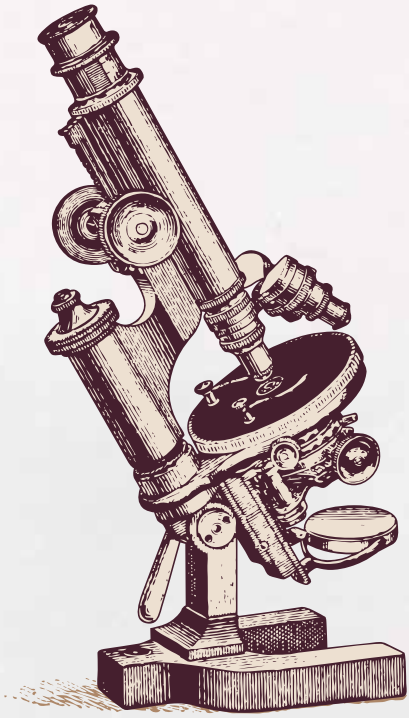
A HISTORY OF THE MEDICAL COUNCIL OF NEW ZEALAND

Compiled by Richard Sainsbury



ABOUT THE AUTHOR

Richard Sainsbury is Emeritus Professor of Geriatric Medicine University of Otago, Christchurch. He was an elected member of the Medical Council of New Zealand from 2009 to 2015. He has an interest in the portrayal of ageing and older people in literature.

ACKNOWLEDGEMENTS

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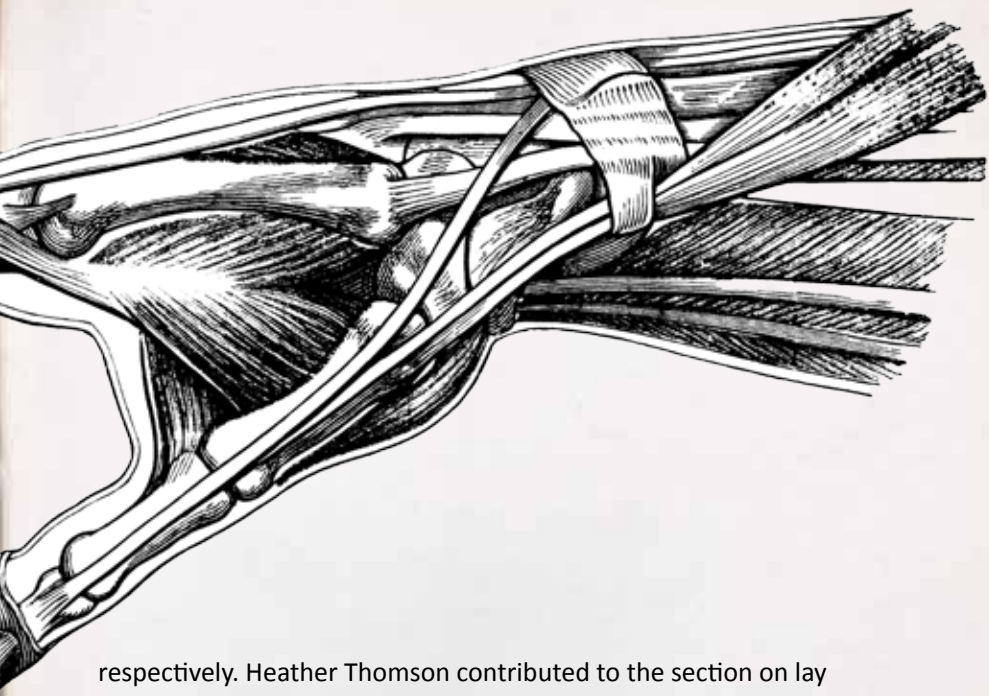

respectively. Heather Thomson contributed to the section on lay membership and the development of cultural policy.

Lynne Urquhart, Joan Crawford, Peter Searle, Susan Yorke, and David Dunbar made useful contributions about recent Council work. David Dunbar provided vital information about the Health Practitioners Competence Assurance Act 2003 and historical details about staff members. Viv Coppins and Marissa O'Leary provided excellent secretarial support for an author with well-known inadequacies in this area!

An editorial subcommittee of Joy Quigley, Mr Andrew Connolly, George Symmes, and Philip Pigou guided the progress of the book with wise counsel and encouragement. Andrew Connolly provided the main substance of the epilogue.

I particularly want to acknowledge George Symmes for his friendship, expertise, and wise advice, which has enabled this book to come to fruition.

When the Council became a corporate body, an official seal was needed. Professor Cecil Lewis, the inaugural Dean of the Auckland School of Medicine, provided four possible designs. These were accepted in 1967 when Council celebrated the centenary of medical registration in New Zealand. The Council logo still embodies much of his original design, which he delivered to Ms Georgina Jones, the Council's Chief Executive, with a note saying that he had completed it at 1.30am and he wished he had more time to pursue this hobby!

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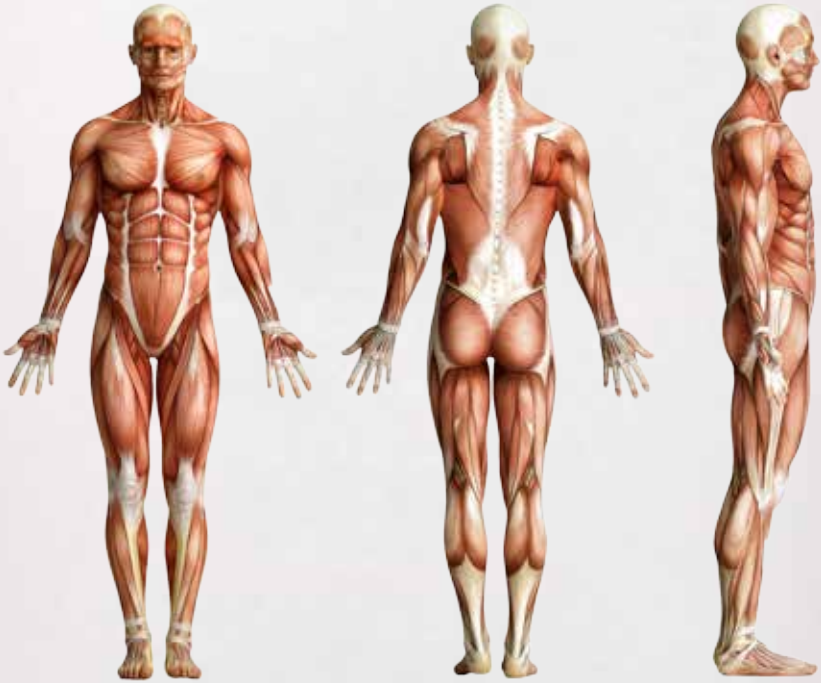
INTRODUCTION



The Medical Council of New Zealand has five main functions, which are to:

- set and promote standards that doctors must meet before and after they are admitted to the register
- maintain a register of those doctors who meet the standards – only registered doctors with a current practising certificate are allowed to work as doctors
- take appropriate action where a doctor's fitness or competence to practise has been called into question
- ensure high standards of education for those training to be a doctor, including hospital internship placements and new vocational scopes of practice
- recognise, accredit and set programmes to develop the competence of doctors.

Why is regulation of professional groups such as doctors necessary? The short answer is that, while the majority are honourable people providing a competent often excellent service, there is the potential for harm. The public need to be protected from the small minority of doctors who are unqualified, incompetent, unwell, dishonest, or unprincipled. There has always been a tension between the profession, who have wanted a high degree of autonomy, and the governments of the day, who have a paramount interest in public safety. In addition, people have become more educated and articulate about medical matters and are more inclined to challenge the doctor than was the case at the beginning of the twentieth century.

This book has been published to celebrate the centenary of the Medical Council of New Zealand (Council) in 2015. There might be

some debate about the choice of March 1915 as the origin of the Council given the existence of the first Medical Practitioners Act 1867. This Act was repealed in 1869 and replaced by the Medical Practitioners Registration Act 1869. In turn, that Act was amended to form the Medical Practitioners Registration Act 1905.

It was, however, the Medical Practitioners Act 1914 that removed the Medical Council/Board from the authority of the Registrar-General to that of the Director-General of Health. This was the forerunner to the structures that have shaped Council to the present day. This Act came into effect on 1 March 1915 and interestingly was entitled 'An Act to make better provision for the registration and *control* of Medical Practitioners' (emphasis added).

A further five Acts and their revisions have guided the Council in the subsequent hundred years, including the Finance Act 1932–33. The current Act under which the Council operates is the Health Practitioners Competence Assurance Act 2003. The principal purpose of this Act is to protect the health and safety of the public by providing for ways to ensure that all health practitioners are competent and fit to practise their profession.

There are 16 regulatory bodies, including the Medical Council, that operate under the Health Practitioners Competence Assurance Act 2003. Part 1 of this book outlines the various Acts that have guided the Council and some of the issues that other Councils of their day have dealt with under these Acts.

The Council has also been affected by other legislation, particularly the Health and Disability Commissioner Act 1994. There have also been a number of inquiries and reports, notably the Cartwright

Inquiry[1] and the Cull Report[2] in New Zealand and *Learning from Bristol: The Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984–1995* in the United Kingdom, which have influenced Council strategy and policy. Some high-profile cases of bad or unqualified doctors both in New Zealand and overseas have also driven the demand for the reform of medical regulation and the need for the Council to continually review its policies.

Major reports and cases of particular influence on the Council are the subject of Part 2.

Part 3 describes the Council's core business, some of the personalities who have chaired Council, and other hard-working and able members of the staff. There have been so many that it is impossible to pay appropriate tribute to them all. Council's three main committees – Audit, Education, and Health – are also discussed in Part 3 along with the development of continuing professional development and regular practice review together with the development of guidelines and position statements and *Cole's Medical practice in New Zealand.*

Future Councils will face new challenges. The rapid development of information technology is continuing at an accelerated pace. Apart from ever-increasing use of the internet by patients as a source of medical information (that is not always reliable), there are also the challenges of video consultation, distance prescribing, and the increasing sophistication of technical procedures, such as robotic surgery, to be faced.

The changing relationships of doctors to other health providers need to be considered as new disciplines such as nurse practitioners and physician assistants are developed. These changes are likely to

1 Cartwright, S. *Report of the Committee of Inquiry into Allegations Concerning the Treatment of Cervical Cancer at National Women's Hospital and into Other Related Matters.* The Committee, 1988.

2 Cull, H. *Review of Processes Concerning Adverse Medical Events.* Ministry of Health, 2001.

be driven by health workforce considerations. Medical training is constantly evolving and being refined, and there has always been a strong link between the Council and the medical schools. The ageing of the population at large, as well as the medical workforce, is another challenge that needs to be faced. These are discussed in an epilogue that looks into some future issues that may affect Council as seen principally through the eyes of the current Chair, Mr Andrew Connolly.

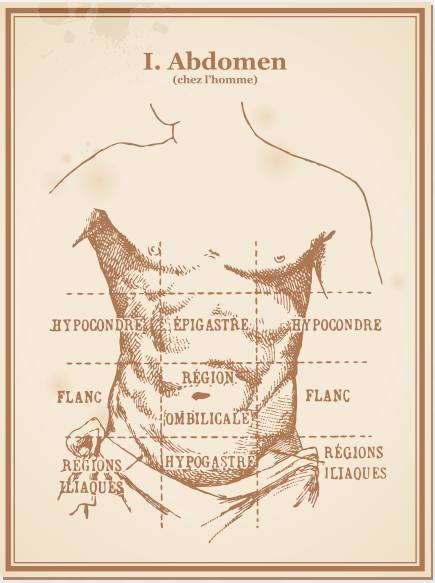
Ms Georgina Jones, a former Chief Executive Officer and Registrar, wrote an unpublished book[3] that was a mixture of history, informative insights, and personal opinion. This current book draws extensively from that work whilst also continuing the history of the Council to the present day.

Going back through the archives of the Council minutes (in specially purchased silk gloves to protect the worn pages) was a fascinating exercise. The archives are a treasure trove of historical issues and cases, and a single book cannot do justice to them. Some cases of registration and conduct have remained remarkably similar over the years. Competence cases have changed substantially because of the remarkable increase in treatments and technology in the past century. It is hoped that, by using a combination of Georgina Jones's earlier observations and a new review of the Council's resource material, this present volume gives a fair reflection of the 100 years of activity of the Council and its regulation of medical practice in this country.

[3] Jones, G. *The Medical Council of New Zealand: A Personal and Informal Perspective of Events During my Time as Chief Executive/Secretary/Registrar from 1986 to 2000.* Medical Council of New Zealand, 2002.

PART 1:
LEGISLATION GOVERNING MEDICAL REGISTRATION IN NEW ZEALAND

CHAPTER 1: BEFORE 1914



Medical registration was introduced in the United Kingdom by the Medical Act 1858 after almost 20 years of trying with abortive Bills. In New Zealand, the earliest attempts at registration were on a provincial basis commencing with the New Munster Province (a province covering part of New South Wales and part of New Zealand) in 1850. Wellington Province had the first medical board in New Zealand appointed in 1854. Otago passed an Act in 1864 that made registration compulsory and provided that a practitioner could be removed from the register if he was deemed to be 'guilty of disreputable or infamous conduct in any professional respect'.[4]

There was a Medical Practitioners Bill before the New Zealand Parliament in 1860, which failed on a technicality, having attracted heavy opposition, particularly from a surprising number of homeopathy supporters.[5] The issue of complementary and alternative medicine and its relationship with mainstream medicine is therefore not a recent one but has dated from the early days of medicine in this country.

MEDICAL PRACTITIONERS ACT 1867

The first statute to regulate the medical profession in New Zealand came into effect on 10 October 1867. The Medical Practitioners Act 1867 was passed by the United Kingdom legislature for the (by then) self-governing colony of New Zealand. The 1867 Act constituted New Zealand's first Medical Board (the Board) and defined the qualifications required of practitioners in medicine and surgery.

The Act permitted the Governor of New Zealand, Sir George Grey, to nominate one of the members as President of the Board, holding a 5-year term with the right of reappointment. Sir James Hector

[4] Wright-St Clair, RE. *A History of the New Zealand Medical Association: The First 100 Years.* Butterworths, 1987.

[5] Ibid.

(1834–1907) – doctor, scientist, adventurer, entrepreneur, and after whom the Hector's dolphin is named – presided over the first Board.

The Board was expected to meet in its first 3 months and to make rules. The President and Deputy President were able to appoint a Registrar/Treasurer and 'clerks and servants'. Interestingly, the 1867 Act allowed for a member of the Board to also hold the office of Registrar or Treasurer. Registration fees were paid to the Governor, who could then reimburse the Board at his discretion. Accounts were to be kept, and annual financial status reports as at 31 March were to be made to the Colonial Treasurer in April of each year. The fees collected were to be used for registration and administration of the 1867 Act, with any surplus going to the Treasurer.

The 1867 Act empowered the Registrar to keep a register of doctors, to change their addresses on the register when necessary, and to remove from the register the names of doctors who had died. Physicians and surgeons applying for registration were required to produce evidence of their qualifications and addresses. In provinces other than Wellington, a Member of Parliament or the resident magistrate in the chief local town was authorised to verify the authenticity of qualifications.

Applicants for registration were required to have qualified through a medical course of not less than 3 years' duration and to have received a diploma, degree, or licence from a university, college, or other body. The Board was also able to register, without further assessment, legally qualified practitioners from England, Scotland, Wales, and Ireland.

In order to be entered on the first New Zealand medical register, doctors had to produce evidence that they had been in medical

practice before 1857 (under the Ordinance of the Legislative Council of New Munster in effect in 1857 but repealed by 1867). If the doctor resided in Wellington, a certificate of practice issued by the Superintendent of the Province of Wellington was deemed sufficient. Doctors legally qualified to practise medicine and surgery in any of the Australian colonies at the time were not required to register separately in New Zealand.

Under the 1867 Act, the registration fee was 5 pounds, and doctors had to present their qualifications in person to the Board or its provincial nominee. Registered doctors were required to keep their addresses up to date, and if no reply was received to a registered letter to their last known address, their names were to be erased from the register. The Registrar of Births and Deaths was required to notify the Board when a doctor died.

So that the public could easily identify unregistered persons or quacks, the 1867 Act protected the titles of:

- physician
- doctor of medicine
- licentiate in medicine
- doctor
- surgeon
- medical and general practitioner
- apothecary
- surgeon-apothecary
- accoucheur (male ‘midwife’)
- licentiate or practitioner of midwifery.

Doctors were accorded a grace period of 182 days from the commencement of the 1867 Act to get themselves onto the register. If they had not done so within that time, unregistered doctors could be fined up to 50 pounds. (This compares dramatically with the fee to deposit qualifications under the Medical Act 1908 of only 1 pound!)

Clause 14 of the 1867 Act was controversial, however, in that it permitted anyone who had been in practice in New Zealand before 1857 to be registered regardless of qualification. Although that appeared to open the register to quacks, only 11 men registered under that clause. Nevertheless, meetings were held in a number of places in New Zealand to discuss this, including one at Dr Deamer's house in Christchurch in 1869 as recorded in the *Lyttelton Times* of 17 June 1869.[6]

The 1867 Act allowed registered doctors who were legally or duly qualified as doctors to sue for fees. Under the 1867 Act, no unregistered person could hold any medical appointment as a physician, surgeon, or other medical officer in any hospital, infirmary, dispensary, lying-in hospital, lunatic asylum, gaol, penitentiary, house of corrections, house of industry, or other public institution for affording medical relief in sickness, infirmity, or old age, or as a medical officer in the militia or volunteer force. Those found to be holding fraudulent qualifications were removed from the register. Registered doctors could add their higher qualifications to the register, which was published annually in the *New Zealand Gazette* and constituted evidence of registration for the courts.

The 1867 Act was clear that it did not cover the practice of chemists or druggists, and it required that the *British Pharmacopoeia* be used in New Zealand hospitals.

[6] Ibid.

It is remarkable how closely many of the provisions of the 1867 Act mirror twenty-first century legislative provisions.

MEDICAL PRACTITIONERS REGISTRATION ACT 1869

In 1869, the General Assembly of the New Zealand Parliament repealed the 1867 Act. The 1869 Act came into effect 2 years after Parliament was moved from Auckland to Wellington, a period when the administrative structure of New Zealand was becoming generally more sophisticated. Amendments to the 1867 legislation included the following requirements.

- The Registrar-General, as well as the Registrars in Auckland, New Plymouth, Napier, Nelson, Hokitika, Picton, Christchurch, Dunedin, and Invercargill, had to keep a register.
- Applicants for registration had to publish (in the newspaper and the *New Zealand Gazette*) notice of their intention to apply 30 days in advance.
- Applicants had to produce evidence of their qualifications (or copies certificated by a Justice of the Peace) to the relevant Registrar.
- Applicants could appeal any decision of the Registrar not to enter their name on the register.
- Doctors would be removed from the register for providing false or fraudulent qualifications or information.
- Doctors convicted of a felony or misdemeanour in Great Britain or Éire, or in any of the British dominions, would be removed from the register.

In line with other punitive measures of the times, the 1869 Act viewed fraudulent procurement of registration extremely seriously. If convicted, the felon was liable to imprisonment – plus or minus hard labour – for up to 3 years.

MEDICAL PRACTITIONERS REGISTRATION ACT 1905

On 27 October 1905, the 1869 Act was amended to include registration of foreign universities whose diplomas were not recognised by the Governor in Council, provided that the doctors passed the University of New Zealand's final medical examination. Powers were given to the Board to remove the name of any doctor registered by the General Medical Council if that person's qualification had been withheld or found to have been false or misrepresented. On application by the President of the British Medical Association, the Supreme Court of New Zealand could remove the person's name. The 1869 Act remained the principal Act.

Otago had been set up in 1875 with a Faculty of Medicine as such in place from 1891. From 1885, there was a 'full curriculum' (4 years) modelled on General Medical Council recommendations.

In 1904, nine students graduated MB ChB (NZ) from the University of Otago Medical School (Otago). They included Te Rangi Hīroa, (also known as Sir Peter Buck), doctor, military leader, health administrator, politician, anthropologist, and museum director. Te Rangi Hīroa was the second Māori doctor and was the first Māori doctor to graduate from the University of Otago in 1904. (Sir Māui Pōmare was the first Māori doctor, graduating in the United States in 1898.)

These nine students brought the total number of students who had graduated from Otago to 82, the first being William Ledingham Christie in 1887.[7]

MEDICAL ACT 1908

In 1908, the General Assembly of New Zealand passed a consolidated Act bringing together the Medical Practitioners Registration Act 1869, the Anatomy Acts of 1875 and 1884, and the Medical Practitioners Registration Act 1905. The 1908 Act was set up in two parts – one to regulate the registration of doctors and the other the practice of anatomy.

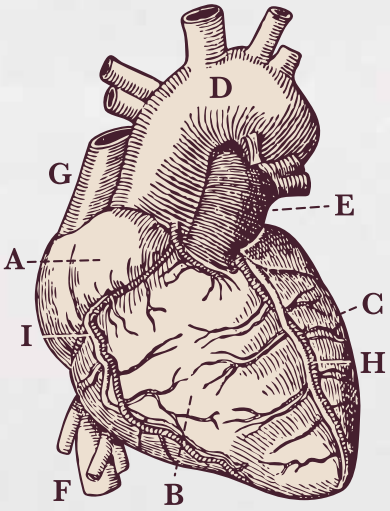
In relation to the registration of doctors, the Registrar-General, as well as the Registrar in named towns, kept a register and issued certificates of registration. The register had to be open for public inspection and, as with earlier legislation, could be corrected and higher qualifications added. The register had to be published annually in December in the *New Zealand Gazette.* Recognised medical qualifications were set out in a schedule to the Act.

The fees for the various services, all of which went into a public account, were:

- deposit qualifications – 1 pound
- issue a certificate of registration – 5 shillings
- alter details on the register – 10 shillings
- add a new qualification – 5 shillings
- inspect the register – 2 shillings.

[7] Page, D. *Anatomy of a Medical School: A History of Medicine at the University of Otago 1875–2000.* Otago University Press, 2008.

The second part of the 1908 Act, which dealt with the practice of anatomy, identified recognised schools of anatomy and made rules pertaining to them.



CHAPTER 2: 1914–1923

MEDICAL PRACTITIONERS ACT 1914

The Medical Practitioners Act 1914 was passed as the world was entering the horrors and destruction of the First World War. The 1914 Act, which came into effect on 1 March 1915, was entitled 'an Act to make better provision for the registration and *control* of medical practitioners' (emphasis added). The 1914 Act was set out in a format that was very similar to its successors. In contrast to the Medical Practitioners Act 1995 and the Health Practitioners Competence Assurance Act 2003, it was highly prescriptive.

The 1914 Act established a Board of seven members comprising the Inspector-General of Hospitals and six doctors, all of whom held 3-year appointments. The Board was required to appoint a Chair annually to preside, and the quorum was four. There were no non-doctors on the Board. The legislation required the Board to determine every question for it by a majority vote of members present, the Chair having a deliberative and casting vote. The Minister of Internal Affairs was to call the first meeting. Thereafter, the Chair or Registrar was entitled to call meetings. The Governor of New Zealand – in 1915, the Earl of Liverpool Arthur Foljambe – was entitled to make rules. If none were made, the Board was able to regulate its own procedure.

Only medical degrees requiring not less than 5 years of study were recognised for registration, and the 1914 Act included the following registration requirements.

- Applicants to send their documents to the Registrar-General or to a country office for the Registrar who would then send them to the Board.

- The Registrar of Births and Deaths to notify deaths of doctors to the Board.
- Registered doctors to notify their change of address or face removal from the register if they failed to do so and could not be located.

The 1914 Act continued to allow for additional qualifications to be entered into the register, the Registrar being required to send all additional qualifications to the Board for processing. If an application was refused, a registered doctor had the right to appeal to the Supreme Court, which was also given the power to remove from the register any doctor found guilty of 'grave misconduct' or of an indictable offence. Practising without registration attracted a penalty, as did accepting commissions from chemists.

All fees connected with the register went into the Government's consolidated fund. The register was published and updated in the *New Zealand Gazette* annually on 30 April. Provisional certificates were issued for a maximum of 3 months, during which time the applicant was deemed to be registered.

The 1914 Act did not affect or regulate the activities of chemists, dentists, midwives, or nurses. The register in existence when the 1914 Act was passed was transferred to the Registrar-General, the names of deceased doctors or those who were non-resident or disqualified having first being deleted.

These provisions in the 1914 Act demonstrate that the Government had a direct relationship with, and control over, the registration of doctors. In the climate of the time, safety and conserving scarce resources took precedence.

The 1914 Act did not prevent those who pretended to be qualified as doctors from practising entirely. Dr Rex Wright-St Clair, a well known medical historian, records that, as early as 1902, the New Zealand Medical Association had written to the Registrar-General about death certificates from JV Shoesmith, an unregistered doctor of Warkworth.[8] As late as 1920, there is reference to Shoesmith still being in practice and to death certificates being accepted from Stewart Peters of the Taieri.[9] Peters had studied medicine in Scotland without taking a qualification. He continued as an unregistered doctor in Mosgiel from 1884 until his death in 1933 aged 71.

Regardless of its limitations, the 1914 Act was the first legislation that provided for a Medical Board, replacing the registration of doctors by the Registrar-General under the 1869 Act.

In 1915, the Board itself was removed from the authority of the Registrar-General and became directly associated with the Director-General of Health, forming the basis of the Medical Council.

COUNCIL ACTIVITIES UNDER THE 1914 ACT

The 1914 Act was expected 'to make better provision for the registration and control of doctors'. As authorised by the 1914 Act, the Registrar-General, Mr Mansfield, called the first meeting of the new Medical Board. The meeting commenced in Wellington at 10am on 31 March 1915 in the room of the Chief Health Officer, Dr JNA Valintine.

[8] Wright-St Clair, RE. *A History of the New Zealand Medical Association: The First 100 Years. Butterworths,* 1987.

[9] *New Zealand Medical Journal,* 19: 141, 198. 1920.

Members of the first Board constituted under the 1914 Act as listed in the minutes were:

- Dr Thomas Harcourt Ambrose Valintine, CBE, MRCS, LRCP, DPH
- James Sands Elliott, MD BSEd, FRCS Edin
- Sir H Lindo Ferguson, MD CMG
- William Irving, MD Cambridge MRCS England LRCP Lon
- William Newlands, BZ Ed, FRCS Edin
- Sir William Henry Parkes, CMG CBE MBMS Edin
- Joseph Edward Wilson Somerville, MD MS Edin 1895.

Drs Irving, Parkes, Elliott, Newlands, and Ferguson were present along with Mr Mansfield and an official from the Health Department, Mr T Hope Lewis, who took the minutes and acted as the Board's Secretary. The Board elected the Chief Health Officer, Dr Valintine, as its first chair.

What is now recognised as core business was transacted that day.

- The Board granted registration to four new graduates with the degree MB ChB New Zealand 1915 and to four other doctors holding provisional registration. It instructed the Secretary to obtain the syllabuses of various examining bodies.
- It declined registration to a Dr Sloane, as he held an Ontario degree for which there was no reciprocity with New Zealand without further examination.
- It resolved to recommend to Government that it set up machinery for an examination for such people as Dr Sloane.
- It removed from the register the names of a number of deceased doctors as well as the names of some who had moved, leaving no

new address (a registered letter system having been implemented to track such doctors).

- It instructed the Secretary to send a circular to all practitioners urging them to 'dissociate themselves' from pharmacies.
- It discussed the case of a Dr John Freeman of Waipawa who had written a death certificate for a 7-month-old infant although he was unregistered and resolved to report the matter to the District Health Officer and then to Crown Law.
- It was agreed that the 1914 Act needed amending to bring it back into line with the 1908 Act so that it was clear that unregistered doctors were not to sign certificates and that only registered doctors should be included in the telephone lists and that the Post and Telegraph should be instructed accordingly.
- It was further agreed that the Secretary should send a synopsis of meetings to the *New Zealand Medical Journal*, that members' travelling expenses would be paid, and that the fee for having additional qualifications entered in the register should be 10 shillings.

At its meeting on 12 October 1915, the Board granted leave of absence to Drs Parkes and Irving, by then absent overseas on 'acts of service'. It granted registration to 16 doctors (nine New Zealand graduates, four English graduates, and three Scots) and refused an MD Brussels entry to the register as his Society of Apothecaries qualification was not recognised. It issued provisional certificates to eight New Zealand graduates and deferred granting provisional registration certificates to another five doctors who had completed only 57 weeks of the medical school curriculum, the full term being 60 weeks, and agreed to advise the Sub-Dean of the University of Otago of the matter.

It changed the registered names of several doctors – Dr Sandstern to Dr Sanderson, Dr Schumacher to Dr Scasforth, and Dr Wohlman to Dr Herbert. These were doctors with German names who felt it prudent to change their names to anglicised ones. The Board noted the Secretary's advice that the Post and Telegraph was now referring to the office all names of registered doctors for the phone list and agreed to request District Health Officers to report to the Board if doctors did not comply with the requirement to disassociate themselves from chemist shops. The Solicitor-General gave a ruling on the presence of doctors in chemist shops at its meeting in May 1916.

A letter about medical men (sic) receiving commissions from surgeons was received, and it was resolved to ask the Solicitor-General to define more clearly what constituted 'practising medicine', noting that chemists practising as doctors should be prosecuted.

A complaint from a man whose wife had been attended by a doctor in Porirua, north of Wellington, who was in an 'intoxicated condition' was heard, and it was decided to obtain more evidence before asking the doctor to respond. (In the end, no action was taken because of a conflict of evidence.)

Concern about the lack of advisory and disciplinary powers to deal with the indiscriminate sale of 'pituitary extract' was aired. A small minority of doctors used this extract in the later stages of pregnancy. This discussion has relevance to the present day, where some doctors, particularly in the complementary and alternative medicine field, argue that patients can be deficient in a hormone or vitamin, even with levels in the normal range. The debate between what constitutes accepted practice and what is outside has been an issue throughout the 100 years of the Medical Board and Council.

At the Board meeting on 3 May 1916, the Chair apologised that he had not taken action on the previous meeting's resolutions about disciplinary powers or the pituitary extract issue 'owing to the pressure of urgent work in connection with his military medical duties'. At that meeting, the Board declined to register a doctor who had graduated in 1909 from Saint Louis University, Missouri, United States, as his course had not been the required minimum 5 years' duration.

The Board considered replies from the Solicitor-General. One stated that it was not an offence for a pharmacist to lend a doctor a room at his shop (but it was an offence if a commission was paid). The other reply stated that it was not possible to give a satisfactory ruling on the definition of the 'practice of medicine' but that merely signing a death certificate was not 'practising', although such a certificate would be invalid.

The Board discussed allegations that 'unnecessary operations' were being done in New Zealand, noting that, under section 22 of the 1914 Act, there were disciplinary rules relating to 'acts of grave impropriety', defined as habitual drunkenness or endangering a patient's life because of intoxication, refusing to assist a registered doctor when requested in cases of grave emergency, and 'any other matter'. It noted that the 1914 Act also included a category for 'infamous conduct' but that the Act did not define what that meant.

A report of a review of Otago Medical School was received (presumably from the General Medical Council of Great Britain), noting that it was 'pleased' that the curriculum, standard of teaching, and examinations were of a 'sufficiently high standard'.

It was decided that requiring compulsory attendance at all 'sick calls' was too complex to regulate.

The meeting of 29 July 1916 debated at some length the question of the right to consultation with a second doctor before an operation was undertaken. It was noted that 'such an arrangement might be carried out in the more thickly populated districts but would be impossible in country districts, where legislation limiting the right to operate without consultation might prove a serious drawback to the public'.

By the meeting on 18 April 1917, members were already drafting proposed amendments to the 1914 Act.

On 2 October 1917, the Board worked with the Solicitor-General to formulate disciplinary offences for inclusion in the proposed amended Act and received a warning from Australia about Sydney doctors who had been removed from the Australian medical register for 'infamous conduct in a professional respect' and who might be attempting to gain registration in New Zealand. It also discussed whether the term of office should be amended from 4 years to 6 years, and the Board expressed a desire to be empowered to inspect and visit medical schools.

