Pursuant to section 130 of the Medical Practitioners Act 1995, the Medical Council of New Zealand hereby reports to the Minister of Health on the operations of the Council for the financial year ended 31 March 1998.

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Members of the Medical Council at 31 March 1998

Dr M A H (Tony) Baird* (President)	Elected by medical practitioners
Dr I M St George* (Deputy President)	Elected by medical practitioners
Dr M J Adams*	Elected by medical practitioners
Miss Carolynn Bull#	Appointed by the Minister of Health
Mrs P C Judd, JP**	Appointed by the Minister of Health
Dr S L Kletchko	Ex officio for the Director General of Health
Dr T W McKergow^	Appointed by the Minister of Health
Dr A J Scott*	Elected by medical practitioners
Professor I J Simpson***	Appointed by the Minister of Health, after consultation with the Deans of the Faculties of Medicine of New Zealand Universities
Mr H T van Roon***	Appointed by the Minister of Health

* Indicates a three year term effective from 13 December 1996
** To 30 June 1998
*** To 30 June 1999
# To 30 September 2000
^ To 31 January 2001

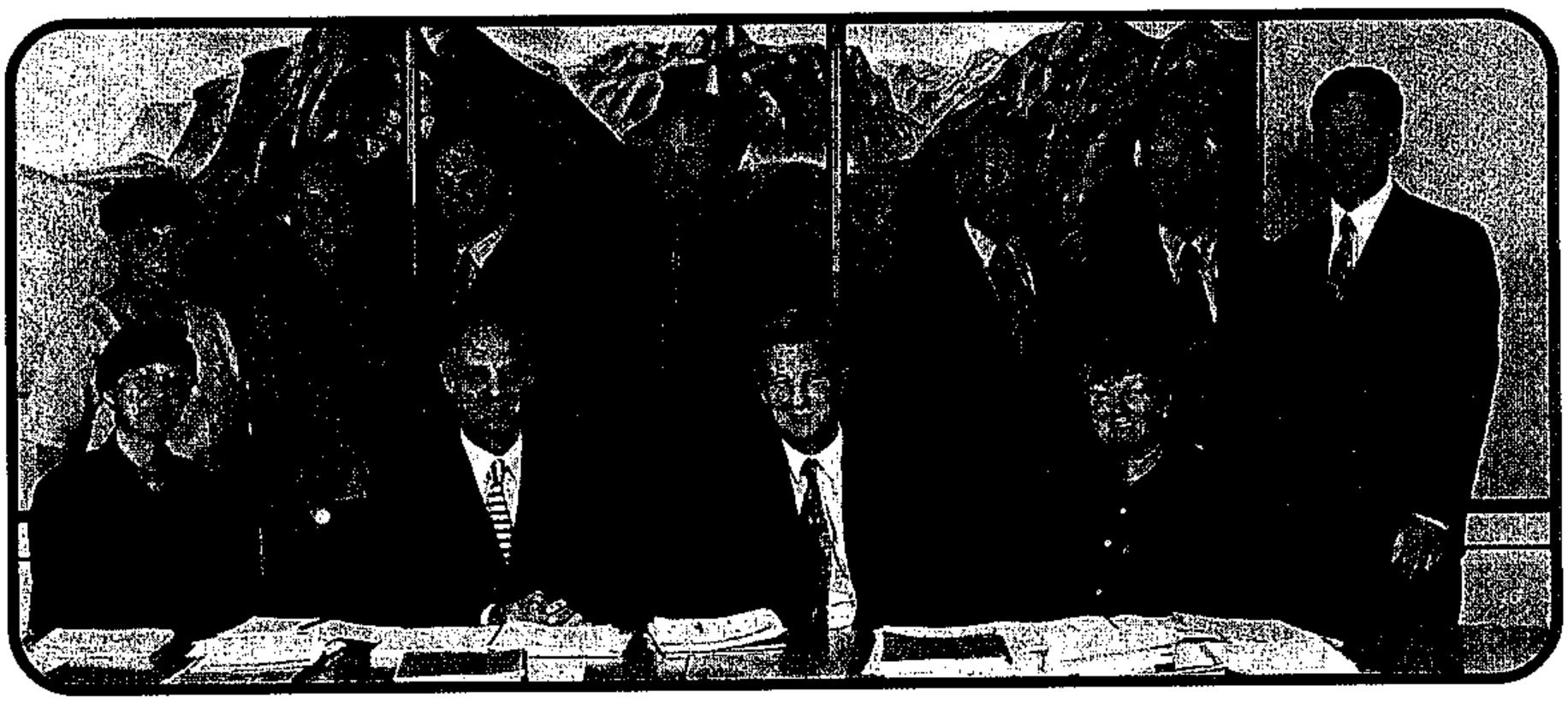
Mission

WE WILL:

- continue to affirm that medicine matters to society
- protect the health and safety of members of the public
- work with all other interested parties
- foster relationships with and between educators, employers, regulators, practitioners and others to guarantee the above
- ensure a medical workforce with internationally acceptable standards
- create an open regulatory environment, well understood, accepted and trusted by the public and the profession.

Vision

A Medical Council which is credible, trusted and respected within New Zealand and internationally in all that it does.



MEDICAL COUNCIL AT 31 MARCH 1998

Left to right:
Seated: Dr S L Kletchko, Dr M A H Baird (President), Dr I M St George (Deputy President), Mrs P C Judd
Standing: Ms G A Jones (Registrar and Chief Executive), Miss C M Bull, Dr T W McKergow, Mr H T van Roon, Dr A J Scott, Professor I J Simpson, Dr M J Adams

From the President of the Medical Council of New Zealand

This report covers the year until the end of March 1998, while the Medical Council was still in a state of transition from the Medical Practitioners Act 1968 to that of 1995, which came into effect on 1 July 1996.

Key milestones for the Council are mentioned elsewhere in this report. In addition, I would like to note here several other events:

- the end of Ken Thomson's involvement in the Medical Council
- the appointment of three lay people to the Council, two of them women
- the creation of committees for Professional Standards and Issues
- the first prosecution by the Health and Disability Commissioner.

Ken Thomson led the Council through the legislative transition and on to the pathway to the future. He is owed a huge debt of gratitude by the medical profession for his efforts. He became the first person to hold the title of President of the Medical Council of New Zealand, in line with that of equivalent bodies in Australia, the United States and the United Kingdom.

In keeping with the new age the activities of this year started with a facilitated residential meeting at which Council members and senior staff worked together on a mission statement and a vision for the Medical Council.

The year has been interesting, involving Council in matters of registration, health, examinations, education, standards and competence. Council revised and promulgated the definition of the practice of medicine (see p. 15). The process of clarifying the types of registration was difficult as policy was being created at the same time as implementation of provisions of the new Act.

Council has continued to work on the issues that arise from the arrival in New Zealand of large numbers of doctors who trained overseas. Some arrive from tragic circumstances and their situation is complex for the Medical Council. Some of the medical immigrants have training and experience equivalent to that of graduates in New Zealand, and they have been assimilated into medical practice and are making a good contribution to the health service. Others who have not held specialist posts overseas and have not reached equivalence for vocational registration experienced hardship as more training and qualifications have been expected of them.

Council has done its best to be fair in the assessment of applicants for vocational registration and has taken the view that all vocationally registered practitioners should have a basic knowledge of medicine and surgery in the broader sense, with documented experience and evidence of an objective assessment.

There are deficiencies in the legislation which became apparent during the year and were added to the list for discussion with the Minister of Health. Council became aware particularly of problems with oversight and resolved to look at the issue again. Council has been meeting each month to try to keep up with such issues and to consider all the applications for registration. The medical colleges and societies have been very helpful in conducting interviews and assessment of those doctors from overseas who seek vocational registration as specialists in their field, although there have been differences in the interpretation of the pathway for assessment and variation in the decisions about equivalence of training and experience.

Large numbers of candidates have been examined for general registration by volunteers with assistance

from the schools of medicine and a review of NZREX was initiated.

Much effort went into the definition of competence and the creation of the process to review competence of individual practitioners which is a feature of the 1995 Act. The dual channel for complaints since 1 July 1996 to the Health and Disability Services Commissioner or to the Medical Council means that there is a circle of correspondence and more than one enquiry into many of the complaints. Complaints about events which occurred before 1 July 1996 have to be checked against the Code of Health and Disability Services Consumers' Rights, and one led to a prosecution by the Commissioner.

In the background to all this activity is the threat of deregulation of the medical profession, which is unsettling so soon after the passage of the new Act which would appear to support self regulation by the medical profession. A change to the composition of the Medical Council was heralded in the Health Sector Occupational Regulation Amendment Bill, the purpose of which included the removal of the Director General of Health or her deputy from all professional boards in the health sector. This proposal has been opposed for medicine, as we seek to maintain a close link with the Ministry as the first option with an additional elected medical practitioner if the Director General is removed from the Medical Council. At the time of the preparation of this Annual Report, there were indications that the views of the Medical Council would be ignored.

The year saw further change within the health service, heightening concerns about reduced or limited resources with provision of care. Council reviewed its statement about practice in such an environment and took the view that the needs of individual patients should not be compromised, although we support the goal of an efficient service that uses taxpayers' money sensibly. It is important for practitioners to get involved in discussions about the provision of services, forming bonds with managers and other professional groups. For its part, Council itself pledged to strengthen links with other organisations.

A great deal has been achieved during the year and there is much more to be done. On behalf of Council I wish to express gratitude to Georgina Jones who has worked tirelessly as both Registrar and Chief Executive Officer, supported by capable, knowledgeable and willing staff.

Report of the Lay Members

From a lay perspective, it has been a challenging, but forward looking and productive year.

During the last three months, lay representation came up to full strength for the first time since the introduction of the 1995 Act. Having three lay members has facilitated ongoing and direct involvement with all of Council's committees and helped spread the workload.

Lay participation has been actively sought: the lay point of view has been integral to the processes of forming policy, assessing issues and developing options for action.

A major concern has been the delays in dealing with complaints against doctors. We believe individual members of the public who lay complaints should have them dealt with as expeditiously as possible.

The Complaints Assessment Committee process, with its involvement of lay people from the community, is a major improvement in dealing with complaints, while the approach taken with competency assessment in a similar manner is also appropriate and a further safeguard.

We consider the Health Committee and Professional Standards Committee processes, dealing respectively with impaired doctors and competence, to be significant in providing for the ongoing health and safety of the public.

As lay persons, we have also become aware of a negative view of Council, as an essentially inward-looking and protective body set up for the protection of the medical profession. Our observation is quite different: the processes of registration, complaints assessment and competency review are prescribed by statute and are required to comply with the provisions of the Medical Practitioners Act. Council must, and does, seek to provide for the protection of the public. In our view, Council policies are soundly based and in the long term public interest. Our statutory responsibility demands that we are vigilant in this regard.

During the year, the Renwick Report on medical education was reviewed. It was pleasing to see that its recommendations are being implemented.

We see the recognition of new branches and adoption of the USMLE assessment exams as further elements in improving and providing greater assurances for the health and safety of members of the public.

Finally, we wish to express appreciation of the tremendous support provided by Council staff. In looking back over the year, an incredible amount of work has been done and their workload has been enormous.

1997

15 April Council:

- receives report commissioned from Associate Professor Robert G Large, "Maintaining Doctors' Competence"
- receives Summer Studentship report, "Doctor/Patient Relationships – Enhancing Teaching About Professional Boundaries"
- notes that Commissioner of Inland Revenue will not appeal to Privy Council – Council's tax status as a charitable body confirmed
- approves revised salary bands, increased staffing and consequent alterations to Council office
- receives new logo and letterhead.

April *MCNewZ* special issue, "The New Zealand Medical Workforce 1997", published.

7 May President and Registrar meet with Overseas Doctors Association representatives.

27 May First Medical Practitioners Disciplinary Tribunal hearing.

5 – 6 June Council holds strategic planning meeting in Auckland.

19 June Council:

- approves criteria recommended by Education Committee for recognition of vocational branches (including Professional Standards Committee draft criteria for recognition of recertification programmes)
- approves creation of Special Purposes Fund from tax refund
- adopts Professional Standards Committee terms of reference
- agrees to NZREX Clinical review by independent working party
- appoints Professor Graham Mortimer to succeed Dr Campbell Maclaurin as NZREX Director.

9 – 11 June, 23 – 24 June, 7 – 8 August 18 hospitals and 10 CHEs visited by Education Committee teams (Auckland, Wellington, Canterbury) to approve probationary (including intern) education programmes.

August Complaints pamphlets published and distributed.

11, 20, 29 August Intern supervisor regional meetings held (Auckland, Wellington, Christchurch) – Code of Health and Disability Services Consumers' Rights emphasised.

18 September Council:

- receives responses to consultation on "Maintaining Doctors' Competence" and decides to appoint Professional Standards Coordinator
- revises definition of practice of medicine
- revises definition of general oversight
- resolves to accept credit card payments for Council's fees, including Annual Practising Certificates (APCs)
- accepts in principle the need for cyclical issue of Annual Practising Certificates from a future date to be decided
- begins review of temporary registration policy.

23 September President and Registrar attend conference called by General Medical Council.

14 October Council:

- nominates Professor Ian Simpson to replace Professor Richard Faull on the Australian Medical Council Accreditation Committee
- receives Victoria Link Research Report, "Expectations and Experience of the Medical Practitioners Act 1995".

October Education Committee considers first applications for recognition as vocational branches according to the new criteria (others considered in March 1998).

20 November Australian Medical Council/Medical Council of New Zealand Working Party meets.

21 November Council delegates attend Australasian Medical Boards and Councils seminar, Sydney.

14 October President, Deputy President and Registrar meet Minister of Health.

27 November Education Committee delegates, Professor Ian Simpson and Dr Gillian Clover, attend the Second National Forum on Prevocational Medical Education, Brisbane.

November Council Summer Studentship increased to $5,000 for 1998/99 year.

Council awards Summer Studentship 1997/98 to Kendall Crossen, Otago University medical student.

December Council publishes revised statement on transmissible major viral infections.

9 December Miss Carolynn Bull, third lay member, attends her first Council meeting.

Council:

- approves budget for year commencing 1 April 1998 and reduces APC fee/disciplinary levy to $695 including GST
- decides to separate Registrar and Chief Executive Officer roles and recruit a new Chief Executive Officer
- decides to underwrite distribution of DHAS handbook "In Sickness and in Health" to NZREX graduates and interns.

31 December Dr Ken Thomson, ministerial appointee, retires.

Professor Graham Mortimer, medical faculties ministerial appointee, retires.

1998

1 January NZREX Clinical examination fee increases to $2,250 including GST.

18 February Dr Tim McKergow, ministerial appointee, attends his first Council meeting (replacing Dr Ken Thomson).

Professor Ian Simpson, medical faculties ministerial appointee, attends his first Council meeting (replacing Professor Mortimer).

Council:

- for the first time, votes in an elected member, Dr M A H (Tony) Baird, as Council President
- proposes new committees and conveners (confirmed March 1998).

10 March Council notes:

- review of temporary registration policy close to completion – graduates of accredited US medical schools to be included from 1 July 1998
- 11 vocational branches now recognised and further applications expected
- in year ending 31 March-
  - 32 cases managed by Health Committee
  - 28 cases referred for review of competence
  - 211 complaints received (including 91 sent to Health and Disability Commissioner) involving 273 doctors
  - 131 new Complaints Assessment Committees (CACs) appointed
  - 195 determinations made by CACs in 160 cases

10 March

[Continued]

- 111 NZREX graduates achieve general registration

- 270 vocational registration assessments completed

- registration applications processed include: probationary 473, general 416, vocational 245, temporary 420, extensions to temporary 293

- register amendments total 3,998

- removals from register (all reasons) total 298

- certificates provided to verify registration (including for purpose of registration outside New Zealand) total 703

- vocational register reaches 4,928

- issue of 9,105 Annual Practising Certificates for 12 months ending 31 March 1998.

Function of Council | Section 123(A):

To authorise the registration of Medical Practitioners under this Act, and to maintain the Register.

In the first full year under the new Act Council and staff have continued to familiarise themselves with and clarify the new Act requirements. Council changed to monthly meetings to consider policy and applications, especially for temporary registration, as this function cannot be delegated. Staff spent significantly more time dealing with applicants, addressing complexities in the legal requirements and preparing papers for Council to consider. Tight deadlines created difficulties for applicants, employers and staff. Particular problems arose because many more temporary registration applications were received from a group of doctors who under the old Act would have been eligible for provisional certificates issued by the Registrar. Despite a number of procedural and staff changes in the registration team, however, processing of registrations proceeded satisfactorily.

TABLE 1

SUMMARY OF REGISTRATION
At 31 March 1998

Probationary Register	559
General Register	12039
Vocational Register	4928
Interim Register	18
Temporary Register	421

Temporary Registration

Council's temporary registration policy, effective from 1 July 1996, allowed visiting university medical graduates from United Kingdom, Eire, Canadian and South African universities to apply for temporary registration for postgraduate experience and locum service posts, especially in shortage areas and disciplines. This policy was a transition arrangement only, valid to 30 June 1998. It was intended that after that date graduates of those medical schools seeking registration for the first time would be required to pass NZREX before registration would be granted.

Council reviewed its temporary registration policy and resolved to continue recognising university medical graduates of those countries for temporary registration. Council was advised by the CHE Chief Medical Advisors that there would be a significant impact on the medical workforce if this source of doctors were no longer available to fill service or training positions, which would not be in the public interest.

In addition, university medical graduates from the USA, and graduates of other university medical schools who pass USMLE Steps 1 and 2 plus the Clinical Skills Assessment, will also be eligible for temporary registration. Graduates of other university medical schools may be granted temporary registration if they satisfy specified criteria which maintain standards. Applications from individuals are considered by Council on their merit.

Requirements of the Act

A person seeking temporary registration must be a *visitor* to New Zealand who is not intending or seeking to reside permanently in New Zealand. Temporary registration may be granted for a period of up to two years in the first instance and may, at Council's discretion, be extended for one further period of not more than one year.

Temporary registration may be granted to:

Class 1	Visiting teachers
Class 2a	Sponsored trainees (sponsored by countries or organisations)
Class 2b	Trainees enrolled in a formal training programme
Class 2c	Doctors undertaking research (visiting research workers who are doctors not eligible for other classes of registration who need registration for a component of their research project)
Class 3a	Service providers - recent graduates (recently qualified doctors who visit New Zealand for work experience, informal training, or overseas experience)
Class 3b	Service providers - locums (doctors visiting New Zealand to fill advertised posts for short term appointments where doctors who are residents of New Zealand are not available or not suitable for appointment)
Class 3c	Doctors required to work in emergencies or for any other unpredictable short term, limited and defined purpose.

