MEDICAL COUNCIL
OF NEW ZEALAND

ANNUAL REPORT
1993

MEDICAL COUNCIL OF NEW ZEALAND

ANNUAL REPORT

FOR YEAR ENDED 30 JUNE 1993

MEMBERS OF THE MEDICAL COUNCIL

at 30 June 1993

	Appointed by Governor-General on recommendation of:
Dr R H Briant (Chair)	Royal Australasian College of Physicians
Dr K J Thomson (Deputy Chair)	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 S L Kletchko	ex officio, for Director-General 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
Professor J G Mortimer	ex officio, Dean, Dunedin Division, Faculty of Medicine, University of Otago
Dr I M St George	Royal New Zealand College of General Practitioners
Dr J A Treadwell	Minister of Health
Vacancy	Minister of Health

SECRETARIAT

at 30 June 1993

Secretary (Chief Executive)	Ms G A Jones, BA
Administration Manager	Mr S M D Willcox, BA
Executive Officer	Ms F A Barber, BA
Registration Officers	Mrs J Lui
	Ms L Urquhart, BCA
	Miss J Maxwell
Examinations Officer	Ms K Marshall, BA SRN
Projects Officer	Ms A Coleman, BA
Secretary/Word Processor Operator	Ms J Hawken
Receptionist	Miss K Arraj, RN
Accounts Officer	Ms C Wood (Part-time)
Tribunals Officer	Mrs S D'Ath, LlB (Part-time)

Council Offices	Level 12, Mid City Tower, 139-143 Willis Street, Wellington
Postal Address	PO Box 11-649, Wellington
Telephone	(04) 384-7635
Fax	(04) 385-8902
Solicitors	Kensington Swan, PO Box 10-246, Wellington
Bankers	Bank of New Zealand, Vivian Street Branch, Wellington ANZ Banking Group (New Zealand) Limited, Courtenay Place Branch, Wellington
Auditors	Miller, Dean and Little PO Box 11-253, Wellington

MEDICAL EDUCATION COMMITTEE

at 30 June 1993

	Appointed by:
Professor J G Mortimer (Chair)	ex officio, Dean, Dunedin Division, Faculty of Medicine, University of Otago
Associate Professor I J Simpson (Deputy Chair)	Faculty of Medicine, University of Auckland
Dr P M Barham	Royal New Zealand College of General Practitioners
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 E Lewis	Faculty of Medicine, University of Otago
Professor B R McAvoy	New Zealand Medical Association
Professor E W Pomare	ex officio, Dean, Wellington School of Medicine, University of Otago
Dr I M St George	Medical Council of New Zealand
Mr J S Simpson	Royal Australasian College of Surgeons
Dr A D Stewart	Royal New Zealand College of Obstetricians and Gynaecologists
Dr M J Vamos	Faculty of Medicine, University of Auckland
Vacancy*	Faculty of Medicine, University of Auckland
Dr S L Kletchko	Observer, Department of Health

*Dr E W Willoughby appointed in July 1993

COMMITTEES

at 30 June 1993

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 C H Maclaurin

Finance and Management Committee
Dr K J Thomson (Chair)
Dr R H Briant
Ms G A Jones

Medical Practitioners Data Committee
Professor J G Mortimer (Chair)
Dr R H Briant
Ms G A Jones
Ms C Leatham (Statistician)
Dr I M St George
Mr G F Spears

Health Committee
Dr R G Gudex (Convener)
Dr R H Briant
Dr M M Herbert
Ms G A Jones
Mrs P C Judd
Dr K J Thomson
Dr J A Treadwell (Health Screener)

Registration Committee
Dr I M St George (Convener)
Mrs P C Judd
Dr M M Herbert
Dr C H Maclaurin

Specialist Registration Sub-Committee
Dr C H Maclaurin

Indicative Register Sub-Committee
Dr M M Herbert

Communications Committee
Dr J A Treadwell (Convener)
Dr R H Briant
Ms G A Jones
Mrs P C Judd
Dr I M St George

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
Professor J D Hutton	Nominee of University of Otago
Dr R G Large	Nominee of University of Auckland
Professor E W Pomare	Nominee of University of Otago
Dr E W Willoughby	Nominee of University of Auckland

REPORT FROM THE CHAIR

Robin Briant

1993 marks 100 years since New Zealand women gained the vote. It is also just three years short of the centenary of the first New Zealand woman to graduate in medicine: Dr Emily Siedeberg-McKinnon. Since that time women have assumed an increasing numerical place in New Zealand medicine, and the 2000th New Zealand woman graduated MBChB in 1992. But the full participation of women in the New Zealand medical workforce is not yet a reality, for complex reasons. These include the uneven sharing of domestic responsibilities, unfriendly work place organisation, and a reluctance to acknowledge the value of part-time work and part-time training. I trust it will not be another century before women's opportunities and achievements in medicine equal those of men.

The theme of council activities in the past year has been fitness to practise. We have discussed many facets of this topic in our work towards what we hope will be better systems in the foreshadowed Health Commissioner and Medical Practitioners legislation. The council has also interacted at various levels in the moves for health service reform.

Professional standards and self-regulation

We need a system to better assess standards of practice of individuals in the profession, and to respond to falling standards. At present the disciplinary process is all that is available, except for those doctors impaired by ill health. The disciplinary process is a very blunt instrument for the task of raising standards. The council proposes that a Professional Standards Committee be established on the lines of the Health Committee. This would explore expressed concerns about an individual's standards, and remedies rather than penalties would be prescribed.

Such a process would inter-relate with the general lifting of standards expected to be achieved by vocational registration and recertification. The Glaxo Foundation sponsored a meeting of colleges, educators and the council in June 1993. Much progress has been achieved by a number of the colleges on the important task of recertification of standards. It is vital that coordination of college and council processes be achieved; it would be unacceptable to the profession to have one process for college recertification and another to endorse continuing vocational registration.

The council has also pondered the self-disclosure aspect of self-regulation. Many registration boards around the world ask questions about ill health and recent litigation with each annual practising certificate application. There are arguments for and against requiring such disclosure, but the ultimate aim is to have a medical workforce of the highest possible quality.

Overseas trained doctors are required to demonstrate their fitness to practise by completing the New Zealand Registration Examination. Currently those tests of English, medical knowledge and clinical skills are followed by at least a further year on probationary registration under supervision. There is an increasing call for matters of ethics and biculturism to be included in these assessments, and the council along with the Examinations Director is looking at this.

Council has now completed its work on strategies to reduce inappropriate prescribing of abusable drugs, though the activities of colleges and educational institutions must be ongoing.

The Sexual Abuse Working Party, established after the multi-disciplinary seminar in 1992, has worked hard to produce baseline information and teaching kits for the profession and the public. Two teaching sessions for key educators have been held. This dedicated working party, made up of both council and non council members from a range of health care professions, has done our profession a great service in an area that is sensitive and difficult. The council recognises that sexual matters are hard to address. Nevertheless, it will move gradually with the profession in addressing them.

Ethical Issues

Throughout the year the council has contributed to discussions on a wide range of ethical issues, from the development of the ethics committee structures for the country, through to the commissioning of reports and collation of opinion on them.

Health Committee activity continues, with improvements made in the monitoring of sick doctors. The committee recognises that monitoring is a long term process, and the expectation is that a once-sick doctor may stay on the books for a long time. The mentoring process has proved successful and, building on experience to date, is being expanded and formalised.

Acknowledgment

As has been the case in recent years, council members have contributed a large portion of their working year to council activities, meetings, hearings, and behind the scenes work. The profession has been well served by the current council members, and I extend to them individually my thanks for the seriousness with which they address their responsibilities. My thanks also to the secretary and staff who continue to provide quality administrative support for council decision-making.

R H Briant
CHAIR

THE MEDICAL COUNCIL - JUNE 1993

From left to right (standing): ***Ms G A Jones (Secretary), Dr J A Treadwell, Dr I M St George, Dr C H Maclaurin, Dr K J Thomson, Dr G F Lamb, Mrs P C Judd.***
From left to right (seated): ***Dr M M Herbert, Dr R H Briant (Chair), Dr R G Gudex, Dr S L Kletchko, Prof J G Mortimer.***

REPORT OF THE LAY MEMBER

Patricia Judd

Over the last twelve months I have attended two international meetings of medical registration boards. One was in Melbourne, a meeting of members of State and Territory Boards and Councils in Australia and New Zealand with Sir Robert Kilpatrick, the chairman of the General Medical Council, delivering one of the keynote addresses.

The second was in San Francisco and was the annual meeting of the Federation of State Medical Boards of the United States. 67 different boards were represented from 50 states, Canada and neighbouring countries. Observers from related medical organisations, eg. AMA, ECFMG, NBME, and from Australia, New Zealand and South Africa also attended. Guest speakers with medical legal and consumer backgrounds drew from US and Canadian experiences.

Both meetings shared common themes which were to do with the changes and challenges occurring in the international medical community, issues with which we in New Zealand are also concerned.

At a personal level, I found it very valuable to meet other lay committee members in Australia and the United States and found that there is a common dilemma to do with the lay role in registration and discipline.

