The Medical Council of New Zealand

A personal and informal perspective

of events during my time as

Chief Executive/Secretary/Registrar from 1986 to 2000

By Georgina Jones  BA, JP
Preamble

This narrative recounts events in the history of the Medical Council as I saw them during the period from 1986 to 2000. I am not a historian, rather a story teller, but I have included some historical background and my interpretation of it, to put the more recent developments in context. In the second part of my story of the Council and its stakeholders I have focused on particular events and recurring issues which put flesh on the bones of medical regulation for community safety.

I was interested to find that Roget categorises the word “history”, under three headings which relate to:

- Retrospection – olden days, lost, passed over
- Record - memoir, chronicle, dossier
- Narrative – portrayal, discourse, commentary.

My contribution to the archives of the Council is a mix of these, combining fact, feelings, philosophy and opinion.

It may not be scholarly work but I hope a future Chief Executive or Chair of Council (even perhaps new members) might find it helpful in understanding the forces which drive regulation, its implementation and constant review - the law, the society, the profession, the politicians, the global context.

Council members and officials have always done their very best to carry out Parliament’s mandate. In the case of the Medical Practitioners Act, this process began just after the New Zealand House of Representatives moved to Wellington, and in the same year added four Maori seats to the General Assembly.

Leadership has been a key to success – but all leaders in time outlive their welcome.

I trust my contribution will be valued in the overall ebb and flow of change, and hopefully improvement.

In my 14 years with Council, and in the time it has taken me to write this story, I have drawn support, skills, inspiration and love from many people, especially my family, old friends and longtime council colleagues. Council’s work is with and for people and that has been a gift to me which I treasure.

Thank You.

GEORGINA JONES
December 2002
# Table of Contents

## PART I

**Regulation of the medical profession**  
- the historical context .......................... 5

1.1 A brief history of the legislation regulating medical practitioners in New Zealand.............................. 6

1.2 Meetings of the New Zealand Medical Board/Council items of interest from early minutes ....................... 21

## PART II

**The Medical Council 1986 to 2000**  
- a personal and informal perspective ..................... 28

2.1 January 1986 to June 1990 - preparing for change  
building human and technological resources .................. 29

2.2 July 1990 to December 1995 - building up to the new Act ................... 49


2.4 1997 - 1998 New Council takes over the reins ................... 73

2.5 1998 - 2000 New Council cracks the whip .................. 78

## PART III

**Commentary on Council and stakeholders** .................. 81

3.1 Council and its office ................................................. 82

3.2 Political and economic realities .................................. 97

3.3 Interface with justice and rights sector ....................... 102

3.4 Voice of society .......................................................... 111

3.5 Workplace relationships ............................................. 120

3.6 Partnerships with education and training providers .......... 124

3.7 Debate and dialogue with doctors organisation .............. 134

3.8 Learning through association with international counterparts ............................................. 140

3.9 Counteracting threats to safety ..................................... 144

3.10 Using feedback loops to foster continuing education and quality improvement ..................................... 149

## APPENDICES

.......................................................... 153

I. Hippocratic Oaths ....................................................... 154

II. Medical Council Staff ............................................... 156

III. Secretaries/Registrars of Medical Council ....................... 163

IV. Ministers of Health ................................................... 164

V. Council Members ....................................................... 165

VI. Committees ............................................................. 170

VII. Milestones 1995 Act : Year One 1997-1998 ................. 185

VIII. Registrar’s Reports 1999 and 2000 ............................. 189

IX. Council Common Seal Drafts 1967 .................................. 191
Glossary

AMC  Australian Medical Council
APC  Annual Practising Certificate
BMA  British Medical Association
Board  Medical Board
Colleges  Vocational Branch Education and Standards bodies for doctors seeking and achieving postgraduate recognition in a particular scope of practice
Council  Medical Council
DCNZ  Dental Council of New Zealand
DDC  Divisional Disciplinary Committee
DG  Director General of Health
DHAS  Doctors Health Advisory Service
Doctor  Registered Medical Practitioner (or seeking registration)
ECFMG  Educational Commission for Foreign Medical Graduates
FTE  Full Time Equivalent
GMC  General Medical Council (of United Kingdom)
HPCA Bill  Health Practitioners Competence Assurance Bill
HRC  Health Research Council
IRD  Inland Revenue Department
(J) RMO  (Junior) Resident Medical Officer
MBChB  Bachelor of Medicine Bachelor of Surgery
MCNZ  Medical Council of New Zealand
MEC  Medical Education Committee
Ministry  Ministry of Health
MPA  Medical Practitioners Act
MPDC  Medical Practitioners Disciplinary Committee
MPDT  Medical Practitioners Disciplinary Tribunal
MRC  Medical Research Council
MRCP  Member of Royal College of Physicians (UK)
MRCS  Member of Royal College of Surgeons (UK)
NZMA  New Zealand Medical Association
NZMJ  New Zealand Medical Journal
NZREX  New Zealand Registration Examination
ODA  Overseas Doctors’ Association
PPC  Preliminary Proceedings Committee
PRENZ  Probationary Registration Examination in New Zealand
RACP  Royal Australasian College of Physicians
RACS  Royal Australasian College of Surgeons
Registrar  Registrar of the Medical Council of New Zealand
RNZCGP  Royal New Zealand College of General Practitioners
RNZCOG  Royal New Zealand College of Obstetricians and Gynaecologists
Secretary  Secretary of the Medical Council of New Zealand
USMLE  United States Medical Licensing Examination
WHO  World Health Organisation
Part I

Regulation of the medical profession -
the historical context
1.1 A brief history of the legislation regulating medical practitioners in New Zealand

Introduction

As far back as the fifth century BC, when the “father of medicine” wrote the Hippocratic oath as a guiding principle, physicians have aspired to live by standards of high professional and ethical conduct. Maintaining the trust and confidence of the public has always been paramount to physicians, giving them a special place in society. Surgeons – originally allied with barbers as part of the guild system – have regulated their own professional and ethical standards since 1745, when the independent Company of Surgeons (later to become the Royal College of Surgeons) was established.

In spite of their history of self-regulation and ethical codes, those wanting to practise the ancient arts of medicine and surgery have not been immune to external regulation. As the structure of society has become increasingly more complex over the centuries, legislative bodies have regulated many aspects of the community, including the medical profession, fearing that chaos, corruption and harm would otherwise result.

Changing fashions have influenced all aspects of rule making. Particularly influential have been a given community’s maturity and level of sophistication; prevalent living conditions; society’s perception of problem areas; ideological theories; and the impact of charismatic leaders.

The word “profession” comes from the Latin for “bound by oath”. While legislation regulating the medical profession has historically respected the oaths of the professions, it has nonetheless sought to impose a level of influence and control from the outside. Political fashions and ideologies, most notably economic trends, have noticeably influenced the construction of medical regulatory legislation in New Zealand, impacting heavily on the various parties considered to be the main “stakeholders” in medical registration and standards.

In recent years, Western culture has been particularly influenced by economic ideologies, globalisation, a high value placed on personal autonomy, and technical advances. Modern values such as transparency and cultural safety have had a huge impact on the way in which society’s perceived needs are debated within the parliamentary context and then constructed into laws.

Regardless of the dominant values of the times, and the processes by which a community develops laws, the content of laws is only ever a means to an end. Ultimately, the systems of rules we incorporate into laws are no more than tools. As such, they inevitably have limited lives, periodically needing to be sharpened, or thrown out altogether and new tools built.
When it comes to regulating professional and occupational groups, particularly powerful and often contradictory forces come into play, for example, respect and suspicion, trust and mistrust, and perceived benefits as against risks and costs. These external forces, alongside the hopes and aspirations of the group being regulated, contribute to parliament’s decisions. Realistically, no legislative system will ever meet fully the expectations of all interested parties. While the goal for the legislation needs to be kept in view on the horizon, compromise is nonetheless inevitable.

When I look back on the history of medical regulatory legislation in New Zealand, a life cycle is apparent. As soon as one interested party sees the need for change but other interested parties have more urgent priorities on their agenda, frustrations inevitably come to the fore. Although legislation could never evolve without compromise, it seems that over the last 135 years, bargaining and expediency have frequently led to law changes that have not always worked as well as intended.

Members of professions have traditionally preferred soft regulation, meaning that they want a reasonably high degree of autonomy within a framework acceptable to non-members. In particular, professionals place a high value on retaining the capacity to deal independently with aberrations within their own professional group, such as poor conduct or poor practice due to ill health or incompetence.

Generally speaking in occupational regulation, public safety is the government’s paramount concern. Failure to observe standards not only places the public at risk, but also undermines the integrity and professionalism of the occupational group concerned. In medicine (and other health professions), the main questions asked in relation to public safety are:

- What does “the practice of medicine” actually mean? That is, how are the parameters of the professional activity defined and delineated?
- How well are doctors expected to perform?
- What happens if things do not go well?
- Who can report “poor conduct” and “poor practice”, and to whom?
- What sanctions and remedial measures are available?
- How is the register of those medical practitioners considered entitled to practice to be kept and controlled, and how does the public access the register?

New Zealand’s legislative history has, perhaps not surprisingly, resembled a pendulum over the last 135 years; it has swung back and forward between much fine print and relative controls on the one hand and, on the other hand, more enabling legislation. The current Medical Practitioners Act 1995 conforms to the prevailing preference for enabling legislation. It provides a clear legislative framework while allowing registered medical practitioners a reasonable degree of autonomy and discretion. This flexibility has the advantage of avoiding the need for constant referral to the legislative body whenever change, in whatever form, becomes
necessary. As history has shown, however, such enabling legislation cannot and should not be taken for granted.

*Medical Practitioners Act 1867*

The first statute to regulate the medical profession in New Zealand came into effect on 10 October 1867. The Medical Practitioners Act 1867 was passed by the United Kingdom legislature for the (by then) self-governing colony of New Zealand. The Act constituted New Zealand’s first Medical Board, and defined the qualifications required of practitioners in medicine and surgery.

The 1867 Act permitted the Governor of New Zealand, then Sir George Gray, to appoint a Medical Board of at least five and up to ten members, not less than two thirds of whom were required to be medical professionals qualified to be registered. The Governor was able to nominate one of the members as President of the Board, holding a five-year term with the right of reappointment. Sir James Hector (1834–1907), doctor, scientist, adventurer and entrepreneur, after whom the Hector’s dolphin is named, presided over the first Board.

The Medical Board was expected to meet in its first three months and to make rules; the President and Deputy President were able to appoint a Registrar/Treasurer and “clerks and servants”. Interestingly, the Act allowed for a member of the Board to also hold the office of Registrar or Treasurer. Registration fees were to be paid to the Governor, who could then reimburse the Board at his discretion. Accounts were to be kept and annual financial status reports as at 31 March were to be made to the Colonial Treasurer in April of each year. The fees collected were to be used for registration and administration of the Act, with any surplus going to the Treasurer.

The 1867 Act empowered the Registrar to keep a register of doctors, to change their addresses on the register when necessary, and to remove from the register the names of doctors who had died. Physicians and surgeons applying for registration were required to produce evidence of their qualifications and their addresses. In provinces other than Wellington, a member of parliament or the resident magistrate in the chief local town was authorised to verify the authenticity of qualifications.

Applicants for registration were required to have qualified through a medical course of not less than three years’ duration, and to have received a diploma, degree or licence from a University, College or other body. The Medical Board was also able to register, without further assessment, legally qualified practitioners from England, Scotland, Wales and Ireland.

In order to be entered on the first New Zealand Medical Register, doctors had to produce evidence that they had been in medical practice before 1857 (under the Ordinance of the Legislative Council of New Munster – a province covering part of New South Wales and part of New Zealand – in
effect in 1857 but repealed by 1867). If the doctor resided in Wellington, a
certificate of practice issued by the Superintendent of the Province of
Wellington was deemed sufficient. Doctors legally qualified to practise
medicine and surgery in any of the Australian colonies at the time were not
required to register separately in New Zealand.

Under the 1867 Act, the registration fee was five pounds and doctors had to
present their qualifications in person to the Board. Registered medical
practitioners were required to keep their addresses up to date and, if no
reply was received to a registered letter to their last known address, their
names were to be erased from the register. The Registrar of Births and
Deaths was required to notify the Board when a doctor died.

So that the public could easily identify unregistered persons or quacks, the
Act protected the following titles:
- physician
- doctor of medicine
- licentiate in medicine
- doctor
- surgeon
- medical and general practitioner
- apothecary
- surgeon-apothecary
- accoucheur (male “midwife”)
- licentiate or practitioner of midwifery.

Doctors were accorded a grace period of 182 days from the commencement
of the Act to get themselves onto the register. If they had not done so
within that time, unregistered doctors could be fined up to fifty pounds.
(This compares dramatically with the fee to deposit qualifications under the
Medical Act 1908 of only one pound!)

The 1867 Act allowed registered doctors who were legally or duly
qualified as medical practitioners to sue for fees. Under the Act, no
unregistered person could hold any medical appointment as a physician,
surgeon or other medical officer in any hospital, infirmary, dispensary,
lying-in hospital, lunatic asylum, gaol, penitentiary, house of corrections,
house of industry, or other public institution for affording medical relief in
sickness, infirmity or old age, or as a medical officer in the militia or
volunteer force. Those found to be holding fraudulent qualifications were
removed from the register. Registered medical practitioners could add their
higher qualifications to the register, which was published annually in the
New Zealand Gazette and constituted evidence of registration for the
courts.

The Act was clear that it did not cover the practice of chemists or druggists,
and it required that the British Pharmacopoeia be used in New Zealand
hospitals.
It is remarkable how closely the provisions of the 1867 Act mirror 21st century legislative provisions.

Medical Practitioners Act 1869

In 1869, the General Assembly of the New Zealand parliament repealed the 1867 Act. The Medical Practitioners Act 1869 came into effect two years after parliament was moved from Auckland to Wellington, a period when the administrative structure of New Zealand was becoming generally more sophisticated. Amendments to the 1867 legislation included the following requirements:

- the Registrar General, as well as the Registrars in Auckland, New Plymouth, Napier, Nelson, Hokitika, Picton, Christchurch, Dunedin and Invercargill, had to keep a register;
- applicants for registration had to publish in the newspaper and in the New Zealand Gazette notice of their intention to apply, 30 days in advance;
- applicants had to produce evidence of their qualifications (or copies certified by a Justice of the Peace) to the relevant Registrar;
- applicants could appeal any decision of the Registrar not to enter their name on the register;
- doctors would be removed from the register for providing false or fraudulent qualifications or information; and
- doctors convicted of a felony or misdemeanour in Great Britain or Ireland, or in any of the British Dominions, would be removed from the register.

In line with other punitive measures of the times, the 1869 Act viewed fraudulent procurement of registration extremely seriously; if convicted, the felon was liable to imprisonment – plus or minus hard labour – for up to three years.

Medical Practitioners Act 1905

In 1904, 90 students graduated MBChB (NZ). On 27 October 1905, the 1869 Act was amended to include registration of medical graduates of foreign universities, whose diplomas were not recognised by the Governor in Council, provided that the doctors passed the University of New Zealand’s final medical examination. The Otago Medical School had been set up in 1875, with a Faculty of Medicine as such in place from 1891. From 1885 there was a “full curriculum” (four years) modelled on GMC recommendations. Powers were given to the Board to remove the name of any doctor registered by the General Medical Council of Great Britain (GMC) if that person’s qualification had been withheld, or found to have been false or misrepresented. On application by the President of the New Zealand branch of the British Medical Association, the Supreme Court of New Zealand could remove the person’s name.

Medical Act 1908

MCNZ - Georgina Jones perspective 1986-2000
In 1908, the General Assembly of New Zealand passed a consolidated Act bringing together the Medical Practitioners Act 1869, the Anatomy Acts of 1875 and 1884, and the Medical Practitioners Act 1905. The Medical Act 1908 was set up in two parts; one to regulate the registration of medical practitioners, and the other to regulate the practice of anatomy.

In relation to the registration of medical practitioners, the Registrar General as well as the Registrar in named towns kept a register and issued certificates of registration. The register had to be open for public inspection and, as with earlier legislation, the register could be corrected and higher qualifications added. The register had to be published annually in December in the New Zealand Gazette. Recognised medical qualifications were set out in a Schedule to the Act.

The fees for the various services, all of which went into a Public Account, were:
- to deposit qualifications - one pound
- to issue a certificate of registration - five shillings
- to alter details on the register - ten shillings
- to add a new qualification - five shillings
- to inspect the register - two shillings

The second part of the Act, which dealt with the practice of anatomy, identified recognised schools of anatomy and made rules pertaining to them.

*Medical Practitioners Act 1914*

Until 1914, legislation regulating medical practitioners provided them with a reasonable degree of autonomy once registered. The Medical Practitioners Act 1914, however, was passed as the world was experiencing horrendous conflict and destruction with World War I. The 1914 Act, which came into effect on 1 March 1915, was entitled “An Act to make better provision for the registration and control of medical practitioners [emphasis added]”. The Act reflected the climate of distrust at the time.

The 1914 Act was set out in a format very similar to what we still have. It was the first modern Act. In contrast to the Medical Practitioners Act 1995, however, it was highly prescriptive.

The 1914 Act established a Board of seven members, being the current Inspector General of Hospitals and six doctors, all of whom held three-year appointments. The Board was required to appoint a Chairman annually to preside, and the quorum was four. There were no non-doctors on the Board.

The legislation required the Board to determine every question before it by a majority vote of members present, the Chair having a deliberative and casting vote. The Minister of Internal Affairs was to call the first meeting and, thereafter, the Chair or Registrar was entitled to call meetings. The
Governor of New Zealand, in 1915 the Earl of Liverpool, was entitled to make rules; if none were made, the Board was able to regulate its own procedure.

Only medical degrees requiring not less than five years of study were recognised for registration, and the Act included the following registration requirements:
- applicants to send their documents to the Registrar General, or to a country office for the Registrar who would then send them to the Board;
- the Registrar of Births and Deaths to notify deaths of practitioners to the Board; and
- registered medical practitioners to notify their changes of address, or face removal from the register if they failed to do so and could not be located.

The 1914 Act continued to allow for additional qualifications to be entered into the register, the Registrar being required to send all additional qualifications to the Board for processing. If an application was refused, a registered medical practitioner had the right to appeal to the Supreme Court, which was also given the power to remove from the register any doctor found guilty of “grave misconduct” or of an indictable offence. Practising without registration attracted a penalty, as did accepting commissions from a chemist.

All fees connected with the register went into the government’s consolidated fund. The register was published and updated in the New Zealand Gazette annually on 30 April. Provisional certificates were issued for a maximum of three months, during which time the applicant was deemed to be registered.

The 1914 Act did not affect or regulate the activities of chemists, dentists, midwives or nurses. The register in existence when the 1914 Act was passed was transferred to the Registrar General, the names of deceased doctors, or those who were non-resident or disqualified, having first been deleted.

These provisions in the 1914 Act demonstrate that the government had a direct relationship with, and control over, the registration of medical practitioners. In the climate of the time, safety and conserving scarce resources took precedence.

*Medical Practitioners Act 1924*

The first Medical Council of New Zealand was constituted with the passing of the Medical Practitioners Act 1924, replacing the Medical Board. The 1924 Act amended the 1914 Act, and gave the new Council a little more autonomy than the Medical Board had had to date. For the first time, the Council had disciplinary powers, powers which remained until they were
transferred to the Medical Practitioners Disciplinary Tribunal which was established under the Medical Practitioners Act 1995.

Reading between the lines, I suspect the 1924 Act is probably evidence of a period of what would now be known as “health sector reform”. Under the 1924 Act, the Inspector General of Hospitals became known as the Director General of Health, and the powers of the Registrar General were transferred to him. The powers of the Registrars of Births and Deaths in Auckland, Wellington, Christchurch and Dunedin were at the same time transferred to Medical Officers of Health in those cities, the Registrar General and the Registrars of Births and Deaths being required to send files on doctors’ qualifications to the Director General and all the medical officers.

Up until 1924, the Governor of New Zealand had appointed all Board members. Under the 1924 Act, membership requirements for the Council were extended to include:

- one member to be appointed on the recommendation of the New Zealand branch of the British Medical Association; and
- one member of the Otago Faculty of Medicine, who was also a member of the Board of Health, to be appointed.

The additional membership requirements were to be instituted when the next vacancies arose on the Council.

In relation to medical practitioners holding “foreign” diplomas (that is, qualifications not from Great Britain or Australia), the 1924 Act empowered the Council to require those doctors to pass an examination in medicine and surgery conducted by the University of New Zealand’s senate. The Council could remove from the New Zealand register any United Kingdom or Dominion doctor whose name had been removed from the register in that country or any other country.

The 1924 Act and Discipline

The 1924 Act set in motion the beginnings of the Council’s disciplinary powers. It provided detailed provisions and procedures for action if there was reason to believe that a registered medical practitioner was guilty of “impropriety” or “infamous conduct in a professional respect”.

In summary, the Act set up the following disciplinary process:

- a notice was to be served on the doctor, setting out the alleged grounds of “impropriety” or “infamous conduct in a professional respect”;  
- the doctor was required to appear before the Council to answer the allegations; and
- if the doctor failed to appear and answer the allegations as requested, the doctor had to explain why.

Disciplinary action could be taken against a doctor who did not appear before the Council, and a suspended doctor was deemed not to be
registered. There was a right of appeal to the Supreme Court within 21 days. No doctor could be found guilty of “impropriety” or “infamous conduct in a professional respect” merely for “adopting or practising” any theory of medicine or surgery, so long as the doctor did so honestly and in good faith.

For the first time, the 1924 Act also directly addressed the issue of “impaired doctors”, albeit under the disciplinary provisions. Any doctor who had been an inmate in an institution under the Mental Defectives Act 1911, either as a committed patient or as a voluntary boarder, could not resume practice without a licence from the Council.

*Finance Act 1932 - 33*

The Medical Practitioners Act 1924 appears to have remained untouched until 1932, when the legislature introduced an additional method of funding medical regulation. Under the Finance Act 1932-33, doctors were required to hold an Annual Practising Certificate (APC) for the period 31 March to 31 March annually. Once an APC application had been made, the certificate was deemed to have been received by the doctor. Doctors employed by government, or who rendered service in an emergency or held a provisional certificate of registration, were exempt from the requirement to hold an APC.

*World War II*

The effect of World War II on New Zealand’s working population led to emergency regulations being passed. In 1941, the government anticipated a shortage of doctors in New Zealand, many of whom were going overseas to assist in the war effort. It thus passed an emergency regulation which empowered the Council to issue provisional registration certificates to medical students. The certificates allowed the students to practise as registered medical practitioners, so long as they intended to graduate after passing all clinical and other examinations in their first five years of training, and to complete the sixth year (later to be known as the “trainee internship”), then the final year of clinical training.

*Medical Practitioners Act 1950*


The 1950 Act introduced a compulsory internship scheme (the seventh year of a doctor’s training), effective from December 1952. This development synchronised with an equivalent provision in the United Kingdom initiated by the GMC. To retain reciprocity, it was necessary for other members of the Empire to fall into line. After the New Zealand scheme was introduced,
the term “conditional registration” differentiated these graduates, now interns in their seventh year of training, from doctors who had been granted “registration as a medical practitioner”, that is, full registration. This innovation was designed to prepare graduating doctors for private practice. Conditional registration could only be undertaken in approved hospitals, gazetted by the Council. However, there was still no probationary registration for doctors with “foreign” qualifications.

The Medical Practitioners Act 1950 also constituted the Medical Practitioners Disciplinary Committee (MPDC). The MPDC comprised four doctors appointed by the Council of the New Zealand branch of the British Medical Association and one doctor, not being a Medical Council member, appointed by the Minister of Health. The Act allowed the committee to elect its own Chair, and established a committee quorum of three members. It also stated that the general secretary of the New Zealand branch of the British Medical Association was to be the disciplinary committee secretary.

Another tier to the disciplinary structure was also established – divisional disciplinary committees (DDCs) were set up, with one of the committee members appointed as honorary secretary. The MPDC could ask the local divisional committees to conduct all or part of an enquiry. All reports of enquiry outcomes were to be sent to the Medical Council.

The Council was also empowered to appoint a legal assessor and disciplinary findings could be published in the New Zealand Medical NZMJ (NZMJ). The 1950 Act, however, did not develop further provisions for dealing with “impaired doctors”.

Amendments soon followed!

From 1950, a long period of ad hoc amendments followed before the 1968 Act was drafted. The amendments included changes to the qualifications required for conditional registration and registration as a medical practitioner, a new penalty for wrongful use of the title doctor and, in 1954, provision for temporary registration for visitors coming to New Zealand to carry out postgraduate teaching or to gain experience.

In 1957, a further amendment streamlined the disciplinary regime by:
- allowing the chairs of disciplinary committees casting votes;
- setting out the functions of the disciplinary committees;
- creating an Investigation Committee to enquire into complaints which possibly amounted to grave impropriety;
- clarifying the disciplinary powers of the Council and giving a right of appeal to the Supreme Court; and
- permitting disciplinary committees at all levels to engage legal assessors.

In 1957, all the 1908 to 1957 statutes were reprinted into one volume, consolidating all the changes made during that time. Clearly, a new Act
was soon going to be necessary, but it was not long before more ad hoc amendments were being made.

In 1962, the 1950 Act was further amended to permit the Council to:
- become a body corporate
- elect a Deputy Chair
- engage a Secretary and other officers
- call meetings, pay fees and travel allowances, and receive payments for expenses.

Nevertheless it was some years before the Council could afford to move out of the Department of Health’s offices.

In 1962, “notification of disability” became mandatory. Provision for the enforcement of contracts for bursars was implemented. Again, the Council’s powers to discipline doctors were clarified, as were the required qualifications for conditional registration and registration as a medical practitioner. The Act continued to provide for restoration to the register, change of name, and removal from the register on request.

*The Medical Practitioners Act 1968*

Finally, on 11 December 1968, a new Act was passed. The Medical Practitioners Act 1968, which came into effect on 1 April 1969, was described as “an Act to consolidate and amend the law relating to the registration and control of Medical Practitioners”.

This Act established a new body called the Medical Education Committee (MEC), separate from the Medical Council and with its own specified composition, functions and powers. Membership of the MEC included the Dean of the new University of Auckland School of Medicine, which was established in 1968.

Under the 1968 Act, the Investigation Committee was renamed the Penal Cases Committee (PCC). The PCC comprised two members of the Council and a solicitor of the High Court, and was charged with investigating complaints to the Council concerning the conduct of any registered medical practitioner. (In 1983, an amendment introduced another change of name, the PCC becoming the Preliminary Proceedings Committee or PPC.)

There continued to be a Medical Practitioners Disciplinary Committee, comprising four doctors appointed by the New Zealand Medical Association (which gained independence from the British Medical Association in 1967), and a fifth doctor appointed by the Minister of Health.

Although the Council had been incorporated in 1962, the 1968 Act clarified that the Council had been given the power to borrow and to invest, that is, to be financially self-sufficient.
The 1968 Act changed the composition of the Council to 11 members. With the exception of the ex-officio members, all were appointed by the Governor General on the advice of the Minister of Health. Under the 1968 Act, the Council’s membership comprised:

- the Director General of Health (ex-officio member)
- the Dean of the Auckland School of Medicine (ex-officio member)
- the Dean of the Otago School of Medicine (ex-officio member)
- two members nominated by the New Zealand Medical Association (NZMA)
- four members nominated by colleges, namely the Royal New Zealand College of General Practitioners (RNZCGP), the Royal Australasian College of Surgeons (RACS), the Royal Australasian College of Physicians (RACP), and the Royal New Zealand College of Obstetricians and Gynaecologists (RNZCOG)
- two members chosen by the Minister of Health

Finally, in 1983, a lay member was added to the Council’s composition, bringing the total number of members to 12.

The 1968 Act also empowered the Council to:

- enter additional qualifications to the register;
- amend the register if a doctor had been wrongfully registered;
- take a doctor off the register if that doctor had been removed in another jurisdiction;
- set up a register of specialists; and
- suspend, if necessary, any doctor notified to it under the now mandatory notification of disability provision.

Further reforms to disciplinary procedures included clauses concerning payment of witnesses and the power to adjourn or postpone hearings.

**Amendments in the 1970s**

In 1970, the 1968 Act was amended to:

- create a new registration category probationary registration, to permit initial registration (after assessment of knowledge and English communication) of foreign doctors;
- set out postgraduate qualifications which could be considered as a basis for probationary registration, as well as overseas qualifications; and
- empower the Minister of Health to require the Council to produce statistical data on its activities, for which the Minister could make a financial contribution.

In 1972, an amendment empowered the Medical Education Committee to include the recently appointed Deans of the Christchurch and Wellington Clinical schools, which had been opened as part of the University of Otago.
A number of amendments to the Medical Practitioners Act 1968 made in the 1970s demonstrate that parliament was becoming increasingly preoccupied with grappling with issues surrounding the registration of “foreign” doctors; that is, doctors trained in countries outside New Zealand, Australia, the United Kingdom, the Republic of Ireland, Canada, South Africa, and some other former Empire territories, who could not be registered without further examination.

The amendments also reflected changing relationships within the British Empire, as countries such as Ceylon and Hong Kong became more self-determining, and in some cases changed their names. Some amendments related to changes of names of countries, for example Ceylon to Sri Lanka, and to changes in accreditation of some universities in Canada. In 1974, however, recognition of graduates from Sri Lanka for provisional registration was withdrawn effective from the beginning of 1975. In 1976 the same rule was applied to Hong Kong, Singapore and Malta, members of the Medical Council of New Zealand having inspected some of their schools, with financial assistance from the Department of Health.

In 1973, an amendment permitted the Penal Cases Committee to appoint one of its members as a convenor.

In 1977, a clause relating to “doctors duties when providing or being asked to provide advice on family planning” appeared for the first time. By this time, oral contraceptives and abortion services were more accessible, provoking a strong stance from the Society for the Protection of the Unborn Child (SPUC). Some doctors were reluctant to provide their services. The hot debate caused some difficulty for the Council, as the Chair of SPUC, Mr Dalgety, was a leading light in the public debate and also at that time the Council’s legal assessor. The new clause required doctors to refer patients on if, for conscience reasons, they did not want to advise or prescribe for a patient seeking contraception.

There were further amendments to the legislation in 1977 and 1978, including a change in membership of the MPDC; it was revised to four doctors appointed by the NZMA, and a doctor and a lay member appointed by the Minister, the first lay member on any professional disciplinary body. The Council had to wait another five years!

In 1979, the Act was amended to allow the Council’s constitution to drop the term “Dominion” and to recognise the Royal New Zealand College of General Practitioners, which in 1979 gained permission from the British College to use that title.

Competence in English was added as a requirement for conditional and probationary registration. In principle, probationary registration could be undertaken in hospitals or general practices.
The Council’s finances and creation of an independent office

Towards the end of the 1950s, the Medical Council was struggling to carry out all the functions it wished to, suffering from restricted funds and a lack of control over setting its own fees and budgeting. These matters go to the heart of the principle of self-regulation, as seen from the perspective of doctors and other professionals. In 1961, the Council was in a serious state financially, having been unsuccessful in its bid to obtain Cabinet approval for an ex gratia grant of five thousand pounds to cover its deficit.

Legislation affecting the medical profession and the Council seemed to be getting the football treatment in parliament – at one stage, the Minister of Finance even suggested that the Council take out a loan from the British Medical Association! Apart from finance and autonomy, there also appears to have been concern about possible conflicts of interest, with the Director General of Health, at that time Dr Turbott, receiving complaints and also sitting as of right on the Council itself.

Body corporate status for the Council had first been endorsed in principle by the Minister of Health in 1957 and 1960. Due to administrative oversights and changes of government, however, no action had been taken. It was a classic example of desirable changes being stalled by changes in government.

For the first decade, 1986-1996, when I was Council Chief Executive and Secretary, we again had to cope with the frustratingly slow process of dealing with a legislature more committed to the big picture than to the needs of individual bodies.

In 1962, however, Cabinet did finally approve draft legislation to grant the Council body corporate status. In his speech on the second reading of the Medical Practitioners Amendment Bill 1962, then Minister of Health Mr Don McKay stated in support of body corporate status for the Medical Council:

“The medical profession is an honourable, highly respected, responsible profession of long standing. It is well able to protect the public interest and its own reputation.”

The leader of the opposition, Sir Walter Nash, was not similarly inspired to see the Medical Council as autonomous, saying, “The responsibility for the management of the profession ought to be shared and the government ought to know how the body is taking care of the country”.

The Bill was duly passed and, effective 1 April 1963, the Medical Council had body corporate status, and therefore the ability to disassociate from the Department of Health.
For several years, however, the Council continued to be frustrated by an inability to shift physically from the premises of the Department of Health, due to lack of funds. By comparison, other professions (including lawyers, accountants, architects, and engineers) as well as “neo-professions” such as pharmacists were already financially autonomous in managing their own registration requirements and standards to protect the public. The Medical Research Council (now the Health Research Council) had already been accorded body corporate status, although it was entirely funded by government grants.

In 1966, the Council finally achieved its goal of setting up an independent secretariat, taking up a joint tenancy with the Medical Research Council in Mayfair Chambers. The MRC owned all the equipment, and employed all the staff, the Medical Council paying a proportion of costs for the MRC’s services.

On 7 and 8 September 1966, the Council held its first meeting at Mayfair Chambers. The Council’s Chair, Dr John Mercer, thanked the Minister of Health, Mr Don McKay, for the Department of Health’s previous assistance with facilities, use of a boardroom, and legal advice. The MRC’s chair, Mr T.H.C Caughey, was thanked for “his vision and appreciation of [the] Council’s requirements”.
1.2 Meetings of the New Zealand Medical Board/Council – items of interest from early minutes

Introduction

In perusing the minutes of meetings of the New Zealand Medical Board/Council since 1915 (when the Board was removed from the authority of the Registrar General and became directly associated with the Director General of Health), I have a sense of déjà vu from my perspective as the Council’s former Secretary/Registrar.

Meetings during World War I

The Medical Practitioners Act 1914, which came into effect on 1 March 1915, was expected “to make better provision for the registration and control of medical practitioners”. As authorised by the Act, the Registrar General Mr Mansfield called the first meeting of the new Medical Board. The meeting commenced at 10am on 31 March 1915 in the room of the Chief Health Officer, Dr J N A Valentine.

The members of the first Board constituted under the 1914 Act as listed in the minutes were:
- William Irving MD Cambridge MRCS England LRCP London
- Sir William Henry Parkes CMG CBE MBMS Edinburgh
- James Sands Elliott MD BSEd, FRCS Edin
- William Newlands BS Edin FRCS Edin
- Sir Henry Fergusson MD CMG
- Joseph Edward Wilson Somerville MD MS Edin 1895.

Drs Irving, Parkes, Elliott, Newlands and Fergusson were present, along with Mr Mansfield and an official from the Health Department, Mr T. Hope Lewis, who took the minutes and acted as the Board’s Secretary. The Board elected the Chief Health Officer, Dr Valentine, as its first Chairman.

What is now recognised as core business was transacted that day. The Board:
- granted registration to four new graduates with the degree MB BCh New Zealand 1915, and to four other doctors holding provisional registration;
- instructed the Secretary to obtain the syllabuses of various examining bodies;
- declined registration to a Dr Sloane, as he held an Ontario degree for which there was no reciprocity with New Zealand without further examination;
- resolved to recommend to government that it set up machinery for an examination for such people as Dr Sloane;
- removed from the register the names of a number of deceased doctors, as well as the names of some who had moved leaving no new address
(a registered letter system having been implemented to track such doctors);

- instructed the Secretary to send a circular to all practitioners urging them to “dissociate themselves” from chemist shops;
- discussed a Dr John Freeman of Waipawa, who had written a death certificate for a seven-month infant although he was unregistered, and resolved to report the matter to the District Health Officer and then to Crown Law;
- agreed that the 1914 Act needed amending to bring it back into line with the 1908 Act so that it was clear that unregistered medical practitioners were not to sign certificates;
- agreed that only registered medical practitioners should be included in the telephone lists and that the Post and Telegraph (P&T) should be instructed accordingly;
- agreed that the Secretary should send a synopsis of meetings to the New Zealand Medical Journal (NZMJ);
- agreed to pay members’ travelling expenses; and
- agreed that the fee for having additional qualifications entered in the register should be ten shillings.

At its next meeting on 12 October 1915, the Board:

- granted leave of absence to Drs Parks and Irving, by then absent overseas on “acts of service”;
- granted registration to 16 doctors (nine New Zealand graduates, four English graduates, and three Scots);
- refused an MD Brussels entry to the register as his Society of Apothecaries qualification was not recognised;
- issued provisional certificates to eight New Zealand graduates;
- deferred granting provisional registration certificates to another five doctors who had completed only 57 weeks of the medical school curriculum, the full term being 60 weeks, and agreed to advise the sub-Dean of the University of Otago of the matter;
- changed the registered names of several doctors – Dr Sandstern to Dr Sanderson; Dr Schumacher to Dr Scasforth; and Dr Wohlman to Dr Herbert;
- noted the Secretary’s advice that the P&T was now referring to the office all names of registered medical practitioners for the phone list;
- agreed to request District Health Officers to report to the Board if doctors did not comply with the requirement to disassociate themselves from chemist shops;
- received a letter about medical men receiving commissions from surgeons;
- resolved to ask the Solicitor General to define more clearly what constituted “practising medicine,” noting that chemists practising as doctors should be prosecuted;
- received a complaint from a man whose wife had been attended by a doctor in Porirua who was in an “intoxicated condition”, and decided to obtain more evidence before asking the doctor to respond (in the end no action was taken because of a conflict of evidence); and
expressed concern about a lack of advisory and disciplinary powers to deal with the indiscriminate sale of “pituitary extract”.

At the Board meeting on 3 May 1916, the Chairman apologised that he had not taken action on the previous meeting’s resolutions about discipline powers or the pituitary extract issue, “owing to the pressure of urgent work in connection with his military medical duties”. At that meeting, the Board:
- declined to register a doctor who had graduated in 1909 from Saint Louis University, Missouri, United States, as his course had not been the required minimum five years duration;
- considered replies from the Solicitor General – one stating that it was no offence for a chemist to lend a medical practitioner a room at his shop (but it was an offence if a commission was paid), and the other stating that it was not possible to give a satisfactory ruling on the definition of the “practice of medicine”, but that merely signing a death certificate was not “practising,” although such a certificate would be invalid;
- granted Dr Elliott, now also on active service, leave of absence;
- discussed allegations that “unnecessary operations” were being done in New Zealand;
- noted that under section 22 of the 1914 Act, there were disciplinary rules relating to “acts of grave impropriety”, defined as habitual drunkenness or endangering a patient’s life because so intoxicated, refusing to assist a registered medical practitioner when requested in cases of grave emergency; and “any other matter” the Board said was grave impropriety;
- noted that the Act also included a category for “infamous conduct” but that the Act did not define what that meant;
- received a report of a review of Otago Medical School (presumably from the General Medical Council of Great Britain), noting that it was “pleased” that the curriculum, standard of teaching, and examinations were of a “sufficiently high standard”; and
- decided that requiring compulsory attendance at all “sick calls” was too complex to regulate.

By the meeting on 18 April 1917, members were already drafting proposed amendments to the 1914 Act.

On 2 October 1917, the Board:
- worked with the Solicitor General to formulate disciplinary offences for inclusion in the proposed amended Act;
- received a warning from Australia about Sydney doctors who had been removed from the Australian medical register for “infamous conduct in a professional respect” and who might be attempting to gain registration in New Zealand;
- discussed whether the term of office should be amended from four to six years; and
expressed a desire to be empowered to inspect and visit medical schools.

In 1918, the Board:
- removed from the register a Dr Arthur Edward Gladstone MRCS England 1898 LRCP London 1898, who the General Medical Council (“GMC”) had struck of its register for “infamous conduct” (committing adultery with a patient); and
- noted that it would advise the Solicitor General that it had identified a Dr Endletsberger as the only “alien medical man” on the New Zealand Medical Register, and that he should be removed from the register.

Post World War I

In May 1919, at its first post World War I meeting, the Board:
- received a report from the Court of Appeal dismissing Dr Gladstone’s appeal against its earlier decision to refuse him registration; and
- agreed to tell the GMC and other overseas boards if it refused a doctor registration or removed a doctor from the register.

At its meeting on 29 October 1919, the Board:
- agreed that the Health Department’s representative (the Director General) should always chair the Board because “he was obviously in the best position to carry on the work between meetings”; and
- discussed whether a state medical service for New Zealand for outlying districts should be instituted; and
- decided to obtain the “foreign list” from the imperial medical register.

The October 1919 meeting was somewhat disrupted, the lunch break being extended from 1.15pm to 3pm to allow Dr Irving and the Secretary to go to Brougham Street Hospital regarding an alleged abduction. At the same meeting, members required to travel by train to Wellington queried whether a special train compartment could be reserved for them. I imagine that request was so that they could prepare for the meeting en route, or get some rest, no meeting fees as such being paid at the time!

In December 1919, the Board agreed that United States graduates could be employed as Junior Resident Medical Officers ("JRMOs") at Wellington Public Hospital, in order to tide over a shortage of house surgeons.

In June 1920, the Board:
- further discussed the issue of hospital staffing, raising questions about reciprocity with Japan and Italy and control of “enemy practitioners”; and
- discussed its desire to have the Act amended to read “all applications for registration based on foreign diplomas should be subject to the principle of reciprocity”; and
- noted that henceforth all medical men employed by the government had to be registered in New Zealand.
At its meeting on 19 November 1920, the Board:
- received advice that parliament was “too busy for an amendment bill”;
- deferred registering a person who was suffering from “acute alcoholism”; and
- again emphasised the importance of sharing information with Australian boards and all kindred boards throughout the Empire.

In March 1921, the Board discussed a Dr Rolley of Otahuhu over alleged incompetence in relation to a meningitis death.

