ANNUAL REPORT 2006

The New South Wales Medical Board

NEW SOUTH WALES MEDICAL BOARD

Annual Report 2006

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ACCESS TO THE BOARD

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CHARTER

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

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

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

- *(a) to promote and maintain high standards of medical practice in New South Wales;*
- *(b) to advise the Minister on matters relating to the registration of medical practitioners, standards of medical practice and any other matter arising under or related to this Act or the regulations;*
- *(c) to publish and distribute information concerning this Act and the regulations to registered medical practitioners and other interested persons;*
- *(d) to provide counselling services for registered medical practitioners and medical students.*

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

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

AIMS AND OBJECTIVES

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

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

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

NEW SOUTH WALES MEDICAL BOARD

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The Office of The President

25 September 2006

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

Dear Minister

I have the pleasure of forwarding to you the Annual Report of the New South Wales Medical Board for the year ending 30 June 2006.

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

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

Yours sincerely

P G Procopis

President

Enclosure

PRESIDENT'S REPORT

The release of the Productivity Commission's report into Australia's Health Workforce in August 2005 marked the first steps toward reforms that have the potential to effect the most profound change on the Medical Board in its history of over 165 years.

The Productivity Commission's workforce recommendations were substantially adopted by the Council of Australian Governments (COAG) in a communique issued on 14 July 2006, and, if carried through in their entirety, may mean that the New South Wales Medical Board will cease to exist in its current form.

In summary, the COAG communiqué envisages a national health registration board responsible for the registration of health care workers in nine different professions across all eight jurisdictions, one of which will be medicine. The information available at the time of this annual report indicates that there will be scope for a "presence" in individual jurisdictions to handle, or possibly advise on, other issues such as complaints, discipline and notifications.

The Board has actively promoted and supported a variety of initiatives designed to break down the often illogical differences and barriers between the jurisdictions in recent years. It considers that in some respects the Productivity Commission/COAG proposals are a logical extension of this process and, accordingly, to be supported. However with the paucity of information currently available, it is not clear how many of the important functions and roles undertaken by the Board to fulfil its charter of public protection will be addressed in the new model.

The Board will be focusing its attention in the coming months to ensure that any new regulatory system does not detract from the highly regarded and sophisticated system that has been developed by the NSW Board since its creation as an independent statutory body in 1987. Of particular significance are the Performance and Impairment Programs, which are recognised as in many respects representing best practice in professional regulation both at national and international levels.

The 2005/2006 year began with the Board co-hosting the National Medical Boards Conference with the Northern Territory Medical Board in Alice Springs. The focus of the meeting was on 'area of need' programs – under which doctors receive temporary registration to work in areas with unmet medical need – and the issues confronting Boards, the profession and the public in meeting the medical workforce and safety needs of remote communities. A key aspect of the conference was a series of visits to remote communities and facilities servicing those communities, and this provided an often sobering insight into the complexity and difficulties encountered in this area.

The year saw the winding up of most of the matters that had arisen as a result of the Special Commission of Inquiry into Camden and Campbelltown Hospitals. It is of note that while a substantial number of doctors were named in the original complaints, in the final analysis only a small number were considered to be in need of referral to formal disciplinary proceedings. In the Board's view, this did not diminish the seriousness of some of the issues raised during the Inquiry, but rather reflected the fact that staff were often working in overstretched and difficult circumstances reflecting some deep-seated systems problems.

The Health Care Complaints Commission also substantially addressed its mandate of dealing with its backlog of longstanding complaints and investigations. In this process the Board conceded that a number of matters considered serious at the time of the initial complaints could not fairly be referred to formal disciplinary proceedings due to the substantial delays that had arisen during the course of the Commission completing its investigations.

The Board's focus on this problem of delay has been reported on in previous annual reports, and it will continue to closely monitor the flow of complaints through the Health Care Complaints Commission's investigatory processes. It is also vital that efforts to reduce delays keep sight of the need for thorough and fair investigation in the interests of both the public and the profession.

Several national issues have had a significant impact on the Board. Of particular note has been the so-called "Dr Death" case in Queensland which has led to an acceleration of changes already being developed to enable Boards to more closely scrutinize the credentials and suitability of international medical graduates working in areas of need. The Board revised its Certificate of Good Standing policy, formalised its English-language competency requirements, and introduced mandatory primary source verification of documents for international medical graduates, as well as generally reviewing and modifying processes to ensure that the chance of a similar case arising in New South Wales is minimised. While cognisant of the workforce pressures which are predicted to become more acute both nationally and internationally, the Board has maintained its requirement of having the competence of each area of need applicant individually assessed.

The Board has continued to be actively involved in other national initiatives, in particular the development of a "portability" model of registration that would entitle a practitioner registered without conditions in any Australian jurisdiction to work in any other jurisdiction without undergoing formal registration processes.
The status of these proposals is at this time unclear due to the Productivity Commission/COAG announcements.

During the year, the Board noted the completion of Dr Bernard Kelly's term as the Royal Australian College of General Practitioners' nominee, after 12 years of valuable contribution to the Board, and the resignations of Diane Robinson (Minister's Legal nominee), Julie McCrossin (Ministerial nominee) and Jamal Rifi (Community Relations Commission nominee) from the Board.

Peter Procopis
President

YEAR IN REVIEW

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

	2003/04	2004/05	2005/06
Number of Registrants by Category			
The following indicates the number of registrants on the 30 June.			
Category of Registration			
General	21798	22307	22630
Interns	487	479	496
AMC Registrants undertaking supervised training	94	150*	137
Postgraduate Trainees	1082	1193	1326
General Practice Trainees	185	200	197
Area of Need	217	247	249
Conditional Specialists	511	624	746
Specialist Trainees	21	15	21
Retired/Non Practising	1563	1625	2116
Other	53	249	**0
Total Registrants	**26011**	**27089**	**27918**
Student Registrants	**2209**	**2716**	**3118**

* Increase in number of AMC graduates registered at 30/06/2005 in main due to mid-year allocation commencing in June instead of August.

** Registrants with additional conditions on their registration are included within their category of registration.

	2003/04	2004/05	2005/06
Professional Conduct			
Complaints received	1,030	1,080	1292
PSCs concluded	11	19	9
Medical Tribunals concluded	19	35	37
Counselling Interviews	12	15	22
Section 66 Inquiries	34	18	22
Health			
Doctors in Health Program	131	126	124
Entrants to Program	40	37	29
IRPs convened	50	48	44
Board Review Interviews	210	211	238
Performance			
Doctors in Performance Program	32*	40*	42
Entrants to Program	19	17	22
Assessments concluded	13	10	28
PRPs concluded	4	7	9
Retired as a result of participation	2	2	4
Performance Interviews concluded	31	18	28

* amended figure

STRUCTURE OF THE BOARD AND SECRETARIAT

MEMBERSHIP OF THE NEW SOUTH WALES MEDICAL BOARD

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

Members of the Board, their qualifications, and nominating body for the period 1 July 2005 to 30 June 2006 are listed below. During this period six ordinary meetings were held. Attendances at these Board Meetings are recorded in square brackets.

A/Professor Peter George Procopis, President, AM, MBBS (Sydney), FRACP, Royal Australasian College of Physicians nominee [4]

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

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

Dr Susan Ieraci, MBBS (Sydney), FACEM, Ministerial nominee [6]

Dr Bernard Raymond Kelly, AM, MBBS (Sydney), FRACGP, BSc, Royal Australian College of General Practitioners nominee (term expired 31 September 2005) [1]

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

Ms Rosemary Eva Kusuma, BSW (Sydney), Ministerial nominee (appointed 30 January 2006) [3]

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

A/Prof Eugen Molodysky, MBBS (Sydney), PhD (Sydney), DRACOG, MRACGP, Community Relations Commission nominee (appointed 24 May 2006) [2]

Ms Julie McCrossin, LLB (NSW), BA (Sydney), Dip Ed (Sydney), Grad Dip Adult Education (UTS), Ministerial nominee (resigned 15 September 2005) [0]

A/Prof Rodney James McMahon, MBBS (Sydney), Flt Lt (ret), DRCOG, DRANZCOG, FAIM, FRACGP, Royal Australian College of General Practitioners nominee (appointed 30 September 2005) [5]

Dr Robyn Stretton Napier, MBBS (Sydney), Australian Medical Association nominee [5]

A/Professor Frederick John Palmer, M.Litt (New England), MB ChB (Sheffield) MD (Sheffield), BA (New England), MRCP (London), DMRD (London), FRACR, FRCR (London), Royal Australasian College of Radiologists nominee [6]

Dr Jamal Rifi, MBBS (Sydney), FRACGP, (resigned 27 September 2005), Community Relations Commission nominee [1]

Dr Denise Margaret Robinson, MBBS (Sydney), MHP, FAFPHM, MRACMA, Department of Health nominee (appointed 21 November 2005) [3]

Ms Diane Joan Robinson, BA (Sydney), LLB (Sydney) LLM (Sydney), Ministerial nominee (Legal) (resigned 30 January 2006) [1]

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

Professor Allan David Spigelman, MBBS (Sydney), FRACS, FRCS, MD, Universities' nominee [6]

Dr Gregory Joseph Stewart, MBBS, MPH (Sydney), FRACMA, FAFPHM, Department of Health Nominee to 1 August 2005, Ministerial nominee from 21 November 2005 [4]

Dr Kendra Sundquist, Ed.D (UTS), MHlth.Sc.(Ed) (Sydney), RN, MCNA, Ministerial nominee [5]

Dr Ian Kenneth Symington, MBBS (Sydney), FRANZCOG, FRCOG, Royal Australian and New Zealand College of Obstetricians and Gynaecologists nominee [6]

Professor Kathleen Anne Wilhelm, AM, MBBS (New South Wales), MD, FRANZCP Royal Australian & New Zealand College of Psychiatrists nominee [3]

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

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

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

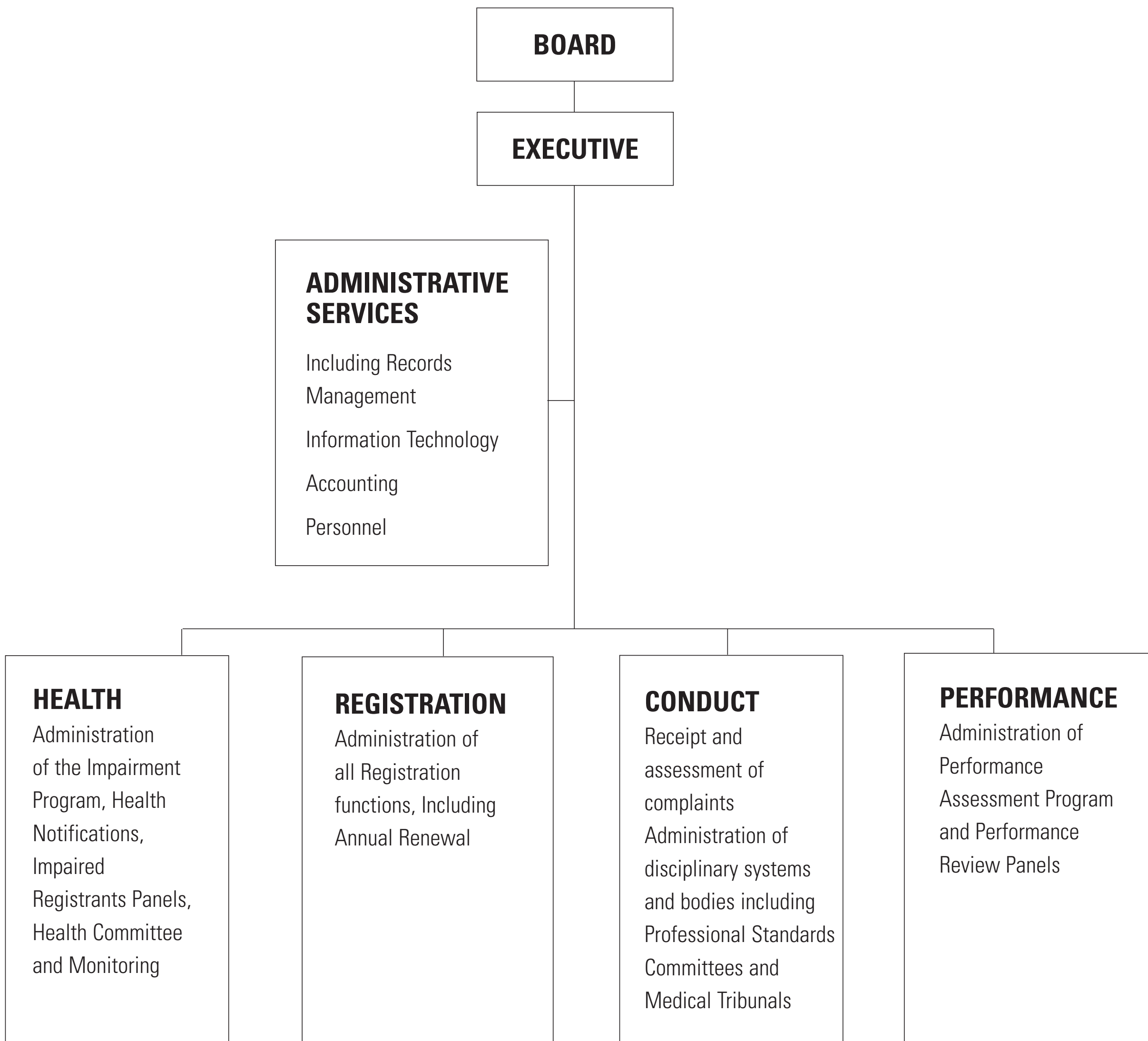
Dr A Abrahams, Dr S Allnutt, Dr K Arnold, Dr P Arnold, Dr A Bean, Dr J Bell, Dr M Bennett, Dr C Berglund, Dr F Black, Dr P Bland, Dr J Branch, Dr D Brash, Dr J Brown, Dr F H Burns, Dr R Carroll, Dr M Carlton, Dr J Caristo, Dr R Chapman-Konarska, Dr I Chaussivert, Dr D Child, Dr C Clifton, Ms A Collier, Ms A Deveson, Dr M Diamond, Dr J Donsworth, Dr G Dore, Prof S Dorsch, A/Prof B

Doust, Dr J Dudley, Dr K Edwards, Ms G Ettinger, Dr A Eyers, Dr R Fisher, Dr D Floate, Dr T French, Dr M Friend, Dr P Friend, Dr R Gertler, Dr M Giuffrida, Prof A Glass, Dr M Gleeson, Prof W Glover, Dr R Gordon, Dr A Gould, Ms A Gray, Prof J Ham, Dr N Harris, Dr J Hely, Dr J Hogg, Dr M Hollands, Dr S Howle, Ms J Houen, Dr D Hunt, Dr S Huntsman, Dr K Hutt, Dr K Ilbery, Mr D Jackett, Dr M Joseph, Dr C Karalaris, Dr M Kearney, Mr R Kelly, Dr B Kelly, Dr J Kendrick, Dr J Kennedy, Dr E Kertesz, Dr G Kesby, Ms H Kiel, Dr L King, Dr R King, Prof P Klineberg, Dr E Kok, Dr B Kotze, Dr P Langeluddecke, Dr C Lauer, Dr V Lele, Dr I Lorentz, Dr J Lovric, Dr R Lyneham, Dr S Mares, Dr F Martin, Prof P McNeill, Dr S Messner, Dr P Morse, Ms M L Napier, Dr J Ng, Dr N O'Connor, Dr M Pasfield, Dr C Peisah, Dr A Pethebridge, Dr J Phillips, Dr S Phillipson, Dr R Pillemer, Dr S Porges, Dr R Rae, Dr J Raftos, Dr K Ramsay, Dr W Reid, Dr S Renwick, Dr G Rickarby, Dr J Rodney, Dr W Ross, Dr I Rotenko, Dr J Russell, Dr J Sammut, Dr A Samuels, Dr G Saunders, Dr R Seidler, Mr R Smith, Dr R Spark, Dr J Spies, Dr S Spring, Dr G Steele, Dr J Stevenson, Dr G Stewart, Dr I Stewart, Dr J Sullivan, Dr D Sutherland, Dr V Sutton, Dr S Toh, Dr S Tomas, Dr J Trollor, Dr P Tucker, Dr M Vamos, Dr F Varghese, Dr M Vukasovic, Ms A Walker, Prof R Walsh, Dr S White, Dr J Warden, Dr B Westmore, Dr J Wilkinson, Dr R Wilson, Dr J Woodforde, Dr M Wright, Dr M Wroth, Dr P Wyllie, Dr G Yeo, Dr I Zetler.

