Medical Council of New Zealand Annual Report 2000

The Medical Council of New Zealand is pleased to submit this Annual Report for the year ending 31 March 2000 to the Minister of Health. The report is presented in accordance with section 130 of the Medical Practitioners Act 1995 and incorporates the report of the Medical Practitioners Disciplinary Tribunal.

Vision

A medical workforce which is effective, competent and safe and meets the varying needs of New Zealanders, ¶ Cooperative relationships with and between educators, employers, regulators, practitioners and others that guarantee the above, ¶ A medical workforce with internationally acceptable standards, ¶ An open regulatory environment, well understood, accepted and trusted by the public and the profession.

Mission

To protect the health and safety of members of the public by regulating the medical profession of New Zealand and promoting high standards of competence, care and conduct.

Members of the Medical Council at 31 March 2000

From top, left to right

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

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

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

Dr John Neutze*
MBChB, MD, MRACP, FRACP. Paediatric cardiologist, Auckland.

Miss Carolyn Bull** MA, Dip Tchg, LLB. Lawyer (family law), Christchurch.

Dr Tim McKergow**
MB ChB, FRANZCP, Chair of Issues Committee. Psychiatrist, Dunedin.

Mrs Heather Thomson**
RN, Obs, Health services manager, Opotiki.

Professor Ian Simpson**
MB ChB, MD, FRACP, Chair of Education Committee. Nephrologist, Chair, Clinical Sciences, University of Auckland.

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

* Elected by Medical Practitioners
** Appointed by the Minister of Health

President's Foreword

This report comes at the end of the first three years of implementation of the provisions of the Medical Practitioners Act 1995, particularly general oversight, recertification and reviews of competence. These are innovative measures designed to protect the public, to provide support within medical practice and to promote lifelong learning. To a large degree they reflect what is already done by professional practitioners to ensure their skills and knowledge are reviewed and kept up to date. Nevertheless these matters are so important they must be done well, formally and as openly as possible.

Whilst the general standard remains high, two cases in the year led the Council to reflect on the standards of practitioners and the level of protection of the public. The cases were those of Dr Morgan Fahey, Christchurch GP convicted of sexual abuse and the allegations of misreading by Dr Michael Bottrill of cervical smears in Gisborne. Many issues arose but two important changes are proposed as a result:

- ensuring the Medical Council, Health and Disability Commissioner and other groups have a process to consider threats to other patients which require action when a complaint is received. The Medical Council believes this provision must apply to all professional people in the health service, not only doctors;
- amendment to the legislation to enable the Medical Council to intervene (for example through suspension) if, during the course of investigation of a complaint or competence, a doctor is found to pose a risk to the public.

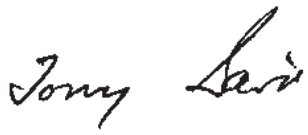
The intention of the Council's processes is to be supportive and educative and a crucial aspect is the identification of poor performers. The Council must be notified when there is a concern about competence or professional conduct if it is to fulfil its principal purpose and we, as doctors, have a professional duty in this regard, inherent in professionalism and self-regulation. Issues of liability are raised, but practitioners can be assured they do not face legal action if they report in good faith.

The Medical Council is closely involved in a project on medical credentialling led by the Health Funding Authority. The project aims to reduce clinical errors by practitioners who work beyond their skill and without the requisite support. There will be national guidelines for all hospital and health services, to help define what practitioners may or may not safely do through a 'scope of practice' in a particular setting.

On registration matters the Council's policies were discussed with the new Labour government and these are under review. After many years of advocacy by the Council, the Government is close to finalising a package to assist overseas trained doctors who are New Zealand residents and have been unable to register here.

There has been a lot of constructive activity during the year which is reported in the following pages, in competence, health and education and work within the office to improve efficiency which has greatly assisted the work of members of the Council.

I extend thanks to members and staff of the Medical Council for their support. There were changes to Council membership during the year including an election and I mention with gratitude the efforts of outgoing members Dr Alister Scott, Mr Henri van Roon, Dr Tony Ruakere and Dr Tim McKergow, and extend warm welcomes to Dr Deborah Read, Mrs Heather Thomson and Dr John Neutze. This was the last year of service of the Registrar, Georgina Jones, whose many talents will long be remembered as the impetus for the new Medical Practitioners Act.



Tony Baird
President

Chief Executive's Review

There has been a second year of effort to document policy and ensure systems are effective to support the work of the Council. Stage one of the new database for registration went live in February. Once the remaining components are built, we anticipate better service to doctors and benefits to staff who will be able to access office-wide information.

Policies were developed for general oversight and recertification and a major review of pathways to vocational registration for overseas trained specialists was completed. The new pathway will come into force in July 2001, to make it easier for doctors who clearly meet the New Zealand standard to become registered. Training will no longer be offered in the pathway for those who are not comparable to a locally trained doctor.

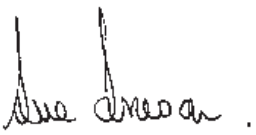
At the end of the reporting year the Medical Council changed from a single bulk issue of annual practising certificates to cyclical issue based on doctors' birthdates. All practising certificates were renewed in March 2000, but for different periods depending on when a doctor moves on to the cycle. This change will ensure that certificates are issued only once the Council is satisfied that a doctor is meeting the Act's requirements for oversight and recertification.

The combined annual practising certificate (APC) fee and disciplinary levy for doctors was $575 in 1999/2000, $100 less than the previous year. Decreases in the last few years indicate that the Medical Council is in a strong financial position. Since the 1995 Act came in, some expenditure has been less than anticipated, but with more experience of new activities such as competence reviews, and a rigorous approach to budgeting, our aim is to keep the annual practising certificate at the current level for the next three years.

The second election of four medical members to the Council under the 1995 Act was held in November. Three sitting members, Dr Tony Baird, Dr Ian St George and Dr Mark Adams were returned and one new member was elected, Dr John Neutze of Auckland. The election attracted 24 candidates and the voter turnout of approximately 40% was similar to that of 1996.

The Medical Council maintains strong links with stakeholders. During the year, the President and I attended meetings with employers and members of the profession in various centres to increase understanding of our policies. This contact is invaluable and more visits are planned in 2000.

Shortages of doctors were again a critical issue and it is often suggested that registration requirements be eased, particularly to help recruitment in rural areas. The Council has shown it will be flexible in considering cases put to it, for example, approving a new scheme for recruiting locums in the Far North. So far there has been no move to lower standards. The Medical Council is firm in its belief that all New Zealanders, despite where they live, are entitled to the same standard of care. Part of the problem is that there has been no objective data on workforce retention rates for New Zealand, so this coming year the Medical Council plans a study of retention trends of both graduates and more experienced doctors.



Sue Ineson
Chief Executive

Registrar's Report

It took 10 years to get the "new" Act, the Medical Practitioners Act 1995, and I was proud to be involved in that process, frustrating though it sometimes was. Already, as I near the date when I leave the Council after 14 years' service as Registrar and as Chief Executive for most of that time, we are working with the latest Minister of Health to make changes to it which she, the public and the profession need.

Change has been the only constant in my period of stewardship of the Medical Council office. Sadly, effective public protection, the purpose of occupational regulatory legislation in any profession or trade, can still be elusive.

I vividly recall the public outrage and expectations surrounding the Cervical Cancer Inquiry 1988 and the reactions which followed. The Medical Council took a strong lead immediately,issuing a far sighted statement in its 1988 Annual Report on the need for: limits to clinical freedom; ethical oversight of treatment and research; peer review in assessment for registration and recognition of individuals and institutions; informed consent and patients' rights; regular review of doctors' competence, health and conduct and a major role for consumers in all deliberations and decisions.

It challenged education and training bodies, hospitals and their boards and Ministry officials to attend to these matters, recognising that Judge Cartwright's findings had implications for medical practice which went far beyond one hospital and one specialty.

Over the next decade, the Council published timely and sometimes radical statements and guidelines for the profession. Advocating and anticipating new legislation, it undertook competence reviews, with consent from employers and doctors. We formed partnerships with standards and accreditation bodies like the Australian Medical Council and the Educational Commission for Foreign Medical Graduates in the USA and looked to counterparts like the UK General Medical Council and the Canadian Colleges of Physicians and Surgeons for models of successful regulation. More recently, we looked forward to maximising our effectiveness through productive relationships with the new Health and Disability Commissioner and the Code of Consumers' Rights.

Neverthless the same issues have a habit of reappearing! Twelve years on from Cartwright, the disturbing stories coming out of this year's Gisborne Cervical Screening Inquiry highlight the continuing existence of many of the same old barriers (and some new ones) to achieving the very reasonable goal of protection of the public. Good intentions backed up by legislation and government mandate, even with appropriate funding, do not of themselves go far enough. Constant reorganisations undermine knowledge and continuity allowing dangerous holes in safety nets to emerge.

Much of my work in the past year has been about addressing knowledge gaps, internally and externally. All health stakeholders are losing patience with errors and oversights and expect redress. Some resort to litigation, desperate to find solutions.

Vigilance over delivery of all services is more essential now than it ever was. In 2000 I think Council's greatest challenges are to:

- transform the words registration, supervision, oversight and recertification into something real for public protection, to benefit the public and the profession;
- facilitate cooperation and fearless self scrutiny throughout the health sector to build confidence while simultaneously identifying and acting on weaknesses, before the public has to raise the alarm;
- insist that reliable frameworks and adequate resources support medical regulators' work everywhere.

