MEDICAL COUNCIL
OF NEW ZEALAND

ANNUAL REPORT
1994

MEDICAL COUNCIL OF NEW ZEALAND

FOR YEAR ENDED 30 JUNE 1994

MEMBERS OF THE MEDICAL COUNCIL

at 30 June 1994

	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 C M Corkill	Minister of Health
Dr C M Feek	ex officio, for Director-General of Health
Dr R G Gudex	Royal New Zealand College of Obstetricians and Gynaecologists
Dr M M Herbert	New Zealand Medical Association
Mrs P C Judd, JP	Minister of Health
Dr G F Lamb	Royal Australasian College of Surgeons
Dr C H Maclaurin	ex officio for Dean, School of Medicine, University of Auckland
Professor J G Mortimer	Dean, Otago Medical School, University of Otago
Dr I M St George	Royal New Zealand College of General Practitioners
Dr J A Treadwell	Minister of Health

SECRETARIAT

at 30 June 1994

Secretary (Chief Executive)	Ms G A Jones, BA
Team Leader Corporate Services	Mr S M Willcox, BA
Team Leader Standards	Ms F A Barber, BA
Team Leader Registration	Ms L Urquhart, BCA
Registration Officers	Mrs J Lui
	Ms T K Larsen, BA (Hons)
	Ms T E Smith
Examination Officer	Ms J E Maxwell, Dip Tchg
Coordinator Policy/Projects	Ms A B Coleman, BA
Administrative Secretary	Ms J Hawken-Incledon
Team Support Officer Corporate Services	Ms J M Watson
Receptionist	Miss K M Arraj, RN
Accounts Officer	Ms C M 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, Knight & Little PO Box 11-253, Wellington

MEDICAL EDUCATION COMMITTEE

at 30 June 1994

	Appointed by:
Professor J G Mortimer (Chair)	Dean, Otago Medical School, 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
Dr A G Dempster	Faculty of Medicine, University of Otago
Dr C M Feek	Observer, Ministry of Health
Professor A R Hornblow	ex officio, Dean, Christchurch School of Medicine, University of Otago
Dr J Kolbe	Faculty of Medicine, University of Auckland
Dr M E Lewis	Faculty of Medicine, University of Otago
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 NZ College of Obstetricians and Gynaecologists
Dr E W Willoughby	Faculty of Medicine, University of Auckland
Vacancy	NZ Medical Association

COMMITTEE MEMBERSHIP

June 1994

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)
Dr M M Herbert
Mrs P C Judd
Dr C H Maclaurin

Specialist Registration Sub-Committee
Dr C H Maclaurin

Indicative Register Sub-Committee
Dr M M Herbert

Issues Committee
Dr R H Briant(Convener)
Dr I M St George
Dr K J Thomson

Board of Examiners

Dr R H Briant (Chair)	Medical Council
Dr P M Barham	Medical Education Committee
Dr G L Glasgow	Examinations Director
Dr M M Herbert	Medical Council
Dr R G Large	Nominee of University of Auckland
Dr D J McHaffie	Nominee of University of Otago
Professor E W Pomare	Nominee of University of Otago
Dr E W Willoughby	Nominee of University of Auckland

REPORT FROM THE CHAIR

Robin Briant

When I wrote my first annual report in July 1991 I commented with hope and expectation on the prospects of a Health Commissioner, and a new Medical Practitioners Act compatible with the Health Commissioner legislation. I could use the same words for my 1994 report. The only palpable progress in the legislation is that the Health Commissioner Bill has emerged from lengthy select committee deliberations (and even longer on the back-burner) and is before Parliament again. At the time of writing the Medical Practitioners Bill has not seen the light of day.

In 1992 I wrote about the upcoming changes in the delivery of health services and expressed my fear that self-interest or management dictate might drive out the sense of duty and ethical behaviour that governs doctors and their actions. I see no evidence that that fear is coming to reality, but stress in the system is high and I remain concerned that resource limitation will profoundly affect the delivery of safe and effective health service to the people of this country.

In 1993 I addressed the maintenance of professional standards. The old Medical Practitioners Act is silent on the matter of competence or performance. Those colleges that require their fellows and members to take part in some form of continuing education or assessment must still rely on voluntary participation; and the Medical Council cannot put conditions on the practice of a doctor who fails a college programme. Until the council is provided with this mandate it cannot demonstrate its serious intention to maintain high standards in the medical profession.

In 1994 workforce issues have been prominent in professional and public discussions. Again the Medical Practitioners Act demonstrates its age, for it requires the council to give full registration to graduates from the universities of several countries, not allowing the council to exercise any discretion in the matter of standards of medical education.

The council has continued to be involved in national and international networking at a variety of levels. The council's Education Committee and Examination Board were represented in Sydney at a workshop on 'Assessment in Medical Education'. This meeting gave birth to the idea of a continuing series of such workshops, probably biennially, and the council will have a nominee on the committee developing these programmes. The secretary and I attended the Australian Medical Council's annual general meeting in Canberra and there continues a close working relationship between the two councils. The decision to combine assessment procedures will see the Otago Medical School visited in August 1994.

Several council members were invited to an international conference of medical boards held in Washington DC in May 1994. This proved to be an extremely valuable and interesting experience, where many of the issues and problems of registration authorities were revealed and shared. We felt our direction and progress were comparable to most other boards attending, but there were always models we can learn from and much valuable material was accumulated and helpful contacts made.

Council members and officers have been involved in many ongoing projects through the year. The Sexual Abuse Working Party has almost completed its task and the information pamphlets are ready for distribution. The council has been involved in meetings and consultations in relation to the revision of the Medical Practitioners Act and the development of Health Commissioner legislation, on medical immigration and medical manslaughter, on the unbundling of clinical training money, and on vocational registration. We had a valuable meeting with intern supervisors and meetings with chief executives, chief medical advisors and personnel managers from crown health enterprises, all aimed at improving dialogue and working relationships.

In the year since the council secretariat moved to its new premises there has been a major expansion of work in the office. The secretary has lead a reorganisation of staff functions aimed at providing the doctors on the register, and all our other clients and inquirers, with a very good service. I am confident that this change, which has been supported by all staff and by the council, will be beneficial when it is all shaken down into place. The diligent work of Ms Jones and all her staff is acknowledged.

We welcome a new council member, Dr Caroline Corkill, from Invercargill, a nominee of the Minister of Health. Her presence changes the gender balance and lowers the average age of the council, as well as expanding its general practice and South Island representation.

Many council members have served more than expected terms on the council, living in the continued expectation of a new Act and a new regime. I wish to record my thanks for their dedication and integrity, and for the support they have given me over my time in the chair.

R H Briant
CHAIR

THE MEDICAL COUNCIL - JUNE 1994

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

REPORT OF THE LAY MEMBER

Patricia Judd

This year I have attended two seminars which have looked at very different developments in medical practice.

The first was held in Palmerston North, looking at 'General Practice at the Fringes' and was organised by Dr Tony Townsend.

The discussion covered a wide range of attitudes towards 'fringe' treatment and there were various themes which emerged.

There was agreement that a societal mistrust of polypharmacy has arisen and that this has led to a search for alternative healing and treatments. As well it was recognised that some now accepted tools of orthodox practice, anaesthetics for example, were seen as fringe at the time of their introduction.

So what were considered to be the obligations of a doctor who is consulted as a registered medical practitioner, with all that is implicit in that designation, in the area of alternative treatment?

The first imperative was that the practice did no harm to the patient and was non-exploitive physically, psychologically or in a pecuniary sense. Because there is a difference between a treatment which may make the body more comfortable and one which claims to cure a serious ailment, it was felt that the registered practitioner should use the medical model first if the safety of the patient is at issue.

One of the main problems in proving or disproving alternative theories was seen to be the restrictive nature of scientific constraints and the fact that the body of supportive evidence is frequently anecdotal. It was felt that practitioners should have appropriate training and qualifications in whatever therapy they intended to use and that informed consent was of particular importance in areas of innovative treatment.

Cases heard by the Medical Council in the disciplinary area reinforced my concerns about patient vulnerability and gullibility in matters to do with illness and treatment. The more desperate the need for a 'cure' the greater the tolerance of strange or unusual treatment methods. In terms of cost the most poignant statement is: "I would pay anything to cure her/him/me." I believe that there is a need for some assessment or quality guide for alternative treatment methods.

The second seminar was discussing the 'Regulation of Assisted Reproductive Techonology'. A variety of speakers contributed to what emerged as a very complex topic with issues that flowed from some of the fundamental needs and taboos of human society.

The taskforce, consisting of Mr Bill Atkin, Reader in Law at Victoria University of Wellington, and Dr Paparangi Reid, research officer with the Maori Health Research Centre at the Wellington School of Medicine, gave an overview of the impressions which they had gained from their investigations on behalf of the government. The views of the Privacy Commissioner, Fertility Associates, the Infertility Society and the Law Commission were also canvassed along with sociological and legal perspectives on possible future developments. The address by Kim Workman, Ministry of Health, giving Maori viewpoints moved the discussion from the rights and needs of individuals to the cultural demands of personal identity and the importance that Maori, and many other cultures, place on the bloodline.

First it was accepted that the new technologies are now a part of our society and there is no going back. What is needed is to devise systems which will provide the best outcomes for all of the people involved. Some of the questions which have been addressed are:

- What is the legitimate state interest in the welfare of this child?
- What are the regulation options?
- What right of access do the children have to their genetic and cultural heritage?
- What body will be the regulatory body for the providers?
- What role do commercial interests play in the process?

