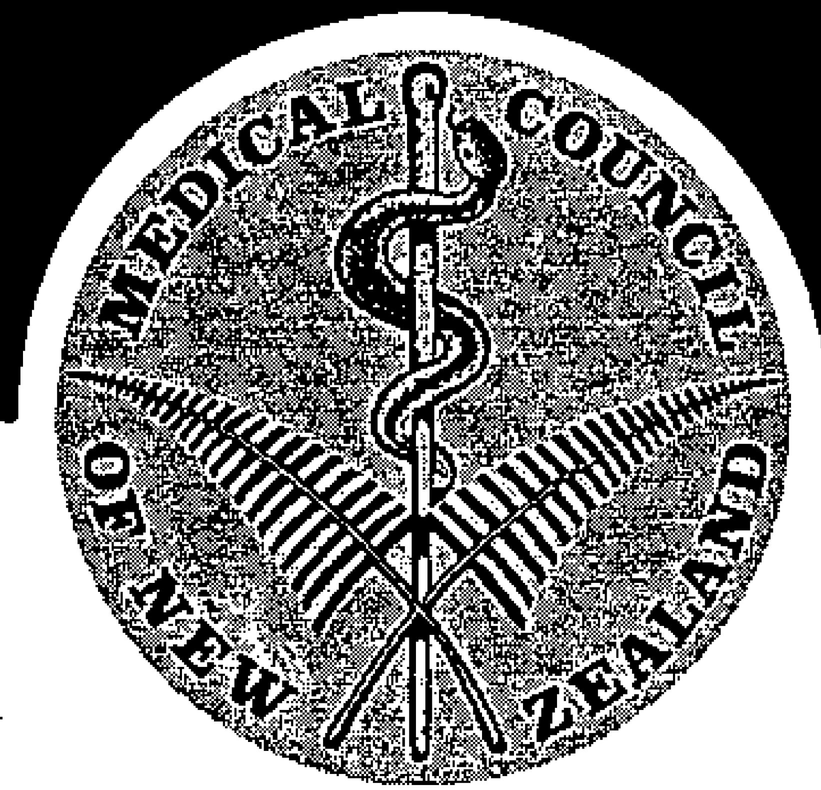
MEDICAL COUNCIL OF NEW ZEALAND

ANNUAL REPORT 1990



MEDICAL COUNCIL OF NEW ZEALAND

ANNUAL REPORT

FOR YEAR ENDED 30 JUNE 1990

Members of the Medical Council	2
Secretariat	3
Medical Education Committee	4
Committees	5
Report from the Chair	6
Visit of Australian Medical Council	9
Report of the Lay Member	10
Report of the Medical Education Committee	11
Discipline in the Medical Profession	12
Report of the Preliminary Proceedings Committee	15
Report of the Health Committee	18
New Zealand Registration Examinations (NZREX)	20
Report of the Secretary	22
Report of the Medical Practitioners Data Committee	27
Report of the Specialist Registration Sub-Committee	30
Report of the Indicative Register Sub-Committee	32
Report of the Communications Committee	34
Report of the Finance and Management Committee	35
Auditor's Report and Financial Statements	37
Fees Schedule	47

MEMBERS OF THE MEDICAL COUNCIL

(At 30 June 1990)

	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, JP	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 1990)

Secretary	Ms G.A. Jones, BA
Deputy Secretary	Mr S.M.D. Willcox, BA
Assistant Secretary	Mr M.J. Richardson, BCA
Council Offices	73 Courtenay Place, Wellington 1
Postal Address	PO Box 9249, Wellington
Telephone	(04) 847-635
Fax	(04) 858-902
Solicitors	Kensington Swan, P.O. 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, P.O. Box 11253, Wellington

Secretariat

Chief Executive Officer:	Ms G.A. Jones
Administration Manager:	Mr S.M.D. Willcox
Executive Officer:	Mr M.J. Richardson
Registration Officers:	Mrs J. Lui (Snr) Mrs A. Hamilton Ms L. Urquhart
Secretary/Word Processor Operator:	Ms J. Hawken
Accounts Officer (Part-time):	Mrs J. Mackay

MEDICAL EDUCATION COMMITTEE

(At 30 June 1990)

	Appointed by:
Professor J.D. Hunter (Chair)	Medical Council
Dr M.I. Asher	Faculty of Medicine, University of Auckland
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
Professor 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 1990)

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 or Dr M.M. Herbert
(alternate for medical members)
Mr P.H. Cook (Legal Member)

Finance and Management Committee
Dr W.S. Alexander (Chair)
Ms G.A. Jones
Dr P.S. Talbot
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. St 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
Dr G.F. Lamb
Dr C.H. Maclaurin

Specialist Registration Sub-Committee
Dr G.F. Lamb (Convener)
Dr C.H. Maclaurin

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

Communications Committee
Dr J.A. Treadwell (Convener)
Dr W.S. Alexander
Ms G.A. Jones
Mrs P.C. Judd

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 eighth Annual Report of the Medical Council of New Zealand gives an account of progress and developments in the year ended 30 June 1990.

The Medical Council has completed a very busy year with a heavy load of disciplinary hearings as well as a full programme of meetings dealing with its various other functions. The year has called for a very considerable commitment of time from Council members and I must express my thanks and that of the profession as a whole to my colleagues who have interrupted their regular schedules to attend to Council duties. Any doctor in active solo practice finds it extremely difficult to find at least three working days every month to attend to Council business and yet the Council must be made up of doctors who are in active practice if it is to reflect the attitudes of the profession on the issues before it.

The highlight of the year was the visit of the Australian Medical Council to Wellington in June. This is reported in a separate section of this document. For several years the Secretary and I have attended the Annual Meeting of the Australian Medical Council and have found the exchange of views on common issues most helpful. This year my colleagues shared that opportunity and we have all found benefit in our various areas of responsibility.

Council is disappointed that progress on the new Medical Practitioners Act has been so slow. Discussions with the Working Group on Occupational Regulation were held in 1989 but the recommendations of the Working Group were not finalised until the end of the year and have so far not been made available to Council. It is now highly unlikely that a Bill will be ready for entry to the House before the election. It is hoped that it will be regarded as of sufficient importance to obtain a high place on the legislative programme for next year.

The Council Working Party on Informed Consent has consulted widely and has produced a comprehensive report on the basis of which Council has issued a Statement which is enclosed with this report. It is hoped that this Statement will assist those grappling with the introduction of new consent procedures – in both public and private practice.

In the education field there has been much effort by members of our Medical Education Committee. The report of the Review Committee on the Education of Medical Undergraduates in New Zealand (Renwick Committee) has been considered by MEC and recommendations made have been developed and referred to the Universities for their reaction. These reactions will be the basis for continuing dialogue with the teaching institutions leading up to a return visit by a review committee in about five years. In discussions with the Australian Medical Council there was considerable support for the view that each country should recognise graduates from medical schools accredited by the other.

Also arising from the Renwick Committee report the MEC has put a great deal of work into a document outlining the registration authority requirements for the pre-registration (first house surgeon) year.

In our desire to ensure that the initial training of young doctors should provide them with knowledge, skills and attitudes for the proper practice of medicine we have held two meetings with area health board managers. These meetings have established a satisfactory rapport with the employing authorities. With the production of the requirements for the pre-registration year (seventh) to be followed by a statement on the eighth year the managers should have a clear indication of Council policy. We have also discussed with managers our views on competence and its assessment. In the new scheme of things the employer as well as the registration authority has to be concerned about competence and fitness to practise.

If under the new Act a tribunal is established to relieve Council of its role in discipline, the issue of competence to practise can receive the attention it deserves. Often impairment of health can be excluded from consideration. A competence committee, having recourse to peer review, could consider the possibility of endorsement of an Annual Practising Certificate to allow limited practice pending remedial measures, including aspects of continuing education as seems appropriate.

Legal protection is essential for any Society or College providing an early warning competence assessment programme, with safeguards against accusation of malice or bad faith.

Assessment of competence was discussed recently with the Australian Medical Council and there was reassuring expression of similarity of experience and intention. Among the answers from working groups asked "what is the next step to making competence assessment a manageable goal" were:

THE MEDICAL COUNCIL – JUNE 1990

From left to right: (standing) Dr M. M. Herbert, Ms G. A. Jones (Secretary), Dr G. F. Lamb, Dr J. M. Broadfoot, Dr I. M. St George, Dr P. S. Talbot, Dr J. A. Treadwell, Professor J. D. Hunter.
(seated) Dr R. G. Gudex, Dr R. H. Briant (Deputy Chair), Dr W. S. Alexander (Chair), Mrs P. C. Judd J.P., Dr C. H. Maclaurin

- Educate the profession towards accepting continuous competence assessment, especially as a constructive rather than threatening activity
- Encourage quality input, alongside protocols for use in monitoring
- Provide indemnity for those reporting the incompetent practitioner
- Establish vocationally oriented registration, which will define for an individual practitioner, the limits within which competence can be assessed
- Develop methodologies for assessment with incentives for self-assessment and remedial education
- Provide resources, especially time and money
- Support practitioners in re-education or rehabilitation programmes
- Engage in dialogue with employers, professional bodies, the government and consumer representatives
- Urge registration authorities to take responsibility for promoting action rather than philosophical discussions only.

As part of the development of the role of the Council as a leading organisation for the profession as well as its function in the public interest, further steps have been taken to strengthen the secretariat. These changes are intended to improve not only the efficiency of the office in dealing with the increasing workload involved with registration, discipline, examination of overseas medical graduates and the activities of the Medical Education Committee, but also the quality of administrative support for Council decision making.

In what has been a busy year with many difficult disciplinary cases and a number of important policy issues I have had tremendous support from my colleagues on the Council each of whom has dealt with their particular portfolio with dedication. Dr Robin Briant as Deputy Chair of Council and Convener of the Preliminary Proceedings Committee has had a particularly heavy workload and we are most appreciative of her contribution. Georgina Jones our Secretary has superintended the revision of the organisation of the office with enthusiasm and the result achieved is a tribute to her efforts. All members of the staff have approached their new tasks with vigour and determination and the Council on behalf of the profession thank them for their efforts.

W S Alexander
CHAIR

VISIT OF AUSTRALIAN MEDICAL COUNCIL 23-27 JUNE 1990

For many years the Chair and Secretary of the Medical Council of New Zealand have attended the Annual Meeting of the Australian Medical Council (AMC) as observers. This meeting is held in the state capitals in rotation. In keeping with the New Zealand 1990 theme the AMC accepted our invitation to hold its annual meeting in Wellington. The National Specialist Qualifications Advisory Committee (NSQAC) held a concurrent meeting here also, as is their custom when the AMC meets in Australia.

On Saturday, 23 June, the meeting opened with a seminar on the topic of "Assessing Competence – Is It A Manageable Goal?" This seminar was opened by Dr Peter Livingstone, former President of AMC and presently Director of Postgraduate Education, University of Queensland. His address set the theme of vocationally oriented registration as a step towards assessment of competence. Other speakers were Associate Professor Norma Restieaux, University of Otago; Professor Joe Correy, University of Tasmania; Professor Ron Kalucy, Flinders University; and Professor Peter Skegg, Professor of Law, University of Otago.

The seminar divided into discussion groups which reported back to the plenary session. The discussions were then summarised by Drs Philip Barham (Auckland) and John Horvath (Sydney) and Mrs Isabelle Sherrard (Carrington School of Health Studies, Auckland). It is expected that a full summary of proceedings from this useful seminar will be available shortly.

On Sunday 24 June a joint meeting of the two Councils examined issues of common concern particularly the accreditation of undergraduate courses in medicine and the examination and assessment of overseas medical graduates.

The Australian Medical Council then proceeded to hold its own annual meeting on Monday 25 and Tuesday 26 June. Members of MCNZ attended as observers.

The exchange of views and ideas on the many issues we have in common with Australia proved most helpful to members of the New Zealand Council and will be the basis for future developments.

The Australian Medical Council graciously presented the Medical Council of New Zealand with an original work created by an Aboriginal painter and this now hangs in the Council boardroom.

REPORT OF THE LAY MEMBER

With the release in June 1990 of the Medical Council's Statement on Information and Consent, all of the undertakings published in the Council's 1988 Annual Report have been completed and a significant factor is that there has been lay involvement in most of the work.

As well, with all of its initiatives for change, the Medical Council has consulted with community groups and published material in the New Zealand Medical Journal. The Renwick Report on Medical Education and the document on Information and Consent are both available from the Council in booklet form.

It is therefore disappointing that most public discussion of Council's activities centres on discipline matters while the new initiatives which will impact on medical treatment for all New Zealanders are largely ignored.

Because of the emphasis on discipline, the Medical Council is sometimes accused of a lack of openness in regard to its activities. However, the only material which is not made public is information about patients which is produced at disciplinary hearings. If a practitioner is found guilty of an offence after appearing before the Disciplinary Tribunal of the Medical Council, the practitioner's name and details of the offence are usually published but in such a way as to protect the complainant.

There is pressure for disciplinary hearings to be open to the public. I have reservations about this because I feel that it could inhibit complainants, both initially as to whether to lay a complaint and also during the hearing. Frequently evidence is produced which involves very personal details, medical records and so on. As well, on occasions, discipline cases involve behaviour which would be 'grist to the mill' for those who seek out the salacious and the bizarre. In a small country such as ours the parties involved, innocent as well as guilty, could be easily identified.

At the moment there is growing concern in our society for the victim's needs. In the same way as every person accused of a crime must be presumed innocent until proven guilty, so the complainant should be seen as a victim until it is shown otherwise.

I do not believe justice is served if the systems we must use provide disincentives to the redressing of wrongs.

