REGULATING MEDICAL PRACTITIONERS – MANAGING RISK TO THE PUBLIC

MEDICAL REGULATION AT WORK IN AUSTRALIA, 2013/14

Regulating medical practitioners in the National Registration and Accreditation Scheme

Medical Board of Australia | AHPRA

Download this summary of the work of the
Medical Board of Australia in 2013/14 from:
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Highlights

Revised regulatory principles

Streamlined assessment and registration of international medical graduates

Consultations on 7 registration standards

99,379
registered medical practitioners in Australia on 30 June 2014; an increase of 3.9% since 2013

Updated *Good medical practice: a code of conduct for doctors in Australia* and other guidance for practitioners

Approved 9 university programs of study and 4 specialist colleges for accreditation purposes

Medical practitioners account for almost half (48%) of all health practitioners aged over 70 years

The state with the largest number of registered practitioners is NSW (31,269)

40% of medical practitioners are women

Wide variation in mandatory reporting across states and territories, with a 79% increase in Queensland, a 13% decrease in NSW and a 5% decrease in Victoria

5,585 notifications lodged about medical practitioners, 3,812 outside NSW

Slight drop in the number of practitioners subject to mandatory notifications per 10,000 practitioners – to 27.2/10,000 from 28.9/10,000 in 2012/13

38% of registered practitioners are aged under 40

67% increase in immediate actions taken (147 to 246)

351 mandatory notifications about medical practitioners nationally, up 17% on last year

Commitment to fund nationally consistent health program

987 medical practitioners being monitored across states and territories, excluding NSW

28% increase in closed medical notifications, or 35% increase excluding NSW

19%
increase in notifications about medical practitioners – or 26% increase when excluding NSW – compared to a 16% increase nationally for all professions

Of 122 notifications finalised after a panel hearing, 76 (62%) led to disciplinary action

Of 43 cases finalised after a tribunal hearing, 36 (84%) led to disciplinary action

39% of closed mandatory notifications led to regulatory action, compared to 15% of all closed medical notifications

73% of immediate actions led to regulatory action

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Message from the Chair, Medical Board of Australia

The fourth year of the National Scheme has been characterised by a strong focus on measuring and improving our performance in core regulatory functions, particularly the management of notifications. The Medical Board, nationally and through state and territory boards, recognises that the notifications process is very stressful for both practitioners and notifiers. We are committed to improving the timeliness and effectiveness of our response to notifications and to monitoring and reporting on our performance. The Medical Board has strongly supported the development of a set of regulatory principles for the National Scheme to ensure that our decision-making is focused on assessing and managing risk to the public, is evidence-based and is consistent with contemporary expectations of professional standards.

In last year's annual report I outlined events in Queensland that led to the absence of that state's board and later, to legislative change. The new system this established for managing health complaints in Queensland starts on 1 July 2014. A small group of very committed individuals, both medical practitioners and community members, was appointed by the National Board in May 2013 to address the backlog of open notifications in Queensland. The Queensland Medical Interim Notifications Group (QMING) worked on this task for two days a week for several months. Early in this calendar year, the Queensland Minister for Health appointed a new state board, which included most of the members of the QMING.

State and territory board members carry out the most important work of medical regulation, dealing with notifications and applications for registration. Australia has been very fortunate to have people of such high calibre, both community and practitioner members, prepared to take on this challenge and to carry out the work with such commitment, generosity and good will.

Doing this work well requires compassion, knowledge, judgement and common sense. It also requires a capacity to digest large volumes of written material and to engage in dialogue and debate to reach wise decisions. I would like to acknowledge the contributions of all my colleagues on the national and state and territory boards, particularly those who completed their terms this year, including retiring state board chairs Dr Phil Henschke in South Australia, Dr Laurie Warfe in Victoria and Dr Peter Sexton in Tasmania.

Our partnership with the Australian Health Practitioner Regulation Agency (AHPRA) is vital to the success of our work and I appreciate the responsiveness and commitment of Dr Joanne Katsoris, Executive Officer, Medical Board of Australia, Martin Fletcher, AHPRA CEO, and all the AHPRA staff who work with board members to develop and deliver medical regulation in Australia.

Dr Joanna Flynn AM
Chair, Medical Board of Australia

Message from the AHPRA Chair and CEO

Patient safety lies at the heart of our health system. Maintaining standards and ensuring we have a safe, competent and patient-centred health workforce is a vital part of our work as a regulator. We can be proud of the quality and dedication of the health practitioners who provide our health services on a daily basis, and we have good systems in place to address the occasional few who do not meet expected standards. This is the work of the National Boards, with the support of AHPRA.

It has been a year of consolidation and improvement across the National Scheme. We have had three main areas of focus during the year: improving the experience of all involved in the notifications process; measuring and improving our performance; and participating in and preparing for the review of the National Registration and Accreditation Scheme.

There has been a consistent increase over the past four years in the number of notifications we receive. This trend appears well established and consistent across Australia, and in line with the experience of overseas regulators. Managing this increase in volume poses considerable challenges for the National Boards and AHPRA. We need to make sure our people and our systems are well equipped to deal with current challenges while we plan for future demands.

We have developed and implemented a set of key performance indicators (KPIs) for the timeliness of notifications management. This work followed our strengthening last year of nationally consistent systems and processes in notifications management. More information on our approach to KPIs is detailed in the 2013/14 annual report of AHPRA and the National Boards. Developing and then applying these KPIs has had a significant impact on our management of notifications. We can see more clearly where the pressure points in our systems are, and as a result are able to target our efforts and resources to address them.

We now set international benchmarks for online registration renewals, matched by high (96%) rates for submission of the workforce survey. The results of this survey, which is completed voluntarily at renewal by registered practitioners, provide invaluable health workforce data that can be used for planning purposes. Such data reflect the importance of the workforce objectives of our work. The accuracy, completeness and accessibility of the national registers is at the heart of our work.

One of the significant events of the year was the inquiry by the Legal and Social Issues Legislation Committee of the Victorian Parliament into the performance of AHPRA. The committee handed down its findings in March 2014 and we welcomed its call for increased transparency, accountability and reporting to parliament.

This year AHPRA and the National Boards have worked closely with the newly appointed health ombudsman in Queensland to make sure the new complaints management system there is effective and efficient when it takes effect on 1 July 2014. At that time, there will be two different co-regulatory models for notifications within the National Scheme. This will establish three different models of health complaints management in Australia, all underpinned by the same set of nationally consistent professional standards for practitioners and with information feeding into the national registers. We are committed to making these models work, but recognise the challenges they may pose for national consistency in decision-making.

After four years, AHPRA is continuing to mature rapidly, but on any international and national regulatory comparison it is still a relatively young organisation. We are not complacent and continue to identify and act on opportunities to improve the performance of the National Scheme in partnership with National Boards.

Michael Gorton AM, Chair, Agency Management Committee

Martin Fletcher, CEO, AHPRA

Regulatory principles

Regulatory principles for the National Scheme

Aboriginal and Torres Strait Islander health practice
Chinese medicine
Chiropractic
Dental
Medical
Medical radiation practice
Nursing and Midwifery
Occupational therapy
Optometry
Osteopathy
Pharmacy
Physiotherapy
Podiatry
Psychology

Australian Health Practitioner Regulation Agency

These regulatory principles underpin the work of the Boards and AHPRA in regulating Australia's health practitioners, in the public interest. They shape our thinking about regulatory decision-making and have been designed to encourage a responsive, risk-based approach to regulation across all professions.

1 The Boards and AHPRA **administer and comply with the Health Practitioner Regulation National Law**, as in force in each state and territory. The scope of our work is defined by the National Law.

2 We protect the **health and safety of the public** by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered.

3 While we balance all the objectives of the National Registration and Accreditation Scheme, **our primary consideration is to protect the public**.

4 When we are considering an application for registration, or when we become aware of concerns about a health practitioner, **we protect the public by taking timely and necessary action under the National Law**.

5 In all areas of our work we:

- **identify the risks** that we are obliged to respond to
- **assess the likelihood and possible consequences** of the risks, and
- **respond in ways that are proportionate and manage risks** so we can adequately protect the public.

This does not only apply to the way in which we manage individual practitioners but in all of our regulatory decision-making, including in the development of standards, policies, codes and guidelines.

6 When we take action about practitioners, **we use the minimum regulatory force to manage the risk** posed by their practice, to protect the public. Our **actions are designed to protect the public and not to punish practitioners**.

While our actions are not intended to punish, we acknowledge that practitioners will sometimes feel that our actions are punitive.

7 Community confidence in health practitioner regulation is important. Our response to risk considers **the need to uphold professional standards and maintain public confidence in the regulated health professions**.

