

**UNDER THE HEALTH & DISABILITY
SERVICES ACT 1993**

**IN THE MATTER OF THE MINISTERIAL
INQUIRY INTO THE UNDER-
REPORTING OF CERVICAL SMEAR
ABNORMALITIES**

BRIEF OF EVIDENCE OF GEORGINA ALICE JONES

16 JUNE 2000

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INTRODUCTION

- 1 My full name is Georgina Alice Jones. I am the Registrar of the Medical Council of New Zealand. I have held this position since 26 May 1986. I am retiring from the Medical Council on 30 June 2000.

BACKGROUND

The Principal Focus of the 1968 Act

- 2 The Medical Practitioners Act 1968, which came into effect on 11 December 1968 (superseding the Medical Practitioners Act 1950 and its Amendment Act 1962) was described as:

“An Act to consolidate and amend the law relating to the registration and control of medical practitioners”.

While the Act itself did not have a clause specifically setting out the principal purpose (in contrast to the Medical Practitioners Act 1995, s3) the Act is set out under the following major headings:

- (a) Medical Council of New Zealand and committees;
 - (b) registration;
 - (c) discipline within the medical profession;
 - (d) general (includes requirement for annual practising certificates and other restrictions on who may practise lawfully under the title “registered medical practitioner”).
- 3 This Act (and all amendments and regulations related to it) focused on the occupational regulation of individual medical practitioners.
 - 4 The Act gave no powers to Council to look at systems issues or wider aspects of medical practice beyond any issue pertaining to an individual registered medical practitioner, or an applicant for registration.

- 5 The Council had no role as a purchaser of services (and therefore no need to monitor or audit such services) nor did it have the overview/monitoring/enforcement role of the Ministry of Health.

Council's powers, functions and obligations

- 6 The 1968 Act provided mechanisms for:
- (a) constituting the Council, the Medical Education Committee, the Preliminary Proceedings Committee, the Medical Practitioners Disciplinary Committee and Divisional Disciplinary Committees;
 - (b) granting entry to the register to medical graduates from New Zealand and overseas;
 - (c) notifying disability (mental or physical) affecting a doctor's ability to perform his or her professional duty satisfactorily;
 - (d) receipt and handling of complaints;
 - (e) the conduct of disciplinary hearings;
 - (f) rights of appeal.
- 7 The Act also required Council to receive advice from the Medical Education Committee on matters relating to medical education, the supervision and training of doctors conditionally registered (ie interns/new graduates) and the regular review (by visitors) of the facilities where instruction and experience in the practice of medicine and surgery were provided.

Composition of Council

- 8 The Medical Council is a body corporate.
- 9 The 1968 Act originally required that the Council comprise eleven members consisting of:

- (a) the Director General of Health;
- (b) the Dean of the Faculty of Medicine of the University of Otago (or an alternate);
- (c) the Dean of the Faculty of Medicine of the University of Auckland (or an alternate);
- (d) four registered medical practitioners appointed by the Governor General of whom two were appointed on the advice of the Minister after recommendations from the New Zealand Medical Association, and two others were appointed on the advice of the Minister, after such consultation and enquiry as the Minister considered expedient;
- (e) four registered medical practitioners appointed by the Governor General on the advice of the Minister, given on the recommendation of:
 - (i) the Royal Australasian College of Physicians;
 - (ii) the Royal Australasian College of Surgeons;
 - (iii) the Royal New Zealand College of Obstetricians and Gynaecologists;
 - (iv) the Royal New Zealand College of General Practitioners.

10 From 1982, a twelfth person, a lay member, was appointed by the Governor General, on the advice of the Minister (ie a person not being a medical practitioner).

Amendments to the 1968 Act relevant to the Inquiry

11 In 1971 the Medical Practitioners (Registration of Specialists) Regulations were passed. These enabled the Council to keep a register of specialists in principal specialities and sub-specialities according to named qualifications and conditions and a doctor was entitled to have

his or her name entered in the Register of Specialists if the Council was satisfied about qualifications, training and experience, recognition by colleagues in the profession, and ability to limit practice to the branch of medicine or surgery in which the doctor was specialised.

DISCIPLINARY PROCESS - 1968 ACT

Receiving complaints

- 12 Complaints could be addressed in writing to the Secretary of the Medical Practitioners Disciplinary Committee (“MPDC”) who was by law the Secretary of the New Zealand Medical Association. Complaints could also be made to the Secretary of the Medical Council, who was also empowered to deal with any advice indicating that a person who was registered as a medical practitioner had been convicted by any court in New Zealand or elsewhere of an offence punishable by imprisonment for a term of three months or more.
- 13 Any complaints or notices of conviction received by the Secretary of the Medical Council were in the first place referred to the Preliminary Proceedings Committee (“PPC”), a committee constituted by the statute to comprise two members of the Medical Council and a legal member appointed by Council. The PPC investigated serious complaints which might result in a charge of disgraceful conduct in a professional respect.
- 14 Complaints received by the Secretary of the MPDC were deemed to be charges of professional misconduct, whether the words professional misconduct appeared in the complaint or not, unless in the opinion of the chairman of the MPDC:
- (a) the complaint was frivolous or vexatious or not sufficiently substantial to amount to a charge of professional misconduct;
- or

- (b) the facts alleged in the complaint would, if proved, constitute disgraceful conduct in a professional respect and should therefore be transmitted to the Secretary of the Council to be dealt with by the Council.

The hierarchy of Divisional Disciplinary Committee (“DDC”), Medical Practitioners Disciplinary Committee (“MPDC”) and Medical Council (“MCNZ”)

15 The three tiered disciplinary structure was as follows.

DDC

16 The NZMA appointed three to six doctors depending on the size of the division, and the Minister appointed one lay person. A quorum of two or four considered complaints which could result in a finding of conduct unbecoming a medical practitioner. After enquiry and hearing, if the doctor was found guilty of conduct unbecoming, he or she could be censured.

MPDC

17 The NZMA appointed four doctors and the Minister appointed one doctor and one lay person. This was the most active of the disciplinary bodies and (with a quorum of at least three) considered complaints giving rise to charges of professional misconduct. Penalties available included censure, financial penalty (maximum \$1,000) and/or conditions imposed on practice for a maximum of three years.