P C Judd
LAY MEMBER

REPORT OF THE MEDICAL EDUCATION COMMITTEE

This Committee continued to meet regularly during the year and held an additional meeting with the Intern Supervisors. Through its Chair, some education matters of concern were raised with the General Managers of the Area Health Boards when the Boards met with Council members on 23 February 1990. Representatives of the Resident Doctors' Association were invited to attend the Committee's meeting on 26 October 1989 to discuss the Committee's working party report on "Requirements for Training and Supervision in the Intern Year".

It was a disappointment to the Committee that a new Medical Practitioners Act did not eventuate. Despite the lengthy deliberations and submissions made to the Minister in the previous year regarding the possible future role and responsibilities for the Medical Education Committee, the functions remain those assigned in 1968 and new initiatives thwarted.

REVIEW OF UNDERGRADUATE MEDICAL EDUCATION

Following receipt of the 1988 report, the Medical Education Committee crystallised recommendations which were adopted by Council and passed on to the Universities and other bodies for consideration and implementation. The Medical Council of New Zealand formally "accredited the courses and curricula leading to graduation in medicine at the University of Otago and the University of Auckland" and indicated that in future major reviews of the medical undergraduate courses be conducted at intervals of not less than five years. Further Council signalled, on the recommendation of the Medical Education Committee, that there would be annual reporting on course and curriculum changes and intermittent selective reviews of specific issues should the need arise.

REVIEW OF REQUIREMENTS FOR TRAINING AND SUPERVISION IN THE INTERN YEAR

Considerable time and effort was devoted by the Committee and its several working parties to reviewing the requirements in the pre-registration year. Matters affecting first year interns themselves, the intern supervisors and the area health boards in which interns work on approved runs were considered. A modified set of guidelines has now been prepared and subject to Council approval, will be adopted for 1991. Before the end of 1990 new statements will be issued to the interns, the intern supervisors and the accredited area health boards. More emphasis has been given to the educational requirements for interns in this supervised pre-registration year as well as to assessment procedures. With respect to the mandatory and optional clinical "run categories" now approved for pre-registration requirements there is now the inclusion of approved general practitioner attachments (for 3 months) if such can be attained on a practical basis. The role of the intern supervisors has been defined more explicitly as have the responsibilities expected from those area health boards who wish to retain their accreditation status.

Once again I stress that the intern supervisors have an essential role in relation to the Medical Education Committee and the conditional year requirements. Co-ordination with this group has been promoted and it was valuable that most of the 37 supervisors in the country could attend the meeting with representatives of the Medical Education Committee on 21 March 1990 and that others could participate in regular visitations to hospitals for accreditation purposes.

RELATIONSHIPS TO AREA HEALTH BOARDS

At a time when area health boards are under great pressure in determining funding priorities it has become increasingly important that those boards wishing to maintain their accreditation status as employers and educators of new graduates continue to recognise, and respond appropriately to, the statutory regulations set by the Medical Education Committee for this purpose. Increased efforts have been made to facilitate communication with the boards on these matters, particularly with regard to implications of the introduction of new roster systems for interns, the availability of intern educational programmes (and allocated time for these) and the role and remuneration of intern supervisors.

SURVEILLANCE OF VOCATIONAL POSTGRADUATE EDUCATION

The possible extended role of the Medical Education Committee to cover the surveillance of vocational postgraduate education pertaining to specialist registration requirements (as mentioned in the last annual report) regrettably could not be pursued due to the protracted delay in revising the Medical Practitioners Act 1968. The Committee continues however to endorse most strongly the concept that one body with an overview of the continuum of medical education from undergraduate through vocational, postgraduate and retirement phases can only enhance the quality of education and service to the community and the profession.

J D Hunter
CHAIR

DISCIPLINE IN THE MEDICAL PROFESSION

It is apparent from the questions raised with the secretariat and Council members and the Chair at the time of the issue of the annual practising certificate and the collection of the disciplinary levy that, despite annual reports to the profession, there is still incomplete understanding of the basis set down in the Medical Practitioners Act for the administration of medical discipline. Although strong submissions have been made to amend this structure, new legislation has not yet come before Parliament.

Under the present Medical Practitioners Act, there are three levels to the disciplinary system:

1. DIVISIONAL DISCIPLINARY COMMITTEE (DDC)

The NZMA appoints 3 or 6 doctors, depending on the size of the Division, and the Minister 1 layperson. A quorum of 2 or 4 considers complaints which could result in a finding of conduct unbecoming a medical practitioner. After enquiry and hearing, if the doctor is found guilty of conduct unbecoming, he or she may be censured.

2. MEDICAL PRACTITIONERS DISCIPLINARY COMMITTEE (MPDC)

The NZMA appoints 4 doctors and the Minister 1 doctor and 1 layperson. This is the most active of the tribunals and (with a quorum of at least 3) considers complaints giving rise to charges of professional misconduct. Penalties available include censure, financial penalty (maximum $1,000) and/or conditions imposed on practice for a maximum of three years.

3. MEDICAL COUNCIL OF NEW ZEALAND (MCNZ)

A quorum of 5 members of Council, excluding those on the Preliminary Proceedings Committee, sit to hear charges of disgraceful conduct, referrals of convictions or recommendations for prescribing prohibitions (under the Misuse of Drugs and Medicines Acts). Most charges arise out of serious complaints about the conduct of a doctor and original complainants and other witnesses, including experts, are called upon by the Preliminary Proceedings Committee (the investigatory arm of the Council) to support the charges. Normally evidence is presented in affidavit form by both prosecution and defence and cross examination follows. Penalties avilable to the tribunal include removal from the register, suspension for not more than 12 months, conditions on practice for maximum of 3 years, financial penalty (maximum $1,000) and censure.

All three levels of tribunal have the power to award costs against a doctor found guilty. Complainants reasonable costs (using legal aid scales) are normally met whether or not the doctor is found guilty. Publication in the New Zealand Medical Journal can also be ordered, with or without the suppression of names. It is very unusual for the patient's name to be disclosed. The Interim Discipline Secretariat provides administrative services for the DDC and the MPDC and the Council secretariat for the Council in its disciplinary mode. Decisions may be appealed by the doctor or the complainant – DDC decisions to the MPDC, MPDC to the MCNZ and MCNZ to the High Court. Findings are not published (nor financial penalties and costs collected) until appeals have been determined.

The expenses of almost all this activity are now met from the disciplinary levy – legal expenses, sitting fees, travel and accommodation costs for tribunal members, administrative and stenographic assistance, venues, expert witnesses, complainants reasonable costs and the fees of the legal assessors who sit alongside the tribunals to advise on matters of evidence, law and procedure, but do not participate in the decision making.

Doctors appearing before these tribunals and the Preliminary Proceedings Committee very often have assistance of a lawyer from their medical defence organisation which gives advice, prepares cases for defence, and can pay the costs awarded against a doctor found guilty. None of this activity is funded by the disciplinary levy, but it is plain that doctors in general contribute through their defence premiums.

Details of the income and expenditure of the Disciplinary Levy are set out in full at the end of the Annual Report in the report of the Finance and Management Committee and the audited Financial Statements.

Complaints may be made to the Secretary of the Medical Practitioners Disciplinary Committee or to the Secretary of the Medical Council. The latter are all referred in the first instance to the Preliminary Proceedings

Table 1

M.P.D.C. AND D.D.C. ENQUIRIES

Table a) – GEOGRAPHIC LOCATION OF RESPONDENT DOCTOR

	GP	GP Locum	GP Duty	R.M.O.	Registrar	M.O.S.S.	Anaesthetist	Cardiologist	Comm. Med.	DOH Employee	Dermatologist	E.N.T.	Gastroenterol	Gen. Surgeon	Neurologist	O. & G.	Orthopaed. Surg	Paediatrician	Pathologist	Physician	Psychiatrist	Plastic Surgeon	Radiologist	Urologist	Venerologist	TOTAL
Main Centres	59	6	13	–	6	2	3	3	–	3	2	6	1	5	2	7	6	1	–	3	11	1	3	4	–	153
Provincial	21	1	7	–	1	–	–	–	–	–	–	1	–	7	–	7	6	–	–	–	1	1	–	1	–	54
Rural	11	–	4	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	15
TOTAL	91	7	24	–	7	2	3	3	–	3	2	7	1	12	2	14	12	1	–	3	12	2	3	5	–	217

Table b) – WHO MAKES THE COMPLAINT

	GP	GP Locum	GP Duty	R.M.O.	Registrar	M.O.S.S.	Anaesthetist	Cardiologist	Comm. Med.	DOH Employee	Dermatologist	E.N.T.	Gastroenterol	Gen. Surgeon	Neurologist	O. & G.	Orthopaed. Surg	Paediatrician	Pathologist	Physician	Psychiatrist	Plastic Surgeon	Radiologist	Urologist	Venerologist	TOTAL
Patient	35	2	9	–	3	1	2	1	–	1	1	2	–	6	2	13	6	–	–	3	10	1	2	5	–	105
Spouse	14	–	5	–	1	1	–	1	–	–	–	–	–	5	–	–	1	–	–	–	–	–	–	–	–	28
Relative	24	–	7	–	3	–	–	1	–	–	1	4	1	–	–	–	4	1	–	1	2	1	–	–	–	50
Friend	4	–	1	–	–	–	–	–	–	–	–	–	–	–	–	–	1	–	–	–	–	–	–	–	–	6
Employer	8	1	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	10
ACC/DOH	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Other	6	4	1	–	–	–	1	–	–	2	–	1	–	1	–	1	–	–	–	–	–	–	1	–	–	18
TOTAL	91	7	24	–	7	2	3	3	–	3	2	7	1	12	2	14	12	1	–	4	12	2	3	5	–	217

Table c) – MAJOR GROUND FOR COMPLAINT

	GP	GP Locum	GP Duty	R.M.O.	Registrar	M.O.S.S.	Anaesthetist	Cardiologist	Comm. Med.	DOH Employee	Dermatologist	E.N.T.	Gastroenterol	Gen. Surgeon	Neurologist	O. & G.	Orthopaed. Surg	Paediatrician	Pathologist	Physician	Psychiatrist	Plastic Surgeon	Radiologist	Urologist	Venerologist	TOTAL
Fees	2	–	1	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	3
Ethics/Bus. Man.	34	2	4	–	–	1	2	1	–	3	–	3	–	3	–	4	3	–	–	1	2	–	1	–	–	64
Failure to provide service	13	4	13	–	1	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	31
Delay in providing service	–	–	1	–	–	–	–	–	–	–	–	–	–	1	–	–	–	–	–	–	–	1	–	–	–	3
Diagnosis incorrect	4	–	–	–	–	–	–	–	–	–	–	–	–	–	1	–	–	1	–	1	7	–	1	–	–	15
Failure to diagnose	25	–	3	–	2	1	1	1		–	2	–	1	2	1	1	1	–	–	2	–	–	1	–	–	44
Failed, unsuccessful	9	1	1	–	1	–	–	1	–	–	–	4	–	5	–	8	7	–	–	–	2	1	–	5	–	45
Inad./inapprop. prescription	4	–	1	–	2	–	–	–	–	–	–	–	–	1	–	–	–	–	–	–	1	–	–	–	–	9
No treatment provided	–	–	–	–	1	–	–	–	–	–	–	–	–	–	–	1	1	–	–	–	–	–	–	–	–	3
TOTAL	91	7	24	–	7	2	3	3	–	3	2	7	1	12	2	14	12	1	–	4	12	2	3	5	–	217

Table d) – OUTCOME OF HEARINGS

Referred for hearing		After enquiries and before appeal			After appeal		
		UB	PMC	D	UB	PMC	D
G.P.	14	5	6	3	4	5	5
Registrar	2	1	1	–	–	1	1
Orthopaedic	4	–	1	3	–	1	3
O. & G.	3	1	2	–	1	2	–
Psychiatrist	1	–	1	–	–	1	–
Opthalmologist	1	–	–	1	–	–	1
General Surgeon	1	1	–	–	1	–	–
Anaesthetist	1	–	–	1	–	–	1
TOTAL	27	8	11	8	6	10	11

UB = Conduct Unbecoming a practitioner
PMC = Professional Misconduct D = Dismissed

NOTES to Table c): **"Fees"** – complaint primarily relating to the fee charged. **"Failure to provide service"** – (self explanatory). **"Delay in providing service"** – Delay in provision of service. **"Ethics/Business Management"** Ethics and/or business management e.g. breach of confidence, failure to write referral letter, rudeness by doctor or his/her staff. **"Diagnosis Incorrect"** – Doctor made a diagnosis which is subsequently proved to be incorrect. **"Failure to diagnose"** – No diagnosis made by doctor. **"Failed, unsuccessful"** – Failed or unsuccessful treatment, e.g. operation failed to achieve expected result. **"Inadequate/Inappropriate prescribing"** – Inadequate or inappropriate medicines prescribed, e.g. wrong drug for condition, incorrect dose. **"No treatment provided"** – No treatment offered or provided to patient.

Committee which also investigates serious complaints referred from the Secretary of the MPDC. Charges are prosecuted before either tribunal depending on whether they are of disgraceful conduct or professional misconduct.

The report of the Preliminary Proceedings Committee gives details of their activities over the past year.

Table 1 summarises the work of the MPDC and DDC. A more detailed report from the Medical Practitioners Disciplinary Committee to the profession will appear in the New Zealand Medical Journal.

All levels of the disciplinary system continue to operate under legislation which shows increasing signs of age – regrettably hopes for the introduction of amending legislation have not been fulfilled.

REPORT OF THE PRELIMINARY PROCEEDINGS COMMITTEE

In the past year the Preliminary Proceedings Committee has been extremely busy.

In 1989 a total of 39 complaints were dealt with by the Committee and in the first six months of 1990 26 complaints have been received. As of the 30th of June 1990 36 cases are still on our active file, a few of them awaiting appeal.

Table 2 demonstrates the current status of the complaints received from the beginning of 1989. The largest category constitutes those dismissed after investigation.

