Medical Council of New Zealand
Te Kaunihera Rata o Aotearoa

MEDICAL COUNCIL OF NEW ZEALAND

2015 ANNUAL REPORT

TE KAUNIHERA RATA O AOTEAROA MEDICAL COUNCIL OF NEW ZEALAND

Protecting the public, promoting good medical practice
Te tiaki i te iwi whānui me te whakatairanga pai i te mahi e pā ana ki te taha rongoā

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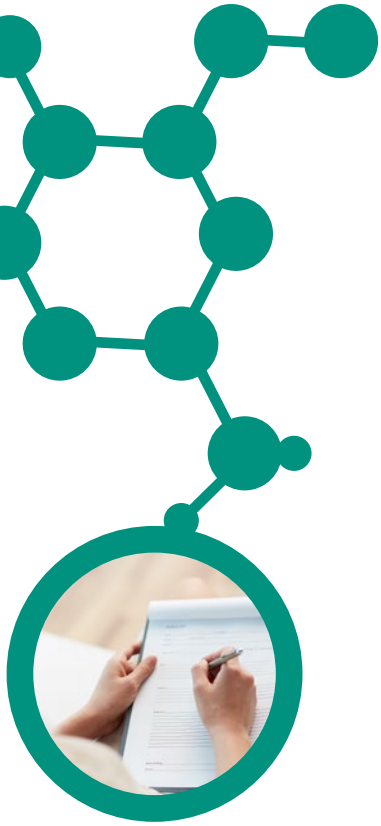

The Medical Council of New Zealand is pleased to submit this report for the year ended 30 June 2015 to the Minister of Health. The report is presented in accordance with section 134 of the Health Practitioners Competence Assurance Act 2003 (HPCAA) and includes a report on activities of the Health Practitioners Disciplinary Tribunal for doctors only.

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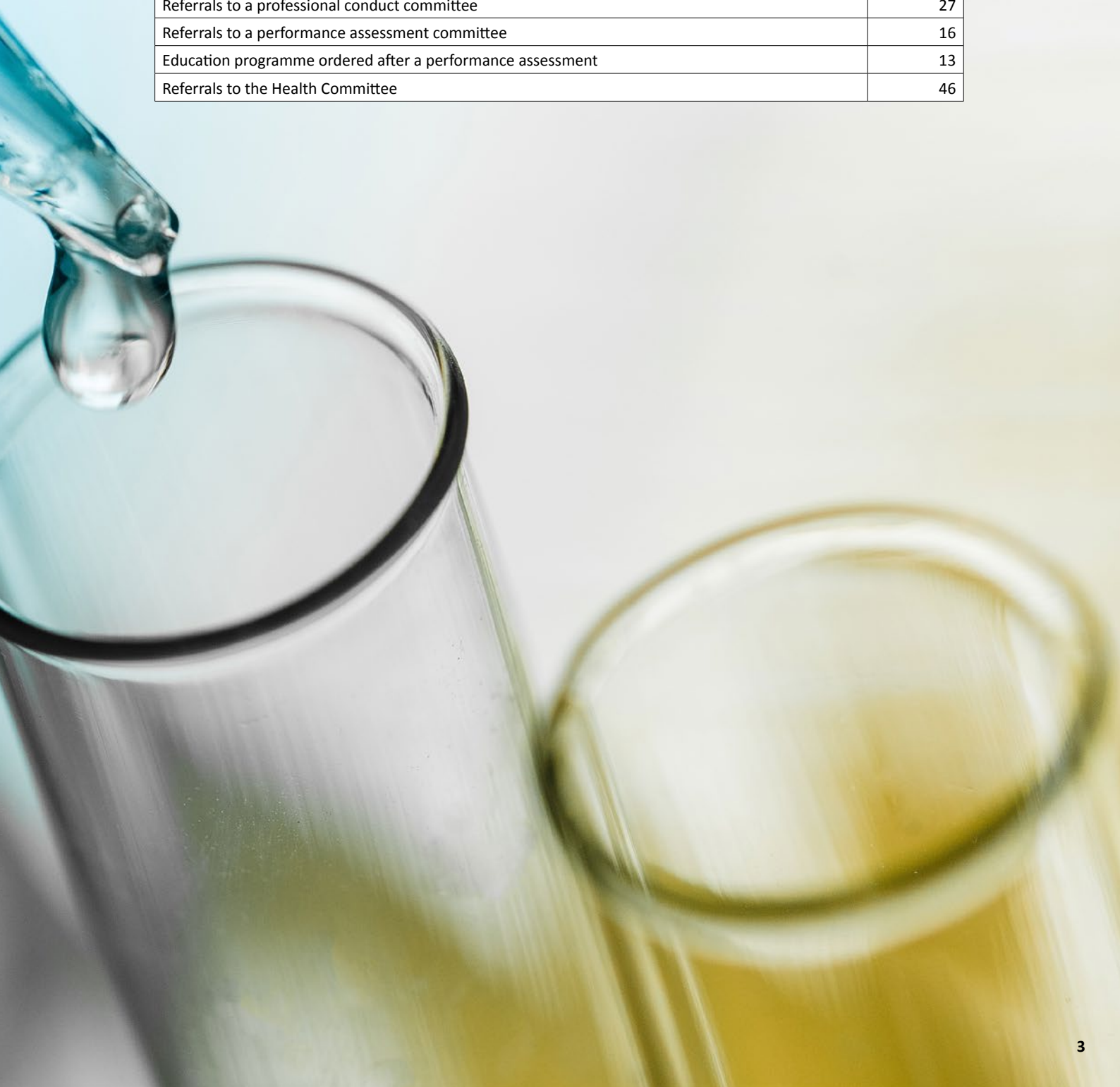
FACTS AT A GLANCE

1 July 2014 to 30 June 2015

Doctors registered (1 July 2014 to 30 June 2015)	
– Trained in New Zealand	421
– International medical graduates	895
Total practising doctors at 30 June 2015	14,677
Doctors registered with vocational scopes	10,672
Candidates who sat NZREX Clinical	48
Candidates who passed NZREX Clinical	22
Referrals to a professional conduct committee	27
Referrals to a performance assessment committee	16
Education programme ordered after a performance assessment	13
Referrals to the Health Committee	46



CHAIRPERSON'S REPORT

The past 12 months have seen considerable work by Council in a variety of areas. We have seen the successful launch of online services, best exemplified by online renewal of practising certificates. This has been resoundingly successful. In addition, much work has been done to enhance medical education and training and to stimulate debate within the profession and with our stakeholders on a variety of issues. The significant damage sustained to our offices in the Wellington earthquake of December 2013 necessitated a move to new office space. This was successfully completed in August 2014 without interruption to our services.

Council remains committed to providing the highest standards of medical regulation and being fair and effective in our legal role of protecting public health and safety.

PREVOCATIONAL EDUCATION AND TRAINING

This year has seen the implementation of the prevocational educational framework for our newest colleagues entering postgraduate year 1. This is a very important initiative, and Council is grateful for the considerable work done by many colleagues to make this a success. Work to establish and grow community attachments for interns is well under way.

BETTER DATA – THE BENEFITS TO THE PROFESSION AND THE PUBLIC

In late March 2015, the Council released a discussion paper, *Better Data – the benefits to the profession and the public,* on the value of performance and outcome data and how such data promotes the competence of doctors.

The discussion paper followed a ruling by Ombudsman and former Health and Disability Commissioner Professor Ron Paterson that a district health board (DHB) should release surgeon-specific case data. This was in response to a journalist seeking information under the Official Information Act.

Good data is required by doctors to allow our patients to receive the best information to allow for an informed choice on their health needs. In addition, good data should aid all of us in reflecting on our performance and influencing our learning.

The Council believes it is important to examine the arguments for making more performance and outcome data publicly available, particularly where it relates to individual clinicians. It needs to serve more than just a 'right to know' purpose. Done well, better data would reassure the public, encourage better engagement in decision-making around service provision, and help informed choice because local outcome figures will be available.

Much progress has been made on this challenging topic, and the coming year will see further debate and progress.

COUNCIL MEMBER CHANGES

On 3 July 2014, Dr Tailulu (Lu'isa) Fonua-Faeamani was appointed for a 12-month term to Council, and on 8 August 2014, Ms Kim Ngārimu was appointed as a layperson member of the Council for a 12-month term of office.

In February 2014, I was again re-elected Chairperson of the Medical Council of New Zealand. Ms Laura Mueller, layperson, was again re-elected as the Council's Deputy Chairperson.

Three of the elected members chose not to stand for election again in March 2015, and their terms expired in mid-2015.

The three members, Drs Rick Acland and Peter Robinson and Professor Richard Sainsbury, have collectively made a tremendous contribution to Council and its governance.

Dr Rick Acland was appointed to Council in July 2006 and subsequently re-elected to Council. Dr Acland has played a valuable governance and oversight role as a member of the Audit Committee, and he made a sustained and invaluable contribution to Council discussions.

Dr Peter Robinson was elected to Council by the profession and appointed to Council in June 2012, bringing knowledge and experience of dealing with sick doctors through his work in medico-legal indemnity. This experience added greatly to Council's skill mix.

Professor Richard Sainsbury was elected to Council by the profession and appointed to Council in June 2009. He was reappointed in June 2012 after being again being re-elected to Council. Professor Sainsbury has made a significant contribution to Council, and in particular, he led debate on addressing the challenging issue of ageing doctors and risk.

The Minister of Health, the Hon Dr Jonathan Coleman, also reappointed Dr Allen Fraser for another 2-year term and Ms Joy Quigley, a layperson member, for another 3-year term in April 2015.

I would like to thank all existing and retired Council members for the contribution they have made to the work of Council.

MEDICAL COUNCIL ELECTION

The Council undertook its 3-yearly election in March 2015 to choose four doctors as Council members and for the first time, the profession could vote online.

The names of the four highest-polling nominees in order of voting were:

- Dr Curtis Walker
- Dr Pamela Hale
- Dr Jonathan Fox
- Dr Kathryn Baddock.

All the nominees were appointed in June 2015 to Council for a 3-year term and took up their new role on 1 July 2015.

Dr Jonathan Fox is an existing Council member who was re-elected to Council.

A total of 15 candidates stood in the Council election, and the total number of valid votes was 3,914. The return was 22.33 percent, being 3, 924 votes from 17, 591 doctors who were eligible to vote. Council would like to see more doctors participate in this important process

PREPARING FOR THE EBOLA VIRUS

In mid-October 2014, on the back of global concerns about the Ebola virus, I emailed all doctors to ensure that we were are all aware of our roles and responsibilities should the virus be brought to New Zealand.

My email drew the profession's attention to resources the Ministry of Health had prepared as well as the Council's *Advice on the standards expected of doctors during a pandemic.*

The most important steps all doctors can take are to be aware of the relevant features of the patient's history and presentation that suggest Ebola as a possible diagnosis, be aware of the immediate actions then to take as detailed by the Ministry, and ensure all infection-control protocols are meticulously followed at all times.

My email noted that Council did not expect any doctor to deliberately put themselves in danger to treat a patient in an emergency. Therefore, no doctor should risk exposure to Ebola if personal protective equipment is inadequate or not available. Similarly, it is clear that the correct use of personal protective equipment includes appropriate assistance to both don and remove the equipment. A lack of such support would place the doctor at unacceptable personal risk.

CONSULTATION ON PROPOSED COUNCIL FEES FOR DOCTORS

When the Council consulted in 2014 about an increase in the practising certificate fee, feedback received included the suggestion that we should adopt a more user-pays approach to the fees we charge and therefore the income we receive.

The principle of user pays has formed the basis of the review of fees that we have undertaken. This has been applied consistent with the principles of the Auditor-General. We also wanted to limit cross-subsidisation so that the new fee structure is fair and equitable and may withstand scrutiny of any audit process or parliamentary enquiry.

I would like to highlight that, while there are increases in several fees, there are also several reductions in fees, including registration of New Zealand and Australian graduates. The new fees schedule takes effect from 1 September 2015.

PRACTISING CERTIFICATE FEE INCREASE

Following consultation with the profession and other stakeholders in June 2014, Council increased the practising certificate fee by $40 with effect from 1 September 2014.

Feedback from the consultation process on the proposed $80 fee increase was equivocal, with approximately 70 responses in support of the increase and 60 opposed.

After taking the feedback into consideration, Council considered options and decided that the $40 (GST exclusive) increase for 2014/2015 was the appropriate amount. This resulted in the practising certificate fee increasing from $711.60 to $757.60. The Council accepted that a further increase would be needed for the 2015/2016 year.

THANKS

I extend my thanks to members and staff of the Council for their support over the past year and meeting the challenges and demands that we have faced.

Mr Andrew Connolly
Chairperson
Medical Council of New Zealand

AUDIT COMMITTEE REPORT

The Audit Committee is a standing committee of the Council.

TERMS OF REFERENCE

The terms of reference for the Audit Committee as approved by Council are to:

- oversee the risk management programme
- review the risk profile (including legal compliance, financial, statutory reporting, and fraud risks)
- monitor the internal control systems and assessment
- oversee the annual external audit by the Office of the Auditor-General
- oversee any internal audit
- ensure the integrity of external financial reporting
- ensure appropriate financial management policies and practices are in place
- ensure that Council and management are provided with financial information that is of high quality and relevant to their judgements
- conduct special investigations as required by Council.

FEES REVIEW

The Audit Committee has spent considerable time overseeing the fees review project and the methodology used in the review. Accountancy firm KPMG was asked to peer review the activity-based costing (ABC) methodology used by Council staff to determine the proposed new fee structure.

The review found that the Medical Council's application of the ABC methodology, and the assumptions used in performing the fee calculations, are appropriate for the current year.

QUARTERLY PRACTISING CERTIFICATE (PC) FEE

The Committee discussed the issue of doctors having to pay a full 12-month PC fee when they may only be working for a short duration after the expiry of their current PC (such as cases where a doctor is leaving to go overseas 6 weeks after the expiry of their PC). The current situation is that, for the doctor to be able to work for that 6-week duration, they would need to pay a full 12-month fee, and no refunds are available. This was seen by many doctors as being unfair and unreasonable and was the source of many complaints to the registration team.

The Audit Committee approved the use of having a quarterly PC fee for these situations where a practising certificate will be issued for a period of less than 12 months and is not to be used as a method of paying the full PC fee by quarterly instalments.

RISK MANAGEMENT

The management team has continued to develop and implement a comprehensive risk management framework. Every quarter, the top 15 risks in the Council's risk register are reviewed by both the management team and the Audit Committee to ensure they are managed appropriately.

I would like to acknowledge the work and contributions of the Audit Committee and staff alike.

Dr Peter Robinson
Chairperson
Audit Committee
Medical Council of New Zealand

EDUCATION COMMITTEE REPORT

PREVOCATIONAL TRAINING

The focus over the last year has been the implementation of a series of changes to prevocational training requirements for doctors in New Zealand during their first 2 years of medical practice.

The first changes took effect in November 2014 with new requirements for interns (graduates of New Zealand and Australian accredited medical schools and doctors who have passed the NZREX Clinical examination). The changes focus on a quality educational experience for interns while also providing timely and useful feedback that will improve the standard of medical practice and ultimately patient safety.

ePORT TO RECORD LEARNING

The e-portfolio system was introduced in November 2014 to enable interns to record and keep track of their learning. The ePort makes it easy for doctors to set goals in their professional development plan and to track their progress in attaining the learning outcomes in the New Zealand Curriculum Framework for Prevocational Medical Training (NZCF). The NZCF lists the learning outcomes to be achieved by new doctors and builds on experience, competencies, attitudes, and behaviours acquired during medical school, particularly during the final year.