It has been a privilege to work with doctors and the public. I will continue to monitor progress, and, I hope, contribute to it as an informed member of the community.

Georgina Jones
Registrar

Public Members' Report

As public members of the Council, our role is to ensure that a non-medical viewpoint is represented in all Council decision-making. Public members sit on every Council committee. Other people in the community give their time and skills to be part of every competence review and complaints assessment committee appointed to deal with concerns and complaints about doctors.

The role is important, given that the primary purpose of the Medical Council is to protect the health and safety of the public. The Medical Council is not a body which represents doctors' interests, that role belongs to others.

We believe the Act has sound principles to ensure doctors are competent and keep their standards high. Now that the Act's newer mechanisms are properly in place we can see where improvements can be made. The Council is committed to reviewing our policies and practices to ensure the letter and intent of the Act 'to protect the health and safety of the public by ensuring doctors are competent to practice medicine,' is achieved in a meaningful way.

During the year there have been questions about how the misconduct of doctors is drawn to the Medical Council's attention. People, both patients and doctors, may not be clear about where to lay complaints or concerns, the threshold for complaining or reporting, and what action the respective bodies are capable of taking. For example, just some of those who may be involved in an enquiry about a doctor are the medical college, the hospital or Independent Practitioners Association, ACC, the Health and Disability Commissioner, or the Medical Council. There is also the issue of when the Medical Council has sufficient information, but no complaints, about a practitioner to spark a concern, and how this can be acted on. The Medical Council has no legal power to act on information, only complaints. These are issues to be working on in the next year.

Another concern has been the widening discrepancies in the quality of health services in New Zealand. We have seen this manifested in the dangerously low levels of junior doctors in peripheral hospitals and rural doctor shortages. In terms of the role of the Medical Council to register doctors, a careful balance is required to be flexible in decisions without lowering standards in the process. Dual standards of healthcare are not acceptable to New Zealanders.

Council members met with rural representatives during the year and also visited over two days Ngati Porou Hauroa and Taiarawhiti Healthcare, including rural clinics and general practices. This visit and others to Nelson and Waikato demonstrate that Medical Council members and staff are ensuring our organisation stays in touch with issues affecting the health service and that we will continue to advocate for improvements in health for both patients and doctors.

Carolyn Bull

Heather Thomson

Alexander Sundakov

Significant Activities

Registration of medical practitioners

Principal activities: maintaining the Medical Register, considering applications for registration, issuing Annual Practising Certificates and Certificates of Good Standing, ensuring supervision and auditing general oversight as appropriate, registration policy development.

Total cost: $1,326,968

In fulfilling its primary duty to protect the public, one of the most important functions of the Medical Council is the registration of medical practitioners.

Practitioners must be registered by the Medical Council before they can practise medicine in New Zealand, and their name must appear on the medical register which is a public document. In this way the public can see that a doctor has been trained to a standard necessary for registration.

Maintaining the medical register also protects the integrity of the profession. Members can be assured that both entry and continuing registration is only granted after the appropriate standards have been achieved.

Registration is the Medical Council's largest activity. It included responding to over 3,500 enquiries from overseas trained doctors in addition to considering applications for registration.

Temporary registration

Temporary registration is available without examination to medical graduates from the United Kingdom and Republic of Ireland, Canada, South Africa and the United States for up to three years and to graduates from other countries for specific puposes. During the year 473 doctors from 38 countries were granted temporary registration, up from 434 in the previous year.

The temporary registration provisions were due to expire on 1 July 2000 but are now extended to July 2003. A meeting of Chief Medical Advisors expressed unanimous support for continuance of temporary registration to meet service needs.

At the request of the new Minister of Health, Hon Annette King, the Medical Council began reviewing the options to assist temporary registrants from countries with similar standards of medical training and practice to become permanently registered as residents of New Zealand. The Council has already resolved to recognise time spent on temporary registration under supervision as sufficient to meet the requirement for probationary registration, to help doctors who are practising safely to reach full registration without delay.

The Council continued its weekly processing of applications which satisfied policy. This rapid approval system is appreciated by employers and doctors. Applications which fall outside Council policy are still discussed in a monthly teleconference or bi-monthy meeting.

Probationary and general registration

Probationary registration is the first step in the doctor's career. It is a minimum one year of supervised practice, when doctors develop their skills in a clinical team. Overseas trained doctors must also practise on probationary registration for at least one year.

The Council's Education Committee is responsible for ensuring that new doctors have a quality teaching and learning environment. A new policy was adopted requiring overseas graduates who have passed the Medical Council registration examination (NZREX) to have the same support, supervision and learning opportunities when beginning work as New Zealand graduates. Given the difficulties of many overseas trained doctors adjusting to the New Zealand health environment – about 30% of NZREX graduates do not perform well initially in the clinical setting – the Council believes more Government help is needed for this group.

General registration follows satisfactory performance on probationary registration. In 1999/00 general registration was granted to 226 New Zealand and Australian graduates, 131 overseas trained doctors and 43 additional overseas trained doctors who had met all the requirements for vocational registration.

The Council approved a policy to allow New Zealand and Australian graduates who successfully complete their internships outside New Zealand or Australia to apply for immediate general registration, approved on a case by case basis.

New Zealand Medical Registration Examination - NZREX Clinical

Total cost: $564, 979

NZREX Clinical is designed to ensure that overseas trained doctors who wish to become registered in New Zealand are safe to practise, at the level (minimum) of a sixth year New Zealand or Australian medical student.

Demand for NZREX Clinical dropped from the previous year; three sessions were held in the five examination centres for 238 candidates (including 98 repeats), compared to 428 in 1998/99. The efforts of the examiners who gave up their weekends to NZREX Clinical were once again much appreciated.

A major review of NZREX Clinical was completed during the year, led by Professor David Newble, Head of Department of Medical Education at the University of Sheffield. The review focused on the technical effectiveness of the exam as an assessment tool, but also on broader issues of cultural and

social adjustment as the system so far has not helped improve performance in these areas. A working group is now actively following up Professor Newble's recommendation to ensure NZREX is fair, equitable and tests the skills needed to operate in New Zealand.

Vocational registration

Doctors on the general register continue to work towards vocational registration. Additions to the vocational register were 367, up from 341 last year. Twenty-eight percent of the total workforce was in training towards vocational registration, half of which were general practitioners. More than one third of doctors in the branches of general practice, emergency medicine, occupational medicine and general surgery described themselves as being in vocational training.

One hundred and twelve new applications for vocational registration were received from overseas trained doctors and 143 doctors were granted vocational registration compared to 127 last year, across 19 branches of medicine (see table 6).

Review of pathway to vocational registration

Many overseas trained specialists do not have wide enough experience or training for vocational registration in New Zealand and do not succeed with their applications, even after a sustained effort. There is a general lack of understanding of the difference between the Australasian standard and some overseas programmes which often have very early specialisation without a general medical experience.

Despite political pressure and adverse publicity, the Medical Council does not see lowering the standard to below that of a New Zealand doctor as the solution to the problem.

From July 2001, the Medical Council will implement a revised pathway whereby applicants who are judged not to be at a comparable standard to New Zealand vocationally registered practitioners after the assessment interview or after a 12 month assessment will be diverted to the general registration pathway to pass USMLE 1 and 2 and NZREX. The Medical Council will inform doctors earlier if they meet the required standard and seek to remove the impression that the vocational pathway is one which offers 'training.'

Requirement to remove doctors from the Medical Register

During the year the Council removed from the Medical Register the names of approximately 1800 doctors who had not lived in New Zealand for six consecutive months in any period of three years. The removal was required under the Medical Practitioners Act 1995 and gave the Council no discretion in this respect. The reason for the requirement is public safety and not knowing what standards doctors have maintained while working in other countries. Subsequently the Council looked at ways to ensure that those returning should not face complex re-registration requirements. The policy adopted was that doctors may be reinstated subject to their fitness for registration and provision of updated Certificates of Good Standing for each medical jurisdiction in which they have worked in the preceeding five years.

Race Relations Office finding in favour of Medical Council

Following a lengthy investigation, the Race Relations Conciliator, Dr Rajan Prasad, in July dismissed the complaints of eight overseas trained doctors against the Medical Council. The doctors alleged that the Council had breached the Human Rights Act after they were unsuccessful in becoming registered.

As part of the investigation, the Race Relations Office considered practices used in the United Kingdom and Australia. The finding referred to the similarity of procedures used to register overseas trained doctors in those countries.

Policy on Certificates and Letters of Standing

A Certificate of Good Standing is a document issued by the doctor's most recent registering authority to confirm the doctor's registration and provide information about the doctor's fitness to practise, including any disciplinary, competence, criminal or health matters.

The Council resolved that where it was not possible for the Registrar to issue a Certificate of Good Standing because there is a current or intended investigation or proceeding before the Council or the Tribunal under the Medical Practitioners Act 1995, a Letter of Standing would instead be issued including a brief statement on the reason for non-issue of the Certificate of Good Standing. The intention is to assist the receiving authority with its decision and reduce the delay and anxiety for the doctor involved.

