alcohol. This condition was breached in 2002, and the Board suspended Dr Lindsey to protect the public. Following an investigation by the Health Care Complaints Commission into a complaint referred by the Board, a complaint was referred to the Tribunal. The Tribunal found that he breached his conditions and he was guilty of professional misconduct. The Tribunal ordered his de-registration with no review of its order for two years.

Anthony Michael, general practitioner, relinquished his drug authority in 1999 and was a participant in the Board's Health Program. Subsequently, the Board was notified of his breach of conditions and, under the provisions of Section 66, the Board suspended him from practice and referred a complaint to the Health Care Complaints Commission for investigation. This resulted in his referral for disciplinary proceedings. In 2002, the Tribunal reprimanded him and imposed conditions on his registration. Almost immediately the practitioner was in breach of these conditions and the Board suspended again. He has not practised since. The Tribunal dealt with a further complaint concerning multiple breaches of his conditions and a complaint that he was impaired within the meaning of the Act. The practitioner admitted all factual matters of the complaint and the complaints were proven. The Tribunal ordered his de-registration with no review of its order for two years.

Karanalu Vinatheya Prakash, general practitioner, was convicted of medifraud and failing to keep a drug register. In 1979 the Medical Disciplinary Tribunal removed his name from the Register. An application for a review of the NSW de-registration order was dismissed in 1992. In 1997 his application for re-registration in NSW was granted, subject to conditions. Following the investigation into a complaint that he was in breach of his conditions and had made a false statement to the HIC, he was again referred to the Tribunal. The 2004 Tribunal found all the particulars of the complaint proven and that the conduct was sufficiently serious to constitute professional misconduct. The Tribunal found that breaching his conditions by practising unsupervised and making a false statement to the HIC warranted the removal of his name from the Register. He was cautioned in relation to writing prescriptions using a practice address at which he was not then practising. The Tribunal ordered his de-registration, with no review of its order for two years.

Graeme Stephen Reeves, a specialist obstetrician and gynaecologist, was ordered by a PSC in 1997 to cease the practise of obstetrics and to be monitored by the Health Program. In 2002, when the Board became aware that he was performing obstetric services, it placed further conditions on his registration and made a complaint to the Health Care Complaints Commission. The practitioner exercised his right to appeal against these conditions and sought a review of the conditions imposed by the PSC. The Health Care Complaints Commission investigation revealed further breaches of his conditions and a complaint was referred to the Tribunal. The practitioner argued that his provision of obstetric services was justified as he had provided them in an emergency setting. The Tribunal found that defiance and deception were the two major features of the practitioner's conduct, and that he had been dishonest in his dealings with the employer and the Board. In finding the complaint proved, the Tribunal noted:

> "It does not suffice that a medical practitioner possesses diagnostic skills or advanced surgical techniques. A practitioner must earn the confidence of the patient as it is only if the practitioner is regarded as frank, truthful and trustworthy that the patient will accept medical advice as being sound. If the practitioner demonstrates that deceptive conduct comes easily, then it is impossible for the patient and the community to afford the practitioner the respect, which must form the basis of a practitioner/patient relationship. . . . Any doctor who is not prepared to obey and comply with restrictions placed on his practice, for sound and obvious reasons, must be regarded as a serious potential risk, if not an actual risk, if he seeks to treat without entitlement so to do."

The Tribunal found there was a substantial defect in the practitioner's character, which manifested itself in his failure to understand his obligations with regard to the practice of medicine and that he had been guilty of gross professional conduct of the most serious kind. The Tribunal ordered his de-registration, with no review of its order for three years.

Breach of Policy

William Kwok Wa Ma, who knew since 1989 that he was hepatitis B positive, undertook exposure prone procedures on patients between 1998 and 2000, including terms in orthopaedics, neurosurgery, general surgery and emergency contrary to the Board's Blood-borne Viruses Policy. He first came to the Board's attention following notification by the Department of Health. The Board initially suspended him under its emergency powers to protect the public and subsequently he returned to practice under strict conditions monitored by the Health Program. The practitioner complied with all conditions. The increased incidence of blood-borne viruses such as Hepatitis B, Hepatitis C and HIV has focused attention on the particular responsibilities of medical practitioners and students in preventing transmission of blood-borne viruses to patients or colleagues. Registrants with blood-borne viruses practise within Board policy, which states in part as follows.

> Infected medical practitioners may continue to practise medicine, provided that public safety is not endangered by either their impaired health or their performance of exposure-prone procedures. They must also ensure they are familiar with and comply with current Department of Health circulars dealing with infected health care workers.
>
> A registrant who is aware that he or she is infected with a blood borne virus must not undertake exposure-prone procedures. For a medical practitioner to do so would, prima facie, constitute unsatisfactory professional conduct and cause the practitioner to be subject to disciplinary proceedings.

A complaint was referred to the Tribunal. The Tribunal was satisfied that the practitioner knew at all relevant times of his status, yet put his own interest in pursuing professional advancement above the interests of his patients, and was dishonest with the Board and the Health Care Complaints Commission. In view of his five months suspension and his strict compliance with his conditions, the Tribunal ordered a reprimand and imposed conditions to be monitored by the Board's Health Program. An audit by the Department of Health did not detect any Hepatitis B transmission to patients.

Prescribing

Ian Geoffrey Barratt, general practitioner, faced a complaint that he prescribed drugs of addiction to 17 patients without prior authority and that he breached the restrictions on his drug authority issued under the Poisons and Therapeutic Goods Act. His name had been removed from the register for non-payment of the registration fee. The Health Care Complaints Commission filed an amended complaint in the Tribunal 2.5 years after he had last practised. The Tribunal noted that that the former practitioner made no effort

to avoid responsibility for the various ways in which he breached the regulations. The breaches were serious, but the Tribunal was not satisfied that a finding of professional misconduct was warranted. It found him guilty of unsatisfactory professional conduct and he was reprimanded. The Tribunal further ordered that should any application be made for reregistration, conditions imposed by the Tribunal were to be placed on his registration. (The practitioner has since been reregistered).

Joshua Ashok Devsam, general practitioner, faced a complaint that he prescribed drugs of addiction without appropriate authorities, for periods exceeding the recognised therapeutic standards without responsible medical judgment. The complaint from the Pharmaceutical Services Branch also concerned his failure to maintain adequate records. Following an inquiry by the Board, he surrendered his Schedule 8 and 4D drug prescribing rights and the Board placed a number of conditions on his registration. The Health Care Complaints Commission argued before the Tribunal that his conduct demonstrated flaws in his character, which warranted de-registration. The practitioner argued that the Tribunal could be satisfied that the public would be protected as he had gained further experience in the treatment of drug-dependent persons. The Tribunal noted that in the three years since the restrictions on his prescribing rights he had continued to practise without any evidence of further misconduct and it determined that in all the circumstances, de-registration or suspension was not warranted. He was severely reprimanded and fined $10,000. The Tribunal also imposed a number of conditions.

Ghalib Mohammad Talib Hamad, a general practitioner, faced a complaint that in 1997 and 1998 he issued large prescriptions for pethidine and morphine to 11 patients in quantities in excess of recognised therapeutic standards, failed to obtain an authority to prescribe from the Department of Health contrary to the Poisons and Therapeutic Goods Act, failed to maintain adequate patient records for the drugs dispensed and to keep a proper drug register. The proceedings in the Tribunal were completed in 2002 but no decision was given prior to the Deputy Chairperson vacating office due to ill health. Those proceedings were terminated in May 2004 and a new Tribunal appointed. The parties agreed that it was appropriate for the new Tribunal to proceed on the basis of the original papers, fresh evidence and updated submissions. The Tribunal found all particulars of the complaint were proved and that the conduct amounted to professional misconduct. The practitioner was reprimanded and conditions imposed which required the practitioner to successfully complete the Pharmaceutical Services Branch course "Assessment for Competency of Schedule 8 Prescribing" and submit to an audit with particular reference to his prescribing, administering and recording of drugs of addiction.

Anthony Joseph, general practitioner, was suspended by a Section 66 Inquiry in 2001 following receipt of an investigation report from the Pharmaceutical Services Branch, which alleged prescribing of restricted medications to 31 patients in significant amounts and/or in combinations, including Schedule 8 narcotics for continuous periods without the relevant authority. An appeal by the practitioner against the Board's suspension was discontinued in 2002 and he moved his name to the non-practising register. The Health Care Complaints Commission investigated the complaint by the Pharmaceutical Services Branch and it was set down for hearing in Tribunal. Prior to the commencement of the proceedings the Tribunal was advised that the Commission would withdraw the complaint upon the undertaking of the practitioner not to practise medicine in NSW or in any other jurisdiction and to remove his name from the Register. The complaint was formally withdrawn and dismissed.

