



NEW * SOUTH * WALES
Medical Board



2007

annual report



annual report 2007

PRESIDENT'S REPORT	3
YEAR IN SUMMARY	4
STRUCTURE OF THE BOARD AND SECRETARIAT	5
MANAGEMENT & ACTIVITIES	9
REGISTRATION	10
PROFESSIONAL CONDUCT	13
HEALTH	18
PERFORMANCE	21
FINANCE AND BUDGET	26
APPENDICES	47

ACCESS TO THE BOARD

Address	Punt Road, Gladesville NSW 1675 (within the grounds of Gladesville Hospital)
Telephone	(02) 9879 2200 Facsimile (02) 9816 5307
E-mail	nswmb@nswmb.org.au
Web Page	www.nswmb.org.au
Hours of Business	9.00 am to 4.30 pm
Mail	The Registrar New South Wales Medical Board PO Box 104 GLADESVILLE NSW 1675 DX 22808 GLADESVILLE

For more copies of this annual report contact:
New South Wales Medical Board
PO Box 104
GLADESVILLE NSW 1675
DX 22808 GLADESVILLE
Telephone (02) 9879 2200
Facsimile (02) 9816 5307
E-mail nswmb@nswmb.org.au

This report can be downloaded from the NSW Medical Board website www.nswmb.org.au

> 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.

9 October 2007

The Hon Ms Reba Meagher
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 2007.

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

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

> president's report

Without doubt the most significant event in the past year, if not in the Board's history, was the announcement in July 2006 by the Council of Australian Governments of the establishment of a National Medical Board, and the consequential abolition of all state and territory medical boards.

The Board has made clear its support for the principle of national registration for a number of years. It has actively contributed to the development of a workable model to simplify mobility of medical practitioners, while at the same time ensuring that the high standards of practice and conduct that it has striven to maintain are not undermined.

Unfortunately, after the initial announcement, the development of the national scheme has been characterised by a disappointing lack of information and meaningful consultation with stakeholders such as the Board, so that one year on there is still no clear indication of what the structure of the scheme will be or how it will work. A slightly more detailed Discussion Paper was released in October 2006, but after input from stakeholders, this model has been superseded by a further, briefer communiqué published in April 2007. It appears that the original implementation date of July 2008 has now been moved to July 2009, and the Board will await developments with interest.

One of the driving forces behind the COAG proposals has been the issue of the medical workforce. Much of the Board's attention has been focused on issues raised by the increasing number of international medical graduates (IMGs) applying for registration who have not gone through the statutory Australian Medical Council pathway. In my previous annual report, I noted the tightening up of the Board's requirements that were made, in part, in recognition of the increasing numbers of IMGs, and also in response to the heightened concern generated by the Dr Patel case in Queensland. Initiatives such as independent primary source verification of qualifications and national standards for English language competency have now been substantially implemented and accepted. As processes have become more demanding, the workload for the Board has increased, but it has been able to meet these challenges with procedural and IT improvements.

One significant consequence of the various government policy changes in relation to workforce has been a dramatic increase in the number of medical student places. The impact of this on hospitals as increasingly large numbers of interns enter the system will be an issue requiring careful management in coming years.

The Board's Performance and Health Programs have continued to offer effective mechanisms to constructively assist practitioners whose health or professional standards have been suboptimal. While it has continued to be a very effective tool for identifying shortcomings in the way in which doctors actually practise, and for formulating suitable remediation, the Performance Program has

been the subject of legal attack. To the regret of the Board, this has diverted resources and attention from the task of assisting the profession in maintaining the high standards of practice that the public is entitled to expect.

The last of the matters arising out of the 2004 Walker Special Commission of Inquiry into Camden and Campbelltown Hospitals was finalised during the year. It is of some interest to note that of the 63 doctors originally named in the various processes of the Inquiry, ultimately only three of the eight referred to disciplinary hearings were the subject of adverse findings.

October 2007 marks the 20th anniversary of the NSW Medical Board's existence as an independent statutory authority. Prior to that time, the Board had functioned as a part of the Department of Health, but following medico-political upheavals in the mid-1980s, the Board was reconstituted as an independent statutory authority responsible for the management of its own business with the primary charter of protecting the public. A new disciplinary structure was introduced which gave much greater flexibility to the Board and the Complaints Unit was accorded a much more significant role in the investigation and prosecution of complaints. Since 1987, the scope of the Board's role has been expanded dramatically, the number of doctors has increased by one third, and the volume and complexity of the work dealt with by the Board has increased significantly. There have been at least three major sets of legislative change, and the Board has been a national leader in innovation in regulatory matters. Since its formation in 1838, the Board has undergone many transformations, and has come an extraordinary distance. While the Board sees the principle of national registration as logical and in the public interest, provided that its already well developed programs are not lost, the prospect of the end of the Board's unbroken 169-year history is one that can only be approached with mixed feelings.



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.

	2004/05	2005/06	2006/07
Registration			
The following indicates the number of registrants by category on the 30 June 2007.			
Category of Registration			
General	22307	22630	23253
Interns	479	496	469
AMC Registrants undertaking supervised training	150	137	116
Postgraduate Trainees	1193	1326	1577
General Practice Trainees	200	197	96
Areas of Need	247	249	245
Conditional Specialists	624	746	885
Specialist Trainees	15	21	20
Retired/Non-Practising/Limited Prescribing and Referral	1625	2116	2254
Other (includes academic and temporary Board discretion)	-	-	13
Student registrants	2716	3118	2990
Total registrants	27089	27918	31918
Professional Conduct			
Complaints assessed	1080	1292	1155
PSCs concluded	19	9	20
Medical Tribunals concluded	35	37	25
Counselling Interviews finalised	15	22	31
Section 66 Inquiries conducted	18	22	35
Health			
Doctors in Health Program	126	124	138
Entrants to Program	37	29	42
IRPs convened	48	44	58
Board Review Interviews	211	238	246
Performance			
Doctors in Performance Program	40	42	40
Entrants to Program	17	22	20
Assessments concluded	10	28	12
PRPs concluded	7	9	8
Retired as a result of participation	2	4	5
Performance Interviews concluded	18	28	41

> structure of the board **and secretariat**

Membership of the NSW Medical Board



Standing: A/Prof Rod McMahon, Dr Sue Ieraci, Mr Anthony Johnson, A/Prof Belinda Bennett, Mr Andrew Dix, A/Prof Eugen Molodysky, Ms Rosemary Kusuma, Dr Ian Symington, Prof John Palmer, Dr Richard Benn, Dr Denis Smith, Dr Alison Reid

Sitting: Ms Maria Kelly, Prof Kay Wilhelm, Prof Helen Lapsley, A/Prof Peter Procopis (President), A/Prof Michael Fearnside (Deputy President), Dr Robyn Napier, Dr Kendra Sundquist

Absent: Dr Denise Robinson, Prof Allan Spigelman, Dr Greg Stewart, Dr Choong-Siew Yong

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 2006 to 30 June 2007 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: 1.10.2003-30.9.2007) [6]

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]

A/Professor Richard Alan Vickery Benn, AM, B.Sc (Med) (Sydney) MBBS (Sydney), FRACP, FRCPA, Royal College of Pathologists of Australasia nominee (current term: 1.10.2006-31.07.2008) [5]

A/Prof Belinda Bennett, B Ec, LLB (Macquarie), LLM, SJD (Wisconsin), Legal Member nominated by the Minister (current term: 7.6.2006-6.6.2010) [4]

Dr Susan Ieraci, MBBS (Sydney), FACEM, Ministerial nominee (current term: 1.10.2003-30.9.2007) [3]

Ms Maria Kelly, B.Pharm. (Sydney), Dip Ed (NSW), Grad Cert Bioethics (UTS), Ministerial nominee (current term: 1.10.2004-30.9.2008) [5]

Ms Rosemary Eva Kusuma, BSW (Sydney), Ministerial nominee (current term: 30.1.2006-30.9.2009) [5]

Professor Helen Madeleine Lapsley, BA (Auckland), MEd (Sydney), FCHSE, Ministerial nominee (current term: 1.10.2006-17.11.2008) [6]

A/Prof Eugen Molodysky, MBBS (Sydney), PhD (Sydney), DRACOG, MRACGP, Community Relations Commission nominee (24.5.2006-30.9.2009) [4]

A/Prof 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) [4]

Dr Robyn Stretton Napier, MBBS (Sydney), Australian Medical Association nominee (current term: 1.10.2004-30.9.2008) [4]

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]

Dr Denise Margaret Robinson, MBBS (Sydney), MHP, FAFPHM, MRACMA, Department of Health nominee (current term: 21.11.2005-30.9.2009) [6]

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: 19.12.2003-30.9.2007) [5]

Dr Gregory Joseph Stewart, MBBS, MPH (Sydney), FRACMA, FAFPHM, Ministerial nominee (current term: 21.11.2005-30.9.2009) [6]

Dr Kendra Sundquist, Ed.D (UTS), MHLth.Sc.(Ed) (Sydney), RN, MCNA, Ministerial nominee (current term: 1.10.2004-30.9.2008) [6]

Dr Ian Kenneth Symington, MBBS (Sydney), FRANZCOG, FRCOG, Royal Australian and New Zealand College of Obstetricians and Gynaecologists nominee (current term: 1.10.2003-30.9.2007) [5]

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) [6]

Dr Choong-Siew Yong, MBBS (Sydney), FRANZCP, Australian Medical Association nominee (current term: 1.10.2004-30.9.2008) [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 a variety of other capacities.

Dr G Abouyanni, Dr A Abrahams, Dr S Allnutt, Dr K Arnold, Dr N Badawi, Dr A Bean, Dr M Bennett, Dr C Berglund, Dr H Bittar, Dr F Black, Dr D Brash, Dr J Brown, Dr P Browne, Dr F H Burns, Dr I Callander, Dr J Campbell, Dr M Carlton, Dr D Child, Dr A Christie, Dr C Clifton, Ms A Collier, Dr C Cooke, A/Prof M da Cruz, Dr G Curtin, Ms A Deveson, Dr M Diamond, Dr J Donsworth, Dr G Dore, Prof S Dorsch, A/Prof B Doust, Dr P Duff, Dr K Edwards, Ms G Ettinger, Dr A Evers, Dr K Fielding, Dr R Fisher, Dr D Floate, Dr T French, Dr M Friend, Dr P Friend, Dr G Frost, Dr R Gertler, Dr M Giuffrida, A/Prof A Glass, Dr M Gleeson, Prof W Glover, Dr R Gordon, Dr A Gould, Ms A Gray, Dr D Grimes, Dr R Gyaneshwar, Dr C Hampshire, Dr J Harbison, 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, Dr R Joffe, Dr M Kearney, Mr R Kelly, Dr B Kelly, Dr J Kendrick, Dr E Kertesz, Dr G Kesby, Ms H Kiel, Dr L King, Dr R King, Prof P Klineberg, Dr E Kok, Dr B Kotze, Dr P Langeluddecke, Dr C Lauer, Dr V Lele, Dr I Lorentz, Dr J Lovric,

Prof P Macneill, Dr S Mares, Dr P McInerney, Dr D McKay, Dr S Messner, Dr M Montebello, Dr P Morse, Ms M L Napier, Dr J Ng, Dr N O'Connor, Dr E O'Brien, Dr B Oliver, Dr M Pasfield, Dr C Peisah, Dr A Pethebridge, Dr J Phillips, Dr S Phillipson, Dr R Pillemer, Dr J Quilter, Dr R Rae, Dr W Reid, Dr S Renwick, Dr G Rickarby, Dr J Rodney, Dr W Ross, Dr I Rotenko, Dr J Russell, Dr J Sammut, Dr A Samuels, Mr R Smith, Dr R Spark, Dr J Spies, Dr S Spring, Dr G Steele, Dr J Stevenson, Dr I Stewart, Dr J Sullivan, Dr D Sutherland, Dr V Sutton, Dr C Tennant, Dr S Toh, Dr R Traill, Dr J Trollor, Dr P Tucker, Dr M Vamos, Dr F Varghese, Dr A Virgona, Ms A Walker, Prof R Walsh, Dr J Warden, Dr B Westmore, Dr J Wilkinson, Dr R Wilson, 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
Anthony Johnson BSc(Hons) LLB (Syd.) LLM(Lond.)	Legal Director

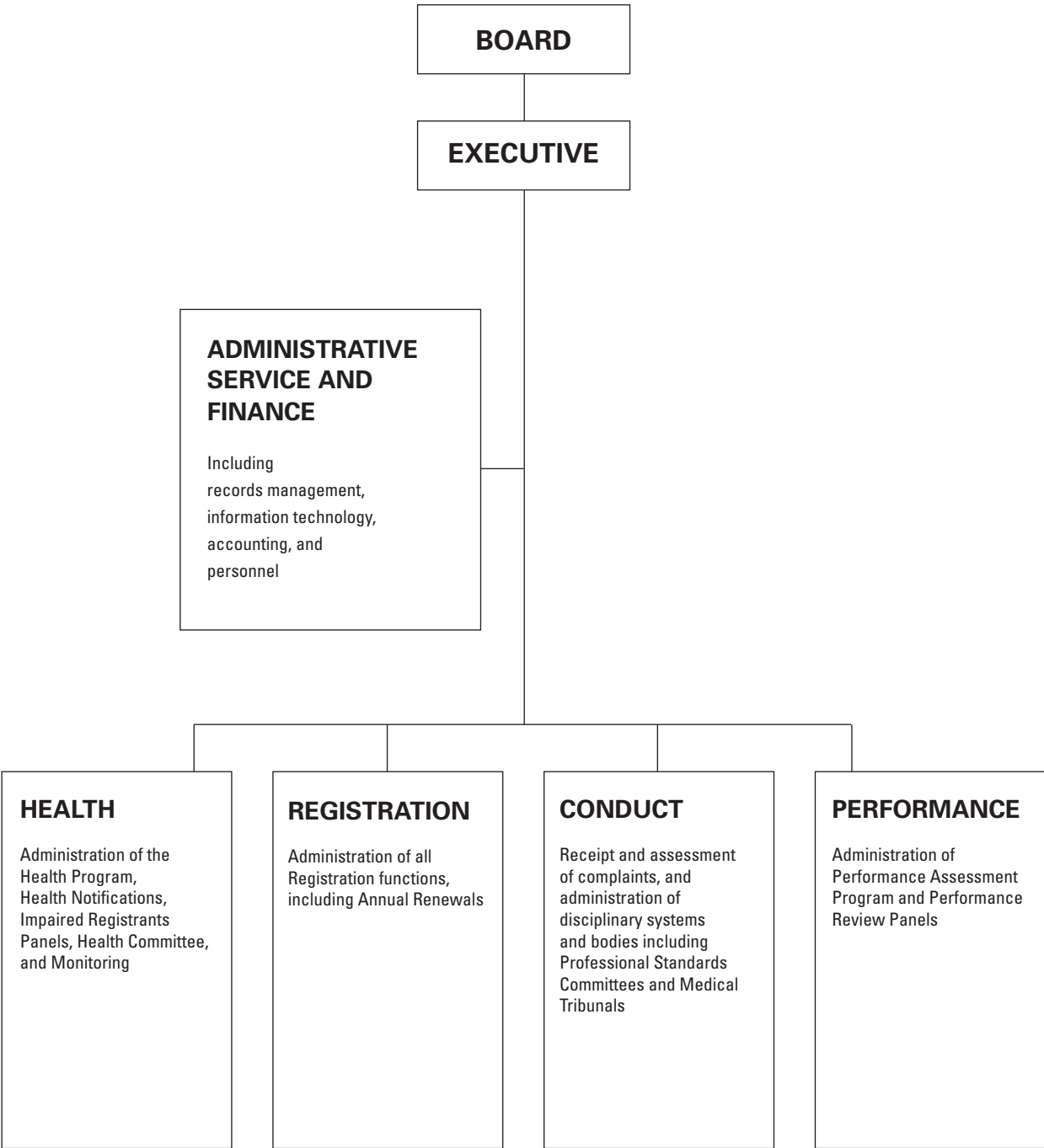
New South Wales Medical Board Committees 2006-2007

