MEDICAL COUNCIL
OF NEW ZEALAND

ANNUAL REPORT
1987

MEDICAL COUNCIL OF NEW ZEALAND ANNUAL REPORT

FOR YEAR ENDED 30 JUNE 1987

MEMBERS OF THE MEDICAL COUNCIL

(At 30 June 1987)

	Appointed by Governor-General on recommendation of:
Dr W.S. Alexander (Chairman)	Minister of Health
Professor D.S. Cole (Deputy Chairman)	ex officio, Dean, University of Auckland, School of Medicine
Dr R.H. Briant	Royal Australasian College of Physicians
Dr T. Farrar	Royal New Zealand College of General Practitioners
Dr R.G. Gudex	Royal New Zealand College of Obstetricians and Gynaecologists
Dr M.M. Herbert	New Zealand Medical Association
Professor J.D. Hunter	ex officio, Dean, Faculty of Medicine, University of Otago
Mrs P.C. Judd, J.P.	Minister of Health
Dr W.J. Pryor (Retired May 1987)	New Zealand Medical Association
Dr G.C. Salmond	ex officio, Director-General of Health
Dr E.C. Watson	Royal Australasian College of Surgeons

Secretary	Mrs G.A. Jones, B.A.
Assistant Secretary	Mr J.R. Coster, B.A.

Council Offices Postal Address Telephone	73 Courtenay Place, Wellington 1. P.O. Box 9249, Wellington. (04) 847-635

Solicitors	Kensington Swan, P.O. Box 10246, Wellington
Legal Assessor	Mr J.J. McGrath, Q.C., P.O. Box 637, Wellington.

Bankers	Bank of New Zealand, Courtenay Place Branch, Wellington. ANZ Banking Group (New Zealand) Limited, Courtenay Place Branch, Wellington.

Auditors	Miller, Dean and Partners, P.O. Box 11253, Wellington.

MEDICAL EDUCATION COMMITTEE

Membership as at 30 June 1987

	Appointed by:
Professor J.D. Hunter (Chairman from June 1987)	Medical Council
Dr P.M. Barham	Royal New Zealand College of General Practitioners
Professor A.M. Clarke	ex officio, Dean, Christchurch School of Medicine, University of Otago
Professor D.S. Cole	ex officio, Dean, University of Auckland School of Medicine
Dr A.G. Dempster	Faculty of Medicine, University of Otago
Dr J.L. Jardine	Royal Australasian College of Surgeons
Dr G.M. Kirk	Royal Australasian College of Physicians
Professor J.D.K. North	Faculty of Medicine, University of Auckland
Professor T.V. O'Donnell	ex officio, Dean, Wellington School of Medicine, University of Otago
Dr W.J. Pryor (retired May 1987; previous Chairman)	Medical Council
Professor R.J. Seddon (resigned April 1987)	Royal New Zealand College of Obstetricians and Gynaecologists
Professor F.T. Shannon	Faculty of Medicine, University of Otago
Dr A.D. Stewart	Royal New Zealand College of Obstetricians and Gynaecologists
Professor R.D.H. Stewart	ex officio, Dean, Dunedin Division, Faculty of Medicine, University of Otago
Associate Professor S.R. West	New Zealand Medical Association
Dr M.W. Guthrie	Observer, Department of Health

COMMITTEES

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

Preliminary Proceedings Committee
Dr E.C. Watson (Convener)
Professor D.S. Cole
Mr D.J. White (Legal Member)

Finance and Management Committee
Dr T. Farrar (Chairman)
Dr W.S. Alexander
Ms C. Edwards
Mrs G.A. Jones
Dr E.C. Watson

Medical Practitioners Data Committee
Professor J.D. Hunter (Chairman)
Dr W.S. Alexander
Mrs G.A. Jones
Ms C. Leatham (Statistician)
Dr G.C. Salmond
Professor D.C.G. Skegg

Registration Sub-Committee
Dr W.S. Alexander (Convener)
Professor D.S. Cole
Dr T. Farrar
Mrs G.A. Jones

Specialist Registration Sub-Committee
Dr R.H. Briant (Convener)
Professor D.S. Cole

Indicative Register Sub-Committee
Dr M.M. Herbert (Convener)
Dr T. Farrar
Mrs G.A. Jones

Probationary Registration Examination New Zealand (PRENZ) Board
Dr W.S. Alexander (Convener)
Professor J.D. Hunter (Chairman, Medical Education Committee)
Nominees of University of Otago: Professor J.G. Mortimer
Professor T.V. O'Donnell
Nominees of University of Auckland: Dr G.L. Glasgow
Dr J. Kolbe

SECRETARIAT

Secretary: Mrs G.A. Jones
Assistant Secretary: Mr J.R. Coster
Clerk: Ms J. Johns
Clerk: Mrs B. Nodelman
Secretary/Word Processor Operator: Ms J. Hawken
Accounts Officer (Part-time): Ms C. Edwards
Temporary Clerks: Ms V. Little
Ms D. McCall

MEMBERSHIP

Last year's report referred to the death of Professor R.W. Medlicott. Professor Medlicott was a nominee of the Minister of Health and had been appointed to the Council on 1 April 1972. During his fourteen years' service on the Council Professor Medlicott had been of tremendous assistance to successive Chairmen with his wise counsel, not only in the many cases of impairment of doctors which Council is called on to consider, but in the wider fields of conduct and the relationship of the Council to the community.

Dr W.J. Pryor O.B.E. was appointed to the Council in May 1981 on the nomination of the New Zealand Medical Association, succeeding Dr N.F. Greenslade. He completed two terms of three years in May 1987 and did not seek re-election. For the past three years he had been Chairman of the Medical Education Committee. Dr Pryor has made a valuable contribution to Council affairs in presenting the views of the Medical Association, of his own discipline and of the Canterbury area. The Medical Education Committee has faced substantial problems in recent years with changes in the pre-registration duties of junior doctors as a result of the M10 determination. Dr Pryor met these difficult situations with tact and was able to bring the various interests together to emphasise the educational requirements of the conditionally registered doctors. He also performed an important task as agent for the Council in the Canterbury-Westland area. We have appreciated his loyal and conscientious work for Council and are proud of the fact that he has been honoured by the Queen for his services to medicine.

Dr N.F. Greenslade O.B.E. died on 12 June 1987. He was appointed to the Council in April 1969 as nominee of the New Zealand Medical Association. In 1972 he was elected Chairman of the Council and, in addition, held the post of Chairman of the Medical Education Committee, and occupied both posts until his retirement in 1981. Dr Greenslade was an able and dedicated leader who won the respect and affection of all who knew him. Many important initiatives to improve and develop the work of the Council were commenced during his term of office. The profession and the Medical Council owe him a debt of gratitude. We extend our sincere sympathy to his family.

CHAIRMAN'S REPORT

In issuing its Fifth Annual Report the Medical Council of New Zealand is pleased to give an account of progress and developments in the year ending 30 June 1987.

MEMBERSHIP

As noted elsewhere several vacancies have arisen in Council membership during the year. Delay in filling these vacancies has occurred, firstly because the Minister of Health insisted on two names being submitted by each nominating body from which he wished to make a final selection, and secondly because he also decided to remove the procedures for calling nominations from the Council office and undertake these in the Department of Health. Some members of Council whose successors have not yet been appointed have continued in office and their help has been invaluable in this transition period. Drs Farrar and Watson have continued their important contributions to Council business and without their goodwill the Council would have had great difficulty in continuing to function.

SECRETARY

The appointment of Mrs Georgina Jones as Secretary to the Medical Council in May 1986 has given the administration of the Council new and energetic leadership. Mrs Jones has established good working relationships within the office, with members of the Council and with the governmental and other bodies with which the Council must work. The new offices which are leased on a long-term rental basis have been fitted out at a reasonable standard of comfort and efficiency and provide pleasant working conditions for staff. As a result of Mrs Jones' interest in staff welfare and the improved working conditions, the staff turnover and the consequent need for expensive temporary assistance has diminished. Wellington is not an easy city in which to get and keep good office workers. The installation of electronic data-processing and word-processing equipment will assist in the continuing effort to improve office efficiency.

