MEDICAL COUNCIL
OF NEW ZEALAND

ANNUAL REPORT
1989

MEDICAL COUNCIL OF NEW ZEALAND
ANNUAL REPORT
FOR YEAR ENDED 30 JUNE 1989

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MEMBERS OF THE MEDICAL COUNCIL

(At 30 June 1989)

	Appointed by Governor-General on Recommendation of:
Dr W.S. Alexander (Chair)	Minister of Health
Dr R.H. Briant (Deputy Chair)	Royal Australasian College of Physicians
Dr J.M. Broadfoot	New Zealand Medical Association
Dr R.G. Gudex	Royal New Zealand College of Obstetricians and Gynaecologists
Dr M.M. Herbert	New Zealand Medical Association
Professor J.D. Hunter	ex officio, Dean, Faculty of Medicine, University of Otago
Mrs P.C. Judd, J.P.	Minister of Health
Dr G.F. Lamb	Royal Australasian College of Surgeons
Professor J.D.K. North	ex officio, Dean, University of Auckland School of Medicine
Dr I.M. St George	Royal New Zealand College of General Practitioners
Dr P.S. Talbot	ex officio, for Director-General of Health
Dr J.A. Treadwell	Minister of Health

SECRETARIAT

(At 30 June 1989)

Secretary	Ms G.A. Jones, BA
Assistant Secretary	Mr J.R. Coster, BA

Council Offices	73 Courtenay Place, Wellington 1
Postal Address	PO Box 9249, Wellington
Telephone	(04) 847-635
Fax	(04) 858-902

Solicitors	Kensington Swan, PO Box 10246, Wellington

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

Auditors	Miller, Dean and Partners, PO Box 11253, Wellington

Secretariat	Secretary:	Ms G.A. Jones
	Assistant Secretary:	Mr J.R. Coster
	Clerk:	Ms J. Johns
	Clerk:	Mrs J. Lui
	Secretary/Word Processor Operator:	Ms J. Hawken
	Accounts Officer (Part-time):	Mr P. Stark

MEDICAL EDUCATION COMMITTEE

(At 30 June 1989)

	Appointed by:
Professor J.D. Hunter (Chair)	Medical Council
Dr P.M. Barham	Royal New Zealand College of General Practitioners
Professor A.M. Clarke	ex officio, Dean, Christchurch School of Medicine, University of Otago
Dr A.G. Dempster	Faculty of Medicine, University of Otago
Dr J.L. Jardine	Royal Australasian College of Surgeons
Dr G.M. Kirk	Royal Australasian College of Physicians
Professor J.D.K. North	ex officio, Dean, University of Auckland, School of Medicine
Professor T.V. O'Donnell	ex officio, Dean, Wellington School of Medicine, University of Otago
Profesor F.T. Shannon	Faculty of Medicine, University of Otago
Dr I.J. Simpson	Faculty of Medicine, University of Auckland
Dr A.D. Stewart	Royal New Zealand College of Obstetricians and Gynaecologists
Professor R.D.H. Stewart	ex officio, Dean, Dunedin Division, Faculty of Medicine, University of Otago
Associate Professor S.R. West	New Zealand Medical Association
Dr P.S. Talbot	Observer, Department of Health

COMMITTEES

(At 30 June 1989)

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

Preliminary Proceedings Committee
Dr R.H. Briant (Convener)
Dr G.F. Lamb
Dr R.G. Gudex (alternate for medical members)
Mr P.H. Cook (Legal Member)

Finance and Management Committee

Dr W.S. Alexander (Chair)
Dr J.M. Broadfoot
Ms G.A. Jones
Mr P. Stark
Dr J.A. Treadwell

Medical Practitioners Data Committee
Professor J.D. Hunter (Chair)
Dr W.S. Alexander
Ms G.A. Jones
Ms C. Leatham (Statistician)
Dr I.M. George
Professor D.C.G. Skegg
Dr P.S. Talbot

Health Committee
Dr R.G. Gudex (Convener)
Dr M.M. Herbert
Mrs P.C. Judd
Dr J.A. Treadwell

Registration Committee

Dr I.M. St George (Convener)
Dr J.M. Broadfoot
Dr M.M. Herbert
Ms G.A. Jones
Dr G.F. Lamb
Dr C.H. Maclaurin

Specialist Registration Sub-Committee
Dr G.F. Lamb (Convener)
Professor J.D.K. North

Indicative Register Sub-Committee
Dr M.M. Herbert (Convener)
Dr J.M. Broadfoot

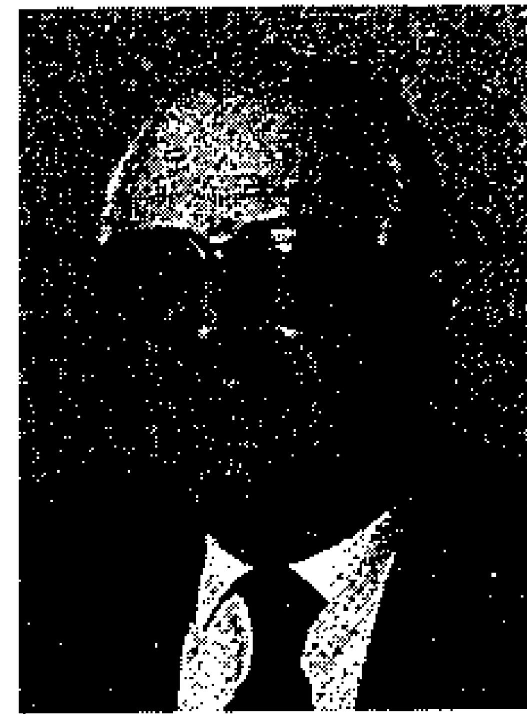
Board of Examiners
Dr W.S. Alexander, (Chair), Medical Council
Dr M.M. Herbert, Medical Council
Professor J.D. Hutton, Nominee of University of Otago
Professor T.V. O'Donnell, Nominee of University of Otago
Dr J. Kolbe, Nominee of University of Auckland
Associate Professor S.R. West, Medical Education Committee
Dr G.L. Glasgow, Examinations Director

REPORT FROM THE CHAIR

The seventh Annual Report of the Medical Council of New Zealand gives an account of progress and developments in the year ending 30 June 1989. A number of important issues which have occupied Council's attention during the year are the subject of separate sections in this Annual Report. The main thrust of Council activity has been to ensure that the outline of proposed changes to the Medical Practitioners Act has received as wide a circulation as possible, and that the proposals have reached Government in time for the drafting of legislation during 1989.

These discussions have taken place in an atmosphere of increasing scrutiny of the medical profession and its organisations. There has been considerable media attention on all aspects of the Council's activities and while the Cartwright and Mason reports have been conspicuous in drawing public attention to various aspects of medical practice in New Zealand, a great deal of attention has been paid to such things as disciplinary matters, registration and professional competence. Stimulated by this interest the flood of complaints continues to swell and official organisations such as the Accident Compensation Corporation add their voices to the criticism.

In this environment the Medical Council has had a difficult task. To some extent it is hampered by the provisions of an Act which may have been adequate in 1968 but is seen to be unduly protective of the medical profession at the present time. The criticism of apparent secrecy is voiced by both the members of the profession and the public, but there are very frequently situations in which the Medical Council is compelled to appear more secret than the normal Court system.



Stewart Alexander

The Medical Council is of the view that if the disciplinary activities of the Council and of the Medical Practitioners Disciplinary Committee are dealt with in an independent Medical Practitioners Disciplinary Tribunal at least the disciplinary functions presently conducted by the Medical Council will be seen to be separate, will generally be more open and hopefully will instill greater public confidence in their impartiality.

In the hope that thus relieved of its disciplinary function, the Medical Council may make a greater contribution both to the profession and to the public of New Zealand, the Council has spent considerable time this year in examining its role in the maintenance of standards particularly with reference to the assessment of and maintenance of competence, the detection and recognition of health related problems in the profession and defining a role for itself in the overview of the continuum of medical education from undergraduate through to continuing education. All of these topics will be described in more detail in various sections of this report.

The report of the Committee to review the undergraduate medical courses in New Zealand (The Renwick Committee) made a number of comments about the responsibility of the medical schools to their students in relation to careers advice and advice on personal health and lifestyle matters. The Medical Council unfortunately has to deal with many cases where individual doctors appear to have had little or no regard for the care of their own health, for stress management within their own lives and for the development of outside interests which provide a balance against the intensity of the practice of medicine. Deficiencies in this area may not appear until relatively late in a medical career and one is distressed to see elderly practitioners well past the normal age of retirement who continue in practice. The recent stock market crash may well have interfered with the retirement plans of a number of our colleagues, but sympathy for such people should not cloud the fact that the public interest is not served by doctors whose competence has waned. It is illogical that an Annual Practising Certificate should be automatically issued to a person who cannot get a drivers licence without demonstrating their competence to control a motor vehicle. Judges, hospital doctors, bank managers and even politicians have an understood retirement age. Is there any good reason why private practitioners should not have the same?

The level of fee for the Annual Practising Certificate and the Disciplinary Levy have as usual attracted considerable criticism. I would encourage readers to study the report of the Finance and Management Committee and to examine the balance sheet carefully. An attempt has been made to give as much information as one possibly can in these documents. The information provided here may assist in avoiding the unacceptable and abusive comments directed to members of the Council staff who are not responsible for the decisions taken by Council.

REVISION OF THE ACT

As was indicated in the Annual Report for 1988 a great deal of detailed work has been completed incorporating proposals for the revision of the Medical Practitioners Act. This material was submitted to the Honorable David Caygill in December 1988. The Honorable Helen Clark, Mr Caygill's successor as Minister of Health has indicated to the Council that this Act revision has a high priority in her legislative plans, and the proposals as submitted to the Minister have been considered by a number of Governmental Committees including the Working Group on Occupational Regulation. At this stage it is still expected that a draft bill may be introduced into the House before the end of 1989. This will permit consideration by a select committee during the recess, and it may be possible to have the Bill passed into legislation in the first half of 1990.

From the point of view of the functions of the Medical Council the major proposal included in the suggested revision is for discipline to pass into the hands of a specially constituted Medical Practitioners Disciplinary Tribunal. While there is still some discussion as to the composition of such a tribunal, how it will reflect community interests and whether it should be headed by a medical professional or someone with judicial experience, the important feature from the point of view of the Medical Council is that it will relieve Council members of a great deal of time consuming disciplinary matters and enable Council to pay attention to a number of other very important matters on which it is felt the Medical Council could offer some leadership in the profession.