In 1918, the Board removed from the register a Dr Arthur Edward Gladstone, MRCS England 1898 LRCP London 1898, who the General Medical Council had struck off its register for 'infamous conduct' (committing adultery with a patient).

There was considerable hostility towards 'hostile alien medical men' (for example, Germans), and the Medical Board received a letter from the British Medical Association urging that 'the Medical Board leave no stone unturned to have the names of hostile alien medical men removed from the Medical Register for the reason that the cause of their internment should be sufficient to debar them from the Register as medical practitioners'.[10] The Board received the letter and noted

[10] Wright-St Clair, RE. *A History of the New Zealand Medical Association: The First 100 Years. Butterworths,* 1987.

that it would advise the Solicitor-General that it had identified a Dr Endletsberger as the only 'alien medical man' on the New Zealand medical register and that he should be removed from the register.

1918–1923

It is interesting that no meeting of the Board appears to have taken place between April 1918 and May 1919. The Board's minute book is continuous, so it cannot be attributed to a loss of minutes. One can only speculate that it had something to do with events at the end of the First World War such as the demands caused by the repatriation of service people, disruptions in transport, or the outbreak of the 1918 influenza pandemic.

In May 1919, at its first post-First World War meeting, the Board received a report from the Court of Appeal dismissing Dr Gladstone's appeal against its earlier decision to refuse him registration. It also agreed to tell the General Medical Council and other overseas boards if it refused a doctor registration or removed a doctor from the register.

At its meeting on 29 October 1919, the Board agreed that the Health Department's representative (the Director-General) should always chair the Board because 'he was obviously in the best position to carry on the work between meetings'. It discussed whether a state medical service for New Zealand for outlying districts should be instituted and decided to obtain the 'foreign list' from the imperial medical register.

The October 1919 meeting was somewhat disrupted, the lunch break being extended from 1.15pm to 3pm to allow Dr Irving and the Secretary to go to Brougham Street Hospital regarding an alleged

abduction involving Drs MacKenzie and Claridge. The Board had heard of the matter from the Wellington Branch of the British Medical Association who alleged that the doctors were implicated in the abduction of a young woman of 18 years of age and in handing her over to a man named Nattrass who had recently been before the court in Wellington in connection with the matter. Drs MacKenzie and Claridge were later found guilty of infamous conduct, and a recommendation was made to the Solicitor-General for their removal from the register.

At the same meeting, members required to travel by train to Wellington queried whether a special train compartment could be reserved for them. Possibly the request was so that they could prepare for the meeting en route or to get some rest. No meeting fees were paid at the time.

In June 1920, the Board:

- further discussed the issue of hospital staffing
- discussed reciprocity with Japan and Italy and control of 'enemy practitioners'
- discussed its desire to have the 1914 Act amended to read 'all applications for registration based on foreign diplomas should be subject to the principle of reciprocity'
- 'noted that henceforth all medical men employed by the government had to be registered in New Zealand'.

At its meeting on 19 November 1920, the Board:

- received advice that Parliament was 'too busy for an amendment bill'

- deferred registering a person who was suffering from 'acute alcoholism'
- again emphasised the importance of sharing information with Australian boards and all kindred boards throughout the Empire.

In March 1921, the Board discussed Dr Rolley of Otahuhu and allegations about his incompetence in relation to a meningitis death.

At its meeting in May 1921, the Board:

- noted that there were now 1,100 doctors on the register
- discussed a Dr M Smith of Rawene whose wife was seeking a divorce, Dr Smith having eloped to New Zealand with another woman in 1914 (the Solicitor-General advised the Board that no further action was necessary!)
- requested registration statistics for the past 10 years on New Zealand and overseas registrants, deaths, and removals from the register
- considered a suggestion from Board member Dr Newlands for an annual report.

On 27 July 1921, the Board discussed a Dr Theimer in relation to alleged 'gross immorality' with a patient. In October 1921, the first 'purge' of the register took place.

The Prime Minister, the Rt Hon William Ferguson Massey, attended the Board's meeting on 30 November 1921, primarily to plead the case of Dr JD Dalziel of Pukekohe. The Board used the unique opportunity to call for more disciplinary powers.

1921 – the Prime Minister pleads the case of a doctor

At the meeting of the Medical Board on 30 November 1921, the case of Dr James Dalziel of Pukekohe for re-registration was considered. The Registrar-General forwarded to the Board an application from Dr Dalziel, who had been struck off the register in 1909 following his conviction in 1907 for performing an illegal operation, for which he was sentenced to 4 years' imprisonment.

The Registrar-General also forwarded to the Board a cablegram from the General Medical Council, London, stating that the applicant did not now hold the diplomas LRCP Edinburgh and LRCS Glasgow. After considerable discussion, the Board decided that, as the colleges referred to in the diplomas had apparently erased Dr Dalziel's name from their medical registers, the applicant did not now legally possess the qualifications he was claiming in the application, and therefore, the Board could not regard him as eligible for registration.

Subsequently, Mr RF Webster JP of Pukekohe waited on the Board to present the following documents in support of Dr Dalziel's application, all of which strongly urged the reinstatement of Dr Dalziel's name on the register.

- A petition signed by 1,024 inhabitants of Pukekohe Borough, Waiuku and Tuakau Town Districts, Franklin County, and part of Raglan County.
- A resolution passed by the Pukekohe Borough Council.
- A resolution passed by the Tuakau Town Board.
- A telegram from the Chair of the Pukekohe Chamber of Commerce.

Mr Webster, in presenting the documents, stated that he had known the applicant ever since he came to the district, and at the time of his offence and subsequent thereto, he had entertained very strong feelings against Dr Dalziel for the offence committed. 'Since Dr Dalziel's release from prison however his exemplary behaviour and ready and willing assistance at all times upon suffering members of humanity, had entirely overcome his antipathy to the man.' He strongly urged the Board to grant the request of the petitioners.

In reply, the Chair, Sir Lindo Ferguson, stated that the Board would consider the representations made and forward its reply to Mr Webster who then withdrew.

After Mr Webster had withdrawn, the Chair informed the Board that he had just received a message that the Prime Minister, the Rt Hon William F Massey, desired to wait on the Board in connection with the case. On this account, the Chair stated that he had not acquainted Mr Webster with his decision. The Board proceeded with the business on the agenda paper, and later in the morning, Mr Massey attended.

Mr Massey said that he had been asked by telegram from the Mayor of Pukekohe to wait on the Board and state what he knew of the case. He simply wanted to assure the Board that, so far as Pukekohe District was concerned, Dr Dalziel had quite recovered his character. Although there were several doctors practising there, he ventured to say that Dr Dalziel did more than any of them.

The Chair said that the Board had already considered the application. The raison d'être of the Board was to keep the profession above reproach and keep off the register any name that would not bear investigation. The members of the Board, as medical men, could quite understand the psychological condition that had produced such a strong feeling in Pukekohe and Districts in favour of Dr Dalziel. In the case of this applicant, the Board had found the colleges that had granted his diplomas had cancelled his parchments. Therefore, legally, he was not qualified, so consequently, he was not eligible for registration. Mr Massey stated that, while he had not attended with a view to bringing any pressure on the Board and wished to make it perfectly clear, he could undertake to remove by legislation any technical obstacle if that were the only objection.

The Chair said he thought it would be a very bad thing to do anything in the direction of lowering the standard of the profession. At that present time, there was no hardship to Dr Dalziel, as he was apparently doing considerable business, and from that point of view, registration was not going to be of much value to him. The Board had already promised Mr Webster to consider the application and forward its reply to him.

The Chair said that he would like to take the opportunity of pointing out to Mr Massey that, while the Board had power as a registering body, it possessed no disciplinary powers except in the direction of referring cases to the Supreme Court for striking off the register.

> The Board had to deal with a host of cases that did not merit so severe attention as that, and it was therefore greatly handicapped in controlling the operations of the profession in cases where discipline was called for. Mr Massey said that he was quite willing to give the Board the disciplinary powers it sought and thanked the Board for the opportunity of stating what he had said about Dr Dalziel and then withdrew.

At the June 1922 meeting, the Board was finally advised that the Medical Practitioners Amendment Bill had been drafted. The members discussed their desire to have some doctors selected rather than appointed to the Board. That concept, however, did not come to fruition until the end of 1996. The Bill did finally get into the House and was passed in October 1923 to come into effect in 1924. Board minutes refer to 'thanks to the Honourable Minister of Health Sir Maui Pomare'.

A notable conduct case was heard just before the advent of the 1924 Act. It is recorded as an illustration of how conduct cases were carried out under the original 1914 Act.

A special meeting of the Board was held on 21 September 1923 for the purpose of holding an inquiry into certain charges that had been brought against Dr Henry Dundas MacKenzie. The charges arose from his use and advocacy of the Abrams system of diagnosis and treatment. Albert Abrams (1863–1924) was an American doctor who claimed that he could diagnose and treat almost any disease, often using electrical machinery.

Mr Paterson of the Crown Solicitor's Office was present, and Dr MacKenzie was represented by his solicitor, Mr JFW Dickson. By permission of the Board, solicitor Mr R McVeagh was allowed to be present, but not to take part in proceedings, on behalf of the British Medical Association (later the New Zealand Medical Association), despite the objections of Mr Dickson. Evidence was heard from 17 lay and medical witnesses before the hearing was adjourned to allow time for the presentation of any further evidence.

After deliberating, the Board decided on the motion of Dr Irving, seconded by Dr Valintine, 'that the Board considers the evidence before it insufficient to sustain the first of the charges against Dr MacKenzie, viz, that on Sunday 6 May 1923 at Auckland he delivered a public lecture in which he, (a) advocated what is known as the Abrams' method of diagnosis and treatment; (b) belittled the ordinary methods of diagnosis and treatment as recognised by the medical profession; and (c) made statements derogatory to the medical profession generally'.

It was further decided that a subcommittee of Dr Hughes, Medical Officer of Health, Auckland, Dr Maguire, Medical Superintendent of Auckland Hospital, and Dr Gilmour, pathologist, should be asked to take part in a test of the Abrams method. The test was to be the taking of blood samples from 12 patients with known diseases and subject them to testing by the Abrams method. MacKenzie disagreed, and the test never took place.

On 25 January 1924, Dr MacKenzie was found guilty of 'grave impropriety or infamous conduct in a professional respect in that he conducted medical practice at Auckland in a manner which is

regarded as disgraceful or dishonourable by his professional brethren of good repute and competency by advocating the Abrams' method of diagnosis and treatment'. The Board then gave leave in writing to the Attorney-General to apply to the Supreme Court for an order for the removal of Dr MacKenzie's name from the register.

There are a number of points of historical interest in the case, but chiefly, it is an example of how discipline cases were dealt with between the 1914 Act and the 1924 Act.

THE FIRST WORLD WAR

During the First World War, 'the medical profession in New Zealand responded nobly to the Empire's call. Three hundred and eighty-five out of some seven hundred doctors embarked for service overseas as officers of the medical corps, together with 3,248 other ranks.'[11]

The medical staff in the First World War served in Samoa, Egypt, France, England, and at sea. They worked at hospitals, depots, and aboard hospital ships. The New Zealand Medical Corps numbers were bolstered with men from all ranks, the total figure given as 1,687. As at 12 November 1918, New Zealand Medical Corps officer casualties were recorded as nine killed in action, three died of wounds, seven died of disease, two accidental deaths, and 35 wounded.

Altogether, 23 doctors who served with the New Zealand Medical Corps, New Zealand Expeditionary Force, died in the First World War. A further five New Zealand doctors who served either in the Royal Army Medical Corps or the Australian Army Medical Corps also lost their lives in the First World War.

[11] Carbery, AD. *The New Zealand Medical Service in the Great War, 1914–1918* (based on official documents). Whitcombe & Tombs, 1924.

The following Board members served overseas with the New Zealand Medical Corps.

James Sands Elliott, MD, BS Ed, FRCS Ed

Dr Elliott was granted leave of absence from Council in 1916 to serve overseas, making him the third member of Council to serve in the First World War, joining Drs Parkes and Irving who had left in 1915. Dr Elliott effectively served in three wars. As an Edinburgh medical student, he had served with the Medical Corps in the South African War 1899–1902, causing a temporary rift with his father who was a minister at the Kent Terrace Presbyterian Church. In the First World War, Dr Elliott was Medical Commander of His Majesty's New Zealand Hospital Ship *Maheno*. In the Second World War, he was Chair from 1940–1945 of both the Joint Council of the Order of St John and the New Zealand Red Cross Society. He was an influential member of the New Zealand Branch of the British Medical Association and was President in 1929. He was also editor of the *New Zealand Medical Journal* from 1911–1933.

Col. William Henry Parkes, CMG, CBE, KtStJ (1864-1933) MB ChM Edinburgh, FRCSEd 1907, MRCP 1919

William Henry Parkes was born in Derby, England, and immigrated to New Zealand in 1847 as a child. Educated in Christchurch, Parkes was accepted into the Otago Medical School, and as was the requirement, after the first 2 years, he completed his training in Edinburgh where he graduated in 1892. After working in Sheffield, he returned to New Zealand in 1894, then went back to the United Kingdom for surgical training and obtained the FRCSEd.

On returning to New Zealand, Dr Parkes was appointed an honorary physician and surgeon at Auckland Hospital and established a busy

private practice. He married Maude Ross in 1889 and had three children. Dr Parkes gained a reputation as both a fine surgeon and administrator, being President of the New Zealand Branch of the British Medical Association in 1914–15. In late 1914, he was appointed to the newly created Medical Council, attending its first meeting in March 1915. He had a long history of service in the Territorial Army, being Assistant Director Medical Services in New Zealand's Northern region immediately prior to the First World War.

Gallipoli

Dr Parkes sailed as Commanding Officer of two New Zealand hospital ships – *Maheno* and *Marama* – in June 1915, which took over the former Egyptian military hospital at Pont de Koubbeh for the remainder of the campaign and was to become the First New Zealand General Hospital. In January 1916, he was promoted to Deputy-Director Medical Services in Cairo where he continued to direct the treatment of sick and wounded ANZAC soldiers until mid-1916 when, promoted to Colonel, he was sent to Europe with the New Zealand Division.

After Gallipoli

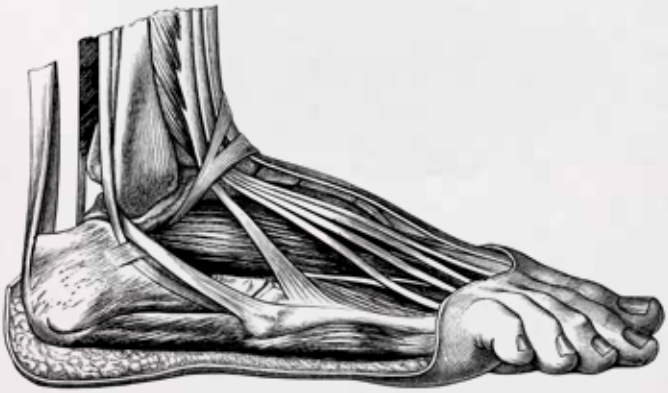
On arrival in the United Kingdom in June 1916, he was appointed Deputy Director Medical Services for the New Zealand Expeditionary Force, then to Director Medical Services in late 1917, a post he held for the remainder of the war. Dr Parkes was made a CMG in 1916 for his services in the Gallipoli campaign and awarded the CBE in 1918. He was made a Knight of the Order of St John in 1919 and twice mentioned in despatches.

Professional life after the First World War

Before returning to New Zealand, Dr Parkes obtained the Membership of the Royal College of Physicians and was awarded an Honorary Fellowship of Surgery by Edinburgh University – only the 33rd such award since 1671. Returning to surgical practice in Auckland, he was active in clinical work and medical administration until he died suddenly in 1933.[12]

[12] Obituary: William Henry Parkes. *B Med J*, 2 (3806): 1148. 1933.

CHAPTER 3: 1924–1949



MEDICAL PRACTITIONERS AMENDMENT ACT 1924

The Medical Practitioners Amendment Act 1924 made significant amendments to the 1914 Act, although the 1914 Act remained the principal Act.

The first Medical Council of New Zealand (by this name) was constituted with the passing of the 1924 Act. This replaced the Medical Board and gave the new Council a little more autonomy than the previous Board. In the 1860s, the term 'Medical Council' was used to refer to the United Kingdom body now known as the General Medical Council.

For the first time, the Council had disciplinary powers, which remained until they were transferred to the Medical Practitioners Disciplinary Tribunal established under the Medical Practitioners Act 1995.

Under the 1924 Act, the Inspector-General of Hospitals became known as the Director-General of Health, and the powers of the Registrar-General were transferred to that position. At the same time, the powers of the Registrars of Births and Deaths in Auckland, Wellington, Christchurch, and Dunedin were transferred to Medical Officers of Health in those cities, the Registrar-General and the Registrars of Births and Deaths being required to send files on doctors' qualifications to the Director-General and all the Medical Officers.

Up until 1924, the Governor-General of New Zealand had appointed all Board members. Under the 1924 Act, membership requirements for the Council were extended to include:

- one member to be appointed on the recommendation of the New Zealand Branch of the British Medical Association

- one member of the Otago Faculty of Medicine, who was also a member of the Board of Health, to be appointed.

The additional membership requirements were to be instituted when the next vacancies arose on the Council.

In relation to doctors holding 'foreign' diplomas (qualifications not from the United Kingdom or Australia), the 1924 Act empowered the Council to require those doctors to pass an examination in medicine and surgery conducted by the University of New Zealand's Senate. The Council could remove from the register any United Kingdom or dominion doctor whose name had been removed from the register in that country. 'Discretionary power was given to the Council to decide whether it would register persons with foreign qualifications irrespective of whether or not they were eligible for registration in the United Kingdom. New Zealand had previously been obliged to register persons with, for instance, Japanese and Italian qualifications because they were eligible for registration in Britain.'[13]

The ability of the Council to exercise this power was not well received by the General Medical Council of the United Kingdom who demanded a repeal of the provision or they would cancel reciprocity with New Zealand. As Dr Rex Wright-St Clair records, 'the Medical Council approached the Prime Minister, the Rt Hon J G Coates, and at his request the Solicitor-General stated a case for the British authorities. The law officers of the Crown ruled in 1931 that reciprocity applied only to practitioners qualified in Britain and New Zealand respectively.'[14] The General Medical Council was forced to back down. In the words of Dr Wright-St Clair, 'New Zealand was finding its feet and was no longer an acquiescent colony'.[15]

[13] Wright-St Clair, RE. *A History of the New Zealand Medical Association: The First 100 Years.* Butterworths, 1987.

[14] Ibid.

[15] Ibid.

The 1924 Act and discipline

The 1924 Act set in motion the beginnings of the Council's disciplinary powers. It provided detailed provisions and procedures for action if there was reason to believe that a registered doctor was guilty of 'impropriety' or 'infamous conduct in a professional respect'.

In summary, the 1924 Act set up the following disciplinary process.

- A notice was to be served on the doctor setting out the alleged grounds of 'impropriety' or 'infamous conduct in a professional respect'.
- The doctor was required to appear before the Council to answer the allegations.
- If the doctor failed to appear and answer the allegations as requested, the doctor had to explain why.

Disciplinary action could be taken against a doctor who did not appear before the Council, and a suspended doctor was deemed not to be registered. The final act of removal from the register still had to be approved by the Solicitor-General. There was a right of appeal to the Supreme Court within 21 days. No doctor could be found guilty of 'impropriety' or 'infamous conduct in a professional respect' merely for 'adopting or practising' any theory of medicine or surgery, so long as the doctor did so honestly and in good faith.

COUNCIL ACTIVITIES UNDER THE 1924 ACT

For the first time, the 1924 Act also directly addressed the issue of 'impaired doctors', albeit under the disciplinary provisions. Any doctor who had been an inmate in an institution under the Mental Defectives

Act 1911, either as a committed patient or as a voluntary boarder, could not resume practice without a licence from the Council. A Dr Martin was reported to the Council in February 1926 and warned against taking morphia, a highly potent opiate analgesic drug. He was finally gazetted on 15 December 1932 under the Dangerous Drugs Regulations (Doctors and Addicts).

Matters of registration and scopes of practice have always been key aspects of Council business.

At its meeting of 4 September 1929, an interesting discussion took place in regard to doctors and the Masseurs Registration Act 1920. The Secretary reported that the Crown Law Office had recently given an opinion to the effect that doctors specially qualified in heliotherapy (the therapeutic use of sunlight, wave therapy, or phototherapy) could not announce the fact unless they were registered under the Masseurs Registration Act 1920 and its amendment in the same way as they are exempted from other Acts such as the Dentists Act. The tenor of the discussion was much like present-day considerations of complementary and alternative medicine.

At the meeting of 11 March 1931, the case of a Dr JS Currie was discussed. Dr Currie had been sentenced to 6 months' imprisonment and hard labour because he had been found guilty of six counts of wilfully and obscenely exposing his person. The Solicitor-General advised Council that 'as the maximum term of imprisonment for the offences was 12 months and the offences did not appear to have been committed 'in a professional respect', Council could not request removal of his name from the Register'. Council was clearly upset by this ruling but did resolve to write to the General Medical Council as Dr Currie was a British graduate.

Finance Act 1932–33

The 1924 Act appears to have remained untouched until 1932, when the legislature introduced an additional method of funding medical regulation.

Under the Finance Act 1932–33, doctors were required to hold an annual practising certificate for the period 1 April to 31 March annually. Once an annual practising certificate application had been made, the certificate was deemed to have been received by the doctor. Doctors employed by government, or who had rendered service in an emergency, or who held a provisional certificate of registration were exempt from the requirement to hold an annual practising certificate. This amendment to the Finance Act was controversial to the profession. As Dr Rex Wright-St Clair records, 'In 1933 at the depths of the Great Depression, the Government found that the Council was running at a loss of 65 pounds per year'.[16] This prompted the levy for the annual practising certificate. An editorial in the *New Zealand Medical Journal* records:

> In the dying hours of an emergency Parliamentary session the New Zealand Government by a majority passed the Finance Act No IV, imposing a special tax on the medical profession, and in this irregular way amended the Medical Practitioners (1924). The medical profession was never consulted and was treated, if not with contempt, certainly with indifference … The new legislation is hasty, ill-advised and pettifogging, and a poor appreciation of war service and the public-spirited and unremunerative work done by the medical profession throughout the country and at a time when there is a virtual moratorium over the payment of medical fees by patients.[17]

[16] Ibid.

[17] *New Zealand Medical Journal*, (32): 95–96. 1933.

Overseas-trained doctors 1936

At the Council's meeting on 31 January 1936, the Chair, Sir Lindo Ferguson, reported on his attendance at a conference of the Australian Boards and Councils in Melbourne at the end of 1935. Council discussed the issue of overseas-trained doctors, as a number of European-trained doctors had been enquiring about registration in New Zealand. The Council recommended that those doctors could qualify for registration if they undertook a 3-year course of approved studies at a New Zealand medical school (there was only one, Otago) followed by examinations. Such doctors could take the first section of the final examination at the end of their second year and the final section at the end of their third year. As discussed later, the issue of registration of foreign medical graduates was very lively throughout the Second World War.

Unusual cases

The Council has always had to consider some unusual cases. At its meeting of 16 December 1936, the Chair reported that correspondence had been received from a Mr MH Hampson, acting on behalf of a Dr Walker. The correspondence complained about the actions of Dr Wallis in 'August last' in leaving Rotorua Hospital during the serious illness of one of his patients and of returning to Rotorua by aeroplane 'in a spectacular manner'. He did this 'allegedly to assist in the grave condition of his patient, thereby reflecting adversely on Dr Walker who had been left in charge of the case'.

The Chair stated that he had instructed the Secretary at the time to inform the Solicitor-General that the case was not one in which the Council could take action. After the matter was discussed, the 'action taken' was confirmed.

At the Council meeting of 6 April 1937, the case of a doctor accused of influencing a patient to change their will in favour of a nurse was referred to the Solicitor-General for consideration. At this meeting, Council also considered a letter from the New Zealand Obstetrical Society drawing attention to its concerns about the performance of 'unethical and illegal operations' (presumably abortions). Council noted the letter but said that it would need something more substantial than rumours before action could be taken.

Political neutrality

During the later years of the 1930s, there was major discord between the medical profession and the Government over what was to become the Social Security Act 1938 and the Social Security Amendment Act 1941.

The opposition was led by the New Zealand Branch of the British Medical Association, which appointed a special committee to try and negotiate with the Government. This was chaired by Dr JPS Jamieson, probably the fiercest critic of all of the new funding proposals of the 1938 Act.

Also very prominent in the opposition to the Bill was Sir Donald McGavin, then Chair of the Council of the British Medical Association and later to become Chair of the Medical Council between 1942 and 1948. Despite the turmoil in the profession and the almost universal severe opposition to the measures, the Medical Council maintained a neutral political stance, which it has done at other times of severe political discord over matters affecting doctors.

THE SECOND WORLD WAR

The effect of the Second World War on New Zealand's working population led to emergency regulations being passed. In 1941, the Government anticipated a shortage of doctors in New Zealand, many of whom were going overseas to assist the war effort. It thus passed an emergency regulation that empowered the Council to issue provisional registration certificates to medical students.

The certificates allowed the students to practise as registered doctors, so long as they intended to graduate after passing all clinical and other examinations in their first 5 years of training, and to complete the sixth year (later to be known as the 'trainee internship'), then the final year of clinical training.

Alan Alldred, later a colourful Professor of Orthopaedic Surgery in Otago, recalls being called to the Hyde Railway Disaster in 1943 as a first-year doctor '…you've got to remember we were medical students during the war time so that we really had quite a lot of experience before that. So it wasn't our first exposure to this type of traumatic accident.'[18]

In 1940, Council also resolved that the final medical examination should be held 6 months earlier than the traditional November date. This also applied to refugee doctors studying at the University of Otago. This ended in March 1946.

The issue of refugee doctors was a point of some discord between Council and the University of Otago. The Medical School's report for 1939 noted that 13 refugee doctors had been admitted to the Medical School to requalify by taking the last 3 years of the medical

[18] Coleman, E, and Swift, G-M. *Stories of the Hyde Railway Disaster – 1943.* Elizabeth Coleman, 2008.

course and the corresponding examinations. In the words of Dr Dorothy Page, this '…roused public feeling to a degree apparently disproportionate to the numbers involved'.[19] The Customs Department had granted them residence in New Zealand, and the Medical Board (Council) had accepted them, and so the University felt obliged to allow them to enter the Medical School.

As Page says, the Medical Faculty felt that they were the victims of 'passing the buck'. The issue aroused strong public feeling as they were perceived to be taking places ahead of New Zealand students. Both the *Otago Daily Times* and *Truth* newspapers ran strong articles and editorials on the subject. One *Truth* headline read 'Aliens Come First', and in 1942, the Royal New Zealand Returned and Services' Association, often referred to as the Returned Services' Association, claimed that '…refugee doctors were building up lucrative practices while New Zealand doctors were serving overseas'.[20]

On the other hand, a Hamilton-based member of the New Zealand University Senate thought it extraordinary that '…an academic body (the Medical School) connected with a humanitarian profession should go out of its way to close its doors on those who had to flee the worst tyranny the world has seen'.[21] In view of pressure on the Otago Medical School position, the Council resolved to admit no more than three doctors a year unless circumstances 'were exceptional'.

Later, the Council adopted a policy of not accepting refugee doctors, and in 1942, Dr Newlands, who was a Medical School member as well as being the then Chair of the Council, was forced to release a media statement explaining the Council's policy. Two days later, he had to defend the Council against accusations that New Zealand was 'the

[19] Page, D. *Anatomy of a Medical School: A History of Medicine at the University of Otago 1875–2000.* Otago University Press, 2008.

[20] Ibid.

[21] Ibid.

most exclusive country in the world'.[22]

Page records that two further cases came before the University of Otago Senate in 1943. The Council was against admitting them, but the Senate questioned the Council's right to refuse entry to the School to any refugee doctor who had been accepted into New Zealand, and the Senate voted to admit them. One member of the University of Otago Council expressed his disgust that the Senate had 'foisted' two more refugees on the Medical School. Eventually, the then Minister of Health, Reverend The Honourable Sir Arnold Nordmeyer, made a statement on Government policy that no more refugee doctors would be admitted during the war.[23]

On 5 December 1941, the South Auckland Branch of the British Medical Association wrote to Council complaining about actions taken by district nurses that would normally be done by doctors such as the issuing of death certificates. Council was reassured that the death certificates supplied by nurses were notifications of death rather than certificates of the cause of death. The increased responsibilities for the nurses had occurred because the general practitioners had been sent overseas with the New Zealand Expeditionary Force.

As a further response to the shortage of doctors, Council granted provisional registration on 18 December 1942 for a number of American doctors working at Auckland Hospital.

AFTER THE SECOND WORLD WAR

[22] Ibid.

[23] Ibid.

In August 1946, seven doctors were registered who had passed the special medical school examination after 3 years and been granted an MB ChB. The following year, the Council mooted the idea of an Empire conference on medical registration. It appears that the British Medical Association may have been funding doctors to come to New Zealand. Reciprocity arrangements in place then, which relied on the General Medical Council's recognition of Commonwealth medical schools, meant that it was relatively easy for doctors trained in Commonwealth countries to come to New Zealand.

Indian doctors were granted temporary registration for postgraduate education, but the settlement of displaced doctors remained an issue.

There was some concern that there might soon be an excess of 'aliens' seeking bridging courses.[24] On the other hand, it was noted that a Polish doctor in charge of medical work at the temporary camp set up at Pahiatua for Polish refugees had been practising for some years without registration. The Council noted that, when the camp closed, the doctor would need to get a reliable registrable qualification.

Towards the end of the 1940s, the concept of reciprocity was pushed further, and the Council agreed that there should be reciprocity in New Zealand with graduates from institutions approved by the General Medical Council in Éire, the United Kingdom, South Africa, and India.

In 1946, Douglas Robb (later Sir Douglas) raised the question of the need for more medical graduates in New Zealand. He raised particular concerns about shortages in general practice and psychiatry, a theme that has been constant to the present day. The vision of a second

[24] Jones, G. *The Medical Council of New Zealand: A Personal and Informal Perspective of Events During my Time as Chief Executive/Secretary/Registrar from 1986 to 2000.* Medical Council of New Zealand, 2002.

medical school in Auckland dates from about this time.

Under the provisions of the 1924 Act, the Medical Council had to apply to the Attorney-General for leave to make a case for the erasure of a doctor's name from the medical register. This became an issue in the case of Dr Ulric Williams in 1947.

Dr Williams was an unorthodox practitioner who was a great enthusiast of dietary treatment and a vigorous opponent of immunisation. He was expelled from the New Zealand Branch of the British Medical Association in 1936 for 'gross breaches of the ethical rules', namely making unscientific statements and advocating strange diets.[25]

In 1947, following the death of one of his patients, he was found by Council to be guilty of grave impropriety in a professional respect. The Attorney-General, the Hon Rex Mason QC, refused leave for erasure on the grounds that, in his opinion, the Court would be obliged to find the facts of the case did not constitute grave impropriety or infamous conduct. Dr Williams remained on the register and continued his unorthodox practice for many years thereafter.

In 1949, the Council raised concerns with the Government over a perceived lack of consultation in the drafting of the Medical Practitioners Amendment Bill, which was to form the basis of the 1950 Act. Council felt particularly concerned about disciplinary committees under the auspices of the New Zealand Branch of the British Medical Association. Council felt that it should have been consulted on the proposed Bill to the same degree as the Association.

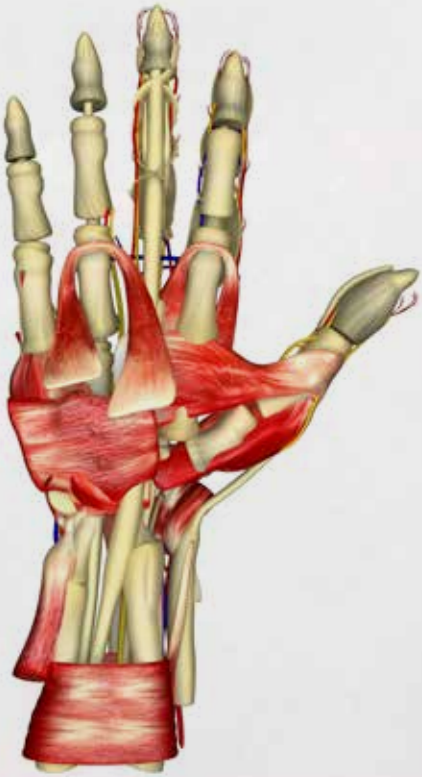
[25] Wright-St Clair, RE. *A History of the New Zealand Medical Association: The First 100 Years.* Butterworths, 1987.