REGISTRATION

Registration of graduates from overseas medical schools forms a considerable part of the Council work-load. The decision to allow hospitals to increase junior medical officer staffing by recruitment from overseas, has resulted in a considerable inflow of recent graduates. Those graduates from Universities listed in the Third Schedule of the Act, have been given full registration. Other graduates, not eligible for full registration, have been given temporary registration for service related duties for one year, renewable for a further year to make a maximum of two years. As anticipated, a number of these young graduates now wish to remain in New Zealand. Council will require those on temporary registration to submit to the Probationary Registration Examination (PRENZ). As the numbers applying for this examination are already increasing urgent consideration is being given to the conduct of this examination, which has been mounted in the last four years by the University of Otago Medical School on behalf of the Council. It is hoped that the examination will be conducted twice yearly, instead of the present once yearly schedule. While the Medical Council is not involved in any aspect of the immigration decisions regarding these overseas graduates, it must maintain vigilance that the standard of competence of those registered in New Zealand matches the standard of graduates from our own schools. Close contact is maintained with the Australian Medical Council, the State Medical Boards in Australia and with the General Medical Council in the United Kingdom, to ensure that the level of scrutiny remains comparable. The proposed changes to The New South Wales Medical Act will require all overseas graduates other than those from New Zealand, seeking registration in New South Wales, to submit to the Australian Medical Council examination. This is an indication of the trend towards insistence on equivalent standards. It is likely to be the forerunner of similar requirements for other registration bodies.

REVISION OF THE MEDICAL PRACTITIONERS ACT

The discussions with Government and professional bodies on the revision of the Medical Practitioners Act continue. Much progress has been made in working party discussions with the New Zealand Medical Association and with Government officials who have interpreted the present administration's attitude to registration of professionals. There is undoubtedly an increased interest on the part of a number of lay organisations representing patients and consumers' rights in the field of professional registration. Any modifications made to the Medical Practitioners Act must take into account these expressions, otherwise there is a real risk that changes which are not in line with the wishes of the profession itself will be made to the Act during the legislative process.

The provisions of the present Act in the field of discipline have been thoroughly examined. It is clear that the mechanism for examining complaints is somewhat complicated and is not fully understood by members of the profession or by the general public. Following prolonged discussions at working party level, a new plan has been prepared and is now in appropriate form for the law draftsman to convert into a Bill. The new plan which has been outlined in the New Zealand Medical Journal, has paid particular attention to the initial procedures for the receipt of complaints and for the screening of these in a conciliatory manner. It also provides for the establishment of a National Conduct Tribunal, where charges of professional misconduct against practitioners would be examined. This is, in general terms, very similar to the arrangements which exist in the legal profession. It is anticipated that the Medical Council itself will thus be relieved of the task of sitting for days at a time on disciplinary matters, although it will retain the ultimate responsibility for ensuring that the new disciplinary system works effectively and efficiently.

There will be several areas of Council activity where lay involvement will be required and this will inevitably mean that the number of lay members of the Council will require to be increased. The opportunity will be taken to increase the size of the Council and it is clear that some, perhaps a majority of the medical members of the Council will be elected by the profession.

EDUCATION

The opportunity will be taken to revise the composition of the Medical Education Committee, which must have the ability to act more independently and less as a sub-committee of the Medical Council. As the keeper of the Medical Registers, the Medical Council has the duty of setting the standards for entry to the Registers. This duty applies to the standards for entry not only to the General Register for the majority at graduation, but to the Specialist Register and to the newly established Indicative Register for General Practice. It follows therefore that, in the field of Medical Education, Council has responsibilities to monitor the training

and experience provided, not only for those seeking to graduate in Medicine but also for those enrolled in vocational College training schemes. This will be a challenge to a reconstituted Medical Education Committee.

The establishment of an Indicative Register for General Practice is the culmination of a long period of discussion between the Council and the Royal New Zealand College of General Practitioners and the New Zealand Medical Association. The Council has accepted the responsibility of maintaining a Register of those, who by training or experience, have received appropriate preparation for the vocation of General Practice. It is hoped that the existence of an Indicative Register will encourage the proper vocational preparation for entry to General Practice and that there will be a consequent stimulus to continuing education in this field.

If the Medical Education Committee is to undertake a measure of overall responsibility for both undergraduate and postgraduate medical education, it will require a tactful and co-operative approach to the teaching institutions and vocational colleges. It could also ensure that the constructive ideas of the recently disbanded Council for Postgraduate Medical Education in areas such as peer review and continuing education are further developed. Professor John Hunter has accepted the challenging task of chairing the Medical Education Committee in this important phase of development.

HEALTH

The Medical Council, having studied the activities of the Health Committee of the General Medical Council in the United Kingdom, has formed the opinion that the new Act should make specific provision for such a Committee. During the year the Council has sponsored workshops on the noncoercive or informal phase of help for the impaired doctor. In keeping with the opinions advanced by those active in this field, the Medical Council is now pleased that the New Zealand Medical Association has accepted responsibility for establishing a National Management Committee for the National Counselling and Welfare Service for Impaired Doctors. This will ensure as far as is possible, that the informal phase of therapeutic approach to the sick or impaired doctor will be free of threat of sanctions. Only if the informal phase should prove unsuccessful, or if there is a perceived risk to patients, will there be need to involve the Medical Council. In cases where this situation is reached, the Council will need to have a Health Committee, made up of members not involved in the disciplinary functions of Council, who will be assisted in their considerations by three or more assessors, one legal, one psychiatric (from a panel) and one from the same discipline as the doctor concerned. The present Act allows for rapid action in established health and impairment cases, but one has the feeling that quite serious impairment is allowed to proceed unreported because the outcome of reporting may be so dramatic. The introduction of a properly organised, informal phase may assist and help avoid situations where known impairment over many years is finally brought to attention at a stage when rehabilitation has less chance of success. The Medical Council feels it is an appropriate extension of its functions on behalf of the profession, to provide financial support for efforts in this field. Another aspect of this problem is the provision of re-education for doctors seeking to return to the medical workforce. There are many institutions willing to create suitable supernumerary posts but funding is limited.

Doctors who are unable to work because of physical or mental disability, may be supported either by the unemployment or the sickness benefit. A few are supported by Health Insurance Policies. There would seem to be a good case for these funds to be channelled into a somewhat more acceptable and dignified form. These short term fellowships would enable doctors returning to the workforce to obtain re-education and experience prior to competing for paid positions in the usual way. This matter will be followed up with the Department of Social Welfare and with the Department of Labour. We are informed that a similar proposal in the United Kingdom is currently receiving serious consideration.

STANDARDS

Changes in the mode of provision of medical services are inevitable and continuous. As the body responsible for determining standards of acceptable conduct, the Medical Council must keep itself informed of what is current common practice in such areas as advertising, service company arrangements, availability to patients, arrangements for locum and deputising services and the extent to which patients can or should be informed on these matters. Our lay member has been a most helpful adviser in conveying public perception of the profession in these "consumer-related" issues. In determining what is or is not misconduct, the disciplinary system must reflect the needs of the community and the extent to which the providers of medical services will meet them.

The Annual Report is designed to inform both the public and the profession of the activities of the Medical Council during the year under review and to indicate areas of future development. The Council's activities are funded by the profession whose Registration and Annual Practising Certificate fees meet the cost of its work. The Council however exists to provide the public with an assurance that doctors admitted to the New Zealand Medical Register are competent and maintain an acceptable standard of competence and practice. This summary of Council activities is intended to provide some insight into what is being done in this field.

OPEN SESSIONS

The Medical Council held an open meeting at the time of the New Zealand Medical Association Centennial Meeting and Council members also accepted an invitation to meet the Waikato Division of the Association. Council would welcome invitations from any group who would like to discuss Council affairs.

In conclusion, I wish to thank all members of Council and all members of the staff for their loyal service during the year. It has been a difficult task to keep the essential work of the Council running smoothly and to cope with the peaks of new registration activity. Throughout the year, however, there has been the feeling that the changes made are progressive and will lead in the near future to a more efficient smooth-running organisation to the benefit of all. For the tremendous cooperation I have received from everyone, I express my sincere thanks.

W.S. Alexander
CHAIRMAN

LAY MEMBER'S REPORT

The first lay member of the Medical Council was appointed in 1983 and following his resignation I was appointed in 1985. Over the last two years I have been a member of sub-committees discussing the impaired doctors programme, the reorganisation of disciplinary procedures and the revision of registration procedures.

In 1986 I had a paper published in the New Zealand Medical Journal in which I said "As science is moving medical practice and treatment into new areas very quickly it is easy to promote anxiety and unease in the community . . . The fact that the public is represented in the professional forums which oversee such changes could be a very reassuring development."