At its meeting in May 1921, the Board:
- noted that there were now 1,100 doctors on the register;
- discussed a Dr M Smith of Rawene whose wife was seeking a divorce, Dr Smith having eloped to New Zealand with another woman in 1914 (the Solicitor General advised the Board that no further action was necessary!);
- requested registration statistics for the past 10 years on New Zealand and overseas registrants, deaths and removals from the register; and
- considered a suggestion from Board member Dr Newlands for an annual report.

On 27 July 1921, the Board discussed a Dr Theimer in relation to alleged “gross immorality” with a patient. In October 1921 the first “purge” of the register took place.

The Prime Minister, the Rt Hon William Ferguson Massey, attended the Board’s meeting on 30 November 1921, at which the Board called for more disciplinary powers.

At the June 1922 meeting, the Board was finally advised that a draft Medical Practitioners Amendment Bill had been written. The members discussed their desire to have some medical practitioners elected rather than appointed to the Board; that concept, however, did not come to fruition until the end of 1996. The Bill did finally get into the House, and was passed in October 1923 to come into effect in 1924. Board minutes refer to “thanks to the Honourable Minister of Health Sir Maui Pomare”.

**Medical Practitioners Act 1924**

The Medical Practitioners Amendment Act 1924 created the first Medical Council of New Zealand.

Reading the minutes of meetings in these early days reinforces for me that the Council continues to deal with the same kinds of issues that arose again and again back then. While various solutions were attempted, the problems, as now, did not seem to go away! Dr Martin who was reported to the Council in February 1926 and warned against taking Morphia, was finally gazetted on 15 December 1932 under the Dangerous Drugs Regulations (Doctors and Addicts).
The 1930s and 1940s and the impact of World War II

At the Council’s meeting on 31 January 1936, Chairman Sir Lindo Fergusson reported on his attendance at a conference of Australian boards and Councils in Melbourne at the end of 1935. At the main meeting of 1936, the Council discussed the issue of overseas trained doctors, as a number of European trained doctors had been enquiring about registration in New Zealand. The Council recommended that those doctors could qualify for registration if they undertook a three-year course of approved studies at a New Zealand medical school, followed by examinations. Such doctors could take the first section of the final examination at the end of their second year, and the final section at the end of their third year.

The issue of registration of foreign medical graduates was very lively throughout World War II. The Council expressed interest in providing a three-year special course for Jewish refugees. The Council also considered requesting a law change, so that the practice locations of foreign medical graduates coming to work in places vacated by New Zealand doctors absent on war service could be controlled. The medical work force was under pressure. As an example, because of the shortage, a doctor working in the Yugoslav Consul General’s office was granted provisional registration to work in New Zealand.

From an historical perspective, there seem to have been a number of anomalies. For example, a special examination was arranged in Dunedin for a doctor with an MB Prague, but no reciprocity was given to graduates from the United States or Canada.

In August 1946, seven doctors were registered who had passed the special medical school examination after three years and been granted an MBChB. The following year, the Council mooted the idea of an Empire conference on medical registration. It appears that the British Medical Association may have been funding doctors to come to New Zealand. Reciprocity arrangements in place then, which relied on the GMC’s recognition of Commonwealth medical schools, meant it was relatively easy for doctors trained in Commonwealth countries to come to New Zealand. Indian doctors were granted temporary registration for postgraduate education, but the settlement of displaced medical practitioners remained an issue. There was some concern that there might soon be an excess of “aliens” seeking bridging courses. On the other hand, it was noted that a Polish doctor in charge of medical work at the temporary camp set up at Pahiatua for Polish war refugees had been practising for some years without registration. The Board noted that when the camp closed the doctor would need to get a reliable registerable qualification.

Towards the end of the 1940s the concept of reciprocity was pushed further and the Council agreed that there should be reciprocity in New Zealand with graduates from institutions approved by the GMC in Eire, United Kingdom, South Africa and India. For some reason, Canada was not granted this status, although Canadians would be eligible if they were
licentiates of the Medical Council of Canada, that is, had completed that Council’s examination.

_The 1950s onwards_

In February 1955, married women practitioners were permitted to register under their maiden names, and reciprocity with New South Wales for the intern year was agreed.

In the late fifties, interviews for overseas trained doctors prior to provisional registration being granted were put in place, requiring the person to produce a registration certificate and a passport, and attend an interview with a certified photo.

In October 1959, for the first time ever a GMC president (Sir David Campbell MCMD) attended a New Zealand Medical Council meeting. The following year, Council member and heart surgeon Douglas Robb was knighted and Dr Turbott (ex-officio member) became president of the World Health Organisation (WHO).

In the sixties, Sir Douglas Robb advocated strongly for the Council to initiate a Council of Medical Education and a register of specialists, and the Council discussed at length the concept of a two-year “conditional registration period” to assist doctors to prepare for private general practice.
Part II

The Medical Council 1986 to 2000 -
a personal and informal perspective
2.1 January 1986 to June 1990 – preparing for change – building human and technological resources

End of an era – K A G Hindes departs

Just before Christmas 1985, after 25 years’ service as Secretary of the Medical Council of New Zealand, Mr K A G Hindes resigned and, in view of annual leave owing, left immediately. Ken Hindes, a former public servant in what was then the Health Department (now the Ministry of Health), had taken over the role in 1961 when the Department provided the Council’s secretarial services. He had also provided secretarial services to the Dental Council of New Zealand and what was then the Medical Research Council of New Zealand (since 1990 the Health Research Council).

In the early 1960s, the Medical and Dental Councils, and the Medical Research Council, were each granted body corporate status and they moved from the Health Department. Mr Hindes worked with them in premises in downtown Wellington, and continued providing each with secretarial services. When the expanding Medical Research Council eventually moved to Auckland, Mr Hindes continued in Wellington as Secretary of the Medical and Dental Councils.

I learned the rather dramatic news of Mr Hindes’ sudden departure from Professor David Cole, the Dean of the Auckland School of Medicine where I was then working. Professor Cole was at that time the Council’s Deputy Chairman. He was also a supportive colleague and announced the news to me saying, “Now there’s a job that would be a real challenge for you, Georgie!”

A fresh approach – Georgie Jones arrives

After graduating from Auckland University in 1963 with my Bachelor of Arts, I had lived and worked for several years in Wellington. I had thoroughly enjoyed the experience and in the early 1980s had seriously considered a number of other options for returning to the capital. I saw the opportunity to apply for the position of Chief Executive/Secretary of the Medical Council as one too good to be missed. The nationally advertised vacancy read:

“…
This position carries a large degree of autonomy and the successful applicant must have a proven high level of competence in formal correspondence and reporting. The ability to interpret legislation would be a definite advantage.

Ideally applicants will have gained practical experience and expertise in similar work within local or central Government.

…”
Having always thrived in roles that offered me scope for independence and innovation, the word “autonomy” in particular leapt out at me, and I promptly applied for the position.

The full Council interviewed me in Wellington in early March 1986. Fortuitously, the interview day fell during the first Wellington (now New Zealand International) Festival of the Arts and that night I heard Dame Joan Sutherland sing in the Town Hall. The next morning I was thrilled to be offered and accept the Council position.

On 23 April 1986, the following notice appeared in the New Zealand Medical NZMJ (“the NZMJ”):

“The Medical Council of New Zealand is pleased to announce the appointment of Mrs Georgina A Jones BA as its new secretary and chief executive officer. Mrs Jones is at present a senior administrative assistant in the University of Auckland School of Medicine. It is expected that Mrs Jones will be able to assume her duties towards the end of May 1986 by which time the Medical Council will have moved into its new accommodation at 73 Courtenay Place, Wellington.

Mrs Jones brings to the Medical Council considerable experience in university affairs as well as administrative experience both in New Zealand and abroad dealing with placement of undergraduate and postgraduate students. For some time she was employed by the British Council in their technical assistance training department and her duties involved the administration, welfare and course planning for foreign undergraduates and graduates including doctors in the United Kingdom coming from all countries in the world. Mrs Jones has also had service as a medical social worker and has completed the Certificate in Social Science and the Certificate in Community Studies. The Medical Council looks forward to a period of improved relationships with the profession under the guidance of Mrs Jones as its secretary.”

As an experienced “bureaucrat” (now almost a dirty word!), I took the view that rules (and “servants”!) were there to help people, not hinder them. Putting a human face to bureaucratic activity had always been essential to me, and I took a deep personal interest in my work. Fired by my characteristic passion, enthusiasm and commitment, I took up my new role on 26 May 1986. In so doing, I embarked on the most enjoyable and stimulating period of my career as what I like to call a “good bureaucrat”.

The day I started, I discovered that I was also expected to be the Secretary/Registrar of the Dental Council of New Zealand. Nobody had bothered to tell me at the interview! I held that post concurrently until June 1995, when I facilitated establishing a separate office for the Dental Council secretariat, due to the Medical Council’s increasing workload and
pressure on office space. The Dental Council was able to do this economically in a joint venture with the Veterinary Council of New Zealand, which had already been talking to me about its future needs after being asked to separate itself from the Ministry of Agriculture and Fisheries.

Before long I had adopted “the Opera” as a metaphor for my days in Wellington and at the Council office. The job certainly lived up to my expectations, complete with the occasional farce, tussles with various conductors, prima donnas and leading men, the odd magnificent aria, and plenty of solid chorus work to give me a fascinating behind-the-scenes insight into a profession dating back centuries. There was certainly no shortage of drama, both tragedy and comedy.

I was proud and excited to bring to the Council my previous administrative and management experience in the public sector and in adult and tertiary education. I returned to full-time work in 1975 after having my three children. From 1976, I spent 10 years at the University of Auckland, first in the Centre for Continuing Education as the inaugural assistant course organiser for two certificate courses and a new programme of short courses in health, welfare and justice, and from 1980 at the School of Medicine as senior administrative assistant for the three clinical years of the MB ChB degree, during a period of significant growth and curriculum change. In 1979, I completed the University’s Certificate in Personnel Management and Industrial Relations (where I was the top graduate), and in the early 1980s the four Stage III papers required for a postgraduate Diploma in Education. I was also the administrative staff representative on the Promotions Committee for Non-Academic Staff, and involved in the establishment of a union for that group, as well as advocacy for staff training and protocols for action on sexual harassment.

In the early 1960s, I had worked in Wellington in the External Aid Division of what was then the Department of External Affairs (later the Ministry of Foreign Affairs and Trade). In that position, my portfolio covered most aspects of the pastoral care and education for all Colombo Plan and Special Commonwealth African Association Plan (SCAAP) students enrolled at Auckland University and in high schools around New Zealand, as well as the occasional World Health Organisation (WHO) Fellow. I also arranged summer vacation placements for over 1,000 students from all over the country.

In the mid-1960s, I worked for the British Council in London. I was a member of the team that supported the educational, welfare and administrative needs of government funded overseas trainees, many from India, Pakistan and Ceylon, who came to the United Kingdom and the Republic of Ireland to complete their professional education. Many of those students were preparing for MRCP and MRCS (membership of the Royal Colleges of Physicians and Surgeons respectively).
I also had plenty of experience in community based health and social services to bring to the role. After returning to New Zealand from the United Kingdom in 1967, my husband Bruce and I moved to Auckland in 1968 with our first daughter Hilary. As a young mother, I was heavily involved in voluntary community development in Auckland. In particular, I worked with Plunket where I chaired committees and liaised with clubs for young mothers, and with the Citizens Advice Bureaux in their early years. From 1968 to 1974, I completed part-time Auckland University’s certificates in social studies and community studies.

In 1975 (by then, Hilary aged 7, Philippa aged 5, and Matthew aged 2), I returned to paid work. I joined the Auckland Hospital Board Extramural Hospital as a medical social worker, making needs assessments and providing ongoing support for people requiring domiciliary services. In that job I was the family breadwinner, primarily to enable Bruce to undertake his Masters in Commerce so that he could take up a lectureship at Auckland University. In April 1976, Bruce died suddenly of chronic myeloid leukaemia, a disease only now curable by a new “miracle” drug.

All my community and paid work experiences had involved coming into positions where there was no handover or little formal induction. Often reform was badly overdue! This work, and other life experiences (not the least of which has been bringing up my children on my own), had given me the confidence and skills to deal with the unknown, and a commitment to do my best. I had also always valued working to contribute to improved international relations and understanding. That desire had been kindled in part by my experience as an American Field Service scholar in upstate New York in 1958/59, and while working with international students in Wellington and London and travelling in Europe. I felt that the Medical Council office would enable me to bring together the experiences and understanding I had gained in the public sector, the community and in other countries. I was not wrong.

The Council and the secretariat in 1986

At the time I joined the secretariat, the Council members were:

- Dr Stewart Alexander Ministerial appointee (Pathologist)
- Professor David Cole Ex-officio Dean of the Auckland School of Medicine
- Dr Robin Briant RACP nominee
- Dr Tom Farrar RNZCGP nominee
- Dr Bob Gudex RNZCOG nominee
- Dr Murdoch Herbert NZMA nominee
- Professor John Hunter Ex-officio Dean of the Otago School of Medicine
- Mrs Patricia Judd Ministerial appointee (Lay member)
- Professor Reg Medlicott Ministerial appointee (Psychiatrist)
- Dr Bill Pryor NZMA nominee
- Dr George Salmond Ex officio;
As they had signaled when announcing my appointment in the NZMJ, the Council members were looking forward to significant changes. The Council had ambitious ideals for what it could achieve and the secretariat needed to move forward with the times in order for that to happen. A report on the secretariat provided by the State Services Commission in the early 1980s had recommended a number of improvements to the way the office was managed, in particular in relation to the Council’s finances and the renewal process for the doctors’ Annual Practising Certificates (APCs). The Council was looking forward to those recommendations being implemented.

Prior to my arrival, the Council had made a positive start by acquiring new premises, its previous temporary home in the Pharmacy Building in Cambridge Terrace not meeting its long-term requirements. In late 1985, the Council leased the top floor of the ANZ Bank Building at 73 Courtenay Place (now the Mermaid Strip and Massage Parlour!) and fitout began. Some aspects of the move were still to be completed when I arrived in May 1986.

When I took up the post of Chief Executive/Secretary, mainly new or temporary staff were struggling valiantly to sustain the Council’s operations. The Council’s Assistant Secretary, appointed in 1982, was responsible for and familiar with only a limited range of the Council’s activities. A temporary administrator hired to fill the gap left by the sudden departure of Mr Hindes was in poor health and left as soon as I arrived. More experienced staff had recently resigned and recruitment of competent office staff was notoriously difficult in Wellington at the time – especially so for the Council, as its pay rates were tagged to those of Otago University and previous unattractive locations had been a significant disincentive. I quickly ascertained that the Medical Council had become known as a workplace to avoid!

I realised it would be critical to give priority to getting the office running well, supporting the staff with modern equipment and good personnel practices, and raising morale. A brief visit to the office in April to meet with the Finance and General Purposes Committee had confirmed this view.

My first week dramatically demonstrated that change was long overdue! On day one, the first of many startling experiences occurred. At morning tea, the Assistant Secretary wheeled out a metal trolley which could well have come from a hospital dissecting room, complete with “railway” cups and “army” teapot; saucers acted as ashtrays on several desks! While obviously this was before the days of smoke-free legislation, I was nevertheless shocked and quickly decided to exercise my judgment with an afternoon announcement that from day two we would have a smokefree environment!
Even for the mid-1980s – and in spite of the fresh new premises with better meeting and disciplinary hearing rooms (hearing rooms being a Council priority as, under the 1968 Act, it heard all charges alleging disgraceful conduct) – the office was still in the dark ages. Minimal accounting records were handwritten into a ledger book and only analysed at the end of the year. Although a photocopier had recently been purchased, agenda papers and minutes were still being prepared on stencils for copying on the Gestetner. In the absence of scissors, paper was cut with a knife. A solitary golfball typewriter had recently been acquired, but the workstation used by the secretary/receptionist was so deficient ergonomically that she had to type “up hill”.

General files and records for the then 6000 practising doctors (and all archival records) were still stored in the original bulky civil service files, some dating back to early in the century – needless to say, not user friendly!

The outgoing Secretary’s beautiful red ink annotations to the minutes looked for all the world as if they had been written with a quill pen! Mr Hindes’ hallmark, however, was his absolute devotion to detail, and his scrupulously accurate files were a great resource as I got to grips with what was expected under the Medical Practitioners Act 1968. An extensive card system and handwritten register contained the details the law required on registered doctors. A limited computerised version of the register held at Otago University was used to print APC renewal application forms and collect annual workforce data.

The staff of five was stretched, but they had struggled on through the transition period without a permanent Secretary and were keen to see changes implemented. The three Wellington-based Council members – Chairman Stewart Alexander, Finance Committee Chairman Tom Farrar, and Convener of the Preliminary Proceedings Committee (until 1983 the Penal Cases Committee) Ted Watson – had been very supportive to them, as they were to me. Those three members also comprised a Finance and Management Committee and I had met with them briefly in April to sort out some immediate needs.

So, as with every other role I had ever had, I began as Secretary and just got on with the job. It was a case of combining commonsense, skills, listening, looking, reading and questioning – and a fair amount of guess work. Dr Alexander was always very accessible and willing to share his experience and vision.

I knew three of the other Council members reasonably well, having worked in the 1980s with Dean David Cole and Clinical Lecturer Robin Briant in the Auckland Medical School faculty, and having met lay member Patricia (Trish) Judd through community work in Auckland with Plunket in the 1970s. Trish was the Council’s second lay member. The first, Mr D V

MCNZ - Georgina Jones perspective 1986-2000
Sutherland, had resigned at the end of 1984 after just one year on the Council.

It did not take me long to appreciate the commitment and talents of all the Council members, who each brought a different perspective to the Council’s work, informed by intellect, experience, energy and humour. I was only sorry not to have been able to meet Professor Medlicott, who died in June 1986.

I had been in the role only a month when the Chairman and I began to write the Council’s first professionally presented annual report. I wrote:

“[I am] aware of the daunting but challenging task ahead of me. ... I hope especially to facilitate prompt and effective communication with all sectors of the medical profession and to create an environment where doctors and members of the public are happy to approach the Council Secretariat on all matters which come within the ambit of the Council.”

The role certainly took me on a continuous learning pathway. The Council members and staff joined forces to advocate for and introduce improvements in legislation, governance, management, communications and external relations.

**My first Council meeting**

I attended my first Council meeting two weeks after I started. It was also the first Council meeting in the new premises and furniture was being delivered up to the day. The Minister of Health, then the Hon Michael Bassett, had agreed to officially open the new premises, and officers from the Department of Health, the New Zealand Medical Association (NZMA), and the professional colleges, as well as previous Council members, had been invited to attend. As I watched them arrive, it seemed to me that the majority were elderly men!

A staff member had assured me that caterers had been organised, and I was horrified when they turned up – with the guests – at 5pm and began frying up chicken wings in the kitchen!

I need not have worried. The Minister had his own agenda and was not interested in being impressed. He made no attempt to hide his impatience with the Council, kept his visit short, shot several political arrows in the direction of a couple of Council members, declared the premises open, and left with his “minder”. The latter happened to have been a stroppy Auckland trainee intern during the fairly recent days when I was the person whose job it was to get interns to meet their obligations! That doctor now holds a top role in public health! I guess this was my introduction to politics and politicians – a fact of life in Wellington, especially if you want your legislation changed.
Lobbying for change

In the early 1980s, the Council began to lobby in earnest for new legislation. In June 1983, ministerial nominee Dr Stewart Alexander succeeded Dr Michael Gilmour as Chairman, when Dr Gilmour resigned from the Council. Dr Alexander was ready to push for a new Act with all his formidable effort!

It is clear from reports and discussion papers printed in the NZMJ that the pressure was on for a new Act. The Council had published discussion papers on topics including the composition of the Council and its committees, and selection of those members, registration reform, and revamp of the disciplinary structures. In the main, the discussion papers attracted little feedback. The only issue that really seemed to excite a few NZMJ correspondents was whether they could attend Council meetings as observers, or better still stand for election to the Council. The NZMA used the opportunity to revisit once again the possibility of being made the statutory registration body, with membership compulsory. In so advocating, the NZMA drew an (inaccurate) analogy with the relationship of barristers and solicitors to the New Zealand Law Society. The idea eventually lost momentum, which allowed energy to be concentrated on proposals for an appropriately constituted and empowered Medical Council and Medical Practitioners Disciplinary Tribunal (MPDT), retaining the NZMA as a separate body to represent the profession. The Ministers of Health at the time appeared to support a rewrite of the whole Act, which had sustained almost annual amendment!

Stakeholders in the profession held numerous meetings, working in groups and struggling with the issues. Like the Council’s legal advisors and assessors, they were familiar with the issues and constraints on the changes which were necessary. The 1968 Act, and its amendments to 1983, had been the product of continuous improvement over seven decades!

Little did we know that the changes seen as urgent would be beaten around the political and economic bush for another nine years before finally coming into effect on 1 July 1996. While at all times Council members urged the government to act expeditiously on the much needed new Act, the delay turned out to be well outside the members’ control. I was heavily involved in the debate and documentation, while keeping the Council’s staff on the rails with the practicalities of serving our customers, yet making allowable improvements in policy and procedure whenever the opportunity presented.

Mobilising modernisation of the Council office

In my first year as Secretary, I gave high priority to improving and modernising the work environment, implementing information systems and encouraging communication with the profession and the public. We installed the office’s first word-processing and computer hardware and over the following two years software was customised, trialled and
installed to process the various registration functions. Until this time, the administrative work of the secretariat, being entirely paper-based, involved laborious and time consuming repetition in ledgers, log books, agenda books, cards and files, for each step in the chain of registration, APCs, examinations, and financial transactions.

Two years before I arrived, consultants had put up a case for computer processing which the Council had accepted as timely, but no action had been taken to implement it. By the time I arrived, computerisation was urgently required. We considered large and small companies and eventually decided to employ a small company in a partnership role. A systems designer/computer programmer, Ian Blythe, was engaged to set up a system and write a first stage programme capable of maintaining the registers for doctors and, in due course, dentists. We had just enough knowledge of processes needed to guide him. Given the state of technology at the time, to achieve networking a Unix-derivative operating system was employed to support the database and word-processing programme.

At the end of 1987 that database was loaded, which meant for the first time we were not slaves to pen and paper for some of the routine work. Also in 1987, the Council finally considered purchasing a facsimile machine! Ten years on, the idea of working without a facsimile machine or email would be laughable.

When I came on board as Secretary/Chief Executive, two temporary staff were manually processing APC renewals, including handwriting banking schedules with separate entries for each cheque! The banking process was soon streamlined but it took some years to satisfactorily redesign the APC and workforce data collection system.

Workforce changes

The 1968 Act was highly prescriptive and detailed (as was most legislation of its era), which was both helpful and problematic. Registration was the core business and, for New Zealand graduates, reasonably straightforward. For decades, registration of “foreign doctors” had been a thorny issue, but most Commonwealth countries had followed the lead of the General Medical Council (GMC) in the United Kingdom. The United Kingdom’s membership of the European Economic Community had meant some new arrangements, and much less reliance on reciprocity as a basis for recognition for registration purposes.

Changes in the New Zealand medical workforce brought registration policy into the spotlight in the second half of the 1980s. The 1968 Act had been amended several times to provide appropriate categories of registration for those coming for supervised short-term training and, in some cases, to settle permanently. From late 1985 registration of overseas trained doctors became an increasingly complex and time consuming area for the Council and staff, as the existing law was not designed for the upsurge in
worldwide medical migration we began to experience. Rules based on reciprocity with the United Kingdom, the Republic of Ireland (Eire), Canada, South Africa and Australia were, however, adequate for the majority. Systems for verifying qualifications, training, competence and the good standing of doctors from many other countries were still in their infancy.

As with other professional registration bodies, the Council had to set up robust procedures to assess doctors who had qualified in other countries. Some of these doctors had relatively familiar cultures, language, medical training, and standards of health service delivery, while the backgrounds of others were not so similar in one or more aspects.

From 1986 there was a steady, then dramatic, increase in overseas trained doctors seeking registration for training or being recruited to work in New Zealand. In late 1985, a new industrial agreement had resulted in junior medical staff being paid more realistically for the long hours they worked. Hospital boards assumed the solution to increasing costs lay in hiring more people. There was thus a constant stream of enquiries from overseas trained doctors interested in coming to live and work in New Zealand. Managing those enquiries demanded extra resources and attention to human rights issues. Initially, the hospital boards, the Department of Health, and the immigration section of the Department of Labour, formed a partnership to recruit young doctors from overseas and, as an incentive, agreed to repay their fares if they remained in New Zealand for two years. A list of shortage specialties was also advertised, and the word soon got around.

Overseas trained doctors who arrived in New Zealand with backgrounds in countries with comparable health and educational institutions found obtaining registration straightforward. For most graduates of Commonwealth institutions, the 1968 Act presented no real problems. However, an increasing number of enquiries were received from others who did not hold the qualifications listed in the 1968 Act (or its schedules), or who were not very fluent in English. Some were desperate to escape from harsh political and social climates or to benefit from what they saw as the excellent work and lifestyle opportunities available in New Zealand.

Some of those under consideration for posts in our hospitals did not meet the criteria for registration, unless they first passed examinations in medicine and English communication. One way around this difficulty, if doctors were entering on work permits/temporary visas and had not applied for permanent residence, was to deem them to be receiving postgraduate instruction or experience and to grant them temporary registration.

Foreshadowing the need for powers to require those seeking permanent residence to submit to assessment or examination in English and/or medicine, the 1968 Act had been amended in the 1970s to include these prerequisites for the new category of probationary registration. Enquiries rose dramatically in the decade from 1985, reaching around 5,000 a year at
their height. The screening examination the Council had developed with the Otago Medical School in 1984 required urgent revamping to cope with this pressure and to ensure a safe level of practice at entry.

The debate on the registration of overseas trained doctors has been a perennial one – often with cultural and political overtones – since early in the 20th century. For most of the decade from the mid-1980s to the mid-1990s, however, the Council was left in the lurch by governments. Safety was an important issue, but the workforce could not be considered safe without transitional education. With considerable help from the universities and employers, the Council took steps to set up fair systems of assessment and supervision, but bridging courses were clearly needed. They were well established in Australia at that government’s expense, but New Zealand governments did not provide them. Finally, in 2001, the government allocated funding to introduce such bridging courses which had been needed since the mid-eighties. These were available to a defined group of doctors who had been given misleading information by Immigration over a defined period in the 1990s, now had permanent residence and were still in New Zealand.

Even in 1987, Council members and secretariat staff were concerned about the number of overseas trained doctors who were arriving in the country, sometimes to take up pre-arranged posts in institutions or the community, without having done their homework on their eligibility for registration or the requirements of registration. New Zealand diplomatic posts did not necessarily provide accurate advice and some employers had a cavalier attitude to trying to force the issue of registration once the person was in the country.

There were many headaches, and examination and assessment programmes were developed to meet changing circumstances.

*Incentives for change*

At the end of my first full year as Secretary, I was fortunate to visit the New South Wales Medical Board in Sydney and, with the Deputy President, attend the Melbourne Annual Meeting of the Australian Medical Council (AMC), including the meeting of Presidents and Registrars. I gained an insight into the principles and practices of their registration bodies, an awareness of common problems, and had my first taste of the professional collegial support and exchange that was to be a highlight of my 14 years with the Council. I made some very good personal contacts, recognising this group as a valuable resource. I was active in making and sustaining my networks with them throughout Australia, and ultimately this led to links beyond Australasia. After my second AMC meeting in Adelaide, I extended links to the Federation of State Medical Boards (FSMB) through meeting their senior executive, Dale Breaden, based then in Fort Worth, Texas.

During 1987 the Council got down to the serious work of writing submissions to push for a revision of the Medical Practitioners Act 1968.
We began with submissions on discipline, which were delivered to the then Minister of Health, David Caygill, in December 1987. In early 1988 submissions on all other aspects of the reform to the Act were also sent to the Minister.

We had hoped the legislation would come into effect in the 1980s, but wide-ranging economic policy reform took precedence. The reforms, driven by competition policy development, were generally averse to legislated occupational regulation, unless there were significant public safety issues. The long path to achieving the new Act was not finally concluded until 1996.

By annual report time mid-1988, I was able to describe the small secretariat team working at 73 Courtenay Place as having grown into a “cooperative, efficient, expert workgroup – stable and cheerful”, and worthy of the respect of the profession. By that time, the secretariat had expanded to six full-time and two part-time staff, attracting a number of talented staff. Two of those staff, Jo Hawken-Incledon and Jane Lui, are still serving the Medical Council in 2002. Angela Coleman, who had previously been employed part-time in university vacations, was also employed full-time. Apart from three years overseas, she was on the Council staff until she resigned to take a post at Otago Healthcare in 2000.

With excellent skills and updated technology, the receptionist/secretary and three registration clerks could cope with the huge volume of word processing, correspondence, reports, agendas and minutes now being produced for the Council and its committees. The Assistant Secretary served the Medical Education Committee (MEC) and the Board of Examiners, which was running a revamped Probationary Registration Examination in New Zealand (PRENZ). I had engaged a part-time accounts clerk in late 1986 and we set up more sophisticated accounting methods and were able to produce more accurate and timely financial reports. These were converted to a computer-based programme in 1988.

Council meetings were held quarterly for two days; in addition, disciplinary hearings (including appeals) in various locations around New Zealand could take anything from a day to a week.

In 1987 I had been able to meet the GMC Registrar at the GMC’s offices in London and discuss roles and improvements in staff management and procedures. At this stage, my main responsibilities were as Secretary of the Council, Tribunals officer, and manager of the secretariat. I developed written job descriptions for all positions. I supervised the registration (and APC) staff and took a hands-on role in the administration of examinations, preparation of Council agendas and papers, general trouble shooting and communications and liaison with other organisations.

**Cartwright Enquiry – a sentinel event**

The 1987 Cervical Cancer Enquiry at National Women’s Hospital, and the 1988 Cartwright Report, had a profound affect on the Council, which was
one of the first professional bodies to respond to the findings of Judge Cartwright immediately they were announced. At the first Council meeting after the Judge’s report was released, member Dr Briant presented a draft response which was adopted without significant change as a Council resolution. It was published immediately in the 1988 annual report for the information of all members of the profession. It was also published in the NZMJ and circulated to all medical schools, colleges and special societies, area health and hospital boards, the Chief Health Officer (Dr Karen Poutasi), the Chief Medical Officer (Dr Peter Talbot, who sat on the Council representing the Director General of Health), the Minister of Health and Judge Cartwright herself.

The Cartwright Report was the catalyst for the Council’s innovative “Statement for the profession on information and consent”, which amounted to a new standard in medical ethics in this area. The whole upheaval at National Women’s focused attention on the need for patient advocates and more involvement of lay people in medical decision making.

Changes in the air

The Council became more active in the management of doctors with mental or physical conditions that could impair their fitness to practise, establishing a Health Screener and a Health Committee based on the GMC model. The Doctors Health Advisory Service (DHAS), an informal support network that received referrals of doctors with potential health problems, had been set up, and the NZMA had agreed to provide administrative support for it, including a freephone line. In 1988, Dr Judith Treadwell, a Wellington psychiatrist, was finally appointed by the Minister to fill the vacancy left by Professor’s Medlicott’s death two years earlier.

These three developments were a big step forward in assisting doctors with potential impairments before they or their patients came to harm. Care was taken to keep the first stage DHAS at arm’s length from the Council, but it was clear that where there was a risk to public safety, the DHAS had an obligation under the 1968 Act to refer the doctor to the Council. The Health Committee would in time also have an important role supervising doctors returning to practice after an episode of impairment.

In the first year of its existence, the Health Screener and the Health Committee dealt with 18 doctors. For two of those doctors, competence was an issue. Six were suspended (including two who had previously been suspended), two recommendations were made on variations of prescribing restrictions, five recommendations were made on registration applications, three applications for revocation of suspension were considered, and one doctor’s suspension was revoked. This sample indicates the variety of fitness to practise matters that routinely involved the Health Committee in the years ahead. I provided secretarial support for the committee in its early years.
Over the next decade, more and more office time became necessary in what evolved into one of the Council’s most respected activities, benefiting from the partnership of Council committee members, experienced long-serving Council staff, workplace supervisors, mentors, psychiatrists and counsellors, Medical Control Officers, communities and families.

After over a decade’s debate, parliament amended the 1968 Act to set up a Register of General Practitioners to be known as the “indicative register” and we sought applications for entry under grand-parenting clauses due to expire in 1990. The Council asked the Royal New Zealand College of General Practitioners (RNZCGP) to evaluate the applications, as it had the specialist colleges in the early 1970s when the Register of Specialists was first introduced. Those with formal qualifications equivalent to membership of the RNZCGP, as well as those recognised by their peers as having comparable experience and competence, were eligible to apply.

By mid-1988, the secretariat was feeling the pressure of the workload arising out of registration applications, the increased frequency of and candidate numbers for PRENZ, and the increasing mobility of junior doctors. The only way the present staff were able to get through the increased work was by making efficiencies in other areas of our work, partly helped by some improved technology and a continuous process of refining our methods of data and record collection, word processing and job design. Already office space was a problem, as we had had to install ergonomic furniture with computer processing. We installed a new rotoscan filing system which allowed us to create a workspace in part of what had been a filing room (big enough to be a ballroom, parquet floor included!). A fax machine was even considered necessary!

In the 1988 annual report, I felt compelled to raise the issue of gender specific language, expressing my disappointment that after two years in the position – with all correspondence going out under my full name – I was still being addressed “Dear Sir”. Unfortunately, this was a battle never entirely won! After vigorous debate, however, and with some effort on the part of the women members of the Council, we did decide to use the term “Chair” for the Council’s principal office holder.

Maintaining standards under workload pressure

By 1989, the increasing mobility of the medical workforce both nationally and internationally was having a real impact on the Council’s work, and was putting increasing pressure on what was still a secretariat of only six people. During the 1988/1989 year, 2,000 doctors (20% of all those on the register) changed their registered addresses, and the secretariat produced 700 certificates of registration and good standing for doctors going to work overseas. In addition, we received more than 1,500 written enquiries from overseas trained doctors who were not eligible for full or conditional registration, that is, doctors who had qualified outside of the United Kingdom, Eire, Canada, Australia or South Africa. Each enquiry had to be acknowledged, informing the doctors of the different requirements for
registration depending on their country of origin, medical qualifications and level of experience. Although records were not kept for telephone enquiries from overseas doctors or their agents, they amounted to hundreds. More than 500 potential examination candidates were sent information booklets on the Council’s registration examinations.

The pass rate in PRENZ was low, in spite of the fact that the majority of candidates had worked in New Zealand hospitals for one or two years. Overall between 1984 and 1987, 34% of the candidates passed the exam, with only 14% passing in 1988. Between 1984 and 1988, only 20% succeeded overall.

As candidate numbers increased, changes in format became necessary. From August 1988, the written examination comprised multiple choice and short answer questions. To recover costs, fees had to be in the range of $1650 to $2000.

In late 1988, the Council gave notice that a new examination format would be introduced under the name NZREX (New Zealand Registration Examination) from May 1989. This announcement brought unwelcome media pressure on staff and candidates. The last PRENZ candidates sat the examination in August and December 1989. Over its six years, 201 attempts at PRENZ had been made, with an overall pass of 23%.

In the year to 30 June 1989, 91 new temporary and 29 new probationary registrants (including those who had passed PRENZ) joined the workforce, and a further 17 graduates from overseas universities achieved full registration after satisfactory completion of the probationary period. Registration of overseas trained doctors required sensitive communications, and some tough talking. Aggressive immigration consultants were rife, and some doctors who repeatedly failed and were disallowed further attempts took legal or political action. Without bridging courses, there was little the Council could offer the doctors by way of preparation. The scope, format and standard of the tests were explained carefully, but the candidates still had to find their own preparation method. Medical school librarians allowed access so long as resources could be stretched to meet demand. As the numbers of overseas trained doctors increased, they had increasing difficulty obtaining observer posts in hospitals to familiarise themselves with standards and practice in New Zealand.

Accrediting New Zealand medical schools

In 1988, another milestone occurred when the MEC and the Council considered recommendations from the Renwick Committee, the first New Zealand accreditation team chaired by Mr Bill Renwick, the retired Director General of Education. The Renwick Committee had reviewed undergraduate medical education in the four medical schools under the jurisdiction of Otago and Auckland universities. Previously, the Council had relied on endorsing the accreditation provided by the GMC, which visited New Zealand medical schools from time to time for its own
purposes, namely to determine whether New Zealand graduates were acceptable for registration in the United Kingdom. With reciprocity no longer being the only driver for recognition, and especially in view of the United Kingdom having joined the EEC, the Council’s reliance solely on the GMC was no longer appropriate.

The Council invited the Renwick Committee, comprised of medical, educational and community reviewers, to visit the four medical schools and report back to it. The secretariat made the arrangements for the Committee to carry out its visits to the Otago and Auckland faculties over a period of two weeks and assisted Mr Renwick to produce and distribute the Report of the Review Committee on Undergraduate Medical Education (“the Renwick report”). This initiative was a precursor to eventual collaboration with the AMC as it prepared its protocols for accreditation across Australian states and territories. The accreditation of medical schools marked a significant extension of the role of the Council and the secretariat, foreshadowing wider functions of surveillance of undergraduate and postgraduate education under the 1995 Act.

By mid-1989, the Preliminary Proceedings Committee (PPC) had 19 cases under investigation or being prepared for hearing. Dr Robin Briant was Convener of the PPC and managed most of the committee’s work from her office in Auckland, supported by legal services from Kensington Swan in Wellington, Mr Philip Cook being the legal member. I also received complaints and organised hearings for the Council when the PPC had laid charges or when a decision of the Medical Practitioners Disciplinary Committee (MPDC) was appealed.

The Council worked hard on building good relations with the area health boards as they went through their formative stages. We eagerly awaited the creation of Health Commissioner legislation! Helen Clark had taken over as Minister of Health from David Caygill and reassured us work was progressing.

In the 1989 annual report, I wrote:

“The workload I have personally faced this year is the heaviest I have encountered in my career to date but it has been a stimulating period. Change in many areas of the health professions and review and reorganisation of the institutions and processes associated with them are almost overwhelming. The Council is not spared the stress of this change and indeed must come to terms with it. I am constantly impressed by their dedication to doing a better job and am grateful that the Secretariat, and especially I, receive their encouragement in these endeavours.

By this time next year, we may yet have the Medical Practitioners Act 1990 and even a totally new Council.”

This optimism was somewhat misplaced, as the demise of the Labour government in 1990 created yet another diversion for the legislature. A
draft bill had not yet come the way of the Council, and it was another year before any sign of progress emerged.

Organisational development

This first period of my tenure as Chief Executive/Secretary had seen many major changes in the range, quality, volume, and complexity of services, and the knowledge and skills expected of and provided by the Council secretariat. Servicing of the Council and its stakeholders had been achieved with only five full-time and one part-time staff members. On reflection, I don’t know how we did it!

I had on occasions personally done virtually every task in the office, including stuffing envelopes; “mucking in” occasionally was appreciated and enabled me to maintain good rapport and understanding of what different staff actually did. I made a point of making myself available, as access to the Secretary was something doctors and the public of course expected, but which had not always existed under the old bureaucracy.

In 1989, we reviewed the structure, workloads and future needs of the secretariat and reconsidered job descriptions and competencies for the future. While it was disappointing that a new Medical Practitioners Act did not eventuate as hoped, and indeed was not to come to fruition for another five years, a new structure and personnel provided the Council and the secretariat with the capacity to manage growth, and it allowed more specialisation in tasks to everyone’s benefit.

In February 1990, with one redundancy, I employed two new executives and some excellent additional staff, including Lynne Urquhart as a registration officer. She was a breath of fresh air and still is!

An Operations Manager came from Victoria University to be Deputy Secretary and took over primary day-to-day responsibility for supervising the tasks associated with registration, APCs, data management, personnel, financial administration and general office management. An Assistant Secretary provided executive support for the Board of Examiners, the MEC, and the Health Committee.

The creation of these two new roles freed me up to devote my attention to policy and planning, servicing the Medical and Dental Council meetings, communications and public relations, managing the impaired doctors, complaints and discipline, staff training, financial risk management and quality improvement.

Medical Council providing services to the Dental Council

Dental Council activity was increasing as a result of new powers in the Dental Act 1988, passed at the end of 1988 (after 10 years in the making)
and immediately effective on 1 January 1989. It included procedures and services for a new separate Dentists Disciplinary Tribunal (DDT) comprising dental and lay members, as well as the power to implement a specialist register and to examine overseas trained dentists. Members of the dental profession elected three members to the Dental Council for three-year terms. Running that election across the country and in separate geographical electorates was a new and interesting experience for me, especially in light of the call for doctors to be elected to the Medical Council when the new Medical Practitioners Act was being considered. Two new ministerial appointees to the Dental Council, both lay members, were also a new experience for the dentists. The first two in this role were women who were well able to hold their own “breaking in” the Dental Council to life with lay members!

The new DDT elected its lay member, also a woman, to the Chair, a post she held for six years. Although the volume of work for the Dental Council was smaller (there were only around 1200 dentists practising out of about 1900 registered), all the same functions had to be covered. Given my similar role with doctors, I was able to assist in setting up examinations for overseas trained dentists. Conversely, the Medical Council learnt from the new Dentists Disciplinary Tribunal’s experience in its inaugural years.

International forces at work

By 1990, after three years’ protracted confusion in the transition from hospital board status, area health boards were increasingly hiring overseas trained graduates. Many did not have the qualifications listed in the 1968 Act for “full” registration, and they had to apply for temporary or probationary registration, which significantly increased the volume of work at Council meetings and in the office. There was also a steady stream of United Kingdom and South African graduates eligible for all forms of registration. In the year to June 1990, 79 doctors trained overseas were granted temporary registration, and an additional 252 received extensions to their temporary registration. The Council required supervisors of temporary and probationary registrants to report every six months, a time consuming task, but an important one in terms of the Council’s responsibility to the New Zealand public to ensure all doctors were practising safely.

