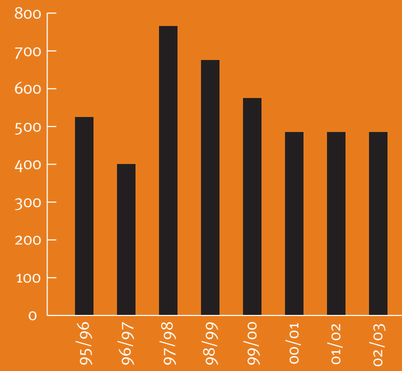
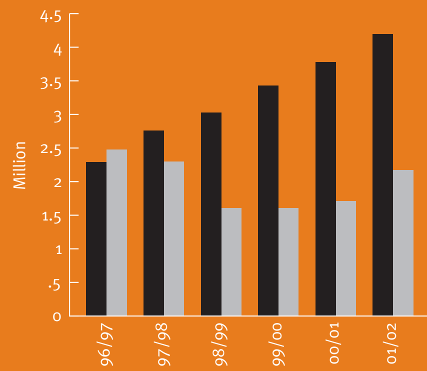
Annual Report 2002

Finances

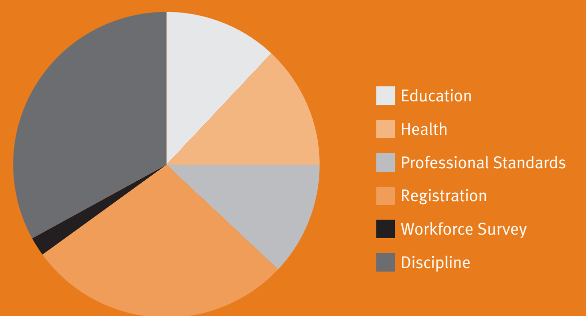


Annual Practising Certificate fee



Total expenditure **(excludes examination fund)**

Discipline Fund
General Fund



Total expenditure

At a glance

	2001	2002
Doctors registered for the first time		
• trained in New Zealand	292	279
• trained overseas	890	1,089
– temporary	700	844
Total practising doctors	9,384	9,964
Candidates NZREX examination	167	83
Passes NZREX	78	48
Doctors on vocational register	5,585 (44.6%)	5,834 (46.3%)
Complaints	382	70
Concerns about competence	82	73
Competence reviews	37	37
Health notifications	30	60

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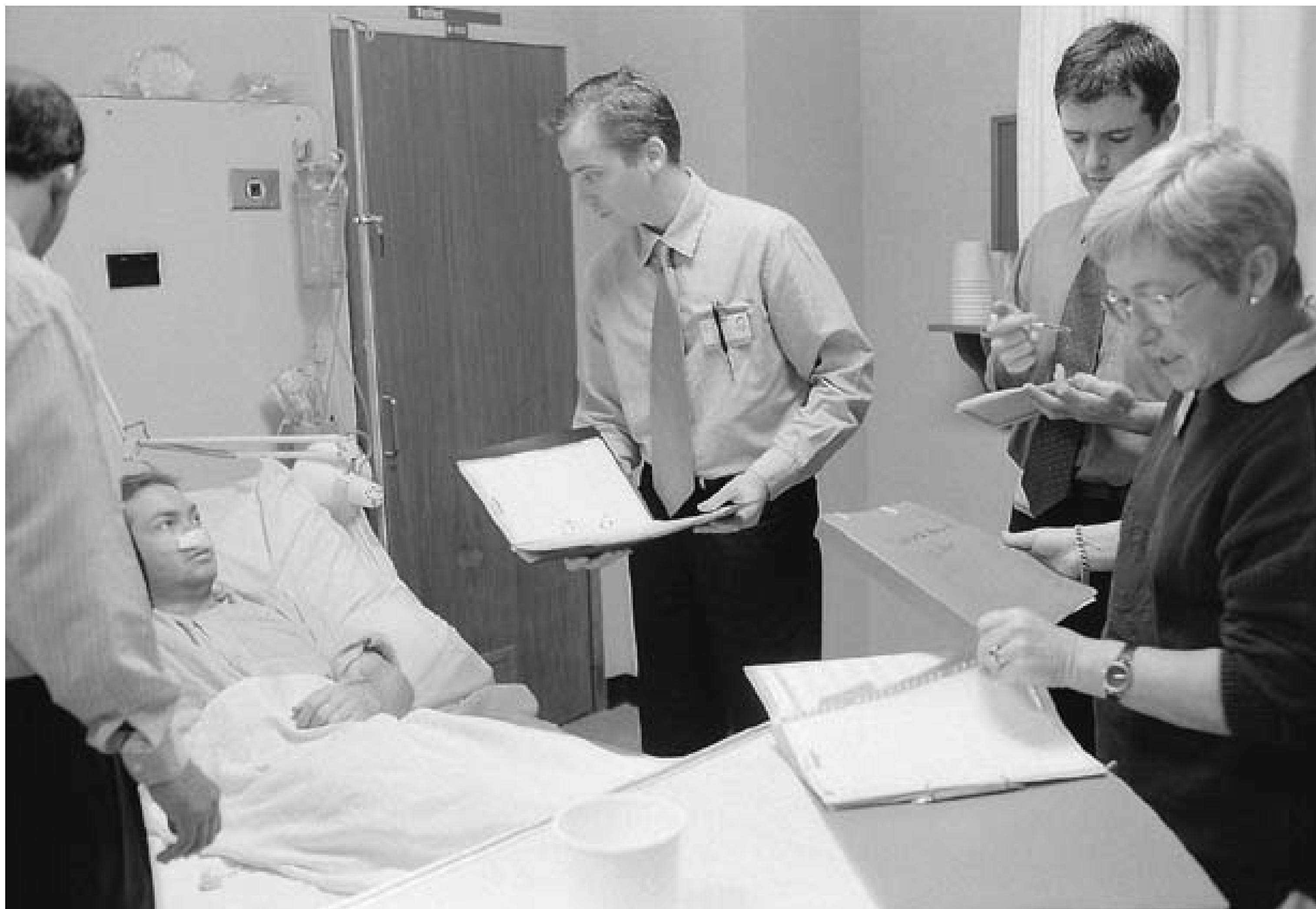


Protecting the public; promoting good medical practice

The Medical Council of New Zealand is pleased to submit this Annual Report for the year ending 31 March 2002 to the Minister of Health. The report is presented in accordance with section 130 of the Medical Practitioners Act 1995 and incorporates the report of the Medical Practitioners Disciplinary Tribunal.

Medical Council of New Zealand

Medical Education	Registration	Professional Standards	Complaints	Doctors' Health	Issues
Accrediting medical schools Monitoring suitability of hospitals for new doctors Approving new branches of medicine and their training and recertification programmes	Maintaining the medical register of 12,000+ doctors Registering new doctors who demonstrate appropriate skills, qualifications and training Issuing annual practising certificates Considering re-registration of disciplined doctors	Reviewing doctors' competence and setting competence programmes Assuring the continued competence of doctors through general oversight and recertification Managing doctors subject to conditions	Assessing complaints about doctors in a fair process for doctors and patients	Managing doctors with health problems, focusing on rehabilitation and protection of the public	Reviewing develop-ments in medical practice to offer timely guidance to the profession
Publications	**Publications**	**Publications**	**Publications**	**Publications**	**Publications**
Education, training and supervision for new doctors	*The Medical Register 2001* *Registration policies*	*Cole's Medical practice in New Zealand* *Good medical practice* *What you can expect: The Competence Review Process* *General oversight* *Recertification*	*Making a complaint about a doctor*	*Doctors' health*	Recent: *Information and consent* *Medical certification* *Patient records* *Self and family care*

Purpose

To protect the health and safety of members of the public by ensuring that medical practitioners are competent to practise medicine.

President's Foreword

The year 2001/2002 included a milestone for the profession. Professional self-regulation as we know it turned five and the transition to the Medical Practitioners Act 1995 was complete.

The purpose of the Medical Practitioners Act is protection of the public. It focuses on standards, accountability and public participation. It is firmly shifting the profession from attaining competence at initial registration to participating in continuous professional development and career-long maintenance of standards.

The full introduction of general oversight and recertification in July was a critical step in this shift. These measures, and our competence and health programmes, complement national and local quality assurance initiatives to support practitioners to remain competent and, when necessary, to provide remediation of performance.

Most of the profession accepts continuing education, peer review and audit, although there have been difficulties with implementation. In our view the competence principle is now an everyday expectation of patients, society and of governments, and the question is not if, but how effectively it can be achieved.

Efforts of the medical profession must be matched with efforts to produce safer systems. Effective clinical quality assurance needs serious commitment by the Government and employers to invest in people, data systems, skills and time to meet goals, without overburdening clinicians or their patients. In turn clinicians must talk with managers to help them detect problems and make changes. There is now acknowledgement of systems issues by the Ministry of Health and encouraging signs that plans of action are moving beyond talk.

The year was positive for other reasons.

1. The government reaffirmed its support for professional self-regulation by introducing the Health Practitioners Competency Assurance Bill. The purpose of the new bill is to reform health occupational regulation and strengthen the provisions that protect the public from harm. The concepts inherent in our Act are being used as the base for all health sector regulation and include improvements to processes we had identified three years ago.

2. Trust has been a central theme in our guidance to the profession. A major consultation and review of our sexual boundary policies and processes was completed and produced many useful recommendations to retain and restore the trust at the heart of the patient-doctor relationship. We have not altered our current position of zero tolerance and will continue to focus our efforts on promotion of standards and support, outside of a purely disciplinary framework.

3. A major revision of our statement on informed consent begun two years ago was all but completed during this year. Consent is portrayed not as an isolated event but a continuing dialogue. In a companion statement, we advise the profession on over 15 pieces of legislation that affect the patient's right to consent, in addition to the Code of Health and Disability Services Consumers' Rights.

4. We were hosts for a highly successful Australasian and New Zealand Medical Boards' and Councils' conference in November, preceded by a workshop on competence. The conference demonstrated that New Zealand is amongst the leaders of open and accountable medical regulation. In an outstanding array of speakers we were fortunate to have overseas presentations from Professor Bruce Barraclough, Chairman of the Australian Council for Safety and Quality in Health Care, Dr Tina Kaigas, Director of Medical Administration at Cambridge Memorial hospital in Ontario, Mr Finlay Scott, Chief Executive of the General Medical Council and Dr George Van Komen, President of the Federation of State Medical Boards. Professor Mason Durie, Head of School of Maori Studies at Massey University, gave an important address about cultural competence.

Like our counterparts overseas, we are meeting external challenges by focusing on professionalism in medicine and stating explicitly the expected standards of good practice. Our flagship publications for setting standards, *Cole's Medical practice* and *Good medical practice* are regularly updated and supported by statements on current issues. For new doctors, we have published the skills, knowledge and supervisory requirements in those critical early years with the help of members of the profession.

While the Council's focus is on the individual doctor, we give advice to the Minister and liaise with many groups including colleges, schools of medicine, hospitals and patient advocacy groups. Our work can impact on and help create safer systems, for example in the area of credentialling of senior medical officers.

With the Ministry of Health we continue to debate and discuss issues of workforce, student debt, quality in health and the Medical Council's processes. We increased our efforts to explain to politicians our registration processes as a public safety mechanism, prompted by a select committee hearing on a foreign doctor registration bill.

There were several changes to Council membership during the year. The Council was sad to lose longstanding member and Deputy President Dr Ian St George but grateful to retain his skill as a professional standards advisor on staff. Dr Mark Adams finished the calendar year as Deputy President, then was replaced by Dr Deborah Read. I acknowledge with gratitude his contribution and that of Mr Alexander Sundakov, public member, whose term finished. The Council warmly welcomed three new members: Dr Philip Barham, elected member; Professor John Campbell, nominee of the schools of medicine; and, Ms Jean Hera, public member.

Our three public members vigorously advocate a patient perspective in all our debates and decisions. Miss Carolynn Bull and Mrs Heather Thomson were very effective in presenting to the Health Select Committee on public safety and I am grateful also to Carolynn Bull for her leadership during public consultation on our sexual boundaries review.

Staff of the Medical Council continued to work at a high standard under the able leadership of Chief Executive Sue Ineson. My sincere thanks go to them.

