Annual Report 2003

2003 Facts
at a glance

	2002	2003
Doctors registered		
• trained in New Zealand	279	315
• trained overseas	1,089	1,345
• temporary	844	899
Total practising doctors as at 31 March 2003	9,964	10,355
Doctors on vocational register	5,834	6,073
Candidates for NZREX examination	83	167
Passes NZREX	48	101
Complaints	70	125
Complaint enquiries		262
Concerns about competence	73	50
Competence reviews	37	58

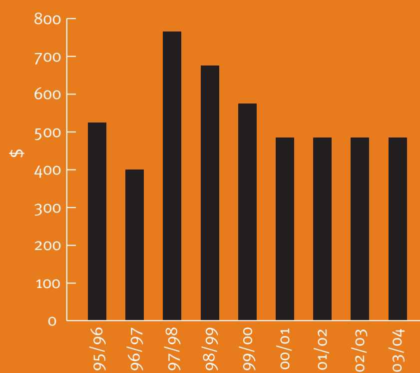
Staff members
of the Medical Council of New Zealand

1st row
Tania Turfrey
Philip Girven
Heather Pettigrew (left)
Raewyn Ogilvie (right)
Betty Wright

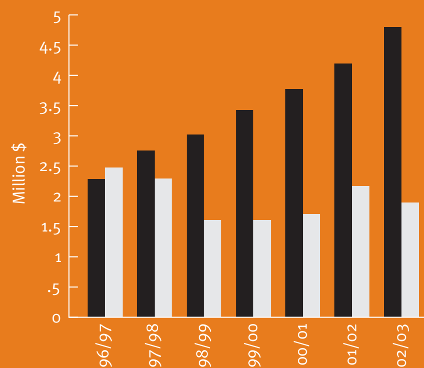
2nd row
Sharon Mason (left)
Diane Latham (right)
John de Wever
Sue Ineson
Nicolé Mistal

3rd row
Hannah Bates (left)
Debbie North (right)
Barbara Eagle
Gyllian Turner
Farina Bains

4th row
Lynne Urquhart
Emma Worden (left)
Nicolé Mistal (right)
Sue Colvin
Tony Hanna

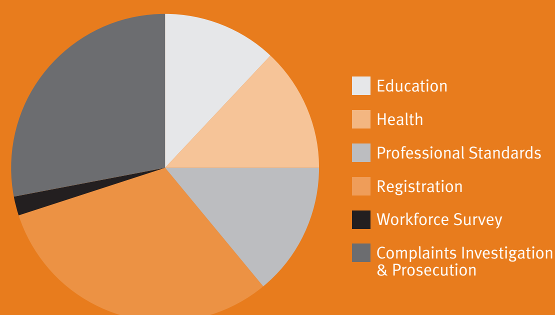


Annual practising certificate fee



Total expenditure (excludes examination fund)

Complaints Investigation & Prosecution Fund
General Fund



Total expenditure

Annual Report 2003

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The Medical Council of New Zealand is pleased to submit this Annual Report for the year ending 31 March 2003 to the Minister of Health. The report is presented in accordance with section 130 of the Medical Practitioners Act 1995 and incorporates the report of the Medical Practitioners Disciplinary Tribunal.

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Medical Council of New Zealand

The purpose of the Medical Council is to ensure that medical practitioners are competent to practise medicine, in order to protect and promote public health and safety.

Four strategic goals support our purpose

1.

To implement mechanisms to ensure doctors are competent to practise

2.

To enhance understanding of the Council and its role to implement the primary purpose of the Medical Practitioners Act 1995

3.

To facilitate self-regulation of the profession in partnership with the public

4.

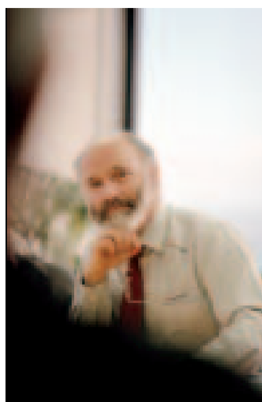
To raise awareness about medical workforce issues

Our core values

Integrity; Openness and accountability; Consistency and fairness; Effectiveness; Commitment; Respect.

Medical Council of New Zealand

Members of the Medical Council at 31 March 2003



Professor John Campbell

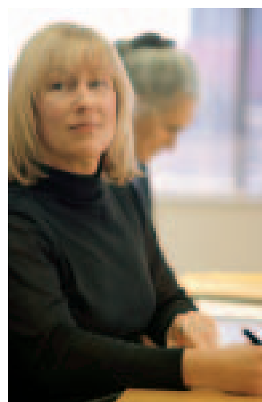
MB ChB Otago 1969, DipObst, MRACP, FRACP, MD Otago 1983
President, Chair of Examinations Committee

Since 1995 Professor Campbell has been Dean, Faculty of Medicine, University of Otago. He is also Professor of Geriatric Medicine and Consultant Physician and Physician in Geriatric Medicine. He is the nominee of the schools of medicine on the Council, appointed by the Minister in 2001. He has numerous professional affiliations. Professor Campbell was a member of the Australian Medical Council Accreditation Committee from 1997 to 2000. He has convened or been a member of government committees on services for the elderly; he is a member of international journal advisory boards for *Age and Ageing* and *Reviews in Clinical Gerontology* and holds other editorial board positions. He has held several World Health Organisation appointments in the Pacific region and elsewhere.

Dr Barnett Bond

MB ChB Otago 1975, FRNZCGP 1986

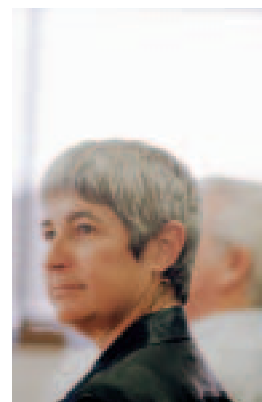
Dr Bond is a general practitioner elected to the Council in 2002, who practised on Waiheke Island from 1994 to 2000. He was part of a group practice in the rural Waikato from 1977 to 1994. He had an obstetric practice and was a teacher in the Family Medicine Training Programme. He did locums in a remote part of Newfoundland and in a small mission hospital in western Thailand.



Dr Kate O'Connor

BHB, MB ChB Auckland 1995, FRANZCR

Dr O'Connor is a radiologist in Auckland, elected to the Council in 2002. She completed her vocational training in diagnostic radiology in 2002 and has worked at Waikato and Tauranga Hospitals. She is a Life Member of the New Zealand Resident Doctors' Association, having participated on the National Executive for six years including two years as National President.



Dr Joanna MacDonald

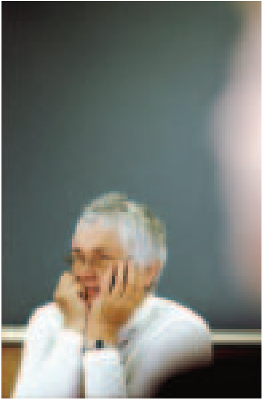
MB ChB Otago 1978, FRANZCP 1986
Chair of Health Committee

Dr MacDonald is a psychiatrist from Wellington, appointed to the Council by the Minister of Health in 2001. She is currently a senior lecturer in the Department of Psychological Medicine at the Wellington School of Medicine and was the Director of the psychiatric registrar training programme for the lower central North Island. She has extensive experience of examination in psychiatry and has spent six years on the Examination Committee of the Royal Australian and New Zealand College of Psychiatrists. Currently she is an ex-officio member of the committee and Chair of the Case History Sub-Committee.

Dr Deborah Read

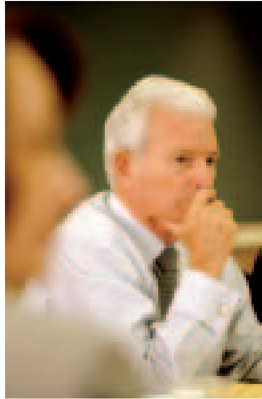
MB ChB Otago 1981, Dip Com Health Otago 1987, MCCM (NZ) 1990, FAFPHM (RACP) 1994
Deputy President, Chair of Education Committee

Dr Read is a public health physician from Wellington, appointed by the Minister of Health to the Council in 2000. She has a special interest in environmental health. She has held positions with the Wellington School of Medicine, the former Public Health Commission and Central Regional Health Authority, Mid-Central Health and the Environmental Risk Management Authority. She was the National Director of Training for the New Zealand Australasian Faculty of Public Health Medicine training programme.



Mrs Heather Thomson

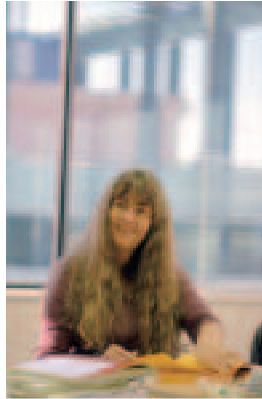
Mrs Thomson is a health service manager from Opotiki. She is a public member appointed by the Minister in 1999. She trained and worked in England as a theatre supervisor for a short time. Later at Middlemore Hospital she established the Young Mothers, Maternity Service, eventually managing the Maternal and Child Health Service at Middlemore Hospital. She has served on many committees and commissions including the Public Health Commission and Maori Health Commission and has had advisory roles in many areas of community development.



Dr Philip Barham

MB ChB Otago 1954, Dip Obst Auckland 1959, MHP Ed, NSW, MRNZCGP, FRNZCGP, MRCGP

Dr Barham is a retired general practitioner from Whangaparaoa, elected to the Council in 2001. He has been involved with the Medical Council since the late 1980s in educational and examination roles. He was a foundation Director of the Goodfellow Unit, and he spearheaded development of activities including quality assurance, rural health and distance learning diplomas. Other positions he has held include Associate Dean of the School of Medicine, Auckland University, and Member/Chair of the Postgraduate Medical Committee.



Ms Jean Hera

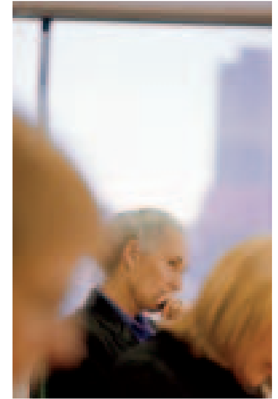
NZ Certificate Science Palmerston North 1977, Bachelor of Social Work (Hons) Massey 1990, PhD Massey 1996

Ms Hera is the Coordinator of Palmerston North Women's Health Collective and is a public member of the Council appointed by the Minister of Health in 2001. Previously she was a tutor and student placement supervisor in the Social Policy and Social Work department for Massey University. She is a member of the Low Income Subcommittee, Palmerston North City Council. She has had 20 years' involvement in many community organisations including membership of the Federation of Women's Health Council's Aotearoa NZ 1996.

Dr Pippa MacKay

MB ChB Otago 1978, Dip Obst Otago 1984, FRNZCGP 1998

Dr MacKay is a general practitioner from Christchurch elected to the Council in 2002. She trained vocationally here and in the United Kingdom, after which she became a partner in general practice in Christchurch in 1987. In 1989 she was elected to the National Executive of the New Zealand Medical Association, and was Chair of the Association from 1999 to 2001. She was appointed to the Establishment Board, then the Board proper, of the Southern Regional Health Authority from 1991 to 1996, also holding an appointment as Maternity Mortality Assessor over that time.



Miss Carolynn Bull

MA Canterbury 1968, Dip Tech Chch Coll of Ed 1970, LLB Canterbury 1977

Miss Bull is a family law practitioner from Christchurch and is a public member of the Council, appointed by the Minister since 1997. She has held several appointments including membership of Lincoln University Council and Christchurch Polytechnic Council. In 1989 she was appointed Human Rights Commissioner, which involved her representing the Commission at the United Nations. Memberships include Te Runaka Ki Otautahi O Kai Tahu (Maori Social Services Charitable Trust); Te Ture Manaaki O Rehua (Maori Legal Services Charitable Trust); and Roopu Awhi Ora (Marae Based Maori Health Clinic Charitable Trust).

President's Foreword

My first report covers the last two months of the reporting year only, following my election as President in January 2003. I was delighted to receive Council members' endorsement to step into the position that for five years was held by Tony Baird.

On behalf of the Council I would like to acknowledge his leadership, vision and integrity. Tony led the profession in some of the more challenging times encountered in medical practice in New Zealand. He oversaw a huge programme of work stemming from the Medical Practitioners Act and ensured, at every opportunity, and in many forums, that the needs of the public and the profession were to the fore.

In the Council election last November three new members were elected. We aim to continue the effective direction taken by earlier Councils to ensure a strong, well regulated, competent medical workforce. This is essential if we are to meet our statutory purpose of protecting the public from harm. This direction is laid out in our new Strategic Plan produced during 2002.

In the process of developing that Plan, we grappled with how we might be most effective in medical workforce matters. We have an historical role in collecting workforce statistics through the annual workforce survey. We use our knowledge gained from this and from work with other parties, such as the colleges, to advocate for a well trained, well supported medical workforce in sufficient numbers to ensure public health and safety.

Whilst we look to the long term, the next few months present us with the immediate challenge of preparing for the passage of the forthcoming Health Practitioners Competence Assurance (HPCA) Bill. The Bill continues the sound principles of public safety and maintenance of professional standards of the Medical Practitioners Act, with discipline separate. Doctors will be registered in "scopes of practice". There is concern amongst doctors that this will blur the distinction between registration and credentialling and restrict individual practice. The Council has been clear in all its submissions that scopes of practice must be broad. Individual scopes of practice will be used rarely and to enable registration of a doctor which might not otherwise be possible.

The ability for doctors to upskill through educative competence reviews, to recertify regularly and to conduct protected quality assurance activities – all vital features – is intact in the Bill. The maintenance of protected quality assurance activities is absolutely fundamental to self-regulation, the maintenance of professional standards and public safety.

