MEDICAL COUNCIL
OF NEW ZEALAND

ANNUAL REPORT
1996

MEDICAL COUNCIL OF NEW ZEALAND
ANNUAL REPORT

FOR YEAR ENDED 30 JUNE 1996

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Members of the Medical Council

at 30 June 1996

	Appointed by the Governor General on the recommendation of:
Dr K J Thomson (Chair)	New Zealand Medical Association
Dr G F Lamb (Deputy Chair)	Royal Australasian College of Surgeons
Dr R H Briant, CBE	Royal Australasian College of Physicians
Dr C M Corkill	Minister of Health
Dr S L Kletchko	ex officio for the Director General of Health
Dr R G Gudex, QSO	Royal New Zealand College of Obstetricians and Gynaecologists
Dr M M Herbert, QSO	New Zealand Medical Association
Mrs P C Judd, JP	Minister of Health
Dr C H Maclaurin	ex officio for Dean of the Faculty of Medicine and Health Science, University of Auckland
Professor J G Mortimer	ex officio for Dean of the Faculty of Medicine, Otago Medical School, University of Otago
Dr I M St George	Royal New Zealand College of General Practitioners
Dr J A Treadwell	Minister of Health

Medical Education Committee

at 30 June 1996

Name	*Appointed by*
Professor J G Mortimer (Chair)	Dean, Otago Medical School, University of Otago
Professor I J Simpson (Deputy Chair)	ex officio, for Dean, Faculty of Medicine and Health Science, University of Auckland
Professor D R Aickin	ex officio, for Dean, Christchurch School of Medicine
Dr B Arroll	New Zealand Medical Association
Dr P M Barham	Royal New Zealand College of General Practitioners
Assoc. Professor J G Buchanan	Royal Australasian College of Physicians
Dr A G Dempster	Faculty of Medicine, University of Otago
Professor L J Holloway	ex officio, Dean, Wellington School of Medicine
Dr J Kolbe	Faculty of Medicine, University of Auckland
Dr M E Lewis	Faculty of Medicine, University of Otago
Dr I M St George	Medical Council of New Zealand
Mr J S Simpson	Royal Australasian College of Surgeons
Dr A D Stewart	Royal New Zealand College of Obstetricians and Gynaecologists
Dr E W Willoughby	Faculty of Medicine, University of Auckland

Other Council Committees

at 30 June 1996

Preliminary Proceedings Committee

Dr C H Maclaurin (Convener)
Dr C M Corkill
Mr P H Cook (Legal Member)

Health Committee

Dr R G Gudex (Convener)
Dr R H Briant
Dr M M Herbert
Ms G A Jones
Mrs P C Judd
Dr K J Thomson
Dr J A Treadwell

Finance and Management Committee

Dr G F Lamb (Convener)
Dr W S Alexander
Ms G A Jones
Dr K J Thomson

Communications Committee

Dr K J Thomson (Convener)
Mrs P C Judd
Dr S L Kletchko

Registration Committee

Dr I M St George (Convener)
Dr S L Kletchko
Dr M M Herbert
Mrs P C Judd
Dr K J Thomson

Medical Practitioners Data Committee

Dr R H Briant
Ms G A Jones

Indicative Register Subcommittee

Dr M M Herbert (Convener)
Dr C M Corkill

Specialist Registration Subcommittee

Dr K J Thomson (Convener)
Dr R H Briant

Board of Examiners

Dr R H Briant (Chair)	Medical Council
Professor D R Aickin	Medical Education Committee
Dr M M Herbert	Medical Council
Dr R G Large	Nominee of University of Auckland
Dr C H Maclaurin	Examinations Director
Dr D J McHaffie	Nominee of University of Otago
Dr D A Abernethy	Nominee of University of Otago
Dr E W Willoughby	Nominee of University of Auckland
Dr R P G Rothwell	Nominee of University of Auckland (Waikato)

Council Secretariat

at 30 June 1996

Registrar (Chief Executive)	Ms G A Jones, JP, BA
Communications Officer	Ms M Keogh, BA, Cert Journ
Human Resources Advisor	Ms G Needham, BA (Hons), Dip PM
Projects & Policy Co-ordinator	Ms A Coleman, BA
Administrative Secretary	Ms J Hawken-Incledon
Wordprocessor	Ms C Smith
CORPORATE SERVICES	
Team Leader Corporate Services and Financial Controller	Mr J de Wever
Receptionist	Mrs D L Kelly
Team Support Officer	Miss D M Overduin
STANDARDS	
Team Leader Standards	Ms L Urquhart, BCA
Education Officer	Ms A B C Coleman, BA
Examinations Officer	Mrs T E N Smith
Tribunals Officer (Part-time)	Mrs S D'Ath, LLM
Standards Administration Officer	Ms C I Bang, BA, LLB, Dip Grad
Team Support Officer	Ms M A Kilkelly
REGISTRATION	
Team Leader Registration	Mrs J Lui
Registration Officer	Ms D L Crawley, BA
Registration Officer	Ms A Elliott
Registration Officer	Mr P D Girven, BA
Team Support Officer	Mrs M Hall
Database Support (Part-time)	Ms J L Woods

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ANZ Banking Group (New Zealand) Ltd
Courtenay Place Branch
Wellington

AUDITORS
Miller, Dean, Knight and Little
PO Box 11 253, Wellington

REPORT FROM THE CHAIR

This is the final report on the activities of the Medical Council conducted under the 1968 Medical Practitioners Act, and by the time this report is read the new 1995 Act will have been in operation for some months. (The 1995 Act became effective on 1 July 1996).

Much has already been said about the deficiencies of the 1968 Act, including the rather undemocratic methods of selecting Council members, the shortage of lay members and the complicated and seemingly poorly responsive disciplinary systems. It has to be remembered that in 1968 the perceptions of both the medical profession and the public were quite different. The nominating bodies (the NZMA and the major colleges) were regarded as almost totally representative of the profession, and the appointment of a single lay member by a later amendment to the Act was seen as a brave and innovative move. Disciplinary complaints were infrequent, not necessarily because medical practice was of a higher standard but more probably because there was a greater reluctance to complain about poor outcomes or inappropriate behaviour.

Since the inception of the 1968 Act the general public has become far better educated over health issues and the emphasis on individual human rights has thrown into sharp relief some aspects of medical practice. The media has developed significant expertise and become an energetic watchdog over the profession. Since the National Women's Hospital inquiry the profession has accepted that it must be openly accountable and that informed consent is an absolute right. The delays in introducing new legislation, mainly because of the need to coordinate a new Medical Practitioners Act with new Health and Disability Commissioner legislation, have been unfortunate, in that the existing complex disciplinary system has been forced to cope with a large number of complaints without the ability to conduct the hearings in public, thus perpetuating the myth of secret, doctor-favouring tribunals.

The delays in introducing the new legislation have also led to the repeated reappointment of many Council members whose terms have been extended for many more than the three or six years originally anticipated. The retiring members of the Medical Council have, for the benefit of the New Zealand public, made an immense contribution in time and have served the profession well. As those who are about to become Council members will soon find out, the workload on individual members is very substantial, even excluding disciplinary cases. For retiring Council members, the increase in disciplinary complaints over the past five years has produced an enormous workload, in dealing with both charges from the Preliminary Proceedings Committee and appeals from the Medical Practitioners Disciplinary Committee. Under the transitional provisions of the new Act the "old" Council members will be required, for possibly a year to come, to continue dealing with the last of the complaints and appeals commenced under the old legislation.

While the demands on Council members have been at times unreasonable, the retiring members can feel proud of their achievements, including the introduction of innovative policies to deal with sexual abuse by medical professionals, and a system of dealing with impaired practitioners which has been a model for other professions to follow.

A new disciplinary tribunal, separate from the Council has been established. The Medical Practitioners Disciplinary Tribunal will hear in public the most serious charges to emerge through the new disciplinary system, whereas Council will be able to intervene where incompetence or impairment is suspected. The new Act allows the Council to require poorly performing practitioners to submit to assessment and possible restriction on practice.

These changes have not been without cost. The workload on our already extended secretariat has been immense, and the Council members and those members of the profession who serve on Council committees will be well aware of the demands placed on our staff.

The failure by immigration officials and

MEDICAL COUNCIL - JUNE 1996

Left to right: Professor J G Mortimer, Dr R H Briant, Dr S L Kletchko, Dr J A Treadwell, Dr R G Gudex, Dr C M Corkill, Dr I M St George, Dr K J Thomson, (Chair) Dr G F Lamb (Deputy Chair), Ms G A Jones (Registrar and Chief Executive), Dr M M Herbert, Mrs P C Judd, Dr C H Maclaurin.

the New Zealand Qualifications Authority to respond to the Council's repeated requests to clarify information for prospective immigrants has led to a steep rise in immigration by overseas graduates, whose basic medical qualifications are not able to be registered under either the 1968 Act or the 1995 Act. Many of these doctors have specialist qualifications which are not easily comparable with recognised and accepted Australasian specialist training and experience. While some of these doctors were aware of the difficulties ahead for them, many claimed to have been told that they could practise medicine on arrival in New Zealand. While Council had no control over the nature of the information given to prospective overseas immigrants, we have now to deal with a large number of distressed and unemployed foreign doctors. This has strained our examination system to its limits, and Council is very grateful to all the examiners who have agreed to conduct extra examination sessions as we attempt to provide access for all candidates to the system. The move from the local NZREX Written to the universally available USMLE Steps 1 and 2 will ease the burden on examiners, while giving successful candidates an internationally acceptable examination pass. The present mandatory NZREX Clinical will be, by the end of 1997, the only local content to our examination process.

It is of concern that where the profession as a whole has failed over recent years has been in the areas of communication with patients, the public, the media and politicians alike. There is no place for arrogance in medicine, especially in the 1990s - humility and a willingness to listen to other points of view are prerequisites for the practice of good and safe medicine.

In conclusion, I would like to thank the staff of the secretariat, particularly the Chief Executive/Registrar, Ms Georgina Jones, for the support and conscientious efforts they have made throughout a difficult year. I would also like to thank those retiring members of Council for their contribution over many years and wish them a happy return to less demanding activities. I record my gratitude to those members of the profession who have served on committees, working parties and examination panels of the Council over the past few years. Without their help the Council would be quite unable to fulfil its functions and their contribution has been very much appreciated.

Finally, I take this opportunity to wish the new Medical Council a smooth passage as it continues to establish the structures needed under the 1995 legislation.

Dr K J Thomson
CHAIR

REPORT OF THE LAY MEMBER

The most significant development for Council in the last twelve months has been the passing of the Medical Practitioners Act 1995, which increases lay membership as follows:

- at least three lay members to be appointed by the Minister to Council itself,
- a legal chairperson added to the Medical Practitioners Disciplinary Tribunal (although still only one non-medical member on the panel),
- a wide variety of lay people serving on Complaints Assessment Committees.

A new Act was first mooted in 1985 and ever since then Council has approached all changes in and alterations to its procedures with the new Act in mind.

There have been six Ministers of Health over the period and all of them have been urged by the Council to speed up the procedures needed to implement the new Act. The process started with the Hon Michael Bassett and has been realised by the Hon Jenny Shipley.

During my 11 years on Council I have been involved in most committees at some stage, but especially with the Health Committee, Registration Committee and disciplinary hearings. I have attended two overseas conferences as a Council delegate, namely the Annual Meeting of the Federation of State Medical Boards in San Francisco and an Australasian Boards Seminar in Melbourne, at which I spoke on Informed Consent. I have been invited to chair a workshop on discipline at the Second International Conference on Medical Registration in Melbourne, in October 1996.

The last decade has been a "golden time" with a talented and forward thinking group of Council members led by innovative chairs, Dr Stewart Alexander, Dr Robin Briant and now Dr Ken Thomson. At the same time, Georgie Jones has developed an efficient secretariat which has been dedicated to Council business and has provided superb backup to Council's rapidly expanding role and responsibilities. In the last ten years many of the changes in our society have been at their most apparent in the delivery of health care in New Zealand and as structures have been erected and dismantled Council has managed to grasp the import of the changes and adapt so that it has been able to maintain its role of guaranteeing standards of medical practice.

Education

Following the Cartwright Report, Council resolved to address the issues raised. A statement was immediately made on the boundaries of clinical freedom. A decision was taken that the time was right to establish New Zealand based accreditation of our medical schools.

The Council established a committee, made up of non Council and predominantly non medical members, chaired by Dr W L Renwick, former Director-General of Education. This committee visited all of the medical schools and issued a report of its findings and recommendations. The then

Dean of Otago Medical School, Professor John Hunter, who was chair of the Medical Education Committee undertook the task of transforming the recommendations of the "Renwick Report" into procedures and practices which could be adopted by the medical schools. An example of one such recommendation which has been implemented is the introduction of the interview system in choosing entrants to the Auckland Medical School for undergraduate education and training.

Discipline

When I joined the Council in 1985 there was already a working party made up of representatives of the Medical Practitioners Disciplinary Committee, PPC, Council, NZMA, and legal assessors, including Douglas White QC.

This committee was initiated by Dr Lloyd Richwhite, who chaired the MPDC for 15 years, Dr Stewart Alexander and Professor David Cole.

Dr Richwhite believed that the medical discipline system needed to have a wider group of medical practitioners involved and he and Dr Alexander were looking at alternative systems. The system which was suggested ten years ago had many similarities to what has evolved under the new Act.

This initiative preceded the Cartwright Report but was given extra impetus following the end of 1988.

Registration

This committee function has become much more onerous since the number of overseas trained doctors has increased. Council is under intense pressure much of the time and has to justify itself. Because the publicity for Council is so bad there is very little public appreciation that the rules are designed to protect the public from incompetent medical practice, not to protect jobs.

Health

The Health Committee came into existence because previous Chairman, Dr Stewart Alexander, and Council members had found that on occasions practitioners were on discipline charges which had their genesis in health problems of one sort or another. The committee has been particularly successful in assisting practitioners into rehabilitation, using the coercive powers of the Act when necessary.

Patricia Judd
LAY MEMBER

Accreditation of New Zealand Medical Schools

The Medical Councils of Australia and New Zealand accredited the Bachelor of Medicine Bachelor of Surgery Course of the School of Medicine University of Auckland for a period of 10 years from 1 January 1996. The degree was therefore approved pursuant to the Medical Practitioners Act 1968 for conditional registration in New Zealand and continues to be acceptable in Australia for the comparable purpose. Council offered their congratulations to the School of Medicine at the University of Auckland on the particularly favourable report acknowledging the school as a place of excellence where teaching, research, service and management were all valued and nurtured.

While there were no conditions on the accreditation, the Accreditation Committee recommended that in its Annual Reports to the Australian Medical Council and Medical Council of New Zealand, the school be asked to cover the following:

- ongoing review of the curriculum and of assessment procedures to ensure better integration across disciplines and between years of the course,
- efforts to increase student involvement in school processes and to provide more explicit mechanisms for dealing with student feedback,
- the outcome of its review of assessment in sixth year,
- the operational plan for further utilising the excellent clinical teaching facilities and opportunities that exist beyond the Medicine and Health Science campus,
- efforts to enhance staff development programmes to engender more innovative teaching methods and programmes,
- developing a strategy for Maori and Pacific Island health and the means by which the school will facilitate the achievement of the plan's objectives,
- plans to improve study facilities in the library and the extension of library hours.

At the same time Council noted that the Australian Medical Council had confirmed the University of Otago's five year period of accreditation (to 30 December 2000), given that a satisfactory report had been received from the Dean of the Otago Faculty on particular concerns highlighted during the previous year's accreditation exercise. Conditions previously placed on that accreditation were lifted. Those conditions related to resource difficulties arising out of the health reforms, to student teaching and learning in obstetrics, and to some personnel and management matters. Council had concerns about the adequacy of student counselling services and academic provisions for the teaching of general practice and behavioural sciences.

The joint accreditation process of the two Councils has proved to be rigorous. Following the completion of the cycle involving all twelve medical schools in Australasia, the Australian Medical Council

began a review of the accreditation process and guidelines, with input from the two New Zealand members of the Accreditation Committee and a member of the Medical Education Committee, Professor Simpson, the New Zealand member of the review working party.

Council acknowledges the important contribution made by Professor Graham Mortimer and Professor Richard Faull as the foundation New Zealand nominees on the Accreditation Committee. Their four year term of office concluded in 1996. Professor Mortimer was replaced by Professor John Campbell and Professor Faull continued as a co-opted member so that his replacement could be nominated by the incoming Medical Council following the implementation of the Medical Practitioners Act 1995.

Based on confidence in the joint accreditation process, the Medical Council of New Zealand and the Australian State and Territory Medical Boards have approved all medical school undergraduate programmes in Australasia, under the appropriate statutes, so that graduates can be granted registration without examination in the two countries. This was particularly important in the lead-up to implementation of the Medical Practitioners Act 1995, which removed named medical schools from registration provisions and instead granted the Medical Council of New Zealand discretion to approve them. Council had no difficulty approving the Australian schools on this basis, whereas graduates from all other schools outside New Zealand have to meet examination and assessment criteria before they can be granted probationary or general registration under the new Act.

During the year the accreditation process faced a new challenge with the development of three new four year graduate entry courses in Australia to replace six year undergraduate entry courses. The Accreditation Committee was required to develop dynamic processes for assessing evolving new schools and for dealing with any serious problems arising in previously accredited schools.

A joint working party between the Australian Medical Council and the Medical Council of New Zealand to explore future relationships is to be appointed later in 1996. While in some areas of the world political alliances and trade agreements have a major impact on the recognition of cross-boundary licensing of doctors, in Australasia standards based criteria are still paramount.

Postgraduate Training and Maintenance of Professional Standards

Under the Medical Practitioners Act 1995 Council's Education Committee will be responsible for setting standards from the initiation of undergraduate medical education to the completion of postgraduate vocational training. The new tasks of developing a methodology for setting standards for vocational training, and mechanisms for competence assessment and recertification of individual doctors, will be major immediate challenges. With respect to the latter, the Chair of the Medical Education Committee,

Professor Mortimer, and Committee member, Professor Aickin, attended the Brisbane November 1995 Conference on Clinical Assessment in Medicine.