In June 1990, for the first time the Medical Council of New Zealand hosted the annual meeting of the Australian Medical Council, including the meeting of Presidents and Registrars, a meeting of the AMC Uniformity committee, and a traditionally concurrent meeting of the National Specialist Qualifications Advisory Committee (NSQAC). The event was held at the recently opened Parkroyal Hotel and began on Saturday 23 June with a day seminar on competence, to which relevant stakeholders from around New Zealand were invited. That night a formal dinner for 70 people was held at The Wellington Club (also brand new). The AMC presented the MCNZ with an aboriginal painting, which until recently hung in the Council reception area. The next day, the guests were taken to
Orongorongo Lodge for lunch, followed by a coastal walk in the brilliant mid-afternoon sun to see the seal colony at Turakirae Head. Four days later the lodge was burnt to the ground!

In the spirit of Closer Economic Relations (CER) – a turning point in New Zealand’s economic relations with Australia – the Australian High Commissioner opened the formal two-day Council meeting with the AMC. We focussed on possible cooperation in three aspects of core business:

- accreditation of medical schools for the purposes of recognition of graduates for registration in both countries;
- examination of overseas trained doctors; and
- uniformity of standards and, where possible, procedures for ensuring fitness to practise in each country.

From this meeting came the practical steps to involve New Zealand in the AMC’s process for accreditation of medical schools in New Zealand and Australia, subject to recognition of New Zealand’s bicultural imperatives.

This milestone meeting was both enjoyable and fruitful, and had an element of drama; our guests experienced a hotel emergency evacuation, an earthquake, and, on the day after the meeting when some were setting off to see the country, an airport nightmare caused by a thick fog! What I wrote in the 1990 annual report still holds true:

“The stimulation of sharing common problems with our trans-Tasman counterparts enhances our own operation. It is also reassuring to find that the Medical Council of New Zealand is at the forefront of developments in pretty well every area of registration board activity. This does not mean that improvements are unnecessary but it does reflect well the skill, understanding and dedication of your Council and secretariat.”

Over the next five years, we continued to strengthen and develop our links in many areas with other registration bodies in New Zealand and overseas, especially focussing on maintaining and assessing competence, including instituting effective remedial action as necessary.

We also valued greater dialogue with the colleges and the area health boards, the latter having migrated and regrouped nationally over a period of three years from hospital board status, which had made communication in the transition quite difficult.

The Council and the secretariat were very disappointed that progress on the new Act was so slow, but we continued to work on other major issues. The Council’s working party on information and consent consulted widely, and published a report and a new statement for the profession in June 1990. The Renwick committee review recommendations on undergraduate medical education were also developed for action by the universities and employers of first-year house surgeons. Two meetings with area health board managers were held to deal with education and training (including early vocational education) for Year 7 and Year 8 doctors.
On reflection, we were managing to carry an enormous workload with a staff of 7.5 full-time equivalents (FTEs) while still maintaining a cheerful workplace.

I was also involved in many disciplinary hearings as Council members heard an increasing number of charges and appeals, many resulting from harm to patients, arising from sexual misconduct, prescribing addictive drugs or using fringe medicine detrimentally.
2.2 July 1990 to December 1995 – building up to the new Act

New directions

After seven years in the position, Dr Stewart Alexander stood down as Chair of the Council in August 1990. Dr Robin Briant, previously Deputy Chair, was elected to succeed him, becoming the first woman in the history of the Medical Council of New Zealand to hold this office. Following Dr Alexander’s resignation, he was honoured with a marvellous Festschrift at which contributors, in similar fashion, recalled his many skills and talents, and his good humour, humanity and creativity.

As well as marking the beginning of a new decade, 1990 in many ways marked the start of a new era for the Council. Dr Alexander had presided over some difficult times for the Council members and staff, always carefully promoting and supporting discussion and constructive options for solutions. This approach sustained even more momentous change in the next decade, particularly leading up to the new legislation and expansion of all aspects of the Council’s work. Dr Alexander’s wise advice and concern for individuals and his interest in governance as well as management was invaluable.

Dr Briant brought another valuable perspective to Council leadership and, in her turn, also enhanced the reputation of the Council for addressing difficult issues. Some of these had become increasingly obvious through disciplinary hearings and liaison with other similar boards around the world. Under Dr Briant’s leadership, we took some brave initiatives on sensitive issues, such as sexual abuse. Dr Briant built on Dr Alexander’s work to improve communication with the profession and the public, launching the Council’s newsletter MCNewZ in March 1991.

Performance issues

1990 was the year when the Medical Council heard charges of disgraceful conduct against Professor Dennis Bonham and Professor Herbert Green, who had been identified in the Cartwright Report as the clinicians primarily responsible for the controversial clinical trial at National Women’s hospital. After considering medical evidence from Professor Green’s counsel and his physician, the Council decided Professor Green was unfit to plead, and the charges against him were stayed.

The Bonham hearing attracted much publicity and an onslaught from the media. Media interest was heightened in part because the hearing, in the Tribunals Division of the District Court in Auckland, was held (as usual) in private. The Council found Professor Bonham guilty of disgraceful conduct. He was censured and fined $1000, the maximum sum under the 1968 Act. (The MPDC later heard charges of professional misconduct against Professor Richard Seddon and Mr Bruce Faris, who were members of a team which in the mid-1970s reviewed cases of cervical cancer at
National Women’s hospital. They were found guilty of the charges for their part in failing to express concern about cases of invasive cancer and one death.)

The PPC was always busy and enjoyed excellent legal assistance from the partners at Kensington Swan, and junior and senior barristers. Aberrant prescribing was a relatively constant cause for charges against general practitioners in particular. In late 1990/early 1991 a single case took four weeks of the Council’s time. Until that point, as Council Secretary, I had attended all hearings to take care of all aspects of their administration. It was a fascinating learning experience, but took me out of the office for substantial blocks of time. I decided to contract a legally qualified Tribunals Officer to work as and when needed. Susan D’Ath, LLB, accepted the offer, and continued in the role until all hearings under the 1968 Act were finally completed in 2001. She was also able to provide services for the Dentists Disciplinary Tribunal. While acting as Tribunals Officer she was able to graduate LLM, with a thesis on professional disciplinary matters.

Under the 1968 Act, the Council Chair and the Health Committee were able to act quickly to protect the public if doctors were referred who were significantly impaired. However, we tried to emphasize preventive action, cooperation in treatment and early development of healthy lifestyles. As respect for the committee’s approach to and management of impaired doctors grew, so did the workload. This was an area where my background in medical social services was helpful.

1991

In 1991, the Council decided to contract independently the services of the intern supervisors so that they were directly responsible to the Council for their work. The Council was concerned that workforce issues arising from the health reforms could possibly undermine the quality of the internship (the seventh year of training and conditional registration year), and place the conditional registrants (and the public) at risk. This was just one example of the vigilance required of the Council, as the influence of competition policy continued to permeate the health sector. There was worse to come.

Council and secretariat a hive of activity

I was constantly involved with the Council and its committees to refine and reform policies and procedures, in many cases making changes to deal with the increased volume and complexity of activity. Teleconferences and mechanising as many processes as possible went some way to keeping costs under control, but the very volume of work and new initiatives inevitably led to the Council having to raise the APC fee and Disciplinary Levy in order to meet its increased budget to cover all proposed activities.
By mid-1991, the data processing system and hardware was reviewed, revised, extended and upgraded, so that recording and producing records, reports and certificates for registration and examinations were all automated. I wrote in my annual report:

“Financial records are all on the database and a new receipting programme is being written. Our word-processing capability is sophisticated and effective, and telephone, fax, copying and printing resources are high quality. Information systems are regularly reviewed, including hard files and library material, and provide ready reference when issues come before Council or its committees.”

Changes to the secretariat structure implemented in 1990 proved worthwhile in the main. They freed me up to spend more time on policy development, quality issues, communication and planning. We also added a junior support person to the general office team. After one year, an Executive Officer responsible for communications, the MEC, the Examinations Board and the Health Committee, replaced the inaugural Assistant Secretary.

NZREX candidate numbers grew exponentially. Between July 1990 and June 1991, candidates made 337 attempts in the four parts of the examination. At that time, NZREX was conducted in two sessions, with Auckland and Wellington alternating as the centre. Later two, and eventually five, centres were needed to cope with demand.

The University of Auckland provided an office for the Examinations Director, Dr Gavin Glasgow, and his assistant, Jenny Hargrave, but the Council office handled all enquiries, enrolments, instructions, results, complaints and payments. Agenda papers for the Board of Examiners were compiled in the Council office, with some meetings held by teleconference and others in Wellington. NZREX Stage I (English and Written) was held in Singapore and London as well. At all times we emphasised that the examination was not designed to be a tool of discrimination but a yardstick to measure safety to practise as a doctor in New Zealand.

Reaching out to stakeholders

We took special care with all aspects of our communications. We responded promptly to letters, convened joint meetings with organisations with common goals, introduced a Council newsletter, and initiated media training for key Council members and myself. We sustained sensitive contact with complainants and doctors, especially where health issues or disciplinary charges were involved. The media was not always helpful with regard to discipline, as they found private hearings frustrating and the frequent long delays before findings were announced (for example, if appeals were lodged) even more riling. We were very aware of the pressure on Council Chairs and the huge commitment it meant for that
office holder. A communication committee considered ways of improving the flow of information.

The annual APC exercise provided a good opportunity for the Council to collect workforce data. A high return rate resulted from thorough follow-up of the questionnaires sent with the APC application form, and New Zealand’s data on the medical workforce was considered the best in the Commonwealth. However, as workforce management had become unfashionable in favour of market forces, the data seemed to languish in the back rooms of the Department of Health before publication, making it out of date. This was disappointing to the secretariat and the Data Committee and to Carol Leatham, the staff member in the Department of Preventive and Social Medicine at Otago Medical School, whose hard work achieving compliance could be tolerated if something useful emerged and was available to researchers and planners.

Workload

From the 1991 annual report onwards, a table on secretariat workload indicators was incorporated into the Secretary’s section of the annual report.

At the beginning of 1991, I took my first extended break from the Council office, spending six weeks in North America. In between visits to family, I was able to meet with executives at the Federation of State Medical Boards (FSMB) in Fort Worth Texas, the international office of the Educational Commission for Foreign Medical Graduates (ECFMG) and the National Board of Medical Examiners (NBME) in Philadelphia, and the College of Physicians and Surgeons of Ontario in Toronto. These links proved enormously helpful to the Council, especially when the examinations were being revised later in the decade and the initiatives to deal with sexual exploitation of patients were underway.

1992

By 1992, six years after my arrival, office staff numbers had moved up to eight FTEs, plus the part-time accounts clerk and the casual tribunals officer. The increase in staff numbers meant spaces originally set aside for use during hearings (such as retiring rooms and private space for legal counsel) were now being used by staff. The Chairman had been moved into the small space where the PPC convener had first been located and casual staff had to squeeze in where they could, including in the boardroom. We were starting to think about another move.

Advice and guidelines

Following its “Statement for the Profession on Information and Consent” and the statement “Responsibilities in Clinical Research in Institutions”, the Council was also getting involved with more standards initiatives. It developed further guidelines for the profession, including “Ethical and
Legal Issues in Biotechnology”, “Sexual Abuse in the Doctor/Patient Relationship”, and “Strategies for Action on the Misuse of Addictive Prescription Drugs”. Angela Coleman was engaged as projects officer on a temporary contract until April 1993 so that we had flexibility if the new Act was passed in the meantime.

Reform widespread

Consumers reacted well to positive initiatives and better handling of communications. Together, these innovations helped mitigate what were otherwise fairly negative perceptions of the Council as merely a self-interested protector of the profession. Consumers began turning to the Council for advice, as did doctors, in contentious areas like patient records, after hours and emergency care, notifying possibly impaired or incompetent doctors, and for advice on resolving grievances with other health sector bodies. It was becoming clearer that a Health Commissioner would be busy! Arising from the Cartwright inquiry, the concept of a Health Commissioner was batted about through various changes in government and ad hoc reports from “experts”, which slowed up drafting a bill ready for a select committee. The Council’s submissions favoured a non-adversarial system and advocated resolution of complaints through independent investigation, information and conciliation.

We increased training for staff and I brought back fresh ideas from international meetings. Health reforms were placing more emphasis on financial constraints and management theory, some of which appeared to impact adversely on patient care and the responsibilities of individual doctors. But this interest in cost effective quality care did help the Council to focus on the need for doctors to remain competent, and to have procedures in place if doctors appeared to be falling behind. Internationally, we were aware that post-entry re-certification of registered doctors would be necessary in the future. Even under the 1968 Act, the Council had carried out some competence reviews at the request of hospital boards, on a user pays basis. The Council grew increasingly frustrated when politicians did not fulfill their promises of a new Act, which meant that the Council had no mandate for interventions such as competence enquiries or regular review of specialists. ACC legislation was amended to clarify definitions of “rarity” and “severity” in medical misadventure claims, but ACC still did not inform the Council of doctors regularly having claims found against them.

Following the meeting with the AMC in June 1990, discussion and negotiation had continued with a view to achieving a joint process for assessing and recognising medical schools in New Zealand, and thus allowing graduates of each to be registerable in both countries. The AMC subsequently changed its constitution to allow New Zealand to have members on the relevant committees and the two Councils to have access to all reports. Trans-Tasman accreditation became a reality. Access to postgraduate training in each country was also improved by this move.
The influx of overseas trained doctors grew, exacerbated by immigration policy which rested on a points system under which medical graduates from overseas could achieve the threshold for permanent residence without having to be referred to the Council for evaluation of their registerability. The confusion, anger and suffering this arrangement caused plagued many of the applicants, their families, and the Council and secretariat, for almost a decade. Unlike the Australian government, the New Zealand government provided no bridging courses until 2001, 10 years after the immigration policy had been introduced.

**Pushing ahead through change**

In March and June 1992, the Council again reviewed examination and registration arrangements and put in place further changes. Giving enquirers accurate information was difficult, as we did not know when the legislation would change, with the result that advice might only be valid for a short period. As a risk management strategy, we therefore had to put time limits on the advice we gave. Of course, the effect was also to increase the enquiry rate dramatically, meaning more processing by staff.

By 30 June 1992, 2477 doctors were on the register of specialists, and another 1293 doctors were on the indicative register of general practitioners.

Our public relations work was now mainly done by the executive officer, who had suitable training, and the Communications Committee redefined the role of external media consultants.

**1993**

In 1993, New Zealand celebrated the centenary of women having gained the vote. The Council now had four women members out of twelve; Robin Briant, Judith Treadwell, Sharon Kletchko (representing the Director General) and lay member Trish Judd. The secretariat had nine full-time, one part-time, and one casual staff members – and only one man among them!

**Continuous improvement**

Pending the arrival of the new Act, the Council and the secretariat continued to work on standards and ethical issues. The work on strategies to reduce inappropriate prescribing of abusable drugs was completed. A Sexual Abuse Working Party, formed after a multi-disciplinary seminar in August 1992, developed statements over the next two years for the profession and the public, and the Council offered education workshops. After wide consultation, pamphlets for the public were also drafted and distributed. The process included involving other professions and using international literature and expert advice, plus consultation with community groups whenever possible. Later, complaints and disciplinary processes were scrutinized and protocols developed which would reduce
the risk of further victimisation of people, mainly women, bringing forward their concerns. The Council contributed to discussions on the development of New Zealand’s ethics committee structure. Work to refine monitoring impaired doctors continued and mentoring became an essential ingredient.

Robin Briant and I developed a good working relationship and the fact that she was based in Auckland did not interfere with that. She found that the staff provided quality administrative support for Council decision-making.

The Council was becoming more involved in international dialogue on matters of common interest. In 1992, the AMC had organised an excellent seminar in Melbourne for board members, with the President of the GMC, Sir Robert Kilpatrick, as one of the guest speakers. Trish Judd gave a paper on informed consent, as she and Professor David Cole had led the Council’s work on the statement published in 1990, which had broken new ground on the concept. In April 1993 several Council members and I attended the Annual Meeting of the Federation of State Medical Boards in San Francisco. For our sole lay member, it was a great opportunity to exchange ideas and common frustrations. A keynote speaker on “professionalism in medicine” provided a timely reminder that professional ethics needed to be nurtured and valued, in the face of powerful economic imperatives based on different principles.

While I was at the San Francisco meeting, the Council office moved to new premises on Level 12, Mid City Tower, Willis Street, Wellington. We had negotiated an excellent deal to obtain a whole floor in the central city, with incentives like “free” fitout and payment by the lessor of our lease in Courtenay Place, which still had a year to go before it expired. These were the days when office space was in oversupply. A ten-year lease was negotiated, and this location has accommodated the expanding secretariat for that decade with occasional modifications to how the space is used. We were able to have two meeting rooms, dedicated private interview rooms, upgrade our telephone system and individual work stations, engage a receptionist and a dedicated examinations officer, and have secure storage on site. At last, we also had the luxury of a staffroom.

Team structure

Quality improvement took high priority. With help from an external facilitator we began a human resources review and agreed in principle to set up a team structure in 1994, under the headings of Corporate Services, Registration and Standards. That organisational development stood the test of time and is largely still in place in 2002, now with a staff of 35 people in those offices in Willis Street. Later professional advisers were appointed and the roles of Chief Executive and Registrar separated.

Continuing health sector reform

From 1992, yet another round of reforms had been upon us, this time Crown Health Enterprises (“CHEs”). Their aggressive market policies put
paid to the coordinating system for matching first-year house officers with hospitals accredited to teach in the conditional registration year. Insufficient seventh-year posts were funded for graduating medical students and many graduates went to Australia, where there happened to be a shortfall. The MEC revisited the possibility of enlisting suitably accredited general practices, but this idea was torpedoed by a lack of funding for such a scheme. Concerns raised in the 1988 Renwick report were still being addressed, including bicultural issues. Some hospital accreditation visits were deferred to allow the upheaval of health sector reform to subside. The unbundling of clinical training funds and the creation of the Clinical Training Agency raised many issues, including educational programmes for eighth-year doctors entering pre-vocational training and the role of Postgraduate Deans. It seemed that the Council and its committees were constantly caught up in the backwash of changes about which they had not been consulted, many with consequences not anticipated by the proponents. As far as possible, the requirements of the Medical Practitioners Act 1968 continued to be implemented, albeit with some frustrations.

*Summer Studentship*

In 1992, I recommended that the Council institute a Summer Studentship to encourage a medical student to carry out a project related to the purpose and principles of the Council and the Act. Mark Edwards was the first recipient and that programme has continued, with a gradual increase in the number of studentships each year to five offered for the summer of 2002/3.

*Communications*

The trend for members of the profession and the public to approach the Council for advice or clarification about aspects of medical practice and ethics continued. I believe this trend reflected uncertainty, confusion and concern about changes in the health sector, some of which destabilized traditional responsibilities and work patterns. The Council’s registration officers were acutely aware of medical migration and workforce issues, often having to deal with distressed and angry doctors and employers, and not helped by the aggressive stance of a growing brigade of immigration consultants.

Some fire fighting was required when disgruntled overseas trained doctors told impressionable journalists, particularly in community newspapers, highly emotive stories riddled with inaccuracies. The Council produced press releases on a wide variety of topics, which indicated the scope of the Council’s involvement in change, despite the frustrating slowness of legislative reform.

In 1992-1993 the PPC was faced with a complex investigation when complaints of malpractice came in, alleging that psychiatrists had been using “deep sleep therapy” at Cherry Farm near Dunedin in the 1970s. The investigating committee finally determined that there was no case to
answer. A detailed press release was made when the complainants were informed, as the issue had sparked considerable public debate. It is interesting to note that, more recently, forensic psychiatric practice in that era has again been under the spotlight over the use of drastic measures to modify the behaviour of “uncooperative inmates” at Lake Alice Hospital near Marton. In the latter case, the allegations were proven, leading to compensation payments and charges being brought against the chief medical officer of the institution, now in Australia.

The Council released draft reports, discussion documents and final policy statements on a number of topics, following consultation with the profession; guidelines on transmissible major viral infections and persistent vegetative state were issued, the biotechnology guidelines were revisited, and policy developments on sexual abuse in the doctor/patient relationship continued.

During 1993, the Council also addressed the bicultural nature of the role of the doctor, after a briefing on marae-based initiatives. One of the highlights of a visit to Waahi marae was meeting Dr David Gilgen and his wife to reflect on the effects of his 1987 striking off (for offences related to addictive drug prescribing) and subsequent rehabilitation, which had relocated him with his iwi, Tainui.

A spanner in the works

On 12 July 1993, the Taxation Review Authority ruled that the Council was exempt from paying income tax on the grounds that it is both a public authority and a charitable organisation. The Commissioner of Inland Revenue, however, appealed the decision, and the issue was not finally resolved for several years, with subsequent appeals. Fortunately, in 1998 the IRD abandoned a possible final appeal to the Privy Council. The Council’s auditors, Miller Dean and Little, and in particular John Little, were unfailingly helpful and supportive in all aspects of financial system reform and mechanisation, and throughout the frustrating saga of IRD’s persistent desire to extract tax from the Council. This led to complex accounting provisions to cover possible liability in the future. When the Court of Appeal found in favour of the Council, and no action was taken to go to the Privy Council, tax provided for in previous years was reversed.

1994 - Tension – frustration vs progress

In the 1993/94 year, frustration with the protracted path to new medical regulation legislation was the dominant theme. There did appear to be a little light at the end of the tunnel, with the Health Commissioner Bill again going before parliament - in Dr Briant’s words, “emerging from the lengthy select committee deliberations and even longer on the back burner”.

The Council was increasingly turning its attention to maintenance of professional standards, realising that the 1968 Act’s silence on competence
and performance was inhibiting necessary reform. Some professional
colleges were able to show the lead with forms of continuing education and
audit – all, of course, on a voluntary basis. The Council needed the
mandate to require such activities, and review and remediation as required,
in order to protect the public more adequately.

By mid-1994, the Sexual Abuse Working Party had almost finished its task
and information pamphlets were ready for distribution. This important
aspect of the Council’s work is described in more detail in Part III of this
report.

Workforce issues were also prominent. The Council was eager to be given
more discretion in registration. The 1968 legislation had been designed in
the days when reciprocity with the Commonwealth was the main driver,
and had never been significantly amended, which meant anomalies arose in
the new immigration environment.

*International networking*

International cooperation in all aspects of medical regulation was becoming
more popular. Two important meetings were held in 1993/94 on assessing
medical education, one in Canberra and another in Sydney. The Australian
and the New Zealand Medical Councils agreed on mutually acceptable
procedures for visiting and accrediting undergraduate medical courses in
the two countries. An accreditation visit to Otago University was
scheduled for August 1994.

In May 1994, on the initiative of the Federation of State Medical Boards,
the United States government called and funded the first International
Conference on Medical Licensure/Registration and Discipline. The
conference took place in Washington DC. Information shared and
recorded from that meeting provided the beginning of a movement to
establish an international forum for debate and sharing of information on
issues faced internationally in licensing doctors. Four Council members
attended and presented papers, along with delegates from Australia, South
Africa, Canada, and the United Kingdom.

*Increasing capacity in secretariat*

Since moving into its new offices, the secretariat’s work had expanded
hugely. This occasioned further staff appointments, including Angela
Coleman as Co-ordinator of Policy and Projects. Internal staff promotions -
Steve Willcox (Corporate Services), Faith Barber (Standards) and Lynne
Urquhart (Registration) filled team leader positions. Tone Smith was
recruited from the Department of Health’s registration secretariat to be the
registration officer with particular responsibility for Dental Council
registration and, in due course, examination of dentists.

In 1994, there continued to be some refinement of the team structure;
although not all workload pressure points had yet been addressed fully,
customer complaints were rare. Staff training, and performance agreements with each staff member, made a tangible difference to accountability and efficiency. Although staff used modern equipment, much of the success of delivering high quality services still depended on the skills, experience and motivation of staff members themselves.

My continuing networking with health registration board executives in Australia, the United States and the United Kingdom, continued to provide fresh ideas and support, as most of the registration boards were facing similar pressures and challenges in all core activities and in new responsibilities. Everywhere, the assessment and integration into the workforce of overseas trained doctors and the rise in consumer complaints against health professionals presented huge hurdles.

Unbundling of clinical training funds proved a controversial issue and the Council took steps to make sure its own obligations under the 1968 Act were not undermined. The Council held meetings with intern supervisors, chief executives, chief medical advisors and personnel managers from crown health enterprises, which were aimed at improving dialogue and working relationships.

In her 1994 annual report, Dr Briant referred to the dedication and integrity of the Council’s members. Over many years of working together, their knowledge, working relationships and wisdom were exemplary. Mrs Judd, the sole lay member since 1985, gave sterling service, and continued to sustain her high school teaching appointment in Auckland. In the Queen’s Birthday honours for June 1994, Robin Briant was appointed a CBE for her far-reaching contribution to the profession and the wider community.

1995

By 1995 the reorganisation of the secretariat was bedded in, bringing immediate improvements in service internally and externally. Staff were aware that many Council members had had their terms of office extended several times, in anticipation of the new legislation which was still not forthcoming. This was particularly burdensome, because the Council was still sitting in its disciplinary capacity to hear complex charges and appeals from MPDC decisions. The MPDC itself had a heavy load of cases to hear and adjudicate on.

In matters of ethics, the Council occasionally commissioned reports from the University of Otago Bioethics Centre. This proved a wise and cost-effective way of promoting debate and serious consideration of some controversial matters, for example issues arising from assisted reproductive technology.

Financial management

The Council was mainly successful in balancing its budget, despite the highly unpredictable nature of calls on the disciplinary fund, fluctuating
numbers of examination candidates (a separate examination fund had been set up), and expenses associated with general Council operations being affected by the rise and fall of various forms of registration activity.

The Dental Council had for many years received secretariat services from Medical Council staff, mainly the Secretary/Chief Executive, as well as a dedicated registration officer and to some extent the financial controller. The Dental Council’s fees to the MCNZ were adjusted from time to time. Increases in the APC fee and disciplinary levy were becoming more frequent as the level of activities increased. It was considered prudent to set aside some “buffer funds” in the general and disciplinary funds, to deal with implementing the new Act, if and when it occurred. We lived in hope!

**Turning points**

The year 1994/95 was marked by a number of turning points. Drafts of the Medical Practitioners Bill 1994 were assessed and reassessed. The Bill was finally introduced to the House in November 1994, and submissions presented to the social services select committee. We hoped the Bill would become law before the end of the life of the current parliament. It had been the result of seven years lobbying six different Ministers of Health! The Bill contained new provisions for vocational registration and recertification of doctors on the register, and permitted the Council to assess the competence of doctors whose standards seemed to be failing.

1994 had brought the passing of the Health and Disability Commissioner legislation, followed by the appointment of Robyn Stent as the first Commissioner in 1995. She immediately drafted and circulated the Code of Health and Disability Services Consumers’ Rights, the Code to form the basis for a new focus on the assessment of complaints against doctors and other providers of health services. The present Council members looked forward to being relieved of their duties to investigate complaints and sit on hearings, some of them having been in office for as long as 10 years by this time. In that time, they had witnessed changes in society and the profession, unprecedented in the century since doctors’ practice was first regulated by law in New Zealand.

Media scrutiny of the Council had also increased dramatically. The Council was sometimes accused of secrecy because its hearings were in private – a consequence of the law, not the Council’s preference. The expectation was that, under future legislation, doctors would have better scope and tools to take charge of their own standards, through practice guidelines, quality assurance, peer review and assessment, and remedial action where necessary.

The Cartwright report had catapulted issues of informed consent into the limelight in 1988. At that time, the Council took the initiative and developed its statement for the profession, which was promulgated in 1990 and widely respected. In September 1995, the statement was reiterated with the addition of a clause concerning the need for information and consent if,
in the course of postgraduate education of specialists, new techniques were being attempted. This amendment highlighted the fact that technology and techniques were constantly changing and, in the early days of any new procedure, some doctors were literally at the cutting edge. Patients needed to be aware of such informed innovations, and have them appropriately described and questions answered.

Leadership change

Dr Briant decided to step down as Council Chair and, on 1 June 1995, Dr Ken Thomson was elected to that office (with Dr Briant moving to Deputy Chair) to take it through the transition to this “new age”. He acknowledged that, without the dedication of Dr Briant, and before her Dr Alexander, this new focus and appropriate mandate in legislation would never have been achieved. The Council looked forward to the new law being passed after select committee consideration, so that we could move on with parliament’s backing, having pushed the 1968 Act to its limits!

One of the major features of the proposed new Council was an expected increase in the number of lay members. Trish Judd had done an outstanding job in this role single handed, and earned the respect of her Council colleagues, the legal fraternity, lay members on other boards, the secretariat and the community. She found particularly disappointing, and indeed dangerous, the often biased presentations of events by NZMJists.

The last year of the “old” Council had many highlights, and the staff took pleasure and pride in them, as partners with the members in realising their goals.

Accreditation through AMC Process

Principal activities and issues dealt with during the year included the accreditation of New Zealand medical schools, the first being Otago whose site visit had been done under the joint MCNZ/AMC process in August 1994. Otago Medical School was given five years, not ten, with weaknesses to be addressed during that time including better access to obstetrics training, which had been undermined by health sector funding changes and a growing preference for non-hospital deliveries. A further five years accreditation would be considered when this issue had been adequately addressed. In principle, the internship (seventh year) was to be available in general practice, but funding issues continued to stymie this innovation, as it had done several decades before. Accident and emergency and night cover again came under the spotlight in relation to supervision available. It was preferable that backup and support for interns in these roles be offered directly, and not from a distance.

A partial return to a “MATCH” system for appointment of interns was introduced but was not progressed to a full programme. The Council’s
Registration Committee continued to deal with a heavy workload, meeting for about 50 hours over the year on formal deliberation, excluding the time taken to read agenda papers.

1995

At 30 June 1995, 11,889 doctors were on the register, 7,998 doctors held APCs, and there were 129 temporary registrants and 79 probationers. Representatives of the Council and the specialist colleges met with their counterparts in Australia concerning specialist training and registration. Several overseas trained doctors chose to go to court to challenge registration decisions. Two were directed by the Court to sit the Council’s examinations to determine their eligibility. Another sought redress in the High Court over the Council’s refusal to grant him probationary registration. The High Court required the Council to grant that doctor probationary registration, despite the Council having concerns about his fitness to practise.

The AMC had been involved in protracted and expensive litigation, as overseas trained doctors took their grievances to the Australian Human Rights Commission. The Council was very aware that it was not immune from similar action here, and of the necessity to adhere to well-constructed policies and practices, and to observe the principles of natural justice, to avoid conviction.

Although the Council had been meeting with the Overseas Doctors Association (ODA) since 1994, many issues remained unsolved because many overseas trained doctors would not accept the Council’s right and responsibility to expect passes in objective examinations of knowledge, skills and communication.

On some occasions, the Health Committee was asked to assess doctors with histories of substance abuse or mental illness prior to registration being granted. The Health Committee was also asked to assess doctors who appeared to be practising at unsafe levels and who should be seriously considering retiring from medical work.

New specialties and sub-specialties continued to emerge, but they could not be recognised without revision of the Schedules to the Specialist Regulations under the 1968 Act. Doctors in emerging specialties such as occupational medicine, rehabilitation medicine, and emergency medicine, called on the Council to recommend that parliament add them to the relevant Act schedules. The pros and cons of “lumping” versus “splitting” sub-specialties were vexing. Generally, the Council preferred mechanisms which were inclusive, to avoid isolation of small groups.
By 30 June 1995, 2870 doctors were on the specialist register and 1464 general practitioners were on the indicative register of general practitioners. In specialities experiencing shortages, such as psychiatry, the Council offered suitable overseas trained doctors temporary registration as an emergency measure. Many United States doctors in the early or late stages of their careers took the opportunity to come to New Zealand for limited periods.

In 1995, the colleges agreed to an interview and assessment process for overseas trained specialists not otherwise eligible for direct entry onto the specialist register. The Council, as the registering body, occasionally disputed the colleges’ advice. All these processes involved careful preparation of papers and supporting evidence of qualifications. College members spent hours on interviews and the increased number of examination candidates.

**Setting standards and supporting doctors**

During 1995, Dr Cole, a previous Dean of Auckland Medical School and a retired member of the Council, revised his handbook, *Medical practice in New Zealand - a guide to entering practice*, a valuable tool for both New Zealand and overseas graduates coming onto the register. It became an essential part of the registration pack received by all new registrants.

The medical workforce survey carried out each year in conjunction with the issue of APCs continued to provide a comprehensive snapshot of doctors and their practice. Since the first New Zealand register of medical practitioners was established in the mid-1800s, doctors from more than 70 countries had been registered in New Zealand. For more than 20 years, Carol Leatham, a statistician in the Department of Preventive and Social Medicine at the University of Otago (under contract to the Department of Health) had collected and analysed the annual workforce surveys, which then formed part of the Department of Health’s planning information. For most of this time, a Medical Practitioners Data Committee – a joint venture between the University of Otago, the Department of Health and the Council – had monitored this project.

The Council considered a variety of issues brought to it, including the ethics of doctors advertising, transfer of medical records, and medico legal questions. During 1994 and 1995, the Council had reconsidered informed consent (redrafting its 1990 statement to include a statement on the matter of specialists learning new techniques), euthanasia, and assisted reproductive technology. The Council also published its draft statement on “Duties in an Environment of Competition and Resource Constraint”.

We used the Council’s newsletter *MCNewZ* to communicate many of these items to the profession. In the March 1995 issue, *MCNewZ* drew attention to new provisions for APCs likely to come into effect with the passing of the new Act. The APC process had been improved by early distribution of
application forms, so that most APCs were now issued before 1 April – a minor miracle!

On the communication front, Dr Thomson met regularly with the chairman of the NZMA to discuss ethical, legal and practice issues. The Council also met with the new Health and Disability Commissioner, Robyn Stent, whose first task was to develop a Code of Patients’ Rights. The Council and the Commissioner had an open exchange of ideas on the Code. The Council supported advocacy as part of new mechanisms for addressing the concerns and complaints of patients. At the same time, the medical law reform group was pressing for amendments to the threshold for medical manslaughter to reduce unwarranted prosecutions, especially in some parts of the country where excessive zeal on the part of the police in monitoring deaths led to distress on all sides.

In February 1995, a joint meeting of the Council and the DHAS addressed boundary issues between the two bodies; the Council funded the DHAS, often the first port of call for families, colleagues or doctors concerned about a doctor’s health, and the Council also held statutory powers in relation to sick doctors. Although the DHAS was maturing in its approach to supporting and advising doctors with potential or early stage health problems, the Council sought greater accountability and wanted the DHAS to refer doctors to it if the risk of harm to patients was likely. The Health Committee had also refined its knowledge, process and reputation in this area, and it was important for referrals under the Medical Practitioners Act to be made in a timely fashion.

In the 1995 annual report I wrote of the dramatic increase in workload for the Council and its office over the 25 years since the 1968 Act had come into effect. That year saw major changes in the management of the medical workforce data collection, which was transferred to the Council office in Wellington. Significant changes to the questionnaire were considered, as well as how the information collected with the APC exercise was to be published. Carol Leatham, who had faithfully and painstakingly administered the database in Dunedin and answered many research enquiries or assisted with research questionnaire distribution, retired and was farewelled and thanked at a lunch in Wellington during the June Council meeting.

In terms of the Council’s finances, the tax liability issue remained unresolved, although the High Court appeal hearing initiated by the Commissioner of Inland Revenue was by now under way. The Council was still paying tax, but remained hopeful of a resolution in its favour.

I was active in promoting and sustaining liaison with other Secretaries and Registrars in health professions in Wellington and overseas. In my dual role as Secretary to the Dental Council, I assisted the Medical Council’s lay member Trish Judd to run a workshop for lay members of all health registration boards. This was very successful and became a regular event.
Dental Council sets up separate office

With ever-increasing workload and implementation of a new Act to contend with in the near future, I advised the Dental Council that it was necessary to terminate its current arrangement to have services provided by the Medical Council’s office. I then assisted the Dental Council and the Veterinary Council – both of similar size and holding similar functions, including separate disciplinary tribunals – to set up a new joint office on The Terrace. This arrangement has worked well and is still in place.

In many ways, I was sad to see the Dental Council move out of our joint office. I had begun my service to them as Secretary three years before their new Act came into place in 1989. At that time, it seemed astonishing to me that they had been waiting 10 years for it! Now I knew better than to expect a quick response to submissions for change, no matter how desirable. The dental profession was the first to have what has now become the model for separate disciplinary processes. The Dentists Disciplinary Tribunal was brave to elect one of its lay members, a lawyer, to chair the first tribunal. The shock of having the first dentist to appear before it take his own life after being found guilty of a professional error made everyone appreciate how vulnerable professionals, like any other human being, can be.

I had received no additional remuneration for my role as Secretary/CEO, and then Registrar, of the Dental Council, but I had learnt a lot and enjoyed the meetings with my counterparts in Australia. For the first time ever, they had come to New Zealand for a joint meeting in October 1986 – actually, the first time I had met with the Dental Council of New Zealand either. Jane Lui, previously a Dental Nurse and Secretary of the Dental Nurses Association, looked after the Dental Register for many years, followed by Tone Smith. We assisted them to set up examinations for overseas trained dentists after the surge in immigration in the early 1990s, and facilitated setting up training for first-year dentists, who had no statutory internship. When I retired from the Medical Council, the Dental Council presented me with a medal for my service, the first ever given to a non-dentist.

Medical Council staff expertise

By 1995, Council office numbers had risen to 17 FTEs with the appointment of team support persons in each team, and a full-time finance officer/corporate services manager, John de Wever, to the corporate team. Lynne Urquhart had taken over as Standards team leader, Jane Lui was appointed Registration team leader and a full-time communications officer was engaged. Jo Hawken-Inclendon became administrative secretary in the CEO’s team, with Angela Coleman sharing the roles of co-ordinator of policy and projects (.5) and education officer (.5).

As we moved closer to the enactment of the long awaited Medical Practitioners Act, we took with us 75 person years of experience in the secretariat which I had recruited and developed over the previous 10 years!
Honouring Dr Robin Briant

Robin’s service to the profession and the public was recognised at functions in Auckland and Wellington. A garden party at Old Government House (now part of Auckland University) was a big success and Robin was presented with a Sylvia Meek watercolour. The Council also purchased a painting “Pararaha” by Mark Hutchins for the Council boardroom to mark her enormous contribution to all aspects of regulation.

The year July 1995 to June 1996 involved business as usual at the same time as we went into top gear preparing to implement the new legislation. Without the skills, knowledge, patience and goodwill of all members of staff at that time, and access to Council members and committees, plus our usual advisors, including those in the Ministry of Health, we would never have succeeded in reaching 1 July 1996 still sane. One extra support person was needed, but I preferred to manage the transition with our existing knowledgeable and flexible people. I believed they were the ones with the capacity to make the transition go as smoothly as possible. They had in-depth knowledge of the rules, the customers, the complications, and the likely pressure points, and I look back on my decision as a wise move.

The Medical Practitioners Act 1995 was finally passed late one night a few days before the Christmas 1995 recess, in a legislative chamber with the minimum quorum in attendance and, in the public gallery, four Council secretariat members (myself included), a handful of alternative medicine practitioners and a group of tourists who must surely have wondered how robust this democracy really was! The “fax attack” on Health Minister Shipley, orchestrated by me, to reinstate a majority of medical members on the Tribunal, succeeded!

The Medical Practitioners Act 1995 came into effect on 1 July 1996.

Council membership gradually transforms

The transition from the 1968 to the 1995 Act, starting on 1 January 1996, was a testing period in the Council’s history.

In February 1996, at the first Council meeting after the new Act had been passed (but still not in effect), the Council re-elected Dr Ken Thomson as Chair, and considered a schedule I had prepared as CEO on existing policies which needed endorsing or amending prior to the 1995 Act coming into effect on 1 July 1996. The Council endorsed the registration policy set out, as well as the arrangement whereby overseas trained doctors seeking vocational registration would first need to be assessed by the relevant college or specialist society, to allow the Council to rule on the appropriate type of primary registration for that doctor, that is, temporary, probationary or general.

Stakeholders who would be most affected by new registration and supervision policies in all categories of registration were invited to attend a full-day workshop the next day, where the Council’s proposals were conveyed and debated. There was a good exchange of general principles and, although some of the principles would make life a little more difficult for employers, there was general support for them in terms of the new Act’s emphasis on increased protection of the public and continuous quality improvement.

One of the major challenges of the new legislation was coping with the migration to a significantly different method of selection and composition of the new Council (Appendices V and VI set out in detail membership over the transition). On 1 July 1996, we immediately acquired a new lay member, Henri van Roon of Auckland, who was appointed by the Minister. The new Act provided for three lay members and the Minister of Health, Jenny Shipley, asked Trish Judd to accept appointment to the new Council for a further two years to assist in the transition, which she agreed to do. The Minister delayed appointing a third lay member until she knew the results of the election of the four medical members, the first Medical Council members ever elected. Dr Ken Thomson had agreed to stay on the Council until 30 December 1997, as had Professor Graham Mortimer to
represent Auckland and Otago Schools of Medicine. He then took on the role of Examinations Director.

**Process for electing four Council members**

We used the April 1996 issue of *MCNewZ* to consult on the proposed election system. There was little feedback or objection to the proposed system, so we were then able to draft the rules in compliance with the Act and gazette them as soon as possible after 1 July. An information pack was put together for potential candidates so that there would be no nasty surprises about workload, tasks and frequency of meetings.

The first meeting of the Council under the new Act (with one more member, a second lay person) was held on 1 July 1996, a noon teleconference to allow the Council to formally adopt the rules for electing the four medical members later in the year. These rules had been drawn up in the previous six months, after consultation with Victoria University political scientist Nigel Roberts, and consideration of electoral systems used by the GMC and the Colleges of Physicians and Surgeons (the Canadian bodies with similar powers and functions to the Medical Council of New Zealand). Proposals had also been circulated to all doctors currently on the Medical Register whether in New Zealand and overseas. For all the debate on Medical Council “democracy” which had gone on in the *NZMJ* in the 1980s, there was very little feedback when doctors actually had the chance to contribute to a real change. One can only assume that what was proposed was to their liking!

