



NEW ★ SOUTH ★ WALES
Medical Board



2008 **annual** report



annual report **2008**

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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 medical practitioners are fit to practise, so 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 2008

The Hon Mr John Della Bosca
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 2008.

The report has been prepared in accordance with the provisions of the Annual Reports (Statutory Bodies) Act, 1984 and the Public Finance and Audit Act, 1983.

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

Yours sincerely



P G Procopis
President

Enclosure

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> president's report

The Board passed two significant, although conflicting, milestones during the year. The Board reached its 170-year anniversary, and Australian governments signed off on the implementation of a national registration system by July 2010. The Board has come an extraordinary distance since its formation in 1838, and approaching an end to the existence of the Board in its current form can only be done with mixed feelings.

A National Registration and Accreditation Implementation Project Team was formed in Canberra and the Board looks forward to making a positive contribution to its consultations on the development of a national scheme in the months and years ahead. The Board supports the principle of national registration provided its well developed programs and standards are not lost.

October 2007 also marked the 20th anniversary of the Board becoming an independent statutory body and the implementation of the disciplinary and organisational structure that became a model for other health boards in NSW. Since 1987, the number of doctors registered to practise in NSW has risen from 18,000 to 30,000, complaints have almost tripled to more than 1,100, and the innovative non-disciplinary Health and Performance programs have been introduced to enhance public protection and safety and quality in medical care. In the search for registration uniformity and health workforce solutions under a national model, the Board will continue to emphasise the need to safeguard public protection and medical standards, and to maintain the Health and Performance schemes that have strengthened the effectiveness of medical regulation.

The year's national registration agenda also included the development of a uniform approach to the registration of international medical graduates. The consultation and preparation for nationally consistent assessment and registration pathways for IMGs has been important and demanding, and the Board has worked hard to contribute positively to the process and to ensure the procedural and IT structures are in place for effective implementation in the year ahead.

Last year I reported on the expected increase in the number of interns entering the hospital system due to government policies to increase Australian medical student places. This year's report on Board registration activities shows that intern registrations rose by 25% compared to the previous three years. With intern numbers to grow over the coming years, the impact on hospitals will continue to require careful management. Although cognisant of these demands, the Board will continue to require that internships include successful completion of an emergency department term before a practitioner moves to general registration.

As this reporting year drew to a close, the Board was also working toward implementation of the provisions of the NSW Medical Practice Amendment Act 2008, passed by NSW Parliament in June 2008. The legislative reforms strengthen and clarify the Board's powers to

protect the public and ensure doctors are fit to practise medicine. Aspects of the new laws had been in development for some time, including improvements to its emergency powers. Others provisions followed a review of matters relating to de-registered doctor Graeme Stephen Reeves. Since the emergence of allegations of serious new complaints against Mr Reeves in early 2008, the Board actively encouraged any person with new information to come forward so matters may be appropriately dealt with.

The circumstances surrounding the employment in 2002 of Reeves as a visiting medical officer in obstetrics and gynaecology by the former Southern Area Health Service were investigated by Peter Garling SC, as part of the Special Commission of Inquiry - Acute Care Services in NSW Public Hospitals. The Inquiry's report on the matters relating to Mr Reeves came to the same conclusion as the Medical Tribunal that de-registered him in 2004, that is, the main reason he was recruited to fill a position he was legally unable to fulfil was his 'intentional and calculated dishonesty'. The Garling report also noted developments in Board processes that had already taken place since that time.

During the year, the Board noted the departure of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists' nominee Dr Ian Symington, and Department of Health nominee Denise Robinson, after eight and three years, respectively, of valuable contribution to the Board. Dr Greg Kesby was welcomed as the Royal Australian and New Zealand College of Obstetricians and Gynaecologists' nominee.



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.

	2005/06	2006/07	2007/08
Registration			
The following indicates the number of registrants by category on 30 June 2008.			
Category of Registration			
General	22630	23253	23872
Interns	496	469	581
AMC Registrants undertaking supervised training	137	116	81
Postgraduate Trainees	1326	1577	1757
General Practice Trainees	197	96	94
Areas of Need	249	245	246
Conditional Specialists	746	885	1050
Specialist Trainees	21	20	23
Retired/Non-Practising/Limited Prescribing and Referral	2116	2254	2311
Other (includes academic and temporary Board discretion)	-	13	21
Student registrants	3118	2990	3195
Total registrants	31036	31918	33231
Professional Conduct			
Complaints assessed	1292	1155	1116
PSCs concluded	9	20	18
Medical Tribunals concluded	37	25	15
Counselling Interviews finalised	22	31	18
Section 66 Inquiries conducted	22	35	26
Health			
Doctors in Health Program	124	138	134
Entrants to Program	29	42	50
IRPs convened	44	58	71
Board Review Interviews	238	246	260
Performance			
Doctors in Performance Program	42	40	45
Entrants to Program	22	20	20
Assessments concluded	28	12	17
PRPs concluded	9	8	8
Retired as a result of participation	4	5	3
Performance Interviews concluded	28	41	50

> structure of the board and secretariat

Membership of the NSW Medical Board

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

Members of the Board, their qualifications, terms of appointment and nominating bodies for the period 1 July 2007 to 30 June 2008 are listed below. During this period six ordinary meetings and one extraordinary meeting were held. Attendances at these Board Meetings are recorded in square brackets.

A/Professor Peter George Procopis, President, AM, MBBS (Sydney), FRACP, Royal Australasian College of Physicians nominee (current term: 1.10.2007-30.9.2011) [6]

A/Professor Michael Robert Fearnside, Deputy President, AM, MBBS (Sydney), MS (Sydney), FRACS, Royal Australasian College of Surgeons nominee (current term: 1.10.2004-30.09.2008) [5]

A/Professor Richard Alan Vickery Benn, AM, B.Sc (Med) (Sydney), MBBS (Sydney), FRACP, FRCPA, Royal College of Pathologists of Australasia nominee (term expired: 31.07.2008) [6]

A/Professor Belinda Bennett, B Ec. LLB (Macquarie), LLM SJD (Wisconsin), GAICD, Legal Member nominated by the Minister (current term: 7.6.2006-6.6.2010) [5]

Dr Susan Ieraci, MBBS (Sydney), FACEM, Ministerial nominee (current term: 1.10.2007-30.9.2011) [5]

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

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

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

Professor Helen Madeleine Lapsley, BA (Auckland), MEc (Sydney), FCHSE, Ministerial nominee (current term: 1.10.2006-17.11.2008) [7]

A/Professor Eugen Molodysky, OAM, MBBS (Sydney), PhD (Sydney), DRACOG, MRACGP, Community Relations Commission nominee (24.5.2006-30.9.2009) [7]

A/Professor Rodney James McMahon, MBBS (Sydney), Flt Lt (ret), DRCOG, DRANZCOG, FAIM, FRACGP, Royal Australian College of General Practitioners nominee (current term: 1.10.2006-30.9.2010) [6]

Dr Robyn Stretton Napier, MBBS (Sydney), Australian Medical Association nominee (current term: 1.10.2004-30.9.2008) [6]

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) [4]

Dr Denise Margaret Robinson, MBBS (Sydney), MHP, FAFPHM, MRACMA, Department of Health nominee (resigned 1.05.2008) [5]

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

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

Dr Gregory Joseph Stewart, MBBS, MPH (Sydney), FRACMA, FAFPHM, Ministerial nominee (current term: 21.11.2005-30.9.2009) [4]

Dr Kendra Sundquist, Ed.D (UTS), MHlth.Sc.(Ed) (Sydney), RN, MCNA, Ministerial nominee (current term: 1.10.2004-30.9.2008) [5]

Dr Ian Kenneth Symington, MBBS (Sydney), FRANZCOG, FRCOG, Royal Australian and New Zealand College of Obstetricians and Gynaecologists nominee (term expired 30.9.2007) [1]

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) [7]

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

The Board acknowledges the invaluable contribution of the following members of the profession and the public who serve as members of Medical Tribunals, Professional Standards Committees, Impaired Registrants Panels, interview panels, Committees, and in a variety of other capacities.

Dr G Abouyanni, Dr A Abrahams, Dr I Alexander, Dr S Allnutt, Dr P Anderson, Dr K Arnold, Dr K Atkinson, Dr R Barnett, Dr M Bennett, Dr C Berglund, Dr H Bittar, Dr F Black, Dr P Bland, Dr D Brash, Dr J Brown, Dr L Brown, Dr G Burton, Dr D Child, Dr A Christie, Ms A Collier, A/Prof M da Cruz, Dr P Curtin, Dr V DeCarvalho, Ms A

Deveson, Dr M Diamond, Dr A Dilley, Dr M Dodd, Dr G Dore, Dr J Dudley, Dr P Duff, Dr K Edwards, Ms G Ettinger, Dr N Evans, Dr A Evers, Dr R Fisher, Dr D Floate, Dr T French, Dr M Friend, Dr S Giltrap, 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 C Hampshire, Dr J Harbison, Prof B Harris, Dr N Harris, Dr P Harvey-Sutton, Dr J Hely, Dr M Hollands, Ms J Houen, Dr S Howle, Dr D Hunt, Dr K Hutt, Dr K Ilbery, Mr D Jackett, Dr M Jarrett, Dr R Joffe, Dr M Kearney, Mr R Kelly, Dr B Kelly, Dr A Kemp, Dr J Kendrick, Dr J Kennedy, Dr E Kertesz, Ms H Kiel, Dr L King, Dr R King, Prof P Klineberg, Dr E Kok, Dr B Kotze, Dr P Langeluddecke, Dr N Latt, Dr V Lele, Dr I Lorentz, Dr J Lovric, Prof P Macneill, Dr S Mares, Dr M McGrath, Dr P McInerney, Dr D McKay, Dr S Messner, Dr P Morse, Dr M Mulligan, Ms M L Napier, Dr J Ng, Dr N O'Connor, Dr E O'Brien, Dr M Pasfield, Dr C Peisah, Dr A Pethebridge, Dr J Phillips, Dr S Phillipson, Dr R Rae, Dr W Reid, Dr

S Renwick, Dr G Rickarby, Dr J Rodney, Dr I Rotenko, Dr D Rowe, Dr J Sammut, Dr A Samuels, Dr P Schofield, Dr Y Skinner, Mr R Smith, Dr R Spark, Dr J Spies, Dr G Steele, Dr I Stewart, Dr E Summers, Dr D Sutherland, Dr V Sutton, Dr I Symington, Dr S Toh, Dr E Tompsett, Dr P Tucker, Dr M Vamos, Dr F Varghese, Dr J Vaughan, Dr A Virgona, Ms A Walker, Dr M Walker, Prof R Walsh, Dr J Warden, Dr B Westmore, Dr P Wijeratne, Dr I Wilcox, Dr J Wilkinson, Dr M Wright, Dr M Wroth, Dr P Wyllie, Dr G Yeo, Dr I Zetler.

Senior Officers

Andrew Dix BA LLB (Syd.)
Registrar/CEO

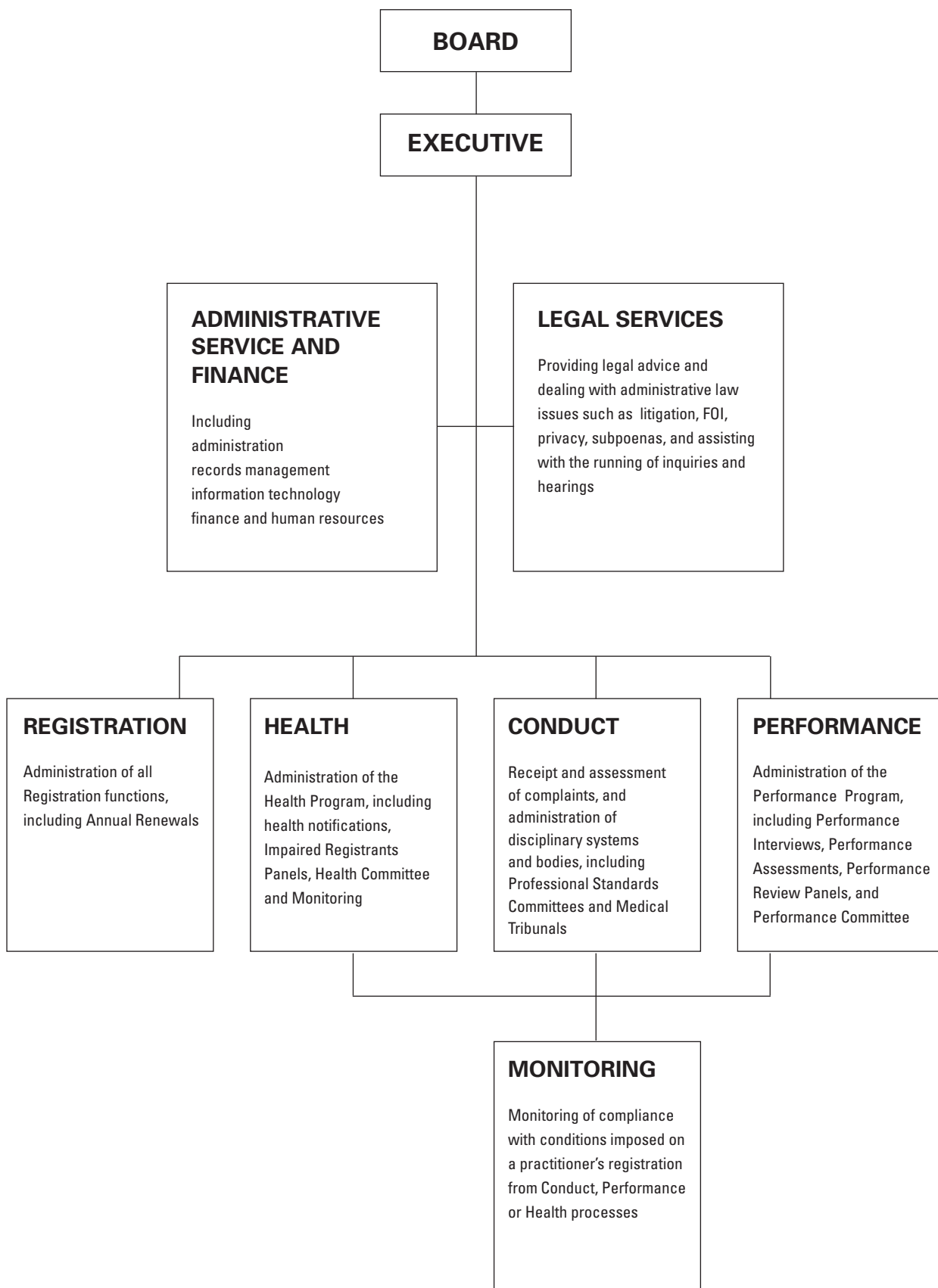
Dr Alison Reid B Med Sc, MBBS (Tas.), MHA, FAFPHM
Medical Director

