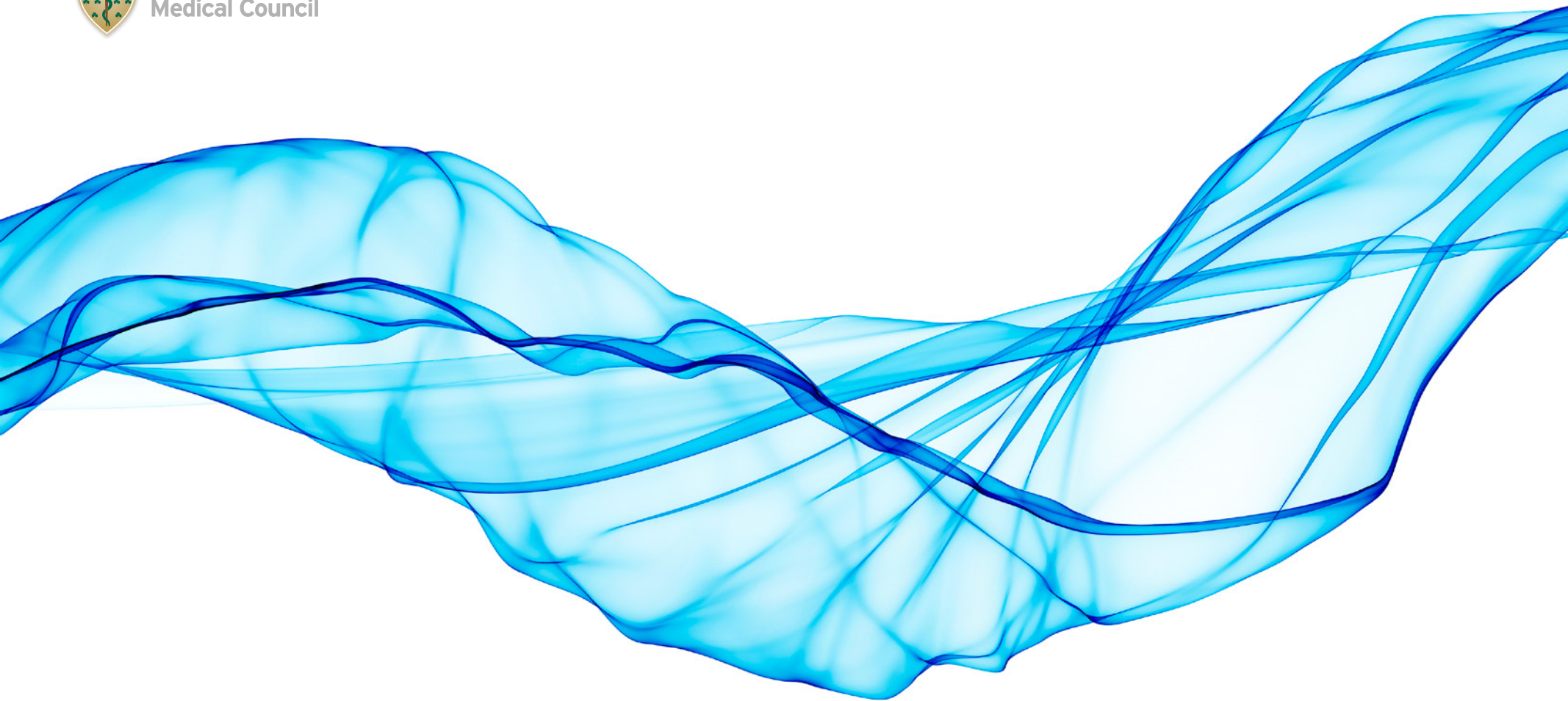


ANNUAL REPORT & FINANCIAL STATEMENTS 2012



Comhairle na nDochtúirí Leighis
Medical Council





KINGRA
HOUSE

CONTENTS

■ President's Statement	4
■ Chief Executive Officer's Review	5
■ The Role and Functions of the Medical Council	7
■ The Medical Council	8
■ Highlights and Key Activities	11
■ The Medical Council Executive	22
■ CEO's Office and Communications	23
■ Directorate of Finance and Administration	24
■ Directorate of Regulation	26
■ Directorate of Professional Development and Practice	27
■ Financial Statements for year ended 31st December 2012	31
■ Report of Comptroller and Auditor General	37
■ Appendices	53
Appendix A: Medical Council Committee & Working Group Structure	54
Appendix B: Council Attendance 2012	55
Appendix C: Committee Attendance 2012	56
Appendix D: Working Group/ Sub-Committee Attendance 2012	66
Appendix E: Statistics	68
Appendix F: High Court/Supreme Court judgements	113
■ Glossary of Terms	116

PRESIDENT'S STATEMENT



Professor Kieran C Murphy
President

In accordance with Section 16 of the Medical Practitioners Act 2007, I am pleased to submit the Annual Report of the Medical Council for the year ended 31st December 2012.

The Medical Council's role has evolved considerably since the introduction of the 2007 Medical Practitioners Act. There has been a significant expansion of the Council's responsibilities with new procedures developed and implemented to ensure the continuing safety of patients in Ireland.

The Council's strategy for 2010-2013 provides us with the framework for our work and Council members and staff remain focused on the delivery of our strategic objectives in partnership with the public and the profession.

In January, we established new procedures for assessing the performance of doctors. This marked the culmination of a number of years of development work and represented a further safeguard to both protect patients and to promote good professional practice among doctors.

Communication with the public, the profession and relevant organisations within the health system is a core strategic objective of the Council and work continued in this area in 2012. In August, we held an Education and Training symposium, with the theme 'From Student to Specialist - Defining Competencies across the Professional Development Spectrum'. The symposium was designed to link closely with the Council's work in standard setting, monitoring and accreditation.

In October, following consultation with doctors, patient representatives and relevant regulatory bodies, we published supplementary guidance on doctors' interactions with pharmaceutical and medical device companies.

Our annual conference in November addressed themes relating to doctors' practice, including doctors' health, the application of professionalism in daily practice, and also provided both national and international perspectives on medical regulation, with presentations from regulatory bodies in the UK and New Zealand.

One of the Council's strategic objectives is to enable effectiveness through appropriate and efficient internal systems and processes. In line with this objective, 2012 saw the implementation of revised Preliminary Proceedings Committee (PPC) procedures for the enhanced management of complaints.

I would like to thank each Council member for their contributions during the year and particularly acknowledge the significant roles of Dr Anna Clarke, Vice President and the Council Committee Chairs. I would also like to recognise the contribution of Professor Bill Powderly who resigned from the Council at the end of 2012. The expanded role of the Medical Council has had a significant impact on the work of the Executive and I would like to thank the Chief Executive Officer Caroline Spillane and all Medical Council staff for their enormous efforts in supporting and contributing to

the work of the Council. Finally, I would like to acknowledge our continued close working relationships with the Department of Health, the Health Service Executive, the Forum of Postgraduate Training Bodies, the Postgraduate Training Colleges and Patient Representative Groups.

A handwritten signature of Professor Kieran C Murphy in black ink.

Professor Kieran C Murphy
President

CHIEF EXECUTIVE OFFICER'S REVIEW



Ms. Caroline Spillane
Chief Executive Officer

The Medical Council continued to strengthen its regulatory role in 2012 with a focus on ensuring good standards of care are provided throughout a doctor's career, from the moment they enter medical school, to their retirement.

Education and training plays a vital role in establishing professional behaviours which are then to be maintained throughout doctors' working lives. To this end, 'Guidelines on Remediation of Doctors in the Intern Year' were published during 2012, to support the delivery of intern training. An additional nine further intern training sites were inspected and approved by Council during the year, bringing the total number of approved intern training sites in the State to 47.

May marked the conclusion of the first year of mandatory professional competence requirements for doctors. All practising doctors now have a legal obligation to keep their knowledge and skills up to date throughout their professional lives, and audit procedures were commenced to ensure compliance. Doctors have displayed diligence and commitment in their adherence to these procedures, which for most have merely formalised activities which were undertaken on a voluntary basis.

The process for doctors' annual retention of registration was strengthened significantly in 2012, as requirements were introduced for doctors to submit information on their continued good standing and fitness to practise as well as adherence to professional competence requirements. The information

provided has strengthened our regulatory oversight, and the practice information provided by doctors will be examined in detail in 2013. This process provides a snapshot of the totality of doctors working within the State and will be used in the coming years to inform policy makers in the areas of education, training and workforce planning.

In order to safeguard the public, it is imperative that the Council takes a rigorous and fair approach to the investigation of complaints about doctors. An unprecedented number of fitness to practise inquiry days were held in 2012 in response to a trend in recent years of increasing complaints received. Procedures for the Preliminary Proceedings Committee (PPC) were enhanced to ensure that processes are in line with best practice and are fair to both patients and doctors.

A Certified Investigator Training Programme was completed by five Case Officers to support the work in investigating complaints and to provide a highly skilled liaison between the PPC, complainants and doctors. The biggest asset of any organisation is its staff, and this training is part of a continued focus on supporting learning and career development of colleagues in the context of the Council's Performance Management and Development System. Educational programmes were undertaken by a number of staff with funding from the Council, as we invested in improving our collective skillset.

I would like to thank my colleagues in the Executive for their continued hard work in 2012 and for their commitment to ongoing improvement. As the Council's role has evolved, so too have the roles of many staff and I would like to acknowledge their continued professionalism and enthusiasm throughout a period of change for the health service as a whole.

I would also like to recognise the support of officials at the Department of Health, as well as our colleagues at the Health Service Executive, postgraduate medical training bodies, medical schools and patient representative organisations, for their continued engagement throughout the year.

On behalf of the staff, I would like to acknowledge the Council President, Professor Kieran Murphy, Vice President, Dr Anna Clarke the Council members and the chairs of Committees and Working Groups for the strategic guidance provided to us in 2012.

I look forward to a continued focus in 2013 on strengthening our systems and processes to ensure that we are in the best possible position to support the provision of high quality and safe care to patients.

A handwritten signature in black ink, reading 'Caroline Spillane'.

Ms. Caroline Spillane
Chief Executive Officer



THE ROLE AND FUNCTIONS OF THE MEDICAL COUNCIL

The objective of the Medical Council is to protect the public by promoting and better ensuring high standards of professional conduct and professional education, training and competence among registered medical practitioners.

Established by the **Medical Practitioners Act 1978** (updated in **2007**), the principal functions of the Medical Council are to:

- Establish and maintain the Register of Medical Practitioners
- Set and monitor standards for undergraduate, intern and postgraduate education and training
- Specify and review the standards required for the maintenance of the professional competence of registered medical practitioners
- Specify standards of practice for registered medical practitioners including providing guidance on all matters related to professional conduct and ethics
- Conduct disciplinary procedures

MISSION STATEMENT

‘Protecting the public by promoting and ensuring the highest professional standards amongst doctors’

The Medical Practitioners Act 2007 has conferred the Medical Council with an increased number of statutory functions that allows Council to exercise this role in a more comprehensive manner. The above principal functions, in addition to the increased responsibilities for establishing standards for undergraduate education and postgraduate training of doctors, provides a stable mandate for achieving Council’s mission statement.

The Medical Council’s Vision, Mission and Values are laid down in our Statement of Strategy 2010-2013, arising from which the six strategic objectives that define the focus for the organisation have been identified.

VISION	MISSION
Patient safety and public confidence is ensured through excellent doctors upholding the highest standards.	Protecting the public by promoting and ensuring the highest professional standards amongst doctors.

VALUES
<ul style="list-style-type: none"> ■ Our primary focus is to ensure our activities are in the best interests of the public and are patient focused at all times. ■ We are a progressive organisation and are continually looking to improve the way in which we work. ■ We are open and transparent in our processes and actions. ■ We constantly aim to deliver effective services as efficiently as possible. ■ We treat everyone with respect and dignity. ■ We discharge our duties in a fair and equitable manner.

THE MEDICAL COUNCIL

The Council has a membership of 25 including both elected and appointed members. Under the provisions of the Medical Practitioners Act 2007, the new Council is comprised of 13 non-medical members and 12 medical members representing a range of medical specialties, teaching bodies, members of the public and stakeholders, all of whose appointments have been approved by the Minister for Health. The current Council's period of office is 2008 to 2013.

**Professor Kieran Murphy (President)**

A doctor specialising in Psychiatry, nominated by the Irish Psychiatric Training Committee.

**Dr Anna Clarke (Vice-President)**

A doctor specialising in Public Health Medicine, elected to the Medical Council.

**Dr Deirdre Madden**

A non-medical member, nominated by the Minister for Health & Children.

**Dr Richard Brennan**

A doctor, nominated by the Irish College of General Practitioners.

**Mr Brendan Broderick**

A non-medical member, nominated by the Health Service Executive to represent the management of the public health sector.

**Ms Katharine Bulbulia**

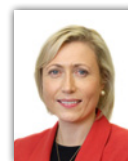
A non-medical member, nominated by the Minister for Health & Children.

**Professor Gerard Bury**

A doctor specialising in General Practice, elected to the Medical Council.

**Dr Pauline Kane**

A doctor practising as a Non-Consultant Hospital Doctor, elected to the Medical Council.

**Dr Regina Connolly**

A non-medical member, nominated by the Minister for Health & Children.

**Ms Marie Kehoe**

A non-medical member, nominated by the Health Information and Quality Authority.

**Ms Anne Carrigy**

A non-medical member, nominated by An Bord Altranais.

**Mr Frank McManus**

A doctor, nominated by the Royal College of Surgeons in Ireland.

THE MEDICAL COUNCIL CONTINUED



Ms Margaret Murphy

A non-medical member, nominated by the Minister for Health & Children.



Dr John McAdoo

A doctor, nominated by University College Cork.



Professor Damien McLoughlin

A non-medical member, nominated by the Minister for Health & Children.



Professor Diarmuid O'Donoghue

A doctor, nominated by the Royal College of Physicians of Ireland.



Professor William Powderly

A doctor, nominated by University College Dublin.



Dr John Monaghan

A doctor specialising in Obstetrics and Gynaecology, elected to the Medical Council.



Dr Daniel O'Hare

A non-medical member, nominated by the Independent Hospitals Association of Ireland.



Ms Marie Murray

A non-medical member, nominated by the Minister for Education and Science after consultation with the Higher Education Authority.



Dr David O'Keefe

A doctor specialising in Radiology, elected to the Medical Council.



Dr John O'Mullane

A non-medical member, nominated by the Health and Social Care Professionals Council.



Dr Michael Ryan

A non-medical member, nominated by the Royal Irish Academy.



Vacant position

A doctor specialising in Anaesthesia, elected to the Medical Council.



Vacant position

A member nominated by the Health Service Executive.



HIGHLIGHTS AND KEY ACTIVITIES

The vision of the Medical Council is that "Patient safety and public confidence is ensured through excellent doctors upholding the highest standards." In order to achieve this vision, the Council's guiding principle is laid out in our mission statement: "to protect the public by promoting and ensuring the highest professional standards amongst doctors". Having set the overall ambition of the organisation in the aforementioned vision and mission, the core values and objectives underpinning all of the activities of the organisation are outlined in our Statement of Strategy 2010-2013 and define the focus for the Medical Council for the period up until 2013. A formal **Business Plan** covering the period January – December 2012 (Q1 to Q4) was submitted to the Department of Health on 24th February 2012. The main areas of activity during 2012 have been aligned to their relevant Strategic Objectives as outlined in the Medical Council's **Statement of Strategy 2010-2013**.

STRATEGIC OBJECTIVE 1: SET AND MONITOR STANDARDS FOR MEDICAL EDUCATION, TRAINING, CONDUCT AND ETHICS

UNDERGRADUATE EDUCATION AND TRAINING

An extensive accreditation schedule was undertaken in 2012. Undergraduate programmes, and the universities or medical schools delivering the programmes, were assessed against Council's criteria, standards and guidelines. Each evaluation is undertaken by a Team, comprising members of Council and external expert assessors, which makes a recommendation on approval to the Medical Council.

A crucial part of each assessment is the dialogue with medical students. Professionalism and ethical issues always feature; medical schools are giving those key elements of medical education and training an increasingly high profile in teaching and learning. The Medical Council always makes students' views an important part of the process of accreditation

Two additional programmes in Ireland were fully approved during 2012 and nine programmes in Ireland now graduate medical students. The standard of the programmes and the graduates remains high.

In the interests of comprehensive quality assurance, Council also undertook the accreditation of four programmes delivered by Malaysian-based medical schools which award (or intend to award) Irish medical degrees.

INTERN TRAINING

The Medical Council continued its responsibilities to quality assure the delivery of intern training in Ireland. This is a key transition in the professional development of doctors as they move from undergraduate medical education into the workplace to commence specialist training. **'Guidelines on Remediation of Doctors in the Intern Year'** were published by the Medical Council during 2012, a guidance document which is aimed primarily at those involved in the teaching and training of interns. This guidance will also support the delivery of the 'National Intern Training Programme', which has been endorsed by the Medical Council

An additional nine intern training sites were inspected and approved by Council, bringing the total number of approved intern training sites in the State to 47.

POSTGRADUATE TRAINING

The Medical Council continued its 2011-2013 postgraduate accreditation schedule. An additional five postgraduate training bodies, and five associated programmes of specialist training, were evaluated by the Medical Council as part of this schedule. A process was also developed to approve those programmes of specialist training which will not be evaluated as part of the 2011-2013 schedule. This process, to be commenced in 2013, will focus primarily on the curriculum and specialty-specific aspects of programmes, and will take full advantage of the intelligence being gathered by Council through its 2011-2013 accreditation schedule.

MONITORING

An annual review process was developed which will require medical schools to report each year on their implementation of recommendations and significant changes. This new process enables the Medical Council to oversee the quality of medical education and training on an ongoing basis and complements its programme of inspections. It will be applied to undergraduate programmes in the first instance, pending the completion of the cycle of postgraduate accreditations. Every approved intern training site is already required to engage in an annual return process so as to monitor the standards of intern training at those sites, and to determine which sites should be re-visited.

RECOGNITION OF SPECIALTIES

There were significant developments in 2012 in relation to the Medical Council's assessment of aspirant specialties. A number of them completed the first stage of the two-stage recognition process, which means that those specialties have established an initial case for recognition. They will undergo a second-stage assessment in 2013. With two specialties having successfully completed the second stage of the recognition process in 2012, the Medical Council will now engage with a number of stakeholders to clarify the proposed delivery of postgraduate training in these two specialties before making its final decision to approve, or otherwise.

HIGHLIGHTS AND KEY ACTIVITIES

CONTINUED

PROFESSIONALISM

The Medical Council's **"Guidelines for Medical Schools on Ethical Standards and Behaviour appropriate for Medical Students"** provide advice to students and medical schools on issues including competence, confidentiality, personal and professional interactions, dress, and health. The accreditation process found

that the Guidelines are being embedded into medical schools' teaching, in line with the high profile given by medical schools and the Medical Council to student professionalism. Work undertaken on the development of a web area for students (which will be launched in 2013) will underline the importance of professionalism at this formative stage of doctors' careers.

EDUCATION AND TRAINING SYMPOSIUM

A symposium on the topic "From student to specialist - defining competencies across the professional development spectrum; implications for curricula, assessment, faculty and patients" was held on 30th August 2012. It was designed to link with the Medical Council's work in standard setting, standard monitoring, and accreditation and participants included leaders of medical schools and postgraduate medical training bodies, patient advocates, senior health officials and members of the Health Service Executive. The keynote speaker was Dr Eric Holmboe, Chief Medical Officer and Senior Vice President of the American Board of Internal Medicine and the ABIM Foundation. Embedding the concept and practice of professionalism from the student stage, and the need to involve patients in education, training, competence and assessment, emerged from the workshop sessions as key themes. The Medical Council wishes to thank all participants for their valuable insights, which will be factored into its policies and processes.



Pictured (left to right): Prof. Bill Powderly, Prof. Kieran Murphy, Dr. Eric Holmboe.



Pictured (left to right): Prof. Paul Finucane, Dr. Nick Fenlon, Dr. Eric Holmboe, Ms. Caroline Spillane, Prof. Kieran Murphy, Ms. Mary Vasseghi.

HIGHLIGHTS AND KEY ACTIVITIES

CONTINUED

INSPECTOR OF ANATOMY

The Medical Council's Inspector of Anatomy, Professor Ceri Davies, undertook an inspection of all anatomy facilities in medical schools in Ireland and produced a report which made some recommendations. This report highlighted the generally high standard of anatomy amenities in this jurisdiction and will inform the Medical Council's future activities in this area. Licences were issued to anatomy leads in medical schools with anatomy facilities in line with requirements under the Medical Practitioners Act 2007, and relevant returns from the medical schools were received so as to monitor quality on an ongoing basis.

STRENGTHENING INTERNATIONAL COOPERATION

International medical education bodies have played a key role in the quality assurance of medical education. The World Federation for Medical Education (WFME) has been particularly involved, and the Head of Education and Training acted as an external advisor on two WFME initiatives. This included work on the 2012 revision of the WFME Global Standards which form the basis of Council's undergraduate standards.

The US Department of Education's National Committee on Foreign Medical Education and Accreditation (NCFMEA) benchmarks the Medical Council's accreditation procedures as meeting the international best practice standards.

Regulatory bodies in other jurisdictions and all major EU medical education organisations e.g. ASME (Association for the Study of Medical Education), AMSE (Association of Medical Schools in Europe) and AMEE (Association for Medical Education in Europe) contributed to the accreditation process in 2012 via the assessor pool.

Involvement in the European Network of Medical Competent Authorities (ENMCA) in ensuring coherent application of EU requirements, in relation to the registration of medical practitioners in particular, provides commentary on proposed changes to EU directives/legislation.

Experts from other jurisdictions contributed to a number of Council events including the Symposium on Education and Training held in August 2012.

STRATEGIC OBJECTIVE 2: SUPPORT DOCTORS IN ATTAINING AND MAINTAINING THEIR REGISTRATION

ASSESSMENT OF APPLICATIONS

In 2012, 1,263 applicants were registered for the first time for entry to the Register of Medical Practitioners by the Medical Council. Of these, 652 applicants were from outside the European Area and require more complex assessment, including in some cases assessment of clinical knowledge and skill. While most applications are standard and can be assessed in line with usual procedures, the Registration Working Group continued to consider non-standard applications for registration across all divisions of the Register. Applications for registration to the Specialist Division continue to be received from applicants who do not benefit from automatic recognition, requiring review by the Postgraduate Training Bodies who provide assessments on applications to the Working Group. Work continues to be undertaken to streamline and strengthen Postgraduate Training Bodies' assessment of applications for Specialist Division registration. In addition, improvements to the procedures supporting requests for reviews of decisions made on applications for registration will enhance transparency and fairness for applicants.

ONGOING PUBLICATION OF THE REGISTER

The Council makes twice-daily updates from its Register to the website and as such, this is the most current version of the Register available. In 2012, there were 161,630 page views of the online register. If a member of the public wishes to obtain a copy of the Register, it can also be produced and provided to them in PDF format on request.

PRE-REGISTRATION EXAMINATION SYSTEM

The Medical Council requires all doctors to meet defined practice standards. Doctors who have qualified outside of the EU/EEA must pass or be exempt from the Council's Pre-Registration Examination System (PRES) if they wish to be registered but do not satisfy the criteria for other registration pathways. This examination is set at the level of medical school exit / intern year entry and includes a computer-delivered multiple choice questionnaire examination (Level 2) and a clinical examination (Level 3) using real clinical scenarios. In 2012 a total of 85 candidates sat the PRES Level 2 in various test centres. Two PRES Level 3 examinations were hosted by the Medical Schools on behalf of Council with a total of 62 candidates sitting this examination in 2012.

EXAMINATION FOR SUPERVISED DIVISION

The Examination for the Supervised Division, including an assessment of clinical skills (Level 2), continued in 2012. Open to non-EU doctors who had obtained a post in Ireland in General Internal Medicine, Surgery, Obstetrics and Gynaecology, Paediatrics, Psychiatry, Emergency Medicine, or Anaesthesia, this Intern exit level examination tests their competence in clinical judgement, communications, and data interpretation in their particular speciality. Two Level 2 Examinations for the Supervised Division were held, in May and December 2012, with successful candidates subsequently registered in the Supervised Division.

HIGHLIGHTS AND KEY ACTIVITIES CONTINUED

CRITERIA FOR SPECIALIST REGISTRATION

A review of Postgraduate Training Body processes regarding the assessment of applications to the Specialist Division was undertaken in 2011. This was conducted with a view to further streamlining processes to ensure robust, timely and fair assessment for applicants in line with EU/EEA legislation (EU Directive 2005/36/EC) and the MPA 2007. In 2012, work commenced with Postgraduate Training Bodies to implement improvement opportunities with a view to finalisation in 2013.

IMPROVEMENT OF THE ANNUAL RETENTION APPLICATION FORM PROCESS

This year saw the introduction of an improved process for retention for registration through the annual retention application form (ARAF). The improved process required practitioners to complete the ARAF on time in order to successfully apply for retention of registration. Application could be made online or in hard copy. This significant re-engineering of a key registration

process provided the Council with greater assurance in relation to those seeking re-registration. The ARAF Project had two stated objectives detailed below:

1. To assess the viability of ensuring 100% compliance with requirements for the completion of an annual declaration (or similar) be all practitioners seeking to be retained on the Register.

Achievement: Following detailed examination and legal advice, section 11 Rules were developed which supported the Council in seeking the completion of an application form for the purpose of maintaining registration with the Council.

2. To revise and/or develop business processes which will support the outcomes of Objective 1, which will bring the necessary rigor to retention processes.

Achievement: Business processes were developed which ensured that any practitioner seeking to maintain their registration completed an ARAF. Where practitioners sought to by-pass this requirement their registration was not renewed until such time as they completed an ARAF or were removed under section 79 provisions.

The achievement of 94.5% return of ARAFs (compared with return rates of around 55% for 2010 and 2011 retention declarations) indicated an effective strategy for engaging with a practitioner community who have limited interaction with the Council. Council now has greater surety about the rigor of the Register and moves annual retention from a financial transaction to a transaction requiring practitioners to review and affirm their fitness to remain on the register.

This process also provided:

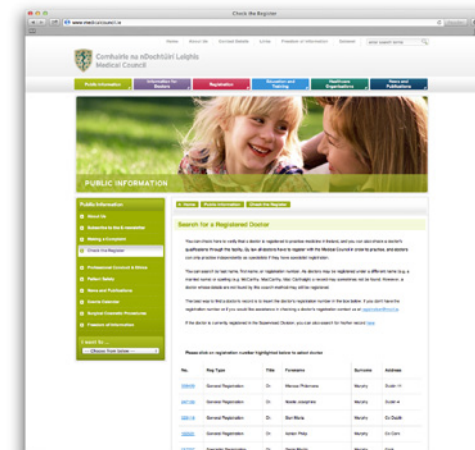
- confirmation of practitioners reporting on maintenance of professional competence and a basis for undertaking associated audits
- details regarding doctors on the register who may warrant investigation as to ongoing retention of registration, which provides a basis for managing risks associated with ongoing access to the register

The Council also introduced a late payment fee of €50 for failing to engage with the process within the timeframe set. Subsequently 856 doctors had the late fee imposed.

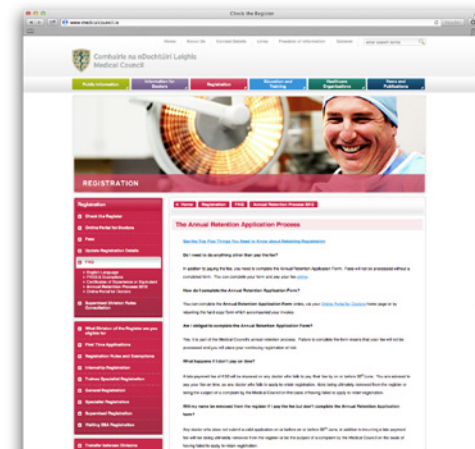
In 2012, 17,811 were issued a notice to retain registration, including the new ARAF and 17,259 retained registration with the Medical Council. The ARAF gathered detailed information about doctor's current practice which provides the Medical Council and other stakeholders with a picture of the medical profession in Ireland.

ONLINE PORTAL FOR DOCTORS

The **Online Portal for Doctors (OPD)** was made active in advance of the annual retention process. The OPD enables doctors who are registered with the Medical Council to maintain their registration through a dedicated online facility. The OPD also enables doctors seeking registration to make their application online. OPD was successfully established in 2012 and the Medical Council will now look to make greater use of OPD as a platform for engaging with doctors.



An index of registered doctors is kept on the Medical Council's website.
www.medicalcouncil.ie



Information on ARAF is available on the Medical Council's website.
www.medicalcouncil.ie

HIGHLIGHTS AND KEY ACTIVITIES

CONTINUED

ENGAGEMENT WITH STAKEHOLDER GROUPS

The Medical Council's establishment and maintenance of the Register is underpinned by European legislation. The Executive continues to attend a number of meetings with various national and EU Union fora relating to the EU Commission's proposed revision of EU Directive 2005/36/EC.

The primary focus of these meetings was the modernisation of this Directive which significantly impacts the manner in which applications for the Registration of doctors from EU/ EEA countries are assessed. The Directive establishes the basis for freedom of movement across many professions and the Council actively provided input into possible changes as part of its remit in protecting the public.

There were ongoing engagements with the HSE, Postgraduate Training Bodies and Medical Manpower Managers in relation to all relevant matters concerning registration. A particular focus in 2012 related to ongoing

utilisation of the Supervised Division by the HSE to ensure sufficient manpower planning within the Irish healthcare system.

As part of the Medical Council's process improvement initiatives a project relating to the assessment of applications to the Specialist Division from doctors (who do not fulfil the automatic recognition of qualifications requirements), the Registration Section undertook an active engagement with all Postgraduate Training Bodies to explore and develop improvements to this process. A draft agreement was subsequently provided to all Postgraduate Training Bodies with a view to finalisation in 2013.

STRATEGIC OBJECTIVE 3: SET AND MONITOR STANDARDS FOR MAINTENANCE OF PROFESSIONAL COMPETENCE

NEW PERFORMANCE PROCEDURES BECOME OPERATIONAL

Building on work in 2012 to design and develop new performance procedures, and following consultation and making of **Further Rules for the Maintenance of Professional Competence**, the Medical Council's new performance procedures became operational in 2012. These procedures provide for an assessment of a doctor's performance in practice in response to concerns about maintenance of professional competence. In many cases, these assessments will confirm that performance is satisfactory. In some cases, areas for improvement will be identified and the Medical Council has established arrangements to support doctors in pursuing improvement of their practice where this is required.