The Council adopted the Single Transferable Vote (“STV”) system of proportional representation to elect the medical members. The electoral system adopted involved one electorate covering all doctors on the register, whether in New Zealand or overseas (as required by the Act), and the election rules were then gazetted. The GMC used STV successfully, Victoria University had a computer programme for counting the votes under this system, which it used for electing academic staff members to the University’s governing body.

The timetable for implementing this regime in 1996 produced an election date at the end of November. The timetable had to take into account:
- announcing the election;
- calling for nominations on the prescribed form (which required brief profiles and photographs of candidates);
- disseminating this information in New Zealand and overseas;
- compiling the voting papers (including information about the candidates and instructions on how to record votes), and
- meeting the deadlines in the gazetted rules.

As required by the Act, in mid-December the election results were to be published in the *New Zealand Gazette*, and the elected members took office the next day.
Getting the first election successfully completed was a major undertaking. Meanwhile, all existing Council members remained in office and attended to many of the transition requirements of the new Act.

**New registration requirements published**

Transition clauses dealt with registration conversions in each category of registration, the system for accrediting supervisors for the seventh-year programme, what to do with suspended doctors, and approved institutions for training of doctors in New Zealand.

Some very significant changes to the registration regime were introduced in the 1995 Act. The Act was not prescriptive. It set out the categories of temporary, probationary, general and vocational registration, and empowered the Council to decide what qualifications it would recognise for registration in those categories.

When the Bill was being considered, the Council had presented a paper to the select committee indicating that it was likely to allow only holders of medical degrees accredited by the joint AMC/MCNZ accreditation process to be granted probationary or general registration without further assessment. Effectively, that meant only graduates of medical schools in New Zealand and Australia would be able to practise permanently without examination. All others would have to complete the Council’s examination, NZREX. The Council came up with this policy to counter any allegations of racial discrimination and reinforce the concept of a clear benchmark by which all other qualifications would be judged.

The Council, on the basis of the AMC/MCNZ accreditation committee’s report, accredited the University of Auckland for 10 years from 1 January 1996. The University of Otago had already been accredited for the five years to 2001. That meant that registering the graduates of the 12 Australian and New Zealand accredited medical schools was straightforward and reciprocal, so long as there were no fitness to practise issues. They provided the benchmark for all other entrants to the register.

In light of expected workforce shortages if the Council implemented its policy without notice, the Council allowed a two-year grace period during which graduates from medical schools in the United Kingdom, Eire, Canada and South Africa could apply for temporary registration (for a maximum of three years).

Changes to registration requirements were advertised worldwide to all agencies likely to be affected, as well as to doctors in New Zealand and those already on the register. As expected, there was a tremendous flood of applications under the 1968 Act through until 28 June 1996, the last working day on which any such applications could be actioned. A great many applications came from South African qualified doctors who on 1 July 1996 lost automatic access to “full” registration without examination.
Under the 1995 Act, processing applications for temporary registration from those without specialist qualifications in their own countries could be done fairly speedily. However, specialists’ applications for vocational registration had to be referred for assessment to vocational colleges, which slowed up the process. Processing their applications was further complicated by the fact that the Council was awaiting advice from the Council of Medical Colleges, which it had asked in 1995 to come up with a consistent process for applications across all disciplines.

**Putting stakeholders in the picture**

The April issue of *MCNewZ* set out in plain English the provisions of the new Act dealing with the Council’s composition, and the requirements for registration and APCs. In May, *MCNewZ* spelt out in more detail the policy changes affecting overseas trained doctors, and the other sections of the Act concerning maintenance of standards, fitness to practise, and conduct. These newsletters were sent to every doctor on the register in New Zealand and overseas.

Going into the new era we were still waiting for a final decision on the Council’s tax status. Although the Taxation Review Authority, the High Court and the Court of Appeal had each found in the Council’s favour, the Commissioner of Inland Revenue was still considering whether or not to appeal to the Privy Council. We were sorry to move into yet another tax year with this uncertainty hanging over us. Our accounting during the transition period was complex enough without that.

**Migrating to new territory**

Converting to new registration terminology and rules required amending the computer database and modifying our merge letters and pathways. Jane Lui worked with our original system designer to achieve the required changes. Some amendments had already been made over the years since 1987 when the computer system first went live, including gradually migrating to Microsoft Windows and Word-based tools. Because the same expert had done all that work, he was aware of the possible complications. Jane and her team advised him on what was required to make the transition to the new Act’s terminology and processes. On 1 July 1996, we were able to go live, complying with the new Act and without any major hitches. That in itself was a significant achievement. It took a little longer to update less frequently used form letters, but from the beginning core activities proceeded relatively smoothly.

Despite constant reminders over the previous three or four years that changes would occur with the new Act, the registration team had to contend with a surge of irate doctors and employers unwilling to accept the new law and policies. Any notion that the registration officers merely did routine clerical work was sadly misguided! A common source of irritation was the fact that applications made but not concluded under the 1968 Act had to resubmitted and considered afresh under the new process.
A desktop publisher was engaged on a short-term contract to make all the required changes to standard letters, design new forms, and a writer prepared new information brochures and packs about the Council’s functions for publication. Many of those forms, letters and brochures with some adjustments for refinements in policy, are still being used in 2002.

I also engaged a part-time human resources advisor to be an independent person to support staff over the transition period, and to provide in-house training and occupational health and safety advice. She acted as a sounding board for me also. Together, we simplified some of the job descriptions and performance contracts. By this time, staff numbers had increased to 19 FTEs and one casual.

*Discipline carried over*

Under transition provisions, the previous Council was required to continue sitting in its disciplinary capacity until all charges awaiting hearing on 1 July 1996 had been concluded, including any appeals from MPDC decisions and any appeals against Council decisions. To add to that hearings workload, transitional provisions required proceedings already under way when the new Act came into effect to be continued and completed as if the new Act had not been passed. Where alleged disciplinary offences had been committed before the commencement of the new Act, and no action had yet been taken, complaints were required to be prosecuted under the old regime in the Medical Practitioners Act 1968, rather than notified to the Health and Disability Commissioner.

In 1996, we were not to know that in 2000 the “old Council” would still be processing some disciplinary matters commenced before 1 July 1996, mainly appeals to the High Court from the Council’s appeal decisions. The MPDC was also still tying up loose ends.

A set of pamphlets was developed to explain to the public how to lay a complaint about a doctor under the regime in force from 1 July 1996. The brochures described the new disciplinary system, and its interface with the Health and Disability Commissioner’s office and the Code of Health and Disability Services Consumers’ Rights. The process for complaining about a doctor was complicated by the fact that complaints about events which occurred before 1 July 1996 were still dealt with by the Medical Council. Complaints about events which occurred after 1 July 1996 were dealt with under the Code, which also came into effect on that day. The new brochures were widely distributed.
**Business as usual**

A Council survey distributed by the ODA at the end of 1995 and early 1996 revealed that there were at least 650 overseas trained doctors in New Zealand still hoping to gain registration, about half of whom were in the 30 to 35 year age bracket. Once again, the Council asked the Minister of Health to do something about providing bridging courses for those doctors, but again to no avail.

There were new challenges on the horizon for our medical schools, as Australian universities started to develop four-year degree programmes for graduate entry. Council expected to work on accrediting postgraduate programmes, for recognition of vocational branches under the new Act.

Shortage specialties posed ongoing problems. A special subcommittee of the Council’s Registration Committee, including a representative from the Royal New Zealand College of Psychiatrists, was formed to scrutinise applications from overseas trained psychiatrists, mainly from the United States. One such psychiatrist, Dr Jack Mates, later played a key role in continuing to attract quality younger and older psychiatrists and in working to get them registered. His advocacy helped Council register many people who gave good service. This proved invaluable in addressing chronic significant undersupply in most parts of New Zealand.

More first-time applicants for registration were disclosing previous impairment, so robust procedures for evaluating their safety were put in place. Practitioners in certain branches of medicine, for example anaesthetics, seemed to be more at risk of drug addiction, possibly because of access to drugs. We were pleased when initiatives in the workplace were developed to intervene at an early stage.

Work on trust in the doctor/patient relationship continued, with the Council drafting guidelines for terminating doctor/patient relationships and for doctors considering sexual relationships with former patients. A process for assessing and rehabilitating offending doctors was put together, with a panel of experts (doctors and clinical psychologists) available to carry out assessments on causes of offending and to encourage entry to therapeutic programmes to re-establish safe principles for practice. We were conscious of the need to keep working on all these initiatives. Our 1990s project was only a start.

The Council continued to urge the government to develop better frameworks for assisted reproductive technology, encouraging MP Diane Yates who had been devoted to this topic over many years, with little real result from the lawmakers.

Telemedicine across different jurisdictions loomed on the horizon as a potential risk area with regard to responsibility for action if a patient made a complaint.
2.4 1997-1998  New Council takes over the reins

From June 1996 to March 1997, there were more changes in Medical Council membership. The “old” Council remained responsible for “old” discipline and gradually the appointments and elections were completed to get the new Council of 10, instead of 12, members in place.

Council members elected for the first time

There were 28 candidates and four members were elected. As I predicted, doctors elected two previous chairmen of the NZMA, the president of the Resident Doctors Association (who then stepped down from that role), and a general practitioner who was in fact already on the previous Council.

Considering all the calls for a democratic system, only 41% of doctors with a New Zealand address took the trouble to vote, and 10% of those with an overseas address. There were only 22 informal ballots cast, although 50 votes arrived too late to be counted. Most voters exercised their right to vote in the week or so immediately after receiving the ballot papers, with a small upsurge around the closing day. The Council received no adverse comment about the way the election had been conducted. No candidates exercised the right to have a scrutineer present when votes were counted, but I appointed one scrutineer for my own protection. Vote counting went without a hitch and all timelines were met according to the gazetted rules. The first election cost approximately $33,000, being about $2.68 per person on the electoral roll.

We provided the new Council members with a comprehensive orientation pack to study over the summer break before the first Council meeting in early February 1997. At that meeting, Dr Ken Thomson was re-elected President and Dr Ian St George was elected Deputy President. Under the 1995 Act, the Secretary became known as the Registrar.

Council strategic planning meetings, sometimes assisted by an external facilitator, had been held since 1991. The first such meeting for the new Council took place in Auckland in February 1997. Mission, vision and values statements were, with difficulty, drafted by the end of the second day, and with some later modifications are still in place and published in the Council’s annual report.

The Council elected its new committees at the February meeting. In principle, the Council aimed to appoint medical and lay members to all committees. We awaited the appointment of the third lay person to join Trish Judd and Henri van Roon, but regrettably the Minister did not do that until the end of 1997. For that reason, the Council had only nine members for a whole year, during which time important decisions on policy and process were being made. Historically, Ministerial delays (despite the fact that vacancies are predictable because the legislation sets down the terms of office) have riled Councils because they put extra stress on members and staff.
The Medical Practitioners Act 1995 allowed the Council to appoint committees as necessary. As the 1995 Act did not specify the composition of committees (except complaints assessment committees), the MEC as constituted under the 1968 Act went out of existence. The Council replaced the MEC with a new Education Committee. New committee appointments were held over until the first Council meeting after the election.

Angela Coleman’s long association with the MEC was of huge benefit to the new Education Committee, whose terms of reference now covered undergraduate and postgraduate issues. The committee continued its work on workplace supervision and refining the guidelines for the intern year. It also processed enquiries and applications relating to recognition of new branches of medicine. Visitors appointed by the Education Committee resumed visits to CHEs. Some new challenges emerged in the competitive environment and gave rise to heated debate, for example employers’ disregard for some minimum standards. For example, informed consent always a hot topic, meant making a clear ruling that the doctor doing the particular procedure should be the one to obtain consent. Traditionally, this task was often delegated to juniors in the team. Although it was a good learning experience for house officers, the consultant still had to take ultimate responsibility despite management reforms.

The new Act also allowed the Council to appoint non-members to committees, a provision the Council welcomed. As the Council had discretion over the composition of the Education Committee, it was revised significantly, bringing in not only relevant academics but also lay people and a consumer of education (a Resident Medical Officer or Registrar). The Education Committee now comprises six members appointed by the Council, and three Council members.

The Health Committee was expanded and it included at least one lay member as before. Transition for the Health Committee was relatively seamless as the model and the committee, with excellent support from the health team, Lynne Urquhart and Jo Hawken-Incledon, were all retained under the new Act.

An embryonic Professional Standards Committee, also including a lay member, was put in place to begin developing principles and processes to put to the Council for endorsement. A quorum of the Council (five members) was deemed to be the Registration Committee and the new lay member, Henri van Roon, sat on that. Henri was keen to learn as much as he could as soon as possible, and he made a great contribution to many committees during his three-year term. We were mindful of the fact that Trish Judd was still sitting on discipline cases under her 1968 Act hat, as she was the only lay member permitted to be on the old “tribunal”.

The Issues Committee dealt with many enquiries from the public and the profession, entrepreneurial practice being one of the more contentious
developments in the market place in which doctors operate. Medical records in electronic form also needed scrutiny from a privacy perspective.

At 1 July 1996, we had 13 Council members, and by 31 March 1997 there were nine. The Director General of Health was still a statutory member of the Council, but a new provision under the 1995 Act permitted the DGH to send a deputy, and that became standard procedure. The Chief Medical Officer at the time usually took on this task, which provided a regular two-way flow of information on what was happening in government policy and service development which did or could affect the medical profession and its governance.

The Council’s tax status was still not resolved!

The new MPDT was appointed, with senior barrister and solicitor Peter Cartwright in the Chair. The Council’s relationship to this independent body, financed by the disciplinary levy collected by the Council, caused a few administrative headaches, but they were resolved before the Tribunal heard any cases in its second full year of operation. The discipline secretariat was also in the bind of having two disciplinary bodies to serve; the MPDC under the 1968 Act, and the MPDT under the new Act. Secretariat staff answered to the Medical Council with respect to the MPDT, and (nominally) to the NZMA with respect to the MPDC.

In light of its mandate under the new Act to protect the public, not just patients, the Council reconsidered the definition of the practice of medicine. The Council deemed medically qualified teachers (including those teaching pre-clinical topics), public health workers, and managers and researchers with medical qualifications, to be practising medicine. They thus required an APC. It required some detective work on our part to identify who they all were in the various institutions.

A definition of, and work on implementing, “general oversight” for general registrants began in earnest. It proved quite challenging with respect to doctors in small rural hospitals, Medical Officers of Special Scale (MOSS), and to doctors in small disciplines not easily brought under the umbrella of existing vocational branches.

Action research

Aware of changes which should be monitored and evaluated in the interests of public safety and the Council’s accountability under the new legislation, I persuaded the Council to begin a programme of action research to evaluate its effectiveness under the new law. By both local and international standards, this was an innovation in medical regulation.

The Council accepted a proposal from Victoria Link, the contract arm of Victoria University, which began the first stage baseline fact gathering process through a postal questionnaire sent to a sample of the register.
Regrettably, when I gave up my role as CEO in 1998, this initiative was not carried through.

**Competence**

In anticipation of exciting, new and long overdue involvement in competence issues, we had commissioned Dr Bob Large, psychiatrist and medical educator, to write a report for the Council. The report was to cover issues concerning maintenance of competence by doctors and could be available to guide the establishment of competence objectives and procedures under the new Act. It was available to the new Council in April 1997.

In 1996, the Council office numbered 21 FTEs. The staff were committed to doing a good job and the Council was well aware of this. Some of the longer standing staff in particular were tremendously dedicated to solving problems arising from the new legislation. They maintained their professional approach, even under severe provocation from some customers and the occasional stroppy Council member.

Following the first very successful International Conference on Medical Registration and Discipline in Washington DC in 1994, Australia offered to host a second and this took place in Melbourne in October 1996. A group of medical and lay members, plus senior staff, attended as delegates from the Medical Council of New Zealand, as well as some representatives from the Ministry of Health. Speakers from the United Kingdom, the United States, Canada, South Africa and New Zealand made excellent presentations, which contributed to an exciting exchange of ideas. Dr Thomson, Trish Judd and I were involved in presentations and workshops. New Zealand offered a one-day satellite meeting for local and overseas participants in Wellington the following week. It was entitled, “Too many and too few doctors – dilemmas in the medical workforce”. It included a timely paper from Dr Mason Durie on the low numbers of Maori doctors. The outgoing ODA president raised issues affecting members of that organization.

As Registrar, I signed a new Ministry of Health contract for medical workforce data collection, with the database relocated to Wellington under revised parameters.

The Medical Practitioners Act 1995 required that the annual report cover the period to 31 March, the end of the financial year, and to be made to the Minister of Health before going to the House of Representatives. Although we had always sent our annual report to the Minister, this had been on an informal basis. We had always provided sufficient copies for all members of parliament, but whether or not they received them was out of our control. It was good to have the annual report become part of the Council’s accountability to the Minister, and tabled in parliament.
As would be expected, the Council’s wider roles increased the workload. The sheer volume of activity put a strain on operations, affecting staff, Council members and committees.

**Personnel changes**

At the end of 1997, the Council accepted my recommendation that the time had come to separate the roles of Registrar and Chief Executive, and we worked on a job description for a new CEO who would join the office early in the coming financial year. After an IT review, an information systems person was hired, and the part-time database support role was upgraded to a full-time information officer, both of these new staff becoming part of the corporate services team.

The Council’s President, Dr Ken Thomson, retired at the end of 1997, as had been agreed with the Minister when the transition was being planned. All staff members had enjoyed Ken’s quiet support during the hectic transition, and his thoughtfulness in coming regularly to the office had been good for staff morale. We were aware that he fitted this in on top of a heavy pathology workload during a severe nationwide shortage of forensic pathology experts.
2.5 1998-2000 New Council cracks the whip

In February 1998, Dr Tony Baird took over as president, the first elected member to do so. Based in Auckland, with clinical and management roles in obstetrics and gynaecology, he too was very much an active member of the profession.

Council membership was still in transition, with Trish Judd continuing as a lay member on the new Council until June 1998. The Minister appointed Carolynn Bull from Christchurch as a new lay member just before Christmas 1998. Later that year, economist Alex Sundakov, was appointed to succeed Trish, making up the complement of three lay members as envisaged in the 1995 Act. Heather Thomson, who had been a member of the Renwick committee in 1987, succeeded Henri van Roon in mid-1999.

Trish was still involved, however, because she was a member of the old Council which was trundling through a series of appeals from MPDC decisions, which seemed to drag on interminably. Mercifully, appeals from the MPDT constituted under the 1995 Act were to go to the District Court. In late 1997, the MPDT got to hear its first case, prosecuted by the Director of Proceedings appointed under the Health and Disability Commissioner Act 1994.

A huge effort was made by staff, by then 27 FTEs. Lynne Urquhart was promoted to Deputy Registrar/General Manager, and Jane Lui continued to handle the formidable role of registration team leader, with a senior registration administrator appointed to concentrate on improving systems and solving problems. Lynne’s successor as Standards team leader spent her year in that role concentrating on recording systems, processes and accountability in that team, which included examinations, complaints assessment, and professional standards (competence). Health was nominally under that team, but in practice the Deputy Registrar and her health administrator, Jo Hawken-Incledon, were fully occupied dealing with an increasing caseload of impaired doctors due to the quality service of the experienced Health Committee and its administrators being widely trusted. The first Professional Standards Committee spent its first year developing its parameters and attempting to come to a workable approach to the tasks required.

The new CEO, Sue Ineson, took up that role in August 1998, and was able to concentrate on management issues, while as Registrar I focused on statutory requirements and associated risk management, including Council’s contribution to the Ministerial Enquiry into under reporting of cervical smear abnormalities in the Gisborne area, arising from allegations against pathologist, Dr Michael Bottrill, who had been the subject of charges and appeals heard under the 1968 Act disciplinary rules.

Continuous improvement
Already deficiencies in the 1995 Act were emerging. The Council met each month for most of the following year to get on top of policy and procedural matters which came to light as work under the Act developed. General oversight was difficult to implement in isolated locations and small specialties, but there were no discretionary powers in the Act.

Bridging courses for overseas trained doctors were still a non-event.

Through the overseas contacts I had nurtured, I was glad to facilitate a further streamlining of NZREX. The Council chose the United States Medical Licensing Examination (USMLE), which the ECFMG and the NBME had designed and refined over the years, as the screening exam for entry to NZREX Clinical. This removed one logistical step in dealing with the ever increasing numbers presenting. USMLE included an English test, so that left the Council clear to run a clinical exam only. The President of ECFMG was well known to me from international meetings and phoned to give the go ahead to use their exam as soon as she received my request. Soon after this, USMLE moved to an electronic format and could be taken virtually on demand in examination centres in major cities in New Zealand and around the world where secure facilities had been developed for computer based testing.

Finally, on 15 April 1998, we learnt that the Commissioner of Inland Revenue was not going to appeal the Council tax issue to the Privy Council. Our charitable status therefore remained intact. A refund of $657,154 income tax was made, but we had to wait longer for our withholding tax, and interest on monies held without justification, to be refunded.

After full consideration by our auditors, we could see no fair way of making refunds to individual doctors, so the refund went into general and discipline funds. I urged the Council not to use it for “housekeeping”, but to keep it as the core of a future research or education fund. For example, I envisaged the money being used to research the efficacy of the new Act’s measures to protect the public, an innovative piece of legislation for its time. A special purpose fund was set up and reported in the 1998 annual report statement of financial position as having been audited by the Council’s auditors. However, later in the 1998-99 financial year, the Council decided to transfer all those monies back into the general and discipline funds, to reduce the APC and Disciplinary Levy. I still think this was short sighted and the action of politicians interested in re-election. The fees doctors in New Zealand pay for registration are modest in comparison with many other countries!

Gradually, the APC fee (including disciplinary levy) was reduced further for all doctors, as there was a relatively low level of disciplinary activity during the transition period to the new Act and the Health and Disability Commissioner procedures. Surpluses increased as fewer disciplinary and competence cases occurred than were forecast. Budget setting will
continue to be subject to variations which cannot be predicted, as complex disciplinary and competence matters can come out of left field at any time.

We also decided to trial a system for partial refunds of the APC/Levy fees to a small but important group of practitioners on low incomes because of parenting or semi-retirement, the latter group frequently providing voluntary services to community and professional organisations. That system has remained in force with some refinements.

The annual report to 31 March 1998 began with three pages of milestones for this watershed year (see Appendix VII). When I read that report I am very aware of the maturity and stamina the milestones mark. They highlight the work of an organisation which had survived and adapted to change over twelve years of relentless growth, reform and challenge. It took guts to get through that period, but we did – the Council, its staff, and its stakeholders empowered by the goal of reducing and preventing harm to patients.

My reflections on the years 1999 and 2000 were printed in the annual reports for those years, attached as Appendices VIII and IX.
Part III

Commentary on Council and stakeholders
3.1 Council and its office

Principles

Self-regulation is a privilege and rests very much on the conduct of the governing body of each profession and the integrity of individual professionals, members who must teach and assist each other, encourage ethical competent practice, support weak members, and have confidence to speak out as standards or ethics are slipping. Individuals cannot afford to be passengers; they must be brave and not shy away from hard stuff, be strong, reflect on practice, encourage truth, serve society not self and set an example.

Today Acts of Parliament mandating such self-regulation goals are not so much about control, though legislation may feel like that, but about empowerment and societal responsibility. That responsibility requires a wise governing body with a degree of continuity, institutional memory and a consistent process; not unresponsive but alert to learning opportunities, sharing ideas, testing them out, consulting with their profession, other professions and professionals, the public, lawmakers, similar overseas bodies.

In order to do what is right for New Zealand, testing out ideas can be achieved through discussion papers, drafts, workshops, working parties preparing the first stage and consulting other stakeholders, in a process which involves iteration, research, brainstorming, listening, getting in experts and taking calculated risks. The body must know when to include and exclude special interest groups, like the NZMA, Colleges and community groups.

Increasingly, governing bodies also have to be cognisant of what is going on in other countries. With globalisation and increases in medical migration, while standards must be protected, too many variations between countries cause a nightmare for doctors wanting to practise in different countries from the ones in which they were originally trained.

The privilege of self-regulation must be safeguarded despite occasional uneasy relationships with ministers and departments. Often political changes are driven by exceptions to the rules, individual cases, political and media spotlight, health sector reforms, funding changes and technology, as well as the occasional cases of aberrant doctors who are bad, sick, dangerous or immoral.

The Council, like all statutory bodies, must observe administrative law, including fair and open decision making. The role of the Council office in supporting all the different dimensions of regulation by providing expert support, advice and information cannot be underestimated. One of the main tasks of the Registrar is to ensure compliance, while at the same time bringing forward to the Council suggestions for change. Management process and expediency can sometimes bring about pressure to take short
cuts. These may turn out to be the very aspects of process that rebound, if a doctor takes a case to court. Sometimes experts are avoided, but they may have the in-depth knowledge to balance against raw public opinion. Doctors themselves have a wide range of views, fostered by their career stage, the setting for their practice, their personal politics, and influenced by their colleagues and patients. The environment externally is very largely affected by custom, trends and sentinel events.

Balancing all parts of the whole is important and, in this regard, Maori culture can teach us a lot. Cultural dimensions are very important – to keep remembering the wisdom of elders and the dynamics of the group so that we can share and nourish each other, including rather than excluding. The Council’s experience of going to Waahi Marae with Tainui elders and hearing David Gilgen and his wife describe the effect on his family of his being struck off made more impact than any “talk fests” about bicultural sensitivity. The presentations made by the community health workers, all women, describing their outreach in primary and public health initiatives, were an education.

Another principle which became apparent to the Council when it was in the long process of legal reform was that small groups can achieve a lot if they get leverage from a wide variety of stakeholders. This was demonstrated with regard to developing the “Strategies for action on misuse of addictive prescription drugs” and the sexual abuse initiative. On other occasions it is appropriate to go to experts, for example the Health Committee’s development of the statement on Transmissible Major Viral Infections. The media can be helpful in pointing out issues, giving shocking examples, but sometimes they focus their intention on those who cannot actually make the change. They should be looked on as producing options, but these still need to be developed and tested, especially now the media is so commercially driven.

The Council is part of a complex jigsaw which requires interaction and cooperation between the Council and the large number of internal and external stakeholders. This part of my reflections on the period from 1986 to 2000 looks at the roles some of those key stakeholders played in their partnerships with the Council to achieve the aims of the legislation, namely protecting patients and enhancing the performance of doctors.

More general educative information about the role of professional regulatory bodies (not just their performance, complaints and investigation procedures) is needed.

Communication

Clearly communication is a critical area which determines success or failure. In the mid-eighties, the Council was aware that its communications were not as effective as they could be and wanted this to be a priority activity when I was appointed as the new Secretary/Chief Executive in 1986. Prior to that, in 1983, the Act had been amended to mandate the
distribution of an annual report on the Council’s work to all members of the profession, which was a good starting point. The format and content of the earlier reports was very modest. From 1986 a much fuller annual report dealing with all aspects of the Council’s operations was sent to all medical practitioners on the register and to the Minister of Health. It covered the main activities of the year. These activities involved:

- Council meetings, committee meetings, working parties and hearings
- reviews of hospitals with regard to the conditional registration year
- examinations for overseas trained doctors requiring screening before they were permitted to practise in New Zealand
- interactions with government agencies such as the Departments of Health, Immigration, Inland Revenue, and Treasury
- communications with state sector health delivery organisations, such as hospital boards (later area health boards, crown health enterprises, district health boards) and, in particular, with their chief medical officers, human resources personnel and intern supervisors
- interaction with organisations in the medical sector such as the NZMA, the ODA and the Resident Doctors Association.

Many individuals also had a role in important communication. These included Council members holding particular responsibilities, such as chairs of the medical education, health, and medical practitioners data committees, the preliminary proceedings committee convenor, examinations directors and agents of a council (especially those in medical schools doing registration interviews) specialist colleges, including the Royal New Zealand College of General Practitioners, involved in vocational training of doctors, bodies concerned with hearing complaints such as the Medical Practitioners Disciplinary Committee, the Divisional Disciplinary Committees and later the Medical Practitioners Disciplinary Tribunal and the Health and Disability Commissioner.

The NZMJ was used to air suggested reforms to the Medical Practitioners Act.

As well as written communications, other methods were used to share ideas and promulgate them. These included, in the 1980s:

- the occasional open Council meeting held at the biennial meeting of the New Zealand Medical Association
- working parties on various topics, such as the misuse of drugs initiative, sexual abuse initiative
- the development of the statement for the profession on information and consent.

Council would occasionally commission reports from bodies, such as the Bioethics Centre at Otago University, or individuals, for instance the paper on Competence from Dr Bob Large, tabled at the first full Council meeting in 1997 and circulated for consultation.
In the 1980s, medical students received a booklet concerning medico-legal matters which was developed by Dr Cole and published with financial support by the Medical Protection Society. The content of it arose out of Dr Cole’s lectures to fifth-year students at Auckland University when they were about to become trainee interns and part of the medical team, under supervision. This eventually grew into a major publication, researched and compiled by Dr Cole, and later formed the basis of the current Medical Council publication, “Cole’s Medical Practice in New Zealand”, edited by Dr Ian St George.

The Council now produces a number of information statements and pamphlets on professional issues and standards.

Council also interacted with overseas registration bodies, some of which were umbrella bodies for state-based organisations similar to the Medical Council and others were examination bodies conducting assessments of new graduates (USA and Canada) and overseas trained graduates (PLAB - Professional Linguistics Assessment Board of the UK) and AMEC – Australian Medical Examination Council).

The Council had professional and business advisers in particular areas, e.g. legal, auditing, IT, and public relations. Key relationships flourished, critical to the Council’s role, with Medical Officers of Health, Medicines Control Advisers and officials in Crown Health Enterprises. Relationships with other professional bodies within New Zealand were beneficial - sometimes these were health professional bodies but others, such as engineers, had the same kind of public safety responsibilities for which robust statutory or self-regulation was the underpinning mechanism.

The vehicles the Council used to convey its messages, apart from the annual report and open meetings, included media statements, official statements and, from 1991, the publication of the Council’s newsletter MCNewZ, usually three times a year. Council members and staff were also willing to meet with individuals or groups who had something to share with us or who wanted to obtain information from us.

The lay member played a critical part in all these different ways of providing and receiving information.

Communications is an industry which has become a core activity in the world as we know it today. This facilitates all kinds of exchange of information and ideas, but also exposes organisations to more scrutiny, sometimes warranted and sometimes not. Speedy responses to media enquiries are essential, although they must be considered responses, the need for the latter sometimes frustrating those wanting an early resolution. Council members and staff received media training and, in 1995, a full-time communications role was included in the office staffing.

Achieving more media coverage of positive developments, even through advertorials, would raise understanding of the Council’s role. Getting
stories into journals without waiting for disaster would help. The publication of pamphlets for patients on branches of medicine has been a great start. It was a brave Council that put out pamphlets on sex abuse – these are still in place after nearly ten years, but more is needed. Holding open meetings in different centres on topical issues, and participating in Deans’ lectures could be helpful. Council is still largely not understood and appreciated. An occasional session on RNZ Health Watch, local TV and radio would be useful. Even “Shortland Street”, whose producers have occasionally consulted the Council, could be prompted to do more stories illustrating positive roles of regulatory bodies.

The Council still needs effective ways of getting the public to contribute to the development of policies.

Lay members do not all have to be patients. The talents welcomed are intelligence, experience, and the ability to absorb and understand issues and facts, and come to reasoned judgement.

In the later chapters of this work I have fleshed out relationships between the Council and some of the major stakeholders.

Finance

All the activities covered in this report cost money, the level of the APC fee including disciplinary levy, being the main way of collecting revenue, was always of considerable interest to individual doctors and to their employers, as many employers refunded these expenses as part of the doctor’s employment package. The ever-widening and deepening scope of the Council’s work is clearly reflected in the level of the APC and levy, based on budgets which became more and more complex, as we attempted to ensure that funding was not excessive nor did it inhibit carrying out the activities which were required and desired.

The financial processes for the Council were extremely modest when I first became the chief executive. The annual practising certificate in the year ending March 1987 was only $63, including a disciplinary levy of $21. Admittedly, at that time rampant inflation was only about to have its effect. Over the next ten years doctors were required to pay significantly more for the APC and levy, but these costs were always based on carefully prepared budgets. The APC was increased during the 1980s to $130 and, between 1990 and 1996, ranged between $264 and $525. In the 1997/98 year, it reached its peak at $765, including $360 for the disciplinary levy. This was the period when the Council was bearing the cost of phasing out the old Act and bringing in the new Act, so this is in some ways not surprising. In general, the APC in the second half of the 1990s was around the $525 mark, including the disciplinary levy.

In the first financial year for which I was responsible I appointed a part-time accounts officer. Accounting needs were modest. The book value of fixed assets was $235,734 and Council’s investments around $200,000.
Income and expenditure were around $450,000, with a surplus of $7000 in the general fund and a deficit of $126,000 in the discipline fund, where expenses of around $300,000 were greater than income of around $178,000.

By 1996, after expanded activity meant a move into new leased premises and considerable expansion in staff numbers, fixed assets had risen to $271,590 and investments just over $5,000,000 (equivalent to one year’s turnover). Income in the general fund was almost $2,000,000 and in the discipline fund over $3,000,000. In addition, an examinations fund had been created which had income of around $350,000. The Medical Council had become a complex organisation with, by then, a financial controller, John de Wever, and part-time assistance as it was needed, for example during the processing of APCs.

By 2000 the financial reporting was more sophisticated and it is interesting to note the following output categories and the costs associated with them as published in the year to 31 March 2000 annual report:

- Education $609,502
- Health $498,252
- Professional Standards $825,106
- Registration $1,326,968
- Workforce $170,212

Fortunately the long-running tax liability dispute with the Commissioner of Inland Revenue was finally resolved in the Council’s favour, with a refund of over $600,000 in tax paid and interest lost unnecessarily. The tax saga has been referred to in Part II of this narrative, but I set out the sequence of events for interest.

1987 Council obtained a legal opinion on whether it was liable for tax.
1988 Legal opinion submitted to the commissioner of Inland Revenue to clarify liability for tax on interest earned.
1989 Solicitors and Commissioner for Inland Revenue still consulting.
1990 Solicitors and Commissioner for Inland Revenue still consulting, but a suggestion that government might exempt all statutory boards from income tax.
1991 Inland Revenue deemed the Council liable for tax and the Council decided to appeal the decision to the Taxation Review Authority (TRA), but meanwhile had to pay tax.
1992 Tax provisions again made.
1993 TRA ruled the Council was exempt and that all taxes paid should be reversed. The Council applied for a refund of $380,079, plus Resident Withholding Tax (RWT) of $6021. Later that year the Commissioner of Inland Revenue appealed the decision.
1994 Council applied for refunds of just over $400,000.
1995 Council again applied for refunds this time of around $460,000. Later in 1995 after an appeal by the Council, the High Court ruled that the Council was exempt from tax. But again the Commissioner of Inland Revenue appealed, this time to the Court of Appeal.
The Court of Appeal having rejected the Commissioner’s appeal and the Commissioner finally deciding not to go to the Privy Council, all refunds due to the Council were received amounting to $657,154.

In terms of preparing final accounts and the audit, this continuing saga with the Inland Revenue Department caused additional work which the Council’s professional advisers and in-house financial officer handled carefully. The responsibility for high standards in this area was considerable given that this was an organisation entirely funded by doctors registered with it. Constant attention was paid to improving fiscal management, budgeting and accounting processes and reporting and to seeing that the technology to support this was available, reviewed and updated as necessary.

The level of accuracy, accountability, and sophistication now reached with accounting, forecasting and reporting is a far cry from the hand-written one-page ledger I encountered when I first arrived at the Council in 1986.

A model for delivering what the public expects – Health Committee Exemplar

I keep coming back to the way in which a large number of stakeholders interweave their work to deliver to the public the outcomes that are expected under the Medical Practitioners Act, whichever Act happens to be in place at the time.

To me the development in the work of the Council’s health committee, first under the “old” Act and then the “new” Act, is a fine example of the way a statutory body, other statutory agencies, and a range of stakeholders can work very sensitively and creatively to produce a respected and effective system. I decided to write in a little more detail about this committee as an illustration of what can be achieved with cooperation throughout the whole sector.

Fitness to practise is a key element of fitness for registration, alongside competence arising from training appropriate to the various career stages. Doctors’ personal health has always been a key to their level of performance. A good health service must have healthy doctors and healthy doctors need to work in a healthy environment to sustain their good health. However, this is not a perfect world and sometimes doctors become ill, placing themselves and their patients at risk. Intervention is then necessary.

Back in 1983 the annual report referred to one suspension, one application for revocation of suspension declined and four cases of sick doctors dealt with informally, voluntarily agreeing to accept treatment and surveillance. The Council Chair referred in his report especially to elderly doctors, who could be frail and in small practices and were frequently the target of drug seekers who could be quite violent and intimidating. Regrettably, this
sometimes led to doctors acceding to their pressure and could result in the doctor’s suspension.

In 1984 the annual report addressed the issue of how difficult it was for a sick doctor to obtain suitable work in an institution during the rehabilitation phase, and there was talk of setting up a fellowship funded by some of the proceeds of the sale of the Medical Council’s premises at Webb Street. Around this time, the Council agreed to a working relationship with the NZMA which meant that they would focus on doctors’ ethics and leave the Council to be the arbiter of professional conduct. Most sick doctor cases revolved around substance abuse and mental health. Bodies such as the New Zealand Medical Society on Alcohol and Alcoholism supported measures to assist doctors in their treatment and rehabilitation. However, if the health problem was chronic and deteriorating, intervention from the Council might be necessary, although it was always preferable for intervention to be supportive rather than punitive. Council was concerned that colleagues must not protect doctors in this situation.

The numbers being reported to the Council were gradually creeping up. It was sometimes necessary for the Council to use its statutory powers which allowed the chairman and one other to be deemed to be a “health committee”, which had the power to decide to suspend a doctor and report the suspension to the next Council meeting. Reports from consultant psychiatrists were clearly important and these were received when the psychiatrist was in charge of the patient or asked to give a report on a patient under consideration, where a doctor under a psychiatrist produced a report of his own volition or a report was sent to the Council by a Dean in a medical school on a student graduating who had fitness to practice issues. This area needed cooperation from all of those entrusted with the medical care of other professional colleagues.

At the NZMA biennial meeting in May 1985 this topic was discussed at an open forum, along with the bioethics issue and discipline reform. When drafting submissions in 1987 for a new Act, an amendment was sought to specifically include a health committee based on the model used by the General Medical Council of the United Kingdom. The Council convened a workshop for interested parties and the NZMA agreed to set up a National Management Committee of the National Counselling and Welfare Service for Impaired Doctors, which would be an informal phase with doctors, not connected with discipline. A panel of three assessors (one legal, one psychiatrist and one from the doctor’s discipline) would look at re-education. Institutions in the health sector were encouraged to provide supernumerary posts for the rehabilitation of such doctors who could apply for a sickness benefit.

In 1988 the Doctors Health Advisory Service was set up, the NZMA being responsible for administration, with the Council underwriting costs but with no direct contact with the organisation apart from its establishment and operation. At that time there was a strong view that there should be no visible or invisible connection between DHAS and the disciplinary (and
registration) authority, but whether this could be maintained was a moot point. The bottom line was that, if patients were at risk, the Council had to be involved. It was essential to have access to rehabilitation and supervision for doctors returning to practice.

In that same year, the first competence review of a specialist was carried out (at the request of the employing authority), and this highlighted another area where a doctor’s health might be the core issue affecting such competence. This doctor was indeed suspended on health grounds.

By 1988, a system for referring sick doctors to the Council was in place. This involved the first report coming to the Council Secretary, then being referred to the Council’s health screener (at that time the Council Chair) and then on to a health committee which had been formally set up within the Council’s committee structure. Numbers were creeping up, with the annual report showing one doctor suspended, eleven progress reports received, six applications for revocation of suspension (of which two were granted, two involved the order being varied and two were adjourned pending a set of further medical reports), one application to the minister under section 23 of the Misuse of Drugs Act for prohibitions on the doctor and one doctor reviewed after returning from overseas.

By the late 1980s, the concept of a screener had been dropped and referrals came directly through the Council Secretary to the standing health committee which had been put in place.

An important aspect of the committee’s work is monitoring and reviewing doctors who had been suspended. In the year to June 1988 there were twelve such doctors - practice for five was still prohibited (these doctors had been suspended in 1978, 1980, 1982, 1983 and 1984), and seven variations to permit practice under close monitoring were allowed (these doctors were suspended in 1973, 1983, 1985, 1986 and 1987).

Over the next decade the Council’s programme for monitoring sick doctors became increasingly sophisticated and trusted. As public scrutiny of the Council became more vigorous, this was essential. The Council’s health committee and its executive support team, now led by Lynne Urquhart, became more knowledgeable and competent in managing all aspects of the programme from the Council’s office. Over the years it has been possible to reduce the number of suspensions necessary because most doctors are referred or identified at an early stage. Their voluntary cooperation can be obtained, a comprehensive programme of treatment, follow up and monitoring implemented and return to work allowed so that the need for a statutory prohibition is less frequent.

At March 2000 the Annual Report referred to: 30 new referrals on which no further action was required for 13, monitoring for nine, further review at the time of issue of the APC for seven, and a follow-up report for one. Carried over from the previous year were 39 doctors under monitoring, including 20 at a low level of monitoring (not required to report in person
to the Council), and two with further review on application for APC renewal. Prescribing restrictions had been reviewed for two, and two other doctors applying for registration who had disclosed health issues were also assessed and registration permitted.

With the new provisions under the 1995 Act concerning APC issue, doctors are now required to disclose health issues each year if they have not already done so. In the year 2000 APC exercise 61 doctors made such a disclosure, 31 of which were not already known to the Health Committee. These doctors were asked to provide reports from treating doctors.

The Health Committee has worked hard in an educational model to raise awareness and seek support for doctors suffering health problems. This issue is covered in a full chapter written by the recently retired chair of the Health Committee, Marc Adams, and the Council Health Manager, Lynne Urquhart, in Cole’s Medical Practice in New Zealand 2001. They note that disorders likely to affect the professional competence of doctors fall into three categories:

- psychiatric disorders - substance abuse, mood disorders, dementias, eating disorders, situational crises and paraphilias
- medical disorders - neurological, sight and hearing, transmissible major viral infections and some other illnesses and conditions
- disruptive behaviour - rudeness, anger, sexual harassment and demands for special attention.