New South Wales Medical Board Committees 2006

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

NSW MEDICAL BOARD ORGANISATIONAL CHART 2006



ACTIVITIES

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

Human Resources

Overview

Following the resignation of the Deputy Registrar in May 2005, a new structure was introduced leading to the appointment of Mr Anthony Johnson as the Legal Director. Under his direction, the Legal Team provides legal services to the Board, and the principal functional areas of Conduct, Health, Performance and Registration.

The Board staff establishment as of 30 June was 39, and during the year four employees resigned and eight new employees were recruited.

Staff Development

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

In-house sessions have been held with staff in relation to testing and upgrading of the REG/PCH database.

Continuing Professional Development also occurred during the year for relevant staff.

Sick Leave

	2002/03	2003/04	2004/05	2005/06
Days lost	177	265	183	280
Per person average	5.5	7.5	4.9	7.37

Equal Opportunity Employment

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

Total Staff	Male	Female	Aboriginal/Torres Strait Islander	NESB
39	4	35	0	9

Four female and two male staff are in management positions.

Occupational Health and Safety

The Board has established an OH&S Consultative Committee comprising of employer (1) and employee representatives (3) being one from each floor. The Registrar is invited to Committee meetings as an observer.

The OH&S Committee meets quarterly, and staff input is encouraged.

Quarterly OH&S inspections are also carried out and any matters requiring attention are referred to the Manager, Administration, for action.

The Board complies with its OH&S obligations by actively participating in committee meetings, inspections and follow up as required for any OH&S matters raised.

Executive Officers

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

Overseas Travel

Board member Dr Denis Smith attended the Federation of State Medical Boards conference in Boston, USA, in March 2006.

Insurance and Risk Management

The Corporate Governance and Audit Committee monitors and reviews the Board's risk management activities each year. A Corporate Governance and Risk Management Review was undertaken during the year with a report to be finalised and tabled at the September 2006 meeting.

Privacy Report

The Board collects and retains information, including personal and health information about medical practitioners and patients, in the course of exercising its functions under the Medical Practice Act. It deals with the collection, use, disclosure, security and quality of this information in accordance with the Privacy and Personal Information Protection Act 1998 and the Health Records and Information Privacy Act 2002.

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

Consultants

Consultancies equal to or more than $30,000

Consultant	Cost	Title/Nature
AIMP Project	$59,092	Development of Australian Index of Medical Practitioners
Smalls Recruiting	$47,600	Review of positions and grading
Checknet Pty Ltd	$99,393	IT Support and system upgrade
Axis Technology Pty Ltd	$65,090	System review and maintenance
Internetrix	$2,550	Web public interface
Acumen Consulting	$40,215	Accounting package upgrade and maintenance
Internal Audit Bureau	$1,955	Accounting & AEIFRS
	$91,135	Process review
	$5,331	Investigation
	$28,575	IT infrastructure review and network rebuild
	$3,205	System Audit and Audit Planning
Total consultancies equal to or more than $30,000	**$444,141**	
Consultancies less than $30,000		
Helen Young – proof reading Annual Report	$400	
Red River Solutions – settlement of costs	$17,805	
Total consultancies less than $30,000	$18,205	
Total Consultancies	**$462,346**	

Ethnic Affairs Priority Statement

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

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

- ➔ Continuing development of policies to facilitate access to area of need and postgraduate training positions.
- ➔ Between July 2005 and June 2006, 30 practitioners were approved for GP area of need positions, and 31 for non-specialist hospital positions.
- ➔ Continued support for the Postgraduate Medical Council orientation course designed to assist AMC graduates prior to their entering teaching hospitals for their requisite period of supervised training.
- ➔ Monitoring the number of Panel members from non-English speaking backgrounds sitting on Professional Standards Committees, Medical Tribunals, Impaired Registrants Panels, Performance Review Panels, conducting peer audits and Board Reviews.
- ➔ Presentation at Information Sessions for overseas trained doctors.

- ➔ Membership of the Department of Health/Australian Doctors Trained Overseas Association Liaison Committee.

Strategies identified for the forthcoming year include the following:

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

Promotions, Publications and Presentations

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 electronic interface with inquirers and registrants.

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

- ➔ Introduction of the Code of Professional Conduct: Good Medical Practice
- ➔ Prescribing or supplying performance enhancing drugs
- ➔ Technology-based patient consultations
- ➔ New registration requirements for international medical graduates
- ➔ Urgent investigation results
- ➔ Obligations in relation to unfit drivers
- ➔ Reporting of child abuse and neglect concerns

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

Waste Reduction and Purchasing Plan (WRAPP)

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

Legal Change

Major legislative amendments to the Medical Practice Act 1992 and the Health Care Complaints Act 1993 were reported in the 2004/2005 annual report. There have been no major legislative changes this year.

Minor amendments were also made to the Medical Practice Regulation 2003 in relation to hand and skin cleaning as part of infection control. The amendments now allow for the use of water and soap or antiseptic as well as non-water cleansers or antiseptics.

Corporate Governance and Audit Committee

The Corporate Governance and Audit Committee met twice during the year. Issues considered included risk assessment and management, review of the corporate governance documentation to align it with the Medical Practice Act, and individual case assessment for Performance reviews.

Freedom of Information

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

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

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

During the year 1 July 2005 to 30 June 2006, the NSW Medical Board received 11 enquiries about applying for documents held by the Board. Members of the public and practitioners are regularly informed by the Board secretariat that consideration should be given to making an application under the Act in appropriate circumstances. Information was provided informally to some enquirers.

The Board received and processed 18 applications for access to documents under the Act within the required timeframe. This compares with 11 applications in 2004/2005 and 15 applications in 2003/2004. The Board provides practitioners with information sought from their personal files unless the FOI exemptions apply.

This year, the Board complied with requests from 10 practitioners to access all or some of the information on their files. Of these, one practitioner was provided with approximately 200 documents, another application involved the assessment of more than 750 documents. In addition, one application received in the previous reporting year was finalised.

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

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

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

REVIEW OF OPERATIONS REGISTRATION

Overview

The major registration issue during the year was the national recognition of workforce shortages, leading to increased focus on registration requirements and processes in relation to International Medical Graduates (IMGs), as well as the continuing moves towards national uniformity.

The Board undertook a review of its processes for assessment and registration of IMGs following the Dr Patel case in Queensland. While for many years NSW was the only Australian Board to undertake an independent clinical assessment of applicants for Area of Need registration, it continues to review its process to achieve further improvements.

Review recommendations that have been implemented include amendments to the Board's website and documentation, supervision requirements and assessment methodologies.

A high level of English language proficiency is required to ensure that medical practitioners can communicate effectively with their patients, and other health professionals. Since July 2005, IMGs applying for registration in NSW have been required to submit evidence of their English language competency as a prerequisite for registration. The NSW Medical Board along with all other Australian Boards, accepts the following as evidence of English language proficiency:

- ➔ A score of 7 in each of the speaking, writing, reading and listening components of the International English Language Testing System (IELTS); or
- ➔ an overall pass in the Occupational English Test (OET) administered by the Centre for Adult Education with grades A or B in each of the four components; or
- ➔ a pass in the English language component of the United States Medical Licensing Examination (USMLE – previously ECFMG); or
- ➔ a pass in the Professional Linguistic Assessment Board (PLAB) examination in the United Kingdom; or
- ➔ a pass in the English language proficiency component of the New Zealand Registration Examination (NZREX).

A satisfactory result must have been achieved in the two years prior to applying for registration.

Applicants may be exempted from these requirements if they can provide evidence of secondary education in a country where English is the native or first language. Other exemptions are at the Board's discretion.

Although the policy was widely publicised and no applicant's registration was delayed during its initial implementation, some employers failed to incorporate the change into recruitment procedures, leading to requests for waiver. This has resulted in a number of IMGs arriving to be registered to commence work only to be declined registration while they undertook an accepted English examination.

Since January 2006, the Board has required primary source verification of the registration documentation submitted by IMGs when applying for registration in NSW. The Educational Commission for Foreign Medical Graduates (ECFMG) through its International Credentials Services (EICS) provides this service for the Board.

EICS verifies the authenticity of the documents directly with an authorised official of the institution that issued the document. Applicants are advised that they should approach EICS as the first step towards registration with the NSW Medical Board. The Board's own processes proceed in parallel, as long as there is proof that EICS has been approached. Registration can be granted on confirmation that EICS has received an application, on the proviso that it will be immediately withdrawn should the practitioner's documents not be verified.

The following documents are routinely primary source verified:

- ➔ basic medical degrees;
- ➔ postgraduate training certificates;
- ➔ certificates of medical registration/licensure.

The Board has always required a current Certificate of Good Standing from the previous jurisdiction of practice from all new applicants for registration and those returning to NSW after a period of absence. The requirement has now been amended to require a current Certificate of Good Standing from each jurisdiction in which the applicant has practised in the previous five years. The Certificates of Good Standing must be received as an original document direct from the registering authority issued within three months prior to the application for registration.

During the year the Board conducted 96 assessments for Area of Need GP and non-specialist hospital positions. Of the 37 non-specialist hospital assessments undertaken, 31 were assessed as suitable for the specified position, while of 59 GP assessments undertaken, only 30 were found suitable. The limited supervision available to Area of Need GP registrants compared to that available in the hospital positions is the primary reason for this result.

The Board's policy limiting the time for interns and AMC supervised trainees to reach a satisfactory level of performance,

introduced in 2004-05, resulted in an increase in the number of interviews undertaken for those not progressing satisfactorily during their first 12 months. Twenty two registrants were interviewed (7 were interviewed twice) and all were required to continue their supervised training beyond 12 months. Registration is only extended if the trainee is showing progress and the hospital is willing to continue offering a position for training. As at September 2006, 14 of the 26 interviewed had progressed to General registration after satisfactorily completing additional terms, eight were still registered to complete additional terms and four were no longer registered as they had not satisfied the Board's requirements for General registration and were unable to meet the hospital requirements to remain in a training position.

The Registration Committee also reviewed a number of applications from practitioners who had been out of clinical practice for an extended period of time. The Board has established guidelines to assess all factors relating to the applicant including:

- ➔ duration of and reasons for absence from practice
- ➔ CPD and professional contact maintained during absence
- ➔ extent of experience prior to absence
- ➔ nature of proposed work after absence
- ➔ health
- ➔ insight

Registration Workflow

General Registration

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

	2003/04	2004/05	2005/06
Internship complete	430	432	425
General registration	129	134	76
Re-registration	556	492	506
Mutual recognition	757	773	778
AMC complete	118	105	171
Total	1990	1936	1956

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.

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. The following table details the number of applicants granted initial registration in each category for this year and previous years.

	2003/04	2004/05	2005/06
Interns	460	463	452
AMC graduates	80	95	110
Postgraduate Trainees	799	848	892
General Practice Trainees	154	152	201
Unmet areas of need	113	114	99
Overseas trained specialists	98	154	126
Specialist assessment	6	1	9
Academic appointments	0	1	0
Temporary Board discretion	18	6	13
Medical exchange	0	0	0
TOTAL	**1728**	**1834**	**1902**

The categories of conditional registration are defined as follows:

➔ Interns

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

➔ Australian Medical Council Graduates

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

➔ Postgraduate Trainees

International medical graduates undertaking a period of postgraduate training.

➔ General Practice Training Program

A reciprocal arrangement exists between training programs in the United Kingdom and the Royal Australian College of General Practitioners which allows UK family practice trainees to work in approved and accredited hospitals in terms which are accredited for general practice training. The majority of terms and training that occurs in these hospitals relates to either obstetrics/gynaecology, accident and emergency, general paediatrics and palliative care.

➔ Unmet Areas of Need

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

➔ Specialists

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

➔ Overseas-trained Specialists Assessment

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

➔ Academic Appointments

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

➔ Public Interest

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

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

Practitioners Removed from the Register

The following table details the number of registrants removed from the Register for the 2005/2006 year and previous years.

	2002/03	2003/04	2004/05
Deceased	56	48	116
At own request	792	408	423
Non-payment of registration fee	996	1000	904
Term of conditional registration expired	666	764	768
Other	73	0	0
Withdrawal	52	54	58
Declined	16	27	33
Medical Tribunal	7	4	2
Total	**2658**	**2305**	**2304**

PROFESSIONAL CONDUCT

Overview

2005/06 saw the finalisation of matters flowing from the Camden/Campbelltown Inquiry of 2003/04, and a continuation of the process of dealing with the backlog of over three hundred complaints under investigation by the HCCC that had been highlighted during the Inquiry. At 30 June 2006, the number of matters under investigation by the HCCC were 189 while 211 investigations were closed during the year.

Of note is the significant increase in the number of complaints being declined after initial assessment, which has gone from 26% to 54% since 2003/04. A major factor has been the HCCC's change in procedure to enable the doctor to respond to the complaint before assessing whether further action is required. Also, there has been a continued decline in referrals to conciliation from 13% to 3% over three years.

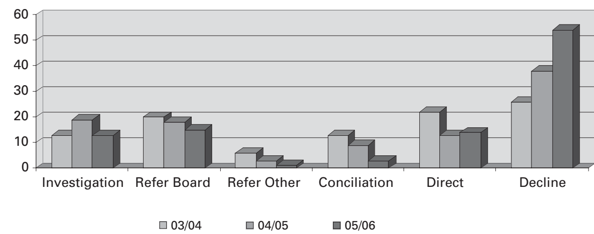
The number of matters referred for hearing to the Medical Tribunal (excluding appeals and review matters) has dropped substantially (17) from last year (35), although it is still higher than the 2003/04 number (15). Twenty one complaints were referred to Professional Standards Committees compared to 18 and 12 in 2004/05 and 2003/04.