A year later I feel that society is now saying quite strongly that it must have a voice in medical matters and that mystique surrounding medical procedures should be removed to provide more accountability.

Last Christmas I visited London and took the opportunity to look at public participation in medical affairs in Britain. I met some of the members of the General Medical Council, including two of the lay members, and sat in on several disciplinary hearings. I had discussions with the Chairman of a Department of Health and Social Services team looking at discipline as part of a review of primary care. As well, I met and talked with people involved in medico-legal ethics and I visited the National Women's Commission.

The main impression which I gained from these visits was that there is already a reasonable amount of lay involvement in Britain and that the public and politicians are demanding more. They want more say in how health services are provided.

There are similarities between what is happening in Britain and what is happening here in New Zealand.

As an example, the United Kingdom report on "Women and the Health Service" identified issues which our Ministry of Women's Affairs is also researching. The general thrust of the report was that women are the major consumers of the National Health Service – on their own account, in the care of young dependent relatives and in the care of elderly dependent relatives. As well there is a call upon gynaecological and maternity care over and above those services affecting the general health of both sexes. Consequently it was felt that there should be a realistic representation of women on health authorities and other consultative bodies.

There are different morbidity and mortality rates among United Kingdom residents of differing ethnic origins. This situation is also found here in New Zealand and there is a call for a Maori and Pacific Island aspect to our medical care. At the New Zealand Medical Association Conference in Auckland this year Professor Eru Pomare spoke on this issue, explaining how cultural differences can prevent individuals seeking the treatment which they may need.

Because of this desire for more public participation, the medical Council in its submissions towards the new Act, is proposing increased lay involvement on the Council and on the committees for which it is responsible.

Having sat for two years on Medical Council disciplinary cases, I have been made very aware that in a one-to-one situation most people have unquestioning faith in the medical practitioner who is treating them. Because of the vulnerability which the majority of individuals display, informed disciplinary tribunals are very important both in protecting the public from the erring doctor and in maintaining the confidence of the profession.

In the United Kingdom the General Medical Council hearings are public and the press attend – just as in a Court of Law situation. I personally have reservations about adopting that procedure in New Zealand because of the conflict betwen the public "right to know" and the individuals "right to privacy". I felt that the United Kingdom press tended to concentrate on the salacious and the bizarre and that here, because of the smallness of our community, many people would not complain if they thought that they and their difficulties could be identified through newspaper stories or items on the television.

I find my involvement with the Medical Council rewarding and do not see the lay role as being a repressive or confining one. Instead I think that it makes an important contribution by bringing the perceptions of the ordinary person to the meeting table.

Patricia Judd
LAY MEMBER

THE MEDICAL COUNCIL OF NEW ZEALAND – 1987

Taken at the September meeting of Council in the Boardroom at 73 Courtenay Place, this photograph shows members and staff, from left to right:

Mrs P. C. Judd, Mrs G. A. Jones (Secretary), Mr J. R. Coster (Assistant Secretary), Professor D. S. Cole (Deputy Chairman), Dr R. H. Briant, Dr E. C. Watson, Dr G. C. Salmond, Dr T. Farrar, Professor J. D. Hunter, Dr R. G. Gudex

Absent were: Dr W. S. Alexander (Chairman) and Dr M. M. Herbert, both overseas, and Dr W. J. Prior, retired May 1987 (see insets left to right)

REPORT OF THE SECRETARY

At the time of writing my report last year, I had been in office only one month. I have now survived four regular and two additional meetings of Council, two major out-of-town and several Wellington disciplinary hearings involving charges and appeals, working party meetings on impaired doctors, revision of disciplinary procedures and registration, the Centennial Meeting of the New Zealand Medical Association, the annual meeting of the Australian Medical Council, and in excess of 250 working days at 73 Courtenay Place. I can certainly report that I know considerably more about the Medical Council, its functions and aspirations, the strengths and weaknesses of its members and its staff, the idiosyncracies of some of the organisations and personnel with whom we must maintain a good working relationship, and the exhilaration and frustrations of living in the capital.

I have been particularly glad of the support I have had from Council members and staff in this busy and sometimes stressful learning period. The secretariat is under constant pressure to perform well, often apparently without much understanding from others of the sheer volume of work and the extent of change in progress. On occasions I am aware that our achievement have fallen short of expectations, but not for want of effort. I do ask that members of the profession exercise tolerance in this continuing period of adaptation and development.

High priority is being given to implementing modern information systems but this must be a gradual process. Wordprocessing and computer hardware have been installed and the software is being introduced in stages. The financial package is running and the appointment of a part-time administrative assistant (accounts) has enhanced this aspect of the Council's management, although restraining expenditure is a constant battle in today's economic climate. Some wordprocessing is now being undertaken and the newly appointed secretary/wordprocessor operator is steadily moving more of the routine communications into this medium. The computer programmer is engaged on designing the system and writing the programme for the maintenance of the registers and doctors' records and we hope to load the base data before the end of 1987. The shift from manual to computerised records will have many benefits in the long run, although inevitably there will be some disruption to work flow or "bugs" in the system in the transition phase, particularly while staff are being retrained.

Stage two will focus on linking the Annual Practising Certificate issue exercise to the data base. Automation of the payment method is being studied, including options such as direct credit, direct debit, electronic cashiering or staggered billing. The impact on the collection of the workforce data is an important consideration as the existing method eventually leads to a high response rate and accurate statistics.

Following a number of enquiries, Council policy on the requirements for holding an Annual Practising Certificate has been clarified. All doctors who intend to write any certificates, prescribe, treat or give advice on a one-to-one basis as a registered medical practitioner, must possess a current Annual Practising Certificate and pay the Disciplinary Levy. Those engaged in teaching and research without clinical involvement are exempt. Those who do not hold an Annual Practising Certificate may still render aid to any person in an emergency.

The design of all Council publications, stationery and certificates is being reviewed with the aim of

making them compatible with the new automated office systems and improving accessibility to Council administration by both practitioners and the public. Consideration has been given to the purchase of a facsimile machine but no action taken yet.

The accompanying registration statistics amply demonstrate the ever increasing volume of applications which must be handled, for inclusion in the three registers (main, specialist and general practice). As this report goes to press, we are approaching the 15,000th admission to the New Zealand Medical Register since personal files were created. Requests for amendments (particularly change of address and additional qualifications) and for documents essential for applications for registration with overseas authorities, continue to rise. There is also a constant (sometimes overwhelming) tide of enquiries from overseas doctors interested in coming to New Zealand to live and work, many desperate to escape from harsh political and social climates or to participate in what they see as the excellent opportunities in New Zealand for postgraduate experience and training.

Strenuous efforts are being made to remind employing and training authorities and overseas diplomatic posts of the requirements for interview and documentation of all doctors coming to work in this country. It is of considerable concern that a number of doctors arrive from overseas to take up posts in institutions and the community without having made adequate prior enquiries about their eligibility for registration or the registration requirements. Details can always be obtained from the Council office, but all applicants must be interviewed on arrival, either in Wellington or by an agent of Council in Auckland, Hamilton, Christchurch or Dunedin. They must produce identification, originals (or certified copies) of medical qualifications, Certificates of Good Standing, (not older than three months) from the registration authority where they last practised and a character reference from a recent colleague or employer. Permission to practise cannot normally be given until this process has been completed and fees paid in full. Assistance in promulgating this information would be valuable.