Council noted continuing difficulties in access at all levels to practical obstetrics training. There is now competition between undergraduates, post-graduates, general practitioners (undertaking the Diploma of Obstetrics), vocational trainees, trainee nurses and midwives for access to obstetrics experience. It may be necessary for this to be obtained in the private sector in future.

The Medical Education Committee received a report from the Resident Doctors' Association expressing concerns about RMO recruitment and retention and issues concerning women doctors. Council is very aware that as the number of women doctors increases, particularly in the younger age groups, equity of access to training programmes and to flexible work arrangements become more critical.

Angela Coleman, Education Officer, provided valuable support to the Medical Education Committee.

THE INTERNSHIP

General Practice Training Runs

A modified questionnaire was developed and sent to 40 general practitioners (27 replying) to establish a database of general practice attachments which could be visited with a view to accreditation for intern attachments. Twentytwo general practices expressed interest in being involved with the pilot but funding was not forthcoming from the Clinical Training Agency. Nevertheless it was decided that a small number of general practices in the Whangarei and Dunedin areas would be assessed to give visitors and the Medical Education Committee experience in general practice accreditation as a foundation for a pilot programme in 1997.

At the March 1996 meeting, Council resolved to recommend to the Minister the approval and gazetting of nine general practices as suitable for employment of pre-registration interns (category B medical runs). Professor Mortimer reported that the teams which undertook the general practice visits were very impressed with the high standard and enthusiastic attitudes of the general practitioners and the excellent systems for preventive care and recall in the practices visited. Visitors who were not general practitioners themselves were particularly impressed with the quality of the experience available for interns. Council endorsed the Medical Education Council's view that all general practitioners offering runs to interns should in principle be vocationally registered. However it did accept that there may be situations when this would be unduly restrictive and it would not want to exclude potentially good applicants from

putting their practices forward. It was considered essential that interns have their own space at the practice.

Council resolved to ask the Clinical Training Agency to include general practices as clinical placements in their draft service specifications for the year one house surgeon programme. In connection with this specification, Council asked the Clinical Training Agency to modify the terminology used to comply with the Medical Practitioners Act 1995. Mandatory clinical experience for those in the pre-registration (soon to be entitled probationary) year would include at least four three month posts of which at least two were category A posts (one surgical and one medical) and two may be category B posts.

Crown Health Enterprise Pre-registration Training

The hospitals in Whangarei, Bay of Plenty, Hawkes Bay, Gisborne and Taranaki were visited for accreditation of intern attachments. The programme for 1996 included Waikato, Manawatu/Wanganui, Mid Central, Nelson/Marlborough, West Coast, Southland and Otago. In the lead up to the implementation of the Medical Practitioners Act 1995, emphasis in the visits shifted to people (approved persons and supervisors) rather than the institution themselves, as the new legislation allows greater flexibility to Council in approving education, training and supervision programmes for doctors (New Zealand and overseas qualified) in the pre-registration year.

Intern Supervisors

Regional meetings for Intern Supervisors were held (attended by Council and Education Committee members and representatives from the Clinical Training Agency) and these were very successful with a great deal of information being gathered and shared on various matters relating to the pre-registration year. Regional meetings are likely to continue in the future.

Methods of appointment and contracts for Intern Supervisors were reviewed and Crown Health Enterprises were encouraged to advertise vacancies and institute a thorough selection process. Committee members, Professor Simpson and Dr Morreau, attended a meeting in Canberra on intern supervision and education. Improved standards for education programmes, support and assessment of interns is of concern on both sides of the Tasman. The programme which has been running in New Zealand for some years is viewed as a good example.

Early discussions about the formation of a health ITO have been attended but little real progress has been noted in this area or in incorporating degrees and postgraduate qualifications into a single harmonised framework, under the auspices of NZQA.

Council approved the appointment of one Intern Supervisor who was working fulltime in private practice to supervise interns in the local Crown Health Enterprise where he had previously had a part-time role. This appointment was approved on a trial basis and will be evaluated at the end

of a year. In another recognition of changing times, Council supported in principle job sharing by interns provided a suitable contract with the Crown Health Enterprise could be negotiated. Each intern would have to do the equivalent of half the acute work to fulfil registration requirements and the Intern Supervisor would have to approve the arrangement in advance.

Informed Consent

Issues of informed consent arose from the hospital accreditation visits and were discussed at length at all three Intern Supervisor meetings. This topic was of great concern to interns and Intern Supervisors. As younger members of the profession are very conscious of medico-legal issues, interns were seeking more detailed guidance than just general principles. Council took the view that the person doing the particular procedure was responsible for obtaining informed consent from the patient as this person was most likely to be aware of all possible outcomes of any given procedure. However, Council stressed that involvement of the intern in the informed consent process, by obtaining relevant information on a particular condition, can be very beneficial educationally. This requires appropriate consultant backup for the intern concerned. Interns need to be proactive in seeking information and issues of patient empowerment also need to be addressed. Council encouraged the development of a consent form separated into two parts, namely provision for (a) the signature of the doctor, who will carry out the procedure, certifying that he or she has provided appropriate information and (b) the signature of the patient (which must be witnessed, possibly by the intern), agreeing that they had received, from the consultant concerned, the information they required to make an informed choice.

MAINTAINING THE NEW ZEALAND MEDICAL REGISTERS

There was considerable pressure on policy and procedures for entry to the New Zealand Medical Register over the past year, as a result of increased medical migration and the realisation that there would be significant changes pursuant to the Medical Practitioners Act 1995 effective from 1 July 1996.

Overseas Trained Doctors

Council was relieved that new immigration policy was implemented effective from October 1995 to address problems arising when overseas trained professionals (including doctors) were granted permanent residence without having established their eligibility for registration in New Zealand. A

survey undertaken by Council with the assistance of the New Zealand Overseas Doctors Association in December 1995 brought to light over 650 such doctors, 500 of whom were resident in the Auckland area. A third of these doctors were from Bangladesh but less than 10 had approached the Council regarding registration. Just under half the 650 were in the 30 to 35 year old bracket and many had brought young families to resettle with them in New Zealand. At least 150 appeared to be people who had been trained or recognised as specialists prior to coming to New Zealand. Very few had attempted the Council's registration examination, NZREX, at that time.

Based on the information provided in the survey, Council was able to provide guidance for these doctors on how to meet the requirements for registration. Work began on developing a pathway which would be an alternative to NZREX for those who believed a general examination was inappropriate when they had trained and worked as specialists for some years.

Council advised the Minister of Health that consideration should be given to funding for bridging courses and assistance with examination preparation and costs as Government policy had had a major role in producing a situation which the overseas trained doctors found unfair and damaging to them and their families.

Many of these doctors hoped that the Medical Practitioners Act 1995 would address their problems. The Act did provide for more Council discretion in setting standards for entry to the Register, but in the end the Council's decision to base entry without examination on recognised undergraduate medical school accreditation procedures, meant that this large group of doctors still faced what they viewed to be severe hurdles before they could obtain registration.

Although Council was sympathetic to their plight, its responsibility is to the New Zealand public and no doctor can be entered on the Register who has not met minimum standards. Managing the followup to the survey and circulation of information to the doctors was problematic. Late in June, over 180 doctors made application for judicial review to the High Court in a class action, alleging Council breaches of the 1968 Act and racial discrimination, amongst other things.

One doctor who had neither succeeded in NZREX nor met the standards for admission to the Specialist Register, but who had been on temporary registration since arriving in New Zealand in 1986, was granted probationary registration as a result of a High Court judgment. The circumstances of this case were peculiar to that doctor and the judgment made it clear that it did not set a precedent.

There was a significant upsurge of applications from doctors whose primary medical qualifications were obtained in South Africa when it became clear that South African graduates would no longer automatically be registered permanently without examination after 30 June 1996.

Although the same situation would apply to graduates in medicine from universities in the United Kingdom, Republic of Ireland and Canada, no major change in the level of applications for registration from that group occurred. Council ruled that for a limited period these doctors could still apply for temporary registration under the new Act.

Table 1

NEW ZEALAND MEDICAL REGISTER STATISTICS
Year ended 30 June 1996

Number on Register at 1 July 1995	11889
Number added during period -	
Qualified in New Zealand	271
Qualified in other countries	564
Number removed during period	680
Number on Register at 30 June 1996	12044
Number of APCs issued	8487
This includes:	
Register of Specialists	
Number on Register at 1 July 1995	2870
Number added during period	227
Number removed during period	3
Number on Register at 30 June 1996	3094
Register of General Practitioners	
Number on Register at 1 July 1995	1464
Number added during period	115
Number removed during period	0
Number on register at 30 June 1996	1579

Shortage Specialities

Shortages in the psychiatric workforce continued. In light of those Council decided to extend its arrangements for granting temporary registration to overseas qualified psychiatrists but only on the condition that other organisations were doing something to address workforce issues longterm. Council surveyed the American psychiatrists who had come in on the special temporary registration programme, and their supervisors and employers. The survey report was distributed to the Minister of Health, the Royal Australian and New Zealand College of Psychiatrists, the Clinical Training Agency, RHAs and recruitment agencies. Council advised that the employers were generally enthusiastic and wanted the scheme to continue. However there were some concerns about insufficient advance information being provided to the psychiatrists and some patchy supervision. The qualifications of the psychiatrists appeared to be above average and the clinical care satisfactory. Council decided that it was safe to continue the scheme but deficiencies noted should be addressed and all participants reminded that it was not a longterm solution. Tighter supervision protocols were drawn up There had been concerns about continuity of care where a series of short-term appointments were made but the survey indicated that this was more a perceived than an actual problem. Council decided that the minimum period for such appointments would be three months but six or twelve months would be preferable.

The College continued to assess overseas trained psychiatrists wishing to remain permanently in New Zealand and Council supported this initiative, along with any

steps to improve the pass rate and recruitment and retention of New Zealand qualified psychiatrists.

There appeared to be some geographical imbalances in the radiology workforce and Council urged those in a position to make change to consider incentives which would enable New Zealand radiologists to be recruited to areas in the country which were not adequately serviced otherwise.

Shortage of medical, paediatric and cardiothoracic registrars appeared to be systemic, and general practice locums are increasingly harder to find.

Telemedicine

This development in technology and provision of services was monitored by Council and attempts by other regulatory bodies to develop codes were useful as a background. Issues arise concerning credentialling, liability, confidentiality, record keeping, unregulated technology and informed consent. Council took the view that the responsibility lies with the doctor in New Zealand who is in charge of the patient care and may refer the patient, using telemedicine, for expert advice from a colleague elsewhere in New Zealand, or in due course, overseas.

Impaired Doctors applying for Registration

Through the work of the Health Committee, it has become clear that some doctors who have experienced health problems (mainly arising from substance abuse or psychiatric disorders) in the course of their medical career, were known to be in some difficulties when in their undergraduate medical education programme, in New Zealand or overseas. Council has urged the medical schools to improve procedures for dealing with this. All new registrants, from whatever country, must disclose any health problems, convictions (eg drunk driving, fraud, assault) when applying for registration. Medical students in New Zealand are aware of this. Council has in place a procedure for reviewing such disclosures and ascertaining whether they indicate any ongoing concerns which would reflect on the doctor's fitness for registration. Medical or psychiatric assessments may be requested before the application for registration is finally considered. Good liaison has been established between the Health and Registration Committees of Council in this regard.

Competence in English Language Communication

Council noted that there were a number of overseas fee paying students likely to qualify MB ChB. Those doctors and some new graduates who are recent immigrants to New Zealand were found by the universities to experience some communication difficulties during the clinical years of the course. Under the new Act every applicant for registration will have to satisfy Council that he or she has a reasonable ability to communicate effectively in English. Where applicants do not have English as their first language, supervisors in the probationary year will be asked to monitor this aspect of performance and report immediately to Council if there are any problems.

Vocational Registration

As the new Act implementation approached many doctors realised that they would be wise to seek specific specialist/vocational registration. Some were doctors already on the Register who qualified under the existing regulations governing specialists and general practitioners but had not previously applied. Others were doctors in emerging branches of medicine which were not yet recognised for the purposes of vocational registration. They were advised that steps would be taken early in the life of the new Act to publish criteria which would enable such branches to meet a training standard satisfactory to Council so that their successful trainees could seek vocational registration.

Council had numerous meetings with colleges and faculties concerning the assessment of overseas trained doctors seeking vocational registration. It was agreed in principle that a consistent method of conducting such assessments needed to be established (with consistent fees) across all branches. A model for such a pathway was accepted in June 1996 ready for implementation under the new Act. Some applications which had been made in the preceding year were held over for this new pathway as they failed to qualify under the 1968 regulations. This caused some frustration for applicants. Council agreed that rulings on "specialist eligibility" which had been given under the 1968 Act, should be valid for the same length as the vocational registration reaccreditation cycle in that particular college, normally 5 years. Applications as such would however have to be made for vocational registration pursuant to the 1995 legislation from 1 July 1996.

NOTIFICATION OF CHANGE OF ADDRESS

All registered doctors have a responsibility to keep the Medical Council informed of their current address. The secretariat must be advised of any changes promptly (within one month). Failure to do so can result in removal from the register. Before removal is actioned, a list of "lost" doctors is published in the New Zealand Medical Journal. The onus is on the doctor to advise the secretariat where a change of address occurs.

Additional Qualifications

Council reviewed the policy for entering additional qualifications in the Register and decided that from 1 July 1996 only qualifications which were the grounds for initial or vocational registration would henceforth be entered in the Register as the quality of such qualifications was known. Additional qualifications which had already been entered in the Register would not be deleted as they had been approved under previous legislation.

Visitors and Permanent Residents

Council revisited policy on definitions of "visiting" (temporary registration) and "intends to reside and practise" (probationary registration) and decided to align these with residential status in New Zealand. A doctor would normally be deemed to be "visiting" New Zealand if that doctor did not hold a permanent resident visa or citizenship but had a visitor or work visa. To meet the legislative requirement of "intends to reside and practise", permanent residence or citizenship was required, along with a firm offer of a position in medicine in New Zealand for a period of 4 months or longer. Doctors with residence permits but remaining in New Zealand less than 4 months would be granted interim registration (probationary) but that would lapse on their departure.

Temporary registrants wanting to remain in New Zealand permanently would have to meet examination and assessment requirements (eg NZREX) in order to be eligible to proceed to probationary registration under the new legislation.

Jane Lui, Team Leader Registration, and her team members faced a daunting, sometimes even overwhelming, workload this year. Registration enquiries, applications and processing increased in the final phase of the 1968 Act and regrettably not all customers treated Council staff with respect or courtesy. At the same time all registration information and systems had to be reviewed and many amendments made in readiness for compliance with the new Act on 1 July 1996. Council acknowledges the enormous contribution made by Jane and her team – they are "the powerhouse" of the secretariat, whose production even under such pressure must be timely, consistent and customer focused. There were inevitably some relatively minor complications and some delays, but all services were consistently maintained with good quality.

Table 2

NEW ZEALAND REGISTER OF SPECIALISTS
at 30 June 1996

	1995	Added	Removed	Net	Total
Anaesthetics	336	34	0	34	370
Public Health Medicine	165	6	3	3	168
Dermatology	47	1	0	1	48
Diagnostic Radiology	184	15	0	15	199
Emergency Medicine	0	7	0	7	7
Gynaecology	1	0	0	0	1
Internal Medicine	536	40	0	40	576
Obstetrics	1	0	0	0	1
Obstetrics & Gynaecology	214	11	0	11	225
Occupational Medicine	0	16	0	16	16
Ophthalmology	100	2	0	2	102
Orthopaedic Surgery	153	7	0	7	160
Otolaryngology	75	4	0	4	79
Paediatrics	174	14	0	14	188
Pathology	185	14	0	14	199
Psychiatry	291	36	0	36	327
Radiotherapy	35	4	0	4	39
Rehabilitation Medicine	0	3	0	3	3
Cardiothoracic Surgery	27	3	0	3	30
General Surgery	240	8	0	8	248
Neurosurgery	15	0	0	0	15
Paediatrics Surgery	5	0	0	0	5
Plastic Surgery	30	2	0	2	32
Urology	41	0	0	0	41
Venereology	15	0	0	0	15
Total	2870	227	3	224	3094
Indicative Register of GPs	1464	115	0	115	1579

NEW ZEALAND REGISTRATION EXAMINATION (NZREX)

This year saw an unprecedented rise in demand for the examination and some management problems as a consequence. Fortunately early in the year a computer upgrade was carried out and enhanced arrangements for data transfer between the Examinations Director and the Council secretariat implemented.

Review of NZREX

In July 1995 the Board of Examiners, with invited experts, reviewed the three parts of NZREX. They were concerned about the capacity of the examination to cope with increased numbers in its present format and the impact of forthcoming changes in legislation which could lead to a significant increase in the numbers of candidates, if graduates from the United Kingdom, Republic of Ireland, Canada and South Africa were required to take NZREX to achieve permanent registration in New Zealand.

As a result of the review the suitability of the Occupational English Test was endorsed. Exemption criteria for doctors trained in English in the United Kingdom and the United States of America were considered. The English Language Institute of Victoria University of Wellington, which administers NZREX English, was asked for comment and further information was sought on the modified TOEFL.