CONDUCT	HEALTH	PERFORMANCE	REGISTRATION	EXECUTIVE	CORPORATE GOVERNANCE & AUDIT
Chair: M Fearnside	Chair: K Wilhelm	Chair: G Stewart	Chair: D Smith	Chair: P Procopis	Chair: H Lapsley
B Bennett	R Benn	B Bennett	R Benn	M Fearnside	B Bennett
R McMahon	S Ieraci	M Fearnside	S Ieraci	H Lapsley	M Fearnside
R Napier	M Kelly	R McMahon	M Kelly	D Smith	R Kusuma
P Procopis	R Kusuma	F J Palmer	R Kusuma	G Stewart	P Procopis
D Smith	H Lapsley	P Procopis	H Lapsley	K Wilhelm	I Symington
G Stewart	E Molodysky	K Sundquist	E Molodysky		
K Sundquist	P Procopis	C-S Yong	R Napier		
I Symington	A Spigelman		F J Palmer		
	I Symington		P Procopis		
	C-S Yong		D Robinson		
			A Spigelman		

Non-Board Members

F Black	F Black	P Browne	S Kent (IAB)
M Hollands	J Hely	J Hely	
G Kesby	M Hollands	P Klineberg	
R Walsh	R Walsh		

> nsw medical board organisational **chart 2007**



> management & **activities**

- **Registration**

- **Professional Conduct**

- **Health**

- **Performance**

> registration

2006-2007 in summary

- 28,928 doctors and 2990 medical students were registered in NSW at 30 June 2007.
- 3522 applications for registration in NSW were granted in 2006/07, including doctors who had completed internships, practitioners from interstate and overseas, and those seeking to reinstate previous registration.
- 35% of GP applicants and 63% of RMO/CMO applicants were successful in seeking registration to work in an Area of Need.
- 2206 doctors were removed from the Register of Practitioners in 2006/07, including those who had died, removed themselves, not paid fees, or been de-registered by the Medical Tribunal.
- The Board secretariat has been actively involved in the development of agreed uniform national standards for the assessment of IMGs and the finalisation of proposals already underway for common standards of English language proficiency and primary source verification of registration documents.

Overview

All the activities of the Board's Registration Department during the year have been carried out against the background of the Council of Australian Government's (COAG) announcements for national registration, the development of uniform standards of assessment of international medical graduates (IMGs), and the continuing changes implemented nationally as a result of the Patel case in Queensland. The COAG proposals have had no immediate practical impact upon the Board's registration function, but the Board secretariat has been actively involved in the development of agreed uniform national standards for the assessment of IMGs which, when commenced, will have significant practical effects in NSW.

As reported last year, the case of Dr Patel in Queensland prompted a national review of standards regarding the vetting of IMGs, and hastened the finalisation of proposals already underway for common standards of English language proficiency and primary source verification of registration documents. To allow for appropriate lead-in time, the revised standards were implemented on a staged basis. By the end of the reporting year they were substantially fully operational. As predicted, they have now become incorporated in processes and initial concerns about their impact on workload and timeframes have been addressed.

As part of a broader review of the Board's IT systems, a number of enhancements have been made to the registration database during the year to streamline processes and to introduce a more checklist-driven system that ensures all requirements are met before registration can be granted. Upgrading of the annual renewal process has also been undertaken and clearer timeframes for processing of registration renewal documentation introduced. A major improvement in the Board's service provision has been achieved with the

publication of the Register On-line, providing information about the registration status of all registrants.

The workload of the Registration Committee and staff continues to rise with increasing numbers of registrants and growing complexity. During the year the Registration Department handled more than 30,000 telephone calls from members of the profession and the public.

Registration workflow

General registration

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

	2004/05	2005/06	2006/07
Internship Complete	432	425	442
General Registration	134	76	92
Re-registration	492	506	441
Mutual Recognition	773	778	981
AMC Complete	105	171	146
Total	1936	1956	1660

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 Australian Medical Council who have completed their internship.

→ General Registration

Applicants who hold primary medical qualifications conferred by Australian and New Zealand universities who are first time registrants in NSW, who have completed an internship and are not eligible for registration under mutual recognition legislation.

→ Re-registration

Applicants seeking restoration to the Register.

→ Mutual Recognition

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

→ **AMC Complete**

Applicants who have completed the Australian Medical Council examinations and either the required period of supervised training or have had appropriate clinical experience in Australia deemed equivalent to the required period of supervised training. Seventy-one doctors had the requirement for supervised training waived on this basis.

Conditional registration

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.

	2004/05	2005/06	2006/07*
Interns	463	452	460
AMC Graduates	95	110	95
Postgraduate Trainees	848	892	865
General Practice Trainees	152	201	112
Unmet areas of Need	114	99	97
Overseas Trained Specialists	154	126	193
Specialist Assessment	1	9	17
Academic Appointments	1	0	0
Temporary Board Discretion	6	13	23
Medical Exchange	0	0	0
TOTAL	1834	1902	1862

* Registrations granted in each category

The categories of conditional registration are defined as follows:

→ **Interns**

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

→ **Australian Medical Council Graduates**

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

→ **Postgraduate Trainees**

International medical graduates undertaking a period of postgraduate training.

→ **General Practice Training Program**

Overseas trained general practice trainees working in 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, only 29 out of 83 GP applicants interviewed and 29 out of 46 RMO/CMO applicants interviewed were successful. Thirty-one specialists were considered suitable for work in an Unmet Area of Need by the relevant specialist college.

→ **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 speciality.

→ **Overseas Trained Specialists Assessment**

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

→ **Academic Appointments**

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

→ **Public Interest**

- (i) **Temporary Board Discretion**
Conditional registration for applicants spending a minimal amount of time in New South Wales eg assisting in an operation, participating in a seminar.
- (ii) **Medical Exchange**
Conditional registration for applicants on an educational exchange, with College support.

Unsatisfactory progress

During the financial year, 30 registration interviews were held involving 26 poorly performing Interns and AMC supervised trainees. Of those:

- nine had been interviewed more than once
- five progressed to General registration
- 10 are undertaking further training
- six were removed from the Register
- one chose to undertake an internship interstate.

Three Area of Need registrants had their registration withdrawn due to unsuitability for the position.

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 for the 2006/07 year and previous years.

The table 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.

	2004/05	2005/06	2006/07
Deceased	48	116	111
At own request	408	423	346
Non payment of Registration fee	1000	904	929
Term of conditional registration expired	764	768	750
Other	0	0	0
Withdrawal	54	58	65
Medical Tribunal	4	2	5
TOTAL	2305	2304	2206
Non-practising	-	-	221
Limited Prescribing and Referral	-	-	207

> professional conduct

2006-2007 in summary

- 1155 complaints were received and assessed by the Board and the HCCC in 2006/07.
- The HCCC declined to deal with 53% of complaints, investigated 13%, and referred 16% to the Board.
- About one-third of investigated complaints (55 matters) were then referred to the Director of Proceedings to determine whether they should be prosecuted before a disciplinary body.
- The Medical Tribunal heard complaints against 17 doctors which resulted in six doctors being de-registered, 10 having conditions imposed on their registration, nine being reprimanded, and two fined.
- Seventeen doctors were referred to a PSC during 2006/07 and 20 hearings were held, resulting in nine doctors having unsatisfactory professional conduct findings made against them. All nine were reprimanded, two were fined, and six had conditions imposed on their registration.
- The number of urgent Board inquiries to take action to protect the public rose from 22 in 2005/06 to 35 this year due in large part to increased referrals about prescribing practices from the Pharmaceutical Services Branch. Twelve doctors were suspended, 19 had conditions imposed on their registration, and two doctors removed their name from the Register.

Overview

There was a reduction in the number of complaints received and assessed, down to 1155 from 1292 in the previous year. The number of matters referred to investigation by the HCCC during the year also reduced from 189 in 2005/06 to 149 this year.

Last year the Board noted the significant increase in the number of complaints being declined after initial assessment. This year 53% of complaints received were declined at this initial stage. There was a decline in the number of matters referred to the Medical Tribunal by the Director of Proceedings this year, falling from 17 to 10. There was no significant change in the number of matters referred to Professional Standards Committees, namely 20 compared with 21 in the previous year.

At 30 June 2007, 38 matters remained with the Director of Proceedings to determine whether they should be prosecuted before a disciplinary body, while 150 matters were under investigation by the HCCC.

This year saw an increase in matters from 22 to 35 where emergency suspension or imposition of conditions by the Board was considered to be required under section 66 of the Act.

The Board took over from the HCCC the role of acting as opponent in matters where a doctor seeks restoration to the register after being de-registered by the Medical Tribunal.

This period also saw the finalisation of the matters referred by the Walker Special Commission of Inquiry into Camden Campbelltown Hospitals. The table below illustrates outcomes of matters referred to the Commission for investigation by incident and practitioner:

Outcome of HCCC investigations of matters referred by Walker Special Commission of Inquiry into Camden Campbelltown Hospitals	Incident n = 70	Practitioner n = 48
No further action	37	20
Comments	17	16
Counselling	8	5
Professional Standards Committee	5*	5*
Medical Tribunal	4	4

*A complaint was withdrawn from the Tribunal by the HCCC prior to the hearing and referred to a PSC.

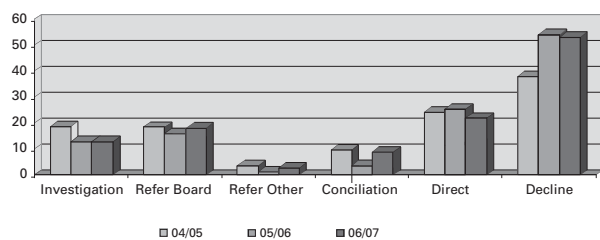
Of the complaints referred to a Professional Standards Committee, two complaints were dismissed, two complaints were not proven and one complaint resulted in the practitioner being cautioned and conditions being imposed. Of the complaints referred to the Medical Tribunal, two practitioners were reprimanded with no conditions imposed, one complaint was dismissed and one complaint was withdrawn from the Tribunal by the HCCC prior to hearing and referred to a PSC.

The complaints handling process

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

Assessment of complaints

During 2006/07, the Medical Board and the Health Care Complaints Commission received 1071 complaints about medical practitioners. The Board and Commission completed an assessment of 1155 complaints (down from 1292 in the previous year), the outcomes of which are illustrated in the following graph. The most common outcome of an assessment was a decline to deal with a complaint (53%), followed by referral to the Medical Board (16%). Thirteen per cent were referred to the HCCC for investigation.



Both the Board and Health Care Complaints Commission (HCCC) can accept complaints from the public 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 taking urgent action under s66 of the Medical Practice Act 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 7% of complaints declined in the period). The Board considers that a complaint should be referred for 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 table below illustrates the trends in complaints assessment for the past three years. It shows that complaint assessments during this reporting year have mirrored those of the last.

Outcome of complaint assessments (%)

	2004/05 n = 1080	2005/06 n = 1292	2006/07 n = 1155
Investigation	19	13	13
Refer to the Medical Board	18	15	16
Refer to another person or body	3	1	2
Conciliation	9	3	8
Direct resolution	13	14	11
Decline to deal with	38	54	53

The next table (right) shows the types of complaints lodged over the past three years. During this reporting period there was a drop in the proportion of complaints concerning competence, but this category continued to dominate as the main area of complaint and includes allegations about incorrect or inadequate treatment or clinical advice, misdiagnosis and complications following treatment.

The proportion of complaints concerning the conduct of a practitioner increased this year. This category includes complaints about professional boundaries, sexual misconduct, inappropriate prescribing, medical records, reports and certificates. Conduct complaints also include those referred to the HCCC by the Board after it takes emergency action under s66 of the Medical Practice Act.

Type of complaint (%)

	2004/05 n = 1080	2005/06 n = 1292	2006/07 n = 1155
Clinical competence	53	57	48
Communication	17	13	17
Conduct	22	22	26
Practice administration	8	8	9

Complaints investigated by the HCCC

During the year, 149 complaints were referred by 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.

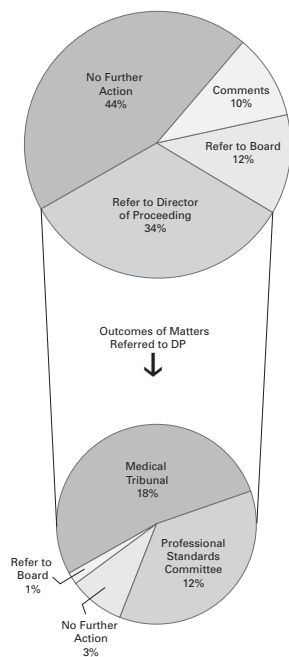
In this period 163 investigations were finalised, compared to 211 in the previous reporting year. Outcomes of the investigations during the year included:

- 44% were terminated and no further action was taken against the practitioner;
- 10% required comments to be made in the form of a letter from the HCCC to the practitioner;
- 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;
- 34% referred the matter to the Director of Proceedings to determine whether a complaint ought to be prosecuted before a disciplinary body (either a Professional Standards Committee or the Medical Tribunal)

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).

HCCC investigation outcomes 2006/07
[n=163]



Complaints referred to the Board

Of the 20 matters referred to the Board following investigations (12% of investigated complaints), 16 resulted in the practitioner being counselled by the Board, three were referred for the consideration of the Performance Program, and in one matter no further action was taken by the Board.

Complaints referred to the Director of Proceedings

During the reporting year, 55 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.

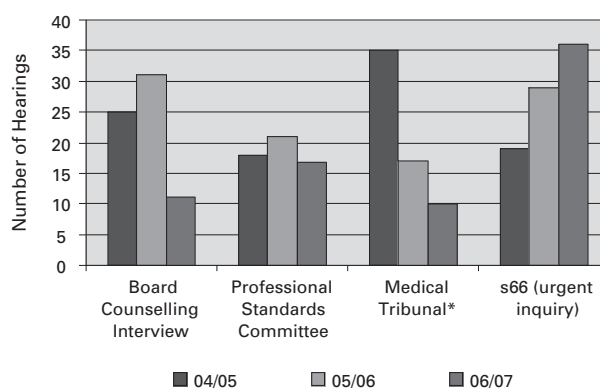
In 2006-2007, the DP referred 10 practitioners to the Medical Tribunal and 17 practitioners to a Professional Standards Committee. Of the matters the Director of Proceedings determined not to prosecute, no further action was taken in relation to four practitioners and one matter was referred back to the Board. The Board directed this practitioner to attend counselling.

Complaints remaining under investigation

At 30 June 2007, the HCCC reported 150 complaints currently under investigation and 38 matters were with the DP for consideration of possible disciplinary action.