8 **We work with our stakeholders**, including the public and professional associations, to achieve good and protective outcomes. **We do not represent the health professions or health practitioners**. However, we will work with practitioners and their representatives to achieve outcomes that protect the public.

Medical Board report

Overview

The Medical Board of Australia is appointed by the Ministerial Council and is made up of 12 members: eight registered medical practitioners, one from each jurisdiction, and four community members. The Ministerial Council appointed the current Board from August 2012. During 2013/14, there was one practitioner vacancy from Queensland.

The Board, with the support of AHPRA, is responsible for administering the National Law. Specific roles of the Board include to:

- develop registration standards, codes and guidelines
- approve accreditation standards and programs of study which qualify an individual for registration
- register medical practitioners and students and oversee the assessment of international medical graduates
- oversee the management of notifications and make decisions about individual practitioners (this is done by state and territory boards), and
- negotiate the Health Profession Agreement with AHPRA.

The National Law provides that a National Board may establish a committee, known as a state or territory board, in a jurisdiction to enable an effective and timely local response in that jurisdiction. The Medical Board has established boards in every jurisdiction and has delegated many of its powers to those boards. State and territory board members are appointed by the responsible Minister in each jurisdiction. The National Board has also appointed committees to assist the state and territory boards to handle their workloads. While most of the committees are drawn from the state and territory boards, the Board has also appointed some non-board members to these committees.

The Board has established a Registration Committee in every state and territory. It has also established the following committees in all states except New South Wales:

- Immediate Action Committee
- Health Committee, and
- Notifications Committee (during 2013/14, the Notification Committees replaced the Notifications Assessment Committees and the Performance and Professional Standards Committees).

The Board has also established a:

- **Finance Committee** to provide advice to the Medical Board of Australia on its financial position, the financial outlook for future years and the implications for medical practitioner fees. It is made up of National Board members.
- **National Specialist International Medical Graduates (IMG) Committee** to provide the Board with policy advice on the assessment of specialist IMGs. This committee includes representatives from the Board, AHPRA, specialist medical colleges, the Australian Medical Council (AMC), consumer groups, jurisdictional governments, the Commonwealth Government, Health Workforce Australia and recruiters of IMGs.
- **Working Group on good practice guidelines** to develop guidelines for specialist colleges on good practice in the specialist IMG assessment process. The group is chaired by Dr Christine Tippett and includes a representative from the Committee of Presidents of Medical Colleges and other individuals who have experience in specialist IMG assessment.
- **Medical Notifications Taskforce** to develop a framework to guide decision-making to ensure that the response to notifications about medical practitioners is consistent, appropriate and effective in protecting the public. It is made up of national and state and territory board members and AHPRA staff.

Major outcomes/achievements 2013/14

Preparing to implement changes to the competent authority and specialist pathways

The National Scheme has created opportunities to streamline and simplify the assessment and registration of IMGs. In 2012/13, the Board consulted on a proposal to make changes to the specialist pathway and to the competent authority pathway for IMGs. In 2013/14, the Board decided to proceed with the changes and developed a comprehensive implementation plan.

The main change to the specialist pathway is that internationally qualified specialists will apply directly to the relevant college to have their qualifications, training and experience assessed. Previously applicants had to apply through the AMC. Communication between relevant parties will also be streamlined through the use of a secure portal.

Major changes have been made to the competent authority pathway so that eligible practitioners will be able to apply for provisional registration, rather than limited registration, and most will be eligible for general registration after 12 months' supervised practice.

The Board has worked with the AMC, specialist colleges and other stakeholders to implement the changes. There was work done to change systems, provide training to staff and communicate the changes to stakeholders.

External health programs

During 2013/14, the Board announced that it would fund health programs to deliver a nationally consistent set of services to medical practitioners and students in all states and territories, to be run at arm's length from the Board. The programs will complement the regulatory focus of the Board and AHPRA, which is to manage practitioners with an impairment that may place the public at risk.

Through these programs, medical practitioners and medical students in all states and territories will have access to the same suite of services, which will include advice and referral, education and awareness, general advocacy, and the development of case management services.

Management of notifications

In 2013/14, the Board focused on the effective management of notifications about medical practitioners. It established a Medical Notifications Taskforce (the Taskforce), made up of Board members and staff, to develop a framework to guide decision-making to ensure that the response to notifications about medical practitioners is consistent, appropriate and effective in protecting the public.

The Board received 5,585 notifications in 2013/14, with 85% of those that closed in 2013/14 resulting in no further action. Through the work of the Taskforce, the Board wants to improve timeframes for closing notifications and to focus attention on notifications that indicate that there may be a risk to the public.

Through the leadership of the Taskforce, states and territories have developed and are implementing strategies to improve the management of notifications.

For notifications data, see page 20.

Accountabilities and responsibilities

The National Scheme is complex and there are many parties involved. Within medicine alone, there is a National Board, eight state and territory boards and more than 30 committees. Given the increasing maturity of the National Scheme, the Board worked with state and territory boards to better articulate the respective responsibilities of the different parties.

As well as dealing with registrations and notifications about individual practitioners, state and territory boards engage with their local stakeholders, monitor local performance, alert the National Board and AHPRA about serious concerns, and identify areas for policy development or other attention by the National Board.

The National Board is responsible for developing registration standards and policies. It will also continue to strengthen the governance partnership with the Agency Management Committee and AHPRA to manage risks, engage with national stakeholders, develop an approach to engaging with the community, monitor national performance, and ensure that the Board is on a sound financial footing. The Board will also continue to be responsive to feedback and concerns from state and territory boards.

Intern year

The intern year is the first year of registration after a practitioner graduates from a medical course. The intern year is highly supervised and there is structured training to support interns making the transition from university to practitioner. The structured nature of intern positions also protects the community by ensuring that newly graduated practitioners are supervised. Intern positions are accredited by authorities that are approved to accredit intern training programs in each state and territory. These authorities are commonly known as postgraduate medical councils (PMCs).

The AMC has been contracted to review and accredit PMCs in each state and territory. After deciding whether to accredit each PMC, the AMC provides an accreditation report to the Board. The Board then decides whether to approve the PMC as an intern training accreditation authority.

New standards for the intern year, and standards for the accreditation of PMCs, were introduced in 2013/14. This is a major development as the standards expected are now uniform across the country.

The Board has approved the following documents that were developed by the AMC:

- **Guide for interns**: An overview of intern training and what is expected of interns.
- **Intern training – Intern outcome statements**: A broad outline of the significant outcomes an intern must achieve to successfully complete an approved internship.
- **Intern training – Guidelines for terms**: A guide to the learning experiences an intern should have during medicine, surgery, emergency medical care, and other terms during internship. Includes notes on supervision.

- **Intern training – Assessing and certifying completion**: A guide on how assessment works in intern training, including assessment criteria, forms, what happens with remediation, and how an intern is certified as having successfully completed their internship.

During 2013/14, the Board:

- approved the following as authorities that accredit intern positions:
  - South Australian Medical Education and Training Health Advisory Council to 31 December 2018
  - Postgraduate Medical Education Council of Tasmania to 31 December 2018, and
- granted initial accreditation and approval, until the AMC completes a formal review, to:
  - Health Education and Training Institute (HETI) – NSW
  - Postgraduate Medical Council of Victoria (PMCV)
  - Northern Territory Postgraduate Medical Council (NTPMC)
  - Canberra Region Prevocational Management Committee (CRPMC) – ACT
  - Postgraduate Medical Council of Queensland (PMCQ)
  - Postgraduate Medical Council of Western Australia (PMCWA).

Review of registration standards

The registration standards that were approved at the start of the National Scheme were due for review after three years. During 2013/14, the Board reviewed and consulted on the following registration standards:

- Professional indemnity insurance
- Recency of practice
- Continuing professional development
- Limited registration for postgraduate training or supervised practice
- Limited registration for area of need
- Limited registration in public interest
- Limited registration for teaching or research

In 2014/15, the Board will analyse feedback from stakeholders and will finalise the standards for submission to the Ministerial Council.

The Board also developed guidelines for short-term training in a medical specialty for IMGs who are not qualified for general or specialist registration, and consulted on this.

Accreditation

An important objective of the National Scheme is to facilitate the provision of high-quality education and training of health practitioners. The accreditation function is the primary way of achieving this objective.

The National Law defines the respective roles of the Board and its appointed accreditation authority, the AMC, in the accreditation of medical schools and medical specialist colleges.

The AMC is the appointed accreditation authority for the medical profession and is responsible for developing accreditation standards for the approval of the Board. Accreditation standards are used to assess whether a program of study, and the education provider of the program, gives people who complete the program the knowledge, skills and professional attributes to practise the profession.