The Bill's introduction is another opportunity to focus on our processes. I am very keen that we clarify our registration policies to deal with growing numbers of applicants who wish to enter New Zealand but who do not meet our criteria. We wish, too, to work with the medical schools on their systems for professional development for students and explore student registration.

Screening the profession at large for possible deficient practice is very difficult and is another focus. We have been heartened by open-minded discussion with branch advisory bodies and other professional groups on whom all systems to maintain professional standards must depend for success.

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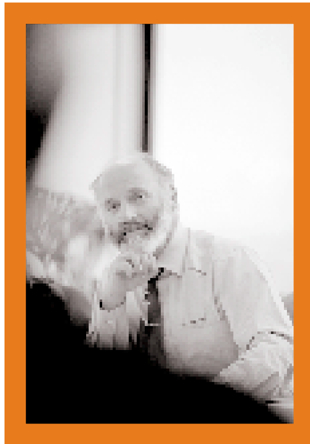
The Council places great emphasis on communicating effectively with the public, the profession and the various health service bodies. We shall continue to listen and to inform about Council direction during this time of change.

On the Council itself each member brings a valued independent perspective, whether from a medical or public viewpoint, ensuring rigorous, informed and thorough debate. I would like to acknowledge members' commitment and hard work. I would also like to thank Sue Ineson, Tania Turfrey who was appointed Registrar during the year, and Council staff for their competence and skills in meeting the significant demands placed on them.



John Campbell
President

Tony Baird
President

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Chief Executive's Introduction

During the year we spent considerable time preparing for the new HPCA Bill. The Bill carries over the principal purpose of patient safety and the maintenance of professional standards from the Medical Practitioners Act.

Rather than undertake new policy initiatives this year, the Council focused instead on identifying how our current procedures can be improved under the new legislation, particularly in the registration and complaints areas.

I'm pleased to report progress in several other projects that will improve our service to the profession and public:

- Major updating of our policies on sexual boundaries.
- A project to enhance cultural awareness by New Zealand and overseas-trained doctors.
- The medical register was placed online to improve access by the public and profession.
- Introduction of an 0800 number.

The online medical register is on the Council's website www.mcnz.org.nz. Inspection of the register is one of the fundamental rights of the public in return for the profession regulating itself, but it has been difficult for the public to access. The register lists details of New Zealand's 10,000 currently practising doctors with search facilities by geographical area and vocational branch. The initiative proved an immediate success, leading to many more visits to our website than previously.

Work with the International Association of Medical Regulatory Authorities (IAMRA) is a major project in which we are taking a leading role. IAMRA's primary purpose is to promote high standards for medical professionals worldwide and to facilitate international cooperation among medical regulatory authorities. During the year I was elected to the IAMRA management committee and I lead the working group on medical passports. The organisation now has 40 members from 20 countries and that number will steadily increase.

In November the Council election took place; the third under the Medical Practitioners Act. Drs Barnett Bond, Pippa MacKay and Kate O'Connor joined as new members and Dr Philip Barham was re-elected. During the year other members who are appointed by the Minister of Health were reconfirmed for further terms of office: Professor John Campbell, Mrs Heather Thomson and Dr Deborah Read.

I have again enjoyed the contact with an array of groups in the profession and in the community. Together, the President (first Tony Baird, then John Campbell), staff and I met with sector groups, hospital personnel, politicians and consumer groups around New Zealand. These contacts are enormously valuable, ensuring that our decision-making is up to date and well informed. Through a media outreach programme we met and had fruitful discussions with key journalists who are our conduit to the wider public.

Medico-legal

Several matters arose during the year, including the following:

- A Ukraine graduate filed court proceedings alleging the Council owed him a duty of care in relation to his application for registration. The District Court found in favour of the Medical Council, determining that the doctor was not owed a duty of care and the Council had not breached the Bill of Rights Act. The basis for the finding was that there is a comprehensive scheme for the consideration of applications for registration set out in the Medical Practitioners Act. The Act also provides comprehensive rights of appeal to the District Court and to the High Court on matters of law, and preserves the right to apply for judicial review.
- A doctor applied for judicial review of a charge laid by a complaints assessment committee. The High Court upheld the doctor's case, that the committee had no power to add new information to a complaint before it. The committee's appeal to the Court of Appeal was unsuccessful.
- In three separate cases, three doctors with general registration lodged appeals in the District Court against the Council's decision to decline to grant them vocational registration (outcomes were pending at year end).
- An earlier appeal lodged by a doctor against the Council's decision to decline to grant him vocational registration in a branch of medicine failed in the District Court. Taking into account all of the circumstances, the Court found that the Council's decision was correct and that the Council had acted reasonably.
- A doctor appealed against the Council's decision to require him to undertake a competence review, and another doctor lodged a notice of appeal against the Council's decision that he undertake a competence programme (outcomes were pending at year end).
- A doctor complained of discrimination by the Council to the Human Rights Commission when the Council deemed that the doctor was not eligible for registration without further examination or assessment, namely sitting and passing the United States Medical Licensing Examination Steps 1 and 2 and the New Zealand Registration Examination (NZREX Clinical). An initial response to the complaint has been sent by the Council to the Human Rights Commission.
- The Medical Practitioners Disciplinary Tribunal handed down a decision on an interlocutory matter that had ramifications for the operations of complaints assessment committees. The Tribunal formed the view that notes taken by committee members as an aide-memoire during a committee meeting should be made available to a doctor if they contain any part of a summary of what was said by the complainant or other witnesses to the committee. The Tribunal also ordered that the complainant disclose medical records that were not held or taken into account by the committee when considering whether there was a case to be answered. The decision has been appealed by the committee.

Office matters

Staffing remained stable during the year but the Council decided to separate once again the roles of Chief Executive and Registrar, appointing Ms Tania Turfrey as Registrar from 1 March 2003. After several years of inhabiting cramped offices, we signed a lease to occupy space on floors 13 and 14 of our current Wellington premises, improving staff morale and creating a more congenial environment for staff and visitors. We have been joined in the same building by the Medical Practitioners Disciplinary Tribunal and the Nursing Council of New Zealand.

Many challenges face us in the present year but it is important to appreciate the strides made. I would like to thank the President and Council members for their support and thank staff for their continued dedication and commitment.

Sue Ineson
Chief Executive

Our core values

Integrity; Openness and accountability; Consistency and fairness; Effectiveness; Commitment; Respect.

Significant Activities

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16 Registration of Medical Practitioners

30 Professional Standards

34 Complaints

38 Doctors' Health

41 Issues

Medical Education

Principal activities: accreditation of medical schools, assessing teaching and learning environments in hospitals, maintaining a network of intern supervisors, setting policy on probationary and pre-vocational years, considering applications for recognition as a vocational branch of medicine, and approving recertification programmes.

Total cost: $838,083

Our focus on medical standards and safety of the public begins with the education of a doctor.

We have four major areas of responsibility:

- Accreditation of medical schools and medical school courses.
- Education, training and supervision during a doctor's probationary year.
- Pre-vocational training.
- Vocational education and training.

The Education Committee membership is a mix of medical professionals and educators and includes two resident medical officers to bring the important perspective of recent graduates. During the year the Committee farewelled two members – Dr Caroline Corkill as the general practice representative, and Dr Mark Davis representing intern supervisors. We warmly acknowledge their many years of service and welcome Dr Lorna Martin and a second junior doctor, Dr Deborah Clarke.

Medical school accreditation

During the year we approved the accreditation reports by the Australian Medical Council for the Schools of Medicine at the University of Adelaide and James Cook University. For over ten years we have run a successful joint medical school accreditation programme with the Australian Medical Council. Professor John Nacey represents New Zealand on the Accreditation Committee. The accreditation process is thorough and means that graduates of the universities are deemed competent for supervised work in either country without further assessment.

Early postgraduate years – hospital visits

Hospitals have a statutory duty to support the educational needs of new doctors. We visit hospitals that employ probationers every three years to accredit them for this purpose. A busy programme in 2002/03 saw visits to Whangarei Hospital, Dunedin and Waikari Hospitals, Southland Hospital, six Canterbury District Health Board hospitals, Timaru Hospital, Grey Hospital, the four Auckland District Health Board hospitals plus Middlemore, North Shore and Waitakere Hospitals, as well as Kenepuru Hospital.

Revisits to hospitals or obtaining progress reports are becoming more frequent as we work to encourage progress between visits. However, strains on resources and overwork of senior staff continue to slow progress in achieving the desired standard of teaching and training of junior doctors. Common problems seen in the visits are abiding by policy limits about junior doctors taking informed consent, and the requirement for senior doctors to set objectives with their juniors for each run, then give regular feedback. The hospitals are very cooperative; their responses to the visit reports are detailed and indicative of a genuine desire to meet requirements.

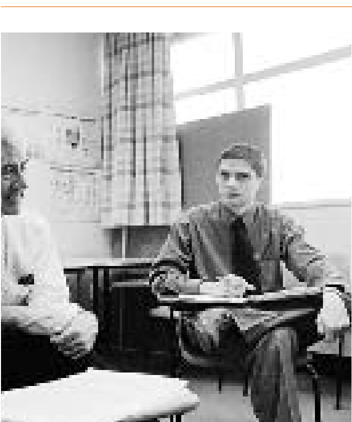
We continue to try to improve the process and during the year significantly altered the form hospitals fill in prior to visits, to adopt a standardised rating system that is used successfully in New South Wales. The visit teams are now slightly larger, averaging four or five members. Each hospital under a District Health Board is now visited separately instead of combining them in a single visit as sometimes happened in the past. The visit team now meets the night before in the area to discuss the visit. While costs have risen slightly as a result of these changes, the benefits are more detailed and robust hospital accreditation reports, and better organised visits.

In June 2002, the Council surveyed intern supervisors and other stakeholders on their response to the handbook, published in 2001, titled *Education, training and supervision of new doctors*. Valuable comments were received, particularly regarding clarification of supervision of probationers on night cover in the first six months, and the use of assessment forms in smaller hospitals.

We acknowledge the continuing efforts of intern supervisors working under contract to the Council to enhance the welfare and opportunities available to graduate doctors. Positive initiatives were shared at the intern supervisors' regular meetings in 2002 in Auckland and Christchurch.

Vocational branch recognition

Clinical genetics was recognised as a new vocational branch (gazetted just after the end of the reporting year), bringing the number of recognised branches of medicine to 34. Next year the moratorium on approval of new vocational branches will be lifted. After 1 July 2004 specialist groups will again be able to apply to the Council for vocational branch recognition. Our criteria for recognition encourage "clumping" of branches rather than proliferation of smaller branches. In December 2002, the Council approved the composition and terms of reference for the separate external group whose role will be to consult with the sector and the public on the need for a new branch and make a recommendation to the Education Committee.



The group will consist of:

- a nominee of the Ministry of Health
- a nominee of the Council of Medical Colleges
- two independent lay people with background and knowledge of health consumer issues
- two members of the Education Committee, including the Chair.

The appointments are due to be made in late 2003.

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It is important that our processes for recognising new vocational branches are in line with the processes of the Australian Medical Council. We are carefully monitoring the work being done by the Australian Medical Council Recognition of Medical Specialties Advisory Committee on which Dr Tony Baird was a member, since replaced by Dr Deborah Read.

Alignment with the Australian process for re-accrediting existing Australasian vocational branches was fully achieved during the year. The process is kept deliberately low level. A pilot exercise was done to re-accredit four existing branches: surgery (including cardiothoracic, general neurosurgery, orthopaedic surgery, otolaryngology, plastic and reconstructive, urology and vascular surgery), radiology (including diagnostic radiology and radiation onocology), general practice and dermatology.

Postgraduate year two

A draft postgraduate year two specification was first developed by the Clinical Training Agency in 2000 but nothing has since been decided about the demarcation of this traditionally unstructured pre-vocational year.

During the year the Committee considered another paper on proposed funding and accreditation of the year and Council officials met with the Clinical Training Agency, but it made no decisions pending requests for further reports.

Summer studentships

Our studentship research grants, now in the 11th year, aim to raise students’ awareness of the dimensions of medical care. To win a studentship, medical students must submit a plan, in consultation with a supervisor, on a topic that takes standards, ethics, conduct and care of patients into account. In 2002 grants of $5,000 were awarded to four students:

- Wayne Hsueh, fourth year student at Christchurch School of Medicine, *What evidence-based interventions promote rural practice?*
- Nicholas Fancourt, second year, Otago University, *The attitudes and beliefs of medical students towards ethics in medical training.*
- Sarah Parker, fourth year, Otago University, *The hidden curriculum in medical education.*
- Melanie Lauti, third year, Otago University, *Obstetricians’ and midwives’ perception of their role in identification and management of family violence.*

Copies of reports are available from the Council office.

