MEDICAL COUNCIL
OF NEW ZEALAND

ANNUAL REPORT
1991

MEDICAL COUNCIL OF NEW ZEALAND

ANNUAL REPORT

FOR YEAR ENDED 30 JUNE 1991

MEMBERS OF THE MEDICAL COUNCIL

(At 30 June 1991)

	Appointed by Governor-General on recommendation of:
Dr R.H. Briant (Chair)	Royal Australasian College of Physicians
Dr W.S. Alexander (Deputy Chair)	Minister of Health
Dr J.M. Broadfoot (resigned 30 April 1991)	New Zealand Medical Association
Dr R.G. Gudex	Royal New Zealand College of Obstetricians and Gynaecologists
Dr M.M. Herbert	New Zealand Medical Association
Mrs P.C. Judd, JP	Minister of Health
Dr G.F. Lamb	Royal Australasian College of Surgeons
Dr C.H. Maclaurin	ex officio for Dean, School of Medicine, University of Auckland
Dr I.M. St George	Royal New Zealand College of General Practitioners
Professor R.D.H. Stewart	ex officio, Dean, Faculty of Medicine, University of Otago
Dr P.S. Talbot	ex officio for Director-General of Health
Dr J.A. Treadwell	Minister of Health

SECRETARIAT

(At 30 June 1991)

Secretary	Ms G.A. Jones, BA
Deputy Secretary	Mr S.M.D. Willcox, BA
Executive Officer	Ms F.A. Barber, BA
Council Offices	73 Courtenay Place, Wellington 1
Postal Address	PO Box 9249, Wellington
Telephone	(04) 384-7635
Fax	(04) 385-8902
Solicitors	Kensington Swan, P.O. Box 10-246, Wellington
Bankers	Bank of New Zealand Courtenay Place Branch, Wellington ANZ Banking Group (New Zealand) Limited, Courtenay Place Branch, Wellington
Auditors	Miller, Dean & Little, P.O. Box 11253, Wellington

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

MEDICAL EDUCATION COMMITTEE

(At 30 June 1991)

	Appointed by:
Professor R.D.H. Stewart (Chair)	ex officio, Dean, Faculty of Medicine, University of Otago
Dr M.I. Asher	Faculty of Medicine, University of Auckland
Professor A.B. Baker	Royal Australasian College of Surgeons
Dr P.M. Barham	Royal New Zealand College of General Practitioners
Associate Professor J.G. Buchanan	Royal Australasian College of Physicians
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 M.A. Lewis	Faculty of Medicine, University of Otago
Professor B.R. McAvoy	New Zealand Medical Association
Professor J.G. Mortimer	ex officio, Dean, Dunedin Division, Faculty of Medicine, University of Otago
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
Dr I. M. St George	Medical Council of New Zealand
Dr I.J. Simpson	Faculty of Medicine, University of Auckland
Dr A.D. Stewart	Royal New Zealand College of Obstetricians and Gynaecologists
Dr P.S. Talbot	Observer, Department of Health

COMMITTEES

(At 30 June 1991)

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

Preliminary Proceedings Committee
Dr G.F. Lamb (Convener)
Mr P.H. Cook (Legal Member)
Dr I.M. St George

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 R.D.H. Stewart (Chair)
Dr R.H. Briant
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 W.S. Alexander
Dr R.H. Briant
Dr M.M. Herbert
Mrs P.C. Judd
Dr J.A. Treadwell (Health Screener)

Registration Committee
Dr I.M. St George (Convener)
Dr W.S. Alexander
Dr M.M. Herbert
Dr C.H. Maclaurin

Specialist Registration Sub-Committee
Dr C.H. Maclaurin
Dr W.S. Alexander

Indicative Register of General Practitioners Sub-Committee
Dr M.M. Herbert

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

Board of Examiners
Dr R.H. Briant (Chair), Medical Council
Dr P.M. Barham, Medical Education Committee
Dr G.L. Glasgow, Examinations Director
Dr M.M. Herbert, Medical Council
Dr J. Kolbe, Nominee of University of Auckland
Professor T.V. O'Donnell, Nominee of University of Otago
Professor E. Pomare (for Professor J. Hutton), Nominee of University of Otago

REPORT FROM THE CHAIR

This report covers the activities of the Council for the year ending 30 June 1991. In August 1990 I was elected Chair of Council, replacing Dr Stewart Alexander who has held the position with distinction for seven years. Dr Alexander remains a Council member, and as Deputy Chair has presided over the majority of the disciplinary hearings. Dr Alexander has a wealth of experience on the Medical Council and in other medico-political activities, and a wide overview of the history and development of our systems. This provides us with an invaluable resource in the negotiation of the new Medical Practitioners Act.

There has been some progress on the Act, the review of which is a high priority for Council. The Bill to set up the office of Health Commissioner has been assessed and Council has made submissions to the Social Services Select Committee. The principle of a Health Commissioner to receive, process and usually mediate complaints involving all aspects of the health system, is welcomed by the Council. However, certain aspects of the Health Commissioner Bill are unsatisfactory and provide for a more adversarial system than we believe is appropriate. Experience in New South Wales, where there are established systems for independent investigation of complaints against doctors and other health workers, reveals that the majority of complaints (96 percent) do not go to any sort of hearing, but are sorted out by investigation, information and conciliation. We agree with the NZMA that the Health Commissioner Bill, and the Medical Practitioners Bill, should interface and provide the best possible system for the resolution of complaints and improvement in health service provision.

Liaison and interchange between the Council and other bodies has increased in the past year or two to everyone's advantage. We have met with Ministers, Area Health Board General Managers, members of Medical Colleges and Referral Bodies, and other groups and individuals. Dr Peter Talbot has been a most able Deputy for the Director General of Health on the Council, and has provided a close link with Health Department activities.

The Medical Council's year has been another busy one. The various committees of Council have worked diligently and all seem to have an increased workload. To cope with this most committees have met more frequently than before, some using telephone link-ups which have proved cost effective, particularly for the Registration Committee and the Board of Examiners of NZREX.

The Registration Committee, with Dr Ian St George in the Chair, has a continuous job of assessing the qualifications of doctors applying for registration in New Zealand. Its members work hard to provide the appropriate uniformity of decision-making and to convey decisions speedily.

The Registration Examination is supervised by the NZREX Board. We are indebted to Dr Gavin Glasgow who runs the examinations and to the examiners from the various centres; particularly the Aucklanders who provide the written examination question bank and the clinical examiners in Auckland and Wellington who have the arduous task of assessing clinical competence. The NZREX examination is evolving well and will undoubtedly have an important part to play in future.

The issue of overseas trained doctors remains critical, with increasing medical migration around the world. There is a move to improve the access of foreign trained specialists to New Zealand, and again we have to walk the tightrope between adequate access of the population to specialist medical services, and the quality of the practice that can be provided.

The Medical Education Committee and the Medical Practitioners Data Committee are now in the hands of Professor David Stewart, who took over as Dean of the Otago Faculty from Professor John Hunter at the beginning of 1991. The high quality input of Professor Hunter to the work of the Medical Council, and particularly the Medical Education Committee, over a number of years is acknowledged here. It was his energy that led the MEC and Council into appointing the Renwick Committee. This committee reviewed undergraduate medical education and defined precisely the education requirements for pre-registration House Surgeons. Another outcome of that initiative was the decision that the Medical Council should independently contract the services of the Intern Supervisors so that they have a direct responsibility to the Council for that aspect of their work.

The Health Committee of the Council with Dr Bob Gudex as Convener, and Dr Judith Treadwell as Health Screener, has been available for the swift assessment of doctors whose health is potentially impairing their practice. Those of us who sit on the Health Committee are aware of the personal tragedies that make up the Health Committee's clients. Most commonly, resort to alcohol or drugs to deal with the otherwise unbearable strains of life or work, leads to addiction and incapacity to practise. The Medical Council sees preventive action as more desirable than the restrictive action that we eventually have to invoke, and urges all doctors to provide medical students and young colleagues with examples of a healthy lifestyle and stress management.

The disciplinary function of the Council continues as its most high profile activity. There is a fundamental conflict between the requirements of Council to deal with the small number of doctors whose practice or behaviour appears to fall below appropriate standards, and at the same time work to encourage the maintenance of standards overall. A separation of the Council from a Disciplinary Tribunal would allow both the necessary degree of independence required by the public, and the time for Council members to address these other issues.

The Preliminary Proceedings Committee (PPC) investigates all complaints and that continues to be a major task. Dr Geoffrey Lamb is Convenor of that committee and carries out the job with diplomacy and attention to detail that is his hallmark. He was ably assisted by Dr John Broadfoot until the end of April 1991 when, to our regret, Dr Broadfoot resigned from the Medical Council because of the unreasonable interference in his work by Council duties. Dr Ian St George is an able replacement, and continues to provide the PPC with general practitioner-specialist balance. Mr Philip Cook, Barrister, remains the PPC's legal member, bringing both experience and particular skill to the committee.

Members of the PPC are disqualified from Tribunal Hearings because of their prior knowledge of the case. As a previous Convener of the PPC I have been unable to participate in hearings until now, and Dr Alexander has chaired them in my stead.

A number of hearings and appeals took place during the year, but two in particular should be mentioned. The charges against Professor Bonham were heard in a two week period in October 1990, those charges against Professor Green having been stayed on the grounds of his ill health. Later, a hearing of charges concerning prescribing anomalies stretched to four

weeks. These hearings are very hard on the defendants and on Medical Council members. Time away from their practices is difficult to compensate.

This last issue is of continuing concern to those of us on the Council who believe that practising doctors must make up the board that regulates the profession, but recognise that the demands of that board interfere substantially with every day work.

In all its disciplinary deliberations the Medical Council is advised on legal process by legal assessors. This year the work has been done predominantly by Miss Kristy McDonald and Sir Duncan McMullin. Their advice has always been well considered and we are grateful for their input.