Approval of programs of study and providers

Based on the accreditation advice from the AMC, the Board approved the following programs of study and providers during 2013/14:

Medical schools:

- **Australian National University**
  - Bachelor of Medicine/Bachelor of Surgery (MBBS) (four-year graduate-entry course) approved to 31 December 2018
  - Medicinae ac Chirurgiae Doctoranda (four-year graduate-entry) approved to 31 December 2019
- **Deakin University**
  - Bachelor of Medicine/Bachelor of Surgery (MBBS) approved to 31 December 2017
- **Monash University**
  - Bachelor of Medicine/Bachelor of Surgery (four- and five-year courses) approved to 31 December 2017
- **University of Melbourne**
  - Bachelor of Medicine/Bachelor of Surgery/ Bachelor of Medical Sciences (MBBS/BMedSc) (six-year course) and Bachelor of Medicine/ Bachelor of Surgery (four-and-a-half-year course) approved to 31 December 2015
- **University of New South Wales**
  - Bachelor of Medical Studies and Doctor of Medicine (six years) and the Bachelor of Medicine/Bachelor of Surgery (four- and six-year courses) and the Doctor of Medicine (three years) approved to 31 March 2020

- **University of Notre Dame Australia (Sydney)**
  - Bachelor of Medicine/Bachelor of Surgery (MBBS) approved to 31 December 2017
- **University of Western Australia**
  - Bachelor of Medicine/Bachelor of Surgery (six-year course and four-and-a-half-year course) approved to 31 December 2017
  - Doctor of Medicine (four-year course) approved to 31 December 2018.

Specialist colleges:

- Australasian College for Emergency Medicine approved to 31 December 2015
- Australasian College of Dermatologists approved to 31 December 2017
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists approved to 31 December 2019
- Royal Australian College of General Practitioners approved to 31 December 2019.

Registration standards, policies and guidelines developed/published

- Ministerial Council approved a revised list of specialties, fields of specialty practice and related specialist titles on 30 May 2013. The list was effective from 25 July 2013. The list was amended to include the field of specialty practice of paediatric intensive care medicine and the associated title of specialist paediatric intensive care physician within the specialty of intensive care medicine.
- The Board revised *Good medical practice: a code of conduct for doctors in Australia*. The revised version was effective from 17 March 2014.

The Medical Board also developed and published:

- Guidance on clinical observerships
- Guidance on inter-jurisdictional technology-based patient consultations
- Information for medical practitioners with limited registration (public interest – occasional practice) who have exhausted the number of renewals permissible under the National Law
- A fact sheet for Australian and New Zealand medical graduates completing internships in New Zealand.

Stakeholder engagement

Publication of a regular e-newsletter

In 2013/14, the Board decided to publish a more frequent and regular e-newsletter. This replaced both the twice-yearly hard copy *Update* and the Communiqué posted on the website after each meeting of the National Board. The e-newsletter brings issues relevant to doctors in Australia to the profession's attention and reports on what the Board has been doing. It also provides links to tribunal decisions about medical practitioners and distributes important alerts.

Revalidation

The Board started a conversation about revalidation in the previous reporting period. During 2013/14, the Board has promoted ongoing discussion and debate by publishing articles in various college publications, attending and contributing to a seminar on revalidation, and attending multiple stakeholder meetings to discuss revalidation.

Fourth Medical Board conference

The Board ran the fourth Medical Board conference with state and territory boards and senior staff from AHPRA. The focus of this year's conference was on the effective management of notifications and on accountabilities within the National Scheme. The conference also provided an opportunity for state and territory board members and staff to contribute to the Board's policy agenda.

Stakeholder meetings

The Board members regularly attend meetings with a range of stakeholders, including:

- Committee of Presidents of Medical Colleges
- Australian Medical Council
- Australian Medical Association
- Individual specialist colleges
- Medical Council of New Zealand
- Professional indemnity insurers
- Health Workforce Australia

Conferences

Board representatives presented at a number of conferences in 2013/14, including:

- Health Professionals Health Conference
- International Physician Assessment Coalition
- General Medical Council (UK) and Federation of State Medical Boards (US) Revalidation Symposium
- 2013 Medical Indemnity Industry Association of Australia (MIIAA) Forum

- Health Workforce Australia 2013 conference
- Medical Deans 2013 conference
- Prevocational Medical Education Forum
- Rural Medicine Australia 2013
- Australian Medical Association and *beyondblue* roundtable on the mental health of doctors and medical students

External committees and meetings

Board representatives attended a range of meetings in 2013/14, including:

- AMC Prevocational Accreditation Committee
- Health Workforce Australia National Medical Training Advisory Network
- Medical Deans – Inherent Requirements Working Group
- Management Committee of the International Association of Medical Regulatory Authorities
- Physician Information Exchange Working Group of the International Association of Medical Regulatory Authorities
- Health Workforce Australia orientation and supervision project

As part of the implementation of the specialist pathway, the Board and the AMC hosted a forum for specialist colleges.

Priorities for the coming year

Revalidation

The Board intends to progress work on revalidation in 2014/15. It will commission social research on the community's expectations about medical practitioners and revalidation. It will also commission research on revalidation, looking at Australian and international literature, and will establish an expert working group to provide options for revalidation that the Board can consider for a pilot.

The Board does not intend to introduce revalidation in 2014/15.

External health programs

The Board will work with major partners, including the Australian Medical Association, to establish a national governance model for external health programs that will then sub-contract with state-based services. The national organisation will manage the Board's funds for external health programs and will ensure the delivery and monitoring of the Board's model in each jurisdiction.

Registration standards and guidelines

The Board intends to finalise the registration standards that were reviewed in 2013/14 and to submit them to Ministerial Council. The Board will also review the following registration standards that will be due for review:

- Granting general registration to medical practitioners in the standard pathway who hold an AMC certificate
- Specialist registration

In 2012/13, the Board reported on work that it had been doing on cosmetic medicine and surgery. The Board developed draft guidelines and released them for limited preliminary consultation. The Office of Best Practice Regulation has informed the Board that it needs to prepare a consultation regulatory impact statement (RIS). The Board is preparing the consultation RIS and plans to consult publicly on the guidelines during 2014/15.

The Board undertook preliminary consultation on revised supervision guidelines for IMGs and will progress to public consultation in 2014/15. It is also planning to require supervisors of IMGs to complete an online module to demonstrate that they understand their supervisory responsibilities.

Members of the Medical Board of Australia

MBA National Board

- Dr Joanna Flynn AM (Chair)
- Professor Belinda Bennett
- Dr Stephen Bradshaw
- Ms Prudence Ford
- Dr Fiona Joske
- Dr Charles Kilburn
- Mr Paul Laris
- Mr Robert Little
- Dr Rakesh Mohindra
- Professor Peter Procopis AM
- Adjunct Professor Peter Wallace OAM

MBA Australian Capital Territory

- Dr Stephen Bradshaw (Chair)
- Dr Tobias Angstmann
- Dr Kerrie Bradbury
- Ms Vicki Brown
- Ms Megan Lauder
- Mr Don Malcolmson
- Dr Timothy McKenzie
- Dr Barbara (Sally) Somi
- Dr Vida Viliunas

MBA New South Wales

- Dr Gregory Kesby (Chair)
- Dr Stephen Adelstein
- Mr Antony Carpentieri
- Dr Annette Carruthers
- Ms Rosemary Kusuma
- Dr Denis Smith

MBA Northern Territory

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- Dr Jennifer Delima
- Ms Judith Dikstein
- Ms Helen Egan
- Dr Paul Helliwell
- Dr Verushka Krigovsky
- Dr Ameeta Patel
- Ms Diane Walsh
- Dr Christine Watson

MBA Queensland

- Associate Professor Susan Young (Chair)
- Dr Mark Waters (Deputy)
- Dr Cameron Bardsley
- Dr Victoria Brazil
- Professor William Coman AM
- Dr Christine Foley
- Ms Christine Gee
- Mr David Kent QC
- Mr Gregory McGuire
- Associate Professor Eleanor Milligan
- Associate Professor David Morgan OAM
- Dr Susan O'Dwyer
- Dr Josephine Sundin

MBA South Australia

- Professor Anne Tonkin (Chair)
- Dr Philip Henschke (Chair)
- Mr Mark Bodycoat
- Dr Peter Joseph AM
- Mr Paul Laris
- Professor Guy Maddern
- Dr Rakesh Mohindra
- Dr Christine Putland
- Dr Lynne Rainey
- Dr Cathy Reid
- Ms Katherine (Kate) Sullivan
- Professor John Turnidge
- Dr Mary White