Full details of Council's temporary registration policy are available from the Council office.

Vocational Registration

The Medical Practitioners Act 1995 and the Royal New Zealand College of General Practitioners' transition provision for those who had not previously completed vocational training provided strong incentives for many experienced GPs to achieve vocational registration rather than remain on general registration and therefore subject to general oversight. Three-quarters of doctors working in emergency medicine, and more than one-third of those working in occupational medicine, general practice, general surgery and paediatrics described themselves as being in vocational training.

TABLE 2

NEW ZEALAND VOCATIONAL REGISTER
1 April 1997 - 31 March 1998

Vocational Branch	Vocational Registration at 31.03.97	Added 1997/98	Removed 1997/98	Net Change	Vocational Registration AT 31.03.98*
Anaesthetics	972	28	2	26	998
Cardiothoracic Surgery	29	1	0	1	30
Dermatology	51	0	1	-1	50
Diagnostic Radiology	219	14	1	13	232
Emergency Medicine	7	4	0	4	11
General Practice	1584	53	10	43	1627
General Surgery	241	14	6	8	249
Internal Medicine	579	36	9	27	606
Neurosurgery	16	0	1	-1	15
Obstetrics and Gynaecology	229	12	3	9	238
Occupational Medicine	23	4	0	4	27
Ophthalmology	104	9	1	8	112
Orthopaedic Surgery	167	7	1	6	173
Otolaryngology	83	0	0	0	83
Paediatrics	187	15	1	14	201
Paediatric Surgery	8	2	0	2	10
Pathology	208	9	1	8	216
Plastic Surgery	34	0	0	0	34
Psychiatry	926	24	6	18	944
Public Health Medicine	164	8	2	6	170
Radiotherapy	40	2	1	1	41
Rehabilitation Medicine	3	0	0	0	3
Urology	43	3	0	3	46
Venereology	13	0	1	-1	12
TOTAL	**4730**	**245**	**47**	**198**	**4928**

* Includes doctors who may currently be inactive (have no APC). Also includes 109 doctors with vocational registration in two branches and two doctors with vocational registration in three branches.

TABLE 3

REGISTRATION ACTIVITIES
1 April 1997 - 31 March 1998

INTERIM CERTIFICATES ISSUED: PROBATIONARY REGISTRATION	
Class 1 New Zealand Graduates (Interns)	257
Class 1 Overseas Graduates (Interns)	1
Class 2 Overseas Graduates (NZREX passes)	130
Class 3 Overseas Graduates (Eligible for Vocational Registration)	14
Class 4 Overseas Graduates (Suitable for assessment - Vocational Registration)	55
Class 5 Reregistration (following erasure)	2
Class 6 Overseas Graduates (Clinical Evaluation - Vocational Registration)	1
Class 7 Overseas Graduates (NZREX - Supernumerary attachments)	13
INTERIM CERTIFICATES ISSUED, GENERAL REGISTRATION	
New Zealand Graduates	7
Australian Graduates	36
TEMPORARY CERTIFICATES ISSUED	
New Certificates	449
Extensions	293
GENERAL REGISTRATION AFTER COMPLETION OF PROBATIONARY PERIOD	
Class 1 New Zealand and Overseas Graduates (Interns)	270
Class 2 Overseas Graduates (NZREX passes)	111
Class 3 Overseas Graduates (Eligible for Vocational Registration)	22
Class 4 Overseas Graduates (Suitable for assessment - Vocational Registration)	10
Class 5 New Zealand and Overseas Graduates (Reregistration following erasure)	3
ADDITIONS TO VOCATIONAL REGISTER	288
AMENDMENTS TO REGISTER	
Change of address	3567
Change of name	32
Additional qualifications	397
Interim suspension	1
Suspension	-
Revocation of suspension / conditions	1
REMOVALS	
Death	43
Discipline order	2
Failure to notify change of address	195
Non-resident doctors	1
At own request	68
ANNUAL PRACTISING CERTIFICATES	9105
Copies of Annual Practising Certificates	65
CERTIFICATES OF GOOD STANDING	404
CERTIFICATES OF REGISTRATION	228
COPIES OF OTHER DOCUMENTATION FOR REGISTRATION OVERSEAS	71

Note : Class 7 probationary registration (for doctors preparing to sit NZREX Clinical) is no longer available.

Two revised Council statements relevant to registration policy and practice were promulgated during the year. These were: definition of the Practice of Medicine, and General Oversight, as follows:

Practice of Medicine

Pursuant to the Medical Practitioners Act 1995 Council defines the practice of medicine as:

- advertising, holding out to the public, or representing in any manner, that one is authorised to practise medicine in New Zealand
- signing any medical certificate required for statutory purposes, such as death and cremation certificates
- prescribing medicines, the sale or supply of which is restricted by law to prescription by medical practitioners
- treating, reporting or giving advice in a medical capacity, using the knowledge, skills, attitudes and competence initially attained for the MB ChB degree (or equivalent) and built upon in postgraduate and continuing medical education, wherever there could be an issue of public safety.

General Oversight

The Medical Practitioners Act requires the Medical Council to ensure that registered medical practitioners are competent to practise. General oversight requires a relationship between a general registrant and a doctor who holds vocational registration that assists the Medical Council in determining that the general registrant is practising competently.

1. To provide this assurance it is desirable for the general registrant to be provided oversight from within the practice environment by an appropriately vocationally registered doctor working in that practice. Where no vocationally registered doctor is at the site, appropriate arrangements must be made for general oversight to be provided from elsewhere. Competence must be reviewed at least monthly through meetings between the general overseer and general registrant.
2. Where a general registrant is in a formal vocational training programme the director of the programme can be deemed to be the overseer, but delegation of this function within a programme, practice, hospital or defined group of hospitals can be acceptable.
3. When a general registrant employed as a hospital medical officer is not in a formal training programme, the intern supervisor (or hospital medical advisor or equivalent) can be deemed to be the overseer, but delegation of the responsibility to the immediate supervisor of the doctor would generally be expected.
4. During the transition period to 30 June 2001 general registrants who meet the five consecutive year APC rule are exempt from oversight and may provide oversight, but only if they have had continuous experience for at least ten years in that branch or sub-branch of medicine.

Registration Issues

Certain issues arose with regard to the vocational registration assessment pathway. Decision making amongst colleges was perceived in some quarters to be inconsistent. Some colleges reported difficulty in assessing suitability for vocational registration as opposed to assessing for Membership/Fellowship requirements. A particular problem arose with a lack of suitable positions for doctors eligible to apply for Class 4 (assessment) probationary registration. The time taken to receive and assess applications and advise

on the outcome is often considered excessive, causing inconvenience to assessors, applicants and employers.

There is a general lack of suitable positions for Class 2 Probationers. Some, having been out of practice for some time, experience difficulty integrating into the New Zealand health system. The lack of bridging courses is addressed under Medical Migration (p. 47). Inadequate induction may result in poor reports, being "suspended" from practice, or having probationary registration extended or cancelled. Some probationers are appointed to inappropriate positions because of recruitment difficulties. Council now usually requests the employer to review risky appointments before registration is granted.

Some doctors, including those not working in recognised branches of medicine and those in emerging specialisations where numbers are very small, have had difficulty complying with general oversight requirements. Following completion of the APC renewal exercise, it is pleasing to note that almost all doctors have met statutory requirements for oversight. Most of those who experienced difficulty are working in medical fields where an Annual Practising Certificate was not required under the old legislation (eg, research and pre-clinical teaching). Some are Medical Officers Special Scale (MOSS) in provincial hospitals. Provision of oversight is also problematic in new branches where the proportion of trainees to vocationally registered doctors is high.

Doctors who have not been resident in New Zealand for six consecutive months within a period of three consecutive years will in future be subject to removal from the register. This regulation came into force on 1 July 1996 and the first such removals will apply from 1 July 1999.

YEAR IN REVIEW

Annual Practising Certificates

Function of Council | Section 123(B)

To consider applications for Annual Practising Certificates referred to it by the Registrar.

As at 1 June 1998, 8189 Annual Practising Certificates had been issued, with 2534 doctors opting to pay by credit card. The large number of doctors submitting incomplete 1998/99 application forms led to delays in processing and follow-up of non-respondents. The issuing of new certificates to doctors who had been without an APC for three years or out of medical work was also delayed as such applications must be referred by the Registrar for Council consideration.

There were 111 disclosures made by doctors about circumstances occurring which may affect their fitness to practise. Of these, 34 doctors made disclosures about previously disclosed circumstances. Two made disclosures about events which had occurred previously but had not been disclosed during the 1997/98 APC exercise. As a result of the disclosures, one doctor has been referred to the Professional Standards Committee and three have been referred to the Health Committee.

Function of Council | Section 123(c)

To review the competence of Medical Practitioners to practise medicine.

The Professional Standards Committee (PSC) appreciates the colleges' energetic work in enabling and supporting the Medical Council to implement the competence provisions of the Medical Practitioners Act 1995. Greater opportunities for liaison on the practicalities of implementation will follow the appointment of a Professional Standards Coordinator later in 1998.

In June 1997 Council resolved to adopt the following terms of reference for the Professional Standards Committee:

1. To support Council's statutory roles in ensuring that medical practitioners, once registered, remain competent to practise medicine.

2. In particular, to be responsible for advising Council on the carrying out of the functions set out in Parts IV (practising certificates), V (competence), and if necessary VI (quality assurance activities) of the Act.

3. To develop, through consultation, criteria for the approval of programmes for the purpose of reassuring Council that continued vocational registration in a branch or sub-branch of medicine is justified (recertification programmes).

4. To receive notifications in respect of individual medical practitioners whose competence to practise is in question.

5. To conduct enquiries into aspects of an individual's medical practice which may impact on patient safety and to recommend a management strategy to Council in light of any findings.

6. To conduct appropriate reviews of competence for individual medical practitioners and, if necessary, implement a competence programme.

7. To make recommendations to Council on the management of the doctor who does not satisfy the requirements of a competence review and programme or recertification programme.

8. To advise Council on any other matters concerning maintenance of professional competence.

In addition, Council has delegated to the Professional Standards Committee the following responsibilities related to registration:

1. To monitor the effectiveness of general oversight and advise Council where issues of implementation or compliance arise.

2. To develop policy regarding the reporting processes and responsibilities of the general overseers.

TABLE 4

COMPETENCE CASES
1 April 1997 - 31 March 1998

SOURCE OF CONCERN	
Peer	10
Complaints Assessment Committee	6
Medical Practitioners Disciplinary Tribunal	4
Ministry of Health	4
Health and Disability Commissioner	1
Self	1
Intern supervisor	1
President	1
TOTAL	**28**

Competence Cases

In the year under review, 28 competence cases were referred to the Professional Standards Committee (Table 4). Sixteen are still awaiting a competence review, while four closed with alternative action. Action on the remaining eight was still to be determined at 31 March 1998. It should be noted that there are too few cases to enable meaningful statistical analysis by age, type of practice, branch of medicine, or other such factors.

As the competence provisions are new, having been introduced in the 1995 Act, Council set about establishing competence review processes with great care. Development began slowly with information gathering, consultation and establishment of processes acceptable to Council. The current priority is to identify doctors and lay people suitable and available to serve on the committees, then to undertake training programmes.

TYPE OF CONCERN*	
Skills	18
Knowledge	17
Judgement	17
Prescribing	6
Communication	5
Attitude	3

* More than one concern may be reported per doctor

Concept of Competence Review Process

The Medical Council's role is to ensure by a fair process that a medical practitioner has an acceptable level of knowledge, skills (including those in procedures and communication), attitude and judgement to practise medicine in accordance with his or her registration. During the year policies, procedures and terms of reference were developed for the Competence Review Process, in line with the English experience of planning and preparing to cover all aspects and contingencies before progressing on cases. There will be a core format and variations for different circumstances.

An information pamphlet on the Competence Review Process has been drafted. The Professional Standards Committee has consulted with colleges and bodies on their capability and availability to participate in competence reviews and remedial programmes. Information sharing has continued with colleagues, organisations and networks overseas, including the GMC and the colleges of physicians and surgeons in Canada. Council's competence framework was well received when presented to the Australasian Medical Boards Seminar in Sydney in November 1997.

Council is working with employers and associates to implement competence review processes and will encourage mechanisms to be put in place for low level consideration of competence issues in the first instance. To date, Council has only initiated its competence review process in response to expressed concerns. When Council has sufficient resources and experience it will be in a position to undertake random or targeted peer reviews. Liaison and information sharing with overseas bodies will guide Council on the effectiveness of such reviews.

There is a need to separate complaints from concerns. In future, the processes for complaints or competence reviews will be explained to informants, enabling them to express a preference for the process which they believe would best address the issues they have raised.

Doctors are still not aware of Council's collaborative intent in respect of competence review. The process is participative and focuses on aspects of care relating to the area of competence found wanting according to the discipline in which the doctor practises. It is an enquiry by the doctor's peers and a lay person that relies on effective communication, understanding and cooperation. Council's approach is to be consultative, supportive and educative, seeking the doctor's perspective on the issue in question. The doctor is encouraged to contribute to the form and focus of the competence review process and to follow the voluntary option. A doctor's competence may be restricted by managerial, environmental, systems or personal issues, and these can be identified and resolved. The doctor, Council and the public will all benefit from a positive outcome, an assurance that the doctor is competent to practise.

Future Initiatives

A database will be established to streamline competence case recording and provide ready access to a range of statistics for the purposes of trend analysis and risk management.

Competence issues arising in respect of unconventional therapies being practised by a registered GP indicate a need to define boundaries and competence levels in these areas.

Communications and public relations initiatives are required to educate the public and health professionals on competence issues. Council will also build on existing collaboration and alliances with the Health and Disability Commissioner, colleges and professional bodies in New Zealand and overseas as it further develops its competence review and assurance systems.

"Maintaining Doctors' Competence"

In June 1997 the report prepared for Council by Associate Professor Robert G Large (dated February 1997) was published by the Medical Council and circulated widely within the profession to stimulate discussion and elicit comment. This consultation process drew responses from 37 organisations and individuals. Fourteen key issues emerged:

1. There is a need for the Medical Council to clarify its role in the process relative to others' involvement.

2. It is essential to involve the vocational colleges throughout the process, while addressing the fact that not all practitioners are college members.

3. Existing MOPS (Maintenance of Professional Standards) programmes provide an appropriate foundation on which to build a programme for maintenance of doctor competency.

4. There is a distinction between competence and performance, and assessment should ultimately focus on the latter.

5. Formative assessment techniques, including peer and practice review, are strongly endorsed.

6. Quality improvement initiatives must be transparently separate from disciplinary procedures.

7. Gradual evolution of the competency programme is strongly supported, suggesting that the profession should set its sights for achievement on the next generation of practitioners.

8. The programme must extend from undergraduate level to senior levels of the profession.

9. Undergraduate training should encompass teaching essential skills such as recognition of, and responsibility for maintaining, personal health, seeking support, self assessment and peer review.

10. Emphasis should be placed on the need for practitioners to develop greater humanistic skills and to improve their communication skills.

11. Within an overall competency maintenance programme, the incompetent doctor, or those at risk of becoming so, should be targeted.

12. Support and protection for the "whistle blower" is needed to encourage reporting of the incompetent or impaired doctor.

13. The considerable cost of a competency maintenance programme should be recognised, but not shirked.

14. While the profession itself should bear some of the cost of maintaining competence, some degree of overt public funding is appropriate because of the public benefits which will ensue. Whichever way funding is appropriated, the health consumer will ultimately bear the cost.

The PSC reviewed the Registrar's report on the outcome of the consultation process and generally agreed with most of the key issues identified. The committee was concerned, however, that:

- MOPS programmes alone would not provide sufficient foundation as they do not universally address all elements of competence, particularly attitude and other humanistic values
- the link between disciplinary procedures and quality improvement initiatives should not be severed
- "targeting" of incompetent doctors, or those at risk of becoming so, is not preferred over

the processes of general oversight and recertification which encourage identification of poor performance and improvements in competence

- the costs of a competence programme should primarily be borne by individual doctors, in line with the overall accountability of the profession.

The committee proposes to develop a strategic plan based on the 14 identified key issues, in alliance with all stakeholders. Particular mechanisms will be required to address situations such as:

- doctors who have not completed recertification or are not involved with accredited professional bodies' recertification programmes
- doctors under general oversight who have been identified by their overseer as having unresolved competence issues.

Recognition and Approval of Vocational Branch Recertification Programmes

To ensure vocationally registered medical practitioners are competent to practise, the Medical Practitioners Act 1995 provides for recertification. During the year under review the PSC reviewed branches, recognised existing programmes subject to their continuing development, and liaised with non-college organisations on their development of recertification programmes for vocational registration. The committee also met with the Royal New Zealand College of General Practitioners on recertification issues facing both members and non-members.

While continuing consultation and review, the PSC developed draft criteria for the recognition of vocational branch recertification programmes for the maintenance of professional standards. These have been sent to colleges and other interested parties for use when applying for vocational registration.

The committee has requested information on proposed recertification programmes, as follows:

- the categories and numbers of practitioners expected to undertake a proposed recertification programme
- whether the proposed recertification programme, or components of it, are available for non-members and, if so, in what form
- who carries the cost for remedial training
- action proposed in response to complaints to the organisation regarding a practitioner's competence
- the organisation's ability to conduct a competence review
- the organisation's ability to advise on the provision of competence programmes
- available sanctions if the standard for competence is not met
- structure of the proposed recertification programme
- considerations in relation to the college which forwarded the certification, such as conflict of definition; concerns with regard to membership of the college and formal links to the college.

Issues

Particular issues arise around recertification/oversight provision for small specialist subgroups. The number, size and diversity of groups seeking recognition also presents particular challenges within the recertification process.

Future Initiatives

Council plans to host an information sharing meeting on recertification in October 1998, which will include workshops for all colleges and small sub-branch groups and interested medical practitioners who are not members of a college.

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.

Statistics on the work of the Health Committee in 1997/98 (Table 5) represent a heavy workload of case management and monitoring. The committee will have met many of the 32 monitored doctors more than once during the year and considered continuing progress reports from all involved in the monitoring programme. In addition, new referrals which often occur in a crisis situation require many hours of information gathering before the health administrator can formulate a proposal for prompt and appropriate action.

