MEDICAL COUNCIL
OF NEW ZEALAND

ANNUAL REPORT
1988

MEDICAL COUNCIL OF NEW ZEALAND ANNUAL REPORT

FOR YEAR ENDED 30 JUNE 1988

MEMBERS OF THE MEDICAL COUNCIL

(At 30 June 1988)

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

SECRETARIAT

Secretary	Ms G.A. Jones, B.A.
Assistant Secretary	Mr J.R. Coster, B.A.
Council Offices	73 Courtenay Place, Wellington 1.
Postal Address	P.O. Box 9249, Wellington.
Telephone	(04) 847-635
Fax	(04) 858-902
Solicitors	Kensington Swan, P.O. Box 10246, Wellington.
Legal Assessor	Mr J.J. McGrath, Q.C., P.O. Box 637, Wellington.
Bankers	Bank of New Zealand, Courtenay Place Branch, Wellington. ANZ Banking Group (New Zealand) Limited, Courtenay Place Branch, Wellington.
Auditors	Miller, Dean and Partners, P.O. Box 11253, Wellington.

Secretariat	Secretary:	Ms G. A. Jones
	Assistant Secretary:	Mr J. Coster
	Clerk:	Mrs M. Barnes
	Clerk:	Ms A. Coleman
	Clerk:	Mrs J. Lui
	Secretary/Word Processor Operator:	Ms J. Hawken
	Accounts Officer (Part-time):	Ms C. Edwards
	Clerk (Part-time):	Ms J. Johns

MEDICAL EDUCATION COMMITTEE

Membership as at 30 June 1988

	Appointed by
Professor J.D. Hunter	Medical Council
Dr P.M. Barham	Royal New Zealand College of General Practitioners
Professor A.M. Clarke	ex officio, Dean, Christchurch School of Medicine, University of Otago
Professor D.S. Cole	ex officio, Dean, University of Auckland School of Medicine
Dr A.G. Dempster	Faculty of Medicine, University of Otago
Dr J.L. Jardine	Royal Australasian College of Surgeons
Dr G.M. Kirk	Royal Australasian College of Physicians
Professor J.D.K. North	Faculty of Medicine, University of Auckland
Professor T.V. O'Donnell	ex officio, Dean, Wellington School of Medicine, University of Otago
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 M.W. Guthrie	Observer, Department of Health

COMMITTEES

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

Preliminary Proceedings Committee
Dr D.S. Cole (Convener)
Dr R.H. Briant
Mr D.J. White (Legal Member)
retired March 1988
Mr P.H. Cook (Legal Member)
replaced Mr White

Finance and Management Committee
Dr W.S. Alexander (Chairman)
Ms C. Edwards
Ms G.A. Jones
Dr J.A. Treadwell

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

Registration Sub-Committee
Dr D.S. Cole (Convener)
Professor J.D. Hunter
Dr G.F. Lamb
Dr I.M. St George
Ms G.A. Jones

Specialist Registration Sub-Committee
Dr G.F. Lamb (Convener)
Dr D.S. Cole

Indicative Register Sub-Committee
Dr M.M. Herbert (Convener)
Ms G.A. Jones

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

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

CHAIRMAN'S REPORT

In issuing its Sixth Annual Report the Medical Council of New Zealand is pleased to give an account of progress and developments in the year ending 30 June 1988.

MEMBERSHIP

I have indicated in a separate section the changes which have taken place in the membership of the Council in the year under review. I would like to pay particular tribute to the assistance given to me by Dr Farrar and Dr Watson retiring members of Council who continued to perform most valuable functions until such time as their successors were appointed.

SECRETARY

It is a pleasure to record the continuing development of the administrative side of Council activities under the energetic leadership of Ms Georgina Jones. As a result of the move into more comfortable accommodation and particularly as a result of greatly improved staff relationships there has been relatively little turnover of administrative staff during the year, and even the peak times of administrative pressure have been managed with considerable efficiency. The installation of electronic data processing equipment in stages has enabled the increasing work load to be handled promptly and efficiently.

The addition in early 1987 of Ms Christine Edwards to the staff as Accounts Officer (half-time) has been of considerable value to the Council. She has taken over the procedures instituted under Dr Farrar's leadership in the Finance Committee and this side of the administration works very smoothly.

REGISTRATION

The continuing inflow of foreign medical graduates, particularly those appointed to junior posts in the hospital service continues to give the Medical Council a great deal of work. The Council itself is not concerned with immigration, nor with recruitment. Changes in policy in both these fields leave the Council in a position where it has to react to decisions taken by other bodies in the best way that it can.

Stewart Alexander

Changes in Council policy have been made and the present situation is that graduates of foreign medical schools appointed as junior hospital medical officers are given temporary registration for a maximum period of two years. During this time any of these doctors may sit the Probationary Registration Examination with a view to qualifying for probationary registration should they be permitted to remain in New Zealand. Until February 1988 this examination was conducted on behalf of the Medical Council of New Zealand by the University of Otago and we are most grateful for the efforts devoted by the staff of the University to this task. Council is concerned that if present pass rates in this examination continue there will be a number of these young doctors who cannot meet the reasonable standard of performance required for success in this examination. These doctors may have permission to remain in New Zealand permanently but it will not be possible for them to be registered as medical practitioners. Council has decided that a preliminary examination should be put in place. This will comprise a preliminary assessment of english language competence and a limited assessment of medical competence. This screening examination will be available to doctors before they leave their home country. This type of assessment is already operating in respect of entry to Australia and is not unlike the requirements for entry to practise in Canada.

From the August 1988 PRENZ for a period of five years the examination will be conducted by the University of Auckland Medical School and we thank the staff of that school for their cooperation. For at least the next few years the examination will need to be conducted twice annually with several hundred candidates likely to be seeking to sit the examination.

Candidates who are successful in the examination must still complete one year of probationary experience in approved hospital or supervised general practice posts. It is not intended that these doctors should be allowed to enter general practice without appropriate pre-registration vocational training.

REVISION OF THE MEDICAL PRACTITIONERS ACT

Progress has been made on proposals for the revision of the Medical Practitioners Act 1968. A working party with representatives of the Medical Practitioners Disciplinary Committee, New Zealand Medical Association and the Medical Council have produced a draft Act which will now be discussed with the Law Revision Committee and will then go to the legal branch of the Health Department prior to incorporation in the revised Act. Discussion papers have been published in the New Zealand Medical Journal on registration and composition of the Medical Council. Papers on the functions of the Medical Council, changes proposed for the Education Committee and proposals for the Health Section of the Act are also in preparation.

EDUCATION

The most important development in the field of education has been the formation of a Committee to visit the Medical Schools in New Zealand. Hitherto the fact that New Zealand Medical Schools remain accredited by the General Medical Council in the United Kingdom has been taken as a sufficient process of accreditation to meet the statutory requirements. The Medical Education Committee for some time has felt that New Zealand should be carrying out its own accreditation of Medical Schools.

Mr W.L. Renwick, recently retired Director General of Education, has agreed to serve on the Committee and act as its Convener. Further details of the activity of this Committee will be found in the report of the Chairman of the Medical Education Committee.

HEALTH

This year has seen the establishment of the Doctors Health Advisory Service. The Medical Council has promised to underwrite the costs incurred by this service in its establishment and operation. The Medical Council has no direct contact with the service and it is the intention of the Management Committee to ensure that there is no visible or invisible connection between the Disciplinary and Registering Authority and the Advisory Service itself. Whether this separation can be maintained indefinitely in every case remains to be seen. At some stage if patients are at risk the Medical Council must be involved. It is accepted that in the early stages of intervention it is

better that there be no direct threats of sanctions.

Now that the Doctors Health Advisory Service has been established attention can be devoted to the rehabilitation phase and proposals developed both to assist and to supervise this aspect of return to practice by doctors who have been sick or out of the medical workforce for any length of time.

For dealing with health related matters the Council itself has set in place a procedure similar to the General Medical Council with a Health Screener and Health Committee to make recommendations to Council.

COMPETENCE

This year there has been considerable attention by the media and by the public in general to issues relating to competence. The present Act is reasonably satisfactory for dealing with impairment resulting from disability due to ill health and the disciplinary system can deal with complaints on conduct. Allegations involving incompetence are less satisfactorily dealt with.

For the first time Council has been required to consider whether a particular specialist should remain on the Specialist Register. The question is whether that doctor is seen by colleagues in the specialty as having the competence necessary to be retained on the Specialist Register. The answer has taken a long time and has involved considerable costs but eventually a decision has been reached. There are undoubtedly other doctors listed on the Specialist Register (including some who are no longer in practice) whose competence to act as specialists must be in question. It is to be hoped that a less protracted and less costly method can be evolved to deal with these issues.