Eckard Roehrich, general practitioner, faced a complaint that between 1997-1998 he prescribed Codeine Phosphate without obtaining an authority, when he knew or ought to have known that the patient was an addict. He also prescribed Diazepam, Temazepam, Oxazepam and Codeine Phosphate in quantities in excess of recognized standards and in inappropriate circumstances, including on demand. The proceedings commenced in the Tribunal in 2002 but proceedings were terminated in May 2004 as the Deputy Chairperson vacated office due to ill health. A new Tribunal was appointed to determine the matter. The Tribunal accepted the evidence of a peer reviewer, which said:

> "The treatment provided to these patients was in fact harmful and dangerous and extremely hazardous considering the nature of these patients, their chaotic lifestyle, their mental health issues and the fact that they were prescribed on demand without control."

The Tribunal found the practitioner guilty of professional misconduct and noted in each case that his conduct amounted to professional misconduct. However the Tribunal considered that the practitioner was motivated by an attempt, misguided though he may have been, to assist his patients, his misconduct was confined to two patients and he had taken steps to advance his knowledge including further education in drug and alcohol detoxification. He was reprimanded and conditions were placed on his registration.

Michael Tsouroutis, a general practitioner, faced a complaint that he prescribed to eight patients Schedule 8 and 4D drugs without exercising responsible judgment, in excess of recognised quantities, in quantities likely to cause dependence, and not for recognised therapeutic standards when he knew or ought to have known the drugs were likely to be abused. Two further complaints concerned his failure to keep adequate records and maintain a drug register in breach of the Poisons and Therapeutic Goods Act. The hearing

before the Tribunal concerned the appropriate orders to be made as the practitioner admitted that he had poor insight into the patients' drug-seeking behaviour and that he had exposed the patients to potential harm from drug dependence. He conceded that his conduct constituted professional misconduct and the Tribunal was comfortably satisfied, on the balance of probabilities, that the practitioner was guilty of professional misconduct.

> ". . . the Tribunal determined that this was a case in which the protective functions of the Act could be well served by allowing the respondent to continue to practise with restrictions"

by way of conditions placed on his registration.

Conviction/Impairment

Dr Paul Herbert Corbett had been deregistered in June 1990 as a result of conviction and imprisonment for Medicare fraud. He was reinstated to the Register in 2000 as the Tribunal was satisfied on the balance of probabilities that he was a fit and proper person to be reregistered, subject to health and employment conditions. The 2000 Tribunal considered two matters concurrently: the practitioner's application to have the conditions varied to allow him to undertake work outside the hospital system, and a complaint that he was in breach of his conditions. Whilst the Tribunal was satisfied that the practitioner had significant difficulty in obtaining work in the public hospital system as required by his conditions, protection of the public was its priority. Noting that it was 15 years since he had last practised as a general practitioner, the Tribunal dismissed his application to allow him to work in general practice. In relation to the breach of his conditions, the Tribunal noted

> ". . . .since the orders made in 2000, he has continued to commit breaches of the criminal law, leading to sentences of imprisonment, to be served by periodic detention or which were suspended . . . .he continued to drink alcohol. He committed offences whilst under the influence of alcohol. Fourthly, he was dishonest with the board-appointed psychiatrist, Dr Samuels, and then with the Commission. The Tribunal sees there being a necessity for honest dealings by him with the Board in any ongoing relationship that he has with it."

The Tribunal found the complaint proved and he was reprimanded.

Competence

Dr David Charles Lindsay, general practitioner faced a complaint concerning operative services provided to two patients. The Tribunal found that the practitioner's action fell well short of the ideal because of his failure to communicate satisfactorily with a patient, which it "regarded as but an example of a more widespread failure to appreciate his patients' emotional and intellectual requirements". The Tribunal found that with respect to surgical audits conducted by the Board, he had learnt little, and he fails to understand the overarching requirement of the regulations to keep medical records "so as to allow another medical practitioner to continue to manage the patient's case". This failure represents a lack of knowledge, judgment and care sufficient to make a finding of unsatisfactory conduct. The practitioner was reprimanded for failing to keep records "even approaching the minimum standard". Conditions were imposed requiring him to submit to a random audit of his medical records, to accept supervision by a person nominated by the Board to provide support and to monitor his capacity to practise medicine safely.

B. Appeals determined by Tribunal 2004/05

Professional Standards Committees

Two appeals against decisions of Professional Standards Committees on points of law were filed in the Tribunal by practitioners. In both cases the matters were resolved without a hearing; one matter was referred to a newly constituted Committee and in the other the conditions were varied.

Registration

An appeal against a decision of the Board to refuse registration or to impose conditions on a practitioner's registration lies to the Tribunal under Section 17 of the Act. Two practitioners appealed against the decision of the Board not to approve their applications for registration to undertake an area of need position. Both were withdrawn and dismissed.

One practitioner exercised his right to appeal against the decision of the Board to refuse his registration but withdrew his application prior to hearing. Another practitioner appealed against the Board's decision to withdraw his registration on the basis of his poor performance. The practitioner withdrew his appeal.

C. Reviews by Medical Tribunal

De-registration orders

During 2004/05 the Tribunal handed down four decisions in respect of applications for review of de-registration orders. In three cases, the Tribunal was comfortably satisfied that the applicants were now fit and proper persons to be restored to the register, subject to conditions. ***(Geoffrey Annetts, Andrew Dalley, Vipal Kumar Mehta)***. The Tribunal refused one application for restoration (***Syed Rahman***).

Review of conditions

Three practitioners filed applications for a review of conditions imposed by the Tribunal. This resulted in the Tribunal lifting the conditions on the registration of ***Jonathan Daniel Bentley*** and new conditions imposed on ***Mahendra Singh Rohatgi. Paul Herbert Corbett's*** application was unsuccessful. The Tribunal made no orders with respect to the application by

Graeme Stephen Reeves for a review of conditions imposed by a Professional Standards Committee.

D. Appeals against Tribunal decisions

There were no appeals against decisions of the Medical Tribunal during 2004/05.

E. Matters in other jurisdictions

One registrant sought orders in the Supreme Court.

Eckard Roehrich

A Section 66 Inquiry suspended Dr Roehrich from practising medicine for eight weeks following his failure to participate in a Performance Assessment, and concern about his practice arising from complaints. He was also the subject of other decisions made by the Board. Dr Roehrich subsequently sought orders in the Supreme Court that various decisions of the Medical Board be quashed, including the decision to suspend him from the practice of medicine.

The Supreme Court dismissed his application to quash the Board's decision to suspend him from practising medicine, but quashed the Board's decision to assess his professional performance. Other matters claimed by Dr Roehrich were stood over and remain outstanding.

HEALTH (IMPAIRED REGISTRANTS PROGRAM)

Overview

The Health Program has been operating under the provisions of the Medical Practice Act since 1992. In that time, more than 400 impaired practitioners have participated in the Program and 162 practitioners have successfully exited, having consolidated their recovery and fulfilled the Board's monitoring requirements.

The Board becomes aware of impaired practitioners through notifications and self-notifications. Although there is no legal obligation for practitioners to notify the Board about impaired doctors, the Board believes that there is a profound professional and ethical obligation to do so. This obligation is set out in the Board's Code of Conduct Good Medical Practice. As confidence in the program has grown, so has the profession's willingness to come forward with information about impaired practitioners.

NOTIFICATIONS BY SOURCE

		%	
	2002/03 n=58	**2003/04** n=63	**2004/05** N=66
Colleagues (including employers)	17	22	18
Pharmaceutical Services Branch	8	6	1
Self referral*	25	46	25
University	10	5	4
Board Committee	9	3	-
Courts	-	2	1
Treating Practitioner	9	10	8
Other	22	6	9

*The Medical Practice Act requires that practitioners make a declaration in relation to their health in the course of completing their annual return to the Board. In the majority of cases, no further action is required, either because the practitioner is not working, or because they are clearly practising safely within the limitations of their illness. In some cases the Health Committee has sought more information, either from the practitioner, their treating doctor or a Board-nominated doctor. Only these cases are included in the table, along with other self-notifications that occur outside the annual return.

