THE COUNCIL OF MEDICAL COLLEGES IN NEW ZEALAND [CMC]

A study in evolution, with occasional revolution.

INTRODUCTION:-

It is of some interest to record and remember the milestones which have led to the present status of CMC as a legal entity through registration as a Charitable Trust on 30 November 2001. Possibly of greater interest and importance, is to keep in mind the factors and forces which resulted in the evolutionary development of the individual medical colleges in Australia and New Zealand. The process began in the 1920s. All 12 full members of CMC founded since then are bi-national [Australian and New Zealand] except the Royal New Zealand College of General Practitioners with its separate Australian counterpart. While the founding of independent colleges was logical and inevitable, with invaluable results, it was also a process which resulted in some fragmentation within the medical profession. The development of what is now the CMC is a sign of the need to de-fragment and to unify the profession on many broad strategic issues within the health sector. This serves to strengthen the voice of the medical colleges both individually and collectively.

EARLY STEPS:-

Many of today's Australian and New Zealand medical colleges have their own published histories and this is not the place to record anything but an illustrative summary of how and why the first two developed. Until the first part of the 20th century, the unifying medical body in both Australia and New Zealand, was the British Medical Association [BMA]. This was not a training, examining, or standard setting body for skills and expertise in the increasing numbers of clinical disciplines. Diplomas in these disciplines, for Australian and New Zealand medical graduates, were almost exclusively gained from Royal Medical Colleges in the United Kingdom, remote in those days from the South Pacific. Also, there was little or no linking governance.

The first attempt to develop standard setting in Australia and New Zealand was made by Professor [later Sir Louis] Barnett, Professor of Surgery at the University of Otago in 1920. He proposed the foundation of an Australasian Surgical Association. The object was to raise the standards of surgery in Australia and New Zealand. This was not agreed unanimously within the trans-Tasman surgical community. It was seen by some as resulting in a weakening of the BMA and by others as a threat to existing higher medical qualifications. There was also an outcry from those who were undertaking surgery with no higher qualification or training. Concern about the latter was a major reason for wishing to establish a standard setting body, Despite these objections [and they continued], things moved on and at the Australasian Medical Congress in Dunedin in 1927 [paradoxically a BMA meeting], the College of Surgeons of Australasia was established. The prefix" Royal" was granted in December 1930 and the current title, Royal Australasian College of Surgeons was established a year later.

A roughly similar path was followed by Physicians in the 1930s. The Association of Physicians of Australasia was founded on 29 November1930. A proposal to establish a College of Physicians of Australasia was put to the Association's council six months later. A formal motion to establish the Australasian College of Physicians was not put until May 1936. The King granted the use of the title" Royal" and the Royal Australasian College of Physicians was incorporated on 1 April 1938.

These early and apparently slow and deliberate developments, probably reflected several factors. Among these, were the still relatively small populations of Australia and New Zealand in the first half of the 20th century, with the inevitability that much postgraduate education and experience was still required in the northern hemisphere, largely in the United Kingdom, but increasingly in the USA. Also, the explosion in bio-medical knowledge and technology and their application were yet to come. With those developments, the result was a proliferation in specialisation. This, together with population growth and greater independence from old world roots, were no doubt important drivers in the establishment and growth of indigenous Australian and New Zealand medical colleges, all with similar high ideals. These included, education programmes, standard setting, scientific endeavour and service to the public. Even in the early 21st century, there are special interest groups seeking to establish new medical colleges. Special societies, remaining as integral parts of existing colleges, have proliferated and also seek, to a variable degree, their own independence.

This inevitable growth in numbers of medical colleges and their special societies, carried with it some real strengths for each discipline and the standards set, but produced a risk of fragmentation and the weakening of a cohesive medical voice when dealing with external agencies, including governments. These are the same very real risks which were expressed concerning the BMA and subsequently the AMA and NZMA, when the Australasian Colleges of Surgeons and Physicians were originally mooted. What goes around really does come around, but needs to be addressed.

