# MEDICAL COUNCIL
## OF NEW ZEALAND

# ANNUAL REPORT 1995

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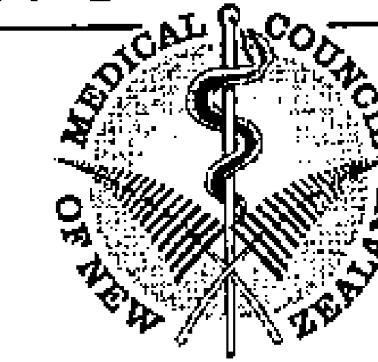
# ANNUAL REPORT

FOR YEAR ENDED 30 JUNE 1995





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## Members of the Medical Council

at 30 June 1995

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



## Secretariat

at 30 June 1995

| | |
|---|---|
| Secretary (Chief Executive) | Ms G A Jones, BA |
| Administrative Secretary | Ms J Hawken-Incledon |
| Coordinator Projects & Policy | Ms A Coleman, BA |
| Team Leader, Corporate Services | Mr J de Wever |
| Communications Officer | Ms M Keogh, BA, Cert Journ |
| Receptionist | Mrs D Kelly |
| Accounts Officer | Mrs C Wood (Part-time) |
| Team Support, Corporate Services | Ms D Overduin |
| Team Leader, Standards | Ms L Urquhart, BCA |
| Education Officer | Ms A Coleman, BA |
| Examinations Officer | Ms M Needham, BA |
| Tribunals Officer | Mrs S D'Ath, LLM (Part-time) |
| Team Support, Standards | Ms M Kilkelly |
| Team Leader, Registration | Mrs J Lui |
| Registration Officer | Ms D Crawley, BA |
| Registration Officer | Ms A Elliott |
| Registration Officer | Mrs D Elvy, MSc (Hon) |
| Team Support, Registration | Mrs K Thompson |

| | |
|---|---|
| Council Offices | Level 12, Mid City Tower, 139-143 Willis Street, Wellington |
| Postal Address | P O Box 11-649, Wellington |
| Telephone | (04) 384-7635 |
| Fax | (04) 385-8902 |
| Solicitors | Kensington Swan, P O Box 10-246, Wellington |
| Bankers | ANZ Banking Group (New Zealand) Limited, Courtenay Place Branch, Wellington |
| Auditors | Miller, Dean, Knight and Little, P O Box 11-253, Wellington |

# Medical Education Committee

at 30 June 1995

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



# Committees

June 1995

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

**Preliminary Proceedings Committee**
Dr C Maclaurin (Convener)
Dr C M Corkill
Mr P H Cook (Legal Member)

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

**Medical Practitioners Data Committee**
Dr R H Briant (Chair)
Dr C M Feek
Ms G A Jones
Mr G F Spears

**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

**Registration Committee**
Dr I M St George (Convener)
Dr C M Feek
Dr M M Herbert
Mrs P C Judd

**Specialist Registration Subcommittee**
Dr C M Feek (Convener)
Dr R H Briant

**Indicative Register Subcommittee**
Dr M M Herbert (Convener)
Dr C M Corkill

**Board of Examiners**

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

This is my last annual report to the profession after nearly five years in the Chair and a total of 10 years on the Medical Council as nominee of the College of Physicians. I have been honoured to serve the profession and the public in this way. The tasks have been challenging, seldom easy but never boring. I thank the Council members who have served over these years for supporting me, the Secretariat for shouldering its heavy workload and the profession for its dedication to high standards and public service.

**Medical Practitioners Bill 1994**

The work of the Medical Council in this past year has been dominated by the assessment of drafts of the Medical Practitioners Bill, culminating in the presentation of submissions to the Social Services Select Committee on the Bill that was introduced to Parliament in November 1994. This is the result of seven years of lobbying six Ministers of Health. It has involved writing submissions and reports, and responding to suggestions on all aspects of medical registration and the functions that flow from that. It is to be hoped that the Bill will become a Medical Practitioners Act before the end of the life of the present Parliament.

The major new provisions in the legislation are for the development of a Vocational Register and recertification of doctors on that Register, and permissive functions to allow the assessment of competence of doctors whose standards appear to be failing.

**Recertification**

The recertification provisions of the Bill aim to raise the standards of the whole profession. The Colleges have all been working to develop systems for recertification, and gradually those will interface with the mandatory requirements of the Bill. There are many practical issues to be resolved and a discussion paper on vocational registration has been circulated for professional input.

**Competence Assessments**

Under the current Act it has been almost impossible to act on evidence of failing competence of a doctor, except through the discipline system, which has never been a satisfactory method of reviewing whole practice. Councils of the future will have a legislative framework for assessment of practice standards and for remedies to be applied.The great challenge is to define methods of assessing competence, methods that are fair to the doctor, measure the right thing and are practical to undertake.

Whilst both the recertification and competence provisions of the legislation appear threatening to us as individuals, I am confident that the profession as a whole will rise to the challenge and the public and profession will benefit from it.

**Health and Disability Commissioner**

1994 saw the completion of the Health Commissioner legislation and the appointment of Mrs Robyn Stent to that position. At the time of writing this report, the Commissioner's proposed draft Health and Disability Services Code of Consumers' Rights has been circulated. The Code will form the basis for a new focus for the assessment of complaints against doctors.

As the Commissioner will receive all complaints against all health professionals, she will provide an independence to the investigation and determination of complaints, both in terms of seriousness and appropriate resolution. It is vital that the Health and Disability Commissioner Act and the Medical Practitioners Act and their operations are perfectly interfaced so that the system runs smoothly and swiftly in the interests of the public and the profession.

**Discipline Overview**

The present members of Council have been in office for anything from one to 10 years and have accumulated approximately 75 years of service and experience.

Over the decade, when I have been part of the Council, changes in society and the profession have been very great. The Council has moved substantially to meet those changes, trying to achieve a balance between the pressure to retain the status quo and the obvious need to move into issues. Professional sexual abuse is one such issue of the 90s, and one which Council has faced with commitment to action. The results of that work have been published through *MCNewZ*.

Recent years have been marked by increased media scrutiny of all doctors, health activities and Council decisions. The primary function of the Medical Council is the registration of doctors and assessment

**THE MEDICAL COUNCIL - JUNE 1995**

*From left to right:* Dr M M Herbert, Dr J A Treadwell, Dr R G Gudex, Dr C Feek, Dr R H Briant, Dr C H Maclaurin, Ms G A Jones (Secretary). *From left to right, seated:* Dr G F Lamb, Dr C M Corkill, Dr K J Thomson, Mrs P C Judd, Prof J G Mortimer. *Absent* Dr I M St George

and maintenance of standards. But the greatest external interest and the greatest professional anxiety are generated by the discipline process. It is a significant regret to me that the Council has not been able, because of slowness in the legislation change, to have discipline hearings in open court. Because of the privacy of hearings, there has been a great tendency for matters to be "reheard" by means of radio talkback or television "documentary", to the detriment of all parties.

I would like to be able to show the profession and the public that the various claims of unfairness or ill direction in the Medical Council or the MPDC are unfounded. All the hearings are under the direct control of a senior barrister as Legal Assessor whose duty is to ensure proper process and fairness. The Legal Assessor does not represent any party, does not participate in any decision making, and brings her/his expertise entirely to the procedural elements. The doctor and the complainant are separately represented. In Medical Council hearings the complainant is represented by lawyers briefed by the Preliminary Proceedings Committee in exactly the same way the Crown Prosecutor represents complainants in the criminal court.

Doctors have real and understandable anxieties about the increasing numbers of complaints filed against individuals and about the apparent arbitrariness of such filings. It is a feature of our systems, and one that the recertification provisions aim to redress, that complaints often correlate poorly with the overall competence and practice standards of the doctor complained about.

Doctors recognise that they must treat all their patients to a high professional standard, with courtesy and dignity. But doctors have bad days and, like the rest of the human race, make mistakes. Many complaints arise in such circumstances where rudeness or poor communication confound an otherwise relatively minor issue. Some doctors complain that the current system is one-sided, with no forum for them to take action against unreasonable or rude patients. That is the way the medical complaints system will continue. The onus is on the doctor at all times to be the trusted professional to do her best in the circumstances. Doctor's rights to make complaints arise when **they** are the consumers.

I accept that the profession is occupying increasingly litigious ground in the practice of medicine. Health professionals in general, and doctors in particular, are at risk of becoming the casualties of the environment where patient expectations are high. The public system is under stress, and the Government continues to claim that healthcare opportunities are improving.

It is important to document carefully all interactions with patients, including telephone calls. Poor records repeatedly let doctors down. Contemporaneously written notes of a consultation are a powerful defence. A doctor's assertion that he or she has detailed recollection of a consultation that occurred years ago, in the absence of any legible notes, is difficult to believe.

Another complaint I hear from doctors is that the discipline hearings are biased against them, that the complainants' views are always preferred over the doctors, and that the outcome is almost always unfavourable to the doctor. The selective publication of discipline findings almost certainly leads to this incorrect view. The only cases published in the NZMJ are those where a complaint has become a charge and the doctor has been found guilty on that charge.

Both the MPDC and the Medical Council have statutory processes for the assessment of complaints, to determine their genuineness and to determine if they reach the threshold of seriousness that requires a hearing. Each year the MPDC receives about 500 complaints of which about 50 go to hearing and in which about 80 per cent of the doctors are found guilty. Forty out of 500 is not a high level of adverse findings. The Medical Council receives about 50 complaints of a serious nature, that might amount to disgraceful conduct, and of these only about 10 per cent come to hearing.

To assist the profession in understanding the range of matters that form complaints, and the relatively small proportion that become charges in the discipline sector, the Council will in the future publish a broader range of its decisions.

**Conclusion**

As we move into the era of a new Medical Practitioners Act we move towards the profession having greater ability to take charge of its standards. This will require new ways of thinking, and a much greater reliance upon the development of best practice guidelines, quality assurance, peer assessment and review of standards. I am confident that Dr Ken Thomson will provide the leadership for the Council and the profession to take us through this next challenge.

R H Briant
CHAIR (to 31 May 1995)

## Dr Robin Briant, CBE

As I take up the challenge of chairing the Medical Council through the transitional phase leading up to the implementation of the new legislation, it is appropriate that I acknowledge on behalf of Council and the profession the immense contribution made by Robin Briant over her term on the Medical Council, and particularly during her five years as Chair. Her enthusiasm and energy has resulted in new approaches to many areas of Council activities, and without her persistence the long overdue Medical Practitioners Bill may still have been gathering dust. Hopefully what emerges from the select committee will soon be legislation which will satisfy the needs of both the public and the profession for years to come. We are all grateful for the major contribution that Robin Briant has made.

KJ Thomson
CHAIR (from 1 June 1995)

## Report of the Lay Member

This year has progressed with the prospect of the new Medical Practitioners Act having an influence on many aspects of Medical Council business. The Council made submissions to the Select Committee and as well, I made my own submissions. Having been a member of the Registration and Health Committees, the Disciplinary Tribunal and the Medical Council itself, I have firm opinions about the composition of the Council and the demands which will be placed on those members. I think the most important attribute needed in both medical and lay members is independence from loyalty to pressure groups.

There are increasing numbers of interest groups who feel their perspective is the only valid viewpoint and those who do not agree with them are somehow morally corrupt. This applies to many areas of our society and is not confined to the provision of medical care. An attitude of discrediting, as opposed to debating, alternative viewpoints seems to be encouraged by the time constraints on discussions about important issues in current affairs programmes on the television.

Earlier this year a television current affairs programme looked at one of Council's disciplinary hearings. Because the producers of the programme were not present during the hearing they were dependent on the perspective of some of the participants who were present for part of the time only. The programme certainly did not reflect the perceptions of those who were involved in the total process but even more worrying was that the programme instilled doubt in people as to the worth of making a complaint.

Exactly which area of the public interest is served by that type of presentation and what slants will be given to issues raised in the new environment of public hearings? I am confronted with the dilemma of wondering what responsible investigative journalism is.

The Council's discipline decisions receive the most publicity. Because the issues are so grave for both the complainant and the accused doctor there is nothing cursory about either the examination of the facts or the deliberations to do with the issues. As a professional disciplinary body the Tribunal has some procedural latitude when receiving evidence, and this can ease the stressful nature of a hearing. However the most important factor is that tribunal members are free of prejudice when they come to each hearing.

My experience of Tribunal members leads me to believe that the public and the medical profession can have confidence in their impartiality.

In my submission to the Select Committee I made a plea that lay members appointed in the future should not be burdened with one issue attitudes.

When the Medical Practitioners Bill is enacted there will be different processes for discipline. The domains of registration, education, health and competence will remain the immediate responsibility of Medical Council members. These areas impact upon every registered medical practitioner. It is hoped that the medical members have the same attribute of impartiality that I would like to see in lay members.

P C Judd
LAY MEMBER

## Professor Eru Pomare

The Medical Education Committee and the Board of Examiners for NZREX lost a valued member when Professor Pomare died suddenly early in 1995.

Up until his death he served on the MEC in his capacity as Dean of the Wellington School of Medicine.

He was a member of many of the MEC's visiting accreditation teams which assess teaching hospitals every three years and he frequently advised various medical education groups in his capacity of teacher, gastroenterologist, physician and advocate of Maori health.

Dr Pomare was appointed in 1991 as one of the two nominees of the University of Otago to the NZREX Board. His wise counsel was always helpful in all the difficult academic and sensitive issues surrounding assessment of overseas trained doctors and their integration into the New Zealand medical workforce.

His valuable contribution was appreciated and is greatly missed.

# Year in Review - Principal Activities and Issues

## Accreditation Of New Zealand Medical Schools

The Medical Councils of Australia and New Zealand have accredited the Faculty of Medicine at the University of Otago for a period of five years. This joint accreditation ensures the eligibility for registration for Otago graduates under the current and proposed Medical Practitioners legislation in this country and in Australia for the next five years.

The accreditation visit was carried out in August 1994. Being assessed by an outside body brought an international perspective and standing to the nature of the Faculty's programmes and training. Preparation for the visit required staff throughout the Faculty of Medicine to identify strengths and weaknesses and prepare a database. The accreditation team was in close agreement with the staff's self-assessment.

The Chair of the AMC Accreditation Committee, Professor Richard Larkins said the Faculty had many of the indicators of a high quality medical school. He commented that the staff were committed and capable and that the students were of a high calibre.

Weaknesses in relation to the health reforms and lack of access to clinical training, particularly in obstetrics, were identified. Some of the weaknesses have already been overcome and initiatives are under way to address others.

The decrease in access to obstetrics training, largely due to the growth in the midwifery movement, is now a general problem throughout New Zealand. The following specific aims for obstetrics training arose directly from the assessment.

Graduates will be required to confirm that they have:

- participated in a minimum of 20 ante-natal consultations, including a minimum of 10 with abdominal palpations conducted personally under supervision
- completed 144 hours of rostered duty in a labour ward/delivery suite during their fifth and sixth years
- actively participated in providing care during at least five labours and deliveries; at least two must have been normal deliveries.

The accreditation could be extended a further five years when sufficient progress is made in addressing the recommendations resulting from the assessment.

The University of Otago Faculty of Medicine was the eleventh of 12 medical schools in Australasia to be assessed and accredited under the AMC and MCNZ's joint process. All 10 medical schools in Australia have now been accredited. The assessment of the University of Auckland Faculty of Medicine in August 1995 completed the cycle. The decisions of the two Councils on accreditation of the Auckland school will be taken in November and December.

## The Internship

### General Practice Training Runs

The Medical Council has for some time accepted that conditionally registered interns should be offered the option of a three month general practice training run. This would provide interns with primary care and community experience and would prepare some for the realities of being a general practitioner. Not only would the run be advantageous to young doctors wanting to specialise in general practice, it would also provide valuable opportunity for widening the perspective of doctors intending to train in other fields.