In most categories, notifications have remained stable, although new student notifications are significantly lower than in preceding years. This issue is addressed later in this report.

Key Activities

While the Health Program's processes are well established, the Health Committee and the Board secretariat have continued to refine and develop various aspects of the program.

➔ The program of invited, expert speakers addressing the Health Committee has continued in this reporting period, with all Board Members and non-Board members of the Conduct Committee invited to attend. The presentations continue to be extremely valuable in confirming the Health Committee's approach to various types of impairment.

The following speakers have addressed the Health Committee in the reporting period:

A/Prof Kay Wilhelm	Depression
Dr Julian Trollor	ADHD
Dr Simon Willcock & Dr Narelle Shadbolt	Doctors Health Advisory Service

This successful program will continue into 2005/06.

➔ The Health Committee's work continues to be guided by its *Health Program Decision Parameters* policy. The primary decision parameters are:

1. *the nature and natural history of the registrant's illness*
   It is neither feasible nor desirable to adopt a rigid, one-size-fits-all approach to impaired registrants. Much is known about the natural history of the conditions that commonly result in a practitioner being considered to be impaired, and decisions should reflect this knowledge.
2. *compliance with the program*
   The dual aims of registration conditions are to protect the public and, where possible, to allow impaired registrants to remain in the medical workforce. It is only through compliance with registration conditions that the Board can be assured that these objectives are met.

   No consideration is given to easing any condition of registration unless a registrant has been fully compliant with all conditions for a period of at least 12 months.
3. *personal support*
   Personal support and engagement with the community are recognised as positive predictors of recovery from all disorders, but particularly from addiction. They demonstrate insight on the part of the impaired practitioner and they increase the chances of early

identification of illness or relapse in addition to providing an environment in which recovery or stabilisation can occur.

4. *professional support*
   Registrants who have supportive professional relationships and work environments are more likely to manage satisfactorily without the involvement of the Board. Those that work in solo practice or are secretive about their impairment require closer supervision by the Board.

5. *insight and motivation*
   It is apparent that a registrant's insight into their impairment and circumstances is a critical factor when considering their progress through the Health Program.

   Insight is, to a large extent, the most important factor distinguishing illness from impairment. An ill doctor who is insightful and practises within their capability is clearly not impaired. An ill doctor who lacks insight into the impact of their illness on their practice is clearly impaired and should enter or remain on the Health Program.

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

	2002/03	2003/04	2004/05
Notifications	58	63	66
Impaired Registrants Panel reports endorsed			
Psychiatric illness	31	40	28
Alcohol	4	2	9
Drug	14	7	8
Physical	6	1	3
Total	**55**	**50**	**48**
Review Interviews held	169	210	211
Exits from the Program	12	15	22
Participants in Program	131	131	126

Hearing Outcomes

Practitioners are advised that an Impaired Registrants Panel is non-disciplinary and is designed to assist them to deal with their impairment and remain in safe practice. While the Board's primary responsibility is to protect the community through maintaining high standards of medical practice, it takes the view that most impaired practitioners can continue to practise, subject to appropriate limitations. As a consequence the most common outcome of an Impaired Registrants Panel is conditional registration.

This year, 77% of Impaired Registrants Panels concluded with the practitioner agreeing to conditions being placed on their registration. A further 4% were adjourned, being reconvened at a later date, 17% resulted in no further action being taken, and 2% resulted in students being prohibited from undertaking clinical studies.

The conditions that are placed on a practitioner's registration are tailored to address their 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 Board's protocol, attend a Board-nominated doctor for monitoring, and surrender their authority to prescribe narcotics. Practitioners who have abused alcohol will also need to attend for ongoing treatment and undertake regular blood testing. Practitioners suffering from a psychiatric illness must attend a treating psychiatrist and comply with treatment ordered by their doctor.

Under the provisions of the Medical Practice Act, the Board is required to notify the practitioner's employer of the conditions on their registration.

Case Studies

Case Study 1

Dr M is a solo general practitioner who was notified to the Board by a concerned colleague who thought that he may have been drinking whilst on duty. Dr M had appeared to be under the influence of alcohol on nursing home visits. A notification also came from the hospital where Dr M had been admitted with complications attributable to excess alcohol consumption.

At the Impaired Registrants Panel Inquiry, Dr M told of his work as a solo general practitioner, with no secretarial or other support. He informed the Panel that he attends general practitioner meetings to satisfy CPD requirements, but no longer reads journals. Dr M reported that he had been drinking for many years, and had also been depressed recently after the death of a close friend. Dr M was reluctant to become involved in the Doctors in Recovery group, or to discuss rehabilitation and support. It was explained to Dr M that alcoholism is a disorder with a high risk of relapse and that ongoing care is important.

The Panel considered that it was necessary for conditions to be placed on Dr M's registration to ensure that he was not drinking at harmful levels. He was asked to agree to Carbohydrate Deficient Transferrin testing, and other conditions including meetings with a mentor, and neuropsychometric testing to consider how long-term alcohol use may have affected his cognitive abilities.

Case Study 2

Dr A is an anaesthetic registrar who came to the Board's attention following notification from his employer that he had been suspected of using propofol whilst on duty. Dr A was assessed by a Board-nominated psychiatrist, and strongly denied any drug use. A further report was made to the Board when another incident occurred. This time Dr A did not deny drug use, and openly

discussed with the Board his use of narcotics and other drugs. Dr A had been subject to an emotionally and physically traumatic childhood and had been through a stressful period where he was put in charge of a large part of an isolated overseas hospital, and started using morphine to relieve stress. He soon became dependent and tried on numerous occasions to withdraw from the drug. He was not successful until he obtained outside help and support in doing this.

The Panel considered what action needed to be taken to protect the public and to also help Dr A in his rehabilitation. It was agreed that thrice weekly urine drug testing should be imposed, as well as regular attendance at a drug and alcohol specialist for treatment purposes. Regular review by the Board-nominated psychiatrist was also considered necessary. Dr A recognised that he may always be tempted to use narcotics if in an environment such as an operating theatre, and agreed that it would not be appropriate for him to continue to work towards becoming an anaesthetist. Dr A was on sick leave at the time of the Inquiry, and agreed to not return to work without Board approval, and to consider alternative career options.

Medical students

The impairment provisions of the Medical Practice Act 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.

In the case of medical practitioners, registration conditions are voluntarily entered into. The significant difference in the case of medical students is that the Panel is required to consider whether it is in the interest of the public to impose conditions on the student undertaking clinical studies. Since the commencement of the provisions, 29 students have been before an Impaired Registrants Panel. Twenty two have had conditions placed on their undertaking clinical studies, usually including regular reporting from the relevant University.

Early notification is seen as essential in supporting the impaired student, and planning their transition into internship. The Medical Faculties are actively refining their management of impaired students, and have invited a variable degree of advice and participation from the Medical Board. It is of some concern that student notifications have dropped further this year.

In May 2005 the Board's Medical Director, Dr Alison Reid was invited by the General Medical Council to present a paper on the registration of medical students at a GMC- sponsored medical education conference where student registration was being considered.

Case Study

Ms X is a final year medical student, notified to the Board by the University after being diagnosed with Bipolar disorder, substance abuse, and other significant health problems. An Impaired Registrants Panel was convened to inquire into Ms X's health status, and her capacity to undertake clinical studies. As a final year student, consideration also had to be given to her future as an intern.

Prior to the Inquiry, Ms X underwent a medical examination by the Board-nominated psychiatrist. A long history of depression and substance abuse was exposed.

Due to the nature of Ms X's health problems, it was explained to her that the Board would likely require long-term monitoring, with particular attention paid to the next few stressful years as a junior doctor. The Panel imposed conditions including the requirement to attend a psychiatrist of choice, and to authorise the psychiatrist to inform the Board of any changes in Ms X's health status. Conditions requiring regular reports from the University, as well as thrice weekly urine drug testing due to Ms X's history of substance abuse, were also imposed.

A further Inquiry was scheduled for later in the year to consider conditions more relevant to an intern, such as limiting the number of hours worked, and ensuring that the Board was kept informed of progress by obtaining term reports.