I would like to acknowledge the important part played by Health Workforce New Zealand who have funded the capital costs of the development of ePort, which enabled us to bring the project to fruition.

ACCREDITATION STANDARDS FOR TRAINING PROVIDERS AND CLINICAL ATTACHMENTS

Council has approved standards for accreditation of training providers and standards for accreditation of clinical attachments to improve the quality of prevocational training and ensure that every clinical attachment provides a quality educational experience with appropriate supervision.

All training providers are required to meet the accreditation standards by November 2015. Assessment against the new standards will take place at the next scheduled accreditation visits for each training provider.

COMMUNITY-BASED ATTACHMENTS

Work has continued to focus on the implementation of community-based attachments for interns. Completing a clinical attachment in a community setting will familiarise interns with the delivery of healthcare outside the hospital setting. This will assist interns to understand the interface between primary and secondary care and prepare them for changing models of care. This is particularly relevant where it is expected that, in the future, a greater share of medical services will be provided in the community.

Community attachments can take place in a wide variety of settings that may include general practice, urgent care, palliative care, and community mental health.

Council's goal is for every intern to complete one clinical attachment in a community-based setting over the course of the two intern years. A staged transition is commencing, with a goal of 10 percent of interns completing a community-based clinical attachment in the year commencing November 2015 and working towards 100 percent compliance by November 2020. Training providers will need to demonstrate progress over this period.

SUPPORT FOR SUPERVISORS

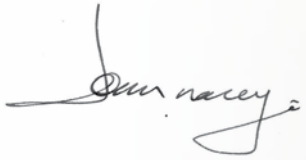
An important aspect of the prevocational changes focus on the assessment and feedback that is provided to interns. To this end, workshops for prevocational and educational supervisors and clinical supervisors have focused on providing education and support to those who supervise interns, with well over 200 attending the training sessions that were held in several centres around the country over the past year.

PUBLICATIONS

A number of publications have been produced to guide supervisors of interns. These include:

- *Guide for Clinical Supervisors of Prevocational Training,* which sets out the responsibilities of the clinical supervisor named as a supervisor of interns as part of the accreditation of a clinical attachment
- *Guide for Prevocational Educational Supervisors,* which outlines the role and responsibilities of the prevocational education supervisor.

Finally, I would like to thank all Council and Education Committee members for the contribution they have made. Likewise, I would like to acknowledge the contribution of the Council's strategic programme manager, Joan Crawford, and her team who have done an outstanding job in driving the prevocational training project forward.



Professor John Nacey
Chairperson
Education Committee
Medical Council of New Zealand

MEMBERS OF THE MEDICAL COUNCIL

During the period 1 July 2014 to 30 June 2015

DR RICHARD (RICK) ACLAND

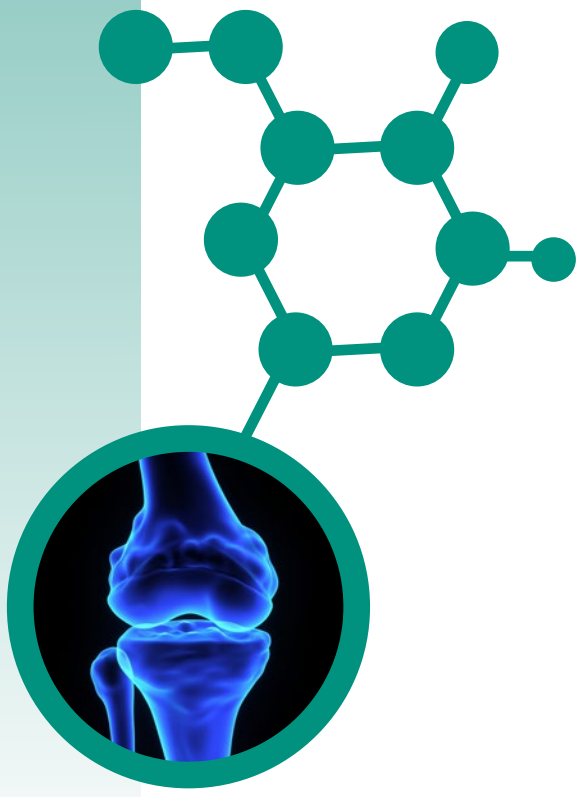
MB ChB 1975 Otago, FFARACS 1982, FANZCA 1992, FAFRM (RACP) 2003

Dr Acland was elected to Council by the profession and appointed to Council in June 2006.

Dr Acland commenced anaesthesia and pain management practice in Auckland in 1983. He is a consultant in rehabilitation, specifically in spinal cord impairment, chronic pain, and neuromodulation. He was elected to the Medical Council in 2006.

Dr Acland is a member of the Council's Audit Committee.

After serving three terms as an elected member, Dr Acland retired in June 2015.



MR ANDREW CONNOLLY

MB ChB 1987 Auckland, FRACS 1994

Appointed to Council in November 2009, Mr Connolly was elected Deputy Chairperson of Council in February 2012 and Chairperson in February 2014. Mr Connolly was re-elected to this position in February 2015.

Mr Connolly is a general and colorectal surgeon, employed full-time at Counties Manukau District Health Board.

Trained in Auckland, Mr Connolly undertook a formal 18-month period of surgical research under Professor G L Hill before completing post-fellowship colorectal training in the United Kingdom. He returned to Middlemore Hospital as a consultant surgeon in late 1997.

He has a strong interest in governance and clinical leadership and has been the Head of Department of General and Vascular Surgery since 2003. He has served on the Ministerial advisory group that was responsible for the *In Good Hands* document. In 2015, he has also served on the Ministry of Health Capability and Capacity Review of the Health Sector.

Mr Connolly has served on various national committees, including the New Zealand Guidelines Group for the screening of patients with an increased risk of colorectal cancer.

He has previously held the role of Presiding Member of the Lotteries Health Research Distribution Committee, he recently chaired a Ministerial review of the impact of the elective waiting times policy, and he was a member of the review panel of the New Zealand Cancer Registry.

He has a strong interest in surgical education and training and acute surgical care as well as taking an active role with surgical research into enhanced recovery. He has a passion for military history, particularly the First World War.

Mr Connolly is an ex offico member of all committees.

MEMBERS OF THE MEDICAL COUNCIL

During the period 1 July 2014 to 30 June 2015

DR T LU'ISA FONUA-FAEAMANI

MBChB 1998 Otago, FRNZCGP 2007

Appointed to Council in July 2014, Dr Lu'isa Fonua-Faeamani is a general practitioner (GP) and clinical director for The Fono – Health and Social Services based in West Auckland. The Fono provides affordable healthcare services including medical, dental, pharmacy, health awareness, and community support services and delivers a combination of these services across four Auckland locations.

Dr Fonua-Faeamani has worked with Pacific health providers in Central and West Auckland as a GP providing care for this high-needs population.

Dr Fonua-Faeamani graduated from Otago Medical School in 1998. She returned to Tonga for 3 years to work at Vaiola Hospital and was posted to the outer island of 'Eua as the only doctor for 8 months before returning to New Zealand for advanced training.

Dr Fonua-Faeamani is particularly interested in Pacific health and the development of Pacific GPs and the Pacific primary health workforce.

Dr Fonua-Faeamani is a member of Council's Health Committee.

DR JONATHAN FOX

MB BS 1974 Lond, MRCS Eng LRCP Lond 1974, MRCGP 1981, FRNZCGP 1998

Dr Fox was elected to Council by the profession and appointed to Council in June 2009. He has been re-elected twice since.

Dr Fox is a general practitioner (GP) based in Auckland. He is a past President of the Royal New Zealand College of General Practitioners (RNZCGP) and past Chair of the Council of Medical Colleges in New Zealand. He is a board member of ProCare Health Limited – the Auckland GP network. He is a Trustee of the Goodfellow Foundation.

He was awarded a Distinguished Fellowship of the Royal New Zealand College of General Practitioners in 2010.

His previous positions included membership of the board and GP Council of the NZMA and the Competence Advisory Team of the Medical Council, Medical Officer to Kings College Auckland, and many RNZCGP Auckland Faculty positions.

Dr Fox qualified from Guys Hospital Medical School, London, in 1974. He then spent 7 years working as a medical officer in the Royal Navy before completing his vocational training in the United Kingdom. After leaving the Navy, he spent 8 years as a GP in Rugby, UK, where he was also medical officer to Rugby School.

He came to New Zealand in 1990 with his GP wife and their children. Over the last 25 years, their practice has grown and is now a six-doctor practice in Meadowbank, Auckland.

Dr Fox has been awarded an Honorary Fellowship by the Royal Australian College of General Practitioners.

Dr Fox is Chairperson of the Council's Audit Committee and Deputy Chairperson of the Education Committee.

MEMBERS OF THE MEDICAL COUNCIL

During the period 1 July 2014 to 30 June 2015

DR ALLEN FRASER

MB ChB 1969 Otago, DPM 1973 Otago, MRCPsych 1976, M 1978 F 1980 RANZCP

Dr Fraser was appointed to Council in August 2008.

Dr Fraser went to medical school in Dunedin in the 1960s and subsequently trained as a psychiatrist in Auckland and at St Thomas' Hospital in London. He was appointed as a consultant psychiatrist in South Auckland in 1977, where he led the development of community-based mental health services, at the same time continuing what has been a career-long commitment to the acute care of the seriously mentally ill.

He has been involved in many local, national, and international professional organisations, including the Royal Australian and New Zealand College of Psychiatrists (RANZCP) since 1980. Dr Fraser was chair of the RANZCP's New Zealand Committee for 4 and a half years. He has been a union leader (President of the Association of Salaried Medical Specialists for 4 years and is now a life member) and a chief medical officer.

Dr Fraser maintains a small private practice in Auckland seeing a few patients with severe mood disorders and undertaking medico-legal assessments. He is also undertaking clinical work for different DHBs as a locum consultant psychiatrist.

Dr Fraser is Chairperson of the Council's Health Committee.

MS SUSAN HUGHES QC

BA, LLB, GDip Bus Studs, MMgt

Appointed in May 2013 as a Council layperson, Ms Hughes was a partner in the New Plymouth law firm of Govett Quilliam for 18 years, leaving in 2006 to commence practice at the independent Bar. She was appointed Queen's Counsel in 2007 and continues her practice in New Plymouth – a broad-based litigation practice spanning diverse jurisdictions of the Courts.

Ms Hughes has held a number of Government appointments over the years. Most recently, she was a Director of the Civil Aviation Authority and the Aviation Security Service from 2004 to 2011.

Ms Hughes has now practised law for more than 30 years, which has honed her interest in matters of process and the effective resolution of disputes.

MEMBERS OF THE MEDICAL COUNCIL

During the period 1 July 2014 to 30 June 2015

MS LAURA MUELLER

BA Psych (Calif) 1992, Juris Doctor (Calif) 1996

Appointed to Council in October 2009, Ms Mueller is a layperson of the Council and was elected the Council's Deputy Chairperson in February 2014. Ms Mueller was again elected to the position of Deputy Chairperson in February 2015.

Ms Mueller was appointed as a judicial officer for the Ministry of Justice in 1999 and sits as a Referee in the Disputes Tribunal at the Tauranga District Court. Ms Mueller has 20 years of business experience, including management of a large accounting and tax practice and experience as a medical insurance underwriter.

With a keen interest in governance and leadership, Ms Mueller has served on the Disputes Tribunal's National Education Committee for more than 7 years. She has served as Treasurer on the Disputes Tribunal's Referees Association Executive and is a mentor for new referees.

Ms Mueller is a member of the Council's Complaints Triage Team and the Audit, Education, and Health Committees, as well as being the Council's liaison member on the Health and Disability Commissioner's Consumer Advisory Group.

PROFESSOR JOHN NACEY

MB ChB 1977 Otago, FRACS 1985, MD 1987 (Otago), MBA

Professor Nacey was appointed to Council in March 2010.

Professor Nacey graduated from the University of Otago in 1977. After completing specialist training in urology, which included an appointment as Chief Resident in Surgery at the Flinders University Medical Centre, Adelaide, Australia, he returned to New Zealand to take up a joint hospital/university position in Wellington. In 1998, he was appointed Dean and Head of Campus at the University of Otago's Wellington School of Medicine, a position he held for 10 years.

With an interest in prostate disease, Professor Nacey has published extensively on this subject. He acts as referee for several major international journals and has chaired the recent Government Prostate Cancer Taskforce. As a past examiner for the Royal Australasian College of Surgeons, he has maintained his interest in teaching undergraduate medical students and postgraduate surgical trainees.

Professor Nacey currently holds the position of Professor of Urology at the Wellington School of Medicine.

He has widespread community involvement including the position of President of the Wellington Medical Research Foundation and Chairman of the Board of Management. He remains a strong advocate for promoting men's health.

Professor Nacey is Chairperson of the Council's Education Committee.

MEMBERS OF THE MEDICAL COUNCIL

During the period 1 July 2014 to 30 June 2015

KIM NGĀRIMU

BBS

Ms Ngārimu was appointed to Council as a layperson in August 2014.

Ms Ngārimu is a director of Tāua Limited, a consulting company specialising in the provision of public policy and management advice and relationships with iwi and Māori communities.

She held the position of Deputy Secretary Policy with Te Puni Kōkiri from March 2007 until December 2013.

Ms Ngārimu has also held positions as Acting Chief Executive of the Ministry of Women's Affairs and Acting Director for the Waitangi Tribunal.

Following the completion of her university studies, Ms Ngārimu worked for Te Rūnanga o Ngāti Porou, gaining a solid grounding in Māori community dynamics and aspirations. Following this, she first joined Te Puni Kōkiri in 1992, and she worked in various senior management, policy management and regional roles until 1999. She left Te Puni Kōkiri in 1999 to take up a sector manager role at the Office of the Controller and Auditor-General.

In the 7 years before rejoining Te Puni Kōkiri, Ms Ngārimu continued to build her experience in policy, strategic management, business, and governance through co-directorship of her management and public policy consulting company.

Ms Ngārimu's tribal affiliation is Te Aitanga ā Mate, Ngāti Porou.

MS JOY QUIGLEY JP

QSO (2008)

Ms Quigley was appointed to Council as a layperson in August 2011.

Ms Quigley served as a National Member of Parliament from 1990 to 1999, chairing the Māori Affairs, Foreign Affairs and Defence, and Social Services Select Committees during that time. After retiring from Parliament, she became the Executive Director of Independent Schools of New Zealand until 2008 and is currently a director, with her husband, of a consultancy business based in Kerikeri.

Ms Quigley graduated from the School of Physical Education, University of Otago in 1967 and subsequently from Christchurch Teachers College. She has been involved with a wide range of local, regional and national voluntary organisations during her adult life. In 2008, she became a Member of the Queen's Service Order recognising her public and community service.

During 2009–2010, Ms Quigley was a member of the Government-appointed panel considering New Zealanders' access to high-cost, highly specialised drugs.

Ms Quigley is a member of the Council's Audit and Education Committees and an alternative layperson member on the Council's Health Committee.

