NEW SOUTH WALES
Medical Board

Annual Report
2009

Annual Report 2009

Contents

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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

9 November 2009

The Hon Ms Carmel Tebbutt
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 2009.

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

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> president's **report**

On 31 December 1838, the first meeting of the New South Wales Medical Board was attended by five gentlemen of the Colony. One hundred and seventy one years later, the Board, which despite numerous legislative changes, has maintained its identity as the regulatory authority for medical practitioners in NSW, has entered its final year, in anticipation of its abolition on 30 June 2010, making way for the assumption of its role by the Medical Board of Australia.

More than 100 years ago, and when the Board was already over 60, the Commonwealth of Australia was founded. It is logical, and eminently sensible in most respects for regulation of medical practitioners within Australia to be undertaken on a national basis, and it is a reflection of the ambivalence that many Australians have had towards federalism that it has taken more than 100 years to achieve this. Nevertheless, the demise of a body with the long and distinguished history of the Board cannot but be viewed with some nostalgia. During its history, many doctors, and more recently, lay members, have served the public of NSW well by their membership of the Board, and their participation in ensuring that it meets its charter of protecting the public. While no doubt in its history there have been less energetic times, there is no doubt that from its humble beginnings on New Years Eve 1838 to the current day, the Board has largely succeeded in ensuring that the standards of conduct and practice of medical practitioners in NSW have been kept at a level that the public has every right to expect.

The "current" Board has its origins in the 1987 amendments to the Medical Practitioners Act, 1938, which granted autonomy to the Board to exercise its functions independent of Government or professional control or influence, while constituting it with significant professional and lay input to enable it to act in the public interest. The Board was granted financial and administrative independence, and as a result it was able to embark upon the program of major changes in regulation which it has ushered in since 1987.

The 1987 amendments also introduced a significantly updated complaints and disciplinary system based around the two tiers of the Medical Tribunal and Professional Standards Committees, with a much broader definition of professional misconduct. The Board developed a fledgling Impairment Program and, following a review of the 1938 legislation, the Medical Practice Act 1992 was introduced, incorporating the current Impaired Registrants system. The next logical step was to find a way to deal with practitioners who were not impaired and whose conduct was not sufficiently substandard to warrant formal disciplinary action, and after careful review of developments in Canada and the USA, the Board proposed and oversaw the introduction of a Performance Assessment Program in amendments to the Act in 2000.

Over the 22-year period since 1987, the New South Wales Medical Board has been at the forefront in development of regulatory practice both nationally and internationally, an achievement of which it can be justly proud.

The development of the National Registration and Accreditation Scheme has been at the centre of the Board's activities during the past year, and whilst it is almost certain that the NSW Government will opt out of the national provisions regarding conduct, performance and health, the move to a national profession with national regulation is supported by the Board. Opting out at this stage has been in response to serious concerns about the complaints handling provisions proposed in the first draft of the legislation, which have been seen to be in many respects a significant backward step from the transparent, flexible and effective system that has been developed in NSW over the past 20 years. It is to be hoped that over time, and with further legislative change, it will become possible for NSW to become a full participant in the national system without compromising the quality of its regulatory system.

With the deadline of 1 July 2010 rapidly approaching, there is much work still to be done by the newly formed Medical Board of Australia, Australian Health Practitioner Regulation Agency, and the secretariat of the Board to ensure that everything is in place for the transition and that the handover is smooth.

Following some two years of development, the Nationally Consistent Pathways to Registration for International Medical Graduates were substantially finalised during the course of the year, and implementation has occurred without more than the expected teething problems. The new national approach will provide a good basis for policy to be adopted by the Medical Board of Australia.

As a result of amendments to the Medical Practice Act in 2008, following a review of matters relating to de-registered doctor Graeme Stephen Reeves, registrants are now mandated to report certain forms of conduct, including colleagues being intoxicated while at work, engaging in sexual improprieties in the course of practice, or practising in a way that is seen as a flagrant departure from acceptable standards. These new provisions in effect provide statutory backing to pre-existing obligations under the Board's Code of Conduct, and are likely to be adopted in the national legislation. Another result of the amendments has been that Professional Standards Committees hearings are now open to the public and chaired by a legally qualified member. Only a small number of Professional Standards Committees have been held since the implementation of this legislation, and no significant change in the way in which they operate has been observed.

When national or high profile issues are occupying an inordinate amount of time, it is easy to overlook the solid and consistent work being undertaken by the Board and secretariat in meeting its core responsibilities across the spectrum of registration, complaints handling, performance and health. The Board has continued to function at a high level of proficiency in these core areas, with their ever-increasing complexity and workload, in addition to the need for staff to also be involved in dealing with the national issues.

During the year Professor Helen Lapsley, A/Professor Richard Benn, and Dr Denise Robinson completed their terms of office. All these members made valuable contributions to the Board during their terms of office, which in the case of Professors Lapsley and Benn was for the statutory maximum period of 12 years.

Peter Procopis
President

> year in **summary**

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.

	2006/07	2007/08	2008/09
Registration			
The following indicates the number of registrants by category on 30 June 2009.			
Category of Registration			
General	23253	23872	24594
Interns	469	581	605
AMC Registrants undertaking supervised training	116	81	89
Postgraduate Trainees	1577	1757	1547
General Practice Trainees	96	94	25
Areas of Need	245	246	241
Conditional Specialists	885	1050	1203
Specialist Trainees	20	23	47
Retired/Non-Practising/Limited Prescribing and Referral	2254	2311	2312
Other (includes academic and temporary Board discretion)	13	21	31
Student registrants	**2990**	**3195**	**3807**
Total registrants	**31918**	**33231**	**34501**
Professional Conduct			
Complaints assessed	1155	1116	1268
PSCs concluded	20	18	18
Medical Tribunals concluded	25	15	19
Counselling Interviews finalised	31	18	18
Section 66 Inquiries conducted	35	26	45
Health			
Doctors in Health Program	138	134	146
Entrants to Program	42	50	30
IRPs convened	58	71	61
Board Review Interviews	246	260	276
Performance			
Doctors in Performance Program	40	45	54
Entrants to Program	20	20	24
Assessments concluded	12	17	19
PRPs concluded	8	8	11
Retired as a result of participation	5	3	5
Performance Interviews concluded	41	50	43
Exit from Program	-	-	15

> structure of the board **and secretariat**

Membership of the NSW Medical Board

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

Members of the Board, their qualifications, term of appointment and nominating body for the period 1 July 2008 to 30 June 2009 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, AM, MBBS (Sydney), FRACP, Royal Australasian College of Physicians nominee (current term: 1.10.2007-30.9.2011) [5]

A/Professor Michael Robert Fearnside, Deputy President, MBBS (Sydney), MS (Sydney), FRACS, Royal Australasian College of Surgeons nominee (current term: 1.10.2004-30.09.2008) [6]

Dr Stephen Adelstein, MB BCh (Wits), PhD (Syd), FRACP, FRCPA, Royal College of Pathologists of Australasia nominee (current term: 1.8.2008-31.7.2012) [6]

Professor Belinda Bennett, B Ec LLB (Hons) (Macquarie), LLM SJD (Wisconsin), GAICD, Legal Member nominated by the Minister (current term: 7.6.2006-6.6.2010) [6]

Mr Antony Carpentieri, LLB (UTS), Ministerial nominee (current term: 7.1.2009-30.6.2010) [2]

Dr Kerry Chant, MBBS (UNSW), FAFPHM, MHA (UNSW), MPH (UNSW), Department of Health nominee (current term: 25.3.2009-30.6.2010) [1]

Dr Susan Ieraci, MBBS (Sydney), FACEM, Ministerial nominee (current term: 1.10.2007-30.9.2011) [4]

Ms Maria Kelly, B.Pharm. (Sydney), Dip Ed (NSW), Grad Cert Bioethics (UTS), Ministerial nomineee (term expired: 30.9.2008) [1]

Dr Gregory John Kesby, MBBS (Sydney), BSc (UNSW), PhD (Cambridge), FRANZCOG, DDU, CMFM, Royal Australian and New Zealand College of Obstetricians and Gynaecologists nominee (current term: 1.10.2007-30.9.2011) [6]

Ms Rosemary Eva Kusuma, BSW (Sydney), Ministerial nominee (current term: 30.1.2006-30.9.2009) [6]

Professor Helen Madeleine Lapsley, BA (Auckland), MEc (Sydney), FCHSE, Ministerial nominee (term expired: 17.11.2008) [1]

A/Professor Eugen Molodysky, MBBS (Sydney), PhD (Sydney), DRACOG, MRACGP, Community Relations Commission nominee (24.5.2006-30.9.2009) [6]

A/Professor Rodney James McMahon, MBBS (Sydney), Flt Lt (ret), DRCOG, DRANZCOG, FAIM, FRACGP, Royal Australian College of General Practitioners nominee (current term: 1.10.2006-30.9.2010) [5]

Dr Robyn Stretton Napier, MBBS (Sydney), Australian Medical Association nominee (current term: 1.10.2008-30.9.2012) [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 (current term: 1.2.2007-31.1.2011) [6]

Ms Lorraine Poulos, RN (St Vincents Hospital), Grad Cert HSM (Edith Cowan), Ministerial nomineee (current term: 7.1.2009-30.6.2010) [3]

Dr Denis Andrew Smith, MBBS (Sydney), MHP, FRACMA, Royal Australian College of Medical Administrators nominee (current term: 1.8.2006-31.7.2010) [5]

Professor Allan David Spigelman, MBBS (Sydney), FRACS, FRCS, MD, Universities' nominee (current term: 19.12.2007-30.9.2011) [6]

Dr Gregory Joseph Stewart, MBBS, MPH (Sydney), FRACMA, FAFPHM, Ministerial nominee (current term: 21.11.2005-30.9.2009) [5]

Dr Kendra Sundquist, Ed.D (UTS), MHlth.Sc.(Ed) (Sydney), RN, MCNA, Ministerial nominee (current term: 1.10.2008-30.9.2012) [6]

Professor Kathleen Anne Wilhelm, AM, MBBS (New South Wales), MD, FRANZCP, Royal Australian & New Zealand College of Psychiatrists nominee (current term: 1.8.2006-31.7.2010) [5]

Dr Choong-Siew Yong, MBBS (Sydney), FRANZCP, Australian Medical Association nominee (current term: 1.10.2008-30.9.2012) [5]

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 and Audit 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, and in a variety of other capacities.

Dr G Abouyanni, Dr A Abrahams, Dr V Ahern, Dr P Anderson, Dr K Arnold, Dr K Atkinson, Dr R Ayscough, Dr R Barnett, Dr A Bean, Dr M Bennett, Dr C Berglund, Dr H Bittar, Dr F Black, Dr J Branch, Dr D Brash, Dr J Brown, Dr L Brown, Dr J Burn, Dr S Cains, Dr R Carroll, Dr R Chaseling, Dr D Child, Dr A Christie, Ms A Collier,

A/Prof M da Cruz, Dr P Curtin, Dr V DeCarvalho, Ms A Deveson, Dr M Diamond, Dr A Dilley, Dr G Dore, Dr P Duff, Dr K Edwards, Ms G Ettinger, Dr N Evans, Dr A Eyers, Dr R Fisher, Dr R Ford, Dr T French, Dr M Friend, Dr J Gillis, Dr M Giuffrida, A/Prof A Glass, Dr M Gleeson, Prof W Glover, Dr P R Gordon, Dr A Gould, Ms A Gray, Dr D Grimes, Dr C Hampshire, Prof B Harris, Dr J Hely, Dr M Hennessy, Dr M Hollands, Ms J Houen, Dr S Howle, Dr D Hunt, Dr K Hutt, Dr K Ilbery, Mr D Jackett, Dr W Jammal, Dr M Jarrett, Dr B Kelly, Mr R Kelly, Ms M Kelly, Dr A Kemp, Dr J Kendrick, Dr E Kertesz, Ms H Kiel, Dr L King, Prof P Klineberg, Dr E Kok, Dr B Kotze, Dr P Langeluddecke, Dr V Lele, Dr S Lertsumitkul, Dr J Lewis, Dr J Livesey, Dr E Loughman, Dr J Lovric, Dr M Mackertich, Dr J Mair, Dr S Mares, Dr F Martin, Dr D McKay, Dr A Meares, Dr S Messner, Dr G Milazzo, Dr P Morse, Dr D Moss, Dr J Ng, Dr N O'Connor, Dr E O'Brien, Dr B Oliver, Dr B Parsonage, Dr C Peisah, Dr A Pethebridge, Dr J Phillips, Dr R Pillemer, Dr R Rae, Prof W Reid, Dr S Renwick, Dr J Rodney, Dr W Ross, Dr I Rotenko, Dr D Rowe, Dr J Sammut, Dr A Samuels, Dr P Schofield, Dr D Semmonds, Mr R Smith, Dr R Spark, Dr J Spies, Dr S Spring, Dr G Steele, Dr I Stewart, Dr E Summers, Dr D Sutherland, Dr V Sutton, Dr I Symington, Dr S Toh, Dr E Tompsett, Dr P Tucker, Dr F Varghese, Dr A Virgona, Ms A Walker, Dr M Walker, Prof R Walsh, Dr J Warden, Dr B Westmore, Dr P Wijeratne, Dr I Wilcox, Dr M Wright, Dr M Wroth, Dr P Wyllie, Dr G Yeo, Dr I Zetler.

Senior Officers

Andrew Dix BA LLB (Syd.)
Registrar/CEO

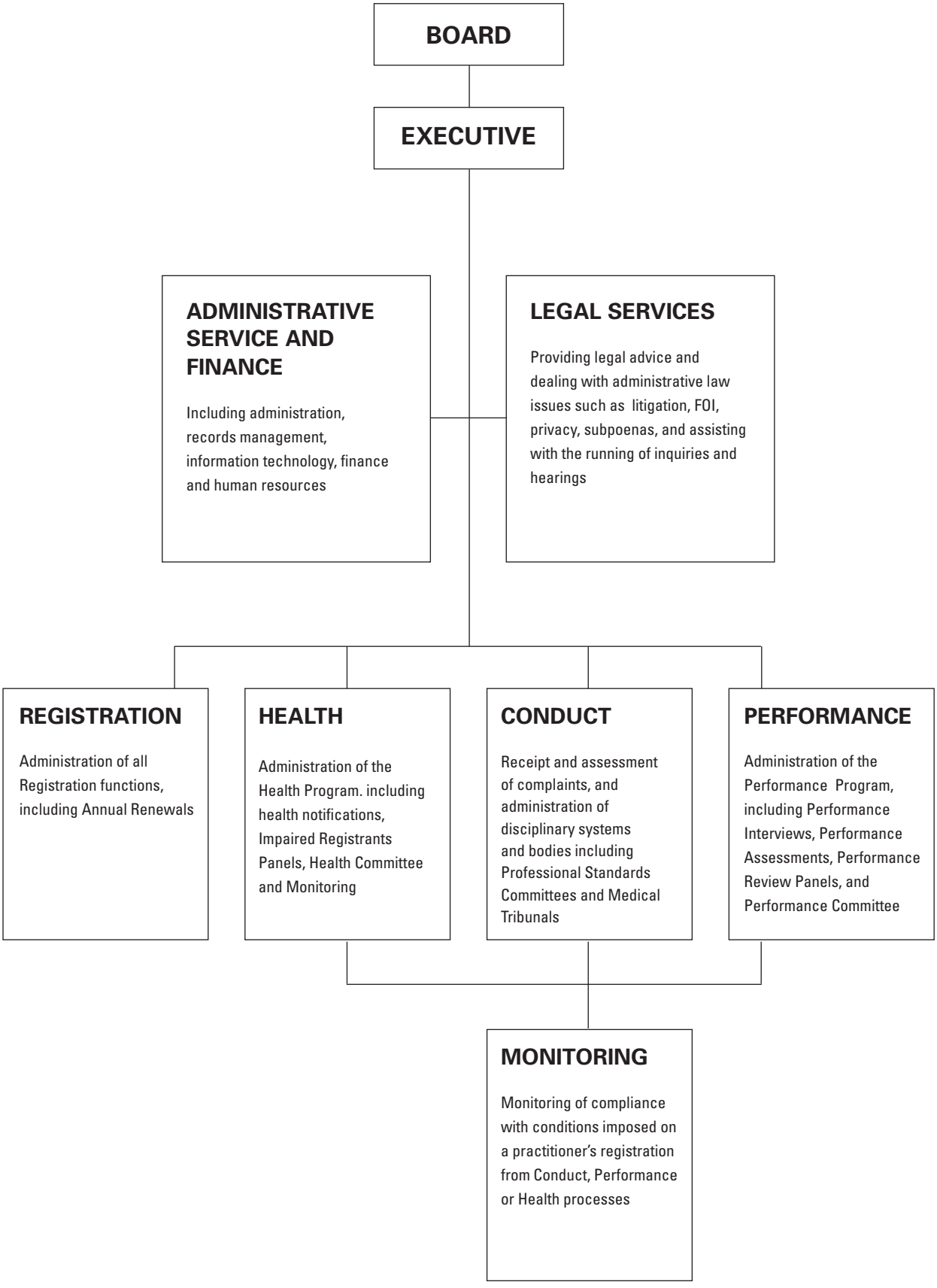
Dr Alison Reid B Med Sc, MBBS (Tas.), MHA, FAFPHM
Medical Director