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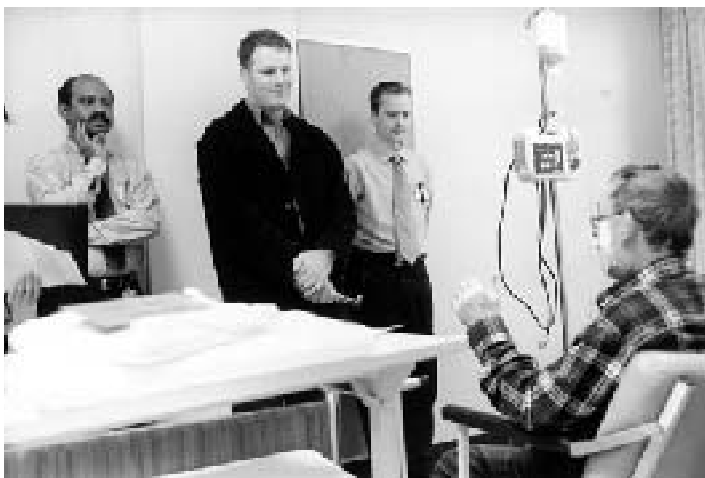

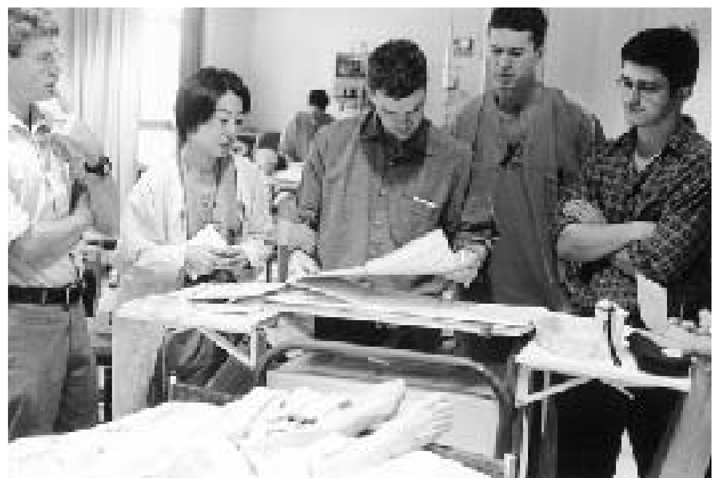

Registration of Medical Practitioners

Principal activities: maintaining the medical register, considering applications for registration, issuing annual practising certificates (APCs) and certificates of good standing, registration policy development.

Total cost: $2,051,584

Registration assures the public that a doctor has met an appropriate standard for medical practice. Entry on the medical register also protects the integrity of the profession.

The number of overseas-trained doctors registered during the year climbed to 1,345, up from 1,089 last year and no slow down is expected. We are now registering doctors from a greater variety of countries than ever before, particularly on temporary registration. Doctors are now registered from 83 countries.

The Medical Council, as the registering body with responsibility for public safety, must steer a path between pressure to register more doctors more quickly and the responsibility to undertake thorough assessment and checks on would-be registrants' backgrounds.

Each applicant's skills, experience and training are compared with those of a New Zealand-trained doctor. We make our requirements transparent through the use of checklists and, for vocational registration, publication of details of the New Zealand standard in each branch of medicine on our website.

With challenges to registration decisions becoming more frequent here and overseas, scrutiny of policy and audits of decision-making are ongoing.

There were changes during the year for United Kingdom graduates. From 1 May 2002 graduates of medical schools accredited by the General Medical Council became eligible for permanent registration without examination (previously they could only work on a temporary basis without examination). The policy has already proven a resounding success, in the first year attracting 197 new doctors from the United Kingdom to bring their skills here longer term.

With more doctors seeking temporary registration from countries with unknown standards, workload has increased along with the degree of risk for Council members in decision-making. Applications from these doctors must be considered as exceptions to policy. As a public safety measure we moved to tighten up requirements for references from senior colleagues, competence in English and recent experience in a similar health and practice environment.

The Council no longer considers registration cases at bi-monthly teleconferences alternating with regular Council meetings. Applications that satisfy policy are circulated to Council members for consideration each week. The Council meets every six weeks to consider complex and difficult registration cases that are outside policy.

Renewal of APCs on target

We are processing approximately 2,500 APCs applications per quarter within 15 working days of receipt. The move to quarterly processing two years ago allows more time to check that requirements for maintaining professional standards are being met. At the end of the year we began audits of compliance, cross-checking the overseers of 10 percent of general registrants and asking 5 percent of general registrants to supply copies of their general oversight records.

Preparing for new legislation

The HPCA Bill was a major focus of the year. Doctors will not notice big changes as the Medical Practitioners Act is the model for the HPCA Bill, but we made some important "in principle" decisions for when the new legislation is enacted:

- Scopes of practice will correspond to the existing registration categories – ie, there will be a "general scope" and a "vocational scope", and scopes will be broadly defined.
- All new registrants will continue to have a period of probationary (or limited) registration, under supervision, to enable them to adapt to the New Zealand health system.
- The Council will do further research on whether regulatory authorities in other countries could be declared "competent authorities". It could then gazette primary qualifications recognised by those authorities and grant "limited" or probationary registration to holders of those degrees.
- The term "general oversight" will be dropped. Doctors on general registration will "recertify" via a collegial relationship to ensure they are taking part in continuing medical education, audit and peer review.

As part of the new legislation we are keen to develop a special pathway for Medical Officer of Special Scale (MOSS) doctors, a group that was effectively stymied under the Medical Practitioners Act. We are pleased to report that under the HPCA Bill, MOSS doctors who are working in hospitals may be able to work more independently in certain situations, defined through credentialling, and recertify via approved maintenance of professional standards programmes.

Our definition of the practice of medicine is unchanged within the context of the HPCA Bill, but for the first time, exemption will be possible. Doctors who can clearly demonstrate that their practice does not impact on public safety will be able to apply for exemption from the requirement to hold an APC. No group, however, will be automatically exempt.

New Zealand medical registration examination – NZREX Clinical

NZREX Clinical tests overseas-trained doctors from outside Australia, New Zealand and the United Kingdom who do not hold postgraduate qualifications recognised for vocational registration. The number of candidates increased from 83 in 2002 to 167 this year due mainly to doctors graduating from the Government's first and second bridging programme courses. The examination's objective is to ensure doctors are competent to enter a period of supervised probationary registration, during which time they will be further assessed.

A major review was completed to enhance the relevance of the examination to New Zealand practice. It will now focus on generic competencies, including communication. The first examination in the new format took place in late April 2003.

We recognise the difficulties for examiners caused by this change. We are grateful to them and mention in particular Professor John Morton and Dr David McHaffie who have contributed over many years to the Examinations Committee and the running of NZREX Clinical. Staff organised a valuable training workshop for examiners in March, which gave them an opportunity to air issues and ideas.

Improving quality of supervision

During the year we surveyed overseas-trained doctors and their supervisors about the quality of their supervision relationships with a view to developing guidelines for supervisors. In a separate initiative, guidelines were written for supervisors of disciplined doctors that clearly state accountabilities and expectations for reporting. The latter was an outcome of our major review of sexual boundaries in the patient/doctor relationship that pinpointed some weaknesses in the area of monitoring of doctors disciplined for sexual misconduct.

Removal of conditions and reregistration of disciplined doctors

As for other New Zealanders, the law provides for rehabilitation of disciplined doctors. Doctors seeking to return to medical practice or resume unconditional practice following a disciplinary offence must put their case to the Council. Sometimes a specified timeframe must pass before the doctor can reapply for practising rights.

The Council considers each case – sometimes over a period of months – and applies a rigorous test to ensure public safety that often involves (always in the case of sexual offenders) expert independent assessment.

The following cases were considered during the year.

1. A doctor imprisoned for fraud in 1995 and removed from the medical register in 1996. After considering submissions and other practitioners' reports, the Council granted probationary registration to the doctor under several conditions, namely: practising in an approved supervised position, remaining on probationary registration for three years, having no financial or management interest in any practice, accepting surveillance of all financial claims, and monitoring by the Council's Health Committee.

2. A doctor removed from the medical register in April 1998 for sexual misconduct. The doctor had completed the requisite three steps of assessment, treatment and re-assessment by the independent Sexual Misconduct Assessment Team. After considering the reports, the doctor was granted probationary registration with conditions, namely: practising in an approved supervised position, caring only for male patients, and remaining on probationary registration for three years.

3. A doctor removed from the medical register in 1993 for sexual misconduct and excessive prescribing, reregistered with conditions in 1996. The Council rejected the doctor's application for removal of conditions on practice. These were: requiring the doctor to maintain an opiate register countersigned by a senior nurse, insisting that a chaperone be present during physical examinations of female patients, and continuing to report at six-monthly

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intervals on the number of patients seen, prescribing of benzodiazepines and appetite suppressants and participation in continuing medical education. Conditions are to be reviewed annually.

4. A doctor removed from the medical register in 1998 for fraud. Following assessment the Council resolved to grant the doctor probationary registration with conditions, which included remaining on probationary registration for a minimum period of two years, having no financial or management interest in any practice, accepting surveillance of all financial claims, and having no involvement in ongoing counselling relationships with patients.

Before being issued with an APC, the doctor and doctor's supervisor were required to submit a detailed induction and supervision plan to the Council for approval, including daily supervision meetings, limited caseloads and direct supervision of procedures.

5. A doctor removed from the medical register in 1985 for sexual misconduct. In March 1997 the Council granted the doctor probationary registration with conditions for a period of not less than two years. In 1999 the Council approved the doctor's application for general and vocational registration, subject to a number of conditions imposed on his practice. The doctor applied for final removal of conditions. The Council considered written submissions, supervisors' reports and letters of support from medical colleagues. It deferred a decision pending an assessment of the doctor by the Sexual Misconduct Assessment Team.

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and expectations for reporting."

1. Summary of registration

At 31 March 2003

	2002	2003
Interim	46	34
Probationary	602	724
General	11,147	11,578
Vocational	5,834	6,073
Temporary	789	758
Total Practising	9,964	10,355
Suspended	4	3

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

2. Registration activities

1 April 2002 – 31 March 2003

Probationary Registration Issued		**Number**
Class 1	New Zealand Graduates (Interns)	292
Class 1	Overseas Graduates (Interns)	5
Class 2	Overseas Graduates (NZREX Passes)	79
Class 3	Overseas Graduates (Eligible for Vocational Registration)	31
Class 4	Overseas Graduates (Suitable for Assessment – Vocational Registration)	73
Class 5	New Zealand and Overseas Graduates (Reregistration Following Erasure)	3
Class 7	Rural Service Provision and Vocational Training	46
Class 8	Graduates of General Medical Council Accredited Medical Schools	197
General Registration Issued		
New Zealand Graduates		9
Overseas Graduates		26
Reinstatements		20
Temporary Certificates Issued		
Class 1	Visiting Teacher	19
Class 2	Training and Research	41
Class 3	Service Provision	836
Class 4	Special Purpose	3
Extensions		538
Interim Registration Issued		7
General registration after Completion of Probationary Period		
Class 1	New Zealand and Overseas Graduates (Interns)	297
Class 2	Overseas Graduates (NZREX Passes)	72
Class 3	Overseas Graduates (Eligible for Vocational Registration)	34
Class 4	Overseas Graduates (Suitable for Assessment – Vocational Registration)	27

Class 5	New Zealand and Overseas Graduates (Reregistration Following Erasure)	0
Class 7	Rural Service Provision and Vocational Training	5
Class 8	Graduates of General Medical Council Accredited Medical Schools	98
Temporary	Eligible for Probationary, Completed 12 Months' Supervised Practice	5
Additions to Vocational Register		447
Amendments to Register		
Change of Address		2,528
Change of Name		42
Additional Qualifications		526
Suspensions		
Suspended or Interim Suspension		0
Revocation of Suspension		1
Conditions Imposed		
Imposed		62
Revoked		11
Removals		
Death Section.43		44
Discipline Order Section.110(1)(a)/46(3)(c)		1
Failure to Notify Change of Address Section.42(2)		19
Non-resident Doctors Issued Section.45(1)(c)		15
At Own Request Section.44(1)		78
Annual Practising Certificates		11,315
Certificates of Good Standing		857
Certificates of Registration		150
Confirmation of Standing		157
Reprints of Practising Certificates		95

3. New Zealand vocational register

1 April 2002 – 31 March 2003

Vocational Branch	Vocational Registration at 31/3/2002[1]	Added 2002/03	Removed 2002/03	Net Change	Vocational Registration at 31/3/2003[1,2]
Accident & Medical Practice	47	35	0	35	82
Anaesthetics	451	26	9	17	468
Breast Medicine	4	0	0	0	4
Cardiothoracic Surgery	29	0	1	-1	28
Dermatology	49	0	3	-3	46
Diagnostic Radiology	256	24	4	20	276
Emergency Medicine	45	11	0	11	56
Family Planning & Reproductive Health	2	22	0	22	24
General Practice	2,264	143	83	60	2,324
General Surgery	257	6	20	-14	243
Intensive Care Medicine	36	9	0	9	45
Internal Medicine	661	41	15	26	687
Medical Administration	9	1	0	1	10
Musculoskeletal Medicine	6	8	0	8	14
Neurosurgery	15	0	0	0	15
Obstetrics & Gynaecology	251	9	6	3	254
Occupational Medicine	35	4	1	3	38
Ophthalmology	115	6	2	4	119
Orthopaedic Surgery	190	5	3	2	192
Otolaryngology Head & Neck Surgery	86	7	3	4	90
Paediatric Surgery	15	1	0	1	16
Paediatrics	214	12	5	7	221
Palliative Medicine	21	6	0	6	27
Pathology	240	15	11	4	244
Plastic & Reconstructive Surgery	40	2	0	2	42
Psychological Medicine or Psychiatry	388	34	7	27	415
Public Health Medicine	174	9	20	-11	163
Radiation Oncology	43	3	3	0	43
Rehabilitation Medicine	10	0	0	0	10
Sexual Health Medicine	16	0	0	0	16
Sports Medicine	10	0	0	0	10
Urology	49	2	0	2	51
Vascular Surgery	5	6	0	6	11
Venereology	10	0	1	-1	9
Total	**6,043**	**447**	**197**	**250**	**6,293**

1. Includes doctors who may currently be inactive (have no APC).
2. Includes 215 doctors with vocational registration in two branches and two doctors with vocational registration in three branches.