MEMBERS OF THE MEDICAL COUNCIL

During the period 1 July 2014 to 30 June 2015

DR PETER ROBINSON LVO

MB ChB 1972 Otago, MSc London 1982, MCCM NZ 1986, DipDHM 1988, FAFPHM (RACP) 1994, FRACMA 1994, FAFOM (RACP) 2004, FFFLM (RCP) 2006, FNZCPHM 2008

Dr Robinson was elected to Council by the profession and appointed to Council in June 2012.

Dr Robinson is a graduate of the University of Otago and subsequently worked in varied positions while always maintaining clinical practice in the fields of public health and occupational medicine, including Research Fellow US Navy Experimental Diving Unit, Director-General of New Zealand Defence Medical Services, Corporate Medical Advisor for ACC, Convenor Civil Aviation, Regional Director of Training for the Royal Australasian Faculty of Public Medicine, Medico-Legal Advisor MPS, and Executive Director New Zealand College of Public Health Medicine.

In 1978, Dr Robinson was made a Lieutenant of the Royal Victorian Order (LVO) for services to the Royal Family.

Presently, Dr Robinson is the Chief Medical Officer/Advisor for a number of insurance providers, including Medicus, is on the list of experts used by lawyers instructed by claimants in injury and illness-related claims, provides fitness-for-work assessments including for soldiers returning from Afghanistan, and is Medical Advisor to the New Zealand Police and Maritime New Zealand. He is the RSA appointment to the War Pensions Appeal Board and has recently been appointed the Chief Clinical Advisor heading the new Clinical Services Directorate at ACC.

Dr Robinson is a member of the Council's Audit and Health Committees.

PROFESSOR RICHARD (DICK) SAINSBURY

MB ChB 1972 Otago, FRACP 1981, MA 2011, Postgrad Dip Arts 2011

Professor Sainsbury was elected to Council by the profession and appointed to Council in June 2009.

After Professor Sainsbury graduated from the University of Otago, he spent 6 years as a resident medical officer in Auckland, before going to the United Kingdom for advanced training.

Since 1982, he has worked as a consultant physician in geriatric medicine in Christchurch in dual university/hospital appointments. He has a particular interest in student teaching and has served a period as trainee-intern coordinator. He has also been involved in the examination, mentoring, and supervision of international medical graduates and is a board member of the New Zealand Artificial Limb Service.

Professor Sainsbury is a member of the Council's Health Committee.

NEW COUNCIL MEMBERS

On 30 June 2015, the Hon Dr Jonathan Coleman, Minister of Health, appointed Drs Kathryn Baddock, Pamela Hale and Curtis Walker and reappointed Dr Jonathan Fox for 3-year terms commencing on 1 July 2015.

The appointments followed the Council's election in March 2015 and the doctors being the four highest-polling candidates.

CHIEF EXECUTIVE'S REPORT

CHANGES TO COUNCIL STRUCTURE

In May 2015, following consultation with staff, I implemented some structural changes to the Council's office:

- Increasing the size of the Registrar's office from one full-time equivalent (FTE) (David Dunbar) to two FTEs (adding Ms Susan Yorke as Deputy Registrar).
- Appointing Ms Valencia van Dyk as General Manager, Core Services (covering both registration and professional standards).
- Changing the four positions of team leader (in registration and professional standards) to team manager and appointing the current incumbents to these positions. The new positions have responsibility for people management and oversight of cases, and policy development within their respective teams.

The reasons for the changes were the high workload of the Registrar and the risk of distracting the legal team from their core tasks (advising professional conduct committees and supporting prosecutions) and blurring the boundaries between the Council and the investigations process.

CONSUMER ADVISORY GROUP

Council's Consumer Advisory Group, made up of Pacific, disability, health and iwi consumer advisers, continues to provide valuable feedback and suggestions to Council on issues such as Council's consultation papers on advertising and cultural competence as well as providing a consumer perspective and input into Council research. The Group provided valuable feedback on the Council's discussion paper *Better Data – the benefits to the profession and the public,* which examined the value of performance and outcome data.

Members also provided valuable feedback from a health consumer's perspective on our document *Principles for the assessment and management of complaints and notifications.*

INTERNATIONAL ASSOCIATION OF MEDICAL REGULATORY AUTHORITIES (IAMRA)

I attended the IAMRA conference in London in early September and chaired the IAMRA General Assembly at which Mr Niall Dickson (Chief Executive of the General Medical Council and Chair-Elect of IAMRA) took over as Chair of IAMRA.

Ms Valencia van Dyk was elected to the IAMRA Management Committee.

MEMORANDUM OF UNDERSTANDING (MOU) WITH PRIMARY HEALTH ORGANISATIONS (PHOS)

A MoU similar to that already agreed with DHBs and private hospitals is close to completion with PHOs. The main focus of the MoU is on managing risk regarding doctors with competence, conduct, and/or health concerns. Other aspects of the MoU cover:

- an expectation that the PHO will ensure that all doctors hold a practising certificate and are meeting their recertification requirements
- advising the Council of doctors who are not meeting PHO quality indicators where there may be a risk of serious harm
- a shared understanding that the PHO will promote the Council's standards for the profession.

myMCNZ

In January 2015, the practising certificate renewal process went online with some 3,800 doctors completing their practising certificate applications electronically.

After the first week, over 1,000 of the 3,800 doctors had successfully completed an online renewal at an average time of 11 minutes per application. Although there were some initial teething problems because of doctors not being familiar with the system, these were quickly resolved by the Council's information technology team.

My thanks go to Mr Andrew Connolly, all Council members, and staff for their support and professionalism this year.

Philip Pigou
Chief Executive

OUR FIVE STRATEGIC GOALS ARE:

1. Optimise mechanisms to ensure doctors are competent and fit to practise.
2. Improve Council's relationship and partnership with the public, the profession, and stakeholders to further Council's primary purpose – to protect the health and safety of the public.
3. Promote good regulation of the medical profession by providing standards of clinical competence, cultural competence, and ethical conduct and ensuring that the standards reflect the expectations of the public, the profession, and stakeholders.
4. Improve medical regulatory and workforce outcomes in New Zealand by the registration of doctors who are competent and fit to practise and their successful integration into the health service.
5. Promote good medical education and learning environments throughout the undergraduate/postgraduate continuum to help ensure all doctors have achieved the necessary practice standards for their practice.

Our four strategic directions each have a work programme that contribute to the Council achieving its goals:

- Direction one: Fitness to practise
- Direction two: Medical workforce
- Direction three: Medical education
- Direction four: Accountability to the public and stakeholders

REGISTRAR'S REPORT

APPOINTMENT OF INTERN SUPERVISORS

As part of implementing the e-portfolio for prevocational training, each district health board (DHB) was requested to supply a list of the accredited clinical attachments that would be allocated to interns during this transitional year up to 24 November 2015 when the new accreditation standards are implemented. As part of this process, each DHB provided details of the clinical supervisors on each attachment. This would allow the clinical supervisors on an attachment to access the e-portfolio of the interns they were supervising for the period of supervision.

Through this process, it became apparent that DHBs had not kept Council up to date with changes to named clinical supervisors. Internal checks on the final list of named clinical supervisors were carried out to ensure all supervisors were registered in a vocational scope of practice and were in good standing with the Council.

There was a small group of doctors identified for whom advice was sought from senior staff about whether any conditions would affect their ability to supervise interns. Council's approach, when notified of a concern, has generally been not to remove a doctor as a supervisor (unless the circumstances clearly require it). In the event, the majority of the doctors reviewed were approved to continue in the role of clinical supervisors.

In future, however, the new e-portfolio-based processes will ensure Council will have a greater capacity to identify in advance, where necessary, any issues relating the appropriateness of a doctor acting in the role of clinical supervisor.

GAZETTE NOTICE – CHANGES TO GENERAL SCOPE PREREQUISITES

At its October 2014 meeting, Council approved changes to the requirements for registration in the general scope for doctors with provisional general registration based on Australian/New Zealand qualifications or NZREX. These reflected the changes to prevocational training requirements being implemented by Council in 2015.

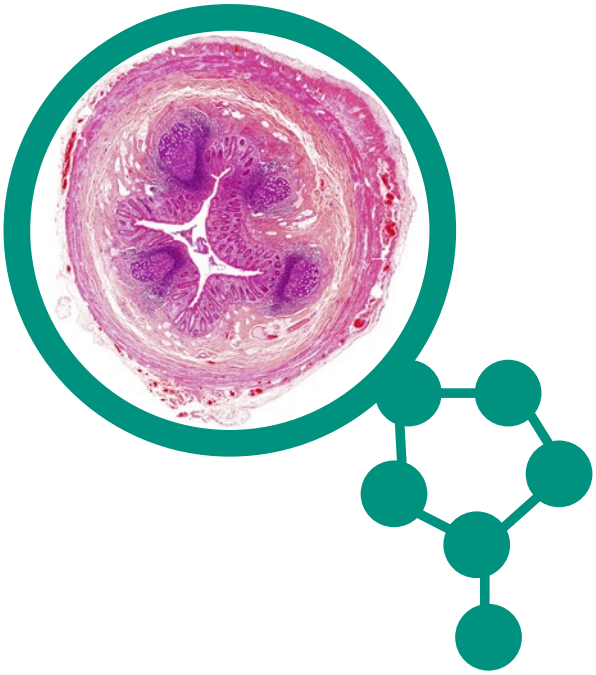
The Health Practitioners Competence Assurance Act 2003 requires that any changes to scopes of practice or prescribed qualifications be published in the *New Zealand Gazette*. In doing this, I continued Council's practice of publishing a stand alone notice covering the requirements for all scopes of practice. Consistent with the requirements of Parliament's Regulations Review Committee, the notice also contains commentary on the background to the changes. The notice was published on 21 November 2014 and came into effect on 22 December 2014.

INTERNATIONAL PHYSICIAN ASSESSMENT COALITION (IPAC) – JOINT CONFERENCE WITH COALITION FOR PHYSICIAN ENHANCEMENT (CPE)

In September 2014, I attended the 2014 IPAC conference held in Ireland in conjunction with the North American-based Coalition for Physician Enhancement. The conference theme was Remediating Performance – Linking Theory and Evidence with Practice.

Reflecting the joint nature of the conference, several keynote presentations were provided by speakers from the United States, which provided a valuable link between IPAC's experience in assessment methodology and CPE members' increasing focus on remediation

David Dunbar
Registrar



REGISTRATION OF DOCTORS AND PRACTISING CERTIFICATES

Principal activities: Maintaining the medical register, considering applications for registration, issuing practising certificates and certificates of good standing, and developing registration policy.

All doctors who practise medicine in New Zealand must be registered by the Council and hold a practising certificate. Registration ensures that a doctor is fit to practise medicine and that the doctor has met the required standards of competence to practise safely. Registered doctors must comply with the Council's recertification requirements each year to maintain their registration (including continuing professional development).

Confirmation of eligibility for doctors seeking registration in general and special-purpose scopes of practice is provided within 20 working days of receiving a completed application. Eligibility for registration within a vocational scope of practice is provided after consultation with the relevant vocational education and advisory body and takes, on average, 6 months.

TABLE 1: SCOPES OF PRACTICE – SUMMARY OF REGISTRATION STATUS

At 30 June 2015

Provisional general	3,534
General	8,105
Provisional vocational	231
Vocational	10,672
Special purpose	253
Total on register	**22,795**
Total practising	14,677
Suspended	18

Note: Doctors holding more than one scope of practice concurrently have been counted once for this table.

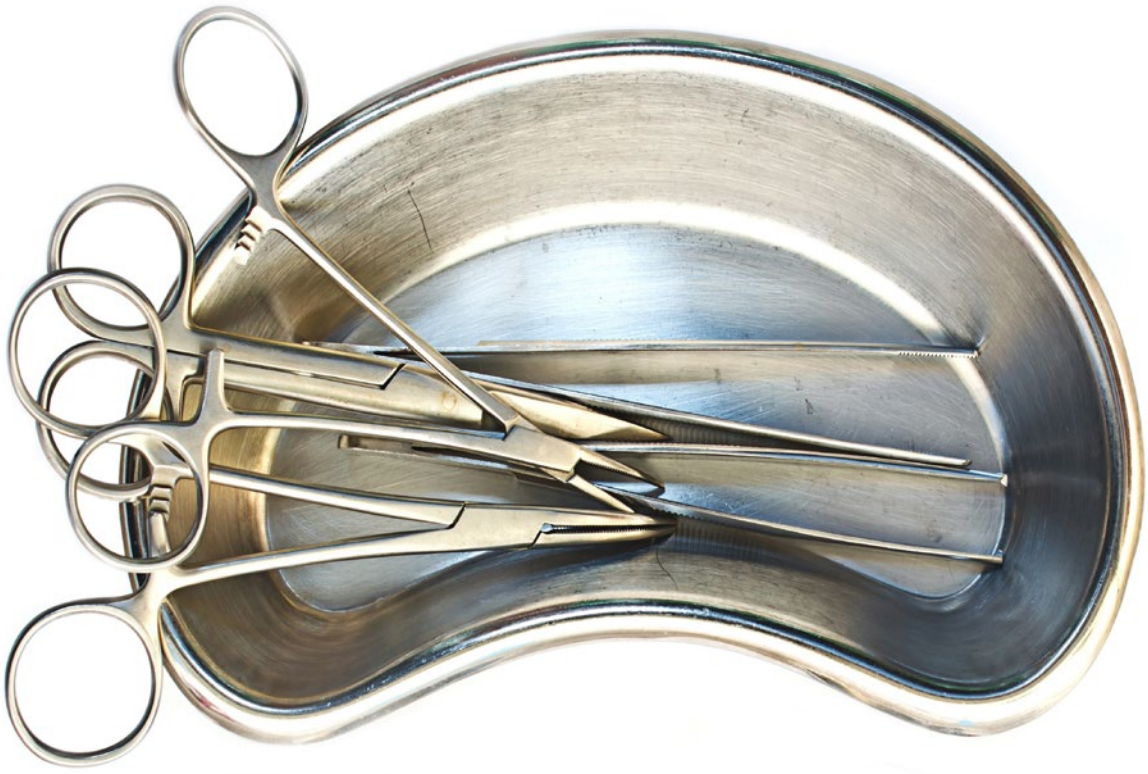


TABLE 2: REGISTRATION ACTIVITIES

1 July 2014 to 30 June 2015

	Number
Provisional general/vocational issued	
New Zealand graduates (interns)	420
Australian graduates (interns)	4
Passed NZREX Clinical	32
Graduate of competent authority accredited medical school	361
Worked in comparable health system	187
New Zealand and international medical graduates reregistration (following erasure)	-
Transitional	-
Non-approved postgraduate qualification – vocational assessment	72
Non-approved postgraduate qualification – vocational eligible	54
Special scope issued	
Visiting expert	45
Research	-
Postgraduate training or experience	35
Locum tenens in specialist post	102
Emergency or other unpredictable short-term situation	-
Teleradiology	-
General scope after completion of supervised period	
New Zealand/Australian graduates (interns)	400
Passed NZREX Clinical	35
Graduate of competent authority accredited medical school	271
Worked in comparable health system	98
Transitional	1
Vocational scope after completion of supervised period	
Non-approved postgraduate qualification – vocational assessment	40
Non-approved postgraduate qualification – vocational eligible	71
Approved vocational education and advisory bodies (VEAB) training programme	3
General scope issued	
New Zealand graduates	3
Overseas graduates	72
Restorations	17
Vocational scope issued	
Approved postgraduate qualification	492
Suspensions	
Suspended or interim suspension	6
Revocation of suspension	2