Miranda St Hill RN, BA LLB (Monash)
Legal Director

NSW Medical Board Committees as at 30 June 2009

CONDUCT	HEALTH	PERFORMANCE	REGISTRATION	EXECUTIVE	CORPORATE GOVERNANCE & AUDIT
Chair	**Chair**	**Chair**	**Chair**	**Chair**	**Chair**
M Fearnside	**K Wilhelm**	**G Stewart**	**D Smith**	**P Procopis**	**B Bennett**
B Bennett	S Adelstein	B Bennett	S Adelstein	B Bennett	M Fearnside
A Carpentieri	S Ieraci	M Fearnside	K Chant	M Fearnside	R Kusuma
G Kesby	R Kusuma	A Carpentieri	S Ieraci	G Kesby	P Procopis
R McMahon	E Molodysky	G Kesby	R Kusuma	D Smith	C-S Yong
R Napier	F J Palmer	R McMahon	E Molodysky	G Stewart	
P Procopis	L Poulos	P Procopis	R Napier	K Wilhelm	
D Smith	P Procopis	K Sundquist	F J Palmer		
K Sundquist	A Spigelman	C-S Yong	P Procopis		
	C-S Yong		L Poulos		
			A Spigelman		
			K Wilhelm		
F Black		F Black	J Hely		
R Walsh		J Hely	P Klineberg		
A Eyers		E Tompsett	M Mackertich		
		R Walsh			

> nsw medical board organisational **chart 2009**



> management & **activities**

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

> national registration

Following a Productivity Commission report in 2006, and COAG agreement in 2007, an Intergovernmental Agreement setting out the framework for a National Registration and Accreditation Scheme for Australian health practitioners was signed in March 2008, and an Implementation Team established to steer the National Registration Project towards the July 2010 implementation date.

A series of discussion papers on central regulatory topics were issued and forums held in late 2008, and the Board and secretariat contributed substantially to these. Serious reservations expressed by NSW in relation to the unwillingness of other jurisdictions to separate the investigation/prosecution and adjudication functions under the proposed Scheme led to a Ministerial Statement in May 2009 indicating that it would be open to jurisdictions to opt out of the complaints handling provisions, and at the time of writing, it is very likely that NSW will do this.

In June 2009, the Exposure Draft of the legislation intended to underpin the National System was released. While covering most of the important aspects of a professional regulatory system, the Bill was seen by the Board as having very significant deficiencies, particularly in the area of management of Complaints, and Performance and Health. The Board, in the ensuing debate and in its submission to the Australian Health Practitioner Regulation Agency and in various forums, has expressed these concerns strongly.

It appears likely that a 'co-regulatory' approach will be adopted by NSW from 1 July 2010, with full participation in the national registration system, while complaints, performance and health matters will be handled at a local level under NSW legislation, with appropriate links to the national system. Significant structural, governance, financial and legislative details regarding these arrangements remain to be resolved.

> registration

2008-2009 **in summary**

- → 30,694 doctors and 3807 medical students were registered in NSW at 30 June 2009.
- → 3758 applications for registration were approved in 2008/09, including new interns, doctors who had completed internships, practitioners from interstate and overseas, and those seeking to reinstate previous NSW registration.
- → The number of new interns registering to practise in NSW rose by 6% in the past year, from an average of 490 in each of the past three years to 605 in 2008/09.
- → 31% of general practitioner applicants and 62% of Resident Medical Officer/Career Medical Officer applicants were successful in seeking registration for positions in Unmet Areas of Need. Applicants are independently assessed against individual positions and success rates reflect the variable specific skills set and demands required by different Area of Need positions.
- → 3612 doctors were removed from the Register of Medical Practitioners, including those who had died, requested to be removed, did not renew their registration, or were de-registered by the Medical Tribunal.
- → 196 International Medical Graduates were registered under the Competent Authority Pathway, 148 under the Standard Pathway and 78 under the Specialist Pathway.

Overview

2008-2009 has been dominated in the Registration Section by the introduction of the Nationally Consistent Pathways to Registration for International Medical Graduates (IMGs). These pathways, developed in 2007-2008, were substantially brought into effect during the year, leading to a situation where, with some minor exceptions, registration as an IMG is achieved in the same way throughout Australia.

In addition to achieving uniformity, the new pathways have introduced new concepts, namely the acceptance of assessment processes in defined Competent Authorities as the basis for determining that a certain minimum standard has been met in granting registration to work in certain positions. Subject to satisfactory completion of workplace-based assessment, Competent Authority registrants are generally awarded the AMC Certificate, thereby conferring an entitlement to General registration.

Practitioners who do not meet the Competent Authority criteria are eligible to enter into other areas of supervised practice via the Standard Pathway on the basis of successful completion of the AMC's Multiple Choice Question (MCQ) Examination and, depending on the nature of the position, the completion of a pre-employment structured clinical interview (PESCI). These pathways supersede the former Area of Need and Postgraduate Trainee categories of registration.

Transitional arrangements meant that many IMGs already in the registration system were able to satisfy the Competent Authority requirements, or had already passed their MCQ exam.

The Board has overhauled and streamlined many registration processes to simplify the introduction of the new pathways, and has obtained accreditation from the AMC of its PESCI, which is now being applied to all IMGs applying for GP positions and some hospital non-specialist positions. As a result of the introduction of the new pathways, the number of PESCI assessments under the Area of Need category has declined significantly.

Registration workflow

General Registration – applications approved

General registration is granted to applicants who meet all requirements for unconditional registration. For data collection purposes, applicants for general registration are separated into various categories.

	2006/07	2007/08	2008/09
Internship Complete	442	434	548
General Registration	92	93	71
Re-registration	441	326	332
Mutual Recognition	981	1008	828
AMC Complete	146	85	155
Competent Authority	n/a	n/a	288
Total	**2012**	**1946**	**2222**

The different pathways to general registration are defined as follows:

➔ *Internship Complete*

Applicants who hold primary medical qualifications conferred by Australian and New Zealand universities accredited by the AMC 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 AMC examinations and either the required period of supervised training or have had appropriate clinical experience in Australia deemed equivalent to the required period of supervised training. Ninety-two doctors had the requirement for supervised training waived on this basis of equivalent experience.

➔ *Competent Authority*

A new category introduced in 2008/09 as part of the move towards nationally consistent registration for IMGs relating to applicants who have been awarded the AMC Certificate on the basis of Advanced Standing under the Competent Authority Model and satisfactory completion of a minimum of 12 months clinical work under supervision in an Institute of Medical Education and Training (IMET)-accredited hospital.

Conditional registration - applications approved

Applicants who do not meet the requirements for general registration may be granted registration in a category to undertake specific training or for a specific purpose. Each category of registration has inherent conditions.

	2006/07	2007/08	2008/09
Interns	460	569	605
AMC Graduates	95	44	47
Postgraduate Trainees	865	771	528
General Practice Trainees	112	92	7
Unmet Areas of Need	97	103	148
Overseas Trained Specialists	193	212	134
Specialist Assessment	17	15	39
Academic Appointments	0	1	2
Temporary Board Discretion	23	29	26
Medical Exchange	0	0	0
TOTAL	**1862**	**1836**	**1536**

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.

➔ *AMC Graduates*

Holders of primary medical qualifications from universities outside Australia and New Zealand who have completed the AMC 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 registered to undertake postgraduate training. They are now assessed under the new Competent Authority Pathway and the Standard Pathway.

➔ *General Practice Training Program*

Overseas trained general practice trainees working in Royal Australian College of General Practitioners (RACGP) approved and accredited hospitals in terms which are accredited for general practice training.

➔ *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. During the year, 33 GP applicants and 12 RMO/CMO applicants and 30 specialists were considered suitable for work in an Unmet Area of Need.

➔ *Overseas Trained 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 NSW, eg, assisting in an operation, demonstration or participating in a seminar.

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

Total Registrants

The following indicates the total number of NSW registrants by category at 30 June 2009, including all new registrants and those completing annual renewals.

Category of Registration	2006/07	2007/08	2008/09
General	23253	23872	24594
Interns	469	581	605
AMC Registrants undertaking supervised training	116	81	89
Postgraduate Trainees	1577	1757	1547
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Retired/Non-Practising/ Limited Prescribing and Referral	2254	2311	2312
Other (includes academic and temporary Board discretion)	13	21	31
Student registrants	2990	3195	3807
TOTAL REGISTRANTS	**31918**	**33231**	**34501**

Practitioners Removed from the Register, or moved to Non-practising or Limited Prescribing and Referral categories

The following table details the number of registrants removed from the Register during 2008/09 and previous two years.
It also shows the registrants who moved to Non-practising or Limited Prescribing and Referral registration categories, which apply to those doctors not practising medicine or those whose practice is limited to, without fee or reward, writing repeat prescriptions and making referrals to another medical practitioner for the purposes of providing health care.

	2006/07	2007/08	2008/09
Deceased	111	101	111
At own request	346	315	394
Non payment of Registration fee	929	1778	2514
Term of conditional registration expired	750	593	451
Withdrawal	65	78	131
Medical Tribunal	5	4	11
TOTAL	**2206**	**2869**	**3612**
Non-practising	221	229	178
Limited Prescribing and Referral	207	158	204

> professional **conduct**

2008-2009 **in summary**

- → 1248 complaints were received by the Board and the Health Care Complaints Commission (HCCC) in 2008/09.
- → 672 (53%) complaints were declined, 122 (10%) were referred for investigation by the HCCC, and 241 (19%) were referred to the Board.
- → More than half (56%) of investigated complaints (67 matters) were then referred to the Director of Proceedings to determine whether they should be prosecuted before a disciplinary body.
- → During the year, the Medical Tribunal made determinations on complaint matters against 12 doctors which resulted in eight doctors being de-registered (or an order made that they not be re-registered), two having a reprimand and critical compliance conditions imposed on their registration, one having conditions imposed and another being reprimanded only. Two matters were referred to the Medical Tribunal directly by the Board under s65 of the MPA, resulting in both doctors being de-registered (or an order that they not be re-registered). A Professional Standards Committee (PSC) also made a recommendation under s63 of the MPA that a medical practitioner be de-registered, and the Tribunal Chairperson so ordered.
- → Eighteen PSC hearings were finalised during the period resulting in 12 doctors having unsatisfactory professional conduct findings made against them, of whom nine were also reprimanded and had conditions imposed on their registration. Three matters were referred to the Medical Tribunal (two referrals under s179 and one recommendation under s63), and in three other matters the complaint was dismissed or no orders were made.
- → Forty urgent Board proceedings to take action to protect the public were held this year as well as 15 review of orders proceedings under Part 4 Division 5. As a result, 11 doctors were suspended, 21 had conditions imposed on their registration, and four practitioners removed their name from the Register or requested to be moved to the non-practising category of registration prior to proceedings being held. One of the matters was part heard.

Overview

A similar number of complaints were received in 2008-09 (1248) compared to the previous reporting year (1167).

A number of complaints have been expressed to be in accordance with the new mandatory reporting provisions, which require a practitioner to report a colleague who appears to have committed reportable misconduct. This new provision came into force in August 2008. No complaint has yet been made that a practitioner who ought to have made such a report has not done so and may themselves be guilty of unsatisfactory professional conduct.

During the year there were increases in the proportion of matters declined (49% to 53%) and those referred to the Board (17% to 19%). There was a corresponding fall in the number of matters referred for direct resolution between a complainant and practitioner (16% to 12%), and continued decrease in the number of matters referred for conciliation (8% in 2006/07, to 6% in 2007/08, and this period 5%).

There was a large increase in the number of matters referred to the Medical Tribunal by the Director of Proceedings (DP) from 12 to 23, along with an increase in the number of matters referred to PSCs (19 compared with 15 in the previous year).

At 30 June 2009, 36 matters remained with the DP to determine whether they should be prosecuted before a disciplinary body (down from 54 matters in the previous reporting period). One hundred and sixty-one matters (concerning 97 medical practitioners) remained under investigation by the HCCC (up from 129).

As at 30 June 2009, 31 matters referred to or lodged in the Tribunal in this or previous years awaited determination. This compares with 21 matters outstanding in the year ending 30 June 2008 and 12 in the year ended 30 June 2007.

The number of matters where emergency suspension or imposition of conditions by the Board was considered to be appropriate under section 66 of the Act rose from 26 in 2007/08 to 40. The number of s66 proceedings held in a year is dependent on the nature and types of matters that come to the Board's attention from various sources. It is difficult to say why there is such a significant increase in s66 proceedings, but this may reflect a greater readiness on the part of agencies and individuals to report matters to the Board in the wake of the publicity in the previous reporting period that surrounded de-registered practitioner Graeme Reeves. It is interesting to note that despite the increase in convened proceedings, the number of practitioners suspended remains very similar to the previous year (11 this year and 10 last year).

In addition to the 40 s66 proceedings, the Board also conducted 15 review proceedings under s66AB and s66A of the Act. One practitioner was the subject of four such review hearings, but nonetheless remains suspended. Two other practitioners remain suspended despite reviews. Six practitioners had their suspensions lifted on review and had conditions imposed on their registration on resumption of practice.

It appears that review proceedings are more frequently requested by practitioners following the August 2008 legislative change including the s66AB review application provisions. (See Appendix 6 for details of legislative changes.)

The complaints handling process

See Appendix 16 of this Annual Report for a summary of complaints bodies and processes.

Assessment of complaints

During 2008/09, the Medical Board and the HCCC received 1248 complaints about medical practitioners. The Board and Commission completed an assessment of 1268 complaints (up from 1116 in the previous year), the outcomes of which are illustrated in the following graph. The most common outcome of an assessment was to decline to deal with the complaint (53%), followed by referral to the Medical Board (19%). Ten per cent were referred to the HCCC for investigation.

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

In general, the HCCC has 60 days from receipt of a complaint to prepare a brief prior to assessment. However, the Commission is also required to notify the Board of a complaint as soon as practicable. This allows the Board to review each complaint received and ensure that complaints which raise serious issues concerning the life, physical or mental health of any person are dealt with by the Board considering urgent action under s66 of the MPA 1992.

At assessment a complaint may be declined if it falls outside the Board's or HCCC's jurisdiction, does not relate to health care or does not raise clinical issues of sufficient seriousness. In some instances a complaint is declined at assessment as the parties have subsequently resolved the matter. This occurred in 8% of complaints declined in the period, down from 11% in the previous reporting period.

The Board considers that a complaint should be referred to the HCCC for disciplinary investigation when there is evidence of unethical, reckless, wilful or criminal behaviour in either clinical or non-clinical domains. In all other circumstances, public protection can be achieved through the application of non-disciplinary and educative responses such as referring complaints to the Board for consideration through the Performance or Health programs, conciliation or assisted resolution with a complaints resolution officer.