NATURE OF COMPLAINTS

The complaints continue a rather familiar theme, improper prescribing, sexual misconduct or poor practice.

The most frequent complaints in 1989 were of inappropriate or excessive prescribing of drugs.

A newer theme is the matter of variations in practice from the norm, involving both the business aspects of medical practice and alternative means of medical diagnosis and treatment. Each complaint provides the Preliminary Proceedings Committee with a new challenge, for its decisions

Table 2

P.P.C. ENQUIRIES

	Referred to MPDC	Charged	Still under Invest.	Dismissed after Invest.	Other Action
1989 Cases (=39)	3	5	6	21	4
1990 Cases (=26) (6 months)	5	0	14	4	3

must reflect current mores and practice standards.

As well the Committee has received complaints on matters of medical standards and competence which are inappropriate to the disciplinary process. The revised Medical Practitioners Act will, we hope, provide the Council with a separate mechanism for dealing with those problems.

PRESCRIBING COMPLAINTS

Of 13 prescribing complaints received in 1989, 10 were allegations of excessive prescribing of drugs of abuse potential, or prescribing for drug dependence. It is not clear whether this increase in referrals is a reflection of worsening prescribing practice, increasing drug use in the community or greater diligence of the Area Health Board Officers in their monitoring role.

It is worth noting in passing that under the provisions of the Misuse of Drugs Act and the Medicines Act it is illegal for doctors to prescribe abusable drugs to drug dependent people, unless they have specific authority to do so.

Other prescribing complaints relate to the perceived or real problems of inappropriate or excessive use of legitimate psychiatric drugs. A number of individuals and concerned consumer groups see this as an increasing problem. The PPC is aware that there is a fine line between good treatment and treatment that may end in drug dependence.

Evidence of excessive prescribing of drugs of abuse is sometimes an indicator of a personal health problem, and the Committee explores that possibility early. Sometimes the practitioner is a substance abuser, and from that starting point prescribes excessively to patients.

In some instances there appears to have been financial gain to the doctor, where individual prescription items attract a specific fee. There have been allegations (and in the past some of these have been proved) that drugs have been provided in return for sexual favours.

Most commonly the practitioner is working in a geographic area known for its low socio-economic groups and drug using population. Doctors, once involved in prescribing for drug users, get known as a "soft touch"; the drug users have a very efficient information network. The doctors begin to prescribe without thinking, or in fear, or alternatively believe they are doing a good thing by keeping drug users out of trouble. The fallacy of this last scenario is repeatedly demonstrated. Neither the people nor the drugs stay off the street and an enormous amount of prescribed medication finds its way to the street market to increase drug abuse and crime.

ACTIONS

The Committee has been aware that the disciplinary process is a rather blunt instrument, and does not necessarily assist in the rehabilitation of doctors whose standards of practice and behaviour are less than desired. In the area of inappropriate prescribing, the heavy hand of discipline has not been laid upon all those against whom complaints appear justified. If the degree of prescribing is not extreme, or if there are not additional components of dishonesty, financial gain or behavioural aberration, the Committee tends to utilise the Area Health Board Officers to monitor the individual doctor's prescribing, and review this after a suitable period of time. Such monitoring is complex and time consuming but there is hope that in the future adequate computerisation of prescriptions will enable Medical Officers of Health to utilise their statutory powers for such observations.

Currently the Medical Officers of Health sometimes will advise the Medical Council of serious prescribing aberration and through the Council the Minister of Health is recommended to make an order in the Gazette prohibiting the practitioner from prescribing certain drugs under either the Misuse of Drugs Act or the Medicines Act. Such a restriction can be protective for the doctor for she or he is no longer in a position to be targeted by drug seekers. In addition the public is protected from the inappropriate prescriptions of this doctor. In many ways this is a more satisfactory resolution of the problem that is the disciplinary process.

For complaints arising in hospitals, the PPC has occasionally used the Area Health Boards' internal investigation committees. If these inquiries indicate disciplinary action should be considered then their report will be referred back to the PPC.

INITIATIVES

Concern about prescribing aberration has been so high that the PPC recommended that the Medical Council undertake a national consultation with doctors and health workers in the drug addiction field. This has been carried out with the able leadership of Drs Cole, Maclaurin, McCormick and Kippax, and the assistance of the Glaxo Foundation for a national meeting in April.

From this we expect that a series of recommendations to the Medical Council will be referred to agencies most able to deal with them. The hoped for outcome is better support for general practitioners who are faced with drug seekers, better treatment for drug addicted people and better surveillance and feedback of prescribing in the community.

CONCLUSION

It has become increasingly evident that the provisions in the Medical Practitioners Act (1968) are inadequate for the volume and complexity of the complaints of the 1990s. This is seen both in the over-burdening and slow processing of the investigation committee, and of the hearing times of the Medical Council. A new Act with new disciplinary provisions is an eagerly awaited outcome of the review and revision of the disciplinary process.

R H Briant
CONVENER

REPORT OF THE HEALTH COMMITTEE

The rehabilitation, not the punishment, of impaired or sick practitioners remains the primary role of the Committee.

Assessment and discussions, when necessary, are conducted on a relatively informal basis and any restrictions resulting are frequently agreed rather than imposed as mandatory sanctions.

Every opportunity is taken to create a situation where practice can continue or where re-entry can follow. Impaired practitioners required to work in supervised positions are often impoverished and need to be paid. Supervised positions are usually in large hospitals or general practices with several partners and as budgets become ever more closely watched, such positions are likely to become difficult to find.

Where permanent physical difficulty remains there may need to be retraining in another aspect of medicine.

Strategies for monitoring and for rehabilitation are becoming better established and the cooperation of the specialists in substance abuse and the Medical Officers of Health is appreciated.

Improved communication with Medical Councils in other countries allows the sharing of information regarding an individual's circumstances and current monitoring programme. The development of guidelines for medical assessments has been valuable and the committee is grateful for the efforts made by its advisers. Resulting reports are regarded as the property of Council rather than of the practitioner assessed. Council in each instance will need to consider the interests of the public and of the individual in deciding to what extent there shall be disclosure of a report. To protect the assessor any disagreement with a report will need to be directed to the Council. The Chair of Council will receive a report and will decide, preferably in consultation with the Health Committee, to what extent and under what circumstances the report will be released to the person assessed.

Increasingly Council has required the Committee to consider aspects of fitness to practise. The management of this under the area of discipline is inappropriate as that emphasises penalty or retribution rather than retraining and rehabilitation. There should be undergraduate and continuing education on commmunication skills, ethics, occupational hazards including self-prescribing and management of personal stress. Resources should provide opportunity for medical education as a life-long process. There should be opportunities for remedial education and for assessment and rehabilitation of diminished capacity.

HOW TO HELP AN IMPAIRED COLLEAGUE

No one likes to initiate review of an impaired colleague but it is seldom in the interest of the colleague or the public to wait until the impairment is obvious to all.

If the problem is not resolved by discussion with the sick doctor's immediate colleagues, therapeutic doctor and family, there should be referral to the DHAS or to the Health Screener of the Medical Council. In each situation the referrral would be treated confidentially so long as there was prospect of resolution.

DHAS REFERRAL
Phone: (04) 721-654 (toll free)
or write: Box 812, Wellington

HEALTH SCREENER
c/- Medical Council of New Zealand
Phone: (04) 847-635
Fax: (04) 858-902
or write: Box 9249, Wellington

SUMMARY OF ACTIVITIES

During the period 1 July 1989 to 30 June 1990, 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	9
Monitoring by Health Committee during treatment, rehabilitation or assessment	*18
New suspensions imposed	5
Full suspension reimposed	–
Full suspension varied to allow limited practice	4
Recommendations made for variations in prescribing restrictions	1
Recommendations made on registration applications	2
Applications for revocation of suspension considered or under consideration	5
Revocation of suspension granted	2

*** includes 2 cases where competence also an issue**

R G Gudex
CONVENER

NEW ZEALAND REGISTRATION EXAMINATIONS (NZREX)

The last sessions of PRENZ (Probationary Registration Examination in New Zealand) took place in August and December 1989. Over the six years that examination was administered, a total of 201 attempts were made by candidates (in the written and clinical sections) and success overall was achieved by 47, the pass rate being 23%. Those 47 doctors proceeded to Probationary Registration and most have now achieved admission to the New Zealand Medical Register.

In May 1989, the first session was conducted of the new sequence of examinations (NZREX). By the end of 1989, a total of 55 candidates, many of whom already held temporary registration had satisfied the examiners in the screening examination (NZREX I and II) and were thus eligible for two years of temporary registration during which time they are required to pass NZREX III and IV in order to proceed to probationary registration. Transition arrangements were made for two groups, firstly those who had commenced PRENZ but not had an opportunity to complete the examination before it was phased out, and secondly, those who were well advanced in specialist training and likely to be "specialist eligible" in 1990 or shortly thereafter. As has always been the case pursuant to Section 33 of the Medical Practitioners Act, foreign medical graduates not eligible for conditional or full registration (ie not holding primary medical degrees granted by universities in the United Kingdom, Eire, Canada, South Africa or Australia) can be granted temporary registration. Certificates can be issued without examination to allow the undertaking of postgraduate education and training or the giving of postgraduate instruction if visitors come to New Zealand sponsored by their own or the New Zealand government, international agencies or professional or academic organisations.

Tables 3 and 4 show the performance of candidates in the four parts of the new examination programme from May 1989 to August 1990. The Board of Examiners is satisfied that the screening examination is fulfilling its role in identifying which foreign medical graduates have met the educational criteria to commence in *supervised* practice in this country, at a similar level to our own graduates on conditional registration. Area Health Boards are responsible for checking references and examining curricula vitae to ensure that each of these temporary registrants is not expected to perform at a level inappropriate for their training, experience and familiarity with New Zealand medical practice and culture.

Table 3

SCREENING EXAMINATION (FOR TEMPORARY REGISTRATION)

NZREX	PART I	PART II	Screening Examination Overall
	MAY 1989		
Candidate attempts	32	37	41
No. of passes:			
Attempt 1	29	10	–
Attempt 2	N/A	N/A	
Attempt 3	N/A	N/A	
No. of Passes Overall	29	10	8
Pass Rate Overall	90%	27%	20%
	Nov 1989		
Candidate attempts	70 (2)	101 (11)	108
No. of passes:			
Attempt 1	55	36	
Attempt 2	1	10	
Attempt 3	N/A	N/A	
No. of Passes Overall	56	46	47
Pass Rate Overall	80%	46%	44%
	May 1990		
Candidate attempts	46 (4)	77 (31)	84
No. of passes:			
Attempt 1	29	18	
Attempt 2	4	18	
Attempt 3	–	–	
No. of Passes Overall	33	36	35
Pass Rate Overall	72%	47%	42%

Note: ( ) repeat candidates included

So that there will be no confusion about the scope of the examination programme now in place, these brief details are repeated from the 1989 Annual Report.

TEMPORARY REGISTRATION is not now issued unless applicants have passed the screening examination (NZREX I and II) or been exempt from it. NZREX I tests competence in English in the medical workplace (listening, speaking, reading and writing) and NZREX II tests medical knowledge across a wide range of clinical topics (similar to that expected of New Zealand fifth year medical students) using the MCQ format (330 questions in total). Exemption is granted to those who either have already passed comparable examinations in Australia, United Kingdom, Canada, and United States of America or hold approved postgraduate specialist qualifications and experience obtained in those countries. The latter group may be suitable for appointment to more senior posts, (still under supervision) if they are near to specialist eligible stage.

PROBATIONARY REGISTRATION is issued to the above doctors when they have proceeded to pass NZREX III and IV, which they are required to achieve within two years of being granted temporary registration. Exemption from these two examinations is normally only granted to those who have achieved specialist eligible status in that two year period, or are very close to it.

NZREX III is a further written examination (in SAQ and MCQ format, of clinical disciplines and applied basic and behavioural science) and **NZREX IV** is a comprehensive clinical and oral examination (equivalent to that of trainee interns about to be granted conditional registration) including a long case in medicine, and short cases and or vivas in surgery, paediatrics, obstetrics and gynaecology, psychiatry and general practice. The examiners have been concerned to note in conducting the clinical examination, that many candidates have serious weaknesses in basic patient examination technique and formulation of management plans, despite the claims by their employers that they perform well in the hospital. The only conclusion that can be drawn is that insufficient time is being given to actual observation of their clinical performance in the early stages of their integration into the New Zealand medical workforce. Council is confident that the standard of each part of the examination is not excessively high and that indeed it is the minimum which can be accepted in the public interest, being that of our own graduates.

Table 4

EXAMINATION FOR PROBATIONARY REGISTRATION

NZREX	Feb 1990 PART III	Mar 1990 PART IV	Proceed to Probationary Registration
Candidate attempts	18	10 (5)	
No. of passes:			
Attempt 1	10 [1]	5	
Attempt 2	N/A	N/A	
Attempt 3	N/A	N/A	
No. of Passes Overall	*10	5 (1)	5
Pass Rate Overall	56%	50%	
	Jul 1990	Aug 1990	
Candidate attempts	28 [7]	21 (6)	
No. of passes:			
Attempt 1	12	5	
Attempt 2	3	3	
Attempt 3	N/A	N/A	
No. of Passes Overall	*15	8 (3)	8
Pass Rate Overall	54%	38%	

Notes: ( ) repeat candidates from PRENZ or NZREX included
* passes include clear passes, conceded passes and provisional passes
[ ] provisional passes only

On completion of all the examination requirements these doctors are supervised for a further year on probationary registation and reports received at 6 and 12 month intervals. Provided these are satisfactory, an application can then be made for "full" registration, ie entry to the New Zealand Medical Register (and if appropriate also to the Specialist Register or Indicative Register of General Practitioners).