4. Candidates sitting and passing NZREX Clinical

1 April 2002 – 31 March 2003

Country	No. Sitting	Attempts					No. of Passes	Passes on Attempts				
		1	2	3	4	5		1	2	3	4	5
Bangladesh	56	34	14	6	2	0	27	13	8	4	2	0
Belarus	1	1	0	0	0	0	1	1	0	0	0	0
Bulgaria	3	0	2	1	0	0	1	0	0	1	0	0
China	6	5	1	0	0	0	6	5	1	0	0	0
Egypt	8	8	0	0	0	0	6	6	0	0	0	0
Germany	2	2	0	0	0	0	1	1	0	0	0	0
India	22	17	2	0	2	1	14	12	1	0	0	1
Iran	4	1	1	1	1	0	2	0	1	0	1	0
Iraq	9	8	1	0	0	0	7	6	1	0	0	0
Ireland	1	1	0	0	0	0	1	1	0	0	0	0
Jordan	2	1	1	0	0	0	0	0	0	0	0	0
Myanmar	1	0	0	1	0	0	1	0	0	1	0	0
Pakistan	2	0	2	0	0	0	2	0	2	0	0	0
Philippines	12	8	3	1	0	0	8	6	2	0	0	0
Poland	1	1	0	0	0	0	0	0	0	0	0	0
Romania	1	1	0	0	0	0	0	0	0	0	0	0
Russia	4	4	0	0	0	0	2	2	0	0	0	0
South Africa	2	2	0	0	0	0	1	1	0	0	0	0
Sri Lanka	19	13	3	1	2	0	14	8	3	1	2	0
Turkey	1	1	0	0	0	0	1	1	0	0	0	0
Ukraine	1	1	0	0	0	0	1	1	0	0	0	0
Yugoslavia (Federal Republic of)	7	4	2	0	1	0	3	1	2	0	0	0
Zimbabwe	2	2	0	0	0	0	2	2	0	0	0	0
Total	**167**	**115**	**32**	**11**	**8**	**1**	**101**	**67**	**21**	**7**	**5**	**1**

Note: There were only two sessions of the NZREX examination held in the 2002/03 financial year, with double the number of candidates sitting due to the bridging programme.

5. Registration issued by country of primary qualification

1 April 2002 – 31 March 2003

	Probationary								Temporary				
Country	Class 1	2	3	4	5	7	8	Total	Class 1	2	3	4	Total
Argentina	0	0	1	0	0	0	0	1	0	0	3	0	3
Australia	5	0	0	1	0	0	0	6	8	1	18	0	27
Bangladesh	0	17	1	1	0	0	0	19	0	1	2	0	3
Belarus	0	0	0	0	0	0	0	0	0	0	1	0	1
Belgium	0	0	1	0	0	0	0	1	0	0	2	0	2
Bulgaria	0	1	0	0	0	0	0	1	0	0	1	0	1
Canada	0	0	0	2	0	1	0	3	2	4	33	0	39
Chile	0	0	0	0	0	0	0	0	0	0	1	0	1
China	0	5	0	0	0	0	0	5	0	0	1	0	1
Colombia	0	0	0	0	0	0	0	0	0	0	1	0	1
Czech Republic	0	0	0	0	0	0	0	0	0	0	2	0	2
Denmark	0	0	0	2	0	0	0	2	0	0	2	0	2
Egypt	0	7	2	1	0	0	0	10	0	0	4	0	4
England	0	0	8	16	0	2	144	170	1	4	314	0	319
Fiji	0	0	0	0	0	0	0	0	0	4	0	0	4
France	0	0	0	0	0	0	0	0	1	0	2	0	3
Georgia	0	0	0	0	0	0	0	0	0	1	0	0	1
Germany	0	1	0	4	0	1	0	6	0	1	17	0	18
Ghana	0	0	0	0	0	0	0	0	0	0	1	0	1
Greece	0	0	0	1	0	0	0	1	0	0	0	0	0
Hungary	0	0	0	1	0	0	0	1	0	0	1	0	1
India	0	10	1	5	0	1	0	17	0	4	25	0	29
Iran	0	1	0	0	0	0	0	1	0	0	1	0	1
Iraq	0	8	0	1	0	0	0	9	0	0	0	0	0
Ireland	0	1	2	2	0	2	0	7	0	2	23	0	25
Italy	0	0	0	0	0	0	0	0	0	0	2	1	3
Japan	0	0	0	0	0	1	0	1	1	1	1	1	4
Jordan	0	0	0	0	0	0	0	0	0	1	1	0	2
Kenya	0	0	0	1	0	0	0	1	0	0	0	0	0
Korea (Republic of)	0	1	0	0	0	0	0	1	0	1	1	0	2
Malaysia	0	0	0	1	0	0	0	1	0	1	1	0	2
Myanmar	0	1	0	0	0	0	0	1	0	0	0	0	0
Netherlands	0	0	1	1	0	0	0	2	0	0	8	0	8
New Zealand	292	0	0	0	3	0	0	295	0	0	11	0	11
Nigeria	0	0	0	1	0	0	0	1	0	0	3	0	3

Country	Probationary Class 1	2	3	4	5	7	8	Total	Temporary Class 1	2	3	4	Total
Northern Ireland	0	0	1	0	0	0	3	4	0	0	6	0	6
Pakistan	0	2	0	2	0	1	0	5	0	0	7	0	7
Philippines	0	6	0	0	0	0	0	6	0	0	2	0	2
Poland	0	0	0	2	0	0	0	2	0	0	5	0	5
Romania	0	0	0	3	0	1	0	4	0	0	3	0	3
Russia	0	3	0	1	0	0	0	4	0	0	0	0	0
Saudi Arabia	0	0	0	0	0	1	0	1	0	0	0	0	0
Scotland	0	0	2	2	0	1	40	45	0	0	91	0	91
Somalia	0	0	0	0	0	0	0	0	0	0	1	0	1
South Africa	0	1	6	13	0	32	0	52	0	0	114	0	114
Spain	0	0	0	0	0	0	0	0	1	0	1	0	2
Sri Lanka	0	11	0	1	0	0	0	12	0	11	1	0	12
Sweden	0	0	0	1	0	0	0	1	0	0	6	0	6
Taiwan	0	0	0	0	0	0	0	0	1	0	0	1	2
Turkey	0	1	0	0	0	0	0	1	0	0	2	0	2
Ukraine	0	1	0	0	0	0	0	1	0	0	0	0	0
United States of America	0	0	3	4	0	0	0	7	4	3	93	0	100
Vietnam	0	0	0	0	0	0	0	0	0	1	0	0	1
Wales	0	0	0	0	0	1	10	11	0	0	14	0	14
Yugoslavia, (Federal Republic of)	0	0	2	2	0	0	0	4	0	0	0	0	0
Zimbabwe	0	1	0	1	0	1	0	3	0	0	7	0	7
Total	**297**	**79**	**31**	**73**	**3**	**46**	**197**	**726**	**19**	**41**	**836**	**3**	**899**

Note: During the year a number of doctors gained registration in one class of registration and then changed to another class.
Probationary class 6 was discontinued in 2001.

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

1 April 2002 – 31 March 2003

Branch of Medicine	Number
Accident & Medical Practice	14
Anaesthetics	7
Diagnostic Radiology	8
Emergency Medicine	2
Family Planning & Reproductive Health	9
General Practice	55
General Surgery	3
Intensive Care Medicine	4
Internal Medicine	18
Medical Administration	1
Musculoskeletal Medicine	4
Obstetrics & Gynaecology	5
Occupational Medicine	1
Ophthalmology	1
Orthopaedic Surgery	1
Otolaryngology Head & Neck Surgery	3
Paediatrics	6
Palliative Medicine	3
Pathology	9
Psychological Medicine or Psychiatry	17
Public Health Medicine	3
Radiation Oncology	2
Vascular Surgery	1
Total	**177**

7. Outcomes of applications for assessment of eligibility for vocational registration

Received between 1 April 2002 and 31 March 2003

Branch	Incomplete Applications	Pending (at College/ Council)	Withdrawn/ Lapsed	Vocational Reg.	Class 3[1] Probationary	Class 4[2] Probationary	Further Training Required	NZREX	Total
Accident & Medical Practice	0	0	0	1	0	0	0	0	1
Anaesthetics	6	7	1	2	4	6	0	1	27
Cardiothoracic Surgery	1	0	0	0	0	0	0	0	1
Dermatology	1	0	2	0	0	0	0	0	3
Diagnostic Radiology	1	2	1	2	1	2	0	0	9
Emergency Medicine	1	1	0	0	2	0	0	0	4
General Practice	3	1	1	0	0	9	1	0	15
General Surgery	8	2	1	0	0	2	0	0	13
Intensive Care Medicine	0	2	0	0	0	0	0	0	2
Internal Medicine	10	16	1	1	1	8	0	0	37
Neurosurgery	0	2	0	0	0	0	0	0	2
Obstetrics & Gynaecology	6	3	0	0	3	6	0	1	19
Occupational Medicine	2	1	0	0	0	0	0	0	3
Ophthalmology	4	0	1	0	1	0	0	0	6
Orthopaedic Surgery	2	4	2	1	0	1	0	0	10
Otolaryngology Head & Neck Surgery	0	3	0	0	0	0	0	0	3
Paediatric Surgery	0	0	0	0	0	1	0	0	1
Paediatrics	3	2	2	1	0	2	0	0	10
Pathology	5	4	0	1	0	3	0	0	13
Plastic & Reconstructive Surgery	1	0	0	0	0	1	0	0	2
Psychological Medicine or Psychiatry	12	11	0	2	0	10	0	0	35
Public Health Medicine	0	0	0	1	1	0	0	0	2
Radiation Oncology	2	1	0	0	1	2	0	0	6
Urology	1	0	1	0	0	0	0	0	2
Total	**69**	**62**	**13**	**12**	**14**	**53**	**1**	**2**	**226**
Percentages Based on 82 Final Outcomes*				14.6%	17.1%	64.6%	1.2%	2.4%	

1. Eligible for vocational registration.
2. Suitable for assessment – vocational registration.
* Does not include incomplete, pending, withdrawn or lapsed applications.

8. Medical practitioners on the New Zealand medical register by country of primary qualification

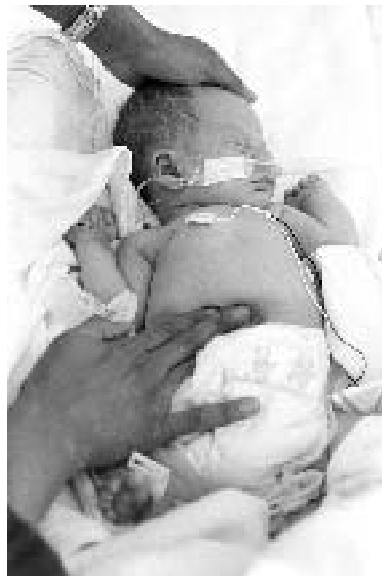
As at 31 March 2003[1]

Country	Interim	Probationary	General	Vocational	Temporary	Total
England	13	107	407	692	269	1,488
South Africa	7	83	322	419	107	938
Scotland	2	24	136	204	83	449
India	1	26	176	150	36	389
Australia	2	6	222	152	5	387
Sri Lanka	0	14	110	141	18	283
Iraq	0	10	123	12	0	145
United States of America	1	10	6	54	66	137
Ireland	0	8	22	43	22	95
Canada	0	4	20	38	30	92
Bangladesh	1	19	61	3	5	89
Germany	0	8	30	28	17	83
China	0	5	19	37	1	62
Wales	3	0	26	24	9	62
Egypt	0	12	24	16	2	54
Fiji	0	0	21	28	4	53
Pakistan	0	7	10	11	8	36
Yugoslavia, (Federal Republic of)	0	5	21	9	0	35
Northern Ireland	0	3	7	17	6	33
Philippines	0	7	9	6	5	27
Zimbabwe	0	3	4	11	6	24
Netherlands	0	1	5	11	5	22
Poland	1	2	12	2	4	21
Singapore	0	0	2	19	0	21
Myanmar	0	0	12	1	1	14
Russia	0	4	5	4	1	14
Japan	0	2	0	1	10	13
Romania	0	5	4	2	2	13
Croatia	0	1	10	0	0	11
Sweden	0	1	1	2	6	10
Bulgaria	0	1	4	3	0	8
Malaysia	0	2	1	4	1	8
Papua New Guinea	0	1	4	3	0	8
Czech Republic	0	0	3	3	1	7
Denmark	0	2	0	4	1	7
Iran	0	2	1	4	0	7

Country	Interim	Probationary	General	Vocational	Temporary	Total
Switzerland	0	0	1	6	0	7
Bosnia and Herzegovina	0	1	4	1	0	6
Nigeria	0	1	1	1	3	6
Norway	0	0	4	2	0	6
Other	0	15	32	31	22	100
New Zealand	3	322	3,623	3,874	2	7,824
Total	**34**	**724**	**5,505**	**6,073**	**758**	**13,094**

Note: There are 42 countries with fewer than six doctors represented by Other.

1. Total number of medical practitioners on the medical register, but not necessarily practising.



Professional Standards

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

Total cost: $972,968

Competence reviews of doctors and competence programmes protect the public and assist doctors to overcome any knowledge or skill gaps.

Fifty doctors were referred to the Council for competence reviews in 2002/03, down from 73 the previous year. There were, as shown in Table 9, fewer referrals from peers and fewer from within the Council via complaints or other forms of notification. Fifty-eight doctors were formally reviewed (reflecting a catch-up in earlier outstanding cases) and six of these were directed to do a competence programme.

During the year the Professional Standards Committee was disbanded and the full Council took up the role of considering competence cases, reflecting a desire to improve their effectiveness for the doctors concerned.

We are aware that past delays in processing cases have caused resentment amongst members of the profession about reviews. This has been compounded by the inevitable discovery during the formative phase of a process of improvements that can be made. There is also a general feeling in the profession that a competence review is detrimental to a doctor professionally, despite the widely publicised fact that the process is non-disciplinary.

We are working hard to improve the process. During the year more staff were appointed and many older cases cleared. Staff completed a major statistical report on referrals to date and analysed evaluations from doctors and reviewers to look at how to improve current procedures.