The following table illustrates the trends in complaints assessment for the past three years. It shows small changes in types of assessment outcomes.

Outcome of complaint assessments (%)

	2006/07 n = 1155	2007/08 n = 1116	2008/09 n = 1268
Investigation	13	10	10
Refer to the Medical Board	16	17	19
Refer to another person or body	2	2	1
Conciliation	8	6	5
Direct resolution	11	16	12
Decline to deal with	50	49	53

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

Type of complaint (%)

	2006/07 n = 1155	2007/08 n = 1116	2008/09 n = 1268
Clinical competence	48	56	54
Communication	17	14	18
Conduct	26	23	24
Practice administration	9	7	4

Complaints investigated by the HCCC

During the year, 122 complaints were referred to the HCCC for investigation. These complaints were referred on the basis that they appeared to either the Board or HCCC at the time of assessment to raise a significant issue of public safety or provide grounds for disciplinary action against a practitioner.
In this period 120 investigations were finalised, compared to 129 in the previous reporting year. Outcomes of the investigations during the year included:

- → 31 cases (25%) were terminated and no further action was taken against the practitioner (down from 32% last year);
- → 8 cases (7%) required comments to be made in the form of a letter from the HCCC to the practitioner (down from 14% last year);
- → 14 cases (12%) referred the practitioner to the Board for it to take appropriate action. Such action may include disciplinary counselling in the form of a letter or interview or referral of the matter for consideration of the Health or Performance pathways (down from 16% last year);
- → 67 (56%) were referred to the DP to determine whether a complaint ought to be prosecuted before a disciplinary body, either a PSC or the Medical Tribunal (up from 38% last year).

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

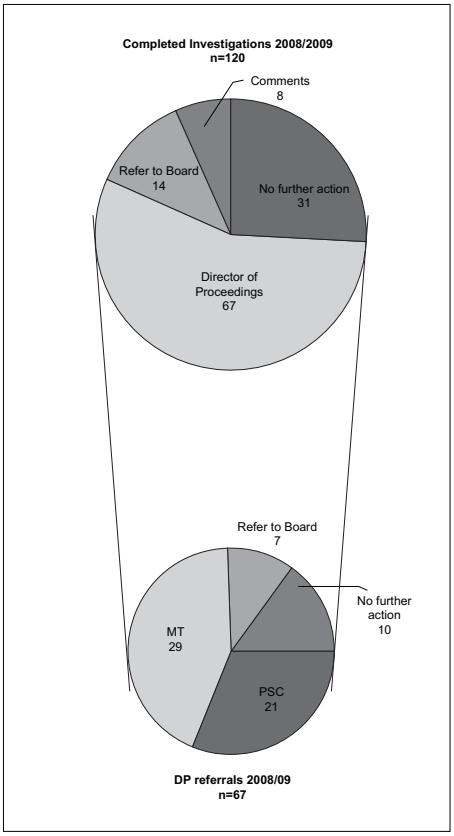
The chart below illustrates investigation outcomes for the period and the outcome of matters referred to the Director of Proceedings (DP).

Complaints referred to the Board after investigation by the HCCC

During this period all of the 14 matters referred to the Board (12% of investigated complaints) resulted in the practitioner being counselled by the Board.

Complaints referred to the Director of Proceedings

During the reporting year, 67 finalised investigations led to a referral to the DP. Upon referral of a matter, the DP is required to determine whether a matter should be prosecuted before a disciplinary body. The DP is required to consult with the Board, but the final determination rests with the Director.



In 2008-09, the DP referred 22 practitioners to the Medical Tribunal (up from 12 last year) and 19 practitioners to a PSC (up from 15 last year).

Of the matters the DP determined not to prosecute, no further action was taken in relation to four practitioners (as the practitioners were no longer registered or de-registered by the Medical Tribunal) and six practitioners were referred back to the Board. The Board directed five of the practitioners to attend counseling. In relation to the remaining practitioner, as the Board was in the process of conducting proceedings in the Medical Tribunal pursuant to section 65 of the Act, and this matter was joined to those proceedings.

Complaints remaining under investigation

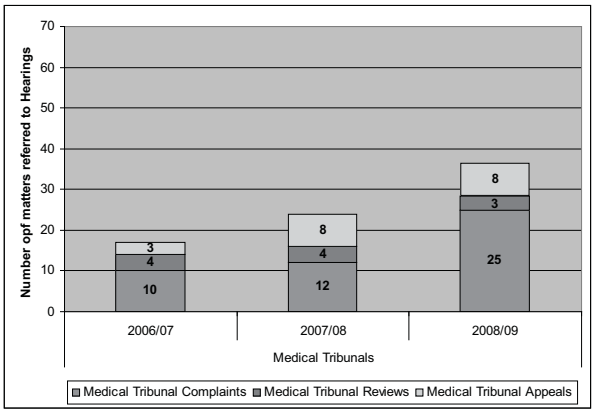
At 30 June 2009, the HCCC reported 161 matters currently under investigation (up from 129 in the previous year) and 36 matters were with the DP for consideration of possible disciplinary action (down from 50).

Disciplinary hearings

Referral to the Medical Tribunal

In addition to the 23 complaints referred by the DP, eight appeals and three restoration applications were commenced in the Tribunal during the reporting year. The Board made two direct referrals pursuant to section 65 and a PSC made a referral pursuant to section 63 to the Tribunal.

The following graph illustrates the number of matters referred to disciplinary hearings before the Medical Tribunal and including consequent appeal and review hearings, over the past three reporting periods.



Matters commenced in the Medical Tribunal

In the year under review, 33 matters (including complaints, appeals, restorations and review applications) were commenced in the Medical Tribunal. This compares with 24 in 2007/2008, and 15 matters in 2006/2007.

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

	2006/07	2007/08	2008/09
Complaints			
Sexual misconduct	2	4	5
Prescribing	2	7	7
Breach conditions	1	1	2
Treatment	0	0	1
Competence/impairment	1	0	0
Fraud	1	0	1
Character	0	0	0
Breach of order	1	0	0
Criminal matter	0	0	3
Section 65 referral by Board	0	0	2
Section 63 recommendation	0	0	1
Appeals			
PSC	2	3	1
Registration	0	2	4
Conditions/suspension	0	2	2
PRP	1	1	0
Board decision	0	0	1
Restorations commenced in Medical Tribunal	**4**	**4**	**3**
Reviews of conditions commenced in Medical Tribunal	**0**	**0**	**0**
Total matters commenced in Medical tribunal	**15**	**24**	**33**

Matters finalised in the Medical Tribunal

The Tribunal determined matters in the following categories:

	2007/08	2008/09
Complaints	6	12
Section 65 referral/s63 recommendation	-	3
Appeals	6	1
Reviews	3	3
Total	15	19

Medical Tribunal matters outstanding

As at 30 June 2009, 31 matters referred to or lodged in the Tribunal in this or previous years await determination. This compares with 21 matters outstanding in the year ending 30 June 2008 and 12 in the year ended 30 June 2007.

Complaints

Heard/part-heard

One matter is currently underway and one matter has been heard and is awaiting judgment.

Listed for hearing and to be listed for hearing

Two matters have been listed for hearing before September 2009 and 18 are yet to be listed for hearing.

Appeals

There are currently six appeals outstanding in the Tribunal, of these three are awaiting hearing dates, two are listed for hearing and one appeal has been heard and is awaiting judgment.

Reviews

Three applications for review of a de-registration order have been lodged in the Tribunal and remain outstanding. These applications are all yet to be listed for hearing.

The Medical Tribunal decisions listed in the table below are published in full on the Board's website (subject to any relevant non-publication directions or orders not to publish made by the Tribunal) at www.nswmb.org.au. A practitioner's current registration status is available on the Board's on-line Register at www.nswmb.org.au, which is updated on a daily basis.

Medical Tribunal Decisions

Judgment date	Practitioner	Tribunal Outcome
COMPLAINTS PROSECUTED BY THE HEALTH CARE COMPLAINTS COMISSION		
20/08/2008	David Charles **Lindsay**	De-registered. May not apply for review for 3 years.
21/10/2008	Arthur Garry **Gow**	Conditions imposed.
05/11/2008	Marcus Andrew **Stoodley**	Reprimanded.
27/11/2008	Wafa Ahmed **Samen**	Reprimanded. Conditions imposed, including some critical compliance conditions.
15/12/2008	Martyn Stuart **Mendelsohn**	De-registered. May not apply for review for 2 years.
18/12/2008	Mark Clifford **Fairbrother**	De-registered. May not apply for review for 2 years.
18/12/2008	Graeme John **Harris**	De-registered. May not apply for review for 7 years.
19/12/2008	David Anthony **Fox**	De-registered. May not apply for review for 3 years.
28/01/2009	Paul Joseph **Ameisen**	De-registered. May not apply for review for 1½ years.
04/02/2009	Margaret Siu-Ying **Tung** (order only)	De-registered.
26/03/2009	Rafid Ghani **Al Ramadan**	De-registered. May not apply for review until 2 years have elapsed after expiry of his current gaol sentence.
26/03/2009	Jason Jefferson **Martin**	Reprimanded. Conditions imposed, including some critical compliance conditions.
10/06/2009	Swapan **Chowdhury**	De-registered. May not apply for review for 2 years from 27 February 2009.
REFERRALS TO THE TRIBUNAL BY THE BOARD		
09/02/2009	Gungor **Olcayto** (order only)	De-registered. May not apply for review for 2 years.
23/06/2009	Rajesh Baddipudi Samson **Dinakar**	De-registered. May not apply for review for 6 months after evidence of satisfactory completion of ethics and prescribing courses.
APPEALS		
20/03/2009	Ashish Dhar **Diwan**	Appeal dismissed.
REVIEW APPLICATIONS FOR RESTORATION TO THE REGISTER		
25/07/2008	Ian Leigh **Ferguson**	Restored with conditions.
28/01/2009	Ian Raymond **Gregory**	Application dismissed. May not apply for review for 5 years.
18/03/2009	Michael Jacob **Bar-Mordecai**	Application dismissed. May not apply for review for 3 years.

Sample Medical Tribunal decisions

Doctor drug dealer
A general practitioner purchased and sold human growth hormone, human chorionic gonadotrophin, androgenic/anabolic steroids, Tertroxin, Duromine, and benzodiazepines to persons unknown and in unknown quantities. In addition, he purchased 5,032 vials of HGH valued at $677,829.90 and 254 of HGH valued at $45,738.00. These drugs were then sold independently of his practice for "anti-aging" and "body building" purposes.

The Tribunal said he "…had abandoned any notion of medical practice and was to all intents a drug dealer." He was found guilty of professional misconduct and that he was not of good character. The Tribunal also found him guilty of unsatisfactory professional conduct arising out of his conviction for failing to comply with the provisions of section 35 of the Poisons and Therapeutic Services Act. As the practitioner had removed his name from the register prior to the hearing, the Tribunal ordered that he may not apply for re-registration for a period of seven years.

Failure to comply with conditions
A suburban general practitioner failed to comply with conditions imposed on his registration (requiring that he complete certain educational courses) firstly by a PSC, again by a Section 66 Inquiry, and yet again by a Medical Tribunal. He also practised without approved professional indemnity insurance, made false representations to the Board in relation to the nature and currency of his insurance and failed to provide information required by the Board relating to his insurance and the matters which were the subject of the conditions upon his registration. He was found guilty of professional misconduct, to be not currently fit to practise medicine and he was de-registered with an order that he not apply for re-registration for 6 months following evidence of successful completion of the educational courses.

Incident of inappropriate prescribing results in patient's death
A general practitioner was found guilty of professional misconduct after inappropriately prescribing morphine tartrate 120mg per ampoule (instead of morphine sulphate 15mg or 30mg per ampoule) to a patient complaining of back pain without adequate instructions for its use. The patient self-administered the drug and died of an overdose. In prior criminal proceedings relating to the same prescription, the practitioner pleaded guilty to manslaughter and received a suspended sentence.

The Medical Tribunal took into account the fact that this was an isolated incident, that it was not the result of indifference nor was it calculated and that the patient was unusually demanding regarding narcotics. It also considered the practitioner's undiagnosed and untreated major depressive disorder which impaired his judgment at the time. Conditions were placed on the practitioner's registration.

Referral to a Professional Standards Committee

In total, the DP referred 19 matters to PSCs and 14 PSC Inquiries were held. Due to legislative change in October 2008 PSC Inquiries are now held in public. Arrangements have been made to hold the public hearings at the premises of the Industrial Relations Commission in Bridge Street, Sydney. Details of public Inquiries are published on the Board's website.

The PSC decisions listed in the table below are published in full on the Board's website (subject to any relevant non-publication directions or orders not to publish made by the PSC) at www.nswmb.org.au. A practitioner's current registration status is available on the Board's on-line Register at www.nswmb.org.au , which is updated on a daily basis. Prior to changes in the legislation which resulted in public PSC hearings and publication of PSC decisions, such decisions were confidential. Please refer to Appendix 17 for summaries of some of those confidential decisions.

PSC DECISIONS OCTOBER 2008 - JUNE 2009

Decision date	Practitioner	Outcome
7/10/2008	Bernard Ka Lim **Lau**	Reprimanded. Conditions imposed.
3/12/2008	Essa Abdul Karim **Syed**	Reprimanded. Conditions imposed.
8/12/2008	Mohamed Gamal **Helmy**	Reprimanded.
13/1/2009	Stephen **Lu**	Reprimanded. Conditions imposed.
8/4/2009	Barry Philip **Cross**	Reprimanded. Conditions imposed.
18/5/2009	**Dr X** (Name suppressed)	Conditions imposed.
23/6/2009	Sanna Mohammed **Ismail**	Reprimanded. Conditions imposed.
26/6/2009	Yvonne **Tambyrajah**	Reprimanded. Conditions imposed.

Referral to a counselling interview

During the year, 22 practitioners were referred to the Board for counselling and 18 practitioners, whose matters were referred to the Board in either this or the previous period, were counselled. A referral to counselling occurs on the basis that a practitioner's departure from acceptable standards is not considered so significant as to warrant referral to the DP, but it still raises concerns that need to be addressed. Counselling provides an opportunity for a practitioner to reflect upon the issues raised within the context of their practice and to critically examine suggestions for improvements to their practice. The Board also invited a practitioner to attend the Board for an interview to discuss concerns that had come to the Board attention.

Schedule 1 Inquiries

The Board referred eight 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. The Board also refers applications for re-registration to a Schedule 1 Inquiry if there are issues of health, character or competence that may affect the applicant's fitness to practise medicine.

Of the eight matters referred, four practitioners were re-registered with imposed conditions and three applications were withdrawn by the medical practitioners concerned. There is one outstanding application to be heard. Three matters referred to a Schedule 1 inquiry in the previous reporting period were finalised in this period, one practitioner was re-registered with conditions, one application was withdrawn and the other matter did not proceed as additional information provided to the Board indicated that section 66 proceedings would be necessary.

Section 94 review

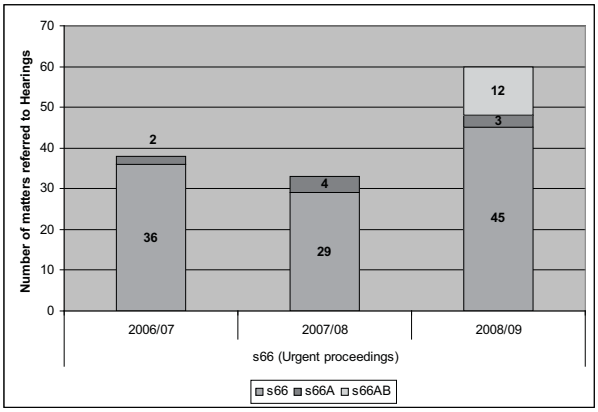
One practitioner made an application under section 94 of the Act to amend the current conditions on their registration previously imposed by a Medical Tribunal. The practitioner's application was unsuccessful.

There were no applications made under section 94 for a review of conditions imposed by a Professional Standards Committee.

