# MEDICAL COUNCIL
## OF NEW ZEALAND

# ANNUAL REPORT
# 1992

# MEDICAL COUNCIL OF NEW ZEALAND

## ANNUAL REPORT

FOR YEAR ENDED 30 JUNE 1992

# MEMBERS OF THE MEDICAL COUNCIL

at 30 June 1992

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



# SECRETARIAT

at 30 June 1992

| | |
|---|---|
| **Secretary (Chief Executive)** | Ms G A Jones, BA |
| **Administration Manager** | Mr S M D Willcox, BA |
| **Executive Officer** | Ms F A Barber, BA, APRINZ |
| **Registration Officers** | Mrs J Lui (Snr) |
| | Mrs A Hamilton |
| | Ms L Urquhart |
| **Secretary/Word Processor Operator** | Ms J Hawken |
| **Clerk (Job-share)** | Ms M Loose and Ms P Jones |
| **Accounts Officer** | Mrs J Mackay (Part-time) |
| **Tribunals Officer** | Mrs S D'Ath (Part-time) |

| | |
|---|---|
| **Council Offices** | 73 Courtenay Place, Wellington 1 |
| **Postal Address** | PO Box 9249, Wellington |
| **Telephone** | (04) 384-7635 |
| **Fax** | (04) 385-8902 |

| | |
|---|---|
| **Solicitors** | Kensington Swan, PO Box 10-246, Wellington |

| | |
|---|---|
| **Bankers** | Bank of New Zealand<br>Courtenay Place Branch, Wellington<br>ANZ Banking Group (New Zealand) Limited,<br>Courtenay Place Branch, Wellington |

| | |
|---|---|
| **Auditors** | Miller, Dean & Little<br>PO Box 11-253, Wellington |

# MEDICAL EDUCATION COMMITTEE

at 30 June 1992

| | *Appointed by:* |
|---|---|
| **Professor J G Mortimer (Chair)** | ex officio, Dean, Dunedin Division, Faculty of Medicine, University of Otago |
| **Dr M I Asher** | Faculty of Medicine, University of Auckland |
| **Professor A B Baker** | Royal Australasian College of Surgeons |
| **Dr P M Barham** | Royal New Zealand College of General Practitioners |
| **Professor J G Buchanan** | Royal Australasian College of Physicians |
| **Professor A M Clarke** | ex officio, Dean, Christchurch School of Medicine, University of Otago |
| **Dr A G Dempster** | Faculty of Medicine, University of Otago |
| **Dr M E Lewis** | Faculty of Medicine, University of Otago |
| **Professor B R McAvoy** | New Zealand Medical Association |
| **Professor J D K North** | ex officio, Dean, School of Medicine, University of Auckland |
| **Professor E W Pomare** | ex officio, Dean, Wellington School of Medicine, University of Otago |
| **Dr I M St George** | Medical Council of New Zealand |
| **Assoc. Professor I J Simpson** | Faculty of Medicine, University of Auckland |
| **Dr A D Stewart** | Royal New Zealand College of Obstetricians and Gynaecologists |
| **Dr J C J Stoke** | Observer, Department of Health |



# COMMITTEES

at 30 June 1992

*Committees appointed by the Council to deal with its principal activities.*

**Preliminary Proceedings Committee**
Dr G F Lamb (Convener)
Mr P H Cook (Legal Member)
Dr C H Maclaurin

**Finance and Management Committee**
Dr W S Alexander (Chair)
Ms G A Jones
Dr J C J Stoke
Dr K J Thomson

**Medical Practitioners Data Committee**
Professor J G Mortimer (Chair)
Dr R H Briant
Ms G A Jones
Ms C Leatham (Statistician)
Dr I M St George
Professor D C G Skegg
Dr J C J Stoke

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

**Registration Committee**
Dr I M St George (Convener)
Dr W S Alexander
Dr M M Herbert
Dr C H Maclaurin

**Specialist Registration Sub-Committee**
Dr C H Maclaurin
Dr W S Alexander

**Indicative Register of General Practitioners Sub-Committee**
Dr M M Herbert

**Communications Committee**
Dr J A Treadwell (Convener)
Dr R H Briant
Ms G A Jones
Mrs P C Judd
Dr I M St George

**Board of Examiners**
Dr R H Briant (Chair), Medical Council
Dr P M Barham, Medical Education Committee
Dr G L Glasgow, Examinations Director
Dr M M Herbert, Medical Council
Professor J D Hutton, Nominee of University of Otago
Dr J Kolbe, Nominee of University of Auckland
Professor E W Pomare, Nominee of University of Otago

# REPORT FROM THE CHAIR

All of us in the business of medicine and health care will remember the year from July 1991 as the beginning of the most radical reforms of health service delivery in this country, and also the most rapidly introduced. Only time will tell whether these changes settle out to be for the public good as the politicians intend them. Whilst health service delivery is not a primary interest of the Medical Council, the changes to medical practice that will inevitably flow from these reforms certainly are. As a profession we must address them now and over the next few years.

Most of the planning and implementation of the changes is in the hands of administrators with little or no experience of the essential elements of the doctor-patient consultation and all that follows from it. There is a fear that self-interest or management dictate may drive out the sense of duty and ethical behaviour that governs doctors, and could affect medical standards profoundly.

The profession is looking anxiously at the changes in relation to the definition of its duty to the individual patient whilst working in an output driven, competitive health service envisaged by the National Interim Provider Board. Events and changes in other New Zealand structures make us recognise that there is a potential for serious conflict between the needs of a profit-making organisation and the public good.

Reforms made to the old Accident Compensation legislation have profoundly affected many people and most practitioners. The Medical Council made vigorous submissions on matters related to medical misadventure. As a result of this, and many other submissions, some improvement in the definition of rarity and severity was achieved. However, the new Act markedly restricts the use of the legislation for those seeking compensation for damage, and they may use the disciplinary system as an alternative way of having their legitimate concerns aired.

Last year I reported on our initiative in relation to abuse of prescribing responsibilities. This year we have begun to address abuse of the doctor-patient relationship, particularly sexual abuse. After a multi-disciplinary seminar in Wellington, a working party under the leadership of Dr R G Gudex has been established. This working party includes members who are not council members and who will bring a wide range of expertise and views to this vexed issue. We expect to be able to make progress in educational requirements (both undergraduate and postgraduate) and research, in order to understand and reduce sexual misbehaviour. In addition, we will modify the way complaints are received and processed in order to assist the victims to achieve any therapy and support they may need.

## Recertification

In my view the major current and future issue for the council is that of continuing assessment of doctors on the register, in terms of their competence for independent practice in their field of special training.

There is increasing evidence that involvement in recertification programmes does improve patient care, as well as reassuring both the public and the legislators that doctors have retained their previously attained standards of excellence. The College of Obstetricians and Gynaecologists is already well down the recertification road and the rest of the colleges are working towards such programmes. It appears that initially they will be based upon involvement in accredited educational programmes. Ultimately some assessment will be built into this process, but we are not at that stage yet.

While such programmes are always aimed at raising standards, there is a downside, namely the identification of doctors who are not making the grade. The council believes that to be effective, and maintain a register in which the public has confidence, it must be able to act upon the findings of recertification programmes. This may result in the limitation of practice licence, or its termination.

Recent public and media scrutiny of doctors whose practice has been alleged to be incompetent, makes it obvious that the disciplinary process is an inappropriate instrument for achieving better standards of medical practice.

To date the Medical Practitioners Act has not been revised, despite political promises for some five years. The council remains extremely limited in its ability to act upon complaints that might indicate incompetence, and only new and appropriate legislation will allow it to fulfil its proper function.

## Trans-Tasman Accreditation

One of the major achievements of the last twelve months has been the negotiation of a relationship between the Australian Medical Council (AMC) and its Accreditation Committee, and the Medical Council

of New Zealand (MCNZ) and the New Zealand universities. The AMC has changed its constitution to allow for New Zealand membership on the Accreditation Committee and assessing panels. Accreditation teams will visit New Zealand medical schools, probably not before 1995, and will report to the AMC and the MCNZ independently. The visit is aimed at the accreditation of our schools so that graduates can be fully registered in Australia for practice in Australia. This is necessary because new Australian legislation will have the effect of limiting registration of doctors to those who have graduated from a medical school accredited by the AMC, or who have passed the Australian Medical Council registration examination.

The report of the Accreditation Committee will be available to the Medical

Council of New Zealand and provide the basis for accreditation of schools for our register.

There is considerable advantage to New Zealand and its graduates if New Zealand qualifications are portable across the Tasman. This new arrangement with the AMC makes post-graduate training or practice in Australia a continuing option for New Zealand doctors.

The close medical relationship between Australia and New Zealand was further cemented by several MCNZ members taking part in a Registration Boards Seminar hosted by the NSW Board in 1991. A second seminar, to discuss matters of common concern, will be held in Melbourne later in 1992.

This report sees the end of the relatively short term of Dr John Stoke who deputised for the Director-General of Health. His contribution has been valuable.

We await the ministerial appointee to replace Dr Stewart Alexander whose lengthy term on the council has now ended. The council, and many of the doctors, lawyers and institutions with whom Dr Alexander has had contact, paid tribute to him in a Festschrift in March of this year. His award of the CBE by the Queen on the occasion of her official birthday was a fitting tribute to his enormous contribution to medicine, pathology, and medical politics in this country over a long and energetic career.

*R H Briant*
CHAIR


## Acknowledgment

Through the year I have been supported by the excellent work of Ms Georgina Jones and dedicated staff of the council who serve you all. My thanks to them.




# REPORT OF THE LAY MEMBER

This year I have been aware of three major themes which have emerged through the activities of the Medical Council.

The first is that as we enter into another series of changes to our system of health provision in New Zealand, issues to do with quality control appear to be very low on the list of priorities. The major emphasis is on fiscal matters and a business-oriented approach. This causes great concern to those of us who see service professions and business concerns as catering to different societal needs. The principle of 'caveat emptor' is alien to the underlying philosophy of the health professions and, in my opinion, is a dangerous attitude for each of us as individuals should it prove acceptable to politicians and their appointees who occupy decision-making positions in the health system.

Secondly, over recent years we have seen a greater involvement of non-medical people in medical matters and more information and autonomy being provided to patients. However, the power imbalance in the doctor-patient relationship has not really changed, and consequently the need for clearly defined patterns of behaviour and boundaries is as important now as in the past. As the mores of our society change there seems to be a greater need for medical professionals to maintain ethical standards.

An interesting aspect of the reforms in such areas as informed consent, is that the changes have occurred through the medical profession responding to public pressure, rather than change being imposed by the courts. Equally, I believe that the present discussion concerning sexual abuse in the doctor-patient relationship, initiated by the Medical Council, will allow both public debate on and greater professional awareness of this problem.

The third area which has presented some ethical dilemmas, and is growing in volume, is that of unorthodox medical care. The Medical Council has jurisdiction over registered medical practitioners only, and the general public can be quite vulnerable in the area of unorthodox treatment and medicines. It is to be hoped that when a Health Commissioner is appointed that person will have an overview and some responsibility for both orthodox and unorthodox therapeutic procedures.