Council decided that, with effect from 1997, NZREX Written would be discontinued in favour of the United States Medical Licensing Examination (USMLE) Steps 1 and 2. The Educational Commission for Foreign Medical Graduates (ECFMG) was consulted on the feasibility of re-establishing a New Zealand test centre (probably Auckland) and using USMLE (and the associated English test, a modified TOEFL) for New Zealand registration purposes. That was agreed and implemented. The Federation of State Medical Boards (FSMB), the National Board of Medical Examiners (NBME), and ECFMG have a joint committee which manages USMLE worldwide. This group offered to amend its rules to allow a candidate who had previously passed USMLE but some time ago, thus not meeting Council's criteria for the "life" of the examination, to repeat if so required by Council. It was agreed that notice be given that the June 1996 session of NZREX Written would be the last at

which new candidates would be admitted and this would allow three opportunities for repeat through until mid-1997 when it was phased out completely. This was subsequently amended to November 1996 on receipt of submissions from overseas trained doctors who had planned to make their first attempt at that session, with phasing out to occur by the end of 1997. The marking policy for NZREX Written was reviewed and revised, giving greater weight to the paper which covers all the major clinical disciplines and less weight to the shorter behavioural science paper and the MCQ paper on pathology and pharmacology. A minimum pass score was set in light of the revised weightings and a formula was devised to enable a candidate meeting certain criteria to be granted a partial pass and allowed to carry forward clear passes but repeat disciplines in which they had shown weakness.

Feedback

Comprehensive feedback is provided to all failed candidates in NZREX Written and Clinical and if necessary the examiners at the English Language Institute will provide commentary for doctors who are having particular difficulty with certain aspects of the English test. Some of the latter group have been recommended to take additional English tuition. Where accent is a problem referral to a speech language therapist is sometimes helpful. Council confirmed that its bottom line for achievement in IELTS (an English test developed by the British Council) and TOEFL need to be considerably higher than that for admission to undergraduate university courses, as ability to communicate effectively in English was critical to success in the workplace, particularly in areas where the patient or employee population was multi-cultural.

Appeals

Some appeals were received from candidates for fourth attempts at the three parts of the examination. Provided progress had been demonstrated and remedial education and training was in place, the Board normally supported a recommendation to Council that a further attempt be allowed. Unfortunately a very small number of candidates make no progress, even slip back under the stress of repeated attempts, and are counselled to seek work in another field rather than pursuing fruitless attempts to register as doctors in New Zealand.

Professional Conduct Test

The Board of Examiners had been asked to look at developing a test of professional conduct (based on the publication "Medical Practice in New Zealand – A Guide to Doctors Entering Practice" prepared for Council by Professor David Cole) probably for administration during the pre-registration year. The Board referred this matter to the Medical Education Committee for further consideration as part of the overall supervision requirements under the new Medical Practitioners Act for probationary registrants.

NZREX Clinical

The Examinations Director went to Australia later in the year to observe the Australian Medical Council Clinical and reported that NZREX Clinical stood up well by comparison but that in New Zealand more flexibility was needed if demand for places increased.

For the April 1996 session of NZREX Clinical a new centre was added at Waikato Hospital. Even so there were insufficient places to accommodate all 100 candidates in Auckland, Hamilton and Wellington and a ballot had to be instituted. A special session was conducted in June 1996, for 40 doctors balloted out in April. Steps were immediately taken to set up NZREX Clinical centres in medical school centres, Christchurch and Dunedin, thus increasing future capacity to 120 in total. There was severe criticism of Council for this shortfall in capacity but Council did not believe candidates who had to wait until June were disadvantaged. Another problem arose for candidates with the addition of centres in the South Island since most of the candidates were residing in the northern half of the North Island. Increased costs and stress are involved in trav-

Tables 3 and 4

CANDIDATES SITTING AND PASSING NZREX CLINICAL
in Year ended 30 June 1996

	August 1995	April 1996	June 1996 (supplementary)
Candidate attempts	55 (26)	60 (18)	40 (2)
Number of passes:			
Attempt 1	14	24	22
Attempt 2	8	8	0
Attempt 3	2	1	1
Number of passes overall	24	33	23
Pass rate overall	44%	55%	58%

Note: ( ) repeat candidates included

CANDIDATES SITTING AND PASSING NZREX ENGLISH AND WRITTEN
in Year ended 30 June 1996

	English	Written	English	Written
	Nov 1995		June 1996	
Candidate Attempts	68 (13)	98 (14)	113 (15)	125 (33)
Number of passes:				
Attempt 1	43	22	82	37
Attempt 2	6	17	7	8
Attempt 3	-	10	3	5
Number of passes overall	49	49	92	50
Pass rate overall	72%	50%	81%	40%

Note: ( ) repeat candidates included

elling to the southern examination centres. As far as possible candidates are given their first choice but are then balloted for other centres so that each of the five centres does not exceed the maximum of 24 candidates. This is the top number of candidates that can be examined in all disciplines over the two days, now a weekend, in order to have access to examination facilities. Holding three clinical examination sessions each year was considered an emergency arrangement, but has had to be adopted as standard policy as numbers continue to escalate.

Council is indebted to all the medical schools for their assistance with this examination. Council is aware that the examiners involved in both the written and the clinical are the same examiners who are heavily involved in undergraduate (and in some cases postgraduate) teaching and examining in the medical schools. While this facilitates the maintenance of equivalent standards in the MB ChB and NZREX examinations, it does place an additional burden on already busy clinicians. As guaranteed access to suitable facilities for the clinical examination can only be achieved through using outpatient departments in weekends, this is an additional inconvenience for the examiners upon whom we rely.

Council has been very ably assisted by the Examinations Officer, Tone Smith, the administrative secretaries at each of the examination centres, particularly Jennifer Hargrave at Auckland who also works with the Examinations Director, and by Dr Campbell Maclaurin, Examinations Director who has steered NZREX through a particularly sharp rise in demand and scrutiny.

MEDICAL WORKFORCE SURVEY

A decision was taken in principle to transfer the workforce survey operation from Dunedin to the Council's office in Wellington, as the longstanding scientific officer, Carol Leatham employed by the University of Otago in the Department of Preventive and Social Medicine, indicated that she would be resigning in early 1996. Council engaged a person to work with Carol over the summer 95/96 to prepare a manual for guidance of the new database administrator.

Once again unit data was requested by the Ministry of Health but Council refused to accede to it as it was very concerned that agreement to the supply of data in this form could result in the identification of small groups within the profession. More importantly, it could undermine the confidence of doctors in the confidentiality of their responses. Some difficulties in negotiating a contract with the Ministry of Health continued but Council was committed to maintaining the data collection nonetheless.

A new questionnaire was developed and trialed prior to mailing in early February. In the past the application for APC and the

accompanying workforce survey questionnaire had often not been distributed until very close to the date when renewal was required. This gave rise to numerous problems. Council therefore resolved to mail the material in early February 1996 allowing two months for doctors to comply. This was very successful and most doctors received their renewed certificates by 1 April 1996. Their co-operation was appreciated. Regrettably data entry of the workforce survey information had to be delayed till much later in the year after the database had been transferred to Wellington, reviewed and re-established. A method of archiving the information in previous surveys must be developed so that this information can still be available for research purposes.

Mr George Spiers of the Department of Preventive and Social Medicine at Otago retired at the end of December. Council records its thanks for the work Mr Spiers did in providing a degree of supervision of the survey operation and advice to the Data Committee. Ms Leatham was involved with this survey for 20 years and had developed a loyal circle of customers (including Council staff) in that time. Council acknowledges her major contribution to the success of this project. Her technical knowledge of the database was incomparable. Carol was farewelled at a function at the June 1996 Council meeting in Wellington.

Enclosed with this Annual Report is a brief summary of New Zealand Medical Workforce information collected early 1996. This was prepared by public health physician, Dr Nicholas Wilson, who was engaged to undertake a review of the database operation following its transfer to Wellington.

Council also acknowledges the important contribution made this year, during a period of change and transition, by Jeni Woods, part-time database administrator in the Council secretariat.

IDENTIFICATION AND MANAGEMENT OF IMPAIRMENT

Council's well established programme continues to develop through the experience of the Health Committee which makes a major commitment to encourage effective rehabilitation and return to safe practice for doctors who have the misfortune to suffer poor physical or mental health. Establishment of the committee in 1988 allowed a uniform Council response to assessment and management of impairment. Staff and Council members' experience gained during discussion with many practitioners and their partners, has helped develop protocols for support and monitoring. Unsuccessful rehabilitation has been rare and users confirm that success has been assisted through early firm application of conditions under which practice may continue. A degree of monitoring is likely to be continued for at least five years but gradual relaxation of the conditions can occur when compliance is assured.

The number of doctors being monitored remained steady. Where possible voluntary undertakings are instituted but in some circumstances it is necessary for Council to exercise its power to suspend. This situation arose in only three cases in the past year. The committee met on eleven occasions and expects that in the future it will be necessary to meet monthly. During the year the committee drafted a statement on its role, particularly pointing out the difference between health and discipline powers of the Council. This statement can be made available to anyone enquiring about the work of the committee or to newly referred doctors who may be involved with the committee for the first time.

Council supported the initiative of anaesthetists in Auckland in establishing an Anaesthetists Addiction Education Committee (AEC) whose aim is to increase awareness and take immediate action to institute treatment and support if an event involving substance abuse is made known to them. The AEC has met with the Health Committee and agreed on the respective responsibilities of the two groups.

The preparation of a handbook by the Doctors Health Advisory Service (DHAS) will contribute to the education of doctors on the need to take care of their own health, an important part of professional life. During the year, the committee was also able to provide some general information to Dr Tony Revel, a South Island general practitioner, who wrote a masters paper entitled 'The Psychological Needs of Doctors and their Mental Health - Physicians Heal Thyself'.

Prevention of problems of health impairment is essential and should be promoted in undergraduate and postgraduate education. Requirements for recertification will in the future offer a great opportunity for discussion of development of health living and lifestyle habits towards good practice. Unreasonable goals can produce high levels of stress. It is sad to see the balance between work and relaxation achieved only after a breakdown in health. The Council's new competence provisions may well bring to light further doctors whose underlying problems relate more to health than to reduced levels of knowledge or skill.

The provision of a mentor is often a significant aspect of the monitoring programme and the Council is indebted to the mentoring coordinator, Dr Ashton Fitchett, for his diligence and sensitivity in arranging appropriate mentor relationships on request from the Health Committee, or occasionally the Medical Practitioners Disciplinary Committee or the Preliminary Proceedings Committee. During the year Dr Fitchett recommended a review of mentoring frequency and this was actioned. Mentoring will now be in place for eighteen months in the first instance rather than two years. The frequency of meetings between mentors and mentored doctors is monthly for the first three months, thereafter two monthly. A financial contribution to the cost of mentoring is required.

The protocol for urine drug screening

was reviewed. In consultation with a medicines control advisor, a medical officer of health, and a pathologist, a new protocol was developed which is more efficient. Urine testing remains a very effective tool in the monitoring process. Although doctors sometimes resist it at initial referral, further on in their rehabilitation they often tell the committee that this was perhaps the single most important action taken which assisted them in their recovery. Similarly the gazetting of prescribing prohibitions, while sometimes seeming harsh, quickly brings about a positive outcome.

Occasionally positive urine test results are reported which surprise the mentored doctor and the committee. The literature indicates that such positive reports are not uncommon, due to the nature of the various screening mechanisms. Clearly a false positive can be a disturbing experience for the monitored doctor but on the other hand any positive results must be taken seriously by the committee as it may indicate relapse. Where such reports are received from the laboratory, the committee now routinely immediately asks the doctor to explain, advises the medicines control advisor and asks for the sample to be tested again using thin layer chromatography (TLC). In some circumstances it may be necessary to have the specimen subjected to gas chromatograph mass spectrometry (GCMS) which is the gold standard confirmatory test. The chain of security must also be reviewed.

It is helpful to be able to share ideas with other registration bodies overseas and in this regard some good ideas have come to light in the past year through the Bulletin of the Federation of State Medical Boards and through information from the South African Medical and Dental Council.

Table 5

HEALTH COMMITTEE ACTION

year ended 30 June 1996

Action	Number
Currently monitored by Health Committee	23
Previously monitored – satisfactory update letters	4
New voluntary undertakings signed	9
APCs voluntarily not issued	14
Voluntary undertakings amended	8
Voluntary undertakings discontinued	1
New suspension imposed	3
Full suspension reimposed	3
Full suspension varied to allow limited practice	2
Conditions of limited suspension amended	5
Suspensions revoked	
(voluntary undertakings retained)	3
(no undertakings retained)	1
Request for revocation of suspension	1
Prescribing restrictions gazetted	1
Prescribing restrictions (gazetted) revoked	nil
Applications for registration considered:	
(a) initial registration supported	3
(b) re-registration (following removal on disciplinary grounds)	
– supported	nil
– not supported	1
(c) full registration from probationary applications	1
Referrals to Health Committee received, but on further investigation, declined	1
Provisional certificate withdrawn	1

The committee considered what policy it should adopt in relation to notification of doctors who had been committed for treat-

ment under the Mental Health Act. Each case must be reviewed on its merits and it is not appropriate to have a policy of automatic suspension. Nevertheless, the committee views seriously such notifications and may in certain circumstances recommend to Council that the doctor be suspended until patient and public safety is clearly not at risk. The type of condition which results in lack of insight in the sufferer is of particular concern to the committee. Early referral for assessment and treatment is important and the committee urges doctors to remember their statutory responsibilities when they become aware that a colleague may be impaired to such an extent that competent practice is in jeopardy.

The committee noted that the Medical Practitioners Act 1995 makes a very clear requirement on Council not to register any person who is not fit to practise medicine by reason of any medical or physical condition and sets out in Part VII revised provisions for handling notifications of conditions affecting fitness to practise medicine. Council views the new authority to require cooperation in the evaluation of impairment as an important gain. Council now has the power to order a medical examination and to impose an interim suspension of registration in cases of suspected impairment. Further restrictions however may only be imposed on practice after the practitioner has been given an opportunity to make submissions and be heard. Such conditions relate to registration itself or the annual practising certificate. Wherever possible the committee prefers to make voluntary undertakings which are not a matter of public record. If such undertakings are breached, however, more coercive action is available. If a doctor agrees not to seek an annual practising certificate because of health problems, that may have to be recorded as a condition on registration.

Lynne Urquhart, Team Leader Standards, acted as Secretary to the Health Committee and greatly improved the administration of this important area of Council work. Her attention to detail and sensitivity was valued by the committee, referred doctors and their support people.

HOW TO HELP A SICK OR IMPAIRED COLLEAGUE

No one likes to initiate a review of an impaired colleague but it is seldom in the interest of the colleague, or the public, to wait until the impairment is obvious.

If the problem cannot be resolved by discussion with the sick doctor's immediate colleagues, therapeutic doctor and family, it should be referred to the Doctors Health Advisory Service (DHAS), the Medical Officer of Health, or the Health Committee of the Medical Council. Where there is a prospect of a resolution, the referral will be treated confidentially.

Please contact one of the following:

DHAS
Freephone: 04 471-2654
PO Box 812
Wellington

Medical Officer of Health
Telephone or write to
local public health office

Health Committee
C/o Medical Council of
New Zealand
Ph: 04 384-7635
Fx: 04 385-8902
PO Box 11-649
Wellington

SUMMER STUDENTSHIP 1995/96

The 1995/96 studentship was awarded to Marie van Wyk, a fifth year medical student at the University of Otago. The research, titled Methods of Solving Clinical Ethical Dilemmas, was completed to a high standard under the supervision of Professor Alistair Campbell, the Director of the Otago Bioethics Research Centre.*

Deputy Chair of Council, Dr Geoffrey Lamb, suggested the studentship topic. It was acknowledged that restoration of ethics committees in recent years, in the wake of the Cartwright Report, had resulted in a committee system which appears specifically focused on research. A hiatus exists for clinicians trying to solve clinical dilemmas.

Ms van Wyk's project examined the existing procedures and considered workable alternatives for future solutions of clinical ethical dilemmas.

Council was pleased to sponsor Ms van Wyk's presentation of the project at this year's Women in Science Conference in Wellington.

*Professor Campbell left the Otago Bioethics Research Centre to take up a post at the University of Bristol. During his years at the Centre he worked with Council on major ethics projects including persistent vegetative state and the withdrawal of food and fluids, biotechnology - particularly assisted human reproduction. His contribution was highly valued by Council.

COMPLAINTS AND DISCIPLINE

The most significant development for Council in the last twelve months has been the introduction of the new Medical Practitioners Act 1995. This will enable complaints and discipline to be handled outside Council direct involvement. Once the transition period is over, the Health and Disability Commissioner's office will play a large part in the assessment of complaints. Hopefully this separation will be more acceptable to the profession who sometimes accused the Council of both setting and testing the rules. It should also be more acceptable to the public as it will use more lay members and the Medical Practitioners Disciplinary Tribunal will be chaired by a lawyer.

Over the years there has been a dramatically increasing number and complexity of complaints received by Council (and the Medical Practitioners Disciplinary Committee [MPDC]) and this has required a huge commitment, particularly where disciplinary hearings were involved. A marked increase in complaints of sexual misconduct and the development by Council of mechanisms to deal with these complaints including formulation of guidelines and standards for both doctors and the public was a major feature of the last decade. Earlier in that period Council also took the initiative to address problems concerning the prescribing of drugs of abuse. Possibly because a number of doctors were removed from the register for prescribing and patient boundary offences, these types of misconduct have been highlighted. However, it would be unwise to be complacent about the potential for professional misconduct in these areas just because there has been a lower level of disciplinary action in this regard in the past twelve months.

The new Act poses particular challenges to Council in the management of complaints assessment, particularly during the period when many complaints received will relate to events prior to 1 July 1996 which will not be covered by the forthcoming Code of Health and Disability Services Consumers' Rights. Prompt and appropriate determination of complaints is the aim but the mechanisms of the 1995 Act do have inbuilt delays. Medical and lay members of the committees will take time to build up experience in assessing complaints but their involvement in the Complaints Assessment Committees is an important aspect of professional self regulation which will be a valuable learning experience of itself. This report covers the last year of operation under the Medical Practitioners Act 1968. However, transition provisions in the new Act require that any matters that have entered the complaints and discipline system under the 1968 Act must be pursued as if the 1995 legislation had not been enacted. This means that a considerable number of complaints will still be under investigation and matters awaiting hearing by the MPDC or the Medical Council. It is anticipated that it will take well into 1997 to complete all these enquiries and hearings. The Council itself will still be required to hear appeals from decisions of the MPDC and such appeals could follow through until the end of 1997, if the current rate of appeal against MPDC findings continues.