Disciplinary hearings

The following chart illustrates the numbers of practitioners referred to disciplinary hearings, a s66 Inquiry, or counselling interviews during the past three reporting periods. It shows a decline in the number of practitioners referred to the Medical Tribunal, and a continuation of the increase in the number of urgent section 66 Inquiries conducted by the Board. This can be attributed in part to a rise in the number of referrals to the Board by the Pharmaceutical Services Branch.



* The total for Medical Tribunals refers to hearings involving complaints against practitioners and does not include appeals, or applications for review of conditions imposed or an order for de-registration.

Referral to the Medical Tribunal

In addition to complaints referred by the Director of Proceedings, three appeals and four restoration applications were commenced in the Tribunal.

Referral to a Professional Standards Committee

In total, the Director of Proceedings referred 17 complaints to Professional Standards Committees and 20 Professional Standards Committees were held.

Referral to a counselling interview

During the year, 16 practitioners were referred to the Board for counselling and 31 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.

Section 93 Application for review of conditions

There were no applications made under section 93 for a review of conditions imposed by a Professional Standards Committee.

Schedule 1 Inquiries

The Board referred five 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.

Two matters were finalised in this reporting period. In both of these matters the applicants were re-registered with imposed conditions. There are three outstanding applications to be heard, one matter requires further information from the applicant before proceeding. One Schedule 1 Inquiry decision is outstanding.

Section 66 Inquiries – Urgent action to protect the public

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

The Medical Board conducted 35 Section 66 Inquiries this year (compared with 22 the previous reporting year) and two reviews of orders imposed under section 66. Three practitioners have each been referred to two Section 66 Inquiries in this reporting period, in relation to issues of competence, breach of conditions, prescribing and impairment. Twelve practitioners were suspended during this reporting period as a result of Board exercising its powers under section 66.

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

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

Medical Tribunal

Matters commenced

In the year under review, 15 matters (including complaints, appeals, restorations and review applications) were referred to and commenced in the Medical Tribunal. This compares with 30 matters in 2005/2006 and 48 in 2004/2005.

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

Complaints	2004/05	2005/06	2006/07
Sexual misconduct	8	5	2
Prescribing	13	8	2
Breach conditions	3	1	1
Treatment	9	1	0
Competence/impairment	2	0	1
Fraud	0	0	1
Character	0	2	0
Breach of order	0	0	1
Appeals			
PSC	3	2	2
Registration	4	1	0
Conditions/suspension	0	2	0
PRP	0	0	1
Restoration	4	6	4
Review of Conditions	2	2	0
TOTAL	48	30	15

Matters finalised

The Tribunal determined matters in the following categories.

Complaints	17
Appeals	3
Reviews	5
Total	25

Matters outstanding

As at 30 June 2007, 12 matters referred to or lodged in the Tribunal in this or previous years await determination. This compares with 23 in the year ended 30 June 2006 and 34 in the year ended 30 June 2005.

Complaints

Heard/part-heard

One matter is part heard with further hearing dates in July.

Listed for hearing and to be listed for hearing

Four matters have been listed for hearing before April 2008 and 4 are yet to be listed for hearing.

Appeals

An appeal against the actions of a Performance Review Panel has been referred to the Tribunal and is yet to be listed for hearing.

Reviews

Two applications for review of a de-registration order have been lodged in the Tribunal and remain outstanding. One has a hearing date in August 2007 and the second is yet to be listed for hearing.

2006-2007 Disciplinary hearings snapshot

Summaries of individual Medical Tribunal, PSC and s66 Inquiry matters and outcomes appear in Appendices 17 - 20 of this Annual Report.

Medical Tribunal matters and outcomes

Seventeen complaints were determined by the Tribunal in 2006/07 and related to issues of prescribing, character, criminal conviction, boundary crossing, drug seeking, impairment, and false medical certificates and records. The Tribunals resulted in six doctors being de-registered, 10 having conditions imposed on their registration, nine being reprimanded, and two fined. Copies 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

Seventeen doctors were referred to a PSC during 2006/07 and 20 hearings were held related to issues of patient management, diagnosis and treatment, clinical error, use of staff, record keeping, impairment, and boundary crossing. Nine doctors had unsatisfactory professional conduct findings made against them, while eight had complaints against them dismissed. Of the nine with findings against them, all were reprimanded, two were fined, and six had conditions imposed on their registration.

Section 66 Inquiry matters and outcomes

The Board conducted 35 s66 Inquiries during the year, related to issues of prescribing, drug use, boundary crossing, criminal charges, impairment, capacity to practice, and breaching of registration conditions. Twelve doctors were suspended, 19 had conditions imposed on their registration, and two doctors removed their name from the Register.

> health

2006-2007 in summary

- 85 notifications were made to the Health Program, up from 68 and 66 notifications in the previous two reporting years.
- More than one-third were self-notifications and another third were made by colleagues or treating practitioners.
- 58 Impaired Registrants Panels (IRPs) were convened and related to psychiatric illness (58.7%), alcohol addiction (13.7%), drug addiction (20.7%), and physical impairment (6.9%).
- 82% of IRPs resulted in the practitioner agreeing to conditions on his/her registration, and 2% in suspension.
- There were 138 participants in the Program and 13 exits.
- General Health Program developments included improvements to administrative processes, the introduction of video-conferencing for selected participants, and continuing education for Board and Committee members and practitioners on bipolar disorder and adult ADHD.

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. In that time, more than 460 impaired practitioners have participated in the Program and 194 practitioners have successfully exited, having consolidated their recovery and fulfilled the Board's monitoring requirements.

The Board becomes aware of impaired practitioners through notifications and self-notifications as well as through its dealings with practitioners in the Performance, Conduct and Registration sections.

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

The average age of 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 almost 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:

	2004/05	2005/06	2006/07
Notifications to Health Program	66	68	85
Impaired Registrants Panel reports endorsed:			
Psychiatric illness	24	28	34
Alcohol	4	9	8
Drug	13	8	12
Physical	3	3	4
Total	44	48	58
Review Interviews held	211	238	246
Exits from the Program	22	19	13
Participants in Program	126	124	138

Key activities

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

Administrative processes

→ New delegation processes have been developed and trialed to manage the Committee's high workload. Under the new model, routine matters can now be considered by a single Health Committee delegate. When the delegate is in doubt or has a conflict of interest, the matter is referred to the full Committee for decision. This system has resulted in smaller Committee agendas, and may be extended as delegates and the Committee become comfortable with the change.

→ The Health Committee continues to benefit from its program of invited speakers. These presentations have been extremely valuable in affirming the Committee's approach to various types of impairment. All Board Members are invited to attend the presentations as guests of the Health Committee. In addition, a highly successful forum for Committee and Board members, Board-nominated practitioners and panel members was held in March 2007. The contribution of the following expert speakers is acknowledged with thanks:

- Dr Michael Diamond *Doctor who do not engage with the Program*
- Prof Phil Mitchell *Bipolar Disorder*
- Dr Julian Troller *Adult ADHD*

→ Selected participants in the Health Program can now use video-conferencing facilities for their regular review interviews. This initiative was developed in recognition of the significant burden that travelling to Sydney imposed on some participants.

Bipolar Disorder

Since the introduction of its Decision Parameters in 2004, the Health Committee's policy in relation to doctors with Bipolar Disorder has been that they should remain on the program indefinitely. While this policy is appropriate for doctors with unstable, relapsing disease, some stable program participants have requested removal of the conditions on their registration. Given the relapsing nature of bipolar disorder, the Committee has been reluctant to accede to these requests.

Following a stimulating discussion at the March 2007 Health Forum, a paper was prepared to canvas an alternative approach to doctors whose condition is stable and who have an established relationship with a treating practitioner. The outcome of this consultation will be reported in the next Annual Report.

Program activity

Notifications

Notifications by source	2004/05 n = 66	2005/06 n = 68	2006/07 n = 85
Colleagues (including employers)	18	13	17
Pharmaceutical Services Branch	1	6	3
Self-notifications	25	27	31
University	4	5	2
Board Committee	-	-	7
Courts	1	-	3
Treating practitioner	8	6	11
Other	9	11	11

There has been a steady increase in the number of self-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 more notifications have been received from treating practitioners, 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.

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.

Impaired Registrants Panel outcomes

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

This year, 82% of IRPs concluded with the practitioner agreeing to conditions being placed on their registration. Ten per cent resulted in no further action being taken, and 5% were referred to other Board committees. In 2% of cases, the practitioner agreed to a period of suspension.

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.

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

Case studies

• Case study 1

Dr A is a psychiatry registrar. He initially came to the attention of the Board in 2002 when he self-reported that he was suffering from depression and alcohol abuse. He attended an Impaired Registrants Panel and agreed to conditions being placed on his registration, including that he abstain from alcohol. He remained abstinent from alcohol and made excellent progress both personally and professionally. Dr A appeared to be in full recovery from his depressive illness, and he exited the Health Program in 2006. In early 2007, Dr A notified the Board that he had injected a drug from an emergency medical bag whilst intoxicated. It subsequently

emerged that Dr A had recommenced social drinking a few weeks prior to the incident and had also obtained diazepam from a colleague on a number of occasions for anxiety symptoms. There was no evidence he had had a relapse of depression at this time. Dr A attended a second Impaired Registrants Panel and agreed to conditions, noting that he had found the support and structure of the Health Program very beneficial on the previous occasion. Dr A remains compliant with the conditions on his registration.

• **Case study 2**

Dr B is a gastroenterologist, who first came to the attention of the Board when notification was received from his treating psychiatrist that he was under his care following a suicide attempt in October 2002. Dr B had voluntarily ceased work due to depression in 2001. Dr B attended an Impaired Registrants Panel in March 2003, at which time there was significant concern about his severe depression and it was agreed to adjourn the Inquiry and reconvene in three months. Dr B agreed to suspension of his registration during this period as he was not well enough to work. At the reconvened Impaired Registrants Panel in June 2003, Dr B's health had improved and he agreed to a set of conditions on his registration.

Dr B was fully compliant with his conditions and attended regular reviews at the Board. He made significant progress during his time on the Program and was extremely responsible about his medical practice, avoiding activities that have any associated risk. Based on his progress, personal and profession support and insight, Dr B exited the Health Program in March 2007.

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.

Early notification is seen as essential in supporting the impaired student, and planning their transition to internship. The university medical faculties continue to refine their management of impaired students, and some have invited advice and participation from the Medical Board. However, there is still occasional misguided reluctance to notify the Board about impaired students. The Board continues to raise this issue with the Deans of the Medical Faculties. Seven medical students were notified to the Board during 2006/7 and four attended an IRP.

Since the commencement of the provisions, 37 students have been before an Impaired Registrants Panel and 28 have had conditions placed on their undertaking clinical studies, usually including regular reporting from the relevant University.

• **Case Study**

Dr C is currently a junior doctor. She first came to the attention of the Board in June 2005 when a letter was received from the university outlining the history of her depressive illness. Dr C attended an Impaired Registrants Panel Inquiry in September 2005. At that time, the Panel concluded she was insightful about her illness and was being treated appropriately, although there were concerns that she was somewhat isolated. Conditions were placed on her student registration. She was reviewed in December 2005, at which time her compliance with conditions and progress were noted. A second Impaired Registrants Panel Inquiry was convened in June 2006 to formulate appropriate conditions, as she was about to commence her internship. At that time it was noted that she was well and stable. It was anticipated she would make the transition to internship relatively comfortably. Conditions were agreed and placed on her registration. Because of her participation in the Health Program, she was given special consideration in the intern allocation process. Dr C's progress was good and she managed the transition into the workforce without significant difficulty. It is likely that she will exit the Health Program during 2007.

Exiting the Health Program

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. The Board has now accumulated sufficient Exit Reports to conduct an analysis of data.

In the year ending 30 June 2007, a total of 27 practitioners exited the Health Program. Of these, 13 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 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. The remainder either retired from practice, died or were referred to other pathways. There is always the possibility that practitioners who have left the program will relapse and be required to re-enter the program. Practitioners with a history of self-administration of narcotics have a significantly higher risk of relapse. One registrant who had previously exited the program re-presented during 2006/7.

Conclusion

The Health Program continues to evolve in its approach to managing impaired medical practitioners and students. Confidence in the Program appears to be growing as evidenced by increasing rates of self-notification and treating practitioner notification. The Board's flexibility to move practitioners between programs is a significant benefit in ensuring an integrated approach to fitness to practice.

> performance

2006-2007 in summary

- The HCCC referred 163 complaints to the Board as performance matters, down from 189 and 202 referrals in the previous two reporting years. The decline can be attributed to the introduction of a new HCCC system of seeking doctors' responses prior to the assessment of most complaints.
- 47 complaints were recommended for a Performance Interview, up from 28 and 31 in previous reporting years. The increase reflects their growing use 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 matters considered for a full Performance Assessment remained steady at 22.
- The Board critically reviewed the Program's policies, procedures and documentation in response to challenges to Performance Assessments by several doctors. Further clarification of these challenges will have to be sought in the courts and through legislative changes.

Overview

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

The program is designed to provide an avenue for education and retraining where inadequacies are identified, while at all times ensuring that the public is appropriately protected. It aims to address patterns of practice rather than one-off incidents unless a single incident is thought to be demonstrative of a broader problem. Assessments are broad-based, and are not limited to the substance of the matter that triggered the assessment. The assessment exercise is conducted 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 (IPAC). The Board's Performance Program is internationally recognised for its innovation and excellence.

Again this year, the Board's decisions in relation to Performance Assessment have been challenged by several doctors. The Board has critically reviewed its policies, processes and documentation and it appears that clarification of the issues raised in these challenges will have to be sought in the courts.

As reported last year, experience to date has exposed a number of deficiencies and anomalies in the Performance Assessment provisions of the Medical Practice Act 1992. The Board has sought legislative amendment to ensure the integrity and ongoing success of the Performance Program but to date these proposals have not been progressed by Parliament.

Program scope

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. These complaints are considered to be 'performance matters'. 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 should undergo a detailed Performance Assessment based on this matter and other history with the Board;
- There are serious issues of professional conduct warranting referral back to the HCCC for investigation.

The process described above provides a timely mechanism by which complaints can be managed and resolved. 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 Performance Assessment 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.

Performance Assessments are conducted in the practitioner's own environment by two peers 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 2006-2007 follows.

The following table reports the number of complaints referred to the Board by the Health Care Complaints Commission. The decline in numbers is due to the fact that, in 2006, the HCCC introduced a system whereby the practitioner's response is sought prior to the assessment of most complaints, thereby increasing the information available at the time of assessment.

Complaints referred to the Board by the HCCC

	2004/05	2005/06	2006/07
	202	189	163

The following table reports the outcomes of complaints referred to the Board by the Health Care Complaints Commission. It shows that more Performance Interviews are being conducted, often as an alternative to full Performance Assessment or as an intermediate step in making a decision to conduct a full Assessment.

Outcome of complaints referred to the Board by the HCCC

	2004/05	2005/06	2006/07
No further action	131	63	97
Letter of apology to patient	8	5	12
Board letter	54	23	32
Performance Interview	31	28	47
Performance Assessment	12	3	6
Section 66 inquiry	2	0	2
Refer to Health Committee	0	1	1
Refer to HCCC for investigation	5	1	1
Direct Resolution with PSO	1	n/a	n/a
Conciliation	8	n/a	0
HCCC (for reassessment)	16	3	2
No longer registered/ suspended, action if applies for re-registration	2	1	1
Total	270	128	199

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

Outcome of Performance Interviews

	2004/05	2005/06	2006/07
No further action	14	21	31
Performance Assessment	3	7	5
Refer to Health Committee	-	-	4
Refer to Conduct Committee	-	-	1
Total	17	28	41

The following table reports the source of matters considered for full Performance Assessment. Referral from other Board Committees remains a significant source of matters, emphasising the integration of the Board's approach to fitness to practise.