Another significant trend has been the continued growth in the number of matters referred for urgent action under Section 66 of the Medical Practice Act, with 22 Section 66 inquiries being held during the year compared to 19 in the previous year.

The year was the first full year of the Board working with the newly established position of the Director of Proceedings, appointed by, but independent of, the HCCC. Should the HCCC consider that a matter may warrant referral to a Professional Standards Committee or the Medical Tribunal at the conclusion of investigation, it consults the Board with a recommendation that the matter be referred to the Director of Proceedings. The Director of Proceedings then makes a determination as to whether a complaint ought to be prosecuted and, if so, before which disciplinary body. The Director of Proceedings must consult with the Board before making this determination.

At 30 June 2006, 14 matters which had been referred to the Medical Tribunal were awaiting hearing dates, while three had been set down but not heard. The Board regularly discusses the Medical Tribunal workload with the Chairperson with a view to ensuring that waiting lists do not become excessive.

For the year ending 30 June 2006, 1,292 complaints received against medical practitioners were jointly considered by the Board and the HCCC and an assessment made as to the appropriate way to deal with each complaint. This is an increase from the 1080 complaints assessed in the previous year. The Board and the HCCC referred 15% of complaints to the Board, 14% of complaints to for direct resolution and 13% of complaints to the HCCC for investigation, these being the most common assessments after declining to deal with complaints (54%).



Of 211 investigations completed by the HCCC, 59% were concluded without referral to a disciplinary outcome, while 41% resulted in disciplinary outcomes (such as referral to the Board, or the Director of Proceedings).

Five appeals were lodged in the Medical Tribunal, two against decisions of Section 66 Inquiries (both of which settled prior to hearing), two against decisions of Professional Standards Committees and one against a decision of the Board following its consideration of an application for registration as a medical practitioner in New South Wales. Six practitioners applied to the Medical Tribunal for review of de-registration orders made by previous Tribunals, and two practitioners applied to the Tribunal to have conditions on their registration reviewed.

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

The Complaint Handling Process

Assessment of Complaints

Both the HCCC and the Board can receive complaints against medical practitioners. The Board and the HCCC, at a weekly Assessment Committee meeting, assess complaints received by either body.

It was the previous practice of the HCCC to submit complaints received by it to the next weekly Assessment Committee meeting with the Board. Following amendments to the Health Care Complaints Act commencing on 1 March 2005, it now conducts an analysis of the issues raised in the complaint and confirms it has correctly identified those issues with the complainant prior to making an assessment of the complaint. Because of this, some complaints may not yet have been assessed and will be reflected in the figures for the next reporting year.

In response to the Board's concern that it was not being immediately notified of complaints as is required by legislation, the HCCC now sends copies as they are received for the purposes of notification rather than consultation and assessment. This enables the Board to review each matter and to determine whether a complaint raises such serious issues that the Board ought to consider whether urgent action is necessary to protect the life or physical or mental health of any person.

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

Type of assessment (%)

	2003/04 n=1030	2004/05 n=1080	2005/06 n=1292
Investigation	13	19	13
Refer to the Medical Board	20	18	15
Refer to another person or body	6	3	1
Conciliation	13	9	3
Direct resolution	22	13	14
Decline to deal with	26	38	54

Broad categories of complaints are as follows:

Type of Complaint (%)

	2003/04 n=1030	2004/05 n=1080	2005/06 n=1292
Clinical Competence	47	53	57
Communication	18	17	13
Conduct	28	22	22
Practice Administration	7	8	8

Of note is the significant increase in the number of matters that the Board and HCCC have declined to deal with, or referred to the Health Conciliation Registry. Matters are declined when they fall outside of the Board's and the HCCC's jurisdiction, they do not relate to health care, they do not raise clinical issues of sufficient seriousness or have already been resolved between the parties at the time of assessment. The HCCC has also been conducting more extensive pre-assessment enquiries in the past two years, and therefore matters that may have otherwise been referred to the Board, the Health Conciliation Registry or for direct resolution have been declined on the basis of the additional information available at the time of assessment.

The Board considers that investigation (with a view to disciplinary action should a complaint be substantiated) is only appropriate in matters where there is evidence of unethical, reckless, wilful or criminal behaviour in either clinical or non-clinical domains. In all other circumstances, public protection can be achieved and professional standards maintained through the application of non-disciplinary and educative responses. This conceptual framework will continue to be used by the Board when assessing new complaints received.

Complaints investigated by the HCCC

Following assessment, the number of complaints referred to the HCCC for investigation was 165. These complaints were referred on the basis that they appeared to one or both parties to the assessment to raise a significant issue of public safety, or to provide grounds for disciplinary action against a medical practitioner. At the completion of investigation, the HCCC consults with the Board's Conduct Sub-Committee on its proposed outcomes for the investigation. The final decision on outcome rests with the HCCC, after the required consultation.

Options include:

- ➔ to terminate the investigation and take no further action against the practitioner;
- ➔ that the HCCC make comments in a letter to the practitioner;
- ➔ to refer the practitioner to the Board for the Board to take appropriate action. Such action may include disciplinary counselling in the form of a letter or interview or consideration of the matter by the Health or Performance Programs; or
- ➔ refer the matter to the Director of Proceedings who will, following consultation with the Board, determine whether a complaint ought to be referred to a disciplinary hearing.

Amendments to the Health Care Complaints Act introduced as a result of the Camden Campbelltown Inquiry established the office of the Director of Proceedings within the HCCC. From 1 March 2005, referral of a complaint directly to the Medical Tribunal or a Professional Standards Committee following investigation has been replaced by referral to the Director of Proceedings. After further consideration, the Director of Proceedings consults with the Board as to whether the matter warrants a Medical Tribunal, a Professional Standards Committee or other outcome. The following data includes a mixture of both pre and post 1 March procedures as a number of Medical Tribunals and Professional Standards Committees were held during the reporting year which had been referred prior to the commencement of the Director of Proceedings provisions.

The number of investigations closed this year was 211, compared with 356 closed in the previous year.

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

The remaining 41% of completed investigations were referred for disciplinary action. This figure includes complaints referred to the Board where the Board counselled the practitioner (35 matters), and referrals to the Director of Proceedings for consideration of disciplinary action following consultation between the Board and the HCCC (42 matters).

Complaints referred to the Director of Proceedings

Within the reporting year 42 investigations were referred to the Director of Proceedings. Following analysis by the Director of Proceedings and consultation with the Board, 13 investigations (which related to nine practitioners) were the subject of a signed complaint by the Director sent to the Board for subsequent referral to the Medical Tribunal, and nine signed complaints by the Director (relating to nine practitioners) were sent to the Board for referral to a Professional Standards Committee. Two of the

Professional Standards Committee matters and one of the Medical Tribunal matters stemmed from matters which were originally referred to the Commission for investigation following the Special Commission of Inquiry into Campbelltown and Camden Hospitals.

Referral to the Medical Tribunal or a Professional Standards Committee

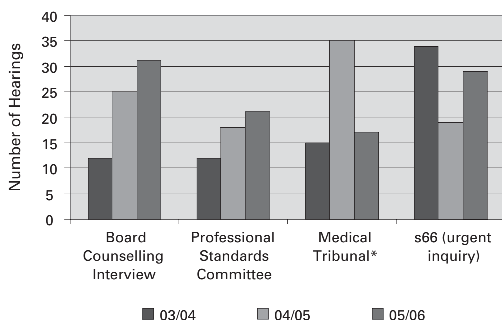
In total, 30 matters were referred to the Medical Tribunal (17 complaints, 5 appeals, 6 restoration applications and 2 applications for review of conditions) and 21 complaints to Professional Standards Committees.

Complaints remaining under investigation

At 30 June 2006, the HCCC reported 189 complaints currently under investigation.

Disciplinary hearings

The following table illustrates the numbers of practitioners referred to disciplinary hearings, or a counselling interview during the last three reporting periods:



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

Professional Standards Committees

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

Counselling

In the year under review, 35 investigations were finalised by the referral to the Board and counseling of the practitioner by way of an interview or by correspondence. Counselling occurs when there are issues of concern, which may constitute a recognised departure from accepted standards of practice, or where the Board feels the need to assure itself that the practitioner is aware of accepted standards of practice and conduct. Counselling provides an opportunity for a practitioner to reflect upon the issues raised within the context of their practice and to critically examine suggestions for improvements to their practice.

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, compared with one in the previous year.

Schedule 1 Inquiries

The Board referred six 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. Two applications were withdrawn following referral to an Inquiry. In one matter after additional information was provided by the applicant the practitioner was asked to attend a Registration interview instead. Another matter involved a practitioner who had previously withdrawn their application following referral in a previous reporting period, sought to be registered. This practitioner withdrew their application again prior to the Inquiry being held. There are no outstanding applications to be heard and there is only one outstanding Schedule 1 Inquiry decision.

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

Section 66 Inquiries – Urgent action to protect the public

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

The Medical Board has conducted 22 Section 66 Inquiries this year and no review of orders imposed under section 66 (compared with one review conducted in the previous reporting year). One practitioner has been the subject of two Section 66 Inquiries in this reporting period, in relation to issues of competence and prescribing. Five practitioners have been suspended during this reporting period as a result of Board exercising its powers under section 66.

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

➔ have been charged with serious criminal matters (particularly if arising within the practice of medicine);

➔ suffer from a serious impairment and demonstrate little or no insight into the extent of their problem and the risk they pose to the public;

➔ have continued to recklessly prescribe drugs in a manner which is dangerous and likely to cause harm, despite previous warnings or counselling.

MEDICAL TRIBUNAL

Matters commenced in Tribunal 2005/2006

In the year under review, 30 matters (including complaints, appeals, restorations and review applications) were referred to the Medical Tribunal. This compares with 48 matters in 2004/2005 and 18 in 2003/2004.

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

Complaints	**2003/04**	**2004/05**	**2005/06**
Sexual misconduct	3	8	5
Prescribing	7	13	8
Breach conditions	1	3	1
Treatment	1	9	1
Competence/Impairment	2	2	0
Fraud	1	0	0
Character	0	0	2
Appeals			
PSC	1	3	2
Registration	0	4	1
Conditions/suspension	0	0	2
Restoration	2	4	6
Review of Conditions	0	2	2
Total	18	48	30

Matters Finalised in the Tribunal 2005/2006

The Tribunal determined matters in the following categories.

Complaints	29
Appeals	4
Reviews	4
Total	**37**

The table below shows the outcome of 29 complaints determined by the Tribunal in 2005/06.

Outcome of Complaints

Sexual Misconduct/ Boundary Crossing	
Haddad, WFWB (026924)	Not to be re-registered, no review for five years
Nanda, PR (068011)	Withdrawn, Dr removed name from Register
Nemec, ZW (068566)	Withdrawn, Dr removed name from Register
Wood, PG (135651)	Withdrawn, Dr elected to be moved to the non-practising Register
Dr X (non-publication order)	Dismissed
Breach Conditions	
Dinakar, RBS (176054)	Conditions, reprimand
Katelaris, AJ (180932)[1]	De-registered, no review for three years
McLeay AC (064184)[2]	Withdrawn, Dr removed name from Register
Prescribing	
Bastas, M (208748)[3]	Conditions, reprimand
Catchlove, SH (074466)	De-registered, no review for two years
Cross, BP (214595)	Conditions
Facchini, FJ (018048)	Withdrawn, Dr removed name from Register
Guest, PJ (035816)	Reprimand, fine
Kwan, CKE (176938)[4]	Conditions, reprimand
Muller, RJ (097601)	Conditions, reprimand
Nadel, I (067685)	Withdrawn, Dr removed name from Register
Singh, R (166852)	Conditions, reprimand, fine
Stewart, PW (110001)	Conditions, reprimand, fine
Whitton, LA (170516)	Conditions, reprimand, fine
Dr X (non-publication order)	Conditions, reprimand

Treatment

El Sanady, S (335422)	Withdrawn, Dr no longer registered, stated that he will not seek to be re-registered in Australia
Patanjali, N (332328)	Dismissed
Dr X[5] (non-publication order)	Withdrawn
Dr X (non-publication order)	Reprimand
Dr X (non-publication order)	Orders, reprimand
Dr X (non-publication order)	Dismissed
Dr X (non-publication order)	Reprimand
Dr X (non-publication order)	Reprimand

Impairment

Caladine, K (147188)	Conditions

[1] complaint also concerned issues of prescribing and self-administration.

[2] complaint also concerned issues of impairment.

[3] complaint also concerned issues of boundary crossing and was the first matter in which a registered medical practitioner's failure to have appropriate Professional Indemnity Insurance in place was considered by the Tribunal.

[4] application for permanent stay also heard, dismissed by Tribunal.

[5] complaint now referred to a Professional Standards Committee.

Matters Outstanding

As at 30 June 2006, 23 matters referred to or filed in the Tribunal in this or previous years await determination. This compares with 34 in the year ended 30 June 2005 and 25 in the year ended 30 June 2004.

Complaints

Heard/part-heard

One matter has been heard and awaits judgment.

Listed for hearing and to be listed for hearing

Three matters have been listed for hearing before December 2006 and 14 are yet to be listed for hearing.

Appeals

An appeal on a point of law arising in a Professional Standards Committee has been referred to the Tribunal and is 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 is awaiting determination, one has a hearing date in July, and the third is yet to be listed for hearing.

One application for review of conditions has been lodged in the Tribunal and remains outstanding, it is yet to be listed for hearing.

CASE STUDIES

PROFESSIONAL STANDARDS COMMITTEES

In the year ending 30 June 2006, the HCCC referred complaints in relation to 18 practitioners to a Professional Standards Committees, and 19 Professional Standards Committee hearings were held. Some examples of the types of matters dealt with at these hearings are reproduced below.

Failure to render urgent attention

The practitioner was a solo general practitioner working in the suburbs. A person collapsed and required resuscitation in a shop about one minute's walk away from his surgery. The GP admitted he failed to attend for the purpose of rendering professional services in his capacity as a registered medical practitioner in a case where he had reasonable cause to believe that the person was in need of urgent attention by a medical practitioner. The GP had not updated his CPR skills since some time between 1998 and 2000, and the Committee had doubts about his grasp of ethical considerations and his grasp of organising priorities in an emergency situation.

He was found guilty of unsatisfactory professional conduct and was reprimanded and ordered to complete two educational courses in relation to CPR and ethics.

Inappropriate prescribing

A solo GP was visited by the Pharmaceutical Service Branch (PSB) of the Department of Health twice in 1996, and once in 1998 and 1999 in relation to his prescribing. His authority to prescribe drugs of addiction was withdrawn in August 1999. A complaint in relation to his inappropriate prescribing of several addictive medications to 12 patients between December 1996 and June 2001 was prosecuted before this PSC.

The Committee noted that the GP had attempted to manage very complex patients when he was a relatively inexperienced GP. However the issue of inexperience diminished in significance as the period under scrutiny progressed. The PSC also noted that prior contacts with PSB did not appear to have had the subsequent impact one might expect on the GP's prescribing.