MCNZ

18 A quorum of five members of Council (excluding those on any PPC which investigated the complaint) sat to hear charges of disgraceful conduct (it was the only body of the three in the hierarchy which was empowered to hear charges of disgraceful conduct), and referrals of

convictions or recommendations for prescribing prohibitions (under the Misuse of Drugs and Medicines Act). Most charges before Council arose out of serious complaints about the conduct of a doctor. Penalties available to the Council sitting as a disciplinary tribunal included removal of the doctor's name from the register ("striking off") (the most severe penalty), suspension from practice for not more than twelve months, conditions on practice for a maximum of three years, financial penalty (maximum \$1,000) and censure.

- 19 The Council was also empowered to hear appeals from the MPDC.
- 20 All three levels of the disciplinary body had the power to award costs against a doctor found guilty. Complainants' reasonable costs (using legal aid scales) were normally met by Council whether or not the doctor was found guilty.
- 21 Publication in the *New Zealand Medical Journal*, with or without the suppression of names, could be ordered by the Council and the MPDC. It was very unusual for a patient's name to be disclosed.

Appeals

- 22 Decisions of any of the three disciplinary bodies (DDC, MPDC or MCNZ) could be appealed by the doctor or the complainant:
- (a) appeals against DDC decisions were to the MPDC;
 - (b) appeals against MPDC decisions (on hearing charges or appeals) were to the MCNZ;
 - (c) appeals against MCNZ decisions (on hearing charges or appeals) were to the High Court.
- 23 Findings were not published (nor financial penalties and costs collected) until appeals had been determined.

- 24 A legal assessor could be appointed by the MCNZ, the MPDC or any DDC, and that assessor could be present at any enquiry or appeal, and then and at any time previously or subsequently, advise the Council or Committee on matters of law, procedure and evidence relating to that enquiry or appeal.
- 25 The hearing procedure for the MPDC and the DDCs was entirely separate from the Council and outside the Council's control.

Disciplinary functions of the Medical Council

- 26 The Medical Council was empowered to hear charges of disgraceful conduct in a professional respect, the only level of charge with a possible penalty of striking off the register.
- 27 The Medical Council was also required to hear appeals against decisions of the MPDC. Appeals could be accepted from the doctor or the complainant, or both.
- 28 Every such appeal was required to be by way of rehearing and on such appeal the Council had the discretion to make an order or recommendation, as the case might be, as it thought proper, having regard to the merits of the case.
- 29 Unless the Council directed otherwise, on any such rehearing the record of the evidence produced at the hearing before the MPDC was required to be placed before Council and it was not permissible (without leave of the Council) to recall witnesses who gave evidence before the MPDC or to call other witnesses.

Disciplinary proceedings at all levels under the 1968 Act held in private as provided by the Act

- 30 There was no requirement under the 1968 Act for disciplinary hearings to be held in public and customary procedure was to hold them in private.

Final appeal to the High Court

- 31 The final appeal against a decision of the Medical Council (in relation to the hearing of charges, the consideration of convictions, or the consideration of appeals from decisions of the MPDC) was to the High Court.
- 32 The decision of the High Court in respect of any appeal was final and conclusive. On any appeal from any order of the Council, the Court had the discretion to revoke or vary the order, and to make any order that could have been made by the Council in the first instance.

REGISTRATION PROCEDURES - 1968 ACT

- 33 By contrast with the 1995 Act the 1968 Act was far more prescriptive. Including Amendments and Regulations made between 1968 and 1987, it provided for the following categories of registration:
- (a) conditional;
 - (b) registration as a medical practitioner;
 - (c) temporary;
 - (d) probationary;
 - (e) registration as a specialist;
 - (f) registration as a general practitioner.
- 34 I deal with registration as a medical practitioner and registration as a specialist below.

Registration as a Medical Practitioner

- 35 This category was commonly known as “full registration” and doctors who satisfactorily completed the period of compulsory experience on conditional registration were eligible to apply. Graduates from

universities in countries whose degrees made them eligible for conditional registration could apply directly for registration as a medical practitioner, if they showed proof of an internship acceptable to Council.

- 36 After the Act was amended in 1970 to provide for probationary registration, those who had qualified in other overseas universities and had satisfactory experience in the practice of medicine and surgery in approved hospitals for not less than twelve months as probationary registrants were also eligible to apply. Such overseas qualified applicants were required to show intention to reside and practise in New Zealand, have a reasonable command of the English language and provide evidence of professional ability, all of which would be examined by the Council and indeed were from 1984.

Registration as a Specialist

- 37 Regulations were passed in 1971 to allow the Council to establish a Specialist Register and specify branches of medicine. A Schedule to the Act set out these branches (principal specialities and sub-specialities) and the body whose qualifications granted in New Zealand and overseas would be recognised in respect of that speciality.
- 38 Council was able to grant registration if applicants could satisfy Council that:
- (a) they held a qualification (as above) or they had undergone comparable training and acquired comparable experience in this speciality; and
 - (b) they were recognised by their colleagues in the medical profession as having such training and experience in the speciality in respect of which the application was made as would entitle them to specialist status in relation to this speciality; and

- (c) they had had at least five years training and practical experience in the speciality in respect of which the application was made; and
- (d) that so far as it was practicable, they would limit their practice to the branch or branches of medicine or surgery in which they specialised.

39 Discretion was also allowed to the Council in certain circumstances in relation to any particular case to enter the name in the register of specialists of a person Council was satisfied was recognised by their colleagues in the medical profession as having special experience in the speciality entitling them to specialist status in relation to that speciality.

Registration as a General Practitioner

40 In 1997 similar Regulations were passed by Government to provide for an Indicative Register of General Practitioners where they met the requirements related to qualifications, training, experience and extent of practice.

41 With respect to both registration of specialists and registration of general practitioners the Council was empowered to delegate this function to a committee and was also given the discretion to consult with such bodies and individual persons of professional standing in the medical profession as it saw fit. From the outset the Council established a solid working relationship with the postgraduate colleges in New Zealand providing training for specialists and general practitioners and used these bodies as expert referral bodies with regard to the suitability of applicants for these two categories of registration. Council sought advice and recommendations from the referral bodies but it was Council's decision whether or not to register an individual applicant, taking into consideration the requirements in the regulations and schedules to them.