The present Act provides for the issuing of an Annual Practising Certificate to any doctor on the register who pays the appropriate fee. It is our view that the Council at this step in the procedure should have the power, where it has good grounds for believing that a doctor's competence is in question, to have a professional audit carried out before the practising certificate is renewed. Doctors like everyone else have to be re-examined for authority to drive their motor vehicles. It makes little sense that they should go through this procedure for driving and no procedure for measuring their competence to continue in a professional capacity.

The issue is all to do with standards. So long as the consumers of health care feel that they have received a service which is below standard there will be continuing criticism of the profession and of the systems in place for ensuring that standards are maintained. An essential part of the profession's response to society's demands must be the provision of adequate facilities for continuing medical education and some method to ensure that those who clearly need continuing medical education are getting it.

I would like to thank all members of Council and all members of the Council staff for their efforts during this year. There has been considerable pressure on the Council and on the staff in all their actvitities and it has not always been possible to deal with matters as expeditiously as we would have liked. Nevertheless I believe that there has been a continuous improvement throughout this past year and I thank all those who have contributed to it.

W.S. Alexander,
CHAIRMAN

MEMBERSHIP

As indicated in last year's annual report some delays were experienced in the appointment of new members to the Medical Council during 1987. Two members of Council who had given sterling service retired during the year. Dr Tom Farrar, who was a nominee of the Royal New Zealand College of General Practitioners had served on Council from 1981 to 1987. Dr Farrar was Chairman of the Finance and Management Committee for the last three years and during this time was responsibile for supervision of the re-housing of the Council in its present location and was also deeply involved in maintaining management procedures during the upheaval following the resignation of the Secretary. Under his wise and active management the financial affairs of the Council have reached a sound basis and this has provided a platform from which Council can now confidently expect to fulfil its functions.

Dr Ted Watson served on Council for six years from 1981 to 1987. He was a nominee of the Royal Australasian College of Surgeons. During part of this period Dr Watson served as Deputy Chairman of Council but in the last three years of his service performed the important function of Convener of the Preliminary Proceedings Committee. During this period the medical profession came under considerable criticism and the number of complaints requiring to be considered by the Preliminary Proceedings Committee increased markedly. Dr Watson's duties as Convener of the Preliminary Proceedings Committee were carried out with careful attention to detail, with consideration for the feelings of both complainants and of practitioners complained against and he served the profession with great distinction during a period in which his professional responsibilities were particularly heavy.

The Council thanks both these doctors for their dedicated service and the profession should be grateful to them.

Dr Robin Briant nominee of the Royal Australasian College of Physicians and Dr Bob Gudex nominee of the Royal New Zealand College of Obstetricians and Gynaecologists and Dr Murdoch Herbert nominee of the New Zealand Medical Association have each been reappointed for a further term. Dr John Broadfoot, a General Practitioner from Wanganui has been appointed as a nominee of the New Zealand Medical Association replacing Dr Bill Pryor. Dr Geoffrey Lamb, an Orthopaedic Surgeon of Auckland has been appointed on the nomination of the Royal Australasian College of Surgeons replacing Dr Watson. Dr Judith Treadwell, a Psychiatrist of Wellington has been appointed by the Minister of Health replacing the late Professor Medlicott. Dr Ian St George, General Practitioner of Dunedin has been appointed on the nomination of the Royal New Zealand College of General Practitioners replacing Dr Farrar.

Judith Treadwell

As the result of the appointments noted above the Council now has three general practitioners. Three of its members are women and this is a welcome development.

REPORT OF THE CERVICAL CANCER INQUIRY 1988

The following resolution of Council is included in this report for the information of all members of the profession. It has also been published in the New Zealand Medical Journal and circulated to all Medical Schools in New Zealand, Colleges and Special Societies, Area Health Board/Hospital Boards, the Chief Health Officer (Dr K. Poutasi), the Chief Medical Officer (Dr P. Talbot), the Minister of Health and to Judge Cartwright herself.

"The Medical Council of New Zealand has read and considered the Report of the Cervical Cancer Inquiry 1988, by Judge Silvia Cartwright. The Council acknowledges the Judge's detailed findings and supporting documentation, and recognises that the findings have implications for medical practice that go far beyond one hospital and one specialty.

The Medical Council

- believes that the concept of "clinical freedom" was never a valid reason to pursue a course of action contrary to standard treatment methods.
- gives notice to the profession and all professional institutions, that the general thrust of the findings will form part of the basis of assessment for individual registration, vocational/specialist registration and institutional accreditation. The necessity for peer review procedures for hospital accreditation was foreshadowed in our letter to hospitals in September 1986.
- requires that all hospitals inform the Medical Council about their systems currently in place for peer review and audit, and about the availability and functioning of committees to oversee treatment and research ethics.
- urges all Hospital and Area Health Boards, Medical Schools and Specialist and General Practice Colleges to incorporate the essence of the Report into their own programme developments. Matters of particular note are peer review, informed consent, patients rights, rights of patients to be treated with dignity and proceures for approval and surveillance of treatment methods. (Chapter 7 of Report, "Ethics and Patient Rights")
- notes that there are published plans for a major revision of procedures to deal with doctors who, by reason of impairment of their own competence, health or conduct, fail their patients. These plans incorporate a major role for the consumer in all deliberations and decisions."

REPORT OF THE SECRETARY

The trend in modern offices is towards more and more automation, accomplished with the technology now available – word processors, electronic typewriters, computers, photocopiers, facsimile machines, sophisticated telephone and mail despatch systems. The list is almost endless and the funds needed to keep up with the latest model if so desired infinite. But what really makes the difference is the people who must interact with the automated office, in particular those who must operate, manage, monitor and change, always ensuring that their expertise enhances the effectiveness of the technology and thus meets the needs of the organisation.

The Medical Council office is no different. We have upgraded our office equipment considerably over the last year and for this improvement we are thankful. But "the Secretariat" is in fact a small team of people who work hard to provide a professional and efficient service not only for the Council members themselves (and for the increasing number of sub-committees and working parties set up for particular tasks), but also for the benefit of nearly 9,000 registered medical practitioners. Countless enquirers, both overseas and local, by mail, phone and personal visit, seek a wide variety of information and guidance and necessary certificates and other documentation.

In the spirit of what one practitioner has called "the Council's glasnost", I take this opportunity to tell you briefly who makes up that team at 73 Courtenay Place and what their special responsibilities are. In so doing I hope the distant and impersonal feeling many people have about the Council and its office will be further broken down and the work of the executive staff acknowledged in context. They are now growing into a cooperative efficient expert workgroup, stable and cheerful,

Georgina Jones

and I believe deserve the respect of the profession.

In mid-1988 the people, mainly women, who comprise the Secretariat are:

Jo Hawken, who came to us from the Reserve Bank and has prime responsibility for *reception* and the huge volume of *word processing of correspondence, reports, agendas and minutes,* as well as the *accepted secretarial functions.*

Margaret Barnes, previously a practice nurse and lately of the Nursing Council staff, who primarily takes care of *overall office cohesion, travel, accommodation and catering arrangements for meetings, enquiries and full registrations of overseas graduates, PRENZ enquiries and examination administration,* and the transition from *conditional to full registration,* mainly of New Zealand graduates.

Angela Coleman, originally one of several student assistants for seasonal tasks but since graduation a full-time employee, who is in charge of all *enquiries and paperwork connected with initial and extended temporary registrations* of foreign medical graduates and *conditional registration of new local graduates,* provision of *certificates of good standing and registration* and compilation and distribution of *monthly circulars of amendments to the register.* Angela also assists with word processing and data management.

Jane Lui, trained and worked as a school dental nurse and was a former executive of the Dental Nurses Institute.

She now has responsibility for the *Dental Council clerical tasks* (since the Medical Council provides a secretariat for the seven member Dental Council and the 1,800 registered dental practitioners). For both Councils, Jane is *chief cashier,* sorting all *mail* and *receiving and banking all monies, issuing Annual Practising Certificates required during the practising year* (the yearly "APC exercise" requires involvement by other team members too), looking after *orders and sales of medical and dental registers.*

Jan Johns, started out as a "temp" (when we found it quite impossible to attract suitable permanent staff) progressed to permanent staff (chief cashier) and now works part-time as she has embarked on an education degree. She and law student **Grant Parker** have provided invaluable casual *help over peak periods,* particularly with respect to the yearly APC production line for both doctors and dentists (and its *time consuming follow-up).* This exercise gives rise to hundreds of amendments to the register (such as *changes of address, name, additional qualifications,* enquiries and applications for the *registers which indicate special training and experience)* and these matters are efficiently actioned by these young people.

Christine Edwards, the *Administrative Assistant – Accounts,* with a half-time appointment, meticulously safeguards the Council's finances, undertaking all *accounting, payroll, fees, tax, investment and budget preparation functions* so that accurate and specific information is available to management at all times.