MBA Tasmania

- Associate Professor Peter Sexton (Chair)
- Dr Brian Bowring AM
- Mr David Brereton
- Ms Christine Fraser
- Dr Fiona Joske
- Ms Leigh Mackey
- Dr Philip Moore
- Professor Peter Mudge
- Dr Andrew Mulcahy
- Dr John O'Sullivan
- Dr Kim Rooney
- Ms Dee Potter

MBA Victoria

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- Dr John Carnie PSM
- Ms Kerren Clark
- Mrs Paula Davey
- Dr Peter Dohrmann
- Mr Kevin Ekendahl
- Dr Felicity Hawker AM
- Dr William Kelly
- Associate Professor Abdul Khalid
- Professor Napier Thomson AM
- Dr Miriam Weisz
- Dr Bernadette White

MBA Western Australia

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- Ms Nicoletta Ciffolilli
- Ms Prudence Ford
- Dr Frank Kubicek
- Dr Michael McComish
- Professor Mark McKenna
- Professor Stephan Millett
- Dr Steven Patchett
- Ms Virginia Rivalland
- Professor Bryant Stokes AM
- Adjunct Professor Peter Wallace OAM

MBA National Specialist IMG Committee

- Dr Joanna Flynn AM (Chair)
- Ms Kym Ayscough
- Mr Stephen Bott
- Dr Peter Dohrmann
- Mr Ian Frank
- Professor Gavin Frost
- Dr Patrick Giddings
- Dr Joanne Katsoris
- Dr Humsha Naidoo
- Ms Monica Novick
- Dr Paddy Phillips
- Professor Ajay Rane OAM
- Dr Denis Smith
- Dr Andrew Singer
- Dr Christine Tippett AM
- Ms Patricia (Patti) Warn
- Dr Richard Willis

MBA Queensland Medical Interim Notifications Group

- Ms Stephanie Gallagher
- Professor Ian Gough
- Associate Professor Eleanor Milligan
- Dr Mark Waters

Non-board committee members:

- Mr John Alati
- Ms Kay Barralet
- Dr Jeannette Best
- Ms Pamela Brown
- Dr Geraldine Chew
- Mr Michael Christodoulou AM
- Dr Jennifer Davidson
- Ms Heather Eckersley
- Dr Carolyn Edmonds
- Dr Janelle Hamilton
- Dr Geoffrey Hirst
- Dr Maria (Tessa) Ho
- Dr Anuja Kulatunga
- Dr Martin Mackertich
- Dr Robyn Napier
- Dr Louise Nash
- Dr Len Notaras AM
- Professor Malcolm Parker
- Ms Lorraine Poulos
- Ms Patricia Rayner
- Dr Roger Rosser
- Professor Allan Spigelman
- Dr Leslie Stephan
- Dr Sam Stevens

During 2013/14, the Board was supported by Executive Officer Dr Joanne Katsoris.

More information about the work of the Board is available at: www.medicalboard.gov.au

Data: the Board's work in 2013/14

These data are drawn from data published in the 2013/14 annual report of AHPRA and the National Boards, reporting on the National Registration and Accreditation Scheme. This report – *Medical regulation at work in Australia, 2013/14* – looks at these national data through a profession-specific lens. Wherever possible, historical data are provided to show trends over time, as well as comparisons between states and territories. For additional context, where relevant, we compare data about medical practitioners to national data about practitioners from all professions. In future years, we will provide more detailed analysis to deepen our understanding of trends within the medical profession, for example across specialties and types of registration.

For completeness and wider context about the National Scheme, as well as analysis across professions, this report should be read in conjunction with 2013/14 annual report of AHPRA and the National Boards.

The medical profession in profile 2013/14: registration data

Numbers: location, age, gender, registration type

There were 99,379 registered medical practitioners in Australia on 30 June 2014 (see Table 1). The number of registered practitioners has increased by around 3.9% since 2013. Growth in the last 12 months has been highest in the Northern Territory (NT) with growth of 9.3% (increased from 992 to 1,084) and lowest in Tasmania with 1.3% growth over that period. The state with the largest number of registered practitioners is New South Wales (NSW) (31,269), which has 31.5% of all medical practitioners, followed by Victoria (24,137) with 24.3% of all medical practitioners and Queensland with 19.2%.

Thirty-eight per cent of registered practitioners are aged under 40, while 12% are aged over 65 (see Table 2). There are more registered practitioners aged over 70 in medicine than in other professions, with medical practitioners representing almost half (48%) of all practitioners aged over 70 years.

Tables 3 and 4 provide details of the gender of medical practitioners by state and territory (see Table 3) and the registration type for practitioners in each state and territory (see Table 4). Forty per cent of medical practitioners are women (this proportion is relatively consistent across states and territories). The concentration in Queensland and Western Australia (WA) of practitioners with limited registration – public interest, occasional practice – reflects that this category of registration was not available in all jurisdictions before the National Scheme, and was only available as a phased transition that ends by law in 2015.

Details of the specialties held by medical practitioners with specialist registration and where they are based are provided in Table 5.

Notifications

In 2013/14 there was a 19% increase in the number of notifications about medical practitioners, compared with a 16% increase in the total number of notifications received nationally across professions. There were 5,585 notifications about medical practitioners nationally, of which 3,812 (68%) were lodged outside NSW (see Table 6). NSW is a co-regulatory jurisdiction and notifications there are not managed by the Board and AHPRA. While we report on NSW numbers to gain a national perspective, the following information relates to notifications in all other states and territories.

Broadly, the proportion of notifications received for each state and territory is aligned to the proportion of practitioners based there. The exceptions are Queensland, with 19% of practitioners and 24% of notifications; and Victoria, with 24.3% of practitioners and 20% of notifications.

Notifications relate to 4.9% of the registrant base nationally, based on the number of practitioners involved in these notifications. Victoria is the state with the lowest proportion of practitioners involved in notifications (4.1%), followed closely by WA (4.2%). NSW is close to the national average with a rate of 4.8%, while the remaining states and territories have rates that are higher than the national average.

Table 6 summarises the notifications received and closed in 2013/14, and those open at the end of that year for each state and territory. There were 3,812 notifications received in states and territories excluding NSW in 2013/14, with Queensland the state where most notifications were made (outside NSW), with 1,361 notifications.

Information about notifications in the National Scheme is published under Notifications on the AHPRA website.

Managing notifications: open and closed matters

During the year, AHPRA and the Medical Board of Australia have invested significant effort to improve the timeliness of our management of notifications. We have introduced KPIs to better monitor and therefore manage our handling of notifications. Information about notifications KPIs and preliminary data about performance against them is published on page 125 of the 2014 annual report of AHPRA and the National Boards. We are committed to transparency and will publish more detailed performance reporting from 2015.

We are starting to see positive results from our work in notifications. In general, we are getting better at managing straightforward notifications more quickly. Continuing to improve the timeliness of investigations is a priority for 2015.

Increases in notifications about medical practitioners varied widely across states and territories (see Table 7). The smallest percentage increase was in NSW at 6% and the largest percentage increase was in the NT at 82%. However, the actual numbers should be taken into consideration as a relatively small increase in the number of notifications will have a significant impact on percentages in states that have low volumes of notifications, such as in the NT and Tasmania. There has been a 19% increase in notifications about medical practitioners nationally. If NSW is excluded, there has been a 26% increase in notifications about medical practitioners.

The number of notifications about medical practitioners closed in 2013/14 increased by 28% nationally, or 35% excluding NSW (see Table 9). This compares favourably to an increase in closed notifications across all professions of 22% nationally. The increase in the number of notifications closed was achieved despite a 19% increase in notifications received nationally or 26% increase excluding NSW. During the year, AHPRA and the Board closed 3,680 notifications (1,835 were closed in NSW). There are variations in the rate of closure across states and territories, with both WA and Tasmania closing more notifications than they received during the year. In Queensland and Victoria, the number of notifications received was only marginally higher than the number closed.