Each year there is one factor which remains the same. That is, that a patient who is seeking help and advice from a medical practitioner usually has complete trust in that individual - both for care and confidentiality. Political fashions and ideologies may fluctuate, but it is important that the ethical rules of the medical profession can be relied upon to remain constant.

*P Judd*
LAY MEMBER

# REPORT OF THE MEDICAL EDUCATION COMMITTEE

## Intern Supervisors

The committee met with the intern supervisors and discussed a number of issues including the nature of mandatory clinical experience; the timeline, procedures, and data base for hospital accreditation visits; the requirements for resuscitation training; the problems of dealing with unsatisfactory interns; and the best form of liaison and support for the intern supervisors in their supervisory role.

## The role of the Medical School Postgraduate Deans

The need for better control and direction of the educational programmes in 7th and 8th year has been acknowledged for some time. A working party addressed this issue and confirmed that there was a need for a specific layer of interaction between the intern supervisors and the Medical Education Committee. The broad proposals within this report were accepted, but full implementation has been deferred until the most appropriate geographical coverage, the financial resource aspects, and the outcomes of the current discussions in the Health Reforms Directorate on funding for clinical training, are known. As a first step, however, the postgraduate deans in Auckland, Wellington and Christchurch have been approached to act as the resource intern supervisors can use for their problem cases.

## Resuscitation Training

The committee received a policy statement on this matter prepared in the form of guidelines for council, employers, and intern supervisors. The recommendations cover the teaching of general resuscitation techniques, the specific skills required, the timing of this process and the requirements for certification and revalidation. It is suggested that the interns should hold a valid certificate with a six month warranty. These recommendations are to be further developed and will be finalised by the MEC in late 1992.

## First Year House Surgeon Appointments

Council has a statutory obligation to ensure that all conditionally registered medical practitioners, who are usually 7th year interns, have an appropriate educational experience in their hospital appointment. Until 1991 there were an adequate number of posts available. Late that year it became apparent that there were insufficient hospital appointments available for the 1991 graduating classes from the Universities of Otago and Auckland. From the expected graduation of 270 students there appeared to be places for 239 first year house surgeons in the 1991/92 appointment year, leaving a shortfall of around 30. It is understood that most of these graduating students went to Australia, with some going to the United Kingdom. Indications for the 1992 classes suggest that there may be a significant shortfall.

The Medical Education Committee and council are concerned to ensure that the present high standards of professional competence are maintained, and that those who enter into medical training in good faith do have the opportunity to obtain full registration. This matter is being actively addressed, and possible courses of action urgently considered.

*J G Mortimer*
CHAIR



# REPORT OF THE PRELIMINARY PROCEEDINGS COMMITTEE

This year Dr Campbell Maclaurin joined the Preliminary Proceedings Committee (PPC) following the resignation of Dr Ian St George. The legal member, Mr Philip Cook, and the convenership remained unchanged. Considerable assistance was given to the committee by staff solicitors at Kensington Swan. In particular two young women solicitors, one of whom has a nursing background, have been of special value in helping to sift hospital notes and in dealing with complainants who have alleged sexual abuse by their doctor. The sensitivity with which these interviews have been conducted has been greatly appreciated.

## Major Enquiries

The year has been a busy one for the PPC, mainly by virtue of the lengthy investigation into the 36 complaints made to the Medical Council from patients who believed, after reading about the Royal Commission into Deep Sleep at Chelmsford Hospital in New South Wales, that they have been subjected to similar therapy in New Zealand. This was a very complex and difficult issue which involved over 600 hours of work, but which has left the committee convinced that the patients' complaints were based on a misapprehension: no deep sleep therapy in the Chelmsford sense was used in New Zealand.

A considerable amount of time was also occupied in pursuit of the allegations and counter-allegations over cosmetic and plastic surgery.

It is gratifying to report that both those issues have now been completed in terms of PPC investigation and determination of what charges should be laid.

## Nature of Complaints

The total number of complaints this year has been slightly lower than in the last year or two, mainly because there has been no new major issue comprising numerous complaints. The spread of complaints has changed, there being fewer complaints in regard to misprescribing, but an upsurge of complaints regarding sexual harassment or sexual abuse. As in past years patients continued to assert that their psychotropic medication is responsible for their current state, a source of considerable concern to the committee because of the difficulty of trying to disentangle symptoms of disease from consequences of treatment.

At the end of the June 1992 year the committee workload comprised:

- four complaints of recent origin under active investigation (two of which concerned psychotropic drugs)
- a further five investigations in which a formal Notice of Complaint had been issued
- five doctors had been charged with disgraceful conduct and were awaiting hearing by the Medical Council
- eight doctors had had charges of professional misconduct referred to the Medical Practitioners Disciplinary Committee
- two doctors under surveillance for improper prescribing.

During the year eight doctors have had the complaints against them dismissed for lack of substance. One doctor was referred to the Health Committee, and two doctors had warning letters sent to them.

Of the 37 files still open the remainder represent situations which have passed beyond the sphere of the Preliminary Proceedings Committee but the cases themselves were still awaiting final determination.

## Complaints Procedures

There is still concern in many quarters, shared by the members of the Preliminary Proceedings Committee, that the complaints procedures as laid down under the Medical Practitioners Act 1968 are cumbersome and often long drawn out. This tends to make the process forbidding to would-be complainants, for many of whom the need is predominantly one of clarification and explanation. It is to be hoped that the new Medical Practitioners Act will expedite and streamline the complaints process by the creation of a separate discipline system, hopefully with the Health Commissioner providing the receiving mechanism for complaints, and also providing the bulk of the conciliation and mediation functions. The professional discipline system would then be required to deal with those cases in which there was prima facie evidence of medical misdemeanour.

From close observation of the complaints process over the past three years I am convinced that no practitioner has any reason to be fearful of the disciplinary process unless they lower their standards in relation to their care of or respect for patients, their communication with patients or their relatives, or are careless or dishonest in regard to the financial management of their practice especially in the matter of claiming state funds.

*G F Lamb*
CONVENER





The need to assess competence to practice is generally accepted, and referral bodies are considering how recertification can be implemented.

The council's programme to assess mental and physical fitness to practise is developing satisfactorily, as the major referrers and treating institutions come to accept and trust the rehabilitation role of the Health Committee.

It has been suggested that the monitoring/mentoring process (long term treatment and management programme), being developed with the Doctors Health Advisory Service and the Censor of Rehabilitation of the Royal New Zealand College of General Practitioners, could be shared with the colleges or referral bodies while keeping outcomes confidential to themselves.

The appropriate duration of monitoring will vary with individual circumstances. It is evident that some doctors are helped by continuing contact with the Health Committee, and the knowledge that relapse will be apparent. The committee was interested in a colleague's description of the satisfaction with which he viewed his growing file of reports of drug-free, randomly tested urine. He supposed that he would choose long term monitoring.

## APC Screening

Some countries use the annual application for the practising certificate to screen mental and physical health. The questions asked may relate to court convictions, alcohol/substance abuse, and physical and mental illness potentially affecting safe practice.

The committee is considering what questions could be included next year in our application for a practising certificate, and it would appreciate expression of opinion.

## HOW TO HELP A SICK OR IMPAIRED COLLEAGUE

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

If the problem cannot be resolved by discussion with the sick doctor's immediate colleagues, therapeutic doctor and family, it should be referred to the DHAS, the medical officer of health, or to the health screener of the Medical Council. The referral is treated confidentially as long as there is prospect of resolution.

**DHAS REFERRAL**
**Phone: (04) 471-2654 (toll free)**
**or write: Box 812, Wellington**

**MEDICAL OFFICER OF HEALTH**
**Phone or write to nearest area health board or health development unit.**

**HEALTH SCREENER**
**C/- Medical Council of New Zealand**
**Phone: (04) 384-7635**
**Fax: (04) 385-8902**
**or write: Box 9249, Wellington**

Table 1

**HEALTH COMMITTEE ACTION**
**year ended 30 June 1992**

| | |
|---|---|
| Monitoring by Health Screener | 2 |
| Monitoring by Health Committee during treatment, rehabilitation or assessment | 12 |
| New suspension imposed | 3 |
| Full suspension reimposed | 1 |
| Full suspension varied to allow limited practice | 4 |
| Prescribing restrictions gazetted | 2 |
| Recommendation made on registration applications | 2 |
| Applications for revocation of suspension considered or under consideration | 6 |
| Revocation of suspension granted | 4 |

The committee has recommended to council that if a doctor receives more than one Drunk in Charge (DIC) conviction within a five year period, the PPC should request a report from the police on the amount of alcohol involved, and then make a decision as to whether the PPC wishes to pursue the matter, or refer it to the Health Committee.

Demonstrated concern by the medical profession for the monitoring of fitness to practise would seem to be very much in the interest of both the public, and the profession, in these changing times.

## Summary of Activities

During the period of 1 July 1991 to 30 June 1992, the Health Committee (with council where appropriate) has been involved in various activities related to individual doctors where fitness to practise was an issue. These are set out above (see Table 1).

*R G Gudex*
Convener



# NEW ZEALAND REGISTRATION EXAMINATION (NZREX)

Previous annual reports have set out in detail the content and administrative arrangements for this four part examination which has now been in place since 1989. The 1991 annual report in particular covered a wide range of issues related to the examination and provided information about particular problems which had arisen. If any practitioners would like a copy of that section of the report for reference it can be provided on request from the secretariat.

Statistics for the sessions of the examination which have been conducted in the last twelve months are set out below. The patterns obvious from previous years remain and indeed the low pass rate in the clinical examination has continued to be a source of great concern to the Board of Examiners and the Registration Committee.

Acknowledgment is due to Dr Gavin Glasgow, Examinations Director, his team of examiners at both Auckland and Wellington Schools of Medicine and their administrative assistants, as well as the Board of Examiners, for the careful way in which this examination is administered. Dr Glasgow has been assisted in Auckland by Dr John Kolbe who has taken a major responsibility for arranging the clinical examination. Dr Kolbe has now resigned from the Board of Examiners and his place has been taken by Dr Ernest Willoughby. He is to be joined by another nominee of the University of Auckland School of Medicine. The two nominees of the Wellington School of Medicine on the Board of Examiners are now Professor Eru Pomare and Professor John Hutton whose experience is invaluable. Administrative secretaries Mrs Jenny Hargrave and Miss Denise Fabian make a particularly important contribution to the smooth running of the examination programme. Despite the quality of the administration, there are of course always aggrieved candidates, but every attempt is made to answer their questions or those of their agents and to be fair to all who participate in the process, which can be stressful.