To assist in outlining some of these areas the Medical Council held a special meeting at which no other routine business was carried out in February 1989. This meeting examined the relationship of the Medical Council to the proposed Area Health Boards and was able to give consideration to ways

in which the Medical Council might assist in matters involving Quality Assurance and Peer Review and Hospital Accreditation and participate in some coordinating fashion with the providers of all levels of medical education.

It is emphasised that if the functions of the Medical Council can be clarified and defined even if only in general terms, it will be easier to make decisions on the appropriate composition of the Medical Council.

ACKNOWLEDGEMENT

I would like to record my appreciation of the assistance given to me by all members of Council. We have endeavoured to run Council affairs as a team with each member of the Council having a particular area of responsibility – this has made my task much easier. We all hope that the present Council structure will be replaced by this time next year with a Council operating under a new Act and with a composition appropriate to its future role. I would like to thank all members of the Council staff for their loyal and hardworking service during the year. With a gradual upgrading of data processing and filing systems, and alterations to records storage which has resulted in more workspace, the staff have better resources and the whole operation is working smoothly under the efficient management of our Secretary, Georgie Jones.

W.S. Alexander,
CHAIRMAN

MEMBERSHIP

On 31 January 1989 Dr David Cole retired as Dean of the University of Auckland, School of Medicine, and from his position as ex officio member of the Medical Council of New Zealand. Dr Cole in recent years has, in addition to his membership of the Council and of the Medical Education Committee, been Deputy Chair of Council and a member, and later Convener of the Preliminary Proceedings Committee. Dr Cole has over the years shown a continuing interest in matters concerning the regulation of the medical profession and his hand book "Medical Practice and Professional Conduct in New Zealand" has gone through a number of editions and is the authoritative work on the subject in this country. Dr Cole has given dedicated service to the Medical Council of New Zealand over many years and his experience will be greatly missed. Fortunately, Dr Cole has had an opportunity of contributing extensively to the proposals for the revisions of the Medical Practitioners Act currently under consideration by Government. In order to assist the Preliminary Proceedings Committee to deal with its cases requiring investigation Dr Cole has been appointed as an Executive Medical Officer for the Committee although he will of course have no part in any of its decisions.

The medical profession in New Zealand has received a long period of dedicated and hardworking service from Dr Cole and I wish to express my gratitude for the loyal support I have received during my period in the chair.

Professor Derek North, the new Dean of the Medical Faculty of the University of Auckland has joined the Council as an ex officio member. Professor North has for some years been a member of the Medical Education Committee and he will bring to the Medical Council considerable experience in the educational area. If as is expected the revised Medical Practitioners Act relieves the Medical Council of much of its disciplinary function, the educational responsibilities of the Medical Council may increase and Professor North's contribution in this area will be welcome.

In the process of reorganisation of the duties of the Director General of Health, it has been decided that the Director General will appoint a permanent deputy to be his representative on the Medical Council of New Zealand. This post is presently occupied by Dr Peter Talbot. Dr Talbot has proved to be a most valuable liaison with the Department of Health and has been of particular value in advice to Council over the relationships to the Area Health Boards and to the proposed Ministry of Health. In addition Dr Talbot who has had considerable experience of medical practice in other countries has brought a very useful opinion in deliberations of the Council on a number of disciplinary cases. His understanding of medical practice both here and abroad has enabled him to make a very valuable contribution in this area.

Derek North *Peter Talbot*

LEGAL ASSESSOR

Mr John J McGrath QC who has been Legal Assessor to the Medical Council of New Zealand for several years has been appointed Solicitor-General and has therefore resigned from his duties with the Council.

John McGrath has been of great assistance to Council in a number of major disciplinary hearings in recent years. His careful work in guiding our deliberations on points of law has been reflected in the failure of appeals to the High Court following Council decisions.

Mr Gerald Tuohy QC has also assisted Council as Legal Assessor on a number of occasions and ably represented Council and Preliminary Proceedings Committee in the recent Gurusinghe appeal hearings.

To both these gentlemen we express our thanks for services and guidance. No doubt Mr McGrath will follow the illustrious careers of earlier legal assessors Sir Thomas Eichelbaum Chief Justice and Mr Justice Ellis.

REPORT OF THE LAY MEMBER

I have found this an increasingly busy year. The Health Committee is now fully operational, more complaints have meant more disciplinary hearings and the Medical Council has been liaising with the Colleges on effective means of assessing competence when there are complaints in that area. There has been continuing work on medical education following the Renwick report and all Council members have been involved in an indepth study of the future role of the Medical Council itself. When one looks at the volume of work undertaken it is important to remember that much of it is being done by Council members in their own time.

In late 1988 I was appointed Convener of a small working party, established by the Medical Council, to offer some guidelines on information and consent. The release of the Cartwright report had initiated widespread discussion on the subject which was and still is, a matter of legal, ethical and consumer debate overseas.

These are my impressions.

The notion of informed consent is comparatively recent. It emerged as a formally stated principle after the Second World War in the Nuremburg Code and referred to medical experimentation on human beings. Since then the concept has been extended to include clinical practice as well as clinical research.

In the United States it has been entered into Federal Law. In Britain, where the courts have consistently supported the "professional standard" rather than the "patient standard" on how much information a doctor should disclose, pressure has been mounting both from consumer organisations and some legal quarters to shift the criteria towards the American standard.

It has been said that the 1980s are the decade of the consumer and the emergence of a variety of pressure groups attest to this. Campaigns about additives and chemical levels in food, atmospheric and land pollution and boycotts on products considered "unhealthy" indicate a desire for active involvement in matters to do with community health. That this desire for information and involvement should include personal health treatment is not surprising; in fact it is logical.

Patricia Judd

However, because of the inclusion of consent issues in litigation and disciplinary actions, the subject of informed consent can be seen as a "them-and-us" situation and approached warily by the medical profession. This conservative attitude is in turn seen as a refusal to cooperate by the consumer groups.

These are some of the questions being asked by consumers:

(a) Should patients be fully involved in making decisions about their treatment?
(b) How much should patients be told about the risks and benefits attaching to a particular treatment?
(c) How much responsibility do patients want to take for their bodies?
(d) Is it correct that patients prefer to leave difficult decisions to doctors?

Then there are factors worrying medical practitioners. First is the serious mistrust of the profession which seems to be surfacing in the country via the media and how this will affect doctor-patient relationships. This relationship should involve profound trust between one individual and another, dealing as it does with the most private, intimate and sometimes stressful area in the patient's life. Confidence in a practitioner is also a vital ingredient in therapeutic treatment.

Secondly, many practitioners have the experience of patients who reject any attempt by the doctor to provide worrying information. Does the patient have the right to refuse information?

These issues are best resolved through dialogue and some very positive initiatives are taking place in New Zealand at the moment. The Health Department has released a document on Ethical Committees to review research and treatment protocols. Joint lay and professional ethics committees have been established nation wide. The New Zealand Health Council has produced a discussion document on consent issues in hospital treatment and throughout the country groups of professionals and consumers are meeting to discuss these issues. The Medical Schools have drawn up guidelines for clinical teaching and the senior lecturer in Medical Ethics at Otago University, Dr Grant Gillett, has been speaking to professional and lay forums throughout New Zealand.

I feel that the Cartwright Report has invoked a societal desire to understand and have input into medical management and health matters. Hopefully the current initiatives will result in combined lay and professional groups resolving areas of dispute, rather than relying on litigation in the courts.

P.C. Judd
LAY MEMBER

REPORT OF THE MEDICAL EDUCATION COMMITTEE

The Committee has met three times during the year and in addition to its regular functions concerned with hospital accreditation for conditional registration purposes, specific attention has been given to several important issues.

REVIEW AND ACCREDITATION OF THE UNDERGRADUATE MEDICAL COURSES IN NEW ZEALAND

Council has reviewed the report of the special committee set up to review the two undergraduate medical courses. The membership of this committee was referred to in the 1988 report. After inviting immediate responses from the two medical faculties to some of the Review Committee's recommendations, the Medical Education Committee has since clarified a number of points with the faculties and has now reported to Council. Council is expected to make a final statement on their view and its outcome shortly.

The Review Committee's recommendations included endorsement of actions already initiated by the Medical Education Committee, for example that a future Medical Education Committee might exercise an overview (or surveillance) of medical education at all levels. Other recommendations were more specifically addressed to the medical faculties but some were policy issues for Council consideration. Surveillance of vocational postgraduate education as related to specialist registration had already been proposed by the Medical Education Committee but the Committee is aware that this additional role must be fully explored with the clinical colleges. Council decisions and statements on these issues are now awaited.

RECOMMENDATIONS ON PROPOSED REVISION OF MEDICAL PRACTITIONERS ACT AS PERTAINING TO THE ROLE OF THE MEDICAL EDUCATION COMMITTEE

The recommendations made concerning medical education and the future of the Medical Education Committee are still under consideration by the Minister. The Medical Education Committee remains in the meantime restricted to its existing statutory role of monitoring standards required for conditional and full registration. The Committee, as well as addressing and noting several matters raised in the Review Committee's report, has proceeded with its own review of the conditional registration year.

CONDITIONAL REGISTRATION REQUIREMENTS

Two working parties have been set up and are due to report shortly.

One is reviewing Medical Council requirements of Area Health Boards if they are to maintain accreditation as approved institutions in which conditionally registered practitioners can achieve full registration. The Committee is aware of "ongoing" changes in employment conditions currently being put into place by several Area Health Boards. The possible effects of these on educational support for interns will be carefully scrutinised as further data is received.

The other working party is giving reconsideration to the requirements of interns in their conditional registration year with a view to establishing more explicit guidelines for the educational objectives of this year and the evaluation of these.

John Hunter

In its supervisory role of conditional registration requirements and the training of interns the Medical Education Committee relies heavily on the intern supervisors. Many of them are under further pressure through the need to supervise foreign medical graduates working on temporary registration. Meetings between the Medical Education Committee and the supervisors which began in 1988, will be continued in 1989.

EDUCATIONAL CONTENT OF THE 'EIGHTH' YEAR

The Medical Education Committee is advising Council to take active steps in the exploration of the educational content and vocational training organisation for this year. It is hoped that discussions can be promoted between those bodies most concerned, eg Area Health Boards, Clinical Colleges and the Resident Doctors Association. One specific and outstanding issue is the place of general practice "runs" that might be embedded in this year as part of an improved and more logical approach to general practice vocational training.