The Health Committee's major policy initiative for the year related to the issue of healthcare workers (HCWs) and Transmissable Major Viral Infections (TMVIs). Council approached Dr Rod Ellis-Pegler, infectious disease physician of Auckland, for advice on progressing the issue. He convened a group of experts, and a report prepared by Dr Mark Thomas, in conjunction with Dr Ellis-Pegler and Dr Arthur Morris (microbiologist, Greenlane Hospital), was considered by Dr Robin Briant and Dr Kitty Croxson (virologist, Auckland Hospital) before submission to Council. The report, describing the incidence of transmission of Hepatitis B virus (HBV), Hepatitis C virus (HBC) and Human Immunodeficiency Virus (HIV) between HCWs and patients, formed the basis of a revised policy statement on TMVIs prepared by Council's Health Committee.

The committee also developed a protocol for management of notifications of TMVIs. A panel of doctors will be appointed to act as consultants to advise doctors and students on infection with HBV, HBC or HIV. Prospective appointees and other selected experts are providing further input to the draft policy statement.

Council has been criticised for not taking a stronger position to encourage all HCWs to be vaccinated against HBV. Council is not in a position to make such a step mandatory but it strongly recommends that all HCWs who are not immune and not infected be vaccinated, for their own and their patients' safety.

TABLE 5

HEALTH COMMITTEE
1 April 1997 - 31 March 1998

NEW REFERRALS	
Received	23
Monitoring commenced	9
No further action required	8
Follow up action taken	5
Agreed to retire	1
CARRIED OVER FROM PREVIOUS YEAR	
Monitoring continued	23
Voluntary undertaking discontinued	1
Deceased	2
OTHER ACTIONS TAKEN	
Interim suspension imposed	-
Interim suspension reimposed	-
Suspensions revoked	-
Application for revocation of suspension supported	1
Conditions imposed on registration	-
Conditions imposed on registration - revoked	1
Prescribing restrictions - gazetted	3
Prescribing restrictions - voluntary	4
Prescribing restrictions revoked	1
Applications for registration considered:	
(a) Initial registration supported	3
(b) Re-registration (following removal on disciplinary grounds) - supported	1
- not supported	-

Future Initiatives

Many doctors are still unaware that every doctor is now obliged to notify the Registrar if he or she has reason to believe that a medical practitioner is not fit to practise because of some mental or physical condition. This duty to notify applies even if the doctor has temporarily withdrawn from practice. The Act excludes the reporting doctor from liability for civil, criminal or disciplinary proceedings provided he or she has not acted in bad faith or without reasonable care. The Health Committee is planning to convene a day workshop to debate the meaning of "fitness to practise" or "unfitness to practise" from medical, legal, ethical and consumer perspectives.

The Committee considers it important that the profession and the community be involved in determining the definition of fitness to practise, and expects such a definition to help members of the profession identify the threshold for reporting. This in turn will make it easier for doctors to decide whether their concerns about a colleague should be reported to the Registrar or whether assistance could be obtained elsewhere.

With the new mandatory reporting responsibilities, Council's Health Committee has been developing a closer relationship with the Doctors' Health Advisory Service (DHAS) and reviewing the boundaries between the activities of Council and the DHAS. Council congratulates the DHAS on publication of the booklet "In Sickness and in Health" in 1997, which will assist doctors to take responsibility for their own wellbeing and recognise and manage personal stress and declining health where necessary.

The Health Committee has well established procedures for intervention and monitoring when a doctor has a health impairment which may prevent him or her practising satisfactorily. These procedures enable the Committee to fulfil its public protection role and ensure the impaired doctor is immediately involved in an effective treatment and rehabilitation programme to allow continued, or safe return to, practice. Early identification and intervention usually allows continued employment, safe practice and a career in medicine.

A doctor unable to cope or perform to expectations may be subject to depression, have a mental or physical illness, or be drinking heavily or misusing drugs. He or she should be encouraged, or required if necessary, to seek professional support and treatment with appropriate follow-up through available referral mechanisms (general practitioner, psychiatrist, psychologist, counselling agencies). In the Health Committee's experience, it is almost never in the impaired doctor's long term interests to take no action at all. In some cases, relationships with colleagues and employers can deteriorate to such an extent that the doctor's job can be put at risk.

Function of Council | Section 123(e)

To promote medical education and training in New Zealand.

The past year has been a settling-in period for the new Education Committee. Its second meeting was in May 1997 and three further one day meetings were held in July and October 1997 and March 1998.

The committee has recently been increased from nine to 11 members. The committee's composition (see p. 82) balances representation in terms of vocational branch and level of employment, geography and gender, and includes an active consumer of education. The committee has developed into a cohesive unit addressing both its historic tasks and its new expanded role.

The committee's role in promoting medical education and training in New Zealand now spans the whole spectrum of medical education, from undergraduate through probationary and pre-vocational to vocational training. It continues to liaise with the Ministry of Health, the Crown Company Monitoring Advisory Unit (CCMAU) and the Clinical Training Agency to address the overall training needs of the workforce.

The Education Committee currently has four major areas of responsibility:

- the approval of medical schools
- arrangements for education, training and supervision during the probationary period
- pre-vocational education and training
- vocational education and training.

Medical Schools

The review of the Australian Medical Council accreditation process used to assess New Zealand and Australian medical schools was completed this year. It followed 10 years of accreditation experience and visits to the 10 Australian and two New Zealand medical schools. The University of Otago School of Medicine was given five years accreditation in 1994 and a further visit will take place in 1999. The University of Auckland School of Medicine will seek accreditation in 2004.

Probationary Period

The committee works closely with the 35 intern supervisors employed by CHEs throughout the country. These doctors are contracted by Council to supervise recent New Zealand graduates and overseas trained doctors who have passed the Council's New Zealand Registration Examination (NZREX). Intern supervisors met with the committee at three regional meetings during August. Focusing on the positive aspects of their role, they identified accessible support systems within their hospitals, discussed teaching resident doctors about the Health and Disability Services Code of Consumers' Rights and explored issues of concern, including the integration of overseas trained doctors.

Written guidelines have been developed for supervising consultants and resident doctors, and are almost complete for registrars working with resident doctors. The guidelines emphasise the key to good education in the probationary year as one-with-one learning in clinical teams. The quality of one-with-one education relies on the relationships between resident doctors and consultants and/or registrars. Probationers require their supervisors to be enthusiastic teachers, supportive and nurturing, and to take time for teaching. As regular feedback (at least twice during the run, in the middle and at the end) is essential, this year's meetings will include a session on communicating feedback to resident doctors. The aim is to improve supervising consultants' confidence and abilities in providing feedback, assessing competence and reporting on performance.

The committee also believes that doctors should learn to manage professional and personal stress, to maintain their own health and wellbeing and

EDUCATION COMMITTEE AT 31 MARCH 1998

Left to right:
Seated: *Ms A B Coleman (Education Administrator), Professor I J Simpson (Convenor), Dr I M St George, Miss C M Bull*
Standing: *Dr M M G Clover, Dr M Davis, Dr M W Ardagh, Dr C M Corkill, Mr H T van Roon, Dr J H Martin*
Absent: *Dr A J Scott*

maximise their ability to provide quality health care to their patients. "In Sickness and in Health" has been distributed by the committee free of charge to intern supervisors, overseas trained doctors during their probationary year and New Zealand graduates, as a teaching resource. One committee member attended the 1998 International Conference on Physician Health: Managing Our Own Health. Education on health and self-care will continue to receive attention.

The committee intends to review the probationary year handbook so that the expected educational content of surgical training is more explicit, and to complete the review of library services and suggested reference book list.

The contribution of overseas trained doctors is valued. However, many who come from a different cultural and medical background and have not been practising for long require support, especially in the early stages of adapting to the New Zealand workforce. These probationers receive close supervision and assessment from their immediate consultant supervisor in relation to their clinical practice. Intern supervisors are now more involved in their general integration into the New Zealand system, providing learning opportunities and support in what can be a very difficult experience. Public health and safety is the primary concern.

One of the major tasks of the committee, which has not changed greatly during the transition to the new Act, is accreditation visits to hospitals which employ recent graduates. This process allows the Medical Council to ensure that probationers receive appropriate education, training and supervision, and allows the hospital to continue to employ probationers. Under the new Act the focus has shifted from approving institutions to approving people, but this has had only a limited effect on the process itself. There was a particularly heavy schedule of visits in 1997 as the committee visited 17 hospitals under nine CHEs: six (3 CHEs) in the Canterbury region, four (3 CHEs) in the Wellington region and seven (3 CHEs) in Auckland, as well as Mercy Hospital. The committee visits every hospital on a three yearly basis.

Accreditation Visit Process

YEAR BEFORE VISIT

Education Committee selects visiting team (typically 2 committee members, 1 recently appointed intern supervisor [IS] from another hospital).

Chief Medical Advisor (CMA) of hospital and local IS supply key information.

ONE MONTH BEFORE VISIT

Letter to RMOs (1st and 2nd year) and overseas trained NZREX graduates explains purpose of visit and encourages participation.

VISIT

Visitors meet privately with RMOs, discuss positive experiences and concerns; also meet relevant clinical staff including CMA, Director Clinical Training, IS, supervising consultants.

→ Tour of hospital to view facilities and assess work situation (library, laboratory, pathology and radiology services, representative medical and surgical wards).

→ Visitors meet CEO and senior management to discuss findings and issues to be reported on.

↓

Visitors' report combined with pre-visit information supplied by hospital.

← Combined reports supplied to key people at hospital for comment.

← Full report submitted to Education Committee.

↓

END OF YEAR

Committee's recommendations submitted to Council:

- appoint CEO of hospital as approved person (1995 Act)
- appoint IS as statutory supervisor (1995 Act)
- approve relevant runs.

Prevocational Years

The prevocational years follow a doctor's probationary year, before a vocational training programme is commenced. Most doctors work in hospitals during these one or more years, where they rotate through various appointments and specialties and decide on a particular medical career path. The general nature of these first years of training is invaluable as the doctor gains wide exposure to various disciplines, most of which are outside the area in which he or she will eventually practise.

Committee members attended the first national forum on prevocational medical education in Sydney in 1996 and the second in 1997 in Brisbane, and will attend again in Melbourne this year. The committee has benefited from the broader range of expertise available through relationships with Australian state postgraduate committees. The Convenor of the Education Committee is also a member of the Prevocational Training Committee of Australia and New Zealand (PTCANZ) which encompasses representatives from postgraduate medical councils and committees in every Australian state and territory and New Zealand. Its primary function is to create a forum for the exchange of ideas and information on training and education during the prevocational years, including discussion of problems and proposed solutions.

The committee continues its close association with the Clinical Training Agency (CTA). The committee is interested in widening the experience available for doctors in their first postgraduate year and has again raised with the CTA the issue of funding general practice runs.

Vocational Training

In the transition to the new Act, recognised branches and sub-branches in which vocational registration could be granted reflected the 1968 Act's provision for specialist registration. In 1997/98 the Education Committee developed criteria for vocational branch recognition and reviewed all current vocational branches, along with a small number of new ones. This has been a major achievement. The committee considered two inter-related tasks: to define the branches and sub-branches and set criteria for their recognition, and to define the standards of education and training for recognised bodies. At its May 1997 meeting criteria for both were developed (see below).

Criteria for Recognition as a Vocational Branch

To gain recognition, a discipline must:

- have a defined body of knowledge and practice
- fulfil a recognised health need
- have a group of practitioners capable of providing an appropriate professional environment
- offer an acceptable training programme with a nationally recognisable qualification
- have an acceptable recertification programme
- have a national body with the authority to advise the Medical Council on matters of vocational registration.

The 1995 Act continues to allow for branches and sub-branches. The committee considered at length various options for grouping branches and sub-branches, but came to the view that these decisions were for practitioners themselves to decide, and that the criteria should apply only to recognition as a branch at this stage. Sub-branches inevitably give rise to issues of hierarchy, which the committee considers is not constructive. The stated criteria apply to all vocational disciplines to encourage smaller professional groups experiencing difficulty to cooperate with like disciplines to meet the requirements.

Some groups draw on more than one allied discipline. Intensive care, for example, has links with both internal medicine and anaesthetics, and family planning has links with both general practice and obstetrics and gynaecology. Some particularly specialised groups with small numbers may have closer links with Australian doctors working in the same field. It was noted that New Zealand culture, both medical and societal, differs from that in Australia, and therefore such relationships with Australia should not be governing ones with policy being set in Australia.

Vocational groups themselves must define appropriate boundaries and smaller or developing branches must define their preferred alliances. In this way, members of the discipline will be responsible for decisions made and the Education Committee will offer advice or assistance only where groups are unable to make appropriate arrangements.

The Professional Standards Committee has been responsible for developing criteria for an acceptable recertification programme. In a complementary process it has considered the recertification portion of each vocational branch application and made separate recommendations to Council in each case.

Once Council approved the criteria, a reporting form was sent to all current branches and emerging groups which had requested recognition. In July 1997 the committee further considered the process for recognition and at the meetings in October 1997 and March 1998 considered 11 applications for branch recognition. Seventeen more have since been considered, in May 1998. All but one of these applications have now been approved by Council. Four of the groups approved (Intensive Care Medicine, Musculoskeletal Medicine, Sexual Health and Vascular Surgery) had not previously been recognised. For others Council has approved slight name changes or recognition as branches rather than sub-branches. The results of this review will shortly be referred to the Minister of Health in the expectation that a new Order in Council will be issued before the end of 1998.

The committee is pleased to have completed the review in this timeframe and now begins its review of the original criteria and to refine its own process for assessing vocational groups against the criteria. It will continue to consider applications from new branches as they emerge.

Summer Studentship

The sixth Medical Council Summer Studentship, of $3,500, was awarded in 1997/98 to Kendall Crossen for her project, "The pattern of self medication among New Zealand general practitioners". Kendall benefited from supervision by Susan Dovey in the Department of General Practice at the University of Otago Medical School.

The project report concludes that self medication by New Zealand general practitioners using prescription-only medicines is common. Strategies for maintaining self medication within safe limits have not been formalised and the interpretation of safe practice varies among individuals. In the interests of better self care for physicians and better practice for patients, professional regulating bodies should initiate debate on this issue.

Kendall and her supervisor have prepared an article on the studentship project for publication in the *New Zealand Medical Journal*. The authors state in their introduction that inappropriate self medication and self treatment may delay the diagnosis of significant illness among doctors. Council's Health Committee has consistently advocated that doctors should have their own general practitioner. This is often the first step recommended by the Health Committee when a doctor's ill health is drawn to the committee's attention. Council is also concerned about older doctors prescribing for themselves and their immediate family when they may not be practising clinical medicine in an environment which allows them to maintain their competence.

The Summer Studentship will be offered again for the summer of 1998/1999 with an increased value of $5,000. The studentship is intended to focus attention on dimensions of individual medical practice which Council believes are essential to promote and maintain high standards of ethics, competence, conduct and care of patients throughout a doctor's career.

Council Newsletter

MCNewZ, the Council's newsletter, is distributed to every registered medical practitioner about three times a year as a vehicle for information provision and consultation. Issues are sometimes devoted to special topics, for example, the New Zealand medical workforce survey information. The newsletter was used to consult with the whole profession about the possibility of introducing a partial refund policy for APC fees and disciplinary levies for doctors who could show that their income from medicine was limited. This proved successful and the policy was announced and introduced shortly after the end of the year under review. Council has appointed a subcommittee to review the newsletter's style.

"Medical Practice in New Zealand: A Guide to Doctors Entering Practice"

An editor will soon be contracted to revise this handbook, originally compiled by Emeritus Professor David Cole, formally Dean of the Auckland School of Medicine and Deputy President of Council. It is a valuable source of information for newly registered doctors, staff and Council members providing guidance on medicolegal, ethical and practice issues, and overseas trained doctors preparing for Council examinations or assessments. The handbook may in future be made available online through a Council website.

Media Issues

Journalists continue to be interested in individual cases of overseas trained doctors claiming to have difficulty obtaining registration with the Medical Council in order for them to practise in New Zealand. A number of emotive personal stories have been published by community newspapers which, regrettably, frequently contain errors or omissions causing bias. Sometimes doctors who are reluctant to use the pathways available to them take the option of putting pressure on Council through local publicity or approaches to members of parliament. Council has established policy and procedures and must consider every case on its merits. That it does, and it will not be coerced into action by political tactics.

Dr Linda Astor's qualification and registration caused adverse publicity for Council. She was working under supervision on probationary registration, originally granted under the 1968 Act on the advice of the Royal Australian and New Zealand College of Psychiatrists, while her claim to be qualified as a specialist psychiatrist was being assessed. Her primary and postgraduate qualifications were verified both by the New Zealand Consul in Poland with the Polish university from which she graduated and also the Polish equivalent of the Medical Council. After concerns were raised about her clinical performance, Dr Astor's work history in the United States was found by Council to be misleading. Dr Astor, who was out of New Zealand on prearranged leave, did not return and her registration was cancelled. Interpol was unable to trace her and Council's attempt to have her charged with a breach of section 141 of the Medical Practitioners Act (for giving false information) was not pursued by the Police because the costs of obtaining the necessary evidence could not be justified. A review of procedures was instigated and the pathways for assessment of vocational registration were changed. They now include an interview with members of the branch vocational advisory committee. This has made the system more robust in assessing overseas trained specialists.

Council is satisfied its document vetting procedures are sufficiently robust to identify most irregularities but, as in other jurisdictions, a very determined smart fraudster can occasionally hoodwink authorities.

Some journalists are also monitoring progress by Complaints Assessment Committees. This is, however, a confidential process unless all parties agree to reveal details. Where the complainant discloses that a complaint has been lodged, it is more difficult for Council to maintain its confidentiality stance.

The Minister and Associate Minister of Health expressed public concerns about the possibility of restrictive practices arising from Council requirements such as general oversight. Council is confident that this cannot be shown to be the case. Council provided information sought by the Commerce Commission to prove this point in a high profile Invercargill case at the end of 1997. Indeed, Council has registered, in the various categories available to it, well over 1,000 doctors who have qualified in more than 50 countries, since the Medical Practitioners Act 1995 came into effect. Nevertheless, Council acknowledges that some doctors trained overseas have found the assessment process and the working environment in New Zealand different from what they expected before arrival.