Fortunately most members of the profession recognise the responsibility to self-regulate effectively. This takes various forms including participating in general oversight and recertification, but for some it will entail an assessment by peers of an aspect of their practice in a competence review. Changing attitudes will take time and will flow from a robust and fair process. However, an effective review is achieved only with the cooperation of doctors and it has been unfortunate to see instances of obstruction and undue legal defensiveness in some recent cases.

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effectively.”

Improvements planned and underway

Changes agreed during the year included:

- seeking advice from referred doctors about any external factors that may be affecting their practice
- better information for doctors before a review, including an outline of tools that will be used
- forwarding the full concern to the Competence Review Committee instead of only a summary
- giving reviewers feedback on the quality of their recommendations to the Council
- updating lawyers on the process
- formation of an "expert advisory group".

The expert advisory group's purpose is very important. Given that the use of reviews is likely to increase, its role is to provide informed, accurate and balanced advice to the Professional Standards team on robust education, assessment and methods of reviewing performance. The inaugural membership of this group appointed during the year is: Dr David Leadbetter; Dr Martin Searle; Dr Leona Wilson; Dr Jonathan Fox; Dr Steven Lillis; Dr David Waite; Mrs Elizabeth Winter; and Mrs Alison de Ridder.

All countries are grappling with the concept of screening systems to identify poor performers. We continue to participate actively in international and national conferences that consider best practice and in this regard two members of staff attended the International Conference on Performance Assessment in Kilkenny, Ireland in September. Despite the difficulty of implementing a defensible screening system, participants agreed that it was of paramount importance to continue this work for the future. Following the Conference, we agreed to explore means of identifying and assessing the performance of doctors in high-risk groups, and discuss with the branch advisory bodies an arrangement to carry out a pilot screening project.

Five-year study completed

The Professional Standards Committee first began assessing competence cases in early 1998. This year all cases since 1998 were reviewed. The review considered three aspects: outcomes of referrals, responses of reviewers to the process and responses of doctors reviewed. While many of the figures are too low to be statistically reliable, they provide a snapshot and information for possible future comparison.

st members of the profession
sponsibility to self-regulate

Results of the first part of the study showed:

- concerns about doctors mainly related to clinical ability and communication
- few of the doctors referred (24 out of 258) were women
- more concerns were expressed about overseas-trained than New Zealand-trained doctors as a percentage of all doctors
- of 92 competence reviews ordered, 23 doctors were judged to require a competence programme.

A competence review case study

Medsafe referred a doctor to the Council for irregularities in prescribing of pethidine. A subsequent independent psychiatric report obtained by the Council's Health Committee found no evidence of self-prescribing. The Council resolved that the doctor should have a competence review, with particular reference to systems of recording and accounting for controlled drug prescribing, prescribing of narcotics, and record-keeping. Issues for investigation were prescribing of pethidine for long-standing pain and for minimising the potential for self-harm in someone suffering from a borderline personality disorder, and deficiencies in patients' medical records.

Continuous professional development

General oversight and recertification ensure that the medical register reflects more accurately doctors' continuing fitness to practise.

It became mandatory from 1 July 2001 for all general registrants to be receiving general oversight from a vocationally registered colleague. Staff continue to provide advice on individual cases for those few instances where it is necessary to work outside an established branch.

Recertification recognises the importance of colleges by accepting evidence of participation in college programmes as sufficient to meet our requirements. Auditing will commence next year. In some cases we will consider exemptions from recertification programmes as long as doctors agree to practise under general oversight, or limit their practice to a specified area, or undertake only non-clinical work. In most cases it is expected that the doctor will give up his or her vocational registration.

9. Competence referrals

1 April 2002 – 31 March 2003

Source of Concern	Number
Accident Compensation Corporation (ACC)	7
Health and Disability Commissioner (HDC)	32
Complaints Assessment Committee	4
Medical Council of New Zealand	1
Public	1
Peer	2
Employer	3
Total Referrals	**50**

Type of Concern	Number
Records	6
Prescribing	10
Clinical Skills	23
Surgical Skills	7
Communication	13
Other	8

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

Outcomes of Competence Referrals (may relate to cases referred in the previous financial year)	Number
To Competence Review	58
No Competence Review	17
To Competence Programme	6
Referred to Other Committee or HDC	6
Pending (Awaiting Meetings, Submissions or On Hold)	**30**

Complaints

Principal activities: operation of complaints assessment committees to consider complaints, policy on complaints assessment process.

Total cost of CACs: $687,785

Complaints assessment committees investigate complaints received against doctors relating to treatment before 1 July 1996.

One hundred and twenty-five complaints were received during the year, including 41 complaints that were referred to the Health and Disability Commissioner (HDC) because they related to events that occurred after 1 July 1996. A further 262 enquiries about the complaints process were received by the office.

Due to the introduction of a separate category for complaint enquiries this year, statistical comparisons with last year are difficult.

Certain types of conduct that have consistently resulted in disciplinary proceedings will automatically be referred to a complaints assessment committee. These include:

- alleged sexual abuse by doctors
- criminal offending by a medical practitioner punishable by three months' imprisonment or more
- certain drug and alcohol related matters
- bad clinical practice
- inadequate standard of care and treatment.

The Council will continue to decide in the first instance what matters beyond these categories should be referred to a complaints assessment committee.

In recent years we have seen a growing trend for some doctors to believe they are exposed to a litigious practice environment. The way the media have reported on some disciplinary cases has almost certainly exacerbated this. Yet Medical Council and HDC historical data shows that few complaints are proven and even fewer – around 1 to 2 percent – result in laying of disciplinary charges. Being the subject of a complaint is always distressing, but the chances of a complaint occurring are very low – compared with the thousands of medical consultations and interactions occurring daily between doctors and patients. Additionally, studies confirmed the high respect in which doctors are held and the high trust patients place in their own doctors in their one-to-one relationships.

High priority is being given to effective complaint resolution. The past few years have seen improved procedures but there is still a need for greater timeliness and transparency. Our regular audits are important in this regard. Following an audit in May that showed some significant delays, procedures were strengthened and by November, the average time taken to set up complaints assessment committees had reduced from eight to two months; 80 percent of old cases were closed, and timeline targets were achieved 68 percent of the time.

Inter-agency reporting

In the lead-up to submissions on the HPCA Bill we continued to argue for comprehensive inter-agency reporting, with a focus on non-disciplinary, early intervention for doctors with possible problems. Reports by ACC to the Council of all medical misadventure in the previous year and some more recent cases showed that several of the doctors with higher rates of misadventure, when matched with information held by the Council, presented possible cause for concern. Care is taken to ensure safeguards for doctors, and cases are only reviewed if there is sufficient information and concrete concerns after reviewing the specific details of the case from ACC.

Important lessons from the Cull review on complaints resolution must not be lost, in particular that one body must have an overview of doctors' practices. Sharing of information between agencies, far from creating a potential for vendettas, is a responsible course of action for protecting the public and safeguarding the profession's integrity.

Case studies – complaints about treatment given before 1 July 1996

1. A patient complained about lack of information from a doctor. The complaints assessment committee believed that there was no incompetence, negligence or attempt to hide information from the patient, but that the doctor's communication could have been better. The committee felt that it would be helpful for both parties to meet to address the issue, and determined the complaint should be the subject of conciliation. Both the doctor and patient regarded the conciliation as an appropriate and helpful process. The patient, however, found the initial assessment of the complaint by the committee to be intimidating. While appreciating the role of the lay chairperson, the patient felt the medical people involved were inclined to express evaluative views.

2. A patient complained about a doctor's treatment of her when she presented with tiredness and sleeping problems. The complaint related to lack of understanding, lack of listening, lack of ethics and failure to diagnose and manage obstructive sleep apnoea. The committee, after considering all the information available to it, found that poor history, examination and management planning by the doctor delayed the diagnosis and treatment of the patient's condition. The committee determined that the doctor should be referred for a competence review.

3. A patient complained about a doctor's sexual impropriety towards them and about the administration of drugs for which there was no medical reason or justification. After considering all the information available, the committee determined that a charge of disgraceful conduct should be laid against the doctor and referred the matter to the Medical Practitioners Disciplinary Tribunal. The charge is pending.

10. Complaints statistics
1 April 2002 – 31 March 2003

Month 2002/03	Complaints Referred to Competence	Complaints Received Pre-1.7.96 for CAC Appt	Complaints Received Post 1.7.96 to HDC to Action
April	0	0	1
May	0	6	2
June	4	3	2
July	2	9	9
August	2	6	9
September	3	1	2
October	5	1	3
November	2	1	3
December	5	2	1
January	6	1	3
February	2	0	4
March	1	1	2
21 pending at 31.3.03	32	31	41

Note: Includes convictions and non-code issues from HDC and when HDC has asked the Council to investigate.

11. Schedule of Complaints Assessment Committees
1 April 2002 – 31 March 2003

New Complaints Assessment Committees Appointed	50
Complaints Carried Forward at 31 March 2003	
Complaints Assessment Committee Pending Determination	30
Number of New Complaints Referred to Complaints Assessment Committees	**31**
Categories of Complaint	
Communication	4
Conviction of an Offence	9
Inappropriate Sexual Behaviour	1
Treatment	16
Cost	1

12. Determinations made

1 April 2002 – 31 March 2003

Competence Review	4
Referred to Conciliation	1
Charge Laid with Medical Practitioners Disciplinary Tribunal	5
No Further Action	43
Withdrawn	1
Health Review	2
Total	**56**

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

Doctors' Health

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

Total cost: $890,410

We seek to protect patients by the appropriate management of a doctor who, because of some mental or physical condition, may not be fit to practise.

The Medical Practitioners Act makes it mandatory for doctors and those in charge of hospitals to notify the Registrar if they suspect a doctor's health may be putting patients at risk. New Zealand is similar to many overseas jurisdictions in this respect. Deciding to notify is not easy, so the Act allows for someone contemplating making a referral to seek other professional opinions.

The Health Committee manages doctors with health problems, focusing on rehabilitation of doctors and safety for patients. There were 38 new referrals in 2002/03, compared with 60 in the previous year, and the progress of 71 doctors was reviewed. The number of doctors actively monitored remains at around 90.

Committee procedures are well established and many doctors find that their initial anxiety about being referred is promptly dispelled. The Committee acts quickly to set in place treatment and monitoring programmes in consultation with doctors and independent assessors. With individual regimes in place, the majority of doctors can continue practising although some may withdraw from practice for periods through mutual agreement with the Committee.

We are indebted to the colleagues of doctors and other health professionals who provide support through treatment, supervision and reporting, to mentors who work with unwell doctors and to employers who assist with workplace issues. In December we were sorry to receive the resignation of Dr Rob Cameron as Mentoring Coordinator and lose the skills and insights he brought to the role. Dr Janet Frater, an Auckland general practitioner, was appointed in his place.

Transmissible major viral infections

The Health Committee is reviewing the Council's current statement on managing doctors with transmissible major viral infections. Amongst other issues the review is considering whether:

- there should be mandatory screening of all doctors, who undertake exposure-prone procedures
- doctors should be required to inform patients when they are infected with hepatitis B virus or hepatitis C virus or human immunodeficiency virus where there is a small, albeit negligible, risk to the public.

The Committee resolved to obtain information on the current policies and guidelines in other jurisdictions, and to establish whether there were practices in other jurisdictions that differed significantly.

Publicity about doctors' health

Our long-standing policy is that a doctor on a committee programme who does not present any risk to patients is entitled to privacy about his or her health, like any other person. Occasionally our stance meets a stringent challenge from the media who may be alerted to a particular case and who will seek assurances that the public's health and safety are not in fact at risk. This can cause difficulties in balancing a doctor's right to privacy and the perceptions or allegations existing about the doctor. While we must observe natural justice, our role is not to protect doctors if the public interest overrides that of an individual doctor. Unsought publicity about cases is infrequent but does happen. In some rare instances we may approach a doctor to negotiate the release of certain information – if this is deemed in the public interest and indicated in legal advice. In such situations, a statement may also be in the doctor's interests.

Case studies

The cases below (with some details changed to protect anonymity) illustrate the variety of situations that arise in the Committee's work.

1. Early intervention by a peer

A colleague was concerned about a doctor's adverse change in coping and performance. Over some months the doctor had developed depressive symptoms with anxiety features, in the context of personal and work-related stress. The doctor resisted help that was offered. After being referred to the Committee by the colleague, the doctor had an independent assessment by a psychiatrist nominated by the Committee. The doctor subsequently agreed to a voluntary undertaking that included maintaining a therapeutic relationship with a GP and psychiatrist and taking antidepressant medication. The doctor's colleague had enabled this doctor's illness to be diagnosed and treated before further deterioration.

2. Drug dependence

A doctor's escalating prescribing of opiates was drawn to the attention of the Health Committee by Medsafe, the agency charged with monitoring the prescribing of controlled drugs and related drug abuse containment activities. The Committee arranged for the doctor to be assessed by a specialist in addiction medicine. It transpired that usage had begun for pain relief and escalated into a dependence. A voluntary undertaking with the Committee included random urine monitoring; restricted access to opiates; and counselling. The latest reports show that the doctor is well established in recovery and continues with good health care practices. The pain problem persists but is being better managed with an exercise programme.

3. Alcohol dependence

A doctor working in a hospital in difficult personal and professional circumstances became alcohol dependent, and was referred to the Committee by a health professional who worked alongside the doctor. The doctor was reluctant to accept the diagnosis of alcohol dependence, as is common in other cases seen by the Committee through its years of dealing with alcohol dependency. The patient failed to engage fully in a treatment programme and had a number of relapses, following which the patient agreed to inpatient treatment. The doctor has a voluntary undertaking with the Committee to support her recovery that includes: a relapse management and maintenance plan; counselling; regular blood tests; and random breath testing. The patient is now well and maintaining sobriety.

Doctors who take time out to participate in one of the recognised treatment programmes generally make better progress. Patients' interests are protected by external monitoring the Committee has in place, such as breath testing during working hours.