Meeting the profession, listening to concerns and advocating our message of patient safety has been a personal priority in my time as President. The current year is my final year and I will miss the contact. I am an absolute believer in the professionalism that underpins good medical care and the primacy of the patient. I am enormously impressed by the selflessness, skill and professionalism of medical practitioners I have met and on behalf of the Council I would like to thank you all for the quality of care you give to the people of New Zealand.

Tony Baird
President

Chief Executive's Review

This was a year of fine-tuning to our processes under the Act. Improving service to doctors and their employers is at the heart of our efforts and I am pleased to report we have met or largely met our targets for quarterly processing of annual practising certificates, registration cases that come within policy and correspondence.

Our regular audits revealed we needed to do better with timelines for complaints and we experienced some backlogs in our competence review caseload. We regret the added pressure these delays cause for doctors. In the competence area we moved to recruit more staff to handle the caseload and by year-end were much more on top of review preparation.

The annual practising certificate fee and levy remained the same for the second year running. Our aim is to keep the fee constant for as long as possible while reserves are reduced to the level specified in Council policy.

Registration

We regularly review our registration policies and procedures, comparing them to international practices and other New Zealand regulatory systems. A report commissioned from KPMG indicated that our examination and assessment requirements are in line with similar countries overseas. We began to research the possibility of approving primary medical degrees from overseas authorities who are seen as "competent authorities", that is, have systems for monitoring doctors' continuing competence. The first move in this direction was approval of primary medical degrees from the United Kingdom.

Under the Ministry of Health's credentialling proposal released during the year, we will be responsible for verifying the background of practitioners and holding their information in a central database. The question will be the extent of verification. We already require information and disclosures that are standard, and currently we are piloting cost-benefits of verification of registrants' backgrounds, plus requiring all hospitals to do verbal referee checks of temporary registrants. Cost and increased processing times are significant barriers to a full verification procedure back to the source institution. A new body – the International Association of Medical Regulatory Authorities, of which we are a founding member, has begun discussing information-exchange between regulators about doctors, including standardising the terms used on certificates of good standing, and exchange of disciplinary findings.

A new law to regulate doctors

A focus this year has been proposals for the new Health Practitioners' Competence Assurance Bill. It is based on the Medical Practitioners Act and links evidence of continuing competence to renewal of the annual practising certificate for 11 health professions. The bill was not introduced to Parliament until after the reporting year but staff were busy looking at how it will work in practice for the medical profession.

All our current functions will remain but there will be changes for the profession if it goes through in its current form, including:

- registration based on a “scope of practice”, possibly a “general” or “vocational” scope to correspond to current registration but with capacity to set narrower scopes and specify what a practitioner may do, when, where and for how long
- improving reporting between agencies of possible risks to other patients if a practitioner’s competence is questioned
- power to suspend doctors if extraordinary risk to patient safety exists on the grounds of competence as well as health
- election of some members of the Medical Council only at the discretion of Minister (currently election is legislated for every three years)
- a single disciplinary tribunal for all health professions made up of the practitioner’s peers and lay members, the latter in a majority.

The Council was concerned that mandatory reporting of incompetence was unenforceable and contrary to safer patient care if doctors tried to cover up mistakes. It prefers to encourage reporting of incompetence as part of professionalism, and to promote the benefits of remediation through competence reviews.

Challenge from Parliament

Earlier in the year Parliament’s Health Select Committee heard a private member’s bill which proposed to make the New Zealand Qualifications Authority responsible for medical registration. In our submissions opposing the bill, we put forward a great deal of factual evidence about our processes and improved timelines, while acknowledging past deficiencies. The evidence overwhelmingly against the bill was that 2,000 of 3,500 doctors registered between 1996-2001 were from overseas. The bill later lapsed but the experience illustrated the difficulties of altering perceptions from earlier years and the need for absolute transparency of process.

Medico-legal

A number of matters arose during the year.

- A doctor applied for judicial review of the Council’s decision to impose a condition on his annual practising certificate, following discipline for practising medicine without holding a certificate. The application was dismissed in the High Court, and subsequently also dismissed on appeal. The doctor plans to take the case to the Privy Council.
- A graduate of the Ukraine filed court proceedings alleging the Council owed him a duty of care in relation to his application for registration. The Council opposed the claim, on the basis that it carried out its statutory duty which entailed considering the application and assessing the doctor as being ineligible for vocational registration without further training.
- A doctor applied for judicial review of a charge laid by a complaints assessment committee on the grounds that the charge laid was outside the powers of a complaints assessment committee. The High Court held that the committee had no power to add new information to a complaint before it. The committee appealed the decision to the Court of Appeal.
- The Privacy Commissioner completed an enquiry into an alleged breach of privacy by the Medical Council dating back to an incident in 1998. The Commissioner found a breach of information privacy principle number three (in effect, not making it clear to the doctor who were the intended recipients of the information collected), but that the actions of the Council did not amount to an interference with the doctor’s privacy.

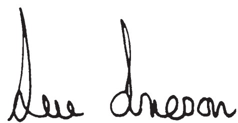
Legal opinions provided during the year included:

- that a doctor's application for vocational registration could not be considered under previous law, the Medical Practitioners Act 1968. The doctor's entitlement to registration under that Act was irrelevant. The application had to be considered under the 1995 Act and the Medical Practitioners (Vocational Registration) Order 1999, solely on the basis of the doctor's actual qualifications and experience
- that a doctor convicted or charged after voluntarily removing his or her name from the medical register is still subject to professional disciplinary proceedings, providing the events being investigated occurred while the practitioner was registered
- that a conviction for excess breath alcohol meets the threshold for referral to a complaints assessment committee
- that a conviction of a medical student may be referred to a complaints assessment committee, notwithstanding that the student was not registered at the time the offence was committed (a general principle being that criminal convictions are relevant to a doctor's fitness, regardless of when they were committed)
- that a breach of the Council's internet guidelines that sets out minimum standards for internet consultations may be referred to a complaints assessment committee. This opinion was in respect of a particular complaint about a doctor's managing of, and prescribing for obese patients, which was subsequently referred as a complaint.

Challenges ahead

Challenges in the coming year will be the HPCA legislation implementation and follow-up work from the sexual boundaries review. The Council will continue to be involved in and affected by workforce issues, and sector work on medical error and quality improvement. Internally we will be considering a review of our competence processes, timelines, costs and outcomes and will continue to look for improvements in handling of all reviews and complaints cases. Through benchmarking we seek to ensure we have the best possible processes and systems. Our information system upgrade is improving processing and service. We want to strengthen our existing advice capacity on regulatory requirements and will continue to provide advice on timely topics for the profession.

There were several staff changes particularly in the competence area, and we welcomed new staff in all sections of the office. I acknowledge the efforts of staff. Their skill and commitment has helped the Council progress in several key areas.



Sue Ineson
Chief Executive

Members of the Medical Council at 31 March 2002

Elected members:

Dr Tony Baird MBChB, DRCOG, FRCOG, FRANZCOG. President, Chair of Registration, Examinations and Issues Committees. Obstetrician and gynaecologist, Auckland.

Dr Mark Adams, MBChB. Anaesthetic registrar, Wellington.

Dr Philip Barham, MBChB Otago, Dip Obst Auckland, MHP Ed, NSW, FRNZCGP, MRCGP. Chair of Professional Standards Committee. Retired general practitioner, Whangaparaoa.

Dr John Neutze, MBChB, MD, MRACP, FRACP. Retired paediatric cardiologist, Auckland.

Appointed members:

Miss Carolynn Bull MA, Dip Tchg, LLB. Family law practitioner, Christchurch.

Professor John Campbell, MBChB Otago 1969, DipObst, MRACP, FRACP, MD Otago 1983. Chair of Audit Committee. Dean, Faculty of Medicine, University of Otago.

Ms Jean Hera, NZ Certificate Science 1977, Bachelor of Social Work (Hons) 1990, PhD 1996. Coordinator, Palmerston North Women's Health Collective.

Dr Joanna MacDonald, MBChB, FRANZCP. Chair of Health Committee. Psychiatrist, Wellington.

Dr Deborah Read, MBChB, Dip Com Health, MCCM (NZ), FAFPHM (RACP). Deputy President, Chair of Education Committee. Public health physician, Wellington.

Mrs Heather Thomson, RN, Obs, Health service manager, Opotiki.

Significant Activities

10 Medical Education

12 Registration

24 Professional Standards

28 Complaints

31 Doctors' Health

33 Issues

35 Medical Workforce Survey

35 Discipline under the 1968 Act

Medical Education

Principal activities: accreditation of medical schools, assessing teaching and learning environment in hospitals, maintaining a network of intern supervisors, policy on probationary and pre-vocational years, considering applications for recognition as a vocational branch of medicine and approving recertification programmes.

Total cost: $744,169

Our focus on medical standards and safety of the public begins with the education of a doctor.

We have four major areas of responsibility:
- the approval of medical schools and medical school courses
- education, training and supervision during a doctor's probationary year
- pre-vocational training, and
- vocational education and training.

The Education Committee welcomed Dr Deborah Read as its new chair, and welcomed as a new member Dr David Spriggs, geriatrician of Auckland. The committee gratefully acknowledged the contributions of Dr Gillian Clover and Professor Bill Gillespie who completed their terms after five years' service.

Medical school accreditation

Since the early 1990s, the New Zealand and Australian Medical Councils have run a joint accreditation programme for Australasian university medical schools. Our accreditation visits ensure that the medical schools' courses and curricula are producing graduates with the knowledge, skills and attitudes needed for competent medical practice under supervision. Accreditation may be given for a maximum of ten years and during the year it was granted to:
- Adelaide University until 31 July 2007
- Tasmania University (extension until 31 December 2002)
- Monash University – a new curricula for MBChB, until 31 December 2008.

Early postgraduate years - hospital visits

Hospitals have a statutory duty to support the educational needs of new doctors. One of our main tasks is visiting hospitals every three years to accredit them for this purpose. During 2001 visits were made to: Capital Coast Health, Wakefield Hospital, Hutt Valley Health, Wairarapa Health, Western Bay Health, Eastbay Health, Lakeland Health, Tairawhiti Health, Taranaki Healthcare and a revisit to Health Waikato, following a visit in 2001. The reviewers' accreditation report aims to provide constructive comment and improvement. Perennial issues include the quality of supervision by senior staff with high workloads and the erosion of dedicated teaching time for trainees. A significant number of new medical staff in hospitals

are overseas-trained and most hospitals provide cultural orientation, but to better understand their effectiveness we resolved to audit the programmes.

Our updated handbook , *Education, training and supervision of new doctors*, was widely released during 2001 as the essential reference for hospital management, supervising medical staff and new doctors on our requirements.

Vocational branch recognition

There are currently 33 recognised branches of medicine, eight approved since the introduction of the Medical Practitioners Act 1995.

There are public safety benefits in recognising new branches of medicine, through establishment of required standards and formal training programmes with regular review by the Education Committee. The branches of accident and medical practice, family planning reproductive health, medical administration and palliative care were formally approved with the passing of the Medical Practitioners (Vocational Registration) Amendment Order 2001 in September. A flurry of applications for vocational registration in the new branches followed.

A moratorium on recognition of new branches is in place until July 2004, allowing us time to review the principles behind vocational branch recognition and existing training and recertification programmes. We are aligning New Zealand policies on accreditation and recertification as closely as possible with the Australian Medical Council (AMC) for the Australasian colleges, to minimise duplication. The same process will be used for New Zealand-only colleges and branch bodies. Our approval and accreditation of new branches will be more robust to encourage "clumping" of branches rather than proliferation of smaller branches. New criteria including audit in recertification programmes and evidence from the community on the need for a new branch will come into effect in 2004.

We are looking to start reviews of existing branches, wherever possible in conjunction with AMC accreditation and reviews are scheduled for the New Zealand Dermatological Society, the Royal New Zealand College of General Practitioners, the Royal Australasian College of Surgeons and the Royal Australian and New Zealand College of Radiologists.

Recertification

During the year we approved recertification programmes for the New Zealand Dermatological Society and the Australasian Society of Breast Physicians. A total of 34 programmes have now been approved.

Contact with undergraduates

In 2001 the President and other members visited Auckland and Otago schools, as part of our regular presentations to fifth and sixth year medical students on the requirements of regulation and professionalism.