There are four sets of people involved: the medical professionals, the donor, the parents and ultimately the child. It is the determination of whose rights are paramount which causes the problems.

When the report is open for public debate, most probably societal opinion will be seen in partisan attitudes. My opinion is that, although the control of information initially resides with the medical professionals and the parents, long term this must pass to the children for their future needs.

Reference was made to the fact that children conceived naturally may have gaps in their genetic knowledge and that adoption can have a similar effect. However, in my opinion that does not diminish any of the responsibility incumbent on persons involved with ART.

I have enormous sympathy for prospective parents who suffer the anguish of infertility and respect the commitment of the medical professionals who have found ways to help in this situation. However, I feel that it is the child or children whose rights come first. As well, I would like to see a long-term view of those rights prevailing over what may be current mores in our society. We often make the welfare of children subject to whatever is the theory of the moment.

Both seminars looked at very different aspects of medical practice, the first a movement away from scientific medicine and the other with issues raised because of innovations in scientific medicine. They reflect the diverse strands of medical activities which the Medical Council oversees in the interests of the public.

P C Judd
LAY MEMBER

REPORT OF THE MEDICAL EDUCATION COMMITTEE

Graham Mortimer

Accreditation of hospital posts

Because all area health boards were changing to crown health enterprises on July 1st, all hospital accreditation visits in 1993 were deferred. These have been resumed in 1994 with accreditation teams, appointed by the Medical Education Committee, visiting the Auckland, Wellington and Christchurch regions. In each of these regions the process is more complex than previously because of the distribution of the hospitals and resident posts to more than one crown health enterprise. Other issues which arise include the mode of appointment and employment of the conditional registrants, and the coordination of their educational needs. The first of these visits has been completed and it is pleasing to report that the needs of these young graduates are being appropriately addressed.

As well as these major triennial visits, the MEC and council secretariat continually review and modify individual hospital runs already categorised as A, B, or C (conditionally registered interns must obtain mandatory clinical experience on runs categorised as A or B). The secretariat now have an accurate and up to date national database of all hospital runs.

Conditional registrants - employment and education issues

Despite earlier concerns it appears that all new graduates from the Auckland School of Medicine and the University of Otago Schools do obtain 7th year employment, although once again 10 percent of New Zealand graduates moved overseas for this first year of employment, mainly to Australia. Within New Zealand the allocation of posts would be enhanced by a reintroduction of a MATCH type process and this is being addressed, in conjunction with the human resource managers and chief medical advisers of the crown health enterprises, who have agreed that there could be major advantages in the reintroduction of some matching of the preferences of the applicants and the employers.

It has also become clear that there are difficulties in observing the current requirements of the MEC with regard to the supervision of conditional registrants in A & E runs and on night cover. The MEC plans to revisit its policy on this after receiving submissions from the intern supervisors, particularly those in smaller centres who have significant concerns about the impact of the present policy on their ability to devise acceptable resident rotations. The MEC has continued to address the availability of posts in general practice acceptable for conditional registrants. This is presently not happening because there is no funding mechanism. A submission to the Taskforce on Strategic Planning for General Practice recommending funding of these posts was made and the outcome is awaited.

Resuscitation training and accreditation

It is now mandatory for 6th year medical students and 7th year conditionally registered doctors to complete cardiac life support teaching and certification requirements in each year. During the year the MEC was asked to consider these requirements for overseas trained doctors. The MEC has recommended, and council has accepted, that all overseas trained doctors who have recently completed the New Zealand Registration Examination, or are currently within the NZREX system, should be certified in these skills prior to full registration being granted. In response to correspondence from the Resident Doctors' Association which supports certification for all medical practitioners in New Zealand, the MEC advised that this was a reasonable suggestion, but that the issue was one for employers and individual doctors to take up, as council has no powers to enforce it at this stage.

Current issues

During the year the MEC had valuable meetings with crown health enterprise chief executive officers, chief medical advisers, and human resource managers. There was a further meeting with intern supervisors and a special workshop on 'Education in the Intern Year' which generated recommendations for the Medical Council, hospital consultants, intern supervisors and the interns themselves. These are being addressed. Other important issues under consideration are the current status of the recommendations of the 'Renwick Report' made to the University of Auckland and the University of Otago in 1988, the problem of poorly performing interns, and the effects of the unbundling of the costs of clinical training on pre-entry and post-entry medical education. A major task for the MEC will be evaluating the outcome and recommendations from the Australian Medical Council Accreditation visit to the University of Otago in August 1994, and to the Auckland School of Medicine in 1995.

J G Mortimer
CHAIR

REPORT OF THE PRELIMINARY PROCEEDINGS COMMITTEE

Geoffrey Lamb

The committee membership has remained unchanged this year and it has continued to work steadily. It has recorded the receipt of 51 new complaints of which nearly half (23) have been sent on to be dealt with by the Medical Practitioners Disciplinary Committee. Of those retained by the Preliminary Proceedings Committee, ie. which might constitute 'disgraceful conduct in a professional respect', almost 50 percent have been issues of a sexual nature. There have also been two complaints which have been dealt with on referral from the MPDC because of the PPC's ability under the Act to perform more detailed investigation.

The committee's 180 sitting hours have been spent mainly in hearing complainants, other witnesses, and defendant doctors and deliberating on the issues. It has held hearings in Auckland, Hamilton, Wellington, Christchurch and Dunedin. Its investigative lawyers have also visited complainants in a number of provincial towns for the purpose of taking statements. At the year's end there were still open 33 files of which 11 were in an active investigation phase, 4 had resulted or were about to result in charges before the Medical Council and a further 3 before the MPDC (the PPC may prosecute charges before either Tribunal), 3 represented convictions in the criminal court which the committee referred to the Medical Council, 2 were watching briefs pending criminal proceedings, 1 was surveillance for prescribing aberrations, 1 had been struck off in an overseas jurisdiction, and 1 was awaiting a judicial review. Seven other files were almost at the point of closure.

One case which consumed a good deal of the committee's time was the complaint by ex-police undercover agents against those police doctors who had been involved in monitoring parts of an undercover operation, on the grounds of subsequent habituation to marijuana. This has raised a number of interesting and difficult points of ethics and professional responsibility in an area where the 'facts' in regard to addiction potential of the drug are soft and controversial.

The increasing complaints alleging sexual harassment or sexual abuse have been a source of major concern for the committee. It is always difficult to investigate or assess events which have taken place in the confines of the consulting room, usually in the absence of a chaperone, for the purpose of determining whether a prima facie case has been established for a tribunal hearing. We are also very aware of the courage required by many of the complainants to bring a complaint of this nature against a doctor, a hurdle later compounded by the necessity to discuss the details before what some have described as a 'committee of old men'. The statute requires that the PPC comprises two members of council plus the legal member and so its composition is dictated by the composition of the council itself. It has been a major relief, therefore, to learn that the Minister has at last appointed a replacement on the council for Dr Stewart Alexander, creating the opportunity to change the composition of the PPC which now includes the new member of council, Dr Caroline Corkill, a general practitioner from Invercargill. This move improves both the age and gender balance of the committee which should be of particular benefit in dealing with the sexual abuse cases. Dr Campbell Maclaurin will assume the convenership for new complaints during the coming year.

The other concerns arising from our observations of complaints of sexual abuse stem from such issues as the frequency with which doctors fail to guard themselves adequately against blurring of the proper boundaries; the frequency of instances in which doctors' actions are misinterpreted, most commonly because of inadequate explanations of what is being done and the reasons for it; and the distress caused to the defendant doctor when mistaken perceptions cause an unfounded complaint. To some extent the remedy for these concerns lies with the profession. Doctors need also to be aware of the extent of the distress felt by a patient who perceives herself (or himself) to have been abused, and the very long-lasting nature of this distress regardless of the outcome of the complaint.

G F Lamb
CONVENER

REPORT OF THE HEALTH COMMITTEE

Bob Gudex

The Health Committee, over its seven years of activity, has developed a monitoring programme to assist doctors whose health is either physically or mentally impaired. Doctors previously associated, and those still involved, with the monitoring programme contribute to the rehabilitation of colleagues by providing valuable comment and feedback on the various elements within the programme.

Most participants will move to a level of review consisting of an annual inquiry as to their well-being. It seems that many will choose to remain involved with some of the conditions of their previous agreement with the council, and to continue what may have developed into a very helpful relationship with their mentor. The success of the mentoring programme indicates that it could play a major role in offering the opportunity for early learning of good practising habits. It has been a privilege to attend and observe at two meetings of the mentors assisting council - they are a valuable resource.

Fitness to practise and competence of elderly doctors

Inquiry of other boards confirms the difficulty council experiences in assessing the fitness to practise of colleagues of advancing years. From Canada there is the expectation that continuing medical education assessments will identify deficiencies for individual who, after counselling, will be reassessed in a year's time. The intention is to provide support, rather than criticism. The Canadian report describes a two year experience using the method of random selection to assess a group of doctors aged between 57 and 60 years. The aim is to promote safe practice for another 10 years.

In this country it is likely that with the implementation of a new Medical Practitioners Act the council will form a Professional Standards Committee and require it to recommend a policy on this issue.

Even recent graduates should consider what will fill their lives satisfactorily when they no longer practise medicine. When spouse, family, psychometric and psychiatric assessment indicate that it is inappropriate for practice to continue, colleagues could be spared the need to say "no more."

