Te Kaunihera Rata o Aotearoa

Medical Council of New Zealand

Annual Report 2019

Contents

Facts at a glance	**4**
Chair's report	**6**
Chief Executive's report	**9**
Strategic goals	**11**
Strategic directions	**12**
Audit Committee report	**17**
Education Committee report	**19**
Health Committee report	**21**
Members of the Medical Council	**22**
Registration of doctors and practising certificates	**27**
Table 1: Scopes of practice – summary of registration status	**27**
Table 2: Registration activities	**29**
Table 3: Doctors registered in vocational scopes	**31**
Table 4: Registrations issued, by country of primary qualification	**33**
Table 5: Vocational scopes granted to doctors, by vocational scope of practice	**34**
Table 6: Outcomes of applications for vocational registration assessments	**36**
Table 7: Doctors on the New Zealand medical register, by country of primary qualification	**38**
Table 8: Referral sources to full Council meeting for performance processes	**39**
Table 9: Referral sources to full Council meeting for conduct processes	**40**
Table 10: Competence-related Council processes	**40**
Table 11: Conduct-related Council processes	**41**
Table 12: PCC as a result of a conviction	**41**
Table 13: Notifications of inability to perform required functions due to mental or physical (health) condition	**42**
Table 14: Outcomes of health notifications	**42**
Table 15: Cadidates sitting and passing NZREX Clinical	**43**
Table 16: Medical charges before the Health Practitioners Disciplinary Tribunal	**45**
Corporate governance	**46**
Finances	**48**
Auditor's Report	**63**

Te Kaunihera Rata o Aotearoa | **Medical Council of New Zealand**

The Medical Council of New Zealand is pleased to submit this report for the year ended 30 June 2019 to the Minister of Health. The report is presented in accordance with section 134 of the Health Practitioners Competence Assurance Act 2003 and includes a report on activities of the Health Practitioners Disciplinary Tribunal (doctor cases only).

Whakahaumaru i te iwi whānui, whakatuarā te kounga o te tikanga rata.

Protecting the public, promoting good medical practice.

Facts at a glance

Doctors newly registered →

(1 July 2018 to 30 June 2019)

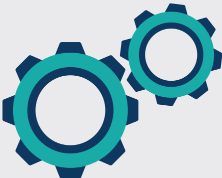
1,072
International medical graduates

511
Trained in New Zealand

601
Doctors newly registered with vocational scopes

83
Candidates who sat NZREX Clinical

48
Candidates who passed NZREX Clinical



20

Referrals to a performance assessment committee

23

Referrals to a professional conduct committee

4

Education programme ordered after a performance assessment

42

Referrals to the Health Committee

16,925

Total practising doctors at 30 June 2019

Chair's report

Tēnā koutou

Ko Mākeo rāua ko Mārotini ngā maunga.
Ko Whakatōhea rāua ko Ngāti Porou ngā iwi.
Tēnā koutou e ngā rata mē ngā tāngata katoa.

At Council's first meeting of the year in February 2019, I had the privilege of being elected Chair of Council and Ms Susan Hughes was elected as Deputy Chair.

Following the meeting, we farewelled and acknowledged the leadership and rangatiratanga of Andrew Connolly, who concluded his 9 year term on Council, having served 5 of those as Chair. We also acknowledged Laura Mueller's service to Council, following her 9 year term, serving 5 years as Deputy Chair.

Andrew has been an outstanding Chair of Council over the past 5 years and has enhanced the mana and respect of Council in the eyes of the public of New Zealand whom we serve and the medical profession we regulate.

During his time on Council and as Chair, Andrew has championed cultural competency, partnership, and health equity. This has led to partnerships between Council and organisations such as Te Ohu Rata o Aotearoa – the Māori Medical Practitioners Association (Te ORA), the Health Quality & Safety Commission, and the Council of Medical Colleges over improving the cultural safety of medical practitioners and the cultural safety of care provided.

Nō reira e te rangatira – haere ki to waka hou, hei oranga ai ngā tāngata o te motu!

Laura was appointed to Council as a lay member in October 2009. Laura was Council's Deputy Chair from February 2014 to February 2019. During her time on Council, Ms Mueller was a member of Council's Complaints Triage Team and the Audit, Education and Health Committees and was also Council's liaison member of the Health and Disability Commissioner's Consumer Advisory Group until February 2019.

On behalf of all Council members, I would like to express our appreciation for the invaluable contribution Laura has made to Council.

Other Council member changes

Dr Jonathan Fox resigned from Council in March 2019.

Elected in March 2009 and subsequently re-elected in 2012 and 2015, Jonathan brought wisdom and sage advice to our decision making based on his many years' experience as a GP. He was a member and Chair of the Health Committee and Chair of our Audit Committee over his time on Council.

In October 2018, Dr Pamela Hale and I were reappointed to Council by the Minister following re-election by the profession. Dr Ainsley Goodman was also appointed at this time, following her election. All the appointments are for a 3-year term.

Ms Kathleen (Kath) Fox was appointed to Council in October 2018 as a layperson for a 3-year term. She has held leadership roles spanning health, education, and the wider social service sector.

The terms of some members expired during the year, and we await either their reappointment or the appointment of new members by the Minister of Health.

Members whose terms expired during the year are Dr Andrew Connolly (December 2018), Dr Lu'isa Fonua-Faeamani (September 2018), Ms Susan Hughes QC (June 2019), Ms Laura Mueller (December 2018), Ms Kim Ngārimu (September 2018), and Professor John Nacey (31 March 2019).

I would like to thank all these members for their continued commitment and work beyond their terms in ensuring public health and safety.

Changes to the legislation governing doctors and other registered health professionals

April 2019 saw Parliament pass the Health Practitioners Competence Assurance Amendment Act 2019 (HPCAA). Our core functions are unchanged, so the changes will have little impact on most doctors.

Some of the operational changes need immediate attention and Council resource to prepare for. Other changes, particularly to our functions and standards setting, will take more time to be reflected in our policies and approach.

We discuss some of the key changes below.

Naming policies

The amended HPCAA requires Council to develop and publish a naming policy (s157). There has always been a section allowing Council to publish any order made about a doctor, although it has rarely used that power. Every responsible authority under the HPCAA now needs to develop a policy, setting out the criteria that will apply in deciding whether (and in what form) to publish an order and the process to follow.

Our policy must be published by April 2020, and we must first consult with:

- all registered doctors
- the Privacy Commissioner
- the Director-General of Health
- the Health and Disability Commissioner.

We are looking to undertake this consultation in late 2019.

Performance reviews

All responsible authorities will have their performance reviewed. The first review must take place before the end of April 2022. The frequency after that will be no more than every 5 years.

We strongly support the idea of some form of regular review where that allows us to identify opportunities to improve our effectiveness and efficiency. In 2010, we commissioned such a review by the United Kingdom-based Council for Health Regulatory Excellence.

Council considers that, to be effective and to deliver constructive benefits, these reviews must be standards-based, well-defined, and well-informed. They will take time and resource, and reviewers must have particular and sufficient expertise. We will be working closely with the Ministry of Health and other responsible authorities on the form of the review and the criteria for selecting reviewers.

Workforce data

A new power is given to the Director-General of Health to require authorities such as Council to provide workforce data to the Ministry of Health. So far, the Ministry has not specified what data it needs. It could include a doctor's name, date of birth, gender, and ethnicity, which is information we hold. Employer, place of employment, and hours of work may also be required. Until now, these details have been collected as part of the annual workforce survey completed with practising certificate applications.

Once the Ministry has advised us of its data needs, we can decide how best to gather the data. Importantly, this information will be confidential to the Ministry. It may not publish data in any way that identifies or could reasonably identify individual doctors.

Interdisciplinary, interprofessional collaboration

An additional function for us (and all responsible authorities) is to promote interdisciplinary or interprofessional collaboration and cooperation in the delivery of health services.

This is likely to become a feature of the ongoing discussion amongst authorities and will necessarily involve professions covered under the HPCAA. At this early stage, it's unclear what specific initiatives this might lead to, if any, but the wording reflects an ongoing discussion within the health sector over evolving models of healthcare delivery.

Cultural competence

An amendment to the description of Council's standards-setting function states that standards of cultural competence may include 'competencies that will enable effective and respectful interaction with Māori'.

A review of Council's Cultural Competence statement, and providing best health care to Māori are well underway, and these are expected to be published in late 2019, following extensive consultation, expert advice, and a national symposium.

New office

In May 2019, we moved into our new office in the Aon Centre in central Wellington. This move followed a period in temporary office space after our previous office space was deemed unsuitable following the 2016 Kaikōura earthquake. Over the previous 2 years, Council staff have worked in less than ideal conditions. However, Council and Joan Simeon, Council's Chief Executive, were not prepared to compromise the health and safety of our staff and visitors to our offices.

The blessing ceremony for the new office was held with taumata kōrero from Te ORA to support the morning, led by Koro Alex, Felicity Buchanan, and Peter Jackson from the local iwi (Te Ātiawa, Taranaki). A particular highlight was the staff waiata, which demonstrates Council's own commitment to the importance of Te Tiriti and a partnership approach. The new office is a fantastic space that will serve Council well in the years ahead.

I would like to thank staff and Council members for their patience over the last 6 years. Their commitment to keeping Council's core business services up and running, whilst pressing on with new initiatives, has been inspiring.

Ngā mihi nui

Curtis Walker
Chairperson
Medical Council of New Zealand

Chief Executive's report

Tēnā koutou

It is with pleasure that I present the 2019 annual report, marking my full first year as Chief Executive since taking up the role in December 2017.

The medical profession is one of the most trusted professions in New Zealand. We have a responsibility as the medical regulator to ensure we set standards for the profession and ensure they are maintained to warrant that ongoing trust. Therefore, our accountability to the public is paramount in our minds as we carry out our functions and continue our focus on achieving our strategic goals as laid out in our 5-year strategic plan, *Towards 2022*.

Over the past year we have had a particular focus on improving our processes. One example of this is the review we have carried out for how notifications about professional boundary breaches are investigated. We have placed a particular focus on how we communicate with those who make notifications and hope by doing so that we have removed barriers for members of the public to make notifications.