Conditions	
Imposed	125
Revoked	41
Cancellations under the Health Practitioners Competence Assurance Act	
Death – s 143	36
Discipline order – s 101 (1)(a)	2
False, misleading, or not entitled – s 146	1
Revision of register – s 144 (5)	1,329
At own request – s 142	315

TABLE 3: DOCTORS REGISTERED IN VOCATIONAL SCOPES

1 July 2014 to 30 June 2015

Vocational scope	Vocational registration at 30/6/2014[1]	Added 2014/2015	Removed 2014/2015	Net change	Vocational scope at 30/6/2015[1,2]
Anaesthesia	868	53	20	33	901
Cardiothoracic surgery	34	3	1	2	36
Clinical genetics	14	-	-	-	14
Dermatology	69	5	3	2	71
Diagnostic and interventional radiology	526	55	14	41	567
Emergency medicine	262	28	2	26	288
Family planning and reproductive health	32	-	-	-	32
General practice	3,814	211	55	156	3,970
General surgery	355	17	14	3	358
Intensive care medicine	92	5	4	1	93
Internal medicine	1,180	78	54	24	1,204
Medical administration	33	3	2	1	34
Musculoskeletal medicine	23	1	1	-	23
Neurosurgery	25	3	-	3	28
Obstetrics and gynaecology	366	26	22	4	370
Occupational medicine	64	2	-	2	66
Ophthalmology	165	6	3	3	168
Oral and maxillofacial surgery	20	-	-	-	20
Orthopaedic surgery	320	3	8	-5	315
Otolaryngology head and neck surgery	130	5	6	-1	129
Paediatric surgery	21	1	-	1	22
Paediatrics	426	17	23	-6	420
Pain medicine	19	4	-	4	23
Palliative medicine	63	8	4	4	67
Pathology	357	16	33	-17	340
Plastic and reconstructive surgery	77	6	7	-1	76
Psychiatry	757	33	55	-22	735
Public health medicine	218	7	18	-11	207
Radiation oncology	75	4	8	-4	71
Rehabilitation medicine	25	4	1	3	28
Rural hospital medicine	88	21	-	21	109
Sexual health medicine	21	-	1	-1	20
Sports medicine	28	2	1	1	29
Urgent care	160	11	8	3	163
Urology	75	4	1	3	78
Vascular surgery	38	3	1	2	40
Total	**10,840**	**645**	**370**	**275**	**11,115**

Notes:

[1] Includes doctors who may currently be inactive (have no practising certificate).

[2] Includes 425 doctors with registration in two vocational scopes and seven doctors with registration in three vocational scopes.

TABLE 4: REGISTRATIONS ISSUED, BY COUNTRY OF PRIMARY QUALIFICATION

1 July 2014 to 30 June 2015

	Provisional general	Provisional vocational	Special purpose	Total
England	235	22	16	273
United States of America	62	33	72	167
Scotland	54	5	5	64
Ireland	46	2	1	49
India	22	9	11	42
Australia	4	2	35	41
Netherlands	24	6	-	30
Canada	11	2	14	27
Wales	19	3	1	23
Germany	13	6	-	19
Fiji	4	1	6	11
Denmark	4	2	3	9
Northern Ireland	9	-	-	9
Sri Lanka	6	2	1	9
Sweden	5	4	-	9
Pakistan	5	2	1	8
Belgium	5	2	-	7
South Africa	3	2	2	7
Other[3]	53	24	14	91
New Zealand	420	1	-	421
Total	**1,004**	**130**	**182**	**1,316**

[3] Other represents 42 countries that had fewer than seven registrations in the reporting period.

TABLE 5: VOCATIONAL SCOPES GRANTED TO DOCTORS, BY VOCATIONAL SCOPE OF PRACTICE

1 July 2014 to 30 June 2015

Vocational scope	New Zealand	Overseas	Total
Anaesthesia	34	19	53
Cardiothoracic surgery	1	2	3
Dermatology	2	3	5
Diagnostic and interventional radiology	18	37	55
Emergency medicine	8	20	28
General practice	105	106	211
General surgery	10	7	17
Intensive care medicine	3	2	5
Internal medicine	35	43	78
Medical administration	2	1	3
Musculoskeletal medicine	-	1	1
Neurosurgery	2	1	3
Obstetrics and gynaecology	8	18	26
Occupational medicine	2	-	2
Ophthalmology	3	3	6
Orthopaedic surgery	2	1	3
Otolaryngology head and neck surgery	2	3	5
Paediatric surgery	-	1	1
Paediatrics	9	8	17
Pain medicine	2	2	4
Palliative medicine	5	3	8
Pathology	7	9	16
Plastic and reconstructive surgery	4	2	6
Psychiatry	9	24	33
Public health medicine	6	1	7
Radiation oncology	2	2	4
Rehabilitation medicine	1	3	4
Rural hospital medicine	9	12	21
Sports medicine	1	1	2
Urgent care	6	5	11
Urology	3	1	4
Vascular surgery	1	2	3
Total	**302**	**343**	**645**

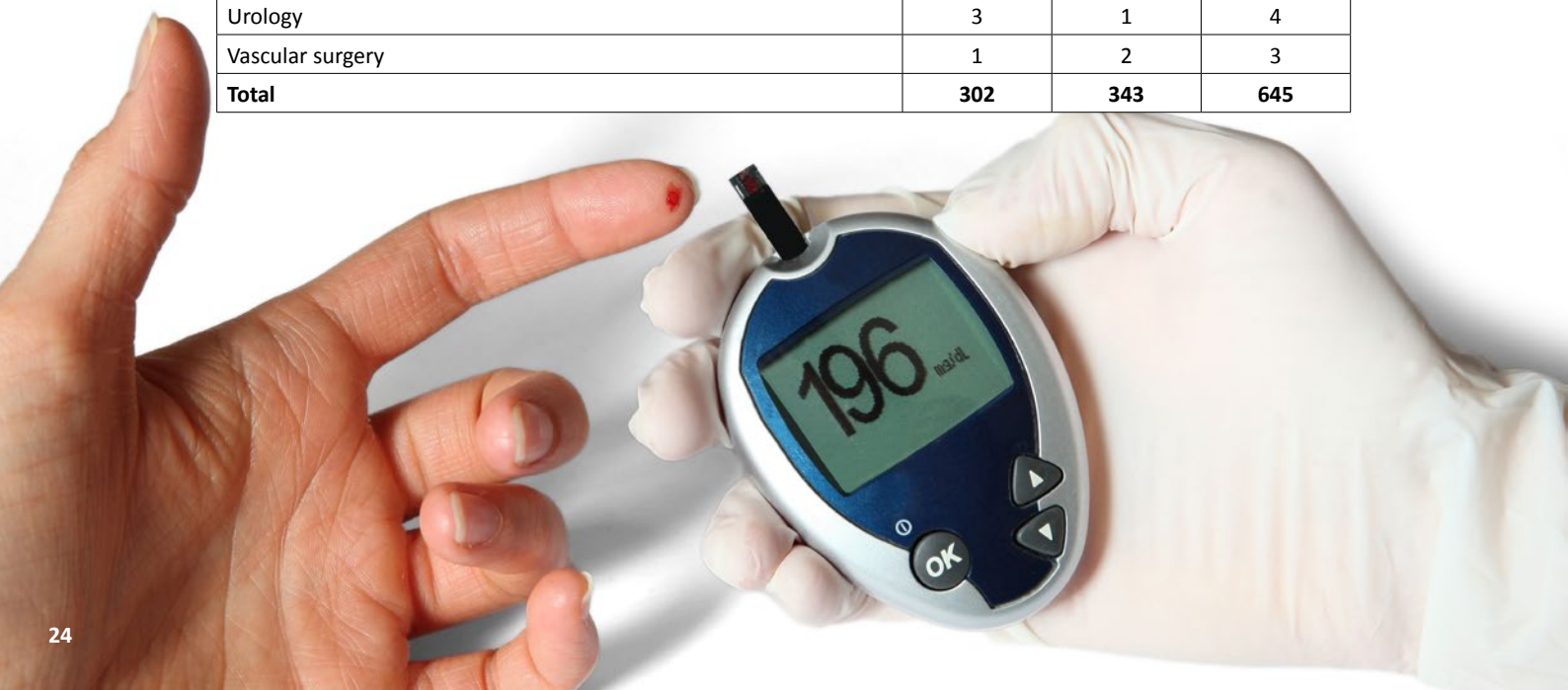


TABLE 6: OUTCOMES OF APPLICATIONS FOR VOCATIONAL REGISTRATION ASSESSMENTS

1 July 2014 to 30 June 2015

Branch	Incomplete applications	Pending	Withdrawn /lapsed	Vocational eligible	Vocational assessment	NZREX	Total
Anaesthesia	13	3	6	12	10	-	44
Cardiothoracic surgery	1	-	-	-	-	-	1
Dermatology	-	2	2	2	1	-	7
Diagnostic and interventional radiology	5	7	1	12	4	-	29
Emergency medicine	2	9	2	6	13	-	32
General practice	7	3	7	1	10	4	32
General surgery	5	6	2	5	2	3	23
Intensive care medicine	1	-	1	-	1	-	3
Internal medicine	10	6	8	14	10	4	52
Neurosurgery	1	1	3	-	1	-	6
Obstetrics and gynaecology	4	1	1	13	2	3	24
Occupational medicine	1	2	-	2	-	-	5
Ophthalmology	1	6	-	1	2	1	11
Oral and maxillofacial surgery	-	1	-	1	-	-	2
Orthopaedic surgery	3	-	3	1	1	-	8
Otolaryngology head and neck surgery	1	-	1	1	2	-	5
Paediatric surgery	1	1	-	-	-	-	2
Paediatrics	1	-	2	4	2	-	9
Pain medicine	-	1	-	-	-	-	1
Palliative medicine	-	1	2	2	-	2	7
Pathology	1	7	2	-	1	-	11
Plastic and reconstructive surgery	2	-	4	1	-	-	7
Psychiatry	15	8	11	13	13	1	61
Public health medicine	1	1	-	1	-	-	3
Radiation oncology	-	-	2	-	-	1	3
Rehabilitation medicine	-	1	-	-	-	-	1
Urology	-	-	-	-	1	-	1
Vascular surgery	-	1	-	-	-	-	1
Total	**76**	**68**	**60**	**92**	**76**	**19**	**391**
Percentages based on total number of outcomes				49%	41%	10%	

TABLE 7: DOCTORS ON THE NEW ZEALAND MEDICAL REGISTER, BY COUNTRY OF PRIMARY QUALIFICATION

As at 30 June 2015

Country	Provisional general	General	Provisional vocational	Vocational	Special purpose	Total	Number with practising certificates
England	1,149	1,275	24	1,339	20	**3,807**	1,865
United States of America	526	117	62	276	125	**1,106**	366
South Africa	68	198	13	764	7	**1,050**	722
Scotland	261	356	8	370	7	**1,002**	511
Australia	11	474	2	355	4	**846**	426
India	81	230	19	390	14	**734**	476
Ireland	184	208	3	75	1	**471**	197
Germany	87	79	18	136	1	**321**	181
Wales	119	113	1	58	3	**294**	95
Sri Lanka	13	72	1	171	9	**266**	141
Canada	123	22	5	66	15	**231**	72
Netherlands	101	29	10	44	-	**184**	87
Iraq	3	64	1	100	2	**170**	106
Pakistan	19	64	3	35	2	**123**	73
Bangladesh	4	30	1	69	1	**105**	49
China	6	38	-	56	-	**100**	75
Sweden	59	14	11	13	-	**97**	13
Northern Ireland	34	33	-	26	1	**94**	40
Egypt	13	23	2	48	2	**88**	53
Fiji	4	14	-	44	16	**78**	69
Russia	6	30	2	19	1	**58**	46
Philippines	2	23	2	28	-	**55**	36
Poland	14	22	4	12	-	**52**	32
Zimbabwe	1	7	3	33	1	**45**	38
Nigeria	13	17	3	10	-	**43**	18
Singapore	7	13	1	21	-	**42**	20
Belgium	18	12	2	9	-	**41**	18
Serbia	2	12	1	24	-	**39**	20
Denmark	18	11	3	5	-	**37**	12
Romania	4	13	1	16	1	**35**	19
Italy	9	8	4	12	-	**33**	17
Austria	15	8	2	2	-	**27**	11
Myanmar	2	9	-	13	1	**25**	14
Spain	8	4	2	11	-	**25**	18
Czech Republic	5	11	-	6	-	**22**	11
Hungary	4	7	-	11	-	**22**	16
Switzerland	9	4	1	8	-	**22**	7
France	6	7	2	6	-	**21**	12
Ukraine	2	13	1	4	-	**20**	17
Malaysia	1	8	-	7	2	**18**	14

Bulgaria	1	7	-	8	-	**16**	13
Croatia	1	6	-	8	1	**16**	11
Iran	3	6	1	3	1	**14**	10
Colombia	3	3	2	3	2	**13**	6
Mexico	4	1	1	6	1	**13**	6
Zambia	1	6	-	6	-	**13**	9
Finland	3	7	1	1	-	**12**	6
Brazil	3	4	1	3	-	**11**	5
Norway	3	-	-	8	-	**11**	7
Papua New Guinea	2	-	-	9	-	**11**	7
Sudan	2	7	-	2	-	**11**	9
Syria	3	5	1	2	-	**11**	8
Dominica	5	2	1	-	2	**10**	3
Israel	3	1	1	4	1	**10**	6
Netherlands Antilles	7	2	-	1	-	**10**	4
Other[1]	35	70	4	71	9	**189**	122
New Zealand	**444**	**4,286**	**-**	**5,845**	**-**	**10,575**	**8,432**
Total	**3,534**	**8,105**	**231**	**10,672**	**253**	**22,795**	**14,677**

[1] Other represents 57 countries with fewer than 10 registered doctors.

PROFESSIONAL STANDARDS

Principal activities: Receiving referrals of concerns, administering the complaints triage committee, undertaking performance assessments, establishing individual education programmes, maintaining assessment tools, developing policy on performance assessment, setting up professional conduct committees, and monitoring doctors who are subject to conditions arising from competence and conduct concerns and disciplinary action.