Section 66 proceedings – 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 appropriate for the protection of the public's health or safety or otherwise in the public interest. 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, if it is appropriate to do so, refer a complaint to a PSC, Medical Tribunal or consent to refer the practitioner to an IRP.

There were 45 practitioners referred to section 66 proceedings, and two of these practitioners were referred to two separate section 66 proceedings, in this reporting period. The Medical Board conducted 40 section 66 proceedings (in addition to 15 review of orders proceedings) during the year, compared with 26 proceedings (and four reviews) the previous reporting year. Eleven practitioners were suspended during this reporting period as a result of Board exercising its powers under section 66. During this reporting period, three practitioners requested a review of their suspension (one practitioner requested their suspension be reviewed four times) and all of these practitioners remained suspended. A further six practitioners successfully had their suspension lifted and conditions imposed.



The Board exercises this power in a variety of circumstances, including where a practitioner:

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

Disciplinary hearings snapshot

Medical Tribunal decisions and some PSC decisions are published in full on the Board's website. Summaries of some PSC decisions and Section 66 decisions appear in the Appendices of this Annual Report.

Medical Tribunal matters and outcomes

Twelve complaints (referred by the DP) were determined by the Tribunal in 2008/09 and related to issues of prescribing, breach of conditions, sexual misconduct, boundary crossing, criminal conviction and impairment. These Tribunals resulted in eight doctors being de-registered (or an order made that they not be re-registered), two practitioners were reprimanded and had conditions and critical compliance conditions imposed on their registration, one practitioner had conditions imposed and one practitioner was reprimanded. Full transcripts of Tribunal decisions, and a list of currently de-registered persons, are available on the Board's website www.nswmb.org.au

Professional Standards Committee matters and outcomes

Nineteen doctors were referred to a PSC during 2008/09 and 14 hearings were held related to issues of patient management, prescribing, financial inducement, diagnosis and treatment, clinical error, competence, record keeping, impairment, medical certificates and boundary crossing. Twelve doctors had unsatisfactory professional conduct findings made against them, of whom nine were also reprimanded and had registration conditions imposed, one doctor just had registration conditions imposed, one had only a reprimand and one doctor had a reprimand imposed with a recommendation for the Board to conduct a PA. Two matters were referred to the Medical Tribunal pursuant to section 179 of the Act and in one matter the Committee pursuant to s 63(2) of the Act, recommended to the Medical Tribunal, deregistration on the grounds of lack or physical or mental capacity, and in three matters the complaint was dismissed or no orders were made.

Section 66 proceedings and outcomes

There were 45 practitioners referred to s66 proceedings. The Board conducted 40 s66 proceedings (one of these matters was part heard) and 15 reviews of orders imposed under s66 during the year (55 proceedings in total). Proceedings related to issues of prescribing, drug use, boundary crossing, criminal charges, impairment, capacity to practice, treatment, and breaching of registration conditions. Eleven doctors were suspended, 21 had conditions imposed on their registration and six matters resolved in no further action (of these four doctors removed their name from the Register or requested to be moved to the non-practising category of registration). A list of currently suspended practitioners is available on the Board's website www.nswmb.org.au

> health

2008-2009 **in summary**

- → 79 notifications were made to the Health Program, down from 92 and 85 notifications in the previous two reporting years.
- → 20% of notifications were made by colleagues, 38% were self-notified, and nearly 17% were made by treating practitioners.
- → 61 Impaired Registrant Panels were convened and related to psychiatric illness (60.7%), drug addiction (24.6%), alcohol addiction (11.5%) and physical impairment (3.3%).
- → There were 146 participants in the Program and 17 exits.
- → Mandatory reporting requirements were introduced into the Medical Practice Act, in relation to practitioners who are reasonably believed to have been practising while intoxicated by drugs or alcohol.

Overview

The primary objective of the Health Program is to protect the public while maintaining impaired practitioners in practice if it is safe to do so.

The Health Program has been operating under the provisions of the Medical Practice Act since 1992 and is the longest established program in Australia. Since its inception, more than 570 impaired practitioners have participated in the Program and more than 200 practitioners have successfully exited, having consolidated their recovery and fulfilled the Board's monitoring requirements.

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

During the reporting year, a mandatory reporting requirement was introduced into the Medical Practice Act in relation to practitioners who are reasonably believed to have been practising while intoxicated through consumption of drugs or alcohol. In the Board's experience, this is an uncommon way for an impaired practitioner to come to its attention, but nevertheless, all medical practitioners should be aware of their statutory obligations in this regard. In all other circumstances, although there is no legal obligation for practitioners to notify the Board, there is a profound professional and ethical obligation to do so. This obligation is set out in the Board's *Code of Professional Conduct: Good Medical Practice.*

The average age of impaired practitioners at the time of notification to the Board is 41 years. Almost 90% of Health Program participants remain in practice and, if it is assumed that they continue to practise until they are 60 years old, program participants can be expected to contribute a total of more than 8000 working years to the medical workforce after the notification to the Board. In the absence of the Health Program, many of these working years would have been lost to the community.

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

	2006/07	2007/08	2008/09
Notifications to Health Program	85	92	79
Impaired Registrants Panel reports endorsed:			
Psychiatric illness	34	38	37
Alcohol	8	7	7
Drug	12	21	15
Physical	4	5	2
Total	**58**	**71**	**61**
Review Interviews held	246	260	276
Exits from the Program	13	16	17
Participants in Program	138	134	146

Notifications

Notifications by source	**2006/07**	**2007/08**	**2008/09**
	n = 85	n = 92	n=79
Colleagues (including employers)	17	27	16
Pharmaceutical Services Branch	3	5	-
Self-notifications	31	24	30
University	2	4	2
Board Committee	7	4	2
Courts	3	-	-
Treating practitioner	11	15	13
Other	11	13	16

Self-notifications continue to be the largest source of notifications to the Health Program. 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 limitation imposed by their illness.

In some cases, the Health Committee seeks more information, either from the practitioner, their treating doctor or a Board-nominated doctor. Only these cases are included in the above table, along with other self-notifications that occur outside the annual return process.
It is pleasing to note that a large proprtion of notifications have been received from treating practitioners and colleagues, perhaps reflecting increasing familiarity and understanding of the Board's processes. Cross-referral from other Board Committees indicates an increasing awareness that underlying health problems may be manifested as

unsatisfactory performance or conduct.

Health Program process

When a notification indicates that a practitioner may be impaired, according to its statutory definition, the practitioner will be assessed by a Board-nominated practitioner, often a psychiatrist, who will prepare a report for the Board. The Health Committee will then review this report and decide whether to convene an Impaired Registrants Panel.

While the Board's primary responsibility is to protect the community through maintaining high standards of medical practice, over the years, it has shown that most impaired practitioners can continue to practise, subject to appropriate limitations. As a consequence, the most common outcome of an Impaired Registrants Panel (IRP) is that conditions are placed on the practitioner's registration. IRPs are non-disciplinary and are designed to encourage impaired practitioners to seek treatment for their impairment and remain in safe practice. This year, 64% of IRPs concluded with the practitioner agreeing to conditions being placed on their registration; 21% resulted in no further action being taken; 8% were adjourned, and in 7%, other action was taken.

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

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 drugs of addiction. 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.

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

The Health Committee requires program participants to attend an exit interview prior to leaving the program. The interview serves to focus attention on the practitioner's insight, learning and relapse prevention strategies. It also provides the Committee with useful feedback about the administration of the program.
In the year ending 30 June 2009, a total of 17 practitioners exited the Health Program. These practitioners all had their conditions lifted and returned to full registration. The Board was satisfied that these practitioners had actively sought to manage their impairment, were willing and able to take responsibility for their own health and were safe to practise unconditionally. In view of the rehabilitative focus of the program, this is regarded as a positive and encouraging outcome. As in previous years, the relapse rate remained below 5%.

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 and supported.

Early notification is seen as essential in supporting the impaired student, and planning their transition to internship. The Board has offered its assistance to the university medical faculties to refine their management of impaired students. However, there remain instances of misguided reluctance to notify the Board about impaired students. The Board continues to raise this issue with the Deans of the Medical Faculties.

There were seven medical students notified to the Board during 2008/9. Only two of these notifications were made by the Universities. The rest came through hospital admissions and from treating practitioners. One of these students deferred their studies; in three cases no further action was taken; two are yet to be finalised, and one was excluded by the university which resulted in the Medical Board having no jurisdiction over the student.

Since the commencement of the provisions, more than 40 students have been before an IRP and more than 30 have had conditions placed on their undertaking clinical studies, usually including regular reporting from the relevant university.

As at 30 June 2009, there were seven interns and two medical students involved in the Health Program. Five of these interns were notified to the Board while they were students, or self-notified in their intern applications.

Conclusion

The strengths of the Board's Health Program include:

- → its acceptance by the profession as a consistent program that achieves its public protection goals in a fair and objective way
- → its structured but non-disciplinary nature
- → the inclusion of medical students
- → its cautious, long term monitoring of impaired practitioners
- → its flexible integration with all other Board activities such that every decision about a practitioner is made in full knowledge of their health status.

As the oldest established Health Program in the country, it is the Board's fervent wish that these attributes continue into the future.

> performance

2008-2009 **in summary**

- → The HCCC referred 234 complaints to the Board as performance matters, up from 181 and 163 in the last two reporting years.
- → The Board also received seven performance notifications in which an employer or colleague, expressed concern about the practitioner's professional performance without making a complaint about them. These notifications are encouraging and recognise the Program's aim of ensuring practitioner's fitness to practise through protective and remedial processes.
- → 54 complaints were referred for a Performance Interview, compared to 43 and 47 in the previous two reporting years. The higher number in the past three years reflects the growing use of interviews in the Program as an alternative to a full Performance Assessment or as an intermediate step in decisions to conduct a full assessment.
- → The number of practitioners referred for a full Performance Assessment (PA) was 24.

Overview

The Medical Board aims to ensure practitioners' fitness to practise, and the first Performance Program in Australia, introduced in NSW in October 2000, is central to this aim. The program is designed to complement the existing Conduct and Health pathways by providing an alternative means of dealing with practitioners who are neither impaired nor have engaged in 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 a single incident is thought to be demonstrative of a broader problem. A Performance Assessment (PA) is broad-based, not limited to the substance of the matter that triggered the assessment. The assessment exercise is conducted 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 or personal stress, which may influence practitioner performance in the short or longer term.

The Performance Committee is highly cognisant 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. The Board continues to participate as an active member of the International Physician Assessment Coalition .The Board's Performance Program is internationally recognised for its innovation and excellence.

As previously reported, experience to date has exposed a number of deficiencies and anomalies in the PA provisions of the Medical Practice Act 1992. The Board has sought legislative amendment to ensure the integrity and ongoing success of the Performance Program. The Board hopes that there may be an opportunity to address these issues leading up to 1 July 2010.

Program process

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 (HCCC) 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. The HCCC discontinues dealing with the complaint once it is referred to the Board under this section.

Complaints referred to the Board under s25B of the Health Care Complaints Act have been assessed as not being likely to lead to disciplinary proceedings under the Medical Practice Act. Nevertheless, these complaints raise issues that require some further consideration. 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 doctor's 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 be offered the opportunity to consent to conditions under s140B as an alternative to possible further formal action.

→ The doctor should undergo a detailed PA 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 with an appropriate intervention. The management of these matters within the Performance Section enables the Board to consider a range of actions in response to the spectrum of performance matters that come to its attention. Full PA is at one end of the spectrum, and is reserved for the most concerning cases. The majority of matters are resolved through the other interventions described above.

PAs are conducted in the practitioner's own environment by two or three practitioners who are familiar with the area of practice of the practitioner concerned. The assessment is broad-based and is not limited to the particulars of the matter that triggered the assessment. Multiple assessment tools are used, but the cornerstone of the assessment is the observation of consultation and medical procedures. The aim of the assessment exercise is to establish whether the practitioner's performance is at a standard expected of a similarly trained or experienced practitioner. Rectification of deficiencies and reassessment complete the process.

Program activity

An overview of the Performance Program activity in 2008 - 2009 follows.

Complaints

The following table reports the number of complaints referred to the Board by the HCCC.

Complaints referred to the Board by the HCCC

	2006/07	2007/08	2008/09
New complaints	163	181	234

Performance notification

Performance notifications are usually made by an employer and express concerns about the professional performance of the practitioner without making a complaint about them. The doctor's response is sought and is considered along with the notification. The following table sets out the total number of performance notifications received during the reporting year and their outcomes.

Performance notifications and outcomes

	2006/07	2007/08	2008/09
Total received	n/a	8	7
No further action	n/a	1	3
Board letter	n/a	0	1
Awaiting Health Committee outcome	n/a	1	0
Performance Interview	n/a	3	1
Performance Assessment	n/a	2	2

Outcomes of referred complaints

The following table reports the outcomes of complaints referred to the Board by the HCCC.

Outcome of complaints referred to the Board by the HCCC

	2006/07	2007/08	2008/09
No further action	97	73	98
Letter of apology to patient	12	13	11
Board letter	32	30	30
Board letter + apology	-	-	4
Performance Interview	47	43	54
Performance Assessment	6	4	13
S140B – consent to conditions	n/a	n/a	1
Section 66 proceedings	2	2	0
Refer to Health Committee	1	2	2
Refer to Conduct Committee	-	-	1
Refer to HCCC for investigation	1	1	4
Advise complainant to seek re-assessment with HCCC for direct resolution with CRO	1	5	4
Advise complainant to seek re-assessment with HCCC for conciliation	n/a	3	0
Refer to HCCC (for reassessment)	2	n/a	n/a
No longer registered/ suspended, action if applies for re-registration	1	1	1
Total	**201**	**177**	**223**

Complainants may seek a review by the Board of the outcome of their complaint. During the year, seven reviews were requested and considered by the Committee, compared to three in the previous reporting year. All these cases had originally been assessed as requiring no further action. One resulted in the complainant being advised to seek reassessment from the HCCC with a recommendation of direct resolution with a Complaints Resolution Officer. Six other matters were reviewed and no change to the outcome was recommended. This compared to the previous year when two out of three resulted in a change to the outcome.

The following table reports the outcome of Performance Interviews conducted by the Board in the reporting period. It includes outcomes of matters derived from HCCC-referred complaints, performance notifications, and HCCC-investigated complaints referred to Board's Performance program.

Outcome of Performance Interviews

	2006/07	2007/08	2008/09
No further action	31	40	29
Performance Assessment	5	8	10
Other	5	1	3
Total	**41**	**49**	**42**

The following table reports the source of matters considered for full PA. Referral from other Board Committees remains a significant source of matters, emphasising the integration of the Board's approach to fitness to practise. Six matters considered for a Performance Assessment were the result of the imposition of registration conditions and Performance Notifications. Twenty-two were referred complaints from patients and others, as well as referrals from other Board programs.

Source of matters considered for Performance Assessment

	2006/07	2007/08	2008/09
Board Committee (Health, Conduct)	13	3	5
Referred because of an imposed condition	n/a	4	4
Complaint originating from:			
i. Patient	4	8	10
ii. Employer (eg Area Health Service)	3	1	0
iii. Colleague	0	2	5
iv. Professional Services Review	1	0	0
v. Department of Health (eg PSB)	1	1	2
Performance Notification	n/a	3	2
Total	**22**	**22**	**28**

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

Practice area of doctors considered for full Performance Assessment

	2006/07	2007/08	2008/09
Anaesthetist	1	0	1
General practitioner	11	14	14
Obstetrician & gynaecologist	4	1	2
Ophthalmologist	1	0	1
Physician	1	0	1
Psychiatrist	0	1	4
Radiologist	1	0	0
Surgeon	2	5	5
Trainee	1	1	0
Total	**22**	**22**	**28**

The following table reports the outcomes of PAs finalised in the reporting period. On receiving a report of a PA, 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 PRP is convened to formalise these orders.