Despite allegations to the contrary, NZREX is not designed to limit entry by overseas trained doctors to the medical workforce. Its sole purpose is to ensure that the performance of those coming into the workforce who have not qualified in Australia, United Kingdom, Eire, Canada or South Africa, is at a compara-

Table 2

**SCREENING EXAMINATION (FOR TEMPORARY REGISTRATION)**

| NZREX | PART I | PART II | Screening Examination Overall |
|---|---|---|---|
| | NOV 1991 | | |
| Candidate attempts | 38 (10) | 50 (15) | 60 |
| No. of passes: | | | |
| Attempt 1 | 25 | 11 | |
| Attempt 2 | 5 | 7 | |
| Attempt 3 | 0 | 5 | |
| No. of passes overall | 30 | 23 | 44 |
| Pass rate overall | 79% | 46% | 73% |
| | MAY 1992 | | |
| Candidate attempts | 30 (8) | 43 (21) | 52 |
| No. of passes | | | |
| Attempt 1 | 15 | 11 | |
| Attempt 2 | 4 | 1 | |
| Attempt 3 | 1 | 1 | |
| No. of passes overall | 20 | 13 | 28 |
| Pass rate overall | 67% | 30% | 54% |

Note: ( ) repeat candidates included

bly high standard to New Zealand graduates.

The objective of the examination is to establish that overseas trained doctors have the required knowledge and clinical competence for the safe practice of medicine under approved supervision in New Zealand.

The standard of the examination is defined as the level of attainment of medical knowledge and clinical skills corresponding to that of newly qualified graduates of New Zealand medical schools who are about to recommence intern training.

## Review of NZREX and proposed change to council examination and registration policy for overseas trained doctors

The examination has been under constant monitoring but a major review was carried out between March and June 1992. As a result of this review council has proposed changes to the examination and registration policy. These changes are set out below.

The following are the reasons for the changes council has resolved to make in 1994, or earlier if the new Medical Practitioners Act is brought into effect in 1993:

- Employers, the profession at large, consumers and the council are increasingly concerned that the standard of knowledge and performance of overseas trained doctors permitted to undertake clinical employment, while preparing for the council examinations, was often below that expected of New Zealand graduates. The quality of patient care was compromised.

Table 3

**EXAMINATION FOR PROBATIONARY REGISTRATION**

| NZREX | PART III | PART IV | Proceeded to Probationary Registration |
|---|---|---|---|
| | JUL 1991 | AUG 1991 | |
| Candidate attempts | 45 (18) | 34 (12) | |
| No. of passes: | | | |
| Attempt 1 | 11 | 6 | |
| Attempt 2 | 9 | 5 | |
| Attempt 3 | 2 | 1 | |
| No. of passes overall | 22* | 12 | 12 |
| Pass rate overall | 49% | 35% | |
| | FEB 1992 | MAR 1992 | |
| Candidate attempts | 37(21) | 31(14) | |
| No. of passes: | | | |
| Attempt 1 | 10 | 5 | |
| Attempt 2 | 4 | 3 | |
| Attempt 3 | 3 | 4 | |
| No. of passes overall | 17* | 12 | 12 |
| Pass rate overall | 46% | 39% | |

Notes: ( ) repeat candidates included
* clear passes only

- Decreasing need for immigrant doctors to fill hospital posts no longer justifies broad interpretation of the Act as proved necessary during the particular employment situation which prevailed in the second half of the 1980s.
- The smaller numbers of candidates now presenting makes feasible a return to a more searching type of examination with less reliance on multiple choice questions, which are gradually being reduced in the medical schools' undergraduates programmes.
- The streamlined programme proposed (which includes only one written examination on medical topics) will be less stressful, in terms of preparation and financial burden, for candidates. However, it will achieve the same object of assessing the candidates theoretical and practical knowledge across all disciplines necessary for the practice of medicine under supervision in New Zealand.

## New policy

Council is moving towards the implementation in 1994 of new policy which will require overseas trained doctors not otherwise eligible for registration in New Zealand to pass all segments (English, written and clinical) of the New Zealand Registration Examination (NZREX) before commencing any form of medical employment or practice in New Zealand.

Certificates of probationary registration (or the equivalent) will be issued to successful candidates who submit the necessary registration documentation and fees.

Such registrants will be required to complete at least twelve months satisfactory practice under supervision approved by council, before applying for full registration as a medical practitioner.

## Revised composition of examination

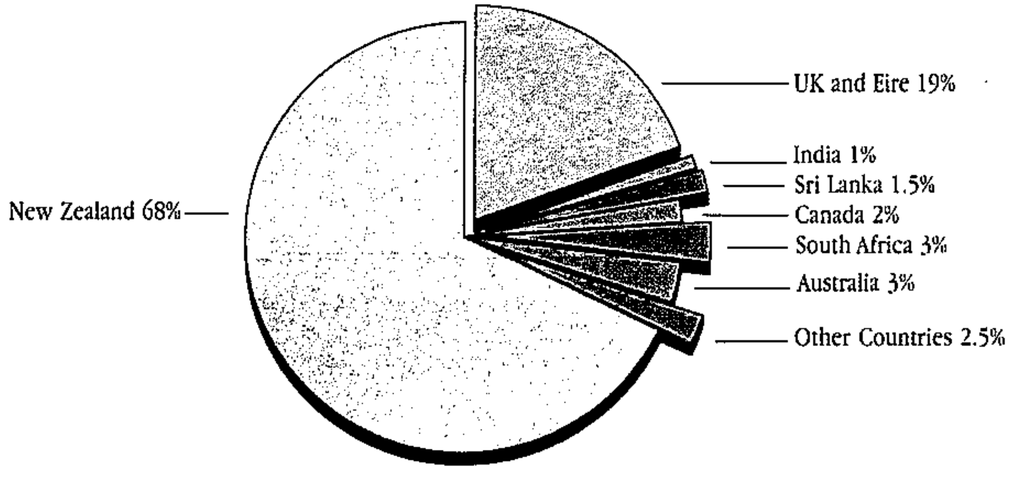
The examination will be streamlined to include three parts only.

- English (similar to the present NZREX I)
- Written (similar to the present NZREX III)
- Clinical (similar to the present NZREX IV)

The English and written parts will continue to be offered each year in New Zealand, Singapore and London in May

Table 4

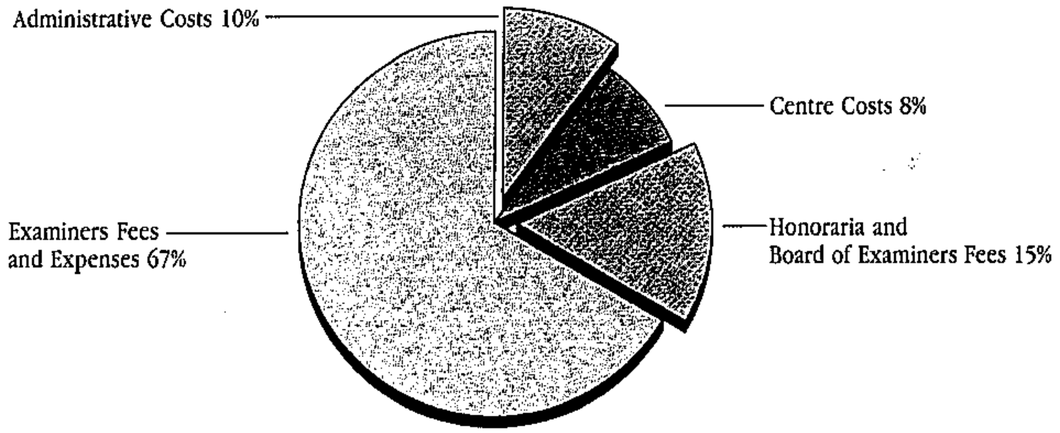
**NEW ZEALAND AND OVERSEAS GRADUATES ON THE NEW ZEALAND REGISTER**
**at 30 June 1992**




**Total on Register 10331**

Table 5

**EXAMINATION FUND EXPENDITURE**
**at 31 March 1992**




and November. The clinical part will be offered in March and August in New Zealand only.

## Temporary registration

Temporary registration will be strictly controlled and certificates will be issued only to those visiting New Zealand for short periods to give or receive post-graduate instruction. Council expects to phase out during 1993 the existing arrangements whereby temporary registration is granted on the basis of a screening examination only. Once the content and effective date for the new Medical Practitioners Bill is known, a more specific timetable will be published.

## Transition

Transition arrangements will be designed to deal fairly with those who are already working in New Zealand on temporary registration, while preparing for NZREX Parts III and IV or college fellowships. In the coming months the Registration Committee will review the files of all temporary registrants part way through examination or advanced training requirements, and specific instructions will be given to each on any steps necessary to comply with the proposed registration regime.

## Exemption

Rules under which applications for exemptions might be considered when the new examination regime is in place will be developed and published early in 1993. Appropriate provisions will be retained to provide limited registration for government sponsored trainees or overseas trained doctors who meet the criteria for vocational registration in medical disciplines but do not have registrable basic qualifications.

## Candidate information

A new edition of the candidate information booklet, which will cover all parts of the examination, is in preparation and will be available from the secretariat from mid September 1992.



## Timetable

The timetable for examinations in 1992/93 remains as previously:

| | |
|---|---|
| NZREX I and II | November 1992 |
| NZREX I and II | May 1993 |
| NZREX I and II | November 1993 |
| NZREX III | February 1993 |
| NZREX IV | March 1993 |
| NZREX III | July 1993 |
| NZREX IV | August 1993 |

Council reserves the right to vary this timetable to render it compatible with the implementation of new legislation concerning registration of medical practitioners, or to introduce the new NZREX three part regime.

*Georgina Jones*
SECRETARY

## ELIGIBILITY RULINGS

The Medical Practitioners Act 1968 provides access without further examination to conditional and full registration for medical graduates of universities in the United Kingdom, Eire, Australia, Canada and South Africa. Overseas trained doctors should be aware that these special privileges may not be retained in new legislation. Because the date of enactment of new legislation in not yet known, and indeed the draft legislation is still awaited, rulings on eligibility for registration from now until further notice will be valid only for three months from the date of issue of the written eligibility ruling.

**New legislation governing registration may be enacted in 1993**

# REPORT OF THE SECRETARY

An important outcome of having to write a section for the annual report is the catalyst it provides to review and reflect on the year, and what the purpose of all the activity in the secretariat has been. There are times when we do wonder! And no doubt some of you do too.

As I see it, we have three main "customers": the public, the profession and the council (and committee) members themselves. Each relationship is different and calls on particular skills and knowledge. In a small office, swapping between roles may be necessary many times in one day, in the continuous cycle of administrative policy and procedures.

## Council and committees

**General council meetings** are scheduled on alternate months, with at least one week for disciplinary enquiries put aside in the intervening months. Sometimes an individual hearing takes more than the week allotted.

**Council** has met on general business on 13 days in the last year. Meeting agendas are structured under the headings of General, Finance and Management, Education, Registration (including examinations), Health, and Discipline and frequently run to more than 400 pages. Under the heading "General" items concerning health reforms, act revision, data collection, overseas liaison, and particularly ethics, come to council attention. Members of the profession and the public, and indeed other professional groups in the health sector, are turning to council for information and guidance, which it attempts to provide or else refer to more appropriate sources.