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

Table 1 **HEALTH COMMITTEE ACTION**
year ended 30 June 1994

Monitoring by Health Screener	3
Monitoring by Health Committee during treatment, rehabilitation or assessment	25
New suspension imposed	2
Full suspension reimposed	1
Full suspension varied to allow limited practice	4
Prescribing restrictions gazetted	0
Recommendation made on registration applications	2
Applications for revocation of suspension considered or under consideration	7
Revocation of suspension granted	3

REPORT OF THE SECRETARY


Georgina Jones

The functions of a health professional board secretariat are part of the regulatory framework which is designed to ensure that patients do not come to harm when they seek advice or treatment. The powers of such boards are set down in legislation and must be administered meticulously on behalf of the board or council which carries the ultimate responsibility. The secretary to council is required not only to carry out the statutory duties but also to manage the secretariat, while continuing to be responsive to the needs of the council, the profession and the public. Like many administrative roles, we often only come to notice when something goes wrong. It is also all too easy to become so closely focused on the paperwork that the overall goal is lost sight of.

Review

Over the past 12 months the secretariat for the Medical Council (which also serves the Dental Council of New Zealand) has made a real effort to review its role and identify ways in which the quality of its service might be improved. Because such registration boards are small in number, particularly in a country as small as New Zealand, it is not always easy to pinpoint appropriate measures for such service. Experience is a powerful learning tool (and a number of our staff have worked together now for a number of years) but objective analysis is also necessary.

The level of complaints received about the work of the secretariat would be one such measure. I am pleased to say that complaints are relatively infrequent and indeed in recent times secretariat staff members have been congratulated on the way in which they carry out their tasks, with efficiency and helpfulness going hand in hand. Nevertheless, as a group of individuals committed to continuous improvement, we felt it important in the past year to take time out to look at some of the difficulties we were experiencing internally with peaks and troughs in the workload, and with communications in an increasingly complex health sector, itself subject to stress and change.

Teams - personnel and training

In January we held a two day staff workshop which aimed to identify what the pressure points were and when they were occurring, how the council's work might change with a new Act, and what resources and skills might be needed. Most importantly, we wanted to develop a strategy for managing change, including recruitment and retraining. Our goal was to improve the focus on meeting the needs of those we serve, encouraging more creativity and initiatives, and facilitating good communication.

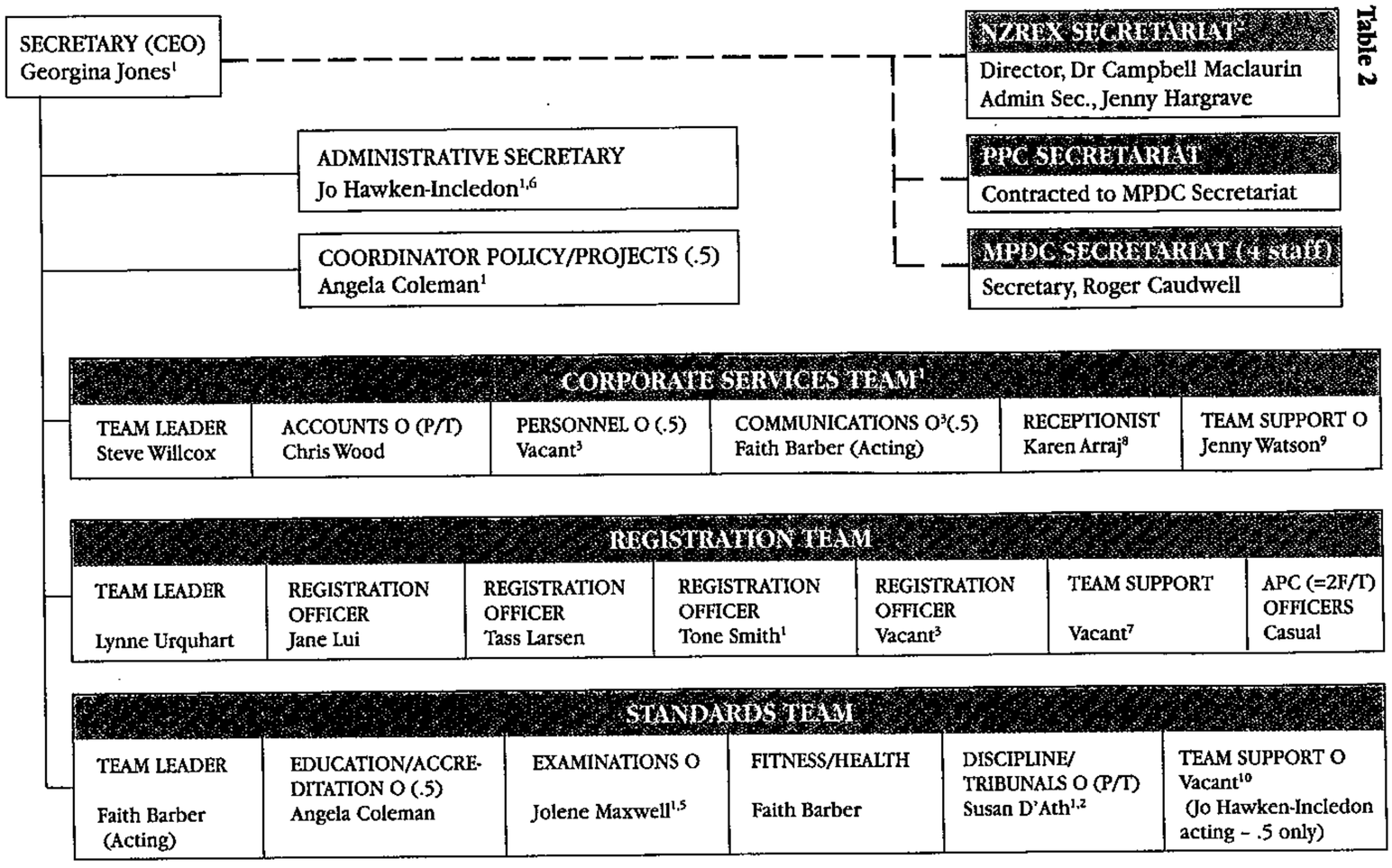
It was recognised that the secretariat was seriously under staffed given the wide range of responsibilities it has according to the statute. In New Zealand all tasks concerned with the registration and control of individual medical practitioners fall on one body whereas in many other countries the examination of overseas trained doctors, and the conduct of inquiries and hearings arising from allegations of professional misconduct, are dealt with in other jurisdictions. We have recently, therefore, reorganised the secretariat into a team structure which we hope will be sufficiently flexible to respond to fu-

Table 2

MEDICAL COUNCIL OF NEW ZEALAND

SECRETARIAT ORGANISATIONAL CHART

(at 30 June 1994)



NOTES

1. Staff/team also serve Dental Council of New Zealand
2. Officers on contract
3. Vacancies to be filled in second stage of implementation - ? 4th quater 1994
4. Satellite Officers funded by MCNZ
5. Currently full-time post, to be .5 after new policy transition period
6. Currently .5 only while acting Standards Team Support
7. Kirstine Thompson appointed wef 21/7/94
8. Replaced by Donna Overduin wef 3/8/94
9. Replacing Julian Palmer wef 19/9/94
10. Miriam Kilkelly appointed wef 19/9/94

O Officer

ture needs. This structure enables staff to utilise and enhance their existing skills and encourages work practices and values that are client focused. Table 2 sets out the new organisational structure with the names of current staff included. It was not possible to implement the whole new structure in one financial year but it should be in place by the end of June 1995, ready for the implementation of long awaited new legislation. Given that there are still some gaps, time is still short and not all workload pressure alleviated, priority has been given to clarifying the functions and expectations of each staff member, and putting in place performance agreements which we believe will, in due course, make a tangible difference to accountability and efficiency. Training needs are being analysed and immediate gaps in knowledge or skills addressed.

Systems and staffing

Concurrently, we also implemented important reviews of some of our systems, including financial recording and reporting, records, staffing and organisational structure. The considerable knowledge of staff members themselves has been drawn upon and consultants have been engaged for specific tasks as required. This partnership has proven to be cost-effective and manageable, given the fact that a large volume of work must continue to be undertaken even in a period of reorganisation. The data in Table 3 'Workload Indicators' shows a steady rise in workload, particularly surrounding the examination and registration of overseas trained graduates. The daily pressure on staff involved in providing information for people wishing to come to New Zealand to live and practise is intense. Modern equipment does help but in the end many of the answers can

Table 3 **WORKLOAD INDICATORS**

	Year ended 30 June 1992	Year ended 30 June 1993	Year ended 30 June 1994
Provisional Certificates:	590	663	910
Conditional Registration	243	247	280
NZ graduates	241	245	274
OS graduates	2	2	6
Full Registration			
OS graduates	298	386	488
Restorations			
NZ graduates	23	11	11
OS graduates	22	19	22
Temporary Certificates:			
New certificates	106	90	99
Extensions	315	291	208
Probationary Certificates:			
New certificates	64	55	48
Extensions	7	26	46
Conditional to Full Registration	248	249	240
Probationary to Full Registration	35	65	63
Additions to Specialist Register	154	169	166
Additions to Indicative (GP) Register	15	13	17
Modifications to NZ Medical Register:	2823	3014	3077
Changes of address	22	27	33
Changes of name	356	512	393
Additional qualifications	6	7	7
Suspensions or variations			
Removals:	49	51	55
Deaths	2	4	6
Discipline	162	98	67
Failure to notify address	233	22	1
Non-resident overseas graduates	53	87	31
At own request	7170	7406	7521
Annual Practising Certificates	550	480	469
Certificates of Good Standing	108	138	131
Certificates of Registration	2639	2869	3037
Receipts Issued (excl APCs)	23395	16619	17491
Total Computer Transactions			

only be given by people, such as our registration and examination officers.