Enough general practices and the appropriate practitioners are available to start a pilot programme in 1996, but the issue of salary payment for the interns remains unresolved.

Because interns are not ready to practise independently the Medical Council does not expect general practices to offer remuneration. This funding issue is now in the hands of the Clinical Training Agency (CTA). The CTA is now responsible for all post-entry clinical training (seventh year and onwards). It is unlikely that a decision will be made about intern remuneration

until October 1995. Unfortunately this may mean the pilot scheme will not start next year.

### Accident and emergency and night cover

Until this year the Medical Council advocated that conditionally registered interns should have immediate supervision when working in emergency medicine and on night cover. The Council still believes that direct supervision offers the safest and most valuable learning experience and confirms that only interns in their second six months of training should be allocated such posts. However, regional variability in supervisors' availability has prompted the Council to liberalise the policy.

*The Council recognised that it is not always possible in some regional centres to have senior staff on site to supervise interns at all times. This advanced the need for guidelines which ensure effective backup and support for all conditionally registered interns. A policy statement was sent to each Crown Health Enterprise in December 1994. The statement clearly set out the appropriate process of consultation needed for interns to acquire backup and support with ease and haste.*

### Human resource database for interns and CHEs

The partial reintroduction of a "MATCH" database has been recognised as a success. It provided a quick and satisfactory means for young doctors to have their posts confirmed in advance and it prevented many doctors from feeling insecure about employment prospects. In some cases it may have prevented doctors from going to Australia to seek a post for their seventh year.

Regrettably, the "MATCH" pilot has not progressed to a full programme. It will however provide a back-up for graduates who do not get the posting of their first choice.

It appears from anecdotal evidence that there is no oversupply of young doctors and most sixth years seem to have been offered postings for 1996. This is an encouraging situation and one the Medical Education Committee and Council warmly supports.

### Assistance for poorly performing interns

Each year a tiny proportion, less than five out of approximately 270, of conditionally registered interns fail to meet the standard required for full registration in their first year.

With Medical Education Committee encouragement, the University of Otago Faculty of Medicine has set up a working party to look at appropriate means of clinical assessment and remedial training which could best help these young doctors address deficiencies.

Some conditionally registered doctors have experienced problems achieving the level of responsibility and standards expected during the intern year. Fortunately the number of poor performers during the pre-registration year is usually small but it has sometimes been difficult to address the issues arising from poor performance amid the complexity of today's health care delivery system.

New graduates who may be struggling for personal or academic reasons require support, wise guidance, and an opportunity to take the time it requires for them to be ready for full registration or, if necessary, a switch to another field of work. Although less than two per cent of new graduates come into this category, it is important they are identified early, or feel they can ask for help.

The Registration Committee and the Medical Education Committee are alert to these vulnerable young doctors and asks the profession to be vigilant also.

## Maintaining the New Zealand Medical Registers

### Process

This activity is the principal responsibility of the Council and is subject to many provisions in the Medical Practitioners Act 1968. Parts II and IV, including regulations and schedules are particularly relevant. Workload indicators set out in table 11 show that the volume of work processed, directly related to maintenance of the register, continued to increase over the last year. Registration decisions formed a major part of the quarterly general Council meetings. Detailed reports were received from the Registration Committee which met regularly to consider applications, deal with policy and procedural issues as they arose and then make recommendations to Council.

The Registration Committee met formally five times during the past year. Its sub-committees concerned with vocational registration in all the specialties, including general practice, also met as required. This represented about 50 hours of formal deliberation, excluding the time taken to read the papers which could run to about 600 pages. The secretariat team handling registration matters (excluding examinations and accreditation) comprised five full time staff. From time to time additional staff were required, for example during the annual practising certificate processing period.

If there were unresolved issues which

**Table 1**

**NEW ZEALAND MEDICAL REGISTRATION INFORMATION**
**at 30 June 1995**

| | |
|---|---|
| Total practitioners on register | 11,889 |
| Total practitioners on register with practising certificates | 7,998 |
| Temporary registrants | 129 |
| Probationary registrants | 79 |
| Names removed from register (various) | 279 |
| Practitioners deceased | 49 |

could benefit from face to face discussion it was useful for the Registration Committee to meet with individual applicants for registration.

**Trans-Tasman Relations**

The convener of the Registration Committee, convenor of specialist registration sub-committee and the registration team leader attended a meeting in Australia of the Australian Medical Council and the Committee of Presidents of Medical Colleges concerning standards for specialist training and registration. Trans-Tasman contact is becoming more frequent, particularly as the New Zealand and Australian governments get closer to signing up the Trans-Tasman Mutual Recognition Agreement affecting services, including those provided by health occupational groups.

**Litigation**

A small number of overseas trained doctors have chosen to challenge the Council's decisions on their registration in the court. Two of these, where Council ruled that they must sit the examination to determine their eligibility for registration, will be heard over the coming year. A doctor currently on temporary registration, who has been refused probationary registration because he has completed neither NZREX, nor a College Fellowship, is testing that decision in the High Court. Another doctor was granted probationary registration by Council as a result of an order of the High Court. Council had some concerns about the doctor's fitness to practise based on inquiries which were proceeding overseas but these were deemed by the court not to be relevant reasons for denying him registration.

In Australia there has also been litigation involving the registration of overseas trained doctors over the past year. A major case was heard by the Human Rights Commission. The Commonwealth government and the AMC have lodged appeals with the Federal Court for review with the aim of having the decision set aside. This trend towards litigation and seeking public support through approaches to politicians and media is of concern to Council. Nevertheless, Council's obligation is to make fair and defensible decisions, always bearing in mind its primary role of public protection through the maintenance of standards.

**Medical Migration**

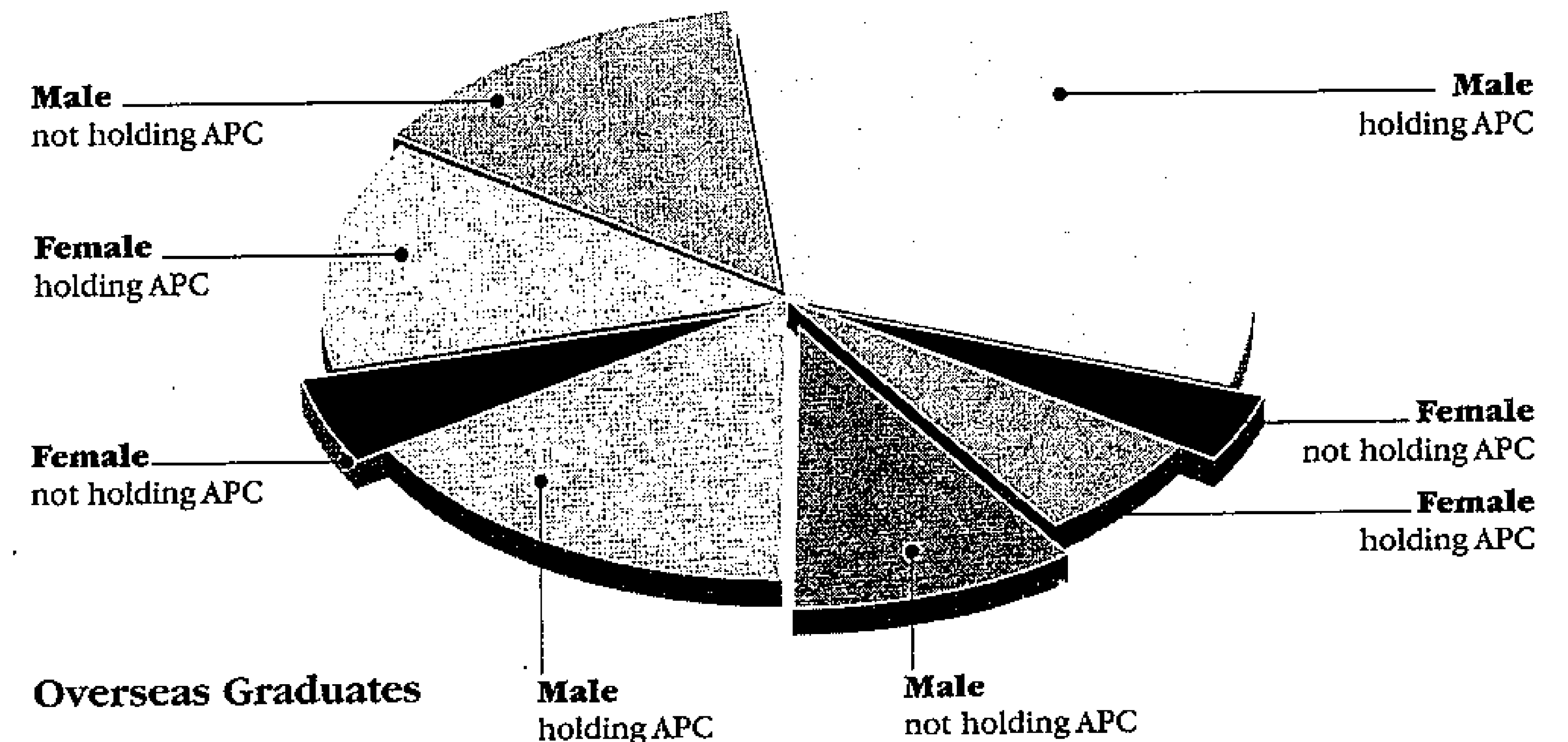
In October 1994 the Registration Committee met with representatives of the Overseas Doctors' Association. Requests were made by the immigrant doctors for representation on the NZREX Board of Examiners and for bridging courses to assist them in their preparation for the examination and subsequent practice in New Zealand.

Immigration policy has led to the granting of permanent residence to several hundred professionals, including doctors, who found themselves ineligible for registration once they reached New Zealand. The policy has taken account of



Table 2

**DOCTORS ON THE NEW ZEALAND MEDICAL REGISTER**
as at 30 June 1995




NZQA certificates of equivalence of medical degrees to other bachelors degrees involving only three years study. This situation is unacceptable to the new immigrants but is outside the control of the Medical Council. Recently immigration policy has been changed so that points awarded on the basis of NZQA equivalence certificates will not be activated until a doctor can also show that he or she is registrable. Meanwhile, the considerable pool of unemployed doctors has been politically active and seeking redress.

The Council maintains its fundamental stance that its duty is to ensure that all doctors registered are competent to practise without risk to patients and that the minimum standard which should be applied in this regard is the same standard as is applied to those graduating MB ChB from New Zealand medical schools. The Council recognises the need for bridging courses if overseas trained doctors are to be integrated into the New Zealand workforce. This is a matter for education and employment policy makers and agencies to address.

**Fitness to Practise**

The Registration Committee has received advice, with regard to fitness to practise, on several occasions from the Health Committee. These usually related to applications for registration where the applicant had disclosed previous mental illness or treatment for substance abuse. Previous convictions which could relate to the

professional conduct of the applicant, for example drink driving or assault, must be examined closely and registration granted only if the Council is satisfied that the applicant is neither impaired nor otherwise not of good reputation or character.

Medical students at the universities of Otago and Auckland are provided with information concerning convictions during their student years. The students are encouraged to discuss such convictions with the Deans if there should be any possibility that these misdemeanours might obstruct their future registration.

Registration can usually be granted in the usual way if the Council is satisfied the conduct has not been repeated and there is no risk of a relapse.

### Retirement

Occasionally the Health Committee advises the Registration Committee that a sick elderly doctor has agreed to surrender his or her annual practising certificate and undertake not to seek a further certificate. Such a doctor is able to retain their name on the medical register but is not able to work as a doctor which might in view of their declining skills and knowledge endanger patients. Although this is a difficult decision for a doctor to take, it is a dignified way of concluding a successful career. This can avoid pressing on and perhaps becoming the subject of disciplinary inquiries or a suspension order. New competence provisions will also be available to be used to deal with these situations in the future.

Table 3
**NEW ZEALAND REGISTER OF SPECIALISTS**
at 30 June 1995

| | 1994 | Added | Removed | Net | Total |
|---|---|---|---|---|---|
| Anaesthetics | 313 | 24 | 1 | 23 | 336 |
| Community Medicine | 165 | 3 | 3 | 0 | 165 |
| Dermatology | 46 | 3 | 2 | 1 | 47 |
| Diagnostic Radiology | 176 | 12 | 4 | 8 | 184 |
| Gynaecology | 1 | 0 | 0 | 0 | 1 |
| Internal Medicine | 501 | 45 | 10 | 35 | 536 |
| Obstetrics | 1 | 0 | 0 | 0 | 1 |
| Obstetrics & Gynaecology | 207 | 11 | 4 | 7 | 214 |
| Ophthalmology | 99 | 3 | 2 | 1 | 100 |
| Orthopaedic Surgery | 148 | 7 | 2 | 5 | 153 |
| Otolaryngology | 75 | 2 | 2 | 0 | 75 |
| Paediatrics | 161 | 14 | 1 | 13 | 174 |
| Pathology | 175 | 13 | 3 | 10 | 185 |
| Psychiatry | 271 | 23 | 3 | 20 | 291 |
| Radiotherapy | 35 | 1 | 1 | 0 | 35 |
| Cardiothoracic Surgery | 26 | 1 | 0 | 1 | 27 |
| General Surgery | 245 | 6 | 11 | -5 | 240 |
| Neurosurgery | 14 | 1 | 0 | 1 | 15 |
| Paediatric Surgery | 5 | 0 | 0 | 0 | 5 |
| Plastic Surgery | 28 | 2 | 0 | 2 | 30 |
| Urology | 41 | 0 | 0 | 0 | 41 |
| Venereology | 16 | 0 | 1 | -1 | 15 |
| **Total** | 2749 | 171 | 50 | 121 | 2870 |
| **Indicative Register of GP's** | 1368 | 110 | 14 | 96 | 1464 |



## New Specialties and Subspecialties

Council recommended changes in regulations to recognise the new specialties of occupational medicine, rehabilitation medicine and emergency medicine. Gazetting of these was finally accomplished in September 1995. A similar request that general practice be gazetted as a specialty is still under consideration by the Ministry but will, in any case, be effected when the Medical Practitioners Bill is enacted and provides for vocational registration in general practice. Meetings have been held with representatives of the Royal New Zealand College of General Practitioners concerning primary health care subgroups who are wanting to be recognised as having special knowledge and skills.

The general issue of whether sub-specialties should be treated by "lumping" or "splitting" is a difficult one as different specialist areas of practice have different needs. This will be an area where a new Medical Council will be required to develop policy which is flexible enough to adapt to changes in medical services and workforce over the next decade or two, without compromising standards. The Council has established a policy for considering requests from new specialist groups which would like to achieve vocational registration status. Decisions are still to be made on whether they should stand alone or be included under the umbrella of other colleges. Some existing specialties have been reviewed, for example venereology.

Emerging and changing specialties have led to Council's consideration of several new additional qualifications and to the recognition of revised qualifications. Examples include community medicine, now known as public health medicine. Additional qualifications recently added to the list of those recognised by Council include qualifications in intensive care, emergency care, professional ethics and epidemiology.

## Vocational Registration of General Practitioners

With the Medical Practitioners Bill before the Select Committee at present, the applications for admission to the Indicative Register have increased during the past six months. The total number on the Register on 30 June 1995 was 1464.