Anthony Johnson BSc(Hons) LLB (Syd.), LLM(Lond.)
Legal Director

NSW Medical Board Committees as at 30 June 2008

CONDUCT	HEALTH	PERFORMANCE	REGISTRATION	EXECUTIVE	CORPORATE GOVERNANCE & AUDIT
Chair	Chair	Chair	Chair	Chair	Chair
M Fearnside	K Wilhelm	G Stewart	D Smith	P Procopis	H Lapsley
B Bennett	R Benn	B Bennett	R Benn	M Fearnside	B Bennett
G Kesby	S Ieraci	M Fearnside	S Ieraci	H Lapsley	M Fearnside
R McMahan	M Kelly	G Kesby	M Kelly	D Smith	R Kusuma
R Napier	R Kusuma	R McMahan	R Kusuma	G Stewart	P Procopis
P Procopis	H Lapsley	F J Palmer	H Lapsley	K Wilhelm	C-S Yong
D Smith	E Molodysky	P Procopis	E Molodysky		
K Sundquist	F J Palmer	K Sundquist	R Napier		
	P Procopis	C-S Yong	F J Palmer		
	A Spigelman		P Procopis		
	C-S Yong		A Spigelman		
			K Wilhelm		
Non-Board Members		Observers	Non-Board Members		Non-Board Members
F Black		F Black	J Hely		S Kent (IAB)
R Walsh		J Hely	P Klineberg		
		K Hutt			
		E Tompsett			
		R Walsh			

> nsw medical board organisational **chart 2008**



> management & **activities**

- **Registration**

- **Professional Conduct**

- **Health**

- **Performance**

- **Monitoring**

> registration

2007-2008 in summary

- 30,036 doctors and 3195 medical students were registered in NSW at 30 June 2008.
- 3782 applications for registration were granted in 2007/08, including new interns, doctors who had completed internships, practitioners from interstate and overseas, and those seeking to reinstate previous NSW registration.
- The number of new interns registering to practise in NSW rose by 25% in the past year, from an average of 460 in each of the past three years to 569 in 2007/08.
- 37% of GP applicants and 56% of RMO/CMO applicants were successful in seeking registration for positions in Unmet Areas of Need. Applicants are independently assessed against individual positions and success rates reflect the variable specific skills set and demands required by different Area of Need positions.
- 2869 doctors were removed from the Register of Medical Practitioners, including those who had died, removed themselves, not renewed their registration, or been de-registered by the Medical Tribunal.

Overview

The activities of the Board's Registration Department during the year have been carried out against the background of the Council of Australian Governments' (COAG) announcements for national registration and uniform standards of assessment of international medical graduates (IMGs).

On 31 March 2008 the Board's registration functions were affected directly by the implementation of the Competent Authority pathway, one of the new nationally agreed pathways for IMG registration. During the year work also continued on the development and planning for the Standard and Specialist registration pathways, due to be implemented in the year ahead. In addition to its involvement in national policy planning and development, the Board sought to raise awareness and readiness for the changes in NSW by regularly communicating information through its newsletter, its website, and through a specific registration 'Bulletin' sent to hospitals, other employers and stakeholders.

As part of a broader review of the Board's IT systems, a number of enhancements have again been made to the registration database during the year to streamline processes and to introduce scanning of employer applications. Work has continued to enhance the usability and relevance of the online Register as a public source of information about the registration status of practitioners. At the same time the Board continued to inform doctors about annual renewal and registered address matters to ensure the integrity and accuracy of the Register.

The workload of the Registration Committee and staff continues to pose challenges as processes and requirements change in order to meet national requirements, many of which are being developed and implemented within a short timeframe. The complexity of cases is also increasing. 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.

	2005/06	2006/07	2007/08
Internship Complete	425	442	434
General Registration	76	92	93
Re-registration	506	441	326
Mutual Recognition	778	981	1008
AMC Complete	171	146	85
Total	1956	2012*	1946

**The 2006/07 annual report incorrectly published this figure as 1660 and it has been corrected in this report.*

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

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

→ Mutual Recognition

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

→ AMC Complete

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

hundred and twenty-one doctors had the requirement for supervised training waived on the basis they had appropriate clinical experience in Australia deemed equivalent to the required period of supervised training.

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.

	2005/06	2006/07	2007/08
Interns	452	460	569
AMC Graduates	110	95	44
Postgraduate Trainees	892	865	771
General Practice Trainees	201	112	92
Unmet Areas of Need	99	97	103
Overseas Trained Specialists	126	193	212
Specialist Assessment	9	17	15
Academic Appointments	0	0	1
Temporary Board Discretion	13	23	29
Medical Exchange	0	0	0
TOTAL	1902	1862	1836

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 48 out of 129 GP applicants interviewed and 27 out of 48 RMO/CMO applicants interviewed were successful. Twenty-nine specialists were considered suitable for work in an Unmet Area of Need by the relevant specialist college.

→ Overseas Trained Specialists

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

→ Overseas Trained Specialists Assessment

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

→ Academic Appointments

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

→ Public Interest

(i) Temporary Board Discretion

Conditional registration for applicants spending a minimal amount of time in New South Wales, eg, assisting in an operation, demonstration, or participating in a seminar.

(ii) Medical Exchange

Conditional registration for applicants on an educational exchange, with College support.

Unsatisfactory progress

During the financial year, 14 registration interviews were held involving poorly performing practitioners undertaking supervised training. Of those:

- two had been interviewed more than once
- four progressed to General registration
- four are undertaking further training
- four were removed from the Register

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

Total Registrants

The following indicates the total number of NSW registrants by category at 30 June 2008, including all new registrants and those completing annual renewals.

Category of Registration	2005/06	2006/07	2007/08
General	22630	23253	23872
Interns	496	469	581
AMC Registrants undertaking supervised training	137	116	81
Postgraduate Trainees	1326	1577	1757
General Practice Trainees	197	96	94
Areas of Need	249	245	246
Conditional Specialists	746	885	1050
Specialist Trainees	21	20	23
Retired/Non-Practising/Limited Prescribing and Referral	2116	2254	2311
Other (includes academic and temporary Board discretion)	-	13	21
Student registrants	3118	2990	3195
TOTAL REGISTRANTS	31036	31918	33231

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

The following table details the number of registrants removed from the Register during 2007/08 and previous years.

It also shows the registrants who moved to Non-practising or Limited Prescribing and Referral registration categories, which apply to those doctors not practising medicine or those whose practice is limited to, without fee or reward, writing repeat prescriptions and making referrals to another medical practitioner for the purposes of providing health care.

	2005/06	2006/07	2007/08
Deceased	116	111	101
At own request	423	346	315
Non payment of Registration fee	904	929	1778
Term of conditional registration expired	768	750	593
Other	0	0	0
Withdrawal	58	65	78
Medical Tribunal	2	5	4
TOTAL	2271	2206	2869
Non-practising	-	221	229
Limited Prescribing and Referral	-	207	158

> professional conduct

2007-2008 in summary

- 1167 complaints about medical practitioners were received by the Board and the HCCC in 2007/08.
- The HCCC declined to deal with 49% of complaints, investigated 10%, and referred 17% to the Board.
- More than one-third (38%) of investigated complaints (49 matters) were then referred to the HCCC Director of Proceedings to determine whether they should be prosecuted before a disciplinary body.
- During the year, the Medical Tribunal made determinations on complaints matters against six doctors which resulted in four doctors being de-registered and two having conditions imposed on their registration, as well as their being reprimanded and fined.
- Seventeen PSC hearings were finalised during the period resulting in 12 doctors having unsatisfactory professional conduct findings made against them, of whom eight were also reprimanded and had conditions imposed on their registration. One matter was referred to the Medical Tribunal, and in three matters the complaint was dismissed or no orders were made. In one matter the doctor was cautioned and conditions were imposed.
- Twenty-six urgent Board proceedings to take action to protect the public were held this year. As a result, ten doctors were suspended, 13 had conditions imposed on their registration, and three practitioners removed their name from the Register or requested to be moved to the non-practising category of registration.

hundred and twenty-nine matters remained under investigation by the HCCC (down from 150).

The number of matters where emergency suspension or imposition of conditions by the Board was considered to be required under section 66 of the Act fell from 35 in 2006/07 to 26 this year. The number of s66 proceedings held in a year is dependent on the nature and types of matters that come to the Board's attention from various sources. The higher figure in last year's report was due in large part to an increase in referrals from the Pharmaceutical Services Branch.

During the year the Board assisted a number of external inquiries, related to the employment of now de-registered doctor Graeme Stephen Reeves by the Southern Area Health Service in 2002, and into new allegations regarding his conduct when he was still registered to practise.

NSW Health engaged retired Judge Deirdre O'Connor to review complaints against and the disciplinary history of Reeves, and identify areas where the Medical Practice Act and statutory operation of the Board and the HCCC might be improved. The Board assisted with the review and made a number of recommendations for change, including reforms to the Board's emergency powers to protect the public. These changes, as well as reforms to the running of the Professional Standards Committee and reporting misconduct, were passed by Parliament in June 2008. The provisions did not commence in this reporting period and are outlined in Appendix 6 of this report.

The circumstances surrounding the employment in 2002 of Reeves as a visiting medical officer in obstetrics and gynaecology by the former Southern Area Health Service were investigated by Peter Garling SC, as part of the Special Commission of Inquiry - Acute Care Services in NSW Public Hospitals. The Inquiry came to the same conclusion as the Medical Tribunal that de-registered Reeves in 2004, determining that the main reason he was recruited to fill a position he was legally unable to fulfil was his 'intentional and calculated dishonesty'. The Garling report also noted developments in Board processes that had already taken place since that time.

Since the emergence of allegations of serious new complaints against Mr Reeves in early 2008, the Board actively encouraged any person with new information to come forward so they may be appropriately dealt with. Police and HCCC investigations into these matters continued during the reporting period.

In line with legislative requirements, decisions of the Medical Tribunal and relevant court decisions are published in full on the Board's website. A list of currently de-registered and suspended doctors is also published online. Publication of this information aims to increase public and professional awareness of serious matters related to the conduct of doctors in NSW.

Overview

A similar number of complaints were received in 2007-08 (1167) compared to the previous reporting year (1155).

During the year there were increases in the proportion of matters directly resolved between practitioner and complainant (11% to 16%) and those referred to the Board (16% to 17%). There was a corresponding fall in the number of matters referred for investigation by the HCCC (from 13% to 10%), and in the proportion of complaints received that were declined at this initial stage (from 50% to 49%).

There was a slight increase in the number of matters referred to the Medical Tribunal by the HCCC Director of Proceedings from 10 to 12, and a reduction in the number of matters referred to Professional Standards Committees, namely 15, compared with 20 in the previous year.

At 30 June 2008, 54 matters remained with the Director of Proceedings to determine whether they should be prosecuted before a disciplinary body (up from 38 matters in the previous reporting period). One

The complaints handling process

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

Assessment of complaints

During 2007/08, the Medical Board and the Health Care Complaints Commission received 1167 complaints about medical practitioners and completed an assessment of 1116 complaints (down from 1155 in the previous year). The most common outcome of an assessment was to decline to deal with the complaint (49%), followed by referral to the Medical Board (17%) and direct resolution between practitioner and complainant (16%). Ten per cent were referred to the HCCC for investigation.

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

In general, the HCCC has 60 days from receipt of a complaint to prepare a brief prior to assessment. However, the Commission is also required to notify the Board of a complaint as soon as practicable. This allows the Board to review each complaint received and ensure that complaints which raise serious issues concerning the life, physical or mental health of any person are dealt with by the Board 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 11% of complaints declined in the period, up from 6% in the previous reporting period.

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

The table below illustrates the trends in complaint assessments for the past three years. It shows small changes in types of assessment outcomes, with a particular increase in direct resolution of complaints.