Health care became more specific, complex and expensive from the 1950s onwards. Largely funded from the public purse, it was predictable that it would become politicised and increasingly regulated. It was time for medical colleges, having developed independently for the reasons given, to find common ground on which to offer advice to governments initially and to other agencies, as they became players in the field.

In Australia and New Zealand in the 1960s, there were as yet only three Royal Medical Colleges, RACS, RACP and RCOG. The latter, London based, had a regional council in New Zealand. In New Zealand 10 1963, the trigger to bring the colleges together in a proposed advisory role, was the expressed intention of the government of the time, to extend the place of the State in medical services, including establishing a specialist register and specialist benefit under the then Social Security system. RACS and RACP in early 1963 had formed a Joint Liaison Committee. This was the first step, a small one, in bringing the profession together once again to address matters of common interest. In Wellington, from 15 May 1963, there was a series of meetings between representatives of the three Royal Colleges, which led on 7 August of that year to the formation of a Conjoint Committee [CC] of those colleges. There were three representatives of each college on this committee. It was recognised that there were many Fellows and Members of United Kingdom Royal Colleges and also GPs whose interests may not be represented through such a committee. It was agreed that the committee would be advisory to the Director General and Minister of Health on matters of common interest to the colleges namely, standards, definition of specialists and related subjects. It would not be political and negotiation in that field would be a role for the New Zealand branch of the BMA, as it then was. A proposal to serve on a committee to address these and other matters, within the framework of the BMA, was rejected by the Conjoint Committee. Rather, it was hoped to form a combined committee with the BMA, to deal with and give advice on all aspects of specialist practise.

DANGEROUS DEALINGS:-

The BMA in New Zealand had formed, independently of the medical colleges, a seventeen member Central Specialist Committee [CSC] in 1963, comprising representatives of public hospital full time and part time senior medical staff. These were largely Fellows of the medical colleges, but not appointed as representing those colleges. There were also BMA and GP representatives on the CSC. This committee, while being part of the BMA structure and therefore involved in negotiating terms and conditions of employment and financial benefits with Government, agreed not to take unilateral action without discussion with the medical colleges. However, the initial aim of the colleges to form a combined committee with the CSC, was not accepted by the latter.

It was just as well that there developed an impasse between the medical colleges and the CSC to form a combined committee for purposes, among others, of negotiating financial rewards in whatever form, for medical specialists. This unrecognised fortuitous situation continued until March 1966, when the CSC finally offered the medical colleges, through the Conjoint Committee, full representational membership. Just as that was about to be accepted, information came to hand from England, of the dangers inherent in such a relationship, which would include direct involvement in discussing and negotiating financial benefits for Fellows and Members. The Royal College of Surgeons in London had almost lost its Charitable Charter by becoming involved in similar financial discussions, infringing the terms of that Charter. It was only saved from that fate, which could have proved terminal, on appeal to the Privy Council and then only by three votes to two. The RCS representatives in London, from then on, did not participate in financial discussions in joint meetings. This general policy was then applied to the colleges in New Zealand, pulling them back from the brink.

The principle of not being involved in negotiations on financial benefits for Fellows applies equally in the 21st century. In the case of CMC, if breached, the Charitable status of the organisation would be lost. With this important caveat, the three Royal Medical Colleges in New Zealand, agreed that they should be represented on CSC through members of the Conjoint Committee joining that body in June 1966. Regardless, College representatives were discussing at CSC one year later, the need for superannuation to be available to part time [less than 50%] hospital specialists employed by Hospital Boards. Also in that year, the Conjoint Committee was engaged in dialogue about such issues as additional salary steps [Supergrade] and private practise for full time public hospital specialists. This was probably pushing acceptable boundaries. Perhaps the final treading on thin ice came in April 1988, when the College Liaison Committee [arising from the Conjoint Committee] supported the CSC in contract negotiations, which seemed to be important in the maintenance of standards of patient care.