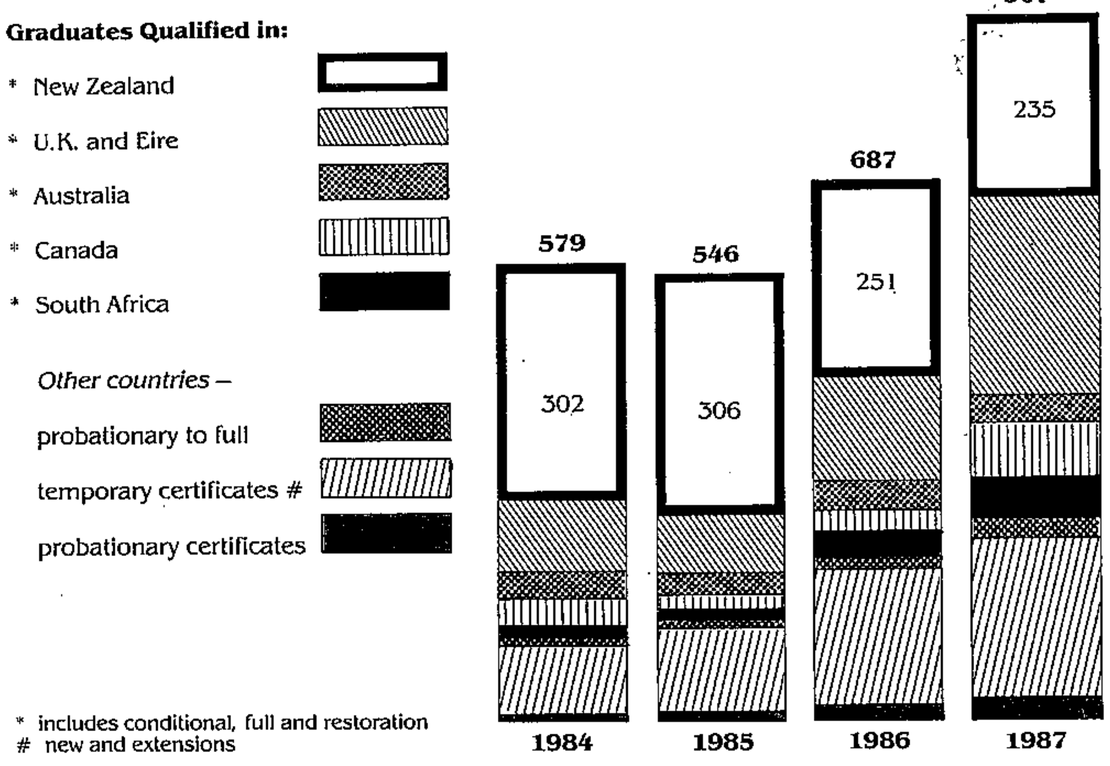
Just as overseas doctors coming to New Zealand need to be aware in advance of our registration requirements, so doctors going abroad from New Zealand are urged to seek similar information from overseas bodies at an early stage in travel plans. We will be able to provide a more efficient service, if doctors intending to work overseas apply for Certificates of Good Standing (and in some cases also Certificates of Registration) in good time, to allow for normal postal and processing delays. In an emergency, documents can be sent by Post Office Bureaufax, but a telephone call (even international) is inexpensive and effective in avoiding last minute panics and embarrassments. The correct fees (currently $22 for each certificate) must be forwarded with the request for a certificate to be issued. If possible the registration authority requiring the certificate should also be specified. Indeed all Australian medical registration boards now expect Certificates of Good Standing to be sent direct to them from the Medical Council of New Zealand. In the past year, just over 400 Certificates of Good Standing and almost 160 Certificates of Registration have been issued by the Secretariat.

Speedy and reliable communication with practitioners is only possible if we know where they are! Prompt notification of changes of address (including advice of overseas addresses) is required by statute but is

often overlooked by busy practitioners. Once again I remind doctors that it is their responsibility to ensure that the Council has a stable address so that the entry for every person on the register is accurate at all times. This address is also retained by the Government Printer and utilised by the Department of Health for the despatch of bulletins to all registered medical practitioners in New Zealand. Monthly amendments to the Register are circulated to a large number of holders of the Register, printed annually as at 30 June. Even this process involves a time lag of as much as six weeks (although this will be reduced when our records are fully computerised) but failure to notify change of address can mean that important mail is being sent to incorrect locations for several months. If doctors cannot be contacted they risk being removed from the register.

Although much of the routine work of the Secretariat pertains to new registrations, maintenance of accurate registers, and administrative support for Council and its committees, a high degree of sensitivity to personal communication and legal precision in handling matters of discipline and fitness to practise is also necessary.

REGISTRATIONS
YEAR ENDING 30 JUNE



* includes conditional, full and restoration
\# new and extensions

AMENDMENTS TO REGISTER
YEAR ENDING 30 JUNE

		1984	1985	1986	1986
(a)	Removals on account of				
	Disciplinary proceedings	1	1	1	2
	Death	47	52	38	48
	Failure to notify change of address	92	38	18	61
	Non-residence of overseas graduates	165	102	45	60
	and at own request	24	27	30	29
(b)	Changes of name	23	25	17	24
(c)	Additional qualifications	120	300	170	177
(d)	Changes of address (approximate figures)	1,800	1,800	1,950	2,050

Interesting discussions on the Council's role in education and the perennial, politically sensitive, debate on the registration of overseas qualified doctors have also been of particular significance this year. All these matters are of particular relevance as we prepare submissions for the revision of the Medical Practitioners Act which we trust will be effected in the next parliamentary term.

Early in my career with the Medical Council, I have been fortunate enough to attend the annual meeting of the Australian Medical Council which includes the meetings of Presidents and Registrars. Very valuable personal contacts, an insight into the principles and practices of the registration bodies, an awareness of common problems and professional collegial stimulation have been the outcome. Liaison with other professional registration authorities in Wellington has also been established. I believe these networks will be beneficial to the Council as it reviews its role and makes plans for the exercising of its functions in the next decade. Constructive comment from practitioners is also welcomed.

Members of the profession are welcome to visit the office if they are in Wellington.

Georgina Jones
SECRETARY

REPORT OF THE MEDICAL EDUCATION COMMITTEE

This Committee met three times during the year. In addition the Chairman of the Committee and Chairman of Council held a special meeting with representatives of the intern supervisors, also attended by representatives of the Resident Medical Officers Association, Department of Health and Council for Postgraduate Medical Education.

The membership of the Committee remained unchanged from that in 1985/86 but Dr W.J. Pryor and Professor R.J. Seddon retired from the Committee in mid-1987.

The main focus of the Committee's activities continued to be on matters concerning conditional registration and in particular the accreditation of hospitals for this purpose. Continuing the pattern of the three-year cycle of visits, in 1986 committee representatives visited hospitals in the Waikato (Te Kuiti, Tokanui, Tokoroa), Thames, Tauranga, Dannevirke, Palmerston North, Wairau, Grey, Oamaru, the Dunedin group, Balclutha and Southland (including Gore). Tokanui Hospital has now been withdrawn from the scheduled list of hospitals approved for the purpose of Section 16 of the Medical Practitioners Act because overall it is no longer appropriate for seventh year intern attachments.

Particular matters concerning the conditional registration year which were addressed again during the year, included the effect of the M10 determination on the educational content of the pre-registration year, peer review activities conducted in hospitals and the role of the intern supervisors.

At the meeting with intern supervisors in August there was a consensus that the M10 determination and the new rosters had affected some educational aspects in the pre-registration year, but the precise effects were still difficult to measure. However, following further discussions with representatives of the Hospital Superintendents Association, Hospital Boards Association, Health Service Personnel Commission and the Resident Medical Officers Association, a submission was made to the Health Services Personnel Commission and this covered eleven points on conditional registration.

The possible inclusion of peer review activities as mandatory or highly recommended procedures in hospitals to be approved for intern training was considered by the Committee and subsequently the following resolution was forwarded to Hospital Boards and Colleges:

"Visitors from the Medical Education Committee when considering intern experience will evaluate and encourage critical assessment of the hospital's medical practice and hospitals should show good reason why one of the accepted forms of peer review cannot be undertaken."

After a fruitful discussion with representatives of the intern supervisors, a clearer appreciation of their important role emerged and provision is to be made for more regular meetings to improve coordination between them and Hospital Boards and the Medical Education Committee.

As part of its responsibilities under Section 9(1)(c) of the Medical Practitioners Act, the Medical Education Committee took further steps towards a plan to monitor more formally the undergraduate medical courses in New Zealand in approving a survey questionnaire to go to the two Medical Faculties and in having observers undertake an assessment of the 5th/6th year examinations.

In April preliminary advice was given to the Medical Education Committee by the Chairman of Council that the Committee might address certain expanded initiatives following approval of these at the June 1987 meeting of Council. Council has acted on the statutory authority given to Council in Section 9(1)(e) of the Act in that the functions of the Medical Education Committee shall include "To perform such other functions as may be imposed on or delegated to it by the Council or by or under any other enactment". Thus Council has now requested the Medical Education to:

1. Maintain an overview of all stages of medical education.
2. Monitor the standards, training and provisions of undergraduate and postgraduate education as required for medical and specialist registration.
3. Promote, and advise on, the achievement of high standards of medical education.
4. Assist in the coordination of medical education whenever possible between the institutions and bodies responsible for its provision and/or granting of degrees and diplomas.