Because the nature of the medical profession is hierarchical in structure with qualifications and publications being a major component of career advancement, it can be difficult for a committee member who is not part of that system to be seen as having a valid role. Some people saw the appointment of lawyers as an answer while others felt that, because medicine and law are alike in organisation, academic constraints and social position, the validity of a similar professional being the lay member could be questioned by the general public.

This diversity of opinion has strengthened my own view that the present 'ad hoc' system of ministerial appointments is likely to be more truly representative of society as a whole than it would be if a particular profession or a pressure group were to have the prerogative of offering the only candidates for these appointments.

Of more general interest were the topics highlighted at both meetings. The over-supply of doctors in developed countries is having far reaching effects as registration boards and governments attempt to handle an influx of overseas trained medical professionals, who often arrive with refugee status. Most countries have restricted entry to their own medical schools and the numbers of overseas doctors seeking permanent residence raise economic issues to do with overservicing and professional issues to do with appropriate medical training.

In Canada two medical schools are being closed and, with the exception of New Zealand, the other countries represented at these meetings had or were introducing legislation to place restrictions of one sort or another on incoming overseas trained doctors. A side effect of this for New Zealand doctors is that in the future it may be more difficult to gain overseas experience, something always seen as being beneficial for our practitioners.

In Melbourne, the theme of the conference oration, given by Dr D Kelly, Chairman of the Victorian Law Reform Commission, was 'Treating the Dying: Emerging Issues', including dilemmas facing the medical profession in the area of euthanasia. His topic went further than the debate on life-support machines. He spoke of a case, in the United Kingdom concerning the role of a doctor in the death of an elderly pain-ridden patient. This particular case has since been reported and the decision published but the address raised issues which not only the medical profession but society as a whole will have to consider in the immediate future.

Other topics discussed were sexual abuse in the doctor-patient relationship, the status of HIV positive health professionals and measures needed to prevent miscreant doctors moving from state to state in order to continue to practise.

In Melbourne I was one of the speakers in the session on Informed Consent. The State of Victoria is considering the introduction of legislation in this area and I was able to describe the processes which have taken place in New Zealand since the Cartwright Report. My theme was that because there had been wide ranging community consultations and because the medical profession, the area health boards and the Health Department took a common course in drawing up guidelines in this area, we in New Zealand have not, as yet, needed the imposition of special legislation. The consensus approach as to what is needed in the areas of information and consent seems to have been more effective in a practical sense than possibly inflexible formal protocols.

Finally, in San Francisco another keynote speaker, Dr E J Stemmler, Executive Vice President of the Association of American Medical Colleges, on the topic 'Professionalism in Medicine', also proved pertinent to current changes in New Zealand. He referred to attitudinal and behavioural effects of the high monetary cost of medical training on medical graduates. He put forward the thesis that because American society is imposing such a huge financial burden on medical students they, the students, do not feel that they have any other responsibility to society than to provide a service and earn as much as they can whilst providing that service. Altruism and feelings of serving the community in a voluntary capacity become subordinate to the fiscal pressures of repaying huge debts and developing a career structure and life style.

This was a sobering message and of particular importance for us in New Zealand. Our society, with its dependence on voluntary workers in so many areas, would become greatly impoverished if a similar pattern occurred here.

I am grateful to have had the opportunity to attend both of these meetings which I found extremely valuable.

P Judd
LAY MEMBER

REPORT OF THE MEDICAL EDUCATION COMMITTEE

Graham Mortimer

First year house surgeon posts

In 1992, for the first time, there were major concerns that there would be insufficient employment posts offered to new graduates for them to complete their requirements for full registration during their seventh year. At the year's end it was clear that this fear had not been confirmed as all graduates did obtain appropriate employment for 1993, although approximately 10 percent (of 270) solved the potential problem by moving to Australia for their seventh year. Those New Zealand graduates will obtain registration with the Medical Council of New Zealand based on their seventh year experience in Australia.

With the introduction of crown health enterprises the employment situation for the graduating classes of 1993 is also uncertain. There are likely to be less places available for seventh years in Australia. The Medical Education Committee is exploring, with the Royal New Zealand College of General Practitioners, the possibility of accrediting posts in general practice, as the council has already approved the principle that up to three months may be regarded as category 'B' experience for conditional registrants. Also the MEC wishes to discuss with the chief executives of the crown health enterprises the council's statutory obligation to ensure appropriate education and training for first year house officers.

Hospital accreditation

During 1992 MEC teams visited and accredited seventh year posts in the following hospitals: Grey, Waikato, Thames, Dunedin, Balclutha, Southland, Whakatane, Nelson, Wairau, Wanganui, and Palmerston North. Each visit uncovers some problems of note, but the co-operation of hospital management in meeting any necessary recommendations from the MEC team is generally forthcoming.

In 1993 accreditation visits to the Auckland, Wellington and Canterbury Area Health Boards were scheduled, but in view of the health sector reforms, and the management transitions to crown health enterprises from 1 July 1993, the MEC decided to defer these visits, unless there were specific troublesome issues or uncertainties. All three area health boards were in agreement with this proposal. As these three boards will be split into multiple crown health enterprises new issues will arise with regard to an approved programme for individual first year house officers, who may need to achieve their required experience in more than one crown health enterprise. The large cities may need a single junior doctor staffing agency, or educational supervisor, to overcome this and other difficulties with the new employment structures. It is planned to inspect these hospitals for accreditation purposes, no later than 1994.

Resuscitation training and accreditation

Early in 1993 a new proposal was considered by the MEC in response to clarification and amendments sought by council. The council's policy guidelines now read: 'that interns be formally taught and assessed in basic and advanced cardiac life support techniques based on the accepted techniques published by the American Heart Association, and that interns should carry a valid assessment from their trainee intern year.' It is also recommended that crown health enterprises should require interns and other junior medical staff (including overseas trained doctors), to achieve and retain on an annual basis certification in basic and advanced cardiac life support. Overseas trained doctors, at the time of seeking full registration, will be required to achieve and retain current certification in basic and advanced cardiac life support.

At year's end the MEC reviewed both the current status of recommendations arising from the 1988 report on *The Education of Medical Undergraduates in New Zealand*, and the role of the doctor with respect to bicultural issues. Ongoing issues, arising in part from the health sector reforms, which the MEC wishes to discuss and clarify with the crown health enterprises and the advisory group on the funding of clinical training, include the following: the concept of central employment agencies; the rotation of seventh years to meet MEC requirements; the educational programmes for eighth year; the role of postgraduate deans in multi crown health enterprise centres; the role for the MEC in relation to postgraduate education; seventh year in general practice; and the reintroduction of MATCH or a similar scheme.

J G Mortimer
CHAIR

REPORT OF THE PRELIMINARY PROCEEDINGS COMMITTEE

Geoffrey Lamb

For the past twelve months the membership of the committee has remained unchanged, the workload has been steady, and most of the comments made in the annual report of 1992 still apply.

The total number of new complaints the Medical Council received during the year was 98 of which 42 were referred on directly to the Medical Practitioners Disciplinary Committee. The remainder were dealt with by the PPC. In keeping with the prominence of public concern about the subject many of the complaints received this year have centred on sexual harassment or abuse. Aberrant prescribing has been responsible for only two complaints. The earlier arguments between those involved in plastic and cosmetic surgery have not been fully laid to rest. No fewer than nine of the complaints raise serious questions about doctor competence. There has been an increase in the number of criminal court convictions, again mainly on sexual charges. There have been no new charges of medical manslaughter.

Two New Zealand registered doctors have been struck off in other jurisdictions (Australia and the USA) and one in Canada is awaiting hearing on criminal charges. Awareness of such occurrences spotlights the loophole in the systems which govern medical movement from one registration jurisdiction to another - to obtain new registration in another jurisdiction a doctor has to be able to produce a Certificate of Good Standing, a document not usually issued for a doctor who is under investigation for or who has been charged with a serious complaint. However for a doctor already on more than one register it may be easy to obtain a current practising certificate in the second jurisdiction even after being struck off in the first. The present New Zealand law for example does not require anything more than the payment of the prescribed fee for an already registered doctor to obtain an Annual Practising Certificate. It is hoped the new Medical Practitioners Bill, when it is produced, will empower the Medical Council to withhold an APC in certain circumstances.

By year's end there were still eleven complaints under active investigation: 1 had had a Notice of Complaint issued and was yet to appear before the committee; in 9 a PPC decision awaits action by another agency eg the police or the courts; 2 doctors were under prescribing surveillance; 4 doctors were awaiting hearing by the Medical Council; 3 were being prosecuted by the PPC before the MPDC. 38 files have been closed.

During the year one doctor escaped a hearing, slipping through the administrative net by successfully applying for removal of his name from the register after leaving the country. 4 doctors have had their names erased by the council for disciplinary reasons.

As in past years several of the complaints, often the most difficult for the PPC to deal with in terms of the time they take up, reflect the puzzlement of patients or their relatives over a sequence of medical events. Either the facts are not fully provided or explained by the doctors concerned, or the physiological or pathological connection linking them has not seemed to them sensible. The resentment or anger which often persists may take a great deal of effort to allay, some at least of which could have been avoided by a careful and understanding explanation at the time the events were unfolding.