1 Summary of Registration

AT 31 MARCH 2000

Interim Register	20
Probationary Register	631
General Register	10823
Vocational Register	5125
Temporary Register	480
Suspended	3
Suspended(Interim)	2

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

2 Registration Activities

1 APRIL 1999 - 31 MARCH 2000

Interim Certificates issued, Probationary Registration		
Class 1	New Zealand Graduates (Interns)	264
Class 1	Overseas Graduates (Interns)	4
Class 2	Overseas Graduates (NZREX passes)	128
Class 3	Overseas Graduates (Eligible for Vocational Registration)	11
Class 4	Overseas Graduates (Suitable for assessment - Vocational Registration)	55
Class 5	Reregistration (following erasure)	0
Class 6	Overseas Graduates (Clinical evaluation - Vocational Registration)	1
Class 7	Overseas Graduates (Vocational Training)	1
Interim Certificates issued, General Registration		
New Zealand Graduates		12
Overseas Graduates		41
Temporary Certificates Issued		
New Certificates		473
Extensions		391
General registration after completion of probationary period		
Class 1	New Zealand and Overseas Graduates (Interns)	226
Class 2	Overseas Graduates (NZREX passes)	131
Class 3	Overseas Graduates (Eligible for Vocational Registration)	16
Class 4	Overseas Graduates (Suitable for assessment – Vocational Registration)	27
Class 5	New Zealand and Overseas Graduates (Reregistration following erasure)	1
Additions to Vocational Register		367
Amendments to Register		
Change of address		2032
Change of name		38
Additional qualifications		371
Suspensions		
Suspended		1
Interim suspension		2
Revocation of suspension / conditions		1
Removals		
Death		25
Discipline order		1
Failure to notify change of address		13
Non-resident doctors		1878
At own request		47
Annual Practising Certificates		9565
Certificates of Good Standing		550
Certificates of Registration		162

3 New Zealand Vocational Register

1 APRIL 1999 – 31 MARCH 2000

Vocational Branch	Vocational Registration at 31/03/1999[1]	Added 1999/2000	Removed 1999/2000	Net Change	Vocational Registration at 31/03/2000[2]
Anaesthetics	419	25	30	-5	414
Cardiothoracic Surgery	31	2	4	-2	29
Dermatology	52	1	5	-4	48
Diagnostic Radiology	243	10	19	-9	234
Emergency Medicine	15	11	0	11	26
General Practice	1776	173	45	128	1899
General Surgery	257	11	18	-7	250
Intensive Care Medicine	0	5	0	5	5
Internal Medicine	634	34	51	-17	614
Neurosurgery	18	1	2	-1	17
Obstetrics & Gynaecology	244	8	17	-9	235
Occupational Medicine	30	3	1	2	32
Ophthalmology	110	4	6	-2	108
Orthopaedic Surgery	180	8	8	0	180
Otolaryngology Head & Neck Surgery	85	4	5	-1	85
Paediatric Surgery	12	2	0	2	14
Paediatrics	210	12	15	-3	205
Pathology	224	10	22	-12	212
Plastic & Reconstructive Surgery	33	3	1	2	35
Psychological Medicine or Psychiatry	368	26	46	-20	348
Public Health Medicine	172	10	20	-10	160
Radiation Oncology	44	0	4	-4	40
Rehabilitation Medicine	5	1	0	1	6
Sexual Health	0	1	0	1	1
Sports Medicine	0	1	0	1	1
Urology	47	1	4	-3	44
Venerology	12	0	0	0	12
Total	5221	367	323	44	5254

Notes:

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

2 Includes 128 doctors with vocational registration in two branches and two doctors with vocational registration in three branches.

4 Candidates sitting and passing NZREX Clinical

1 APRIL 1999 - 31 MARCH 2000

Country	No. Sitting	Attempts 1	2	3	4	No. of Passes	Passes on Attempts 1	2	3	4
Bangladesh	37	21	11	5	0	10	3	3	4	0
Botswana	1	1	0	0	0	0	0	0	0	0
Bulgaria	1	1	0	0	0	0	0	0	0	0
Burma	3	3	0	0	0	2	2	0	0	0
Canada	2	1	0	0	1	2	1	0	0	1
China	4	4	0	0	0	1	1	0	0	0
Colombia	1	1	0	0	0	0	0	0	0	0
Egypt	21	11	7	3	0	6	2	3	1	0
England	2	2	0	0	0	2	2	0	0	0
Germany	3	2	0	1	0	2	1	0	1	0
India	46	22	15	8	1	21	8	7	5	1
Indonesia	1	0	0	1	0	0	0	0	0	0
Iran	3	2	1	0	0	1	0	1	0	0
Iraq	23	13	4	5	1	14	9	1	3	1
Israel	2	0	1	1	0	0	0	0	0	0
Italy	2	1	1	0	0	0	0	0	0	0
Pakistan	4	2	2	0	0	3	1	2	0	0
Papua new guinea	2	1	1	0	0	1	0	1	0	0
Philippines	9	5	2	2	0	2	0	0	2	0
Scotland	1	1	0	0	0	1	1	0	0	0
South Africa	18	16	2	0	0	17	15	2	0	0
Sri Lanka	22	11	8	3	0	12	7	4	1	0
Sudan	3	0	2	1	0	2	0	1	1	0
Taiwan	1	1	0	0	0	0	0	0	0	0
Tanzania	1	1	0	0	0	1	1	0	0	0
UK	2	2	0	0	0	2	2	0	0	0
Unknown	5	4	1	0	0	1	1	0	0	0
USSR	1	0	0	1	0	0	0	0	0	0
Wales	1	1	0	0	0	1	1	0	0	0
West Germany	1	1	0	0	0	1	1	0	0	0
Yugoslavia	15	9	5	0	1	5	2	2	0	1
	238	140	63	31	4	110	61	27	18	4

5 Registration issued to overseas trained doctors

1 APRIL 1999 - 31 MARCH 2000

	Temporary			Probationary				
Country	**Class 1**	**2**	**3**	**Class 1**	**2**	**3**	**4**	**6**
Australia	3	1	8	3	-	-	-	-
Austria	-	1	-	-	-	-	-	-
Bangladesh	-	-	-	-	21	-	-	-
Bulgaria	-	-	1	-	-	-	-	-
Burma	-	-	-	-	2	-	-	-
Canada	-	5	15	-	-	-	-	-
China	-	-	-	-	1	-	-	-
Croatia	-	-	-	-	1	-	-	-
Czechoslovakia	-	-	-	-	1	-	-	-
Dominica	-	1	-	-	-	-	-	-
Egypt	-	-	1	-	5	-	1	-
England	-	8	183	-	1	-	5	-
Fiji	-	-	-	-	1	-	-	-
Finland	1	-	-	-	-	-	-	-
France	-	1	-	-	-	-	-	-
Germany	1	-	5	-	2	-	1	-
Ghana	-	-	1	-	-	-	-	-
Grenada	-	-	1	-	-	-	-	-
Hong Kong	-	-	-	-	-	1	1	-
India	-	3	5	-	28	1	7	1
Indonesia	-	1	-	-	-	-	-	-
Iran	-	3	-	-	-	-	-	-
Iraq	-	-	1	-	27	-	-	-
Ireland	-	1	6	-	-	-	1	-
Israel	-	1	-	-	-	-	-	-
Italy	-	-	2	-	-	-	-	-
Japan	1	1	-	-	-	-	-	-
Mexico	-	-	3	-	-	-	-	-
Montserrat	-	-	1	-	-	-	-	-
Netherlands	1	1	1	-	-	-	-	-
Northern Ireland	-	-	3	-	-	-	-	-
Oman	-	1	-	-	-	-	-	-
Pakistan	-	-	4	-	3	-	-	-
Papua New Guinea	-	-	-	-	1	-	-	-
Philippines	-	-	2	-	1	-	1	-
Poland	-	-	2	-	3	-	1	-
Russia	-	-	-	-	-	-	2	-

Saudi Arabia	-	1	-	-	-	-	-	-
Scotland	-	3	55	-	-	2	1	-
South Africa	-	-	69	1	5	-	7	-
Spain	-	-	1	-	-	-	-	-
Sri Lanka	-	1	1	-	18	1	-	-
Sudan	-	-	-	-	1	-	-	-
Switzerland	-	1	1	-	-	-	-	-
U.S.S.R.	-	-	-	-	-	-	2	-
United States	2	2	46	-	-	-	-	-
Wales	-	-	5	-	-	1	-	-
West Indies	-	1	-	-	-	-	-	-
Yugoslavia	-	-	-	-	3	-	2	-
Zimbabwe	-	-	3	-	-	-	-	-
Total	9	38	426	4	125	6	32	1

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

1 APRIL 1999 - 31 MARCH 2000

Branch of Medicine	Number
Anaesthetics	13
Cardiothoracic Surgery	1
Diagnostic Radiology	2
Emergency Medicine	9
General Practice	62
General Surgery	4
Intensive Care Medicine	2
Internal Medicine	11
Obstetrics & Gynaecology	6
Occupational Medicine	2
Ophthalmology	2
Orthopaedic Surgery	1
Otolaryngology Head & Neck Surgery	1
Paediatrics	2
Pathology	4
Plastic & Reconstructive Surgery	1
Psychological Medicine or Psychiatry	16
Public Health Medicine	3
Sexual Health	1
Total	143

7 Outcomes of applications for assessment of eligibility for Vocational Registration

1 APRIL 1999 – 31 MARCH 2000

Outcome	Number
Pending Outcome	29
NZREX	9
NZSPEX	6
Class 3 probationary (eligible for Vocational Registration)	18
Class 4 probationary (suitable for assessment – Vocational Registration)	39
Vocational Registration	7
Other*	4
Total	112

* completing council requirements

8 Active Medical Practitioners in New Zealand

1 APRIL 1999 – 31 MARCH 2000

Country	Probationary	General	Vocational	Temporary	Total
U.K.	39	804	783	262	1888
South Africa	26	438	289	86	839
India	54	161	111	12	338
Australia	3	191	133	4	331
Sri Lanka	28	90	128	2	248
Iraq	50	68	6	0	124
United States	5	6	47	40	98
Canada	1	37	35	13	86
Ireland	1	28	40	13	82
Germany	5	29	20	5	59
Hong Kong	1	13	38	0	52
Fiji	4	23	21	2	50
Bangladesh	23	14	1	1	39
Egypt	12	14	9	1	36
Yugoslavia	7	19	8	0	34
Pakistan	4	4	7	6	21
Singapore	0	4	16	0	20
Other	33	107	77	33	250
New Zealand	335	3648	3356		7339

Professional Standards

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

Total cost: $825,106

A major innovation in the Medical Practitioners Act for protecting the public is the provision to ensure that medical practitioners, once registered, remain competent to practise medicine.