- 42 Applications for registration as a specialist (or registration as a general practitioner) were completed by the doctor and received by Council. They were then referred to the relevant “referral body” for scrutiny and recommendation on suitability.
- 43 All applicants for registration (any category) were required to show they were of good character. Current Certificates of Good Standing from overseas registration bodies were mandatory.

DR BOTTRILL - REGISTRATION HISTORY

- 44 Attached is a copy of Dr Bottrill’s Medical Council file (“GAJ/MCNZ/0001”).
- 45 It shows that Dr Bottrill obtained his primary medical degree from the University of Birmingham, graduating MB ChB in 1953. He was first registered in the United Kingdom by the General Medical Council on 26 November 1954. On 3 October 1961 he wrote to the Medical Council of New Zealand from Whangarei Hospital advising that he had been appointed pathologist at that hospital and wished to be registered in New Zealand. As the UK qualification he held was recognised under the Medical Practitioners Act for the issue of registration as a medical practitioner he was invited to make application at the office of the Medical Officer of Health in Whangarei and complete the appropriate form. As was standard practice, he was required to obtain a Certificate of Good Standing issued by the General Medical Council, to the effect that he held current registration with that Council and that no disciplinary procedures were outstanding against him. Once that documentation and the fee prescribed in the Fees Regulations were received by the Council secretary (24 October 1961) he was issued with a provisional certificate to commence practice in New Zealand with effect from 31 October 1961.
- 46 On the application form for medical registration in New Zealand Dr Bottrill indicated that since qualifying he had practised at Birmingham

Children's Hospital (1953-1954) Pembury Hospital, Kent (1955 – 1956) and St James Hospital, Leeds (1957-1961). He had served his internship at Birmingham Children's Hospital and East Surrey Hospital, Red Hill. He stated his reason for coming to New Zealand as "immigration to practise as a pathologist". He confirmed he was registered in the UK and gave the names of three referees, Professor C L Oakley, FRCS Department of Bacteriology, University of Leeds, Dr W Goldy, FRCP, St James Hospital, Leeds, and Dr J Adler, MRCP Pinderfields General Hospital, Wakefield, Yorks. He gave his date of birth as 12 June 1929.

- 47 The references received were unanimously supportive and included the following comments:

"I have formed a very high opinion of his professional and personal character. I would certainly recommend that he be granted medical registration in New Zealand."

"He is a competent hard working colleague with a high ethical standard of work and behaviour and during my annual holiday he controlled working of the laboratory completely satisfactorily. He seemed of a very abstemious character and of a high moral standard and from what I know of his personal and professional character I would have no hesitation in recommending him for medical registration in New Zealand."

"This young man came under my notice when he entered the training scheme for pathologists in this region. He worked in my department for four months and I saw him at fairly regular intervals thereafter. During his period of training, he became a competent, trustworthy and altogether reliable pathologist and bacteriologist capable of doing a very large amount of work, but not in any way notable for originality. He proved a very pleasant person and worked in well with my staff. From what I know of him I should strongly recommend that he be granted medical registration in New Zealand."

- 48 By letter of 19 March 1962 Dr Bottrill was advised that at a meeting of the New Zealand Medical Council held recently he had been registered as a medical practitioner and his name had been placed in the register of medical practitioners. This registration was effective from 15 March 1962.

- 49 From 1 March 1966 Dr Bottrill’s registered address changed to Cook Hospital, Gisborne. From 1967 Dr Bottrill was established in private practice in Gisborne.
- 50 On 30 June 1971, pursuant to the recently enacted Regulations for the Registration of Specialists, Dr Bottrill submitted an application for inclusion on the register of specialists under the speciality pathology. On that application he indicated the following as his relevant training and experience:
- | | |
|-----------------|--|
| 1956 - 1961 | Trainee pathologist (registrar grade) in the scheme run jointly by the University of Leeds and the Leeds United Hospitals. |
| 1961 – 1966 | Sole pathologist (junior specialist grade) to the Northland Hospital Board. |
| 1966 to present | Pathologist (specialist) Cook Hospital Board and in private pathology practice. He indicated he practised in his speciality exclusively. |
- 51 On 21 October 1971 the Medical Council held a special meeting at which it considered all the first applications for admission to all the recognised specialities and sub-specialities pursuant to the recently enacted Specialist Registration Regulations.
- 52 Applications in each of the specialities and sub-specialities had been considered by the relevant referral body. In the case of pathology the following is minuted:
- “A letter from the New Zealand Society of Pathologists was considered in detail. After consideration it was resolved that the Medical Practitioners named in appendix one to these minutes under the speciality of pathology be accepted for inclusion in the register of specialists.”
- 53 The appendix to the minutes includes Dr Bottrill’s name amongst sixty pathologists so recommended for specialist registration on that day.

- 54 On 29 October 1971 Dr Bottrill was advised that Council had approved his name being included in the Register of Specialists under the speciality of pathology.
- 55 Like a number of other doctors in all specialities, Dr Bottrill did not hold a formal qualification in his speciality at the time he applied for entry to the specialist register and in that regard Council, on the advice of the referral body (in this case the Society of Pathologists), exercised its discretion that they be entered on the Specialist Register as Council was satisfied they were recognised by their colleagues in the medical profession as having special experience in the speciality in respect of which the application was made entitling them to specialist status in relation to that speciality.
- 56 On 22 April 1974 the Royal College of Pathologists of Australia certified that Dr Bottrill had passed the examinations and satisfied the training requirements prescribed by the Board of Censors and had been admitted to the Fellowship of the Royal College of Pathologists of Australia on 10 December 1973. In May 1974 Dr Bottrill requested that this Fellowship be entered in the New Zealand medical register, including the register of specialists, and at the June 1974 Council meeting that amendment to the register to include his additional qualification FRCPA 1973 was approved.
- 57 Dr Bottrill applied for and was issued with an annual practising certificate (APC) for every practising year from 1961 until the year ending 31 March 1998. By contrast with a large number of practitioners, no reminder notices were necessary.
- 58 In April 1994 Dr Bottrill requested that his address be amended to 24 Russell Street, Gisborne, rather than the post office box in Gisborne.
- 59 On 1 July 1996 Dr Bottrill's full registration as a medical practitioner entitled him under the transitional provisions in the Medical Practitioners Act 1995 to be granted "general registration" and

similarly his registration as a specialist in pathology entitled him to be granted “vocational registration” under the new Act under the category “pathology”.