TABLE 8: REFERRAL SOURCES FOR PERFORMANCE PROCESSES

1 July 2014 to 30 June 2015

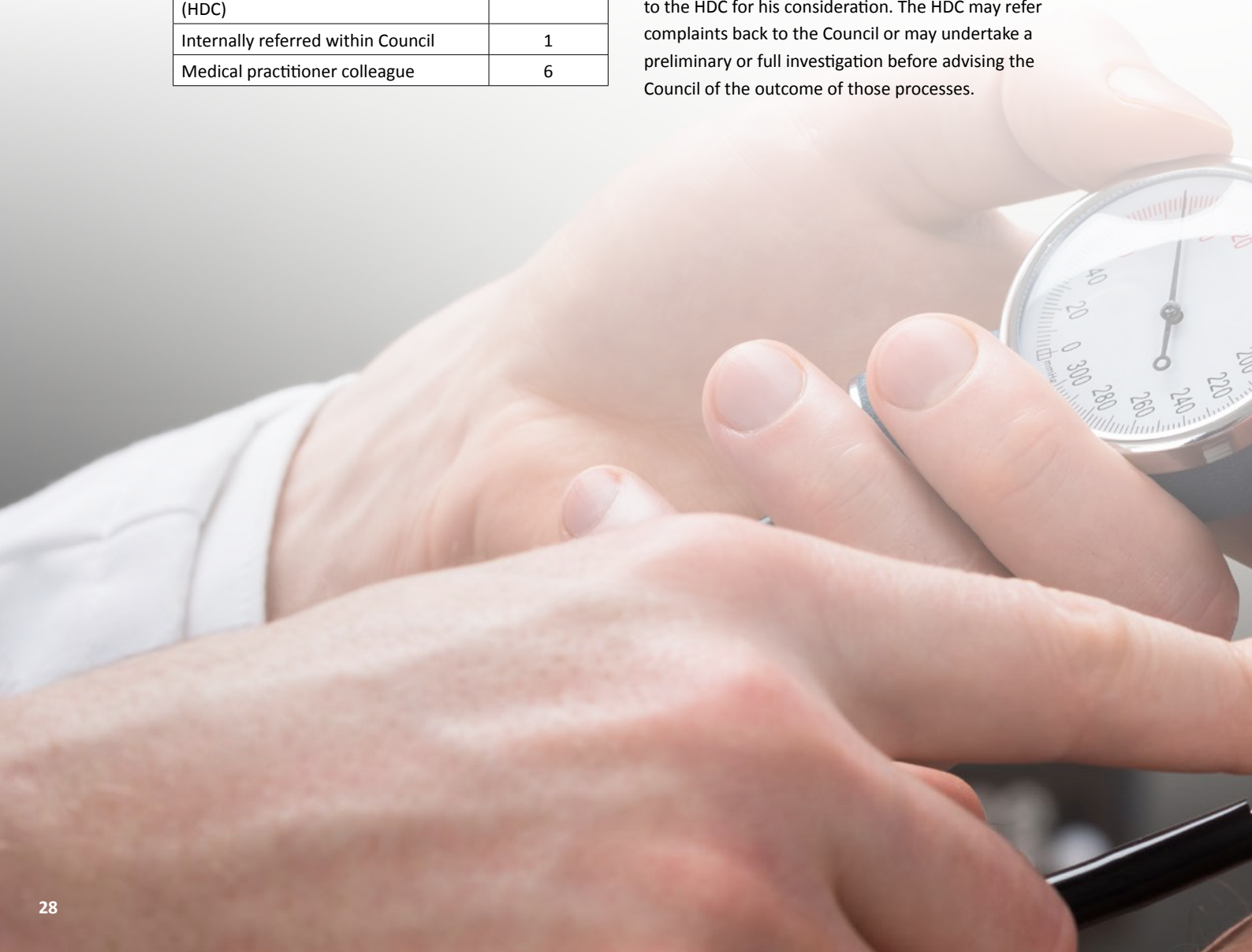
ACC	2
Coroner	2
Employer (DHB)	6
Employer (private hospital or general practice)	4
Member of public or patient	1
Health and Disability Commissioner (HDC)	24
Internally referred within Council	1
Medical practitioner colleague	6

TABLE 9: REFERRAL SOURCES FOR CONDUCT PROCESSES

1 July 2014 to 30 June 2015

Coroner	1
Employer (DHB)	12
Employer (private hospital or general practice)	5
Member of public or patient	3
HDC	13
Council initated	7
Medical practitioner colleague	10
Pharmacist	5
Ministry of Health	2
Media	1
Police	4
Courts	9
Self-disclosure	6

Complaints about doctors by consumers can be made either to the Council or the Health and Disability Commissioner (HDC) but all complaints must be referred to the HDC for his consideration. The HDC may refer complaints back to the Council or may undertake a preliminary or full investigation before advising the Council of the outcome of those processes.



PERFORMANCE

The Council seeks to implement mechanisms to ensure doctors are competent to practise. When receiving referrals that relate to a doctor's competence to practise, the Council does not investigate specific incidents (that is the HDC's role) but considers whether the circumstances raise questions about whether the doctor's competence may be deficient.

Table 10 shows the number of cases considered by Council during the year that related to a doctor's competence to practise and Council's decisions as to how those cases should be addressed. The table shows the number of Council's processes during the year rather than the number of individual doctors. Some doctors will have been the subject of more than one decision or process because the numbers reflect processes during the year. The numbers include processes that commenced before the year commencing 1 July 2014 and processes that continued after 30 June 2015 and illustrates the volume of Council's work during the year in this area.

TABLE 10: PERFORMANCE RELATED COUNCIL PROCESSES[1]

1 July 2014 to 30 June 2015

No further action or educational letter on first consideration	22
Await HDC after first consideration	3
Recertification programme ordered on first consideration	5
Referral to performance assessment committee (PAC)[2]	16
Doctor meets required standard of competence following PAC	15
Doctor does not meet the required standard of competence following PAC	14
Recertification programme ordered after PAC (section 41)	4
Educational programme ordered after PAC (section 38)	13
Conditions ordered after PAC (section 38)	4
Further action after PAC deferred (doctor not working, retired)	1
Recertification programme completed satisfactorily	8
Educational programme completed satisfactorily	7
Did not complete recertification programme satisfactorily	1
Recertification programme ordered after educational programme	1

[1] Part 3 of the HPCAA refer to Competence but Council calls it Performance.

[2] Council's processes can extend over 12 months, so the number of referrals to PACs may not necessarily correlate with outcomes within the same year.

CONDUCT

Where the Council receives information that raises one or more questions about the appropriateness of the conduct or the safety of the practice of a doctor, it may refer any or all of those questions to a professional conduct committee (PCC).

Table 11 shows the number of cases considered by Council during the year that related to a doctor's conduct and Council's decisions as to how those cases should be addressed. The table shows the number of Council's processes during the year rather than the number of individual doctors. Some doctors will have been the subject of more than one decision or process because the numbers reflect processes during the year. The numbers include processes that commenced before the year commencing 1 July 2014 and processes that continued after 30 June 2015 and illustrates the volume of Council's work in this area.

Council is prevented by statute from referring a doctor to a professional conduct committee while the HDC is conducting an investigation in relation to a consumer complaint. Council may, however, make an order for interim suspension or impose conditions on the doctor's practice if it considers that the doctor poses a risk of harm to the public.

Where a doctor is convicted of any offence punishable by imprisonment for a term of 3 months or longer or of an offence under certain specified Acts, the doctor is automatically referred to a professional conduct committee.

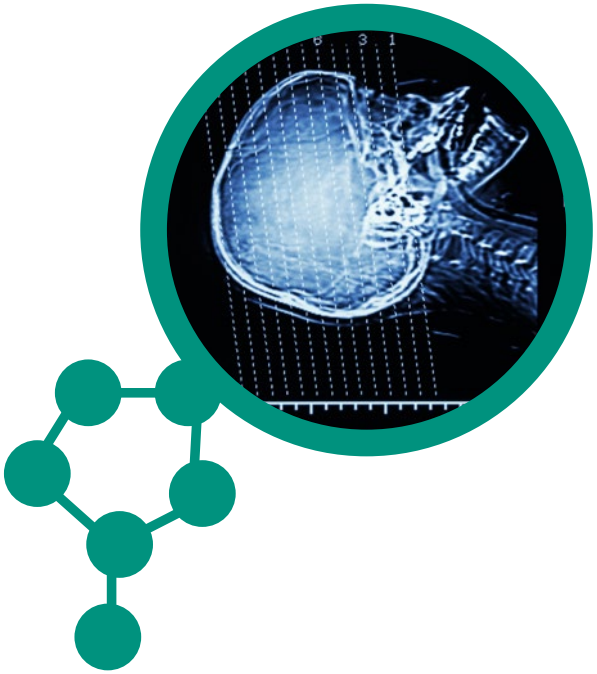
TABLE 11: CONDUCT-RELATED COUNCIL PROCESSES

1 July 2014 to 30 June 2015

No further action or educational letter on first consideration	21
Further information requested	5
Recertification programme ordered on first consideration	3
Referral to professional conduct committee (PCC)[1]	27
Refer new information to existing PCC	1
Interim conditions ordered (section 69)	4
Interim suspension ordered (section 69)	3
Cancellation of registration (section 146)	1
PCC determined charge be brought in the Health Practitioners Disciplinary Tribunal	9
PCC recommend no further action and Council endorses	7
PCC recommend counselling or mentoring and Council endorses	3
PCC recommended review of fitness to practise and Council endorses	6
PCC recommend review of competence to practise and Council endorses	3

[1] Council's processes can extend over 12 months, so the number of referrals to PCCs may not necessarily correlate with outcomes within the same year.

DOCTORS' HEALTH



Principal activities: Considering the cases of doctors with possible health conditions, establishing treatment and monitoring programmes for doctors whose health conditions affect their fitness to practise, and promoting doctors' health.

The Council aims to protect patients by appropriately managing doctors who may not be fit to practise because of a mental or physical condition.

Doctors, like the general population, can suffer from various afflictions, including drug and alcohol dependence, psychiatric problems, and a wide range of physical disorders, any of which can affect their performance.

TABLE 12: NOTIFICATIONS OF INABILITY TO PERFORM REQUIRED FUNCTIONS DUE TO MENTAL OR PHYSICAL (HEALTH) CONDITION

1 July 2014 to 30 June 2015

Source	HPCAA				
		Existing	New	Closed	Still active
Health service	s 45 (1) a	-	1	-	1
Health practitioner	s 45 (1) b	-	29[1]	2	27
Employer	s 45 (1) c	-	10	3	7
Medical Officer of Health	s 45 (1) d	-	-	-	-
Any person	s 45 (3)	-	5	1	4
Person involved with education	s 45 (5)	-	1		1
Total		**-**	**46**	**6**	**40**

[1] 21 of the 29 were self-referred.

TABLE 13: OUTCOMES OF HEALTH NOTIFICATIONS

1 July 2014 to 30 June 2014

Outcomes	HPCAA	Number[1]
No further action		10
Order medical examination	s 49 (1)	103[2]
Interim suspension	s 48 (1) (a)	8[3]
Conditions	s 48 (1) (b)	-
Restrictions imposed	s 50 (3) or (4)	See note[4]

[1] There may be more than one outcome.

[2] 19 assessments agreed voluntarily and 84 reports from treating clinicians, occupational physicians, or other testing.

[3] Achieved through voluntary agreement.

[4] Requisite monitoring for 40 doctors still active achieved through informal agreement without use of statutory provisions of the Health Practitioners Competence Assurance Act 2003.

EXAMINATIONS

Principal activity: Ensuring that international medical graduates who wish to be registered in New Zealand are safe to practise medicine.

NEW ZEALAND REGISTRATION EXAMINATION – NZREX CLINICAL

New Zealand's health system requires all doctors to meet practice standards defined by the Council.

Doctors who qualified outside New Zealand and Australia must pass the Council's medical registration exam, NZREX Clinical, if they wish to be registered in New Zealand and do not satisfy the criteria for other registration pathways. This examination is set at the level of a recent New Zealand graduate.

NZREX Clinical is a 16-station objective-structured clinical examination that tests various competencies including history, clinical examination, investigating management, clinical reasoning, communication, and professionalism.

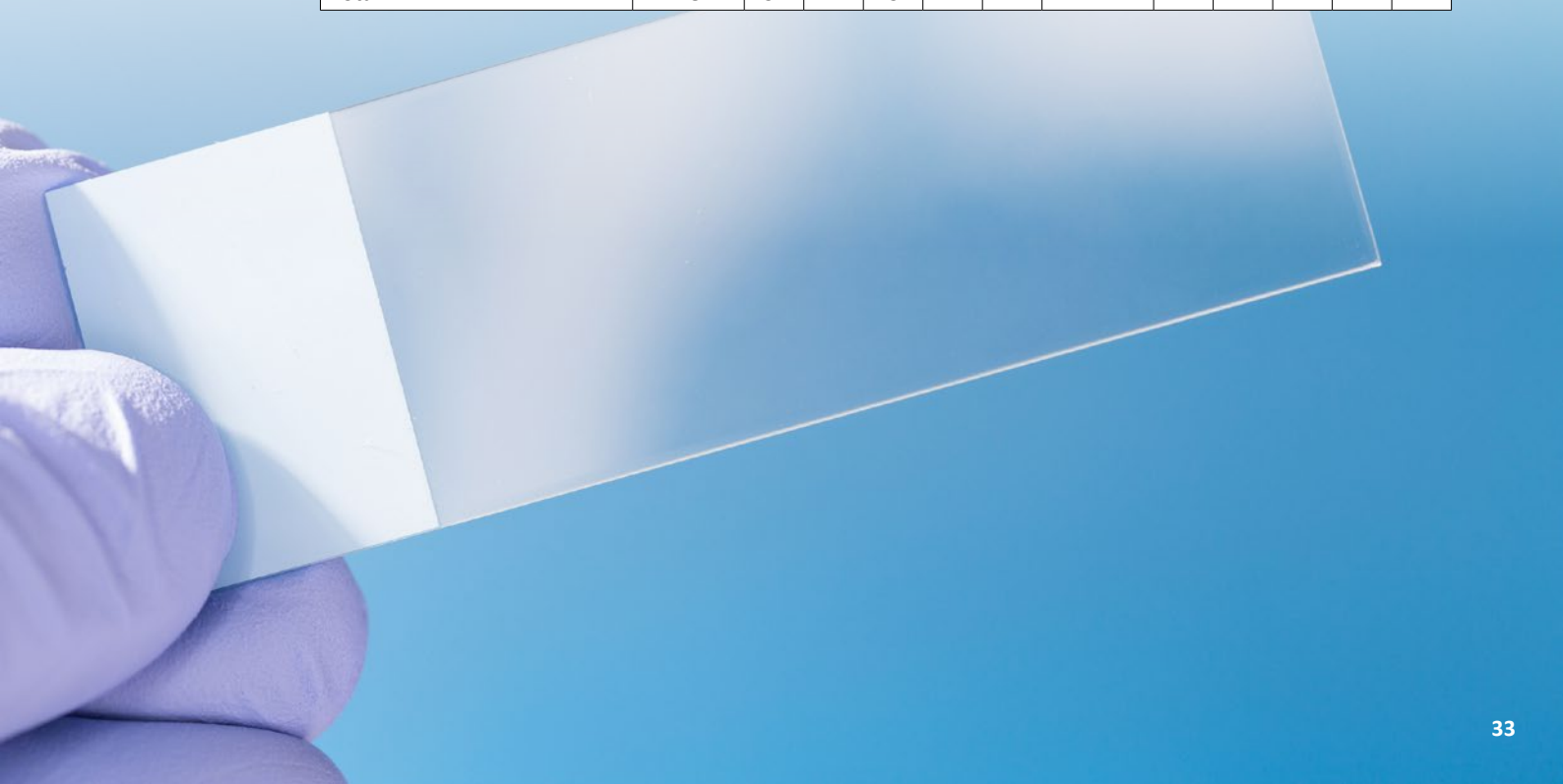
The prerequisites for applying to sit NZREX Clinical are:

- a medical degree listed in the World Directory of Medical Schools
- meeting the Council's English language policy
- within the last 5 years having passed United States Medical Licensing Examination (USMLE) Steps 1 and 2 (Clinical Knowledge) or having passed the Australian Medical Council multi-choice examination.

