MEDICAL COUNCIL *of* NEW ZEALAND

ANNUAL REPORT

1997

MEDICAL COUNCIL of NEW ZEALAND

PLEASE NOTE THE FOLLOWING CORRECTION:

Medical Council of New Zealand Annual Report 1997 **Table 5, Page 52**
should read

Proportion of Maori doctors **among**

– House Officers **3.7%**

Note also: More details of the New Zealand Medical Workforce in 1996 are set out in the Supplement to the Council's Annual Report 1996.

MEDICAL COUNCIL of NEW ZEALAND

ANNUAL REPORT 1997

FOREWORD

This report is the first to be published by the Medical Council of New Zealand under the Medical Practitioners Act 1995. Section 130 requires the Council to report to the Minister of Health on the operations of the Council for the past financial year. The report then goes before the House of Representatives.

The text of this report covers only the period between 1 July 1996 (when the Act became effective) and 31 March 1997. However, the financial statements in the report cover the full financial year from 1 April 1996 to 31 March 1997.

The period reported on saw a change in Council members, with a number of the 1968 Act Council members retiring in December 1996. The new Council (under the 1995 Act) met for the first time in February 1997, with four medical members elected by medical practitioners, two lay members, one medical practitioner appointed by the Minister, a medical school representative also appointed by the Minister, and the Director General of Health's alternate. A further lay member is still to be appointed.

MEDICAL PRACTITIONERS ACT 1995

3. Principal purpose

(1) The principal purpose of this Act is to protect the health and safety of members of the public by prescribing or providing for mechanisms to ensure that medical practitioners are competent to practise medicine.

(2) Without limiting the generality of subsection (1) of this section, this Act seeks to attain its principal purpose by, among other things,

(a) Imposing various restrictions on the practice of medicine:

(b) Providing for the registration of medical practitioners, and the issue of annual practising certificates:

(c) Providing for the review of the competence of medical practitioners to practise medicine:

(d) Providing for the notification of any mental or physical condition affecting the fitness of a medical practitioner to practise medicine:

(e) Providing for the disciplining of medical practitioners:

(f) Providing certain protections for medical practitioners who take part in approved quality assurance activities.

CONTENTS

MEMBERS OF THE MEDICAL COUNCIL

As at 1 July 1996

Dr K J Thomson (President)	Appointed by Minister of Health (1995 Act).
***Dr G F Lamb** (Deputy President)	Royal Australasian College of Surgeons nominee, appointed by the Governor General on the recommendation of the Minister of Health.
***Dr R H Briant**, CBE	Royal Australasian College of Physicians nominee, appointed by the Governor General on the recommendation of the Minister of Health.
***Dr C M Corkill**	Appointed by the Minister of Health (1968 Act).
***Dr R G Gudex**, QSO	Royal New Zealand College of Obstetricians and Gynaecologists nominee, appointed by the Governor General on the recommendation of the Minister of Health.
***Dr M M Herbert**, QSO	New Zealand Medical Association nominee, appointed by the Governor General on the recommendation of the Minister of Health.
Mrs P C Judd, JP	Appointed by the Minister of Health (1995 Act).
Dr S L Kletchko	ex officio for the Director-General of Health.
***Dr C H Maclaurin**	ex officio for the Dean, Faculty of Medicine and Health Science, University of Auckland (1968 Act).
Professor J G Mortimer	appointed by the Minister of Health, after consultation with the Deans of the Faculties of Medicine of New Zealand Universities.
***Dr I M St George**	Royal New Zealand College of General Practitioners nominee, appointed by the Governor General on the recommendation of the Minister of Health.
***Dr J A Treadwell**	Appointed by the Minister of Health (1968 Act).
Mr H T van Roon	Appointed by the Minister of Health (1995 Act).

*Continued in office under transitional provisions (Medical Practitioners Act, 1995, sec 150)

MEDICAL COUNCIL AT 1 JULY 1996

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

REPORT OF THE PRESIDENT

This report covers the period from 1 July 1996 to 31 March 1997, a time of considerable change and upheaval both within the Medical Council itself and within the profession as both seek to adapt to the Medical Practitioners Act 1995. Essentially this nine month period has been one of transition, with the "retirement" of the former Medical Council members (those appointed under the 1968 Act) and the election or appointment of most of the members of the current Council under the 1995 Act. One ministerial appointment, a lay person, is still outstanding.

The new Act provides a sound base on which Council can work to fulfil its prime objective, which is to protect the health and safety of the public. The new legislation allows Council to take a more interventionist role in the maintenance of professional competence, but at the same time defines a separate single disciplinary tribunal to hear charges at all levels. During the transition phase Council has worked hard with various professional groups to introduce the new features of the Act and to educate the wider profession about the changes necessary. It has been encouraging to see the general acceptance of the legislation, an acknowledgment that the profession as a whole recognises the need for ongoing review of doctors' fitness to practise throughout their entire career. Whilst the previous legislation had enabled Council to establish a very effective system for monitoring sick or impaired practitioners, the new Act also allows Council to monitor routinely the competence of doctors in their chosen field throughout their practising life, and to initiate specific competence assessments where these are indicated.

The new registration provisions, in allowing Council more discretionary powers, enable a fair and equitable assessment of all doctors intending to practise in New Zealand, no matter where they originally qualified. Primary medical degrees must be from Council accredited medical schools or else graduates must satisfy an assessment or examination process to establish that the standards of their qualifications are equivalent to those attained in accredited schools.

When setting entry standards for any group of doctors, but particularly for doctors wishing to practise in vocational areas, Council is well aware of the tension which exists between those who set the standards for local qualifications and those who wish to relieve staffing shortages in our health workforce. Council has been determined to see that public safety remains the paramount factor in approving these applications; we will not allow doctors to enter practice in any area if their qualifications or standards are less than those we expect of locally trained people. Neither will Council tolerate attempts by specialist groups to impose unrealistic or unattainable standards on such applicants. It is important that the registration system remains sufficiently flexible to cope with the major changes which are already occurring in medical practice. Council is committed to acting in the public interest at all times, regardless of pressure groups. The new legislation enables appropriate conditions to be imposed on registrants, if their competence and performance necessitates such limitation.

The interface with the Health and Disability Commissioner's office has provided Council with an opportunity to be much more aware of the types of situation bringing doctors into conflict with patients. All too often, inadequate or inappropriate communication has resulted in dissatisfaction and a subsequent complaint. Council appreciates the heavier burdens placed on many practitioners by the recent rapid changes in the health sector. Regardless of these pressures, however, the patient is still the most important part of the equation. Council's mission is to see that the New Zealand public receive safe and appropriate care from the medical profession.

I would like to thank all those who have contributed to the Council over this challenging year. The Medical Council members, in both old and new bodies, have faced ever increasing demands on their time and patience. The various functions of Council would not operate without

the assistance of a large group of doctors and lay people who contribute on a number of committees, act as examiners and serve as members of Complaints Assessment Committees. The colleges and special societies have been heavily involved in the implementation of the new Act, and their efforts are much appreciated. Underpinning all these contributions has been the Medical Council staff, whose never easy task has been even more demanding since the 1995 Act was passed. The profession and the public are well served by the Registrar and her team, and I thank them on behalf of the Medical Council.

Kenneth J Thomson
PRESIDENT

MEDICAL PRACTITIONERS ACT 1995

123. Functions of Council

The functions of the Council are as follows:

(a) To authorise the registration of medical practitioners under this Act, and to maintain the register:

(b) To consider applications for annual practising certificates referred to it by the Registrar:

(c) To review the competence of medical practitioners to practise medicine:

(d) To consider the cases of medical practitioners who, because of some mental or physical condition, may not be fit to practise medicine:

(e) To promote medical education and training in New Zealand:

(f) To provide administrative and related services to the Tribunal:

(g) To advise, and make recommendations to, the Minister in respect of any matter relating to the practice of medicine:

(h) To exercise and perform such other functions, powers, and duties as are conferred or imposed on it by or under this Act or any other enactment.

REPORT OF THE LAY MEMBERS

Following a gestation of ten years the Medical Practitioners Act 1995 finally became operative on the 1st of July 1996. A significant change is the increased lay member involvement on Council. The Council now has ten members, down from twelve, and the number of lay persons has increased from one to three, with the possibility of a fourth, at the discretion of the Minister of Health.

Mr Henri van Roon was appointed immediately for a three year term and Mrs Patricia Judd was reappointed for a further two years. Appointment of a third lay member is still awaited.

Two new committees were formed, Professional Standards and Issues. With the increased lay membership, there is now lay participation on every committee of Council, thus ensuring a lay perspective is brought to all of the matters which are presented and considered.

Discipline was transferred to the Medical Practitioners Disciplinary Tribunal, following determinations on complaints considered and investigated by Complaints Assessment Committees (appointed by the Council President), and therefore no longer involves Council members. Nevertheless the overall workload is still heavy and ways of streamlining it are being looked at.

Council is reviewing its overall role under the new Act. This includes a review of administrative procedures. Many of these had developed incrementally over a long period of time. Now the levels of detail and degrees of delegation required to function cost effectively within the legislation are being assessed afresh.

The registration process is part of this ongoing review. There is absolutely no evidence to date of any restrictive practices in the way in which the registration process is being applied by Council. It is being done in an open and professional manner.

We have been impressed by the degree of emphasis in all Council discussions on public interest matters. The overall approach has been to debate issues in an open and supportive manner, with information being shared willingly.

Lay involvement has been readily included beyond the committee level on various working parties such as general oversight, professional competence, data and research.

We have also been most impressed with the professionalism of the staff in coping with the new legislation and transition provisions, whilst their workload was added to by the influx of applications for registration of overseas trained doctors.

Patricia C Judd
Henri T van Roon
LAYMEMBERS

1996

1 July Medical Practitioners Act 1995 takes effect.

1 July *First meeting of "transition" Council*

- *adopts rules for election of Medical Members of Council*
- *confirms Dr K J Thomson as President, Dr G F Lamb as Deputy President, Ms G A Jones as Registrar and membership of Council Committees*
- *welcomes new layperson, Mr H T van Roon, appointed by Minister.*

July General Oversight implementation begins.

July *Implementation begins of new pathway for assessment of overseas trained doctors recognised as specialists prior to reaching New Zealand.*

8 August Registrar publishes Election Rules, approved by Minister, in New Zealand Gazette.

20 August *Minister appoints Medical Practitioners Disciplinary Tribunal Chairperson (and Deputy) and panels of medical practitioners and laypersons.*

30 August Notice of Election and call for nominations goes to all registered medical practitioners.

9 September *Associate Professor R G Large signs Council contract to prepare report on questions concerning maintenance of competence by registered medical practitioners.*

26 September Council:

- approves contract for review of Workforce Survey operation
- receives first report on implementation of Complaints Assessment Committee process, including interim guidelines
- appoints interim Professional Standards Committee and adopts draft terms of reference
- resolves to give interim approval to existing MOPS (Maintenance of Professional Standards) programmes for recertification
- adopts new definition of "Practice of Medicine" (Section 9) and consequent requirement for Annual Practising Certificate (APC) for future applications under the 1995 Act.

30 September *Returning Officer receives 28 nominations for election to Council (4 vacancies).*

30 September First publication of Register under 1995 Act.

13 October *115 candidates present for NZREX Clinical in 5 centres nationwide.*

27-30 October Council delegates attend Second International Conference on Medical Registration, Melbourne.

5-6 November *Council sponsors Wellington Conference (satellite to Melbourne Conference), "Too Many and Too Few Doctors – Dilemmas in the Medical Workforce".*

29 November Election Poll closes.

1996

11 December *Council:*

- *sets APC fee and Disciplinary Levy for year commencing 1 April 1997*
- *adopts new Education Committee composition and terms of reference, including approval of vocational training programmes*
- *receives reports on 1996 hospital visits to approve persons and supervisors for education and training of probationers*
- *receives report of General Oversight working party, identifying implementation problems and suggesting solutions.*

12 December

- Returning officer publishes Election result in New Zealand Gazette.
- Council elects Interim Deputy President of Council, Dr I M St George.

13 December

- *3 year term of office begins for elected members, Drs A J Scott, I M St George, M J Adams, M A H Baird.*
- *"Transition Council" members' responsibilities consequently confined to disciplinary matters commenced under the 1968 Act.*

23 December Registrar despatches Briefing Manual to new Council members.

1997

19-20 February *Council:*

- *holds information sharing meeting on Council functions for newly constituted Medical Council, including four elected members and two laypersons; Director General of Health attends to brief new Council on 1995 Act*
- *elects Dr K J Thomson President and Dr I M St George Deputy President and appoints Council Committees, including new Issues Committee and newly constituted Education Committee*
- *resolves to accept a proposal requested from Victoria Link for the first stage of independent research on the efficacy of the Medical Practitioners Act 1995*
- *receives report commissioned, "Maintaining Doctors' Competence", written by Associate Professor R G Large.*

28 February Registrar signs new 2 year contract for Workforce Survey Information with New Zealand Health Information Service.

31 March *Council notes:*

- *registration applications processed under 1995 Act (9 month period) total 1240 (probationary 380, general 285, vocational 173, temporary 402)*
- *register amendments total 3546*
- *removals from register (all reasons) total 264*
- *certificates provided to verify registration (including for purpose of registration outside New Zealand) total 628*
- *issue of 8077 Annual Practising Certificates for* ***12 months*** *ending 31 March 1997.*

REGISTRATION

Function of Council – Section 123(a): *To authorise the Registration of Medical Practitioners under this Act, and to maintain the Register*

The implementation of the Medical Practitioners Act 1995 had a very significant impact on all aspects of registration policies, procedures and administration which in turn resulted in the necessity for Council to increase resources to administer the registration provisions.

The Act allowed Council to delegate to committees all functions except registration. That requirement resulted in the Registration Committee, constituted as a quorum of Council, meeting monthly to consider registration applications.

The two current lay members and the three newly elected medical members of Council have all participated in Registration Committee meetings. An increase in the number and complexity of applications being considered, and the greater flexibility and discretionary powers given to Council, led to an increase in the duration of Committee meetings. Major issues of principle or procedure were considered by all Council members at quarterly general Council meetings.

Definition of Practice of Medicine

In keeping with the purpose of the Act, and the trust placed by the public in the competency of registered medical practitioners, Council defined the "practice of medicine" as follows: "signing any certificate, prescribing, treating, reporting or giving advice in a medical capacity, using the knowledge, skills, attitudes and competence initially attained for the MBChB degree (or equivalent) and built upon in postgraduate and continuing medical education. "Practice" in this context went wider than clinical medicine to include teaching, research, medical or health management, in hospitals, clinics, general practices and community and institutional contexts". This meant that a number of medical practitioners were required to apply for an Annual Practising Certificate (APC) for the year commencing 1 April 1997, even though they may not have done before and do not practise "clinical" medicine. Council understanding is that the linkage in the Act between probationary registration, general registration and vocational registration, designed to protect the public by ensuring continuing competence of registered medical practitioners, must apply to all persons with medical degrees who are working in a variety of activities which draw on those medical qualifications. Council saw that there was potential for members of the public to come to harm not only in clinical but also in non-clinical contexts. Incompetent or unprofessional delivery of services in teaching, research, public health medicine or management, for example, could adversely affect the community, possibly even more dramatically than poor practice by an individual doctor in a clinical context. Council received a number of submissions from affected parties on the appropriateness of its definition and a review of the practical problems arising from the definition is in place. A consequence of this definition is that it brings under the requirement for supervision, general oversight and vocational recertification (with new branches required) areas of medical work not previously subjected to registration body scrutiny of continuing professional competence.

General Oversight

All doctors with general registration are required to practise under the general oversight of another medical practitioner who is vocationally registered in the same branch or sub-branch in which the general registrant is practising.

In July 1996, Council promulgated a memorandum which included a draft definition of "general oversight" and guidelines for its implementation. The colleges were asked to provide further information on the practical application of general oversight in their branch of medicine.

The definition was modified slightly at the December 1996 meeting to:

General oversight of a general registrant involves a mutually agreed relationship with a colleague who holds vocational registration in the same branch or sub-branch. The objective of the oversight is to provide assurances to the Council and the public that the general registrant is practising competently. During the transition to 30 June 2001, certain general registrants are also permitted to provide general oversight.

There were about 2000 general registrants who were required to comply with the general oversight provisions. However a number of them, for a variety of reasons, experienced difficulty in making suitable arrangements. The reasons given to Council included geographical isolation (often in smaller hospitals), lack of collegial networks (especially relevant to new immigrants), practising a very specialised type of medicine (not necessarily in a currently recognised branch or sub-branch), a feeling of intrusion on the registrant's 'right to practise' and inability to gain agreement from an overseer.

Some doctors raised concerns about the legal liability of overseers and this was addressed in the July 1996 memorandum. In December 1996 Council added this statement to its policy:

The overseer is not liable for the actions of the general registrant, but is responsible for ensuring that appropriate oversight is provided. Any alleged omission in the oversight, or action in bad faith, would have to be proven to be negligent.

Council recognised that for a small number of practitioners the implementation of general oversight was not easy and work continues on drafting clearer guidelines, in consultation with faculties and colleges and employers. There is no discretion in the Act for Council to exempt doctors from oversight, except for the transition provision below. It is an innovative provision for which policy and procedures will evolve over time with experience of what works best in the public interest.

Doctors, excused from the general oversight provisions on the basis that they held five consecutive annual practising certificates in New Zealand under the 1968 Act, only qualify for exemption until 30 June 2001. After that date they must be vocationally registered if they wish to practise independently, ie without oversight. If they choose not to complete vocational training they will be subject to the general oversight provisions in the Act for the remainder of their career while they practise in New Zealand.