Fortunately, medical colleges since 1989 have been protected from involvement in negotiating financial remuneration for Fellows in the public sector by the formation of the Association of Salaried Medical Specialists [ASMS]. This organisation is much better equipped to negotiate the increasingly complex financial and conditions of employment issues than well intentioned, but possibly misguided medical colleges, either independently or collectively.

An important related matter was raised in 1989. This was the need for medical practitioners to conform to the requirements of the Commerce Act and to avoid anticompetitive activity. Discussions were held between the College Liaison Committee and members of the Commerce Commission to explain what was required. Perhaps this

information was not disseminated widely enough, or collective memory was too short to protect some Ophthalmologists from scrutiny and indictment early in the 21st century, under the Commerce Act

THE EVOLVING ORGANISM:-

It took over 38 years for the embryonic Conjoint Committee, comprising representatives of the 3 Royal Medical Colleges in New Zealand in 1963 to evolve to become The Council of Medical Colleges in New Zealand [Charitable Trust] in November 2001. There were several intermediate steps, some proactive, but others reactive to external influences.

In the decade following 1963, there was a proliferation of medical colleges. The need to network, for the purpose of collaboration between organisations with broad objectives in common, seemingly a simple task, has been a long standing difficulty in the health sector. However, as early as 1969, there were discussions between the medical colleges and the Ministries of Health and of Works concerning a possible joint Colleges headquarters on land next to the new Wellington urban motorway. Exactly what land would be available would not be known for years. The MRC [now the HRC], was also applying for a site. The next year, with some backing from trading banks, possible Wellington commercial sites were explored. In July 1970 the Department of Health was prepared to provide support with a substantial grant to move medical colleges and the Conjoint Committee into the National Health Institute building opposite Wellington Hospital in Riddiford St. It was possible that this would be alongside the MRC, the soon to be formed Council for Postgraduate Medical Education and the manpower committee of the Medical Council. This was perhaps the high point in relationships between several medical organisations and government. However Cabinet deferred a decision on this in March 1971 and such broad plans faded completely from sight.

It was becoming clear by the late 1960s, that the Conjoint Committee, representing only 3 medical colleges, was too narrow in its focus and was losing credibility as a result. The several more newly established colleges had a rightful part to play. There was external criticism, including from Mr. David Cole [later Dean of the Auckland University School of Medicine] in the NZ Medical Journal in January 1974. In March of that year the Conjoint Committee recommended that a conference of all medical colleges be called to discuss joint action to advance the interests of all. A meeting of representatives of the 8 medical colleges in New Zealand at that time was held on 1 May 1974. Those colleges and their 1974 names were as follows:- Royal Australasian College of Surgeons, Royal Australasian College of Physicians, Royal College of Obstetricians and Gynaecologists, Royal New Zealand College of General Practitioners, Royal Australasian College of Radiologists, Royal College of Pathologists of Australasia, Australian and New Zealand College of Psychiatrists and the Australian College of Dermatologists.

It was agreed that an organisation with representation of all the above colleges was appropriate and the following month a name change to the "College Liaison Committee" [CLC], to effect this, occurred. Functions of the committee were as follows:-

1. To be concerned with the maintenance of proper standards of training and practise in the various medical specialties.
2. To ensure that the views of Colleges and related bodies are made known to the Council for Postgraduate Medical Education [CPGME].

3. To act in an advisory capacity to such bodies as Central Specialists Committee, Medical Council of New Zealand and Health Department on matters of specialist training and practise, specialist registration and other similar concerns.

This seemed a broad and appropriate brief at the time.

The CLC like the CC before it, served as a forum for raising, discussing and debating issues of common interest to all colleges and for disseminating information. Representation by CLC members on such organisations as the CSC of the Medical Association of New Zealand [to become the NZMA] and the CPGME, assisted in this work. Also, there were at this time, 2 medical college representatives on the MRC. These were elected by the CLC after receiving nominations from all the medical colleges.

In February 1979, the Director General of Health, stated the importance of the CLC, hoping it would continue and regarding it as the channel by which the Department of Health communicated with all the colleges.