Candidate information booklets are available from the Council office and detailed feedback can be provided to candidates to enable them to make adequate preparation for the examinations. Employers must also play their part in this process. No funds are available from government or any other source for bridging courses or tuition. Council is indebted to the Universities for assistance in mounting the examination programme. The service of Dr Gavin Glasgow and Mrs Jenny Hargrave is also greatly valued.

REPORT OF THE SECRETARY

The past 12 months have seen significant changes in the structure of the secretariat. While the transition period has been stressful, we are confident that the restructuring will lead to improved effectiveness in Council administration as it relates to serving the public interest, individual practitioners and Council and Committee members themselves.

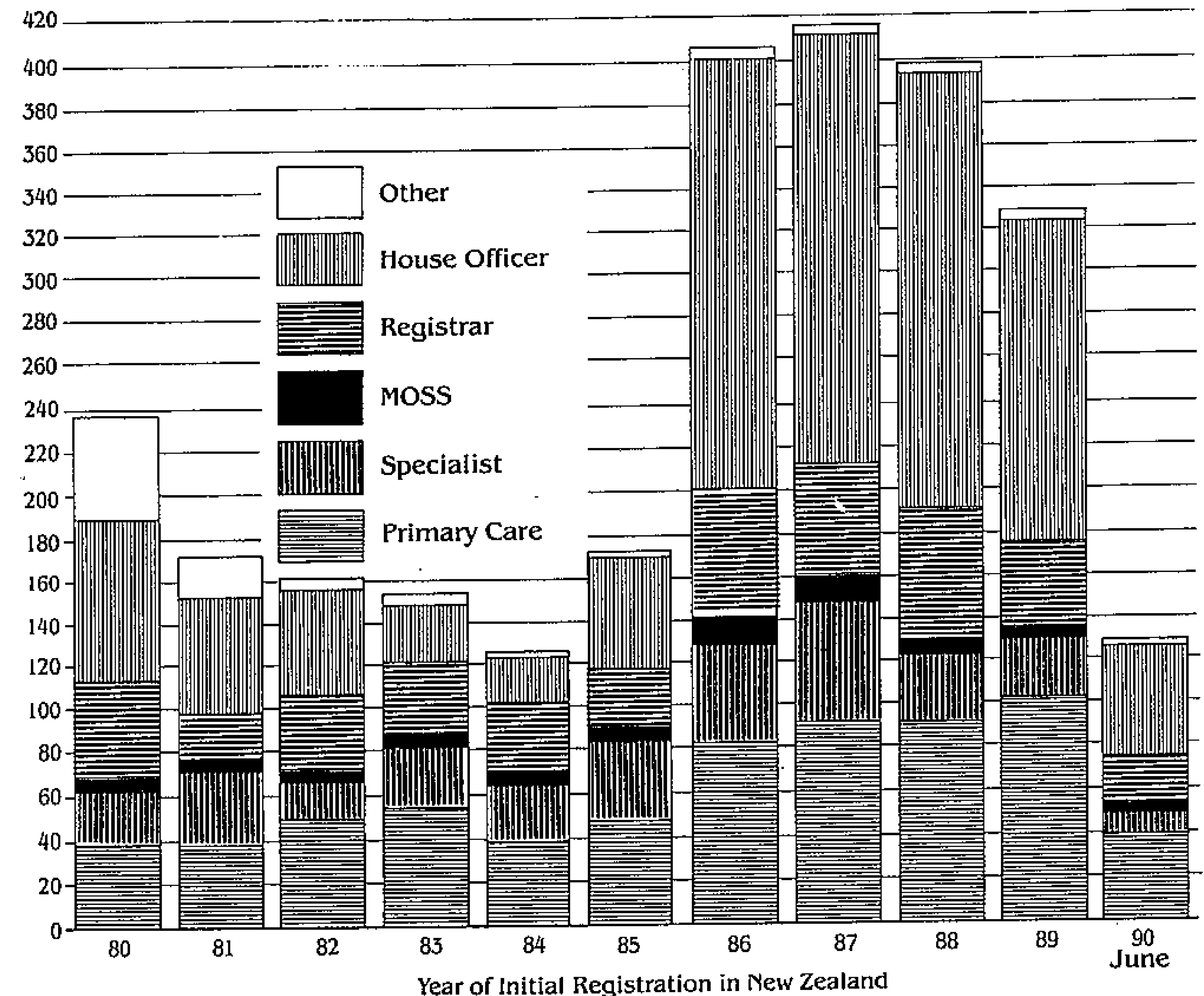
In my report last year I looked forward to a new Medical Practitioners Act 1990. This we are still awaiting but believe the changes in structure and staffing of the secretariat will facilitate the eventual transition.

STAFFING AND DUTIES

The tasks associated with registration, Annual Practising Certificates, data management, personnel and financial administration and general office management have been separated out and in February 1990 the newly appointed Deputy Secretary, **Steve Willcox**, took over primary responsibility on a day to day basis for these. Steve came to the Council after administrative experience at Victoria University and the Ministry of Foreign Affairs – the health sector is a new challenge to him. As Administration Manager he supervises the work of the registration officers, accounts officer, secretary/wordprocessor operator and the casual clerks. He is also Secretary to the following committees: Registration, Finance and Management, and Data.

Administrative support for the Board of Examiners, Medical Education Committee, Health and Communications Committees is now provided by our second new executive officer, **Mike Richardson**, who was appointed in February as Assistant Secretary. Mike has worked in administration in education but is also new to the intricacies of the medical world. Running the comprehensive series of examinations for foreign medical graduates and providing support for the accreditation of hospitals for interns, as well as assisting me with paperwork for discipline hearings and impaired doctor reporting

Table 5. **OVERSEAS GRADUATES REGISTERING IN NEW ZEALAND**
in years ending 1980 to 30 June 1990



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 1990 data therefore does not take into account those coming onto the register in the period 1 July to 31 December 1990.

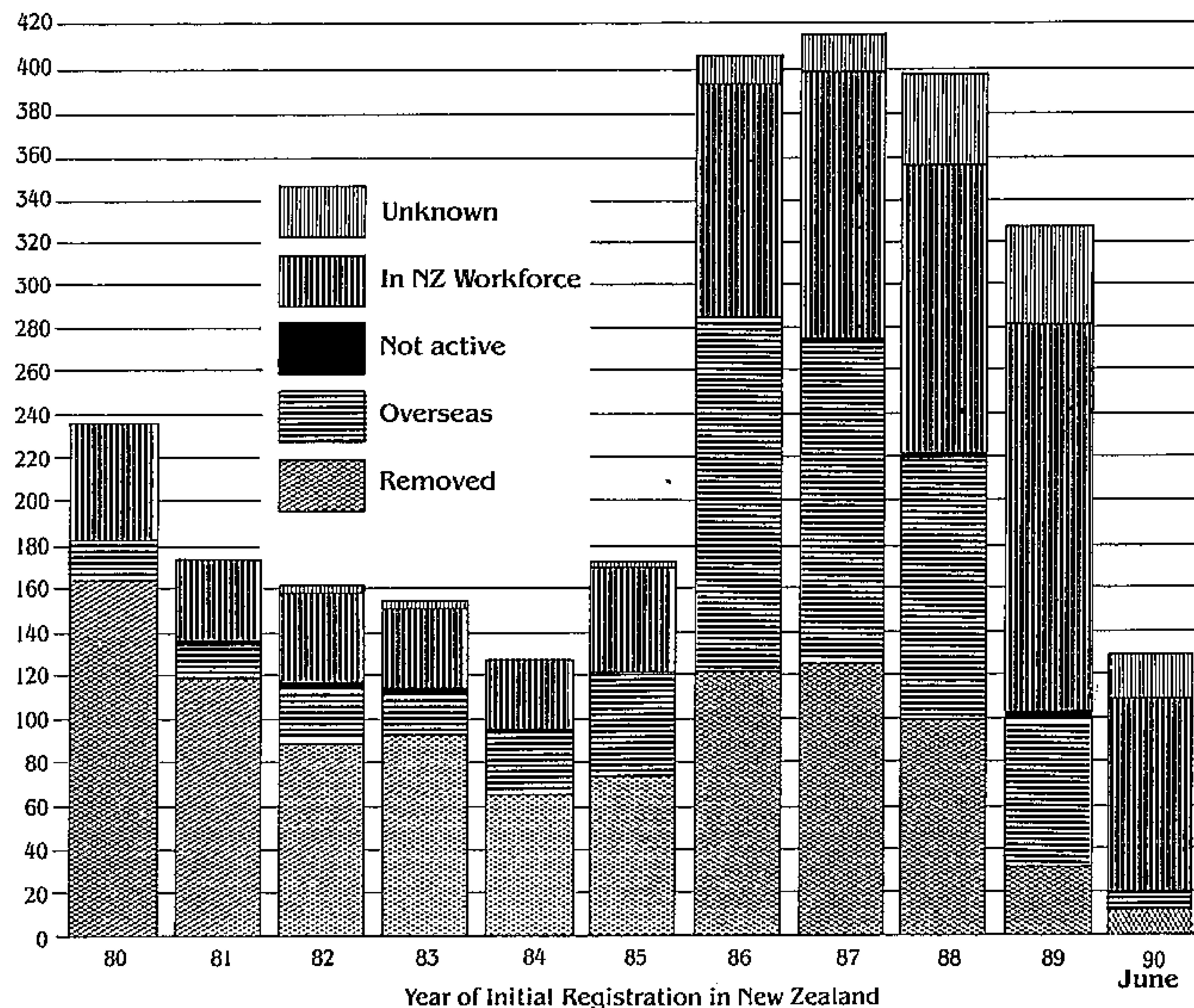
and monitoring takes sensitivity, energy and attention to detail.

Jane Lui, now Senior Registration Officer, and **Jo Hawken**, Secretary/Wordprocessor, have been on the staff throughout the period of growth and changes since 1987 and their knowledge and expertise is constantly drawn upon. We are gradually implementing better data management and word processing systems to assist them in their very heavy workload. Jane is now particularly involved in vocational registration (and clerical support for the Dental Council).

Lynne Urquhart, **Ann Hamilton** and

Table 6. **OVERSEAS GRADUATES REGISTERING IN NEW ZEALAND**
in years ending 1980 to 30 June 1990

Current Workforce Status



NOTES: Calendar years are the basis of this data. The 1990 data therefore does not take into account those coming onto the register in the period 1 July to 31 December 1990.

Joyce Mackay joined the team in the first half of the year as registration and accounts officers respectively. Lynne has particular reponsibility for temporary registration and the monthly circular of updates to the register. University students continue to help out at peak times to our mutual benefit.

WORKLOAD

Over 9,000 computer transactions, excluding those associated with the Annual Practising Certificate exercise, were carried out in the year ended 30 June 1990 – these relate to maintenance and constant updating of the New Zealand Medical Register alone. In tandem with them go telephone and personal enquiries, document verification and advising on and sorting out registration problems. 604 provisional certificates were issued as follows:

Conditional Registration	
– NZ graduates	221
– Overseas graduates	12
Full Registration	
– Overseas graduates	330
Restorations	
NZ and OS graduates	41

220 New Zealand graduates went from conditional to full and 39 foreign graduates from probationary to full registration.

The usual raft of changes were made to details concerning doctors already registered:

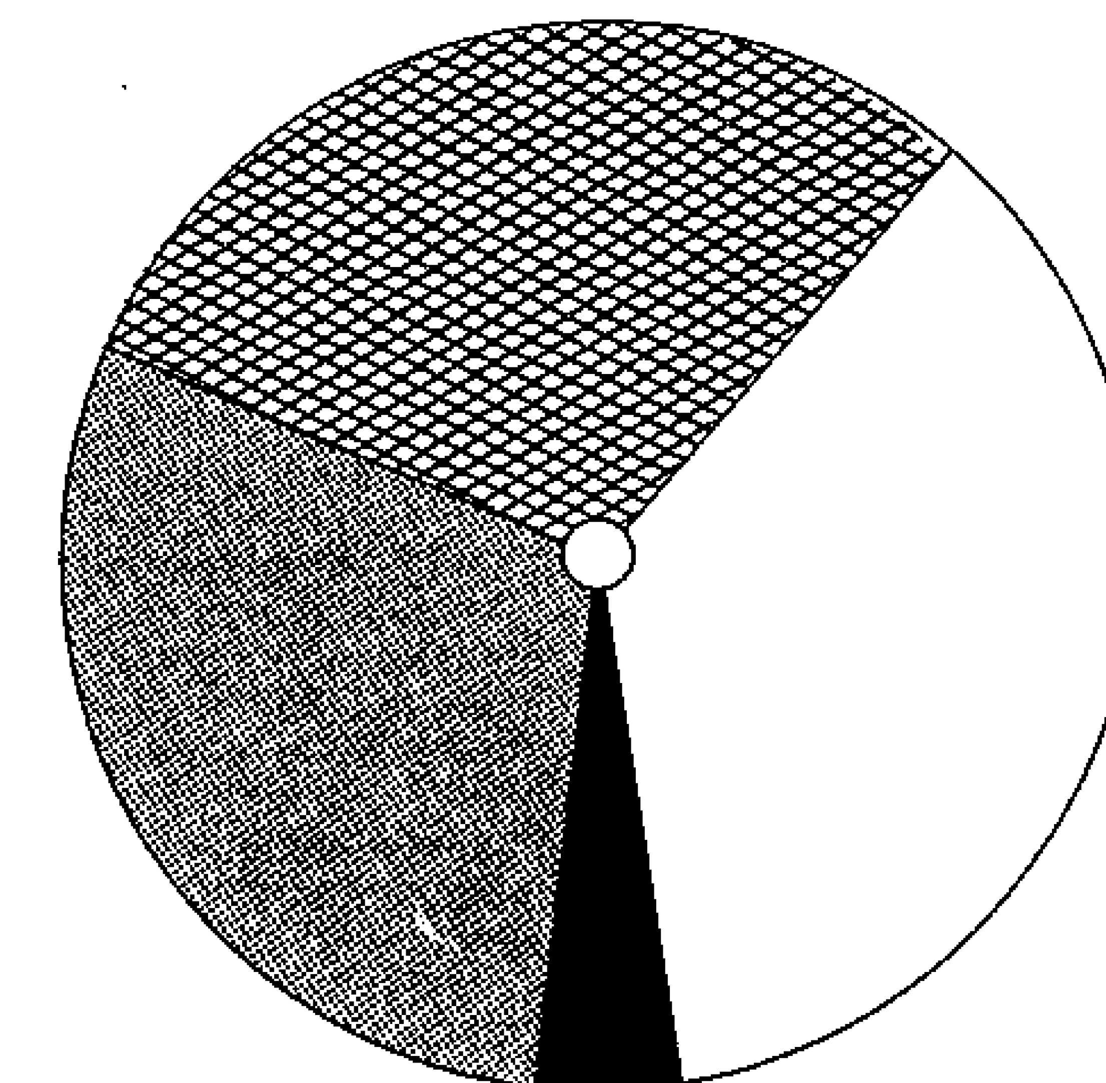
Changes of address	2,550
Changes of name	25
Additional qualifications	307
Removals (deaths)	53
(discipline)	4
(failure to notify address)	129
(non-resident overseas graduates)	105
(at own request)	46