Vocational Registration

All doctors who were previously on the Register of Specialists or on the Indicative Register of General Practitioners under the 1968 Act were deemed to hold vocational registration pursuant to the transition provisions of the new legislation. This meant that all branches (and sub-branches) previously recognised under the 1968 Act were carried forward as recognised branches pursuant to Section 21 and are now designated as such according to the Order in Council made by the Governor General on the advice of the Minister after consultation with Council.

Council received requests for recognition of new branches or sub-branches of medicine for vocational registration.

Council's new Education Committee was given the responsibility of determining appropriate criteria for the recognition of new branches, and began this task at its first meeting in March 1997. These will be promulgated with an application protocol so that they can be considered at the end of 1997 or early 1998.

The Act contains provisions which are aimed at ensuring competence of vocationally registered medical practitioners. These doctors may be required to participate in approved recertification programmes. However, unlike general oversight, there is provision to exempt individual doctors or classes of doctor from recertification programmes.

Council's Professional Standards Committee is responsible for determining the criteria for recognition of recertification programmes. Council has given provisional approval in principle to the entry and recertification programmes currently provided by the various vocational colleges, but a

detailed review of the programmes is to be undertaken. Other organisations may submit recertification programmes for approval.

The 1995 Act provided an incentive for doctors who had specialist qualifications, training and experience, but had not previously sought entry to the specialist register under the 1968 Act, to seek admission to the new vocational register. This incentive also applied to general practitioners with approved advanced training and experience in general practice. In contrast to the old legislation, the qualifications required for vocational registration under the new Act were not specified in Schedules but were left to Council to decide.

There was a significant increase in the level of applications for vocational registration in the first year of operation of the new Act (and the six months before that). Information in Table 1 sets this out for all currently recognised branches of medicine.

To qualify for vocational registration in a particular branch or sub-branch of medicine an applicant must satisfy Council that he or she holds general registration and such qualifications, training and experience as Council determines are appropriate, along with demonstrated competence to practise in that branch. Council accepted that the minimum standard for admission to the vocational register should be the standard equivalent to that established (and previously recognised in law) by the Australian and New Zealand colleges and faculties in the various specialities including general practice.

For those who have obtained vocational qualifications, experience and recognition outside Australia and New Zealand, a pathway of interview and assessment by each of the branches of medicine was established, after due consultation. The colleges and faculties were asked to evaluate where on the continuum an applicant for vocational registration sat and to advise Council accordingly whether or not vocational registration was appropriate, immediately or only following the completion of certain objective tests of advanced knowledge, skill and competence under supervision. Council stressed that emphasis must be placed on the capacity of the doctor to perform at specialist or consultant level, rather than on the need to spend a particular length of time in training.

At 31 March 1997, 306 overseas trained doctors had applied for assessment through this new pathway. Fifty seven interviews had taken place. The recommendations from the interviews must

Table 1

NEW ZEALAND VOCATIONAL REGISTER
at 31 March 1997

	30 June 1996	Added	Removed	Net	Total
Anaesthetics	370	18	0	18	388
Public Health Medicine	168	6	0	6	174
Dermatology	48	2	0	2	50
Diagnostic Radiology	199	24	0	24	223
Emergency Medicine	7	0	0	0	7
General Practice	1579	24	0	24	1603
Gynaecology	1	0	0	0	1
Internal Medicine	576	22	0	22	598
Obstetrics	1	0	0	0	1
Obstetrics & Gynaecology	225	11	0	11	236
Occupational Medicine	16	2	0	2	18
Ophthalmology	102	5	0	5	107
Orthopaedic Surgery	160	9	0	9	169
Otolaryngology	79	5	0	5	84
Paediatrics	188	4	0	4	192
Pathology	199	12	0	12	211
Psychiatry	327	14	0	14	341
Radiotherapy	39	2	0	2	41
Rehabilitation Medicine	3	0	0	0	3
Cardiothoracic Surgery	30	1	0	1	31
General Surgery	248	4	0	4	252
Neurosurgery	15	1	0	1	16
Paediatrics Surgery	5	3	0	3	8
Plastic Surgery	32	2	0	2	34
Urology	41	2	0	2	43
Venereology	15	0	0	0	15
Total	**4673**	**173**	**0**	**173**	**4846**

be considered by Council's Vocational Registration Sub-committee before applicants are advised. As with any new development, there has been a steep learning curve for all parties as Council has not been able to specify in advance the exact requirements each applicant must satisfy to achieve registration. The policy continues to be refined to address issues raised which were previously unforeseen. It will take several more months to interview all applicants and communicate outcomes to them. Delays and costs inherent in the process are already causing concern to applicants and employers, yet public protection must be uppermost.

It may be that in the future some new branches and sub-branches of medicine are recognised for which the training is rigorous and appropriate but can be accomplished in a relatively short period of time, say two to three years rather than the more traditional four or five.

Council also made it clear that where a vocationally registered doctor practises in a branch in which he or she does not hold vocational registration, he or she must comply with general oversight requirements in that branch.

Temporary Registration

The Act provides for temporary registration for doctors visiting New Zealand to give post-graduate instruction, or obtain post-graduate training or experience or carry out research. Council can also grant temporary registration to visitors for other purposes, at its discretion.

Council has defined "visitor" as a person not having residence status (for immigration purposes). Such doctors have visitor, student or work permits. Doctors entitled to reside permanently in New Zealand (including citizens) are not normally entitled to apply for temporary registration. Over the period of change in immigration policy (effective in October 1995) and in legislation governing registration of doctors in New Zealand, some anomalies have been drawn to the Registration Committee's attention and have been dealt with on a case by case basis.

Under the discretionary category, as a transition policy due to expire on 30 June 1998, Council granted temporary registration to holders of university primary medical degrees from the United Kingdom, Republic of Ireland, Canada and South Africa (formerly registerable under the 1968 Act) to retain a viable workforce of a reasonably well known and acceptable standard. The Act permits temporary registration for up to three years maximum.

Council received many requests from employers seeking clarification of the arrangements beyond 30 June 1998. Council has been asked to continue to recognise the UK, Irish, Canadian and South African medical degrees for temporary registration, in order to meet perceived likely workforce shortages. Council has no mandate to determine workforce numbers or composition; its function is to set standards for entry to and retention on the New Zealand Medical Register. Nevertheless, it does recognise that there could be a significant impact on workforce if registration of non-Australasian trained medical graduates is restricted to those who have satisfied Council through either the New Zealand Registration Examination (NZREX) or the vocational registration assessment pathway.

As at 31 March 1997, no decision had been made about changes to Council's temporary registration policy beyond 30 June 1998. A review was under way. It is likely that in future the justification for granting temporary registration in the discretionary category will involve meeting strict criteria, eg specific, short-term appointments related to documented needs where recruitment and retention difficulties are not yet resolved long-term, and may not be based on the origin of the primary medical degree.

General Registration

Doctors who have satisfactorily completed primary medical degrees from accredited universities in Australia (and New Zealand) and an approved internship ie, pre-registration period (minimum 12 months) under supervision, may apply for general registration without

examination. The standard of their education and training and their individual performance is known and acceptable. However, overseas trained doctors wishing to remain in New Zealand longer than 3 years, and particularly any granted permanent residence (after perhaps initially arriving on visitor permits or work visas), must show they have reached a comparable standard, by meeting Council's assessment requirements. This means either passing the NZREX, or being exempt NZREX by meeting the requirements for vocational registration through completing vocational qualifications and experience to a standard comparable to those approved for fellowship in an

Table 2

REGISTRATION ACTIVITIES

1 July 1996 to 31 March 1997[1]

INTERIM CERTIFICATES ISSUED, PROBATIONARY REGISTRATION[2]	
Class 1 New Zealand Graduates (Interns)	255
Class 1 Overseas Graduates (Interns)	6
Class 2 Overseas Graduates (NZREX passes)	72
Class 3 Overseas Graduates (Eligible for Vocational Registration)	13
Class 4 Overseas Graduates (Suitable for Assessment - Vocational Registration)	16
Class 6 Overseas Graduates (Clinical Evaluation - Vocational Registration)	1
Class 7 Overseas Graduates (NZREX - Supernumerary Attachments)	17
INTERIM CERTIFICATES ISSUED, GENERAL REGISTRATION	
New Zealand Graduates	5
Australian Graduates	17
TEMPORARY CERTIFICATES ISSUED[2]	
New Certificates	402
Extensions	133
GENERAL REGISTRATION AFTER COMPLETION OF PROBATIONARY PERIOD	
Class 1 New Zealand and Overseas Graduates (Interns)	232
Class 2 Overseas Graduates (NZREX passes)	15
Class 3 Overseas Graduates (Eligible for Vocational Registration)	12
Class 4 Overseas Graduates (Suitable for Assessment - Vocational Registration)	4
ADDITIONS TO VOCATIONAL REGISTER	173
AMENDMENTS TO MEDICAL REGISTER	
Change of Address	3325
Change of name	34
Additional Qualifications	175
Interim Suspension	4
Suspension	0
Revocation of suspension/conditions	10
REMOVALS	
Death	48
Discipline order	1
Failure to notify Change of Address	48
Non-resident Graduates	68
At own request	99
ANNUAL PRACTISING CERTIFICATES	8077
CERTIFICATES OF GOOD STANDING	429
CERTIFICATES OF REGISTRATION	199

Notes: [1] This is a 9 month period. Future reports will contain annual statistics.
[2] See Table 9 for analysis by country of primary degree.

Australasian College. For such doctors a probationary period of at least twelve months is a prerequisite for general registration.

Probationary Registration

The 1995 Act brought together under a single category the pre-registration requirements for doctors who had obtained their primary medical qualifications in New Zealand, Australia and all other countries. The old distinction (with different conditions) between conditional and probationary registration was removed.

The internship remains a compulsory requirement for new graduates from all medical schools. In reality the internship is undertaken in New Zealand mainly by New Zealand graduates although a small number have come from overseas, just as a small number of New Zealand graduates have gone overseas, for this purpose. The requirements for the internship are set by Council's Education Committee which retained the process of visiting institutions and general practices for accreditation of education and training facilities and supervision for this purpose.

Every probationary registrant must practise only with an approved person who may be the employer or associate. That approved person must arrange for the probationer to be appropriately supervised by one or more medical practitioners approved by Council in order to ensure that the probationer receives appropriate education or training of the kinds specified by Council. Transition provisions in the Act allowed the previously recognised institutions (mainly hospitals) to continue to be recognised for this purpose under the 1995 Act.

Specific legal requirements of supervisors are set out in the Act. They must assess and report to Council at intervals specified by Council on the performance of the probationer and make recommendations on whether or not the probationer should be granted general registration. Quarterly consultant reports on interns are monitored by designated "Intern Supervisors", and a recommendation on suitability for general registration given at the completion of intern requirements. Other probationers are reported on at 3 months and, if there are no major problems, again at 12 months.

Doctors receiving their primary medical degrees from outside Australia and New Zealand may progress to probationary registration only through examination or assessment. They also must work with an approved person under supervision. In the first year of the new Act such doctors were not required to undertake an internship, as such, unless they had not already done so. Their supervisors were appointed from within the team (or general practice) in which they were employed. No requests were received for approval of probationary employment and supervision in general practice in the period under review.

The number of overseas trained doctors applying for probationary registration has increased as a result of medical migration and the success by some in completing the NZREX or being admitted to the assessment period for overseas trained specialists after evaluation by the relevant college or faculty. Supervision requirements for overseas trained doctors granted probationary registration are more complex and problematic. Council's Education Committee was asked to review these requirements and it is likely that changes will be recommended before the end of 1997 to improve the integration of overseas trained doctors into the New Zealand medical workforce (where permanent residence has been granted or has been applied for) and to ensure that levels of performance are reached which protect the safety of the public.

Re-registration

As part of the re-registration process, doctors who have been struck off the register on disciplinary grounds may also be required to re-enter practice on probationary registration, as a first step, under supervision and conditions, should Council decide that that is appropriate. This process may apply to others who have been out of the medical workforce for a significant period.

Supernumary attachments

Council also made provision for NZREX Clinical candidates, and certain overseas trained doctors under vocational registration preliminary assessment, to be admitted to a brief period of probationary registration to enable them to become familiar with the practice of medicine in New Zealand before they were subject to more rigorous appraisal of their clinical skills. The numbers of doctors granted probationary registration under these categories were small as can be seen from Table 2. This partly arose from the fact that there was limited capacity in Crown Health Enterprises and general practices for such attachments, usually supernumerary.

ANNUAL PRACTISING CERTIFICATES

Function of Council – Section 123 (b): *To consider applications for Annual Practising Certificates referred to it by the Registrar*

These certificates now have a key significance in the protection of the health and safety of members of the public as they provide evidence that doctors are fit to continue practising medicine. They are no longer automatically issued merely on request, on payment of the fee. In early 1997, the first occasion certificates were renewed under the new legislation, applicants were required to make disclosures covering the previous decade about their personal health, professional conduct, and any other circumstances that could have affected their fitness to practise. In future, disclosures concerning only the previous twelve months will be sought. The Act permits Council to place restrictions on the APC, but only after the applicant is advised of Council's proposal and is given an opportunity to make submissions or be heard by Council in response to the proposal. In such a situation, the issue of an APC may be delayed. In some circumstances, an interim APC (valid for up to 4 months) can be issued while certain conditions are met.

About 4% of practising doctors (approximately 360 people) made disclosures in 1997 under the new requirements. Almost all the matters disclosed were in fact already known to Council. After follow up of disclosures, only one doctor was asked to meet with the Health Committee and no APCs had to be declined, nor any interim APCs issued. Monitoring was implemented as appropriate.

The Registrar must now refer for Council consideration applications for APCs by doctors returning to practice, who have not held an APC in New Zealand or have not been engaged in the practice of medicine during the preceding three years. In support of their applications, doctors returning from overseas must now provide Certificates of Good Standing from the registration authority in each country in which they have worked as a doctor. No such applications have to date been declined.

For the 12 months ending 31 March 1997, 8077 APCs were issued (the majority under the Medical Practitioners Act 1968). For the year ending 31 March 1998, 8400 APCs were issued by the midpoint of the year under the Medical Practitioners Act 1995.

The revised definition of the "practice of medicine" now brings public health medicine specialists, pre-clinical educators, researchers and medical managers under the requirement for an APC (see item on page 10 under Registration).

COMPETENCE

Function of Council – Section 123(c): *To review the competence of Medical Practitioners to practise medicine*

The primary principle underlying the new Act is maintenance of standards. The Act put in place structures to mandate the now established concept that doctors must make a life-long commitment to maintaining their professional competence. More than ever before, the public expects this to be the norm, and is ready to speak out if it appears to be in doubt.

The Council was given a new responsibility in setting standards for the profession by leading the way in clarifying what is necessary to maintain those standards, co-operating with employers, post graduate colleges, universities and other agencies to that end.

During 1996 Council commissioned Associate Professor Robert G Large to report on the following questions:

- How is competence to practise medicine defined and how is it measured?
- What steps should be put in place for rehabilitating and retraining doctors whose competence is found wanting?
- How is the success of those processes measured?

Dr Large's report entitled "Maintaining Doctors' Competence" was received in February 1997. He reviewed the current literature, met face to face with a wide variety of people in New Zealand and overseas, and drew together many important and stimulating ideas and models for Council's consideration. Council decided to distribute the report to those who have a significant interest in how the far reaching new responsibilities concerning competence should be implemented and to seek comment. Reports on action arising from that consultation will follow in the coming year.

Professional Standards Committee

In February 1997 a new Professional Standards Committee (PSC) was appointed as a standing committee of Council and terms of reference developed to guide its work under the 1995 Act. That PSC met for the first time in April 1997 and will report on matters referred to it in the next Annual Report. The Committee will support Council's statutory roles in ensuring that doctors, once registered, remain competent to practise.

Conferences

In August 1996 a "Competence Forum" was arranged in Wellington by the Registrars of the Boards and Councils regulating medical professionals. Associate Professor David Newble of the University of Adelaide was the keynote speaker. The Second International Conference on Medical Registration in Melbourne in October 1996 devoted a full session, led by the Canadians, to professional competence principles and models for action. Council delegates, including the Examinations Director and some Education Committee members, also attended an October 1996 Conference in Brisbane on "Assessment of Clinical Competence in Medicine".

RESPONSIBILITIES OF PSC INCLUDE:

- development of criteria for approval of recertification programmes
- receiving notifications of doctors whose competence to practise is in question
- conducting enquiries into aspects of an individual's medical practice which may impact on patient safety and recommending a management strategy to Council in light of any findings
- conducting appropriate reviews of competence for individual doctors and, if necessary, implementing a competence programme
- making recommendations to Council on the management of doctors who do not satisfy the requirements of competence reviews and programmes or recertification programmes
- advising Council on matters concerning maintenance of professional standards.

Function of Council – Section 123(d): *To consider the cases of Medical Practitioners who, because of some Mental or Physical condition, may not be fit to practise medicine*

Implementation of Part VII of the new Act enabled the Council's Health Committee to continue to develop its comprehensive procedures for intervention when a doctor has a health condition, physical or mental, which may prevent him or her from practising satisfactorily. Many of the provisions in the new Act were not dissimilar to those in the 1968 Act. There were however two new provisions which helped the Council to fulfil its public protection role.

Mandatory Reporting

Reporting to the Registrar is now mandatory if a person in charge of a hospital, or any doctor, or medical officer of health, believes a registered doctor is unfit to practise. Any other person may also report such concerns to the Registrar. In addition, the Dean of a medical school must report, if a person graduating with a medical degree would be unfit to practise.