Arising from the many complaints of misprescribing that were sent to the PPC in 1989 and 1990, the Council set up a Working Party to look at the complex issues relating to the misuse of addictive prescription drugs. Under the excellent organisational hand of Dr Campbell Maclaurin the Working Party established a series of consultative meetings throughout the country, where those with an involvement or interest in substance abuse contributed their knowledge and understanding. The reports from the consultative meetings were brought together and a national meeting was held under the aegis of the Glaxo Foundation for Medical Education in Palmerston North. Council acknowledges the assistance of the Foundation and Mrs Beverley Gill. The result is a report which itself was widely scrutinised while in draft form, and substantially modified by this input. That report has been published and distributed to all New Zealand doctors, and to all other professions who have prescribing or dispensing responsibility, namely midwives, dentists, veterinarians and pharmacists. Medical, dental, nursing and law students have access to the report, and all Area Health Boards' Substance Abuse Units and Community Agencies have received it. The Associate Minister of Health, Hon Maurice Williamson, has

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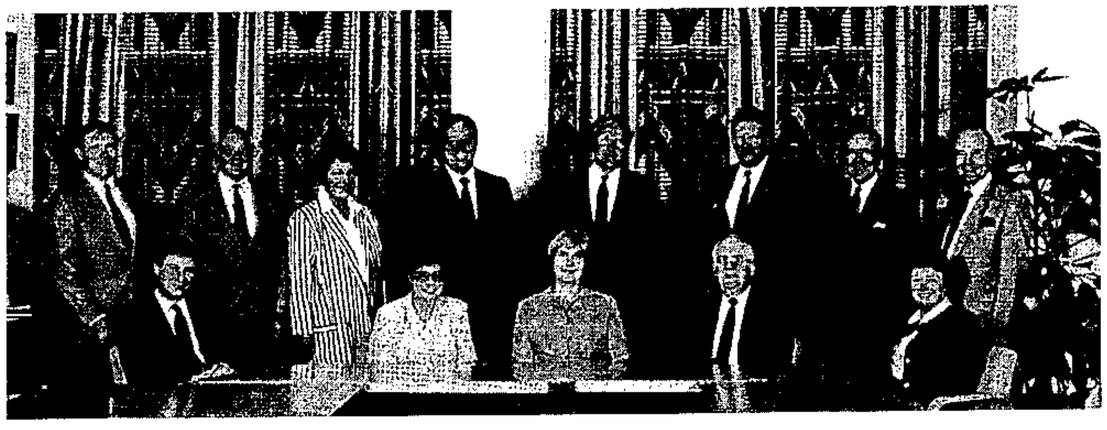


From left to right: Professor R. D. H. Stewart, Dr M. M. Herbert, Dr J. A. Treadwell, Dr J. M. Broadfoot, Dr R. G. Gudex, Dr P. S. Talbot Dr C. H. Maclaurin, Dr G. F. Lamb. *(seated)* Dr I. M. St George, Ms G. A. Jones (Secretary), Dr R. H. Briant (Chair), Dr W. S. Alexander (Deputy Chair), Mrs P. C.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

supported the principles and suggested strategies in the report, and the Health Department, and many other groups, are working on the best ways to implement these recommendations.

An innovation for the Council during 1991 has been 'MCNewZ', a brief newsletter to update the profession on the various responsibilities of a registered practitioner. It has long been a criticism of Council that it is remote and disconnected from the every day action of the profession it registers. Communication with a large and widely dispersed body of people is always fraught and difficult. We hope that this small contribution towards exchange of information will play its part in all of our lives. We have been gratified by the positive response.

Medicine in New Zealand is undergoing profound changes; changes wrought by financial necessity, political philosophy and greater freedom to advertise services. The profession itself is in the centre of this change, whether willingly or unwillingly. I see that the Medical Council's role is to assist in the evolution of change, making sure that what is imposed on the profession from the outside is consistent with the high standards of practice that are the norm for this country. One of the greatest concerns expressed by colleagues is the question of providing appropriate standards of care within the resource restraints of the public system. It is a matter of great distress to all doctors to have to be at the forefront of rationing, and to have to explain to patients that the optimal therapy is not available and only a second best can be offered.

My final action for the year has been to attend (with the Secretary), the annual meeting of the Australian Medical Council (AMC), in Hobart. For some years now the AMC has invited the Chair and Secretary of the New Zealand Medical Council to its annual meetings, and this has improved liaison between our two countries. The AMC is an organisation of Australian Medical Boards and Councils. It is made up of the Presidents of the Medical Boards of all states and territories, some Deans, and the Examinations Director. It has a special role in developing procedures for uniformity amongst the states, for the inspection and approval of medical faculties, and for the examination of overseas trained doctors. I thank the President of the AMC, Dr B Neal, for his hospitality.

The Executive Secretary, Ms Georgina Jones, continues to provide for the Council and the profession an extremely high standard of work, in an office that is both harmonious and efficient.

I wish to thank all members of the Medical Council for the great support they have given me in my first nine months of office, and the quality work that they have given to the profession over a number of years. In particular I would like to mention Dr Murdoch Herbert and Mrs Patricia Judd. Dr Herbert, despite his busy general practice, is always willing to sit on the Tribunal for its hearings and to participate in all aspects of committee work. Mrs Judd involves herself in every aspect of the Council's work, and is always available for hearings and committees, beyond the call of duty. She combines this with a full time job as a teacher and a mother, and the profession owes her a great debt.

Finally, I pay tribute to Dr Stewart Alexander for his years of service to the profession, and for his skilful chairing of the Council over years of change. His wisdom, energy and leadership have been much valued. His retirement from a busy pathology practice in Wellington is noted, and we wish him happiness and good health.

R H Briant
CHAIR

REPORT OF THE LAY MEMBER

The last five years have seen a gradual expansion of the role of the Medical Council of New Zealand. While its prime concern has traditionally been the maintenance of medical standards by keeping a register of properly qualified medical practitioners, and having an overview of undergraduate training, changes in our society have broadened this responsibility.

Successive governments have shown themselves to be mainly concerned with the financial aspect of health provision, and the various restructurings which have occurred have had fiscal objectives rather than quality assurance as their base. One of the major changes in this regard has been the transference of many Health Department responsibilities to Area Health Boards, and the consequent development of local standards in the provision of health care. As the Health Department's role has been altered the Medical Council has had to extend its role in the protection of the public interest.

Through its discipline and competency activities, the Council has been able to identify trends both in problem areas within the profession and in public expectations. Consequently, it has produced reports and issued guidelines to the profession in areas such as medical education, registration, informed consent, duty of care and substance abuse. It has also established procedures for medical audit in cooperation with the Colleges, and so has provided Area Health Boards with a standardised process which can be used to investigate questions of professional competence.

An important communication link has been established with the Managers of the Area Health Boards and the Medical Council is now meeting with them, or their representatives, once or twice a year. This provides an excellent opportunity to discuss areas of common concern, and is particularly valuable in matters to do with undergraduate and postgraduate placement in public hospitals.

This has been an interesting time for me to be a member of the Medical Council of New Zealand, and I would like to pay tribute to Dr Stewart Alexander and the members of the Council with whom I have been working. It would have been quite easy for them to have pushed me to the sideline and diminished the role of the Lay member on Council. The opposite occurred. At my second meeting it was suggested that I might like to present a paper to Council on lay participation in professional bodies, which I did. Subsequently the paper was submitted to the New Zealand Medical Journal for publication. This began a pattern of full involvement in Council activities, so that the lay contribution could be seen in all areas under discussion, and in any suggested reforms or changes.

Because this has been a time of great change in public attitudes to medical matters and there has been close scrutiny of the workings of the profession, Council members have had to undertake a large workload to produce the necessary reports and discussion papers. As we await the introduction of a new Medical Practitioners Act, which will hopefully introduce new systems to spread the workload, I would urge members of the medical profession to ensure that future members of the Medical Council have the same foresight as those with whom I have worked over the last five years.

P Judd
LAY MEMBER

REPORT OF THE MEDICAL EDUCATION COMMITTEE

REVIEW OF REQUIREMENTS FOR TRAINING AND SUPERVISION IN THE INTERN YEAR

The major business of the Medical Education Committee in this past year has been the introduction and implementation of Council policy on training and supervision in the intern year. Pamphlets outlining the educational requirements for the intern year covering Guidelines for Interns, Intern Supervisors, and Area Health Boards have been published and distributed. These guidelines state explicitly the obligations of interns, of intern supervisors and of employing hospitals, and were developed by working parties of the Medical Education Committee in 1989-90. They will serve as a valuable reference during times of further change in the hospital system.

Introduced at the same time were minor changes in the methods of categorising runs for intern experience. The signing of the new contract between the Intern Supervisors and Council, and the payment of a small emolument, recognises the statutory responsibilities.

INTERN SUPERVISORS

The committee continues to recognise the importance of Intern Supervisors in the early postgraduate training of doctors in New Zealand. They provide an invaluable link between the Council, the interns and the employing hospitals. No meeting has been held with the Intern Supervisors since July 1990, but one is planned for September 1991.

EMPLOYING HOSPITALS

The annual meeting of representatives of Area Health Boards with Council, held on 18 June, provided a useful opportunity to discuss issues relating to intern experience in the employing hospitals.

Most hospitals appear to have developed rosters for house surgeons which are generally acceptable to the parties concerned, although ensuring that appropriate continuity of care is provided is still an issue in some hospitals.

A concern expressed at this meeting was that of the intern whose performance fell below expected standards. This is more of a worry when the intern is employed in a smaller hospital away from a teaching centre, under which circumstances it is less easy to arrange an appropriate corrective programme. It was recognised that, in a restructured health service, such interns may have difficulty in finding continuing employment.

R D H Stewart
CHAIR

REPORT OF THE PRELIMINARY PROCEEDINGS COMMITTEE

This year has seen several changes in the personnel of the Preliminary Proceedings Committee (PPC). In August 1990 Robin Briant was elected Chair of Council and left the committee, having served both as member and as a very able Convener. John Broadfoot was elected to the committee in her place but resigned from Council as at 30 April 1991, and was succeeded by Ian St George. The legal member has remained Philip Cook of Kensington Swan's Wellington office, and I followed Robin Briant as Convener.

As indicated in last year's report the volume of complaints considered by this committee has grown significantly in recent years, from six complaints in 1986 to 53 in the 1990 calendar year. 1991 began slowly and it seemed that the surge of complaints had ceased, but with a recent upswing the workload has increased by virtue of their complexity as well as their number. In particular, there has been a raft of complaints about the Deep Sleep treatments of the 1970s, stimulated by the horrific revelations of the Chelmsford Enquiry in New South Wales. The official enquiry by the Department of Health in New Zealand did not reveal any such patterns as had received publicity in Australia, and the administration of narcosis here was more in keeping with the original British protocol. However, every complaint has involved the committee in perusing the hospital notes of the complainant, in order to try and identify correctly the prescribing doctor and the precise nature of the treatment administered. Some of those who have complained were not included in the departmental enquiry. These investigations are still continuing and may not end until late in the year.

More recently there has been the public media controversy between the plastic and the cosmetic surgeons, which was followed by the official lodging of complaints, and which has involved interviewing a number of people.