- 60 Dr Bottrill last indicated that he was practising and required an APC when he made an application under the Medical Practitioners Act 1995 for the first time on 17 March 1997. He stated he was practising as a consultant for Medlab in Gisborne.
- 61 On 24 March 1998 he returned the APC application form indicating that he was no longer practising, did not require a certificate but wished to remain on the Register. He provided the same information on 1 March 1999 with respect to the APC year commencing 1 April 1999 and ending on 31 March 2000.
- 62 Under the 1968 Act the Council secretary was required to issue an APC on application and payment of the fee by the practitioner. No quality assurance mechanisms directly related to the annual APC renewal were in place under the 1968 Act.
- 63 The Medical Practitioners Act 1995 now directly links the issue of an APC to demonstration of competence and the Registrar is empowered to refer an application to the Council if the Registrar believes on reasonable grounds that the applicant has at any time failed to maintain a reasonable standard of professional competence. The Act goes on to provide several methods of dealing with any indication of lack of competence. At the time Dr Bottrill applied for an APC for the first time under the new Act (17 March 1997), the Council Registrar had not been advised of the order of the MPDC (23 July 1997) following a disciplinary inquiry under the 1968 Act, held in Auckland on 20 February 1997.
- 64 Dr Bottrill in fact appealed against the decision of the MPDC (as did the complainant) and this in effect stayed the implementation of the order (censure, fine, costs and condition) under the Medical

Practitioners Act 1968 until the hearing of the appeal by the Medical Council. The appeal was heard on 27 November 1997 and the Council's order dated 10 December 1997, dismissing the appeals, was received by the Council constituted under the 1995 Act at the regular quarterly Council meeting on 10-11 March 1998, in the papers under Discipline Matters Heard (1995 Act and 1968 Act).

- 65 The MPDC was responsible for ensuring conditions placed by it on doctors under the 1968 Act, were implemented. This applied to Dr Bottrill but, in any event, the committee had been informed he was no longer reading or reporting cytopathology slides.
- 66 Dr Bottrill's Council file was annotated by the Acting Registrar on 29 April 1999 to indicate that if an APC application for that year was received it should be referred to Council. In the event no such application was received, Dr Bottrill having indicated the year before (24 March 1998) that he was no longer practising.
- 67 In summary there has been nothing in Dr Bottrill's registration history to alert Council to any concerns about his overall competence in his field of practice. The complaint to the MPDC (and the ACC finding of medical error in relation to a claim for medical misadventure) was not of itself a proven charge of professional misconduct. Medical misadventure allegations (whether referred by ACC or the patient) were dealt with as complaints and the MPDC and the Council were constrained by the jurisdiction accorded each of them under the 1968 Act. The Medical Practitioners Act 1995 introduced more options for dealing with reports of alleged poor performance by doctors and these are covered under s3, paragraph 21.4.

SHORTCOMINGS AND PROBLEMS AREAS IDENTIFIED UNDER THE 1968 ACT RELEVANT TO THE SUBJECT MATTER OF THIS INQUIRY; AND ACTION TAKEN BY MEDICAL COUNCIL

- 68 As early as 1984 the then Minister of Health the Honourable Michael Bassett, had indicated that he was not prepared to put before Parliament any more amendments to the 1968 Act in view of the fact that it had been continuously amended since it was passed and now needed a complete overhaul.
- 69 Members of the Medical Council, the Preliminary Proceedings Committee, the Medical Practitioners Disciplinary Committee and the New Zealand Medical Association were also aware of, and anxious to see implemented, improved provisions for the protection of the public through the regulation of medical practitioners, compatible with society's expectations.
- 70 There was particular dissatisfaction with the construction of the system for medical discipline and awareness that the options for dealing with poor practice as provided in the current legislation were inadequate. No provision was available for conciliation or mediation. While health issues could be considered separately from discipline, and the existing provisions were reasonably satisfactory, there were no provisions for dealing with reports of incompetence (including the more acute problem of negligence).
- 71 Provision for lay membership of disciplinary bodies was inadequate, placing great stress on the single lay person appointed in the mid 1980s to the Medical Council and similarly to the Medical Practitioners Disciplinary Committee . Public perception of the disciplinary bodies was that they were "old boys networks" or "closed shops" and Council therefore recommended that a separate Disciplinary Tribunal, not comprising Medical Council members, be put in place, with a medical chairperson and adequate lay membership.

- 72 Council was very concerned to have incorporated in new legislation workable and wide ranging quality assurance provisions which were essential for continuing review of medical practice and standards by encouraging peer review in an environment where there was some protection for the practitioner against adverse consequences of honest disclosure.
- 73 Alongside quality assurance provisions, provisions to enable Council to require competence assessments of individual doctors whose standards of practice may be failing were long overdue. Council had observed that a number of the cases coming as disciplinary charges before the DDCs and MPDC could have been dealt with more effectively if such quality assurance and competence provisions were in place.
- 74 The issue and renewal of APCs was largely administrative in nature, as there was no provision to deny the certificate if there were concerns about lengthy absence from practice or competence, health or fitness to practise matters, which had not already been dealt with through the disability and disciplinary mechanisms. The public was under the misapprehension that holding an APC implied that the practitioner was safe to practise.
- 75 Council recommended that re-certification provisions be provided which would allow all doctors on the Specialist and General Practice Registers (soon to be combined into a Vocational Register) to have their qualifications to practise independently re-certified at regular intervals.
- 76 Council believed that more flexibility under registration should be allowed to future Councils to determine standards and procedures relevant to the time. Any new legislation should allow more discretion to Council rather than binding it by naming particular institutions and particular countries as giving education and training in medicine

which was automatically of acceptable standard for practice in New Zealand. The capacity to examine or assess any applicant for registration if warranted, was fundamental to any new registration mechanism. There should be direct links to health, competence and discipline for the renewal of an APC, which should be issued only if Council was assured that the doctor was sufficiently competent to practise without endangering the public.