Over the past year the Preliminary Proceedings Committee (PPC) has comprised Dr Campbell Maclaurin as convenor, Dr Caroline Corkill and Mr Phil Cook (legal member). They received 94 complaints (involving 99 doctors) during the year, of which 65 were referred to the Chairman of the MPDC for consideration, one has been dismissed and 28 retained for further investigation. Charges were laid against 3 doctors. A major investigation involved complaints concerning the under cover programme of the New Zealand Police. The report by the PPC on this issue, which did not result in

charges against any doctors, received considerable media attention. At the June 1996 Council meeting, the PPC convenor reported 29 files still open. The MPDC had 174 files open.

Charges coming before Council involved sexual abuse, fraud and perjury. Completion of the disciplinary process was delayed in three cases because the doctors were overseas, only one returning to New Zealand during the year (to face medical manslaughter charges). Fraud investigations and convictions appear to be on the increase following rigorous review by ACC and Health Benefits Ltd.

Persistent attempts to obstruct the disciplinary process through use of appeal and judicial review mechanisms can result in additional costs for the Medical Council. A small number of doctors adopt this attitude but rarely succeed in the end. Council would hope that this kind of activity would diminish under the new legislation.

The MPDC has borne the greatest burden of hearings under the 1968 Act. They are well served by the secretariat managed by

Table 6

DISCIPLINE ACTIVITIES

In the year ending 30 June 1996, the following matters have been before the Council sitting as a disciplinary tribunal:

- Charges of disgraceful conduct in a professional respect against two doctors were heard. Both were proven. The Council ordered that the names of the doctors be removed from the register. In both cases, appeals were lodged against the decisions of the Medical Council with the High Court. Each of the doctors were granted a stay of the Council's orders pending determination of their appeals in the High Court.
- A criminal conviction was referred by the Preliminary Proceedings Committee involving one doctor. The doctor's name was subsequently removed from the register.
- Fourteen appeals against decisions of the Medical Practitioners Disciplinary Committee, including one against name suppression and one against costs (seven were upheld, two partly upheld, and five dismissed).
- Two appeals, held over from the previous year were heard by the High Court. In one, the High Court quashed the Council's order for costs and substituted a new order. In the other, the High Court partly upheld a doctor's appeal against a Council decision (on an appeal against a decision of the Medical Practitioners Disciplinary Committee).
- The Medical Council heard three applications for re-registration following removal from the register on disciplinary grounds. These applicants were subsequently granted probationary registration with conditions.

Mr Roger Caudwell which will continue to provide administrative support (funded by Council) for the new Tribunal. Council acknowledges the considerable time, effort and expertise which has been devoted to the MPDC by its Chairman Dr Dean Williams and all the members. While matters brought to Divisional Disciplinary Committees do not usually result in much publicity, there has also been a valuable commitment made by the profession to deal with complaints at the level of conduct unbecoming a medical practitioner. Under the new legislation, a single tribunal will sit to hear all charges, whether arising from referrals from convictions, Complaints Assessment Committees or the Director of Proceedings pursuant to the Health and Disability Commissioner Act.

Dealing with complaints and disciplinary hearings is always difficult. Complainants have mixed emotions - expectations versus apprehensions - and their emotional needs are rarely met in the course of an investigation or a hearing. Frequently the expectations of the process are unrealistically high despite the not infrequent bad press. For the investigators it is hard to strike the balance between attempting to satisfy the hopes of the complainant on the one hand and being as fair as possible to the doctor on the other. Currently society's focus tends to be more strongly on the victim and most complainants see themselves as victims irrespective of the alleged facts of the matter. It is not infrequent to observe that what a complainant has seen as offensive may have a perfectly ordinary medical explanation and the fault lies only in poor communication by the doctor or an inadequate rapport between doctor and patient. It has been a good thing to have a woman member of the PPC, especially one with sexual abuse training.

Some Council members were disappointed that the Medical Council's recommendations for the composition of the new Disciplinary Tribunal did not find favour with the politicians. Lay membership is still limited to one and there are fears that the disciplinary process could become a much more expensive exercise than it has already been. There are anxieties about having the 'judicial member' sit as part of the 'jury'.

TRUST IN THE DOCTOR/PATIENT RELATIONSHIP

Reference is made under Communications to the promulgation in July of draft guidelines on "Ending a Professional Relationship" and "Sexual Relationships with a Former Patient".

Assessment and Rehabilitation

Throughout the year Council continued to work on refining policy and guidelines on "Assessment and Rehabilitation" in relation to doctors sanctioned or removed from

the register on the basis of sexual misconduct. A clinical psychologist experienced in this field was appointed as Assessment Co-ordinator along with a panel of psychiatrists and psychologists who could be asked to assist when Council required assessments. Council considered it a duty not to return doctors to practice who could reoffend. Protocols and consents were developed to allow relevant information to be shared with assessors. Council decided not to specify particular people who could provide therapy as this was the offending doctor's responsibility. Although it was sensible for Council to remain at arm's length from treatment, doctors requiring treatment or therapy could, if they wished, seek advice on suitable providers from the Assessment Co-ordinator. Council agreed that the assessors should meet annually for training and that the draft protocol should be given a 12 month trial period. Council has a duty to protect the public but must also be fair and reasonable in its expectations of doctors.

Training

Council sponsored a New Zealand visit by a North American clinical psychologist who is widely known in this field. Mr Gary Schoener conducted a day workshop for assessors and also seminars in Christchurch and Auckland for interested professional and other workers in the field. The overview and pointers for action he provided were considered very useful by many of the 230 people who attended.

Council delegates attended a major conference on professional sexual abuse in Sydney in April 1996 and presented a workshop and a paper on New Zealand experiences which were well received.

Council continued to refine its victim support policies and to share this information with other professional regulatory groups who were dealing with the same dilemmas. It will be important for this information to be passed on to those involved with complaints and discipline under the new legislation, including the Health and Disability Commissioner and her associates.

The dedication and competence of Angela Coleman, Project Co-ordinator, greatly enhanced the ability of the Sexual Abuse Working Party and Council to achieve its goals in this field.

Future Activity

Although Council was criticised by some doctors for its firm stance on sexual misconduct, Council's initiatives on sexual abuse (like its project on reducing prescribing of drugs of abuse before that) were well researched and developed through consultation in a genuine attempt to reduce the incidence of these problems. It is necessary to sustain the work in these areas as the problems continue to surface despite attempts to reduce them through education.

CURRENT ISSUES

Informed Consent

Council reviewed its 1990 informed consent statement and updated it for publication with the 1995 Annual Report. The terminology in the statement was amended to comply with the reformed health sector. The only major change made to the content was to stress that within educational contexts it was important that informed consent by patients be strictly adhered to, not only by students and general medical staff, but also in the postgraduate education and experimental training of more senior doctors in respect of techniques new to them.

Council acknowledged that the Health and Disability Commissioner was developing the Code of Health and Disability Services Consumers' Rights and when this was published, further review of the Council's statement should be undertaken. Council believes that it is still useful to the profession to have a statement from the Council, provided that does not lead to any confusion. The Commissioner had some misgivings about this approach and these were noted.

Assisted Reproductive Technology (ART)

Council has been urging Government for over a decade to consider whether there is a need for legislation on ART and if so to enact it in relation to a variety of developments in biotechnology, affecting humans. Council supported the introduction of a Private Members Bill on ART by Diane Yates. Council recognised that the Bill had a number of deficiencies but believed it was necessary to get this matter in front of a Select Committee so that proper consideration and informed submissions could be made.

Euthanasia

Council noted that the NZMA was working on a policy document and preferred to do so without consultation with Council. Council therefore decided to take no further action at this stage. Council believes that issues surrounding assistance to die with dignity must be widely and thoroughly debated by society in general, recognising that health workers have been faced with them in their practice for many years.

Doctors and Midwives

Council continued to monitor developments in the sometimes difficult relationships between midwives (particularly domiciliary), general practitioners practising obstetrics, and specialists in obstetrics, as new regulatory and funding mechanisms and accountability relationships were negotiated. Council was concerned if a situation should arise whereby a doctor was held culpable in a situation where he or she was involved only after the likelihood of a bad outcome was high. Council noted the Draft Midwifery Competencies prepared by the Nursing Council of New Zealand. It also conveyed to the Clinical Training Agency its serious concerns about education and training opportunities for medical students and vocational trainees including general practitioners in obstetrics and gynaecology. The AMC accreditation report on the Otago medical course had highlighted these.

Mental Health Services

Council noted and in general supported the Mason Report and advised the Minister of Health accordingly. Council was asked to comment on the report of the working party on Mental Health Workforce Development entitled "Towards Better Mental Health Services". Action needs to be given priority.

Resource Constraints

Council continued to receive concerns about resource constraints and duty of care. Council had published a statement on this topic in 1994 reminding doctors that they have an ethical responsibility to provide the best standards of service possible with the resources available to them. They also have a responsibility, as advocates for their patients, to seek the provision of appropriate resources for the treatment of perceived needs.

Some issues of continuity of care arose where more entrepreneurial types of primary healthcare were being provided. It was also necessary for Council to make a statement on doctors' personal safety especially in rural areas.

Consultation and Guidance on Ethical Issues

There was some discussion about liaison with other bodies on ethical and other professional matters. Council believes it has a duty to inform the profession on matters of ethics although the NZMA regards this as an important aspect of its activities. Consultation began on the possibility of establishing a joint Council NZMA Ethics Advisory Group. There was also a proposal that a joint committee between Council and the Law Society be set up to consider matters of common interest in professional regulation and practice.

MEDICAL COUNCIL LIAISON WITH OTHER BODIES

Australian Medical Council

Council has continued to maintain a good relationship with the Australian Medical Council and the medical boards and councils of the various states and territories. This has been achieved through attendance at Australian Medical Council special and annual meetings and board seminars. A highlight of the year was the receipt by both Councils of the accreditation reports on the medical schools at the Universities of Auckland and Otago. Accreditation has been granted to Otago until 31 December 2000 and to Auckland to 31 December 2005.

In February the Council Chair and Secretary were able to meet with the President of

the Australian Medical Council, Professor John Horvath, in Wellington. The continuing relationship of the two Councils was discussed along with the outcome of the court action under human rights legislation in Australia, taken by aggrieved overseas trained doctors. They challenged various aspects of the legislation required for registration and the application of a health ministers' quota on the number of doctors permitted to sit the clinical examination at any session. The examination requirement and content were found not to be a breach of human rights legislation and the health ministers were endorsed in their ability to limit the over supply of doctors. The administration of the quota was ruled unacceptable. The Australian Medical Council immediately moved to distance itself from the quota which was required by the health ministers.

The two Councils have exchanged information concerning the migration of Australian doctors to New Zealand and New Zealand doctors to Australia. Such migration has been a matter of concern, particularly to policy makers in Australia in their desire to limit health expenditure. The Trans Tasman Mutual Recognition Agreement (TTMRA) between the Commonwealth Government of Australia and New Zealand has been signed but doctors have been excluded from that agreement.

Council looks forward to sending delegates to the Second International Conference on Medical Registration to be held in Melbourne at the end of October 1996.

Council resolved to sponsor a Wellington satellite conference in early November 1996, to focus on issues concerning workforce planning and the international movement of medical practitioners.

Overseas Doctors Association

Dr Thomson spoke to the October Auckland conference of the New Zealand Overseas Doctors Association to an audience of more than 200 doctors. Early in 1996 some Council members met with two representatives of this group in Wellington to consider ways of addressing the registration, employment and social problems of migrant doctors which had arisen as a result of government immigration policies.

New Zealand Bodies

The Chair was invited to speak at the Institute of Health Management and attended a meeting with the Universities Academic Audit Unit, making available to that unit the Australian Medical Council accreditation reports on the two New Zealand medical schools.

A good working relationship was maintained with the NZMA, chiefly through Dr Thomson, Dr Pezaro and the Chairman of the Ethics Committee, Dr Shackleton. Issues of common concern have been discussed so that the ideas of both bodies can be incorporated into statements for the profession.

The Chair was also active in the Medical Law Reform group and early in the year a meeting was held with representatives of the Medical Defence Union.

The Health and Disability Commissioner and members of her staff met with representatives of Council and Medical Practitioners Disciplinary Committee secretariats to discuss issues concerning the draft code and the likely modus operandi when the code became law. Council Secretary also met with Medical Practitioners Disciplinary Committee and Preliminary Proceedings Committee representatives to plan operations in the transition from the 1968 to the 1995 requirements for complaints and discipline.

Learning from North America

Meetings with DHAS have clarified their relationship and accountability to Council and have resulted in an agreement for a quarterly report to be furnished, indicating the scope of the services provided by DHAS. The concept of an anonymised report was taken from the Bulletin of the Federation of State Medical Boards which reported on an initiative in Missouri. This highlights the benefit for Council in liaison with the Medical Boards in the USA and Canada. The Chair was able to attend the annual meeting of the Federation in Chicago in April at which topics such as fraud and the role of HMOs in the maintenance of competence were covered.

COMMUNICATIONS

Media Issues - Immigrant Doctors

It was a frustrating year for the Council with the media pursuing issues regarding unregistered overseas trained doctors who had immigrated to New Zealand.

To more accurately gauge the true number of unregistered overseas trained doctors living in New Zealand and likely to seek assistance, Council, with the co-operation of the New Zealand Overseas Doctors Association (NZODA), carried out a survey commencing in the latter part of 1995. The results showed that by March 1996 there were at least 650 overseas trained doctors residing in New Zealand without registration. This resulted in negative publicity for the Council, rather than the immigration and economic policies of government which were the root cause.

Council faced many unsubstantiated allegations about the New Zealand Registration Examination. Some overseas trained doctors claimed through the media that the examination was deliberately designed to be difficult and expensive and that they were being discriminated against. The Medical Council responded by emphasising its statutory obligation to protect the public by maintaining high standards, that the examinations were necessary to test competence to practise in New Zealand, and that the examinations were set at a similar level to those used for assessing fifth and sixth year medical students. Council also reiterated

that it was quite unfair to expect registered doctors in New Zealand to subsidise the examination through their annual practising certificate fee.

In addition Council was, on a number of occasions, frustrated by the one-sided reporting of issues in the media. An on going problem faced by Council involved some overseas trained doctors taking their legal challenges to the media, with the resulting stories being based solely on the overseas trained doctors' statements or claims, without due checking of the validity. Council maintained its policy of refusing to comment on cases where they were to be heard before the court. This policy was preserved in the interest of allowing both sides the right to an unprejudiced hearing.

Media Issues - Complaints and Discipline

Media interest was also shown in disciplinary cases before Council and the Medical Practitioners Disciplinary Committee, especially where there was an appeal by the doctor concerned.

Attempts to have the Crimes Act amended in relation to medical manslaughter, research on sexual relationships between doctors and patients, publication of the outcome of the professional misconduct charges against Dr Faris and Professor Seddon, and the removal of a doctor from the register who had been convicted for ACC fraud were all widely reported.

A high profile doctor who is an international sportsman, but has had to overcome pethidine abuse, received publicity which was useful in helping members of the profession and the public to understand that, while such addictions are very problematic for the person concerned, they do not necessarily result in a person's career being ruined, provided a sustainable recovery is reached.

Great interest also surrounded the dismissal of a Dunedin surgeon following receipt of a report by the Royal Australasian College of Surgeons.

On the positive side the Medical Council attempted to maintain its professional integrity by providing accurate information, both when requested by the media and in a proactive manner through media releases and interviews.

Council reviewed its public relations services and decided to reappoint Busby Ramshaw Grice. Kevin Ramshaw has been of particular assistance to Council over a number of years. Terms of reference for the Communications Committee were reviewed as this Committee was reactivated.

MCNewZ

Three issues of MCNewZ were distributed to doctors on the New Zealand Medical Register (in New Zealand and overseas) in the past year. This newsletter has been an important vehicle for Council to advise registrants of forthcoming changes related to the new Medical Practitioners Act. It played a major part in the consultation over the rules for election of medical members to Council. The July 1995 issue alerted all registered doctors to the fact that this was likely to be a provision in the new legislation and indicated some of the aspects of the election process on which feedback would be welcome - electorate, voting system, nominations. About 40 practitioners took the time to provide feedback. There were no very strong preferences expressed either way. Some thought that the current system of receiving nominations from major bodies within the profession should be retained. One section of the April 1996 issue was devoted to proposed election rules, including a sample voting paper. There was virtually no disagreement with what Council was proposing and these draft rules therefore formed the basis of the rules which were eventually gazetted under the Medical Practitioners Act 1995, following Ministerial approval.

MCNewZ is also used to promulgate draft guidelines on professional conduct and other practice or ethical matters. In July 1995, guidelines on "Ending a Professional Relationship" and "Sexual Relationships with a Former Patient" were published. Council pointed out that policy development is an evolutionary process and feedback is important. With this in mind, Council had sought opinions on aspects of informed consent through the December 1994 issue and in July 1995 published a letter from a surgeon on the question "if a specialist is learning a new procedure what information should be provided when obtaining consent from the prospective patients during the phase when the specialist is gaining experience in that procedure?". The respondent thought it would be difficult to specify this but raised another issue, "what happens if the surgeon is experienced in the procedure but only does a small number per year?". Council's statement on informed consent published in 1990 was reviewed and slightly amended and distributed later in the year with the 1995 Annual Report.