Comhairle na nDochtúirí Leighis
Medical Council

Professional Competence
Reaching for Improvement

NEW ARRANGEMENTS TO MONITOR AND AUDIT DOCTORS' MAINTENANCE OF PROFESSIONAL COMPETENCE

In June 2012, the Medical Council commenced its monitoring of doctors maintenance of professional competence through its annual retention application form. Doctors were asked to declare that they were maintaining professional competence in line with new legal requirements. These declarations were collated and in December 2012 the Medical Council selected 1,000 doctors to participate in audit wherein they were asked to submit evidence to support the declaration made earlier that year regarding maintenance of professional competence. This oversight of doctors' maintenance of professional competence will continue in 2013 and, where necessary, the Medical Council will continue to follow-up with individual doctors to ensure that professional competence is being maintained.

STRATEGIC OBJECTIVE 4: TAKE APPROPRIATE ACTION TO PROTECT THE PUBLIC WHERE STANDARDS ARE NOT MET BY INDIVIDUAL PRACTITIONERS

MANAGEMENT OF PRELIMINARY PROCEEDINGS COMMITTEE PPC FUNCTIONS

Following a review of the PPC processes and procedures, revised procedures for the processing of complaints received through the PPC were developed and approved by Council for publication in February 2012. These procedures are available on the **Medical Council website**.

As part of the review a requirement for additional investigative support for the PPC was also identified. Arising from this, a business case requesting the creation of six Case Officer posts was submitted and subsequently approved by the Department of Health. Case Officers were appointed to assist the PPC in the investigation of complaints and, in order to ensure the necessary skills to assist the PPC, a comprehensive training programme was developed by 2 Collaborate and McDowell Purcell Solicitors and has been accredited by the Chartered Institute of Arbitrators.

The training programme was carried out over a period of 9 months and was delivered by trainers from organisations such as 2 Collaborate, McDowell Purcell Solicitors, La Touche Training, the Rape Crisis Centre and Mental Health Reform. The Case Officers as part of the training programme completed assessments and assignments on each module and are required to maintain their Continued Professional Development (CPD).

HIGHLIGHTS AND KEY ACTIVITIES

CONTINUED

Complaints against registered doctors continued to be investigated in an efficient and transparent way by the PPC with management of approximately 35 new complaints per month in 2012 compared to 32 complaints in the previous year. A total of 423 new complaints were received in 2012, representing a 12% increase from 2011. The PPC made decisions in relation to 396 complaints and referred 56 complaints to the Fitness to Practise Committee (FTPC) for inquiry.

In 2012 the Medical Council developed an online complaints form which was made available **online** for download to facilitate easier accessibility to the public. The information available to the public was further enhanced particularly on **www.medicalcouncil.ie**. Videos, booklets and guidance regarding the complaints process can be accessed on the website and via YouTube. A list of patient support groups for members of the public was also made available and can be accessed **[here](#)**.

FITNESS TO PRACTISE INQUIRIES

The inquiry caseload continued to be managed by the FTPC which, during the course of 2012 completed 41 inquiries over 100 days (including one part-heard inquiry which, as at December 2012, had sat for 22 days of hearings and is estimated to last a further 6 to 7 days in 2013) and held 11 separate Call-over meetings to hear preliminary issues arising in respect of the inquiries.

Of the inquiries heard, 4 reports are waiting to go before Council for consideration in relation to sanction; 6 doctors have had conditions attached to their registration; 2 doctors had their registration cancelled; 4 doctors were suspended; 11 doctors received advice/admonishment/censure; 11 doctors were found not guilty and a further 14 provided undertakings to the FTPC.

The Medical Council first published **Indicative Sanctions Guidance** in May 2012. This document provides guidance on the principles used by the Fitness to Practise Committee/Medical Council when recommending or determining appropriate sanction(s). A summary of the sanctions imposed by the Medical Council arising from allegations found proven by the FTPC since the commencement of Parts 7, 8 and 9 of the Act is also provided within this guidance document.

A number of training programmes were delivered in 2012 for PPC, FTPC and Council members. These programmes provided additional training on the processes and procedures to be applied under Parts 7, 8 and 9 of the MPA 2007.

ETHICAL GUIDE

The Ethics Working Group completed a review of relationships between practising doctors and industry and the resulting **guidance** was published on the Medical Council website in October 2012. The guidance was issued electronically to all practising doctors, resulting in approximately 1,000 views in the 24 hours following publication.

HEALTH COMMITTEE

The **Health Committee** continued to provide advice to Council on matters relating to doctors with relevant medical disabilities. The underlying principle behind the establishment of this Committee is to monitor and support medical practitioners in maintaining their registration during illness and/or disability. A Relevant Medical Disability is defined at section 2 of the Medical Practitioners Act as a physical or mental disability of the practitioner (including addiction to alcohol or drugs) which may impair the practitioner's ability to practise medicine or a particular aspect thereof.

The Health Committee continued to offer its support and advice to doctors who were referred by Council, who provided undertakings to the FTPC (section 67), were referred by third parties or who self referred in 2012. As at December 2012, 35 doctors were availing of the Health Committee's support.

A review of this Committee was conducted and presented to Council in December 2012 arising from which it was agreed that a Memorandum of Understanding (MoU) would be developed between the Medical Council and the Sick Doctors Scheme. This MoU will enable enhanced engagement with doctors with health problems and a clear well publicised mechanism for referral of non-compliant doctors or those with potential misconduct issues to the Medical Council in 2013. This development will provide further support for doctors with health difficulties whilst preserving patient safety and the public interest.

MONITORING GROUP

The Monitoring Group continued to monitor doctors with conditions attached to their registration and to facilitate compliance with these conditions. As at December 2012 19 doctors were taking part in monitoring processes.

HIGHLIGHTS AND KEY ACTIVITIES

CONTINUED

STRENGTHENING INTERNATIONAL COOPERATION

The Medical Council is a member of the European Conference of the Orders of the Doctors (CEOM), established to promote the practice of high quality medicine respectful of patients' needs within the European Union and the European Free Trade Association. The Medical Council cooperates with other participating organisations on action that helps to develop quality standards and common positions in relation to medical ethics and professional conduct, medical regulation, movement of healthcare professionals and training.

The Medical Council continues to be a member of the Association of Regulatory and Disciplinary Lawyers to promote best practice on regulatory law. Council is a partner on the Health Professionals Crossing Borders, a European cooperative initiative and implements its "General Memorandum of Understanding Covering the Proactive and Case-by-Case Exchange of Disciplinary Information between Competent Authorities and Similar Bodies".

The Medical Council is registered with the EC Internal Market Information Systems (IMI) which helps member states co-operate in a standard way when dealing with requests for information between competent authorities. The IMI system also provides for the issuing of Certificates of Current Professional Status (CCPS) in a standardised format. We continue to share and learn best practice on medical regulation through our membership of the International Association of Medical Regulatory Authorities and collaboration with the International Physician Assessment Coalition and the Coalition for Physician Enhancement.

STRATEGIC OBJECTIVE 5: ENGAGE PROACTIVELY WITH THE PUBLIC, THE PROFESSION AND OTHER STAKEHOLDERS

COMMUNICATIONS STRATEGY 2012

The Communications Strategy for 2012 encompassing proactive engagement with the public, profession and other stakeholders was developed and implemented with strategic direction provided by the Communications and Research Group.

ONLINE

The Medical Council website, www.medicalcouncil.ie is the primary communications resource for the public, profession and stakeholders. There were approximately 450,000 visits to the website in 2012 which was continuously updated in line with the information needs of various audiences. The website contains information on the Council's work at strategic level, including business plans and summary minutes of Council meetings, in addition

to information on the Council's operational level activities. Information on registration requirements and verification of a doctor's registration status was the most popular site content in 2012. To improve engagement with the website, a number of interactive user-guides were created to make it easier for users to complete **registration** tasks and also to assist members of the public should they need to **make a complaint** about a doctor. Continued monitoring of website visits was conducted to assess areas where website content could be updated and improved.

A Medical Council conference on the subject of professionalism was held in the Royal Hospital Kilmainham and streamed live on the Medical Council website. In addition to 150 delegates attending the main conference event a number of delegates watched the event online, with over 100 delegates interacting with the Council website during the conference by scanning a Quick Response bar code, on conference packs via their smart phone. A programme of four interactive **workshops** on topics such as clinical audit, professional performance, doctors' health and management of complaint also featured as part of the conference.

The Medical Council issued four E-newsletters in 2012 covering a range of different themes relevant to the profession including Council's new rules governing the annual retention process, professional competence audit procedures, and the Council's Education and Training Symposium. The opening rate of the newsletter was 58%, which compares favourably to other organisations, as on average just 10% of newsletters achieve in excess of 51% opening rates.¹ Our E-newsletters are available to view on the Medical Council **website**.

RESEARCH

The Council engaged in research during 2012 to assist in explaining various aspects of its role and also gain a more detailed understanding of its audiences.

A survey to assess **Public Awareness and Confidence** in the medical profession was published in October 2012. This research found that doctors remained the most trusted profession in Ireland, while over 90% of those surveyed were satisfied with the performance of their doctor.

Research undertaken as part of the annual retention of registration process found that 93% of doctors registered with the Council had practised medicine in the past 12 months, with 75% working solely in the Republic of Ireland, 15% working outside of the Republic of Ireland and 10% working both in Ireland and abroad.

¹ Email Marketing Insight 2012/ 2013 (p15). Accessible at: <http://www.mii.ie/uploads/email-marketing/email-marketing-insight-2012.pdf>

HIGHLIGHTS AND KEY ACTIVITIES

CONTINUED

The Council is committed to undertaking research projects to inform the development of procedures and communications activities, and further research projects will be published in 2013.

MEDIA

The Medical Council encouraged regular media coverage throughout the year by responding in a timely manner to queries and issuing relevant press releases.

The Medical Council continued its commitment to facilitating learnings from public fitness to practise inquiries by providing updates on forthcoming inquiries for the media and general public to attend, while also presenting case studies in newsletters aimed at the medical profession. Interviews were secured in the national press and broadcast media on areas such as the introduction of performance procedures, guidance on the relationship between doctors and industry, complaints and inquiry statistics and public trust in the medical profession.

PUBLICATIONS

The Council developed a range of publications in 2012. In addition to the Council's first on-line and interactive **Annual Report**, the annual business plan, revised PPC procedures and guidance to the profession on relationships between doctors and industry were published to highlight the most important information for the respective audiences. All Council publications in 2012 are accessible via the Medical Council **website**.

The Medical Council continued to be involved in a group established by the Ombudsman's Office to assist in the development of a website, **Healthcomplaints**. Aimed at members of the public, this website provides guidance on how to make a complaint/raise a concern about health and social care services in Ireland.

STRENGTHENING COMMUNICATION AND COLLABORATION WITHIN THE HEALTH SYSTEM

The Medical Council was proactive in 2012 in communicating with a number of key stakeholder groups, representing patients, doctors, employers and other relevant organisations within the health system. These interactions continued to be monitored and their value measured thereby setting a path for continued development of the ways in which we engage with these audiences in 2013.

Members of Council and the Executive continued to communicate with advocacy groups, regulatory bodies and other organisations on areas of shared interest.



Pictured at the RHK conference (left to right): Prof. Martin Roland, Dr. Richard Brennan, Dr. Ide Delargy, Prof. Kieran Murphy, Dr. David O'Keeffe, Prof. John Jenkins.



Pictured at the RHK conference (left to right): Mr. Niall Dickson, Prof. Kieran Murphy, Ms. Caroline Spillane, Dr. Ambrose McLoughlin, Mr. Philip Pigou.

HIGHLIGHTS AND KEY ACTIVITIES

CONTINUED

Presentations were delivered to a variety of groups and organisations over the year, including medical students, patient representative groups, employers and Medical Manpower Managers, to illustrate the work of the Council.

The Tripartite group (Medical Council, HSE and Forum of Postgraduate Training Bodies) continued to meet in 2012 to discuss issues of mutual interest and solutions to these issues were implemented where appropriate.

The Council's A/Director of Regulation & Legal Advisor is a member of the Irish Medicines Board's (IMB) Consultative Panel on the Legal Classification of Medicines which was established to assist the IMB in their review of licensing of prescription only or over the counter medicines.

The Medical Council's CEO is a member of a Working Group on Retention of Medical Talent in Ireland, led by the Forum of Postgraduate Medical Training Bodies and the Advisory Group to the Minister for Health on the development of a new Specialist Grade.

ENGAGEMENTS WITH ELECTED REPRESENTATIVES

Engagement with elected representatives is important in raising public awareness of the Council's role in protecting the public. The Council responded to numerous queries from elected representatives on behalf of constituents over a range of issues, from the registration of doctors to the complaints and inquiry process.

STRATEGIC OBJECTIVE 6: ENABLE EFFECTIVENESS THROUGH APPROPRIATE AND EFFICIENT INTERNAL SYSTEMS AND PROCESSES

COUNCIL PROCESSES

Council members continued to receive Council documentation electronically realising savings in both cost and human resources. Additional ICT functionality was introduced whilst maintaining the security of this sensitive and confidential documentation via use of a secure extranet system. This electronic document management system was expanded in 2012 and rolled out to other Committees and Working Groups.

BUSINESS PLANNING

The Business Plan for 2012 was developed by the Executive and approved by the Council on 26th January 2012. The Medical Council's Balanced Scorecard set out the organisation's key objectives, targets and timescales over four quadrants, representing the main areas of the Medical Council's corporate focus and performance namely: Relationships with Stakeholders

(public, profession and other stakeholders), Regulatory Systems and Processes, People (staff and Council) and Arrangements for Financial and Corporate Management.

Use of this scorecard, which provided both the Medical Council and its external stakeholders with a clear and straightforward mechanism for measuring the organisation's performance in areas of greatest strategic importance, was incorporated into the CEO's report to Council in the latter half of 2012 to streamline our reporting processes.

The Business and Risk Management Plan for 2013 was prepared in Q4 2012 for approval by Council in January 2013. An online survey process enabled the organisation to gather feedback from the Executive at Directorate and Sectional levels, from which the development of the Business and Risk Management Plan for 2013 arose. This collaborative approach has encouraged members of staff to engage further in the process and to develop awareness of the organisation as a whole.

RISK MANAGEMENT

A Risk Management Framework was developed in 2011 to identify and plan for issues that may impact on the successful delivery of the Medical Council's strategic and operational objectives. An independent review of this framework was conducted in Q3 2012 with positive findings reported to Council, commending the current risk management procedures and processes. With risk management featuring as a key item for both the Council and Executive it remains a standing item on all meeting agendas. In order to further embed risk management within the Council it was recommended that risk reporting and

management be incorporated into the business planning process going forward and this has been implemented for the 2013 plan.

CORPORATE GOVERNANCE

In line with best practice in corporate governance a developmental day for Council members took place on 12th December 2012 at which topics including risk management, strategy and legislative requirements were discussed. The information arising from this will be incorporated into the planning process for the new Statement of Strategy 2014-2018 and this new Term of Office. The Professional Standards Section continued to provide legal advice to Council and the organisation on all matters relating to the Council's statutory functions, obligations and duties and on powers under the 2007 Act.

INTERNAL AUDIT

The Medical Council is fully committed to maintaining effective financial management and reporting. This is ensured through the operation of an internal audit function. Due to the size of the organisation this function is appropriately outsourced, with two internal audits conducted in 2012 focusing on the ICT function and a comprehensive review of internal financial controls.

In addition to these internal audits a comprehensive review of financial controls and procedures was carried out. Other sections within the Directorate were also reviewed to identify areas for process improvement and realisation of further efficiencies i.e. ICT and Human Resources.

HIGHLIGHTS AND KEY ACTIVITIES

CONTINUED

REVENUE

The target of 3.33% diversity of revenue streams was exceeded in 2011 and achievement of the figure of 2.5% for 2012 is on target with income from the accreditation process of Undergraduate Bodies and Programmes, aspirant specialties and investment income continuing to provide revenue. The successful letting of the Medical Council's premises at Lynn House, Rathmines also provided an additional income stream in 2012. A medium term financial plan, developed in 2011 to map the Medical Council's financial structure enabling better planning in line with best practice, continued to provide strong direction in this area. The budget for 2013 was prepared in late 2012 and will be presented to Council by the Audit Committee in January 2013.

HUMAN RESOURCES

Following the establishment of an internal HR function in 2011 a number of HR initiatives were developed including the Performance Management Development System (PMDS) which was rolled out to all staff in January 2012. Interim reviews were conducted mid-year and the end of year reviews are taking place from January 2013. Following completion of the PMDS reviews an analysis will be conducted to inform an organisational Training and Development plan for 2013.

In line with the Croke Park Agreement and its directions a number of specific HR initiatives were implemented:

- a staff mobility policy continued to be part of the Council's HR programme in 2012 and was implemented across the organisation where resource requirements were identified and redeployment within equivalent grades was feasible.
- a repeat Staff Satisfaction Survey was conducted in 2012, in line with the HR strand of internal communications and the strategic objective of focusing on individuals' welfare and work-life balance, with a 4.8% satisfaction increase across the organisation. Feedback arising from this survey will be further assessed through a series of staff workshops in early 2013 and a repeat survey will be also conducted in 2013.

INTERNAL COMMUNICATIONS

The Internal Communications Group established in 2011, with membership from a representative sample from all Sections of the organisation, continued to provide valuable recommendations for improvements in internal communications.

ICT SYSTEMS

Implementation of the On-line Portal for Doctors (OPD) was completed in Q1 2012. This was a significant milestone towards creating efficiencies for the Medical Council and its stakeholders in automating labour-intensive processes by facilitating a number of on-line processes including those for applications for retention of registration, change of addresses and fee payments. An upgrade of operating systems on core servers to continue to meet business requirements was completed in addition to the implementation of Documatics Legal Evolve Case Management software, which included an electronic brief creation functionality to support the Preliminary Proceedings function.

The in-house design and deployment of a new network and e-mail infrastructure produced a robust, modern platform to serve the Council into the future whilst making considerable savings through utilising existing resources to their fullest.

DISASTER RECOVERY AND BUSINESS CONTINUITY

After consultation with all Sections of the organisation, a comprehensive Disaster Recovery and Business Continuity Plan was developed, the recommendations from which were implemented in 2012. Planning for disaster is essential in ensuring that the continuity of business is attained in circumstances outside of normal occurrences i.e. flooding, ICT systems failure, breach of security and this plan has been developed to mitigate against any such disasters and ensure business continuity.

PROCUREMENT

The Medical Council is committed to meeting its obligations under the National Public Procurement Policy Framework. A number of procurement related initiatives were conducted in 2012 with a view to heightening procurement awareness and achieving value for money in all purchases of goods and services.

A number of significant tender processes were completed in 2012 including provision of an on-line strategy for Website development, Stenography and Learning and Development services. The Council has also successfully signed up to a number of National Procurement Service framework agreements.



COMHAIRLE NA NDOCHTÚIRÍ LEIGHIS
MEDICAL COUNCIL

THE MEDICAL COUNCIL EXECUTIVE

The Executive functions of the Medical Council are organised under three Directorates which, together with the Office of the CEO, work collaboratively to manage the day-to-day affairs and operations of the organisation. The Office of the CEO incorporates the Council's Communications and Strategy Unit.

The Medical Council staff work in the seven sections of the Executive, each of which is led by a Head of Section. The Chief Executive Officer is appointed to manage and co-ordinate the administration and business of the Council and to perform any other functions that may be delegated by the Council. The CEO is responsible for the day-to-day activities of the Council with the assistance of a management team comprised of the Directors and Heads of Section (Registration, Professional Standards, Education & Training, Professional Competence, Finance, Operations & ICT and the Secretary to Council & Head of Corporate Services).



Ms Caroline Spillane
Chief Executive Officer



Mr Marcus Balfe
A/Director of Finance and Administration



Mr William Kennedy
Legal Advisor & A/Director of Regulation



Dr Paul Kavanagh
Director of Professional Development and Practice



Dr Anne Keane
Head of Education & Training



Mr Philip Brady
Head of Registration



Ms Lisa Molloy
Secretary to Council and Head of Corporate Services & HR



Mr Jim McDermott
Head of Operations & ICT

CEO'S OFFICE AND COMMUNICATIONS

The Office of the CEO incorporates the Council's Communications Unit.

CEO'S OFFICE AND COMMUNICATIONS

CEO:

Caroline Spillane

Communications Manager

Lorna Farren

Executive Officer:

Barbara O'Neill

Clerical Officer:

Jana Tumova, Lisa Flynn*
(maternity cover from November 2012)*

THE MAIN DUTIES OF THE CEO INCLUDE:

- managing and controlling the administration of the Council and the business of the Council
- maintaining a dialogue with the President on important and strategic issues
- ensuring that the Council has timely and accurate information to fulfil its statutory objectives and functions
- working with the President to develop the Medical Council's strategy and overall objectives
- implementing the Medical Council's annual business and corporate plans
- advising the Council on legal/statutory/procedural issues pertaining to the Council's statutory responsibilities
- ensuring that risk identification, measurement and mitigation strategies are in place
- the effective administration of the Council including ensuring that an appropriate organisational structure is in place and is adequately resourced
- representing the Council in public when so required
- approving, in consultation with the President, decisions to respond to cases brought to the courts under the MPA 2007
- presentation of evidence at the Fitness to Practise Committee.

In line with the strategic objective of proactive engagement with the public, profession and other stakeholders, the Communications function has responsibility for the development and implementation of comprehensive strategies for engagements with these three groups. Arising from this objective, the function coordinates and manages all aspects of Medical Council communications including: overseeing communications with the public, profession and other stakeholders, the development of messaging for use in media relations work, the development of the Medical Council website and various publications, managing media relations and public affairs on behalf of the Council, President and CEO, and advising on the development of materials for internal and external communications.

COMMUNICATIONS AND RESEARCH GROUP

The Communications and Research Group, chaired by the CEO, meets on a weekly basis to assess internal and external strategic communications with the public, profession and other groups, including media relations and public affairs.

NOMINATIONS SUB-COMMITTEE (NSC) - PROFESSOR KIERAN MURPHY, CHAIR

The role of the Nominations Sub-Committee is to ratify appropriate individuals, not being members of Council or Council staff, for membership to Council Committees and Working Groups. When ratified by the Nominations Sub-Committee, the names will be put before Council for approval and then recorded in the Council minutes.

DIRECTORATE OF FINANCE AND ADMINISTRATION

The Directorate of Finance and Administration was established in 2012 and provides cross-organisational support to ensure the effective and efficient implementation of objectives of the Council. The Directorate incorporates the functions: Financial Planning and Management; Human Resources Management; ICT; Corporate Affairs and Operations and is chiefly concerned with key areas such as Risk Management, compliance with statutory reporting in addition to legislative and governance requirements and responsibilities. The Directorate is led by the A/ Director of Finance and Administration and has three main Sections: Finance, Corporate Services & Human Resources and ICT & Operations.

FINANCE SECTION

A/Director and Head of Finance:
Marcus Balfe

Senior Executive Officers:
Bred Foster, Philip Beattie

Executive Officer:
Cilla Hickey

Clerical Officers:
Clare Naidoo

CORPORATE SERVICES & HUMAN RESOURCES SECTION

Head of Section & Secretary to Council:
Lisa Molloy

Senior Executive Officers:
Ciara McMorrow, Jan Fitzpatrick

Clerical Officers:
Claire Lako, Emma Duffy,
Theresa McGuinness

OPERATIONS & ICT SECTION

Head of Section:
Jim McDermott

Executive Officers:
Davinia O'Donnell, John Cussen

Services Officer:
Derek O'Connor

FINANCE

In line with the strategic objective of optimising the use of Medical Council resources, the Finance Section is responsible for the management of the finances of the Medical Council in a prudent and efficient manner, ensuring that the Council fulfils its legislative requirements and applies best practice to the governance of its financial affairs, maintaining appropriate levels of reserves, managing exposure to risk and diversifying the Council's revenue streams.

The Director of Finance and Administration carries out the additional role of Chief Risk Officer (CRO). The management of risk is a key focus for the Medical Council and the CRO holds responsibility for managing this in accordance with the Risk Management Framework, reporting as appropriate to the Audit Committee and Council.

FINANCE-RELATED COMMITTEES AND WORKING GROUPS:

AUDIT COMMITTEE (AC) - PROFESSOR DAMIEN MCLOUGHLIN, CHAIR

The Medical Council has an Audit Committee which is responsible for providing a framework for accountability; for examining and reviewing all systems and methods of control both financial and otherwise including risk analysis and risk management; and for ensuring the Medical Council is complying with all aspects of the law, relevant regulations and good practice. The external auditor meets periodically with the Committee to brief them on the outcome of the external audit. The Medical Council's internal auditor conducts annual reviews of internal financial controls.

REMUNERATION WORKING GROUP (RemWG) - MRS ANNE CARRIGY, CHAIR

The Remuneration Working Group reports to the Audit Committee. This Working Group meets when required to review matters relating to the remuneration of Council members and the CEO and to make recommendations to the Audit Committee.

CORPORATE SERVICES AND HUMAN RESOURCES

The Corporate Services and HR Section, as led by the Head of Corporate Services & HR and Secretary to Council, provides support to the achievement of strategic and operational objectives by enabling effectiveness through appropriate and efficient internal systems and processes. This support includes liaison and meeting support to Council, with 8 scheduled and 4 extraordinary meetings taking place in 2012. The provision of documentation to Council in an electronic format continued in 2012 with the initiative expanded to encompass a number of Council Committees and Working Groups.

The Section also is responsible for advising on and ensuring compliance with legislative and corporate governance requirements, managing the **Freedom of Information** function, managing corporate events for the Council and co-ordinating and managing corporate **publications** such as the Annual Report and Business Plans.

DIRECTORATE OF FINANCE AND ADMINISTRATION CONTINUED

In accordance with the objective to ensure a focus on excellence in people management and personal development, the HR function continues to implement policies and procedures in line with the HR Strategy as well as maintaining a focus on the development of staff. The Reception function was incorporated into Corporate Services & Human Resources in 2012. Following a review of this function the staffing arrangements were streamlined and, in line with the Council's mobility policy, a team was identified and trained to provide support and cover for this customer-facing position.

OPERATIONS AND ICT

The Operations & ICT function is focused on enabling the Council to achieve one of its key Strategic Objectives to "Enable effectiveness through appropriate and efficient internal systems and processes". Operations and ICT continuously monitor and review internal systems and processes in order to implement appropriate information and

communication technologies (ICT) to support the ever-expanding operations of the Council. This Section focuses on the delivery of technology, operations and services which best support business needs within the Council.

Key areas of focus for this Section also include strategic procurement, contract management and projects to create efficiencies for the Medical Council.

OPERATIONS AND ICT RELATED COMMITTEES AND WORKING GROUPS:

ICT SUB-COMMITTEE (ICTSC) - MS EILEEN FITZGERALD AND MR JEAN-CHRISTOPHE DISPLAT ON A ROTATIONAL BASIS, CHAIR

The ICT Sub-Committee was established in March 2011 and provides advice and guidance to the Audit Committee on matters relating to the governance of ICT, in particular with regard to ICT budgets, the monitoring of ICT delivery on projects and performance of day to day or operational activities.

DIRECTORATE OF REGULATION

The Directorate of Regulation was established in 2012 to incorporate the work of the Professional Standards Section and the enhanced Complaints remit. In line with the strategic objective of taking appropriate action to protect the public where standards are not met by individual doctors, the Professional Standards Section has responsibility for the handling of complaints against registered medical practitioners in a timely and transparent manner; corresponding with complainants and doctors about whom complaints have been made; organising, supporting and facilitating Fitness to Practise Committee inquiries concerning allegations of professional misconduct, poor professional performance and/ or relevant medical disability of doctors; drafting guidelines and carrying out investigations. In carrying out its functions, this Directorate supports the work of the Preliminary Proceedings Committee (PPC) and the Fitness to Practise Committee (FTPC).

In addition to the work of the PPC and the FTPC the Directorate supports the Health Committee and the Monitoring and Ethics Working Groups. The Directorate supports and advises the Medical Council on its functions, obligations and powers under the MPA 2007.

PROFESSIONAL STANDARDS SECTION

A/ Director and Head of Section:
William Kennedy

Senior Executive Officers:
John Sidebottom, Finola O'Dwyer (Solicitor)

Executive Officer:
Jane Horan

Case Officers:
Roslyn Whelan, Ruth Thompson, Robert McGrattan, Elva Tarpey, Rebecca Lonsdale

PROFESSIONAL STANDARDS-RELATED COMMITTEES AND WORKING GROUPS:

PRELIMINARY PROCEEDINGS COMMITTEE (PPC) - MR FRANK MCMANUS, CHAIR

The Preliminary Proceedings Committee was established pursuant to section 20 of the Medical Practitioners Act 2007 'to give initial consideration to complaints' against registered doctors and can provide an opinion to Council that:-

- there is no further action to be taken in relation to a complaint
 - the complaint be referred to another body or authority
 - the complaint be referred to a professional competence scheme
 - the complaint, with the consent of the parties, be resolved by mediation
- or
- Refer complaints to the Fitness to Practise Committee for inquiry

A total of 423 complaints were received in 2012.

FITNESS TO PRACTISE COMMITTEE (FTPC) - DR DANIEL O'HARE, CHAIR

Inquiries are heard by a Fitness to Practise "Panel" which is made up of three members of the Fitness to Practise Committee, two non-medical people and one doctor. The Chairperson of the Inquiry Panel is a member of the Medical Council and is responsible for making sure that the inquiry is conducted in accordance with fair procedures. In order to ensure effective and efficient case management the FTPC holds regular "Callover meetings" where dates are fixed for inquiries and any preliminary applications can be made (i.e. for the inquiry to be held in private or public).

HEALTH COMMITTEE (HC) - DR RICHARD BRENNAN, CHAIR

The Health Committee was established by Council under section 20 of the Act to support doctors with relevant medical disabilities and those who have provided undertakings to the FTPC to undergo medical treatment. The HC also addresses issues that are referred by the Standards in Practice Committee.

ETHICS WORKING GROUP (EWG) - DR DEIRDRE MADDEN, CHAIR

The EWG develops guidance to the profession on all matters relating to professional conduct and behaviour and has continued to progress further work on ethical issues which require additional consideration in collaboration with other relevant stakeholders. Please [click here](#) to read the Medical Councils' Guide to Professional Conduct and Ethics for Registered Medical Practitioners.