The issue of male circumcision, particularly who should perform it and where, was raised in 1950. Sixty years later, Council was to debate the same issue. The issue at the time was a request by a general practitioner as to whether he could give an anaesthetic for a rabbi who stated that he held a certificate for performing this rite for Jewish children. The President's direction, ratified by Council, was that the general practitioner should stipulate that, from a surgical point of view, the patient should be under his professional supervision so that he might safeguard health and life should the operation endanger the patient. It can be stated confidently that such a request nowadays would receive a blanket refusal.

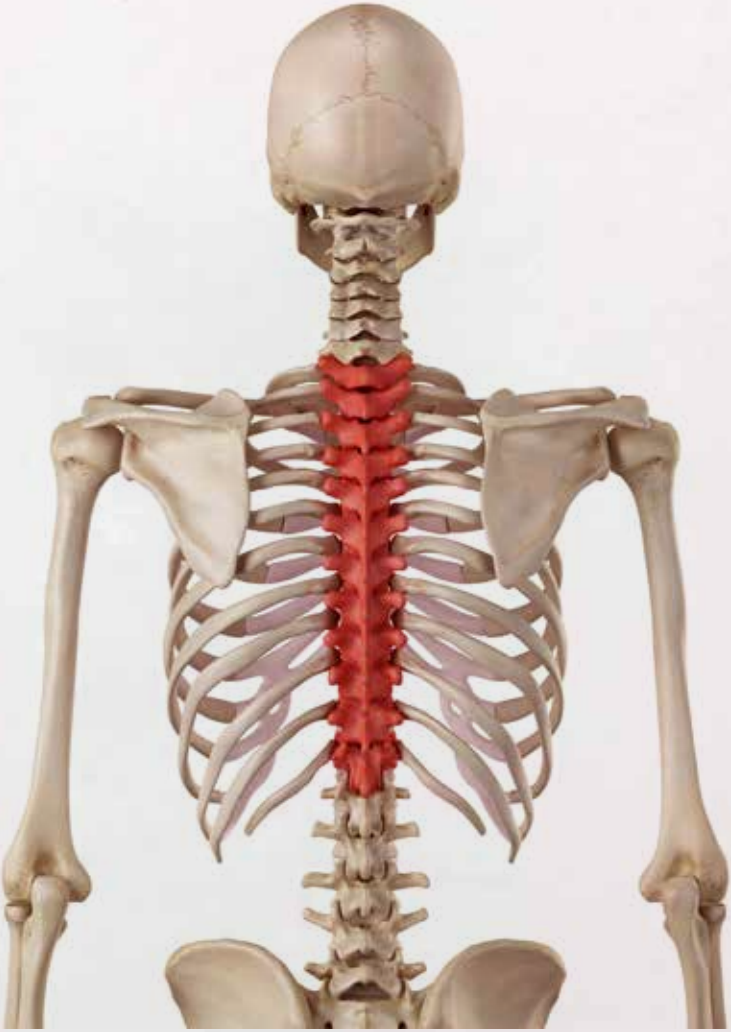
A particularly serious case came before Council in 1949, shortly before the new Act. In November 1949, Council considered a case of infamous conduct by a general practitioner who was charged with performing an abortion on a woman who was 4 months pregnant and then arranging for her to be admitted to a house 10 miles away under the supervision of a woman who was not qualified as a nurse. The following day, the patient suffered a severe haemorrhage and was dead when she arrived at a private hospital to which she had been transferred.

The general practitioner then performed a limited autopsy on the woman, removing her pelvic organs without the consent of her husband or relatives. These were not kept. The doctor then provided a death certificate with the annotation 'post-mortem not intended to be held'. The police ordered an exhumation of the body, and the pathologist performing the post-mortem was unable to give a cause of death as the pelvic organs had been removed.

The case was heard by the Supreme Court between 10 and 16 May 1950. The doctor was found guilty of infamous conduct, and an order was made for his removal from the medical register. The judge was unable to determine whether the doctor had carried out an abortion or not, but his subsequent actions were deemed to be grossly unprofessional and carried out to obtain concealment. The Court of Appeal unanimously upheld the judgment, and the doctor withdrew an appeal to the Privy Council.



CHAPTER 4: 1950–1967



MEDICAL PRACTITIONERS ACT 1950

Early in 1950, in order to comply with legislative changes in the United Kingdom, the New Zealand General Assembly amended the legislation governing the regulation of doctors. The Medical Practitioners Act 1950 consolidated and amended the Acts of 1914 and 1924, an amendment Act passed in 1949 and the Finance Act 1932–33.

The 1950 Act introduced a compulsory internship scheme (the seventh year of a doctor's training), effective from December 1952. This development synchronised with an equivalent provision in the United Kingdom initiated by the General Medical Council.

To retain reciprocity, it was necessary for other members of the Commonwealth to fall into line. After the New Zealand scheme was introduced, the term 'conditional registration' differentiated these graduates, now interns in their seventh year of training, from doctors who had been granted 'registration as a doctor', that is, full registration. This innovation was designed to prepare graduating doctors for private practice. Conditional registration could only be undertaken in approved hospitals, gazetted by the Council. However, there was still no probationary registration for doctors with 'foreign' qualifications.

The 1950 Act also constituted the Medical Practitioners Disciplinary Committee. The Committee comprised four doctors appointed by the Council of the New Zealand Branch of the British Medical Association and one doctor, not being a Medical Council member, appointed by the Minister of Health.

The 1950 Act allowed the Committee to elect its own Chair and established a Disciplinary Committee quorum of three members. It also stated that the General Secretary of the New Zealand Branch of the British Medical Association was to be the Disciplinary Committee Secretary.

Another tier to the disciplinary structure was also established – divisional disciplinary committees were set up, with one of the committee members appointed as Honorary Secretary. The Medical Practitioners Disciplinary Committee could ask the local divisional committees to conduct all or part of an enquiry. All reports of enquiry outcomes were to be sent to the Council.

The Council was also empowered to appoint a legal assessor, and disciplinary findings could be published in the *New Zealand Medical Journal*. The 1950 Act, however, did not develop further provisions for dealing with 'impaired doctors'.

From 1950, a long period of ad hoc amendments followed before the 1968 Act was drafted. The amendments included changes to the qualifications required for conditional registration and registration as a doctor, a new penalty for wrongful use of the title 'doctor', and, in 1954, provision for temporary registration for visitors coming to New Zealand to carry out postgraduate teaching or to gain experience.

In 1957, a further amendment streamlined the disciplinary regime by:

- allowing the Chairs of disciplinary committees casting votes
- setting out the functions of the disciplinary committees
- creating an investigation committee to enquire into complaints that possibly amounted to grave impropriety

- clarifying the disciplinary powers of the Council and giving a right of appeal to the Supreme Court
- permitting disciplinary committees at all levels to engage legal assessors.

In 1957, all the 1908–1957 statutes were reprinted into one volume, consolidating all the changes made during that time. Clearly, a new Act was soon going to be necessary, but it was not long before more ad hoc amendments were being made.

In 1962, the 1950 Act was further amended to permit the Council to:

- become a body corporate
- elect a Deputy Chair
- engage a Secretary and other officers
- call meetings, pay fees and travel allowances, and receive payments for expenses.

It was some years before the Council could afford to move out of the Department of Health's offices.

In 1962, 'notification of disability' became mandatory. Provision for the enforcement of contracts for bursars was implemented. Again, the Council's powers to discipline doctors were clarified, as were the required qualifications for conditional registration and registration as a doctor. The 1950 Act continued to provide for restoration to the register, change of name, and removal from the register on request.

COUNCIL ACTIVITIES UNDER THE 1950 ACT

The years between 1950 and 1968 were a relatively stable time for the Council. This reflects the fact that, between the very acrimonious 1951 waterfront dispute, which lasted for 151 days, and New Zealand's commitment of troops to the Korean War and Vietnam War, it was a period of political stability in New Zealand.

As recorded in the previous section, the 1950 Act was subject to a number of amendments. During the 1950s and 1960s, Council also had to deal with applications for reciprocity with an increasing number of Commonwealth medical schools. For example, reciprocity with Myanmar (Burma) was declined, and reciprocity with Pakistan was deferred until further information was available.

One issue that was dealt with in a more leisurely fashion compared with the present day was the question of doctors practising before they were fully registered. In 1956, Council considered the failure of 26 of the 1956 graduating class to apply for registration on a conditional basis before commencing duties as house officers. The Council noted that all graduates were duly warned by the Otago Medical School authorities of their responsibilities in this matter and further noted that superintendents of public hospitals were warned that such graduates were not eligible for appointment unless they were registered.

The issue arose again in June 1965 in the case of an Australian graduate employed by Masterton Hospital who had still not applied for registration despite having commenced work 3 months earlier. The Chair wrote to the Superintendent of Masterton Hospital expressing Council's displeasure at breaches of sections 54, 55, and 56 of the 1950 Act.

It was also resolved to ask the Director-General of Health to reissue his circular letter of 5 October 1962 drawing attention to the fact that hospitals should not employ or pay unregistered doctors.

Shortly after the 1950 Act came into force, Council was asked by a Christchurch pathologist whether he was practising medicine within the meaning of the 1950 Act. Council was firm in its view that pathologists were, indeed, practising medicine under the Act's provisions.

In the area of discipline, Council had to consider whether cases constituted 'grave impropriety or infamous conduct in a professional respect'. One doctor whom Council found had behaved in this manner had been charged with engaging a non-registered doctor in treatment and administering an 'inordinately large' dose of morphine and barbiturate, which he should have known would be dangerous to the life of the patient and subsequently caused her death. The High Court subsequently quashed the conviction the following year. In another case, a doctor was found guilty of performing an abortion where the woman subsequently died. He was suspended for 12 months and had to pay substantial costs.

At its meeting of 17 January 1956, Council received a letter from Mr Eric Roe, the Rotorua Coroner, following an inquest, asking these questions.

- Where an operation has been carried out on a patient who is the patient of a hospital, should the clinical examination carried out by the anaesthetist just prior to the operation be as comprehensive as when the patient has only just been admitted to hospital?
- To what extent, if at all, is the anaesthetist entitled to rely on statements made to him by the hospital staff as to the patient's condition?

- In the case under review, was a proper clinical examination carried out by the anaesthetist?

A copy of the depositions taken at the inquest were discussed, and it was resolved by Council that:

> …the Coroner be informed that the Council did not consider it within its province to determine the questions as submitted but that it would, in the opinion of the Council, be impossible to lay down rules of procedure which would cover all possible circumstances relating to the administration of anaesthetics.
>
> It was further resolved that: The Coroner be informed that members of the Council had discussed the depositions and were of the opinion that no evidence of neglect was disclosed in the evidence placed before the Council.

The Council continued to regularly debate the question of disciplinary investigation.

On 17 December 1963, Dr PP Lynch, a Wellington forensic pathologist who acted for many years as convenor of the Medical Practitioners Investigation Committee, addressed Council on medical discipline. Dr Lynch was a highly respected member of the profession who had served as Secretary of the British Medical Association (New Zealand Branch) from 1936 to 1940 and had been an expert witness in a number of notable New Zealand murder trials.

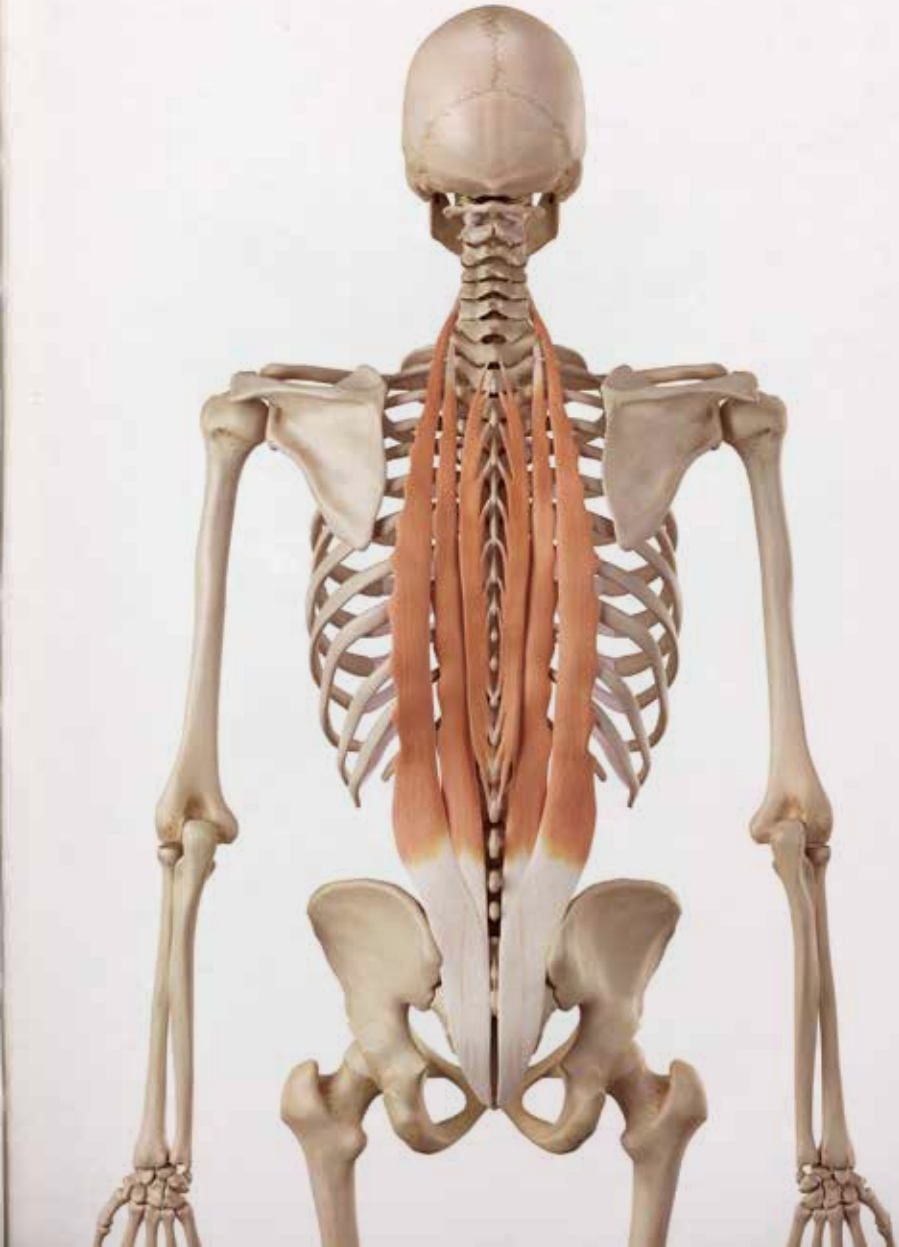
It was his opinion that all complaints should be made by the Crown Solicitor and be investigated by an investigations committee appointed by Council and presided over by the Crown Solicitor. The findings should be forwarded to the Solicitor-General for action.

Dr Lynch said he was concerned that, under section 43C(3) of the 1950 Act, the defendant was not necessarily permitted to be present. Whilst he felt that the British Medical Association (New Zealand Branch) was not the appropriate body to hear complaints, Council should have wider representation from the British Medical Association (New Zealand Branch), that is, at least two further members. Council itself should have the power to strike doctors off the register. These views are of interest in the framing of subsequent legislation.

At its meeting of 16 August 1967, it was noted that Council 'celebrated its centenary this year', and it was agreed that Council should hold a centenary dinner at the Wellington Club on 9 November 1967, to which the Chair should invite the Chief Justice, the Solicitor-General, the Minister of Health and other leaders of the profession at his discretion. The Chair undertook to deliver an address on the history of the Council during the first 100 years!

What that Council was celebrating was, in fact, the centenary of medical registration under the 1867 Act. The structure of the Medical Council of New Zealand as we know it today was determined by the 1914 Act and so the centenary celebrations of the 2015 Medical Council were not held 48 years too late!

CHAPTER 5: 1968–1994



MEDICAL PRACTITIONERS ACT 1968

The Medical Practitioners Act 1968, which came into effect on 1 April 1969, was described as 'an Act to consolidate and amend the law relating to the registration and control of Medical Practitioners'. The Act established a new body called the Medical Education Committee, which was separate from the Medical Council, with its own specified composition, function, and powers. Membership of the Medical Education Committee included the Dean of the new University of Auckland's Faculty of Medical and Health Sciences, which was established in 1968.

Under the 1968 Act, the Medical Practitioners Investigation Committee was renamed the Penal Cases Committee (not to be confused with professional conduct committee for which the abbreviation PCC now stands). The Penal Cases Committee comprised two members of the Council and a solicitor of the High Court and was charged with investigating complaints to the Council concerning the conduct of any registered doctor. The name of the Penal Cases Committee was changed to the Preliminary Proceedings Committee in 1983. There continued to be a Medical Practitioners Disciplinary Committee comprising four doctors appointed by the New Zealand Medical Association (which gained independence from the British Medical Association in 1967) and a fifth appointed by the Minister of Health.

Although the Council had been incorporated in 1962, the 1968 Act clarified that Council had been given the power to borrow and invest, that is, to be financially self-sufficient.

The 1968 Act changed the composition of the Council to 11 members. With the exception of the ex officio members, all were appointed

by the Governor-General on the advice of the Minister of Health. Council's membership comprised:

- the Director-General of Health (ex officio)
- the Dean of the Auckland School of Medicine (ex officio)
- the Dean of the Otago School of Medicine (ex officio)
- two members nominated by the New Zealand Medical Association
- four members nominated by the colleges, namely, the New Zealand Council of the Royal College of General Practitioners, the Royal Australasian College of Surgeons, the Royal Australasian College of Physicians, and the Royal New Zealand College of Obstetricians and Gynaecologists
- two members chosen by the Minister of Health.

It was not until 1983 that a lay member was added, bringing the total membership to 12.

The 1968 Act also empowered the Council to:

- enter additional qualifications to the register
- amend the register if a doctor had been wrongly registered
- remove a doctor from the register if that doctor had been removed in another jurisdiction
- set up a register of specialists
- suspend, if necessary, any doctor notified to it under the notification of the disability provision, which had become mandatory.

Further reforms to disciplinary procedures included clauses concerning payment of witnesses and the power to adjourn or postpone hearings.

A number of amendments made to the 1968 Act in the 1970s reflect changes in the British Commonwealth. There were an increasing number of 'foreign' doctors, that is, doctors trained in countries other than New Zealand, such as Australia, the United Kingdom, Éire, Canada, South Africa, and some other Commonwealth countries, who could not be registered without further examination. In 1970, the 1968 Act was amended to:

- create a new registration category – probationary registration – to permit initial registration (after assessment of knowledge and English communication) of foreign doctors
- set out postgraduate qualifications that could be considered as a basis for probationary registration as well as overseas qualifications
- empower the Minister of Health to require the Council to produce statistical data on its activities for which the Minister could make a financial contribution.

In 1972, an amendment empowered the Medical Education Committee to include the recently appointed Deans of the Christchurch and Wellington schools, which had been opened as part of the University of Otago.

In 1973, an amendment permitted the Penal Cases Committee to appoint one of its members as convenor.

In 1977, a clause relating to doctors' duties when providing or being asked to provide advice on family planning appeared for the first time. This was a result of the passage of the Contraception, Sterilisation, and Abortion Act 1977.

The new clause required doctors to refer patients on if, for conscience reasons, they did not want to advise or prescribe for a patient seeking contraception. The heated debate caused difficulty for the Council

as its legal assessor Mr Des Dalgety was also the Chair of the Society for the Protection of the Unborn Child. This acrimonious debate had echoes in 2010 when Council attempted to produce a statement on beliefs, which was defeated in the Supreme Court.

Other amendments included changes in the composition of the disciplinary committees, the dropping of the word 'Dominion' in favour of 'New Zealand' in recognition of the Royal New Zealand College of General Practitioners, which, in 1979, gained permission from the British College to use that title. Competence in English was added as a requirement for conditional and probationary registration. In principle, probationary registration could be undertaken in hospitals or general practices.

The 1968 Act, with its amendments, remained in force for 27 years, but for at least the last 12 years, it was apparent that new legislation was required to reflect the rapid changes in society and medical practice. A number of Chairs and Executives of Council expressed frustration about the inordinate length of time that was being taken to draft new legislation. As Dr Robin Briant, Chair 1990–95, records in the first issue of *Medical Council News* in March 1991:

> The legislation under which the Medical Council functions, the Medical Practitioners Act (1968) is inappropriate for the 1990s. Wide consultation was taken with the profession and the public was undertaken in 1988, and submissions on legislative change made to the previous Government. There has been no obvious progress, but we hope the Bill will proceed during 1991, and Select Committee Hearings will provide an opportunity for everyone dissatisfied with the current system to assist in its improvement.

The reality was that the new legislation was not passed until 1995.

COUNCIL ACTIVITIES UNDER THE 1968 ACT

Dr JO Mercer was Chair of Council when the 1968 Act came into effect. He was succeeded by Sir Douglas Robb who was Chairman from 1969 until 1972 and succeeded by Dr NF Greenslade. It was significant that Sir Douglas, who had been so heavily involved in the establishment of the Auckland Medical School, should be Chairman when the first cohorts of Auckland students were entering their clinical years. The first Auckland graduates were conditionally registered at the Council meeting on 28 and 29 March 1974.

Vlastimal (Milan) Brych (see Chapter 9) appeared before Council on 8 November 1974 with his counsel Mr DGR Short. He would not answer any questions about Czechoslovakia or his treatment methods. Council resolved to remove his name from the medical register with effect from midnight. As recorded later in this book, this began a prolonged saga, with Brych seeking legal redress from the Privy Council in 1977.

Dr CLEL Sheppard, a Christchurch general practitioner, retired from Council in 1975 after 18 years of service. Apart from some of the early Chairs, this was one of the longest periods of service at the time. The centenary of the Otago Medical School was held in February 1975, and Dr Sheppard, as well as Dr Greenslade and Professor WE Adams, were among representatives from the Medical Council.

The Council meeting of 12 and 13 August 1976 was held in Hamilton. It was not unusual for one Council meeting a year to be held out of Wellington in the 1960s and 1970s. Dr Rex Wright-St Clair addressed Council on the history of medical registration in New Zealand up until 1868.

On 3 April 1977, Wellington City Council declined the Medical Council's proposal to purchase property in Hobson Street, but an alternative property at 81 Webb Street was offered. At this meeting, Council also considered correspondence that caused it to be 'disturbed' by the association of doctors in the Cook Islands with Vlastimal Brych who by then had set up a clinic in the Cook Islands. They resolved to write to Dr Davis (later Sir Tom Davis and Prime Minister of the Cook Islands 1978–83 and 1983–87), Chair of the Medical Association of the Cook Islands, to see whether he had any evidence that any New Zealand-registered doctor had been guilty of professional misconduct through their association with Brych.

Press reports resulted in confusion because of references to the Council of the Medical Association of New Zealand and the Medical Council of New Zealand were discussed at the meeting of 1 and 2 June 1978. The situation was further complicated by the fact that the Council of the Medical Association of New Zealand had only reverted back to that name in the mid-1960s, having been the New Zealand Branch of the British Medical Association since 1896.

The 1960s also saw a rival association – the New Zealand Medical Association – being formed by Dr Erich Geiringer and having around 300 members in its heyday. There was thus plenty of scope for confusion. Council resolved to 'give consideration to the alteration of its title to 'the General Medical Council of New Zealand' when the Act is next under review'. This was to prove to be another 17 years, and the name change was never made.

At its meeting of 4 and 5 March 1981, Council stood in memory of Dr Humphrey Walter Gowland, Chair of Council, who died on 20 February 1981, and passed the following resolution and tribute to him:

> The Medical Council of New Zealand has been deeply shocked and distressed by the sudden unexpected death of Humphrey Gowland the Chairman. Nominated by the Royal Australasian College of Surgeons he had been a member of Council since 1969 and was elected Chairman in June 1980. Besides bringing distinction to his discipline of urology he had served his college, hospital and the whole profession with unselfish energy, sound judgement and great good sense. His interest in sport and other affairs apart from medicine gave him a broad and balanced outlook and he was endowed with personal qualities which made an excellent capacity for warm sincere and loyal friendship. A modest and somewhat reluctant occupant of the Chair of Council he had already demonstrated his capability and laid the foundation of what would have inevitably been a distinguished Chairmanship. Members of Council record their affectionate and respectful memories of him and offer their sincere sympathy to his wife Jean and his family.

In 1981, meetings of the Medical Council were held at the Van Staveren room in the Jewish Community Centre in Webb Street. This was because there were no rooms of suitable size in the Council's office. In September 1981, Council therefore resolved to try and find more suitable premises for their meetings.

An interesting debate occurred at the Council meeting in September 1981 relating to certificates of good standing. The discussion arose as the result of a doctor who had been referred to the Medical Practitioners Disciplinary Committee as he had been charged with doing an indecent act 'with or upon another male' in a public toilet. Although the doctor was discharged without conviction, the case was considered by the Medical Practitioners Disciplinary Committee, which found him guilty of professional misconduct and censured him, fined him, and charged him costs. In addition, conditions were put on his place of work, namely that he work under direction in a particular hospital environment and not be able to carry out any other form of medical practice such as locum work, and the conditions were imposed for a period of 3 years. After about a year, the doctor sought work overseas and applied for a certificate of good standing.

Council sought an opinion from its barrister, Mr IT Eichelbaum, later Sir Thomas, who recorded that, although the Council had been issuing certificates of good standing for many years, there was in fact no provision to authorise Council to do so under the 1968 Act. He considered this a most unsatisfactory situation and noted that the only reference to such certificates in the Act was an indirect one among the powers to prescribe fees contained in section 75.

Mr Eichelbaum advised against providing a certificate of good standing in this particular case, as to issue such a document would allow the doctor to obtain employment in another country where he would not be subject to the restrictions that the Council intended. The ultimate movements of the particular doctor are unrecorded, but it did raise the interesting question of whether the hundreds of certificates of good standing that Council had written under the 1968 Act were in fact worthless.

At this meeting, there was also brief discussion of the constitution of Council, which had been raised by Dr PD Delany, general practitioner. He argued that there should be greater general practitioner representation on the Council, given that general practitioners made up 55 percent of the medical workforce, yet there were only two general practitioners out of a total of 11 Council members.

In 1983, there was also robust debate about Council's decision to establish an indicative vocational register of general practice. Despite strong opposition from the Royal Australasian College of Surgeons, the Faculty of Anaesthetists of the Royal Australasian College of Surgeons, and the resident Medical Officers Association, amongst others, Council stood firm in its resolve to have an indicative register and later to recognise general practice as a vocational scope.

Over the years, there had occasionally been some tension between voluntary organisations representing sectors of the doctor population and the Council, a statutory body, with powers given by Parliament for the principal purpose of protecting the public. This was highlighted in September 1983, when Professor Geoffrey L Brinkman, then Dean of the Otago Medical School and a member of Council, wrote an editorial in the *New Zealand Medical Journal*, dated 14 September 1983, entitled 'Medical Ethics'. The editorial had been prompted by the debate on in vitro fertilisation. Dr D Williams of the New Zealand Medical Association countered with a very strong letter that contended that the Association was the body that establishes the medical profession's code of ethics.[26]

In the mid-1980s, there was still a high level of the membership of the New Zealand Medical Association (around 85 percent). The Association still retained an interest in becoming the governing

[26] *Medical Council News*. Issue No. 14. April 1996.

body for the profession, with a statutory mandate for compulsory membership similar to that of the New Zealand Law Society. The issue was again debated thoroughly when moves were made to seek new legislation for a fresh Act of Parliament. In the end, the New Zealand Medical Association abandoned the idea and supported Council retaining the mandatory role of registering all doctors in New Zealand. The New Zealand Medical Association has always maintained a code of medical ethics for the New Zealand medical profession.

Historically, New Zealand Medical Association members and nominees, often appointed by ministers, have been on the governing bodies of the profession, the Medical Council, and the Medical Education Committee. The disciplinary mechanism set up under the Acts prior to 1995 also involved the Medical Practitioners Disciplinary Committee, being served by the Association's Secretary, and having members on it nominated by that body.

There have always been very active New Zealand Medical Association members and representatives holding office in the Council, including that of Council Chair.

Dr WS (Stewart) Alexander, Council Chair from 1983 until 1990, had been involved with the Association, as was
Dr W (Bill) Pryor, who was its representative on Council. Other Association nominees who served for years on the Council include Drs P (Paddy) Delaney, JM (John) Broadfoot, and MM (Murdoch) Herbert, who was appointed in 1987 and remained through until the last disciplinary hearings under the 1968 Act were heard in 2000.

Dr KJ (Ken) Thomson was appointed to Council by the Minister on advice from the New Zealand Medical Association, despite his not being a

member of the organisation at the time. When the 1995 Act came into effect in 1996, the four doctors who were elected included Drs AJ (Alister) Scott and Tony Baird, both past Chairs of the New Zealand Medical Association. Subsequent to that, Dr JB (John) Adams, Chair of the Medical Council from 2010 to 2013, had also chaired the New Zealand Medical Association. There has always been a close relationship between the Medical Association and the Council despite, at times, robust debate about who sets ethical standards.

At its meeting on 20 June 1984, it was resolved that there would be no smoking allowed at meetings of the Council.

The issue of trainee intern prescribing was raised at this meeting by Dr KE Berendsen. Until this time, it had been commonplace for trainee interns to write prescriptions that were dispensed without countersignature by a registered doctor. The matter was referred to the Medical School Deans, and trainee intern prescribing stopped. It was recommended that the principles of safe prescribing should be included in the trainee intern teaching programmes.

On 28 and 29 November 1984, the Council, under section 58(1) of the 1968 Act, decided to issue a certificate of probationary registration to Dr DF (David) Minnitt who had been convicted of the 1980 manslaughter of his wife. This enabled him to practise as a doctor for a period of 12 months in such hospital or institution in a post approved by the Chair of Council. This caused considerable debate within Council, and Dr RH (Robin) Briant abstained from the vote. The decision also caused widespread public debate, and one senior general practitioner wrote to Council asking whether its decision could be subject to formal review by a body such as a Court.

The proposed revision of the 1968 Act was discussed by Council in June 1988, although, in reality, the new Act was 7 years away. One Council member, Dr IM (Ian) St George, who had joined Council in March 1988 as the nominee of the Royal New Zealand College of General Practitioners, favoured a lay majority and all medical members elected with no ex officio or balancing appointments. A lay majority was also suggested in the Council for Healthcare Regulatory Excellence report 2010[27] but to date has not eventuated.

At its meeting of 29, 30 and 31 August 1988, Council received the *Report of the Committee of Inquiry into Allegations Concerning the Treatment of Cervical Cancer at National Women's Hospital and into Other Related Matters,* which became to be commonly referred to as the Cartwright Inquiry. Council accepted unanimously Dr Robin Briant's statement on clinical freedom that she developed as a result of the report. (This is discussed further in Chapter 8, which contains the full wording of the Council's resolution on the subject.)

In August 1988, Council also recognised emergency medicine as a separate specialty and the Fellowship of the Australasian College for Emergency Medicine as an additional qualification in the medical register.

In March 1989, Professor John Hunter expressed concern to the Council that a new Government policy to allow the entry of fee-paying students into New Zealand medical schools could make the selection of New Zealand students into medical schools extremely difficult. Otago could potentially take 20–30 such students. Council was advised to keep the issue under scrutiny as it had long-term implications for the medical workforce.

[27] Council for Healthcare Regulatory Excellence (UK). *Performance Review of the Medical Council of New Zealand.* 2010.