We have been very pleased to work closely with our partners Te Ohu Rata o Aotearoa, (Te ORA), as we have reviewed our resources related to cultural safety, partnership and health equity. We expect to release new resources later this year that will set standards for cultural safety and provide guidance to the profession and to our stakeholders about expectations in this area and what that means for the doctor – patient relationship.

As in previous years, I continue to have one-on-one meetings with colleagues on other Councils or Boards.

We have also worked closely with the medical colleges, in New Zealand and in Australia as well as our international medical regulator colleagues as we have developed a new framework for vocationally registered doctors to demonstrate their ongoing competence through recertification programmes and continuing professional development. The emphasis is shifting to those activities that we know are most effective for making positive change, in particular those focused on reviewing and reflecting on practice and measuring and improving outcomes.

Our Consumer Advisory Group has continued to provide excellent input to our strategy and policy development, ensuring that we have a true focus on patient and public safety. Their feedback was crucial to our review of our standards on sexual and professional boundaries in the doctor-patient relationship. I would like to acknowledge the members of the Consumer Advisory Group for their ongoing commitment.

Our commitment to working as effectively as efficiently as possible has continued with a particular focus on quality improvement. We have recently undertaken a privacy review to ensure that we are looking after the data we hold safely, securely and within privacy legislative requirements.

We have continued our ongoing collaboration of many years with other regulatory authorities, for example we shared our submission on amendments to the Health Practitioners Competence Assurance Act. The benefit of this sort of collaboration, is the sharing of ideas that not only improve public health and safety, but also make for best regulatory practice.

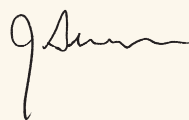
In February this year, we were pleased to welcome Dr Curtis Walker as the new Chair of Council when Andrew Connolly's 9-year term on Council drew to a close. I would like to acknowledge Andrew's tremendous leadership of Council and also within the profession. Andrew's commitment to medical regulation and to the public has been outstanding. It has been a privilege to work alongside Andrew, and I wish to thank him, Curtis, and Council for their dedication and their support.

Finally, I wish to acknowledge our people. I am proud of the commitment and enthusiasm of our staff. In late May, we moved into our new office in the Aon Centre in central Wellington, which will meet our needs for many years. This followed 2 years of being in temporary accommodation after our building was damaged in the Kaikōura earthquake. The health and safety of staff is paramount, and we had no option but to vacate our premises.

I would like to thank the staff for their resilience during this challenging period.
Our achievements over the past year are a credit to their ongoing dedication.

I feel confident that we are well placed to continue our excellent work through 2020.

Ngā manaakitanga



Joan Simeon
Chief Executive
Medical Council of New Zealand

Medical Council of New Zealand's strategic goals 2018/19

Goal one Optimise mechanisms to ensure doctors are competent and fit to practise.

Goal two 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.

Goal three 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.

Goal four 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.

Goal five Promote good medical education and learning environments throughout the undergraduate/postgraduate continuum to help ensure all doctors have achieved the necessary standards for their practice.

Strategic directions

Below are some of our key achievements for each strategic direction over the past year.

Strategic direction 1 – Accountability to the public and stakeholders

Council is accountable to the public, to Parliament, and to the profession. Engagement and collaboration with many individuals and groups raises awareness of Council's role and functions, gives us valuable feedback into our strategic and policy development, and improves how we perform our functions. The best interests of the public are integral to all Council strategic planning, policy development, and business activity.

Professional boundary breach notifications and support for notifiers

We have changed how we approach notifications alleging professional boundary breaches. We undertook a comprehensive review of how we respond to these notifications and how our Professional Conduct Committee's investigate these allegations, which has resulted in significant changes.

We have removed the need for written notifications and have ensured flexibility in our approach to professional boundary breaches. We have ensured that notifiers have more choice throughout the investigation process. This may include changing the format of an interview, arranging for additional support, or updating a notifier at the frequency that works for them. We provide support throughout this process for notifiers.

We engaged a forensic clinical psychologist to train our Professional Conduct Committee members and our Board members. The training focused on different aspects for each group; with the main focus being on breaking down misconceptions about notifications and investigations.

Since making these changes, we have received positive feedback from notifiers about their experience throughout the process. Long term, we hope that these changes will encourage the public to come forward with their concerns by removing barriers to notification. We are continuing our work in this area.

Review of Council's statements

During the past year, we asked for feedback from medical colleges, doctors, our Consumer Advisory Group, employers, including District Health Boards (DHBs), and a wide range of other stakeholders on the statement *Informed Consent: Helping patients make informed decisions about their care*.

It was also pleasing to finalise and send these statements to the profession and other stakeholders:

- *Professional boundaries in the doctor-patient relationship*
- *Safe practice in an environment of resource limitation*
- *Sexual boundaries in the doctor-patient relationship*

The feedback we received has helped to shape what goes in our statements, and I would like to thank all stakeholders who have taken time to share their views.

Strategic direction 2 – Cultural competence, partnership, and health equity

A doctor's culture and world view influence the way they interact with patients and the way they understand health, health care and wellness. Council expects that doctors will consider their own views and biases and how these may impact on equity in the delivery of care, and the cultural safety for patients.

The key outcome for this strategic direction is to develop cultural safety in the doctor-patient relationship, improve Māori health outcomes and aim for health equity.

Cultural safety is important for all population groups, along multiple cultural dimensions of Indigenous status, age or generation, gender, sexual orientation, socioeconomic status, ethnicity, religious or spiritual belief and disability.

To this end, it is important that others doctors reflect on how their personal biases and behaviour can impact on the doctor-patient relationship and considering the cultural safety of patients when they receive care.

Council has been pleased to continue to work closely in partnership with Te Ohu Rata o Aotearoa, (Te ORA) and with support from an expert Advisory Group and Governance Group. The focus most recently has been on revising Council's standards and guidance for doctors to bring these in line with current thinking. The documents are our *Statement on cultural safety* outlining what cultural safety means, why it is important, and the standards for all doctors; and *He Ara Hauora Māori: A Pathway to Māori Health Equity* that gives guidance on how doctors and health organisations can support best health outcomes for Māori.

In June we held our second Cultural Safety, Partnership and Health Equity Symposium at the Museum of New Zealand Papa Tongarewa. The event brought together over 200 people from a broad range of organisations from across the health sector, both within New Zealand and from Australia. This included representatives from medical colleges, other regulatory authorities, District Health Boards, Primary Health Organisations, Non-Government Organisations, Ministry of Health, PHARMAC, ACC, unions, and counterparts in Australia, the Australian Medical Council and the Australian Health Practitioner Regulation Agency.

The theme of the symposium, *Mahia te mahi, hei painga mō te iwi, Getting the job done for the wellbeing of the people* was reflected in the presentations from a wide range of excellent leaders. The aim was to build on the 2017 symposium and investigate ways of working together to improve cultural safety and work towards health equity.

Council is encouraging doctors and health organisations to establish and strengthen their partnerships with Māori organisations, with the aim of including Māori participation within their governance structures.

Strategic direction 3 – Promoting competence

Council applies the principles of 'right touch' regulation to ensure all doctors maintain competence, have up-to-date knowledge, and are fit to practise throughout their medical career. Competence includes not only the doctor's own practice, but also their interactions within interdisciplinary and multidisciplinary teams, and their obligations within the wider context of the practice setting. The key outcome of our vision is to continually improve the current high quality of medical practice in New Zealand.

One of the ways to achieve this is through the recertification programmes that are generally run by the medical colleges or associated societies. These involve a range of activities through which Council can ensure doctors maintain their competence, are up to date, and continually strive to develop their practice and improve patient care.

Towards strengthening recertification

In 2019, Council established updated, strengthened Recertification requirements for vocationally registered doctors. These standards were developed in close consultation with the specialist medical colleges, DHBs and other key stakeholders, and are already being implemented by colleges. The strengthened recertification provides assurance that doctors are remaining up to date in their knowledge, reflecting and reviewing their practice and measuring their outcomes as being key to continuous quality improvement.

The emphasis of the model has changed from a time-based approach, to one where the focus is on the value of the activities according to that doctor's scope of practice, where they work, and the actual work they do.

This aligns with the key principles we set back in 2016 that quality recertification activities are those that are:

- evidence based
- formative in nature
- informed by relevant data
- based on the doctor's actual work and workplace setting
- profession led
- directed to clinical and cultural competencies
- informed by public input and referenced to the New Zealand Code of Health and Disability Services Consumers' Rights
- supported by employers.

The feedback we received following a consultation on the proposed model was generally supportive of this approach. This led to further work to refine and clarify the specifics of the core elements that would be required for all recertification programmes. These are summarised in this diagram:

Recertification providers for vocationally registered doctors will be developing their programmes to ensure that their doctors complete these core requirements:

- Doctors must complete a mix of activities, as prescribed by the programme provider, across all three categories of continuing professional development (CPD):
  - Reviewing and reflecting on practice.
  - Measuring and improving outcomes.
  - Educational activities (continuing medical education – CME).
- Doctors must have a structured conversation with a peer, colleague, or employer every year to discuss the outcome from activities undertaken (for example, CPD or educational activities, or other), the doctor's personal reflection on their practice, learning aspirations, wellbeing, and their career stage and intentions.
- Doctors should use the information gathered from activities and the structured conversation to inform the development and ongoing maintenance of a professional development plan (PDP). Setting and achieving goals in a PDP can guide learning to address identified development needs, achieve educational and career aspirations, consider changes for improving the doctor's own health and wellbeing, and plan for their future.

Cultural safety and a focus on health equity must be embedded within all of these activities.

Strategic direction 4 – Medical education

One of Council's functions is to ensure the competence of doctors through their education and training programmes, from undergraduate to postgraduate education and to prescribe the qualifications required for registration.

The key outcome of this strategic direction is to ensure a quality educational experience for all doctors and medical students.

Continuous improvement of intern training

We have continued to work on a range of initiatives to improve the prevocational medical training programme for NZREX doctors and those in their first 2 years of practice following medical school.

The training programme has been in place since 2014 and provides a platform for these doctors, known as interns, to complete a range of learning activities across the 2-year programme under clinical and educational supervision by their employer.

We have recently completed an evaluation of the whole training programme, which showed the programme is generally working well but improvements could be made to enhance the learning experience for interns. Some of these changes are already under way.