MONITORING WORKING GROUP (MWG) - MS MARY CULLITON, CHAIR

The Monitoring Working Group's primary function is to monitor a doctor's compliance with conditions attached to their registration following sanction by the Medical Council.

For more information on Professional Standards and on making a complaint about a doctor please click [here](#).

DIRECTORATE OF PROFESSIONAL DEVELOPMENT AND PRACTICE

The Directorate of Professional Development and Practice manages Medical Council operations which are mapped against the career of a doctor from when a medical student first enters university until the time when a doctor retires from practice and are designed to develop and ensure good professional practice among doctors. The Directorate, led by a Director of Professional Development and Practice, was established in 2012 to incorporate the functions of Registration, Education & Training, and Professional Competence. The work of this Directorate is concerned with ensuring that medical education and training is in line with the highest international standards, that the Register of Medical Practitioners is robust and provides assurance to the public of a doctor's good standing and that doctors are supported to maintain their professional competence throughout their career.

REGISTRATION SECTION

Head of Registration:

Philip Brady

Senior Executive Officers:

Ann Curran, Eoin Keehan

Executive Officers:

Alan Armstrong, Katie Charmant, David Griffith, Jessica Wu, Mary Atkinson, Fiona Waters, Sarah Lowther

Clerical Officers:

Teresa Byrne, Donagh O'Doherty, Nicola Hodgkinson, Deirdre Brennan, Moya Farrell* (*Maternity Cover from September)

EDUCATION AND TRAINING SECTION

Head of Education and Training:

Anne Keane

Senior Executive Officers:

Karen Willis, Paul Lyons

Executive Officers:

Elizabeth Molloy, Emmet Murray, Aoife Fitzsimons, Aoise O'Reilly (commenced August 2012), Ruth Thompson (until June 2012)

Clerical Officer:

Rebecca Lonsdale (until July 2012)

PROFESSIONAL COMPETENCE SECTION

Director and Head of Section:

Paul Kavanagh

Senior Executive Officer:

Fergal McNally

Executive Officers:

Gráinne Behan, Anne Jensen

Clerical Officer:

Maureen Bradley-Vardy, Barbara Shirto

REGISTRATION

The Registration Section supports the Council's functions in supporting doctors in attaining and maintaining their registration on the appropriate division of the Register of Medical Practitioners. This function includes the processing of applications for general, specialist, trainee specialist, supervised, visiting EEA and internship registration; implementation of policies and decisions set by the Registration Working Group and the Standards in Practice Committee; maintenance of the Register and assisting with registration related queries.

REGISTRATION-RELATED COMMITTEES AND WORKING GROUPS:

STANDARDS IN PRACTICE COMMITTEE (SIPC) - PROFESSOR GERARD BURY (CHAIR)

The SIPC is responsible for setting standards in respect of the registration, practice and assessment of registered doctors to include issues relating to the health, remediation and professional competence assessment of individuals.

REGISTRATION WORKING GROUP (RWG) - DR ANNA CLARKE (CHAIR)

The role of the RWG is to set the standards for the registration of individual registered doctors, report to and make recommendations to the Standards in Practice Committee where appropriate.

For more information on Registration, please click [here](#).

DIRECTORATE OF
PROFESSIONAL
DEVELOPMENT AND
PRACTICE
CONTINUED

EDUCATION AND TRAINING

The main function of the Education and Training Section is to support Council's role in setting and monitoring standards in undergraduate, intern and postgraduate education and training in Ireland. This includes producing rules, standards, criteria and guidelines; accrediting medical schools, their programmes and their clinical training sites; ensuring high standards of training during internship; accrediting postgraduate bodies and programmes; determining which medical specialties should be recognised; and monitoring activity on an ongoing basis to ensure that standards are adhered to and where possible enhanced. The Section also manages the examinations of doctors' knowledge and clinical skills that are applied by the Council.

EDUCATION AND TRAINING-RELATED COMMITTEES AND SUB-COMMITTEES THAT REPORT TO PDC:

Education and Training issues are considered by the Professional Development Committee (PDC); its sub-committees are the Intern Training Sub-Committee (ITSC), Setting Standards Sub-Committee (SSSC), Monitoring Standards Sub-Committee (MSSC) and the Examinations Sub-Committee (ESC).

PROFESSIONAL DEVELOPMENT COMMITTEE (PDC)

The PDC advises Council on medical education and training policies and issues. It strives to ensure and enhance the quality of medical education and training through the development of rules, standards, criteria and guidelines that form the framework for the regulation of education and training. It oversees Council's quality assurance role, assessing the delivery of education and training by medical schools, postgraduate training bodies and clinical training sites. An important part of this quality assurance role is the evaluation, inspection and where appropriate approval of medical schools, postgraduate training bodies and clinical training sites. These functions are undertaken by teams mandated by the Medical Council to undertake this assessment activity.

STANDARD SETTING SUB-COMMITTEE (SSSC)

The primary focus of the SSSC is to ensure that criteria, standards and guidelines for medical education and training are up to date, and that new standards are developed. In common with all the PDC Sub-Committees, it includes medical education and training experts. The voice of patients is also represented on the SSSC.

STANDARD MONITORING SUB-COMMITTEE (SMSC)

The primary focus of the SMSC is to oversee the work of ensuring that criteria, standards and guidelines are being implemented. Like the SSSC, the SMSC remit applies across the spectrum of the training pathway of undergraduate, intern and postgraduate education and training.

INTERN TRAINING SUB-COMMITTEE (ITSC)

The ITSC is the focal point for the development of intern training criteria, standards and guidelines as required by section 88(3) of the Medical Practitioners Act 2007 (MPA). Membership includes the key stakeholders: medical school deans, postgraduate medical training bodies, trainees, a patient advocate, and the Health Service Executive.

EXAMINATION SUB-COMMITTEE (ESC)

The ESC is the focal point for the review and development of the Council's examinations that test doctors' knowledge and clinical skills: the Pre-Registration Examination and the Examination for the Supervised Division. The ESC advises PDC on examination standards and acts as the Examinations Board that considers and verifies results. This Sub-Committee encompasses the previous remits of both previous groups, the Pre-Registration Examination System Sub-Committee and the Examination for the Supervised Division Working Group.

For more information on Professional Development and Education and Training, please click [here](#).

DIRECTORATE OF
PROFESSIONAL
DEVELOPMENT AND
PRACTICE
CONTINUED

PROFESSIONAL COMPETENCE

The Professional Competence Section is responsible for developing and implementing a system for the regulation of the maintenance of professional competence in line with Council policy. This will be achieved through establishing, operating and monitoring schemes for the maintenance of professional competence applicable to all registered doctors and schemes for the assessment of professional performance in response to specific concerns regarding individual registered doctors.

PROFESSIONAL COMPETENCE- RELATED COMMITTEES AND WORKING GROUPS:

PROFESSIONAL COMPETENCE COMMITTEE (PCC)-DR DAVID O'KEEFFE (CHAIR)

The PCC directs and oversees the Council's duties under Part 11 of the Medical Practitioners Act 2007 (MPA2007) – Maintenance of Professional Competence.

ASSESSOR SUB-COMMITTEE (ASC)

The ASC comprises medical and non-medical assessors who have been selected, trained and nominated to conduct performance assessments and produce reports for the consideration of the PCC.

For more information on Professional Competence, assessment and related schemes, please click [here](#).



FINANCIAL STATEMENTS
FOR THE YEAR ENDED
31ST DECEMBER 2012

COUNCIL MEMBERS AND OTHER INFORMATION

PRESIDENT

Professor Kieran Murphy

VICE PRESIDENT

Dr Anna Clarke

CHIEF EXECUTIVE OFFICER

Ms Caroline Spillane

COUNCIL

Professor Kieran Murphy

Mr Brendan Broderick

Professor Gerard Bury

Dr Regina Connolly

Professor Anthony Cunningham*

Dr Pauline Kane

Dr Deirdre Madden

Professor Damien McLoughlin

Dr John Monaghan

Ms Marie Murray

Dr Daniel O'Hare

Dr John O'Mullane

Dr Anna Clarke

Dr Richard Brennan

Ms Katharine Bulbulia

Ms Anne Carrigy

Ms Mary Culliton

Ms Marie Kehoe O'Sullivan

Mr Frank McManus

Ms Margaret Murphy

Professor Diarmuid O'Donoghue

Dr David O'Keeffe

Professor William Powderly**

Dr Michael Ryan

* Resigned January 2012

** Resigned December 2012

The current term of office for the Medical Council began on 3rd July 2008 when the 7th Council took office.

OFFICES

Kingram House
Kingram Place
Dublin 2

AUDITORS

Comptroller & Auditor General
Dublin Castle
Dublin 2

BANKERS

Bank of Ireland
Rathmines Road
Rathmines
Dublin 6

SOLICITORS

McDowell Purcell
The Capel Building
Mary's Abbey
Dublin 7

FINANCIAL STATEMENTS FOR THE YEAR ENDED 31ST DECEMBER 2012

CONTINUED

COUNCIL'S REPORT

The Council present their report and the audited financial statements for the year ended 31st December 2012.

PRINCIPAL ACTIVITY

The Medical Council is the statutory body for the registration and regulation of doctors engaged in medical practice.

The primary objective of Council is to protect the public by promoting and better ensuring high standards of professional conduct and professional education, training and competence among registered medical practitioners.

Established by the Medical Practitioners Act 1978 (updated in 2007), the principal functions of the Medical Council include:

- Establishing and maintaining the register of medical practitioners;
- Approving and reviewing programmes of education and training necessary for the purposes of registration and continued registration;
- Specifying and reviewing the standards required for the purpose of the maintenance of professional competence of registered medical practitioners;
- Specifying standards of practice for registered medical practitioners including providing guidance on all matters related to professional conduct and ethics;
- Disciplinary procedures.

The Council has a membership of 25 including both elected and appointed members. Under the provisions of the Medical Practitioners Act 2007, the Council is comprised of 13 non-medical members and 12 medical members representing a range of medical specialties, teaching bodies and members of the public and stakeholders, all of whose appointments have been approved by the Minister for Health. The current Council's period of office is 2008 to 2013. The Medical Council is funded exclusively by the annual payments of registered doctors; no funds are received from government or other sources.

REVIEW OF DEVELOPMENTS IN THE YEAR

2012 was another very busy and challenging year for the Medical Council. The Business Plan 2013 was prepared in Q4 2012 and sets out in detail the objectives of the Medical Council for the coming year. This plan was approved by Council in January 2013 for submission to the Department of Health in accordance with Section 15 of the Medical Practitioners Act 2007.

Other significant developments during the year were as follows:

- The Medical Council launched its Annual Report for 2012 online, encompassing the key developments for the previous year in addition to statistical data.
- The newly developed Performance Management Development System (PMDS) was initiated and was fully operational by the end of January 2012.

- A Risk Management Framework was developed in 2011 to identify and plan for issues that may impact on the successful delivery of the Medical Council's strategic and operational objectives. An independent review of the Risk Management process was conducted in Q3 2012 with positive findings reported to Council. The framework was commended by the independent review body.
- The Council received 423 complaints in 2012, representing a 12% increase from 2011. The PPC made decisions in relation to 396 complaints and referred 56 complaints to the Fitness to Practise Committee (FTPC) for inquiry.
- The Online Portal for Doctors (OPD) was successfully established in 2012 and made active in advance of the annual retention process, enabling doctors who are registered with the Medical Council to maintain their registration through a dedicated online facility.

COUNCIL MEMBERS

The 7th Council took office in July 2008. The membership of the Council is set out above.

The Council comprises of 25 members, appointed in accordance with Section 7 (1) to (8) of the Medical Practitioners Act 2007.

FINANCIAL STATEMENTS
FOR THE YEAR ENDED
31ST DECEMBER 2012
CONTINUED

FUTURE DEVELOPMENTS

The Council is sincere in maintaining and developing the core strategies and objectives of the Statement of Strategy 2010-2013.

Strategic Objective 1:

Set and monitor standards for medical education, training, conduct and ethics

Strategic Objective 2:

Support doctors in attaining and maintaining their registration

Strategic Objective 3:

Set and monitor standards for maintenance of professional competence

Strategic Objective 4:

Take appropriate action to protect the public where standards are not met by individual practitioners

Strategic Objective 5:

Engage proactively with the public, the profession and other stakeholders

Strategic Objective 6:

Enable effectiveness through appropriate and efficient internal systems and processes

INTERNAL AUDIT

Council has an internal audit function which it outsources to D'Arcy Lynch Partners, Chartered Accountants and Registered Auditors.

BOOKS OF ACCOUNT

To ensure that proper books and accounting records are kept, the Council has established an internal finance department and have employed appropriately qualified accounting personnel and have maintained appropriate computerised accounting systems. The books of account are located at the Council's office at Kingram House, Kingram Place, Dublin 2.

Approved by the Council on 20 March 2013 and signed on its behalf by



Professor Kieran C Murphy
President



Ms. Caroline Spillane
Chief Executive Officer

Dated:
28 March 2013

FINANCIAL STATEMENTS
FOR THE YEAR ENDED
31ST DECEMBER 2012
CONTINUED

**STATEMENT OF COUNCIL
RESPONSIBILITIES**

Section 32 of The Medical Practitioners Act 2007 requires the Council to prepare financial statements for each financial year which give a true and fair view of the state of affairs of the Council and of the income and expenditure for that year. In preparing these financial statements, the Council is required to:

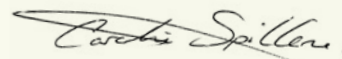
- select suitable accounting policies and apply them consistently
- make judgements and estimates that are reasonable and prudent
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the Council will continue in operation
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the financial statements

The Council is responsible for keeping proper books of account which disclose with reasonable accuracy at any time the financial position of the Council and which will enable it to ensure that the financial statements comply with Section 32 of the Medical Practitioners Acts 2007. The Council is also responsible for safeguarding the assets of the Council and hence taking reasonable steps for the prevention of fraud and other irregularities.

Approved by the Council on 20 March 2013
and signed on its behalf by



.....
Professor Kieran C Murphy
President



.....
Ms. Caroline Spillane
Chief Executive Officer

Dated:
28 March 2013

FINANCIAL STATEMENTS
FOR THE YEAR ENDED
31ST DECEMBER 2012
CONTINUED

PRESIDENT'S STATEMENT ON THE SYSTEMS OF INTERNAL FINANCIAL CONTROL

RESPONSIBILITY FOR SYSTEM OF INTERNAL FINANCIAL CONTROL

On behalf of the Council I acknowledge our responsibility for ensuring that an appropriate system of internal financial control is maintained and operated. The system can only provide reasonable and not absolute assurance that assets are safeguarded, transactions authorised and properly recorded and material errors or irregularities are either prevented or would be detected in a timely period.

KEY CONTROL PROCEDURES

The Council has taken steps to ensure an appropriate control environment by:

- Establishing a dedicated Audit Committee chaired by a council member other than the President;
- Clearly defining management responsibilities and powers;
- Appointment of internal auditors;
- Developing a culture of accountability at all levels of the organisation.

The Council has established processes to identify and evaluate business risks by:

- Identifying the nature, extent and financial implication of risks facing the organisation including the extent and categories which it regards acceptable;
- Assessing the likelihood of identified risks occurring;

- Working closely with the Department of Health and other Government departments and agencies to ensure support for achieving the goals of the Medical Council.

The system of internal financial control is based on a framework of regular management information, administration procedures including segregation of duties and a system of delegation and accountability. In particular it includes:

- A comprehensive budgeting system with an annual budget which is reviewed and agreed by the Council;
- Regular reviews by the Council of periodic and annual financial reports which indicate performance against forecasts;
- Setting targets to measure financial and other performance;
- Compliance with public procurement policies and directives.
- An Internal Audit function is in place and the Internal Auditors operate in accordance with the framework Code of Practice for the Governance of State Bodies. The function is overseen by the Audit Committee.

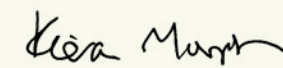
During the year ended 31st December 2012 the following controls were reviewed/implemented:

- Monthly management accounts with explanation of significant deviations from budget;

- Annual Accounts for 2011 with explanation of significant variances;
- Annual budget plan for 2013;
- Internal audit performed by Mazars on the payroll function.
- A review of the Internal Systems of Control was performed by D'Arcy Lynch Partners.

The Council conducted a review of the effectiveness of the system of internal financial control for the year ended 31st December 2012.

Signed on behalf of the Medical Council



Professor Kieran C Murphy
President

Dated:
28 March 2013

FINANCIAL STATEMENTS
FOR THE YEAR ENDED
31ST DECEMBER 2012
CONTINUED

**CODE OF PRACTICE FOR THE
GOVERNANCE OF STATE BODIES**

I wish to confirm that the Medical Council is complying with the Code of Practice for the Governance of State Bodies. The Council has adopted an Internal Audit Charter and Terms of Reference for the Audit Committee, which was established in 2004. In accordance with the Code of Practice I wish to confirm that:

- All appropriate procedures for financial reporting, internal audit, procurement and assets' disposals are being carried out;
- A statement on the system of internal financial control is included with the financial statements in this report;
- Codes of Conduct for Council members and employees have been put in place and adhered to;
- Government policy on the pay of the Chief Executive Officer and all members of the Council is being complied with;
- The Medical Council does pay fees to eligible Council members and reimburses travel expenses in accordance with public sector guidelines;
- There are no significant post balance sheet events to report;

- The Guidelines for the Appraisal and Management of Capital Expenditure Proposals are being complied with;
- The Council's obligations under taxation laws are being complied with.

Signed on behalf of the Medical Council



.....
Professor Kieran C Murphy
President

Dated:
28 March 2013

FINANCIAL STATEMENTS FOR THE YEAR ENDED 31ST DECEMBER 2012

CONTINUED

THE MEDICAL COUNCIL

I have audited the financial statements of the Medical Council for the year ending 31 December 2012 under the Medical Practitioners Act 2007. The financial statements, which have been prepared under the accounting policies set out therein, comprise the statement of accounting policies, the income and expenditure account, the statement of total recognised gains and losses, the balance sheet, the cash flow statement and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and generally accepted accounting practice in Ireland.

RESPONSIBILITIES OF THE MEMBERS OF THE COUNCIL

The Council is responsible for the preparation of the financial statements, for ensuring that they give a true and fair view of the state of the Council's affairs and of its income and expenditure, and for ensuring the regularity of transactions.



Comptroller and Auditor General

Report for presentation to the Houses of the Oireachtas

RESPONSIBILITIES OF THE COMPTROLLER AND AUDITOR GENERAL

My responsibility is to audit the financial statements and report on them in accordance with applicable law.

My audit is conducted by reference to the special considerations which attach to State bodies in relation to their management and operation.

My audit is carried out in accordance with the International Standards on Auditing (UK and Ireland) and in compliance with the Auditing Practices Board's Ethical Standards for Auditors.

SCOPE OF AUDIT OF THE FINANCIAL STATEMENTS

An audit involves obtaining evidence about the amounts and disclosures in the financial statements, sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of

- Whether the accounting policies are appropriate to the Council's circumstances, and have been consistently applied and adequately disclosed

- The reasonableness of significant accounting estimates made in the preparation of the financial statements, and

- The overall presentation of the financial statements.

I also seek to obtain evidence about the regularity of financial transactions in the course of audit.

In addition, I read the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my report.

OPINION ON THE FINANCIAL STATEMENTS

In my opinion, the financial statements, which have been properly prepared in accordance with Generally Accepted Accounting Practice in Ireland, give a true and fair view of the state of the Council's affairs at 31 December 2012 and of its income and expenditure for the year then ended.

In my opinion, proper books of account have been kept by the Council. The financial statements are in agreement with the books of account.

MATTERS ON WHICH I REPORT BY EXCEPTION

I report by exception if

- I have not received all the information and explanations I required for my audit, or
- My audit noted any material instance where moneys have not been applied for the purposes intended or where the transactions did not conform to the authorities governing them, or
- The information given in the Council's Annual Report for the year which the financial statements are prepared is not consistent with the financial statements, or
- The Statement on internal financial control does not reflect the Council's compliance with the Code of Practice for the Governance of State Bodies, or
- I find there are other material matters relating to the manner in which public business has been conducted.

I have nothing to report in regard to those matters upon which reporting is by exception.

Patricia Sheehan

for and on behalf of the Comptroller
and Auditor General
29th March 2012

FINANCIAL STATEMENTS
FOR THE YEAR ENDED
31ST DECEMBER 2012
CONTINUED

ACCOUNTING POLICIES

for the year ended 31 December 2012

BASIS OF PREPARATION

The financial statements are prepared in accordance with generally accepted accounting principles under the historical cost convention as modified by the revaluation of land and buildings and comply with financial reporting standards of the Accounting Standards Board, as promulgated by Chartered Accountants Ireland. The following accounting policies have been applied consistently in dealing with items which are considered material in relation to the financial statements.

TANGIBLE FIXED ASSETS AND DEPRECIATION

Tangible fixed assets are stated at cost or at valuation, less accumulated depreciation. The charge to depreciation is calculated to write off the original cost or valuation of tangible fixed assets, less their estimated residual value, over their expected useful lives as follows:

Buildings

- 2% straight line

Office equipment

- 20% straight line

Fixtures and fittings

- 12.5% straight line

Computer equipment and software development

- 33.3% straight line

The premises at Lynn House are subject to a policy of revaluation every 5 years with an interim valuation in year 3 per FRS 15 Accounting for Fixed Assets. The premises were valued at an open market basis at 31st December 2009 (Note 5). As the Council is a not-for-profit organisation, it opted not to carry out an interim valuation in accordance with its accounting policy on this property for cost benefit reasons.

Software development costs on major systems are treated as capital items and are written off over the period of their expected useful life from the date of their implementation.

INVESTMENTS

Investments held as fixed assets are stated at their market value. Any surplus or deficiency is accounted for through the statement of total recognised gains and losses and the income and expenditure account respectively. Income from investments together with any related withholding tax is recognised in the income and expenditure account in the year in which it is receivable.

FOREIGN CURRENCIES

Monetary assets and liabilities denominated in foreign currencies are translated at the rates of exchange ruling at the balance sheet date. Transactions, during the year, which are denominated in foreign currencies are translated at the rates of exchange ruling at the date of the transaction. The resulting exchange differences are dealt with in the income and expenditure account.

INCOME

Fees, other than retention fees, are recognised as income in the year in which they are received. Retention fees are charged annually in respect of practitioners who apply to continue on the Council's register. Retention fees and other income are recognised as income in the year to which they relate.

PENSIONS

Medical Council operates a defined benefit scheme which is funded annually on a pay as you go basis from monies available to it and from contributions deducted from staff salaries.

Pension Scheme liabilities are measured on an actuarial basis using the projected unit method.

Pension costs reflect pension benefits earned by employees in the period and are shown net of staff pension contributions which are retained by Medical Council.

Actuarial gains and losses arise from

changes in actuarial assumptions and from experience surpluses and deficits and are recognised in the Statement of Total Recognised Gains and Losses for the year in which they occur.

Pension liabilities represent the present value of future pension payments earned by staff to date.

The pension reserve represents the funding deficit on the pension scheme obligations.

FINANCIAL STATEMENTS
FOR THE YEAR ENDED
31ST DECEMBER 2012
CONTINUED

**INCOME AND EXPENDITURE
ACCOUNT FOR THE YEAR
ENDED 31ST DECEMBER 2012**

The results for the year refer to continuing operations.

The Statement of Accounting Policies, Cash Flow Statement and the notes form part of the financial statements.

Approved by the Council on 20 March 2013 and signed on its behalf by



Professor Kieran C Murphy
President



Ms. Caroline Spillane
Chief Executive Officer

Dated:
28 March 2013

	Notes	2012 €	2011 €
Income			
Retention fees		7,558,617	7,648,484
Registration fees	1	1,391,537	1,635,159
Miscellaneous income	1	319,776	291,339
Total income		9,269,930	9,574,982
Expenditure			
Wages and salaries	3	3,026,130	3,178,126
Pension Costs	3/10	976,015	1,033,000
Council and meeting expenses		636,005	536,526
Staff recruitment, training and education		101,318	100,465
Rent and rates		927,719	949,067
Legal expenses	2	2,394,566	2,472,698
General administration	2	1,166,221	1,218,172
Consultancy and other professional fees	2	809,819	483,745
Finance charges		30,895	38,036
Audit fees		13,630	12,560
Depreciation		503,264	651,509
Advertising		47,445	50,151
Total Expenditure		(10,633,027)	(10,724,055)
Operating (deficit)/surplus		(1,363,097)	(1,149,073)
Interest receivable		193,047	166,726
Investment income		27,672	37,568
(Deficit)/surplus for the year	11	(1,142,378)	(944,779)

FINANCIAL STATEMENTS
FOR THE YEAR ENDED
31ST DECEMBER 2012
CONTINUED

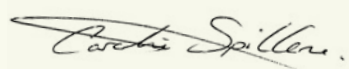
	Notes	2012 €	2011 €
(Deficit)/surplus for the year	11	(1,142,378)	(944,779)
Actuarial gain/(loss) on pension liabilities	10	686,000	713,000
Revaluation gain on investments	6	102,233	11,826
Total Recognised Losses for the year		(354,145)	(219,953)

STATEMENT OF TOTAL
RECOGNISED GAINS AND
LOSSES FOR THE YEAR ENDED
31ST DECEMBER 2012

Approved by the Council on 20 March
2013 and signed on its behalf by



Professor Kieran C Murphy
President



Ms. Caroline Spillane
Chief Executive Officer

Dated:
28 March 2013

FINANCIAL STATEMENTS
FOR THE YEAR ENDED
31ST DECEMBER 2012
CONTINUED

**BALANCE SHEET AS AT
31ST DECEMBER 2012**

The Statement of Accounting Policies, Cash Flow Statement and the notes form part of the financial statements.

Approved by the Council on 20 March 2013 and signed on its behalf by



Professor Kieran C Murphy
President



Ms. Caroline Spillane
Chief Executive Officer

Dated:
28 March 2013

	Notes	2012 €	2011 €
Fixed Assets			
Tangible assets	5	3,895,920	4,164,722
Financial assets	6	2,796,356	2,684,806
		6,692,276	6,849,528
Current Assets			
Debtors	7	1,609,384	1,630,229
Cash at bank and in hand		10,398,151	9,559,952
		12,007,535	11,190,181
Creditors: Amounts falling due within one year	8	(5,357,246)	(4,442,999)
Net Current Assets		6,650,289	6,747,182
Total Assets less Current Liabilities Before Pensions		13,342,585	13,596,710
Pension Liabilities	10	(11,400,000)	(11,300,000)
Net Assets		1,942,585	2,296,710
Capital and Reserves			
Revaluation reserve	11	1,016,127	913,894
Accumulated surplus	11	12,326,438	12,682,816
Pension reserve	11	(11,400,000)	(11,300,000)
Total		1,942,585	2,296,710

FINANCIAL STATEMENTS
FOR THE YEAR ENDED
31ST DECEMBER 2012
CONTINUED

CASH FLOW STATEMENT
FOR THE YEAR ENDED
31ST DECEMBER 2012

Approved by the Council on 20 March
2013 and signed on its behalf by



Professor Kieran C Murphy
President



Ms. Caroline Spillane
Chief Executive Officer

Dated:
28 March 2013

	2012 €	2011 €
(Deficit)/surplus for the year	(1,142,378)	(944,779)
Difference between pension paid and pension charge	786,000	813,000
Interest received	(193,047)	(166,726)
Depreciation	503,264	651,509
Decrease / (Increase) in debtors	20,846	(150,763)
Increase / (Decrease) in creditors	914,247	(197,241)
Diminution in investments	-	-
Investment income	(27,672)	(37,568)
Management fee	30,529	28,240
Net cash inflow / (outflow) from operating activities	891,788	(4,328)
Return on investments		
Interest received	180,874	162,775
Capital expenditure	(234,463)	(116,436)
Increase/(Decrease) in cash	838,199	42,011
Net funds at beginning of year	9,559,952	9,517,941
Net funds as at 31st December 2012	10,391,151	9,559,952
Analysis of change in net funds		
At beginning of year	9,559,952	9,517,941
Cash flows	838,199	42,011
Net funds as at 31st December 2012	10,398,151	9,559,952

FINANCIAL STATEMENTS
FOR THE YEAR ENDED
31ST DECEMBER 2012
CONTINUED

NOTES TO THE FINANCIAL
STATEMENTS FOR THE YEAR
ENDED 31ST DECEMBER 2012

1. INCOME

Income items are made up as follows:

	2012 €	2011 €
Registration fees		
Internship	244,240	139,045
General registration	1,019,917	1,311,869
Restoration to G.R.M.P	110	640
Specialist registration fees	127,270	183,605
	1,391,537	1,635,159
Miscellaneous income		
Service fees	12,382	15,086
Accreditation Fees	39,706	50,000
Examinations	47,835	110,789
Certificate of good standing	108,190	94,315
Legal costs recovered	42,350	-
Conference	10,693	12,001
Rental Income	8,230	9,148
Software License	35,390	-
	15,000	-
	319,776	291,339

FINANCIAL STATEMENTS
FOR THE YEAR ENDED
31ST DECEMBER 2012
CONTINUED

2. EXPENDITURE

Expenditure items are made up as follows:

	2012 €	2011 €
Legal Expenses		
Legal and professional	302,976	209,765
Part V (a) inquiries	1,852,192	1,926,904
Part V (b) High Court & Supreme Court proceedings	239,398	336,029
	2,394,566	2,472,698
General Administration		
Insurance	91,171	91,429
Light and heat	91,239	85,153
Repairs and maintenance	201,333	160,044
Equipment maintenance	4,497	678
Printing, postage and stationery	222,390	217,251
File administration and storage	43,806	37,204
Telephone and modem charges	54,609	44,779
Computer costs	144,870	279,221
Caretaking and cleaning	40,309	40,567
Security	48,678	76,797
Accreditations	195,222	170,269
General expenses	28,097	14,780
	1,166,221	1,218,172
Consultancy and other professional fees		
Business consultancy	78,180	36,358
Consultancy fees	731,639	447,327
	809,819	483,685

The increase in Consultancy Fees is a direct result of an initiative by the Council to establish a Case Officer Training Programme, to operate in tandem with the Preliminary Proceedings Committee.