J.D. Hunter
CHAIR

REPORT OF THE PRELIMINARY PROCEEDINGS COMMITTEE

CURRENT STATUS

At the time of reporting, 30 June 1989, the Preliminary Proceedings Committee (PPC) has before it 19 cases in various stages of investigation and preparation. These 19 comprise 4 still unresolved from 1987, 5 from 1988 and 10 from 1989.

Altogether in the first six months of 1989, 23 complaints have been received by the Preliminary Proceedings Committee. This compares with 19 in the whole of 1987 and 37 in the whole of 1988.

Of those 23 complaints, 13 have had their investigation completed, and 10 are still being processed. The breakdown of those 23 outcomes is:

Investigated, no case to answer	9
Withdrawn	3
Referred to MPDC	1
Still under investigation	9
To be heard by Medical Council	1
TOTAL	23

It is regretted that some matters have taken a long time to finalise. Those left over from 1987 and 1988 include situations of considerable complexity, some where more than one doctor is involved. In a number of instances, where charges have been laid, there is delay in getting a hearing date, or the hearing has been adjourned. Of the 9 left over from previous years, 5 are nearing completion. It is acknowledged that a great deal of distress is experienced by doctors when a complaint is laid against them, and the distress is exaggerated by delays in investigation. The PPC is conscious of these matters, but its resources do not necessarily allow for great speed or flexibility.

In the past year the PPC has prepared charges against doctors and prosecuted them before either the Medical Council or the Medical Practitioners Disciplinary Committee (MPDC). The Medical Council has heard charges of disgraceful conduct against 3 doctors and 3 more are awaiting hearing. Four cases have been heard before the MPDC and 2 (involving 3 doctors) are awaiting hearing.

Robin Briant *Geoffrey Lamb*

THE PROCESS

The Preliminary Proceedings Committee comprises two doctors and a lawyer. All three are involved in other aspects of medical and legal practice, and committee work is additional to their usual tasks. The Medical Practitioners Act requires that the PPC investigate any complaint against a doctor that might amount to disgraceful conduct, to determine if there is a case to answer. The case will be put before the Medical Council or the MPDC, depending on whether the charges, if proved would appear to amount to disgraceful conduct or to professional misconduct.

When the PPC has determined that there is a case to answer, it takes over the role of the prosecution, and the complainants become witnesses. The work of Mr Cook and his team of lawyers at Kensington Swan, now assisted by Dr David Cole our Executive Medical Officer, have provided excellent preparation of cases, allowing the tribunals the best opportunity to come to the right decision.

COMPLAINTS

The nature of the complaints that come to the PPC remains similar to that of previous years. Most complaints are allegations of excessive prescribing, sexual impropriety, and a range of happenings that may amount to incompetence or negligence. The increased number of complaints is probably a reflection of greater community awareness of how to lay a complaint and recognition that this is a course of action available, rather than it being a reflection of significant deterioration in medical standards. The fact that in the majority of cases the PPC does not find that the doctor has a case to answer, bears that out.

Early this year there was considerable publicity about bad prescribing of drugs of abuse. Such prescribing contravenes good medical practice as well as the law. It occurs in most parts of New Zealand and involves a small but important minority of doctors.

The Preliminary Proceedings Committee has before it several complaints on the matter of excessive prescribing. Several charges have been laid. This is a situation where the PPC has little difficulty in proving its charges for the evidence is there in the doctor's own hand.

If a doctor has got into a situation of prescribing to known addicts and in an indiscriminate way, and is finding it difficult to extricate him or herself from this, there are means of terminating the relationship with drug abusers. The first course of action is to request the help of either the Police or the local Medical Officer of Health or both. Recognition of drug seekers and a very firm line against prescribing for them will begin to reduce the requests. Another means of escape from the cycle is for the doctor to request, via the Medical Council, this his or her name be gazetted against the prescribing of controlled drugs and other drugs of abuse.

If anyone wishes to discuss the matter, a call to the Preliminary Proceedings Committee Convener or to the Medical Officer of Health would assist in getting such a process underway.

INVESTIGATION

The process of investigation is an important one. The PPC almost invariably interviews the complainant and this often gives a great deal more information about the person and about the problem than is ever conveyed on paper. To an extent this gives the complainant recognition, that their complaint has been taken seriously, and weighed up in an appropriate manner, even if it does not go on to a charge. Of course not everyone is satisfied by our inquiries, and some people are left with the feeling that their apparently legitimate complaints have not been acted upon.

MEDIATION

It is particularly important where complex matters have arisen, often in hospitals. Here many people may be involved in a single unacceptable outcome, doctors, nurses, paramedical people and the administration. As the medical discipline system can only deal with doctors it seems totally inappropriate to discipline only doctors when they have been part of a system which has failed.

Recently in circumstances such as this we have written lengthy reports on our findings, and made these available to the complainants; the doctors and the systems in which they work. These aim at improving systems and preventing repetition of a problem. This has involved the PPC in a great deal of additional work and effort, and it is not

possible to measure the value of that effort.

The proposal of the Minister of Health to have a Health Commissioner who will oversee some aspects of patient/health professional interaction, will probably allow the development of a mediation system that I am sure will be invaluable.

ACKNOWLEDGEMENT

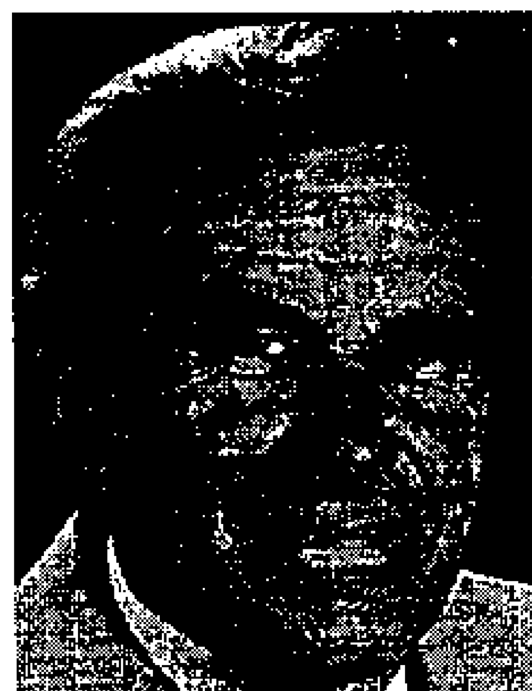
The Preliminary Proceedings Committee acknowledges with thanks the services of secretaries, Janice Bowman and Christine Maurice.

R.H. Briant
CONVENER

REPORT OF THE HEALTH COMMITTEE

In 1988 the Medical Council established a Health Committee to support the Health Screener and to manage health related problems in the medical profession. The Health Committee functions confidentially from the Council while investigation and treatment are carried out satisfactorily. There is however a responsibility to report to Council where there is a need for further action.

The Act provides that in an emergency the Council Chairman is able to suspend a licence to practise but it is hoped that the Health Committee will not be seen as a threatening or last resort situation and that it will be used for early intervention. The Committee might require a person to remain under medical supervision and attend at intervals for advice and assessment and comply with recommendations concerning management. These could include restricting practice to an institution or to association with a particular colleague; abstaining absolutely from use of a substance or drug which has been misused; attending regular meetings of appropriate support groups.



Bob Gudex

Judith Treadwell

The Medical Council encouraged and support financially the DHAS but on various occasions had become aware of a real possibility of conflict of interest if the functions of Council and DHAS remained linked, even if only financially. In discussion the Management Committee of DHAS reaffirmed their view that their effectiveness could be reduced if a would-be referrer had any fear that at the end of the process there could be referral to the Council's Health Committee although that referral remained totally confidential from Council while there was voluntary compliance with treatment and any necessary restraints. While their choice

to avoid the direct link was understood, it was requested that the DHAS should re-examine sources of funding as Council could not guarantee further funding after 31 March 1990 believing that if there was a link, however tenuous, between DHAS and Council, reference to DHAS could fairly be claimed to be an early entry to formal assessment of fitness to practise. Council could not accept that a failed case sent back by DHAS to the referrer could remain in its files without being resolved with the public interest paramount.

Issues which have been considered this year include Council's relationsip with the Doctors' Health Advisory Service (DHAS) and fitness to practise, particularly subsequent to implementation of the State Sector Bill, the need for provision in the new Act for power to deregister a doctor whose health has required suspension from all practice for a continuous period of five years, and the desirability of provisions which would enable the Council to require assessment of knowledge and performance in order to evaluate suitability to resume practice if there has been an absence (voluntary or imposed) from practice of greater than three years for health reasons.

Council must coordinate all these activities with employers, chiefly the Area Health Boards, and also the Health Ministry and Health Council.

SUMMARY OF ACTIVITIES

During the period 1 July 1988 to 30 June 1989, the Health Committee (with Council where appropriate) has been involved in the following activities related to individual doctors where fitness to practise was an issue:

Activity	Number
Monitoring by Health Screener	7
Monitoring by Health Committee during treatment, rehabilitation or assessment	*11
New suspensions imposed	4
Full suspension reimposed	2
Full suspension varied to allow limited practice	2
Recommendations made for variations in prescribing restrictions	2
Recommendations made on registration applications	5
Applications for revocation of suspension considered or under consideration	3
Revocation of suspension granted subject to agreement to retire from practice	1

* includes 2 cases where competence also an issue

R.G. Gudex
CONVENER

REGISTRATION OF FOREIGN MEDICAL GRADUATES

Graduates of Universities in the United Kingdom, Ireland, Australia, Canada and South Africa continue to be eligible for full registration whether they are junior hospital doctors taking up service positions or specialists taking up senior positions. Whether the Universities in all of these countries will continue to be recognised when the new Act comes into force remains to be seen.

Graduates of other medical schools are treated differently depending on whether they are moving into specialist positions or whether they are seeking posts as junior hospital doctors.

Doctors holding scheduled specialist qualifications may well be eligible for probationary registration if they are appointed to a supervised post generally within the New Zealand hospital system. The specialist qualifications of the applicant are submitted to the appropriate vocational referral body. If the candidate is classified as specialist eligible there is usually no difficulty but where such classification is not made there may well be significant problems. Under the requirements of the European Economic Community Great Britain is required to recognise medical degrees obtained in the EEC and specialist qualifications as well. It seems likely therefore that there will be pressure to recognise at least some of the European specialist qualifications that have not hitherto been accepted in Australasia. Another group of doctors who have had considerable specialist training and have frequently passed higher qualifications in English speaking countries have had difficulty in having their training recognised because they do not carry the Certificate of Joint Committee on Higher Training. It appears that the number of registrar posts in the United Kingdom which must be occupied to obtain this certificate are rather limited and it is simply not possible for some doctors to obtain this certificate. The United Kingdom authorities have recognised this and are proposing to issue a second form of certificate for doctors who have occupied registrar posts at a certain level. Whether this certificate will carry sufficient weight to enable these doctors to be recognised in Australasia remains to be seen. A few probationary certificates have also been issued for work in approved general practice posts under the supervision of family medicine trainers.