Performance Assessment outcomes

	2006/07	2007/08	2008/09
Retired or non-practising before having PA	4	1	3
S66	1	2	2
No further action	4	4	5
Counselling	2	0	0
Consent to conditions under s140B	n/a	n/a	1
Performance Review Panel	7	10	11
Total	**18**	**17**	**22**

The following table reports the outcomes of PRPs held and completed during the reporting period. The Performance Program is based on remediation and retraining. When deficiencies are identified, almost all practitioners are required to undertake some sort of remediation, tailored to their individual needs. This may entail attending courses, spending time observing another practitioner, engaging in Continuing Professional Development 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 or require supervision. 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 outcomes

	2006/07	2007/08	2008/09
PRP held	8	8	11
Did not proceed (eg retired, name removed from Register)	1	1	3
PRP completed – outcome:	8	8	11
remediation orders	7	5	7
protective orders	7	7	11

Conclusion

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

The strengths of the Board's Performance Program include:

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

As the initiator of Performance Assessment in Australia and an acknowledged international leader in this field, the Board is committed to continuing this innovative and effective program after 1 July 2010 and seeks to maintain its strengths and integrity.

> monitoring

2008/2009 **in summary**

- → The compliance of 225 doctors with registration conditions was under active monitoring by the Medical Board.
- → 70 new cases were referred to the Board's Monitoring Section during the year.
- → A "Conditions Bank" was developed as a resource for Hearing Members responsible for the drafting of conditions.

The Monitoring Section is responsible for the monitoring of compliance with all Practice Conditions resulting from decisions of a Medical Tribunal (MT), Professional Standards Committee (PSC), Schedule 1 Inquiry, proceedings under s66 or s94 of the Medical Practices Act, a Performance Review Panel Inquiry (PRP), an Impaired Registrants Panel Inquiry (IRP) or action pursuant to Mutual Recognition legislation. Monitoring of compliance with Health Conditions on a practitioner's registration, except for any drug testing and alcohol testing requirements, is the responsibility of the Health Program Section and undertaken primarily through the system of regular Board Review Interviews.

Once a case is referred to the Monitoring Section, initial contact is established with the practitioner to clarify the requirements for satisfactory compliance with each condition. Due dates for each action are set and the Section maintains a schedule of action due for each case. Required approvals are processed, including positions, supervisors, mentors and courses, by way of submissions to delegates of the appropriate Committee. Templates are provided to reporting practitioners and reports assessed as received and referred to the appropriate Committee if concerns are indicated. Audits are arranged and audit reports similarly referred to the responsible Committee. Where applicable, data is requested from Medicare Australia or from the Pharmaceutical Services Branch to check on the practitioner's prescribing or patient consultation restrictions. Required drug testing and alcohol testing results are recorded and any discrepancies or anomalies followed up.

Ongoing contact is maintained with the practitioner and with third parties such as employers and supervisors to facilitate, where necessary, ease and effectiveness of compliance with the conditions.

Submissions are prepared for the appropriate Committee agenda on questions of satisfactory compliance with a condition, variation or removal of a condition or breach of a condition and the Monitoring Section follows up on the Committees' resolutions which may range from removal of all conditions to the lodging of a complaint with the Health Care Complaints Commission (HCCC). The Section also liaises with the HCCC on cases where conditions are in effect while a complaint is under investigation, providing periodic updates on the practitioner's compliance history

During the reporting year, the Section dealt with its first case under the new critical compliance provisions of the Act. The mandatory nature of the condition, as well as the arbitrary consequence of a breach of such condition, was explained in detail to the medical practitioner.

The level, complexity and duration of monitoring activity will vary considerably over the range of cases administered by the Section. Some may require no more than a periodic letter to confirm the practitioner's circumstances. Others require more frequent activity and scrutiny. The efficiency and effectiveness of the monitoring function overall is dependent to a considerable degree on the quality and relevance of the conditions themselves. During the reporting year, the Section initiated Hair Drug Testing in the first such case seen for some years.

Hearing members responsible for the drafting of conditions are encouraged to refer to the Section for advice and comment on the relative monitorability of conditions proposed, as the chosen wording can have considerable impact on the practitioner's ability to comply and on the Section's ability to monitor that compliance. A Conditions Bank has been developed by the Section to provide a resource for all Hearing Members and Panellists in that regard.

Highlights of legislative changes such as critical compliance conditions, reportable misconduct, new public hearings by PSCs and the powers of the Board for the protection of the public were also dealt with at a Hearing Members Training Evening in April 2009.

As at 30 June 2009, there was a total of 225 cases under active monitoring by the Section, a net increase of 58 over the total as at 30 June 2008. The totals according to sole or primary source of conditions are as follows:

Sole or primary source of conditions	New cases in 2008/09	New cases in 2007/08	Total active cases 2008/09	Total active cases 2007/08
Health Program	30	16	98	73
Performance Program	8	10	25	20
Conduct Program	32	16	102*	74
Total	**70**	**42**	**225**	**167**

* includes conditions imposed under Mutual Recognition and by Schedule 1 Inquiries.

The Monitoring Section continues to provide strength to the Board's authority in relation to the various outcomes from disciplinary and non-disciplinary bodies and committee by:

- → providing advice to legal officers assisting determining bodies on the monitorability of proposed conditions;
- → providing information and advice to assist practitioners in meeting the requirements of conditions imposed on their registration;
- → ensuring compliance by practitioners with conditions on registration and follow-up when difficulties or non-compliance occur;
- → alerting the Board's Committees and Legal Section when non-compliance or breach of conditions has become an issue.

> finance and budget

Overview - Financial Performance - Year ended 30 June 2009

The total income for the period was $8,995,000. Expenditure for the period was $10,225,000. The operating deficit was $1,238,000 for the year ended 30 June 2009.

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 meets the expenses of the Medical Services Committee ($98,593).

The Board also contributed to the Australian Medical Council ($215,807), Institute of Medical Education and Training ($152,351) and the Doctors Health Advisory Services ($35,000).

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 two newsletters in the financial year ($69,308).

Investment Performance

The return on internally managed funds for the year ended 30 June 2009 was 4.00%.

The Board's externally managed funds were held in Treasury Corporation's HourGlass Cash Facility. An average return of 4.5% was achieved for the current financial year.

Budget

Performance against Budget for the year ending 30 June 2009 and Budget for the year ending 30 June 2010

	30 June 2009 Budget (000)	30 June 2009 Actual (000)	30 June 2010 Budget (000)
Registration Fees	7,913	8,289	8,300
Fines	40	2	40
Interest	700	528	600
Other	72	89	80
Area of Need Income	192	87	115
TOTAL INCOME	**8,917**	**8,995**	**9,135**
Salaries and related expenses	3,047	3,324	3,100
Sitting Fees	1,379	1,310	1,279
Funding Contributions	475	416	500
Computer and Consultancy	731	973	450
Members Fees	364	247	244
Medical Tribunal Funding	600	600	675
Professional Conduct and Health	711	925	900
Postage, Courier and Phone	188	235	232
Loss on disposal of plant and equipment	-	8	-
Administration Expenses	833	850	857
Superannuation	689	891	763
Vehicle, travel and accommodation	179	213	110
Depreciation and Amortisation	210	222	210
Audit Fees	20	19	20
TOTAL EXPENDITURE	**9,426**	**10,225**	**9,340**
OPERATING SURPLUS/(LOSS)	**(509)**	**(1,238)**	**(205)**

Income

The budget for the year ending 30 June 2010 is based on the following estimates:

- The annual registration fee to remain at $270.

Expenditure

The following significant changes in expenditure are anticipated:

- 4% increase in staff salaries has been allowed.
- Computer and Consultancy has been reduced as the Board will not be undertaking any new projects /reviews in the current year.

GPO BOX 12
Sydney NSW 2001

INDEPENDENT AUDITOR'S REPORT

New South Wales Medical Board

To Members of the New South Wales Parliament

I have audited the accompanying financial report of the New South Wales Medical Board (the Board), which comprises the balance sheet as at 30 June 2009, the income statement, statement of changes in equity and cash flow statement for the year then ended, a summary of significant accounting policies and other explanatory notes.

Auditor's Opinion

In my opinion, the financial report:

- presents fairly, in all material respects, the financial position of the Board as at 30 June 2009, and its financial performance for the year then ended in accordance with Australian Accounting Standards (including the Australian Accounting Interpretations)
- is in accordance with section 41B of the *Public Finance and Audit Act 1983* (the PF&A Act) and the Public Finance and Audit Regulation 2005.

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

Significant uncertainty regarding the future of the Board

Without qualification to the opinion expressed above, I draw attention to Note 20 'Announcement regarding the Future of the Board', which discusses the implications of the National Registration Scheme for the Board. Until the Scheme's arrangements are finalised, there is significant uncertainty about how, when and at what value the Board's assets will be realised and its liabilities extinguished. Because of this uncertainty, the Board's financial report does not reflect any potential effects of the Scheme.

The Board's Responsibility for the Financial Report

The members of the Board are responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards (including the Australian Accounting Interpretations) and the PF&A Act. This responsibility includes establishing and maintaining internal controls relevant to the preparation and fair presentation of the financial report that is free from material misstatement, whether due to fraud or error; selecting and applying appropriate accounting policies; and making accounting estimates that are reasonable in the circumstances.

Auditor's Responsibility

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

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

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

My opinion does *not* provide assurance:

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

Independence

In conducting this audit, the Audit Office of New South Wales has complied with the independence requirements of the Australian Auditing Standards and other relevant ethical requirements. The PF&A 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 of New South Wales are not compromised in their role by the possibility of losing clients or income.

Heather Watson
Director, Financial Audit Services

9 November 2009
SYDNEY

New South Wales Medical Board

Statement by the members of the Board

For the year ended 30 June 2009

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 report exhibits a true and fair view of the financial position and performance of the New South Wales Medical Board; and

2. The financial report has been prepared in compliance with the *Public Finance and Audit Act 1983*, the *Public Finance and Audit Regulation 2005*, Treasurer's Directions and in compliance with Australian Accounting Standards, which include Australian Accounting Interpretations.

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

President

03 November 2009

Board Member

> balance sheet

AS AT 30 JUNE 2009

	Notes	2009 $'000	2008 $'000
Current Assets			
Cash and cash equivalents	7	9,302	10,894
Receivables	8	1,098	796
Total-Current Assets		**10,400**	**11,690**
Non-Current Assets			
Plant and Equipment	9	257	247
Intangible Assets	10	419	80
Leasehold improvements	11	2,058	2,130
Total Non Current Assets		**2,734**	**2,457**
Total Assets		**13,134**	**14,147**
Current Liabilities			
Payables	12	702	1,069
Provisions	13	470	390
Other	14	5,228	4,657
Total Current Liabilities		**6,400**	**6,116**
Non Current Liabilities			
Provisions	15	-	59
Total Non Current Liabilities		**-**	**59**
Total Liabilities		**6,400**	**6,175**
Net Assets		**6,734**	**7,972**
Equity			
Accumulated Funds	16	6,734	7,972
Total Equity		**6,734**	**7,972**

The accompanying notes form part of the financial report

> income statement

FOR THE YEAR ENDED 30 JUNE 2009

	Notes	2009 $'000	2008 $'000
Expenses	2	(10,225)	(9,091)
Revenues	3	8,995	9,256
Gain/(Loss) on disposal of plant and equipment	4	(8)	0
Surplus/(Deficit) for the year		**(1,238)**	**165**

The accompanying notes form part of the financial report

> statement of changes in equity

FOR THE YEAR ENDED 30 JUNE 2009

	Notes	2009 $'000	2008 $'000
Accumulated Funds at the beginning of the year		**7,972**	**7,807**
Surplus/ (Deficit) for the Year		(1,238)	165
Accumulated Funds at the end of the year	**16**	**6,734**	**7,972**

The accompanying notes form part of the financial report

> cash flow statement

FOR THE YEAR ENDED 30 JUNE 2009

	Notes	2009 $'000	2008 $'000
Cash Flows from Operating Activities			
Receipts from registrants and other debtors		9,332	9,087
Payments to suppliers and employees		(10,945)	(8,777)
Interest received		528	704
Net Cash flows from/(used in) operating activities	**18**	**(1,085)**	**1,014**
Cash Flows from Investing Activities			
Payments for leasehold improvements, plant and equipment		(535)	(230)
Proceeds from sale of plant and equipment		28	0
Net Cash Flows from Investing activities		**(507)**	**(230)**
Net increase/decrease in cash held		(1,592)	784
Cash at the beginning of the financial year		10,894	10,110
Cash at the end of the financial year	**7**	**9,302**	**10,894**

The accompanying notes form part of the financial report

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

FOR THE YEAR ENDED 30 JUNE 2009

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

a. Reporting Entity

The NSW Medical Board, as a reporting entity, comprises all activities under its control. The NSW Medical Board is a not-for-profit entity (as profit is not its principal objective) and it has no cash generating units.

The financial report for the year ended 30 June 2009 has been authorised for issue by the Board on 3rd November 2009.

b. Basis of Preparation

The financial report is a general purpose financial report which has been prepared on an accrual basis and in accordance with applicable Australian Accounting Standards (which include Australian Accounting Interpretations), and the requirements of the Public Finance and Audit Act 1983 and Regulation.

Property, plant and equipment are measured at fair value. Other financial report items are prepared in accordance with the historical cost convention.

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

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

c. Statement of Compliance

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

d. New Australian Accounting Standards issued but not effective

It is not anticipated that there will be any material impact for the New South Wales Medical Board during the period of intitial application of new Accounting Standards that have not been applied or not yet effective.

e. Income Recognition

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

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

f. Investment Revenue

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

g. Accounting for the Goods and Services Tax

Revenues, expenses,assets and liabilities are recognised net of the amount of goods and services tax (GST), except where that amount of GST incurred by the Board as a purchaser 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 Balance Sheet.

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

h. Employee benefits and other provisions

(i) Salaries and Wages, Annual Leave, Sick Leave and On-Costs

Liabilities for salaries and wages (including non monetary benefits) and annual leave that fall due wholly within 12 months of the reporting date are recognised and measured in respect of employees' services up to the reporting date at undiscounted amounts based on the amounts expected to be paid when the liabilities are settled.

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

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

(ii) Long Service Leave

Long service leave is measured at present value in accordance with AASB 119 *Employee Benefits*. This is based on the application of certain factors (specified in NSWTC 09/04) to employees with five or more years of service, using current rates of pay. These factors were determined based on an actuarial review to approximate present value.

(iii) Superannuation- backpay

The Board approved a scheme of payment of backdated superannuation to both present and past staff. An amount of $48,536 for past staff and an amount of $82,857 for present staff totalling $131,393 was included in other creditors under current liabilities-payables.

i. Insurance

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

j. 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 the amount of cash or cash equivalents paid or the fair value of the other consideration given to acquire the asset at the time of its acquisition or construction or, where applicable, the amount attributed to that asset when initially recognised in accordance with the specific requirements of other Australian Accounting Standards.

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 knowledgeable, willing parties in an arm's length transaction.

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

k. Capitalisation Thresholds

Computing equipment costing over $1,000 and other non-current assets costing over $5,000 are capitalised.

l. Revaluation of Plant and Equipment

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

m. Impairment of Property, Plant and Equipment

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

n. Depreciation of Plant and Equipment

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

Depreciation rates used are as follows:

Motor Vehicles	18%
Equipment	20%
Furniture and Fittings	20%
Computer Equipment	25%
Building Refurbishments - Building 54	1.70%
Building Refurbishments - Building 45	3.40%
Building Extension - Building 54	4.00%

o. Maintenance

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

p. 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 commencement of the lease term. 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 Income Statement in the periods in which they are incurred.

q. Intangible Assets

The Board recognises intangible assets only if it is probable that future economic benefits will flow to the Board and the cost of the asset can be measured reliably. Intangible assets are measured initially at cost. Where an asset is acquired at no or nominal cost, the cost is its fair value as at the date of acquisition.
All research costs are expensed. Development costs are only capitalised when certain criteria are met. The useful lives of intangible assets are assessed to be finite.
Intangible assets are subsequently measured at fair value only if there is an active market. As there is no active market for the Board's intangible assets, the assets are carried at cost less any accumulated amortisation.
The Board's intangible assets are amortised using the straight line method over a period of four years.
In general, intangible assets are tested for impairment where an indicator of impairment exists. However, as a not-for-profit entity with no cash generating units, the Board is effectively exempted from impairment testing. 'Refer Note (1m)'.

r. Receivables

Receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. These financial assets are recognised initially at fair value, usually based on the transaction cost or face value. Subsequent measurement is at amortised cost using the effective interest method, less an allowance for any impairment of receivables. Any changes are accounted for in the Income Statement when impaired, derecognised or through the amortisation process.
Short-term receivables with no stated interest rate are measured at the original invoice amount where the effect of discounting is immaterial.

s. Payables

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

t. Adjustment due to prior period error

Certain comparative elements of the financial statements as presented have been adjusted following the detection of a prior period error as defined by AASB 108. The error relates to the valuation of the deferred revenue current liability,which represents the amount of registration fees related to the unelapsed portion of the annual registration period.