The GP was found guilty of unsatisfactory professional conduct. He was reprimanded, ordered to attend two courses on prescribing and general practice medicine and ordered to submit to an audit of his medical records in relation to his recent prescribing.

Inappropriate treatment of a patient

The practitioner was a career medical officer (CMO) in anaesthetics who was asked to attend the Intensive Care Unit (ICU) to assist with a patient with acute severe asthma. The complaint alleged the practitioner administered a drug that was contraindicated in the circumstances and that he failed to document the assessment of the patient's pre- and post-care procedures. The practitioner and another medical officer in the ICU had a brief discussion before the practitioner left the ICU and it was the other medical officer in the ICU that created the medical records.

The Committee viewed his administration of the drug in question, having had due consideration for the potential problems, as not amounting to unsatisfactory professional conduct. The Committee did not find that the agreement that the medical officer in the ICU write up the notes was a delegation by the practitioner of the functions prescribed by clause 13 of the 1998 Medical Practice Regulations. The Committee found that it was not the responsibility of the practitioner to make the notes and therefore he could not delegate a duty for which he was not responsible.

Failure to release medical records

The practitioner was a nephrologist who had treated a patient for 13 years. The practitioner ceased to treat the patient and provided a transfer letter but refused to provide a Workcover certificate or to release the medical records to the patient's new nephrologist. The practitioner refused the request on the basis of not wanting to become involved in any legal matter related to a claim for compensation. The patient lodged a complaint with the Federal Privacy Commission who advised that the practitioner had breached Commonwealth privacy legislation. The complaint also alleged that the records provided to the other practitioner did not provide sufficient detail as required under law and that the practitioner's refusal to provide the records was not appropriate. The Committee found the complaint of unsatisfactory professional conduct proven and imposed a reprimand.

Inappropriate exposure of the practitioner's religious beliefs

A psychiatrist in private practice in Sydney breached acceptable professional boundaries by exposing a patient to his own personal religious beliefs, inviting the patient to move into his home, giving the patient an unsolicited neck massage and provided the patient with a prescription for anabolic steroids for his lack of appetite. The Committee was concerned by the fact that the practitioner did not recognise that he had breached acceptable boundaries despite his professional training. The Committee determined that a complaint of unsatisfactory professional conduct was proven. The practitioner was reprimanded and conditions were placed his registration.

Inadequate treatment of a patient

A medical officer working in an emergency department faced a complaint that he failed to conduct an adequate examination of an elderly patient who had recent skin graft surgery. Following a discussion with the visiting medical officer at the hospital, the patient was discharged and later collapsed and died of a pulmonary embolism. The Committee found that the doctor had failed to consider the symptoms and risk factors when making his diagnosis and failed to adequately communicate with the visiting medical officer when discussing the decision to discharge the

patient. The Committee found the complaint proven. The doctor was cautioned and a condition was placed on his registration requiring him to undertake two courses – emergency medicine crisis management and advanced paediatric life support as his training in this area was also considered deficient.

Failure to appreciate blood test results

A specialist pathologist working in a general practice locum position diagnosed a patient with influenza and anaemia and asked her to return for review in a month. Three days later the patient consulted another practitioner who admitted her to hospital where she was found to have a serious medical condition. A complaint was made that the doctor failed to adequately examine the patient, properly check her pathology test results and failed to appreciate the clinical significance of the results and to take appropriate action which, when combined, resulted in a failure to recognise that the patient was seriously ill. The doctor acknowledged that he was excessively narrow in his clinical assessment of the patient. The PSC found that that doctor had shown a lack of adequate knowledge, skill and judgment in the practice of medicine which represented a departure from acceptable standards. The PSC found him to have engaged in unsatisfactory professional conduct and noted that many of the issues arose because of his failure to communicate adequately with the patient. He was reprimanded and conditions were placed on his registration requiring him to undertake further training.

SECTION 66 INQUIRIES – EMERGENCY IMPOSITION OF CONDITIONS

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. Some examples of matters considered by the Board in these inquiries are reproduced below.

Self-prescribing

The PSB informed the Board of the withdrawal of a solo general practitioner's authority to prescribe drugs of addiction. Subsequently the practitioner's treating psychiatrist notified the Board of her admission to hospital and the closure of her practice. An Inquiry was convened after the practitioner failed to attend for a mandatory assessment by a Board-nominated psychiatrist without explanation. The practitioner's drug use and self-prescribing had escalated which gave rise to serious concern about her ability to practise as a medical practitioner. Conditions restricting her employment were imposed under section 66, as well as conditions designed to assist her to deal with her addiction. The Board recommended that the practitioner be dealt with under the special provisions for impairment under the Medical Practice Act and she was placed in the Board's impairment program.

Professional conduct

An Inquiry was convened to consider information from the Queensland Medical Board and an Area Health Service which revealed a locum registrar had been dishonest in relation to the detail provided in his curriculum vitae. He had not revealed that his employment had been terminated in another state because of complaints about his clinical abilities, communication skills and professional behaviour. Conditions were imposed to ensure that he receives close supervision in a hospital-based practice only and that regular reports to the Board regarding his practice of medicine are made.

Multiple boundary breaches with a vulnerable patient

An Inquiry was convened to consider information that a general practitioner in private practice who was providing psychotherapy to a patient had breached professional boundaries on several occasions. The Inquiry found the practitioner's explanation that he was professionally isolated and that this had lead to a poor understanding of appropriate boundaries was unacceptable. The Inquiry found that he should have clearly understood that his actions were highly inappropriate and had occurred over a significant period of time. The practitioner had conditions imposed on his registration.

Competence

An inquiry was convened to examine information that showed that a pathologist had an extremely high variation error rate in his diagnoses. During the inquiry he attributed the problems to his style of reporting. The Inquiry considered that he would require a substantial period of retraining under close supervision before it would be safe for him to practise independently as a staff specialist in pathology. It imposed conditions on his registration to this effect.

Impairment

A doctor in the Board's Health Program tested positive for barbiturates in regular urine drug testing. He admitted to taking the drugs. The Inquiry found that the doctor was highly vulnerable, lacked insight into his impairment and had clearly breached his registration conditions. Given the breach of health conditions the Inquiry suspended him from practising medicine for a period of eight weeks.

Impairment

Concerns about a general practitioner's clinical performance and management of patients while undertaking a hospital-based locum resulted in a Section 66 Inquiry imposing conditions on his registration in 2004. The inquiry was unable to determine if the practitioner suffered from an impairment, but formed the view that his behaviour and presentation presented a risk to the public. Health conditions were imposed to investigate this further. Subsequently, on assessment the practitioner was found to have marked neurological deficits and a second Inquiry suspended him from the practice of medicine.

Impairment

The practitioner was found by the Medical Board of Queensland to "suffer from a condition that detrimentally affects or is likely to detrimentally affect his professional performance". He had allowed his registration in Queensland to lapse however he was registered in NSW and worked as a registrar in mental health. The Board referred him to an Impaired Registrants Panel and he failed to attend. He also failed to attend an Inquiry convened under section 66. The Inquiry suspended him from medical practice until the issues relating to his fitness to practise and health status are satisfactorily addressed.

Sexual assault

A solo general practitioner notified the Board that he had been charged with administering a stupefying drug before sexually assaulting a patient during a consultation. The inquiry imposed conditions requiring the practitioner to have a chaperone during consultations. This practitioner has been committed to stand trial to face the criminal charges.

Manslaughter charge

The Board was advised by the general practitioner that he had been charged with the offence of manslaughter, in that it was alleged he had caused the death of a patient by prescribing a single high dose of morphine.

After careful consideration of the facts of the matter the Inquiry did not consider it was necessary to take any immediate action to protect the health or safety of any person under section 66. An investigation at the Health Care Complaints Commission was ongoing, as were criminal proceedings. A subsequent s.66 Inquiry (outside the reporting period) removed the doctor's rights to prescribe drugs of addiction.

Prescribing

The Board received a report from the PSB regarding a general practitioner's prescribing for one particular patient. The practitioner had prescribed high doses of addictive drugs as well as continuing to prescribe for the patient without any consultation between him and the patient. The inquiry imposed a condition on his registration that he not prescribe drugs of addiction to the patient.

Prescribing

A PSB report provided to the Board alleged a large amount of inappropriate prescribing to a significant number of patients by a solo suburban general practitioner. The practitioner had previously been counselled by the PSB about his prescribing practices. The Inquiry imposed conditions on his registration that he relinquish his authority to prescribe addictive drugs and that he not possess, supply, administer or prescribe such drugs. The Inquiry also strongly recommended that he be referred for a Performance Assessment on the basis of evidence put before the Inquiry that indicated his professional performance was unsatisfactory.

Prescribing

A PSB report provided to the Board revealed that a general practitioner was inappropriately prescribing addictive drugs to a number of patients. In both 1991 and 1999 the practitioner had been interviewed by the PSB in relation to his prescribing of drugs. The Inquiry determined to impose conditions that he not possess, supply, administer or prescribe any S8 or S4 drugs and that he relinquish his authority to do so.

Prescribing

The NSW Police Service notified the Board in 2005 that the practitioner was providing a number of prescriptions to known drug addicts for addictive drugs (Serepax, Rivotril and valium). The persons attended the doctor's practice from outside the geographical area to obtain these drugs. The police advised that these drugs were then traded on the street near his practice. As the drugs were often prescribed by private prescription detection by the PSB was avoided. At the same time a staff specialist in emergency medicine at a major teaching hospital informed the Board that the practioner's 74 year old wife was admitted for a narcotic overdose from drugs prescribed the doctor. The Board resolved to hold an Inquiry under section 66 of the Act. The practitioner removed his name from the register prior to the inquiry.

Prescribing

The practitioner had been in the Health Program since 2000 after admitting to self-prescribing pethidine and morphine. He had exited the Board's health program three weeks before the Section 66 Inquiry was held. An investigation by the PSB revealed that the practitioner had failed to account for 367 ampoules of Sustanon 250 and 5,224 vials of human growth hormone known to have to come into his possession, contrary to section 35 of the Poisons and Therapeutic Goods Act. The practitioner denied self-administration but admitted he sold the drugs for profit to body-builders and for anti-aging purposes on demand to numerous people. The practitioner told the inquiry that he did so to avoid these people obtaining such drugs "off the street". The inquiry did not accept his "harm minimisation" explanation, as there were no records to show any communication between him and the purchaser who determined the quantities, frequencies and dosage. The Inquiry found that the practitioner demonstrated a flagrant disregard for the wellbeing and safety of patients and total failure to consider their physical and mental health. The inquiry did not consider that the public would be adequately protected by conditions and he was suspended.

Impairment

This was a second appearance before a Section 66 Inquiry (the first being a year previously) by a practitioner in relation to obtaining multiple ampoules of pethidine in breach of registration conditions. The practitioner denied using the pethidine, though admitted obtaining it as a result of deceptive conduct. The inquiry determined to suspend the practitioner from practising medicine and recommended that the matter be dealt with as a complaint to the Commission in spite of the obvious impairment.

Performance

This was a second appearance before a Section 66 Inquiry (the first being six months previously) by a general practitioner in solo

practice. The first Inquiry dealt with prescribing and resulted in conditions being placed on the practitioner's registration. That Inquiry also strongly recommended that the practitioner be referred for a performance assessment on the basis of evidence put before the Inquiry that indicated his professional performance was unsatisfactory. A subsequent performance assessment concluded that the practitioner's clinical judgment was so far below an acceptable level as to put his patients at serious risk. The second Section 66 Inquiry considered that the practitioner displayed a lack of insight about his clinical shortcomings and that this was of grave concern. The practitioner was suspended from practising medicine for eight weeks.

Prescribing/complementary medicine

A renal patient's condition suddenly deteriorated and the treating renal physician was concerned to learn that he had been receiving courses of very high doses of Vitamin C (80g daily) intravenously from a general practitioner that practices complementary medicine. A Section 66 Inquiry revealed the deficiencies in relation to the GP's practice of medicine, particularly lack of satisfactory communication with a patient's other treating practitioners, insufficient monitoring of a patient's clinical progress and initiation of treatment that does not have a sound clinical or scientific basis for being effective or safe. Conditions were imposed on the GP's registration.

(The GP subsequently appealed this decision. The appeal was withdrawn on the basis that his registration be subject to amended conditions.)

SCHEDULE 1 INQUIRY INTO APPLICATIONS FOR REGISTRATION

When the Board is not satisfied as to the eligibility of an applicant for registration, it must conduct an Inquiry under Schedule 1 of the Medical Practice Act into the application. The Inquiry may grant or refuse registration or may determine that registration be granted subject to the imposition of conditions. Some examples of practitioners the subject matter of an inquiry are reproduced below.

Complaint in another jurisdiction

A general practitioner applied for registration in 2005 after removing his name in from the register in 1985. There was a current complaint under investigation in Queensland alleging he had inappropriately treated his wife with narcotics. The practitioner had been in solo general practice in a small town where there were no alternative medical practitioners to treat his wife. After carefully taking into consideration all the evidence an Inquiry determined the practitioner was entitled to be conditionally registered in NSW.

Impairment

In 2004 an anaesthetist was found in Queensland to have abused anaesthetic substances and suffered from depression. In July 2005 the practitioner applied for re-registration in NSW. An Inquiry considered the level of the practitioner's impairment, its impact on his ability to practice, his level of insight and the current level of his medical skills and knowledge. The practitioner was eligible for conditional registration and was placed in the Board's Health Program.

Previous impairment

In August 2003, a general practitioner requested that he be registered with the Board as 'non-practising' due to his ongoing treatment for depression. The practitioner subsequently applied for registration to enable him to resume practice. The practitioner's health had significantly improved. The Inquiry was more than satisfied and very impressed with strenuous efforts the practitioner had made to re-educate, retrain and maintain his medical knowledge and skills and that his depression was now in remission. The practitioner was eligible for registration subject to conditions covering supervision, attending continuing medical education and monitoring of his health.

Re-registration after six years non-practising

A general practitioner who had qualified in 1993 stopped working in 1999, although her name remained on the register until 2004. Her application for re-registration was successful. The Inquiry was impressed with her frankness, enthusiasm and insight and was satisfied she was well aware of the requirements to keep her knowledge and skills up to date. She was re-registered with no conditions.

Re-registration after four years non-practising

A rural general practitioner had been on the Board's Health Program for a number of years and subject to stringent conditions before he ceased practice in 2000. His name was removed from the register by order of the Tribunal in 1981 for narcotics self-administration and was restored in 1986, subject to conditions. In 2004 he faced a complaint in the Tribunal that he prescribed drugs of addiction without authority in breach of his conditions. The Tribunal found him guilty of unsatisfactory professional conduct and ordered that should any application be made for a practising certificate, conditions imposed by the Tribunal were to be placed on his registration. The Board granted his application for registration subject a number of employment and health conditions in addition to Tribunal-imposed employment conditions.