While the final details of the Bill are not completed, the probability is that only general practitioners on the vocational register for general practice will be allowed to practise independently. It is anticipated however, that there will be a transitional phase of up to five years. This will give those who have held an Annual Practising Certificate for a consecutive period of five years since gaining general registration time to fulfil the requirements necessary for admission to the vocational register. These

Table 4

## NEW REGISTRANTS IN VOCATIONAL DISCIPLINES

**for Year ended 30 June 1995**

| | New Zealand | | Overseas | | |
|---|---|---|---|---|---|
| | Males | Females | Males | Females | Total |
| Anaesthetics | 8 | 3 | 6 | 6 | 23 |
| Community Medicine | 1 | 1 | 1 | 0 | 3 |
| Dermatology | 1 | 1 | 1 | 0 | 3 |
| Diagnostic Radiology | 3 | 3 | 5 | 1 | 12 |
| Gynaecology | 0 | 0 | 0 | 0 | 0 |
| Indicative Register of GP's | 44 | 18 | 33 | 15 | 110 |
| Internal Medicine | 20 | 8 | 13 | 4 | 45 |
| Obstetrics | 0 | 0 | 0 | 0 | 0 |
| Obstetrics & Gynaecology | 0 | 1 | 8 | 2 | 11 |
| Ophthalmology | 2 | 1 | 0 | 0 | 3 |
| Orthopaedic Surgery | 5 | 1 | 1 | 0 | 7 |
| Otolaryngology | 1 | 0 | 1 | 0 | 2 |
| Paediatrics | 6 | 1 | 3 | 4 | 14 |
| Pathology | 7 | 1 | 3 | 2 | 13 |
| Psychiatry | 1 | 4 | 16 | 2 | 23 |
| Radiotherapy | 0 | 0 | 1 | 0 | 1 |
| Cardiothoracic Surgery | 0 | 0 | 1 | 0 | 1 |
| General Surgery | 3 | 0 | 3 | 0 | 6 |
| Neurosurgery | 0 | 0 | 1 | 0 | 1 |
| Paediatric Surgery | 0 | 0 | 0 | 0 | 0 |
| Plastic Surgery | 2 | 0 | 0 | 0 | 2 |
| Urology | 0 | 0 | 0 | 0 | 0 |
| Venereology | 0 | 0 | 0 | 0 | 0 |
| **Total** | 60 | 25 | 64 | 21 | 170 |

requirements will probably be very similar to the present ones for the Indicative Register, with the additional condition that to remain vocationally registered in general practice, all doctors will have to undertake a re-accreditation cycle such as that offered at present by the Royal New Zealand College of General Practitioners. It is possible that some other bodies such as the Universities may be prepared to offer an alternative re-accreditation pathway in the future, but all re-accreditation programmes will have to be approved for this purpose by the Medical Council.

Some doctors may question whether vocational registration is necessary at all, since many other countries do not as yet have it. However there would probably be general agreement that the present situation is unsatisfactory, when any doctor on the Medical Register with an Annual Practising Certificate can practise surgery in private practice and any specialist can retire after 30 years in their specialty and start in practice as a general practitioner. A vocational register is a means of ending this potentially risky situation. This will provide assurance to the public, colleagues and such bodies as the ACC and insurance companies, that a doctor on a vocational register has completed approved postgraduate training and supervised experience in the discipline and is participating in a re-accreditation cycle to maintain competence in the services offered.

There has been an upsurge in applications for entry to the Indicative Register of General Practitioners in the past year. This was due to encouragement given by the Royal New Zealand College of General Practitioners to its members to acquire this registration in time go onto the vocational register under the new Medical Practitioners Act. Such registration will be essential as the first step in the process which will include continuing recertification as a requirement for retaining a place on the vocational register in general practice.



***The relevant clauses of the Medical Practitioners (Registration of General Practitioners) Regulations 1987 are as follows:***

"4. Qualification for registration -

(1) A medical practitioner shall be entitled to have his or her name entered in the register if the Council is satisfied-

a) That the practitioner holds a qualification specified in the second column of the Schedule to these regulations, and granted by a College specified in the first column of that Schedule in relation to that qualification; and

b) That the practitioner has been qualified as a medical practitioner for not less than 5 years; and

c) That the practitioner has had training and practical experience in general practice and family medicine for not less than 3 years; and

d) That, so far as practicable, the practitioner limits his or her practice to general and family medicine.

(2) Notwithstanding anything in subclause (1) of this regulation, if the Council sees fit in relation to any particular case, the name of a medical practitioner may be entered in the register if the Council is satisfied that he or she is recognised by his or her colleagues in the medical profession as having special experience in the discipline of general practice and family medicine

The requirement to be a fellow or member of an appropriate professional college was not mandatory until 1 April 1990.

***The SCHEDULE referred to above is as follows:***

**SCHEDULE**
**Qualifications**

| **Body** | **Qualification** | |
|---|---|---|
| Royal New Zealand College of General Practitioners | (a) Fellowship<br>(b) Membership | |
| Royal Australian College of General Practitioners | Fellowship | Where the prescribed course of training and criteria for fellowship or membership is considered by Council to be at least equivalent to that required for membership of the Royal New Zealand College of General Practitioners |
| Royal College of General Practitioners of the United Kingdom | (a) Fellowship<br>(b) Membership | |
| Any other College or body of General Practitioners | (a) Fellowship<br>(b) Membership | |

## Temporary and Probationary Registration of Overseas Trained Doctors

Much of the time of the Registration Committee and Council is devoted to applications for registration by doctors who have qualified overseas and wish to come to New Zealand to work on a temporary or permanent basis. Temporary registration has always been granted to those coming to give postgraduate instruction or receive postgraduate experience and teaching. From 1985 to 1992 it was also granted as the first step on the pathway to probationary registration for overseas trained doctors who had passed the screening examination. Since 1993 this has been discontinued and replaced by a three part registration examination leading to probationary registration.

Council has continued to honour its responsibility to provide registration for training for overseas doctors who recognise this country's particular expertise. A wide variety of sponsored trainees were accepted without examination. These trainees met the strict requirements of the sponsored trainee protocol which included support by their home government or institution, a formal programme with defined supervision, strict time limits and the undertaking that they would return to their own country, which the training was to benefit.

Over the last year temporary registration has been granted for sponsored trainees from Fiji, Western Samoa, Kiribati, Papua New Guinea, Hong Kong, Taiwan, Japan, India, Thailand, Poland, Belgium, Switzerland, Norway, Denmark, Canada and the United States. The trainees came to New Zealand for training in many different fields including obstetrics and gynaecology, anaesthetics, paediatric surgery, nephrology, cardiology, radiation oncology, gastroenterology, ophthalmology, geriatrics, neurology, orthopaedics, cardiothoracic surgery, coronary angioplasty and spinal injuries.

Limited periods of temporary registration have also been granted in shortage specialties, particularly psychiatry. Overseas trained doctors with specialist training in psychiatry have been recruited to take up positions throughout the country for varying periods of time until permanent staff could be appointed if available. Council accepted this situation was not ideal and that continuing this programme might contribute to masking the real difficulties facing the maintenance and development of the psychiatric workforce and the delivery of appropriate mental health services in New Zealand. Nevertheless, in the current climate where mental health services simply cannot be sustained without stop gap measures, the shortage specialty programme in psychiatry continues. Council has been made aware that solutions will not be reached in the short term but trusts these particular registration arrangements will not need to continue beyond the medium term to the current extent.

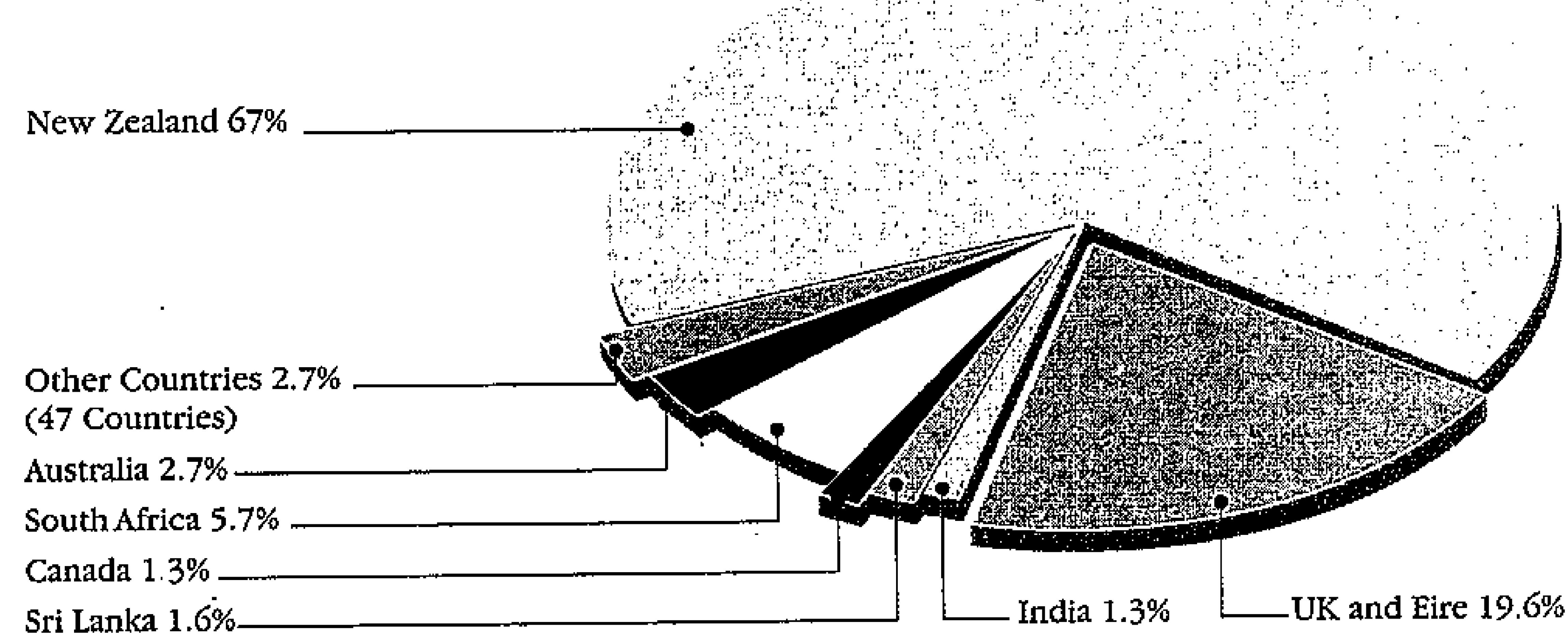
Applications from overseas trained doctors for recognition of their specialist qualifications and experience formed a major part of the Committee's work. Reliance is placed on advice from the special societies and medical colleges. Occasionally this advice was disputed by Council, but this situation arose in only about half a dozen instances over the past year. Many applications have been declined (over 40 in the past year) because the applicants did not meet the criteria set down in the Medical Practitioners Act and Specialist Regulations for registration as a specialist in New Zealand. When possible, such candidates were advised of the steps necessary for them to reach the entry requirements.

Where overseas trained doctors were already in New Zealand (for example those who had already been granted permanent residence) the Colleges were able to offer facilities for interview and possibly further assessment of their credentials and competence. In the past year doctors who qualified in Yugoslavia, Spain, Ghana, Sri Lanka, South Africa, Germany and the United Kingdom have been deemed "acceptable for assessment" in such specialties as internal medicine, general practice, anaesthetics, diagnostic radiology, obstetrics and gynaecology and paediatrics. Provided appropriate clinical work and supervision was available, they were granted limited periods of probationary registration.

All overseas trained doctors not automatically eligible for full registration must complete at least a year in supervised practice on probationary registration. This is

Table 5 **NEW ZEALAND AND OVERSEAS GRADUATES ON THE NEW ZEALAND REGISTER**
at 30 June 1995

**Total on Register 11889**



regardless of whether they gained registration by passing NZREX or were deemed "acceptable for assessment" or "specialist eligible". This is a very important period in which they can learn more about the way medicine is practised in New Zealand and the expectations of the community, both public and professional, with regard to health services and conduct.

During that probationary period overseas trained doctors are now required to obtain current certification in basic and advanced cardiac life support. Probationary registration is most frequently undertaken within publicly funded institutions although Council has recently approved supervised specialist practice in a private clinic.

## New Zealand Registration Examination (NZREX)

The new format of NZREX has been held twice in the past year, the english and written components being available in Auckland, Wellington, Singapore and London; clinical in Auckland and Wellington.

The English examination is run by Dr John Read of the English Language Institute at Victoria University and tests skills in writing, reading, listening and speaking english. The consistently high pass rate of around 70 per cent has been maintained and presumably indicates the good preparation the candidates make for their life in New Zealand.

The written examination is the largest hurdle, comprising multiple choice and short answer question formats in four papers over ten hours of examination. The examination is based upon the qualifying examination for the Auckland School of Medicine fifth year students. Some of the subjects and some of the modes of examination are unfamiliar to some candidates from abroad, and this is reflected in the difficulty experienced with this examination.

The clinical examination covers the major fields of clinical practice - medicine, surgery, psychiatry, obstetrics and gynaecology, paediatrics and general practice. A variety of examination modes are adopted, which are standardised between Auckland and Wellington. They include observations of history taking, interaction with patients and examination techniques. About a third of those candidates who complete the written examination pass the clinical examination on their first attempt.

The three parts of the examination are all labour intensive for examiners. This makes it expensive for the candidates. The capacity of the examination has almost been reached, both in terms of physical space, time and availability of experienced examiners. On this background the Council recognises that the Medical Practitioners Bill as it is currently drafted will require that more, not fewer, overseas trained doctors will be subject to examination for registration. The NZREX Board was therefore charged with a review of the whole examination and its practical limitations. Recommendations from that review are expected.

### Handbook for Doctors Entering Practice

During the year, Emeritus Professor David Cole, previous Dean of the Auckland School of Medicine, has produced a handbook entitled "Medical Practice in New Zealand - A Guide to Doctors Entering Practice". The book is based upon his very successful publication "Medical Practice and Professional Conduct". It updates this material and focuses it for doctors commencing practice in New Zealand.

The need for such a book evolved from the recognition of the very special, yet undocumented medico-legal and cultural characteristics of practice in New Zealand. It is likely that this material will form the basis of an assessment to be completed before a doctor moves from probationary to full registration.

The book is available for doctors already on the register from the Council secretariat at $20 (including GST) per copy. New registrants are provided with a copy as part of their registration package.

The Council and Professor Cole would value comments on the content and format of the book so it can be continually updated and improved.

Table 7

**CANDIDATES SITTING AND PASSING NZREX CLINICAL**
**in Year ended 30 June 1995**

| | Clinical August 1994 | Clinical March 1995 |
|---|---|---|
| Candidate attempts | 36 (13) | 36 (10) |
| No. of passes: | | |
| Attempt 1 | 12 | 14 |
| Attempt 2 | 6 | 6 |
| Attempt 3 | 5 | - |
| No. of passes overall | 23 | 20 |
| Pass rate overall | 64% | 56% |

Note: ( ) repeat candidates included

Table 6

**CANDIDATES SITTING AND PASSING NZREX ENGLISH AND WRITTEN**
**in Year ended 30 June 1995**

| | Nov 1994 English | Nov 1994 Written | May 1995 English | May 1995 Written |
|---|---|---|---|---|
| Candidate attempts | 56 (4) | 89 (24) | 72 (11) | 78 (36) |
| No. of passes: | | | | |
| Attempt 1 | 36 | 10 | 43 | 5 |
| Attempt 2 | - | 6 | 9 | 7 |
| Attempt 3 | - | - | 1 | 4 |
| No. of passes overall | 36 | 16 | 53 | 16 |
| Pass rate overall | 64% | 18% | 74% | 21% |

Note: ( ) repeat candidates included

## Medical Workforce Survey

Doctors from over 60 countries have been entered on the New Zealand medical register since it was established in 1870 and the Council database includes basic information on every New Zealand medical graduate since 1887. Including overseas trained doctors granted full registration, the total number of doctors ever registered in New Zealand has now topped 21,000.