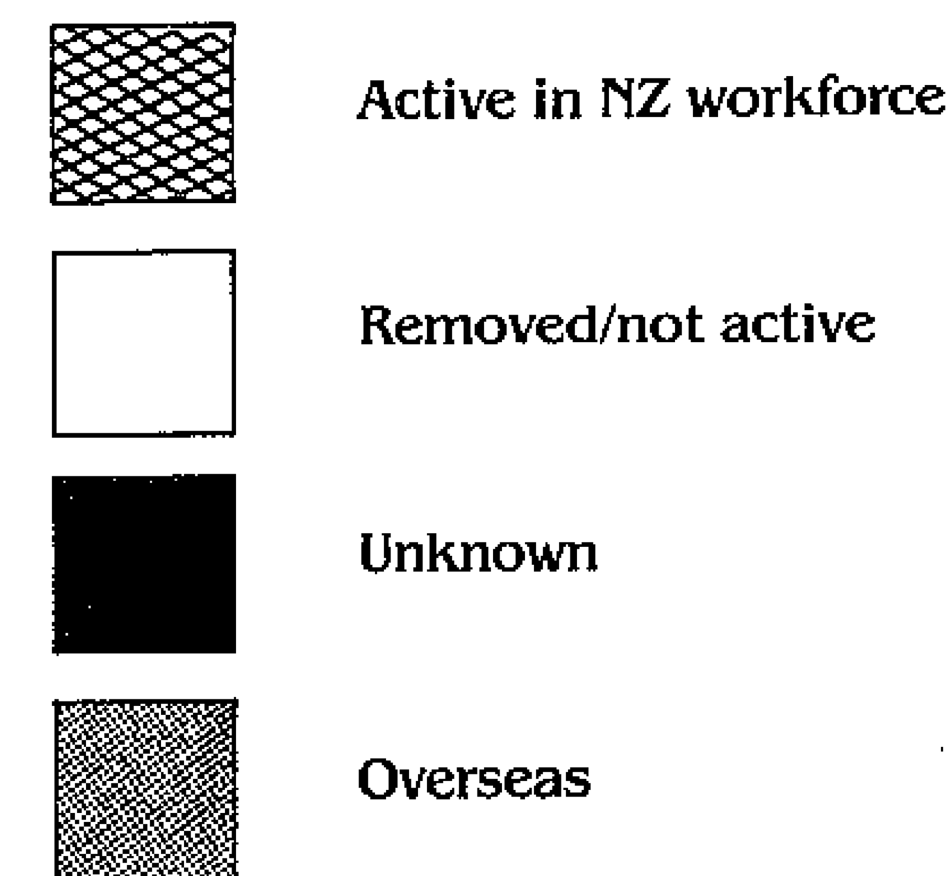
In addition, 94 further names were added to the Specialist Register and 376 to the Indicative Register of General Practitioners.

With so many area health boards hiring temporary and probationary registrants this area of secretariat activity (including the examination programme) is demanding in both volume and complexity. Elsewhere in this Annual Report are statistics relating to the programme of Registration Examinations which give rise also to thousands of enquiries. In the past year 79 new certificates and 252 extensions of temporary registration were issued. Although regular monitoring of temporary registrants with 6 monthly reporting has increased the workload in this sector considerably, it is a most important aspect of the Council's responsibility to the public of New Zealand. 31 new probationary certificates were also issued and these

Table 7. **OVERSEAS GRADUATES REGISTERING AS HOUSE OFFICERS 1980 – June 1990**

Current Workforce Status





doctors, many of whom are specialists, are also reported on at 6 monthly intervals in the usual 12 month period of supervised practice prior to eligiblity to apply for entry in the New Zealand Medical Register.

A revised "Registration Procedures" handbook is in preparation and should be distributed well before the

commencement of the new hospital employment year in late November. *Meanwhile I ask that those involved in recruitment seek early and accurate information on eligibility and certificate issue from the secretariat prior to the starting date for any prospective employee. As usual I remind all registered medical practitioners to keep their registered address up to date by notifying me of changes immediately they occur.* The consequences of not doing so can be removal and the costly nuisance of having to apply for restoration! Early requests for Certificates of Registration and/or Good Standing also save embarrassment – over 600 were issued last year – members of the medical profession are a mobile lot!

ACCESS TO SECRETARY

As Secretary I take primary responsibility for policy and planning, Council agendas (Medical and Dental), communications and public relations, Council support, matters concerning impaired doctors and discipline, staff training and other tasks properly pertaining to the role of Chief Executive. To enhance my time management, I have sought the cooperation of staff in referring to me only matters necessitating my direct involvement. Telephone enquiries in particular are therefore frequently directed to the relevant member of staff in the secretariat. I do not wish this to be seen as any kind of "closed door" policy – it is an essential management tool in a small and intensely demanding organisation. I am always available to discuss difficulties or clarify policy, but you may need to wait for me to call you back. Every effort is made to acknowledge and action correspondence without delay. Council is now meeting every month on either general or disciplinary business, sometimes for several days at a time, and it is simply not possible for me to accede to every request for an urgent or immediate response. I ask that you respect this situation which is likely to remain at least until new medical registration and discipline legislation is enacted.

It was a pleasure to host the annual meeting of the Australian Medical Council in June. The stimulation of sharing common problems with our transtasman counterparts enhances our own operation. It is also reassuring to find that the Medical Council of New Zealand is at the forefront of developments in pretty well every area of registration board activity. This does not mean that improvements are unnecessary but it does reflect well the skill, understanding and dedication of your Council and secretariat, with whom I am privileged to serve. My personal thanks is offered to them and all the people who support and join me as colleagues in this important professional activity. The ever developing exchange between the Council and the Colleges and Area Health Boards is greatly valued. The secretariat looks forward to the daunting work of 1990-91 with confidence. I will be particularly interested to work on issues relating to the assessment and measurement of competence.

G A Jones
SECRETARY

REPORT OF THE MEDICAL PRACTITIONERS DATA COMMITTEE

USE OF THE DATABASE

For a number of years doctors in New Zealand have completed a questionnaire at the time of application for the Annual Practising Certificate. This information is stored on the University of Otago computer and is held in complete security.

Under an arrangement with the Department of Health, who make a substantial contribution to the costs, workforce statistics are derived by the Council's statistician employed as a scientific officer at the University of Otago. These are used by the Department to prepare its publications on the medical workforce and its distribution. *This statistical information is supplied without any names of doctors.* From time to time the Department seeks different or additional information and this requires changes in the questionnaire which some find disturbing. The preamble to the questionnaire states that the information is supplied on a confidential basis although most would agree that the information is not of a particularly sensitive nature. Nevertheless, probably because of the assurance of confidentiality we have a very high rate of response and our statistics are the envy of other registration authorities.

Council has limited access to this database by requiring any researcher seeking to obtain information to supply details of the research protocol and the approval of the relevant ethical committee. Information which is included in the New Zealand Medical Register, which is a public (gazetted) document, is not treated as confidential.

Council is now concerned that better use of this valuable database might be made and would make the following suggestions.

Any research team which could make use of the data collected should feel free to place their proposal before the Chair of the Data Committee who will do anything possible to assist bona fide projects.

Council feels that lists of doctors giving their major professional field of activity (derived from the work classification list in the questionnaire) would be helpful to many organisations in continuing education. It would be a considerable economy to a college or postgraduate society offering a

Table 8 **NEW ZEALAND MEDICAL REGISTRATION INFORMATION**
as at 30 June 1990

Total practitioners on register	9,643
Total practitioners with practising certificates	6,806
Temporary registrants	165
New probationary registrants	31
Names removed from register (various reasons)	284
Practitioners deceased	53

specialised course to be able to send the promotional material to a selected group rather than having to mail as at present to all doctors. Council feels that this information may well become part of the published New Zealand Medical Register if proposals for vocationally oriented registration are implemented under the new Act. Doctors should be quite clearly assured that what is intended, with effect from 1 April 1991, is to make possible the provision of a list of doctors giving name, address and principal area of medical activity. No further expansion of this list is contemplated. Anyone who feels this might be an infringement of confidentiality will be invited to annotate the Annual Practising Certificate accordingly and this will be scrupulously honoured.

PUBLICATION OF STATISTICS

Figures in tables 8 and 9 show the general distribution of the Medical Workforce and in particular, the principal "active" practitioners.

The total active workforce continues to increase slowly and in 1989 reached a new high of 6,286 (and full time equivalents of 5,764), an increase of 730 over the last five years, and 112 since the previous year. The number and percentage of New Zealand medical graduates in the active workforce in 1989 has increased by 339 (8%) over the last five years. It is interesting to record that in 1989 New Zealand graduates constituted the following proportions of registered medical practitioners working in New Zealand. (The figures do not however take into account the increasing number of foreign medical graduates working on temporary and probationary registration, some of whom will at a future stage achieve full registration.)

70.5% of total active workforce
74% of house officers
80.5% of registrars
70.5% of general practitioners
68% of specialists

Comprehensive figures for both 1987 and 1988 were published by the Department of Health in June 1990. It is anticipated that the 1989 analyses will be published before the end of 1990. These publications on "New Zealand Medical Workforce Statistics" are available from the Workforce Development Section, Department of Health.

J D Hunter
CHAIR

NEW ZEALAND MEDICAL WORKFORCE 1989

Table 9

	1985		1986		1987		1988		1989	
	Total	N.Z. Graduates	Total	N.Z. Graduates	Total	N.Z. Graduates	Total	N.Z. Graduates	Total	N.Z. Graduates
Active	5556	4095	5747	4188	6095	4302	6174	4326	6286	4434
Full time Equivalents	5156.1	3834.3	5330.3	3913.5	5620.0	3986.5	5692.5	4000.0	5763.9	4070.4
House Officers	628	600	668	568	731	539	728	525	719	533
Registrars	718	592	746	630	780	626	771	620	765	616
Medical Officers Special Scale	150	75	149	67	167	74	180	87	176	95
General	2106	1473	2141	1512	2278	1601	2293	1608	2383	1681
Other Primary Medical Care	95	62	103	70	125	85	124	81	139	92
Specialists	1767	1248	1819	1272	1897	1306	1953	1338	1957	1326
Miscellaneous (non specialist)	92	45	121	69	117	71	125	67	147	93

REPORT OF THE SPECIALIST REGISTRATION SUB-COMMITTEE

Specialist registration continues unabated with 94 specialists being added to the Register in the 1989/90 year. Table 10 shows the numbers of new registrants by specialty and the current specialty totals. It should be noted that not all practising specialists have their names on the register since not all of those in practice before the register was started applied to join it.

Misunderstandings still occur about the registration system as it applies to overseas trained doctors. There are essentially two groups, those whose primary degree (listed in the Third Schedule to the Medical Practitioners Act)is automatically registrable in New Zealand and those whose primary degree is not. Both groups contain some doctors who have acquired overseas specialist qualifications, training and experience of such quality that it is recognised by the appropriate local referral body as conferring specialist status in New Zealand.

Doctors who intend to reside and practise in New Zealand and whose primary medical degree is automatically registrable are entitled to have their name registered on the New Zealand Medical Register ie they are entitled to full medical registration. If they are recognised as holding specialist status in New Zealand their names go on to the Register of Specialists as well. Immigration status is a separate matter dealt with by the Department of Immigration.

Doctors (whether they have specialist qualifications or not) whose primary degree is *not* automatically registrable have two forms of registration open to them. *Temporary* registration may be granted after completion of (or exemption from) NZREX Parts I and II and *probationary* registration may be granted upon completion of NZREX Parts III and IV *or* upon being declared specialist-eligible by the Medical Council after considering advice from its appropriate referral body.

Temporary registration is normally limited to a duration of two years. Exemption from NZREX Parts I and II may be granted to a candidate who has higher qualifications and experience gained in an English speaking environment but who is not declared specialist-eligible eg FRCS but without the Certificate of Higher Surgical Training.

Probationary registration requires satisfactory completion of a period of at least a year under supervision (which means in a post, and under named supervisors, specifically approved by the Council).

From the viewpoint of an overseas trained doctor wishing to practise in New Zealand in a specialty that goal may be achieved in one of two ways:

(a) by being declared specialist-eligible and then becoming fully registered by right or by completion of probationary registration, or

(b) through completing specialist training within New Zealand after gaining probationary or full registration.