Multisource feedback

Other improvements in the training programme include the introduction of multisource feedback for interns. This provides interns with the opportunity to gather feedback from a wide range of colleagues on their professionalism, communication, and other behaviours, which can inform their development as doctors.

An expert advisory group was set up to find a suitable tool that could be used in New Zealand. It is hoped the group would gather the kind of information that would most benefit the intern and help support their learning. This tool is expected to be in place to help interns from the end of August 2019.

Community-based clinical attachments

DHBs are continuing to work towards fully establishing community-based clinical attachments for all interns to experience the delivery of health care outside the hospital as part of their training. While the number of interns able to gain experience in these clinical attachments is increasing, there is still some way to go to ensure all interns have this opportunity.

We are continuing to work closely with DHBs to increase the number of community-based clinical attachments. One initiative is to revise how a community-based attachment is defined to allow for more flexible attachments while still benefitting the intern's learning.

New Zealand Curriculum Framework

What interns have to learn during that time is outlined in the New Zealand Curriculum Framework, which is one element of the programme currently under review. An expert steering group was set up to look at how we can simplify the framework and make it more meaningful for the intern but still ensure a quality learning experience that sets interns up for vocational training in future.

The steering group considered a range of options and is now working to develop a new model that brings together the 373 individual tasks (called learning outcomes) in the current programme and incorporating these into 14 more general learning activities that more closely align with the day-to-day work interns do. Interns will be able to reflect on what level of achievement they have reached in that activity and make plans for further learning in each area.

The idea will shortly be tested with a focus group of interns and other experts to see if this could work for the New Zealand training environment. If it is viable, we will make to changes to the electronic portfolio (ePort) that interns use to record their learning.

Strategic direction 5 – Research and evidence-based regulation

The key outcome is to ensure all strategic and policy decisions are supported by valid and reliable evidence, with the public interest at the centre.

Council is aware of the fast pace of technological and communication advances and the need to ensure policy and standards are supported by evaluation, research and evidence.

Audit Committee report

The Audit Committee is a standing committee of Council. The Audit Committee consists of four members of Council and one external member with audit and accounting experience.

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 relevant and of high quality
- conduct special investigations as required by Council.

The Audit Committee this year looked at a number of issues including the following:

Premises

In May 2019, we relocated to permanent office premises at 1 Willis Street, Wellington. This followed an extensive search for suitable premises across the Wellington region, ending a significant period of displacement and disruption for Council and its staff.

We were in temporary office accommodation from mid-February 2017, after an independent engineer's report identified potential safety risks in our previous permanent accommodation, likely sustained in the November 2016 Kaikōura earthquake.

Despite remedial works being completed in December 2017, the advice received did not allay our safety concerns for the building should a similar seismic event occur. On that basis we made the decision to permanently vacate our office, which is leased until July 2023.

Our financial statements recognise the onerous lease provision, and we must continue to meet our lease obligations. We have engaged with the building's owner throughout this process to seek a mutually agreeable solution regarding the lease. However, this matter is unresolved at the end of the year.

We have also lodged a business interruption insurance claim for additional costs incurred as a result of the earthquake. We consider a settlement is probable and is likely to be resolved in the next financial year.

Risk management programme

The Audit Committee this year continued to monitor key risks to Council. The risk impact assessment Council uses has been useful in managing issues including business disruption, allowing both Council and staff to anticipate and proactively mitigate and manage issues. We have also continued to monitor risk around the premises issues and prioritised the implementation of a privacy programme to drive a culture of privacy awareness across the organisation.

Health and safety

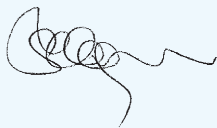
The Audit Committee continues to take an active role in seeking to be informed about health and safety issues and the actions that management are taking in order to mitigate potential risks to staff and other stakeholders.

Health, safety, and wellbeing meetings are held regularly by staff and management, and the minutes of each meeting are considered by the Audit Committee.

Annual financial statements

The Committee reviewed the annual financial statements prepared by management and liaised with the external auditors during the audit process. An unqualified audit opinion was issued by the external auditors.

I would like to acknowledge the excellent contribution of the Audit Committee and Council staff in presenting these annual financial statements.



Ms Susan Hughes QC
Chairperson
Audit Committee
Medical Council of New Zealand

Education Committee report

Accreditation of prevocational medical training providers

Under the HPCAA, we are required to accredit and monitor educational institutions that deliver medical training for doctors and to promote medical education and training in New Zealand. The purpose of the accreditation of prevocational training providers is to ensure that minimum standards have been met for the provision of education and training for postgraduate year 1 and 2 (PGY1 and PGY2) interns. *Accreditation of Specialist Medical Training and Recertification Programmes: Standards and Procedures* for New Zealand Training Providers (2014) was used by us to assess the vocational medical training and recertification programmes for New Zealand-based training providers and colleges.

The following training providers have been assessed by one of our appointed accreditation teams as part of their requirement to meet our accreditation standards.

Prevocational medical training

- Auckland DHB – site visit conducted in July 2018.
- South Canterbury DHB – site visit conducted in July 2018.
- Waitematā DHB – site visit conducted in September 2018.
- Whanganui DHB – site visit conducted in April 2019.

Vocational medical training and recertification programmes

The following training provider has been assessed by one of our appointed accreditation teams as part of their requirement to meet our accreditation standards.

- Family Planning and Reproductive Health College of the New Zealand Sexual and Reproductive Health Educational Charitable Trust – site visit conducted in March 2018.

2018 prevocational educational supervisor meetings

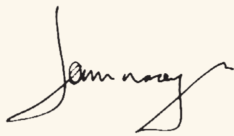
Three annual prevocational educational supervisor meetings were held in Auckland and Wellington in August, and September 2018. The agenda for each meeting followed a similar format. The meetings included a presentation on the role of our Health Committee and the roll-out of multisource feedback. The review of the New Zealand Curriculum Framework was also discussed. Prevocational educational supervisors presented on a range of topics including how best to support struggling interns and valuable learnings from being a prevocational accreditation team member. There was a panel session featuring updates from Council staff on PGY2 requirements and themes from the first cycle of accreditation.

Vocational standards

We reviewed and consulted on the vocational standards for assessment and accreditation of vocational medical training and recertification programmes for New Zealand colleges. The new standards will be in effect from 1 July 2020 for the next cycle of New Zealand college accreditation. The purpose behind reviewing the current standards was to align our accreditation process and standards more closely with those of the Australian Medical Council. The standards for New Zealand colleges were last revised in 2014.

Australian and New Zealand Prevocational Medical Education Forum (ANZPMEF)

I am pleased to advise that we were successful in our bid to host ANZPMEF in Auckland in October 2020, the first time since 2011 that the conference has been held in New Zealand. This is an important annual event, which brings together national and international professionals committed to medical education, including clinical trainers and educators, health service managers, resident doctors, educational researchers, and other academics interested in healthcare education. The main focus is on the years between medical school graduation and entry into vocational training. The conference is being held at the Aotea Centre from 18–21 October.



Professor John Nacey
Chairperson
Education Committee
Medical Council of New Zealand

Health Committee report

Doctors' health 2019

The Health Committee acts for Council by reviewing all notifications about a doctor's health that may affect the doctor's ability to safely practise medicine.

Most doctors manage their health appropriately by taking time off work when they cannot function safely, and they do not require any oversight by the Health Committee.

Where we receive a notification, either from the doctor themselves or someone else such as a worried colleague, it is the Health Committee's role to decide whether there is a health condition adversely affecting the doctor's ability to work. The Health Committee can request independent assessments of the doctor, when applicable, to assess whether the doctor is safe to work independently or requires supportive measures to enable safe practice. Rarely, the doctor may be required to stand down from work until their health is restored.

We also have a role to encourage any doctor to obtain appropriate treatment.

Where patient safety is an issue, we will advise the Registrar about the suitability of issuing a practising certificate.

In the year ending 30 June 2019, Council's Health Committee received 42 new referrals – see Table 13. We also reviewed 193 disclosures doctors made about their health on their registration and practising certificate applications.

The Health Committee meets every 2 months and will have teleconferences at other times when urgent decisions are required.

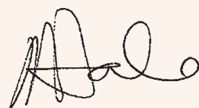
The conditions that are most likely to require Health Committee oversight include drug and alcohol dependence, mental illness such as depression or bipolar illness, neuropsychiatric conditions such as dementia, and progressive physical conditions such as Parkinson's disease or multiple sclerosis.

Supporting and assisting an unwell doctor requires particular skills for which our health team/case managers have ongoing training. We have well-developed reliable processes and systems to manage the complexities and dilemmas we face in this work.

We receive detailed reports and recommendations from psychiatrists, occupational physicians, neuropsychologists, and other specialists who carry out independent assessments for us. Their advice informs our decision making.

The health team's work can be demanding when dealing with sensitive information and unwell and upset doctors. They liaise with the doctors, organise the assessments, ensure that treatment packages are coordinated, manage substance screening, share information as is necessary, respond to any concerns or crises about the doctor, and keep the Health Committee members briefed between meetings. At all times, the safety of the doctor and their patients is at the forefront.

Health Committee and health team work is critical for public safety and at times very stressful. However, it is also very rewarding when we enable doctors to return to a profession that has been a lifelong passion.



Dr Pamela Hale
Chairperson
Health Committee
Medical Council of New Zealand

Members of the Medical Council

During the period 1 July 2018 to 30 June 2019

Mr Andrew Connolly, NMZM

BHB 1984, MB ChB 1987 Auckland, FRACS 1994

Appointed to Council in November 2009, Mr Connolly was elected Deputy Chairperson of Council in February 2012 and as Chairperson from February 2014, a position he held until February 2019.

Mr Connolly is a general and colorectal surgeon, employed full-time at Counties Manukau DHB where he was Head of Department of General and Vascular Surgery from 2003 until June 2019.

He has a strong interest in governance, education, and clinical leadership. He served on the Ministerial advisory group that was responsible for the *In Good Hands* document. In 2015, he was a member of 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 also served on several Australian Medical Council accreditation reviews of specialist colleges.

He has previously held the role of Presiding Member of the Lotteries Health Research Distribution Committee, he 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. Mr Connolly currently also serves on the Southern Partnership Group for the redevelopment of Dunedin Hospital. In mid-2019, he was appointed by the Minister of Health as Deputy Commissioner, Waikato DHB.