For more than 20 years, a comprehensive database containing workforce information has been maintained by the Council's statistician working in the Department of Preventive and Social Medicine at the University of Otago Medical School. The database has been the invaluable resource which has enabled the Council to honour its statutory obligation set out in section 14A in the Medical Practitioners Act. Pursuant to Section 14A, the Minister may request the supply of specific statistical information about the medical workforce. In return a contribution has been made from Vote Health to the costs of Council's work in collecting and supplying these statistics. The overall management of the operation has been monitored by the Medical Practitioners Data Committee which comprised representatives of the Medical Council, the University of Otago and the Ministry (previously Department) of Health.

Doctors have been asked to complete a medical workforce questionnaire every year with the collection of the annual practising certificate fee. They have done so in such a comprehensive manner that New Zealand's database is the envy of many overseas registration boards. The response rate to the questionnaire has been excellent and all data collected since the 1972 questionnaire is in computer files.

In the 1970s a limited range of questions were asked but since the early 1980s the questionnaire has been extended to cover detailed information on hours, category, location and level of work undertaken. When the Department of Health took a more active role in workforce planning this data was used by policy analysts and was also published along with other health workforce statistics reasonably regularly. Although the form of these questions has been modified from time to time and the format of the questionnaire itself altered, the base data is the same. In addition, questions have been asked on plans for leaving or returning to the medical workforce in New Zealand to assist with predictions about the future workforce. Workforce planning has now been decentralised and new bodies such as the Regional Health Authorities and the Clinical Training Agency are taking an interest. The Colleges also have a stake in the accuracy of this information and with mandated vocational registration appearing on the horizon under the new Medical Practitioners Bill, accurate data is essential.

Difficulties arise in providing accurate statistics when a significant number of doctors fail to complete some questions



Table 8

### NEW ZEALAND MEDICAL WORKFORCE 1994

| | 1989 Total | 1989 NZ Graduates | 1990 Total | 1990 NZ Graduates | 1991 Total | 1991 NZ Graduates | 1992 Total | 1992 NZ Graduates | 1993 Total | 1993 NZ Graduates | 1994 Total | 1994 NZ Graduates |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Active | 6286 | 4434 | 6339 | 4480 | 6570 | 4621 | 6722 | 4733 | 6872 | 4790 | 7180 | 4886 |
| Full Time Equivalents | 5763.9 | 4070.4 | 5863.3 | 4151.6 | 6111.4 | 4303.8 | 6210.4 | 4372.0 | 6257.0 | 4343.8 | 6561.6 | 4454.5 |
| House Officers | 719 | 533 | 679 | 538 | 698 | 562 | 677 | 569 | 687 | 560 | 720 | 589 |
| Registrars | 765 | 616 | 799 | 627 | 823 | 618 | 856 | 651 | 854 | 612 | 912 | 630 |
| Medical Officers Special Scale | 176 | 93 | 173 | 87 | 181 | 89 | 203 | 95 | 201 | 88 | 215 | 84 |
| General Practitioners | 2383 | 1681 | 2429 | 1705 | 2549 | 1779 | 2616 | 1818 | 2660 | 1857 | 2730 | 1841 |
| Other Primary Medical Care | 139 | 92 | 165 | 101 | 152 | 97 | 159 | 105 | 180 | 121 | 239 | 151 |
| Specialists | 1957 | 1326 | 1952 | 1325 | 2021 | 1376 | 2066 | 1396 | 2131 | 1441 | 2184 | 1460 |
| Miscellaneous (non specialist) | 147 | 93 | 142 | 97 | 146 | 100 | 145 | 99 | 159 | 111 | 180 | 131 |

adequately, or at all. Each year about ten per cent of respondents have to be followed up to obtain information not initially supplied in useable form.

The database is used to answer various questions about the workforce and to assist with research questionnaires and other targeted mail outs.

The workforce category list is reviewed annually and new dimensions of medical practice are included as appropriate. In recent years the Ministry of Health has occasionally requested that ethnicity be included as an item and this is requested again for 1996. Council is aware some practitioners have reservations about responding to such questions but the information is requested from doctors and all other registered practitioners in the health workforce.

The Council recently participated in a research project commissioned by the Ministry of Health to determine the user requirements for health workforce data. Respondents significantly favoured annual collection of information and found the most useful data (in rank order) to be: qualifications, type of work, age, year of qualification, hours of work, date of New Zealand registration, gender, ethnicity, place of qualification, employers names and employers location. Respondents also wanted regular publication of summary information and statistics on a range of health professional groups and publication of more in depth analysis on specific health professions.

***The Council has not released any raw data and has maintained total security and ownership of the database. On occasions the Ministry of Health has requested that Council release unit data, this request has been declined because of concerns about privacy.***

There was also a fairly strong appeal for analysed reports on specific information and specific raw data on request.

The report also commented on international approaches to health workforce information and the trend to increased internationalisation of medicine was noted. This trend involves migration of medical workers from a variety of disciplines and technological developments such as telemedicine, increasingly giving rise to boundary blurring. Government officials developing policy for Trans-Tasman Mutual Recognition of doctors registered to practise in the two countries (as a development of CER) have questioned the accuracy of medical workforce data currently available in Australia.

It is clear from developments in the past year that there is a continuing need for accurate and accessible data. It appears the Medical Council (like other registration bodies) is in the unique position to collect and maintain reliable statistics on the qualifications of doctors and the work they undertake.

The Council has begun planning to move the data collection operation from the University of Otago to the Council's Wellington secretariat.



## Identification and Management of Impairment

Early identification of health impairment among medical practitioners and implementation of remedial measures has been emphasised by Council. This means the public is protected and doctors are immediately involved in effective rehabilitation programmes which enable them to return to safe practice without delay. The Health Committee, which handles this aspect of Council's work, has built up very useful knowledge and experience over the eight years since establishment. Through regular communication with impaired doctors and those involved in their monitoring and recovery the Committee has refined the protocols which are now in use.

The old assumption that a doctor referred to Council would immediately be suspended is incorrect. If the referral is made at an early stage, a voluntary undertaking is often sufficient and the most appropriate method of satisfying the public and professional need for risk reduction. It is clear that close supervision and support are key aspects of the recovery process, whether or not the doctor signs a voluntary agreement or is the subject of a full or partial suspension order. If the doctor concerned cooperates the Health Committee is able to carry out the agreement or order in a non-coercive manner

Early reporting of substance abuse or ill health which impairs fitness to practise is desirable. Early intervention usually allows continued employment, safe practice and a career in medicine. Most doctors visiting the Committee, as is required on a regular basis, report that supervision during the recovery phase is not unduly inconvenient or irksome. Some say, understandably, that in the beginning they were resistant to Council intervention but later recognised this was part of the difficult continuum of coming to terms with the addiction or other problem.

Some doctors reported to the Committee that, looking back, they realised the institution of random urine screening or gazetting of prescribing prohibitions, and even suspension, was the single most effective tool in assisting their recovery.

During the past year the Health Committee reviewed 37 doctors' files and 19 of these doctors met in person with Committee members. Twelve were new referrals. Two of these, overseas trained doctors applying for registration, after review of current health reports were deemed not to be at risk and were therefore recommended for registration.

Impairment comes in many forms including physical disability, alcohol or drug dependency, psychological or psychiatric disability or impairment through aging. Most of the doctors seen by the Health Committee are those suffering from drug dependency or psychiatric disorders.

Table 9

**HEALTH COMMITTEE ACTION**

year ended 30 June 1995

| | |
|---|---|
| Currently monitored by Health Committee | 23 |
| Previously monitored – satisfactory update letters | 6 |
| New voluntary undertakings signed | 3 |
| Voluntary undertakings - no APC issued | 5 |
| Voluntary undertakings amended | 4 |
| Voluntary undertakings discontinued | 1 |
| New suspension imposed | 2 |
| Full suspension reimposed | 1 |
| Full suspension varied to allow limited practice | 2 |
| Conditions of limited suspension amended | 4 |
| Suspensions revoked (voluntary undertaking retained) | 3 |
| Prescribing restrictions gazetted | - |
| Prescribing restrictions (gazetted) revoked | 1 |
| Applications for registration considered: | |
| (a) Initial registration - supported | 2 |
| (b) Re-registration (following removal on disciplinary grounds) | |
| - supported | 1 |
| - not supported | 1 |
| Referrals to Health Committee received, but, on further investigation, declined | 2 |

The Committee's monitoring programme is likely to include several of the following requirements:

- supervised practice subject to conditions of reporting on clinical performance
- appointment of a senior practitioner as a mentor to provide close support and practice advice
- regular assessment by the Council's independent psychiatric, or other, assessor
- initiation and maintenance of a therapeutic relationship between the doctor and an appropriate therapist who is not required to report to the Committee except to confirm that the doctor is continuing in the therapeutic relationship
- random urine testing pursuant to a protocol recently agreed between the National Medical Officer of Health and Medicine Control Advisors
- prescribing restrictions (voluntary or if necessary gazetted pursuant to the Medicines and Misuse of Drugs Acts)
- attendance at support groups such as Alcohol/Narcotics Anonymous or doctors self-help or other groups
- commitment to maintain total abstinence from alcohol and mood changing substances not prescribed by a therapist
- regular supervision by the doctor's own general practitioner.

The new Medical Practitioners Bill will carry forward the same type of provisions which exist in the 1968 legislation. In addition it gives the Council the power to require a medical report on a doctor. Annual practising certificates may be withheld in future from doctors whose competence is found deficient on the basis of impaired health.

When circumstances require a significant absence from practice, a further opening in



## 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 Committee of the Medical Council. As long as there is prospect of a resolution the referral is treated confidentially.

**DHAS REFERRAL**
**Phone: (04) 471-2654 (toll free)**
**or write: P O Box 812 WELLINGTON**

**MEDICAL OFFICER OF HEALTH**
**Phone or write to nearest Crown Health Enterprise or Health Development Unit.**

**HEALTH COMMITTEE**
**C/- Medical Council of New Zealand**
**Phone: (04) 384-7635**
**Fax: (04) 385-8902**
**or write: P O Box 11-649 WELLINGTON**

medicine may not be available. There are now few opportunities for subsidised, sheltered employment during rehabilitation. This is of real concern to Council as, with successful treatment and management, the skills of a doctor who has suffered impairment should not be lost for the long term.

Educators in medical schools and colleges should be aware of this and remind medical students and graduates at all levels to recognise and deal with personal stress. They should be aware of avoiding dubious, and even dangerous (such as self prescribing), ways of coping with professional and personal pressures.

Table 9 sets out the summary of the Health Committee's actions over the last year. It does not include details of the many telephone calls and requests for information and guidance from supervisors and colleagues where a doctor appears to be impaired.

The Doctors' Health Advisory Service (DHAS) continues to provide a very useful avenue for early intervention and assistance. DHAS work, though funded by the Medical Council, is entirely separate from the Council. If DHAS intervention is unsuccessful it may be necessary, in the public interest, for the impaired doctor to be referred by the Medical Officer of Health to the Health Committee. The Medical Officer of Health has a statutory reporting role. Two such referrals were made during the year.

It is important for all professional groups working with impaired doctors to be absolutely clear about each other's

responsibilities, roles and boundaries. Meetings for defining these areas were held during the year with the DHAS and people who have set up hospital based addiction programmes for at risk groups. Anaesthetists, for example, have such a programme. The sharing of information on process and aim proved very valuable.

A nationwide protocol for random urine testing of health professionals with drug dependency problems has been adopted. This resulted from a meeting between Health Committee members, a Medical Officer of Health, medicines control advisor and a pathologist who is involved in this type of testing. It is endorsed by the National Medical Officer of Health and clarifies lines of reporting and methodology. This is important in retaining the integrity of the testing programme.

The mentors meet each year to review mentoring arrangements and to learn from each other so that the quality of the mentoring can be continuously improved.

Council is indebted to Dr Ashton Fitchett, Censor for Rehabilitation for the Royal New Zealand College of General Practitioners, who is the Mentoring Co-ordinator for the programme. This mainly involves general practitioners, but it is also available to medical specialists. Mentored doctors contribute to the cost of this programme because in the long run it is in interest of the doctor as well as the public. It is an important aspect of the professional support which is essential for sustained recovery. At any time approximately 12 mentors are involved with referrals from the Health Committee, the Council itself, Medical Practitioners Disciplinary Committee or the PPC.

A doctor who recently "graduated" from the monitoring programme of the Health Committee accepted that such collegial support was necessary. The doctor recommended that early contact between a newly referred doctor and one who had made good progress through the programme would be encouraging. Another doctor, while acknowledging the place of collegial support, pointed out that it was equally important to set up one's own long term support network to assist in being a doctor and being healthy. The doctor thought the medical school selection process needed to take into account many young doctors' perception of the work environment as unhealthy and harsh.

The Committee was particularly pleased to receive positive feedback from five doctors whose lengthy period of close supervision had concluded in the previous four years. The doctors reported that their health, medical practice and personal situations were thriving.



## SUMMER STUDENTSHIP 1994-1995

The aim of the studentship is to encourage awareness among medical students in their clinical years of the qualities of medical practitioners which contribute to the highest standards of medical ethics, conduct and care of patients. The third summer studentship was offered by the Medical Council on the topic "The Acculturation of Overseas Trained Doctors".

Doctors trained in New Zealand are expected to learn attitudes appropriate to gender and cultural issues during their undergraduate education. Whereas the clinical knowledge and skills of overseas trained doctors are tested by the New Zealand Registration Examination, such attitudes are not. When the advertising for the studentship was circulated the questions posed were:

- Should or can gender and cultural values and attitudes appropriate for professionals in New Zealand society be learned by those not born in New Zealand?
- Should they be assessed in overseas trained doctors wanting to practise in New Zealand?

Unfortunately, no suitable applicant took up this challenging topic. Council realised in hindsight that the topic of acculturation was an extremely difficult one and probably not so relevant to medical students in the undergraduate phase of their education.

Council did, however, decide to award a special summer studentship on the topic "Medical Student Alcohol Use". This topic was brought forward by a teacher in the Department of Psychiatry and Behavioural Science at the University of Auckland School of Medicine who was concerned that student consumption had increased.

The studentship was awarded to Nicola Mills who prepared a report entitled "Medical Student Patterns of Use and Attitudes towards Alcohol". The report was distributed to Alcohol and Drug Teaching Coordinators at both medical schools, the Dean of the Auckland Medical School, student representatives and Associate Deans with the responsibility of student welfare and ALAC contacts.

Nicola Mills was grateful for the guidance of her supervisor, Dr Peter Adams. In her summary she stated that the attitudes of medical students were of particular interest because of the possible impact not only on their own future use of alcohol, but also on their ability to detect and intervene with problems of colleagues and their work with patients in the future. Her study used qualitative research methods.

Key themes which emerged supported changes to the medical training programme which could possibly mitigate these problems identified including:

- Promoting a greater sense of responsibility for their own health and the health of their colleagues.
- Increasing awareness of personal risks of long-term heavy drinking.

- Training in alternative stress reduction strategies.
- Developing systems of peer and mentor support.

The summer studentship report on alcohol use followed very nicely on the report prepared by the 1993/94 summer studentship holder on "The Good Doctor".

During recent discussions with young doctors who are currently under Health Committee surveillance for problems related to drug and alcohol abuse, the Committee has been told that it is not uncommon for junior doctors to resort to mood altering substances for recreational or stress reduction purposes.

"The Vulnerable Young Doctor" was the subject of a Saturday morning seminar organised by Council in August 1994 when Professors Nadelson and Notman were visiting from the United States of America. Council is eager to encourage young doctors to adopt healthy means of managing stress and change in their personal and professional lives right from the outset of their medical education and training. It is hoped that the outcome of the 1994/95 studentship report will assist in this regard.

## Investigation of Complaints

At the beginning of the year under review Dr Caroline Corkill replaced Dr Geoffrey Lamb as a member of the Preliminary Proceedings Committee (PPC) and Dr Campbell Maclaurin became Convenor. Mr Phil Cook continues as the legal member giving invaluable advice from the legal point of view in all deliberations.