John Coster, joined the Council in 1982 after many years of civil service experience in social security, defence and health, and as *Assistant Secretary* now acts as *Council Minutes Secretary, Committee Clerk* for the *Finance and Management, Specialist and General Practice Registration and Medical Education Committees* (plus their offspring such as *intern supervisors meetings, hospital visits for review of conditional year experience,* and the innovative *review and accreditation of undergraduate medical education).* He is also *administrator for probationary and specialist registration,* including the large number of requests for information from employers and foreign doctors wanting to fill vacancies at consultant level.

I was appointed as *Secretary to Council* in mid 1986 having been employed for the preceding ten years at the University of Auckland in Continuing Education and School of Medicine Administration and prior to that in work involving foreign students (including doctors), community development and medical social services. My *main functions are as Chief Executive of the Council and manager of the Secretariat.* I take particular responsibility for all *discipline, health, and examination matters, liaison with other organisations, preparation of Council agendas and papers,* and "trouble shooting" in the *non-routine aspects of registration.* (I am also the Secretary of the Dental Council of New Zealand and carry out all statutory functions of that office.)

Many other tasks, such as removals from the register and the establishment of the Indicative Register of General Practitioners have been shared amongst the whole team as gaps in the workflow allowed.

I have set out these brief notes on the people and their particular functions to help you understand the volume and the complexity of the day to day work of the secretariat. Although many of our communications with you must inevitably be "mass prdouced", I trust you nevertheless in the main do obtain the quality of service you expect. I believe that this year, with a dedicated staff, we have shortened the response time for most of the documents you require and have been able to give prompt and accurate advice on request. Of course I accept that occasional delays and errors arise in this kind of operation and ask for your understanding if you have been a victim of such frustrations. We welcome constructive comment and suggestions.

The burden of additional workload arising out of the increased frequency and candidate numbers for PRENZ, the creation of the Indicative Register, and the mobility of junior doctors now exacerbated by the influx of overseas graduates, has been absorbed by the present staff only because of increased efficiency in other areas of the ongoing work. I hope this pattern will prevail in the coming year as more refinements are made to data and records management, word processing and job design. Space is still a problem even in the Council's new premises as insufficient thought was given in the planning stages to the impact of electronic data processing and unforeseen developments in work patterns. Although the environment is now very attractive, there are some deficiencies from the ergonomic viewpoint still to be overcome.

It appears to me that the Secretariat's relations with those in headquarters of the New Zealand Medical Association, the Colleges, the medical schools, the Department of Health, the hospital and area health boards and overseas registration boards are good and that our liaison over matters of mutual concern is not only leading to greater understanding of our respective roles but also to tangible results. There is still room however for more consultation about the development and implementation of new policies affecting the medical workforce and this goal is one of the secretariat's priorities for the coming year.

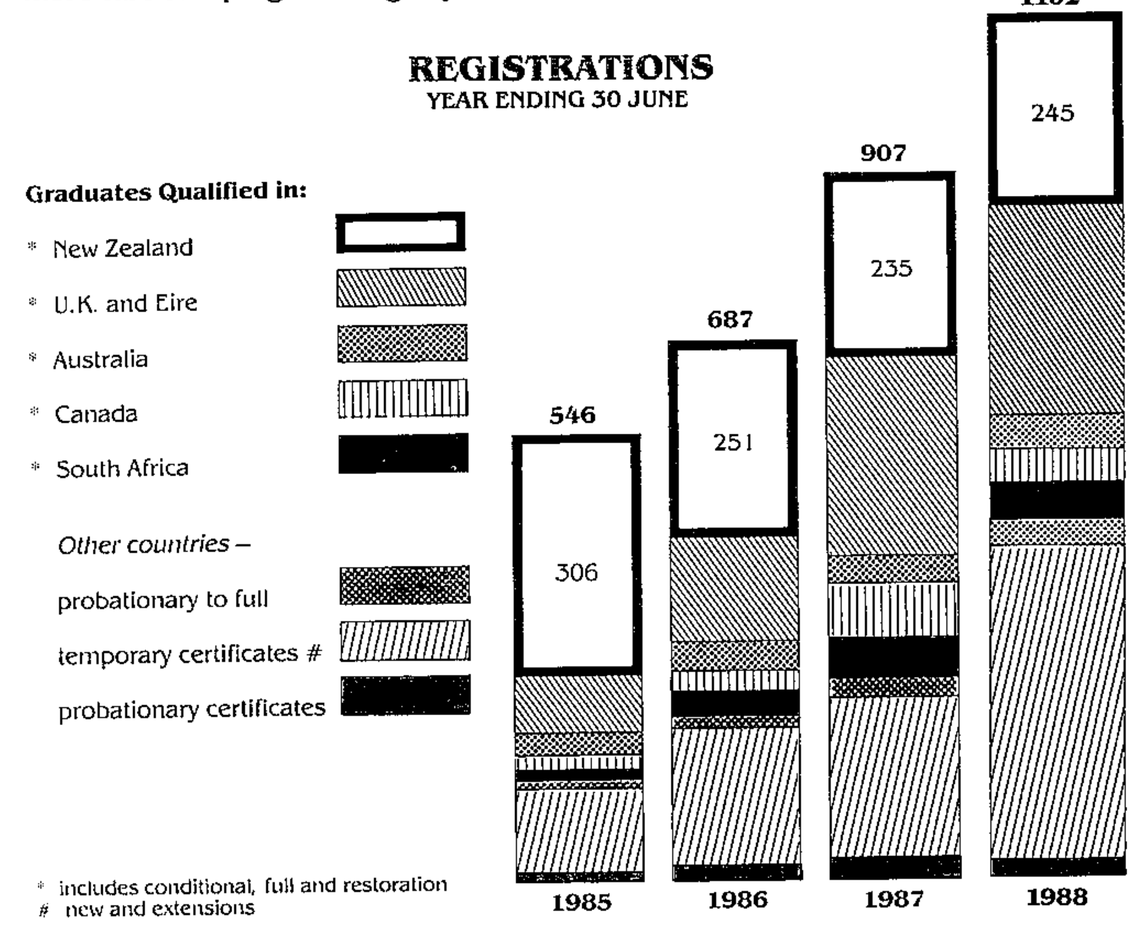
Two situations continue to prevail which cost the Council (and thus the practitioners) unnecessary time and money. Repeated reminders about them seem to have little effect. Steps to overcome this inertia are under consideration for the new Act. I am certain you will not be surprised when I say that these perennials are *failure to report changes of address and serious procrastination in paying for annual practising certificates or returning the application form appropriately completed.* These are *mandatory statutory obligations* – they should be entered as essential tasks in every registered medical practitioner's management diary. Thousands of dollars in postage and administrative resources are wasted (not to mention lost revenue) trying to track doctors down. Some end up being removed from the register although they are no doubt still practising in New Zealand. Others go on claiming benefits to which they are not entitled. Liaison with the Department of Health with respect to both these derelictions has been stepped up – I urge you to avoid punitive action by making a greater effort to organise yourselves.

There is one other matter which I feel compelled to raise. That is gender-specific language. It is appropriate to do so in this year's Annual Report, in light of the present heightened focus on the relationships of doctors and the community. Members of the profession have much to offer through their knowledge, skill and understanding, but also much to learn. In particular, the sensitivity of doctors to the needs and concerns of women could be improved. I am saddened that so many practitioners still use sexist language in

their everyday communications both written and oral. This is an important issue, and I do believe that we must each make a conscious effort to reform, so that we demonstrate our respect for others. Breaking the habit is not easy. It may be mere laziness, habit or lack of awareness and it implies the unacceptable attitudes of some doctors which are at last being rejected by society. For example I find it insulting that the majority of letters I receive from practitioners in New Zealand are addressed *"Dear Sir"*, despite the fact that I have now held the office of Secretary for over two years and my full name has been on every document and letter I have sent in that period. A little more care or reprogramming of your wordprocessor would be welcome by all the women you address. The booklet "Watch Your Language" published this year by the State Services Commission provides useful advice.

It has been a challenging year and I greatly appreciate the cooperation I have experienced from Council and committee members, staff and the profession in general. I am sure we have a great many strengths which the coming year will allow us ample scope to express. I look foward to further constructive change and development of the Council's work. Your feedback is always valued.

Georgina A. Jones,
SECRETARY.



LAY MEMBER'S REPORT

This year has been significant for the results which have been achieved in the areas of conduct and discipline. A working party drawn from the Medical Council and the Medical Practitioners Disciplinary Committee has met regularly and is proposing a revised disciplinary process which would have increased lay participation and a new committee structure. While this has been in progress the Medical Council approached a wide range of consumer groups explaining that the disciplinary process was under review and that the Council was soliciting suggestions and ideas from them as consumers in the health system. The working party proposals were not distributed at this time because there was a desire to elicit input which had not been influenced in any way by proposals from the medical profession.

The response was very rewarding with groups providing conclusions which have been drawn from consumer research both in New Zealand and overseas. The working party proposals were then sent out and comment was requested from the same groups. Hopefully this interchange of information will produce proposals which offer the consumer protection and an involvement in the monitoring of health services and as well will help the professionals who provide the service to maintain the highest standards of medical practice.