Council received positive publicity about its statements for the profession published during the year, including "Confidentiality and the Public Safety", ethical guidelines on practice in an environment of resource limitation, and the revised statement (December 1997) on transmissable major viral infections.

Colleges and Employers

Both these groups have had regular and sometimes intense communications with Council. Council delegates have, on request, attended meetings of the Chief Medical Advisors and of various colleges, as well as the Council of Medical Colleges. Council gathered detailed information from public hospital employers when reviewing the transitional temporary registration policy due to expire on 30 June 1998.

Medical Association

Council maintains contact with the Medical Association, coming together for discussion when matters of common interest are at stake. Council noted the NZMA's statement on sexual relationships between doctors with former patients, which is reasonably compatible with Council's own policy. In the event of a complaint, however, the investigatory and judicial bodies will decide on the merits of the case. Council initiatives to educate doctors and patients about the dangers of sexual exploitation have not been pursued vigorously in 1997/98, although Council is committed to producing a training video for doctors. The 1997 Summer Studentship report suggests suitable teaching scenarios.

Doctors' Health Advisory Service (DHAS)

Council continues to fund, but keeps at arms length from, the DHAS. The service provides initial supportive counselling and guidance to doctors referred, or self-referred, because of imminent or escalating health problems, particularly substance abuse and psychological or emotional disorders. Council underwrote the cost of distribution of "In Sickness and in Health" to probationary registrants for the next two years.

"Maintaining Doctors' Competence"

Council initiated an extensive consultation process with more than 300 stakeholders on Associate Professor Robert G Large's report (see p. 20). As a result, Council will appoint a Professional Standards Coordinator as recommended to manage implementation, and progress on that appointment will be announced shortly.

Health Sector Consultation

Council is regularly called upon by the Ministry of Health to make submissions on forthcoming changes to legislation. In the year under review Council provided comment on the Health Occupational Registration Acts Amendment Bill (and attended the select committee), the generic substitution of medicines, aspects of prescribing, and proposals for limited prescribing rights for nurses. Regrettably, the Ministry allows only a very short timeframe for public and professional response to some documents, which precludes well-considered comment.

Council wrote to the Minister of Health concerning ethics and risks involved in computer or drug company inducements to practitioners, and met him and some opposition MPs who have a particular interest in issues in Council's jurisdiction.

Council added its weight to submissions to government for changes in the threshold for medical manslaughter and was pleased to see amendments to the Crimes Act in place before the end of 1997.

Council has a good working relationship with the Clinical Training Agency (CTA) but would like to see more careful attention paid to the links between funding, education, training and competent practice, including promoting healthy study and work environments. The Council President has participated in the recently created medical workforce strategic networking group.

Consultation with Commissioners

Both outgoing and incoming Presidents of Council have regularly discussed with the Health and Disability Commissioner complaints or concerns about doctors. Council published a set of pamphlets about the complaints procedures under the Medical Practitioners Act 1995. These are quite complicated as the pathways differ according to the date of the events being complained about. Gradually this complexity will resolve itself as the majority of complaints fall into timeframes over which the Health and Disability Commissioner has jurisdiction connected with the Code of Health and Disability Services Consumers' Rights.

The Privacy Commissioner was invited to attend the December Council meeting to discuss privacy issues affecting the practice of medicine. The NZMA President and Chief Executive also participated. Some areas of misunderstanding in the application of the Privacy Act and the Health Information Privacy Code were clarified. In *MCNewZ* Council reminded doctors that the Commissioner's 0800 telephone number may be used by doctors to clarify privacy requirements.

Council Committee Consultations

The major standing committees of Council have adopted the principle of inviting individuals or representatives of organisations closely connected with their functions to attend meetings to share information. The Education Committee, Professional Standards Committee and Health Committee have all found this valuable. Council has also heard submissions from people with concerns about registration policy and procedures under the new Act.

Conferences

Council delegates have attended a number of important conferences over the last year. These include the Population Conference – New Zealand Immigration Policy and Trends (November 1997), the CAPE Seminar on Occupational Regulation, The Doctor in 2020, sponsored by the Medical Faculties of the Universities of Auckland and Otago (February 1998) and the UNESCO-sponsored Values in Education Summit (March 1998).

Australian Medical Council

The President and Registrar (or their deputies) regularly attend the General and Annual General Meetings of the Australian Medical Council at which they are accorded observer status. In November 1997 a small joint working party of the two councils discussed continued development of relationships. Council is also involved in working parties appointed by the Australian Medical Council in areas of mutual concern, for example, vocational and specialist registration.

Council is entitled to have a representative on the Australian Medical Council's Accreditation Committee. Following Professor Richard Faull's retirement after the maximum four year term, Professor Ian Simpson took up this role. This is particularly useful as Professor Simpson is Convener of the Council's Education Committee and, since the beginning of 1998, a full member of Council, replacing Professor Graham Mortimer who retired as Dean of the Dunedin School of Medicine at the end of 1997.

Council members attended a seminar for members of Australasian Boards and Councils held in Sydney in November 1997. Dr Sharon Kletchko was invited to present a paper on the major topic of maintaining doctors' competence.

Worldwide Links

Prior to his retirement from Council, Dr Ken Thomson, President, and Georgina Jones, Registrar, attended a meeting called by the General Medical Council in Broadway, England, in September. This meeting was called partly to plan for the Third International Conference on Medical Registration and Discipline to be held in Capetown in September 1998 but also to take stock of progress on matters of mutual concern to the Presidents and Registrars of the major licensing bodies in Australia, Canada, the United States, South Africa, Eire and Sweden. Steps are now being taken to create a world federation of such bodies. This initiative will be taken forward at the Capetown conference.

The Broadway conference identified as opportunities for the future:

- working towards more effective sharing of disciplinary and registration data
- sharing ideas and practices in regard to recertification and renewal of registration
- establishing means by which disciplinary and impairment actions, and the thinking behind them, can be shared
- establishing a mechanism whereby any legislative initiative with implications for medical registration can be rapidly shared between registration authorities
- sharing experiences and ideas about new influences on professional conduct and medical registration
- looking at the possibility of international licensing standards (and common assessment tools)
- describing the principles of good practice
- considering ways of maintaining good practice
- compiling a directory of regulatory arrangements and a bibliography of useful information
- defining the concept of a "competent authority", with regard to mutual recognition of accreditation standards
- identifying the best means of protecting the public.

Function of Council | SECTION 123(F)

TO PROVIDE ADMINISTRATIVE AND RELATED SERVICES FOR THE TRIBUNAL.

DISCIPLINE ACTIVITIES

Transitional provisions relating to existing proceedings commenced under the 1968 Act

A number of existing proceedings (investigations, enquiries and other matters) that had been commenced, but not completed, before the new Act came into effect on 1 July 1996, continued as if that Act had not been passed.

Medical Council (constituted under the 1968 Act)

In the year under review the following matters have been before Council sitting as a disciplinary tribunal under the 1968 Act:

- Charges of disgraceful conduct in a professional respect against five doctors.

  Doctors A and B: Two charges were proven and Council ordered that their names be removed from the register.

  Doctor C: Faced three charges of which one was proven and the other two not proven. This doctor was censured and conditions were placed on his practice.

  Doctor D: Faced two charges. One was proven and the other was proven at the level of professional misconduct at the highest level. This doctor was censured and conditions were placed on his practice. Council's decision has been appealed to the High Court.

  Doctor E: Council granted a stay of the eight charges of disgraceful conduct in a professional respect on the grounds he was unfit to plead.

- Eight appeals against decisions of the Medical Practitioners Disciplinary Committee (three upheld, five 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 the penalty should be reduced. Council determined the first particular (on its own) amounted to conduct unbecoming at the higher end of the scale rather than professional misconduct.

- Three appeals (one held over from 1995) were heard by the High Court against Council decisions (on appeals against decisions of the Medical Practitioners Disciplinary Committee). The High Court allowed one of the appeals and dismissed the other. The third was partly heard but not concluded.

- Council's application to the High Court to strike out proceedings in one case was successful.

- Council heard two applications for re-registration following removal from the register on disciplinary grounds. Both doctors were granted probationary registration with conditions.

Preliminary Proceedings Committee

At 31 March 1997, 19 files remained open. Two remained open at 31 March 1998. Both involved maintaining a watching brief on a court case. Charges will not necessarily be laid but these matters cannot be concluded until the court hearings are over. Seven appeals against Council decisions were awaiting hearing in the High Court. Council will progress these appeals as far as possible but accepts that there can be lengthy delays.

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

The year under review represents a transition period for the MPDC and DDCs as they adjust to the requirements of the new Act. This transition period will continue into 1998 as predictions of completing the MPDC's work by March 1998 have not been fulfilled.

The MPDC had one matter still outstanding at 31 March 1998 as a number of adjournments have delayed High Court proceedings to July 1998. Another matter before the Committee is expected to be completed by October 1998.

At 1 April 1997, 34 complaints remained outstanding under the 1968 Act, 29 to be heard by the MPDC and 5 by the DDCs.

COMPLAINTS UNDER THE NEW ACT

The Council expresses its appreciation to those few doctors who, despite heavy workloads and family commitments, contribute to the Complaints Assessment Committees (CACs), recognising the profession's duty to self-regulate. More doctors are needed to share this responsibility.

With the introduction of the Medical Practitioners Act 1995, complaints against a doctor for conduct which occurred after 1 July 1996 are directed by the Registrar to the Health and Disability Commissioner.

No further action can be taken until the Commissioner notifies the President of Council of any action she will be taking. Good relationships

TABLE 6

OUTCOMES OF FORMAL CHARGES
1 April 1997 - 31 March 1998

Medical Practitioners Disciplinary Committee	**Completed (including 4 under appeal):**	**27**
	Guilty of professional misconduct	2
	Guilty of conduct unbecoming	10
	Not guilty	10
	Withdrawn	5
	Not yet completed	1
	Yet to be heard	1
	Appealed:	8
	Upheld	2
	Failed	2
	Yet to be completed	4
Divisional Disciplinary Committees	**Completed:**	5
	Guilty of conduct unbecoming	1
	Not guilty	3
	Withdrawn	1

with the Commissioner and her staff assist in the discussion and appropriate resolution of complaints. With this new process in train, it was expected that the number of complaints about conduct which occurred before 1 July 1996 would decline, but this has not yet been the case. Complainants are still notifying concerns from many years ago, the majority concerning diagnosis, treatment and communication.

Role of Complaints Assessment Committees

The role of a CAC is to assess a complaint, giving the doctor and the complainant a reasonable opportunity to make a written explanation or statement. Fact-finding meetings with the parties are not formal hearings as are those before a Tribunal. Following the meetings, the CAC

TABLE 7

COMPLAINTS ASSESSMENT COMMITTEES: SCHEDULE OF ACTIVITIES

CACs established before 1 April 1997 and ongoing at 31 March 1998	6
• gone to conciliation	1
• doctor now overseas, complainant (ACC) declining to proceed	4
• delay in establishing CAC due to specialists knowing either doctor or complainant	1
• doctor's apology accepted by complainant, awaiting close off by CAC	1
Complaints closed without proceeding to a CAC Reasons included the complainant withdrawing the complaint, the complaint having previously been dealt with by the MPDC, and the claimant and complainant (ACC) declining to proceed.	33
New CACs established 1 April 1997 - 31 March 1998	161
Cases determined to 31 March 1998 (see Table 10 for determinations)	160
Time taken from date complaint received by Medical Council to date of determination: • Shortest time 15 weeks • Average time 39 weeks • Longest time 66 weeks	
Cases taking more than 60 weeks before determination	8
Reasons included: • delays in appointing 2 CACs, due to lack of follow-up systems on ACC matters. Determined within 12 weeks of reaching CAC. Follow-up systems now in place • difficulty in dealing with complainant, who has now taken CAC and Medical Council to the Complaints Review Tribunal • delay due to appeal of a conviction notified in January 1997; referred to CAC following appeal, December 1997 • CAC determined conciliation subsequently rejected by complainant.	
CACs ongoing at 31 March 1998 (including 6 established prior to 1 April 1997)	65

TABLE 8

SCHEDULE OF COMPLAINTS

Complaints carried forward at 31 March 1998 (either awaiting decision of Health and Disability Commissioner or appointment of CAC)	65
Number of new complaints received (includes 91 referred to HDC - see Table 12)	211
Number of doctors involved	273
Categories of complaint:	
• Access	5
• Communication	35
• Conviction of an offence	3
• Cost	1
• Group Systems	2
• Other	20
• Rights	13
• Treatment	194

FIGURE 1

COMPLAINTS STATISTICS

1 April 1997 - 31 March 1998

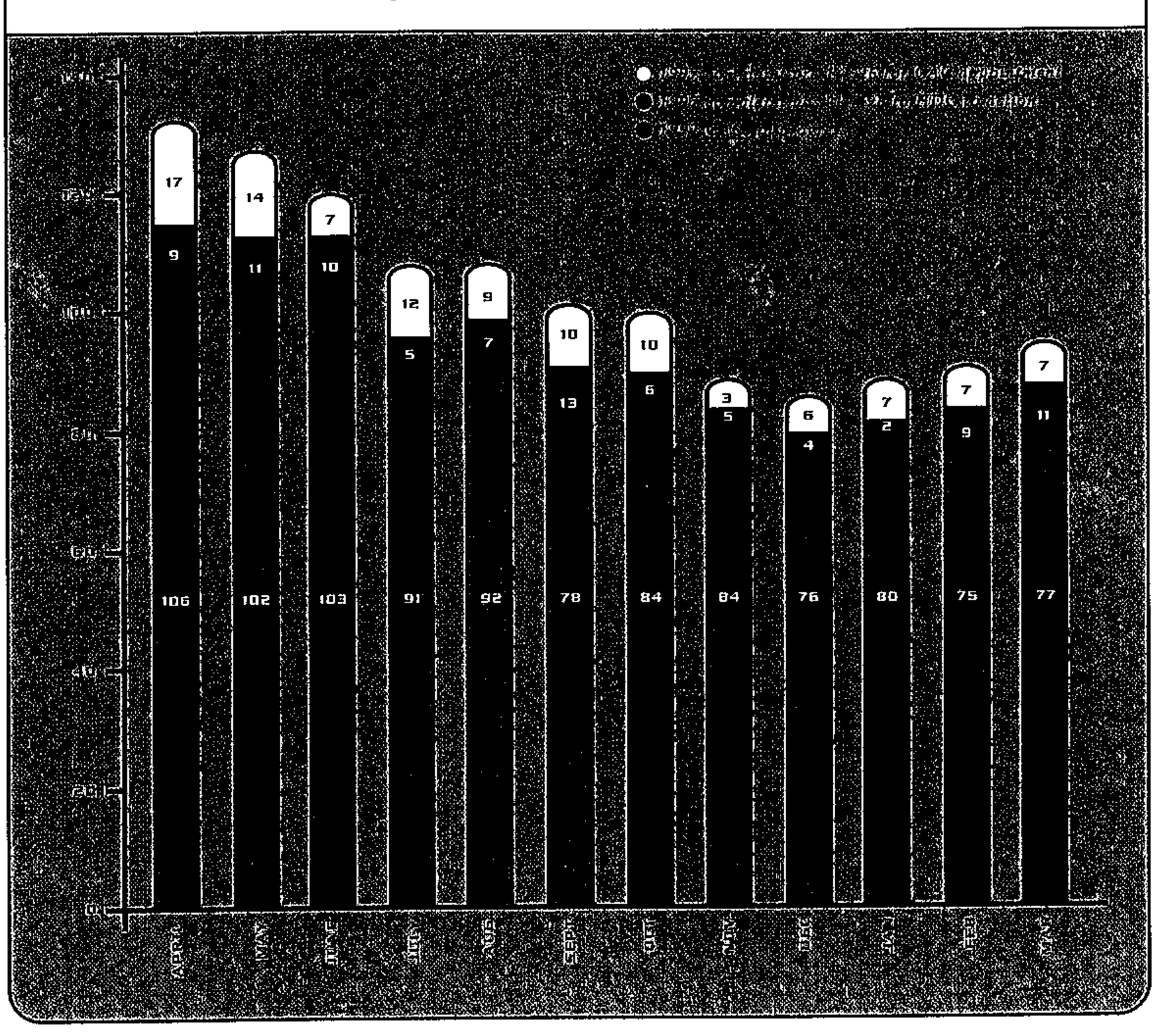


TABLE 9A

DOCTORS SUBJECT TO COMPLAINT BY BRANCH OF MEDICINE

Branch of Medicine	Vocationally registered		Not vocationally registered	
	N	%	N	%
Anaesthetics	5	1.8	2	1.2
Dermatology	1	2.4	-	
Diagnostic Radiology	3	1.7	2	1.1
General Practice	52	3.5	67	4.5
Internal Medicine	16	3.4	1	0.3
Obstetrics and Gynaecology	17	9.7	2	7.4
Ophthalmology	1	1.2	-	
Orthopaedic Surgery	19	13.1	-	
Otolaryngology	2	2.8	1	12.5
Paediatrics	5	3.3	1	1.3
Pathology	2	1.2	-	
Psychiatry	26	10.4	5	2.7
Public Health	1	1.6	-	
Radiotherapy	2	7.4	1	25.0
Cardiothoracic Surgery	1	5.2	-	
General Surgery	17	9.0	3	7.3
Neurosurgery	4	20.0	-	
Plastic Surgery	2	6.1	-	
Urology	6	17.6	-	
Other areas of work:				
ACE Mined			1	
ACC Assessor	-		1	
Alternative medicine			1	
Cosmetic surgery	-		1	
Emergency room of hospital			1	
Homoeopathic medicine	-		1	
Hospital duties			1	
Industrial doctor	-		1	

TABLE 9B

DOCTORS SUBJECT TO COMPLAINT BY LOCATION

Location of Doctor* (former Area Health Board regions)	N	% of FTEs
Northland	19	6.9
Auckland	67	2.1
Waikato	39	4.6
Bay of Plenty	11	2.2
Taitawhiti	0	0
Hawkes Bay	7	2.4
Taranaki	4	1.8
Manawatu-Wanganui	34	6.6
Wellington	41	3.4
Nelson-Marlborough	5	2.1
West Coast	3	5.6
Canterbury	20	1.6
Otago	19	2.9
Southland	4	1.8
TOTAL	**273**	

* Some complaints involve more than one doctor.

determines 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, the ability of the practitioner to practise medicine; or
- in the case of a complaint, the complaint shouldbe the subject of conciliation under section 94; 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.