FINANCIAL STATEMENTS
FOR THE YEAR ENDED
31ST DECEMBER 2012
CONTINUED

3. EMPLOYEES AND REMUNERATION

The average number of persons employed during the year was 51 (2011: 51).

The staff costs are comprised of:

	2012	2011
	€	€
Wages and salaries	2,777,127	2,977,954
Social welfare costs	249,003	200,172
	3,026,130	3,178,126
Pension costs	976,015	1,033,000
	4,002,145	4,211,126

3.1 Ms Caroline Spillane is the Chief Executive Officer of the Medical Council. Ms Spillane received a salary of €145,952 in 2012 covering the period from 1 January 2012 to the 31 December 2012. The pension entitlements of the Chief Executive Officer do not extend beyond the pension entitlements in the public sector defined benefit superannuation scheme.

3.2 In 2012, the Council paid a total of €203,265 to The Department of Health in relation to the pension levy. This comprised:

- €165,508 which had been deducted from staff salaries during 2012.
- €37,757 in relation to pension deductions which had not been deducted from staff salaries during 2011 as a result of a payroll error. The Council is recovering €21,140 of this amount from staff salaries over a five year period. It does not plan to recover the balance - €16,617.

3.3 No Bonus payments were made to staff during 2012.

3.4 An amount of €72,470 was paid in fees to nine eligible Council members in 2012 as follows:-

- Dr Richard Brennan
€7,696
- Ms Katharine Bulbulia
€7,696
- Ms Margaret Murphy
€7,696
- Mr Frank McManus
€7,696
- Dr Daniel O'Hare
€7,696
- Professor Diarmuid O'Donoghue
€7,696
- Ms Anne Carrigy
€7,696
- Ms Marie Murray
€8,978
- Mr Michael Ryan
€9,620

Also €37,148 was paid to Council members in relation to reimbursable travel and subsistence expenses.

3.5 An amount of €65,328 was paid in relation to the reimbursement to Beaumont Hospital for locum hire to cover the time spent on Council business by the Council President, Professor Kieran Murphy.

3.6 In addition to the expenditure noted in 3.4 and 3.5 above a total of €461,059 was incurred on Council meeting and operations as follows.

€201,958 in Travel and Subsistence expenditure incurred by Council members, Committee members and staff on official Council operations.

€198,311 in respect of allowances paid to 50 people who are members of Sub-Committees and Working Groups. The individual payments ranged from €300 to €17,600.

€60,790 in respect of catering costs for Council, Sub-Committee and Inquiries.

FINANCIAL STATEMENTS FOR THE YEAR ENDED 31ST DECEMBER 2012

CONTINUED

4. TAXATION

Section 32 of the Finance Act 1994 provides exemption from taxation on investment income of the Medical Council. The Medical Council is, however, not entitled to a repayment of D.I.R.T. where this has been deducted from deposit interest.

The Medical Council is a Non Commercial State Sponsored Body within the meaning of Section 227 Taxes Consolidation Act and Schedule 4 of that Act.

The Medical Council does not charge VAT on its fees and it does not reclaim VAT on its purchases.

5. TANGIBLE FIXED ASSETS

	Buildings €	Office Equipment €	Fixtures and fittings €	Computer Equipment €	Total €
Cost or Valuation					
As at 1st January 2012	3,808,594	297,353	1,451,374	2,280,252	7,837,573
Additions	-	-	10,412	224,050	234,462
Revaluation	-	-	-	-	-
At 31st December 2012	3,808,594	297,353	1,461,786	2,504,302	8,072,035
Depreciation					
As at 1st January 2012	515,288	285,475	825,991	2,046,097	3,672,851
Charge for the year	76,172	6,017	149,647	271,428	503,264
Revaluation	-	-	-	-	-
At 31st December 2012	591,460	291,492	975,638	2,317,525	4,176,115
Net book value					
At 31st December 2012	3,217,134	5,861	486,148	186,777	3,895,920
At 31st December 2011	3,293,306	11,878	625,383	234,155	4,164,722

A valuation was carried out by HT Meagher O'Reilly at 31st December 2009 and this resulted in the Lynn House property being revalued in the books of the Council from €3m to €2m. The property was valued on an open market basis. The historical cost of the property is €1,650,298. The Council are aware of the current developments in the property market and are keeping the matter under review.

Listed amongst the values for fixtures and fittings is a small selection of decorative art which is situated in the offices at Kingram House. This artwork is valued in line with the directives of FRS 30. It currently has a carrying value of €33,607

FINANCIAL STATEMENTS
FOR THE YEAR ENDED
31ST DECEMBER 2012
CONTINUED

6. FINANCIAL FIXED ASSETS

	2012	2011
	€	€
Listed Investments		
Cost		
At 1st January	2,684,807	2,659,701
Increase in value of investment	102,234	11,826
Investment income	27,672	37,568
Management fee	(30,529)	(28,240)
Interest income	12,172	3,951
At 31st December	2,796,356	2,684,806

7. DEBTORS

	2011	2010
	€	€
Prepayments and other debtors	1,609,384	1,630,229

Included in prepayments is an amount of €807,000 being an upfront rent payment on the Kingram House property.

FINANCIAL STATEMENTS
FOR THE YEAR ENDED
31ST DECEMBER 2012
CONTINUED

8. CREDITORS

	2012	2011
	€	€
Amounts falling due within one year		
Trade creditors and accruals	1,267,755	416,928
PRSA accrual	-	(138)
Deferred Income - Retention fees (Note 9)	3,791,326	3,767,289
Provision for legal costs	298,165	258,920
	5,357,246	4,442,999

Movement in legal provision:-

Legal provision at 1st January 2012	258,920
Utilised in 2012	(121,750)
Provided for in 2013	160,995
	298,165

9. DEFERRED INCOME - RETENTION FEES

This related to fees received in respect of periods after the year end.

FINANCIAL STATEMENTS
FOR THE YEAR ENDED
31ST DECEMBER 2012
CONTINUED

10. PENSION COSTS

	2012 €	2011 €
a. Analysis of total pension costs charged to Expenditure		
Current service costs	490,000	530,000
Interest on Pension Scheme Liabilities	620,000	620,000
Employee contributions	(133,985)	(117,000)
	976,015	1,033,000
b. Movement in net Pension Liability during the financial year		
Net Pension Liability at 1st January	11,300,000	11,200,000
Current Service Cost	490,000	530,000
Interest Costs	620,000	620,000
Actuarial (gain)/loss	(686,000)	(713,000)
Pensions paid in the year	(324,000)	(337,000)
	11,400,000	11,300,000
c. History of defined benefit obligations		
Defined benefit obligations	11,400,000	11,300,000
Experience gains on scheme liabilities Amount	686,000	713,000
Percentage of Scheme Liabilities	(6%)	(6%)

The cumulative actuarial gain recognised in the Statement of Total Recognised Gains and Losses amounts to €1,553,000.

d. General Description of the Scheme

The pension schemes are defined benefit final salary pension arrangements with benefits and contributions defined by reference to current "model" public sector scheme regulations. The scheme provides a pension (1/80th per year of service), a gratuity or lump sum (three eightieths per year of service) and spouse's and children's pensions. Average retirement age is a member's 62nd birthday. Pre 1 April 2004 the minimum pension age is 60 and the maximum retirement age is 65. For new scheme entrants that have been appointed to public sector employment on or after 1 April 2004, the minimum pension age is age 65 and there is no fixed retirement age. Pensions in payment (and deferment) normally increase in line with general public sector salary inflation.

The valuation used for FRS17 (Revised) disclosures has been based on a full actuarial valuation at 31st December 2012 by a qualified independent actuary taking account of the requirements of the FRS in order to assess the scheme liabilities at 31 December 2012.

The principal actuarial assumptions were as follows:

	2012	2011
Rate of increase in salaries	4.0%	4.0%
Rate of increase in pensions in payment	4.0%	4.0%
Discount Rate	5.5%	5.5%
Inflation Rate	2.0%	2.0%

Mortality basis:

PMA80 (C=2000) for males and PFA80 (C=2000) for females with a deduction of two years in each case.

11. RESERVES

	Pension reserve €	Revaluation reserve €	Accumulated surplus €	Total €
1st January 2012	(11,300,000)	913,894	12,682,816	2,296,710
Revaluation of investments	-	102,233	-	102,233
Deficit for the year	-	-	(1,142,938)	(1,142,938)
Pension Actuarial gain for the year	686,000	-	-	686,000
Pension reserve adjustment	(786,000)	-	786,000	-
At 31st December 2012	(11,400,000)	1,016,127	12,325,878	1,942,005

An adjustment has been made to bring the pension reserve in line with the pension liability. The adjustment consists of the cumulative pension costs and funding of pensioners' pay since the adoption of FRS 17. As the adjustment does not affect prior year results no restatement of figures is necessary.

FINANCIAL STATEMENTS
FOR THE YEAR ENDED
31ST DECEMBER 2012
CONTINUED

12. OPERATING LEASE COMMITMENTS

The Medical Council has signed a five year lease agreement for its new premises, Kingram House, at an annual rent of €820,000. There was also an option to purchase the shareholding of Tanat Limited (incorporating Kingram House) for a fixed price. This option expired on 31st March 2011. As the Council did not exercise its option then the owners of Tanat Limited have a call option whereby the Council are obliged to enter into a long term lease of twenty years at the current annual rent of €820,000. The Council are currently negotiating with the owners.

13. CONTINGENT LIABILITIES

A number of High Court proceedings have been taken against The Medical Council. The Council is vigorously defending the proceedings and is satisfied that they will not be successful and have not provided for any liability arising thereon. Council's costs in relation to defending the proceedings have been provided for in note 8.

14. APPROVAL OF FINANCIAL STATEMENTS

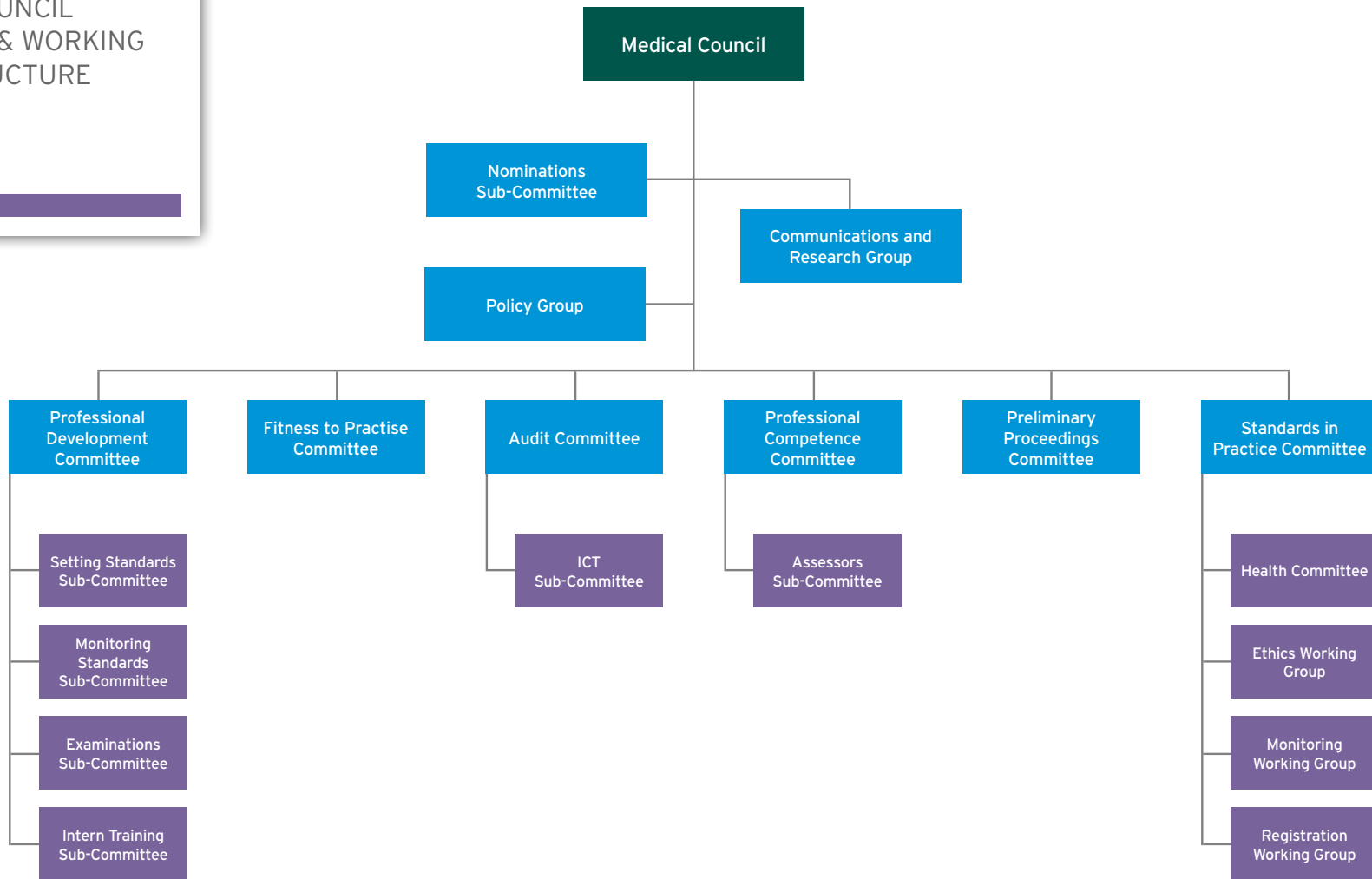
The financial statements were approved by the Council on 20 March 2013.



APPENDICES

■ Appendix A: Medical Council Committee & Working Group Structure	54
■ Appendix B: Council Attendance 2012	55
■ Appendix C: Committee Attendance 2012	56
■ Appendix D: Working Group/ Sub-Committee Attendance 2012	66
■ Appendix E: Statistics	
Examinations	68
Preliminary Proceedings Committee	75
Fitness to Practise Inquiries	85
Register of Medical Practitioners	96
Freedom of Information requests	107
Website	110
Professional Competence	112
■ Appendix F: High Court/ Supreme Court judgements	113

APPENDIX A:
MEDICAL COUNCIL
COMMITTEE & WORKING
GROUP STRUCTURE



APPENDIX B: COUNCIL ATTENDANCE 2012

MEMBER	JAN 4th (E)	JAN 26th	MAR 13th/ 14th	APR 12th (E)	APR 25th	MAY 23rd (E)	MAY 30th + 31st	JUL 5th	SEPT 11th/ 12th	OCT 24th	DEC 12th/ 13th	TOTAL MEETINGS 8 Scheduled 3 Extraordinary (E)
Dr Richard Brennan	•		•		•		•	•	•	•	•	7 (1)
Mr Brendan Broderick		•	•	•	•		•	•	•	•	•	8 (1)
Ms Katharine Bulbulia		•	•		•	•	•	•	•	•	•	8 (1)
Professor Gerard Bury	•	•	•		•		•		•	•	•	7 (1)
Mrs Anne Carrigy			•	•	•	•	•		•		•	5 (2)
Dr Anna Clarke	•	•	•		•	•	•	•	•	•	•	8 (2)
Dr Regina Connolly			•	•	•				•	•	•	5 (1)
Dr Pauline Kane		•		•			•		•			3(1)
Ms Marie Kehoe		•	•		•		•				•	5
Dr Deirdre Madden	•	•		•	•		•	•	•		•	6 (2)
Professor John McAdoo	•		•		•		•	•	•	•	•	7(1)
Professor Damien McLoughlin	•		•								•	2(1)
Mr Frank McManus		•	•	•	•		•	•	•	•	•	8 (1)
Dr John Monaghan		•			•				•	•	•	5
Ms Marie Murray			•		•	•		•		•	•	5 (1)
Professor Kieran Murphy (Chair)	•	•	•	•	•		•	•	•	•	•	8 (2)
Ms Margaret Murphy		•	•		•	•		•	•		•	6 (1)
Professor Diarmuid O'Donoghue		•	•		•		•	•	•	•	•	8
Dr Daniel O'Hare	•	•	•		•		•	•	•	•	•	8 (1)
Dr David O'Keeffe		•	•		•	•	•		•	•	•	7 (1)
Dr John O'Mullane	•	•			•		•	•	•	•	•	7(1)
Professor William Powderly		•	•		•		•	•	•	•	•	8
Dr Michael Ryan	•		•	•	•	•	•	•		•	•	6(3)

APPENDIX C: COMMITTEE ATTENDANCE 2012

AUDIT COMMITTEE

MEMBER	FEB 8th	MAR 5th	MAR 13th	APR 18th	JUN 26th	SEPT 3rd	NOV 19th	TOTAL MEETINGS 7
Mrs Anne Carrigy	•		•	•	•	•	•	6
Mr Stephen McGovern	•	•	•	•	•	•	•	7
Professor Damien McLaughlin (Chair)	•	•	•	•	•	•	•	7
Mr Frank McManus				•	•	•	•	4
Dr Terry McWade	•	•	•	•	•	•		6
Professor Kieran Murphy							•	1
Professor William Powderly				•	•			2

APPENDIX C:
COMMITTEE ATTENDANCE
2012
CONTINUED

PRELIMINARY PROCEEDINGS COMMITTEE

MEMBER	JAN	FEB	MAR	APR	MAY	JUN	JUL	SEPT	OCT	NOV	DEC	TOTAL MEETINGS 10
Ms Katharine Bulbulia	•	•	•	•	•	•	•	•	•	•	•	10
Dr Tony Carney	•			•	•	•			•		•	5
Mrs Anne Carrigy	•	•	•	•		•	•	•	•		•	8
Dr John Casey	•	•	•		•	•	•	•	•		•	8
Professor Frank Keane*	•	•	•	•		•						5
Dr Michael McGloin**									•	•	•	2
Mr Frank McManus (Chair)	•	•	•	•	•	•	•	•	•	•	•	10
Dr Angela McNamara	•	•	•	•	•	•	•	•		•		9
Ms Margaret Murphy		•		•			•		•		•	4
Dr Philip Murphy	•	•	•	•								4
Dr Ailis Ní Riain	•	•	•	•	•	•	•	•	•		•	9
Professor Diarmuid O'Donoghue	•		•		•	•		•	•	•	•	7
Dr David O'Keeffe	•	•	•	•	•	•	•	•	•	•	•	10
Dr Gordon Watson**									•	•	•	2

* Resigned in July 2012

** New member from November 2012

APPENDIX C:
COMMITTEE ATTENDANCE
2012
 CONTINUED

FITNESS TO PRACTISE COMMITTEE INQUIRY

MEMBER	JAN	FEB	MAR	APR	MAY	JUN	JUL	SEPT	OCT	NOV	DEC	TOTAL MEETINGS 10
Dr Daniel O'Hare (Chair)	1	1				4		1				7
Ms Grace Barry					1							1
Dr Richard Brennan	1				2					1		4
Mr Brendan Broderick	2		2	1	2		1		3	4	3	18
Mr Michael Brophy		1					1	1	2	1	1	7
Ms Mary Buckley								1	2	1		4
Dr Abdul Bulbulia	1	1	1	1	1	1	3	2	3	6	5	25
Mr Robert Burke		2						1				3
Professor Gerard Bury									2			2
Dr Regina Connolly												0
Dr Geraldine Corrigan												0
Ms Mary Culliton	4					1			1	1	1	8
Mr Denis Doherty											2	2
Ms Annette Durkan		1		2	2							5
Ms Catherine Earley			1	2					1		4	8
Mr Tom C. Ewing	1	1				1			1	2		6
Dr Nuala Healy		1	1	1	1			1	1			6
Dr Brendan Healy					3		1		1	1	1	7
Dr Mary Henry	2			3		5		1	7	3	6	27
Ms Winifred Jeffers					1				2	2		5
Mr Stephen Kealy	2				2						1	5
Ms Marie Kehoe-O'Sullivan												0
Mr John Kincaid										4		4
Dr Deirdre Madden		1		1	2	1		1	2	1	1	10

APPENDIX C:
COMMITTEE ATTENDANCE
2012
 CONTINUED

FITNESS TO PRACTISE COMMITTEE INQUIRY (CONTINUED)

MEMBER	JAN	FEB	MAR	APR	MAY	JUN	JUL	SEPT	OCT	NOV	DEC	TOTAL MEETINGS 10
Dr Michael McDermott						1						1
Professor Damien McLoughlin												0
Dr John Monaghan	3	1	1					1		1	2	9
Mr Peter Mooney	3											3
Professor David Morgan						4						4
Ms Meg Murphy		2	1					1				4
Mr Paul Murphy	1			1	1				2	3		8
Dr Tim O'Neill		1	2	1	1		3	2	2	5	5	22
Ms Melanie Pine					1				1			2
Professor William Powderly		2										2
Ms Catherine Rawluk												0
Dr Michael Ryan				3	1	1	3	2	7	5	5	27
Ms Joan Tatan-Dennis											2	2

APPENDIX C:
COMMITTEE ATTENDANCE
2012
CONTINUED

PROFESSIONAL COMPETENCE COMMITTEE

MEMBER	JAN 30th	MAR 2nd	APR 17th	MAY 23rd	JUN 28th	SEPT 5th	OCT 9th	NOV 28th	TOTAL MEETINGS 8
Dr David O'Keeffe	•	•	•	•	•	•	•	•	8
Professor Kieran Murphy	•	•	•	•	•	•	•	•	8
Dr Richard Brennan*		•	•		•				3
Professor Conor O'Keane	•								1
Dr Ellen O'Sullivan	•	•	•	•		•	•		6
Ms Katharine Bulbulia		•	•	•	•	•	•	•	7
Ms Mary Culliton	•	•	•	•	•	•	•	•	8
Dr Ian Callanan	•	•	•		•	•	•	•	7
Ms Anne Maher	•	•	•	•	•	•	•	•	8
Professor Paul Finucane	•			•	•		•	•	5
Ms Mary Vasseghi			•	•		•			3
Mr Paddy Duggan	•		•		•	•	•		5
Dr Consilia Walsh	•		•	•	•	•	•	•	7
Professor A. Tanner	•		•	•		•	•		5
Dr Niamh Macey		•	•				•	•	4
Dr John McAdoo	•		•						2
Dr Mary Holohan**		•	•	•	•	•	•	•	7
Dr Mary Sheehan	•	•	•			•	•	•	6

* Resigned as of PCC meeting of 17th Jan 2013

** Appointed February 2012

APPENDIX C:
COMMITTEE ATTENDANCE
2012
 CONTINUED

HEALTH COMMITTEE

MEMBER	FEB 16th	APR 5th	JUN 6th	AUG 30th	OCT 4th	NOV 29th	TOTAL MEETINGS 6
Dr Richard Brennan (Chair)	•	•	•	•	•	•	6
Dr Abdul Bulbulia	•	•	•	•	•	•	6
Ms Mary Duff			•	•			2
Ms Veronica Larkin			•	•		•	3
Dr John Latham	•		•	•	•	•	5
Professor James Lucey			•	•			2
Dr Eamonn Keenan			•	•	•	•	4
Dr Timothy Lynch							0
Dr Claire McNicholas	•	•	•			•	4
Dr Siobhan Rooney*							0
Dr Peter Staunton	•			•	•	•	4
Dr Blainaid Hayes	•	•		•		•	4
Mr Rolande Anderson	•	•	•	•		•	5

* Resigned in March 2012

APPENDIX C: COMMITTEE ATTENDANCE 2012

CONTINUED

PROFESSIONAL DEVELOPMENT COMMITTEE

MEMBER	JAN 17th	FEB 7th	APR 3rd	MAY 8th	JUN 26th	AUG 28th	OCT 9th	NOV 23rd	DEC 5th	DEC 12th	TOTAL MEETINGS 10
Ms Katharine Bulbulia	•	•	•	•	•			•	•	•	8
Professor Gerard Bury	•	•	•		•	•		•	•	•	8
Dr Anna Clarke(Chair)**		•	•		•	•	•		•	•	7
Dr Pauline Kane											0
Dr John McAdoo			•	•	•	•	•	•	•	•	8
Mr Frank McManus								•		•	2
Professor Kieran Murphy	•	•	•	•	•	•	•	•	•		9
Ms Marie Murray	•	•		•	•		•			•	6
Professor Diarmuid O'Donoghue	•		•		•	•				•	5
Dr John O'Mullane		•	•					•		•	4
Professor William Powderly (Chair)*	•	•	•	•	•	•	•	•	•	•	10

* Resigned in March 2012

APPENDIX C:
COMMITTEE ATTENDANCE
2012
 CONTINUED

STANDARDS IN PRACTICE COMMITTEE

MEMBER	FEB 23rd	APR 4th	JUN 14th	JUL 26th	OCT 10th	DEC 3rd	TOTAL MEETINGS 6
Dr Richard Brennan	•		•	•	•	•	5
Professor Gerard Bury (Chair)	•	•	•	•	•		5
Dr Anna Clarke		•	•	•	•	•	5
Dr Regina Connolly			•			•	2
Dr Ciaran Craven							0
Ms Mary Culliton	•	•	•	•	•	•	6
Geraldine Feeney**	•	•	•		•	•	5
Dr Deirdre Madden*							
Dr John Monaghan		•	•	•	•	•	5
Professor Kieran Murphy (President)	•	•	•		•	•	5

* Resigned in October 2012

** Joined the Committee in April 2012

SETTING STANDARDS SUB-COMMITTEE

MEMBER	AUG 14th	OCT 3rd	NOV 30th	TOTAL MEETINGS 3
Dr Geoff Chadwick	•	•	•	3
Dr Gerard Flaherty	•	•	•	3
Professor Mary Horgan		•		1
Professor Alan Johnson (Chair)	•	•	•	3
Professor Tom O'Dowd				0
Dr Dermot Power		•		1
Mrs Mary Vasseghi	•			1

APPENDIX C:
COMMITTEE ATTENDANCE
2012
 CONTINUED

ICT SUB-COMMITTEE

MEMBER	MAR 26th	APR 11th	MAY 24th	JUN 28th	OCT 12th	NOV 29th	TOTAL MEETINGS 6
Ms Eileen Fitzgerald	•	•	•	•	•	•	6
Mr Jean-Christophe Displat	•	•	•	•		•	5
Mr Marcus Balfe	•	•	•	•	•	•	6
Mr Jim McDermott	•	•	•	•	•	•	6

INTERN TRAINING SUB-COMMITTEE

MEMBER	APR 3rd	JUL 17th	TOTAL MEETINGS 2
Ms Katharine Bulbulia	•	•	2
Professor Gerard Bury	•		1
Ms Sheila Carew	•		1
Dr Martina Hennessy	•		1
Dr Siobhan MacHale	•		1
Professor T J McKenna	•	•	2
Professor Eilis McGovern	•	•	2
Mr Stephen McMahon	•	•	2
Ms Ciara Mellett	•	•	2
Dr Finbarr O'Connell	•	•	2
Dr Margaret O'Connor/Mr Paul Burke	•	•	2
Professor Diarmuid O'Donoghue (Chair)	•	•	2
Dr Dermot Power	•		1
Dr Matthew Sadlier	•	•	2
Professor Cillian Twomey	•	•	2

APPENDIX C:
COMMITTEE ATTENDANCE
 2012
 CONTINUED

MONITORING STANDARDS SUB-COMMITTEE

MEMBER	JUL 24th	SEPT 18th	OCT 23rd	TOTAL MEETINGS 3
Professor Peter Cantillon	•	•	•	3
Dr Martina Hennessy	•			1
Professor Alan Johnson	•	•	•	3
Dr John McAdoo (Chair)	•	•	•	3
Mr Stephen McMahon	•	•	•	3
Dr Ian Surgeon	•	•	•	3

EXAMINATIONS SUB-COMMITTEE

MEMBER	FEB 8th	JUN 22nd	NOV 19th	DEC 11th	TOTAL MEETINGS 4
Professor Gerard Bury (Chair)	•	•	•	•	4
Professor Patricia Casey	•				1
Dr Geoff Chadwick	•			•	2
Dr Gerard Flaherty	•	•	•	•	4
Dr Martina Hennessy		•		•	2
Dr Deirdre McGrath			•		1
Dr Siún O'Flynn			•		1
Mr Ian Surgeon/Ms R Flaherty	•				1
Dr Ian Surgeon	•	•	•	•	3

*Examinations Sub-Committee meetings can be called at very short notice.

NOMINATIONS SUB-COMMITTEE

Note: This group meet electronically, with documentation circulated by email.

APPENDIX D:
WORKING GROUP/
SUB-COMMITTEE
ATTENDANCE 2012

MONITORING WORKING GROUP

MEMBER	FEB 8th	APR 5th	JUN 7th	AUG 30th	OCT 4th	NOV 9th	NOV 29th	TOTAL MEETINGS 7
Ms Mary Culliton (Chair)	•	•	•	•	•	•	•	7
Mr Brendan Broderick	•	•	•	•	•	•	•	7
Ms Cora McGaughan			•	•	•			3
Dr Eamonn Breatnach		•	•	•	•	•	•	6
Dr Declan Woods		•		•	•	•	•	5

REGISTRATION WORKING GROUP

MEMBER	JAN 23rd	MAR 5th	APR 16th	MAY 28th	JUL 2nd	SEPT 24th	NOV 12th	TOTAL MEETINGS 7
Dr Anna Clarke (Chair)	•	•	•	•	•	•	•	7
Dr Peter Daly			•		•			2
Dr Fenton Howell	•	•	•	•		•	•	6
Dr John Loughrey	•	•	•	•	•	•	•	7
Professor T Joseph McKenna	•	•		•		•	•	5
Dr Ciara McMeel	•	•		•		•	•	5
Dr Daniel O'Hare							•	1
Dr Mary Staines	•		•	•	•	•	•	6
Mr David Sweeney								0
Professor Arthur Tanner	•		•	•	•	•	•	6

APPENDIX D: WORKING GROUP/ SUB-COMMITTEE ATTENDANCE 2012

CONTINUED

POLICY GROUP

MEMBER	MAR 13th	MAY 30th	SEPT 11th	TOTAL MEETINGS 3
Mr Marcus Balfe	•	•	•	3
Dr Anna Clarke	•	•	•	3
Dr Paul Kavanagh	•	•	•	3
Mr William Kennedy	•	•	•	3
Mr Damien McLoughlin	•			1
Mr Frank McManus	•	•	•	3
Ms Lisa Molloy	•	•	•	3
Professor Kieran Murphy (Chair)	•	•	•	3
Dr Danny O'Hare	•	•	•	3
Mr David O'Keeffe	•	•	•	3
Professor William Powderly	•	•	•	3
Ms Caroline Spillane	•	•	•	3

Note: In addition to those listed all Council Members are eligible to attend these meetings.