One of the proposals which I support strongly is that of having a lay mediator/observer attached to each Area Health Board. Obviously these people would have to be selected with care and only be those who could work effectively with a wide cross section of the community and not be intimidated by high ranking professionals. The public needs easy and quick access to the complaints system and setting up


Patricia Judd

this service within area health board premises or hospitals would provide an identifiable place easily approached by those who feel dissatisfied or aggrieved about some aspect of their health care and are looking for a resolution of their problem.

In conjunction with this close examination of the systems for conduct and discipline, the Council has addressed the need to protect the public from unwell and incompetent medical practitioners. The Health Committee of the Medical Council has been established, the completely independent Doctors Health Advisory Service is operational and the Council has adjudicated two matters concerning competence in recent months.

The area which is the Medical Council's prime responsibility, that of registration, has also been under review. With the increased intake of overseas trained doctors the screening system used by the Council has come under pressure. Accordingly, the Council has looked at systems used in Australia, Canada and Britain and is moving quickly to introduce a comparable initial evaluating system for New Zealand. As a consumer I have expressed concern that overseas trained medical practitioners can be working and assuming responsibilities in our hospitals for one or two years before being required to sit the examination which determines the New Zealand standard of medical competence.

The majority of patients in our hospitals are unable to differentiate

between say registrars and others more senior in the system and they are totally dependent on the integrity of the hospitals supervisory procedures and the standards maintained through the Medical Council. It is hoped that the new procedures will provide greater consumer protection.

Medical Education has also been under review and an Accreditation Committee to review both medical schools' courses was established. Again it was deemed important that other sectors in the community joined the medical members of the team. Accordingly the Review Committee was chaired by a former Director-General of Education and there were nominees from the Ministry of Womens Affairs, Maori Affairs Department, the Nursing profession, community health, and other faculties from the University. Their report will be of interest to both the profession and the public. As the lay representative on the Medical Council it has been reassuring to be part of a committee which is keen to have consumer input at this time of change.

P. C. Judd,
LAY MEMBER.

REPORT OF THE MEDICAL EDUCATION COMMITTEE

The Committee met three times during the year and, in addition, representatives of the Committee met with intern supervisors from the South Island in the first of a series of such meetings to be held in three regions of the country during 1988.

Hospital accreditation for conditional registration purposes continued in 1987/88, on the three-yearly visitation basis, with visits in 1988 to hospitals in Northland, Taumarunui, Gisborne, Taranaki Base, Hawera, Wanganui, Masterton, Nelson and Timaru. Over the last year accreditation has not been withdrawn from any hospital on the gazetted list.

In addition to this regular accreditation of hospitals the Education Committee undertook a re-examination of its role and responsibilities and brought forward further revised recommendations to Council. After agreement by Council to proceed, various actions were taken during the year, these including:

1. A structured and more formal process of accreditation of the two undergraduate medical courses was introduced and a review committee of ten members was set up under the chairmanship of Mr W.L. Renwick, recently retired Director-General of Education. Other members included four medical professionals (Professor P.R. Joyce, Mr J.L. Jardine, Dr L.B. Quennell and Dr A.A. Young) and five lay members involved in other fields of education (Associate-Professor J.D.S. McKenzie, Mrs R.A. Novitz, Mrs I.M. Sherrard, Mrs H. Thomson and Mr S. Rolleston). The review process, which commenced in June 1988, has included on-site visitations to the Schools of Medicine. The Review Committee's report will be considered by the Medical Education Committee and then referred to Council later this year.

John Hunter

2. Recommendations on amendments to the Medical Practitioners Act as relating specifically to the Medical Education Committee and its functions were prepared and are about to be forwarded by Council to the Minister. The proposed amendments have referred particularly to functions as set out in Section 9 of the Act, to a possible modified membership of the Committee as previously set out in Section 8, and to possible additional statutory responsibilities for the Committee, in particular "to exercise a general supervision and undertake regular accreditation of the postgraduate qualifications and training prerequisites used for vocational/ specialist registration purposes in New Zealand".

3. The Medical Education Commitee also began a review of training and educational requirements desirable for interns in the conditional registration year, this to complement the Committee's traditional function of accreditation of hospitals. In this regard the Committee has noted the revised "Recommendations on General Clinical Training" in the pre-registration year as published by the General Medical Council in October 1987.

In an effort to achieve a closer examination of possible educational prerequisites for this important intern year, as well as to enhance closer communication with intern supervisors, a series of regional meetings with the supervisors was introduced in early 1988. The intern supervisors, of whom there are 37 in the country, continue to

give valuable service to the Medical Council, the accredited hospitals and to the interns. Currently, in some of the larger metropolitan hospitals there remains considerable concern about the effect of the existing Resident Medical Officers' rostering system (applied under the HS57 determination) on training and education in the pre-registration year. Visiting Committee members will continue to monitor this situation as well as the ongoing development, or otherwise, of peer review processes in hospitals to be accredited. The outcome from these further explorations will be examined later in 1988.

4. The matter of basic vocational education requirements for those entering independent general practice without enrolling in the Family Medicine Training Programme and the question as to whether the period of conditional registration should be extended to two years (the second year to be undertaken in an approved hospital or approved general practice) has received further consideration but no action has been taken by Council at this stage. The future use of the indicative register may have a bearing on the outcome of this issue, so also any changes that might be approved in an amended Medical Practitioners Act.

J. D. Hunter,
CHAIRMAN.

AMENDMENTS TO REGISTER

YEAR ENDING 30 JUNE

		1985	1986	1987	1988
(a)	**Removals on account of**				
	Disciplinary proceedings	1	1	2	1
	Death	52	38	48	45
	Failure to notify change of address	38	18	61	137
	Non-residence of overseas graduates	102	45	60	270
	and at own request	27	30	29	38
(b)	**Changes of name**	25	17	24	22
(c)	**Additional qualifications**	300	170	177	377
(d)	**Changes of address** (approximate figures)	1,800	1,950	2,050	2,560

REPORT OF THE PRELIMINARY PROCEEDINGS COMMITTEE

The present Convener took over a year ago and Dr Robin Briant formally became the second medical member in September 1987. In March 1988 Mr Douglas White, the legal member, took silk and the Council appointed Mr Philip Cook a partner in the Wellington firm of Kensington Swan to replace him. The Council is greatly indebted to Mr White QC, who has for six years been the legal member and has prosecuted many cases in front of the Medical Council of New Zealand and one in front of the Medical Practitioners Disciplinary Committee. His skills will still be available to the Preliminary Proceedings Committee as an independent counsel.

The data for complaints referred to the Convener of the P.P.C. are as follows:

David Cole

Robin Briant

For Year From 30/6/87 to 30/6/88	
Cases under consideration at 30/6/87	4
Cases under consideration at 30/6/88	19
Cases which were not proceeded with or withdrawn (some with a warning letter)	5
Cases referred to Ethical Committee of N.Z.M.A.	1
Cases referred to Health Committee to M.C.N.Z.*	1
Cases referred directly to the M.P.D.C.™	4
Cases referred to M.P.D.C.™ after investigation	1
Cases heard and convicted by M.C.N.Z.*	2
Cases awaiting hearing by M.C.N.Z.*	1
Cases still under investigation (of which 4 are almost ready for M.C.N.Z.* hearing)	18

™ M.P.D.C. = Medical Practitioners Disciplinary Committee
* M.C.N.Z. = Medical Council of New Zealand

As the data shows, there has been a marked increase in the work of the P.P.C. for which there are a number of reasons. A contributing factor is an increased willingness of patients or their relatives, to lay a formal complaint to Council or to M.P.D.C. – that is undoubtedly a trend and one that will continue. A further reason is that by agreement the P.P.C., which alone has statutory powers of investigation, is receiving some complaints referred by the M.P.D.C. Chairman. These complicated and serious cases merit investigation prior to hearing. Complaints involving death or serious disability, especially in the hospital service, may well require considerable sorting out. Until a new Act with wider and separate investigating procedures is in operation, the high workload of the P.P.C. will continue. The A.C.C. also laid two complaints this year, one alleging incompetence and one alleging fraud.

The fact that a good many cases are still under consideration, some of many months duration, deserves some explanation. There are two principal reasons. The first is that as frequent appeals to higher courts show, the

standard of proof required in disciplinary cases is certainly increasing. Where doctors may be deprived of their livelihood by suspension or erasure, the standard of proof is close to the criminal standard (i.e. beyond reasonable doubt) rather than the civil standard (i.e. on the balance of probabilities). This means the investigating P.P.C. may need more than one meeting with the parties concerned and must prepare affidavits, or seek special advice. The medical defence societies also need time and, not infrequently, ask for extensions. Nor should one underestimate the very extensive checking work required in cases relating to pharmaceutical drug prescriptions of which a number have been and are being considered.