The Council meeting of June 1989 received the report of the review committee to advise Council on accreditation of New Zealand undergraduate medical courses,[28] known as the Renwick Report, or: after the committee convener. (This is discussed further in Chapter 14.) Professor Hunter said the review committee did not have a brief to examine postgraduate medical education, although it had made some comments on it. Council through its Medical Education Committee did not intend to act as a provider of education but wanted to have a monitoring and overseeing role in assessing the standards achieved by both undergraduate and postgraduate education. Both the faculties and colleges would be responsible for the determination of curriculum and standards.

The annual practising certificate was then $400 (GST inclusive) or $688.43 today (September 2015).

1990

In May 1990, it was clarified that Malaysian students who had been accepted by Otago University Medical School after an approach by New Zealand Education Ltd had to return to Malaysia after graduating after completion of the trainee intern year.

After 7 years in the position, Dr WS (Stewart) Alexander stood down as Chair of Council in August 1990.

As well as marking the beginning of a new decade, 1990 in many ways marked the start of a new era for Council. Dr Alexander had presided over some difficult times for Council members and staff, always carefully promoting and supporting discussion and constructive options for solutions. This approach sustained even more momentous

[28] Renwick, WL. *The Education of Medical Undergraduates in New Zealand: Report of the Review Committee set up by the Medical Council of New Zealand.* Medical Council of New Zealand, 1988.

change in the next decade, particularly leading up to the new legislation and expansion of all aspects of Council's work. Dr Alexander's wise advice, concern for individuals, and interest in governance as well as management was invaluable.

Dr Briant, previously Deputy Chair, was elected to succeed him, becoming the first – and, to date, only – woman in the history of the Medical Council of New Zealand to hold this office. Following Dr Alexander's resignation, he was honoured with a 'Festschrift' or book in which contributors honoured and recalled his many skills and talents, and his good humour, humanity, and creativity.

Dr Briant brought another valuable perspective to Council leadership and, in her turn, also enhanced the reputation of Council for addressing difficult issues. Some of these had become increasingly obvious through disciplinary hearings and liaison with other similar boards around the world. Under Dr Briant's leadership, Council took some brave initiatives on sensitive issues, such as sexual abuse. Dr Briant built on Dr Alexander's work to improve communication with the profession and the public, launching Council's newsletter *MCNewZ* in March 1991.

Performance issues

1990 was the year when Council heard charges of disgraceful conduct against Professor DG (Dennis) Bonham and Professor GH (Herbert) Green, who had been identified by the Cartwright Inquiry as the clinicians primarily responsible for the controversial clinical trial at National Women's Hospital. After considering medical evidence from Professor Green's counsel and his physician, Council decided Professor Green was unfit to plead, and the charges against him were stayed.

The Bonham hearing attracted much publicity. Media interest was heightened, in part, because the hearing, in the Tribunals Division of the District Court in Auckland, was held (as usual) in private. Council found Professor Bonham guilty of disgraceful conduct. He was censured and fined $1,000, the maximum sum under the 1968 Act. (The Medical Practitioners Disciplinary Committee later heard charges of professional misconduct against Professor RJ (Richard) Seddon and Mr IB (Bruce) Faris, who were members of a team that, in the mid-1970s, reviewed cases of cervical cancer at National Women's Hospital. They were found guilty of the charges for their part in failing to express concern about cases of invasive cancer and one death.)

The Preliminary Proceedings Committee was always busy and enjoyed excellent legal assistance from the partners at Kensington Swan, and junior and senior barristers. Aberrant prescribing was a relatively constant cause for charges. In late 1990 and early 1991, a single case took 4 weeks of Council's time. Until then, the Council Secretary had attended all hearings to take care of all aspects of their administration. It was decided to contract a legally qualified Tribunals Officer to work as and when needed.

Ms Susan D'Ath, LLB, accepted the offer and continued in the role until all hearings under the 1968 Act were finally completed in 2001. She was also able to provide services for the Dentists Disciplinary Tribunal.

Under the 1968 Act, the Council Chair and Health Committee were able to act quickly to protect the public if doctors were referred who were significantly impaired. However, Council tried to emphasise preventive action, cooperation in treatment, and early development of healthy lifestyles. As respect for the Health Committee's approach to and management of impaired doctors grew, so did the workload.

At its meeting in March 1990, Council noted that the new Medical Practitioners Bill might reach the House by July 1990! The Bill was finally passed into law in 1995.

In August 1990, Council heard that a pharmaceutical company had written to doctors inviting them to join a wine appreciation club. This was considered to be a blatant example of drug company advertising with no demonstrable educational or clinical value. The 1980s was the decade where the relationship between doctors and drug companies was first subject to serious scrutiny. Guidelines for these relationships were developed, the latest of which is the Medical Council's position statement *Doctors and health related commercial organisations* (2012).

In October 1990, letters were received from a plastic and reconstructive surgeon and the Advisory Committee of Women's Health expressing concern about itinerant doctors, especially those from Australia, performing surgical procedures with no specialist qualifications. This was the first of many considerations by Council of the procedure of tumescent liposuction, which has continued to be a vexed issue to the present day.

The following year, the Honorary Secretary, Dr JN (John) Nacey (later, as Professor Nacey, an appointed member of the Medical Council) of the Royal Australasian College of Surgeons New Zealand Branch, wrote to say that the College regarded liposuction as a procedure to be carried out by adequately trained surgeons.

Issues resulting from 'appearance medicine' and anti-ageing medicine continue to be subjects of concern to Council to the present day.

December 1990 saw the retirement of Professor JD (John) Hunter from the Medical Education Committee.

1991

In 1991, Council decided to contract independently the services of the intern supervisors so that they were directly responsible to Council for their work. Council was concerned that workforce issues arising from the health reforms could possibly undermine the quality of the internship (the seventh year of training and conditional registration year) and place the conditional registrants (and the public) at risk. This was just one example of the vigilance required of Council.

Ms Georgina Jones, Council Registrar and Chief Executive Officer, records that she was constantly involved with Council and its committees to refine and reform policies and procedures, in many cases making changes to deal with the increased volume and complexity of activity.[29] Teleconferences and mechanising as many processes as possible went some way to keeping costs under control, but the very volume of work and new initiatives inevitably led to Council having to raise the practising certificate fee and disciplinary levy in order to meet its increased budget to cover all proposed activities.[30]

By mid-1991, the data-processing system and hardware was reviewed, revised, extended, and upgraded so that recording and producing records, reports, and certificates for registration and examinations were all automated. Ms Jones records:

> Financial records are all on the database and a new receipting programme is being written. Our word-processing capability is sophisticated and effective, and telephone, fax, copying and printing resources are high quality. Information systems are regularly reviewed, including hard files and library material, and provide ready reference when issues come before Council or its committees.[31]

[29] Jones, G. *The Medical Council of New Zealand: A Personal and Informal Perspective of Events During my Time as Chief Executive/Secretary/Registrar from 1986 to 2000.* Medical Council of New Zealand, 2002.

[30] Ibid.

[31] Ibid.

An increasing workload necessitated an increase in staff, including an Executive Officer for Communications, the Medical Education Committee, Examinations Board, and Health Committee.[32]

New Zealand Registration Examination Clinical (NZREX) candidate numbers grew exponentially. Between July 1990 and June 1991, candidates made 337 attempts in the four parts of the examination. At that time, New Zealand Registration Examination Clinical was conducted in two sessions (March and August) each year. These alternated between Auckland and Wellington initially, and as candidate numbers grew, examinations had to be held in Wellington and Auckland concurrently. Eventually, five centres were needed to cope with demand.

The University of Auckland provided an office for the Examinations Director, Dr GL (Gavin) Glasgow, and his assistant, Ms Jenny Hargrave, but the Council office handled all enquiries, enrolments, instructions, results, complaints, and payments. Agenda papers for the Board of Examiners were compiled in the Council office, with some meetings held by teleconference and others in Wellington. New Zealand Registration Examination Part I (English) and Part II (Medical multiple-choice questions) was held in Singapore and London as well as Auckland and Wellington. At all times, Council emphasised that the examination was not designed to be a tool of discrimination but a yardstick to measure safety to practise as a doctor in New Zealand.

Council took steps to improve communications with stakeholders by responding promptly to letters, convening meetings with organisations with common goals, and introducing a Council newsletter, *MCNewZ*. Media training for key Council members was initiated. They sustained

[32] Ibid.

sensitive contact with complainants and doctors, especially where health issues or disciplinary charges were involved. The news media found private hearings frustrating and were critical of delays before the findings were announced. A communication committee considered ways of improving the flow of information.

The annual practising certificate exercise provided a good opportunity for Council to collect workforce data. A high return rate resulted from thorough follow-up of the questionnaires sent with the practising certificate application form, and New Zealand's data on the medical workforce was considered the best in the Commonwealth. There was a sense of disappointment that the data was not better used, and this may have been a reflection of the market force philosophy of the time.

From the 1991 annual report onwards, a table on secretariat workload indicators was incorporated into the Secretary's section of the report.

Ms Georgina Jones went on a study tour to the United States of America and Canada to review policies on registration of international medical graduates and sexual boundaries.

The health reforms of the National Government were announced in the 1991 Budget. Part of these involved trying to develop a definition of core health services, that is, those it was necessary for the state to provide, including a ranking of their importance. Council resolved to make a submission on core health services including the effect of these on professional standards and discipline. Ultimately, the register of core services was never completely developed. The implementation of the health reforms caused considerable disquiet in the medical profession, particularly because of the hostile divisions that occurred

between doctors and managers in a number of places. During these turbulent times, Council was able to maintain a politically neutral stance just as it had during the late 1930s when the profession was up in arms about the Social Security Act 1938 introduced by the Labour Government of the time.

In 1992, following its *Statement for the profession on information and consen*t and the statement *Responsibilities in clinical research in institutions*, Council was also getting involved with more standards initiatives. It developed further guidelines for the profession, including *Ethical and legal issues in biotechnology, Sexual abuse in the doctor-patient relationship*, and *Strategies for action on the misuse of addictive prescription drugs*.

There was a growing expectation that post-entry recertification of registered doctors would be introduced in the future. Even under the 1968 Act, Council had carried out some competence reviews at the request of hospital boards on a user-pays basis. Council grew increasingly frustrated when politicians did not fulfil their promises of a new Act, which meant that Council had no mandate for interventions such as competence enquiries or regular review of specialists. The Accident Rehabilitation and Compensation Insurance Act 1992 was amended to clarify definitions of 'rarity' and 'severity' in medical misadventure claims, but the Accident Compensation Corporation (ACC) still did not inform Council of doctors regularly having claims found against them.

Following a meeting with the Australian Medical Council in June 1990, discussion and negotiation had continued with a view to achieving joint accreditation of medical schools in New Zealand and thus

allowing graduates of each to be registered in both countries. The Australian Medical Council subsequently changed its constitution to allow New Zealand to have members on the relevant committees and for the two Councils to have access to all reports. Trans-Tasman accreditation became a reality. Access to postgraduate training in each country was also improved by this move.

The influx of international medical graduates grew, exacerbated by immigration policy that rested on a points system under which medical graduates from overseas could achieve the threshold for permanent residence without having to be referred to Council for evaluation of their registrability. Unlike the Australian Government, the New Zealand Government provided no bridging courses for international medical graduates until 2001, 10 years after the immigration policy had been introduced.

By 30 June 1992, 2,477 doctors were on the register of specialists, and another 1,293 doctors were on the indicative register of general practitioners.

In 1993, New Zealand celebrated the centenary of women having gained the vote. Council now had four women members out of 12 – Drs RJ (Robin) Briant, JA (Judith) Treadwell, and SL (Sharon) Kletchko (representing the Director-General) and lay member Mrs Patricia Judd. The secretariat had nine full-time staff members, one part-time staff member, and one casual staff member – and only one man among them.

Pending the arrival of the new Medical Practitioners Act (passed in 1995), Council and the secretariat continued to work on standards and ethical issues. The work on strategies to reduce inappropriate

prescribing of abusable drugs was completed.

A Sexual Abuse Working Party, formed after a multi-disciplinary seminar in August 1992, developed statements over the next 2 years for the profession and the public, and Council offered education workshops. After wide consultation, pamphlets for the public were also drafted and distributed. There was consultation with other professions and the use of international literature and expert advice, plus consultation with community groups whenever possible. Later, the Council's complaints and disciplinary processes were scrutinised and protocols developed that would reduce the risk of further victimisation of people, mainly women, bringing forward their concerns.

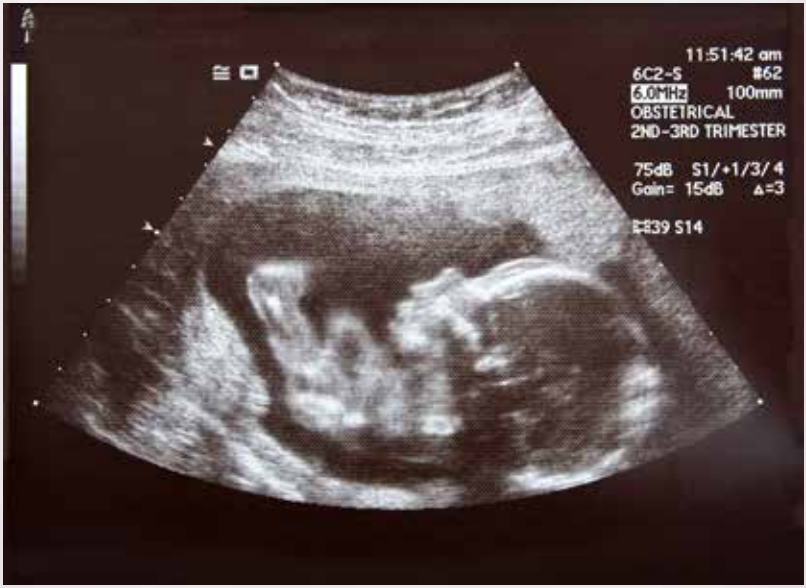
Council contributed to discussions on the development of New Zealand's ethics committee structure. Work to refine monitoring of impaired doctors continued, and mentoring became an essential ingredient.

Council was becoming more involved in international dialogue on matters of common interest. In 1992, the Australian Medical Council organised a seminar in Melbourne for Board and Council members, with the President of the General Medical Council, Sir Robert Kilpatrick, as one of the guest speakers. Mrs Patricia Judd gave a paper on informed consent, as she and Dr DS (David) Cole had led Council's work on the statement published in 1990, which had broken new ground on the concept. In April 1993, several Council members and the Chief Executive attended the annual meeting of the Federation of State Medical Boards in San Francisco.

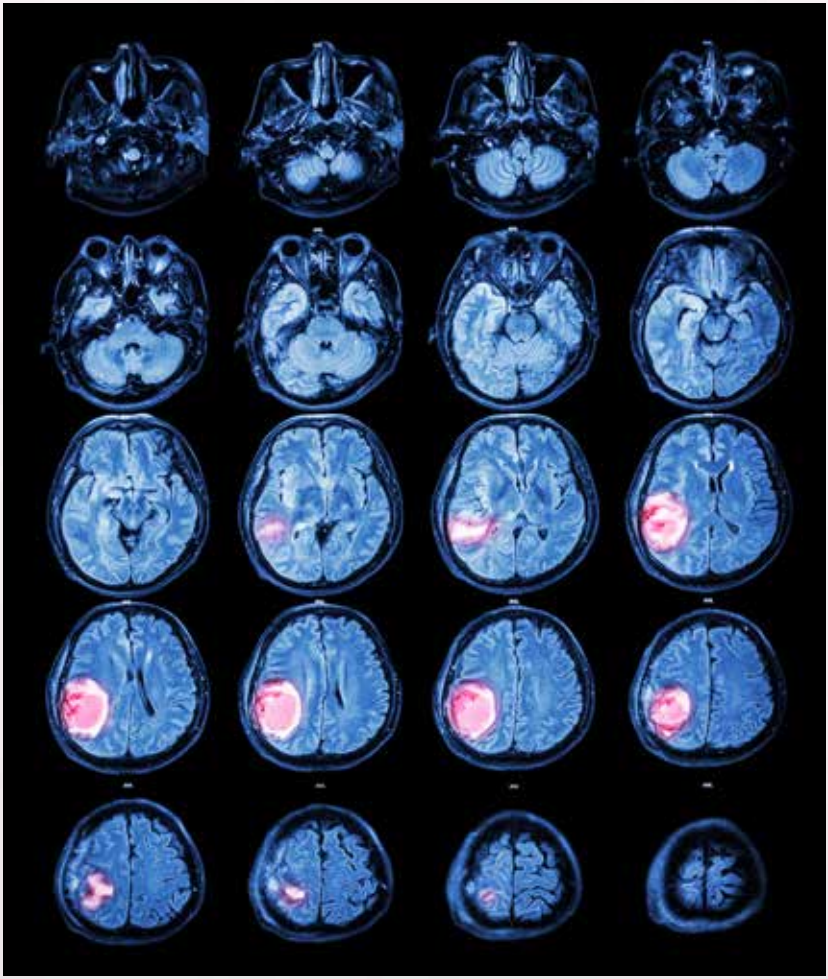
In 1993, the Council office moved to new premises on Level 12, Mid City Tower, 139–141 Willis Street, Wellington. A favourable deal was negotiated to obtain a full floor on a 10-year lease. This included

more meeting rooms and a staffroom.

Quality improvement took high priority. With help from an external facilitator, a human resources review occurred, and it was agreed in principle to set up a team structure in 1994, under the headings of Corporate Services, Registration, and Standards. That organisational structure remained relatively unchanged in 2002. Later, professional advisers were appointed, and the roles of Chief Executive and Registrar were separated.



CHAPTER 6: 1995–2003



MEDICAL PRACTITIONERS ACT 1995

The Medical Practitioners Act 1995 came into effect on 1 July 1996. Ms Georgina Jones recalls that the Act was:

> …finally passed late one night a few days before the Christmas recess, in a legislative chamber with a minimum quorum in attendance and, in the public gallery, four council secretariat members...a handful of alternative medical practitioners and a group of tourists...[33]

The Act had had an elephantine gestation period starting in the late 1980s.

Dr KJ (Ken) Thomson, the then Chair of Council, outlined the provisions of the new Act in the *Medical Council News.*[34] This edition also included a supplement titled 'The Medical Practitioners Act 1995 – What's New?'.

Section 3 set out the principal purpose of the Act itself:

(1) The principal purpose of this Act is to protect the health and safety of the public by prescribing or providing for mechanisms to ensure that medical practitioners are competent to practise medicine.

(2) Without limiting the generality of subsection (1) of this section, this Act seeks to attain its principal purpose by, among other things, –

(a) Imposing various restrictions on the practice of medicine.

(b) Providing for the registration of medical practitioners, and the issue of annual practising certificates.

(c) Providing for the review of the competence of medical practitioners to practise medicine.

[33] Ibid.

[34] *Medical Council News.* Issue No. 14. April 1996.

(d) Providing for the notification of any mental or physical condition affecting the fitness of a medical practitioner to practise medicine.

(e) Providing for the disciplining of medical practitioners.

(f) Providing certain protections for medical practitioners who take part in approved quality assurance activities.

The specific functions of the Medical Council were set out in section 123.

(a) To authorise the registration of medical practitioners under this Act, and to maintain the register.

(b) To consider applications for annual practising certificates referred to it by the Registrar.

(c) To review the competence of medical practitioners to practise medicine.

(d) To consider the cases of medical practitioners who, because of some mental or physical condition, may not be fit to practise medicine.

(e) To promote medical education and training in New Zealand.

(f) To provide administrative and related services for the Tribunal.

(g) To advise, and make recommendations to, the Minister in respect of any matter relating to the practice of medicine.

(h) To exercise and perform such other functions, powers, and duties as are conferred or imposed on it by or under this Act or any other enactment.

The new Council comprised a total of 10 members. Four were to be elected medical members, and up to four (one of whom may be a doctor) were to be nominated by the Minister. The remaining

two members were the Director-General of Health and a member of a faculty of medicine in a New Zealand university (appointed by consultation with the Deans of the faculties of medicine).

A single separate disciplinary tribunal, the Medical Practitioners Disciplinary Tribunal, was established to consider and judge doctors charged with disgraceful conduct, professional misconduct, or conduct unbecoming a medical practitioner that reflects adversely on the practitioner's fitness to practise. The legislation was to work in tandem with the implementation of the Code of Health and Disability Services Consumers' Rights under the Health and Disability Act 1994.

Dr Thomson commented:

> …we should not pretend that the interface between these two pieces of legislation will necessarily be straightforward, simple, effective or inexpensive. From the beginning, however, a genuine desire to make them work will certainly speed up the 'settling in' period … [S]ome doctors may see this new legislation as unduly intrusive and punitive, [but] it need not be, provided we accept the need for effective regulation of the profession and participate fully in the processes required to establish a smoothly running system.[35]

Dr Thomson said that the profession should welcome the opportunity to rise to the challenge of monitoring its own standards. The new Act allowed future Medical Councils to develop policies and procedures that meet the needs of the community, without sacrificing fairness and professional autonomy for doctors and without the need to recourse to continual amendment to the Act.

[35] Ibid.

All currently fully registered doctors were deemed to be on the general register with effect from 1 July 1996, but an important new requirement was placed on the general registrant – he or she was permitted to practise only under the general oversight of a doctor who held registration in the branch or sub-branch of medicine concerned.

All doctors on the then specialist register and the indicative register of general practitioners were deemed to be on the vocational register as from 1 July 1996. A preliminary list of 24 branches and sub-branches of medicine to be recognised as vocations was compiled. It was recorded that more branches would need to be added from time to time.

The 1995 Act also created five categories of probationary registration. Probationary Registration (Class 1) referred to doctors in their first year after graduation (now postgraduate year 1). The other classes referred to were:

- New Zealand Registration Examination passes
- specialist eligible
- eligible for assessment
- re-registration (following erasure).

Temporary registration was for overseas-trained doctors visiting New Zealand and was intended for those receiving postgraduate instruction or experience, research or, in certain circumstances, to meet special needs in the workforce such as deployment in shortage specialties.

The 1995 Act gave the Council discretion to approve or accredit medical schools and universities as institutions whose graduates were entitled to apply for registration. The Council's new Medical Education

Committee was to assume responsibility for managing and advising on the accreditation process for primary medical degrees. It was recognised that accreditation of medical schools was expensive and Council would not have the resources to run a worldwide programme.

Accreditation would have to be done by credible outside agencies. The old 'reciprocity' arrangements were deemed to be no longer acceptable. The only fair method of assessment of standards of graduates of non-accredited medical schools was to be a test of the individual applicant. International medical graduates would now have to pass the New Zealand Registration Examination or have their 'specialist' qualifications, experience, and competence deemed to be equivalent to those of New Zealand-trained doctors. This led to two pathways for entry to probationary registration and ultimately to general and possible vocational registration. Restrictions on registration pathways were also defined.

COUNCIL ACTIVITIES UNDER THE 1995 ACT

From 1996 to March 1997, there were more changes in the Council membership. Gradually, the appointments and elections were completed to get the new Council of 10, compared to 12 previously.

The 'old' Council (residual from the 1968 Act) remained responsible for discipline arising from existing issues that had been commenced but not completed prior to the 1995 Act.

Council elections were held for the first time. There were 28 candidates, and four members were elected. They included two past Chairs of the New Zealand Medical Association, Drs MAH (Tony) Baird and AJ (Alister) Scott, the President of the New Zealand Resident Doctors'

Association, Dr MJ (Mark) Adams, and a general practitioner who had been on the previous Council, Dr IM (Ian) St George.

In 1997, Council also received the report *Maintaining Doctor's Competence* written by Associate Professor RG (Bob) Large. A new Issues Committee and the newly constituted Education Committee were established and appointments made.

The President's report for 1998 made reference to two particular issues of current concern: the threat of possible deregulation of the medical profession and the question of the large numbers of overseas qualified doctors applying for registration.

1999

This year saw the celebration of the centenary of the graduation of the late Sir Māui Pōmare (1898) as a doctor. The celebration was held at the annual meeting of Te Ohu Rata O Aotearoa, the Māori Medical Practitioners Association (Te ORA), at Hongoeka Marae at Plimmerton, north of Wellington. Council was represented at this celebration.

2000

Major issues for the Council in 2000 were the cases of Dr MB (Michael) Bottrill, for alleged misreading of cervical smear reports in Gisborne, and Dr MF (Morgan) Fahey, a Christchurch general practitioner who was convicted of sexual abuse. (These cases are discussed in Chapters 8 and 9.)

Shortages of doctors, particularly in rural areas, was again a critical issue. Council debated initiatives to attract doctors to rural areas while affirming that there was no question of lowering standards.

2001

The *Review of Processes Concerning Adverse Medical Events* (the Cull Report)[36] was published in 2001 (see Chapter 8). The possible provisions of the new Health Practitioners Competence Assurance Bill were discussed.

An ACT Party private member's Bill proposing to make the registration of international medical graduates the responsibility of another body than the Medical Council was referred to the Health Select Committee. The Bill was not well supported by politicians or members of the Overseas Doctors Association, which had often been critical of Council. It was felt that the proposed Bill represented a real need for Council to address public perceptions of the issue of registering doctors from overseas.

Professor Ron Paterson was appointed as the second Health and Disability Commissioner, succeeding Ms Robyn Stent, and a Government review of adverse medical event reporting was announced.

2002

Dr MAH (Tony) Baird, President of the Medical Council, viewed the 2001/02 year as a particularly positive one.

Professional self-regulation had turned 5 as the transition to the Medical Practitioners Act 1995 had been completed. The year was positive for other reasons.

- The Government reaffirmed its support for professional self-regulation by introducing the Health Practitioners Competence Assurance Bill. The concepts of the 1995 Act were being used as a base for health sector regulation for a number of professions.

[36] Cull, H. *Review of Processes Concerning Adverse Medical Events*. Ministry of Health, 2001.

- Trust had been a central theme in Council's guidance to the profession. This included a major consultation and review of sexual boundary policies, which was completed and produced many useful recommendations to retain and restore the trust at the heart of the doctor-patient relationship. Council reaffirmed its position of zero tolerance and focused on promotion of standards and support, outside of a purely disciplinary framework.
- A major revision of Council's statement of informed consent, begun 2 years previously, was all but completed. A companion statement advising the profession on over 15 pieces of legislation that affect a patient's right to consent was also prepared.

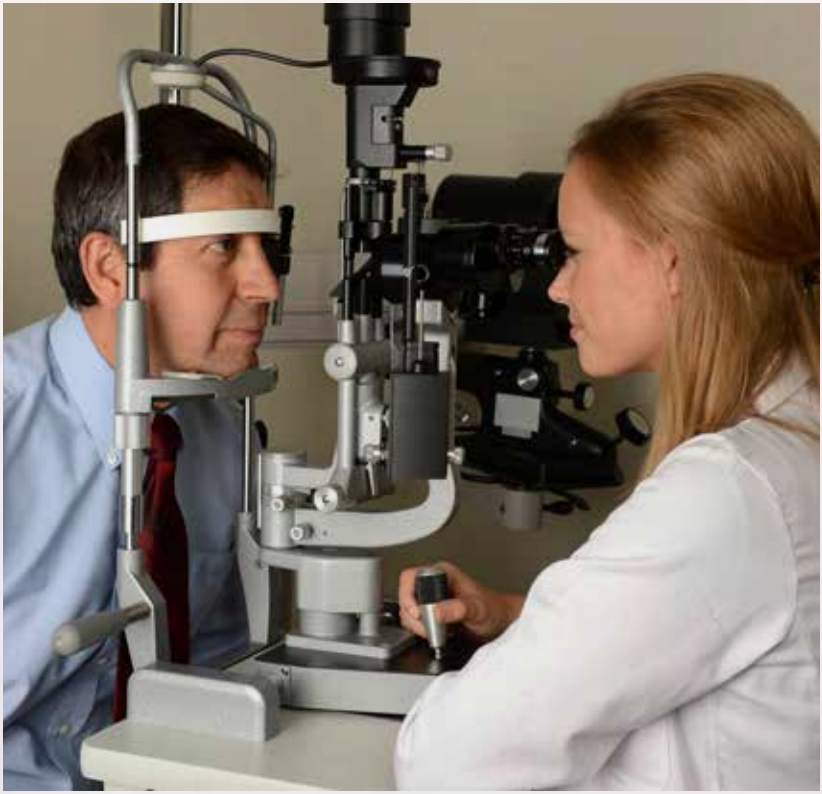
A highly successful Australian and New Zealand Medical Boards and Councils conference was hosted in Wellington in November 2001. This was preceded by a workshop on competence. Prominent speakers included Professor Bruce Barraclough, Chair of the Australasian Council for Safety and Quality in Health Care, Dr Tina Kaigas, Director of Medical Administration at Cambridge Memorial Hospital in Ontario, Mr Finlay Scott, Chief Executive Officer of the General Medical Council, Dr George van Komen, President of the Federation of State Medical Boards, and Professor Mason Durie, Head of the School of Māori Studies at Massey University, who gave an address on cultural competence.

2003

Professor AJ (John) Campbell became President of the Medical Council of New Zealand. He was a Professor of Geriatric Medicine with a worldwide reputation for his research into falls in older people. At the time of his appointment as President of Council, he was the Dean of the Otago School of Medicine. Among Professor Campbell's

many contributions were his commitment to continuing professional development and regular practice review. He was a champion of medical education and was very concerned about professional isolation of solo practitioners.

CHAPTER 7: 2003–2015



HEALTH PRACTITIONERS COMPETENCE ASSURANCE ACT 2003

The Health Practitioners Competence Assurance Act (2003 Act) was passed by Parliament on 1 September 2003 and received Royal Assent on 18 September 2003. It came fully into force on 18 September 2004. In doing so, the Act repealed 11 occupational statutes governing 13 professions.[37] The 2003 Act added osteopathy as a regulated profession, split midwifery and nursing, and created five regulated professions under the Dental Council and the Optometrists and Dispensing Opticians Board. More recently, the Government has added anaesthetic technology as a newly regulated profession, which is overseen by the Medical Sciences Council of New Zealand.

The principal purpose of protecting the public was emphasised, and the 2003 Act included mechanisms to ensure that health practitioners are competent and fit to practise their professions for the duration of their professional lives. It was argued that having one legislative framework allowed for consistent procedures and terminology across the professions regulated by the 2003 Act, whilst acknowledging that not all health professions are regulated under the 2003 Act.[38]

The 2003 Act included provision for making regulations to enable elections, and members could not be elected until such regulations were made. The Minister of Health at the time, Hon Annette King, stated that she did not intend to have elections at that time and that all members of the Medical Council would be by Ministerial appointment. The 1995 Act had required 10 members, but the 2003 Act, while not prescribing the exact number of members, set a cap of 14 members. The appointment of members by the Minister was a major concern to the profession.

[37] Ministry of Health. Health Practitioners Competence Assurance Act. 29 October 2014. Retrieved from http://www.health.govt.nz/our-work/regulation-health-and-disability-system/health-practitioners-competence-assurance-act.

[38] Ibid.

Elected members for the Council were finally restored in 2005 in response to lobbying by the profession. All was not entirely serene however. After the election in 2006, the Minister of Health, the Hon Pete Hodgson, appointed the top three and the fifth polling candidates, bypassing the fourth. The Hon Tony Ryall, as Opposition Spokesperson on Health (later the Minister of Health from 2008 to 2014), gave an undertaking that he would appoint the top four polling candidates, and this applied in the 2009 and 2012 elections.

A further election was held in March 2015. There were 14 candidates, and the current Minister of Health, the Hon Dr Jonathan Coleman, agreed to appoint the successful candidates. This election was the first time the Council held electronic voting. Disappointingly, only around 20 percent of eligible doctors voted.

In general, the 2003 Act included more obligations to provide information (and some additional powers to compel information) to Council and the other bodies under Council's control to assist them to carry out their functions. The 2003 Act provided a common disciplinary tribunal for all authorities, using a panel appropriate to the profession. A common form of wording that covered bad or offensive behaviour in all professions needed to be developed, accompanied by common thresholds for referral. This met with some resistance from the medical profession.

One of the biggest changes in the 2003 Act was to move away from a disciplinary focus to a more dispassionate competence/rehabilitative focus. There was greater separation of competence and conduct issues through the performance assessment committees and professional conduct committees. The concept of a performance

assessment committee was not intended to be punitive – although some professionals viewed them as such.