ETHICS WORKING GROUP

Note: There were no meetings of the Ethics Working Group in 2012.

APPENDIX E: STATISTICS EXAMINATIONS STATISTICS

EXAMINATIONS

GENERAL DIVISION - PRE-REGISTRATION EXAMINATION SYSTEM (PRES)

The Medical Council requires all doctors to meet defined practice standards and ensures that doctors entering the medical register have the necessary knowledge and skills to practise medicine safely in Ireland. One way it does this is through requesting doctors to participate in examinations, known as the Pre-Registration Examination System (PRES). This examination is similar to those run by other international bodies involved in medical regulation such as the NZREX (New Zealand), PLAB (UK) and USMLE (USA). Doctors who have qualified outside the EU/EEA must pass or be exempt from the Council's Pre-Registration Examination System (PRES) if they wish to be registered in the General Division but do not satisfy the criteria for other registration pathways. Standard setting for this exam is at the level of final medical/ entry to internship year.

TEMPORARY REGISTRATION ASSESSMENT SYSTEM (TRAS)

On 16th March 2009 the TRAS examination, which consisted of Multiple Choice Questions (MCQ) and an Objective Structured Clinical Examination (OSCE), was replaced by the PRES Level 2 Examination

LEVEL 2 EXAMINATION

Level 2 is a computer delivered written examination and is currently in the form of a Multiple Choice Questions (MCQ) examination. A pass in Level 2 is valid for a period of two years from the date of passing. Candidates must pass Level 3 within two years from the date of passing Level 2.

LEVEL 3 EXAMINATION

Level 3 is an examination of clinical competence, including practical and communication skills, as well as data interpretation skills.

SUPERVISED DIVISION - CLINICAL EXAMINATIONS

Applicants for registration to the Supervised Division must fulfil a number of criteria for registration, including passing an examination of their clinical skills. Firstly, the HSE must propose the candidates to the Medical Council, including the speciality of the post, the duties the doctor will be charged with and the supervisory arrangements which will be in place. Similar to candidates for the General Division, all applicants for the Supervised Division must then undergo a Level One assessment and verification of their documentation. Eligible candidates are then required to sit a clinical examination in the area of specialty they will be working in, measuring competence in the areas of clinical judgement, communication and data interpretation. This examination is set at the level of intern exit/ entry to basic specialist training. In August and November 2011, examinations were sat by 266 and 109 candidates respectively in seven specialties (Anaesthesia, Emergency Medicine, General Internal Medicine, Obstetrics & Gynaecology, Paediatrics, Psychiatry, Surgery). In May and December 2012 further examinations were held in the specialties Emergency Medicine and Surgery with 10 and 4 candidates sitting respectively.

TRAS

Temporary Registration Assessment Scheme

MCQ

Multiple Choice Questions

OSCE

Objective Structured Clinical Examination

PRES

Pre-Registration Examination System

Level 2

Computer Based Assessment

Level 3

Clinical Assessment

APPENDIX E: STATISTICS
EXAMINATIONS
STATISTICS
CONTINUED

PRES LEVEL 2 2010

NUMBER OF NATIONALITIES	TOTAL SAT PRES LEVEL 2 2010	TOTAL PASS PRES LEVEL 2 2010
19	127	61



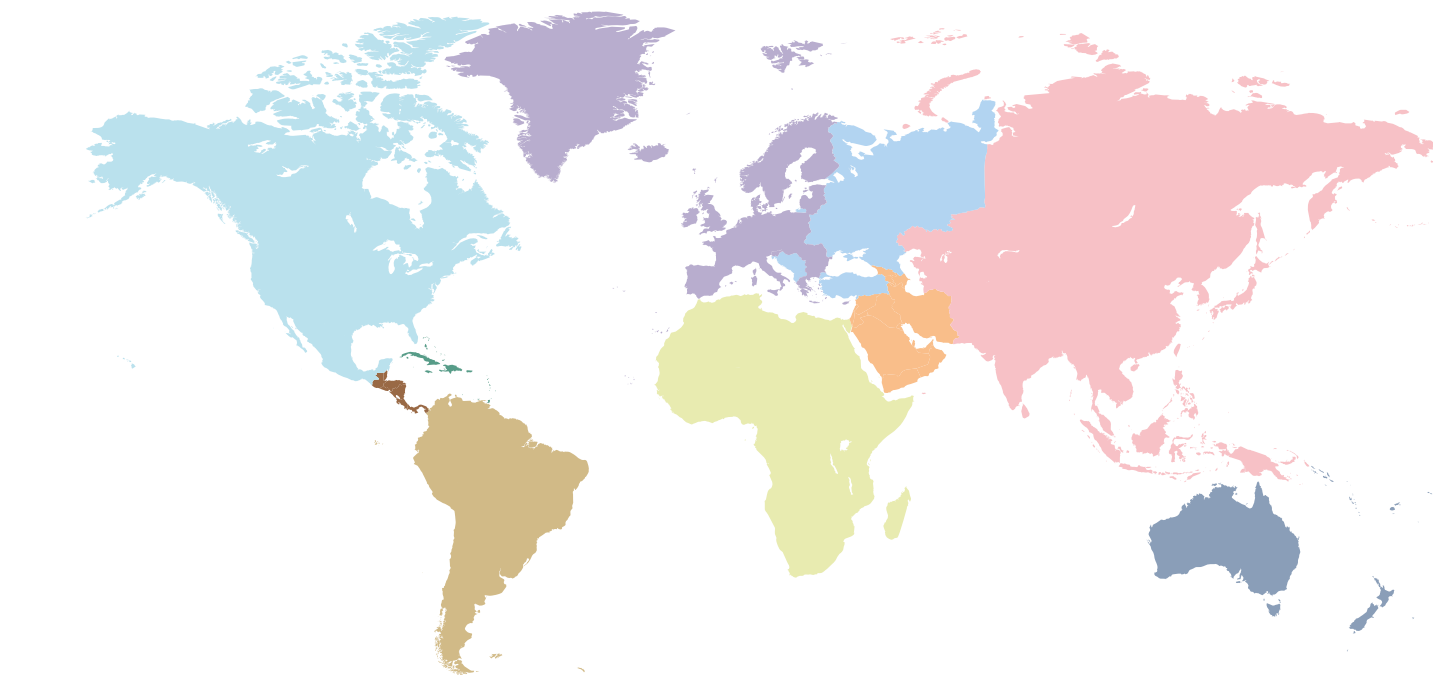
Geographical Region

Africa	52	29
Asia	57	21
Central America	–	–
Eastern Europe	7	1
European Union/EEA	–	–
Middle East	6	6
North America	–	–
Oceania	4	3
South America	–	–
The Caribbean	1	1

APPENDIX E: STATISTICS
EXAMINATIONS
STATISTICS
CONTINUED

PRES LEVEL 2 2011

NUMBER OF NATIONALITIES	TOTAL SAT PRES LEVEL 2 2011	TOTAL PASS PRES LEVEL 2 2011
16	145	87

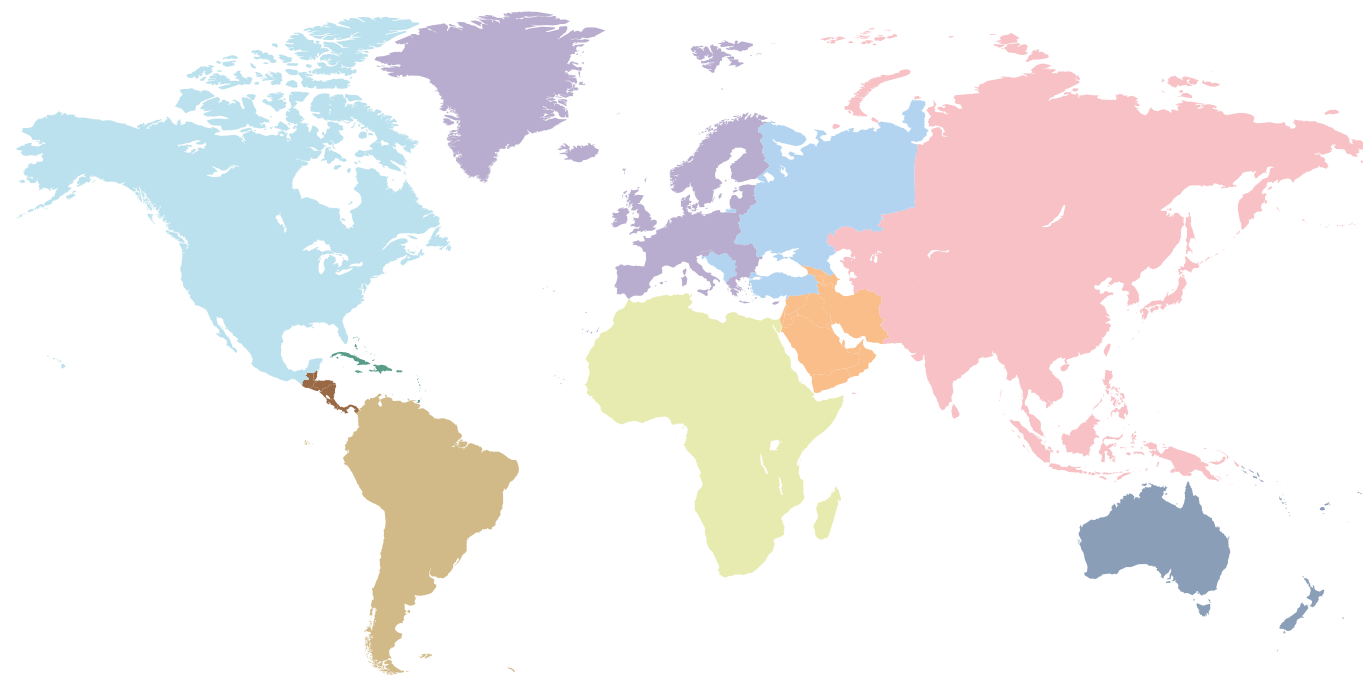


Geographical Region

Africa	70	46
Asia	54	33
Central America	–	–
Eastern Europe	11	2
European Union/EEA	–	–
Middle East	10	6
North America	–	–
Oceania	–	–
South America	–	–
The Caribbean	–	–

APPENDIX E: STATISTICS
EXAMINATIONS
STATISTICS
CONTINUED

NUMBER OF NATIONALITIES	TOTAL SAT PRES LEVEL 2 2012	TOTAL PASS PRES LEVEL 2 2012
15	78	49



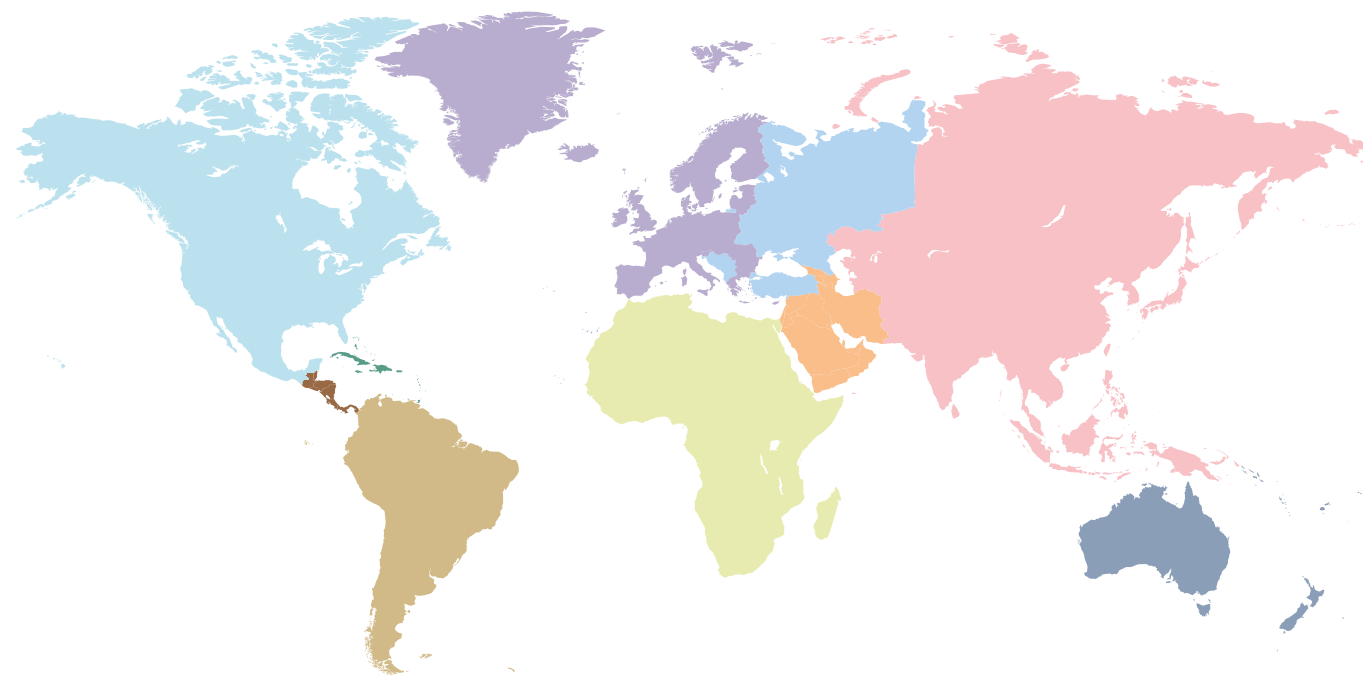
PRES LEVEL 2 2012

Geographical Region

Africa	35	22
Asia	29	18
Central America	–	–
Eastern Europe	8	4
European Union/EEA	–	–
Middle East	5	4
North America	–	–
Oceania	–	–
South America	–	–
The Caribbean	1	1

APPENDIX E: STATISTICS
EXAMINATIONS
STATISTICS
CONTINUED

NUMBER OF NATIONALITIES	TOTAL SAT PRES LEVEL 3 2010	TOTAL PASS PRES LEVEL 3 2010
19	255	149



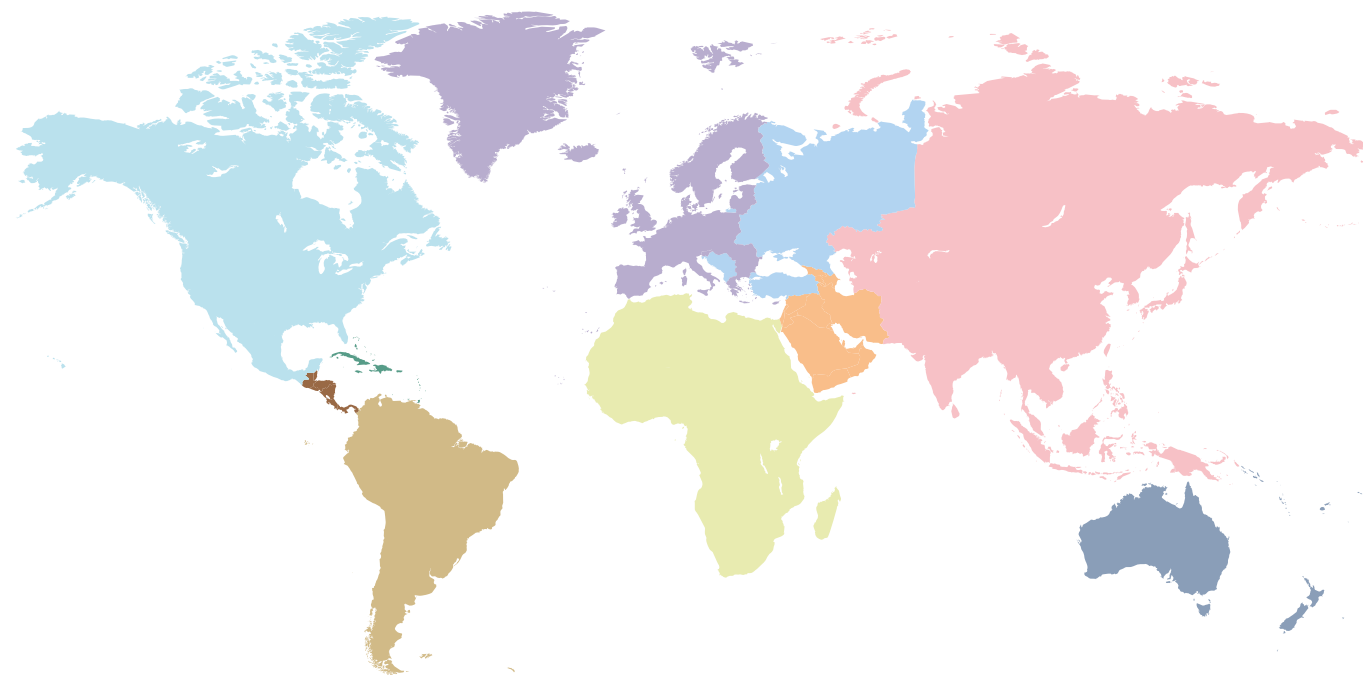
PRES LEVEL 3 2010

Geographical Region

Africa	144	82
Asia	87	52
Central America	–	–
Eastern Europe	5	4
European Union/EEA	–	–
Middle East	16	9
North America	–	–
Oceania	–	–
South America	2	1
The Caribbean	1	1

APPENDIX E: STATISTICS
EXAMINATIONS
STATISTICS
CONTINUED

NUMBER OF NATIONALITIES	TOTAL SAT PRES LEVEL 3 2011	TOTAL PASS PRES LEVEL 3 2011
17	142	76



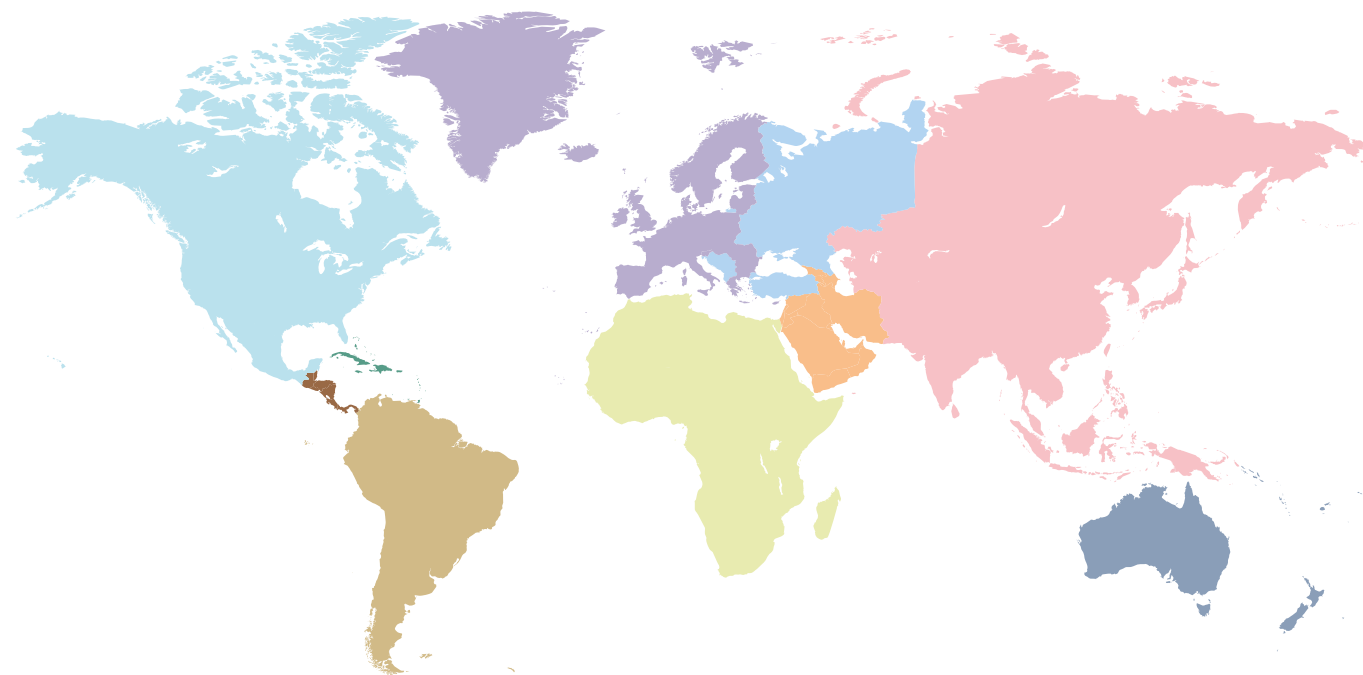
PRES LEVEL 3 2011

Geographical Region

Africa	76	43
Asia	48	26
Central America	–	–
Eastern Europe	6	0
European Union/EEA	–	–
Middle East	12	7
North America	–	–
Oceania	–	–
South America	–	–
The Caribbean	–	–

APPENDIX E: STATISTICS
EXAMINATIONS
STATISTICS
CONTINUED

NUMBER OF NATIONALITIES	TOTAL SAT PRES LEVEL 3 2012	TOTAL PASS PRES LEVEL 3 2012
15	62	44



PRES LEVEL 3 2012

Geographical Region

Africa	25	19
Asia	28	18
Central America	–	–
Eastern Europe	5	3
European Union/EEA	1	1
Middle East	2	2
North America	–	–
Oceania	–	–
South America	–	–
The Caribbean	1	1

APPENDIX E: STATISTICS PRELIMINARY PROCEEDINGS COMMITTEE STATISTICS

PRELIMINARY PROCEEDINGS COMMITTEE

PRELIMINARY PROCEEDINGS COMMITTEE (PPC)

SETTING PROFESSIONAL STANDARDS

The Medical Council sets and promotes standards for doctors publishing a 'Guide to Professional Conduct and Ethics for Registered Medical Practitioners.' This booklet provides guidance to doctors on issues such as consent, confidentiality, end-of-life care, provision of information to the public, prescribing practices and referral of patients.

MONITORING PROFESSIONAL STANDARDS

Doctors can only work in Ireland if they are entered on the Medical Council's Register. In certain instances, the Medical Council has the power to: advise, admonish or censure a doctor; remove or suspend a doctor from the Register or place restrictions on his or her registration. The Medical Council protects the public interest by responding to complaints made about doctors using a fair and robust process. Anybody can make a complaint about a doctor. This includes members of the public, a doctor's employer, other healthcare professional's or the Medical Council itself. The majority of complaints about doctors in Ireland are made by members of the public, in contrast to international trends, whereby the majority of complaints are made by healthcare professionals, employers or public bodies.

THE COMPLAINTS PROCESS

When a complaint about a registered doctor is received the Medical Council's Preliminary Proceedings Committee (PPC) considers the information received as well as any information from the doctor. The PPC may look for additional information relating to the complaint. The PPC will decide whether the case should go forward for an inquiry by the Medical Council's Fitness to Practise Committee (FtPC).

In any other case the PPC forms the opinion that the following is required:

- a) no further action
- b) referral to another body/ authority/ competence scheme
- c) mediation

The Council makes a decision based on the PPC opinions or can direct the complaint to be referred to the FtPC for inquiry. Complaints received in any given year may be carried over to the next year. Therefore, there is a difference between the number of decisions (prima facie and non prima facie) and the number of complaints received. In the event of an inquiry, the FtPC will usually be made up of three people: two without a medical background and one doctor. The FtPC is chaired by a member of the Medical Council. An inquiry may be held in public or if the FtPC believes it is appropriate, all or part of an inquiry may be heard in private. The person who made the complaint, the doctor, who is the subject of the complaint or any other witness, can apply to have

all or part of inquiry held in private. After hearing an inquiry, the FtPC reports its findings to the Medical Council. If the FtPC finds that the allegations against the doctor have been proven, the Council may impose sanctions on the doctor including advice, admonishment, censure or removing the doctor from the Register so that he or she cannot practise for a specific length of time.

APPENDIX E: STATISTICS
PRELIMINARY
PROCEEDINGS COMMITTEE
STATISTICS
CONTINUED

ALL DECISIONS

COMPLAINTS STATISTICS (PPC)

DECISIONS	2012	2011	2010
PF	56	39	55
NPF	340	328	259
Total Decisions made	396	367	314

NPF OF WHICH	2012	2011	2010
No further action	306	299	227
Mediation	5	6	16
Professional Competence	5	–	–
Another Body	9	1	–
Withdrawal	15	22	16
Total No of Cases	340	328	259

NPF = No Prima Facie Decision.

This means that a Fitness to Practise inquiry was not called. Cases within this category could also be withdrawn, referred to another body, referred to mediation or for performance assessment under the MPA 2007.

PF = Prima Facie Decision.

This means that a Fitness to Practise inquiry was called.

GENDER OF DOCTORS

	2012		2011		2010	
	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE
Involved in PF cases	50	7	35	3	46	8
Involved in NPF cases	315	98	290	101	224	62
Number of Doctors*	470		429		340	
Total individual Doctors involved in cases decided upon**	428		424		337	

Note: Categories of complaint were updated in 2012 to better reflect the Ethical Guide. As such it is now possible for Case Officers to attach more than one category to a complaint.

* A complaint may involve multiple doctors. Therefore the number of doctors and the number of decisions will not match in any given year.

** The same doctor can be involved in different cases where a complaint is made about a doctor on more than one occasion.

APPENDIX E: STATISTICS
PRELIMINARY
PROCEEDINGS COMMITTEE
STATISTICS
CONTINUED

RATIO OF COMPLAINTS RECEIVED

	2012	2011	2010
Number of Doctors on Register	18,184	18,812	18,770
Number of Doctors Complained Against	494	433	384
Percentage of Doctors Complained Against	2.7%	2.30%	2.05%

In 2012, approximately **1 in every 37 doctors** on the Register was the subject of a complaint made to the Medical Council.

Note: Data on Complaints Received includes cases where decisions are pending at year end.

RATIO OF COMPLAINTS RECEIVED

APPENDIX E: STATISTICS
PRELIMINARY
PROCEEDINGS COMMITTEE
STATISTICS

CONTINUED

CATEGORIES OF COMPLAINT

2012

Professional Conduct	29
Criminal Convictions	5
Informing Medical Council of other regulatory proceedings/decisions, criminal charges and/or convictions.	8
Breach of the Medical Practitioners Act 2007	3
Dishonesty	13
Responsibilities to Patients	229
Reporting obligations concerning abuse of children/elderly/vulnerable adults	3
Treating patients with dignity	32
Refusal to treat	29
Conscientious objection	0
Emergencies	4
Appropriate Professional Skills	25
Adequate language Skills	0
Communication	106
Physical and intimate examinations	19
Personal relationships with patients	6
Assisted Human Reproduction	1
End of life care	4
Medical Records and Confidentiality	27
Maintenance of accurate and up to date patient medical records	15
Confidentiality	12
Professional Practice	100
Maintaining Competence	4
Reporting concerns about colleagues	1
Professional relationships between colleagues	9
Professional Indemnity	0
Accepting Posts	0
Treatment of relatives	0
Advertising	4

APPENDIX E: STATISTICS
PRELIMINARY
PROCEEDINGS COMMITTEE
STATISTICS
CONTINUED

CATEGORIES OF COMPLAINT
(CONTINUED)

2012	
Premises and Practice Information	5
Medical reports	20
Certification	16
Prescribing	28
Referral of patients	11
Locum and rota arrangement	0
Telemedicine	0
Retirement and transfer of patient care	2
Relevant Medical Disability	7
Alcohol Abuse	0
Drug Abuse	1
Mental or behavioural illness	3
Physical illness	3
Treatment	295
Consent	12
Clinical investigations and examinations	77
Diagnosis	105
Follow up care	55
Surgical Procedures	33
Continuity of care	13
Other	1
Total categories attached to complaints	688

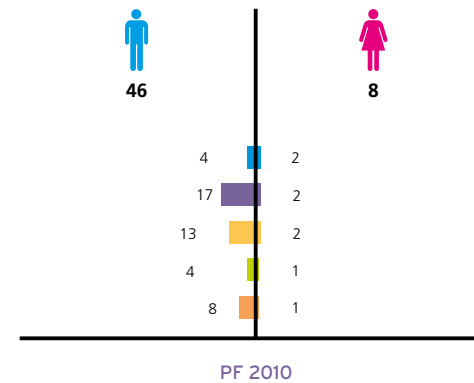
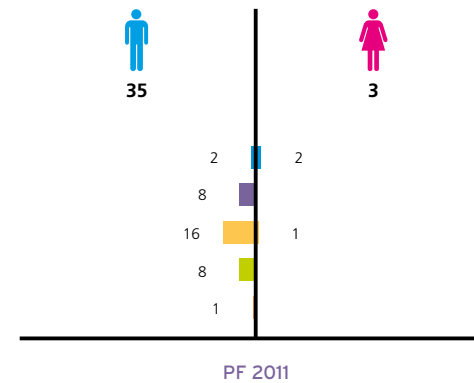
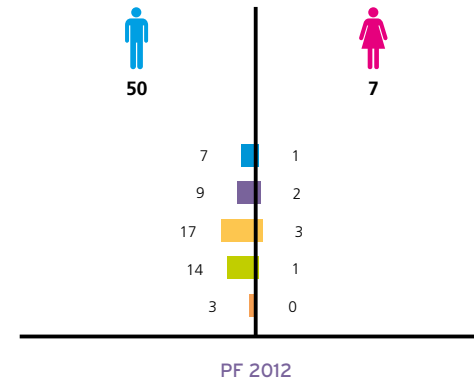
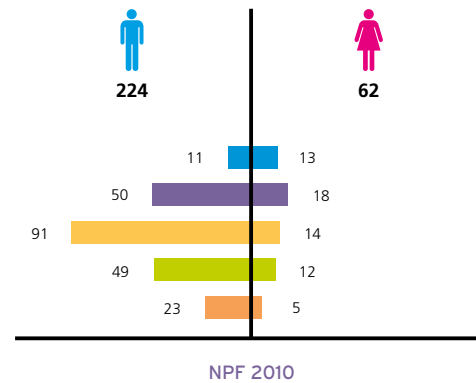
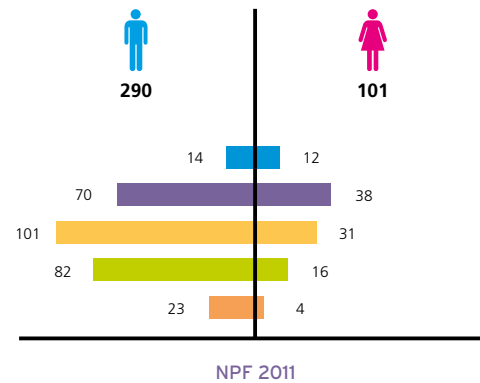
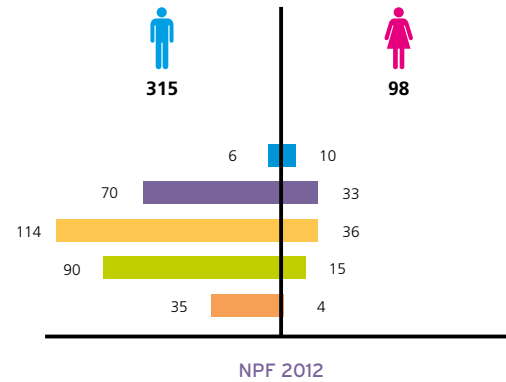
Note: Categories of complaint were updated in 2012 to reflect the Ethical Guide. It is now possible for Case Officers to attach more than one category to a complaint i.e. the complaint might be in relation to poor communication but may also mention failure to refer a patient. As such the categories do not add to the number of complaints received in a year i.e. 423 complaints received in 2012.