Dr Lamb's contribution to the work of the PPC has been greatly appreciated during his six years as a member, four of them as the Convenor. His careful analysis of complaints and his wise judgement in decision making were highly valued by his fellow Committee members and the Council is indebted to him for his work.

During the year charges have been laid and heard in one case and in five others charges were awaiting hearings at 30 June. Three of these are to be heard by the Medical Council and two by the MPDC. Charges have now also been laid in two other cases involving complaints made in the previous year. These cases await hearing by the Council.

Finally, six cases from the current year are still under investigation. Two of these are from the previous year and involve doctors who are the subject of criminal investigation in other countries.

The year's workload has been steady, involving 22 Committee meetings. Lawyers assisting the PPC have spent a great deal of time interviewing complainants and other witnesses in many parts of the country. Their thorough and painstaking attention to detail has been a major factor in ensuring that the PPC's decisions are based on fully researched information and collection of evidence.

The worrying increase in the proportion of cases involving allegations of sexual abuse was referred to in the last annual report.

Although the Council's guidelines for both patients and doctors published last year were widely distributed, there has not been any further upsurge in the number of complaints involving sexual abuse.

Cases involving sexual misconduct remain a source of real concern to the Council however, and their investigation comprises a good third of the Committee's work.

The PPC recognises inadequacies and inappropriateness of many parts of the disciplinary complaints system under the present Act and looks forward to a significant improvement in the whole structure when the Bill, introduced in 1994, becomes law. Many of the complaints now dealt with by the Committee will be handled by the Health and Disability Commissioner's office in the future. While regrettably there will always be complaints of seriously inadequate clinical care or impropriety, which the professional disciplinary process will have to address, many of the less serious complaints may be resolved more appropriately using the provisions in the Health and Disability Commissioner Act.

Members of the public are understandably concerned when they perceive that they have not received appropriate treatment or personal respect in their dealings with medical practitioners. The present disciplinary process is quite inappropriate to deal with many of these problems, in particular when issues of clinical competence are the focus of a complaint. To date Council has limited powers to prescribe appropriate re-education or training rather than imposing disciplinary sanctions. The new competence, recertification and Annual Practising Certificate provisions will address this gap.

***In the year ending June 30 1995, there was an increase in the number of complaints received by the PPC, 102 compared with 52 in the previous year. Of these, 74 were referred to the Medical Practitioners Disciplinary Committee (MPDC) for consideration and 28 were retained for consider-ation by the PPC. Twelve of these were later dismissed after preliminary investigation. A further four cases were withdrawn by the complainants.***

***The broad categories of complaints dealt with this year are:***

| Category | Cases |
|---|---|
| **bad/inadequate clinical care** | **8 cases** |
| **alleged sexual misconduct** | **10 cases** |
| **other** | **10 cases** |

## Discipline Activities

Each year Council sets aside a week in the months of February, April, May July, August, October and November for the timetabling of disciplinary fixtures. In this way undue delays are avoided as a quorum of Council (five members for hearing charges of disgraceful conduct and six for other matters) is always available. Applications for adjournment are however sometimes made, occasionally at a late stage, and hearings have to be postponed. Hearings involving charges are normally given priority over hearings of appeals against decisions of the Medical Practitioners Disciplinary Committee. Council has been able to keep relatively up to date over the last year using this scheme. Regrettably, if decisions of the Council are then appealed to the High Court, lengthy delays occur before matters are finalised.

Throughout the period of investigation of complaints, hearing by the tribunal and any subsequent appeal, Council maintains confidentiality. The Medical Practitioners Act 1968 does not provide for such matters to be released to the public until the final stage and then only if publication is ordered. Dr Briant has referred in her report to the difficulties this has caused Council as this adherence to the law was frequently interpreted as unwarranted secrecy on the part of the profession.

***Over the past twelve months the following matters have been before Council sitting as a disciplinary tribunal:***

- Charges of disgraceful conduct in a professional respect against six doctors (five proven - four removed from register and one censured).
- Criminal convictions referred by the Preliminary Proceedings Committee involving two doctors (one removed from register and one censured).
- Thirteen appeals against decisions of the Medical Practitioners Disciplinary Committee, including one by the Preliminary Proceedings Committee against costs (one upheld, three partially upheld, eight dismissed and one no jurisdiction).
- One decision on publication referred back by the High Court for rehearing.
- Three applications for re-registration following removal from the register on disciplinary grounds (one granted probationary registration, two declined at this time).
- Two applications for full registration following completion of a probationary period ordered as part of the re-registration process following disciplinary action (both granted).

*Four of these decisions have been appealed to the High Court.*

Council considered two requests from doctors who had previously been gazetted with prescribing prohibitions pursuant to the Misuse of Drugs and Medicines Acts and support in principle for the revocation of such gazetted prohibitions was given. Gazetted doctors must make application direct to the Minister for such prohibitions to be lifted but it is common practice for the Council's views to be sought before the Minister's decision is made.

The outcome of disciplinary action against Drs Sidebotham, Guy, Bragan, Geard, Wilkie, Howard and Narayan have been published in the New Zealand Medical Journal. One doctor was acquitted and in the case referred back from the High Court publication was ordered without disclosure of the doctor's name.

Looking towards possible re-registration applications, Council has taken a particular interest in the assessment of doctors disciplined for sexual misconduct. It is important that the profession understands Council's expectations about the standards to be achieved before any person can be returned to the register. This is particularly so in relation to sexual offenders. This issue is dealt with in more detail under the section of the report concerning Council's sexual abuse initiatives.

A brochure setting out procedure when complaints are lodged with the Medical Council (rather than the Medical Practitioners Disciplinary Committee) has been printed and is made available on request. It will need to be modified when the interface with the Health and Disability Commissioner is activated in 1996.

Council considered at some length the handling of complaints against doctors which involve events which are outside the doctor/patient relationship. The present Council takes the view that each complaint must be looked at on its merits and if professional conduct is at issue it should be considered as coming within the Council's disciplinary jurisdiction. There may, never-theless, be occasions when the matter has also been subject to civil or criminal proceedings or where any one of a variety of bodies which have a legitimate interest in the conduct have also taken action.

## Current Issues

Council has been regularly approached for comment on a variety of issues. They ranged from legislation contemplated or recently introduced to parliament to matters of concern to individual doctors or patients or particular professional or community groups, for example advertising, medical records, and medicolegal questions. An Issues Committee was established to deal with these requests as deadlines for responses were often tight. During the past year the committee and Council considered questions raised concerning informed consent, assisted reproductive technology, euthanasia and developments in the educa-tional sector involving the New Zealand Qualifications Authority and the Health Industry Training Organisation.

The Council's draft statement on "Duties in an Environment of Competition and Resource Constraint" is available on request and has been given to a number of individual doctors who had concerns.

Council has used its regular newsletter, *MCNewZ*, and the NZ Medical Journal to publish any statements for guidance of the profession. Topics raised in the August *MCNewZ* included responsibility for medical workforce planning, fitness to practise in elderly doctors, and the release of pamphlets for the profession and the public on trust in the doctor/patient relationship.

The December issue of *MCNewZ* highlighted communicating in medicine, the Council's statement on inclusion of a clinical teaching component in the CHE employment contracts, and competence in relation to age.

The March issue of *MCNewZ* focussed on the annual practising certificate and changes which will occur when the new Medical Practitioners Act links the annual practising certificate to continuing competence and fitness to practise. Council noted that the earlier distribution of the annual practising certificate application form was highly successful and aims to carry out this mailout in February 1996 so that the majority of certificates can be issued by 1 April.



## Trust in the Doctor/Patient Relationship

Further developments in Council's initiatives on this important internationally recognised concern were reported throughout the year.

### Pamphlet published

Following wide consultation the Council distributed a booklet for doctors and two patient pamphlets. The doctors' booklet contained an outline of the Council's position, advice on professional boundaries and the safeguards a doctor should adopt to avoid misunderstandings, inappropriate behaviour and complaints. It was sent to all registered medical practitioners, the Doctors' Health Advisory Service, Medical Defence Union and the Medical Protection Society.

Two pamphlets containing information and guidelines for patients were also published. "Patient Information about Professional Sexual Boundaries" was of a general nature and was intended for wide distribution through consumer health and community agencies including pharmacies. It advised patients of the key issues and of the professional behaviour they should expect from their doctors. It was hoped that doctors would make them available in their surgeries.

A more detailed pamphlet "Guidelines for Concerned Patients about Professional Sexual Boundaries" was specifically aimed at patients who have definite concerns about the behaviour of their doctors. It included the Council's definition of sexual abuse and explained policy on the issue and was distributed to organisations such as Citizens Advice Bureaus, Family Planning, Help Centres and the Sexual Abuse Counselling Services.

### Reporting patients' concerns

At its September meeting Council adopted a new ethical policy to guide doctors in reporting patients concerns about doctor/patient sexual misconduct. Doctors who learn of doctor/patient sexual misconduct have an ethical obligation to help patients to make a report or to make a report themselves, but only if the patient agrees. This includes informing the patient of her or his rights by providing copies of the Medical Council's information pamphlets on sexual abuse and on the complaints procedure. Doctors should answer any questions a patient raises about the issue of professional sexual misconduct and ask whether the patient wants to make a report. If the patient agrees, the doctor needs to ensure that the patient files a written report with the secretary of Council within 30 days, disclosing their name, the name of the involved doctor and the details of the incident(s). If the patient is unwilling to do this but still wants to report the situation the doctor should file a written third party report with the secretary.

Council acknowledged that if the patient states they want no report filed on the

situation, the doctor has then fulfilled his or her ethical obligation by providing the information leaflets, discussing the issue and offering to assist with making a report.

### Former patients

In the first half of 1995 Council focussed on developing draft guidelines and statements on "Ending a Professional Relationship" and "Sexual Relationships with a Former Patient". Both of these drafts were published in the July 1995 issue of *MCNewZ*. Council noted that in the past there had been no general guidelines on these issues and provided the drafts to assist with the process. Previous issues addressed concentrated on current patients but a number of doctors and patients had raised issues concerning relationships with former patients. Policy development is an evolutionary process and must involve continuing consultation with both doctors and patients and their advocates. Feedback was welcomed.

### Assessment and treatment

Policy on assessment and rehabilitation of doctors admitting or found guilty of sexual misconduct was adopted in June 1995 based on the following principles:

Council -

(a) believes that its first priority is protection of the public.

(b) acknowledges that although the rehabilitation of sexual offenders will not always be successful, it will encourage assessment and treatment at the earliest opportunity.

(c) stresses that the onus is on the doctor to meet proper standards of rehabilitation before re-registration.

(d) stresses that the onus is on the doctor to meet the costs of assessment and rehabilitation, and of assessment of progress.

(e) stresses that successful rehabilitation requires the doctor to show understanding of the behaviour found improper and develop victim empathy.

Protocols are being developed for each of the steps necessary for reregistration:

*Step 1 - Assessment of Doctor*

The Medical Council will maintain a panel of psychiatrists and psychologists with expertise in sexual abuse matters. An offending doctor wishing to apply for re-registration must be assessed by a professional from each discipline, the assessment aimed at defining the nature of the offending, suitable treatment and the likely outcome of therapy.

*Step 2 - Rehabilitation of Doctor*

The Medical Council will maintain a panel of therapists with expertise in the rehabilitation of sexual offenders. The assessed doctor will attend one of these accredited therapists as the assessors and therapist recommend. The therapy will be aimed at ensuring, as far as is possible, that the doctor will practise safely in the future.

*Step 3 - Reassessment of Doctor*

Before hearing an application for re-registration the Medical Council will require an independent assessment of the doctor's progress following therapy. A full report of this reassessment, indicating changes the doctor has made during therapy, must be made available to the Medical Council with the re-registration application. The aim of the reassessment is to ascertain the safety of the doctor to be a registered medical practitioner.

Copies of all publications can be obtained from the Council's office. Council will arrange for systematic documentation and regular review of its assessment and rehabilitation processes. This will provide a database of New Zealand information which will enhance the effectiveness of future intervention and education in this field.

## Informed Consent

In 1990 the Medical Council published a statement on information and consent which has been very highly regarded as a comprehensive, up to date and workable guideline in a key area of doctor/patient relationships.

During the year a disciplinary case heard by the Medical Practitioners Disciplinary Committee drew attention to the need for refinement of the statement with respect to postgraduate experiential training and utilisation of new techniques and technology. The 1990 statement covered the learning situation of trainees but was silent on the matter in relation to specialists.

The statement has therefore been modified and is reprinted with this annual report. It incorporates a sentence to cover the situation where a specialist is learning a new procedure relevant to his or her area of expertise and what information should be provided when obtaining consent from prospective patients during the phase that the specialist is gaining experience in that procedure.

Council acknowledges that the Code of Consumers Rights will also address these issues.

## MEDICAL COUNCIL LIAISON WITH OTHER BODIES

As the governing body of the medical profession, Council is one of a number of organisations concerned with the promotion and maintenance of high standards of patient care and professional conduct. Council's statutory functions can tend to isolate it from ongoing contact with such bodies and special effort has therefore been made to maintain good working relationships and meet face to face occasionally with representatives of such groups. Such meetings have focussed on issues of particular concern at the time.

Regular meetings have been held between the Chair of Council and the Chairman of New Zealand Medical Association. Debate has often been lively and this is a healthy sign. Issues which have arisen over the past year which have been of particular concern to these two major players in the profession include the Minister of Social Welfare's controversial change to the Social Security Act, development of policy and guidelines on persistent vegetative state and more recently attitudes to euthanasia, advice to the profession on standards of conduct in times of resource constraint, privacy issues and a variety of amendments to other legislation.

Council met with the newly appointed Health and Disability Commissioner in order to establish good communication from the outset as the Commissioner and Council will in the future be required to work together to resolve complaints. The Council looks forward to the educational effect on doctors of the publication of the Code of Consumers Rights. The existence of a nationwide system of patient advocacy will undoubtedly address what is often perceived by patients to be an imbalance in the power relationship with their medical advisors.

Dr Thomson was a member of in the Medical Law Reform group which pressed for legislative change concerning medical manslaughter. The benefit of making a concerted effort where an issue is of major concern was demonstrated by the outcome the group achieved.

Council, as the funder of DHAS, expects accountability from this body although it respects the need for the two organisations to be at arms length in order to protect confidentiality and encourage referrals to DHAS. To clarify boundary issues between Council and DHAS a meeting was held in February 1995. A variety of topics were covered, particularly relating to the Health Committee's continuing surveillance and monitoring of impaired doctors. Issues to do with reporting and subsequent action where doctors were believed to be in breach of the trust relationship through sexual involvement with patients were covered in detail. Council was concerned that any such doctors who might be placing patients at risk should not be allowed to shelter under the umbrella of DHAS and avoid facing up to the consequences of unethical conduct.

Council has maintained regular contact with bodies concerned with standards of obstetric practice, eg the Nursing Council, the College of Midwives, the Royal New Zealand College of Obstetrics and Gynaecology and has tried to work towards resolving boundary difficulties which are alleged to have contributed to some unhappy out-comes for mothers and babies.

Council delegates have attended relevant conferences over the last year. Examples include the February 1995 Ethics in Healthcare Conference at Massey University and medico-legal and privacy updates.

## SECRETARIAT REPORT

### Authority

One sentence in the Medical Practitioners Act 1968 covers the provision for a Council secretariat. Clause 6, entitled "Secretary and other officers, servants and agents", states "the Council shall from time to time appoint a Secretary to the Medical Council of New Zealand and such other officers, servants, and agents as it thinks fit, and may pay them such remuneration as it considers appropriate". On further scrutiny of the Act, reference is made to the Secretary in a great many other clauses. Particular duties which are to be carried out in the Secretary's own right subject to the direction of the Chairman or Council are set down. In addition, there are roles related to committees, these include the Medical Education Committee, Preliminary Proceedings Committee and other committees which Council may appoint pursuant to section 13 of the Act.