13. Health statistics

1 April 2002 – 31 March 2003

New Referrals	
Received	38
• No Further Action Required	6
• Monitoring Programmes Initiated	20
• Further Review Required Before APC Issued	1
• Follow-up Report to be Provided	9
• Pending	2
Carried Over from Previous Years	
Monitoring Programme Reactivated or Continued from Previous Year	53
Low Level Monitoring or Review	59
Further Review Required Before APC Issued	14
Cases Closed	21
Other Actions Taken	
Conditions Imposed on APC	1
Conditions Imposed on Registration	2
Applications for Registration Considered and Initial Registration Supported	7

Health disclosures on APCs

In addition to those under Health Committee monitoring shown in the table above, 58 doctors disclosed a health condition at the time of applying for an APC.

Of these, 21 were doctors who had not disclosed previously. Sixteen doctors were asked to arrange for their treating doctor to sign a form confirming their fitness to practise. Five doctors were asked to submit a more detailed report, with another five being requested to submit a further report next year. In some cases reports were submitted with the application for the APC, which were sufficient for an APC to be issued straight away.

Issues

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

Total cost: As this work covers all areas of Council business it is apportioned against the major activities of the Council.

One of our main roles is guiding the profession on standards of professional conduct. Doctors must be aware of evolving standards of practice should their actions ever be questioned.

During the year the Issues Committee was disbanded. The Council now considers the need for guidance on new issues, and systematically updates older statements and guidelines.

Five statements were published in the year, four were under review and three new statements were in drafting stages.

Doctors can request from us (or access at www.mcnz.org.nz) over 30 statements and guidelines that address contemporary and ethically challenging issues in the practice of medicine. These short statements and guidelines summarise the standards expressed in our popular publications *Cole's Medical Practice in New Zealand* and *Good Medical Practice*, and all are free of charge to doctors.

To enable more doctors to access existing information, we decided during the year to introduce a free resource folder of all our statements and guidelines.

Review of sexual boundaries policies

Following a major external review of our sexual boundaries policies in 2000, the Council reconfirmed a policy of "zero-tolerance" of sexual relations in current patient-doctor relationships. Revision work has now been underway for nearly two years on several related policies. During the year good progress was made on:

- trust in the patient-doctor relationship and the importance of proper boundaries – separate information pamphlets were in draft stages for doctors and patients. They will include the Council's stance on doctors reporting about colleagues, and doctors who become sexually involved with former patients

- the presence of a third person in a medical consultation. We faced a challenge in producing a statement that could cover several scenarios: an observer in a learning situation, a patient support person, an interpreter, and a chaperone attending as part of disciplinary conditions on a doctor. The statement is relevant to all of the above. The Council agreed that the term "chaperone" would be used only in a disciplinary context. This statement was circulated for comment in late 2002. We were grateful for the many helpful comments. A decision was made to produce a separate guide to specify who is acceptable as a chaperone and the detailed requirements of the role.

Also progressed was a protocol for handling informal complaints of a sexual nature, and a project with the HDC and ACC on common or comparable complaint categories, for consistency in data. In December 2002 our free phone number (0800 286 801) was launched for improved service to callers.

"Doctors can no[w] statements and g[...] contemporary a[...] the practice of m[...]

Informed consent

Statements distributed to the profession during the year included *Information and consent* and *Legislative requirements about informed consent* (which sets out all legislation that allows a doctor to proceed with treatment without obtaining informed consent).

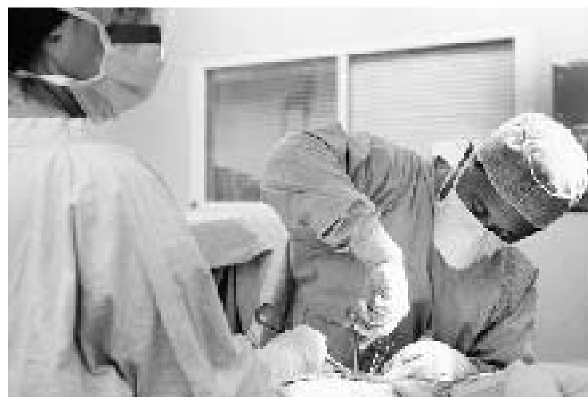
The responsibilities of those who employ doctors were outlined in an *Employer guide for health providers*, and the statement *A doctor's duty in an emergency*, originally written in 1990, was updated. All statements are sent to the profession via the Medical Council newsletter. A draft statement was circulated for comment on the relationship between the medical profession and the pharmaceutical industry.

Medical assessments of patients for third parties

The role of doctors who perform medical assessments or file reviews for third parties has been the subject of growing debate. We receive a number of enquiries from doctors, employers and patients, indicating that the nature of the relationship between the patient and assessing doctor is confusing.

We began researching and drafting a statement on standards of care applying to doctors employed by organisations like ACC, insurance companies and patients' employers, and doctors who are contracted by organisations to perform medical assessments of individual patients.

The basis of the statement is that a doctor is still required to maintain a professional standard of care, as set out in *Good Medical Practice*, even though the relationship between the patient and assessing doctor is not the same as an established doctor-patient relationship.



w request from us over 30 guidelines that address nd ethically challenging issues in nedicine."

Cultural competence

We have been working with the profession for two years in the area of "cultural competence". This involves establishing processes that will enable the development of a cost-effective programme to educate, test and monitor the cultural competence of all registered medical practitioners in New Zealand. Setting standards for cultural competence is now also required under the HPCA Bill.

Once established, the programmes will educate overseas and New Zealand-trained doctors in cultural diversity to help them function better with New Zealand-born patients and with other cultural groups, and to help them recognise how their own beliefs, values, behaviours and medical practices affect the health outcomes of patients.

During the year at meetings with colleges and branch advisory bodies we agreed that the best use of resources would be for the Council to investigate and identify the necessary definition and standards of cultural competence for the profession, rather than each college undertaking its own research. We would then notify the colleges of the expected standard and provide a framework for educational programmes. Each college would then implement its own educational programmes, with the Council including cultural competence in the overall competencies expected for registration.

In phase one, we have contracted Victoria Link, the research arm of Victoria University, to undertake research, beginning with a literature review of the current context for and scope of cultural competence in medical training and practice.

Report of the Medical Practitioners Disciplinary Tribunal

The Medical Practitioners Disciplinary Tribunal is a statutory body constituted under section 8 of the Medical Practitioners Act 1995. The Tribunal and its membership are entirely separate from the Medical Council.

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

Members and officers of the Tribunal at 31 March 2003

Dr D B Collins, QC
(Chair)

Miss S M Moran
(Senior Deputy Chair)

Ms P Kapua
(Deputy Chair)

Panel of medical practitioners

Dr F E Bennett

Dr I D S Civil, MBE

Dr J C Cullen

Dr L Ding

Dr G S (Ru) Douglas

Dr R S J Gellatly

Professor W R Gillett

Dr J W Gleisner

Dr L R Henneveld

Dr A R G Humphrey

Dr R W Jones

Dr B D King

Dr M G Laney

Dr C P Malpass

Dr U Manukulasuriya

Dr F M McGrath

Dr J M McKenzie

Associate Professor Dame N J Restieaux

Dr A A Ruakere

Dr A D Stewart

Dr J L Virtue

Dr L F Wilson

Panel of public members
(One is appointed by the chairperson for each hearing)

Mr P Budden

Ms S Cole

Mrs J Courtney

Mr G Searancke

Mrs H White

Office of the Tribunal

Ms G J Fraser
Secretary

Mrs D M Haswell
Administrative Assistant

Ms K Davies
Hearing Officer

Level 13, Mid City Tower
139 – 143 Willis St, Wellington
P O Box 24463, Manners St
Tel 04 802-4830
Fax 04 802-4831
mpdt@mpdt.org.nz
www.mpdt.org.nz

During the year under review the Tribunal received eight charges relating to eight doctors; two from the Director of Proceedings and six from complaints assessment committees. In the previous year, 31 charges relating to 19 doctors were received.

During the year, the Tribunal sat to hear 20 charges relating to ten doctors over a combined number of 31 days. Of these 20 charges, 14 were charges received in the previous year 2001/02 and six from the current year.

Charges heard by the Medical Practitioners Disciplinary Tribunal
1 April 2002 – 31 March 2003

Nature of Charges	
Disgraceful Conduct	9
Professional Misconduct	5
Conduct Unbecoming a Medical Practitioner and that Conduct Reflects Adversely on the Practitioner's Fitness to Practise Medicine	5
Convictions	1
Charges in the Alternative	0
Total	**20**

Source	
Prosecution of Charges Brought by Complaints Assessment Committee	12
Prosecution of Charges Brought by Director of Proceedings	5
Charges Brought by Complaints Assessment Committee Yet to be Heard	0
Charges Brought by Director of Proceedings Yet to be Heard	0
Charges Brought by Director of Proceedings Yet to be Completed	3
Total	**20**

Outcome of Hearings	
Guilty – Disgraceful Conduct	1
Guilty – Professional Misconduct	5
Guilty – Conduct Unbecoming a Medical Practitioner and that Conduct Reflects Adversely on the Practitioner's Fitness to Practise Medicine	5
Guilty of Conviction	1
Not Guilty	5
Yet to be Completed	3
Total	**20**

Further information relating to these statistics can be found on the Tribunal's website www.mpdt.org.nz

Medical Workforce Survey (2001)

Total cost: $121,219

The Council collects workforce data annually. The data is used by the Ministry of Health and by the Health Workforce Advisory Committee to analyse workforce needs.

The workforce survey is sent to doctors with probationary or general registration, a current APC and a New Zealand address (excludes temporary registrants).

Ninety-four percent of doctors holding an APC responded to the Council's 2001 survey. The four periods of data in this report are November 2000, February 2001, May 2001 and August 2001 and are presented as at 31 March 2001. The major findings were:

Demographics: The proportion of women in the workforce (32.6 percent) was the same as in 2000. The proportion of overseas-trained doctors also remained the same as in 2000, at 34.4 percent. The proportion of Maori doctors increased slightly to 2.6 percent but, along with Pacific Island doctors at 1.1 percent, Maori continue to be markedly under-represented compared with the general population.

Work type: Since 1999 there have been decreases in the larger work groups anaesthetics, diagnostic radiology, general practice and primary care; and increases in paediatrics, psychiatry and internal medicine.

Geographical distribution: In territorial local authorities, full-time equivalent general practitioners ranged from 43 to 192 per 100,000 people. The average, 85 full-time equivalent general practitioners per 100,000 people, was a decrease of 2.4 percent since 2000.

The highest ratio of general practitioners was in Nelson, Kapiti, Clutha districts, Queenstown Lakes, South Wairarapa and Thames/Coromandel. The lowest ratio was in South Taranaki, Western Bay of Plenty, Tasman and Southland, where the number dropped below 50 per 100,000 people.

The full survey report is available on www.mcnz.org.nz.

Our purpose

The purpose of the Medical Council is ensuring that medical practitioners are competent to practise medicine, in order to protect and promote the public health and safety.

Finance

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Finance

The attached financial statements are for the year 1 April 2002 to 31 March 2003.

The Medical Council received another unqualified audit opinion this year.

General Council operations

The general fund covers registration of doctors, and activities to promote medical education, develop guidelines, carry out competence reviews, manage doctors with health problems and produce the annual workforce survey. The fund shows a surplus for the year of $89,616, compared with the deficit budgeted of $169,000 and the surplus in the previous year of $619,057.

Total revenue increased by $148,000 from the previous year. Revenue from fees increased by $77,000 with the number of doctors entering probationary registration and the number of APCs issued both being up from the previous year as graduates, many from the UK, converted time spent on temporary registration to probationary registration and then moved on to general registration. Revenue from vocational registration is down $49,000 from the previous year. Revenue from vocational registration was higher the previous year as doctors had been trying to meet the requirements for vocational registration prior to the expiry of the general oversight transition arrangements. Other revenue is up $70,000 due to a refund of fringe benefit tax by Inland Revenue commencing from June 1997.

Total expenditure increased by $677,000 from the previous year and exceeded budget by $104,000. Total administration and operating expenditure was up $533,000 from the previous year, with communications being the main contributor to the increase. This was due to initiatives such as the folder of statements and guidelines now available free to the profession – this initiative was seen as a way the Council can be of assistance to the whole profession. Also, the Council history project (the previous Registrar's perspective) was completed during the current year and will shortly be available on the Council's website.

Depreciation costs were $127,000 more than the previous year reflecting the Council's investment in information technology (IT).

Total Council and committee expenditure was $144,000 up on the previous year. The Issues Committee and the Professional Standards Committee were disbanded at the start of the year as these areas were considered core functions of the Council. As a result, Council costs were greater than the previous year but the savings from the disbanded committees offset this. The remuneration rate for intern supervisors was increased this year after remaining unchanged since 1997, and the cost of hospital accreditation visits also increased as improvements were made in the accreditation process.

As at 31 March 2003 the general fund capital account was $7,000,661 with this comprising both the cash and non-cash assets of the Council. A significant deficit is budgeted for 2003/04 and small increases to the APC may be considered, as the Council does not want the impact of the anticipated deficit to result in reserves falling below the target level in Council policy.

Complaints investigation and prosecution fund – formerly the discipline fund

During the year the Council decided to change the name of the discipline fund to the complaints investigation and prosecution fund to reflect better the activities of the fund.

The complaints investigation and prosecution fund covers the work of complaints assessment committees and it also fully funds the operations of the Medical Practitioners Disciplinary Tribunal.

The fund shows a deficit for the year of $486,576, compared with the deficit budgeted of $161,000 and the deficit in the previous year of $643,488.

Total revenue was down $90,000 from the previous year, but disciplinary levy fees were up $28,000 as more revenue was received for probationary registrations and APCs.