Table 3

HEALTH COMMITTEE 1 July 1996 to 31 March 1997	
Currently monitored by Health Committee	28
Previously monitored	2
New voluntary undertakings signed	6
Voluntary undertakings, no APC issued	6
Voluntary undertakings amended	17
Voluntary undertakings discontinued	1
Interim suspension imposed	2
Interim suspension reimposed	2
Suspensions revoked (voluntary undertakings retained)	6
Conditions imposed on registration	1
Prescribing restrictions gazetted	1
Prescribing restrictions revoked	nil
Applications for registration considered:	
(a) Initial registration supported	3
(b) Re-registration (following removal on disciplinary grounds):	
– supported	nil
– not supported	1
Referrals to Health Committee received, but declined	4

People considering reporting are entitled to seek medical advice, psychiatric or otherwise, to assist them in forming an opinion and must state whether such advice has been obtained when giving notice to the Registrar. Reporters are excluded from civil, criminal or disciplinary proceedings provided they act in good faith and with reasonable care.

Power to Order a Medical Examination

The Council has been given the power to require a doctor to undergo a medical examination where it appears to the Council (whether or not as a result of a formal notification made to the Registrar) that a registered medical practitioner may be unfit to practise. The Act requires the Council to give not less than five working days notice to the doctor.

If the circumstances warrant it, the President of the Council, after consulting with two members of the Council, may, without advance warning to the doctor, order an interim suspension of registration for a period of not more than ten working days, in order to protect the health and safety of the members of the public.

Health Committee action between 1 July 1996 and 31 March 1997 is set out in Table 3. The President needed to impose an interim suspension order on four occasions during that period. However, two instances involved imposing a second order on the same doctor. This was necessary as the timeframe set down in the Act did not prove sufficient for the Council to give the requisite notice to the doctor to attend for a medical examination, obtain a report from its nominated examiner and then allow the doctor a reasonable opportunity to make written submissions or to be heard on the matter. The situation was resolved in both cases by the doctors involved cooperating with the Council and signing agreements to withdraw from practice until reports had been received and a suitable hearing date arranged.

As in other years, a small number of doctors voluntarily informed the Council's Health Committee that they had a condition which was affecting their ability to practise. The Health Committee, in addition to ensuring the public was protected, was able to ensure that all the doctors reported to it were immediately involved in effective treatment and rehabilitation or monitoring programmes.

It was fairly rare for a doctor to have already progressed in treatment sufficiently when the report was received, to have unfettered practice or registration at that point. If the referral was however made at an early stage, a contract with the Council in the form of a voluntary undertaking was often sufficient. Such undertakings contained a number of elements related to supervision and monitoring of the doctor's health as well as continuation of the doctor's recovery.

Initiatives for the Year Ahead

It is the Health Committee's experience that doctors who are reported to the Council have not generally established the long term habits and support networks that all doctors need to assist them not only to be good doctors but also to keep themselves healthy. The Health Committee reminds doctors that they need to be responsible for their own well being and to recognise and deal with personal stress and declining health. The Committee continues to promote self-care policies and practices. It actively encourages doctors to have regular appointments with their own general practitioners for the purposes of general medical checkups and monitoring of any particular health difficulties or stress factors, to guard against their escalation to potentially hazardous conditions.

Punitive Action by Employers

The Council was disappointed that several large employers chose to dismiss doctors following disclosure of an episode of addiction, even though no harm came to patients. The Council is very concerned that such punitive employment decisions are likely to drive doctors or other health professionals to cover up, rather than disclose, their problem. This is a potentially dangerous situation. If the doctor or other health professional has support to declare their abuse, addiction or illness, and seek help, the outcome is better all round. The Council proposes to contact all Crown Health Enterprises and other major employers to discuss this aspect of risk management.

EARLY HELP FOR A SICK OR IMPAIRED COLLEAGUE

It is seldom in the interest of the colleague, or the public, to wait until impairment reaches the level which requires mandatory reporting to the Health Committee. When the problem first comes to notice, the sick doctor's immediate colleagues and family should intervene and encourage the doctor to seek appropriate advice about management of any particular health difficulties or stress factors. If the doctor is not willing to take advice, assistance can be obtained from any of the following:

DHAS

Freephone: (04) 471-2654 or write: P O Box 812, WELLINGTON

HEALTH COMMITTEE

C/- Medical Council of New Zealand. Phone: (04) 384-7635, Fax: (04) 385-8902

MEDICAL OFFICER OF HEALTH

C/- Local Public Health Office

EDUCATION

Function of Council – Section 123(e): *To promote medical education and training in New Zealand*

Establishment of New Education Committee

The major focus of the outgoing Education Committee (whose composition and functions were prescribed in the 1968 Act) was the future membership and terms of reference of a new committee. The Committee appointed under the new Act is smaller but has wider representation in keeping with the broader mandate of this Act. The three Council members include the academic member from a New Zealand Faculty of Medicine, a lay member and one of the elected doctors. The other six members were appointed by Council bearing in mind the desirability of having a balance in terms of geography, gender, vocational branch and level of employment. They include a representative from the other New Zealand Faculty of Medicine, three vocationally registered doctors (at least one of whom must be a general practitioner), an intern supervisor and an active consumer of education with minimum experience equivalent to eighth year.

The terms of reference come under the three major areas of responsibility:

- the approval of medical schools, for purposes of registration of graduates
- arrangements for the probationary (pre-registration) period, and
- vocational education and training

Approval of Medical Schools

The process of approval of medical schools was developed under the 1968 Act. It aimed at ensuring that the courses and curricular leading to graduation in New Zealand universities produced a graduate fit for initial registration. The established joint accreditation process for Australian and New Zealand medical schools, involving the Medical Council of New Zealand and the Australian Medical Council, which reviewed and accredited (for 5 years) the University of Otago in 1994, and similarly the University of Auckland (for 10 years) in 1995, continues under the 1995 Act.

Education, Training and Supervision of Probationers

The role of ensuring that the education, training and supervision, the work allocated and the facilities for obtaining experience in medicine during the probationary year are appropriate has in the past been carried out by regular visits to hospitals and (since 1995) general practices. This also continues. Requirements are set out in Council's handbook, "Statement of Medical Registration Requirements in the Pre-registration Year", updated in August 1996. Amendments to take account of the needs of overseas trained doctors (particularly those passing NZREX) are under consideration. The committee relies heavily on intern supervisors (with whom Council has a formal contract), appointed at all hospitals where interns are working and on other supervisors appointed by employers on a case by case basis for overseas trained doctors assigned to teams not accredited for interns. Site visits normally occur on a three year cycle and at that time approved persons and supervisors are designated pursuant to Section 16 of the Medical Practitioners Act 1995. Employment locations and supervisors for other doctors on probationary registration (eg overseas trained specialists under assessment, doctors and returning to practice "after striking off") are individually determined in consultation with the relevant branches of medicine as indicated.

Vocational Education and Training

A major new task for the Committee related to vocational education and training. Existing branches and sub-branches were still recognised in the Order in Council but the new Education Committee was asked to set generic criteria for future recognition of branches so that all vocational training programmes would be of an acceptable standard for successful trainees to enter to the vocational register. Good working relationships with the Clinical Training Agency (CTA) were established.

Principles

The new Education Committee held its first meeting in March 1997. It made a commitment to fostering a clinical environment that is supportive of trainees, whether they be undergraduate students under the jurisdiction of the University, probationers (local or overseas graduates) completing their probationary period immediately following graduation (or as part of their assessment for general and vocational registration) eighth and ninth years completing pre-vocational training or registrars undertaking vocational training in various branches of medicine. The Committee supports the view that the practice of medicine is an indivisible blend of patient service, postgraduate and continuing education, lifelong learning and teaching at all levels, and quality assurance. The Committee and Council hopes to foster a culture which provides for a nurturing environment where Resident Medical Officers have opportunities to learn, while meeting service commitments and all practising doctors contribute to the learning experiences of others.

Other educational issues that the Committee addressed over this initial period included informed consent, the educational content of surgical runs for probationers, the development of written guidelines for supervising consultants, and the development of a professional conduct test for probationers. Criteria for recognising emerging branches of medicine are next on the agenda.

SUMMER STUDENTSHIP

The studentship was established in 1992 with the intention of focusing medical students' attention on the qualities that contribute to a practitioner's high standards of medical ethics, patient care and conduct.

The 1996/97 Medical Council Summer Studentship was awarded to Gregory Williams, a third year Otago University student at the Wellington School of Medicine. He drew on Council's earlier work on doctor/patient relationships to develop teaching materials about professional boundaries.

Boundary Education

Gregory Williams found that formal professional boundary education is relatively new in New Zealand medical school curricula, with most being offered during the clinical years of the medical degree. Post graduate colleges have tended to set up appropriate ethical codes of conduct and rely on role models to further develop attitudes. In Canada, where a professional boundary teaching programme was recently trialed at post graduate level, it met with an enthusiastic response. Council hopes this project report will go some way to encourage medical schools and post graduate colleges to expand professional boundary teaching within their curricula and continuing education programmes.

The Professional Boundaries project was presented in three sections:

- an Issues document, which summarised many of the important areas raised in previous literature about doctor/patient relationships,
- a Teaching Resource Handbook, which provided information for organisations wanting to design courses on professional boundaries, including suggestions on putting together a course and teaching ideas,
- a Scripts document, which provided a number of scenario scripts based on the Teaching Resource Handbook.

Action

The Medical Council will consider the feasibility of developing audio or video teaching aids for use by the medical schools and post graduate colleges.

COMMUNICATION AND LIAISON

New Registration Provisions

Information regarding the registration of doctors under the new Medical Practitioners Act 1995 was communicated to doctors through Council newsletters, MCNewZ, and correspondence with individuals and classes of registrant. A special bulletin was sent worldwide alerting doctors to the changes in the Medical Practitioners Act. The President of Council, invited to give the Arnold Nordmeyer oration at the Wellington School of Medicine, took this opportunity to explain some of the changes in medical registration and their ramifications.

Briefing and Consultation

Council can only achieve a number of its statutory functions by working in close consultation and co-operation with other bodies in New Zealand and overseas.

Immediately prior to the commencement of the new legislation on 1 July 1996, Council met for briefing purposes with the Council of Medical Colleges, and representatives of the Crown Health Enterprises. Council agents who are required to interview all prospective applicants for registration, once their eligibility for registration has been established, also attended a meeting so that new rules and processes could be explained. Since that time most meetings have been with representatives of individual post graduate colleges and societies, particularly in relation to the implementation of the new pathway for assessment of overseas trained doctors regarding eligibility for vocational registration.

Health and Disability Commissioner

The President of Council has met regularly, in person or by telephone, with the Health and Disability Commissioner concerning complaints about doctors. Good working relationships have been established with the Commissioner's office.

Colleges

The colleges have regular contact with Council representatives and have participated in meetings to clarify issues concerning general oversight, vocational registration, vocational assessment, and the development of protocols for recognising new branches and professional standards programmes.

Ministry of Health

Consultation with Ministry of Health officials has been necessary in relation to implementation of the Medical Practitioners Act 1995. The President and Registrar also met with the Minister of Health, Hon Bill English, and the Associate Minister, Hon Neil Kirton.

Medical Association

The New Zealand Medical Association (NZMA) no longer has direct representation on Council although two past presidents have been elected by the profession under the new constitution of Council. When appropriate, Council confers with NZMA on policy issues effecting the public and the profession. Dr Thomson was invited to attend the Policy Council of NZMA and has had ongoing dialogue with the Chairman of the NZMA Ethics Committee, in an attempt to evolve a satisfactory arrangement whereby ethical issues facing the profession are considered in all their facets, in the context of professional self-regulation.

Media Issues

Media issues concerning overseas trained doctors continued to generate considerable interest. Highly emotive stories about doctors on the dole, working in non-medical employment, and suffering undue stress featured in most forms of the media, with Council's registration examination being blamed as discriminatory. Considerable effort was given to allaying misinformation, through liaison with the media and the New Zealand Overseas Doctors Association (NZODA), emphasising the need for Council to maintain mechanisms for assessing standards of all doctors, including those from overseas, for the protection of the public of New Zealand, as required under the Medical Practitioners Act 1995. No concerns raised under Human Rights legislation have resulted in any formal action to date.

Communications were hindered by litigation against Council instituted by individuals and groups of overseas trained doctors. Concerns were also published about the registration of an Australian trained ophthalmologist on short term contract in Southland. The Commerce Commission sought documents from Council and is investigating the issue. There has been no outcome at this stage. Other issues concerned doctor/patient relationships, and the Council's taxation status. Some disciplinary decisions also attracted considerable publicity.

International Liaison

Australian Medical Council

Since the establishment of the Australian Medical Council (AMC) in the mid 80s, the Council President and/or Registrar have attended all annual general meetings of the Council as observers. Closer links were forged from the early 90s when the Medical Council of New Zealand and the Australian Medical Council co-operated in a joint accreditation programme for all medical schools in Australia and New Zealand, for the purposes of recognising the primary medical degrees as the appropriate basic standard for entry to the respective medical registers in states and territories in Australia and in New Zealand. Nominees of the Medical Council of New Zealand serve on the Accreditation Committee and assessment teams under the constitution of the Australian Medical Council.

In addition to the Annual General Meeting (which is now normally held in November) there is also a special meeting mid-year. The President and Registrar attended this meeting in Melbourne and as a result the two Councils approved in principle the setting up of a joint working party to look at how the Medical Council of New Zealand and the AMC might develop their relationship. Issues of common interest are standards for entry to the register and standards for the internship, examination and assessment of overseas trained doctors, registration concerns around areas of need, particularly shortage specialities, and developments in the handling of illness, incompetence or unsatisfactory conduct amongst registered practitioners. From time to time Australasian meetings are also arranged for members of the respective Boards and Councils and these focus on policy and procedural concerns across the wide range of functions which all such Boards have in the public interest. The next is scheduled for November 1997 in Sydney and will be an excellent opportunity for newly elected and appointed Council members to increase their awareness of common challenges facing regulatory bodies.

International Conferences

Following the successful First International Conference on Medical Registration and Discipline in Washington DC, sponsored by the Federation of State Medical Boards and the United States Government in May 1994, a Second International Conference on Medical Registration was arranged by the Australian Medical Council and held in Melbourne at the end of October 1996. Council delegates, medical and lay, attended this very worthwhile three day meeting, as did senior managers from the Council office. Dr Thomson, Mrs Judd and Ms Jones were involved in presentations at the workshop on the third day. All agreed that this international liaison provided an excellent opportunity to assess the progress of the Medical Council of New Zealand against other bodies worldwide and to receive new ideas on ways of approaching issues which are now common to most standards setting bodies in medicine in the developed world.

Developments

Attention is now being given to formalising a wider international linkage, high priority being accorded assessment of credentials of overseas trained doctors and exchange of knowledge and resources concerning promotion and measurement of competent performance, including methods of dealing with deficiencies when identified. The Medical Practitioners Act 1995 places New Zealand at the forefront of these developments although in a practical sense the Colleges of Physicians and Surgeons in the provinces of Canada and the General Medical Council of the United Kingdom have moved further ahead in implementation.

REPORT OF THE REGISTRAR

The Council's mission is to protect the health and safety of members of the public by regulating the medical profession in New Zealand and promoting high standards of competence, care and conduct. The law provides the framework. People and processes are the keys to success in its implementation. All Council work requires effective communication. The Council members and staff must implement change in a dynamic and consultative manner, respond to new ideas and be able to listen to both the public and the profession's concerns.

Council Offices

As Registrar I aim to manage the Council office so that it supports Council in all its various activities, by:

- carrying out the statutory functions pursuant to the Medical Practitioners Act 1995 and other relevant Acts in an efficient and timely fashion
- advising Council on any perceived risks or breaches of statutory duty which might arise from policy or procedures contemplated
- ensuring Council is provided with all the information it requires to make decisions and is kept informed about developments relevant to its functions including current issues and relevant legislation
- maintaining accurate reports of all Council activities and operations, including financial transactions
- communicating clearly and concisely in terms that those we serve can readily understand
- liaising with other bodies who have a common interest in the maintenance of high professional standards amongst doctors
- providing leadership in planning and developing strategic goals and proposing and supporting projects undertaken by Council.

As Council must also provide administrative and related services to the Medical Practitioners Disciplinary Tribunal, a separate office, funded by the Disciplinary Levy, is established under the management of the Secretary to the Tribunal. A small office at Auckland University, funded from examination fees, is used by the Examinations Director and his administrative secretary.

Review of Organisational Structure

With the help of a human resources specialist working two days weekly with Council managers, staffing requirements, work patterns and workloads were reviewed and changes implemented to strengthen and extend expertise necessary in the office given the wider scope of Council's jurisdiction.

During the transition from the 1968 to the 1995 Act, staff have been particularly busy and therefore our service has not always met the high standard we expect to achieve. Other sections of the Annual Report cover numerous changes implemented over the last nine months. Some new positions have been created, all with a view to providing high quality external and internal customer services. Some activities, eg complaints receipt, formerly carried out by other bodies are now dealt with in the Council office. Appointment of and support for Complaints Assessment Committees is a major new time consuming role.

Committee Support

The continuing high volume of overseas trained doctor enquiries, assessments and applications and the complexity of administering new registration provisions, which are now subject to a much greater degree of Council discretion, has required more frequent Registration Committee meetings, processing more detailed documentation prepared by an enlarged Registration team. The Examinations Officer has managed more than double the previous number of candidates and an increase to five clinical examination centres, with three sessions a year. The Education Committee's wider responsibilities necessitate a fulltime Education Officer. The level and volume of communication between the Council and the vocational branches has increased dramatically. Council's involvement with doctors suffering from conditions which might impair their fitness

to practise has grown sharply over the last year, partly because of increased confidence in the effectiveness of the Health Committee and its administrator. Assessors, supervisors, therapists and mentors assisting doctors with health problems to receive treatment and return to the workforce are in regular communication with staff who administer the monitoring programmes. Financial management, involving detailed accountability from the Financial Controller, is described in more detail in the next section of the Report.

Good Employer Practices

Attention was given to health and safety policy and procedures, position specifications, performance measures, and appraisals. Regular training was offered – stress management, team work, skills development, project management, budgeting and strategic planning. Occupational overuse syndrome (OOS) has presented challenges but interventions focused on education, management and job design have resulted in a significant reduction in new cases.

