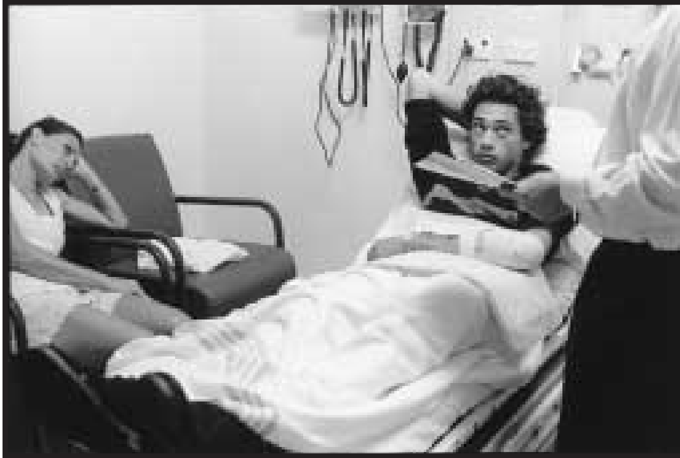
Medical Council of New Zealand

Annual Report 2001



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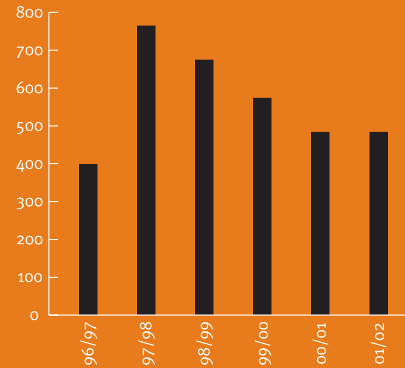
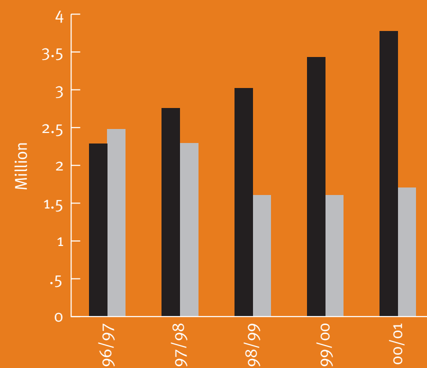
Finances

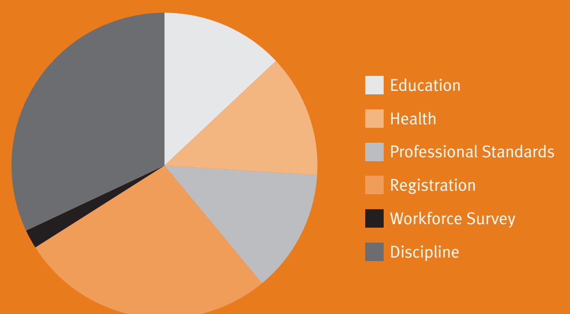


Annual Practising Certificate fee



Total expenditure (excludes examination fund)

Discipline Fund
General Fund



Total expenditure

At a glance

	2000	2001
Doctors registered for the first time:		
• trained in NZ	276	292
• trained overseas (34.5% of medical workforce)	714	890
– temporary	473	700

	2000	2001
Candidates NZREX examination	238	167
Passes NZREX	110	78
Doctors on vocational register	5,254 (44%)	5,585 (44.6%)
Complaints	254	382
‘Concerns about competence’	61	82
Competence reviews	23	37
Health notifications	30	30

The Medical Council of New Zealand is pleased to submit this Annual Report for the year ending 31 March 2001 to the Minister of Health. The report is presented in accordance with section 130 of the Medical Practitioners Act 1995 and incorporates the report of the Medical Practitioners Disciplinary Tribunal.

Purpose To protect the health and safety of members of the public by ensuring that medical practitioners are competent to practise medicine.

Medical Council
of New Zealand

Values Integrity – being ethical and honest ¶ Openness and accountability – working with all interested parties and meeting all statutory requirements ¶ Consistency and fairness – taking relevant legislation and the principles of natural justice into account when making decisions ¶ Effectiveness – achieving results ¶ Commitment – working together to deliver a quality service ¶ Respect – being responsive to different values and cultures.

Protecting the public; promoting good medical practice

President's Foreword

Most years it seems there are events which challenge the profession in some fundamental way and from which lessons emerge.

In 2000/2001, two major enquiries centred, at least initially, on medical practitioners – the Gisborne enquiry into cervical smear under-reporting and the Helen Cull review, looking at the reporting of complaints and events in the health service. Both escalated beyond individuals to look deeply at systems and the health environment. The Medical Council believed their scopes were appropriate and has supported the broad findings and recommendations of both reviews. On the other hand, there were vitally important lessons for the medical profession, lessons, for example, on:

- the dangers of isolation from peers,
- support for colleagues,
- need for continuing professional development, and
- a duty to report dangerous practice,

which fall squarely within the responsibility of the profession, of us all as individuals, and which are the direct mandate of the Medical Council.

It is never possible to state that something would not have happened but I believe that our current legislation has the means within it to greatly minimise the isolation of practitioners which characterised the Gisborne case. It has taken four years of transition, but from the 1st of July all practitioners must participate in a recertification programme or have an overseer, providing, for the first time, some measure of compulsory continuing professional development and eventually, peer review and audit. Competence reviews, another recent measure, are undertaken when a practitioner's competence is in doubt and aim to be non-punitive. It is tempting to see such measures as a panacea for all ills, which of course they are not and we are only at the beginning, but the shift in ideals of practice and values is important. These efforts by the Council are now being supported by official recognition that systems must also change, and as part of this, that there needs to be a move away from the ultimately fruitless naming and blaming of individuals.

The Whangarei case pointed to a need to detect practitioners with possible problems about whom various agencies hold separate information. There are understandable anxieties about the prospect of sharing personal information, but equally it is not in the profession's interests for serious problems to go undetected, or for individuals to hide behind the system. Early detection, support and appropriate remediation are vital in addition to a disciplinary process.

Other matters for the coming year are the possibility of limited powers of interim suspension and mandatory reporting of incompetence. Suspension is contentious but is supported by the Council; at present it can not take immediate steps to protect patients if a practitioner is widely believed to pose a safety risk. Restrictions can only be activated following a statutory review process, which can take several months. The provision is intended for extreme situations and the necessary safeguards are envisaged for practitioners. Mandatory reporting of incompetence is contentious also and potentially divisive and the Council is yet to finalise a position, but we have stated that there must be methods of enforcement and defined thresholds to guide the profession if it is to be more than a token gesture.

Quality initiatives

It is very rewarding to see the Government working on quality improvement in health. The Council has no official role in health systems but we have contributed actively to initiatives which clarify the roles expected of doctors and improve their environment. The Ministry of Health released its credentialling

report in September and the tasks envisaged for the Council, although not confirmed, were holding 'credentials' of practitioners on our database and further verification of their qualifications and experience.

New Act for all health professions

The Government began work on a new Health Professionals Competence Assurance Bill to cover all health occupations, modelled on the Medical Practitioners Act. Separate boards would continue with profession-specific provisions. The Council has agreed with the principles in the new Bill but not with some specific proposals, for example, the proposal to do away with four elected members and turn the Council into a purely appointed body. A single disciplinary tribunal is supported so long as medical practitioners continue to hear complaints about their peers, but the Chair of that body should not be a District Court judge if appeals are to go to the District Court.

Reviews

The Council has been very keen to ensure trust within the patient / doctor relationship. We held meetings with doctors and women's groups in Christchurch, to explore barriers to reporting any sexual misconduct and what can be done to raise awareness of professional boundaries. Shortly afterwards a major independent review of our 10 year-old policies began, involving a wide consultation, written submissions and focus group meetings.

A second major event was an ACT private member's Bill referred to the Health Select Committee, proposing to make registration of overseas trained doctors the responsibility of another body. The Bill is not well supported, even by politicians or the Overseas Doctors Association, but there is a need to address public perceptions on the issue of registering doctors from overseas. The Council has been involved in the bridging courses to help prepare some doctors for work here.

Relationships

The Council welcomed the appointment of Ron Paterson as the new Health and Disability Commissioner. The Commissioner has shown interest in using our competence provisions to recommend appropriate remedial action for doctors. I am pleased with our work building relationships with others and a recent feature is invitations to people to our bi-monthly meetings.

To remain in touch with doctors' concerns and raise awareness of the intentions of the Medical Practitioners Act 1995, I travelled with the Chief Executive or staff to meet groups at Nelson hospital, Lakeland Health, Whangarei, Wanganui and New Plymouth. We liaise closely with the colleges on regulatory issues, attending meetings of the Council of Medical Colleges, and have constructive liaison with the New Zealand Medical Association.

Work overseas

Links with overseas regulatory bodies allow a practical exchange of ideas and information, and have the potential to save the Council a lot of energy and resources. During the year I attended: the fourth international conference on medical regulation in Oxford, England; meetings of the Australian Medical Council; the Autralasian Boards Seminar; and the 6th European forum on quality and healthcare in Bologna, Italy.

In the countries I have been fortunate to visit and the meetings I have attended with leaders in health and medicine, it has been clear to me that New Zealand is doing as much as any other country with a similar health service to assess competence and support continuous professional development. This is enormously reassuring.

Everywhere there are efforts to define the expected standards and promulgate them in a clear and timely manner. Two key publications of the Council supported this work: the new edition of Cole's

Medical Practice capably edited by Ian St George, and a concise booklet of standards, Good Medical Practice, which was launched in September.

Thanks

I have been honoured to serve as President for a third year. I would like to thank Council members for their experience, initiative, commitment and vision. The Council is ably served by Chief Executive Sue Ineson who with her staff have fostered our vision so thoroughly and brought a new dimension to office systems.

Thank you to the many practitioners and members of the public up and down the country who support self-regulation by being part of our processes.

The Council warmly welcomed Dr Joanna MacDonald and Dr Deborah Read, appointed by the Minister. We farewelled with much sadness Professor Ian Simpson who chaired the Education Committee; he will be extremely hard to replace. Registrar Georgina Jones, who for many years personified the organisation and paved the way for the current Act, was farewelled at two enjoyable functions in Auckland and Wellington.

Last word

The year has shown vividly how external forces are arrayed on our profession swiftly and decisively in answer to the actions of a tiny group. Pressure for change then gains a momentum which at times threatens reason. We can either hide from it or face it. I believe we should see and exploit the opportunities as those before us have done, and that we are well placed to do so. Medicine is more open and accountable than ever and our regulation is looked upon as a model. But strong communication continues to be absolutely essential – on regulatory issues, the facts of medical error and the work on continuing medical education, and we must self-regulate effectively, including the duty to report poor practice, in order to remain the valued professionals we have worked so hard to become.

Tony Baird
President

Chief Executive's Review

As a mark of the times, external matters seemed to dominate the year, in particular:

- the Gisborne enquiry into under-reporting of cervical smears;
- the Government's announcement of the long-awaited overseas trained doctors bridging programme;
- proposals for a new over-arching Bill to cover doctors and all health professionals, which will replace the Medical Practitioners Act;
- an ACT private member's Bill on overseas doctor registration referred to the Health Select Committee and a separate hearing of the Committee into an individual doctor;
- a Government review of reporting of adverse medical events.

We have in my view worked very effectively to meet these challenges and to maintain a strong voice on public safety. Numerous discussion and strategy documents also demanded response. We made 18 submissions on diverse issues from the future of primary health care and the Public Health and Disability Services Bill, to systematic event reporting and optometrist prescribing.

We kept up a hectic liaison schedule, ensuring the Council is seen in the profession, and involved as much as possible in health initiatives. Between us the President and I attended over 100 meetings, excluding overseas travel.