Re-registration refused on character grounds

The practitioner's name was removed from the register by the Tribunal in 1994 after a finding by a criminal court that he was guilty of sexual offence against a male patient. In 1998 his name was restored, subject to conditions. In 2003 he was charged with another sexual offence against a male patient. When the offence of assault with an act of indecency was proved, the Board suspended the practitioner and he subsequently requested that the Board remove his name from the register. After his appeal against the conviction was successful, he applied for re-registration. The issue for the Board was whether the practitioner should be re-registered subject to conditions requiring a chaperone and when a serious complaint concerning alleged sexual misconduct had been referred to the Tribunal. The Inquiry found that the practitioner was not of good character and that he was unfit in

the public interest to practise medicine. The application for re-registration refused. An appeal was lodged with the Tribunal.

MEDICAL TRIBUNAL

A. Complaints determined by the Tribunal

Competence

Dr Navin Patanjali
This matter arose from the Special Commission of Inquiry into Camden and Campbelltown Hospitals. In February 2002 the practitioner was a locum at Camden Hospital. It was alleged that he was called to review an 84-year-old female patient who had fallen and had hit her head. The complaint alleged that the practitioner failed to examine the patient after her fall. It is also alleged the practitioner falsified his entry in the patient's clinical notes by asserting he had undertaken a series of clinical assessment when no such action had been undertaken. Due to the various disparities in the evidence, the complaint was dismissed.

Dr X – Non-publication order on doctor's name
On 30 June 2006 the Medical Tribunal handed down a decision about a surgeon who undertook a surgical procedure on a patient by operating in the wrong area. The surgeon informed the patient's family in a full and frank manner, making sure the patient received the highest standard of care. The practitioner and the hospital have made several changes to their practice to ensure that an event of this type does not occur again. The practitioner was reprimanded.

Dr X – Non-publication order on doctor's name
In 2001 a general practitioner attended a female patient at Villawood Detention Centre who was dehydrated and withdrawing from heroin. It is alleged the practitioner prescribed an excessively large dose of Largactil and failed to monitor the patient's fluid status. The Tribunal found the practitioner guilty of unsatisfactory professional conduct and reprimanded her.

Prescribing

Dr Barry Philip Cross
Dr Barry Philip Cross was a general practitioner who in 2001 and 2002 inappropriately prescribed excessive amounts of drugs to patients he knew or should have known were drug dependant. The Tribunal found Dr Cross guilty of unsatisfactory professional conduct. He had conditions imposed on his registration including the withdrawal of his authority to prescribe addictive drugs, a medical records audit and a supervisor to review his case management of patients.

Dr Peter Stewart
The Tribunal found the Lismore general practitioner guilty of professional misconduct after hearing a complaint in relation to his prescribing of anabolic/androgenic steroids and other medications to 22 patients for inappropriate purposes, without adequate monitoring, and failing to keep proper records. Dr Stewart admitted that he prescribed anabolic steroids, but that at all times he believed he was acting in the best interests of his patients. He was reprimanded and fined $10,000. The Tribunal also directed that if Dr Stewart was to practise after 24 January 2006 (a date Dr Stewart had nominated for his retirement) his registration was to be subject to conditions that he not undertake any solo general practice, and that he not prescribe, possess or administer any anabolic steroid or androgenic steroid.

Dr Ching Kun Edmond Kwan
On 24 November 1999, the PSB complained that Dr Kwan, a general practitioner, had inappropriately prescribed drugs of addictions to patients. Dr Kwan filed a motion seeking a permanent stay of the Tribunal proceeding alleging delay in the HCCC's investigation and prosecution of the matter. He claimed that the delay had denied him the opportunity of a fair hearing by disadvantaging his defence. The stay application was dismissed.

The complaint alleged inappropriate prescribing between 1996 and 1999 to 31 patients and inappropriate provision of religious instruction and advice to patients during his professional consultations.

The Tribunal found that Dr Kwan's conduct amounted to professional misconduct and noted that despite repeated counselling about his prescribing pattern he had continued his erroneous prescribing behaviour. Dr Kwan was reprimanded and had conditions imposed on his registration.

Dr Phillip John Guest
A complaint was made that this general practitioner inappropriately prescribed anabolic/androgenic steroids to 12 patients between February 1999 and February 2001 and also that he failed to make appropriate records of the consultations. Dr Guest admitted to prescribing the steroids for body building purposes. He claimed that he was unaware of any restriction on the prescription of steroids and was further unaware of the requirements that there be appropriate intervals for repeat prescriptions.

The Tribunal did not accept the practitioner's professed ignorance of the prohibition against the prescription of steroids for non-medical use. The Tribunal said:

> *"This was not the case of a newly qualified inexperienced doctor prescribing steroids on an occasional or one-off basis. As stated, he was a highly qualified general practitioner with a large practice, who issued a multitude of steroid prescriptions, seemingly to a stream of persons seeking to enhance their physiques."*

The Tribunal found Dr Guest guilty of professional misconduct and imposed a reprimand and a $10,000 fine.

Dr X – Non publication order on doctor's name
A general practitioner admitted to inappropriately prescribing drugs in excessive amounts without clinical justification or proper authority to several patients. The Tribunal held the conduct amounted to unsatisfactory professional conduct and imposed a reprimand and conditions on his registration. The conditions removed his ability to possess, supply, administer or prescribe any Schedule 8 or Schedule 4D drugs, not to work as a sole practitioner and to attend an educative course on prescribing.

Dr Susan Catchlove
Neutral Bay general practitioner Dr Susan Catchlove appeared before the Tribunal in relation to a complaint about her prescribing for 24 patients over several years. Allegations included prescribing inappropriate quantities, for excessive periods, to patients who were likely to be drug dependent and for whom she did not have the relevant authorities. She had received about 30 letters over several years warning her that her patients were 'doctor shoppers'. She had also been previously interviewed, written to and counselled by PSB.

Dr Catchove accepted that her conduct amounted to unsatisfactory professional conduct, however the Tribunal considered that the matters before it clearly amounted to professional misconduct and ordered that Dr Catchlove's name be removed from the Register and she is not to apply for re-registration for two years.

Dr Robert Joseph Muller
This general practitioner faced a complaint in the Tribunal concerning a patient whose cause of death in 1999 was caused by clomipramine toxicity combined with the effects of codeine, doxylamine and benzodiazepines. The practitioner had prescribed clomipramine and benzodiazepines to the patient but the other drugs were not necessarily prescribed. Following an investigation by the PSB prescribing irregularities with respect to other patients were noted. The practitioner was counselled by PSB in 1995 and surrendered his Schedule 4D and 8 authority to prescribe in 1999.

The Tribunal found that the practitioner had inappropriately prescribed to five patients, failed to comply with the requirements for prescribing drugs of addiction and restricted substances and failed to maintain proper records of his treatment of patients in accordance with the provisions of the Medical Practice Regulation 1998. The Tribunal found the practitioner's conduct demonstrated a lack of adequate knowledge, skill, judgment and care in the practice of medicine and was improper or unethical. Although the Tribunal found the practitioner guilty of unsatisfactory professional conduct it was not of a sufficiently serious nature to justify removal of his name from the register.

The Tribunal noted: *"The delay that has occurred between the commission of the acts (in 1999) upon which the (Commission) relies and the complaint dated April 2005 is a matter which the Tribunal has taken into account in considering any penalty in relation to the unsatisfactory professional conduct..."*. He was reprimanded and conditions were imposed on his registration.

Prescribing/conduct/failure to hold insurance

Dr Maria Bastas
Marrickville general practitioner Dr Maria Bastas was the subject of a hearing before the Tribunal for alleged failure to maintain a drug register; lack of Professional Indemnity Insurance cover during the period the subject of the complaint; inappropriate prescribing of S8 drugs and anabolic steroids during 2002 in relation to four patients, most particularly to Patient A with whom she developed a personal relationship during the time she was prescribing morphine and pethidine; and poor medical record keeping.

Dr Bastas's conduct was found to amount to professional misconduct and reprimanded. Stringent conditions were imposed on her registration including that she attend a course and maintain her vocational registration, and that she be mentored and supervised in a group practice.

This was the first time the Tribunal considered a complaint that the practitioner was guilty of unsatisfactory professional conduct for contravention of section 19(1) of the Health Care Liability Act 2001 (by practicing as a medical practitioner without being covered by approved professional indemnity insurance). Because Dr Bastas admitted the particular, this issue did not receive much attention, except that the Tribunal noted the peer reviewer's opinion that *"the failure of Dr Bastas to maintain medical indemnity insurance also attracted his severe criticism and severe disapproval"*.

Prescribing/impairment

Andrew John Katelaris
In 1991 Andrew Katelaris was suspended for 12 months from the practice of medicine because of his opiate use. However on return to practice Mr Katelaris continued to indulge in use of restricted or illegal substances, including morphine, pethidine, cannabis and Ketamine.

In December 2005 the Medical Tribunal found Mr Katelaris guilty of professional misconduct conduct and ordered his de-registration with no review period for three years. The Tribunal found Mr Katelaris had inappropriately prescribed schedule 8 narcotics, a schedule 4D drugs and cannabis to friends, family and to himself not in accordance with therapeutic standards. It was also alleged he breached his registration conditions. The Tribunal considered that the flagrant disregard by Mr Katelaris of the conditions on the his registration was conduct that portrayed indifference and an abuse of the privileges which accompany registration as a medical practitioner.

Complaints against obstetrician dismissed

Dr X – Non-publication order on doctor's name
An obstetrician had two complaints against him dismissed in the Tribunal. The Tribunal stated:

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

From my own point of view I do not believe there was such a mistake and the evidence does not support it, but if there were it is not such a mistake as could possibly be categorised as unsatisfactory professional conduct. Accordingly I would dismiss both complaints".

Conduct

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

The Tribunal heard a complaint about a hospital registrar who mistakenly injected a patient with vincristine intrathecally. The patient died a month later.

A series of hospital system failures and mistakes by other personnel contributed to the situation, but the practitioner did admit before the Tribunal that he neither checked the drug nor the route of administration before giving the injection. He also admitted that he did not notice a warning sticker that was on the procedure report when he signed it afterwards. The Tribunal found the practitioner was guilty of unsatisfactory professional conduct and he was reprimanded.

Competence

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

The practitioner, a locum junior medical officer in the Emergency Department at Campbelltown Hospital, was primarily responsible to the care and treatment of a patient in circulatory shock. The proceedings in the Tribunal followed the Special Commission of Inquiry into the Camden/Campbelltown Hospital. The issues concerned the respective roles and responsibilities of practitioners in the care of the patient. The Tribunal said:

"..the system which operated at Campbelltown (and apparently other hospitals) made a mismatch between a doctor's level of skill and the problems with which he was required to deal with almost an inevitability."

The Tribunal also noted that there is an "*unregulated industry*" of career medical officers. "*These practitioners, with respect to them, are not required to have specialist training or even to undergo regular meaningful professional education*."

The Tribunal further stated:

"...the aggregation of the respondent's missed opportunities persuades the Tribunal that, in conformity with the unanimous views of the peer reviewers, the respondent's conduct fell below an acceptable level".

The Tribunal found him guilty of demonstrating a lack of judgment and care and he was reprimanded. The Tribunal found the shortcomings of the practitioner are at the lowest end of the scale of seriousness and that the outcome was tragic. The tribunal stated that the doctor may have contributed by failing to act, but his failure to act was in no way a gross dereliction of duty. The tribunal stated that in those circumstances it is somewhat surprising that a complaint was made to bring him before the Medical Tribunal. There was no need to impose any conditions on the practitioner's registration and the Tribunal ordered his name not be published.

Impairment/conduct

Dr Keith Caladine

Dr Caladine is a general practitioner. Following a series of complaints about his conduct and allegations relating to prescribing practices, Dr Caladine was suspended by the Board in 2003. Although the Board imposed conditions which allowed him to return to practise, he elected not to practise medicine until the proceedings before the Tribunal had been concluded and he has not worked since 2003. The Tribunal considered two complaints – one of impairment and, in the alternative, a complaint of professional misconduct or unsatisfactory professional conduct demonstrated by his communications with patients. The Tribunal found that the practitioner suffers from an impairment and the alternative complaint was dismissed. An application by the practitioner to suppress his name was refused. The Tribunal imposed employment conditions and health conditions, which require him to be monitored through the Health Program.

B. Appeals determined by the Medical Tribunal

Professional Standards Committees

Two appeals against decisions of Professional Standards Committees on points of law were filed in the Tribunal by practitioners. In one matter the practitioner withdrew their appeal, and in the other matter the practitioner was successful and their appeal was allowed. A general practitioner appealed against the appropriateness of the imposition of conditions that his records be subjected to and that he pay for a clinical audit. The Professional Standards Committee found the practitioner had engaged in an improper commercial venture with a patient with a previous history of depression; and secondly, the practitioner had failed to make a record of 21 consultations with that patient. The Tribunal held the audit condition was inappropriate and allowed the appeal on this ground.

One matter lodged in the previous reporting period was also determined by the Tribunal, and the practitioner was successful in this appeal. The conditions imposed by a Professional Standards Committee were set aside, the Tribunal severely reprimanded the practitioner and imposed new conditions.

Appeals against s66 suspension/conditions

There were two appeals under section 95 of the Act against the action taken by the Board under section 66, which gives power to the Board to either impose conditions or suspend a practitioner to protect the public. One appeal was withdrawn, the other matter was resolved by consent.

Registration

An appeal against a decision of the Board to refuse registration or to impose conditions on a practitioner's registration lies to the Tribunal under section 17 of the Act. One practitioner appealed against the decision of the Board to refuse his registration but did not appear to prosecute the matter and the appeal was dismissed. This practitioner was also the subject of a complaint being prosecuting before the Medical Tribunal and the Appeal and complaint matters were both heard together.

C. Reviews by Medical Tribunal

Restoration to the Register

During 2005/06 the Tribunal handed down four decisions in respect of applications for review of deregistration orders. In two cases, the Tribunal was comfortably satisfied that the applicants were now fit and proper persons to be restored to the register, subject to conditions (Stuart Roger Anderson, Aladdin Matter). The Tribunal refused two applications for restoration (Ian Leigh Ferguson, Monier Gad).

Ian Leigh Ferguson

Mr Ian Leigh Ferguson unsuccessfully applied for restoration to the Register, having been removed from the Register for both professional misconduct and unsatisfactory professional conduct in May 2001. This was his first application for restoration. His application was dismissed and he is not to re-apply for 18 months on the basis that he is not currently a fit and proper person to be re-registered. The 2006 Tribunal found there was no objective evidence that there had been any change in attitude by Mr Ferguson in relation to drug prescribing, nor any evidence he had sought to redress the defects in his conduct that lead to his de-registration.

Review of conditions

One practitioner filed an application for a review of conditions imposed by the Tribunal. This resulted in the Tribunal lifting the conditions on his registration.

D. Appeals against Tribunal decisions

There were two appeals determined by the NSW Court of Appeal.