It is a difficult area and unless it can be shown that no unduly restrictive practices are applying there may well be some changes forced upon the registration committee. The situation is made worse by workforce requirements in smaller hospitals who frequently do not obtain New Zealand graduates for their vacant specialist positions and, in the present economic and social climate the apparent reluctance of doctors to move into general practice in isolated and rural communities.

DOCTORS IN TRAINING POSTS

Many doctors coming to New Zealand for advanced or postgraduate training are treated in a special category. Provided their competence in communication in English is assured, they have been sponsored by their home Government or other recognised authority and a training establishment in New Zealand has undertaken to accept them for supervised training, they may be granted temporary registration without examination. The Council receives progress reports on the trainee's performance and the temporary registration is extended if satisfactory progress is being made. Difficulties arise if at the conclusion of the training period the overseas doctor has found some method of satisfying the Immigration authorities and wishes to remain in New Zealand. If as a result of the training process they have satisfied the examiners for a higher Australasian diploma the Medical Council usually has no difficulty in granting them probationary and ultimately full registration. The Immigration requirements are of course not our concern.

DOCTORS IN SERVICE POSTS – REGISTRATION EXAMINATIONS

In 1985 as a means of overcoming what was considered to be a crisis in junior hospital medical officer staffing, a number of junior doctors were permitted to take up posts in New Zealand hospitals without preliminary examination. For those doctors who wished or were able to remain permanently in New Zealand the Probationary Registration Examination New Zealand (PRENZ) was established. This examination was somewhat difficult to administer for all but small numbers and did not prove entirely satisfactory as a means whereby the large numbers of junior doctors coming into the New Zealand system from around the world could establish the fact that they had met an appropriate standard to join our workforce.

The Medical Council has set out to replace this examination with a new examination programme referred to as the New Zealand Registration Examination (NZREX).

This examination programme comprises four parts:

Part I– Is an examination in English communication skills developed in Australia for medical practitioners and applied in the New Zealand setting on behalf of the Council by the English Language Institute of Victoria University. It is a searching "state of the art" examination covering reading, writing, listening and speaking.

Part II– Is a multiple choice question examination (3 papers) covering the whole range of basic medical knowledge in the professional disciplines and derived at present from fifth year examinations conducted in New Zealand medical schools.

Part III– Consists of four papers covering paediatrics, psychological medicine (psychiatry), surgery, internal medicine, obstetrics and gynaecology, general practice, pharmacology, clinical pharmacology, pathology, applied anatomy, applied physiology and applied behavioural science.

Part IV– Is a clinical examination in internal medicine (long case), surgery, paediatrics, obstetrics and gynaecology, general practice and psychological medicine.

Parts I and II (the screening examination) must now be passed before the doctor can take up any form of medical post in New Zealand and are now being held in New Zealand and in Singapore and London. Exemptions on the basis of passes in comparable Canadian, American, Australian or British examinations are granted to those who qualify.

This assessment should ensure competence in English communication and a reasonable standard of basic medical education from foreign qualified doctors entering the workforce. Doctors who can pass Parts I and II are given temporary registration for a period of up to two years. By the end of this period they must have passed Parts III and IV of the examination to obtain Probationary Registration, if they seek to continue practising medicine in New Zealand on a long term basis.

The final examination of the old PRENZ system for candidates who had already started on that programme was to be held in August 1989.

No doctors have been given temporary registration since March 1989 who have not already passed or been exempt Parts I and II of the NZREX examination. Existing temporary registrants, if not exempt, have been required to obtain a pass in Parts I and II by the end of November 1989.

The Medical Council now has a comprehensive and searching examination system in place which it believes will ensure that the standard reached by graduates of foreign medical schools who seek registration in New Zealand will be similar to that required of graduates from New Zealand medical schools.

The pass rates in the PRENZ and NZREX examinations to date are not significantly different from the outcome seen by the Australian Medical Council with its entry examinations and by the General Medical Council with its test conducted by the Professional and Linguistic Assessments Board (PLAB).

The effect of the new examination programme on the medical workforce and in particular on the supply of junior hospital doctors will be carefully watched. It will undoubtedly create a problem for those doctors who cannot reach the required standard. To date there has been little or no interest shown in the provision of bridging courses or coaching although it is quite clear that those candidates who have been given suitable preparation for the exam generally perform much better.

Although the Universities from which these candidates come are listed in the World Health Organisation Directory of Medical Schools, it is clear that the WHO list is not a reliable indicator of the standard of the medical school concerned, and there is also a strong suggestion that because New Zealand did not have an entry examination in the 1985-86 period it was attractive to the weaker candidates from those schools. There already exists a growing number of foreign medical graduates who have New Zealand residence status but who will not be able to practise as medical practitioners because they cannot satisfy the registration requirements. As has already occurred in Australia this situation has the potential for creating political pressures.

The situation in the United Kingdom is in the process of change and this may have some secondary effects on medical recruitment in New Zealand. With free access to the United Kingdom of graduates from the EEC countries where there is extensive medical unemployment, the opportunities for medical practitioners from the third world in the United Kingdom may well be signficantly reduced. This may increase the pressure for entry to New Zealand.

The possible introduction of a two year pre-registration (including internship) requirement for registration in Australia may stimulate a greater number of New Zealand graduates to complete a second year in a house surgeon role.

The tables on pages 23 and 28 show the proportions of New Zealand and Overseas graduates on the New Zealand Medical Register at 30 June 1989 and the proportions of overseas graduates added in the last 12 months.

Ian St George

John Broadfoot

The past year has been an exceedingly busy one for the Secretariat – in every aspect of the Council's work, both operations and policy, there has been an increase in volume and complexity of activity. Sometimes our resources (and patience) have been tested to the limit but I am pleased to report that we have survived and have been stimulated to think of ways of working smarter. My sincere thanks go to the team at 73 Courtenay Place – full time staff, part time staff and casual workers, who have each contributed most willingly.

THE NEW ZEALAND MEDICAL REGISTER

The constant comings and goings of New Zealand and overseas graduates give rise to thousands of transactions which impact on the register and its maintenance. Readers who are impressed by statistics may be interested to know that in the year ended 30 June 1989, over 2,000 changes of address were recorded, 597 new conditional and full registrants (NZ and overseas graduates) added to the register and 121 names removed from the register, not to mention changes of name and entry of additional qualifications and the issue of 700 certificates of good standing and registration certificates. Because of pressure from other more important tasks, the usual purge from the register was not carried out for those with overseas qualifications no longer living in New Zealand and not having practised here for 3 years. Similarly removal of those whose addresses have not been kept current was not as actively pursued as in previous years. These two factors mean that the overall number on the register (9,453) is probably inflated by up to 300 names. Attention will be given to remedying this in the coming year!

Georgina Jones

Some of the tedious followup would be avoided if ALL practitioners would notify change of address promptly (as required by law) and would think IN ADVANCE about documentation needed for work in other countries. Evidence of additional qualifications must be produced if these are to be considered for entry in the register – examination results are not sufficient in themselves – we need to see your membership or fellowship diploma or conferred university degree or diploma. Similarly, evidence of change of name must be produced if a new listing is requested.

EXAMINATION AND REGISTRATION OF FOREIGN MEDICAL GRADUATES

In the past twelve months over 1,500 enquiries from overseas doctors not eligible for full or conditional registration have been received and each has had to be acknowledged setting out the requirements for temporary or probationary registration and the pathway to full registration for those who may eventually qualify, particularly those with acceptable specialist qualifications and experience. In addition information booklets on the Council's registration examinations have been sent to over 500 potential candidates. Records are not kept of the number of telephone enquiries from foreign medical graduates or their agents but these would certainly amount to hundreds per year. Accurate and courteous information must be provided in every case, even where communcation is impeded by language or other difficulties. The registration statistics show that some of these enquiries result in the registration and

employment or training of doctors from overseas but there is inevitably a much larger number who are disappointed in their wish to emigrate to New Zealand because they do not meet the minimum criteria. This situation prevails in many western countries and adverse comment on the function of registration authorities is a common feature of criticism from those who are rejected or find the path to entry stressful and expensive. In fact, 91 new temporary and 29 new probationary registrants (including those who passed PRENZ) joined the workforce and a further 17 foreign medical graduates achieved full registration after satisfactory completion of the probationary period.

REGISTRATION NUMBERS

You will have noticed that letters and the Annual Practising Certificate all carry your personal file number, which is in effect your registration number. Council resolved at the June 1989 meeting to publish these numbers in the New Zealand Medical Register at 30 June 1990 when it is printed in Spring 1990. This is already the practice for dentists. It will enable you to identify yourself readily in communications with the Council and will be available to other institutions which also require numerical identification of registered medical practitioners.

COMMITTEES AND COUNCIL

Secretariat assistance in the arrangements for the Renwick Committee to carry out its visits to the Otago and Auckland faculties and in the production and distribution of the Report of the Review Committee on Undergraduate Medical Education was an additional function in 1988 – one with which we were very pleased to be associated. If the Council through its Medical Education Committee is granted wider functions concerning the surveillance of education under new legislation, there will be a consequent increase in demand for support services and appropriately trained people will be needed to assist committee members and working groups.

The Health Committee has dealt with over 40 reports on impaired doctors in the past year and crises and routine reporting and follow up must be handled sensitively and confidentially by staff. Most of this work falls to the Secretary but can only be managed with the cooperation of the whole team. Similarly the administrative aspect of handling complaints and arranging disciplinary hearings (including appeals) has seen a significant increase this year. 10 hearings have been held, of which 3 were outside Wellington and necessitated finding suitable facilities for Council and all parties. The amount of paper to be distributed (and later disposed of) is often considerable, but more importantly the people involved deserve a professional and caring approach throughout the process. This we have tried to give.

The Board of Examiners has experienced a great increase in its workload with 204 candidates being tested in the last 12 months over 8 examination sessions (including specials). This has meant a whole new administrative structure – and some unwelcome media pressure on staff and candidates. Contracts have also had to be negotiated with organisations to supply and conduct the new English test (NZREX Part I) and with managers in appropriate centres in New Zealand and overseas for NZREX Part II.