Source of matters considered for Performance Assessment

	2004/05	2005/06	2006/07
Board Committee (Health, Conduct)	9	12	13
Complaint originating from:			
→ Patient	8	5	4
→ Employer	2	4	3
→ Colleague	1	2	0
→ Professional Services Review	2	1	1
→ Department of Health	0	0	1
Total	22	24	22

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

Practice area of doctors considered for full Performance Assessment

	2004/05	2005/06	2006/07
Anaesthetist	1	1	1
General practitioner	15	16	11
Obstetrician & gynaecologist	0	0	4
Ophthalmologist	1	0	1
Paediatrician	0	1	0
Pathologist	2	0	0
Physician	0	0	1
Psychiatrist	2	2	0
Radiologist	0	0	1
Surgeon	1	3	2
Trainee	0	1	1
Total	22	24	22

The following table reports the outcomes of Performance Assessments finalised in the reporting period. On receiving a report of a Performance Assessment, the Performance Committee has a range of options available to it. When the assessors identify no significant performance deficiencies, no further action is taken in relation to the practitioner. However, in most of these cases, the assessors have already used the assessment exercise to counsel, there are performance issues that do not require the Board to order remediation, but that need to be drawn to the practitioner's attention. If remediation is required, or if there are issues of public protection, then a Performance Review Panel is convened to formalise these orders.

Performance Assessment outcomes

	2004/05	2005/06	2006/07
Retired or non-practising before having PA	3	3	4
S66 prior to Assessment	1	2	1
Interim PA report	0	2	0
No further action	1	4	4
Interview after PA	0	2	0
Counselling	1	5	2
Performance Review Panel	7	7	7
Total	13	25	18

The following table reports the outcomes of Performance Review Panels held and completed during the reporting period. The Performance Program is based on remediation and retraining. 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 'shadowing' 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, require supervision etc. These conditions may be lifted after they have satisfactorily completed their remediation and been reassessed. Alternatively, practitioners may elect not to return to some aspects of their practice and remain conditionally registered in the long term.

Performance Review Panel outcomes

	2004/05	2005/06	2006/07
PRP held	5	7	8
Did not proceed (retired, name removed)	1	1	1
PRP completed – outcome:	7	9	8
counseled	0	2	0
remediation orders	6	6	7
protective orders	6	8	7

The following table reports the outcomes of re-assessments conducted after practitioners have completed their remediation program.

Outcome of reassessment

	2004/05	2005/06	2006/07
Satisfactory – exited program	2	5	0
Making progress	0	1	1
Unsatisfactory - PRP needed	0	2	0
Total	2	8	1

Case studies

The following case studies illustrate the Performance Assessment Program's work during 2006-2007:

• Case study 1

Dr X is a surgeon. His employer noted his long reputation as a skilful surgeon but raised general concerns about operative technique, effective management of intraoperative bleeding and complications and preoperative case selection. The notifier suggested that Dr X's health should be assessed in view of his age.

Dr X attended a Board-nominated neurologist who found no significant evidence of cognitive impairment. He also attended for neuropsychological testing that showed very mild cognitive decline. An Impaired Registrants Panel was convened. It was decided that Dr X's health is well-managed and that involvement with the Health Program would not offer any benefit. The Panel referred him to the Performance Committee as concerns were raised about his practice that would best be resolved in the Performance program. The Performance Committee resolved that a Performance Assessment be conducted. Two surgeons assessed Dr X's professional performance at his consulting rooms and in the operating theatre. His performance was found to be satisfactory and no further action was necessary. However, during the course of one of the observed surgical procedures the patient's X-rays were required but were unavailable and were eventually found on the ward. It was apparent that the hospital did not observe the 'Time Out' procedure for patient identification and safety.

The hospital was advised to consider implementing the beneficial Time Out procedure used in most NSW hospitals. The hospital was provided with a copy of the NSW Health Policy Directive for Patient Identification – Correct Patient, Correct Procedure and Correct Site Model Policy which includes the 'Time Out' procedure. The Board received positive feedback from the hospital which had incorporated 'Time Out' into its Procedure Manual.

This case illustrates the beneficial integration of the Health and Performance programs in assessing a practitioner's fitness to practise. It also emphasises the benefit of on-site assessment in identifying related and unrelated systems issues.

• Case study 2

Dr Y is a specialist. A complaint of verbal abuse towards an elderly patient was made by a support worker who accompanied the patient in the consultation. After considering the complaint and Dr Y's response the Committee resolved that Dr Y attend a Performance Interview. The interviewers had concerns about Dr Y's workload, his self-care and his ability to deliver quality care. The Performance Committee considered the report of the Interview and resolved that a Performance Assessment be obtained. Two assessors attended Dr Y's practice. Dr Y is fluent in several languages and is often referred patients who speak those languages. He finds it more efficient to work on his own and to manage his own appointments because of the language difficulty that reception staff seem to have with his patients.

The assessors were concerned about his extremely long work hours. He has two practices and does home visits in the evening and on Saturdays. He is frequently provided with food by the families that he visits. He sees very disadvantaged patients and feels he can't refuse to see anyone.

The assessors found that Dr Y's clinical performance was adequate. However, he remains at extremely high risk of negative professional or personal consequences as a result of his high workload and his lack of recognition of the need to maintain better personal and professional boundaries.

In considering the report of his assessment the Performance Committee resolved that Dr Y be counseled about the numbers of patients he sees per day and his current strategies for maintenance of appropriate professional boundaries. Dr Y was extremely receptive to counseling, and had already made a number of sensible changes to his practice.

This case illustrates the use of a Performance Interview as a useful intermediate step in the decision to conduct a full Performance Assessment.

• **Case study 3**

Dr Z is a procedural GP. A complaint was made by a mother in relation to a procedure on her son and included a video of the procedure. After considering the complaint and Dr Z's response, the Committee resolved that Dr Z attend a Performance Interview. The interviewers had concerns about his aseptic technique, inadequate pain relief and the quality of his surgical assistant. The Committee considered the report of the Interview and resolved that a Performance Assessment be conducted. Two assessors attended Dr Z's practice. They reported that several areas of his practice were unsatisfactory: patient management skills; interaction/ communication with patients; content of medical records and his facilities. The Performance Committee resolved that a Performance Review Panel be convened.

The Panel found that Dr Z had sold his practice but remained working there. The new owners had improved the facilities and computerised the record keeping. The Panel found Dr Z's professional performance to be unsatisfactory in certain areas, in that it was below the standard reasonably expected of a practitioner of an equivalent level of training or experience. The Panel imposed conditions on his registration so that a specific procedure could not be performed until Dr Z completed courses on aseptic technique and resuscitation. His medical records had to be improved to acceptable standard and he was to be re-assessed six months later. The Panel also recommended that he undertake appropriate Continuing Professional Development activities to improve his patient management skills in specific areas.

This case illustrates the imposition of both protective and remedial conditions, in line with the Performance Program's objective of public protection and remediation of performance deficits.

Conclusion

The scope of options that is available to the Performance Committee in response to a complaint or notification reflects the spectrum of performance difficulties that range from relatively minor to serious. The challenge for the Board is to ensure that the appropriate option is selected for each case that comes before it.

While it is disappointing that a small minority of practitioners are uncooperative with the Program, the Board is committed to delivering a Performance Program that is fair to the doctor concerned, valid, and most importantly, results in lasting improvement in the doctor's performance.

> finance and budget

Overview - Financial Performance - Year ended 30 June 2007

The total income for the period was \$8,596,000. Expenditure for the period was \$8,236,000. An operating surplus of \$360,000 was achieved in the year ended 30 June 2007.

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 (\$129,300).

The Board also contributed to the Australian Medical Council (\$185,052) and the Doctors Health Advisory Services (\$40,000).

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 (\$43,433).

Investment Performance

The return on internally managed funds for the year ended 30 June 2007 was 6.00%.

The Board's externally managed funds were held in Treasury Corporation's HourGlass Cash Facility. An average return of 6.41% was achieved for the current financial year.

Budget

Performance against Budget for the year ending 30 June 2007 and Budget for the year ending 30 July 2008

	30 June 2007 Budget (000)	30 June 2007 Actual (000)	30 June 2008 Budget (000)
Registration Fees	7,416	7,519	7,732
Fines	20	135	40
Interest	500	607	550
Profit on sale of non-current assets	-	4	-
Other	43	125	65
Area of Need Income	140	206	174
TOTAL INCOME	8,119	8,596	8,561
Salaries and related expenses	2,695	2,774	2,846
Sitting Fees	1,241	1,074	1,432
Funding Contributions	380	691	475
Computer and Consultancy	467	578	608
Members Fees	373	333	374
Medical Tribunal Funding	600	600	600
Professional Conduct and Health	400	429	412
Postage, Courier and Phone	165	244	185
Loss on disposal of assets	-	-	-
Administration Expenses	741	652	677
Superannuation	369	508	450
Vehicle, travel and accommodation	91	135	162
Depreciation and Amortisation	260	209	212
Audit Fees	15	9	17
TOTAL EXPENDITURE	7,797	8,236	8,450
OPERATING SURPLUS	322	360	111

Income

The budget for the year ending 30 June 2008 is based on the following estimates:

- a 4% increase in registrants with the annual registration fee to remain at \$270. This is due to the changes to the Mutual Recognition and Re-registration process where these categories will be charged a registration fee along with the application fee.

Expenditure

The following significant changes in expenditure are anticipated:

- 4% increase in staff salaries has been allowed.



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 2007, and the income statement, statement of recognised income and expense 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 New South Wales Medical Board as of 30 June 2007, and of its financial performance and its cash flows 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.

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 control 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 control relevant to the entity'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 entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by the *members of the 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 they have carried out their activities effectively, efficiently and economically, or
- about the effectiveness of their internal controls.

Independence

In conducting this audit, the Audit Office 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 are not compromised in their role by the possibility of losing clients or income.



M P Abood, CPA
Director, Financial Audit Services

22 October 2007
SYDNEY



New South Wales Medical Board

Statement by the members of the Board

For the period ended 30 June 2007

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

1. The financial statements for the period ended 30th June 2007 exhibit a true and fair view of the financial position and transactions of the New South Wales Medical Board; and
2. The financial statements have been prepared in accordance with Accounting Standards, Urgent Issues Group Consensus Views, other authoritative pronouncements of the Australian Accounting Standards Board, and the Public Finance and Audit Act, 1983, the Public Finance and Audit (General) Regulation, 2005, and the Treasurer's Directions.

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

President

19 October 2007

Board Member

> balance sheet

FOR THE YEAR ENDED 30 JUNE 2007

	Notes	2007 \$'000	2006 \$'000
Current Assets			
Cash and cash equivalents	7	10,110	9,416
Receivables	8	603	609
Total-Current Assets		10,713	10,025
Non-Current Assets			
Plant and Equipment	9	209	234
Intangible Assets	10	14	26
Leasehold improvements	11	2,223	2,324
Total Non Current Assets		2,446	2,584
Total Assets		13,159	12,609
Current Liabilities			
Payables	12	562	485
Provisions	13	397	353
Other	14	3,929	3,884
Total Current Liabilities		4,888	4,722
Non Current Liabilities			
Provisions	15	24	-
Total Non Current Liabilities		24	-
Total Liabilities		4,912	4,722
Net Assets		8,247	7,887
Equity			
Accumulated Funds	16	8,247	7,887
Total Equity		8,247	7,887

The accompanying notes form part of the financial report

> income statement

FOR THE YEAR ENDED 30 JUNE 2007

	Notes	2007 \$'000	2006 \$'000
Expenses from ordinary activities	2	8,236	7,363
Revenues from ordinary activities	3	8,592	7,983
Gain/(Loss) on disposal of plant and equipment	4	4	(15)
Results for the year from ordinary activities		360	605

The accompanying notes form part of the financial report

> statement of recognised income and expense

FOR THE YEAR ENDED 30 JUNE 2007

	Notes	2007 \$'000	2006 \$'000
Total Income and Expense recognised directly in Equity		0	0
Surplus / (Deficit) for the Year		360	605
Total Income and Expense recognised for the Year	16	360	605

The accompanying notes form part of the financial report

> cash flow statement

FOR THE YEAR ENDED 30 JUNE 2007

	Notes	2007 \$'000	2006 \$'000
Cash Flows from Operating Activities			
Receipts from registrants and other debtors		8,468	7,921
Payments to suppliers and employees		(8,324)	(7,133)
Interest received		614	498
Net Cash provided by operating activities	18	758	1,286
Cash Flows from Investing Activities			
Payments for leasehold improvements, plant and equipment		(96)	(110)
Proceeds from sale of plant and equipment		32	8
Net Cash used in Investing activities		(64)	(102)
Net increase in cash held		694	1,184
Cash at the beginning of the financial year		9,416	8,232
Cash at the end of the financial year	7	10,110	9,416

The accompanying notes form part of the financial report

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

FOR THE YEAR ENDED 30 JUNE 2007

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 2007 has been authorised for issue by the Board on 19th October 2007.

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 equivalents to International Financial Reporting Standards (AIFRS)), and the requirements of the Public Finance and Audit Act and Regulation.

Property, plant and equipment, assets (or disposal groups) held for sale and financial assets at "fair value through profit or loss" and "available for sale" 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 Board's financial report and notes comply with Australian Accounting Standards, which include the Australian equivalents to International Financial Reporting Standards (AIFRS).

d. 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.

e. Investment Revenue

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

f. Accounting for the Goods and Services Tax

Revenues, expenses and assets are recognised net of the amount of goods and services tax (GST), except where that amount of GST incurred is not recoverable from the Australian Taxation Office (ATO). In these circumstances the GST is recognised as part of the cost of acquisition of the asset or as part of an item of the expense.

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

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

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

g. 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. Long-term annual leave that is not expected to be taken within twelve months is measured at present value in accordance with AASB 119 Employee Benefits.

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 and Superannuation

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 07/04) 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.

The superannuation expense for the financial year is determined by using the formulae specified in the Treasurer's Directions. The superannuation expense for the financial year is calculated as a multiple of the employees superannuation contributions.

h. 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.

i. Acquisitions 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 a 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.

j. Capitalisation Thresholds

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

k. Revaluation of Plant and Equipment

Physical non-current assets are valued in accordance with "Valuation of Physical Non-Current Assets at Fair Value" Policy and Guidelines Paper (TPP 07-1). This policy adopts fair value in accordance with AASB 116 Property, Plant and Equipment and AASB 140 Investment Property.

Plant and equipment is measured on an existing use basis, where there are no feasible alternative uses in the existing natural, legal, financial and socio-political environment. However, in the limited circumstances where there are feasible alternative uses, assets are valued at their highest and best use.

There has been no re-valuation 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.

l. 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.

m. Depreciation of Plant and Equipment

Depreciation and amortisation 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%

Amortisation rates used are as follows:

Building Refurbishments - Building 54	1.70%
Building Refurbishments - Building 45	3.40%
Building Extension - Building 54	4.00%

Intangible Assets (Application software)	25%
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n. 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.