Please click [here](#) to view the 2011 Annual Report which provides a breakdown of categories of complaint for previous years.

APPENDIX E: STATISTICS PRELIMINARY PROCEEDINGS COMMITTEE STATISTICS

CONTINUED

AGE RANGES



- 20 - 35 years
- 36 - 45 years
- 46 - 55 years
- 55 - 64 years
- 64 + years

NPF = No Prima Facie Decision. This means that a Fitness to Practise inquiry was not called. Cases within this category could also be withdrawn, referred to another body, referred to mediation or for performance assessment under the MPA 2007.

PF = Prima Facie Decision. This means that a Fitness to Practise inquiry was called.

[Click here](#) to view a breakdown of the Register.

APPENDIX E: STATISTICS

PRELIMINARY PROCEEDINGS COMMITTEE STATISTICS

CONTINUED

CATEGORIES OF APPLICANTS

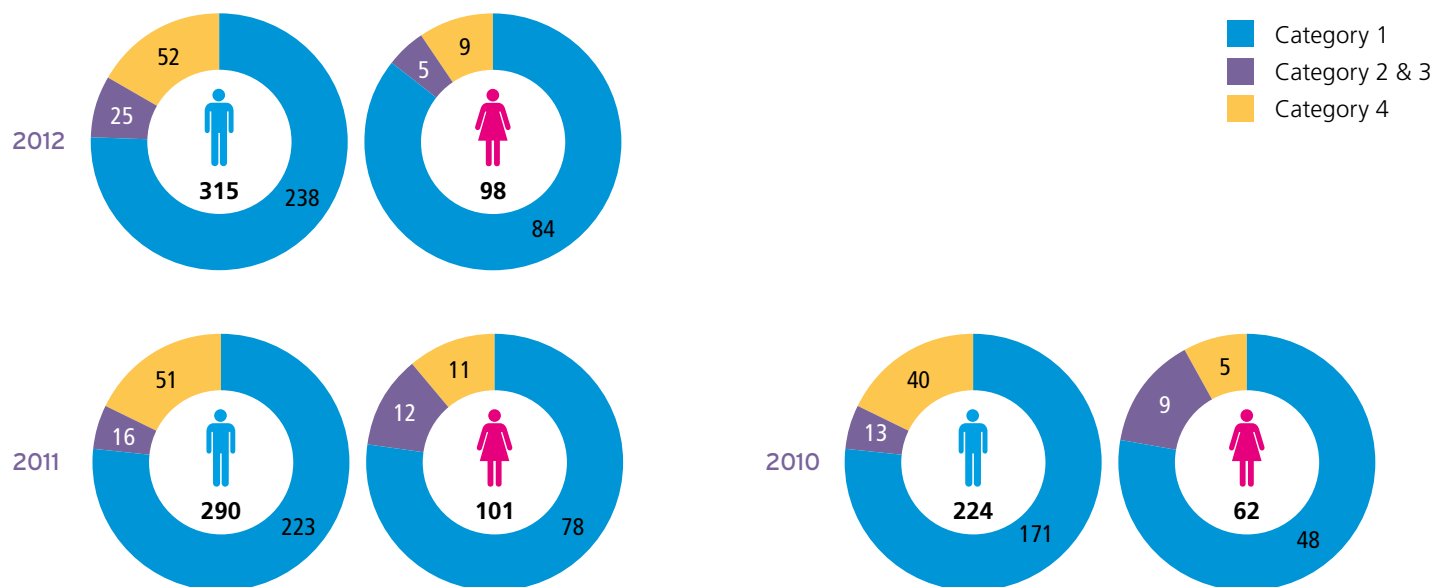
The four main categories of applicants for either the General Division or Specialist Division are:

CATEGORY 1	CATEGORY 2	CATEGORY 3	CATEGORY 4
Graduates of Irish medical schools.	EU citizens who graduated in an EU medical school and/or their qualifications are recognised under EU directive 2005/36/EC (recognition of professional qualifications for EU citizens).	Non-EU citizens who graduated in an EU medical school and/or their qualifications would be recognised under EU directive 2005/36/EC (recognition of professional qualifications) if they were an EU citizen.	Doctors who do not meet the criteria for any of the above categories.

NOTE:

For the purposes of this report, Category 2 & 3 have been combined so that this illustrates the number of doctors which have graduated from EU Medical Schools and/or whose qualifications would be recognised under EU Directive 2005/36/EC (recognition of professional qualifications) if they were an EU citizen.

NPF CATEGORIES



NPF = No Prima Facie Decision. This means that a Fitness to Practise inquiry was not called. Cases within this category could also be withdrawn, referred to another body, referred to mediation or for performance assessment under the MPA 2007.

PF = Prima Facie Decision. This means that a Fitness to Practise inquiry was called.

APPENDIX E: STATISTICS
PRELIMINARY
PROCEEDINGS COMMITTEE
STATISTICS
CONTINUED

PF CATEGORIES



APPENDIX E: STATISTICS
PRELIMINARY
PROCEEDINGS COMMITTEE
STATISTICS
CONTINUED

2012	NPF		PF	
	MALES	FEMALES	MALES	FEMALES
Asia	28	5	10	-
EU	249	91	20	4
Middle East	4	-	-	-
Africa	25	2	14	3
Oceania	1	-	-	-
North America	5	-	6	-
South America	2	-	-	-
Unknown	1	-	-	-
Total	315	98	50	7

2011	NPF		PF	
	MALES	FEMALES	MALES	FEMALES
Asia	21	6	6	-
EU	235	89	19	3
Middle East	4	-	-	-
Africa	25	5	10	-
Oceania	4	1	-	-
North America	1	-	-	-
Total	290	101	35	3

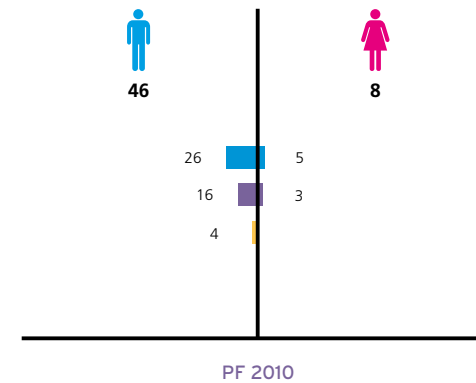
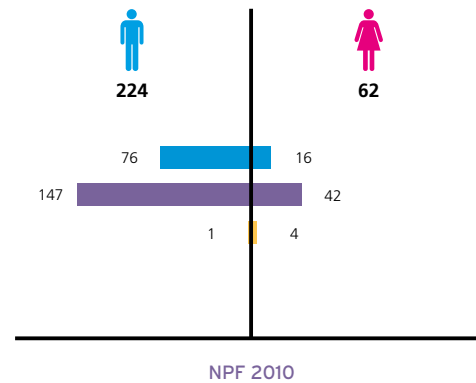
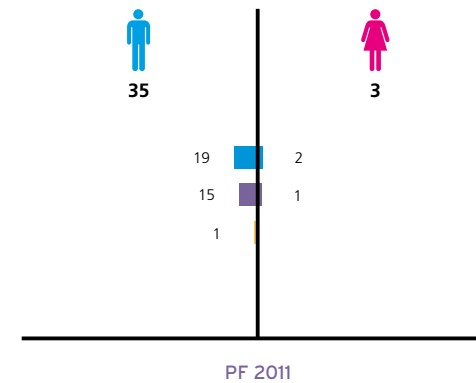
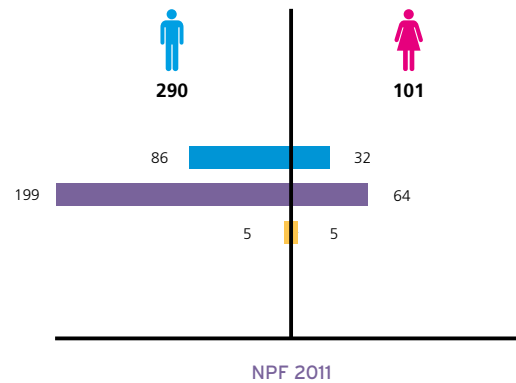
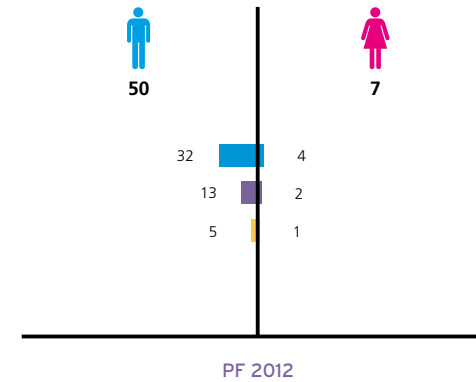
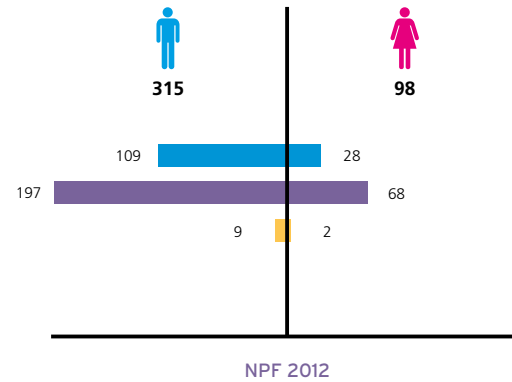
2010	NPF		PF	
	MALES	FEMALES	MALES	FEMALES
Asia	26	5	7	1
EU	177	55	28	5
Middle East	3	-	1	-
Africa	18	1	10	2
North America	-	1	-	-
Total	224	62	46	8

COUNTRY OF ORIGIN

NPF = No Prima Facie Decision. This means that a Fitness to Practise inquiry was not called. Cases within this category could also be withdrawn, referred to another body, referred to mediation or for performance assessment under the MPA 2007.

PF = Prima Facie Decision. This means that a Fitness to Practise inquiry was called.

APPENDIX E: STATISTICS
PRELIMINARY
PROCEEDINGS COMMITTEE
STATISTICS
CONTINUED



- General Division
- Specialist Division
- Trainee Specialist Division
- Intern Registration
- Supervised Division

NPF = No Prima Facie Decision. This means that a Fitness to Practise inquiry was not called. Cases within this category could also be withdrawn, referred to another body, referred to mediation or for performance assessment under the MPA 2007.

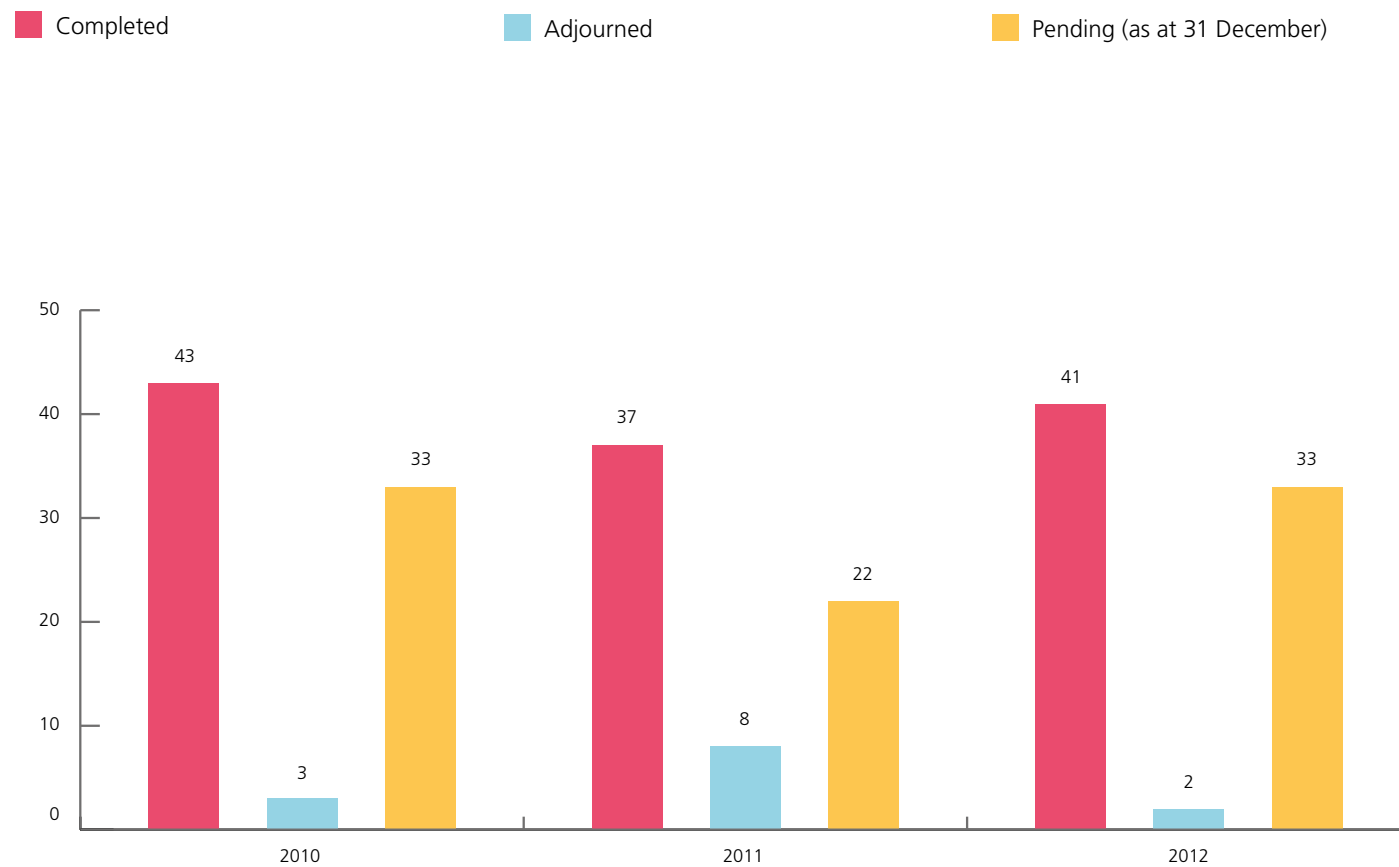
PF = Prima Facie Decision. This means that a Fitness to Practise inquiry was called.

[Click here](#) to view a breakdown of the Register.

DIVISIONS OF THE REGISTER
VS. GENDER

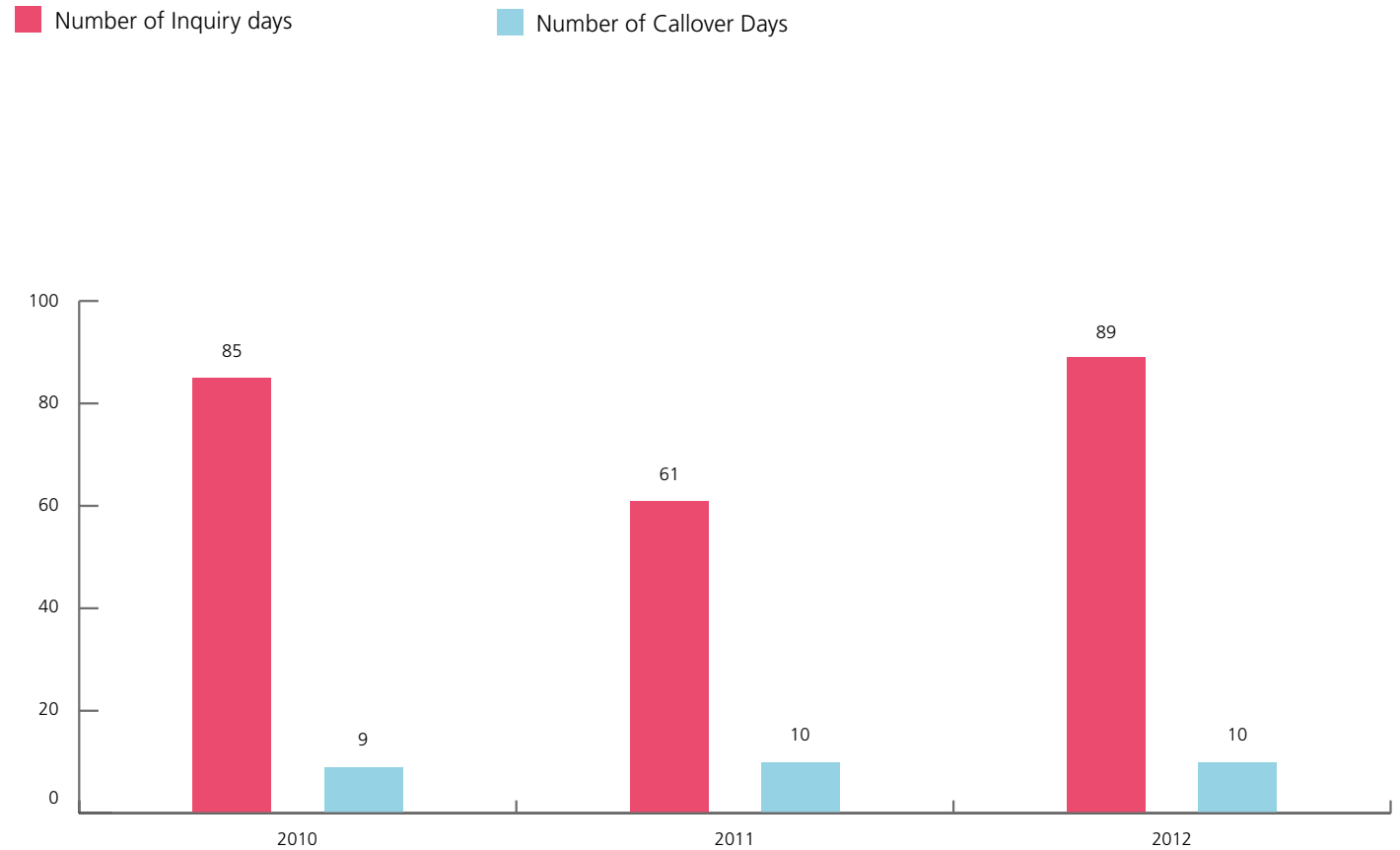
APPENDIX E: STATISTICS FITNESS TO PRACTISE STATISTICS

STATUS OF INQUIRIES HELD



APPENDIX E: STATISTICS FITNESS TO PRACTISE STATISTICS CONTINUED

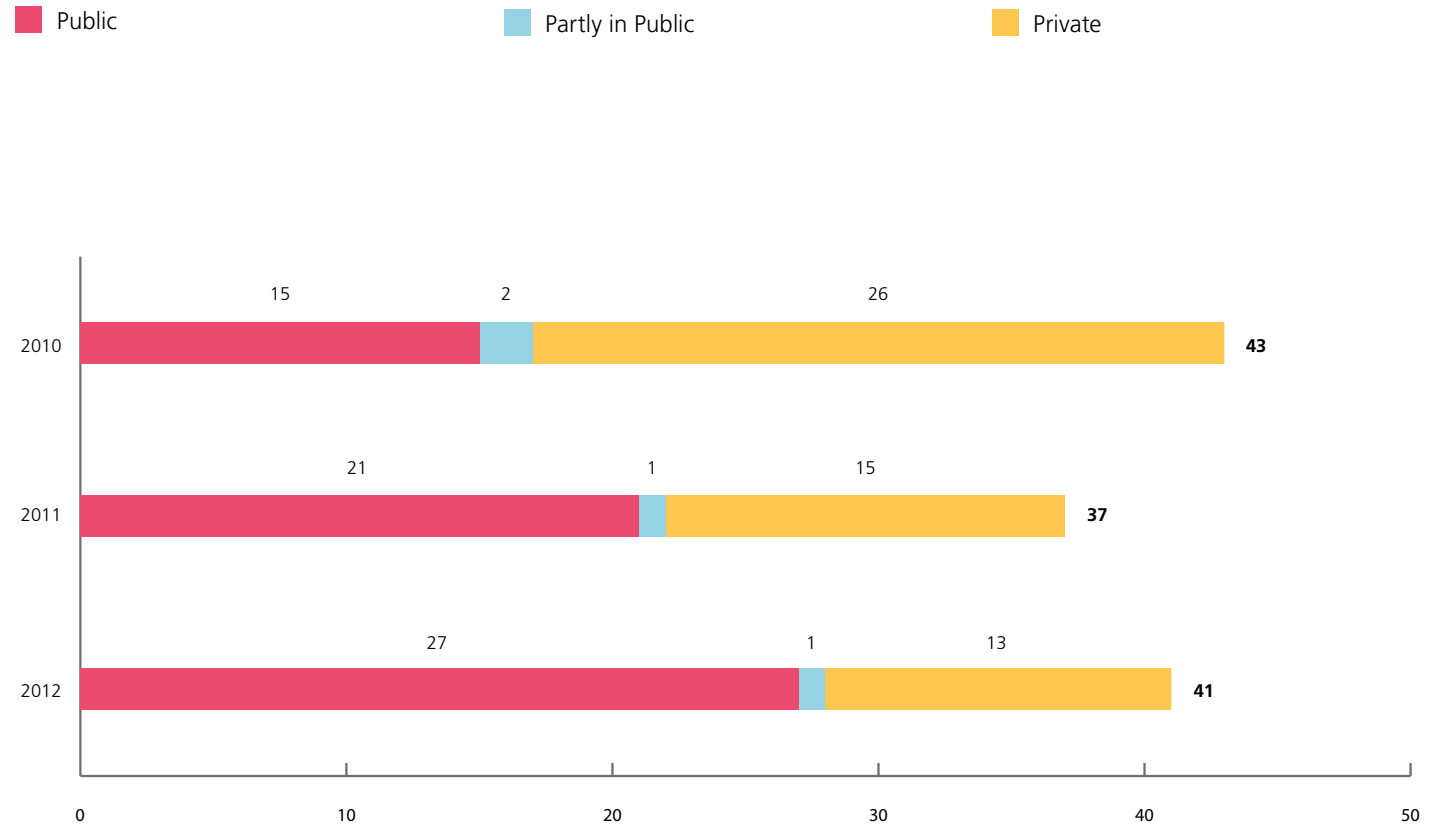
STATUS OF INQUIRIES HELD (CONTINUED)



1. **Fitness to Practise Callover meetings** – A case management system was introduced in 2010 and does not therefore apply to the years prior to this. The Callover takes place before a panel of three Fitness to Practise Committee (FTPC) members. Doctors and/or their legal representative(s) are invited to attend before the FTPC. The purpose of the Callover is to fix dates for hearings, decide as to whether an inquiry will be held in private/public/part public and any other preliminary issues that may arise.
2. In 2012 the average number of days per inquiry was 2.3. This compares with previous years where between 2008 and 2011 an average of 2.2 days was recorded.

APPENDIX E: STATISTICS FITNESS TO PRACTISE STATISTICS CONTINUED

BREAKDOWN OF INQUIRIES HELD



Note: more than one sanction can be imposed on a registered medical practitioner.

Transparency

The Medical Council strives to carry out its work in an open and transparent manner to ensure the confidence of doctors and the public. In March 2009, the first public inquiry was heard under the Medical Practitioners Act 2007. Inquiries are held in public unless an application is made by the complainant, the doctor, or a witness to hold all, or part, of the inquiry in private, and the Fitness to Practise Committee is satisfied that it would be appropriate in the circumstances to do so. Under the Medical Practitioners Act, 1978 all inquiries were held in private.

APPENDIX E: STATISTICS
FITNESS TO PRACTISE
STATISTICS
CONTINUED

	2010	2011	2012
Number of inquiries held	43	37	41
Number of doctors	45	37	43
Number of doctors with legal representation	39	22	33
Number of doctors without legal representation	6	15	10

Note: The Medical Council encourages all doctors who are the subject of an inquiry to retain legal representation.

DOCTORS LEGAL REPRESENTATION

APPENDIX E: STATISTICS FITNESS TO PRACTISE STATISTICS

CONTINUED

	2010		2011		2012	
	1978 ACT	2007 ACT	1978 ACT	2007 ACT	1978 ACT	2007 ACT
Guilty of Professional Misconduct	1	18	1	11	0	12
Unfit to engage in practice of medicine/ Relevant Medical Disability (RMD)	0	2 (RMD)	0	0	0	1
Poor professional performance	N/A	4	N/A	9	0	10
Not Guilty / Fit to engage in practice of medicine / No case	1	5	2	7	0	5
Consent to Censure/ Undertaking pursuant to S67	N/A	11	N/A	7	0	14
Case Struck Out by FTPC	N/A	4	N/A	6	0	11

Note 1: As a doctor can be found guilty of a number of different allegations the total figures can amount to a higher number than the number of inquiries held.

Note 2: Section 67 – Allows the FtPC to request the doctor, the subject of the complaint, to:

- not repeat the conduct of the complaint and/or
- be referred to a professional competence scheme and/ or
- undergo medical treatment and/ or
- being censured by the Medical Council

Note 3: Section 2 of the MPA 2007 defines a Relevant Medical Disability (RMD) as a physical or mental disability of the practitioner (including addiction to alcohol or drugs) which may impair the practitioner's ability to practise medicine or a particular aspect thereof.

Please click [here](#) for Health Committee statistics.

OUTCOME OF INQUIRIES

APPENDIX E: STATISTICS

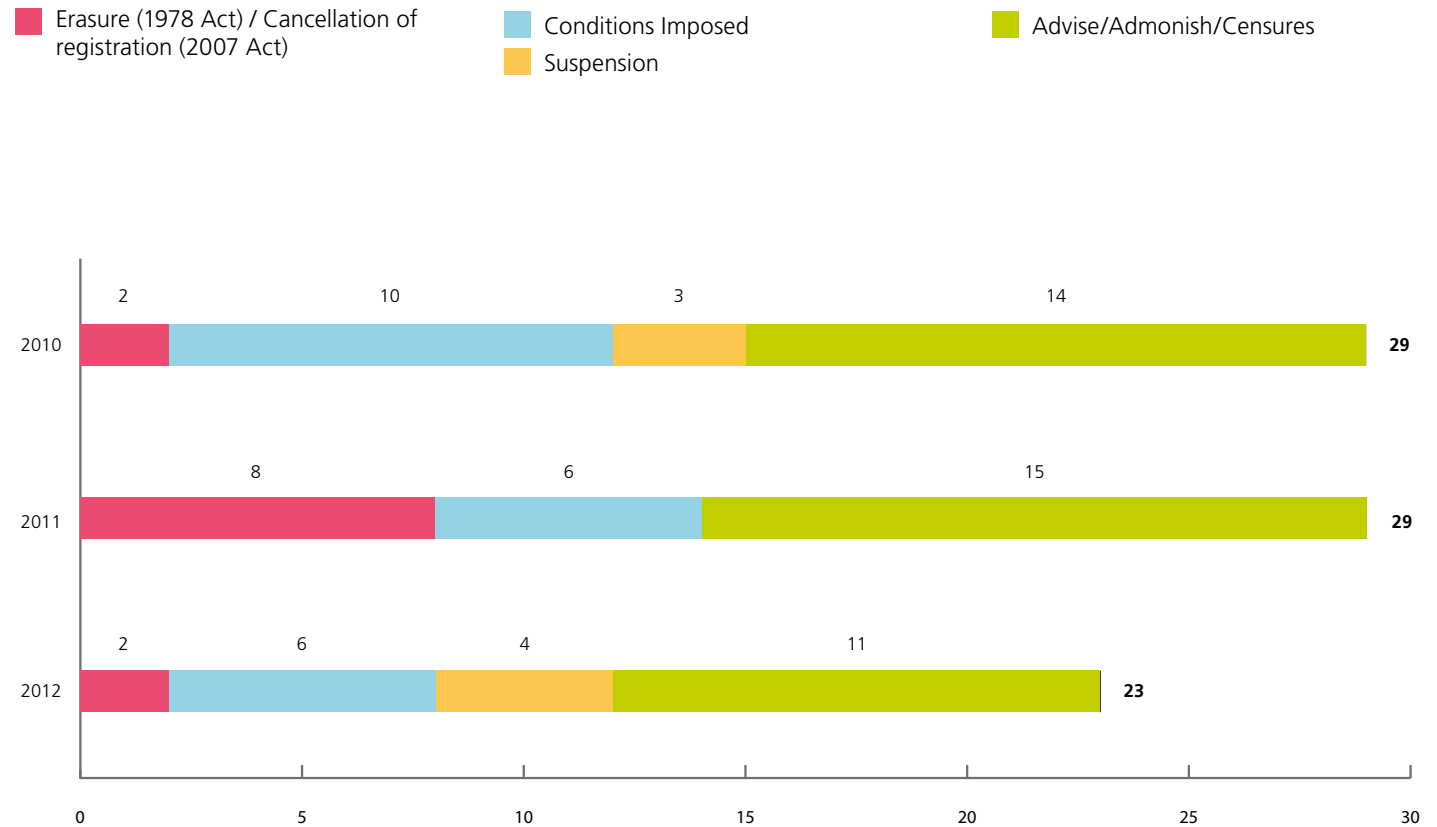
FITNESS TO PRACTISE

STATISTICS

CONTINUED

BREAKDOWN OF INQUIRIES HELD

SANCTIONS IMPOSED

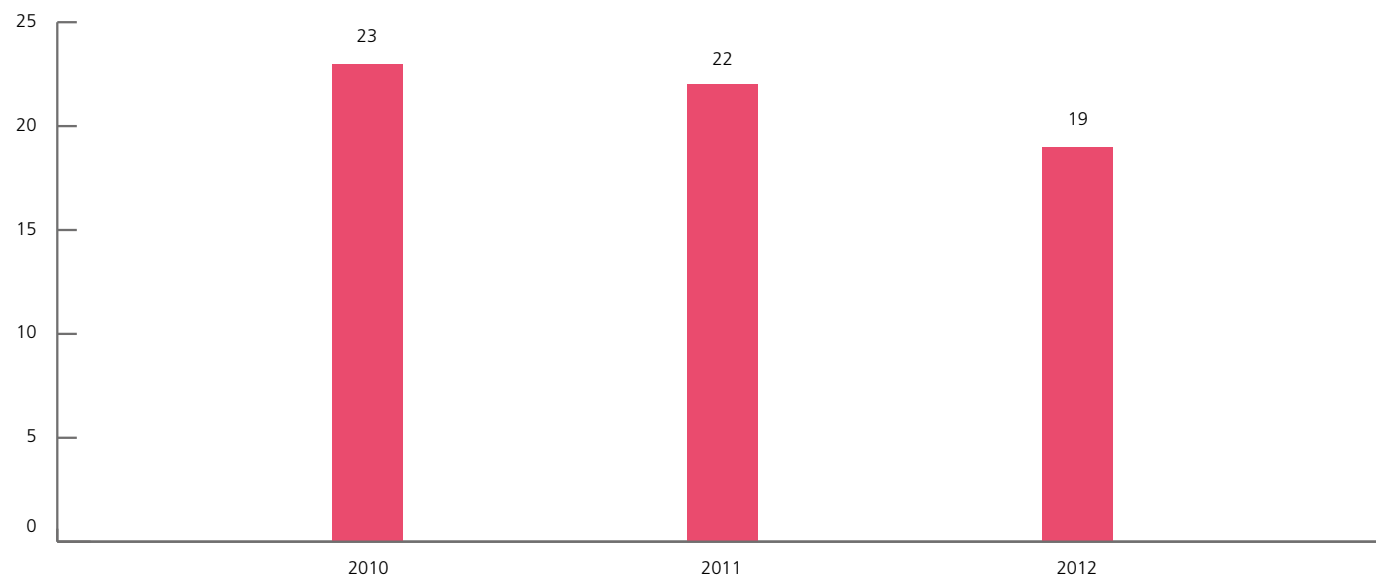


Monitoring Working Group

Following a Fitness to Practise Inquiry, the FTPC may impose conditions on a doctor's continued registration. Restrictions may be imposed on where or how a doctor can practise or a doctor may be required to complete a specific training course or may be referred for treatment. The Monitoring Working Group monitors compliance by doctors in relation to conditions imposed on their continued registration. If the doctor fails to comply with the conditions imposed, the Monitoring Working Group will refer the issue back to the Medical Council.