The committee structure has increasingly been utilised, to cut back time spent by full council on "nuts and bolts." **Registration (and its subcommittees)** meet monthly, as does **Finance and Management. Health Committee** meets bi-monthly, although there are frequently urgent matters which need to be dealt with in between, and this is often accomplished when Health Committee members are together at disciplinary hearings. Teleconferences are used where practical, particularly by the Registration Committee and the **Board of Examiners** (who meet after each session of the examination, normally six times a year). The **Medical Education Committee** has met twice and meetings have also been called with the intern supervisors. Council has met with general managers, medical officers of health, the Council of Medical Colleges and also, in small groups, with representatives of various referral bodies. Similarly the Health Committee has met with representatives of the DHAS, treating hospitals, and medical students, in addition to regular interviews with monitored doctors and, if appropriate, their spouses. In total 18 days have been allocated to committee and special meetings.

Executive support for council and committees has been strengthened by new appointments in the last few years but there is a continually growing demand for this expertise. Shortage of office space is causing some problems with workload management. Considerable administrative assistance is also required for council initiatives, such as the development of guidelines for the profession in various key areas of practice or ethics: *Biotechnology Revisited, Sexual Abuse in the Doctor-Patient Relationship,* and follow-up of *Strategies for Action on the Misuse of Addictive Prescription Drugs,* launched in 1991. The occasional help of medical school administrative officers and Dr Briant's practice secretary has been valuable.

In view of the council's aim to act positively to enhance the quality of medical practice, other projects of this type will be launched in future, particularly in relation to the new Medical Practitioners Act. A projects officer has been appointed to manage these activities, and the talents of our public relations executive will increasingly be drawn upon. The appointment of a tribunals officer to provide administrative support for the council in its disciplinary mode has proven very worthwhile. This appointment is on a contract basis, until April 1993 at this stage, so that any changes brought about by new legislation can readily be accommodated.

## The profession

Most individual customers in the profession have infrequent contact with the secretariat. However, in the past year staff have been involved in about 24000 computer transactions, correspondence (15000 inwards and 32000 outwards) and phone calls, the latter too numerous to count! Every effort is made to respond promptly and accurately.

Once again I remind all doctors on the register to keep addresses up to date and to have a current APC if practising within the terms of council policy (see box). Government funders are monitoring the

### COUNCIL POLICY

*on the requirement for issue of annual practising certificate (including payment of discipline levy) is:*

1. A current APC must be held by all registered medical practitioners who
   (a) sign any certificates;
   (b) prescribe, treat or give advice (in a one to one relationship) in a medical capacity.
2. Teaching and/or research which does not involve any of the above activities is exempt.
3. Within the terms of Section 67(5) of the Medical Practitioners Act 1968, exemption is also granted to:
   (a) any person rendering medical or surgical aid to any person in an emergency;
   (b) any person holding a provisional certificate or certificate of temporary or probationary registration.

There is no provision for deferred payment of the fees nor for special arrangements for those practising less than full time.

registers much more closely in this competitive output oriented environment and privileges are being withdrawn (and refunds demanded) if doctors claim benefits while unregistered. Unregistered practice is not only illegal but now expensive - please take steps to ensure you are not in this group. We have recently begun publishing in the New Zealand Medical Journal a list of the names of those about to be removed from the Medical Register (because they have failed to notify an address at which they can be reached) - we hope that this will reinforce for practitioners the need to keep their file with the council up to date at all times.

If practitioners have any queries about registration (including the rules for overseas trained doctors), education requirements, impaired, incompetent or unprofessional practice, conflicts between doctors, ethical dilemmas or other concerns, secretariat staff and council members are very willing to answer them or seek solutions through other channels.

## The public

Regrettably the customer group I label "the public" frequently only sees the council in a negative way when complaints and disciplinary matters are in the headlines. Changes have been made to render the statutory requirements as user friendly as possible but by their very nature they are currently rather restrictive, and certainly formal, and therefore daunting. Council's recent positive initiatives are very much in the public interest, and better handling of communications when major enquiries have been concluded are slowly breaking down the perception of

Table 6 **WORKLOAD INDICATORS**

| | Year ended 30 June 1991 | Year ended 30 June 1992 |
|---|---|---|
| **Provisional Certificates:** | 703 | 590 |
| **Conditional Registration** | 279 | 243 |
| NZ graduates | 271 | 241 |
| OS graduates | 8 | 2 |
| **Full Registration** | | |
| OS graduates | 370 | 298 |
| **Restorations** | | |
| NZ graduates | 25 | 23 |
| OS graduates | 29 | 22 |
| **Temporary Certificates:** | | |
| New certificates | 101 | 106 |
| Extensions | 273 | 315 |
| **Probationary Certificates:** | | |
| New certificates | 38 | 64 |
| Extensions | 14 | 7 |
| **Conditional to Full Registration** | 271 | 248 |
| **Probationary to Full Registration** | 37 | 35 |
| **Additions to Specialist Register** | 136 | 154 |
| **Additions to Indicative (GP) Register** | 30 | 15 |
| **Modifications to NZ Medical Register:** | | |
| Changes of address | 2734 | 2823 |
| Changes of name | 19 | 22 |
| Additional qualifications | 428 | 356 |
| Suspensions or variations | 9 | 6 |
| **Removals:** | | |
| Deaths | 35 | 49 |
| Discipline | 2 | 2 |
| Failure to notify address | 118 | 162 |
| Non-resident overseas graduates | - | 233 |
| At own request | 43 | 53 |
| **Annual Practising Certificates** | 7015 | 7170 |
| **Certificates of Good Standing** | 443 | 550 |
| **Certificates of Registration** | 156 | 108 |
| **Receipts Issued (excl APCs)** | 2900 | 2639 |
| **Total Computer Transactions** | 17461 | 23395 |

council as merely a self-interested protector of the profession. Its statutory role is quite the opposite, although in the long run the interest of the public can only be served by a profession with the highest possible standards.

Perhaps because of the higher profile of the council in the last year, consumers are now turning to the secretariat for advice on a variety of issues, such as patient records, after hours and emergency care, notification of possibly impaired or incompetent doctors, concerns about some aspects of the practice of medicine (for example, the management of psychiatric illness) and, as a last resort, when longstanding unresolved grievances with other institutions in the health sector have driven them almost to wits' end. A Health Commissioner would obviously have an important place in handling such problems.

## Personnel and premises

I attempt to accommodate new demands without always requiring additional resources. Over the last twelve months every member of the secretariat has been asked to produce more without sacrificing quality and I am very pleased to say that this has been achieved in an excellent atmosphere of cooperation and dedication.

To enhance the quality of service by the secretariat on present workload and prepare for the transition to, and implementation of, new requirements and procedures in the new Medical Practitioners Act, training has been increased and total quality management principles are to be introduced. To this end we are attempting to measure performance on a number of parameters and have the benefit of access to a self assessment instrument for medical boards developed over two years by the Federation of State Medical Boards of the United States of America. Regular meeting and sharing of problems and solutions with the registration boards in Australia, and written communication with comparable bodies in the UK and Canada after earlier personal visits which established contacts, are invaluable in the lifelong process of continuous improvement. Cross-fertilisation with the Dental Council, for which the secretariat also work, is another catalyst for change and development in the best interests of all parties.

The complex and exacting task of secretary to the Medical Council would be quite impossible to execute without the full cooperation of staff, council members and others with whom we must interact. Such cooperation and support is given at all times, for which I am very grateful, and together I believe a good job is being done even within some constraints which are beyond our control. Your contribution is important too.

*Georgina Jones*
SECRETARY

# REPORT OF THE MEDICAL PRACTITIONERS DATA COMMITTEE

The 1991 statistics complete twenty years of annual workforce surveys issued by the Medical Council (and processed at the University of Otago) in association with the renewal of annual practising certificates.

Information is available from two sources:

- the NZ Medical Register
- workforce survey information.

Lists of practitioners names, derived from information contained in the medical register, are readily available. For example, the names of those who hold a current practising certificate and with a current New Zealand address in the register, are easily obtainable. A fee is charged for this service.

Workforce survey information is handled differently, in that groups wanting to send material to practitioners engaged in, say primary care, must forward their material to the University of Otago where it is addressed and distributed. However, the identity of those who receive the material is not released to the groups making the mailout requests. A fee is also charged for this service.

There is an increasing number of requests from professional bodies and individual researchers who require access to medical workforce data. They may require statistics from the most recent survey, or comparable statistics from several surveys. The Department of Health publication, *New Zealand Medical Workforce Statistics 1987 and 1988,* became available in June 1990. The department published a few statistics from the 1990 survey in *The New Zealand Health Workforce 1990,* which became available in December 1991.

## 1991 Medical Workforce Survey

Around 8400 questionnaires were sent to conditionally or fully registered doctors with a registered New Zealand address. This survey counted 6570 doctors as 'active' in medically-related work in New Zealand as at June 1991, and working 6111 full time equivalents. A practitioner fully employed is counted as 1.0 full time equivalent, and those working less than full time have their full time equivalents calculated based on 4 hours being 0.1 full time equivalent. Doctors with temporary or probationary registration are not included in the workforce and do not appear in these statistics.

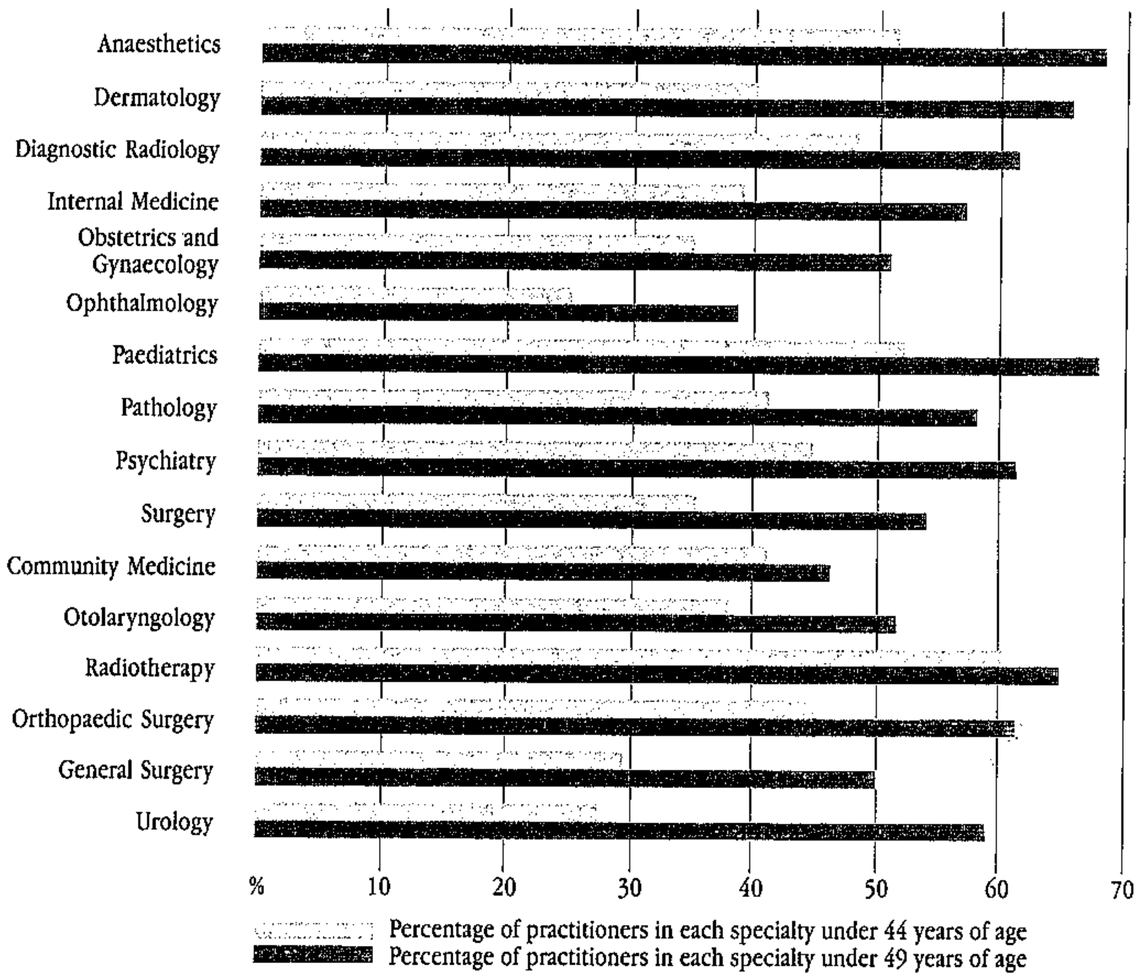
Each active practitioner is grouped into one of the seven categories indicated in table 7, based on the type of medical employment at the main work location. The figures in table 7 indicate the number of active practitioners working mainly in each of the seven groups. Some practitioners also undertake work in a category other than that which is indicated here. For example, a general practitioner who also has a part time MOSS appointment is included in the general practitioner count if the hours worked as a GP are greater than those worked for the MOSS appointment. For each of these categories, the count of those doing some medical work in a particular category would be higher than indicated in table 7.