TABLE 10

DETERMINATIONS MADE
1 April 1997 - 31 March 1998

Competence review	9
Ability review	5
Referred to conciliation*	15
Charges laid with MPDT	14
No further action	157
TOTAL	**195**

NB: Each case may involve more than one doctor; each determination relates to one doctor.
* 8 ongoing; 4 successfully resolved; 3 no further action following unsuccessful conciliation

TABLE 11

CONVICTION NOTICES RECEIVED
1 April 1997 - 31 March 1998

Nature of Conviction	
Manslaughter	1
Indecent assault/sexual violation	1
Burglary/assault/use of a firearm to commit a crime	1
TOTAL	**3**

Outcome of Conviction Notice	
Subject to appeal to Privy Council	1
Charges laid by CAC with MPDT (yet to be heard at 31 March 1998)	2
TOTAL	**3**

Achievements

During the year under review all CACs were surveyed to identify issues requiring resolution and ideas for improvement. Meetings for CAC members were held in Auckland and Wellington in September 1997 to focus on understanding the five determinations, identifying the most effective CAC practices, identifying problems in the CAC process, and establishing improved procedures.

Regular two-monthly progress reports to Council have been developed, which include comparative statistical information and proposals to improve the complaints assessment process. At the time of reporting, detailed guidelines to streamline the process are reaching completion. The guidelines have been developed from the experience and suggestions of CAC members and Council staff after one year of operation under the new legislation. They include more detail on the five determinations and information to assist networking among CAC members.

Throughout the year CAC convenors have ensured that CAC processes have met statutory obligations and that documentation is sufficiently robust to contribute to proceedings in the event of review.

TABLE 12

COMPLAINTS FORWARDED TO HEALTH AND DISABILITY COMMISSIONER (HDC)
1 April 1997 - 31 March 1998

Resolved by HDC	5
Returned back not CAC appointment	7
No breach of HDC Code (referred to CAC)	1
No breach of HDC Code (President and Commissioner agreed not to appoint a CAC)	9
No breach of HDC Code (President asked for competence review)	1
Breach of HDC Code (Referred to Director of Proceedings)	2
Breach of HDC Code (President and Commissioner agreed not to appoint a CAC)	1
Complaint withdrawn	2
Not in HDC jurisdiction: awaiting action by Medical Council	3
Under consideration/action by HDC	26
Awaiting response by HDC	32
Direct referral by ACC	2
TOTAL	**91**

MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL (MPDT)

(Appointed 20 August 1996 for a three year term)

Mr P J Cartwright (Chairperson)

Mrs 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
(on sick leave from 11 January 1998)

Dr I D S Civil, MBE

Dr J C Cullen

Professor 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 (retired December 1997)
Deputy Secretary	Ms G J Fraser (appointed Secretary January 1998)
Administrative Assistant	Mrs D M Haswell

26 The Terrace

P O Box 5249, Wellington

Tel: (04) 499 2044

Fax: (04) 499 2045

The Tribunal has completed almost two years in its role as adjudicator of charges brought by a Complaints Assessment Committee or the Director of Proceedings from the Health and Disability Commissioner's office. Since the 1997 Annual Report, when three charges had been received by the Tribunal, a further 18 charges have been received. Four of these 18 were brought by the Director of Proceedings.

During the year under review the Tribunal heard 14 charges, nine in public. Two of the charges received in the previous year were among those heard; the third was withdrawn prior to hearing. All but one of the charges heard related to events which occurred before 1 July 1996 and thus were heard under the transitional provisions of the Medical Practitioners Act 1995, to which the 1968 Act penalties applied.

The Tribunal's decisions are published in the *New Zealand Medical Journal*. Copies of decisions may be obtained from the Tribunal's Secretariat or the Auckland District Law Society Library.

TABLE 13

CHARGES BEFORE THE MPDT
1 April 1997 - 31 March 1998

Nature of Charges	
Disgraceful Conduct	2
Professional Misconduct	11
Conduct Unbecoming	5
Convictions	3
TOTAL	**21**

Outcome of Hearings	
Guilty - Disgraceful Conduct	1
Guilty - Professional Misconduct	3
Guilty - Conduct Unbecoming	3
Not Guilty	6
Charges Withdrawn before Hearing	2
Not completed	1
Yet to be Heard	5
TOTAL	**21**

* Both charges were of Professional Misconduct.

Prosecution of charges brought by CAC	12
Prosecution of Charges Brought by Director of Proceedings	2
Charges brought by CAC but withdrawn	2
Yet to be Heard	5
TOTAL	**21**

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.

Major achievements in the past year were the review of the Council's ethical guidelines on "Doctors' Duties in an Environment of Competition or Resource Limitation" (published in the *New Zealand Medical Journal* and the general medical press) and the formulation of a statement on "Confidentiality and the Public Safety" (published in *MCNewZ*, May 1998). Council continues to publish statements or guidelines for the profession in *MCNewZ*.

Other issues, set out below, were referred to the President or the Issues Committee during the year and a range of responses made. Some resulted in Council making submissions to the Ministry, select committees or relevant Ministers:

- provision of medical care in rest homes
- general practitioners and the provision of after hours medical calls
- after hours responsibilities in remote locations
- policy and procedures for the transfer of information from general practice to other parties
- registered medical practitioners and standards of acupuncture and a proposal for licensing of non-medically qualified lay acupuncturists
- inducements and "kickbacks"
- Osteopaths Bill
- Human Assisted Reproductive Technology Bill
- revision of the legislation covering therapeutic products and of the Medicines Act 1981
- medical practitioners and the Privacy Act
- "The wellbeing of Maori whanau"
- "Consumer safety regime: Taking Care II"
- a combined Council/NZMA Ethics Committee
- system failures and individual responsibility in the health service
- "Safety and quality issues associated with extended limited prescribing rights to nurses"
- interference in the doctor/patient relationship.

Council asked the committee to consider papers which had originally been given at the CAPE conference in July 1996 relating to occupational regulation in the health sector.

The Issues Committee has reviewed its terms of reference and is embarking on two major projects to advise Council on telemedicine and the practice of complementary medicine. The committee is able to draw on international developments as both these fields have been of recent interest to like regulatory bodies in Australia and the United States.

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.

The 1997 medical workforce survey[1] attracted an improved response rate of 95 percent, helping to maintain the high standard of information available on the New Zealand medical workforce.[2]

An issue of definition arose in respect of the question on ethnicity. Several respondents objected to use of the "European" category to cover the range of responses including New Zealander, European and Pakeha. With hindsight, "New Zealand European/ Pakeha" would have been preferable, as used by Statistics New Zealand in the last census. The census guidelines reveal a history of healthy debate in Statistics New Zealand about the best method of gaining accurate responses. The current classification aims to distinguish clearly between people who identify as New Zealand Maori, as New Zealanders with predominantly European descent, or specifically with their European origins. No doubt changes will continue to mirror New Zealand's growing awareness of both ethnic diversity and independent nationhood.

Despite some criticism of the category definitions, the 99 percent response rate to this question, compared with 83 percent in 1996, provides Council with much more reliable information to assist planning. Numbers of Maori and Pacific Islands doctors continue to increase, representing 2.5 percent and 0.8 percent respectively of the active medical workforce in 1997. Both groups remain under-represented, however, when compared with their proportions within the New Zealand population (14.5% and 4.8%).

Females continue to be under-represented in the medical workforce at 30 percent, although the higher proportion of females among younger age groups should ultimately reduce this disparity. The proportion of female doctors varies widely by vocational group, the highest proportion (38%) being of the group providing primary care other than general practice.

For the first time in recent years, the proportion of doctors who obtained their primary medical qualification in another country was slightly down, from 34.2 percent in 1996 to 33.7 percent in 1997. Because of Council policies introduced since the Medical Practitioners Act 1995 came into effect, there has been a decrease in the number of overseas trained doctors working with permanent registration, but an increase in temporary registration (periods up to three years).

General practice accounted for 40.2 percent of work by all doctors at their main work site, followed by internal medicine (10.8%). Of the larger vocational groups, there were significant increases in primary care other than general practice (60% increase), other surgical sub-specialties (29%), emergency medicine (23%), urology surgery (21%), internal medicine (18%) and psychiatry (18%).

At 31 March 1997, the proportion of the medical workforce undertaking training towards inclusion on the vocational register increased by 84 percent over 1996, to 29.5 percent. Over half of these were general practitioners (Table 14).

Further improvements to the survey methodology are planned to improve survey accuracy in 1998/99. For the first time, the 1998 workforce survey will also include doctors with temporary registration, who now comprise around 5 percent of the active workforce. As the definition of "practice of medicine" has been broadened to include teaching, research, and medical or health management, additional data on doctors in these fields will also become available as they join the APC/workforce survey cycle.

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[1] A summary report of the findings of the New Zealand Medical Workforce Survey 1997 was published in a special issue of *MCNewZ*, Issue 20, April 1998.

[2] Council has a statutory responsibility 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.

TABLE 14

PROPORTION OF VOCATIONAL TRAINEES BY BRANCH OF MEDICINE

Vocational Branch	Number in vocational training	Trainees as % of total on vocational register
Anaesthetics	142	29
Cardiothoracic Surgery	7	7
Dermatology	3	25
Diagnostic Radiology	61	75
Emergency Medicine	77	40
General Practice	1195	16
General Surgery	85	26
Internal Medicine	128	41
Neurosurgery	6	24
Obstetrics and Gynaecology	58	17
Occupational Medicine	22	35
Opathalmology	24	19
Orthopaedic Surgery	30	32
Otolaryngology	10	31
Paediatrics	77	29
Paediatric Surgery	3	29
Pathology	31	37
Plastic Surgery	6	28
Psychiatry	141	25
Public Health Medicine	36	18
Radiotherapy	9	16
Rehabilitation Medicine	4	25
Urology	6	17
Venereology	5	15
TOTAL	**2163**	**29**

NB: Number in vocational training and percentage are based on doctors working four or more hours per week at 31.3.97.
Source: 1997 Medical Workforce Survey (31 March 1997)

Overseas Trained Doctors

Council is considering a large volume of applications from overseas trained doctors and is granting an appropriate form of registration to many of them, provided they meet the minimum standards for English competence, general registration and/or vocational registration. The latter two are entered via probationary registration.

In the two years since the new Act has been in place over 8,000 enquiries have been received from doctors residing in 97 countries, 4,000 of them in the last year. Fewer doctors are now being granted permanent residence without having their eligibility for registration tested. As a consequence of the change in legislation with the 1995 Act, the number of temporary registrants has risen sharply. From 1 July 1996 to 31 March 1998, 831 such registrants have been brought into the workforce, of which 449 have been registered in the year covered by this report. These 831 temporary registrants qualified in 55 countries. The majority have obtained their primary medical qualifications in university medical schools in the United Kingdom, Eire, South Africa, Canada and the United States. Most temporary registrations are issued to service providers although New Zealand employers continue to attract visiting teachers, sponsored trainees and researchers from overseas.

NZREX

Data on candidates entering and succeeding in the general registration pathway assessment, NZREX, are shown in Tables 15 and 16. At the end of December 1997, following two years notification of the change, Council discontinued NZREX English and NZREX Written in favour of United States Medical Licensing Examination (USMLE) Steps 1 and 2, combined with approved English tests including IELTS and the modified TOEFL.

Large numbers of candidates are still applying to take NZREX Clinical which continues to be offered in Auckland, Hamilton, Wellington, Christchurch and Dunedin three times a year. Council is also aware that there is significant enrolment for USMLE Steps 1 and 2, the Auckland centre processing between

TABLE 15

CANDIDATES SITTING AND PASSING NZREX CLINICAL
1 April 1997 - 31 March 1998

	April	June	November
Candidate attempts	112 (42)	57 (45)	115 (44)
Number of passes:			
Attempt 1	34	22	26
Attempt 2	27	20	12
Attempt 3	7	1	3
Attempt 4	0	1	2
Number of passes overall	67	44	43
Pass rate overall	60%	45%	37%

* [Number of repeat candidates included]

350 and 400 candidates at any of the two sessions for each step of the examination each year.

Council is pleased to note that the overseas trained doctors who meet Council's standard by passing NZREX Clinical are progressively being integrated into the New Zealand medical workforce. Approximately 10 percent experience some difficulties in the early months, especially if they have not been practising for some years or are offered busy service posts where they need time to find their feet. Over the probationary period most reach a very satisfactory standard and gain general registration after 12 months supervised practice in a New Zealand hospital. A very small number cause concern and need extended probationary registration. Of those only a handful have their probationary registration cancelled to allow a period in an observer role before they can proceed. Only one practitioner has been found so unsafe as to necessitate the indefinite cancellation of his probationary registration.

Council is more concerned that some successful NZREX Clinical candidates are unable to find work. There is also a small number of candidates who after three attempts at NZREX Clinical are still unsuccessful and appear to be making little progress. This is not surprising as no bridging courses or funding are available to them. Some of these doctors appeal to Council for a fourth or fifth attempt but are normally declined if there is no evidence of satisfactory progress or of the doctor having made private arrangements for educational assistance to improve his or her performance.

Most candidates pass the English test at the first or second attempt. Some, however, experience communication difficulties in the early months of working in our health system. These difficulties are usually overcome with increased confidence but sometimes necessitate remedial action. Council is not aware of English communication courses specifically targeted for overseas professionals including doctors.

TABLE 16

CANDIDATES SITTING AND PASSING NZREX ENGLISH AND WRITTEN

1 April 1997 - 31 March 1998

	July		December	
	English	Written	English	Written**
Candidate attempts	36 (36)*	85 (83)*	15 (15)*	49 (49)*
Number of passes:				
Attempt 1	1	0	1	0
Attempt 2	25	24	2	4
Attempt 3	0	7	3	12
Attempt 4	1	1	0	4
Attempt 5	0	1	0	1
Number of passes overall	27	33	6	21
Pass rate overall	75%	39%	40%	43%

* [Number of repeat candidates included] ** Final session

The fees for NZREX Clinical were increased to $2,250 per session (including GST) and Council appreciates that there may be financial barriers to preparation or remediation. Council continues to administer the examination on a self funding basis. In the 1997/98 financial year the fund has experienced a loss as NZREX English and Written were phased out. The change in candidate mix had a one-off effect on the level of overheads in the overall financial structure of the examination (see p. 62). This has been addressed in the new fee for NZREX Clinical and Council expects that the deficit will gradually be absorbed. It is difficult to predict the precise number of candidates each year for budgeting purposes, but Council anticipates that close to a "full house" of 120 candidates each session will continue for some time yet.

Eligibility for vocational registration

Council has met with the Minister and Associate Minister of Health to explain the NZREX process and the process for assessment of eligibility for the vocational register. The latter has caused anguish in some quarters but Council is satisfied that with the cooperation and support of the colleges and special societies, a transparent, fair and reasonable process is being offered. In the year under review 270 doctors were referred for assessment by the colleges.

TABLE 17

REGISTRATION EXAMINATION RESULTS
1984 - 31 March 1998[1]

1984 - 1989 (PRENZ) 178 candidate attempts 39 candidates completed overall	Overall completion rate	22%
1990 - 31.03.98 (NZREX) 975 new candidates[2] 511 candidates attempted Clinical 447 candidates completed Clinical	Overall completion rate Clinical pass rate	46% 87%
1994 - 31.03.98 (3 part NZREX) 685 new candidates 403 candidates attempted Clinical 351 candidates completed Clinical	Average attempts required to pass: English Written Clinical Overall completion rate Clinical pass rate	1.9 2.4 1.6 51% 87%

[1] This profile of results over the last 14 years mirrors performance in other countries in similar examinations.
[2] Candidates who attempted any part of NZREX for the first time between 1990 and 31 March 1998.

TABLE 18

OUTCOMES OF APPLICATIONS FOR ASSESSMENT OF ELIGIBILITY FOR VOCATIONAL REGISTRATION

1 April 1997 - 31 March 1998

	NZREX	NZSPEX	Class 3 Probationary	Class 4 Probationary	Class 6 Probationary	Application withdrawn	Pending outcome / Other	Total
Anaesthetics	9	2	1	6			7	25
Cardiothoracic Surgery	1	1		1				3
Dermatology		1				2	1	4
Diagnostic Radiology	1	2		4			4	11
Emergency Medicine		1					1	2
General Practice		3		4			3	10
General Surgery	11	7	1	10		1	5	35
Internal Medicine	3	6	1	6		6	9	31
Neurosurgery	1			2			1	4
Obstetrics & Gynaecology	10	8	4	2			5	29
Occupational Medicine								
Ophthalmology	1			1		1	2	5
Orthopaedic Surgery	5	5	1	3		1	1	16
Otolaryngology	5	1				1	5	12
Paediatrics	3			4			5	12
Paediatric Surgery							1	1
Pathology	2	7	3	1			2	15
Plastic Surgery	2						2	4
Psychiatry		4	3	13	2	1	13	36
Public Health Medicine		3		1			1	5
Radiotherapy	1		1					2
Rehabilitation Medicine						1		1
Urology	3			2			2	7
Total	**58**	**51**	**15**	**60**	**2**	**14**	**70**	**270**

Of those, 58 were redirected to the NZREX pathway, 51 were invited to sit NZSPEX (the specialist knowledge test), 15 were deemed eligible for vocational registration after the satisfactory completion of 12 months probationary registration, and 62 were deemed eligible for clinical assessment of vocational eligibility under supervision. Fourteen candidates withdrew their applications and 70 were awaiting interview or the college report to Council on the interview (Table 18).

At 31 March 1998 14 doctors were working on probationary registration who will proceed to vocational registration (and general registration) at the end of the 12 month period. A further 59 doctors

TABLE 19

DOCTORS GRANTED VOCATIONAL REGISTRATION WHOSE PRIMARY MEDICAL QUALIFICATION WAS OBTAINED OVERSEAS, BY BRANCH OF MEDICINE
1 April 1997 - 31 March 1998

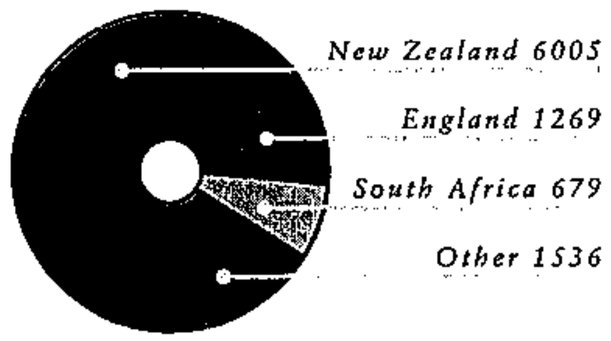
Branch of Medicine	
Anaesthetics	10
Diagnostic Radiology	7
Emergency Medicine	3
General Practice	18
Internal Medicine	6
Occupational Medicine	1
Obstetrics & Gynaecology	8
Ophthalmology	2
Orthopaedic Surgery	2
Paediatrics	4
Pathology	5
Psychiatry	16
Public Health Medicine	1
Radiotherapy	2
Cardiothoracic Surgery	0
General Surgery	7
Paediatric Surgery	1
Urology	0

are working on Class 4 probationary registration under assessment and will be expected to proceed to vocational registration, provided they meet the standards expected, over the next year or two.