Overall, there was a small increase (1% nationally or 7% excluding NSW) in the number of notifications open on 30 June 2014, compared to the previous year (see

Table 1: Registered medical practitioners at 30 June 2014

Medical Practitioner	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP*	Total	% change from prior year
2013/14		31,269	1,084	19,032	7,554	2,155	24,137	9,889	2,299	99,379	3.86%
2012/13	1,894	30,333	992	18,413	7,403	2,128	23,402	9,426	1,699	95,690	4.41.%
2011/12	1,784	28,972	945	17,682	7,142	2,048	22,365	8,855	1,855	91,648	3.80%
% change from prior year	3.5%	3.1%	9.3%	3.4%	2.0%	1.3%	3.1%	4.9%	35.3%		
State/territory medical practitioners as % of all medical practitioners	2.0%	31.5%	1.1%	19.2%	7.6%	2.2%	24.3%	10.0%	2.3%		
All health practitioners 2013/14	10,723	181,025	6,650	117,622	51,352	13,572	160,286	64,015	14,264	619,509	
Medical practitioners as % of all practitioners in the state or territory	18.3%	17.3%	16.3%	16.2%	14.7%	15.9%	15.1%	15.4%	16.1%	16.0%	

*Principal place of practice

Table 2: Registered practitioners by age at 30 June 2014

Medical Practitioner	U-25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80 +	N/A	Total
2013/14	857	10,624	13,164	13,541	12,359	10,680	10,317	9,162	7,035	5,347	3,262	1,666	1,365		99,379
2012/13	751	10,237	12,524	12,942	11,710	10,477	10,136	8,819	6,807	5,128	3,071	1,387	1,686	15	95,690
2011/12	747	9,287	11,985	12,406	11,187	10,297	9,888	8,534	6,481	4,917	2,864	1,545	942	568	91,648
Age bracket as % of all medical practitioners	0.9%	10.7%	13.2%	13.6%	12.4%	10.7%	10.4%	9.2%	7.1%	5.4%	3.3%	1.7%	1.4%		
All practitioners 2013/14	23,712	77,524	78,693	70,999	74,178	68,306	72,425	69,895	47,013	23,672	8,242	3,051	1,799		619,509
Medical practitioners as % of all practitioners	3.6%	13.7%	16.7%	19.1%	16.7%	15.6%	14.2%	13.1%	15.0%	22.6%	39.6%	54.6%	75.9%		16.0%

Table 10). This occurred in the context of a significant increase in notifications received (see Table 7).

Table 11 shows the variation in the percentage of the registrant base with notifications received in each state and territory, ranging from 4.1% in Victoria to 8.3% in the NT.

Mandatory notifications

A total of 351 mandatory notifications were received in 2013/14. Of these, 76 were made in NSW and 275 were made in the rest of the country.

There was wide variation in rates of mandatory reporting about medical practitioners across states and territories in 2013/14, with a national increase from 299 in 2012/13 to 351 in 2014 (up 17%). In Queensland, the number of mandatory notifications increased from 75 to 134 (79%), while NSW recorded a decrease from 87 to 76 (13%) and Victoria a decrease from 41 to 39 (5%). There was also significant variation in states and territories with smaller volumes, so small changes in actual numbers can translate into significant percentage changes.

Queensland received significantly more mandatory notifications than other states and territories, with almost half of the mandatory notifications received outside of NSW received in Queensland (134 of 275). Medical practitioners account for 30.7% of all mandatory notifications received nationally (see Table 12).

Table 3: Registered practitioners by 'principal place of practice' and gender

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP *	Total 2013-14	Total 2012-13	Total 2011-12	% Change 2012/13-2013/14
Medical Practitioner	1,960	31,269	1,084	19,032	7,554	2,155	24,137	9,889	2,299	99,379	95,690	91,648	3.86%
Female	875	12,498	530	7,496	2,948	875	9,947	4,010	784	39,963	37,723	35,443	5.94%
Male	1,085	18,771	554	11,536	4,606	1,280	14,190	5,879	1,515	59,416	57,967	56,192	2.50%
Not stated or inadequately described												13	

*Principal place of practice

Table 4: Registered practitioners by 'principal place of practice' and registration type

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP [1]	Total 2013-14	Total 2012-13	Total 2011-12	% Change 2012/13-2013/14
Medical Practitioner	1,960	31,269	1,084	19,032	7,554	2,155	24,137	9,889	2,299	99,379	95,690	91,648	3.86%
General	679	10,499	451	6,468	2,295	626	7,638	3,058	675	32,389	29,293	26,483	10.57%
General (Teaching and Assessing)		10		7	5		7	5		34	30	23	13.33%
General (Teaching and Assessing) and Specialist		1					1			2	2	1	0.00%
General and Provisional [2]												2	
General and Specialist	890	15,927	370	8,744	3,907	1,074	12,477	4,182	547	48,118	47,210	46,409	1.92%
Limited	111	1,279	91	636	394	107	1,032	688	9	4,347	5,151	5,670	-15.61%
Limited (Public Interest - Occasional Practice)		19		126		1		247	6	399	1,089	1,239	-63.36%
Non-practising	38	669	3	228	121	49	489	176	704	2,477	2,377	2,379	4.21%
Provisional	96	1,113	63	861	310	87	937	371	8	3,846	3,522	3,253	9.20%
Provisional and Specialist [2]												1	
Specialist	146	1,752	106	1,962	522	211	1,556	1,162	350	7,767	7,016	6,188	10.70%

Notes
1. No principal place of practice (PPP) will include practitioners with an overseas address.
2. Practitioners holding general or specialist registration and limited/provisional registration for a registration subtype within the same profession.

Table 5: Medical practitioners with specialties at 30 June 2014[1]

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP *	Total 2013-14	Total 2012-13	Total 2011-12	% Change 2012/13-2013/14
Medical Practitioner	1,159	19,244	521	11,682	4,945	1,386	15,449	5,822	963	61,171	59,432	57,056	2.9%
Addiction medicine	2	64	3	26	15	9	30	13	4	166	165	164	0.6%
Anaesthesia	74	1,345	40	899	357	111	1,081	479	109	4,495	4,317	4,055	4.1%
Dermatology	5	182	1	80	39	6	128	41	7	489	468	451	4.5%
Emergency medicine	31	383	31	349	101	41	394	187	50	1,567	1,419	1,264	10.4%
General practice	411	7,442	226	4,820	1,899	617	5,652	2,370	187	23,624	23,343	22,804	1.2%
Intensive care medicine	22	237	10	169	67	16	183	68	24	796	738	683	7.9%
Paediatric intensive care medicine							2			2			
No subspecialty declared	22	237	10	169	67	16	181	68	24	794			
Medical administration	15	102	7	83	16	4	65	32	7	331	323	316	2.5%
Obstetrics and gynaecology	30	545	14	353	134	38	497	158	45	1,814	1,749	1,681	3.7%
Gynaecological oncology		16		9	4	1	11	2		43	42	40	2.4%
Maternal-fetal medicine		13	1	7	3		9	5	1	39	39	36	0.0%
Obstetrics and gynaecological ultrasound		13		5	4		53	3	2	80	80	80	0.0%
Reproductive endocrinology and infertility		27		4	6	1	13	2		53	53	55	0.0%
Urogynaecology	1	10		6	1		8	4		30	29	28	3.4%
No subspecialty declared	29	466	13	322	116	36	403	142	42	1,569	1,506	1,442	4.2%
Occupational and environmental medicine	16	92	1	43	29	6	65	41	7	300	296	295	1.4%
Ophthalmology	12	354	5	160	71	20	225	75	13	935	909	879	2.9%
Oral and maxillofacial surgery											1	2	-100.0%
Paediatrics and child health	36	772	22	404	166	40	572	245	58	2,315	2,155	1,995	7.4%
Clinical genetics		15		1			5	1		22	17	12	29.4%
Community child health		16		9	2		7		1	35	22	10	59.1%

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP *	Total 2013-14	Total 2012-13	Total 2011-12	% Change 2012/13-2013/14
General paediatrics	28	583	17	315	128	31	437	173	32	1,744	1,681	1,635	3.7%
Neonatal and perinatal medicine	6	42		22	8	3	36	24	4	145	122	92	18.9%
Paediatric cardiology		5	1	5			5	4	2	22	19	18	15.8%
Paediatric clinical pharmacology		1								1	1	1	0.0%
Paediatric emergency medicine		8		9	4		8	7	1	37	30	20	23.3%
Paediatric endocrinology	1	10		4	1		2	2		20	16	8	25.0%
Paediatric gastroenterology and hepatology		4		2	1		6	3	3	19	15	11	26.7%
Paediatric haematology		3		1			2	1		7	6	3	16.7%
Paediatric immunology and allergy		3		2	3		3			11	11	5	0.0%
Paediatric infectious diseases		4	1	3	1		6			15	12	7	25.0%
Paediatric intensive care medicine		4		1						5	3	2	66.7%
Paediatric medical oncology		7		3	1		4	2	1	18	12	10	50.0%
Paediatric nephrology		5								5	4	1	25.0%
Paediatric neurology		15		3	1	1	5	1	2	28	22	15	27.3%
Paediatric palliative medicine		1		1						2			
Paediatric rehabilitation medicine		4			1					5	5	2	0.0%
Paediatric respiratory and sleep medicine		9		6	1		3	4		23	17	11	35.3%
Paediatric rheumatology		3		2	1		3	2		11	8	3	37.5%
No subspecialty declared	1	30	3	15	13	5	40	21	12	140	132	129	6.1%