There have been a couple of instances in which doctors have tried to use the disciplinary system to deal with professional differences with neighbouring doctors. Such quarrels seem most often to represent failure to observe rules of etiquette, occasionally lapses of ethics, but very rarely indeed do they encroach on the realm of discipline. They are best resolved by direct discussion, if necessary with a mediator.

I should like to pay tribute to the large volume of work so conscientiously done by the other members of the committee, Mr Maclaurin and Mr Cook, for it is a task often unpleasant and almost always thankless.

G F Lamb
CONVENER

REPORT OF THE HEALTH COMMITTEE

Bob Gudex

The Health Committee is concerned with doctors whose health is either physically or mentally impaired. However, suspension from practice on the grounds of health impairment is not usual, and if imposed, is likely to be brief.

A 'variation' of suspension allows practice to continue under certain conditions. These can, as necessary, be quickly agreed to, and are tailored to suit an individual's needs.

The committee appreciates the contribution so many make to ensure the success of the monitoring programme. Therapists and mentors report only if developments may endanger the health of patients.

The impaired colleague meets with the Health Committee at an early stage for assessment, to discuss monitoring and mentoring arrangements, with follow-up meetings as necessary. There are often several such interviews at a Health Committee meeting.

Personal health programme

Frequently the hazards of self-prescribing are apparent, and committee members are sure that fitness to practise could be improved by early and continuing education.

Colleagues describe insufficient understanding of the risks of overwork; of the lack of recreational activity; and of the need to balance vocational demands with those of domestic life.

The need for, and feasibility of providing, a personal health programme for medical

students, was examined in the 1992 Medical Council Summer Studentship. It confirmed the impression that students would benefit from more knowledge of stress management, communication skills, and the risk of substance abuse. It has been suggested that medical students who take responsibility for their own health will be more likely to promote healthy activities for patients in their own practices.

At a recent meeting of State Medical Boards of the United States it was predicted that the incidence of impairment of fitness to practise could be reduced by:

- a more critical selection of applicants for medical school
- a reduction of the 'frenetic pace of learning' to which students are exposed, and
- the establishment of explicit programmes of professional and personal development.

It was said that it is the responsibility of medical schools and teaching hospitals to maintain the idealism with which students enter medical school, and that the environment for medical practice is threatened by the commercial pressures to which it is increasingly subjected, and that it is to the credit of the medical profession that these pressures are generally so well resisted.

Summary of activities

During the period of 1 July 1992 to 30 June 1993, the Health Committee (with council where appropriate) has been involved in various activities related to individual doctors where fitness to practise was an issue (see Table 1).

R G Gudex
CONVENER

HOW TO HELP A SICK OR IMPAIRED COLLEAGUE

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

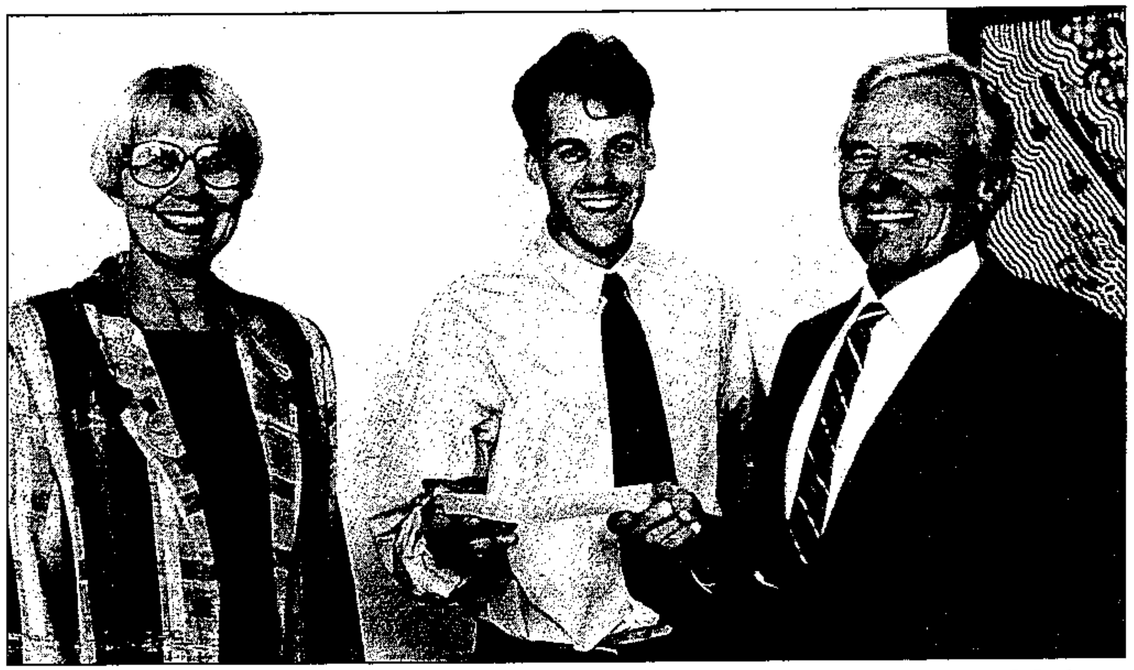
If the problem cannot be resolved by discussion with the sick doctor's immediate colleagues, therapeutic doctor and family, it should be referred to the DHAS, the Medical Officer of Health or to the Health Screener of the Medical Council. The referral is treated confidentially, as long as there is prospect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

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

MEDICAL OFFICER OF HEALTH
Phone or write to nearest Crown Health Enterprise or Public Health Unit

HEALTH SCREENER
C/- Medical Council of New Zealand
Phone: (04) 384-7635
Fax: (04) 385-8902
or write: Box 11-649, Wellington

SUMMER STUDENTSHIP 1992



Winner of the 1992 Summer Studentship, Mark Edwards, receives his cheque from Dr R G Gudex (Health Committee Chair) and Dr R H Briant (Council Chair).

Table 1 **HEALTH COMMITTEE ACTION**

year ended 30 June 1993

Monitoring by Health Screener	4
Monitoring by Health Committee during treatment, rehabilitation or assessment	19
New suspension imposed	3
Full suspension reimposed	1
Full suspension varied to allow limited practice	2
Prescribing restrictions gazetted	0
Recommendation made on registration applications	4
Applications for revocation of suspension considered or under consideration	4
Revocation of suspension granted	0

NEW ZEALAND REGISTRATION EXAMINATION (NZREX)

The New Zealand Registration Examination (NZREX) has been in place since 1989, and although problems have arisen, they have been resolved, and council is satisfied with the current programme. 1994 will see a more efficient and streamlined examination system as NZREX is modified to coincide with changing legislation.

The 1991/92 annual report outlined the revised composition of NZREX examinations:

- English
  (similar to the present NZREX I)
- Written
  (similar to the present NZREX III)
- Clinical
  (similar to the present NZREX IV)

Policy

The new policy will require overseas trained doctors, not otherwise eligible for registration in New Zealand, to pass all segments (English, written and clinical) of NZREX before commencing any form of medical employment or practice in New Zealand. The English and written parts will continue to be offered each year in New Zealand (Auckland and Wellington), Singapore and London, in May and November. The clinical parts will be offered in March and August in New Zealand only. The objective of NZREX is to establish that overseas trained doctors have the required knowledge and clinical competence for the safe practice of medicine in New Zealand. The standard of the examination is defined as the level of attainment of medical knowledge and clinical skills corresponding to that of newly qualified graduates of New Zealand medical schools who are about to commence intern training. Further information will be available from the secretariat after November 1993.

Examination Results

In the past year higher pass rates in Parts III and IV were achieved, although overall this rate still remains below 50 per cent. Council will be closely monitoring the pass rate in the new regime to establish any comparable differences. The number of overseas doctors attempting NZREX has also increased, with the two centres in Auckland and Wellington booked to full capacity at the March 1993 Clinical. The May 1993 examination also shows increased numbers, with a total of 79 candidates attempting NZREX I and II.

Table 2

SCREENING EXAMINATION (FOR TEMPORARY REGISTRATION)

NZREX	PART I	PART II	Screening Examination Overall
	Nov 1992		
Candidate attempts	36 (7)	49 (17)	52 (24)
No. of passes:			
Attempt 1	N/A	17	
Attempt 2	4	4	
Attempt 3	N/A	8	
No. of passes overall	25	29	26
Pass rate overall	69%	49%	50%
	May 1993		
Candidate attempts	59 (10)	68 (11)	77 (18)
No. of passes:			
Attempt 1	30	17	
Attempt 2	5	7	
Attempt 3	3	N/A	
No. of passes overall	38	24	24
Pass rate overall	64%	22%	31%

Note: () repeat candidates included

Acknowledgement

The extensive examination programme demands considerable expertise and commitment from the Board of Examiners. Acknowledgement is due to Dr Gavin Glasgow, Examinations Director, and his team of examiners at the Wellington and Auckland Schools of Medicine and their administrative assistants. Dr Glasgow has been assisted by Mrs Jennifer Hargrave who has taken a major responsibility for the administration of the clinical examination in Auckland. At the beginning of 1993 a second nominee from the Auckland School of Medicine , Dr Robert Large, was a welcome addition to the Board of Examiners. Dr John Reid of the English Language Institute, Victoria University, continues to administer the English component of NZREX efficiently. The assistance given in the mounting of NZREX I and II in overseas centres is also appreciated.