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

FOR THE YEAR ENDED 30 JUNE 2007

o. 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.

p. 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 para.(l)'.

q. 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.

r. Investments

Investments are initially recognised at fair value plus, in the case of investments not at fair value through profit or loss, transactions costs. The Board determines the classification of its financial assets after initial recognition and, when allowed and appropriate, re-evaluates this at each financial year end.

s. Payables

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

t. New Australian Accounting Standards issued but not effective

In accordance with NSW Treasury Mandates, the following new Accounting Standards have not been applied and are not yet effective:

- * AASB 7 Financial Instruments Disclosure
- * AASB 8 Operating segments
- * AASB 101 Presentation of financial statements
- * AASB 123 Borrowing costs
- * AASB 1049 Financial Reporting or General Government Sectors by Governments
- * AASB 2005-10 Amendments to Australian Accounting Standards [AASB 132, AASB 101, AASB 114, AASB 117, AASB133, AASB 139, AASB 1, AASB 4, AASB 1023, AASB 1038]
- * AASB 2007-1 Amendments to Australian Accounting Standards [AASB 2]
- * AASB 2007-2 Amendments to Australian Accounting Standards [AASB 1, AASB 117, AASB 118, AASB 120, AASB 121, AASB 127, AASB 131, AASB 139]
- * AASB 2007-3 Amendments to Australian Accounting Standards [AASB 5, AASB 6, AASB 102, AASB 107, AASB 119, AASB 127, AASB 134, AASB 136, AASB 1023, AASB 1038]
- * AASB 2007-4 Amendments to Australian Accounting Standards [AASB 1,2,3,4,5,6,7,102,107,108,110,112,114,116,117,118,119,120,121,127,128,129,130,131,132,133,134,136,137,138,139,141,1023,1038]
- * AASB 2007-5 Amendments to Australian Accounting Standards [AASB 102]
- * AASB 2007-6 Amendments to Australian Accounting Standards [AASB 1, AASB 101, AASB 107, AASB 111, AASB 116, AASB 138]

It is not anticipated that there will be any material impact for the New South Wales Medical Board during the period of initial application of these Standards.

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

FOR THE YEAR ENDED 30 JUNE 2007

	2007	2006
	\$'000	\$'000
2. EXPENDITURE FROM ORDINARY ACTIVITIES		
Salaries and related expense	2,774	2,610
Sitting Fees	1,074	1,027
Funding Contributions	691	354
Computer and Consultancy	578	504
Board Members Statutory Fees	333	307
Medical Tribunal Funding	600	600
Legal, Professional Conduct and Health Costs	429	337
Postage, Courier and Phone	244	153
General Administration Expenses	655	754
Superannuation	508	397
Vehicle, Travel and Accommodation	135	95
Depreciation and Amortisation	206	208
Auditor's remuneration-audit or review of financial reports	9	15
Software expenses written off	-	2
	8,236	7,363
3. REVENUES FROM ORDINARY ACTIVITIES		
Registration Fees	7,519	7,226
Fines	135	55
Interest Revenue (Note 5)	607	492
Other Revenue (Note 6)	331	210
	8,592	7,983
4. GAIN/(LOSS) ON SALE OF PLANT AND EQUIPMENT		
Cost of plant and equipment	44	215
Less Accumulated depreciation	(16)	(192)
Written Down Value	28	23
Less Proceeds from Disposal	(32)	(8)
Gain/(Loss) on Disposal of plant and equipment	(4)	15
5. INTEREST REVENUE		
Bank Interest	28	82
TCorp Hour Glass Cash Facility	579	410
	607	492

	2007	2006
	\$'000	\$'000
6. OTHER REVENUE		
Application Fee for Area of Need Assessments	206	141
Other	125	69
	331	210

7. CURRENT ASSETS - CASH AND CASH EQUIVALENTS

Cash at bank and on hand	321	1,806
TCorp Hour Glass Facility	9,789	7,610
	10,110	9,416

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)	10,110	9,416
Closing cash and cash equivalents (per Cash Flow Statement)	10,110	9,416

8. CURRENT ASSETS - RECEIVABLES

Accrued Interest	2	9
Other	572	584
Prepayments	29	16
	603	609

> notes to and forming part of the financial report

FOR THE YEAR ENDED 30 JUNE 2007

	2007				2006
	\$'000				\$'000
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 2006					
At Fair Value	44	116	329	199	688
Accumulated depreciation and impairment	(13)	(79)	(268)	(95)	(455)
Net Carrying Amount	31	37	61	104	233
At 30 June 2007					
At Fair Value	52	143	329	217	741
Accumulated depreciation and impairment	(5)	(96)	(297)	(134)	(532)
Net Carrying Amount	47	47	32	83	209

9. NON-CURRENT ASSETS - PLANT AND EQUIPMENT - 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 2007

Net carrying amount at start of year	31	37	61	104	233
Additions	52	27	0	18	97
Disposals	(44)	0	0	0	(44)
Depreciation expense	(8)	(17)	(29)	(39)	(93)
Other movements-write back on disposal	16	0	0	0	16
Net carrying amount at end of year	47	47	32	83	209

At 1 July 2005

At Fair Value	44	116	329	317	806
Accumulated depreciation and impairment	(5)	(64)	(239)	(246)	(554)
Net Carrying Amount	39	52	90	71	252

At 30 June 2006

At Fair Value	44	116	329	199	688
Accumulated depreciation and impairment	(13)	(79)	(268)	(95)	(455)
Net Carrying Amount	31	37	61	104	233

Reconciliation

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 2006

Net carrying amount at start of year	39	52	90	71	252
Additions	0	0	0	97	97
Disposals	0	0	0	(215)	(215)
Depreciation expense	(8)	(15)	(29)	(41)	(93)
Other movements-write back on disposal	0	0	0	192	192
Net carrying amount at end of year	31	37	61	104	233

10. NON-CURRENT ASSETS - INTANGIBLE ASSETS

	Intangibles	Total
	\$'000	\$'000
At 1 July 2006		
At Fair Value	425	425
Accumulated depreciation and impairment	(399)	(399)
Net Carrying Amount	<u>26</u>	<u>26</u>

At 30 June 2007		
At Fair Value	425	425
Accumulated depreciation and impairment	(411)	(411)
Net Carrying Amount	<u>14</u>	<u>14</u>

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 2007

Net carrying amount at start of year	26	26
Additions	0	0
Disposals	0	0
Depreciation expense	(12)	(12)
Other movements-write back on disposal	0	0
Net carrying amount at end of year	<u>14</u>	<u>14</u>

At 1 July 2005

At Fair Value	493	493
Accumulated depreciation and impairment	(464)	(464)
Net Carrying Amount	<u>29</u>	<u>29</u>

At 30 June 2006

At Fair Value	425	425
Accumulated depreciation and impairment	(399)	(399)
Net Carrying Amount	<u>26</u>	<u>26</u>

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 2006

Net carrying amount at start of year	29	29
Additions	12	12
Disposals	(81)	(81)
Depreciation expense	(13)	(13)
Other movements-write back on disposal	79	79
Net carrying amount at end of year	<u>26</u>	<u>26</u>

> notes to and forming part of the financial report

FOR THE YEAR ENDED 30 JUNE 2007

11. NON-CURRENT ASSETS - LEASEHOLD IMPROVEMENTS

	Building Extension	Refurbishment	Total
	\$'000	\$'000	\$'000
At 1 July 2006			
At Fair Value			
Accumulated depreciation and impairment	248	3,328	3,576
Net Carrying Amount	(102)	(1,150)	(1,252)
	146	2,178	2,324

At 30 June 2007			
At Fair Value	248	3,328	3,576
Accumulated depreciation and impairment	(111)	(1,242)	(1,353)
Net Carrying Amount	137	2,086	2,223

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 2007

Net carrying amount at start of year	146	2,178	2,324
Additions	0	0	0
Disposals	0	0	0
Depreciation expense	(9)	(92)	(101)
Other movements-write back on disposal	0	0	0
Net carrying amount at end of year	137	2,086	2,223

At 1 July 2005			
At Fair Value	248	3,328	3,576
Accumulated depreciation and impairment	(92)	(1,058)	(1,150)
Net Carrying Amount	156	2,270	2,426

At 30 June 2006			
At Fair Value	248	3,328	3,576
Accumulated depreciation and impairment	(102)	(1,150)	(1,252)
Net Carrying Amount	146	2,178	2,324

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 2006

Net carrying amount at start of year	156	2,270	2,426
Additions	0	0	0
Disposals	0	0	0
Depreciation expense	(10)	(92)	(102)
Other movements-write back on disposal	0	0	0
Net carrying amount at end of year	146	2,178	2,324

	2007	2006
	\$'000	\$'000
12. CURRENT LIABILITIES - PAYABLES		
Accrued expenses	477	418
Trade Creditors	85	67
	562	485

13. CURRENT LIABILITIES - PROVISIONS

Employee benefits and related on-costs		
Annual Leave Provision	251	203
Long Service Leave Provision	146	150
	397	353

Unconditional employee leave provisions are shown as a Current Liability.

The nature of these liabilities is as follows:

Annual Leave Provision		
- Short Term	185	150
- Long Term	66	53
	251	203
Long Service Leave Provision		
- Short Term	0	0
- Long Term	146	150
	146	150

14. CURRENT LIABILITIES - OTHER

Deferred Revenue	3,929	3,884
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The balance of deferred Revenue represents the amount of Registration Fees related to the unexpired portion of the annual Registration period.

15. NON CURRENT LIABILITIES - PROVISIONS

Employee benefits and related on-costs		
Long Service Leave Provision	24	-
	24	-

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

FOR THE YEAR ENDED 30 JUNE 2007

	2007	2006
	\$'000	\$'000
16. CHANGES IN EQUITY		
Accumulated funds		
Balance at the beginning of the financial year	7,887	7,282
Changes in equity- other than transactions with owners as owners		
Surplus/ (deficit) for the year	360	605
Total	360	605
Balance at the end of the financial year	8,247	7,887

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 and not provided for in the accounts

-Within one year	33	33
-Between one and five years	132	132
-Greater than five years	398	431
-Total (including GST)	563	596

The total of lease commitments as at 30 June 2007 above includes input tax credits of \$51,000 (\$54,000 in 2005/06) that are expected to be recoverable from the Australian Taxation Office.

	2007	2006
	\$'000	\$'000
18. RECONCILIATION OF SURPLUS FOR THE PERIOD TO NET CASH FLOWS FROM OPERATING ACTIVITIES		
Net Profit	360	605
Depreciation and amortisation	206	208
Net loss/(gain) on disposal of fixed assets	(4)	15
Increase/(decrease) in employee provisions	68	101
(Increase)/decrease in receivables and other assets	6	63
Increase/(decrease) in deferred revenue	45	28
Increase/(decrease) in payables	77	264
Assets written off	-	2
Net Cash provided by operating activities	758	1,286

19. CONTINGENT LIABILITIES AND CONTINGENT ASSETS

During the year, the Board has become aware of a contingent liability relating to the Board's superannuation scheme for employees. Because some past and present employees of the Board were not formally notified of their eligibility to join the scheme, these individuals may now be eligible to make backdated contributions to the scheme, which the Board would be obliged to match. The maximum potential liability of the Board is approximately \$450,000. A provision has not been booked, because it is not currently possible to reliably estimate the future uptake of the option to make backdated contributions.

20. 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 for speculative purposes. The Board does not use financial derivatives.

Cash

Cash comprises cash on hand and bank balances. Interest is earned on a daily bank balances at a commercial rate. The average interest rate for the year was 6.0% (2006-5.25%)

Receivables

All trade debtors are recognised as amounts receivable at balance date. Collectability of trade debtors is reviewed on an ongoing basis. Debts which are known to be 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. The credit risk is the carrying amount (net of any allowance for impairment). No interest is earned on trade debtors. The carrying amount approximates net fair value.

Hour Glass Investment Facilities

The Board has investments in the TCorp Hour Glass Investment Facilities. The Board's investment is represented by a number of units in managed investments within the facilities. Each facility has different investment horizons and comprises a mix of asset classes appropriate to that investment horizon. TCorp appoints and monitors fund managers, and establishes and monitors the application of appropriate investment guidelines.

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

FOR THE YEAR ENDED 30 JUNE 2007

The Board's Investments are:

	2007	2006
	\$000	\$000
Cash Facility	9,789	7,610

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

The average interest rate for the year was 6.41% (2006-5.69%)

Bank Overdraft

The Board does not have a bank overdraft facility.

Trade Creditors and Accruals

The liabilities are recognised for amounts due to be paid in the future for goods or services received, whether or not invoiced. Amounts owing to suppliers (which are unsecured) are settled in accordance with 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 statement is received. Treasurer's Direction 219.01 allows the Minister to award interest for late payment. The rate of interest applied during the year was 0% (2006- Nil %).

21. ANNOUNCEMENT REGARDING THE FUTURE OF THE BOARD

The Council of Australian Governments announced on the 14th July, 2006 that agreement was reached on the arrangements for a new national system for registration of health professionals and the accreditation of their training and education programs for implementation by July 2008.

The accounts of the New South Wales Medical Board as at 30 June 2007 have been prepared on a going concern basis, because management consider it likely that the implementation of the new national scheme will be delayed beyond July 2008, and that the Board will continue in its current role for more than 12 months beyond the date of signing the accounts.

End of Financial Report

> appendices

Appendix 1:	Employees
Appendix 2:	Equal Employment Opportunity
Appendix 3:	NSW Government Action Plan for Women
Appendix 4:	Occupational Health and Safety
Appendix 5:	Insurance and risk management
Appendix 6:	Legal change
Appendix 7:	Departures from Subordinate Legislation Act
Appendix 8:	Ethnic Affairs Priority Statement
Appendix 9:	Overseas travel
Appendix 10:	Waste Reduction and Purchasing Policy
Appendix 11:	Use of consultants
Appendix 12:	Consumer response
Appendix 13:	Freedom of Information
Appendix 14:	Privacy management
Appendix 15:	Policies and publications
Appendix 16:	Overview of complaints bodies and processes
Appendix 17:	Professional Standards Committee case summaries
Appendix 18:	Section 66 Inquiry summaries
Appendix 19:	Schedule 1 Inquiry summaries
Appendix 20:	Medical Tribunal summaries
Appendix 21:	Matters in other jurisdictions

Appendix 1: Employees

This year saw the departure of nine staff from the Board, including the Registration Manager and two Coordinators (Conduct) and (Monitoring). Nine new staff were appointed and 15 staff promoted from within the Board during the year. From May to December 2006, one of the Board's Legal Officer's was seconded to the NSW Department of Health. The Board also engaged a part-time media consultant to assist with media relations, publications and dealing with stakeholders generally.

Staff Development

Staff attended a wide range of relevant external training courses, seminars and in-house activities, in areas such as record management, staff management, communication, reporting, medical and health law, business writing, management of difficult clients, and IT software. Staff also attended Hearing Member training workshops. Continuing Professional Development also occurred during the year for relevant staff.

Sick Leave

	03/04	04/05	05/06	06/07
Days lost	265	183	280	285
Per person average	7.5	4.9	7.37	7.31

Executive Officers

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

Appendix 2: 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 2006-2007	Male	Female	Aboriginal/Torres Strait Islander	NESB
40	5	35	0	9

Four female and two male staff are in management positions.