The 1991 active workforce is an increase of 3.6 percent on the 1990 count and 14.3 percent since 1986. The number of active New Zealand graduates has increased by 10.3 percent since 1986. Overseas graduates account for 29.7 percent of the 1991 workforce, compared to

Table 7 **NEW ZEALAND MEDICAL WORKFORCE 1991**

| | 1987 | | 1988 | | 1989 | | 1990 | | 1991 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Total | NZ Graduates | Total | NZ Graduates | Total | NZ Graduates | Total | NZ Graduates | Total | NZ Graduates |
| Active | 6095 | 4302 | 6174 | 4326 | 6286 | 4434 | 6339 | 4480 | 6570 | 4621 |
| Full Time Equivalents | 5620.0 | 3986.5 | 5692.5 | 4000.0 | 5763.9 | 4070.4 | 5863.3 | 4151.6 | 6111.4 | 4303.8 |
| House Officers | 731 | 539 | 728 | 525 | 719 | 533 | 679 | 538 | 698 | 562 |
| Registrars | 780 | 626 | 771 | 620 | 765 | 616 | 799 | 627 | 823 | 618 |
| Medical Officers Special Scale | 167 | 74 | 180 | 87 | 176 | 93 | 173 | 87 | 181 | 89 |
| General Practitioners | 2278 | 1601 | 2293 | 1608 | 2383 | 1681 | 2429 | 1705 | 2549 | 1779 |
| Other Primary Medical Care | 125 | 85 | 124 | 81 | 139 | 92 | 165 | 101 | 152 | 97 |
| Specialists | 1897 | 1306 | 1953 | 1338 | 1957 | 1326 | 1952 | 1325 | 2021 | 1376 |
| Miscellaneous (non specialist) | 117 | 71 | 125 | 67 | 147 | 93 | 142 | 97 | 146 | 100 |

**Table 8** **AGE DISTRIBUTION OF SPECIALIST WORKFORCE 1991**




27.1 percent in 1986. The 1991 specialist workforce count of 2021 is an increase of 3.5 percent compared with 1990, and 11.1 percent since 1986. The general practitioner count is an increase of 4.9 percent on the 1990 count, and 19.1 percent increase since 1986. House officer numbers show a small increase on 1990 after small decreases each year since 1987. Registrar numbers have continued to increase.

1234 of the 6570 active doctors were in the 30-34 year age group, compared with 379 in the 55-59 year age group, and 1244 over 54 years of age. Analysis of the age distribution of the specialist workforce by main specialties shows considerable differences between specialties (see table 8). Some specialties have a high proportion of doctors in the younger age group than in the older age groups. This may be desirable in a 'short-age' discipline. Alternatively it could be of concern if there is an imbalance, with a greater number of younger specialists coming through than are required to replace retiring doctors.

The number of women doctors in the active workforce increased by 120 since 1990 to 1636, whereas the number of men increased by 111 in the same period. 45.4 percent of the house officers in 1991 are women. The increased proportion of women medical graduates during the last decade is being reflected in the increased numbers entering various disciplines.

## 1992 Medical Workforce Survey

Almost 8500 questionnaires have been issued – approximately 100 more than for the corresponding period in 1991.

The 1992 questionnaire was designed with the assistance of the Department of Health to satisfy their requirements for 1992 medical workforce statistics. Consequently, some of the statistics derived from the council's medical workforce surveys before 1992 will not be available from the 1992 questionnaire.

*J G Mortimer*
CHAIR

**Table 9** **NEW ZEALAND MEDICAL REGISTRATION INFORMATION**
**at 30 June 1992**

| | |
|---|---|
| Total practitioners on register | 10331 |
| Total practitioners with practising certificates | 7170 |
| Temporary registrants | 184 |
| New probationary registrants | 64 |
| Names removed from register (various) | 450 |
| Practitioners deceased | 49 |

# REPORT OF THE REGISTRATION COMMITTEE

This is a hard working committee which meets monthly to discuss, often in great depth, individual cases and applications for registration in New Zealand including those from our own graduates here and abroad, as well as overseas trained doctors.

The examination of the credentials of doctors wishing to practise here is a major part of the council's work of assuring the New Zealand public of the quality of those entering medical practice. The council, and in particular its Registration Committee, has only that function – it has no remit to take workforce predictions or requirements into account. Furthermore, it has no remit to cultivate the xenophobia that would allow New Zealand graduates favourable consideration ahead of overseas graduates. Its only task is to ensure that those who do wish to practise in New Zealand have achieved a sufficiently high standard to do so.

On the other hand, young overseas trained doctors aspiring to practise here should not be favoured over our own graduates. Whereas New Zealand graduates must pass clinical and theoretical examinations before conditional registration; overseas graduates (at present) need only pass theoretical examinations without any clinical component, and may then begin as temporary registrants in supervised positions. When they have gained sufficient clinical experience in New Zealand they then sit the clinical examinations and undergo a probationary year, before becoming registered here.

Furthermore, there is a perception that while we regard sensitivity to New Zealand cultural matters as essential in our own graduates, no such requirement is demanded of overseas trained doctors.

There is a very small group of temporarily registered doctors who come here as sponsored trainees, generally from Third World countries and as part of an overseas aid programme and only for short periods. This group has not been required to sit the NZREX examinations – not because the exam is judged to be too difficult for them, but because they are here for specific postgraduate training in specific disciplines for short periods, and are often bound to return to their own countries.

Others who have recognised specialist qualifications (including such qualifications in general practice), and who have evidence of an ability to speak English well, may be exempt the NZREX examinations on the basis that they have already passed an equivalent or more exacting examination.

Policy and procedures for assessing overseas trained doctors are continuously reviewed and changes are made when appropriate. The eventual arrival of a new Medical Practitioners Act will no doubt bring further adjustments.

The council has to work within the Medical Practitioners Act in addressing these issues, though it is permitted some flexibility in its registration procedures in order to adapt to changing employment conditions. Its task is to assure New Zealanders of the highest standards of medical care. To this end it will ensure that overseas trained doctors of high calibre will continue to compete for practice positions in New Zealand, and will continue to bring injections of overseas knowledge and culture, to the advantage of our society.

*I M St George*
CONVENER

**Table 10**

**NEW REGISTRANTS IN VOCATIONAL DISCIPLINES**
**1 July 1991 to 30 June 1992**

| | New Zealand | | Overseas | | |
|---|---|---|---|---|---|
| | Men | Women | Men | Women | Total |
| Anaesthetics | 8 | 3 | 7 | 0 | 18 |
| Community Medicine | 4 | 4 | 2 | 1 | 11 |
| Dermatology | 0 | 0 | 1 | 0 | 1 |
| Diagnostic Radiology | 3 | 1 | 2 | 1 | 7 |
| General Practice | 7 | 0 | 4 | 4 | 15 |
| Gynaecology | 0 | 0 | 0 | 0 | 0 |
| Internal Medicine | 17 | 2 | 15 | 1 | 35 |
| Obstetrics | 0 | 0 | 0 | 0 | 0 |
| Obstetrics & Gynaecology | 1 | 0 | 4 | 3 | 8 |
| Ophthalmology | 5 | 0 | 1 | 0 | 6 |
| Orthopaedic Surgery | 8 | 0 | 1 | 0 | 9 |
| Otolaryngology | 2 | 0 | 1 | 0 | 3 |
| Paediatrics | 8 | 1 | 5 | 0 | 14 |
| Pathology | 3 | 1 | 3 | 1 | 8 |
| Psychiatry | 5 | 2 | 13 | 0 | 20 |
| Radiotherapy | 0 | 0 | 2 | 0 | 2 |
| Cardiothoracic Surgery | 1 | 0 | 1 | 0 | 2 |
| General Surgery | 7 | 0 | 4 | 0 | 11 |
| Neurosurgery | 0 | 0 | 0 | 0 | 0 |
| Paediatric Surgery | 0 | 0 | 0 | 0 | 0 |
| Plastic Surgery | 0 | 0 | 0 | 0 | 0 |
| Urology | 0 | 0 | 1 | 0 | 1 |
| Venereology | 0 | 0 | 0 | 0 | 0 |
| Total | 79 | 14 | 67 | 11 | 171 |



# REPORT OF THE SPECIALIST REGISTRATION SUBCOMMITTEE

As at 30 June 1992 there were 2477 practitioners on the New Zealand Register of Specialists (this figure includes 54 with dual specialist registration).

Although there has been a continuing flow of applications from New Zealand graduates, there does seem to have been a diminution in the number of applications from overseas trained doctors, particularly from countries whose basic qualifications are not recognised in New Zealand. This may well stem from the difficulty of obtaining full registration: either by taking the New Zealand Registration Examination, or by being declared specialist eligible by virtue of acceptable higher qualifications.