The third category has perhaps arisen as a result of the pressure experienced in the whole health sector.

Concluding this section, I note that to manage and retain in the workforce an otherwise capable doctor suffering from some kind of health problem which might impair his or her fitness to practice and place patients at risk requires the input and cooperation of a wide variety of Council stakeholders. These include the doctor, his or her family, employers, treating doctors including psychiatrists, general practitioners and specialists (e.g. neurologists), and experts in the management of substance abuse. On return to work monitoring continues with the help of employers, supervisors, Medical Officers of Health, Medicines Control Advisers, urine or blood screening units, mentors, voluntary agencies, support groups, friends, and family. It is encouraging when doctors, some of whom may reluctantly enter this process, are able two or three years down the line, to say that the intervention of the Council’s Health Committee at the time when they were first reported as being vulnerable has been one of the best things that has happened to them.

Health issues are not confined to underperformers, indeed some high profile, highly intelligent and competent doctors have suffered serious health problems. Where these doctors have been willing to speak out in public about what led to their illness and how they have recovered from it, is very educational for the public and the profession. Recently, there has been debate about whether doctors’ patients should be told that a doctor is under the monitoring of the committee. Some would say yes, but others
would prefer that this be dealt with in terms of the doctor’s right to privacy, provided the Council and all those involved in his or her rehabilitation are satisfied that there is no risk to safety.

A collaborative approach to managing the issue of impairment in doctors is an excellent example of how all aspects of medical regulation can, and perhaps will, be part of the day-to-day activities of the public and the profession, accepted and endorsed without media hype. Under the 1968 Medical Practitioners Act funding for initiatives to assist impaired doctors had to be derived from the disciplinary levy. Under the 1995 Act this aspect of protecting the public is included in the budgeting for general registration activities. The Council’s mentoring programme was a key intervention. It was funded by the doctors themselves with respect to time spent, the infrastructure costs coming out of the health budget.

In recent years, the Council’s international networks have been valuable in this important area of responsibility. Excellent seminars and presentations have been held in Australia and New Zealand and as part of international meetings, particularly in the United States, under the auspices of the Federation of State Medical Boards. The Council has been able to base and then build its own initiatives on examples from experts in the field in many countries and on the General Medical Council model.

The new international organisation for medical regulatory bodies will be examining ways of identifying (and where appropriate assisting) impaired doctors moving from one country to another, so that the public is always protected and, if possible, the doctor retained in the workforce.

Core business - Registration and Examination

Registration of overseas trained doctors who were not automatically eligible for conditional or full registration has frequently been a troublesome issue for the Council. Over the years, the Act had been amended to allow temporary registration (restricted to doctors coming to New Zealand to provide postgraduate education or instruction or to receive it), but this form of registration was limited to three years. In the early days of temporary registration the politicians were adamant that no drain on the public purse should arise from such registration, that is, temporary registrants were not to provide services in the private sector, for example in general practice. In the 1970s, probationary registration was put in place so that doctors who had not qualified in medical schools in the United Kingdom, the Republic of Ireland, Canada, South Africa or Australia could be examined and assessed for competence in medicine and the ability to communicate in English. When these provisions were first enacted, the Council recognised the examination offered world-wide by the American organisation, the Educational Commission for Foreign Medical Graduates (ECFMG), set up in the 1950s to deal with migration of doctors to the United States, particularly for registrar training. In the beginning, the Council was not empowered to insist on examinations of its own, and amendments to facilitate this were only made in the early 1980s. In the
early part of the century medical migration usually seemed to arise out of war-time discrimination against certain doctors and was not at a high level. Some undertook a three-year course at Otago University and then passed an examination set by the University which enabled them to receive a New Zealand degree.

Through until the end of the 1960s registration of doctors qualified outside New Zealand mainly rested on principles of reciprocity, meaning within the British Empire, that is, the GMC was the driver. American graduates from prestigious institutions such as Yale could not get registration in New Zealand without further assessment and this, of course, meant that they did not bother.

In the early 1980s the Council turned its mind to setting its own examination and enlisted the help of the medical schools at Otago and Auckland universities. After a trial with one doctor in 1983, the first group of doctors to take an external examination required by the Council did so in 1984. Problem solving and short essay questions were provided by Otago University and two papers of multiple choice questions were provided by Auckland University. There was no formal test of English; however, any holders of the ECFMG certificate had to have reached a level of competence in English, certainly in writing, which gave some protection.

After the major changes which occurred with the entry of the United Kingdom into the European community (and consequent reciprocity with many countries in Europe), the flow of English trained doctors continued and our doctors went to the UK. Reciprocity with quite a number of countries in South East Asia, which had formerly rested on reciprocity with the GMC was abandoned. This coincided with those countries giving more attention to their own national identity and national languages. Previously, medicine had mainly been taught in English, but changes occurred so that in countries such as Sri Lanka, Singapore, Hong Kong, and Malaysia instruction in medical schools switched to local languages.

Indian doctors had always been educated in English and this remained. Nevertheless, the huge proliferation of medical schools in that country, and the impossibility of keeping up with the standards in all of them, meant that there was some caution in registering doctors with Indian qualifications other than those from the traditional, highly respected and well-known institutions. In the 1960s many Indian and Pakistani doctors went to the UK for their immediate postgraduate education, obtaining membership of the Royal College of Physicians or the College of Surgeons, and, initially, these qualifications were recognised in the Medical Practitioners Act 1968 in New Zealand.

As all these changes affected the degrees which were recognised for registration of overseas trained doctors in New Zealand (on the same basis as a medical graduate from Australia or New Zealand), it appeared to many doctors wanting to come to New Zealand from other countries that the barriers were insuperable. Some of the doctors recruited through the joint
programme (Immigration Department, Health Department and Hospital Boards) in the years immediately after 1985, when the junior resident medical officers award was changed, were able to obtain temporary registration under the category “receiving postgraduate experience and training”. The Council was not consulted about the recruitment programme in the first place, but agreed to interpret eligibility for temporary registration broadly so that overseas trained doctors could stay for up to three years.

New Zealand’s reputation as a paradise and a peaceful place, particularly after the 1980s’ anti-nuclear initiatives were successful, attracted a number of doctors from Europe, especially Germany. As countries in Eastern Europe became less regimented, their graduates also came our way. Naturally, they were proud of their qualifications and were quite affronted by any suggestion that they were not competent to practise in New Zealand without first passing examinations.

The acceptability of their qualifications was one issue, but their competence to communicate effectively in English was another. A third factor was the reality that medical services were organised quite differently in some of the countries these doctors came from compared with New Zealand. In some cases their specialisation did not fit with the pattern of practice in New Zealand; in other cases the label for their practice, for instance general practice, was not what we meant by general practice in New Zealand. Clearly, to protect the public, the Council was required to provide some kind of screening mechanism, which it set about developing to deal with the ever-increasing numbers arriving from the mid-1980s.

In the second half of the 1980s, I was able to establish good relations with registrars in the various Australian State and Territory Boards and Councils, as well as the Australian Medical Council, and to obtain information about the bridging courses and examinations conducted in Australia.

In 1987 I was able to visit the General Medical Council in London and draw on their experience of the examination they called PLAB (Professional and Linguistics Assessment Board).

I learnt of the English language assessment process in Australia involving an occupational English language test developed there by the Department of Education, Employment and Training.

In Britain, the English test relied on was an international test administered by the British Council (IELTS). When the examination we entitled PRENZ (Probationary Registration Examination in New Zealand) was first set up in 1984, those were the tools on which that examination was modelled.

As the number of candidates grew, the format was amended and certain doctors were able to be granted exemption from parts of the test. Regrettably the pass rates in PRENZ were poor. This was partly attributed
to the fact that a lot of the doctors were practising on temporary registration, working long hours, sometimes in rural areas without access to educational resources. They were simply unable to prepare well for the examination and were discouraged from doing so by many of their supervisors who believed their performance was satisfactory. This was not mirrored in the examination results, which, on safety grounds, became more and more concerning to the Council.

After a review, the Council decided to develop a two-stage examination - NZREX (the New Zealand Registration Examination). Part One was an English test using the instruments developed in Australia. I negotiated a contract between the Australian government and the Council for the English Language Institute in Wellington to administer the test in Wellington and Auckland on contract to the Council. Part Two was a multiple choice examination covering all basic medical knowledge taught in New Zealand medical schools. The papers were compiled from the University of Auckland database of examinations for fifth-year student finals.

A pass in these English and MCQ tests enabled a doctor to obtain temporary registration and work for up to two years, during which time NZREX Parts Three and Four had to be accomplished.

NZREX Part Three was a written examination, mainly in short answer question format, across clinical disciplines using short answer questions, which again had been developed and tested over hundreds of students at the University of Auckland. NZREX subjects covered were paediatrics, psychological medicine, surgery, internal medicine, obstetrics and gynecology, general practice, pharmacology, pathology, applied anatomy, applied physiology and applied behavioural science. Part Four was a clinical examination in long case and short case format, across all the major clinical disciplines, as used for local fifth-year students.

Many doctors struggled to complete all four parts and achieve probationary registration. Competition for their time from clinical duties was often cited as a contributing factor, but results showed many gaps in basic knowledge, skills and attitudes.

NZREX continued on into the 1990s. Many of the candidates for it were doctors who had arrived in New Zealand after receiving sufficient immigration points through New Zealand Qualifications Authority (NZQA) assessment of their degrees to get permanent residence. However, they did not have information from the Immigration Service that registration was compulsory in New Zealand and was under the jurisdiction of the Medical Council, which had its own legal requirements. Try as we might to get overseas posts to give accurate information, we were not successful. Candidates should have been advised by overseas posts to contact the Council office directly, but some went through immigration consultants who were cavalier in their regard for the Council’s role. There was a great deal of aggravation caused by this hurdle, which was seen by
many to be racially biased. The fact was that the Council was operating under legislation at that time which insisted on such protection of the public.

Unfortunately, the good example of bridging courses which had been successful in Australia could not be implemented in New Zealand because the government would not put any money into it. It was clearly not feasible for candidates to enter such training on a “user pays” basis as many of them were unemployed or working in low paid jobs to try to keep their families alive. Some refused on principle to do anything other than protest.

It was not surprising that the ODA grew rapidly, being mainly comprised of doctors who flatly refused to take any examinations, and tried to exert political pressure to solve what they perceived as a major problem and barrier to their life in New Zealand. As many of these doctors had settled in Auckland when they arrived in New Zealand, certain members of parliament were also under pressure to make supplications to the Council on their behalf and of course readily did so, as there was a vote in it for them.

The whole situation was complicated by the fact that, from the late 1980s, the Council was constantly expecting that there would be a new Medical Practitioners Act coming into being, and so rulings on eligibility for registration were time limited to deal with that likelihood. Thousands of enquiries came in each year and we did our best to give doctors and their agents accurate information. A large number of doctors did accept that they had to meet the Council’s standards and, in time, were successful in the examination process, going on to gain temporary and probationary registration. Another group flatly refused to have anything to do with the examination and decided to use the judicial review process to try to remedy their unhappy position.

Some of the doctors were under the misapprehension that when the new Act came into place all would be easy for them. In effect, the new Act made it more difficult for more doctors, because after 1 July 1996 the only doctors who could have registration without any further assessment were those who had degrees from a university accredited by the joint AMC/MCNZ process, that is, Australian and New Zealand graduates only. Even the old “Commonwealth” doctors were required to take the examination if they wished to stay in New Zealand permanently, although they were entitled to temporary registration if they were visitors on work permits, that is, not seeking to reside and practise permanently in New Zealand.
3.2 Political and economic realities

Reflecting on the particular circumstances of medical registration over the last 150 years, it is clear that the tools tend to be out of date almost by the time they have been constructed. In other words, they are terminally flawed. There is a tension between wanting stability yet immediately seeing deficiencies. Fashions in legislation change like a swinging pendulum. Recent developments where legislation empowers but does not restrict unduly do have the capacity to deal with fluctuations, and give a degree of control, which society’s governing bodies, including the medical profession and parliament itself, favour.

As I see it, the role of legislation is to mandate and give transparency to society’s structure, to establish boundaries, and to provide a formula to sort out complications and conflicting interests. Of itself, legislation is not useful unless it is widely accepted, known to all players and capable of timely amendment if justified. It is not an end in itself. It depends very heavily on the quality of those who are involved in designing the parameters and mechanisms and in interpreting the law and its effect on all the parties involved. It is an insurance against self-interest, rogues and political interference.

In the 20th century, the emphasis in medical regulation was definitely on control. The Acts involved much fine print, with a lot of energy spent changing relatively small sections. The public, let alone patients themselves, were not referred to in the processes, their protection being left to parliamentarians and to the profession itself. The Council depended on the state bureaucracy and government funding was involved until the early sixties, despite the introduction an APC in the 1932-33 financial year.

It appears from looking at minutes and observing the number of amendments to the legislation since the beginning of the 20th century that there was a constant need to tweak the law. Much of the change was driven by the profession itself, in particular by the wise men, and they were all men, who sat on the Medical Council. They were not immune to being affected by political footballs. Economic drivers were also important, particularly as the profession moved from being funded privately and directly by patients to state funding under Part II of the Social Security Act 1964. Politicians were always wary about whether changes were going to lead to increased costs. This argument was particularly strong when the Annual Practising Certificate was first introduced. As all registered medical practitioners, including those who were working in public hospitals and other public institutions, were liable to hold one and employers were reimbursing fees, these costs would be reflected in the cost of providing services and ultimately the cost to consumers. Consumers are voters.

The views of parliament did vary according to which party was in power. From the early 1960s when New Zealand had to develop a different
economic relationship with the United Kingdom, the effects filtered through to all levels of society. International economic cycles also had their effect. Proposed changes in medical regulation were put on the back burner in the late fifties. The debate in the early 1960s about the Council becoming a body corporate highlighted government reluctance to get into a situation where it would be called upon to underwrite any losses. This was clearly connected with economic times generally, as well as with principles of self-regulation. Again, in the early 1980s, after a period of economic difficulty, including a price freeze, major changes in economic direction, with preference for competition policy and reliance on market forces, profoundly changed the attitude to occupational regulation. When the Hon Aussie Malcolm was National’s Minister of Health in 1983 he accepted that the 1968 Act had been amended many times and a fresh start was needed. Yet that goal would take another twelve years to achieve, even though the new Labour government, with Michael Bassett as Minister of Health, shared his view that it was time for rationalisation in medical practitioner regulation.

Although the Council made its submissions to Minister of Health David Caygill in late 1987 and early 1988, it was not until 1989 that the government Working Party on Occupational Regulation met with the Council as part of its review of all professions, trades and occupations currently regulated by statute. Government was keen to simplify legislation to free up the market, remove compliance costs, and rely on self-regulation, as long as safety was not threatened.

There was talk of deregulating dentistry, but swift action by the NZDA pointed out the likely risks to patients, especially in lower socio-economic groups in the community. The Dental Act 1988, in effect from 1 January 1989, had some features later seen in the Medical Practitioners Act 1995.

Regrettably, over the period from 1987 to 1989, the Council was pretty much kept in the dark over progress. In 1990 a Bill was drafted within the Department of Health, but the Council was not permitted to see it. My understanding was that this was something to do with the stand-off between the Labour Minister of Health, Helen Clark, and the National spokesperson for health. Eventually, after a change of government in 1991, the Associate Minister of Health, Katherine O’Regan, made this draft available to the Council. It also went to a number of other parties for review in light of concerns about the interface between a new Medical Practitioners Act and other legislation, particularly the desired creation of a Health Commissioner and changes to accident compensation provisions. By this time significant changes in public attitudes to regulation meant “consumers”, as they came to be known, were more assertive, expecting to play an active part in all deliberations of health professional (and many other) regulatory bodies handling complaints and hearing disciplinary charges.

A number of high profile discipline cases involving fraud, abuse of drugs, sexual violation of patients and examples of incompetence heightened the profile of the Council and the Medical Practitioners Disciplinary
Committee, with the media playing an active role in publicising issues. At the same time, constant reform of the health sector first converted hospital boards to area health boards over a period of three years then, that accomplished, proceeded with further reorganisation, splitting providers from funders, creating Crown Health Enterprises (CHEs) to deliver hospital services. It appeared that law change reflecting management theories and financial imperatives was taking more precedence than protection of the public. Certainly, professionals felt concerned that their role was being undervalued by comparison with the rise in managerial influence. Intrusion on the previously sacrosanct doctor-patient relationship was regarded with great concern.

Government departments were introducing policies driven by economic realities which affected Council’s work. The Department of Labour Immigration Service, taking advice from the NZQA developed policy and procedures which influenced migration patterns, causing an influx of overseas trained doctors, many of whom could not be registered as they did not have the training, experience or fluency in English to meet the current thresholds set out in the Medical Practitioners Act 1968. The Commerce Commission kept a close eye on the Council and the Medical Colleges, looking for examples of anti-competition behaviour, which in fact did not exist.

The Commissioner of Inland Revenue challenged the Council’s previous tax free status (although of course the Council was registered for GST) on the basis of being a charitable body. This was highly ironic as the education committee of the NZMA had been able to obtain charitable status sometime before that through the services of a clued up adviser.

The Council’s protracted battle with the Inland Revenue Department took it to the Taxation Review Authority, the High Court and the Court of Appeal over a period of twelve years. Finally, the Commissioner of Inland Revenue decided not to appeal to the Privy Council; only then did the Council receive back the $657,154 it had put into the taxation pool over all those years. The financial effect of this was significant, but amply demonstrates how economic theories and fiscal imperatives infiltrated every aspect of society, even bodies created to protect the public.

In the mid-1990s, the Commerce Commission persistently threatened to take action against the Society of Ophthalmologists concerning its attitude to registering overseas trained specialists, as it believed the society was manipulating the market for its own benefit.

Somehow the high cost of training, keeping up to date and providing state-of-the-art technology is overlooked.

As far as I am aware, the Council always managed its finances in a very responsible (even frugal) manner, especially in the period when it was severely constrained by a low level of fees, lacked control over them and had to pay the monies to the consolidated fund. When the Council was
finally given body corporate status in 1962, it literally managed on a shoestring and this affected the provision of modern equipment and the recruitment of staff members who could have shouldered some of the administrative responsibilities falling to Council members. Although this began to change in the mid-1980s, there was always tension about the level of the APC and levy. The latter was difficult to set as the Council had no direct control over likely expenditure, which hinged on the number and scope of investigations and hearings in any particular year. The process for obtaining fee changes was frustrating as it meant painfully slow scrutiny by the Department of Health and then alterations to fee regulations. Finally, more autonomy in setting fees for services was provided under with the Medical Practitioners Act 1995, as long as fee schedules were published in the New Zealand Gazette.

Eventually, after the Health and Disability Commissioner Act was passed in 1994, some serious movement began on passing a compatible Act to cover the regulation of the medical profession. The interface of these two pieces of legislation has proved problematical and is again on parliament’s books for amendment. Much discussion and negotiation goes into the work of writing new legislation. Officials exchange ideas and work through the fine print. This was certainly true for the Medical Practitioners Act 1995. Departmental officials were very helpful and supportive to office holders in the Council and other bodies over the long period of working through draft and redraft.

The Health Select Committee is now considering submissions on the Health Practitioners Competence Assurance Bill, the principles and mechanisms of which are based generally on the model of the Medical Practitioners Act 1995. That level of confidence in the 1995 Act gives me a great sense of satisfaction. We made an important contribution to a new age of health practitioner regulation.

No doubt the coming debate will revisit many of the ideological and political issues covered when the Council and other bodies appeared before the Health Select Committee (with different composition) in 1995. My impression at that time was that many of the members of the committee were coming at the issue from purely personal views, experiences and, regrettably, prejudices. While select committees are a central feature of the democratic process, I am not so sure that they produce a well-reasoned outcome in all cases, as they are of course influenced by party and personal politics and pressure groups.

In the end, the law has to be a compromise between what government expects, what the profession can live with and what the community is able to tolerate. It never meets all expectations. Ideology, fashion, bargaining and expediency all have their impact, especially in an MMP parliament where the debate is sure to be wide ranging and challenging. While Council members and office staff do their best to put forward ideas which they believe are necessary and will work, these are not always reflected in the final product. I was not convinced that the relatively free market approach
produced the best care and protection from risks for consumers. Robust competence assurance mechanisms are vital.

One of the patent risks in today's climate of financial constraints and shortages in many health workforce areas is the stress this places on all health professionals, including doctors, and on the systems themselves. It is interesting that serious shortages of key health professionals have led to a renewed interest in workforce planning, which at the height of economic reform, became highly unfashionable. In the mid-1970s and early part of the 1980s the Council, University of Otago and Department of Health had a good working relationship which produced comprehensive data on all aspects of the health workforce. When market forces gained the ascendancy, this was pushed into the back room. Given the difficulties that many rural and urban communities are now experiencing in attracting and retaining suitable health professionals, and in modifying the way in which the services are delivered, it will be interesting to see to what degree politicians push their own values on these matters when the HPCA bill is debated in parliament later in 2003.

From time to time, private members’ bills, usually relating to single issues in regulation of the profession, have been introduced to parliament, commonly around individual examples in medical migration procedures. It is disappointing to see in such Bills an utter misunderstanding of the purposes of registration and regulation, with the main emphasis being on alleged restrictive practices and discrimination.
3.3 Interface with justice and rights sector

As a quasi judicial body the Council is required to observe the principles of natural justice, and it is subject to the rules of administrative law. Observing procedural fairness inevitably takes time and care, and in some situations procedures become more drawn out and take longer than parties would prefer. All involved can find this frustrating. Overall, the Council has maintained a good record, with the courts overturning relatively few of its decisions because of lack of fairness, rationality or care in the process.

Law reform

Since the 1980s particularly, economic reform has not been the only driver for change. Rights and duties in many areas of human interaction have also come under complex scrutiny. New codes setting out those rights, and methods for dealing with alleged breaches, have emerged, with education on compliance paramount. Individuals in society have been empowered, and protection of consumers in a market driven environment has been a recurring theme.

Law reform was generally given a high priority, even if achieving it took time and resources. Obvious examples were:

- human rights, including anti-discrimination measures, especially on the grounds of race, gender or sexual orientation
- focus on consumer awareness, employment law, competition policy and advertising
- privacy and informed consent
- children’s rights
- health and disability rights
- international relations
- anti-nuclear policies.

New Zealand seemed to turn itself into a kind of laboratory for reform, putting itself on the line internationally. We were able to develop and try out reforms partly because our small population and single state governance reduced the “fallout” which might have occurred in larger and more complex societies. Nevertheless, success in fully resolving issues - current and historical - remained elusive, most notably in the case of Maori initiatives to regain resources through claims under the Treaty of Waitangi.

Vexing issues for doctors were:

- the threshold for medical manslaughter
- medical misadventure and accident compensation
- professional sexual abuse
- biotechnology developments such as Assisted Reproductive Technology (ART)
- end of life matters, including dealing with persistent vegetative state (PVS)
- euthanasia
- attendance in emergencies
- management encroachment in allocations of scarce health resources
- resort to withdrawal of labour by health professionals as a method of drawing attention to perceived inequities.

In the 1990s, further issues affecting patient safety and the role of doctors included confidentiality, complementary and alternative medicine, and medicine and the internet, including any role for internet prescribing.

With over 70 Acts of parliament directly affecting doctors, there are plenty of potential hazards (in the form of both acts and omissions), where doctors can be called to account if breaches occur. And this does not include offending of a general kind as an ordinary member of society.

The Council showed initiative and courage in stimulating and/or participating in debate on these matters, attempting where feasible to develop wise guidelines or statements to highlight ambiguous or easily overlooked areas.

Standards - Ethics

The Council’s sexual abuse initiative will be dealt with in the next chapter. At this point, I think it important to highlight matters where the Council contributed something important to the debate - some would say straying into territory the New Zealand Medical Association, and the Ministries of Health, Justice and Commerce had previously considered their domain. The Council was an important stakeholder in formulating principles, and showed a good example to its own stakeholders in being willing to express its views publicly and have them scrutinized by the profession and the public.

Council Chair Robin Briant acknowledged in the first Council newsletter, published in March 1991, that there had been no obvious progress with the anticipated legislation except – the Council hoped - that a bill might be drafted later in the year, after urging priority with the new Minister of Health Simon Upton and his Associate Minister Katherine O’Regan. Standards initiatives provided an outlet for reform energy within Council’s existing powers and gave the Council the chance to work in a number of different areas, with a wide range of stakeholders. This improved understanding of each other’s roles, parameters and resources.

Setting standards

That first MCNewZ issue reported that Dr Maclaurin (deputy for the Auckland Dean on the Council, and from 1991 a member of the Preliminary Proceedings Committee), was convening a group to develop strategies to reduce the misuse of addictive prescription drugs. A Drugs in Sport directive was also published in 1991 (and stood until revision in
December 2000), setting out in detail the substances which were not to be dispensed to enhance performance or for any other fringe purpose.

Both statements were developed through sharing and discussing ideas and events with relevant stakeholders. Forums such as workshops and taskforces brought together interested and affected parties, such as medical officers of health, medicines control advisers, pharmacists, pharmacologists, sports medicine practitioners, general practitioners, drug companies, the police, and the profession’s investigation, disciplinary and disability committees. The police and courts had been involved in cases of such abuse and were aware of doctors repeatedly flouting the law. Without good communication between law enforcement and the regulatory bodies, abuses could have continued unchecked. In any case, constant vigilance and robust reporting and action needs to be reinforced as offenders do not always learn from experience, new ones come on the scene, and new loopholes are detected. The Council developed a statement on what, in its view, constituted improper prescribing - whether indiscriminate, excessive or reckless. Until the revised statement published in October 2000, this statement had been used as a yardstick in disciplinary hearings and determinations, including those where the behaviour is not necessarily illegal but could not be considered safe and proper.

**Crimes**

Fraud involving public monies, especially untenable and excessive claims for general medical services benefits or ACC payments, also brought doctors before the courts. Preparing evidence for such cases was very hard as it involved tracing forms from previous years, as there was no computerised data. Investigators often had to sift manually through hundreds of scripts or benefit claims in musty basements!

**New birth technologies**

The most interesting development, and still unresolved from my perspective, was that surrounding Assisted Reproductive Technology (ART). With the backing of Council member Professor Geoffrey Brinkman, then Otago Medical School Dean, the Council, NZMA, the Royal Society and the NZ Law Society prepared a joint approach in 1985 for the Deputy Prime Minister and the Minister of Justice, David Lange, urging government to develop bioethical guidelines, anticipating considerations necessary as new birth technologies were developed. This topic had been aired in an open forum led by Council at the NZMA’s 1984 biennial conference in Hamilton, and a multi-disciplinary standing committee had been mooted. Later, a report commissioned from Otago University ethicists was widely circulated for public and professional comment, which was freely given. The responses were compiled and sent to many professional and community groups with a particular interest in these developments. Hamilton MP Diane Yates took up the cause and, even now, with a seat in government, she is still fighting for appropriate
safeguards and codes in this contentious, rapidly growing, and commercially profitable area of scientific development. Doctors, parents and children could all be harmed by unscrupulous operators in the field. Although national ethics committees were finally set up, their contribution to progress has been minimal. The market still seems to rule.

Medical manslaughter and other prosecutions

After years of lobbying, the threshold for medical manslaughter was finally raised in 1997. Council Chair Ken Thomson took a lead in that quiet campaign, wearing his forensic pathology and Council “hats”. It was another example of using networks effectively. While in some regions the police took what appeared to be an over zealous approach to prosecution, which undermined trust, in the main good relationships with the police existed. The Council was sometimes given advance information of likely charges pending, and was able to forewarn the PPC of matters which could bring a doctor under the scrutiny of the justice system. Progress could then be monitored on impending cases, and outcomes advised so that there was no undue delay if action under the Medical Practitioners Act was warranted. Examples were cases of alleged fraud involving ACC and medical benefits, breaches of the Medicines or Misuse of Drugs Acts, and Transport Act prosecutions for alleged “drunk in charge” episodes.

Consumer rights

Some medical procedures came under the scrutiny of the Consumers Institute or the Advertising Standards Complaints Board, especially those involving highly entrepreneurial or controversial techniques. Cosmetic surgery by general practitioners increasingly led to disappointing or distressing outcomes for patients affected by misrepresentation as well as poor practice. Some of these cases did not meet the criteria for disciplinary measures at the top end of the scale. Some products marketed by doctors interested in alternative medicine either proved less effective than patients hoped or, in hindsight, the patient felt manipulated into buying products or complying with procedures offered by the doctor. Magazine publicity given to these issues reached these two consumer organisations and this was often the most effective way of warning patients and highlighting boundaries between safe and dodgy or unnecessary treatments. Council was always glad to assist with accurate information and cooperate in helpful publicity which might offer protection to consumers in these circumstances. Getting the message out to the public via the media was useful, and such proactive work by consumer bodies generally made more impact than any formal guidelines.

Human rights and allegations of discrimination

Interface with discrimination law generally occurred in the context of overseas trained doctors’ frustrations over registration. This issue is also relevant to the section on workforce matters.
From the Council’s perspective, the enquiry stage of the Race Relations Conciliator’s process did not appear very open. In the major issue which developed around overseas trained doctor examination and registration, resolution was achieved without reaching the threshold for a formal complaint against the Council. A few overseas trained doctors tried to obtain remedies through avenues such as the Disputes Tribunal.

Doctors’ primary and specialist qualifications (not their nationality or colour) influenced access to registration. Under the 1968 Act, a Schedule to the Specialist Regulations set out all the specialist qualifications which were recognised for entry to the specialist register in the various approved branches of medicine. Like primary qualifications, most were from institutions in English speaking Commonwealth countries, such as the United Kingdom, Eire, Canada, South Africa, Australia and New Zealand, and some from the United States. The colleges in New Zealand and Australia which trained and examined the various vocational groups all had examination processes in place for their own trainees and, from the 1980s, they played a part in assessing, on paper, the qualifications and experience of overseas trained specialists wanting to practise in their specialty in New Zealand.

Some specialties were invariably in short supply, for example radiology, psychiatry and anaesthetics. As New Zealand’s demographics and medical migration patterns changed in the 1980s, gaps in specialisation and supply occurred. Most health service providers at some time needed to recruit people from outside New Zealand.

Those who had completed their training in Australasia presented no problem. However, overseas trained people were sometimes required to do “top up” practical training and/or face further assessment similar to that expected of local trainees at the exit level in the various vocational disciplines. Overseas trained doctors saw this further hurdle as an unnecessary barrier and it started to draw adverse comment. This was exacerbated by 1990s immigration policy as some of these “specialists” had arrived permanently in the country expecting that they would be able to practise without any further assessment.

In 1995, the Medical Council asked the Council of Medical Colleges to arrange for its constituent colleges to initiate a personal interview system and a consistent process for the assessment of all overseas trained specialists. To avoid adverse comment about fairness, it had to be comparable across all the different disciplines, with advice given on how to bridge gaps in eligibility. Over time, anomalies between different colleges had appeared and were of course interpreted as artificial barriers.

When parliament passed the Medical Practitioners Act 1995 in December 1995, it allowed a six-month period before it came into effect in July 1996. During this period, the 1968 Act and policies still applied. Anticipating change, this caused a surge in registration applications from doctors around the world, but particularly from countries such as South Africa, where
existing social conditions meant that doctors were more and more tempted to make a break. It was clear that the new Act would most likely no longer give preferential treatment to Commonwealth countries as had existed since the early 1970s, and that, in the interests of protecting the public, all applicants were likely to be subject to some kind of assessment process before they were permitted to practise in New Zealand.

As 1 July 1996 approached, the Council received more and more enquiries and it became obvious that there were far more people in New Zealand likely to be seeking registration in all categories than we had previously realised. Data from the Department of Labour’s Immigration Service was difficult to obtain, and even more difficult to interpret! The ODA, formed in the early 1990s, drew most of its members from the group of doctors who had, up to that point, refused to accept any examination or assessment process, plus a few who had repeatedly failed. After consultation with the ODA, the Council decided to survey their members to try to get better information on the scope of the problem, and the likely demand for future assessments. The ODA agreed to distribute the questionnaire to its 150 or so members, seeing this as a positive step. Both the Council and the ODA were quite overwhelmed to receive more than 600 completed questionnaires. The responses revealed that many doctors had made no attempt to contact the Council or obtain prior information about working in New Zealand. We even heard that, for a fee of $50, a person was handing out our questionnaire at the airport to doctors coming off planes, on the basis that, if they completed it, they were on the path to obtaining registration; the “entrepreneurial offender” was never apprehended!

At about this time, just over 180 doctors decided to make a joint application to the High Court for judicial review on the basis that they believed that the Medical Council’s process was not fair and reasonable. This application was, however, not lodged with the Court until the last day when registration would have been possible under the 1968 Act. The new Act came into effect on 1 July 1996 and made no provision for retrospective approvals, nor for transition for existing applicants. The only transition registration arrangements were for those on the register under the 1968 Act on 30 June 1996. The first step in preparing to rebut the alleged breach of procedural fairness was to review our files as best we could to trace each person’s history. We discovered many had not had any prior contact with us. Research was complicated as enquiry files older than two years were destroyed, this fact being explained to enquirers at the time.

The lawyer acting for the group of doctors had not been fully or accurately briefed and was herself quite overcome by the numbers. As the transition provisions in the new Act did not provide any capacity for retrospective recognition of any applicants under the old rules, the action was doomed to fail.

In consultation with the Council’s legal advisers, we took steps to have the application for judicial review struck out. In the end, almost all the doctors withdrew from the action. A core group of about ten doctors held out hope
for a legal remedy – sadly, they comprised people most unlikely to succeed.

About the same time, we learnt that some aggrieved doctors had made complaints to the Office of the Race Relations Conciliator. The Council provided detailed answers to all requests for information by the Conciliator’s office, but, from our perspective, the process was protracted and cloaked in mystery. The complainants’ names, but not the precise nature of the complaints, were sent to the Medical Council. In general, the process was difficult to handle as it took a long time and the ground rules seemed to shift. At no point was any formal charge brought against the Council under the Race Relations legislation. I was particularly keen to see the matter resolved through conciliation. The Council’s legal adviser and I held meetings with the remaining complainants and the Conciliator to try to suggest other avenues for them to pursue which would be more helpful to them. It seemed to me that some of these doctors were themselves not committed to the action, but were being driven by family members because of the perceived disgrace to the family that their doctor member and breadwinner was not able to practise in New Zealand.

Finally, the action for judicial review was completely dropped and the Race Relations Conciliator ruled that no charges would be brought against the Council. I was the butt of the doctors’ anger as I was the prime representative of the Council throughout this period of challenge and negotiations. I was pleased that I was able to satisfy the Race Relations Conciliator that the Council (like other similar bodies overseas) was acting within the law and had no intention to discriminate on the basis of race against doctors wanting to practise in New Zealand. Standards of practice and public safety were the prime concern and all overseas trained doctors had access to valid assessment processes if they chose to participate.

Some of the doctors involved in this case did finally meet the requirements, but some left the country. Others waited until they had been registered in New Zealand, been granted permanent residence and then citizenship, then migrated to Australia.

Communication with the ODA was difficult as their position was entrenched and highly political, with some members of parliament encouraging them to pursue it for motives I had to question. The ODA itself was wracked with political turmoil. If a president was elected and did not succeed in getting registration for the members, unachievable as it was, he would lose his office. Another would be elected and usually came to the same fate. Dr Thomson, Council President during most of the fiery period, enjoyed the company of the ODA at their annual meeting on more than one occasion and tried to allay their fears of discrimination, no doubt unsuccessfully. On one amusing occasion when two ODA representatives were invited to come to Wellington to meet us, they did so and took themselves to lunch at The White House before the meeting down the street with the Medical Council. I was very sceptical about whether they knew in advance that the White House was probably at that time the most
expensive restaurant in Wellington! When their travel claims were
submitted they had also managed to run up several hundred dollars in taxis
to and from the airport at both ends of the journey. In a perverse way, their
style had to be admired!

NZQA’s arrogance from the early 1990s onwards in their approach to
evaluating medical qualifications from around the world was a core
problem. As long as the degree was listed in the WHO Directory, it was
deemed equivalent to a Bachelors degree (i.e. a three-year degree) in New
Zealand, which led to the Immigration Service awarding sufficient “points”
to enable the holders to obtain permanent residency without any reference
to the Council. Despite meetings with NZQA to try to persuade them that
their misleading policy and procedures were resulting in unrealistic
expectations and distress for the overseas trained doctors and the Council,
it was impossible to persuade them to do otherwise. After about four years
of frustrating “stand off”, the only concession I managed to achieve was to
get them to add one sentence to the letter provided to doctors with the
decision on their eligibility for permanent residence, pointing out that they
would need to approach the Medical Council of New Zealand concerning
registration. The way the form letters to successful migrants were phrased
was most misleading in that they were congratulated on the fact that they
were now eligible for permanent residence and told they would be able to
“live and work in New Zealand”. That phrase was misleading, as it did not
refer to work as doctors, nor to any procedures for registration. From afar
and not knowing the culture of New Zealand or its institutions, it was not
surprising that doctors interpreted that letter in the best light possible,
taking it to mean that they would be able to practise immediately on
coming to New Zealand.

This, in my view, constituted possible breaches of human rights and
international relations more than any action taken by the Council under the
provisions of its governing legislation. Further abuse occurred because
many unscrupulous immigration agents promised help to such doctors, but
could achieve nothing other than collect large fees for a service not
provided. Such agents were very aggressive to Council staff and that did
not reflect well on their professionalism, rather emphasising their
commercial motivation. In a wry twist, a former Minister of Immigration,
Aussie Malcolm, himself by then an immigration consultant, told me he
thought immigration consultants needed regulation!

The fundamental difficulty presented by the absence of bridging
programmes undoubtedly led to great anguish on the part of the doctors,
their families, and also Council members and Council staff.

At the end of the century, the government was finally persuaded that the
best solution was to institute bridging courses for those who were
erroneously led to believe that they would be able to practise in New
Zealand under the policies in place for immigration (based on NZQA
assessment of degrees) in the years 1991-1995. The first of those courses
has now been concluded. Some doctors have successfully completed the
programme and gone into positions in the workforce. Nevertheless, barriers to their smooth assimilation into the workforce in New Zealand arise because of differences in knowledge, practice parameters, cultural norms and communication in English. Though medicine may be perceived as a very portable occupation, in reality, in sophisticated countries with ever-changing health structures, technology, and fiscal pressures, it is not as easy as it looks to incorporate practitioners whose attitudes, skills and knowledge have been formed in an entirely different environment.

Back in the 1950s, when shortages of doctors were becoming obvious, the government was persuaded to open a second medical school in Auckland, more than doubling the output of graduates each year in this country. It is interesting to reflect that the main driver now to increase student numbers in medical schools is to provide more places for fee paying foreign students (and graduates doing shorter courses) in order to underwrite the cost of medical education for New Zealand students. I fear that this development could also lead to allegations of racial discrimination in due course as some of the overseas undergraduate students are quite likely to experience difficulties in adjusting to New Zealand cultural norms, communication in a bicultural nation, and liberal attitudes to roles of men and women.

A further step to ensuring legal and cultural safety for all doctors, including New Zealand graduates, entering the workforce is still to be actioned, being first mooted ten years ago. The Medical Council has in principle agreed that, prior to granting registration in New Zealand, all doctors, regardless of origin, must satisfy the Council that they have a real understanding of legal, professional, ethical and cultural requirements which will protect patients and themselves. They will derive this knowledge from appropriate intellectual and personal learning experiences, based on material such as that in the Council publication, “Cole’s Medical Practice in New Zealand”. To date an instrument for testing whether doctors both local and overseas trained, have reached a satisfactory standard in this area during the probationary year has not been developed.
3.4 Voice of society

In some countries the equivalent of the Medical Council is managed by doctors. I like the New Zealand model where a lay person has the role of Registrar or CEO, with expert advisers used when necessary, to supplement the capacity of Council members and staff. Inviting individual doctors or community members to bring their concerns to the Council table increases transparency, but must not be a token gesture in the absence of real accountability.

Doctors and their governing bodies are now much more aware of the fact that they can always learn something from patients, families, and members of the lay community. Some of these individuals and groups may need support to come to a formal arena but are unfailingly eloquent in what they say.

Lay members on Council

In 1984 the first, and only, lay member, Mr D V Sutherland, was appointed to Council, but resigned after one year of his three-year term because of pressures from his other commitments. Health Minister Michael Bassett then appointed Mrs Patricia Judd and she served from 1985 right through to June 1998.

Strong submissions for more lay participation were put to the Select Committee on the 1995 Bill and this led to provision for up to three lay members on the Council and a lay member on each of the Council’s complaints assessment committees. Even so, it took until late 1998 before the complement of three on the Council was reached. In 1977 a lay member had been included on the Medical Practitioners Disciplinary Committee hearing professional misconduct charges under the 1968 Medical Practitioners Act.

Such a role is not always easy for a single lay member as, in a sense, they have no caucus. Not surprisingly, the 1995 Act recognised that it was essential to have more lay people on the Council and on the panel for the new Medical Practitioners Disciplinary Tribunal, not only to spread the workload but to allow a variety of lay contributions to debates and decision making. Lay members are not consumer representatives - they each bring their own perspective to their role under the Medical Practitioners Act. They are informed by their family, community, professional or personal experiences, but they are not bound by mandates from a “constituency” to which they are accountable.

They are accountable only to the Minister. The quality of those appointed by various Ministers of Health has been very high. Prior consultation by officials with the Council President or Registrar has been useful. Most lay members have been willing and available, despite their other responsibilities, to make a commitment and untiring contribution to the
work of the bodies constituted under the Medical Practitioners Act. I believe this is a key reason why they have been so highly valued and accepted on these professional bodies. Despite their small numbers, they have not been token members. We have come a long way since 1984, when the first lay person was appointed to the Council.