A continuing group of complaints arises from patients who have had psychiatric illness and who believe that their medication has given rise to some, at least, of their symptoms. There are various support groups at work within the community which encourage and promote these complaints, which by their very nature may be difficult to sort out.

There have been few complaints this year of impropriety.

The final group which has exercised the committee a good deal comprise doctors who are seen as over-prescribing, especially if they are dealing with dependent or addicted patients. There is real concern that a significant proportion of street drugs arise from prescribed medicines and all practitioners have a major responsibility, morally as well as legally, to ensure that their prescribing habits do not add to that social evil. The situation is made more difficult for the addict, the doctor, the community and the disciplinary system by the inadequate provisions of appropriate centres for treating substance abuse. (The Medical Council has issued a pamphlet on substance abuse, and a statement on drugs in sport, which make its attitude clear.)

The size of the PPC workload means that progress by this part-time committee is often slow. Hopefully, the new Medical Practitioners Act will introduce an independent disciplinary system (supported by a full-time Secretariat) so that the investigative processes can be expedited. There will doubtless be debate on the most appropriate composition of the disciplinary bodies when a Bill appears, and I hope all practitioners will take an active interest in it – it will set the disciplinary scene for some years to come.

G F Lamb
CONVENER

Table 1

PPC ENQUIRIES
Year Ended 30 June 1991

Cases under consideration as at 1.7.90	42
Cases under consideration as at 30.6.91 (made up of 117 complaints)	57
Cases resolved	32
Charges laid before Medical Council	9
Charges laid before Medical Practitioners Disciplinary Committee	4
Practitioner agreement to voluntary imposition of conditions on practice	4
Complaints withdrawn	2
Cases referred to Medical Practitioners Disciplinary Committee	60
Cases still under investigation (from initial 42 as at 1.7.90)	25

REPORT OF THE HEALTH COMMITTEE

In considering health-related problems in the medical profession, the committee seldom finds conflict between the public interest and the needs of the practitioner for rehabilitation.

As the practitioner is a valuable and often scarce resource, it is in the public interest that there is minimal interference with practice.

Meetings with the Health Committee are essentially informal, the practitioner often accompanied by relatives or supporters, and cooperation is usually complete. The agreement for future monitoring of practice may evolve from the doctor's self-assessment and proposed programme for supervision.

In such circumstances, as soon as health permits, a return to work is seen as likely to reduce personal, domestic and financial stress and to promote rehabilitation.

Appointment of a mentor (after consultation with the appropriate College) is now standard procedure, and is a vital element in the success of the monitoring and rehabilitation programme. Council sees this as an increasingly important aspect of self-discipline in the profession.

The Colleges play a valuable role in practice audit under the legal indemnity of the Council.

Area Health Boards, including Medical Officers of Health, may also know of impairment, and this should be reported to Council if patients' safety is at risk. Health sector reform will necessitate greater vigilance.

The community expects doctors to have high standards of competence and fitness to practice. Discussion with counterparts in Australia, United States, Canada and the United Kingdom revealed a similar approach to that in New Zealand. There is concern that real progress is made. In today's economic climate, the aging practitioner presents a special challenge.

At a recent meeting of lay and medical members of Medical Councils and Boards in Australasia, there was unanimous agreement that health provisions should be completely separate from discipline. It is hoped that the current revision of the Medical Practitioners Act will make this a reality in New Zealand. More time is needed to give consideration to raising the standards of medical practice overall.

Table 2 **HEALTH COMMITTEE ACTION**
Year ended 30 June 1991

Monitoring by Health Screener	10
Monitoring by Health Committee during treatment, rehabilitation or assessment	18
New suspensions imposed	5
Full suspension reimposed	1
Full suspension varied to allow limited practice	3
Prescribing restrictions gazetted	2
Recommendations made on registration applications	4
Applications for revocation of suspension considered or under consideration	6
Revocation of suspension granted	2

SUMMARY OF ACTIVITIES

During the period 1 July 1990 to 30 June 1991, the Health Committee (with Council where appropriate) has been involved in a variety of activities related to individual doctors where fitness to practise was an issue (see Table 2).

R G Gudex
CONVENER

HOW TO HELP A SICK OR IMPAIRED COLLEAGUE

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

If the problem cannot be resolved by discussion with the sick doctor's immediate colleagues, therapeutic doctor and family, it should be referred to the DHAS, the Medical Officer of Health, or to the Health Screener of the Medical Council. The referral is treated confidentially as long as there is prospect of resolution.

DHAS REFERRAL
Phone: (04) 471-2654 (toll free)
or write: Box 812, Wellington

MEDICAL OFFICER OF HEALTH
Phone or write to nearest Area Health Board or Health Development Unit.

HEALTH SCREENER
C/- Medical Council of New Zealand
Phone: (04) 384-7635
Fax: (04) 385-8902
or write: Box 9249, Wellington

NEW ZEALAND REGISTRATION EXAMINATIONS (NZREX)

The sequence of examinations leading to temporary and probationary registration for overseas trained doctors (whose basic medical degree was not obtained in Australia, Canada, South Africa, United Kingdom or the Republic of Ireland, and for whom there is therefore no direct entry to full registration) has now been in place for two years. Although disappointed candidates and short-staffed employers are sometimes quick to criticise, the Council is very satisfied with the programme and has proposed that it be retained under new medical registration legislation currently being drafted.

Parts I (English) and II (Medical – MCQs) are the screening examinations designed to test the candidate's standard of basic education and proficiency in English and medicine. They are the minimum requirements to be met before an application can be made for temporary registration. Temporary registration will permit an overseas trained doctor to work under close supervision while being integrated into the New Zealand workforce. It allows time for the doctor to become sufficiently familiar with the practice of medicine, the pattern of disease and health service delivery, and the culture of this country, before proceeding to further training or seeking probationary and full registration.

A pass in NZREX I and II is not a guarantee of employment, nor should it be. Employers must carefully scrutinise the curriculum vitae of every applicant, and follow up meticulously references from past employers. New workers should not be expected to perform at an inappropriate level, or in disciplines in which they may have had no previous practical experience or direct responsibility for patients. A small number of overseas trained doctors come to New Zealand straight from completing their basic medical degree and have not been exposed to the high standard of 'hands-on' undergraduate clinical experience and teaching which is the norm in our medical courses. These people need particularly careful handling in the early stage of their work in our busy hospitals.

The Council requires employers to ensure that every temporary registrant has a clinical supervisor who is expected to report on progress when extensions of registration are sought. Also important is access to adequate teaching and other resources to enable the newcomer to prepare for and succeed in further examinations, should the intention be to seek permanent employment, registration and residence in New Zealand.

A small number of overseas trained doctors are granted exemption from NZREX I and II on the basis of recent passes in comparable examinations conducted in Australia, USA, Canada or the United Kingdom. Sponsored trainees who meet the Council criteria, and who come here to complete specific formal or experiential training programmes so as to take these skills back to their homeland, are also able to seek exemption. Some overseas trained specialists and general practitioners who have higher qualifications and experience (obtained in countries where English is the first language, and the pattern of medical education and health service is similar to that in Australasia), but who do not satisfy 'specialist eligible' criteria, are also granted temporary registration without examination. This group may be permitted to work in smaller provincial hospitals, but in general temporary registrants are restricted to working in hospitals accredited for intern training, though not necessarily on first year house officer runs. General practice, even under supervision, is not available to temporary registrants.

Two years is the usual limit on temporary registration. During this period some doctors may have embarked on advanced training and be very close to achieving 'specialist eligibility'. Those who wish to remain in New Zealand longer to complete training, or take up permanent service posts in hospitals or the community, must have passed the examination for probationary registration, NZREX Parts III (Medical – SAQs) and IV (Clinical) during the two year period of temporary registration. This examination assesses the candidate's professional knowledge in basic sciences and clinical topics. It includes a clinical patient-centred examination.

All written examinations require a pass of the same standard as that required of New Zealand undergraduates at fifth year level (when the major written examinations are conducted). The test of clinical competence is similarly set in the same format, and at the same level, which a young New Zealand doctor graduating MB ChB must reach before being granted conditional registration for the pre-registration year. Although Council recognises that overseas trained doctors will have been exposed to a curriculum, teaching methods and assessment for qualification to practise medicine appropriate to the institutions and needs of their own country, the public must be assured that such doctors meet the standards and expectations of the community in New Zealand. A lesser or different minimum level of attainment for initial registration here simply cannot be defended. The experienced examiners who conduct the Council's examination are also familiar with the work of our own students and graduates. They understand the considerable stress involved in appearing for these vital tests, but cannot excuse inadequate preparation or performance.

Table 3

SCREENING EXAMINATION (FOR TEMPORARY REGISTRATION)

NZREX	PART I	PART II	Screening Examination Overall
	NOV 1990		
Candidate attempts	52 (15)	77 (35)	83
No. of passes:			
Attempt 1	34	19	
Attempt 2	14	16	
Attempt 3	1	2	
No. of passes overall	49	37	42
Pass rate overall	94%	48%	51%
	MAY 1991		
Candidate attempts	39 (2)	56 (11)	65
No. of passes:			
Attempt 1	19	15	
Attempt 2	1	2	
Attempt 3	N/A	3	
No. of passes overall	20	20	17
Pass rate overall	51%	36%	34%

Note: ( ) repeat candidates included

Regrettably many candidates appearing for the clinical examination (NZREX IV) show surprisingly poor knowledge and skill in applying their book knowledge, and therefore fail initially to reach the minimum standard. Deficiencies in history taking, physical examination, assessment of the patient's problem and formulation of a differential diagnosis are common, especially at the first attempt at the examination. Sensitivity to communication and cultural dimensions is also lacking in a number of candidates. The clinical covers medicine, surgery, paediatrics, obstetrics and gynaecology, psychiatry and general practice, which are essential disciplines for any person expecting to work in a general, rather than specialised, role.

It is vital that employers and colleagues take their supervisory and teaching roles seriously and contribute to the upgrading of the performance of

these doctors, if they are to be retained in our workforce. Given this era of severe resource constraints it is imperative that all members of the profession work to the highest standards of competency, ethics, communication with patients and general management. The Council has a statutory duty to see that both New Zealand and overseas trained doctors either reach this standard, or are excluded.

Exemption from NZREX III and IV is granted to those who satisfy the requirements for eligibility to enter the vocational registers in general practice, or the medical specialties, according to the standards of training, experience and competence set by the Council in consultation with the Colleges, but who do not have basic registerable degrees.