NSW Court of Appeal

Mr Karanalu Vinatheya Prakash

On 16 June 2006 the Court of Appeal dismissed the appellants appeal. In 2004 Mr Prakash had his named removed from the Register in NSW by an order of the Medical Tribunal for breaching his registration conditions, failure to comply with the legal requirements of the Poisons and Therapeutic Goods regulations and providing false information to the Health Insurance Commission. Mr Prakash was given a non review period by the Tribunal until 17 December 2006. The Court of Appeal found that the de-registration order was proportionate in view of Mr Prakash's serious misconduct and history.

Dr David Charles Lindsay

Dr David Charles Lindsay appealed to the Court of Appeal in relation to an August 2004 Medical Tribunal decision which found him guilty of unsatisfactory professional conduct in relation to three findings. He was reprimanded and two conditions were ordered to be imposed on his registration.

Prior to the Court of Appeal hearing in September 2005, the parties agreed that the Tribunal had failed to accord procedural fairness to Dr Lindsay because in determining that he was guilty of unsatisfactory professional conduct it had wrongly taken into account material that was provided solely in relation to any protective orders it may make. The Court of Appeal stated there had been a clear error of law in this regard.

The result of the appeal was that the wording of a condition on his registration was narrowed, and he was found not guilty of unsatisfactory professional conduct in relation to one of the findings. Otherwise the Tribunal's previous findings and decisions were not disturbed.

NSW Supreme Court

Dr Eckhard Roerich

This matter was reported in last year's annual report. In March 2006 the Supreme Court in a further judgment found that the plaintiff was not entitled to bring a private action for breach of duty by the Board. The Supreme Court found that an employee of the Board had committed a technical trespass when entering the plaintiff's surgery and awarded damages to the plaintiff in the sum of $100.

Matters in other jurisdictions

Administrative Decisions Tribunal

Mr Asaad Razaghi

In 1999 Mr Razaghi, an overseas trained doctor, lodged a complaint with the Administrative Decisions Tribunal (ADT) which stated that the Department of Health and the Board had discriminated against Mr Razaghi because he was not eligible for positions classed as 'area of need'. In 2006 the ADT found that because Mr Razaghi could be registered in other registration categories and due to a lack of substantial evidence, his complaints could not be proven. Mr Razaghi applied for leave to appeal the ADT's findings however leave was refused.

HEALTH (IMPAIRED REGISTRANTS PROGRAM)

Overview

The Health Program has been operating under the provisions of the Medical Practice Act since 1992. In that time, more than 420 impaired practitioners have participated in the Program and 181 practitioners have successfully exited, having consolidated their recovery and fulfilled the Board's monitoring requirements.

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

NOTIFICATIONS BY SOURCE %

	2003/04 n=63	**2004/05** n=66	**2005/06** n=68
Colleagues (including employers)	14	18	13
Pharmaceutical Services Branch	4	1	6
Self referral*	29	25	27
University	3	4	5
Board Committee	2	-	-
Courts	1	1	-
Treating Practitioner	6	8	6
Other	4	9	11

*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 has sought more information, either from the practitioner, their treating doctor or a Board-nominated doctor. Only these cases are included in the table above, along with other self-notifications that occur outside the annual return process.

Key Activities

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

A highlight of the year was an address to the Board and Health Committee members by Dr Mamta Gautam MD, FRCP(C). Dr Gautam is a psychiatrist in private practice in Ottawa, and an Assistant Professor in the Department of Psychiatry at the University of Ottawa, Canada. Doctors make up her entire patient population. Her presentation provided an invaluable insight into the challenges of treating a doctor and being a doctor/patient.

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

1. The nature and natural history of the registrant's illness

It is neither feasible nor desirable to adopt a rigid, one-size-fits-all approach to impaired registrants. Much is known about the natural history of the conditions that commonly result in a practitioner being considered to be impaired, and decisions should reflect this knowledge.

2. Compliance with the program

The dual aims of registration conditions are to protect the public and, where possible, to allow impaired registrants to remain in the medical workforce. It is only through compliance with registration conditions that the Board can be assured that these objectives are met.

No consideration is given to easing any condition of registration unless a registrant has been fully compliant with all conditions for a period of at least 12 months.

3. Personal support

Personal support and engagement with the community are recognised as positive predictors of recovery from all disorders, but particularly from addiction. They demonstrate insight on the part off the impaired practitioner and they increase the chances of early identification of illness or relapse in addition to providing an environment in which recovery or stabilisation can occur.

4. Professional support

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

5. Insight and motivation

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

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

An overview of the activities of the Health Committee in this and previous years follows:

	2003/04	2004/05	2005/06
Notifications	63	66	68
Impaired Registrants Panel reports endorsed			
Psychiatric illness	40	28	24
Alcohol	2	9	4
Drug	7	8	13
Physical	1	3	3
Total	**50**	**48**	**44**
Review Interviews held	210	211	238
Exits from the Program	15	22	19
Participants in Program	131	126	124

Hearing Outcomes

Impaired Registrants Panels (IRPs) are convened if a notification and assessment of a doctor reveals evidence of impairment.

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

This year, 64% of IRPs concluded with the practitioner agreeing to conditions being placed on their registration. Twenty nine percent resulted in no further action being taken, and 7% were referred to other Board committees.

The conditions that are placed on a practitioner's registration are tailored to address their particular circumstances and type of impairment. Practitioners with a drug addiction are generally required to attend an appropriate specialist (usually a psychiatrist) for treatment, undertake urine drug testing according to the Board's protocol, attend a Board nominated doctor for monitoring, and surrender their authority to prescribe drugs of addiction. Practitioners who have abused alcohol will also need to attend for ongoing treatment and undertake regular blood testing. Practitioners suffering from a psychiatric illness must attend a treating psychiatrist and comply with treatment ordered by their doctor.

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

Case Studies

Case Study 1

Dr A is a metropolitan general practitioner who was notified to the Board by the Pharmaceutical Services Branch of the Department of Health when his Schedule 8 prescribing rights were withdrawn due to self-prescribing of Schedule 8 drugs.

Dr A suffers from generalised anxiety and obsessive-compulsive disorder, and major depression. He commenced using codeine following an accident where he was injured, and continued to take it when faced with anxiety and significant family stressors.

At an Impaired Registrants Panel Inquiry, Dr A agreed to a number of conditions being placed on his registration, including attending a drug and alcohol specialist on a regular basis, and thrice weekly urine drug testing.

Dr A was not fully compliant with urine drug testing requirements. His non-compliance included dilute samples, unexplained, intermittent traces of morphine and missed samples without providing a medical certificate from his treating doctor. Non-compliance continued over a significant period, despite warnings that a complaint would be made to the Health Care Complaints Commission.

The conditions on Dr A's registration were maintained due to his non-compliance, and because the Board-nominated psychiatrist felt that Dr A was still in the early stages of recovery from substance abuse.

While making allowances for minor infractions, the Board cannot tolerate continued non-compliance, and a complaint was made to the Health Care Complaints Commission and an investigation instigated.

Case Study 2

Dr C has been involved with the Health Program on and off over the last 10 years. She has a long history of bipolar disorder dating back to her teenage years. Several serious episodes of hypomania have resulted in her being hospitalised.

More recently, Dr C attended an Impaired Registrants Panel Inquiry and was again made a participant in the Health Program. She had suffered a relapse following the cessation of her mood stabiliser. After a 12 month period of being well, Dr C requested to exit the Health Program. The Health Committee did not agree to this request as Dr C has a history of relapsing illness, and the Board felt that long-term low-level monitoring of Dr C was appropriate.

Dr C suffered another relapse two years later, and had to be hospitalised and off work for an extended period of time.

Dr C has now been well for another two years. The Health Committee has formalised its view that doctors with bipolar disorder need to remain on the Health Program with low level monitoring in the long term. In accordance with this policy decision, the Health Committee aims to keep Dr C on the Health Program.

Medical students

The impairment provisions of the Medical Practice Act also apply to medical students. The primary objective of the program as it applies to medical students is public protection. A clear, secondary objective is ensuring that the student's transition into the medical workforce is assisted.

In the case of medical practitioners, registration conditions are voluntarily entered in to. The significant difference in the case of medical students is that the Panel is required to consider whether it is in the interest of the public to impose conditions on the student undertaking clinical studies. Since the commencement of the provisions, 33 students have been before an Impaired Registrants Panel. Twenty-four have had conditions placed on their undertaking clinical studies, usually including regular reporting from the relevant University.

Early notification is seen as essential in supporting the impaired student and planning their transition into internship. The Medical Faculties have different approaches to managing impaired students, and have invited a variable degree of advice and participation from the Medical Board. It is of concern that student notifications remain at a low level, and that these few notifications generally occur late in the student's training.

The Board will again raise these issues with the Deans of the Medical Schools.

Case Study

Ms B is a final year medical student. She was notified to the Board by the Dean of the Medical School, due to concern about her health when she had taken significant time off from her studies, and had been an inpatient receiving ECT due to severe depression.

An Impaired Registrants Panel Inquiry was convened early in the year, and conditions were imposed on her student registration.

As is often the case, a second Impaired Registrants Panel was convened just prior to her graduation so as to revise the conditions on her registration to assist in her transition from student to intern.

At the time of the second IRP, Ms B's health had improved dramatically. Conditions agreed to at this time included a restriction on working night shifts or significant amounts of overtime, and a requirement that she establish a supportive relationship with the Director of Clinical Training. Ms B has progressed well in her intern year.

Exiting the Program

In the year ending 30 June 2006, a total of 28 practitioners exited the Health Program. Nineteen of these had their conditions lifted and returned to full registration. The Board's practice of conducting an exit interview is now well established and provides valuable feedback to both the Board and the practitioner. The Board was satisfied that these 19 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. However, no registrants who had exited the program during the year re-presented during 2005/06.

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

Conclusion

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

PERFORMANCE

Overview

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

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

The professional performance of a registered medical practitioner is defined to be unsatisfactory if it is below the standard reasonably expected of a practitioner of an equivalent level of training or experience. This is the basis for using peer rather than expert assessors.

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

During the year, the Board's decision to conduct a Performance Assessment has been challenged by several doctors. These challenges have resulted in the Board critically reviewing its policies, processes and documentation. Six years' experience has exposed a number of deficiencies and anomalies in the Performance Assessment provisions of the Medical Practice Act 1992. The Board is seeking legislative amendment to ensure the integrity and ongoing success of the Performance Program.

The Performance Assessment process continues to be refined and developed. During the year, the Board designed and introduced an objective tool for assessing procedural performance. In addition, the NSW Medical Board provided advice and support for several other Australian jurisdictions that are designing or implementing performance programs.

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.

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 response has satisfactorily addressed the issues raised in the complaint and that no further action is required;

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

The process described above provides a timely mechanism by which complaints can be managed and resolved. The management of these matters within the Performance Section enables the Board to consider a range of actions in response to the spectrum of performance matters that come to its attention. Full Performance Assessment is at one end of the spectrum, and is reserved for the most concerning cases. The majority of matters are resolved through the other interventions described above.

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

Program Activity

An overview of the Performance Program activity in 2005-2006 follows.

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

Complaints referred to the Board by the HCCC	2003/04	2004/05	2005/06
Total	204	202	189

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

Outcome of complaints referred to the Board	2003/04	2004/05	2005/06
No further action	68	131	63
Letter of apology to patient	4	8	5
Board letter	23	54	23
Performance Interview	24	31	28
Performance Assessment	14	12	3
Section 66 inquiry	3	2	0
Refer to Health Committee	1	0	1
Refer to HCCC for investigation	5	5	1
Direct Resolution with PSO	14	1	n/a
Conciliation	13	8	n/a
Refer to HCCC (for reassessment)	n/a	16	3
No longer registered, action if applies for re-registration.	n/a	2	1
Total	**169**	**270**	**128**

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

Outcome of Interviews	2003/04	2004/05	2005/06
No further action	23	14	21
Performance Assessment	3	3	7
Total	**26**	**17**	**28**

The following table reports the source of matters considered for full Performance Assessment.

Matters considered for Performance Assessment by source	2003/04	2004/05	2005/06
Board Committee (Health, Conduct)	8	9	12
Complaint originating from:			
➔ Patient	8	8	5
➔ Employer	3	2	4
➔ Colleague	0	1	2
➔ Professional Services Review	3	2	1
Total	**22**	**22**	**24**

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	2003/04	2004/05	2005/06
Anaesthetist	0	1	1
General Practitioner	13	15	16
Obstetrician & Gynaecologist	1	0	0
Ophthalmologist	0	1	0
Surgeon	5	1	3
Pathologist	0	2	0
Psychiatrist	2	2	2
Paediatrician	0	0	1
Trainee	0	0	1
Total	**21**	**22**	**24**

The following table reports the Performance Committee's resolutions for those doctors considered for full Performance Assessment. Most assessments occur within three months of the Committee's decision to conduct a Performance Assessment.

Outcomes for doctors considered for full Performance Assessment	2003/04	2004/05	2005/06
PA is not indicated	1	3	2
Performance Assessment	19	17	20
Performance Interview	1	1	3
Performance Review Panel (without Performance Assessment)	0	0	1
Total	**21**	**21**	**26**

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 exercise to counsel and advise the practitioner. More formal counseling can occur when there are performance issues that do not require the Board to order remediation, but that need to be drawn to the practitioner's attention. If remediation is required, or if there are issues of public protection, then a Performance Review Panel is convened to formalise these orders.

Performance Assessment Outcomes	2003/04	2004/05	2005/06
Retired or Non-practising before having PA	1	3	3
S66/reassessed – now Investigation	0	1	2
Interim PA report – until work situation changes	0	0	2
No further action	3	1	4
Performance Interview	0	0	2
Counselling	0	1	5
Performance Review Panel	10	7	7

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, or engaging in Continuing Professional Development.

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

Performance Review Panel	2003/04	2004/05	2005/06
PRP Held	8	5	7
Did not proceed (retired, name removed)	0	1	1
PRP completed – outcome:	4	7	9
counseled	2	0	2
remediation orders	4	6	6
protective orders	4	6	8

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

Outcome of Reassessment	2003/04	2004/05	2005/06
Satisfactory – exited program	1	2	5
Making progress	0	0	1
Unsatisfactory – PRP needed	0	0	2
Total to date	**1**	**2**	**8**

Case Studies

The following case studies illustrate the Performance Assessment Program's work during 2005-06:

Case Study 1

Dr X gained his MBBS in New Zealand and trained as a surgeon. In the 1970s he began practising as a general practitioner working in a small group practice in Sydney where he has remained.

A complaint was made in 2004 about the death of a patient from a drug related overdose. It alleged that Dr X prescribed medications inappropriately. An investigation by HCCC led to Dr X being counseled. The counselors were concerned about Dr X's reluctance to actively elicit information from patients, relying instead on patients voluntarily disclosing information. They were also concerned about Dr X's general lack of treatment and follow-up plans in that he relied on patients returning to him if they considered they had a need rather than giving explicit instructions to them.

Dr X was referred to the Performance Committee due to concerns raised in the counseling report. The Performance Committee resolved that a Performance Assessment was required.

Dr X is in his 80s and had no previous complaints. He advised the Board he had health problems but that he could not get anyone to take over his practice and that he would retire in a few months. He requested that his registration be changed to Non-Practising. As a result the Performance Assessment did not proceed.