### Activities - Then and Now

The Secretary has responsibility for many aspects of registration. These include the annual publication of the New Zealand Medical Registers. She receives notifications of disability and complaints of possible misconduct and ensures the proper procedures are followed when such information is received and actioned. The Secretary must issue annual practising certificates, collect workforce data and receive fees set periodically in regulations.

In 1969, the first year of operation of the "new" Act, when Sir Douglas Robb was Chairman of the Council and Mr K A G Hindes the Secretary and there were less than 4500 doctors on the New Zealand Medical Register, it was necessary for the Secretary to have administrative assistance to effectively serve the Council and also the practitioners who were seeking registration. At that time there was no lay member of Council and approaches from the public to the Council secretariat were infrequent. The annual practising certificate fee was $5. There was no disciplinary levy, nor any provision for one.

The Medical Council held quarterly meetings lasting one to two days. The business transacted in November 1969 included 14 temporary registrations, 10 applications from overseas graduates for full registration, seven New Zealand graduates granted full registration following house officer service in approved hospitals, conditional registration of one overseas graduate, the removal of 16 names from the register (including five who had died), two applications for change of name and 100 for entry of additional qualifications.

There was no specialist registration provision at that time and many of the advanced qualifications were obtained from colleges and institutions in the United Kingdom. The Australasian Colleges of Surgeons and Physicians and the Australian and New Zealand College of Psychiatrists



Table 11

**WORKLOAD INDICATORS**

| | Year ended 30 June 1993 | Year ended 30 June 1994 | Year ended 30 June 1995 |
|---|---|---|---|
| Provisional Certificates: | 663 | 910 | 818 |
| Conditional Registration | 247 | 280 | 267 |
| NZ graduates | 245 | 274 | 262 |
| OS graduates | 2 | 6 | 5 |
| Full Registration | | | |
| OS graduates | 386 | 488 | 406 |
| Restorations | | | |
| NZ graduates | 11 | 11 | 4 |
| OS graduates | 19 | 22 | 25 |
| Temporary Certificates: | | | |
| New certificates | 90 | 99 | 86 |
| Extensions | 291 | 208 | 211 |
| Probationary Certificates: | | | |
| New certificates | 55 | 48 | 77 |
| Extensions | 26 | 46 | 42 |
| Conditional to Full Registration | 246 | 240 | 264 |
| Probationary to Full Registration | 65 | 63 | 54 |
| Additions to Specialist Register | 169 | 166 | 166 |
| Additions to Indicative (GP) Register | 13 | 17 | 106 |
| Modifications to NZ Medical Register: | | | |
| Changes of address | 3014 | 3077 | 3645 |
| Changes of name | 27 | 33 | 37 |
| Additional qualifications | 512 | 393 | 402 |
| Suspensions or variations | 7 | 7 | 7 |
| Removals: | | | |
| Deaths | 51 | 55 | 49 |
| Discipline | 4 | 6 | 4 |
| Failure to notify address | 98 | 67 | 59 |
| Non-resident overseas graduates | 22 | 1 | 64 |
| At own request | 87 | 31 | 152 |
| Annual Practising Certificates | 7406 | 7521 | 9160 |
| Certificates of Good Standing | 480 | 469 | 533 |
| Certificates of Registration | 138 | 131 | 123 |
| Receipts Issued (excl APCs) | 2869 | 3037 | 2744 |
| Total Computer Transactions | 16619 | 17491 | 29169 |

had been established however. Council had adopted the following criteria for considering applications for inclusion in a provisional list of specialists: "qualified for at least 15 years, at least eight years practical experience, recognition by colleagues as having specialist standing and working 50 per cent or more in the field".

Also on the agenda was the publication of medical register statistics, consideration of amendments already needed for the new 1968 Act, and a disciplinary hearing. The charges involved a complaint of "grave impropriety in a professional respect" made by the Solicitor General under the Medical Practitioners Act 1950. Evidence was adduced and the accused doctor cross-examined. Council found the complaint proven and ordered that the doctor be censured. Costs and publication were also ordered. The hearing was concluded within the agenda of the ordinary Council meeting.

Twenty five years later the workload indicators in table 11 show the dramatic increase in workload over the last three decades. This resulted from changing needs and expectations of the public, doctors, politicians and Council members themselves. The increased complexity of health care delivery, and the trend towards globalisation, which has brought an upsurge in medical migration, have also affected workload.

The Secretary must not only continue to carry out all the statutory functions in an accurate, prompt manner but also manage a significant number of staff.

Today, although the volume is much greater and secretariat staffing has increased accordingly, the core functions remain similar, namely:

- preparation of agendas
- recording of minutes of Council and committee meetings
- processing of applications for all forms of registration and maintenance of the NZ medical registers
- maintenance of Council records and preparation of correspondence
- receipt and processing of complaints and, as required, administration of hearings for disciplinary purposes
- assistance to the Council's Health Committee in the monitoring of impaired doctors, including if necessary the administration of suspension provisions
- liaison with Ministry of Health, specialist colleges and societies, other health regulatory bodies in New Zealand and overseas, NZMA and other professional groups, employers, funders and community groups
- service of the Medical Education Committee and the NZREX Board of Examiners
- financial management and reporting
- special projects associated with particular Council initiatives (topics such as informed consent, biotechnology and professional sexual boundaries were not on the agenda in 1969 !)
- handling inquiries from overseas trained doctors wishing to register for work in New Zealand, including management of the Council's examination and assessment procedures.

New relationships have been established over the years such as those with ACC (regarding referrals of medical misadventure matters) and the Health and Disability Commissioner. When the Code of Consumers' Rights is operational in the near future regular consultation between the Council and the Commissioner will increase.

### Quality Assurance and Development

The secretariat aims to focus on the needs of those it serves and to improve its practices and procedures continuously. In the past year the upgraded computer system has brought many benefits but it will be necessary for more modifications and expansion of databases to occur over the next two years to enable the volume of work to be handled efficiently. This will be important to accommodate the new interfaces in the Medical Practitioners Bill 1994 between competence, recertification and annual practising certificates.

The workforce database will be located to Wellington in 1996.

The restructured secretariat was described in the 1994 Annual Report and has passed through the settling down period. Real gains are now being obtained from the team structure. Some fine tuning is still necessary as some members of staff are overloaded and there are one or two gaps in the establishment. Staff have worked efficiently and in a dedicated manner over the last year and very few days have been lost from sick leave despite the fact that an air conditioned building is not always conducive to good health! Regular staff training was offered and key staff members were involved in Council meetings with individuals or organisations who have a joint stake in medical registration and maintenance of standards. Consultants were used where necessary but mainly the secretariat is committed to building up its own expertise in as wide a range of skills as possible.

Considerable thought is now going into preparations for administration of the new Medical Practitioners Bill once it becomes legislation, hopefully in 1996.

### Performance

Every member of the secretariat made a significant contribution to the management and activities of the Council. The team leaders have particularly critical roles and made good progress in building their teams from the point of view of expertise, efficiency and good working relationships. These strengths are reflected in the positive comments frequently made about the way secretariat members provide services to people.

The Education and Examination Executives had a particularly busy, and sometimes trying, year. Project work has tailed off somewhat in the last few months as major policy development on "Trust in the Doctor/Patient Relationship" moved towards completion.

### NOTIFICATION OF CHANGE OF ADDRESS

*All registered doctors have a* ***statutory responsibility*** *to keep Council informed of their* ***current address****. Changes must be notified promptly (that is within one month) - failure to do so can result in removal from the register. Before removal is actioned, a list of "lost" doctors is published in the New Zealand Medical Journal. The onus is on* ***doctors****, not the Council secretariat, to advise the Secretary where a change of address occurs.*

In June 1995 an appointment was made to the communications role as it appeared this would be very necessary in the transition to the new legislation.

### Liaison

The Secretary continued to maintain liaison with other Secretaries and Registrars in the health professional regulatory field, in New Zealand and overseas. In her previous dual role as Secretary of the Dental Council she was involved in organising workshops for lay members of boards and councils and also for those involved in the management of complaints and disciplinary processes. The Dental Council has now established its own secretariat separate from the Medical Council as the ever increasing workload of both was becoming incompatible. Given the changes over the next few years, the Medical Council

secretariat needs to be able to focus without distraction on the principal development and issues facing the medical profession and its governing body.

### Acknowledgments

The secretariat has appreciated the support of Council over the past year. The good working relationships forged with all external agencies and their staff was greatly valued. Individual doctors and patients have given positive feedback on the quality of staff communications and advice. This reinforcement of the key role of the secretariat contributed to morale and continuous improvement.

## FINANCE

The attached financial statement covers the period 1 April 1994 to 31 March 1995, although the year under review is to 30 June 1995.

### General Council Operations

There was a very slight increase in operating expenses over the previous year some of which was due to the change in timing of the annual practising certificate issue. Agents fees were increased to recognise the important role of the registration interview. There were some significant one off payments associated with the reorganisation of the Council office and records system and the upgrading of the computer system. Public relations activities, including publication of the Annual Report, *MCNewZ*, and media consultancy costs were almost double that of the previous year.

Council and committee expenses remained at a similar level to the preceding year with the exception of meetings in relation to provisions of the Medical Practitioners Bill, which required a substantial involvement of Council members while the Bill was before the Select Committee.

Intern supervisors' meetings and hospital accreditation visits resumed. There were none in the previous year during the initial stages of CHE organisation. An apparent drop in the expenditure on intern supervisors contracts reflects the reluctance of some intern supervisors to claim the allowances due to them.

There was a substantial contribution towards the costs of accreditation of the University of Otago by the AMC Accreditation Committee and a similar payment towards the Auckland Medical School will be noted in the 1995/96 year's accounts. These are being drawn from the Education Fund which was established in 1991/92 for this purpose.

Income increased by about 10 per cent, partly through an increase in interest received, which reflected the more substantial balance in the Council accounts, due to two annual practising certificate



collections (one late, and one early) falling in the same financial year.

### Discipline Fund

There was a very substantial increase in income in this fund resulting from the increased disciplinary levy, and the higher amount of disciplinary costs recovered after proceedings. Some of these costs had been outstanding for some time awaiting the outcome of appeal hearings.

However, expenditure on High Court actions also rose reflecting the large number of appeals to the High Court made during the current year. The legal expenses of the Preliminary Proceedings Committee rose about eight per cent and advice from media consultants was needed to attempt to deal effectively with outcomes of some decisions on complaints.

The costs of the sexual abuse initiatives, including the working party, training workshops and the pamphlets for doctors and patients, are contained in the discipline fund. A general rise in some of the other expenses reflects only the length and complexity of some of the disciplinary hearings.

At the end of this year, the fund was in a more satisfactory position than at the end of the last financial year, but the unpredictability of disciplinary expenditure remains a major problem when budgeting for an appropriate disciplinary levy.

### Examinations Fund

The increase in candidate fees received reflected the growing number of candidates rather than any rise in the fees themselves. The higher number of candidates was also reflected in the increase in examiners fees and expenses and the need for a full rather than half time examination officer. A small surplus has been carried forward and will be necessary to cover examination review and development as the new Bill's provisions are implemented.

### Taxation

At the time of writing, the appeal by the Commissioner of Inland Revenue against the decision of the Taxation Review Authority on the Medical Council's tax status was being heard.

### Finance and Management Committee

The full committee has met at least quarterly and regular monthly financial reports have been mailed to each member. Computer and staffing problems which arose in the latter months of the financial period under review caused some disruption but they are now satisfactorily resolved. The processing of payments, record keeping and reporting are all now of higher quality.

The accounts and financial statements follow. Responses to requests for explanation of any items can be published in *MCNewZ*.

# Miller Dean Knight & Little

Chartered Accountants

**THE MEDICAL COUNCIL OF NEW ZEALAND**
**AUDITORS' REPORT**
**FOR THE YEAR ENDED 31 MARCH 1995**

**To : Members of the Medical Council Of New Zealand**

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

We have audited the attached financial statements which provide information about the past financial performance of the Council and its financial position as at 31 March 1995. This information is stated in accordance with the accounting policies set out in the notes to the financial statements.

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

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

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

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

We carry out other assignments for the Council in the area of taxation advice and systems consultancy and have assisted with the preparation of the statement of cash flows. Other than this, we have no other interests in The Medical Council.

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

Unqualified Opinion
We have obtained all the information and explanations we have required. In our opinion the attached financial statements fairly reflect the financial position of The Medical Council as at 31 March 1995 and the results of its operations and cash flows for the year ended on that date.

Date Of Opinion
Our audit was completed on the date shown below and our opinion is expressed as at that date.

Miller Dean Knight & Little

**17 October 1995**





## NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENT
**for the year ended 31 March 1995**

### 1. Statement of Accounting Policies

**Reporting Entity**

The Medical Council of New Zealand is a statutory body constituted under the Medical Practitioners Act 1968.

**General Accounting Policies**

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

**Measurement Base**

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

**Specific Accounting Policies**

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

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

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

Air-conditioning and office alterations at the former premises at Courtenay Place were sold during the financial year and the losses have been included under Depreciation for Year (Note 5).

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

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

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

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

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

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

### Changes in Accounting Policies

There have been no material changes in accounting policies. All accounting policies have been applied on bases consistent with those used in pervious years.

### 2. Taxation

In July 1993 the Taxation Review Authority found the Medical Council to be exempt from Income Tax. In view of this decision the tax provided for in previous years has been reversed. An application will be made for the tax paid to 31 March 1995 amounting to $459,432 plus Resident Withholding Tax deducted ($36,599) to be refunded.

This decision of the Taxation Review Authority has been appealed by the Commissioner of Inland Revenue to the High Court. (Note 10)

At the time of publishing the annual accounts the case had been heard but the judge had reserved his decision.

### 3. Payments in Advance and Debtors

The debtors figure includes outstanding contribution to the workforce survey of $38,000 (excluding GST).

### 4. Term Deposits

| | 1995 | 1994 |
|---|---|---|
| ANZ Bank | 1,430,453 | 100,825 |
| BNZ Finance | 1,094 | 60,339 |
| National Bank | 18,368 | 50,288 |
| Trust Bank | 1,894,701 | 152,611 |
| Westpac | - | 74,465 |
| TOTAL INVESTMENTS | $3,344,616 | $438,528 |

The first ranking debentures in Equiticorp Finance Limited and interest accrued are not shown in the books. The original capital invested was written down to 85% and the accrued interest to nil, reflecting the expected realisation of this investment. Some 96% of the original capital has now been recovered but the investment balance is shown as nil. Recoveries in excess of the written down amount are shown as Prior Year Income in the General Fund.



### 5. Fixed Assets

| | Cost | Deprec for Year | Accum Deprec | Book Value | Cost | Accum Value | Book Value |
|---|---|---|---|---|---|---|---|
| | 31/3/95 | 31/3/95 | 31/3/95 | 31/3/95 | 31/3/94 | 31/3/94 | 1/4/94 |
| Air-Conditioning | - | 4,000 | - | - | 36,704 | 31,704 | 5,000 |
| Computer | 303,474 | 33,459 | 185,716 | 117,758 | 204,637 | 152,257 | 52,380 |
| Furniture and Fittings | 150,407 | 14,905 | 90,783 | 59,624 | 135,376 | 75,878 | 59,498 |
| Office Alterations | - | 3,533 | - | - | 157,364 | 152,364 | 5,000 |
| Office Alterations - New Premises | 100,416 | 10,042 | 19,949 | 80,467 | 99,065 | 9,907 | 89,158 |
| Office Equipment | 72,513 | 11,178 | 41,412 | 31,101 | 63,286 | 30,235 | 33,051 |
| | $626,810 | $77,117 | $337,860 | $288,950 | $696,432 | $452,345 | $244,087 |

Depreciation for year includes write-offs for fixed assets at the former premises at Courtenay Place:

| | 1995 Loss on Sale | 1994 Write Down |
|---|---|---|
| Air-conditioning | 4,000 | 12,236 |
| Office Alterations | 3,533 | 45,793 |
| | $7,533 | $58,029 |

### 6. Prior Year Adjustments

Details of prior year adjustments are as follows:
Recovery of Investments previously written off-

| | General Fund 1995 | General Fund 1994 |
|---|---|---|
| Equiticorp Finance Limited | 8,230 | 3,249 |

### 7. Related Parties

There were no related party transactions.