The number of inquiries from members of the public and the profession concerning issues to do with the practice of medicine, which seem to have become more complicated in the reformed health structure, continues to escalate. Uncertainty is prevalent and this in itself creates additional stress. We attempt to answer all inquiries as quickly as possible but do find that around meeting times correspondence sometimes has to take second place. Improving turnaround time on all communications is a constant aim.

Although only forty three written complaints about doctors were received by the secretariat during the past twelve months, many other telephone calls were received from individuals seeking guidance or explanation. The work of the tribunals officer and the coordinator policy/projects in dealing with issues to do with professional ethics and conduct has been particularly onerous in the twelve months covered by this report. The acting team leader standards, assisting the Health Committee in the assessment and monitoring of impaired doctors, and policy issues related to this vital aspect of self-regulation, has also had a busy year. Their expertise in facilitating the work of the council in these areas is highly valued. I also continue to be involved on a day to day basis in this work.

Highly proficient and patient support staff, especially in finance and secretarial services, are critical to getting the job done and have contributed in a very positive way to all activities.

Networks

Meetings within New Zealand with other health registration board executives, in Australia with staff and members of the Australian Medical Council and the Australasian Boards, in the United States with delegates to the FSMB Annual General Meeting and to the First International Conference on Medical Licensure/Registration and Discipline, and in the United Kingdom with staff of the General Medical Council have provided opportunity for broadening perspectives, sharing problems and possible solutions, and getting some feel for the standard of the work undertaken by the Medical Council and the secretariat in New Zealand. This networking is supportive and economical, avoiding waste from reinventing wheels.

Accountability

This annual report is an essential aspect of maintaining accountability to the profession, which funds the work of self-regulation, and to the public, whose interests are best served by safe and expert practitioners. Councils registering and controlling health professionals should also attempt to evaluate their own performance. A measure such as the Self Assessment Instrument (SAI) developed by the Federation of State Medical Boards of the United States (FSMB), provides us with over 300 questions, the answers to which can form a database for identifying areas where changes are needed.

The council has an uneasy relationship with the media. Rarely is there an attempt to understand the job which has to be done or to address the problems associated with it. It is much more commercially advantageous to stir controversy, spreading bad rather than good news. Any attempt by council to correct biased or incorrect information is likely to be unsuccessful. Nevertheless, every effort is made, within the present restricting legislation, to be open and frank, to acknowledge weaknesses and clarify misunderstandings. Council has initiated important forward-looking projects, for example, discussion and guidance on issues surrounding the ethics of new birth technologies, management of dying patients, preventing the transmission by professionals of major viral infections, and trust in the doctor/patient relationship.

These place council in the vanguard, rather than the rearguard, of action to ensure protection of the public from poor, or worse still, harmful, medical intervention in people's lives. It is disappointing that even these positive steps can be used as vehicles for further adverse media commentary. However, as the role of the media in informing the community is acknowledged, the council staff and members continue to strive to maintain good relationships with journalists, however time consuming, with the goal of assisting this process.

Thanks

All secretariat activities have been undertaken with professionalism, goodwill and in the interest of the public. I am indebted to each and every member of staff, including assistants who work outside the secretariat, particularly in the universities, or the casual workers at APC time, and also to the council's legal and media advisors. Council members themselves provide support, dedication and direction in a field of work which is easy for others to criticise but nevertheless essential for community well-being.

We believe that the secretariat is shaping up well to carry out its statutory functions in a humane and creative manner in the next decade. We look forward to fruitful cooperation with the office of the Health and Disability Commissioner in the near future.

Georgina Jones
SECRETARY

DR ROBIN BRIANT CBE

Council members and staff congratulate Dr Briant on her appointment (published in the Queens Birthday Honours List June 1994) as a Commander of the Most Excellent Order of the British Empire (CBE) for services to the medical profession.

Dr Briant, nominee of the Royal Australasian College of Physicians since 1983, was the first woman appointed to the Medical Council. She has served as convenor of Specialist Registration and Preliminary Proceedings Committees and was elected Chair of Council in August 1990.

Dr Briant's contribution to the profession has been far reaching as she has devoted energy to undergraduate and postgraduate teaching, research and publication, and has participated in management and student activities in the Auckland medical school.

Her intelligence, humanity and wisdom have been applied to important initiatives taken in recent years by the council. She has had a formative role in bodies such as International Physicians for the Prevention of Nuclear War (IPPNW), Medical Women's Association, Auckland Medical Aid Trust, and many other professional groups. She has a special interest in women's health issues and in refugee settlement.

It is a matter of pride and delight to the council that Robin Briant has now also been acknowledged by the wider community.

REPORT OF THE MEDICAL PRACTITIONERS DATA COMMITTEE

Graham Mortimer

The council's database contains information on almost 20200 medical practitioners and includes basic information on every New Zealand medical graduate since 1887. The 9400 New Zealand graduates account for 46.6 percent of the database entries. Medical practitioners from about 60 countries have been entered on the New Zealand Medical Register since 1870.

1993 active medical workforce

Of the 10787 medical practitioners with conditional or full registration at 30 June 1993, 6872 were counted as being 'active' in medical or related work in New Zealand. This is an increase of 27 percent since 1983.

Overseas graduates account for 30.3 percent of the workforce. Women account for 26.6 percent of the workforce and are mainly in the younger age groups. Half of the house officers and 31.4 percent of the registrars are women. House officer numbers have remained relatively stable since 1990. Registrar numbers have increased a little each year in recent years, but may now be levelling off. The number of doctors working mainly as general practitioners or primary medical care doctors continues to increase. They were 41.3 percent of the 1993 workforce, compared with 37.8 percent in 1983. The number of doctors working mainly as specialists has increased by 19 percent since 1983, with overseas graduates accounting for 50 percent of the increase. Overseas graduates accounted for 29 percent of the specialist workforce in 1983 compared with 32.4 percent in 1993.

Of the 2660 doctors working mainly as general practitioners, 27.1 percent are women. Two-thirds of these women are under 40 years of age. Some health districts have a much higher percentage of women general practitioners than others, eg. 34.7 percent in the Wellington area, but only 15.7 percent in Manawatu/Wanganui.

There is also considerable variation in the geographical distribution of New Zealand graduates working mainly as general practitioners. Nationally, 30.2 percent of general practitioners gained their initial medical qualification overseas. However, on the West Coast 57.1 percent of the general practitioners are overseas graduates, and in Northland the figure is 41.9 percent, compared with 26.8 percent in the Auckland area and 20.7 percent in Otago.

The data on career discipline suggests that a higher proportion of women graduates intend careers in general practice/primary medical care than men. Since 1988 women have made up at least 45 percent of all New Zealand medical graduates, so differences in the career choices of men and women will need to be monitored to determine the workforce implications for various disciplines.

1994 medical workforce survey

The 1994 questionnaire has returned to the pre-1992 format and allows computer-held information to be printed back for practitioners to correct and update as appropriate. Approximately 9000 questionnaires were issued to registered practitioners with a New Zealand address when the applications for renewal of practising certificate were sent out in mid-April. At 30 June, approximately 90 percent of these questionnaires have been returned and the computer records updated.

Practitioners with overseas addresses were sent APC forms and questionnaires late in June, bringing the total number of questionnaires issued in the three months to 30 June 1994 to around 11450. A priority is to determine the workforce status of practitioners as at the end of June, and in particular to determine which practitioners are 'active' in medical work in New Zealand.

Of concern is the large number of questionnaires returned without indicating the hours in medical work. Without this information, it is not possible to determine full-time equivalents. Approximately 40 percent of the 'active' practitioners will require follow-ups to obtain information about the time spent in medical work.

The co-operation of practitioners in returning follow-up forms promptly is appreciated. Each practitioner's response is important in ensuring the data collected is accurate and complete so that the best possible information about the medical practitioner population and the current active workforce is available.

J G Mortimer
CHAIR

OVERSEAS GRADUATES REGISTERING IN NEW ZEALAND

The following figures refer to doctors with full registration only. It should be noted that there are also around 300 temporary registrants, over 90 probationary registrants and 63 doctors who moved from probationary to full registration.

The number of overseas graduates registering in New Zealand since 1986 has increased considerably, with United Kingdom graduate registrations being about the same, or slightly greater than, the number of New Zealand graduate registrations. Canadian registrations have decreased to half the number in 1986-87. Australian graduate registrations have also decreased. South African graduate registrations have varied considerably over the past decade but increased dramatically from 41 in 1992 to 140 in 1993. A further 86 South Africans registered in the first six months of 1994.

Whereas in 1986-88 half of the overseas graduates registering in New Zealand intended to work as house officers, in 1993 only 30 percent had this intention, with a further quarter working as general practitioners/primary medical care doctors, 21 percent as registrars, and 14.8 percent as specialists. Many of the overseas graduates come to New Zealand as part of their 'overseas experience' or on exchange, particularly those from the United Kingdom, Canada and Australia, but those from other countries tend to settle and remain in the New Zealand workforce.