The competence process is separate from the complaints process and separate from the provision for Medical Practitioners Disciplinary Tribunal hearings.

During the year procedures for competence reviews and competence programmes were refined, and policies were produced on general oversight and recertification.

Competence reviews

A competence review is an evaluative process to ensure a doctor is practising safely.

Sixty-one new competence concerns were referred to the Professional Standards Committee compared to 27 the previous year. Twenty-three doctors were formally reviewed. A review committee

consists of two doctors and a member of the public. A list was begun of reviewers in each branch of medicine based on nominations by branch advisory bodies.

Following consideration of reviews, three doctors were then directed to undertake a competence programme. Programmes are educational in nature and include a reassessment of the doctor at the end of the programme. They are specific to the practitioner and are usually supervised by another doctor in the same branch of medicine.

As seen in table 9, doctors are referred to the Medical Council for competence issues from a variety of sources. Often referrals are made as a result of a single error, but sometimes as a result of a pattern of poor performance. The process does not focus on, nor investigate complaints or errors, but rather assesses the competence of the medical practitioner either generally or in one aspect of their practice.

It was encouraging that referrals from peers increased to eight, compared to one in the previous year. The Council continues to stress the non-punitive nature of reviews and the need for a climate of openness which acknowledges that doctors can not be expected to be perfect, but, like any other person, may need help to update knowledge and skills. Individual doctors, their patients and the profession benefit generally through a lifting of standards.

What is competence?

Competence: the capacity to perform a task or role at the level of registration held

Performance: translating competence into action

Basic elements of competence: clinical judgement, medical knowledge, clinical skills, human qualities, communication skills, continuing scholarship

Examples of reviews conducted in 1999/2000:

1 A doctor prescribed a course of treatment but did not inform the patient of the possible side effects. Following a response from the doctor to the concern, the Professional Standards Committee referred the doctor for a competence review. The review focused on the doctor's procedure for obtaining informed consent and knowledge of drugs involved in the case and their side effects. Based on information contained in the referral, the doctor made changes to avoid similar problems reoccurring. A competence programme was not required.

2 A doctor failed to provide an adequate standard of care to a patient, resulting in harm to a patient. The doctor was referred to the Professional Standards Committee by a colleague. Following comment from the doctor, the Committee referred the doctor for a review. The review team found serious deficiencies in the doctor's knowledge base and procedures. The doctor was referred for a competence programme with a further review to be carried out at the end of that programme.

Competence reviews are not normally publicised, but in the case of a rural GP who was reviewed for excessive prescribing of an addictive drug and management of cardiovascular patients, the Council released findings of the review, to allay concerns which were already public, and to ensure correct information. The Council has powers to publicise reviews if it wishes through an order under S 138 (1) of the Act. However given the aim of a competence review is to be educational and separate from the disciplinary process, the Council will not routinely publish reviews, but consider it only in exceptional circumstances serving the public, patient's or doctor's interest.

Following concerns about reading of cervical smears in Gisborne, the Medical Council began assisting a Ministry of Health working party looking into possible changes to the Act. The changes, if passed into law, will encourage reporting of competence concerns and give greater assurance that the Medical Council or Ministry will be alerted to possible public safety issues arising from investigations into individual practitioners.

General oversight

General oversight applies mainly to doctors on the general register, but it may also apply to vocationally registered doctors if they are practising in other branches without vocational registration.

Oversight is an important feature of the 1995 Act for doctors' continuing competence. As in recertification, doctors are required to participate in continuing education and peer review.

The Medical Council has estimated that about 2,200 doctors are already having general oversight. However almost 1900 doctors are excused oversight until 1 July 2001, under a transitional provision in the Medical Practitioners Act. It is estimated that about 1600 of the currently exempt 1900 doctors will require oversight in July 2001.

Practitioners have been strongly encouraged to prepare for oversight and start establishing a relationship well before the cut-off date of 1 July next year. Auditing of oversight will begin then and doctors should be aware that non-compliance could result in their annual practising certificates being withheld.

During the year the Medical Council looked actively for solutions for 'specialising career medical officers' (ScaMPs), a diverse group having difficulty becoming vocationally registered or arranging oversight with another practitioner because they work across different branches. Many in this group have now seen a way they can become vocationally registered through an existing college, but there will undoubtedly be those for whom temporary solutions will need to be found. If planned changes to the Act proceed later in 2000 to allow overseers to be in a different branch of medicine, their situation will be eased.

Few doctors appear to disagree with the principle of general oversight, but the Council is aware that it has been seen as a burden or only a paper exercise. Detailed guidelines have now been sent to all doctors. The Council's firm view is that continuing education is not discretionary, it is irrespective of status or qualifications, and it can only succeed through a true commitment by the individual. Acceptance may take time, but it is hoped the initial resistance will lessen once more doctors are properly experiencing oversight.

Recertification

From 1 July 2001 all vocationally registered doctors will be required to recertify to maintain their vocational registration.

The Council approved criteria for recognition of recertification programmes provided by the branch advisory bodies or by other groups, as well as what doctors will be expected to do to recertify. Next year the Medical Council will write to all doctors on the vocational register about these requirements and about the three year period within which they must comply. Failure to comply may lead to the Council placing conditions on a doctor's registration or annual practising certificate, or even suspension if this was considered necessary in the interests of public safety.

The Council understands that most vocationally registered doctors participate in some form of maintenance of professional standards programme, and for these doctors the requirements will not be unduly onerous. However peer review and audit will become mandatory in future.

During the year recertification programmes were approved in emergency medicine, sports medicine, musculoskeletal medicine, rehabilitation medicine, pathology and obstetrics and gynaecology.

The Council recognised three new branches of medicine: sports medicine, breast medicine and medical administrators. Subsequently medical administrators was not approved by the Ministry of Health leading to a delay in recognition. The Council will make another application for this group.

9 Competence referrals

1 APRIL 1999 TO 31 MARCH 2000

Source of concern	Number
Health and Disability Commissioner (HDC)	25
Medical Officer of Health	2
Complaints Assessment Committee	3
Medical Council	1
Medical Council President	8
Public	8
Registration exam via Council policy	2
Medical Practitioners Disciplinary Tribunal	1
Peer	8
Peer/Employer/Ministry of Health	1
Medical Council Registration/Employer	1
Australian Medical Board	1
Total referrals	61

Outcomes of competence referrals

To Competence Review	To Competence Programme	No Competence Review	To HDC to investigate	Sent to CAC	Sent to Health Committee
25 (2 did not proceed)	3	31	2	2	1

Type of Concern	Number
Prescribing	10
Skills & knowledge	36
Judgement	22
Communication style and attitude	18
Not within jurisdiction – i.e employment related	1

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

Complaints

Principal activities: operation of complaints assessment committees (CACs) to consider complaints, referrals to the Health and Disability Commissioner, policy on complaints process.

Total cost of CACs: $660,779

The Council takes all complaints against doctors seriously and works to ensure a fair process.

The Medical Practitioners Act removed the disciplinary role of the Medical Council, replacing it instead with a mandate to maintain high standards of practice and to support rehabilitation of practitioners. Therefore the Medical Council's complaints role is restricted to investigating complaints about events which precede 1 July 1996. Seventy-eight such complaints were received in the year, compared to 67 last year. Any complaint received against a doctor for conduct which occurred after 1 July 1996 must be sent by the Registrar to the Health and Disability Commissioner in the first instance; during the year the Medical Council forwarded to the Commissioner 176 complaints.

Complaints are considered by complaints assessment committees which are independent of the Medical Council. Each committee consists of two doctors and a member of the public. The committee does not determine the guilt or otherwise of a doctor; it focuses on whether there is a case to answer and the appropriate course of action, which may be a review of competence or health, conciliation, a charge before the Tribunal or no further action.

Nature of complaints

As seen in table 10, complaints include all facets of practice. Many complaints continue to highlight an underlying poor approach to communication by the doctor, either as the cause of the complaint, or exacerbating the complaint. In such cases a doctor can be found guilty of a charge by the Medical Practitioners Disciplinary Tribunal despite having performed his or her professional duties competently.

Some important lessons can be learned from cases whether they proceed to further investigation, a hearing, or result in no further action. In the near future the Medical Council plans to disseminate information which it is hoped will assist doctors avoid complaints or adverse findings.