As indicated in the last annual report, a mechanism has been developed for the clinical assessment of overseas trained specialist doctors whose higher qualifications do not quite meet the criteria laid down. This has been developed in association with the colleges as the council's referral bodies. Several doctors in different parts of New Zealand are presently undertaking such a programme of assessment, and this new development will ensure that there is flexibility in the system for recognising overseas specialist qualifi-

Table 11

**NEW ZEALAND REGISTER OF SPECIALISTS**
at 30 June 1992

| | Added | Removed | On Register |
|---|---|---|---|
| Anaesthetics | 18 | 4 | 275 |
| Community Medicine | 11 | 3 | 155 |
| Dermatology | 1 | 1 | 41 |
| Diagnostic Radiology | 7 | 7 | 151 |
| Gynaecology | 0 | 0 | 1 |
| Internal Medicine | 35 | 9 | 453 |
| Obstetrics | 0 | 0 | 1 |
| Obstetrics & Gynaecology | 8 | 2 | 188 |
| Ophthalmology | 6 | 2 | 95 |
| Orthopaedic Surgery | 9 | 4 | 129 |
| Otolaryngology | 3 | 1 | 70 |
| Paediatrics | 14 | 3 | 144 |
| Pathology | 8 | 1 | 158 |
| Psychiatry | 20 | 8 | 238 |
| Radiotherapy | 2 | 0 | 31 |
| Cardiothoracic Surgery | 2 | 0 | 23 |
| General Surgery | 11 | 7 | 228 |
| Neurosurgery | 0 | 0 | 14 |
| Paediatric Surgery | 0 | 0 | 4 |
| Plastic Surgery | 0 | 0 | 27 |
| Urology | 1 | 0 | 34 |
| Venereology | 0 | 1 | 17 |
| **Total** | **156** | **53** | **2477** |

Three new disciplines have been approved, in principle, for inclusion in the list of specialties on the Specialist Register. These are Emergency Medicine, Occupational Medicine and Rehabilitation Medicine. This follows submission of information on education prescriptions, the establishment of appropriate training programmes, examination requirements and mechanisms by which advice can be given to the council. When requirements are finalised council will apply for these disciplines (and their appropriate qualifications) to be gazetted. These new sections of the Register of Specialists will then be opened for application by appropriately qualified practitioners. The recognition of venereology as an independent specialty is on hold while the new Australasian College of Venereologists reaches the point where its qualification can be accepted as equivalent to other recognised specialist qualifications. When this point is reached this section of the register will also be reopened for application by appropriately qualified practitioners.

*C H Maclaurin*
CONVENER

cations, if people measure up to the local assessment of competence in their particular fields. The criteria to be applied were finalised in December 1991, but it will be another twelve months or so before sufficient experience has accumulated to indicate the success, or otherwise, of this new development.



# REPORT OF THE INDICATIVE REGISTER (GENERAL PRACTICE) SUBCOMMITTEE

The majority of suitably qualified practitioners are now on the Indicative Register. New applications are limited to doctors who have obtained membership of the Royal New Zealand College of General Practitioners, have been five years qualified and have been at least three years in general practice; or to overseas doctors coming to work in general practice in New Zealand who have membership of another approved academic College of General Practice overseas, with equivalent training and entry criteria.

With changes in the health services, and the expected arrival of a new Medical Practitioners Act, it is advisable that all doctors who qualify under the above criteria have their names placed on the register. It is possible that in future purchasing agencies may refer to the register when considering proposals from intending providers of primary care.

A few applications are still being received from practitioners who have passed Part I only of the RNZCGP examination. This is not a sufficient qualification as the criteria demand membership of the college.

Another misapprehension is that entry to the Indicative Register, under the initial entry prior to April 1990, entitles the doctor to use the qualification MRNZCGP. This is not so, unless the appropriate requirements for membership of the college have been met.

Reasons for applications being declined in the past year have been:

- lack of evidence of training for general practice
- insufficient experience on general practice
- applications from doctors who are not at present working in general practice
- applications from doctors who are working overseas
- applications from doctors who are not confining their practice to general practice.

Table 12

**GEOGRAPHIC DISTRIBUTION OF DOCTORS WITH APC ON INDICATIVE REGISTER (GENERAL PRACTICE)**
at 30 June 1992

| North Island | | % |
|---|---|---|
| Whangarei | 49 | 4 |
| Auckland | 415 | 32 |
| Hamilton | 90 | 7 |
| Thames | 12 | 0.8 |
| Tauranga | 65 | 5 |
| Rotorua | 22 | 2 |
| Gisborne | 14 | 1 |
| Napier/Hastings | 50 | 4 |
| New Plymouth | 36 | 3 |
| Wanganui | 15 | 1 |
| Palmerston North | 60 | 5 |
| Masterton | 10 | 0.7 |
| Wellington | 153 | 12 |
| **South Island** | | |
| Nelson | 25 | 2 |
| Blenheim | 16 | 1 |
| Westport | 2 | 0.1 |
| Greymouth | 4 | 0.3 |
| Christchurch | 148 | 11 |
| Timaru | 11 | 0.8 |
| Oamaru | 4 | 0.3 |
| Dunedin | 68 | 5 |
| Invercargill | 24 | 2 |
| TOTAL NORTH ISLAND | 991 | 77 |
| TOTAL SOUTH ISLAND | 302 | 23 |
| **Total** | **1293** | **100** |

All correspondence concerning the Indicative Register should be directed to:
**The Convener**
**Indicative Register (General Practice) Subcommittee**
**Medical Council of New Zealand**
**PO Box 9249 Courtenay Place**
**Wellington**

and not to the Royal New Zealand College of General Practitioners.

There are at present 1362 doctors on the register.

*M M Herbert*
CONVENER

# REPORT OF THE COMMUNICATIONS COMMITTEE

Following the appointment during the year of an executive officer with public relations skills, the committee was able to re-define the role of external public relations consultants. These now concentrate on 'crisis management' of specific individual projects, and media training. The staff member has responsibility for on-going public relations advice, and for the production of the council's newsletter, *MCNewZ,* which helps the medical profession gain greater knowledge of the role and work of the council. Feedback from the profession has been valued.

The Communications Committee remains concerned about both the public and the profession's perceptions of council, and recognises that more needs to be done to improve understanding. It is hoped the staff member's public relations role can be expanded in the coming year.

In the meantime, a two-way communication is developing between members of the profession and council, through the *MCNewZ* newsletter. For about $2.50 a year every practitioner in New Zealand receives council's news and the views of fellow practitioners. A small number are sent to interested parties, including members of parliament and the media.

Feedback to date suggests that the newsletter is providing a valuable service. However, we recognise the need to monitor response and to seek out opinions, suggestions and ideas. Therefore, a simple survey will be carried out in the near future. Then we shall assess, review, and make any changes needed.

The committee believes there is a growing need for the concerns of the profession, and the council's role, to be acknowledged as promised health reforms are implemented. No doubt problems will emerge, but the committee is confident the council will be able to respond swiftly and appropriately.

*J A Treadwell*
CONVENER



# REPORT OF THE FINANCE AND MANAGEMENT COMMITTEE

This report covers the period 1 July 1991 to 30 June 1992, although the financial statements included with it cover the financial year 1 April 1991 to 31 March 1992.

## Taxation

Council has paid provisional tax for the year under review. On advice from our taxation consultants an appeal to the Taxation Review Authority has been lodged and, in addition, application has been made for the Medical Council to be declared a charitable organisation under the appropriate section of the taxation legislation. There also remains a possibility that specific legislative provision declaring the council tax exempt may be forthcoming. In the meantime tax has been paid and no arrears have been incurred.

## General council operations

Income for the year is reduced overall. This results from a reduction in registration fee payments and from a lower interest income from funds held on deposit. No adjustment was permitted in registration fees for the year under review. In particular, a fee to cover the shift from conditional to full registration was declined. This fee would have matched increased costs in the supervision of conditionally registered graduates. It is also possible that a number of graduates from New Zealand schools are finding it necessary or desirable to do their conditional year elsewhere and not all of these return to the New Zealand register.

Appropriate administration fees have been charged for services rendered to the Dental Council and to the Discipline and Examination Funds. The increase in administration expenses overall has generally been within the budget and is less than eight percent. Attention is drawn to increased expenditure in public affairs, which includes both training of staff and members called upon to make public statements, and advice as required from public relations consultants.

A special project on Biotechnology was commissioned from the Bioethics Research Centre at Otago University.

Staff salaries have been reviewed following an evaluation by consultants. Their report has provided a framework against which staff responsibilities can be matched with levels available in the market place. Previously council had relied on the scales for the universities, however, these are no longer entirely suitable. The cost of this evaluation exercise is reflected in the expenditure of the Finance and Management Committee.

Additional expenditure has been involved in maintaining contact with the Australian Medical Council. Elsewhere the important changes have been referred to but these have had costs in time and travel.

The educational expenses of the MEC have risen, largely due to the expansion of the intern supervisor contract system, and will increase still further if the postgraduate deans are involved. As noted above, a separate fee proposal was declined by the Minister last year but this application will be renewed for next year. The Education Fund reserve is being built up with the prospect of further accredita-

tion visits within the next year or so. This may well be in association with the Australian Medical Council but will still require funding on our part.

## Discipline fund

At long last the Discipline Fund shows a surplus of income over expenditure. There is, therefore, a small reserve for the first time in several years. This is due, at least in part, to the fact that some hearings expected to be expensive have been delayed by appeals. The costs of implementing the mentoring system as part of the supervision of doctors with health or discipline problems is likely to increase. Steps are being taken to establish some degree of 'user-pays' for this system.

As part of its wish to provide guidelines, the council held workshops on the misuse of prescription drugs, and this lead to the publication of a statement. Such projects are likely to continue on appropriate topics.

## Examination fund

The Examination Fund shows a small overall deficit. This arises from problems in estimating costs when the number of candidates is diminishing. The fees for 1993 examinations will be carefully examined. A contemplated change in the examination format will also lead to a review of the fee levels. There is no intention that this process should be other than self-supporting.

## General

The accounts and financial statements, the accompanying notes and this report of the Finance and Management Committee, convey an accurate account of the financial affairs of the council. If any further explanations are needed the committee would be pleased to provide these in a future edition of *MCNewZ*.

*W S Alexander*
CHAIR



# AUDITOR'S REPORT

## Miller, Dean & Little

CHARTERED ACCOUNTANTS
WELLINGTON

AUDITORS' REPORT TO THE MEMBERS OF

MEDICAL COUNCIL OF NEW ZEALAND

We have examined the books and vouchers of the Council in accordance with generally accepted auditing standards and practices and have obtained all the information and explanations that we have required. In our opinion proper accounting records have been kept by the Council so far as appears from our examination of those records.

As stated in Note 2 to the Financial Accounts the Council has been deemed liable for taxation. This decision is being appealed but in the interim provision has been made for normal taxation as from 1989. No provision has been made for additional taxation for late payment.

Subject to the above, in our opinion and according to the information and explanations given to us and as shown by the said records, the financial statements are properly drawn up so as to give a true and fair view of the financial position of the Council as at 31 March 1992 and the results of its activities for the year ended on that date.

Miller Dean & Little

Chartered Accountants

WELLINGTON
1 September 1992

# NOTES TO ACCOUNTS

## 1. Statement of Accounting Policies

**General Accounting Policies**
The measurement base adopted is that of historical cost. Reliance is placed on the fact that the council is a going concern. Accrual accounting is used to match expenses and revenues.

**Particular Accounting Policies**
The following is a summary of the significant accounting policies adopted by the council in the preparation of the accounts.

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

| | |
|---|---|
| Furniture and Fittings | 10%pa |
| Office Equipment | 20%pa |
| Office Alterations | 10%pa |

(b) **Tax** - The income tax charged to the profit and loss account includes current and deferred tax calculated at the current rate applicable to companies. Deferred taxation, calculated using the liability method, is accounted for in respect of those timing differences to reverse in the foreseeable future.