Table 4 **NEW ZEALAND MEDICAL WORKFORCE 1993**

	1991		1992		1993	
	Total	NZ Graduates	Total	NZ Graduates	Total	NZ Graduates
Active	6570	4621	6722	4733	6872	4790
Full Time Equivalents	6111.4	4303.8	6210.4	4372.0	6257.0	4343.8
House Officers	698	562	677	569	687	560
Registrars	823	618	856	651	854	612
Medical Officers Special Scale	181	89	203	95	201	88
General Practitioners	2549	1779	2616	1818	2660	1857
Other Primary Medical Care	152	97	159	105	180	121
Specialists	2021	1376	2066	1396	2131	1441
Miscellaneous (non specialist)	146	100	145	99	159	111

	1988		1989		1990	
	Total	NZ Graduates	Total	NZ Graduates	Total	NZ Graduates
Active	6174	4326	6286	4434	6339	4480
Full Time Equivalents	5692.5	4000.0	5763.9	4070.4	5863.3	4151.6
House Officers	728	525	719	533	679	538
Registrars	771	620	765	616	799	627
Medical Officers Special Scale	180	87	176	93	173	87
General Practitioners	2293	1608	2383	1681	2429	1705
Other Primary Medical Care	124	81	139	92	165	101
Specialists	1953	1338	1957	1326	1952	1325
Miscellaneous (non specialist)	125	67	147	93	142	97

Table 5 **NEW ZEALAND MEDICAL REGISTRATION INFORMATION**
at 30 June 1994

Total practitioners on register	11413
Total practitioners on register with practising certificates	7521
Temporary registrants	133
Probationary registrants	51
Names removed from register (various)	90
Practitioners deceased	65

REPORT OF THE REGISTRATION COMMITTEE

Ian St George

Matters of major concern for the Registration Committee this year have been the registration of new specialities, the recognition of the qualifications of overseas trained doctors and future periodic recertification.

Recognition of rehabilitation medicine, emergency medicine and occupational medicine as specialties has been completed, and recognition of venereology is in the pipeline. The recognition of general practice as a specialty by the Medical Council has been an important milestone this year - but it has still to be given the governmental nod of approval. Throughout the world in the 1990s general practice is affirmed as a discipline requiring special vocational training for efficient and humane practice. It is absurd that graduates, prepared at medical school only for further vocational training, should enter the specialty of general practice after only a year of internship in a hospital. Specialty status alone will not prevent this dangerous situation and we hope that the new Medical Practitioners Act will have further measures to protect the public.

Overseas trained doctors must now pass NZREX (equivalent in standard to our 5th and 6th year student examinations) before beginning work, but graduates from some countries of the old British Empire are still allowed full registration in New Zealand - this is a requirement of the Act, and a situation that the Medical Council has no power to change.

Some overseas doctors coming from other countries have gained immigration points as desirable migrants on account of their medical qualifications. But their qualifications are not registrable in New Zealand, and this anomaly has resulted in anger and disillusionment as they have arrived here expecting to work. The council seems powerless to persuade the NZQA and Immigration that their degrees should not count towards immigration points.

While periodic recertification is now being developed and is the norm for some vocational colleges, it is still not a requirement for registration by the Medical Council. Again we hope that a new Act will address this issue.

I M St George
CONVENER

Table 6

NEW REGISTRANTS IN VOCATIONAL DISCIPLINES
at 30 June 1994

	New Zealand		Overseas		
	Males	Females	Males	Females	Total
Anaesthetics	7	1	11	1	20
Community Medicine	4	1	0	0	5
Dermatology	1	0	0	0	1
Diagnostic Radiology	9	1	4	4	18
General Practice	7	0	9	1	17
Gynaecology	0	0	0	0	0
Internal Medicine	12	3	8	1	24
Obstetrics	0	0	0	0	0
Obstetrics & Gynaecology	4	3	4	4	15
Ophthalmology	3	0	2	0	5
Orthopaedic Surgery	7	0	0	0	7
Otolaryngology	2	0	1	0	3
Paediatrics	6	2	3	0	11
Pathology	5	3	2	0	10
Psychiatry	5	3	12	0	20
Radiotherapy	0	0	2	0	2
Cardiothoracic Surgery	0	0	0	0	0
General Surgery	7	2	1	0	10
Neurosurgery	0	0	0	0	0
Paediatric Surgery	0	0	0	0	0
Plastic Surgery	2	0	0	0	2
Urology	2	0	1	0	3
Venereology	0	0	0	0	0
Total	83	19	60	11	173

REPORT OF THE SPECIALIST REGISTRATION SUBCOMMITTEE


Campbell Maclaurin

Applications

The number of applications for specialist registration or for assessment of eligibility for entry to the register has risen considerably over the last year. Approximately 110 files are open at any one time. The rise seems to result from requirements by funders and crown health enterprises that practising specialists be registered as such, and from increased immigration, particularly from South Africa.

The assessment process utilising advice from the specialist colleges and societies remains unchanged. However, there has been concern expressed by some of the colleges that changes in the standards of certain overseas qualifications are not readily taken into account, given the rather rigid structure of the current statutory regulations. These are laid down in the Medical Practitioners (Registration of Specialists) Regulations associated with the Medical Practitioners Act 1968, and list particular qualifications that were deemed acceptable during the 1970's and early 1980's when they were gazetted. The standards of at least some of these is believed, by the colleges concerned, to have fallen behind those of the equivalent Australasian qualifications.

The lack of flexibility, requiring formal change in the regulations, is a cause for concern in certain disciplines. It is hoped that under the long-awaited new Medical Practitioners Act the council itself will be given increased authority to make a regular review of the equivalence of such qualifications upon appropriate advice. In the meantime, council must make the best determination that it can upon the advice given, and try to ensure that the standard of practice of all those entering the country is equivalent to that of those holding Australasian qualifications. It is partly for this reason that increasing use is now being made of the category 'acceptable for assessment' in the advice received from the colleges, whereby individuals who have had their training in other parts of the world can be assessed locally, under supervision, before admission to the specialist register.

New specialties

The Minister of Health has accepted the council's recommendations for the gazetting of emergency medicine, occupational medicine and rehabilitation medicine as recognised specialties in terms of the specialist regulations. Gazetting is expected to take place shortly. Along the same lines the discipline of venereology is being reconsidered by the council in respect of its own recognition, as it is likely that in due course this will become, once again, a recognised specialty under the regulations.

The discipline of general practice was also recommended to the Minister of Health for gazetting as a specialty discipline, but as yet no decision has been forthcoming.

Shortage

Following representations from the Royal Australian and New Zealand College of Psychiatrists, council has deemed the discipline of psychiatry a shortage specialty, and has made special provisions to assist short-term recruitment of psychiatrists from the United States and elsewhere to meet this need. In the case of psychiatrists, specialist practice

is permitted when they have completed residency training and are deemed eligible, and many do not subsequently proceed to becoming board certified. The latter is the qualification required under the Specialist Regulations in this country, and after careful consideration council has temporarily suspended this provision for psychiatry to allow the recruitment of board eligible psychiatrists, provided referees' reports are satisfactory and they are not going to be working in isolation. This arrangement has allowed New Zealand to recruit a significant number of people for short-term appointments to help address the very severe shortage in this specialty.

Overall, the council feels that the very careful monitoring of the qualifications, training and experience of those admitted to the Register of Specialists serves the New Zealand public well in ensuring that proper quality of practice in each of the specialties is recognised in the register.

C H Maclaurin
CONVENER

Table 7

NEW ZEALAND REGISTER OF SPECIALISTS
at 30 June 1994

	1993	Added	Remvd	Net	1994 Actual
Anaesthetics	293	20	0	20	313
Community Medicine	164	5	4	1	165
Dermatology	45	1	0	1	46
Diagnostic Radiology	159	18	1	17	176
Gynaecology	1	0	0	0	1
Internal Medicine	483	24	6	18	501
Obstetrics	1	0	0	0	1
Obstetrics & Gynaecology	196	15	4	11	207
Ophthalmology	96	5	2	3	99
Orthopaedic Surgery	142	7	1	6	148
Otolaryngology	73	3	1	2	75
Paediatrics	151	11	1	10	161
Pathology	168	10	3	7	175
Psychiatry	255	20	4	16	271
Radiotherapy	33	2	0	2	35
Cardiothoracic Surgery	26	0	0	0	26
General Surgery	242	10	7	3	245
Neurosurgery	14	0	0	0	14
Paediatric Surgery	5	0	0	0	5
Plastic Surgery	26	2	0	2	28
Urology	38	3	0	3	41
Venereology	17	0	1	-1	16
Total	2628	156	35	121	2749

REPORT OF THE INDICATIVE REGISTER (GENERAL PRACTICE) SUBCOMMITTEE

Murdoch Herbert

While a year has passed and the new Medical Practitioners Bill has not yet reached the House, the application of the Royal New Zealand College of Practitioners that general practice be included as a specialty in the proposed vocational register has been approved by the Medical Council and forwarded to the Minister for approval. When this is given, those doctors not on the present indicative register and without the qualifications required to be accepted as eligible for the proposed specialist register of general practitioners, may be in the position of having to work under supervision, as is the case in the United Kingdom.

It is also likely that the regional health authorities, who now seem to be turning their attention to primary care, will expect general practitioners seeking contracts for the provision of services, to give evidence of suitable training and experience.

There are still experienced general practitioners, some of them members and fellows of the college or equivalent colleges, who have not applied to go on the Indicative Register for various reasons. They may wish to reconsider and submit an application before the new Act is passed. For their benefit, and for overseas trained doctors in general practice in New Zealand, the criteria for entry to the Indicative Register (General Practice) are that a medical practitioner must:

- hold the MRNZCGP, 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.