Outcome statistics are shown in table 11 (note, the statistics refer mainly to complaints received in previous years which have been resolved in the 2000 year). As can be seen, 58 complaints were resolved with no further action. In reaching this conclusion the allegations are carefully considered. In some cases the complaint is resolved by an apology during the process. Often the committee, even if determining no further action on the complaint, will nevertheless highlight that the doctor should pay attention to some aspect of his or her practice.

The Council recognises the complaints process is stressful for doctors and patients and has attempted to reduce the time taken. There has been some progress but there are legally required steps in each investigation and there may be difficulties appointing appropriate members to committees. Above all the process must be fair. Any change is therefore likely to be incremental.

The Council is very grateful to those doctors and members of the public who serve on Complaints Assessment Committees (CACs). Self-regulation depends on their participation. They take their duties seriously and most committees members worked well together to reach a consensus determination.

10 Schedule of Complaints

New Complaints Assessment Committees(CACs) appointed	47
Complaints carried forward at 31 March 2000	
CAC pending determination	14
Number of new complaints received (includes 176 referred to HDC)	**254**
Number of doctors involved	237
Categories of complaint	
Access	2
Communication	44
Conviction of an offence	3
Consent	6
Costs	1
Group systems	1
Rights	25
Treatment	170
Other	2

Note: One complaint can cover more than one category

Sexual abuse complaints

The major complaints case in the year related to sexual abuse by Dr Morgan Fahey, general practitioner of Christchurch. This distressing case has diminished trust in the medical profession at a time when such cases coming before the Council had been in steady decline. The Council position contained in our numerous statements and publications is that sexual relationships with patients are never acceptable.

The Council realises that the great majority of doctors are professional, hard-working and have high ethical standards. The concern for the Medical Council is the reluctance of the profession to report misconduct. Professional responsibility demands that practitioners report to the Medical Council any misconduct or incompetence, in the interests of patient safety and the credibility of the profession as a whole.

11 Complaints Statistics

1 APRIL 1999 – 31 MARCH 2000

Month 1999/00	CACs in Progress	Complaints received pre-1.7.96 for CAC appt	Complaints received post 1.7.96 to HDC to action
April	31	2	16
May	24	2	6
June	31	2	8
July	34	3	12
August	32	2	16
September	31	1	16
October	34	3	22
November	31	1	17
December	35	0	16
January	36	0	11
February	35	0	8
March	30	3	10

12 Determinations Made

1 APRIL 1999 - 31 MARCH 2000

Competence Review	1
Referred to conciliation	4
Charge laid with MPDT	6
No further action	58
Total	69

Note: Each case may involve more than one doctor; each determination relates to one doctor

Health

Principal activities: considering the cases of doctors with possible health conditions, establishing assessment and monitoring programmes for doctors with health conditions affecting fitness to practise, promotion of doctors' health.

Total cost: $498,252

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

The Council's health committee has delegated authority from the Council to manage doctors with health conditions affecting their practice.

Under the Medical Practitioners Act it is mandatory for practitioners to notify the Council if their own or another doctor's fitness to practise may be affected by ill-health.

There were 30 new referrals in the 1999/00 year, compared to 34 for the previous year. Doctors, like the general population, suffer from a range of afflictions, including drug and alcohol abuse, psychiatric disorders and a wide range of physical disorders, all of which can impair their performance.

The focus of the health committee is first to protect the public and second to ensure effective treatment and rehabilitation for an unwell doctor. In the committee's experience, early identification is essential for dealing with a problem, which, if left unresolved, could put patients and the doctor at risk.

The committee has well-established procedures and in the majority of cases a doctor can continue to work while receiving treatment and monitoring.

The Council contributed $39,186 towards the running of the Doctors' Health Advisory Service (DHAS) in 1999/00. DHAS is asked to provide the committee with coded reports and an assessment of risk of doctors it is helping. The interface between DHAS and the health committee was reviewed and the Council agreed in principle to co-opt key DHAS members to the health committee; put into effect for the first time at the committee's December meeting. The committee hopes in this way to develop better understanding of its non-punitive approach to notification of doctors.

Defining 'Fitness to Practise'

A day workshop was held in May to debate the meaning of 'fitness to practise' from medical, legal, ethical and consumer perspectives. Following the workshop the committee produced a definition of fitness to practise. The conditions affecting fitness include alcohol or drug dependence, other psychiatric disorders, a temporary stress reaction, an infection with a transmissible disease, declining competence due to age related loss of motor skills or to the early stages of dementia, and certain illnesses and injuries.

What is 'fitness to practice?'

Signs a problem may be present are if a doctor:

- is unable to make safe judgements, or
- is unable to demonstrate the level of skill and knowledge required for safe practice
- behaves inappropriately
- risks infecting patients with whom he or she comes into contact, or
- acts or omits to act in ways that impact adversely on patient safety.

Health Statistics

1 APRIL 1999 TO 31 MARCH 2000

New Referrals

Received	30
• No further action required	13
• Monitoring programmes initiated	9
• Further review required before APC issued	7
• Follow up report to be provided	1

Carried Over from Previous Years

Monitoring programme reactivated or continued from previous year	39
Low level monitoring or review	20
Further review required before APC issued	2

Other Actions Taken

Prescribing restrictions revoked	2
Applications for registration considered and initial registration supported	2

Annual Practising Certificate (health) disclosures

On the applications for the APC for the year ended 31 March 2000, 61 doctors gave a positive answer to the question had they "… any continuing addictive, mental or physical condition which had the potential to affect your fitness to practise medicine?". In about half of the cases sufficient information was provided and practising certificates were issued. 31 doctors were asked to obtain certification of their fitness to practise from their treating doctors. These are doctors who are not already involved in the Health Committee's monitoring programme.

Education

Principal activities: accreditation of medical schools, assessing teaching and learning environment in hospitals, maintaining a network of intern supervisors, policy on first and second house surgeon years, considering applications for recognition as a vocational branch of medicine and approving recertification programmes.

Total cost: $609,512

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

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

The committee membership is a mix of medical professionals and educators from all levels of the system and different parts of the country, including a resident medical staff member.

Accreditation visit to Otago Medical School

In March 1999 an accreditation assessment team visited the Otago Medical School on behalf of the Australian and New Zealand Medical Councils. The Otago Medical School was last accredited in 1994. In August it was announced that the Medical School's accreditation was extended for the remainder of the

maximum period of ten years, to December 2004. The accreditation committee assessors praised Otago's progress in teaching and research and the improved relationships with local health services. Suggestions were made for further development by the university in the areas of student selection and Maori health.

Probationary period

The Council acknowledges the work of intern supervisors who have overall responsibility for graduate doctors in their probationary year. Intern supervisors also supervise the integration of overseas trained doctors who have passed the New Zealand medical registration exam, NZREX.

Thirty-five intern supervisors based in hospitals around the country are contracted by the Medical Council to supervise and report on the performance of new doctors.

The education committee carries out accreditation visits to hospitals which employ probationary registrants to ensure they offer a suitable learning environment. Visits are three-yearly and provide valuable information-sharing opportunities. Visits were made to Northland, Hawkes Bay, Otago, Southland, Canterbury and Wakefield hospitals during 1999.

The committee continues to advocate to the Ministry of Health for a voluntary supervised clinical bridging programme on behalf of overseas trained doctors, akin to that for a trainee intern; this would lead to faster assimilation and development of the required work-based skills by this group. The Ministry is working with hospitals and medical schools on plans for such a programme.

New handbook on Council requirements for Resident Medical Officers

This handbook describes the Council's policy and the objectives on the probationary period and pre-vocational training. It was last updated in 1996 and has now been altered in the light of the Clinical Training Agency reviews and Australian reviews of early post-graduate training.

In the first house surgeon year there is greater emphasis on producing objectives and outcomes at run level, based on an extended list of learning outcomes and indicative skills. In the pre-vocational years the Council continues to emphasise the long-term benefits of a broad-based medical education before vocational training.

Developing the draft handbook was a major exercise for the education committee during the year. It was to be ready for consultation with the profession from May 2000.

Recognition of vocational branches

The amended Order In Council with the complete schedule of branches of medicine recognised under the 1995 Act (including four new ones) was passed in November 1999.

As intended there was consultation with the vocational branches on a process for the Council to assess smaller branches seeking recognition. The great majority of responses supported the stance of the education committee that small groups can be recognised, provided they are affiliated or associated with larger vocational groups to assist them with continuing education and other professional requirements.

Summer Studentship

Two summer studentships were granted in 1999/2000, valued at $5000 each. This was the eighth year the Council has awarded the studentship. The recipients were Paul Young, 6th year Auckland University student, for his topic "A comparison of the career experiences of New Zealand doctors who undertook medicine as school leavers with those who undertook medicine as graduates" and Patrick Pritzwald-Stegman, third year at Otago University, for his topic "To explore how general oversight has affected Medical Officers of Special Scale." Summaries of both studentships are available.

Issues

Principal activities: considering and anticipating developments in the practice of medicine and in health services for the formulation of statements and guidelines for the profession; calling for submissions on issues.

Total cost: The cost of this committee's work is apportioned as an overhead against the major activities of the Council.

The Medical Council's issues committee reviews trends and issues occurring in medical practice so that it can offer timely guidance to the profession. Doctors must be aware of the accepted standards of practice against which they will judged should their registration be questionned.

During the year the committee updated the statement first issued in 1998 on 'Ethical guidelines on doctors' duties in an environment of competition or resource limitation.' This statement attempts to resolve some of the dilemmas doctors face when there are not sufficient resources to offer the ideal treatment to patients.