At least a year must be spent on probationary registration, working alongside colleagues who are able to monitor progress and report to Council whether the doctor is able to communicate in English, demonstrate a level of medical knowledge and clinical judgment, has ethical standards and attitudes, and clinical effectiveness (including industry records, personal relations and readiness to accept responsibility) to justify full (ie unrestricted) registration.

Between July 1990 and June 1991, 337 attempts have been made by candidates in the four parts of the examination process, which are conducted in two sessions annually. Tables 3 and 4 set out the results. Specific feedback is provided for failed candidates to assist them in their repeat efforts. Some do not pass within the expected timeframe, or exhaust their three attempts at each part, and appeal to the Council for special consideration. Such appeals may be granted if the case merits. Occasionally employers must be advised that their failing candidate is considered to be so deficient as to be a potential danger to patient welfare, and that registration for that particular post cannot be continued until remedial action is taken and a further assessment made.

The extensive examination programme demands considerable expertise and commitment from the Council staff, agents and Board of Examiners. Dr Gavin Glasgow heads a very effective small unit based at the School of Medicine in Auckland which puts together the examinations, coordinates examiners and patients, provides feedback to candidates and advice to the Board. He is assisted by Mrs Jenny Hargrave and a large team of examiners (including clinicians in Wellington) whose cooperation is invaluable. The services of the English Language Institute in Wellington which is contracted to administer the occupational English test (held in Auckland, Wellington, Singapore and

Table 4

EXAMINATION FOR PROBATIONARY REGISTRATION

NZREX	PART III	PART IV	Proceed to Probationary Registration
	JUL 1990	AUG 1990	
Candidate attempts	28 (3)	# 22 (5)	
No. of passes:			
Attempt 1	6	5	
Attempt 2	2	4	
Attempt 3	N/A	N/A	
No. of passes overall	8	9	9
Pass rate overall	29%	41%	
	FEB 1991	MAR 1991	
Candidate attempts	36 (12)	# 27 (10)	
No. of passes:			
Attempt 1	7	4	
Attempt 2	3	5	
Attempt 3	N/A	N/A	
No. of passes overall	10	9	9
Pass rate overall	28%	50%	

Notes: ( ) repeat candidates included
† clear passes only
# includes some provisional passes in NZREX III

London), and the Managers in the centres where NZREX II and III are held, are relied upon to a great degree and the help they give is much appreciated. We trust that resource constraints in the health and education sectors will not impede us in holding these examinations. This is especially so in relation to the clinical examination which is the most telling of all in the assessment of readiness for registration. With the large number of candidates now presenting for this part of the NZREX programme it will be necessary to examine in both Auckland and Wellington concurrently, and senior clinical academics such as Dr John Kolbe, and Professor Eru Pomare, will continue to be called upon to make this feasible.

NZREX is self-funding and some detail of the income and expenditure is set out in the financial statements. Goodwill is, however, the critical ingredient and we hope to be able to retain that through consultation and review. The examination is not designed to be a tool of discrimination but rather a yardstick, albeit minimal, by which to measure safety to practise as a doctor in New Zealand. It compares well with overseas counterparts, particularly since no funding or support for administration, development or preparation of candidates comes from outside sources, such as Vote Immigration, Health, Education, or External Relations and Trade.

Candidate Information Handbooks and dates for forthcoming sessions are available from the Council Secretariat in Wellington.

REPORT OF THE SECRETARY

Reading again my report at June 1990 I am impressed by the range and volume of work which must be accomplished by the Secretariat in support of the Council's statutory responsibilities. If that sounded like a very busy year, the past twelve months have been even more hectic and, with the strong possibility that our new Act will be a reality, the next year could be the most intensive yet.

I am confident in assuring you that the team at 73 Courtenay Place is well equipped to handle the demands placed upon it. Data processing systems and hardware have been reviewed and revised, extended or upgraded considerably, so that all records, reports and certificates for registrations and examinations are automated. Financial records are all on the database and a new receipting programme is being written. Our wordprocessing capability is sophisticated and effective, and telephone, fax, copying and printing resources are high quality. Information systems are regularly reviewed, including hardfiles and library material, and provide ready reference when issues come before Council or its committees.

Equipment aside, the critical factor in assuring a high quality of service from the Secretariat to the Council, the profession at large and the public, is the commitment and expertise of the staff. I am particularly pleased to report that the changes in structure and personnel in the Council office which were put in place in early 1990 have largely proved worthwhile. As we had a number of new staff members last year there was a lot for them to get to grips with, and they have done well. In some cases it was 'deep end' learning as disciplinary proceedings took me away from Wellington on many occasions. After consultation with Council members at our annual 'retreat' in January, I appointed a junior Clerk and a part-time Tribunals Officer to ease some of the pressure, and this was a good move. In June 1991, Ms Faith Barber took over as Executive Officer with responsibility for communications, Medical Education Committee, NZREX, and the Health Committee. She is a university graduate, with considerable experience in journalism and administration, and has already proved an asset. As we move into a new era of health services delivery and significant legislative changes, including our own Act and the proposed Health Commissioner, the diversity of Council communications will increase and become critical to the successful execution of our functions. Faith's talents in public relations will, I am sure, be reflected in the effectiveness of our future communications.

In the past year we have made a special attempt to improve all aspects of communication, ensuring that correspondence is acknowledged and actioned without delay, introducing the newsletter MCNewZ, holding a variety of joint meetings with organisations which share common goals, and offering the services of Council members who are prepared to act as agents in listening to the concerns of individuals or groups. One disappointment is that it appears the Annual Report is not retained for reference by a number of practitioners – this is obvious from the queries raised during the year which have already been covered. May I suggest that you keep a file for Medical Council publications as they are certain to arrive on your desk with more frequency from now on!

The Annual Practising Certificate exercise still produces frustrations on both sides. We discover that practitioners have changed their address, gone overseas or come back, retired, changed their names, added qualifications and so on, and have failed to advise us. This adds to the already heavy workload of processing the applications and issuing certificates, which are required by law, if you are working in medicine in New Zealand or prescribing, certifying or consulting, even if on a very limited or voluntary basis.

In general, the response to the mailout of applications has been very prompt. Thank you for your cooperation and patience with the short notice given of fees required. A small proportion of doctors on the register do not reply, despite several reminders. They may not be practising or requiring an APC, but we must have specific confirmation of that. No response adds to the administrative cost of follow-up – time and money we cannot afford to waste if you expect us to keep the APC at the current level.

Individuals who object to paying the fees, in particular, the disciplinary levy, have written to me or Dr Briant and received an explanation of Council policy. Partial payment or reduced rates are not available at present. The function of the APC is likely to be redefined in the new Act and this will be the opportunity for the payment and issue regime to be reassessed also. Meanwhile, Council takes the view that every person who requires an APC must contribute to the cost of self-regulation of the profession, including the now substantial discipline expenditure. Retired or semi-retired doctors have sought special treatment, but their position is no different from that of the younger doctors who may work part-time, or sporadically, as they care for dependents or work outside medicine. You will have a chance to make your views known when the Bill is before the Select Committee.

Disciplinary proceedings have been referred to elsewhere in this report. I wish to assure practitioners that all matters connected with conduct and health are handled with the utmost care and confidentiality by the Secretariat, in fairness to both the doctor and the public. Occasionally the media get onto a story from another source and we are placed in the difficult position of being asked to confirm information which we

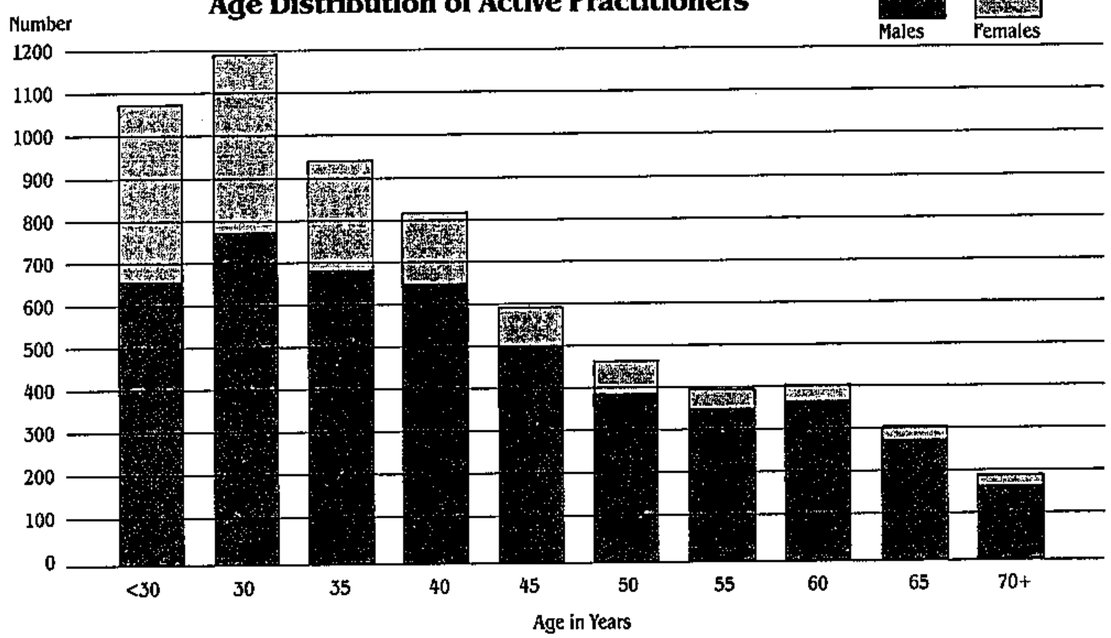
Table 5

WORKLOAD INDICATORS

	Year Ended 30 June 1990	Year Ended 30 June 1991
Provisional Certificates:	604	703
Conditional Registration	233	279
NZ graduates	221	271
OS graduates	12	8
Full Registration		
OS graduates	330	370
Restorations		
NZ graduates	41	25
OS graduates		29
Temporary Certificates:		
New certificates	79	101
Extensions	252	273
Probationary Certificates:		
New certificates	31	38
Extensions	N/A	14
Conditional to Full Registration	220	271
Probationary to Full Registration	39	37
Additions to Specialist Register	94	136
Additions to Indicative (GP) Register	376	30
Modifications to NZ Medical Register:		
Changes of address	2,550	2,734
Changes of name	25	19
Additional qualifications	307	428
Suspensions or variations	11	9
Removals:		
Deaths	53	35
Discipline	4	2
Failure to notify address	129	118
Non-resident overseas graduates	105	–
At own request	46	43
Annual Practising Certificates	6,806	7,015
Certificates of Good Standing	422	443
Certificates of Registration	155	156
Receipts Issued (excl APCs)	N/A	2,900
TOTAL COMPUTER TRANSACTIONS	9,000	17,461

Table 6 **NEW ZEALAND MEDICAL WORKFORCE STATISTICS 1990**

Age Distribution of Active Practitioners



regard as confidential. Each incident must be handled sensitively to protect the rights of all concerned, without appearing to be unreasonably secretive. This is a tightrope which we will have to walk more often as the activities of doctors, and indeed other professionals, are under public spotlight and scrutiny. We are keen to see mechanisms in place which will separate discipline from issues of health, fitness to practise and competence.