- 77 On 15 September 1988 a letter jointly signed by Dr Stewart Alexander, then chairman of the Medical Council, Dr Dean Williams, then chairman of the Medical Practitioners Disciplinary Committee and Dr M A H Baird, then chairman of the New Zealand Medical Association was sent to Mr David Caygill, Minister of Health. This letter went on behalf of the working party that had considered changes to the system for medical discipline and included the committee's final draft of suggested legislation to replace Part III of the Medical Practitioners Act 1968, along with some explanatory notes.
- 78 In sending these recommendations to the Minister first, the working party saw change in this area as most critical and urgent. It informed the Minister that advice and submissions had been received from a number of organisations and where possible those ideas had been incorporated into the proposals which had been developed on the basis of study of systems overseas and experience in New Zealand over many years.
- 79 The working party commented that it was clear that a deficiency in the existing system was in the early part of the process, the entry of complaints, their initial handling and current lack of adequate mediation and explanation. This had been emphasised by the *Cartwright Report* along with the need to link with day to day surveillance of health procedures, ie peer review.

- 80 In the light of the *Cartwright Report* on patient advocates, hospital and area health board procedures and perhaps the Health Commissioner under the Human Rights Commission, the working party stressed that their proposals were for procedures that would be complimentary to these and would follow where specific action with medical practitioners was required.
- 81 The Medical Council of New Zealand, as the registration body whose chief role is quality assurance, recommended it have other links with conduct and the disciplinary process, for example:
- (a) where a doctor's health impairs clinical performance a new section of the Act was proposed to provide a much clearer and more specific process of protecting the patients while rehabilitating the doctor;
 - (b) the Council's role in registration, both general and in the higher vocational roles (Specialist and General Practitioner Registers) required enhanced sections, both on establishing initial standards and ensuring continuing competence through peer review and annual certification (a new section of the Act was proposed to deal with this);
 - (c) there would still be issues of an ethical/etiquette nature where it would be necessary to consult the profession's own organisations with these often ill understood components of medical practice; for this reason reference to Ethical Committees was allowed for.
- 82 In making these initial submissions the Council noted the organisations involved in discussions as follows:
- (a) Medical Council of New Zealand;
 - (b) New Zealand Medical Association (and *New Zealand Medical Journal*);

- (c) Health Department (including policy and communication section);
- (d) Ministry of Women's Affairs;
- (e) Consumers Institute;
- (f) ZONTA;
- (g) Citizens Advice Bureaux;
- (h) Fertility Action;
- (i) various Australian Medical Boards and the United Kingdom Medical Council;
- (j) Ministerial Advisory Committee on the medical workforce;
- (k) New Zealand Plunket Society;
- (l) National Council of Women;
- (m) Ministry of Consumer Affairs;
- (n) Medical Practitioners Disciplinary Committee.

83 On 22 December 1988 Council's proposals for revision of all other parts of the Act were sent to the Minister. The broad principles on which they were based were that:

- (a) the Medical Council had taken into account issues which needed to be taken into account in bringing the Medical Practitioners Act into a suitable form for the next ten years;
- (b) the functions of the Medical Council needed to be defined in the new Act with an appropriate formula for the composition of the Council depending on the functions to be performed;

- (c) in general the Act should be enabling rather than a collection of detailed provisions which would require amending Acts for any change;
- (d) the need for regulations and some provisions could be replaced by authority for the Medical Council to determine these autonomously, eg fees, qualifications;
- (e) the Medical Council should have power to make or approve rules of procedure for Council and its committees both standing and ad hoc.

84 These proposals put forward to the Minister included new parts of the Act as follows:

- (a) functions and composition;
- (b) registration;
- (c) education;
- (d) fitness to practise:
 - (i) APCs, competence and health;
 - (ii) conduct and discipline within the medical profession (already forwarded);
 - (iii) general.

ATTEMPTS TO HAVE 1968 LEGISLATION CHANGED

85 By 1990 a draft Medical Practitioners Bill had been prepared within the Department of Health but was not made available to the Medical Council. Finally in 1991 after a change in government a copy of this Bill was made available to Council. Given the length of time since the original recommendations were made some issues were becoming

even more urgent. Council regularly sought advice on progress and urged action without any real success between 1991 and 1993.

86 The Health and Disability Commissioner Act 1994 was passed and the Social Services Select Committee eventually sought submissions on a Medical Practitioners Bill 1994 (somewhat amended from the 1990 draft Bill) and Council along with over forty other organisations and individuals made written submissions. Council also appeared before the committee to make oral submissions along with over forty others. The select committee considered all these written and oral submissions in 1995 by which time the draft Health and Disability Services Code of Consumers' Rights ("the Code") was also under way and the newly appointed Commissioner expected to have it accepted by late 1995. Finally, after intervention by the Minister of Health, the Honourable Jenny Shipley, who saw these two inter-linked pieces of legislation as increasingly urgent, the Medical Practitioners Act 1995 was passed in late December 1995 and became effective from 1 July 1996, the day the Code also became operative.

87 A period of over ten years (and at least six Ministers of Health, some delegating it to Associate Ministers outside Cabinet) had ensued since Council's comprehensive attempt to have the 1968 Act re-written. Even then at the last minute a revision to the Disciplinary Tribunal composition was necessary through a supplementary order paper introduced on the night by the Minister herself. This put in place a Tribunal comprising a legal chair, three medical members and one lay member (the medical members and lay members being selected from a larger panel).

MEDICAL PRACTITIONERS ACT 1995

Background

88 The Medical Practitioners Act 1995 came into effect from 1 July 1996. On the same date the Health and Disability Services Code of

Consumers' Rights also became effective and these two pieces of legislation were interwoven with regard to the receipt of complaints and the disposition of them as they related to registered medical practitioners.

Purpose of the Act

89 The purpose of the Act was to consolidate and amend the law relating to medical practitioners and in particular:

- (a) to impose various restrictions on the practice of medicine;
- (b) to provide for the registration of medical practitioners and the issue of annual practising certificates;
- (c) to provide for the review of competence of medical practitioners to practise medicine;
- (d) to provide for the notification of any mental or physical condition affecting the fitness of a medical practitioners to practise medicine;
- (e) to provide for the disciplining of medical practitioners;
- (f) to provide for matters incidental to the above.

90 Section 3 of the Act sets out the principal purpose adding that it is to protect the health and safety of members of the public by prescribing or providing for mechanisms to ensure that medical practitioners are competent to practise medicine. In addition to the purposes set out above, the Act also provides certain protection for medical practitioners who take part in approved quality assurance activities.