APPENDIX E: STATISTICS
FITNESS TO PRACTISE
STATISTICS
CONTINUED

NUMBER OF DOCTORS WITH
CONDITIONS ON REGISTRATION

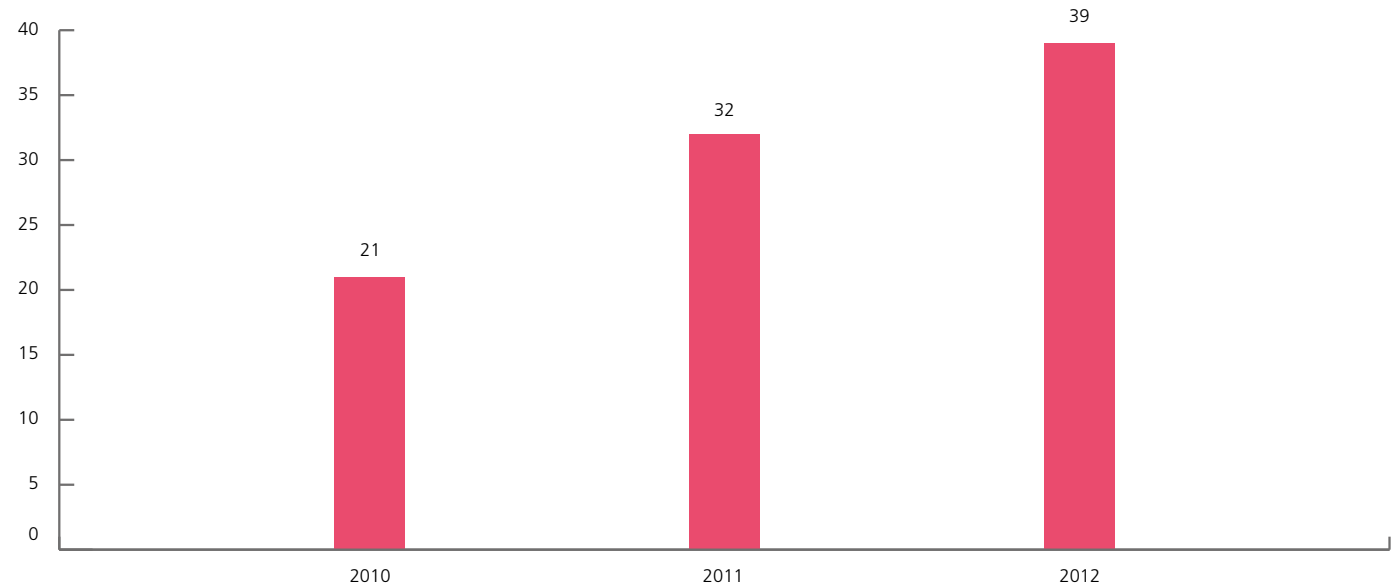


Monitoring Working Group

Conditions can be attached by the Medical Council, both as a sanction following a Fitness to Practise inquiry and in accordance with section 53(3) of the MPA 2007 where the doctor has declared a relevant medical disability.

APPENDIX E: STATISTICS
FITNESS TO PRACTISE
STATISTICS
CONTINUED

DOCTORS ATTENDING
HEALTH COMMITTEE



Note: 1 doctor of the 32 referred to the Health Committee in 2011 was referred for 2 different reasons and therefore the number of referrals totals 33.

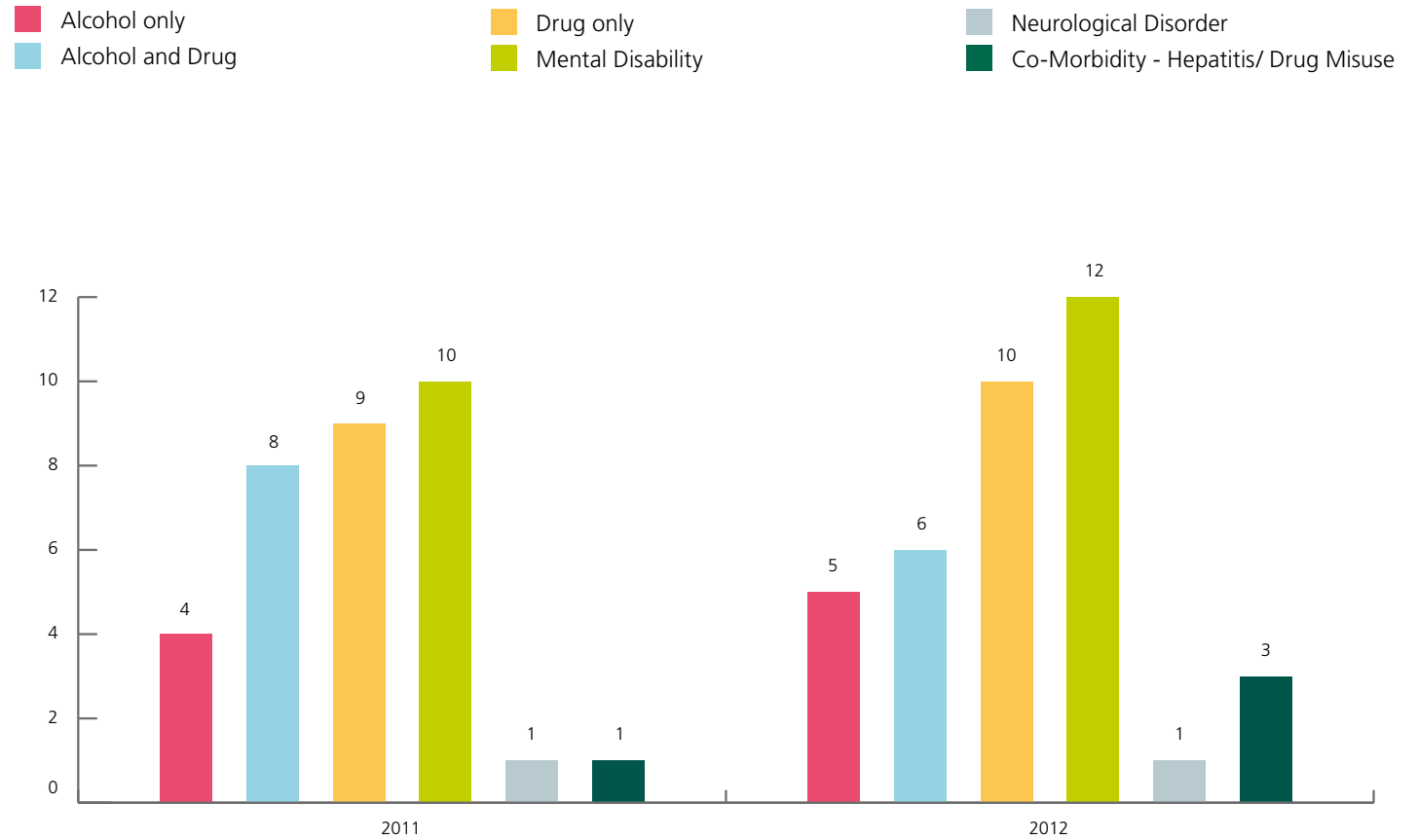
The Health Committee supports both doctors with relevant medical disabilities and those who have provided undertakings to the Fitness to Practise Committee to undergo medical treatment.

APPENDIX E: STATISTICS

FITNESS TO PRACTISE

STATISTICS

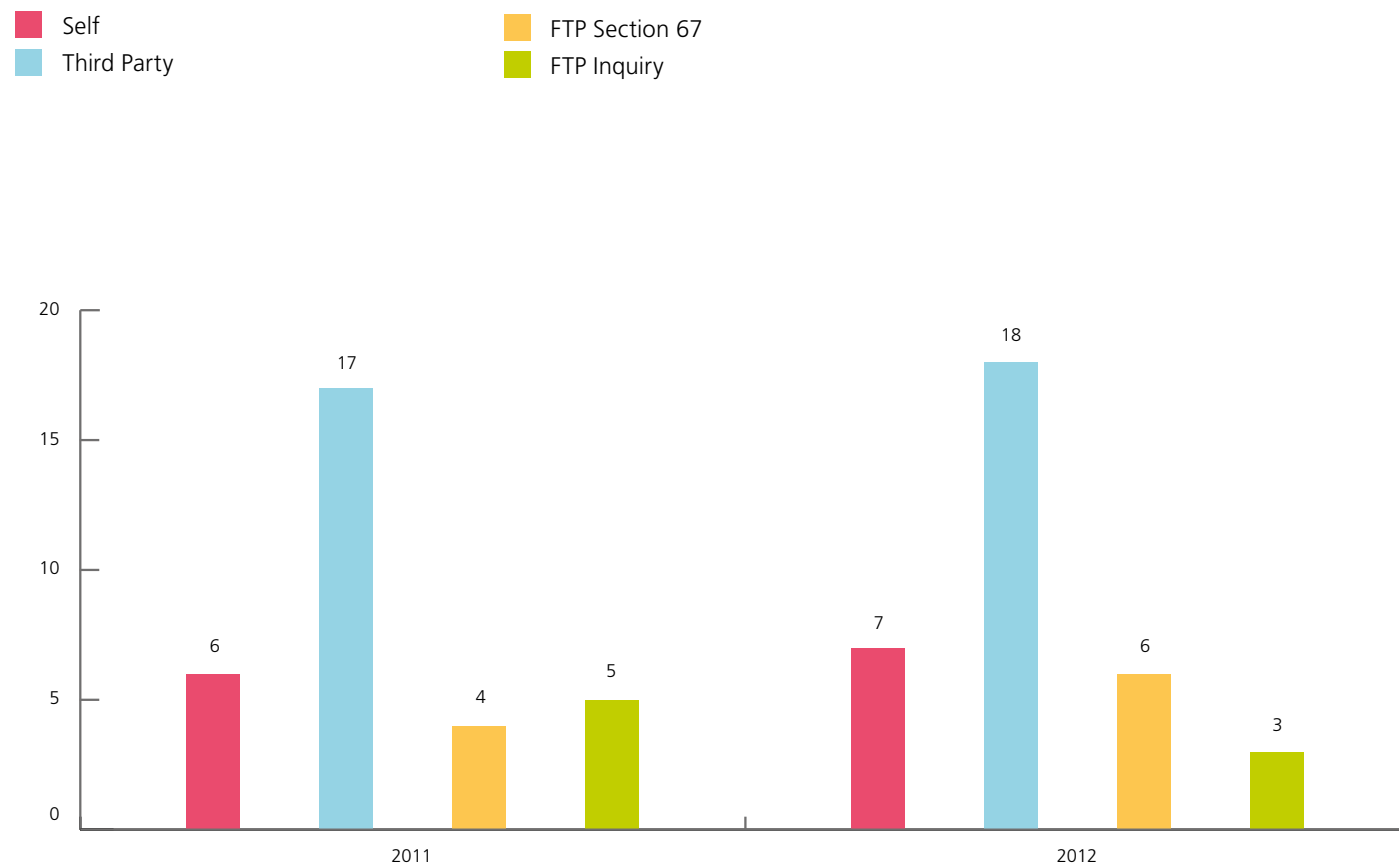
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REASONS FOR REFERRAL TO

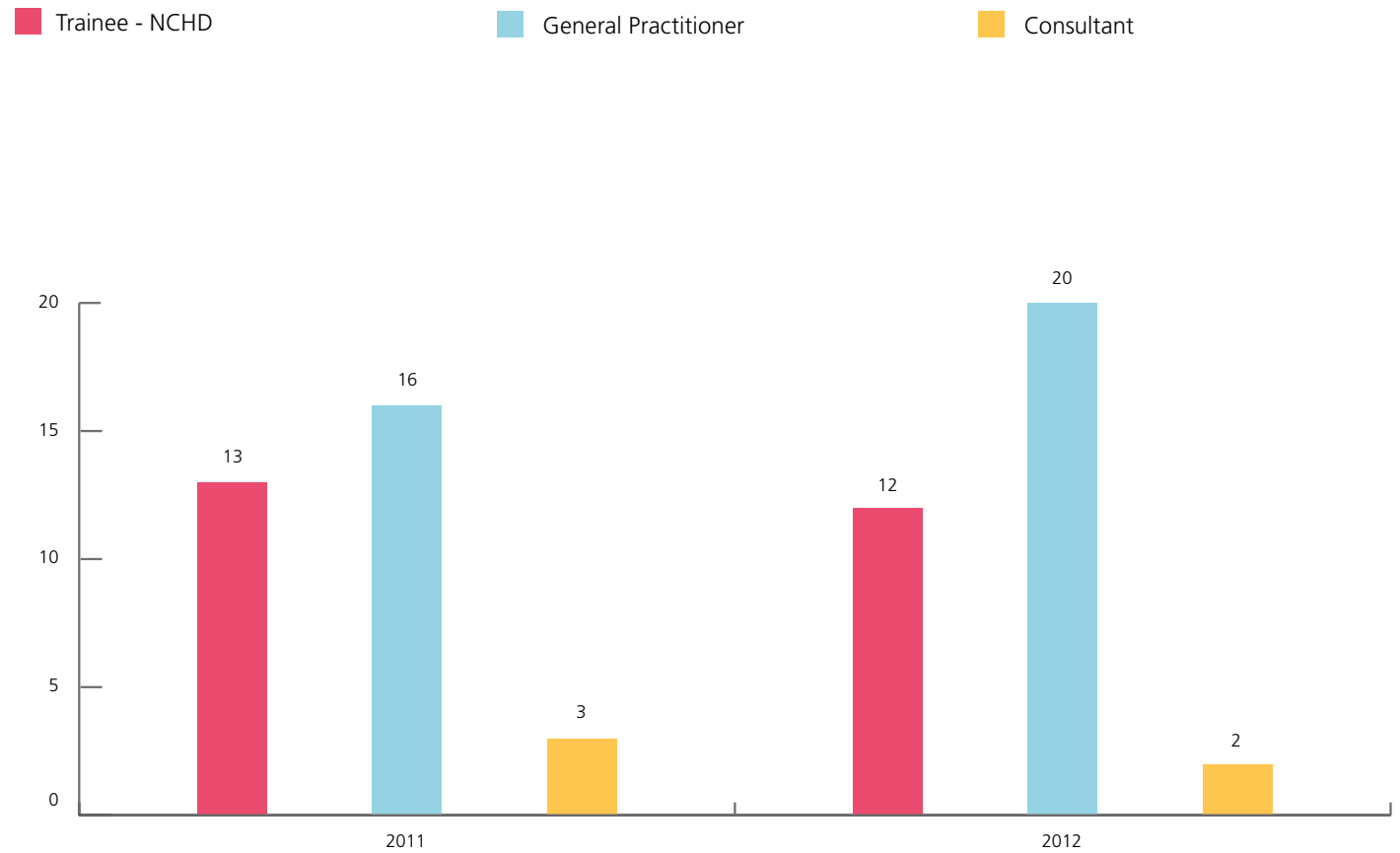
HEALTH COMMITTEE

APPENDIX E: STATISTICS
FITNESS TO PRACTISE
STATISTICS
CONTINUED



SOURCE OF REFERRAL TO
HEALTH COMMITTEE

APPENDIX E: STATISTICS
FITNESS TO PRACTISE
STATISTICS
CONTINUED



CATEGORY OF REFERRAL TO
HEALTH COMMITTEE

APPENDIX E: STATISTICS THE REGISTER OF MEDICAL PRACTITIONERS

THE REGISTER OF MEDICAL PRACTITIONERS

MAINTAINING THE REGISTER OF DOCTORS

The Medical Council ensures that only properly qualified doctors are registered and allowed to practise in Ireland. The Medical Council's register lists the details of these doctors, whose qualifications are recognised by the Council. It provides assurance to the public of a doctor's good standing and continuing competence.

The Register is published on www.medicalcouncil.ie so that the public can check whether a doctor is listed.

In order to remain on the Register, doctors must pay an annual retention fee and complete an annual declaration, validating their ability to practise medicine. All doctors are required to demonstrate that they have fulfilled the professional competence requirements.

In certain circumstances, the Medical Council has the power to remove or suspend a doctor from the Register or impose certain conditions on his or her registration.

ROUTES TO REGISTRATION

When doctors apply for registration with the Medical Council they must indicate under which division they are applying, however, it is the Council which determines the division to which a doctor is registered. There are five divisions on the Register:

1. Trainee Specialist Division

This includes internship registration for medical graduates, who are completing a 12-month internship in a hospital recognised by the Medical Council. Graduates of most medical schools in Ireland and the rest of the EU can apply for internship registration.

This division also includes qualified doctors, who are in approved postgraduate training posts. This training normally takes place in a hospital, health institution, clinic, medical practice or other health service setting approved by the Council. All applicants to this division must have been awarded a document, which is at least the equivalent of the Certificate of Experience (Internship Certificate). Doctors from outside the EU/EEA who received their qualification outside of the EU/EEA must also pass or have been exempted from the Pre-Registration Examination System (PRES). The PRES tests a candidate's factual knowledge and clinical skills of the main clinical disciplines.

2. General Division

This includes qualified doctors, who have not engaged in specialist training recognised by a relevant training body in Ireland and who do not work in an individually numbered postgraduate training position. All applicants for this division must have a recognised basic medical degree from a medical school in Ireland or another EEA country or Switzerland or have been awarded a document which is at least the equivalent of the Certificate of Experience (Internship Certificate) or have passed or been exempted from the PRES.

3. Specialist Division

This includes doctors, who have completed specialist training recognised by the Medical Council and can practise independently as a specialist.

4. Visiting EEA Registration

This includes doctors who are citizens of EEA countries and who are fully established to practise medicine in an EEA country. These doctors may practise medicine in Ireland on a temporary and occasional basis without having to take out specialist or general registration. This form of registration is limited, as stated to temporary and occasional bases and cannot exceed 30 days annually.

5. Supervised Division

Established in July 2011, this division includes doctors employed by the HSE who are in a supervised post, in a hospital setting approved by the Medical Council. Before an applicant is registered in this division, the HSE must propose the candidates to the Medical Council, including the specialty of the post, the duties the doctor will be charged with and the supervisory arrangements which will be in place. The candidate must also complete a clinical examination in the area of specialty they will be working in, measuring competence in the areas of clinical judgement, communication and data interpretation.

APPENDIX E: STATISTICS
THE REGISTER OF
MEDICAL PRACTITIONERS
CONTINUED

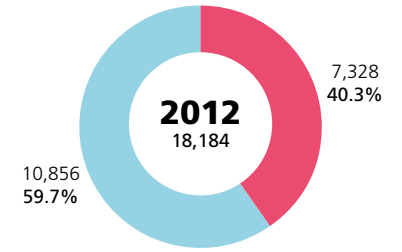
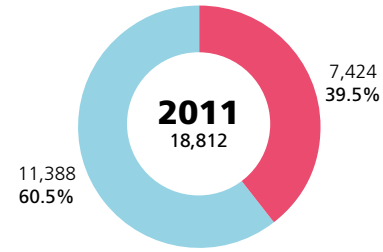
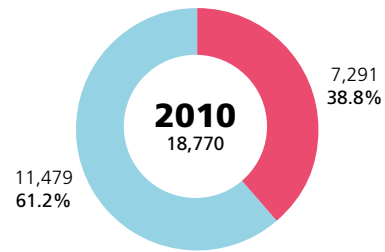
NUMBER OF DOCTORS ON THE REGISTER

2008	2009	2010	2011	2012
17,741	18,854	18,770	18,812	18,184

Female

Male

BREAKDOWN OF THE REGISTER
BY GENDER



MPA 2007, section 55 (3) - Correction of the Register

The Council shall take such steps as it considers necessary from time to time to ensure that the particulars entered in the register are accurate.

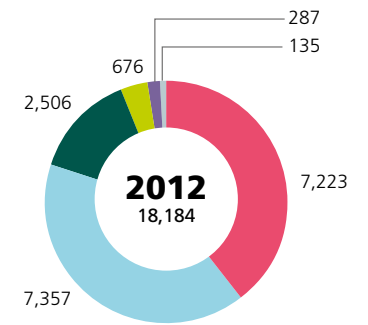
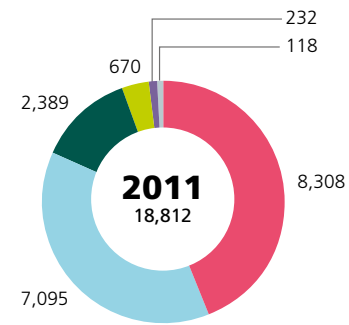
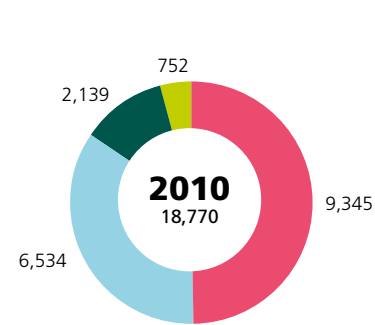
APPENDIX E: STATISTICS THE REGISTER OF MEDICAL PRACTITIONERS CONTINUED

General Division
Specialist Division

Trainee Specialist Division
Intern Registration

Supervised Division
Visiting EEA

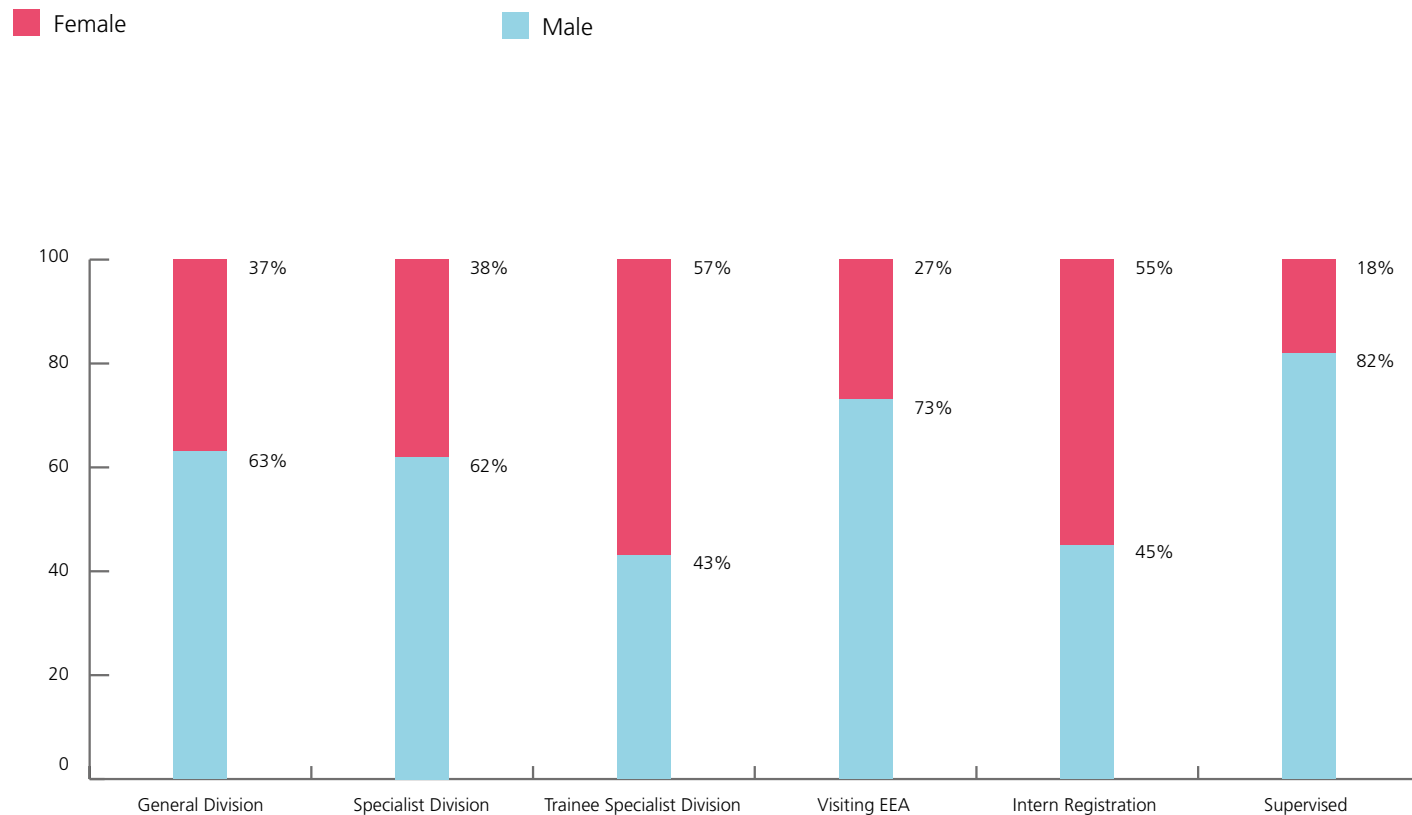
BREAKDOWN OF THE REGISTER BY DIVISION



Click [here](#) for further information on the Divisions of the Register.

APPENDIX E: STATISTICS THE REGISTER OF MEDICAL PRACTITIONERS CONTINUED

BREAKDOWN OF REGISTER - DIVISION VS. GENDER 2012



Click [here](#) for further information on the Divisions of the Register.

APPENDIX E: STATISTICS
THE REGISTER OF
MEDICAL PRACTITIONERS
CONTINUED

BREAKDOWN OF THE REGISTER
BY MAJOR SPECIALTY GROUPING

SPECIALITY	2010	2011	2012
Anaesthesia	508	535	549
Medicine	1370	1496	1560
Emergency Medicine	85	88	84
General Practice	2270	2562	2731
Obstetrics & Gynaecology	209	225	228
Occupational Health	94	95	102
Ophthalmology	146	145	138
Paediatrics	264	290	303
Pathology	311	337	350
Psychiatry	665	712	721
Public Health Medicine	103	110	106
Radiology	387	400	398
Sports and Exercise Medicine	27	29	30
Surgery	795	831	859
Total	7234	7855	8159

Note: Doctors may be entered on the Specialist Division in one or more specialty categories.

APPENDIX E: STATISTICS
THE REGISTER OF
MEDICAL PRACTITIONERS
CONTINUED

BREAKDOWN OF THE REGISTER
BY SPECIALTY

SPECIALITY	2010	2011	2012
Anaesthesia	508	535	549
Cardiology	121	128	129
Cardiothoracic Surgery	25	30	31
Chemical Pathology	7	8	10
Child and Adolescent Psychiatry	121	131	129
Clinical Genetics	6	6	6
Clinical Neurophysiology	9	9	12
Clinical Pharmacology and Therapeutics	15	14	13
Dermatology	54	56	58
Emergency Medicine	85	88	92
Endocrinology and Diabetes Mellitus	62	71	74
Gastroenterology	106	112	115
General (Internal) Medicine	539	592	616
General Practice	2270	2562	2731
General Surgery	255	267	286
Genito-Urinary Medicine	7	7	7
Geriatric Medicine	91	101	108
Haematology (Clinical & Laboratory)	74	80	81
Histopathology	161	174	177
Immunology	7	6	7
Infectious Diseases	19	25	26
Medical Oncology	44	51	53
Microbiology	58	66	70
Nephrology	46	46	53
Neurology	51	55	62
Neuropathology	4	5	5
Neurosurgery	23	25	25
Obstetrics and Gynaecology	209	225	228
Occupational Medicine	94	95	102

APPENDIX E: STATISTICS
THE REGISTER OF
MEDICAL PRACTITIONERS
CONTINUED

BREAKDOWN OF THE REGISTER
BY SPECIALTY (CONTINUED)

SPECIALITY	2010	2011	2012
Ophthalmic Surgery	95	94	98
Ophthalmology	146	145	138
Oral and Maxillo-Facial Surgery	17	17	16
Otolaryngology	84	85	87
Paediatric Cardiology	3	3	4
Paediatric Surgery	9	12	14
Paediatrics	261	290	299
Palliative Medicine	37	39	46
Pharmaceutical Medicine	-	7	8
Plastic, Reconstructive & Aesthetic Surgery	60	63	59
Psychiatry	449	473	477
Psychiatry of Learning Disability	34	36	37
Psychiatry of Old Age	61	72	78
Public Health Medicine	103	110	106
Radiation Oncology	43	44	44
Radiology	344	356	354
Rehabilitation Medicine	14	13	12
Respiratory Medicine	95	98	100
Rheumatology	52	59	60
Sports and Exercise Medicine	27	29	30
Trauma and Orthopaedic Surgery	166	177	174
Tropical Medicine	2	2	2
Urology	61	61	61
Total Specialties	7234	7855	8159
Total Doctors with Specialties	6480	7095	7357

APPENDIX E: STATISTICS THE REGISTER OF MEDICAL PRACTITIONERS CONTINUED

CATEGORIES OF APPLICANTS

The four main categories of applicants for either the General Division or Specialist Division are:

CATEGORY 1	CATEGORY 2	CATEGORY 3	CATEGORY 4
Graduates of Irish medical schools.	EU citizens who graduated in an EU medical school and/or their qualifications are recognised under EU directive 2005/36/EC (recognition of professional qualifications for EU citizens).	Non-EU citizens who graduated in an EU medical school and/or their qualifications would be recognised under EU directive 2005/36/EC (recognition of professional qualifications) if they were an EU citizen.	Doctors who do not meet the criteria for any of the above categories.