CONSULTATION AND COMMUNICATION

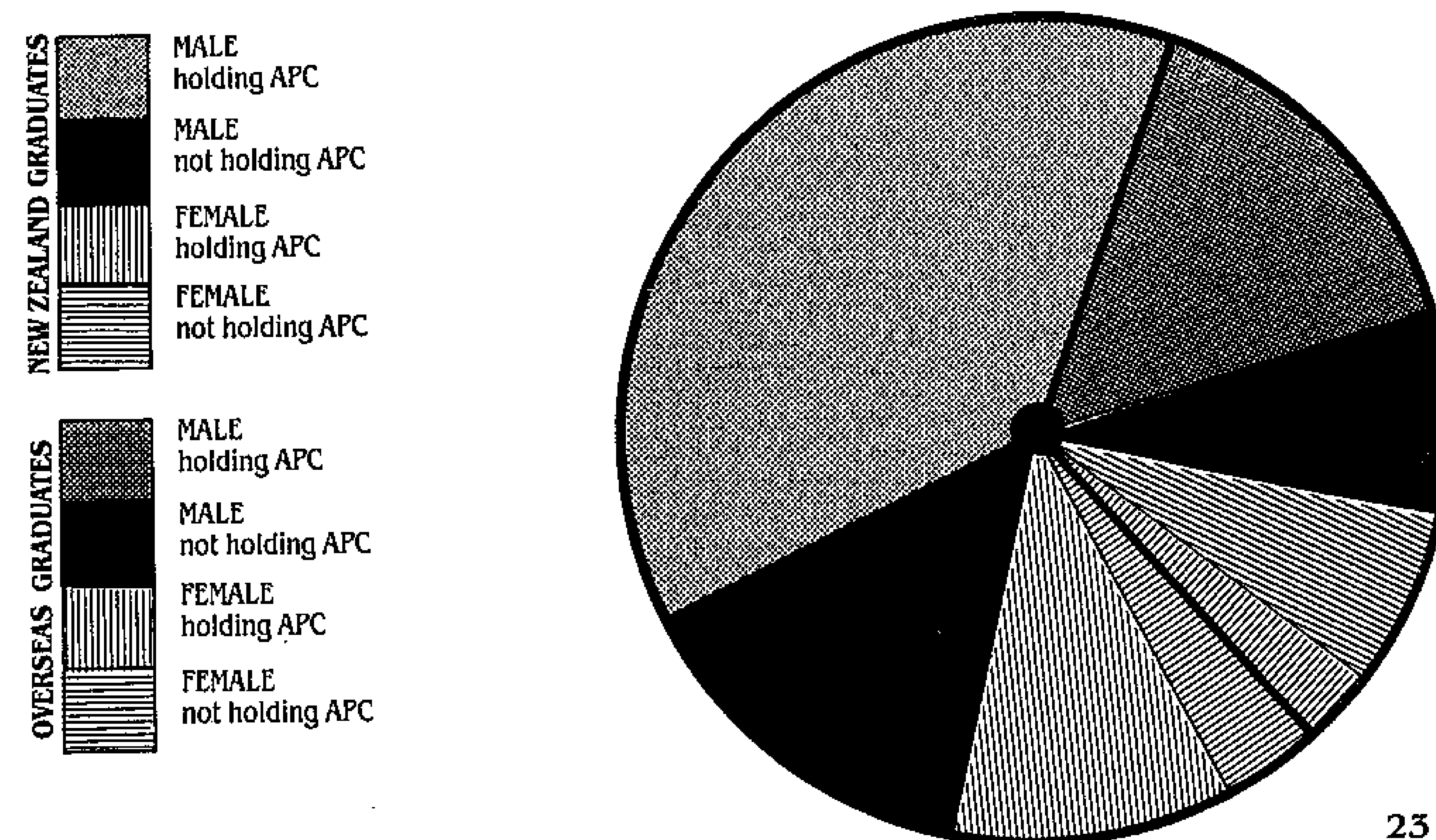
In the 1988 Annual Report I expressed a hope that our efforts in these two important areas would see improved results. I believe both the Secretariat and the Council have taken some useful initiatives but there is room for continuing development. Thank you to the many doctors who have made a personal effort to avoid sexist language – I notice the difference! You will find in this Report some interesting data on women in the New Zealand medical workforce, see tables on pages 26 and 29. We have tried to foster good relationships with Area Health Boards as they go through their formative stages and look forward to exchange of views on all aspects of common concern. The creation of the Health Commissioner is another new development eagerly awaited and supported. The appointment of Helen Clark as Minister of Health was noted with interest and two meetings have been held with her.

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

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

G.A. Jones
SECRETARY

Table 1 **DOCTORS ON THE NEW ZEALAND MEDICAL REGISTER**
as at 30 June 1989



REPORT OF THE MEDICAL PRACTITIONERS DATA COMMITTEE

Annual medical workforce data collection has continued and additional information, particularly in relation to general practice, was sought in the 1988 and 1989 questionnaires. The outcome of this data collection and analysis is proving of considerable value not only to Council but the Department of Health and numerous professional groups reviewing planning and problems in their specific workforce. Data processing still takes place in the University of Otago Department of Preventive and Social Medicine and the Committee is appreciative of the efficient services provided by statistician Ms Carol Leatham.

Figures in tables 2 and 3 show the general distribution of the Medical Workforce and in particular, the principal "active" practitioners.

The total active workforce continues to increase and in 1988 reached an all time high of 6,174 (full time equivalents of 5,692), a 14% increase over the last five years. The number of New Zealand medical graduates in the active workforce are not significantly altered since 1987 nor are the number of general practitioners. It is anticipated that the Department of Health will shortly publish another "red book" giving detailed analyses of the 1987 and 1988 medical workforce statistics.

Additional information was sought in the 1988 questionnaire and modified again in the 1989 questionnaire. The response to specific questions made for general practitioners was not entirely satisfactory, partly because no responses were provided by so many and partly because of a misinterpretation of the reference to general practitioner "training". Council had agreed to a request made to it that some attempt should be made to determine how many practitioners were entering general practice without vocational training. The questions on this item were repeated in the 1989 questionnaire and a more complete analysis and interpretation of the responses should be available shortly.

The annual questionnaire is under review for the 1990 return and some further simplifications can be expected after consideration of the numerous suggestions provided in response to Council's invitation for comments in 1988.

Many requests for access to medical workforce data continue to be received.

Table 2

NEW ZEALAND MEDICAL REGISTRATION INFORMATION

as at 39 June 1989

Total practitioners on register	9,453
Total practitioners with practising certificates	6,631
Temporary registrants	216
New probationary registrants	29
Names removed from register (various reasons)	90
Practitioners deceased	34

NEW ZEALAND MEDICAL WORKFORCE 1988

Table 3

	1984		1985		1986		1987		1988	
	Total	N.Z. Graduates	Total	N.Z. Graduates	Total	N.Z. Graduates	Total	N.Z. Graduates	Total	N.Z. Graduates
Active	5437	3936	5556	4095	5747	4188	6095	4302	6174	4326
Full time Equivalents	5061.3	3704.1	5156.1	3834.3	5330.3	3913.5	5620.0	3986.5	5692.5	4000.0
House Officers	627	598	628	600	668	568	751	539	728	525
Registrars	695	565	718	592	746	630	780	626	771	620
Medical Officers Special Scale	159	77	150	75	149	67	167	74	180	87
General Practitioners	1998	1353	2106	1473	2141	1512	2278	1601	2293	1608
Other Primary Medical Care	89	55	95	62	103	70	125	85	124	81
Specialists	1770	1239	1767	1248	1819	1272	1897	1306	1953	1338
Miscellaneous (non specialist)	99	49	92	45	121	69	117	71	125	67

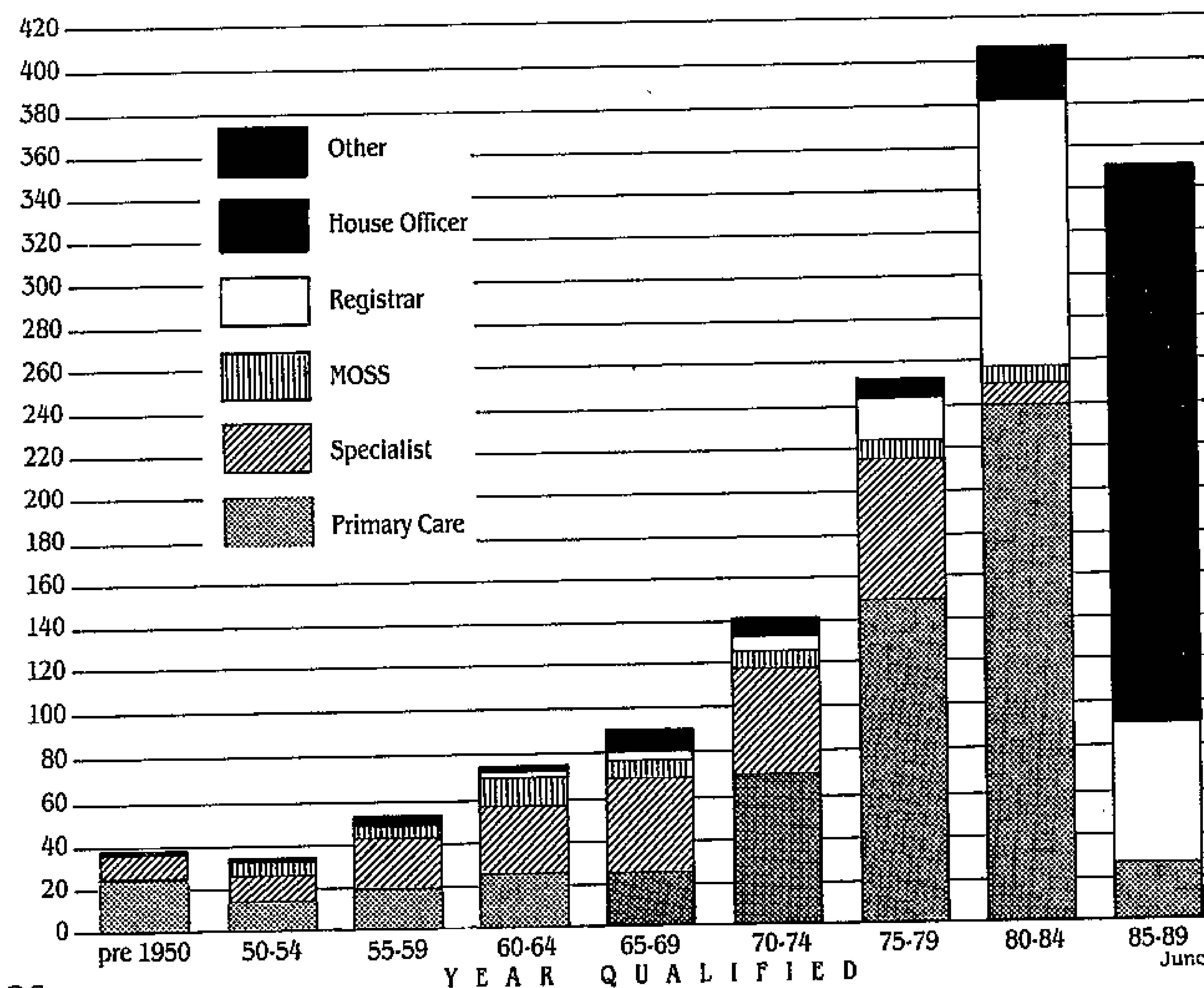
The existing policy covering release of information has not changed and every effort is made to preserve confidentiality. Access by particular groups of practitioners for the purpose of research are referred to the Chairman of the Council for approval. Opportunities exist for research projects to be undertaken in the Otago department. Simple address lists or labels (updated from those printed in the register) can be made readily available to approved organisations on payment of suitable fees.