A visit to the United States assisted the Council to establish a position on the growing practice of medicine over the Internet. The first significant developments in this area happened in New Zealand in 1999. The committee responded quickly by drafting a discussion paper on standards expected in e-medicine and distributed it to key stakeholders. Final guidelines were well advanced by the end of the year.

Doctors today are moving into management roles and providing a valuable clinical perspective. In a recent case in the United Kingdom, a doctor holding a management post was held professionally culpable for non-clinical decisions which nevertheless lead to adverse impacts on patients. In light of this and other cases the committee began drafting guidance for doctors undertaking management tasks. The Council's position is that doctors' first consideration must continue to be interests and safety of patients regardless of their managerial responsibilities.

As a result of the Cull enquiry into chest physiotherapy on pre-term babies at National Women's Hospital, the Council began to review its statement on informed consent in consultation with the profession.

Discipline activities arising from the 1968 Act

A number of proceedings under the old Act had been commenced but not completed before the new Act came into effect on 1 July 1996. These proceedings continued to be dealt with under the 1968 disciplinary system.

Medical Practitioners Disciplinary Committee (MPDC)

Final proceedings before the MPDC under the 1968 Act were closed in the previous year. The terms of conditions for two doctors imposed by the Committee ended in March 2000. The Committee has now ceased to function.

Medical Council (constituted under the 1968 Act)

There have been no hearings but a number of appeals remained to be dealt with:

- Four appeals against decisions of the Medical Practitioners Disciplinary Committee. One was discontinued and one was heard and upheld. In the third the finding was upheld except for in one particular and penalties and censure were revoked. The remaining appeal was adjourned indefinately.
- Four appeals against Council decisions (on appeals against decisions of the MPDC) were with the High Court. One was dismissed; two discontinued and one was still awaiting hearing at the close of the year.

Medical Workforce Survey

Total cost: $170,212

The 1999 New Zealand Medical Workforce Survey attracted a 96% response rate, 1% lower than last year. The survey was sent to doctors with probationary or general registration, a current annual practising certificate and a New Zealand address at 31 March 1999.

The major findings were:

- **Size of workforce:** 8616 doctors were in active employment, an increase of 1.5% from 1998. This provides one doctor per 442 people in March 1999, compared to one per 386 people in Australia at December 1996. This ratio has increased by 21% since 1990 and 45% since 1980.
- **Demographics:** women are now 31.9% of the workforce, up 0.6% from 1998. The proportion of overseas trained doctors is 33.9%, up from 29.3% in 1990. Maori doctors at 2.2%, and Pacific Island doctors at 1.2%, continue to be markedly under-representative of the general population.
- **Work by vocational group:** the fastest growing areas since 1990 have been anaesthetics, emergency medicine, internal medicine, occupational medicine, paediatrics, primary care, psychiatry, public health medicine and venereology/sexual health medicine. The proportion of the total workforce undertaking training towards inclusion on the vocational register was 28%, half of which were GPs.
- **Geographical distribution:** in local authority regions, full-time equivalent general practitioners ranged from 41 to 142 per 100,000 people.

A full summary report of the Medical Workforce Survey 1999 was to be published in August 2000 and will be available on the Medical Council website, www.mcnz.org.nz.

In June 2000 a fuller analysis of 2000 data was to commence including a focus on measuring trends in retention of New Zealand doctors.

Report of the Medical Practitioners Disciplinary Tribunal

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

The Medical Council provides administrative services and funding for the Tribunal through the Disciplinary Levy collected from all practitioners each year. Hence the activities of the Tribunal are reported in this Annual Report.

Members and officers of the Tribunal at 31 March 2000

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

Panel of Medical Practitioners

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

Panel of Public Members

(One is appointed by the Chairperson for the purposes of each hearing)
Mr P Budden
Ms S Cole
Mr G Searancke
Mrs H White
Mrs J Courtney

Office of the Tribunal

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

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

During this year under review, the Tribunal received 13 charges (compared with 24 in the previous year), seven from Complaints Assessment Committees and six from the Director of Proceedings from the Health and Disability Commissioner's Office.

The Tribunal sat to hear 15 charges during the 1999/00 year, six of these being charges received in the previous year. Four of the 13 charges received in the year under review are set down for hearings in the 2000/01 year. Two charges received in the 1999/2000 year are still to be heard.

Charges before the Medical Practitioners Disciplinary Tribunal

1 APRIL 1999 TO 30 MARCH 2000

Nature of Charges	
Disgraceful conduct	2
Professional misconduct	6
Conduct unbecoming a medical practitioner and that conduct reflects adversely on the practitioner's fitness to practise medicine	2
Convictions	2
Alternative	1
Total	**13**

Source	
Prosecution of charges brought by Complaints Assessment Committees	5
Prosecution of charges brought by Director of Proceedings	4
Charges brought by Complaints Assessment Committees but withdrawn	0
Charges brought by Complaints Assessment Committees but yet to be heard	2
Charges brought by Director of Proceedings but yet to be heard	2
Total	**13**

Outcome of Hearings*	
Guilty - conviction	3
Guilty - disgraceful conduct	0
Guilty - professional misconduct	3
Guilty - conduct unbecoming a medical practitioner and that conduct reflects adversely on the practitioner's fitness to practise medicine	6
Not guilty	3
Yet to be heard	6
Total	**21**

* Includes six charges received in 1998/99 year

Finance

Finance

The attached financial statements cover the year 1 April 1999 to 31 March 2000.

General Council Operations

The general fund of the Medical Council covers activities other than those funded by the disciplinary levy and examination fees. The fund operated well within budget showing a surplus of $1,583,393 compared to a budgeted surplus of $270,700.

The main reason for this variance relates to lower than expected expenditure particularly in the area of competence review committees, which were under budget by $332,000. The Council also budgeted $320,000 for activities that did not go ahead, some of which may commence in the 2000/2001 year. Revenue was up with interest being $110,000 greater than expected.

Year 2000 expenditure is $405,000 up on the previous year. The main contributors were competence costs $124,000, the Council election and handbook review costs $64,000, and staff costs $146,000.

A substantial reserve is considered appropriate because the Council could face major litigation at any time. As at 31 March 2000 the general fund capital account stands at $5,442,967 which is in excess of the level of one year's turnover stated in the Council's reserves policy. Assuming a continuation of an APC at the level set for the 2000/2001 year, deficits are budgeted for the next three years.

Discipline Fund

The discipline fund also operated well within budget showing a small deficit of $3,573 compared to a budgeted deficit of $431,250.

The main factors for the variance relate to additional revenue with recovery of fines and costs $191,000 up on budget and expenditure down by 142,000. As in the past, income from fines and costs fluctuates from year to year and remains most difficult to predict. Significant contributors to the reduced expenditure were spending on complaint assessment committees down $76,000 and Medical Practitioners Disciplinary Tribunal down $117,000.

Year 2000 expenditure is $2,000 down on the previous year. Administration and operating costs are up by $235,000 as the fee to meet overhead costs incurred by the general fund is now based on the proportion of staff engaged in this activity. As is expected, costs associated with the 1968 Act are reducing with these being $200,000 less than last year.

The discipline fund capital account now stands at $3,927,780 and as with the general fund is in excess of the level of one year's turnover stated in the Council's reserves policy. Assuming a continuation of a disciplinary levy at the level set for the 2000/2001 year, deficits are forecast for the next three years.

Examination Fund

The examination fund shows a deficit of $88,735 for the year. A deficit was expected as costs of the examination review were met with recovery of these to be made over a number of years. However, the deficit was larger than expected as only 238 candidates sat the three examinations held during the year while the budget was based on 360 candidates.

Year 2000 income and expenditure are down on the previous year as three examinations were held compared to four in 1998/99. Operational savings were made with fewer examination centres used. Committee costs were higher as an additional meeting was held.

The examination fund capital account now shows a deficit of $79,709. Examination review discussions continue and it is too early to predict what form examinations will take in the future, or the Council's involvement in the process. The Council remains of the opinion that examination fees be set as closely as possible to cost recovery. However, the Council has maintained the 1999/00 examination fee for 2000/01 and budgeted for a further deficit awaiting the outcome of the review.

Miller Dean Knight & Little

Chartered Accountants

MEDICAL COUNCIL OF NEW ZEALAND
AUDITORS' REPORT
FOR THE YEAR ENDED 31 MARCH 2000

To : Members of the Medical Council Of New Zealand

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

We have audited the attached financial statements which provide information about the past financial performance of the Council and its financial position as at 31 March 2000. This information is stated in accordance with the accounting policies set out in the notes to the financial statements.

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

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

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

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

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

Unqualified Opinion
We have obtained all the information and explanations we have required. In our opinion the attached financial statements fairly reflect the financial position of the Medical Council of New Zealand as at 31 March 2000 and the results of its operations and cash flows for the year ended on that date.

Date Of Opinion
Our audit was completed on 27 July 2000 and our unqualified opinion is expressed as at that date.