Phase out of the 1968 Act and replaced by the 1995 Act

- 91 A somewhat complex mechanism to manage change in the composition of Council was set up and some members of the 1968 Act Council remained as the new Council in the transition phase.

Composition of Council

- 92 The 1995 Act provided, for the first time, for election of four medical members, but reduced the overall size of Council from 12 to 10, with Ministerial appointments, not Governor General. The new composition allowed for up to four lay members ie non-doctors.
- 93 The first meeting of the full Council as constituted under the Medical Practitioners Act 1995 was the meeting held in March 1998, almost two years after the Act came into effect. The lay person appointed to replace the outgoing lay person who had served since 1985 (as the sole lay person on Council) was not in place until November 1998.
- 94 Alongside all of the changes and transition described above, all 12 members of the Medical Council as constituted under the 1968 Act were required to continue to be available to consider disciplinary matters already commenced under the 1968 Act, namely hearing of charges of disgraceful conduct, and referrals of convictions or appeals from decisions of the Medical Practitioners Disciplinary Committee. These transition responsibilities continued with the last hearing of an appeal conducted in mid-May 2000.

Principal differences between the 1968 Act and the 1995 Act

- 95 These differences are set out below in relation to those that are relevant to this inquiry.

Registration of doctors

- 96 Under the new Act the Medical Council has greater flexibility in registering overseas trained doctors as it has the power to approve overseas institutions for registration rather than have them dictated by the Act itself. However Council retains policy and procedures which require an overseas trained doctor, who does not have approved qualifications, to pass the Council's registration examination. The only graduates exempt from this examination are graduates of New Zealand and Australian Medical Schools, accredited by the joint Australian Medical Council/Medical Council of New Zealand process.
- 97 The 1995 Act is novel compared with overseas legislation in that, as part of the competence mechanism, it sets up an inter-linked system whereby no person on the New Zealand Medical Register with a practising certificate would be able to practise in isolation or without some capacity for monitoring continuing performance. This was achieved by:
- (a) mandatory education and supervision for probationers;
 - (b) general oversight for general registrants (with a specific exemption in some cases for the first five years of the Act);
 - (c) re-certification for vocationally registered doctors;
 - (d) conditions on practice (supervision) on temporary registrants.
- 98 The outgoing Council commissioned a substantial report from an independent respected member of the medical profession, on the topic of competence to practise, as a resource for the incoming Council once those persons were all in office under the 1995 Act.
- 99 Only vocationally registered doctors are able to practise relatively independently under the new Act. The Vocational Register combines the previous Register of Specialists and Register of General

- Practitioners. The Act provides for Council to recognise re-certification programmes and it is envisaged that these be offered by the post graduate education and training colleges. Doctors who do not comply (once this requirement is made compulsory), would risk losing their vocational registration or even suspension from the register. Once the five year period of exemption from general oversight for certain general registrants has passed, vocationally registered doctors would only be able to practise outside their branch of medicine with general oversight. These provisions had the effect of motivating doctors to complete all the requirements for admission to the Vocational Register in any branch in which they wished to practise. General practitioners have been especially diligent in this regard.
- 100 Temporary registration was retained but a three year time limit was placed on it. The new Act widened the scope of circumstances in which the Council could approve temporary registration on a discretionary basis. This does allow Council to address potentially serious workforce shortages arising from any sudden restriction on the registration of graduates from countries previously named in the 1968 Act, ie United Kingdom, South Africa, Eire, and Canada. Their standards are well known and they have proven themselves capable of integration into the New Zealand medical workforce without problems. This provision was particularly important in relation to areas of the country or medical specialities where shortages or maldistributions were significant. It should be noted that pathology is experiencing a shortage world wide.

Competence to practise

- 101 The 1995 Act introduced wide ranging and thorough new processes for Council to assess competence and require doctors found deficient to undergo competence programmes, with provision for the implementation of conditions on practice or in the worse case scenario suspension. No such mechanism existed under the previous Act

although some voluntary competence reviews had been undertaken by the 1968 Council on request by, and with the co-operation of employers.

- 102 Some frustrations were experienced in setting up all the policy and procedures to implement the competence section of the 1995 Act. Worldwide medical registration bodies were grappling with these issues and some models were available (but only in their infancy) from countries such as Canada and the United States. Council decided to adopt the Complaints Assessment Committee model of two doctors and one lay person for its competence review teams and took immediate steps to appoint a Professional Standards Committee (“PSC”) to implement the new powers under Part VI of the Act.
- 103 Two part time professional standards co-ordinators were also engaged to assist in the development of policy and procedures for competence reviews and competence programmes and to be involved in the initial phase of implementing these.
- 104 The members of the standards team of the Medical Council office assist the committee and the professional standards co-ordinators and the President in setting up and monitoring competence reviews and competence programmes.
- 105 The new Act provided for the Council to review at any time the competence to practise of any medical practitioner who holds an APC, whether or not there is reason to believe the practitioner’s competence may be deficient. To date the provision for competence reviews has been used mainly in relation to practitioners where doubts about their competence have been raised either by the Health and Disability Commissioner (“HDC”) or on referral from a Complaints Assessment Committee (“CAC”). Referral for competence review by a CAC is mandatory on Council.

- 106 The Registrar was also given the power in relation to issuing APCs to refer applications to the Council if on reasonable grounds the applicant appeared to have at any time failed to maintain a reasonable standard of competence or had not satisfactorily completed the requirements of any competence programme or had not completed the requirements of a mandatory re-certification programme or had not held an APC within the three years immediately preceding the date of application or had not engaged in the practice of medicine within the three years immediately preceding the date of application. Following such referral Council could refuse to issue an APC or could impose conditions on such a certificate in which case it might choose to issue an interim APC until those conditions were satisfied.
- 107 Council has published pamphlets explaining the competence review process and emphasising the importance of the maintenance of professional standards in medical practice. A competence review aims to ensure that a doctor is practising safely and has an acceptable level of knowledge, skills (including those required in procedures and communication), attitudes and judgement in accordance with his or her registration. The review procedures are designed to protect the public, to focus on improvement, and to use a process that is thorough and fair. The doctor being reviewed is involved in the process and this is designed to be educative. It is not a disciplinary process. To date concerns about doctors have come from a number of sources:
- (a) medical colleagues;
 - (b) other health workers;
 - (c) a health authority;
 - (d) a CAC;
 - (e) the Medical Practitioners Disciplinary Tribunal (MPDT);