Outcome of complaint assessments (%)

	2005/06 n = 1292	2006/07 n = 1155	2007/08 n = 1116
Investigation	13	13	10
Refer to the Medical Board	15	16	17
Refer to another person or body	1	2	2
Conciliation	3	8	6
Direct resolution	14	11	16
Decline to deal with	54	50*	49

* The 2006/07 annual report incorrectly published this figure as 53% and it has been corrected in this report.

The table below shows the types of complaints lodged over the past three years. During this reporting period there was an increase in the proportion of complaints concerning clinical competence (which includes allegations about incorrect or inadequate treatment or clinical advice, misdiagnosis and complications following treatment). This category of complaint continued to dominate as the main area of complaint. The remaining proportion of complaint categories dropped slightly.

Type of complaint (%)

	2005/06 n = 1292	2006/07 n = 1155	2007/08 n = 1116
Clinical competence	57	48	56
Communication	13	17	14
Conduct	22	26	23
Practice administration	8	9	7

Complaints investigated by the HCCC

During the year, 117 complaints were referred to the HCCC for investigation. These complaints were referred on the basis that they appeared to either the Board or HCCC at the time of assessment to raise a significant issue of public safety or provide grounds for disciplinary action against a practitioner.

In this period, 129 investigations were finalised, compared to 163 in the previous reporting year. Outcomes of the investigations during the year included:

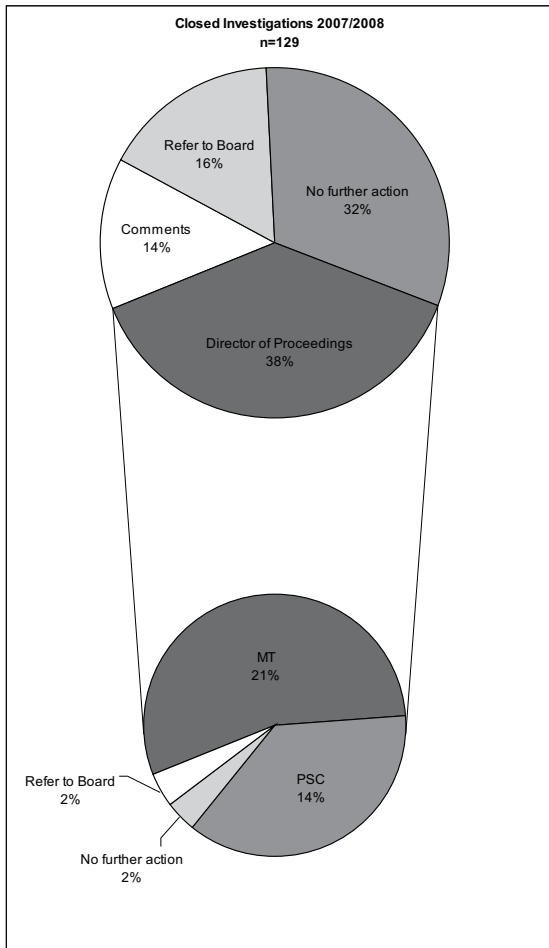
- 32% were terminated and no further action was taken against the practitioner (down from 44% last year);
- 14% required comments to be made in the form of a letter from the HCCC to the practitioner (up from 10% last year);
- 16% referred the practitioner to the Board for it to take appropriate action. 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 (up from 12% last year);

- 38% were referred to the HCCC 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 (up from 34% last year).

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

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



Complaints referred to the Board

Of the 21 matters referred to the Board (16% of investigated complaints), 20 resulted in the practitioner being counselled by the Board and one was referred for the consideration of the Performance Program.

Complaints referred to the Director of Proceedings

During the reporting year, 49 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.

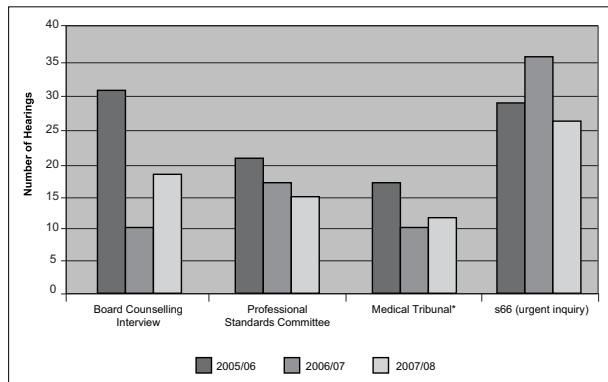
In 2007-08, the DP referred 12 practitioners to the Medical Tribunal and 15 practitioners to a Professional Standards Committee. Of the matters the Director of Proceedings determined not to prosecute, no further action was taken in relation to two practitioners, and two matters were referred back to the Board. The Board directed these two practitioners to attend counselling.

Complaints remaining under investigation

At 30 June 2008, the HCCC reported 129 complaints currently under investigation (down from 150 in the previous year), and 50 matters were with the DP for consideration of possible disciplinary action (up from 38).

Disciplinary hearings

The following chart illustrates the numbers of practitioners referred to disciplinary hearings, s66 proceedings, or counselling interviews during the past three reporting periods.



* 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 the 13 complaints referred by the Director of Proceedings, eight appeals and four restoration applications were commenced in the Tribunal.

Referral to a Professional Standards Committee

In total, the Director of Proceedings referred 19 matters to Professional Standards Committees, and 15 Professional Standards Committees were held.

Referral to a counselling interview

During the year, 19 practitioners were referred to the Board for counselling and 18 practitioners, whose matters were referred to the Board in either this or the previous period, were counselled. A referral to counselling occurs on the basis that a practitioner's departure from acceptable standards is not considered so significant as to warrant referral to the DP, but 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 seven 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.

Seven matters were finalised in this reporting period. Of these matters four practitioners were re-registered with imposed conditions, one was re-registered without conditions, and two applications were unsuccessful. There are two outstanding applications to be heard, and one application referred to an Inquiry did not proceed on the basis of the practitioner being unwell.

Section 94 review

One practitioner made an application under section 94 of the Act to amend the current conditions on their registration. This hearing resulted in the practitioner's conditions being amended.

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 or Medical Tribunal, or consent to refer the practitioner to an Impaired Registrant's Panel.

The Medical Board conducted 26 Section 66 proceedings (one matter

was determined on the papers without hearing) during the year, compared with 35 the previous reporting year, and four reviews of orders imposed under section 66. One practitioner was referred to two Section 66 proceedings in this reporting period, in relation to issues of impairment. One practitioner was referred to a section 66 and subsequently requested a review of the suspension hearing, which was unsuccessful. A further practitioner had a review of the suspension hearing at which conditions were imposed, and was subsequently suspended without hearing later in this reporting period for breach of these conditions. Eleven practitioners were suspended during this reporting period as a result of the 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;
- have breached registration conditions.

Medical Tribunal

Matters commenced

In the year under review, 24 matters (including complaints, appeals, restorations and review applications) were referred to and commenced in the Medical Tribunal. This compares with 15 in 2006/2007, and 30 matters in 2005/2006.

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

	2005/06	2006/07	2007/08
Complaints			
Sexual misconduct	5	2	4
Prescribing	8	2	7
Breach conditions	1	1	1
Treatment	1	0	0
Competence/impairment	0	1	0
Fraud	0	1	0
Character	2	0	0
Breach of order	0	1	0
Appeals			
PSC	2	2	3
Registration	1	0	2
Conditions/suspension	2	0	2
PRP	0	1	1
Restorations	6	4	4
Reviews of conditions	2	0	0
TOTAL	30	15	24

Matters finalised

The Tribunal determined matters in the following categories:

Complaints	6
Appeals	6
Reviews	3
Total	15

Matters outstanding

As at 30 June 2008, 16 matters referred to or lodged in the Tribunal in this or previous years await determination. This compares with 12 in the year ending 30 June 2007, and 23 in the year ended 30 June 2006.

Complaints

Heard/part-heard

One matter is currently underway.

Listed for hearing and to be listed for hearing

Seven matters have been listed for hearing before September 2008 and eight are yet to be listed for hearing.

Appeals

An appeal against the actions of a Performance Review Panel and an appeal against a refusal of registration under s7(1)E have been referred to the Tribunal and are yet to be listed for hearing.

Reviews

Three applications for review of a de-registration order have been lodged in the Tribunal and remain outstanding. One had a hearing date in May 2008 and judgment is reserved; the other two applications are yet to be listed for hearing.

Disciplinary hearings snapshot

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

Medical Tribunal matters and outcomes

Six complaints were determined by the Tribunal in 2007/08 and related to issues of prescribing, breach of conditions, boundary crossing, impairment, and fraud. The Tribunal hearings resulted in four doctors being de-registered, two having conditions imposed on their registration, one also being reprimanded, and the other one also being fined. Full transcripts of Tribunal decisions, and a list of currently de-registered persons, are available on the Board's website www.nswmb.org.au

Professional Standards Committee matters and outcomes

Fifteen doctors were referred to a PSC during 2007/08 and 15 hearings were held related to issues of patient management, prescribing, diagnosis and treatment, clinical error, record keeping, impairment, and boundary crossing. Twelve doctors had unsatisfactory professional conduct findings made against them of whom, eight were also reprimanded and had registration conditions imposed. One matter was referred to the Medical Tribunal pursuant to section 179 of the Act, and in three matters the complaint was dismissed or no orders were made. In one matter the doctor was cautioned and registration conditions were imposed.

Section 66 proceedings and outcomes

The Board conducted 26 s66 proceedings and four reviews of orders imposed under s66 during the year, related to issues of prescribing, drug use, boundary crossing, criminal charges, impairment, capacity to practise, treatment, and breaching of registration conditions. Ten doctors were suspended, 13 had conditions imposed on their registration, and three doctors removed their name from the Register or requested to be moved to the non-practising category of registration. A list of currently suspended practitioners is available on the Board's website www.nswmb.org.au

> health

2007-2008 in summary

- 92 notifications were made to the Health Program, up from 85 and 68 notifications in the previous two reporting years.
- Almost one-third (29%) of notifications were made by colleagues, 26% were self-notified, and 16% were made by treating practitioners.
- 71 Impaired Registrant Panels were convened. These related to psychiatric illness (53.5%), drug addiction (29.6%), alcohol addiction (9.9%), and physical impairment (7%).
- There were 134 participants in the Program and 16 exits.
- A new approach to Bipolar Disorder and Eating Disorders was successfully introduced as part of developments in relation to chronic relapsing mental illnesses.
- Continuing education topics for Board and Committee members and participants included cognitive testing and impaired doctors in the hospital system.

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 510 impaired practitioners have participated in the Program and 210 practitioners have successfully exited, having consolidated their recovery and fulfilled the Board's monitoring requirements.

During the year the Board undertook a review of the Program which found that the average age of practitioners at the time of notification to the Board is 41 years, and 40% of notifications are self-referrals. The relapse rate after doctors exited the Program was less than 5%. 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.

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.

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

	2005/06	2006/07	2007/08
Notifications to Health Program	68	85	92
Impaired Registrants Panel reports endorsed:			
Psychiatric illness	28	34	38
Alcohol	9	8	7
Drug	8	12	21
Physical	3	4	5
Total	48	58	71
Review Interviews held	238	246	260
Exits from the Program	19	13	16
Participants in Program	124	138	134

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.

Speaker program

→ 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. The contribution of the following speakers is acknowledged with thanks

- Ms Tayia Yeates, St Vincent's Hospital

Impaired doctors in the hospital system

- Ms Alexandra Walker, neuropsychologist

Cognitive testing

Chronic Relapsing Mental Illness

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

Following a stimulating discussion at the March 2007 Health Forum, a new approach to Bipolar Disorder and Eating Disorders has been developed and introduced. In essence, program participants whose

condition is stable and who can demonstrate that they have good support systems in place can be exited from the program, providing they authorise their treating practitioner to contact the Board should any concerns arise. The decision parameters have been developed with assistance from clinical experts in the field. This approach has proved to be popular with participants and to date, appears to have been a successful initiative. The model may be extended to other relapsing mental illnesses in the future.

Program activity

Notifications

Notifications by source	2005/06 n = 68	2006/07 n = 85	2007/08 n = 92
Colleagues (including employers)	13	17	27
Pharmaceutical Services Branch	6	3	5
Self-notifications	27	31	24
University	5	2	4
Board Committee	-	7	4
Courts	-	3	-
Treating practitioner	6	11	15
Other	11	11	13

Self-notifications continue to be a significant source of notifications to the Health Program. The Medical Practice Act requires that practitioners make a declaration in relation to their health in the course of completing their annual return to the Board. In the majority of cases, no further action is required, either because the practitioner is not working, or because they are clearly practising safely within the limitation imposed by their illness.

In some cases, the Health Committee seeks more information, either from the practitioner, their treating doctor or a Board-nominated doctor. Only these cases are included in the above table, along with other self-notifications that occur outside the annual return process. It is pleasing to note that more notifications have been received from colleagues and 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, 71.5% of IRPs concluded with the practitioner agreeing to conditions being placed on their registration, 13.5% resulted in no further action being taken, 10.5% were adjourned, and in 4.5% of matters, other action was taken.

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 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 study

Dr Y is a senior resident who came to the Board's attention in 2007 when a consultant psychiatrist informed the Board that he had been admitted as an involuntary patient and diagnosed with an episode of psychosis.

Prior to an Impaired Registrants Panel Inquiry being convened, Dr Y had been on leave from work for a month. At the hearing, he described a stressful period at work where he was working long hours, that he had been bullied, and had been rundown and sleeping poorly. He became depressed, and then anxious, and took time off work.