Miller Dean Knight & Little

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

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

Statement of Financial Position

AS AT 31 MARCH 2000

	2000	1999
CURRENT ASSETS		
Petty Cash	200	200
ANZ Bank Account	193,071	261,925
Sundry Debtors and Payments in Advance (Note 7)	50,804	46,609
Interest Accrued	209,511	72,417
Taxation Refund Due (Note 6)		8,980
Term Deposits (Note 8)	11,145,056	10,339,214
Total Current Assets	$11,598,642	$10,729,345
FIXED ASSETS (Note 9)	639,434	415,722
Total Assets	$12,238,076	$11,145,067
CURRENT LIABILITIES		
Sundry Creditors	676,423	565,610
Salaries and Holiday Pay Accrued	135,602	61,548
GST	158,731	216,366
Payments Received in Advance	1,976,282	2,501,590
Total Current Liabilities	$2,947,038	$3,345,114
CAPITAL ACCOUNT		
General Fund	5,442,967	3,859,574
Discipline Fund	3,927,780	3,931,353
Examination Fund	(79,709)	9,026
	$9,291,038	$7,799,953
	$12,238,076	$11,145,067

The accompanying notes form part of these financial statements

President

Chief Executive

Consolidated Statement of Financial Performance

FOR THE YEAR ENDED 31 MARCH 2000

	2000	1999
INCOME		
Fees Received	5,744,399	6,793,017
Interest Received	542,448	714,059
Other Income	385,176	250,241
	$6,672,023	$7,757,317
EXPENDITURE		
Audit Fees	8,500	11,500
Other payments to auditors	2,000	2,000
Depreciation	139,329	106,411
Fees paid to Council Members	358,668	328,007
Loss on disposal of fixed assets		1,263
Other administrative costs	4,542,905	4,709,162
Rent	129,536	130,919
	$5,180,938	$5,289,262
Net Surplus for Year	$1,491,085	$2,468,055

The accompanying notes form part of these financial statements

Statement of Movements in Equity

FOR THE YEAR ENDED 31 MARCH 2000

	2000	1999
A) ACCUMULATED FUNDS AND RESERVES		
Balance at 31 March 1999	7,799,953	5,331,898
Add: surplus	1,491,085	2,468,055
Balance at 31 March 2000	$9,291,038	$7,799,953
B) ANALYSIS OF INDIVIDUAL FUNDS		
1) General Fund		
Balance at 31 March 1999	3,859,574	2,095,769
Add: surplus	1,583,393	1,493,363
Add: transfer from Special Purposes Fund 1999		197,925
Add: transfer from Education Fund 1999		72,517
Balance at 31 March 2000	$5,442,967	$3,859,574
2) Discipline Fund		
Balance at 31 March 1999	3,931,353	2,617,941
Add: surplus 1999		945,838
Less: deficit 2000	(3,573)	
Add: transfer from Special Purposes Fund 1999		367,574
Balance at 31 March 2000	$3,927,780	$3,931,353
3) Education Fund (Note 13)		
Balance at 31 March 1999		72,517
Less: transfer to General Fund 1999		(72,517)
Balance at 31 March 2000		
4) Examination Fund		
Balance at 31 March 1999	9,026	(19,828)
Less: deficit 2000	(88,735)	
Add: surplus 1999		28,854
Balance at 31 March 2000	($79,709)	$9,026
5) Special Purposes Fund (Note 14)		
Balance at 31 March 1999		565,499
Less: transfer to Discipline Fund 1999		(367,574)
Less: transfer to General Fund 1999		(197,925)
Balance at 31 March 2000		

The accompanying notes form part of these financial statements.

Statement of Cashflow

FOR THE YEAR ENDED 31 MARCH 2000

Cash flow from statutory functions		**2000**	**1999**
Cash was provided from:			
Receipts pertaining to statutory functions	6,136,151		7,111,196
Refund of tax	8,980		224,747
	6,145,131		7,335,943
Cash was also distributed to:			
Payment for Council fee and disbursements and Council office expenses	(5,548,286)		(5,151,585)
	(5,548,286)		(5,151,585)
Net cash flow from statutory functions		596,845	2,184,358
Cash flow from investing activities			
Cash was provided from:			
Interest received	405,354		700,046
Sale of assets	2,000		3,767
	407,354		703,813
Cash was applied to:			
Purchase of assets	(267,211)		(178,961)
Short term investments	(805,842)		(2,822,967)
	(1,073,053)		(3,001,928)
Net cash flow from investing activities		(665,699)	(2,298,115)
Net increase/(decrease) in cash held		(68,854)	(113,757)
Opening cash brought forward		262,125	375,882
Ending cash carried forward		**$193,271**	**$262,125**
Represented by:			
Petty cash		200	200
ANZ bank account		193,071	261,925
		$193,271	**$262,125**

The accompanying notes form part of these financial statements.

Notes to and forming part of the Financial Statements

FOR THE YEAR ENDED 31 MARCH 2000

1. STATEMENT OF ACCOUNTING POLICIES

REPORTING ENTITY

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

GENERAL ACCOUNTING POLICIES

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

MEASUREMENT BASE

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

SPECIFIC ACCOUNTING POLICIES

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

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

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

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

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

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

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

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

(g) **Administration Charge** – This is a levy on the Discipline and Examination Funds to meet overhead costs incurred by the General Fund. In the current year the charge to the Discipline Fund is based on the proportion of staff engaged in this activity.

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

CHANGES IN ACCOUNTING POLICIES

There have been no material changes in accounting policies. All accounting policies have been applied on bases consistent with those used in the previous year.

2. GENERAL FUND

Statement of Financial Performance
FOR THE YEAR ENDED 31 MARCH 2000

	2000	1999
REVENUE		
Annual Practising Certificates and Other Fees	4,195,743	3,896,787
Administration Fee - Discipline Fund (Note 1)	359,600	100,000
Administration Fee - Examination Fund (Note 1)	60,000	60,000
Interest Received	307,341	365,094
Workforce Survey and Other Income	90,759	95,984
Total Revenue	$5,013,443	$4,517,865
ADMINISTRATION AND OPERATING EXPENSES		
Communications	116,077	149,033
Election, Handbook Review, and Other Project Costs	82,806	17,900
Legal Expenses and Other Consultancy	97,431	71,852
Other Administration and Operating Expenses	651,970	613,300
Staff Costs including Recruitment and Training	1,516,540	1,370,048
Total Administration and Operating Costs	$2,464,824	$2,222,133
COUNCIL AND COMMITTEE EXPENSES		
Council		
- Fees and Expenses	246,087	252,083
- Conference and Liaison Costs	51,807	80,475
Finance and Management Committee		
- Fees and Expenses	5,728	10,160
Health Committee		
- Fees and Expenses	49,897	46,506
- Health Reports, Mentoring, DHAS and Other Costs	95,575	81,967
Issues Committee		
- Fees and Expenses	15,206	13,123
- Retention of Health Information Project	8,552	
Education Committee		
- Fees and Expenses	50,725	39,889
- Hospital Visits and Intern Supervisor Costs	231,444	174,835
Professional Standards Committee		
- Fees and Expenses	44,516	33,557
- Competence Review Costs	159,948	35,467
Registration Committee		
- Fees and Expenses	5,741	34,307
Total Council and Committee Expenses	$965,226	$802,369
Total Expenditure	$3,430,050	$3,024,502
Net Surplus for Year	$1,583,393	$1,493,363

3. DISCIPLINE FUND

Statement of Financial Performance
FOR THE YEAR ENDED 31 MARCH 2000

	2000	1999
REVENUE		
Fines Imposed, Costs and Mentoring Recovered	294,417	154,257
Interest Received	230,419	333,632
Levies Received	1,077,100	2,065,425
Total Revenue	$1,601,936	$2,553,314
ADMINISTRATION AND OPERATING EXPENSES		
Administration Fee (Note 1)	359,600	100,000
General Administration and Operating Expenses	25,057	49,730
Total Administration and Operating Expenses	$384,657	$149,730
1995 ACT PROCESS		
COUNCIL AND TRIBUNAL EXPENSES		
Complaints Assessment Costs		
- Fees	226,487	312,252
- Expenses	434,292	432,187
Total Complaints Assessment Costs	660,779	744,439
Medical Practitioners Disciplinary Tribunal		
- Administration and Operating Expenses	202,719	163,485
- Fees and Other Hearing Expenses	326,779	319,126
Total Medical Practitioners Disciplinary Tribunal Costs	529,498	482,611
Total 1995 Act Process	$1,190,277	$1,227,050
1968 ACT TRANSITIONAL PROCEEDINGS		
COUNCIL AND COMMITTEE EXPENSES		
Medical Council Discipline Fees and Expenses	2,710	59,340
Medical Practitioners Disciplinary Committee	7,143	92,426
Legal and Mentoring Expenses	20,722	78,930
Total Transitional Proceedings (1968 Act)	$30,575	$230,696
Total Expenditure	$1,605,509	$1,607,476
Net (Deficit)/Surplus for Year	($3,573)	$945,838

4. NEW ZEALAND REGISTRATION EXAMINATION FUND

Statement of Financial Performance

FOR THE YEAR ENDED 31 MARCH 2000

	2000	1999
REVENUE		
NZREX Candidate Fees	471,556	830,805
Interest Received	4,688	15,333
Total Revenue	$476,244	$846,138
ADMINISTRATION AND OPERATING EXPENSES		
Administration Fee (Note 1)	60,000	60,000
Centre Costs	109,335	171,015
Examiners Fees and Expenses	286,690	495,669
General Administrative Expenses	5,281	7,926
Honorarium, Salaries and Other Staff Costs	51,666	70,960
Total Administration and Operating Expenses	$512,972	$805,570
COMMITTEE EXPENSES		
Committee Fees and Expenses	14,415	4,818
Review Costs	37,592	6,896
Total Committee Expenses	$52,007	$11,714
Total Expenditure	$564,979	$817,284
Net (Deficit)/Surplus for Year	($88,735)	$28,854

5. GENERAL FUND

Statement of Financial Performance by Outputs

FOR THE YEAR ENDED 31 MARCH 2000

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

As this is the first year of output reporting comparative figures are not available.