1990 saw the first woman, Dr Robin Briant, elected Chair of Council; now with more lay members, a lay person will one day soon be elected President of the Medical Council.

The complement of three lay members is now just sufficient to allow lay membership on each of the Council’s committees, and to take a leading role in governance. The 1995 Act meant a significant breakthrough in that lay members were mandated on Council, the tribunal, and complaints assessment committees. Council committee membership policy means they participate alongside medical members on all decision-making bodies and have access to consultation and training opportunities in every aspect of the Council’s statutory mandate. The Council report at 31 March 2000 indicated that each committee had at least one or two lay members, except for the Finance and Management Committee where the CEO was the non-Council member. However, as for the medical members, this work is in addition to their other paid and voluntary work and adequate recognition and recompense is essential. The depth and breadth of the contribution made by Trish Judd as the sole lay member on the previous Council was awesome in that context, given that it included hearing disciplinary charges. In the 1998 New Year’s honours she was awarded a CNZM for her services to Health Administration, acknowledging her additional roles in ethics committees and Health Ministry working parties. As more lay people become involved with the passing of the Health Practitioners Competence Assurance Bill, attention should be given to support and training to allow them to contribute even more effectively.

I am not suggesting that pressure from lay people and society at large is needed to galvanise the medical profession into action! In my experience, Council members and office holders are very tuned in to public protection issues. Naturally, they look at such issues from their professional perspectives, but they too are members of society.

_Cartwright Enquiry_

The Council’s response to the 1988 Enquiry into Cervical Cancer at National Women’s Hospital, and the subsequent “Cartwright Report” in 1989 was immediate and effective. Led by Dr Robin Briant and Dr Stewart Alexander, a statement for the profession on clinical freedom, guidelines for institutions on clinical research and a working party on informed consent were activated forthwith. The 1990 Statement for the Medical Profession on Information and Consent, and its review published in 1995, which added a clause covering specialist as opposed to student learning environments, were invaluable documents for the period before legislation was passed to create and appoint the first Health and Disability
Commissioner and adopt the Code of Health and Disability Services Code of Consumers’ Rights.

The community and the profession became more and more frustrated over the time it took to adopt the legal reforms recommended by Judge Cartwright, following the long and painful public hearings in 1988, so the Council’s lead in this area was a key bridging mechanism, which was a credit to them. The NZMA took the initiative in laying complaints against the key doctors involved, and the Council hearing of charges of disgraceful conduct in a professional respect against Professor Bonham proceeded in the interim. Although the Bonham hearing was, by virtue of the law at time, held in private, Council took the unprecedented step of agreeing to hold press conferences at the start and the end to keep the public informed of progress. It took its duty to the public very seriously at all times. Professor Herbert Green did not answer complaints laid against him because of his health status. The Preliminary Proceedings Committee prosecuted complaints before the Medical Practitioners Disciplinary Committee against Professor Seddon and Dr Faris.

Advocacy

Prior to the creation of a nationwide advocacy service under the Health and Disability Act 1994, the Council actively supported and encouraged existing patient support groups, who adopted a facilitative role in assisting patients and their families to come forward with their concerns and get them addressed. While some services adopted a rather aggressive stand, for example in Auckland, others such as a Waikato community trust were able to empower patients to take constructive steps to find out why things had not gone as they expected.

Apart from a few high profile 1970s disciplinary cases, the Council maintained a low public profile for many decades. There was, however, the saga of migrant “Dr” Milan Brych, who claimed to have developed a cure for cancer. He had been registered as a doctor by the Medical Council, but was struck off after he turned out to be an impostor with a criminal history and no medical qualifications.

Feminist protests took place when general practitioner Dr David Minnitt, who killed his wife, was found guilty in the courts of manslaughter, not murder, and some years later was restored to the register.

Trust between doctors and patients

It is probably fair to say that community development and, in particular, the women's liberation movement in the seventies and early eighties encouraged people to think about the structures of society and where the traditional power basis lay. Professions began to come under more scrutiny, particularly with respect to the key fiduciary element of the relationship between professional and client. When individual doctors or the profession at large was under the spotlight, members of the public were
less likely to take at face value all the information that was provided and to use their own judgement to scrutinise the actions of those they might previously have trusted without question. The enquiry in the late eighties by Judge Silvia Cartwright into events at National Women's hospital certainly put the medical profession to the test, bringing information and consent onto centre stage. Following that enquiry and its wide-ranging recommendations, patients and their families were much more likely to come forward, sometimes assisted by advocates, if they were not happy with the services they were receiving from their health professionals, particularly doctors. Levels of awareness rose and complaints of all kinds about doctors started to increase.

However, at that stage the professional bodies were not overtly involved in advocacy or in educating the public about what to expect of their health professionals. In the eighties, the Council heard several very serious cases involving sexual aberration and exploitation of patients by doctors. Around the world, the lid started to be lifted on the secrecy that had tended to accompany sexual abuse of any kind, whether it was within the family, in schools, in churches, or by health professionals.

In October 1991, Council chair Dr Briant received the report from the College of Physicians and Surgeons of Ontario on sexual boundary breaches in medicine, which had been prepared by an advisory group after six months extensive community consultation. Dr Treadwell, the ministerial appointee on the Council and a psychiatrist who undertook sexual abuse assessments for ACC, recommended that the Medical Council adopt a multi-disciplinary approach to this issue. The Council thought it prudent to seek the involvement of other health professionals in any initiatives because it recognised that all professional relationships were vulnerable. The Council accepted there was a real problem and envisaged developing policy on all aspects of the topic. It set about consulting with others who could be involved. In May 1992 a multi-disciplinary seminar was held with fifty attendees from a range of professions and consumer groups. Discussion was lively.

From the outset, it was agreed in principle that it was important to take a positive approach, emphasising education and research rather than anything that could amount to a witch hunt. The profession would be kept in the picture through the Council's newsletter. Suggestions were made for a number of approaches to the issue, including a small working group as a committee of Council or an umbrella organisation for all health professions. In the interests of the public and the profession, there was an urgent need for protocols for sensitive and effective handling of complaints of sexual abuse. The Council decided to set up a small working party comprising Council members, doctors and other health professionals with experience in this area, and a lay member. Priority tasks included developing definitions of abuse, identifying danger signs, providing guidelines for proper behaviour, collating relevant research, and prioritising education programmes. Such a working party was a new venture for the Council. It was convened by Council member Dr Bob
Gudex, an obstetrician and gynaecologist, and included psychiatrist Dr Judith Treadwell, clinical psychologist and faculty member at Wellington Clinical School Dr John Bushnell, Auckland social worker Ann Epston who had a strong research background in sexual abuse issues, general practitioner Dr Ros Galletly from Blenheim, and Helen Chambers from Christchurch who had founded THAW, a women’s health action group. I believe this multi-disciplinary approach proved very acceptable. There were some shaking down problems concerning the relationship of the working party to the Council and the funding for some of the initiatives the working party proposed.

The working party spent two years, from 1992-1994, drafting policy and action statements, and pamphlets for doctors and the public. Later the Council took responsibility for progressing all these initiatives for distribution. Initially, the working party hoped to produce a single pamphlet for both patients and doctors, but later realised separate information for each would be more effective. We took expert advice on communications on sensitive topics, particularly in light of the fact that multi-cultural and bi-cultural issues would need to be taken into account. All draft policies and publications were circulated among other health professionals and community groups for comment, the most extensive consultation and information exercise the Council had done to date. This was very useful as it brought into the loop a large number of organisations that did not have the resources to do such work on their own. We benefited from their comments and they were empowered to use and adapt the material developed by the Council so that it could be widely distributed to health professionals, clergy, and counsellors - those whose association with clients’ personal issues over months or years could lead to boundary breaches.

The following information brochures were produced on various aspects of this matter:
- **Trust in your doctor/patient relationship – patient information about professional sexual boundaries** – brochure of general information for patients, June 1994
- **Trust in your doctor/patient relationship – guidance for concerned patients about professional sexual boundaries** – brochure for patients concerned about sexual abuse, June 1994
- **Trust in the doctor/patient relationship** - general information brochure for doctors, June 1994

The working party also developed the following policy statements:
- **Statement for the profession**, June 1994
- **Chaperone statement**, June 1993
- **Policy on victim support**, March 1994
- **Policy on victim impact reports**, March 1994
- **Guidelines for victim impact reports**, March 1994
- **Policy on reporting sexual abuse by doctors**, September 1994
• **Policy on assessment and rehabilitation of doctors admitted or found guilty of sexual misconduct**, June 1995
• **Policy statement on sexual relationships with former patients**, December 1996
• **Guidelines for doctors ending a professional relationship**, December 1996

A thorough annotated bibliography of resources was also published.

In December 1993 there was some adverse comment by Dr Felicity Goodyear-Smith concerning the distinction between “harmful” and “unethical”, with a flurry of correspondence published in the NZMJ. This exchange of views was taken into account when the 1994 brochures and statements were published. The Council again reviewed the doctor/patient relationship statement which had first been published in the December 1992 issue of MCNewZ.

In anticipation of considerable media attention, we handled the distribution of statements and pamphlets very carefully. The Council was eager to avoid any perception of harvesting or seeking complaints. An 0800 number for a whole year for general complaints was suggested rather than emphasis on a short-term option and, if this were implemented, the Council staff would deal with enquiries rather than counsellors who would not be familiar with the Council's position. In the event, this service was not offered. The Council kept the NZMA in the picture, emphasising that the pamphlets would be released to doctors initially, with copies available to other groups on request. Subsequently, the patient version would be distributed to the public through agencies such as the Citizens Advice Bureaux and possibly pharmacies. Back-up counsellors were available on call over the first month the public pamphlets were distributed, but in the end were not necessary.

Feedback from colleges indicated that, with regard to relationships with former patients, it might be good to have a group of “wise counsellors” with whom a doctor could check out his or her situation. Whenever this topic was considered the issue of doctors in small rural communities was raised. In this context, if the Council’s guidelines were unrealistic and too rigid, there could be boundary problems if doctors were not able to socialise in their small community where they might be the only medical practitioner. Clearly a common-sense approach had to be developed which would not compromise ethical standards or lead to unnecessary isolation of doctors in such small or remote towns. The NZMA published its own guidelines written by a Christchurch child psychiatrist specialising in abuse.

The Council’s package of teaching materials was launched at separate seminars for medical schools and colleges. It included a comprehensive bibliography (later updated in 1999) of relevant reading material on all these topics which could be used for teaching or reference in developing other policies. The Council agreed in principle to consider producing a
public education video, and later an MCNZ Summer Studentship recipient drafted suitable scenarios. Meanwhile, a video made by a North Shore women's group on the subject of professional boundaries and the meaning of abuse in that context was used as it covered doctors as well as other health professionals and lawyers. Training days were arranged for members of the Medical Council, the Preliminary Proceedings Committee and the Medical Practitioners Disciplinary CommitteeTribunal at which information on rehabilitation and re-registration was also included.

*Overseas input*

The Council collected information that had been produced by other bodies, including clips from some notable American cases. Through my contacts in the United States through attendance at Federation of State Medical Board meetings, I met Mr Gary Schoener who, with Jeanette Milgrom, had established a sexual abuse counselling centre in Milwaukee. He was an expert on the topic of professional abuse and had given evidence in court and conducted education sessions over a number of years. The Council invited Mr Schoener to offer two public seminars in New Zealand, one in Auckland and the other in Christchurch, which were attended by several hundred people.

*Sharing resources*

Just as other New Zealand health professional bodies were interested in the Council’s developments and were in the loop for consultation on all policies and publications, so were other medical boards, particularly those in Australia. Everyone agreed that it was wise to pool resources and to learn from one another. As long as any publications based on another organisation’s work was acknowledged, we were happy for material to be widely shared. This sharing was extended to church-based initiatives, which in Australia were particularly strong. At conferences held in Sydney and Melbourne on the topic of sexual abuse by health professionals and the clergy, MCNZ representatives offered papers on the risks and boundary issues arising when long-term support relationships exist between professional and client, where the client and both may be vulnerable.

*Encouraging victims to come forward*

The publicity did give rise to an increased number of complaints, but we were also aware that, because of the damage they had suffered, often many years before, and their reluctance to bring that painful history into the light, it was extremely difficult for complainants to come forward. This aspect of dealing with breaches of boundaries was particularly troublesome because no action could be taken unless a complaint was lodged and the identity of the complainant and doctor disclosed. In some cases, boundary breaches were multiple and involved other boundaries, such as financial, as well as sexual. It was clear that other members of the profession could have been aware of transgressions, but were not willing to lodge complaints,
especially without the consent of the patient concerned. This is a very difficult dilemma, despite the Council’s protocol on it.

Recent high profile cases, for example that of Dr Morgan Fahey, involving damage to a number of patients over decades may get the message through that, where there is suspicion, steps should be taken to bring this to the attention of those with the power to make further enquiries. Complications can also occur when patients make complaints to the Police, but do not want to go through the criminal justice system, for example giving evidence in open court, being cross-examined, or facing the alleged perpetrator, all of which perpetuates the abuse of the victim. In some areas of the country, police will liaise with the Council to avoid double handling. Criminal hearings of this kind were further complicated in some cases by the different definitions of consent in the criminal justice system and in the professional context. Some poor conduct, which the medical profession would regard seriously and worthy of punishment, would not be a breach in terms of consent of the victim in the criminal context.

Eventually, when the media did disclose Dr Fahey’s alleged abuse, this brought the whole issue of reporting out into the open and emphasised the need for victims or those who knew of victims to share the information with the appropriate professional body or the police at an early stage. Given the pattern of offending in sexual abuse cases, there is every likelihood that more than one victim will be involved and media publicity can galvanise those other victims to come forward.

Cover up undesirable

A situation which, I hope, would now be unlikely to occur is when employers know that health practitioners have been breaching boundaries and dismiss them without reporting the matter to the Council or another body that could take action. This leads to continuing abuse. The most widely known episode of this kind of abuse involved a psychiatrist, Dr Unni, who came from England to New Zealand in the 1980s. He was investigated in his first job because of boundary incidents, then committed further offences in the second institution and fled the country as soon as the Council laid charges against him. He was struck off the New Zealand register and many years later struck off the GMC’s register, but later reinstated. Only after a current affairs television investigation, partly filmed in New Zealand, highlighted this information and used hidden cameras to expose the extent of his misdemeanours and crimes in England was he finally gaoled. Because this is such a damaging area for patients individually and for confidence in the profession, we constantly need to be looking at methods of making it safe for people to bring forward their information and to be supported through a process where the accused can be confronted.

In some cases not involving criminal acts, practising rights can be reinstated after a doctor has undergone intensive therapy and developed new strategies for dealing with the issues which led to the boundary
breaches. The Council engaged as advisors a panel of psychologists and psychiatrists with experience in sexual abuse assessment and treatment in New Zealand. This advisory process has been implemented and, in some cases where the risks of further offending are very low and the capacity to monitor the doctor is high, practitioners have been returned to the register under very strict conditions which are likely to stay on their registration for the rest of their practising lives. In other cases, especially where crimes occur and the doctor is gaolled, and despite prison-based programmes of assessment and treatment, re-registration is unlikely.

From my perspective as Secretary/Registrar this area of my work was one of the most troubling and yet worthwhile activities with which to be involved. However, like a number of areas of conduct, it requires constant vigilance and repeated training and highlighting in the community and in the profession. Norms and values may shift on the continuum, but abuse does not diminish in its capacity for harm. It was somewhat surprising to learn from research done by Professor Alex Thompson and Dr John Coverdale in New Zealand of the fairly permissive attitude found amongst a significant number of general practitioners who were surveyed about their own and their colleagues’ relationships with patients.

Public enquiries

Public enquiries have their place. However, on reflection, the National Women’s Hospital Cervical Cancer Cancer Enquiry 1988 and the 2000 Ministerial Enquiry into Under Reporting of Cervical Smear Abnormalities in the Gisborne Region I can't help thinking that lengthy, often emotional, public outpourings of criticism and anguish may be cathartic, but they have the potential to damage relations between patients and doctors in the community they work in. The recent tendency for Select Committees to be used as a forum for further so-called fact finding only exacerbates delay and increases the level of distrust. Prompt action at a local level, with a “round the table” non-punitive approach is surely more likely to lead to remedy with far less cost of every kind to all involved. This can only occur in supportive environments where health professionals and patients feel able to speak up without fear of retribution.

The current highly legalized, adversarial, and centralized process, though independent of the regulatory bodies, under the Health and Disability Services Code of Consumers Rights is serving a purpose, but is not a process I would like to see perpetuated. Moving back to the local community and using conciliation and mediation more effectively would surely produce better, faster results. This applies as much to individual patient concerns about their treatment as it does to issues about service delivery to communities. A national database of all notified outcomes perceived as below standard (including medical misadventure), with a tracking system for their consideration and resolution, could give better warning of poor performers in all aspects of health care delivery.
3.5 Workplace relationships

A safe workforce

Doctors wanting to be registered and those already registered are principal stakeholders in the product of the Medical Council - the medical register. Through fees they fund all the activities under the Medical Practitioners Act. But the purpose of the Act is to protect the public. Practitioners are therefore making an investment in their own and their colleagues’ ability to practise medicine once they have reached the thresholds of competence and fitness to enter the register. Doctors and their employers have a key role to play in making sure the working environment is safe for them and their colleagues and patients. The Council’s work is critical to this and must be taken into account at all times. Sometimes we got the feeling the Council was an unwanted intrusion, coming along with rules and regulations and questionnaires that were a nuisance and intruding on the real work.

Partnership is central to regulation for occupational safety. We need each other. Those who fund the institutions, whether private or public, have an immediate impact on the capacity of the institution and the individual to deliver appropriate, safe services to those most needing them. Funders directly influence services through their strategic goals, set by parliament at budget time. Managers must implement them, often with scarce resources.

The Council made a real effort to get them on side, so they could understand the basis for certain rules and processes to maintain a safe, informed workforce. As attracting and keeping competent professionals came under pressure, it was even more necessary to see that the right people went into the right jobs, and had the support and supervision they needed to thrive.

Getting management on side

At a strategic level that meant making sure changes in legislation and implementation were signaled as far in advance as possible, and flexibility over transition periods was allowed where legally tenable. Meetings with Chief Executives and General Managers of CHEs early in the life of the new Act proved worthwhile. Since then, the human resource managers have been in regular contact with Council staff, especially over recruitment of medical staff, complying with supervision or oversight and notifying those not performing to minimum standards.

Since the Register of Specialists and the Register of General Practitioners were introduced in the 1970s and 1980s respectively, the Colleges have also been stakeholders in maintaining a well-qualified workforce. Since the 1995 Act was passed, more emphasis is put on branches of medicine, and empowering them to have a “womb to tomb” approach to their “members” in terms of teaching, support, supervision, review, guidance, and remediation.
Workforce data

The Council was diligent in collecting workforce data over several decades after the tripartite arrangement between the Council, the University of Otago, and the Department of Health was instituted in the 1970s. Information was collected at APC renewal date, to collect, analyze and learn from statistics on doctors registered and working in New Zealand, wherever they qualified or practised. This resulted in a high compliance rate for workforce questions.

During the 1980s, market driven policy meant workforce planning became unfashionable. We now realise that market forces do not always work in society’s favour. It is good to see health workforce across the board now receiving better scrutiny and strategies for retention and recruitment put in place in what is now a global market. In the late 1990s, government policy makers and funders again had to focus on workforce issues in all areas of medical practice.

Medical migration

Outside forces are pulling younger, experienced and retiring doctors round the whirlpool of employment. Political upheavals in some countries, self-determination, preference for teaching in their own language rather than always in English, and local health needs, all impact on the type of doctor produced.

Fashions and fads in practice

The Council is aware of a changing practice environment influenced by factors such as the balance between the public and private sectors, privately insured and uninsured customers, fashions and fads in treatment (e.g. cosmetic and appearance medicine, alternative remedies and practitioners). For a standards body, there are dire concerns if some registered doctors are hiding fringe or maybe dangerous practice behind registration. Allegations of this nature are not easy to prove. In its disciplinary role, the Council did succeed in the case against Dr Matthew Tizard, but he still has a loyal following even without the title of “Doctor”.

General practitioners are under pressure. They finally achieved vocational status under the 1995 Act – a long haul from the mid-70s when it was first mooted! Accident and medical practitioners also recently achieved vocational branch recognition.

The Council was keen to support more Maori and Pacific Island doctors in training and practice.
Reforms impact on practice

Continuous reforms in the sector were, and still are, very disruptive. It is hard for organisations and individuals to keep up! Fortunately, data collection was not abandoned, even if analysis of it went into a vacuum. The importance of workforce information is having a rebirth under the Health Workforce Advisory Committee reporting to the Minister of Health.

Team supervisors are the key to safety maintenance. The apprenticeship model is under pressure, but is worth keeping, provided there is still honest reporting.

Unions need to watch their capacity to undermine goodwill, which is essential in the healthcare team. Already doctors are not, as of right, the team leaders. The nurse practitioner model has potential in some settings, and this will affect accountability. In future, scopes of practice will be a more flexible mechanism, but grey areas with potential for boundary disputes could be problematic.

The Quality Assurance provisions of the 1995 Act were greatly under-utilised. That forum has the power to really get to the bottom of errors and get away from the so-called “naming and blaming” culture. Processes need to be robust, whether they relate to quality assurance, competence, health or discipline. Quality assurance is not a way to hide things. Research activities need to be covered by the same protections. Introducing new techniques or ways of working may be more beneficial, but patients and other professionals need to be informed and give consent.

For decades shortage specialties have continued to be a problem. The Council did what it safely could to assist. For example, in general, United States temporary registrants as mental health professionals have done a good job, but this is not a long-term solution. This is an area where the nurse practitioner may help in the long run. Current investment in mental health professional training will take time to bear fruit; meanwhile, high-profile disasters are not good for the Council’s image or public confidence. Quality assurance programmes are needed in this field.

Occasionally, registration catastrophes will still happen – fraudsters are a clever breed. As in other sectors of society, a small percentage of the profession is fatally flawed, and the Council just has to wear it. Medical Schools could identify them; in the same way impaired graduates should be notified at initial registration. Why is quality assurance not applied to entry programmes as well as to ongoing work? What data do colleges extract and share about flawed trainees?

Robust inspection and credentialing of private as well as public facilities is necessary, especially in emerging, highly commercially sensitive scopes of practice. Reporting bad practice observed in other health professionals has to become a given, with adequate legal protection. But members of teams may have to be trained in speaking up constructively.
I was always concerned about the influence of the Accident Compensation Corporation and its failure to share performance data. Though this will soon be mandated, it seems it still requires goodwill and cooperation from all gatekeepers. ACC failure to report repeat “offenders” will be addressed in the Health Practitioners Competence Assurance Bill and amendments to Health and Disability Commissioner legislation, but other health professionals, for example nurses and laboratory technicians, can also see what is going on. They should be subject to mandatory reporting, as it protects reporter and subject, combined with approved robust quality assurance programmes.
3.6 Partnerships with education and training providers

Medical schools

From the inception of the Medical Council as we know it, medical educators have played a vital role in informing and shaping the style of legislation and the initiatives taken by the Council. The University of Otago Medical School and the New Zealand branch of the British Medical Association came into existence well over a hundred years ago and, not surprisingly, wanted representation on the governing body of the profession. Relationships between educators and the Council have not always been easy, and the stars of one or the other have waxed and waned. The interface between medical schools and the Council became more active in the 1940s when workforce shortages arising from World War II resulted in some fairly radical emergency measures, for example allowing final year medical students to practise on the basis that they would eventually complete the full medical course and the internship. The University of Otago was asked to provide instruction and an examination as a form of bridging to allow some European qualified doctors migrating to New Zealand to achieve registration although their degrees were not on the “reciprocity” list.

The Medical Practitioners Act 1950 constituted the Medical Council so that it included the Director General of Health and the Dean of the Faculty of Medicine in the University of Otago, and it empowered the Council to appoint such committees as it considered necessary. An Education Committee was created, but was hamstrung by lack of statutory powers. In the next decade the General Medical Council took steps to introduce a pre-registration (seventh-year) period and, in order to preserve reciprocity, this mechanism was added into the New Zealand legislation. Accreditation of undergraduate courses, as well as preparation of young medical practitioners for independent practice as private practitioners, was discussed. In that era, the men on the Medical Council, as they all were, were of high standing in their respective practice domains and took initiatives to improve all aspects of medical practice and its regulation. The Deans of Otago and later Auckland medical schools have always been active in driving change. The Acts governing the practice of medicine in New Zealand have been under constant scrutiny and criticism, followed by reform, the latter not infrequently far too slow for the liking of Council members. Many initiatives taken by the Council arose from ideas put forward by Deans.

As an interesting aside, when the Council became a corporate body an official seal was needed. This was, in fact, designed by Professor Cecil Lewis, the inaugural Dean of the Auckland School of Medicine in the Council’s centennial year, 1967. The Council logo still embodies his original design concept, which he delivered to the secretary accompanied by a note saying that he had completed it at 1:30am and he wished he had more time to pursue this hobby!
Deans have always been active in continuous improvement in medical education, including pushing for new medical schools, signalling workforce issues, extending the scope of the undergraduate course and access to it, and ensuring that continuing education through to specialisation is of a high calibre. The latter role was the core work of Postgraduate deans in their time. These deans also acted as Council agents, interviewing new applicants for registration and scrutinising qualifications and other documents.

**Medical Education Committee (MEC)**

It was not until the Medical Practitioners Act 1968 was passed that a separately constituted Medical Education Committee came into being. At that time parliament was persuaded that this needed to be a large committee with representation not only from medical schools but also from colleges providing education for specialists. The functions of that committee were all set down in detail and covered:

- giving advice to the Council of any University in New Zealand on any matter relating to medical education;
- exercising general supervision over the training, work and duties allocated to, and the facilities for obtaining experience in the practice of medicine and surgery provided for persons on conditional registration;
- taking all reasonable steps to satisfy itself that the courses and curricula leading to graduation in medicine and surgery in any University in New Zealand (and the training, work, duties and facilities referred to above) were sufficient to ensure that the medical practitioners had the basic knowledge and skill requisite for practising medicine and surgery efficiently;
- advising the Council on any recommendations to be made by them to the minister and performing such other functions as Council delegated to it.

The 1968 Act specifically referred to the need for the Medical Education Committee to visit universities, hospitals and other institutions in New Zealand where instruction was being given to medical students or to interns under conditional registration. Visitors were deemed to be agents of the Council. The definition of instruction was broad, including training. Although reciprocity across the Commonwealth, based on GMC decisions, was a strong driver through until the 1960s and 1970s, at various times Council and MEC members expressed preference for having local control over this and establishing a stronger partnership with Australian medical boards, especially as economic reforms encouraged closer relationships between the two countries.

Since publication of an annual report by the Council to the profession was legislated in 1983, subsequent annual reports had regular reports from the MEC. By that time, the MEC comprised the Council chairman, each of the
four medical school Deans ex-officio, representatives of the faculties of medicine at each University, and representatives of the Royal Australasian College of Surgeons, the Royal New Zealand College of General Practitioners, the Royal Australasian College of Physicians and the New Zealand College of Obstetricians and Gynaecologists. The NZMA had a representative, and an observer from the Department of Health normally attended meetings. Through most of the 1980s the MEC held two or three meetings each year, at which a major part of the business was receiving reports on the hospital visits and approving hospitals for pre-registration house surgeon experience. It is notable that in the early eighties a very wide variety of hospitals received this accreditation and were gazetted as suitable for this key stage of postgraduate medical education. In some ways it is sad to note that some of these hospitals have now gone completely out of existence.

Students and junior doctors

The functions and duties of intern supervisors were a key element in the seventh-year education and training. Work continued on categorising clinical runs to minimise discrepancies between what should be comparable runs in different hospitals. That first 1983 report also referred to the committee’s statutory duty to consider the content of the undergraduate curriculum. It noted that, in general, New Zealand schools adhered to the outlines laid down by the GMC of the UK. Submissions were called for from both medical schools and both clinical schools, the latter by then established in Christchurch and Wellington. Educational needs of eighth-year house surgeons and registrars were also of interest to the committee, and they decided to send their chairman or their deputy to the Resident Medical Officers Establishment Committee meetings.

Accreditation

Developments in Australia were always closely monitored. These included a local medical school accreditation system and a process for examining and assessing overseas trained doctors.

On 1 January 1985 the Australian Medical Council was constituted. It comprised mainly Presidents of State Medical Boards and nominees of universities. The Council chairman commented that there were likely to be considerable advantages to both countries if committees concerned with accreditation remained in close contact and adopted comparable criteria. The AMC had invited the Chairman of the New Zealand Medical Council to attend this meeting to facilitate an exchange of views and information.

Examination

In 1984, the Council introduced the first probationary registration examination for overseas trained doctors. Held in February, this was conducted on behalf of the Council by the University of Otago at the Wellington School of Medicine. Otago agreed to continue to be the
examining agent for the Council for at least the next four years, the idea being that the responsibility might then be handed over to Auckland and a rotation of this kind set up to share the load. For candidates in such examinations to have a reasonable prospect of passing, they would need an opportunity to see New Zealand medicine at close quarters, and proposals to facilitate this were under consideration. In 1986, a Board of Examiners was set up by the Council, separate from MEC.

Workload

In the Council’s 1985 Annual Report changes in MEC membership included Dr Ian Simpson and Dr Philip Barham joining the committee. This report also noted growing concerns from the MEC that some resident staff in Auckland hospitals had a very heavy workload and this was affecting their educational needs. At that time, the view was that the MEC could not in any way interfere with the relationship between the employing hospital board and the resident medical staff in relation to terms and conditions of service, but it was of concern to the MEC when service demands became so pressing that the education requirements of the intern year may not be fulfilled. This issue appears to be a hardy annual.

In 1986, the effect of the determination by the Health Services Personnel Commission (usually referred to as M10) on junior hospital medical staff workloads had a significant impact. As a consequence, it led to the beginning of very significant immigration of doctors who were not readily registered without assessment and, in some cases, further training.

General practice

At the time I joined the Council, slow action on legislative change was of concern to members. They had sought establishment of an Indicative Register of General Practice, but had little success in getting support from the Minister. I suspect, once again, because financial flow-on to higher fees might have been anticipated.

The MEC prepared a definition of a medical graduate and, for the first time, published it in the 1986 annual report. It stated:

"By the time of qualification graduates should be educated and humane individuals with an understanding of the structure and functions of the human body in health and in disease, of normal and abnormal human behaviour, of the techniques of diagnosis and treatment, of preventive medicine and of medical conduct and ethics sufficient to provide the basic knowledge, attitudes and skills to justify conditional registration and prepare them for vocational training and continuing education throughout their professional career".

The report went on to state, "A proposal for the establishment of an accreditation committee has been submitted to Council and funding for these activities will be included in a subsequent budget". The definition had
been forwarded to the 1985 National Conference on “The Role of the Doctor in New Zealand - implications for medical education”.

Relations between the Medical Councils in New Zealand and Australia strengthened and information was shared on the development of accreditation processes, as well as examination for overseas trained doctors.

The MEC reported to the profession that it felt it would be strengthened in its range of functions, and these might indeed be expanded, if it had non-academic and lay members and consumer representation to strengthen its educational efforts. The MEC was also very keen to see peer review activities established in all hospitals.

1987 was a watershed year in the life of the MEC, with Dr Bill Pryor retiring as chairman and Professor John Hunter, new Dean at the University of Otago Medical School, taking up the role. While the three-year cycle of visits to hospitals continued unabated, concerns were still high about the effect of the M10 determination on the education aspects of the pre-registration year, though this was difficult to measure. There was a very fruitful discussion with representatives of the intern supervisors and a clearer idea of their important role emerged, so it was agreed that regular meetings between them, hospital boards and the MEC would be worthwhile.

At the June 1987 meeting of the Council, acting under its statutory authority, the MEC was mandated to:

- maintain an overview of all stages of medical education;
- monitor the standards, training and provisions of undergraduate and postgraduate education as required for medical and specialist registration;
- promote and advise on the achievement of high standards of medical education;
- assist in the coordination of medical education wherever possible between the institutions and bodies responsible for its provision and/or granting of degrees or diplomas.

**Renwick Committee**

These expanded functions clearly established the concept that the statutory body must be concerned with the outcome of medical education at all levels. In 1998, a very important development in the field of education occurred when the first formal accreditation of New Zealand medical schools was carried out quite separately from any visit from the General Council of the UK. Professor Hunter’s leadership in education really came to the fore in this year and continued over a period of years to make a big impact on the work of the Council and its stakeholders in universities, hospitals, and vocational colleges. The first structured and formal process of accreditation of the two undergraduate medical courses was undertaken.
by a ten-member review committee. This was highly significant as it comprised equal numbers of medical and non-medical/lay people and represented the first leap forward into a new era of medical regulation where, ultimately, lay and medical members would automatically take on the responsibility of ensuring that the highest possible quality was achieved in medical practice. This committee was chaired by Mr Bill Renwick, recently retired Director General of Education. Other members included four medical professionals (Professor Peter Joyce, Mr Jim Jardine, Dr Lindsay Quennell and Dr Andrew Young) and five lay members, three from the education sector (Associate Professor John McKenzie, Mrs Rosemary Novitz (sociology) and Mrs Isabelle Sherrard (nursing)) and two from the Maori community, Mrs Heather Thomson (a health manager, now a Medical Council lay member) and Mr Sam Rolleston, a community consultant/facilitator. The Committee composition recognised the relationship between medical practitioners and other health professionals and the need for health care in New Zealand to be delivered by professionals who understood and accepted the bicultural nature of our society.

The MEC did not blow its own trumpet, but, throughout all the years that I have been associated with the Council, it has worked very professionally and steadily, setting out its goals and working towards achieving them in an efficient, cost-effective and sensitive manner.

This was enhanced further under the 1995 Act, which allowed the Council the power to appoint committees if deemed necessary and set down the membership and mandate for those committees. The roles of the Council’s Education Committee under the new Act mirror very closely those envisaged by Professor Hunter and others a decade before, as does the composition. Sometimes progress towards these goals seems slow, but this has the merit of making sure that what is implemented has been well thought through and has been aired for consultation and amendment prior to its introduction. Later in the 1990s this process had to be followed in setting up the first Professional Standards Committee and mobilising it to carry out all the important roles envisaged in competence provisions under the new legislation.

In another section of the report I have referred to the strong relationship developed with the Australian Medical Council with regard to accreditation of medical schools based on agreements made when the two Councils met in June 1990. The “Renwick committee” recommendations were thorough, farsighted, and reasonable in the context of medical education and practice in New Zealand. Ultimately, it has been to New Zealand's advantage to join forces with the Australian Medical Council in this exercise, which has led to both Otago and Auckland Medical Schools being accredited for a ten-year period, with review early in the 21st century. New Zealand members have been appointed to the AMC's accreditation committees and Professor Ian Simpson, prior to retiring from the Council, chaired this important Australasian committee over an interesting period when four-year graduate entry programmes were being developed in Australia.
As alluded to above, the universities have not only assisted in training local students but have also had an important part to play in ensuring safe standards in overseas trained doctors. Otago University was the first to take up the task of conducting examinations at the Council’s request, and later the University of Auckland took over this somewhat arduous role as numbers and challenges increased.

Tensions between the Council and the MEC and employers have waxed and waned. Sometimes the Council’s standards have been regarded as too high, involving insurmountable barriers, but of course when there is a major disaster in a hospital it is the Council and the employers that have to take the blame for allowing sub-standard services.

**Employers also trainers**

The 1995 Act required more ongoing involvement of employers as trainers and supervisors of all probationary registrants, this category under the new Act covering doctors not yet eligible for general registration (formerly full registration) no matter where they had originally qualified. Support for intern supervisors was strengthened when the Council decided to have individual contracts with each of them to ensure that there was no ambiguity about their role and their responsibilities to the registration body, as opposed to the employing body, while compatible with both.

**General oversight**

A new idea, introduced in the 1995 Act, required all general registrants, that is those who satisfied the probationary registration standards but had not yet completed education and assessment for entry into the vocational register, to have general oversight. A five-year transition period to June 2001 was allowed for this new safety provision to be developed and implemented. It was envisaged that most junior doctors who had achieved general registration, that is had completed the internship, would be working in a team situation, in an early vocational setting or under training in a particular branch of medicine, in a context where nominating a particular overseer would not prove too great a hurdle. Politically, it did cause some disturbance in the early years of implementation as the medicolegal aspects were clarified and the purpose of oversight set out in information brochures for those concerned. The aim of the general oversight concept was to ensure that doctors did not isolate themselves from others in terms of professional or personal support and that, where any difficulties were being experienced, there was an avenue for discussion and resolution before such difficulties resulted in potential harm to patients. General oversight was not intended to be intrusive, but it was recognised as another layer of accountability that the public were entitled to expect. General oversight became mandatory after July 2001.
APC cycle changes

I could see that the process for monitoring general oversight on a regular basis, as well as receiving reports on probationary registrants and evidence of recertification by those vocationally registered, would have to be linked to the issue of the APC, which signified that the doctor was still competent. This necessitated a change in administration of the issue of APCs to a quarterly cycle to spread the load over the year. This has now been implemented and the necessary data on each registrant is obtained in time for the practising certificate to be issued immediately or, if there are any concerns, they can be addressed and remedied before it is issued. Instead of being a taxation mechanism only, the APC as come to be a signal that the doctor is competent to practice within the particular scope of practice approved for that doctor, with adequate supervision oversight or recertification.

Small hospitals

These new layers of accountability in the new Act put pressure on small hospitals and on some small branches of medicine and on groups of practitioners, such as Medical Officers of Special Scale (MOSS), who often had quite specialist knowledge and experience but had never completed in full or, in some cases, attempted the vocational branch fellowship in that field. Gradually, in the interests of public safety, a system to monitor levels and types of practitioner has evolved.

Colleges

The specialist colleges, as they were formerly known, and the college of general practitioners, now collectively referred to as vocational branches, were justifiably cautious about the approach taken in the 1995 Act. The colleges preferred to see themselves as collegial, educational and not regulatory in a negative sense. The Council, especially the new Council appointed under the 1995 Act, has had to work very sensitively and steadily to obtain the cooperation of all colleges in the activities necessary under the statute, but which should also be compatible with the colleges’ own goals for their members.

The Council has tried not to interfere in any fundamental way with the way colleges operate, but to use their strengths to assure the public that their members and their trainees are not engaging in risky or unprofessional work.

To achieve the Council’s standards in this area there has had to be some standardisation in describing levels of competence, but, as far as possible, the colleges have been left to use their own preferred mechanisms for ensuring the standards.
Branches of medicine

A mechanism is now also in place so that new branches of medicine can be recognised and new colleges welcomed into this network. Naturally, there has been some debate about the proliferation of small specialised groups, but in the main these debates have been resolved fruitfully. A good example would be the recognition of accident and medical practice as a vocational branch distinct from general practice. In some ways the Council’s initiatives in this area have had a positive effect, reducing allegations by watchdogs, such as the Commerce Commission, who suspect “patch protection” and anti-competitive practices in some specialist groups. The Council has been able to put pressure on colleges to bring their processes into line and ensure that there are no anomalies between different branches of medicine at the entry or continuing practice levels, while still allowing for diversity. Vocational colleges are integral to the provision of oversight of general registrants and recertification of vocational registrants, both important protection mechanisms for the public. The universities, employers and colleges have all now been asked to participate in statutory mechanisms, such as competence reviews, to measure and, if necessary, lift the standards of individual doctors. Where disciplinary enquiries, health matters or competence reviews reveal areas where a practitioner needs to upgrade, even retrain, the role of the universities, employers and colleges are all vital. Over time, this should lead to greater trust amongst these groups.

NZMA and RDA

The Education Committee of the New Zealand Medical Association has traditionally stood at arms length from the Council and its committees. The junior doctors’ union, the Resident Doctors Association (RDA) has, in the past, had a very adversarial approach to the Council’s work. Under the 1995 Act, office holders of the RDA have been elected to the Council in triennial elections. Junior doctors do therefore have through them a voice on the Council, and the Education Committee has a specific slot for a “consumer of education”.

Deans

Conflicts of interest are problematic in the medical regulatory field as in any other domain. Traditionally, the Council over the last twenty years has not had a Dean as Chair of Council, nor has it had a former union president! Apart from their educational role, various Deans have taken a very active interest in other aspects. For example Dr Cole, a PPC member, took a special interest in medico-legal matters over several years and then compiled vital information on all aspects of practice to inform those about to begin their professional work as doctors.

The Council’s main handbook distributed to every doctor coming onto the register in New Zealand reflects Dr Cole’s emphasis on standards in all
areas. It is now edited by Dr Ian St George, but named “Cole’s Medical practice in New Zealand”.

The Deans or their deputies have been involved in investigation of complaints (under the 1968 Act) and in decisions made by the examinations committees running the assessments for overseas trained doctors wishing to practise in New Zealand.

The Deans have, understandably, always taken an interest in workforce issues, this being particularly true for the Otago Dean where the medical workforce database was established in the mid-seventies. The recently revived Health Workforce Advisory Committee, reporting to the Minister of Health, is notable for its contribution from medical academics.

When Professor Mortimer retired as Dean he took on the role of Examinations Director (for overseas trained doctors), a heavy workload in an area always under scrutiny. Prior to that two Auckland-based Examinations Directors were Dr Gavin Glasgow (formerly Clinical Sub-Dean) and former Council member Dr Campbell Maclaurin (previously Postgraduate Dean).

Deans have always had international links with other Deans and have often been aware of trends before they were apparent in New Zealand. The Medical Practitioners Act 1995 broke new ground as a model for professional regulation, so now the boot is possibly on the other foot!

The comprehensive and detailed work of the Education Committee has always been underpinned by dedicated executives within the Medical Council. Since restructuring into teams in 1993, an Education Officer has worked full time on assisting the committee and carries a very substantial workload. Angela Coleman deserves special mention as she worked through the period of transition from the 1968 to the 1995 Act.
3.7 Debate and dialogue with doctors organisations

Profession represented on governing bodies

Understandably, there was occasionally some tension between voluntary organisations representing sectors of the doctor population and the Council, a statutory body, with powers given by parliament for the principal purpose of protecting the public.