Our studentship research grants have been going now for ten years, and aim to raise the awareness of students of dimensions of medical care. Grants of $5000 were awarded to four students:

Simon Ussher, 4th year Otago, *The ethical and legal responsibilities of a medical practitioner when providing or referring a patient to a complementary medical service*

Kristin Chard, 3rd year Otago, *Reasons for the current doctor shortage*

Todd Hore, 4th year Otago, *Is the PRIME (Primary Response in Medical Emergency) scheme acceptable to rural general practitioners in New Zealand?*

Daniel Hobbs, 3rd year, Otago, *Preserving the dignity of the living patient: toward better patient care in medicine.*

We are impressed with the quality of reports submitted by students and the very good information on current day issues in medicine.

Registration of medical practitioners

Principal activities: maintaining the Medical Register, considering applications for registration, issuing annual practising certificates and certificates of good standing, registration policy development.

Total cost: $1,765,474

Registration assures the public that a doctor has met an appropriate standard for medical practice. Entry on the medical register also protects the integrity of the profession.

When granting registration, we seek evidence that a doctor has the required knowledge, skills, experience and fitness for practice in New Zealand, as set down in the Medical Practitioners Act 1995.

New Zealand is fortunate in having a medical workforce equivalent to the best in the world, one that is increasingly multinational. The public expects a high quality service and in order to achieve this we require overseas applicants for registration to meet the standard of locally trained graduates.

1,368 new doctors were entered on the medical register during the year, compared to 1,182 the previous year. 1,089 were overseas-trained, up from 890 in 2001, coming to New Zealand from 55 countries. At 31 March 2002 there were 12,584 doctors on the Medical Register, of whom 9,964 were practising.

Medical services under strain sought temporary doctors in greater numbers – 844 temporary doctors were registered compared to 700 the year before. This creates pressure on staff and members for a quick turnaround of applicants. Most doctors come to work for shorter periods than three years and up to 32% are employed for only three to six months.

Communication efforts

We have intensified outreach communication with employers of doctors and recruitment personnel in the past three years. Four of our popular registration workshops were held during the year to explain registration policy, and we visited North Island hospitals and independent practitioner associations to update individual employers. We seek a clear understanding from employers of the role of the Medical Council to determine eligibility for medical practice, against that of the employer who must check references, work history and credentials for the actual job being applied for.

Exceptions to policy

We receive many registration applications from doctors that are outside current policy. Registration policy provides a benchmark for public safety but members have always exercised discretion in how the policy

is applied, to allow for international variations in medical practice. A section of our meeting agenda is devoted to "exceptions to policy" and each case is worked through individually. Safety for the public is the first consideration, with a requirement of natural justice for applicants. Cases during the year included:

1. Dr B, general practitioner. His primary medical degree was not from a Council-approved medical school in South Africa. He was granted temporary registration as a general practitioner under supervision and as a MOSS in a provincial hospital on the basis of sufficient relevant experience from South Africa for both positions.
2. Dr C, intensivist. Dr C's primary medical degree was not from one of the five countries recognised automatically by the Medical Council for temporary registration and the Council does not currently recognise any overseas postgraduate qualifications in the branch of intensive care medicine (intensivists have trained in anaesthetics or internal medicine until recently.) However Dr C was American-board certified in critical care medicine, had excellent references and appropriate experience. He was considered eligible for the proposed consultant position in a city hospital.
3. Dr R, surgeon. Dr R did not have the continuous work experience required for registration. However he had extensive experience as a consultant surgeon in Canada, and excellent references. His application to work as a general surgeon at a DHB for three months under supervision was granted.

Supervision of temporary doctors is an important safeguard. During the year staff surveyed a sample of doctors on their satisfaction with the quality of their supervision. As to be expected, responses varied. The next step will be to develop a supervision and induction template to achieve greater consistency.

United Kingdom graduates

United Kingdom graduates comprise 25% of the active medical workforce in New Zealand, and over half of the temporary workforce. In February we removed the examination requirement for United Kingdom graduates seeking permanent residence to become generally registered.

Under the policy, effective from 1 May 2002, doctors with a primary medical degree from a United Kingdom medical school accredited by the General Medical Council will be eligible for probationary, leading to general, registration.

The decision took into account the sound accreditation systems for medical schools in the United Kingdom and the move to revalidation of their doctors, and proven performance of the graduates working in the New Zealand health system.

We have taken the view that this decision was part of a policy of considering other countries that show they can meet similar criteria.

New Zealand medical registration examination – NZREX Clinical

Doctors qualified outside New Zealand and Australia wishing to be registered must pass our medical registration exam, NZREX Clinical, set at the level of a sixth year medical student.

There were 83 candidates in 2001/02 (including 37 repeats) compared with 167 the year before, confirming the trend of fewer new candidates. We closed the Wellington centre and decided to use the other four centres on a rotating basis.

Following a major review of the examination in 1999, a working party was in the process of developing a competency-based exam to more appropriately reflect the attributes required for New Zealand practice.

Exemption from Annual Practising Certificate fee

In recognition of the valuable contribution to ethics committees and other honorary positions made by retired doctors and those not in active practice, the President and Registrar were empowered to waive the annual practising certificate fee if a retired doctor is practising medicine voluntarily for the benefit of the profession.

Register on-line

Internationally, medical regulators have adopted principles of transparency in their processes to maintain public confidence. One form this takes is improving the ability of members of the public to inspect the medical register. We began a project to put the already public information from the medical register on-line, due for completion in August 2002.

Removal of conditions/re-registration of disciplined doctors

Safety of the public is our first priority when considering applications from disciplined doctors to return to practice or have conditions removed. In particular, sexual offenders are subject to a rigorous assessment protocol seeking evidence of rehabilitation, and expert assessment from an independent panel of psychiatrists and psychologists. Long-term conditions are generally imposed.

We heard six applications for re-registration of doctors struck off the medical register or for removal of conditions.

1. A general practitioner convicted of fraud and removed from the medical register in February 2000. Following reports and assessments of the doctor's fitness for registration, the doctor was granted probationary registration under conditions, including surveillance of all financial claims made by the doctor.
2. A general practitioner convicted of fraud and removed from the medical register in 1998. The doctor was granted probationary registration in principle, subject to finding suitable employment. Conditions included a minimum time of 24 months on probationary registration under supervision, prohibition on sole practice and surveillance of all financial claims by an approved person.
3. A general practitioner removed from the medical register in 1996 for a sexual relationship with a patient, subsequently re-registered on probationary registration in 1997 with conditions. The doctor applied for general registration and removal of conditions. General registration was granted, but conditions requiring a chaperone and prohibiting sole practice and ongoing counselling relationships with patients remained in place.
4. A general practitioner removed from the medical register in 1988 for sexual misconduct, re-registered in 1997. Application for removal of conditions was rejected.
5. A general practitioner removed from the medical register in 1994 for sexual misconduct, re-registered in 1996. Two conditions on non-boundary matters were lifted but a condition requiring a chaperone during examinations of female patients remained, and a notice in the waiting room to this effect.
6. A general practitioner suspended from medical practice in 1997, following a court conviction for indecent assault and sexual violation by unlawful sexual connection. The doctor resumed practice in 1998 with conditions set by the Tribunal, which expired during 2001. Final supervision and mentor reports were received. As there is no ability under law to renew expired conditions, the next opportunity to consider imposing conditions will be when the doctor applies for a new practising certificate.

1. Summary of Registration

At 31 March 2002

Interim Register	46
Probationary Register	602
General Register	11147
Vocational Register	5834
Temporary Register	789
Total practising	9964
Suspended	3
Suspended(Int)	1

Note: All doctors on the vocational register also have general registration

2. Registration Activities

1 April 2001 – 31 March 2002

Probationary Registration issued		
Class 1	New Zealand Graduates (Interns)	269
Class 1	Overseas Graduates (Interns)	8
Class 2	Overseas Graduates (NZREX passes)	64
Class 3	Overseas Graduates (Eligible for Vocational Registration)	23
Class 4	Overseas Graduates (Suitable for assessment - Vocational Registration)	48
Class 5	New Zealand and Overseas Graduates (Re-registration following erasure)	1
Class 7	Rural Service Provision and Vocational Training	59
General Registration issued		
New Zealand Graduates		10
Overseas Graduates		43
Reinstatements		18
Temporary Certificates Issued		
Class 1	Visiting Teacher	10
Class 2	Training and Research	44
Class 3	Service Provision	788
Class 4	Special Purpose	2
Extensions		401
Interim Registration issued		**23**
General registration after completion of probationary period		
Class 1	New Zealand and Overseas Graduates (Interns)	259
Class 2	Overseas Graduates (NZREX passes)	86
Class 3	Overseas Graduates (Eligible for Vocational Registration)	49
Class 4	Overseas Graduates (Suitable for assessment - Vocational Registration)	46
Class 5	New Zealand and Overseas Graduates (Re-registration following erasure)	0
Class 7	Rural Service Provision and Vocational Training	1

Additions to Vocational Register	**669**
Amendments to Register	
Change of Address	2651
Change of name	41
Additional qualifications	595
Suspensions	
Suspended	0
Interim suspension	2
Revocation of suspension	1
Conditions imposed	
Imposed	46
Revoked	16
Removals	
Death 43	32
Discipline order 110(1)(a)/46(3)(c)	1
Failure to notify change of address 42(2)	18
Non-resident doctors 45(1)(c)	478
At own request 44(1)	81
Practising Certificates issued	**10464**
Certificates of Good Standing	**717**
Certificates of Registration	**106**
Confirmation of Standing	**162**

3. New Zealand Vocational Register

1 April 2001 – 31 March 2002

Vocational Branch	Vocational Registration at 31/3/2001[1]	Added 2001/02	Removed 2001/02	Net Change	Vocational Registration at 31/3/2002[1,2]
Accident & Medical Practice	0	47	0	47	47
Anaesthetics	438	33	20	13	451
Breast Medicine	0	4	0	4	4
Cardiothoracic Surgery	28	2	1	1	29
Dermatology	48	1	0	1	49
Diagnostic Radiology	249	18	11	7	256
Emergency Medicine	36	12	3	9	45
Family Planning & Reproductive Health	0	2	0	2	2
General Practice	2027	299	62	237	2264
General Surgery	256	13	12	1	257
Intensive Care Medicine	28	8	0	8	36
Internal Medicine	635	46	20	26	661
Medical Administration	0	9	0	9	9
Musculoskeletal Medicine	6	0	0	0	6
Neurosurgery	17	0	2	-2	15
Obstetrics & Gynaecology	245	15	9	6	251
Occupational Medicine	34	3	2	1	35
Ophthalmology	113	7	5	2	115
Orthopaedic Surgery	183	8	1	7	190
Otolaryngology Head & Neck Surgery	85	5	4	1	86
Paediatric Surgery	14	1	0	1	15
Paediatrics	214	12	12	0	214
Palliative Medicine	0	21	0	21	21
Pathology	226	25	11	14	240
Plastic & Reconstructive Surgery	37	4	1	3	40
Psychological Medicine or Psychiatry	369	39	20	19	388
Public Health Medicine	166	16	8	8	174
Radiation Oncology	40	6	3	3	43
Rehabilitation Medicine	8	2	0	2	10
Sexual Health Medicine	14	2	0	2	16
Sports Medicine	10	0	0	0	10
Urology	46	5	2	3	49
Vascular Surgery	1	4	0	4	5
Venereology	12	0	2	-2	10
Total	**5585**	**669**	**211**	**458**	**6043**

Notes:

1 Includes doctors who may currently be inactive (have no APC)

2 Includes 200 doctors with vocational registration in two branches and four doctors with vocational registration in three branches

4. Candidates sitting and passing NZREX Clinical

1 April 2001 – 31 March 2002

Country	No. Sitting	Attempts 1	Attempts 2	Attempts 3	Attempts 4	No. of Passes	Passes on Attempts 1	Passes on Attempts 2	Passes on Attempts 3	Passes on Attempts 4
Bangladesh	8	4	4	0	0	4	1	3	0	0
Bulgaria	1	1	0	0	0	0	0	0	0	0
China	1	1	0	0	0	0	0	0	0	0
Egypt	4	2	2	0	0	3	1	2	0	0
England	1	1	0	0	0	1	1	0	0	0
Fiji Islands	1	1	0	0	0	1	1	0	0	0
India	16	10	4	1	1	8	4	3	0	1
Iran	4	2	1	1	0	1	0	0	1	0
Iraq	6	5	1	0	0	6	5	1	0	0
Korea (Republic Of)	1	0	1	0	0	1	0	1	0	0
Libya	1	0	1	0	0	1	0	1	0	0
Myanmar	1	0	1	0	0	0	0	0	0	0
Netherlands	1	1	0	0	0	0	0	0	0	0
Pakistan	3	2	1	0	0	2	1	1	0	0
Philippines	6	3	2	0	1	1	0	0	0	1
Poland	2	1	1	0	0	1	0	1	0	0
Romania	4	1	2	1	0	2	0	1	1	0
Russia	2	1	1	0	0	1	0	1	0	0
Singapore	1	0	0	1	0	1	0	0	1	0
South Africa	6	4	1	1	0	6	4	1	1	0
Sri Lanka	6	2	3	1	0	4	2	1	1	0
Switzerland	2	1	1	0	0	0	0	0	0	0
Wales	1	1	0	0	0	1	1	0	0	0
West Indies	1	0	0	1	0	0	0	0	0	0
Yugoslavia	3	2	1	0	0	3	2	1	0	0
Total	**83**	**46**	**28**	**7**	**2**	**48**	**23**	**18**	**5**	**2**

Note: There were only two sessions of the NZREX examination held in the 2001/02 financial year.