Projects

Important projects managed during the initial period of the new Act included election of medical members to Council, publication of medical registers in a revised format, implementation of a new vocational registration assessment pathway for overseas trained specialists, and the introduction of "global English" in communications with overseas trained doctors. Work began on a comprehensive information technology review.

Communications

A comprehensive briefing manual was prepared for members of the newly constituted Council. The Financial Controller gave particular attention to improving the way financial information was presented to Council and committees by including graphs to highlight key points. Staff became aware that the Council telephone system was stretched to its limit. We expect improved telephone and electronic communication to be offered within the next year, when major improvements are made to other information systems and technology.

Legal Action

Legal action taken by a number of overseas trained doctors pursuant to the Medical Practitioners Act 1968 diverted resources, particularly the Registrar and Registration Team Leader's time, to assist Council's lawyers to prepare documentation and arguments in Council's defence. Some complaints were made to the Race Relations Conciliator and these required detailed responses. Council has not been found guilty of any of the alleged offences. Legal challenges are common to all licensing authorities, where automatic unfettered access by immigrant doctors to medical work is not allowed, in the interests of public health and safety.

Acknowledgement

Council staff have been expected to go beyond the call of duty in the past year as implementation of new provisions in the Medical Practitioners Act 1995 occurred. Senior managers in particular worked long hours and in some cases were unable to take leave due. I valued greatly their support and contribution. We enjoy cordial relations with Council members and thank them, particularly President Ken Thomson, for their encouragement and co-operation during significant developments in doctor self regulation.

I was particularly pleased when Council adopted my proposal that an independent research agreement be negotiated with Victoria University of Wellington to evaluate the effectiveness of the new legislation over a period of time. The first stage of this project will commence later in 1997 when baseline information will be collected. This will assist us to target areas where there is misunderstanding or doubt about the intentions or implementation of the provisions of the new Act.

Georgina A Jones
REGISTRAR

FINANCE

The attached financial statements cover the year 1 April 1996 to 31 March 1997, although the period under review commences from 1 July 1996 only when the Medical Practitioners Act 1995 became effective.

The financial statements meet the requirements of the Institute of Chartered Accountants of New Zealand and therefore now include a "Statement of Movements in Equity" and a "Consolidated Statement of financial Performance" as well as the previously published "Statements of Financial Performance (including Schedules of Expenses)" for the General, Discipline and Examination Funds, along with the "Statement of Cash Flow".

General Council Operations

Activities funded by fees other than the Disciplinary Levy and Examination Fees showed a loss for the year of $93,269 compared with a surplus for the previous year of $188,463. While income for the year in the General Fund increased by about $240,000, expenditure was up by just over $500,000.

Income rose as a result of the following factors. There was a significant increase in fees from applications for specialist and vocational registration as a result of a change in the size of the application fee and a sharp increase in the number of applications for assessment of eligibility for vocational registration. There were transfers from the Discipline Fund (arising out of the change in legislation) of about $95,000 related to health activities. Council doubled the administration fee paid by the Examination Fund to the General Fund in view of the greatly increased workload in this area.

Increases in Council and Committee expenses were relatively modest at $23,000, the most significant contributing factor being costs of the Health Committee which had previously been met from the Discipline Fund under the 1968 Act. A large increase in administration and operating expenses arose from preparation for, and implementation of, the Medical Practitioners Act 1995. Additional staff were employed and the outlay on salaries, benefits, recruitment and training amounted to approximately $250,000. It was also necessary to make a provision for unused holiday pay as it was difficult for staff to take the leave owing to them during this period. Other increases directly related to increased workload and changes in legislation included computer consultancy ($27,000), a new professional indemnity insurance ($12,000), printing and stationery including redesigned forms and Annual Practising Certificates ($30,000) and special projects, including the election of medical members (approximately $33,000) and the commissioning of the report "Maintaining Doctors' Competence" (approximately $40,000). Other items coming within this increased expenditure were a rise of $8,000 in ACC levies due to ACC reclassification, $28,000 contribution to the Doctors Health Advisory Service (formerly paid from the Disciplinary Levy), a rent increase of $24,000 (after the first triennial review) and the costs of transferring the medical workforce survey operation from Dunedin to Wellington ($7,000).

Discipline Fund

This Fund showed a loss of $169,498 compared with a surplus for the previous year of $1,094,888. Revenue reduced by $1,000,000, chiefly as a result of Council's 1995 decision to lower the disciplinary levy which happened to coincide with a drop in fines and discipline costs recovered of almost $175,000.

An increase in expenditure from the Discipline Fund of $307,000 was largely the result of implementation and operation of new procedures and requirements under the 1995 Act, while continuing to deal during the transition period with matters arising from the 1968 Act. There were some paper gains by the transfer of health related activities (Health Committee and DHAS predominantly) but the Medical Practitioners Disciplinary Committee had a particularly heavy year and Complaints Assessment Committees were operating alongside the Preliminary Proceedings Committee. Although the Medical Practitioners

Disciplinary Tribunal did not sit to hear any charges during this financial year, there were establishment and training costs amounting to $66,500. The office serving the Tribunal continued to serve the Medical Practitioners Disciplinary Committee.

In future years details of the various categories of expenditure by the Medical Practitioners Disciplinary Tribunal will be set out in more detail.

As in previous years it is very difficult to predict the level of activity, and thus expenditure, for the bodies charged with investigating complaints and, as appropriate, subsequently hearing charges. The pattern of outcomes from the Complaints Assessment Committee process is not yet clear, but it must be noted that there are now more options open to those Committees for resolution of complaints. To date there have been no prosecutions by the Director of Proceedings pursuant to the Health and Disability Commissioner Act.

Examinations Fund

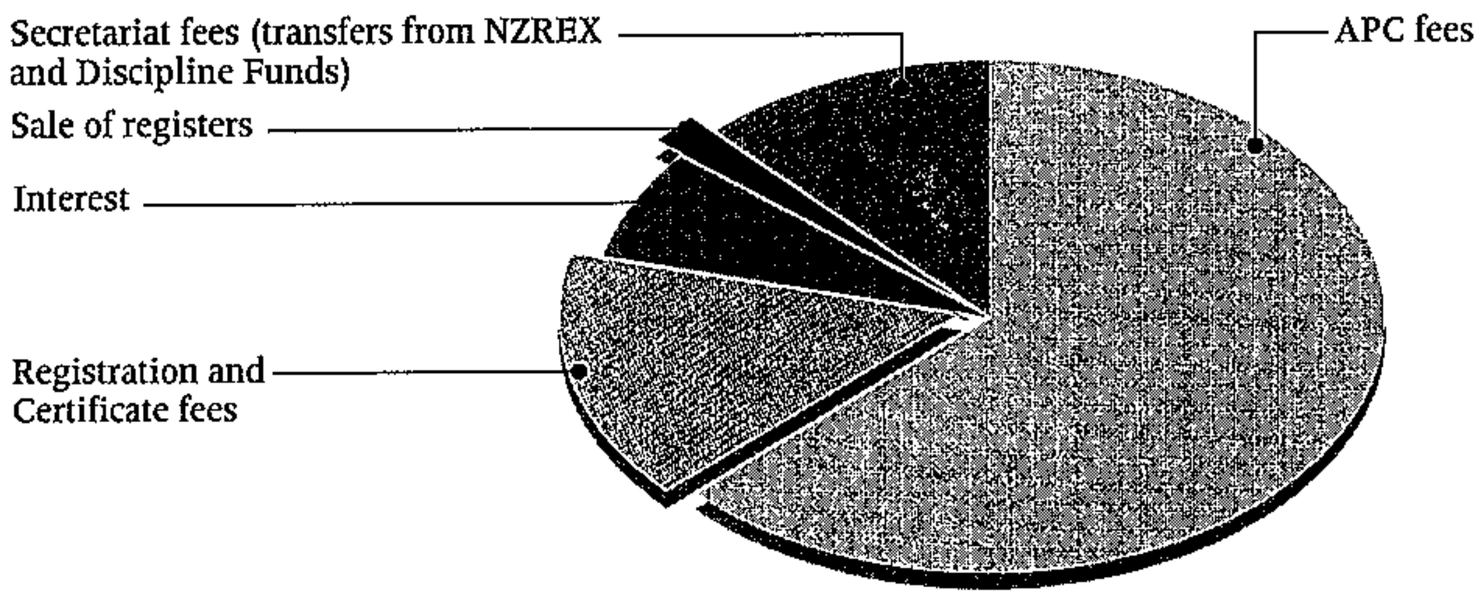
This fund showed a loss for the year of $2,535 compared with a loss for the previous year of $3,975. Actual volumes more than doubled during the period reported upon. There is no indica-

DISTRIBUTION OF COUNCIL REVENUE AND EXPENDITURE

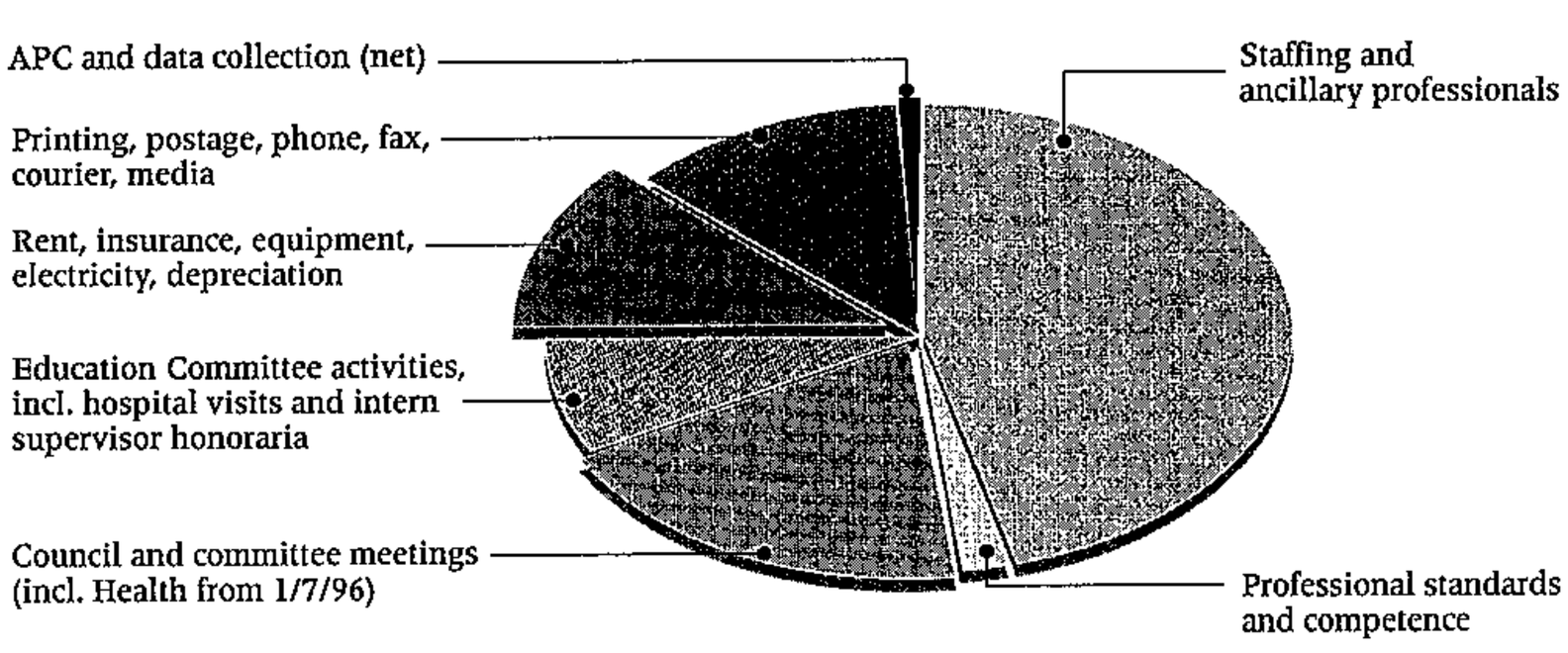
For the year ended 31 March 1997

GENERAL FUND (48%)

Revenue



Expenditure



tion that this is likely to decrease in the coming financial year. The examinations are run strictly on a user pays basis and examination fees for all components are published in the New Zealand Gazette accordingly.

Taxation

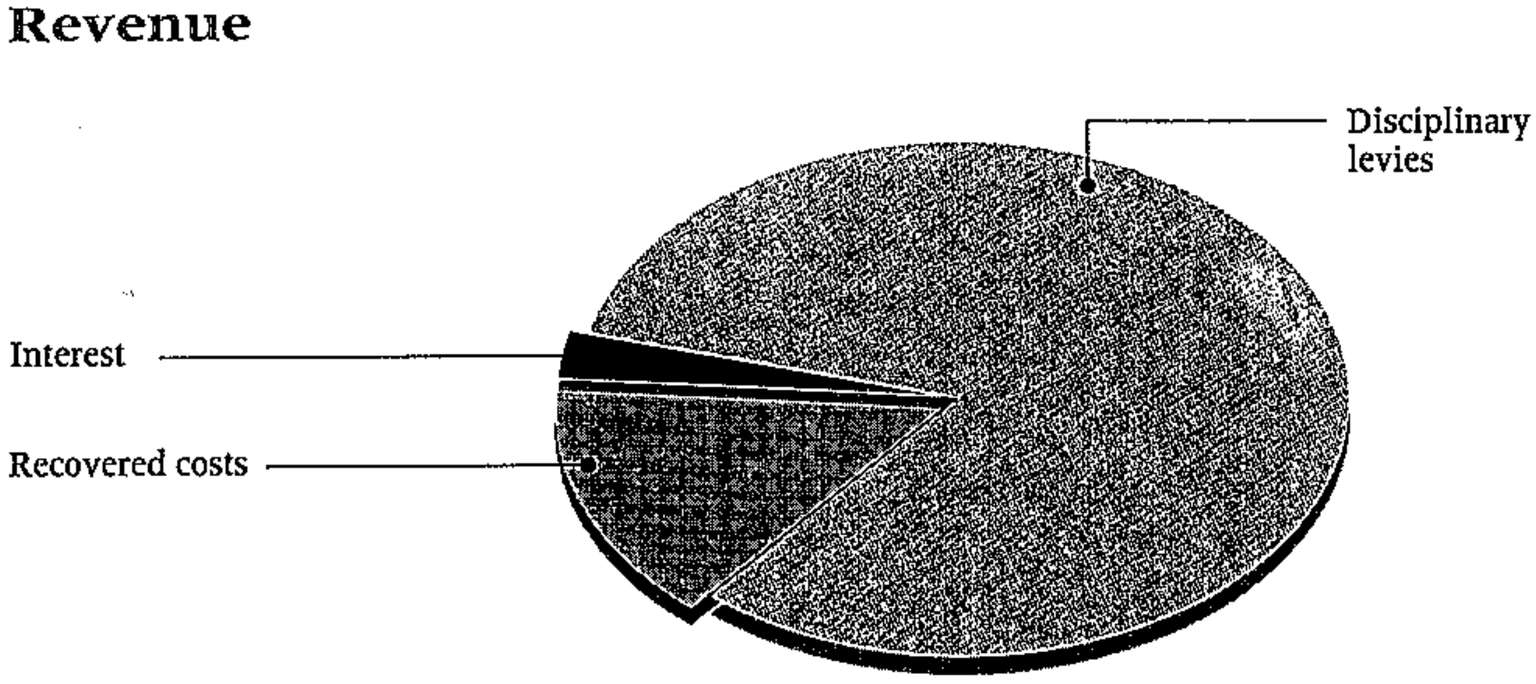
As a result of the ruling of the Court of Appeal, and the Commissioner of Inland Revenue's decision not to appeal this to the Privy Council, Council is now no longer obliged to pay income tax. Council activities were ruled to be beneficial to the community and to meet legal criteria for charitable purposes, ending nine years of challenge. Tax provided for in previous years has been reversed and an application made to Inland Revenue for a refund. Council intends to use this refund to establish a Special Purposes Fund for designated projects (including research) and risk management.