Appendix 3: NSW Government Action Plan for Women

The NSW Government Action Plan for Women outlines the NSW Government's policy commitments, priorities and initiatives for women and sets out a whole-of-government approach to addressing women's issues and concerns. The Plan also considers the ways in which Government agencies take account of women in delivering their core services.

The Board is committed to gender equity within the workforce, to promoting equitable work practices, and to developing our female staff, and will continue to actively support this initiative in the future.

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 2006-2007 year with only six minor reports of injury.

Appendix 6: Legal change

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

New prohibition order powers

As of 4 December 2006, the Medical Tribunal has the power to make a 'prohibition order' to prevent a de-registered doctor from providing other health services.

New laws passed by NSW Parliament in December aimed to address circumstances in which practitioners have been deregistered but then continue to practise in unregistered health fields.

For example, a de-registered psychiatrist could try to continue to work as a psychotherapist or counsellor.

Under the NSW Health Legislation Amendment (Unregistered Health Practitioners) Act 2006, the Tribunal has the power to make a prohibition order if it is satisfied that a person 'poses a substantial risk to the health of members of the public'.

In such cases the Tribunal may:

- prohibit the person from providing health services or specified health services;
- place conditions on the provision of health services or specified health services.

The prohibition or conditions may be for a specified period or permanent.

Online Medical Tribunal decisions

Another change made to the Medical Practice Act 1992 introduced by the NSW Health Legislation Amendment (Unregistered Health Practitioners) Act 2006, requires the Board to publish Medical Tribunal

decisions. Medical Tribunal decisions are being placed on the Board's website, subject to any relevant non-publication directions. Work is ongoing to have all publishable past decisions on the site, which will result in about 400 decisions being available online. Other relevant court decisions are also being placed on the website. Currently there are more than 320 decisions on the website.

List of unregistered doctors online

The NSW Health Legislation Amendment (Unregistered Health Practitioners) Act 2006 also requires the Board to publish a list of persons who are currently de-registered. The list appears on the Board's website.

The current list of 114 persons details the date of the deregistration order and the period the deregistered person must wait before applying to be re-registered as a medical practitioner.

The laws also require affected persons to inform each of their prospective patients about their prohibition order and de-registration, and to include the information in any advertising.

New laws proposed for emergency powers

New legislative proposals to clarify and support the Medical Board's ability to act in an emergency situation under section 66 of the Medical Practice Act 1992 were announced by then Health Minister John Hatzistergos in early 2007.

The announcement followed a Ministerial inquiry held in December 2006 into the adequacy of the Board's powers and processes to take urgent action to protect the life or physical or mental health of any person. Legislation is anticipated in the Spring 2007 session of Parliament.

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 2006-2007.

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 ethnicity of applicants. The Board is, however, able to grant discretionary registration, and it is in this area that it has focused its attention to ensure equal treatment, regardless of country of origin or training.

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

- Continuing development of policies to facilitate access to area of need and postgraduate training positions
- Continued support for the Postgraduate Medical Council orientation course designed to assist AMC graduates prior to their entering teaching hospitals for their requisite period of supervised training
- Monitoring the number of Panel members from non-English speaking backgrounds sitting on Professional Standards Committees, Medical Tribunals, Impaired Registrants Panels, Performance Review Panels, conducting peer audits and Board Reviews
- Presentation at Information Sessions for overseas trained doctors
- Membership of the Department of Health/Australian Doctors Trained Overseas Association Liaison Committee
29 practitioners were approved for GP area of need positions, 29 for RMO/CMO positions and 31 for specialist positions. These practitioners are overseas-trained doctors from a range of countries such as South Africa, India, China, Philippines, Pakistan, Egypt, United Kingdom, the Netherlands and Burma.

Strategies identified for the forthcoming year include the following:

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

Appendix 9: Overseas travel

Board members Peter Procopis, Michael Fearnside, Maria Kelly, Helen Lapsley, Denis Smith, Allan Spigelman, Greg Stewart and Choong-Siew Yong, Committee members Frances Black and Joanna Hely, and Board staff Alison Reid and Diane Mackowski, travelled to Wellington, New Zealand, to attend the International Association of Medical Regulatory Authorities (IAMRA) seventh conference, 11-14 November 2006.

Board staff also attended a meeting of the International Physician Assessment Coalition in Wellington, New Zealand, prior to the IAMRA conference (8-11 November 2006).

Appendix 10: Waste Reduction and Purchasing Policy

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

Appendix 11: Use of consultants

Consultancies equal to or more than \$30,000

Consultant	Cost	Title/Nature
Checknet Pty Ltd	\$124,714	IT Support and project management
Oakton Consulting Pty Ltd	\$110,679	Accounting package support and project expenses
Axis Technology Pty Ltd	\$133,740	Database support and project expenses
Internal Audit Bureau	\$818	Accounting
	\$86,603	Business Analysis
	\$8,450	IT Environment review
Edwina Light	\$41,329	Media Consultant
Total consultancies equal to or more than \$30,000	\$506,333	

Consultancies less than \$30,000

The University of Sydney	\$10,039	Project expenses-50%
I dex on line Pty Ltd	\$1,860	Provision for 360 degree feedback
Total consultancies less than \$30,000	\$11,899	
Total Consultancies	\$518,232	

Appendix 12: Consumer response

During 2006-2007, the Board received a small number of complaints from the public and members of the profession. These largely related to unhappiness with the outcome of complaints or investigations concerning medical practice. The publication of the Register of Medical Practitioners online generated some complaints regarding privacy and access to information. These 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.

Appendix 13: Freedom of Information

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

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

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

During 2006-2007, the Medical Board received nine 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 13 applications for access to documents under the Act within the required timeframe. This compares with 18 applications in 2005/2006 and 11 applications in 2004/2005. The Board provides practitioners with information sought from their personal files unless the FOI exemptions apply. This year, the Board complied with requests from seven practitioners to access all or some of the information on their files. In addition, one application received in the previous reporting year was provided with additional documents.

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

In the reporting period, three applications were received for an internal review of the Board's decision. One internal review application did not proceed and the other two, upon review resulted in no additional documents being provided to the applicants. 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 Medical Practice Act. It deals with the collection, use, disclosure, security and quality of this information in accordance with the Privacy and Personal Information Protection Act 1998 and the Health Records and Information Privacy Act 2002.

The Board is required to maintain a register of all medical

practitioners in New South Wales and to make the information on the register publicly available. The Board makes allowances for registered medical practitioners to have their registered address suppressed on the Register in accordance with Section 58 of the Privacy and Personal Information Protection Act 1998. A number of medical practitioners have asked the Board to suppress such details. Five applications for internal review under Part 5 of the Privacy and Personal Information Protection Act 1998 were received and finalised 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 its primary means of communicating with the public and the profession, and the site is updated regularly to reflect legislative and policy changes, and to provide an electronic interface with inquirers and registrants.

Publications and information available on the website to registrants and the public include the *Code of Professional Conduct: Good Medical Practice* as well as other specific policies on medical practice and standards.

The Board newsletter, *Board News*, is sent bi-annually to all registrants and relevant stakeholders, and issues covered in this reporting period have included:

- National registration proposals
- Emergency powers
- Registration processes, issues and developments
- The online Register
- Code of Professional Conduct
- Standards for delegating treatment
- New laws on unregistered practitioners
- False sickness certificates
- Over-servicing
- CPD requirements
- Patient record summaries
- Medical Tribunal decisions.

Board News is also made publicly available on the website.

The Board also communicates relevant developments directly to hospital stakeholders via a Bulletin, which during the year covered registration and international medical graduate issues.

In 2006-2007, the Board reviewed its database of public and media inquiries and published a set of frequently asked questions and answers on its website to enhance the publicly available information about the Board and its processes.

Board members and secretariat staff speak at seminars, conferences and meetings on a wide range of issues.

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 inquires, and to monitor any conditions or restrictions on a medical practitioners practice of medicine.

→ **The Health Care Complaints Commission (HCCC):** The HCCC's role in relation to complaints is to investigate and prosecute complaints in relation to medical practitioners and to consult with the 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):** A PSC is an independent inquiry body 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:** A 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 2007, the HCCC referred complaints in relation to 17 practitioners to Professional Standards Committees (PSCs), and 20 Professional Standards Committee hearings were held. Some examples of the types of matters dealt with at these PSC hearings are reproduced below.

Patient management

A GP/VMO at a small country hospital was responsible for the assessment and care of an elderly patient who was admitted to emergency during the early hours of the morning. The practitioner's responsibility extended from the time of admission to the time of transfer. The practitioner, however, failed to attend and review the patient despite being requested by nursing staff to do so and despite being advised about a marked deterioration in the patient's condition. The practitioner was reprimanded by the Committee.

Use of inappropriate staff

A metropolitan GP employed his wife, a qualified enrolled nurse, as practice manager. Her enrolment status had been cancelled for non-payment of registration fees. Her principal duties in the practice were administrative but she undertook some nursing duties.

The complaint arose from a patient allegation that the practitioner allowed his wife to perform duties that, as an unregistered enrolled nurse, she was not qualified to perform. The issue before the PSC was not the GP's medical competence but his failure, as the principal of a medical practice, to fulfil his obligation to ensure his staff members are appropriately qualified and registered to undertake the duties allocated to them.

He was found guilty of unsatisfactory professional conduct as his wife had administered Schedule 8 drugs. The practitioner was reprimanded and fined \$5,500.

Diagnosis and care

A four-year-old child with unexplained vomiting came under the care of a paediatrician and others at a major teaching hospital. After assessment by the paediatrician's team, extensive consultations and investigations, no clinical abnormality was found. A CAT scan revealed no abnormalities. After four weeks admission, an MRI scan revealed an extremely rare cerebral tumour in the brain stem (cervicomedullary) in an unusual location poorly visualised on CAT scan. Curative treatment was not possible and the child died some months later.

The complaint alleged that the practitioner failed to consider a neurological cause or obtain a neurological review or an MRI in a timely manner. Almost all cerebral tumours in children are diagnosed relatively late, and particularly brain stem tumours. While MRI is the preferred investigation, most will have a CAT scan first. The 'normal' CAT excluded a tumour and diverted attention from a neurological cause so other investigations were pursued.

Following a careful review of all the evidence available and taking into account the appropriate weighting of the peer reviewers' opinions, circumstances existing, and the rarity of the condition, the PSC was not able to be satisfied to the required level of proof that any of the particulars of the complaint were proven and it was dismissed.

Treatment and workload

A radiologist allegedly failed to report properly on an x-ray which identified a mass in the right posterior thorax. The patient was inappropriately discharged home only to have a diagnosis of Stage IV Neuroblastoma made two years later. The delay in diagnosis resulted in the enlargement of the tumour and metastases forming prior to any treatment being offered.

The HCCC's peer reviewer rejected that workload and working conditions constituted 'an acceptable excuse' for falling below an acceptable standard.

The practitioner admitted that he failed to diagnose the abnormality on the chest x-ray in question and expressed sincere regret at this mistake. The doctor blamed the conditions in which he worked for the 'mistake' but he said the workload was not unusual.

The Committee recognised the environmental challenges the practitioner faced when reviewing the x-ray but noted many radiologists face the same challenges. The Committee found the complaint of unsatisfactory professional conduct proved and determined that the doctor be reprimanded and conditions be imposed on his registration.

Boundary crossing

A GP also practising as a psychotherapist treated the wife of a practitioner colleague for two years. She presented with depression,

anxiety, panic attacks and severe alcohol dependence. During the therapeutic relationship she made overt expressions of sexual interest which became more blatant as consultations progressed. The practitioner was found guilty of unsatisfactory professional conduct in relation to his ongoing treatment of a patient with whom he had social contact and his failure to cease the therapeutic relationship and refer the patient to another practitioner. He was severely reprimanded and conditions were imposed that required him to see a mentor for 12 months.

Post-op treatment

A VMO surgeon had just completed his first year of private practice in upper gastrointestinal surgery and was undertaking a locum position at the time of the conduct that was the subject of the complaint. The six particulars of the complaint concerned his post op care for a patient for whom he had performed semi-urgent elective surgery. It was undisputed by any of the five experts who gave evidence that the patient presented a particularly difficult diagnostic challenge and the Committee was of the view that the decisions faced by the practitioner were not clear cut. The practitioner was not found guilty of unsatisfactory professional conduct.

Boundary crossing

A GP was found guilty of professional misconduct arising out of his consensual sexual relationship with a patient, who was also his medical receptionist. The patient maintained that she did not consider herself to have been the victim of inappropriate behaviour, nor to have been exploited. The Committee noted it is because of the risk of exploitation and harm that the legislation and approved standards of conduct have been formulated. The Board's Sexual Misconduct Policy is based on tenets long adhered to and acknowledged by the medical profession. *'It is an absolute rule that a medical practitioner who engages in sexual activity with a current patient is guilty of professional misconduct.'* *Not even a consensual relationship between the patient and practitioner can be excused or tolerated. The Committee relied on the Queensland Court of Appeal decision in Medical Board of Qld v Thurling: 'The contention that the relationship was relevantly consensual ignores the feature that it arose out of the inherently unequal professional relationship between doctor and patient...'*

The practitioner was found guilty of professional misconduct. He was severely reprimanded and conditions were imposed on his registration.

Appendix 18: Section 66 Inquiry summaries

The Board is required under section 66 of the Act to take action by either suspending a practitioner or imposing conditions on the registration of a practitioner if such action is necessary to protect the life or physical or mental health of any person. The Board conducted 35 s66 Inquiries during the reporting year. Some examples of matters considered by the Board are reproduced below.

Inappropriate prescribing

The Board was advised that a GP was recently investigated by the Pharmaceutical Services Branch concerning his prescribing of both steroids and benzodiazepines to patients, his self-prescribing, his health, and breaches of the doctor-patient boundary. The medical practitioner made a number of admissions during the course of the Inquiry concerning his inappropriate prescribing to patients and discussed his use of alcohol and benzodiazepines. The delegates of the Board considered that the gravity of the practitioner's misconduct and his lack of insight about the harm and risk he had exposed his patients to, together with his lack of compliance with his legislative responsibilities, required the practitioner's immediate suspension.

Prescribing while suspended

The Pharmaceutical Services Branch (PSB) conducted an investigation into the prescribing practices of a GP that had been working in a hospital setting.

The PSB investigation demonstrated that the doctor had been prescribing restricted substances in a false name while her registration was suspended. The delegates of the Board found that the conduct was caused by the doctor's impairment, and health and restrictive practice conditions were placed on the doctor's registration.

Prescribing practices

A s66 inquiry was held in relation to an elderly doctor's prescribing of restricted substances, including his failure to obtain relevant authorities to prescribe, and his failure to appreciate or understand proper patient management, especially those with chronic pain or drug dependency issues. During the hearing the practitioner elected to change his registration to the non-practising category and no further action was taken by the delegates of the Board.

Breaching conditions

The Board received information from the Pharmaceutical Services Branch that a GP had continued to write prescriptions for Schedule 8 and Schedule 4D medications despite registration conditions imposed by an earlier section 66 Inquiry which prohibited such conduct. Information was also received indicating that the practitioner had failed to maintain his professional indemnity insurance. The Inquiry suspended the practitioner with immediate effect.