### 8. Foreign Currencies

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

## 9. Reconciliation of Net Surplus with the Net Cash Flow from Statutory Functions

**for the year ended 31 March 1995**

| | | 1995 | 1994 |
|---|---|---|---|
| **Surplus (Deficit) for year** | | | |
| General Fund | | 324,255 | 339,005 |
| Discipline Fund | | 658,666 | (722,158) |
| Examination Fund | | 29,409 | 24,207 |
| | | 1,012,330 | (358,946) |
| Less Taxation Paid | | (36,599) | (73,332) |
| | | 975,731 | (432,278) |
| Add Non-Cash Items - Depreciation | | 77,117 | 117,385 |
| | | 1,052,848 | (314,893) |
| Add Movements in Working Capital items | | | |
| Increase in Debtors and Prepayments | (19,951) | | 73,773 |
| Increase in Receipts in Advance | 2,445,117 | | 64,853 |
| Increase in Creditors and GST | 325,948 | | (150,600) |
| | | 2,751,114 | (11,974) |
| | | 3,803,962 | (326,867) |
| Less Items Classified as Investing Activity-Interest | | (159,246) | (85,790) |
| Net Cash flow from Statutory Functions | | $3,644,716 | ($412,657) |

## 10. Contingent Liabilities

A contingent liability relating to income tax exists until the Council's tax status is determined in the courts (Note 2). It is not possible to estimate the tax liability should the Council be found liable for income tax, until the Commissioner of Inland Revenue has determined from which year tax is to be assessed. Should the Council be found liable for income tax at rates applicable to companies from the year ended 31 March 1990 to the year ended 31 March 1995 (6 years inclusive) the liability is estimated at $550,000. This amount does not include any additional tax or interest on arrears of tax which may be assessed.

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

## 11. Events occurring after Balance Date

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

## 12. Commitments – Operating Leases

Lease commitments under non-cancellable operating leases;

| | 1995 | 1994 |
|---|---|---|
| Not more than one year | 93,396 | 77,132 |
| Later than one year and not later than two years | 93,396 | 93,396 |
| Later than two years and not later than five years | 280,188 | 280,188 |
| Later than five years | 287,971 | 381,367 |
| | $754,951 | $832,083 |

## 13. Financial Instruments

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

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

Debtors are shown at a fair value.

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

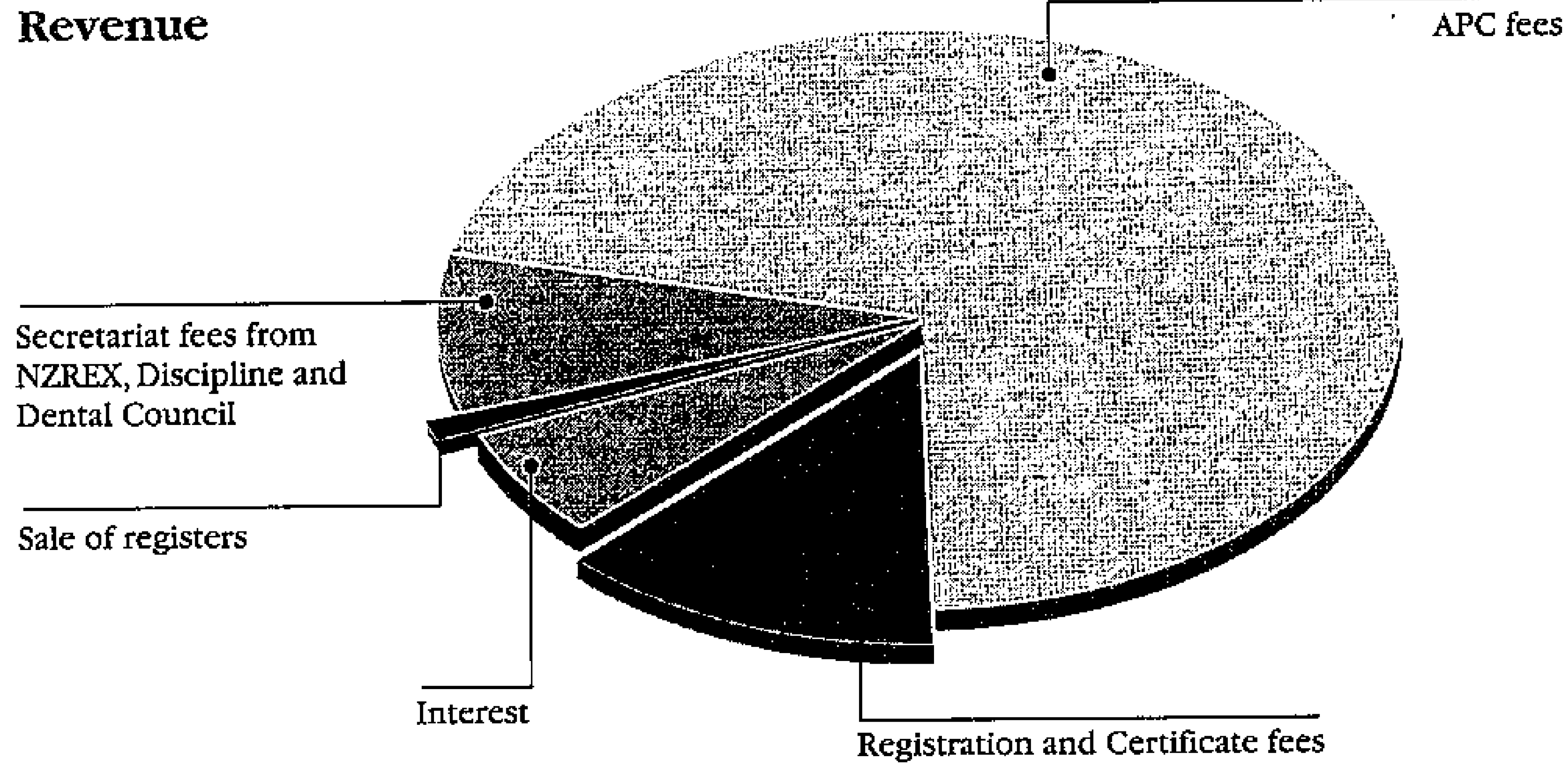
| | 1995 | 1994 |
|---|---|---|
| Receivables | 56,011 | 26,467 |
| Bank-balances | 4,074,047 | 387,496 |
| Payables | (544,372) | (217,844) |

# Distribution of Council Revenue and Expenditure

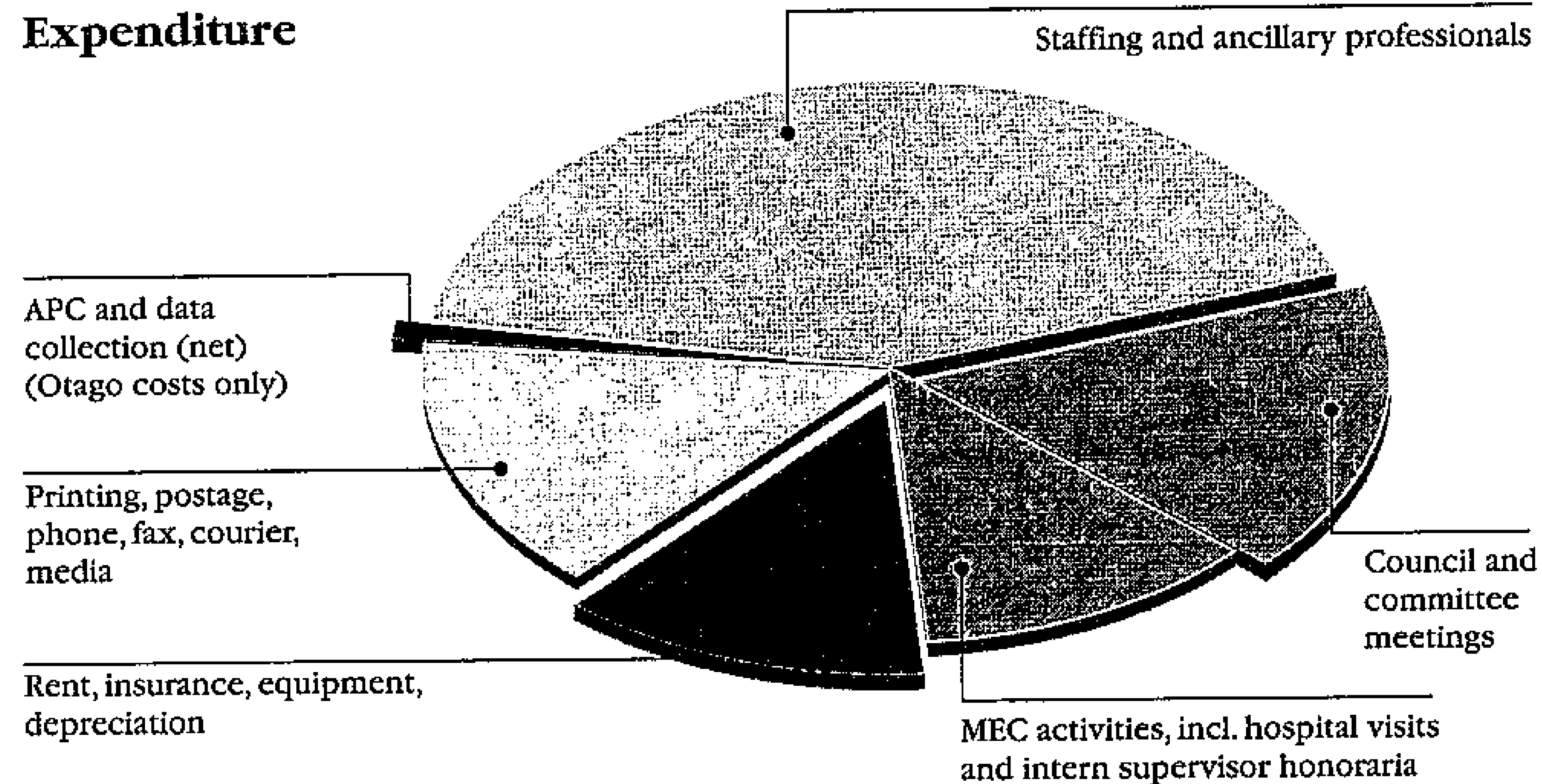
**for the year ended 31 March 1995**

### General Fund (37% of turnover)

## Revenue




## Expenditure

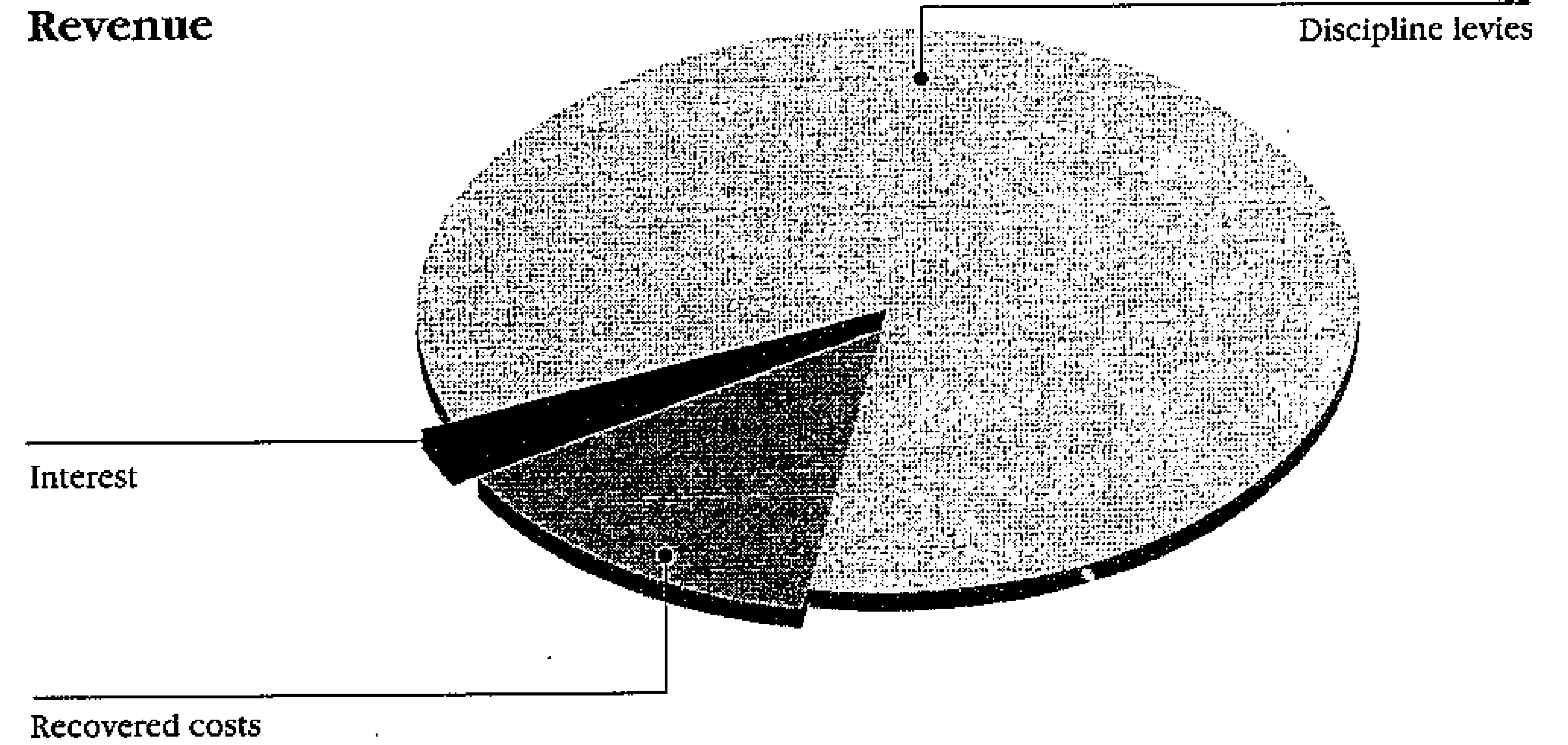



These graphics are to be read in conjunction with detailed financial reports on pages 51 to 55 and pages 58 to 64.