The second reason, not unconnected with this high level of investigation, is the lack of a permanent secretariat and reliance on the part-time activities of two busy doctors and a lawyer. The new Act has provision for a secretariat to handle all complaints and where the matter requires investigation then more professional and more extensive help is needed. Private investigators are both expensive and not entirely appropriate and it is likely the secretariat will employ an appropriately trained investigator as the G.M.C. lawyers have done in the U.K.

During the year, the Convener, took part in a number of Discipline Working Party meetings, along with Dr Alexander, Mrs P. Judd, Mr D. White and the Secretary. These discussions with lawyers and the N.Z.M.A. have provided a sound basic plan. The public view seems to be that such committees should have equal numbers of lay persons. However, most of those fully conversant with the process believe the need is for a substantially increased or equal number of lay people both as watchdogs of the process and as the patient's voice in decisions. The frequently complicated medical nature of the hearings means that a substantial medical presence is needed, particularly to do the 'leg-work' and to retain the confidence of the profession.

Last year the P.P.C. drew attention to the issue of allegations of sexual harassment and this worrying issue continues. There is also evidence of persisting and improper indiscriminate prescribing of drugs of abuse. The Health Department pharmaceutical surveillance section and the P.P.C. are cooperating in this area, where there have already been some convictions.

The P.P.C. supports the comments that it is confusing to consider allegations of incompetence within the conduct and disciplinary procedures. It is manifestly inadequate to find an incompetent doctor guilty of misconduct or unbecoming conduct and impose a fine or reprimand. Often the real need is rehabilitation and retraining and while some patients want retribution, most want assurance that this misadventure will not occur again. The Council will seek a separate process in the Act to handle incompetence rather than lumping it in with frank misbehaviour and disgraceful conduct.

Finally, it is a fact of modern medico-legal life that the costs of discipline are rising dramatically and until some consolidation in an independent secretariat is achieved the actual costs, ignoring the voluntary time given by many colleagues, cannot be readily contained. No state money has been contributed to the process of managing complaints by the statutory bodies and such independence is important.

D.S. Cole
CONVENER.

REPORT OF THE HEALTH COMMITTEE

The Medical Council established a Health Committee this year to support the Health Screener and to manage health related problems in the medical profession.

At the first approach to the Council Secretary the option of referral to the D.H.A.S. might be offered. If that approach was not appropriate the matter could be referred to the Health Screener.

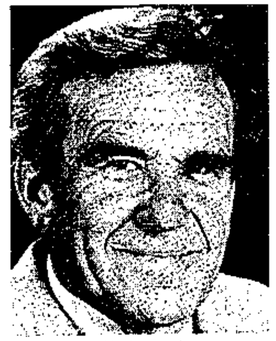
Referrals reach the Screener in various ways including information from a relative, colleague, patient, Medical Officer of Health, or an employer.

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

The Health Committee would like to see members of the medical profession better prepared to deal with stress in themselves and in their colleagues and will work towards improvement in that situation.

SUMMARY OF ACTIVITIES

During the twelve months to 30 June 1988 the Health Committee has been involved with Council in the following deliberations related to impaired practitioners.



Bob Gudex

1 doctor suspended following special investigation into competence and health

11 progress reports received, of which one resulted in the reimposition of full suspension

6 applications received for revocation of suspension (including 4 heard in person), of which 2 resulted in revocation, 2 in variation of the suspension order to permit limited practice and 2 in adjournment pending receipt of further medical reports

1 application from the Department of Health that Council recommend to the Minister prohibition of prescribing under Section 23 of the Misuse of Drugs Act was heard and approved

1 application for registration from a doctor under the voluntary surveillance of an overseas health screener was heard and a recommendation made to Council that a form of registration be granted where similar monitoring could continue for the first 12 months in New Zealand.

As at 30 June 1988, 12 doctors were subject to suspension orders under Section 34 of the Medical Practitioners Act. Of these 5 are not permitted any form of practice, their suspensions having been in effect since 1978, 1980, 1982, 1983 and 1984 respectively. Seven have however had their suspension orders varied to permit practice under certain clearly specified conditions which include adequate supervision and monitoring of their health during the rehabilitation phase

and regular reporting to Council. These doctors were suspended in 1973, 1983, 1985, 1986 and 1987 (3 doctors).

In addition, the Chairman of Council, currently acting as Health Screener, reported that he was monitoring 6 cases which did not at this stage require intervention under Section 34. One further case was causing concern due to the practitioner's unwillingness to participate in peer review to establish fitness to practise. This was an issue which would be addressed in the new Act.

R. G. Gudex
CONVENER

THE PROBATIONARY REGISTRATION EXAMINATION IN NEW ZEALAND (PRENZ)

This examination for foreign medical graduates who intend to remain in New Zealand for longer than two years but do not have basic medical qualfications which entitle them to full registration has been conducted each year since 1984.

In view of changes in New Zealand's immigration policy and the rapidly increasing numbers of "temporary" recruits to the medical workforce who have applied for or been granted permanent residence, PRENZ was held twice in 1988 and will be offered twice annually (session I normally in February/March and session II normally in August)in future. An information booklet is available on request from the Council secretariat.

The number of attempts rose dramatically to 87 in 1988. The fomat of the examination (at fifth and sixth year New Zealand medical student level) remained as before, namely written and clinical/oral sections, but in August 1988 the written examination contained multiple choice and short answer questions only as these can be managed more effectively for larger numbers of candidates. Nevertheless the fees overall for the examination must be set in the $1,650 – $2,000 range to cover actual costs.

Despite the fact that the majority of candidates in 1988 had already been working in New Zealand hospitals for at least one or two years, the pass rate was low. This situation also pertains in other countries, e.g. Australia, Canada, U.S.A. U.K., conducting similar examinations.

A pre-employment screening examination with medical and english components is now being developed for administration in New Zealand and overseas, commencing in mid-1989 if possible.

SUMMARY OF PRENZ RESULTS 1984 TO 1988

Country of Training	1984-1987 Written No. Cand.	1984-1987 Clinical Pass	1988 Written No. Cand.	1988 Proceed to Clin.	1988 Clinical No. Cand.	1988 Pass	1984-1988 Overall Pass Rate
Albania			2	0/2			0/2
Cambodia			1	0/1			0/1
China	1	–	2	–			0/1
Egypt	1	1	11	3	3	2	2/11
Fiji			1	–	–		0/2
France	1	–	1	1	1	1	2/2
India	12	5	35	12	18	5	10/47
Iran			1	–	–		0/1
Japan	1	–	1	1	1	–	0/1
Netherlands	2	2					2/2
Nigeria			1	1	1	–	0/1
Pakistan	3	1					1/3
Papua New Guinea			6	1	1	1	0/6
Peru	3		1	–	–		0/4
Philippines	3	1					1/3
Poland			1	1	1	–	0/1
Romania	1	–	1	1	1	1	1/2
Singapore			1	–	–		0/2
Sri Lanka			8	3	3	1	1/8
Switzerland	2	–					0/2
Taiwan	1	1	12	4	5	3	1/1 5/21
W. Germany	9	2					
Vietnam	1	1					1/1
Zambia	1	–	2	–	–		0/3
TOTAL	41[b]	14[b]	87[c]	26[d]	32[e]	12[f]	26/128
	Overall Pass Rate 34%			Overall Pass Rate 14%			20%

Notes: a Includes 9 repeat attempts
b Includes 7 passes on re-examination
c Includes 15 repeat attempts
d Includes 10 provisional passes only
e Includes 7 repeats of part of all of clinical
f Includes 3 passes on re-examination

REPORT OF THE MEDICAL PRACTITIONERS DATA COMMITTEE

Medical workforce data collection continued in 1987 and the annual questionnaire to registered medical practitioners was modified slightly for 1988. Further modifications will be introduced in 1989. The 1988 questionnaire sought additional information from practitioners for the purpose of identifying further factors that might improve predictability of future workforce trends, for example information on expected early retirements and on "overseas experience". As before, questionnaires were sent to all registered medical practitioners with a New Zealand address in the register at the end of February. The emphasis has been on the collection of data from those in the "active" New Zealand medical workforce as opposed to total registrations.

Selected figures reflecting the composition of the 1987 medical workforce are given in tables 2 and 3. The total "active" workforce has again increased, reaching a figure of 6095, this representing a 6% increase over the 1986 figure and a 25% increase since 1980. New Zealand graduates in the "active" workforce in 1987 total 4302 (70% of workforce), this representing a 3% increase in the last year and a 32% increase since 1980. The number of overseas graduates (approimxately 30% of the total workforce in 1987) have increased by 15% over last year's figure and by 11% since 1980.

General practitioners have shared in the general workforce increase and this group remains stable at 37% of the total active workforce. Information is now being sought on the number of graduates entering general practice without recognised vocational training.