Six months later Dr Y developed auditory hallucinations and paranoid delusions, and spent six weeks as an inpatient in a psychiatric facility. Another Impaired Registrants Panel Inquiry was held, and the Panel noted ongoing concerns regarding Dr Y's health and ability to work. This Inquiry was reconvened two months later prior to Dr Y's return to work. He was well at that time. He agreed to conditions being placed on his registration, including regular review by his treating and Board-nominated psychiatrists, continuing to take medication prescribed

by his treating psychiatrist, and working no overtime in his Board-approved employment.

Since that time Dr Y has had periods of being unwell, and has taken time off work appropriately. He continues to practise with the support and supervision of the Board.

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. Six medical students were notified to the Board during 2007/08. Two of these students deferred their studies, one was assessed by a Board-nominated psychiatrist and no further action was taken, and the other cases are yet to be finalised.

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.

At 30 June 2008, there were six interns and one medical student involved in the Health Program. Four of these interns were notified to the Board while they were students, or self-notified in their intern applications.

The notifications from universities do not represent the total number of student notifications. Some come through hospital admissions and from treating practitioners.

• Case Study

Mr A is a final year medical student who was notified to the Board when he was a second year student, and was scheduled to a psychiatric hospital in the context of suicidal behaviour when intoxicated with alcohol. He attended an Impaired Registrants Panel Inquiry early the following year (2007). The Panel noted that Mr A had a history of a poorly treated depressive disorder.

Some weeks after the Inquiry, Mr A took a further overdose and was hospitalised as an involuntary patient for a period of two weeks. He then deferred his medical studies for six months and returned to live with his family. After a further suicide attempt he was diagnosed with

Major Depressive Disorder and Borderline Personality Disorder and prescribed medication for this. The Board-nominated psychiatrist held concerns that Mr A should be closely monitored for an emerging psychotic illness.

When a further Impaired Registrants Panel Inquiry was convened Mr A was in the middle of a clinical term and was enjoying his work. He was well at the time.

Shortly after that hearing, the Board was notified that Mr A had been admitted to hospital with health problems associated with alcohol abuse. A further Inquiry was held. Mr A was suspended from clinical studies.

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 2008, a total of 16 practitioners exited the Health Program. These all had their conditions lifted and returned to full registration. The Board was satisfied that these practitioners had actively sought to manage their impairment, were willing 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.

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. Two registrants who had previously exited the program re-presented during 2007/08.

Conclusion

The Health Program continues to evolve in its approach to managing impaired medical practitioners and students. Confidence in the Program is evidenced by the increasing rate of colleague and treating practitioner notifications. The Board's flexibility to move practitioners between programs is of significant benefit in ensuring an integrated approach to fitness to practise.

> performance

2007-2008 in summary

- The HCCC referred 182 complaints to the Board as performance matters, up from 163 last reporting year and slightly down from 189 in the previous year.
- The Board also received eight 'performance notifications'. 'Performance notification' is a new category of reporting. Such notifications, usually made by an employer, express concerns about the professional performance of the practitioner without making a complaint about them. These referrals are encouraging and recognise the Program's aim of ensuring practitioners' fitness to practise through protective and remedial processes.
- 43 complaints were recommended for a Performance Interview, compared to 47 and 28 in the previous two reporting years. The higher number in the past two years reflects the growing use of interviews in the Program as an alternative to a full Performance Assessment or as an intermediate step in decisions to conduct a full Assessment.
- The number of matters considered for a full Performance Assessment remained steady at 22.

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.

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.

During the year the first appeal brought by any practitioner against a Performance Review Panel was heard in the Medical Tribunal. The Tribunal re-imposed similar registration conditions to those imposed by the PRP and ordered the doctor be assessed through the Program.

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

Program activity

An overview of the Performance Program activity in 2007-2008 follows.

Complaints

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

Complaints referred to the Board by the HCCC

	2005/06	2006/07	2007/08
New complaints	189	163	181
Investigated complaints	-	-	1

Performance notification

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

Performance notifications and outcomes

	2005/06	2006/07	2007/08
Total received	n/a	n/a	8
No further action	n/a	n/a	1
Board letter	n/a	n/a	0
Awaiting Health Committee outcome	n/a	n/a	1
Performance Interview	n/a	n/a	3
Performance Assessment	n/a	n/a	2

Outcomes of referred complaints

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

Outcome of complaints referred to the Board by the HCCC

	2005/06	2006/07	2007/08
No further action	63	97	73
Letter of apology to patient	5	12	13
Board letter	23	32	30
Performance Interview	28	47	43
Performance Assessment	3	6	4
Section 66 inquiry	0	2	2
Refer to Health Committee	1	1	2
Refer to HCCC for investigation	1	1	1
Advise complainant to seek re-assessment with HCCC for direct resolution with CRO	n/a	n/a	5
Advise complainant to seek re-assessment with HCCC for conciliation	n/a	n/a	3
Refer to HCCC (for reassessment)	3	2	n/a
No longer registered/ suspended, action if applies for re-registration	1	1	1
Total	128	201	177

Complainants may seek a review by the Board of the outcome of their complaint. This most often occurs when the outcome is No Further Action. The complaint and the complainant's letter and any new information is sent to the doctor for his/her response. The matter is then considered by the Performance Committee. During the year three reviews were requested and considered by the Committee. A review of two matters originally assessed as requiring no further action resulted in one being referred for conciliation between the complainant and the practitioner, and the other in a Performance Interview of the doctor which recommended he provide an apology to the complainant. A third matter was reviewed and no change to the outcome was recommended.

Outcome of complainant seeking review of complaint

	2005/06	2006/07	2007/08
Total reviews requested	Not reported	Not reported	3
Change to outcome	Not reported	Not reported	2

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

Outcome of Performance Interviews

	2005/06	2006/07	2007/08
No further action	21	31	40
Apology	0	0	1
Further action recommended -			
doctor retired	0	0	1
Performance Assessment	7	5	8
Refer to Health Committee	-	4	0
Refer to Conduct Committee	-	1	0
Total	28	41	50

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. One-third of matters considered for a Performance Assessment were the result of the imposition of registration conditions and performance notifications. More than half were referred complaints from patients and others, as well as referrals from other Board programs.

Source of matters considered for Performance Assessment

	2005/06	2006/07	2007/08
Board Committee (Health, Conduct)	12	13	3
Referred because of an imposed condition*	n/a	n/a	4
Complaint originating from:			
→ Patient	5	4	8
→ Employer	4	3	1
→ Colleague	2	0	2
→ Professional Services Review	1	1	0
→ Department of Health	0	1	1
→ Performance notification*	-	-	3
Total	24	22	22

* New reporting categories

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

	2005/06	2006/07	2007/08
Anaesthetist	1	1	0
General practitioner	16	11	14
Obstetrician & gynaecologist	0	4	1
Ophthalmologist	0	1	0
Paediatrician	1	0	0
Pathologist	0	0	0
Physician	0	1	0
Psychiatrist	2	0	1
Radiologist	0	1	0
Surgeon	3	2	5
Trainee	1	1	1
Total	24	22	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 and advise the practitioner. More formal counselling can occur when there are performance issues that do not require the Board to order remediation, but that need to be drawn to the practitioner's attention. If remediation is required, or if there are issues of public protection, then a Performance Review Panel is convened to formalise these orders.

Performance Assessment outcomes

	2005/06	2006/07	2007/08
Retired or non-practising before having PA	3	4	1
S66 prior to Assessment	2	1	2
Interim PA report	2	0	0
No further action	4	4	4
Interview after PA	2	0	0
Counselling	5	2	0
Performance Review Panel	7	7	10
Total	25	18	17

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 or require supervision. These conditions may be lifted after they have satisfactorily completed their remediation and been re-assessed. 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

	2005/06	2006/07	2007/08
PRP held	7	8	8
Did not proceed (retired, name removed)	1	1	1
PRP completed – outcome:	9	8	8
counselled	2	0	0
remediation orders	6	7	5
protective orders	8	7	7

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

Outcome of re-assessment

	2005/06	2006/07	2007/08
Satisfactory – exited program	5	0	1
Making progress	1	1	0
Unsatisfactory - PRP needed	2	0	3
Total	8	1	4

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.

The Board remains 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. The future of the Performance Program in the National Registration and Accreditation Scheme, commencing 1 July 2010, will be of considerable interest to the Board. The Board's experience of running its Performance and other non-disciplinary programs has made it clear that these initiatives offer additional and effective ways to protect the public, improve safety and quality, and support doctors in practice, than through disciplinary processes alone.

Case studies

The following case studies illustrate the Performance Assessment Program's work during 2007-2008.

• *Case study 1*

Dr X is a surgeon. He remains in the Board's Health program although there are no current concerns about the health matter that brought Dr X to the Board's attention. However, the Health Committee was concerned that Dr X had developed a condition that was severe enough to require opioid analgesia and felt that his fitness to practise could be affected both by his condition and his medication. The Health Committee referred Dr X to the Performance Committee as their concerns 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 in an assessment that was limited to observation of his surgical skills in the operating theatre. His performance was found to be satisfactory and no further action was necessary. He continues to be supported by the Health Program.

This case illustrates the beneficial integration of the Health and Performance programs in assessing a practitioner's fitness to practise. In addition, it illustrates that a satisfactory Performance Assessment can serve to allay the Board's concerns about a practitioner.

• *Case study 2*

Dr Y is a GP who works several hours drive from Sydney during the week and returns to Sydney for the weekend. During a Professional Services Review (PSR) Committee hearing, in relation to the provision of services that attracted Medicare PBS benefits, concerns arose about Dr Y's performance. The PSR Committee considered that Dr Y inappropriately managed three patients in that he failed to take adequate histories and ignored potentially fatal conditions. Accordingly a complaint was made and was referred to the Board under s25B of the MPA.

Dr Y attended a Performance Interview and the interviewers had concerns that three years after the event and with the hindsight of the PSR process, Dr Y's management of a particular condition (the same condition that was inadequately managed by Dr Y in one of the above patients) was still inadequate and that his medical records remained unsatisfactory. The Performance Committee considered the report of the Interview and resolved that a Performance Assessment be conducted.

Three assessors attended Dr Y's practice. Dr Y said that he planned to retire in a few years but his wife would like him to retire immediately. Dr Y appeared to have no concept of taking responsibility for a patient's total care and was unsatisfactory in all observed areas of his

practice. It seemed to the assessors that Dr Y operated in isolation from both his peers and other health services. Even his CPD, although considerable, was obtained without peer interaction. In considering the report of the Performance Assessment, the Performance Committee resolved that a Performance Review Panel be convened. Dr Y chose to retire and the Performance Review Panel did not occur. This case illustrates the use of a Performance Interview as a useful intermediate step in the decision to conduct a full Performance Assessment and retirement as a satisfactory outcome of the Performance Assessment process.

• *Case study 3*

Dr Z is a GP. A complaint was made by a father about Dr Z's management of his baby and that Dr Z allegedly made several insensitive comments to the child's mother. On seeking a second opinion at a hospital soon after, a different diagnosis was made. Dr Z attended a Performance Interview in which the interviewers drew Dr Z's attention to remarks he made in his written response to the complaint and he agreed they were hasty and inappropriate. The interviewers found Dr Z's records for this consultation to be inadequate. Of concern was his admitted unfamiliarity with computer recording which had been introduced in the practice three years previously. Also of concern was that Dr Z had allowed his proposed treatment of the baby to be influenced by the wishes of the parents.

The Performance 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; prescribing skills; interaction/communication with patients and medical records (content). In considering the Assessment report the Performance Committee resolved that a Performance Review Panel be convened.

The Panel found Dr Z's professional performance to be unsatisfactory 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 limiting his patient numbers and requiring him to be trained in the use of the computer-based system until he was proficient; so that his medical records improved to acceptable standards and he was to be re-assessed at a later date. He was also required to undertake appropriate Continuing Professional Development activities to improve his patient management skills including, but not limited to: communication with patients; prescribing skills; and updated management of common conditions in general practice; and to provide evidence of this at six-monthly intervals.

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.

> monitoring

2007-2008 in summary

- 167 doctors' compliance with registration conditions was under active monitoring by the Medical Board.
- 42 new cases were referred to the Board's Monitoring Section during the year.
- A resource to assist members of hearings and panels to write effective and practical conditions was developed during the year.

Any Professional Conduct, Performance or Health process can give rise to conditions being imposed on a practitioner's registration and the Medical Board is responsible for monitoring compliance with these conditions.

Prior to 2003, the monitoring of practitioners' compliance with conditions on their registration was part of the administrative activities undertaken by the Professional Conduct, Health and Performance sections of the Board. Since the creation of a separate Monitoring Section in 2003, originally comprising one monitoring coordinator and one monitoring officer position, the number and complexity of cases has grown and the importance of its function in achieving the Board's objectives to protect the health and safety of the public has been increasingly highlighted. As a result, the staff of the section was increased in 2005, and again in 2008. The section now comprises a monitoring coordinator and three monitoring officers. The coordinator reports directly to both the Legal Director and the Medical Director of the Board.

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

Ongoing contact is maintained with the practitioner, and with third parties such as employers and supervisors, to facilitate, where necessary, ease and effectiveness of compliance with the conditions. Submissions are prepared for the appropriate Committee agenda on questions of satisfactory compliance with a condition, variation or removal of a condition, or breach of a condition. The Monitoring

Section follows up on the Committees' resolutions, which may range from removal of all conditions to the lodging of a complaint with the Health Care Complaints Commission (HCCC). The Section also liaises with the HCCC on cases where conditions are in effect while a complaint is under investigation, providing periodic updates on the practitioner's compliance history.