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP *	Total 2013-14	Total 2012-13	Total 2011-12	% Change 2012/13-2013/14
Pain medicine	2	82		53	30	8	42	30	4	251	238	220	5.5%
Palliative medicine	6	94	2	44	22	12	61	28	6	275	259	246	6.2%
Pathology	58	769	9	405	190	51	529	239	26	2,276	2,231	2,153	2.0%
Anatomical pathology (including cytopathology)	19	266	3	163	63	17	192	90	8	821	786	742	4.5%
Chemical pathology	2	23		15	8	2	20	15	4	89	86	84	3.5%
Forensic pathology		8	1	13	4	2	10	5		43	41	39	4.9%
General pathology	11	182	2	78	55	13	120	36	5	502	526	551	-4.6%
Haematology	10	156	2	79	35	12	128	34	4	460	440	408	4.5%
Immunology	6	46		12	10	1	19	17		111	106	97	4.7%
Microbiology	7	75	1	38	15	4	37	33	1	211	207	199	1.9%
No subspecialty declared	3	13		7			3	9	4	39	39	33	0.0%
Physician	176	2,806	66	1,520	818	166	2,632	742	163	9,089	8,707	8,234	4.4%
Cardiology	17	381	6	236	110	20	314	83	33	1,200	1,147	1,059	4.6%
Clinical genetics		33		7	9		16	5		70	69	66	1.4%
Clinical pharmacology		13		11	9		11	5	2	51	50	49	2.0%
Endocrinology	11	199	6	107	33	11	170	44	1	582	555	525	4.9%
Gastroenterology and hepatology	21	241	3	133	62	13	219	61	10	763	734	697	4.0%
General medicine	32	398	10	332	246	36	541	121	37	1,753	1,721	1,688	1.9%
Geriatric medicine	9	188	2	76	48	9	174	62	6	574	538	485	6.7%
Haematology	8	161	2	87	37	9	140	30	11	485	466	439	4.1%
Immunology and allergy	7	55	1	14	12	1	29	22	2	143	135	127	5.9%
Infectious diseases	8	88	12	51	26	7	140	28	8	368	339	308	8.6%
Medical oncology	9	158	2	92	42	9	201	36	4	553	509	445	8.6%
Nephrology	9	155	12	77	26	10	148	34	11	482	443	412	8.8%
Neurology	11	187	1	69	33	7	171	40	7	526	502	481	4.8%
Nuclear medicine	7	100		32	26	6	58	19	1	249	245	236	1.6%
Respiratory and sleep medicine	11	191	4	121	52	12	154	55	10	610	583	552	4.6%
Rheumatology	8	113	1	46	36	7	98	30	8	347	333	320	4.2%

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP *	Total 2013-14	Total 2012-13	Total 2011-12	% Change 2012/13-2013/14
No subspecialty declared	8	145	4	29	11	9	48	67	12	333	338	345	-1.5%
Psychiatry	52	1,018	15	609	283	60	952	283	57	3,329	3,218	3,076	3.4%
Public health medicine	28	134	24	80	30	11	78	43	7	435	441	440	-1.4%
Radiation oncology	14	116	2	68	22	8	103	21	4	358	342	323	4.7%
Radiology	52	643	3	412	167	48	560	236	99	2,220	2,140	2,023	3.7%
Diagnostic radiology	41	568	3	351	151	43	458	204	83	1,902	1,850	1,772	2.8%
Diagnostic ultrasound		1					3			4	4	4	0.0%
Nuclear medicine	4	39		51	11	4	63	9	3	184	176	167	4.5%
No subspecialty declared	7	35		10	5	1	36	23	13	130	110	80	18.2%
Rehabilitation medicine	6	213	3	55	35	6	117	16	3	454	442	414	2.7%
Sexual health medicine	5	52	1	18	7	1	25	6		115	113	112	1.8%
Sport and exercise medicine	11	40	1	11	4	2	36	10		115	114	113	0.9%
Surgery	95	1,759	35	1,021	443	105	1,422	459	83	5,422	5,305	5,113	2.2%
Cardio-thoracic surgery	6	57		42	11	3	62	14	5	200	192	180	4.2%
General surgery	24	626	17	344	157	35	525	134	33	1,895	1,879	1,826	0.9%
Neurosurgery	7	75		42	15	4	61	21	1	226	220	207	2.7%
Oral and maxillofacial surgery	4	23	3	29	9	1	25	10	1	105	94	81	11.7%
Orthopaedic surgery	27	414	7	274	116	22	302	129	22	1,313	1,273	1,227	3.1%
Otolaryngology - head and neck surgery	8	160	3	88	42	9	113	43	8	474	467	451	1.5%
Paediatric surgery	4	34		13	9	2	26	8	2	98	97	92	1.0%
Plastic surgery	6	126	2	67	39	13	129	42	4	428	414	400	3.4%
Urology	6	129	1	79	29	10	105	39	1	399	386	360	3.4%
Vascular surgery	3	70	1	43	16	6	59	15	2	215	206	202	4.4%
No subspecialty declared		45	1				15	4	4	69	77	87	-10.4%

*Principal place of practice

Notes

1. The data record the number of practitioners with registration in the specialist fields listed. Individual practitioners may be registered to practise in more than one specialist field.

There has been a slight drop in the number of practitioners subject to mandatory notifications per 10,000 practitioners – to 27.2/10,000 from 28.9/10,000 in 2012/13. This compares with a rate of 15.8/10,000 for other registered health practitioners and is not surprising given the complexity of medical practice (see Table 13). Nationally, there were notifications about 4.9% of medical practitioners compared to 1.4% of all health practitioners (see Table 11).

The Medical Board of Australia *Guidelines for mandatory notifications* are published on its website under Codes, guidelines and policies.

Outcomes of mandatory notifications

The assessment of 250 mandatory notifications was finalised during the year (excluding NSW) (see Table 14). Of these, 166 out of 250 (66%) were referred for further regulatory action and 34% (84 out of 250) were closed. Of the cases referred for further regulatory action, 118 out of the 166 (81%) were referred for investigation only; 23 were referred for performance or health assessment, 17 were referred for both investigation and health or performance assessment, three matters were referred directly to panels and five matters were referred directly to a tribunal. Of the cases closed after assessment, in 65 of 84 cases (77%) boards decided no further regulatory action was needed to manage risk to patients and in 19 out of 84 cases (23%) boards took disciplinary action (see Table 14).

Of the 231 mandatory notifications closed in 2013/14 (see Table 15), in 142 cases (61%) the Board determined that no further regulatory action was required to keep the public safe. The remaining 89 cases led to disciplinary action, including issuing a caution (32 cases), imposing conditions (32 cases) accepting undertakings (17 cases) and suspending the practitioner's registration (two cases).

Immediate action

The Medical Board of Australia has the power to take immediate action as an interim step to manage risk to patients, pending other inquiries. Information about immediate action is published under Notifications on the AHPRA website.

Taking immediate action is a serious step. The threshold for the Board to take immediate action is high and is defined in section 156 of the National Law. To take immediate action, the Board must reasonably believe that:

- because of their conduct, performance or health, the practitioner poses a 'serious risk to persons' and that it is necessary to take immediate action to protect public health or safety, or
- the practitioner's registration was improperly obtained, or
- the practitioner or student's registration was cancelled or suspended in another jurisdiction.

In relation to students, the Board must reasonably believe that they:

- have been charged, convicted or found guilty of an offence punishable by 12 months' imprisonment or more, or
- have or may have an impairment, or
- have or may have contravened a condition on their registration or an undertaking given to the Board, and it is necessary to take action to protect the public.