The bald statement of statutory responsibilities as set out in the Medical Practitioners Act gives no indication of the breadth and depth of knowledge and skills which must be possessed by Council members, staff and agents in carrying them out. Dr Briant has already referred to the dedication and ability of Council members. I would like to endorse her remarks and, at the same time, acknowledge the special burden carried by the Chair. Dr Alexander has been a tower of strength to the Secretariat, never too busy to care about our needs as people and employees. I am indebted to him for his support, encouragement and affirmation over the five years I have held the position of Secretary. Dr Briant carries on this excellent relationship in her way – she is a stimulating and challenging leader, with a knack for giving balance and humour their rightful place. I am sure I speak for all members of the Secretariat in thanking both our recent Chairs for their consideration of our needs and their acknowledgment of our hard work.

During the year I have had the chance to visit the office of the Federation of State Medical Boards of the USA in Fort Worth, Texas; the international office in Philadelphia of the Educational Commission for Foreign Medical Graduates (ECFMG); the Secretariat in the same city of the National Board of Medical Examiners; and the offices in Toronto of Council's counterpart, the College of Physicians and Surgeons of Ontario. These brief stopovers during my annual leave proved to be worthwhile in gathering additional information and establishing contacts, which will be useful during the transition to our new Act. Everywhere people were interested to learn of developments in this country and to welcome a colleague from down under. Our association with the General Medical Council in the UK, and the Australian Medical Council (and its constituent Boards and Councils), is also an important ingredient in raising issues for discussion and examining policies and procedures which are being tried elsewhere.

The work of the Secretariat continues unabated and the staff still remain cheerful and willing to cope with whatever comes their way. I am very dependent on and grateful to them. Each has particular responsibilities, and now considerable expertise, and they work together admirably, in somewhat confined conditions. We hope to survive the inevitable changes over the next year, and seek your cooperation together with respect for our requests.

Georgina Jones
SECRETARY

REPORT OF THE MEDICAL PRACTITIONERS DATA COMMITTEE

USE OF THE DATA BASE

Council is receiving an increasing number of requests for use of the data base from researchers, professional bodies, government and quasi-government agencies and commercial organisations. Considerable care is taken that the meeting of these requests does not breach the confidentiality of individual information held. Most requests can be met under conditions mutually acceptable to the Council and the applicant, which means that this valuable asset is being used increasingly. The modest income received helps offset the costs of collecting and maintaining the data base.

The Council would like to know of any general or specific concerns that practitioners have about the release of information from the data base, as it is concerned that practitioners should continue to have confidence in the privacy of the information held on their behalf.

Council continues to be disappointed at the delay in the publication of national health workforce statistics by the Department of Health. The full review of data from the 1989 and 1990 surveys has not yet been published.

NEW ZEALAND MEDICAL WORKFORCE 1990

Around 8000 questionnaires were sent to doctors with a registered New Zealand address. This survey, of those with conditional and full registration, showed that 6339 doctors were in the active New Zealand medical workforce as at June 1990. These doctors worked 5863.3 full-time equivalents giving an average of 92.5 percent.

Excluding temporary and probationary registrants, the number of overseas graduates working as house officers decreased. However, there was an increase in the number working as registrars. Overseas graduates accounted for 29.3 percent of the active workforce, and women comprised 23.9 percent.

There is an increasing percentage of the workforce in the younger age groups with 35.7 percent of the 1990 workforce under 35 years of age. 82.2 percent were working full-time, and only 5.3 percent were working less than 50 percent full-time equivalent. 40.9 percent were working as primary care doctors; 30.8 percent as specialists; and 23.3 percent as house officers or registrars. 37 percent had been qualified ten years or less, and 56.3 percent first registered in New Zealand before 1980. 32.9 percent of the active workforce were in the Auckland Area Health Board region, with 26.4 percent in the South Island.

The active workforce in 1980 was 4881 doctors, so the increase over ten years to 1990 was 29.9 percent; with primary care increasing 38.3 percent,

Table 7 **NEW ZEALAND REGISTRATION INFORMATION**

as at 30 June 1991

Total practitioners on register	10 179
Total practitioners with practising certificates	7 015
Temporary registrants	183
New probationary registrants	38
Names removed from register (various)	168
Practitioners deceased	35

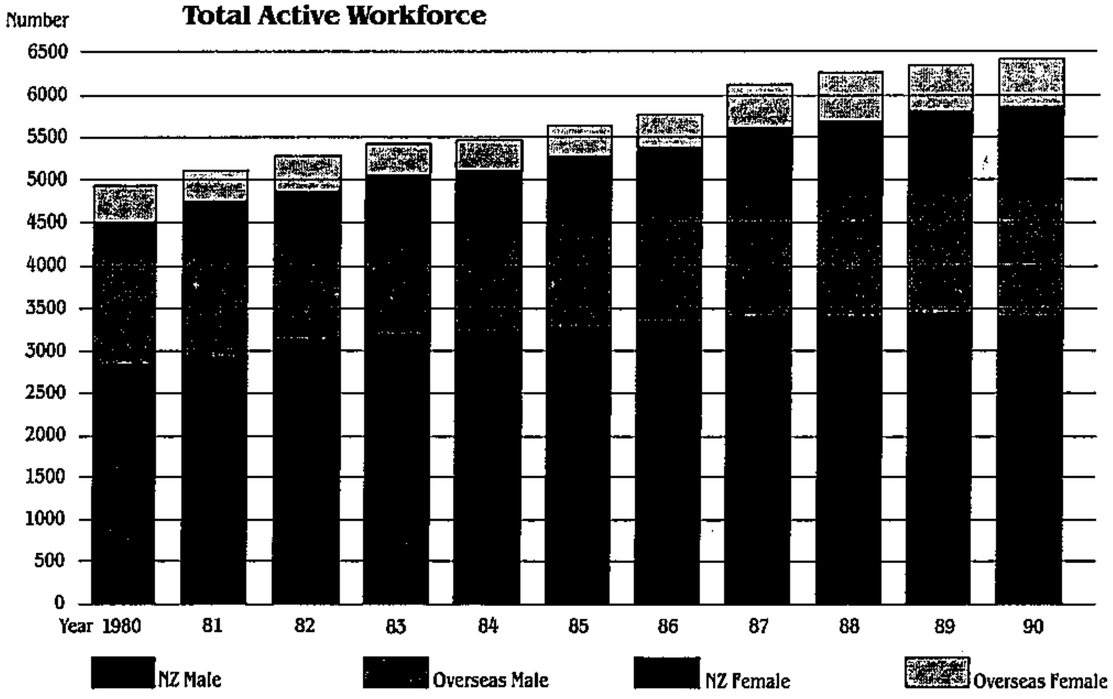
Table 8 **NEW ZEALAND MEDICAL WORKFORCE 1990**

	1986		1987		1988		1989		1990	
	Total	NZ Graduates	Total	NZ Graduates	Total	NZ Graduates	Total	NZ Graduates	Total	NZ Graduates
Active	5747	4188	6095	4302	6174	4326	6286	4434	6339	4480
Full Time Equivalents	5330.3	3913.5	5620.0	3986.5	5692.5	4000.0	5763.9	4070.4	5863.3	4151.6
House Officers	668	568	751	539	728	525	719	533	679	538
Registrars	746	630	780	626	771	620	765	616	799	627
Medical Officers Special Scale	149	67	167	74	180	87	176	93	175	87
General	2141	1512	2278	1601	2293	1608	2383	1681	2429	1705
Other Primary Medical Care	103	70	125	85	124	81	139	92	165	101
Specialists	1819	1272	1897	1306	1953	1338	1957	1326	1952	1325
Miscellaneous (non specialist)	121	69	117	71	125	67	147	93	142	97

Table 9

NEW ZEALAND MEDICAL WORKFORCE STATISTICS

Total Active Workforce



specialists 17.8 percent, house officers 19.3 percent, and registrars 42.4 percent.

A third of the house officers in 1990 did not have a preferred career discipline. Only 48 percent of first year house officers indicated they had a preference, compared with 73 percent of second years and 86 percent of senior house officers. Half of the 67 percent of house officers who did have a preference, and 14 percent of registrars, indicated primary care as their intended discipline.

1991 MEDICAL WORKFORCE SURVEY

Around 8400 questionnaires were sent to doctors with a registered New Zealand address in March, or who changed to a New Zealand address before 30 June 1991. This was a 5 percent increase on the 1990 figure. Approximately 92 percent have been returned, and a priority is to determine the active workforce as at 30 June 1991. Provisional data indicates a continuing increase in the total workforce, and an increasing number of doctors working in primary care compared with those working as specialists.

Some interesting patterns are emerging from the new data on hours worked, but as a large number of questionnaires will require follow-ups it is too early to indicate final results. It does appear that the hours worked will provide much valuable data which will require detailed and careful analysis. There are considerable differences in the total hours worked, and hours spent in various activities, when looking at the different employment categories.

The 1991 workforce statistics should be available from December.

R D H Stewart
CHAIR

REPORT OF THE REGISTRATION COMMITTEE

As we await vocational registration in the new Medical Practitioners Act, with the marrying of the indicative register of 'general' practitioners with the 'specialist' register of those in other disciplines, it is worth examining the pattern of registration in the various vocational disciplines over the last year.

Figures are available for 1 July 1990 to 30 June 1991. Thirty two were added to the Indicative Register of General Practitioners, and 136 to the Register of Specialists covering other disciplines. Applications for the Indicative Register of General Practitioners were artificially low, as the deadline for the 'grandparent clause' expired before the beginning of the year. In future, general practice figures are likely to be low in comparison with the number actually entering the general practice workforce, unless registration as a general practitioner becomes necessary for employment in the discipline.

The numbers of new registrants by main vocational disciplines, with subdivisions by sex and origin, are shown in Table 10. Of those registering women are still greatly outnumbered by men in most disciplines, but they are beginning to make an appearance, though rarely in the surgical disciplines.