These expanded functions clearly establish the concept that the Medical Education Committee must be concerned with the outcome of medical education at all levels, yet not the provision of it nor its content. (Already in August 1987 the Medical Education Committee has held a special meeting to plan a programme of extended initiatives in 1987/88).

Preparative work has commenced on proposals for possible reform of the role, responsibilities and membership of the Medical Education Committee, these to be considered in any revision of the Act.

W.J. Pryor (retired) and J.D. Hunter
CHAIRMEN

REPORT OF PRELIMINARY PROCEEDINGS COMMITTEE

Complaints of serious misconduct within the profession, which may lead to the charge of "disgraceful conduct in a professional respect" are referred by the New Zealand Medical Association, the Secretary of the Medical Council, or other groups to the Convener of the Preliminary Proceedings Committee. This medical member of the Council along with another medical member and a lawyer, constitute an investigating committee named in the Medical Practitioners Act as the Preliminary Proceedings Committee (PPC).

Unlike the inquisitorial mode of the Medical Practitioners Disciplinary Committee (MPDC), the Medical Council hears discplinary cases in a formal adversarial mode, following thorough investigation and preliminary meeting by the PPC with the people concerned. In the course of an investigation the PPC is empowered to summons witnesses but before the charge is framed it must give the doctor an opportunity to make an explanation in writing and/or in person. The PPC medical members take no part in any Council Hearings which may ensue although the lawyer member normally prosecutes the case.

It is becoming apparent that this process of initial inquiry is becoming very time consuming and expensive, for the requirements of natural justice and the possible threat of erasure demand a high standard of proof. Some cases have taken many months to prepare, often after involvement with police and Health Department investigators.

In addition, any Court conviction of a medical practitioner which would attract a potential sentence of three months imprisonment or more, is also prepared by the PPC for Council's consideration as evidence of disgraceful conduct. One such case occurred this last year.

The PPC members have been actively involved during the past year in discussions with the New Zealand Medical Association representatives about revised and more efficient disciplinary procedures. A revision of Section III of the Medical Practitioners Act is necessary and outlines of the proposals have already been published twice in the New Zealand Medical Journal.

Criticism of closed hearings in professional tribunals continues. It is important to appreciate that the names of patients and other complainants involved in each charge, are almost always suppressed. This aspect of privacy for the complainant must be emphasised, for it is felt that many serious complaints would not be made if the glare of full publicity was to face a complainant or complainants. Changes in the Act will, we believe, include provision for open hearings as in the Law Practitioners Disciplinary Tribunal. It will be essential to provide anonymity to patients and other complainants where appropriate.

Some situations of apparent misconduct arise from the actions of doctors who are not fit to practise because of impairment from physical or mental disability or substance abuse. This is now a major concern here as in other countries. Discipline and Health procedures must be kept separate, each dealing with cases appropriate to its brief. Cases therefore may need to be referred from one committee to the other.

EXTENT OF PROCEDURES

At any one time, the PPC may have a dozen cases under consideration. Following investigation, the doctor concerned may receive written warning that the Committee is aware of the allegations and the circumstances without further hearing.

Some cases are referred to the MPDC for hearing and the PPC functions as prosecutor. One such case referred in the past year involved alleged improper conduct with female patients.

Three cases proceeded to full hearings by the Medical Council. These three doctors were found guilty of disgraceful conduct in a professional respect. One doctor's practise was modified significantly. Two erasures were ordered. Two of these cases involved serious mismanagement of controlled drugs and raised issues of excessive and inappropriate prescribing (NZMJ 100, 436:1987).

One major and prolonged case eventually resulting in erasure (NZMJ 100, 870:1986) involved the PPC in appearances in the High Court for a Judicial Review and in the Court of Appeal. The Court of Appeal Judgment in favour of the PPC established an important legal precedent. This judgment approved the amalgamation of a number of separate charges, even of separate acts of misconduct, as indicating a manner of conduct of practice which could justify an omnibus charge of cumulative disgraceful conduct.

The PPC continues to receive complaints about sexual advances to female patients and draws the attention of the profession to the great need for care in chaperoning examinations which could be construed as sexual harrassment or interference.

Dr Watson is retiring as Convener of the PPC after a six year involvement in consideration of allegations of serious professional misconduct. Sixteen cases have had defended hearings before the Medical Council. In each case the charge of disgraceful conduct in a professional respect was found to be proven by the Medical Council. In one other case heard by the MPDC a finding of professional misconduct resulted.

As final observation the Convenor indicates that nearly all complaints received by the Preliminary Proceedings Committee were serious and with foundation. It is distinctly unusual to have complaints referred to the PPC, which lack substance, or could be considered frivolous and vexatious.

E.C. Watson (CONVENER)
D.S. Cole
D.J. White

REPORT OF THE SPECIALIST REGISTRATION SUB-COMMITTEE

Accession to the Specialist Register continued over the last twelve months at a similar rate to the previous year. One hundred and twelve specialists have been registered since the last report was compiled. This year the majority came from four specialty areas – 23 joined the various surgical categories, 16 are physicians, 16 are psychiatrists and 14 are anaesthetists. At present, the total number of registered specialists in New Zealand stands at 1,985. (Number in each category is shown in the table below.)

The category of Specialist-Eligible has been utilised in an informal way, and in the past year 20 doctors have been determined as Specialist-Eligible. The assessment of acceptability of this category to the Referral Bodies is still being made, but informal discussions with young doctors gives the impression that they find it helpful to be so designated, for they can then be more positive in their career planning. Of the first 29 doctors who were designated Specialist-Eligible, 19 have been admitted to the full Specialist Register.

An activity that has increased in recent times has been the determination of possible Specialist status for doctors from abroad applying for Specialist positions in New Zealand hospitals. It is now required by the Health Services Personnel Commission that overseas appointees can be reasonably assured that Specialist Registration will be available to them, though for some full determination must await the completion of their Probationary Registration period. This assessment adds another burden to the bodies to whom the Medical Council refers all matters of Specialist Registration. The Council acknowledges the work done on behalf of the profession by these colleagues who assess the information about applicants, and make recommendations.

The Specialist Registration regulations do have provision for the removal of names from the Specialist Register, but this has seldom, if ever been invoked. A name is removed, of course from the Specialist Register when it lapses from the General Register. There is now particular need for members of the profession to demonstrate continuing competence in their areas of practice. In the near future the Medical Council must begin the process of removing names from the Specialist Register because of incompetence. The Convener would be interested to have information from, and discussions with, members of the profession in relation to the practicalities of reassessment of competence for retention on the Specialist Register. The opinions of the Referral Bodies have already been sought on this matter, and they would have a central role in policy and decisions on individual doctors.

Robin H. Briant
CONVENER

NUMBERS IN EACH SPECIALTY AT 30 JUNE 1987

Anaesthetics	200
Community Medicine	121
Dermatology	35
Diagnostic Radiology	118
Gynaecology	1
Internal Medicine	355
Obstetrics	1
Obstetrics and Gynaecology	154
Ophthalmology	82
Orthopaedic Surgery	94
Otolaryngology	57
Paediatrics	113
Pathology	134
Psychological Medicine or Psychiatry	179
Radiotherapy	18
Surgery and Sub-Specialities	
Cardiothoracic Surgery	17
General Surgery	215
Neurosurgery	13
Paediatric Surgery	4
Plastic Surgery	25
Urology	29
Venereology	20
Total	1,985

REPORT OF THE MEDICAL PRACTITIONERS DATA COMMITTEE

The Data Committee held one formal meeting during the year to review current administrative arrangements for the provision and analysis of the medical workforce questionnaire, the cost of data processing and matters relating to access to the data bank. The next major printing of questionnaire forms is due for use in 1988 and any proposed modifications are to be considered by Council later in 1987.

The Committee noted the increasing number of enquiries and requests for use of material, particularly for specific professional groups. Council's policy has been reconfirmed in that confidentiality and anonymity must be guaranteed before information is released. Only professional representatives or organisations, as opposed to commercial agencies, have potential access to data. Only statistical information is released or material mailed to a listing of practitioners on behalf of the investigator. Justification of the research and the bona fides of the investigating body must be provided in a formal application to Council. With the increasing demands for assistance Council has been requested to review its statement of policy on access to the data base.