Core activities

I am pleased to report that regardless of turbulence externally, the core activities of the Council have proceeded – with improved efficiency in many cases – to register doctors, to conduct examinations, carry out competence reviews, assess complaints, issue practising certificates, monitor those with health problems and visit and report on hospitals' suitability for junior doctors.

Work on oversight and recertification has progressed, but not without some difficulty, in preparation for the full implementation of these activities in July 2001. There have been frustrations with the Act, particularly for oversight, and legislative change will be essential.

There were key projects completed or begun: a major review of the NZREX examination; an expanded workforce survey for 2000; a review of policy on doctor/patient sexual boundaries; and improved information-sharing with the Health and Disability Commissioner and ACC.

Our IT upgrade progressed more slowly than expected but the registration improvements are nearly complete. With much relief our website went live in 2000 which has greatly cut down generalised enquiries on registration. We completed a smooth transition to issue of practising certificates on a quarterly cycle, which entailed a large amount of extra work. I thank the profession for its patience and co-operation in making this changeover which was designed to speed up processing and monitor fitness to practise. Instead of being a tax-gathering exercise, the APC is now issued on evidence of a doctor's continuing competence.

Two surveys – of doctors and the public – were done to assess knowledge and attitudes to the Council. These have proved valuable in guiding our communications efforts.

The Council continues to lead the profession on standards of practice and during the year adopted a strong stance on internet medicine. Over the year, two new guidelines and five revised statements were completed, 18 were under review and three new guidelines were in draft form.

Staff changes

There have been staff changes and key positions filled. After June I took on the role of Registrar and a new Assistant Registrar, Tania Turfrey was appointed, previously practising law at Simpson Grierson. Former Registration Manager Jane Lui became the new Quality Assurance Manager, in line with a new focus to ensure compliance and robust processes internally. Her deputy Sean Hill became the Registration Manager and Karen Gardner the new deputy for registration. We farewelled longstanding Education Administrator Angela Coleman to Otago. Chris Aitchison has become the Council's policy analyst assisting the Council to prepare a position on issues and at the year end, plans were underway to appoint a corporate manager and a medical advisor to assist staff in medical matters, particularly referrals for competence reviews. Thanks go to Wellington surgeon John Simpson who had fulfilled this latter role on contract and who left during the year. At year end staffing stood at 35.

Registration

The year was punctuated again with stories of individual doctors who claimed the Council was stopping them becoming registered. We have worked harder to explain to politicians, officials and media the purpose of assessment for public safety, the need for a general medical training without narrow specialisation, and the great variation in medical standards between countries. Some streamlining of our process was needed and has now occurred.

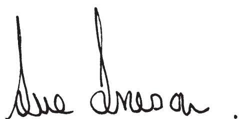
Applications for the Government's bridging programme closed on 31 October 2000. 1,191 applications were received, more than double the number expected. The number of eligible applicants at that date, 228, far exceeded the number of available places. The eventual solution was to ballot the 100 places for the 2001 courses. Final numbers of eligible applicants will not be known until 31st October 2001. In November they will be balloted for the remaining 150 places on the course.

Unscheduled work to verify the applications from overseas trained doctors dominated the time of two staff members for several months.

Treaty of Waitangi

The Council spent time reviewing how we are meeting the Government's objectives in regard to Maori and produced a definition of 'cultural competence'. The objectives in the coming year will be to work with medical schools and other bodies to encourage inclusion of Maori matters, including auditing hospitals during visits, and colleges through their recertification programmes, and incorporating cultural competence into the probationary year following NZREX clinical.

Finally I would like to thank Council members for their support and thank staff for their dedication and hard work. The year has been extremely interesting and I am confident we are on a sound footing to meet new challenges.



Sue Ineson
Chief Executive

Members of the Medical Council at 31 March 2001

from top, left to right

Elected members:

Dr Tony Baird MB ChB, DRCOG, FRCOG, FRANZCOG, President, Chair of Registration and Examinations and issues, Committees. Obstetrician and gynaecologist, Auckland.

Dr Ian St George MD, FRACP, MRCGP, FRNZCGP, D Obst, RCOG, Dip Ed, Deputy President, Chair of Professional Standards Committee. General practitioner, Wellington.

Dr Mark Adams MB ChB, Chair of Health Committee. Anaesthetic registrar, Wellington.

Dr John Neutze, MBChB, MD, MRACP, FRACP. Retired paediatric cardiologist, Auckland

Appointed members:

Miss Carolynn Bull MA, Dip Tchg, LLB. Family law practitioner, Christchurch.

Dr Deborah Read, MBChB, Dip Com Health, MCCM (NZ), FAFPHM (RACP). Public health physician, Wellington.

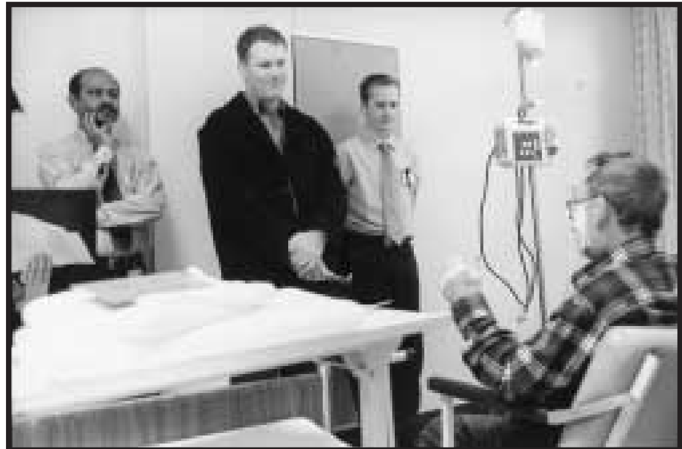
Mrs Heather Thomson, RN, Obs, Health service manager, Opotiki.

Professor Ian Simpson, MB ChB, MD, FRACP, Chair of Education Committee. Nephrologist, Auckland.

Dr Joanna MacDonald, MB ChB, FRANZCP. Psychiatrist, Wellington.

Mr Alexander Sundakov, MSc (Economics), Chair of Finance and Management Committee. Director of the New Zealand Institute of Economic Research, Wellington.

Significant Activities



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33 Issues

34 Discipline Activities (1968 Act)

35 Medical Workforce Survey

Registration of medical practitioners

Principal activities: maintaining the Medical Register, considering applications for registration, issuing annual practising certificates and certificates of good standing, registration policy development. Total cost: $1,484,121

Public safety is the driving force behind all Medical Council registration decisions.

This was another busy year for registration. In addition to those moving from one category of registration to another, 1,186 new doctors entered the workforce, up from 990 the previous year. Eight hundred and ninety were overseas trained, from 55 countries. Credit goes to the staff of the registration team who efficiently process applications for Council approval, fast-tracked weekly wherever possible, monthly or bi-monthly. At 31 March 2001 there were 12,505 doctors on the Medical Register, of whom 8,738 held practising certificates.

New Zealand is becoming more reliant on a temporary, transient workforce. Seven hundred temporary doctors from overseas were registered, 227 more than last year.

Doctors from both New Zealand and overseas who seek registration must demonstrate to the Council that they are fit to practise, can communicate in English and possess the required knowledge, skills and experience for work in New Zealand. Doctors are registered in four main categories: probationary, general, vocational and temporary registration. A minimum year on probationary is the stepping stone to general and/or vocational registration.

At each stage there are legal requirements which help to assure the Council and public that a doctor is practising competently. Supervision is required for doctors on probationary and temporary registration; generally registered doctors must practise under general oversight and vocational registrants must be regularly recertified in their branch(es) of medicine.

Overseas trained doctors

In addition to the large volume of applications for registration from overseas trained doctors, there are two to three hundred enquiries every week. The majority apply for and are granted temporary registration based on their medical qualifications from the United Kingdom, Republic of Ireland, Canada, South Africa and the United States.

The most significant development of the year, following discussions with the Minister, was our decision announced in December to waive the usual NZREX examination requirement for temporary doctors from the five eligible countries to transfer to general registration. The Government welcomed the policy, but it elicited claims of racism from others despite the fact that many doctors trained in the countries have a variety of ethnic backgrounds. In addition any doctors who apply under the new policy, which was to be effective from 1 April 2001, must still be assessed and will have conditions placed on practice, including being prepared to work in provincial centres.

Assessment of overseas specialists

After four years and continual refinement there is now a very clear cut process for assessing overseas specialists. Annual Reports from 1996 reveal how much work was required by the Council and medical colleges to deal with the sudden flood of overseas applicants with degrees of all types and to begin to develop from scratch a fair assessment pathway to vocational registration. Just as the good work was being achieved it came under threat as the year ended, from the ACT MP Ken Shirley whose private members Bill, the Medical Practitioners (Foreign Qualified Medical Practitioners) Amendment Bill was referred to Parliament's Health Select Committee. The Bill proposed to transfer the job of assessing competence of overseas trained doctors to the New Zealand Qualifications Authority, arguing undue restrictions and delays by the Council. The Authority did not want the job and our view was that there should be only one body involved in the registration of overseas trained doctors and one standard for all applicants.

Open discussion is important and we nevertheless welcomed the opportunity to resolve publicly the outstanding issues which are in the main about historical matters.

The hearing was set down for May 2001 but it was preceeded in February by a separate hearing into the registration of an American dermatologist who objected to the vocational registration assesement process. The case showed the tension between individual doctors who believe they do not need assessment because they have practised in their own country with the Council's mandate to seek objective and even-handed evidence of doctors' claims. Subsequently such doctors may complain they are 'refused' registration when in fact they are registered but working under supervision and/or assessment.

Procedures have been improved and there is now a clear distinction between 'experts' who need no assessment, those who do need assessment, and those who clearly do not meet the New Zealand standard and who should apply for general registration.

Commerce Commission investigation

Scrutiny of Council processes was not confined to Parliament. Two other reviews in 2000 failed to show evidence of excessive barriers or restrictive practice. In July a judicial review of our processes failed in the High Court. Secondly, the Commerce Commission reviewed, over several months, a selection of decisions on the registration applications of overseas trained doctors across various branches of medicine. It com-

pleted a report on the matter in February, closing the proactive investigation with no further action.

The Council welcomes reviews of its processes. It is well understood that decisions must be fair and, as importantly, be seen to be fair. We are aware that some of our counterparts overseas are also subject to investigations. Such reviews are costly to the profession, they divert staff and money from core activities and detract from good work on maintaining standards. Medical regulators recognise the need to be open and fair but we must increase our efforts to inform the public, the media and governments of the benefits of self-regulation for the public.

Review of New Zealand medical registration examination – NZREX Clinical

To gain general registration doctors trained outside New Zealand and Australia must pass in most cases an approved English test and the United States Medical Licensing Examination steps I and II followed by NZREX Clinical. NZREX Clinical is a practical test of knowledge and skill, set at the level of a New Zealand trainee intern.

There were 167 candidates in 2000/01 (including 64 repeats) compared with 238 the year before, marking a continuing steep decline in new candidates.

Throughout the year a working party met to consider a major review of the examination which had been conducted in 1999. At year end the working party was set to recommend a change in focus of assessment in NZREX to move from each individual discipline receiving separate marks to an overall assessment of competence, therefore bringing the examination into line with medical schools who are giving much greater emphasis to competence-based testing and direct observation of students carrying out clinical tasks.

The Council believes the standard of the examination is appropriate. A lowered standard would be ill-advised, given that 20% of doctors who pass and are registered have performance problems in their first year of work. With perseverance and support from employers and senior doctors, most of these doctors improve to reach the standard for general registration after 12-18 months in practice, but some can not find employment in hospitals because of the extra support they require.