The specialist-eligible category still draws criticism from a minority of colleges but is necessary not only for prospective employers who wish to know the status of prospective employees prior to paying to bring them out here, but also in terms of defining eligiblity for probationary registration for overseas trained doctors (see above). Problems have occurred because that assessment of specialist-eligible status by the referral body is inevitably a paper exercise which in one or two cases has proved inadequate when the candidate has actually been observed in practice in New Zealand.

An area which causes Council concern is a general failure of involvement of new migrants in local College activities and thus poor integration into the New Zealand medical scene. The specialist pool has increased by migration by 274 in the last five years. It must surely be to the ultimate advantage both of the public and the profession if *all* doctors are involved in their appropriate professional bodies with continuing emphasis on standards and CME. For those overseas trained doctors who possess well regarded specialist qualifications some local Colleges are prepared to offer a truncated form of examination which leads to College membership or fellowship, but others are quite strongly exclusive by placing high barriers to membership in the form of stringent prerequisites and extensive examinations or high cost. One referral body has declined to recognise fellows of its own College because they have been trained in Hong Kong, a situation which has led to some tension within that College!

For overseas trained specialists who have been granted specialist recognition in this country and who are permanent residents there would be considerable merit in the idea of the Colleges following the lead of the Royal Australasian College of Radiologists by establishing a truncated examination which would allow full entry into the College and possession of the Diploma of Fellowship. Such a test could also be taken by the Council as an indication of competence in the field which could provide a useful adjunct to the supervisors' reports on a probationary registrant.

Removal from the Register of Specialists

The only removals from this register this year have been at the request of the doctor or as part of the regular purging to remove names of overseas qualified doctors no longer resident in New Zealand from the general register; no names have been removed by the Council this year because of proven incompetence. However the question of maintenance of continuing competence continues to be the subject of vigorous debate. Such mechanisms as that of the RNZCOG, which issues time-limited fellowships subject to later renewal on the basis of demonstration of participation in CME, or the possibility that doctors whose competence has been seriously questioned may be required to be able to demonstrate their continuing competence in order to obtain renewal of the Annual Practising Certificate are being promoted as desirable.

G F Lamb
CONVENER

Table 10 NUMBERS ON SPECIALIST REGISTER at 30 June 1990

	1989	Added	1990
Anaesthetics	233	22	255
Community Medicine	135	4	139
Dermatology	37	5	42
Diagnostic Radiology	129	10	139
Gynaecology	1	–	1
Internal Medicine	400	9	409
Obstetrics	1	–	1
Obstetrics and Gynaecology	170	5	175
Ophthalmology	85	4	89
Orthopaedic Surgery	108	4	112
Otolaryngology	63	2	65
Paediatrics	126	6	132
Pathology	146	6	152
Psychiatry	207	4	211
Radiotherapy	23	3	26
Cardiothoracic Surgery	21	1	22
General Surgery	222	6	228
Neurosurgery	12	–	12
Paediatric Surgery	4	–	4
Plastic Surgery	25	1	26
Urology	30	2	32
Venereology	18	–	18
TOTAL	2,196	94	2,290*

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 1990 totals do not allow for removals of names through purging from the main register, which involved a total of 39 specialist registrations.

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

With the end of the period of grace for initial entry to the Indicative Register on 31 March 1990, the first quarter of this year has been marked by a flood of last minute applications for entry to the register.

This has entailed a heavy workload for Council staff and the referral body which scrutinizes the applications at the request of the council. There have been inevitable delays in processing some of the applications, especially when insufficient details of previous training for general practice, experience of general practice, and recent appointments in general practice were forwarded, necessitating further enquiries to be made.

All applications received by the Council before 1 April 1990 are being processed under the regulations pertaining to that period and every effort has been made to approve these applications for inclusion in the register at 30 June 1990. Of necessity, some with insufficient details on first application will be held over until the next publication of the register.

The current figures are:

Approved and entered on the register	1329
Currently processing	65
Declined on various grounds	55

The main grounds for approval being declined have been:

1. lack of evidence of training for general practice
2. insufficient experience in general practice
3. applications from doctors who are not at present in general practice
4. applications from doctors who are working overseas
5. a few applications from doctors who are not confining their practice as far as possible to general practice.

Doctors are reminded that from 1 April 1990 the requirement to be a fellow or member of an appropriate professional college became mandatory. The criteria for inclusion in the Indicative Register (as set down in the regulations to the Medical Practitioners Act) as they now are, are set out on the following page.

All correspondence concerning the register shouldbe directed to the

Secretary
Medical Council of New Zealand
PO Box 9249
Courtenay Place
WELLINGTON

and not to the Royal New Zealand College of General Practitioners.

The Sub-committee is grateful to the referral body and the Council staff who have completed the major part of the compilation of the register.

Although Council and the College hope that all those eligible for entry to this register will in fact apply, it is not mandatory under existing legislation to be on the Indicative Register in order to work in general practice and family medicine. Full registration is however normally mandatory for general practice and vocational training, through the Family Medicine Training Programme or the College Membership examinations and assessment, is strongly encouraged.

M M Herbert
CONVENER

"4. Qualification for registration – (1) A medical practitioner shall be entitled to have his or her name entered in the register if the Council is satisfied:

(a) That the practitioner holds a qualification specified in the second column of the Schedule to these regulations, and granted by a College specified in the first column of that Schedule in relation to that qualification; and
(a) That the practitioner has been qualified as a medical practitioner for not less than 5 years; and
(c) That the practitioner has had training and practical experience in general practice and family medicine for not less than 3 years; and
(a) That, so far as is practicable, the practitioner limits his or her practice to general practice and family medicine.

(2) Notwithstanding anything in subclause (1) of this regulation, if the Council sees fit in relation to any particular case, the name of a medical practitioner may be entered in the register if the Council is satisfied that he or she is recognised by his or her colleagues in the medical profession as having special experience in the discipline of general practice and family medicine.

The schedule referred to above is as follows:

Schedule – Qualifications Reg 4(1)(a)

Body	Qualification	
Royal New Zealand College of General Paractitioners	(a) Fellowship (b) Membership	
Royal Australian College of General Practitioners	Fellowship	Where the prescribed course of training and criteria for fellowship or membership is considered by the Council to be at least equivalent to that required for membership of the Royal NZ College of General Practitioners"
Royal College of General Practitioners of the United Kingdom	(a) Fellowship (b) Membership	
Any other College or body of General Practitioners	(a) Fellowship (b) Membership	

REPORT OF THE COMMUNICATIONS COMMITTEE

During the 1989-90 year a small Council Working Party was asked to draw up terms of reference for a Communications Committee. The aim of the Committee's work was primarily to improve the Council's communications in all aspects of its work. This applied particularly to external communications such as those with the public, registered medical practitioners, special societies and professional groups, employers and government agencies. It further included internally directed communications between Council members involved in committees, with legal assessors, and with the secretariat.

Additional objectives addressed the need to design methods of evaluating the outcome of any changes made and of monitoring the effectiveness of communication. Identifying resources and training facilities to assist in all the above, including the role public relations professionals might play, is another function of the Committee.

In June 1989, Council appointed the Committee convened by Dr Treadwell and comprising the Council Chair, Secretary and layperson.

The Committee has met on three occasions during this year. One of the early proposals was to instigate a regular bulletin to be sent to the profession in which matters of recent concern can be succinctly explained. It is hoped such a bulletin will come out three or four times a year, commencing late 1990. Press statements have been edited where necessary and advice from media consultants is being sought as required on a trial basis.

In this time of increased public scrutiny, it was felt important that key Council members receive media awareness training. We have initiated such training and this will continue during 1990/91. Initial feedback suggests this will prove helpful.

This has been a year in which the Communications Committee has been establishing itself. It now seems healthy and looks forward to the oncoming year with confidence.

J A Treadwell
CONVENER

REPORT OF THE FINANCE AND MANAGEMENT COMMITTEE

This report covers the period from 1 July 1989 to 30 June 1990 although the financial statements included with it cover the period from 1 April 1989 to 31 March 1990.

1. GENERAL COUNCIL OPERATION

Council and Committee activities including registration and all activities of the Medical Education Committee are paid for from the Annual Practising Certificate fee and from fees paid by registrants. These fees are adjusted annually in line with movements in CPI and anticipated workload. It will be seen that a net surplus resulted for the year ended 31 March 1990 amounting to slightly more than 10% of gross revenue. The issue of taxation status remains uncertain at the time of writing and much of the surplus may be needed to pay income tax if Council remains tax liable. If the tax situation is resolved and Council does not have to pay tax it is proposed that part of the surplus be set aside for developments in the education field. Two proposals, one for the payment of intern supervisors for functions carried out on behalf of Council, the other concerning follow up of the accreditation process at the Medical Schools, and special education projects such as the current initiatives on aberrant prescribing will require funding. Reserves set aside now will assist in the planning and execution of these additional activities.

The examination programme for Overseas Trained Doctors is self-funding. A small surplus in the year under review has been placed in an Examination Development Fund. There will be costs involved in implementing a new database, continuing the review of examination material, and meeting the demand for better feedback for candidates and employers. Moves to establish a form of international liaison between authorities called upon to consider registering overseas trained doctors will be followed and may also call for some expenditure.

Reorganisation of the secretariat has resulted in some recruitment expenditure not likely to be recurrent. A substantial payment of fringe benefit tax was incurred as part of the severance payments for the previous Assistant Secretary.

The triennial rent review has produced a noticeable increase in the provision for this item.

Council and committee expenses have remained within budget. The work of the Council has been progressively channelled into committee structures and the accounts show these activities as separate items. Honoraria paid to the Chair of Council and Convener of the Preliminary Proceedings Committee have been reviewed. It is Council's view that any member of Council elected to either of these onerous posts should be adequately compensated for the demands on the person and on their practice which are very considerable and would almost preclude anyone in solo practice from doing the job. This should not be so and the best person for the task should be able to accept the challenge without financial hardship.

2. DISCIPLINE FUND

Discipline produces a significant portion of the work of Council and complaints about the disciplinary levy much mail. Perusal of the accounts will show that recovery of costs is a comparatively small item despite the disciplinary tribunals' careful attention to the imposition and collection of costs as appropriate to the findings. The year under review began with a deficit of $273,408. This has been reduced to $64,566 but the account still remains in deficit. In the light of a further increase in workload a significant increase in disciplinary levy in the current year was inevitable. When the New Zealand

Medical Association decided to halve their contribution to the administration of discipline this required a further increase in levy. It should be noted that as a matter of policy no call has been made on Government for a direct contribution and as a result no funds are specifically budgeted from that source. The budget for the year ending March 1990 was drawn up in the hope that the deficit in the account might be removed completely. As it has turned out a modest deficit is carried over into the current year. The disciplinary levy for the year ending March 1991 was based on budget expectations that there would be no carry over at the beginning of the year and that the NZMA contribution would continue at the present level. Neither of these expectations has been fulfilled.

There is an increasing trend to prolonged defended hearings. Protracted hearings set down for the next few months will very likely absorb all the available funds. The costs of defending a doctor before a disciplinary hearing are met by his or her indemnity organisation funded by the premiums of its members. The costs associated with the investigations of the Preliminary Proceedings Committee, prosecution of the case before the tribunal and the sitting costs of the tribunals themselves are met from the Disciplinary Reserve Account. Where a doctor is found guilty an order for costs will be made but such orders are seldom more than 60% of costs incurred. Any higher order is regarded as a deterrent to the proper conduct of a defence. The indemnity organisation does not meet any fine imposed but may decide to meet the order for costs. The very substantial amounts involved are therefore funded by the profession in two ways, by their indemnity insurance premium and the disciplinary levy.

The principle followed by the Medical Council has always been that discipline within the medical profession should be funded by the profession. The Medical Association moves are based on their view that *all* doctors should contribute equally and the members of the Association should not carry a double charge. The emphasis therefore is on the whole profession carrying the cost and only those who are fully retired (and not holding a practising certificate) should escape their share of this burden.

I urge you to study the Financial Statements, the Notes to the Accounts, and the accompanying illustrations carefully, as it is apparent from a number of complaints received that misunderstandings still exist, despite the publication of this information every year in this report.

W S Alexander
CHAIR

AUDITOR'S REPORT

Miller, Dean & Partners

CHARTERED ACCOUNTANTS
WELLINGTON AND CARTERTON

AUDITORS' REPORT TO THE 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 and have obtained all the information and explanations that we have required. In our opinion proper accounting records have been kept by the Council so far as appears from our examination of those records.

As stated in note 11 to the Financial Accounts the Council's tax status is still to be resolved and no provision has been made for any possible tax liability.

Subject to the above, in our opinion and according to the information and explanation given to us and 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 1990 and the results of its activities for the year ended on that date.

Miller Dean & Partners
Chartered Accountants

WELLINGTON
21 August 1990

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 changes in accounting policies from those adopted in the previous year, except that a Statement of Cash Flows is now included in the Annual Accounts in line with standard accounting practice.

3. DEBTORS

The debtors figure includes $21,257 outstanding on a competence assessment, $77,241 outstanding refund of GST. Payments in advance of $6,694 relate to rent and insurance.

4. PRIOR YEAR ADJUSTMENT

The sum of $12,215 relates to arrears of rent for the year ended 31 March 1989 not paid until the current year, pending resolution of the rent review.

5. INVESTMENTS

(a) General Fund	1990	1989
BNZ Finance Call Account	–	29,887
National Bank Call Account	171,971	–
Equiticorp Finance Limited (In Statutory Management)	55,000	100,000
ANZ Call Account	90,576	–
	$317,547	$129,887

With respect to the investment in Equiticorp Finance Limited First Ranking Debenture Stock, $35,000 has been received in the year ended 31 March 1990 ($20,000 at 20 cents in the dollar and $15,000 at 15 cents in the dollar) and a further $6,000 (at 6 cents in the dollar) has been received in June 1990. In view of correspondence from the statutory manager it is now anticipated that accrued interest ($2,286.03) will not be paid out and not more than 90% of the original capital will be realised. $10,000 of the original investment has therefore been written off.