Selected figures for the 1986 New Zealand Medical Workforce are given in tables 1 and 2. These show a further increase in the total active workforce as well as in each of the categories specified in table 2 excepting one (Medical Officers Special Scale group). The new total of 5,747 signifies a 14 per cent increase over the last five years, the 1981 figure being 5,037. New Zealand medical graduates constitute 73 per cent of this total and the general practitioner sector, although slightly increased, is holding at 37 per cent of the workforce.

Temporary registrants show an increase from 102 in 1985 to 177 in 1986, this reflecting the result of the limited service scheme introduced by the Minister of Health. This figure is not included in the total (full registration) active workforce figure of 5,747.

Other more detailed information on the medical workforce is provided in the latest publication from the National Health Statistics Centre, "The New Zealand Medical Workforce Statistics, 1986" (ISSN 0111-7793).

J.D. Hunter
CHAIRMAN

Table 1

NEW ZEALAND MEDICAL REGISTRATION INFORMATION

as at 30 June 1987

	1987
Total practitioners on register	8,794
Total practitioners with practising certificates	6,390
New Zealand population (June 1987)	3,279,500
Temporary registrants	205
New probationary registrants	32
Names removed from register (various reasons)	152
Practitioners deceased	48

Table 2

NEW ZEALAND MEDICAL WORKFORCE 1986

	1982		1983		1984		1985		1986	
	Total	N.Z. Graduates	Total	N.Z. Graduates	Total	N.Z. Graduates	Total	N.Z. Graduates	Total	N.Z. Graduates
Active	5210	3666	5403	3854	5437	3936	5556	4095	5747	4188
Full-time Equivalents	4894.4	3475.3	5043.8	3634.5	5061.3	3704.1	5156.1	3834.3	5330.3	3913.5
House Officers	611	539	648	599	627	598	628	600	668	568
Registrars	623	439	662	495	695	565	718	592	746	630
Medical Officers Special Scale	159	80	166	81	159	77	150	75	149	67
General Practitioners	1908	1271	1968	1321	1998	1353	2106	1473	2141	1512
Other Primary Medical Care	61	34	78	43	89	55	95	62	103	70
Specialists	1748	1255	1784	1267	1770	1239	1767	1248	1819	1272
Miscellaneous (non-specialist)	100	48	97	48	99	49	92	45	121	69

THE PROBATIONARY REGISTRATION EXAMINATION IN NEW ZEALAND (PRENZ)

This examination, for foreign medical graduates who intend to remain permanently in New Zealand but who do not have basic medical qualifications which entitle them to full registration initially, has been conducted annually in February since 1984. Candidates have in the past been accepted when they could demonstrate (through interview) an adequate standard of English and could provide evidence of permission to reside in New Zealand. The table below shows the performance of candidates in the years 1984 to 1987. The examination has consisted of written papers over two days designed to test knowledge of clinical science at a level expected of fifth year New Zealand medical students, and, for those successful in the written section, assessment of clinical skills, patient management and communication by a classical clinical examination (short and long cases and an optional viva) at the level expected of sixth year (or qualifying) students in New Zealand. The Universities of Auckland and Otago have compiled the examination and marked the candidates performance and the fees for the examination have been set to make PRENZ self-financing if possible. A similar format for PRENZ will be used in February 1988.

After February 1988, PRENZ will be offered twice annually, most likely in August and February. The newly established PRENZ Board of Examiners has been reviewing the content and administration of the examination and expects to make some modifications to permit not only economies of scale in the administration and fee structure, but increased opportunities for candidates to demonstrate their competence to proceed towards full registration. In this respect the decision has already been taken to increase the frequency of the examination and to accept candidates who are living in New Zealand and wish to remain long-term, irrespective of their immigration status at application. Such candidates will as usual firstly be interviewed by an agent of Council and secondly be assessed for competence in English. Serious consideration is being given by the PRENZ Board to introducing a formal assessment of competence in English. A pass in this assessment would then become a prerequisite for admission to the written section of PRENZ. Advice is being sought from the Council on Overseas Professional Qualifications (COPQ) in Canberra and from the English Language Institute at Victoria University of Wellington, on the most appropriate method of testing the ability of a foreign medical graduate to communicate in the New Zealand medical environment.

Full details of the "newlook" PRENZ will be available in late March or early April 1988. Fees, closing dates for applications, examination centres, dates, content of the examination and guidance on appropriate resources for preparation for PRENZ will be published. Candidates who obtain offers of employment from Hospital Boards in the period leading up to their attempting PRENZ will be eligible for the issue of Certificates of Temporary Registration, provided their English is adequate and their registration documentation complete.

SUMMARY OF PRENZ RESULTS 1984 TO 1987

Key: [ ] pass after re-examination ( ) conceded pass (in written section) [2]second attempt [3]third attempt

Country of Training	1984 Written Sit	1984 Written Pass	1984 Clinical Sit	1984 Clinical Pass	1985 Written Sit	1985 Written Pass	1985 Clinical Sit	1985 Clinical Pass	1986 Written Sit	1986 Written Pass	1986 Clinical Sit	1986 Clinical Pass	1987 Written Sit	1987 Written Pass	1987 Clinical Sit	1987 Clinical Pass	Overall Pass Rate
China									1	–							0/1
Egypt					1	1	1	[1]									1/1
France									–								0/1
India	2	–			2[2]	2	2	1+[1]	1	1	1	1	7	3	3	1+[1]	5/12
Japan									–								0/1
Netherlands					1	1	1	1	1	[1]	1	[1]					2/2
Pakistan	1	–											1[3]	1	1	1	1/3
Peru	1	–			1[2]	–			–								0/3
Philippines	2	1	1	[1]													1/3
Rumania									–								0/1
Switzerland					1	–			–				1	–			0/2
Taiwan													1	1	1	1	1/1
W. Germany					2	1	1	[1]	–				5[3]	(1)	1	[1]	2/9
Vietnam	1	1	1	1													1/1
Zambia													1	–	6	5	0/1
	7	2	2	2	8	5	5	5	9	2	2	2	17	6	6	5	14/41
	29%				63%				22%				35%				34%

REPORT OF THE FINANCE AND MANAGEMENT COMMITTEE

This report covers the period from 1 July 1986 to 30 June 1987 although the financial statements cover the period from 1 April 1986 to 31 March 1987.

The Committee has met nine times. All its members reside in Wellington, so that in addition to the formal meetings they are readily available to assist the Council staff in an advisory capacity.

I. COUNCIL PREMISES

The new premises in the ANZ Bank Building, Courtenay Place, have been in use for just over a year now, and are very satisfactory both for the staff and for Council meetings. The Board Room is available for hire to other professional bodies. The appearance of the offices has been enhanced by the acquisition of the winning painting, photography, weaving and pottery entries at an art competition for doctors and their families, sponsored by the Council at the New Zealand Medical Association Centennial meeting in Auckland in May 1987.

The original 1985 budget price for the architecturally designed partitioning and total furbishing of the premises was $175,000. The final cost was $196,000, which was completely paid from the Building Fund.

The Building Fund was established in 1982 with $15,000 from Council general funds, and a further $15,000 was added in 1983. There were no further additions to it from Council funds. The major contribution came from capital gains from the sale of the Webb Street property in 1984 and interest from the investments of this sum.

II. COMPUTERISATION

Following assessment of the Council's needs by the consultant firm, Computer Sciences of New Zealand Limited, a contract was drawn up early in 1987 with Micro-Solutions Limited for the supplying of a fully customised system. The word processor and the financial package are now functional.

A sum of $1,200 was paid in the previous financial year from the General Fund for preliminary investigations. The remaining costs for consultancy, hardware and software have been totally met from the Building Fund. They amount to $55,526, less a contribution of $6,500 from the Dental Council. The Council has therefore spent $49,026 on computerisation in the past financial year. A further $7,424 has been paid out in the period from 1 April to 30 June 1987. It is estimated that costs will amount to a further $13,000 over the next year.

III. INCOME

The Council's total income for the 1987 financial year was $454,069, an increase of $164,984 on 1986.

(a) Annual Practising Certificates and Registration Fees

Fees for annual practising certificates and registrations are the largest contributors to the Council's income. Of the increased income an extra $113,938 came from annual practising certificates. This was partly due to an increase in the level of this fee from $25 in 1985 to $40 in 1986, and partly to the rise in the number of annual practising certificates issued. The other source of income contributing significantly to the increased total, was an extra $26,205 from registration fees. Part of this total is from the upsurge of overseas doctors registering to fill temporary junior hospital posts in a service capacity. This followed the negotiation of the new M10 determination for junior doctors in 1985 and the consequent decision by the Department of Health to recruit personnel from overseas in quite large numbers.