A further source of concern to the profession was section 13 of the 2003 Act, which deals with qualifications and gives the Minister the ability to audit against these (section 124). In fact, this provision has never been used. The Minister also had the ability to intervene if there were disputes between authorities about scopes of practice. As a result of some general misapprehensions about the Act, it included the provision for review after 3 years.

COUNCIL ACTIVITIES SINCE THE HEALTH PRACTITIONERS COMPETENCE ASSURANCE ACT 2003

Professor Campbell, in his first annual report in 2003, reflected on the Health Practitioners Competence Assurance Bill, which was shortly to be enacted.

Ms Sue Ineson, the Chief Executive, reported that there had been a major updating of the policies on sexual boundaries and a project to enhance cultural awareness by New Zealand and overseas-trained doctors. 2003 was the year that the medical register was placed online to improve access by the public and the profession, and Council introduced an 0800 telephone number.

2004

The 2003 Act came into force on 18 September 2004. Council actively consulted stakeholders on how changes brought about by the new Act would affect them. Three high-level scopes of practice were developed – vocational, general, and special purpose.

Council invited former Council member Dr AA (Tony) Ruakere to be its kaumātua and to advise on cultural matters. Dr Ruakere helped at the workshop for international medical graduates run by the Council and the Confederation of Postgraduate Medical Education Councils.

Council played a leading role in the formation of Health Regulatory Authorities of New Zealand (HRANZ), an informal group of 15 registering authorities established as a forum for discussions of common interest.

2005

Professor Campbell, whose title had changed from President to Chair with the 2003 Act, recorded:

> Today Council is the body that registers doctors, maintains competence and standards, and provides guidance to the profession. It is no longer involved in complaints investigation or discipline.[39]

Ms Sue Ineson, the Council's Chief Executive, reported that the task of implementing the 2003 Act had represented a huge workload.

A performance evaluation programme was developed for trial in conjunction with the New Zealand Orthopaedic Association and the Royal New Zealand College of General Practitioners.

A number of statements were developed and revised during the year.

- *Complementary and alternative medicine*
- *Disclosure of harm*
- *Ending a doctor-patient relationship*
- *Responsibilities of doctors in management and governance*

[39] Medical Council of New Zealand. *Annual Report.* 2004.

- *Statement on employment of doctors and the Health Practitioners Competence Assurance Act*
- *A doctor's duty to help in a medical emergency*

A blueprint was developed for an updated New Zealand Registration Examination involving the use of Observed Structured Clinical Examinations.

Ms Sue Ineson resigned in July 2005 to manage her own health consultancy business. She was replaced by Mr Philip Pigou.

2007

Workforce issues generated considerable interest during this year, particularly because of the shortages that existed in certain regions and specialties and the extent to which New Zealand relies on doctors who obtained their primary medical degree in another country. International medical graduates, including doctors who had undertaken their postgraduate training in New Zealand, made up 41 percent of the workforce in 2007. The Council stated that it believed New Zealand should train enough doctors to meet our health service needs, and this meant increasing medical student numbers and retaining a higher proportion of those we do train.

Council took steps to improve cultural competence. Mauri Ora Associates Ltd developed the booklet *Best health outcomes for Māori: Practice implications* for the Council. This booklet provides general guidance on Māori cultural preferences and includes practical advice and specific examples.

2008

During this year, there was intense scrutiny of the Council's processes, particularly in light of the Dr Roman Hasil case (see Chapter 9). As a result, Council wrote to all district health boards and recruitment agencies to remind them that they must provide all relevant information to Council when submitting a registration application and add a declaration to the effect that it had been provided.

From 1 August 2008, all doctors applying for registration in New Zealand were required to provide a certificate of good standing from each jurisdiction in which they had worked in the last 5 years. In addition, any doctor disclosing concerns about competence, conduct, or health was required to supply a certificate of good standing from the jurisdiction in which the doctor was registered at the time, regardless of the time elapsed.

The new vocational scope of rural hospital medicine was registered, bringing the number of vocational scopes to 35.

2009

During May 2009, Council conducted a series of roadshow meetings around the country to speak to doctors about two major initiatives: regular practice review and new supervision arrangements.

Council proposed that a regular practice review be incorporated into the continuing professional development programmes of medical colleges and branch advisory bodies. The review was intended as a supportive and collegial assessment of the doctor's clinical practice by two peers.

The primary purpose of the review was to enhance doctors' clinical practice by providing formative feedback that doctors could then use to focus their learning.

Simpler supervision arrangements under the 2003 Act were proposed to support doctors new to New Zealand and provide them with the information to adjust to a new country and health service.

The method of supervision was an alternative to one-on-one supervision. In the new option, a service would be accredited for supervision. The Council would recognise that the doctor was working in an accredited service and would receive periodic reports from the service. The service could be a clinical practice group within a district health board, across two or more district health boards, or a general practice organised group.

Despite some initial concerns by some doctors about the time and expense of regular practice review, Council received very positive feedback about the proposals.

2010

Dr JB (John) Adams became Chair of Council in February 2010, succeeding Professor John Campbell, who had held the post for 7 years.

Dr Adams had been Dean of the Dunedin School of Medicine for 5 years and Chair of the New Zealand Medical Association for 5 years before. He had a good working knowledge of the 2003 Act before joining Council as the Bill was going through the House when he was Association Chair, and he led their submission before the Select Committee.

In his first Chair's report, he paid tribute to the leadership and direction that Professor Campbell had given, particularly during the implementation of the 2003 Act.

Dr Adams also reflects, 'I was surprised by the extent and depth of the Council's work, I am sure that I am not alone amongst new Council members in being overwhelmed by the first delivery of the agenda papers.' (Agenda papers could be up to 50 centimetres thick and weigh up to 12 kilograms!) He was concerned that, particularly in the policy and strategic area, the Council's work could expand and extend into areas that were the province of professional organisations. He considered that Council should be very careful to limit its functioning to the roles stipulated in the 2003 Act and clarifying core activities as those related to regulation and patient safety.

Dr Adams was keen to see more clarity and rigour being brought into Council processes. This involved setting up the weekly triage meeting involving Council members and some senior Council staff, which became known as the Complaints Triage Committee on a more formal basis, and recognising the health aspects within conduct referrals.

April 2010 saw the commencement of approved practice settings for focused supervision of international medical graduates, which had been discussed in the roadshow meetings the previous year.

2010 was also the year in which the Council for Healthcare Regulatory Excellence undertook an independent audit of Council (see Chapter 8). A survey of medical migration was carried out, and Council went 'live' with its new information system and continued work on actively developing enhanced online capacity.

2011

In February 2011, Council members elected Ms Liz Hird as its Deputy Chair. She became the first lay person to hold this position.

The Australian Medical Council and the Medical Council of New Zealand signed a Memorandum of Understanding that signalled a new stage in their 20-year history of collaboration. Since 1992, the two Councils had worked together to accredit Australian and New Zealand colleges and medical schools.

In February, Health Workforce New Zealand sought comment from all regulatory authorities on their discussion document *Proposal for a shared secretariat and office function for all health-related regulated authorities together with a reduction in the number of regulatory authority board members.* Council fully considered the Health Workforce New Zealand proposal and agreed that there were benefits in closer collaboration between authorities. Council made a number of submissions that reflected concern about possible negative effects the proposal might have on the working of the 2003 Act and recommended that the number of board members remained at current levels.

Council began a review of the prevocational training requirements for interns (postgraduate year 1) and second year doctors (postgraduate year 2). It also formed a working group to explore issues about medical student registration and held four workshops for supervisors of international medical graduates.

The Hon Georgina te Heuheu, Minister of Pacific Island Affairs, launched a new Medical Council resource for doctors, *Best health outcomes for Pacific Peoples: Practice implications.*

2012

Council reported a deficit in the disciplinary fund and announced that the disciplinary levy would have to be increased from $120.11 to $195.11 (GST inclusive). There were several reasons for this. Firstly, there was an increase in the number of charges laid against doctors before the Health Practitioners Disciplinary Tribunal. Fifteen charges were laid in 2010/11 compared with six per year for the previous 3 years. Secondly, the number and cost of professional conduct committee investigations had increased, and thirdly, specific one-off cases resulted in extraordinary costs for Council. Council faced costs of close to $1 million in relation to the investigation and prosecution of one doctor!

Mr Philip Pigou, the Council's Chief Executive, reported the findings of the survey to find out why doctors leave New Zealand. Approximately 55 percent of doctors who were invited to participate completed the survey, with a total of 182 surveys completed. The highest proportion of respondents were doctors registered in a general scope of practice who had worked in New Zealand for longer than 3 years. The majority of these doctors worked in general practice, general medical, or surgical runs, and a variety of reasons for leaving were given including:

- the desire for training opportunities and work experience in overseas settings
- increased remuneration
- family reasons
- improved working conditions
- locum opportunities.

In May, the Council launched its new website, which featured bold colours and uncluttered design. There were three main sections or portals.

- Patients and the public – with information for patients and the public about expectations of doctors, how to find a doctor, and how to make a complaint.
- Doctors already practising in New Zealand – with details for doctors already working in New Zealand, as well as information on practising certificates, recertification, and health concerns.
- Doctors wanting to practise in New Zealand – which offered a 'one-stop shop' on how to get registered with the Council and links to key government agencies such as Immigration New Zealand.

2013

After further discussion on the possibility of a shared secretariat and other moves towards amalgamation of health regulatory authorities, the proposal was shelved. Council had expressed considerable disquiet about the proposal.

As the Council's 2012 annual report noted, the main arguments for the proposal were greater efficiency and costs saving, more consistent accountancy processes, more consistent policy and processes, and a single database of health practitioner workforce information and knowledge.

The Council expressed concerns, for example, that it would need to retain its own governance, ensure independence and ownership of regulation, retain its strategic development and policy capacity, retain the knowledge and skills to set standards, and manage the risks to public safety specific to the medical profession.

The first year of the implementation of a strengthened recertification for doctors registered in a general scope of practice was completed. They were required to enrol in the Inpractice recertification administered by Best Practice Advisory Council (bpac^{nz}) on behalf of the Council. During each 12-month programme cycle, participants were required to complete 50 hours of continuing professional development including:

- a professional development plan
- 20 hours of continuing medical education
- 10 hours of peer review
- an audit of medical practice
- meetings with a nominated collegial relationship provider (six in the first year and four in subsequent years'.

In addition to the annual requirements, participants must complete:

- the essentials test in the first year and then once every 3 years
- multi-source feedback once in every 3-year period
- a regular practice review visit when scheduled (not required in the first 3 years after attaining a general scope).

PART 2:
MAJOR REPORTS AND CASES OF PARTICULAR INFLUENCE On COUNCIL

CHAPTER 8: MAJOR REPORTS

THE CARTWRIGHT INQUIRY

In 1987–1988, Judge Silvia Cartwright (later Dame Silvia and Governor-General of New Zealand) conducted a 7-month long inquiry into allegations concerning the treatment of cervical cancer at National Women's Hospital (Auckland) and into other related matters.[40] This had been requested by the Minister of Health, the Hon Dr Michael Bassett.

> The government ordered inquiry into unethical research practices related to the treatment of cervical cancer at National Women's Hospital was instigated by Women's Health Action (formerly Fertility Action) and was a major challenge to medical dominance at the time. It led to significant reforms towards a patient-centred health care system by giving patient rights the force of law in New Zealand – a global first – and establishing a system of accountability to patients external to the medical profession through the creation of the role Health and Disability Commissioner.[41]

The inquiry was established in the wake of a *Metro* magazine article[42] in June 1987 by two prominent women's health advocates and writers, Sandra Coney and Phillida Bunkle.

The article revealed that women with precancerous carcinoma of the cervix in situ and some micro invasive cancer of the cervix or vaginal vault had, without their knowledge, received repeated diagnostic biopsies and cervical smears but had been left untreated or undertreated in order to study the extent to which these lesions

[40] Cartwright, S. *Report of the Committee of Inquiry into Allegations Concerning the Treatment of Cervical Cancer at National Women's Hospital and into Other Related Matters.* The Committee, 1988.

[41] Women's Health Action. *Cartwright Inquiry.* Retrieved from http://www.womens-health.org.nz/consumer-rights/cartwright-inquiry/

[42] Coney, S, and Bunkle, P. `An Unfortunate Experiment at National Women's.' *Metro*, June 1987: 47–65.

developed into invasive cancer. The study had been commenced in 1966 and formalised into a research programme that continued even when, in the early 1970s, it appeared deaths were occurring and the dangers became apparent. The women involved had been entered into what was a de facto research project without their knowledge and consent.

The inquiry confirmed the claims made by Sandra Coney and Phillida Bunkle, and the ensuing report provided a detailed analysis of the evidence presented to the inquiry as well as the findings and recommendations.

The recommendations were key to the establishment of a national, centrally coordinated screening programme. The report also led to sweeping changes in law and practice around consumers' rights. The Office of the Health and Disability Commissioner was established along with the Code of Health and Disability Services Consumers' Rights, which enshrined informed consent. Teaching practice was changed at National Women's Hospital and the Schools of Medicine to conform to international practice, independent health ethics committees were set up throughout New Zealand, and a national cervical screening programme was established.

The Council's response to the inquiry was led by Drs Briant and Alexander who produced a statement for the profession on clinical freedom. Guidelines for institutions in clinical research and a working party on informed consent were established promptly.

Council received the Cartwright Inquiry report and accepted Dr Briant's statement on clinical freedom, which read:

> The Medical Council of New Zealand has read and considered the Report of the Cervical Cancer Inquiry 1988, by Judge Silvia Cartwright. The Council acknowledges the Judge's detailed findings and supporting documentation, and recognises that the findings have implications for medical practice that go far beyond one hospital and one specialty.
>
> The Medical Council:
>
> - believes that the concept of 'clinical freedom' was never a valid reason to pursue a course of action contrary to standard treatment methods.
> - gives notice to the profession and all professional institutions, that the general thrust of the findings (of the Cartwright report) will form part of the basis of assessment for individual registration, vocational/specialist registration and institutional accreditation. The necessity for peer review procedures for hospital accreditation was foreshadowed in our letter to hospitals in September 1986.
> - requires that all hospitals inform the Medical Council about their systems currently in place for peer review and audit, and about the availability and functioning of committees to oversee treatment and research ethics.
> - urges all Hospitals and Area Health Boards, Medical Schools and Specialist and General Practice colleges to incorporate the essence of the Report into their own programme developments. Matters of particular note are peer review,

informed consent, patients [sic] rights, rights of patients to be treated with dignity and procedures for approval and surveillance of treatment methods.

- notes that there are published plans for a major revision of procedures to deal with doctors who, by reason of impairment of their own competence, health or conduct, fail their patients. These plans incorporate a major role for the consumer in all deliberations and discussions.

This was moved by Dr Briant, seconded by Dr John Broadfoot, and passed unanimously.

Dr Briant recalls that there was much debate over the expression 'clinical freedom'. Council remained resolute that 'clinical freedom' was not an invitation for doctors to do as they liked

The 1990 *Statement for the medical profession on information and consent* and its review published in 1995, which added a clause covering 'specialist' as opposed to 'student' learning environments, provided guidelines for the period before the Health and Disability Commissioner Act 1994 and the adoption of The Code of Health and Disability Services Consumers' Rights, which was circulated to all doctors with the Council's annual report.

HEALTH AND DISABILITY COMMISSIONER ACT 1994

The Health and Disability Commission is an independent agency established by the Health and Disability Commissioner Act 1994. Its purpose, as described in section 6 of the Act, is to:

> …promote and protect the rights of health consumers and disability services consumers, and, to that end, to facilitate the fair, simple, speedy, and efficient resolution of complaints relating to infringements of those rights.

The main role of the Health and Disability Commissioner is to ensure that the rights of consumers are upheld. This includes making sure that complaints about health or disability services providers are taken care of fairly and efficiently.

The Code of Health and Disability Services Consumers' Rights became law on 1 July 1996. It grants a number of rights to all consumers of health and disability services in New Zealand and places corresponding obligations on providers of those services.

The Council has enjoyed a good working relationship with the three Commissioners who have held the post – Robyn Stent, Professor Ron Paterson, and Anthony Hill – and have sought to have close lines of communication and regular meetings.

Robyn Stent was Commissioner from 1994 until 2000. Her tenure was difficult at times, as there was suspicion about the new post when she started and she held the post during the turbulent period of the health reforms of the 1990s. Her landmark report on Canterbury Health Ltd investigating patient care at Christchurch Hospital[43] arose from a document prepared by a group of senior Christchurch clinicians titled *Patients are Dying*. This report was an indictment on the managerially focused health system of the 1990s but also on the dysfunction at Christchurch Hospital at the time.

[43] Stent, R. *Canterbury Health Limited: A Report by the Health and Disability Commissioner, April 1998.* Wellington: Health and Disability Commissioner, 1998. Retrieved from http://www.hdc.org.nz/media/30148/canterbury%20health%20report.pdf

Professor Ron Paterson (who later became an Ombudsman) became the second Commissioner in 2000. His book *The Good Doctor: What Patients Want*[44] is based primarily on his experiences as Commissioner and argues strongly for more rigorous continuing professional development and increased access of information for the public about the performance of doctors, particularly those with conditions. (A condition is a legal requirement that a doctor does something or does not do something as part of their medical practice.)

Professor Paterson was also critical of Council in several cases where he considered action against a doctor was too slow. Despite these issues, Council enjoyed a good working relationship with him, and it was a period of closer working between the agencies. The positive relationships have continued under the present Commissioner appointed in 2010, Anthony Hill, who had previously been in the Ministry of Health.

There has been a progressive increase in the number of referrals to the Health and Disability Commissioner, and this has put a lot of pressure on the agency to deal with cases expeditiously. A continuing challenge for both the Health and Disability Commissioner and the Council will be to ensure that delays are minimised and that prompt referral of cases between agencies occurs.

THE GISBORNE CERVICAL SMEAR INQUIRY

An inquiry into the under-reporting of cervical smear abnormalities in the Gisborne region was commenced in April 2000. It arose after a court judgment that pathologist Dr MB (Michael) Bottrill was found to be negligent in reading certain cervical smears. Dr Bottrill had worked as the sole pathologist employed by a private laboratory in Gisborne

[44] Paterson, R. *The Good Doctor: What Patients Want.* Auckland: University Press, 2012.

between 1974 and 1996. He operated as the sole primary screener reading cervical smears, and no-one checked his work.

A massive reread of 12,000 cervical smears (originally reported by Dr Bottrill) showed that 1,997 smears had been misread (with 616 cases involving high-grade abnormalities). Nine deaths and over 60 cases of alleged injury were revealed in the Gisborne region. The Gisborne Cervical Smear Inquiry found serious problems in the running of the National Cervical Screening Programme, noting that an effective, well-designed and well-implemented programme would have prevented Dr Bottrill from practising in this way.

The report recorded:

> There are no competency requirements for a medical practitioner to undertake formal continuing education or for them to have their competence reassessed. The Committee considers that this was a factor that is likely to have led to considerable under-reporting in the Gisborne region. Had Dr Bottrill been required to undergo formal continuing education and a reassessment of his competency as a medical practitioner it is unlikely that he would have continued to practice as he did.[45]

Reflecting on the Gisborne case, the then President of Council, Dr Baird, said that 'there were vitally important lessons for the medical profession', for example, on:

- the dangers of isolation from peers
- support for colleagues
- need for continuing professional development
- a duty to report dangerous practice.

[45] Duffy, AP, Barrett, DK, and Duggan, MA. *Report of the Ministerial Inquiry into the Under-reporting of Cervical Smear Abnormalities in the Gisborne Region.* Ministry of Health, 2001.

Dr Baird felt these fell squarely within the responsibility of the profession, as individuals, and were the direct mandate of the Medical Council.

Dr Baird stated that, from 1 July 2001, all doctors must participate in a recertification programme and have an overseer providing, for the first time, some measure of compulsory continuing professional development and eventually peer review and audit. Competence reviews, another recent measure, are undertaken when a practitioner's competence is in doubt and aim to be non-punitive. Dr Baird reaffirmed Council's commitment to continuing professional development and noted that there was official recognition that systems must change, and as part of this, there needed to be a move away from fruitless naming and blaming of individuals.

The Gisborne Cervical Smear Inquiry was a powerful driver of the Council's determination to improve continuing professional development.

THE CULL REPORT

In 2001, the then Minister of Health, the Hon Annette King, commissioned an inquiry into whether there were 'any regulatory and institutional barriers to information sharing and coordination regarding adverse medical outcomes' between three key statutory agencies: the Accident Compensation Commission, the Health and Disability Commissioner, and the Medical Practitioners Disciplinary Tribunal.

The inquiry arose from public concern about the performance of a gynaecologist about whom multiple complaints had been received and was conducted by Helen Cull QC. The inquiry report 'confirmed the existence of silos that could allow poor practice to continue undetected'.[46]

[46] Cull, H. *Review of Processes Concerning Adverse Medical Events.* Ministry of Health, 2001.

In his President's Foreword for the Council's 2001 annual report, Dr Baird observed that in 'most years it seems that there are events which challenge the profession in some fundamental way and from which lessons emerge'.[47] He said that the index case in the Cull Inquiry pointed to a need to detect practitioners with possible problems about whom various agencies hold separate information. While there were understandable anxieties about the prospect of sharing information, it was equally not in the profession's interest for serious problems to go undetected or for individuals to hide behind the system. Early detection, support, and appropriate remediation are vital in addition to a disciplinary process.

The Cull Inquiry led to the enactment of the Health Practitioners Competence Assurance Act 2003 and the Health and Disability Commissioners Amendment Act 2003. Former Health and Disability Commissioner Professor Ron Paterson considers that one positive development has been that key agencies share information. The Health and Disability Commissioner can therefore forward additional relevant information to the Medical Council about a doctor who is already under investigation by Council.

THE COUNCIL FOR HEALTHCARE REGULATORY EXCELLENCE (CHRE) REPORT

In late 2009, the Council requested a full performance review of the organisation. This was carried out by the UK-based Council for Healthcare Regulatory Excellence (CHRE), which scrutinises and oversees the work of nine regulatory bodies that set standards for the training and conduct of health professionals.

[47] Medical Council of New Zealand. *Annual Report.* 2001.

The CHRE operates under section 26 of the National Health Service Reform and Health Care Professions Act 2002 (UK) and section 114(6) of the Health and Social Care Act 2008 (UK). The outcomes of its reviews are published annually to Parliament and devolved administrations in the United Kingdom.

The CHRE reviewed the role of the Medical Council and the regulatory environment in New Zealand and provided matters for consideration by the Council in their report[48] under the headings of:

- standards
- registration
- fitness and competence to practise
- education.

The CHRE was impressed by the Council's approach to regulation, and this is recorded in the first paragraph of their overall assessment:

> We were impressed with many aspects of the approach to regulation that has been adopted in New Zealand. In particular, the philosophy of attempting to deal with concerns about fitness to practise in a collaborative, non-adversarial way appears to work effectively in protecting the public in a majority of cases. There are aspects to this approach that could usefully be applied by regulators in other countries.[49]

They praised the comprehensiveness and quality of the Council's standards and performance documents. They also praised the work of the Health Committee and noted that Council had developed strong mechanisms for assessing doctors' clinical competence. They also expressed approval of Council's development of regular practice review.

[48] Council for Healthcare Regulatory Excellence (UK). *Performance Review of the Medical Council of New Zealand.* 2010.

[49] Ibid.

They did throw out some challenges, however.

They questioned the fact that full Council and its committees all had a majority of doctors and also raised the advisability of a lay member chairing Council. Their comment was that:

> In the UK regulation has moved from self regulation to shared regulation with public members of councils having at least parity with professional members and with the majority of councils having a publicly appointed lay chair. This makes clear that public not professional protection is the first priority of a regulator.[50]

The CHRE also questioned whether some cases that were currently dealt with under 'competence' would be more appropriately dealt with under 'conduct'. Arguably, their severest criticism was reserved for the lack of information available to the public on the medical register database, which they saw as 'a serious weakness' that indicated a 'lack of transparency' in Council's communication with the public.

The CHRE recommended that the details of conditions on a doctor's practice, other than those related to health, should appear on the database so as to be available to the public. Moreover, the names of doctors who had been suspended or erased should remain on the register with the information on suspension or erasure recorded. The comments about information on the database have been echoed by former Health and Disability Commissioner Professor Ron Paterson.[51]

Other comments by the CHRE included praise for the times in which professional conduct committees are conducted and the recommendation that Council have the ability to refer conduct cases to the Health Practitioners Disciplinary Tribunal even if a professional conduct committee had not recommended that action.

[50] Ibid.

[51] Paterson, R. *The Good Doctor: What Patients Want*. Auckland: University Press, 2012.

CHAPTER 9: SOME NOTABLE CASES INVOLVING DOCTORS

This chapter outlines a number of cases that have been challenging to the Council and in some instances prompted the Council to modify its policies. The list is by no means comprehensive and is confined to the last 40 years. Quite a number of earlier cases are discussed in Part 1 under the various Acts that guided the deliberations of the Council of the time.

VLASTIMIL (MILAN) BRYCH

Those who criticise the Council as being too slow or too particular in registering international medical graduates would do well to remember that, over the last century, a number of unqualified bogus 'doctors' have gained listing on the register. Some doctors have also misrepresented postgraduate qualifications in an attempt to gain unjustified specialist registration.

The most infamous case of a bogus 'doctor' gaining registration was that of Vlastimil (Milan) Brych. Two main questions arise from the Brych affair.

- How did he gain registration in the first place?
- Why did it take so long to erase him from the register?

Dr NF (Norman) Greenslade, Chair of Council, was finally able to outline the case against Brych in the *New Zealand Medical Journal* in May 1977:

> At long last the Medical Council can tell the profession the facts about Vlastimil Brych. The long delay of two and a half years has been a tremendous worry to the Council, not only because an impostor was continuing to practise but the evidence on which we acted was sub judice. Therefore the Council could not tell the

> public or the profession the facts and were powerless to stop Brych while his appeals continued.[52]

Professor John Scott (later Sir John) travelled to Czechoslovakia and several other countries on behalf of the Council to obtain the truth about Brych. Brych had arrived at Trieste in Northern Italy on 8 July 1968 as an apparent refugee a month before the overthrow of the Dubcek administration by the Union of Soviet Socialist Republics and other Warsaw Pact partners.

In his interview with the United Nations and the Italian police, Brych claimed to have a doctorate in biology. He later claimed to have a medical degree. He claimed that he had no documentation with him because he had had to flee Czechoslovakia with virtually only the clothes he stood up in. There was considerable sympathy towards refugees from Czechoslovakia at the time, and Brych obtained temporary registration even though the only document he submitted was his United Nations travel document.

He had been accepted into New Zealand on the understanding that he was a doctor, and it was assumed that his qualifications had been fully checked out in Italy. While he held temporary registration, 'surprising gaps in his knowledge', poor note taking, and an apparent poor command of English were assumed to be the result of differences in training programmes in Eastern Europe. He gained full registration in 1972 and obtained a senior position in the Department of Radiotherapy at Auckland Hospital even though the only document he submitted was his United Nations travel document. This stated his profession as 'dottore-laureato in biologia', which, translated from Italian, is 'doctor of biology'.

[52] Greenslade, NF. 'The Medical Council of New Zealand's Case Against Brych.' Report. *NZMJ* (85): 387–390. 1977.

What happened next is well remembered. Even as Brych gained full registration, the Chair of Council, Dr Greenslade, had cautioned Brych about self publicity. This followed a television appearance on 26 July 1972 (which he undertook with the approval of officers of the Auckland Hospital Board Administration) that prompted a number of letters of complaint to the Medical Council. Dr Greenslade wrote to Brych advising him of the expectation of doctors in New Zealand regarding self publicity.

Fully registered, Brych rapidly gained a near cult following because of his claims of having 'a new and secret method for treating various forms of tumour and cancer'. He used the term 'immunotherapy' without details of what it entailed. His answers about his treatments were vague, inconsistent, and, at times, scientifically contradictory. Concern over the veracity of his claims culminated in an Inquiry into Cancer Services at Auckland Hospital, held at the Auckland Town Hall, by Professor R Douglas Wright of Melbourne – a one-man inquiry, notwithstanding references to 'the Committee' in the transcripts of evidence. Public opinion and the news media were almost universally in favour of Brych who was perceived as being a poor refugee doctor being persecuted by the medical hierarchy who were jealous of his great discoveries.

In mid-1974, the Council commenced its investigations into Brych, which revealed that not only had he never been qualified but that, during the time he claimed to be in medical school, he was, in fact, in prison convicted of crimes of violence.

The Council met as a tribunal on 8 November 1974 and, on the basis of the evidence it had collected, directed that Brych's name be erased from the register from midnight on that date.

Brych filed a motion in the Wellington Supreme Court on 11 November 1974 to have his name restored. His eventual erasure from the register in February 1977 was delayed until his several appeals had been heard. Brych finally withdrew his appeal in the face of written testimony filed by the Council in the Supreme Court in Auckland on 25 February 1977. Council recorded that they would have welcomed the opportunity to have the evidence heard and witnesses cross examined.[53]

Following the Council's order in November 1974 to remove Brych from the register, a scenario worthy of a Gilbert and Sullivan opera arose. The Penal Cases Committee of the Medical Council had initially refused to investigate complaints of disgraceful conduct against Brych on the grounds that 'he was not a doctor'. However, legally, he was a doctor because he had been registered as a doctor by the Council and his deregistration had been stayed by the Supreme Court.

The Penal Cases Committee, in due course, changed its mind, and Mr J Larsen, the Crown Prosecutor in Wellington, visited Auckland on several occasions to investigate matters, and a raft of charges of disgraceful conduct were laid. These were, however, never heard by the Council as it all took so long. In the end, as previously noted, Brych simply withdrew his appeal against deregistration and in 1977 moved to the Cook Islands where he had political support and was able to set up a clinic, which was later discredited. Brych was later arrested and imprisoned for 6 years in the United States of America for grand theft and practising medicine without a licence.

[53] Ibid.

DR KOLATHUR VARIATH SREEKANTAN UNNI

The need for close collaboration between agencies is illustrated by the case of Dr Unni.

Dr Unni came to New Zealand in the mid-1980s and worked at Whakatane Hospital as a psychiatrist. It was alleged that he indecently offended a patient. The then Bay of Plenty Hospital Board did not sack him or report him to the Council. He resigned for 'personal reasons' and went to work for the Waikato Hospital Board at Te Kuiti Hospital where it was alleged further offending occurred. By the time it came to the attention of the Council, he had left the country. He was struck off and fined $26,000, which was never retrieved.

Dr Unni gained registration with the General Medical Council in the United Kingdom, but he was struck off by them in 1989 after notification by the Medical Council of New Zealand.

After 6 years of stacking supermarket shelves, he regained registration with the General Medical Council in 1995 after two appeals. He was struck off by them for a third time after a case of indecent assault on a female patient. It was feared that there were probably a number of other undetected cases.

Dr Unni's case prompted then Health and Disability Commissioner Robyn Stent to have a close look at the rules in New Zealand governing the re-registration of doctors in New Zealand who have been struck off the register.

Under the current Memorandum of Understanding between Council and district health boards, Dr Unni would have come to Council's attention after the original offence.

DR MORGAN FRANCIS FAHEY

Dr Morgan Fahey, Christchurch general practitioner, was jailed for 6 years on 1 June 2000 for rape, sexual violation, and indecent assault on women who were his patients. The Solicitor-General sought unsuccessfully to have the sentence increased to 10 years

In October 2000, Dr Fahey was struck off the medical register and fined 75 percent of his prosecution costs by the Medical Practitioners Disciplinary Tribunal. Dr Fahey had been considered a 'pillar of society'. He was an international authority on trauma medicine, had served on the Christchurch City Council, including a period as Deputy Mayor, and over many years, he had done a large amount of voluntary work.

An editorial in *The New Zealand Herald* titled 'Doctor exposed – 34 years too late'[54] described his actions as 'about as bad an exploitation of power as might be imagined in medicine'. Clearly, Fahey imagined that, because of his position and reputation, no-one would believe the accusations of his victims. The editorial referred to the vulnerability of patients: '…on one side of the stethoscope there is knowledge and the authority it carries, on the other side there is illness and often anxiety, with all the disadvantage that brings'. The editor concluded that the Medical Council should reappraise its procedures in the light of it, adding, 'It should not have taken journalism to expose a man with a history such as his.'