The April and May 1996 issues were used to provide a comprehensive summary of all aspects of the Medical Practitioners Act 1995. Intended Council policies concerning qualifications recognised for registration, general oversight, supervision, vocational registration and the new key role of the annual practising certificate were explained. The new arrangements for competence, consideration of conditions affecting fitness to practise, complaints and discipline were all set out in some detail. Copies of the April and May 1996 MCNewZ items on the new legislation continue to be distributed in the information packs provided to all new registrants.

Council recognises that some of this information has been rather dense and perhaps not as eyecatching as it could be. Council welcomes feedback on the contents and format of MCNewZ.

It is anticipated that the new Medical Practitioners Act will require considerable dissemination of information in the coming year, both within the profession and to the public and the media.

NEW LEGISLATION

Health and Disability Commissioner Act 1994 (Code)

Council was involved in consultation by the Health and Disability Commissioner, Robyn Stent, on the draft Code of Health and Disability Services Consumers' Rights and was impressed with the progress made by the Commissioner to place the proposed Code before the Minister less than a year after her initial appointment. The process of consultation on the Code was exhaustive but provided an opportunity for the Commissioner to promote the concepts underlying the Code and to stress the importance of education rather than punishment as a goal of the implementation of the Code. As this development in the health sector gathered momentum, it was clear that there would be a beneficial effect on what until then had been a very slow process of passing the new medical practitioners regulatory legislation.

Medical Practitioners Act 1995

From mid 1995 submissions and consideration of them by the Health and Social Services Select Committee on the Medical Practitioners Bill gathered speed. The Council was given an opportunity to make submissions in response to some key areas of concern to the Select Committee which arose from other submissions made earlier in the year. Council was advised that the Minister intended, if possible, to have the Code of Consumers' Rights and the new Medical Practitioners Act effective together on 1 July 1996. A very useful meeting was held with the Minister in July 1995 and her commitment to seeing the new medical legislation enacted was greatly appreciated. To provide a degree of continuity, the current Chair of Council, Dr Ken Thomson and the laymember, Mrs Patricia Judd, were approached by the Minister to consider reappointment in the transition period between the 1968 and the 1995 Act and they agreed but for limited terms. Professor Mortimer was nominated by the two medical faculties to be their representative on Council and was appointed by the Minister under the new Act.

In the end there was a flurry of activity in December just before the Act was passed when it was discovered that the original composition of the Medical Practitioners Disciplinary Tribunal as contained in the Bill had been altered to introduce a legally qualified Chairperson, two medical practitioners and two laymembers. This in effect meant a minority of medical practitioners on their professional tribunal. Professional and legal opinion was very much opposed to this situation. A brief campaign was mounted to convince the Minister that this needed to be rectified and on the basis of a Supplementary Order Paper in the last 24 hours of the life of the Bill, the composition of the Tribunal was put before the House for ratification as a legal Chairperson, three medical practitioners and one non-medically qualified person. The Minister of Health was subject to some criticism for this move but Council was pleased that she had acted on its concerns.

The Act was finally passed on 20 December 1995 to come into effect on a date to be appointed by the Governor General by Order in Council, this subsequently being 1 July 1996.

Through the consultation process over the previous ten years, Council was gratified that many of its recommendations had been incorporated. Of greatest significance to Council was the separation of discipline to a separate tribunal and the establishment of provision to address deficiencies in competence through non-disciplinary means. Other features of the new legislation which Council had supported from the outset were:

- an overall mandate to ensure registered doctors remained competent,
- greater flexibility in registering overseas trained doctors,
- simplification of registration categories,
- a single vocational register for all those with advanced qualifications, training and experience including general practitioners,
- more adequate power for the Council to require a doctor who might be impaired to submit to medical examination,
- independent assessment of complaints and provision for hearings by the Tribunal to be in public,
- a Medical Council with a significantly increased proportion of non-medical members and provision for medical members to be elected by the profession at large.

The Council was satisfied that the legislation as passed was sufficiently enabling and flexible to be workable through a variety of changes in the health sector and society at large, not forgetting global developments in medical migration, trade agreements, medical science and regulatory policies.

At the commencement of 1996 preparatory work began in earnest for implementing the new legislation as there was no certainty of its precise final form until it was law. The Secretary began drafting rules for the election of medical members, the consultation on these, and finally the Ministerial approval so that the process could begin at the earliest date after the implementation of the Act and result in all new Medical Council members being in place before the end of 1996. Council was advised in June that Mr Henri van Roon had been appointed as the second laymember, but the appointment of the third would be considered by the Minister when the result of the election of medical members was known.

A special Council meeting was held in February to review the new Act in detail and establish the aspects on which policy and procedures would need to be developed, particularly where these were very different from those currently in place under the 1968 Act. The day after that special meeting, representatives of a wide variety of groups who had a significant interest in the new legislation were invited to attend a

workshop at Council to provide comment on the implementation of the Act as they saw it.Topics included:

- qualifications for registration in New Zealand,
- probationary supervision,
- general oversight,
- the difference between vocational registration and the previous specialist and indicative general practice registration,
- Register and annual practising certificate requirements, and
- proposals for a new committee structure given that the incoming Council would have 10 rather than 12 members, of whom a maximum of 6 only would be doctors.

Council recognised the need for good consultation and communications strategies in promoting the principles which underpinned the new legislation.These principles included professional accountability, lifelong obligation to maintain fitness and competence to practise, independent discipline, public participation, and cost effective self regulation, with a view to the maintenance of standards which protect the health and safety of the public.

Council also noted some slight changes in the funding of Council activities in that the provisions to deal with doctors who may be suffering from a condition which may affect their fitness to practice are no longer to be funded from the disciplinary levy. Council now has discretion to gazette fees and levies, without first having to obtain Ministerial approval.

Council noted that the Secretary (soon to be renamed Registrar) would proceed to gazette the approved medical schools and universities for the purposes of probationary, general and temporary registration and that all Chief Executive Officers in Crown Health Enterprises would be advised about the new procedure for approved persons and supervisors for probationary registrants. A definition of general oversight was drafted and discussed with the consultation group ready for sending to the vocational branches of medicine for comment and a request that they develop guidelines for implementation.

Council supported in principle the Secretary's recommendation that a contract be negotiated with a suitable provider to carry out ongoing research on the effectiveness of all aspects of the new legislation.

A small group of Council members met with the Minister at the end of February to express appreciation for the fact that she had brought the legislation to fruition and to discuss other items of current concern including the continuing shortage of psychiatrists and thus the necessity for so called "temporary" arrangements to register overseas trained psychiatrists, particularly from the United States.

SECRETARIAT

Business during the past 12 months fell into two quite distinct areas: Firstly, support for Council in all functions pursuant to the 1968 Act, along with eager anticipation that the new Medical Practitioners Act would be passed soon. Secondly, maintaining all these activities while undertaking forward planning and process review to meet the deadline of 1 July 1996 when the new Act indeed became effective.At the time it felt like the busiest year the secretariat had ever had, but there were even more demanding changes and transitions to come!

The Dental Council established its own separate secretariat in July 1995.The Medical Council staff were available to give support and advice to the new employees in that office but were relieved that they no longer had primary responsibility for the administration of functions under the Dental Act 1988, as it had become increasingly difficult to provide that service at an acceptable level, given the ever rising demands related to the registration of doctors. It had been a happy and interesting relationship, which provided some insight into the practical implications of working with less prescriptive legislation and a smaller Council.

The duties of the Chair and Committee Conveners and terms of reference for all committees received Council attention, following preparation of drafts by appropriate secretariat staff.As the year progressed it became clear that the permanent staff establishment was hardly sufficient to cope with the volume of work and teams were asked to review their responsibilities, procedures and job designs.

There were some equipment upgrades including photocopiers and computers (hardware and software, particularly in the finance area). Work stations were all carefully reviewed as there was a marked increase in cases of occupational overuse syndrome (OOS).This was partly due to inadequate work stations but also work overload and difficulty in managing competing priorities. Stresses on registration and examination staff were particularly high, mainly as a consequence of increased medical migration. Managing contracts and continuity where staff were taking or returning from maternity leave presented a new challenge. In December 1995 Council engaged Deloitte Touche Tohmatsu to undertake another job evaluation as the secretariat composition and responsibilities had changed considerably since the previous one was done in 1991. Council received that evaluation and the details of their National Remuneration Survey, and reports on completed appraisals. A number of staff qualified for increased remuneration which was backdated to 1 December 1995.Appraisals highlighted the quality of current staff and the need not only to remunerate them accordingly but also to take care to ensure their overall wellbeing in the workplace, which is a statutory requirement. Staff held a development workshop and it was agreed the team structure, Corporate Services, Registration and Standards, was operating well with team leaders and team

supports proving very valuable.That team structure certainly assisted the secretariat to deal with the ever increasing workload. Lynne Urquhart acted as Secretary while Georgina Jones took an overdue vacation.

From the very beginning of 1996 the workload increased dramatically partly due to the passing of the new legislation but also to continuing pressure from medical migration.The Council meeting timetable for 1996 was drafted to take into account the need to continue to even out peaks and troughs in workload.

The Secretary was involved in a number of projects and liaison, planning and briefing meetings connected with new Act implementation. She was also closely associated with several fact finding exercises as a background to implementation of the forthcoming competence provisions in the 1995 Act. These included a workshop on competence arranged with other health occupational boards in July, a seminar for Council members presented by Dr Tiina Kaigas from the College of Physicians and Surgeons of Ontario (where competence models and procedures are being developed), and setting up a contract for a report commissioned from Dr R G Large on issues concerning doctors' competence, ready for submission to the incoming Council.

Political and media fallout from pressure on Council's registration examination had been severe.The communications area was particularly active with many requests for information received partly as a side effect of increased publicity for Council's role.

Table 7

REGISTRATION STATISTICS

	Year ended 30 June 1994	Year ended 30 June 1995	Year ended 30 June 1996
*Provisional Certificates	910	818	823
*Conditional Registration	280	267	271
NZ graduates	274	262	255
OS graduates	6	5	16
*Full Registration			
OS graduates	488	406	517
*Restorations			
NZ graduates	11	4	4
OS graduates	22	25	31
*Temporary Certificates			
New	99	86	79
Extensions	208	211	121
*Probationary Certificates			
New	48	77	93
Extensions	46	42	43
*Conditional to full Registration	240	264	260
*Probationary to full Registration	63	54	54
*Additions to Specialist Register	166	166	236
*Additions to Indicative (GP) Register	17	106	128
*Modifications to NZ Medical Register:			
Change of address	3077	3645	3720
Change of Name	33	37	19
Additional qualifications	393	402	617
Suspensions	7	7	14
Deaths	55	49	43
Discipline	6	4	2
Failure to notify address	67	59	193
Non resident	1	64	295
At own request	31	152	147
*Annual Practising Certificates	7521	9160	8487
*Certificates of Good Standing	469	533	464
*Certificates of Registration	131	123	200
*Receipts issued (excl APCs)	3037	2744	3528
*Total computer transactions	17491	29169	25101

A number of bulletins and notices were published related to implementation of new legislation, including the gazetting of approved institutions for recognition of overseas medical qualifications and a revised schedule of fees.

The secretariat worked hard to maintain good working relationships with Crown Health Enterprises, Colleges, DHAS, examiners and assessors, and other registration bodies in New Zealand and overseas.The advice and assistance of Michael Chapman in Consumer Protection, Ministry of Health, was welcome and given in good humour at all times.

The secretariat retained the confidence and support of Council members through a particularly difficult period and appreciated the fact that Council recognised this commitment, which involved many additional hours, by making an ex gratia payment to each member of staff in the form of a bonus. It is clear from the financial statements that the increasing workload of the secretariat is reflected in a rise in the salaries budget in recent years. Even so the secretariat had difficulty keeping up. Contributing to this was unusual circumstances, the most obvious being the new Medical Practitioners Act which changes the responsibilities of the Council considerably, requiring major transitional arrangements, much of which were not envisaged when the Act was first drafted.

The Secretary is a great source of knowledge and an invaluable resource, ably assisted by the team leaders, John de Wever, Jane Lui and Lynne Urquhart, who have taken on a lot of responsibility for their various areas. Despite some problems staff have maintained an outwardly happy, if occasionally stressed, demeanour and work well and co-operatively together. For the new Council this infrastructure will have to provide a lot of extra support for new members so the period of stress will continue well into 1997 and beyond.The secretariat is committed to working with the new Act and with new Council members, which will involve significant new skills, knowledge and sensitivity to organisational and cultural change.

FINANCE

The attached financial statement covers the period 1 April 1995 to 31 March 1996, although the year under review is to 30 June 1996.

General Council Operations

Despite efforts to contain costs, there was a small increase in operating expenses over the previous year chiefly arising from increased workload. Computer consultancy fees doubled as the Council operating systems were upgraded and new reporting arrangements particularly in registration and examinations were incorporated.Transition problems arising from software changes, particularly in the accounting area, were prolonged and costly but eventually resulted in improved efficiency. Legal expenses were

incurred through the ongoing litigation concerning Council's taxation status and a small number of registration matters. The handbook 'Medical Practice in New Zealand - A Guide to Doctors Entering Practice' prepared by Professor Cole was published in A4 spiral bound format and distributed free of charge to all new registrants, ie. New Zealand graduates, NZREX graduates and other overseas trained doctors. This will be an annual expense item.

After a job evaluation and remuneration review at the end of 1995 by Deloitte Touche Tohmatsu (following a similar exercise in 1991), appropriate salary bands were agreed by Council. As a consequence of appraisals of staff performance, most staff received an increase in remuneration. This exercise combined with a small increase in staff establishment led to increases in salaries for the year but benefits paid as part of the remuneration package remained similar to 1995 overall. ACC decided to lift the rate of its levy and it had to be applied to a slightly larger number of employees. Overall salaries and associated items were not greatly over budget, despite a continuing increase in workload.

Council and committee expenses remained at a similar level to the preceding year with the exception of the Registration Committee which was required to meet much more frequently to handle the increased volume of registration applications. Meetings concerning revision of the Medical Practitioners Act drew on more financial resources than the previous year. Regional meetings for intern supervisors were held in three locations and were highly successful with an increased level of attendance. More supervisors now claim the honorarium available to them. These two factors almost doubled expenditure on these two items.

Income from fees was up about $75,000 on the previous year, mainly because of an increased number of annual practising certificates issued and a higher than usual level of applications for specialist registration, no doubt in view of the forthcoming change in legislation. Income from other sources was fairly steady. After more than 20 years association, the Dental Council secretariat moved out of the Medical Council office in July 1995, with a consequent drop in administration fee paid. Interest received was 50% higher than last year.

Discipline Fund

There was a $200,000 increase in revenue for the fund, mainly arising from the number of levies paid and a very significant increase in interest received.

Administration and operating expenses were slightly lower than the preceding year as a result of reduced expenditure on expert witnesses, legal expenses, High Court actions, media consultancy and the sexual abuse project.

Fees and expenses for disciplinary hearings were also lower than the previous year, but expenses incurred by the Health Committee rose as a result of a heavier workload.

Council resolved in December 1995 to reduce the disciplinary levy for the year commencing 1 April 1996.

Examination Fund

Council aims to set fees to cover all outgoings on the examination but this is somewhat problematical as it is not easy to predict numbers of candidates. A small operating deficit occurred in the year ended 31 March 1996 but overall the fund remains in credit. This reserve acts as a buffer and also provides funds for the development of the examination as required.

Taxation

Council's taxation status was regrettably still unknown at June 1996. The Taxation Review Authority and the High Court (to which the Commissioner of Inland Revenue appealed) both found in favour of the Council being tax exempt on the grounds of being a public authority and a body established for charitable purposes. However the Commissioner has gone to the Court of Appeal, further delaying a definitive outcome.

A modest operating surplus (half the previous year) in the general fund and the disciplinary fund left Council in a reasonably sound financial position at the end of the financial year, but the tax position is a matter of concern.

Finance and Management Committee

The committee met regularly, at least once between Council meetings and sometimes also by teleconference. Each face to face meeting lasted for half a day and involved a broad agenda. During the 1995/96 year it was strengthened by the contributions of Dr Stewart Alexander, past Chairman of Council, who agreed to assist at a time when he was still resident in Wellington. Beyond oversight of the day to day management of the Council's affairs, the committee's principal task each year is to try to construct a sensible budget for the ensuring year, an outcome made difficult by the great variety of unknowns. This is particularly so as the Council prepares to undertake new functions as well as to fund the new and untried Disciplinary Tribunal. The daily cost of running a tribunal hearing is very considerable and there is at present no way of knowing how the workload might be divided between the office of the Health and Disability Commissioner and the Medical Practitioners Disciplinary Tribunal. A great deal of the decision making in that regard lies with the Health and Disability Commissioner who has not as yet given clear indications of where her policy may lead. The Director of Proceedings has not yet been appointed and the Director and the Commissioner between them may elect to use the Complaints Review Tribunal in preference to the professional tribunal, or both may be involved in serious cases. It is unclear to what extent, if any, the Medical Council will be responsible for funding the disciplinary activities over and above CACs and the Tribunal.

The committee depends greatly on the meticulous work of its secretary, John de Wever, Team Leader Corporate Services, who takes endless pains to ensure that the committee's documentation is accurate and complete. Council has also benefitted from continuing high quality service from its auditors, Miller Dean Knight and Little.