NOTE:

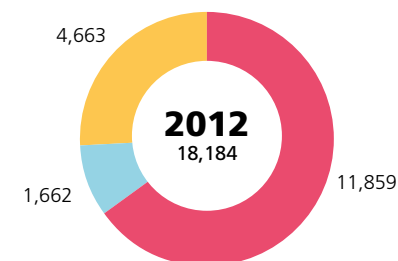
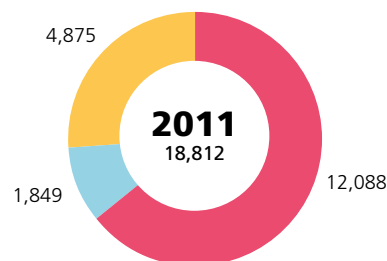
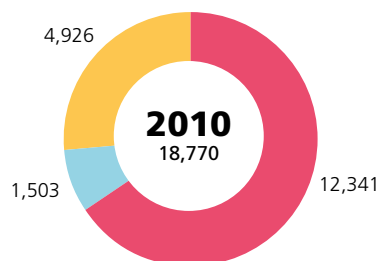
For the purposes of this report, Category 2 & 3 have been combined so that this illustrates the number of doctors which have graduated from EU Medical Schools and/or whose qualifications would be recognised under EU Directive 2005/36/EC (recognition of professional qualifications) if they were an EU citizen.

Category 1

Category 2 & 3

Category 4

BREAKDOWN OF THE REGISTER BY CATEGORY



APPENDIX E: STATISTICS
THE REGISTER OF
MEDICAL PRACTITIONERS
CONTINUED

BREAKDOWN OF THE REGISTER
BY COUNTRY OF QUALIFICATION

COUNTRY	GENERAL	SPECIALIST	TRAINEE SPECIALIST DIVISION
Albania	1	1	-
Algeria	-	-	1
Argentina	2	3	2
Armenia	2	-	-
Australia	85	43	2
Austria	3	1	1
Bangladesh	12	2	2
Belarus	7	1	3
Belgium	3	11	-
Brazil	1	-	2
Brunei Darussalam	-	-	-
Bulgaria	21	20	4
Cameroon	1	-	-
Canada	2	3	-
Cayman Islands	-	-	1
Channel Islands	-	-	-
China	3	-	1
Congo	1	-	-
Costa Rica	1	-	-
Cuba	3	-	-
Croatia	1	2	1
Cyprus	-	-	-
Czech Republic	34	18	17
Denmark	-	3	-
Egypt	130	63	14
Ethiopia	2	2	2
Finland	1	-	-
France	9	12	-
Germany	40	53	5
Ghana	3	1	-

APPENDIX E: STATISTICS
THE REGISTER OF
MEDICAL PRACTITIONERS
CONTINUED

BREAKDOWN OF THE REGISTER
BY COUNTRY OF QUALIFICATION
(CONTINUED)

COUNTRY	GENERAL	SPECIALIST	TRAINEE SPECIALIST DIVISION
Greece	4	8	1
Grenada	1	1	-
Haiti	4	6	2
Hungary	87	59	18
India	241	125	59
Iran	3	2	2
Iraq	71	15	5
Ireland	3,488	5,811	1871
Italy	27	21	2
Jordan	7	2	1
Kenya	3	1	-
Latvia	36	3	15
Libya	60	25	3
Lithuania	14	12	6
Macedonia	-	1	-
Malaysia	2	1	3
Malta	6	2	-
Mexico	4	2	-
Morocco	1	-	-
Myanmar	-	1	2
Netherlands	13	9	-
New Zealand	19	16	3
Nigeria	308	38	91
Oman	4	1	-
Pakistan	731	274	99
Palestinian Territories	1	2	-
Philippines	6	-	2
Poland	65	90	29
Portugal	-	1	-
Republic of Moldova	7	-	4

APPENDIX E: STATISTICS
THE REGISTER OF
MEDICAL PRACTITIONERS
CONTINUED

BREAKDOWN OF THE REGISTER
BY COUNTRY OF QUALIFICATION
(CONTINUED)

COUNTRY	GENERAL	SPECIALIST	TRAINEE SPECIALIST DIVISION
Romania	204	51	31
Rwanda	-	-	-
Russian Federation	12	4	6
Saudi Arabia	2	2	-
Slovakia	33	13	11
Slovenia	1	1	-
South Africa	695	70	12
Spain	13	15	3
Sri Lanka	1	2	1
Sudan	424	50	94
Sweden	2	5	-
Switzerland	3	4	1
Syrian Arab Republic	14	8	2
Trinidad & Tobago	2	1	1
Turkey	1	2	1
Ukraine	12	1	4
United Arab Emirates	2	-	-
United Kingdom	215	339	63
United Republic of Tanzania	1	1	-
United States of America	4	22	1
Uruguay	1	-	-
Uzbekistan	3	-	-
Yemen	-	-	1
Venezuela	1	-	-
Zimbabwe	1	2	1
Total	7,223	7,357	2,506

APPENDIX E: STATISTICS

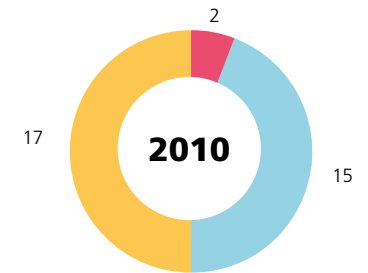
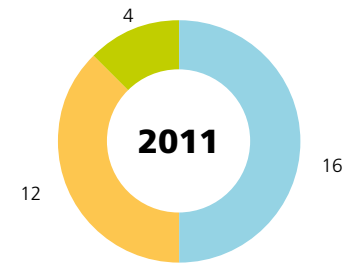
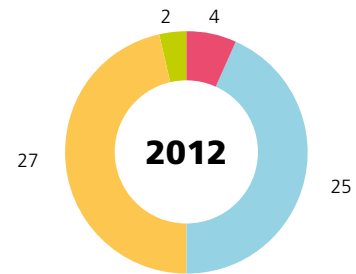
FREEDOM OF INFORMATION STATISTICS

Cases brought forward from previous year

Requests received in current year
Cases answered in current year

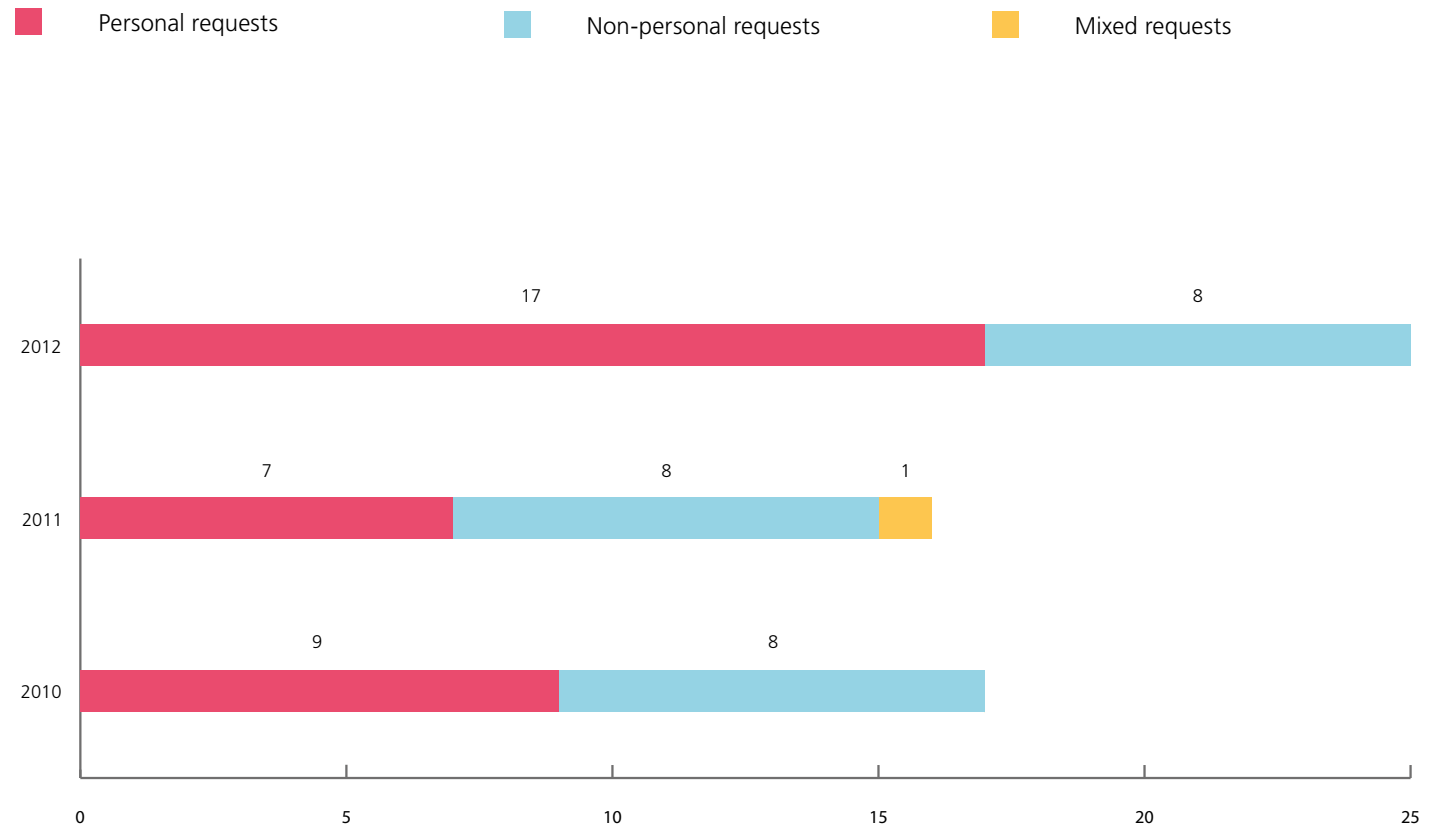
Live cases at year end

TOTALS



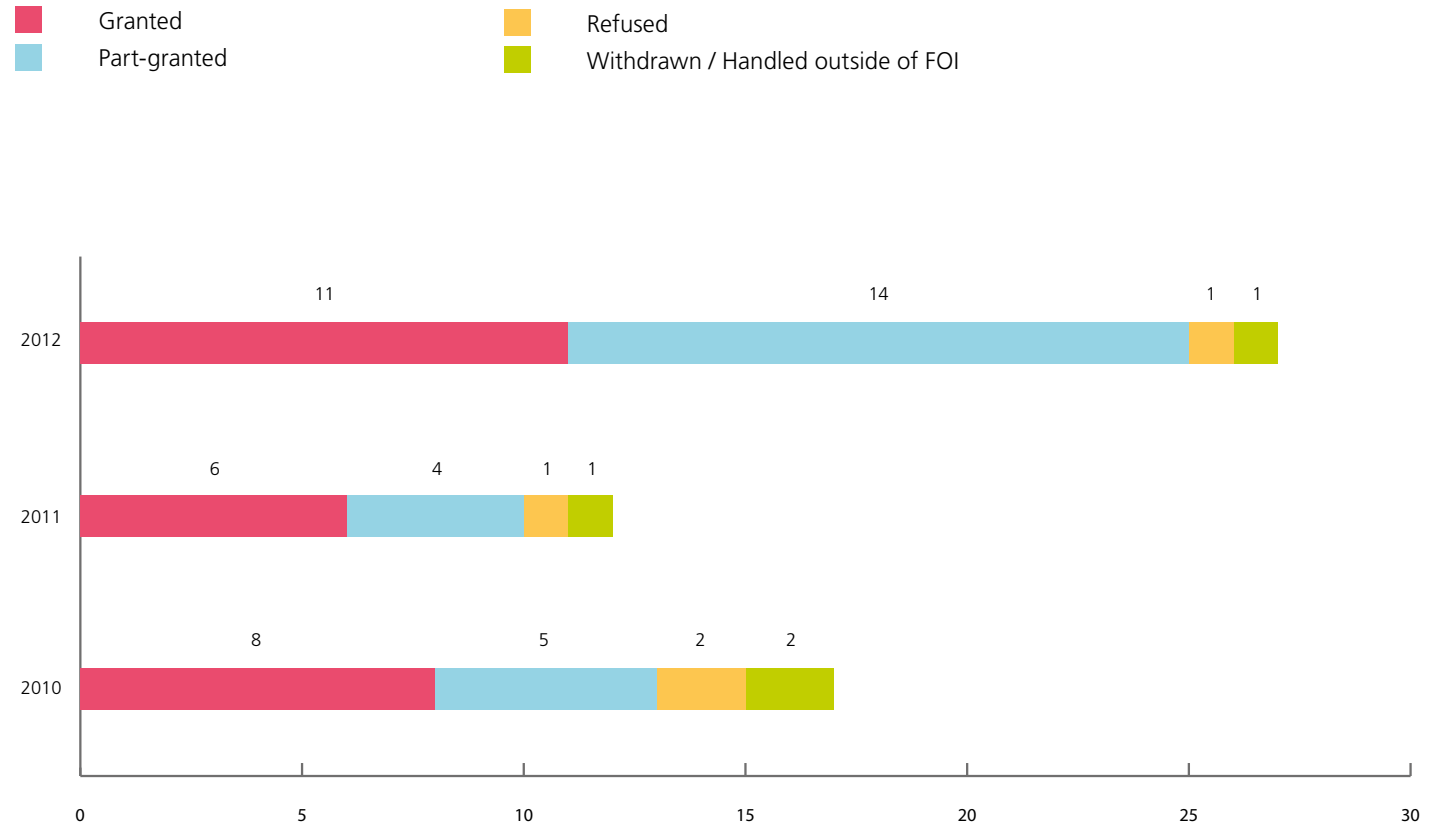
APPENDIX E: STATISTICS
FREEDOM OF
INFORMATION STATISTICS
CONTINUED

TYPE OF REQUESTS



APPENDIX E: STATISTICS
FREEDOM OF
INFORMATION STATISTICS
CONTINUED

STATUS OF REQUESTS

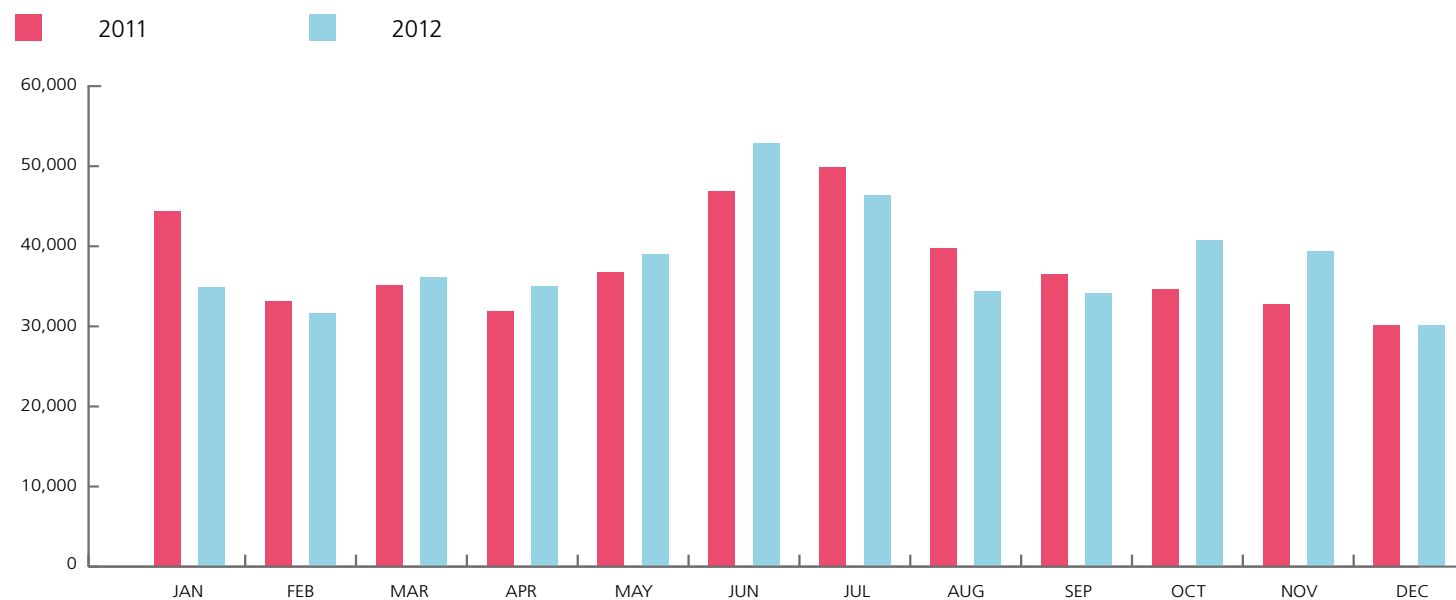


APPENDIX E: STATISTICS

WEBSITE STATISTICS

OVERVIEW

	2012	2011
Visits to www.medicalcouncil.ie	454,693	452,060
Unique Visitors	200,375	195,017
Page views	2,588,625	2,901,933



	2012	2011
Jan	44,389	34,910
Feb	33,194	31,621
Mar	35,146	36,173
Apr	31,902	34,993
May	36,747	38,981
Jun	46,865	52,907
Jul	49,895	46,335
Aug	39,738	34,342
Sep	36,514	34,129
Oct	34,650	40,822
Nov	32,832	39,364
Dec	30,188	30,116

APPENDIX E: STATISTICS
WEBSITE STATISTICS
CONTINUED

COUNTRY/TERRITORY	VISITS 2011	% VISITS 2011	VISITS 2012	% VISITS 2012
Ireland	241,797	53.49%	270,952	59.59%
United Kingdom	41,906	9.27%	38,361	8.44%
Pakistan	27,067	5.99%	19,087	4.20%
Saudi Arabia	18,167	4.02%	12,368	2.72%
India	13,612	3.01%	12,674	2.79%
United States	10,907	2.41%	12,541	2.76%
Sudan	10,435	2.31%	-	-
Romania	7,769	1.72%	5,714	1.26%
Australia	6,263	1.39%	6,869	1.51%
(not set)	4,888	1.08%	5,641	1.24%
Canada	-	-	5,163	1.14%

LOCATION OF VISITS

APPENDIX E: STATISTICS

PROFESSIONAL COMPETENCE STATISTICS

As of May 2011, doctors are legally obliged to maintain their professional competence by enrolling in professional competence schemes and following requirements set by the Medical Council.

Schemes are operated by postgraduate training bodies and have been developed to drive good professional practice which is centred on patient safety and the quality of patient care. The activities which doctors engage in are straightforward and practice based.

Participation in a Professional Competence Scheme helps registered doctors to demonstrate that they are fulfilling their new statutory duty. Schemes are in place for all registered doctors on the Specialist and General Division of the Medical Register. Doctors registered in the Supervised Division of the register are also required to enroll in a Professional Competence scheme related to their chosen specialty.

SECTION 5: PROVISION OF ACTIVITIES

Number of hours of activities provided directly by the recognised postgraduate training body May 2011-April 2012 (Total and breakdown by province)

	7,264.75
Leinster	5,507.25
Munster	823.5
Connacht	547
Ulster	297

SECTION 6: RECOGNITION OF ACTIVITIES

Number of hours of activities recognised by the recognised postgraduate training body since May 2011-April 2012 (Total and breakdown by province)

	22,907
Leinster	15,556.25
Munster	3,203
Connacht	2,149
Ulster	1,780.75

APPENDIX F: HIGH COURT/ SUPREME COURT JUDGEMENTS

DR R

On the 14th of October 2011 a fitness to practice inquiry was held in relation to the care that was afforded by a doctor to his patient following gastric band surgery. The inquiry found the doctor guilty of professional misconduct arising out of his failure to provide an adequate aftercare service to his patient. On the 15 December 2011 the Medical Council made a decision to cancel the doctor's registration pursuant to section 71(f) of the Medical Practitioners Act, 2007. The doctor appealed the decision of the Medical Council to the High Court. There was subsequently no appearance by the practitioner at the High Court hearing which took place in June 2012. The President of the High Court having considered the submissions of the Council's legal representatives struck out the doctor's application and affirmed the decision of the Medical Council to cancel the doctor's registration. The Court awarded the costs of the application to the Medical Council.¹

DR A H

Four separate complaints were received by the Medical Council alleging professional misconduct and poor professional performance on the part of the doctor in respect of the care afforded by him to three of his patients. A fitness to practice inquiry found that the doctor had failed to apply the standards of clinical judgement and/or competence that could reasonably be expected of a consultant gynaecologist.² On the 19th January 2011 the Medical Council informed the doctor that it had made a decision pursuant to section 71(a)

of the Medical Practitioners Act, 2007 and that it would be advising the public of that decision. The doctor then sought an order from the High Court by way of judicial review to quash the decision of the Medical Council. The doctor also sought an injunction to restrain the Medical Council from publishing its decision.³

The doctor argued that in taking steps to advise the public of its decision the Medical Council was acting *ultra vires* its powers as prescribed by the Medical Practitioners Act, 2007. The doctor argued that there was no specific power contained in section 71(a) of the Act permitting the Council to notify the public and furthermore that the Council could not rely on those provisions of the Act which permit the Council to advise the public on all matters of public interest. In response the Council argued that when considering statutory interpretation the act should be examined as a whole.

The doctor's application was refused and the Court held that section 7(1) 2(k) and 5 of the Act of 2007 vest in the Medical Council the discretion to publish a sanction or advice or admonishment if it is in the public interest to do so. The Court further noted that a distinction can be drawn between communicating to the public at large and notifying a third party who has a significant connection to the complaint and an interest in its outcome. The Court declined to consider the doctor's argument regarding the unfairness of publishing the sanction as this argument had not been included in the original submissions. The doctor has now filed an appeal against this decision to the Supreme Court.

DR M

The doctor brought an application for judicial review arising from a fitness to practice inquiry conducted to investigate allegations that the practitioner altered a patient's medical notes. The Committee found that the doctor was guilty of professional misconduct.⁴ The Committee based its finding in respect of whether the altering of medical records amounted to misconduct not on the evidence of the expert who was specifically called to provide evidence on this issue but on the more appropriate evidence of another medical practitioner who was a witness of fact. On the 14 April 2011 the Council decided to advise the doctor of his professional misconduct in accordance with section 71(a) of the Medical Practitioners Act, 2007.

The doctor's application before the High Court was to have the report of the Committee together with the decision of the Council quashed.⁵ The Court held that contrary to the doctor's submissions the Committee had provided him with adequate reasons for the basis of its ultimate finding and the procedural decisions it made during the course of the inquiry. The Court was also satisfied that there was adequate evidence before the Committee to enable it to decide that there had been professional misconduct. In respect of issues relating to evidence the Court stated that while the inquiry was bound to apply the criminal standard of proof in respect of the evidence before it this did not mean that it had to follow all of the evidential rules which may exist in the

¹ The High Court order was perfected on the 19th June 2012.

² The Fitness to Practice Inquiry took place on the 10th, 11th and 12th of March, 27th, 28th and 29th of April and the 27th and 28th September 2010.

³ Leave to apply for judicial review was granted in May 2011 and a full hearing took place before Mr Justice Michael White in the High Court on the 13 and 14 December 2011.

⁴ The Inquiry took place on the 8th October 2010 and the 10th and 11th of March 2011.

⁵ Judgment was delivered by Kearns J on the 14th August 2012.

APPENDIX F: HIGH COURT/ SUPREME COURT JUDGEMENTS CONTINUED

context of a criminal trial. Furthermore the Court suggested that as the maintenance of accurate medical records is such a basic function of any medical practitioner an inquiry into the altering of those records would not require evidence of an expert witness. The Court went on to hold that as the Committee had chosen to call such an expert it must bear the consequences of that decision when the chosen expert did not provide the appropriate evidence. The Court concluded that the Committee was in breach of fair procedures in failing to notify the doctor of its decision to base its finding on the evidence of a witness who was not called for the purpose of providing expert evidence regarding the altering of medical records.

DR A

A fitness to practice inquiry was conducted in February 2012 to investigate the failure of the doctor to diagnose a patient with a bowel obstruction. The patient subsequently died from the condition a few days later. The Council, on considering the findings of the fitness to practice committee, decided under the provision s 71(1)(a) of the Medical Practitioners Act, 2007 to advise the doctor in relation to his poor professional performance and as such the doctor had no right of appeal against the decision.⁶

The doctor brought judicial review proceedings seeking an order to quash the decision of the Medical Council. The doctor also sought a declaration from the High Court that Part 8 and 9 of the Act of 2007, insofar as they denied him a right of appeal against the decision of

Medical Council, were in breach of his fair procedures, his constitutional rights and his rights as enshrined in the European Convention of Human Rights. In particular the doctor argued that the actions of the Medical Council had infringed his right to equality under Article 40.1 of the Constitution as he was being treated differently from other medical practitioners found guilty of professional misconduct. The doctor submitted that he was entitled to a declaration that section 75(1) insofar as it denied him the right of appeal against the imposition of a sanction or the making of a finding by the Medical Council, was repugnant to the Constitution and therefore void. At the commencement of the hearing the doctor withdrew his application that the decision should be quashed on the basis of want of fair procedures or irrationality and the case essentially became an argument regarding the breach of the doctor's constitutional rights.

The Court, in refusing to grant the reliefs sought, held that Article 40.1 recognises that perfectly equal treatment is not always achievable nor is it always desirable as it could lead to indirect inequality because of the different circumstances in which people find themselves. The Court also stated it is only invidious discrimination which offends the constitutional provision and therefore the provisions contained in section 70(a) of the Act of 2007 had not breached the doctor's rights to equality before the law. The Court further recognised that the sanction being imposed was the least available to the Council and it did not deprive the doctor of his employment or his ability to earn a livelihood. As regards the procedures being followed by the

medical council in respect of regulation the Court held that it was satisfied that there was no infringement on the doctor's civil rights owing to the carefully constructed statutory scheme which vindicates the rights of doctors to fair procedures at each stage, and as such it saw no reason to hold that the scheme must provide for an internal appeal. Finally the Court stated that the doctor's arguments in relation to the infringement of the European Convention of Human rights had not been advanced properly before the Court and the Court rejected the application in this regard also.⁷

⁶ The Council made its decision on the 14th day March 2012.

⁷ The case was considered by the High Court in November 2011 and judgment was delivered in the case by Kearns P on the 1st February 2013.



GLOSSARY OF TERMS

ASPIRANT SPECIALTIES:

Medical disciplines who wish to be recognised by the Medical Council under section 89 of the Medical Practitioners Act 2007

CME:

Continuing Medical Education. CME consists of educational activities which serve to maintain, develop, or increase the knowledge, skills, and professional performance and relationships that a physician uses to provide services for patients, the public or the profession.

CPD:

Continuing Professional Development. CPD is a continuing learning process that complements formal undergraduate and postgraduate education and training. CPD requires doctors to maintain and improve their standards across all areas of their practice.

EAP:

Employment Assistance Programme. This worksite-based programme, provided by VHI, is designed to assist organisations and their employees:

IELTS:

International English Language Testing System, used to determine an applicant's level of English proficiency.

LEVEL 4 ASSESSMENT:

An evaluation of the candidate's postgraduate education, training, qualifications and experience to establish the candidate's appropriateness or otherwise for general registration.

LEVEL 5 ASSESSMENT:

A Level 5 assessment constitutes a referral of the specialist training and experience part of the application to an approved Postgraduate Training Body for assessment.

MEDIATION:

Mediation is a form of alternative dispute resolution whereby the parties attempt to resolve their dispute / complaint with the assistance of an independent third party called a mediator. Mediation is a confidential process.

MPA:

Medical Practitioners Act, established in 1978 and updated in 2007.

MSF:

Multi-Source Feedback. It is a quality assessment method used internationally as part of a broader assessment of a doctor's performance.

PMDS:

Performance Management Development System. A two-way process which aims to enhance both the individual and organisational performance. It involves establishing a shared understanding between the staff member and manager about what is to be achieved and how it is to be achieved in terms of role, business objectives, performance, development needs, career aspirations and support.

PRES:

Pre-Registration Examination System. The PRES is undertaken by applicable registration applicants and consists of two parts. Level 2 is a written examination and is currently in the form of a Multiple Choice Questions examination. Level 3 is a clinical examination and is currently in the form of an Objective Structured Clinical Examination (OSCE).

PGTB:

Postgraduate Training Body. The Medical Council currently approves 13 training bodies in Ireland for the purpose of granting evidence of satisfactory completion of specialist training.

TRAS:

Temporary Registration Assessment Scheme

SEO:

Senior Executive Officer

VISITING EEA:

Visiting EEA Registration is only available to eligible EU/EEA/Swiss citizens who are established (hold "full registration" or equivalent) in another EU/EEA member state or in Switzerland and wish to practise medicine in Ireland on a temporary and/or occasional basis.

WFME:

World Federation for Medical Education. WFME is the global organisation concerned with promoting high standards in the education and training of medical doctors.



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