This case illustrates a common situation; an older doctor who wants to retire but is concerned about who will care for their patients and works on with a sense of obligation to the community.

Case Study 2

Dr Y is a psychiatrist who trained overseas and has been registered in NSW for more than 20 years. He has a long complaint history with the Board.

A complaint was made by the wife of one of Dr Y's patients alleging:

- ➔ inappropriate prescribing,
- ➔ refusal to include her in consultations, or discuss her husband's treatment, despite being her husband's carer and having his written authority.

The Performance Committee considered the complaint and Dr Y's very long complaint history and resolved that a Performance Assessment was required. The Assessors, found Dr Y's professional performance to be unsatisfactory and recommended that a Performance Review Panel be convened and that he have neuropsychometric testing before the performance review. They reported a fairly rigid and simplistic approach to diagnosis and treatment, difficulties with memory and attention, and lack of insight regarding his cognitive deficiencies.

The neuropsychometric testing was conducted and reported attention, memory and executive deficits. It was expected that Dr Y would have considerable difficulty in competently diagnosing and treating new patients, particularly if required to process a relatively large number of patients in a short period of time.

Dr Y attended the Performance Review Panel which made a finding of unsatisfactory professional performance. Conditions were placed on his registration including that he see no new patients, limit his daily patient numbers, and work with a supervisor to monitor and review his clinical practice and compliance with his conditions.

An objective of the Performance Program is to require practitioners to remediate the deficiencies identified in their practice. However, in this case, neuropsychometric testing indicated that Dr Y's capacity for remediation was extremely limited. Therefore, conditions were imposed focusing on public protection, but enabling Dr Y to remain in limited, highly supervised practice.

Case Study 3

Dr Z is a surgeon who gained his MBBS in NSW. He is a Fellow of Royal Australasian College of Surgeons.

Several years ago, the Board was advised that Dr Z's clinical privileges had been suspended at a public hospital. This followed an internal investigation which identified serious deficiencies in his clinical management of various patients and in his supervision of junior medical staff. Dr Z also voluntarily withdrew his services from a private hospital. A section 66 inquiry was held to consider the issues raised by the public hospital. At that inquiry, Dr Z indicated that he had ceased practice and that he wished to place

his name on the Register as a non-practising practitioner. He acknowledged that he had been suffering from an illness. The Panel indicated to Dr Z that should he seek to return to practice, he would be subject to a Schedule 1 inquiry.

When Dr Z applied to change his registration category and return to work he had conditions placed on his registration from the Schedule 1 inquiry. The Panel accepted that Dr Z had organised and received appropriate treatment for his illness and that the symptoms and initial difficulties he experienced as a result of his illness had been alleviated. The panel noted the opinion of Dr Z's treating specialist that Dr Z should make a graduated return to practice with a reduced workload. These conditions required Dr Z to participate in the Board's Health Program, and to work under supervision when performing a certain level of complex surgery.

Dr Z's supervisor subsequently reported two incidents of poor surgical outcome. The Performance Committee resolved that a Performance Assessment was required.

The assessment was undertaken by two peers who concluded that the technical, surgical aspects of his professional performance were adequate but that his current surgical complication rate appeared to be above the standard expected. However, as the total numbers were low, the assessors recommended that he needed to perform more of these procedures under supervision.

The Performance Committee resolved that a Performance Review Panel be convened. This was held and Dr Z's professional performance was found to be unsatisfactory. Conditions were imposed, requiring Dr Z to be supervised when performing a certain level of complex surgery and to collect audit data for all his surgical procedures

The audit data was reviewed by a peer and Dr Z was reassessed by 2 peers one of whom had conducted the original assessment. They reported that Dr Z's professional performance was satisfactory.

The Performance Committee removed all Employment conditions on Dr Z's registration except the condition limiting his hours of work – which was left to the Health Committee to review.

Dr Z has traveled a long road back to unrestricted surgical practice after a lengthy period of illness. Conditions on his registration restricted his practice while he regained his confidence and improved his surgical skills. Operating under supervision allowed him to observe and learn new skills and facilitated his safe return to practice.

This case illustrates the Board's flexibility in moving practitioners between its programs, as well as the interrelationship between poor health and poor performance.

Conclusion

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

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

FINANCE AND BUDGET

Overview – Financial Performance – Year ended 30 June 2006

The total income for the period was $7,983,000. Expenditure for the period $7,378,000 was against a budgeted figure of $6,974,000.

An operating surplus of $605,000 was achieved in the year ended 30 June 2006.

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 ($94,234).

The Board also contributed to the Australian Medical Council ($152,581) and the Doctors Health Advisory Services ($30,000).

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 ($26,397).

Investment Performance

The return on internally managed funds for the year ended 30 June 2006 was 5.25%.

The Board's externally managed funds were held in Treasury Corporation's HourGlass Cash Plus Facility. An average return of 5.76% was achieved for the current financial year.

Budget

Performance against Budget for the year ending 30 June 2006 and Budget for the year ending 30 July 2007

	30 June 2006 Budget ($'000)	30 June 2006 Actual ($'000)	30 June 2007 Budget ($'000)
Registration fees	7,219	7,226	7,416
Fines	20	55	20
Interest	360	492	500
Profit on sale of non-current assets	–	–	–
Other	43	69	43
Area of Need income	176	141	140
TOTAL INCOME	**7,818**	**7,983**	**8,119**
Salaries and related expenses	2,224	2,610	2,695
Sitting fees	1,126	1,027	1,241
Funding contributions	340	354	380
Computer and consultancy	365	504	467
Members fees	373	307	373
Medical Tribunal funding	400	600	600
Professional Conduct and Health	420	337	400
Postage, courier and phone	150	153	165
Loss on disposal of assets	–	15	
Administration expenses	772	754	741
Superannuation	352	397	369
Vehicle, travel and accommodation	168	95	91
Depreciation and amortisation	270	208	260
Audit Fees	14	15	15
Software development expenses written off		2	
TOTAL EXPENDITURE	**6,974**	**7,378**	**7,797**
OPERATING SURPLUS	**844**	**605**	**322**

Income

The budget for the year ending 30 June 2007 is based on the following estimates:

➔ a 2% 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 AUDIT REPORT

NEW SOUTH WALES MEDICAL BOARD

To Members of the New South Wales Parliament

Audit Opinion

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

- presents fairly the Board's financial position as at 30 June 2006 and its performance for the year ended on that date, in accordance with Accounting Standards and other mandatory financial reporting requirements in Australia, and
- complies with section 41B of the *Public Finance and Audit Act 1983* (the Act) and the *Public Finance and Audit Regulation 2005.*

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

Scope

The Financial Report and Board's Responsibility

The financial report comprises the balance sheet, income statement, statement of changes in equity, cash flow statement and accompanying notes to the financial statements for the Board, for the year ended 30 June 2006.

The members of the Board are responsible for the preparation and true and fair presentation of the financial report in accordance with the Act. This includes responsibility for the maintenance of adequate accounting records and internal controls that are designed to prevent and detect fraud and error, and for the accounting policies and accounting estimates inherent in the financial report.

Audit Approach

I conducted an independent audit in order to express an opinion on the financial report. My audit provides *reasonable assurance* to Members of the New South Wales Parliament that the financial report is free of *material* misstatement.

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

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

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

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.

Audit Independence

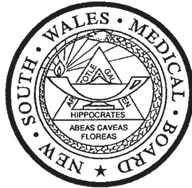
The Audit Office complies with all applicable independence requirements of Australian professional ethical pronouncements. The Act further promotes independence by:

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

M Abood

M P Abood, CPA
Director, Financial Audit Services

SYDNEY
20 October 2006



New South Wales Medical Board

Statement by the members of the Board

For the period ended 30 June 2006

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

1. The financial statements for the period ended 30th June 2006 exhibit a true and fair view of the financial position and transactions of the New South Wales Medical Board; and

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

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

President

Board Member

20 October 2006

BALANCE SHEET
AS AT 30 JUNE 2006

	Notes	2006	2005
		$'000	**$'000**
Current Assets			
Cash and cash equivalent	7	9,416	8,232
Other Receivables	8	609	672
Total-Current Assets		**10,025**	**8,904**
Non-Current Assets			
Plant and Equipment	9	234	252
Intangible Assets	10	26	29
Leasehold improvements	11	2,324	2,426
Total-Non Current Assets		**2,584**	**2,707**
Total Assets		**12,609**	**11,611**
Current Liabilities			
Payables	12	485	221
Provisions	13	353	252
Other	14	3,884	3,856
Total Current Liabilities		**4,722**	**4,329**
Total Liabilities		**4,722**	**4,329**
Net Assets		**7,887**	**7,282**
Equity			
Accumulated Funds	15	7,887	7,282
Total Equity		**7,887**	**7,282**

The accompanying notes form part of the financial report.

INCOME STATEMENT

FOR THE YEAR ENDED 30 JUNE 2006

	Notes	2006	2005
		$'000	**$'000**
Expenses from ordinary activities	2	7,363	5,879
Revenues from ordinary activities	3	7,983	7,768
Gain/(Loss) on disposal of plant and equipment	4	(15)	(36)
Results for the year from ordinary activities		**605**	**1,853**

The accompanying notes form part of the financial report.

STATEMENT OF CHANGES IN EQUITY

FOR THE YEAR ENDED 30 JUNE 2006

	Notes	2006	2005
		$'000	**$'000**
Total income and Expenses recognised directly in Equity		0	0
Surplus / (Deficit) for the Year		605	1,853
Total Income and Expense recognised for the Year		**605**	**1,853**

The accompanying notes form part of the financial report.

CASH FLOW STATEMENT
FOR THE YEAR ENDED 30 JUNE 2006

	Notes	2006	2005
		$'000	$'000
Cash Flows from Operating Activities			
Receipts from registrants and other debtors		7,921	7,760
Payments to suppliers and employees		(7,133)	(5,839)
Interest received		498	373
Net Cash provided by operating activities	**17**	**1,286**	**2,294**
Cash Flows from Investing Activities			
Payments for leasehold improvements,plant and equipment		(110)	(206)
Proceeds from sale of plant and equipment		8	27
Net Cash used in Investing activities		**(102)**	**(179)**
Net increase in cash held		1,184	2,115
Cash at the beginning of the financial year		8,232	6,117
Cash at the end of the financial year	**7**	**9,416**	**8,232**

The accompanying notes form part of the financial report.

NOTES TO AND FORMING PART OF THE FINANCIAL REPORT
FOR THE YEAR ENDED 30 JUNE 2006

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 2006 has been authorised for issue by the Board on 20 October 2006.

b. Basis of Preparation

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

Property, plant and equipment, assets (or disposal groups) held for sale and financial assets at 'fair value through profit or loss' and available for sale are measured at fair value. Other financial report items are prepared in accordance with the historical cost convention. Judgements, key assumptions and estimations management has made are disclosed in the relevant notes to the financial statements.

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

c. Statement of Compliance

The Board's financial report and notes comply with Australian Accounting Standards, which include the Australian equivalents to International Financial Reporting Standards (AEIFRS). This is the first financial report prepared based on AEIFRS and comparatives for the year ended 30 June 2005 have been restated accordingly, except as stated below.

In accordance with AASB 1 *First-time Adoption of Australian Equivalents to International Financial Reporting Standards* and Treasury Mandates, the date of transition to AASB 132 *Financial Instruments: Disclosure and Presentation* and AASB 139 *Financial Instruments: Recognition and Measurement* was deferred to 1 July 2005. As a result, comparative information for these two Standards is presented under the previous Australian Accounting Standards which applied to the year ended 30 June 2005.

The basis used to prepare the 2004/05 comparative information for financial instruments under previous Australian Accounting Standards is discussed in Note 1 (u) below.

Reconciliations of AEIFRS equity and surplus or deficit for 30 June 2005 to the balances reported in the previous AGAAP 2004/2005 financial report are detailed in Note 20. This note also includes separate disclosure of the 1 July 2005 equity adjustments arising from the adoption of AASB 132 and AASB 139.

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 an registration period elapses.

e. Investment Revenue

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

f. Accounting for the Goods and Services Tax

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

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

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

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

g. Employee benefits and other provisions

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

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

Long-term annual leave that is not expected to be taken within twelve months is measuredat present value in accordance with AASB 119 *Employee Benefits*. Market yields ongovernment bonds of 5.78% are used to discount long-term annual leave.

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

(ii) Long Service Leave and Superannuation

Long service leave is measured at present value in accordance with AASB 119 *Employee Benefits*. This is based on the application of certain factors (specified in NSWTC 06/09) to employees with five or more years of service, using current rates of pay. These factors were determined based on an actuarial review to approximate present value.

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

h. Insurance

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

i. Acquisitions of Assets

The cost method of accounting is used for the initial recording of all acquisitions of assets controlled by the Medical Board. Cost is the amount of cash or cash equivalents paid or the fair value of the other consideration given to acquire the asset at the time of its acquisition or construction or, where applicable, the amount attributed to that asset when initially recognised in accordance with the specific requirements of other Australian Accounting Standards.

Assets acquired at no cost, or for nominal consideration, are initially recognised as assets and revenues at their fair value at the date of acquisition.

Fair value means the amount for which an asset could be exchanged between a knowledgeable, willing parties in an arm's length transaction.

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

j. Capitalisation Thresholds

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

k. Revaluation of Plant and Equipment

Physical non-current assets are valued in accordance with "Valuation of Physical Non-Current Assets at Fair Value" Policy and Guidelines Paper (TPP 05-3). This policy adopts fair value in accordance with AASB 116 *Property, Plant and Equipment* and AASB 140 *Investment Property*.

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

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

l. Impairment of Property, Plant and Equipment

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

m. Depreciation of Plant and Equipment

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

Depreciation rates used are as follows:

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

Amortisation rates used are as follows:

Building Refurbishments – Building 54 4%
Building Refurbishments – Building 45 3.4%
Building Extension – Building 54 1.7%

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 – Year Ended 30 June 2006 (refer Note 1 (u) for 2004/05 policy)

Receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. These financial assets are recognised initially at fair value, usually based on the transaction cost or face value. Subsequent measurement is at amortised cost using the effective interest method, less an allowance for any impairment of receivables. Any changes are accounted for in the Income Statement when impaired, derecognised or through the amortisation process.

Short-term receivables with no stated interest rate are measured at the original invoice amount where the effect of discounting is immaterial.

r. Investments – Year ended 30 June 2006 (refer Note 1 (u) for 2004/05 policy)

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

NOTES TO AND FORMING PART OF THE FINANCIAL REPORT
FOR THE YEAR ENDED 30 JUNE 2006

s. Payables – Year ended 30 June 2006 (refer Note 1 (u) for 2004/05 policy)
These amounts represent liabilities for goods and services provided to the Board and other amounts, including interest. Payables are recognised initially at fair value, usually based on the transaction cost or face value. Subsequent measurement is at amortised cost using the effective interest method. Short-term payables with no stated interest rates are measured at the original invoice amount where the effect of discounting is immaterial.

t. Comparative Information
Comparative figures have been restated based on AEIFRS with the exception of financial instruments information, which has been prepared under the previous AGAAP Standard (AAS 33) as permitted by AASB 1.36A (refer para. (u) below). The transition to AEIFRS for financial instruments information was 1 July 2005. The impact of adopting AASB 132 / 139 is further discussed in Note 19.

u. Financial instruments accounting policy for 2004/05 comparative period.
Investment Income

Interest revenue is recognised as it accrues.