The level, complexity and duration of monitoring activity varies considerably over the range of cases administered by the Section. Some may require no more than a periodic letter to confirm the practitioner's circumstances. Others require more frequent activity and scrutiny. The efficiency and effectiveness of the monitoring function overall is dependent to a considerable degree on the quality and relevance of the conditions themselves.

The members of proceedings that are responsible for drafting conditions - such as the Medical Tribunal, Professional Standards Committees, Performance Review Panels, Impaired Registrants Panels - are encouraged to refer to the Section for advice and comment on the degree to which the conditions can be monitored, as the chosen wording can have considerable impact on the practitioner's ability to comply and on the Section's ability to monitor that compliance. During the past year the Section has been developing a 'Conditions Bank' to be available as a resource for all Hearing Members and Panellists in that regard

At 30 June 2008, there were a total of 167 cases under active monitoring by the Section.

Sole or primary source of conditions	New cases in 2007-08	Total active cases 2007-08
Health Program	16	73
Performance Program	10	20
Professional Conduct	16	74
Total	42	167

> finance and budget

Overview - Financial Performance - Year ended 30 June 2008

The total income for the period was \$9,264,000. Expenditure for the period was \$9,091,000. An operating surplus of \$173,000 was achieved in the year ended 30 June 2008.

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 (\$97,288).

The Board also contributed to the Australian Medical Council (\$185,052), Institute of Medical Education and Training \$103,875.75 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 2008 was 6.50%.

The Board's externally managed funds were held in Treasury Corporation's HourGlass Cash Facility. An average return of 7.01% was achieved for the current financial year.

Budget

Performance against Budget for the year ending 30 June 2008 and Budget for the year ending 30 June 2009

	30 June 2008 Budget (000)	30 June 2008 Actual (000)	30 June 2009 Budget (000)
Registration Fees	7,732	8,054	7,913
Fines	40	22	40
Interest	550	704	700
Other	65	210	72
Area of Need Income	174	274	192
TOTAL INCOME	8,561	9,264	8,917
Salaries and related expenses	2,846	2,780	3,047
Sitting Fees	1,432	1,272	1,379
Funding Contributions	475	426	475
Computer and Consultancy	608	538	731
Members Fees	374	283	364
Medical Tribunal Funding	600	600	600
Professional Conduct and Health	412	834	711
Postage, Courier and Phone	185	211	188
Administration Expenses	677	764	833
Superannuation	450	1,036	689
Vehicle, travel and accommodation	162	109	179
Depreciation and Amortisation	212	219	210
Audit Fees	17	19	20
TOTAL EXPENDITURE	8,450	9,091	9,426
OPERATING SURPLUS	111	173	(509)

Income

The budget for the year ending 30 June 2009 is based on the following estimates:

- a 4% increase in registrants with the annual registration fee to remain at \$270.

Expenditure

The following significant changes in expenditure are anticipated:

- 4% increase in staff salaries has been allowed.



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 2008, the income statement, statement of changes in equity and cash flow statement for the year then ended, a summary of significant accounting policies and other explanatory notes.

Auditor's Opinion

In my opinion, the financial report:

- presents fairly, in all material respects, the financial position of the Board as at 30 June 2008, and its financial performance and 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

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

The Board's Responsibility for the Financial Report

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

Auditor's Responsibility

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

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

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

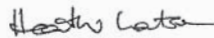
My opinion does *not* provide assurance:

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

Independence

In conducting this audit, the Audit Office of New South Wales has complied with the independence requirements of the Australian Auditing Standards and other relevant ethical requirements. The PF&A Act further promotes independence by:

- providing that only Parliament, and not the executive government, can remove an Auditor-General, and
- mandating the Auditor-General as auditor of public sector agencies but precluding the provision of non-audit services, thus ensuring the Auditor-General and the Audit Office of New South Wales are not compromised in their role by the possibility of losing clients or income.



Heather Watson
Director, Financial Audit Services

24 October 2008
SYDNEY



New South Wales Medical Board

Statement by the members of the Board

For the year ended 30 June 2008

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

1. The financial report exhibits a true and fair view of the financial position and performance of the New South Wales Medical Board; and
2. The financial report has been prepared in compliance with the *Public Finance and Audit Act 1983*, the *Public Finance and Audit Regulation 2005*, Treasurer's Directions and in compliance with Australian Accounting Standards, which include Australian Accounting Interpretations.

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

President

20 October 2008

Board Member

> balance sheet

FOR THE YEAR ENDED 30 JUNE 2008

	Notes	2008 \$'000	2007 \$'000
Current Assets			
Cash and cash equivalents	7	10,894	10,110
Receivables	8	796	603
Total-Current Assets		11,690	10,713
Non-Current Assets			
Plant and Equipment	9	247	209
Intangible Assets	10	80	14
Leasehold improvements	11	2,130	2,223
Total Non Current Assets		2,457	2,446
Total Assets		14,147	13,159
Current Liabilities			
Payables	12	1,069	562
Provisions	13	390	397
Other	14	4,209	3,929
Total Current Liabilities		5,668	4,888
Non Current Liabilities			
Provisions	15	59	24
Total Non Current Liabilities		59	24
Total Liabilities		5,727	4,912
Net Assets		8,420	8,247
Equity			
Accumulated Funds	16	8,420	8,247
Total Equity		8,420	8,247

The accompanying notes form part of the financial report

> income statement

FOR THE YEAR ENDED 30 JUNE 2008

	Notes	2008 \$'000	2007 \$'000
Expenses from ordinary activities	2	9,091	8,236
Revenues from ordinary activities	3	9,264	8,592
Gain/(Loss) on disposal of plant and equipment	4	0	4
Results for the year from ordinary activities		173	360

The accompanying notes form part of the financial report

> statement of changes in equity

FOR THE YEAR ENDED 30 JUNE 2008

	Notes	2008 \$'000	2007 \$'000
Accumulated Funds at the beginning of the year		0	0
Surplus for the Year		173	360
Accumulated Funds at the end of the year	16	173	360

The accompanying notes form part of the financial report

> cash flow statement

FOR THE YEAR ENDED 30 JUNE 2008

	Notes	2008 \$'000	2007 \$'000
Cash Flows from Operating Activities			
Receipts from registrants and other debtors		9,087	8,468
Payments to suppliers and employees		(8,777)	(8,324)
Interest received		704	614
Net Cash provided by operating activities	18	1,014	758
Cash Flows from Investing Activities			
Payments for leasehold improvements, plant and equipment		(230)	(96)
Proceeds from sale of plant and equipment		0	32
Net Cash used in Investing activities		(230)	(64)
Net increase in cash held		784	694
Cash at the beginning of the financial year		10,110	9,416
Cash at the end of the financial year	7	10,894	10,110

The accompanying notes form part of the financial report

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

FOR THE YEAR ENDED 30 JUNE 2008

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 2008 has been authorised for issue by the Board on 20th October 2008.

b. Basis of Preparation

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

Property, plant and equipment, assets held for sale and certain financial instruments 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. 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 101 (Sept 2007) and AASB 2007-8 regarding presentation of financial statements.

AASB 1004 (Dec 2007) regarding contributions.

AASB 1049 (Oct 2007) regarding the whole of government and general government sector financial reporting.

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.

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

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

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

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

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.

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

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

(ii) Long Service Leave

Long service leave is measured at present value in accordance with AASB 119 *Employee Benefits*. This is based on the application of certain factors (specified in NSWTC 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.

(iii) Superannuation - backpay

The Board approved a scheme of payment of backdated superannuation to both present and past staff. The offer has been made to present staff and \$144,398 has been paid to 30 June 2008. A further \$123,387 has been booked as a provision in the accounts for present staff. These amounts will be paid to present staff when they make matching contributions. \$111,357 has been booked as a provision in the accounts as the maximum liability for past staff.

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 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.

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%

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

FOR THE YEAR ENDED 30 JUNE 2008

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%
--	-----

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.

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. Payables

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

	2008	2007
	\$'000	\$'000
2. EXPENDITURE FROM ORDINARY ACTIVITIES		
Salaries and related expense	2,780	2,774
Sitting Fees	1,272	1,074
Funding Contributions	426	691
Computer and Consultancy	538	578
Board Members Statutory Fees	283	333
Medical Tribunal Funding	600	600
Legal, Professional Conduct and Health Costs	834	429
Postage, Courier and Phone	211	244
General Administration Expenses	764	655
Superannuation	657	508
Superannuation backpay	379	0
Vehicle, Travel and Accommodation	109	135
Depreciation and Amortisation	219	206
Auditor's remuneration-audit or review of financial reports	19	9
	9,091	8,236

3. REVENUES FROM ORDINARY ACTIVITIES

Registration Fees	8,054	7,519
Fines	22	135
Interest Revenue (Note 5)	704	607
Other Revenue (Note 6)	484	331
	9,264	8,592

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

Cost of plant and equipment	0	44
Less Accumulated depreciation	0	(16)
Written Down Value	0	28
Less Proceeds from Disposal	0	(32)
(Gain)/Loss on Disposal of plant and equipment	0	(4)

5. INTEREST REVENUE

Bank Interest	30	28
TCorp Hour Glass Cash Facility	674	579
	704	607

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

FOR THE YEAR ENDED 30 JUNE 2008

	2008	2007
	\$'000	\$'000
6. OTHER REVENUE		
Application Fee for Area of Need Assessments	274	206
Other	210	125
	484	331

7. CURRENT ASSETS - CASH AND CASH EQUIVALENTS

Cash at bank and on hand	431	321
TCorp Hour Glass Facility	10,463	9,789
	10,894	10,110

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)	10,894	10,110
Closing cash and cash equivalents (per Cash Flow Statement)	10,894	10,110

8. CURRENT ASSETS - RECEIVABLES

Accrued Interest	2	2
Other	770	572
Prepayments	24	29
	796	603

	2008	2007
	\$'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 2007					
Gross Carrying Amounts	52	143	329	217	741
Accumulated depreciation and impairment	(5)	(96)	(297)	(134)	(532)
Net Carrying Amount	47	47	32	83	209
At 30 June 2008					
Gross Carrying Amounts	52	279	329	222	882
Accumulated depreciation and impairment	(14)	(125)	(327)	(169)	(635)
Net Carrying Amount	38	154	2	53	247

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 2008

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

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 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

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

FOR THE YEAR ENDED 30 JUNE 2008

10. NON-CURRENT ASSETS - INTANGIBLE ASSETS

	Intangibles	Total
	\$'000	\$'000
At 1 July 2007		
Gross Carrying Amounts	425	425
Accumulated depreciation and impairment	(411)	(411)
Net carrying amount	14	14

At 30 June 2008		
Gross Carrying Amounts	505	505
Accumulated depreciation and impairment	(425)	(425)
Net carrying amount	80	80

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 2008

Net carrying amount at start year	14	14
Additions	80	80
Depreciation expense	(14)	(14)
Net carrying amount at end of year	80	80

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 2007

Net carrying amount at start year	26	26
Depreciation expense	(12)	(12)
Net carrying amount at end of year	14	14

11. NON-CURRENT ASSETS - LEASEHOLD IMPROVEMENTS

	Leasehold Improvements		Total
	Building Extension	Refurbishment	
	\$'000	\$'000	\$'000
At 1 July 2007			
Gross Carrying Amounts			
Accumulated depreciation and impairment	248	3,328	3,576
Net Carrying Amount	(111)	(1,242)	(1,353)
	137	2,086	2,223
At 30 June 2008			
Gross Carrying Amounts	248	3,337	3,585
Accumulated depreciation and impairment	(121)	(1,334)	(1,455)
Net Carrying Amount	127	2,003	2,130

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 2008

Net carrying amount at start of year	137	2,086	2,223
Additions	0	9	9
Depreciation expense	(10)	(92)	(102)
Net carrying amount at end of year	127	2,003	2,130

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 2007

Net carrying amount at start of year	146	2,178	2,324
Depreciation expense	(9)	(92)	(101)
Net carrying amount at end of year	137	2,086	2,223

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

FOR THE YEAR ENDED 30 JUNE 2008

	2008	2007
	\$'000	\$'000
12. CURRENT LIABILITIES - PAYABLES		
Accrued expenses	699	477
Trade Creditors	370	85
	1,069	562

13. CURRENT LIABILITIES - PROVISIONS

Employee benefits and related on-costs

Annual Leave Provision	255	251
Long Service Leave Provision	135	146
	390	397

Unconditional employee leave provisions are shown as a Current Liability.

The nature of these liabilities is as follows:

Annual Leave Provision		
- Short Term	172	185
- Long Term	83	66
	255	251
Long Service Leave Provision		
- Short Term	0	0
- Long Term	135	146
	135	146

14. CURRENT LIABILITIES - OTHER

Deferred Revenue	4,209	3,929
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The balance of deferred Revenue represents the amount of Registration Fees related to the unelapsed portion of the annual Registration period.