As expected by virtue of the limited service scheme for Registered Medical Officers, the number of temporary registrants (numbers that are not included in the active workforce tables) has now increased to 232. House officers who are overseas graduates but fully or conditionally registered have increased from 29 in 1984 to 192 in 1987.

During the year the Data Committee met to review administrative and access arrangements with representatives of the Department of Health with a view to renegotiation on responsibilities and funding. Many requests for data and analyses of various medical workforce groups continue to be received from an increasing number of professional bodies and individual researchers. Council's policy is again reconfirmed that confidentiality and anonymity must be guaranteed before information is

Table 1

NEW ZEALAND MEDICAL REGISTRATION INFORMATION

as at 30 June 1988

Total practitioners on register	8,980
Total practitioners with practising certificates	6,664
Temporary registrants	232
New probationary registrants	24
Names removed from register (various reasons)	446
Practitioners deceased	45

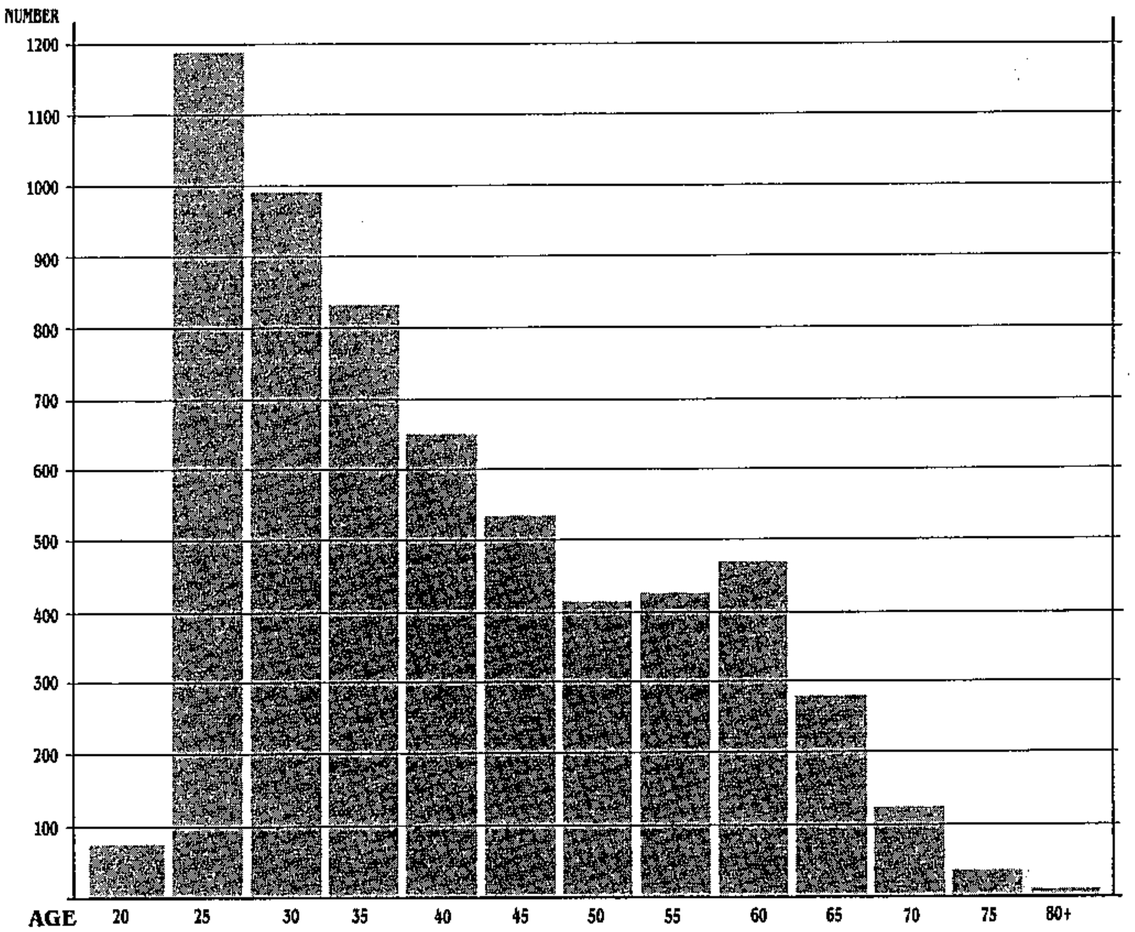
NEW ZEALAND MEDICAL WORKFORCE 1987

Table 2

	1983		1984		1985		1986		1987	
	Total	N.Z. Graduates	Total	N.Z. Graduates	Total	N.Z. Graduates	Total	N.Z. Graduates	Total	N.Z. Graduates
Active	5403	3854	5437	3936	5556	4095	5747	4188	6095	4302
Full-time Equivalents	5043.8	3634.5	5061.3	3704.1	5156.1	3834.3	5330.3	3913.5	5620.0	3986.5
House Officers	648	599	627	598	628	600	668	568	731	539
Registrars	662	495	695	565	718	592	746	630	780	626
Medical Officers Special Scale	166	81	159	77	150	75	149	67	167	74
General Practitioners	1968	1321	1998	1353	2106	1473	2141	1512	2278	1601
Other Primary Medical Care	78	43	89	55	95	62	103	70	125	85
Specialists	1784	1267	1770	1239	1767	1248	1819	1272	1897	1306
Miscellaneous (non-specialist)	97	48	99	49	92	45	121	69	117	71

Table 3

AGE DISTRIBUTION – 1987
OF THE N.Z. ACTIVE MEDICAL WORKFORCE



released. Only professional representatives or organisations, as opposed to commercial agencies, have potential access to data. Only statistical information is released or material mailed to a listing of practitioners on behalf of the investigator. Justification of the research and the bona fides of the investigating body must be provided in a formal application to Council. Even given that the release of data is approved, because of the current workload and other priorities, it is not always possible to provide workforce information without unavoidable delays.

J.D. Hunter,
CHAIRMAN.

REPORT OF THE SPECIALIST REGISTRATION SUB-COMMITTEE

The Specialist Register continues to grow steadily. The total number on the specialist register at 30 June 1988 is 2083 spread among the various categories as shown in the table below. The largest increases were in Anaesthetics, Internal Medicine and Psychiatry.

Use of the category "Specialist-eligible" has continued, its particular applicability being to those overseas graduates who are seeking posts in New Zealand and who (or whose prospective employers) wish to know in advance what their status would be here. (New Zealand graduates who have satisfied the Council that they are eligible for specialist status but who are not yet so employed are dubbed specialist-elect.)


Geoffrey Lamb

As foreshadowed in the 1987 report of this sub-committee the removal of a name from the register of specialists for professional incompetence occurred this year and the profession needs to be aware of the increasing emphasis on, and public demand for, peer review and reassessment. Recertification, although a current

NUMBERS IN EACH SPECIALTY AT 30 JUNE

	1987	1988
Anaesthetics	200	219
Community Medicine	121	127
Dermatology	35	35
Diagnostic Radiology	118	124
Gynaecology	1	1
Internal Medicine	355	369
Obstetrics	1	1
Obstetrics and Gynaecology	154	162
Ophthalmology	82	83
Orthopaedic Surgery	94	102
Otolaryngology	57	59
Paediatrics	113	121
Pathology	134	140
Psychological Medicine or Psychiatry	179	191
Radiotherapy	18	23
Surgery and Sub-Specialities		
Cardiothoracic Surgery	17	18
General Surgery	215	218
Neurosurgery	13	12
Paediatric Surgery	4	4
Plastic Surgery	25	26
Urology	29	29
Venereology	20	19
TOTAL	1,985	2,083

reality within the United States, is still some way off for New Zealand but the various events of the past year stress the importance for the of vigilance in its maintenance of standards both of practice and behaviour. The nettle of assessment of competence of practising doctors is one which the colleges and other referral bodies need to grasp if the profession is to continue to be self-regulating.

The Council is grateful to the Referral Bodies on whose opinions it relies for assistance in matters concerning specialist registration and for whom this work represents a significant burden.

Members of the profession who have suggestions or opinions to offer on the mechanisms of specialist registration are most welcome to communicate them to the Convener, particularly at this time when the Medical Practitioners Act is in the process of revision.

G.F. Lamb,
CONVENER.

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

Since the Medical Practitioners (Registration of General Practitioners) Regulations 1987 came into force on 1 April 1987, establishment of the Register has proceeded smoothly, despite some initial confusion among some members of the profession.

The intention of the Register is to *indicate* to the public, to medical colleagues, and to anyone else who is interested, that the doctors on the register have been adequately trained, or are experienced practitioners, and that so far as is possible, their practice is confined to that of general practice.

Until 31 March 1990, a general practitioner who has been qualified for five years and has been in general practice for not less than three years is entitled to apply for inclusion in the Register of General Practitioners.