Table 10

NEW REGISTRANTS IN VOCATIONAL DISCIPLINES

1 July 1990 to 30 June 1991

	Total	NZ Graduates		Overseas	
		Women	Men	Women	Men
General Practice	32	5	11	3	13
Internal Medicine	27	4	12	2	9
(Surgery)	(23)	(2)	(13)	(-)	(4)
Orthopaedics	12	1	10	–	1
General Surgery	4	–	2	–	2
Neurosurgery	2	–	1	–	1
Plastic Surgery	1	1	–	–	–
Urology	4	–	3	–	1
Psychiatry	18	2	6	2	8
Diagnostic Radiology	16	3	6	2	5
Anaesthetics	11	1	7	–	3
Obstetrics and Gynaecology	10	–	3	1	6
Pathology	8	2	3	–	3
Community Medicine	9	3	4	2	–
Opthalmology	4	–	3	–	1
Otolaryngology	3	1	2	–	–
Paediatrics	3	2	1	–	–
Oncology					
Radiotherapy	3	–	3	–	–
Dermatology	1	–	1	–	–
TOTAL	168	25	78	12	53

How long do New Zealand graduates registering in the various disciplines spend from first registration in New Zealand before they register in their vocational discipline? Of the 85 New Zealand graduates registering in disciplines other than general practice, the pattern is shown in Table 11. New Zealand graduates register in these disciplines a surprisingly long time after full registration, reflecting the length of training, and the possibility of vocational change late in career.

Table 11

NUMBER OF YEARS FROM FIRST REGISTRATION UNTIL VOCATIONAL REGISTRATION FOR NZ GRADUATES REGISTERING IN VOCATIONAL DISCIPLINES

1 July 1990 to 30 June 1991

Years	Number
<8	–
8	4
9	18
10	15
11	14
12	10
13	5
14	1
15	2
>15	15

Overseas graduates granted registration in the various disciplines gained their initial qualifications in the countries shown in Table 12.

Table 12

COUNTRY OF GRADUATION FOR OVERSEAS GRADUATES REGISTERING IN VOCATIONAL DISCIPLINES

1 July 1990 to 30 June 1991

	GP	Other Disciplines
UK	12	19
Sri Lanka	1	6
Canada	1	1
Australia	1	2
South Africa	1	8
Ireland		2
Malaysia		2
Nigeria		2
Egypt		1
Finland		1
Hong Kong		1
India		1
Iran		1
Singapore		1
West Indies		1
TOTAL	16	49

I St George
CONVENER

REPORT OF THE SPECIALIST REGISTRATION SUBCOMMITTEE

In November 1990 I succeeded Dr G F Lamb as Convener of the subcommittee. In taking over this role I would like to pay tribute to Dr Lamb's careful and very painstaking work during his term of office.

As at 30 June 1991 there were 2319 practitioners on the New Zealand Register of Specialists. Applications for specialist registration continue to occupy a significant proportion of the time of the Registration Committee. And more time has been needed to consider requests for the determination of eligibility for specialist registration from overseas trained doctors. This reflects the rising level of interest among overseas trained specialists in applying for hospital appointments in New Zealand, or in entering private specialist practice.

Applications from those with recognised qualifications and the required supervised training and experience are not a problem. If their referees' reports on competence and professional standing are satisfactory, they are readily recommended for approval by the Council, on the advice of the relevant specialist college or special society acting as the Council's referral body.

It is considerably more difficult if the applicants basic or higher qualifications are not recognised under the Medical Practitioners Act or the Registration of Specialists Regulations 1971; or are incomplete, as with UK fellowships where certification of higher specialist training in the UK is a requirement under New Zealand regulations. Equivalence of supervised training and experience is difficult to determine in the absence of formal certification, and in most cases does not exist in comparison with that required in New Zealand and Australia. The purpose of the regulations is to maintain standards and protect the public. Council, and its referral bodies, do their best to make sure that all specialists gaining entry to the Register of Specialists meet the requirements laid down, while at the same time being fair to all applicants.

Recently, following consultation with the referral bodies, a mechanism for clinical assessment has been under consideration for overseas trained specialists practising in New Zealand,

Table 13

NEW ZEALAND REGISTER OF SPECIALISTS

as at 30 June 1991

	Added	On Register
Anaesthetics	11	261
Community Medicine	9	147
Dermatology	1	41
Diagnostic Radiology	16	151
Gynaecology	–	1
Internal Medicine	27	427
Obstetrics	–	1
Obstetrics and Gynaecology	10	182
Opthalmology	4	90
Orthopaedic Surgery	12	124
Otolaryngology	5	68
Paediatrics	5	133
Pathology	8	151
Psychiatry	18	225
Radiotherapy	3	29
Cardiothoracic Surgery	–	21
General Surgery	4	224
Neurosurgery	2	14
Paediatric Surgery	–	4
Plastic Surgery	1	27
Urology	4	33
Venereology	–	18
TOTAL	136	2,372

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 Register of Specialists.

The 1991 totals do not allow for removals of names through purging from the main register, which involved a total of 19 specialist registrations.

but not otherwise eligible for specialist registration. While problems are anticipated with measuring competence in assessment (if examinations are not to be used), such a mechanism would provide flexibility in the determination of specialist eligibility. Obviously no guarantee could be given as to the outcome of assessment, and all costs would have to be met by the employing health board or the individual doctor.

The recognition of new vocational disciplines by the Council is another area of concern. We need to make sure that they meet the same rigorous criteria for training and the assessment of trainees that are maintained in the established disciplines. During the 1990/91 year formal criteria for recognition have been developed, and discussions have been held by the Registration Committee with a number of smaller groups seeking recognition. Council recognises the value of reciprocal recognition of specialties with Australia, but is not bound by decisions in that country.

The impact on specialist registration of the new Medical Practitioners Act may be considerable, depending on the provisions included. It is anticipated, however, that future Councils will continue to rely on the Medical Colleges and special societies nominated as referral bodies for advice on vocational registration matters. These include not only registration itself, but also requirements and mechanisms for involvement in continuing education, and for recertification to remain on the Vocational Register if this becomes a formal requirement for the issuing of a practising certificate. A recommendation has been made to the Minister that the separate Register of Specialists and the Indicative Register of General Practitioners be merged in the new Act to become a single Vocational Register, with sections for each recognised discipline, including general practice. This should rationalise the present confusing divisions and give equal standing to both groups.

C Maclaurin
CONVENER

REPORT OF THE INDICATIVE REGISTER (GENERAL PRACTICE) SUBCOMMITTEE

There was a flood of applications just before 1 April 1990, but since then applications have been submitted in a steady stream. The Secretariat and the referral body have processed these in time for approval at the following Council meeting, except for the few who initially provided insufficient detail.

From 1 April last year the requirements are that a practitioner must have had the equivalent of three years fulltime general practice, and five years practice since qualification, for admission to the Indicative Register of General Practitioners. In addition, an applicant must be a member or a fellow of the Royal New Zealand College of General Practitioners, or of another approved academic College of General Practice with equivalent training and entry criteria. It is apparent from applications that some practitioners are under the misapprehension that passing Part 1 of the RNZCGP exam is sufficient qualification, whereas the criteria demand full College membership.

With a new Medical Practitioners Act pending, and the possibility of the Annual Practising Certificate having a vocational endorsement, now is the time for general practitioners not on the Indicative Register of General Practitioners to take the necessary steps to qualify for inclusion.

At 30 June 1991, the Indicative Register has 1357 general practitioners listed.

M M Herbert
CONVENER

REPORT OF THE COMMUNICATIONS COMMITTEE

The main achievement of the Communications Committee this year has been the launching of the Council newsletter MCNewZ. The first issue was sent to practitioners in March 1991. Council can now communicate news direct to the profession; and we hope the profession will use it to share their ideas with us and fellow practitioners. At a time when the health service is undergoing profound changes it is important that there are as many routes as possible for the exchange of views professionally.

In addition, each of the twelve Council members acts as a communication agent between practitioners and the Council as a whole. The Council members convey proposals or concerns put forward by those on the register to the Council forum. The current geographical distribution means that the majority are in the North Island, but a Council member is available to practitioners in the South Island.

Media training continues: both initiating new key members into the programme, and extending the training of those earlier identified as speakers for the Council. The benefits of training have been considerable in the past, sometimes difficult, year.

A third venture has been the putting together of an 'information pack'. It consists of separate information sheets which can be added to, or omitted, as appropriate. The aim of the pack is to convey the Council's role and functions to the media, parliamentarians, and other enquirers. We believe it will be an important resource in the coming year with legislative changes before Parliament.

All legislation likely to have an impact on the medical profession is monitored, and if necessary, submissions are made on its behalf.

In all this has been a very active year for communications.

J A Treadwell
CONVENER

REPORT OF THE FINANCE AND MANAGEMENT COMMITTEE

This report covers the period 1 July 1990 to 30 June 1991, although the financial statements included with it cover the period 1 April 1990 to 31 March 1991.

TAXATION

The tax position has been given further consideration. As the Inland Revenue Department will not reverse its earlier decision, Council has taken the advice of its taxation consultant and paid tax for the 1989/90 year of $38,449.95, and for the 1990/91 year of $48,913.59.

The Minister of Revenue, Hon W. Creech, will be approached to explain the Council's concern on this issue, and he will be asked to review the whole matter.

No tax was payable on the 1988/89 year as the accounts ended with a deficit which was carried forward in calculating tax liability for the 1989/90 year. The first instalment of provisional tax has been paid for the 1991/92 year.

Should our appeal succeed the amounts paid at this time will be refunded. As yet no advice has been received as to whether the Council is subject to penalty for late payment. Our taxation consultant is hopeful that the long drawn-out consultations will be accepted as an adequate reason for the delay.

GENERAL COUNCIL OPERATIONS

The expenses of the committees of Council have been shown in detail. The new contract arrangement for Intern Supervisors is reflected in this item under Medical Education Committee expenses. The amount for a whole year will be approximately $60,000.

Council fees and expenses reflect a small increase in sitting fees for Council members, and the costs of an additional general Council meeting required because of the time demands of disciplinary issues on Council.

The demands on Council members' time have become almost intolerable. It is to be hoped that before long Council will be relieved of its disciplinary role and will be able to concentrate on its statutory functions with reduced demands on Council members' time.

The year ended with a surplus of $116,658 after tax. This is less than 10 percent of total income.