15. NON CURRENT LIABILITIES - PROVISIONS

Employee benefits and related on-costs

Long Service Leave Provision	59	24
	59	24

	2008	2007
	\$'000	\$'000
16. CHANGES IN EQUITY		
Accumulated funds		
Balance at the beginning of the financial year	8,247	7,887
Changes in equity- other than transactions with owners as owners		
Surplus for the year	173	360
Total	<u>173</u>	<u>360</u>
Balance at the end of the financial year	<u>8,420</u>	<u>8,247</u>

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	365	398
-Total (including GST)	<u>530</u>	<u>563</u>

The total of lease commitments as at 30 June 2008 above includes input tax credits of \$48,000 (\$51,000 in 2006/07) that are expected to be recoverable from the Australian Taxation Office

> notes to and forming part of the financial report

FOR THE YEAR ENDED 30 JUNE 2008

	2008	2007
	\$'000	\$'000
18. RECONCILIATION OF SURPLUS FOR THE PERIOD TO NET CASH FLOWS FROM OPERATING ACTIVITIES		
Net Profit	173	360
Depreciation and amortisation	219	206
Net loss/(gain) on disposal of fixed assets	0	(4)
Increase/(decrease) in employee provisions	28	68
(Increase)/decrease in receivables and other assets	(193)	6
Increase/(decrease) in deferred revenue	280	45
Increase/(decrease) in payables	507	77
Net Cash provided by operating activities	1,014	758

19. CONTINGENT LIABILITIES AND CONTINGENT ASSETS

The contingent liability reported in the previous year relating to the Board's superannuation scheme for employees has been resolved. The Board has paid \$144,398 and provided a further \$234,744 in the accounts. (Note 1 g iii). As at the reporting date the NSW Medical Board is not aware of any contingent liabilities and contingent assets that will materially affect its financial position.

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, including derivative financial instruments, for speculative purposes.

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

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

(a) Financial Instrument Categories

Financial Assets	Note	Category	Carrying Amount	
			2008	2007
Class:			\$'000	\$'000
Cash and cash equivalents	7	N/A	10,894	10,110
Receivables (1)	8	Receivables at (amortised cost)	740	574
Financial Liabilities	Note	Category	Carrying Amount	Carrying Amount
Class:			2008	2007
			\$'000	\$'000
Payables (2)	12	Financial liabilities measured at amortised cost	1,069	544

Notes:

(1) Excludes statutory receivables and prepayments (ie not within scope of AASB 7)

(2) Excludes statutory payables and unearned revenue (ie not within scope of AASB 7)

20. FINANCIAL INSTRUMENTS (cont'd)

(b) Credit Risk

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

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

Cash

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

Receivables - trade debtors

All trade debtors are recognised as amounts receivable at balance date. Collectability of trade debtors is reviewed on an ongoing basis. The majority of receivables recognised as trade debtors represent registration fees outstanding. Uncollected registration fees will result in the deregistration of the medical practitioner.

Debts which are known to be uncollectible are written off. An allowance for impairment is raised when there is objective evidence that the entity will not be able to collect all amounts due. This evidence includes past experience, and current and expected changes in economic conditions and debtor credit ratings. No interest is earned on trade debtors. Sales are made on 15 day terms.

The Board is not materially exposed to a concentrations of credit risk to a single trade debtor or group of debtors.

The Board's debtors represent a large number of individual medical practitioners whose credit ratings will vary and are unknown to the Board. Based on past experience, debtors that are not past due (2008: nil; 2007: nil) are not considered impaired and these represent 100% of the total trade debtors.

There are no debtors which are currently not past due or impaired whose terms have been renegotiated.

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

(c) Liquidity Risk

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

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

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

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

> notes to and forming part of the financial report

FOR THE YEAR ENDED 30 JUNE 2008

20. FINANCIAL INSTRUMENTS (cont'd)

2008	Weighted Average Effective Interest Rate	Nominal Amount (1) \$'000	Fixed Interest Rate	Interest Rate Exposure (\$'000)		Maturity Dates < 1 yr
				Variable Interest Rate	Non-interest Bearing	
Payables	-	1,069	-	-	1,069	1,069
2007						
Payables	-	544	-	-	544	544

Notes:

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

(d) Market Risk

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

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

A reasonably possible change in risk variable has been determined after taking into account the economic environment in which the Board operates and the time frame for the assessment (i.e until the end of the next annual reporting period). The sensitivity analysis is based on risk exposures in existence at the balance sheet date. The analysis is performed on the same basis for 2007. The analysis assumes that all other variables remain constant.

Interest Rate Risk

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

20. FINANCIAL INSTRUMENTS (cont'd)

	Carrying Amount	(\$'000)			
		-1% Profit	Equity	1% Profit	Equity
2008					
<i>Financial Assets</i>		0	0		
Cash and cash equivalents	10,894	(109)	(109)	109	109
Receivables	740	0	0	0	0
<i>Financial liabilities</i>					
Payables	1,069	0	0	0	0
2007					
<i>Financial Assets</i>					
Cash and cash equivalents	10,110	(101)	(101)	101	101
Receivables	574	0	0	0	0
<i>Financial liabilities</i>					
Payables	544	0	0	0	0

Other price risk – TCorp Hour Glass facilities

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

Facility	Investment Sectors	Investment Horizon	2008 \$'000	2007 \$'000
Cash facility	Cash, money market instruments	Up to 1.5 years (Pre-June 2008 up to 2 years)	10,463	9,789

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

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

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

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

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

FOR THE YEAR ENDED 30 JUNE 2008

20. FINANCIAL INSTRUMENTS (cont'd)

	Change in unit price	Impact on profit/loss	
		2008 \$'000	2007 \$'000
Hour Glass Investment – Cash Facility	+/- 1%	\$105	\$98

(e) Fair Value

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

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

21. ANNOUNCEMENT REGARDING THE FUTURE OF THE BOARD

The Council of Australian Governments proposals for National Registration are proceeding, and a National Registration and Accreditation Implementation Project has been established. Legislation establishing the broad structural arrangements is to be finalised by the end of 2008 and adopted in each jurisdiction. It is anticipated that the legislation which will in effect abolish the Board and transfer its functions to the new body will be passed in late 2009, presumably to take effect on 1 July 2010.

The accounts of the New South Wales Medical Board as at 30 June 2008 have been prepared on a going concern basis, because the implementation of the new national scheme is scheduled for 1 July 2010, and that the Board will continue in its current role for 12 months beyond the date of signing the accounts.

End of Audited Financial Report

> appendices

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Appendix 2:	Equal Employment Opportunity
Appendix 3:	NSW Government Action Plan for Women
Appendix 4:	Occupational Health and Safety
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Appendix 17:	Professional Standards Committee case studies
Appendix 18:	Section 66 Inquiry case studies
Appendix 19:	Schedule 1 Inquiry case studies
Appendix 20:	Medical Tribunal summaries
Appendix 21:	Matters in other jurisdictions

Appendix 1: Employees

This year saw the departure of seven staff from the Board. Two staff members took maternity leave which allowed others to move into acting positions and the employment of contract staff to fill the vacant positions created by the moves. Seven new staff members were appointed and eight staff promoted from within the Board during the year, either permanently or into acting positions.

Staff Development

Staff members attended a wide range of relevant external training courses, seminars and in-house activities, in areas such as HR management, communication, reporting, medical and health law, business writing, management of difficult clients, writing Standard Operating Procedures and Policies, and IT software courses. Staff members also attended Hearing Member training workshops and internal training on team work and the use of TRIM, the Board's records management system.

Sick Leave

	04/05	05/06	06/07	07/08
Days lost	183	280	285	416.68
Per person average	4.9	7.37	7.31	10.16

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 2007-2008	Male	Female	Aboriginal/Torres Strait Islander	NESB
41	5	36	1	3

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 (3) representatives. 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 2007-2008 year with only six minor reports of injury or near misses.

Appendix 6: Legal change

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

Health Legislation Amendment Act 2007

The Health Legislation Amendment Act, 2007 amended s148 of the Medical Practice Act, 1992 to allow a chairperson or deputy chairperson of a Tribunal to continue sitting on a Tribunal if the chairperson's term of appointment expired while sitting. It also amended Clause 6 of Schedule 2 of the Medical Practice Act, 1992 to expand the definition of non-publication directions to include pictures, information or any other material that might identify a person.

Other changes introduced by this Act include:

- Changes to the entitlement to general registration based on certain qualifications and training.
- Widening the Board's powers to have medical students and practitioners assessed by registered health practitioners, including psychologists.
- Clarifying the Board's power to delegate to its Committees.
- Minor amendments in relation to the definition of excluded offences under the Medical Practice Regulations.

Medical Practice Amendment Act 2008

The Medical Practice Amendment Act, 2008 received Royal Assent on 11 June 2008, although the provisions of the Act did not commence during this reporting period.

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

- Specifying that protection of the health and safety of the public is to be the paramount consideration when exercising functions under the Act.

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

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 2007-2008.

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 hospital training positions.
- 48 practitioners were approved for GP area of need positions, 27 for RMO/CMO positions and 29 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, Burma, Albania, Brazil, Peru and Syria.
- 771 practitioners were approved for registration to undertake a period of postgraduate training. These practitioners are

international medical graduates from a range of countries such as India, the United Kingdom, Sri Lanka, Philippines, Belgium, Iran, Pakistan, and South Africa.

- Continued support for the Institute of Medical Education and Training orientation course designed to assist AMC graduates prior to their entering teaching hospitals for their requisite period of supervised training.
- 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.

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 about enhancing the support provided to practitioners trained overseas to orient them to Australian practice.

Appendix 9: Overseas travel

Dr Alison Reid, Medical Director, attended the International Physician Assessment Coalition (IPAC) Annual Meeting in San Diego in October 2007, where she was elected Vice-President of the organisation.

Appendix 10: Waste Reduction and Purchasing Policy

The Board's Waste Reduction and Purchasing Plan (WRAPP) was developed in conjunction with the Department of Environment and Conservation (NSW). The Board 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
Axis Technology Pty Ltd	\$48,250	Database support and maintenance
Oakton Consulting Pty Ltd	\$54,654	Accounting package support and project expenses
Edwina Light	\$54,654	Communications consulting
IAB Internal Audit Bureau	\$88,106	Superannuation review & consulting
Checknet Pty Ltd	\$143,596	IT support and project management

Appendix 12: Consumer response

During 2007-2008, the Board received a small number of complaints from the public and members of the profession. These largely related to dissatisfaction with the outcome of complaints or investigations concerning medical practice. The publication of the Register of Medical Practitioners online also generated some complaints regarding privacy and access to information. Complaints were referred to the appropriate area for investigation and speedy resolution, and the Board's policies and procedures were reviewed and amended where necessary. The Board's policy regarding handling complaints against staff members is being updated in line with NSW Ombudsman guidelines.

Appendix 13: Freedom of Information

This year has seen 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 Panels
- Performance Review Panels.

During the year 1 July 2007 to 30 June 2008, the NSW Medical Board received six inquiries 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 inquirers.

The Board received and processed 11 applications for access to documents under the Act within the required timeframe. This compares with 13 applications in 2006/07 and 18 applications in 2005/06. The Board provides practitioners with information sought from their personal files unless the FOI exemptions apply.

This year, the Board complied with requests from five practitioners to access all or some of the information on their files. The Board complied with four requests from media organisations for information.

The Board received one request for a transfer of an application made under Freedom of Information from another government department.

In the reporting period, there were no applications received for an internal review of the Board's decisions. 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.

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

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

Appendix 15: Policies and publications

The Board's website is 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.

During the year the Board introduced a 'News and Updates' section on its site to facilitate the communication of registration, legal and other key developments to the profession and the community.

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
- Uniform national registration pathways for international medical graduates
- The Health Program and impaired practitioners
- Registration processes, issues and developments
- Common conduct and complaints matters
- The Australian Medical Council
- Medical Tribunal decisions.

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

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 inquiries, and to monitor any conditions or restrictions on a medical practitioner's practise of medicine.

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

→ **The Director of Proceedings (DP) at the HCCC:** The role of the DP is to independently assess and prosecute matters before a Professional Standards Committee or Medical Tribunal and to consult with the Board in relation to this.

→ **A Professional Standards Committee (PSC):** PSCs are independent inquiry bodies set up under the Medical Practice Act

to determine any complaint that a medical practitioner may have engaged in unsatisfactory professional conduct.

→ **A Medical Tribunal:** The Medical Tribunal is an independent inquiry body set up under the Medical Practice Act, and chaired by a judge of the District Court, to determine serious complaints that a medical practitioner may have engaged in professional misconduct or unsatisfactory professional conduct. The Tribunal also has a role in determining certain appeals against decisions of the Board or a PSC and whether a de-registered person might be returned to the register of practitioners.

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

- The Board may take immediate action under s66 of the *Medical Practice Act, 1992*. Section 66 empowers the Board to suspend or place conditions on a practitioner's registration if necessary to protect the life or physical or mental health of any person.
- After assessment a complaint may require further investigation. Following completion of any further investigation by the HCCC, a complaint may be:

- referred to the Director of Proceeding for a determination as to whether to prosecute the complaint before a PSC or a Tribunal.
- referred for conciliation or complaint resolution.
- terminated.
- referred to the Board for appropriate action. A referral of a complaint to the Board may result in a medical practitioner being interviewed or counselled in relation to his/her conduct. They might also be dealt with in the Board's Health or Performance programs.

Appendix 17: Professional Standards Committee case studies

In the year ending 30 June 2008, the HCCC referred complaints in relation to 15 practitioners to a Professional Standards Committee (PSC), and 15 Professional Standards Committee hearings were held. Some examples of the types of matters dealt with at these PSC hearings are reproduced below.