Finance and Management Committee

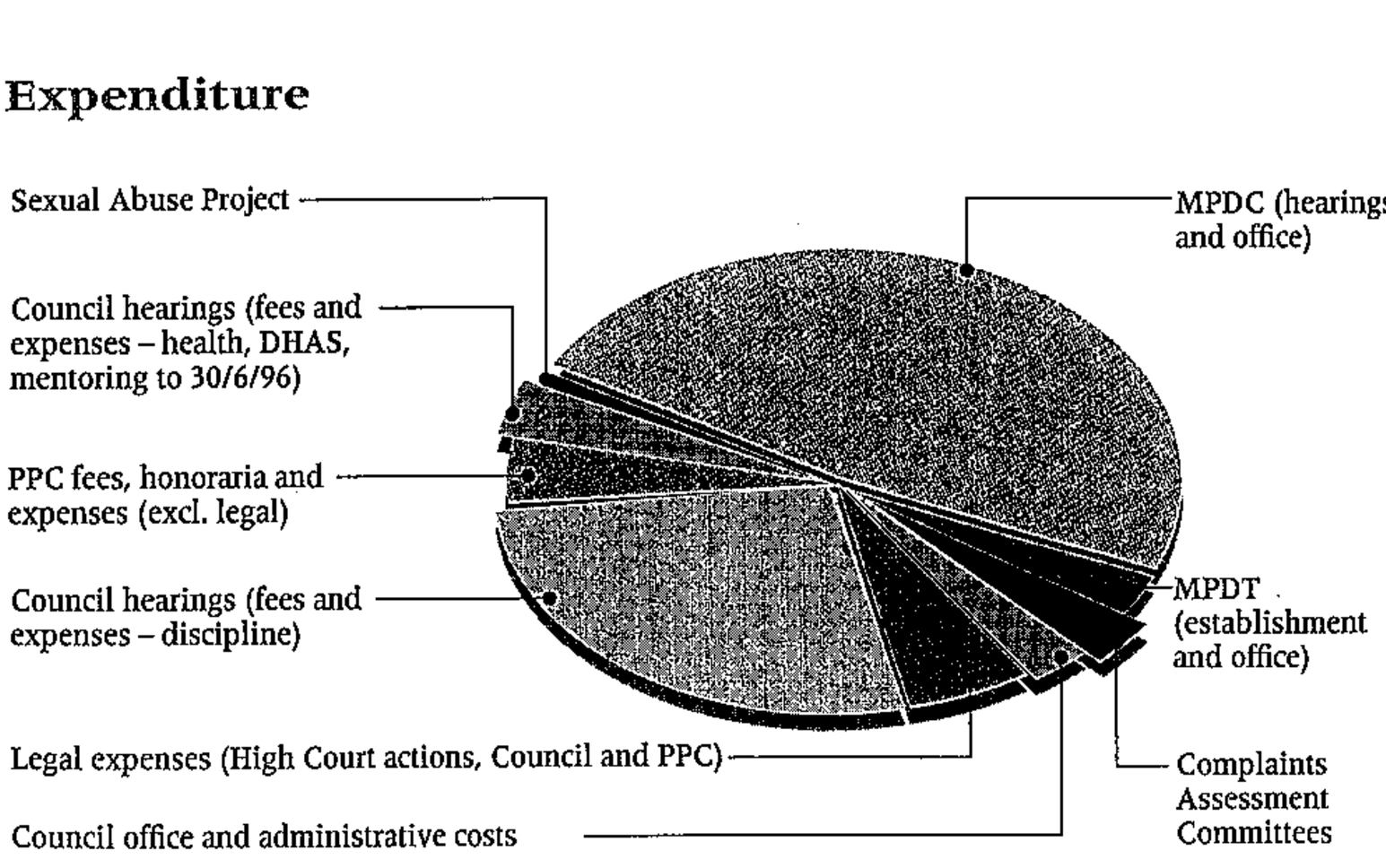
The Committee has met regularly and received monthly financial reports. It has also dealt with other financial and management issues related to Council activities. In December 1996, on the basis of a recommendation from the outgoing Committee, Council resolved to recommend to

DISCIPLINE FUND (52%)

Revenue



Expenditure



the incoming Council that, as a matter of policy and prudent financial management since Council is unable to borrow, Council should aim to accumulate and maintain reserves equivalent to one year's turnover, of which 70% could be placed in base investments (longer term thereby locking in better rates) with the balance in short-term investments.

At that meeting, on a motion put by the then Convener of the Finance and Management Committee, the outgoing Council resolved that 1997/98 APC fee be $320 and the Disciplinary Levy $360, making a total of $680 excluding GST, this being $765 including GST. All Council fees are published in the New Zealand Gazette. In concluding discussion on fees and reserves, Council expressed its concern about the magnitude of the increases in expenditure budgeted in 1997/98. However it believed the increases were inevitable and unavoidable given the Act changes affecting all areas of Council operation. These include the core business of registration, now much more time consuming to administer, operational problems of administering discipline provisions of two Acts concurrently, and the uncertainties of the policies of the Health and Disability Commissioner and how these may affect disciplinary costs. In addition, Council is at the mercy of flow-on effects from Government immigration policy and notes that it is difficult to quantify the costs associated with handling the volume of enquiries from overseas trained doctors, subsequent assessments and in some cases litigation.

Council is still to consider resource implications from implementation of the new Annual Practising Certificate and competence provisions in the Medical Practitioners Act 1995. This will be a major activity in the forthcoming year, when the commissioned report "Maintaining Doctors' Competence" is circulated and appropriate action on it formulated.

Council assures the Minister and all registered medical practitioners that close attention is given to monitoring income and expenditure and achieving efficiencies where feasible. Although almost all Council's funding comes from fees and levies paid by medical practitioners as part of their responsibility for professional self regulation, it is inevitable that a portion of these costs will be passed on to other individuals and bodies in the health sector, including to some extent members of the public.

The financial statements follow. The Registrar, with the assistance of the Financial Controller, will respond to requests for explanation of any items, either through the Council newsletter, MCNewZ, or individual letter. An explanation of the basis for any changes in annual practising certificate or disciplinary levies is provided at the time these are payable. Council expects that the current level of fees should be adequate to meet all contingencies for the next few years. During the financial year ending 31 March 1998 Council is considering the feasibility of any exemptions, waivers or refunds of any fees or levies for any class or classes of practitioner. Such variations in fee or levy amounts would however impact on the overall budget and flow through to other practitioners. The alternative is for Council to consider other payment methods, which allow the burden of substantial fees to be spread over a period of time.

Miller Dean Knight & Little

Chartered Accountants

MEDICAL COUNCIL OF NEW ZEALAND
AUDITORS' REPORT
FOR THE YEAR ENDED 31 MARCH 1997

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 1997. 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 1997 and the results of its operations and cash flows for the year ended on that date.

Date Of Opinion
Our audit was completed on 25 July 1997 and our unqualified opinion is expressed as at that date.

Miller Dean Knight, Ltd

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENT

for the year ended 31 March 1997

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 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 – The Council is not subject to 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.

(h) Interest Received – Interest owing at balance date has been accrued except for that owing on the income tax refund (Note 2).

Changes in accounting policies

There have been no material changes in accounting policies except provision has been made for holiday pay owing at balance date. No provision was made in previous years as the amount was not material. All other accounting policies have been applied on bases consistent with those used in the previous year.

2. Taxation

On 20 December 1996 the Court of Appeal found the Medical Council to be exempt from Income Tax. Tax provided for in previous years has been reversed. An application will be made for the tax paid to 31 March 1996 amounting to $577,310 plus Resident Withholding Tax deducted in the year ended 31 March 1997 ($79,115) to be refunded. In April 1997 a partial refund was received including some $82,000 use of money interest. The interest has not been included in these financial statements as the final amount to be paid has yet to be determined.

3. Payments in advance and debtors

	1997	1996
Outstanding contribution to workforce survey	38,000	38,000
Other debtors	16,451	551
Payments in advance	36,097	5,107
	$90,548	$43,658

4. Term deposits

	1997	1996
ANZ Bank	1,450,350	1,340,715
ASB	437,789	400,000
BNZ Finance	905,119	748,291
National Bank	931,344	834,172
Countrywide Bank	500,026	
Trust Bank		906,001
Westpac Bank		813,481
Westpac Trust	1,575,812	
TOTAL INVESTMENTS	$5,800,440	$5,042,660

5. Fixed assets

	Cost 31/3/97	Deprec for Year 31/3/97	Accum Deprec 31/3/97	Book value 31/3/97	Cost 31/3/96	Accum Deprec 31/3/96	Book Value 31/3/96
Computer	381,907	59,088	303,686	78,221	336,863	244,598	92,265
Furniture and fittings	190,625	12,644	117,968	72,657	167,566	105,324	62,242
Office alterations	109,882	10,906	40,896	68,986	100,416	29,990	70,426
Office equipment	99,949	17,728	58,061	41,888	90,966	44,309	46,657
	$782,363	$100,366	$520,611	$261,752	$695,811	$424,221	$271,590

(a) Some assets have been reclassified and appropriate adjustments have been made to the comparitive figures

(b) Depreciation for the year includes write-offs of $869 for fixed assets disposed of during the year.

6. Extra ordinary items

Details of extra ordinary items are as follows:

	General Fund	
	1997	1996
Recovery of investments previously written off-		
Equiticorp Finance Limited		3,520

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 1997

Surplus (Deficit) for year	1997	1996
General Fund	(93,269)	188,463
Discipline Fund	(169,498)	1,094,888
Examination Fund	(2,535)	(3,975)
	(265,302)	1,279,376
Less taxation paid	(79,115)	(81,279)
	(344,417)	1,198,097
Add non-cash items – Depreciation (Note 5)	100,366	104,083
	(244,051)	1,302,180
Add movements in working capital items		
Increase/(Decrease) in debtors and prepayments	(49,939)	19,103
Increase/(Decrease) in receipts in advance	841,502	(82,212)
Increase/(Decrease) in creditors and GST	265,282	77,731
	1,056,845	14,622
	812,794	1,316,802
Less items classified as investing activity-Interest	(386,043)	(361,801)
Net cash flow from statutory functions	$426,751	$955,001

10. Medical Practitioners Act 1995 – Transition year

The Medical Practitioners Act 1995 has placed new responsibilities on the Council. In discharging these responsibilities the Council is incurring additional costs and these are reflected in the schedule of expenses.

Some changes to the accounting of the current years expenditure have been necessary. From 1 July 1996, activities pursuant to Part VII, Fitness to Practise Medicine, (referred to as "Health") are no longer funded by the Disciplinary Levy. This has necessitated a transfer from the Discipline Fund to the General Fund of $94,800.

The costs of the new Complaints Assessment Committees (CACs) have been met from existing financial resources. The extent of financial resources necessary to allow the 116 CACs constituted at 31 March 1997 to assess complaints received since 1 July 1996 is unknown and depends on the length and complexity of the assessment. Expense claims relating to the year ended 31 March 1997 and lodged by 30 June 1997 have been included in the current year's expenditure. The Preliminary Proceedings Committee will continue its work until matters referred to it under the 1968 Act have been completed.

The Medical Practitioners Disciplinary Committee (1968 Act) and Medical Practitioners Disciplinary Tribunal (1995 Act) are funded from the Disciplinary Levy. Both continue to function while complaints received before 1 July 1996 are being considered. The expenditure shown includes all administration and hearing costs.

11. Contingent liabilities

There were no material contingent liabilities at balance date. As at 31 March 1996 a contingent liability relating to income tax existed but the matter has been resolved in the Court of Appeal (Note 2).

12. Events occuring after balance date

Except for comments made in note 2, Taxation, 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.

13. Commitments – Operating leases

Lease commitments under non-cancellable operating leases:

	1997	1996
Not more than one year	118,269	116,196
Later than one year and not later than two years	118,269	118,269
Later than two years and not later than five years	354,807	354,807
Later than five years	137,981	246,394
	729,326	$835,666

14. 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;

	1997	1996
Receivables	54,451	38,551
Bank balances	6,002,330	5,284,708
Payables	(910,056)	(627,987)

MEDICAL COUNCIL OF NEW ZEALAND

STATEMENT OF FINANCIAL POSITION

as at 31 March 1997

	1997	1996
CURRENT ASSETS		
Petty Cash	300	310
ANZ Bank Account	201,890	242,048
Sundry Debtors and Payments in Advance (Note 3)	90,548	43,658
Interest Accrued	56,433	31,945
Taxation Refund Due (Note 2)	656,425	577,310
Term Deposits (Note 4)	5,800,440	5,042,660
	6,806,036	5,937,931
Fixed Assets (Note 5)	261,754	271,590
TOTAL ASSETS	$7,067,790	$6,209,521
CURRENT LIABILITIES		
Sundry Creditors	629,455	430,270
Salaries and Holiday Pay Accrued (Note 1)	54,873	
GST	225,728	197,717
Payments Received in Advance	3,367,669	2,526,167
TOTAL CURRENT LIABILITIES	4,277,725	3,154,154
CAPITAL ACCOUNT		
General Fund	1,292,548	1,390,817
Discipline Fund	1,395,765	1,565,263
Education Fund	67,517	62,517
Examination Fund	34,235	36,770
	2,790,065	3,055,367
	$7,067,790	$6,209,521

The accompanying notes on pages 32 to 35 form part of these financial statements

MEDICAL COUNCIL OF NEW ZEALAND

GENERAL FUND STATEMENT OF FINANCIAL PERFORMANCE

for the year ended 31 March 1997

	1997	1996
FEES RECEIVED		
Annual Practising Certificates	1,327,939	1,304,933
Other Certificates/Register Amendments	26,931	18,336
Registration Applications	222,460	203,104
Specialist/Vocational Registration Applications	85,697	30,742
INCOME FROM FEES	1,663,027	1,557,115
OTHER INCOME		
Administration Fee – Dental Council		10,867
Administration Fee – Discipline Fund (Note 1)	100,000	100,000
Administration Fee – Examination Fund (Note 1)	60,000	30,000
Health – Transfer from Discipline Fund (Note 10)	94,800	
Interest Received	157,459	151,542
Sales of Medical Registers	42,233	30,440
Sundry Income	4,248	1,649
INCOME FROM OTHER SOURCES	458,740	324,498
TOTAL INCOME FOR YEAR	2,121,767	1,881,613
Less Expenses from Schedule	2,215,036	1,696,670
Net (Deficit)/Surplus for Year Before Extra Ordinary Item	(93,269)	184,943
Extra Ordinary Item (Note 6)		3,520
Net (Deficit)/Surplus for Year After Extra Ordinary Item	($93,269)	$188,463

The accompanying notes on pages 32 to 35 form part of these financial statements

MEDICAL COUNCIL OF NEW ZEALAND

GENERAL FUND SCHEDULE OF EXPENSES

for the year ended 31 March 1997

		1997	1996
ADMINISTRATION AND OPERATING EXPENSES			
ACC Levies		17,086	9,115
Agents Registration Fees		21,354	12,519
Audit Fees		7,000	6,300
Other Fees Paid to Auditors		1,000	700
Computer Consultancy		63,920	36,564
Depreciation (Note 5)		99,497	100,218
Doctors Health Advisory Service (Note 10)		28,145	
Fringe Benefit Tax		7,515	3,018
General, Archives, Cleaning, Electricity, and Equipment Hire		26,608	22,475
Insurance		14,479	2,441
Legal Expenses		42,573	40,142
Loss on Disposal of Assets (Note 5)		869	3,865
Medical Workforce Survey (Net after Government Contribution)		22,572	14,806
Photocopying Expenses		24,067	20,842
Postage and Courier		56,023	44,731
Printing and Stationery		114,606	84,076
Projects	– Election of Medical Members	32,902	
	–"Maintaining Doctors' Competence"	39,227	
	– "Medical Practice in NZ"	10,675	24,433
	– New Act Research	427	
	– Summer Studentship	3,720	2,934
	– "Too Many And Too Few Doctors" Conference	4,226	
Public Communications		49,972	61,515
Rent		117,709	93,396
Repairs and Maintenance		14,408	10,267
Salaries, Benefits, Recruitment and Training (Note 1)		859,970	595,978
Telephone and Tolls		29,936	25,115
TOTAL ADMINISTRATION EXPENSES		1,710,486	1,215,450
COUNCIL AND COMMITTEE EXENSES			
Communications Committee		375	
Council Expenses	– President's Honorarium	63,462	60,017
	– Fees and Expenses	132,625	113,602
	– Conference and Liaison Meeting Expenses	37,323	4,975
Data Committee		1,195	4,210
Finance and Management Committee		9,886	7,637
Health Committee (Note 10)	– Fees and Expenses	29,724	
	– Medical Reports	16,629	
	– Mentoring	15,175	
Issues Committee		1,459	
Medical Education Committee	– Education Activities	4,561	2,215
	– Fees and Expenses	25,790	35,577
	– Hospital Visits	26,262	20,126
	– University Accreditation		55,711
Intern Supervisors Contracts and Meeting Costs		102,674	112,104
New Act		1,673	38,103
Professional Standards Committee		1,036	
Registration Committee		36,535	25,109
TOTAL COUNCIL AND COMMITTEE EXPENSES		504,550	481,220
TOTAL EXPENDITURE		2,215,036	1,696,670

The accompanying notes on pages 32 to 35 form part of these financial statements

MEDICAL COUNCIL OF NEW ZEALAND

DISCIPLINE FUND STATEMENT OF FINANCIAL PERFORMANCE

for the year ended 31 March 1997

	1997	1996
REVENUE		
Fines Imposed and Discipline Costs Recovered	226,703	400,881
Interest Received	198,809	187,944
Levies Received	1,882,446	2,676,462
TOTAL REVENUE	2,307,958	3,265,287
ADMINISTRATION AND OPERATING EXPENSES		
Administration Fee (Note 1)	100,000	100,000
Audit Fees	3,000	3,000
Debt Collection		5,559
Doctors Health Advisory Service (Note 10)	6,064	29,726
General Expenses	9,271	5,562
Health – Transfer to General Fund (Note 10)	94,800	
Higher Court Actions	52,270	23,993
Legal Expenses	592,815	538,843
Media Consultancy	205	1,593
Medical Practitioners Disciplinary Committee (Note 10)	1,206,847	1,159,326
Medical Practitioners Disciplinary Tribunal (Note 10)	66,514	
Mentoring and Expert Witnesses	6,199	26,825
Projects – Sexual Abuse	13,979	17,260
Stenographers Fees	13,952	12,440
Telephone, Tolls, and Facsimile	8,467	8,204
Tribunals Officer	15,792	21,978
TOTAL ADMINISTRATION AND OPERATING EXPENSES	2,190,175	1,954,309
COUNCIL AND COMMITTEE EXPENSES		
Complaints Assessment Committees (Note 10)		
– Fees	32,246	
– Expenses	44,654	
Council Expenses (Discipline)		
– Fees	98,809	79,829
– Expenses	43,759	47,482
Council Expenses (Health) to 30 June 1996 (Note 10)		
– Fees and Expenses	5,842	30,077
Preliminary Proceedings Committee		
– Fees and Honorarium	46,506	52,708
– Travelling and Accommodation	15,465	5,994
TOTAL COUNCIL AND COMMITTEE EXPENSES	287,281	216,090
TOTAL EXPENDITURE	2,477,456	2,170,399
Net (Deficit)/Surplus for Year	($169,498)	$1,094,888