Outside of medicine, he has a passion for military history, particularly the First World War.

Dr T Lu'isa Fonua-Faeamani

MB ChB 1998 Otago, FRNZCGP 2007

Appointed to Council in July 2015, Dr Fonua-Faeamani is a GP at The Fono. 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 (Dist), FRACGP 2010 (Hon), CMinstD

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 GP based in Auckland. He is a past President of the Royal New Zealand College of General Practitioners (RNZCGP) and past Chairperson of the Council of Medical Colleges in New Zealand. He is also a past board member of ProCare Health Limited – the Auckland GP network. He is also a member of various charitable and research trusts in the Auckland region.

Dr Fox was awarded a Distinguished Fellowship of the RNZCGP in 2010. He has also been awarded an Honorary Fellowship by the Royal Australian College of General Practitioners.

His previous positions included membership of the board and GP Council of the New Zealand Medical

Association 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 27 years, their practice grew and is now a seven-doctor practice in Meadowbank, Auckland. Dr Fox retired from general practice in mid-June 2018.

Dr Fox resigned from Council in late February 2019.

Ms Kath Fox

MBA, MA, BA, DHA, Dip Tchg

Appointed to Council in October 2018 as a layperson, Ms Fox has held a wide range of senior executive and governance positions in the public, non-government, private, and voluntary sectors in New Zealand. In a career spanning health, education, and the wider social service sector, she has held leadership roles in diverse areas including strategy, organisational development and transformation, workforce development, post-entry clinical training, aged care, special education, Māori development, mental health and disability support, health service management, policy, funding, and research.

Ms Fox has had a long involvement in health and disability sector leadership and management and has held many governance roles, including Ministerial appointments, in the health sector. Her current governance roles include directorships with Mercy Hospital Dunedin Ltd, Brackenridge Services, and the Canterbury Medical Research Foundation.

Ms Fox brings wide-ranging governance, strategic, and leadership experience and a career-long commitment to working with organisations that promote excellence and evidence-based practice and thereby support individual and community health and wellbeing.

Dr Pamela Hale

MB ChB Otago 1982, FRACP 1991

Dr Hale was appointed to Council in July 2015 following Council's election earlier that year. In March 2018, she was re-elected.

Dr Hale graduated from Otago University in 1982 and completed medical training in Christchurch, Tauranga, Hamilton, Dunedin, and the United Kingdom, becoming a Fellow of the Royal Australasian College of Physicians in 1991.

Dr Hale has been a specialist general physician/ endocrinologist in Nelson since 1992 developing the diabetes and endocrinology service. She is Head of the Department of Medicine and a Clinical Senior Lecturer for the University of Otago with respect to the Nelson trainee interns. Previously, she was the intern supervisor for many years.

Dr Hale has always been interested in professionalism and has led annual tutorials on this with interns.

Her interests include acute general medicine and the holistic management of type 1 diabetes and, outside of work, her family.

She is Chairperson of Council's Health Committee.

Ms Susan Hughes QC

BA, LLB, GDip Bus Studs, MMgt

Appointed in May 2013 as a Council lay member, 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.

Ms Hughes is Chairperson of Council's Audit Committee.

Dr Ainsley Goodman

MB ChB 1994 Otago, FRNZCUC 2006, FRNZCGP 2017

Dr Goodman was elected to Council in 2018. She graduated MB ChB from the University of Otago in 1994 and completed fellowships in urgent care in 2006 and general practice in 2017.

Her career experience has been diverse, working in both primary and secondary care in the military as a civilian doctor and in New Zealand, Ireland, and Australia.

Dr Goodman was elected to the Executive Committee of the Royal New Zealand College of Urgent Care from 2015 to 2018, serving on their Board of Censors and Education Committee.

She was a member of Council's professional conduct committees from 2015 to 2018 until elected to Council.

Dr Goodman currently works as a locum in both emergency medicine and general practice in Auckland and is enrolled in the postgraduate programme in healthcare law and ethics at the University of Dundee.

Dr Goodman is a member of Council's Education Committee.

She is Council's representative on the Australian Medical Council's Progress Reports Subcommittee.

Dr Paul Hutchison

MB ChB 1970 Otago, MRCOG 1978, FRANZCOG 1983, Dip Com Health

Dr Hutchison graduated from the University of Otago in 1970 and was appointed to Council in May 2017.

He spent time doing postgraduate work at Case Western Reserve University in the United States, National Women's Hospital in Auckland, and Addenbrooke's Hospital in Cambridge, England, and was a clinical lecturer for the University of London at St Thomas' Hospital in Central London.

He also undertook medical and general practice work in Papua New Guinea, Western Samoa, and the United Arab Emirates.

Dr Hutchison qualified as a specialist in obstetrics and gynaecology and became a consultant at National Women's Hospital and North Shore Hospital during the 1980s and 1990s.

He has held executive positions in the New Zealand Obstetric Society, New Zealand Medical Association (NZMA), and Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

Dr Hutchison became Member of Parliament for Port Waikato, then Hunua from 1999 to 2014. He Chairperson Parliament's Health Select Committee from 2008 to 2014. During that time, he initiated an inquiry into improving child health outcomes and preventing child abuse.

In 2014, Dr Hutchison received the NZMA Chairperson's Award for making an outstanding contribution to health in New Zealand.

Dr Hutchison currently works in a high-needs South Auckland general practice. He holds a number of directorships and is a trustee of Entrust, the majority shareholder of Vector.

Ms Laura Mueller

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

Appointed to Council in October 2009, Ms Mueller is a lay member of Council and was Council's Deputy Chairperson from February 2014 to February 2019.

Ms Mueller was a member of Council's Complaints Triage Team and the Audit, Education and Health Committees and was also Council's liaison member of the Health and Disability Commissioner's Consumer Advisory Group until February 2019.

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 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 7 years. She has served as Treasurer on the Disputes Tribunal's Referees Association Executive and is a mentor of new referees.

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 chaired the recent Government Prostate Cancer Taskforce. As 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 and remains a strong advocate for promoting men's health.

Professor Nacey is Chairperson of Council's Education Committee.

Ms Kim Ngārimu

BBS

Ms Ngārimu is a director of a consulting company specialising in the provision of public policy and management advice, and is a member of a number of statutory boards. Her roles in the health sector also include board roles with Capital & Coast DHB and Ngāti Porou Hauora, and she is a member of the Australian Medical Council's Specialist Education Accreditation Committee.

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 is a member of Council's Audit, Education, and Health Committees.

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

Dr Curtis Walker

MB ChB 2007 Auckland, FRACP 2015

Dr Walker was first elected to Council in 2015 and re-elected in March 2018. In February 2019, he was elected Chairperson of Council.

Ko Whakatōhea rāua ko Ngāti Porou ngā iwi.

Formerly a veterinarian, Dr Walker retrained in human medicine and qualified from Auckland in 2007. He started work as a house officer at Waikato Hospital and commenced internal medicine training there before moving to Palmerston North and Wellington to complete his fellowships in nephrology and general medicine (Fellow of the Royal Australasian College of Physicians) in 2015 and 2016 respectively.

During his time as a resident doctor, he was President of the New Zealand Resident Doctors Association for 5 years and currently serves on the board of Te Ohu Rata o Aotearoa – Māori Medical Practitioners Association (Te ORA). These roles reflect the strong commitment that Dr Walker has to improving health outcomes for Māori and supporting doctors during the long and challenging years spent in specialist training.

Dr Walker works as a renal and general physician at MidCentral DHB and loves living in Palmerston North with his wife and two young children.

Dr Walker is an ex officio member of Council's Audit, Education, and Health Committees.

Registration of doctors and practising certificates

Principal activities: maintaining the medical register, considering applications for registration, issuing practising certificates and certificates of professional status (good standing), and developing registration policy.

All doctors who practise medicine in New Zealand must be registered by 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 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, 4–6 months.

Table 1: Scopes of practice – summary of registration status

At 30 June 2019

Provisional general	3,905
General	9,713
Provisional vocational	260
Vocational	12,534
Special purpose	241
Total on register	**26,653**
Total practising	16,925
Suspended	10

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

All doctors who practise medicine in New Zealand must be registered by Council and hold a practising certificate.

Table 2: Registration activities

1 July 2018 to 30 June 2019

Registration activities	Number
Provisional general/vocational issued	
New Zealand graduates (interns)	507
Australian graduates (interns)	4
Passed NZREX Clinical (interns)	26
Australian general registrants	2
Graduate of competent authority accredited medical school	527
Worked in comparable health system	186
New Zealand and international medical graduates reregistration (following cancellation)	–
Non-approved postgraduate qualification – vocational assessment	81
Non-approved postgraduate qualification – vocational eligible	74
Special purpose scope issued	
Visiting expert	21
Research	3
Postgraduate training or experience	43
Locum tenens in specialist post	111
Emergency or other unpredictable short-term situation	–
Teleradiology	–
General scope after completion of supervised period	
New Zealand/Australian graduates (interns)	483
Passed NZREX Clinical	33
Graduate of competent authority accredited medical school	442
Worked in comparable health system	94
Vocational scope after completion of supervised period	
Non-approved postgraduate qualification – vocational assessment	50
Non-approved postgraduate qualification – vocational eligible	74
General scope issued	
New Zealand graduates	5
Overseas graduates	85
Restorations	22

Table 2 continued

Registration activities	Number
Vocational scope issued	
Approved postgraduate qualification	421
Suspensions	
Suspended or interim suspension	2
Revocation of suspension	1
Conditions	
Imposed	124
Revoked	87
Cancellations under the HPCAA	
Death – section 143	43
Discipline order – section 101(1)(a)	2
False, misleading or not entitled – section 146	–
Revision of register – section 144(5)	147
At own request – section 142	188