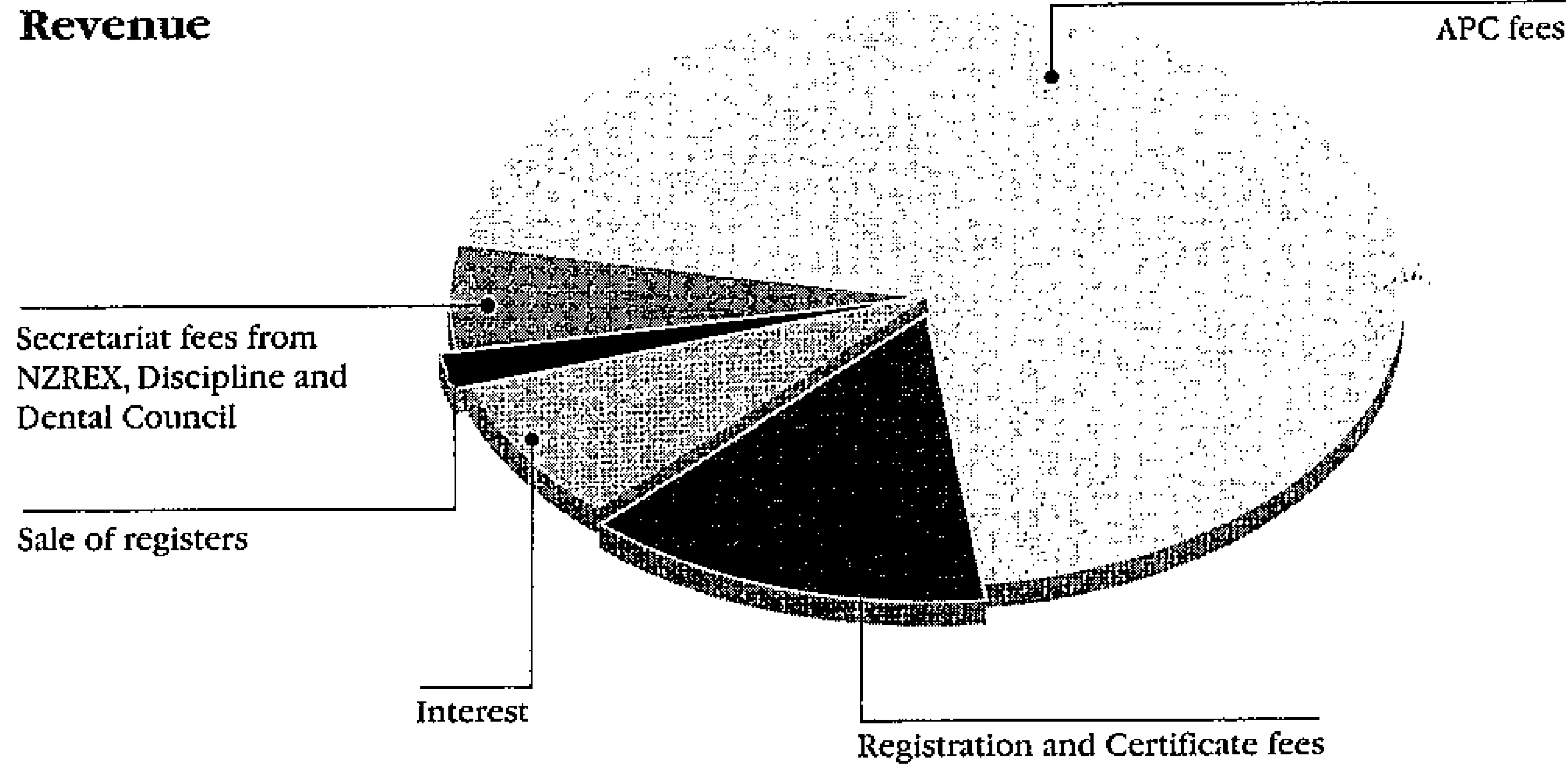
Accounts and financial statements follow.

Distribution of Council Revenue and Expenditure

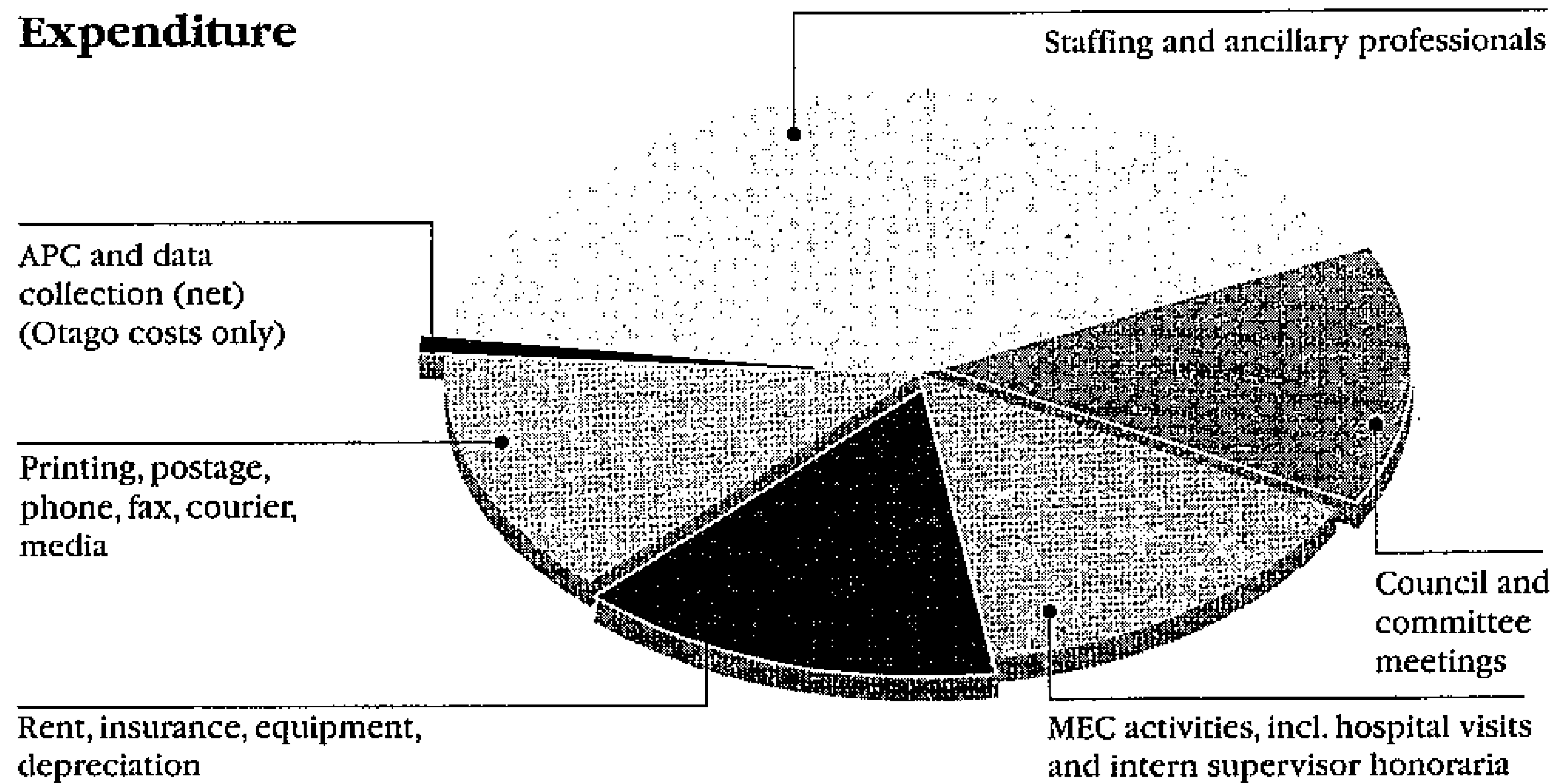
for the year ended 31 March 1996

General Fund (37% of turnover)

Revenue



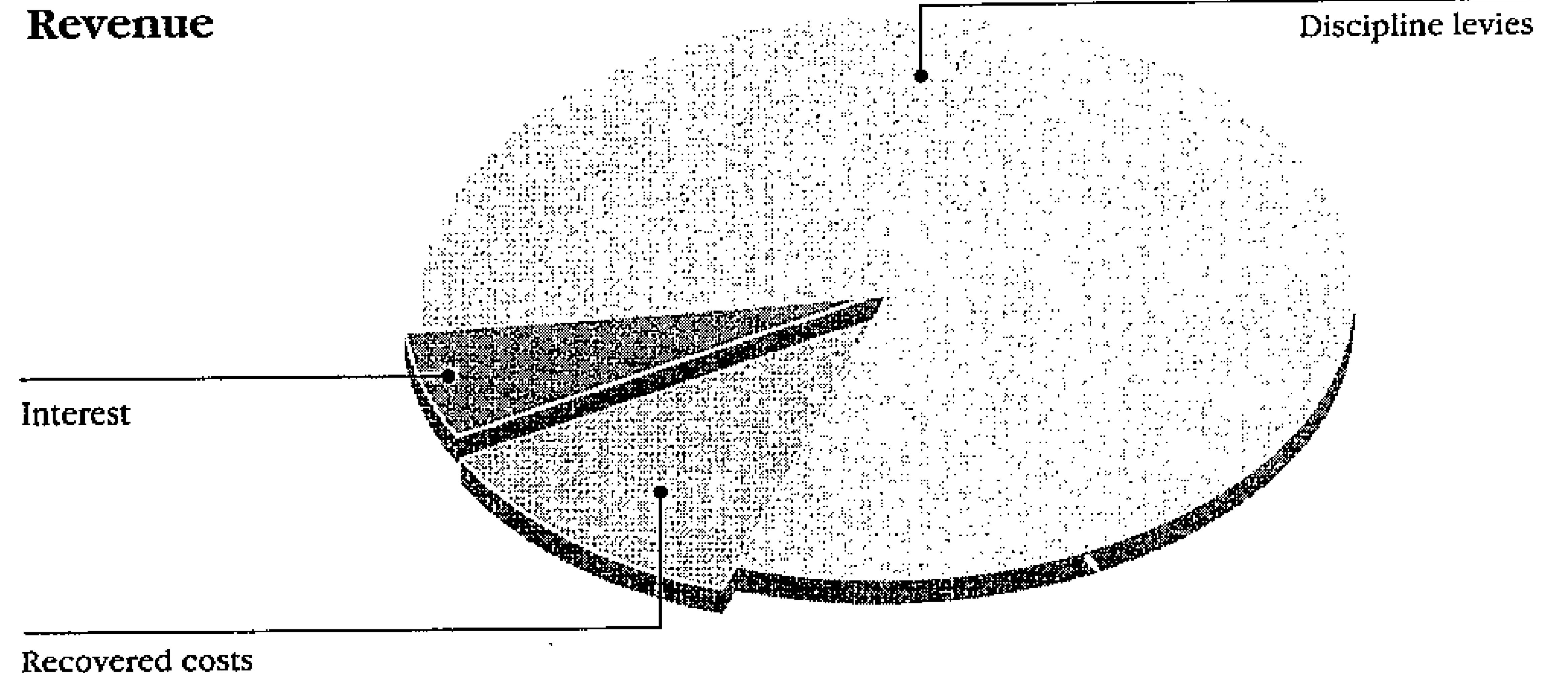
Expenditure



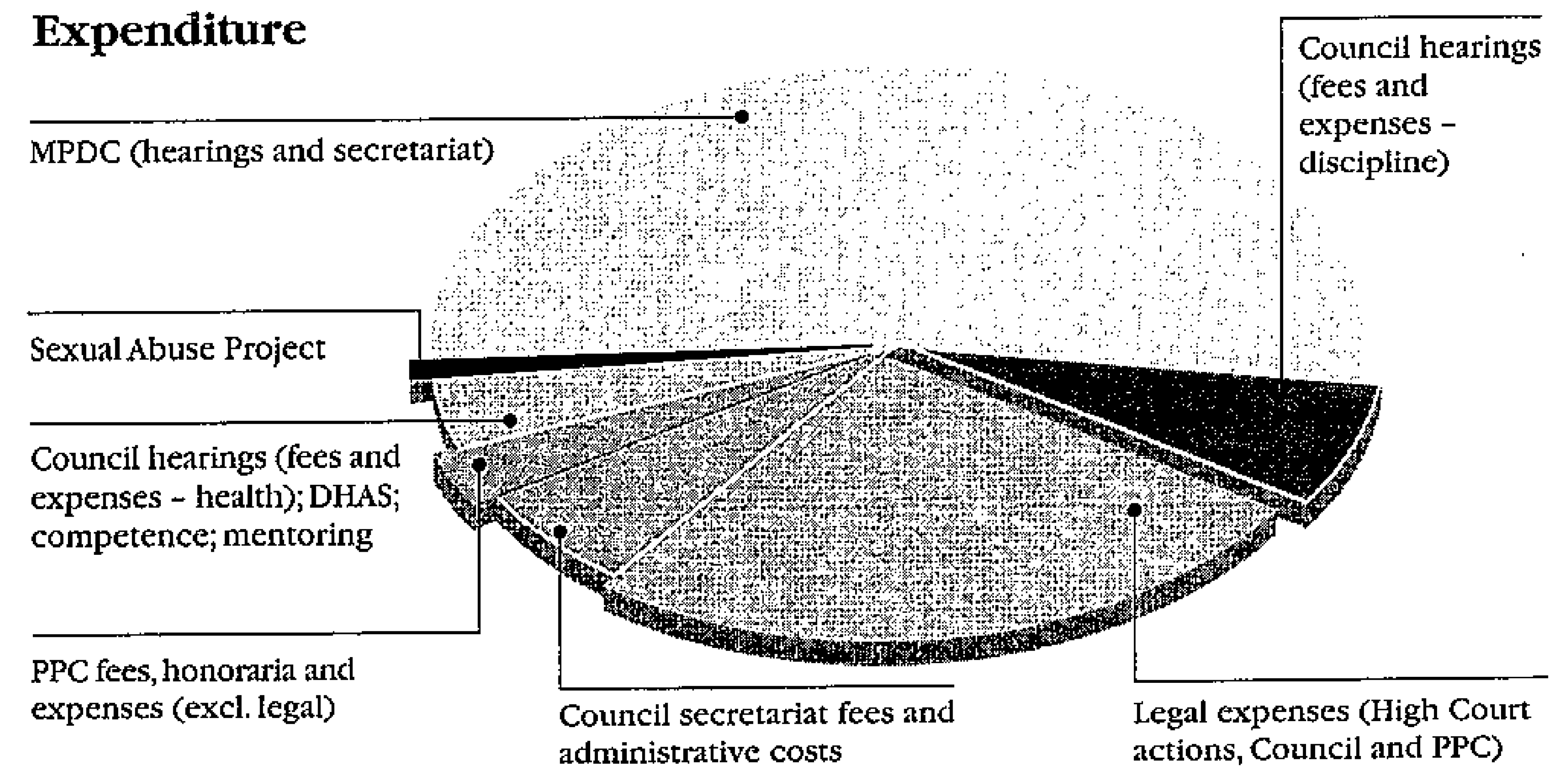
These graphics are to be read in conjunction with detailed financial reports on pages 51 to 63.

Discipline Fund (63% of turnover)

Revenue



Expenditure



These graphics are to be read in conjunction with detailed financial reports on pages 51 to 63.

Miller Dean Knight & Little

Chartered Accountants

THE MEDICAL COUNCIL OF NEW ZEALAND
AUDITORS' REPORT
FOR THE YEAR ENDED 31 MARCH 1996

To : Members of the Medical Council Of New Zealand

We were appointed auditors of the Council under Section 14 (5) of The Medical Practitioners Act 1968.

We have audited the attached financial statements which provide information about the past financial performance of the Council and its financial position as at 31 March 1996. This information is stated in accordance with the accounting policies set out in the notes to the financial statements.

Council's Responsibilities
The Council is responsible for the preparation of financial statements which fairly reflect the Council's financial position as at the above date and of its financial performance for the year ended on that date.

Auditor's Responsibilities
It is our responsibility to form an independent opinion on the financial statements presented by the Council and to report our opinion to you.

Basis of Audit Opinion
An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures in the financial statements. It also includes an assessment of the significant estimates and judgements made by the Council in the preparation of the financial statements and whether the accounting policies are appropriate to the Council's circumstances, consistently applied and adequately disclosed.

We conducted our audit in accordance with auditing standards issued by the New Zealand Society of Accountants. We planned and performed our audit so as to obtain all the information and explanations which we considered necessary in order to provide us with sufficient, reliable and relevant evidence to give reasonable assurance that the financial statements are free from material misstatements, whether caused by error, fraud, or other irregularity. In forming our opinion we also evaluated the overall adequacy of the presentation of information in the financial statements.

In addition to our role as auditors, we provide taxation advice to the Council and have assisted with the preparation of the statement of cash flows. Other than this, we have no other interests in The Medical Council.

Contingent Liability
In forming our unqualified opinion, we have considered the adequacy of the disclosures made in the financial statements concerning the possible outcome of the appeal in the Court of Appeal to decide whether the Council is liable for income tax. Although the estimated tax liability, plus any additional tax payable may be a material amount, we believe this impost would not affect the current viability of the Council.

Unqualified Opinion
We have obtained all the information and explanations we have required. In our opinion the attached financial statements fairly reflect the financial position of The Medical Council of New Zealand as at 31 March 1996 and the results of its operations and cash flows for the year ended on that date.

Date Of Opinion
Our audit was completed on 9 August and our unqualified opinion is expressed as at that date.

Miller Dean Knight & Little

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENT

For The Year Ended 31 March 1996

1. Statement of Accounting Policies

Reporting Entity

For this financial report,The Medical Council of New Zealand is a statutory body constituted under the Medical Practitioners Act 1968. From 1 July 1996 the Council continues under Section 122 of the Medical Practitioners Act 1995.

General Accounting Policies

These financial statements are a General Purpose Financial Report as defined in the New Zealand Society of Accountants' Statement of Concepts and have been prepared in accordance with generally accepted accounting practice as defined in that Statement.

Measurement Base

The accounting principles recognised as appropriate for the measurement and reporting of financial performance and financial position on a historical cost basis are followed by the Council.

Specific Accounting Policies

The following specific accounting policies which materially affect the measurement and reporting of financial performance and financial position have been applied:

(a) Depreciation - Assets have been depreciated on a straight line basis at the following rates:

Furniture and Fittings	10%pa
Office Alterations	10%pa
Office Equipment	20%pa
Computer Hardware and Software	33%pa (previously 20%)

(b) Fixed Assets are shown at cost less accumulated depreciation (Note 5).