Overall about 46% of overseas trained doctors pass NZREX Clinical on their first attempt. The broad scope of the examination is often criticised but we continue to point out the country's requirement for doctors with a broad medical knowledge and experience rather than narrowly focused specialists.

1 Summary of Registration

AT 31 MARCH 2001

Interim Register	36
Probationary Register	574
General Register	11249
Vocational Register	5420
Temporary Register	646
Suspended	3

Note: All doctors on the vocational register also have general registration

2 Registration Activities

1 APRIL 2000 - 31 MARCH 2001

Interim Certificates issued, probationary registration		
Class 1	New Zealand Graduates (Interns)	282
Class 1	Overseas Graduates (Interns)	6
Class 2	Overseas Graduates (NZREX passes)	91
Class 3	Overseas Graduates (Eligible for Vocational Registration)	18
Class 4	Overseas Graduates (Suitable for assessment - Vocational Registration)	31
Class 5	Reregistration (following erasure)	0
Class 6	Overseas Graduates (Clinical evaluation - Vocational Registration) discontinued	0
Class 7	Overseas Graduates (Vocational Training)	5
Interim Certificates issued, general registration		
New Zealand Graduates		10
Overseas Graduates		39
Temporary Certificates Issued		
New Certificates		700
Extensions		430
General registration after completion of probationary period		
Class 1	New Zealand and Overseas Graduates (Interns)	286
Class 2	Overseas Graduates (NZREX passes)	142
Class 3	Overseas Graduates (Eligible for Vocational Reregistration)	23
Class 4	Overseas Graduates (Suitable for assessment - Vocational Registration)	33
Class 5	New Zealand and Overseas Graduates (Reregistration following erasure)	0
Additions to Vocational Register		410
Amendments to Register		
Change of address		2369
Change of name		61
Additional qualifications		419
Suspensions		
Suspended		0
Interim suspension		1
Revocation of suspension		1
Removals		
Death		43
Discipline order 110(1)(a)		2
Failure to notify change of address 42(2)		0
Non-resident doctors 45(1)(c)		32
At own request 44(1)		70
Annual Practising Certificates		16720*
Certificates of Good Standing		662
Certificates of Registration		133

* Many doctors received two certificates for the year in the transition to cyclical APC issue.

3 New Zealand Vocational Register

1 APRIL 2000 – 31 MARCH 2001

Vocational Branch	Vocational registration at 31/3/2000[1]	Added 2000/01	Removed 2000/01	Net change	Vocational registration at 31/3/2001[1,2]
Anaesthetics	414	28	4	24	438
Cardiothoracic Surgery	29	0	1	-1	28
Dermatology	48	0	0	0	48
Diagnostic Radiology	234	18	3	15	249
Emergency Medicine	26	10	0	10	36
General Practice	1902	153	28	125	2027
General Surgery	250	12	6	6	256
Intensive Care Medicine	5	23	0	23	28
Internal Medicine	615	30	10	20	635
Musculoskeletal Medicine	0	6	0	6	6
Neurosurgery	17	0	0	0	17
Obstetrics & Gynaecology	235	14	4	10	245
Occupational Medicine	32	2	0	2	34
Ophthalmology	108	6	1	5	113
Orthopaedic Surgery	180	8	5	3	183
Otolaryngology Head & Neck Surgery	85	3	3	0	85
Paediatric Surgery	14	0	0	0	14
Paediatrics	205	12	3	9	214
Pathology	212	16	2	14	226
Plastic & Reconstructive Surgery	35	2	0	2	37
Psychological Medicine or Psychiatry	348	27	6	21	369
Public Health Medicine	160	11	5	6	166
Radiation Oncology	40	1	1	0	40
Rehabilitation Medicine	6	2	0	2	8
Sexual Health Medicine	1	13	0	13	14
Sports Medicine	1	9	0	9	10
Urology	44	3	1	2	46
Vascular Surgery	0	1	0	1	1
Venereology	12	0	0	0	12
Total	5258	410	83	327	5585

Notes:

1 Includes doctors who may currently be inactive (have no APC)

2 Includes 157 doctors with vocational registration in two branches and four doctors with vocational registration in three branches

4 Candidates sitting and passing NZREX Clinical

1 APRIL 2000 – 31 MARCH 2001

Country	No. Sitting	Attempts				No. of Passes	Passes on Attempts			
		1	2	3	4		1	2	3	4
Bangladesh	42	25	13	4	0	17	4	10	3	0
Brazil	1	1	0	0	0	1	1	0	0	0
Bulgaria	2	2	0	0	0	1	1	0	0	0
Burma	1	1	0	0	0	0	0	0	0	0
China	4	3	1	0	0	2	2	0	0	0
Colombia	1	0	1	0	0	1	0	1	0	0
Czechoslovakia	1	1	0	0	0	1	1	0	0	0
Egypt	6	1	2	3	0	3	1	0	2	0
England	8	8	0	0	0	7	7	0	0	0
Fiji islands	1	1	0	0	0	1	1	0	0	0
Germany	5	4	1	0	0	4	3	1	0	0
India	21	11	7	3	0	5	2	2	1	0
Indonesia	1	0	0	0	1	0	0	0	0	0
Iran	1	0	1	0	0	0	0	0	0	0
Iraq	14	6	4	2	2	7	2	2	1	2
Libya	1	1	0	0	0	0	0	0	0	0
Nigeria	1	1	0	0	0	0	0	0	0	0
Pakistan	5	4	1	0	0	2	2	0	0	0
Philippines	1	0	0	1	0	0	0	0	0	0
Romania	1	1	0	0	0	0	0	0	0	0
Russia	1	0	0	1	0	0	0	0	0	0
Scotland	1	1	0	0	0	1	1	0	0	0
Singapore	2	1	1	0	0	0	0	0	0	0
South africa	14	12	2	0	0	10	9	1	0	0
Sri Lanka	18	10	5	3	0	8	4	3	1	0
Switzerland	1	1	0	0	0	0	0	0	0	0
Taiwan	2	2	0	0	0	0	0	0	0	0
Tanzania	1	1	0	0	0	1	1	0	0	0
United Kingdom	1	1	0	0	0	1	1	0	0	0
West Indies	1	0	1	0	0	0	0	0	0	0
Yugoslavia	7	3	2	2	0	5	1	2	2	0
	167	103	42	19	3	78	44	22	10	2

5 Registration issued to overseas trained doctors

1 APRIL 2000 – 31 MARCH 2001

	Probationary						Temporary			
Country	**Class 1**	**2**	**3**	**4**	**7**	**Total**	**Class 1**	**2**	**3**	**Total**
Australia	3	-	-	-	-	3	3	4	8	15
Bangladesh	-	20	-	-	-	20	-	-	2	2
Belgium	-		-	-	-	0	1	-	-	1
Brazil	-	1	-	1	-	2	-	-	-	0
Bulgaria	-	1	-	1	-	2	-	2	1	3
Canada	-	-	-	-	-	0	-	3	33	36
China	-	1	1	-	-	2	-	-	-	0
Colombia	-	1	-	-	-	1	-	-	-	0
Denmark	-	-	-	-	-	0	-	1	-	1
Ecuador	-	-	-	-	-	0	-	1	-	1
Egypt	-	4	-	-	-	4	-	-	1	1
England	-	4	4	9	2	19	5	5	255	265
Fiji	-	-	-	-	-	0	-	5	-	5
Former Yugoslav Republic of Macedonia	-	2	-	-	-	2	-	-	-	0
Germany	2	1	-	-	-	3	-	4	4	8
Ghana	-	-	-	-	-	0	-	-	1	1
Greece	-	-	-	-	-	0	-	-	1	1
Grenada	-	-	-	-	-	0	-	-	1	1
India		12	1	4	1	18	-	6	17	23
Iran	-	1	-	1	-	2	-	-	-	0
Iraq	-	11	-	2	-	13	-	-	1	1
Ireland	-	-	-	-	-	0	-	-	27	27
Israel	-	-	-	-	-	0	-	-	1	1
Italy	-	-	-	-	-	0	-	2	1	3
Japan	-	-	-	-	-	0	-	-	1	1
Kuwait	-	-	-	2	-	2	-	-	-	0
Malaysia	-	-	-	-	-	0	-	1	-	1
Myanmar	-	-	-	-	-	0	-	-	1	1
Nigeria	-	-	-	-	-	0	-	-	1	1
Northern Ireland	-	-	-	1	-	1	-	-	5	5
Pakistan	1	-	-	1	-	2	-	-	7	7
Papua New Guinea	-	1	-	-	-	1	-	-	-	0
Philippines	-	1	-	-	-	1	-	1	4	5
Poland	-	-	-	-	-	0	-	-	2	2
Romania	-	-	-	-	-	0	-	-	3	3
Russia	-	-	-	-	-	0	-	-	1	1

Saudi Arabia	-	-	-	-	-	0	-	1	-	1
Scotland	-	1	1	4	-	6	-	1	76	77
Singapore	-	-	1	1	-	2	1	1		2
South Africa	-	15	6	2	2	25	-	-	79	79
Sri Lanka	-	9	-	1	-	10	-	-	3	3
Sudan	-	1	-	-	-	1	-	-	-	0
Sweden	-	-	-	-	-	0	-	-	2	2
Switzerland	-	-	-	-	-	0	-	1		1
Syria	-	-	-	-	-	0	-	-	1	1
Taiwan	-	-	-	-	-	0	-	-	1	1
Thailand	-	-	-	-	-	0	-	-	1	1
Trinidad and Tobago	-	-	-	-	-	0	-	-	3	3
Ukraine	-	-	-	1	-	1	-	-	-	0
United States	-	-	3	-	-	3	2	5	71	78
Wales	-	-	1	-	-	1	-	1	21	22
Yugoslavia Federal Republic of	-	4	-	-	-	4	-	-	1	1
Zambia	-	-	-	-	-	0	-	-	1	1
Zimbabwe	-	-	-	-	-	0	-	-	3	3
Total	6	91	18	31	5	151	12	45	642	699

6 Vocational registration of doctors with an overseas primary qualification, by branch of medicine

1 APRIL 2000 – 31 MARCH 2001

Branch of Medicine	Number
Anaesthetics	15
Diagnostic Radiology	7
Emergency Medicine	4
General Practice	60
General Surgery	9
Intensive Care Medicine	5
Internal Medicine	12
Musculoskeletal Medicine	2
Obstetrics & Gynaecology	9
Occupational Medicine	1
Ophthalmology	3
Orthopaedic Surgery	1
Otolaryngology Head & Neck Surgery	3
Paediatrics	7
Pathology	10
Plastic & Reconstructive Surgery	1
Psychological Medicine or Psychiatry	16
Public Health Medicine	3
Radiation Oncology	1
Rehabilitation Medicine	1
Sexual Health Medicine	5
Sports Medicine	1
Urology	1
Vascular Surgery	1
Total	178