Overall expenses have increased by 20 percent, while income from all sources has increased by 18 percent. A substantial source of income is interest received on invested funds. As interest rates have fallen appreciably, any further increase in operating expenses will erode the surplus. The Finance and Management Committee have taken care in the current year to ensure that administration expenses incurred on behalf of the Dental Council, the disciplinary functions, and the examination programme, are measured and appropriate funding transferred. This process is continuing and will ensure that each activity accepts its full share of costs of the services and overheads of the Secretariat.

DISCIPLINE

The year has involved heavy expenditure on all aspects of the discipline system. Despite a considerable increase in the discipline levy it has not been possible to achieve a surplus in the account, nor to reduce the accumulated deficit.

Careful attention has been paid to the cost of services provided by the Council Secretariat to the discipline function. If this function is to be transferred to a separate Medical Practitioners Disciplinary Tribunal, it is essential that an accurate summary of all related costs should be available for budgeting for the new tribunal.

The New Zealand Medical Association has reduced its contribution to a token $25,000, which means that all discipline costs are now met by the

discipline levy. The principle that the profession as a whole meets the cost of discipline is certain to remain. This means that all on the Register must contribute, whatever individual doctors perceive as their likelihood of being involved in discipline proceedings. Just as all doctors who engage in any form or level of practice for whatever remuneration should belong to an indemnity organisation, so should they contribute to the discipline levy. When the revenue from the levy exceeds the cost of the discipline function it may be possible to establish an 'Inactive Register', to abate part of the levy, and possibly part of the Annual Practising Certificate, for those who are retired.

EXAMINATION FUND

As with other Council activities, further attention has been paid to ensure that all examinations related services provided by the Secretariat are charged to the Examination Fund. This fund must be self-supporting and fees for the various parts of the examination set at realistic cost-covering levels. It is still difficult to predict numbers for Parts I and II, although numbers for Parts III and IV can be predicted with reasonable accuracy as those doctors are already in New Zealand and working towards the ultimate goal of full registration.

GENERAL

The accounts and financial statements, the accompanying notes and this report of the Finance and Management Committee, convey an accurate account of the financial affairs of the Council. If any further explanations are needed the committee would be pleased to provide these in a future edition of MCNewZ.

W S Alexander
CHAIR

AUDITOR'S REPORT

Miller, Dean & Little

CHARTERED ACCOUNTANTS
WELLINGTON

AUDITORS' REPORT TO THE MEMBERS OF
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 10 to the Financial Accounts the Council has been deemed liable for taxation. This decision is being appealed but in the interim provision has been made for normal taxation as from 1989. No provision has been made for additional taxation for late payment.

Subject to the above, in our opinion and according to the information and explanations 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 1991 and the results of its activities for the year ended on that date.

Miller Dean + Little

Chartered Accountants

WELLINGTON
2 October 1991

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

In accordance with recommended practice the cash flow statement has been prepared on a GST exclusive basis and the comparative figures for 1990 have been amended accordingly. With this exception there have been no material changes in accounting policies which have been applied on a basis consistent with previous years.

3. DEBTORS

The debtors figure includes $43,575 outstanding on competence assessments, $62,328 outstanding refund of GST, $38,000 outstanding contribution to Workforce Survey.

4. INVESTMENTS

(a) General Fund	1991	1990
BNZ Finance Call Account	102,045	–
National Bank Call Account	16,742	171,971
Equiticorp Finance Limited (In Statutory Management)	34,977	55,000
ANZ Call Account	178,419	90,576
Westpac Call Account	14,237	–
	$346,420	$317,547

The interest accrued on the investment in Equiticorp Finance Limited first ranking debenture stock is not shown in the accounts due to the uncertainty of its realisation. In view of correspondence from the statutory manager it is now anticipated that not more than 85% of the original capital will be realised. Therefore another $5,000 has been written off, reducing the original investment by $15,000.

(b) Discipline Fund	
ANZ Call Account	1,192
National Bank Call Account	961
	$2,153

(c) Examination Fund	
ANZ Call Account	$115,671

A separate set of bank accounts was opened to identify the transactions of the self-funding examination activities. The substantial balance in the investment account mainly represents examination entry fees paid in advance for the May 1991 examination session.

5. FIXED ASSETS

	Cost 31/3/91	Book Value 1/4/90	Depreciation For Year	Book Value 31/3/91	Accumulated Depreciation to 31/3/91
Air Conditioning	35,904	27,326	3,590	23,736	12,168
Computer	153,201	47,290	25,535	81,716	71,485
Furniture and Fittings	107,182	63,968	10,287	67,347	39,835
Office Alterations	157,364	98,002	15,736	82,266	75,098
Office Equipment	31,273	8,559	5,236	15,092	16,181
	$484,924	$245,145	$60,384	$270,157	$214,767

6. REGISTRATION EXAMINATIONS

The following is a brief summary of fees and expenses in the year ended 31 March 1991.

	1991	1991	1990
Fees Received		176,998	132,169
Interest Received		7,631	
Examiners Expenses	92,394		
Secretariat Expenses	35,465		
Board of Examiners Expenses	3,351		(4,110)
Examination Running Expenses (including Council Administration)	44,788		(117,127)
Audit Fee	1,000		
		7,631	10,932
Less Provision for Taxation		2,518	–
		$5,113	$10,932

During the year $10,932 was transferred from the Examination Development Fund back to Accumulated Capital Fund to cover purchase of new computer equipment and software. The surplus this year has been transferred to the Examination Development Fund to finance further review and development of the examination process. An Administration Fee has been paid to the General Fund to cover a share of office salaries and overhead expenses.

7. SUNDRY CREDITORS EXAMINATION ACCOUNT

This figure includes $49,227 for expenses incurred in conducting NZREX Parts III and IV in February; including $7,445 for computer equipment.

8. EDUCATION FUND

This year a further $50,000 has been transferred to this fund.

9. DISCIPLINE

Only two competence enquiries were carried out during the year. The cost incurred in one has been recovered. For the first time an administration charge has been made on the Discipline Fund to recover from the General Fund a percentage of Medical Council staff salaries and office overheads.

10. TAXATION

The Inland Revenue Department have deemed the Council liable for taxation. However this decision is being appealed. Provision has been made in the accounts for the current year's taxation together with the prior year adjustment for 1989 and 1990. No provision has been made for additional taxation for late payment.

11. PRIOR YEAR ADJUSTMENT

Provision for taxation relating to 1989 and 1990 (ref note 10)

General Fund	$11,494
Discipline Fund	$32,878

1990 prior year adjustment relates to rent.

BALANCE SHEET

as at 31 March 1991

	1991	1990
CURRENT ASSETS		
Petty Cash	310	210
General Fund Cheque Account at ANZ Bank	26,600	2,152
Discipline Fund Cheque Account at BNZ	(4,131)	32,620
Discipline Fund Cheque Account #2 at BNZ	393	2,864
Examinations Fund Cheque Account at ANZ Bank	258	–
Payments in Advance and Sundry Debtors (Note 3)	155,597	112,704
Interest Accrued	5,893	–
	184,920	150,550
INVESTMENTS (Note 4)	464,244	317,547
FIXED ASSETS (Note 5)	270,157	245,145
TOTAL ASSETS	$919,321	$713,242
CURRENT LIABILITIES		
Sundry Creditors		
– General Fund	97,657	151,249
– Discipline Fund	221,171	166,850
– NZREX (Note 6)	68,348	–
Payments Received in Advance	78,584	71,917
Provision for Taxation	75,884	–
TOTAL CURRENT LIABILITIES	$541,644	$390,016
TERM LIABILITIES		
Provision for Deferred Taxation	13,318	–
CAPITAL ACCOUNT		
Accumulated Capital	382,843	326,860
Discipline Fund – (Deficit)	(123,597)	(64,566)
Education Fund	100,000	50,000
Examination Development Fund	5,113	10,932
	$364,359	$323,226
	$919,321	$713,242

The accompanying notes on pages 36 to 38 form part of these financial statements.

MEDICAL COUNCIL OF NEW ZEALAND

GENERAL FUND REVENUE STATEMENT

for year ended 31 March 1991

FEES RECEIVED		1991	1990
Annual Practising Certificate		682,860	625,304
Certificate of Good Standing		11,953	11,407
Medical Registration Certificate		3,580	3,272
Change of Name		397	476
Registration Fees – including conditional, temporary, probationary and restoration		177,770	134,080
Specialist Registration Fee and General Practice Registration Fee		13,912	21,650
INCOME FROM FEES		890,472	796,189
OTHER INCOME			
Administration Fee – Dental Council		27,500	21,500
Administration Fee – Discipline Fund		90,000	–
Administration Fee – Examination Fund		13,990	–
Interest Received		79,614	49,151
Sales of Medical Registers		34,071	16,645
Sundry Income		407	467
INCOME FROM OTHER SOURCES		245,582	87,763
REGISTRATION EXAMINATION FEE (Net) (Note 6)		7,631	10,932
TOTAL INCOME FOR YEAR		$1,143,685	$894,884
Less Expenses as per Schedule		969,316	804,300
Net Surplus for the Year Before Taxation		174,369	(90,584)
Less Provision for Taxation		57,711	–
Net Surplus for the Year After Taxation		116,658	90,584
Accumulated Capital Brought Forward 31/3/90	319,423		319,423
Less Prior Year Adjustment (Note 11)	11,494		12,215
		315,366	307,208
		432,024	397,792
Less Investment Written Off	5,000		10,000
Transfer to Education Fund	50,000		50,000
Transfer to Examination Development Fund	5,113		10,932
		60,113	70,932
		371,911	326,860
Plus Transfer from Examination Development Fund (Note 6)		10,932	
ACCUMULATED CAPITAL CARRIED FORWARD		$382,843	$326,860

The accompanying notes on pages 36 to 38 form part of these financial statements.