During the past year several membership applications were declined because although the applicants had passed Part 1 of the college examination they had not fulfilled all the requirements necessary to complete membership. Others applied on the grounds that they were in practice before 1 April 1990, and had they applied then they would have been eligible. These too have been declined as the Regulations apply as from 1 April 1990.

As at 30 June 1994 there are 1263 doctors with annual practising certificates on the Indicative Register (General Practice).

M M Herbert
CONVENER

NEW ZEALAND REGISTRATION EXAMINATION (NZREX)

This examination, which plays an important role in the maintenance of high standards of practice in New Zealand, relies heavily on the skills of a wide variety of examiners and administrators. In May a new format NZREX came into effect consisting of:

- English (similar to the old Part I)
- Written (similar to the old Part III)
- Clinical (similar to the old Part IV)

Under this new arrangement the whole examination must be completed before any form of registration is granted and practice commenced in New Zealand. Successful candidates are eligible to apply for probationary registration (a minimum of 12 months in approved practice under supervision in either hospital or general practice). During that probationary year, acceptable standards of communication, clinical knowledge, judgement and effectiveness, ethics and attitude must be demonstrated before full registration is approved by council. New methods of assessing some of these components are currently under consideration by the council, in consultation with the Board of Examiners.

The transition period from the old to the new format NZREX has been relatively smooth, July 1993 marking the commencement of that transition period and March 1994 the end. There are still a number of transition candidates (ie. those on temporary registration who entered the examination system in the old four part format) who are now required to complete the new format.

A large number of candidates sat the English and written examinations in May 1994 as it was the first available examination for new candidates since May 1993. The numbers for the first of the new format NZREX Clinical in August 1994 were also high with 41 applications on the closing date in June. This places considerable strain on the resources needed to run this examination. The cooperation of the clinical schools and the Crown Health Enterprises in Auckland and Wellington has been vital and very much valued, but costs are rising and access to facilities is more difficult. Candidates pay high fees which are set at a 'break even' level only.

Table 8

NZREX	PART I	PART II	Screening Examination Overall
		November 1993	
Candidate attempts	21(17)	36(34)	57(51)
No. of passes:			
Attempt 1	2	1	
Attempt 2	8	15	
Attempt 3	1	4	
No. of passes overall	11	20	31
Pass rate overall	52%	56%	54%
		Jan 1994 (Special)	
Candidate attempts		(15)	72(66)
No. of passes:			
Attempt 1			
Attempt 2			
Attempt 3		9	
No. of passes overall		9	40
Pass rate overall		60%	55%

New Format – First Sessions

	English May 1994	Written	Clinical August 1994
Candidate attempts	59(4)	88	46(26*) (Enrolled)
No. of passes:			
Attempt 1	46	14	
Attempt 2	-	n/a	
Attempt 3	2	n/a	
No. of passes overall	48	14	
Pass rate overall	78%	22%	

Note: ( ) repeat candidates included
(*) candidates from old format NZREX

Issues of examination security and Privacy Act implementation have also concerned council to a greater extent in the past twelve months.

The examinations require a very high level of commitment, coordination and expertise from all involved. It is with great sadness that Dr Gavin Glasgow is farewelled from the Board of Examiners. After almost ten years of involvement with Medical Council examinations Dr Glasgow is retiring from the position of Examinations Director, which he took up in 1988. His dedication and wise advice have been crucial to the development and continuous improvement of the council's examination system. Dr Glasgow will be missed by all involved in the examinations and he has the best wishes of his colleagues for his retirement.

Dr Campbell Maclaurin has been appointed to the position of Examinations Director commencing 1st July 1994. He brings to the position considerable experience in postgraduate education and administration.

The Board of Examiners has worked hard to design and put in place the new format NZREX. All members of the Board of Examiners have generously given time and energy and these efforts are appreciated. Dr David McHaffie replaced Professor John Hutton as nominee from the University of Otago in March 1994. Professor Hutton made a significant contribution to the quality of the examination and that is acknowledged. Dr McHaffie has now taken responsibility for coordination of the Wellington clinical examination.

Thanks are due to the team of experienced examiners from both Auckland and Wellington Schools of Medicine who have spared time to examine overseas trained doctors. The good work of the administrative staff who assist with the organisation of NZREX, Mrs Jennifer Hargrave in Auckland, Ms Denise Fabian and Ms Lorraine Cartwright in Wellington, is also acknowledged.

Table 9

NZREX	Part III	Part IV
	July 1993	Aug 1993
Candidate attempts	46(10)	33(23)
No. of passes:		
Attempt 1	7	1
Attempt 2	1	12
Attempt 3	2	5
No. of passes overall	10	18*
Pass rate overall	21%	55%
	**Feb 1993	**Mar 1994
Candidate attempts	60(29)	26(14)
No. of passes:		
Attempt 1	8	3
Attempt 2	4	3
Attempt 3	1	5
No. of passes overall	13	11*
Pass rate overall	21%	42%

Notes: ( ) number of repeat candidates included
* does not include partial passes
** last session in this format

Dr John Read and his examiners from the English Language Institute, Victoria University, continue to administer the English examination (old Part I) in Wellington and Auckland. The council is indebted to staff at the Regional Language Centre Examination Bureau in Singapore, and Birkbeck College University of London, for administration of both the English and written examination in the old and new format in those overseas centres.

Jolene Maxwell has carried the burden of all secretariat administration of examinations for overseas trained doctors (and for the Dental Council, dentists) in the past year and has managed well under pressure from

many quarters. The deluge of enquiries alone (up to 5000 each year) is daunting. Communication with potential candidates has been confused by advice, policies and procedures of official bodies outside council's control. We continue to address these problems of mixed messages.

Future councils will probably have greater discretion in the acceptance of primary degrees obtained overseas than our present Act allows. Under a revised Medical Practitioners Act a wider group of overseas trained doctors may need to pass NZREX to achieve probationary registration. Such a change could do away with perceived anomalies or discrimination in the view of some overseas trained doctors seeking a pathway to registration and practice in New Zealand.

REPORT OF THE FINANCE AND MANAGEMENT COMMITTEE

Ken Thomson

This report covers the period 1 July 1993 to 30 June 1994, although the financial statements included with it cover the period 1 April 1993 to 31 March 1994.

Taxation

At the time of writing this report the appeal by the Commissioner of Inland Revenue against the decision of the Taxation Review Authority that the Medical Council be exempt from the payment of income tax, on the grounds that it is both a public authority and charitable organisation, has not yet come to a hearing. The appeal procedures are such that it may be at least six months before the final position is reached. As a result no tax has been refunded, pending the outcome of the appeal.

General council operations

The general operating expenses of council rose slightly, but this was offset by a significant increase in fees received for annual practising certificates. Expenditure from the general fund has increased over the previous year. Some of this increase reflected depreciation on the air-conditioning unit and office alterations at the former premises at Courtenay Place which have been written down in the current financial year to their estimated realisable value of $5000 each. There was also a significant increase in legal expenses, most of which was associated with the ongoing taxation dispute. The increased workload on the council secretariat was reflected in an increase in salaries and associated recruitment costs.

Council and committee expenses were lower than in the previous year, due to a reduction in the number of meetings held per year.

During the year there has been a review of all council's operations resulting in a reorganisation of the secretariat which will result in a substantially improved service to the profession and the public. All secretariat functions were reviewed and a more efficient and effective secretariat management structure put in place. Associated with this reorganisation the council has upgraded its accounting software, and this is providing much improved budgetary information and financial reporting in the current year.

A review of information systems is currently in progress, and it is hoped that improvement to our records systems, together with the reorganisation of the secretariat, will enable council and the secretariat to respond swiftly to any changes imposed in the forthcoming Medical Practitioners Act.

Discipline

The difficulties of predicting expenditure on discipline have been highlighted in the past financial year. While original budgetary predictions were for a modest commencing surplus and decreased expenditure during the year, unexpectedly large legal expenses earlier in the year made it clear that the levy set in 1993 was insufficient. The resulting deficit was also accentuated by substantial unpaid costs (only some delayed by pending High Court action), and as a result the disciplinary levy for the 1994/95 year has to be increased. Unfortunately, even with the best budgeting system, it is quite impossible to predict what demands are going to be placed on the discipline fund.

In spite of very effective management by the Interim Disciplinary Secretariat (IDS), the costs of the Medical Practitioners Disciplinary Committee increased slightly due to workload. Legal expenses were also higher. The substantial increase in council expenses for discipline related to several prolonged disciplinary tribunals held during the year, and likewise there were similar increases in expenditure on the Health Committee which increased its activities.

Compentency

Competence enquiries are normally self funding as hospitals requesting them are expected to contribute when the exercise undertaken under council powers and immunity is completed. The amount expended in 1993/1994 arose, however, as a follow-up to a complex performance matter raised by the PPC, and not suitable for charging back.

The administration fee charged to the discipline fund to reflect realistic costs of the secretariat facilities, time and other resources, has been cut back this year in light of the considerable deficit for the year in the fund. It should be recognised, however, that it forms a not insubstantial item in the overall cost of discipline and disability functions.

Examination fund

This fund showed a small surplus for the current financial year, following the increase in examination fees. This increase also allowed the fund to make a contribution to the real costs of the council secretariat infrastructure, without which the examinations could not be administered. The cost of examinations continues to rise, particularly that associated with the clinical examination and it is likely that a further modest increase in fees will be necessary to keep this fund self-sufficient. The sum shown as an investment (para. 4 of the Notes to the Accounts) reflects the fees at year end paid in advance of the May 1994 English and written tests, and is not therefore surplus. The modest surplus shown on page 41 in the NZREX Fund Revenue Statement should be maintained to provide for examination development.