The annual setting of these fees by Regulations, on the advice of the Minister of Health, continues to be a problem. No matter how carefully a budget is prepared and presented in the November/December period of the previous year, approval of the scale of fees allowed has never been given before the second half of March. This makes it impossible to issue the annual practising certificates in time for doctors to pay and receive a valid certificate signed by the Secretary, prior to 1 April. Moreover, the presence of continuing inflation makes the setting of an accurate budget in October 1986 for the financial year ending 31 March 1988, an extremely difficult task.

With the revision of the Medical Practitioners Act now being undertaken, it is planned to request the removal of the Regulations for the setting of fees, and have the fees set by resolution of the Medical Council as already applies for the disciplinary levy. The last two Ministers of Health had both agreed to this in principle.

The current fees for various Medical Council services are shown on page 37.

(b) Other Income

(i) Dental

The Council Secretary is also Secretary for the Dental Council and she and her staff administer all the Dental Council business. The volume of work done for the Dental Council is very small compared to that of the Medical Council. The Dental Council administration fee was increased substantially in 1986 and will be reviewed annually.

(ii) Interest

This increased by $3,864 over the previous year to $22,933. Long term investment is not now possible as recent governments have not allowed the Council to accumulate funds. Debenture stock have to fulfill authorised trustee status according to the Trustee Amendment Act 1974. A variety of investments are made in the April/May period when the majority of the Council's income is received and are withdrawn as required during the financial year.

(iii) Medical Registers and Monthly Amendments

Income from these increased by $9,626 to $15,906 as they have now been costed on a "user pay" basis, whereas previously many registers and all amendments were distributed free of charge.

IV. EXPENDITURE

Total expenditure for the 1987 financial year was $446,392, an increase of $138,972 on 1986. Rental/property expenses were listed separately last year but are now included under "Administration and Operating Expenses".

(a) Salaries

At $200,496, this continues to be the largest item and is $43,118 more than in 1986. Permanent and temporary staff have been combined as one item in this year's schedule of expenses. The staff situation has been very much more settled, but it will always be necessary to employ temporary staff at peak periods.

(b) Medical Workforce and Associated Expenses

The net figure paid by the Council after the Department of Health Grant of $20,000 was $13,884. The $20,000 grant had not been reassessed since 1982 and submissions have been made to the Department for a review.

(c) Probationary Registration Examination Expenses

The net cost to Council this year was $3,773, as the level of fees collected from candidates unfortunately did not

cover the increased costs of the examination. Discussions are under way with the University of Otago to obtain more precise estimates for the 1988 examinations which should be self-funding.

(d) Other Administration and Operating Expenses
Postage, printing and stationery, telephone and tolls, have all increased by significant amounts. These are accounted for by a greater volume of work going through the office as well as by inflation.

(e) Council and Committee Expenses
At $57,265 these were $11,793 more than last year due in part to an extra meeting of the Medical Education Committee and rises in travel and accommodation expenses.

(f) Fees and Honoraria
These were increased to take effect on 10 June 1987.

(i) Ordinary Council Meeting Fees
These were based on a percentage increase in Public Service salaries following on recommendations from the Higher Salaries Commission in January 1987. The daily attendance fees are now $200 for the Chairman and $172 for members.

(ii) Honoraria
The Council Chairman's Honorarium is fixed at 1/20th of the 4th merit step of the Hospital Specialists' Scale. It now stands at $4,812. The Convener of the Preliminary Proceedings Committee receives 70% of this sum – $3,368 and the Chairman of the Finance and Management Committee 20% – $962..

(iii) Fees for Medical Council Disciplinary and Medical Practitioners Disciplinary Committee Hearings
Following proposals from the New Zealand Medical Association, these were increased to $300 a day or $150 per half day.

V. COUNCIL INCOME/EXPENDITURE SUMMARY

For the first time since 1984 the Council has ended the financial year with a net surplus, amounting to $7,677. This compares with a net deficit of $18,335 in 1986 and of $23,890 in 1985. This is to some extent fortuitous, as expenses exceeded those budgeted for, but income was fortunately also greater than had been expected. With inflation still not under control, the setting of the Annual Practising Certificate fee at $55 for the 1987/88 financial year appears to be at a realistic level.

VI. DISCIPLINARY RESERVE

Total disciplinary income amounted to $178,093, largely coming from the disciplinary levy of $20.

Disciplinary expenses totalled $304,534, a very large increase of $141,770 over the 1986 figure.

The disciplinary reserve has been totally eroded from $121,261 to a deficit of $5,180. The disciplinary levy for 1987/88 was set in March this year at $25. It may well be that this proves to be insufficient.

Disciplinary costs, which include Medical Practitioners Disciplinary Committee expenses, are impossible to predict accurately. The number of cases being investigated and coming before the two bodies and the number of appeals, do not arise at a steady level and vary tremendously in the costs that they generate. During the last year the Council had a five day disciplinary hearing in Auckland and a three day hearing in Christchurch, both quite separate from ordinary Council meetings.

The total costs relating to all the legal processes regarding one doctor amounted to about $56,000. This covered a period of more than one year.

Some of the costs can be recovered from the doctor if the charge is proven, or the appeal dismissed, but often the imposition of costs does not necessarily mean that they will be paid. If a case goes on appeal to the High Court this causes a further delay in their possible recovery.

At present about $62,000 is owed to the Council by four doctors. Where appropriate a debt collecting agency is now being employed by the Council for the first time.

The costs of running the soon to be established National Counselling and Welfare Service for Impaired Doctors will have to be met, even though this body will be totally independent of the Medical Council. Section 50 of the Medical Practitioners Act gives authority for this to be met from the Disciplinary Fund.

A considerable increase in the Disciplinary Levy can therefore be anticipted for 1988.

VII. CONCLUSION

In the Annual Report last year, I concluded by saying that "with the acquisition of premises which should be near permanent and the appointment of a new Secretary, we look ahead to a more stable coming twelve months". Fortunately, this has indeed been the case. The decision by the Secretary to increase the staff by the appointment of a part-time accounts officer has proved to be well justified. Financial records are accurately kept, computerised, and good liaison exists with the Council's auditors.

After six and a half years as a member of the Medical Council, and three and a half years as Chairman of this Committee, I shortly conclude my term of office on the Council, confident that the Council's affairs will be well managed in the future.

T. Farrar
CHAIRMAN

AUDITORS' REPORT

Miller, Dean & Partners

CHARTERED ACCOUNTANTS
WELLINGTON AND CARTERTON

AUDITORS' REPORT

TO MEMBERS OF THE MEDICAL COUNCIL OF NEW ZEALAND

We have examined the books and vouchers of the Council in accordance with accepted auditing standards and have carried out such procedures as we considered necessary.

The financial Statements have been prepared under the historic cost convention, by us from information shown in the Books of the Council and in our opinion are properly drawn up so as to give a true and fair view of the financial position of the Council as at 31 March 1987 and results of its activities for the year ended on that date.

Miller Dean + Partners

CHARTERED ACCOUNTANTS

WELLINGTON

22 October 1987

NOTES TO ACCOUNTS

1. GENERAL ACCOUNTING POLICY

The general principles recommended by the New Zealand Society of Accountants for the measurement and reporting of results and financial position on the basis of historical costs (except for the particular policies stated below) have been adopted.

Particular Accounting Policies

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

Furniture and Fittings	10% p.a.
Office Equipment	20% p.a.
Office Alterations	10% p.a.

Computer installation – the full cost, including consultancy has been capitalised (except for preliminary investigation carried out in 1986) and will be depreciated at 20% p.a. No depreciation has been claimed in the current year as the system was not operational.

(b) *Legal Expenses and Recovery.* No provision has been made for legal proceedings which have not been settled and/or claimed for at balance date. Recovery of legal expenses is accounted for on a cash basis.

2. CHANGES IN ACCOUNTING POLICIES

There have been no changes in accounting policies from those adopted in the previous year.