Table 6: Notifications received and closed in 2013/14 and open at 30 June 2014 by state and territory

State/ Territory	Notifications received	% of all medical notifications	Mandatory received	% of all medical notifications	Notifications closed	% of all medical notifications	Open at 30 June	% of all medical notifications
ACT	166	3%	5	1%	145	3%	117	4%
NT	109	2%	2	1%	63	1%	66	3%
QLD	1,361	24%	134	38%	1,342	24%	575	22%
SA	421	8%	51	15%	339	6%	244	9%
TAS	173	3%	17	5%	180	3%	93	4%
VIC	1,125	20%	39	11%	1,111	20%	552	21%
WA	457	8%	27	8%	500	9%	280	11%
Subtotal	3,812		275		3,680		1,927	
NSW	1,773	32%	76	22%	1,835	33%	704	27%
Total	5,585		351		5,515		2,631	

Table 7: Notifications received by state and territory by three-year history

Medical Practitioner	ACT	NT	QLD	SA	TAS	VIC	WA	Sub Total	NSW	Total
2013/14	166	109	1,361	421	173	1,125	457	3,812	1,773	5,585
2012/13	115	60	1,154	275	108	989	331	3,032	1,677	4,709
2011/12	100	45	866	207	145	743	267	2,373	1,628	4,001
% change from 2012/13 to 2013/14	44%	82%	18%	53%	60%	14%	38%	26%	6%	19%
All notifications received 2013/14	267	216	2,375	793	298	2,112	750	6,811	3,236	10,047
Medical as % of all notifications received	62.2%	50.5%	57.3%	53.1%	58.1%	53.3%	60.9%	56.0%	54.8%	55.6%

There was a total of 246 immediate actions taken nationally in 2013/14. This is a 67% increase in the number of times that state and territory medical boards took immediate action during the year compared with the previous reporting year (147 immediate actions in 2012/13). This increase varies widely across states and territories. The biggest increase was in WA, where the WA Board took immediate action 38 times, up from 11 in 2013 (a 245% increase). In Queensland, the Queensland Board, or, in the early part of the reporting year, the Queensland Medical Interim Notifications Group (QMING), took immediate action 89 times, up from 35 in the previous year (a 154% increase). In South Australia, there were 20 immediate actions taken, up from 11 in 2013 (an 82% increase). The number of immediate actions in Victoria increased from 26 in 2013 to 31 in 2014 (19% increase) and in NSW they increased from 44 to 48 (a 9% increase). The actual number of immediate actions taken in other states and territories is relatively small but the percentage changes vary. There were fewer immediate actions taken in both the Australian Capital Territory (ACT) and Tasmania (see Table 8).

Outcomes of immediate action

Of the 198 immediate actions taken by medical boards around Australia (excluding NSW), 137 (69%) led to regulatory action of some sort. In 61 cases (31%), boards decided no further regulatory action was needed as an interim step to keep the public safe, pending other regulatory action. This compares to 23% for all professions. All other cases resulted in action: conditions were imposed in 39% of cases, undertakings given (17%), registration suspended (13%) and in one case the Board accepted surrender of the practitioner's registration. In one case the decision was still pending at the end of the reporting year year (see Table 18).

What happened? Outcomes of closed notifications

Tables 16–22 provide details of the outcomes of notifications, excluding NSW data.

Tables 16 and 17 provide details about the 3,680 notifications about medical practitioners closed during the year. Most (72%) were closed after

Table 8: Immediate action cases by state or territory (including NSW data)

Medical Practitioner	ACT	NT	QLD	SA	TAS	VIC	WA	Subtotal	NSW	Total
2013/14	7	10	89	20	3	31	38	198	48	246
2012/13	8	4	35	11	8	26	11	103	44	147
% change from 2012/13 to 2013/14	-13%	150%	154%	82%	-63%	19%	245%	92%	9%	67%
All practitioners 2013/14	2.2%	2.7%	1.7%	1.4%	2.0%	1.2%	1.1%	1.4%	1.5%	1.4%

Table 9: Notifications closed by three-year history by state or territory

Medical Practitioner	ACT	NT	QLD	SA	TAS	VIC	WA	Sub Total	NSW	Total
Closed 2013/14	145	63	1,342	339	180	1,111	500	3,680	1,835	5,515
Closed 2012/13	112	52	1,119	252	111	825	262	2,733	1590	4,323
Closed 2011/12	101	47	685	200	126	588	180	1,927	1,452	3379
% change from 2012/13 to 2013/14	29%	21%	20%	35%	62%	35%	91%	35%	15%	28%
All notifications closed 2013/14	225	148	2,327	676	292	2,090	798	6,556	3247	9803
Medical as % of all notifications closed	64.4%	42.6%	57.7%	50.1%	61.6%	53.2%	62.7%	56.1%	56.5%	56.3%

Table 10: Open notifications at 30 June 2014 by state and territory

Medical Practitioner	ACT	NT	QLD	SA	TAS	VIC	WA	Sub Total	NSW	Total
2013/14	117	66	575	244	93	552	280	1,927	704	2,631
2012/13	85	22	591	149	87	553	315	1,802	806	2,608
2011/12	88	11	517	136	58	448	280	1,538	633	2,171
% change 2012/13 to 2013/14	38%	200%	-3%	64%	7%	-0.2%	-11%	7%	-13%	1%
All cases open 2013/14	214	138	1,166	525	169	1,192	523	3,927	1,310	5,237
Medical as % of all open cases	54.7%	47.8%	49.3%	46.5%	55.0%	46.3%	53.5%	49.1%	53.7%	50.2%

Table 11: Percentage of registrant base with notifications received by state or territory

Medical Practitioner	ACT	NT	QLD	SA	TAS	VIC	WA	Sub Total	NSW	Total
2013/14	7.2%	8.3%	6.1%	5.0%	7.2%	4.1%	4.2%	4.9%	4.8%	4.9%
2012/13	4.4%	5.1%	5.3%	3.3%	4.4%	3.6%	3.1%	4.0%	4.7%	4.2%
2011/12	4.9%	4.7%	4.2%	2.7%	6.1%	2.8%	2.7%	3.4%	4.0%	3.5%
All practitioners 2013/14	2.2%	2.7%	1.7%	1.4%	2.0%	1.2%	1.1%	1.4%	1.5%	1.4%

assessment, compared with 67% closed at this stage for all professions. A further 21% were closed after investigation (compared with 22% for all professions) and 4.5% were closed after a disciplinary hearing (compared with 5.3% for all professions).

Of the matters closed, boards decided in 58% of cases that no further regulatory action was needed to keep the public safe (57% for all professions); 27% of cases were retained by the health complaints entity or referred to another agency (compared to 21% of cases for all profession; and medical boards took disciplinary action in 15% of cases that were closed (compared 22% for all professions).

What happened at each stage of the notifications process?

The National Law is flexible and designed to enable boards take action as needed to manage risk to the public. As a result, the notifications process is not linear. More information about the process – including a flow chart – is published on the AHPRA website under The notifications process and in the 2014 annual report of AHPRA and the National Boards (from page 124).

Tables 19–22 provide details of the outcomes of notifications finalised at different stages of the notifications process during the year.

Table 12: Mandatory notifications received by three-year history by state or territory (including NSW data)

Medical Practitioner	ACT	NT	QLD	SA	TAS	VIC	WA	Sub Total	NSW	Total
2013/14	5	2	134	51	17	39	27	275	76	351
2012/13	10	4	75	43	13	41	26	212	87	299
2011/12	10	4	68	22	8	25	12	149	72	221
% change from 2012/13 to 2013/14	-50%	-50%	79%	19%	31%	-5%	4%	30%	-13%	17%
All mandatory notifications received 2013/14	11	8	376	180	51	189	88	903	242	1,145
Medical as % of all mandatory notifications received	45.5%	25.0%	35.6%	28.3%	33.3%	20.6%	30.7%	30.5%	31.4%	30.7%

Table 13: Registrants involved in mandatory notifications by profession (including NSW data)

	2013/14		2012/13 [1]		2011/12	
Profession	No. practitioners	Rate / 10,000 practitioners	No. practitioners	Rate / 10,000 practitioners	No. practitioners	Rate / 10,000 practitioners
Medical practitioner	270	27.2	277	28.9	204	22.3
All registrants	976	15.8	951	16.1	732.0	13.3

Notes:
1. Figures present the number of practitioners involved in the mandatory reports received.

Table 14: Outcomes of assessment of mandatory notifications by grounds for the notification (excluding NSW data)

	End matter							Refer to further stage								
Grounds for notification	No further action	Refer all of the notification to another body	Caution	Accept undertaking	Impose conditions	Surrender registration	Total closed after assessment	Health or performance assessment	Investigation	Investigation and health/ performance assessment	Panel hearing	Tribunal hearing	Total referred to further stage	Total assessments finalised 2013/14	Total assessments finalised 2012/13	Total assessments finalised 2011/12
Standards	51		11		2		64	6	94	5	1	3	109	173	107	57
Impairment	8			1	3		12	14	9	9	1		33	45	30	30
Sexual misconduct	1						1		13		1	2	16	17	16	8
Alcohol or drugs				1		1	2	3	2	3			8	10	13	7
Not classified	5						5						0	5	0	1
Total 2013/14	65		11	2	5	1	84	23	118	17	3	5	166	250		
Total 2012/13	44	1	6	4	6		61	16	6				22		166	
Total 2011/12	22		1	2	3		28	18	56			1	75			103

Table 15: Outcome at closure for mandatory notifications closed in 2013/14 (excluding NSW)

Closure outcome	
No further action	142
Caution	32
Reprimand	5
Accept undertaking	17
Impose conditions	32
Practitioner surrender	1
Suspend registration	2
Total	231

Table 16: Stage at closure for notifications closed (excluding NSW)

Stage at closure	Medical registrants	All registrants
Assessment	2,653	4,387
Health or performance assessment	91	356
Investigation	771	1,469
Panel hearing	122	228
Tribunal hearing	43	116
Total	3,680	6,556

Outcomes at assessment stage

Of the 3,811 assessments finalised, 30% were referred for further regulatory action and 70% were closed after assessment. Of those referred for further action, 91% were referred for investigation and the rest for a health or performance assessment, or a panel or tribunal hearing.