7 Outcomes of applications for assessment of eligibility for vocational registration

1 APRIL 2000 – 31 MARCH 2001

Branch	Incomplete applications	Pending (at College)	Withdrawn/Lapsed	Vocational Registration	Class 3 probationary (eligible for Vocational Registration)	Class 4 probationary (suitable for assessment –Vocational Registration)	Class 6 probationary (clinical evaluation to determine suitability for class 4)	Further training/ examination required (General registrant*)	NZSPEX	NZREX	Total
Anaesthetics	2	8	6	7	8	24	0	1	3	14	73
Cardiothoracic Surgery	0	0	1	0	0	5	0	0	0	1	7
Dermatology	1	2	1	0	2	0	0	1	1	3	11
Diagnostic Radiology	1	0	6	3	3	7	0	1	3	1	25
Emergency Medicine	0	1	1	2	5	1	0	0	1	1	12
General Practice	4	0	4	0	3	44	0	3	6	0	64
General Surgery	5	5	9	0	2	14	0	1	8	21	65
Internal Medicine	7	15	15	3	7	26	0	0	12	12	97
Neurosurgery	1	1	0	0	0	3	0	0	1	2	8
Obstetrics and Gynaecology	5	2	4	3	7	6	0	0	28	12	67
Occupational Medicine	0	2	0	2	1	1	0	0	0	1	7
Ophthalmology	1	3	3	1	1	3	0	2	5	8	27
Orthopaedic Surgery	2	5	3	1	2	4	0	2	3	9	31
Otolaryngology Head and Neck Surgery	1	4	2	0	2	4	0	0	4	5	22
Paediatric Surgery	0	0	0	0	1	1	0	1	1	0	4
Paediatrics	2	7	11	4	5	8	0	2	3	7	49
Pathology	2	1	5	5	14	6	0	1	6	2	42
Plastic and Reconstructive Surgery	0	4	2	2	1	1	0	0	0	1	11
Psychological Medicine or Psychiatry	9	9	6	12	16	41	5	0	8	3	109
Public Health Medicine	1	0	2	0	0	3	0	0	5	0	11
Radiation Oncology	4	1	2	0	2	1	0	0	0	1	11
Sports Medicine	0	1	0	0	0	0	0	0	0	0	1
Urology	3	2	2	0	0	3	0	0	0	3	13
Total	51	73	85	45	82	206	5	15	98	107	767
Percentages based on 558 final outcomes **				8.1%	14.7%	36.9%	0.9%	2.7%	17.6%	19.2%	

* Applicant already has general registration via a different registration policy.

** Doesn't include incomplete, pending, withdrawn or lapsed applications

8 Active Medical Practitioners in New Zealand

1 APRIL 2000 – 31 MARCH 2001

Country	Interim	Probationary	General	Vocational	Temporary	Total
England	6	37	549	614	248	1454
South Africa	6	30	417	331	95	879
Australia	6	3	214	141	2	366
Scotland	0	11	160	192	2	365
India	1	35	180	124	24	364
Sri Lanka	0	18	105	136	3	262
Iraq	0	23	104	7	0	134
United States	1	10	4	50	54	119
Ireland	0	2	35	37	20	94
Canada	0	0	34	36	21	91
Scotland	0	0	0	0	81	81
Wales	1	2	26	20	23	72
Germany	2	3	31	27	5	68
China	0	5	22	40	0	67
Bangladesh	1	23	32	2	3	61
Fiji	0	1	23	24	6	54
Egypt	0	11	19	11	1	42
Yugoslavia, Federal Republic of	0	5	17	8	1	31
Pakistan	0	4	7	8	10	29
Northern Ireland	0	1	8	16	3	28
Singapore	0	2	3	16	1	22
Philippines	0	4	8	4	4	20
Zimbabwe	1	1	4	9	3	18
Poland	0	0	14	2	1	17
Netherlands	0	1	3	11	0	15
Myanmar	0	2	11	0	1	14
Russia	0	7	4	0	1	12
Croatia	0	2	9	0	0	11
Bulgaria	0	3	3	1	3	10
Other	1	15	52	48	30	146
New Zealand	10	313	3731	3505	0	7559

Note: There are 53 countries with less than 10 active doctors represented by Other. They are Albania, Argentina, Austria, Belgium, Bosnia and Herzegovina, Brazil, Cambodia, Colombia, Czech Republic, Denmark, Dominican Republic, Ecuador, Finland, Former Yugoslav Republic of Macedonia (FYROM), France, Ghana, Greece, Grenada, Hungary, Iran, Israel, Italy, Jamaica, Japan, Jordan, Kenya, Korea (Republic of), Kuwait, Latvia, Lebanon, Libya, Malaysia, Mexico, Nigeria, Norway, Papua New Guinea, Peru, Puerto Rico, Romania, Slovakia, Spain, Sudan, Sweden, Switzerland, Syria, Taiwan, Thailand, Trinidad and Tobago, Turkey, Ukraine, Uzbekistan, Vietnam, Zambia.

Professional Standards

Principal activities: undertaking competence reviews of doctors and establishing competence programmes, development of policy on competence reviews, general oversight and recertification, managing doctors who are subject to conditions arising from disciplinary action. Total cost: $731,294

Part of the Council's primary purpose is ensuring that doctors, once registered, maintain their competence.

Competence reviews

Competence reviews of doctors and competence programmes provide protection for the public and assist doctors to overcome any knowledge or skill gaps.

Currently the Council reviews doctors' competence to practise in response to concerns from others, usually in one specific area of practice. Eighty-two referrals were received during the year compared with 61 the previous year. Thirty-seven doctors were formally reviewed and six were directed to undertake an educational competence programme. Other outcomes from referrals are shown in table 9.

Competence programmes are educational but there is the ability to restrict a doctor if unsafe practice is confirmed. To date, the great majority of Council competence reviews have not resulted in programmes or restrictions. So far, the Council has not moved to introduce targeted reviews based on known risk factors which some bodies overseas are introducing, as these require extra resources. In the first three years our focus has been on gaining experience of this new tool. This coming year we will review the process and whether, for example, an inexpensive first-level screening can be set up.

There is an apparently greater readiness to report concerns about colleagues which is a welcome sign of awareness. There were 13 referrals by peers during the year compared to eight the previous year. It is accepted there is uncertainty about the threshold, decisions to refer are necessarily subjective and it is difficult to report a colleague. So long as a report is in good faith and shows reasonable care there is no liability.

We reviewed our policy of informing employers about a doctor employee's competence review and/or programme. We will not routinely disclose that a doctor is having a competence review, because a 'concern' has not been tested at that point and because co-operation by the doctor is required. On the other hand an employer will always be notified about a competence programme because supervision is required at the workplace and because employers have certain rights to know about performance issues affecting their staff.

General oversight

The Medical Practitioners Act requires general registrants to practise under the general oversight of a vocationally registered doctor in the same branch of medicine. With exemptions for well over 1,000 doctors expiring on 1 July 2001, many doctors contacted the Council office to seek advice on appropriate overseers. Section 20 of the Act has allowed us little flexibility to make sensible oversight decisions where there is no appropriate vocational branch. Despite repeated requests to the Ministry of Health no change to the Act will occur in time for July 2001. Problems arise mainly for doctors working in narrow areas. Most cases were resolved on an individual basis and we are confident that any outstanding cases can be solved in the spirit intended by the Act, to ensure all doctors take part in continuing education and peer review.

A few vocationally registered doctors will require oversight because they are working in other branches without vocational registration, however the Council ruled oversight would not be required where doctors can show that their recertification programmes are broad enough to cover the work in other areas.

Recertification

From 1 July 2001 all vocationally registered doctors must 'recertify' by participating in their maintenance of professional standards (MOPs) programme or equivalent. Early in 2001 detailed guidelines were sent to all doctors with the list of approved programmes.

Policies and guidelines for general oversight and recertification were put on the Council's website, www.mcnz.org.nz.

The Act intends that recertification will help doctors practise competently. The Royal New Zealand College of General Practitioners and others expressed concern that MOPs programmes are educative and not designed to ensure competence or detect incompetence. While acknowledging the concerns, the Council position is that MOPs is important because evidence suggests that isolated doctors not involved with their peers are more likely to develop competence problems. Peer review and audit will eventually be compulsory in recertification. Ultimately, ensuring competence is a Council responsibility but we will work developmentally with Colleges towards the Act's mandate.

9 Competence referrals

1 APRIL 2000 – 31 MARCH 2001

Source of concern	Number
Health and Disability Commissioner (HDC)	27
Complaints Assessment Committee	2
Medical Council President	12
Public	2
Via NZREX registration examination	1
Medical Practitioners Disciplinary Tribunal	1
Peer	13
Peer/Employer/Ministry of Health	1
Medical Council registration/employer	6
Medical Council Registrar	5
Medical Council Assistant Registrar	2
Director of Proceedings	2
Medical Council Standards Manager	6
Medical Council Health Committee	2
Total referrals	82

Type of concern	Number
Medicines practice	12
Skills and knowledge	61
Judgement	22
Communication	21

Note: one referral to a competence review may cover more than one category.

Outcomes of competence referrals	Number
To competence review	37
No competence review	15
To competence programme	6
To HDC	3
To Health Committee	3
To Boundaries Committee	3
To Registration	1
Awaiting further information	12
On hold	2

Complaints

Principal activities: operation of complaints assessment committees (CACs) to consider complaints, policy on complaints assessment process. Total cost of CACs: $654,434

The Council must appoint complaints assessment committees to investigate all complaints it receives against doctors relating to treatment before 1 July 1996.

In the past two years complaints to the Medical Council have almost doubled (increasing from 199 in 1999 to 382 in the year under review). There is a similar pattern of increasing complaints reported by the Office of the Health and Disability Commissioner. The Council, however, agrees with Commissioner that there is no evidence to suggest a decline in the quality of health care. In addition, when seen in perspective, these figures represent only a tiny proportion of the profession – 290 doctors out of more than 8,700 doctors who are practising in this country.

The Medical Council only investigates complaints about treatment before 1 July 1996 and all others are referred to the Commissioner's office. The older complaints are frequently more complex and emotionally draining, it having taken some years for patients to come forward. Some who have suffered trauma can only deal with it years later, but society's heavier focus on the victim also leads some people to complain who would otherwise have moved on. Because the complaints go back some years, they are more difficult to assess and it is problematic when the standards of medicine that applied five or ten years ago are different to those of today.

Of the 382 complaints to the Council the vast majority – 232 – were about treatment issues. Two hundred and sixty-two of the complaints received were referred to the Commissioner while the remaining 120 were within the Medical Council's jurisdiction (42 relating to one doctor), compared with 78 the year before. The Commissioner referred 7 complaints to the Council which were outside his jurisdiction.

The Council appreciates the efforts of the doctors and public who serve on CACs. There are about 300 doctors and 47 public members who are available for CACs, but a move was made to operate a smaller more experienced pool of CAC members to improve efficiency and consistency. Regular training is given and in March a very successful one day workshop was held in Auckland which attracted 70 participants.

Currently CACs determine their own procedures but it is proposed that certain steps be mandatory when change permits: the CAC 'must' rather than 'may' contact the complainant and doctor, and the CAC 'shall' rather than 'may' appoint a legal assessor. Investigatory powers and the ability to appeal a CAC decision to the District Court were also proposed.

Cull review of reporting adverse medical events

This report was released at the end of March 2001, ordered by the Government in the aftermath of the case of Northland gynaecologist Dr Graham Parry. It recommended sweeping changes, including a one-stop-shop for medical complaints in the Health and Disability Commissioner's Office. The Council position was that 'concerns about competence' must continue to be received by the Council in accordance with our mandate, and not referred to the Commissioner as a 'complaint.'

The report did however acknowledge the significant progress by the Council in reducing the timeframe for complaints from over 52 weeks to under 19 weeks since 1996.

Sexual boundaries

Following the offending of Christchurch GP Dr Morgan Fahey we began to review our policies on maintaining proper boundaries between doctors and patients. In March a discussion document went out to over 200 doctor and public groups and several focus groups were arranged around the country. There will be a report to the profession in the latter half of 2001 on what if any changes are needed to the current policies and their promotion.