Receivables

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

Payables

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

v. New Australian Accounting Standards issued but not effective
The NSW Medical Board is of the opinion that the following new Australian Accounting Standards issued but not effective would not have significant impact on its financial statements. The standards apply to annual reporting periods beginning on or after 1 January 2006 –

- AASB 7 Financial Instruments Disclosure (issued August 2005)
- AASB 2004-3 Amendments to Australian Accounting Standards (issued December 2004)
- AASB 2005-1 Amendments to Australian Accounting Standards (issued May 2005)
- AASB 2005-5 Amendments to Australian Accounting Standards (issued June 2005)
- AASB 2005-9 Amendments to Australian Accounting Standards (issued September 2005)
- AASB 2005-10 Amendments to Australian Accounting Standards (issued September 2005)
- AASB 2006-1 Amendments to Australian Accounting Standards (issued January 2006)

	2006	2005
	$'000	$'000

2. EXPENDITURE FROM ORDINARY ACTIVITIES

	2006 $'000	2005 $'000
Salaries and related expense	2,610	2,262
Sitting Fees	1,027	744
Funding Contributions	354	258
Computer and Consultancy	504	222
Board Members Statutory Fees	307	333
Medical Tribunal Funding	600	400
Legal, Professional Conduct and Health Costs	337	206
Postage, Courier and Phone	153	149
General Administration Expenses	754	599
Superannuation	397	316
Vehicle, Travel and Accommodation	95	83
Depreciation and Amortisation	208	218
Auditor's remuneration-audit or review of financial reports	15	14
Software expenses written off	2	75
	7,363	**5,879**

3. REVENUES FROM ORDINARY ACTIVITIES

	2006 $'000	2005 $'000
Registration Fees	7,226	7,115
Fines	55	43
Interest revenue (Note 5)	492	377
Other Revenue (Note 6)	210	233
	7,983	**7,768**

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

	2006 $'000	2005 $'000
Cost of plant and equipment	215	115
Less Accumulated depreciation	(192)	(52)
Wriiten Down Value	23	63
Less Proceeds from Disposal	(8)	(27)
Gain/(Loss) on Disposal of plant and equipment	(15)	(36)

NOTES TO AND FORMING PART OF THE FINANCIAL REPORT

FOR THE YEAR ENDED 30 JUNE 2006

	2006	2005
	$'000	$'000
5. INTEREST REVENUE		
Interest	82	177
TCorp Hour Glass Investment Facility	410	200
	492	**377**
6. OTHER REVENUE		
Application Fee for Area of Need Assessments	141	171
Other	69	62
	210	**233**
7. CURRENT ASSETS – CASH AND CASH EQUIVALENTS		
Cash at bank and on hand	1,806	1,033
Treasury Corporation Hour Glass Facility	7,610	7,199
	9,416	**8,232**
For the purposes of the Cash Flow Statement, cash and cash equivalents include cash at bank, cash on hand and short term deposits.		
Cash and cash equivalent assets recognised in the Balance Sheet are reconciled at the end of the financial year to the Cash Flow Statement as follows:		
Cash and cash equivalents (per Balance Sheet)	9,416	8,232
Closing cash and cash equivalents (per Cash Flow Statement)	**9,416**	**8,232**
8. CURRENT ASSETS – RECEIVABLES		
Accrued Interest	9	15
Other	584	638
Prepayments	16	19
	609	**672**

9. NON-CURRENT ASSETS – PLANT AND EQUIPMENT

	Plant and Equipment				
	Motor Vehicle	Equipment	Furniture & Fittings	Computer Equipment	Total
	$'000	$'000	$'000	$'000	$'000
At 1 July 2005					
At Fair Value	44	116	329	317	806
Accumulated depreciation and impairment	(5)	(64)	(239)	(246)	(554)
Net Carrying Amount	**39**	**52**	**90**	**71**	**252**
At 30 June 2006					
At Fair Value	44	116	329	199	688
Accumulated depreciation and impairment	(13)	(79)	(268)	(95)	(455)
Net Carrying Amount	**31**	**37**	**61**	**104**	**233**
Reconciliation					
A Reconciliation of the carrying amount of each class of plant and equipment at the beginning and end of the current reporting period is set out below.					
Year ended 30 June 2006					
Net carrying amount at start of year	39	52	90	71	252
Additions	0	0	0	97	97
Disposals	0	0	0	(215)	(215)
Depreciation expense	(8)	(15)	(29)	(41)	(93)
Other movements – writeback on disposal	0	0	0	192	192
Net carrying amount at end of year	**31**	**37**	**61**	**104**	**233**
At 1 July 2004					
At Fair Value	55	118	329	691	1,193
Accumulated depreciation and impairment	(16)	(80)	(209)	(608)	(913)
Net Carrying Amount	**39**	**38**	**120**	**83**	**280**
At 30 June 2005					
At Fair Value	44	116	329	317	806
Accumulated depreciation and impairment	(5)	(64)	(239)	(246)	(554)
Net Carrying Amount	**39**	**52**	**90**	**71**	**252**
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 2005					
Net carrying amount at start of year	39	38	120	83	280
Additions	44	38	0	31	113
Disposals	(55)	(40)	0	0	(95)
Depreciation expense	(10)	(15)	(30)	(43)	(98)
Other movements – writeback on disposal	21	31	0	0	52
Net carrying amount at end of year	**39**	**52**	**90**	**71**	**252**

NOTES TO AND FORMING PART OF THE FINANCIAL REPORT

FOR THE YEAR ENDED 30 JUNE 2006

10. NON CURRENT ASSETS – INTANGIBLE ASSETS

	Intangibles	Total
	$'000	$'000
At 1 July 2005		
At Fair Value	493	493
Accumulated depreciation and impairment	(464)	(464)
Net Carrying Amount	**29**	**29**
At 30 June 2006		
At Fair Value	425	425
Accumulated depreciation and impairment	(399)	(399)
Net Carrying Amount	**26**	**26**

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.

	Intangibles	Total
Year ended 30 June 2006		
Net carrying amount at start of year	29	29
Additions	12	12
Disposals	(81)	(81)
Depreciation expense	(13)	(13)
Other movements – writeback on disposal	79	79
Net carrying amount at end of year	**26**	**26**
At 1 July 2004		
At Fair Value	91	91
Accumulated depreciation and impairment	(42)	(42)
Net Carrying Amount	**49**	**49**
At 30 June 2005		
At Fair Value	493	493
Accumulated depreciation and impairment	(464)	(464)
Net Carrying Amount	**29**	**29**

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.

	Intangibles	Total
Year ended 30 June 2005		
Net carrying amount at start of year	49	49
Additions	17	17
Disposals	(19)	(19)
Depreciation expense	(18)	(18)
Other movements – writeback on disposal	0	0
Net carrying amount at end of year	**29**	**29**

11. NON-CURRENT ASSETS – LEASEHOLD IMPROVEMENTS

	Leasehold Improvements		
	Building Extension	**Refurbishment**	**Total**
	$'000	**$'000**	**$'000**
At 1 July 2005			
At Fair Value	248	3,328	3,576
Accumulated depreciation and impairment	(92)	(1,058)	(1,150)
Net Carrying Amount	**156**	**2,270**	**2,426**
At 30 June 2006			
At Fair Value	248	3,328	3,576
Accumulated depreciation and impairment	(102)	(1,150)	(1,252)
Net Carrying Amount	**146**	**2,178**	**2,324**
Reconciliation			
A Reconciliation of the carrying amount of each class of leasehold improvement at the beginning and end of the current reporting period is set out below.			
Year ended 30 June 2006			
Net carrying amount at start of year	156	2,270	2,426
Additions	0	0	0
Disposals	0	0	0
Depreciation expense	(10)	(92)	(102)
Other movements – writeback on disposal	0	0	0
Net carrying amount at end of year	**146**	**2,178**	**2,324**
At 1 July 2004			
At Fair Value	248	3,328	3,576
Accumulated depreciation and impairment	(82)	(966)	(1,048)
Net Carrying Amount	**166**	**2,362**	**2,528**
At 30 June 2005			
At Fair Value	248	3,328	3,576
Accumulated depreciation and impairment	(92)	(1,058)	(1,150)
Net Carrying Amount	**156**	**2,270**	**2,426**
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 2005			
Net carrying amount at start of year	166	2,362	2,528
Additions	0	0	0
Disposals	0	0	0
Depreciation expense	(10)	(92)	(102)
Other movements – writeback on disposal	0	0	0
Net carrying amount at end of year	**156**	**2,270**	**2,426**

NOTES TO AND FORMING PART OF THE FINANCIAL REPORT

FOR THE YEAR ENDED 30 JUNE 2006

	2006	2005
	$'000	$'000

12. CURRENT LIABILITIES – PAYABLES

	2006 $'000	2005 $'000
Accrued expenses	418	156
Trade Creditors	67	65
	485	**221**

13. CURRENT LIABILITIES – PROVISIONS

	2006 $'000	2005 $'000
Employee benefits and related on-costs		
Annual Leave Provision	203	159
Long Service Leave Provision	150	93
	353	**252**
Unconditional employee leave provisions are shown as a Current Liability. The nature of these liabilities is as follows:		
Annual Leave Provision		
– Short Term	150	80
– Long Term	53	79
	203	**159**
Long Service Leave Provision		
– Short Term	0	0
– Long Term	150	93
	150	**93**

14. CURRENT LIABILITIES – OTHER

	2006 $'000	2005 $'000
Deferred Revenue	**3,884**	**3,856**

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

15. CHANGES IN EQUITY

	2006	2005
	$'000	**$'000**
Accumulated fund		
Balance at the beginning of the financial year	7,282	5,429
AASB 139 first-time adoption	0	0
Other changes in accounting policy	0	0
Correction of errors	0	0
Restated opening balance	**7,282**	**5,429**
Changes in equity – transactions with owners as owners		
Increase/decrease in net assets from equity transfers	0	0
Total	**0**	**0**
Changes in equity – other than transactions with owners as owners		
Surplus/(deficit) for the year	605	1,853
Increment/decrement on revaluation of plant and equipment	0	0
Other increases/(decreases)	0	0
Total	**605**	**1,853**
Transfers within equity		
Asset revaluation reserve balance transferred to accumulated funds on disposal of asset	0	0
Total	**0**	**0**
Balance at the end of the financial year	**7,887**	**7,282**

NOTES TO AND FORMING PART OF THE FINANCIAL REPORT
FOR THE YEAR ENDED 30 JUNE 2006

	2006	2005
	$'000	$'000

16. 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

	2006 $'000	2005 $'000
– Within one year	33	33
– Between one and five years	132	132
– Greater than five years	431	465
– Total (including GST)	596	630

The total of lease commitments as at 30 June 2006 above includes input tax credits of $54,000 ($58,000 in 2004/05) that are expected to be recoverable from the Australian Taxation Office

17. RECONCILIATION OF SURPLUS FOR THE PERIOD TO NET CASH FLOWS FROM OPERATING ACTIVITIES

	2006 $'000	2005 $'000
Net Profit	605	1,853
Depreciation and amortisation	208	218
Net loss/(gain) on disposal of fixed assets	15	36
Increase/(decrease) in employee provisions	101	51
(Increase)/decrease in receivables and other assets	63	(8)
Increase/(decrease) in deferred revenue	28	92
Increase/(decrease) in payables	264	(23)
Assets written off	2	75
Net Cash provided by operating activities	**1,286**	**2,294**

18. CONTINGENT LIABILITIES AND CONTINGENT ASSETS

As at the reporting date the NSW Medical Board in not aware of any contingent liabilities and contingent assets that will materially affect its financial position.

19. FINANCIAL INSTRUMENTS

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

Cash

Cash comprises cash on hand and bank balances. Interest is earned on a daily bank balances at a commercial rate. The average interest rate for the year was 5.25% (2005-4.9%)

Receivables

All trade debtors are recognised as amounts receivable at balance date. Collectability of trade debtors is reviewed on an ongoing basis. Debts which are known to be uncollectable are written off. An allowance for impairment is raised when there is objective evidence that the entity will not be able to collect all amounts due. The credit risk is the carrying amount (net of any allowance for impairment). No interest is earned on trade debtors. The carrying amount approximates net fair value.

Hour Glass Investment Facilities

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

The Board's Investments are:

	2006	2005
	$'000	$'000
Cash Facility	7,610	7,199

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

The average interest rate for the year was 5.69% (2005-5.4%)

Bank Overdraft

The Board does not have a bank overdraft facility.

Trade Creditors and Accruals

The liabilities are recognised for amounts due to be paid in the future for goods or services received, whether or not invoiced. Amounts owing to suppliers (which are unsecured) are settled in accordance with the policy set out in Treasurer's direction 219.01. If trade terms are not specified, payment is made no later than the end of the month following the month in which an invoice or statement is received. Treasurer's Direction 219.01 allows the Minister to award interest for late payment. The rate of interest applied during the year was 0% (2005 – Nil %).

NOTES TO AND FORMING PART OF THE FINANCIAL REPORT

FOR THE YEAR ENDED 30 JUNE 2006

20. FINANCIAL IMPACT OF ADOPTING AUSTRALIAN EQUIVALENTS TO INTERNATIONAL FINANCIAL REPORTING STANDARDS

The NSW Medical Board has applied AEIFRS for the first time in the 2005/2006 financial report.

The key areas where changes in accounting policies have impacted the financial report are disclosed below. Some of these impacts arise because AEIFRS requirements are different from previous AASB requirements (AGAAP). Other impacts arise from options in AEIFRS that were not available or not applied under previous AGAAP. The NSW Medical Board has adopted the options mandated by NSW Treasury for all NSW public sector agencies. The impacts below reflect Treasury's mandates and policy decisions.

The impact of adopting AEIFRS on total equity and surplus/(deficit) as reported under previous AGAAP are shown below.

There are no material impacts on the NSW Medical Board's cash flows.

a) Reconciliation – 1 July 2004 and 30 June 2005

Reconciliation of equity under previous Accounting Standards (AGAAP) to equity under AEIFRS:

	30 June 2005	1 July 2004
	$'000	$'000
Total equity under previous AGAAP	7,282	5,429
Total Equity under AEIFRS	7,282	5,429

* = adjustments as at the date of transition

** = cumulative adjustments as at date of transition plus the year ended 30 June 2005

Reconciliation of surplus/(deficit) under previous AGAAP to surplus/(deficit) under AEIFRS:

Year ended 30 June 2005

Surplus/(deficit) under previous AGAAP	1,853
Surplus/(deficit) under AEIFRS	1,853

21. AFTER BALANCE DATE EVENTS

There are no known after balance date events

End of Audited Financial Report