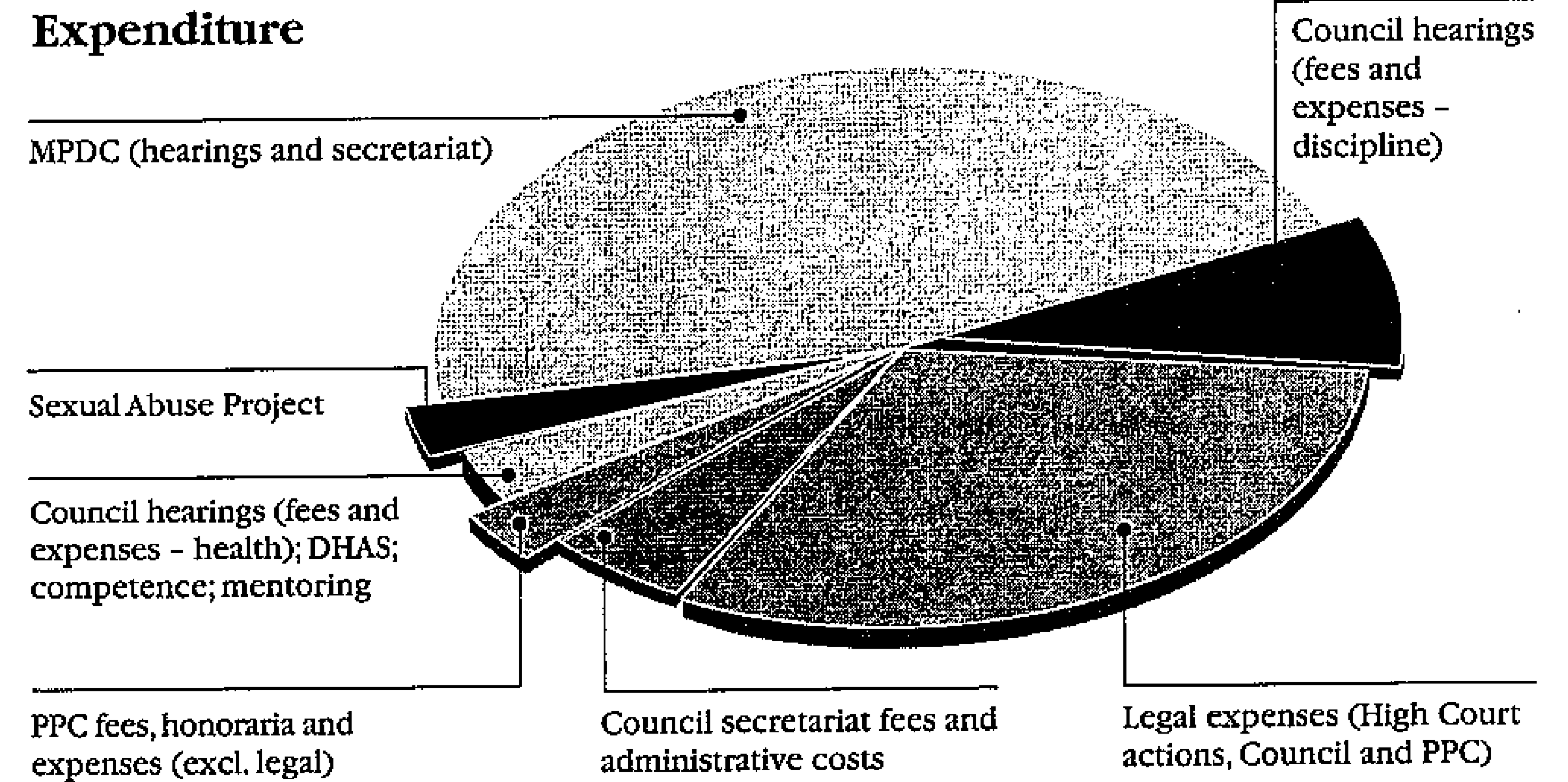


### Discipline Fund (63% of turnover)

## Revenue




## Expenditure




These graphics are to be read in conjunction with detailed financial reports on pages 51 to 55 and pages 58 to 64.

MEDICAL COUNCIL OF NEW ZEALAND

## BALANCE SHEET

**as at 31 March 1995**

| | 1995 | 1994 |
|---|---|---|
| CURRENT ASSETS | | |
| Petty Cash | 310 | 310 |
| ANZ Bank Account | 729,431 | (51,032) |
| Sundry Debtors and Payments in Advance | 63,761 | 42,810 |
| Interest Accrued | 5,640 | 2,399 |
| Taxation Refund Due (Note 2) | 496,031 | 459,432 |
| Term Deposits (Note 4) | 3,344,616 | 438,528 |
| | 4,639,789 | 892,447 |
| FIXED ASSETS (Note 5) | 288,950 | 244,087 |
| TOTAL ASSETS | $4,928,739 | $1,136,534 |
| CURRENT LIABILITIES | | |
| Sundry Creditors | | |
| - General Fund | 104,553 | 107,748 |
| - Discipline Fund | 205,552 | 163,273 |
| - NZREX | 34,684 | 10,042 |
| GST | 199,583 | (63,219) |
| Payments Received in Advance | 2,608,376 | 163,259 |
| TOTAL CURRENT LIABILITIES | 3,152,748 | 381,103 |
| CAPITAL ACCOUNT | | |
| Accumulated Capital | 1,146,643 | 757,386 |
| Discipline Fund | 470,375 | (188,291) |
| Education Fund | 118,228 | 175,000 |
| Examination Fund | 40,745 | 11,336 |
| | 1,775,991 | 755,431 |
| | $4,928,739 | $1,136,534 |

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



MEDICAL COUNCIL OF NEW ZEALAND

## GENERAL FUND REVENUE STATEMENT

**for the year ended 31 March 1995**

| | 1995 | 1994 |
|---|---|---|
| FEES RECEIVED | | |
| Annual Practising Certificate | 1,262,437 | 1,235,249 |
| Certificate of Good Standing | 13,388 | 12,658 |
| Medical Registration Certificate | 3,239 | 3,206 |
| Change of Name | 1,120 | 747 |
| Registration Fees | 185,114 | 182,700 |
| Specialist Registration Fees | 20,534 | 13,085 |
| INCOME FROM FEES | 1,485,832 | 1,447,645 |
| OTHER INCOME | | |
| Administration Fee - Dental Council | 32,600 | 27,500 |
| Administration Fee - Discipline Fund (Note 1) | 100,000 | 60,000 |
| Administration Fee - Examination Fund (Note 1) | 30,000 | 30,000 |
| Interest Received | 107,358 | 46,862 |
| Sales of Medical Registers | 25,358 | 26,783 |
| Sundry Income | 1,145 | 730 |
| INCOME FROM OTHER SOURCES | 296,461 | 191,875 |
| TOTAL INCOME FOR YEAR | 1,782,293 | 1,639,520 |
| Less Expenses from Schedule | 1,458,038 | 1,303,764 |
| Net Surplus for Year | 324,255 | 335,756 |
| Prior Year Income (Note 6) | 8,230 | 3,249 |
| Retained Earnings at Start of Year | 757,386 | 443,381 |
| Transfer from/(to) Education Fund | 56,772 | (25,000) |
| RETAINED EARNINGS AT END OF YEAR | $1,146,643 | $757,386 |

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

## GENERAL FUND SCHEDULE OF EXPENSES

**for the year ended 31 March 1995**

| | | 1995 | 1994 |
|---|---|---|---|
| ADMINISTRATION AND OPERATING EXPENSES | | | |
| ACC Levies | | 5,930 | 5,263 |
| Audit Fees | | 7,000 | 8,500 |
| Agents Registration Fees | | 12,540 | 5,110 |
| Computer Consultancy | | 18,120 | 4,693 |
| Cleaning | | 4,327 | 3,603 |
| Courier | | 8,696 | 6,267 |
| Depreciation | | 77,117 | 117,385 |
| Electricity | | 1,924 | 6,419 |
| Equipment Hire | | 6,287 | 3,732 |
| Fringe Benefit Tax | | 3,346 | 5,060 |
| General Expenses | | 4,972 | 2,031 |
| Legal Expenses | | 2,080 | 39,293 |
| File Management | | 10,939 | 1,244 |
| Medical Workforce Expenses | | 13,362 | 17,298 |
| Photocopying Expenses | | 19,343 | 12,644 |
| Postage | | 35,019 | 31,179 |
| Printing and Stationery | | 89,950 | 72,474 |
| Privacy | | 264 | 1,267 |
| Projects | - Administration Review | 3,124 | |
| | - Biotechnology Revisited | | 15,009 |
| | - Persistent Vegetative State | 123 | |
| | - Summer Studentship | 3,041 | 2,600 |
| Public Communications | | 47,762 | 29,045 |
| Rent and Insurance | | 89,971 | 81,933 |
| Repairs and Maintenance | | 7,758 | 12,241 |
| Salaries | | 470,588 | 412,810 |
| Superannuation and Health Insurance | | 39,421 | 36,808 |
| Staff Recruitment & Training | | 36,664 | 28,837 |
| Telephone and Tolls | | 20,219 | 17,436 |
| TOTAL ADMINISTRATION EXPENSES | | 1,039,887 | 980,181 |



| | 1995 | 1994 |
|---|---|---|
| TOTAL ADMINISTRATION EXPENSES Carried forward | 1,039,887 | 980,181 |
| COUNCIL AND COMMITTEE EXPENSES | | |
| Council Expenses | | |
| - Chairperson's Honorarium | 59,417 | 58,524 |
| - Fees and Expenses | 115,846 | 125,828 |
| - Australasian Liaison Meetings | 13,938 | 11,629 |
| - Conference Expenses | 10,990 | |
| Registration Committee | 12,964 | 12,129 |
| Act Revision | 25,168 | 4,955 |
| Data Committee | 941 | 2,669 |
| Finance & Management Committee | 6,204 | 6,477 |
| Issues Committee | 1,709 | |
| Medical Education Committee | | |
| - Fees and Expenses | 21,508 | 21,324 |
| - Hospital Visits | 22,333 | |
| - University Accreditation | 56,772 | |
| Intern Supervisors Meetings | 10,956 | 288 |
| Intern Supervisors Contracts | 59,405 | 79,760 |
| TOTAL COUNCIL AND COMMITTEE EXPENSES | 418,151 | 323,583 |
| TOTAL EXPENDITURE | $1,458,038 | $1,303,764 |

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

# Revenue Statement For Discipline Fund

for the year ended 31 March 1995

| | 1995 | 1994 |
|---|---|---|
| REVENUE | | |
| Levies Received | 2,562,376 | 1,277,416 |
| Interest Received | 46,385 | 34,075 |
| Fines Imposed and Discipline Costs Recovered | 444,365 | 146,743 |
| TOTAL REVENUE | 3,053,126 | 1,458,234 |
| ADMINISTRATION AND OPERATING EXPENSES | | |
| Audit Fees | 3,000 | 3,500 |
| Administration Fees (Note 1) | 100,000 | 60,000 |
| Competence Inquiries | | 11,154 |
| Debt Collection | 3,705 | |
| Doctors Health Advisory Service | 33,211 | 27,109 |
| Expert Witnesses | 14,188 | 14,416 |
| General Administration Expenses | 3,350 | 2,960 |
| Higher Court Actions | 61,429 | 8,983 |
| Legal Expenses | 657,165 | 608,896 |
| Medical Practitioners Disciplinary Committee | 1,107,435 | 1,017,885 |
| Mentoring Expenses | 18,208 | 13,285 |
| Projects - Sexual Abuse | 72,175 | 42,831 |
| Media Consultancy | 9,336 | |
| Stenographers Fees | 42,660 | 34,395 |
| Telephone and Tolls | 9,375 | 8,069 |
| Tribunals Officer | 21,909 | 17,259 |
| TOTAL ADMINISTRATION AND OPERATING EXPENSES | 2,157,146 | 1,870,742 |
| COUNCIL AND COMMITTEE EXPENSES | | |
| Council Expenses (Discipline) | | |
| - Fees | 108,664 | 139,175 |
| - Expenses | 43,913 | 56,112 |
| Council Expenses (Health) | | |
| - Fees and Expenses | 16,237 | 32,455 |
| Preliminary Proceedings Committee | | |
| - Fees and Honorarium | 63,326 | 68,343 |
| - Travelling and Accommodation | 5,174 | 13,565 |
| TOTAL COUNCIL AND COMMITTEE EXPENSES | 237,314. | 309,650 |
| TOTAL EXPENDITURE | 2,394,460 | 2,180,392 |
| Net Surplus/(Deficit) for Year | 658,666 | (722,158) |
| Retained Earnings/(Deficit) at Start of Year | (188,291) | 533,867 |
| RETAINED EARNINGS/(DEFICIT) AT END OF YEAR | $470,375 | $(188,291) |

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





# New Zealand Registration Examination Fund Revenue Statement

for the year ended 31 March 1995

| | 1995 | 1994 |
|---|---|---|
| REVENUE | | |
| NZREX Candidate Fees | 376,722 | 272,030 |
| Interest | 5,503 | 4,853 |
| TOTAL REVENUE | 382,225 | 276,883 |
| ADMINISTRATION AND OPERATING EXPENSES | | |
| Audit Fees | 1,000 | 1,000 |
| Centre Costs (NZ and Overseas) | 31,404 | 19,365 |
| Honorarium and Salaries | 61,549 | 38,460 |
| Examiners Fees and Expenses | 204,407 | 141,669 |
| General Administrative Expenses | 16,497 | 14,486 |
| Administration Fee (Note 1) | 30,000 | 30,000 |
| | 344,857 | 244,980 |
| COMMITTEE EXPENSES | | |
| Board of Examiners Fees | 7,959 | 7,696 |
| TOTAL EXPENDITURE | 352,816 | 252,676 |
| Net Surplus for Year | 29,409 | 24,207 |
| Retained Earnings/(Deficit) at Start of Year | 11,336 | (12,871) |
| RETAINED EARNINGS AT END OF YEAR | $40,745 | $11,336 |

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

## Statement of Cashflow

**for the year ended 31 March 1995**

| | | 1995 | 1994 | |
|---|---|---|---|---|
| **Cash Flow from Statutory Functions** | | | | |
| Cash was provided from | | | | |
| receipts pertaining to statutory functions and administration fee from Dental Council | 7,766,703 | | 3,369,266 | |
| Cash was also distributed to payment for council fees and disbursement and Secretarial expenses | (4,085,388) | | (3,708,591) | |
| Payment of Tax | (36,599) | | (73,332) | |
| | (4,121,987) | | (3,781,923) | |
| Net Cash Flow from Statutory Functions | | 3,644,716 | (412,657) | |
| **Cash Flow from Investing Activities** | | | | |
| Cash was provided from: | | | | |
| Short Term Investments | - | | 318,393 | |
| Interest Received | 164,235 | | 87,791 | |
| | 164,235 | | 406,184 | |
| Cash was applied to: | | | | |
| Purchase of Assets | (122,400) | | (149,703) | |
| Short Term Investments | (2,906,088) | | - | |
| | (3,028,488) | | (149,703) | |
| Net Cash Flow from Investing Activities | | (2,864,253) | 256,481 | |
| Net Increase (Decrease) in Cash Held | | 780,463 | (156,176) | |
| Opening Cash Brought Forward | | (50,722) | 105,454 | |
| **Ending Cash Carried Forward** | | $729,741 | ($50,722) | |
| Represented by: | | | | |
| Petty Cash | | 310 | 310 | |
| ANZ Bank Account | | 729,431 | (51,032) | |
| | | $729,741 | ($50,722) | |

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



## Fees Schedule

**to be paid on application for Medical Council services during Council financial year 1 April 1995 to 31 March 1996**

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

| | | Fee | GST from 1/4/95 | Total to Pay from 1/4/95 |
|---|---|---|---|---|
| **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 | | 150.00 | 18.75 | 168.75 |
| For discipline levy | (1) | 316.67 | 39.58 | 356.25 |
| | (2) | 134.45 | 16.80 | 151.25 |
| Total fees on registration | (1) | 664.01 | 82.99 | 747.00 |
| | (2) | 481.79 | 60.21 | 542.00 |
| **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) | | 546.67 | 68.33 | 615.00 |
| For annual practising certificate including discipline levy | (1) | 466.67 | 58.33 | 525.00 |
| | (2) | 284.45 | 35.55 | 320.00 |
| For *restoration of name to Register after removal therefrom (including provisional certificate) | | 624.00 | 78.00 | 702.00 |
| For initial entry on Specialist Register | | 60.00 | 7.50 | 67.50 |
| For entry on Specialist Register in a second or further specialty | | 10.00 | 1.25 | 11.25 |
| For initial entry on Indicative Register of General Practitioners | | 60.00 | 7.50 | 67.50 |
| 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 1/04/95 and 30/10/95

(2) Fee for persons registering for the first time or applying for APC between 1/11/95 and 31/03/96

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