The sexual offending of Dr Fahey prompted a number of people to ring the Council office with concerns about other doctors. Even though they were untested allegations, this was very disappointing when the stance within the profession is so clear cut. The matter is extremely serious for the profession, even though only a tiny number unscrupulously offend in this way.

Informal or anonymous complaints

This issue arose because people had ‘passed on’ information about Dr Fahey to others but no formal complaints were made. From time to time the Council receives information which is not a complaint, but we have had no policy on how to respond. Natural justice is a vital issue and the challenge is always to balance the rights of doctor with the broader public interest of public protection.

It was decided that when serious issues are brought to our attention we will contact the doctor with our policies and either:

(a) propose to do a competence review of a doctor (action needed), or,

(b) keep the information on the doctor’s file with the doctor’s and informant’s knowledge for five years, which may be acted on only if similar issues arise in future (no immediate action needed).

The Council is aware of potential for vexatious reports, which are, nevertheless, very rare. Informal or anonymous information is likewise infrequent and our first priority is to ensure the formal process is followed whenever possible. In all situations doctors will have the opportunity to respond to information passed on about them as a first step.

10 Schedule of Complaints

1 APRIL 2000 – 31 MARCH 2001

New Complaints Assessment Committees(CACs) appointed	130
Complaints carried forward at 31 March 2001	
CAC pending determination	51
Number of new complaints received (includes 262 referred to HDC)	382
Number of doctors involved	290
Categories of complaint	
Communication	70
Communication and Treatment	13
Conviction of an offence	5
Cost	4
Inappropriate Sexual Behaviour	17
Rights	31
Rights and Communication	1
Rights and Treatment	3
Systemic	1
Treatment	232
Other	5

Note: One complaint can cover more than one category

11 Complaints Statistics

1 APRIL 2000 – 31 MARCH 2001

Month 2000/2001	CACs in Progress	Complaints received pre-1.7.96 for CAC appt	Complaints received post 1.7.96 to HDC to action
April	34	5	7
May	35	7	23
June	41	6	19
July	41	7	23
August	41	5	22
September	43	26	22
October	49	41	22
November	48	11	19
December	49	1	24
January	50	8	23
February	49	0	28
March	50	5	28

12 Determinations Made

1 APRIL 2000 – 31 MARCH 2001

Competence Review	1
Referred to conciliation*	2
Charge laid with MPDT	5
No further action	44
Total	51

Note: Each case may involve more than one doctor; each determination relates to one doctor.
*One unsuccessful conciliation resulting in charge laid with MPDT; one ongoing.

Health

Principal activities: considering the cases of doctors with possible health conditions, establishing treatment and monitoring programmes for doctors with health conditions affecting fitness to practise, promotion of doctors' health.
Total cost: $731,344

The Council ensures that the public is protected by the appropriate management of a doctor who, because of some mental or physical condition, may not be able to practise safely.

The Council's Health Committee manages doctors with health conditions affecting their practice. Over 12 years of operation the Committee has developed a very sound programme with good rates of rehabilitation. There were 11 cases closed in the year, with a further 22 doctors requiring only low level monitoring. Most of the monitored doctors are undergoing treatment for drug or alcohol addiction. Some have psychiatric disorders including depression and bipolar disorder, while others may suffer neurological conditions, viral conditions or sensory problems, eg. eyesight impairment.

Eighty-two health cases were reviewed on top of 30 new referrals to the committee. In addition to these the Committee Chair and Health Manager dealt with approximately 40 cases requiring action between meetings.

The Committee does all it can to allay unfounded anxiety but there are frequently fears that the process is disciplinary. On the contrary, the doctor will usually remain in work while being monitored and there are very few instances where the Committee must enforce a period of non-working, as the doctor will usually come to the realisation on his or her own. In the last six years suspension has been used only twice. Wherever possible the Committee prefers to make 'voluntary undertakings' with doctors which are not made public. The process is not at all easy, especially to begin with, but many doctors later confirm that aspects such as urine testing have played a major role in helping them to recover.

The Committee continues to raise awareness in the profession of the mandatory requirement on doctors to report another doctor's ill-health affecting fitness to practise. A special edition of the Council's newsletter in May on doctors' health was well received and resulted in media reporting of the issues.

Referrals have been steady and there were 30 new cases, the same as the previous year. The Committee uses a network of independent assessors to provide expert advice for each doctor referred. Other colleagues of the doctor or health professionals provide support through supervision and reporting to the Council, and mentors have been appointed as part of some agreements. The Committee is indebted to those who take on these roles as they are pivotal to doctors' recovery.

Workplace pressures are looming larger in the health problems of doctors being seen. There are currently three doctors from one provincial hospital under Health Committee monitoring, all of whom are being affected by work pressure. Work stresses are inevitable but doctors have generally been poor at looking after their own health. It is vital that doctors examine their own attitudes, have their own GPs, and seek help if appropriate from the very wide range of counselling services now available in the community.

The Council contributed $35,868 towards the running of the Doctors' Health Advisory Service (DHAS) in 2000/01. DHAS is asked to provide the committee with coded reports and an assessment of risk of doctors it is helping. Doctors considering whether to report may find it helpful to discuss the case with an experienced DHAS member but it continues to be stressed that this does not amount to a notification under the Act.

Health Statistics

1 APRIL 2000 – 31 MARCH 2001

New Referrals

Received	30
• No further action required	4
• Monitoring programmes initiated	19
• Further review required before APC issued	1
• Follow up report to be provided	2
• Pending	4

Includes 5 referred from Professional Standards Committee

Carried Over from Previous Years

Monitoring programme reactivated or continued from previous year	49
Low level monitoring or review	22
Further review required before APC issued	5
Cases closed	11

Other Actions Taken

Conditions imposed on registration	3
Prescribing restrictions revoked	2
Applications for registration considered and initial registration supported	2
Deaths (cause not related to impairment)	2

Health disclosures on annual practising certificates (APCs)

In addition to those under Health Committee monitoring shown in the table above, 73 doctors disclosed a health condition at the time of applying for an annual practising certificate. Of those 27 were from people who had not disclosed previously. Fifteen people were asked to arrange for their treating doctor to sign a form confirming their fitness to practise. Three people were requested to submit a more detailed report. In some cases reports were submitted along with the application for an APC which held the relevant information required to be able to issue an APC straight away.

Note: these figures are based on certificates which were issued on the new quarterly cycle introduced on 1 September 2000. Figures are given for APCs issued from 1 April 2000, 1 September 2000 to 31 August 2001 and 1 December 2000 to 31 November 2001.

Education

Principal activities: accreditation of medical schools, assessing teaching and learning environment in hospitals, maintaining a network of intern supervisors, policy on probationary and pre-vocational years, considering applications for recognition as a vocational branch of medicine and approving recertification programmes. Total cost: $709,610.

The Medical Council promotes high standards of initial and continuing medical education to equip doctors for safe practice.

The Education Committee of the Council has four major areas of responsibility: the approval of medical schools and medical school courses; education, training and supervision during a doctor's probationary year; pre-vocational training; and vocational education and training.

The committee membership is a mix of medical professionals and educators and includes a resident medical officer to bring the important perspective of recent graduates.

It was with great sadness that the resignation of Professor Ian Simpson, Chair of the Committee, was received at the end of the year. His service spanned nearly thirty years. He became the committee chair from 1996 and joined the Council itself in 1998 as the nominee of Otago and Auckland Schools of Medicine. The Council wished him well in his new appointment as Chair of the Accreditation Committee of the Australian Medical Council, becoming the first resident New Zealander ever to sit on that Committee.

Medical school accreditation

Since the early 1990s, the New Zealand and Australian Medical Councils have run a joint accreditation programme for Australasian university medical schools. Accreditation visits ensure that the medical schools' courses and curricula are producing graduates with the knowledge, skills and attitudes needed for competent medical practice under supervision in both countries. Accreditation may be given for a maximum of ten years. During the year, the New South Wales Faculty of Medicine was accredited for six years, until July 2006.

Vocational branch recognition

There are currently 29 recognised branches of medicine, a mix of older specialties and newer branches such as musculoskeletal medicine and sexual health. The Council affirmed its approach to vocational recognition and continues to promote the difference between specialist and vocational registration, which is not yet accepted or understood in some quarters. The Council's test for vocational registration is only that a person is competent, and it does not make value judgements about factors such as competitive entry or length of training which are criteria in established specialties. Permitting the formation of newer and smaller vocational branches enables the Council to give assurances to the public that doctors are competent to work in small, well-defined areas. To avoid variations in standards and insularity, however, affiliation with larger branches is encouraged.

New vocational branches accepted by the Council during the year were palliative medicine and family planning reproductive health. An application from accident and medical practitioners (AMPA) for

recognition was approved in August. Medical administrators was again forwarded to the Ministry of Health. These now need the consent of Cabinet and the Governor-General to be formally recognised.

New Zealand's vocational branch recognition was reviewed against specialty recognition in Australia and the United States. Criteria for recognition were strengthened with effect in 2004, to include audit in recertification programmes and evidence from the community on the health need to be fulfilled. A larger body is to be established by 2004 to advise the Council on the need for new vocational branches involving Colleges, health planners, the profession, health industry and members of the public.

A three year moratorium was placed on approval of new branches of medicine from July 2001, to allow review of the principles behind vocational branch recognition plus review of existing branch training and recertification programmes. Reviews will take place on a new five year cycle. The dates set for branch reviews have therefore been extended.

Student debt

Statistics began to show evidence of a mounting doctor exodus which until recently was largely anecdotal. Our workforce survey for 2000 revealed only 72% of second year doctors being retained and a sharp drop to 58% retained at third year post-graduation. The better pay and conditions in Australia and high medical student debt are factors causing doctors to leave. The Council is as concerned as anyone about this issue and submitted to the Minister on the need for swift action to avert a crisis. Frustratingly there appears to have been little done as yet.

Hospital visits

Hospitals have a statutory duty to support the education needs of new doctors. A major task of the Education Committee is visiting hospitals every three years to accredit them for this purpose. Visits were made to Auckland hospitals in 2000 – Auckland, Starship, Green Lane, National Women's, North Shore, Waitakere, Mercy and Middlemore – and to Waikato, Thames, Palmerston North, Wanganui and Nelson, Wairau, and Grey Hospitals. Each of the visits represents a major workload for the hospital in preparation, filling in a detailed questionnaire and compiling statistics, and for the visiting team who must follow a demanding schedule of meetings and reporting over one or two days.

The visiting team considers the hospital resources, relationships, and teaching available to junior doctors on the job. Specific or more general concerns were noted in most of the hospitals visited. The Committee found that consultants are doing the apprenticeship training of junior doctors as best they can juggling high service loads, but require more support. The following comments from a hospital visited during the year are typical:

'…Our meeting with intern supervisors and senior medical officer emphasised that senior medical staff are experiencing a distinct sense of pressure and overload. This meant that less time during the day was available to discuss cases with junior staff in an apprenticeship model. The visitors considered that the sense of pressure and low morale amongst the senior medical officers may have a significant effect on the teaching environment of the junior staff and may be a contributing factor to the variable sense of satisfaction with the teaching environment in [hospital] and New Zealand hospitals.'

Notwithstanding these general concerns there was evidence of real progress in many hospitals in terms of improvements to orientation, teaching, communications and administrative support for interns since the last visit.

The Committee determined to incorporate questions on systems for identifying and reducing error during hospital visits, and it also resolved to look more closely at off-site (by telephone) supervision of probationers in provincial hospitals following concerns about back-up at night and in emergency departments.

Initiatives

Two members of the Committee visited the Taranaki Maori Health pilot. This pilot between Taranaki Health and Tui Ora proposes to employ first year doctors for working with Maori, and training in Maori health. It is an innovative proposal with potential to be a model for elsewhere. More work was needed on the proposal and a further visit is planned.