Table 3: Doctors registered in vocational scopes

1 July 2018 to 30 June 2019

Vocational scope	Vocational registration at 30/6/2018[1]	Added 2018/19	Removed 2018/19	Net change	Vocational scope at 30/6/2019[1,2]
Anaesthesia	1,020	44	7	37	1,057
Cardiothoracic surgery	41	4	–	4	45
Clinical genetics	19	1	–	1	20
Dermatology	84	5	4	1	85
Diagnostic and interventional radiology	659	41	6	35	694
Emergency medicine	390	32	3	29	419
Family planning and reproductive health	34	5	1	4	38
General practice	4,362	158	38	120	4,482
General surgery	396	14	2	12	408
Intensive care medicine	116	7	3	4	120
Internal medicine	1,392	85	11	74	1,466
Medical administration	42	3	1	2	44
Musculoskeletal medicine	25	–	–	–	25
Neurosurgery	30	1	–	1	31
Obstetrics and gynaecology	411	23	8	15	426
Occupational medicine	70	5	–	5	75
Ophthalmology	185	12	2	10	195
Oral and maxillofacial surgery	27	3	–	3	30
Orthopaedic surgery	351	15	1	14	365
Otolaryngology head and neck surgery	140	6	–	6	146
Paediatric surgery	29	2	–	2	31
Paediatrics	480	20	3	17	497
Pain medicine	31	2	1	1	32
Palliative medicine	85	10	–	10	95
Pathology	391	23	2	21	412
Plastic and reconstructive surgery	86	4	–	4	90

Table 3 continued

Vocational scope	Vocational registration at 30/6/2018[1]	Added 2018/19	Removed 2018/19	Net change	Vocational scope at 30/6/2019[1,2]
Psychiatry	838	36	7	29	867
Public health medicine	221	3	1	2	223
Radiation oncology	84	5	1	4	88
Rehabilitation medicine	31	2	1	1	32
Rural hospital medicine	125	4	1	3	128
Sexual health medicine	24	1	–	1	25
Sport and exercise medicine	31	2	–	2	33
Urgent care	237	19	–	19	256
Urology	86	2	1	1	87
Vascular surgery	43	2	–	2	45
Total	**12,616**	**601**	**105**	**496**	**13,112**

1 Includes doctors who may currently be inactive (have no practising certificate).
2 Includes 551 doctors with registration in two vocational scopes and 13 doctors with registration in three vocational scopes.

Table 4: Registrations issued, by country of primary qualification

1 July 2018 to 30 June 2019

Country	Provisional general	Provisional vocational	Special purpose	Total
England	315	36	24	**375**
United States of America	59	34	66	**159**
Scotland	103	12	4	**119**
Ireland	87	3	5	**95**
India	8	11	17	**36**
South Africa	4	19	8	**31**
Netherlands	29	2	–	**31**
Canada	16	4	10	**30**
Germany	11	7	1	**19**
Wales	17	–	–	**17**
Australia	4	1	8	**13**
Fiji	1	–	7	**8**
Northern Ireland	5	1	1	**7**
Pakistan	6	–	1	**7**
Belgium	6	1	–	**7**
Spain	6	1	–	**7**
Denmark	4	–	2	**6**
Singapore	3	3	–	**6**
Sweden	5	1	–	**6**
Other[1]	55	16	22	**93**
New Zealand	507	2	2	**511**
Total	**1,251**	**154**	**178**	**1,583**

1 Other represents 45 countries that had fewer than six registrations in the reporting period.

Table 5: Vocational scopes granted to doctors, by vocational scope of practice

1 July 2018 to 30 June 2019

Vocational scope	New Zealand	Overseas	Total
Anaesthesia	25	19	**44**
Cardiothoracic surgery	1	3	**4**
Clinical genetics	–	1	**1**
Dermatology	–	5	**5**
Diagnostic and interventional radiology	14	27	**41**
Emergency medicine	12	20	**32**
Family planning and reproductive health	1	4	**5**
General practice	82	76	**158**
General surgery	6	8	**14**
Intensive care medicine	3	4	**7**
Internal medicine	36	49	**85**
Medical administration	3	–	**3**
Neurosurgery	–	1	**1**
Obstetrics and gynaecology	10	13	**23**
Occupational medicine	1	4	**5**
Ophthalmology	6	6	**12**
Oral and maxillofacial Surgery	–	3	**3**
Orthopaedic surgery	9	6	**15**
Otolaryngology head and neck surgery	2	4	**6**
Paediatric surgery	2	–	**2**
Paediatrics	9	11	**20**
Pain medicine	–	2	**2**
Palliative medicine	4	6	**10**
Pathology	12	11	**23**
Plastic and reconstructive surgery	1	3	**4**

Table 5 continued

Vocational scope	New Zealand	Overseas	Total
Psychiatry	7	29	**36**
Public health medicine	2	1	**3**
Radiation oncology	1	4	**5**
Rehabilitation medicine	1	1	**2**
Rural hospital medicine	2	2	**4**
Sexual health medicine	1	–	**1**
Sport and exercise medicine	1	1	**2**
Urgent care	6	13	**19**
Urology	2	–	**2**
Vascular surgery	1	1	**2**
Total	**263**	**338**	**601**

Table 6: Outcomes of applications for vocational registration assessments

1 July 2018 to 30 June 2019

Branch	Incomplete applications	Pending	Withdrawn/ lapsed	Supervision path	Assessment	NZREX	Total
Anaesthesia	19	1	7	4	4	–	**35**
Cardiothoracic surgery	1	–	–	–	–	–	**1**
Clinical genetics	2	–	–	1	–	–	**3**
Dermatology	–	–	2	1	–	–	**3**
Diagnostic and interventional radiology	24	5	9	4	2	1	**45**
Emergency medicine	9	2	4	4	5	1	**25**
General practice	5	1	5	2	2	–	**15**
General surgery	9	–	10	–	1	1	**21**
Intensive care medicine	3	1	2	1	–	–	**7**
Internal medicine	28	4	10	20	4	1	**67**
Neurosurgery	3	–	–	–	–	–	**3**
Obstetrics and gynaecology	12	–	5	4	–	2	**23**
Occupational medicine	–	–	–	2	–	–	**2**
Ophthalmology	5	1	2	2	–	1	**11**
Oral and maxillofacial surgery	1	–	–	1	–	–	**2**
Orthopaedic surgery	15	–	8	2	–	1	**26**
Otolaryngology head and neck surgery	4	–	2	4	2	1	**13**
Paediatrics	10	4	1	3	–	–	**18**
Pain medicine	1	–	–	–	–	–	**1**
Palliative medicine	1	–	1	1	–	–	**3**
Pathology	19	2	8	–	–	–	**29**
Plastic and reconstructive surgery	6	–	2	–	–	–	**8**
Psychiatry	31	3	11	7	8	2	**62**

Table 6 continued

Branch	Incomplete applications	Pending	Withdrawn/ lapsed	Supervision path	Assessment	NZREX	Total
Public health medicine	2	1	1	1	–	–	**5**
Radiation oncology	4	–	–	1	–	1	**6**
Rehabilitation medicine	1	–	–	–	1	1	**3**
Sports medicine	–	–	1	–	–	–	**1**
Urology	4	–	1	–	–	–	**5**
Vascular surgery	–	–	–	–	–	1	**1**
Total	**219**	**25**	**92**	**65**	**29**	**14**	**444**
Percentages based on total number of outcomes (%)				60.2	26.9	13.0	

Table 7: Doctors on the New Zealand medical register, by country of primary qualification

As at 30 June 2019

Country	Provisional general	General	Provisional vocational	Vocational	Special purpose	Total	Number with practising certificates
New Zealand	567	4,789	1	6,735	2	**12,094**	9,737
England	1,216	1,783	22	1,609	22	**4,652**	2,199
South Africa	59	166	29	788	9	**1,051**	738
Scotland	309	510	15	448	2	**1,284**	618
Australia	8	612	1	487	3	**1,111**	574
India	63	215	19	471	31	**799**	509
United States of America	563	162	70	372	112	**1,279**	385
Ireland	204	369	3	95	4	**675**	291
Germany	87	89	14	166	–	**356**	191
Netherlands	127	61	9	60	–	**257**	116
Wales	114	151	2	73	2	**342**	115
Sri Lanka	9	65	1	169		**244**	115
Iraq	6	54	–	115		**175**	109
Canada	145	30	8	74	13	**270**	85
Pakistan	24	64	1	52	1	**142**	79
China	5	36	–	63	–	**104**	75
Fiji	2	15	–	46	15	**78**	64
Northern Ireland	31	50	–	35	2	**118**	54
Russia	8	33	1	27	–	**69**	54
Bangladesh	5	28	–	70	–	**103**	44
Philippines	2	25	2	29	1	**59**	44
Egypt	16	18	2	51	1	**88**	43
Poland	16	19	5	25	1	**66**	38
Zimbabwe	2	2	–	40	–	**44**	36
Singapore	8	22	2	25	–	**57**	30

Table 7 continued

Country	Provisional general	General	Provisional vocational	Vocational	Special purpose	Total	Number with practising certificates
Belgium	28	17	4	13	–	**62**	28
Spain	10	10	1	16	–	**37**	28
Italy	9	7	4	20	–	**40**	23
Serbia	–	9	1	24	–	**34**	22
Malaysia	4	11	–	12	3	**30**	22
Other[1]	258	291	43	324	17	**933**	459
Total	**3,905**	**9,713**	**260**	**12,534**	**241**	**26,653**	**16,925**

1 Other represents 88 countries with fewer than 21 active doctors.

Professional standards

Principal activities: receiving referrals of concerns, administering the Complaints Triage Team undertaking performance assessments, establishing individual education programmes and recertification 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 to full Council meeting for performance processes

1 July 2018 to 30 June 2019

Source	Number
ACC	8
Employer (DHB)	2
Employer (private hospital or general practice)	4
Health and Disability Commissioner (HDC)	21
Medical practitioner colleague	6
Health practitioner colleague	1
Member of public or patient	1
Other	2
Total	**45**

Table 9: Referral sources to full Council meeting for conduct processes

1 July 2018 to 30 June 2019

Employer (DHB)	5
Employer (private hospital or general practice)	2
Member of public or patient	5
HDC	3
Internally referred within Council	2
Medical practitioner colleague	10
Health practitioner colleague	2
Ministry of Health	1
Media	–
Other	10
Total	**40**

Performance

We look to find ways to implement mechanisms to ensure doctors are competent to practise. When receiving referrals that relate to a doctor's competence to practise, we do not investigate specific incidents (that is the Health and Disability Commissioner's role) but consider whether the circumstances raise questions about deficiencies in the doctor's competence.