(c) **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 except for the accrual of recoveries received immediately after balance date.

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

**Changes in Accounting Policies**
There have been no material changes in accounting policies which have been applied on a basis consistent with previous years.

## 2. Taxation

The Inland Revenue Department have deemed the council liable for taxation. However, this decision is being appealed. Provision has been made in the accounts for taxation. No provision has been made for additional taxation for late payment.

## 3. Debtors

The debtors figure includes $71,820 outstanding refund of GST and $38,000 outstanding contribution to workforce survey.



## 4. Investments

| | 1992 | 1991 |
|---|---|---|
| (a) **General Fund** | | |
| BNZ Finance Call Account | 106,225 | 102,045 |
| National Bank Call Account | 4,576 | 16,742 |
| Equiticorp Finance Limited (in Statutory Management) | 26,077 | 34,977 |
| ANZ Call Account | 24,400 | 178,419 |
| Westpac Call Account | 31,207 | 14,237 |
| | $192,515 | $346,420 |
| (b) **Discipline Fund** | | |
| ANZ Call Account | 164,247 | 1,192 |
| National Bank Call Account | 80,301 | 961 |
| BNZ Finance Call Account | 161,618 | - |
| Westpac Call Account | 79,429 | - |
| | $485,595 | $ 2,153 |
| (c) **Examination Fund** | | |
| ANZ Call Account | 89,566 | 115,671 |
| **Total Investments** | $767,676 | $464,244 |

The interest accrued on the investment in Equiticorp Finance Limited first ranking debenture stock is not shown in the accounts due to the uncertainty of its realisation. In view of correspondence from the statutory manager it is anticipated that not more than 85 percent of the original capital will be realised.

## 5. Fixed Assets

| | Cost 31/3/92 | B/V 1/4/91 | Depn For Year | B/V 31/3/92 | Acc Depn 31/3/92 |
|---|---|---|---|---|---|
| Air Conditioning | 36,704 | 23,736 | 3,630 | 20,906 | 15,798 |
| Computer | 175,193 | 81,716 | 32,804 | 70,904 | 104,289 |
| Furniture and Fittings | 112,782 | 67,347 | 11,147 | 61,800 | 50,982 |
| Office Alterations | 157,364 | 82,266 | 15,736 | 66,530 | 90,834 |
| Office Equipment | 38,635 | 15,092 | 3,278 | 24,737 | 13,898 |
| | $520,678 | $270,157 | $66,595 | $244,877 | $275,801 |

## 6. New Zealand Registration Examinations

A separate revenue statement for the examination fund has been prepared for the first time this year. The comparative figures in the general fund for the prior year have been amended accordingly.

MEDICAL COUNCIL OF NEW ZEALAND

# BALANCE SHEET

as at 31 March 1992

| CURRENT ASSETS | 1992 | 1991 |
|---|---|---|
| Petty Cash | 310 | 310 |
| General Fund Cheque Account at ANZ Bank | 32,451 | 26,600 |
| Discipline Fund Cheque Account at BNZ | 32,921 | (4,131) |
| Discipline Fund Cheque Account #2 at BNZ | 2,030 | 393 |
| Examination Fund Cheque Account at ANZ Bank | 8,992 | 258 |
| Payments in Advance and Sundry Debtors (Note 3) | 124,623 | 155,597 |
| Interest Accrued | 5,941 | 5,893 |
| | $207,268 | $184,920 |
| INVESTMENTS (Note 4) | 767,676 | 464,244 |
| FIXED ASSETS(Note 5) | 244,877 | 270,157 |
| TOTAL ASSETS | $1,219,821 | $919,321 |
| **CURRENT LIABILITIES** | | |
| Sundry Creditors | | |
| - General Fund | 107,836 | 97,657 |
| - Discipline Fund | 250,599 | 221,171 |
| - NZREX | 63,699 | 68,348 |
| Payments Received in Advance | 61,019 | 78,584 |
| Provision for Taxation (Note 2) | 79,895 | 75,884 |
| **TOTAL CURRENT LIABILITIES** | $563,048 | $541,644 |
| TERM LIABILITIES | | |
| Provision for Deferred Taxation | 9,787 | 13,318 |
| **CAPITAL ACCOUNT** | | |
| Accumulated Capital | 413,062 | 382,843 |
| Discipline Fund | 115,916 | (123,597) |
| Education Fund | 125,000 | 100,000 |
| Examination Development Fund | (6,992) | 5,113 |
| | $646,986 | $364,359 |
| | $1,219,821 | $919,321 |

The accompanying notes on page 36 to 37 form part of these financial statements.



MEDICAL COUNCIL OF NEW ZEALAND

# GENERAL FUND REVENUE STATEMENT

for the year ended 31 March 1992

| FEES RECEIVED | | 1992 | 1991 |
|---|---|---|---|
| Annual Practising Certificate | | 712,210 | 682,860 |
| Certificate of Good Standing | | 12,978 | 11,953 |
| Medical Registration Certificate | | 2,814 | 3,580 |
| Change of Name | | 560 | 397 |
| Registration Fees - including conditional, temporary, probationary and restoration | | 145,998 | 177,770 |
| Specialist Registration Fee and General Practice Registration Fee | | 11,310 | 13,912 |
| INCOME FROM FEES | | $885,870 | $890,472 |
| **OTHER INCOME** | | | |
| Administration Fee - Dental Council | | 27,500 | 27,500 |
| Administration Fee - Discipline Fund | | 100,625 | 90,000 |
| Administration Fee - Examination Fund | | 13,000 | 13,990 |
| Interest Received | | 54,485 | 79,614 |
| Sales of Medical Registers and Register Information | | 45,590 | 34,071 |
| Sundry Income | | 810 | 407 |
| INCOME FROM OTHER SOURCES | | 241,910 | 245,582 |
| **TOTAL INCOME FOR YEAR** | | $1,127,780 | $1,136,054 |
| *Less* Expenses as per Schedule | | $1,045,364 | 969,316 |
| Net surplus for the Year Before Taxation | | 82,416 | 166,738 |
| *Less* Provision for Taxation | | 27,197 | 55,193 |
| Net Surplus for the Year After Taxation | | 55,219 | 111,545 |
| Accumulated Capital Brought Forward 31/3/91 | 382,843 | | 326,860 |
| *Less* Prior Year Adjustment | - | | 11,494 |
| | | 382,843 | 315,366 |
| | | 438,062 | 426,911 |
| *Less* Investment Written Off | | - | 5,000 |
| Transfer to Education Fund | | 25,000 | 50,000 |
| | | 413,062 | 55,000 |
| | | - | 371,911 |
| Plus Transfer from Examination Development Fund | | - | 10,932 |
| Accumulated Capital Carried Forward | | $413,062 | $382,843 |

The accompanying notes on pages 36 to 37 form part of these financial statements.

MEDICAL COUNCIL OF NEW ZEALAND

# GENERAL FUND SCHEDULE OF EXPENSES

for the year ended 31 March 1992

| ADMINISTRATION AND OPERATING EXPENSES | 1992 | 1991 |
|---|---|---|
| ACC Levies | 7,482 | 5,447 |
| Accounting and Audit Fee | 12,798 | 7,935 |
| Agents Registration Fees | 3,410 | 4,480 |
| Computer Consultancy | 5,872 | 8,675 |
| Cleaning | 3,127 | 3,380 |
| Courier | 4,136 | 6,946 |
| Depreciation | 66,595 | 60,384 |
| Electricity | 4,562 | 5,964 |
| Fringe Benefit Tax | 4,089 | 2,720 |
| General Expenses | 2,162 | 3,065 |
| Legal Expenses | 9,135 | 8,961 |
| Micro Film Files and Storage | 1,529 | 1,443 |
| Medical Workforce and Associated Expenses (Net after Government Contribution) | 19,946 | 17,497 |
| Overseas Travel - Secretary | 2,559 | 1,200 |
| Photocopying Expenses | 7,324 | 4,368 |
| Postage | 26,539 | 19,085 |
| Printing and Stationery | 71,973 | 90,656 |
| Projects - Biotechnology Revisited | 3,270 | - |
| Public Affairs | 31,223 | 13,456 |
| Rent and Insurance | 61,682 | 64,631 |
| Repairs and Maintenance | 2,053 | 5,993 |
| Salaries | 341,468 | 308,843 |
| Superannuation and Health Insurance | 16,759 | 16,225 |
| Staff Recruitment and Training | 500 | 4,609 |
| Telephone and Tolls | 15,789 | 13,943 |
| **TOTAL ADMINISTRATION AND OPERATING EXPENSES** | $725,982 | $679,906 |
| **COUNCIL AND COMMITTEE EXPENSES** | | |
| Council Expenses | | |
| - Chairperson's Overseas Travel | 3,271 | 500 |
| - Chairperson's Honoraria and Office Expenses | 62,211 | 56,148 |
| - Fees and Expenses | 147,818 | 160,144 |
| Registration Committee Fees and Expenses | 9,823 | 10,455 |
| Communications Committee Fees and Expenses | 4,062 | 3,318 |
| Data Committee Fees and Expenses | 2,924 | 1,521 |
| Finance & Management Committee Fees & Expenses | 13,243 | 6,707 |
| Informed Consent Working Party Fees & Expenses | - | 942 |
| Medical Education Committee | | |
| - Fees and Expenses | 15,773 | 20,103 |
| - Hospital Visits | 9,248 | 10,713 |
| Intern Supervisors Meeting Fees and Expenses | 6,107 | 511 |
| Intern Supervisors Contracts | 44,902 | 18,348 |
| **TOTAL COUNCIL AND COMMITTEE EXPENSES** | $319,382 | $289,410 |
| **TOTAL EXPENDITURE** | $1,045,364 | $969,316 |

The accompanying notes on pages 36 to 37 form part of these financial statements.