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 Knight & Little Chartered Accountants

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 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 1994 and the results of its activities for the year ended on that date.

Miller Dean Knight + Little

Chartered Accountants

WELLINGTON
24 June 1994

NOTES TO ACCOUNTS

1. Statement of Accounting Policies

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.

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

except that air-conditioning and office alterations at the former premises at Courtenay Place have been written down in the current financial year to their estimated realisable value of $5,000 each. The amounts written off have been included under Depreciation for Year under Note 5.

(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

Administration fees charged in the current financial year compared to the previous year are as follows:

	1994	1993
Dental Council	$27,500	$ 27,500
Discipline Fund	$60,000	$100,000
Examination Fund	$30,000	-

Assets at the former premises in Courtenay Place have been written down to their estimated realisable value in lieu of the standard 10% straight line depreciation adopted by the council. This is an additional write-off of $38,622 in this financial year. Apart from the above, 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 1994 amounting to $432,408 plus Resident Withholding Tax deducted ($27,024) to be refunded.
This decision of the Taxation Review Authority has been appealed by the Commissioner of Inland Revenue.

3. Payments in Advance and Debtors

The debtors figure includes $64,238 outstanding refund of GST, $17,778 outstanding contribution to the workforce survey.

4. Investments

	1994	1993
(a) **General Fund**		
BNZ Finance Call Account	60,339	23,323
National Bank Call Account	50,288	106,997
Equiticorp Finance Limited (in Statutory Management)	-	16,039
ANZ Call Account	21,123	25,489
Westpac Call Account	74,465	6,636
Trust Bank Call Account	152,611	56,678
	$358,826	$235,162
(b) **Discipline Fund**		
ANZ Call Account	-	167,685
National Bank Call Account	-	43,659
BNZ Finance Call Account	-	20,202
Westpac Call Account	-	71,963
Trust Bank Call Account	-	102,118
	$ -	$405,627
(c) **Examination Fund**		
ANZ Call Account	79,702	116,132
Total Investments	$438,528	$756,921

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. The original capital in this investment had been written down to 85%. Slightly more than this amount has now been recovered but the investment balance is shown as Nil. Recoveries in excess of the written down amount are shown as Prior Year Adjustment in the General Fund.

5. Fixed Assets

	Cost 31/3/94	B/V 1/4/93	Depn For Year	B/V 31/3/94	Acc Depn 31/3/94
Air-Conditioning	36,704	17,236	12,236	5,000	31,704
Computer - General	204,637	68,519	26,323	52,380	152,257
Furniture and Fittings	135,376	51,767	13,496	59,498	75,878
Office Alterations	157,364	50,793	45,793	5,000	152,364
Office Alterations - New Premises	99,065	9,877	9,907	89,158	9,907
Office Equipment	63,286	21,791	9,630	33,051	30,235
	$696,432	$219,983	$117,385	$244,087	$452,345

Depreciation for year includes write-downs for fixed assets at the former premises at Courtenay Place:

Air-conditioning	12,236
Office Alterations	45,793
	$58,029

6. Prior Years Adjustments

Details of prior years adjustments are as follows:

	1994 General Fund	1993 General Fund	1993 Discipline Fund	1993 Exam Fund
Equiticorp Finance Limited Note (4)	3,249			
Reversal of Earlier Tax Provisions Note (2)		93,883	137,965	(3,443)

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		1994	1993
General Fund		339,005	(38,564)
Discipline Fund		(722,158)	279,986
Examination Fund		24,207	(2,436)
		(358,946)	238,986
Less Taxation Paid		(73,332)	(247,376)
		(432 ,278)	(8,390)
Add Non-Cash Items - Depreciation		117,385	59,159
		(314,893)	50,769
Add Movements in Working Capital Items			
Decrease in Debtors and Prepayments	73,773		(55,179)
Increase in Receipts in Advance	64,853		37,387
Decrease in Creditors	(150,600)		30,205
		(11,974)	12,413
		(326,867)	63,182
Less Items Classified as Investing Activity			
Interest		(85,790)	(122,537)
Net Cash Flow from Statutory Functions		($412,657)	($59,355)

MEDICAL COUNCIL OF NEW ZEALAND

BALANCE SHEET

as at 31 March 1994

	1994	1993
CURRENT ASSETS		
Petty Cash	310	310
General Fund Cheque Account	(51,032)	105,144
Sundry Debtors and Payments in Advance (Note 3)	106,029	179,802
Interest Accrued	2,399	4,400
Taxation Refund Due (Note 2)	459,432	386,100
	517,138	675,756
INVESTMENTS (Note 4)	438,528	756,921
FIXED ASSETS (Note 5)	244,087	219,983
TOTAL ASSETS	$1,199,753	$1,652,660
CURRENT LIABILITIES		
Sundry Creditors		
- General Fund	107,748	99,615
- Discipline Fund	163,273	264,120
- NZREX	10,042	76,142
Payments Received in Advance	163,259	98,406
TOTAL CURRENT LIABILITIES	444,322	538,283
CAPITAL ACCOUNT		
Accumulated Capital	757,386	443,381
Discipline Fund	(188,291)	533,867
Education Fund	175,000	150,000
Examination Fund	11,336	(12,871)
	755,431	1,114,377
	$1,199,753	$1,652,660

The accompanying notes on page 33 to 36 form part of these financial statements.

MEDICAL COUNCIL OF NEW ZEALAND

GENERAL FUND REVENUE STATEMENT

for the year ended 31 March 1994

	1994	1993
FEES RECEIVED		
Annual Practising Certificate	1,235,249	708,922
Certificate of Good Standing	12,658	12,414
Medical Registration Certificate	3,206	3,787
Change of Name	747	853
Registration Fees	182,700	161,502
Specialist Registration Fee	13,085	12,573
INCOME FROM FEES	1,447,645	900,051
OTHER INCOME		
Administration Fee - Dental Council	27,500	27,500
Administration Fee - Discipline Fund	60,000	100,000
Administration Fee - Examination Fund	30,000	-
Interest Received	46,862	38,945
Sales of Medical Registers	26,783	31,594
Sundry Income	730	4,062
INCOME FROM OTHER SOURCES	191,875	202,101
TOTAL INCOME FOR YEAR	1,639,520	1,102,152
Less Expenses as per Schedule	1,303,764	1,140,716
Net Surplus (Deficit)	335,756	(38,564)
Prior Year Adjustment (Note 6)	3,249	93,883
Accumulated Capital	443,381	413,062
Transfer to Education Fund	25,000	25,000
ACCUMULATED CAPITAL	$757,386	$443,381

The accompanying notes on pages 33 to 36 form part of these financial statements.

MEDICAL COUNCIL OF NEW ZEALAND

GENERAL FUND SCHEDULE OF EXPENSES

for the year ended 31 March 1994

	1994	1993
ADMINISTRATION AND OPERATING EXPENSES		
ACC Levies	5,263	4,939
Accounting and Audit Fees	8,500	8,550
Agents Registration Fees	5,110	3,666
Computer Consultancy	4,693	6,566
Cleaning	3,603	2,989
Courier	6,267	4,926
Depreciation	117,385	59,159
Electricity	6,419	4,362
Fringe Benefit Tax	5,060	6,825
General Expenses	7,240	7,800
Legal Expenses	39,293	6,663
Micro Film Files	1,244	1,160
Medical Workforce Expenses	17,298	24,837
Photocopying Expenses	12,644	8,264
Postage	31,179	22,950
Printing and Stationery	72,474	61,679
Privacy	1,267	-
Projects - Biotechnology Revisited	15,009	1,042
- Persistent Vegetative State	-	10,037
- Transmissible Major Viral Infections	-	938
Public Affairs	27,568	45,579
Rent and Insurance	81,933	66,032
Repairs and Maintenance	12,241	4,246
Salaries	430,810	363,776
Superannuation and Health Insurance	18,808	16,454
Staff Recruitment and Training	28,837	6,402
Telephone and Tolls	17,436	17,086
TOTAL ADMINISTRATION EXPENSES	977,581	766,927
COUNCIL AND COMMITTEE EXPENSES		
Council Expenses		
- Chairperson's Honoraria	58,524	56,200
- Fees and Expenses	125,828	163,166
- Australasian Liaison Meetings	11,629	21,379
Registration Committee	12,129	11,701
Act Revision	4,955	-
Data Committee	2,669	6,576
Finance & Management Committee	6,477	8,832
Summer Studentship	2,600	2,600
Medical Education Committee		
- Fees and Expenses	21,324	27,686
- Hospital Visits	-	12,945
Intern Supervisors Meetings	288	4,311
Intern Supervisors Contracts	79,760	58,393
TOTAL COUNCIL AND COMMITTEE EXPENSES	326,183	373,789
TOTAL EXPENDITURE	$1,303,764	$1,140,716

The accompanying notes on pages 33 to 36 form part of these financial statements.