J.D. Hunter
CHAIR

Table 4

NUMBER OF WOMEN GRADUATES (New Zealand and overseas) IN THE ACTIVE MEDICAL WORKFORCE IN NEW ZEALAND as at 30 June 1989

NOTES: "Registrar" includes community medicine and family medicine training programme. "Primary Care" includes general practice, family planning, student health, armed services, company doctors. "Other" includes non-specialists in research, community medicine. Calendar years are the basis of this data – the 1985-89 data therefore does not take into account women coming onto the register in the period 1 July to 31 December 1989 – estimated to be at least 170 and mainly house officers, i.e. new NZ graduates or new registrants from overseas.



REPORT OF THE SPECIALIST REGISTRATION SUB-COMMITTEE

Applications for specialist registration continue steadily and are likely to do so as this registration becomes a prerequisite for specialist appointment to Area Health Boards. During this year 113 more names have been added to the Specialist Register, the largest increases being in Internal Medicine and Psychiatry which rose by 9% and 8% respectively. The numbers in each specialty at 30 June are shown in the table below.

One of the major difficulties this year has been in the area of assessment of the training of specialists who have trained outside Australasia and the United Kingdom and the Medical Council's Referral Bodies have worked hard and patiently at trying fairly to assess the curricula vitae of foreign graduate applicants. They deserve the thanks of the whole profession for this often unsung and at times very frustrating labour. The Colleges and Societies have been working over the last ten years to implement training programmes in New Zealand to meet our workforce needs. As this planning matures and results in better matching of the postgraduate training numbers to

Table 5

NUMBERS ON THE SPECIALIST REGISTER AT 30 JUNE 1989

	Males	Females	Total
Anaesthetics	191	42	233
Community Medicine	115	20	135
Dermatology	31	6	37
Diagnostic Radiology	117	12	129
Gynaecology	1	–	1
Internal Medicine	384	16	400
Obstetrics	1	–	1
Obstetrics and Gynaecology	147	23	170
Ophthalmology	76	9	85
Orthopaedic Surgery	108	–	108
Otolaryngology	63	–	63
Paediatrics	100	26	126
Pathology	125	21	146
Psychiatry	153	54	207
Radiotherapy	20	3	23
Cardiothoracic Surgery	21	–	21
General Surgery	222	–	222
Neurosurgery	12	–	12
Paediatric Surgery	3	1	4
Plastic Surgery	25	–	25
Urology	30	–	30
Venereology	14	4	18
TOTAL	1,959	237	2,196

NOTE: These statistics do not take into account the significant number of doctors who have already completed or will shortly complete their specialist training programmes, but who have yet to apply for admission to the Specialist Register.

the fall-out from the ranks of the various disciplines, there will be greater local competition for hospital posts and less and less need to rely on foreign medical specialist graduates whose competence may be hard to determine prior to appointment.

The reciprocity of recognition of medical training between the UK and the EEC has not influenced the Registration Committee which decided to ignore the UK status of EEC trained doctors and treat them as though the reciprocity did not exist.

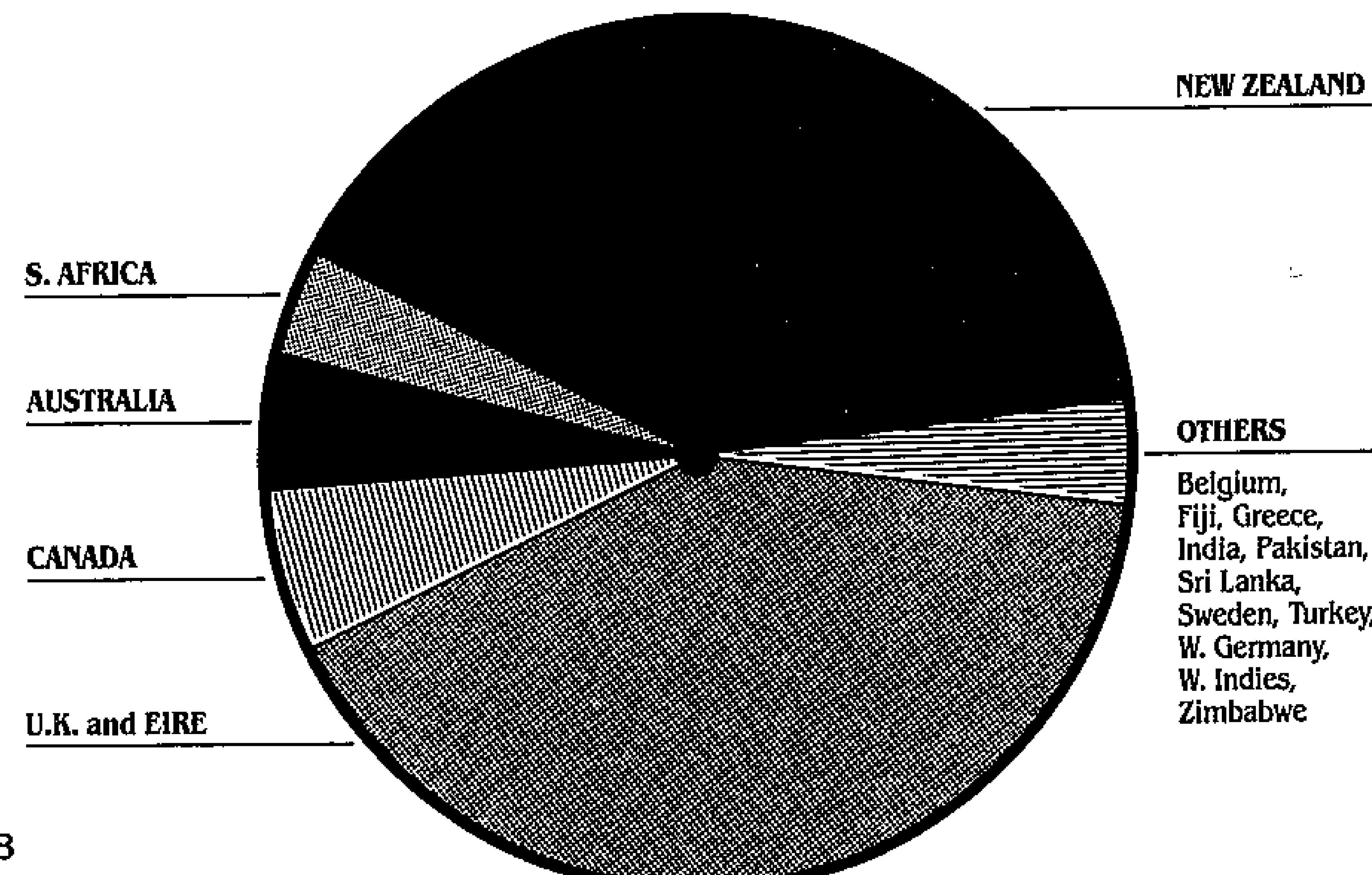
Attention is being directed at the registration of smaller specialty groups such as Occupational Medicine, Rehabilitation Medicine, and Emergency Medicine, a topic due for further consideration later this year.

Professional competence is one of the criteria for recognition as a specialist and its maintenance is still high on the Council's agenda. As a step towards this goal it is hoped that in the rewritten Medical Practitioners Act there will be legal protection from litigation for the members of audit and peer review committees. A good case exists (and public pressure may mount) for a review of the competence of all doctors at intervals of five to ten years and peer review systems are an important part of that process particularly for specialists. By the same token all private hospitals should have active Credentials Committees to keep under regular review the competence of their attending staff members.

In previous reports the Convener has expressed interest in receiving feedback of views from the profession on matters of registration but there has been little response. Does this mean the profession is in general happy with the present methods and processes?

G.F. Lamb
CONVENER

Table 6 **NEW ZEALAND AND OVERSEAS GRADUATES ADDED TO NEW ZEALAND REGISTER (Full or Conditional Registration)**
in the year ended 30 June 1989



REPORT OF THE INDICATIVE REGISTER (GENERAL PRACTICE) SUB-COMMITTEE

The applications for admission to the Indicative Register fell during the first half of the year, following the large number of applications when the Register was first instituted. However, the second part of the year has been notable for the large increase in applications. Most of the applicants are eligible and are approved by the Council following the recommendation of the Indicative Register Sub-committee on the advice of the referral body, the Royal New Zealand College of General Practitioners. Delays occur due mainly to insufficient details on the application, either of past experience of general practice, or of continuing education and a few due to lack of information on the present employment. Intending applicants are advised to keep a detailed diary of their experience in general practice, since the equivalent of three full years experience in general practice is required for admission to the register, in addition to five years practice since qualification. Practitioners are reminded that after 1 April 1990 membership or fellowship of the Royal New Zealand College of General Practitioners, or of another academic college with equivalent training or entry criteria, will be mandatory for inclusion in the register of General Practitioners.