Table 3

EXAMINATION FOR PROBATIONARY REGISTRATION

NZREX	Part III	Part IV	Proceed To Probationary Registration
	Nov 1992	Aug 1992	
Candidate attempts	34 (16)	37 (19)	
No. of passes:			
Attempt 1	10	7	
Attempt 2	4	4	
Attempt 3	4	4	
No. of passes overall	18	15	15
Pass rate overall	53%	41%	
	Feb 1993	Mar 1993	
Candidate attempts	37 (13)	44 (21)	
No. of passes:			
Attempt 1	15	7	
Attempt 2	4	7	
Attempt 3	3	7	
No. of passes overall	22	21	21
Pass rate overall	59%	48%	

Notes: () repeat candidates included

Transition Period

At its June meeting council approved recommendations for a transition period to provide time for current candidates to try and complete NZREX under the current regime, while minimising the likelihood of anomalies in the new regime. The dates for 1994 will change to accommodate the new format.

Funding

NZREX is self-funding and some detail of the income and expenditure is set out in the financial statements. It compares favourably with overseas screening examinations since no funding or support for administration, development, or preparation of candidates comes from outside sources.

The examination is not designed to be a tool of discrimination, but a measure of safety to practise as a doctor in New Zealand

Georgina Jones
SECRETARY

REPORT OF THE SECRETARY

Georgina Jones

New Premises

The highlight of the past year for the secretariat has been the move to larger premises which provide much better working conditions for staff and council members than existed in the Courtenay Place offices. While the latter was very workable when the council workload was significantly smaller, space was very cramped over the last 2 to 3 years particularly. At a very competitive rent and with a major part of the relocation costs met by the lessor, the secretariat now has a much better working environment which should satisfy council's needs for the next 10 years. Stress caused by overcrowding has already dropped dramatically and new telephone arrangements, including central reception, are much more effective. Secure storage, work stations and staff facilities have all been upgraded and appropriate interview and meeting rooms made available. The move was accomplished with minimal disruption to everyday activities. The central city location provides ready access for staff, council members and visitors, in a safe neighbourhood. To have accomplished this with minimal additional outlay is a bonus.

Workload and Quality

Workload continues to increase as can be seen from table 4 which shows workload indicators. The past twelve months involved the secretariat in support services for a number of major council initiatives, several submissions on legislative change including proposals for the new Medical Practitioner Bill, consultations with ministers, the public and the profession, and an ever increasing level of council and committee meetings for general purposes and discipline, 82 meeting days in total.

Administrative support for council activities is now at a very satisfactory level with continuous improvements being introduced in the quality of policy and procedural documentation. Such improvement has been accomplished through constant monitoring of opportunity for new systems, and also through the appointment of staff with particular responsibilities over and above those undertaken by the team of registration officers. Such staff include the examinations officer, projects officer, tribunals officer (who is now also the designated privacy officer for the council), a new appointment in the accounts section and the designation of one staff member as Quality Management Coordinator. The council retreat held in the Waitakeres for part of a weekend in August 1992 was useful in clarifying goals and expectations of the secretariat. Quality improvement ideas have also come from meeting with other registration boards particularly in Australia, the United States and Canada.

Financial Systems

Particular attention is being paid to financial systems with the aim of cost containment and improved management advice. Precise budgets, contracts, monitoring of costs recovery (in the discipline and health areas) and vigorous annual practising certificates follow-up are among the steps taken to keep expenditure within income. An increase in the annual practising certificate fee (excluding discipline levy) was approved by government for the year commencing 1 April 1993. I expect that this level of fee should be able to be retained for some time to come, depending of course on the resources required to meet statutory obligations under new legislation.

Communications

All members of the secretariat place importance on good communications. A large number of enquiries come to us in many different forms and responses are provided, as far as possible, in a way that is sensitive to the needs of the enquirers. Speedy turnaround of written communications is also important. As soon as the new medical practitioners legislation is finalised information brochures about all aspects of council's functions will be produced. Meanwhile updates and policy statements are being published through the regular Medical Council newsletter *MCNewZ* and the *NZMJ*. Practitioners are encouraged to retain these, and the council's annual report, in a binder for ready access and useful references. An information pack has been put together mainly for use by journalists. It has recently been sent to all crown health enterprises and could be made available to members of the profession on request if any doctor has a particular need for more detail about the work of council.

Guidance

There has been a noticeable recent trend for both members of the profession and public to approach the council with various questions about medical ethics and practice. Some uncertainties seem to be arising as a result of health reforms and new legislation, eg. Privacy, Human Rights, Health Commissioner. Some of these queries pose problems for which there is no easy solution. Public

Table 4 **WORKLOAD INDICATORS**

	Year ended 30 June 1992	Year ended 30 June 1993
Provisional Certificates:	590	663
Conditional Registration	243	247
NZ graduates	241	245
OS graduates	2	2
Full Registration		
OS graduates	298	386
Restorations		
NZ graduates	23	11
OS graduates	22	19
Temporary Certificates:		
New certificates	106	90
Extensions	315	291
Probationary Certificates:		
New certificates	64	55
Extensions	7	26
Conditional to Full Registration	248	249
Probationary to Full Registration	35	65
Additions to Specialist Register	154	169
Additions to Indicative (GP) Register	15	13
Modifications to NZ Medical Register:		
Changes of address	2823	3014
Changes of name	22	27
Additional qualifications	356	512
Suspensions or variations	6	7
Removals:		
Deaths	49	51
Discipline	2	4
Failure to notify address	162	98
Non-resident overseas graduates	233	22
At own request	53	87
Annual Practising Certificates	7170	7406
Certificates of Good Standing	550	480
Certificates of Registration	108	138
Receipts Issued (excl APCs)	2639	2869
Total Computer Transactions	23395	16619

education on a whole range of topics to do with the delivery of health services and patients rights is clearly urgently required, although this is largely outside council's statutory role.

Workforce

Council registration officers are acutely aware of medical migration and workforce issues which come to light through the process of registration. Coordinated workforce planning appears to be in a vacuum in the newly competitive environment. Changes in council examination and registration policy in the public interest are being implemented but as with any kind of change are giving rise to stress in some quarters. It is most important that employers obtain up to date information on registration and examination particularly over the next twelve months in the transition to a new Medical Practitioners Act. It is quite disastrous if doctors arrive from overseas expecting to take up positions in New Zealand only to find themselves unregisterable. Employers also need to have in place adequate monitoring to identify doctors working without registration or current annual practising certificates.

Acknowledgment

I have had the full support of Medical Council members and staff in carrying out my statutory functions as secretary, for which I express my appreciation and hope that such cooperation will continue. We are also assisted by dedicated people such as our Examinations Director, Mentoring coordinator, Council Agents, Examiners, Colleges and Special Societies, and on some occasions administrative staff in practices and institutions where council members work. Self-regulation of the medical profession has to be a team effort and I trust that new legislation will enhance not inhibit this goal.

Georgina Jones
SECRETARY

REPORT OF THE MEDICAL PRACTITIONERS DATA COMMITTEE

The council's 1991 database continues to be the basis of many requests for statistics on the New Zealand medical workforce, particularly as the 1992 questionnaire did not seek comparable data.

The Health Department's 1987/88 data (published in June 1990) remains the most recent publication of comprehensive medical workforce statistics. Few statistics were published from the department's 1990 survey, and none from its 1991 survey.

Individuals or organisations wanting material sent to practitioners engaged in particular types of medical work (for example, primary care) must send their material to the council's statistician at the University to Otago, where it is addressed and distributed. The identity of those who receive the material is not released to the individual or organisation making the mail-out request. A fee is charged for this service.

1992 medical workforce survey

The 1992 workforce questionnaire was designed with the assistance of the Department of Health so as to meet its particular requirements for statistical data. Therefore, this latest information, based on new selection criteria, cannot be easily compared with past information. Changes made to the questionnaire format, content and classification groups have made the task of producing a comparable 'active workforce' figure, a difficult one. Follow-ups are continuing to improve the situation so that some comparable statistics are available from the 1992 data, and changes in the workforce size and composition monitored.

Provisional figures indicate that the active workforce has increased from 6570 in 1991, to approximately 6720 in 1992. The number of general practitioners or primary care doctors continues to increase. Overseas graduates remain at approximately 30 percent of the active workforce. There appears to be a slight increase in the specialist workforce total, but more follow-up work is necessary before further analyses can be done. It appears house officer numbers have not increased, but there may be an increase in registrar numbers.

1993 medical workforce survey

A revised 1993 questionnaire should provide some data comparable with that obtained before 1992.

The 1993 questionnaire has been issued to registered practitioners with overseas addresses as well as those with New Zealand addresses. Over 10 720 questionnaires were issued in March, and by the end of May approximately 90 percent of those with New Zealand addresses, and 60 percent of those with overseas addresses, had been returned. Priority is being given to determining which practitioners are in active medical work in New Zealand, and to entering the information recorded on their questionnaires.