TABLE 14: CANDIDATES SITTING AND PASSING NZREX CLINICAL

1 July 2014 to 30 June 2015

	Number sitting	Attempts					Number of passes	Passes on attempts				
COUNTRY		**1**	**2**	**3**	**4**	**5**		**1**	**2**	**3**	**4**	**5**
Bangladesh	**1**	1	-	-	-	-	**-**	-	-	-	-	-
Belarus	**1**	1	-	-	-	-	**-**	-	-	-	-	-
Brazil	**1**	1	-	-	-	-	**1**	1	-	-	-	-
Canada	**1**	1	-	-	-	-	**1**	1	-	-	-	-
Cayman Islands	**1**	1	-	-	-	-	**1**	1	-	-	-	-
China	**4**	-	3	1	-	-	**2**	-	1	1	-	-
India	**6**	4	1	1	-	-	**3**	2	1	-	-	-
Iran	**1**	1	-	-	-	-	**-**	-	-	-	-	-
Iraq	**2**	2	-	-	-	-	**1**	1	-	-	-	-
Ireland (Éire)	**1**	1	-	-	-	-	**1**	1	-	-	-	-
Kosovo	**2**	1	1	-	-	-	**-**	-	-	-	-	-
Nigeria	**1**	1	-	-	-	-	**-**	-	-	-	-	-
Oman	**1**	1	-	-	-	-	**1**	1	-	-	-	-
Pakistan	**4**	4	-	-	-	-	**-**	-	-	-	-	-
Philippines	**5**	5	-	-	-	-	**1**	1	-	-	-	-
Poland	**1**	1	-	-	-	-	**1**	1	-	-	-	-
Russia	**5**	3	1	1	-	-	**2**	1	-	1	-	-
Samoa	**1**	1	-	-	-	-	**1**	1	-	-	-	-
Seychelles	**1**	1	-	-	-	-	**-**	-	-	-	-	-
South Africa	**2**	2	-	-	-	-	**2**	2	-	-	-	-
Sri Lanka	**1**	1	-	-	-	-	**1**	1	-	-	-	-
St Kitts and Nevis	**2**	1	1	-	-	-	**-**	-	-	-	-	-
Sudan	**1**	1	-	-	-	-	**1**	1	-	-	-	-
Ukraine	**1**	-	-	-	1	-	**1**	-	-	-	1	-
United Arab Emirates	**1**	1	-	-	-	-	**1**	1	-	-	-	-
Total	**48**	37	7	3	1	-	**22**	17	2	2	1	-



HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL (HPDT)

Principal activities: Disciplinary proceedings brought against doctors are heard and determined by the Health Practitioners Disciplinary Tribunal (HPDT) under the Health Practitioners Competence Assurance Act 2003.

MEDICAL CHARGES BEFORE THE HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL

During the year, the HPDT received 22 charges relating to 13 doctors – 10 of these charges were received from a professional conduct committee, and three were received from the Director of Proceedings.

One of the 10 charges was received in 2013/2014. The other nine charges were received in 2014/2015. Twelve charges received during 2014/2015 are yet to be heard.

The HPDT sat during the year to hear 10 charges relating to seven doctors over 10 days.

TABLE 15: MEDICAL CHARGES BEFORE THE HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL

1 July 2014 to 30 June 2015

Nature of charges	
Professional misconduct 2013/2014	1
Conviction 2014/2015	4
Professional misconduct 2014/2015	17
Total	**22**

Source	
Prosecution of charges brought by professional conduct committee 2013/2014	1
Prosecution of charges brought by professional conduct committee 2014/2015	9
Charges brought by professional conduct committee yet to be heard	9
Charges brought by Director of Proceedings yet to be heard	3
Total	**22**

Outcome of hearings	
Guilty – professional misconduct 2013/2014	1
Guilty – conviction 2014/2015	2
Guilty – professional misconduct 2014/2015	7
Yet to be heard 2014/2015	12
Total	**22**

Further information about these statistics can be found on the HPDT website www.hpdt.org.nz.

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CORPORATE GOVERNANCE

Role of Council: members of Council set the strategic direction of the organisation, monitor management performance, and ensure the Council meets the requirements of the Health Practitioners Competence Assurance Act 2003.

The Council is accountable for its performance to Parliament, the Minister of Health, the medical profession, and the public.

COUNCIL MEMBERSHIP

The Council aims to have members who represent:

- a range of age, gender, and ethnic groups
- a broad mix of the medical profession, New Zealand society as a whole, and people with a wide general knowledge and breadth of vision and who also have one of the following:
  - Broad health sector knowledge.
  - Experience in one of the main vocational scopes of practice.
  - Experience in health service delivery in a variety of provincial and tertiary settings.
  - Experience in medical education and assessment.

COUNCIL COMMITTEE STRUCTURE

The Council operates three standing committees – Audit, Health, and Education. Members of these committees are listed on page 36. The Council receives committee meeting minutes at its formal meetings and, in approving those minutes, confirms the decisions made. Delegation limits are established.

LINKING WITH STAKEHOLDERS

We have continued to be actively involved with registration bodies overseas. We share ideas for future developments and maintain contact with organisations including:

- Australian registration boards
- the International Association of Medical Regulatory Authorities
- the Federation of State Medical Boards and the Educational Commission for Foreign Medical Graduates (United States of America)
- the Medical Council of Canada
- the General Medical Council (United Kingdom)
- the Irish Medical Council.

As in previous years, the Council has had regular meetings with key stakeholders to discuss matters of mutual interest. Those stakeholders include:

- the Accident Compensation Corporation
- medical colleges and associations
- chief medical officers of DHBs
- the Council of Medical Colleges
- District Health Boards New Zealand
- the Health and Disability Commissioner
- the Independent Practitioners Association Council of New Zealand
- the Medical Protection Society
- the Minister of Health
- the Ministry of Health
- the New Zealand Medical Association
- members of the profession, other regulatory authorities, medical students, and community groups.

COUNCIL STANDING COMMITTEES AT 30 JUNE 2015

AUDIT COMMITTEE

Mr Andrew Connolly (ex officio)[1]

Dr Jonathan Fox (Chairperson)

Dr Rick Acland

Ms Joy Quigley JP

Dr Peter Robinson

Mr Roy Tiffin (co-opted member)

EDUCATION COMMITTEE – COUNCIL MEMBERS

Mr Andrew Connolly (ex officio)[1]

Dr Jonathan Fox (Deputy Chairperson)

Ms Susan Hughes QC

Professor John Nacey (Chairperson)

Ms Laura Mueller

Ms Joy Quigley JP

EDUCATION COMMITTEE MEMBERS - NON-COUNCIL MEMBERS

Professor Peter Ellis
Medical Council of New Zealand representative on MedSAC

Dr Liza Lack
Nominee of appropriate college or branch advisory body Royal New Zealand College of General Practitioners

Dr Sarah Nicolson
Nominee of appropriate college or branch advisory body – Australian and New Zealand College of Anaesthetists

Dr Greig Russell
Nominee of appropriate college or branch advisory body Royal New Zealand College of Urgent Care Physicians

Dr John Thwaites
Nominee of appropriate College or branch advisory body – Royal Australasian College of Physicians

Dr Emma Merry
Intern supervisor representative

Dr Martin Mikaere
Resident medical officer representative

Dr Thomas Wilkinson
Resident medical officer representative

HEALTH COMMITTEE

Dr Allen Fraser (Chairperson)

Mr Andrew Connolly (ex officio)[1]

Ms Laura Mueller

Dr Luisa Fonua-Faeamani

Ms Joy Quigley JP (alternative layperson)

[1] The Chairperson is an ex officio member of all committees. External members of committees are recognised by Council as being desirable on some committees although a minimum of two Council members and at least one layperson must sit on each committee.

OFFICE OF THE COUNCIL AT 30 JUNE 2015

Chief Executive	Philip Pigou
Registrar	David Dunbar
Deputy Registrar	Susan Yorke
Senior Legal Adviser	Alison Mills
Legal Adviser	Emily Bergin
Executive Assistant	Dot Harvey
Strategic Programme Manager	Joan Crawford
Project Manager	Andrea Flynn
Project Coordinator	Krystiarna Jarnet
Project Coordinator	Antonia O'Leary

ADVISER GROUP

Communications Manager	George Symmes (part-time)
Human Resources Adviser	Shannon Michl (part-time)
Medical Adviser	Dr Steven Lillis (part-time)
Medical Adviser	Dr Kevin Morris (part-time)
Senior Policy Adviser and Researcher	Kanny Ooi

CORPORATE SERVICES

Chief Financial Officer	Peter Searle
ICT Team Leader	Bill Taylor
ICT Systems Analyst	Alecia Thomson (part-time)
Senior ICT Systems Analyst	Andrew Cullen
ICT Systems Analyst	Ray van der Veen
Business Analyst	Diane Latham
Business Process Analyst	Carolyn Berry (part-time)
Senior Office Administrator	Dianne Newport
Office Administrator	Melissa Baldwin
Office Administrator	Casey Dalton (part-time)
Office Administrator	Leanne Nightingale (part-time)
Office Administrator	Jenny Porter
Assistant Accountant	Jim Peebles (part-time)
Finance Officer	Atish Pathak
Finance Officer	Marika Puleitu (part-time)

HEALTH

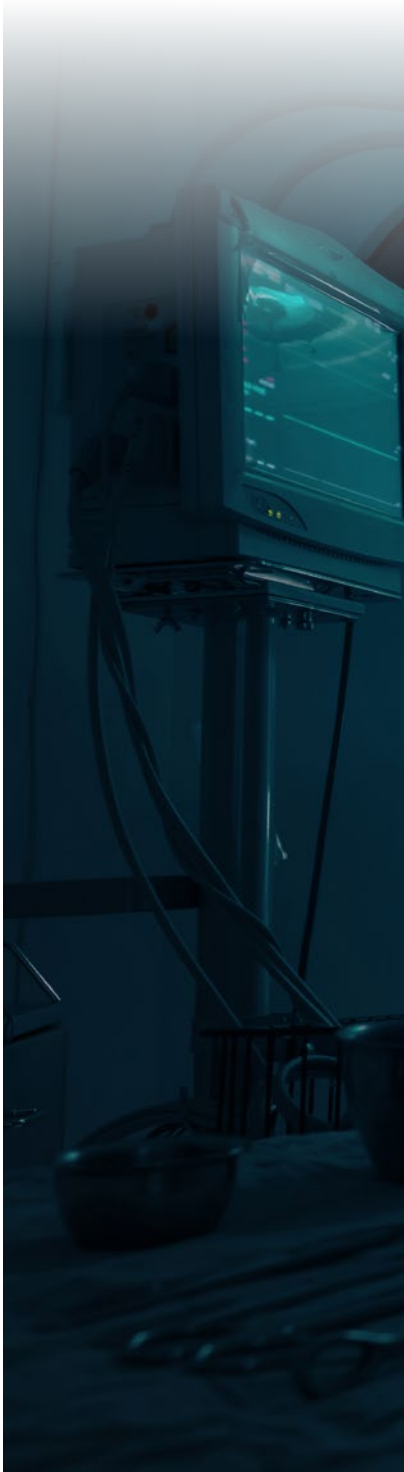
Health Manager	Lynne Urquhart
Health Administrator	Viv Coppins
Health Case Manager	Constance Hall
Health Case Manager	Victoria Harrison
Health Case Manager	Jo Hawken
Health Case Manager	Sarah Shaw
Health Case Manager	Garth Wyatt

HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL (HPDT) FOR MEDICAL PRACTITIONERS

HPDT Manager	Gay Fraser
Executive Officer	Debra Gainey
Legal Officer	Kim Davies (part-time)
Personal Assistant to Executive Officer	Deborah Harrison

REGISTRATION

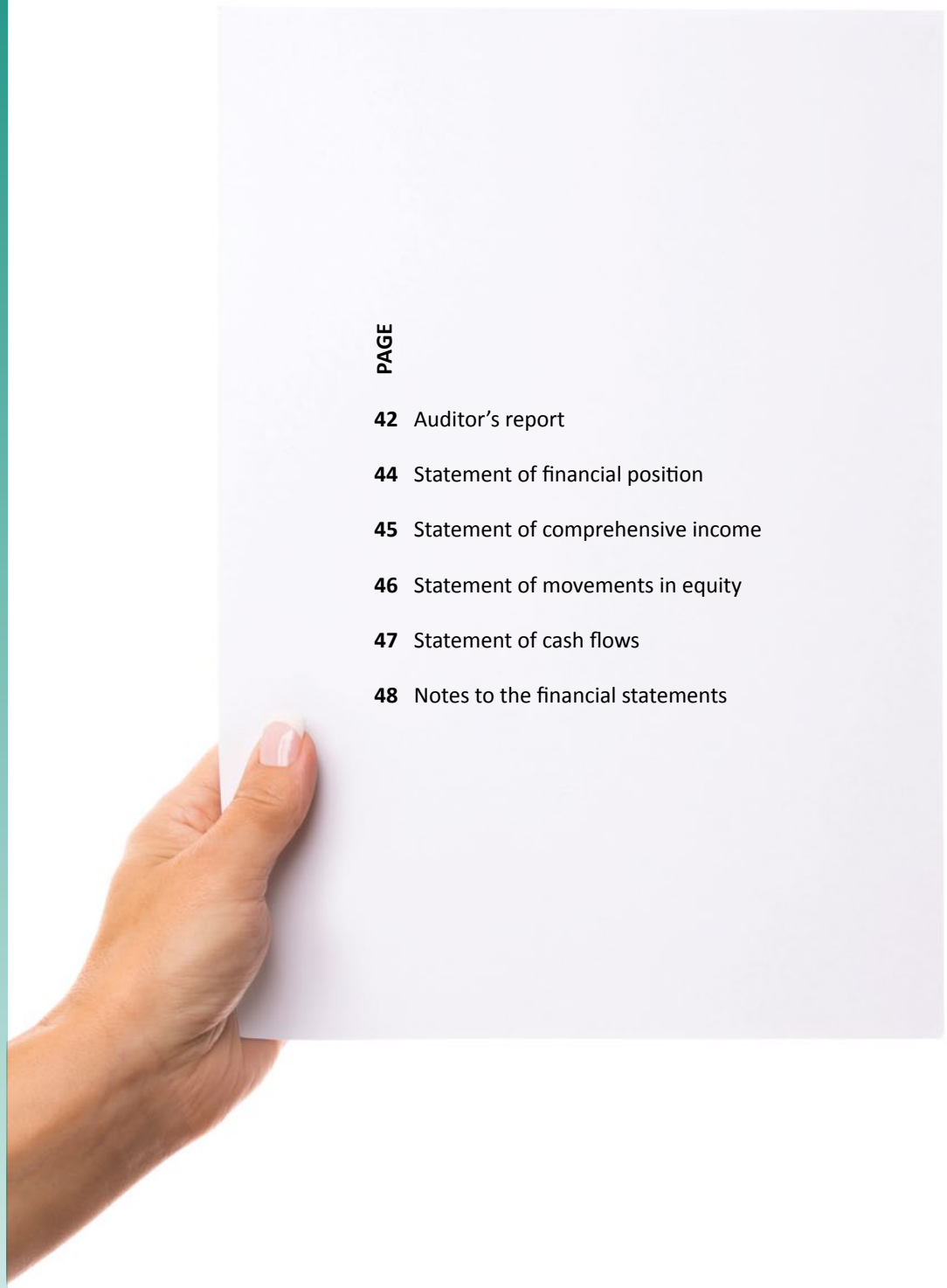
General Manager of Core Services and Human Resources	Valencia van Dyk
Senior Registration Coordinator	Gyllian Turner
Registration Team Manager – General	Kylie Johnston
Registration Coordinator – General	Miriam Brown
Registration Coordinator – General	Trudy Clarke
Registration Coordinator – General	Prakash Joseph
Registration Coordinator – General	Patrick McKane
Registration Coordinator – General	Devan Menon
Registration Coordinator – General	Eleanor Quirke
Registration Coordinator – General	Chrissy Takai
Registration Coordinator – General	Madeline West
Registration Team Manager – Vocational	Laura Lumley
Registration Coordinator – Vocational	Sandra Clark
Registration Coordinator – Vocational	Imojini Kotelawala
Registration Coordinator – Vocational	Geetha Raghunath
Registration Coordinator – Vocational	Daniel Smith
Registration Coordinator – Vocational	Sandra Tam
Registration Team Manager – Practising Certificates	Helen Vercoelen
Practising Certificate Coordinator	Bronwyn Courtney
Practising Certificate Coordinator	Elaine Pettigrew (part-time)
Practising Certificate Audit Administrator	Sharon Mason (part-time)



PROFESSIONAL STANDARDS

Professional Standards Team Manager	Charlotte Provan
Professional Standards Coordinator	Tanya Campbell
Professional Standards Coordinator	Anna Palmer-Oldcorn
Professional Standards Coordinator	Angela Pigott
Professional Standards Coordinator	Heather Roblin
Professional Standards Coordinator	Simon Spence
Professional Standards Coordinator	Nikita Takai
Professional Standards Coordinator	Anna Yardley

APPENDICES - FINANCE



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FINANCIAL STATEMENTS 2015

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staplesrodway
CHARTERED ACCOUNTANTS

INDEPENDENT AUDITOR'S REPORT

TO THE READERS OF MEDICAL COUNCIL OF NEW ZEALAND'S FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2015

The Auditor-General is the auditor of Medical Council of New Zealand (the Council). The Auditor-General has appointed me, Robert Elms, using the staff and resources of Staples Rodway Wellington, to carry out the audit of the financial statements of the Council on her behalf.