5. Registration issued by country of primary qualification

1 April 2001 – 31 March 2002

Country	Probationary Class 1	2	3	4	5	7	Total	Temporary Class 1	2	3	4	Total
Argentina	0	0	0	0	0	0	0	0	0	1	0	1
Australia	6	0	0	0	0	0	6	3	0	16	1	20
Austria	0	0	0	0	0	0	0	0	1	0	0	1
Bangladesh	0	9	0	0	0	1	10	0	0	4	0	4
Belgium	0	0	0	0	0	0	0	0	0	3	0	3
Canada	0	0	0	0	0	1	1	0	2	34	0	36
China	0	1	0	0	0	0	1	0	2	1	0	3
Colombia	0	0	0	1	0	0	1	0	0	1	0	1
Congo (Democratic Republic of)	0	0	1	0	0	0	1	0	0	0	0	0
Cuba	0	0	0	0	0	0	0	0	0	1	0	1
Czech Republic	0	0	0	0	0	0	0	0	0	2	0	2
Denmark	0	0	0	0	0	0	0	0	0	1	0	1
Egypt	0	3	0	0	0	0	3	0	0	3	0	3
England	0	5	9	10	0	21	45	2	9	317	1	329
Fiji	0	2	0	0	0	0	2	0	4	0	0	4
Former Yugoslav Republic of Macedonia (FYROM)	0	2	0	0	0	0	2	0	0	0	0	0
Georgia	0	1	0	0	0	0	1	0	0	0	0	0
Germany	2	1	1	2	0	0	6	1	0	11	0	12
Ghana	0	0	0	0	0	0	0	0	0	2	0	2
Greece	0	0	0	0	0	0	0	0	0	1	0	1
Hungary	0	0	0	0	0	0	0	0	0	1	0	1
India	0	7	0	6	0	2	15	0	8	21	0	29
Iran	0	1	0		0	0	1	0	2	0	0	2
Iraq	0	5	0	2	0	0	7	0	0	0	0	0
Ireland	0	1	0	1	0	3	5	0	0	18	0	18
Italy	0	0	0	1	0	0	1	0	0	2	0	2
Jamaica	0	0	0	1	0	0	1	0	0	0	0	0
Japan	0	0	0	1	0	0	1	0	4	3	0	7
Kenya	0	0	0	0	0	0	0	0	0	1	0	1
Lebanon	0	0	0	0	0	0	0	0	0	1	0	1
Libya	0	1	0	0	0	0	1	0	0	0	0	0
Malaysia	0	0	0	2	0	0	2	0	0	0	0	0
Netherlands	0	0	0	0	0	0	0	0	0	3	0	3
New Zealand	269	0	0	0	1	0	270	2	0	0	0	2

Nigeria	0	0	0	0	0	0	0	0	0	2	0	2
Northern Ireland	0	0	0	0	0	0	0	0	0	8	0	8
Oman	0	0	0	0	0	0	0	0	1	0	0	1
Pakistan	0	2	1	0	0	0	3	0	0	5	0	5
Papua New Guinea	0	0	0	0	0	1	1	0	1	0	0	1
Philippines	0	1		0	0	0	1	0	0	5	0	5
Poland	0	1	1	0	0	0	2	0	0	2	0	2
Romania	0	2	1	0	0	0	3	0	0	4	0	4
Russia	0	0	0	0	0	0	0	0	1	1	0	2
Scotland	0	1	0	4	0	7	12	0	1	94	0	95
Singapore	0	1	0	0	0	0	1	0	0	0	0	0
South Africa	0	8	7	13	0	21	49	0	0	109	0	109
Sri Lanka	0	5	0	0	0	0	5	0	1	6	0	7
Sweden	0	0	0	0	0	0	0	0	0	3	0	3
Syria	0	0	0	1	0	0	1	0	0	1	0	1
Thailand	0	0	0	0	0	0	0	0	0	1	0	1
Trinidad and Tobago	0	0	0	0	0	0	0	0	0	1	0	1
United States of America	0	1	1	3	0	0	5	2	7	82	0	91
Uruguay	0	0	0	0	0	0	0	0	0	1	0	1
Wales	0	1	0	0	0	2	3	0	0	14	0	14
Yugoslavia, Federal Republic of	0	2	0	0	0	0	2	0	0	0	0	0
Zimbabwe	0	0	1	0	0	0	1	0	0	1	0	1
Total	**277**	**64**	**23**	**48**	**1**	**59**	**472**	**10**	**44**	**788**	**2**	**844**

6. Vocational registration of doctors with an overseas primary qualification, by branch of medicine

1 April 2001 – 31 March 2002

Branch of Medicine	Number
Accident & Medical Practice	24
Anaesthetics	19
Breast Medicine	2
Cardiothoracic Surgery	2
Diagnostic Radiology	5
Emergency Medicine	5
Family Planning & Reproductive Health	1
General Practice	99
General Surgery	5
Intensive Care Medicine	1
Internal Medicine	26
Medical Administration	7
Obstetrics & Gynaecology	13
Occupational Medicine	3
Ophthalmology	2
Orthopaedic Surgery	4
Otolaryngology Head & Neck Surgery	1
Paediatric Surgery	1
Paediatrics	10
Palliative Medicine	14
Pathology	10
Plastic & Reconstructive Surgery	1
Psychological Medicine or Psychiatry	28
Public Health Medicine	7
Radiation Oncology	3
Rehabilitation Medicine	1
Sexual Health Medicine	1
Urology	2
Total	**297**

7. Medical Practitioners in New Zealand
at 31 March 2002 by country of primary qualification

Country	Interim	Probationary	General	Vocational	Temporary	Total
England	9	58	363	671	306	1407
South Africa	6	62	339	377	112	896
Scotland	1	14	126	205	98	444
India	2	21	176	144	31	374
Australia	2	6	207	146	8	369
Sri Lanka	2	12	107	137	7	265
Iraq	1	10	117	11	0	139
United States of America	0	7	5	54	65	131
Ireland	2	4	23	43	18	90
Canada	1	1	21	37	25	85
Germany	1	8	32	24	13	78
Bangladesh	0	21	44	2	4	71
Wales	1	5	19	22	18	65
China	0	2	20	39	3	64
Fiji	0	1	21	27	5	54
Egypt	2	9	21	14	2	48
Yugoslavia, Federal Republic of	1	2	20	9	0	32
Pakistan	0	5	7	10	9	31
Northern Ireland	0	0	6	17	7	30
Philippines	0	3	10	4	6	23
Singapore	0	2	1	18	0	21
Netherlands	1	1	3	11	1	17
Zimbabwe	0	0	4	9	3	16
Poland	0	2	11	1	1	15
Myanmar	0	0	12	1	1	14
Russia	0	3	5	2	3	13
Croatia	0	1	10	0	0	11
Bulgaria	0	1	3	3	2	9
Japan	0	1	0	1	7	9
Czech Republic	0	0	5	2	1	8
Iran	0	1	2	3	2	8
Papua New Guinea	0	0	5	2	1	8
Romania	0	2	3	1	2	8
Switzerland	0	0	1	6	1	8
Hungary	1	0	4	1	1	7

Bosnia and Herzegovina	0	1	5	0	0	6
Former Yugoslav Republic of Macedonia (FYROM)	0	2	3	1	0	6
Malaysia	0	2	1	3	0	6
Other	2	12	26	33	26	99
New Zealand	11	320	3525	3743	0	7599
Total	**46**	**602**	**5313**	**5834**	**789**	**12584**

Note: There are 46 countries with fewer than six doctors represented by Other. They are Denmark, Sweden, Mexico, Nigeria, Sudan, Syria, Ukraine, Belgium, Colombia, Ghana, Greece, Italy, Kenya, Kuwait, Norway, Zambia, Austria, Brazil, Cambodia, France, Jamaica, Korea (Republic of), Lebanon, Libya, Peru, Puerto Rico, Saudi Arabia, Trinidad and Tobago, Albania, Argentina, Congo (Democratic Republic of), Cuba, Dominican Republic, Finland, Georgia, Grenada, Jordan, Latvia, Oman, Slovakia, Spain, Taiwan, Thailand, Turkey, Uzbekistan, Viet Nam.

Professional Standards

Principal activities: undertaking competence reviews of doctors and establishing competence programmes, development of policy on competence reviews, general oversight and recertification, managing doctors who are subject to conditions arising from disciplinary action.

Total cost: $772,196

Competence reviews of doctors and competence programmes protect the public and assist doctors to overcome any knowledge or skill gaps.

During the year, newly elected Council member Dr Philip Barham became the Chair of the Professional Standards Committee, succeeding longstanding Council member Dr Ian St George.

Competence reviews and programmes aim to help doctors remain competent. Along with general oversight and recertification, they emphasise education and remediation to help maintain our standards as a profession. These are vital measures under the Medical Practitioners Act 1995 to improve public safety.

The Professional Standards Committee decides, following initial assessment, if a review will be done. Most referrals do not result in reviews, for two main reasons: on first enquiry it becomes clear that a concern is a result of a misunderstanding or misrepresentation of the facts, or, a doctor will have changed his or her practice to address the reason for the concern, obviating the need for a time-consuming review process. These cases do not, in our opinion, lessen the value of reviews, one advantage of which is the flexibility to receive concerns without attempting to define thresholds for referral. Furthermore we will sometimes receive a referral that may appear minor but on further enquiry reveals significant underlying problems.

A review may be indicated by a single failing, or by a pattern of events. Reviews are done by peers of the doctor and a member of the public who are trained in the use of review tools. The review scope may be either general or confined to specific aspects of practice, and is agreed beforehand with the doctor.

A review seeks to establish whether a doctor:

- has the skill and knowledge required to practise medicine in accordance with his or her registration; and
- meets the standard reasonably to be expected of a medical practitioner who holds registration of the type held by the practitioner.

The outcome of a review is a rating of the doctor on a competency scale of one to six, as follows:

1 Outstanding
2 Good to average
3 Adequate, requires some upgrading
4 Below average. Should undertake a competence programme and report on the outcome or be reassessed
5 Presents risks to patients but remediable. Should undertake a competence programme and then be reassessed
6 Presents risks to patients, may not be remediable. Should undertake a competence programme and then be reassessed.

The competency rating determines whether a doctor is required to do an educational competence programme.

Seventy-three referrals were received during the year (compared with 82 the previous year), of which 12 were from doctors' peers. Thirty-seven doctors were formally reviewed and six were directed to do a competence programme.

Normally we do not make the fact of a review public, to try and ensure that the process is seen as remedial and non-blaming. We expect doctors undergoing a review to tell their employer or a senior colleague and we will notify the employer if a competence programme is required.

Regular workshops are held around the country with competence reviewers to discuss the process and share experiences. A workshop in Wellington in February attracted over 100 medical and lay reviewers.

Case summaries

Below are examples of competence reviews that resulted in competence programmes during the year.