Exiting the Program

In the year ending 30 June 2005, a total of 22 practitioners exited the Health Program. Fifteen of these had their conditions lifted and returned to full registration. The Board's practice of conducting an exit interview is now well established and provides valuable feedback to both the Board and the practitioner. The Board was satisfied that these 15 practitioners had actively sought to manage their impairment, were willing to take responsibility for their own health, and were safe to practise unconditionally. In view of the rehabilitative focus of the program, this is viewed as a positive and encouraging outcome.

Experience indicates that a number of exited practitioners will relapse and be required to re-enter the Program. Practitioners with a problem of self-administration of narcotics have a significantly higher risk of relapse. No registrants who had exited the program in the same year re-presented during 2004/5.

Exit from the Health Program is not always the Board's objective in managing impaired practitioners. Some, with chronic relapsing illness such as Bipolar Affective Disorder remain on the program indefinitely, albeit with low level occasional monitoring.

Conclusion

The Health Program continues to develop and apply evidence-based, consistent decision making and monitoring processes. This work is expected to continue in the coming year, when a detailed analysis of exit interview data is expected to provide valuable to assist the Health Committee in further refining the Health Program.

PERFORMANCE

Overview

The Medical Board aims to ensure practitioners' fitness to practise, and the Performance Program introduced in October 2000 is central to this aim. The program is designed to complement the existing conduct and health streams by providing an alternative pathway for dealing with practitioners who are neither impaired nor guilty of professional misconduct, but for whom the Board has concerns about the standard of their clinical performance.

The program is designed to provide an avenue for education and retraining where inadequacies are identified, while at all times ensuring that the public is appropriately protected. It aims to address patterns of practice rather than one-off incidents unless the single incident is thought to be demonstrative of a broader problem. Assessments are broad-based, and are not limited to the substance of the matter that triggered the assessment. The assessment exercise is conducted by two peers of the subject doctor and occurs on-site in the doctor's practice. In this way, doctors are assessed in the context of their work environment and the contribution of system issues to their 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. This is the basis for using peer rather than expert assessors.

The causes of poor performance are many and varied. Professional isolation and inattention to continuing professional development are common contributing factors. On occasions, doctors present with adequate knowledge, but an inability to apply it in their day-to-day practice. This may be due to external factors such as illness and financial stress which may influence practitioner performance in the short or longer term.

The Performance Committee is highly cognizant of the contribution of systems issues to the performance of individual practitioners. Assessors and Performance Review Panels regularly highlight systems issues relevant to hospitals, area health services and Colleges. This is an extremely valuable byproduct of the Performance Program and the Board has established a process whereby these concerns are formally raised with the appropriate body. The Department of Health has been particularly receptive to this advice.

Networking

In May 2005 the Board's Medical Director, Dr Alison Reid, attended the fifth international workshop on performance assessment in London. The workshop was attended by representatives of assessment programs from New Zealand, the UK, the USA, Canada, Ireland and South Africa, and built on the achievements of the previous meetings. Following the workshop, Dr Reid represented Australia at a European workshop on Performance Assessment.

Program Scope

Matters referred under Section 25B of the Health Care Complaints Act

Under the co-regulatory model established by the Medical Practice Act 1992 and the Health Care Complaints Act 1993, the Medical Board and the Health Care Complaints Commission are required to consult on the action to be taken in regard to complaints received by either body.

The Board or the HCCC may decide that, on the information available, a complaint should be referred to the Board under Section 25B of the Health Care Complaints Act, rather than being investigated by the Commission with a view to disciplinary action. (Prior to 1 March 2005, these complaints were referred to the Board under section 26 of the HCCA. The amended provision requires that the HCCC discontinues dealing with the complaint once it is referred to the Board). This means that, while the complaint requires some further consideration, it has been assessed as not being likely to lead to disciplinary proceedings under the Medical Practice Act.

When a performance matter is referred to the Board, a response to the issues raised in the complaint is sought from the doctor. The response is considered in conjunction with the initial complaint to determine whether further action is required. Where possible, the Board provides a copy of the response to the complainant.

The Board may decide that:

- the response has satisfactorily addressed the issues raised in the complaint and that no further action is required;
- no further action is required by the Board but there remain unresolved issues of concern to the complainant, amenable to resolution with the assistance of a Complaint Resolution Officer from the HCCC;
- no further action is required by the Board but there are outstanding issues of concern to the complainant, amenable to conciliation between the doctor and the complainant;
- the doctor's actions have caused distress to the complainant and that the doctor be requested to write an apology to the complainant;
- a letter be sent to the doctor, drawing attention to particular issues of concern to the Board;
- the doctor should attend the Board for a Performance Interview;
- the doctor should undergo a detailed Performance Assessment based on this matter and other history with the Board;
- there are serious issues of professional conduct warranting referral back to the HCCC for investigation.

The process described above provides a timely mechanism by which complaints can be managed and resolved. More serious matters can be referred on for detailed Performance Assessment or investigation by the HCCC. However, the majority of matters are resolved through the other interventions described above.

The management of these matters within the Performance Section has enabled the Board to consider a range of actions in response to the spectrum of performance matters that come to its attention. Full Performance Assessment is at one end of the spectrum, and is reserved for the most concerning cases.

Continuing Professional Development

The Medical Practice Act requires all registered medical practitioners to make an annual declaration in relation to their participation in continuing professional development in the preceding 12 months. The Board's policy is that;

> *It is the responsibility of every registered medical practitioner to participate in continuing professional development that is relevant to their practice of medicine.*

The Performance Committee has established a process to manage those doctors who in three consecutive Annual Returns indicate that they have:

(i) participated in CPD but have not sent documentation to support their statement, or

(ii) not participated in CPD.

The majority of practitioners respond by providing the necessary documentation and the Board takes no further action, other than restating its expectations in relation to participation in CPD.

The Board is seeking clearer legislation in this area.

Case Studies

The following case studies illustrate the Performance Assessment Program's work during 2004/05:

Case Study 1

Dr X is a general practitioner working in solo practice in Sydney. He trained overseas and gained a Master of Surgery, but is not a Fellow of the RACS. Dr X has never had any specific training in general practice. Many of his patients attend for procedural work, which includes circumcision for ethnic/religious reasons.

Dr X was referred to Professional Services Review by the Health Insurance Commission in relation to his Medicare billing. In the course of these proceedings, the PSR Committee became concerned about Dr X 's ability to conduct a medical practice and his ability to perform surgical procedures. The Director of PSR referred the matter to the Board as provided for by the Health Insurance Act 1973.

The Board resolved that a performance assessment was required. The assessors found Dr X's surgical skills to be satisfactory but his consulting and patient management skills, medical records and infection control outside of the operating room were found to be unsatisfactory. A Performance Review Panel was convened.

The major issue considered by the Panel was Dr X's understanding of the roles, standards and practices required in respect of his general practice. The Panel noted that Dr X primarily sees himself as a surgeon with his main area of expertise being minor surgery, despite the fact that half of his current work is in general practice.

Conditions were placed on Dr X's registration that included spending time as an observer with an experienced general practitioner as well as attendance at courses for general practitioners and a requirement to improve his records to the standard set by the RACGP and Medical Practice Regulation 2003.

This case illustrates a common problem encountered by the Board when practitioners whose interests and training are in specialist practice find themselves working in general practice, for which they have little or no training or interest.

Case Study 2

Dr Y is a general practitioner in Sydney. The Performance Committee considered a complaint made by a patient who attended a medical centre and requested a Pap smear. It was the first time she had consulted with Dr Y, as no female practitioners were available. When he became aware that she was a medical student it is alleged that he showed her how to insert the speculum and suggested she try herself. He also explained the Sanskrit for vagina and penis and also discussed the 'G spot'.

The Performance Committee noted a history of previous complaints and that Dr Y had failed to respond to the Board's request to address the issues raised in the complaint. It was resolved that Dr Y attend the Board for a Performance Interview to discuss the matter further.

The interview raised concerns about the adequacy of Dr Y's communication and about his judgment. The Performance Committee considered the report of this interview and resolved that a Performance Assessment be undertaken.

Meanwhile, another complaint was received. It concerned Dr Y's failure to communicate effectively with the patient to ensure that he had a necessary blood test. As a result the patient's malaria was not diagnosed in a timely fashion.

On the day of the assessment Dr Y was found to have a mixed practice and the majority of consultations were for procedures. The assessors found his consulting and patient management skills, communication with patients and his medical records to be unsatisfactory. A Performance Review Panel was convened.