In the Council's annual report for 2000, the President, Dr Baird, recorded:

> Whilst the general standard remains high, two cases in the year led the Council to reflect on the standards of practitioners and the

[54] Editorial. 'Doctor exposed – 34 years too late.' *The New Zealand Herald*, 30 June 2000. Retrieved from http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=137992

level of protection of the public. The cases were those of Dr Fahey, Christchurch GP convicted of sexual abuse and the allegations of misreading by Dr Michael Bottrill of cervical smears in Gisborne. Many issues arose but two important changes are proposed as a result:

- ensuring the Medical Council, Health and Disability Commissioner and other groups have a process to consider threats to other patients which require action when a complaint is received. The Medical Council believes this provision must apply to all professional groups, not only doctors;
- amendment to the legislation to enable the Medical Council to intervene (for example through suspension) if, during the course of an investigation of a complaint or competence, a doctor is found to pose a risk to the public.[55]

Council employed an external evaluator, Ms Clare Bear, in September 2000 to evaluate and assess Council's policies on sexual boundaries in the doctor-patient relationship. The evaluation included a literature review, assessment of the Council's policies and processes, and consultation with the profession, Council stakeholders, and members of the public.

Council received and noted a completed report by Ms Bear at its meeting in August 2001. From this and the research conducted, two statements on sexual boundary guidelines were drafted in 2002 – *Sexual boundaries in the doctor-patient relationship: A resource for doctors and The importance of clear sexual boundaries in the patient-doctor relationship: A guide for patients.*

These replaced the 1994 guidelines *Trust in the doctor/patient relationship.*

[55] Medical Council of New Zealand. *Annual Report.* 2000.

DR ROMAN HASIL

Dr Roman Hasil was employed as an obstetrician and gynaecologist by the Whanganui District Health Board in August 2005. The department was understaffed and unable to recruit specialists. His case came to light because six of the 32 tubal ligations he carried out on women in 2005 were unsuccessful. This failure rate of 19 percent compared with the usual rate of 0.2 percent.

Even before the cases of failed sterilisation came to light, staff were expressing concerns about Hasil's competence and conduct. Several people had noted alcohol on his breath whilst he was on duty. The case was the subject of an investigation by the Health and Disability Commissioner.[56]

From 1996 to 2005, Hasil had had what the Health and Disability Commissioner termed a 'chequered work and medical registration career in Australia. Dr Hasil did not have good standing in Tasmania, yet he did in New South Wales. South Australia did not recognise him as a specialist, but Victoria did. Some of this can be put down to Dr Hasil's evasive answers to regulation questions, but at least some can be attributed to the fragmented nature of individual state registration in Australia at the time.

By keeping on the move through a succession of locums, Dr Hasil was able to delay recognition of problems with his competence.

Health and Disability Commissioner Professor Ron Paterson was severely critical of the locum agency and the Whanganui District Health Board, concluding that 'Hasil's background should have come to light during the

[56] Paterson, R. *Dr Roman Hasil and the Whanganui District Health Board 2005–2006: A Report by the Health and Disability Commissioner.* Wellington: Health and Disability Commissioner, 2008. Retrieved from http://www.hdc.org.nz/media/30154/whanganui%20dhb%20feb08.pdf

processing of his employment and registration in New Zealand. It did not, owing to inadequate reference checking and credentialling'.[57]

Professor Ron Paterson was also somewhat critical of the Medical Council. Council had received a certificate of good standing from the New South Wales Medical Board but, in retrospect, like the Whanganui District Health Board, might have sought more up-to-date references. Council also asked for written confirmation from 'Dr B' who had raised concerns by telephone. The written confirmation was not sent, and no further action was taken.

The Commissioner also expressed concern that Dr Hasil's annual practising certificate was renewed in mid-March 2006, shortly after a health report was received from the New South Wales Medical Board. He concluded that 'it is reassuring that since these events took place, the Medical Council has reviewed its processes of registering doctors. In particular, the Council is taking steps to ensure it obtains all relevant information about a doctor from recruitment agents and employers'.[58] He also noted that Council was working with district health boards to ensure that its health programme is better understood and that referrals are made promptly.

There were lessons for all parties involved in the Hasil case, which highlights the tension between some district health boards who have difficulties recruiting staff and want people in posts quickly with the need to ensure that those doctors are appropriately qualified.

[57] Ibid

[58] Ibid.

DR RHYS MICHAEL CULLEN

Dr Cullen was a South Auckland general practitioner who appeared before the Health Practitioners Disciplinary Tribunal on charges relating to the prescribing of more than 46,000 tablets of the pseudoephedrine-based drug Sudomyl between January 2003 and December 2004 without medical or clinical justification.

Pseudoephedrine is a precursor for the manufacture of the class A drug methamphetamine or 'P'.

Dr Cullen advanced several explanations for his actions including a claim that he was a heavy prescriber of Sudomyl as it was a better alternative to antibiotics for relieving flu symptoms. He also claimed that he was acting as a 'mystery shopper' as he was planning a review article based on the premise that pharmacists were concerned by legitimate prescriptions for Sudomyl.[59] The Tribunal did not accept these explanations, although Dr Cullen did not formally rely on them in his defence.

Dr Cullen was struck off for professional misconduct and fined $15,000 and ordered to pay $25,000 in costs. He was also ordered to hand over patient records to the Counties Manukau District Health Board.

A problem arose when the Tribunal was unable to find Dr Cullen, who had closed down his practice. He could not officially be struck off as a doctor until legal papers had been served. Ultimately, he was struck off but appealed the decision to the High Court. In December 2008, the High Court upheld the Tribunal's decision, saying his behaviour amounted to professional misconduct but that the Tribunal should not have ruled on whether his actions had been for an 'illegal purpose'.

[59] 'Rhys Cullen still struck off.' *New Zealand Doctor.* 24 April 2007.

THE MEDICAL COUNCIL AND THE PRIVY COUNCIL

Referrals of decisions and actions of the Medical Council to the Privy Council have been very rare.

Vlastimil (Milan) Brych appealed to the Privy Council in 1977.

In 1998, the Court of Appeal rejected the Commissioner of Inland Revenue's appeal about the tax status of the Medical Council (see Chapter 11). Inland Revenue initially planned to appeal the decision to the Privy Council but changed its mind.

In November 1999, the Medical Practitioners Disciplinary Tribunal found Dr Miles Roger Wislang guilty of practising without a practising certificate between August 1994 and April 1998, such practice being professional misconduct. The Tribunal suspended Dr Wislang's registration for 2 months, censured him, fined him $8,500, and ordered him to pay $15,560.28 in costs.

Dr Wislang was subsequently permitted by Council to obtain a practising certificate on condition that he name a mentor to supervise him and that he restrict his work to hair transplants and the teaching of anatomy and bio-surgical research. He objected to part of the Tribunal's decision and the mentoring condition and took his case unsuccessfully through the lower courts, seeking to quash these orders. Subsequently, he was granted leave to appeal to the Privy Council regarding:

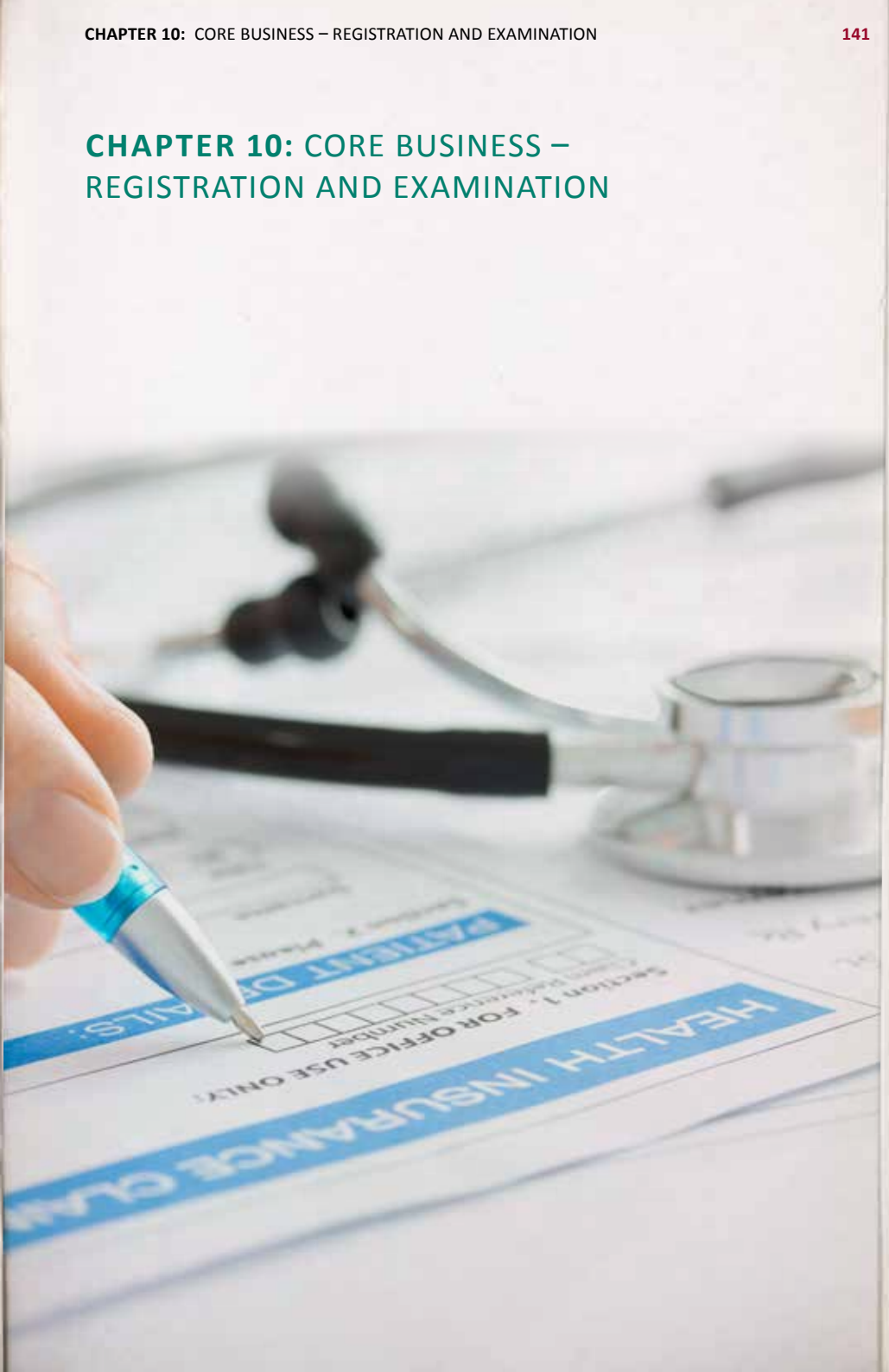
- the Tribunal's order for interim suspension of his registration in 1999 pending hearing the charge of professional misconduct against him

- the quantum of the Tribunal's order as to payment of costs and the fine
- the Council's imposition of the mentoring condition on his practising certificate.

The case was heard by the Privy Council in 2004, who agreed with the rulings of the lower courts.

PART 3:
COUNCIL BUSINESS AND OFFICERS

CHAPTER 10: CORE BUSINESS – REGISTRATION AND EXAMINATION



Registration of international medical graduates who were not automatically eligible for conditional or full registration has been a continuing issue for Council. In its early years, the Council was bound by the decisions of the General Medical Council of the United Kingdom. This changed with the passing of the 1924 Act but not without disquiet from the General Medical Council, which required Prime Ministerial intervention to resolve (see Chapter 3).

Later, the 1968 Act was amended to allow temporary registration (restricted to doctors coming to New Zealand to provide postgraduate education or instruction or to receive it), but this form of registration was limited to 3 years. In the early days of temporary registration, the politicians were adamant that no drain on the public purse should arise from such registration, that is, temporary registrants were not to provide services in the private sector, for example, in general practice.

In the 1970s, probationary registration was established so that doctors who had not qualified in medical schools in the United Kingdom, Éire, Canada, South Africa, or Australia could be examined and assessed for competence in medicine and the ability to communicate in English. When these provisions were first enacted, Council recognised the examination offered worldwide by the American organisation the Educational Commission for Foreign Medical Graduates, set up in the 1950s to deal with migration of doctors to the United States, particularly for registrar training. In the beginning, Council was not empowered to insist on examinations of its own, and amendments to facilitate this were only made in the early 1980s.

In the early part of the twentieth century, medical migration usually seemed to arise out of wartime discrimination against certain doctors

and was not at a high level. Some undertook a 3-year course at the University of Otago and then passed an examination set by the university that enabled them to receive a New Zealand degree.

Through until the end of the 1960s, registration of doctors qualified outside New Zealand mainly rested on principles of reciprocity, meaning with the then British Empire, that is, the General Medical Council was the driver. American medical graduates from prestigious institutions such as Yale could not get registration in New Zealand without further assessment, and this, of course, meant that many did not bother.

In the early 1980s, Council turned its mind to setting its own examination and enlisted the help of the medical schools at Otago and Auckland Universities. After a trial with one doctor in 1983, the first group of doctors to take an external examination required by Council did so in 1984. Problem solving and short essay questions were provided by the University of Otago, and two papers of multiple-choice questions were provided by the University of Auckland. There was no formal test of English. However, any holders of the Educational Commission for Foreign Medical Graduates certificate had to have reached a level of competence in English, certainly in writing, which gave some protection.

Even after the major changes that occurred with the entry of the United Kingdom into the European community (and consequent reciprocity with many countries in Europe), the flow of English-trained doctors still continued, and New Zealand doctors still continued to go to the United Kingdom.

Reciprocity with quite a number of countries in Southeast Asia, which had formerly rested on reciprocity with the General Medical Council, was abandoned. This coincided with those countries giving more attention to their own national identity and national languages. Previously, medicine had mainly been taught in English, but changes occurred so that, in countries such as Sri Lanka, Singapore, Hong Kong, and Malaysia, instruction in medical schools switched to local languages.

Indian doctors had always been educated in English, and this continued. Nevertheless, the huge proliferation of medical schools in that country, and the impossibility of keeping up with the standards in all of them, meant that there was some caution in registering doctors with Indian qualifications.

The exceptions were those from the traditional, highly respected and well-known institutions. In the 1960s, many Indian and Pakistani doctors went to the United Kingdom for their immediate postgraduate education, obtaining membership of the Royal College of Physicians or Fellowship of the College of Surgeons, and initially, these qualifications were recognised in the Medical Practitioners Act 1968 in New Zealand.

As all these changes affected the degrees that were recognised for registration of international medical graduates in New Zealand (on the same basis as a medical graduate from Australia or New Zealand), and it appeared to the many doctors wanting to come to New Zealand from other countries that the barriers were insuperable. Some of the doctors recruited through the joint programme (Immigration Department, Health Department, and Hospital Boards) in the years immediately after 1985, when the resident medical officers award

was changed, were able to obtain temporary registration under the category 'receiving postgraduate experience and training'. Council was not consulted about the recruitment programme in the first place but agreed to interpret eligibility for temporary registration broadly so that international medical graduates could stay for up to 3 years.

New Zealand's reputation as a paradise and peaceful place, particularly after the 1980s anti-nuclear initiatives were successful, attracted a number of doctors from Europe, especially Germany. As countries in Eastern Europe became less regimented, their graduates also came our way. Naturally, they were proud of their qualifications and were quite affronted by any suggestion that they were not competent to practise in New Zealand without first passing examinations.

The acceptability of their qualifications was one issue, but their competence to communicate effectively in English was another. A third factor was the reality that medical services were organised quite differently in some of the countries these doctors came from compared with New Zealand. In some cases, their specialisation did not fit with the pattern of practice in New Zealand. In others, the label for their practice, for instance, general practice, was not what we meant by general practice in New Zealand. Clearly, to protect the public, Council was required to provide some kind of screening mechanism, which it set about developing to deal with the ever-increasing numbers arriving from the mid-1980s.

In the second half of the 1980s, Ms Georgina Jones was able to establish good relations with registrars in the various Australian State and Territory Boards and Councils, as well as the Australian Medical Council, and obtain information about the bridging courses and examinations conducted in Australia.

In 1987, she visited the General Medical Council in London and drew on their experience of the examination they called the Professional and Linguistics Assessment Board (PLAB).

In the United Kingdom, the English test relied on was an international test administered by the British Council known as the International English Language Testing System (IELTS). When the Probationary Registration Examination in New Zealand (PRENZ) was first set up in 1984, those were the tools on which that examination was modelled.

An occupational English language test developed by the Department of Education, Employment and Training in Australia was used as a template.

As the number of candidates grew, the format was amended, and certain doctors were able to be granted exemption from parts of the test. Regrettably, the pass rates in the PRENZ were poor. This was partly attributed to the fact that a lot of the doctors were practising on temporary registration and working long hours – sometimes in rural areas without access to educational resources. They were simply unable to prepare well for the examination and discouraged from doing so by many of their supervisors who believed their performance was satisfactory. This was not mirrored in the examination results, which, on safety grounds, became more and more concerning to Council.

After a review, Council decided to develop a two-stage examination – the New Zealand Registration Examination (NZREX).

Part I was an English language test using the instruments developed in Australia. A contract between the Australian Government and the Council was negotiated, and the English Language Institute of

Victoria University in Wellington was engaged to administer the test in Wellington and Auckland on contract to Council.

Part II was a multiple-choice examination covering all basic medical knowledge taught in New Zealand medical schools. The papers were compiled from the University of Auckland database of examinations for fifth-year student finals.

A pass in these English and multiple-choice questions tests made a doctor eligible to apply for temporary registration and work for up to 2 years, during which time New Zealand Registration Examination Parts III and IV had to be achieved.

The New Zealand Registration Examination Part III was a written examination, mainly in short-answer question format, across clinical disciplines using short-answer questions, which again had been developed and tested over hundreds of students at the end of fifth-year studies at the University of Auckland. Subjects covered were applied anatomy and physiology, applied behavioural science, clinical pharmacology, internal medicine, paediatrics, psychological medicine, surgery, obstetrics and gynaecology, general practice, pathology, and pharmacology.

Part IV was a clinical examination, in long-case and short-case format, across all the major clinical disciplines as used for local fifth-year students.

Many doctors struggled to complete all four parts and achieve probationary registration. Competition for their time from clinical duties was often cited as a contributing factor, but results showed many gaps in basic knowledge, skills, and attitudes.

The New Zealand Registration Examination in this format continued on into the 1990s. Many of the candidates were doctors who had arrived in New Zealand after receiving sufficient immigration points through New Zealand Qualifications Authority assessment of their degrees to get permanent residence. However, they did not have information from the New Zealand Immigration Service that registration was compulsory in New Zealand and under the jurisdiction of the Medical Council, which had its own legal requirements. Council was frustrated by its inability to get overseas posts and diplomatic missions to give accurate information.

Candidates should have been advised by overseas posts to contact the Council office directly, but some went through immigration consultants who were cavalier in their regard for Council's role. There was a great deal of aggravation caused by this hurdle, which was seen by many to be racially biased. The fact was that Council was operating under legislation at that time that insisted on such protection of the public.

Unfortunately, the good example of bridging courses, which had been successful in Australia, could not be implemented in New Zealand because the Government would not put any money into it. It was clearly not feasible for candidates to enter such training on a user-pays basis as many of them were unemployed or working in low-paid jobs. Some refused on principle to do anything other than protest.

It was not surprising that the Overseas Doctors Association grew rapidly, being mainly comprised of doctors who flatly refused to take any examinations, and tried to exert political pressure to solve what they perceived as a major problem and barrier to their life in New Zealand. As many of these doctors had settled in Auckland when

they arrived in New Zealand, certain Members of Parliament were also under pressure to make representations to Council on their behalf.

The whole situation was complicated by the fact that, from the late 1980s, Council was constantly expecting that the new Medical Practitioners Act was imminent, and so rulings on eligibility for registration were time limited to deal with that likelihood. Thousands of enquiries came in each year, and Council did its best to give doctors and their agents accurate information. A large number of doctors did accept that they had to meet Council's standards and, in time, were successful in the examination, going on to gain temporary and probationary registration. Another group flatly refused to have anything to do with the examination and decided to use the judicial review process to try to remedy their unhappy positions.

Some of the doctors were under the misapprehension that, when the new Act came into place, all would be easy for them. In effect, the new Act made it more difficult for more doctors, because after 1 July 1996, the only doctors who could obtain registration without any further assessment were those who had degrees from a university accredited by a joint process of the Medical Council of New Zealand and the Australian Medical Council, that is, restructuring it to Australian and New Zealand graduates only. Even the old 'Commonwealth' doctors were required to take the examination if they wished to stay in New Zealand permanently, although they were entitled to temporary registration if they were visitors on work permits and did not seek to reside and practise permanently in New Zealand.

With the implementation of the Health Practitioners Competence Assurance Act in 2003, Council was able to introduce new pathways

to registration. International medical graduates with qualifications from and experience practising in countries that the Council considers to have health systems equivalent or comparable to New Zealand now have options for registration that do not require that they pass the registration examination. International medical graduates with qualifications from and experience practising in countries considered by Council not to have health systems comparable to New Zealand may still gain registration by sitting and passing the New Zealand Registration Examination. The prerequisites for gaining entry to the examination are holding an approved primary medical degree and evidence of English proficiency, having passed (within the last 5 years) the English, Professional and Linguistics Assessment Board the Australian Medical Council's multiple-choice question examination, or the United States Medical Licensing Examination written examination.

An international medical graduate who passes the New Zealand Registration Examination is required to find a position as a first-year house officer in an accredited internship role, and after a year of satisfactory supervised practice, they will be eligible to apply for full, unlimited general registration.

In 2004, Council became aware that the New Zealand Registration Examination was showing signs of age. The format of many of the stations had been similar to college examinations, with long cases combined with up to two shorter ones. The examination was being run in different centres with considerable associated logistical issues as well as problems in ensuring inter-test consistency.

To modernise the examination, Dr Steven Lillis was appointed as Examinations Director. From 2005, the New Zealand Registration

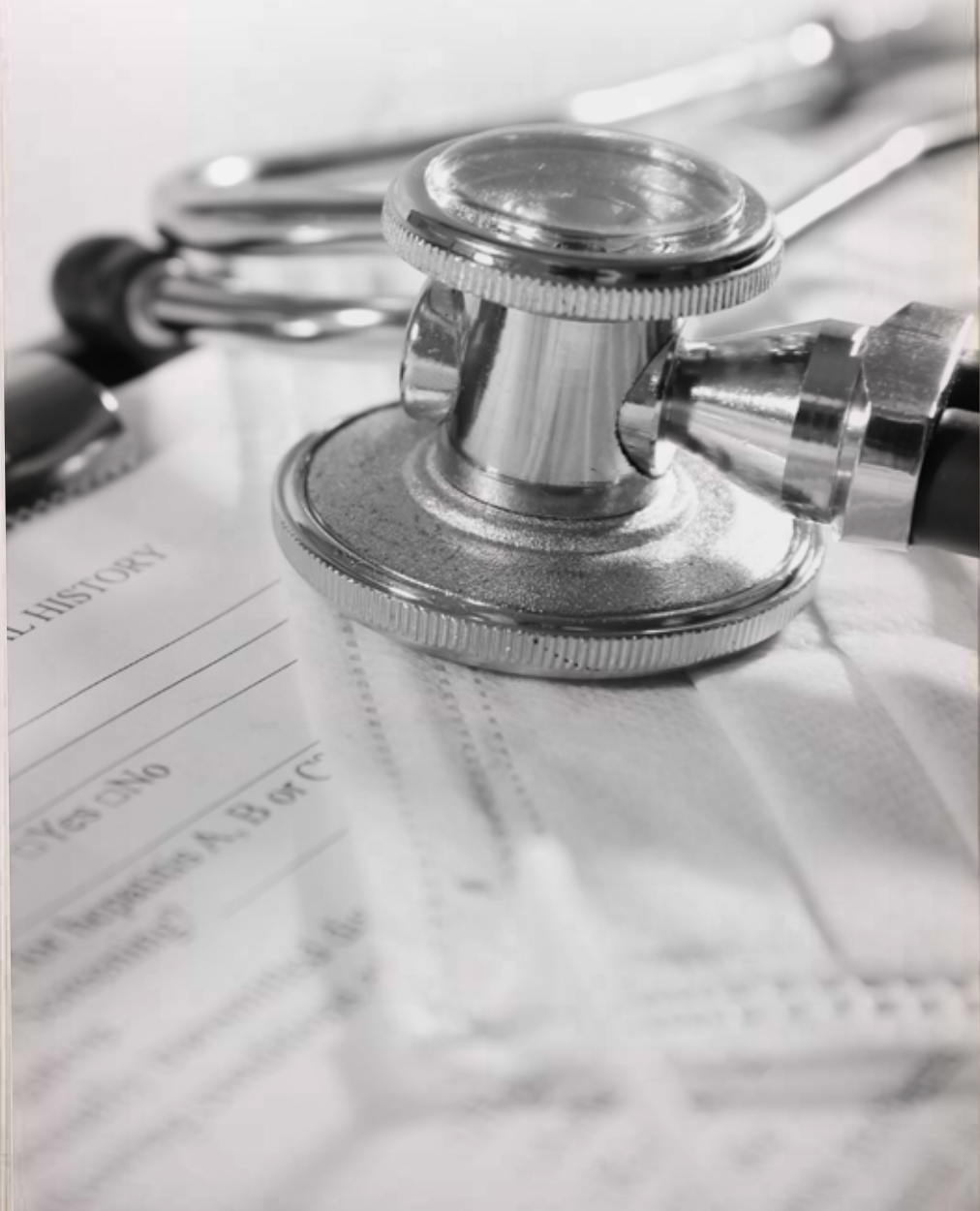
Examination took the form of a 16-station objective structured clinical examination using a standard blueprint to improve reliability and validity. The format proved successful and has remained essentially the same since then. Currently, over 120 stations have been developed and tested and are available for inclusion. The examination has been described in a paper in the *New Zealand Medical Journal*,[60] and a separate paper has described the progress of successful candidates in their first year of clinical work.[61]

The registration of international medical graduates continues to be an area that is testing for the Council at times. This is particularly the case when a doctor has been registered as a specialist in their country of origin or another jurisdiction and is seeking vocational registration. The Council is very reliant on the information given to it by the relevant vocational education and advisory bodies as to whether the doctor's qualifications are 'equivalent to, or as satisfactory as' those of a similarly trained New Zealand graduate. Often, they are not 'equivalent to' because the examination requirements or training times differ between jurisdictions. What is more difficult to determine is whether the candidate's training is 'as satisfactory as' that of a local person. A doctor might have spent less time in a training programme, for instance, but more than made up for this in their subsequent clinical experience. This is an area of continuing discussion between the Council and the vocational education and advisory bodies.

[60] Lillis, S, Stuart, M, and Sidonie, NT. 'New Zealand Registration Examination (NZREX Clinical): 6 years experience as an Objective Structural Clinical Examination (OSCE).' *NZMJ*, 125 (1361):74–80. 2012.

[61] Lillis, S, and Roblin, H. 'Progress of successful New Zealand Registration Examination (NZREX Clinical) candidates during their first year of supervised clinical practice in New Zealand.' *NZMJ*, 127 (1399): 36-42. 2014.

CHAPTER 11: FINANCE



The activities of the Medical Council cost money. The practising certificate fee, including disciplinary levy, is the main way of collecting revenue. Reference is made in Chapter 3 to the 1933 amendment to the Finance Act, which established the first fee and its unpopularity with the profession at the time. The fee is always of considerable interest to individual doctors and their employers, as many employers refund these expenses as part of the doctor's employment package. The ever-widening and deepening scope of Council's work is clearly reflected in the level of the practising certificate and levy, based on budgets that have become more and more complex.

The financial processes of Council were extremely modest when Ms Georgina Jones first became the Chief Executive. The annual practising certificate in the year ending March 1987 was only $63, including a disciplinary levy of $21. Admittedly, at that time, rampant inflation was only about to have its effect. Over the next decade, doctors were required to pay significantly more for the practising certificate and levy, but these costs were always based on carefully prepared budgets.

The price of the annual practising certificate was increased during the 1980s to $130, and between 1990 and 1996, it ranged between $264 and $525. In the 1997/98 financial year, it reached its peak at $765, including $360 for the disciplinary levy. This was the period when Council was bearing the cost of phasing out the 1995 Act and bringing in the Health Practitioners Competence Assurance Act 2003, so in some ways, this is not surprising. In general, the annual practising certificate in the second half of the 1990s was around $525, including the disciplinary levy.

A part-time Accounts Officer was appointed in 1987. Accounting needs were modest. The book value of fixed assets was $235,735, and Council's investments were around $200,000.

In 1987, income and expenditure were around $450,000, with a surplus of $7,000 in the general fund and a deficit of $126,000 in the discipline fund, where expenses of around $300,000 were greater than income of around $178,000. As a result of the deficit for the year, the disciplinary reserve account was in deficit at 31 March 1987.

By 1996, after expanded activity meant a move into new leased premises and considerable expansion in staff numbers, the net book value of fixed assets had risen to $271,590 and investments just over $5,000,000 (equivalent to 1 year's turnover). Income in the general fund was almost $1,900,000 and in the discipline fund over $3,200,000. In addition, an examinations fund had been created, which had income of around $350,000. Council had become a complex organisation with, by then, a Financial Controller, Mr John de Wever, and part-time assistance as it was needed, for example, during the processing of annual practising certificates.

By 2000, the financial reporting was more sophisticated, and it is interesting to note the following output categories and the costs associated with them as published in the year to 31 March 2000 annual report.

- Education – $609,512
- Health – $498,252
- Professional standards – $825,106
- Registration – $1,326,968
- Workforce – $170,212

Fortunately, the long-running liability dispute with the Commissioner of Inland Revenue was finally resolved in Council's favour, with a refund of over $600,000 as tax paid and interest lost unnecessarily. The sequence of events was as follows.

1987 Council obtained a legal opinion on whether it was liable for tax.

1988 Legal opinion submitted to the Commissioner of Inland Revenue to clarify liability for tax on interest earned.

1989 Solicitors and Commissioner of Inland Revenue still consulting.

1990 Solicitors and Commissioner of Inland Revenue still consulting, but there was a suggestion that Government might exempt all statutory boards from income tax.

1991 Inland Revenue deemed Council liable for tax, and Council decided to Appeal the decision to the Taxation Review Authority but meanwhile had to pay tax.

1992 Tax provisions again made.

1993 The Taxation Review Authority ruled Council was exempt and that all taxes paid should be reversed. Council applied for a refund of $380,079, plus resident withholding tax of $6,021. Later that year, the Commissioner of Inland Revenue appealed the decision.

1994 Council applied for refunds of just over $400,000.

1995 Council again applied for refunds, this time of around $460,000. Later in 1995, after an appeal by Council, the High Court ruled that Council was exempt from tax. Again, the Commissioner of Inland Revenue appealed, this time to the Court of Appeal.

1996 On 20 December 1996, the Court of Appeal found the Medical Council to be exempt from income tax.

1998 The Court of Appeal, having rejected the Commissioner's appeal, finally decided not to go to the Privy Council. All refunds due to Council were received, amounting to $657,154.

1999 The annual report for the year ending 31 March 1999 notes that tax provided for in previous years had been reversed and that refunds had been applied for.

2000 The annual report for the year ending 31 March 2000 notes that all taxes paid in previous years had been refunded.

In terms of preparing final accounts and the audit, this continuing saga with Inland Revenue caused additional work, which Council's professional advisers and in-house financial officer handled carefully. Ms Georgina Jones recalls the responsibility for high standards in this area was considerable given that this was an organisation entirely funded by doctors registered with it. Constant attention was paid to improving fiscal management, budgeting and accounting processes, reporting, and seeing that the technology to support this was available, reviewed, and updated as necessary.

The level of accuracy, accountability, and sophistication reached in 1998 with accounting, forecasting, and reporting was a far cry from the handwritten one-page ledger Ms Georgina Jones encountered when she first arrived at Council in 1986.