J G Mortimer
CHAIR

Table 5 **NEW ZEALAND MEDICAL WORKFORCE 1992**

	1988		1989		1990		1991		1992	
	Total	NZ Graduates	Total	NZ Graduates	Total	NZ Graduates	Total	NZ Graduates	Total	NZ Graduates
Active	6174	4326	6286	4434	6359	4480	6570	4621	6722	4733
Full Time Equivalents	5692.5	4000.0	5763.9	4070.4	5863.3	4151.6	6111.4	4303.8	6210.4	4372.0
House Officers	728	525	719	533	679	538	698	562	677	569
Registrars	771	620	765	616	799	627	823	618	856	651
Medical Officers Special Scale	180	87	176	93	173	87	181	89	203	95
General Practitioners	2293	1608	2383	1681	2429	1705	2549	1779	2616	1818
Other Primary Medical Care	124	81	139	92	165	101	152	97	159	105
Specialists	1953	1338	1957	1326	1952	1325	2021	1376	2066	1396
Miscellaneous (non specialist)	125	67	147	93	142	97	146	100	145	99

Table 6 **NEW ZEALAND MEDICAL REGISTRATION INFORMATION**
at 30 June 1993

Total practitioners on register	10787
Total practitioners with practising certificates	7406
Temporary registrants	151
Probationary registrants	55
Names removed from register (various)	211
Practitioners deceased	51

REPORT OF THE REGISTRATION COMMITTEE

Ian St George

The Registration Committee's task is to advise council on the recognition and registration of medical ability in terms of training, experience and qualifications. The tension here is between expectations of quality from the New Zealand public, and the expectations of a right to practise from doctors of varying experience, education and qualifications. Three specific matters illustrate this.

The first concerns the recognition of general practice as a specialty. In almost every other country in the developed world, either general practice is recognised as a specialty, or specific vocational training is required before a general practitioner may begin independent practice. In New Zealand we have an Indicative Register of General Practitioners and a Register of Specialists. The Medical Council has asked for an inclusive 'vocational register' where no distinction is made between general practice and any other special discipline. In the past the council has stopped short of recognising general practice as a specialty in its own right, but this matter is again before it in 1993.

Overseas trained doctors

The second matter involves advanced training for overseas trained doctors. As a developed country New Zealand has an obligation to assist in the advanced training of doctors for developing countries. This has been done by specialist units accepting sponsored trainees to work, often in tasks that are unattractive to New Zealand graduates. These

trainees work in New Zealand under supervision for a period and then return home. But while they are working here they treat New Zealand patients – and yet at no time has their ability been formally assessed in a New Zealand examination.

The third matter also involves overseas trained doctors. In order to staff our hospitals at junior level, overseas trained doctors were in the past allowed to begin practice as house surgeons before passing a practical clinical examination – they had to pass NZREX Parts III and IV within two years of beginning practice in New Zealand. Often extensions beyond two years were permitted if doctors appeared to be making satisfactory progress. But should this continue now that New Zealand hospitals appear to be adequately staffed at junior level? The council has decided that in future those overseas trained doctors who are required to sit NZREX should pass all of it before beginning practice in New Zealand.

The line between protection of the public and council's other obligations is not always clear.

I M St George
CONVENER

Table 7

NEW REGISTRANTS IN VOCATIONAL DISCIPLINES
1 July 1992 to 30 June 1993

	New Zealand		Overseas		
	Men	Women	Men	Women	Total
Anaesthetics	7	0	11	2	20
Community Medicine	6	2	1	0	9
Dermatology	3	0	0	1	4
Diagnostic Radiology	3	0	6	1	10
General Practice	4	4	6	0	14
Gynaecology	0	0	0	0	0
Internal Medicine	14	4	16	1	35
Obstetrics	0	0	0	0	0
Obstetrics & Gynaecology	1	3	4	1	8
Ophthalmology	2	0	0	0	2
Orthopaedic Surgery	11	1	1	0	13
Otolaryngology	4	1	0	0	5
Paediatrics	5	1	1	0	7
Pathology	7	2	4	0	13
Psychiatry	4	5	8	2	19
Radiotherapy	0	0	2	0	2
Cardiothoracic Surgery	2	0	1	0	3
General Surgery	9	1	5	0	15
Neurosurgery	0	0	0	0	0
Paediatric Surgery	1	0	0	0	0
Plastic Surgery	0	0	0	0	0
Urology	2	0	2	0	4
Venereology	0	0	0	0	0
Total	85	24	68	7	184

REPORT OF THE SPECIALIST REGISTRATION SUBCOMMITTEE

Applications for admission to the New Zealand Register of Specialists have continued steadily throughout the year, the greater proportion as in years past, being received from New Zealand graduates who have completed their specialty training in this country. The qualifications of all applicants are carefully assessed by the Registration Committee, utilising advice from the colleges and specialist societies acting as the council's referral bodies. This system continues to work effectively, although assessment of overseas applicants may sometimes be significantly delayed when referee's reports must be awaited and there is difficulty in determining the equivalence of an individual's higher qualifications.

As indicated in the 1992 annual report some overseas trained specialists, whose qualifications do not completely satisfy the requirements of the specialist regulations, are now being assessed within New Zealand by the relevant colleges on behalf of the council. This usually takes the form of assessment of the individual's work in a supervised clinical appointment, and may include the successful completion of part of the examination requirements of the college concerned, to ensure that the standard of knowledge and practice is equivalent to that required of Australian and New Zealand counterparts. If formal examination assessment is necessary the candidate must pay the requisite fee, and it has also been agreed that any additional costs for the informal component of the assessment will be met by the candidate or their employing authority.

Equivalence in training, experience and competence – all of which are required under the specialist regulations – is seen as very important in the maintenance of standards of specialist care within New Zealand. Where such equivalence cannot be

Table 8

NEW ZEALAND REGISTER OF SPECIALISTS
at 30 June 1993

	1992	Added	Remvd	Net	1993 Actual
Anaesthetics	275	20	2	18	293
Community Medicine	155	9	0	9	164
Dermatology	41	4	0	4	45
Diagnostic Radiology	151	10	2	8	159
Gynaecology	1	0	0	0	1
Internal Medicine	453	35	5	30	483
Obstetrics	1	0	0	0	1
Obstetrics & Gynaecology	188	8	0	8	196
Ophthalmology	95	2	1	1	96
Orthopaedic Surgery	129	13	0	13	142
Otolaryngology	70	5	2	3	73
Paediatrics	144	7	0	7	151
Pathology	158	13	3	10	168
Psychiatry	238	19	2	17	255
Radiotherapy	31	2	0	2	33
Cardiothoracic Surgery	23	3	0	3	26
General Surgery	228	15	1	14	242
Neurosurgery	14	0	0	0	14
Paediatric Surgery	4	1	0	1	5
Plastic Surgery	27	0	1	-1	26
Urology	34	4	0	4	38
Venereology	17	0	0	0	17
Total	2477	170	19	151	2628

determined from first hand knowledge of the overseas qualifications concerned, local assessment (as outlined above) is essential to ensure that standards are maintained. The assessment of eligibility for specialist registration is a time-consuming exercise and the council is grateful to the colleges and specialist societies for their assistance.

New specialties

Recommendations are to be made to the Minister of Health for the gazetting of Emergency Medicine, Occupational Medicine and Rehabilitation Medicine as recognised specialties in terms of the specialist regulations. This move was delayed until two new colleges, for occupational medicine and rehabilitation medicine, were included as faculties within the Royal Australasian College of Physicians. Each faculty will continue to award its own fellowship under the umbrella of the College of Physicians, and it will be in this form that the qualification is identified ultimately in the specialist register.

An application by the Royal New Zealand College of General Practitioners for recognition under the criteria covering specialist registration has also been received. This application is being discussed with the college, although it may be more appropriate to defer recognition of general practice as a specialty under the specialist regulations until the projected vocational register is established, when the new Medical Practitioners Act has been passed.

C H Maclaurin
CONVENER

REPORT OF THE INDICATIVE REGISTER (GENERAL PRACTICE) SUBCOMMITTEE

1992-93 was a quiet year for the Indicative Register Subcommittee as the majority of appropriately qualified general practitioners are now on the register.

Several applications were declined as they failed to meet the criteria laid down in the regulations.

The criteria for entry to the Indicative Register (General Practice) are that a medical practitioner must:

- hold the MRNZGP, FRACGP or MRCGP, or a fellowship or membership of any other college which is considered by the council to have a prescribed course of training and criteria for membership or fellowship equivalent to that required for membership of the Royal New Zealand College of General Practitioners
- have been qualified for not less than five (5) years
- have had training and practical experience in general practice and family medicine for not less than three (3) years
- so far as is practicable, limit his or her practice to general or family medicine.

Notwithstanding the above, the name of a general practitioner may be entered in the Indicative Register if council is satisfied that he or she is recognised by colleagues in the medical profession as having special experience in the discipline of general practice and family medicine.

The transfer of responsibility from area health boards to regional health authorities for purchasing primary care services, and the new Medical Practitioners Act, will both affect the situation of general practitioners.