In April members attended the Confederation of Postgraduate Medical Education Councils meeting in Adelaide. In Australia the Colleges are pressuring to use the second house surgeon year for core vocational training rather than as a generic second year. In November 2000 representatives attended the 5th National Forum on Pre-vocational Medical Education held in Australia.

The committee progressed a review of its 'book list' of resources required in hospital libraries, in consultation with librarians and medical teachers. In October a new list of recommended textbooks, manuals, journals and electronic resources was produced. Its aim is to list the resources needed to support medical education in the immediate postgraduate years prior to vocational training.

The committee has done extensive updating to its handbook on its requirements for new doctors. It held consultation meetings on the handbook with resident medical officers in Wellington and consultants in Christchurch. At the end of the year the handbook was being trialled with intern supervisors prior to wide release in 2001.

Summer Studentship

The ninth annual summer studentship grants of $5000 were awarded to Lilian Fraser, BHBII at Auckland University for a "Review of attitudes to the Treaty of Waitangi in sixth year medical students" and to Joanna Lawrence, BHBIII at Auckland University for her topic "To determine the critical features of specialties that are attractive to women." The Council congratulates the students for their high quality reports, both of which are available from the Council.

Issues

Principal activities: considering and anticipating developments in the practice of medicine and in health services for the formulation of statements and guidelines for the profession; calling for submissions on issues. Total cost: As the work of this committee covers all areas of Council business it is apportioned against the major activities of the Council.

The Medical Council's Issues Committee reviews developments occurring in medical practice so that it can offer timely guidance to the profession. Doctors must be aware of the accepted standards of practice should their standards ever be questioned.

Complaint against a doctor in management

A major statement on 'Responsibilities of Doctors in Management and Governance' was promulgated to the profession, and it was tested in the first complaint the Council has considered against a doctor appointed as a director on one of the country's hospital boards. The complaints assessment committee (CAC) in that case was charged with determining whether the board member did sufficient in response to claimed 'serious concerns repeatedly expressed by senior medical staff,' about the impact of Board decisions on care of patients. The CAC' s investigation concluded there was no basis for disciplinary action, citing evidence from board minutes and interviews with relevant parties on the efforts the director had made to address concerns. It noted: ...'we consider it would be unfair to single out one individual for blame in what was predominantly a structural issue within a situation of acute rationing.'

This was a complex case of conflicting priorities and a system under extreme pressure. It underscored that doctors must become highly conscious of their positions and responsibilities. The Council's statement provides options for action by doctors concerned that Board decisions are putting patients at risk, and the clear guiding principle given is that: '[Doctors'] first consideration must continue to be the interests and safety of patients regardless of their managerial responsibilities.'

Updates to statements

Updating older statements and guidelines continued. Statements were updated on 'Improper Prescribing of Addictive Drugs' and 'Use of Drugs in Sport.' There was consultation on a revised statement on 'Responsibilities in Clinical Research in Institutions' (subsequently deferred pending decisions on regional ethics committees). A substantive review began of the 1990 statement on informed consent, as part of the Council's response to the Cull enquiry into chest physiotherapy on pre-term babies at National Women's Hospital. Responses were very useful with particular reference to the clear approach used by the General Medical Council in the United Kingdom. Following amendment, further consultation was planned.

Many queries are received from doctors about the duty of care in an emergency. Revision was planned for the current Council statement which does not address some frequently asked questions.

Advisory service for the profession

The Issues Committee discussed the possibility of offering an advisory service in the form of a telephone service to assist the profession with general queries about regulatory matters and some initial scoping was planned.

Patient guide

Drafting began of a booklet for patients on what they can expect from their doctor, and their obligations as patients. It will also explain in plain English the different branches of medicine, how medical registration helps assure standards and how to access a doctor's qualifications. The Committee also planned to produce information specifically for small health providers, and for overseas trained doctors on aspects of New Zealand culture.

Work in progress

Patient information storage and retention is an area of complaints and confusion in the profession, with many gaps in the current 1996 regulations. Problems arise in the fate of records through death or retirement of doctors. The Committee raised the difficulties of storage with the Ministry of Health, and began formulating a position on appropriate retention in medical specialties beyond the statutory ten years.

The Council receives many queries (and some complaints) about different types of medical certificates completed by doctors. Generally most queries relate to disclosure of private information to employers and retrospective sickness certificates. A working draft was begun on medical certificate writing, noting also the position of the New Zealand Medical Association on retrospective certificates.

A second new statement was drafted on self-care and family treatment by doctors. The Council prefers not to issue annual practising certificates to retired doctors for them to write prescriptions for family and friends (in addition, doctors in this situation must be under general oversight), and it recommends all doctors have their own GP, but there has been no formal guidance on these matters.

Discipline activities arising from the 1968 Act

Proceedings under the old Act which had been commenced before the new Act took effect are nearly complete.

Medical Council (constituted under the 1968 Act)

One appeal remained to be dealt with against a decision of the Medical Practitioners Disciplinary Committee. The hearing was held in May 2000 and the appeal was unsuccessful.

Appeals to the High Court

One appeal against a Council decision was awaiting hearing in the High Court during the year. At 31 March 2001 no date had yet been set.

Medical Workforce Survey

Total cost: $120,289

To mark a new decade, the 2000 workforce report provided more extensive information on changes in the medical workforce. The most pressing issue identified in the 2000 survey was the sudden rise in numbers of New Zealand graduates leaving to work overseas:

- decreasing retention of New Zealand graduates up to 15 years post-graduation compared with 1995;
- in the past year, an increasing loss of New Zealand post-graduate year two and three doctors overseas;
- the number of new overseas trained doctors registering in New Zealand during the last three years decreased by 50 percent compared with the three-year period prior to 1995. But, the proportion of overseas trained doctors working in New Zealand has increased in 2000 compared with 1995 as practising doctors stay longer;
- increase in the proportion of short-stay overseas trained doctors with temporary registration.
- retention of women is higher than men between eight to 14 years post-graduation;

As well as discussion of significant changes in workforce composition, this year's report also included new analysis of comparative retention across vocational branches which will be a useful input into future workforce planning:

- limited growth in the number of general practitioners over the last three years, decline in the number of house officers and medical officers of special scale in the last year, rapid growth in the number and proportion of registrars 1995-2000;
- growing proportions of women in general practice, and in the specialist branches of radiation oncology, paediatrics, psychiatry, pathology and several areas of surgery;
- relatively low retention rates for new vocational registrants in some branches, including psychological medicine and psychiatry, emergency medicine and pathology;
- increasing divergence in general practice service levels across rural/urban divisions and between Health Funding Authority localities;

The proportion of women in the workforce continued to increase rapidly, and some exploratory analysis was provided on participation differences by gender. Projections were included for future participation by women, Maori and Pacific peoples in the medical workforce. The main conclusions were:

- women in general practice work on average 33 hours per week compared with 48 hours per week on average for men;
- the participation of women in terms of hours worked, or FTE, may increase as more women move into specialties other than general practice;
- an increasing number of recent women graduates are training in vocational specialties other than general practice;
- in the early post-graduate years a higher proportion of women hold more than one job, compared with men;
- women move out of hospital employment into the private sector or non-medical employment earlier than men;
- under current conditions it is projected that the number of women doctors will increase from 2811 to 4232 or 51 percent in the next ten years and they will comprise approximately 40 percent of the total medical workforce;
- it is estimated that the Maori workforce may increase by 18 percent over the next five years from 198 to 234 practitioners and comprise approximately 2.9 percent of the workforce in 2005;
- it is estimated that the Pacific peoples workforce may increase by 35 percent over the next five years from 95 to 128 practitioners and comprise approximately 1.3 percent of the workforce in 2005.

The full report is available from the Council, mcnz@mcnz.org.nz.

Report of the Medical Practitioners Disciplinary Tribunal

The Medical Practitioners Disciplinary Tribunal is a statutory body constituted under Section eight of the Medical Practitioners Act 1995. The Tribunal and its membership are entirely separate from the Medical Council.

The Council provides administrative services and funding for the Tribunal through the disciplinary levy collected from all doctors annually. Hence the activities of the Tribunal are reported in this Annual Report.

Members and officers of the Tribunal at 31 March 2001

Mrs W N Brandon (Chair)
Mr T F Fookes (Senior Deputy Chair)
Mr G D Pearson (Deputy Chair)

Panel of Medical Practitioners

Dr F E Bennett
Dr I D S Civil, MBE
Dr J C Cullen
Dr G S (Ru) Douglas
Dr R S J Gellatly
Professor W Gillett
Dr J W Gleisner
Dr L Henneveld
Dr R W Jones
Dr B D King
Dr M G Laney
Dr U Manukulasuriya
Dr A M C McCoy
Dr F McGrath
Dr J M McKenzie
Associate Professor Dame N Restieaux
Dr A D Stewart
Dr B J Trenwith
Dr L F Wilson

Panel of Public Members

(One is appointed by the Chairperson for the purposes of each hearing)

Mr P Budden
Ms S Cole
Mr G Searancke
Mrs H White
Mrs J Courtney

Office of the Tribunal

Secretary – Mrs G J Fraser
Administrative Assistant – Mrs D M Haswell
Hearing Officer – Ms K Davies

28 The Terrace
P O Box 5249, Wellington
Tel (04) 499 2044
Fax (04) 499 2045
Email: gfraser@mpdt.org.nz
www.mpdt.org.nz

During this year under review, the Tribunal received 13 charges (the same as the previous year), six from complaints assessment committees and seven from the Director of Proceedings from the Health and Disability Commissioner's Office.

The Tribunal sat to hear 11 charges during the 2000/01 year, two of these being charges received in the previous year and one from the year before. Seven of the 13 charges received in the year under review are set down for hearings in the 2001/02 year. One charge received in the 1998/99 year is still to be heard.

Charges before the Medical Practitioners Disciplinary Tribunal

1 APRIL 2000 – 30 MARCH 2001

Nature of Charges	
Disgraceful conduct	3
Professional misconduct	6
Conduct unbecoming a medical practitioner and that conduct reflects adversely on the practitioner's fitness to practise medicine	2
Convictions	2
Total	**13**

Source	
Prosecution of charges brought by Complaints Assessment Committees	3
Prosecution of charges brought by Director of Proceedings	4
Charges brought by Complaints Assessment Committees but withdrawn	0
Charges brought by Complaints Assessment Committees but yet to be heard	3
Charges brought by Director of Proceedings but yet to be heard	3
Total	**13**

Outcome of Hearings*	
Guilty - conviction	2
Guilty - disgraceful conduct	1
Guilty - professional misconduct	2
Guilty - conduct unbecoming a medical practitioner and that conduct reflects adversely on the practitioner's fitness to practise medicine	0
Not guilty	2
Yet to be heard	7
Total	**14**

* Includes one charge received in 1998/99 year

DT

Finance

Medical
Council
of New Zealand

Finance

The attached financial statements cover the year 1 April 2000 to 31 March 2001.

General Council operations

The Medical Council's finances are well managed, affirmed by another unqualified audit opinion this year. The Council's activities have expanded under our 1995 legislation and expenses have increased, but these will be offset by reserves for some time to come (see below). The Council has also significantly improved forecasting and reporting (now by outputs) since the early days of the new Act, which will ensure greater stability in doctors' practising fees in the long-term.

This is somewhat tempered by the fact that financial projections have become a more complex exercise. It is expected that the increased mobility in the international medical workforce will continue to affect our income, the major part of which is derived from registration.