3. FIXED ASSETS

	Cost 31/3/87	Book Value 1/4/86	Depreciation For Year	Book Value 31/3/87	Accumulated Depreciation to 31/3/87
Computer	49,026	–	–	49,026	–
Furniture & Fittings	55,819	3,667	5,582	48,670	7,149
Office Equipment	15,766	8,811	3,153	7,153	8,613
Office Alterations	145,428	115,736	14,542	130,886	14,542
	266,039	128,214	23,277	235,735	30,304

4. INVESTMENTS

		1987	1986
(a)	**General Fund**		
	BNZ Finance Limited – Telephone Call Deposit	104,223	53,119
(b)	**Disciplinary Fund**		
	BNZ Finance Limited – Telephone Call Deposit	22,440	8,518
	Equiticorp Holdings Limited Debenture @ 20.5% Maturing 7/5/87	59,888	–
	Barclays New Zealand Limited Debenture @ 22.75% Matured	–	100,837
		82,328	109,355
(c)	**Building Fund**		
	BNZ Finance Limited – Telephone Call Deposit	7,218	–
	Michael Veal & Associates 1st Mortgage @ 11% Matured	–	20,000
	Westpac Merchant Finance Limited Debentures @ 13.25% & 18% Matured	–	169,257
	Marac Holdings Limited Debenture @ 16.5% Matured	–	22,248
	Bank of New Zealand – Autosave – Matured	–	1,393
		7,218	212,898

BNZ Finance Telephone Call Deposits in the 1986 Balance Sheet have been transferred from Current Assets to Investments.

5. BUILDING RESERVE

Balance as at 1/4/86	124,751
Plus Interest Credited or Accrued for Year	12,233
	136,984
Less Transfer to Accumulated Capital – Alterations to Office, Office Furniture and Computer Installation	128,739
Balance as at 31/3/87	8,245

6. CONTINGENT LIABILITY – TAXATION

The question has been raised regarding the Council's status on taxation of income from interest received. Legal opinion is currently being sought.

BALANCE SHEET

for Year ended 31 March 1987

	1987	1986
CURRENT ASSETS		
Petty Cash	50	50
General Fund Cheque Account at ANZ Bank	25,256	9,127
Disciplinary Fund Cheque Account at BNZ	–	24,047
Payments in Advance and Sundry Debtors	20,665	8,412
Interest Accrued	4,068	2,989
	50,039	44,625
INVESTMENTS (Note 4)		
General Fund	104,223	53,119
Disciplinary Fund	82,328	109,355
Building Fund	7,218	212,898
	193,769	375,372
FIXED ASSETS (Note 3)	235,735	128,214
	479,543	548,211
CURRENT LIABILITIES		
Disciplinary Fund Cheque Account at BNZ	521	–
Sundry Creditors	134,066	131,684
Payments Received in Advance	88,240	53,280
	222,827	184,964
CAPITAL ACCOUNT		
Accumulated Capital	253,651	117,235
Disciplinary Reserve – (Deficit)	(5,180)	121,261
Building Reserve (Note 5)	8,245	124,751
	256,716	363,247
	479,543	548,211

MEDICAL COUNCIL OF NEW ZEALAND

REVENUE STATEMENT

for Year ended 31 March 1987

	1987	1986
FEES RECEIVED		
Annual Practising Certificate	277,930	163,992
Certificate of Good Standing	8,247	7,613
Medical Registration Cetificate	2,782	2,130
Change of Name	401	370
Registration Fees – including conditional, temporary, probationary and restoration	101,015	74,810
Specialist Registration Fee	7,110	5,508
Probationary Registration Examination Fee	7,000	3,313
INCOME FROM FEES	404,485	257,736
OTHER INCOME		
Administration Fee – Dental Council	10,500	6,000
Interest Received	22,933	19,069
Sales of Medical Registers	15,906	6,280
Sundry Income	245	–
INCOME FROM OTHER SOURCES	49,584	31,349
TOTAL INCOME FOR YEAR	454,069	289,085
Less Expenses as per Schedule	446,392	307,420
NET SURPLUS (DEFICIT) FOR YEAR ENDED 31/3/87	7,677	(18,335)
Accummulated Capital Brought Forward	117,235	19,834
	124,912	1,499
Plus Transfer from Building Reserve (Note 5)	128,739	115,736
ACCUMULATED CAPITAL	253,651	117,235

MEDICAL COUNCIL OF NEW ZEALAND

SCHEDULE OF EXPENSES

for Year ended 31 March 1987

	1987	1986
ADMINISTRATION AND OPERATING EXPENSES		
ACC Levy	2,494	447
Audit and Accountancy Fee	5,070	6,720
Agents Registration Fees	5,560	–
Cleaning	2,041	1,455
Computer Consultants	–	1,200
Depreciation	23,277	3,377
Electricity	2,743	1,017
General Expenses	5,762	4,157
Legal Expenses	1,534	1,065
Micro Film Files	417	255
Medical Workforce and Associated Expenses (Net after Government Grant)	13,884	12,500
Photocopying Expenses	3,395	1,774
Probationary Registration Examination Expenses	10,773	1,824
Postage	15,682	8,145
Printing and Stationery	30,439	20,871
Rent and Insurance	29,457	14,986
Repairs and Maintenance	2,846	–
Salaries – Permanent and Temporary Staff	200,496	157,378
Superannuation	9,077	9,575
Staff Recruiting – Advertising and Placement	15,615	11,002
Telephone and Tolls	8,565	4,200
TOTAL ADMINISTRATION & OPERATING EXPENSES	389,127	261,948
COUNCIL AND COMMITTEE EXPENSES		
Council Expenses		
– Chairman's Overseas Travel	2,171	1,211
– Chairmen's Honoraria	5,250	4,082
– Fees, Travelling and Accommodation Expenses	22,509	28,969
Medical Education Committee		
– Fees, Travelling and Accommodation Expenses	18,557	5,538
– Hospital Visits	8,778	5,672
TOTAL COUNCIL AND COMMITTEE EXPENSES	57,265	45,472
TOTAL EXPENDITURE	446,392	307,420

MEDICAL COUNCIL OF NEW ZEALAND

REVENUE STATEMENT FOR DISCIPLINARY RESERVE ACCOUNT

for Year ended 31 March 1987

	1987	1986
Levies Received	139,260	66,122
Plus Interest Received	33,554	42,690
Recovery of Disciplinary Costs	5,279	4,700
	178,093	113,512
Less Payments:		
Accounting and Audit Fees	1,000	–
Fees and Honorarium	21,253	12,464
Legal Expenses (Medical Council and Preliminary Proceedings Committee)	163,927	101,363
Medical Practitioners Disciplinary Committee	73,835	40,022
General Expenses	5,905	5,519
Travel and Accommodation Expenses	20,777	3,396
Expert Witness's Reports	6,223	–
Stenographers Fees and Expenses	7,696	–
Establishment Costs for Impaired Doctors Programme	3,918	–
TOTAL EXPENSES	304,534	162,764
Net Deficit for Year Ended 31/3/87	126,441	49,252
Disciplinary Reserve Balance brought forward	121,261	170,513
TOTAL DISCIPLINARY RESERVE – (Deficit)	(5,180)	121,261

FEES

TO BE PAID ON APPLICATION FOR MEDICAL COUNCIL SERVICES DURING COUNCIL FINANCIAL YEAR 1 APRIL 1987 TO 31 MARCH 1988

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

	Fee	GST	Total To Pay
REGISTRATION: (Conditional or Full)			
On deposit of evidence of qualifications	144.00	14.40	158.40
For provisional certificate	20.00	2.00	22.00
For annual practising certificate	55.00	5.50	60.50
For disciplinary levy	25.00	2.50	27.50
Total fees on registration	244.00	24.40	268.40
OTHER:			
For certificate of temporary registration	144.00	14.40	158.40
For eligibility for probationary registration	80.00	8.00	88.00
For certificate of probationary registration	80.00	8.00	88.00
For *full registration (from probationary, including practising certificate)	150.00	15.00	165.00
For annual practising certificate including disciplinary levy	80.00	8.00	88.00
For *restoration of name to Register after removal therefrom (including provisional certificate)	210.00	21.00	231.00
For initial entry on Specialist Register	50.00	5.00	55.00
For entry on Specialist Register in a second or further specialty	10.00	1.00	11.00
For initial entry on Indicative Register of General Practitioners	50.00	5.00	55.00
For change of name or other entry in Register, excluding change of address or entry of additional qualifications (free)	20.00	2.00	22.00
For Certificate of Good Standing	20.00	2.00	22.00
For Certificate of Registration (or other document in connection with applications to register in another country)	20.00	2.00	22.00
For any inspection of the Register	8.00	0.80	8.80

* Includes Annual Practising Certificate and Disciplinary Levy to be paid at the time of this application


MEDICAL COUNCIL
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