(c) Goods and Services Tax - These financial statements have been prepared on a GST exclusive basis.

(d) Legal Expenses and Recovery - Legal expenses have been accounted for on an accrual basis and include provisions for proceedings still pending. Recovery of legal expenses has been accounted for on a cash basis.

(e) Income Tax - No provision has been made for income tax (Note 2).

(f) Sundry Debtors - Sundry debtors are valued at the amount expected to be realised.

(g) Administration Charge - This is a levy on the Discipline and Examination Funds to meet overhead costs incurred by the General Fund.

Changes in Accounting Policies

The depreciation of computer hardware and software has been increased from 20% to 33% of cost price per annum. The additional depreciation cost for the year ended 31 March 1996 is $19,325. Other than this there have been no material changes in accounting policies. All accounting policies have been applied on bases consistent with those used in previous years.

2. Taxation

In July 1993 the Taxation Review Authority found the Medical Council to be exempt from Income Tax. In view of this decision the tax provided for in previous years has been reversed. An application will be made for the tax paid to 31 March 1995 amounting to $496,031 plus Resident Withholding Tax deducted in the year ended 31 March 1996 ($81,279) to be refunded.

The decision of the Taxation Review Authority was appealed by the Commissioner of Inland Revenue to the High Court. In November 1995 the High Court found in favour of the Council. The Commissioner of Inland Revenue has appealed this decision to the Court of Appeal. (Note 10)

At the time of publishing the annual accounts the case had not been heard in the Court of Appeal.

3. Payments in Advance and Debtors

	1996	1995
Outstanding Contribution to:		
Workforce Survey	38,000	38,000
Other Debtors	551	18,011
Payments in Advance	5,107	7,750
	$43,658	$63,761

4. Term Deposits

	1996	1995
ANZ Bank	1,340,715	1,430,453
ASB	400,000	
BNZ Finance	748,291	1,094
National Bank	834,172	18,368
Trust Bank	906,001	1,894,701
Westpac Bank	813,481	
TOTAL INVESTMENTS	$5,042,660	$3,344,616

The $100,000 investment in first ranking debentures in Equiticorp Finance Limited has been repaid in full. The original capital invested was written down to 85% and the accrued interest to nil, reflecting the expected realisation of this investment. Recoveries in excess of the written down amount are shown as Prior Year Income in the General Fund. In the current year, interest amounting to $4,691 was received and is included in Interest Received, General Fund.

5. Fixed Assets

	Cost 31/3/96	Deprec for Year 31/3/96	Accum Deprec 31/3/96	Book Value 31/3/96	Cost 31/3/95	Accum Deprec 31/3/95	Book Value 1/4/95
Computer	329,094	59,288	243,821	85,273	303,474	185,716	117,758
Furniture and Fittings	168,842	14,604	105,388	63,454	150,407	90,783	59,624
Office Alterations	100,416	10,042	29,990	70,426	100,416	19,949	80,467
Office Equipment	97,459	16,282	45,022	52,437	72,513	41,412	31,101
	$695,811	$100,216	$424,221	$271,590	$626,810	$337,860	$288,950

Depreciation for year includes write-offs for fixed assets disposed of during the year:

6. Extra Ordinary Items

Details of extra ordinary items are as follows:

	General Fund 1996	General Fund 1995
Recovery of Investments previously written off- Equiticorp Finance Limited	3,520	8,230

7. Related Parties

There were no related party transactions.

8. Foreign Currencies

Foreign Currency transactions have been recorded at the rate of exchange applicable on the day of completion. There were no settlements due at balance date.

9. Reconciliation of Net Surplus with the Net Cash Flow from Statutory Functions for the Year Ended 31 March 1996

Surplus (Deficit) for year	1996	1995
General Fund	188,463	332,485
Discipline Fund	1,094,888	658,666
Examination Fund	(3,975)	29,409
	1,279,376	1,020,560
Less Taxation Paid	(81,279)	(36,599)
	1,198,097	983,961
Add Non-Cash Items - Depreciation	104,083	77,117
	1,302,180	1,061,138
Add Movements in Working Capital items		
Increase in Debtors and Prepayments	19,103	(19,951)
Increase in Receipts in Advance	(82,212)	2,445,117
Increase in Creditors and GST	77,731	325,948
	14,622	2,751,114
	1,316,802	3,812,192
Less Items Classified as Investing Activity-Interest	(361,801)	(167,476)
Net Cash flow from Statutory Functions	$955,001	$3,644,716

10. Contingent Liabilities

A contingent liability relating to income tax exists until the Council's tax status is determined in the courts (Note 2). It is not possible to estimate the tax liability should the Council be found liable for income tax, until the Commissioner of Inland Revenue has determined from which year tax is to be assessed. Should the Council be found liable for income tax at rates applicable to companies from the year ended 31 March 1990 to the year ended 31 March 1996 (7 years inclusive) the liability is estimated at $970,000. This amount does not include any additional tax or interest on arrears of tax which may be assessed.

Other than this there were no contingent liabilities at balance date.

11. Events occurring after Balance Date

No adjustable or non-adjustable events (as defined in the applicable financial reporting standard) occurred between balance date and the date of completion of the financial statements.

12. Commitments - Operating Leases

Lease commitments under non-cancellable operating leases;

	1996	1995
Not more than one year	116,196	93,396
Later than one year and not later than two years	118,269	93,396
Later than two years and not later than five years	354,807	280,188
Later than five years	246,394	287,971
	$835,666	$754,951

13. Financial Instruments

Financial instruments which potentially subject the Council to credit risk consist principally of bank balances and accounts receivable.

The Council places investments with various recognised banking institutions and is not exposed to any concentrations of credit risk.

Debtors are shown at a fair value.

The estimated fair values of the financial instruments are as follows;

	1996	1995
Receivables	38,551	56,011
Bank-balances	5,284,708	4,074,047
Payables	(627,987)	(544,372)

Balance Sheet

as at 31 March 1996

	1996	1995
CURRENT ASSETS		
Petty Cash	310	310
ANZ Bank Account	242,048	729,431
Sundry Debtors and Payments in Advance	43,658	63,761
Interest Accrued	31,945	5,640
Taxation Refund Due (Note 2)	577,310	496,031
Term Deposits (Note 4)	5,042,660	3,344,616
	5,937,931	4,639,789
FIXED ASSETS (Note 5)	271,590	288,950
TOTAL ASSETS	$6,209,521	$4,928,739
CURRENT LIABILITIES		
Sundry Creditors		
- General Fund	158,882	104,553
- Discipline Fund	262,602	205,552
- NZREX	8,786	34,684
GST	197,717	199,583
Payments Received in Advance	2,526,167	2,608,376
TOTAL CURRENT LIABILITIES	3,154,154	3,152,748
CAPITAL ACCOUNT		
Accumulated Capital	1,390,817	1,146,643
Discipline Fund	1,565,263	470,375
Education Fund	62,517	118,228
Examination Fund	36,770	40,745
	3,055,367	1,775,991
	$6,209,521	$4,928,739

The accompanying notes on pages 51 to 55 form part of these financial statements.

General Fund Income Statement

for the year ended 31 March 1996

	1996	1995
FEES RECEIVED		
Annual Practising Certificate	1,304,933	1,262,437
Certificate of Good Standing	13,428	13,388
Medical Registration Certificate	4,401	3,239
Change of Name	507	1,120
Registration Fees	203,104	185,114
Specialist Registration Fee	30,742	20,534
TOTAL INCOME FROM FEES	1,557,115	1,485,832
OTHER INCOME		
Administration Fee - Dental Council	10,867	32,600
Administration Fee - Discipline Fund (Note 1)	100,000	100,000
Administration Fee - Examination Fund (Note 1)	30,000	30,000
Interest Received	151,542	107,358
Sales of Medical Registers	30,440	25,358
Sundry Income	1,649	1,145
TOTAL INCOME FROM OTHER SOURCES	324,498	296,461
TOTAL INCOME FOR YEAR	**1,881,613**	**1,782,293**
Less Expenses from Schedule	1,696,670	1,458,038
Net Surplus for Year Before Extra Ordinary Item	184,943	324,255
Extra Ordinary Item (Note 6)	3,520	8,230
Net Surplus for Year After Extra Ordinary Item	**$188,463**	**$332,485**

The accompanying notes on pages 51 to 55 form part of these financial statements.

General Fund Schedule of Expenses

for the year ended 31 March 1996

	1996	1995
ADMINISTRATION AND OPERATING EXPENSES		
ACC Levies	9,115	5,930
Audit Fees	7,000	7,000
Agents Registration Fees	12,519	12,540
Computer Consultancy	36,564	18,120
Cleaning	4,188	4,327
Courier	6,503	8,696
Depreciation (Notes 1 and 5)	104,083	77,117
Electricity	5,653	1,924
Equipment Hire	5,614	6,287
Fringe Benefit Tax	3,018	3,346
General Expenses	3,832	5,095
Insurance	2,441	1,989
Legal Expenses	40,142	2,080
File Management	2,448	10,939
Medical Workforce Expenses	14,806	13,362
Photocopying Expenses	20,842	19,343
Postage	38,228	35,019
Printing and Stationery	84,076	89,950
Privacy	740	264
Projects - Medical Practice in NZ	24,433	
- Administration Review		3,124
- Summer Studentship	2,934	3,041
Public Communications	61,515	47,762
Rent	93,396	87,982
Repairs and Maintenance	10,267	7,758
Salaries	531,784	470,588
Superannuation and Health Insurance	40,216	39,421
Staff Recruitment & Training	23,978	36,664
Telephone and Tolls	25,115	20,219
TOTAL ADMINISTRATION AND OPERATING EXPENSES	1,215,450	1,039,887

	1996	1995
TOTAL ADMINISTRATION EXPENSES Carried forward	1,215,450	1,039,887
COUNCIL AND COMMITTEE EXPENSES		
Council Expenses		
- Chairperson's Honorarium	60,017	59,417
- Fees and Expenses	113,602	115,846
- Australasian Liaison Meetings	4,975	13,938
- Conference Expenses		10,990
Registration Committee	25,109	12,964
Act Revision	38,103	25,168
Communication Committee Expenses	375	
Data Committee	4,210	941
Finance & Management Committee	7,637	6,204
Issues Committee	1,459	1,709
Medical Education Committee		
- Fees and Expenses	35,577	21,508
- Hospital Visits	20,126	22,333
- University Accreditation	55,711	56,772
- Education Activities	2,215	
Intern Supervisors' Meetings	20,636	10,956
Intern Supervisors' Contracts	91,468	59,405
TOTAL COUNCIL AND COMMITTEE EXPENSES	481,220	418,151
TOTAL EXPENDITURE	**1,696,670**	**1,458,038**

The accompanying notes on pages 51 to 55 form part of these financial statements.

Discipline Fund Income and Expenses Statement

for the year ended 31 March 1996

	1996	1995
REVENUE		
Levies Received	2,676,462	2,562,376
Interest Received	187,944	46,385
Fines Imposed and Discipline Costs Recovered	400,881	444,365
TOTAL REVENUE	3,265,287	3,053,126
ADMINISTRATION AND OPERATING EXPENSES		
Audit Fees	3,000	3,000
Administration Fee (Note 1)	100,000	100,000
Debt Collection	5,559	3,705
Doctors Health Advisory Service	29,726	33,211
Expert Witnesses	6,397	14,188
General Administration Expenses	5,562	3,350
Higher Court Actions	23,993	61,429
Legal Expenses	538,843	657,165
Medical Practitioners Disciplinary Committee	1,159,326	1,107,435
Mentoring Expenses	20,428	18,208
Projects - Sexual Abuse	17,260	72,175
Media Consultancy	1,593	9,336
Stenographers Fees	12,440	42,660
Telephone and Tolls	8,204	9,375
Tribunals Officer	21,978	21,909
TOTAL ADMINISTRATION AND OPERATING EXPENSES	1,954,309	2,157,146
COUNCIL AND COMMITTEE EXPENSES		
Council Expenses (Discipline)		
- Fees	79,829	108,664
- Expenses	47,482	43,913
Council Expenses (Health)		
- Fees and Expenses	30,077	16,237
Preliminary Proceedings Committee		
- Fees and Honorarium	52,708	63,326
- Travelling and Accommodation	5,994	5,174
TOTAL COUNCIL AND COMMITTEE EXPENSES	216,090	237,314
TOTAL EXPENDITURE	2,170,399	2,394,460
Net Surplus for Year	$1,094,888	$658,666

The accompanying notes on pages 51 to 55 form part of these financial statements.

New Zealand Registration Examination Fund Income and Expenses Statement

for the year ended 31 March 1996

	1996	1995
REVENUE		
NZREX Candidate Fees	347,306	376,722
Interest	18,795	5,503
TOTAL REVENUE	366,101	382,225
ADMINISTRATION AND OPERATING EXPENSES		
Audit Fees	1,000	1,000
Centre Costs (NZ and Overseas)	39,085	41,254
Honorarium and Salaries	75,838	61,549
Examiners' Fees and Expenses	191,034	194,557
General Administrative Expenses	22,959	16,497
Administration Fee (Note 1)	30,000	30,000
	359,916	344,857
COMMITTEE EXPENSES		
Board of Examiners' Fees and Expenses	10,160	7,959
TOTAL EXPENDITURE	370,076	352,816
Net (Deficit)/Surplus for Year	$(3,975)	$29,409

The accompanying notes on pages 51 to 55 form part of these financial statements.

Movements In Equity Statement

for the year ended 31 March 1996

	1996	1995
A) ACCUMULATED FUNDS AND RESERVES		
Balance at 31 March 1995	1,775,991	755,431
Add: Surplus	1,279,376	1,020,560
Balance at 31 March 1996	$3,055,367	$1,775,991
B) ANALYSIS OF INDIVIDUAL FUNDS		
(1) General Fund		
Balance at 31 March 1995	1,146,643	757,386
Add:Surplus	188,463	332,485
Add:Transfer from Education Fund	55,711	56,772
Balance at 31 March 1996	$1,390,817	$1,146,643
(2) Discipline Fund		
Balance at 31 March 1995	470,375	(188,291)
Add:Surplus	1,094,888	658,666
Balance at 31 March 1996	$1,565,263	$470,375
(3) Education Fund		
Balance at 31 March 1995	118,228	175,000
Less:Transfer to General Fund	55,711	56,772
Balance at 31 March 1996	$62,517	$118,228
(4) Examination Fund		
Balance at 31 March 1995	40,745	11,336
Less: Deficit	3,975	
Add: Surplus		29,409
Balance at 31 March 1996	$36,770	$40,745

The accompanying notes on pages 51 to 55 form part of these financial statements.

Cashflow Statement

for the year ended 31 March 1996

		1996		1995
CASH FLOW FROM STATUTORY FUNCTIONS				
Cash was provided from –				
receipts pertaining to statutory functions and administration fee from Dental Council	4,964,302			7,766,703
Cash was also distributed to payment for council fees and disbursement and secretarial expenses	(3,928,022)		(4,085,388)	
Payment of Tax	(81,279)		(36,599)	
	(4,009,301)		(4,121,987)	
Net Cash Flow from Statutory Functions		955,001		3,644,716
CASH FLOW FROM INVESTING ACTIVITIES				
Cash was provided from:				
Interest Received	331,976		156,005	
	331,976		156,005	
Cash was applied to:				
Purchase of Assets	(79,836)		(122,400)	
Short Term Investments	(1,694,524)		(2,897,858)	
	(1,774,360)		(3,020,258)	
Net Cash Flow from Investing Activities		(1,442,384)		(2,864,253)
Net Increase (Decrease) in Cash Held		(487,383)		780,463
Opening Cash Brought Forward		729,741		(50,722)
Ending Cash Carried Forward		$242,358		$729,741
Represented by:				
Petty Cash		310		310
ANZ Bank Account		242,048		729,431
		$242,358		$729,741

The accompanying notes on pages 51 to 55 form part of these financial statements.

NOTES

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THE NEW ZEALAND MEDICAL WORKFORCE IN 1996

SUMMARY

In 1996 an estimated 93% of doctors registered in New Zealand responded to the Medical Council's annual workforce survey. The major findings were:

Continuing expansion of the workforce: The overall size of the medical workforce continues to expand and has reached 1 full-time equivalent (FTE) medical practitioner per 388 New Zealanders.

Under-representation of females, Maori, and Pacific peoples: Females comprised only 29% of the workforce. The proportions of Maori doctors (at 1.9%) and Pacific Islands doctors (at 0.9%) were markedly under-representative of the general population.

Overseas doctors: The proportion of doctors who obtained their primary medical qualification in another country was 34%.

Work by vocational group: General practice continues to be the most common type of medical work at 42% of the workforce.

Spatial distribution: There was an over two fold variation in total FTEs worked by doctors between former area health board regions.

INTRODUCTION

For over two decades the Medical Council of New Zealand has collected medical workforce data on an annual basis. These data have previously been summarised in the Council's Annual Reports and also by the Ministry of Health (eg, covering data for 1990[1] and for 1994[2]). This supplement describes the results of the 1996 medical workforce survey.

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[1] Hannah A, Roser B, Linton M. The New Zealand Health Workforce 1990. Wellington, Department of Health.

[2] New Zealand Health Information Service. The New Zealand Health Workforce 1994. Wellington: Ministry of Health, 1996.

METHODS

The sampling frame for the workforce survey is the doctors on the registration database (excluding ones who have been suspended or who are not practising on health grounds).

The questionnaire used for the 1996 survey was fairly similar to that used in previous years. It was posted out in February 1996 and most doctors completed it within two months after this time (those not responding were sent a series of reminder letters).

The data from the questionnaires were entered into a Microsoft Access database.

Addresses of medical work sites were automatically geocoded by Statistics New Zealand.

Data for area health board (AHB) boundaries was generated by amalgamating data at the territorial local authority (TLA) level. Population data for AHBs was determined from TLA populations derived from the 1996 Census.