The general fund covers activities to register doctors, promote medical education, develop guidelines, carry out competence reviews, manage doctors with health problems and produce the annual workforce survey. The fund produced a surplus for the year of $893,509, compared to the budgeted deficit of $18,450. Key points are:

- total revenue fell from the previous year because of a cut in the APC fee from $575 to $485 for 2001, however we received more revenue than expected from interest, fees for temporary registration, and cost savings achieved by grouping together some vocational registration interviews.
- total expenditure increased by $346,000 to cover staff costs, depreciation and increased liaison with the profession, but it was still $547,000 less than budget, mainly due to lower administration and operating expenses (down $52,000), and lower competence review costs (down $391,000).

Discipline Fund

The discipline fund covers the work of complaints assessment committees set up by the Council and it fully funds the operations of the Medical Practitioners Disciplinary Tribunal. It showed a deficit for the year of $167,827 compared to the budgeted deficit of $500,100.

In the circumstances, this result was satisfactory. Revenue was $140,000 more than budget, mainly due to increased earnings on investments. Total expenditure was $191,000 less than budget, reflecting only 11 Tribunal hearings against 30 allowed for in the budget. General administration and operating expenditure was over budget due to the costs incurred by the Council in the ministerial inquiry into cervical smear under-reporting.

Examination fund

The examination fund covers the cost of the medical registration examination, NZREX Clinical. The fund produced a deficit for the year of $76,471 compared to the budgeted deficit of $2,650 as only 167 candidates sat the examination compared to 335 budgeted. Total income and expenditure were both below budget but the deficit resulted as the fixed costs are applied against fewer candidates.

Reserves

As part of prudent risk management the Council policy is to hold reserves equivalent to approximately one year's trading to be available in the event of major litigation. As at 31 March 2001 the Council's combined reserves for the general fund, discipline fund, and examination fund are approximately $3,000,000 more than the $6,100,000 required in the reserves policy. After consulting with the profession, the Council has decided to keep the APC fee constant for as long as possible, forecasting deficits for the next three years and beyond to work towards the desired reserve level.

Miller Dean Knight & Little

Chartered Accountants

MEDICAL COUNCIL OF NEW ZEALAND
AUDITORS' REPORT
FOR THE YEAR ENDED 31 MARCH 2001

To : Members of the Medical Council Of New Zealand

We were appointed auditors of the Medical Council of New Zealand in accordance with the Second Schedule of the Medical Practitioners Act 1995.

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 2001. 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 Institute of Chartered Accountants of New Zealand. 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 and other advice to the Council. Other than this, we have no other interests in the Medical 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 2001 and the results of its operations and cash flows for the year ended on that date.

Date Of Opinion
Our audit was completed on 31July 2001 and our unqualified opinion is expressed as at that date.

Level 5, Southmark House, 203-209 Willis Street, PO Box 11-253, Wellington, NZ. Tel 0-4-385 0862; Fax 0-4-384 3381

Maurice A. Knight CA., A.N.Z.I.M. John W. Little B.C.A., CA.

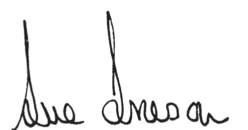
Statement of Financial Position

AS AT 31 MARCH 2001

	2001	2000
CURRENT ASSETS		
Petty Cash	300	200
ANZ Bank Account	143,443	193,071
Sundry Debtors and Payments in Advance (Note 7)	22,575	50,804
Interest Accrued	436,709	209,511
Term Deposits (Note 8)	11,349,143	11,145,056
Total Current Assets	$11,952,170	$11,598,642
FIXED ASSETS (Note 9)	782,857	639,434
Total Assets	$12,735,027	$12,238,076
CURRENT LIABILITIES		
Sundry Creditors	541,417	676,423
Salaries and Holiday Pay Accrued	121,844	135,602
GST	38,679	158,731
Payments Received in Advance	2,092,838	1,976,282
Total Current Liabilities	$2,794,778	$2,947,038
CAPITAL ACCOUNT		
General Fund	6,291,988	5,442,967
Discipline Fund	3,759,953	3,927,780
Examination Fund	(111,692)	(79,709)
	$9,940,249	$9,291,038
	$12,735,027	$12,238,076

The accompanying notes form part of these financial statements.

President



Chief Executive

Consolidated Statement of Financial Performance

FOR THE YEAR ENDED 31 MARCH 2001

	2001	2000
INCOME		
Fees Received	5,070,869	5,744,399
Interest Received	759,068	542,448
Other Income	297,590	385,176
	$6,127,527	$6,672,023
EXPENDITURE		
Audit Fees	10,000	8,500
Other payments to auditors	2,000	2,000
Depreciation	236,571	139,329
Fees paid to Council Members	378,760	358,668
Other administrative costs	4,722,387	4,542,905
Rent	128,598	129,536
	$5,478,316	$5,180,938
Net Surplus for Year	$649,211	$1,491,085

The accompanying notes form part of these financial statements.

Statement of Movements in Equity

FOR THE YEAR ENDED 31 MARCH 2001

	2001	2000
A) ACCUMULATED FUNDS AND RESERVES		
Balance at 31 March 2000	9,291,038	7,799,953
Add: surplus	649,211	1,491,085
Balance at 31 March 2001	$9,940,249	$9,291,038
B) ANALYSIS OF INDIVIDUAL FUNDS		
1) General Fund		
Balance at 31 March 2000	5,442,967	3,859,574
Less: Examination Review Costs (Note 10)	(44,488)	
Add: surplus	893,509	1,583,393
Balance at 31 March 2001	$6,291,988	$5,442,967
2) Discipline Fund		
Balance at 31 March 2000	3,927,780	3,931,353
Less: deficit	(167,827)	(3,573)
Balance at 31 March 2001	$3,759,953	$3,927,780
3) Examination Fund		
Balance at 31 March 2000	(79,709)	9,026
Plus: Examination Review Costs (Note 10)	44,488	
Less: deficit	(76,471)	(88,735)
Balance at 31 March 2001	(111,692)	($79,709)

The accompanying notes form part of these financial statements.

Statement of Cashflow

FOR THE YEAR ENDED 31 MARCH 2001

Cash flow from statutory functions		2001		2000
Cash was provided from:				
Receipts pertaining to statutory functions	5,393,456			6,136,151
Refund of tax				8,980
	5,393,456			6,145,131
Cash was also distributed to:				
Payment for Council fee and disbursements				
and Council office expenses	(5,432,893)			(5,548,286))
	(5,432,893)			(5,548,286)
Net cash flow from statutory functions		(39,437)		596,845
Cash flow from investing activities				
Cash was provided from:				
Interest received	531,870			405,354
Sale of assets				2,000
	531,870			407,354
Cash was applied to:				
Purchase of assets	(337,874)			(267,211)
Short term investments	(204,087)			(805,842)
	(541,961)			(1,073,053)
Net cash flow from investing activities		(10,091)		(665,699)
Net increase/(decrease) in cash held		(49,528)		(68,854)
Opening cash brought forward		193,271		262,125
Ending cash carried forward		**$143,743**		**$193,271**
Represented by:				
Petty cash		300		200
ANZ bank account		143,443		193,071
		$143,743		**$193,271**

The accompanying notes form part of these financial statements.

Notes to and forming part of the Financial Statements

FOR THE YEAR ENDED 31 MARCH 2001

1. STATEMENT OF ACCOUNTING POLICIES

REPORTING ENTITY

The Medical Council of New Zealand is a statutory body constituted under successive Medical Practitioners Acts, including the Medical Practitioners Act 1968 and, from 1 July 1996, the Medical Practitioners Act 1995.

GENERAL ACCOUNTING POLICIES

These financial statements are a General Purpose Financial Report as defined in the Institute of Chartered Accountants of New Zealand 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

(b) **Fixed Assets** are shown at cost less accumulated depreciation (Note 9).

(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** – The Council is not subject to income tax (Note 6).

(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. The charge to the Discipline Fund is based on the proportion of staff engaged in this activity.

(h) **Interest Received** – Interest owing at balance date has been accrued.

CHANGES IN ACCOUNTING POLICIES

Council has decided to transfer costs of the examination review previously charged to the Examination Fund to the General Fund as any resulting improvements in the examination process will benefit the entire profession. Other than this there have been no material changes in accounting policies which have been applied on bases consistent with those used in the previous year.

2. GENERAL FUND

Statement of Financial Performance

FOR THE YEAR ENDED 31 MARCH 2001

	2001	2000
REVENUE		
Annual Practising Certificates and Other Fees	3,633,507	4,195,743
Administration Fee – Discipline Fund (Note 1)	351,800	359,600
Administration Fee – Examination Fund (Note 1)	60,000	60,000
Interest Received	474,840	307,341
Workforce Survey and Other Income	150,020	90,759
Total Revenue	$4,670,167	$5,013,443
ADMINISTRATION AND OPERATING EXPENSES		
Communications	241,433	162,891
Election		35,992
Legal Expenses and Other Consultancy	116,834	97,431
Other Administration and Operating Expenses	774,029	651,970
Staff Costs including Recruitment and Training	1,655,703	1,516,540
Total Administration and Operating Expenses	$2,787,999	$2,464,824
COUNCIL AND COMMITTEE EXPENSES		
Council		
– Fees and Expenses	272,792	246,087
– Conference and Liaison Costs	107,322	51,807
Audit Committee		
– Fees and Expenses	5,526	5,728
Health Committee		
– Fees and Expenses	45,268	49,897
– Health Reports, Mentoring, DHAS and Other Costs	83,626	95,575
Issues Committee		
– Fees and Expenses	16,340	15,206
– Retention of Health Information Project		8,552
Education Committee		
– Fees and Expenses	46,461	50,725
– Hospital Visits, Intern Supervisor and Other Costs	261,274	231,444
Professional Standards Committee		
– Fees and Expenses	44,028	44,516
– Competence Reviews and Other Costs	76,012	159,948
Registration Committee		
– Fees and Expenses	11,732	5,741
– Verification of Qualifications and Other Costs	13,037	
– Examination Review Costs (Note 10)	5,241	
Total Council and Committee Expenses	$988,659	$965,226
Total Expenditure	$3,776,658	$3,430,050
Net Surplus for Year	$893,509	$1,583,393

3. DISCIPLINE FUND

Statement of Financial Performance

FOR THE YEAR ENDED 31 MARCH 2001

	2001	2000
REVENUE		
Fines Imposed, Costs and Mentoring Recovered	147,570	294,417
Interest Received	283,947	230,419
Levies Received	1,107,020	1,077,100
Total Revenue	$1,538,537	$1,601,936
ADMINISTRATION AND OPERATING EXPENSES		
Administration Fee (Note 1)	351,800	359,600
General Administration and Operating Expenses	74,170	25,057
Total Administration and Operating Expenses	$425,970	$384,657
1995 ACT PROCESS		
COUNCIL AND TRIBUNAL EXPENSES		
Complaints Assessment Costs		
– Fees	226,064	226,487
– Expenses	428,370	434,292
Total Complaints Assessment Costs	654,434	660,779
Medical Practitioners Disciplinary Tribunal		
– Administration and Operating Expenses	260,704	202,719
– Fees and Other Hearing Expenses	317,383	326,779
Total Medical Practitioners Disciplinary Tribunal Costs	578,087	529,498
Total 1995 Act Process	$1,232,521	$1,190,277
1968 ACT TRANSITIONAL PROCEEDINGS		
COUNCIL AND COMMITTEE EXPENSES		
Medical Council Discipline Fees and Expenses	21,744	2,710
Medical Practitioners Disciplinary Committee		7,143
Legal and Mentoring Expenses	26,129	20,722
Total Transitional Proceedings (1968 Act)	$47,873	$30,575
Total Expenditure	$1,706,364	$1,605,509
Net (Deficit) for Year	($167,827)	($3,573)

4. NEW ZEALAND REGISTRATION EXAMINATION FUND

Statement of Financial Performance

FOR THE YEAR ENDED 31 MARCH 2001

	2001	2000
REVENUE		
NZREX Candidate Fees	330,342	471,556
Interest Received	281	4,688
Total Revenue	$330,623	$476,244
ADMINISTRATION AND OPERATING EXPENSES		
Administration Fee (Note 1)	60,000	60,000
Centre Costs	73,577	103,515
Examiners Fees and Expenses	202,595	292,510
General Administrative Expenses	4,053	5,281
Honorarium, Salaries and Other Staff Costs	55,714	51,666
Total Administration and Operating Expenses	$395,939	$512,972
COMMITTEE EXPENSES		
Committee Fees and Expenses	11,155	14,415
Examination Review Costs (Note 10)		37,592
Total Committee Expenses	$11,155	$52,007
Total Expenditure	$407,094	$564,979
Net (Deficit) for Year	($76,471)	($88,735)

5. GENERAL FUND

Statement of Financial Performance by Outputs

FOR THE YEAR ENDED 31 MARCH 2001

These output categories represent the main activities of the General Fund and are discussed in detail in the text of the annual report.