1. A pregnant woman presented to a doctor with lower abdominal pain. The doctor diagnosed gastroenteritis, but did not do a vaginal examination. Shortly afterwards the patient gave birth at about 24 weeks gestation and the baby died. The Health and Disability Commissioner referred the doctor for a possible competence review. The review found the doctor to be a category 4, below the acceptable range of 2–3. In this case an undertaking was agreed to by the doctor that included restricting practice to only seeing patients with a surgical condition, pre-operatively and post-operatively.

2. An elderly patient presented with a pyloric gastric ulcer. The doctor failed to perform an abdominal or rectal examination. Peers of the doctor sent a concern to the Medical Council. A review was completed of the doctor's general diagnostic and therapeutic skills and record-keeping. The review found the doctor to be category 6, presenting risks to patients, and possibly not remediable. Currency of knowledge and in particular, some basic general practice interventions caused serious concern. The doctor was to go onto a competence programme under educational and clinical supervision, with three conditions placed on the doctor's annual practising certificate.

3. Peers of a doctor wrote to the Medical Council concerned about a doctor's prescribing of controlled drugs, record-keeping and communication skills. The competence review found deficiencies in the doctor's prescribing of benzodiazepines, with a rating of 5. In other areas the doctor was rated below average, at 4. The doctor went onto a competence programme requiring clinical supervision, an educational programme and audit of drug prescribing.

Example of a referral that did not need to proceed to a competence review:

- A patient complained to the Health and Disability Commissioner that a doctor did not refer her for follow-up specialist investigation following her mammography in 1986 and did not advise her of this option. The Commissioner found the doctor had breached the Code of Rights. The Professional Standards Committee considered the need for a competence review. The committee noted from the doctor's submission that practices of referral and follow-up had been reviewed in the doctor's practice and all results of investigation and laboratory tests were viewed by the doctor and initialled to confirm witnessing of results, with follow-up of abnormal results. Therefore, a review was not required.

Continuous professional development

With the full phasing in of general oversight and recertification from the 1st of July, all doctors were required to start participating in continuing education and peer review. While these measures cannot ensure competence they are important in preventing the professional isolation that we often see in cases of doctors referred for a possible competence review.

General oversight is supportive and collegial based on a mutual agreement between two doctors. Providing oversight is voluntary and the overseer is not liable for the actions of the registrant, unless he or she is aware of deficiencies and takes no steps to address the problem. Oversight may be provided from a distance.

Recertification with peer review and audit supports a doctor to be competent in actual practice, with potential to respond appropriately to less common, but important problems, as well as maintain high ethical and interpersonal standards with patients. Doctors are required to spend a minimum of 50 hours per year on specified activities. A useful workshop with Colleges on recertification was held during the year.

For many doctors, these minimum provisions simply formalised what the profession has always done to maintain knowledge and what the public had already come to expect. Others are having to work hard to develop continuous professional development strategies that they otherwise would not have done.

What is the difference between supervision and oversight?

Supervision	Oversight
Supervisor must set learning objectives and monitor the doctor's progress	Overseer "mentors" the doctor, helps choose appropriate CME, resolve professional concerns
Supervisor must report to the Council	No report to the Council; instead overseer signs practising certificate application
Supervision is frequent and directive	Oversight less frequent, may be from a distance

8. Competence referrals

1 April 2001 – 31 March 2002

Source of concern	Number
Accident Compensation Corporation (ACC)	6
Health and Disability Commissioner (HDC)	26
Complaints Assessment Committee	5
Medical Council of New Zealand	13
Public	2
Medical Practitioners Disciplinary Tribunal	2
Peer	12
Employer	5
Self-referral	2
Total referrals	**73**

Type of concern	Number
Records	6
Prescribing	6
Clinical skills	43
Surgical skills	14
Boundaries	2
Communication	16
Other	10

Note: one referral to a competence review may cover more than one category.

Outcomes of competence referrals	Number
To competence review	37
No competence review	39
To competence programme	6
Referred to other committee or HDC	5
Pending	13

Complaints

Principal activities: operation of complaints assessment committees (CACs) to consider complaints, policy on complaints assessment process.

Total cost of CACs: $848,016

Complaints assessment committees investigate complaints received against doctors relating to treatment before 1 July 1996.

We received 70 complaints about 82 doctors in the year under review, a decrease from 382 complaints the previous year. We can only investigate complaints about treatment before 1 July 1996 and must refer all others to the Health and Disability Commissioner. One hundred and sixty were referred to that office during the period, compared to 262 the year before.

Occasionally a complaint comes to the Council that has already been investigated by the Commissioner. We adopted the following policy: "Where a complaint has been previously investigated by the Health and Disability Commissioner and an opinion of 'no breach of the code' is given, the Council should not refer the matter to a complaints assessment committee for further investigation of the complaint unless issues relating to patient safety or issues that may bring the profession into disrepute are apparent".

The complaints assessment committee gathers information and clarifies the issues in the complaint. Its task is not to decide guilt, but to ensure matters that raise serious issues about a doctor's conduct are referred to the Medical Practitioners Disciplinary Tribunal. Most complaints do not meet that test because, although serious to those involved, they do not indicate a departure from an accepted professional standard.

Since 1996 more complaints are resolved in a non-disciplinary way. Some complainants are disappointed if they feel a doctor should be punished, and some suggest that "too few" doctors are disciplined now compared with previously. However, every year a number of doctors are judged by their peers and held to account for shortcomings before the Tribunal. The difference in recent years is a greater emphasis on low level resolution as a more effective, faster and less cumbersome avenue to patient redress and fewer matters being considered bluntly as "disciplinary".

Delays in assessing complaints continue to cause concern. To an outsider a matter may appear simple but the opposite is often true. More complaints now involve one or more complainants and possibly their lawyers, and one or more doctors and their lawyers. The longest delays occur when constituting an assessment committee if staff have difficulty finding appropriately experienced people willing to do the job, who are acceptable to all parties.

Our efforts to minimise delays continue. During the year we audited timelines as a benchmark for progress and plans are underway to introduce electronic tracking and alerts at each stage.

Referrals of medical misadventure from ACC

As a result of cases against Dr Graham Parry and attempts to identify poor performance early, we asked ACC to notify the Council of all claims that it accepted as medical misadventure, mishap as well as error. There were two components: historical data from 1991 to 2000, and ongoing monthly reports.

Hundreds of historical cases were forwarded. A small group of 40 doctors reached the threshold set to warrant further investigation (five or more findings of medical misadventure in five years). The Professional Standards Committee considered all cases and sought further information, but was unable to gain reliable information on mishap cases from ACC district offices.

Ten monthly reports were received from ACC for the reporting year. Regular reports ceased when new ACC legislation made referral to regulatory bodies a discretionary matter. In total 15 mishap cases and 9 error cases were reported all involving different doctors. No error cases were referred by ACC as the complainant. In one case ACC forwarded a report on one doctor with six findings of error and mishap since 1992, with a request for a competence review. The committee was considering three further cases from the data (historical and monthly reports) at the close of the year.

It is worrying that a requirement for ACC reporting has been taken out of the Health Practitioners Competency Assurance Bill, even at the reasonable threshold of five misadventure findings in five years. In hearings on the bill we will continue to argue for full inter-agency reporting on the grounds that non-disciplinary, confidential early intervention with appropriate safeguards for doctors is beneficial to both the profession and the public.

9. Schedule of Complaints

1 April 2001 – 31 March 2002

New Complaints Assessment Committees(CACs) appointed	43
Complaints carried forward at 31 March 2002	
CAC pending determination	42
Number of new complaints received	**70**
Number of doctors involved	82
Categories of complaint	
Communication	13
Conviction of an offence	10
Inappropriate sexual behaviour	4
Treatment	43

Note: One complaint can cover more than one category

10. Complaints Statistics

1 April 2001 – 31 March 2002

Month 2000/2001	Complaints received pre-1.7.96 for CAC appt	Complaints received post 1.7.96 to HDC to action
April	9	5
May	4	0
June	2	0
July	4	2
August	8	2
September	0	5
October	0	5
November	4	8
December	1	3
January	0	0
February	2	3
March	1	2

Note: Includes convictions and non-code issues from HDC and when HDC has asked Council to investigate.

11. Determinations Made

1 April 2001 – 31 March 2002

Competence Review	16
Referred to conciliation*	2
Charge laid with MPDT	22
No further action	74
Withdrawn	13
Total	**127**

Note: Each case may involve more than one doctor; each determination relates to one doctor.

* One unsuccessful conciliation resulted in a new CAC.

Doctors’ Health

Principal activities: considering the cases of doctors with possible health conditions, establishing treatment and monitoring programmes for doctors with health conditions affecting fitness to practise, promotion of doctors’ health.

Total cost: $819,445

We seek to protect patients by the appropriate management of a doctor who, because of some mental or physical condition, may not be fit to practise.

During the year Dr Mark Adams stepped down as chairman of the Health Committee and was succeeded by Dr Joanna MacDonald. Dr Adams was chairman for two years, during which time his sensitive and pragmatic approach earned the respect of his colleagues and the doctors involved with the committee.

It is mandatory for doctors and those in charge of hospitals to notify the Council Registrar about a suspected unwell doctor, and there is a penalty for failing to notify under the Medical Practitioners Act. Deciding to notify is not an easy decision, so the Act allows for someone contemplating doing so to seek other professional opinions.

Health cases are delegated to the Health Committee and do not go before the full Council, except for information. The committee focuses on rehabilitation and safety for patients. There were 60 new referrals, 30 more than last year, however, the increase was largely due to inclusion of referrals for some minor matters that were not previously included.

Doctors, like the general population, suffer from a range of afflictions, including drug and alcohol abuse, psychiatric disorders and a wide range of physical disorders, all of which can hamper their performance. The total number of doctors actively monitored is now 90, and progress of 69 doctors was reviewed. With treatment and monitoring regimes in place the majority of doctors can continue practising although some may withdraw from practice for periods through mutual agreement with the committee.

We are indebted to the colleagues of doctors and other health professionals who provide support through supervision and reporting, and to mentors who work with unwell doctors. A productive mentors meeting was held during the year.

Decisions during the year included:

- a doctor under Health Committee monitoring will not automatically be issued with a certificate of good standing but will be assessed individually
- if a conviction for a drug or alcohol offence is received the committee’s advice will always be sought on whether evaluation and treatment of the doctor should be undertaken
- the committee’s advice will also be sought for graduates and other applicants for registration who have convictions for drugs or alcohol that are less than five years old.

We produced a pamphlet about our functions and steps for managing doctors with health conditions, available on our website www.mcnz.org.nz.

Financial support of $43,870 went to the Doctors' Health Advisory Service (DHAS) in 2001/02. Through a longstanding agreement, DHAS provides the committee with coded reports and an assessment of risk of doctors it is helping.

Fitness to practise

Doctors are legally required to report a doctor whom they have reason to believe is not fit to practise. A doctor may not be fit if he or she:

- is unable to make safe judgements, or
- is unable to demonstrate the level of skill and knowledge required for safe practice, or
- behaves inappropriately, or
- risks infecting patients with whom he or she comes into contact, or
- acts or omits to act in ways that impact adversely on patient safety.

12. Health statistics

1 April 2001 – 31 March 2002

New Referrals	
Received	60
• No further action required	20
• Monitoring programmes initiated	20
• Further review required before APC issued	10
• Follow up report to be provided	5
• Pending	4
• Deaths (cause not related to impairment)	1
Referred from Professional Standards Committee to Health	4
Referred from Health to Professional Standards Committee	3
Carried Over from Previous Years	
Monitoring programme reactivated or continued from previous year	38
Low level monitoring or review	32
Further review required before APC issued	3
Cases closed	23
Other actions taken	
Conditions imposed on APC	1
Applications for registration considered and initial registration supported	1

Health disclosures on annual practising certificate (APCs)

In addition to those under Health Committee monitoring shown in the table above, 62 doctors disclosed a health condition at the time of applying for an APC. Of those, 26 were from people who had not disclosed previously. Seventeen people were asked to arrange for their treating doctor to sign a form confirming their fitness to practise. Eight people had been asked to submit updates with their next APC application.

Issues

Principal activities: considering and anticipating developments in the practice of medicine and in health services for the formulation of statements and guidelines for the profession.

Total cost: As the work of this committee covers all areas of Council business it is apportioned against the major activities of the Council.