For some years the council has encouraged the idea that all practitioners should be vocationally trained. The annual practising certificate could specify the vocation of the practitioner, and it would only be issued following evidence that competence was maintained. The maintenance of competence is a subject engaging the attention of the RNZCGP and all other colleges at present.

While the present Register of General Practitioners is an Indicative Register, as indeed is the specialists register, it may be that under the new Medical Practitioners Act the Indicative Registers become Vocational Registers. In that case a change of vocational registration may only be possible after evidence is provided of appropriate and satisfactory training in the new discipline.

The regional health authorities, as purchasing authorities, conceivably may ask for evidence of appropriate training of applicants who wish to provide services.

With all these possibilities ahead, it is advisable for all general practitioners who qualify under the criteria, to apply to have their names placed on the Indicative Register of General Practice. Those who do not fulfill the criteria may wish to take steps to equip themselves for admission to the register.

M M Herbert
CONVENER

REPORT OF THE COMMUNICATIONS COMMITTEE

The council's communication needs for the past year have been met by the services of the executive officer who has public relations skills, and by the use of an external public relations consultant for specific projects. With the success of this dual approach, the council resolved at its June 1993 meeting to dissolve its Communications Committee. The nature of the Communications Committee was transitional, in that its purpose was to establish good communications practice.

Increased Communications

Council's views on matters of concern to the profession have been made clear to the public through a dozen media releases. This year's included: release of the findings of the Modified Narcosis ("Deep Sleep") Inquiry; the Health and Disabilities Services Bill; a call for government action on the revised Medical Practitioners Act; the strike by junior doctors; ethical guidelines; disciplinary findings; and the setting up by council of its summer studentship which allows a medical student to undertake a research project.

The council's newsletter *MCNewZ* has now celebrated its second year of publication. This two-way communication channel between members of the profession and council is available to every practitioner in New Zealand. Copies are also sent to members of parliament, and the media, to keep them updated on the issues of concern to council and the profession.

In addition, the council has released draft reports, discussion documents or final policy statements on a variety of topics, following consultation with the profession. These included: Transmissable of Major Viral Infections; Persistent Vegetative State; Biotechnology Revisited; and Sexual Abuse in the Doctor-Patient Relationship.

During 1993 council addressed the bicultural nature of the role of the doctor in New Zealand. Attitudinal changes were identified as the key to the development of successful bicultural practice of medicine by both maori and pakeha doctors. Council was briefed on some of the independent marae-based initiatives taken by Maori, and this was followed up by some members visiting a marae to learn of health initiatives and maoritanga at firsthand.

The coming year will see many changes in the health environment as the proposed health reforms are implemented. Council will continue to respond swiftly and comment appropriately whenever the need arises. There is a continuing need for the role of council, and the concerns of the profession, to be acknowledged.

J A Treadwell
CONVENER

REPORT OF THE FINANCE AND MANAGEMENT COMMITTEE

Ken Thomson

This report covers the period 1 July 1992 to 30 June 1993, although the financial statements included with it cover the period 1 April 1992 to 31 March 1993.

Taxation

In a decision released on 12 July 1993 the Taxation Review Authority ruled the Medical Council exempt from the payment of income tax on the grounds that it is both a public authority and a charitable organisation. The decision has however been appealed by the Commissioner of Inland Revenue. The appeal procedures are such that it may be another year before the final position is reached. In the meantime on advice from council's auditors, monies previously budgetted for deferred taxation, have been reversed in the annual accounts and an application made to the Inland Revenue Department for a refund of the tax paid to 31 March 1993, which amounts to $386,100.

General council operations

Council's general operation expenses are shown in detail. The final result is a small deficit in the General Fund. Income is slightly down on the previous year due to the issue of a reduced number of annual practising certificates, entry of only a small number of general practitioners to the Indicative Register now that the grandparent phase has passed, fewer sales of registers and register information and lower interest rates.

The steadily increasing workload on council members is reflected in the increase in general expenses, indicating an increase in the number of meetings required. Committee expenses have not risen in proportion, with the exception of the Registration Committee. Cost of running the workforce data collection programme, including meetings of the Data Committee, have risen as a result of implementation of a revised questionnaire, and changes in charges made by the University of Otago where the database is situated. Finance and Management Committee meetings have cost less as greater use has been made of teleconferencing. Overseas travel by the chair and secretary to meetings in Australia is no longer itemised separately, as the continued development of regular trans-Tasman communication justifies including these costs in the ordinary council and committee meeting expenses.

Council has continued to take initiatives on important matters of concern to the public. The work on ethical and legal issues surrounding Biotechnology (including Assisted Reproductive Technology) commenced in 1991 has continued, and a new initiative has been taken to promote informed debate on legal and ethical issues surrounding withdrawal of nutrition and hydration for patients in a persistent vegetative state. Council has benefitted from wise and cost-effective assistance from the University of Otago Bioethics Centre in both these subjects.

Appropriate administration fees have been charged for service provided to the

Dental Council and to the Discipline Fund, although a fee has not been charged to the Examination Fund which showed a deficit for the financial year ending 31 March 1993.

The increase in the annual practising certificate portion of the total fee for the 1993-94 year reflects the actual cost of general council activities, excluding discipline. The additional income derived will offset the modest deficit in the 1992-93 year and will provide sufficient funds for council, committee and secretariat work in the transition to, and implementation of, new medical practitioners legislation which is anticipated in the near future.

Discipline

The discipline fund again showed a modest surplus of income over expenditure in 1993.

The expenses reflects the prolonged and costly Modified Narcosis ("Deep Sleep") Inquiry, including the particular care which was taken with communication of the findings to the public and to those who had made complaints; and an increase of over $180,000 in the costs of the Medical Practitioners Disciplinary Committee due to the heavy workload facing that tribunal. Council involvement in competence assessment gave rise to a small amount of expenditure which could not be recouped as claims related to inquiries held in the previous financial year, and in one case to an inquiry in which the council and the relevant area health board board agreed to share costs. Overall expenditure was only 6.5 per cent higher than in the previous year. The decision on tax liability has improved considerably the final balance in the fund, but the result of the appeal could cancel this again.

The Health Committee (whose work is a charge on the discipline fund) has continued to develop its mentoring programme, and in the long run this will lead to cost savings while at the same time being highly valuable preventive work in the interests of the public, and the particular doctors, whose health has been impaired. Similarly, the investment in the working party on Sexual Abuse in the Doctor-Patient Relationship, while initially requiring substantial funds, in the future will result in considerable savings in pain and suffering for victims, members of the profession, and those who must fund the inevitably expensive disciplinary inquiries or hearings if action is not taken to eradicate this abuse.

The improving state of the discipline fund has enabled the council to seek ministerial approval for a more realistic level of payment for the annual practising certificate overall, incorporating a reduction in the discipline levy. The intended removal of some disciplinary functions from direct council involvement, when the new Medical Practitioners Act comes into being, emphasises the importance of both areas being accurately costed and funded.

Examination Fund

This fund continues to show a small deficit. However, the difference between income and expenditure remained at about $5000 excluding payment of an administration fee. The recent increases in examination fees are likely to meet all costs related to examinations. Budgetting is somewhat problematical, given the need to estimate likely candidate numbers. Candidates fees must be set well in advance of the examination sessions in fairness to prospective candidates but costs relate very closely to actual candidate numbers, particularly for NZREX Parts I, III and IV.

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*.

K J Thomson
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 2 to the Financial Accounts the Council has been adjudged to be exempt from income tax and the Accounts have been adjusted for earlier tax provisions and payments. However the Commissioner of Inland Revenue has now lodged an appeal to this judgment.

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 1993 and the results of its activities for the year ended on that date.

Miller Dean Little

Chartered Accountants

WELLINGTON
18 August 1993

NOTES TO ACCOUNTS

1. Statement of Accounting Policies

General Accounting Policies
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.

Going Concern
Reliance is placed on the fact that sufficient income will be received to maintain the activities of the council at their current level.

Particular Accounting Policies

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

Furniture and Fittings	10%pa
Office Equipment	20%pa
Office Alterations	10%pa

(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.

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

Changes in Accounting Policies
No administration fee has been charged to the Examination Fund. Apart from that there have been no material changes in accounting policies which have been applied on a basis consistent with previous years.

2. Taxation

In July 1993 the Taxation Review Authority found the Medical Council to be exempt from Income Tax. In view of this decision the tax provided for in previous years has been reversed. An application will be made for the tax paid to 31 March 1993 amounting to $380,079 plus Resident Withholding Tax deducted ($6,021) to be refunded. This decision has been appealed by the Commissioner of Inland Revenue.

3. Payments in Advance and Debtors

The debtors figure includes $97,358 outstanding refund of GST, $32,075 outstanding contribution to the workforce survey, and $32,582 outstanding administration fees and expenses from the Dental Council.