Today, all of the Council's accounting systems are computerised. Banking and payments by doctors for practising certificates are done electronically - major advance in both technology and efficiency on 30 years ago.

CHAPTER 12: THE HEALTH COMMITTEE

Recognition, treatment, and rehabilitation of the 'sick doctor' was one of the topics discussed at the Biennial Conference of the New Zealand Medical Association in May 1985. A proposal to set up a fund with contributions from the profession for fellowships that could be awarded to doctors ready to be reintroduced into practice was examined. The fellowships would provide financial support during the period of retraining, rehabilitation, and re-establishment. A number of organisations were involved, including the New Zealand Society on Alcoholism and Drug Dependency.

In 1986, a working party meeting was held at which representatives of many organisations concerned with the recognition and treatment of impairment of doctors discussed proposals formulated by the New Zealand Society on Alcoholism and Drug Dependency for a 'help-line programme' similar to one that had been developed in the United Kingdom. Council distributed the outline of the programme to all doctors with the 1986 annual report – it was expected that a National Trust would be set up to administer the programme and manage the necessary finances.

Council then sponsored workshops on the informal phase. The New Zealand Medical Association accepted responsibility for establishing a National Management Committee for the National Counselling and Welfare Service for impaired doctors in 1987. This was to ensure that the informal phase of therapeutic approach to the sick or impaired doctor would be free of sanctions. The thinking at the time was that only if the informal approach proved unsuccessful, or if there were a perceived risk to patients, would there be a need to involve the Medical Council.

COUNCIL'S HEALTH COMMITTEE

The Council's Health Committee currently has five members including one lay person and the Chair of Council ex officio. Council first decided to set up a Health Committee in 1988 to deal with doctors who were at real or perceived risk from health issues. Originally, the committee was to be assisted in its considerations by three or more assessors – one legal, one psychiatric (from a panel), and one from the same discipline as the doctor concerned. Although the legislation at that time, the 1968 Act, allowed for rapid action in established health and impairment cases, quite serious impairment occasionally went unreported, possibly because the outcome of reporting could be suspension.

The work of the Health Committee received favourable comment from the Council for Healthcare Regulatory Excellence (see Chapter 8). In assessing a doctor's health problems, a balance has to be found between rehabilitation of the doctor and the safety of the public, the latter being paramount. A different approach is needed when dealing with a doctor reported with an addiction problem who is in denial compared with one with a slowly progressive neurological illness, for example. Independent reviews from specialists, particularly dual diagnosis psychiatrists, are crucial in the Committee's decision making.

Dr J (Joanna) MacDonald was a member of the Medical Council for 8 years. She served on the Health Committee for the whole of that time and was Chair for 6 years. She described the work of the Health Committee in an article in the *Medical Council News*.[62]

Dr MacDonald was left with three key impressions. The first was the complexity of the situation that arises when a doctor has an illness, the second was the dilemmas that such situations present for all involved,

[62] *Medical Council News*. Issue No. 46. December 2008.

and the third was the dedication to the public of all those involved.

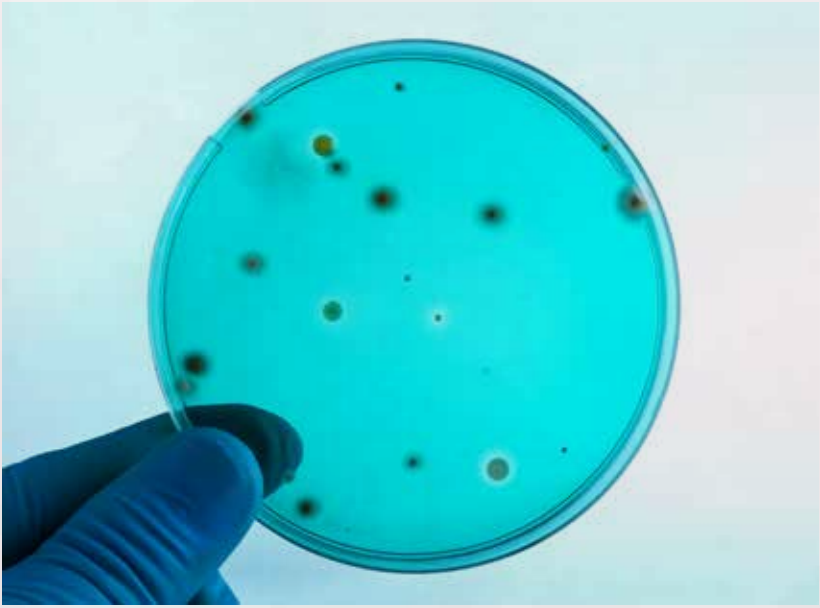
She noted that doctors with an illness came to the attention of the Committee by a number of avenues. These included self-referral or notification by colleagues, employers, supervisors, or family members. Sometimes, a doctor who had been referred to Council with a possible conduct or competence issue may have been directed to the Health Committee if it was thought that they had a health issue that was affecting their ability to function safely. The multiple potential lines of referral led to what Dr MacDonald described as the complexity of these situations. The unwell doctor usually already had a general practitioner or other treating doctor.

They may also have had a counsellor, social worker, or other health professional providing care for them. Their referral to the Health Committee almost invariably resulted in the need for an independent opinion, which increased the number of people involved.

The complexity of the various health issues involving doctors invariably led on to some of the dilemmas that Dr Macdonald discussed. These included the consequences, financial and personal, of doctors who were asked to withdraw from work or reduce their working hours. She recognised that the Committee needed to understand the concerns of employers, and the public, to have doctors who are fit enough to work, and the concerns of the treating doctors not to betray their patient-doctor. Additional problems could arise if the doctor was appearing to make poor choices such as refusing to cooperate with treatment or was in denial of the problem – in her words, 'focussing on public protection has to be the Committee's lodestone'.

Dr MacDonald regarded the reward of working for the Health Committee was that the majority of doctors were helped to continue working in some capacity by being helped to manage their illness in a way that helped them to practise safely. She also noted that, while some doctors may have had negative initial reactions to their involvement with the Committee, many expressed their gratitude at the conclusion of the process. In fact, some doctors chose to stay under the Committee's supervision, albeit at arm's length, as a form of safety net.

Finally, Dr MacDonald acknowledged the dedication and professionalism of the members of the Health team who had been ably led by Ms Lynne Urquhart since 1998.



CHAPTER 13: *COLE'S MEDICAL PRACTICE IN NEW ZEALAND* AND POSITION STATEMENTS

In the 1980s, medical students received a booklet concerning medico-legal matters that was written by Dr DS (David) Cole, Dean of the Auckland Medical School, and published with financial support by the Medical Protection Society. The content arose out of Professor Cole's lectures to fifth-year students at the Auckland Medical School who were about to become trainee interns. This eventually became a book and formed the basis of the Council's publication *Cole's Medical practice in New Zealand.* This has been edited for many years by Dr IM (Ian) St George.

As well as being editor of *Cole's Medical practice in New Zealand*, Dr St George was a long-serving Council member and former Deputy Chair of Council. New chapters have been added to *Cole's* on the basis of changing medical needs. Currently, *Cole's* is in its 13th edition (published February 2013) and is available online.

The Council also produces policy statements that are scheduled for review every 5 years. Prior to 1991, they used to be mailed out to doctors as they were developed or revised. They were then incorporated into the Medical Council newsletter, the first edition of which was published on 1 March 1991. Since 2000, they have been published on the Council's website.

Currently, there are 31 statements under the following headings.

- Medical care (4)
- Good prescribing practice (3)
- Communication and informed consent (8)
- Cultural competence (4)
- Management (1)

- Professionalism (7)
- Patients (4)

These position statements form the basis of what the Council regards as safe medical practice and have been developed and modified in the light of events. For example, *Communication and informed consent* was heavily influenced by the Cartwright Inquiry, and *Sexual boundaries in the doctor-patient relationship* has been modified in the light of some high-profile, but rare, conduct cases. The Council places great importance on its cultural competence statements, which are due for review and need to take into account New Zealand's increasing cultural diversity. Rapid advances in medical technology and communications necessitate regular review of policy as techniques such as distance reporting and robotic surgery develop.

CHAPTER 14: THE MEDICAL COUNCIL AND MEDICAL EDUCATION

Ensuring the quality of undergraduate and postgraduate medical education has been part of the core business of Council since its inception. Medical educators have played a vital role in informing and shaping the educational initiatives taken by the Council and the style of legislation required to enact them.

The Deans of the medical schools have been ex officio members of Council under most of the Acts guiding its legislation, and four Chairs of Council have been concurrently Deans of one of the schools during their tenure. Unlike the British General Medical Council, it did not concern itself with the conduct of medical education in the times of the first three Deans of the Otago School but did appoint inspectors to witness and report to them on the final professional examinations.

In early 1946, the University of New Zealand set up a committee to review medical education. This comprised the Chancellor and Vice-Chancellor (Chair) of the University of New Zealand, Sir Hugh Acland, Messrs Cocker, Herron, Johnstone, and Stout, and the Dean of the Medical Faculty. The whole question of medical education in New Zealand was considered, including the postgraduate phase. Interestingly, the outcome of the discussion was that the colleges considered that continuing professional development was the business of colleges and not that of Council.

Arguably, the most significant event in the development of the Medical Council's education strategy occurred in June 1965 as a result of a discussion paper produced by Sir Douglas Robb. He proposed the need for a council of medical education as he felt that medical education had largely been left to the Medical Faculty at the University of Otago. He believed that the Medical Council

should have educational powers similar to the General Medical Council. He was also foreshadowing the opening of the Auckland Medical School, which admitted its initial second-year intake in 1969. Sir Douglas had ideas that were ahead of his time, and 50 years later, many of his ideas are still key elements of education policy. He argued that medical education was a lifelong process involving undergraduate, graduate, and postgraduate phases. He suggested a regular 'warrant of fitness' for doctors, nowadays represented by continuing professional development, including regular practice review. He advocated a closer relationship between Council and the vocational colleges and the need to ensure a better learning experience in hospital runs for first and second-year doctors that Council should monitor. Effectively, these were the forerunner of hospital accreditation.

In June 1965, Council held an informal meeting to consider Sir Douglas's paper. It was attended by six Council members, the Secretary Mr Hindes, and representatives from the colleges of surgeons, physicians, psychiatrists, general practitioners, and obstetrics and gynaecology, together with representatives from the New Zealand Branch of the British Medical Association and the New Zealand Postgraduate Medical Foundation. This meeting was the forerunner to what was to become regular meetings between Council and the vocational colleges. Interestingly, not all agreed with Sir Douglas's ideas, with the physicians being particularly negative about hospital accreditation being undertaken by the Council.

The 1968 Act required the establishment a new body called the Medical Education Committee. This was separate from the Medical Council, with a clearly defined constitution, functions, and powers.

Membership of the Medical Education Committee included the Dean of the newly established Auckland School of Medicine. The Medical Education Committee was faced with a rapidly changing health environment, with health services being the subject of increasing public scrutiny. Questions were being asked about medical expertise and how medical knowledge should be learned and the processes in place for doctors to maintain their knowledge and skills beyond graduation from medical school. The conduct of medical practice was increasingly the subject of public debate from the point of view of the rights of patients.

Throughout the 1970s, the Medical Education Committee positioned itself to ensure that doctors embraced the importance of 'life-long learning' and that educational opportunities were provided not just by the vocational colleges but also by the hospitals for the growing number of prevocational doctors in their employment. It was recognised that a large proportion of resident doctors would be entering general practice, yet many were receiving 'service experience' that bore no relevance to their vocational intentions.

In October 1985, a national conference on medical education was held in Palmerston North. This was convened by Dr GL (Geoffrey) Brinkman, Dean of the Otago Medicine School and Council member. The principal theme was 'The standard expected of a medical graduate on qualification'.

THE RENWICK REPORT

In 1988, Council commissioned a report on the education of medical undergraduates in New Zealand. It was chaired by Mr William

Renwick, the recently retired Director-General of Education. The 10-member committee included lay people, university educators from various faculties, and four medical graduates. The terms of reference included a review of medical school admission policies, curriculum content, and examination and evaluation procedures. The Committee also considered the continuum of learning into the postgraduate years, including that provided by the vocational colleges.

The report produced 26 recommendations, the principal of which was that the Council should seek a change in section 9 of the Medical Practitioners Act 1968 to give it responsibility for the overall supervision of postgraduate as well as undergraduate medical education. Historically, there had always been a tension between Council and universities about this issue, but the Renwick Report set the stage for greater involvement by Council, which has continued to the present day.

Other recommendations included developing policies for increasing the number of graduate students, other health professionals, Māori and Pacific peoples, mature students with varied life experiences, and students with 'personal or social handicap or deficiencies in their schooling who are judged to have the potential to meet the requirements of a medical course'.

In April 1994, a workshop convened to review the educational programme of seventh-year interns emphasised the importance of structured educational programmes and learning activities. It was recommended that Council should encourage hospital consultants to create an environment conducive to apprenticeship training that included formal education underpinned by educational goals and plans.

The 1995 Act saw a complete restructuring of the Medical Education Committee, which included new flexibility of membership and the Council's ability to create a better balance of interests. With increased discretionary powers, it was acknowledged that Council and its committees needed to be responsible for fair, timely, and consistent decision making supported by sound justification. This reinforced the Education Committee's role and encouraged greater collaboration with stakeholders, including the Australian Medical Council.

The importance of joint accreditation standards between Australia and New Zealand was emphasised along with the need to extend these standards beyond undergraduate education to the vocational colleges and the prevocational years. This would represent a body of work continuing to the present time. In 1997, the Education Committee developed the first strategic plan for influencing undergraduate, early postgraduate, and vocational training in New Zealand in order to persuade key stakeholders to acknowledge that one of the responsibilities of the Crown Health Enterprises was the education and training of the New Zealand medical workforce. Over the next 2 years, the Education Committee developed and refined guidelines for learning outcomes for postgraduate years 1 and 2, and this was finally published as a policy statement in 1999. The document emphasised the importance of cognitive skills and knowledge, interpersonal and professional relationships, and technical skills.

Over the next few years, Council and the Education Committee worked closely with key stakeholders to progress the issues of medical education and training. The relationship with the Confederation of Postgraduate Medical Education Councils became particularly important, as this eventually became the peak body in Australia for

overseeing key developments in prevocational medical education and training matters in Australia and New Zealand. The Confederation of Postgraduate Medical Education Councils was strongly represented by key clinical educators, junior doctors, clinical supervisors, medical students, medical education staff, and other stakeholders in prevocational medical education. The Australian Curriculum Framework for Junior Doctors was developed under the auspices of the Confederation of Postgraduate Medical Education Councils by a writing group of experienced clinicians and educators. The Confederation of Postgraduate Medical Education Councils undertook extensive consultation and feedback prior to the launch of the Framework at the 11th National Prevocational Forum in Adelaide in November 2006.

There were now numerous reports exploring issues related to medical education, training, and the health workforce. This included reports from the Medical Training Board[63] and the Resident Medical Officers Commission.[64] Building on these reports, Council initiated a review of prevocational training in late 2010. This focused on issues relating to the education and training of doctors during postgraduate years 1 and 2. The review was undertaken by Council with the support of Health Workforce New Zealand. The intention of Council was to enhance and further develop the education and training of doctors during postgraduate years 1 and 2 to ensure they received the quality education and training experience they required.

The Council recognised that there are many stakeholders who each have an important role in service delivery, training, and support of doctors. Council supported greater collaboration between these

[63] Medical Training Board. *The Future of the Medical Workforce: First Annual Report November 2007 – December 2008*. Wellington: Ministry of Health, 2008; Medical Training Board. *Foundations of Excellence Building Infrastructure for Medical Education and Training*. Wellington: Ministry of Health, 2009.

[64] Commission on the Resident Medical Officer Workforce. *Treating People Well: Report of the Director-General of Health's Commission on the Resident Medical Officer Workforce*. Wellington: Ministry of Health, 2009.

stakeholders and recognised the importance of consensus in order to achieve the desired outcomes. In recognition of this Council established a stakeholder advisory group including representation from all the major stakeholder groups. The group provided a forum through which the Council and Health Workforce New Zealand could regularly engage with stakeholders about prevocational training and provided oversight of a Council plan to initiate a change process that would see a great improvement in the quality of prevocational training, thereby ensuring public safety and quality of care. A newly established prevocational training working group under the chairmanship of Professor JN (John) Nacey was given responsibility for carrying out the project. The group comprised individuals with expertise in medical education and a team of Council staff ably led by Council's Strategic Programme Manager Ms Joan Crawford.

The working group developed the standards for Council's own curriculum framework with detailed criteria against which training hospitals and the individual clinical attachments undertaken by doctors in postgraduate years 1 and 2 were to be accredited by Council.

The curriculum framework was based on the Australian curriculum framework and completed in 2012. This underpinned a great deal of the subsequent work. Council was determined to introduce quality-based learning in order to provide the greatest benefit to postgraduate years 1 and 2. The curriculum framework was designed to ensure that there are clear expectations for all involved in prevocational training. Specific attachment objectives linked to the curriculum framework allow for a clear and common understanding for interns, supervisors, and training providers of what needs to be addressed and achieved.

The framework builds on undergraduate medical education by instilling in recently graduated doctors the attributes of professionalism, communication, and patient care. It provides generic training that ensures doctors in postgraduate years 1 and 2 develop and demonstrate a range of essential interpersonal skills for managing patients with both acute and long-term conditions, regardless of the specialty. It also provides the opportunity to develop leadership, team work, and supervisory skills in order to deliver care in the setting of a contemporary multi-disciplinary team and to begin to make independent clinical decisions with appropriate support.

The prevocational changes were implemented in 2014 and supported by a web-based e-portfolio where new doctors are able to record and keep track of their learning. Council's achievement was duly recognised by the Confederation of Postgraduate Medical Education Councils. The Australian postgraduate medical councils awarded the prestigious Geoffrey Marel Medal to Professor Nacey to acknowledge his unprecedented contribution in promoting trans-Tasman links in prevocational training and the success of the comprehensive review of prevocational training arrangements in New Zealand.

OVERSIGHT OF PREVOCATIONAL TRAINING

The Council, under the Health Practitioners Competence Assurance Act 2003, has the authority to set competence and recertification programmes for doctors working to achieve general registration and to recertify once general registration has been achieved. The Council's role is primarily about the setting of standards, and this includes the provision of the curriculum framework for the postgraduate years 1 and 2.

Health Workforce New Zealand funds both prevocational and vocational trainees. Decisions made by Health Workforce New Zealand regarding the funding and therefore the ability of district health boards to provide accredited attachments can affect the ability of doctors to meet the Council's standards relating to prevocational training.

This highlights the important relationship between the Council in its role as regulator and Health Workforce New Zealand in its role as funder. Each organisation has separate, albeit related, areas of responsibility.

CHAPTER 15: LAY MEMBERS OF THE MEDICAL COUNCIL

The Medical Council of New Zealand has had lay members since 1984. Currently, there are four lay members (known as lay persons in the 2003 Act) who also serve on Council's Education, Health, and Audit Committees. Two lay members, Ms Liz Hird and Ms Laura Mueller, have also been elected to the position of Deputy Chair of Council. The current three-person performance assessment committees and professional conduct committees appointed by Council all have a lay member, often as Chair. The ideal number of lay members on Council is a matter of continuing debate, raised most recently in the Council for Healthcare Regulatory Excellence report of 2010 (see Chapter 8).

The first lay member was Mr DV Sutherland. He resigned after 1 year of his 3-year term because of pressure from his other commitments. The Minister of Health, the Hon Michael Bassett, then appointed Mrs Patricia Judd of Auckland, who served from 1985 until June 1998. Her term had been extended to assist with the issues arising from the transition from the 1968 Act to the 1995 Act.

Her contribution to Council cannot be overestimated. At times, being the sole lay member on Council must have been daunting, particularly considering some of the issues that came before Council during her tenure, including the report of the Cartwright Inquiry. She was awarded CNZM in the 1998 New Year's Honours for her services to Council as well as her additional appointments on ethics committees and Health Ministry working parties.

Strong submissions were made to the Health Select Committee considering the 1995 Bill for more lay representation on Council, and this led to the provision of three lay members on Council when the Act was passed, in addition to a lay member on each of Council's

complaints assessment committees. Nevertheless, it was late 1998 before the complement was reached. At this time, Ms Carolyn Bull, a solicitor from Christchurch, Mr Alexander Sundakov, an economist from Wellington, and Mr Henri van Roon, a management consultant from Auckland, joined the Council. Mrs Heather Thomson, a long-standing lay member, joined in 1999. The other lay members have been Ms Jean Hera, Ms Liz Hird, Ms Judith Fyfe, Ms Laura Mueller, Mr Jacob Te Kurapa, Ms Joy Quigley, Ms Susan Hughes QC, and Ms Kim Ngārimu.

Lay members each bring their own perspective to the role and are guided by their family and whānau, community, and professional and personal experiences. They are not bound by mandates to a 'constituency', and they are accountable only to the Minister. It is extremely rare for the lay members to vote one way and the medical members the other. Ms Georgina Jones reflects on how difficult it must have been to be a sole lay member.[65]

Mrs Thomson recalls that Council was a lot more formal when she joined and that Ms Bull helped to ease her into the role. Mrs Thomson said she hated being referred to as 'our Māori member'. She saw herself as a lay member and had hoped that the patient-centred care philosophy would have negated the need for a cultural representative.

She recalls one particularly unusual case that was heard by Council. This was an applicant for registration by a 'doctor' from the Middle East. His wife had notified Council of his alleged behavioural misdemeanours. In his defence, Council was asked by him to listen to a tape supposedly of his wife having sex. He then produced photos that he considered inappropriate of his wife cuddling their 4-year-old

[65] Jones, G. *The Medical Council of New Zealand: A Personal and Informal Perspective of Events During my Time as Chief Executive/Secretary/Registrar from 1986 to 2000.* Medical Council of New Zealand, 2002.

son. He permitted only Ms Bull and Mrs Thomson, the two female lay members, to view the photos, which looked quite normal to them. By the time Council got back to the doctor with the results of their deliberations, he had disappeared overseas. Further investigation revealed that the information he had given was false, and he had never qualified as a doctor!

The Council has been very fortunate to be served by such outstanding lay members. The Council for Healthcare Regulatory Excellence report of 2010[66] raised questions about a lay Chair and the balance of Council, which will be a source of ongoing debate as the Council moves on from its first 100 years.

[66] Council for Healthcare Regulatory Excellence (UK). *Performance Review of the Medical Council of New Zealand.* 2010.

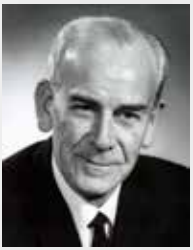
CHAPTER 16: COUNCIL LEADERS
















DOCTORS WHO HAVE CHAIRED THE MEDICAL COUNCIL OF NEW ZEALAND

Dr THA Valintine
1915–1920

Sir Lindo Ferguson
1919–1927

Dr W Irving
1927–1934

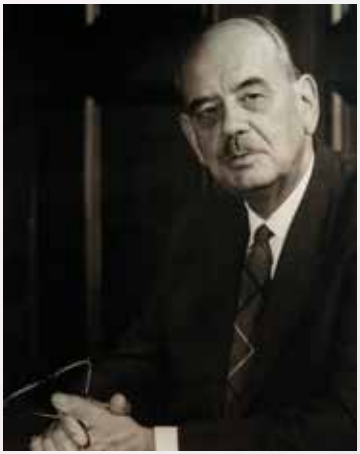
Dr WN Newlands
1934–1942

Sir Donald McGavin
1942–1948

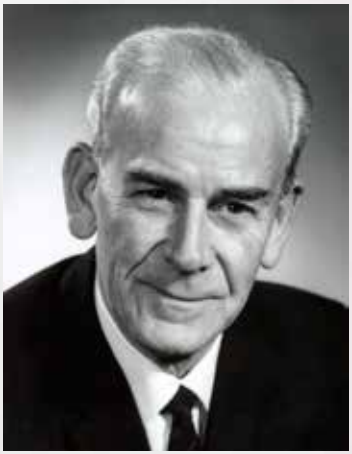
Dr PS Foster
1948–1957

Sir Edward Sayers
1957–1964

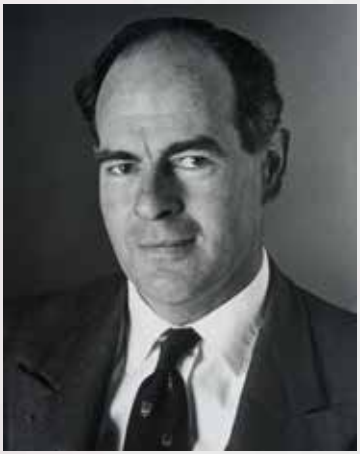
Dr JO Mercer
1964–1969



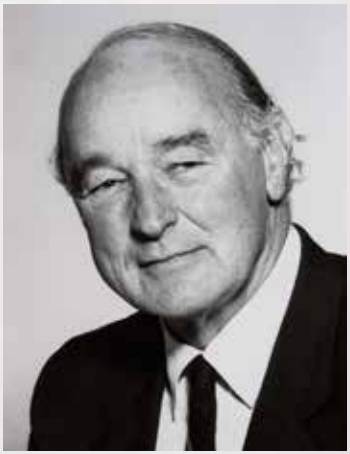
Sir Douglas Robb
1969–1972



Dr NF Greenslade
1972–1980



Dr HW Gowland
1980–1981



Dr AOM Gilmour
1981–1983

Dr WS Alexander
1983–1990

Dr RH Briant
1990–1995

Dr KJ Thomson
1995–1997

Dr MAH Baird
1998–2002

Professor AJ Campbell
2003–2010

Dr JB Adams
2010–2014

Mr AB Connolly
2014–

Medical Council of New Zealand 1969

Seated: Dr CLEL Sheppard, Professor WE Adams (Deputy Chair), Sir Douglas Robb (Chair), Dr JO Mercer, Professor CWD Lewis

Standing: Mr D Bassett (Assistant Secretary), Dr HW Gowland, Dr M Williams, Dr NF Greenslade, Dr DP Kennedy, Dr BW Grieve, Dr LA Scrivin, Mr KAG Hindes (Secretary)

Medical Council of New Zealand 1972

Seated: Professor RW Medlicott, Professor WE Adams (Deputy Chair), Dr NF Greenslade (Chair), Dr HW Gowland, Dr CLEL Sheppard

Standing: Mr KAG Hindes (Secretary) Dr DS Cole, Dr FB Desmond, Dr LA Scrivin, Dr M Williams, Dr DP Kennedy, Dr B W Grieve, Mr D Bassett (Assistant Secretary)

Medical Council of New Zealand 1975

Seated: Dr HW Gowland, Dr BW Grieve (Deputy Chair), Dr NF Greenslade (Chair), Dr HJH Hiddlestone, Professor RW Medlicott

Standing: Mr KAG Hindes (Secretary), Dr DS Cole, Dr FB Desmond, Dr AOM Gilmour, Dr WAB Brabazon, Dr LA Scrivin

Medical Council of New Zealand 1980

Seated: Dr BW Grieve, Dr AOM Gilmour (Deputy Chair), Dr HW Gowland (Chair), Dr NF Greenslade (Chair)

Standing: Mr KAG Hindes (Secretary), Dr PD Delany, Dr WAB Brabazon, Dr HJH Hiddlestone, Professor RW Medlicott, Professor GL Brinkman, Dr GPG Sim, Dr DS Cole

Medical Council of New Zealand 1983

Seated: Dr PD Delany, Dr EC Watson, Dr AOM Gilmour, Dr BW Grieve, Professor RW Medlicott

Standing: Dr T Farrar, Professor GL Brinkman, Dr WJ Pryor, Dr WS Alexander, Dr DS Cole, Dr RA Barker, Mr KAG Hindes

Medical Council of New Zealand 1986

Seated: Ms GA Jones (Secretary), Dr RH Briant, Dr WS Alexander (Chair), Professor DS Cole (Deputy Chair), Dr WS Pryor, Mrs PC Judd

Standing: Mr JR Coster (Assistant Secretary) Dr MM Herbert, Dr RG Gudex, Dr EC Watson, Professor JD Hunter, Dr GC Salmond, Dr T Farrar

Absent: Professor RW Medlicott

Medical Council of New Zealand 1990

Seated: Dr RG Gudex, Dr RH Briant (Deputy Chair), Dr WS Alexander (Chair), Mrs PC Judd, Dr CH Maclaurin

Standing: Dr MM Herbert, Ms GA Jones (Secretary), Dr GF Lamb, Dr JM Broadfoot, Dr IM St George, Dr PS Talbot, Dr JA Treadwell, Professor JD Hunter

Medical Council of New Zealand 1991

Seated: Dr IM St George, Ms GA Jones (Secretary), Dr RH Briant (Chair), Dr WS Alexander (Deputy Chair), Mrs PC Judd

Standing: Professor RDH Stewart, Dr MM Herbert, Dr JA Treadwell, Dr JM Broadfoot, Dr RG Gudex, Dr PS Talbot, Dr CH Maclaurin, Dr GF Lamb

Medical Council of New Zealand 1993

Seated: Dr MM Herbert, Dr RH Briant (Chair), Dr RG Gudex, Dr SL Kletchko, Professor JG Mortimer

Standing: Ms GA Jones (Secretary), Dr JA Treadwell, Dr IM St George, Dr CH Maclaurin, Dr KJ Thomson, Dr GF Lamb, Mrs PC Judd

Medical Council of New Zealand 1994

Seated: Dr JA Treadwell, Dr MM Herbert, Dr KJ Thomson, Dr RH Briant (Chair), Mrs PC Judd, Professor JG Mortimer

Standing: Dr GF Lamb, Dr RG Gudex, Dr IM St George, Dr CH Maclaurin, Dr CM Corkill, Ms GA Jones (Secretary)

Absent: Dr CM Feek

Medical Council of New Zealand 1995

Seated: Dr GF Lamb, Dr CM Corkill, Dr KJ Thomson (Chair), Mrs PC Judd, Professor JG Mortimer

Standing: Dr MM Herbert, Dr JA Treadwell, Dr RG Gudex, Dr CM Feek, Dr RH Briant, Dr CH Maclaurin, Ms GA Jones (Secretary)

Absent: Dr IM St George

Medical Council of New Zealand 1996

Left to right: Professor JG Mortimer, Dr RH Briant, Dr SL Kletchko, Dr JA Treadwell, Dr RG Gudex, Dr CM Corkill, Dr IM St George, Dr KJ Thomson (Chair), Dr GF Lamb (Deputy Chair), Ms GA Jones (Registrar and Chief Executive), Dr MM Herbert, Mrs PC Judd, Dr CH Maclaurin

Medical Council of New Zealand 1997

Seated: Mrs PC Judd, Dr KJ Thomson (President), Professor JG Mortimer, Ms GA Jones (Registrar and Chief Executive)

Standing: Dr MAH Baird, Dr SL Kletchko, Mr HT van Roon, Dr MJ Adams, Dr A J Scott

Absent: Dr IM St George (Deputy President)

Medical Council of New Zealand 1998

Seated: Dr SL Kletchko, Dr MAH Baird (President), Dr IM St George (Deputy President), Mrs PC Judd

Standing: Ms GA Jones (Registrar and Chief Executive), Miss CM Bull, Dr TW McKergow, Mr HT van Roon, Dr AJ Scott, Professor IJ Simpson, Dr MJ Adams

Medical Council of New Zealand 1999

Left to right: Mr A Sundakov, Dr AJ Scott, Professor IJ Simpson, Dr IM St George (Deputy President), Ms GA Jones (Registrar), Dr AA Ruakere, Dr MAH Baird (President), Dr TW McKergow, Miss CM Bull, Dr MJ Adams, Mr HT van Roon, Ms SL Ineson (Chief Executive)

Medical Council of New Zealand 2000

Seated: Mrs H Thomson, Ms SL Ineson (Chief Executive), Dr MAH Baird (President), Dr IM St George (Deputy President)

Standing: Ms GA Jones (Registrar), Dr MJ Adams, Miss CM Bull, Dr JM Neutze, Mr A Sundakov, Professor IJ Simpson

Absent: Dr TW McKergow

Medical Council of New Zealand 2001

Seated: Dr J MacDonald, Dr IM St George (Deputy President), Dr MAH Baird (President), Dr DA Read