- (f) the HDC;
 - (g) a patient.
- 108 Currently most competence reviews result from a concern expressed rather than by order of a CAC determination. The Health & Disability Commissioner now frequently refers doctors for review.
- 109 If competence is found wanting a competence programme may be necessary and this may include:
- (a) an education programme, a period of practical experience and/or training;
 - (b) passing an examination;
 - (c) working under observation;
 - (d) reviewing the clinical records kept by the doctor;
 - (e) taking other measures the Council considers appropriate;
 - (f) accepting one or more conditions on registration or practising certificate or both.
- 110 The Council may also specify the period within in which the doctor must comply with the requirements of the competence programme. Each course of action has clearly defined objectives to produce the best possible programme for that doctor. The doctor's progress is monitored and an assessment may be undertaken at the end of the programme. Review costs are met by the profession as a whole (ie the Council pays) but the competence programme costs are paid for by the doctor.
- 111 If the doctor's competence is seen as posing a risk to the health and safety of patients, the Council can place restrictions or conditions on a doctor's registration and/or APC. If the competence programme is

unsuccessful it may be necessary to suspend a doctor's vocational or other registration/or APC. Any changes in registration or practising status are public, as they must be included in the public document, the New Zealand Medical Register.

- 112 Council is now well established in implementing the competence provisions of the 1995 Act as the attached statistics show (“GAJ/MCNZ/0002”).

Notification of mental or physical condition affecting fitness to practise

- 113 The old 1968 Act used the term disability whereas the 1995 Act uses the more comprehensive wording “mental or physical condition affecting fitness to practise medicine”. Under the 1995 Act the Medical Council may require a doctor to submit to a medical examination and the President of Council has the power to immediately suspend a doctor for ten days where there is a need to protect the health and safety of members of the public. The most significant change has been the ability of the Medical Council itself to require a doctor to submit to a medical examination.
- 114 Part VII of the 1995 Act sets out the mechanisms to protect the health and safety of members of the public from doctors who may be impaired. There is a mandatory requirement on doctors, medical officers of health and persons in charge of a hospital to notify the Council Registrar if they have reason to believe a doctor is not fit to practise. This reporting is completely separate from the disciplinary provisions under the same Act. People considering making a notification are entitled to seek medical advice, psychiatric or otherwise, to assist in forming an opinion and must state whether such advice has been obtained when giving notice to the Registrar. Any person making such a notification is protected from civil, criminal or disciplinary proceedings unless the person acts in bad faith or without reasonable care.

- 115 Council defines a doctor as not fit to practise medicine if, because of a mental or physical condition, he or she:
- (a) is unable to make safe judgments; or
 - (b) is unable to demonstrate normal levels of skills and knowledge required for safe practice; or
 - (c) behaves inappropriately; or
 - (d) risks infecting patients with whom she or he comes in contact; or
 - (e) acts or omits to act in ways that impact adversely on patient safety.
- 116 The Council's Health Committee has delegated authority to manage all aspects of intervention to protect the public and rehabilitate the doctor on receipt of notification under s76 of the 1995 Act. Early reporting and agreement to voluntary undertakings are encouraged.
- 117 Where the Council is satisfied the practitioner is not fit to practise medicine because of some mental or physical condition, or the practitioner has not submitted himself or herself to medical examination in accordance with s80, the Council may order the practitioner's registration be suspended or that conditions be placed on the practitioners registration or APC. Such conditions or suspension are carried out in the form of a Medical Council order which must be given in writing. Any person who is dissatisfied with all or part of such an order may appeal to the District Court. This is an extremely rare event.

APC's

- 118 No person is entitled to practise as a medical practitioner unless he or she holds both an appropriate form of registration and a current

- practising certificate. Breaches of this mandatory requirement make a person liable on summary conviction to a fine not exceeding \$10,000.
- 119 Part IV of the Medical Practitioners Act sets out the scheme for annual issue of practising certificates (exemption being granted to doctors who hold temporary registration or interim registration). On application for a certificate a practitioner is required to provide information confirming the nature of the practice currently undertaken.
- 120 Mandatory restrictions are placed on the Registrar in connection with the issue of an annual practising certificates if the applicant's competence has not been demonstrated or there has been a significant absence from practice. Council is empowered to place conditions on the annual practising certificate in the interests of public safety and such conditions must be published in the register.
- 121 Every annual practising certificate is endorsed to indicate the type of registration held by the practitioner, whether the practitioner holds vocational registration and if so in which branch or sub branch and, if any conditions have been imposed under the Act on the registration of the practitioner or on the certificate, the details of those conditions. Such conditions may arise from the review of a practitioner's competence, restrictions imposed on account of a condition affecting fitness to practise or orders of the Medical Council or the Medical Practitioners Disciplinary Tribunal.
- 122 A practitioner is required to surrender the practising certificate if:
- (a) his or her name has been removed from the register, or
 - (b) registration or the practising certificate has been suspended, or
 - (c) the practising certificate is required for endorsement by the Registrar.

- 123 At every application for an annual practising certificate Council has the opportunity to review the doctor's compliance with all the public protection mechanisms of competence, health and conduct. Questions pertaining to the scope of practice and the quality mechanisms above are asked on the application form and all disclosures of information which could amount to a public safety issue, are referred to the relevant Council committees for appropriate action prior to the issue of the certificate.
- 124 In essence the annual practising certificate is a signal to the public that the holder is competent to practise according to the provisions of the Act. Voluntary or mandatory surrender of practising certificates can be sought if the circumstances necessitate.
- 125 The annual practising certificate fee and accompanying disciplinary levy also provide the major portion of Council's income allowing it to carry out its statutory functions.
- 126 Council is currently changing to a quarterly cyclical issue of annual practising certificates to facilitate thorough and regular monitoring of all the above public protection measures.