4. Investments

	1993	1992
(a) **General Fund**		
BNZ Finance Call Account	23,323	106,225
National Bank Call Account	106,997	4,576
Equiticorp Finance Limited (in Statutory Management)	16,039	26,077
ANZ Call Account	25,489	24,400
Westpac Call Account	6,636	31,207
Trust Bank Call Account	56,678	-
	$235,162	$192,515
(b) **Discipline Fund**		
ANZ Call Account	167,685	164,247
National Bank Call Account	43,659	80,301
BNZ Finance Call Account	20,202	161,618
Westpac Call Account	71,963	79,429
Trust Bank Call Account	102,118	-
	$405,627	$485,595
(c) **Examination Fund**		
ANZ Call Account	116,132	89,566
Total Investments	$756,921	$767,676

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 anticipated that not more than 85 percent of the original capital will be realised.

5. Fixed Assets

	Cost 31/3/93	B/V 1/4/92	Depn For Year	B/V 31/3/93	Acc Depn 31/3/93
Air Conditioning	36,704	20,906	3,670	17,236	19,468
Computer - General	194,453	70,904	21,645	68,519	125,934
Furniture and Fittings	114,149	61,800	11,400	51,767	62,382
Office Alterations	157,364	66,530	15,737	50,793	106,571
- New Premises	9,877	-	-	9,877	-
Office Equipment	42,396	24,737	6,707	21,791	20,605
	$554,943	$244,877	$59,159	$219,983	$334,960

6. Overseas Travel

The overseas travel costs of the chairperson and the secretary are now included under Council Expenses - Australasian Liaison Meetings.

7. Reconciliation of Net Surplus Before Taxation with the Net Cash Flow from Statutory Functions (Indirect Method) for the Year Ended 31 March 1993

Surpluses (deficits) before taxation	1993	1992
General Fund	(38,564)	82,416
Discipline Fund	279,986	357,481
Examination Fund	(2,436)	(18,066)
	238,986	421,831
Less Taxation Paid	(247,376)	(138,724)
	(8,390)	283,107
Add Non-Cash Items - Depreciation	59,159	66,595
	50,769	349,702
Add Movements in Working Capital Items		
Increase in Debtors and Prepayments	(55,179)	30,974
Increase in Receipts in Advance	37,387	(17,565)
Increase in Creditors	30,205	11,033
	12,413	24,442
	63,182	374,144
Less Items Classified as Investing Activity		
Interest	(122,537)	(145,898)
Net Cash Flow from Statutory Functions	($59,355)	$228,246

MEDICAL COUNCIL OF NEW ZEALAND

BALANCE SHEET

as at 31 March 1993

	1993	1992
CURRENT ASSETS		
Petty Cash	310	310
General Fund Cheque Account at ANZ Bank	40,524	32,451
Discipline Fund Cheque Account at BNZ	34,569	32,921
Discipline Fund Cheque Account #2 at BNZ	1,420	2,030
Examination Fund Cheque Account at ANZ Bank	28,631	8,992
Payments in Advance and Sundry Debtors (Note 3)	179,802	124,623
Interest Accrued	4,400	5,941
Taxation Refund Due (Note 2)	386,100	-
	$675,756	$207,268
INVESTMENTS (Note 4)	756,921	767,676
FIXED ASSETS (Note 5)	219,983	244,877
TOTAL ASSETS	$1,652,660	$1,219,821
CURRENT LIABILITIES		
Sundry Creditors		
- General Fund	99,615	107,836
- Discipline Fund	264,120	250,599
- NZREX	76,142	63,699
Payments Received in Advance	98,406	61,019
Provision for Taxation (Note 2)	-	79,895
TOTAL CURRENT LIABILITIES	$538,283	$563,048
TERM LIABILITIES		
Provision for Deferred Taxation (Note 2)	-	9,787
CAPITAL ACCOUNT		
Accumulated Capital	443,381	413,062
Discipline Fund	533,867	115,916
Education Fund	150,000	125,000
Examination Fund	(12,871)	(6,992)
	$1,114,377	$646,986
	$1,652,660	$1,219,821

The accompanying notes on page 34 to 36 form part of these financial statements.

MEDICAL COUNCIL OF NEW ZEALAND

GENERAL FUND REVENUE STATEMENT

for the year ended 31 March 1993

		1993	1992
FEES RECEIVED			
Annual Practising Certificate		708,922	712,210
Certificate of Good Standing		12,414	12,978
Medical Registration Certificate		3,787	2,814
Change of Name		853	560
Registration Fees - including conditional, temporary, probationary and restoration		161,502	145,998
Specialist Registration Fee and General Practice Registration Fee		12,573	11,310
INCOME FROM FEES		$900,051	$885,870
OTHER INCOME			
Administration Fee - Dental Council		27,500	27,500
Administration Fee - Discipline Fund			100,000
100,625			
Administration Fee - Examination Fund (Note 1)		-	13,000
Interest Received		38,945	54,485
Sales of Medical Registers and Register Information		31,594	45,490
Sundry Income		4,062	810
INCOME FROM OTHER SOURCES		202,101	241,910
TOTAL INCOME FOR YEAR		$1,102,152	$1,127,780
Less Expenses as per Schedule		$1,140,716	$1,045,364
Net surplus (Deficit) for the Year Before Taxation		(38,564)	82,416
Less Provision for Taxation (Note 2)		-	27,197
Net Surplus (Deficit) for the Year After Taxation		(38,564)	55,219
Accumulated Capital Brought Forward 31/3/92	413,062		382,843
Plus Prior Year Adjustment- Taxation (Note 2)	93,883		-
		506,945	382,843
		468,381	438,062
Transfer to Education Fund		25,000	25,000
Accumulated Capital Carried Forward		$443,381	$413,062

The accompanying notes on pages 34 to 36 form part of these financial statements.

MEDICAL COUNCIL OF NEW ZEALAND

GENERAL FUND SCHEDULE OF EXPENSES

for the year ended 31 March 1993

	1993	1992
ADMINISTRATION AND OPERATING EXPENSES		
ACC Levies	4,939	7,482
Accounting and Audit Fee	8,550	12,798
Agents Registration Fees	3,666	3,410
Computer Consultancy	6,566	5,872
Cleaning	2,989	3,127
Courier	4,926	4,136
Depreciation	59,159	66,595
Electricity	4,362	4,562
Fringe Benefit Tax	6,825	4,089
General Expenses	2,499	2,162
Legal Expenses	6,663	9,135
Micro Film Files and Storage	1,160	1,529
Medical Workforce and Associated Expenses (Net after Government Contribution)	24,837	19,946
Overseas Travel - Secretary (Note 6)	-	2,559
Photocopying Expenses	8,264	7,324
Postage	28,251	26,539
Printing and Stationery	79,235	71,973
Projects - Transmissible Major Viral Infections	938	-
Projects - Biotechnology Revisited	1,042	3,270
Projects - Persistent Vegetative State	10,037	-
Public Affairs	28,023	31,223
Rent and Insurance	66,032	61,682
Repairs and Maintenance	4,246	2,053
Salaries	363,777	341,468
Superannuation and Health Insurance	16,453	16,759
Staff Recruitment and Training	6,402	500
Telephone and Tolls	17,086	15,789
TOTAL ADMINISTRATION AND OPERATING EXPENSES	$766,927	$725,982
COUNCIL AND COMMITTEE EXPENSES		
Council Expenses	-	3,271
- Chairperson's Overseas Travel (Note 6)	56,200	62,211
- Chairperson's Honoraria and Office Expenses	163,165	147,818
- Fees and Expenses	21,379	-
- Australasian Liaison Meetings	11,702	9,823
Registration Committee Fees and Expenses	-	4,062
Communications Committee Fees and Expenses	6,575	2,924
Data Committee Fees and Expenses	8,832	13,243
Finance & Management Committee Fees & Expenses	2,600	-
Summer Studentship		
Medical Education Committee	27,687	15,773
- Fees and Expenses	12,945	9,248
- Hospital Visits	4,311	6,107
Intern Supervisors Meeting Fees and Expenses	58,393	44,902
Intern Supervisors Contracts	$373,789	$319,382
TOTAL COUNCIL AND COMMITTEE EXPENSES		
TOTAL EXPENDITURE	$1,140,716	$1,045,364

The accompanying notes on pages 34 to 36 form part of these financial statements.