Despite these internal and external expressions of support for its activities and the valuable connections being developed on behalf of all the medical colleges, the future of CLC was debated repeatedly within the medical community. In July 1983, it was first suggested as a means of representing medical college views more forcefully, that CLC should become a Committee of College Chairs. This would have brought it in line with the Committee of Presidents of Medical Colleges [CPMC] in Australia. The first response to this suggestion was not supportive. It was believed that such a move would make the work of College Chairs too onerous. However, discussion continued with reference back to all colleges. Eventually there was a unanimous agreement that this valuable step should be taken and it was implemented in October 1986. At this time also there was the first debate about formalising a Constitution for CLC, but the first steps in writing one were not taken until over a decade later.

Accommodation and secretarial/ administrative support for the medical colleges in their formative days and for CLC, remained a variable feast. To a large extern, CLC was supported through the goodwill and resources of successive Chairs and there was no permanent home, let alone a fixed address, a sort of well- intentioned itinerant. Following the withdrawal of government support for joint headquarters in 1971, there was a further and briefly, more successful flurry of activity in 1976. This arose from discussions between the Wellington Clinical School of Medicine, Wellington Hospital authorities, RACS, RACP, the newly established NZ Colleges of Obstetrics and Gynaecology [NZCOG] and of Community Medicine [NZCCM, later to become the Australasian Faculty of Public Health Medicine of the RACP], CPGME and the Manpower Committee of NZMC. The proposal was for a joint headquarters for all those organisations, within the School or the Hospital. The medical colleges, no doubt wishing to have some geographic independence, stated through CLC, that they were in favour of a joint Colleges HQ and if that were not available, to then consider sharing with the other organisations. Eventually, in 1983, the above colleges and the CPGME, were provided with rental accommodation on the top floor of the Clinical Services Block of Wellington Hospital, with their own offices and shared conference space.

Somewhat earlier, in 1981, the regular secretarial servicing of CLC became a task shouldered by RACP and in 1984, gaining use of their PO Box. Mrs. Dorothy Simmons from RACP undertook the duties until July 1994 and was succeeded by Mrs. Jo Jones until May 1999.

The joint HQ in Wellington Hospital was quite short lived. The NZCOG withdrew in 1984, the fading CPGME in Decemberl986 and the RACS, when they purchased their permanent home at Elliott House on Kent Terrace, in December 1991.

By 1990, the need for a name change for CLC, reflecting widening activities and greater accountability of the medical colleges collectively, was recognised. The present name, Council of Medical Colleges in New Zealand, was adopted on 28 March 1990. Shortly before that, formal contact was established with the equivalent body in Australia, the Committee of Presidents of the Medical Colleges [CPMC]. Initially, it was suggested that agendas and possibly minutes, could be exchanged. Then an invitation to the Chair of CPMC to attend a meeting of CMC was extended. This became reciprocal, as the mutual benefits of exchanging information became evident. The two way trans-Tasman exchange has evolved into a fairly regular six monthly exercise. With only the Colleges of General Practitioners not being Trans-Tasman, one might question why two inter-college Committees or Councils are necessary. It is true that in earlier times, when Colleges were concerned purely with matters of training and standards of practice, final decisions were taken largely by College Councils based in Australia, but things change. In an increasingly regulated health sector, with some differences in legislative frameworks between Australia and New Zealand, different responsibilities and duties have been placed on Colleges on the two sides of the Tasman. Two of the most important are those related to the roles of regulatory authorities and of CME/CPD, obligatory at the time of writing in NZ, but not in Australia. There is mutual benefit in discussing and learning from these and other differences, which mean that in some areas separate decision making is necessary in the two countries.

The RACP and therefore also CMC remained at Wellington Hospital, but shifted to the old finance department, since demolished. They were accompanied by the NZCCM, which had by now become the Australasian Faculty of Public Health Medicine of the RACP. This accommodation continued until June 1992 when the move to 99 The Terrace occurred as the result of the RACP having purchased its HQ space there.