	2001	2000
Total Income For Year	$4,670,167	$5,013,443
Less Expenditure		
EDUCATION		
Administration and Operating Costs	335,320	277,831
Council and Committee Costs	81,820	81,347
Hospital Visits	54,986	37,574
Intern Supervisor Costs	197,440	193,870
Probationers Handbook	8,848	
Liaison and Other Costs	31,196	18,890
Total Education Costs	$709,610	$609,512
HEALTH		
Administration and Operating Costs	532,083	315,091
Council and Committee Costs	101,253	80,519
Doctors Health Advisory Service Contract	35,868	39,186
Fitness to Practise Seminar		6,175
Independent Medical Assessments	30,612	30,613
Mentoring Costs	12,988	9,637
Liaison and Other Costs	18,540	17,031
Total Health Costs	$731,344	$498,252
PROFESSIONAL STANDARDS		
Administration and Operating Costs	532,578	557,547
Council and Committee Costs	100,013	98,105
Competence Review Costs	46,736	159,948
Sexual Boundaries and Assessors Meeting Costs	29,276	
Liaison and Other Costs	22,691	9,506
Total Professional Standards Costs	$731,294	$825,106
REGISTRATION		
Administration and Operating Costs	1,278,840	1,162,171
Council and Committee Costs	150,221	142,615
Examination Review Costs (Note 10)	5,241	
Consultation Meetings	7,463	
Liaison and Other Costs	42,356	22,182
Total Registration Costs	$1,484,121	$1,326,968
WORKFORCE SURVEY		
Administration and Operating Costs	109,178	152,185
Council and Committee Costs	8,840	15,311
Liaison and Other Costs	2,271	2,716
Total Workforce Survey Costs	$120,289	$170,212
Total Expenditure	$3,776,658	$3,430,050
Net Surplus for Year	$893,509	$1,583,393

6. TAXATION

On 20 December 1996 the Court of Appeal found the Medical Council to be exempt from Income Tax.

7. PAYMENTS IN ADVANCE AND DEBTORS

	2001	2000
Outstanding Contribution to Workforce Survey		19,000
Other Debtors	10,279	14,207
Payments in Advance	12,296	17,597
	$22,575	$50,804

8. TERM DEPOSITS

	2001	2000
ANZ	2,325,266	2,122,723
ASB	2,077,258	2,013,894
BNZ	1,447,832	1,661,179
Hong Kong Bank	1,027,886	1,079,676
National Bank	2,215,537	2,112,486
Taranaki Savings Bank	657,180	613,484
Westpac Trust	1,598,184	1,541,614
Total Investments	$11,349,143	$11,145,056

9. FIXED ASSETS

	Cost 31/3/01	Depreciation For Year 31/3/01	Accumulated Depreciation 31/3/01	Book Value 31/3/01	Cost 31/3/00	Accumulated Depreciation 31/3/00	Book Value 31/3/00
Computer	895,946	166,255	389,563	506,383	550,709	241,207	309,502
Furniture and Fittings	181,129	15,851	90,043	91,086	173,590	74,192	99,398
Office Alterations	227,888	22,766	125,915	101,973	226,531	103,149	123,382
Office Equipment	193,840	31,699	110,425	83,415	189,144	81,992	107,152
	$1,498,803	$236,571	$715,946	$782,857	$1,139,974	$500,540	$639,434

Costs of setting up and maintaining websites for the Medical Practitioners Disciplinary Tribunal and the Medical Council have been expensed in the year incurred.

10. EXAMINATION REVIEW COSTS

Council has decided that costs of the examination review previously charged to the Examination Fund should be charged to the General Fund, as any resulting improvements in the examination process will benefit the entire profession. Review costs up to 31 March 2000 of $44,488 have been transferred from the Examination Fund to the General Fund in the Statement of Movements in Equity.

11. RELATED PARTIES

Council members are paid fees for attending to Council and Committee business.
There were no other related party transactions.

12. 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.

13. RECONCILIATION OF NET SURPLUS WITH THE NET CASH FLOW FROM STATUTORY FUNCTIONS

FOR THE YEAR ENDED 31 MARCH 2001

Surplus / (Deficit) for year	2001	2000
General Fund	893,509	1,583,393
Discipline Fund	(167,827)	(3,573)
Examination Fund	(76,471)	(88,735)
	649,211	1,491,085
Add tax refunded		8,980
	649,211	1,500,065
Add non-cash items – Depreciation (Note 9)	236,571	139,329
	885,782	1,639,394
Add movements in working capital items		
(Increase)/decrease in debtors and prepayments	29,352	(4,195)
Increase/(decrease) in receipts in advance	116,556	(525,308)
Increase/(decrease) in creditors and GST	(312,059)	29,402
	(166,151)	(500,101)
	719,631	1,139,293
Less items classified as investing activity-interest	(759,068)	(542,448)
Net cash flow from statutory functions	($39,437)	$596,845

14. CONTINGENT LIABILITIES

The Medical Council is party to a number of legal proceedings. The potential financial liability is not considered to be material. (Nil as at 31 March 2000).

15. EVENTS OCCURRING AFTER BALANCE DATE

There have been no adjustable or non-adjustable events (as defined in the applicable financial reporting standard) between balance date and the date of completion of the financial statements.

16. COMMITMENTS – OPERATING LEASES

Lease commitments under non-cancellable operating leases;

	2001	2000
Not more than one year	116,760	116,760
Later than one year and not later than two years	116,760	116,760
Later than two years and not later than five years	9,730	126,490
	$243,250	$360,010

COMMITMENTS – CAPITAL EXPENDITURE

There were no material capital commitments at balance date. ($62,000 as at 31 March 2000)

17. 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 recognised banking institutions within an approved reserves and investment policy to limit exposure to concentrations of credit risk.

Debtors are shown at a fair value.

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

	2001	2000
Receivables	10,279	33,207
Bank-balances	11,492,586	11,338,127
Payables	(701,940)	(970,756)

Council Committees at 31 March 2001

The Council appoints committees to deal with its principal activities. Each committee has a minimum of two Council members. Registration decisions must be taken by the whole Council, not delegated.

Professional Standards Committee

Dr Ian St George (Chair)
Dr Mark Adams
Miss Carolynn Bull
Dr Joanna MacDonald
Dr John Neutze
Mr Alexander Sundakov
Mrs Heather Thomson

Health Committee

Dr Mark Adams (Chair)
Miss Carolynn Bull
Dr Joanna MacDonald
Dr John Neutze

Issues Committee

Dr Tony Baird (Chair)
Dr Mark Adams
Dr Joanna MacDonald
Dr John Neutze
Dr Deborah Read
Mrs Heather Thomson

Audit Committee

Mr Alexander Sundakov (Chair)
Dr Mark Adams
Dr Deborah Read
Professor Ian Simpson

Education Committee

Members appointed by the Council

Dr Mike Ardagh
Selected from Vocational Branch nominees

Dr Caroline Corkill
Selected from Vocational Branch nominees

Dr Gillian Clover
Selected from Vocational Branch nominees

Dr Mark Davis
Selected from Intern Supervisors

Professor Bill Gillespie
Member of academic staff of Faculty of Medicine,Otago

Dr Elaine Kan
Resident doctor

Council members

Professor Ian Simpson (Chair)
Miss Carolynn Bull
Dr Deborah Read
Mrs Heather Thomson

Examinations Committee

Members appointed by the Council

Professor Graham Mortimer
Examinations Director

Professor Peter Stone
University of Auckland nominee

Professor Peter Ellis
University of Otago nominee

Dr Pat Alley
Examinations Co-ordinator, Auckland

Dr David McHaffie
Examinations Co-ordinator, Wellington

Dr Peter Rothwell
Examinations Co-ordinator, Hamilton

Professor John Morton
Examinations Co-ordinator, Christchurch

Associate Professor Jim Reid
Examinations Co-ordinator, Dunedin

Council members

Dr Tony Baird (Chair)
Dr Joanna MacDonald
Professor Ian Simpson
Dr Ian St George
Mrs Heather Thomson

Office of the Council at 31 March 2001

Ms Sue Ineson
Chief Executive/Registrar

Ms Tania Turfrey
Assistant Registrar

Ms Lynne Urquhart
Deputy Registrar

Mrs Stephanie Pett
Senior Secretary

Registration

Mr Sean Hill
Registration Manager

Ms Karen Gardner
Senior Registration Administrator

Ms Gyllian Turner
Registration Administrator

Mr Philip Girven
Registration Administrator

Ms Ritu Nair
Registration Administrator

Mr Luke Baddington
Registration Administrator

Ms Jane Rossiter
Registration Administrator

Ms Justine Fleming
Registration Administrator (part-time)

Ms Linda Tan
APC Coordinator

Ms Dora Morgan
APC Administrator

Standards

Ms Sandy Gill
Standards Manager

Ms Joanna Dunning
Education Administrator

Ms Kristine Couch
Examination Administrator

Ms Michele Clarke
CAC Administrator

Ms Debbie North
Complaints Administrator

Mr Peter Cossar
Professional Standards Administrator

Ms Karyl Newbold
Standards Administrator

Dr John Simpson
Professional Standards Co-ordinator (part-time, contract)

Health

Ms Lynne Urquhart
Health Manager

Ms Jo Hawken-Incledon
Health Administrator

Mrs Viv Coppins
Health Administrator

Corporate Services

Mrs Jane Lui
Quality Assurance Manager

Ms Chris Aitchison
Policy Analyst

Mr John de Wever
Financial Controller

Ms Moyra Hall
Finance Accounts Officer

Mr Bill Taylor
Information Systems

Ms Susan Pattullo
Communications Coordinator

Ms Diane Latham
Information Officer

Ms Donna Overduin
Office Administrator

Mrs Rita Umaga – Ta'ulelei
Customer Services

Ms Kate Walker
Customer Services

Solicitors

KPMG Legal
P O Box 10 246
Wellington

Bankers

ANZ Banking Group (New Zealand) Ltd
Victoria Street branch
Wellington

Auditors

Miller, Dean, Knight and Little
P O Box 11 253
Wellington

Medical Council of New Zealand

Level 12
Mid City Tower
139 – 143 Willis St
P O Box 11 649
Wellington
Tel: 04 384 7635
Fax: 04 385 8902
Email: mcnz@mcnz.org.nz
Website: www.mcnz.org.nz

MEDICAL
COUNCIL
of NEW ZEALAND