The three classes of applicants which have caused problems are:

(a) Those who have had sufficient training and/or experience, but who are not in general practice in New Zealand, either because they are overseas or because they are engaged in some other branch of medicine at present. Since the register is indicative, it has been decided to hold these applicants in an "eligible" classification pending their re-entry into general practice in New Zealand.

(b) Applicants who have been three years in general practice, but who have not been engaged full-time in general practice during the three years. The Registration Sub-committee of Council, bearing in mind the information obtained by, and the recommendations of the referral body, has to make a decision when sufficient experience has been acquired.

The particular difficulties of women practitioners who are working as well as rearing a family, have been kept in mind in this respect.

Murdoch Herbert

(c) Applicants, especially in the smaller towns, who have to combine practice in another specialty with general practice. These applicants may already be on the Specialist Register in another discipline. While it has been adopted as Medical Council policy that no doctor should be on two registers at the one time, it is recognised that there will be some exceptions owing to the organisation of medical services in smaller towns in New Zealand. As a rule, these applicants are expected to spend at least 5/10 of their time in general practice. The opinions of the Specialist Referral Bodies on this matter are being sought.

Acknowledgement is made of the help the Sub-comittee has received from the Royal New Zealand College of General Practitioners which has acted as the Referral Body in this discipline and the work of the council Secretariat in publicising the new register and actioning applications and admissions.

875 applications have been received since 1 April 1987, and have been sent for consideration to the Referral Body. Of these, 652 have been approved by 29 June 1988, 15 have been refused admission and some have been required to obtain further experience in general practice. 6 who are overseas have been placed in the "eligible" category.

Some applicants may have experienced delay in a decision being

forwarded to them. In most cases this is due to insufficient information being provided on training or experience on the original application, necessitating further more detailed enquiries before the Sub-committee can reach a final decision.

There is considerable pressure, both from outside and inside the profession, that doctors on any register should be expected to retain sufficient competence to remain on that register and the Convener would welcome submissions from interested parties on any aspect of continuing competence in general practice.

M.M. Herbert
CONVENER.

Ian St George

John Broadfoot

REPORT OF THE FINANCE AND MANAGEMENT COMMITTEE

This report covers the period from 1 July 1987 to 30 June 1988 although the financial statements included with it cover the period from 1 April 1987 to 31 March 1988.

1. COUNCIL PREMISES

The Council premises have been improved by the installation of air conditioning in the Board Room and main offices. The next step in the modernisation will be the installation of a modern filing system.

2. COMPUTERISATION

The computer programme which is related to office procedures is being implemented in stages and is streamlining routine procedures considerably.

3. INCOME

The total income for the 1988 financial year amounted to $718,933.

(a) Annual Practising Certificates and Registration Fees
The Annual Practising Certificate continues to be the main source of Council income. An increase in the number of new registrants particularly from overseas resulted in an increased receipt of registration fees.

(b) Other Income
The only significant increase in other income came from interest received. This reflected relatively high interest rates during the period under review.

4. EXPENDITURE

Total expenditure from the general fund amounted to $612,822.

(a) Salaries
The modest increase in expenditure under this heading reflects the low turnover of staff during the year.

(b) Medical Workforce and Associated Expenses
There have been some difficulties in arriving at a satisfactory arrangement with Government for the expenses associated with the medical workforce data collection. These matters have now been attended to and with the costs coming to hand more regularly it is possible to ensure that net expenditure under this heading can be kept at a reasonable level.

(c) Probationary Registration Examination Expenses
In the year under review the net cost of the Probationary Registration Examination was $7,250. With a considerable increase in the number of candidates for this examination every effort will be made to ensure that it is self supporting financially.

(d) Fees and Honoraria
(i) Ordinary Council Meeting Fees – Sitting fees for Council members have been further increased to $400.00 per day for members and $460.00 per day for the Chairman.

(ii) Honoraria – The Council Chairman's honorarium remains fixed at 1/20th of the 4th merit step of the Hospital Specialists Scale. Although the Chairman is paid a sitting fee for days on which the Council is in session, the level of the honorarium does not compensate realistically for absence from medical practice. In order that the position of Chairman can be accepted by any member of the profession it will be necessary for a more realistic level of honorarium to be established.

5. COUNCIL INCOME/EXPENDITURE SUMMARY

For the year ended 31 March 1988 the general fund showed a surplus of

income over expenditure of $106,111. The significant feature is that Council is now able to consider extension of its activities particularly in the education field as funds are now available. It is anticipated that the Annual Practising Certificate fee will now require to be increased only by a figure related to the rate of inflation or the Consumer Price Index. It should be noted that an application has been made to the Inland Revenue Department to determine the tax liability of the Medical Council in relation to its income derived from interest. Should it be determined that the Council is liable for income tax on this income, a significant part of the surplus would be required to meet this obligation.

6. DISCIPLINARY FUND

Total income for the Discipline Fund for the year ended 31 March 1988 was $231,521. Total expenses however amounted to $390,536 leaving a net deficit for the year of $159,015.

Despite a significant increase in the size of the Disciplinary Levy there has been a much greater increase in costs incurred. These are impossible to predict with much accuracy. It should be noted that an enquiry into the competence of one doctor involved a total expenditure of $45,730. This was charged half against the general fund and half against the discipline fund. An appeal to the High Court by a doctor who had been erased from the Medical Register has so far cost $85,388. Should the appeal be successful it is even possible that the Medical Council may have costs awarded against it. Under the heading of Medical Practitioners Disciplinary Committee it should be noted that this does not include a similar level of expenditure for office administration and expenses which is met by the New Zealand Medical Association.

Legal expenses continue to be a major item for the Medical Council and for the Preliminary Proceedings Committee. A number of options are being examined in an attempt to reduce the rather expensive legal fees incurred. As the number of complaints being investigated continues to rise however it is unlikely that a substantial increase in the Disciplinary Levy can be avoided.

7. CONCLUSION

The General Fund of the Council is at present in a satisfactory state. The costs of Council administration have been kept under careful control and have remained stable throughout the year under review. From this position the Council can look forward to extending and expanding its activities both in the service of the profession and in the service of the public.

The cost of maintaining professional discipline however is of serious concern to the Medical Council. In the present climate of consumerism there is little likelihood that the number of complaints against doctors will decrease, while the cost of investigating complaints continues to rise. If the profession wishes to maintain its own discipline the cost of doing this will be reflected in a progressive increase in the Disciplinary Levy. The Finance and Management Committee is of the opinion that all doctors holding an Annual Practising Certificate should contribute to the cost of maintaining discipline within the profession.

W.S. Alexander
CHAIRMAN.

AUDITORS' REPORT

Miller, Dean & Partners

CHARTERED ACCOUNTANTS
WELLINGTON AND CARTERTON

AUDITOR'S REPORT

TO MEMBERS OF THE MEDICAL COUNCIL OF NEW ZEALAND

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

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

In our opinion and according to the information and explanations obtained, as shown by the said records, the financial statements are properly drawn up so as to give a true and fair view of the financial position of the Council as at 31 March 1988 and the results of its activities for the year ended on that date.

Miller Dean & Partners
Chartered Accountants

WELLINGTON
26 August 1988

FINANCIAL STATEMENT

for Year ended 31 March 1988

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. This year legal expenses have been accounted for on an accrual basis and include provisions for proceedings still pending. Recovery of legal expenses is accounted for on a cash basis.

2. CHANGES IN ACCOUNTING POLICIES

Legal expenses have been accounted for on an accrual basis. In previous years no provision was made for legal proceedings not settled and/or claimed for at the end of the financial year.

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

3. FIXED ASSETS

	Cost 31/3/88	Book Value 1/4/87	Depreciation For Year	Book Value 31/3/88	Accumulated Depreciation to 31/3/88
Air Conditioning	33,251	–	1,663	31,588	1,663
Computer	67,105	49,026	12,356	54,749	12,356
Furniture and Fittings	56,932	48,670	5,693	44,090	12,842
Office Alterations	145,428	130,886	14,543	116,343	29,085
Office Equipment	26,829	7,153	4,259	13,957	12,872
	$329,545	$235,735	$38,514	$260,727	$68,818

4. INVESTMENTS

		1988	1987
(a)	**General Fund**		
	BNZ Finance Limited – Telephone Call Deposit	**30,565**	104,223
	National Bank – Telephone Call Deposit	**89,680**	–
	Equiticorp Holdings Limited Debenture @ 17.25%, maturing 1/6/88	**100,000**	–
		$220,245	$104,223
(b)	**Disciplinary Fund**		
	BNZ Finance Limited – Telephone Call Deposit	$46,951	$22,440

(c)	**Building Fund**		
	BNZ Finance Limited – Telephone Call Deposit	–	$7,218

5. BUILDING RESERVE

Balance as at 1/4/87	8,245
Plus Interest Credited or Accrued for Year	624
	8,869
Less Transfer to Accumulated Capital – Alterations to Office, Office Furniture and Computer Installation	8,869
Balance as at 31/3/88	–

6. DISCIPLINE FUND CHEQUE ACCOUNT

On 6 April 1988 $35,000 was transferred from the cheque account and invested at BNZ Finance Limited – Telephone Call Deposit.