As medicine becomes more complex and society changes, guiding the profession becomes more challenging. Doctors must be aware of evolving standards of practice should their actions ever be questioned.

Our Issues Committee considers the need for guidance on new issues that come to its attention, and is systematically updating older statements and guidelines.

Review of sexual boundaries policies

In the previous year we initiated a major independent review of our policies on sexual boundaries in the patient-doctor relationship, which are nearly ten years old. A discussion document went out to 200 medical and public groups inviting written submissions, and we held nine focus groups around the country. Seventy written submissions were received.

The independent evaluation report, written by lawyer Clare Bear, was presented in September with over 100 recommendations, including the need to move away from a complaints and disciplinary framework for boundary breaches to promotion of standards and prevention.

We plan to retain the current "zero-tolerance" of sexual relations in current patient-doctor relationships, with a case-by-case approach towards former patient-doctor relationships. Ms Bear's report identified the need to clarify the use and purpose of third party support people during medical consultations and as a priority, the monitoring of sexual misconduct doctors who return to medical practice with conditions.

Her extensive recommendations covered the complaints function; the training of complaints assessors and Council staff in the dynamics of sexual offending; improving systems for peer reporting; treatment of third party complaints; training of medical students and development of anti-harassment standards within the profession, and improvement in the resources and support for the medical profession.

It will take two years or possibly longer to implement the recommendations. Quarterly updates on our website inform stakeholders of progress.

New statements

New guidelines circulated to the profession were *Maintenance and retention of patient records, Medical certification* and a statement: *Self and family care*. Sixteen other statements and guidelines were under review during the year.

Four were at the stage of final Council approval:

- *Information and consent*
- *Legislative requirements about informed consent* (including all legislation that allows a doctor to proceed with treatment without obtaining informed consent)
- *Employer guide for health providers*
- *A doctor's duty to help in an emergency*.

Our statement on *Information and consent*, first issued in 1994, required a major revision. We consulted with chief medical advisors, colleges, the Health and Disability Commissioner, Director-General of Health, medical indemnity insurers and the New Zealand Medical Association, and received over thirty submissions. The new statement refers extensively to the Code of Health and Disability Consumers' Rights but goes more widely to advise on the Guardianship Act, court orders, obtaining consent for removal of body parts and patients involved in research or as part of a screening programme. Advice is given on obtaining separate written consent for certain procedures.

We updated guidelines on *Responsibilities of doctors in governance and management* in light of the Protected Disclosures Act, restating the core principle that doctors' first consideration must continue to be the interests and safety of patients, regardless of their managerial responsibilities.

We produced a resource folder of Council publications for chief medical advisors and work began to make the folders available to the profession in general.

Cultural competence

We have begun to consider how "cultural competence" can be more explicitly incorporated into the day to day practice of medical professionals. Our draft definition has two components: providers' statutory responsibilities towards Maori under the Treaty of Waitangi; and a more general cultural understanding of New Zealand society, particularly for overseas-trained doctors which requires:

- ability to communicate effectively in English
- sensitivity to gender expectations of healthcare delivery including the rights of women to make independent decisions about their health, and the equal standing of women doctors in New Zealand
- cultural differences with regard to the sanctity of life.

Systems for incorporating cultural competence into medical education and training are due to be developed in the next year.

Future work

Our future workplan includes the following:

- accreditation of internet medical sites
- the relationship between doctors and pharmaceutical companies, including use of kickbacks and the influence pharmaceutical companies have on practitioner prescribing and medical research
- doctors' responsibilities when working in a third party relationship, eg, as medical assessors for ACC, insurance companies.

Medical Workforce Survey

Total cost: $95,886

The Medical Council collects workforce data annually. Data are widely used by the Ministry of Health and by the recently formed Health Workforce Advisory Committee for its vital task of analysing workforce needs. In the previous year an extended report was completed on changes in the medical workforce up to 2000, focusing on retention of practitioners.

At the time of publication of this report, the workforce survey report for 2001 was not finalised, due to the transition to quarterly gathering of data. The delay is for this year only, and the report is expected to become available after August 2002 on www.mcnz.org.nz.

Discipline Activities

arising from the 1968 Act

One outstanding proceeding under the old Act, which had commenced before the new Act took effect, was closed during the year.

Appeal to the High Court

The Council considered the progress of an appeal by Dr E to the High Court against a Medical Council decision to lift name suppression and whether it should pursue the matter after no action since 1996.

It was resolved to take no further steps in respect of the appeal, since any historical benefit to the public would be outweighed by costs incurred in pursuing the matter.

Report of the Medical Practitioners Disciplinary Tribunal

The Medical Practitioners Disciplinary Tribunal is a statutory body constituted under Section 8 of the Medical Practitioners Act 1995. The Tribunal and its membership are entirely separate from the Medical Council.

The Medical Council provides administrative services and funding for the Tribunal through the disciplinary levy collected from all practitioners each year. Hence the activities of the Tribunal are reported in this Annual Report.

Members and officers of the Tribunal

at 31 March 2002

Mrs W N Brandon (Chair)
Miss S M Moran (Senior Deputy Chair)
Ms P Kapua (Deputy Chair)

Panel of medical practitioners

Dr F E Bennett
Dr I D S Civil, MBE
Dr J C Cullen
Dr L Ding
Dr G S (Ru) Douglas
Dr R S J Gellatly
Professor W Gillett
Dr J W Gleisner
Dr L Henneveld
Dr A R G Humphrey
Dr R W Jones
Dr B D King
Dr M G Laney
Dr C P Malpass
Dr U Manukulasuriya
Dr A M C McCoy
Dr F McGrath
Dr J M McKenzie
Associate Professor Dame N Restieaux
Dr A A Ruakere
Dr A D Stewart
Dr J L Virtue
Dr L F Wilson

Panel of public members

(One is appointed by the chairperson for the purposes of each hearing)

Mr P Budden
Ms S Cole
Mrs J Courtney
Mr G Searancke
Mrs H White

Office of the Tribunal

Secretary – Ms G J Fraser
Administrative Assistant – Mrs D M Haswell
Hearing Officer – Ms K Davies

28 The Terrace
PO Box 5249, Wellington
Tel (04) 499-2044
Fax (04) 499-2045
Email: mpdt@mpdt.org.nz
www.mpdt.org.nz

During the year under review the Tribunal received 31 charges, 13 from the Director of Proceedings and 18 from complaints assessment committees. In the previous year 13 charges were received.

During the year, the Tribunal sat to hear 21 charges over a combined number of 39 days. Of these 21 charges, six were charges received in the previous year and 15 from the 2001/02 year. Following an application to the Tribunal to stay seven of the charges received, two were stayed and the Tribunal is yet to hear 14 of the current charges.

Charges before the Medical Practitioners Disciplinary Tribunal

1 April 2001 – 30 March 2002

Nature of Charges	
Disgraceful conduct	7
Professional misconduct	15
Conduct unbecoming a medical practitioner and that conduct reflects adversely on the practitioner's fitness to practise medicine	9
Total	**31**
Source	
Prosecution of charges brought by complaints assessment committee	9
Prosecution of charges brought by Director of Proceedings	6
Charges brought by complaints assessment committee but stayed	2
Charges brought by complaints assessment committee yet to be heard	7
Charges brought by Director of Proceedings yet to be heard	7
Total	**31**
Outcome of Hearings	
Guilty – disgraceful conduct	0
Guilty – professional misconduct	1
Guilty – conduct unbecoming a medical practitioner and that conduct reflects adversely on the practitioner's fitness to practise medicine	4
Not guilty	4
Stayed	2
Not completed	6
Yet to be heard	14
Total	**31**

Medical
Council
of New Zealand

Finance

Finance

The attached financial statements are for the year 1 April 2001 to 31 March 2002.

The Medical Council received another unqualified audit opinion this year.

General Council operations

The general fund covers activities to register doctors, promote medical education, develop guidelines, carry out competence reviews, manage doctors with health problems and produce the annual workforce survey. The fund shows a surplus for the year of $619,057, compared to the budgeted surplus of $143,000 and the surplus in the previous year of $893,509. Key points are:

- Total revenue increased by $146,000. Revenue from fees increased by $80,000 as more temporary registration applications were received from overseas-trained doctors, and more applications were made for vocational registration as doctors, who had previously worked under general oversight, applied for vocational registration so they could practise independently. The administration fee of $464,000 received from the discipline fund was raised to cover the increase in administration and overhead costs. Interest received from investments increased slightly. Other revenue was down, but in the previous year the Council received $50,000 from the Ministry of Health for administration costs relating to the overseas-trained doctor bridging programme.
- Total expenditure increased by $420,000 from the previous year but remained $267,000 below budget. The staffing structure was altered to provide better service to the profession, and staff and related recruitment and training costs increased by $93,000 but remained under budget. Other administration and operating expenses increased by $129,000, mostly due to an increase of $106,000 in depreciation. Expenditure reduced in the areas of legal and other consultancy and communications, reflecting better use of external advice and increased internal access to legal advice. Total council and committee meeting costs and expenditure on projects and core business increased by $294,000. Most of the increase related to extra work in the competence area, costing $179,000 more than the previous year. The net cost of the combined Australian and New Zealand Boards' and Councils' conference held in Wellington in November was $66,000 and resulted in an increase of $36,000 spent on conference and international liaison from the previous year. Expenditure by the Health Committee on health reports increased more than $20,000 reflecting the complexity of some of the cases considered.
- As at 31 March 2002 the general fund remained in a strong financial position and the capital account, comprising both the cash and non-cash assets, stands at $6,911,045. These reserves exceed the sum stated in the Council's reserves policy and it is expected that over the coming years these will slowly reduce to the desired level of approximately one year's turnover.

Discipline Fund

The discipline fund covers the work of complaints assessment committees set up by the Council and it also fully funds the operations of the Medical Practitioners Disciplinary Tribunal. The fund shows a deficit for the year of $643,488 compared to the budgeted deficit of $290,000 and a deficit in the previous year of $167,827. Key points are:

– Total revenue dropped by $13,000. Revenue from the disciplinary levy increased mainly due to the number of temporary registration applications from overseas-trained doctors. Interest received from investment was less than the previous year reflecting the decrease in discipline fund reserves.

– Total expenditure increased by $462,000 from the previous year and exceeded budget by $418,000. Administration and operating expenses were greater than the previous year as the fee paid to the general fund to cover administration and overhead expenditure was increased in line with actual costs. The Council's complaints assessment costs and the cost of funding the Tribunal increased by $399,000 from the previous year, $393,000 more than budget. This reflects the complexity of many of the complaints cases and the additional hearings held by the tribunal (19 hearings in 2002 compared to 11 the previous year).

– Although the discipline fund shows a significant deficit this year, the fund remains in a strong financial position with a capital account balance as at 31 March 2002 of $3,116,465. As with the general fund, these reserves exceed the sum stated in the reserves policy and are expected to continue to reduce over the coming years to the desired level of approximately one year's turnover.

Examination fund

The examination fund covers the operating costs of the medical registration examination, NZREX Clinical. As in the past two years, the fund produced a significant deficit of $66,108, due to the continued decline in candidates (83) in 2001/02. Including the deficit from the year under review (2002), the accumulated capital account deficit as at 31 March 2002 is $177,800 and a further but smaller deficit is predicted next year (2003). It is unlikely in the short term that the examination fund will be in a position to operate sufficient surpluses to recover the accumulated deficit. Therefore, following any changes to the examination from the recent review, the Council may transfer the accumulated deficit from the examination fund across to the general fund. While the Council has acknowledged that historically examinations have been partly subsidised by the general fund, it prefers full cost recovery.

Miller Dean Knight & Little

Chartered Accountants

MEDICAL COUNCIL OF NEW ZEALAND
AUDITORS' REPORT
FOR THE YEAR ENDED 31 MARCH 2002

To : Members of the Medical Council Of New Zealand

We were appointed auditors of the Medical Council of New Zealand in accordance with the Second Schedule of the Medical Practitioners Act 1995.

We have audited the attached financial statements which provide information about the past financial performance of the Council and its financial position as at 31 March 2002. This information is stated in accordance with the accounting policies set out in the notes to the financial statements.

Council's Responsibilities
The Council is responsible for the preparation of financial statements which fairly reflect the Council's financial position as at the above date and of its financial performance for the year ended on that date.

