ANZCA
FPM

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Consultation: Composition of NSW Health Professional Councils

Question 1: Is the current membership number for each Council appropriate?

In relation to medical council numbers – these should be sufficient to represent most specialty groups, as well as community representation. The number seems appropriate for each case management committee to allow for appropriate time to read through material and discuss the cases presented for management of performance/ impairment etc.

Question 2: Should membership numbers be made more consistent across the Councils and, if so, how?

Consistency between different councils seems less important if each relevant group is adequately represented within each council.

Question 3: Should the education member be removed from the 6 Councils that currently have an education member?

Some questions arise from this in relation to the medical council – such as, do the “new” universities offering medical degrees need representation? Or do we do away with an educational representative? Who is best to speak to the educational requirements if an issue arises with a student?

Questions 4 and 5: Should the Medical Council and the Nursing and Midwifery Council continue to have college members? If so, how should college members be selected?

The key point is having enough diversity across subspecialty groups in the case management committees so that a member understands the nuances of the field of specialty of the practitioner/s whose case/complaint is before the committee. The bulk of case work involves GPs, so it’s important to have enough representation of specialist GPs. The 8 colleges represented seem sensible choices, given most of the cases managed by the medical council’s case management committees involve practitioners from these subspecialty areas. It seems sensible for these 8 colleges to nominate their preferred representative.

Question 6: Should Councils continue to have association members?

The argument for members, nominated by professional bodies such as the AMA, is less clear. Are they seen as senior, experienced practitioners in the eyes of the professional body, whose input is useful for that reason? From a council case management committee, they are not representing the interests of the professional body, so it's hard to see why they are there in place of, say, another medical college representative.

Question 11: Should all Councils have community members?

Community members provide a useful insight into the expectations of the community around safety and protection from harm. Their role in the medical council is helpful, and it seems sensible that this could be extended to other counsels.

Question 15: Should the Councils continue to have legal members?

Legal members provide the necessary legal information that is relevant to each case being considered by the case management committees.

Question 16: Should the Medical Council continue to have a member nominated by Multicultural NSW?

Multicultural safety and awareness training would be useful for council members and may remove the need for a single multicultural council member. Ideally, members of the council will organically have different cultural perspectives, thereby bringing their knowledge and experience to the council.

Question 18: Should Council members be required to have NSW as their principal place of residence/practice?

Medical Council members should have a connection to NSW, whether through their place of practice or place of residence, given the differences in practice between different states. Practitioners living close to state borders may be uniquely placed to be members of the council for either state, as they may be aware of the issues in both. It's hard to see how a practitioner that does not live or work in a particular state is well placed to represent the people from that state.