The accompanying notes on pages 32 to 35 form part of these financial statements

MEDICAL COUNCIL OF NEW ZEALAND

NEW ZEALAND REGISTRATION EXAMINATION FUND
STATEMENT OF FINANCIAL PERFORMANCE

for the year ended 31 March 1997

	1997	1996
REVENUE		
NZREX Candidate Fees	785,826	347,306
Interest	29,775	18,795
TOTAL REVENUE	815,601	366,101
ADMINISTRATION AND OPERATING EXPENSES		
Administration Fee (Note 1)	60,000	30,000
Audit Fees	1,000	1,000
Centre Costs (NZ and Overseas)	77,136	39,085
Examiners Fees and Expenses	521,383	191,034
General Administrative Expenses	56,355	22,959
Honorarium and Salaries (Note 1)	92,106	75,838
TOTAL ADMINISTRATION AND OPERATING EXPENSES	807,980	359,916
COMMITTEE EXPENSES		
Board of Examiners Fees and Expenses	10,156	10,160
TOTAL EXPENDITURE	818,136	370,076
Net (Deficit) for Year	($2,535)	($3,975)

The accompanying notes on pages 32 to 35 form part of these financial statements

MEDICAL COUNCIL OF NEW ZEALAND

STATEMENT OF CASHFLOW

for the year ended 31 March 1997

		1997	1996
CASH FLOW FROM STATUTORY FUNCTIONS			
Cash was provided from:			
Receipts pertaining to statutory functions and administration fee from Dental Council	5,469,438		4,964,302
Cash was also distributed to:			
Payment for council fees and disbursements and office expenses	(4,963,572)		(3,928,022)
Payment of Tax	(79,115)		(81,279)
	(5,042,687)		(4,009,301)
Net Cash Flow from Statutory Functions		426,751	955,001
CASH FLOW FROM INVESTING ACTIVITIES			
Cash was provided from:			
Interest Received	361,556		331,976
	361,556		331,976
Cash was applied to:			
Purchase of Assets	(70,695)		(79,836)
Short Term Investments	(757,780)		(1,694,524)
	(828,475)		(1,774,360)
Net Cash Flow from Investing Activities		(466,919)	(1,442,384)
Net Increase/(Decrease) in Cash Held		(40,168)	(487,383)
Opening Cash Brought Forward		242,358	729,741
Ending Cash Carried Forward		$202,190	$242,358
Represented by:			
Petty Cash		300	310
ANZ Bank Account		201,890	242,048
		$202,190	$242,358

The accompanying notes on pages 32 to 35 form part of these financial statements

MEDICAL COUNCIL OF NEW ZEALAND

STATEMENT OF MOVEMENT IN EQUITY

for the year ended 31 March 1997

		1997	1996
A)	**ACCUMULATED FUNDS AND RESERVES**		
	Balance at 31 March 1996	3,055,367	1,775,991
	Less: Deficit 1997	265,302	
	Add: Surplus 1996		1,279,376
	Balance at 31 March 1997	$2,790,065	$3,055,367
B)	**ANALYSIS OF INDIVIDUAL FUNDS**		
(1)	**General Fund**		
	Balance at 31 March 1996	1,390,817	1,146,643
	Less: Deficit 1997	93,269	
	Less: Transfer to Education Fund 1997	5,000	
	Add: Surplus 1996		188,463
	Add: Transfer from Education Fund 1996		55,711
	Balance at 31 March 1997	$1,292,548	$1,390,817
(2)	**Discipline Fund**		
	Balance at 31 March 1996	1,565,263	470,375
	Less: Deficit 1997	169,498	
	Add: Surplus 1996		1,094,888
	Balance at 31 March 1997	$1,395,765	$1,565,263
(3)	**Education Fund**		
	Balance at 31 March 1996	62,517	118,228
	Less: Transfer to General Fund 1996		55,711
	Add: Transfer from General Fund 1997	5,000	
	Balance at 31 March 1997	$67,517	$62,517
(4)	**Examination Fund**		
	Balance at 31 March 1996	36,770	40,745
	Less: Deficit	2,535	3,975
	Balance at 31 March 1997	$34,235	$36,770

The accompanying notes on pages 32 to 35 form part of these financial statements

MEDICAL COUNCIL OF NEW ZEALAND

CONSOLIDATED STATEMENT OF FINANCIAL PERFORMACE

for year ended 31 March 1997

	1997	1996
INCOME		
Fees Received	4,331,299	4,580,883
Interest	386,043	358,281
Other Income	273,184	443,837
	4,990,526	5,383,001
EXPENDITURE		
Audit Fees	11,000	10,300
Other Payments to Auditors	1,000	700
Depreciation (Note 5)	99,497	100,218
Loss on Disposal of Fixed Assets (Note 5)	869	3,865
Other Administrative Costs	5,025,753	3,898,666
Rent	117,709	93,396
	5,255,828	4,107,145
SURPLUS/(DEFICIT) BEFORE EXTRA ORDINARY ITEMS	(265,302)	1,275,856
Extra Ordinary Item		3,520
SURPLUS/(DEFICIT) FOR YEAR	($265,302)	$1,279,376

The accompanying notes on pages 32 to 35 form part of these financial statements

COMPLAINTS AND DISCIPLINE

Function of Council – 123(f): *To provide administrative and related services for the Tribunal*

DISCIPLINE ACTIVITIES – TRANSITION PROVISIONS

The new legislation contained transition provisions relating to existing proceedings (investigations, enquiries or other matters) that had been commenced, but had not been completed, before the new Act came into effect on 1 July 1996. These proceedings must be continued and completed as if the new Act had not been passed.

Medical Council

Under the 1968 Act, Council continues to meet to hear charges of disgraceful conduct in a professional respect, as well as appeals against findings of the Medical Practitioners Disciplinary Committee. This has placed an additional workload on the five members of that Council who were appointed and elected to the new Council.

COUNCIL DISCIPLINARY HEARINGS

Over the past nine months the following matters have been before the 1968 Council sitting as a disciplinary tribunal:

- 2 doctors charged with disgraceful conduct in a professional respect – both proven, 1 doctor censured; Council recommended to the Minister that prescribing prohibitions be imposed on both doctors.
- 1 criminal conviction – doctor removed from the Register.
- 13 appeals against decisions of the Medical Practitioners Disciplinary Committee – 5 allowed, 8 dismissed.

Five appeals against decisions of the Council were heard by the High Court (two allowed, including one against penalty, three dismissed). In addition one decision was referred back from the High Court for Council to determine whether one of two particulars found not to be proven, on its own, amounted to professional misconduct and whether penalty should be reduced.

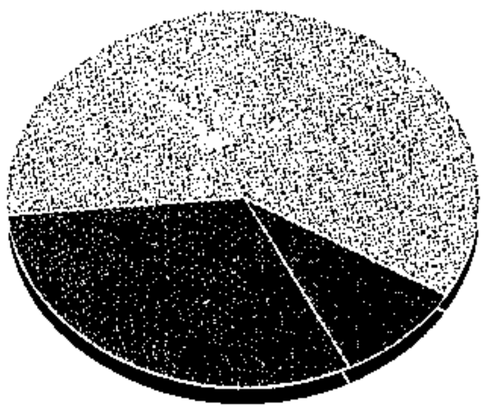
Three applications were heard for re-registration following removal from the register on disciplinary grounds (2 granted probationary registration, 1 declined).

Preliminary Proceedings Committee

The residual investigations and prosecutions of complaints and convictions by the Preliminary Proceedings Committee (PPC) are tailing off. At 1 July 1996, 29 files remained open. 19 files remained open at 31 March 1997 but charges will not necessarily be laid in all of these cases. Some matters cannot be concluded until related Court hearings are over.

Medical Practitioners Disciplinary Committee (MPDC) and Divisional Disciplinary Committees (DDC)

At 1 July 1996, 174 complaints remained outstanding under the 1968 Act. These consisted of:

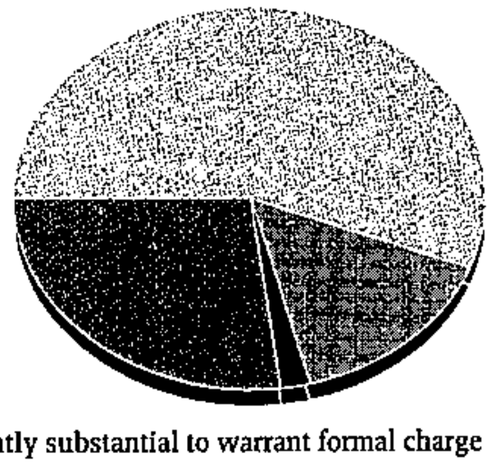


105 Complaints yet to be determined by MPDC Chairman

15 DDC enquiries yet to be heard

54 MPDC enquiries yet to be heard

The MPDC chairman determined as follows on those 105 complaints:



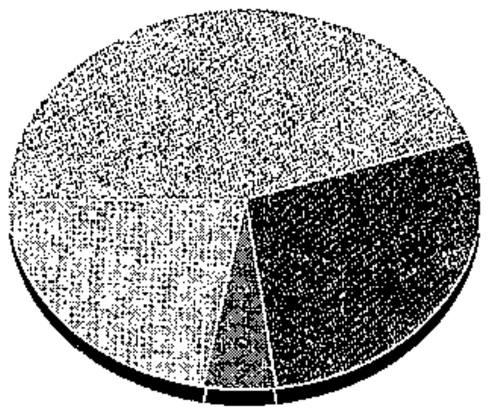
59 Found not sufficiently substantial to warrant formal charge

16 Referred to DDC

2 Still awaiting determination

28 Referred to MPDC

At 31 March 1997, the following had been achieved:



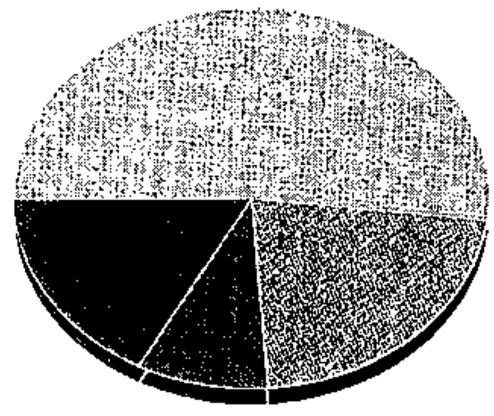
MPDC: 46 Completed (incl.12 under appeal, 12 awaiting appeal expiry period)

MPDC: 29 To be heard (incl. 1 referred to DDC to be heard)

DDC: 5 To be heard

DDC: 23 Completed (incl. 1 under appeal to MPDC, 1 awaiting expiry appeal period)

Appeals from MPDC/DDC decisions – 23 (including 1 against DDC)



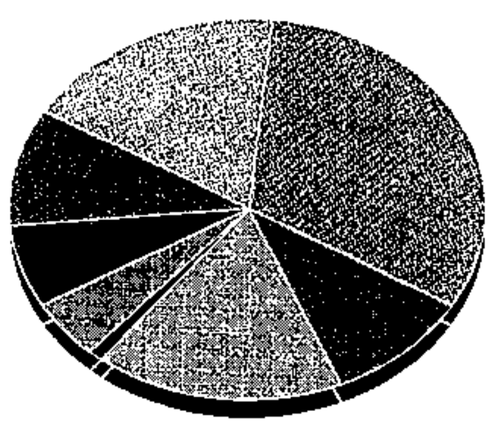
12 To be heard (incl. 1 DDC)

2 Failed

5 Withdrawn

4 Successful (incl. 1 on publication)

Outcomes of formal charges in the year 1 July 1996 to 31 March 1997:



MPDC: 7 Withdrawn

MPDC: 10 Guilty of Professional Misconduct

MPDC: 19 Not Guilty

MPDC: 34 Guilty of Conduct Unbecoming

DDC: 11 Guilty of Conduct Unbecoming

DDC: 18 Not Guilty

DDC: 1 Referred to MPDC

DDC: 5 Withdrawn

Some members of the MPDC and DDCs were appointed to the panel for the MPDT, and thus, like some Council members, have a continuing disciplinary workload, arising from the perceived desirability of a degree of continuity in the disciplinary process. A substantial number of matters were still to be concluded, with MPDC hearings scheduled to November 1997.

Transition Continues into 1998

It is therefore likely that, under the 1968 Act, the Medical Practitioners Disciplinary Committee and the Medical Council of New Zealand will continue to be involved in disciplinary functions until at least the end of 1997 if not March 1998. Because lengthy delays can occur when Council decisions are appealed to the High Court, it is possible that some appeals may not finally be completed until well into 1998.

COMPLAINTS UNDER NEW ACT

Complaints About Conduct Which Occurred Before 1 July 1996

The new legislation set out the procedure for handling complaints about doctors. Complaints about conduct which occurred prior to 1 July 1996, which would have justified proceedings of a disciplinary nature under the 1968 Act, but were not initiated and concluded under that Act, may be made to the Registrar under the new Act. Such complaints do not have to be notified to the Health and Disability Commissioner as there is no jurisdiction prior to the advent of the Health and Disability Services Code of Consumers Rights.

The Council President had a significant workload handling the one hundred and sixteen complaints submitted to the Council under the transition provisions relating to events prior to 1 July 1996. 116 Complaints Assessment Committees (CACs) were established to 31 March 1997 and more will be required in future to deal with the steady flow of complaints still being made about events prior to 30 June 1996.

CAC Role

The CAC's role is to assess the complaint, and in doing so it is required to give the doctor and

the complainant a reasonable opportunity to make a written explanation or statement. Meetings with the parties are in the nature of investigation and fact finding. They are not formal "hearings" in the way that a hearing before a Tribunal would be. The CAC must then determine one of the following statutory courses of action to be taken:

- the Council should review, under Part V of [the] Act, the competence of the practitioner to practise medicine; or
- the Council should review, under Part VII of [the] Act, the ability of the practitioner to practise medicine; or
- in the case of a complaint, the complaint should be the subject of conciliation under section 94 of [the] Act; or
- the complaint or conviction should be considered by the Tribunal; or
- no further steps should be taken under [the] Act in relation to the complaint or conviction.

CAC Process

Although the new Act enables CACs to regulate their procedure in such manner as they see fit, the Council did produce guidelines to assist the work of the CACs. An information sharing session was held at the Council office on 12 November 1996 to provide new appointees with a forum for raising their concerns and questions about how they could go about their investigations and to clarify their role in the context of the new legislation. Those who attended reported that the session was very valuable and some suggested that it be made compulsory. A further session is planned for 1997.

The Council is very grateful to doctors and laypersons who have been giving up time, for moderate recompense, to participate in this process. Self-regulation does depend on members of the profession being willing to accept, from time to time, responsibility to serve on these committees. 97 people (78 medical and 19 lay), served on CACs in the period to 31 March 1997. Legal assessors provided them with legal procedure, and if necessary, the drafting of determinations or charges.

A set of public information pamphlets are in production.

Council resolved to gather feedback on the complaints assessment process. Council took this decision after considering an audit proposal prepared by a person who had been involved with victim self help groups. An appropriate questionnaire is being developed, containing core questions applicable to all kinds of complaints and additional sections dealing with specific types of complaints, eg sexual abuse.

Table 4

COMPLAINTS SENT TO COMPLAINTS ASSESSMENT COMMITTEES
1 July 1996 to 31 March 1997

Categories of Complaint	Number of complaints received
Access	1
Communication	20
Conviction of an Offence	1
Cost	1
Other	5
Rights	5
Systemic	1
Treatment	82
Breakdown of Treatment Category	**Number of complaints**
Delay in Treatment	9
Inadequate/wrong diagnosis	22
Inadequate/wrong treatment	35
Rough/off hand treatment	0
Unskilled/incompetent treatment	1
Inappropriate prescribing	5
Medical misadventure	0
Failed to provide treatment	3
Other	7

Referrals of Convictions

The new Act clearly anticipates, in the interest of the public and the profession, that medical practitioners who are convicted of certain kinds of offences should be subject to disciplinary enquiry and appropriate action. Court Registrars are required to notify certain convictions to the

the Council received one such notice from the Courts. A CAC was appointed to make a determination about what action should be taken. The conviction was however appealed and the CAC will have to wait until the appeal has been heard and the outcome of the appeal known before it can proceed to make its determination.

As of 31 March 1997, 16 determinations had been made by CACs. Three complaints resulted in charges being laid before the MPDT. In the other 13 cases, the CAC determined no further action was required.

Concerns were raised with Council by members of the public, the media, politicians, complainants and the doctors who are the subject of complaints, about the length of time it was taking for complaints to be assessed. The profession must be accountable but Council is satisfied that the majority of complaints before CACs are progressing appropriately, within the constraints of the legislation. As experience is gained by committee members, processing time is likely to be reduced. There are inherent administrative and due process barriers in the procedures contained in the Act now that a single person no longer has the "screening" role.

Complaints About Conduct Which Occurred After 1 July 1996

When a complaint is received against a doctor about conduct which occurred after 1 July 1996, the Registrar must refer it to the Health and Disability Commissioner (the Commissioner) and no further action can be taken until the Commissioner notifies the President of Council of what action, if any, she will be taking. Twentysix complaints of this kind were received and referred to the Commissioner. The Commissioner was still considering 19 of these at 31 March 1997, 3 had been withdrawn, and 4 were referred back to the President of Council to consider whether or not to appoint a CAC.

Council staff have been conscious of the need to establish a good working relationship with the Commissioner and her investigating staff in Auckland and Wellington to help ensure that the new legislation (including the Code of Health and Disability Service Consumers Rights) improves the processes and outcomes for patients and doctors.

Medical Practitioners Disciplinary Tribunal

On August 20 1996 the Minister of Health appointed senior barristers and solicitors, Peter Cartwright and Wendy Brandon, as Chairperson and Deputy Chairperson respectively of the Medical Practitioners Disciplinary Tribunal (MPDT). The Minister also appointed four persons who were not medical practitioners and 16 medical practitioners, the latter widely representative of the profession, as members of the panel from whom Tribunal membership (one layperson and three doctors) is drawn.