	2000
Total Income for Year	$5,013,443
Less Expenditure	
EDUCATION	
Administration and Operating Costs	277,831
Council and Committee Costs	81,347
Hospital Visits	37,574
Intern Supervisor Costs	193,870
Liaison and Other Costs	18,890
Total Education Costs	$609,512
HEALTH	
Administration and Operating Costs	315,091
Council and Committee Costs	80,519
Doctors Health Advisory Service Contract	39,186
Fitness to Practise Seminar	6,175
Independent Medical Assessments	30,613
Mentoring Costs	9,637
Liaison and Other Costs	17,031
Total Health Costs	$498,252
PROFESSIONAL STANDARDS	
Administration and Operating Costs	557,547
Council and Committee Costs	98,105
Competence Review Costs	159,948
Liaison and Other Costs	9,506
Total Professional Standards Costs	$825,106
REGISTRATION	
Administration and Operating Costs	1,162,171
Council and Committee Costs	142,615
Liaison and Other Costs	22,182
Total Registration Costs	$1,326,968
WORKFORCE SURVEY	
Administration and Operating Costs	152,185
Council and Committee Costs	15,311
Liaison and Other Costs	2,716
Total Workforce Survey Costs	$170,212
Total Expenditure	$3,430,050
Net Surplus for Year	$1,583,393

6. TAXATION

On 20 December 1996 the Court of Appeal found the Medical Council to be exempt from Income Tax. All taxes paid in previous years have been refunded.

7. PAYMENTS IN ADVANCE AND DEBTORS

	2000	1999
Outstanding Contribution to Workforce Survey	19,000	38,000
Other Debtors	14,207	2,045
Payments in Advance	17,597	6,564
	$50,804	$46,609

8. TERM DEPOSITS

	2000	1999
ANZ	2,122,723	2,096,536
ASB	2,013,894	1,280,056
BNZ	1,661,179	1,292,324
Hong Kong Bank	1,079,676	1,228,650
National Bank	2,112,486	2,656,756
Taranaki Savings Bank	613,484	621,279
Westpac Trust	1,541,614	1,163,613
Total Investments	$11,145,056	$10,339,214

9. FIXED ASSETS

	Cost 31/3/00	Depreciation For Year 31/3/00	Accumulated Depreciation 31/3/00	Book Value 31/3/00	Cost 31/3/99	Accumulated Depreciation 31/3/99	Book Value 31/3/99
Computer	550,709	68,393	241,207	309,502	266,829	191,508	75,321
Furniture And Fittings	173,590	15,047	74,192	99,398	246,796	149,326	97,470
Office Alterations	226,531	22,624	103,149	123,382	225,671	80,525	145,146
Office Equipment	189,144	33,265	81,992	107,152	174,791	77,006	97,785
	$1,139,974	$139,329	$500,540	$639,434	$914,087	$498,365	$415,722

10. RELATED PARTIES

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

11. 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.

12. RECONCILIATION OF NET SURPLUS WITH THE NET CASH

Flow from Statutory Functions

FOR THE YEAR ENDED 31 MARCH 2000

Surplus / (Deficit) for year	2000	1999
General Fund	1,583,393	1,493,363
Discipline Fund	(3,573)	945,838
Examination Fund	(88,735)	28,854
	1,491,085	2,468,055
Add tax refunded	8,980	224,747
	1,500,065	2,692,802
Add non-cash items – Depreciation (Note 9)	139,329	106,411
– Loss on disposal of assets		1,263
	1,639,394	2,800,476
Add movements in working capital items		
(Increase)/decrease in debtors and prepayments	(4,195)	(35,170)
Increase/(decrease) in receipts in advance	(525,308)	(20,687)
Increase/(decrease) in creditors and GST	29,402	153,798
	(500,101)	97,941
	1,139,293	2,898,417
Less items classified as investing activity-interest	(542,448)	(714,059)
Net cash flow from statutory functions	$596,845	$2,184,358

13. EDUCATION FUND

This fund met the first round of AMC accreditation costs of medical schools. The fund has been disestablished as the Council now provides for all expenditures in its usual budgetary process.

14. SPECIAL PURPOSES FUND

This fund was disestablished in 1999 as Council now provides for all expenditure in its usual budgetary process.

15. CONTINGENT LIABILITIES

There is no known material contingent liability at balance date. In 1999 there were matters that were before the Race Relations Conciliator's Office, which have now been dismissed.

16. EVENTS OCCURRING AFTER BALANCE DATE

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

17. COMMITMENTS – OPERATING LEASES

Lease commitments under non-cancellable operating leases:

	2000	1999
Not more than one year	116,760	118,269
Later than one year and not later than two years	116,760	118,269
Later than two years and not later than five years	126,490	256,250
	$360,010	$492,788

COMMITMENTS – CAPITAL EXPENDITURE

The Council has entered into a contract with Wang NZ Ltd for the development of an information system. The amount still to be paid at balance date was $62,000.

18. 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;

	2000	1999
Receivables	33,207	40,045
Bank-balances	11,338,127	10,601,139
Payables	(970,756)	(843,524)

Council Committees at 31 March 2000

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

Professional Standards Committee

Dr Ian St George (Chair)

Dr Mark Adams

Miss Carolynn Bull

Dr John Neutze

Mrs Heather Thomson

Health Committee

Dr Tim McKergow (Chair)

Dr Mark Adams

Miss Carolynn Bull

Dr John Neutze

Issues Committee

Dr Tim McKergow (Chair)

Dr Tony Baird

Dr John Neutze

Mr Alexander Sundakov

Finance and Management Committee

Mr Alexander Sundakov (Chair)

Dr Mark Adams

Professor Ian Simpson

Ms Sue Ineson

Education Committee

Members appointed by the Council

Dr Mike Ardagh
Selected from Vocational Branch nominees

Dr Caroline Corkill
Selected from Vocational Branch nominees

Dr Gillian Clover
Selected from Vocational Branch nominees

Dr Mark Davis
Selected from Intern Supervisors

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

Dr Jenny Martin
Resident doctor

Council members

Professor Ian Simpson (Chair)

Miss Carolynn Bull

Dr Ian St George

Mrs Heather Thomson

Examinations Committee

Members appointed by the Council

Professor Graham Mortimer
Examinations Director

Dr John Collins
University of Auckland Nominee

Associate Professor Richard Clemett
University of Otago Nominee

Dr Pat Alley
Examination Co-ordinator, Auckland

Dr David McHaffie
Examination Co-ordinator, Wellington

Dr Peter Rothwell
Examination Co-ordinator, Hamilton

Professor John Morton
Examination Co-ordinator, Christchurch

Dr Jim Reid
Examination Co-ordinator, Dunedin

Dr Mark Davis
Education Committee Nominee

Council members

Dr Tony Baird (Chair)

Professor Ian Simpson

Mrs Heather Thomson

Office of the Council at 31 March 2000

Ms Sue Ineson
Chief Executive

Ms Georgina Jones
Registrar

Ms Lynne Urquhart
Deputy Registrar

Mrs Stephanie Pett
Senior Secretary

Registration

Mrs Jane Lui
Registration Manager

Mr Sean Hill
Senior Registration Administrator

Ms Gyllian Turner
Registration Administrator

Ms Karen Gardner
Registration Administrator

Mr Philip Girven
Registration Administrator

Miss Diane Latham
Registration Administrator

Mrs Moyra Hall
Registration Administrator

Ms Linda Tan
APC Supervisor

Standards

Ms Sandy Gill
Standards Manager

Ms Angela Coleman
Education Administrator

Ms Ritu Nair
Examination Administrator

Ms Kirsty Glen
CAC Administrator

Ms Chris Aitchison
Professional Standards Administrator

Miss Kristine Couch
Standards Administrator

Dr John Simpson
Professional Standards Coordinator
(part-time)

Mrs Sue D'Ath
Old Council Tribunals Administrator

Health

Ms Lynne Urquhart
Health Manager

Ms Jo Hawken-Incledon
Health Administrator

Corporate Services

Mr John de Wever
Financial Controller

Mr Bill Taylor
Information Systems

Ms Susan Pattullo
Communications Coordinator

Mr Greg Waite
Information Officer

Ms Donna Overduin
Office Administrator

Mrs Debbie North
Customer Services

Mrs Rita Umaga-Ta'ulelei
Customer Services

Mrs Viv Coppins
Registrar's Secretary

Mr Richard Bull
Office assistant (part time)

Solicitors

KPMG Legal
P O Box 10 246
Wellington

Bankers

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

Auditors

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

Medical Council of New Zealand

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

Medical Council Staff

From top, left to right:

Sandy Gill

Karen Gardner

Luke Baddington
(registration)

Michael Clarkson
(registration)

John de Wever

Viv Coppins

Philip Girven

Moyra Hall

Eva Dabrowski
(temp registration)

Richard Bull

Angela Coleman

Susan Pattullo

Michele Clarke
(complaints)

Debbie North

Rita Umaga-Ta'ulelei

Gyllian Turner

Peter Cossar
(professional standards)


MEDICAL
COUNCIL
of NEW ZEALAND