6. FIXED ASSETS

	Cost 31/3/90	Book Value 1/4/89	Depreciation For Year	Book Value 31/3/90	Accumulated Depreciation to 31/3/90
Air Conditioning	35,904	28,262	3,590	27,326	8,578
Computer	93,240	59,956	18,104	47,290	45,950
Furniture and Fittings	93,516	69,985	9,352	63,968	29,548
Office Alterations	157,364	101,802	15,736	98,002	59,362
Office Equipment	30,264	9,857	3,252	8,559	21,705
	$410,288	$269,862	$50,034	$245,145	$165,143

7. REGISTRATION EXAMINATIONS

NZREX has replaced PRENZ from 1 January 1990. The same policy is in place, namely that the examinations be self-funding, including Board of Examiners meeting fees and expenses. For the year commencing 1 April 1990 a separate bank account has been established. The following is a brief summary of fees and expenses in the year ended 31 March 1990. The surplus has been transferred to the Examination Development Fund which will be used to finance administrative and academic reviews and developments with respect to the examination of overseas trained doctors seeking registration in New Zealand.

PRENZ Examination Fees Received		37,428
PRENZ Examination Expenses (excluding Council Administration)	32,123	
NZREX Examination Fees Received		94,741
NZREX Examination Expenses (excluding Council Administration)	85,004	
PRENZ/NZREX Board of Examiners Fees and Expenses	4,110	
		10,932

8. EDUCATION FUND

To finance special education projects and continuing reviews of the education of medical undergraduates in New Zealand, a separate fund has been established with an initial transfer of $50,000 in the year ended 31 March 1990. Regular transfers will be made in subsequent years and details of revenue and expenditure provided in future annual accounts.

9. DISCIPLINE

(a) An Interim Disciplinary Secretariat was established on 1 April 1989. Direct payment (rather than reimbursement) of MPDC sitting fees, committee and staff travel, accommodation expenses and legal costs have been made (totalling $279,343) from a separate account, Disciplinary Fund Cheque Account #2, and a contribution of $219,301 for the year ended 31 March 1990 has also been made from the Disciplinary Fund to staff salaries and administration expenses of the Secretariat.

(b) Recovery of disciplinary costs for all three levels of the disciplinary system now appear as a specified item in the accounts. Previously this figure related only to costs recovered by the Medical Council as the Medical Practitioners Disciplinary Committee expenses were shown nett of recovered costs.

10. COMMITTEE EXPENSES

To provide more detailed information to the profession, Committee fees and expenses are now itemised in the accounts of both the general fund and the disciplinary reserve. In previous years the comparative figures were included with Council expenses.

11. CONTINGENT LIABILITY – TAXATION

The Council's tax status is still unresolved and consultations continue. Current legislation before Parliament indicates however that Government is adopting a policy of exempting statutory registration boards from payment of income tax.

BALANCE SHEET

as at 31 March 1990

	1990	1989
CURRENT ASSETS		
Petty Cash	210	110
General Fund Cheque Account at ANZ Bank	2,152	22,820
Disciplinary Fund Cheque Account at BNZ	32,620	2,253
Disciplinary Fund Cheque Account #2 at BNZ (Note 9a)	2,864	–
Payments in Advance and Sundry Debtors (Note 3)	112,704	31,574
Interest Accrued	–	150
	$150,550	56,907
INVESTMENTS (Note 5)		
General Fund	317,547	129,887
FIXED ASSETS (Note 6)	245,145	269,863
TOTAL ASSETS	$713,242	$456,657
CURRENT LIABILITIES		
Sundry Creditors		
– General Fund	151,249	104,299
– Discipline Fund	166,850	262,807
– PRENZ/NZREX (Note 7)	–	4,098
Payments Received in Advance	71,917	39,437
TOTAL LIABILITIES	$390,016	410,641
CAPITAL ACCOUNT		
Accumulated Capital	326,860	319,424
Disciplinary Reserve – (Deficit)	(64,566)	(273,408)
Education Fund (Note 8)	50,000	–
Examination Development Fund (7)	10,932	–
	323,226	46,016
	$713,242	$456,657

The accompanying notes (pages 38, 39, 40) form part of these financial statements.

MEDICAL COUNCIL OF NEW ZEALAND

REVENUE STATEMENT

for year ended 31 March 1990

		1990	1989
FEES RECEIVED			
Annual Practising Certificate		625,304	436,050
Certificate of Good Standing		11,407	10,449
Medical Registration Certificate		3,272	3,523
Change of Name		476	432
Registration Fees – including conditional temporary, probationary and restoration		134,080	128,642
Specialist Registration Fee and General Practice Registration Fee		21,650	16,674
INCOME FROM FEES		$796,189	$595,770
OTHER INCOME			
Administration Fee – Dental Council		21,500	15,000
Interest Received		49,151	42,545
Sales of Medical Registers		16,645	16,108
Sale of register information to Department of Health		–	9,000
Sundry Income		467	–
INCOME FROM OTHER SOURCES		87,763	82,653
REGISTRATION EXAMINATION FEE (Note 7)		10,932	13,990
TOTAL INCOME FOR YEAR		894,884	692,413
Less Expenses as per Schedule		804,300	739,352
NET SURPLUS (DEFICIT) FOR YEAR ENDED 31/3/90		90,584	(46,939)
Accumulated Capital Brought Forward	319,423		
Less Prior Year Adjustment (Note 4)	12,215	307,208	
		397,792	319,424
Less Transfers to:			
– Education Fund (Note 8)		50,000	
– Examination Development Fund (Note 7)		10,932	
– Investment written off (Note 5)		10,000	
ACCUMULATED CAPITAL CARRIED FORWARD		$326,860	$319,424

The accompanying notes (pages 38, 39, 40) form part of these financial statements.

MEDICAL COUNCIL OF NEW ZEALAND

SCHEDULE OF EXPENSES

for year ended 31 March 1990

	1990	1989
ADMINISTRATION AND OPERATING EXPENSES		
Acc Levy	4,174	4,650
Audit and Accountancy Fee	6,000	4,940
Agents Registration Fees	4,730	2,630
Computer Consultancy	3,430	–
Cleaning	2,863	2,574
Courier	3,339	2,444
Depreciation	50,034	46,292
Electricity	5,121	4,717
Fringe Benefit Tax	15,765	3,379
General Expenses	3,811	4,096
Legal Expenses	1,200	2,411
Micro Film Files	488	1,108
Medical Workforce and Associated Expenses (Net after Government Contribution)	13,516	14,746
Overseas Travel – Secretary	1,977	2,088
Photocopying Expenses	7,062	6,783
Postage	20,366	20,926
Printing and Stationery	60,407	56,048
Rent and Insurance	63,540	27,350
Repairs and Maintenance	4,238	3,055
Salaries	277,757	245,840
Superannuation and Health Insurance	19,087	13,242
Staff Recruiting – Advertising and Placement	19,979	289
Telephone and Tolls	7,555	12,056
TOTAL ADMINISTRATION & OPERATING EXPENSES	596,439	481,664
COUNCIL AND COMMITTEE EXPENSES (Note 10)		
Council Expenses		
– Chairman's Overseas Travel	2,278	2,627
– Chairman's Honoraria	55,000	4,813
– Fees and Expenses	92,218	85,638
Registration Committee Fees and Expenses	3,054	–
Communications Committee Fees and Expenses	1,585	–
Data Committee Fees and Expenses	1,460	–
Finance & Management Committee Fees and Expenses	3,500	–
Informed Consent Working Party Fees and Expenses	3,463	–
Competence Enquiry	–	5,457
Medical Education Committee		
– Fees and Expenses	23,252	18,847
– Hospital Visits	15,348	11,898
Intern Supervisors Meeting Fees and Expenses	6,703	10,351
TOTAL COUNCIL AND COMMITTEE EXPENSES	207,861	139,631
REVIEW COMMITTEE ON EDUCATION OF MEDICAL UNDERGRADUATES IN NEW ZEALAND (Note 8)	–	118,057
TOTAL EXPENDITURE	$804,300	$739,352

The accompanying notes (pages 38, 39, 40) form part of these financial statements.

REVENUE STATEMENT FOR DISCIPLINARY RESERVE ACCOUNT

for year ended 31 March 1990

	1990	1989
REVENUE		
Levies Received	1,103,647	447,197
Interest Received	51,209	20,463
Recovery of Disciplinary Costs (Note 9b)	191,409	57,822
Sundry Income	14	–
TOTAL REVENUE	1,346,279	525,482
ADMINISTRATION AND OPERATING EXPENSES		
ACC Levies	1,391	1,214
Accounting and Audit Fees	2,000	1,860
Competence Inquiries	20,768	5,457
Doctors Health Advisory Service	27,495	18,137
Expert Witnesses and Medical Assessments	13,945	622
General Administration Expenses	1,815	3,417
High Court Appeal	15,335	28,009
Legal Expenses (Medical Council and Preliminary Proceedings Committee)	390,014	195,450
Medical Practitioners Disciplinary Committee (Note 9a)	498,644	270,738
Stenographers Fees and Expenses	9,381	4,085
Telephone and Tolls	7,061	7,302
TOTAL ADMINISTRATION AND OPERATING EXPENSES	987,849	536,331
COUNCIL AND COMMITTEE EXPENSES		
Council Expenses (Discipline)		
– Fees and Honorarium	65,422	36,638
– Expenses	30,295	25,820
Council Expenses (Health)		
– Fees and Expenses	8,816	5,818
Preliminary Proceedings Committee (excluding legal member)		
– Fees and Honoraria	36,859	20,024
– Travelling, Accommodation and Secretarial Expenses	8,196	10,064
TOTAL COUNCIL AND COMMITTEE EXPENSES	149,588	98,364
TOTAL EXPENSES	1,137,437	634,695
Net Surplus (Deficit) for Year Ended 31/3/90	208,842	(109,213)
Disciplinary Reserve Balance Brought Forward – (Deficit)	(273,408)	(164,195)
TOTAL DISCIPLINARY RESERVE – DEFICIT	$(64,566)	$(273,408)

The accompanying notes (pages 38, 39, 40) form part of these financial statements.