MEDICAL COUNCIL OF NEW ZEALAND

GENERAL FUND SCHEDULE OF EXPENSES

for year ended 31 March 1991

	1991	1990
ADMINISTRATION AND OPERATING EXPENSES		
ACC Levy	5,447	4,174
Audit and Accountancy Fee	7,935	6,000
Agents Registration Fees	4,480	4,730
Computer Consultancy	8,675	3,430
Cleaning	3,380	2,863
Courier	6,946	3,339
Depreciation	60,384	50,034
Electricity	5,964	5,121
Fringe Benefit Tax	2,720	15,765
General Expenses	3,065	3,811
Legal Expenses	8,961	1,200
Micro Film Files and Storage	1,443	488
Medical Workforce and Associated Expenses (Net after Government Contribution and Sundry Income)	17,497	13,516
Overseas Travel – Secretary	1,200	1,977
Photocopying Expenses	4,368	7,062
Postage	19,085	20,366
Printing and Stationery	90,656	60,407
Public Affairs	13,456	–
Rent and Insurance	64,631	63,540
Repairs and Maintenance	5,993	4,238
Salaries	308,843	277,757
Superannuation and Health Insurance	16,225	19,087
Staff Recruitment and Training	4,609	19,979
Telephone and Tolls	13,943	7,555
TOTAL ADMINISTRATION AND OPERATING EXPENSES	$679,906	$596,439
COUNCIL AND COMMITTEE EXPENSES		
Council Expenses		
– Chairperson's Overseas Travel	500	2,278
– Chairperson's Honoraria	56,148	55,000
– Fees and Expenses	160,144	92,218
Registration Committee Fees and Expenses	10,455	3,054
Communications Committee Fees and Expenses	3,318	1,585
Data Committee Fees and Expenses	1,521	1,460
Finance & Management Committee Fees and Expenses	6,707	3,500
Informed Consent Working Party Fees and Expenses	942	3,463
Medical Education Committee		
– Fees and Expenses	20,103	23,252
– Hospital Visits	10,713	15,348
Intern Supervisors Meeting Fees and Expenses	511	6,703
Intern Supervisors Contracts	18,348	–
TOTAL COUNCIL AND COMMITTEE EXPENSES	$289,410	$207,861
TOTAL EXPENDITURE	$969,316	$804,300

The accompanying notes on pages 36 to 38 form part of these financial statements.

MEDICAL COUNCIL OF NEW ZEALAND

REVENUE STATEMENT FOR DISCIPLINE FUND

for year ended 31 March 1991

		1991	1990
REVENUE			
Levies Received		1,917,395	1,103,647
Interest Received		88,159	51,209
Recovery of Discipline Costs		225,592	191,409
Sundry Income		–	14
TOTAL REVENUE		$2,231,146	$1,346,279
ADMINISTRATION AND OPERATING EXPENSES			
ACC Levies		2,723	1,391
Accounting and Audit Fees		2,600	2,000
Administration Fee		90,000	–
Competence Inquiries		26,787	20,768
Doctors Health Advisory Service		5,000	27,495
Expert Witnesses and Medical Assessments		149,638	13,945
General Administration Expenses		3,803	1,815
High Court Actions		48,326	15,335
Hire of Rooms		17,172	–
Legal Expenses (Medical Council and Preliminary Proceedings Committee)		834,351	390,014
Medical Practitioners Disciplinary Committee		624,625	498,644
Stenographers Fees and Expenses		64,046	9,381
Telephone and Tolls		8,117	7,061
TOTAL ADMINISTRATION AND OPERATING EXPENSES		1,877,188	987,849
COUNCIL AND COMMITTEE EXPENSES			
Council Expenses (Discipline)			
– Fees and Honorarium		253,703	65,422
– Expenses		68,299	30,295
Council Expenses (Health)			
– Fees and Expenses		8,521	8,816
Preliminary Proceedings Committee (Excluding Legal Member)			
– Fees and Honoraria		51,966	36,859
– Travelling, Accommodation and Secretarial Expenses		10,503	8,196
TOTAL COUNCIL AND COMMITTEE EXPENSES		392,992	149,588
TOTAL EXPENSES		$2,270,180	$1,137,437
Net (Deficit) Surplus for the Year Before Taxation		(39,034)	208,842
Tax Benefit to be realised		12,881	–
Net (Deficit) Surplus After Taxation		(26,153)	208,842
Accumulated (Deficit) brought forward 31/3/90	(64,566)		(273,408)
Prior Year Adjustment (Note 11)	(32,878)		–
		(97,444)	(273,408)
TOTAL DISCIPLINE FUND – DEFICIT		$(123,597)	$(64,566)

The accompanying notes on pages 36 to 38 form part of these financial statements.

STATEMENT OF CASH FLOW

for year ended 31 March 1991

Cash Flow from Statutory Functions	1991		1990
Cash was provided from			
Receipts pertaining to Statutory Functions and Administration fee from Dental Council	3,300,299		2,207,733
Cash was also distributed to			
Payment for Council Fees and Disbursements and Secretarial Expenses	(3,247,133)		(2,072,605)
Net Cash Flow from Statutory Functions		53,166	135,128
Cash Flow from Investing Activities			
Cash was provided from			
Interest Received	169,511		100,510
Cash was applied to			
Purchase of Assets	(85,396)		(25,315)
Short Term Investments	(151,697)		(197,660)
	(237,093)		(222,975)
Net Cash Used in Investing Activities		(67,582)	(122,465)
Net Increase (Decrease) in Cash Held		(14,416)	12,663
Opening Cash Brought Forward		37,846	25,183
Ending Cash Carried Forward		$23,430	$37,846

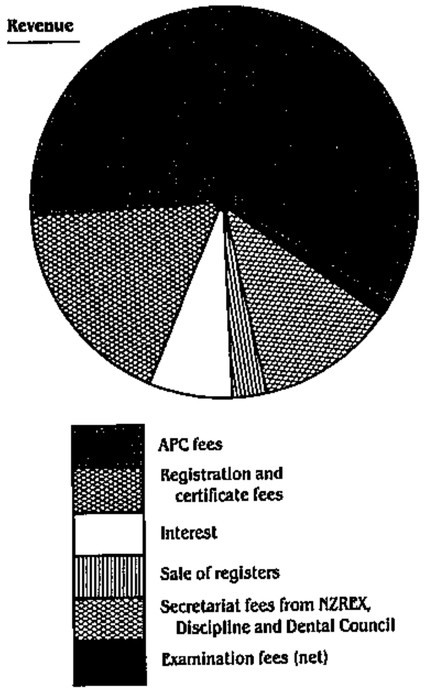
The accompanying notes on pages 36 to 38 form part of these financial statements.

DISTRIBUTION OF COUNCIL REVENUE AND EXPENDITURE

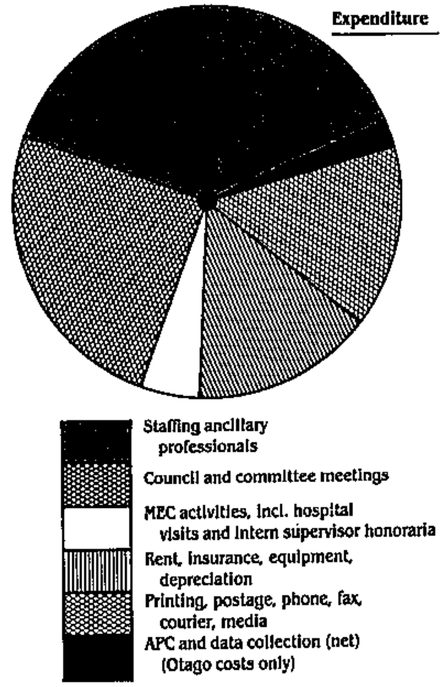
for year ended 31 March 1991

GENERAL FUND
(34% OF TURNOVER)

Revenue

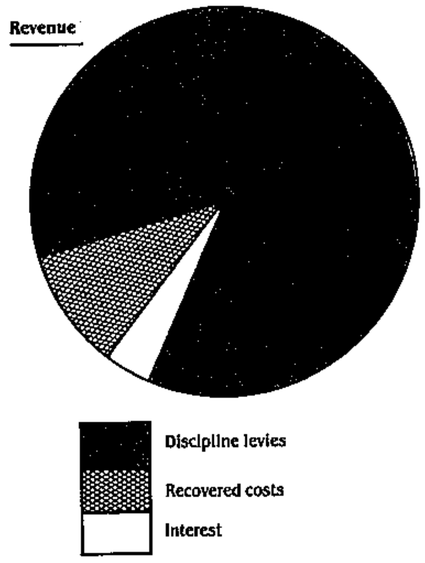


Expenditure

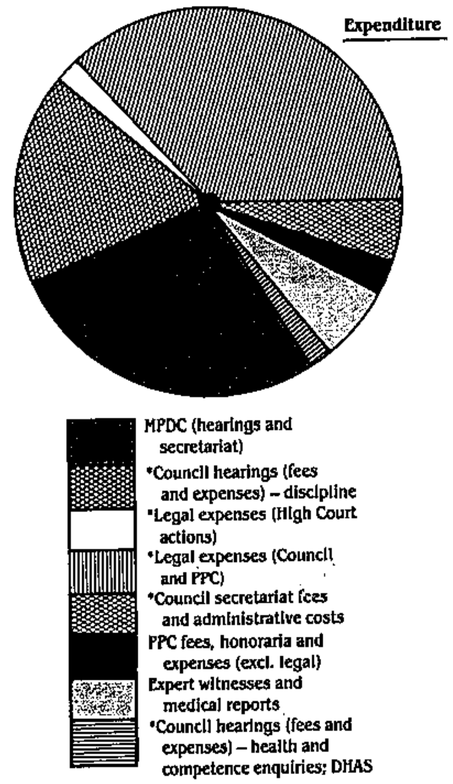


DISCIPLINE FUND
(66% OF TURNOVER)

Revenue



Expenditure



*Note: With the exception of DHAS, these items were combined in the graphics in the 1990 Annual Report.

These graphics are to be read in conjunction with the detailed Financial Reports on pages 36 to 43.

FEES

TO BE PAID ON APPLICATION FOR MEDICAL COUNCIL SERVICES DURING COUNCIL FINANCIAL YEAR 1 APRIL 1991 TO 31 MARCH 1992

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

		Fee	GST from 1/4/91	Total to Pay from 1/4/91
REGISTRATION: (Conditional or Full)				
On deposit of evidence of qualifications		170.67	21.33	192.00
For Provisional Certificate		26.67	3.33	30.00
For Annual Practising Certificate		92.00	11.50	103.50
For Discipline 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		95.11	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 Discipline Levy		235.00	29.38	264.38
For *restoration of name to Register after removal therefrom (including Provisional Certificate)		512.90	64.10	577.00
For initial entry on Register of Specialists		50.00	6.25	56.25
For entry on Register of Specialists in a second or further specialty		10.00	2.50	12.50
For initial entry on Indicative Register of General Practitioners		50.00	6.25	56.25
For change of name or other entry in Register, excluding change of address or entry of additional qualifications (free)		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 Discipline Levy to be paid at the time of this application

(1) Fee for persons registering for the first time between 1/04/91 and 30/10/91
(2) Fee for persons registering for the first time between 1/11/91 and 31/03/92