Prior to the Panel, Dr Y had reduced his hours in general practice and was concentrating on what he thought he is good at, which is procedural work. The Panel reminded him that good communication and adequate medical records are relevant not just to general practice but to procedural work as well.

Both complaints raised issues of poor communication. Conditions were placed on his registration that included time spent as an observer with an experienced general practitioner as well as participation in communication and general practice courses.

This case also illustrates a welcome outcome of performance assessment, as Dr Y proactively changed some aspects of his practice in response to the assessment report, without being compelled to do so by the Board.

Case Study 3

Dr Z is a VMO at public and private hospitals in Sydney. A notification was made to the Board by the Area Health Service in relation to a small cluster of adverse patient events.

Dr Z was assessed by two peers. This included observation of his operating list and an assessment at his consulting practice. His surgical skills were found to be satisfactory on the basis of the procedures observed.

Dr Z had reflected extensively on his situation and made significant effort to rectify the deficiencies that he himself recognised. He had ceased undertaking a certain procedure, was more selective in choosing surgical cases, and referred more than he did previously. Dr Z had also developed an extensive guide to his medical practice, which he developed prior to the assessment. He has also undertaken an extensive and meaningful audit of his high-risk cases and was able to demonstrate to the assessors that his complication rates were at an acceptable level.

Dr Z was found to be a competent clinician and adequate surgeon, and identified significant system and circumstantial influences on the patient events that resulted in his notification to the Board. The assessors recommended that Dr Z would benefit from some constructive feedback in the form of informal counselling and that no further action need be taken.

This case reflects the fact that not all doctors having a Performance Assessment are found to be unsatisfactory and that a Performance Review Panel is not always required. The Board and notifier's concern about the standard of Dr Z's practice were allayed by the Performance Assessment process.

Program Activity

During the reporting year, the Performance Section dealt with 26 practitioners referred to the Board in relation to complaints arising in Campbelltown and Camden Hospitals. (This matter is reported in more detail in the Professional Conduct section of this annual report.) The volume and complexity of these cases added significantly to the workload of the section and, to some extent, diverted resources from other areas of the section's activities. Nevertheless, the majority of these cases were finalised within 2004-05.

An overview of the Performance Program activity in 2004-05 follows.

The following table reports the breakdown of complaints (including Camden/Campbelltown matters) referred to the Board by the Health Care Complaints Commission under section 26/25B of the Health Care Complaints Act.

REFERRAL OF COMPLAINTS UNDER S26/25B, HCCA	2002/03*	2003/04	2004/05
Routine referrals	n/a	194	188
**Referred directly to Performance Committee for consideration of full Performance Assessment		6	n/a
Reassessed as s26/25B referrals		12	14
Total	**–**	**212**	**202**

* previously reported by the Professional Conduct Section

** prior to November 2003

The following table reports the outcomes of complaints referred to the Board by the Health Care Complaints Commission under section 26 / 25B of the Health Care Complaints Act.

OUTCOME OF COMPLAINTS FOLLOWING REFERRAL UNDER s26/25B, HCCA	2002/03*	2003/04	2004/05
No further action	n/a	68	131
Letter of apology to patient	n/a	4	8
Board letter	n/a	23	54
Interview	n/a	24	31
Performance Assessment	n/a	14	12
Section 66 inquiry	n/a	3	2
Refer to Health Committee	n/a	1	0
Refer to HCCC for investigation	n/a	5	5
Direct Resolution with PSO	n/a	14	**1
Conciliation	n/a	13	**8
HCCC (for reassessment)	n/a	n/a	**16
No longer registered, action if applies for re-registration.	n/a	n/a	2
Total	**–**	**169**	**270**

* previously reported by the Professional Conduct Section

** Since April 2005 matters previously recorded as referred to Direct Resolution or to Conciliation are now recorded as HCCC (for reassessment).

The following table reports the outcome of Performance Interviews conducted in the reporting period.

OUTCOME OF INTERVIEWS	2002/03*	2003/04	2004/05
No further action	n/a	23	**14
Performance Assessment	n/a	3	3
Total		**26**	**17**

* previously reported by the Professional Conduct Section

** although there was no further action taken by the Board; in 2 cases the practitioner was advised to consider a course relevant to the issue raised in the complaint. In another 2 cases the Board advised the Medical Centre/Area Health Service of a systems issue raised in the complaint.

The following table reports the source of matters considered for full Performance Assessment. Since November 2003, all complaints referred to the Board under section 26 of the Health Care Complaints Act are treated in the first instance as 'Performance Matters' for which consideration for Performance Assessment is only one possible outcome.

NOTIFICATIONS BY SOURCE	2003/04	2004/05
Board Committee	8	9
HCCC (s 86F, Medical Practice Act))	0	1
HCCC (s26, HCCA; direct to Performance Committee: pre-November 2003	6	n/a
HCCC (s26 referral); originating from:		
➔ Patient	6	7
➔ Employer	1	2
➔ Colleague	0	1
➔ Professional Services Review	1	2
➔ Dept of Health	0	0
Total	***22**	**22**

*1 doctor has had 2 notifications to Performance

The following table reports the professional background of practitioners considered for full performance assessment. As expected, General Practitioners make up the majority of performance notifications, reflecting their numbers in the medical workforce.

PRACTICE AREA OF DOCTORS CONSIDERED FOR FULL PERFORMANCE ASSESSMENT	2002/03	2003/04	2004/05
Anaesthetist	1	0	1
General Practitioner	16	13	15
Obstetrician & Gynaecologist	0	1	0
Ophthalmologist	0	0	1
Orthopaedic Surgeon	1	0	0
Surgeon	3	5	1
Pathologist	0	0	2
Psychiatrist	0	2	2
Physician	0	0	0
Total	**21**	**21**	**22**

The following table reports the Performance Committee's resolutions for those doctors considered for full performance assessment. Notifications are considered by the Performance Committee at its monthly meeting, in the context of the practitioner's complaint and other relevant history with the Board. If there is an indication that a practitioner's performance is below an acceptable standard, then a Performance Assessment is undertaken. Most assessments occur within three months of the Committee's decision.

NOTIFICATION OUTCOMES	2002/03	2003/04	2004/05
PA is not indicated	3	1	3
Performance Assessment	15	19	17
Refer to Conduct Committee	3	0	0
Refer to HCCC	0	0	0
Performance Interview	n/a	1	1
Total	**21**	**21**	***21**

Performance Interview was not available within the Performance Program prior to August 2003
*1 outcome has been deferred by the Committee following the notification – awaiting report from AHS.

The following table reports the outcomes of full Performance Assessments finalized in the reporting period. On receiving a report of a performance assessment, the Performance Committee has a range of options available to it. When the Assessors identify no significant performance deficiencies, no further action is taken in relation to the practitioner. However, in most of these cases the Assessors have already used the assessment exercise to counsel and advise the practitioner. More formal counseling can occur when there are performance issues that do not require the Board 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 to formalise these orders. In addition, the PRP allows the practitioner an opportunity to respond to the assessment report and make submissions.

POST PERFORMANCE ASSESSMENT OUTCOMES	2002/03	2003/04	2004/05
Retired or NP before having PA	1	1	3
PA no longer required	2	0	0
Re-assessed - now Investigation	0	0	1
No further action	5	3	1
Counselling	2	0	1
Performance Review Panel	8	10	7

The reports of 2 Reassessments have also been to the Committee and the 2 practitioners have now exited the program. Another 5 Performance Assessments have been conducted but were not finalized within the reporting year.

The following table reports the outcomes of Performance Review Panels held and completed during the reporting period. The Performance Program is based on remediation and retraining. As a result almost all practitioners are required to undertake some sort of remediation, tailored to their individual needs. This may entail attending courses, spending time 'shadowing' another practitioner, engaging in CPD etc.

A smaller number of practitioners require orders that ensure the public is adequately protected while they are undertaking remediation. Such orders may limit the scope of their practice, require supervision etc. These conditions may be lifted after they have satisfactorily completed their remediation and been reassessed. Alternatively, practitioners may elect not to return to some aspects of their practice and remain conditionally registered in the long term.

PERFORMANCE REVIEW PANEL	02/03	03/04	04/05
PRP Held	10	8	5
Did not proceed (retired, name removed)	1	0	1
PRP completed – outcome:	10	4	7
counseled	4	2	0
remediation orders	9	4	6
protective orders	6	4	6

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 which range from relatively minor to serious. The challenge for the Board is to ensure that the appropriate option is selected for each case that comes before it.