In the mid-eighties there was a high level of membership of the NZMA (around 85%). The NZMA still retained an interest in becoming the governing body for the profession, with a statutory mandate for compulsory membership similar to that of the Law Society. This issue was again debated thoroughly when moves were being made to seek new legislation through a fresh act of parliament. In the end, the NZMA abandoned that idea and supported the Council retaining the mandatory role of registering all doctors in New Zealand.

Of course, NZMA members and nominees, often appointed by ministers, have been on the governing bodies of the profession, the Medical Council and the Medical Education Committee. The disciplinary mechanism set up under previous Acts also involved the Medical Practitioners Disciplinary Committee being served by the Secretary of the NZMA and having members on it nominated by that body. In the past, there had always been very active NZMA members and representatives holding office in the Council, including that of Council chairman. The chairman at the time I joined the Council’s secretariat, Dr Alexander, had been involved with NZMA. At that time the chair of the MEC, Dr Pryor, was the NZMA representative on the Council. Other NZMA nominees who served for many years on the Council included Dr Paddy Delaney, Dr John Broadfoot (who had a period as NZMA chairman and then returned to the Council), and Dr Murdoch Herbert who was appointed in 1987 and remained right through until the last disciplinary hearings of the old Council were heard in 2000.

Following the resignation of Dr Broadfoot, Dr Ken Thomson was appointed by the minister on advice from NZMA, despite his not being a member of NZMA at the time. Later Dr Thomson succeeded Dr Briant as Chair of the Council, presiding over the complex transition period from the 1968 to the 1995 Act. When the 1995 Act came into effect in 1996, four medical practitioners had to be elected by all medical practitioners on the register. The first election resulted in two past chairmen of NZMA being voted onto the Council, Dr Alister Scott and Dr Tony Baird, along with a past president of the Resident Doctors Association, Dr Marc Adams. The fourth elected member was Dr Ian St George, who had already been on the Council for nine years as a nominee of the Royal New Zealand College of General Practitioners appointed by the minister.
By 1996 the membership levels of NZMA had dropped considerably and a number of other political organisations had come on the scene, partially driven by the wide variety of health sector reforms which had been made over the decade between the mid-eighties and the mid-nineties. It seemed to me that the Council and the NZMA had a relatively cordial, if distant, relationship with an element of coolness from time to time. In my early years as secretary, the Council had the opportunity to hold two open meetings at the biennial meetings of the NZMA, and these were an opportunity for some issues concerning the form of the legislation to be aired. That concept fizzled out when the NZMA itself needed all the time available at meetings to deal with its own business and new legislation was expected before the turn of the decade.

Dr John Broadfoot was somewhat unique in serving two terms on the Council, one before and one after he held the role of chairman of the NZMA. Once a person was appointed by the minister or elected to the Council, they no longer directly carried a mandate from any organisation which may have nominated them. They were expected to act as individuals, drawing on their experiences, including those in bodies with which they had been associated, but contributing with an open mind to a team of people governing the profession, not acting on political agendas from within the profession.

Medical Education Committee

The Medical Education Committee was also very well served by NZMA nominees, including Associate Professor Rae West (through to his retirement at the end of December 1990, when he was replaced by Professor Brian McAvoy). When Professor McAvoy left New Zealand, the NZMA position on the MEC was vacant for some time before Dr Bruce Arrol was appointed. These positions on the Council and the MEC, along with the close association of the MPDC and the divisional disciplinary committees, meant that there was, within the statutory arena, a sharing of responsibilities which appeared to work well. The method of appointment led to continuity over a considerable period of time, which would probably not now be regarded as so desirable. At that time, however, this was a bonus as the profession grappled with a large number of complex issues in a commercial and professional environment, troublesome in some respects as it arose from new economic theories of competition which could be in conflict with the ethics of the profession.

Decision making style

Lord Richardson, former Chair of the General Medical Council, stated, “Each member must think and act as a member of Council and not of any particular interest - be a representative of Council and not a representative within it.” This point was made in the context of the Medical Council of New Zealand Composition Discussion Paper printed in the NZMJ on 16 May 1985.
The Council, in most cases, used consensus decision making and, although particular members had their viewpoints informed by their particular backgrounds and political perspectives, politics did not really enter into the Council deliberations in any obvious form. In providing support for the two lower tiers of the disciplinary system, NZMA made a very important contribution to the regulation of medical practitioners. It was not surprising that, in the mid-eighties, there was considerable lobbying, particularly through correspondence in the NZMJ about access to and representation on the Council, election of members being advocated. In hindsight a number of issues seem disproportionately troublesome. One was about representation and the other was the creation of a disciplinary levy and steady increases in the level of APC fees. The work of the MEC was also carefully monitored by NZMA, but this was a natural consequence of serious concern about medical “manpower” in the early part of the decade. Ironically, there was a suggestion in the discussion when the Minister of Health George Gair spoke at the NZMA Annual Meeting in Paihia in 1980 that, by the end of the decade or even sooner, there could be a situation where New Zealand had more doctors coming out of its medical schools than we could hope to employ! A letter in the NZMJ “Viewpoint” contended that this was no comfort to Taihape, Kaikohe, Inglewood, Twizel, Te Anau or Buller. Twenty years later that does have a familiar ring.

Democratic process

In a proposal which went to the minister in 1983, the issue of uneven geographic and discipline representation on the Council was concerning those considering recommendations on a revised composition. Suggestions to address that included having elections by discipline rather than geographically, or having some elected by the profession as a whole. There was a preference for the chairperson to be elected by Council members annually. In practice, most Council Chairs in the last 20 years served in that role for around five years.

One of the difficulties with NZMA wanting to have more involvement in the statutory regulation was that the public perception was that doctors would only be interested in their own professional agendas. Amendment to the Act in the mid-eighties to increase membership by one, a lay member, started to break down this perception, but to an extent I believe it still persists.

Unions

With regard to doctors’ “unions”, the Council had little formal contact with the Association of Salaried Medical Specialists. The MEC’s attempts to build bridges with the Resident Doctors Association were nearly all in vain on account of the stance of the union advocates. The RDA became more aggressive industrially as it adopted confrontational methods in its attempts to get better conditions for junior doctors. Its leadership was never satisfied.
with anything the Council or the MEC did and communication was poor throughout the 1990s.

**Colleges and special societies – competence reviews**

The Council interacted more productively with Colleges and Special Societies. A more professional manner was acceptable as they had issues in common concerning the standards of specialist practice and the development of vocational registration and continuing competence. Although there were no specific powers to allow competence reviews under the 1968 Act, the Council was approached by employing boards on several occasions when there were concerns about the functioning of a particular doctor, often in a provincial hospital. In those circumstances, with the consent of the doctor, his or her legal representatives, plus agreement by the board (including the board’s undertaking to pay the costs), some embryonic competence reviews were carried out using the expertise of college members. In one case, this led to a doctor being suspended on health grounds as the investigation uncovered the fact that this was the prime reason why his performance was failing and repeated accidents were occurring with female patients in his care. There was always frustration that medical error and medical mishap were not reported by ACC to the Council in any way, even if a particular doctor was repeatedly before the misadventure committees.

**Sick doctors**

In considering the management of doctors impaired by substance abuse, physical or mental illness or other deteriorations, the NZMA was always interested in assisting. It was involved in all discussions from the beginning of the establishment of the Doctors Health Advisory Service (DHAS) and took on the role of providing management backup for that organisation. This was a useful role for NZMA and kept them involved in a way that was satisfactory to all parties. They were able to contribute something to public protection and also help individual doctors, which they were very keen to do. There was some tension between the ideals of the DHAS and the powers of the Council under the disability section of the Act. When the DHAS was first set up those promoting it did not want to have any connection with the Council, except for funding. Inevitably, however, there would be people referred to DHAS who did not respond or, indeed, refused to cooperate, and those doctors could place patients at risk in such a way that the Council had to become involved. As the Council’s Health Committee gained experience and was ably supported by executives within the office in the management of the cases, with excellent networks around the country for diagnosis, treatment and monitoring, the fear that the Council would act in a punitive way towards sick doctors was gradually dissipated. A system of anonymous reporting of progress with cases on the DHAS list was developed, and this gave the Council’s Health Committee an opportunity to become aware of doctors who were “permanent clients” of DHAS and should perhaps be transferred into the care of the Council’s Health Committee. On that basis, the Council was willing to continue
funding DHAS on an annual basis. with a budget prepared for the services costing in the region of $30,000.

**Ethics**

Another area where boundaries were sometimes troublesome between the Council and the NZMA was questions of ethics. Of course, the NZMA complied with the World Medical Association ethical directives and had a central ethics committee to consider ethical matters. Without any sanctions available to the NZMA, other than evicting members, the Council did not find this entirely satisfactory as the only method of dealing with ethical matters. Gradually, over the 1990s particularly, the Council developed a number of statements and became involved in issues of an ethical nature. The NZMA along with other medical bodies and appropriate community bodies were consulted whenever these statements were being drafted. This was particularly so when the Council undertook its major initiative to attempt to eradicate sexual abuse in doctor/patient relationships.

The Council’s report on Persistent Vegetative State led to discussion on euthanasia, but the NZMA was very opposed to any further involvement by the Council in that issue.

**Bicultural developments**

From time to time other organisations sprang up which wanted support from the Council. One example was Te Ora, the Association for Maori Medical Practitioners. The Council was acutely aware of the disproportionately small number of Maori doctors compared with the population at large and was keen to support any initiatives which would bring more Maori into the medical profession. The incentives built into admission into the medical schools were not often sufficient to address this scarcity of Maori doctors. The Council was pleased to cooperate with an initiative where, at the issue of the APC, doctors were encouraged to declare their ethnicity and give permission for material to be sent to Maori doctors in particular. At that time the Ministry of Health was not only interested in ethnicity from the bicultural perspective, but wished to have this data to address other gaps in service for major groups of the population.

**Women in medicine**

The Medical Women’s Association had a good relationship with the Council, particularly concerning information about women practitioners. Carol Leatham, who ran the workforce database from Dunedin, was always interested in providing information on figures to the Medical Women’s Association. This enabled a book to be published in 1989, “Women and Men in Medicine – the career experience”, by Gillian Durham, Clare Salmond and Julie Eberly. The Association lobbied the Council in the 1990s to have a reduced annual practising certificate fee for part-time practitioners, particularly young women and retired doctors who were not
earning sufficient to pay the full APC, which by that time had risen to more than $700. Eventually, a policy was put in place for a 50% refund for any practitioner with income from any source of less than $20,000. Over the years, more women have been elected or appointed to the Council. The highlight was when Dr Robin Briant, nominated by Royal Australasian College of Physicians in 1990, became the first woman Chair of the Medical Council. It is interesting to note that the number of women on the Council has steadily risen and there is now a real prospect of a second woman president.

*New Zealand Medical Journal*

The NZMJ was traditionally used as the method of promulgating information to the profession by the Council prior to the 1983 Act amendment permitting publication of an annual report. Discussion papers on changing the legislation, registration statistics, reports of disciplinary enquiries where a doctor had been penalised, and occasional responses to letters to the editor appeared relatively frequently in the 1980s. From 1983 onwards the Council was entitled to publish an annual report. It did so and, from 1990, the Council's own newsletter, MCNewZ, was more effective than the NZMJ as it could be sent to every doctor on the register. The NZMJ is the organ of the NZMA, but it is an international peer reviewed NZMJ and thus accessible to people online. This situation may again affect the frequency with which the Council publishes in the NZMJ, as this could result in even wider coverage for Council developments. This could be particularly useful in the case of ethical statements developed over a wide range of issues that now have international impact, for example internet medicine, the role of doctors in management and governance, and health, competence and conduct developments.
3.8 Learning through association with international counterparts

*General Medical Council*

The Medical Council of New Zealand always had a strong relationship with the GMC. Various chairmen and members of the Council, as well as executives, visited the offices of the GMC in London over the years. The Empire and later the Commonwealth was very dependent on the GMC, which set standards for reciprocity in a large number of countries prior to the United Kingdom joining the European Union. In the pre-European Union era, the GMC accredited other English-speaking medical schools in the British Empire, including New Zealand. New Zealand tended to follow the lead of the GMC in making any alterations to eligibility for conditional or full registration for graduates in various countries. This is particularly noticeable under the 1968 Act. With the introduction of a specialist register in the early 1970s, the same situation persisted. When arrangements for reciprocity came under some stress as nations around the world became more independent, including some of those within the Commonwealth, the Council received some financial assistance from the Department of Health to fund visitors to Sri Lanka and Hong Kong to decide whether they should continue to be entitled to registration in New Zealand, on the basis of reciprocity, without any assessment.

In the late 1980s various Council personnel visited the GMC, for example Dr Cole, who was interested in their arrangements for discipline and health committees, which were emulated by New Zealand soon after, and Mrs Judd, the lay member. In 1987, early in my term as Secretary/Chief Executive, I spent two days with GMC management. The last meeting with GMC visitors was when the new Auckland University School of Medicine was being scrutinised in the 1970s for the purposes of reciprocity and entry of our graduates to practice in the United Kingdom.

As New Zealand became more interested in forming strong relationships with Australia, we started to develop new networks. The GMC came to be regarded as somewhat paternalistic. The clearest break was when we appointed the first New Zealand committee (the Renwick Committee) to review our medical schools for the purposes of accreditation. We looked more towards Australia, Canada and the United States after making contact with their bodies, which were comparable to the Council, and to some of their overview bodies, through more international meetings in the late 1980s and early 1990s. Nevertheless, we continued to pursue a number of the GMC concepts.

*Canada*

The association with Canada was very interesting and useful. I was able to visit the College of Physicians and Surgeons of Ontario in Toronto in early 1991 and discover more about their work on competence of doctors. Although New Zealand recognised graduates with Canadian qualifications
at primary and specialist level, it was in fact quite difficult for practitioners from New Zealand to go to Canada because they had very prohibitive entry rules to protect the Canadian workforce. At that time, they were graduating plenty of doctors and not wanting too many others to join the permanent workforce. The college model was interesting and worked well for them. It was like a combination of a medical board and a medical association, that is, it was owned by the doctors, and doctors were in key roles as registrars in various capacities. They put out very good newsletters, monitored aberrant drug prescribing and were able to move forward on competence issues, setting up trial models and gathering data. Each province was autonomous but, in competence matters, Ontario was prepared to take the lead. Dr Tiina Kaigas, whose husband was a New Zealander, was very active in that college and, as they travelled reasonably frequently to New Zealand to see family, she was able to share with us in Wellington many of their initiatives. This proved to be an excellent link for us and we were impressed by the suitability of their model of assessment monitoring and mentoring for New Zealand conditions. Their initiatives influenced the Council’s decision to employ professional standards coordinators in the early stages of implementing the competence provisions of the Medical Practitioners Act 1995. I also spent valuable time later in the 1990s visiting the office in Vancouver of the College of Physicians and Surgeons of British Columbia.

USA

In 1994, the United States government funded a meeting in Washington DC entitled the First International Conference on Medical Registration and Regulation. Through contacts with the FSMB made in Adelaide in the 1980s, the Council was invited to send four delegates to this conference, which was attended by delegates from the United Kingdom, Australia, Canada, South Africa and Israel. The conference of 30 delegates was set up as a research event and, in this way, the ECFMG was also able to participate. I was able to cement good relationships with the FSMB during my visit to the United States in 1990/91 and to spend time at the headquarters in Philadelphia of the Educational Commission for Foreign Medical Graduates (ECFMG) and the National Board of Medical Examiners (NBME). This meant that when we wished to use their instruments for our own purposes, that is assessing the large numbers of foreign medical graduates who were arriving in New Zealand, an arrangement was able to be negotiated very quickly by telephone with the President of the ECFMG.

Although the USA legal system had a big impact on the way the medical boards in the United States functioned, particularly with respect to discipline, and some of their approaches had been far more legalistic than we would ever want to have, their annual meetings held in different states were a source of very good contacts, information and new ideas. We began attending these in San Francisco in 1993, and a relationship with this organisation proved very helpful. The FSMB meeting was always linked with a meeting of the Citizens Advocacy Centre (CAC), an umbrella
advocacy organisation for lay members of all professional licensing and examining bodies. I joined their mailing list and received publications from the CAC, which held an annual conference separate from FSMB. At the FSMB annual meetings, the CAC would hold a forum for lay members which Mrs Judd, our sole lay member at that time, was able to attend. Through these contacts I was also able to visit the Minnesota Medical Board and meet the founders of the Walk-in Centre, Gary Schoener and Jeanette Milgrom, experts in professional sexual abuse. Later, Gary was invited to come to New Zealand to provide training for a wide variety of people interested in eradicating sexual abuse from professional and clergy relationships. We had two large meetings, one in Auckland and one in Christchurch, which were very important in putting all the issues before people at a time when the Council was setting up its sexual abuse protocols and hearing arrangements and other groups, such as psychologists, were initiating sexual abuse policy and procedures.

Another body which met in conjunction with the FSMB annual meeting was Administrators in Medicine (AIM), which was in effect a body comprising all the executive directors (or “registrars” in our language) of all the boards in the United States and Canada. In 1999 I became their first international member. It was a forum for support and sharing ideas. Many of the executive directors were lawyers, and it was noticeable that much of the framework for medical regulation in the United States (US) was highly legalistic. It mirrored the very legalistic approach to risk management in the US generally. There was lots of fine print and printing! In North America there is a tendency to measure the success of the regulatory body by the number of prosecutions it succeeds in having and bringing doctors to account for their conduct. This concept does not fit well with New Zealand's approach to disciplinary charges, proven or otherwise. It was interesting that, on one occasion, when we wished to obtain information from New Hampshire on a doctor whose health record was not good and who was attempting to register in New Zealand, we were unsuccessful. However, in the case of Dr Linda Astor, who claimed to have worked in Florida and was subsequently run out of New Zealand, I was able to establish at an FSMB meeting through contact with members of the Florida board attending the conference that the work history she had put to the New Zealand Council was unlikely to be true.

A number of States in the US are now required by law to provide profiles of doctors’ qualifications, education and training, health history and disciplinary history. On another occasion I visited Boston to see how the Massachusetts Medical Board handled the implementation of this. It was awesome, as they were required to produce 35,000 requests in the first few months with no extra funding from government to do so.

After the first international meeting in Washington DC the concept of an international association gradually started to take off. FSMB had plenty of resources to put into developing it. A second conference was held in Melbourne and, two years later, a conference in the United Kingdom. What came to be known as the Lygon Arms group, that is the presidents and
registrars invited by the GMC to meet in the Cotswolds in 1997, began to develop a framework for an international association. That organisation is now in place and will work to exchange information internationally on issues, workable systems and, ultimately, will develop effective means of sharing information on individual, more internationally mobile practitioners.

*Examination bodies*

We also learnt a lot from Australia about examinations and from the Medical Council of Canada, whose Chief Executive, Dr Dale Dauphinee, was very helpful to us when the Council's examination system was being reviewed.

I had a good working relationship with the ECFMG President, who was also helpful. The ECFMG had a database of performance information which indicated whether overseas trained doctors undergoing their examination in Canada, the United States and later New Zealand were uniformly performing at a level which was not appropriate for registration without further education.

*International Association fostered*

My final efforts on the international front were at the international conference in Cape Town, South Africa, in 1998, where I contributed to discussion on a model for the now-established body, the International Association of Medical Regulatory Authorities. My final input to that work was a three-hour teleconference link in the dead of night to the conference in Halifax, Canada, in 1999.
3.9 Counteracting threats to safety

Misconduct

Right from the start of medical regulation, investigating reported misconduct was a key reason for the very existence of a board or council. Where practising privileges were issued, the other side of the coin was that alleged breaches of standards were viewed very seriously and, if proven, exposed the doctor to severe penalties. Bad or illegal practice, unseemly sexual liaisons, lack of care in delivering babies, involvement in illegal acts such as abortion, consuming excessive alcohol or addictive drugs and arriving to treat patients while under the influence of these substances, practising while not in a safe mental state, using unconventional remedies which were considered fringe for commercial gain or associating too closely with druggists or chemists for commissions, failing to attend patients in an emergency, and being convicted of an indictable offence, to name a few were accompanied by immediate referral to the Crown Solicitor for investigation and possibly hearing of charges before the Council or the court. Early minutes regularly refer to these events, especially before registration issues took on greater prominence.

Legal services

Prior to separation from the Department of Health (even after becoming a body corporate), legal services were provided by Crown agencies. When the Council became financially independent, it found a significant part of its expenditure went on legal costs associated with discipline functions, for example the investigation committee (later to become the Penal Cases Committee, then in 1983 the Preliminary Proceedings Committee) and legal advice and legal assessors. A legally qualified member was eventually added to the PCC and its successor the PPC.

Funding

A disciplinary levy, separately identified from the APC fee, though both were collected at the same time, only came into being in the mid-1980s, when the number of investigations and hearings began to increase considerably. Some decades before that, the Act was amended to set up an investigation committee, which could lay charges before the Council in matters of disgraceful conduct. Second and third tiers of enquiry and hearing provisions were passed to a Medical Practitioners Disciplinary Committee (MPDC) and Divisional Disciplinary Committees (DDCs) associated with the Medical Association of New Zealand (and served by their Secretary) who could consider charges of professional misconduct and, later, conduct unbecoming a medical practitioner.

Once an independent office for the Council was set up, the Council was free to choose its own legal advisers and assessors. Outstanding service was given by lawyers who were held in high regard in their profession,
many going on to become judges in Family, District and High Courts, and the Court of Appeal, QCs, and in one case Solicitor General. Given the standing of the medical profession in the eyes of the community, it is vital that only the best quality advice from other professionals is engaged for the proper implementation of administrative justice, preparation and prosecution of cases, and defence of appeals in higher courts. I found it interesting and reassuring to work with a range of respected barristers and solicitors whose professionalism was unquestioned and good humour essential in some very trying circumstances.

Representation

In most cases, doctors appearing before Council were also very ably represented by barristers from the medical defence societies. My role as Secretary gave me a fascinating insight into the process of justice. It was revealing to discover the wide range of approaches and tactics that might be adopted by defence or prosecution. With medical practitioners chairing such hearings, the seriousness of the event could not be avoided by all present. Peers judging peers is a tough call. Without diminishing the contributions from lay members and lawyers, I still strongly support having disciplinary hearings before a majority of peers, with the hearing tribunal chaired by a member of the profession with a legal assessor available to guide the process. Over time, the medical chairs of the tribunals became skilled in this role. Some were already familiar with the adversarial process from being expert witnesses, for example pathologists in coroners and high courts. They knew how vital it was to make judgements only on the evidence presented in the hearing room.

Administration of hearings

As Secretary to the Council it was my responsibility to arrange the hearing date and ensure that the venue, court recording, security and domestic arrangements for the Council, stenographers, patients, defendant, witnesses, lawyers and support people were all high quality. When the Council heard sexual abuse charges special care was taken in setting up the hearing location and facilities, making sure privacy was carefully managed (including screens if necessary), whether hearings were in the Council boardroom or in a proper location in another town or city. Justice Department Tribunals Divisions were helpful in allowing us access to their hearing and retiring rooms, particularly in Auckland. Hotels were sometimes satisfactory if chosen carefully on the basis of being able to isolate us as far as possible from other guests.

Preliminary Proceedings Committee

Council members of the PPC were not, of course, permitted to sit on the Council hearing a matter with which they were already familiar. If hearings were tough on members, being a member of the PPC was more so. From the mid-1980s the number of serious complaints coming up for investigation rose dramatically. Preliminary investigation, notice to the
doctor, interviewing numerous parties, remaining impartial yet showing concern for patient safety, and maintaining a good working relationship with the legal member of the committee and his firm, who carried out the processing and preparation of documents, were all important. Members of the PPC were not changed too frequently as they grew into an effective team, which meant competent execution of their responsibilities. Chairing the PPC took quite a toll on that Council member’s resources.

**Teamwork**

Similarly, Council members available to sit on hearings (and in the same fashion the MPDC) became accustomed to the process. But each case was different, and, for 12 years, our one and only lay member, Patricia Judd, sat on almost every case, including appeals from decisions of the lower hearing bodies, when those arose. Naturally, she advocated for more lay members on the Council, tribunals, complaints assessment committees and committees in general when submissions were made on the shape of the new Act. The bonus of the disciplinary role was that it enabled members to get to know each other very well and to respect their different viewpoints. The Council worked as a very efficient and sensitive team, basing decisions on consensus models in most situations, and this was reflected in their strong loyalty to their role, their dedication to seeing changes allowing more lay members, and their understanding of each other’s community and ethical perspectives.

The benefits of this team work flowed through into “ordinary” Council work, decision making and lobbying for change, including wider powers to deal effectively with poorly performing doctors and ethical breaches. Arising from issues encountered at hearings, some important education initiatives brought the Council into touch with more doctors and more members of the public, enhancing their standing and appreciation of each other’s concerns. This partly compensated for the frustrating delay in getting the 1995 legislation passed and into effect.

**Setting precedents**

Of course, there were often appeals by one or other party against findings of the lower hearing body – this is part of our system of justice. It was rare for the Council to be found out of order procedurally, but refinements in the legal process and new precedents did evolve from statements made in judgments by the High Court. Some were issues of public interest, for example alleged breaches of privacy by Dr Ian Duncan in speaking out about a bus driver with a serious health condition; others related to the way charges were framed, for example setting out separate charges and an omnibus charge, as happened in the case against Dr Nihal Gurusinghe involving sexual misconduct. Precedents often drew on cases in other jurisdictions, such as GMC and Australia.

The Council’s work on information and consent was regarded as setting a precedent for judgments in this area in the vacuum before the passing of
the Health and Disability Commissioner legislation and the development of the first Health and Disability Services Code of Consumer’s Rights.

*Legal assessors and advisers*

We were always able to seek advice from the Council’s legal assessors, such as John McGrath, who later became Solicitor General and a High Court Judge, Rhys Harrison, John Upton, Gerald Tuohy and Kristy McDonald; the MPDC also had assistance from experienced legal assessors, such as Warwick Gendall. Likewise, senior lawyers, such as Douglas White, Philip Cook, and Matthew McClelland, from the Council’s solicitors, Kensington Swan, assisted the Preliminary Proceedings Committee.

*Medico-legal specialists*

Occasionally, a Queen’s Counsel would be called on for specialist advice. It was clear to me that the justice system, of which the medical tribunals are only a small part, depends very much on the quality of the legal advice, representation and advocacy provided, not forgetting formidable skill, understanding of technicalities and sheer strategy. Medico-legal practice is a specialist area; sometimes parties who chose to obtain advice or be represented by barristers and solicitors without that background disadvantaged themselves. The Medical Defence Society lawyers acting for doctors clearly had the experience to deal with a wide range of issues in law and medicine.

*Public vs private hearings*

Some cases were highly emotive and attracted media attention. Until the 1995 Act, the lack of a legal requirement for hearings to be held in public was a constant irritation to journalists and the public at large. Openness is welcome, but in reality may not be all that exciting! It is still necessary in some circumstances to be able to exclude the public because of the highly sensitive nature of the allegations, circumstances and evidence. As Secretary, I certainly experienced some emotionally draining cases.

*Convictions*

Court convictions could also lead to hearings under the Medical Practitioners Act, for example medical manslaughter, fraud, and sexual abuse.

Hearings involving violations of female patients were particularly difficult for all parties concerned, including stenographers recording proceedings verbatim.
Investigations

Investigation of class actions, such as allegations of deep sleep therapy, did not always result in charges, but the work involved for the investigation committee was huge.

The provisions currently in place are very complex, still lead to delays, and do not, I think, benefit the public as effectively as was intended. Much more use of early mediation should be considered. The advocacy arrangements could be used more effectively, complaints assessment committees need wider low level powers, such as warning letters, referral for remedial action other than competence assessment, and capacity for recommending “suspended sentences”.

Conduct vs competence

Under the 1968 Act the MPDC heard some charges which were really competence issues, but this has now been addressed by competence review provisions under the 1995 Act. Investigation is a time-consuming procedure, sometimes taking years to finalise. It seems that, in this domain, getting answers is more often than not a drawn out affair, overly legalistic and not very empowering for complainants or doctors.

Code of Health and Disability Consumers Rights

Robyn Stent, the first Health and Disability Commissioner, did brilliantly to get the Code drafted, through national and bicultural consultation, and into effect in just one year.

The old system, where the registration body also heard disciplinary charges, had the advantage of the doctors on the tribunal knowing what was going on outside the discipline arena and vice versa.

Future single tribunal

The ability for one tribunal to hear charges against a range of health professionals could lead to fairer and faster results. This is being canvassed as the HPCA Bill goes through the legislative process.

Health Practitioners Competence Assurance Bill

This legislation, modelled on the mechanisms in the Medical Practitioners Act 1995, is currently being considered by parliament for application to all registered health professions. The framework will be put in place by the recognized governing body for each health profession, which will comprise a mix of professional and lay members appointed by the Minister after a nomination or consultation process.

A separate Disciplinary Trubunal will hear charges prosecuted against members of that profession.
3.10 Using feedback loops to foster continuing education and quality improvement

Continuous improvement

In my experience, the majority of doctors are well trained and motivated to make the best contribution they can to the health and safety of the community. Commercial incentives are important too, but rarely totally overtake professional ethics. As the nature of society and the knowledge and technologies available to it in all fields become more complex and the speed of change more rapid, the demands on doctors (and others in the health sector) are huge. Health professionals are not superhuman – they need opportunity for support and refreshment just as much as patients. Feedback can only be processed if time is made for that. Building it into every aspect of working life (which happens anyway if the brain can keep functioning effectively with this overload) is the ideal, but this can feel threatening.

More openness and vigilance in the workplace is being promoted, but all players need to be able to trust any system that encourages public highlighting of errors or poor practices in order to use them to educate not punish.

Quality assurance

Improved quality assurance provisions and credentialing processes should identify problems in advance – before they reach the threshold for disciplinary action. This was clear years ago in hearing cases where doctors had been convicted of medical manslaughter.

Quality improvement, review, audit and credentialling may raise general competence and increase early detection of system failures, but will never cancel out the need to investigate individual conduct in certain circumstances. Mandatory reporting of apparently substandard or dangerous practice should be required of all individuals, health professionals or not, to enhance public safety.

Mandatory reporting

The concept of mandatory reporting of poor outcomes or processes or poorly performing individuals or teams is often challenged on the grounds that it will create a climate of fear, but that does not have to be the case. The legal protection granted to those reporting in good faith is a powerful back up. Mandatory reporting of doctors believed to have health problems that may be impairing their competence has been in place for decades and has not led to malicious reports. Where safety is the bottom line, it is necessary to have access to the big stick if a change in attitude or culture is required. Early reporting leads to early intervention and observing the benefits of that increases voluntary reporting. Over the last decade, the work of the Council’s Health Committee has been a shining example of this
process. In my opinion, there is no reason why the same cannot occur in competence and conduct matters. This intervention is, however, at a micro level.

The Council’s Health Committee uses a variety of tools to assist an impaired doctor. It insists on keeping the monitoring and treatment in place for an extended period, to ensure ongoing stability. This model can work well in other areas of weakness.

_Credentialling_

Recent credentialling initiatives add another useful tool in the continuous improvement circle, to the extent that they examine the fit of the individual practitioner and the particular context, type and level of work in which they are functioning. This is particularly important in branches of medicine where length of experience in that particular field or facility is directly linked to skills and knowledge for that field. When more emphasis is placed on scopes of practice, credentialling has the potential to allow doctors with narrow but essential expertise to be permitted to practise in those areas, with quality monitoring the responsibility of the employer, as well as the vocational college, and permission to practise dependent on regular audit.

_Data collection_

We also need systems to gather data at the macro level. Recent comprehensive research reviewing patient records in the United Kingdom and New Zealand which looked at patient safety and levels of adverse events in hospitals has revealed a surprisingly high numbers of patients suffering injuries or other illnesses during their treatment period. These “accidents” have resulted in some patients being worse off at discharge than at admission. The Council was continually frustrated by the ACC’s unwillingness to release medical misadventure information which could have alerted us to doctors working in high-risk situations, which may have required organisational improvements, or doctors whose repeated accidents may have resulted from incompetence.

When this information comes to light only after a formal enquiry or disciplinary hearing, it undermines trust and feeds negative attitudes if it is not put into context. More timely preventive action to gather this kind of feedback as a routine aspect of measuring health outcomes would have led to faster intervention and change. Each person has to play a part, but this needs to be supplemented by reliable data. New Zealand collects plenty of health information. It needs to be centralised and analysed, with facts or trends noted and brought to light for more and faster scrutiny.

_Constructive work settings_

Workplaces have to be supportive, well staffed, well trained, nurtured – commercially driven competition can lead to cheating as we often see in sport! The current climate is not conducive to managing risk effectively.
Overstretched and constantly changing institutions mean burnout in individuals. No wonder they are now leaving the country at alarming rates. How can we know that those replacing them will not go the same way?

Forums for modelling good programmes and outcomes are being developed slowly and I expect these will lead to higher levels of exchange of expertise, with patients adding their wisdom as of right.

**Fact finding**

Research which taps into patient/client feedback is always enlightening in just the same way as testimony from patients in hearings is always helpful. We do not have to wait for expensive select committees to stir up drama, or even more costly major enquiries to bring out the best, and the worst, in people. We have the information available and we need to let it flow freely. Qualitative and quantitative data is needed. Peer review, quality assurance, action research and audit in the health services have never been more necessary.

Complaints systems easily become over legalised, bureaucratic and confrontational, as we have seen with the Health and Disability Commissioner Act, despite the best efforts of all the players. Conversations, dialogues, and narratives need to be encouraged at the time the health service is being offered so it becomes an integral part of the process. Simplistic customer satisfaction surveys are not sufficient!

**Building loops into registration**

The Medical Practitioners Act 1995 mandated a form of collegial relationship with meaningful feedback between doctors at each level of practice, which was an important step towards activating those interactions for mutual benefit. It needs to be extended to all actors in the health sector. Individual practitioners and their teams can do it, and so can the various organizations that control resources.

**Exchanging information internationally**

Ultimately, with globalisation, similar transparency and accountability has to come about between medical regulatory bodies internationally. The recent creation of a formal International Association of Medical Regulatory Authorities has moved the medical boards and councils down this road. In some states in the US there is a legal requirement for each doctor to make available to the public, through the licensing body, a professional profile indicating undergraduate, postgraduate and continuing education undertaken, fitness to practise (full disclosure of any health, competence and malpractice/disciplinary actions or enquiries), maintenance of standards activities such as recertification complied with, and honours given.
All these mechanisms are designed to contribute to continuous quality improvement, throughout organizations and during the careers of individuals. They also have the capacity to expose unsafe or unethical fringe, or even bogus, practitioners and bring them to justice.
Appendices
Appendix I

**Hippocratic Oath – Classical Version**

I swear by Apollo Physician and Aesclepius and Hygieia and Panaceia and all the gods and goddesses, making them my witnesses, that I will fulfil according to my ability and judgment this oath and this covenant:

To hold him who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them this art - if they desire to learn it - without fee and covenant; to give a share of precepts and oral instruction and all the other learning to my sons and to the sons of him who has instructed me and to pupils who have signed the covenant and have taken an oath according to the medical law, but no one else.

I will apply dietetic measures for the benefit of the sick according to my ability and judgement; I will keep them from harm and injustice.

I will not give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. In purity and holiness I will guard my life and my art.

I will not use the knife, not even on sufferers from stone, but will withdraw in favour of such men as are engaged in this work.

Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons, be they free or slaves.

What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself, holding such things shameful to be spoken about.

If I fulfil this oath and do not violate it, may it be granted to me to enjoy life and art, being honoured with fame among all men for all time to come; if I transgress it and swear falsely, may the opposite of all this be my lot.

[www.pbs.org/wgbh/nova/doctors/oath_classical.html](http://www.pbs.org/wgbh/nova/doctors/oath_classical.html)
**Hippocratic Oath – Modern Version**

I swear to fulfill, to the best of my ability and judgment, this covenant:

I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow.

I will apply, for the benefit of the sick, all measures which are required, avoiding those twin traps of over-treatment and therapeutic nihilism.

I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug.

I will not be ashamed to say “I know not,” nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery.

I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God.

I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person’s family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.

I will prevent disease whenever I can, for prevention is preferable to cure.

I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm.

If I do not violate this oath, may I enjoy life and art, respected while I live and remembered with affection thereafter. May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help.

www.pbs.org/wgbh/nova/doctors/oath_modern.html
Appendix II

Medical Council Staff

As printed in Annual Reports 1986-1996 as at 30 June, 1997-2000 as at 31 March.