Breaching professional boundaries

In the course of an impaired medical practitioner's review with a Board-nominated psychiatrist, the practitioner revealed that he had recently formed a relationship with woman who he had met and treated in the emergency department of the hospital where he was employed. An earlier incident which involved inappropriate written contact with a female staff member was also considered at the Inquiry. The delegates considered that the public could be adequately protected by ensuring further monitoring and supervision

of the doctor's practice. The delegates imposed further conditions on the doctor's registration removing the time limit on his employment supervision and requiring the practitioner to obtain Board approval prior to changing the nature or place of his employment.

Breaching conditions

A GP had been enrolled in the Impaired Registrants Program since 2002 following self-administration of pethidine. There had been concerns about isolated positive results following urine drug testing (UDT), the adequacy of supervision, dilute samples and missed testing. The Inquiry was convened following the receipt of a report from the Pharmaceutical Services Branch which indicated that the practitioner had continued to collect large quantities of Mersyndol Forte through prescriptions written in her name. She had been warned and counselled on two previous occasions concerning this conduct. The delegates could not be satisfied whether or not the medication had been used for self-medication because at times her UDT has been incomplete and the results uncertain. Following consideration of the matter, the delegates determined to suspend the practitioner.

Impairment

The Board received a complaint from a patient alleging that a psychiatrist was under the influence of alcohol during a consultation. The complaint was considered in the context of the psychiatrist's previous involvement with the Board's Health Program because of alcohol abuse. The psychiatrist admitted that he had relapsed and consumed alcohol. Conditions were imposed on the psychiatrist's registration to address concerns about his professional isolation and to ensure that he received appropriate treatment and remained abstinent from alcohol through ongoing monitoring. It was also recommended that the psychiatrist be referred to an Impaired Registrants Panel following assessment by a Board-nominated psychiatrist.

Capacity

The Board received information that a part-time GP was not fit to practise. The Board had the mature practitioner assessed by a mini-health exam which concluded he had a delusional disorder associated with paranoia and grandiosity. During the Inquiry the practitioner made a number of admissions which raised concerns about his clinical practice and handling of medication. The Inquiry imposed conditions on the practitioner's registration which included full neuropsychometric testing, explicit conditions that he does not treat his wife, and that he must not possess S4D or S8 drugs. In light of the prescribing practices highlighted by a Pharmaceutical Services Branch investigation, the Inquiry was concerned that practitioner had little insight concerning the breadth of knowledge and skills required in general practice. The Inquiry asked that the Board's Performance Committee consider a performance assessment for this practitioner.

Inappropriate prescribing

A practitioner who had spent the last 10 years doing locum work was investigated by Pharmaceutical Benefits Branch concerning his self-prescribing, and prescribing to his partner, of various drugs not in compliance with professional standards. At the Inquiry the practitioner admitted to prescribing a variety of medications such as DHEA and testosterone troches, Diazepam ampoules, Edronax, Ketamine, pethidine and Ritalin, in his name as the patient when in fact the medication was intended for the use of his partner. The delegates of the Board considered that the seriousness of the practitioner's misconduct and his lack of insight about the harm and risk he had exposed himself and his partner to, together with his lack of compliance with his legislative responsibilities, required the practitioner's immediate suspension.

Breach of conditions/impairment

A rural solo GP was a participant in the Health Program. The Pharmaceutical Services Branch informed the Board of concerns that the practitioner was self-injecting pethidine and phenergan. The practitioner was also in material breach of both his practice and health registration conditions. The delegates were strongly of the view the practitioner should be suspended as he manifested a lack of insight in relation to his health and the inappropriate aspects of his practising medicine which may have had significant adverse consequences for both himself and his patients.

Inappropriate prescribing

A GP was investigated by Pharmaceutical Services Branch concerning apparent inappropriate prescribing of benzodiazepines for a large number of patients. The PSB reported that its concerns about the GP's prescribing were compounded by his responses when interviewed by its officers, his age (79 years), and his poor prescribing records. After having given some evidence at the Section 66 Inquiry (which gave rise to the delegates having great concern about his practise of medicine) the GP decided to retire immediately and provided a written request that his name be removed from the Register. The Inquiry was discontinued.

Breach of conditions

A general surgeon was in breach of the conditions on his registration in that there were delays of up to 56 days between him providing urine samples for testing and the samples reaching the testing service. As a result the Board could not meaningfully monitor his drug taking status. The evidence demonstrated that the practitioner was complying with his conditions in this regard and that the delays appeared to be due to the supervisor. The importance of compliance with conditions was discussed, but no action was taken under section 66.

Review of suspension

An obstetrician who had been suspended in April 2006 for breach of registration conditions, having obtained large amounts of pethidine by forging prescriptions, applied to have the suspension lifted.

The application was successful due to demonstrated progress with treatment and development of insight into the practitioner's addiction. The practitioner was considered safe to return to very restricted practice, but with no after hours responsibilities, under close supervision and with the benefit of consulting a mentor. Health registration conditions were also re-imposed.

Charge of sexual assault

A solo GP, being the subject of two charges of indecent assault and one charge of aggravated indecent assault allegedly in relation to two incidents in his surgery involving two adult female patients, had conditions imposed on his registration by a s66 Inquiry. The conditions included the requirement that he have a nurse chaperone present whenever he provided any medical service to a female patient.

Drug use/forging prescriptions

A GP participant in the Board's Health Program was found to have obtained and self-administered pethidine on four separate occasions over the previous year, having previously advised the Board he would be on leave and therefore unable to provide the required urine samples for drug testing. The practitioner admitted forgery of another practitioner's signature on receipt of the pethidine. The seriousness of the relapses was considered to have been compounded by the deceptive conduct involved. The practitioner was considered to be at high risk of further relapse and to have ongoing impaired judgment in relation to his addiction and was suspended.

Capacity to practise medicine

A GP self-notified to the Board that he had been convicted of shoplifting in the context of having drunk alcohol. This led to a psychiatric assessment and neuro-psychological testing being performed. The tests concluded that the practitioner was significantly cognitively impaired and that he was at high risk of making major errors in his medical practice. The s66 delegates were unable to reconcile the practitioner's seemingly appropriate and logical presentation at the Inquiry with the concerning test results. Health conditions were imposed while the practitioner undergoes further medical investigation and he was referred to the Board's Health Program.

Inappropriate prescribing

A CMO was referred to a s66 Inquiry following a report by Pharmaceutical Services Branch which raised concerns about the practitioner's health and his inappropriate or dangerous prescribing of methylphenidate, dexamphetamine, morphine, antidepressants and benzodiazepines.

The practitioner admitted prescribing for his father, who he was treating for depression, his mother, his sisters and a friend. He was aware that his prescribing had been both inappropriate and potentially dangerous. Conditions were imposed on his registration requiring him to relinquish his authorities under Schedule 8 and 4D; and prohibiting him being the primary care provider for himself or immediate family members except in an emergency. His conditions

required him to attend a Board-nominated psychiatrist and an Impaired Registrants Panel prior to recommencing work.

Inappropriate prescribing/breach of conditions

In 1997, a Medical Tribunal found a metropolitan GP guilty of professional misconduct arising out of his prescribing of benzodiazepines and narcotic analgesics and his name was removed from the Register. In 2000 his application for re-registration was successful and he was restored to the Register with a number of conditions restricting his prescribing and requiring supervision. The Board became aware that the practitioner had breached his Tribunal imposed conditions when he administered Pethidine and Morphine intramuscularly to a patient several times per week over a period of years and failed to inform the principal or practice manager of his conditions. His failure to comply with the conditions imposed to protect the public was a serious matter. As no further conditions could be applied, the practitioner was suspended.

Inappropriate prescribing

A metropolitan GP was counselled by the Pharmaceutical Services Branch in 2002 about his prescribing of anabolic/androgenic steroids, benzodiazepines and various Schedule 8 drugs and was advised to obtain prior authority if he wished to prescribe drugs of addiction. In 2006, the PSB initiated another investigation following numerous complaints alleging inappropriate and/or dangerous prescribing of drugs of addiction. The PSB found deficiencies in his prescribing records, and that he had prescribed Schedule 8 drugs without authority for periods ranging from four to 18 months. At the Section 66 Inquiry the practitioner stated that he thought he was helping patients but conceded that he had not made adequate inquiries as to whether they were obtaining drugs from another doctor or were in the methadone program. The Board imposed conditions requiring the practitioner to relinquish his authorities under Schedule 8 and 4D and other conditions.

Charged with a sexual offence

A solo metropolitan GP notified the Board that he had been charged by Police with 'assault with an act of indecency' and the alleged assault took place in the course of the practise of medicine against a female aged 24. The practitioner, on legal advice, was unable to respond to the allegations. It was not the Board's role to give any consideration to his guilt or innocence in relation to the criminal charges. In view of the seriousness of the charge the Inquiry determined that the public would be protected by chaperone conditions being placed on his registration.

Conviction for criminal offence

A practitioner was found guilty by a jury after trial of two criminal offences – sexual intercourse without consent and assault. The offences did not arise in his practice of medicine. At the time of the Inquiry the doctor was subject to strict bail conditions and awaited sentence. He subsequently appealed against his conviction. The Inquiry noted a finding of fact by a jury of two serious offences and

the criminal process was not yet concluded. The delegates noted that the whole situation might change as soon as the appeal was determined but that the Board had a duty to protect the public. It imposed conditions requiring chaperones for intimate examination of female patients over 14 years and Board approval prior to commencing and thereafter changing the nature or place of his employment.

Appendix 19: Schedule 1 Inquiries

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. Some examples of practitioners the subject matter of an inquiry are reproduced below.

Registration after 10 years

The medical practitioner sought re-registration although he had not practised medicine for approximately 10 years. The medical practitioner had previously been employed as a Career Medical Officer in psychiatry. The Inquiry found that the practitioner had endeavoured to update his knowledge in relevant areas of psychiatric medicine and the more common aspects of physical medicine. He presented as having a cautious, insightful approach to the practice of medicine which suggested that he would work within the limits of his knowledge and experience and seek the guidance of others when appropriate. The practitioner was eligible for re-registration subject to conditions requiring the medical practitioner to work in a hospital-based position for a period of 12 months with four-monthly reports to be provided to the Board by his clinical manager.

Registration after voluntary removal

A GP applied to be re-registered after taken his own name off the Register two years earlier. Just prior to the practitioner's name being removed from the register the Medical Tribunal had imposed conditions upon the practitioner's registration. The Inquiry approved the doctor's re-registration but imposed additional conditions that clarified some aspects of the supervision ordered by the Medical Tribunal.

Appendix 20: Medical Tribunal summaries

Medical Tribunal decisions are published in full on the Board's website (subject to any relevant non-publication directions). Readers are advised to read the full decision and to ascertain the current status of any medical practitioner's registration on the Board's online register and not to rely on the summary.

A. Complaints determined by the Medical Tribunal

Complaints against obstetrician dismissed

The following matter is a clarification from page 24 of the 2006 annual report and replaces the summary contained in that report:

Dr X – Non-publication order on doctor's name

An obstetrician had two complaints against him dismissed in the Tribunal. The Tribunal stated:

'No doubt there are cases where an individual mis-judgment is so egregious that it demonstrates there is a lack of adequate knowledge, skill, judgment, or care. On the other hand there may be many mis-judgments made in the course of emergency situations that do not constitute or demonstrate a lack of adequate knowledge, skill, judgment, or care. Minds may differ in this case as to whether or not at an earlier stage the practitioner should have called, or could have called, a paediatrician. The weight of the evidence that has been tendered is that there was no such requirement in the circumstances of this case. Allowing for a spectrum of views about it and including the view of Dr [called by the HCCC] it may be that some people could come to the conclusion that this was a case where for more abundant caution a paediatrician could have been called at an earlier stage. If that conclusion were reached however, in my view it would not constitute unsatisfactory professional conduct because in the circumstances of this case it would merely demonstrate a mistaken judgment on a particular issue. From my own point of view I do not believe there was such a mistake and the evidence does not support it, but if there were it is not such a mistake as could possibly be categorised as unsatisfactory professional conduct. Accordingly I would dismiss both complaints.'

Prescribing

Dr Adrian John Cohen

The complaint alleged that Dr Cohen, a general practitioner, had obtained cocaine for his own use by issuing prescriptions in the names of patients. Further allegations concerned Dr Cohen's purchasing drugs at wholesale prices for use overseas and at sporting venues in Australia despite not holding a wholesale licence, obtaining drugs via his doctor's bag order which were allocated to various centres where he provided medical services, and failing to keep a drug register. The Tribunal found the conduct proven, found Dr Cohen guilty of professional misconduct and unsatisfactory professional conduct, reprimanded him, fined him \$15,000, and imposed supervision and health-related conditions on his registration.

Dr Steven Anthony Goodman

The complaint alleged that Dr Goodman, a general practitioner, had inappropriately prescribed restricted substances and drugs of addiction in excessive quantities to drug dependent patients. Dr Goodman admitted to all of the particulars of the complaint and admitted that his conduct amounted to professional misconduct. The Tribunal found that Dr Goodman knew at all relevant times that his course of prescribing posed significant risks to his patients. The Tribunal found Dr Goodman guilty of professional misconduct and ordered that his name be removed from the Register of Medical Practitioners and that he not apply to be re-registered for a period of three years.

Dr Christopher James Roberts

The complaint concerned allegations that Dr Roberts, a general practitioner, had inappropriately prescribed restricted substances and drugs of addiction in excessive quantities to drug dependent patients. Dr Roberts admitted to all of the particulars of the complaint and admitted that his conduct amounted to professional misconduct. The practice by Dr Roberts in prescribing benzodiazepines on demand to drug addicted patients was an anathema to proper standards of professional medical practice and drew extreme disapproval from his peers.

The Tribunal found Dr Roberts guilty of professional misconduct and ordered that his name be removed from the Register of Medical Practitioners and that he not apply to be re-registered for a period of five years. Dr Roberts was also prohibited from offering a health service in the nature of counselling until such time as he was re-registered.

Dr Brendan Thomas O'Sullivan

Sydney psychiatrist Dr Brendan O'Sullivan was found guilty of unsatisfactory professional conduct for prescribing flunitrazepam inappropriately to a patient. The practitioner was reprimanded and orders were made in relation to his involvement with continuing medical education.

Dr Gregory George Wilcox

Solo metropolitan GP Dr Gregory Wilcox purchased, at the wholesale price of \$55,892.54, large quantities of anabolic/androgenic steroids and pituitary hormones known to have high illicit value. The Board conducted a section 66 Inquiry in 2003 and imposed conditions under its emergency powers to protect the public. In the Tribunal proceedings, the practitioner admitted that contrary to the regulations and without responsible medical judgment he supplied/prescribed hCG to 13 patients; supplied/prescribed Clomid and inappropriately prescribed testosterone contrary to regulation; failed to make proper medical records and was in breach of his registration conditions. The practitioner was found guilty of unsatisfactory professional conduct and professional misconduct. The Tribunal found that with appropriate conditions the public would be protected adequately and he could continue to practise. He was fined \$25,000 and stringent practice and health conditions imposed on his registration.

Dr Chuen (Wallis) Lam

Dr Lam, a GP, had his name removed from the Register of Medical Practitioners after a finding of professional misconduct, with an order that no application for review be made within two years. The main issue during the hearing was inappropriate prescribing of anabolic/androgenic steroids and human growth hormones to numerous patients. The Tribunal considered the practitioner demonstrated little insight into the severity of the potential consequences of his conduct, and found parts of his evidence to be deliberately and demonstrably false.