Ninety-three doctors who obtained their primary medical qualification overseas have been granted vocational registration in the last year. Table 19 sets out the disciplines in which these doctors have been registered. Of the 245 additions to the vocational register (ie, including primary medical graduates from Australasia), 38 had obtained their post-graduate qualifications overseas.

Council regularly scrutinises the NZREX Clinical examination, the vocational registration pathway and the expectations of probationary registrants. They are regularly modified to improve access, clarity of intention and expectations, and overseas trained doctors are offered guidance. Nonetheless, Council remains subject to litigation and a small number of complaints are currently under consideration by the Office of the Race Relations Conciliator under the Human Rights Act 1993.

FIGURE 2

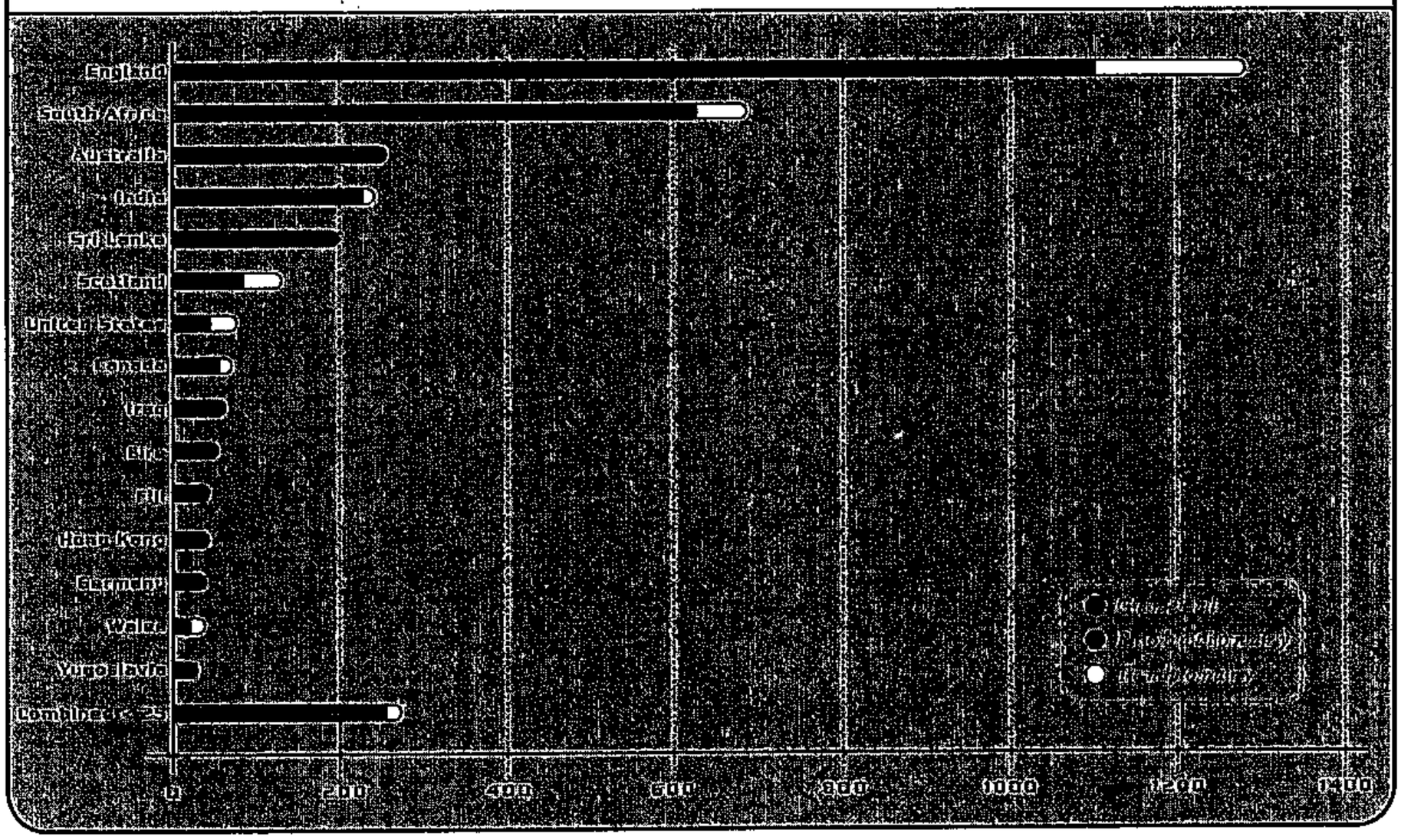


Active* Medical Practitioners in New Zealand at 31 March 1998 by Main Countries of Primary Qualification

* Active is defined as residing in New Zealand and having a current practising certificate (including temporary registrants).

FIGURE 3

ACTIVE MEDICAL PRACTITIONERS IN NEW ZEALAND
at 31 March 1998 by Country of Primary Qualification



NB: "Combined <25" : Fewer than 25 doctors qualified in each of the following countries: Northern Ireland (21), Egypt (21), Singapore (18), Zimbabwe (16), Netherlands (16), Pakistan (12), Philippines (11), China (10), Burma (9), Germany (8), Switzerland (8), Poland (7), Bangladesh (7), Papua New Guinea (6), Hungary (6), Croatia (6), Russia (5), Norway (5), Czechoslovakia (5). Fewer than 5 doctors qualified in each of a further 39 countries (a total of 72 doctors).

TABLE 20

REGISTRATION ISSUED TO OVERSEAS TRAINED DOCTORS
1 April 1997 - 31 March 1998

Primary degree obtained in:	Temporary Registration			Probationary Registration			
	Class 1	2	3	Class 2	3	4	7
Argentina			1				
Australia	6		1				
Bangladesh				5 (6)			
Belgium		1			1		
Bulgaria				1		1	
Burma		1	1	2 (1)			1
Canada			25 (4)		2	1	
China			1 (1)	3 (3)			
Croatia				2 (4)			
Czechoslovakia				1			
Dominican Republic			(2)				
Egypt			1	11 (7)		2	
Eire			3 (1)				
England	3		213 (129)		3	7 (1)	
Fiji		5	1	3			
Germany		1		6 (4)		(1)	
Hong Kong	1			1		1	
Hungary				1 (1)			
India		4 (1)	9 (8)	44 (23)		8	1
Iran						1	
Iraq				32 (17)		10 (6)	
Italy			1				
Japan		2	1				
Jordan				1			
Kampuchea (Cambodia)		1		1 (1)			

continued over...

[ ]= 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 5: Overseas Graduates (clinical evaluation - vocational registration);
Class 7: Overseas Graduates (NZREX - supernumerary attachments).

TABLE 20 cont.

REGISTRATION ISSUED TO OVERSEAS TRAINED DOCTORS
1 April 1997 - 31 March 1998 (cont.)

Primary degree obtained in:	Temporary Registration			Probationary Registration			
	Class 1	2	3	Class 2	3	4	7
Korea			1 (1)				
Latvia				1			
Malaysia	1						
Mexico		1 (1)	1 (1)				
Netherlands			1 (1)			2	
Northern Ireland			1				
Norway				2		1 (1)	
Pakistan			1 (1)	1 (1)	1 (1)		
Papua New Guinea		1 (1)					
Philippines			2 (2)	1			
Poland			1	2 (2)			
Puerto Rico			1				
Romania			1				
Russia				4 (4)			
Scotland		2	44 (20)				
South Africa	1		52 (33)	1	2	6	
Sri Lanka		1 (1)		18 (19)	1	1	
Sweden			2 (1)				
Switzerland		1					
Syria				1			
United States	2	4 (3)	27 (29)				
Wales			17 (7)		2	4	
West Indies			(2)				
Yugoslavia				13 (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 5: Overseas Graduates (clinical evaluation - vocational registration);
Class 7: Overseas Graduates (NZREX - supernumerary attachments).

Council Membership

This report covers the first financial year during which the Council, as constituted and elected under the Medical Practitioners Act 1995, was in office for a full twelve months. Regrettably, the Ministry of Health did not appoint the third lay person until December 1997, so that Council had to carry out its sometimes onerous work for most of the year with only nine members instead of 10. Delays in ministerial appointments, commonplace in many countries, occur because of Ministers' failure to act, not for want of encouragement by boards and councils!

Council membership is constantly changing as elected doctors take their seats along with ministerial appointees, including lay members. At the end of 1997 Council staff were sorry to farewell Dr Ken Thomson and Professor Graham Mortimer, both of whom had a detailed understanding of the challenges facing Council members and staff and an ability to bring good humour, kindness and consistency to their work. A briefing manual for new Council members has been prepared as it is essential that they quickly obtain a broad and reasonably detailed appreciation of the wide range of tasks to be undertaken pursuant to the legislation, bearing in mind the constraints and opportunities inherent in implementation.

New Act Research

In that regard it was exciting to receive the first stage report of research commissioned by Council to evaluate the effectiveness over time of the Medical Practitioners Act 1995. Victoria Link's report entitled "Expectations and Experience of the Medical Practitioners Act 1995" (dated 8 September 1997) highlighted the degree to which practitioners were aware of the Act and perceived its impact upon them. The report also canvassed practitioners' opinions about the main provisions of the legislation. The survey design was informed by 19 interviews with people identified by Council as having a valuable perspective on the new legislation and the strategic forces that led to its development. A survey by postal questionnaire had a disappointing response rate of only 34 percent. Nevertheless, the profile of the respondents very closely matched the profile of the interview sample, giving greater confidence in the findings than might otherwise have been the case.

Only a small proportion of respondents considered themselves to be very familiar with the new legislation and over two-thirds rated themselves not at all or only slightly familiar with the 1995 Act. The chief reason given was that practitioners are deluged by so much information, particularly since the health reforms, that it is impossible to keep up with it all, and difficult to know what is really important.

Respondents were fairly evenly divided about whether the new registration provisions improved public safety. There were some concerns about provisions for general registration and vocational registration. There was obviously an imperative on Council to clearly define supervisors' liability, general oversight, competence programmes and recertification measures. Practitioners were guarded about the latter requirements, many commenting that they would reserve judgement until recertification processes were seen to be working in practice.

As in the key informant interviews, the survey revealed substantial discomfort with the role of the Health and Disability Commissioner in addressing complaints against medical practitioners. The common view was that the balance of complaints procedures has now swung too far in favour of consumers.

On a positive note, most respondents agreed that the functions of the Medical Council outlined in the 1995 Act are appropriate, registration and reviewing competence being seen as the most important.

Fifty-seven percent of respondents were happy with the composition of Council but a number commented that they were unhappy about the number of ministerial appointees, expressing the fear that this could lead to political interference in Council business. When delays occur in ministerial appointments to Council, this fear is heightened.

While three-quarters of respondents believe that Council carries out its tasks in a professional manner, about one-third believe that Council does not keep practitioners well enough informed about what it is doing and about practitioners' responsibilities. In addition, concerns were raised about dissatisfaction with increased regulation and political control, frustration with increases in administrative requirements and costs, and disappointment with reduced potential for exchange of ideas and expertise between New Zealand and other practitioners.

Forward Planning and Process Improvements

Council has made a start on strategic and business planning and staff have committed themselves to education and training in both these areas to improve performance. Staff members have been heavily involved in service delivery, projects and planning. As Registrar and Chief Executive Officer (since my appointment in May 1986), I have been involved in all rounds of policy, communications, management and statutory functions. Key staff members have been heavily involved in reviewing policies and procedures related to all aspects of registration, particularly temporary registration, given the continuing need for competent workers in current shortage areas who will not necessarily form part of the permanent workforce in New Zealand.

Staff turnover has been higher than we would have liked. This, combined with a changing composition of Council and the annual election of President and Deputy President (and concurrently the appointment of committees and conveners), necessitates robust information and transparent communications systems so that valuable historical or organisational knowledge is retained, enabling successive Councils to achieve their mission and vision. Work pressure prevented some staff from taking all leave to which they were entitled. This gives rise to health problems and consideration of this will be a priority when Council actions its decision, taken in December 1997, to appoint a separate Chief Executive Officer. Physical health of staff is important and occupational overuse syndrome a risk requiring management. All work sites were assessed during the year and attention was paid to evening out work loads and flows.

The IT systems review is progressing. Meanwhile, internal e-mail is very useful and external e-mail is being used to a limited extent. The system will be expanded later in 1998 to include a Council website and access to internet and possibly intranet.

Revised agenda and minuting procedures were developed. Draft Standing Orders were formulated to streamline the way Council meetings are conducted and specify timeframes for related papers. Council delegations to committees were refined and included in Standing Orders.

Council staff have a wealth of talent and experience and this is shared via the team management structure, in staff meetings and through regular and comprehensive appraisals, training and coaching.

Organisational Changes

In July 1997 a revised organisational structure was approved by Council and implemented. Lynne Urquhart was appointed Deputy Registrar/General Manager to share the ever-increasing workload in these two areas with myself, Registrar/Chief Executive Officer. We were fortunate to attract

Ros Hall-Jones from Northland Health as the new Standards Manager. Two Customer Services personnel were selected, who not only deal with all person to person, telephone and e-mail reception and faxes, but also provide clerical and word processing services when time permits. New positions were created for an Information Systems Coordinator, an Information Officer (responsible for the workforce survey operation and internal data transfer requirements), a Professional Standards Administrator and a temporary position to handle the reasonably high volume of complaints which do not come within the jurisdiction of the Health and Disability Commissioner.

Extensive office alterations were made to provide more work spaces. The outcome is pleasing but naturally there were disruptions and frustrations during the process. Lynne Urquhart managed this major project effectively with the assistance of Donna Overduin.

With the phasing out of NZREX English and Written (in favour of USMLE Steps 1 and 2 and other approved English tests conducted by outside bodies), the NZREX office in Auckland was closed down at the end of February 1998. At that time Dr Campbell Maclaurin retired as Examinations Director and the post was taken over by Professor Graham Mortimer, recently retired and living in Dunedin. I thank Administrative Secretary Jennifer Hargrave for the substantial contribution she made to the administration of NZREX over a period of eight years, working initially with Dr Gavin Glasgow and then with Dr Campbell Maclaurin. Jennifer is still involved in assisting the NZREX Clinical Auckland Centre Coordinator and is able to provide advice to other centre administrators.

By the end of the financial year the part-time contract for service for a Tribunals officer was nearing the point where it could be terminated. Susan D'Ath, Barrister and Solicitor, has arranged and attended all meetings of the Medical Council in its disciplinary mode (hearing charges and appeals) since 1991. This task has demanded diplomacy, counselling skills, organisational ability, flexibility and patience in varying degrees. Sue has demonstrated these throughout an unprecedented period of disciplinary cases involving serious and often disturbing matters. The size of the discipline fund (and therefore the levy) in the 1990s alone indicates the workload in this area. As we approach the tail end of proceedings pursuant to the Medical Practitioners Act 1968, I record my sincere thanks to Sue for the way she has carried out her duties, often in difficult physical conditions and dealing with very emotional circumstances. Over the years her good work has been acknowledged by Council members, prosecution and defence lawyers, both complainants and doctors complained about, stenographers and venue staff. Her versatility and attention to detail have been great assets to Council.

I also acknowledge the work carried out by the secretariat of the Medical Practitioners Disciplinary Committee. Secretary Roger Caldwell retired from this position at the end of 1997 and having trained his deputy Gay Fraser over many years in this role, was able to hand over to her with confidence. She now provides similar services, with the assistance of Dianne Haswell, to the newly constituted Medical Practitioners Disciplinary Tribunal. Unless one has worked in this demanding area it is quite difficult to understand the dedication which is required, given that the adversarial system of dispute resolution is often a "lose/lose" situation for all parties. Nevertheless, it is an essential element of professional self regulation and must be carried out competently, fairly and reasonably.

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Impairment Programme

Another Council function in which Council staff play a key role is identifying, assessing and monitoring doctors who may have a mental or physical condition which could impair their practice. Lynne Urquhart (assisted by Jo Hawken-Incledon) has effectively managed increasing notifications, in association with the Council's Health Committee. As Council moves into competence review and remediation, the model developed over the last decade by the Health Committee and its support staff provides a fine example of how to implement statutory provisions in a way which enhances respect for Council, reduces risk for patients, and results in continued, even improved, performance by doctors.

Acknowledgements

All staff members make valuable contributions. Jane Lui's team handling registrations have to contend with some disgruntled clients (whose disgruntlement is not always justified) and balance the need for administrative thoroughness with strong listening and problem solving ability. It is therefore disheartening when legal actions or complaints are lodged with the courts or the Human Rights Commission. Council constantly reviews and refines its processes to comply with natural justice, particularly fairness and reasonableness in exercising discretion. Registration is underpinned by the work of the Examinations Committee, supported by Tone Smith, and the Education Committee, supported by Angela Coleman. Both have lengthy experience in other aspects of Council's work. The relatively inexperienced staff in the standards team now grappling with new complaints and competence administration can draw on the knowledge and skills of staff who have been involved with Council responsibilities for many years.

As the Council operation becomes more complex, the need for sound financial management and reporting increases. John de Wever has diligently served the Finance and Management Committee for three years, managing his time effectively to meet all deadlines despite escalating pressure.

Separate Chief Executive Officer to be Appointed

Council's decision to recruit a separate Chief Executive Officer and to renew my contract as Registrar, focusing on planning, policy development, managing risk and performance of all statutory duties as required under the Medical Practitioners Act 1995, is a wise one. I trust that my relations with the President and members of Council, external agencies, the Chief Executive Officer and Council staff will continue to be strong and healthy and that my leadership, judgement and communication skills will be appreciated. I acknowledge the support given me by the new President Dr Tony Baird and his deputy Dr Ian St George.