STATEMENT OF CASH FLOW

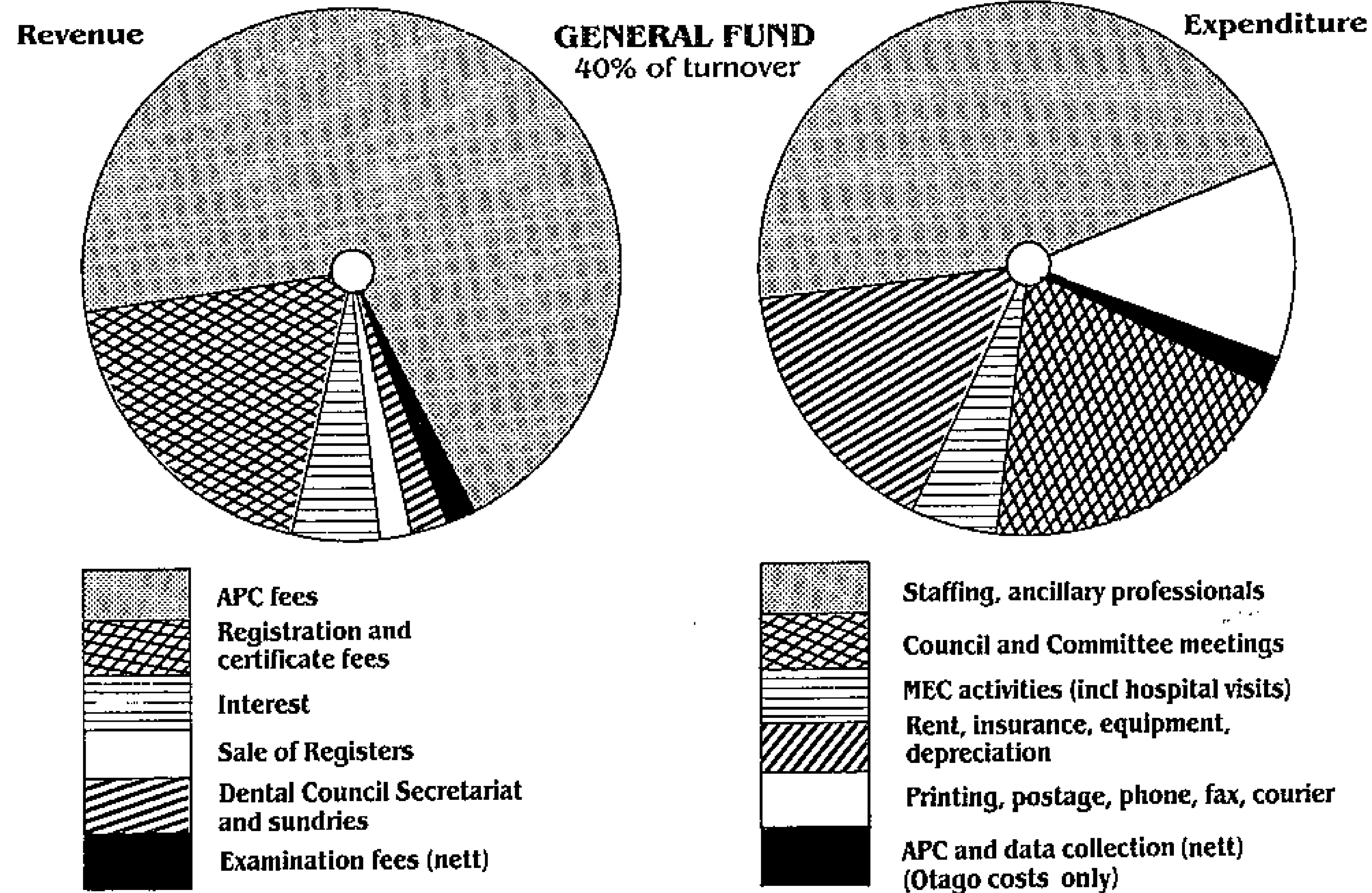
for year ended 31 March 1990

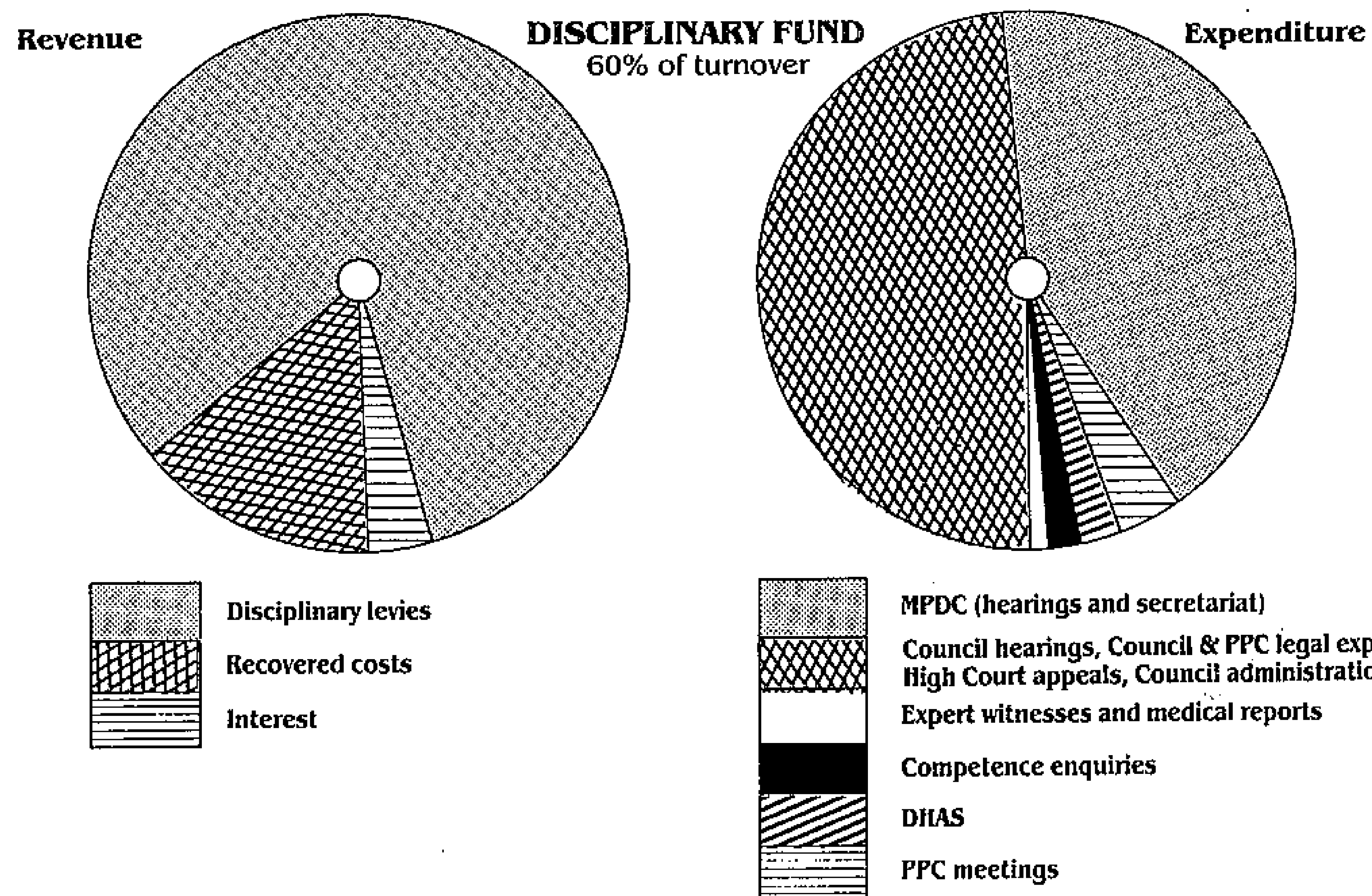
Cash flow from statutory functions		
Cash was provided from		
Receipts pertaining to statutory functions and Administration fee from Dental Council	2,466,135	
Cash was also distributed to		
Payment for Council fees and disbursements and secretarial expenses	(2,325,482)	
Net cash flow from statutory functions		140,653
Cash flow from investing activities		
Cash was provided from		
Interest received	100,510	
Cash was applied to		
Purchase of assets	(30,840)	
Short term investments	(197,660)	
	(228,500)	
Net cash used in investing activities		(127,990)
Net increase in cash held		12,663
Opening cash brought forward		25,183
Ending cash carried forward		$37,846

The accompanying notes (pages 38, 39, 40) form part of these financial statements.

DISTRIBUTION OF COUNCIL REVENUE AND EXPENDITURE

for year ended 31 March 1990





These graphics are to be read in conjunction with the detailed Financial Reports on pages 39 to 45.

FEES

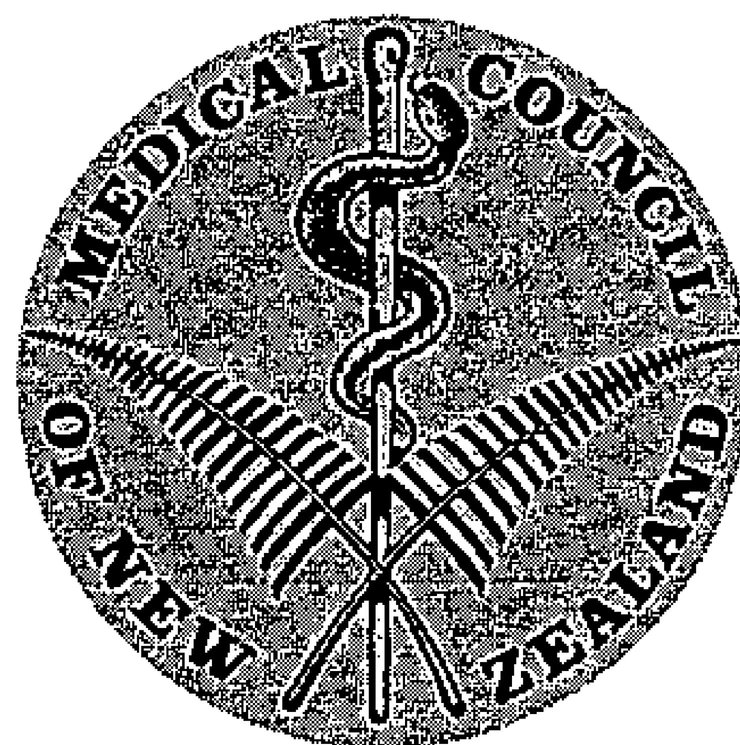
TO BE PAID ON APPLICATION FOR MEDICAL COUNCIL SERVICES DURING COUNCIL FINANCIAL YEAR 1 APRIL 1990 TO 31 MARCH 1991

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

		Fee	GST from 1/4/90	Total to Pay from 1/4/90
REGISTRATION: (Conditional or Full)				
On deposit of evidence of qualifications		170.00	21.33	192.00
For provisional certificate		26.67	3.33	30.00
For annual practising certificate		92.00	11.50	103.50
For disciplinary levy	(1)	263.56	32.94	296.50
	(2)	112.45	14.05	126.50
Total fees on registration	(1)	552.90	69.10	622.00
	(2)	401.79	50.21	452.00
OTHER:				
For certificate of temporary registration		276.00	34.50	310.50
For eligibility for probationary registration		95.1i	11.89	107.00
For certificate of probationary registration		95.11	11.89	107.00
For *full registration (from probationary, including practising certificate)		435.56	54.44	490.00
For annual practising certificate including disciplinary levy		355.56	44.44	400.00
For *restoration of name to Register after removal therefrom (including provisional certificate)		512.90	64.10	577.00
For initial entry on Specialist Register		60.00	7.50	67.50
For entry on Specialist Register in a second or further specialty		10.00	1.25	11.25
For initial entry on Indicative Register of General Practitioners		60.00	7.50	67.50
For change of name or other entry in Register, excluding change of address or entry of additional qualifications (free)		26.67	3.33	30.00
For Certificate of Good Standing		26.67	3.33	30.00
For Certificate of Registration (or other document in connection with applications to register in another country)		26.67	3.33	30.00
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

(1) Fee for persons registering for the first time between 1/04/90 and 30/10/90
(2) Fee for persons registering for the first time between 1/11/90 and 31/03/91


MEDICAL COUNCIL
OF NEW ZEALAND

THE MEDICAL COUNCIL OF NEW ZEALAND

JUNE, 1990

A STATEMENT FOR THE MEDICAL PROFESSION ON INFORMATION AND CONSENT

PREAMBLE

In late 1988, in the wake of the widespread debate and the variety of initiatives which followed the publication of the Cartwright report, the Medical Council established a small working party to prepare the basis for a statement and to offer some guidelines on information and consent. This Committee was made up of the lay person on the Medical Council Patricia Judd, the Senior Lecturer in Medical Ethics at the University of Otago, Grant Gillett and a former Deputy Chairperson of the Medical Council, David Cole. A report was prepared by Mrs Judd and Dr Cole after discussions with Dr Gillett and this report was received by Council in June 1990.

The Medical Council resolved to publish the Statement as set out over. In the course of researching the subject of Informed Consent, the Working Party of the Medical Council of New Zealand became aware of the dichotomy which lay, legal and medical groups all around the world, are attempting to reconcile. There is a need for a system which can accommodate both the patient's rights of self-determination and information, and also the practitioner's requirement for varying degrees of professional discretion in individual cases. Along with the procedures established to meet this need Council recommends ongoing community and professional dialogue to deal with technological and procedural changes as they occur in the future.

Copies of this statement and the full working party report may be obtained from the Secretary of Council
P O Box 9249
(73 Courtenay Place)
WELLINGTON
Ph: 04-847-635, Fax: 04-858-902
at a cost of $10 including postage and GST.
Alternatively, institutions are welcome to photocopy this pamphlet containing the Council Statement.

A STATEMENT FOR THE MEDICAL PROFESSION ON INFORMATION AND CONSENT

The Medical Council of New Zealand takes the view that (except in an emergency or a related circumstance) the proper sharing of information, and the offering of suitable advice to patients, is a mandatory prerequisite to any medical procedure instituted by a medical practitioner. This applies whether the procedure is a diagnostic one, a medical or pharmacological regimen, an anaesthetic, or any surgical, obstetric, or operative procedure.

There is a special responsibility when there is an element of investigative research or trial of treatment in the contemplated management. Within the health professions there is an ethical duty to share knowledge and to teach and learn throughout a practitioner's career. Nevertheless, when educational activities involve particular patients, it is a further and vital duty that the patients understand and approve their participation.

The Council affirms that trust is a vital element in the doctor-patient relationship. This trust is more easily achieved if the patients are treated sympathetically and particularly if they are fully aware of their right to confidentiality and their right to full information about their current medical condition (and their health in general) and about the risks and benefits of possible treatment. Information must be conveyed to the patient in such detail and in such a manner, using appropriate language, as to ensure that an informed decision can be made by that particular patient. The necessary standard for this requirement (that is the extent, specificity and mode of offering the information) should be that which would reflect the existing knowledge of the actual patient and the practitioner. More generally, it should also reflect what a prudent patient in similar circumstances might expect.

The prevailing attitude of both the health professions and those who represent health consumers should also, but to a lesser extent, be taken into account. The particular patient's autonomy is the over riding consideration but other issues may justifiably modify the doctor's approach to providing information. For example, the patient may decline to discuss detail or desire a limit to the extent of the information. When further information is sought it must be provided. Throughout patient management, there are certain items of information which should always be considered by the doctor.

(a) The nature, status and purpose of the procedure, including its expected benefits, and an indication as to whether it is orthodox, unorthodox or experimental.

(b) The likelihood of the available doctors achieving the specific outcome that the patient seeks.

(c) The appropriate and relevant management options or alternatives with their possible effects and outcomes.

(d) The associated physical, emotional, mental, social and sexual outcomes that may accompany the proposed management.

(e) Significant known risks, including general risks associated with procedures such as anaesthesia, the degree of risk and the likelihood of it occurring for that particular patient.

(f) Any likely or common side effects, particularly in drug therapy.

(g) The consequences of not accepting the proposed treatment.

(h) The name and status of the person who will carry out the management and of others, from time to time, who may continue the management.

The Medical Council affirms that if it can be shown that a doctor has failed to provide adequate information and thereby has failed to ensure that the patient comprehends, so far as is possible, the factors required to make decisions about medical procedures, such failure could be considered as medical

misconduct and could be the subject of disciplinary proceedings.

In judging whether the medical practitioner has fallen short of acceptable practice in these matters, disciplinary authorities should have recourse to guidelines that are published from time to time by such bodies as the Medical Council, the Area Health Boards (and their Ethics Committees), the Health Research Council, the Colleges and the New Zealand Medical Association.

The Council does not believe that these guidelines should themselves be enacted in legislative form. However it supports the view that legislation should ensure that any definition of medical misconduct should include the inadequate transfer of information to a patient deciding on a medical procedure.

This statement has been endorsed by Professor P D G Skegg, Dean of Law at the University of Otago, a recognised expert in medico-legal matters. It offers an overview of the issue for the medical profession of New Zealand, but Council expects that details, especially on implementation, will be developed by various bodies, such as the Health Research Council, Area Health Boards and the Colleges. All practitioners are encouraged to retain this pamphlet for future reference and guidance.