Auditor's Responsibilities
It is our responsibility to form an independent opinion on the financial statements presented by the Council and to report our opinion to you.

Basis of Audit Opinion
An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures in the financial statements. It also includes an assessment of the significant estimates and judgements made by the Council in the preparation of the financial statements and whether the accounting policies are appropriate to the Council's circumstances, consistently applied and adequately disclosed.

We conducted our audit in accordance with auditing standards issued by the Institute of Chartered Accountants of New Zealand. We planned and performed our audit so as to obtain all the information and explanations which we considered necessary in order to provide us with sufficient, reliable and relevant evidence to give reasonable assurance that the financial statements are free from material misstatements, whether caused by error, fraud, or other irregularity. In forming our opinion we also evaluated the overall adequacy of the presentation of information in the financial statements.

In addition to our role as auditors, we provide taxation and other advice to the Council. Other than this, we have no other interests in the Medical Council.

Unqualified Opinion
We have obtained all the information and explanations we have required. In our opinion the attached financial statements fairly reflect the financial position of the Medical Council of New Zealand as at 31 March 2002 and the results of its operations and cash flows for the year ended on that date.

Date Of Opinion
Our audit was completed on 31July 2002 and our unqualified opinion is expressed as at that date.

Level 5, Southmark House, 203-209 Willis Street, PO Box 11-253, Wellington, NZ. Tel 0-4-385 0862; Fax 0-4-384 3381

Maurice A. Knight CA., A.N.Z.I.M. John W. Little B.C.A., CA.

Statement of Financial Position

as at 31 March 2002

	2002	2001
CURRENT ASSETS		
Petty Cash	300	300
ANZ Bank Account	207,815	143,443
Sundry Debtors And Payment In Advance (Note 7)	48,293	22,575
Interest Accrued	551,208	436,709
Term Deposits (Note 8)	11,047,957	11,349,143
Total Current Assets	$11,855,573	$11,952,170
FIXED ASSETS (Note 9)	1,014,756	782,857
Total Assets	$12,870,329	$12,735,027
CURRENT LIABILITIES		
Sundry Creditors	605,875	541,417
Salaries & Holiday Pay Accrued	125,999	121,844
GST	28,746	38,679
Payments Received In Advance	2,259,999	2,092,838
Total Current Liabilities	$3,020,619	$2,794,778
CAPITAL ACCOUNT		
General Fund	6,911,045	6,291,988
Discipline Fund	3,116,465	3,759,953
Examination Fund	(177,800)	(111,692)
	$9,849,710	$9,940,249
	$12,870,329	$12,735,027

The accompanying notes form part of these financial statements.

President

Chief Executive

Consolidated Statement of Financial Performance

for the year ended 31 March 2002

	2002	2001
INCOME		
Fees Received	5,037,945	5,070,869
Interest Received	741,298	759,068
Other Income	229,030	297,590
	$6,008,273	$6,127,527
EXPENDITURE		
Audit Fees	12,300	10,000
Other Payments to Auditors	2,000	2,000
Depreciation (Note 1a, 9)	343,498	236,571
Fees Paid to Council Members	419,975	378,760
Other Administrative Costs	5,191,629	4,722,387
Rent	129,410	128,598
	$6,098,812	$5,478,316
Net Surplus / (Deficit) for Year	($90,539)	$649,211

The accompanying notes form part of these financial statements.

Statement of Movements in Equity

for the year ended 31 March 2002

	2002	2001
A) ACCUMULATED FUNDS AND RESERVES		
Balance at 31 March 2001	9,940,249	9,291,038
Add: surplus 2001		649,211
Less: deficit 2002	(90,539)	
Balance at 31 March 2002	$9,849,710	$9,940,249
B) ANALYSIS OF INDIVIDUAL FUNDS		
1) General Fund		
Balance at 31 March 2001	6,291,988	5,442,967
Less: Examination Review Costs (Note 10)		(44,488)
Add: surplus	619,057	893,509
Balance at 31 March 2002	$6,911,045	$6,291,988
2) Discipline Fund		
Balance at 31 March 2001	3,759,953	3,927,780
Less: deficit	(643,488)	(167,827)
Balance at 31 March 2002	$3,116,465	$3,759,953
3) Examination Fund		
Balance at 31 March 2001	(111,692)	(79,709)
Add: Examination Review Costs (Note 10)		44,488
Less: deficit	(66,108)	(76,471)
Balance at 31 March 2002	($177,800)	($111,692)

The accompanying notes form part of these financial statements.

Statement of Cashflow

for the year ended 31 March 2002

Cash flow from statutory functions		2002	2001
Cash was provided from:			
Receipts pertaining to statutory functions	5,245,522		5,393,456
Cash was also distributed to:			
Payment for Council fee and disbursements			
and Council office expenses	(5,534,861)		(5,432,893)
Net cash flow from statutory functions		(289,339)	(39,437)
Cash flow from investing activities			
Cash was provided from:			
Interest received	626,799		531,870
Sale of assets	1,123		
Short term investments	301,186		
	929,108		531,870
Cash was applied to:			
Purchase of assets	(575,397)		(337,874)
Short term investments			(204,087)
	(575,397)		(541,961)
Net cash flow from investing activities		353,711	(10,091)
Net increase/(decrease) in cash held		64,372	(49,528)
Opening cash brought forward		143,743	193,271
Ending cash carried forward		**$208,115**	**$143,743**
Represented by:			
Petty cash		300	300
ANZ bank account		207,815	143,443
		$208,115	**$143,743**

The accompanying notes form part of these financial statements.

Notes to and forming part of the financial statements

for the year ended 31 March 2002

1. Statement Of Accounting Policies

Reporting Entity

The Medical Council of New Zealand is a statutory body constituted under successive Medical Practitioners Acts, including the Medical Practitioners Act 1968 and, from 1 July 1996, the Medical Practitioners Act 1995.

General Accounting Policies

These financial statements are a General Purpose Financial Report as defined in the Institute of Chartered Accountants of New Zealand Statement of Concepts and have been prepared in accordance with generally accepted accounting practice as defined in that Statement.

Measurement Base

The accounting principles recognised as appropriate for the measurement and reporting of financial performance and financial position on a historical cost basis are followed by the Council.

Specific Accounting Policies

The following specific accounting policies which materially affect the measurement and reporting of financial performance and financial position have been applied:

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

Furniture and Fittings	10%pa
Office Alterations	10%pa
Office Equipment	20%pa
Computer Hardware and Software	33%pa

b) **Fixed Assets** are shown at cost less accumulated depreciation (Note 9).

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

d) **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.

e) **Income Tax** – The Council is not subject to income tax (Note 6).

f) **Sundry Debtors** – Sundry debtors are valued at the amount expected to be realised.

g) **Administration Charge** – This is a levy on the Discipline and Examination Funds to meet overhead costs incurred by the General Fund. The charge to the Discipline Fund is based on the proportion of staff engaged in this activity.

h) **Interest Received** – Interest owing at balance date has been accrued.

Changes in Accounting Policies

There have been no material changes in accounting policies, which have been applied on bases consistent with those used in the previous year.

2. General Fund

Statement of Financial Performance

for the year ended 31 March 2002

	2002	2001
REVENUE		
Annual Practising Certificates and Other Fees	3,713,413	3,633,507
Administration Fee - Discipline Fund (Note 1)	464,000	351,800
Administration Fee - Examination Fund (Note 1)	60,000	60,000
Interest Received	501,910	474,840
Workforce Survey and Other Income	76,904	150,020
Total Revenue	$4,816,227	$4,670,167
ADMINISTRATION AND OPERATING EXPENSES		
Communications	180,475	241,433
Legal Expenses and Other Consultancy	80,585	116,834
Other Administration and Operating Expenses	903,765	774,029
Staff Costs including Recruitment and Training	1,749,233	1,655,703
Total Administration and Operating Expenses	$2,914,058	$2,787,999
COUNCIL AND COMMITTEE EXPENSES		
Council		
– Fees and Expenses	293,537	272,792
– Conference and Liaison Costs	143,664	107,322
Audit Committee		
– Fees and Expenses	9,992	5,526
Health Committee		
– Fees and Expenses	48,881	45,268
– Health Reports, Mentoring, DHAS and Other Costs	115,512	83,626
Issues Committee		
– Fees and Expenses	35,087	16,340
Education Committee		
– Fees and Expenses	56,278	46,461
– Hospital Visits, Intern Supervisor and Other Costs	229,773	261,274
Professional Standards Committee		
– Fees and Expenses	63,940	44,028
– Competence Reviews and Other Costs	254,547	76,012
Registration Committee		
– Fees and Expenses	12,790	11,732
– Verification of Qualifications and Other Costs	18,375	13,037
– Examination Review Costs (Note 10)	736	5,241
Total Council and Committee Expenses	$1,283,112	$988,659
Total Expenditure	$4,197,170	$3,776,658
Net Surplus for Year	$619,057	$893,509

3. Discipline Fund

Statement of Financial Performance

for the year ended 31 March 2002

	2002	2001
REVENUE		
Fines Imposed, Costs and Mentoring Recovered	152,126	147,570
Interest Received	239,388	283,947
Levies Received	1,133,714	1,107,020
Total Revenue	$1,525,228	$1,538,537
ADMINISTRATION AND OPERATING EXPENSES		
Administration Fee (Note 1)	464,000	351,800
General Administration and Operating Expenses	72,972	74,170
Total Administration and Operating Expenses	$536,972	$425,970
1995 ACT PROCESS		
COUNCIL AND TRIBUNAL EXPENSES		
Complaints Assessment Costs		
– Fees	230,119	226,064
– Expenses	617,897	428,370
Total Complaints Assessment Costs	848,016	654,434
Medical Practitioners Disciplinary Tribunal		
– Administration and Operating Expenses	224,645	260,704
– Fees and Other Hearing Expenses	559,083	317,383
Total Medical Practitioners Disciplinary Tribunal Costs	783,728	578,087
Total 1995 Act Process	$1,631,744	$1,232,521
1968 ACT TRANSITIONAL PROCEEDINGS		
COUNCIL AND COMMITTEE EXPENSES		
Medical Council Discipline Fees and Expenses		21,744
Legal and Mentoring Expenses		26,129
Total Transitional Proceedings (1968 Act)		$47,873
Total Expenditure	$2,168,716	$1,706,364
Net (Deficit) for Year	($643,488)	($167,827)

4. New Zealand Registration Examination Fund

Statement of Financial Performance

for the year ended 31 March 2002

	2002	2001
REVENUE		
NZREX Candidate Fees	190,818	330,342
Interest Received		281
Total Revenue	$190,818	$330,623
ADMINISTRATION AND OPERATING EXPENSES		
Administration Fee (Note 1)	60,000	60,000
Centre Costs	36,395	73,577
Examiners Fees and Expenses	100,151	202,595
General Administrative Expenses	2,521	4,053
Honorarium, Salaries and Other Staff Costs	48,525	55,714
Total Administration and Operating Expenses	$247,592	$395,939
COMMITTEE EXPENSES		
Committee Fees and Expenses	9,334	11,155
Total Committee Expenses	$9,334	$11,155
Total Expenditure	$256,926	$407,094
Net (Deficit) for Year	($66,108)	($76,471)

5. General Fund

Statement of Financial Performance by Outputs

for the year ended 31 March 2002

These output categories represent the main activities of the General Fund and are discussed in detail in the text of the Annual Report.