Clinical treatment

A solo general practitioner faced a complaint concerning his excision of skin lesions on an elderly patient. It was alleged that following the excision he placed all the lesions in one container for transport to

pathology, failed to make an adequate record of the consultation, and administered a combination of opiates, benzodiazepines and local anaesthetic to the patient in inappropriate circumstances and without appropriate emergency resuscitation equipment or trained staff. It was also alleged that on a subsequent occasion the practitioner inappropriately used pethidine in an excessive dose as a sedative to excise a further skin lesion, and did not have an adequate or properly functioning emergency resuscitation equipment or access to an opiate reversal agent.

The practitioner admitted to all of the particulars of the complaint and that his conduct amounted to unsatisfactory professional conduct.

The Committee reprimanded the practitioner and directed that conditions be imposed on his registration relating to his practice and health.

Clinical practice

An experienced surgical specialist practising solo in rooms and also as a VMO in private hospitals and clinics was found guilty of unsatisfactory professional conduct in relation to his failure to assess the axillary glands in a male breast cancer patient on whom a wide excision had been performed, and in relation to his failure to ensure follow up and completion of treatment when the patient failed to keep an appointment.

The practitioner was cautioned and conditions were imposed on his registration requiring that he not treat breast cancer until he updated his knowledge of treatment of early breast cancer, and that he submit to a random audit of patient and practice records that relate to methods/systems for patient follow up.

The PSC also recommended that the Board's Performance Committee consider whether the practitioner's professional performance should be assessed.

Medical certificates

A suburban GP wrote five consecutive medical certificates at the request of an international student without identifying the certificates as copies. The student subsequently presented the certificates to a Commonwealth authority in order to satisfy the minimum attendance requirement of his student visa.

The Committee found that in failing to identify the certificates as copies the practitioner had contravened the requirements of the Medical Practice Regulation 2002.

The Committee cautioned the doctor and ordered that practice conditions be imposed on his registration requiring him to undertake educational activities and submit to an audit of records.

Inadequate investigation

A solo metropolitan GP first came to the Board's attention following notification by the Pharmaceutical Services Branch (PSB), which had received reports from police and pharmacists concerned with his prescribing of benzodiazepines and drugs of addiction to drug dependent patients. Following an investigation by the PSB and the HCCC, a complaint about his prescribing with respect to 11 patients came before the PSC. The practitioner had relinquished his Schedule 4 Appendix D authority and it remained withdrawn at the time of the PSC.

The practitioner admitted that he prescribed large quantities of benzodiazepines for 10 of the 11 patients for more than two years but denied that he lacked responsible medical judgment. Although aware the patients were receiving treatment for a range of conditions from other doctors, he did not liaise with other treating doctors. Peer opinion was that a practitioner of an equivalent level of standing and experience ought to have recognised that the patients were or could have been addicted to benzodiazepines. He should have had a high level of suspicion and been more diligent in attempting to establish this before issuing prescriptions.

The practitioner was found guilty of unsatisfactory professional conduct, reprimanded, and conditions were imposed on his registration in relation to his prescribing, and requiring him to undertake prescribing courses.

Standards of medical records

A practitioner in isolated rural general practice for nearly 30 years admitted to a complaint regarding his medical records for a long-term patient, which he failed to keep in accordance with the *Medical Practice Regulation, 1998 and 2003*.

The patient's medical records were prepared as an aide memoir, which the practitioner conceded would not have assisted another practitioner caring for the patient. The Committee noted with approval the improvements made by him to his medical record keeping since the initial complaint, in particular the practice's AGPAL accreditation, which commented favourably on his improvements.

The practitioner was found guilty of unsatisfactory professional conduct and registration conditions requiring a random audit of his medical records to monitor the continuation of the improved standard of his record keeping were imposed.

Appendix 18: Section 66 Inquiry case studies

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. Matters are then referred to the HCCC for investigation. The Board conducted 26 s66

Inquiries during the reporting year. Summaries of matters considered by the Board are reproduced below.

Drug use

After a specialist anaesthetist notified the Board of his 'recreational use of propofol', an anaesthetic agent, he joined the Health program and health conditions were imposed on his registration.

In accordance with his conditions he had to submit to testing by PaLMS, the Board's drug testing agency. Subsequently, he returned five positive tests for propofol and the Board convened proceedings under Section 66. The doctor denied that he had 'knowingly' taken the drug and posited that a nurse had the opportunity to 'spike' his food.

In addition to the health conditions, practice conditions were imposed on his registration.

Prescribing human growth hormone

A GP with more than 20 years experience was more recently practising 'anti-ageing medicine', working in a city practice and from his home. Following a complaint from SA Police, the Pharmaceutical Services Branch investigated the practitioner's supply of somatrophin (human growth hormone) and other drugs.

In less than 17 months the practitioner obtained 5,555 vials of somatrophin with an additional 199 vials unaccounted for. The PSB estimated the minimum wholesale value of somatrophin obtained by him for on-supply as \$800,000. He also procured 1251 Pregnyl ampoules. The drugs were purchased from a wholesaler with invoices issued to another practitioner. Patients were charged the wholesale price for the drugs and his income was derived by an up-front fee in exchange for advice and monitoring by him.

The doctor's evidence indicated a lack of insight into the deficiencies in his clinical practice and that there was no recognised independent medical or scientific evidence adduced to support his views of anti-ageing medicine. The practitioner was suspended for eight weeks and then the suspension was lifted and conditions were imposed.

Inappropriate prescribing

The Board was advised that a GP had been investigated by the Pharmaceutical Services Branch in relation to his prescribing of steroids, narcotics and benzodiazepines to patients, his self-prescribing and his purchase and supply of large quantities of human growth hormone. The medical practitioner acknowledged that his prescribing was not appropriate and not in accordance with recognised therapeutic purposes.

Conditions were imposed on the GP's registration that he relinquish his Schedule 8 and Schedule 4 Appendix D authorities and that he not possess, supply, administer or prescribe such medications, including human growth hormone. The practitioner was also directed to attend for further assessment by Board-nominated practitioners to determine

whether he suffered from an impairment. A recommendation was also made that the doctor be referred to the Performance program on the basis of the paucity of his medical records.

Impaired practitioner breaching conditions

An impaired GP had breached registration conditions previously agreed to at an Impaired Registrants Panel by not remaining abstinent from alcohol. The s66 delegates did not consider that suspension was necessary. The practitioner was warned that any future breach would lead to further s66 action, with suspension being the likely outcome. Further conditions were imposed on his registration, including that he only work in a group practice with another practitioner always on site, that he attend for treatment by a drug and alcohol specialist, and that he undertake monthly full blood count and liver function testing in addition to the existing monthly CDT testing.

Prescribing practices

A practitioner came to the attention of the Pharmaceuticals Services Branch following an investigation. Of particular concern was the prescribing of large amounts/high doses of opiates and benzodiazepines to patients known, or ought to have been known to be opiate dependent and/or on methadone programs, prescribing without authority and prescribing without confirming whether another doctor held an authority.

The s66 delegates noted that the practitioner had failed to substantially alter his prescribing habits despite being advised to by the PSB 12 months earlier.

Conditions to relinquish authorities to prescribe Schedule 8 and Schedule 4D drugs and to undertake further investigations of the practice at a broader level were imposed on his registration.

Serious criminal charges

The Board was notified that a general surgeon was charged with two offences under section 61I (sexual intercourse without consent) and one offence under section 61L (assault with act of indecency) of the Crimes Act. The charges arose out of his alleged conduct when a female patient consulted him in his rooms. The surgeon works in public hospitals, private hospitals and consulting rooms.

Conditions were imposed on his registration including that a chaperone be present when he provided medical services to female patients.

Clinical practice – multiple complaints

A solo practitioner was suspended from practising medicine on the basis of multiple issues in relation to his/her practise of medicine including communication, record keeping and impairment concerns. When considered individually these issues did not necessarily provide sufficient concern to warrant suspension, but when considered all together, the delegates were satisfied the threshold of concern that necessitated action being taken under section 66 had been reached.

The level of concern was increased by the delegates' observation of the practitioner during the proceedings and their consideration of the practitioner's responses to their questions. The practitioner denied any impairment, but the delegates concluded the possibility of impairment was a clear issue of concern. Suspension was considered necessary as the delegates had material before them which demonstrated the practitioner had not complied with conditions previously imposed on his/her registration by the Supreme Court.

Appendix 19: Schedule 1 Inquiries case studies

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

Registration after failure to renew

A medical practitioner sought re-registration after failing to renew his registration. At the time his name was removed from the Register he was not compliant with health and practice conditions imposed by a Performance Review Panel (PRP) in 2005. His deliberate non-compliance together with his oral evidence and the documentation available were relevant to the 'competence' and 'good character' requirements of the Medical Practice Act. The medical practitioner failed to demonstrate any meaningful insight regarding his professional performance and failed to reply to requests for information. The application for re-registration was refused.

Non-practising registration

A GP who had requested to be transferred to the non-practising registration category in 2004 because of psychiatric ill-health applied to be re-registered in the General category. The Board was satisfied he was eligible to be re-registered without conditions because he had demonstrated over the previous three years that safety checks and balances had worked when he was not mentally capable of practising medicine safely. Those checks and balances remain in place.

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

Functional impairment

It was alleged Dr Theodore David Potts (University of NSW, 1975), a metropolitan GP, suffered an impairment which detrimentally affected his ability to practise medicine. It was also alleged the doctor was guilty of unsatisfactory professional conduct and/or professional misconduct in relation to his treatment of and manner with seven patients while undertaking a weekend locum at Moruya Hospital in 2004. The complaint of impairment was denied by the doctor, but the Tribunal heard evidence that tests had revealed impaired cognitive functions associated with a traumatic brain injury (the respondent had been in a car accident in the 1970s in which he was injured and as a result was unconscious for two weeks). Although it was not necessary to define with precision what condition lay beneath the impairment, the Tribunal found *'There is no evidence that, whatever the underlying cause whether organic or personality or both, there will be any improvement either through treatment or the passage of time. The Tribunal is satisfied that the respondent lacks sufficient insight or self-awareness to monitor (and change) his behaviour and, in the result, could not prevent a recurrence of the behaviours which drove the history of complaints.'*

The Tribunal concluded the only way in which he could safely practise medicine would be if he was supervised one to one in every aspect of that practice, amounting to his being chaperoned. It determined the only appropriate order was that his name be removed from the Register and that he not apply to be deregistered for two years.

Date of Medical Tribunal decision: 17 August 2007

Professional boundaries

It was alleged Dr Anthony Frederick Jebb (University of Sydney, 1970) was guilty of unsatisfactory professional conduct and/or professional misconduct in relation to a patient complaint about his medical treatment, namely psychotherapy. The complaint included allegations of inappropriate personal and professional boundaries, including hugging and inappropriate discussions, and a failure to refer the patient to specialist care. In 2005, the Board imposed conditions on his registration following an urgent section 66 inquiry and referred a complaint to the HCCC for investigation. The Tribunal concluded that the *'inappropriateness of Dr Jebb's conduct towards Patient A was amplified by the nature of her problems, the degree of instability that her history revealed, and his role as medical practitioner treating her in whom she was entitled to repose considerable confidence.'*

The Tribunal found him guilty of professional misconduct and reprimanded him. Conditions were also placed on his registration.

Date of Medical Tribunal decision: 19 September 2007

Breach of conditions

It was alleged Dr Ian Alex McHue (University of Newcastle, 1984), a rural anaesthetist, was guilty of unsatisfactory professional conduct

and/or professional misconduct in relation to multiple breaches of registration conditions and deliberate attempts to mislead the Board and the Tribunal about his alcohol consumption.

Dr McHue reported his alcohol dependence to the Board in 2001 and a number of health conditions were placed on his registration, which were revised on three occasions over the next few years. The Tribunal concluded the practitioner had breached his registration conditions many times by consuming alcohol and failing to attend treatment and testing, had not been truthful about the extent of his drinking, and had been given considerable opportunity to deal with the problem of his alcohol dependency.

It noted that without honest dealings by practitioners with registration conditions, *'the entire system developed to benefit both public and practitioner will be imperilled.'* Regarding the issue of dishonesty, it also stated that: *'Practitioners whose conduct of medicine is called into question must appreciate that this Tribunal may treat dishonest statements and explanations to the Board, to Panels and to experts appointed by the Board and to this Tribunal as justifying suspension or de-registration even where the original conduct may well not have, of itself, led to such a result.'*

The Tribunal found the doctor guilty of professional misconduct and ordered he be de-registered for a minimum period of two years.

Date of Tribunal decision: 14 December 2007

Inappropriate prescribing

Dr Andrzej Kazmierczak

It was alleged Dr Andrzej Kazmierczak (Gdansk Medical Academy, 1973; AMC Certificate, 1984), a metropolitan GP, was guilty of unsatisfactory professional conduct and/or professional misconduct in relation to his prescribing of Schedule 8 and Schedule 4D drugs to nine patients.

It was alleged he prescribed Schedule 8 and 4D drugs without exercising responsible medical judgement, in quantities and for periods in excess of the recognised therapeutic standards, and in circumstances where he knew or ought to have known the drugs were being or likely to be abused. It was also alleged that in relation to some patients, the doctor prescribed for a period in excess of two months without obtaining the relevant authority from the NSW Health Department, and when the continued prescription had been advised against by a pain clinic.