The medical disciplinary system under the 1995 Act and complaints about doctors

- 127 The 1995 Act, which came into effect on 1 July 1996, established a new disciplinary system for medical practitioners in New Zealand.
- 128 On the same day, the Health and Disability Services Code of Consumers' Rights also came into effect. Together, the Code and the Act have introduced new procedures for dealing with complaints about doctors.

The structure of the new disciplinary system

- 129 The 1995 Act replaced the three levels of disciplinary hearing bodies (under the 1968 Act) with a single, independent body, the Medical Practitioners Disciplinary Tribunal (“MPDT”). The Tribunal is therefore a new statutory body and is not to be confused with the old Medical Practitioners Disciplinary Committee established under the 1968 Act. The Tribunal hears all charges against medical practitioners under the 1995 Act. Decisions of the Tribunal can be appealed to the District Court (and on matters of law to the High Court).
- 130 The establishment of the Tribunal removed the disciplinary function from the Medical Council. Membership of the Tribunal is entirely separate from membership of Council.

The Medical Council’s role in the new system

- 131 The Medical Council’s role in the disciplinary system is now limited to receiving complaints (written or oral), appointing Complaints Assessment Committees (CACs) which investigate complaints about doctors and, where appropriate, may lay charges before the Tribunal. Members of the Medical Council and members of the Tribunal are not allowed to be members of a CAC.
- 132 The Medical Council provides administrative services and funding for the Tribunal and its secretariat through the disciplinary levy, which is collected from medical practitioners once a year when they pay their annual practising certificate fee.

How proceedings reach the Medical Practitioners Disciplinary Tribunal

- 133 Proceedings against medical practitioners come before the Tribunal via one of two routes:
- (a) a **Complaints Assessment Committee**, after investigating a complaint made to the Medical Council against a doctor (or a

conviction referred by a Court Registrar), may decide to refer it to the Tribunal in the form of a charge or charges under 1995 Act;

- (b) the **Director of Proceedings** (an independent officer appointed under the Health and Disability Commissioner Act) may lay charges against doctors who have breached the Code of Health and Disability Services Consumers' Rights. The Director of Proceedings is also empowered to institute proceedings against other health and disability service providers.

How complaints about doctors are handled

- 134 The Code gives a patient the right to complain about a doctor. Possible breaches of the Code are handled by the Health and Disability Commissioner, who is an independent officer.
- 135 The Medical Practitioners Act 1995 continues to authorise the Medical Council to receive complaints about doctors. However, the Act requires the Council's Registrar to forward all complaints about events which occurred since the enactment of the Code (1 July 1996) to the Health and Disability Commissioner in the first instance. Council can take no further action until the Commissioner has decided what action, if any, he is going to take.
- 136 The Commissioner's emphasis is on fair, timely, low level resolution of complaints. However, in some cases the Commissioner may decide to refer a complaint to the Director of Proceedings, who may lay charges before the Medical Practitioners Disciplinary Tribunal.
- 137 Alternatively, the Commissioner may decide to refer a complaint back to the Medical Council. If so, the Council's President must appoint a Complaints Assessment Committee to investigate the complaint, unless the Commissioner and the President agree otherwise. The Commissioner may ask Council to carry out a competence review.

The role of Complaints Assessment Committees (CACs)

- 138 Complaints Assessment Committees are independent assessment teams made up of two doctors and a person who is not a doctor. Members of the Medical Council and members of the Medical Practitioners Disciplinary Tribunal are not allowed to be on a CAC.
- 139 The CAC has no power to decide whether or not a doctor is “guilty”. Instead, the CAC investigates a complaint and chooses from one of several courses of action. Under the Act, the CAC can:
- (a) request the Medical Council to review the doctor’s competence to practise medicine;
 - (b) request Council to review the doctor’s fitness to practise medicine, because of some mental or physical condition;
 - (c) make the complaint the subject of conciliation;
 - (d) decide no further steps should be taken;
 - (e) lay a charge or charges before the Medical Practitioners Disciplinary Tribunal.

How proceedings before the Tribunal are conducted

- 140 The Complaints Assessment Committee and the Director of Proceedings frame charges to reflect the seriousness of the allegation. Charges may be conduct unbecoming a medical practitioner and that conduct reflects adversely on the practitioner’s fitness to practise, professional misconduct or disgraceful conduct in a professional respect.
- 141 An important change from previous legislation is that hearings are held in public, unless the Tribunal is satisfied that a public hearing would be undesirable. Another important change is that the Act authorises the Tribunal, having reviewed a charge, to suspend a doctor

or to place conditions on a doctor's practice until disciplinary proceedings have been determined, if the Tribunal is satisfied that is necessary to protect the health and safety of members of the public.

- 142 Forthcoming proceedings of the Tribunal are printed in the public notices column of the main local newspaper and of the main national newspaper for the region not less than two weeks before a hearing.

Penalties available under the Medical Practitioners Act 1995

- 143 If charges are upheld, the Tribunal may:
- (a) censure the doctor;
 - (b) fine the doctor up to \$20,000 (except for events pre-dating the Act which have a maximum allowable fine of \$1000);
 - (c) impose conditions on the doctor's practice for a maximum of three years;
 - (d) suspend the doctor from the Medical Register for a period not exceeding 12 months;
 - (e) in very serious cases, strike the doctor off the Medical Register so that he or she can no longer practise medicine.

- 144 The Tribunal is also able to award costs against a doctor found guilty and order publication of findings and orders in the *New Zealand Medical Journal* or other medium.

- 145 An anonymised copy of orders of the Tribunal is also deposited in the Auckland District Law Society library in Parliament Street, Auckland.

The Medical Council's role following disciplinary proceedings

- 146 If the Tribunal imposes conditions on a doctor's practice, it is the Medical Council which monitors those conditions. Similarly, if a

doctor is struck off the Medical Register, the Medical Council is the body which considers applications for re-registration.

- 147 Provided the doctor consents, the Tribunal may require him or her to undergo examination, treatment, counselling or therapy. The Tribunal may fix a time after which a person may apply for re-registration.
- 148 Re-registration is not automatic. Council's first priority is protection of the public and it must be satisfied that the doctor is fit to practise medicine. Any conditions ordered by the Tribunal must be satisfied before a doctor who has been struck off can apply for his or her name to be restored to the Medical Register. Council can also impose conditions when re-registering a doctor.

Georgina Jones
Registrar, Medical Council of New Zealand
16 June 2000