	2008		
	Original Amount	**Correction due to error adjustment**	**Revised amount as per financial statement**
	$'000	**$'000**	**$'000**
Current Liabilities-Other	4,209	448	4,657
Accumulated Funds	8,420	448	7,972
Revenue	9,264	(8)	9,256
Surplus/Deficit for the year	173	(8)	165

As part of the restatement of comparative balances due to the correction of this error, opening accumulated funds as at 1 July 2008 have been reduced by $440,000 to $7,807,000.

	2009	2008
	$'000	$'000

2. EXPENSES

Salaries and related expense	3,324	2,780
Sitting Fees	1,310	1,272
Funding Contributions	416	426
Computer Expenses	93	69
Consultancy	880	469
Board Members Statutory Fees	247	283
Medical Tribunal Funding	600	600
Legal, Professional Conduct and Health Costs	925	834
Postage, Courier and Phone	235	211
General Administration Expenses	850	764
Superannuation	891	657
Superannuation backpay	-	379
Vehicle, Travel and Accommodation	213	109
Depreciation and Amortisation	222	219
Auditor's remuneration-audit or review of financial reports	19	19
	10,225	**9,091**

3. REVENUE

Registration Fees	8,289	8,046
Fines	2	22
Interest Revenue (Note 5)	528	704
Other Revenue (Note 6)	176	484
	8,995	**9,256**

4. GAIN/(LOSS) ON SALE OF PLANT AND EQUIPMENT

Cost of plant and equipment	140	0
Less Accumulated depreciation	(104)	0
Written Down Value	**36**	**0**
Less Proceeds from Disposal	28	0
Gain/(Loss) on Disposal of plant and equipment	**(8)**	**0**

5. INTEREST REVENUE

Bank Interest	18	30
TCorp Hour Glass Cash Facility	510	674
	528	**704**

6. OTHER REVENUE

Application Fee for Area of Need Assessments	87	274
Other	89	210
	176	**484**

	2009	2008
	$'000	$'000

7. CURRENT ASSETS - CASH AND CASH EQUIVALENTS

Cash at bank and on hand	378	431
TCorp Hour Glass Facility	8,924	10,463
	9,302	**10,894**

For the purposes of the Cash Flow Statement, cash and cash equivalents include cash at bank, cash on hand and short term deposits.

Cash and cash equivalent assets recognised in the Balance Sheet are reconciled at the end of the financial year to the Cash Flow Statement as follows:

Cash and cash equivalents (per Balance Sheet)	9,302	10,894
Closing cash and cash equivalents (per Cash Flow Statement)	**9,302**	**10,894**

8. CURRENT ASSETS - RECEIVABLES

Accrued Interest	1	2
Accounts receivable	1,076	770
Prepayments	21	24
	1,098	**796**

9. NON-CURRENT ASSETS - PLANT AND EQUIPMENT

	Plant and Equipment				
	Motor Vehicle $'000	Equipment $'000	Furniture & Fittings $'000	Computer Equipment $'000	Total $'000
At 1 July 2008					
Gross Carrying Amounts	52	279	329	222	882
Accumulated depreciation	(14)	(125)	(327)	(169)	(635)
Net Carrying Amount	**38**	**154**	**2**	**53**	**247**
At 30 June 2009					
Gross Carrying Amounts	74	209	342	262	887
Accumulated depreciation	(10)	(81)	(331)	(208)	630
Net Carrying Amount	**64**	**128**	**11**	**54**	**257**

Reconciliation

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

Year ended 30 June 2009					
Net carrying amount at start of year	38	154	2	53	247
Additions	73	18	12	40	143
Disposals	(52)	(88)	-	-	(140)
Depreciation expense	(13)	(42)	(3)	(39)	(97)
Depreciation write back	18	86	-	-	104
Net carrying amount at end of year	**64**	**128**	**11**	**54**	**257**

A Reconciliation of the carrying amount of each class of plant and equipment at the beginning and end of the previous reporting period is set out below.

Year ended 30 June 2008					
Net carrying amount at start of year	47	47	32	83	209
Additions	0	136	0	5	141
Depreciation expense	(9)	(29)	(30)	(35)	(103)
Net carrying amount at end of year	**38**	**154**	**2**	**53**	**247**

10. NON-CURRENT ASSETS - INTANGIBLE ASSETS

	Intangibles	Total
	$'000	$'000
At 30 June 2008		
Gross Carrying Amounts	505	505
Accumulated amortisation	(425)	(425)
Net carrying amount	**80**	**80**
At 30 June 2009		
Gross Carrying Amounts	864	864
Accumulated amortisation	(445)	(445)
Net carrying amount	**419**	**419**

Reconciliation

A Reconciliation of the carrying amount of each class of intangible asset at the beginning and end of the current reporting period is set out below.

Year ended 30 June 2009		
Net carrying amount at start of year	80	80
Additions	359	359
Amortisation expense	(20)	(20)
Net carrying amount at end of year	**419**	**419**

Reconciliation

A Reconciliation of the carrying amount of each class of intangible asset at the beginning and end of the previous reporting period is set out below

Year ended 30 June 2008		
Net carrying amount at start year	14	14
Additions	80	80
Amortisation expense	(14)	(14)
Net carrying amount at end of year	**80**	**80**

11. NON-CURRENT ASSETS - LEASEHOLD IMPROVEMENTS

	Leasehold Improvements		
	Building Extension	Refurbishment	Total
	$'000	$'000	$'000
At 1 July 2008			
Gross Carrying Amounts	248	3,337	3,585
Accumulated depreciation	(121)	(1,334)	(1,455)
Net Carrying Amount	**127**	**2,003**	**2,130**
At 30 June 2009			
Gross Carrying Amounts	248	3,368	3,616
Accumulated depreciation	(131)	(1,427)	(1,558)
Net Carrying Amount	**117**	**1,941**	**2,058**
Reconciliation			
A Reconciliation of the carrying amount of each class of leasehold improvement at the beginning and end of the current reporting period is set out below.			
Year ended 30 June 2009			
Net carrying amount at start of year	127	2,003	2,130
Additions	0	31	31
Depreciation expense	(10)	(93)	(103)
Net carrying amount at end of year	**117**	**1,941**	**2,058**
Reconciliation			
A Reconciliation of the carrying amount of each class of leasehold improvement at the beginning and end of the previous reporting period is set out below.			
Year ended 30 June 2008			
Net carrying amount at start of year	137	2,086	2,223
Additions	0	9	9
Depreciation expense	(10)	(92)	(102)
Net carrying amount at end of year	**127**	**2,003**	**2,130**

	2009	2008
	$'000	$'000

12. CURRENT LIABILITIES - PAYABLES

Accrued expenses	432	699
Other Creditors	270	370
	702	**1,069**

13. CURRENT LIABILITIES - PROVISIONS

Employee benefits and related on-costs		
Annual Leave Provision	267	255
Long Service Leave Provision	203	135
	470	**390**

Unconditional employee leave provisions are shown as a Current Liability.
The nature of these liabilities is as follows:

Annual Leave Provision		
- Short Term	267	172
- Long Term	0	83
	267	**255**
Long Service Leave Provision		
- Short Term	203	0
- Long Term	0	135
	203	**135**

14. CURRENT LIABILITIES - OTHER

Deferred Revenue	5,228	4,657
	5,228	**4,657**

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

15. NON CURRENT LIABILITIES - PROVISIONS

Employee benefits and related on-costs		
Long Service Leave Provision	0	59
	0	**59**

	2009	2008
	$'000	$'000

16. CHANGES IN EQUITY

Accumulated funds		
Balance at the beginning of the financial year	7,972	7,807
Changes in equity- other than transactions with owners as owners		
Surplus/(Deficit) for the year	(1,238)	165
Total	**(1,238)**	**165**
Balance at the end of the financial year	**6,734**	**7,972**

17.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 are not provided for
in the accounts. However with the creation of the National Body commencing
operations 1 July 2010, the Board will cease to exist and the current lease
is expected to be terminated without penalty.

-Within one year	33	33
-Between one and five years	-	132
-Greater than five years	-	365
-Total (including GST)	**33**	**530**

The total of lease commitments as at 30 June 2009 above includes input tax credits of $3,000 ($48,300 in 2008/09) that are expected to be recoverable from the Australian Taxation Office.

	2009	2008
	$'000	$'000

18. RECONCILIATION OF SURPLUS/(DEFICIT) FOR THE YEAR TO NET CASH FLOWS FROM OPERATING ACTIVITIES

Surplus/(Deficit)	(1,238)	165
Depreciation and amortisation	222	219
Net loss/(gain) on disposal of fixed assets	8	0
Increase/(decrease) in employee provisions	21	28
(Increase)/decrease in receivables and other assets	(302)	(193)
Increase/(decrease) in deferred revenue	571	288
Increase/(decrease) in payables	(367)	507
Net Cash provided by operating activities	**(1,085)**	**1,014**

19. FINANCIAL INSTRUMENTS

The Board's principal financial instruments are outlined below. These Financial instruments arise directly from the Board's operations or are required to finance the Board's operations. The Board does not enter into or trade financial instruments, including derivative financial instruments, for speculative purposes.

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

The Board of Management has overall responsibility for the establishment and oversight of risk management and reviews and agrees policies for managing each of these risks. Risk management policies are established to identify and analyse the risks faced by the Board, to set risk limits and controls and to monitor risks. Compliance with policies is reviewed by the Executive Management Team on a continuous basis.

(a) Financial Instrument Categories

Financial Assets	Note	Category	Carrying Amount	Carrying Amount
Class:			**2009**	**2008**
			$'000	**$'000**
Cash and cash equivalents	7	N/A	9,302	10,894
Receiveables (1)	8	Receivables at (amortised cost)	1,058	740

Financial Liabilities	Note	Category	Carrying Amount	Carrying Amount
Class:			**2009**	**2008**
			$'000	**$'000**
Payables (2)	12	Financial liabilities measured at amortised cost	702	1,069

Notes:
(1) Excludes statutory receivables and prerepayments (ie not within scope of AASB 7)
(2) Excludes statutory payables and unearned revenue (ie not within scope of AASB 7)

19. FINANCIAL INSTRUMENTS (cont'd)

(b) Credit Risk

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

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

Cash

Cash comprises cash on hand and bank balances. Interest is earned on daily bank balances at a commercial rate determined by the bank. The Tcorp Hour Glass Cash facility is discussed in paragraph (d) below.

Receivables - trade debtors

All trade debtors are recognised as amounts receivable at balance date. Collectability of trade debtors is reviewed on an ongoing basis. The majority of receivables recognised as trade debtors represent registration fees outstanding. Uncollected registration fees will result in the deregistration of the medical practitoner.
Debts which are known to be uncollectible are written off. An allowance for impairment is raised when there is objective evidence that the entity will not be able to collect all amounts due. This evidence includes past experience, and current and expected changes in economic conditions and debtor credit ratings. No interest is earned on trade debtors. Sales are made on 15 day terms.

The Board is not materially exposed to a concentrations of credit risk to a single trade debtor or group of debtors. The Boards debtors represent a large number of individual medical practitioners whose credit ratings will vary and are unknown to the Board. Based on past experience, debtors that are not past due (2009: nil; 2008: nil) are not considered impaired and these represent 100% of the total trade debtors.
There are no debtors which are currently not past due or impaired whose terms have been renegotiated.

The Board does not have any debtors that are past due.

(c) Liquidity Risk

Liquidity risk is the risk that the Board will be unable to meet its payment obligations when they fall due. The Board continuously manages risk through monitoring future cash flows and maturities planning to ensure adequate holding of high quality liquid assets. The objective is to maintain a balance between continuity of funding and flexibility through the use of overdrafts, loans and other advances.

During the current and prior years, there were no defaults or breaches on any loans payable. No assets have been pledged as collateral. The Board's exposure to liquidity risk is deemed insignificant based on prior periods' data and current assessment of risk.

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

The table following summarises the maturity profile of the Board's financial liabilities together with the interest rate exposure.

19. FINANCIAL INSTRUMENTS (cont'd)

			Interest Rate Exposure ($'000)			Maturity Dates
2009	**Weighted Average Effective Interest Rate**	**Nominal Amount (1)** $'000	**Fixed Interest Rate**	**Variable Interest Rate**	**Non-interest Bearing**	**< 1 yr**
Payables	-	702	-	-	702	702
2008						
Payables	-	1,069	-	-	1,069	1,069

Notes:
(1) The amounts disclosed are the contractual undiscounted cash flows of each class of financial liabilities, therefore the amounts disclosed above may not reconcile to the balance sheet.

(d) Market Risk

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

The effect on profit and equity due to a reasonably possible change in risk variable is outlined in the information below, for interest rate risk and other price risk.

A reasonably possible change in risk variable has been determined after taking into account the economic environment in which the Board operates and the time frame for the assessment (i.e until the end of the next annual reporting period). The sensitivity analysis is based on risk exposures in existence at the balance sheet date. The analysis is performed on the same basis for 2008. The analysis assumes that all other variables remain constant.

Interest Rate Risk

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

19. FINANCIAL INSTRUMENTS (cont'd)

		($'000)			
		-1%		1%	
	Carrying Amount	Profit	Equity	Profit	Equity
2009					
Financial Assets					
Cash and cash equivalents	9,302	(93)	(93)	93	93
Receivables	1,058	0	0	0	0
Financial liabilities					
Payables	702	0	0	0	0
2008					
Financial Assets					
Cash and cash equivalents	10,894	(109)	(109)	109	109
Receivables	740	0	0	0	0
Financial liabilities					
Payables	1,069	0	0	0	0

Other price risk – TCorp Hour Glass facilities

Exposure to 'other price risk' primarily arises through the investment in the TCorp Hour Glass Investment facilities, which are held for strategic rather than trading purposes. The Board has no direct equity investments. The Board holds units in the following Hour Glass investment trusts:

Facility	Investment Sectors	Investment Horizon	2009	2008
			$'000	$'000
Cash facility	Cash, money market instruments	Up to 1.5 years (Pre-June 2008 up to 2 years)	8,924	10,463

The unit price of each facility is equal to the total fair value of net assets held by the facility divided by the total number of units on issue for that facility. Unit prices are calculated and published daily.

NSW TCorp is trustee for the above facility is required to act in the best interest of the unit holders and to administer the trusts in accordance with the trust deeds. As trustee, TCorp has appointed external managers to manage the performance and risks of each facility in accordance with a mandate agreed by the parties. However, TCorp acts as manager for part of the Cash facility. A significant portion of the administration of the facilities is outsourced to an external custodian.

Investment in the Hour Glass facilities limits the Board's exposure to risk, as it allows diversification across a pool of funds, with different investment horizons and a mix of investments.

NSW TCorp provides sensitivity analysis information for each of the facilities, using historically based volatility information collected over a ten year period, quoted at two standard deviations (ie 95% probability). The TCorp Hour Glass Investment facilities are designated at fair value through profit and loss and therefore any change in unit price impacts directly on profit (rather than equity). A reasonably possible change is based on the percentage change in unit price (as advised by TCorp) multiplied by the redemption value as at 30 June each year for each facility (balance form Hour Glass statement).