Of those closed at assessment, in 55% of cases (58% for all professions), medical boards decided no further regulatory action was needed to manage risk to patients. In 37% (31% for all professions), boards referred the matter for management by the health complaints entity or to another agency; and 7% of cases involved disciplinary action (see Table 19).

Outcomes of investigations

Of the 998 investigations finalised during the year, 23% were referred for further regulatory action, either to a panel or tribunal hearing, or for a health or performance assessment.

Of those closed after investigation, in 73% of cases boards decided no further regulatory action was needed to manage risk to the public, and 26% led to disciplinary action (see Table 20).

Outcomes of panel and tribunal hearings

Of the 122 notifications finalised following a panel hearing, 62% led to disciplinary action. In 38% of these cases, panels decided no further regulatory action was needed to manage risk to patients, compared to 24% for all professions (see Table 21). Of the 43 cases finalised following a tribunal hearing (see Table 22), 84% led to disciplinary action and in 16% (seven cases) tribunals decided no further action was required (12% for all professions).

Table 17: Outcome at closure for notifications closed (excluding NSW)

Outcome at closure	Medical registrants	All registrants
No further action	2,132	3,744
Refer all or part of the notification to another body	13	22
Health complaints entity to retain	982	1,342
Caution or reprimand	361	798
Accept undertaking	56	218
Impose conditions	121	382
Fine registrant	4	7
Suspend registration	6	18
Practitioner surrender	2	11
Cancel registration	3	12
Other tribunal order		2
Total	3,680	6,556

Table 18: Outcome of immediate actions (excluding NSW)

Outcome	Medical registrants	All registrants
Not take immediate action	61	110
Accept undertaking	33	93
Impose conditions	77	187
Accept surrender of registration	1	3
Suspend registration	25	75
Decision pending	1	6
Total	198	474

Table 19: Outcomes of assessments finalised in 2013/14 (excluding NSW)

	Medical registrants	All registrants
Outcome of decisions to take the notification further		
Investigation	1,050	2,055
Health or performance assessment	74	324
Panel hearing	23	27
Tribunal hearing	11	16
Subtotal	1,158	2,422
Outcome of notifications closed following assessment		
No further action	1,470	2,550
Health complaints entity to retain	982	1,342
Refer all of the notification to another body	5	10
Caution	162	366
Accept undertaking	13	58
Impose conditions	21	58
Practitioner surrender		3
Subtotal	2,653	4,387
Total assessments finalised	3,811	6,809

Table 20: Outcomes of investigations finalised in 2013/14 (excluding NSW)

	Medical registrants	All registrants
Outcome of decisions to take the notification further		
Health or performance assessment	12	41
Panel hearing	116	242
Tribunal hearing	99	190
Subtotal	**227**	**473**
Outcome of notifications closed following investigation		
No further action	564	989
Refer all or part of the notification to another body	8	12
Caution	140	304
Accept undertaking	26	67
Impose conditions	33	96
Practitioner surrender		1
Subtotal	**771**	**1,469**
Total investigations finalised	**998**	**1,942**

Table 21: Outcomes from panel hearings finalised in 2013/14 (excluding NSW)

Outcome	Medical registrants	All registrants
No further action	46	55
Caution	33	57
Reprimand	13	26
Accept undertaking	2	2
Impose conditions	26	82
Practitioner surrender	2	2
Suspend registration		4
Total	**122**	**228**

Table 22: Outcomes from tribunal hearings finalised in 2013/14 (excluding NSW)

Outcome	Medical registrants	All registrants
No further action	7	14
Fine registrant	4	7
Caution or reprimand	10	36
Accept undertaking		6
Impose conditions	14	25
Practitioner surrender		2
Suspend registration	5	12
Cancel registration	3	12
Other tribunal order		2
Total	43	116

Keeping the public safe: monitoring

Health practitioners and students may have restrictions placed on their registration for a range of reasons including as a result of a notification, the assessment of an application for registration or a renewal of registration.

On 30 June 2014, there were 987 medical practitioners monitored across states and territories excluding NSW. Queensland has the highest number with 396 practitioners being monitored and the largest proportion (42%) of medical practitioners being monitored (see Table 23). Table 24 outlines the proportion of cases monitored in relation to conduct, health, performance and suitability/eligibility.

Table 23: Active monitoring cases at 30 June 2014 by state

	Medical practitioner	All practitioners	Medical as % of all practitioners
ACT	39	113	34.5%
NT	33	95	34.7%
QLD	396	937	42.3%
SA	157	494	31.8%
TAS	42	123	34.1%
VIC	177	695	25.5%
WA	143	370	38.6%
Total	987	2,827	34.9%

Table 24: Active monitoring cases at 30 June 2014 by stream

	Medical practitioner	All practitioners	Medical as % of all practitioners
Conduct	162	475	34.1%
Health	260	832	31.3%
Performance	237	501	47.3%
Suitability/ eligibility	328	1,0191	32.2%
Total	987	2,872	34.9%

continued overleaf

Types of restrictions being monitored include:

Drug and alcohol screening – requirements to provide biological samples for analysis for the presence of specified drugs and/or alcohol.

Health – requirements to attend treating health practitioner(s) for the management of identified health issues (including physical and psychological/psychiatric issues).

Supervision – restrictions that require a health practitioner to practise only if they are being supervised by another health practitioner (usually registered in the same profession). The restrictions detail the form of supervision.

Mentoring – requirements to engage a mentor to provide assistance, support and guidance in addressing issues, behaviours or deficiencies identified in skills, knowledge, performance or conduct.

Chaperoning – restrictions that allow patients generally, or specific groups of patients, to be treated or examined only when a suitable third party is present.

Audit – requirements for a health practitioner to submit to an audit of their practice, which may include auditing records and/or the premises from which they practise.

Assessment – requirements that a health practitioner or student submits to an assessment of their health, performance, knowledge, skill or competence to practise their profession.

Practice and employment – requirements that a practitioner or student does, or refrains from doing, something in connection with their practice of their profession (for example, restrictions on location, hours or scope of practice, or rights in respect of particular classes of medicines).

Education and upskilling – requirements to attend or complete a (defined) education, training or upskilling activity, including prescribed amounts of continuing professional development.

A health practitioner or student may simultaneously have restrictions of more than one type and/or category in place on their registration at any time.

Statutory offences: advertising, practice and title protection

Concerns raised about advertising, title and practice protection during the year were managed by AHPRA's statutory compliance team.

During 2013/14, AHPRA received 116 statutory offences complaints about medical practitioners, related to sections 113–136 of the National Law. These complaints included 48 about advertising and 64 about practice and title protections. During the year, AHPRA closed 88 statutory offences complaints, including 41 about advertising and 32 about practice and title protections.

More detail about our approach to managing statutory offences is reported on page 119 of the 2013/14 annual report of AHPRA and the National Boards.

Criminal history checks

Under the National Law, applicants for initial registration must undergo criminal record checks. National Boards may also require criminal record checks at other times. Applicants seeking registration must disclose any criminal history information when they apply for registration, and practitioners renewing their registration are required to disclose if there has been a change to their criminal history status within the preceding 12 months.

While a failure to disclose a criminal history by a registered health practitioner does not constitute an offence under the National Law, such a failure may constitute behaviour for which the Board may take health, conduct or performance action. The criminal record check is undertaken by an independent agency which provides a criminal history report. AHPRA may also seek a report from a police commissioner or an entity in a jurisdiction outside Australia that has access to records about the criminal history of people in that jurisdiction. The criminal history reports are used as one part of assessing an applicant's suitability to hold registration.

During the year, the Board refused registration to one person as a result of a criminal history check. In 11 cases, the Board imposed conditions or required an undertaking from the practitioner as a result of a criminal history check.

More detailed information about criminal record checks is published from page 115 of the 2013/14 annual report of AHPRA and the National Boards.

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