MEDICAL COUNCIL OF NEW ZEALAND

REVENUE STATEMENT FOR DISCIPLINE FUND

for the year ended 31 March 1994

REVENUE	1994	1993
Levies Received	1,277,416	2,004,406
Interest Received	34,075	81,019
Fines Imposed and Discipline Costs Recovered	146,743	139,768
TOTAL REVENUE	1,458,234	2,225,193
ADMINISTRATION AND OPERATING EXPENSES		
Accounting and Audit Fees	3,500	3,700
Administration Fees (Note 1)	60,000	100,000
Competence Inquiries	11,154	6,742
Disciplinary Stress Support Group	-	1,500
Doctors Health Advisory Service	27,109	24,222
Expert Witnesses	14,416	8,156
General Administration Expenses	2,960	3,635
Higher Court Actions	8,983	51,761
Hire of Rooms	5,330	1,710
Legal Expenses	603,566	488,109
Medical Practitioners Disciplinary Committee	1,017,885	918,431
Mentoring Expenses	13,285	27,127
Projects		
- Misuse of Drugs	-	116
- Public Affairs	-	5,996
- Sexual Abuse	42,831	50,327
Stenographers Fees and Expenses	34,395	18,831
Telephone and Tolls	8,069	8,146
Tribunals Officer	17,259	11,673
TOTAL ADMINISTRATIVE AND OPERATING EXPENSES	1,870,742	1,730,182
COUNCIL AND COMMITTEE EXPENSES		
Council Expenses (Discipline)		
- Fees and Honorarium	139,175	52,906
- Expenses	56,112	29,253
Council Expenses (Health)		
- Fees and Expenses	32,455	13,757
Preliminary Proceedings Committee		
- Fees and Honorarium	68,343	75,133
- Travelling and Accommodation	13,565	43,976
TOTAL COUNCIL AND COMMITTEE EXPENSES	309,650	215,025
TOTAL EXPENDITURE	2,180,392	1,945,207
Net Surplus (Deficit) for the Year	(722,158)	279,986
Accumulated Surplus(Deficit)	533,867	115,916
Prior Year Adjustment (Note 6)	-	137,965
ACCUMULATED DISCIPLINE FUND	($188,291)	$533,867

The accompanying notes on pages 33 to 36 form part of these financial statements.

NEW ZEALAND REGISTRATION EXAMINATION FUND REVENUE STATEMENT

for the year ended 31 March 1994

REVENUE	1994	1993
NZREX Candidate Fees	272,030	218,702
Interest	4,853	2,573
TOTAL REVENUE	276,883	221,275
ADMINISTRATION AND OPERATING EXPENSES		
Audit and Accountancy Fees	1,000	1,000
Centre Costs (NZ and Overseas)	19,365	21,930
Honoraria	38,460	35,970
Examiners Fees and Expenses	141,669	147,472
General Administrative Expenses	14,486	11,786
Administration Fee (Note 1)	30,000	-
	244,980	218,158
COMMITTEE EXPENSES		
Board of Examiners Fees	7,696	5,553
TOTAL EXPENDITURE	252,676	223,711
(Deficit) Surplus for Year	24,207	(2,436)
Accumulated Surplus (Deficit)	(12,871)	(6,992)
Prior Year Adjustment (Note 6)	-	(3,443)
TOTAL EXAMINATION FUND	$11,336	($12,871)

The accompanying notes on pages 33 to 36 form part of these financial statements.

MEDICAL COUNCIL OF NEW ZEALAND

STATEMENT OF CASHFLOW

for the year ended 31 March 1994

Cash Flow from Statutory Functions		1994	1993
Cash was provided from			
receipts pertaining to statutory functions			
and administration fee from Dental Council	3,369,266		3,418,529
Cash was also distributed to payment			
for council fees and disbursements and			
secretarial expenses	(3,708,591)		(3,230,508)
Payment of Tax	(73,332)		(247,376)
	(3,781,923)		(3,477,884)
Net Cash Flow from Statutory Functions		(412,657)	(59,355)
Cash Flow from Investing Activities			
Cash was provided from:			
Short Term Investments	318,393		10,755
Interest Received	87,791		124,078
	406,184		134,833
Cash was applied to:			
Purchase of Assets	(149,703)		(46,728)
Net Cash Flow from Investing Activities		256,481	88,105
Net Increase (Decrease) in Cash Held		(156,176)	28,750
Opening Cash Brought Forward		105,454	76,704
Ending Cash Carried Forward		($50,722)	$105,454
Represented by:			
Petty Cash		310	310
General Fund Cheque Account ANZ Bank		(51,032)	40,524
Discipline Fund Cheque Account BNZ		-	34,569
Discipline Fund Cheque Account BNZ#2		-	1,420
Examination Fund Cheque Account ANZ Bank		-	28,631
		($50,722)	$105,454

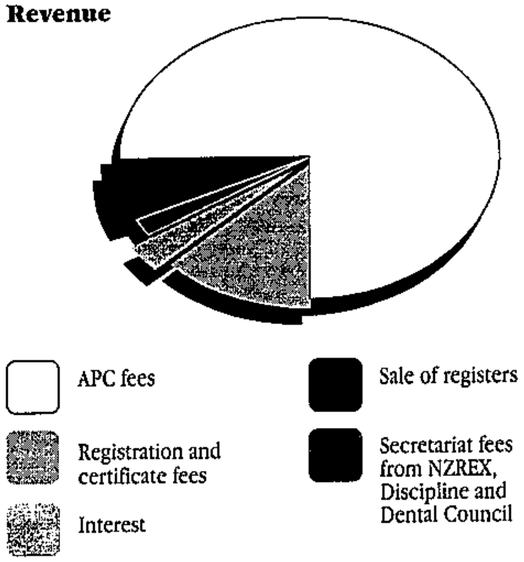
The accompanying notes on pages 33 to 36 form part of these financial statements.

DISTRIBUTION OF COUNCIL REVENUE AND EXPENDITURE

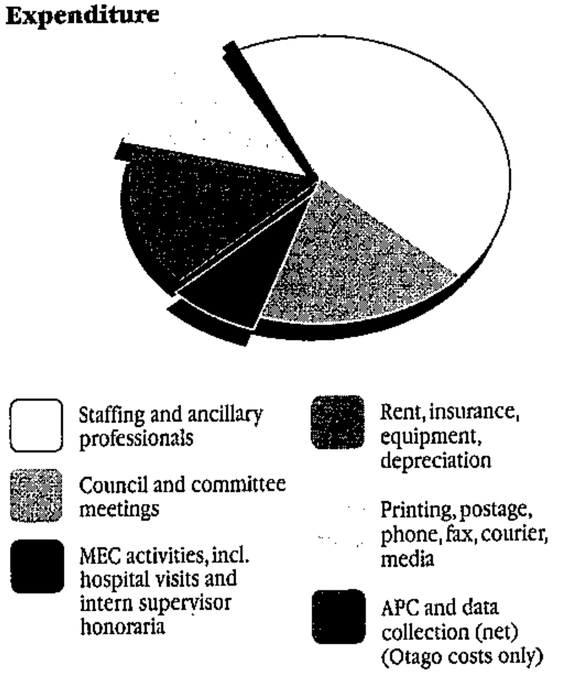
for the year ended 31 March 1994

GENERAL FUND (53% of turnover)

Revenue

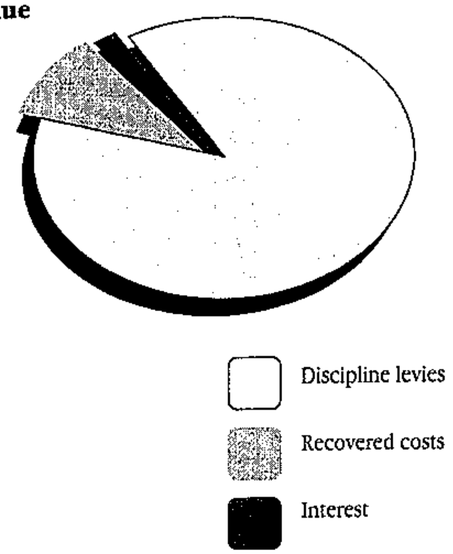


Expenditure

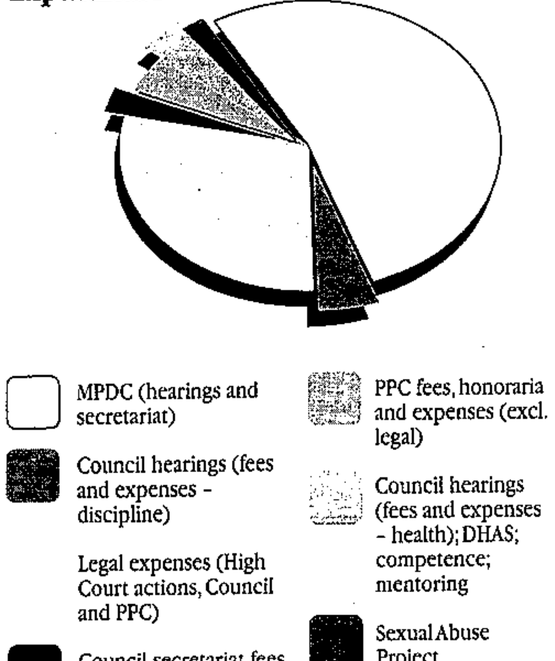


DISCIPLINE FUND (47% of turnover)

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 1994 to 31 March 1995

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

		Fee	GST from 1/4/94	Total to Pay from 1/4/94
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)	316.67	39.58	356.25
	(2)	134.45	16.80	151.25
Total fees on registration	(1)	664.01	82.99	747.00
	(2)	481.79	60.21	542.00
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)		546.67	68.33	615.00
For annual practising certificate including discipline levy	(1)	466.67	58.33	525.00
	(2)	284.45	35.55	320.00
For *restoration of name to Register after removal therefrom (including provisional certificate)		624.00	78.00	702.00
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 1/4/94 and 30/10/94
(2) Fee for persons registering for the first time or applying for APC between 1/11/94 and 31/3/95