19. FINANCIAL INSTRUMENTS (cont'd)

		Impact on profit/loss	
	Change in unit price	**2009**	**2008**
		$'000	**$'000**
Hour Glass Investment – Cash Facility	+/- 1%	89	105

(e) Fair Value

Financial instruments are generally recognised at cost, with the exception of the TCorp Hour Glass facilities, which are measured at fair value. As discussed, the value of the Hour Glass Investments is based on the Board's share of the value of the underlying assets of the facility, based on the market value. All of the Hour Glass facilities are valued using 'redemption' pricing.

The amortised cost of financial instruments recognised in the balance sheet approximates the fair value, because of the short-term nature of many of the financially instruments.

20. ANNOUNCEMENT REGARDING THE FUTURE OF THE BOARD

The accounts of the New South Wales Medical Board as at 30 June 2009 have been prepared on a going concern basis.

The Council of Australian Governments signed the Inter-governmental Agreement for a National Registration and Accreditation Scheme for Health Professionals currently registered in all jurisdictions. Aspects of the transition to a National Registration and Accreditation Scheme due to occur on 1 July 2010 are still to be resolved. The key aspect still to be resolved is what functions, staff and funds will be retained. Resolution of this issue is being undertaken at a Ministerial level, and therefore is largely outside the control of the Board.

End of Audited Financial Report

> appendices

Appendix 1: List of Shortened Forms

AMC	Australian Medical Council
CMO	Career Medical Officer
DP	Director of Proceedings
FOI	Freedom of Information
GP	General Practitioner
HCCC	Health Care Complaints Comission
IMET	Institute of Medical Education and Training
IMG	International Medical Graduates
IRP	Impaired Registrants Panel
MCQ	Multiple Choice Question
MPA	Medical Pracitce Act 1992
MT	Medical Tribunal
PA	Performance Assessment
PESCI	Pre-Employment Structured Clinical Interview
PGT	Postgraduate Trainee
PRP	Performance Review Panel
PSC	Professional Standards Committee
RACGP	Royal Australian College of General Practitioners
RMO	Resident Medical Officer

Appendix 2: Employees

This year saw considerable movement within the staff of the Board. Two staff members took maternity leave which allowed others to move into acting positions. Contract staff were employed to fill the vacant positions created by the moves. Six staff members were promoted or changed roles permanently within the Board and four were appointed to acting positions either short or long term. Agency staff filled the gaps left by staff members taking Long Service Leave and during recruitment phases.

The Registration Section was restructured creating a more flexible workforce with a focus on multi-skilling. There was a net gain of 12 staff members during this financial year reflecting the increase in activity within the Board.

Staff Development

Staff members attended a range of relevant external training courses, seminars and in-house activities, in areas such as management development, FOI, medical and health law, Workcover OHS Consultation, Pandemic Influenza planning, TRIM, Records Management and Fire Warden training. Staff members also attended Hearing Member training workshops.

Sick Leave

	2005/06	2006/07	2007/08	2008/09
Days lost	280	285	416.68	383.86
Per person average	7.37	7.31	10.16	7.83

Executive Officers

The Board employs one SES level 2 and one Staff Specialist Medical Director.

National Registration

On 12 June 2009, draft legislation for the national registration and accreditation scheme for the health professions was released for consultation by the Australian Health Workforce Ministerial Council. Transitional Staffing Arrangements announced in May 2009 provide for transition to AHPRA for permanent staff, other than defined senior staff, with current terms and conditions maintained for one year and current permanent pay rate being guaranteed as a minimum in perpetuity. In the context of what the Board believes to be significant shortcomings in the draft legislation underpinning the national scheme, in areas such as Conduct and Performance and Health, the NSW Department of Health has indicated that it is likely to opt out of the Complaints provisions.

The impact of this on staffing arrangements has not yet been resolved. At every stage of the process, staff at the Board have been kept informed in relation to the likely impact on employment conditions and salaries.

Appendix 3: Equal Employment Opportunity

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

Total Staff	Male	Female	Aboriginal/Torres Strait Islander	NESB
2008/2009				
52	3	49	0	4
2007/2008				
41	5	36	1	3

The management team comprises five female and one male employees.

Appendix 4: Occupational Health and Safety

The Board has an Occupational Health and Safety (OH&S) Consultative Committee comprising employer (1) and employee representatives (3). The OH&S Committee meets quarterly, and staff input is encouraged.

Quarterly OH&S inspections are carried out and followed-up as required. No significant OH&S issues were identified during the year.

Appendix 5: Insurance and risk management

The Corporate Governance and Audit Committee monitors and reviews the Board's risk management activities. The Board has developed guidelines for threat management to persons or property. These threat management guidelines support the assessment, decision-making and management of threats made against individual members of, or property belonging to, the NSW Medical Board. Workers compensation injuries remained low during the 2008-2009 year with only four minor reports of injury or near misses.

Appendix 6: Legal change

During the course of the reporting year the following legislative developments occurred:

Medical Practice Amendment Act 2008

The Medical Practice Amendment Act, 2008 received Royal Assent on 11 June 2008, although the provisions of the Act commenced at various times during this reporting period.

The Act amends the Medical Practice Act, 1992 in the following ways:

- Specifying that protection of the health and safety of the public is to be the paramount consideration when exercising functions under the Act.
- Strengthening the Board's authority to act under its emergency powers, including introducing a new 'public interest' test, granting the Board power to gather relevant evidence, limiting rights of appeal on points of law initially to the Medical Tribunal, and requiring audio recordings of proceedings.
- Requiring Professional Standards Committees to be chaired by a legally qualified person and to be held in public, and requiring the publication of PSC decisions.
- Requiring the Board and disciplinary bodies to take into account the totality of a medical practitioner's history when dealing with matters, including past complaints and disciplinary outcomes.
- Enabling a disciplinary body to specify that a breach of conditions will lead to automatic suspension and de-registration.
- Introducing mandatory reporting of misconduct.
- Requiring practitioners to produce evidence of professional indemnity insurance when submitting Annual Returns.

Health Legislation Amendment Act 2009

The Health Legislation Amendment Act 2009 makes miscellaneous amendments to various Acts. The Act commenced on 13 May 2009, except for the provisions which amend the Medical Practice Act 1992 which are to commence on proclamation. The changes to the Medical Practice Act, which will commence in the next reporting period, will allow the parties to a PSC Inquiry to have legal representation.

Queensland Health Practitioner Regulation (Administrative Arrangements) National Law Act, 2008

This Act, which received assent on 25 November 2008, gives effect to the new National Law and sets up the administrative arrangements for the National Registration and Accreditation System scheduled to commence on 1 July 2010.

Although not yet law, the release of the Exposure Draft of the Queensland Health Practitioner Regulation National Law 2009 (Bill B) on 12 June 2009 marked another significant step in the movement towards national registration.

Appendix 7: Departures from Subordinate Legislation Act

The Subordinate Legislation Act 1989 requires that before any principal statutory rule is made, the responsible Minister must ensure that a number of requirements are met, including that a regulatory impact statement is prepared and made publicly available.

There were no departures by the Medical Board from the Subordinate Legislation Act during 2008-2009.

Appendix 8: 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 cultural and linguistic background 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:

- Ensuring that Board staff are sensitive and aware to the needs of applicants from diverse cultural and linguistic backgrounds when providing information and guidance about the registration process in New South Wales.
- Continuing the development of policies to facilitate access to area of need and hospital training positions.
- The Board is responsible for conducting the Pre-employment Structured Clinical Interview (PESCI) of International Medical Graduates who apply for Area of Need positions. During 2008/2009 the Board approved registration for 33 general practitioners, 12 RMO/CMO practitioners and 30 specialists. These practitioners are overseas-trained doctors from a range of countries including Bangladesh, Burma, Canada, China, Croatia, Czech Republic, Egypt, France, Germany, Hungary, India, Iran, Iraq, Israel, Latvia, Nepal, Nigeria, Philippines, Pakistan, Russia, Sri Lanka, Saudi Arabia, South Africa, Sudan, Sweden, United Kingdom and United States of America.
- Delivering presentations and providing continued support for the Institute of Medical Education and Training orientation course designed to assist AMC graduates prior to their entering teaching hospitals for their requisite period of supervised training.
- Ensuring that Professional Standards Committees, Medical Tribunals, Impaired Registrants Panels, Performance Review Panels, peer audits and Board Reviews include Panel members from diverse cultural and linguistic backgrounds.
- Active input and participation into the Liaison Committee that brings together the Department of Health, the Australian Doctors Trained Overseas Association and the NSW Medical Board.

- → Active input and participation into the Department of Health's Area of Need Advisory Committee which, in addition to workforce matters, focuses on other aspects that may affect IMGs in their transition to the Australian health care system.
- → Membership of the Board's Registration and Health Committees include a representative nominated by the Community Relations Commission.

Strategies identified for the forthcoming year include the following:

- → Continuing exploration of ways to include greater cultural and linguistic diversity on Board Committees, hearing panels and peer audits including an audit of the existing structures to ensure diversity is maintained or enhanced.
- → Continued review and implementation of policies in relevant areas, and promotion of national uniformity in relation to these policies.
- → Staff in direct public contact positions will receive training to enhance their awareness about working in a culturally diverse environment.

Appendix 9: Overseas travel

The Board funded the following overseas travel:

- → Board members Greg Kesby and Denis Smith, and the Registrar and Medical Director attended the 8th International Conference on Medical Regulation (IAMRA) in Capetown, South Africa in October 2008.
- → The Medical Director was given financial support to attend an Executive Course on Global Health Diplomacy in Geneva, June 2009, followed by a consultancy at the Irish Medical Council, in part reimbursed by the Council.
- → The Registrar was invited to give the keynote address the Federation of Medical Regulatory Authorities of Canada Annual meeting in Halifax, Nova Scotia, in June 2009. His expenses were in part reimbursed by FMRAC.

Appendix 10: Waste Reduction and Purchasing Policy

The Board's Waste Reduction and Purchasing Plan (WRAPP) was developed in conjunction with the Department of Environment and Conservation (NSW). The Board actively encourages staff members to reduce waste by use of electronic communications, use of recycled materials, and staff education in relation to these matters.

Appendix 11: Use of consultants

Consultancies equal to or more than $30,000

Consultant	Cost	Title/Nature
Checknet Pty Ltd	$171,378	IT Support and project management
Oakton Consulting Pty Ltd	$79,848	Accounting package support and software upgrade
Axis Technology Pty Ltd	$277,532 $336,120	Database support and enhancement . Net Project
Internal Audit Bureau	$63,849 $2,565 $37,378	Documentation and Business analysis Accounting . Net Project
Alphawest Pty Ltd	$117,395	Trim support and electronic document management support
Edwina Light	$68,560	Communications
Sydney University	$47,684	Research focussed on the Performance program with particular reference to assessment of surgeons.
Total consultancies equal to or more than $30,000	**$1,202,309**	

Consultancies less than $30,000

Consultant	Cost	Title/Nature
Internetrix	$9,720	Web site consulting
Miriam Gross	$2,150	HR consulting services
Nicole Newton	$5,600	Media Consultant
Total consultancies less than $30,000	**$17,470**	
Total Consultancies	**$1,219,779**	

Appendix 12: Consumer response

During 2008/09, the Board received a small number of complaints from the public and members of the profession. These largely related to dissatisfaction with the outcome of complaints or investigations concerning medical practice. The publication of the Register of Medical Practitioners online continues to generate some complaints regarding privacy and access to information. Complaints were referred to the appropriate area for investigation and speedy resolution, and the Board's policies and procedures were reviewed and amended where necessary. The Board's policy regarding handling complaints against staff members is being updated in line with NSW Ombudsman guidelines.

Appendix 13: Freedom of Information

This year has seen more 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 Panels
- → Performance Review Panels.

During 2008/09, the Medical Board received seven 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 20 applications for access to documents under the Act (one application was ultimately withdrawn). This compares with 11 applications in 2007/08 and 13 applications in 2006/07. The Board provides practitioners with information sought from their personal files unless the FOI exemptions apply. This year, the Board complied with requests from 13 practitioners to access all or some of the information on their files. One application involved consideration of more than 2000 documents by the secretariat. One applicant made 8 separate FOI applications in this reporting period. In addition, one application received in the previous reporting year was finalised in this reporting period and there is one application that has been lodged pending determination.

The Board did not receive any transfers of applications made under Freedom of Information from other government departments.

In the reporting period, four applications were received for an internal review of the Board's decision. One internal review application resulted in an additional document being provided and another two resulted in no additional documents being provided to the applicants. The fourth application for review was considered to be outside the provisions of the FOI Act. There have been no appeals filed in the Administrative Appeals Tribunal of NSW.

Appendix 14: Privacy management

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 MPA. 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.

Two applications for internal review under Part 5 of the Privacy and Personal Information Protection Act 1998 were received during the reporting period.

The Board regularly reviews its compliance with the relevant legislation and its procedures and policies are amended where necessary.

Appendix 15: Policies and publications

The Board's website is one of 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 circulate important public health information such as the NSW Health updates on the H1N1 Influenza 09.

Other key developments such as submissions relating to the national registration scheme in 2010, the implementation of new registraion pathways for international medical graduates, and of the amendments to the Medical Practice Act (Annual Renewals, mandatory reporting, PSC processes) have been included on the website as they occurred.

During the year the NSW Medical Board completed a review of its website to enhance the function and accessibility of the site for visitors. The volume of visitors to the website continues to grow – approximately 27,530 each month – and the most commonly viewed pages include those related to key Board activities such as the online Register, annual renewals and new applications for registration, news and updates, legal decisions and policy resources.

The importance of the website's ability to provide accurate and up-to-date information to doctors and the community will continue to expand over the next 12 months, particularly as the range of recent significant changes to registration and disciplinary systems in NSW are consolidated and as the transition toward a national registration scheme in 2010 accelerates.

With this in mind, the Board reviewed the website to improve its structure and content. The review was completed during the reporting year and the website improvements were due to be implemented in July 2009.

Appendix 16: Overview of complaints bodies and processes

The Medical Board Conduct section operates generally under the provisions contained in the *Medical Practice Act 1992* and the *Health Care Complaints Act 1993* in relation to complaints. The bodies, persons or entities that deal with complaints against medical practitioners are:

- → **The Medical Board:** The Board's role in relation to complaints is to consult with the HCCC on the course and outcome of a complaint, to take relevant action under the Medical Practice Act, to appoint medical and lay members to sit on relevant inquiries, and to monitor any conditions or restrictions on a medical practitioner's practise of medicine.
- → **The Health Care Complaints Commission (HCCC):** The HCCC's role in relation to complaints is to investigate and prosecute complaints in relation to medical practitioners and to consult with the Board as to the course and outcome of a complaint.
- → **The Director of Proceedings (DP) at the HCCC:** The role of the DP is to independently assess and prosecute matters before a Professional Standards Committee or Medical Tribunal and to consult with the Board in relation to this.
- → **A Professional Standards Committee (PSC):** PSCs are independent inquiry bodies set up under the Medical Practice Act to determine any complaint that a medical practitioner may have engaged in unsatisfactory professional conduct.
- → **A Medical Tribunal:** The Medical Tribunal is an independent inquiry body set up under the Medical Practice Act, and chaired by a judge of the District Court, to determine serious complaints that a medical practitioner may have engaged in professional misconduct or unsatisfactory professional conduct. The Tribunal also has a role in determining certain appeals against decisions of the Board or a PSC and whether a de-registered person might be returned to the register of practitioners.

Any person can make a complaint about a registered medical practitioner. Each complaint is assessed by the HCCC in consultation with the Board. Consultation occurs at various stages during the investigative stage and prior to any prosecution of a complaint before a disciplinary body. When a complaint is made the following may occur, depending on the facts of the complaint and the degree of evidence available:

- The Board may take immediate action under s66 of the *Medical Practice Act, 1992*. Section 66 empowers the Board to suspend or place conditions on a practitioner's registration if necessary to protect the life or physical or mental health of any person.
- After assessment a complaint may require further investigation. Following completion of any further investigation by the HCCC, a complaint may be:
  - → referred to the Director of Proceeding for a determination as to whether to prosecute the complaint before a PSC or a Tribunal.
  - → referred for conciliation or complaint resolution.
  - → terminated.
  - → referred to the Board for appropriate action. A referral of a complaint to the Board may result in a medical practitioner being interviewed or counselled in relation to his/her conduct. They might also be dealt with in the Board's Health or Performance programs.