The attached financial statements cover the year 1 April 1997 to 31 March 1998 and meet the requirements of the Institute of Chartered Accountants of New Zealand.

General Council Operations

Activities funded by fees other than the disciplinary levy and examination fees showed a surplus for the year of $1,038,970 compared with a loss in the previous year of $126,093. Income increased by $1,749,116 whereas expenditure did so by only $584,053.

Income rose mainly because the outgoing Council made a significant increase in the APC fee, based on a budget that acknowledged that new provisions under the Medical Practitioners Act could give rise to new and unpredictable expense in carrying out competence provisions. An increase in the number of applications and the fees for temporary and vocational registration contributed to fees income doubling. Increased reserves led to greater interest received on investments, approximately $130,000 higher than the previous year. Income from other sources was similar to that in the year ended 31 March 1997. Fees collected from overseas trained doctors entering the interview (first steps) of the vocational registration eligibility assessment pathway will be paid out to Council agents (ie, colleges) conducting the interviews. Fees paid in this regard exceed college claims to date by $39,750.

Administration and operating expenses and Council and committee expenses were greater than in the previous year. Higher agents' fees for, and numbers of, registration interviews accounted for a $3,000 increase. Computer consultancy costs rose as the new legislation necessitated continuous modifications to the database systems. Council introduced credit card payment facilities for the Annual Practising Certificate exercise which resulted in charges of approximately $3,000. As customers begin to use credit card facilities for payment of other fees throughout the year these charges will increase but Council considers the service necessary in today's market. Most of the increase under the heading general, archives, cleaning, electricity and equipment hire results from a payment of $16,975 for electricity relating to the period commencing 1 January 1996 when the building manager last did a reconciliation. As a result, Council's monthly electricity bill has increased from $471 to $1,158. Insurance costs increased because Council had to take out professional indemnity cover for the full year, the original cover having commenced only part way through the previous financial year.

In the past medical workforce survey expenses have been shown as a net cost with the government contribution offset against expenses. Now that the operation has shifted from Dunedin to Wellington the level of direct expenses has reduced and indirect expenses, mainly staff time, have increased. Workforce survey revenue is now included under other income.

Publication expenses in the previous year for the report "Maintaining Doctors' Competence" were not repeated, but collation of responses to consultation on the report was an expense this year. Council also commissioned research on the expectations and implications of the new Medical Practitioners Act from Victoria Link at a cost of almost $40,000.

The item public communications includes annual reports for the years ending 30 June 1996 and 31 March 1997, which were both published in the current reporting year, mid 1997. This item also includes printing and postage for the Council's newsletter *MCNewZ*, which costs on average less than $1 per issue per registered medical practitioner practising in New Zealand or overseas.

Changes in the office staff structure increased costs by approximately $208,000.

Council and committee expenses rose partly because fees for a notional eight hour day were increased from $500 to $650 in late 1996. Compared with the previous part year, fees were paid at the higher rate for the full 12 months of the current year. Committee composition and meeting preparation time also affect these costs. A strategic planning meeting was held in July 1997 and in January 1998 Council began meeting monthly between the three-day quarterly meetings. Conferences attended by Council delegates in the year under review included the Annual General Meeting of the Federation of State Medical Boards of the United States in April 1997, a conference of Presidents and Registrars called by the General Medical Council in England in September 1997, the General and Annual General Meetings of the Australian Medical Council in July and November 1997 respectively, conferences in Brisbane and Sydney in November 1997 and March 1998 on postgraduate education and training. The Doctor in 2020 conference at the University of Auckland in February 1998 also involved Council members and staff.

Committee meeting expenditure was similar to the previous year. The Issues Committee was reinstated

Distribution of Council Revenue and Expenditure for the year ended 31 March 1998 General Fund 49%

Revenue

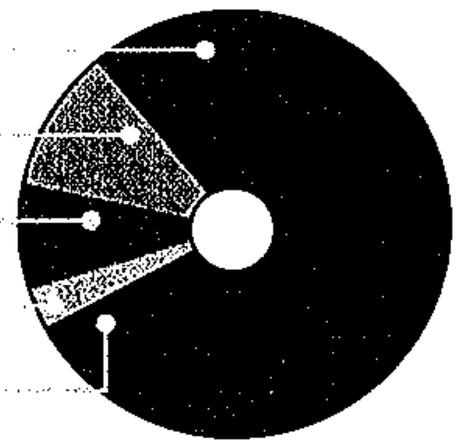
APC fees 74%

Registration and Certificate fees 11%

Interest 8%

Sale of registers and assorted information 3%

Administration fees (transfers from NZREX and Discipline Funds) 4%



Expenditure

Staffing and ancillary professionals 47%

Education Committee activities, incl. hospital visits and intern supervisor honoraria 10%

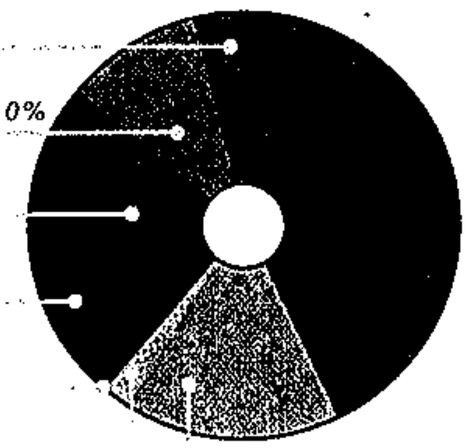
Printing, postage, phone, fax, courier, media 12%

Rent, insurance, equipment, electricity, depreciation, credit card charges 12%

Professional standards and competence 1%

Research 2%

Council and committee meetings 16%



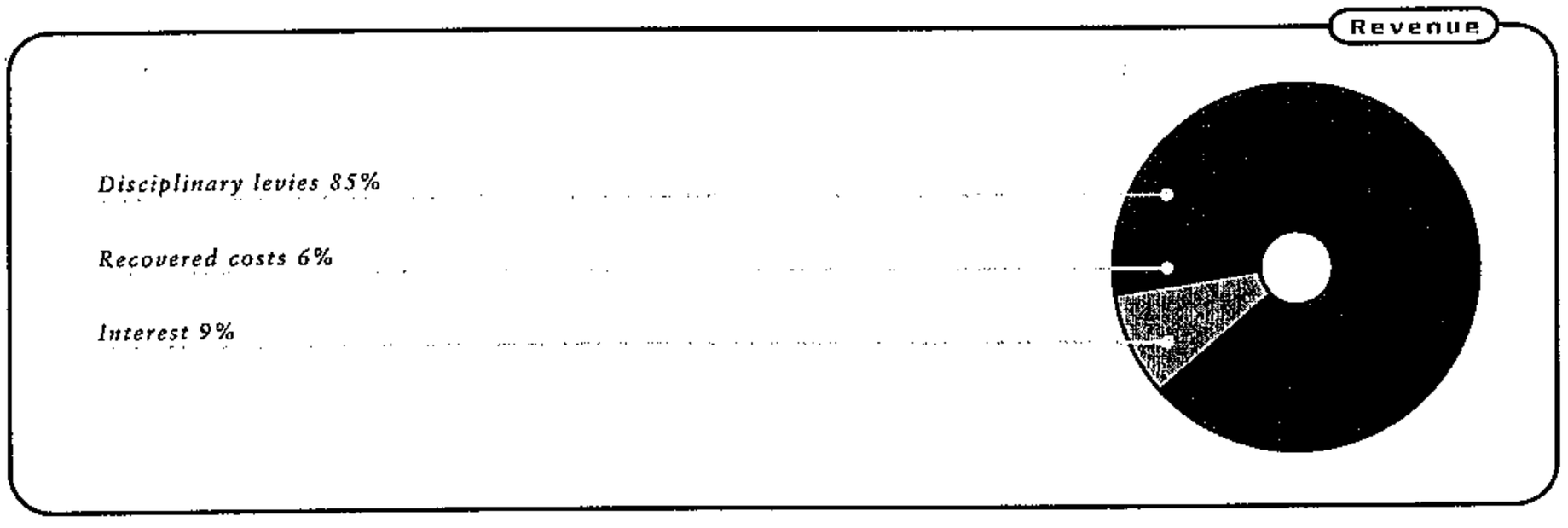
but Data and Communications Committees disbanded. The Education Committee held additional meetings due to volume of work. Three regional meetings for intern supervisors were held in 1997/1998 whereas none were held in the previous year. A new Professional Standards Committee was also established which met regularly to develop policy and procedures related to Council's functions under Part V of the Act.

Discipline Fund

This fund showed a surplus of $1,589,750 compared with a deficit in the previous year of $169,498. Revenue from levies increased by $1,400,000 due to an increase in the levy from $205.56 to $360 (excluding GST) put in place by the outgoing Council. They acknowledged that disciplinary provisions of the new Act had to be implemented parallel to transitional provisions under the old Act. The statement of financial performance for the Discipline Fund has been set out to reflect activities in these two categories. It now appears likely that the 1968 Act transitional proceedings will continue through to the end of the financial year 31 March 1999, or maybe slightly beyond.

Fines imposed and discipline costs recovered are notoriously difficult to predict but were at a remarkably similar level for both years. Interest income increased because of increasing reserves.

Distribution of Council Revenue and Expenditure.
for the year ended 31 March 1998
Discipline Fund 51%



Credit card charges also affected the Discipline Fund for the first time. It is pleasing to note that expenditure on legal opinions decreased significantly. These mainly related to matters concerning the administration of the new Act. Increases in telephone, tolls and facsimile costs are related to administration of Complaints Assessment Committees (CACs). In the year under review, 131 CACs were appointed and 195 determinations reached, compared with 82 CACs and 16 determinations in the previous year. In September 1997, two CAC training meetings were held at a cost of approximately $52,000.

In the previous year the Tribunal was not active in hearings, most costs being related to setting up procedures. In the year under review the Tribunal held a number of hearings and the costs of these, and the administration associated with them, are reflected in a significant increase, approaching $300,000.

Meanwhile 1968 Act transitional proceedings have incurred hearing expenses at roughly the same rate as the previous year, although the majority of hearings have been appeals against Medical Practitioners Disciplinary Committee decisions rather than prosecutions of charges brought by the Preliminary Proceedings Committee. Under the transitional arrangements, the Medical Practitioners Disciplinary Committee has been active over the past year, incurring costs of almost $500,000. Overall, transitional proceedings incurred costs at just under half the rate of the previous year but a further reduction is expected for the year ending 31 March 1999.

As more complaints relate to events which occurred post-1 July 1996, it is anticipated that the costs of CACs will gradually diminish since the responsibility for investigating such complaints under the Code of Health and Disability Services Consumers' Rights rests with the Health and Disability Commissioner's office. Where these lead to charges being heard and found proven, with penalties imposed by the Medical Practitioners Disciplinary Tribunal, however, costs may be awarded in favour of the Commissioner and these debts will be collected as a debt to Council and the Commissioner.

Examination Fund

Examination fees are set on a cost recovery basis. Nevertheless, the Examination Fund ended up with a deficit of $86,887 in the year under review, compared with a surplus of $30,289 in the previous year. This somewhat unexpected outcome resulted from a different examination candidate mix (more Clinical, fewer English and Written) this year as compared with previous years. The per-candidate running costs (separate from overheads) of the Clinical examination absorb approximately 90 percent of the Clinical fee income whereas those of the English and Written examinations absorb only 60 percent of their fee income. As a result of Council's decision to phase out NZREX English and Written in favour of the Educational Commission for Foreign Medical Graduates (ECFMG) examination USMLE, for which Steps 1 and 2 are now the only prerequisites accepted for entry to NZREX Clinical, approximately 78 percent of the Examination Fund's fee income was derived from the Clinical examination, compared with 44 percent in the previous year. Overheads (over and above running costs) were inadequately covered by the fees set in 1996.

From the start of 1998 the Clinical examination fee increased to $2,250 (including GST). A breakeven point has been calculated at the relatively conservative estimate of 300 candidates for the year (360 places are available if required).

Council became aware in December 1997 that there was likely to be a deficit of $90,000 and that has proved true. Based on current candidate numbers we hope that the fund should balance this year. If not, a further fee increase may need to occur. Administrative and operating expenses for the examinations have remained consistent over the last two financial years.

Taxation

As foreshadowed in the 1997 Annual Report, Council established a Special Purposes Fund using the $565,499 refunded to date by the Inland Revenue Department as a result of the final determination of Council's taxation status. A further refund of withholding tax is still awaited. As explained in the notes to the financial statements, this fund is available for designated projects (including research) and risk management.

Reserves

The outgoing Council recommended, and the incoming Council adopted, a policy that reserves approximately equivalent to one year's trading should be held as prudent risk management. Including the Special Purposes Fund, that position should be reached in the coming two or three years.

Finance and Management Committee

The committee has met quarterly and received monthly financial reports within those periods. Budget procedures have been reviewed and refined. Council was pleased to be able to reduce the total Annual Practising Certificate fee, including the disciplinary levy, for the financial year commencing 1 April 1998. All Council fees are published in the *New Zealand Gazette*.

To date expenditure on competence reviews has not impacted on the budget but is likely to do so in the coming financial year.

Although a relatively small proportion of cases considered by the Health and Disability Commissioner, the Director of Proceedings and Complaints Assessment Committees proceed to formal hearing before the Medical Practitioners Disciplinary Tribunal, expenditure in this area is unpredictable and is increasing as CACs established prior to 1 April 1997 bring forward their determinations in 1998 and 1999.

Refunds Introduced in 1998

Early in 1998 Council decided to make available refunds of Annual Practising Certificate fees and disciplinary levies, to a maximum of 50 percent, for practitioners who could demonstrate that they had limited income from medicine, that is, less than $20,000 per annum. This policy will ease the financial burden for practitioners working part-time and those providing voluntary or largely pro bono services as they near retirement. Currently both the General Fund and Discipline Fund are in a healthy state and can absorb the loss of income from these refunds. This situation will be kept under surveillance by the Finance and Management Committee.

Trends

Total General Fund expenditure has increased at a steady pace over the last decade reflecting the volume of work carried out in the Council office and by Council members, pursuant to the legislation. It is pleasing to note that administrative and operating expenses have increased at a slightly lower rate compared with Council and committee expenses. Within administrative and operating expenses, staff salaries and benefits have increased at a slightly lower rate than other outgoings.

Discipline Fund expenditure has fluctuated following dramatic increases in complaints, hearings and disciplinary action from 1990 onwards. Expenditure peaked in 1997 at almost $2,500,000.

In the last two financial years the balance between the APC fee and the disciplinary levy has been restored to close to 1:1. This follows a previous period of seven years when disciplinary activity cost the medical profession considerably more than other functions of Council under the Medical Practitioners Act 1968. Council reiterates that every attempt is made to contain expenditure but the primary consideration must be fair, reasonable and competent administration of the law, a modest price to pay for professional self regulation.

Miller Dean Knight & Little

Chartered Accountants

Medical Council of New Zealand
Auditors' Report

For the year ended 31 March 1998

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 1998. 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 1998 and the results of its operations and cash flows for the year ended on that date.

Date of Opinion

Our audit was completed on 12 August 1998 and our unqualified opinion is expressed as at that date.

Miller Dean Knight + Little

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

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

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.

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

2. 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 has been made for income tax paid plus Resident Withholding Tax deducted to be refunded. A partial refund has been received including some $95,000 use of money interest which relates to the current and earlier financial years. Any interest yet to be received has not been included in these financial statements as the amount is indeterminable.

3. Payments in Advance and Debtors

	1998	1997
Outstanding contribution to workforce survey		38,000
Other debtors	4,829	16,451
Payments in advance	6,610	36,097
	$11,439	$90,548

4. Term Deposits

	1998	1997
ANZ Bank	1,472,553	1,450,350
ASB	956,444	437,789
BNZ Finance	733,563	905,119
Countrywide Bank	1,074,996	500,026
Hong Kong Bank	750,000	
National Bank	693,215	931,344
Taranaki Savings Bank	300,000	
Westpac Trust	1,535,476	1,575,812
Total Investments	$7,516,247	$5,800,440

5. Fixed Assets

	Cost 31.3.98	Depreciation for Year 31.3.98	Accumulated Depreciation 31.3.98	Book Value 31.3.98	Cost 31.3.97	Accumulated Depreciation 31.3.97	Book Value 31.3.97
Computer	396,705	53,656	357,342	39,361	381,907	303,686	78,221
Furniture & fittings	214,602	15,047	133,015	81,587	190,625	117,968	72,657
Office alterations	223,584	17,081	57,977	165,606	109,882	40,896	68,986
Office equipment	114,979	18,855	76,916	38,066	99,951	58,061	41,890
	$949,870	$104,639	$625,250	$324,620	$782,365	$520,611	$261,754

6. Workforce Survey

In previous years the workforce survey was contracted to Otago University with the Council disclosing its share of costs after deducting the government contribution. Council administrative costs were not included. The survey is now undertaken without the need for Otago University services. Council total revenues and direct costs are disclosed. Administrative costs are not included. Comparative figures for 1997 have been adjusted in line with the current practice.

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 1998

	Note	1998	1997
Surplus/(Deficit) for year			
General Fund		1,038,970	(126,093)
Discipline Fund		1,589,750	(169,498)
Examination Fund		(86,887)	30,289
		2,541,833	(265,302)
Add tax refunded/(paid)		422,698	(79,115)
		2,964,531	(344,417)
Add non-cash items - Depreciation	5	104,639	100,366
		3,069,170	(244,051)
Add movements in working capital items			
(Increase)/Decrease in debtors and prepayments		87,553	(49,939)
Increase/(Decrease) in receipts in advance		(845,392)	841,502
Increase/(Decrease) in creditors and GST		(225,057)	265,282
		(982,896)	1,056,845
		2,086,274	812,794
Less items classified as investing activity-interest		(636,322)	(386,043)
Net cash flow from statutory functions		$1,449,952	$426,751

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 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 necessitated a transfer from the Discipline Fund to the General Fund of $94,800 in the year ended 31 March 1997. In the current year these activities have been funded from the general levy portion of the Annual Practising Certificate.

The costs of Complaints Assessment Committees (CACs) have been met from existing financial resources. The extent of financial resources necessary to allow the CACs to assess complaints received since 1 July 1996 is unknown and depends on the length and complexity of the assessment. Expense claims lodged by 30 June 1998 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 and the Medical Council (1968 Act), as well as the new Medical Practitioners Disciplinary Tribunal (1995 Act) are funded from the disciplinary levy. All continue to function while complaints received under both Acts are being considered. The expenditure shown includes all administration and hearing costs.