A useful one day training workshop was held in November, 1996.

The first three charges were received by the MPDT from CACs in late February and early March and scheduled to be heard in May and June, 1997.

The Tribunal prepared a document to inform those appearing before it about procedures to be followed prior to and during the hearing.

MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL (MPDT)

(Appointed 20 August 1996 for a three year term)

Mr P J Cartwright (Chairperson), Ms W N Brandon (Deputy Chairperson)

Panel of medical practitioners
(three are appointed by the Chairperson for the purposes of each hearing):

Dr F E Bennet
Dr R A Cartwright
Dr I D S Civil, MBE
Dr J C Cullen
Dr B D Evans
Dr R S J Gellatly
Dr J W Gleisner
Dr A M C McCoy
Dr J M McKenzie
Dr M J P Reid
Assoc. Professor Dame Norma Restieaux
Dr A D Stewart
Dr A F N Sutherland
Dr B J Trenwith
Dr D C Williams
Dr L F Wilson

Panel of laypersons
(one is appointed by the Chairperson for the purposes of each hearing):

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

Office of the Tribunal	Secretary	Mr R P Caldwell
	Deputy Secretary	Ms G J Fraser
	Administrative Assistant	Ms D M Haswell

Location

26 The Terrace
PO Box 5249, Wellington
Tel: 04 499 2044
Fax: 04 499 2045

CURRENT ISSUES

Function of Council – Section 123 (g): *To advise, and make recommendations to the Minister in respect of any matter relating to the practice of medicine.*

Enquiries from Profession and Public

As noted under the Section "Communication and Liaison", the President and Registrar met with the Minister of Health, Hon Bill English, and later the Associate Minister, Hon Neil Kirton. At these meetings the following topics were raised:

- assessment and registration of overseas trained doctors granted permanent residence in New Zealand, particularly litigation pending,
- Council taxation status (at that time the subject of continuing litigation by the Commissioner of Inland Revenue),
- Ministry's role in workforce development (issues concerning co-ordination, the need for more Maori doctors and psychiatrists, declining numbers in rural general practice),
- Crown Health Enterprise employment issues concerning impaired doctors in rehabilitation (Medical Practitioners Act 1995 Part VII),
- interface of provisions in legislation governing Medical Council of New Zealand, ACC and Health and Disability Commissioner,
- Commerce Commission concerns regarding possible anti-competitive arrangements, and
- practical problems surrounding implementation of the Medical Practitioners Act 1995, particularly general oversight, vocational registration (Order in Council specifying branches), temporary registration and the electorate for Council elections of medical members.

Council President signalled to the Minister that some amendments to the Act were likely to be sought within the next year. The Minister was reminded that there was still a further laymember to be appointed by him to Council, and with the smaller number of Council members under the 1995 Act, this appointment was urgent. The Minister was advised that Council had entered an agreement with Victoria Link, the research arm of Victoria University, to begin a programme of evaluation of the effectiveness of the new Act.

Council receives a steady flow of enquiries from members of the profession about practice and ethical issues of concern to them. These queries were dealt with by the President, consulting with Council members as required, with any background material available supplied by the Registrar. At the Council's February 1997 meeting, the Issues Committee was reactivated and now receives referrals of these matters from the Registrar or President. Issues raised over the period covered by this report include the following:

Developments Concerning Medical Records, Particularly in Electronic Form

Dr Kletchko volunteered to be Council's representative on the Electronic Medical Records Sub-committee of Standards New Zealand. The use of information technology in the health sector is burgeoning. Council has maintained a watching brief. Council noted that the New South Wales Medical Records Consortium Report (received in November 1996) covered regulations for making and keeping medical records, and guidelines for the creation, content, storage and disposal of medical records. In New Zealand these issues have been dealt with by the Privacy Commissioner and the Director General of Health. Though electronic communications can improve efficiency and effectiveness of information transfer, Council expects basic standards of doctor/patient confidentiality and consent to be rigorously maintained.

Entrepreneurial Practice

A more robust market approach by some doctors and clinics to the delivery of health services has raised some issues concerning quality of care and ethics. Several doctors have written to Council with dilemmas about the provision of after hours care and 24 hour cover. Council has

provided guidance and where necessary has referred resource or contract dilemmas to bodies such as Regional Health Authorities.

Fee splitting and kickbacks are not considered by Council to be ethical in medical practice. Recent questions have arisen concerning the Ophthamology/Optometry interface and laboratory services. Council has asked the Issues Committee to develop a comprehensive statement, rather than dealing with queries on a case by case basis.

Rural General Practice

Council acknowledged that there are real concerns for patient safety if rural doctors are not able to have time off. Incentives need to be developed to retain competent practitioners in rural practice with systems set up to use adjacent doctors for cover. RHAs were asked to examine carefully the question of appropriate contracts, given that difficulties are being compounded by people leaving solo practice.

Resource Constraints

An approach was received from PHARMAC regarding doctors' responsibilities in spending health dollars. Council considered that its 1994 statement "Doctors' duties in an environment of competition or resource limitation" was still applicable and did not require amendment. Copies of this statement can be obtained from the Council office.

Consultation Documents Prepared by the Ministry of Health

Various substantial documents were received. Where they related directly to the practice of medicine, Council made submissions. Sometimes the timeframe for consultation was rather short.

Euthanasia

Council received the statement of the NZMA but resolved to take no further action on the topic at that time. As the definitive statement had already been ratified by the NZMA Policy Council without consultation with the Medical Council, Council did not believe it could add anything to it. Council noted with concern that the NZMA statement did not define what was understood by the term "euthanasia". This is another issue on which Council keeps a watching brief. Academic papers on the topic are available to Council members.

Sterilisation of Severely Handicapped Persons

A question about the proper way of dealing with this vexing issue was received and the writer was asked to consult in the first instance with the local Ethics Committee. The notion that there be a national committee with representation from obstetricians, paediatricians, physicians, IHC consumers, ethicists, lawyers and professional groups could then be explored if appropriate.

Privacy Act

Council members agreed with the lay-members that there was some unease in the wider community about the implementation of the Privacy Act. It was generally agreed that there was not only confusion in the community but also to some extent in the medical profession, possibly representing a gulf between the hopes of the Privacy Commissioner and the understanding and the practical problems of those working with the Act and the Code on a daily basis. Council has arranged to have a joint meeting with NZMA representatives and the Privacy Commissioner later in 1997.

Doctor/Patient Relationships

Council was pleased to receive from NZMA a draft statement prepared by Dr Karen Zelas. The paper provided good educational material and consideration was given to seeking permission from NZMA to include it in the Council booklet, "Trust in the Doctor Patient Relationship", which is distributed to every registered medical practitioner. In the end it was decided that its length and content better suited it standing alone. However, it will be included in reading references in the revised edition of Council's publication

"Medical Practice in New Zealand – A Guide to Doctors Entering Practice".

Council continued to work on initiatives related to its aim of eradicating sexual abuse in doctor patient relationships and encouraging trust. At the December meeting of Council the final form of two further statements was endorsed. These cover:

- ending a professional relationship
- sexual relationships with former patients, and

These are in substantially the same form as the draft statements originally published in 1995. Copies are available from the Council office.

Council noted several local research initiatives in this area. The findings of one research project as published in the New Zealand Medical Journal were challenged.

Disclosures of breaches of trust in professional relationships continue, not only in the medical profession. Media focus escalates when disciplinary findings are published involving doctors or other professionals. Council continues to develop educational resources and guidelines, as proactive steps to raise awareness amongst doctors and prevent boundary breaches are considered essential for protection of the public.

MEDICAL WORKFORCE SURVEY

Function of Council – Section 123 (h): *To exercise and perform such other functions, powers, and duties as are conferred or imposed on it by or under this Act or any other Enactment.*

Council continues to have a statutory requirement to provide statistical information to the Minister. Section 131 of the Medical Practitioners Act 1995 specifically states that the term "statistical information" does not include information about an identifiable individual. The Minister may from time to time give notice to Council that he wishes to have such statistical information relating to the Council's functions or the functions of any of its committees. Council has a specific standing committee, the Data Committee, to oversee this requirement.

Relocation and Review of Database Operation

The systematic collection of medical workforce information was set up by joint agreement between the Medical Council, the Department of Health and the University of Otago in the early 70s.

During the year covered by this report, the workforce survey database was moved to the Council office in Wellington, and a new database administrator engaged. Dr Nicholas Wilson, public health physician, was engaged by Council to review the medical workforce information system. He reported in October 1996 and his major recommendations were all adopted by Council, namely that:

- Council acknowledge the value of its involvement in the collection, analysis and dissemination of medical workforce information regardless of whether there is an actual statutory requirement on the Council.
- Council establish a contract with the Ministry of Health regarding the collation and analysis of workforce data as soon as possible, addressing during discussion of the contract the following issues:

- frequency of data collection
- level of precision for geographical coding
- classification of vocational categories
- length of contract.

- Council maintain its current approach of not providing unit data from the workforce survey to any other agency. Instead Council should explore using additional printed tables of workforce information that meet all of the Ministry of Health's information needs, while guaranteeing that no individual doctors can be identified.
- the database used for the workforce survey be redesigned to make it more suitable for data entry and for generating a range of reports, and an associated user manual be produced.
- the questionnaire used in the next survey be redesigned and pilot tested before it is finalised.

Dr Wilson made some operational recommendations including that Council give consideration to negotiating with the Ministry of Health about putting summary information on the medical workforce on the Ministry's worldwide web site. He encouraged Council to give consideration to inviting proposals from the health research community of New Zealand for longitudinal study of the medical workforce (eg, for the period since the data was computerised in 1972).

Survey Findings – 1996 Data

Once the revised form of the database had been settled, data collected in the early months of 1996 were entered in the latter part of the year and the tables supplied to the Ministry of Health, through the New Zealand Health Information Service, at the end of February 1997, in line with the two year contract, finally negotiated and signed in that month.

A summary report of the major findings was produced.

The medical workforce database in New Zealand has always been very comprehensive and the envy of many other registration bodies world-

Table 5

NEW ZEALAND MEDICAL WORKFORCE PROFILE

at 30 June 1996

	Number
Doctors practising medicine	8,390
Doctors responding to survey	7,775
[1] Doctors working 4 or more hours per week	7,634
[2] Female doctors	2,247
Median age for female doctors	37 years
Median age for male doctors	44 years
[3] Ethnicity:	
Proportion of female doctors	
– European	32.0%
– Chinese	23.0%
– Maori	26.0%
Proportion of Maori doctors	
– House Officers	32.0%
– Registrars	1.5%
– General Practitioners	2.1%
– Specialists (excluding General Practitioners)	1.2%

Notes:
[1] This group is described as being in active employment.
[2] Higher proportion in younger groups.
[3] 83% of respondents answered the ethnicity question.

wide. The annual financial contribution made by the Ministry (and prior to that the Department) of Health to the operational costs of the survey and database administration has assisted Council to maintain a high quality exercise. Although the attitude to organised workforce planning has waxed and waned over the years, Council has continued to collect information on which such planning could be based. Because of the high level of co-operation from doctors completing the questionnaire at the time of application for Annual Practising Certificate, the response rate has been above 90% and the data accurate. The fact that Council has insisted on retaining control over the raw data and not releasing unit data has enabled the profession to have confidence in supplying the personal information sought. Council has been in a unique position to collect accurate and complete data on a regular basis and this has been a very valuable resource. The Ministry is the main

user of the data deriving from the workforce survey and has indicated its willingness to support Council in this activity.

Conference : "Too Many and Too Few Doctors – Dilemmas in the Medical Workforce"

Council does not have a statutory role with respect to the size or composition of the New Zealand medical workforce. Council's functions relate entirely to standards of entry to the medical profession, registration in New Zealand, and the maintenance of sound competence, health and professional conduct by all those who are registered. Nevertheless Council is aware that standards and resources can be adversely affected by doctor over-supply, under-supply, maldistribution and competition. Any potential undermining of doctors' standards is of grave concern to the Council and the community. Council has a key role in protecting the health and safety of members of the New Zealand public.

Council considered that it was time that a forum was provided for open discussion of current facts and concerns about the medical workforce. It therefore convened a conference in Wellington from 5 to 6 November 1996 in conjunction with an international meeting in Melbourne on medical registration and discipline. It was attended by a wide variety of practising doctors, educators and medical managers from across the country and some guests from Canada, the United States of America, United Kingdom, South Africa and Australia.

The transcript of conference proceedings is available on request from the Council office, and a summary of the key issues and questions raised is being prepared.

The consensus at the end of the conference was that a commitment to some form of co-ordinated medical workforce development was necessary in New Zealand as the fragmented decentralised approach adopted over the last decade had caused more problems than solutions.

Workforce Survey 1997

In February 1997 redesigned questionnaires were distributed with the redesigned Annual Practising Certificate application form, which had been extended to comply with the new legislation. The data collected during the months to June 1997 (several reminders are necessary in order to get a comprehensive response from all doctors who need an Annual Practising Certificate), will all be entered by spring 1997 and will be published before the end of the 1997 calendar year. Council anticipates that there may be some significant changes in the demographics of the workforce in light of medical migration patterns over recent years and the impact of new registration requirements arising from the 1995 Act.

Services Associated with the Workforce Information System

Services are provided by Council to those requiring information or assistance with research projects involving workforce information or distribution of surveys covering specified branches or areas of practice. There were some delays this year in providing these services due to the changes which were taking place in the management of the database and its operation. Such delays are being eradicated and Council encourages researchers and others interested in obtaining accurate information about the medical workforce to contact the Council Registrar for assistance.

1990s to date

In the early 90s the New Zealand Government adopted an open door immigration policy, welcoming overseas trained professionals. Unfortunately the lack of accurate information given to prospective immigrant doctors by immigration consultants and officials, and the method used by New Zealand Qualifications Authority (NZQA), for assessing equivalence of foreign medical qualifications for immigration purposes led to a very large number of overseas trained doctors being granted permanent residence in New Zealand before their eligibility for registration with the Medical Council of New Zealand was established. Under the Medical Practitioners Act 1968 many did not qualify automatically for registration and could only establish the equivalence of their qualifications for practice in New Zealand by undertaking a rigorous examination programme. Some found this unpalatable and refused to sit the examinations. Under the 1968 Act, specialists were badly affected as specialist qualifications acceptable for registration were inflexible, being set down in the Schedules to Act Regulations. Some overseas trained specialists who had obtained qualifications from the United Kingdom met some, but not all, of the criteria for registration in New Zealand. They too then faced a comprehensive general examination which they found objectionable.

Once again Council was faced with a situation not of its own making where reasonable access to a fair method of measuring competence to practise in New Zealand was demanded.

Council again reviewed the format of NZREX, streamlining it with effect from 1994 by reducing it to three sections: English, Written and Clinical. All were compulsory prerequisites for joining the medical workforce. This last rule was made in the interests of the safety of the public in New Zealand, as under the previous 2 stage (4 part) scheme, a significant number of doctors were able to continue working while repeatedly failing the second stage of the examination. No funds were provided by Government to assist these new immigrant doctors to prepare for the examinations or become familiar with the practice of medicine in New Zealand.

1995 to date

Eventually the Ministry of Immigration heeded the concerns expressed by the Council and others about the growing numbers of unemployed doctors (and other professionals) in New Zealand and immigration policy was changed in October 1995. By that time there were several thousand unregistered doctors in this country. Many had families and were receiving income support. A number have taken no steps to approach Council about examination or registration requirements.

Medical Practitioners Act 1995

The heavy demand for registration from overseas trained doctors was compounded by the news that there was to be a new Medical Practitioners Act in effect from 1 July 1996, which would remove the different mechanism previously applied only to persons who had graduated in medicine in the United Kingdom, Republic of Ireland, Canada and South Africa. There was a surge of immigration from South Africa in the last months of the 1968 Act and many of these doctors moved into general practice in the northern half of New Zealand.

Table 6

CANDIDATES SITTING AND PASSING NZREX CLINICAL

In Period 1 July 1996 to 31 March 1997

	October 1996
Candidate attempts	114 (32)
Number of passes:	
Attempt 1	39
Attempt 2	17
Attempt 3	4
Attempt 4	2
Number of passes overall	62
Pass rate overall	54%

Note ( ) repeat candidates included

Table 7

CANDIDATES SITTING AND PASSING NZREX ENGLISH AND WRITTEN

In Period 1 July 1996 to 31 March 1997

	November 1996	
	English	Written
Candidate attempts	143 (23)	172 (50)
Number of passes:		
Attempt 1	87	28
Attempt 2	15	12
Attempt 3	1	3
Attempt 4	–	1
Number of passes overall	103	44
Pass rate overall	72%	26%

Note ( ) repeat candidates included

Litigation

While a large number of overseas trained doctors have either completed NZREX or succeeded in the vocational registration assessment pathway over the last decade, a significant number fail the examination or seek to resist the principle that they must sit NZREX or other assessments. This situation also prevails in Australia, Canada and the United Kingdom. On the last day of the 1968 Act, an application for judicial review was lodged by two overseas trained doctors on behalf of over one hundred and eighty others as plaintiffs.

None of these doctors was eligible for conditional or full registration under the old Act. They alleged that Council had discriminated against them, breached the rules of natural justice and acted in excess of its powers under the Act. They stated that Council had acted so as to protect its own interests and the interests of New Zealand trained and conditionally registered medical practitioners and specialists unlawfully and unreasonably and had effectively imposed a quota system upon overseas doctors which was outside its powers. Council denied these allegations and also applied to the Court to have the action struck out on the grounds that it was futile as, with the passing of the Medical Practitioners Act 1995, Council had no residual powers to grant registration under the old legislation. Justice Doogue upheld Council's application. An appeal was lodged but to date has not been pursued.