Table 10 shows the number of cases considered by us during the year that related to a doctor's competence to practise and our decisions as to how those cases should be addressed. The table shows the number of our processes during the year rather than the number of individual doctors. Many 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 2018 and processes that continued after 30 June 2019 and illustrates the volume of work we undertake during the year in this area.

Table 10: Competence-related Council processes

1 July 2018 to 30 June 2019

No further action or educational letter on first consideration	9
Await HDC after first consideration	5
Defer – request further information after first consideration	2
Recertification programme ordered on first consideration	4
Referral to performance assessment committee (PAC)[1]	20
Doctor meets required standard of competence following PAC	11
Doctor does not meet required standard of competence following PAC	4
Recertification programme ordered after PAC (section 41)	3
Educational programme ordered after PAC (section 38)	4
Conditions ordered after PAC (section 38)	1
Educational programme completed satisfactorily	5

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

Table 11 shows the number of cases considered by us during the year that related to a doctor's conduct and our decisions as to how those cases should be addressed. The table shows the number of our processes during the year rather than the number of individual doctors. Many of these 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 started before the year commencing 1 July 2017 and processes that continued after 30 June 2018 and illustrate the volume of Council's work in this area.

We are 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. We may, however, make an order for interim suspension or impose conditions on the doctor's practice if we consider that the doctor poses a risk of harm to the public.

When 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. It is not a Council decision. Table 12 shows the PCCs that were commenced as a result of a conviction.

Table 11: Conduct-related Council processes

1 July 2018 to 30 June 2019

No further action or educational letter on first consideration	16
Recertification programme ordered on first consideration	–
Referral to professional conduct committee (PCC)[1]	23
Refer new information to existing PCC	8
Interim conditions ordered (section 69)	2
Interim suspension ordered (section 69)	–
PCC determined charge be brought in the Health Practitioners Disciplinary Tribunal	16
PCC recommended no further action and Council endorses	6
PCC recommended counselling or mentoring and Council endorses	6
PCC recommended review of fitness to practise and Council endorses	7
PCC recommended review of competence to practise and Council endorses	–

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.

Table 12: PCC as a result of a conviction

1 July 2018 to 30 June 2019

Professional conduct committee as a result of a conviction	5

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.

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

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

If a doctor has an issue with their own health, wherever possible, our health team try to help them to remain in practice while it is being resolved. That said, our primary objective is to protect the health and safety of the public, which may mean that the doctor will be unable to practise safely or will be limited in what they can do until they are well enough to fully resume practice.

Table 13: Notifications of inability to perform required functions due to mental or physical (health) condition

1 July 2018 to 30 June 2019

Source	Health Practitioners Competence Assurance Act	Existing	New	Closed	Still active
Health service	section 45(1)a	–	2	-	2
Health practitioner	section 45(1)b	–	29[1]	4	25
Employer	section 45(1)c	–	7	–	7
Medical Officer of Health	section 45(1)d	–	–	–	–
Any person	section 45(3)	–	2	–	4
Person involved with education	section 45(5)	–	2	1	1
Total		**–**	42	**5**	37

1 25 of the 29 were self-referred.

Table 14: Outcomes of health notifications

1 July 2018 to 30 June 2019

Outcomes	HPCAA	Number[1]
No further action	–	4
Order medical examination	section 49(1)	–[2]
Interim suspension	section 48(1)(a)	24[3]
Conditions	section 48(1)(b)	–
Restrictions imposed	section 50(3) or (4)	See note[4]

1 There may be more than one outcome.

2 35 assessments agreed voluntarily (two of which are pending), and 147 reports from treating clinicians, occupational physicians, and so forth.

3 Achieved through voluntary agreement.

4 Requisite monitoring for 37 doctors still active achieved through informal agreement without use of statutory provisions of the HPCAA 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

International medical graduates are required to sit and pass NZREX Clinical if they are not eligible for registration under any other registration pathway. This examination is set at the level of a recent New Zealand medical 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. NZREX is currently held three times a year.

The prerequisites for applying to sit NZREX Clinical are:

- a medical degree listed in the World Directory of Medical Schools
- meeting Council's English language policy
- within the last 5 years having passed one or more of:
  - the United States Medical Licensing Examination (USMLE) Steps 1 and 2 (Clinical Knowledge)
  - the Australian Medical Council multi-choice (MCQ) examination
  - the Medical Council of Canada Qualifying Examination (MCCQE Part I)
  - the United Kingdom's Professional and Linguistic Assessments Board (PLAB) Part 1.

Table 15: Cadidates sitting and passing NZREX Clinical

1 July 2018 to 30 June 2019

Country	Number sitting	Attempts				Number passed	Passes			
		1	2	3	4		1	2	3	4
Argentina	2	2	-	-	-	2	2	-	-	-
Bangladesh	4	2	1	1	-	2	1	1	-	-
China	10	5	4	1	-	5	2	2	1	-
Czech Republic	1	1	-	-	-	-	-	-	-	-
Egypt	2	1	1	-	-	1	-	1	-	-
Ethiopia	1	1	-	-	-	-	-	-	-	-
Fiji	1	-	-	1	-	-	-	-	-	-
France	1	-	1	-	-	1	-	1	-	-
Hong Kong	1	1	-	-	-	1	1	-	-	-
India	12	7	3	1	1	4	2	1	-	1
Iraq	6	6	-	-	-	5	5	-	-	-
Jamaica	1	1	-	-	-	1	1	-	-	-
Malaysia	4	3	1	-	-	4	3	1	-	-

Table 15 continued

Country	Number sitting	Attempts				Number passed	Passes			
		1	2	3	4		1	2	3	4
Mauritius	1	-	1	-	-	1	-	1	-	-
Nigeria	1	-	1	-	-	1	-	1	-	-
Pakistan	13	9	4	-	-	7	5	2	-	-
Philippines	9	4	3	2	-	4	3	1	-	-
Russia	3	1	1	-	1	2	1	-	-	1
Samoa	1	1	-	-	-	1	1	-	-	-
South Africa	2	2	-	-	-	1	1	-	-	-
Sri Lanka	1	1	-	-	-	1	1	-	-	-
St Kitts and Nevis	1	1	-	-	-	1	1	-	-	-
St Lucia	1	1	-	-	-	1	1	-	-	-
Taiwan	2	1	1	-	-	1	-	1	-	-
United Arab Emirates	2	1	1	-	-	1	-	1	-	-
Total	**83**	**52**	**23**	**6**	**2**	**48**	**31**	**14**	**1**	**2**

Health Practitioners Disciplinary Tribunal

Principal activities: disciplinary proceedings brought against doctors are heard and determined by the Health Practitioners Disciplinary Tribunal.

Medical charges before the Health Practitioners Disciplinary Tribunal

During the year, the HPDT received 14 charges relating to 13 doctors – all charges were received from a professional conduct committee (PCC).

The HPDT sat during the year to hear eight charges relating to seven doctors over 14 days. Two of the eight charges were received in 2017/18. One charge was adjourned part heard and is set down for 4 further days in October 2019. Five charges received during 2018/19 are yet to be heard.

Table 16: Medical charges before the Health Practitioners Disciplinary Tribunal

1 July 2018 to 30 June 2019

Nature of charges	
Professional misconduct 2017/18	2
Professional misconduct 2018/19	9
Conviction 2018/19	5
Total	**16**

Source	
Prosecution of charges brought by a PCC 2017/18	2
Prosecution of charges brought by a PCC 2018/19	5
Prosecution of charges brought by a PCC 2018/19 adjourned part heard	1
Charges brought by a PCC yet to be heard	8
Total	**16**

Outcome of hearings	
Guilty – professional misconduct 2017/18	2
Guilty – professional misconduct 2018/19	1
Guilty – conviction 2018/19	4
Yet to be completed adjourned part heard	1
Yet to be heard 2018/19	8
Total	**16**

Further information about these statistics can be found on the Tribunal's website **www.hpdt.org.nz**.

Corporate governance

Role of Council: members of Council set the strategic direction of the organisation, monitor the CEO's performance and ensure Council meets the requirements of the HPCAA 2003.

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

Council membership

Although the Minister of Health appoints Council members, we aim to have members who represent a broad mix of doctors and laypeople with different ages, genders, and ethnicities that reflect the diversity of New Zealand society and who have a wide general knowledge and breadth of vision as well as also having 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.
- Experience in financial management.

Council committee structure

Council operates three standing committees – Audit, Education, and Health – each with clearly established levels of delegated authority. Members of these committees are listed on page 47. Council receives committee meeting minutes at its formal meetings and, in approving those minutes, confirms the decisions made.

Links with medical regulatory bodies

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

- Australian Health Practitioner Regulation Agency
- Federation of State Medical Boards and the Educational Commission for Foreign Medical Graduates (United States of America)
- International Association of Medical Regulatory Authorities
- General Medical Council (United Kingdom)
- Irish Medical Council
- Medical Board of Australia and Australian Medical Council
- Medical Council of Canada.

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

- Te Ohu Rata o Aotearoa (Te ORA)
- the Accident Compensation Corporation
- the Association of Salaried Medical Specialists
- chief medical officers of DHBs
- the Council of Medical Colleges
- the Health and Disability Commissioner
- members of the profession, other regulatory authorities, medical students, and community groups
- medical colleges and associations
- the Medical Protection Society
- the Minister of Health
- the New Zealand Resident Doctors' Association
- the New Zealand Medical Association.

Council committees[1]

Council standing committees as at 30 June 2019

Chair – Dr Curtis Walker
Deputy Chair – Ms Susan Hughes QC

Audit Committee

- Ms Susan Hughes QC (Chair)
- Dr Paul Hutchison
- Ms Kim Ngārimu
- Mr Roy Tiffin

Audit Committee – non-Council member

- Mr Roy Tiffin

Health Committee

- Dr Lu'isa Fonua-Faeamani
- Dr Pamela Hale (Chair)
- Ms Kim Ngārimu
- Alternative layperson: Ms Kath Fox

Health Committee – non-Council member

- Dr Charles Hornabrook

Education Committee – Council members

- Dr Ainsley Goodman
- Professor John Nacey (Chair)
- Ms Kim Ngārimu

Education Committee – non-Council members

Dr Liza Lack	Nominee of appropriate college/vocational medical training provider or vocational education and advisory body and the Medical Council's representative on MedSAC
Dr Carmen Chan	Active consumer of education – PGY1 representative member
Dr Mark Huthwaite	Medical academic appointed from nominations by the Medical Schools in New Zealand
Dr Sarah Nicolson	Nominee of appropriate college/vocational medical training provider or vocational education and advisory body and the Medical Council's representative on SEAC
Dr Jonathan Albrett	Nominee of appropriate college/vocational medical training provider or vocational education and advisory body
Dr John Thwaites	Nominee of appropriate college/vocational medical training provider or vocational education and advisory body
Dr Suzanne Busch	Prevocational educational supervisor representative member
Dr Cameron Wells	Active consumer of education – RMO representative member
Dr Bryony Nicholls	Active consumer of education – trainee representative member

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 public member must sit on each committee.