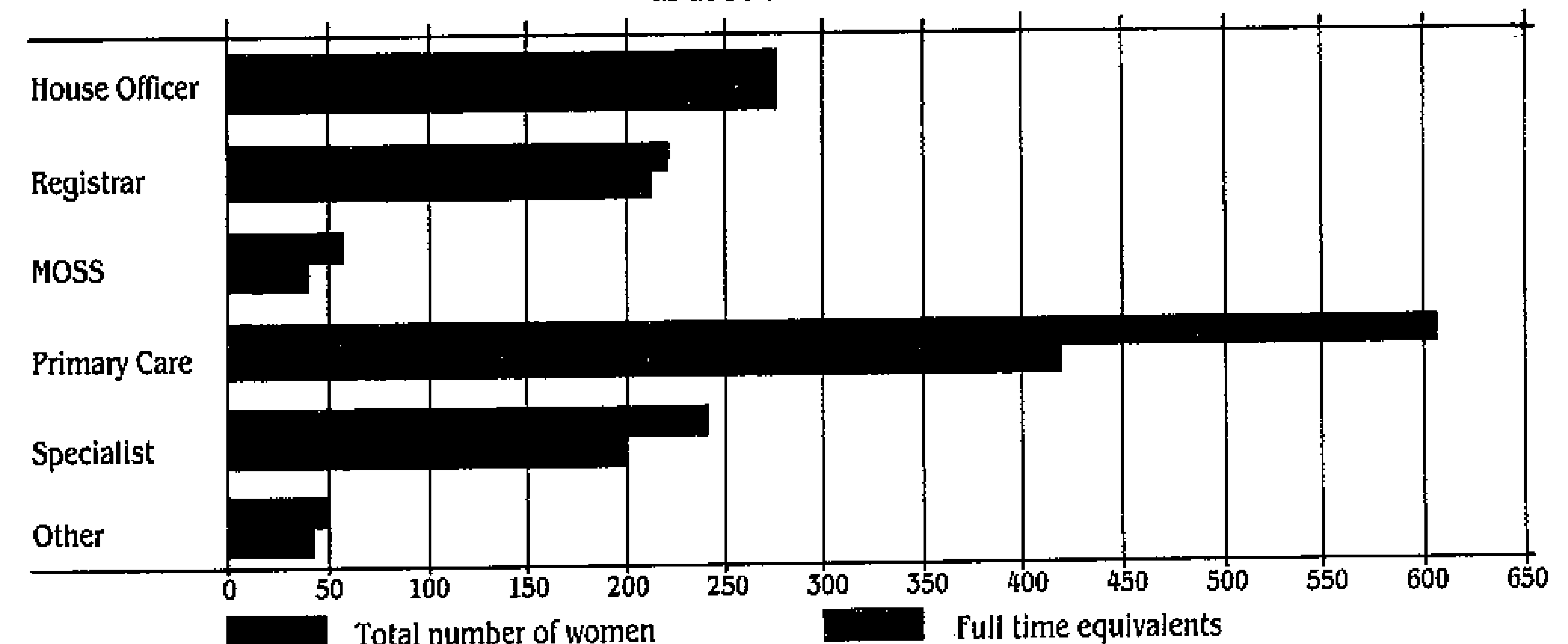
Murdoch Herbert

With the present radical changes in the organisation of health care in New Zealand, the prospect of tendering for the provision of primary care, and the emphasis on competence and accountability, the time may be not too far distant when inclusion on the indicative register is a prerequisite for establishment as an independent general practitioner in New Zealand.

At 30 June 1989, the register has 953 general practitioners listed, with at least another 130 applications under consideration.

M.M. Herbert
CONVENER

Table 7 **WOMEN GRADUATES (New Zealand and overseas) IN ACTIVE MEDICAL WORKFORCE IN NEW ZEALAND**
as at 30 June 1989



REPORT OF THE FINANCE AND MANAGEMENT COMMITTEE

This report covers the period from 1 July 1988 to 30 June 1989 although the financial statements included with it cover the period from 1 April 1988 to 31 March 1989.

1. GENERAL COUNCIL OPERATION

The schedule of expenses (p37) gives a breakdown of Council operating expenses. Most of these items are within budget and show expected levels of increase over the previous year.

One item which exceeded budget was the cost of the Review Committee on Undergraduate Medical Education. In retrospect the budget for this Committee was inadequate and did not allow for the considerable time and effort involved in producing the report. The excellent report justifies the cost and will be a most useful document both for Council and for the Universities. Had this exercise been less expensive the Council fund might well have shown a small surplus. The fee for Annual Practising Certificate 1988/89 was set at a figure which Council understood could be approved without delay. In the event it should have been set at a higher level so avoiding the larger increase required for the current year.

The Dental Council contribution to administration expenses has been increased. Changes in the Dental Act may make further demands on the staff and the contribution is therefore reviewed annually.

The cost of the Medical Workforce Survey has been the subject of ongoing discussion with the Department and the net cost to the Medical Council has been reduced this year. This survey should be funded on a "user-pays" basis as far as possible and costs to the Council therefore kept at present levels.

2. DISCIPLINE FUND

Despite doubling of income, this year finished with a deficit, smaller than last year, but the cumulative effect is that the Disciplinary Fund now has a deficit of $273,408.

Discipline costs cannot be budgeted except that the steady increase in the number of complaints will ensure that each year's expenditure will be greater than that of the year before.

As examples of costs involved:
Dr A was the subject of a complaint to the Medical Practitioners Disciplinary Committee who made a finding of conduct unbecoming. Dr A appealed to the Medical Council who allowed the appeal. All costs therefore fell on the disciplinary fund as follows:

Cost of MPDC hearing	28,186.71
Appeal – Council fees and costs	7,358.47
– Legal Assessor	8,295.55
Complainants representative at appeal	4,642.93
Printing	156.80
	$48,640.46

The practitioners legal costs are not met from the Disciplinary Fund but are a matter between the practitioner and the indemnifier. They may far exceed the cost to the profession, through the Discipline Fund.

Dr B was found guilty of disgraceful conduct on three charges following an undefended hearing:

Legal costs of collecting affidavit evidence	21,910.00
Council fees and costs	3,290.38
Legal Assessor	972.00
Miscellaneous	308.82
	$26,481.20

This practitioner has had a substantial award of costs made against him but as he has left the country chances of collection are slim.

Dr C was the subject of a complicated enquiry into complaints of incompetence with related health issues. Costs to the Fund eventually amounted to:

Fees for medical assessments	22,729.89
Fees for Legal Services	
to Council	26,570.61
to Complainants	5,177.04
Council fees and costs	3,011.24
Miscellaneous	444.22
	$57,933.00

Dr D was the subject of a prolonged hearing over five days in late 1986. Total costs amounted to $71,236.96 of which Council fees and costs amounted to $14,514.09. An award of costs against the doctor of $30,000, only just paid, cost nearly $3,500 to collect, fortunately offset by the Master of the High Court ruling that interest on the overdue costs also be paid!

Dr E was found guilty of professional misconduct and disgraceful conduct on two charges involving a hearing lasting three days. Total costs amounted to $50,502.36 with $1,400 in fines and $20,000 costs recovered from the practitioner.

Dr F appealed to the High Court and then to the Court of Appeal against a finding of disgraceful conduct made in 1985. Our representation at these appeals, which were successful, cost $39,500. The practitioners costs in the appeal were met by Legal Aid.

These examples are given to indicate the costs incurred in the disciplinary process. At present three appeals to the High Court against findings of the Council are pending.

The Council has been examining ways in which these costs may be contained. The present standard rate for Senior Counsel is $520 per half day in court or hearing plus $130 per hour for preparation. The setting up of an Independent Discipline Secretariat may provide an opportunity for a Staff Solicitor and an Investigating Officer who between them can do much of the investigating and preparation work for the counsel who will actually prosecute the case. It may not only cost less but could possibly speed things up as well.

GOODS AND SERVICES TAX

An increase in this tax was announced in mid March just as the forms for application for Annual Practising Certificate were being printed and distributed to over 8,000 doctors with New Zealand addresses on the Register. The best advice available at the time was taken but in the end in early June when information bulletins were received from the Department of Inland Revenue, the Council along with many other organisations, had applied the rise from 10% to 12½% incorrectly. Failure to act in March however could have resulted in a cost to Council of well over $30,000. Practitioners who paid in response to that original application (invoice) for APC (whether or not the payment was received by 1 July 1989) are **now in credit with the Council to the sum of $4.41 each and this will be taken into account when the APC exercise is carried out in March 1990.**

Any slight inconvenience caused by this situation is regretted – it is simply not cost effective to make such a small refund to such a large number of people in the current year. The Secretary has reported that practitioners were relatively prompt this year in their response to the application for Annual Practising Certificate (including the substantial disciplinary levy) and this cooperation is welcome. The APC represented nearly 75% of Council's revenue for general purposes (ie excluding Discipline) in the past year.

W.S. Alexander
CHAIR

AUDITOR'S REPORT

Miller, Dean & Partners

CHARTERED ACCOUNTANTS
WELLINGTON AND CARTERTON

AUDITOR'S REPORT

TO MEMBERS OF THE MEDICAL COUNCIL OF NEW ZEALAND

We have examined the books and vouchers of the Council in accordance with generally accepted auditing standards and practices.

All the information and explanations required have been obtained and proper accounting records have been kept as far as appears from the examination of those records.

In our opinion and according to the information and explanations obtained, as shown by the said records, the financial statements are properly drawn up so as to give a true and fair view of the financial position of the Council as at 31 March 1989 and the results of its activities for the year ended on that date.

Miller Dean & Partners.

Chartered Accountants

WELLINGTON

26 August 1989

FINANCIAL STATEMENT

for year ended 31 March 1989

NOTES TO ACCOUNTS

1. GENERAL ACCOUNTING POLICY

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

Particular Accounting Policies

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

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

(b) 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 except for the accrual of recoveries received immediately after balance date.

2. CHANGES IN ACCOUNTING POLICIES

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

3. DEBTORS

The debtors figure includes $22,000 recovered soon after balance date on behalf of the disciplinary fund.

4. INVESTMENTS

	1989	1988
General Fund		
BNZ Finance Limited – Telephone Call Deposit	29,887	30,565
National Bank – Telephone Call Deposit	–	89,680
Equiticorp Finance Limited (In Statutory Management)	100,000	100,000
	$129,887	$220,245

The Investment in Equiticorp Finance Ltd First Ranking Debenture Stock has interest accrued to 31 March 1989 of $2,286.03 not shown in the accounts due to the uncertainty of its realisation. According to correspondence with the statutory manager it is expected that the deposit will be repaid in full over a period of time. The first payment of twenty cents in the dollar was received in July 1989.