7. PROBATIONARY REGISTRATION EXAMINATION

The policy is that the examination be self-funding. The costs include PRENZ Board meeting fees and expenses and these were budgetted as being a charge against Council in this first year of the Board's operation. In subsequent years the candidates fees will be calculated to cover this cost.

PRENZ Examination Fees Received		48,769
PRENZ Board Meeting, Fees and Expenses	6,600	
PRENZ Examination Expenses	50,555	57,155
Charge against Council		$8,386

8. MEDICAL PRACTITIONERS DISCIPLINARY COMMITTEE

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

9. COMPETENCE INQUIRY

The lengthy and complex enquiry into one doctor whose fitness and competence to practise was in question, fianlly resulted in action in both the health (suspension) and registration (removal from Register of Specialists) areas. Costs of the enquiry have been apportioned equally.

Competence Inquiry – Registration Issue	22,865
Competence Inquiry – Health Issue	22,865
	$45,730

10. CONTINGENT LIABILITY – TAXATION

After consultation with Council's solicitors a submission has been made to the Commissioner of Inland Revenue for clarification of the Council's status on taxation of income from interest.

MEDICAL COUNCIL OF NEW ZEALAND

BALANCE SHEET

as at 31 March 1988

	1988	1987
CURRENT ASSETS		
Petty Cash	60	50
General Fund Cheque Account at ANZ Bank	9,516	25,256
Disciplinary Fund Cheque Account at BNZ (Note 6)	38,652	–
Payments in Advance and Sundry Debtors	4,460	20,665
Interest Accrued	3,118	4,068
	55,806	50,039
INVESTMENTS (Note 4)		
General Fund	220,245	104,223
Disciplinary Fund	46,591	82,328
Building Fund	–	7,218
	266,836	193,769
FIXED ASSETS (Note 3)	260,727	235,735
	$583,369	$479,543
CURRENT LIABILITIES		
Disciplinary Fund Cheque Account at BNZ	–	521
Sundry Creditors		
– General Fund	81,637	46,563
– Discipline Fund	239,338	87,503
Payments Received in Advance	60,226	88,240
	381,201	222,827
CAPITAL ACCOUNT		
Accumulated Capital	366,363	253,651
Disciplinary Reserve – (Deficit)	(164,195)	(5,180)
Building Reserve (Note 5)	–	8,245
	202,168	256,716
	$583,369	$479,543

MEDICAL COUNCIL OF NEW ZEALAND

REVENUE STATEMENT

for Year ended 31 March 1988

	1988	1987
FEES RECEIVED		
Annual Practising Certificate	398,298	277,930
Certificate of Good Standing	9,372	8,247
Medical Registration Certificate	3,023	2,782
Change of Name	360	401
Registration Fees – including conditional temporary, probationary and restoration	132,216	101,015
Specialist Registration Fee	6,771	7,110
Indicative (General Practice) Registration Fee	38,390	–
INCOME FROM FEES	588,430	397,485
OTHER INCOME		
Administration Fee – Dental Council	9,000	10,500
Interest Received	56,381	22,933
Sales of Medical Registers	15,217	15,906
Sundry Income	–	245
INCOME FROM OTHER SOURCES	80,598	49,584
PROBATIONARY REGISTRATION EXAMINATION FEE (Note 7)	48,769	7,000
TOTAL INCOME FOR YEAR	717,797	454,069
Less Expenses as per schedule	613,954	446,392
NET SURPLUS FOR YEAR ENDED 31/3/88	103,843	7,677
Accumulated Capital Brought Forward	253,651	117,235
	357,494	124,912
Plus Transfer from Building Reserve (Note 5)	8,869	128,739
ACCUMULATED CAPITAL	$366,363	$253,651

MEDICAL COUNCIL OF NEW ZEALAND

SCHEDULE OF EXPENSES

for Year ended 31 March 1988

	1988	1987
ADMINISTRATION AND OPERATING EXPENSES		
ACC Levy	3,902	2,494
Audit and Accountancy Fee	4,000	5,070
Agents Registration Fees	4,360	5,560
Cleaning	2,345	2,041
Courier	1,145	–
Depreciation	38,514	23,277
Electricity	4,341	2,743
Fringe Benefit Tax	894	–
General Expenses	6,825	5,762
Legal Expenses	6,299	1,534
Micro Film Files	1,832	417
Medical Workforce and Associated Expenses (Net after Government Grant)	24,145	13,884
Overseas Travel – Secretary	2,637	–
Photocopying Expenses	5,260	3,395
Postage	16,423	15,682
Printing and Stationery	39,753	30,439
Rent and Insurance	27,147	29,457
Repairs and Maintenance	836	2,846
Salaries	226,631	200,496
Superannuation and Health Insurance	12,294	9,077
Staff Recruiting – Advertising and Placement	1,118	15,615
Telephone and Tolls	9,577	8,565
TOTAL ADMINISTRATION & OPERATING EXPENSES	440,278	378,354
COUNCIL AND COMMITTEE EXPENSES		
Council Expenses		
– Chairman's Overseas Travel	4,579	2,171
– Chairman's Honoraria	4,812	5,250
– Fees, Travelling and Accommodation Expenses	48,461	22,509
Medical Education Committee		
– Fees, Travelling and Accommodation Expenses	22,310	18,557
– Hospital Visits	6,585	8,778
Competence Inquiry – Registration Issue (Note 9)	22,865	–
TOTAL COUNCIL AND COMMITTEE EXPENSES	109,612	57,265
REGISTER OF GENERAL PRACTITIONERS (Establishment Costs)	6,909	–
PROBATIONARY REGISTRATION EXAMINATION EXPENSES (Note 7)	57,155	10,773
TOTAL EXPENDITURE	$613,954	$446,392

MEDICAL COUNCIL OF NEW ZEALAND

REVENUE STATEMENT FOR DISCIPLINARY RESERVE ACCOUNT

for Year ended 31 March 1988

	1988	1987
Levies Received	180,928	139,260
Plus Interest Received	27,784	33,554
Recovery of Disciplinary Costs	22,809	5,279
	231,521	178,093
Less Payments		
Accounting and Audit Fees	1,000	1,000
Competence Inquiry – Health Issue (Note 9)	22,865	–
Council and Committee Expenses		
– Fees and Honorarium	16,164	21,253
– Travel and Accommodation	4,552	20,777
Doctors Health Advisory Service	2,159	3,198
Expert Witness Reports	1,041	6,223
General Administration Expenses	3,250	3,075
High Court Appeal	85,388	–
Legal Expenses (Medical Council and Preliminary Proceedings Committee	102,387	163,927
Medical Practitioners Disciplinary Committee (Note 8)	146,532	73,835
Stenographers Fees and Expenses	1,794	7,696
Telephone and Tolls	3,404	2,830
TOTAL EXPENSES	390,536	304,534
Net Deficit for Year Ended 31/3/88	159,015	125,441
Disciplinary Reserve Balance brought forward	(5,180)	121,261
TOTAL DISCIPLINARY RESERVE – (Deficit)	$(164,195)	$(5,180)

FEES

TO BE PAID ON APPLICATION FOR MEDICAL COUNCIL SERVICES DURING COUNCIL FINANCIAL YEAR 1 APRIL 1988 TO 31 MARCH 1989

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

	Fee	GST	Total To Pay
REGISTRATION: (Conditional or Full)			
On deposit of evidence of qualifications	144.00	14.40	**158.40**
For provisional certificate	20.00	2.00	**22.00**
For annual practising certificate	58.36	5.84	**64.20**
For disciplinary levy	59.82	5.98	**65.80**
Total fees on registration	282.18	28.22	**310.40**
OTHER:			
For certificate of temporary registration	144.00	14.40	**158.40**
For eligibility for probationary registration	80.00	8.00	**88.00**
For certificate of probationary registration	80.00	8.00	**88.00**
For *full registration (from probationary, including practising certificate)	188.18	18.82	**207.00**
For annual practising certificate including disciplinary levy	118.18	11.82	**130.00**
For *restoration of name to Register after removal therefrom (including provisional certificate)	248.18	24.82	**273.00**
For initial entry on Specialist Register	50.00	5.00	**55.00**
For entry on Specialist Register in a second or further specialty	10.00	1.00	**11.00**
For initial entry on Indicative Register of General Practitioners	50.00	5.00	**55.00**
For change of name or other entry in Register, excluding change of address or entry of additional qualifications (free)	20.00	2.00	**22.00**
For Certificate of Good Standing	20.00	2.00	**22.00**
For Certificate of Registration (or other document in connection with applications to register in another country)	20.00	2.00	**22.00**
For any inspection of the Register	8.00	0.80	**8.80**

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


MEDICAL COUNCIL
OF NEW ZEALAND