Finances

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand
Statement of Comprehensive Revenue and Expenses
For the year ended 30 June 2019

	Notes	2019 (000's)	2018 (000's)
Revenue from non-exchange transactions			
Practising certificate (PC) fees and disciplinary levies		11,945	11,331
Disciplinary fines and recoveries		276	360
Total non-exchange revenue		**12,221**	**11,691**
Revenue from exchange transactions			
Fees received		2,533	2,198
Interest income		137	176
Other income		103	170
Total exchange revenue		**2,773**	**2,544**
Total revenue		**14,994**	**14,235**
Expenses per schedules	**5**		
Administration expenses		9,594	9,177
Council and profession expenses		3,433	3,432
Disciplinary expenses		1,385	1,599
Examination expenses		175	169
Total expenses		**14,587**	**14,377**
Results before expenses incurred due to the effects of the Kaikoura eathquake		**407**	**(142)**
Expenses due to the effects of the Kaikōura earthquake			
Impairment expense	**10**	403	-
Onerous lease provision	**13**	2,386	-
Total expenses incurred due to the effects of the Kaikōura earthquake	**17**	**2,789**	**-**
Total surplus/(deficit) for the year		**(2,382)**	**(142)**
Other comprehensive revenue and expense for the year		-	-
Total comprehensive revenue and expense for the year		**(2,382)**	**(142)**

1

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand
Statement of Changes in Net Assets
For the year ended 30 June 2019

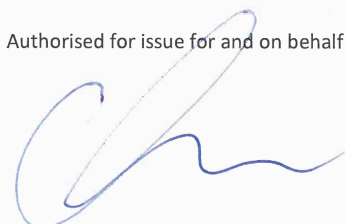
	General Reserve (000's)	Disciplinary Reserve (000's)	Examination Reserve (000's)	Total Equity (000's)
Opening equity balance 1 July 2018	6,814	1,557	429	8,800
Total surplus / (deficit) for the year	(2,782)	413	(13)	(2,382)
Other comprehensive revenue	-	-	-	-
Closing equity balance 30 June 2019	**4,032**	**1,970**	**416**	**6,418**
Opening equity balance 1 July 2017	7,103	1,376	463	8,942
Total surplus / (deficit) for the year	(289)	181	(34)	(142)
Other comprehensive revenue	-	-	-	-
Closing equity balance 30 June 2018	**6,814**	**1,557**	**429**	**8,800**

These financial statements should be read in conjunction with the notes to the financial statements

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand
Statement of Financial Position
As at 30 June 2019

	Notes	2019 (000's)	2018 (000's)
Current assets			
Cash and cash equivalents		1,730	229
Short term investments		2,500	4,750
Receivables	7	446	310
Total current assets		**4,676**	**5,289**
Non-current assets			
Intangible assets	8	4,304	4,703
Work in progress	9	482	-
Property, plant and equipment	10	2,060	737
Total non-current assets		**6,846**	**5,440**
Total assets		**11,522**	**10,729**
Current liabilities			
Payables (from exchange transactions)	11	1,789	726
Employee entitlements	12	553	599
Provisions	13	605	-
Lease rent free liability		-	35
Revenue received in advance		305	377
Total current liabilities		**3,252**	**1,737**
Non-current liabilities			
Lease rent free liability		-	141
Employee entitlements	12	71	51
Provisions	13	1,781	-
Total non-current liabilities		**1,852**	**192**
Total liabilities		**5,104**	**1,929**
Net assets		**6,418**	**8,800**
Equity			
General reserve		4,032	6,814
Disciplinary reserve		1,970	1,557
Examination reserve		416	429
Total Equity		**6,418**	**8,800**

Authorised for issue for and on behalf of the Council on 8 October 2019.



Dr Curtis Walker
Chairperson

Susan Hughes QC
Deputy Chair | Chair - Audit Committee

These financial statements should be read in conjunction with the notes to the financial statements

3

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand
Statement of Cash Flows
For the year ended 30 June 2019

	2019 (000's)	2018 (000's)
Cash flows from operating activities		
Receipts		
Receipts from operating activities	14,703	14,255
Payments		
Payments to suppliers and employees	(12,494)	(13,313)
Net cash flows from operating activities	**2,209**	**942**
Cash flows from investing activities		
Receipts		
Interest received	155	187
Redemption of investments	4,250	1,000
Payments		
Purchase of property, plant and equipment	(1,953)	(109)
Purchase of intangible assets	(1,160)	(1,513)
Investments in short term deposits	(2,000)	(500)
Net cash flows from investing activities	**(708)**	**(935)**
Net increase/(decrease) in cash and cash equivalents	**1,501**	**7**
Cash and cash equivalents at 1 July	229	222
Cash and cash equivalents at 30 June	**1,730**	**229**
Represented by:		
Petty Cash	1	1
ASB Bank Account - General	109	9
ASB Bank Account - Call	1,620	219
	1,730	**229**

These financial statements should be read in conjunction with the notes to the financial statements

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand
Notes to the financial statements
For the year ended 30 June 2019

1 Reporting entity

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

These financial statements and the accompanying notes summarise the financial results of the activities carried out by the Council. In order to protect the health and safety of the New Zealand public, the Council provides mechanisms to ensure that medical practitioners are competent and fit to practise in their professions. The Council is a charitable organisation registered under the Charities Act 2005.

These financial statements have been approved and were authorised for issue by the Council on 8 October 2019.

2 Statement of compliance

The financial statements have been prepared in accordance with generally accepted accounting practice in New Zealand (NZ GAAP). They comply with public benefit entity international public sector accounting standards (PBE IPSAS) and other applicable financial reporting standards as appropriate that have been authorised for use by the New Zealand External Reporting Board for public sector entities. For the purposes of complying with NZ GAAP, the Council is a public sector public benefit entity and is eligible to apply Tier 2 Public Sector PBE IPSAS on the basis that it does not have public accountability and is not defined as large.

The Council has elected to report in accordance with Tier 2 public sector PBE accounting standards and, in doing so, has taken advantage of all applicable reduced disclosure regime (RDR) disclosure concessions.

3 Summary of Accounting Policies

The significant accounting policies used in the preparation of these financial statements as set out below have been applied consistently to both years presented in these financial statements.

3.1 Basis of measurement

These financial statements have been prepared on the basis of historical cost.

3.2 Functional, presentational currency and rounding

The financial statements are presented in New Zealand dollars ($), which is the Council's functional currency. All amounts disclosed in the financial statements have been rounded to the nearest thousand dollars unless otherwise stated.

3.3 Revenue

Revenue is recognised to the extent that it is probable that the economic benefit will flow to the Council and revenue can be reliably measured. Revenue is measured at the fair value of the consideration received. The following specific recognition criteria must be met before revenue is recognised.

Revenue from non-exchange transactions

Practicing certificate (PC) fees and disciplinary levies

PC fees are 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.

Disciplinary fines and recoveries

Disciplinary recoveries represent fines and costs awarded to the Council by the Health Practitioners Disciplinary Tribunal (HPDT). The amount awarded represents a percentage or a portion of the Professional Conduct Committees (PCC) and HPDT costs.

Once awarded by the HPDT, disciplinary recoveries are reflected in the accounts at the time those costs were incurred and at the amount determined by the HPDT.

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand
Notes to the financial statements
For the year ended 30 June 2019

Revenue from exchange transactions

Fees received

Fees received include application and registration fees for general, vocational and special scopes of practice, examinations, certification and assessment related activities. All fees are recognised when invoiced except for:

- New Zealand registration examination fees which are recognised when the examination is held.
- Vocational registration income is recognised at the time of invoicing, however a portion equivalent to 2.4 months (2018: 2.4 months) is assessed and held as payments in advance.

Interest income

Interest income is recognised as it accrues, using the effective interest method.

Other income

All other income from exchange transactions are recognised when earned and is reported in the financial period to which it relates.

3.4 Financial instruments

Financial assets and financial liabilities are recognised when the Council becomes party to the contractual provisions of the financial instrument.

The Council ceases to recognise a financial asset or, where applicable, a part of a financial asset or part of a group of similar financial assets, when the rights to receive cash flows from the asset have expired or are waived, or the Council has transferred its rights to receive cash flows from the asset or has an assumed obligation to pay the received cash flows in full without material delay to a third party; and either:

- the Council has transferred substantially all the risks and rewards of the asset; or
- the Council has neither transferred nor retained substantially all the risks and rewards of the asset but has transferred control of the asset.

Financial assets

Financial assets within the scope of PBE IPSAS 29 Public Sector (PS) Financial Instruments: Recognition and Measurement are classified as financial assets at fair value through surplus or deficit, loans and receivables, held-to-maturity investments or available-for-sale financial assets. The classifications of the financial assets are determined at initial recognition.

The Councils financial assets include cash and cash equivalents, short-term investments, receivables from non-exchange transactions and receivables from exchange transactions.

Impairment of financial assets

During the year $335k was written off from the provision for doubtful debts. There were no other impairments of financial assets for the year.

Financial liabilities

The Council's financial liabilities include creditors (excluding goods and services (GST)) and pay as you earn (PAYE) tax and employee entitlements.

All financial liabilities are initially recognised at fair value (plus transaction costs for financial liabilities not at fair value through surplus and deficit) and are subsequently measured at amortised cost using the effective interest method except for financial liabilities at fair value through surplus or deficit.

3.5 Cash and cash equivalents

Cash and cash equivalents are short term, highly liquid investments that are readily convertible to known amounts of cash and which are subject to an insignificant risk of changes in value. Cash and cash equivalents are held for the purpose of meeting short term cash commitments rather than for investment or other purposes.