Opinion

We have audited the financial statements of the Council on pages 44 to 60, that comprise the statement of financial position as at 30 June 2015, the statement of comprehensive income, statement of movements in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information.

In our opinion the financial statements of the Council:

- present fairly, in all material respects:
    - its financial position as at 30 June 2015; and
    - its financial performance and cash flows for the year then ended; and
- comply with generally accepted accounting practice in New Zealand and have been prepared in accordance with Tier 2 Public Sector Public Benefit Entity Accounting Standards.

Our audit was completed on 14 October 2015. This is the date at which our opinion is expressed.

The basis of our opinion is explained below. In addition, we outline the responsibilities of the Council and our responsibilities, and explain our independence.

Basis of opinion

We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the International Standards on Auditing (New Zealand). Those standards require that we comply with ethical requirements and plan and carry out our audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

Material misstatements are differences or omissions of amounts and disclosures that, in our judgement, are likely to influence readers' overall understanding of the financial statements. If we had found material misstatements that were not corrected, we would have referred to them in our opinion.

An audit involves carrying out procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the preparation of the Council's financial statements in order to design audit procedures that are appropriate in the circumstances but not for the purpose of expressing an opinion on the effectiveness of the Council's internal control.

An audit also involves evaluating:

- the appropriateness of accounting policies used and whether they have been consistently applied;
- the reasonableness of the significant accounting estimates and judgements made by the Board of Directors;
- the adequacy of the disclosures in the financial statements; and
- the overall presentation of the financial statements.

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements. Also we did not evaluate the security and controls over the electronic publication of the financial statements.

We believe we have obtained sufficient and appropriate audit evidence to provide a basis for our audit opinion.

Responsibilities of the Council

The Council is responsible for the preparation and fair presentation of financial statements for the Council in accordance with Tier 2 Public Sector Public Benefit Entity Accounting Standards.

The Council's responsibilities arise from the Health Practitioners Competence Assurance Act 2003.

The Council is responsible for such internal control as it determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error. The Council is also responsible for the publication of the financial statements, whether in printed or electronic form.

Responsibilities of the Auditor

We are responsible for expressing an independent opinion on the financial statements and reporting that opinion to you based on our audit. Our responsibility arises from section 15 of the Public Audit Act 2001.

Independence

When carrying out the audit, we followed the independence requirements of the Auditor-General, which incorporate the independence requirements of the External Reporting Board.

Other than the audit, we have no relationship with or interests in the Council.

Robert Elms
Staples Rodway Wellington
On behalf of the Auditor-General
Wellington, New Zealand

MEDICAL COUNCIL OF NEW ZEALAND
Statement of financial position
as at 30 June 2015

	Notes	2015	2014
Current assets			
Petty cash		600	600
Bank accounts		14,857	8,905
GST	6	43,777	319,400
Receivables	6	253,104	268,929
Interest accrued		41,295	77,303
Investments	7	4,190,000	3,941,278
Total current assets		$4,543,633	$4,616,415
Term assets			
Receivables	6	0	19,371
Property, plant and equipment	8	928,207	588,834
Intangibles	9	3,873,463	3,865,922
Total term assets		$4,801,670	$4,474,127
Current liabilities			
Sundry creditors		869,460	827,970
Employee entitlements		410,821	351,568
Lease rent free liability		34,927	34,927
Payments received in advance		355,074	202,783
Total current liabilities		$1,670,282	$1,417,248
Term liabilities			
Employee entitlements		62,216	66,345
Lease rent free liability		245,292	279,415
Total term liabilities		307,508	345,760
TOTAL NET ASSETS		**$7,367,513**	**$7,327,534**
CAPITAL ACCOUNT			
General Fund		5,179,902	5,094,936
Complaints Investigation and Prosecution Fund		1,721,352	1,744,217
Examination Fund		466,259	488,381
Total capital account		**$7,367,513**	**$7,327,534**

Authorised for issue for and on behalf of the Council.

Andrew Connolly
Chairperson
Dated: 14/10/15

Philip Pigou
Chief Executive
Dated: 14/10/15

These financial statements should be read in conjunction with the attached accounting policies and notes to the accounts.

MEDICAL COUNCIL OF NEW ZEALAND
Statement of comprehensive income
for the year ended 30 June 2015

	Notes	2015	2014
Income			
Exchange Income			
Fees received		1,016,243	1,251,226
Vocational registration income		392,982	1,019,133
Interest received		170,044	197,670
Recovery of staff costs		85,697	85,137
Other income		1,560	3,793
		1,666,526	2,556,959
Non Exchange Income			
APC Fees		9,286,629	8,656,168
Recovered legal costs		40,839	134,298
Fines received		7,500	0
		9,334,968	8,790,466
		$11,001,494	$11,347,425
Expenditure			
Employee benefits		5,412,436	5,227,318
Legal prosecutor		255,432	80,594
Depreciation and amortisation	10	928,959	661,103
Loss on disposal of assets		(1,877)	98,501
Fees paid to members of Council and standing committees		521,192	585,439
Medsys service level agreement		85,612	56,037
Debt collection costs and debt impairment expense		49,999	62,259
Rent		524,925	855,945
Intern supervisors payments		285,422	315,413
Health Practitioners Disciplinary Tribunal fees		138,306	173,303
Vocational registration expenses		368,145	849,675
Reports and health assessments		132,411	125,246
Credit card fees and commissions		5,546	8,039
Professional Conduct Committees fees		145,318	173,451
Other Legal & advisors		4,850	313
Advice and consultancy		44,232	83,027
Repairs and maintenance office equipment		138,834	98,020
Archives		61,057	65,430
Information brochures and notices		5,966	5,094
Audit fees		31,168	28,796
Other administrative costs		1,823,582	1,940,761
		$10,961,515	$11,493,764
Net surplus / (deficit) for year		$39,979	($146,339)
Other comprehensive income		0	0
Total comprehensive income		$39,979	($146,339)

These financial statements should be read in conjunction with the attached accounting policies and notes to the accounts.

MEDICAL COUNCIL OF NEW ZEALAND
Statement of movements in equity
for the year ended 30 June 2015

	Notes	2015	2014
A) ACCUMULATED FUNDS AND RESERVES			
Balance brought forward		7,327,534	7,473,873
Total comprehensive income		39,979	(146,339)
Closing balance		$7,367,513	$7,327,534
B) ANALYSIS OF INDIVIDUAL FUNDS			
1) General Fund			
Balance brought forward		5,094,935	5,628,601
Total comprehensive income	2	84,966	(533,666)
Closing balance		$5,179,902	$5,094,935
2) Complaints Investigation and Prosecution Fund			
Balance brought forward		1,744,217	1,454,054
Total comprehensive income	3	(22,865)	290,163
Closing balance		$1,721,352	$1,744,217
3) New Zealand Registration Examination Fund			
Balance brought forward		488,381	391,217
Total comprehensive income	4	(22,122)	97,164
Closing balance		$466,259	$488,381

These financial statements should be read in conjunction with the attached accounting policies and notes to the accounts.

MEDICAL COUNCIL OF NEW ZEALAND
Statement of cash flows
for the year ended 30 June 2015

	Notes	2015	2014
Cash flows from operating activities			
Cash was provided from:			
Receipts pertaining to statutory functions		10,801,915	11,149,755
Cash was distributed to:			
Council fees, disbursements and office expenses		(9,462,927)	(10,943,722)
Net cash flows from operating activities	12	1,338,988	206,033
Cash flows from investing activities			
Cash was provided from:			
Interest received		199,579	227,174
Short-term investments		1,000,000	2,820,116
		1,199,579	3,047,290
Cash was applied to:			
Purchase of assets		(1,283,893)	(1,057,184)
Short-term investments		(1,248,722)	(2,250,000)
		(2,532,615)	(3,307,184)
Net cash flows from investing activities		(1,333,036)	(259,894)
Net increase / (decrease) in cash and cash equivalents		5,952	(53,861)
Opening cash brought forward		9,505	63,366
Ending cash carried forward		$15,457	$9,505
Represented by:			
Petty cash		600	600
ASB bank account		14,857	8,905
		$15,457	$9,505

These financial statements should be read in conjunction with the attached accounting policies and notes to the accounts.

MEDICAL COUNCIL OF NEW ZEALAND

Notes to and forming part of the financial statements
For the year ended 30 June 2015

1. Statement of accounting policies

Basis of preparation

The Medical Council of New Zealand ('Council') is a statutory body constituted under the Health Practitioners Competence Assurance Act 2003.The Council is a public benefit entity (PBE).

The Council has elected to apply New Zealand Tier 2 Public Sector Public Benefit Entity accounting Standards (PBE Accounting Standards). The Council is eligible to report in accordance with Tier 2 PBE Standards as the Council does not:

- Have public accountability in respect of issuing debt or equity instruments
- Hold assets in a fiduciary capacity for a broad group of outsiders
- Have expenses over $30 million per annum.

The financial statements have therefore been prepared in accordance with Tier 2 PBE Standards under which certain disclosure concessions are available. The Council has chosen to continue to disclose the following information for which a disclosure concession is available:

- Reconciliation of Plant, Property and Equipment movements for the prior year (Note 8)
- Reconciliation of Intangible Assets for the prior year (Note 9)
- Reconciliation of net surplus with the net cash flow from operating activities (Note 12)
- The nature and extent of exposures to credit risk, liquidity risk and market risk (Note 15)
- Capital management note (Note 17).

The financial statements are presented in New Zealand dollars and all values are rounded to the nearest dollar. They are prepared on the historical cost basis.

Statement of compliance

These financial statements are a general purpose financial report as defined in the External Reporting Board's Framework, and are prepared in accordance with Public Sector Public Benefit Entity Accounting Standards and Generally Accepted Accounting Practice in New Zealand (NZGAAP).

Transition to the PBE Accounting Standards

This is the first set of financial statements presented in accordance with the PBE Accounting Standards. The conversion from the New Zealand equivalent of International Financial Reporting Standards has resulted in changes to accounting policies, with changes to significant accounting policies detailed below.

Measurement base

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

Specific accounting policies

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

(a) **Revenue** – Practising certificate (PC) revenue is recognised in full upon the commencement of the practising year to which it relates. Revenue from the provision of other services is recognised when the service has been provided. Where provision of services is extended

over a period of time the stage of completion is estimated and revenue recognised when the degree of service has been provided.

New Zealand registration examination revenue is recognised at the time the exam is held.

Vocational registration income is recognised at the time of invoicing. However a value equivalent to three month's invoicing (the average time taken to process applications) is assessed and held in payments made in advance

(b) **Depreciation** – Property, plant and equipment have been depreciated on a straight line basis at the following rates:
Furniture and fittings 10%pa
Office alterations..... 10%pa
Office equipment 20%pa
Computer hardware..... 33%pa

(c) **Property, plant and equipment** – is shown at cost less accumulated depreciation (Note 8).

(d) **Goods and services tax** – These financial statements have been prepared on a GST exclusive basis except for receivables and sundry creditors which include GST.

(e) **Fines and costs recovered** – Fines and recovery of legal costs have been accounted for on an accrual basis from the date of judgement.

(f) **Income tax** – The Council is not subject to income tax (Note 5).

(g) **Receivables** – Receivables are valued at the amount expected to be realised (Note 6).

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

(i) **Payments received in advance** – The outstanding balance at 30 June 2015 represents payments in advance or deposits made by debtors for services to be provided but not yet completed by the Council at balance date.

(j) **Salaries, holiday pay accrual, long service leave–** An accrual is made for any salaries relating to the current financial period paid after balance date. Holiday pay owing at balance date is valued at the applicable salary rate applying at the date of valuation. Long service leave is valued at the salary rate applicable at valuation date and discounted on an actuarial basis recognising the probability that the employee will reach entitlement as well as discounting for expected inflation and expected salary increases

(k) **Leases –** The value of the leases are recognised in the statement of commitments at the current negotiated value of the annual lease. At balance date, the Council is residing in office space at 80 The Terrace, Wellington. The Council has signed a long term lease on these premises effective from July 2014.

(l) **Intangible assets** – Intangible assets comprise software development costs, intellectual property costs and software licences. The external costs for the development of registration software is capitalised and disclosed as an intangible asset in the statement of financial position. Intangible assets under construction are not amortised until they are available for use.

Intangible assets have a finite useful life and are amortised on a straight line basis at 10% and 33% per annum.

(m) **Provisions** – A provision is made for the amount of accounts receivable that are expected not to be received. This provision is created by reviewing all outstanding amounts at the end of the year and assessing the likelihood of payment. Where a payment plan is in place,

amounts scheduled to be recovered after 5 years are provided in full and other balances are provided for after assessment of the likelihood of collection.

(n) **Statement of cash flows**

'Cash' refers to amounts held in banks, net of bank overdraft. It also includes short term deposits held as part of day-to-day cash management but excludes short term cash investments held for the intention of investing.

'Operating activities' are amounts received for the supply of services by the Council, and payments made to employees and suppliers necessary to support those services. Operating activities also include any transactions or events that are not investing or financing activities.

'Investing activities' are the acquisition, holding and disposal of property, plant and equipment and investments.

'Investments' include securities not falling within the definition of cash.

'Financing activities' are the receipt and repayment of the principal on borrowings.

Significant changes in accounting policies

There has only been one significant change in accounting policies which has occurred as a result of the transition to the PBE Accounting Standards.

Revenue
The PBE Accounting Standards require revenue to be identified/classified as exchange or non-exchange.