MEDICAL COUNCIL OF NEW ZEALAND

# REVENUE STATEMENT FOR DISCIPLINE FUND

for the year ended 31 March 1992

| | 1992 | 1991 |
|---|---|---|
| **REVENUE** | | |
| Levies Received | 1,991,156 | 1,917,395 |
| Interest Received | 86,128 | 88,159 |
| Recovery of Discipline Costs | 104,740 | 225,592 |
| **TOTAL REVENUE** | $2,182,025 | $2,231,146 |
| **ADMINISTRATION AND OPERATING EXPENSES** | | |
| ACC Levies | 2,290 | 2,723 |
| Accounting and Audit Fees | 3,900 | 2,600 |
| Administration Fees | 100,625 | 90,000 |
| Competence Inquiries | - | 26,787 |
| Doctors Health Advisory Service | 16,454 | 5,000 |
| Expert Witnesses and Medical Assessments | 29,876 | 149,638 |
| General Administration Expenses | 2,223 | 3,803 |
| Higher Court Actions | 95,203 | 48,326 |
| Hire of Rooms | 2,787 | 17,172 |
| Legal Expenses (Medical Council and Preliminary Proceedings Committee) | 504,628 | 834,351 |
| Medical Practitioners Disciplinary Committee | 733,708 | 624,625 |
| Mentoring Expenses | 8,378 | - |
| Projects - Misuse of Addictive Prescription Drugs | 19,552 | - |
| Stenographers Fees and Expenses | 23,102 | 64,046 |
| Telephone and Tolls | 8,258 | 8,117 |
| Tribunals Officer | 5,470 | - |
| **TOTAL ADMINISTRATIVE AND OPERATING EXPENSES** | 1,556,454 | 1,877,188 |
| **COUNCIL AND COMMITTEE EXPENSES** | | |
| Council Expenses (Discipline) | | |
| - Fees and Honorarium | 98,857 | 253,703 |
| - Expenses | 40,115 | 68,299 |
| Council Expenses (Health) | | |
| - Fees and Expenses | 23,941 | 8,521 |
| Preliminary Proceedings Committee (excluding legal member) | | |
| - Fees and Honoraria | 85,079 | 51,966 |
| - Travelling, Accommodation and Secretarial Expenses | 20,098 | 10,503 |
| **TOTAL COUNCIL AND COMMITTEE EXPENSES** | 268,090 | 392,992 |
| **TOTAL EXPENDITURE** | $1,824,544 | $2,270,180 |
| Net (Deficit) Surplus for the Year Before Taxation | 357,481 | (39,034) |
| Provision for Taxation | 117,968 | 12,881 |
| Net (Deficit) Surplus After Taxation | 239,513 | (26,153) |
| Accumulated (Deficit) Brought Forward 31/3/91 | (123,597) | (64,566) |
| Prior Year Adjustment | - | (32,878) |
| | - | (97,444) |
| **ACCUMULATED DISCIPLINE FUND CARRIED FORWARD** | $115,916 | $(123,597) |

The accompanying notes on pates 36 to 37 form part of these financial statements.

# NEW ZEALAND REGISTRATION EXAMINATION FUND REVENUE STATEMENT

for the year ended 31 March 1992

| REVENUE | 1992 | 1991 |
|---|---|---|
| NZREX Candidate Fees | 204,049 | 175,013 |
| Interest | 5,285 | 7,631 |
| **TOTAL REVENUE** | $209,334 | $182,644 |
| **ADMINISTRATION AND OPERATING EXPENSES** | | |
| Audit and Accountancy Fee | 1,000 | 1,000 |
| Centre Costs (NZ and Overseas) | 18,811 | 14,688 |
| Honoraria (Examinations Director and Administrative Secretary) | 29,000 | 27,500 |
| Examiners Fees and Expenses | 150,812 | 101,452 |
| General Administrative Expenses | 9,548 | 13,032 |
| Administration Fee | 13,000 | 13,990 |
| | 222,171 | 171,662 |
| **COMMITTEE EXPENSES** | | |
| Board of Examiners Fees and Expenses | 5,229 | 3,351 |
| | 5,229 | 3,351 |
| **TOTAL EXPENDITURE** | $227,400 | $175,013 |
| (Deficit)/Surplus for the Year Before Taxation | (18,066) | 7,631 |
| Tax benefit to be realised | 5,961 | (2,518) |
| (Deficit)/Surplus for the Year After Taxation | (12,105) | 5,113 |
| Accumulated Surplus Brought Forward 31/3/91 | 5,113 | - |
| **TOTAL EXAMINATION FUND – SURPLUS/(DEFICIT)** | ($6,992) | $5,113 |

The accompanying notes on pages 36 to 37 form part of these financial statements.



MEDICAL COUNCIL OF NEW ZEALAND

# STATEMENT OF CASHFLOW

for the year ended 31 March 1992

| **Cash Flow from Statutory Functions** | | 1992 | 1991 |
|---|---|---|---|
| Cash was provided from receipts pertaining to statutory functions and administration fee from Dental Council | 3,277,257 | | 3,300,299 |
| Cash was also distributed to payment for council fees and disbursement and secretarial expenses | (2,910,287) | | (3,247,133) |
| Payment of Tax | (138,724) | | - |
| | (3,049,011) | | (3,247,133) |
| Net Cash Flow from Statutory Functions | | 228,246 | 53,166 |
| **Cash Flow from Investing Activities** | | | |
| Cash was provided from Interest Received | 145,850 | | 169,511 |
| Cash was applied to Purchase of Assets | (17,390) | | (85,396) |
| Short Term Investments | (303,432) | | (151,697) |
| | (320,822) | | (237,093) |
| Net Cash Used in Investing Activities | | (174,972) | (67,582) |
| Net Increase (Decrease) in Cash Held | | 53,274 | (14,416) |
| Opening Cash Brought Forward | | 23,430 | 37,846 |
| **Ending Cash Carried Forward** | | $76,704 | $23,430 |

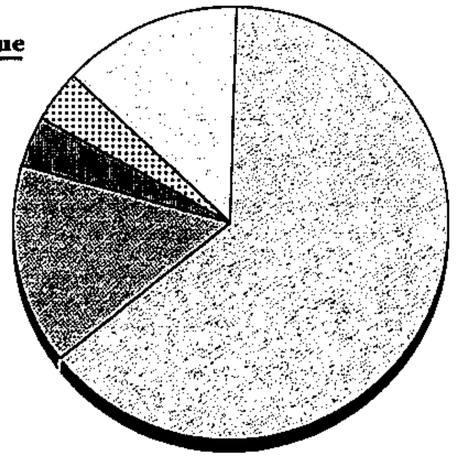
The accompanying notes on pages 36 to 37 form part of these financial statements.

# DISTRIBUTION OF COUNCIL REVENUE AND EXPENDITURE

for the year ended 31 March 1992

**GENERAL FUND** (34% of turnover)

**Revenue**



APC fees

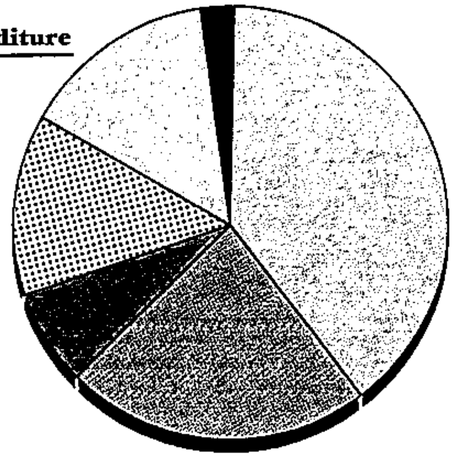
Registration and certificate fees

Interest

Sale of registers and register information

Secretariat fees from NZREX, Discipline and Dental Council

**Expenditure**



Staffing and ancillary professionals

Council and committee meetings

MEC activities, incl. hospital visits and intern supervisor honoraria

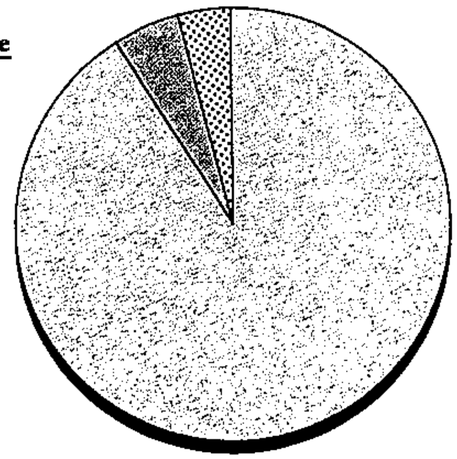
Rent, insurance, equipment, depreciation

Printing, postage, phone, fax, courier, media

APC and data collection (net) (Otago costs only)

**DISCIPLINE FUND** (66% of turnover)

**Revenue**

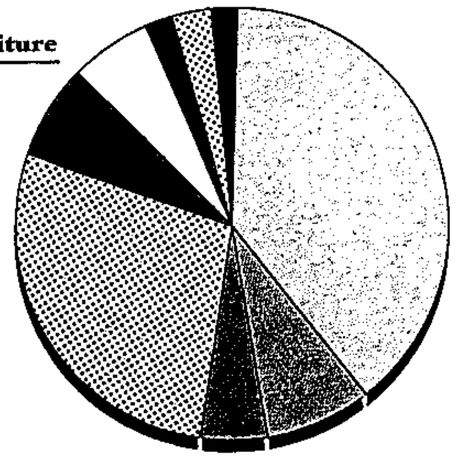


Discipline levies

Recovered costs

Interest

**Expenditure**



MPDC (hearings and secretariat)

Council hearings (fees and expenses) - discipline

Legal expenses (High Court actions)

Legal expenses (Council and PPC)

Council secretariat fees and administrative costs

PPC fees, honoraria and expenses (excl. legal)

Expert witnesses and medical reports

Council hearings (fees and expenses) - health; DHAS

Mentoring and prescribing projects

These graphics are to be read in conjunction with the detailed Financial Reports on pages 36 to 43.



# FEES

To be paid on application for medical council services
during council financial year
1 April 1992 to 31 March 1993

The following fees have been fixed by regulations under the Act:

| | | Fee | GST from 1/4/92 | Total to Pay from 1/4/92 |
|---|---|---|---|---|
| **REGISTRATION:** (Conditional or Full) | | | | |
| On deposit of evidence of qualifications | | 170.67 | 21.33 | 192.00 |
| For provisional certificate | | 26.67 | 3.33 | 30.00 |
| For annual practising certificate | | 92.00 | 11.50 | 103.50 |
| For discipline levy | (1) | 263.56 | 32.94 | 296.50 |
| | (2) | 112.45 | 14.05 | 126.50 |
| Total fees on registration | (1) | 552.90 | 69.10 | 622.00 |
| | (2) | 401.79 | 50.21 | 452.00 |
| **OTHER:** | | | | |
| For certificate of temporary registration | | 276.00 | 34.50 | 310.50 |
| For eligibility for probationary registration | | 95.11 | 11.89 | 107.00 |
| For certificate of probationary registration | | 95.11 | 11.89 | 107.00 |
| For *full registration (from probationary, including practising certificate) | | 435.56 | 54.44 | 490.00 |
| For annual practising certificate including discipline levy | (1) | 355.56 | 44.44 | 400.00 |
| | (2) | 204.45 | 25.55 | 230.00 |
| For *restoration of name to Register after removal therefrom (including provisional certificate) | | 512.90 | 64.10 | 577.00 |
| For initial entry on Specialist Register | | 50.00 | 6.25 | 56.25 |
| For entry on Specialist Register in a second or further speciality | | 10.00 | 2.50 | 12.50 |
| For initial entry on Indicative Register of General Practitioners | | 50 | 6.25 | 56.25 |
| For change of name or other entry in Register, excluding change of address or entry of additional qualifications (free) | | 26.67 | 3.33 | 30.00 |
| For Certificate of Good Standing | | 26.67 | 3.33 | 30.00 |
| For Certificate of Registration (or other document in connection with applications to register in another country) | | 26.67 | 3.33 | 30.00 |
| For any inspection of the Register | | 8.00 | 1.00 | 9.00 |

*includes Annual Practising Certificate and Discipline Levy to be paid at the time of this application

(1) Fee for persons registering for the first time between 1/04/92 and 30/10/92
(2) Fee for persons registering for the first time or applying for APC between 1/11/92 and 31/03/93

MEDICAL COUNCIL OF NEW ZEALAND