The Board is committed to delivering a Performance Program that is fair to the doctor concerned, valid, and most importantly, results in lasting improvement in the doctor's performance.

FINANCE AND BUDGET

Overview – Financial Performance – Year ended 30 June 2005

The total income for the period was $7,768,000. Expenditure for the period was $5,915,000 against a budgeted figure of $6,900,000.

A significant decrease in claims for sitting fees, as a result of a decrease in the number of matters referred for hearing has been a major factor in this surplus, together with a variation in the amount budgeted for payment to the Medical Tribunal.

An operating surplus of $1,853,000 was achieved in the year ended 30 June 2005.

Statement of Financial Position Commentary

The Board is a self-funded body operating in an environment where unpredictable legal actions and other factors beyond the Board's control can result in substantial unbudgeted expenditure. The Board must therefore maintain sufficient funds to meet extraordinary items of expenditure. The Board believes the level of funds is adequate for the current circumstances.

Grants

Under section 144(2) (b) of the Medical Practice Act, 1992, the Board met the expenses of the Medical Services Committee ($94,234).

The Board also contributed to the Australian Medical Council ($152,581) and the Doctors Health Advisory Services ($25,000).

Medical Education and Research Account

Under Section 145 of the Medical Practice Act, 1992, the Board has established a Medical Education and Research Account. Funds from this account covered the publication of a newsletter ($13,181).

Investment Performance

The return on internally managed funds for the year ended 30 June 2005 was 5.5%.

The Board's externally managed funds were held in Treasury Corporation's HourGlass Cash Plus Facility. An average return of 5.7% was achieved for the current financial year.

Budget

Performance against Budget for the year ending 30 June 2005 and Budget for the year ending 30 July 2006

	30 June 2005 Budget ($'000)	30 June 2005 Actual ($'000)	30 June 2006 Budget ($'000)
Registration fees	6,900	7,115	7,219
Fines	22	43	20
Interest	230	377	360
Profit on sale of non-current assets	–	–	–
Other	43	62	43
Area of Need income	143	171	176
TOTAL INCOME	**7,338**	**7,768**	**7,818**
Salaries and related expenses	2,182	2,262	2,224
Sitting fees	1,072	744	1126
Funding contributions	340	258	340
Computer and consultancy	152	222	365
Members fees	331	333	373
Medical Tribunal funding	550	400	400
Professional Conduct and Health	438	206	420
Postage, courier and phone	142	149	150
Loss on disposal of assets	–	36	
Administration expenses	790	599	772
Superannuation	339	316	352
Vehicle, travel and accommodation	190	83	168
Depreciation and amortisation	320	218	270
Audit Fees	14	14	14
Software development expenses written off		75	
TOTAL EXPENDITURE	**6,860**	**5,915**	**6,974**
OPERATING SURPLUS	**478**	**1,853**	**844**

Income

The budget for the year ending 30 June 2006 is based on the following estimates:

- a 3% increase in registrants with the annual registration fee to remain at $270.

Expenditure

The following significant changes in expenditure are anticipated:

- Decrease in Medical Tribunal Funding as the Board has not been billed for transcripts for the past three years.
- Increased salary costs due to staffing changes.
- Increase in consultancy fees to include $200,000 project costs.

AUDITOR-GENERAL
NEW SOUTH WALES

GPO BOX 12
Sydney NSW 2001

INDEPENDENT AUDIT REPORT

New South Wales Medical Board

To The Minister for Health

Audit Opinion

In my opinion, the financial report of the New South Wales Medical Board:

(a) presents fairly the New South Wales Medical Board's financial position as at 30 June 2005 and its financial performance and cash flows for the year ended on that date, in accordance with applicable Accounting Standards and other mandatory professional reporting requirements in Australia, and

(b) complies with section 41B of the *Public Finance and Audit Act 1983* (the Act).

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

The Board's Role

The financial report is the responsibility of the members of the New South Wales Medical Board. It consists of the statement of financial position, the statement of financial performance, the statement of cash flows and the accompanying notes.

The Auditor's Role and the Audit Scope

As required by the Act, I carried out an independent audit to enable me to express an opinion on the financial report. My audit provides *reasonable assurance* that the financial report is free of *material* misstatement.

My audit accorded with Australian Auditing and Assurance Standards and statutory requirements, and I:

- evaluated the accounting policies and significant accounting estimates used by the Board in preparing the financial report, and
- examined a sample of the evidence that supports the amounts and other disclosures in the financial report.

An audit does *not* guarantee that every amount and disclosure in the financial report is error free. The terms 'reasonable assurance' and 'material' recognise that an audit does not examine all evidence and transactions. However, the audit procedures used should identify errors or omissions significant enough to adversely affect decisions made by users of the financial report or indicate that the Board had not fulfilled their reporting obligations.

My opinion does *not* provide assurance:

- about the future viability of the New South Wales Medical Board,
- that it has carried out its activities effectively, efficiently and economically, or
- about the effectiveness of its internal controls.

Audit Independence

The Audit Office complies with all applicable independence requirements of Australian professional ethical pronouncements. The Act further promotes independence by:

- providing that only Parliament, and not the executive government, can remove an Auditor-General, and
- 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 are not compromised in their role by the possibility of losing clients or income.

P. K. Brown

P K Brown FCPA
Director, Financial Audit Services

SYDNEY
21 October 2005

New South Wales Medical Board

Statement by the members of the board

For the period ended 30 June 2005

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

1. The financial statements for the period ended 30th June 2005 exhibit a true and fair view of the financial position and transactions of the New South Wales Medical Board; and

2. The financial statements have been prepared in accordance with Accounting Standards, Urgent Issues Group Consensus Views, other authoritative pronouncements of the Australian Accounting Standards Board, and the Public Finance and Audit Act, 1983, the Public Finance and Audit (General) Regulation, 1995, 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

Board Member

19 October 2005

STATEMENT OF FINANCIAL POSITION

AS AT 30 JUNE 2005

	Notes	2005	2004
		$'000	$'000
Current Assets			
Cash	15	8,232	6,117
Receivables	7	653	662
Other	8	19	2
Total-Current Assets		**8,904**	**6,781**
Non-Current Assets			
Plant and Equipment	9	281	329
Leasehold improvements	10	2,426	2,528
Total-Non Current Assets		**2,707**	**2,857**
Total Assets		**11,611**	**9,638**
Current Liabilities			
Payables	11	221	244
Employee Provisions	12	80	73
Other	13	3,856	3,764
Total Current Liabilities		**4,157**	**4,081**
Non-Current Liabilities			
Employee Provisions	12	172	128
Total Non-Current Liabilities		**172**	**128**
Total Liabilities		**4,329**	**4,209**
Net Assets		**7,282**	**5,429**
Equity			
Accumulated Funds	17	7,282	5,429
Total Equity		**7,282**	**5,429**

The accompanying notes form part of the financial report.

STATEMENT OF FINANCIAL PERFORMANCE

FOR THE YEAR ENDED 30 JUNE 2005

	Notes	2005	2004
		$'000	$'000
Expenses from ordinary activities	2	5,879	5,606
Revenues from ordinary activities	3	7,768	6,573
Gain/(Loss) on disposal of plant and equipment	4	(36)	–
Results for the year from ordinary activities		**1,853**	**967**
Total changes in equity other than those resulting from transactions with owners as owners		**1,853**	**967**

The accompanying notes form part of the financial report.

STATEMENT OF CASH FLOW

FOR THE YEAR ENDED 30 JUNE 2005

	Notes	2005	2004
		$'000	$'000
Cash Flows from Operating Activities			
Receipts from registrants and other debtors		7,760	7,598
Payments to suppliers and employees		(5,839)	(5,656)
Interest received		373	269
Net Cash provided by operating activities	**15**	**2,294**	**2,211**
Cash Flows from Investing Activities			
Payments for leasehold improvements,plant and equipment		(206)	(1,186)
Proceeds from sale of plant and equipment		27	–
Net Cash used in Investing activities		**(179)**	**(1,186)**
Net increase in cash held		2,115	1,025
Cash at the beginning of the financial year		6,117	5,092
Cash at the end of the financial year	**15**	**8,232**	**6,117**

The accompanying notes form part of the financial report.