	2002	2001
Total Income For Year	$4,816,227	$4,670,167
Less Expenditure		
EDUCATION		
Administration and Operating Costs	376,502	335,320
Council and Committee Costs	100,298	81,820
Hospital Visits	45,384	54,986
Intern Supervisor Costs	177,507	197,440
Liaison and Other Costs	44,478	40,044
Total Education Costs	$744,169	$709,610
HEALTH		
Administration and Operating Costs	561,898	532,083
Council and Committee Costs	113,218	101,253
Doctors Health Advisory Service Contract	43,870	35,868
Independent Medical Assessments	52,037	30,612
Mentoring Costs	10,127	12,988
Liaison and Other Costs	38,295	18,540
Total Health Costs	$819,445	$731,344
PROFESSIONAL STANDARDS		
Administration and Operating Costs	392,251	532,578
Council and Committee Costs	107,960	100,013
Competence Review Costs	217,443	46,736
Sexual Boundaries and Assessors Meeting Costs	34,492	29,276
Liaison and Other Costs	20,050	22,691
Total Professional Standards Costs	$772,196	$731,294
REGISTRATION		
Administration and Operating Costs	1,500,942	1,278,840
Council and Committee Costs	188,870	150,221
Examination Review Costs (Note 10)	736	5,241
Consultation Meetings	12,374	7,463
Liaison and Other Costs	62,552	42,356
Total Registration Costs	$1,765,474	$1,484,121
WORKFORCE SURVEY		
Administration and Operating Costs	82,465	109,178
Council and Committee Costs	10,158	8,840
Liaison and Other Costs	3,263	2,271
Total Workforce Survey Costs	$95,886	$120,289
Total Expenditure	$4,197,170	$3,776,658
Net Surplus for Year	$619,057	$893,509

6. Taxation

On 20 December 1996 the Court of Appeal found the Medical Council to be exempt from Income Tax.

7. Payments In Advance And Debtors

	2002	2001
Outstanding Contribution to Workforce Survey	20,000	
Other Debtors	8,919	10,279
Payments in Advance	19,374	12,296
	$48,293	$22,575

8. Term Deposits

	2002	2001
ANZ	2,045,953	2,325,266
ASB	1,644,599	2,077,258
BNZ	1,574,214	1,447,832
Hong Kong Bank	1,067,698	1,027,886
National Bank	2,290,393	2,215,537
Taranaki Savings Bank	695,410	657,180
Westpac Trust	1,729,690	1,598,184
Total Investments	11,047,957	$11,349,143

9. Fixed Assets

	Cost 31/3/02	Depreciation For Year 31/3/02	Accumulated Depreciation 31/3/02	Book Value 31/3/02	Cost 31/3/01	Accumulated Depreciation 31/3/01	Book Value 31/3/01
Computer	1,331,640	271,764	559,250	772,390	895,946	389,563	506,383
Furniture and Fittings	169,675	15,778	84,776	84,899	181,129	90,043	91,086
Office Alterations	254,242	24,546	150,461	103,781	227,888	125,915	101,973
Office Equipment	193,232	31,410	139,546	53,686	193,840	110,425	83,415
	$1,948,789	$343,498	$934,033	$1,014,756	$1,498,803	$715,946	$782,857

Costs of setting up and maintaining websites for the Medical Practitioners Disciplinary Tribunal and the Medical Council have been expensed in the year incurred.

10. Examination Review Costs

The Council has decided that costs of the examination review previously charged to the Examination Fund should be charged to the General Fund, as any resulting improvements in the examination process will benefit the entire profession. Review costs up to 31 March 2000 of $44,488 have been transferred from the Examination Fund to the General Fund in the Statement of Movements in Equity.

11. Related Parties

The Council members are paid fees for attending to Council and Committee business. There were no other related party transactions.

12. Foreign Currencies

Foreign currency transactions have been recorded at the rate of exchange applicable on the day of completion. There were no settlements due at balance date.

13. Reconciliation Of Net Surplus With The Net Cash Flow From Statutory Functions

for the year ended 31 March 2002.

Surplus / (Deficit) for year	2002	2001
General Fund	619,057	893,509
Discipline Fund	(643,488)	(167,827)
Examination Fund	(66,108)	(76,471)
	(90,539)	649,211
Add non-cash items – Depreciation (Note 9)	343,498	236,571
	252,959	885,782
Add movements in working capital items		
(Increase)/decrease in debtors and prepayments	(26,841)	29,352
Increase/(decrease) in receipts in advance	167,161	116,556
Increase/(decrease) in creditors and GST	58,680	(312,059)
	199,000	(166,151)
	451,959	719,631
Less items classified as investing activity-interest	(741,298)	(759,068)
Net cash flow from statutory functions	($289,339)	($39,437)

14. Contingent Liabilities

The Council may be liable for costs in the vicinity of $90,000 as respondent in a recent High Court case (nil as at 31 March 2001).

15. Events Occurring After Balance Date

There have been no adjustable or non-adjustable events (as defined in the applicable financial reporting standard) between balance date and the date of completion of the financial statements.

16. Commitments – Operating Leases

Lease commitments under non-cancellable operating leases:

	2002	2001
Not more than one year	116,760	116,760
Later than one year and not later than two years	9,730	116,760
Later than two years and not later than five years		9,730
	$126,490	$243,250

17. Commitments – Capital Expenditure

There were no material capital commitments at balance date (nil as at 31 March 2001).

18. Financial Instruments

Financial instruments which potentially subject the Council to credit risk consist principally of bank balances and accounts receivable.

The Council places investments with recognised banking institutions within an approved reserves and investment policy to limit exposure to concentrations of credit risk. Debtors are shown at a fair value. The estimated fair values of the financial instruments are as follows:

	2002	2001
Receivables	28,919	10,279
Bank-balances	11,255,772	11,492,586
Payables	(760,620)	(701,940)

Information held by the Medical Council

Public information about doctors is that which is contained in the Medical Register. Other information held on the Council's database and doctors' individual files is not public.

Information about doctors that is public

1. Information on the Medical Register
2. Tribunal hearings, unless suppressed or partially suppressed
3. Competence reviews only if the Council publishes a notice under S. 138 of the Act. (Note: the Health and Disability Commissioner may refer a doctor for a competence review in an open opinion but the Council decision whether to do a review is not disclosed)
4. Competence reviews and health undertakings that are included in conditions imposed by the Tribunal following a disciplinary hearing
5. Any other information published where the Council makes an order under S. 138 of the Medical Practitioners Act 1995.

Information about doctors that is not public

6. Personal details:
   - a doctor's place of work and position, current and previous
   - a doctor's phone, fax and email
   - additional qualifications not listed on the Medical Register.

7. Discipline:
   - current complaints
   - anonymous or informal complaints
   - past complaints (unless the complaint resulted in a Tribunal hearing)
   - fitness 'flags' on doctors' files to alert staff (note: flags refer to any issue with a doctor, not only discipline).

8. Competence and health matters:
   - competence review investigation
   - competence review report
   - competence programme
   - doctors' voluntary undertakings with the health committee

Exceptions to point 8: competence review investigations and reports may be notified to the employer if the Council has reasonable cause to believe there is a risk to public health and safety. Competence programmes are notified to the employer and others legitimately involved in implementing the programme.

The Medical Council is subject to the Privacy Act and information privacy principles. If requested, the Medical Council must disclose to individual medical practitioners what personal information is held about them on Council files. The purposes for which the information is collected must comply with provisions of the Medical Practitioners Act, to satisfy the Council that a doctor has the skills and knowledge to practise medicine.

Under certain conditions, and acting in accordance with the Privacy Act, the Medical Council may make normally confidential information about individual practitioners available to some organisations:

- Health and Disability Commissioner, pursuant to the Health and Disability Commissioner Act 1995
- Medical Practitioners Disciplinary Tribunal
- Director of Proceedings
- Ministry of Health
- New Zealand Police
- a complaints assessment committee
- employers of doctors
- overseas regulatory bodies.

Information requests

During the 2001/02 year, 29 requests for disclosure of personal information were made, six requests for information were received from the Office of the Privacy Commissioner and one request was received from the Ombudsman. A request was made for anonymised Council decisions granting vocational registration.

Categories of documents held by the Medical Council

- agendas, minutes and papers for Council meetings and Council committees
- the New Zealand Medical Register
- doctors' registration files
- doctors' complaints and discipline files
- competence review committee reports
- doctors' health files
- Medical Practitioner Disciplinary Tribunal decisions
- files on Council functions under the Medical Practitioners Act
- medical workforce statistics
- policy and procedures manuals
- books, pamphlets, statements and guidelines to inform the profession of Council functions
- legal advice/opinions
- general administration files
- accounts, financial statements, budgets
- personnel records
- computer records relating to all Council operations

All information requests to Council privacy officer: Tania Turfrey, Assistant Registrar.

Council Committees at 31 March 2002

The Council appoints committees to deal with its principal activities. Each committee has a minimum of two Council members. Registration decisions must be taken by the whole Council, not delegated.

Professional Standards Committee

Dr Philip Barham (Chair)

Dr Mark Adams

Miss Carolynn Bull

Ms Jean Hera

Dr Joanna MacDonald

Dr John Neutze

Dr Deborah Read

Mrs Heather Thomson

Health Committee

Dr Joanna MacDonald (Chair)

Dr Mark Adams

Dr Philip Barham

Miss Carolynn Bull

Dr John Neutze

Issues Committee

Dr Tony Baird (Chair)

Dr Philip Barham

Miss Carolynn Bull

Professor John Campbell

Ms Jean Hera

Dr Joanna MacDonald

Dr John Neutze

Mrs Heather Thomson

Audit Committee

Professor John Campbell (Chair)

Dr Mark Adams

Dr Deborah Read

Mrs Heather Thomson

Education Committee

Members appointed by the Council

Dr Mike Ardagh
Selected from Vocational Branch nominees

Dr Caroline Corkill
Selected from Vocational Branch nominees

Dr Mark Davis
Selected from Intern Supervisors

Dr Nichola Wilson
Resident doctor

Dr David Spriggs
Nominated by the Council

One vacancy

Council members

Dr Deborah Read (Chair)

Dr Philip Barham

Professor John Campbell

Ms Jean Hera

Mrs Heather Thomson

Examinations Committee

Members appointed by the Council

Professor Graham Mortimer
Examinations Director

Professor Peter Stone
University of Auckland Nominee

Professor Peter Ellis
University of Otago Nominee

Professor Pat Alley
Examinations Co-ordinator, Auckland

Dr David McHaffie
Examinations Co-ordinator, Wellington

Dr Peter Rothwell
Examinations Co-ordinator, Hamilton

Professor John Morton
Examinations Co-ordinator, Christchurch

Associate Professor Jim Reid
Examinations Co-ordinator, Dunedin

Council members

Dr Tony Baird (Chairperson)

Professor John Campbell

Dr Joanna MacDonald

Mrs Heather Thomson

Office of the Council at 31 March 2002

Ms Sue Ineson
Chief Executive/Registrar

Ms Tania Turfrey
Assistant Registrar

Ms Lynne Urquhart
Deputy Registrar

Mrs Dot Harvey
Senior Secretary

Registration

Mr Sean Hill
Registration Manager

Ms Karen Gardner
Registration Coordinator

Ms Gyllian Turner
Registration Administrator

Mr Philip Girven
Registration Administrator

Ms Ritu Nair
Registration Administrator

Mr Luke Baddington
Registration Administrator

Ms Nicola Bradshaw
Registration Administrator

Mr Chris Gilman
Registration Administrator

Mrs Emma Worden
APC Coordinator

Ms Rebecca Wilson
APC Administrator

Standards

Ms Sue Colvin
Standards Manager

Ms Joanna Dunning
Education Administrator

Ms Kristine Couch
Examination Administrator

Ms Michele Clarke
CAC Administrator

Ms Debbie North
Complaints Administrator

Ms Rachel Cornes
Professional Standards Administrator

Ms Karyl Newbold
Standards Administrator

Dr Ian St George
Professional Standards Advisor

Health

Ms Lynne Urquhart
Health Manager

Ms Jo Hawken-Incledon
Health Administrator

Mrs Viv Coppins
Health Administrator

Corporate Services

Mrs Jane Lui
Quality Assurance Manager

Ms Chris Aitchison
Policy Analyst

Mr John de Wever
Financial Controller

Ms Moyra Hall
Finance Accounts Officer

Ms Susan Pattullo
Communications Coordinator

Ms Hannah Bates
Customer Services

Mr Tony Hanna
Corporate Manager

Ms Sharon Mason
Customer Services

Mr Bill Taylor
Information Systems

Ms Diane Latham
Information Officer

vacant
Office Administrator

Solicitors

KPMG Legal
P O Box 10 246
Wellington

Bankers

ANZ Banking Group (New Zealand) Ltd
Victoria Street branch
Wellington

Auditors

Miller, Dean, Knight and Little
P O Box 11 253
Wellington

Medical Council of New Zealand

Level 12
Mid City Tower
139 – 143 Willis St
P O Box 11 649
Wellington

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Website www.mcnz.org.nz

MEDICAL
COUNCIL
of NEW ZEALAND