Total expenditure was $247,000 less than the previous year but exceeded budget by $335,000. Administration and operating expenses were $51,000 more than the previous year due to the payment by the Council of costs as a respondent in a High Court case. Complaints assessment committee costs were $160,000 less than the previous year but up compared with budget. Fifty complaints assessment committees were set up this year compared with 43 the previous year. Complaints assessment committee costs vary significantly depending on the type of complaint.

Medical Practitioners Disciplinary Tribunal costs were $138,000 less than the previous year and in line with budget. The Tribunal held 12 hearings for 20 charges requiring 31 sitting days compared with ten hearings for 21 charges requiring 39 sitting days in the previous year.

As at 31 March 2003 the complaints investigation and prosecution fund capital account was $2,629,889. Another significant deficit is budgeted for 2003/04 and small increases in the disciplinary levy may be considered in coming years to avoid reserves falling below the target level.

Examination fund

The examination fund covers the operating costs of NZREX Clinical. The fund produced a small surplus for the year to 31 March 2003 of $4,113 compared with the deficit in 2001/02 of $66,108. As at 31 March 2003 the examination fund capital account shows a deficit of $173,687. Recently the Council confirmed the aim that the NZREX Clinical is to be totally self-funding and examination fees will need to continue to increase.

Miller Dean Knight & Little

Chartered Accountants

MEDICAL COUNCIL OF NEW ZEALAND
AUDITORS' REPORT
FOR THE YEAR ENDED 31 MARCH 2003

To : **Members of the Medical Council Of New Zealand**

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

We have audited the attached financial statements which provide information about the past financial performance of the Council and its financial position as at 31 March 2003. This information is stated in accordance with the accounting policies set out in the notes to the financial statements.

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

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

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

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

In addition to our role as auditors, we provide taxation and other advice to the Council. Other than this, we have no other interests in the Medical Council.

Unqualified Opinion
We have obtained all the information and explanations we have required. In our opinion the attached financial statements fairly reflect the financial position of the Medical Council of New Zealand as at 31 March 2003 and the results of its operations and cash flows for the year ended on that date.

Date Of Opinion
Our audit was completed on 21 July 2003 and our unqualified opinion is expressed as at that date.

Level 8, [illegible] House, 208-209 Willis Street, PO Box 11 253, Wellington, NZ. Tel 0 4 385 [illegible] Fax [illegible]

Maurice A. Knight CA, [illegible]

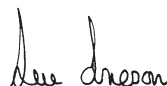
Statement of Financial Position

as at 31 March 2003

	2003	2002
Current Assets		
Petty Cash	300	300
ANZ Bank Account	157,847	207,815
Sundry Debtors and Payments made in Advance (Note 7)	67,347	48,293
Interest Accrued	439,513	551,208
Term Deposits (Note 8)	10,931,870	11,047,957
Total Current Assets	$11,596,877	$11,855,573
Fixed Assets (Note 9)	1,061,911	1,014,756
Total Assets	$12,658,788	$12,870,329
Current Liabilities		
Sundry Creditors	657,124	605,875
Salaries and Holiday Pay Accrued	157,360	125,999
GST	35,770	28,746
Payments Received in Advance	2,351,671	2,259,999
Total Current Liabilities	$3,201,925	$3,020,619
Capital Account		
General Fund	7,000,661	6,911,045
Complaints Investigation and Prosecution Fund (Note 10)	2,629,889	3,116,465
Examination Fund	(173,687)	(177,800)
	$9,456,863	$9,849,710
	$12,658,788	$12,870,329

The accompanying notes form part of these financial statements.

John Campbell
President



Sue Ineson
Chief Executive

Consolidated Statement of Financial Performance

for the year ended 31 March 2003

	2003	2002
Income		
Fees Received	5,328,964	5,037,945
Interest Received	683,955	741,298
Other Income	243,630	229,030
	$6,256,549	$6,008,273
Expenditure		
Audit Fees	10,000	12,300
Other Payments to Auditors	1,600	2,000
Depreciation (Note 1a, 9)	471,025	343,498
Fees Paid to Council Members	408,714	419,975
Other Administrative Costs	5,628,647	5,191,629
Rent	129,410	129,410
	$6,649,396	$6,098,812
Net Deficit for Year	($392,847)	($90,539)

The accompanying notes form part of these financial statements.

Statement of Movements in Equity

for the year ended 31 March 2003

	2003	2002
A) ACCUMULATED FUNDS AND RESERVES		
Balance at 31 March 2002	9,849,710	9,940,249
Less: Deficit	(392,847)	(90,539)
Balance at 31 March 2003	$9,456,863	$9,849,710
B) ANALYSIS OF INDIVIDUAL FUNDS		
1) General Fund		
Balance at 31 March 2002	6,911,045	6,291,988
Add: Surplus	89,616	619,057
Balance at 31 March 2003	$7,000,661	$6,911,045
2) Complaints Investigation and Prosecution Fund		
Balance at 31 March 2002	3,116,465	3,759,953
Less: Deficit	(486,576)	(643,488)
Balance at 31 March 2003	$2,629,889	$3,116,465
3) Examination Fund		
Balance at 31 March 2002	(177,800)	(111,692)
Less: Deficit 2002		(66,108)
Add: Surplus 2003	4,113	
Balance at 31 March 2003	($173,687)	($177,800)

The accompanying notes form part of these financial statements.

Statement of Cash Flow

for the year ended 31 March 2003

		2003	2002
Cash Flow from Statutory Functions			
Cash was provided from:			
Receipts Pertaining to Statutory Functions	5,542,447		5,245,522
Cash was also distributed to:			
Payment for Council Fees and Disbursements			
and Council Office Expenses	(5,986,864)		(5,534,861)
Net Cash Flow from Statutory Functions		(444,417)	(289,339)
Cash Flow from Investing Activities			
Cash was provided from:			
Interest Received	795,650		626,799
Sale of Assets			1,123
Short Term Investments	116,087		301,186
	911,737		929,108
Cash was applied to:			
Purchase of Assets	(517,288)		(575,397)
	(517,288)		(575,397)
Net Cash Flow from Investing Activities		394,449	353,711
Net Increase/(Decrease) in Cash Held		(49,968)	64,372
Opening Cash Brought Forward		208,115	143,743
Ending Cash Carried Forward		$158,147	$208,115
Represented by:			
Petty Cash		300	300
ANZ Bank Account		157,847	207,815
		$158,147	$208,115

The accompanying notes form part of these financial statements.

Notes to and Forming Part of the Financial Statements

for the year ended 31 March 2003

1. Statement of Accounting Policies

Reporting Entity

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

General Accounting Policies

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

Measurement Base

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

Specific Accounting Policies

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

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

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

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

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

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

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

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

g) Administration Charge – This is a levy on the complaints investigation and prosecution fund and the examination fund to meet overhead costs incurred by the general fund. The charge to the complaints investigation and prosecution fund is based on the proportion of staff engaged in this activity.

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

i) Changes in Accounting Policies – There have been no material changes in accounting policies, which have been applied on bases consistent with those used in the previous year.

2. General Fund

Statement of Financial Performance
for the year ended 31 March 2003

	2003	2002
REVENUE		
Annual Practising Certificates and Other Fees	3,790,777	3,713,413
Administration Fee – Complaints Investigation and Prosecution Fund (Note 1)	461,000	464,000
Administration Fee – Examination Fund (Note 1)	60,000	60,000
Interest Received	497,407	501,910
Workforce Survey and Other Income	154,696	76,904
Total Revenue	$4,963,880	$4,816,227
ADMINISTRATION AND OPERATING EXPENSES		
Communications	350,249	180,475
Election of Members	39,687	
Legal Expenses and Other Consultancies	150,101	80,585
Administration and Operating Expenses	1,037,048	903,765
Staff Costs Including Recruitment and Training	1,870,558	1,749,233
Total Administration and Operating Expenses	$3,447,643	$2,914,058
COUNCIL AND COMMITTEE EXPENSES		
Council		
– Fees and Expenses	392,756	293,537
– Conference and Liaison Costs	154,572	143,664
Audit Committee		
– Fees and Expenses	7,182	9,992
Health Committee		
– Fees and Expenses	49,897	48,881
– Health Reports, Mentoring, Doctors Health Advisory Service and Other Costs	115,658	115,512
Issues Committee		
– Fees and Expenses		35,087
Education Committee		
– Fees and Expenses	59,543	56,278
– Hospital Visits, Intern Supervisor Contracts and Other Costs	296,308	229,773
Professional Standards Committee		
– Fees and Expenses		63,940
– Competence Reviews and Other Costs	260,708	254,547
Registration		
– Fees and Expenses	4,675	12,790
– Workshops and Related Costs	10,606	18,375
– Examination Review Costs	74,716	736
Total Council and Committee Expenses	$1,426,621	$1,283,112
TOTAL EXPENDITURE	$4,874,264	$4,197,170
Net Surplus for Year	$89,616	$619,057

3. Complaints Investigation and Prosecution Fund

Statement of Financial Performance
for the year ended 31 March 2003

	2003	2002
REVENUE		
Disciplinary Levy Received	1,162,065	1,133,714
Fines, Costs and Mentoring Recovered	86,531	152,126
Interest Received	186,548	239,388
Total Revenue	$1,435,144	$1,525,228
ADMINISTRATION AND OPERATING EXPENSES		
Administration Fee (Note 1)	461,000	464,000
General Administration and Operating Expenses	127,150	72,972
Total Administration and Operating Expenses	$588,150	$536,972
COUNCIL AND TRIBUNAL EXPENSES		
Complaints Assessment Costs		
– Fees	231,468	230,119
– Expenses	456,317	617,897
Total Complaints Assessment Costs	687,785	848,016
MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL		
– Administration and Operating Expenses	225,837	224,645
– Fees and Other Hearing Expenses	419,948	559,083
Total Medical Practitioners Disciplinary Tribunal Costs	645,785	783,728
Total Council and Tribunal Expenses	$1,333,570	$1,631,744
TOTAL EXPENDITURE	$1,921,720	$2,168,716
Net (Deficit) for Year	($486,576)	($643,488)

4. New Zealand Registration Examination Fund

Statement of Financial Performance
for the year ended 31 March 2003

	2003	2002
REVENUE		
NZREX Candidate Fees	376,122	190,818
Other Income	2,403	
Total Revenue	$378,525	$190,818
ADMINISTRATION AND OPERATING EXPENSES		
Administration Fee (Note 1)	60,000	60,000
Centre Costs	69,224	36,395
Examiners' Fees and Expenses	195,712	100,151
General Administrative Expenses	2,525	2,521
Honorariam, Salaries and Other Staff Costs	37,263	48,525
Total Administration and Operating Expenses	$364,724	$247,592
COMMITTEE EXPENSES		
Committee Fees and Expenses	9,688	9,334
Total Committee Expenses	$9,688	$9,334
TOTAL EXPENDITURE	$374,412	$256,926
Net Surplus/(Deficit) for Year	$4,113	($66,108)

5. General Fund

Statement of Financial Performance by Outputs
for the year ended 31 March 2003

These output categories represent the main activities of the general fund and are discussed in detail in the text of the Annual Report.

	2003	2002
TOTAL INCOME FOR YEAR	$4,963,880	$4,816,227
Less Expenditure		
EDUCATION		
Administration and Operating Costs	398,012	376,502
Council and Committee Costs	107,536	100,298
Hospital Accreditation Visits	66,046	45,384
Intern Supervisor Contract Payments and Meeting Costs	226,862	177,507
Liaison and Other Costs	39,627	44,478
Total Education Costs	$838,083	$744,169
HEALTH		
Administration and Operating Costs	635,056	561,898
Council and Committee Costs	121,886	113,218
Doctors Treating Doctors Health Initiative	13,115	
Doctors Health Advisory Service Contract	43,773	43,870
Independent Medical Assessments	46,038	52,037
Mentoring Costs	9,370	10,127
Liaison and Other Costs	21,172	38,295
Total Health Costs	$890,410	$819,445
PROFESSIONAL STANDARDS		
Administration and Operating Costs	591,186	392,251
Council and Committee Costs	71,989	107,960
Competence Review Costs	207,898	217,443
Development of Assessment Tools	41,485	
Liaison and Other Costs	60,410	54,542
Total Professional Standards Costs	$972,968	$772,196
REGISTRATION		
Administration and Operating Costs	1,717,136	1,500,942
Council and Committee Costs	200,644	188,870
Examination Review Costs	74,716	736
Liaison and Other Costs	59,088	74,926
Total Registration Costs	$2,051,584	$1,765,474
WORKFORCE SURVEY		
Administration and Operating Costs	106,253	82,465
Council and Committee Costs	11,998	10,158
Liaison and Other Costs	2,968	3,263
Total Workforce Survey Costs	$121,219	$95,886
TOTAL EXPENDITURE	$4,874,264	$4,197,170
Net Surplus for Year	$89,616	$619,057

6. Taxation

On 20 December 1996 the Court of Appeal found the Medical Council to be exempt from income tax.

7. Payments in Advance and Debtors

	2003	2002
Outstanding Contribution to		
Workforce Survey	43,222	20,000
Other Debtors	21,328	8,919
Payments in Advance	2,797	19,374
	$67,347	$48,293

8. Term Deposits

	2003	2002
ANZ	2,121,649	2,045,953
ASB	1,185,646	1,644,599
BNZ	1,609,108	1,574,214
Hong Kong Bank	988,441	1,067,698
National Bank	2,503,475	2,290,393
Taranaki Savings Bank	739,166	695,410
Westpac	1,784,385	1,729,690
Total Investments	$10,931,870	$11,047,957

9. Fixed Assets

	Cost 31/3/03	Depreciation for Year 31/3/03	Accumulated Depreciation 31/3/03	Book Value 31/3/03	Cost 31/3/02	Accumulated Depreciation 31/3/02	Book Value 31/3/02
Computers	1,772,238	399,356	926,017	846,222	1,331,640	559,250	772,390
Furniture and Fittings	169,724	16,121	99,209	70,515	169,675	84,776	84,899
Office Alterations	258,615	25,507	175,968	82,647	254,242	150,461	103,781
Office Equipment	205,025	30,041	142,498	62,527	193,232	139,546	53,686
	$2,405,602	$471,025	$1,343,692	$1,061,911	$1,948,789	$934,033	$1,014,756

Costs of setting up and maintaining websites for the Medical Practitioners Disciplinary Tribunal and the Medical Council have been expensed in the year incurred.