Exchange transaction revenue arises when one entity receives assets or services, or has liabilities extinguished, and directly gives approximately equal value in exchange. Non-exchange transaction revenue arises from transactions that are not exchange transactions and do not give approximately equal value in exchange.

The standard requires individual revenue lines to be identified on the face of the Statement of comprehensive income as exchange or non-exchange revenue.

The change in standard has not resulted in a change in the recognition of total revenue. Accordingly, there has been no material effect on revenue reported in these financial statements as a result of this change.

Critical accounting estimates and assumptions

The preparation of financial statements in conformity with PBE IPSAS requires management to make judgements, estimates and assumptions that affect the application of policies and reported amounts of assets and liabilities, income and expenses. The estimates and associated assumptions are based on historical experience and various other factors that are believed to be reasonable under the circumstances, the results of which form the basis of making the judgements about carrying values of assets and liabilities that are not readily apparent from other sources. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amount of assets and liabilities within the next year are:

Estimating the useful lives and residual values of intangible assets
At each balance date, Council reviews the useful lives and residual values of intangible assets. Assessing the appropriateness of useful life estimates requires Council to consider the expected period of use of the asset by Council.

An incorrect estimate of the useful life affects the depreciable amount of an asset, therefore affecting the amortisation expense recognised in the surplus or deficit and the asset's carrying amount. Council minimises the risk of this estimation uncertainty by an asset replacement program.

Council has not made any changes to past assumptions concerning useful lives.

Estimating the doubtful debt provision
At each balance date each debtor is reviewed and an assessment is made on the likelihood of collection of the amount owed. Where this assessment indicates that impairment exists, a further assessment is made of the amount of that impairment and a provision is created. Any receivable that is uncollectible is written off against the provision. An impairment will be assessed to exist where there has been no payment received, no payment schedule has been entered into, an existing payment programme is breached or information is received that would indicate the likelihood of collection is diminished.

Impairment
Asset carrying values are reviewed at the end of each year to determine whether there is any indication that the assets have suffered an impairment loss or increase in fair value. If any such indication exists, the fair value of the asset is estimated in order to determine the extent of the impairment loss or gain.

Administration charge
This is a charge on the Complaints Investigation and Prosecution Fund and the Examination Fund to meet overhead costs incurred by the General Fund. The charge is based on the proportion of staff engaged in the activity. This is an internal charge and is not represented on the statement of comprehensive income.

2.
General Fund
Statement of financial performance
for the year ended 30 June 2015

	Notes	2015	2014
REVENUE			
Exchange Income			
Fees received	1	799,923	857,486
Vocational registration income		392,982	1,019,133
Interest received	1	145,446	149,016
Administration fee - Complaints Investigation and Prosecution Fund	1	775,000	600,000
Administration fee - Examination Fund		90,000	95,000
Workforce survey and other income		46,128	36,341
		2,249,479	2,756,976
Non Exchange Income			
APC Fees		7,581,530	7,067,170
		7,581,530	7,067,170
Total revenue		**$9,831,009**	**$9,824,146**
ADMINISTRATION AND OPERATING EXPENSES			
Communications		189,251	28,293
Legal expenses and other consultancies		44,232	83,027
Administration and operating expenses		2,282,333	2,542,353
Staff costs including recruitment and training		5,091,393	4,895,549
Total administration and operating expenses		$7,607,209	$7,549,222
COUNCIL AND COMMITTEE EXPENSES			
Council			
- Fees and expenses		551,609	574,459
- Conference and liaison costs		74,899	49,561
- Strategic directions		133,077	97,765
Audit committee			
- Fees and expenses		10,835	25,262
Health committee			
- Fees and expenses		44,704	33,213
- Independent assessment reports, Doctors' Health Advisory Service, other costs		134,127	141,108
Education committee			
- Fees and expenses		49,654	63,437
- Hospital visits, intern supervisor contracts and other costs		325,627	412,222
Professional standards			
- Performance assessments and other costs		299,108	414,232
Registration			
- Workshops and other costs		515,194	997,331
Total Council and committee expenses		$2,138,834	$2,808,590
TOTAL EXPENDITURE		**$9,746,043**	**$10,357,812**
Net surplus/(deficit) for year and total comprehensive income		**$84,966**	**($533,666)**

3.

Complaints Investigation and Prosecution Fund
Statement of financial performance
for the year ended 30 June 2015

	Notes	2015	2014
Revenue			
Exchange Income			
Recovery of staff costs		85,697	85,136
Interest received		17,729	39,543
		103,426	124,679
Non Exchange Income			
APC Fees		1,705,100	1,588,999
Recovered costs		40,839	134,298
Fines received		7,500	0
		1,753,439	1,723,297
Total revenue		$1,856,865	$1,847,976
ADMINISTRATION AND OPERATING EXPENSES			
Administration fee	1	775,000	600,000
Debt impairment expense relating to unpaid penalties and costs		49,999	60,945
General administration and operating expenses		298,472	311,077
Total administration and operating expenses		$1,123,471	$972,022
COUNCIL AND TRIBUNAL EXPENSES			
Professional conduct committee costs			
- Fees		145,317	173,451
- Expenses		406,474	152,460
Total professional conduct committee costs		551,791	325,911
Health Practitioners Disciplinary Tribunal			
- Administration fee		66,162	86,577
- Fees and other hearing expenses		138,306	173,303
Total Health Practitioners Disciplinary Tribunal costs		204,468	259,880
Total Council and Tribunal expenses		$756,259	$585,791
TOTAL EXPENDITURE		$1,879,730	$1,557,813
Net surplus/(deficit) for year and total comprehensive income		**($22,865)**	**$290,163**

4.

New Zealand Registration Examination Fund
Statement of financial performance
for the year ended 30 June 2015

	Notes	2015	2014
Revenue			
Exchange Income			
NZ Rex candidate fees		169,999	356,575
Interest received		6,870	9,110
Other income		1,751	4,618
Total revenue		$178,620	$370,303
ADMINISTRATION AND OPERATING EXPENSES			
Administration fee	1	90,000	95,000
Centre costs		32,602	67,093
Examiners' fees and expenses		30,624	62,428
Honorarium, staff costs and other administrative expenses		47,516	48,618
Total administration and operating expenses		$200,742	$273,139
Net surplus/(deficit) for year and total comprehensive income		**($22,122)**	**$97,164**

5. Taxation

The Medical Council is registered as a charity with the Charities Commission and accordingly its transactions for a charitable purpose are exempted from income tax.

6. Receivables

	2015	2014
Debtors	1,022,474	1,031,724
Provision for impairment	(921,696)	(871,697)
	100,778	160,027
Payments in advance	152,326	128,273
	253,104	288,300
GST	43,777	319,400
Total debtors and other receivables	**$296,881**	**$607,700**

Fair Value

The carrying value of debtors and other receivables approximates their fair value.

Non exchange receivables

The value of non-exchange revenue recognised in receivables is $833,940 (2014: $854,923).

Impairment

The age profile of receivables at year end is detailed below:

	2015			2014		
	Gross	Impairment	Net	Gross	Impairment	Net
Not past due	32,797	0	32,797	108,222	0	108,222
Past due 1-30 days	33,298	0	33,298	10,659	0	10,659
Past due 31-60 days	6,591	0	6,591	30,289	0	30,289
Past due 61-90days	9,986	0	9,986	6,916	0	6,916
Past due >90 days	939,802	(921,696)	18,106	875,638	(871,697)	3,941
Total	**$1,022,474**	**($921,696)**	**$100,778**	**$1,031,724**	**($871,697)**	**$160,027**

The provision for impairment has been calculated on a review of all debtor balances.

7 Investments

	2015	2014
ASB - Call Account -2.85%	1,440,000	441,278
ANZ - Matured 22 Jul 2014 -3.90%	0	250,000
ANZ - Matured 25 Sep 2014 -3.95%	0	250,000
ANZ - Matures 27 Oct 2015 -4.50%	250,000	250,000
ASB - Matured 10 Dec 2014 - 4.20%	0	250,000
ASB - Matures 8 Jul 2015 - 4.40%	250,000	250,000
ASB - Matures 9 August 2015 - 4.10%	250,000	250,000
ASB - Matures 10 Oct 2015 - 4.30%	250,000	250,000
BNZ - Matures 29 Jul 2015 - 4.56%	500,000	500,000
BNZ - Matures 1 Aug 2015 - 3.50%	250,000	0
BNZ - Matures 22 Oct 2015 - 4.10%	250,000	500,000
Westpac - Matures 23 July 2015 - 4.40%	250,000	250,000
Westpac - Matures 6 Aug 2015 - 4.40%	250,000	250,000
Westpac - Matures 16 Aug 2014 - 4.40%	250,000	250,000
	$4,190,000	**$3,941,278**
Current	4,190,000	3,941,278
Term	0	0
	$4,190,000	**$3,941,278**

8. Property, plant and equipment

	Computer Hardware	Furniture and Fittings	Office Alterations	Office Equipment	Artwork	TOTAL
Cost						
Balance at 1 July 2013	723,400	320,194	704,693	264,807	7,138	2,020,232
Additions	143,653	18,252	324,697	2,735	0	489,337
Disposals	0	0	(704,693)	0	0	(704,693)
Balance at 30 June 2014	867,053	338,446	324,697	267,542	7,138	1,804,876
Balance at 1 July 2014	867,053	338,446	324,697	267,542	7,138	1,804,876
Additions	70,802	45,718	423,185	2,632	0	542,337
Disposals	(381,632)	0	0	(35,020)	0	(416,652)
Balance at 30 June 2015	556,223	384,164	747,882	235,154	7,138	1,930,561
Accumulated depreciation and impairment losses						
Balance at 1 July 2013	590,776	270,188	593,234	231,426	0	1,685,624
Depreciation expense	95,980	12,662	12,958	15,010	0	136,610
Impairment losses	0	0	98,501	0	0	98,501
Disposals	0	0	(704,693)	0	0	(704,693)
Balance at 30 June 2014	686,756	282,850	0	246,436	0	1,216,042
Balance at 1 July 2014	686,756	282,850	0	246,436	0	1,216,042
Depreciation expense	98,725	15,343	73,160	7,510	0	194,738
Impairment losses	0	0		0	0	0
Disposals	(379,827)	0	0	(28,599)	0	(408,426)
Balance at 30 June 2015	405,654	298,193	73,160	225,347	0	1,002,354
Carrying amounts						
At 1 July 2013	132,624	50,006	111,459	33,381	7,138	334,608
At 30 June and 1 July 2014	180,298	55,596	324,697	21,106	7,138	588,834
At 30 June 2015	150,570	85,971	674,722	9,807	7,138	928,207

9. Intangible assets

	Intangibles
Cost	
Balance at 1 July 2013	4,890,982
Additions	983,353
Disposals	0
Balance at 30 June 2014	5,874,335
Balance at 1 July 2014	5,874,335
Additions	741,762
Disposals	0
Balance at 30 June 2015	6,616,097
Accumulated amortisation and impairment losses	
Balance at 1 July 2013	1,483,920
Amortisation expense	524,493
Impairment losses	0
Disposals	0
Balance at 30 June 2014	2,008,413
Balance at 1 July 2014	2,008,413
Amortisation expense	734,221
Impairment losses	0
Disposals	0
Balance at 30 June 2015	2,742,634
Carrying amounts	
At 1 July 2013	3,407,062
At 30 June and 1 July 2014	3,865,922
At 30 June 2015	3,873,463

Included in Intangible assets is the cost of acquiring Intellectual Property rights in relation to the registration software. These costs are incidental to the construction of the registration software and have not been separately identified so it is not possible to measure their separate carrying value.

10. Depreciation

	2015	2014
Depreciation on Plant, Property and Equipment	194,738	136,610
Depreciation on Intangible Assets	734,221	524,493
Total Depreciation	**$928,959**	**$661,103**

11. Related party transactions

	2015	2014
Salaries and other short-term employee benefits	1,416,003	1,385,768
Other long-term benefits	40,084	38,811
Total key management personnel compensation	**$1,456,087**	**$1,424,579**

Key management personnel compensation

Key management personnel include the Chief Executive and the other 8 members (2014: 8) of Council's management team.

There were no other related party transactions.

12. Reconciliation of net surplus with the net cash flow from operating activities

	2015	2014
Surplus / (deficit) for year	39,979	(146,339)
Add non-cash items:		
Depreciation and amortisation	928,959	661,103
Loss on disposal of assets	(1,877)	98,501
Employee entitlements	55,124	(8,598)
Provision for Doubtful Debts	49,999	62,259
	1,032,205	813,265
Add movements in working capital items:		
(Increase) / decrease in receivables	39,575	(3,789)
(Increase) / decrease in GST	275,623	(154,258)
Increase / (decrease) in receipts in advance	152,291	(256,992)
Increase / (decrease) in sundry creditors	(30,640)	151,816
	436,849	(263,223)
	1,509,033	403,703
Less items classified as investing activity – interest	(170,045)	(197,670)
Net cash flows from operating activities	**$1,338,988**	**$206,033**

13. Statement of contingent liabilities

There are no known contingent liabilities (2014: Nil).

14. Statement of commitments

Lease commitments under non-cancellable operating leases;

	2015	2014
Less than one year	536,850	527,300
Between 1 and 5 years	2,684,250	2,684,250
Greater than 5 years	1,073,700	1,610,550
	$4,294,800	**$4,822,100**

Lease commitments less than one year for 2014 included one month's lease rental on a previously leased property. Lease commitments for the 2015 year relate solely to the Council's lease at 80 The Terrace, Wellington.

15. Financial instruments

Credit Risk
Financial instruments which potentially subject the Council to credit risk consist principally of bank balances and accounts receivable. The Council places investments with recognised banking institutions within an approved reserves and investment policy to limit exposure to concentrations of credit risk.

The Council's maximum credit risk exposure for each class of financial instrument is represented by the total carrying amount of bank accounts, receivables and investments.

Liquidity Risk
This is the risk that Council will encounter difficulty raising liquid funds to meet commitments as they fall due. Council manages liquidity risk by monitoring forecast and actual cash flow requirements and investment maturities.

Market Risk
The Council is exposed to interest rate risk as interest rate movements will affect the returns generated from investments and related cash flows. At year end the interest rates on term deposits ranged from 3.90% to 4.63% (2014: 3.90% to 4.56%).

The estimated fair values of the financial instruments are as follows:

	2015	2014
Receivables	$338,176	$685,003
Bank balances	$14,857	$8,905
Investments	$4,190,000	$3,941,278
Sundry creditors	($1,224,534)	($1,030,752)

For financial instruments held at balance date, the Council has no exposure to market risk that give rise to an impact on surplus or deficit.

16. Council members' fees and allowances

	2015	2014
Attendance allowance:		
Daily	$916.00	$916.00
Hourly	$114.50	$114.50
Communication allowance:		
Quarterly	$150.00	$150.00
Total fees and allowances paid to members of Council	**$521,192**	**$585,439**

Council members receive a daily fee for attending meetings and an hourly rate for any preparatory work for any Council or Committee meeting.

In addition a communications allowance has been approved to cover incidental costs of an internet connection, telephones calls and postage/courier charges.

17. Capital management

The Council's capital is its equity, which comprises retained surpluses. Equity is represented by net assets.

Council's equity is largely managed as a by-product of managing revenues, expenses, assets, liabilities, investments and general financial dealings.

The objective of managing Council's equity is to ensure that the Council effectively achieves its objectives and purpose whilst remaining a going concern.

Medical Council of New Zealand
Te Kaunihera Rata o Aotearoa