The Tribunal was satisfied that the conduct amounted to a failure to exercise the skill, judgement and care expected of a medical practitioner. *'It is serious misconduct exacerbated by the respondent's persistence in it over a significant period.'* The Tribunal concluded that: *'Overall, the flavour of the respondent's evidence was that he was the slave to the patients' requests for drugs, he could counsel and advise them to reduce but in the end he submitted to their demands. The Tribunal finds this demonstrates both a lack of insight but also a failure to exercise his responsibilities as a medical practitioner.'*

The Tribunal found the doctor guilty of professional misconduct and

ordered he be de-registered for a minimum period of one year.

Date of Tribunal decision: 14 December 2007

Dr Peter Keith

It was alleged Dr Peter Keith (University of NSW, 1967), a rural GP, was guilty of unsatisfactory professional conduct and/or professional misconduct in relation to his prescribing of Schedule 4, 4D and 8 drugs to seven patients.

The allegations included that he provided prescriptions for Schedule 4, 4D and 8 drugs without exercising responsible medical judgement as to whether it was appropriate to issue such prescriptions, in quantities and for periods in excess of recognised therapeutic standards, when he ought to have known the drugs were or would be likely to be abused, and when such prescribing was contraindicated as the patients had a history of drug dependency. It was also alleged the doctor failed to make proper records of his treatment of certain patients.

Noting that its findings could justify suspension or de-registration, the Tribunal considered a number of factors including Dr Keith's admissions and degree of remorse, that there were no previous unprofessional conduct findings, his general contribution to local medical services, and the support of colleagues.

The Tribunal found the doctor guilty of professional misconduct and ordered he be fined \$20,000, banned from prescribing benzodiazepines and Schedule 8 drugs for two years, and have conditions imposed on his registration relating to education, counselling, supervision and auditing of his practice.

Date of Tribunal decision: 19 December 2007

Falsification of registration cards

Dr Fareed Bahrami

It was alleged Dr Fareed Bahrami (University of Otago, NZ, 1995), a metropolitan general practitioner, was guilty of unsatisfactory professional conduct and/or professional misconduct in relation to complaints that he falsified registration documents and provided such documents to a medical college.

Dr Bahrami's registration had been subject to practice and health conditions, imposed by the Medical Tribunal in 2003 after it severely reprimanded him in relation to complaints of professional misconduct and conviction of criminal offences.

The 2008 Tribunal heard complaints that the practitioner had on multiple occasions altered photocopies of his registration card to replace the word 'conditional' to 'general', presented the altered registration card to a Justice of the Peace for certification, and then provided the altered card to the medical college as part of his application for entry to its training program.

The Tribunal found the complaints proven and concluded it could not 'confidently determine that the respondent would accept the high standards of probity demanded of a member of the medical profession when he states that he was unaware of the gravity of the criminal act of making a false declaration'. It noted he had all the necessary technical qualifications to be

registered as a practitioner, but did not consider that 'as at this time the respondent has the necessary character to fulfil his ambitions'. The Tribunal de-registered Dr Bahrami for a minimum period of three years.

Date of Tribunal decision: 6 June 2008

B. Appeals determined by the Medical Tribunal

Appeal against Performance Assessment process

The Medical Tribunal heard an appeal by Dr Robert Darlow Smith (University of Sydney, 1952), a metropolitan medico-legal practitioner, against a decision of a Performance Review Panel (PRP), which considered issues related to his medico-legal practice. This was the first appeal brought by a practitioner against a PRP decision.

The Tribunal considered that the evidence presented to both it and the PRP established that Dr Smith's method of dealing with patients 'falls short of the standard of a competent medico-legal expert', that he had 'poor communication skills', and that there was a basis for concerns that his diagnostic skills may no longer be sufficient.

The Tribunal re-imposed similar registration conditions to those imposed by the PRP, including that his practice be limited to medico-legal work, his practice be supervised, he complete a communication program, and that his professional practice be assessed through the Board's Performance Program.

Date of Tribunal decision: 11 December 2007

Appeal against Board's decision to suspend

Dr David Charles Lindsay

Dr Lindsay was a solo practitioner in a metropolitan skin cancer clinic. He was suspended from practising medicine under section 66 of the Medical Practice Act on 19 December 2007. An order extending the period of suspension was made on 8 February 2008. The focus of the appeal to the Medical Tribunal was against the orders to suspend him and the nature of multiple complaints relating to his conduct with patients, and the question of whether he may be impaired.

The Tribunal found the number of complaints and their similarities gave rise to serious concerns about Dr Lindsay's conduct towards his patients, posing a risk to their physical and mental health. The Tribunal also concluded it was gravely concerned that he may suffer from a psychiatric condition and was possibly impaired. The Tribunal found that no condition could be imposed which would protect Dr Lindsay's patients from the risks identified.

The appeal was dismissed and the suspension confirmed.

Date of Tribunal decision: 15 April 2008

C. Tribunal Reviews by the Medical Tribunal

Restoration to the Register

During 2007-08 the Medical Tribunal handed down three decisions in respect of application for a review of de-registration orders. The Tribunal refused all applications for restoration.

Chris Tsioutis

In 1996, the Medical Tribunal de-registered Chris Tsioutis following his conviction in the District Court for making false Medicare claims. He was released on recognisance without sentence but was ordered to pay a pecuniary penalty of \$5,000 to the Commonwealth. Mr Tsioutis had previously made an unsuccessful application for reinstatement to the Register in 1999.

The 2007 Tribunal was still not satisfied that the applicant had demonstrated he was a fit and proper person for registration.

'The Tribunal still has concerns about his candour and whether he has in fact overcome the defect of character which caused his deregistration in the first place. The Tribunal is equally unimpressed with the ill thought out and incomplete plans put forward for his possible reintegration into the profession. The onus lies on the applicant. As has been repeatedly stressed, it is a heavy onus. The applicant has simply, on this evidence, failed to discharge it.'

The application for reinstatement was refused.

Date of Tribunal decision: 9 October 2007

John Herbert Bannister

In 1992, the Medical Tribunal de-registered John Herbert Bannister following its consideration of a patient treatment complaint, as well as his establishment of a billing system through which he charged for services he had not provided over a period of five years.

The Tribunal concluded the system of billing comprised a 'deliberate deceit perpetrated for the motive of financial gain'.

In considering this, his fourth, application for re-registration, the Tribunal was unconvinced that Mr Bannister was a 'different person of reformed character'. Apart from the issues of character, the Tribunal determined re-registration would not be appropriate given the lengthy time Mr Bannister had been away from surgery and general medicine.

The majority of the Tribunal was 'not persuaded that he is a changed man who has now demonstrated he is of sufficient good character to now be permitted to practise medicine or that he is now competent to be re-admitted to the register, even with conditions'.

The application for reinstatement to the Register of Medical Practitioners was refused.

Date of Tribunal decision: 19 December 2007

Karanalu Prakash

Karanalu Prakash was de-registered by order of the Medical Tribunal in 2004 and banned from applying for re-registration until December 2006. The Tribunal had found him guilty of professional misconduct

in relation to his breach of registration conditions that required him to be supervised in medical practice, breaches of prescribing regulations, and making false statements to the then Health Insurance Commission.

The Tribunal considered Mr Prakash seemed incapable of acknowledging the dishonesty that led to his de-registration and was concerned by his continuing dishonesty. *'We are not persuaded he has overcome the relevant defect in his character. We are not persuaded he is a fit and proper person to practise medicine.'*

The application for reinstatement to the Register of Medical Practitioners was refused.

Date of Tribunal decision: 11 April 2008

D. Appeals against Tribunal decisions

Two appeals were determined by the NSW Court of Appeal during the reporting period.

HCCC appeal: Dr Rupasenana Karalasingham

In March 2007, the Medical Tribunal found Dr Rupasenana Karalasingham guilty of professional misconduct in relation to his provision of false medical certificates to three overseas students, but a complaint that he was not of good character was dismissed. The GP was reprimanded, fined \$20,000, and had conditions imposed on his registration.

The HCCC appealed the Tribunal's decision to dismiss the character complaint, as well as its failure to de-register the doctor.

The NSW Court of Appeal dismissed the Commission's appeal.

Date of NSW Court of Appeal decision: 2 October 2007

HCCC appeal: Dr Richard Wingate

The HCCC appealed against the decision of the Medical Tribunal which dealt with three complaints against Dr Wingate concerning his conduct in relation to the possession of, and subsequent conviction for, possession of child pornography.

The HCCC challenged three aspects of the Tribunal's decision: that the Tribunal erred in dismissing a complaint that Dr Wingate was not of good character; that the Tribunal misdirected itself by taking into account the fact that Dr Wingate had been dealt with by the criminal law; and that there was error in the Tribunal permitting Dr Wingate to continue to treat persons under 18 years of age whilst requiring a chaperone.

The first two aspects of the appeal were dismissed. The third was allowed in part, with the result that one of the conditions on Dr Wingate's registration was varied so it now states that he is not to attend, treat or perform operations on patients under 18 years of age.

Date of decision: 20 November 2007

Appendix 21: Matters in other jurisdictions

NSW Supreme Court

Bhatia v New South Wales Medical Board [2007] NSWSC 1316

The NSW Supreme Court dismissed an application by Dr Satya Pal Bhatia, a metropolitan cosmetic surgeon, for an interlocutory order restraining the Medical Board and its delegates from taking action under section 66, which was to determine whether the doctor's registration should be suspended or have conditions placed upon it. The decision to take section 66 action followed the receipt of complaints that raised concerns about the doctor's removal and re-implantation of a breast implant, infection control standards, treatment of a known infection, and the adequacy of the doctor's response to the Board. Before the Supreme Court, Dr Bhatia alleged errors of law including that the Board's delegation decision was invalid in relation to the appointment of two delegates to consider action under section 66.

Justice Harrison determined that the challenge to the Board's appointment of the delegates was 'without merit'. He also concluded that: *'...the plaintiff has not pointed to any specific (procedural) prejudice to him. There is no certainty that any of the powers conferred upon the third defendants [the delegates] by s66(1) will be exercised to the detriment of the plaintiff and there are good reasons to permit the inquiry to proceed having regard to the protective function which it is both intended and designed to serve.'*

Date of NSW Supreme Court decision: 8 November 2007

Lindsay v New South Wales Medical Board [2008] NSWSC 40

The NSW Supreme Court dismissed a challenge by Dr David Charles Lindsay, a metropolitan doctor working in skin cancer medicine, against a decision and order made by the Board's delegates in December 2007 to suspend him for a period of eight weeks. When ordering his suspension, the delegates considered a number of issues of concern including complaints made against the practitioner in relation to his communication and behaviour, his lack of insight into the complaints and disciplinary processes, his impairment, and inadequate history taking and medical record keeping.

The doctor argued the order under section 66 was void and of no effect and sought a judicial review of the lawfulness of the action taken by the Board pursuant to s66, including a wide-ranging attack on procedural fairness and delegation powers.

Justice Hall rejected all of the doctor's claims for relief from the Board's orders and supported the processes and functions by which the Board exercised its s66 powers.

Date of NSW Supreme Court decision: 7 February 2008

Holding out as a doctor: Yao Guo Lin (aka David Lin)

Yao Guo Lin (aka David Lin) received a suspended 13-month jail sentence in the NSW Supreme Court after he pleaded guilty to 31 breaches of section 105 of the Medical Practice Act. Under this

section of the Medical Practice Act, it is an offence for a person who is not a registered medical practitioner to advertise or hold himself or herself out to be qualified or willing to practise medicine, or to give or perform any medical or surgical advice, service, attendance or operation.

The Medical Board prosecuted Mr Lin for holding himself out as a doctor and supplying a medical service, including providing RU486 for an abortion, and providing false medical certificates to students.

Mr Lin was released from custody upon entering into a 13-month good behaviour bond.

Date of NSW Supreme Court decision: 3 August 2007

NSW Local Court

Holding out as a doctor: Lorraine Brooke-Smith

Lorraine Brooke-Smith received a suspended jail sentence in the NSW Local Court for falsely holding herself out as a registered doctor. She was also sentenced for breaching her bond in relation to similar offences. Ms Brooke-Smith pleaded guilty to the Board's allegations that in 2004 she posed as a doctor and on that basis was hired by Life Without Barriers, a not-for-profit organisation as a carer.

The most recent case against Ms Brooke-Smith followed the Board's successful prosecution against her in 2003 for 27 breaches of the 'holding out' provisions of the Medical Practice Act.

Her sentence of imprisonment totalled 12 months, which was suspended upon her entering into a good behaviour bond.

Date of NSW Local Court decision: 31 October 2007

NSW Administrative Decisions Tribunal

JD v NSW Medical Board [2008] NSWADT 67

The applicant, JD, a medical practitioner, had sought review of conduct of the NSW Medical Board pursuant to section 55(1) of the Privacy and Personal Information Protection Act, 1998 (PPIP Act).

The conduct in question was a letter concerning JD, written and sent by the Board to the Privacy Commissioner. JD contended that the letter contained 'personal information' and 'health information' about him and that the provision of this information to the Privacy Commissioner was a breach of the limits on disclosure of personal information principle found in section 18 of the PPIP Act, and the health privacy principle found in item 11 of Schedule 1 of the Health Records Information Privacy Act 2002 (the HRIP Act).

The Board had conducted an internal review of the conduct and determined to take no further action as it found that the information about JD in the letter was not 'personal information' coming within the PPIP Act or 'health information' coming within the HRIP Act.

The Tribunal concluded that the letter provided to the Privacy Commissioner was not a 'disclosure' and disposed of JD's application.

Date of NSW ADT decision: 4 March 2008