RESULTS

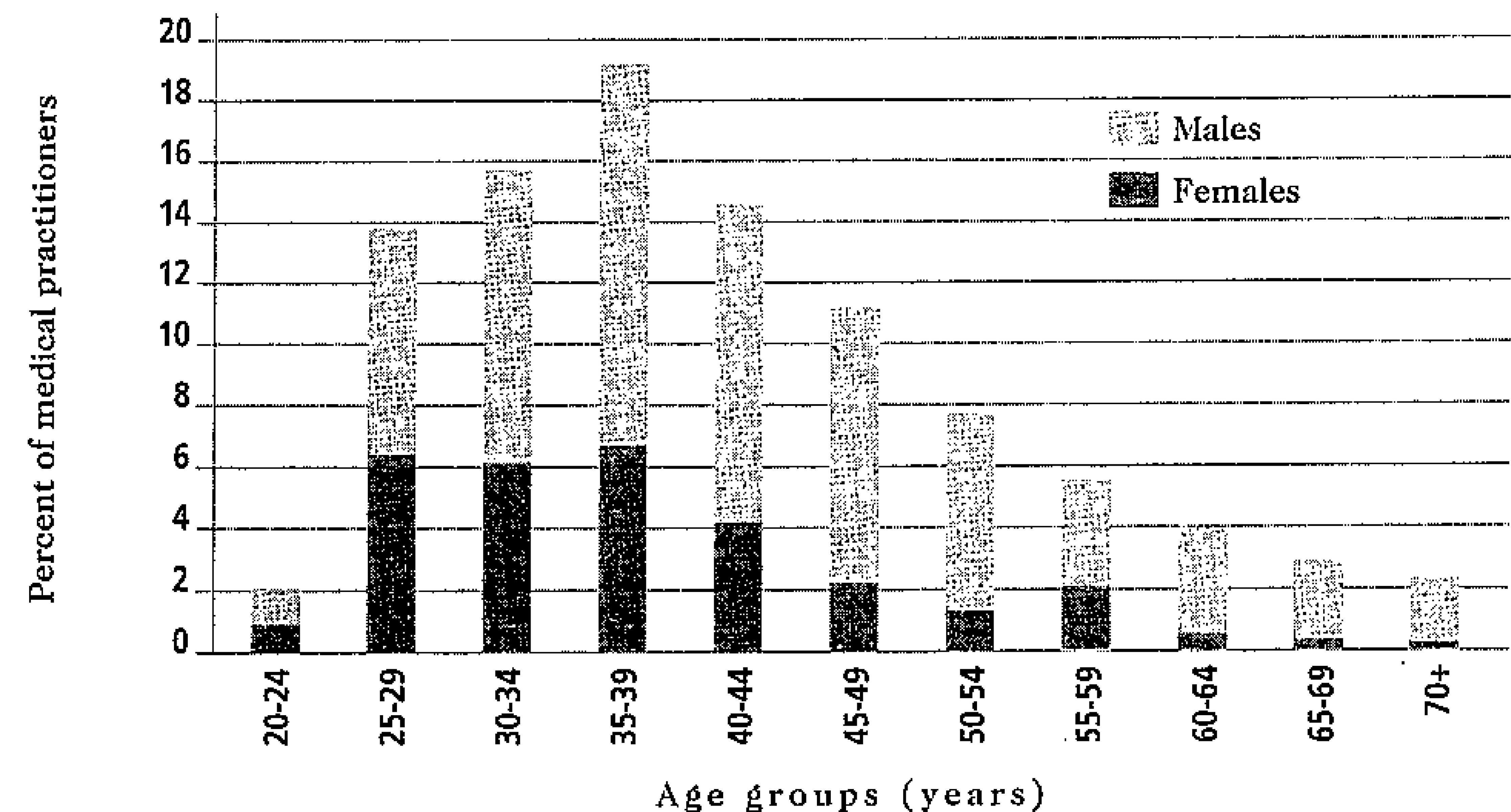
Size of the medical workforce: As at 30 June 1996, the medical register recorded a total of 8390 doctors practising medicine in New Zealand (ie, had just purchased an Annual Practising Certificate for the 1996/1997 year). Of these, a total of 7775 doctors completed the questionnaire ie, a response rate of 92.7%. Among doctors aged less than 65 years the response rate to the questionnaire was 94.4% (7295/7730).

Of the questionnaire respondents, 7634 (98.2%) worked for four or more hours per week in New Zealand. The rest of the results detailed in this supplement relate specifically to this group who are described as being "in active employment".

Distribution by sex and ethnicity: The overall proportion of female doctors was 29.4% (2247/7634) and was higher in younger age groups *(Figure 1)*. The median age for females doctors was significantly younger at 37 years compared to 44 years for males. The proportion of females by ethnic group was 32% in Europeans and ranged from 23% among Chinese to 36% among Maori.

Among the 83% who answered the ethnicity question, the results were European/Pakeha (80.9%), Chinese (4.7%), Indian (3.8%), Maori (1.9%), Pacific Islands people (0.9%) and other ethnic groups (7.8%). The proportion of Maori among house officers was 3.7%, registrars: 1.5%, general practitioners: 2.1%, and specialists: 1.2%.

Figure 1. Age and sex distribution of doctors in active employment



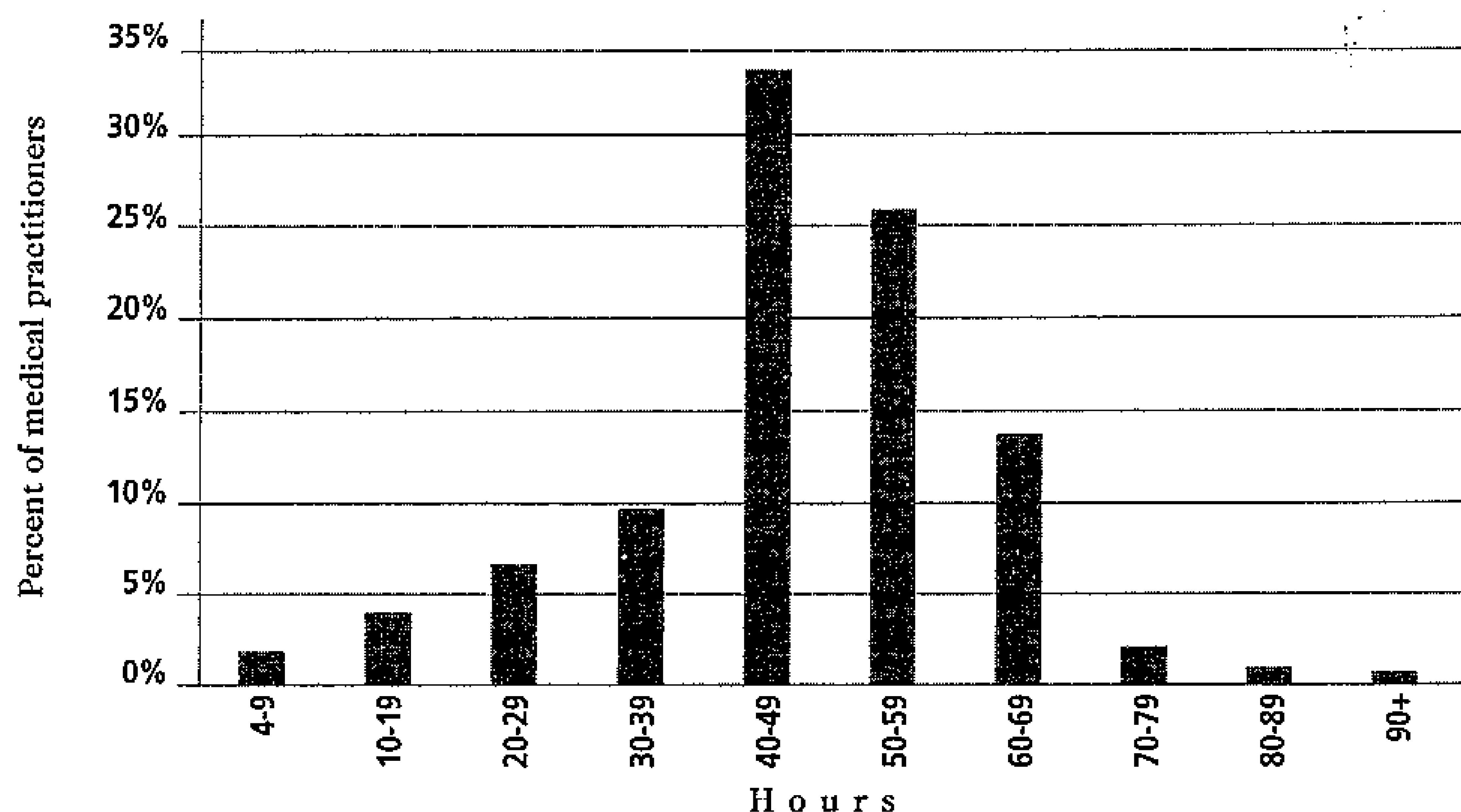
Country of primary medical qualification: The proportion of doctors who obtained their primary medical qualification in another country was 34.2%. The major countries were the United Kingdom (46.5%), South Africa (22.2%), Australia (7.5%), Sri Lanka (5.6%), India (4.8%), Canada (1.9%), Ireland (1.8%), Hong Kong (1.4%), Fiji (1.0%) and the United States (0.9%).

Hours worked: The median number of hours per week worked among those in active employment (ie, four hours per week or more) was 46 hours. The median for females was 40 hours and for males it was 49 hours. The median number of hours worked per week declined with increasing age: 20-24 years: 58 hours; 25-29 years: 55; 30-34 years: 47; 35-39 years: 44; 40-44 years: 45; 45-49 years: 47; 50-54 years: 45; 55-59 years: 45; 60-64 years: 41; 65-69 years: 30.5; 70 years and over: 20.

House officers and registrars had the highest median number of hours per week worked (both 55 hours). For general practitioners the figure was 40 hours

and for specialists 47 hours. The total weekly output of work by the medical workforce was 8704 full time equivalents (with an FTE being 40 hours).

Figure 2. Distribution of total work hours at all work sites



Work environment: 87.7% of work was performed at the main work site and 10.1% at the next main site. The major employers were as follows: Crown health enterprises: 45.2%; self employed/ private practice: 43.4%; universities/ polytechnics: 3.4%; commercial companies (including private hospitals): 1.7%; and government agencies (eg, RHAs): 1.5%.

Medical Work by Vocational Group: Work in general practice (at the main work site) involved 42.1% of doctors with the next major area being internal medicine (9.9%). Registrars made up 13.0% of the workforce, house officers 9.9%, and medical officers of special scale (MOSS) 3.8%.

The proportion of females doctors varied widely by vocational group (0% to 50%) as did the proportion with a basic medical qualification from overseas, ie, 13% to 75% (*Table 2*).

Table 1. Medical work in the main vocational groups based on the main work site (excluding house officers but including registrars, MOSSs and others not necessarily on the vocational register)

Vocational group	No. of doctors	Percent of the workforce	Total FTEs worked (all work sites) #	No. in "vocational training" **	Trainees as a % of each vocational group **
Anaesthetics	428	6.2%	535	118	28%
Basic medical science*	10	0.1%	14	–	–
Dermatology	37	0.5%	44	3	8%
Diagnostic radiology	232	3.4%	249	52	22%
Emergency medicine	84	1.2%	101	48	57%
General practice	2898	42.1%	2877	650	22%
Internal medicine	679	9.9%	857	121	18%
Obstetrics & gynaecology	182	2.6%	236	43	24%
Occupational medicine	50	0.7%	56	19	38%
Ophthalmology	84	1.2%	93	14	17%
Pathology	167	2.4%	183	33	20%
Primary care other than general practice*	260	3.8%	262	–	
Paediatrics	213	3.1%	265	55	26%
Public health medicine & management	192	2.8%	208	24	13%
Psychiatry	369	5.4%	398	125	34%
Rehabilitation medicine	15	0.2%	19	1	7%
Radiotherapy	42	0.6%	51	7	17%
Venereology	17	0.2%	16	3	18%
Surgery					
General surgery	209	3.0%	286	55	26%
Cardiothoracic	23	0.3%	34	2	9%
Neurosurgery	13	0.2%	20	3	23%
Otolaryngology	72	1.0%	86	9	13%
Orthopaedic	176	2.6%	240	25	14%
Paediatric	7	0.1%	11	3	43%
Plastic	36	0.5%	44	7	19%
Urology	34	0.5%	46	5	15%
Other surgical subspecialties*	31	0.5%	41	34	110%
Other training	128	1.9%	168	6	–
Not known	194	2.8%	–	–	–
Total	6882	100.0%	7440	1465	21%

Notes: * Not an official vocational group. Also doctors working in health services administration and management were included in the "Public Health Medicine and Management" category.

** These results may not be particularly accurate as some respondents may have interpreted "vocational training" very broadly ie, those doing various diplomas that were not actually part of official vocational training programmes.

Table 2. Demographic characteristics of doctors working in the main vocational groups (specialists and GPs only)

Vocational group	Median age	Percent Maori *	Percent female	% with overseas primary medical qualification
Anaesthetics	44	2%	20%	44%
Basic medical science	46	0%	0%	50%
Dermatology	44	0%	25%	22%
Diagnostic radiology	42	1%	23%	33%
Emergency medicine	39	0%	8%	75%
General practice	41	2%	33%	34%
Internal medicine	47	1%	13%	35%
Obstetrics & gynaecology	47	1%	26%	41%
Occupational medicine	47	6%	11%	32%
Ophthalmology	51	0%	12%	15%
Pathology	46	0%	25%	32%
Primary care other than general practice	55	0%	14%	24%
Paediatrics	46	2%	23%	42%
Public health medicine & management	45	2%	28%	27%
Psychiatry	45	1%	27%	54%
Rehabilitation medicine	56	0%	0%	29%
Radiotherapy	44	0%	7%	54%
Venereology	52	0%	29%	57%
Surgery				
General surgery	49	1%	2%	28%
Cardiothoracic	45	0%	7%	36%
Neurosurgery	47	0%	0%	67%
Otolaryngology	44	2%	3%	28%
Orthopaedic	45	2%	3%	13%
Paediatric	47	0%	50%	25%
Plastic	54	0%	4%	15%
Urology	50	0%	4%	26%
Other surgical subspecialties	49	0%	0%	33%

Note: * Out of the 83% responding to the ethnicity question.

Spatial distribution of the medical workforce: The FTEs worked by doctors ranged from 140 to 313 FTEs per 100 000 population in the West Coast and Otago regions respectively (*Table 3*). For general practice the range was narrower at 60 to 84 FTEs per 100 000 population.

Table 3. Spatial distribution of the medical workforce within New Zealand
(by Area Health Board region of main work site)

Former Area Health Board Region	FTEs for all doctors at all work sites	FTEs for all doctors per 100 000 popn.	FTEs for GPs at main work site	FTEs for GPs per 100 000 popn.	Overseas trained GPs (%)	Percent of total FTEs worked by Maori doctors
Northland	244	172	109	77	47%	2.1%
Auckland	2855	262	799	73	30%	1.7%
Waikato	740	206	254	71	48%	1.8%
Bay of Plenty	452	194	165	71	33%	3.0%
Tairawhiti	85	185	31	67	37%	2.3%
Hawkes Bay	274	190	103	72	48%	1.4%
Taranaki	215	202	68	64	37%	1.6%
Manawatu-Wanganui	480	227	147	70	45%	1.4%
Wellington	1054	254	285	68	28%	2.2%
Nelson-Marlborough	213	174	91	74	34%	1.8%
West Coast	50	140	21	60	70%	2.5%
Canterbury	1175	246	359	75	29%	1.1%
Otago	612	313	164	84	22%	0.6%
Southland	179	180	66	66	44%	1.5%
Locums	*44*	–	*41*	–	*26%*	*2.0%*
Total	8672	236	2704	73	34%	1.7%

DISCUSSION

The value of the data in this survey is to some extent limited by the incomplete response rate (estimated at 93%) and lack of response to some questions (eg, on ethnicity). Nevertheless, it provides the most up-to-date description available of the medical workforce in New Zealand.

Size of the workforce: The overall size of the medical workforce continues to expand. Based on hours worked by the respondents there was 1 FTE medical practitioner per 388 New Zealanders in March 1996 (out of those working four or more hours per week).

Distribution by sex and ethnicity: Females continue to be under-represented in the medical workforce at 29%. However, the higher proportion of females among younger age groups should ultimately reduce this disparity. Relative to the New Zealand population, the proportions of Maori doctors (at 1.9%) and Pacific Islands doctors (at 0.9%) were markedly under representative. Even among recently graduated doctors (such as house officers) the proportion who were Maori was only 3.7%.

Overseas doctors: The proportion of doctors who obtained their primary medical qualification in another country was 34% (which is similar to previous years: 30% in 1993 and 29% in 1990).

Hours worked: The data on the total hours worked should be treated with some caution given that some doctors may have described the hours spent "on call" as being work hours (even though this may not necessarily have involved constant medical work). Nevertheless, the fact that 18% of doctors work 60 or more hours per week is a possible concern given some evidence of adverse health effects of excessive work.

Work by vocational group: General practice continues to be the most common type of medical work at 42% of the workforce (compared to 43% in 1990). Vocational groups where more than one third of the doctors described themselves as being in vocational training included emergency medicine, occupational medicine, psychiatry and paediatrics.

Spatial distribution: The over two fold variation in total FTEs worked by doctors between former area health board (AHB) regions may be partly attributable to certain training locations and urban concentrations of some vocational groups. While the regional variation in general practitioners was not particularly great at the AHB level, the variation is greater at smaller geographical levels (eg, territorial local authority regions).

Further data on the medical workforce in 1996 may be published by the Medical Council and Ministry of Health in other formats. Also, with improvements made to the design of the workforce questionnaire used in 1997, it is likely that the value of the information collected will be further enhanced.

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