1986 Courtenay Place office

<table>
<thead>
<tr>
<th>Position</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secretary/CE</td>
<td>Georgina Jones</td>
</tr>
<tr>
<td>Assistant Secretary</td>
<td>John Coster</td>
</tr>
<tr>
<td>Clerks</td>
<td>Joan Davies</td>
</tr>
<tr>
<td></td>
<td>Elizabeth Hill</td>
</tr>
<tr>
<td></td>
<td>Jan Johns</td>
</tr>
<tr>
<td>Typist Receptionist</td>
<td>Margaret Monks</td>
</tr>
</tbody>
</table>

1987

<table>
<thead>
<tr>
<th>Position</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secretary/CE</td>
<td>Georgina Jones</td>
</tr>
<tr>
<td>Assistant Secretary</td>
<td>John Coster</td>
</tr>
<tr>
<td>Clerks</td>
<td>Jan Johns</td>
</tr>
<tr>
<td></td>
<td>Bella Nodelmann</td>
</tr>
<tr>
<td>Secretary/Word Processor</td>
<td>Jo Hawken</td>
</tr>
<tr>
<td>Accounts Administrator P/T</td>
<td>Christine Edwards</td>
</tr>
<tr>
<td>Temporary Clerks</td>
<td>Val Little</td>
</tr>
<tr>
<td></td>
<td>Dianne McCall</td>
</tr>
</tbody>
</table>

1988

<table>
<thead>
<tr>
<th>Position</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secretary/CE</td>
<td>Georgina Jones</td>
</tr>
<tr>
<td>Assistant Secretary</td>
<td>John Coster</td>
</tr>
<tr>
<td>Clerks</td>
<td>Margaret Barnes</td>
</tr>
<tr>
<td></td>
<td>Angela Coleman</td>
</tr>
<tr>
<td></td>
<td>Jane Lui</td>
</tr>
<tr>
<td>Secretary/Word Processor</td>
<td>Jo Hawken</td>
</tr>
<tr>
<td>Accounts Administrator P/T</td>
<td>Christine Edwards</td>
</tr>
<tr>
<td>Clerk P/T</td>
<td>Jan Johns</td>
</tr>
</tbody>
</table>

1989

<table>
<thead>
<tr>
<th>Position</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secretary/CE</td>
<td>Georgina Jones</td>
</tr>
<tr>
<td>Assistant Secretary</td>
<td>John Coster</td>
</tr>
<tr>
<td>Clerks</td>
<td>Jan Johns</td>
</tr>
<tr>
<td></td>
<td>Jane Lui</td>
</tr>
<tr>
<td>Secretary/Word Processor</td>
<td>Jo Hawken</td>
</tr>
<tr>
<td>Accounts Officer P/T</td>
<td>Paul Stark</td>
</tr>
</tbody>
</table>
### 1990

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secretary/CE</td>
<td>Georgina Jones</td>
</tr>
<tr>
<td>Deputy Secretary/Administration Manager</td>
<td>Steve Willcox</td>
</tr>
<tr>
<td>Assistant Secretary/Executive Officer</td>
<td>Michael Richardson</td>
</tr>
<tr>
<td>Registration Officers</td>
<td>Jane Lui (Snr Reg)</td>
</tr>
<tr>
<td></td>
<td>Ann Hamilton</td>
</tr>
<tr>
<td></td>
<td>Lynne Urquhart</td>
</tr>
<tr>
<td>Secretary/Word Processor</td>
<td>Jo Hawken</td>
</tr>
<tr>
<td>Accounts Officer P/T</td>
<td>Joyce MacKay</td>
</tr>
</tbody>
</table>

### 1991

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secretary/CE</td>
<td>Georgina Jones</td>
</tr>
<tr>
<td>Administration Manager</td>
<td>Steve Willcox</td>
</tr>
<tr>
<td>Executive Officer</td>
<td>Faith Barber</td>
</tr>
<tr>
<td>Registration Officers</td>
<td>Jane Lui (Snr Reg)</td>
</tr>
<tr>
<td></td>
<td>Ann Hamilton</td>
</tr>
<tr>
<td></td>
<td>Lynne Urquhart</td>
</tr>
<tr>
<td>Secretary/Word Processor</td>
<td>Jo Hawken</td>
</tr>
<tr>
<td>Clerk</td>
<td>Mahi Loose</td>
</tr>
<tr>
<td>Accounts Officer P/T</td>
<td>Joyce MacKay</td>
</tr>
<tr>
<td>Tribunals Officer (P/T)</td>
<td>Susan D’Ath</td>
</tr>
</tbody>
</table>

### 1992

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secretary/CE</td>
<td>Georgina Jones</td>
</tr>
<tr>
<td>Administration Manager</td>
<td>Steve Willcox</td>
</tr>
<tr>
<td>Executive Officer</td>
<td>Faith Barber</td>
</tr>
<tr>
<td>Registration Officers</td>
<td>Jane Lui (Snr Reg)</td>
</tr>
<tr>
<td></td>
<td>Ann Hamilton</td>
</tr>
<tr>
<td></td>
<td>Lynne Urquhart</td>
</tr>
<tr>
<td>Secretary/Word Processor</td>
<td>Jo Hawken</td>
</tr>
<tr>
<td>Clerk (job share)</td>
<td>Mahi Loose/Philippa Jones</td>
</tr>
<tr>
<td>Accounts Officer P/T</td>
<td>Joyce Mckay</td>
</tr>
<tr>
<td>Tribunals Officer P/T</td>
<td>Susan D’Ath</td>
</tr>
</tbody>
</table>

### 1993 (Willis Street office)

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secretary/CEO</td>
<td>Georgina Jones</td>
</tr>
<tr>
<td>Administration Manager</td>
<td>Steve Willcox</td>
</tr>
<tr>
<td>Executive Officer</td>
<td>Faith Barber</td>
</tr>
<tr>
<td>Registration Officers</td>
<td>Jane Lui</td>
</tr>
<tr>
<td></td>
<td>Lynne Urquhart</td>
</tr>
<tr>
<td></td>
<td>Jolene Maxwell</td>
</tr>
</tbody>
</table>
Examinations Officer  
Secretary/Word Processor  
Receptionist  
Accounts Officer P/T  
Tribunals Officer P/T  

Kerry Marshall  
Jo Hawken  
Karen Arraj  
Chris Wood  
Susan D’Ath

1994

SecretaryCE  
Team Leader Corporate Services  
Team Leader Standards  
Team leader Registration  
Registration Officers  

Georgina Jones  
Steve Willcox  
Faith Barber  
Lynne Urquhart  
Jane Lui  
Tass Larsen  
Tone Smith

Examinations Officer  
Coordinator Policy/Projects  
Administration Secretary  
Team Support Officer Corporate Services  
Receptionist  
Accounts P/T  
Tribunals Officer P/T  

Jolene Maxwell  
Angela Coleman  
Jo Hawken-Incledon  
Jenny Watson  
Karen Arraj  
Chris Wood  
Susan D’Ath

1995

Secretary/CE  
Administration Secretary  
Coordinator Policy & Projects (.5)  
Team Leader Corporate Services/Financial Officer  
Communications Officer  
Receptionist  
Accounts Officer P/T  
Team Support Corporate Services  
Team Leader Standards  
Education Officer (.5)  
Examinations Officer  
Tribunals Officer P/T  
Team Support Standards  
Team Leader Registration  
Registration Officers  

Georgina Jones  
Jo Hawken-Incledon  
Angela Coleman  
John de Wever  
Megan Keogh  
Donna Kelly  
Chris Wood  
Donna Overduin  
Lynne Urquhart  
Angela Coleman  
Margaret Needham  
Susan D’Ath  
Miriam Kilkelly  
Jane Lui  
Delwyn Crawley  
Danette Elvy  
Ann Elliott  
Kirstine Thompson

Team Support Registration
1996

Registrar/CEO  Georgina Jones
Communications Officer  Megan Keogh
Human Resources Adviser P/T  Geraldine Needham
Projects and Policy Coordinator (.5)  Angela Coleman
Administrative Secretary  Jo Hawken-Incledon
Word Processor  Caroline Smith

Corporate Services Team
Team Leader/Financial Controller  John de Wever
Reception  Donna Kelly
Team Support  Donna Overduin

Standards Team
Team Leader Standards  Lynne Urquhart
Education Officer (.5)  Angela Coleman
Examination Officer  Tone Smith
Tribunals Officer P/T  Susan D’Ath
Standards Administration Officer  Catherine Bang
Team Support  Miriam Kilkelly

Registration Team
Team Leader  Jane Lui
Registration Officers  Delwyn Crawley
Senior Secretary  Annmarie Elliott
Philip Girven

Team Support  Moyra Hall
Database Support  Jenny Woods

Under Medical Practitioners Act 1995

Office of the Council at March 1997

Registrar/CEO  Georgina Jones
Communications Executive  Richard Silcock
Human Resources Adviser P/T  Geraldine Needham
Senior Secretary  Vacant

Registration Team
Team Leader  Jane Lui
Senior Registration Officer  Delwyn Crawley
Registration Officers  Philip Girven
Victoria McKeogh
Allison Cattanach

Support Officer  Moyra Hall
Database Administrator P/T  Jenny Woods
Standards Team
Team Leader Lynne Urquhart
Education Officer Angela Coleman
Examination Officer Tone Smith
Old Council Tribunals Officer P/T Susan D’Ath
Administration Officer Catherine Bang
Administrative Secretary Jo Hawken-Incledon
Support Officer (CACs) Miriam Wypych (Kilkelly)

Corporate Services
Team Leader/Financial Controller John de Wever
Support Officer Donna Overduin
Receptionist Donna Kelly

1998
Registrar/CEO Georgina Jones
General Manager/Deputy Registrar Lynne Urquhart
Human Resources Adviser P/T Geraldine Needham
Senior Secretary Stephanie Pett

Registration Team
Registration Manager Jane Lui
Senior Registration Administrator Delwyn Crawley
Registration Administrators Christina Andersen
Philip Girven
Kathryn Perigo
Justine Fleming

Registration Administrator P/T Emma Rabone
Registration Administrator Moyra Hall
APC Coordinator (temp) Chris Aitchison

Standards Team
Standards Manager Ros Hall-Jones
CAC Coordinator Miriam Wypych
Education Administrator Angela Coleman
Examination Administrator Tone Smith
Health Manager Lynne Urquhart
Health Administrator Jo Hawken-Incledon
Prof’l Standards Administrator P/T Karla Orr
Standards Administrator Kristine Couch
Old Council Tribunals Administrator P/T Susan D’Ath

Corporate Services
Financial Controller John de Wever
Information Systems Bill Taylor
Information Officer Greg Waite

MCNZ - Georgina Jones perspective 1986-2000
Administrator
Customer Services

Donna Overduin
Debbie North
Rita Umaga-Ta’ulelei

1999

CEO
Sue Ineson
Registrar
Georgina Jones
Deputy Registrar
Lynne Urquhart
Senior Secretary
Stephanie Pett

Registration Team
Manager
Jane Lui
Senior Registration Administrator
Sean Hill
Registration Administrators
Gyllian Turner
Jey Swami
Karen Gardner
Philip Girven
Diane Latham
Moyra Hall

APC Support P/T
Linda Tan

Standards Team
Manager
Sandy Gill
Education Administrator
Angela Coleman
Examination Administrator
Ritu Nair
CAC Administrator
Kirsty Glen
Professional Standards Administrator
Frank Minehan
Standards Administrator
Kristine Couch
Professional Standards Coordinators P/T
Dr John Simpson
Dr Jocelyn Tracy
Old Council Tribunals Administrator P/T
Susan D’Ath

Health Team
Manager
Lynne Urquhart
Administrator
Jo Hawken-Incledon

Corporate Services
Financial Controller
John de Wever
Information Systems
Bill Taylor
Communications Coordinator
Susan Patullo
Information Officer
Greg Waite
Office Administrator
Donna Overduin
Customer Services
Debbie North
Rita Umaga-Ta’ulelei
## 2000

<table>
<thead>
<tr>
<th>Position</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CEO</strong></td>
<td>Sue Ineson</td>
</tr>
<tr>
<td><strong>Registrar</strong></td>
<td>Georgina Jones</td>
</tr>
<tr>
<td><strong>Deputy Registrar</strong></td>
<td>Lynne Urquhart</td>
</tr>
<tr>
<td><strong>Senior Secretary</strong></td>
<td>Stephanie Pett</td>
</tr>
<tr>
<td><strong>Registration Team</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Manager</strong></td>
<td>Jane Lui</td>
</tr>
<tr>
<td><strong>Senior Registration Administrator</strong></td>
<td>Sean Hill</td>
</tr>
<tr>
<td><strong>Registration Administrators</strong></td>
<td>Gyllian Turner, Karen Gardner, Philip Girven, Diane Latham, Moyra Hall</td>
</tr>
<tr>
<td><strong>APC Supervisor</strong></td>
<td>Linda Tan</td>
</tr>
<tr>
<td><strong>Standards team</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Manager</strong></td>
<td>Sandy Gill</td>
</tr>
<tr>
<td><strong>Education Administrator</strong></td>
<td>Angela Coleman</td>
</tr>
<tr>
<td><strong>Examination Administrator</strong></td>
<td>Ritu Nair</td>
</tr>
<tr>
<td><strong>CAC Administrator</strong></td>
<td>Kirsty Glen</td>
</tr>
<tr>
<td><strong>Professional Standards Administrator</strong></td>
<td>Chris Aitchison</td>
</tr>
<tr>
<td><strong>Standards Administrator</strong></td>
<td>Kristine Couch</td>
</tr>
<tr>
<td><strong>Professional Standards Coordinator</strong></td>
<td>Dr John Simpson</td>
</tr>
<tr>
<td><strong>Old Council Tribunals Officer</strong></td>
<td>Susan D’Ath</td>
</tr>
<tr>
<td><strong>Health Team</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Manager</strong></td>
<td>Lynne Urquhart</td>
</tr>
<tr>
<td><strong>Administrator</strong></td>
<td>Jo Hawken-Incledon</td>
</tr>
<tr>
<td><strong>Corporate Services</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Financial Controller</strong></td>
<td>John de Wever</td>
</tr>
<tr>
<td><strong>Information Systems</strong></td>
<td>Bill Taylor</td>
</tr>
<tr>
<td><strong>Communications Coordinator</strong></td>
<td>Susan Patullo</td>
</tr>
<tr>
<td><strong>Information Officer</strong></td>
<td>Greg Waite</td>
</tr>
<tr>
<td><strong>Office Administrator</strong></td>
<td>Donna Overduin</td>
</tr>
<tr>
<td><strong>Customer Services</strong></td>
<td>Debbie North</td>
</tr>
<tr>
<td><strong>Registrar’s Secretary</strong></td>
<td>Rita Umaga -Ta’ulelei</td>
</tr>
<tr>
<td><strong>Office Assistant P/T</strong></td>
<td>Viv Coppins</td>
</tr>
<tr>
<td><strong>Office Assistant P/T</strong></td>
<td>Richard Bull</td>
</tr>
</tbody>
</table>
Appendix III

Secretaries/Registrars of the Medical Council of New Zealand

*Public Servants on appointment

<table>
<thead>
<tr>
<th>Name and Job Title</th>
<th>Name of Board</th>
<th>Period of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>T Hope-Lewis*</td>
<td>Medical Board</td>
<td>1914</td>
</tr>
<tr>
<td>C J Drake*</td>
<td>Medical Council</td>
<td>21 May 1919 to 17 November 1948</td>
</tr>
<tr>
<td>J F Tasker*</td>
<td>&quot;</td>
<td>23 February 1949 to 18 November 1954</td>
</tr>
<tr>
<td>M Dew*</td>
<td>&quot;</td>
<td>18 November 1954 to 13 September 1961</td>
</tr>
<tr>
<td>K A G Hindes</td>
<td>&quot;</td>
<td>14 September 1961 to December 1985</td>
</tr>
<tr>
<td>(* to 1964)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Georgina Jones</td>
<td>&quot;</td>
<td>26 May 1985 to June 2000</td>
</tr>
<tr>
<td>CEO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Registrar</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix IV

Ministers of Health

<table>
<thead>
<tr>
<th>Year</th>
<th>Party</th>
<th>Minister</th>
<th>Associates</th>
</tr>
</thead>
<tbody>
<tr>
<td>1984</td>
<td>National</td>
<td>Aussie Malcolm</td>
<td>-</td>
</tr>
<tr>
<td>1984-1987</td>
<td>Labour</td>
<td>Michael Bassett</td>
<td>-</td>
</tr>
<tr>
<td>1987-1990</td>
<td>Labour</td>
<td>David Caygill</td>
<td>-</td>
</tr>
<tr>
<td>1990</td>
<td>Labour</td>
<td>Helen Clark</td>
<td>Michael Cullen (also Deputy Prime Minister)</td>
</tr>
<tr>
<td>1991-1992</td>
<td>National</td>
<td>Simon Upton</td>
<td>Katherine O’Regan</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Maurice Williamson</td>
</tr>
<tr>
<td>1993</td>
<td>National</td>
<td>Bill Birch</td>
<td>Katherine O’Regan</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Maurice Williamson</td>
</tr>
<tr>
<td>1994-1997</td>
<td>National</td>
<td>Jenny Shipley</td>
<td>Katherine O’Regan</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Maurice Williamson</td>
</tr>
<tr>
<td>1997</td>
<td>National</td>
<td>Bill English</td>
<td>Neil Kirton</td>
</tr>
<tr>
<td>1997 to date</td>
<td>Labour</td>
<td>Annette King</td>
<td>(Various)</td>
</tr>
</tbody>
</table>
APPENDIX V

1968 Act
Medical Council Members

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Alexander, Dr WS*</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Cole, Prof DS**</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Briant Dr RH Phys+</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Brinkman Prof GL++</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>Hunter JD</td>
</tr>
<tr>
<td>Delany Dr PD+++</td>
<td>✓</td>
<td>Broadfoot JM</td>
<td>Herbert MM</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Farrar DrT GP+</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Grieve Dr BW O&amp;G+</td>
<td>✓</td>
<td>Gudex RG</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Medlicott, Prof RW^</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓ (died)</td>
<td>-</td>
</tr>
<tr>
<td>Pryor WJ+++</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Watson, Mr EC Surg+</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓ (Retired 5/87)</td>
</tr>
<tr>
<td>Barker Dr RA^^</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Salmond,G</td>
<td></td>
</tr>
<tr>
<td>Sutherland, Mr (lay) DV</td>
<td></td>
<td>Judd, Mrs (Lay) PC</td>
<td>✓ Lay</td>
<td>✓ Lay</td>
<td></td>
</tr>
</tbody>
</table>

* Chair  
** Deputy Chair  
+ College nominees  
++ Deans  
+++ NZMA nominees  
^ Ministerial appointees  
^\^ Director General
### 1968 Act

#### Medical Council Members - Continued

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Alexander, WS*</td>
<td>^</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cole,D++</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>North,JDK</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maclaurin,C (dep)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Briant,R Phys+</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dep Chair</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hunter,J++</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stewart, RD (dep)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Mortimer, JG</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Herbert, M+++</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>St George, Dr I GP+</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Gudex, R O&amp;G+</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Treadwell, Dr J^</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Broadfoot, J+++</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>(to 30-4-91)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thomson, K</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lamb, G Surg+</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Salmond, G^</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>(Dep) Talbot PS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stoke JC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Judd, P (lay)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>- lay</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- lay</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- lay</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- lay</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- lay</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MCNZ - Georgina Jones perspective 1986-2000
### 1968 Act
#### Medical Council Members - Continued

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>^</td>
<td>-</td>
<td>Corkill C</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Maclaurin++</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Briant*</td>
<td>✓*</td>
<td>✓*</td>
<td>✓*</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Mortimer+</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Herbert+++</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>St George+</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Gudex+</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Treadwell^</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Thomson+++</td>
<td>✓</td>
<td>✓**</td>
<td>✓*</td>
<td>✓*</td>
<td>✓^</td>
</tr>
<tr>
<td>Lamb</td>
<td>✓</td>
<td>✓</td>
<td>✓**</td>
<td>✓**</td>
<td>✓</td>
</tr>
<tr>
<td>Kletchko^ &amp;</td>
<td>✓</td>
<td>Feek (DG)</td>
<td>✓</td>
<td>Kletchko (DG)</td>
<td>+ ✓</td>
</tr>
<tr>
<td>For DG</td>
<td>✓lay</td>
<td>✓lay</td>
<td>✓lay</td>
<td>✓lay</td>
<td>✓lay</td>
</tr>
<tr>
<td>Judd (lay) ^</td>
<td>✓lay</td>
<td>✓lay</td>
<td>✓lay</td>
<td>✓lay</td>
<td>✓lay</td>
</tr>
</tbody>
</table>
Medical Council Members - Transition to New Act
1-7-96 to 31-3-97

<table>
<thead>
<tr>
<th>MCNZ at 1-7-96</th>
<th>MCNZ at 31-7-97</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Minister Appt</strong></td>
<td>Thomson,K (95) ✓ (to 31-12-97)</td>
</tr>
<tr>
<td>RACS</td>
<td>Lamb,G*</td>
</tr>
<tr>
<td>RACP</td>
<td>B riant,R*</td>
</tr>
<tr>
<td><strong>Minister Appt</strong></td>
<td>Corkill,C(68)</td>
</tr>
<tr>
<td>O&amp;G</td>
<td>Gudex,R*</td>
</tr>
<tr>
<td>NZMA</td>
<td>Herbert,M*</td>
</tr>
<tr>
<td><strong>Minister Appt</strong></td>
<td>Judd (68/95) ✓ (to 30-6-98)</td>
</tr>
<tr>
<td>DG rep ex officio</td>
<td>Kletchko,S ✓</td>
</tr>
<tr>
<td>Dean, All</td>
<td>Maclaurin,C</td>
</tr>
<tr>
<td>Dean (AU/OU)</td>
<td>Mortimer,J (95) ✓ (to 31-12-97)</td>
</tr>
<tr>
<td>GP</td>
<td>St George,I ✓ (Elected) 3 yrs to Dec 99</td>
</tr>
<tr>
<td><strong>Minister Appt</strong></td>
<td>Treadwell,J (68)</td>
</tr>
<tr>
<td><strong>Minister Appt</strong></td>
<td>Van Roon,H (95) ✓ (to 30-6-99)</td>
</tr>
<tr>
<td></td>
<td>Adams,M (elected) 3 yrs to Dec 99</td>
</tr>
<tr>
<td></td>
<td>Baird,MAH (elected) 3 yrs to Dec 99</td>
</tr>
<tr>
<td></td>
<td>Scott,AJ(elected) 3 yrs to Dec 99</td>
</tr>
<tr>
<td><strong>Minister Appt (lay)</strong></td>
<td>Vacant</td>
</tr>
</tbody>
</table>

* remain till election but for '68 discipline stay until all cases concluded.
### 1995 Act

**New Medical Council of New Zealand from 1.1.97**

<table>
<thead>
<tr>
<th></th>
<th>Adams, Dr, MJ</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baird, Dr MAH</td>
<td></td>
</tr>
<tr>
<td>Van Roon HT (lay)</td>
<td></td>
</tr>
<tr>
<td>Scott, Dr AJ</td>
<td></td>
</tr>
<tr>
<td>St George Dr IS I, Dep President</td>
<td></td>
</tr>
<tr>
<td>Vacancy (lay)</td>
<td></td>
</tr>
<tr>
<td>Mortimer, Prof JG</td>
<td></td>
</tr>
<tr>
<td>Lay (Judd)</td>
<td></td>
</tr>
<tr>
<td>Thomson, Dr KT, President</td>
<td></td>
</tr>
<tr>
<td>+ DG rep Kletchko</td>
<td></td>
</tr>
</tbody>
</table>

^^^ elected doctors
### Appendix VI

#### 1968 Act

**Medical Council Committees**

**30-6-1983 to 1986**

<table>
<thead>
<tr>
<th>Committees</th>
<th>30-6-1983</th>
<th>1984</th>
<th>1985</th>
<th>1986</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Education Committee</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCNZ Appointee</td>
<td>Alexander WS Pryor, WJ</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>AU Fac Med</td>
<td>Boas, Prof RA</td>
<td>✓</td>
<td>Simpson, IT</td>
<td></td>
</tr>
<tr>
<td>AU Fac Med</td>
<td>North, Prof JDK</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>OU Fac Med</td>
<td>Heslop, A./Prof JH</td>
<td>✓</td>
<td>Dempster, AO</td>
<td></td>
</tr>
<tr>
<td>OU Fac Med</td>
<td>Shannon, Prof FT</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Ex Off Dean: AK SOM</strong></td>
<td>Cole, Prof DS</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Wgtn SOM</td>
<td>Johnson, Prof RH</td>
<td>✓</td>
<td>✓</td>
<td>O’Donnell, TV</td>
</tr>
<tr>
<td>ChCh SOM</td>
<td>Hunter, Prof JD</td>
<td>✓</td>
<td>✓</td>
<td>Clarke, AM Prof</td>
</tr>
<tr>
<td>Otago SOM</td>
<td>Brinkman, Prof GL</td>
<td>✓</td>
<td>✓</td>
<td>Stewart RDH for Dean</td>
</tr>
<tr>
<td>Colleges: Surg</td>
<td>Jardine, Dr JL</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>GP</strong></td>
<td>McLennan, Dr LJE</td>
<td>✓</td>
<td>Barham, PM</td>
<td>✓ For Barham JC Murdoch</td>
</tr>
<tr>
<td>Physicians</td>
<td>O’Donnell, Prof TV</td>
<td>✓</td>
<td>✓</td>
<td>Kirk, GM</td>
</tr>
<tr>
<td>O&amp;G</td>
<td>Seddon, Prof RJ</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>NZMA</strong></td>
<td>West, A/Prof SR</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Observer, Dept Health</strong></td>
<td>AJ Sinclair, Dr</td>
<td>✓</td>
<td>✓</td>
<td>Guthrie, MW</td>
</tr>
<tr>
<td><strong>Medical Practitioners Data Committee</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>Dean Otago</td>
<td>Brinkman, Prof GL</td>
<td>✓</td>
<td>✓</td>
<td>Hunter, Prof JD</td>
</tr>
<tr>
<td>Chair, MCNZ</td>
<td>Alexander, Dr WS</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>DG Health</td>
<td>Salmond, Dr G</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>OU Com Health/ Prev Med</td>
<td>Skegg, Prof DCG</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Statistician</td>
<td>Leatham, Carol</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Secretary MCNZ</td>
<td>Hindes, KAG</td>
<td>✓</td>
<td>✓</td>
<td>Jones, GA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Committees</strong></th>
<th>30-6-1983</th>
<th>1984</th>
<th>1985</th>
<th>1986</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preliminary Proceedings (formerly Penal Cases) Committee</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCNZ Member</td>
<td>EC Watson</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>MCNZ Member</td>
<td>BW Grieve, Cole, Prof DS</td>
<td>✓</td>
<td>(or Dr Briant)</td>
<td></td>
</tr>
<tr>
<td>Legal Appointee</td>
<td>Mr DJ White</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Specialist Register</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCNZ Rep</td>
<td>Grieve, BW Briant, Dr RH</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCNZ Rep</td>
<td>Cole, DS, Prof</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>Finance &amp; General Purpose</strong></td>
<td><strong>Finance and Management</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All MCNZ (4) and Registrar</td>
<td>Delany P Barker, RA (DG)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alexander, WS</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Farrar, T</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Watson, EC</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>KAG Hindes Secretary</td>
<td>✓ Sutherland, DV</td>
<td>✓</td>
<td>G Jones CE/Secy</td>
<td></td>
</tr>
</tbody>
</table>
# 1968 Act
## Medical Council Committees
### 1987 - 1991

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MEC</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCNZ Nom</td>
<td>Pryor, W (retired May) Hunter, J from June 87</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>St George, I</td>
</tr>
<tr>
<td>Fac AU</td>
<td>-</td>
<td>Simpson IJ</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Fac AU</td>
<td>North, JDK</td>
<td>✔️</td>
<td>Vac</td>
<td>Asher MI</td>
<td>✔️</td>
</tr>
<tr>
<td>Fac OU</td>
<td>Dempster, AG</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Fac OU</td>
<td>Shannon, FT</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>Lewis, MA</td>
</tr>
<tr>
<td>Deans AU</td>
<td>Cole, DS</td>
<td>✔️</td>
<td>North, JDK</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Deans Wgtn</td>
<td>O’Donnell, TV</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Deans ChCh</td>
<td>Clarke, AM</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Deans OU</td>
<td>Stewart, RDH</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Colls - Surg</td>
<td>Jardine, JL</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>Barker, Prof AB</td>
</tr>
<tr>
<td>Colls - GP</td>
<td>Barham P</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Colls - Phys</td>
<td>Kirk, GM</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>Buchanan, Prof JG</td>
</tr>
<tr>
<td>Colls - O&amp;G</td>
<td>Seddon, Prof (Retired) Stewart D</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>NZMA</td>
<td>West, SR</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>McAvoy, BR</td>
</tr>
<tr>
<td>Ministry Observer</td>
<td>Guthrie, MW</td>
<td>✔️</td>
<td>Talbot, P</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Dean Dunedin Div</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Mortimer, JG</td>
</tr>
</tbody>
</table>
### PCC/PPC

<table>
<thead>
<tr>
<th>MCNZ Non</th>
<th>Watson, EC</th>
<th>Briant, RH</th>
<th>✔</th>
<th>✔</th>
<th>St George, IG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grieve, BW</td>
<td>Cole, Prof</td>
<td>Lamb, G (or Gudex, R)</td>
<td>✔</td>
<td></td>
<td>Lamb, G</td>
</tr>
<tr>
<td>Legal</td>
<td>White, DJ (then P Cook)</td>
<td>Cook P</td>
<td>✔</td>
<td>✔</td>
<td></td>
</tr>
</tbody>
</table>


#### PRENZ

<table>
<thead>
<tr>
<th>MCNZ Chair</th>
<th>Alexander, WS</th>
<th>✔</th>
<th>✔</th>
<th>✔</th>
<th>Briant, RB</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEC Chair</td>
<td>Hunter, JD</td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OU Nom</td>
<td>Mortimer JG</td>
<td>✔</td>
<td>Hutton, JD</td>
<td>✔</td>
<td>(Prof EPomare)</td>
</tr>
<tr>
<td>OU Nom</td>
<td>O’Donnell, TV</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>AU Nom</td>
<td>Glasgow, GL</td>
<td>✔</td>
<td>West, R (MEC)</td>
<td>✔ (MEC)</td>
<td>Barham (MEC)</td>
</tr>
<tr>
<td>AU Nom</td>
<td>Kolbe, J</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>MCNZ</td>
<td>Herbert, M</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td></td>
</tr>
</tbody>
</table>

#### COMMUNICATIONS

| Exam Director | Glasgow, GL | ✔ | ✔ |

#### MP Data

<table>
<thead>
<tr>
<th>Dean, OU</th>
<th>Hunter, JD</th>
<th>✔</th>
<th>✔</th>
<th>✔</th>
<th>Stewart, RDH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chair, MCNZ</td>
<td>Alexander, WS</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>Briant, RB</td>
</tr>
<tr>
<td>DG Health</td>
<td>Salmond, GS</td>
<td>✔</td>
<td>Talbot, PS</td>
<td>Talbot, PS</td>
<td>✔</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------------</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>------</td>
</tr>
<tr>
<td>OU Com/Med</td>
<td>Skegg, D</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Statistician</td>
<td>Leatham, C</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>CEO</td>
<td>Jones, G</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>(MCNZ Dunedin)</td>
<td>St George, I</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCNZ</td>
<td>Gudex, R</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>MCNZ</td>
<td>Herbert, M</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>MCNZ</td>
<td>Judd, P</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>MCNZ</td>
<td>Treadwell, J</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>+ Alexander, W</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>+ Briant, R</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F&amp;M</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chair</td>
<td>Alexander, W</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Member</td>
<td>Farrar, T</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Member</td>
<td>Treadwell, J</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Member</td>
<td>Watson</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Broadfoot</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Talbot, P</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Registrar CEO</td>
<td>Jones, G</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Acct</td>
<td>Edwards C</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reg’n</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCNZ</td>
<td>Alexander, WS</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hunter, JD</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Broadfoot, J</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCNZ</td>
<td>Cole, DS</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Herbert, M</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lamb, G</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secretary</td>
<td>Jones, G</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>St George, I</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

MCNZ - Georgina Jones perspective 1986-2000
<table>
<thead>
<tr>
<th>Specialist</th>
<th>Briant, R</th>
<th>Lamb, G</th>
<th>✓</th>
<th>✓</th>
<th>Alexander, S</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCNZ</td>
<td>Cole, D</td>
<td></td>
<td>✓</td>
<td>North, JD</td>
<td>Maclaurini (AU)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Sub-Indic(GP)</td>
<td>Herbert, M</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>MCNZ</td>
<td>Farrar, T</td>
<td>-</td>
<td>Broadfoot, J</td>
<td>✓</td>
<td>-</td>
</tr>
<tr>
<td>Secretary</td>
<td>Jones, G</td>
<td>✓</td>
<td></td>
<td></td>
<td>-</td>
</tr>
</tbody>
</table>
### 1992 - 1996

<table>
<thead>
<tr>
<th>Committees</th>
<th>MEC</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>MCNZ Nom</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fac AU</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fac AU</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fac OU</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fac OU</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deans AU</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deans Wgtn</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deans ChCh</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deans Dunedin</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colls - Surg</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colls - GP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colls - Phys</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colls - O&amp;G</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NZMA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DOH (Observer)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| PPC | | | | | |
| MCNZ | Maclaurin, C |     |     |     |     |
| MCNZ | Lamb, G |     |     |     | Corkill, C |
| Legal | Cook, P |     |     |     |     |

<table>
<thead>
<tr>
<th>Committee</th>
<th>Exams</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MCNZ - Georgina Jones perspective 1986-2000
<table>
<thead>
<tr>
<th>MCNZ Chair</th>
<th>Briant,R</th>
<th>✓</th>
<th>✓</th>
<th>✓</th>
<th>✓</th>
</tr>
</thead>
<tbody>
<tr>
<td>OU Nom</td>
<td>Hutton,J</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>McHaffie, DJ</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OU Nom</td>
<td>Pomare,E</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Abernethy, DA</td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>AU Nom</td>
<td>Kolbe,J</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Large, RG</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>AU Nom</td>
<td>Kolbe,J</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Willoughby EW</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>MCNZ/MC</td>
<td>Herbert/ Barham</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Aickin, Prof (MEC)</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Ex Director</td>
<td>Glasgow,G</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hamilton</td>
<td>Maclaurin, C</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rothwell, P</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**COMS**

<table>
<thead>
<tr>
<th>MCNZ</th>
<th>Treadwell, J</th>
<th>✓</th>
<th>✓</th>
<th></th>
<th>Thomson, K</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCNZ</td>
<td>Briant, R</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCNZ</td>
<td>Judd, P</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCNZ</td>
<td>St George, I</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CEO</td>
<td>Jones, G</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Data**

| Dean, OU        | Mortimer, J  | ✓ | ✓ |   |             |
| Chair, MCNZ     | Briant, R    | ✓ | ✓ | ✓ | ✓            |
| DG Health       | Stoke, J (for DG) | - | - | Feek, C | -          |
| OUComMed        | Spears, GF   | ✓ |   | Spears, GF | -         |
| Statistician    | ✓ | ✓ | ✓ |   |             |
| CEO             | ✓ | ✓ | ✓ | Jones, G | ✓          |
| MCNZ Dunedin    | St George, I | ✓ | ✓ |   |             |

**Committees**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCNZ</td>
<td>Gudex, R</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>MCNZ</td>
<td>Herbert, M</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>MCNZ</td>
<td>Judd, P</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

MCNZ - Georgina Jones perspective 1986-2000
<table>
<thead>
<tr>
<th></th>
<th>Treadwell, J</th>
<th>✓</th>
<th>✓</th>
<th>✓</th>
<th>✓</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Screener)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCNZ</td>
<td>Thomson, K</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>MCNZ</td>
<td>Briant, R</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>(Chair)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CEO</td>
<td>Jones, G</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>F&amp;M</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCNZ Chair</td>
<td>(Not Chair)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Alexander</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCNZ</td>
<td>Thomson, K</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>MCNZ</td>
<td>Stoke, J</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCNZ</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CEO</td>
<td>Jones, G</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Reg’n</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCNZ</td>
<td>St George, I</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>MCNZ</td>
<td>Alexander, W</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Judd, P</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCNZ</td>
<td>Herbert, M</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>MCNZ</td>
<td>Maclaurin, C</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sub-Spec</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCNZ</td>
<td>Alexander, W</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCNZ (+/-)</td>
<td>Maclaurin, C</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sub - Indic</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCNZ</td>
<td>Herbert, M</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>MCNZ (+/-)</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MCNZ - Georgina Jones perspective 1986-2000
# Medical Council Committees

## 1968 - 1995 Act Transition

<table>
<thead>
<tr>
<th>Committees</th>
<th>Pre Election (1-7-96)</th>
<th>Post Election (20-2-97)</th>
<th>From 31-3-98</th>
<th>At 31-3-99</th>
<th>At 31-3-00</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Regn</strong></td>
<td></td>
<td></td>
<td>(Full MCNZ - 1 lay vacancy)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Quorum of C'I)</td>
<td>Herbert, M</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Judd, P</td>
<td>✓</td>
<td>McKergow, T</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Kletchko, S</td>
<td></td>
<td>Ruakere, T</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Van Roon, H</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Adams, M</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>Quorum of Council Replaces</td>
</tr>
<tr>
<td></td>
<td>Baird, MAH</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Thomson, K</td>
<td></td>
<td>St George, I</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Temp Psych</th>
<th>* Replaced/combined with Voc Reg</th>
</tr>
</thead>
<tbody>
<tr>
<td>St George, I</td>
<td></td>
</tr>
<tr>
<td>McKergow, T</td>
<td></td>
</tr>
<tr>
<td>Treadwell, J</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Voc Reg Sub-com</th>
<th>Reg Advisory Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thomson, K</td>
<td>Thomson, K</td>
</tr>
<tr>
<td>Briant, R</td>
<td>Adams, M</td>
</tr>
<tr>
<td>Corkill, C</td>
<td>McKergow, T</td>
</tr>
<tr>
<td>Herbert, M</td>
<td>Van Roon, H</td>
</tr>
<tr>
<td>Baird, MAH</td>
<td>Baird, MAH</td>
</tr>
<tr>
<td>Kletcho, S</td>
<td></td>
</tr>
<tr>
<td><strong>Data</strong></td>
<td><strong>Pre-election</strong></td>
</tr>
<tr>
<td>-----------</td>
<td>------------------</td>
</tr>
<tr>
<td>Van Roon,H</td>
<td>Van Roon,H</td>
</tr>
<tr>
<td>Briant,RH</td>
<td></td>
</tr>
<tr>
<td>Kletchkko,S</td>
<td></td>
</tr>
<tr>
<td>Jones, G (CEO)</td>
<td>✓</td>
</tr>
<tr>
<td>Scott, AJ</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>F&amp;M</strong></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Lamb, G</td>
<td>St George, I</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jones CEO</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thomson, K</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Van Roon,H</td>
<td>Van Roon,H</td>
<td>Van Roon,H</td>
<td>Sundakov, A</td>
<td>Sundakov, A</td>
<td></td>
</tr>
<tr>
<td>Adams, M</td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Simpson IJ</td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Ineson, S</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Coms</strong></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Thomson, K</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Judd, P</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kletchkko,S</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jones, G</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>StGeorge</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Issues</strong></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Scott, AJ</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Neutze, J</td>
</tr>
<tr>
<td>Baird, MAH</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Health</td>
<td>Pre Election (1-7-96)</td>
<td>Post Election 20-2-97</td>
<td>From 31-3-98</td>
<td>At 31-3-99</td>
<td>At 31-3-00</td>
</tr>
<tr>
<td>--------</td>
<td>----------------------</td>
<td>----------------------</td>
<td>--------------</td>
<td>------------</td>
<td>------------</td>
</tr>
<tr>
<td>Gudex,R Briant,R Herbert,M</td>
<td>Judd,P</td>
<td>Judd,P</td>
<td>✓</td>
<td>Bull,C</td>
<td>✓</td>
</tr>
<tr>
<td>Jones,G (Registrar)</td>
<td>Thomson,K</td>
<td>Thomson,K</td>
<td>McKergow,T</td>
<td>✓</td>
<td>(✓)</td>
</tr>
<tr>
<td>Treadwell,J</td>
<td>Adams,M</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Van Roon,H</td>
<td>Scott,AJ</td>
<td>✓</td>
<td>✓</td>
<td>Neutze,J</td>
<td></td>
</tr>
</tbody>
</table>

| Prof. Standard | From 26-9-96 - interim |
| Thomson,K | Bull,C | ✓ | ✓ |
| Lamb,G | St George | ✓ | ✓ |
| Judd,P | Judd,P | ✓ | Van Roon | Heather Thomson |
| Kletchko,S | Kletchko | ✓ | Adams,M |
| Baird,MAH | ✓ | Scott,AJ | Neutze,J |

**Research Steering**

| St George,I | StGeorge.I |
| Jones (CEO) | JonesCEO |
| Kletchko,S | Scott,AJ |
| Van Roon | Van Roon |

**Education**

| Dean OU | Mortimer Prof | MCNZ Members (3) |
| Dean ChCh | Aickin, Prof | MCNZ Appointees: See over |
| NZMA | Arroll,B |
| GPs | Barham,P |
| Phys | Buchanan,J G |
| OU Fac | Dempster,A |
| Dean Wgtn | HollowayProf |
| AU Fac | Kolbe,J |
| AU Fac | Lewis,M |
| MCNZ | ✓ | St George,I |
| SubDean | Simpson IJ | ✓ |
| Surgeon | Stewart AD |
| MCNZ | Van Roon,H | MCNZ Member |
| AU Fac | Willoughby,E | MCNZ Member |

*MCNZ - Georgina Jones perspective 1986-2000*
<table>
<thead>
<tr>
<th>Committees</th>
<th>Pre Election (1-7-96)</th>
<th>Post Election (20-2-97)</th>
<th>From 31-3-98</th>
<th>At 31-3-99</th>
<th>At 31-3-00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exams</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCNZ Pres</td>
<td>ThomsonKJ</td>
<td>Baird,MAH</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>MCNZ Nom</td>
<td>Mortimer,JG</td>
<td>Van Roon,H</td>
<td></td>
<td>Heather Thomson</td>
<td>Heather Thomson</td>
</tr>
<tr>
<td>Ex Director</td>
<td>Maclaurin,C</td>
<td>Mortimer,JG</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>AU Nom</td>
<td>Collins, JP</td>
<td></td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>OU Nom</td>
<td>Abernethy,D</td>
<td>Clemett,R</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exam Coord Wgttn</td>
<td>McHaffie,D</td>
<td></td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Exam Coord Hmltn</td>
<td>Rothwell,P</td>
<td></td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Exam Coord ChCh</td>
<td>Morton JB</td>
<td></td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Exam Coord Dunedin</td>
<td>Reid JJ</td>
<td></td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Exam Coord AK</td>
<td>Alley,P</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education Committee Nominee</td>
<td>Vacant</td>
<td>Davis,M</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCMZ Member</td>
<td>Simpson, IJ</td>
<td></td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td>31-3-99</td>
<td>31-3-00</td>
<td></td>
</tr>
<tr>
<td>MCNZ Members (3)</td>
<td></td>
<td>Simpson IJ</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>St George,I</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Van Roon,H (to 30-6)</td>
<td>Heather Thomson</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bull,C</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCNZ Appointees</td>
<td></td>
<td>Ardagh,M</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Voc Reg Br (3)</td>
<td>Corkill,C</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clover,G</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IS</td>
<td>Davis M</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
<td>---------</td>
<td>---</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resident Dr</td>
<td>Martin, Jenny</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Med School Rep (Otago)</td>
<td>Gillespie, WJ</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix VII

1995 ACT FIRST FULL YEAR

Milestones April 1997 - March 1998

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.


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  18 hospitals and 10 CHEs visited by Education Committee teams (Auckland, Wellington, Canterbury) to approve probationary (including intern) education programmes.

23-24 June  Complaints pamphlets published and distributed.

7-8 August  Intern supervisors regional meetings held (Auckland, Wellington, Christchurch) – Code of Health and Disability Services Consumers’ Rights emphasised.

11, 20, 29 August Complaints pamphlets published and distributed.

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

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

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

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 $5000 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 $2250 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
  - 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.
Appendix VIII

Registrar's Annual Report
1999

Registrar's Report - Recurring themes in Registrars' reports received from comparable overseas bodies include:

- underlying principles of acting to serve the public interest by maintaining standards
- increasing complexity in modern medical practice and related law, and
- lack of understanding by the public, politicians and news media of what such bodies are attempting to achieve in times of unprecedented change.

Particular activities evolve as a response to the circumstances of the times. There has never been a time when trust and confidence in such regulatory bodies has been more frequently challenged.

The Registrar role (a mandated statutory appointment) is focusing on sharing expert knowledge and experience in public administration areas which under the new Act present particular risks arising from innovation, complexity or degree of discretionary power. Support, education and training for new members of the Council office has therefore been a key activity.

Significant events included:

- appointing Dr Ian St George as editor to review and supervise the rewrite of "Medical Practice in New Zealand - A Guide to Doctors Entering Practice", commonly known as "the Cole Book", last published by Council in August 1995. Originally written for senior New Zealand medical students to help them understand the legislation and registration issues that would affect them as new graduates, it has since proven useful to a wider readership including overseas trained doctors seeking or obtaining registration in New Zealand.
- examining, at the request of the Ministers of Health, the need for any amendments to the Medical Practitioners Act 1995 in light of practical experience with implementing its provisions over almost three years. Shifting political and economic realities affect occupational regulation. Perceived barriers to obtaining registration, highlighted by the numbers of overseas trained doctors permanently resident but not practising in New Zealand, influence demands for change which may not be justified.
- responding to allegations of racial discrimination or restrictive practices made to Members of Parliament and the Race Relations Conciliator. Council's mandate to protect the public is paramount and the yardstick for minimum standards is only that expected of New Zealand graduates (at primary and vocational level). Due process and fair and reasonable decision making are always prerequisites. Council's lawyers and the Registrar have met several times with affected parties and with the Conciliator hoping to reach a solution without litigation
- enhancing international relationships with similar bodies through participation in a steering committee aiming to establish an international association of medical licensing authorities early in the new millennium. We urgently need to agree on internationally acceptable minimum standards, establish comprehensive databases which identify safe medical practitioners, and develop electronic communications to facilitate validation of credentials and good standing of doctors wanting to work abroad.

A small proportion of doctors create the largest proportion of activity for all medical regulatory bodies. The Registrar's time is often diverted to problem cases in registration, competence, health and discipline. Both the Health and Disability Commissioner and the Council continue to find that in a small number of doctors there is inadequate appreciation of the vital importance of the Code of Health and Disability Services Consumers' Rights and good medical practice founded on ethical principles, good communication, respect for professional boundaries, and active maintenance of self care, alongside technical competence.

Georgina Jones
Registrar

Medical Council of New Zealand

MCNZ - Georgina Jones perspective 1986-2000
Registrar's Annual Report
2000

Registrar's Report

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

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

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

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

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

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

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

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

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

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

Georgina Jones
Registrar

Medical Council
of New Zealand
Appendix IX

Council Common Seal

Professor Lewis’s Drafts (1967)