MEDICAL COUNCIL OF NEW ZEALAND

REVENUE STATEMENT FOR DISCIPLINE FUND

for the year ended 31 March 1992

	1993	1992
REVENUE		
Levies Received	2,004,406	1,991,157
Interest Received	81,019	86,128
Fines Imposed and Discipline Costs Recovered	139,768	104,740
TOTAL REVENUE	$2,225,193	$2,182,025
ADMINISTRATION AND OPERATING EXPENSES		
ACC Levies	-	2,290
Accounting and Audit Fees	3,700	3,900
Administration Fees	100,000	100,625
Competence Inquiries	6,742	-
Disciplinary Stress Support Group - Seeding Funds	1,500	-
Doctors Health Advisory Service	24,222	16,454
Expert Witnesses and Medical Assessments	8,156	29,876
General Administration Expenses	3,635	2,223
Higher Court Actions	51,761	95,203
Hire of Rooms	1,710	2,787
Legal Expenses (Medical Council and Preliminary Proceedings Committee)	488,109	504,628
Public Affairs	5,996	-
Medical Practitioners Disciplinary Committee	918,431	733,708
Mentoring Expenses	27,127	8,378
Projects - Misuse of Addictive Prescription Drugs	116	19,552
Projects - Sexual Abuse	50,327	-
Stenographers Fees and Expenses	18,831	23,102
Telephone and Tolls	8,146	8,258
Tribunals Officer	11,673	5,470
TOTAL ADMINISTRATIVE AND OPERATING EXPENSES	1,730,182	1,556,454
COUNCIL AND COMMITTEE EXPENSES		
Council Expenses (Discipline)		
- Fees and Honorarium	52,906	98,857
- Expenses	29,253	40,115
Council Expenses (Health)		
- Fees and Expenses	13,757	23,941
Preliminary Proceedings Committee (excluding legal member)		
- Fees and Honoraria	75,133	85,079
- Travelling, Accommodation and Secretarial Expenses	43,976	20,098
TOTAL COUNCIL AND COMMITTEE EXPENSES	215,025	268,090
TOTAL EXPENDITURE	$1,945,207	$1,824,544
Net Surplus for the Year Before Taxation	279,986	357,481
Less Provision for Taxation (Note 2)	-	117,968
Net Surplus After Taxation	279,986	239,513
Accumulated Surplus (Deficit) Brought Forward 31/3/92	115,916	(123,597)
Plus Prior Year Adjustment - Taxation (Note 2)	137,965	-
ACCUMULATED DISCIPLINE FUND CARRIED FORWARD	$533,867	$115,916

The accompanying notes on pages 34 to 36 form part of these financial statements.

NEW ZEALAND REGISTRATION EXAMINATION FUND REVENUE STATEMENT

for the year ended 31 March 1993

	1993	1992
REVENUE		
NZREX Candidate Fees	218,702	204,049
Interest	2,573	5,285
TOTAL REVENUE	$221,275	$209,334
ADMINISTRATION AND OPERATING EXPENSES		
Audit and Accountancy Fee	1,000	1,000
Centre Costs (NZ and Overseas)	21,930	18,811
Honoraria (Examinations Director and Administrative Secretary)	35,970	29,000
Examiners Fees and Expenses	147,472	150,812
General Administrative Expenses	11,786	9,548
Administration Fee (Note 1)	-	13,000
	218,158	222,171
COMMITTEE EXPENSES		
Board of Examiners Fees and Expenses	5,553	5,229
	5,553	5,229
TOTAL EXPENDITURE	$223,711	$227,400
(Deficit)/Surplus for the Year Before Taxation	(2,436)	(18,066)
Tax Benefit to be Realised (Note 2)	-	5,961
(Deficit)/Surplus for the Year After Taxation	(2,436)	(12,105)
Accumulated Surplus (Deficit) Brought Forward 31/3/92	(6,992)	5,113
Less Prior Year Adjustment (Note 2)	(3,443)	-
TOTAL EXAMINATION FUND – (DEFICIT)	($12,871)	($6,992)

The accompanying notes on pages 34 to 36 form part of these financial statements.

MEDICAL COUNCIL OF NEW ZEALAND

STATEMENT OF CASHFLOW

for the year ended 31 March 1992

		1993	1992
Cash Flow from Statutory Functions			
Cash was provided from			
receipts pertaining to statutory functions			
and administration fee from Dental Council	3,418,529		3,277,257
Cash was also distributed to payment			
for council fees and disbursement and			
secretarial expenses	(3,230,508)		(2,910,287)
Payment of Tax	(247,376)		(138,724)
	(3,477,884)		(3,049,011)
Net Cash Flow from Statutory Functions		(59,355)	228,246
Cash Flow from Investing Activities			
Cash was provided from			
Short Term Investments	10,755		-
Interest Received	124,078		145,850
	134,833		145,850
Cash was applied to			
Purchase of Assets	(46,728)		(17,390)
Short Term Investments	-		(303,432)
	(46,728)		(320,822)
Net Cash Flow from Investing Activities		88,105	(174,972)
Net Increase (Decrease) in Cash Held		28,750	53,274
Opening Cash Brought Forward		76,704	23,430
Ending Cash Carried Forward		$105,454	$76,704
Represented by:			
Petty Cash		310	310
General Fund Cheque Account ANZ Bank		40,524	32,451
Discipline Fund Cheque Account BNZ		34,569	32,921
Discipline Fund Cheque Account BNZ#2		1,420	2,030
Examination Fund Cheque Account ANZ Bank		28,631	8,992
		$105,454	$76,704

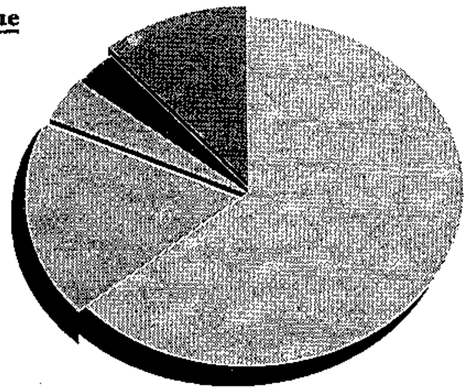
The accompanying notes on pages 34 to 36 form part of these financial statements.

DISTRIBUTION OF COUNCIL REVENUE AND EXPENDITURE

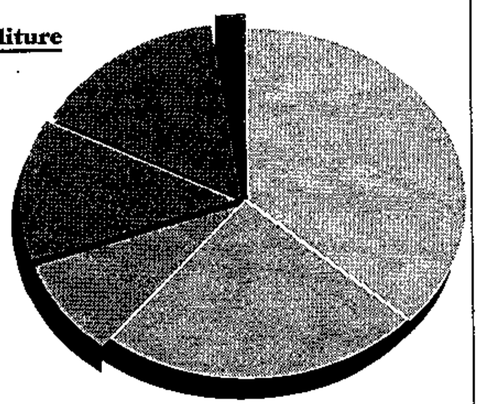
for the year ended 31 March 1993

GENERAL FUND (33% of turnover)

Revenue

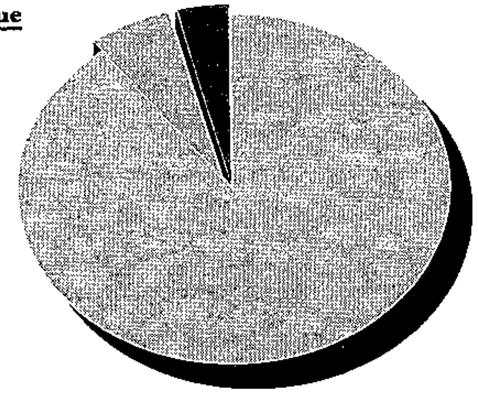


Expenditure

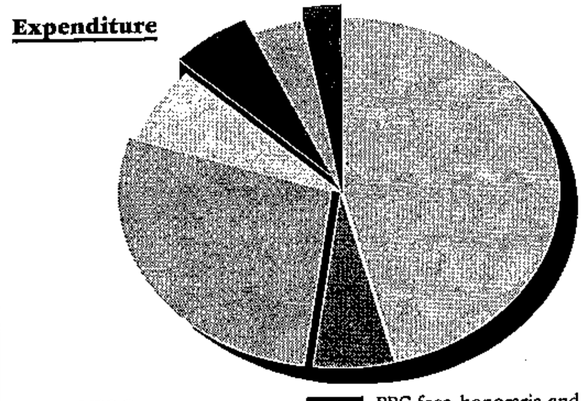


DISCIPLINE FUND (67% of turnover)

Revenue



Expenditure



These graphics are to be read in conjunction with the detailed financial reports on pages 33 to 42

FEES

To be paid on application for Medical Council services
during council financial year 1 April 1993 to 31 March 1994

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

		Fee	GST from 1/4/93	Total to Pay from 1/4/93
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		150.00	18.75	168.75
For discipline levy	(1)	161.11	20.14	181.25
	(2)	72.22	9.03	81.25
Total fees on registration	(1)	508.45	63.55	572.00
	(2)	419.56	52.44	472.00
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)		391.12	48.88	440.00
For annual practising certificate including discipline levy	(1)	311.11	38.89	350.00
	(2)	222.22	27.78	250.00
For *restoration of name to Register after removal therefrom (including provisional certificate)		468.44	58.56	527.00
For initial entry on Specialist Register		60.00	7.50	67.50
For entry on Specialist Register in a second or further speciality		10.00	1.25	11.25
For initial entry on Indicative Register of General Practitioners		60.00	7.50	67.50
For change of name or other entry in Register, excluding change of address or entry of additional qualifications (free)		26.67	3.33	30.00
For Certificate of Good Standing		26.67	3.33	30.00
For Certificate of Registration (or other document in connection with applications to register in another country)		26.67	3.33	30.00
For any inspection of the Register		8.00	1.00	9.00

*includes annual practising certificate and discipline levy to be paid at the time of this application

(1) Fee for persons registering for the first time between 1/04/93 and 30/10/93
(2) Fee for persons registering for the first time or applying for APC between 1/11/93 and 31/03/94

MEDICAL COUNCIL OF NEW ZEALAND
LEVEL 12 • MID CITY TOWER
139-143 WILLIS STREET • WELLINGTON
PO BOX 11-649 WELLINGTON
TELEPHONE (04) 384-7635 • FAX (04) 385-8902