NOTES TO AND FORMING PART OF THE FINANCIAL REPORT

FOR THE YEAR ENDED 30 JUNE 2005

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

a. Basis of Accounting

The financial report is a general purpose financial report which has been prepared in accordance with Accounting Standards, Urgent Issues Group Consensus Views, other authoritative pronouncements of the Australian Accounting Standards Board and the Public Finance and Audit Act, 1983. An accruals basis of accounting has been adopted. The Statement of Financial Performance has been prepared on the historical cost basis and does not take into account changing money values, or fair values of non-current assets.

In the absence of a specific Accounting standard, other authoritative pronouncement of the AASB or UIG Consensus View, the hierarchy of other pronouncements as outlines in AAS6 "Accounting Policies" is considered.

Where there are inconsistencies between the above requirements, the legislative provisions have prevailed.

All amounts are rounded to the nearest one thousand dollars and are expressed in Australian currency.

b. Capitalisation Policy

Computing equipment costing over $1000 and other non-current assets costing over $5000 are capitalised.

c. Revenue Recognition

Registration Fees are progressively recognised as revenue by the Board as the annual registration period elapses.

Interest revenue is recognised as it is accrued, taking into account the effective yield on the financial asset.

d. Goods and Services Tax

Revenues, expenses and assets are recognised net of the amount of goods and services tax (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.

The net amount of GST recoverable from, or payable to, the ATO is included as a current asset or liability in the statement of financial position.

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

e. Employee benefits

Liabilities for employee entitlements to wages and salaries, annual leave and other current employee entitlements are accrued at nominal amounts calculated on the basis of current wage and salary rates.

Liabilities for other employee entitlements, which are not expected to be paid or settle within 12 months of balance date, are accrued in respect of all employees at the nominal values. It is considered that this measurement technique produces results not materially different from the estimates determined by using the present value basis of measurement.

f. Acquisition of Assets

The cost method of accounting is used for the initial recording of all acquisitions of assets controlled by the Medical Board. Cost is determined as the fair value of the assets given as consideration plus the costs incidental to the acquisition.

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 means the amount for which an asset could be exchanged between a knowledgeable, willing buyer and a knowledgeable, willing seller in an arm's length transaction.

Where settlement of any part of cash consideration is deferred, the amounts payable in the future are discounted to their present value at the acquisition date. The discount rate used is the incremental borrowing rate, being the rate at which similar borrowing could be obtained.

g. Maintenance and repairs

The costs of 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. Leased Assets

A distinction is made between finance leases which effectively transfer from the lessor to the lessee substantially all the risks and benefits incidental to ownership of the leased assets, and operating leases under which the lessor effectively retains all such risks and benefits.

Where a non-current asset is acquired by means of a finance lease, the asset is recognised at its fair value at the inception of the lease. The corresponding liability is established at the same amount. Lease payments are allocated between the principal component and the interest expense.

Operating lease payments are charged to the Statement of Financial Performance in the periods in which they are incurred.

i. Receivables

Receivables are recognised and carried at cost, based on the original invoice amount less a provision for any uncollectable debts. An estimate for doubtful debts is made when collection for the full amount is no longer probable. Bad debts are written off as incurred.

j. Payables

These amounts represent liabilities for goods and services provided to the Hospital and other amounts, including interest. Interest is accrued over the period it becomes due.

k. Plant and Equipment

Depreciation and amortisation

The Board, as a not-for-profit entity whose service potential is not related to its ability to generate net cash inflows, is not required to apply a recoverable amounts test to the value of its non current assets per Australian Accounting Standard 10.

Depreciation rates used are as follows:

Motor Vehicle 18%
Equipment 20%
Furniture and Fittings 20%
Computer Equipment 25%

Amortisation rates used are as follows:
Building Refurbishments – Building 54 4%
Building Refurbishments – Building 45 3.4%
Building Extension – Building 54 1.7%

NOTES TO AND FORMING PART OF THE FINANCIAL REPORT

FOR THE YEAR ENDED 30 JUNE 2005

	2005	2004
	$'000	$'000
2. EXPENDITURE FROM ORDINARY ACTIVITIES		
Salaries and related expense	2,262	2,072
Sitting Fees	744	707
Funding Contributions	258	331
Computer and Consultancy	222	134
Board Members Statutory Fees	333	337
Medical Tribunal Funding	400	400
Legal, Professional Conduct and Health Costs	206	360
Postage, Courier and Phone	149	136
General Administration Expenses	599	565
Superannuation	316	268
Vehicle, Travel and Accommodation	83	60
Depreciation and Amortisation	218	224
Audit Fees	14	11
Software Development expenses written off	75	–
	5,879	**5,606**
3. REVENUES FROM ORDINARY ACTIVITIES		
Registration Fees	7,115	6,133
Fines	43	20
Interest revenue (Note 5)	377	273
Other Revenue (Note 6)	233	147
	7,768	**6,573**
4. GAIN/(LOSS) ON SALE OF PLANT AND EQUIPMENT		
Cost of plant and equipment	115	–
Less Accumulated depreciation	(52)	–
Wriiten Down Value	63	–
Less Proceeds from Disposal	(27)	–
Gain/(Loss) on Disposal of plant and equipment	(36)	–

	2005	2004
	$'000	$'000
5. INTEREST REVENUE		
General	177	99
Treasury Corporation Hour Glass Facility	200	174
	377	**273**
6. OTHER REVENUE		
Application Fee for Area of Need Assessments	171	125
Other	62	22
	233	**147**
7. RECEIVABLES		
Accrued Interest	15	11
Other	638	651
	653	**662**
8. OTHER ASSETS		
Prepayments	19	2
	19	**2**
9. PLANT AND EQUIPMENT		
Motor vehicle – cost	45	55
Accumulated depreciation	(5)	(16)
Written down value	**40**	**39**
Equipment – cost	116	118
Accumulated depreciation	(64)	(80)
Written down value	**52**	**38**
Furniture & fittings – cost	329	329
Accumulated depreciation	(239)	(209)
Written down value	**90**	**120**
Computer equipment – cost	810	781
Accumulated depreciation	(711)	(649)
Written down value	**99**	**132**
Total Plant and Equipment	**281**	**329**

NOTES TO AND FORMING PART OF THE FINANCIAL REPORT

FOR THE YEAR ENDED 30 JUNE 2005

9. PLANT AND EQUIPMENT (continued)

	Motor Vehicle	Equipment	Furniture & Fittings	Computer Equipment	Total
	$'000	$'000	$'000	$'000	$'000
At Cost					
Balance 1 July 2004	55	118	329	782	1,284
Additions	44	38	–	48	130
Disposals	(55)	(40)	–	(19)	(114)
Balance 30 June 2005	**44**	**116**	**329**	**811**	**1,300**
Accumulated Depreciation					
Balance 1 July 2004	16	80	209	650	955
Depreciation for the year	10	15	30	61	116
Writeback on disposal	(21)	(31)	–	–	(52)
Balance 30 June 2005	**5**	**64**	**239**	**711**	**1,019**
Written Down Value	**39**	**52**	**90**	**100**	**281**

10. LEASEHOLD IMPROVEMENTS

	2005	2004
	$'000	$'000
Cost	3,576	3,576
Accumulated Amortisation	(1,150)	(1,048)
Written Down Value	**2,426**	**2,528**
Total Written Down Value	**2,426**	**2,528**

RECONCILIATION NON-CURRENT ASSETS LEASEHOLD IMPROVEMENTS

	Building Extension $'000	Building Refurbishments $'000	Total
At Cost			
Balance 1 July 2004	248	3,328	3,576
Additions	–	–	–
Disposals	–	–	–
Transfer of Asset	–	–	–
Balance 30 June 2005	248	3,328	3,576
Accumulated Depreciation			
Balance 1 July 2004	82	966	1,048
Depreciation for the year	10	92	102
Writeback on disposal	–	–	–
Balance 30 June 2005	**92**	**1,058**	**1,150**
Written Down Value	**156**	**2,270**	**2,426**

NOTES TO AND FORMING PART OF THE FINANCIAL REPORT

FOR THE YEAR ENDED 30 JUNE 2005

11. PAYABLES

	2005	2004
	$'000	$'000
Accrued expenses	156	201
Trade Creditors	65	43
	221	**244**

12A. CURRENT LIABILITY

Annual Leave Provision	**80**	**73**

12B. NON CURRENT LIABILITY

Annual Leave Provision	79	64
Long Service Leave Provision	93	64
	172	**128**

13. OTHER LIABILITIES

Deferred Revenue	**3,856**	**3,764**

The balance of deferred Revenue represents the amount of Registration Fees related to the unelapsed portion of the annual Registration period.