10. Change of Name for the Discipline Fund

The Council has decided to change the name of the discipline fund to complaints investigation and prosecution fund to reflect better the activities of the fund.

11. Related Parties

The Council members are paid fees for attending to the Council's and committee business. There were no other related party transactions.

12. Foreign Currencies

Foreign currency transactions have been recorded at the rate of exchange applicable on the day of completion. There were no settlements due at balance date.

13. Reconciliation of Net Surplus with the Net Cash Flow from Statutory Functions for the Year Ended 31 March 2003

Surplus/(Deficit) for year	2003	2002
General Fund	89,616	619,057
Complaints Investigation and Prosecution Fund	(486,576)	(643,488)
Examination Fund	4,113	(66,108)
	(392,847)	(90,539)
Add Non-cash Items – Depreciation (Note 9)	471,025	343,498
	78,178	252,959
Add Movements in Working Capital Items		
(Increase)/Decrease in Debtors and Prepayments	(19,054)	(26,841)
Increase/(Decrease) in Receipts in Advance	91,672	167,161
Increase/(Decrease) in Creditors and GST	88,742	58,680
	161,360	199,000
	239,538	451,959
Less Items Classified as Investing Activity-Interest	(683,955)	(741,298)
Net Cash Flow from Statutory Functions	($444,417)	($289,339)

14. Contingent Liabilities

There are no known material contingent liabilities at balance date ($90,000 as at 31 March 2002).

15. Events Occurring After Balance Date

The Council relocated premises shortly after balance date. The fixed assets associated with the fit-out of the previous premises will be written off in the next financial period. Other than this, there were no adjustable or non-adjustable events (as defined in the applicable financial reporting standard) between balance date and the date of completion of the financial statements.

16. Commitments – Operating Leases

Lease commitments under non-cancellable operating leases:

	2003	2002
Not More than One Year	222,257	116,760
Later than One Year and Not Later than Two Years	231,848	9,730
Later than Two Years and Not Later than Five Years	695,544	
	$1,149,649	$126,490

Commitments – Capital Expenditure

The Council has made the decision to relocate from the 12th floor to the 13th and 14th floors of Mid City Tower in Wellington. The total budgeted cost for the restoration of the 12th floor, fit-out of the 13th and 14th floors and relocation is $480,000 (nil as at 31 March 2002).

17. Financial Instruments

Financial instruments which potentially subject the Council to credit risk consist principally of bank balances and accounts receivable.

The Council places investments with recognised banking institutions within an approved reserves and investment policy to limit exposure to concentrations of credit risk. Debtors are shown at a fair value. The estimated fair values of the financial instruments are:

	2003	2002
Receivables	64,550	28,919
Bank Balances	11,089,717	11,255,772
Payables	(850,254)	(760,620)

Corporate Governance

Establishing sound corporate governance policies and procedures has been a Council priority, to ensure a continuing improvement in the standard of our operations. The Strategic Plan and annual business plan and budget set out the goals the Council has agreed should be achieved.

There are clear policies and delegations in place for financial and operational areas. The Chief Executive Officer reports to the Council six-weekly on progress and variances to the agreed plan and budget and annually to the Audit Committee on organisational risks. An internal quality audit programme regularly reviews all our procedures and processes.

Role of the Medical Council

Members of the Medical Council set the strategic direction of the Council, monitor management performance and set delegated authority limits across the Council's functions in addition to those in the Medical Practitioners Act. The Council is accountable to Parliament, the profession and the public for how well its functions are performed.

The duties of Council members are to:

- ensure the functions of the Council as set out in section.123 of the Act are carried out
- set the strategic direction for, and approve policy of, the Council
- appoint and monitor the performance of the Chief Executive and, through that position, work with the Council staff
- approve the annual business plan and budget
- ensure compliance with all statutory requirements
- maintain good relationships with stakeholders.

Council membership

The size (and to some extent the composition) of the Council is set by the Act in section.124(a) and its amendments, which state that the Council shall consist of:

- a member of the academic staff of a faculty of medicine in a New Zealand university, who shall be appointed by the Minister after consultation with the Deans of the Faculties of Medicine of New Zealand universities
- four medical practitioners elected by medical practitioners in accordance with rules made under section.125 of the Act; or regulations made under section.140 of the Act
- five other persons appointed by the Minister, two of whom may be medical practitioners.

The Council aims to have members who represent:

- a range of ages, gender and ethnicities
- a broad mix of the medical profession, New Zealand society as a whole, and who have a wide general knowledge and breadth of vision and: broad health sector knowledge; or experience in one of the main vocational areas of medical practice; or experience in health service delivery in a variety of provincial and tertiary settings; or experience in medical education and assessment.

The key competencies for members across a range of professional and personal attributes have been documented.

Members are bound by a code of conduct that was approved in December 2002, in which several duties and responsibilities are articulated. In addition, each member of the Council must sign a confidentiality pledge to agree to non-disclosure of information obtained during their term of office and subsequently.

The Council has an agreed policy on conflict of interest, updated in February 2002. When members believe they have a conflict of interest on a subject which will prevent them from reaching an impartial decision or undertaking an activity consistent with the Council's functions, they must declare that conflict of interest and absent themselves from the discussion or activity.

Consistency of administrative decision-making

The Medical Practitioners Act provides the Council with discretion in approving applications for registration and in exercising its other functions under the Act. While Council policies set out clearly how the Council will act, the Council can and does exercise its discretionary powers. It does so conscious of the test of legality, reasonableness and fairness that applies and may seek legal advice in particular instances. The Council usually makes its decisions within policy unless the exceptional circumstances of a particular case justify otherwise. All applications and cases that fall outside policy are referred to the Council to decide.

Council meetings

In the last financial year the Council met ten times, in addition to meetings of committees. Teleconferences were held to deal with some ordinary matters and some extraordinary business of the Council and committees. In addition the Council holds:

- a yearly strategy meeting
- a planning day, to determine the areas in the business plan for the forthcoming year. In the coming year these are: induction of new members, review of sexual boundaries, review of workforce issues, review of registration policies in light of new legislation, cultural competence project and review of communications strategy
- an annual training day, to focus on specific matters of interest in members' governance role. In 2002 members discussed risk assessment and application of the conflict of interest policy; the focus in 2003 will be on position descriptions, code of conduct and ongoing work on risk management.

Annual performance assessment

Over the past four years members have taken part in an assessment process of their functioning as a Council across several indicators. This has resulted in improvements to agenda structure, refinement of delegation and new features such as stakeholder links at each meeting. Examples of good work include improved relationships with external groups, new initiatives such as the online medical register and effective auditing. Areas for improvement include building understanding of Council functions by stakeholders and being proactive on emerging issues.

Remuneration

Council members' fees are set according to the public service remuneration survey and are subject to an annual external review. The Council President receives an honorarium.

Committee structure

The Council operates four standing committees: Audit, Examinations, Health and Education. Membership of committees is on page 67. Chairs of committees are appointed by the President. The Council receives the minutes of the committees at its formal meetings and in approving those minutes it confirms the decisions made. Delegation limits are established. The Health Committee has full delegated decision-making powers.

Information held by the Medical Council

Public information about doctors is that which is contained in the medical register. Other information held on the Council's database and doctors' individual files is not public.

Information about doctors that is public

1. Information on the medical register.

2. Tribunal hearings, unless suppressed or partially suppressed.

3. Competence reviews only if the Council publishes a notice under section.138 of the Act. (Note: the HDC may refer a doctor for a competence review in an open opinion but the Council decision on whether to do a review is not disclosed).

4. Competence reviews and health undertakings that are included in conditions imposed by the Tribunal following a disciplinary hearing.

5. Any other information published where the Council makes an order under section.138 of the Medical Practitioners Act 1995.

Information about doctors that is not public

6. Personal details:
   - A doctor's place of work and position, current and previous.
   - A doctor's phone, fax and email.
   - Additional qualifications not listed on the medical register.

7. Discipline:
   - Current complaints.
   - Anonymous or informal complaints.
   - Past complaints (unless the complaint resulted in a Tribunal hearing).
   - Fitness "flags" on doctors' files (note: flags refer to any issue with a doctor, not only discipline).

8. Competence and health matters:
   - Competence review investigation.
   - Competence review report.
   - Competence programme.
   - Doctors' voluntary undertakings with the Health Committee.

The Council is subject to the Privacy Act and information privacy principles. If requested, the Council must disclose to individual medical practitioners what personal information is held about them on Council files.

Privacy requests

During the 2002/03 year, 21 requests for disclosure of personal information were made. Categories of documents held by the Medical Council include:

- agendas, minutes and papers for Council meetings and Council committees
- the New Zealand medical register
- doctors' registration files
- doctors' complaints and discipline files
- competence review committee reports
- doctors' health files
- Medical Practitioner Disciplinary Tribunal decisions
- files on the Council's functions under the Medical Practitioners Act
- medical workforce statistics
- policy and procedures manuals
- books, pamphlets, statements and guidelines to inform the profession of Council functions
- legal advice/opinions
- general administration files
- accounts, financial statements, budgets
- personnel records
- computer records relating to all Council operations.

All privacy information requests go to the Council's privacy officer: Tania Turfrey, Registrar.

Council Committees at 31 March 2003

The Council appoints committees to deal with its principal activities. Each committee has a minimum of two Council members. Registration decisions can be delegated by Council.

During 2002/03, the Professional Standards Committee and Issues Committee were disbanded and their functions resumed by the Council.

Audit Committee

Dr D A Read
(Acting Chairperson)

Dr B R Bond

Professor J A Campbell

Mrs H Thomson

Education Committee

Members appointed by the Council

Professor M W Ardagh
Selected from vocational branch nominees

Dr M Davis
Selected from intern supervisors

Dr D A Clarke
Active consumer of education

Dr L A Martin
Nominee of appropriate college or branch advisory body – general practitioner

Dr D A Spriggs
Nominated by the Council

Dr N C Wilson
Active consumer of education

One vacancy
Nominee of appropriate college or branch advisory body – surgeon

Council members

Dr D A Read (Chairperson)

Dr P M Barham

Professor J A Campbell

Ms J Hera

Mrs H Thomson

Examinations Committee

Members appointed by the Council

Professor P G Alley
Examinations Coordinator, Auckland

Dr H B Cook
Examinations Coordinator, Christchurch

Professor P M Ellis
University of Otago nominee

Dr D J McHaffie
Examinations Coordinator, Wellington

Professor J G Mortimer
Examinations Director

Associate Professor J J Reid
Examinations Coordinator, Dunedin

Dr R P G Rothwell
Examinations Coordinator, Hamilton

Professor P R Stone
University of Auckland nominee

Council members

Professor J A Campbell (Chairperson)

Dr J MacDonald

Mrs H Thomson

Health Committee

Dr J MacDonald (Chairperson)

Dr P M Barham

Miss C Bull

Dr K A O'Connor

Alternate lay person Mrs H Thomson

Staff members
of the Medical Council of New Zealand

1st row
Emma Kennedy
Hannah Bates (left)
Sharon Mason (right)
Dot Harvey
Dr Ian St George

2nd row
Sean Hill
Hannah Bates
Farina Bains (left)
Rachael Heslop (right)
Gabrielle Shaw

3rd row
Nicola Bradshaw (left)
Justine Fleming (right)
Bill Taylor
Emma Worden
Justine Fleming

4th row
Nicola Bradshaw
Sharon Mason
Rebecca Wilson
Rachael Heslop

Office of the Council at 31 March 2003

Ms Sue Ineson
Chief Executive

Ms Tania Turfrey
Registrar

Mrs Barbara Eagle
PA to Chief Executive

Registration

Mr Sean Hill
Registration Manager

Ms Karen Gardner
Registration Coordinator

Ms Gyllian Turner
Registration Administrator

Mr Philip Girven
Registration Administrator

Ms Justine Fleming
Registration Administrator

Ms Heather Pettigrew
Registration Administrator

Ms Nicola Bradshaw
Registration Administrator

Ms Rebecca Wilson
Registration Administrator

Mrs Emma Worden
APC Coordinator

Ms Nicolé Mistal
APC Administrator

Standards

Ms Sue Colvin
Standards Manager

Ms Gabrielle Shaw
Education Administrator

Ms Emma Kennedy
Examinations Coordinator

Ms Hannah Bates
CAC Administrator

Ms Debbie North
Complaints Administrator

Ms Rachael Heslop
Professional Standards Administrator

Ms Farina Bains
Professional Standards Officer

Health

Ms Lynne Urquhart
Health Manager

Ms Jo Hawken-Incledon
Health Administrator

Mrs Viv Coppins
Health Administrator

Corporate Services

Mr Tony Hanna
Corporate Manager

Mr Bill Taylor
Information Systems Coordinator

Ms Diane Latham
Information Systems Administrator

Mrs Dot Harvey
Senior Secretary

Ms Betty Wright
Office and Records Administrator

Ms Sharon Mason
Customer Services

Finance

Mr John de Wever
Financial Controller

Ms Moyra Hall
Finance Accounts Officer

Advisor Group

Dr Ian St George
Medical Advisor

Mrs Jane Lui
Quality Assurance Manager

Ms Chris Aitchison
Policy Analyst

vacant
Communications Coordinator

Medical Council of New Zealand

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Facsimile 04 385-8902
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Wellington

Bankers

ANZ Banking Group

Victoria Street branch
Wellington

Auditors

Miller, Dean, Knight & Little

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