Table 8

REGISTRATION EXAMINATION RESULTS 1984-1997

1984 – 1989 (PRENZ) 178 Candidate attempts	39 Candidates complete overall		Pass rate 22%
1990 – 1997 (NZREX) 1176 Candidates enrolled	405 Candidates complete overall		Pass rate 34%
Since 1994 (3 part NZREX introduced) Average Session pass rates	English	74%	
	Written	29%	
	Clinical	59%	
	*Most Clinical Candidates pass in 3 attempts; those attempting for the second time have a 67% pass rate.		
June 1996 to April 1997 New Candidates presenting	English	220	
	Written	215	
	Clinical	152	
Repeat Candidates presenting	English	36	
	Written	82	
	Clinical	74	

Note: This profile of results over the last 13 years mirrors performance in other countries in similar examinations.

Table 9

REGISTRATION ISSUED TO OVERSEAS TRAINED DOCTORS

1 July 1996 to 31 March 1997

Primary degree obtained in:	Temporary				Probationary				
	Class 1	Class 2	Class 3	Class 2	3	4	6	7
Australia	3	1	2					
Bangladesh				1				
Belguim	1							
Burma				1				1
Canada			23 (3)					
China			1					
Croatia				4				1
Czechoslovakia				1				
Denmark			1					
Dominican Republic			1 (2)					
Egypt				2	1			1
England	1		202 (44)	1	3	2		
Fiji		1 (5)		2	1			1
Finland			1					
France			1 (1)					
Germany		(1)	(2)	3		1	1	
Hong Kong		1 (1)		2				
India		2 (4)	2 (5)	21	1	2	1	8
Iraq				12	2	1		
Ireland (Eire)	1	1	5 (4)					
Japan		(1)	1 (3)					
Korea			1	1				1
Netherlands	1				1			
Northern Ireland			1					
Norway				1				
Pakistan				1				
Papua New Guinea		3 (2)			1			
Peru			1					
Philippines			1					
Poland				3				1
Russia								1
Scotland			57 (8)					
South Africa			30 (5)			3		
Sri Lanka		3		10				
Switzerland				1				
Taiwan		1	1					
Turkey			1					
United States of America		4	4 (3)	25 (33)		4	2	
Wales			17 (6)					
Yugoslavia			4	1	4			

( ) = extensions, after initial issue.
Key to Classes: Temporary Registration: *Class 1:* Visiting Academics; *Class 2:* Sponsored Trainees; *Class 3:* Discretionary. **Probationary Registration:** *Class 2:* Overseas Graduates (NZREX passes); *Class 3:* Overseas Graduates (Eligible for Vocational Registration); *Class 4:* Overseas Graduates (Suitable for Assessment – Vocational Registration); *Class 6:* Overseas Graduates (Clinical Evaluation – Vocational Registration); *Class 7:* Overseas Graduates (NZREX – Supernumerary Attachments).

Assessments

New Zealand Registration Examinations

NZREX English and Written has been offered in Auckland, Wellington, Singapore and London. NZREX Clinical can only be done in New Zealand. Since April 1996, the Clinical has been available in five centres, Auckland, Hamilton, Wellington, Christchurch and Dunedin, a maximum of 24 candidates can be examined in the 2 day Clinical at any one centre, making 120 places overall.

From 1998 NZREX English and Written are discontinued in favour of the ECFMG administered United States Medical Licensing Examination (USMLE) Steps 1 and 2 and specified English tests. These examinations are available worldwide, including in New Zealand. NZREX Clinical remains.

Vocational Registration Assessment Pathway

Council offers a separate assessment pathway to doctors trained and recognised as specialists prior to coming to New Zealand. This is described on page 12 under Vocational Registration. This must be on a user pays basis and involves time and expense.

Employment Issues

Recently a new hurdle has arisen for overseas trained doctors seeking to work in New Zealand. Some who have completed NZREX have been unable to find suitable positions in hospitals. Their lack of experience practising medicine in developed western countries, the length of time that has elapsed since they last practised and the pattern of recruitment in their location or branch of medicine means that they must begin work in New Zealand in positions at a comparatively junior level where careful induction and close supervision is provided. No government assistance has been provided for "bridging courses" for overseas trained professionals, granted permanent residence under the previous "open door" immigration policies. Most immigrant doctors have settled in the Auckland region. All such doctors must go through a probationary period before being permitted to proceed to general registration. This requirement means that many will have to seek positions in other centres, involving additional costs of all sorts, including moving or being separated from family.

Media stories about the plight of some the migrant doctors, some now citizens, have highlighted the stresses they have been under and the disappointment they have faced through New Zealand's inadequate immigration and resettlement policies and procedures. Council has been unfairly accused of racist and protectionist attitudes. Council's mandate is to protect the health and safety of members of the public in New Zealand by maintaining appropriate standards for entry to the register and continuing practice. All assessments (NZREX and vocational) are benchmarked to the minimum standard required of New Zealand graduates (primary and vocational). Council has no jurisdiction over workforce planning, composition or numbers. It appears to Council that additional funding, possibly through the Clinical Training Agency (CTA), will be necessary if these doctors are to pursue their careers constructively and contribute appropriately to health and disability services in New Zealand.

Fees for all examinations and assessments must be set on a cost recovery basis taking into account the outlay by Council and other agencies which assist. Clinical examinations in particular are intensive of examiners' time and other resources, such as hospital facilities and access to patients. Enquiries about registration assessments and work possibilities in New Zealand, account for a significant workload in the Council office.

Figures obtained from the New Zealand Immigration Service show that 5322 doctors were approved for permanent residence in the years ending 1992 to 1996. 1823 have been approved between October 1995 and July 1997. The level of immigration appears to be declining but enquiries to Council about medical registration and work in New Zealand run at about 4000 a year.

Direct Election of Medical Members

For the first time ever, medical members of Council have been directly elected by their colleagues who are on the New Zealand Medical Register and live in New Zealand and overseas. When the Medical Practitioners Bill was under consideration, Council promoted the concept that it was timely for the profession as a whole to take responsibility for the election of medical members, recognising that the new legislation was likely to include increased lay members appointed by the Minister. In the second half of 1995 Council consulted, through its newsletter to all registered doctors, MCNewZ, and letters to major organisations within the profession, on the preferred methods of establishing an electorate, receiving nominations for election and counting votes. Council also reviewed overseas schemes and took professional advice on election systems. Once the Act was passed in December 1995 a second round of consultation occurred on proposed election rules. Once again MCNewZ was used to canvas opinions from all those on the Register.

Electorate

Council considered the size of the New Zealand electorate, the wide variety of occupations and disciplines within medicine, the distribution of doctors between general practice and hospital based practice, the number and type of major groups within the profession, and the fact that many doctors on the Register have trained or worked together at some stage of their career. It decided that one constituency comprising all registered medical practitioners would be the most appropriate rather than a constituency divided on the basis of geography, occupational, practising or registration status.

Voting System

Council decided to use a preferential voting system to determine which candidates had majority support. Single transferable voting (STV) ensures that as far as possible every voter has a positive part in helping to elect some candidate and any group, voting as a block, cannot fill all four vacancies.

The combination of a single electorate, encompassing all those on the Register, and STV appeared to Council to meet the ten criteria by which voting systems can be judged: legitimacy, fairness, representation of minorities in special groups, effective government, integration, participation and representation.

Rules

On 1 July 1996 the transitional Medical Council (namely those members in office pursuant to the 1968 Act plus a new lay person appointed by the Minister) adopted the draft rules pursuant to the Medical Practitioners Act 1995. These were then forwarded to the Minister of Health for approval and gazetting.

First Election Conducted

Twelve thousand three hundred and six (12,306) notices were mailed to registered medical practitioners worldwide on Friday 30 August 1996, advising that nominations would close on 30 September 1996 for a postal ballot on 29 November 1996. Twentyeight candidates stood for election. They came from all over New Zealand, a wide variety of branches of medicine, and a broad spectrum of ages and career stages. Five women stood. One late nomination and two incomplete nominations from overseas had to be rejected by the Returning Officer, the Registrar of Council.

Voting papers with instructions, candidate profiles and a return ballot envelope were mailed on 30 October 1996. Most votes were received by the Returning Officer within the first ten working days of the voting papers being mailed. When the poll closed at noon on Friday 29 November 1996, 4,253 votes had been cast. 41% of voters had New Zealand addresses and 10% overseas addresses. The highest proportion of votes cast were by vocationally registered doctors with New Zealand address (53%) followed by probationers with New Zealand addresses (39%) and general registrants with New Zealand addresses (32%); 16%

of vocationally registered doctors with overseas addresses participated in the election.

Result

The election result was published in the New Zealand Gazette on Thursday 12 December 1996 and four elected members came into office the following day for a term of three years. On that day members of the 1968 Council (unless reappointed under the 1995 Act) relinquished their responsibilities as Council members except for transition provisions relating to discipline.

The successful candidates (in rank order) were Dr Alister Scott, Dr Ian St George, Dr Mark Adams and Dr Tony Baird. The top polling unsuccessful candidate was Dr Caroline Corkill. Drs Scott and Baird are past presidents of the New Zealand Medical Association, Dr Adams a past president of the Resident Doctors Association, and Dr St George was formerly the nominee of the Royal New Zealand College of General Practitioners, appointed by the Minister.

Review

Excluding Council office time and resources, the election cost each doctor on the electoral roll about $2.50. As the return from voters with overseas addresses was disappointingly low (although not unexpected), Council is considering seeking an amendment to the Act to limit the electoral roll to those actively practising in New Zealand with a current Annual Practising Certificate. This proposal was made in the February 1997 issue of MCNewZ when the outcome of the election was promulgated. Only one person expressed opposition at that time.

MEMBERS OF THE MEDICAL COUNCIL

As at 31 March 1997

[1]**Dr K J Thomson** (President)	Appointed by the Minister of Health
***Dr I M St George** (Deputy President)	Elected by medical practitioners
***Dr M J Adams**	Elected by medical practitioners
***Dr M A H Baird**	Elected by medical practitioners
[2]**Mrs P C Judd**, JP	Appointed by the Minister of Health
Dr S L Kletchko	Ex officio for the Director General of Health
[1]**Professor J G Mortimer**	Appointed by the Minister of Health, after consultation with the Deans of the Faculties of Medicine of New Zealand Universities.
[3]**Mr H T van Roon**	Appointed by the Minister of Health
***Dr A J Scott**	Elected by medical practitioners
Vacant	Layperson to be appointed by the Minister of Health.

* Indicates a three year term effective from 13 December 1996.
[1] To 31 December 1997. [2] To 30 June 1998. [3] To 30 June 1999.

MEDICAL COUNCIL AT 31 MARCH 1997

From left to right – *Seated:* Mrs P C Judd, Dr K J Thomson (President), Professor J G Mortimer, Ms G A Jones (Registrar and Chief Executive). *Standing:* Dr M A H Baird, Dr S L Kletchko, Mr H T van Roon, Dr M J Adams, Dr A J Scott. *Absent:* Dr I M StGeorge (Deputy President).

COUNCIL COMMITTEES

Council appoints Committees to deal with its principal activities. Each Committee has a minimum of two Council members. (*Denotes non Council member)

Registration Committee (Quorum of Council)

From 1 July 1996
Dr I M St George (Convener)
Dr M M Herbert
Mrs P C Judd
Dr S L Kletchko
Mr H T van Roon

From 20 February 1997
Dr I M St George (Convener)
Dr M J Adams
Dr M A H Baird
Mrs P C Judd
Mr H T van Roon
Dr K J Thomson

Temporary (Psychiatrists) Registration Sub Committee

From 1 July 1996
Dr I M St George (Convener)
*Dr T W McKergow
Dr J A Treadwell

Vocational Registration Sub Committee

From 1 July 1996
Dr K J Thomson (Convener)
Dr R H Briant
Dr C M Corkill
Dr M M Herbert

From 20 February 1997
Dr K J Thomson (Convener)
Dr M A H Baird
Dr S L Kletchko

Workforce Data Committee

From 1 July 1996
Mr H T van Roon (Convener)
Dr R H Briant
Dr S L Kletchko
*Ms G A Jones (Registrar)

From 20 February 1997
Mr H T van Roon (Convener)
*Ms G A Jones (Registrar)
Dr A J Scott

Finance and Management Committee

From 1 July 1996
Dr G F Lamb (Convener)
*Dr W S Alexander
*Ms G A Jones (Registrar)
Dr K J Thomson
Mr H T van Roon

From 20 February 1997
Dr I M St George (Convener)
Dr M J Adams
*Ms G A Jones (Registrar)
Mr H T van Roon

Communications Committee

From 1 July 1996
Dr K J Thomson (Convener)
Mrs P C Judd
Dr S L Kletchko

From 20 February 1997
Dr K J Thomson (Convener)
*Ms G A Jones (Registrar)
Mrs P C Judd
Dr I M St George

Issues Committee

From 20 February 1997
Dr A J Scott (Convener)
Dr M A H Baird
Mrs P C Judd
Mr H T van Roon

Health Committee

From 1 July 1996
Dr R G Gudex (Convener)
Dr R H Briant
Dr M M Herbert
*Ms G A Jones (Registrar)
Mrs P C Judd
Dr K J Thomson
Dr J A Treadwell

From 20 February 1997
Dr K J Thomson (Convener)
Dr M J Adams
Mrs P C Judd
Mr H T van Roon
Dr A J Scott

Professional Standards Committee

From 26 September 1996 (Interim)
Dr K J Thomson (Convener)
Dr G F Lamb
Mrs P C Judd
Dr S L Kletchko

From 20 February 1997
Dr S L Kletchko (Convener)
Dr M A H Baird
Mrs P C Judd

Research Steering committee

From 1 July 1966
Dr I M St George (Convener)
*Ms G A Jones (Registrar)
Dr S L Kletchko
Mr H T van Roon

From 20 February 1997
Dr I M St George (Convener)
Ms G A Jones (Registrar)
Mr H T van Roon
Dr A J Scott

Education Committee

From 1 July 1996 (Interim, as under 1968 Act)

Professor J G Mortimer (Convener)	ex officio, Dean, Dunedin Medical School, University of Otago
Professor D R Aickin	ex officio, Dean, Christchurch School of Medicine
Dr B Arroll	New Zealand Medical Association appointee
Dr P M Barham	Royal New Zealand College of General Practitioners appointee
Dr J G Buchanan	Royal Australasian College of Physicians appointee
Dr A G Dempster	Faculty of Medicine, University of Otago appointee
Professor L J Holloway	ex officio, Dean, Wellington School of Medicine
Dr J Kolbe	Faculty of Medicine, University of Auckland appointee
Dr M E Lewis	Faculty of Medicine, University of Otago appointee
Dr I M St George	Medical Council member
Professor I J Simpson	ex officio, for Dean, Faculty of Medicine and Health Science, University of Auckland
Mr J S Simpson	Royal Australasian College of Surgeons appointee
Dr A D Stewart	Royal New Zealand College of Obstetricians and Gynaecologists appointee
Mr H T van Roon	Medical Council member
Dr E W Willoughby	Faculty of Medicine, University of Auckland appointee

Education Committee – *continued*

From 20 February 1997

Six members appointed by Council:

Professor I J Simpson (Convener)	Member of academic staff of Faculty of Medicine and Health Science, University of Auckland
Dr M W Ardagh	Selected from vocational branch nominees
Dr M M G Clover	
Dr C M Corkill	
Dr M Davis	Selected from Intern Supervisors
Dr J H Martin	Active consumer of education

Three members of Council:

Professor J G Mortimer	Member of academic staff of Faculty of Medicine,University of Otago
Mr H T van Roon	Layperson
Dr A J Scott	Elected medical practitioner

Examinations Committee

From 1 July 1996

Dr R H Briant (Convener)	Medical Council
Dr C H Maclaurin	Examinations Director
Dr M M Herbert	Medical Council nominee
Professor D R Aickin	Education Committee nominee
Dr R G Large	University of Auckland nominee
Dr E W Willoughby	University of Auckland nominee
Dr D J McHaffie	University of Otago nominee
Dr D A Abernethy	University of Otago nominee
Dr R P G Rothwell	Examination Co-ordinator, Hamilton

From 20 February 1997

Dr K J Thomson (Convener)	President of Council
Professor J G Mortimer	Nominee of Council
Dr C H Maclaurin	Examinations Director
Dr J P Collins	University of Auckland nominee
Dr E W Willoughby	University of Auckland nominee
Dr D A Abernethy	University of Otago nominee
Dr D J McHaffie	Examination Co-ordinator, Wellington
Dr R P G Rothwell	Examination Co-ordinator, Hamilton
Professor J B Morton	Examination Co-ordinator, Christchurch
Dr J J Reid	Examination Co-ordinator, Dunedin
Vacant	Education Committee nominee

OFFICE OF THE COUNCIL

at 31 March 1997

Registrar/Chief Executive	Ms G A Jones, BA, JP
Communications Executive	Mr R A Silcock, Dip Jnl
Human Resources Adviser (part time)	Ms G Needham, BA (Hons), Dip PM
Senior Secretary	Vacant

Registration

Team Leader Registration	Mrs J Lui
Senior Registration Officer	Ms D L Crawley, BA
Registration Officer	Mr P D Girven, BA
Registration Officer	Ms V L McKeough
Registration Officer	Ms A Cattanach
Support Officer	Mrs M Hall
Database Administrator (part time)	Ms J L Woods

Standards

Team Leader Standards	Ms L Urquhart, BCA
Education Officer	Ms A B C Coleman, BA
Examinations Officer	Mrs T E N Smith
Tribunals Officer (part time)	Mrs S D'Ath, LLM
Administration Officer	Mrs C I Bang, BA, LLB, Dip Grad
Administrative Secretary	Ms J Hawken-Incledon
Support Officer (CACs)	Mrs M A Wypych

Corporate Services

Team Leader Corporate Services and Financial Controller	Mr J de Wever
Support Officer	Ms D M Overduin
Receptionist	Mrs D L Kelly

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Auditors

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

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