Prescribing and boundary crossing

Dr Nicholas Kalokerinos

Shellharbour GP Dr Nicholas Kalokerinos was found guilty of professional misconduct in relation to his prescribing of drugs of addiction to 15 patients over an extended period and in relation to his failure to maintain proper professional boundaries in relation to a 17-year-old female patient, particularly on two occasions after he had offered to give her driving lessons.

The Tribunal was not persuaded Dr Kalokerinos had reformed in the time since the conduct had occurred and found him to be a 'most unsatisfactory witness'. The Tribunal ordered Dr Kalokerinos's name be removed from the Register of Medical Practitioners and that he not apply to be re-registered for three years.

Criminal conviction

Dr Leonard Albert Ware

Anaesthetist Dr Leonard Ware was charged and sentenced on 23 September 2005 at Wagga Wagga District Court in relation to firearm offences and was sentenced to two years imprisonment with a non-parole period of 12 months. The Board made a complaint to the HCCC based on Dr Ware's criminal conviction. The complaint was referred to the Medical Tribunal, which reprimanded him and imposed conditions on his registration.

Character and prescribing

Dr John Gawdat Shashati

Dr John Shashati, a GP, faced allegations of inappropriately prescribing excessive amounts of medication to 11 of his patients and lying to previous hearings. Immediately prior to the Tribunal he disclosed a long-standing drug addiction and depression. Given the persistent lies in the face of those who were in a position to assist Dr Shashati - including the Board, Board reviewers, and treating practitioners - and the lies maintained and continued during the hearing, the Tribunal did not believe it could have confidence that he was a person whom the public and profession could repose confidence. This was the first time a 'not of good character' complaint had been made out solely on allegations of lying to the Board and the Pharmaceutical Services Branch. The Tribunal ordered Dr Shashati's name be removed from the Register of Medical Practitioners and that he not apply to be re-registered for three years.

Character and terminations of pregnancy

Dr Suman Sood

Dr Suman Sood was a GP practising in the area of women's health, particularly performing terminations. She was found guilty of unsatisfactory professional conduct and professional misconduct, as well as being not of good character. Eleven complaints were prosecuted in the Tribunal.

The complaints established show that the respondent:

- (a) lacks competence as a medical practitioner;*
- (b) is dishonest with her patients, fellow professionals, and the Health Insurance Commission;*
- (c) has knowingly misled the Medical Board and the District Court and others;*
- (d) has failed to keep proper medical records, and has created false ones when she has seen it as necessary in her own interests;*
- (e) shows indifference to orders of the Medical Board and to legislation which regulates the Medical Profession.*
- (f) Has difficulties learning from complaints and peer reviews.'*

The Tribunal ordered that the respondent be de-registered and that she not apply for re-registration for 10 years.

Character and false medical certificates

Dr Rupasen Karalasingham

Solo metropolitan GP Dr Rupasen Karalasingham issued fraudulent medical certificates to non-citizen overseas students to cover their breach of their student visa requirements, provided false and misleading information to the Board, and the created false medical records. The Tribunal found him guilty of professional misconduct but a complaint that he was not of good character was dismissed. The practitioner was reprimanded, fined \$20,000 and conditions concerning mentorship and ethics training were imposed. At the date of publication of this report an appeal had been lodged by the HCCC.

Impairment and drug seeking

Dr Dale Lynton Schnapp

Dr Dale Schnapp, a specialist anaesthetist, was registered in NSW under mutual recognition provisions subject to a number of conditions, which reflected those imposed in Victoria due to his addiction to drugs. In 2001 he came to the attention of the NSW Medical Board for behaviour possibly associated with drug-seeking. He was initially suspended then further conditions were placed on his registration. He appealed to the Medical Tribunal, which in 2002 confirmed the Board's action. In the 2007 complaint proceedings the practitioner admitted that he had sought to remove Propofol from a hospital with the intention of diverting it for his own use, and had inappropriately attempted to dissuade two members of nursing staff at the hospital from completing incident forms about his conduct. The Tribunal found that he 'showed very little understanding of how his behaviour would have been seen by those supervising the conditions on his registration...and that he, as a practitioner who had abused drugs, should expect to be subjected to a higher level of scrutiny than others.' The Tribunal found him guilty of unsatisfactory professional conduct. It noted that the practitioner currently practises in Victoria without any conditions and ordered that he should not practise medicine in NSW without conditions on his registration.

Boundary crossing

Dr David Ellis

This GP was found guilty of professional misconduct for having continued to treat Patient A over several years whilst he had a personal and sexual relationship with her. He also failed to refer Patient A to another GP, and failed to keep adequate medical records of her treatment. He was reprimanded and conditions were imposed on his registration, requiring him to do an ethics course, appoint a professional mentor and submit to an audit of his medical records.

Dr Engsan Teoh

This gynaecologist was found guilty of unsatisfactory professional conduct and reprimanded for inappropriate remarks made to a patient, who was seeking a hysterectomy, during a consultation. An allegation of inappropriate examination of the patient's nipple without clinical justification was not proven.

Dr B (temporary non-publication order on doctor's name, until 1 January 2008)

Dr B, a psychiatrist, was found guilty of professional misconduct in relation to his inappropriate continuation of providing psychotherapy to Patient A after he had developed personal feelings for her, which were disclosed to her, and while he was discussing the possibility of pursuing a personal relationship with her. He inappropriately entered into a personal and sexual relationship with Patient A. He was found to currently have significant insight into his previous behaviour, to be undergoing appropriate continued psychiatric treatment for his depressive illness, and to have ongoing support from peers. Dr B was reprimanded and health and practice conditions were imposed on his registration, which require Dr B's clinical practice and compliance with conditions to be supervised.

B. Appeals determined by the Medical Tribunal

Professional Standards Committee

Two appeals against decisions of Professional Standards Committees on points of law were filed in the Tribunal by the HCCC. In one matter consent orders were filed and the Chief Judge of the Medical Tribunal remitted the matter back to the PSC to provide additional reasons for its decision. In the other matter the Commission was successful and their appeal was upheld.

A third appeal on a point of law was lodged by the HCCC in the previous reporting period but the appeal was determined by the Tribunal in this period. That matter was remitted back to a new PSC to determine the admissibility question in accordance with the law.

Dr Paramalingam Lingathas

An appeal was lodged in the Medical Tribunal by the HCCC on a question of law. The matter was heard by the Deputy Chairperson of the Tribunal sitting alone. The question of law involved the decision

of the PSC to refuse to admit a number of expert reports on the basis that they did not comply with section 30 of the Health Care Complaints Act 1993 which requires an expert to make a declaration of no personal, financial or professional connection with the medical practitioner, and the fact that they reports had been obtained for different purposes and were hence unreliable. Leaving aside the second issue in determining the appeal, the Tribunal found that section 30 has no application to the reports obtained by the HCCC after it had completed its investigation. The matter was remitted to the PSC to determine the admissibility question in accordance with the law.

C. Reviews by the Medical Tribunal

Restoration to the Register

During 2006/07 the Tribunal handed down four decisions in respect of applications for review of de-registration orders. The Tribunal refused all applications for restoration. An application filed in the previous reporting period was dismissed by the Chief Judge of the Medical Tribunal.

Michael Jacob Bar-Mordecai

In 2000, the applicant was struck off the Register after he had engaged in unethical conduct in that he commenced a sexual relationship with a patient, had obtained financial advantages from her and had administered 30 mg morphine to her and signed her death certificate. The Tribunal ordered that there could be no application for a review of its de-registration order for seven years. The Board sought to have the re-registration application struck out on the basis he was premature in his application. The applicant proposed that this proscription did not apply as he 'significant fresh evidence' that would lead the Tribunal to re-consider the 2000 order. The Tribunal remarked that Mr Bar-Mordecai had already exhausted the avenues available to him in the Court of Appeal to challenge the Tribunal's 2000 decision to deregister him. The Tribunal dismissed the application.

Rick Patrick Dallas

Following the Board's prosecution, the practitioner was convicted of offences of aiding and abetting his brother Mark Dallas, (who was not and never had been registered as a medical practitioner), to hold himself out as willing to perform medical services in Rick Dallas' metropolitan general practice. Based on his conviction, the Tribunal found Rick Dallas guilty of professional misconduct and ordered his deregistration in 2000 with no review for four years. In 2007 he sought a review of his de-registration, which the Tribunal dismissed. 'While matters such as the effect of the criminal and disciplinary proceedings on an applicant may have great cost in terms of money, emotional stress and privation, and be highly relevant if the purpose of these proceedings was punitive, the purpose of these proceedings is entirely protective.' The Tribunal found it difficult 'to ascertain from the applicant's version of events, when and how he became aware of what his brother was doing, why he permitted it to occur once he

became aware of it, and the nature and extent of the role he played in the conduct that led to his de-registration.'

Mr Bruce Desmond Litchfield

Mr Litchfield was removed from the register in 1997 following a finding of the Medical Tribunal that he was guilty of professional misconduct. His misconduct involved sexual misconduct connected to three female patients who lodged formal complaints and a fourth patient who made no formal complaint. Mr Litchfield repeatedly inferred that the allegations were based on inadequacies in his communication skills and explanations of medical procedures, introducing preventative or alternative medical techniques and engaging in conversation at personal levels. There was further inconsistency between his acceptance that his conduct was sexually motivated and his proposition that he projected sexual needs or a want of sexual gratification. This evidence had the appearance of an attempt to minimise the serious nature of his misconduct. The Tribunal did not accept that Mr Litchfield had the required level of insight into his misconduct. What was fatal was the inconsistency between an acknowledgment that the allegations were true and the assertion that the conduct involved was in some way justified or misinterpreted. The Tribunal was not satisfied that Mr Litchfield would not re-offend if reinstated to the Register of Medical Practitioners. The application for reinstatement was rejected.

Mansoor Haider Zaidi

This solo GP was charged with sexual and/or indecent assault on five patients during 1986-88. While on bail a further alleged assault was committed on a patient in 1990. The Tribunal, finding that he had breached his registration conditions on his registration and was guilty of professional misconduct in relation to three patients, ordered his de-registration in 1990. Subsequently, the Court of Criminal Appeal overturned his convictions and ordered new trials. He was found not guilty in relation to one patient and the other two patients did not wish to give further evidence and those charges were withdrawn. The final result was that he was found not guilty or no bills were entered in relation to all criminal charges laid against him. In 2007 the Tribunal considered his fourth application for a review of the 1990 de-registration order. In dismissing the application, the Tribunal was of the view that his unsuitability to practise is so entrenched that it doubted that he will ever be an appropriate candidate for readmission and stated: '...we have already indicated that it is not the Tribunal's role to punish, but we do not accept that the "needs of the community" could be served by allowing an unsuitable candidate to practise.'

Review of conditions

One practitioner filed an application for a review of conditions imposed by a Professional Standards Committee.

Dr Frank Simonson

The practitioner is a GP in rural area of need. In 1995 a PSC found

the practitioner guilty of unsatisfactory professional conduct arising from his prescribing and imposed conditions on his registration. The Tribunal granted his application for the restrictions on his prescribing rights to be lifted on the basis that 11 years had passed since the restrictions were imposed, the practitioner had been compliant with his conditions during the period, he was now a sole practitioner and could not pass the care of patients needing such medication to his partner as he had in the past, and that the practitioner worked in a rural area of need and there was a public benefit in having the restrictions removed.

D. Appeals against Tribunal decisions

Seven appeals against decisions of the Medical Tribunal have been lodged in the NSW Court of Appeal in this reporting period. Of these the HCCC was successful in having one appeal struck out and one appeal was later withdrawn by the practitioner. Three matters have hearing dates for later in 2007 and a further two matters are awaiting allocation of hearing dates. An appeal against the decision of the Board to conduct a Performance Assessment in the previous reporting period was withdrawn by the practitioner, who is now no longer registered. Two appeals were determined by the NSW Court of Appeal during the reporting period.

Rivera v HCCC

The Medical Tribunal was found correct in its use of 'similar fact evidence' to assist with its determination of a second complaint against the medical practitioner. 'Similar fact evidence' is a way of using evidence from a series of incidents or actions that are strikingly similar in nature.

The Court of Appeal considered the issue in relation to Medical Tribunal decisions in a case in which patient A's allegations against Dr Rivera included that in February 2000 he had performed a non-consensual and not clinically-indicated genital examination, and had failed to adhere to standard infection control requirements. Another patient (B) alleged that, in September 2000, Dr Rivera performed a not clinically-indicated visual examination of her genital area. In another examination later that month, patient B alleged he repeated this act, and also inappropriately rubbed her anus and clitoris and massaged her legs, and failed to adhere to standard infection control requirements.

The two sets of allegations from totally unrelated persons had sufficient similarities to assist the Tribunal in drawing the conclusion that the required standard of proof had been reached for two of the three alleged incidents. The Court of Appeal agreed the Tribunal had not made an error in law. The doctor's appeal against the decision was dismissed.

Saville v HCCC & Anor

The practitioner's appeal on a question of law was centred around the issue that a Medical Tribunal had imposed conditions on a practitioner's registration which were not contained in proposed

consent orders agreed between the HCCC and the practitioner.

The practitioner had earlier exercised his right to appeal from the orders of a Professional Standards Committee to the Medical Tribunal. His notice of appeal alleged, in general terms, that the conditions were 'excessive and unnecessary in light of the nature and extent of the unchallenged findings of unsatisfactory professional conduct'. However, prior to the hearing before the Tribunal, he reached agreement with the Commission that the constraints on his ability to operate as a sole general practitioner were unnecessary. A statement of agreed facts was prepared, together with consent orders which removed the conditions imposed by the Committee that limited his rights in respect of practising in general practice by himself. The Tribunal however considered that the proposed consent orders did not afford adequate protection to the public.

The Court of Appeal held that the Tribunal was not limited to the acceptance of the orders proposed by the parties and could impose further conditions on the practitioner in order to protect the public.

Appendix 21: Matters in other jurisdictions

Administrative Decisions Tribunal

JD v NSW Medical Board

On 3 November 2005 the Administrative Decisions Tribunal (ADT) found that the Board had disclosed personal information to the Pharmaceutical Services Branch (PSB) concerning "JD", a registered medical practitioner in breach of the Privacy and Personal Information Protection Act 1998. On 5 December 2006 the Board was ordered to pay to JD damages of \$7,500. The maximum that can be awarded by the ADT is \$40,000.

Local Court

The Board successfully prosecuted Nancy Xiao under section 105 of the Medical Practice Act for falsely holding herself out as a registered medical practitioner.

Xiao, 51, of Hurstville, had never been a registered medical practitioner in Australia and was consulted by a woman, 36, who was planning to have a baby and wanted to check that she was healthy for when that happened. Following an examination, Xiao located an externally protruding haemorrhoid and offered to provide a Traditional Chinese Medical treatment to remove it. Xiao removed the haemorrhoid by tying it with silk thread soaked in a traditional Chinese preparation. Xiao told the woman that the haemorrhoid would 'drop off' after about five days, but the woman was admitted to Concord Hospital for 10 days when the area where the haemorrhoid had been tied became necrotic and infected and required surgery.

On 21 July 2006, Xiao was convicted and fined \$3000 in Sutherland Local Court for holding herself out as having been entitled, qualified, able or willing to carry out the procedure. She was placed on a three-year good behaviour bond and ordered to pay the Board's legal costs.