5. FIXED ASSETS

	Cost 31/3/89	Book Value 1/4/88	Depreciation For Year	Book Value 31/3/89	Accumulated Depreciation 31/3/89
Air Conditioning	33,251	31,588	3,325	28,263	4,988
Computers	87,802	54,749	15,490	59,956	27,846
Furniture and Fittings	90,182	44,090	7,355	69,985	20,197
Office Alterations	145,428	116,343	14,541	101,802	43,626
Office Equipment	28,310	13,957	5,581	9,857	18,453
	$384,973	$260,727	$46,292	$269,863	$115,110

6. REGISTRATION EXAMS

(a) N.Z.R.E.X.

Some fees for the May Part I and Part II examination and establishment costs incurred in this financial year relate to the 1990 financial year and are therefore carried forward.

Fees	7,500
Expenditure	3,402
	$4,098

(b) Probationary Registration Examination (PRENZ)

The policy is that the examination be self-funding, including PRENZ Board meeting fees and expenses.

PRENZ Examination Fees Received		102,236
PRENZ Board Meetings, Fees and Expenses	3,497	
PRENZ Examination Expenses (Excluding Council Administration	84,749	88,246
		$13,990

7. REGISTER INFORMATION

The sale of this information was a once only transaction with the Department of Health and the funds were used to purchase a micro-computer for use by the Council statistician at Otago University.

8. COMPETENCE INQUIRY

The lengthy and complex inquiry into one doctor whose fitness and competence to practise was in question, finally resulted in action in both the health (suspension) and registration (removal from Register of Specialists) areas. Additional costs of the inquiry have been apportioned equally as was done in the 1987/88 year when the major part of the expenditure on this matter occurred.

Competence Inquiry – Registration Issue	5,457
Competence Inquiry – Health Issue	5,457
	$10,914

9. MEDICAL PRACTITIONERS DISCIPLINARY COMMITTEE

Payments to the M.P.D.C. were for committee fees, committee and staff travel, accommodation expenses and legal costs. The Council did not pay for M.P.D.C. staff salaries or administration expenses.

10. PRELIMINARY PROCEEDINGS COMMITTEE

Comparative figures for the 1988 year are unavailable (they are included in Council and Administration Expenses for that year).

11. CONTINGENT LIABILITY – TAXATION

The Councils solicitors are continuing their consultation with the Commissionier of Inland Revenue to clarify the Council's tax status.

BALANCE SHEET

as at 31 March 1989

	1989	1988
CURRENT ASSETS		
Petty Cash	110	60
General Fund Cheque Account at ANZ Bank	22,820	9,516
Disciplinary Fund Cheque Account at BNZ	2,253	38,652
Payments in Advance and Sundry Debtors (Note 3)	31,574	4,460
Interest Accrued (Note 4)	150	3,118
	$56,907	55,806
INVESTMENTS (Note 4)		
General Fund	129,887	220,245
Disciplinary Fund	–	46,591
	$129,887	266,836
FIXED ASSETS (Note 5)	269,863	260,727
TOTAL ASSETS	$456,657	$583,369
CURRENT LIABILITIES		
Sundry Creditors		
– General Fund	104,299	81,637
– Discipline Fund	262,807	239,338
– N.Z.R.E.X. (Note 6a)	4,098	–
Payments Received in Advance	39,437	60,226
TOTAL LIABILITIES	$410,641	381,201
CAPITAL ACCOUNT		
Accumulated Capital	319,424	366,363
Disciplinary Reserve – (Deficit)	(273,408)	(164,195)
	46,016	202,168
	$456,657	$583,369

MEDICAL COUNCIL OF NEW ZEALAND

REVENUE STATEMENT

for year ended 31 March 1989

	1989	1988
FEES RECEIVED		
Annual Practising Certificate	436,050	398,298
Certificate of Good Standing	10,449	9,372
Medical Registration Certificate	3,523	3,023
Change of Name	432	360
Registration Fees – including conditional temporary, probationary and restoration	128,642	132,216
Specialist Registration Fee and General Practice Registration Fee	16,674	38,252
INCOME FROM FEES	$595,770	$581,520
OTHER INCOME		
Administration Fee – Dental Council	15,000	9,000
Interest Received	42,545	56,381
Sales of Medical Registers	16,108	15,217
Sale of register information to Department of Health (Note 7)	9,000	–
INCOME FROM OTHER SOURCES	82,653	80,598
PROBATIONARY REGISTRATION EXAMINATION FEE (Note 6b)	13,990	(8,386)
TOTAL INCOME FOR YEAR	692,413	653,733
Less Expenses as per Schedule	739,352	549,890
NET SURPLUS (DEFICIT) FOR YEAR ENDED 31/3/89	(46,939)	103,843
Accumulated Capital Brought Forward	366,363	253,651
	319,424	357,494
Plus Transfer from Building Reserve	–	8,869
ACCUMULATED CAPITAL	$319,424	$366,363

MEDICAL COUNCIL OF NEW ZEALAND

SCHEDULE OF EXPENSES

for year ended 31 March 1989

	1989	1988
ADMINISTRATION AND OPERATING EXPENSES		
Acc Levy	4,650	3,902
Audit and Accountancy Fee	4,940	4,000
Agents Registration Fees	2,630	4,360
Cleaning	2,574	2,345
Courier	2,444	1,145
Depreciation	46,292	38,514
Electricity	4,717	4,341
Fringe Benefit Tax	3,379	894
General Expenses	4,096	6,825
Legal Expenses	2,411	6,299
Micro Film Files	1,108	1,832
Medical Workforce Survey and Associated Expenses (Net after Government Grant)	14,746	24,145
Overseas Travel – Secretary	2,088	2,637
Photocopying Expenses	6,783	5,260
Postage	20,926	16,423
Printing and Stationery	56,048	39,753
Rent and Insurance	27,350	27,147
Repairs and Maintenance	3,055	836
Salaries	245,840	226,631
Superannuation and Health Insurance	13,242	12,294
Staff Recruiting – Advertising and Placement	289	1,118
Telephone, Tolls and Facsimile	12,056	9,577
TOTAL ADMINISTRATION & OPERATING EXPENSES	481,664	440,278
COUNCIL AND COMMITTEE EXPENSES		
Council Expenses		
– Chairman's Overseas Travel	2,627	4,579
– Chairman's Honoraria	4,813	4,812
– Fees, Travelling & Accommodation Expenses	85,638	48,461
Medical Education Committee		
– Fees, Travelling & Accommodation Expenses	18,847	22,310
– Hospital Visits	11,898	6,585
Intern Supervisors Regional Meetings		
– Fees and Travelling Expenses	10,351	–
Competence Inquiry – Registration Issue (Note 8)	5,457	22,865
TOTAL COUNCIL AND COMMITTEE EXPENSES	139,631	109,612
REVIEW COMMITTEE ON EDUCATION OF MEDICAL UNDERGRADUATES IN NEW ZEALAND	118,057	–
TOTAL EXPENDITURE	$739,352	$549,890

MEDICAL COUNCIL OF NEW ZEALAND

REVENUE STATEMENT FOR DISCIPLINARY RESERVE ACCOUNT

for year ended 31 March 1989

	1989	1988
REVENUE		
Levies Received	447,197	180,928
Interest Received	20,463	27,784
Recovery of Disciplinary Costs	57,822	22,809
TOTAL REVENUE	525,482	231,521
ADMINISTRATION AND OPERATING EXPENSES		
ACC Levy	1,214	175
Audit and Accounting Fee	1,860	1,000
Competence Inquiry – Health Issue (Note 8)	5,457	22,865
Doctors Health Advisory Service	18,137	2,159
Expert Witness Reports	662	1,041
General Administration Expenses	3,417	3,075
High Court Appeal	28,009	85,388
Legal Expenses (Medical Council and Preliminary Proceedings Committee)	195,450	102,387
Medical Practitioners Disciplinary Committee (Note 9)	270,738	146,532
Stenographers Fees and Expenses	4,085	1,794
Telephone, Tolls and Facsimile	7,302	3,404
TOTAL ADMINISTRATION AND OPERATING EXPENSES	536,331	369,820
Council and Committee Expenses		
Council Expenses (Discipline)		
– Fees and Honorarium	36,638	16,164
– Travelling and Accommodation	25,820	4,552
Council Expenses (Impaired Doctors)		
– Travelling and Accommodation	5,818	–
Preliminary Proceedings Committee (excluding legal member) (Note 10)		
– Travelling, Accommodation and Secretarial Expenses	10,064	–
– Fees and Honorarium	20,024	–
TOTAL COUNCIL AND COMMITTEE EXPENSES	98,364	20,716
TOTAL EXPENSES	634,695	390,536
Net Deficit for Year Ended 31/3/89	109,213	159,015
Disciplinary Reserve Balance Brought Forward – (Deficit)	(164,195)	(5,180)
TOTAL DISCIPLINARY RESERVE – (Deficit)	$(273,408)	$(164,195)

FEES

TO BE PAID ON APPLICATION FOR MEDICAL COUNCIL SERVICES DURING COUNCIL FINANCIAL YEAR 1 APRIL 1989 TO 31 MARCH 1990

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

	Fee	GST from 1/7/89	Total Pay from 1/7/89
REGISTRATION: (Conditional or Full)			
On deposit of evidence of qualifications	170.00	18.00	162.00
For provisional certificate	25.00	3.13	28.13
For annual practising certificate	85.00	10.63	95.63
For disciplinary levy	150.00	18.75	168.75
Total fees on registration	430.00	53.75	483.75
OTHER:			
For certificate of temporary registration	144.00	18.00	162.00
For eligibility for probationary registration	95.00	11.88	106.88
For certificate of probationary registration	95.00	11.88	106.88
For *full registration (from probationary, including practising certificate)	315.00	39.38	354.38
For annual practising certificate including disciplinary levy	235.00	29.38	264.38
For *restoration of name to Register after removal therefrom (including provisional certificate)	390.00	48.75	438.75
For initial entry on Specialist Register	50.00	6.25	56.25
For entry on Specialist Register in a second or further specialty	10.00	2.50	12.50
For initial entry on Indicative Register of General Practitioners	50.00	6.25	56.25
For change of name or other entry in Register, excluding change of address or entry of additional qualifications (free)	25.00	3.13	28.13
For Certificate of Good Standing	25.00	3.13	28.13
For Certificate of Registration (or other document in connection with applications to register in another country)	25.00	3.13	28.13
For any inspection of the Register	8.00	1.00	9.00

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

MEDICAL COUNCIL
OF NEW ZEALAND