Appendix 17: Professional Standards Committee case studies

In the year ending 30 June 2009, the HCCC referred 19 complaints to a Professional Standards Committee (PSC). Fourteen of those complaints were dealt with before a PSC Inquiry and two were terminated and referred to be dealt with by a Medical Tribunal. Three inquiries resulted in the complaints being dismissed. The remaining inquiries resulted in orders being made and/or conditions being imposed.

Due to legislative changes that occurred during this reporting period (see Appendix 5) in relation to the publication of PSC decisions, and PSC inquiries being held in public, eight PSC decisions are published in full on the Board's website at www.nswmb.org.au . The remaining inquiries were not open to the public and the decisions remain confidential. Some examples of the types of matters dealt with at the closed PSC inquiries are reproduced below.

Impairment

A practitioner was the subject of two complaints alleging failure to provide a response to a request for information by the Board under s127C of the Medical Practice Act 1992, and that the practitioner suffered from impairment. The PSC concluded that the practitioner's impairment affected her ability to interact with others in a professional setting and that she failed to recognise that she has a problem necessitating ongoing medical treatment.

The PSC could not be satisfied that conditions would achieve adequate protection for the public and so made a recommendation to the Chairperson of the Medical Tribunal that the practitioner be deregistered on the basis that she did not have sufficient mental capacity to practise medicine. The Tribunal accepted the recommendation, and her name was removed from the Register.

Missed diagnosis

A general practitioner visiting medical officer discharged a pregnant patient with abdominal pain from hospital on the basis of his diagnosis of gastroenteritis. Several hours later the patient's ectopic pregnancy ruptured, causing her death.

The PSC made a finding of unsatisfactory professional conduct on the basis that the practitioner had discharged the patient when he knew, or should have known, that her blood pressure had fallen despite being given IV fluids, and that she fell into a high risk category for ectopic pregnancy. The practitioner was reprimanded and had

Practice Conditions imposed on his registration, including that he is required to submit to an audit, undergo mentoring, and complete the Emergency Life Support Course.

Failure to adequately examine

A general practitioner visiting medical officer discharged an elderly patient with a Glasgow Coma Score of 14/15 from hospital. The patient later died. The patient had presented to the emergency department with a history of an unwitnessed fall and head injury. The practitioner disputed the GCS as he maintained it had been incorrectly completed by ambulance personnel, which the PSC accepted.

Nevertheless the PSC found him guilty of unsatisfactory professional conduct based on its findings that he had failed to perform an adequate neurological examination of the patient prior to discharge, and that he had discharged the patient when he was at greater risk of intra-cranial bleeding due to his age, and was unsteady on his feet. The practitioner was reprimanded and had conditions imposed on his registration requiring him to attend an Emergency Life Support course and obtain Board approval prior to practising emergency medicine in any hospital.

Lack of information and skill

A practitioner was found guilty of unsatisfactory professional conduct in failing to provide adequate information to the parents of three young patients regarding the procedure of circumcision and associated risks, demonstrating a lack of adequate skill in failing to achieve haemostasis in relation to at least one of his patients, and in failing to recognise that the same patient suffered from complications arising from the procedure. The practitioner was reprimanded and conditions were placed on his registration.

Appendix 18: Section 66 and 66AB proceedings

The Board is required to take action under section 66 of the Medical Practice Act 1992 by either suspending a practitioner from practising medicine or imposing conditions on a practitioner's registration if it is satisfied it is appropriate to so for the protection of the life or safety of any person or if it is otherwise in the public interest to do so. The public interest test was introduced on 1 August 2008. (See Appendix 6 regarding legislative change.)

Practitioners can seek a review of such a decision by making an application under section 66AB of the Act. The Board can also shorten or terminate a suspension, or alter or remove conditions that have been imposed under section 66 by conducting proceedings under section 66A of the Act.

If the Board takes any action under section 66 the matter that triggered the proceedings must either be referred to the Health Care Complaints Commission for investigation as a complaint or be referred to an Impaired Registrants Panel Inquiry (subject to consultation and agreement with the Commission).

The Board conducted 40 section 66 proceedings and 15 section 66AB or 66A proceedings during the reporting year.

Summaries of some of the matters considered by the Board appear below.

Criminal conviction

The Board was advised that a physician had pleaded guilty, and had been given a suspended sentence, in relation to two criminal charges concerning possession of child pornography in his home. The Board accepted the opinions of the Board-nominated psychiatrist and the practitioner's psychologist that he was in a low-risk category in relation to re-offending and did not manifest the character of a sexual recidivist. Practice conditions were imposed, including that the practitioner not treat persons under 18 except in the event of a medical emergency, limitations on the number of work hours, onsite supervision by another practitioner, and treatment by a psychiatrist with expertise in the treatment of sexual offenders. The matter was referred to the Health Care Complaints Commission for investigation.

Criminal charges

A general practitioner was charged with two offences under section 61 of the Crimes Act 1900, namely sexual intercourse without consent and assault with act of indecency. The charges arose out of alleged conduct by the doctor during a consultation with the patient.

The section 66 proceedings ordered that conditions should be imposed on the doctor's registration, including that a chaperone be present at all times whenever the doctor provides a medical service to a female patient (including any consultation, interview, examination or treatment). The matter was referred to the Health Care Complaints Commission for investigation.

Professional boundaries

A general practitioner had previously been found guilty of professional misconduct in 2006 by the Medical Tribunal in relation to inappropriate prescribing to a male patient with whom she had a close personal relationship. Conditions were imposed by the Medical Tribunal, including health conditions, and these were still in effect when the Board became aware of an investigation by the Health Care Complaints Commission into a new complaint alleging the practitioner began a sexual relationship with a patient (who is now her ex-husband) soon after she began treating him and an allegation of violating professional boundaries in relation to another patient.

Section 66 proceedings were convened. The practitioner denied having been the primary treating practitioner for the two patients, though she admitted to writing prescriptions in respect to both of them and providing services for which Medicare benefits were claimed.

The section 66 delegates imposed further conditions, noting that the allegations related to boundary violations in the period that had

previously been the subject of scrutiny in the 2006 Medical Tribunal proceedings. They determined that the practitioner seemed to have been well advised since her dealings with the Medical Tribunal, to have gained insight into her actions, to have obtained strong professional support and has been compliant with the conditions imposed since 2006. The matter was referred to the Health Care Complaints Commission for investigation and has been subsequently finalised through disciplinary counselling by the Board.

Inappropriate prescribing

The Board was provided with material by the NSW Health Department's Pharmaceutical Services Branch alleging that a self-employed general practitioner had inappropriately prescribed Schedule 4D and Schedule 8 drugs to five patients. The GP's registration had previously been suspended on similar grounds. The Board also noted a possible boundary crossing issue in the GP's efforts to source job opportunities for one of the patients.

Conditions were imposed on the GP's registration including that his S8 and S4D authorities be withdrawn, that he undertake professional development activities, that he submit to audits of his medical records and that he be supervised. The matter was referred to the Health Care Complaints Commission for investigation.

Inappropriate prescribing

Justice Health notified the Board when two patients of a general practitioner were taken into custody, charged with the murder of their daughter, as the practitioner had prescribed large quantities of benzodiazepine and codeine-based drugs to them. A subsequent review by the NSW Health Department's Pharmaceutical Services Branch showed inappropriate prescribing to other patients as well. The Board imposed conditions on the practitioner's registration, which prohibited prescribing, possessing, supplying, administering, handling or dispensing any S8, S4D or S4D derivative drugs and requiring audits of the practitioner's medical records. The matter was referred to the Health Care Complaints Commission for investigation.

Inappropriate prescribing

An ENT surgeon with an interest in anti-ageing medicine was the subject of section 66 proceedings after the Board received a report from the NSW Health Department's Pharmaceutical Services Branch which raised concerns about prescription and supply of HGH, Pregnyl, Clomid, Arimidex and steroids.

The Board was satisfied that protection of the public was required in relation to prescribing, which was in apparent contravention of the Poisons and Therapeutic Goods legislation, and also was not in accordance with recognised therapeutic standards. The patient records also did not appear to comply with the requirements of Schedule 2 of the Medical Practice regulation 2003. Conditions were imposed on the practitioner's registration and the matter was referred to the Health Care Complaints Commission for investigation.

Inappropriate prescribing

In the last reporting period, a rural general practitioner was suspended as a result of section 66 proceedings, for deliberately breaching conditions previously imposed in relation to inappropriate prescribing of both Schedule 8 and Schedule 4D drugs. Also in 2007/2008, the practitioner was the subject of a 66A review hearing, which ordered that the suspension remain in force as the practitioner had displayed little insight into the reasons for his suspension.

In this reporting period, one section 66A review and three section 66AB review proceedings took place. In these hearings the delegates found that new evidence put forward by the practitioner did not adequately address the issue of the practitioner's competence to return to the practise of medicine and that he had in fact continued to prescribe contrary to the conditions, and he continued to have little insight into the reasons for his suspension. The suspension remains in force, and the matter has subsequently been investigated by the Health Care Complaints Commission and is due to be prosecuted as a complaint before the Medical Tribunal.

Impairment

A general practitioner whose registration was already subject to practice and health conditions as a result of a previous Medical Tribunal hearing in 2006 was suspended from practising medicine under section 66. He was suspended for breaching practice and health conditions on his registration which required him to limit alcohol consumption, to have a regular treating GP and to complete an ethics course. He was advised that he would remain suspended until he could satisfy the Board he had sufficiently addressed his problem of alcohol consumption and was having adequate psychiatric and medical treatment.

Subsequent s66AB review proceedings nine weeks later lifted the suspension order and his registration was again made subject to conditions, including a requirement that he abstain completely from alcohol. He was subsequently referred to an Impaired Registrants Panel Inquiry and is monitored by the Board's Health Program.

Impairment

A private practitioner specialist was the subject of a health notification to the Board. Section 66 delegates formed the view that it was appropriate to impose conditions on his registration, including supervision of his practice and that he be required to undergo psychiatric treatment. The practitioner was subsequently referred to an Impaired Registrants Panel Inquiry and for monitoring in the Board's Health Program.

A few weeks after the delegates took the above action, the Board received notification of several incidents suggesting that the practitioner had engaged in inappropriate conduct concerning patients, in one case just one week after the section 66 proceedings. Further section 66 proceedings were convened.

The delegates concluded that the incidents that occurred subsequent to the first proceedings highlighted the conduct component of the practitioner's behaviour and that there was no evidence indicating he was unwell at the time of the incidents, nor that he presented as mentally unwell at the time of the second proceedings. The matter was referred to the Health Care Complaints Commission for investigation, with his health conditions continuing to be monitored by the Board.

Competence

Section 66 proceedings were convened following a referral from the Board's Performance Committee, which noted that despite this GP having been in the Performance Program since 2003 he appeared to have little insight into his ongoing poor performance and remediation had been unsuccessful.

The delegates noted that the deficiencies identified in the GP's performance related to very basic aspects of medical practice and that they could not have confidence in further conditions achieving sufficient protection of the public. It was considered appropriate to suspend him from practising medicine and the matter was referred to the Health Care Complaints Commission for investigation.

Competence

An ophthalmologist who worked in a group practice as a general practitioner has had, since1988, conditions on his registration which restricted the circumstances in which he could perform spinal manipulations.

Section 66 proceedings were convened as a result of concerns raised in a Performance Assessment report. The section 66 delegates concluded that the practitioner uses an unconventional form of spinal manipulation to treat a wide range of medical conditions, thus depriving some patients of clinically proven effective treatments. The delegates were not able to formulate appropriate workable conditions that would satisfactorily address the Board's paramount consideration of the protection of the health and safety of the public. The practitioner was suspended and the matter was referred to the Health Care Complaints Commission for investigation.

Appendix 19: Schedule 1 Inquiries case studies

When the Board is not satisfied as to the eligibility of an applicant for registration, it must conduct an Inquiry into the application under Schedule 1 of the Medical Practice Act. The Inquiry may grant or refuse registration or may determine that registration be granted subject to the imposition of conditions. The Board referred eight applications for registration to a Schedule 1 Inquiry during the reporting period. Some examples of the subject matter dealt with at these inquiries are reproduced below.

Impaired practitioner registered with conditions

A practitioner with a complex medical and psychiatric history sought registration in New South Wales after working in New Zealand, where her registration was already subject to practice and health conditions. The Inquiry took into account evidence that the practitioner had remained well and stable for at least 12 months prior to the Inquiry, her willingness to comply with conditional registration, her established support networks, her motivation to develop specialist skills, and her compliance with the monitoring and support programs of overseas medical councils. The practitioner was granted registration with practice and health conditions.

Re-registration with conditions following previous disciplinary proceedings

A GP removed his name from the Register following investigations by the NSW Health Department's Pharmaceutical Services Branch, which revealed that he had been inappropriately prescribing both Schedule 8 and Schedule 4D drugs. In 2007 the resultant Professional Standards Committee Inquiry reprimanded him and ordered conditions be imposed on his registration in the event he be re-registered. In 2008 the practitioner applied to be re-registered and the application was considered by a Schedule 1 Inquiry.

The practitioner demonstrated to the Inquiry that he was competent to practice medicine and of good character by displaying insight into the reasons for his reprimand. He had appropriate future plans which involved undertaking relevant courses, meeting with a mentor and working in a supervised setting. The Inquiry concluded he was eligible to be re-registered and ordered conditions be imposed on his registration, including that he only practice in a group general practice with on-site supervision, and that he complete several refresher courses.

Appendix 20: Matters in other jurisdictions

The following decisions are available on the Board's website at www.nswmb.org.au:

SUPREME COURT

Attorney General for the State of New South Wales v Michael BAR-MORDECAI
Judgment of Schmidt AJ on 19 June 2009

When the Medical Tribunal refused Mr Bar-Mordecai's application for restoration to the Register of Medical Practitioners in March 2009, he sought to appeal this decision to the Court of Appeal. In 2005 the Supreme Court had declared him a vexatious litigant so Mr Bar-Mordecai was first required to seek leave of the Supreme Court under the provision of the *Vexatious Proceedings Act 2008*. His application for leave was refused as the Court held there were no prima facie grounds in relation to his allegations of bias in the Medical Tribunal.

Richard Francis Gorman v. Performance Review Panel & the New South Wales Medical Board
Judgment of Hidden J on 29 May 2009

On 18 April 2008 a Performance Review Panel handed down a decision directing that eight conditions be imposed on the registration of Dr Gorman. Dr Gorman applied to the Supreme Court for a stay of the conditions pending the hearing of his appeal against the imposition of the conditions to the Medical Tribunal. Hidden J was not persuaded to order a stay and he dismissed Dr Gorman's application.

SUPREME COURT OF NEW SOUTH WALES COURT OF APPEAL

Dr Richard Francis GORMAN v New South Wales Medical Board & Anor
Judgment of Ipp JA and McColl JA on 24 February 2009

Dr Gorman sought leave to appeal against the decision of Hidden J (see above). The only question raised by Dr Gorman was whether Hidden J erred when dealing with the question of bad faith. The Court noted Dr Gorman was unrepresented and that papers before the court were inadequate. On the basis of that material there was no evidence on which to come to a conclusion that it was arguable that there was bad faith on the part of the Performance Review Panel. Leave to appeal was not granted.

BURWOOD LOCAL COURT

Medical Board of New South Wales v Vitomar ZEPINIC
Judgment of Magistrate Barkell on 22 July 2009

Mr Zepinic, who is not a registered medical practitioner, was found guilty of six counts of offending against s105(1) of the Medical Practice Act in that he used the intials MBBS on six psychological reports which he prepared for an insurance company. This was found to indicate that he possessed a qualification which was capable of entitling him to be registered when he is not registered. He was convicted on each count and released on entering a bond to be of good behaviour for a period of two years.