CMC remained under the benign supportive wing of the RACP until May 1999. It had a separate budget, with income derived exclusively from individual College levies determined according to size. RACP provided budgetary management, secretarial support and accommodation. This arrangement continued until a number of events from 1998 until 2000 required sensible constructive change.

The first of these was the increasing recognition, early in 1998 by the Ministry of Health and encouraged by the Colleges, that there should be more coordinated dialogue, particularly on matters related to postgraduate medical education, maintenance and improvement in standards and quality of health care and many other issues of common interest. There was agreement to establish a Memorandum of Understanding between CMC and the Ministry. One of the objectives was to eliminate any “surprises" between the organisations. This MoU was signed off on 19 August 1998 and remained unchanged until a new one was agreed in 2005. The Health Funding Authority [HFA], a creation of the tumultuous health reforms of the 1990s, was the next cab off the rank in seeking a MoU with CMC from late 1998. The HFA eventually went cool on the subject, was fragmented into Regional Health Authorities, which in tum disappeared following a change of government a year later.

One of the implied requirements in the MoU with the Ministry, was that the Director General of Health with one or more officials would attend part of all CMC meetings. There

was two- way traffic, with the CMC Chair and sometimes College Chairs being invited to discuss matters at the Ministry on a more regular basis.

The next issue, but a vexing and longstanding one, was to seek means by which the strength of College voices could be increased through a reorganised CMC. Two moves were mooted. The first of these, to include the executive officers of all the colleges in CMC meetings, occurred in March 1999. It was an important and valuable step. One of the deficiencies in the effectiveness of CMC has been the lack of institutional memory and therefore the risk of inconsistent action. Most college Chairs are in office for only two years. The inclusion of Executive Officers in meetings helped to provide continuity. There are caveats however. Executive officers administer College affairs, support college Chairs and attend meetings as valuable observers. They do not have a vote, since the final responsibility for matters debated and decided at CMC meetings, is in the hands of the elected Chairs. For some sensitive issues, such as determining the terms and conditions of employment of a CMC staff member or contractor of services, they may be excluded from part of a meeting. The EOs' duties in a CMC forum, relate to management rather than governance and recognising and noting the difference, can be a delicate balancing act.

A further step was to appoint a part time executive officer to CMC. The first appointee, Ms. Shona Speedy, attended her first meeting on 28 May 1999. Having an employee, allowed CMC to become increasingly independent of any one College, in itself an important philosophic and practical move. This helped strengthen the organisation within and on behalf of all the medical colleges. It also allowed all the colleges to be seen increasingly as important players by other stakeholders in the health sector. Separate leased space was taken up the following year at 99 The Terrace, Wellington, with independent telephone, fax and PO Box. The premises shifted to a separate office within the RNZCGP headquarters at 88 The Terrace in mid-2005.

In late 1999, the pace of CMC activities began to quicken significantly. The colleges were looking to define “A Way Forward”. With substantial assistance from the RACP Health Policy Unit, a booklet with that title was published in December and distributed widely, including to all College trainees, MoH, Politicians, NZMA and Medical Council. The object was to inform a wide range of stakeholders, including the incoming Labour Government of the key issues of concern for medical colleges, collectively, in the continuing and often confusing and disruptive, health sector reforms. The booklet specified how medical colleges, through CMC, could create strong constructive linkages between players in the sector, to the benefit of the community.

The concerns expressed by the Colleges in the booklet, included among others:-

- Provision of health services to provincial and rural New Zealand.
- The absence of an effective, high- profile, powerful and supported health consumer voice.
- The challenge of providing a medical workforce that meets NZ health needs.
- Ensuring the effective and efficient use of resources to provide the highest possible quality of care.
- Fees for medical and other health related students and an increasingly high level of debt carried by those students.