Standing: Ms SL Ineson (Chief Executive), Mr A Sundakov, Dr MJ Adams, Dr JM Neutze, Miss CM Bull, Mrs H Thomson

Medical Council of New Zealand 2002

Seated: Dr DA Read (Deputy President), Dr MAH Baird (President), Ms SL Ineson (Chief Executive), Mrs H Thomson

Standing: Ms J Hera, Dr J MacDonald, Dr PM Barham, Dr JM Neutze, Dr MJ Adams, Proessor AJ Campbell, Miss CM Bull

Medical Council of New Zealand 2003

Seated: Ms SL Ineson (Chief Executive), Professor AJ Campbell (President), Dr J MacDonald,
Dr DA Read (Deputy President)

Standing: Dr B Bond, Miss TM Turfrey (Registrar), Dr P Mackay, Ms J Hera, Dr PM Barham, Dr K O'Connor, Mrs H Thomson, Miss CM Bull

Medical Council of New Zealand 2004

Seated: Ms SL Ineson (Chief Executive), Dr DA Read (Deputy President), Professor AJ Campbell (President), Miss TM Turfrey (Registrar)

Standing: Dr PM Barham, Dr K O'Connor, Mrs H Thomson, Dr J MacDonald, Ms J Hera, Dr B Bond

Absent: Dr P Mackay, Ms L Hird

Medical Council of New Zealand 2005

Seated: Miss TM Turfrey (Registrar),Ms SL Ineson (Chief Executive), Professor AJ Campbell (Chair), Dr DA Read (Deputy Chair)

Standing: Dr B Bond, Dr KA O'Connor, Dr PM Barham, Dr J MacDonald, Dr PW Moller, Ms L Hird, Mrs H Thomson, Ms J Hera

Medical Council of New Zealand 2006

Seated: Dr J MacDonald, Dr DA Read (Deputy Chair), Professor AJ Campbell (Chair), Mr P Pigou (Chief Executive)

Standing: Ms J Hera, Dr BR Bond, Mrs H Thomson, Dr PM Barham, Dr KA O'Connor, Dr PW Moller, Ms L Hird

Medical Council of New Zealand 2007

Seated: Dr J MacDonald, Dr DA Read (Deputy Chair), Professor AJ Campbell (Chair), Mr P Pigou (Chief Executive)

Standing: Dr IM St George, Dr KA O'Connor, Mr Simon Robb (Registrar), Ms L Hird, Dr PW Moller, Mrs H Thomson, Dr BR Bond, Dr RH Acland, Ms J Hera

Medical Council of New Zealand 2008

Seated: Dr AR Fraser, Dr KA O'Connor, Professor AJ Campbell (Chair), Mr P Pigou (Chief Executive), Ms J Fyfe

Standing: Mr DP Dunbar (Registrar), Dr JB Adams, Ms J Hera, Dr RH Acland, Dr PW Moller, Ms L Hird, Dr BR Bond, Mrs H Thomson, Dr IM St George

Medical Council of New Zealand 2010

Seated: Mrs L Mueller, Dr AR Fraser, Dr KA O'Connor, Dr JB Adams (Chair), Mr AB Connolly, Ms L Hird

Standing: Mr P Pigou (Chief Executive), Professor JN Nacey, Professor R Sainsbury, Dr RH Acland, Mrs H Thomson, Mr PD Dunbar (Registrar), Dr JEM Fox, Ms J Fyfe

Medical Council of New Zealand 2011

Seated: Mr P Pigou (Chief Executive), Dr AR Fraser, Ms L Hird (Deputy Chair), Dr JB Adams (Chair), Mr AB Connolly, Mrs H Thomson

Standing: Dr KA O'Connor, Professor JN Nacey, Dr JEM Fox, Mr DP Dunbar (Registrar), Dr RH Acland, Mrs L Mueller, Professor R Sainsbury, Ms J Fyfe

Medical Council of New Zealand 2012

Seated: Ms L Hird, Ms J Quigley, Mr AB Connolly (Deputy Chair), Dr JB Adams (Chair), Mr P Pigou (Chief Executive), Dr AR Fraser, Ms L Mueller

Standing: Professor JN Nacey, Dr JEM Fox, Mr DP Dunbar (Registrar), Dr PH Robinson, Dr RH Acland, Professor R Sainsbury, Mr J Te Kurapa

SECRETARIES/REGISTRARS/CHIEF EXECUTIVE OFFICERS OF THE MEDICAL COUNCIL OF NEW ZEALAND

Name	Title	Period of service
T Hope-Lewis	Secretary	1914
CJ Drake	Secretary	21 May 1919 – 17 November 1948
JF Tasker	Secretary	23 February 1949 – 18 November 1954
M Dew	Secretary	18 November 1954 – 13 September 1961
Ken Hindes	Secretary	14 September 1961 – 20 December 1985
Georgina Jones	Secretary/CEO	26 May 1986 – 4 August 1998
Georgina Jones	Registrar	5 August 1998 – 30 June 2000
Sue Ineson	CEO	5 August 1998 – 31 October 2005
Philip Pigou	CEO	14 November 2005 –
Tanya Turfrey	Registrar	26 June 2000 – 21 April 2006
Simon Robb	Registrar	26 June 2006 – 4 November 2008
David Dunbar	Registrar	9 February 2009 –
Susan Yorke	Deputy Registrar	11 May 2015 –

Ken Hindes

Just before Christmas 1985, after 25 years' service as Secretary of the Council, Mr KAG Hindes resigned. Ken Hindes was a former public servant in what was then the Health Department, now the Ministry of Health, and had taken over the role of Secretary to Council in 1961 when the Department still provided the Council's secretarial services. The following tribute was paid to him in the Council's 1986 annual report:

> Members of the medical and dental professions will have noticed that the signature on their annual practising certificates this year is not that familiar signature of K A G. Hindes. After service to the professions for 26 years Ken Hindes has resigned. Mr Hindes first became responsible for the affairs of the Medical Council when the secretarial services were provided by the Health Department of which he was then a member. Sometime later the activities of the Medical and Dental Councils and of the Medical Research Council were moved out of the Health Department and Mr Hindes left the employ of the Department to become the Secretary of all three bodies in their new quarters. When the administrative offices of the Medical Research Council were moved away from Wellington Mr Hindes continued as the Secretary to the Medical and Dental Councils until his resignation at the end of 1985.
>
> During these years the Councils moved several times occupying accommodation in an office block on The Terrace, a house in Webb Street and a suite above the Urgent Pharmacy in Cambridge Terrace. Each shift must have been a considerable strain on the keeper of the records. All the files and registers

had to be accessible and locatable within hours of each move. For those who were more closely associated with Council activities the meticulous accuracy and attention to detail involved in the maintenance of the record system was always a source of wonder. Everything was checked and rechecked and every transaction for each doctor or dentist was recorded in the personal file. Despite the enormous volume of paper work involved it was always a source of amazement to find how Mr Hindes' phenomenal memory carried the details of matters long since passed and how the records confirmed his recollection of these events.

The Councils have had the benefit of a long period of dedicated service from a very able man. Those who come after will have the advantage of a carefully maintained record system and, while they may have the assistance of modern data-processing equipment, they will have a tradition of accuracy and completeness which will be difficult to maintain and impossible to surpass.

Ken Hindes has served our professions well and we owe a considerable debt of gratitude for his selfless dedication to the requirements of the registration bodies. His knowledge of precedent and of past problems will be missed. We wish him well in the future and thank him for his contribution to the Medical and Dental Councils for the past 26 years.[67]

[67] Medical Council of New Zealand. *Annual Report*. 1986.

Georgina Jones

The Council premises in the Pharmacy Building in Cambridge Terrace were only ever considered to be temporary. In late 1985, the Council leased the top floor of the ANZ Bank Building at 73 Courtenay Place (now the Mermaid striptease and massage parlour!). The move was not totally complete until May 1986 when the new Chief Executive/ Secretary arrived.

Mr Hindes' successor as Secretary and Chief Executive Officer was Ms Georgina Jones who had been working at the University of Auckland School of Medicine. She learned of the vacancy from Dr DS (David) Cole who was then Dean of the Auckland School and Deputy Chair of Council. She set about making changes. At morning tea on the first day, she noticed that it was delivered from an urn on a trolley in thick cups like those of railway cafeterias of the time. She also noticed that saucers were being used as ashtrays. At afternoon tea, she announced that, from day two of her tenure, the office was going to be smokefree. This was accepted with minimal discord despite being many years before the enactment of smokefree legislation. She was also keen to remove sexist language. Despite the fact that she used to sign her letters with her full name and title, it frustrated her that, after over 2 years in post, she was still receiving letters addressed 'Dear Sir'.[68]

Ms Jones is widely credited as one of the major driving forces behind the development of the 'new legislation', the Medical Practitioners Act 1995. When she took up her post in May 1986, it was expected that the introduction of the Bill to enact the new legislation was imminent. It was a matter of great frustration to her, several Chairs of Council, and the Council members of the time that it was a further

[68] Jones, G. *The Medical Council of New Zealand: A Personal and Informal Perspective of Events During my Time as Chief Executive/Secretary/Registrar from 1986 to 2000*. Medical Council of New Zealand, 2002.

9 years before the Bill was passed. It should be remembered that a new Act had first been proposed in the late 1970s, so it was for the best part of 17 years before action was taken. Ms Jones attributes the delay not only to a number of changes of Government but also to the major policy changes that were occurring at the time.

Between 1987 and 1990, there was discord within the Labour Party between the monetary reformists and those who wanted to pause and – in the expression of then Prime Minister the Rt Hon David Lange – call for a cup of tea. When the National Party assumed power in 1990, major health reforms were introduced, so it is not surprising that the issue of medical regulation was delayed until the future shape of the health service was established.

The period after the implementation of the 1995 Act was particularly busy for Council because of the overlap in the provisions of the old and new Acts. Ms Jones guided Council through this time with great skill. Her other major contribution was the overseas contacts that she developed, which were of particular value to Council in the development of continuing professional development.

In her final Registrar's report in Council's 2000 annual report, she observed:

> Vigilance over delivery of all services is more essential now than it ever was. In 2000 I think Council's greatest challenges are to:
>
> - transform the words registration, supervision, oversight and recertification into something real for public protection, to benefit the public and the profession;
> - facilitate cooperation and fearless self scrutiny throughout the health sector to build confidence while simultaneously

identifying and acting on weaknesses, before the public has to raise the alarm;

- insist that reliable frameworks and adequate resources support medical regulators' work everywhere.

It has been a privilege to work with doctors and the public. I will continue to monitor progress, and, I hope, contribute to it as an informed member of the community.[69]

Her personal and informative perspective of events during her time as Chief Executive/Secretary/Registrar from 1986 to 2000 has formed a substantial contribution to this present history of the Council.

Sue Ineson

Sue Ineson joined the Council in August 1998 having been Executive Director of the New Zealand Family Planning Association for the previous 5 years and, before that, the National Director of Barnados. For several years, she had been Chair of Amnesty International Aotearoa New Zealand, and in 1986, she was awarded a QSM for community service. She left Council in 2006 to manage her own health consultancy business.

When Ms Ineson became Chief Executive Officer, Ms Jones became the Registrar. As Chief Executive Officer, Ms Ineson had to guide the implementation of the Health Practitioners Competence Assurance Act 2003. She was also responsible for ensuring that mechanisms were in place for auditing continuing professional development.

The incoming Chief Executive Officer, Philip Pigou, acknowledged in the 2006 annual report the contributions that Ms Ineson had made to the work and profile over the past 7 years and noted that her work

[69] Medical Council of New Zealand. *Annual Report*. 2000.

and vision for the Council had left the organisation in good stead for the challenges ahead.

Philip Pigou

Mr Philip Pigou became Chief Executive Officer of the Council in November 2005. He has a Bachelor of Law degree and a postgraduate Diploma in Business focusing on general management and leadership. Previously, he had worked in the health sector (Health Funding Authority and South Island Shared Service Agency Ltd) and in the courts. He has brought a strategic vision to the Council.

In 2012, Mr Pigou received a major honour when he was installed as Chair of the International Association of Medical Regulatory Authorities for a 2-year term. The Association's purpose is to encourage best practice among medical regulatory authorities worldwide in the achievement of their mandate – to protect, promote, and maintain the health and safety of the public by ensuring proper standards for the profession of medicine.

Setting out a road map for his 2-year term, Mr Pigou told Association delegates that the three key things to ensuring patient safety were:

- sharing knowledge and information about best practice and solutions to key policy issues
- sharing information about migrating doctors
- assisting countries develop their regulatory systems

All of these directions require good relationships within International Association of Medical Regulatory Authorities – and with other relevant groups. There have been and continue to be policy issues that many of us face in our day-to-day practice.

> This includes how we ensure doctors are competent to practise. Whether we call it recertification, revalidation or maintenance of licensure – ensuring the competence of doctors is one major policy issue we face.[70]

Ms Sue Ineson, the former Chief Executive Officer of the Council, also served on the Executive of the International Association of Medical Regulatory Authorities, and in 2015, a senior manager of the Medical Council, Ms Valencia Van Dyk, was elected to the management committee of the Association.

David Dunbar

Mr David Dunbar is the Council's current Registrar and a qualified lawyer. Before joining the Council in 2009, he was the Registrar of the Dental Council of New Zealand. In 2014, he was elected Chair of the International Physician Assessment Coalition – a network of organisations, academics, and practitioners with an interest in assessment and remediation best practice.

He is Vice-President of the Wellington Branch of the New Zealand Law Society and a member of the governance committee of the Corporate Lawyers Association of New Zealand. Mr Dunbar was heavily involved in the development and implementation of the Health Practitioners Competence Assurance Act 2003 in his role as a senior analyst with the Ministry of Health.

[70] 'New Zealander installed as chair of International Association of Medical Regulatory Authorities.' *New Zealand Doctor*. 15 October 2012.

MEDICAL ADVISERS

The position of medical adviser to the Council arose principally from the performance clause in the 1995 Act, which Dr St George, one of the early medical advisers, described as 'revolutionary'. Dr St George feels this made matters more just and fairer. In many cases, patient complainants just wanted the doctor to learn from the mistake rather than be punished.

Prior to this, Dr St George believes there were cases where doctors were being disciplined for being in unfortunate medical situations that anyone might encounter. Dr St George held the position from 2001 until 2006. Before this, he had been a Ministerial appointee to the Council, and in 2006, he became an elected member.

Dr IM (Ian) Brown, an obstetrician and gynaecologist, became a medical adviser in February 2009 and served until May 2012. Council recognised that there was a need for a second medical adviser, and Dr Steven Lillis, a Hamilton general practitioner, was appointed in February 2007. He has been instrumental in developing and refining the New Zealand Registration Examination (see Chapter 10).

There are two factors that have markedly increased the workload of medical advisers.

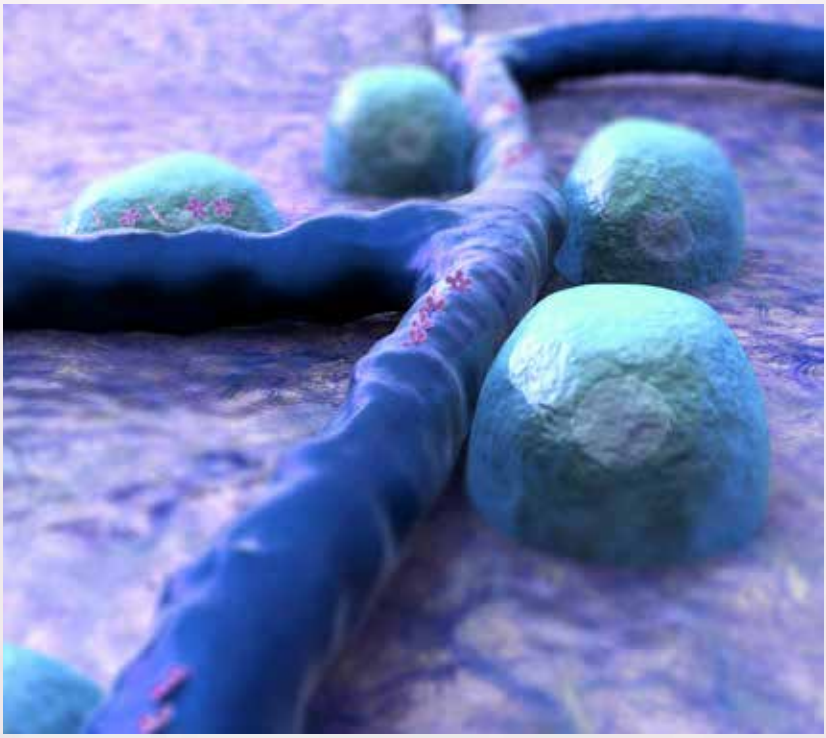
- The development of vocational practice assessments. These are undertaken to determine if a doctor (usually an overseas qualified specialist seeking New Zealand registration) is practising at the standard of an Australasian-trained specialist.
- Increased educational programmes for doctors who have been found wanting in a competence review. As well as helping to

design appropriate education programmes for doctors needing remediation, a medical adviser might also visit a workplace to determine whether any systems problems are contributing to a doctor's poor performance.

With the development of mandatory regular practice review and the increased sophistication of continuing professional development, it is likely that the work of the medical advisers will increase further in the future.

Medical adviser	**Period of service**
Dr JM (Jocelyn) Tracey	17 August 2008 – 31 December 1999
Dr JS (John) Simpson	1 December 1998 – 28 February 2001
Dr IM (Ian) St George	9 July 2001 – 7 August 2006
Dr CMT (Nina) Sawicki	17 September 2007 – 20 March 2008
Dr S (Steven) Lillis	5 February 2007 –
Dr IM (Ian) Brown	10 February 2009 – 2 May 2012
Dr KA (Kevin) Morris	27 August 2012 –

CHAPTER 17: ON SHAKY GROUND – THE COUNCIL RELOCATES IN 2013



The Council's current headquarters is situated at 80 The Terrace, Wellington. Formerly, the Council had been on levels 13 and 14 at 139 Willis Street, Wellington. Following the Christchurch earthquake in February 2011 and the earthquakes centred in Seddon and felt heavily in Wellington during July and August 2013, there was an increased awareness and concerns about the suitability of the Willis Street offices. Many staff were unnerved by the Seddon earthquakes and the integrity of the building they worked in.

The Council had noted that, during the 2013 Wellington earthquakes, some structural damage had occurred in the basement area of the leased building. Council was reassured by the engineering reports provided by a national engineering firm that the building was structurally sound, and this was compounded by the understanding that the leased building was at 71 percent of the new building standard, which exceeded the industry standard of being in excess of 67 percent of the new building standard.

Information provided by the building owner, Brookfield Funds Management Ltd (Brookfield), to the Medical Council on 17 December 2013 as a result of further structural analysis undertaken by the Beca Group indicated that the building occupied by the Council was only at 40 percent of the new building standard.

Although strengthening work on the stairwells for the building was being undertaken by Fletcher Construction, the engineering report advised that, even when the stairwell work had been completed, the building would still only get to 55 percent of the new building standard.

As soon as Corporate Services Manager Peter Searle became aware of this information, steps were taken to immediately notify Council

Chief Executive Philip Pigou of the risk to staff and Council. Chair Dr John Adams, Deputy Chair Laura Mueller, and Chair of the Audit Committee Mr Jacob Te Kurapa were all told of this new information immediately. Mr Te Kurapa requested that a special meeting of the Audit Committee be established with the purpose of discussing options available to Council.

On the morning of 18 December 2013, Mr Pigou called a staff meeting and told staff about the new rating and immediately closed the office. Other tenants in the building, The Public Trust and Contact Energy, subsequently vacated the building, leaving the Nursing Council of New Zealand as the sole tenant.

Council staff subsequently worked from home, keeping the Council's core service functions of health, professional standards, and registration going, and communicated with each other through email and Facebook.

On 23 December 2013, Council met and considered three options.

- Continue with the existing lease until April 2015. This was not a preferred option to the Council's management.
- Break the lease immediately and move into temporary premises until such time as more adequate premises may be located.
- Break the lease immediately and relocate to new premises that met a standard to be determined by Council management that is satisfactorily acceptable to Council, staff, and stakeholders.

The Council opted for the second option.

In the one remaining business day before the Christmas break, Corporate Services Manager Peter Searle and Gay Fraser from the

Health Practitioners Disciplinary Tribunal worked tirelessly with letting agents to find temporary accommodation for the Council staff, finally settling on the 'old' Customhouse in Whitmore Street.

The corporate services team worked through their holidays, together with movers, packing up the office and infrastructure needed to support the business for the move to Whitmore Street.

On Monday 6 January 2014, staff arrived at their new workplace to find their computers and desks set up and surrounded by cardboard boxes of files and personal possessions. The new office was spread between three floors, affecting the interaction and communication between teams.

A 6.2 magnitude earthquake on Wellington Anniversary Day January 2014 vindicated the decision to leave the Willis Street building for staff and Council alike.

Mr Searle scoured Wellington looking for suitable long-term premises before recommending floors 6 and 7 at 80 The Terrace, Wellington. Council approved the new premises at a meeting in April 2014.

The building, which accommodates the New Zealand Fire Service office and engineering firms, has been earthquake strengthened and meets 80 percent of the new building standard. Over the next 3 months, the floors were fitted out with new meeting and interview rooms, kitchens, and offices for managers following consultation and feedback from staff. Staff moved into their open-plan work space with views over State Highway 1 and Te Ahumairangi Hill (Tinakori Hill) on 25 July 2014.

That business continuity for the Council during 6 disruptive months was seamless is a tribute to the focus and commitment of Mr Searle and his corporate services team.

CHAPTER 18: THE MEDICAL COUNCIL CENTENARY DINNER

Mr Andrew B Connolly, Medical Council, Chair and the Hon Dr Jonathan D Coleman, Minister of Health.

On 10 March 2015, a dinner was held at The Grand Hall of the Old Parliament Building in Wellington to celebrate the centenary of the Medical Council of New Zealand.

This was hosted by the Minister of Health, the Hon Dr Jonathan Coleman, and was attended by around 120 guests including past and present Council members and Chairs, the three Health and Disability Commissioners, a number of barristers with expertise in representing doctors, chief medical officers, senior management from district health boards, and other distinguished guests.

Council was particularly honoured by the presence of Executive Director of the Medical Council of Canada Dr Ian Bowmer, Chief Executive Officer of the Australian Medical Council Mr Ian Frank, President of the Australian Medical Council Professor Robin Mortimer, and Chair of the Medical Board of Australia Dr Joanna Flynn. Master of ceremonies for the evening was Ms Joy Quigley, a lay Council member and former Member of Parliament. There were addresses by the Minister and by Mr Andrew Connolly, current Chair of Council.

The after-dinner speaker was Dr Glenn Colquhoun, doctor, poet, and children's writer, who has won Best First Book of Poetry at the 2000 Montana New Zealand Book Awards and the Montana Readers' Choice Award in 2003. In 2004, he was the recipient of the Prize in Modern Letters. He was a superb choice, entertaining and challenging the audience with his mixture of humility, philosophy, and reflection about the practice of medicine.















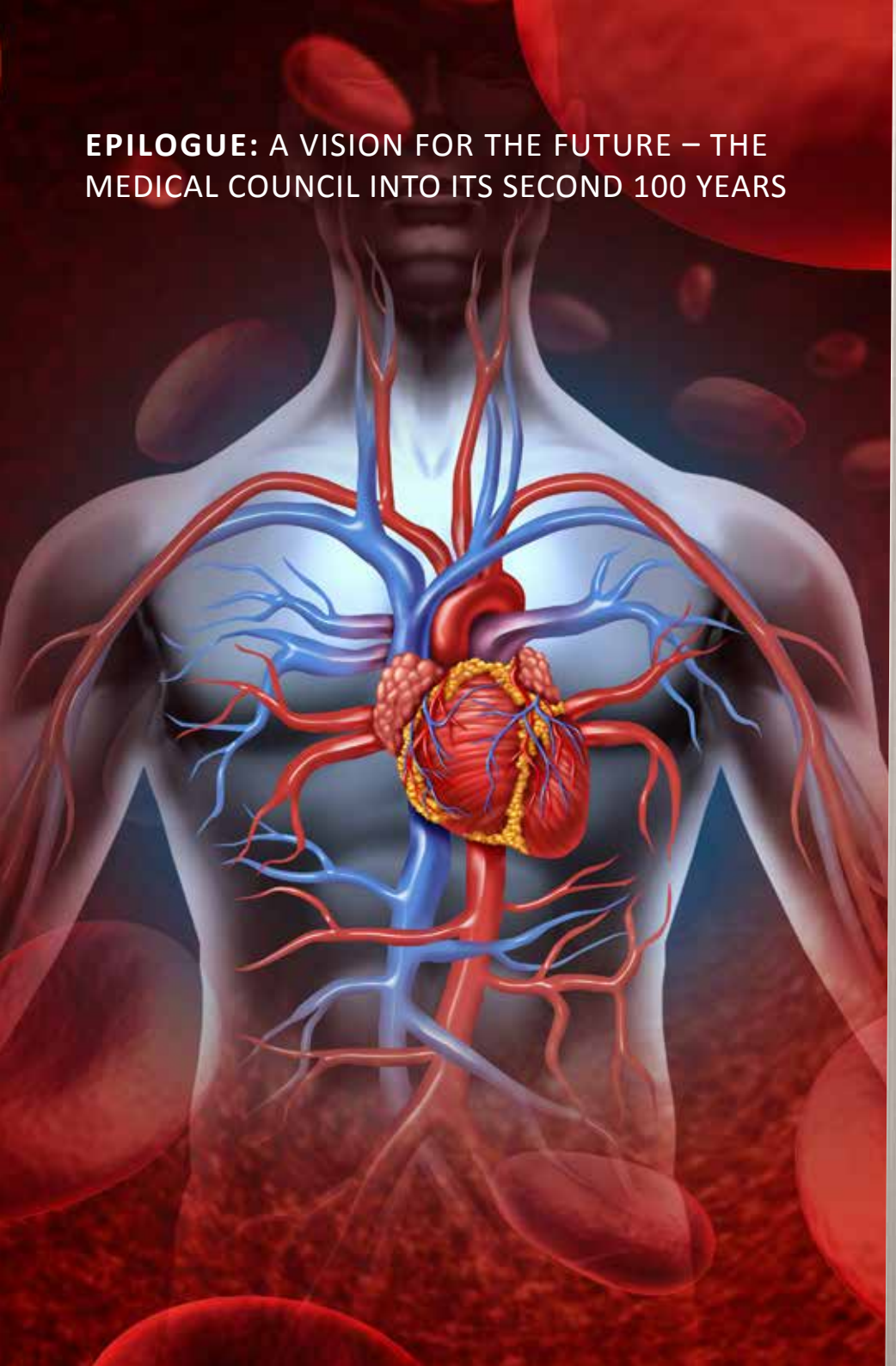









EPILOGUE: A VISION FOR THE FUTURE – THE MEDICAL COUNCIL INTO ITS SECOND 100 YEARS



As the Council celebrates its first centenary, it is appropriate to look into the future and consider possible forthcoming challenges. Given the rapid advances in medical technology and treatments, particularly since the Second World War, it would be both bold and unwise to predict what will be happening in 2115. Doing that only runs the risk of providing a source of humour to a future generation. Nevertheless, it is interesting to speculate on and discuss some of the challenges of the foreseeable future. Mr AB (Andrew) Connolly, the current Chair of Council, and others have provided thoughts on a number of issues worth consideration.

Mr Connolly sees the key in the immediate future is around the concept of how to ensure we maintain competence relevant to the doctor's scope of practice. This ties in with performance. Revalidation and recertification should be a sum of knowledge and skills gained plus a robust assessment of how the doctor is performing. These then allow logical planning for the knowledge and skills to be gained within the next 12-month revalidation cycle. This needs investment in data and time to allow clinicians to effectively review and plan. It also needs considerable 'investment' by clinicians to remember that they are professionals. The work that Council has commenced on continuing professional development, revalidation, and recertification will need to be further developed.

Public release of more performance data on individual clinicians and departments can be anticipated. The National Health Service in the United Kingdom already does this in broad terms. Professor Ron Paterson, the previous Health and Disability Commissioner, argues strongly for this in his book *The Good Doctor: What Patients Want*,[71] and this view is broadly supported. The key point is context – if it is

[71] Paterson, R. *The Good Doctor: What Patients Want*. Auckland: University Press, 2012.

done right, it will not be a bad thing. The challenge to the Council will be aiding the debate as to how to achieve balance and context.

Mr Connolly's personal view is that the Health Quality and Safety Commission should be responsible for this process and release the data. It does involve the Council, as it may face complaints from the public and possibly the profession about outcomes and published data. It is possible that some doctors could use the data as advertising, comparing their figures to others in the field. Council will need to lead the profession through the debate and police the outcomes.

Technology will continue to expand at an ever-increasing rate, and this will change the way the profession works and how patients interact with the profession. Council has already had to debate the question of telemedicine, which has been identified as an area for strategic development. Telehealth will continue and expand. Overseas-based doctors can deliver healthcare such as radiology and pathology reporting. Distance consultation has proved of great value in large geographical areas such as Queensland and has the potential to be used across countries. Surgeons can already perform robotic surgery via the internet. This has huge implications for Council as it will need systems to assess qualifications and experience. Transnational agreements and processes will be needed to ensure maintenance of competence and public safety.

Major changes in the health workforce are already occurring and will continue. The population of New Zealand is ageing, as are doctors in a number of specialty groups, particularly general practice. The traditional model of general practice is not always attractive to younger doctors, particularly those with young families.

General practice is also being affected by the development of vocational scopes such as urgent care and rural health medicine. The Council has always recognised the central importance of general practice, and this should continue despite demographic changes and the development of new scopes and styles of practice. Future Councils will need to ensure that standards of competency are maintained despite changes in practice patterns.

The traditional nursing role is expanding, and there have been some trials of extended non-doctor roles such as physician assistants. The changes may be made easier by technology, but for Council, the key issues will involve the role of doctors in the appropriateness of delegation of tasks and the supervision of any non-medical staff under the delegated authority of a doctor. The Health Practitioners Competence Assurance Act 2003 is due for review, and this will undoubtedly include a consideration of which, if any, new professions should be covered by the Act.

For the first time in New Zealand's history the proportion of medical students identifying as Māori has reached parity with the proportion of Māori in the country. This is a very important achievement and on that the Council believes needs to lead to Māori completing specialist training programmes in similar proportions to non-Māori doctors. Council is beginning an important body of work on the role medical regulation should play in reducing health inequity for Māori.

Medical workforce distribution (both by numbers and geography) is increasingly involving Council, especially in the arena of what doctors in postgraduate years 1 and 2 do and where they can do it. This will continue as an important theme, and Council's role in accreditation

of training sites and supervisors will increase. Mr Connolly anticipates that Council will also need to be more influential in terms of power to make changes and a link between Council's assessment of training posts and their effectiveness and Health Workforce New Zealand funding. It is hoped that this will enhance education. Registration of trainee interns with the Council is imminent, and registration of all medical students could occur. This should help define scopes of practice and make new doctors more prepared for practice.

The ageing population will also raise challenges to healthcare. These will arise through the increase in numbers of very old people, many of whom will have multiple pathology, and the types and complexity of treatments that are possible. It has been known for some time that the majority of health funding occurs in the last year of a person's life. Decisions about withdrawing life-extending or life-sustaining treatments are becoming more common. In addition, the debate about the legalisation of voluntary active euthanasia is intensifying. Council will have an increasing role in setting the ethical framework for the profession.

Advances in treatments will raise more ethical considerations by Council. For instance, the array of uses of gene therapies and stem cells will probably be determined by Parliament, or at least by the Government under funding decisions. The financial cost of healthcare versus the ability of the country to fund it will mean a change in the overall way doctors approach each patient. Doctors need to be encouraged to be far more aware of the overall costs of healthcare and to accept that doctors will have to make decisions based not only on what is best for the individual patient but what is also right for the overall health of the country. This will need careful thought, debate, and clear guidance, and Council will have a key and central role.


Medical Council
of New Zealand
Te Kaunihera Rata
o Aotearoa