11. Special Purposes Fund

The Council established a Special Purposes Fund from the taxes refunded by the Inland Revenue Department. These monies will enable Council to meet designated project and research obligations arising from the Medical Practitioners Act 1995 and to provide a risk management contingency fund.

12. Legal Expenses

Legal expenses of $32,824 incurred in the year ended 31 March 1997 relating to the examination and registration of overseas trained doctors were disclosed with general administrative expenses in the New Zealand Registration Examination Fund in the previous financial year. Such costs are now considered to be registration costs and are with other legal costs in the General Fund. The comparative figures for 1997 have been adjusted accordingly.

13. Contingent Liabilities

Complaints have been made to the Race Relations Conciliator's Office. As these are still being investigated it is too early to determine the extent to which Council could be at risk. Other than this, there were no material contingent liabilities at balance date (1997:Nil).

14. Events Occurring After Balance Date

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

15. Commitments - Operating Leases

Lease commitments under non-cancellable operating leases:

	1998	1997
Not more than one year	118,269	118,269
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	19,712	137,981
	$611,057	$729,326

16. 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:

	1998	1997
Receivables	4,829	54,451
Bank balances	7,891,929	6,002,330
Payables	(666,144)	(910,056)

STATEMENT OF FINANCIAL POSITION

As at 31 March 1998

	Note	1998	1997
Current Assets			
Petty cash		200	300
ANZ Bank account		375,682	201,890
Sundry debtors and payments in advance	3	11,439	90,548
Interest accrued		58,404	56,433
Taxation refund due	2	233,727	656,425
Term deposits	4	7,516,247	5,800,440
		$8,195,699	$6,806,036
Fixed assets	5	324,620	261,754
Total Assets		$8,520,319	$7,067,790
Current Liabilities			
Sundry creditors		453,177	629,455
Salaries and Holiday Pay accrued		81,732	54,873
GST		131,235	225,728
Payments received in advance		2,522,277	3,367,669
Total Current Liabilities		$3,188,421	$4,277,725
Capital Account			
General Fund		2,095,769	1,259,724
Discipline Fund		2,617,941	1,395,765
Education Fund		72,517	67,517
Examination Fund	12	(19,828)	67,059
Special Purposes Fund	11	565,499	
		5,331,898	2,790,065
		$8,520,319	$7,067,790

The accompanying notes on pages 65 to 69 form part of these financial statements.

GENERAL FUND

STATEMENT OF FINANCIAL PERFORMANCE

For the year ended 31 March 1998

	Note	1998	1997
Fees Received			
Annual Practising Certificates		2,818,572	1,327,939
Other certificates		22,125	26,931
Registration applications (including Vocational)		372,476	308,157
Vocational registration eligibility interviews		178,585	23,028
Income from Fees		$3,391,758	$1,686,055
Other Income			
Administration fee - Discipline Fund	1	100,000	100,000
Administration fee - Examination Fund	1	60,000	60,000
Health - Transfer from Discipline Fund	10		94,800
Interest received		288,406	157,459
Sales of Medical Registers and sundry income		55,203	46,481
Workforce survey		39,730	41,186
Income from Other Sources		$543,339	$499,926
Total Income for Year		$3,935,097	$2,185,981
Less expenses from Schedule		2,896,127	2,312,074
Net [deficit]/surplus for year		$1,038,970	($126,093)

The accompanying notes on pages 65 to 69 form part of these financial statements.

GENERAL FUND

SCHEDULE OF EXPENSES

For the year ended 31 March 1998

	Note	1998	1997
Administration and Operating Expenses			
ACC levies		13,359	17,086
Agents' fees			
- registration interviews		24,354	21,354
- vocational registration interviews		138,835	23,028
Audit fees		8,000	7,000
Other fees paid to auditors		2,000	1,000
Computer consultancy		70,478	63,920
Credit card charges		3,180	
Depreciation	5	104,639	99,497
Doctors' Health Advisory Service	10	36,382	28,145
Fringe Benefit Tax		7,531	7,515
General, archives, cleaning, electricity, and equipment hire		54,181	26,608
Insurance		30,443	14,479
Legal expenses	12	81,610	75,397
Loss on disposal of assets			869
Medical workforce survey	6	24,266	63,758
Photocopying expenses		30,854	24,067
Postage and courier		53,708	56,023
Printing and stationery		113,440	114,606
Projects			
- Election of Medical Members			32,902
- "Maintaining Doctors' Competence"		6,358	39,227
- "Medical Practice in New Zealand"		6,976	10,675
- New Act research		39,204	427
- Summer Studentship		4,374	3,720
- "Too Many And Too Few Doctors" Conference			4,226
Public communications		111,210	49,972
Rent		118,269	117,709
Repairs and maintenance		19,807	14,408
Salaries, benefits, recruitment and training		1,068,221	859,970
Telephone and tolls		31,301	29,936
Total Administration and Operating Expenses		$2,202,980	$1,807,524

	Note	1998	1997
Council and Committee Expenses			
Council expenses			
- President's honorarium		58,214	63,462
- Fees and expenses		162,749	132,625
- Conference and liaison meeting expenses		63,090	37,323
Data Committee			731
Finance and Management Committee		8,309	9,886
Health Committee	10		
- Fees and expenses		32,074	29,724
- Medical reports		23,790	16,629
- Mentoring		18,809	15,175
Issues Committee		4,646	464
Education Committee			
- Fees and expenses		42,775	25,790
- Hospital visits		30,609	26,262
Intern Supervisors' contract costs		169,761	102,674
Intern Supervisors' meeting costs		21,919	
New Act			1,673
Professional Standards Committee		24,895	1,036
Registration Committee		28,687	36,535
Total Council and Committee Expenses		$693,147	$504,550
Total Expenditure		$2,896,127	$2,312,074

The accompanying notes on pages 65 to 69 form part of these financial statements.

DISCIPLINE FUND

STATEMENT OF FINANCIAL PERFORMANCE

For the year ended 31 March 1998

	Note	1998	1997
Revenue			
Fines imposed and discipline costs recovered		248,770	226,703
Interest received		328,050	198,809
Levies received		3,302,570	1,882,446
Total Revenue		$3,879,390	$2,307,958
Administration and Operating Expenses			
Administration fee	1	100,000	100,000
Audit fees		4,500	3,000
Credit card charges		1,866	
General expenses		10,600	9,476
Legal opinions		3,238	15,944
Projects - Sexual Abuse			13,979
Telephone, tolls, and facsimile		10,078	8,467
Total Administration and Operating Expenses		$130,282	$150,866
1995 Act Process			
Council and Tribunal Expenses			
Complaints Assessment Committees	10		
- Fees		410,418	32,246
- Expenses		425,538	44,654
Complaints brochures		8,833	
Total Complaints Assessment Committees expenses		844,789	76,900
Medical Practitioners Disciplinary Tribunal	10		
- Administration		144,144	43,985
- Hearing fees		81,058	13,000
- Other hearing expenses		124,797	9,529
Total Medical Practitioners Disciplinary Tribunal expenses		349,999	66,514
Total 1995 Act Process		$1,194,788	$143,414

	Note	1998	1997
1968 Act Transitional Proceedings			
Council and Committee Expenses			
Medical Council			
- Discipline fees and expenses		141,547	142,568
- Health fees and expenses			5,842
- Preliminary Proceedings Committee		6,075	61,971
Total Medical Council expenses		147,622	210,381
Medical Practitioners Disciplinary Committee	10	482,065	1,206,847
Doctors' Health Advisory Service	10		6,064
Health - Transfer to General Fund	10		94,800
Higher court actions		40,766	52,270
Legal expenses		259,601	576,871
Mentoring and expert witnesses		2,815	6,199
Stenographers' fees		16,109	13,952
Tribunals Officer		15,592	15,792
Total Transitional Proceedings (1968 Act)		964,570	2,183,176
Total Expenditure		$2,289,640	$2,477,456
Net (deficit)/surplus for year		$1,589,750	($169,498)

The accompanying notes on pages 65 to 69 form part of these financial statements.

NEW ZEALAND REGISTRATION EXAMINATION FUND

STATEMENT OF FINANCIAL PERFORMANCE

For the year ended 31 March 1998

	Note	1998	1997
Revenue			
NZREX candidate fees		676,222	785,826
Interest		19,866	29,775
Total Revenue		$696,088	$815,601
Administration and Operating Expenses			
Administration fee	1	60,000	60,000
Audit fees		1,000	1,000
Centre costs (New Zealand and overseas)		61,168	77,136
Examiners' fees and expenses		540,490	517,498
General administrative expenses	12	18,003	27,416
Honorarium and salaries		92,900	92,106
Total Administration and Operating Expenses		$773,561	$775,156
Committee Expenses			
Examinations Committee fees and expenses		9,414	10,156
Total Expenditure		$782,975	$785,312
Net (deficit)/surplus for year		($86,887)	$30,289

The accompanying notes on pages 65 to 69 form part of these financial statements.

STATEMENT OF CASHFLOW

For the year ended 31 March 1998

	1998	1997
Cash Flow from Statutory Functions		
Cash was provided from:		
Receipts pertaining to statutory functions	6,847,126	5,492,466
Refund of tax	432,408	
	7,279,534	
Cash was also distributed to:		
Payment for Council fees and disbursements and Council office expenses	(5,819,872)	(4,986,600)
Payment of tax	(9,710)	(79,115)
	(5,829,582)	(5,065,715)
Net cash flow from statutory functions	1,449,952	426,751
Cash Flow from Investing Activities		
Cash was provided from:		
Interest received	634,351	361,556
	634,351	361,556
Cash was applied to:		
Purchase of assets	(194,804)	(70,695)
Short term investments	(1,715,807)	(757,780)
	(1,910,611)	(828,475)
Net cash flow from investing activities	(1,276,260)	(466,919)
Net increase/(decrease) in cash held	173,692	(40,168)
Opening cash brought forward	202,190	242,358
Ending cash carried forward	$375,882	$202,190
Represented by:		
Petty cash	200	300
ANZ Bank account	375,682	201,890
	$375,882	$202,190

The accompanying notes on pages 65 to 69 form part of these financial statements.

STATEMENT OF MOVEMENTS IN EQUITY

For the year ended 31 March 1998

	1998	1997
[A] Accumulated Funds and Reserves		
Balance at 31 March 1997	2,790,065	3,055,367
Add: Surplus 1998	2,541,833	
Less: Deficit 1997		265,302
Balance at 31 March 1998	$5,331,898	$2,790,065
[B] Analysis of Individual Funds		
[1] General Fund		
Balance at 31 March 1997	1,259,724	1,390,817
Add: Surplus 1998	1,038,970	
Less: Transfer to Special Purposes Fund 1998	197,925	
Less: Transfer to Education Fund	5,000	5,000
Less: Deficit 1997		126,093
Balance at 31 March 1998	$2,095,769	$1,259,724
[2] Discipline Fund		
Balance at 31 March 1997	1,395,765	1,565,263
Add: Surplus 1998	1,589,750	
Less: Transfer to Special Purposes Fund 1998	367,574	
Less: Deficit 1997		169,498
Balance at 31 March 1998	$2,617,941	$1,395,765
[3] Education Fund		
Balance at 31 March 1997	67,517	62,517
Add: Transfer from General Fund	5,000	5,000
Balance at 31 March 1998	$72,517	$67,517
[4] Examination Fund		
Balance at 31 March 1997	67,059	36,770
Less: Deficit 1998	86,887	
Add: Surplus 1997		30,289
Balance at 31 March 1998	($19,828)	$67,059
[5] Special Purposes Fund [Note 11]		
Balance at 31 March 1997		
Add: Transfer from Discipline Fund 1998	367,574	
Add: Transfer from General Fund 1998	197,925	
Balance at 31 March 1998	$565,499	

The accompanying notes on pages 65 to 69 form part of these financial statements.

CONSOLIDATED STATEMENT OF FINANCIAL PERFORMANCE

For the year ended 31 March 1998

	Note	1998	1997
Income			
Fees received		7,231,715	4,290,113
Interest		636,322	386,043
Other income		343,703	314,370
		$8,211,740	$4,990,526
Expenditure			
Audit fees		13,500	11,000
Other payments to auditors		2,000	1,000
Depreciation	5	104,639	99,497
Loss on disposal of fixed assets			869
Other administrative costs		5,431,499	5,025,753
Rent		118,269	117,709
		$5,669,907	$5,255,828
Surplus/(deficit) for year		$2,541,833	($265,302)

The accompanying notes on pages 65 to 69 form part of these financial statements.

COUNCIL COMMITTEES

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

Registration Committee

[Quorum of Council]

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

Registration Committee

From 31 March 1998

Dr M A H Baird

Dr I M St George

Dr M J Adams

Dr S L Kletchko

Dr T W McKergow

Dr A J Scott

Miss C M Bull

Mrs P C Judd

Mr H T van Roon

Vocational Registration Subcommittee

From 20 February 1997

Dr K J Thomson (Convener)

Dr M A H Baird

Dr S L Kletchko

Registration Advisory Subcommittee

[Replacing previous Temporary Psychiatrists and Vocational Registration Committees]

From 31 March 1998

Dr M A H Baird (Convener)

Dr M J Adams

Dr T W McKergow

Mr H T van Roon

Workforce Data Committee

From 20 February 1997

Mr H T van Roon (Convener)

*Ms G A Jones (Registrar)

Dr A J Scott

Finance and Management Committee

From 20 February 1997

Dr I M St George (Convener)

Dr M J Adams

*Ms G A Jones (Registrar)

Mr H T van Roon

Finance and Management Committee

From 31 March 1998

Mr H T van Roon (Convener)

Dr M J Adams

Professor I J Simpson

*Ms G A Jones (Registrar)

Communications Committee

From 20 February 1997

Dr K J Thomson (Convener)

*Ms G A Jones (Registrar)

Mrs P C Judd

Dr I M St George

Health Committee

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 20 February 1997

Dr S L Kletchko (Convener)

Dr M A H Baird

Mrs P C Judd

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 31 March 1998

Dr M J Adams (Joint Convener)

Dr T W McKergow

Dr A J Scott (Joint Convener)

Mrs P C Judd

Mr H T van Roon

Professional Standards Committee

From 31 March 1998

Dr S L Kletchko (Convener)

Dr M A H Baird

Dr I M St George

Miss C M Bull

Mrs P C Judd

Issues Committee

From 31 March 1998

Dr S L Kletchko (Convener)

Dr T W McKergow

Dr A J Scott

Miss C M Bull

Education Committee

From 20 February 1997

Six members appointed by Council:

Professor I J Simpson (Convener)	Member of academic staff, Faculty of Medicine and Health Science, University of Auckland
Dr M W Ardagh	Selected from vocational branch nominees
Dr M M G Clover	Selected from vocational branch nominees
Dr C M Corkill	Selected from vocational branch nominees
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, Faculty of Medicine, University of Otago
Mr H T van Roon	Lay person
Dr A J Scott	Elected medical practitioner

Examinations Committee

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 Coordinator, Wellington
Dr R P G Rothwell	Examination Coordinator, Hamilton
Professor J B Morton	Examination Coordinator, Christchurch
Dr J J Reid	Examination Coordinator, Dunedin
(vacant)	Education Committee nominee

Education Committee

From 31 March 1998

Council members appointed to this committee:

Professor I J Simpson (Convener)

Dr I M St George

Dr A J Scott

Miss C M Bull

Mr H T van Roon

Non-Council members:

Professor B Gillespie	Member of academic staff, Faculty of Medicine, University of Otago
Dr M W Ardagh	Selected from vocational branch nominees
Dr M M G Clover	Selected from vocational branch nominees
Dr C M Corkill	Selected from vocational branch nominees
Dr M Davis	Selected from intern supervisors
Dr J H Martin	Active consumer of education

Examinations Committee

From 31 March 1998

Council members appointed to this committee:

Dr M A H Baird (Convener)

Professor I J Simpson

Non-Council members:

Professor J G Mortimer	Examinations Director
Dr J P Collins	University of Auckland nominee
(vacant)	University of Otago nominee
Dr P Alley	Examination Coordinator, Auckland
Dr D J McHaffie	Examination Coordinator, Wellington
Dr R P G Rothwell	Examination Coordinator, Hamilton
Professor J B Morton	Examination Coordinator, Christchurch
Dr J J Reid	Examination Coordinator, Dunedin
Dr M Davis	Education Committee nominee

OFFICE OF THE COUNCIL

At 31 March 1998

Registrar/Chief Executive	Ms G A Jones, BA, JP
Deputy Registrar/General Manager	Ms L Urquhart, BCA
Human Resources Adviser (part-time) to 27 March 1998	Ms G Needham, BA (Hons), Dip PM
Senior Secretary	Mrs S A Pett

Registration

Registration Manager	Mrs J Lui
Senior Registration Administrator	Ms D L Crawley, BA
Registration Administrator	Ms C B Andersen, BA
Registration Administrator	Ms A C Cattanach
Registration Administrator	Mr P D Girven, BA
Registration Administrator	Mrs K A Perigo
Registration Administrator	Ms J T Fleming, BA
Registration Administrator (part time)	Ms E Rabone, BCom
Registration Administrator	Mrs M Hall
APC Coordinator (temporary)	Miss C Aitchison, BA (Hons) Crim

Standards

CAC Administrator	Mrs M A Wypych
Education Administrator	Ms A B Coleman, BA
Examinations Administrator	Ms T E N Smith
Health Administrator	Ms J Hawken-Incledon
Health Manager	Ms L Urquhart, BCA
Professional Standards Administrator (part time)	Ms K Orr, BA
Standards Administrator	Miss K Couch
Standards Manager	Ms R Hall-Jones, BSc
Tribunals Administrator (part time)	Mrs S D'Ath, LLM

Corporate Services

Financial Controller	Mr J de Wever
Information Systems	Mr W J Taylor
Information Officer	Mr G S Waite, BA
Administrator	Miss D M Overduin
Customer Services	Mrs D V North
Customer Services	Mrs R Umaga-Ta'ulelei

Location

Level 12

Mid-City Tower

139-143 Willis Street

P O Box 11-649

Wellington

Tel: 04 384 7635

Fax: 04 385 8902

Solicitors

Kensington Swan

P O Box 10-246

Wellington

Bankers

ANZ Banking Group (New Zealand) Limited

Courtenay Place Branch

Wellington

Auditors

Miller, Dean, Knight and Little

P O Box 11-253

Wellington