THE 21st CENTURY

AI the beginning of the new millennium, CMC was poised to expand its activities and horizons. It seemed important to extend the range of invitees to sit regularly at CMC meetings. The first of these was the NZMA. This organisation, two years earlier, had commenced hosting a three monthly, informal discussion group called the Medical Leaders Forum. The group included CMC, some individual medical colleges, the Resident Doctors Association [RDA], the Association of Salaried Medical Specialists [ASMS] and for an hour or so, representatives of the MoH. No minutes were kept, views were expressed and exchanged, but no action arose. It was inevitable that such an informal group would fade and eventually it did so in 2005. It was replaced by a more formal group at CMC instigation, called the Pan-Professional Medical Forum, comprising Chairs and CEOs of CMC, NZMA, ASMS and RDA. It studiously avoided debate or negotiations on industrial matters when CMC was present.

Returning to 2000, the NZMA Council Chair and CEO were invited and attended their first regular CMC meeting on 17 May. The second organisation invited to attend every CMC meeting was the Medical Council of New Zealand [MCNZ]. The President and CEO of MCNZ attended their first CMC meeting in August 2000. It also became a regular agenda item to invite representatives of a wide range of external organisations to make presentations with discussion on key topics of their own choosing or requested by CMC.

Having publicised collective concerns of the medical colleges and established some important external linkages, CMC needed to consider where this should lead. The first step was to place its money where its mouth was situated. The initial move in this process was the decision to publish and circulate a discussion paper entitled "Isolated Town and Rural Health Services in New Zealand". This occurred in March 2000. The preparation of the paper was assisted by the Health Policy Unit of the RACP. In the paper, CMC offered to establish a Taskforce on Rural Medical Workforce and Training. This was just one key move to address the burgeoning difficulties in continuing to provide appropriate health care to provincial and rural communities.

The sequel, since the broad subject struck an already sensitised nerve in the MoH, was for CMC to be offered a contract by the Ministry. A workforce and health service crisis was developing in North Auckland and CMC was invited to offer a solution by contracting to produce a comprehensive, well-researched and referenced document entitled “Review of Medical and Health Workforce Recruitment and Retention in Northland” [ISBN 0-473-07889-9]. This task was completed, again with marked assistance from the Health Policy Unit of the RACP, over a one year period, in July 2001.

The offer of a contract gave rise to an administration problem for CMC. Although some rules and a first draft Constitution had been drawn up in 1999, CMC was not yet a legal entity and could not enter into a contract on its own. This problem was solved by the development of a MoU with the RACP so that the latter would provide a formal supporting role until CMC had acquired legal entity status. This allowed CMC to undertake the contract work in its own name on behalf of all the Medical Colleges.

Prospects of possible further contracts with outside agencies gave further impetus to gaining legal status, but what form should it take? The best solution appeared to be a Charitable Trust and this was agreed in May 2000. The production of a Trust Deed appears simple, but does not occur over night. In this case it took 18 months! One of the sticking points was the question of how decisions of CMC were to be reached, let alone conveyed to outside agencies. A minority view was expressed, that any single College should have the

right to veto the view of the majority. Such a course may have prevented CMC giving a response or opinion on important issues, diminished its credibility in the sector and risked making it a laughing stock. Fortunately common-sense prevailed and allowance was made for recognition and expression of minority views when full consensus could not be reached.

The Deed of Trust of the Council of Medical Colleges in New Zealand Charitable Trust, was finally signed off by all eleven member Colleges, at the time, on 30 November 2001 and subsequently approved by the Registrar of Incorporated Societies. It is on the basis of that Deed and status that CMC has been able to move forward, strengthening the position and standing in the community of medical colleges both collectively and individually. Some examples of this increased recognition since 2001 follow.

CMC Chair was appointed to participate in writing the following MoH sponsored guides:-

- "A Framework for the Credentialing of Senior Medical Officers in New Zealand" [ISBN 0-478-24330-8]
- "An Introduction to Clinical Audit, Peer Review and other Clinical Practice Improvement Activities" [ISBN 0-478-27039-9].
- "Developing Consumer Participation in New Zealand Health Services".