14. COMMITMENTS

Lease Commitments

The New South Wales Medical Board does not own real estate. For the purpose of carrying on its activities, the Board occupies the Medical Board Building located off Punt Road, Gladesville NSW.

A 30 year lease commencing 1 April 1990 with the NSW Department of Health has been negotiated with an agreed rental of $20,000 per annum.

Additional premises were leased for a period of 30 years from 13 January 2003 at an agreed rental of $10,000 per annum.

Amounts contracted for rental commitments and not provided for in the accounts

Within one year	33	33
Between one and five years	132	132
Greater than five years	465	497
Total (including GST)	**630**	**662**

The total of lease commitments as at 30 June 2005 above includes input tax credits of $58,000 that are expected to be recoverable from the Australian Taxation Office

15. CASH FLOW INFORMATION

	2005	2004
	$'000	$'000
For the puposes of the statement of cash flows, cash includes cash on hand, deposits held at call with banks and investments with NSW Treasury Corporation Cash and Cash Plus Hour Glass facilities. Market and book values of the Hour Glass Facility are considered equivalent due to their short-dated nature.		
Reconciliation of Cash Cash at the end of the financial year as shown in the statement of cash flows and balance sheet is made up of:		
Cash	1,033	2,618
Treasury Corporation Hour Glass Facility	7,199	3,499
	8,232	**6,117**
Reconciliation of net cash flows from operating activities to net surplus/(deficit) for the period		
Net Profit	1,853	967
Depreciation and amortisation	218	224
Net loss/(gain) on disposal of fixed assets	36	–
Increase/(decrease) in employee provisions	51	36
(Increase)/decrease in receivables and other assets	(8)	90
Increase/(decrease) in deferred revenue	92	879
Increase/(decrease) in payables	(23)	15
Assets written off	75	–
Net Cash provided by operating activities	**2,294**	**2,211**

16. FINANCIAL INSTRUMENTS

Cash

Cash comprises cash on hand and bank balances. Interest is earned on a daily bank balances at a commercial rate. The average interest rate for the year was 4.9% (2004-4.75%)

Receivables

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 uncollectable are written off. A provision for doubtful debts is raised when some doubt as to collection exists. The credit risk is the carrying amount (net of any provision for doubtful debts). No interest is earned on trade debtors. The carrying amount approximates net fair value.

Hour Glass Facilities

The Board has investments in the Treasury Corporations Hour Glass Facility. The Boards investment is represented by a number of units of a managed investment pool, with each particular pool having different investment horizons and being comprised of a mix of asset classes appropriate to that investment horizon. Treasury Corporation appoints and monitors fund managers, and establishes and monitors the application of appropriate investment guidelines.

The Board's Investments are:

	2005	2004
	$'000	$'000
	7,199	3,499

Cash Facility

This investment is able to be redeemed with 24 hours notice. The value of the investments held can decrease as well as increase depending upon market conditions. The value that best represents the maximum credit risk exposure is the net fair value. The value of the above investment represents the Board's share of the value of the underlying assets of the facility and those assets are stated at net fair value.

The average interest rate for the year was 5.5% (2004-5.3%)

Bank Overdraft

The Board does not have an bank overdraft facility.

Trade Creditors and Accruals

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 trade terms. 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 statement is received.

17. EQUITY

Balance at beginning of financial year	5,429	4,462
Surplus for the year from ordinary activities	1,853	967
Balance at end of financial year	7,282	5,429

18. IMPACT OF ADOPTING AUSTRALIAN EQUIVALENTS TO AEIFRS

Transition to AEIFRS

The NSW Medical Board will apply AEIFRS from the reporting period beginning 1 July 2005.

The NSW Medical Board is managing the transition to the new standards by allocating internal resources and engaging consultants to analyse the pending standards and Urgent Issues Abstracts to identify key areas regarding policies, procedures, systems, and financial impacts affected by the transition.

As a result of this exercise, the NSW Medical Board has taken the following steps to manage the transition to new standards:

- The NSW Medical Board Executive Committee is oversighting the transition. The Finance Manager is responsible for the project and reports regularly to the Committee on progress against the plan
- An analysis of current activities and existing assets and liabilities disclosed in the Financial Statements;
- Detailed comparison of existing Standards and AEIFRS;
- Recognition/de-recognition, reclassification and remeasurement or evaluation exercise for all current activities and existing assets and liabilities disclosed in the Financial Statements; and
- Preparation and incorporation of comparative figures and opening balances as at 1 July 2005 and closing balances as at 30 June 2005.

NSW Treasury is assisting agencies to manage the transition by developing policies, including mandates of options; presenting training seminars to all agencies; providing a website with up to date information to keep agencies informed of any new developments; and establishing an IAS Agency Reference Panel to facilitate a collaborative approach to manage the change.

The NSW Medical Board has determined the key areas where changes in accounting policies are likely to impact the financial report. Some of these impacts arise because AEIFRS requirements are different from existing AASB requirements (AGAAP). Other impacts are likely to arise from options in AEIFRS. To ensure consistency at the whole of government level, NSW Treasury has advised agencies of options it is likely to mandate for the NSW Public Sector. The impacts disclosed below reflect Treasury's likely mandates (referred to as "indicative mandates").

Shown below are management's best estimates as at the date of preparing the 30 June 2005 financial report of the estimated financial impacts of AEIFRS on the NSW Medical Board's equity and profit/loss. The NSW Medical Board does not anticipate any material impacts on its cash flows. The actual effects of the transition may differ from the estimated figures below because of pending changes to the AEIFRS, including the UIG Interpretations and / or emerging accepted practice in their interpretation and application. The NSW Medical Board's accounting policies may also be affected by a proposed standard to harmonise accounting standards with Government Finance Statistics (GFS). However, the impact is uncertain because depends on when this standard is finalised and whether it can be adopted in 2005-06.

a) Reconciliation of key aggregates

No change is required in reported equity as at 1 July 2004 and 30 June 2005 or the reported net profit for the year ended 30 June 2005 due to the transition to AEIFRS.

A re-classification of Non-current assets will however be required due to the capitalisation of application of software as Plant and Equipment which will now be disclosed as an INTANGIBLE ASSET under AEIFRS (AASB 138).

Non-Current Assets	AEIFRS 1 July 2004	AGAAP 1 July 2004
	$ ' 000	$ ' 000
Plant & Equipment	280	329
Leasehold Improvements	2,528	2,528
Intangible Asset	49	0
Total Non-Current Assets	**2,857**	**2,857**

Non-Current Assets	AEIFRS 30 June 2005	AGAAP 30 June 2005
	$ ' 000	$ ' 000
Plant & Equipment	252	281
Leasehold Improvements	2,426	2,426
Intangible Asset	29	0
Total Non-Current Assets	**2,707**	**2,707**

b) Financial Instruments

In accordance with NSW Treasury's indicative mandates, The NSW Medical Board will apply the exemption provided in AASB 1 First-time Adoption of Australian Equivalents to International Financial Reporting Standards not to apply the requirements of AASB 132 Financial Instruments: Presentation and Disclosures and AASB 139 Financial Instruments: Recongnition and Measurement for the financial year ended 30 June 2005. These Standards will apply from 1 July 2005. None of the information provided above includes any impacts for financial instruments. However, when these Standards are applied, they are likely to impact on retained earnings (on first adoption) and the amount and volatility of profit/loss. Further, the impact of these Standards will in part depend on whether the fair value option can or will be mandated consistent with Government Finance Statistics.

c) Grant recognition for *non-for-profit* entities

The NSW Medical Board will apply the requirements in AASB 1004 Contributions regarding contributions of assets (including grants) and forgiveness of liabilities. There are no differences in the recognition of requirements between the new AASB 1004 and the current AASB 1004. However, the new AASB 1004 may be amended by proposals in Exposure Draft (ED) 125 Financial Reporting by Local Governments. If the ED 125 approach is applied, revenue and / or expense recognition will not occur until either the NSW Medical Board supplies the related goods and services (where grants are in-substance agreements for the provision of goods and services) or until conditions are satisfied. ED 125 may therefore delay revenue recognition compared with AASB 1004, where grants are recognised when controlled.

However, at this stage, the timing and dollar impact of these amendments is uncertain.

End of Audited Financial Report