The latter was one of the key issues raised by the Colleges in the CMC publication "A Way Forward". Australia has a huge lead in this field, with New Zealand scarcely off the starting blocks by comparison and despite continuing efforts by CMC. The MoH publication had great potential to address the matter on a broad front, but the Ministry preferred to confine the work to act as a guide for District Health Boards in recruiting health consumers to Credentialing Committees for Senior Medical Officers. This was a great opportunity lost and must be regarded as serious unfinished business.

In April 2003, the then Minister of Health, Hon. Annette King asked CMC Chair to meet with her quarterly and for either party to raise and discuss issues of common interest. These meetings, with usually two College Chairs present, were fruitful in developing dialogue on matters of importance, both to the medical community and the Minister. The agenda was limited to 3 to 4 subjects, to allow full discussion, with appropriate MoH officials present. These meetings continue following a change of Minister.

Also from 2003, CMC was represented by the Chair on the following external reference groups [ERGs] or working parties: Magnet NZ; Medical Reference Group [MRG] of the Health Workforce Advisory Committee; Public Health Bill ERG; MCNZ New Branch Vocational Advisory Group. Prof. Keith Grimwood also represented CMC on the Doctors in Training Workforce Roundtable. Many of these and future representations, extend over a period beyond the term of the office holders' membership of CMC. It was decided, that in order to provide continuity, this was appropriate, with regular feedback to CMC. Without such an agreement, the age old problem of only 2 years in office for most College Chairs would count against the credibility of CMC with outside bodies, which evolve policies over a longer time frame.

CONCLUSIONS

This history, highlighting only some of the joint activities of Medical colleges in New Zealand, is by its nature incomplete. Coordination and increasing collaboration between Colleges, has been an evolutionary process. The need for each new College to establish itself, particularly with regard to promoting standards of practice and robust training and

continuing education programmes, has been vital. However, until recently that important individualistic approach, has at times obscured the need to have a united collective voice on a number of big issues in the health sector. In the 21st century this is no longer the case and as a result of increasingly unified opinions and policies there is growing outside recognition of the value of the Medical Colleges collectively, through CMC and therefore of each and every individual College and what it stands for. In that environment there is also the opportunity for Medical Colleges to take the initiative on important developments in health care and support services, rather than merely having to react to the effects of ideologically driven policy shift, either individually, or as an uncoordinated group. The recent publication by the Royal College of Physicians of London: "Doctors in Society-medical professionalism in a changing world", strongly implies such a proactive approach.

Dr. P.N.Leslie FRACP March 2006

References:

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Winton R.R.- Why the Pomegranate ISBN 1988 0 909783 23 3

Royal College of Physicians of London-Doctors in Society: medical professionalism in a changing world 2005

ISBN I 86016 255 X

Minutes and papers of The Council of Medical Colleges in New Zealand and its predecessors from 1963 -2006.

APPENDIX: Chairs: 8 July 1963 Conjoint Committee

8 July 63 M. Williams RACP
7 July 63 E.G.Gibbs RACS
26 Aug 65 J.A.Keeling RACP
1 Dec 65 J.L.Adams RACP
1 June 66 M.Wi1liams RACP
5 Sept 67 J.E.Giesen RCOO
1 Oct 69 C.T.Collins RACS
27 Oct 71 G.F.Hall RACP
4 July 72 J-M.Tweed RACP
11 Mar 74 A.M.Rutherford RCOG
12 June 1974 Colleges Liaison Committee
3 Nov 76 A.Hall ANZCP
7 Feb 79 W.S.Alexander RCPA
1 Apr 81 L.D.Richards RACS
13 Apr 83 PGibson RNZCGP
2 Oct 85 POO Manin RACP
21 Oct 87 J.W.Hamer RCPA
27 June 1990 Council of Medical Colleges in New Zealand
27 June 90 BJ.Trenwith RACR

25 Oct 92 P.D.Manin RACP
1 June 95 M.AH.Baird RNZCOG
26 June 97 W.Miles RANZCP
1 Dec 99 P.N.Leslie RACP
18 Aug 04 P.Bagshaw RACS