3.6 Short term investments

Short term investments are held with the intention of investing and comprise term deposits that have a maturity within 12 months of reporting date.

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand
Notes to the financial statements
For the year ended 30 June 2019

3.7 Receivables

Receivables are recorded at their fair value, less any provision for impairments.

Impairment of a receivable is established when there is objective evidence that the Council will not be able to collect amounts due according to the original terms of the receivable. Significant financial difficulties of the debtor, probability that the debtor will enter into bankruptcy, receivership or liquidation and default in payments are considered indicators that the debtor is impaired. The impairment is the difference between the assets carrying amount and the present value of amount expected to be collected.

3.8 Property, plant and equipment

Items of property, plant and equipment are measured at cost less accumulated depreciation and impairment losses. Cost includes expenditure that is directly attributable to the acquisition of the asset. Where an asset is acquired through a non-exchange transaction, its cost is measured at its fair value as at the date of acquisition.

Depreciation is charged on a straight-line (SL) basis over the useful life of the asset. Depreciation is charged at rates calculated to allocate the cost of valuation of the asset less any estimated residual value over its remaining useful life:

- Furniture and fittings 10% SL p.a.
- Office alterations 10% SL p.a.
- Office equipment 20% SL p.a.
- Computer hardware 33% SL p.a.

3.9 Intangible assets

Intangible assets acquired separately are measured on initial recognition at cost. The cost of intangible assets acquired in a non-exchange transaction is their fair value at the date of the exchange.

Following initial recognition, intangible assets are carried at cost less any accumulated amortisation and impairment losses. Internally generated intangibles, excluding capitalised development costs, are not capitalised and the related expenditure is reflected in surplus or deficit in the period which the expenditure is incurred.

The useful lives of intangible assets are assessed as either finite or indefinite. The Council does not hold any intangible assets that have an indefinite life.

Intangible assets with finite life are amortised over the useful economic life and assessed for impairment whenever there is an indication that the intangible asset may be impaired.

The amortisation period and the amortisation method for an intangible asset with a finite useful life are reviewed at least at the end of each reporting period. Changes in the expected useful life or the expected pattern of consumption of future economic benefits or service potential embodied in the asset are considered to modify the amortisation period or method, as appropriate, and are treated as changes in accounting estimates.

The amortisation expense on intangible assets with finite lives is recognised in surplus or deficit as the expense category that is consistent with the function of the intangible assets.

The amortisation periods for the Council's assets are as follows:

- Developed software 10% - 33% SL p.a.
- Purchased software 10% SL p.a.

3.10 Leases

Payments on operating lease agreements, where the lessor retains substantially the risk and rewards of ownership of an asset, are recognised as an expense on a straight-line basis over the lease term.

3.11 Work in progress

Work in progress is stated at cost and not depreciated. Depreciation on work in progress commences when assets are ready for their intended use.

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand
Notes to the financial statements
For the year ended 30 June 2019

3.12 Employee entitlements

Short term employee entitlements

Employee entitlements expected to be settled within 12 months of reporting date are measured at nominal values based on accrued entitlements at current rates of pay.

These include salaries and wages accrued up to reporting date, annual leave earned but not yet taken at reporting date and long service leave entitlements expected to be settled within 12 months.

Long term employee entitlements

Employee entitlements that are due to be settled beyond 12 months after the end of the reporting period in which the employee renders the related service, such as long service leave, are calculated on an actuarial basis where practical. The calculation is based on:

- likely future entitlement accruing to employees, based on years of service, years to entitlement, the likelihood that employees will reach the point of entitlement and contractual entitlements information; and
- the present value of the estimated future cash flows.

Expected future payments are discounted, factoring inflation and the expected long term increase in remuneration for employees.

3.13 Provisions

A provision is recognised for future expenditure of uncertain amount or timing when:

- there is a present obligation (either legal or constructive) as a result of a past event;
- it is probable than an outflow of future economic benefits will be required to settle the obligation; and
- a reliable estimate can be made of the amount of the obligation.

Provisions are measured at the present value of the expenditures expected to be required to settle the obligation using a pre-tax discount rate that reflects current market assessments of the time value of money and the risks specific to the obligation. The increase in the provision due to the passage of time is recognised as an interest expense.

3.14 Income tax

The Council is exempt from Income Tax. The Council was registered as a charitable entity under the Charities Act 2005 on 30 June 2008 to maintain its tax exemption status.

3.15 Goods and services tax (GST)

These financial statements have been prepared on a GST exclusive basis except for receivables and sundry creditors which include GST.

3.16 Equity

Equity is the professions' interest in the Council and is measured as the difference between total assets and total liabilities. Equity is classified into the following categories which fulfil a specific purpose:

General reserve

General reserves is used to separate all funding and expenditure related to the operational activities of the Council and excludes any disciplinary and examination activities.

Disciplinary reserve

Disciplinary reserves is used to separate all funding and expenditure related to disciplinary matters known or anticipated in any one year.

Examination reserve

Examination reserves is used to separate all funding and expenditure related to the New Zealand Registration Examination (NZREX Clinical).

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand
Notes to the financial statements
For the year ended 30 June 2019

4 Significant accounting judgements, estimates and assumptions

The preparation of the Council's financial statements requires management to make judgements, estimates and assumptions that affect the reported amounts of revenues, expenses, assets and liabilities, and the accompanying disclosures, and the disclosure of contingent liabilities. Uncertainty about these assumptions and estimates could result in outcomes that require a material adjustment to the carrying amount of assets and liabilities affected in future periods.

Judgements

In the process of applying the Council's accounting policies, management have not made any significant judgements that would have a material impact on the financial statements, except for the onerous lease provision outlined below.

Provisions

Onerous lease provision

Management has exercised its judgement in recognising an onerous lease provision and impairment of assets associated with 80 The Terrace, Wellington. The provision arises from a non-cancellable lease where the unavoidable costs of meeting the lease exceed the economic benefits to be received from it. Further information is provided in Note 13 and 17.

The provision recognises the discounted future lease payments over the remainder of the lease which expires in July 2023. Additionally, the Council is required at the expiry of the lease to make-good any damage caused to the premises and to remove any fixtures or fittings installed by the Council. No offsetting amounts, such as sublease recoveries, have been factored. The key assumptions in calculating the provision are as follows:

- a discount rate of 6% p.a. has been applied
- no allowance for market rent reviews have been factored recognising the condition of the building, however a rent review is due in July 2020.
- operational expenses incurred under the lease are assumed to increase by 5% p.a. over the remainder of the lease; and
- $300,000 has been estimated in relation to the make-good with the timing of the cash outflow to occur at the expiry of the lease.

Estimates and assumptions

The key assumptions concerning the future and other key sources of estimates uncertainty at the reporting date, that have a significant risk of causing a material adjustment to the carrying amounts of the assets and liabilities within the next financial year, are described below.

The Council based its assumptions and estimates on parameters available when the financial statements were prepared. Existing circumstances and assumptions about future developments, however, may change due to market changes or circumstances arising beyond the control of the Council. Such changes are reflected in the assumptions when they occur.

Useful lives and residual values

The useful lives and residual values of assets are assessed using the following indicators to determine potential future use and value from disposal:

- The condition of the asset
- The nature of the asset, its susceptibility and adaptability to changes in technology and processes
- The nature of the processes in which the asset is deployed
- Availability of funding to replace the asset
- Changes in the market in relation to the asset

The estimates useful lives of the asset classes held by the Council are listed in Notes 3.8 and 3.9. The Council has not made any changes to past assumptions concerning useful lives.

Long service leave

The measurement of long service lease was based on a number of assumptions. An assessment of 74 employees employed at 30 June 2019 was undertaken as to which employees would reach the long service criteria. 8 employees had entitlements and this is reflected as the current portion. The non-current portion reflects the assessment of the probability of employees earning long service leave in the future. Due to the number of employees affected and relatively low length of service, discount rates and salary inflation factors were not incorporated into the calculation.

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand
Notes to the financial statements
For the year ended 30 June 2019

5 Expenses

	Administration	Council and profession	Disciplinary	Examination	Total
2019	**(000's)**	**(000's)**	**(000's)**	**(000's)**	**(000's)**
Administration expenses	251	-	-	-	251
Amortisation	1,077	-	-	-	1,077
Communication expenses	47	-	-	-	47
Council expenses	-	729	-	-	729
Depreciation	227	-	-	-	227
Disciplinary or legal expenses	-	195	809	-	1,004
Education committee expenses	-	85	-	-	85
Education general expenses	-	963	-	-	963
Health committee expenses	-	88	-	-	88
Health general expenses	-	224	-	-	224
HPDT disciplinary expenses	-	-	187	-	187
Insurance	47	-	-	-	47
IT & systems expenses	418	-	-	-	418
NZRex clinical expenses	-	-	-	132	132
Premises expenses	1,005	-	-	-	1,005
Professional standards expenses	-	371	-	-	371
Registration expenses	-	621	-	-	621
Staff general expenses	389	-	7	-	396
Staff remuneration	6,133	-	382	43	6,558
Strategy expenses	-	157	-	-	157
Total expenses	**9,594**	**3,433**	**1,385**	**175**	**14,587**
2018					
Administration expenses	257	-	-	-	257
Amortisation	899	-	-	-	899
Communication expenses	88	-	-	-	88
Council expenses	-	737	-	-	737
Depreciation	192	-	-	-	192
Disciplinary or legal expenses	-	164	842	-	1,006
Education committee expenses	-	59	-	-	59
Education general expenses	-	892	-	-	892
Health committee expenses	-	46	-	-	46
Health general expenses	-	209	-	-	209
HPDT disciplinary expenses	-	-	402	-	402
Insurance	41	-	-	-	41
IT & systems expenses	316	-	-	-	316
NZRex clinical expenses	-	-	-	133	133
Premises expenses	1,214	-	-	-	1,214
Professional standards expenses	-	418	-	-	418
Registration expenses	-	723	-	-	723
Staff general expenses	364	-	6	-	370
Staff remuneration	5,806	-	349	36	6,191
Strategy expenses	-	184	-	-	184
Total expenses	**9,177**	**3,432**	**1,599**	**169**	**14,377**

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand
Notes to the financial statements
For the year ended 30 June 2019

6 Auditor's remuneration

Baker Tilly Staples Rodway Audit Limited provide audit services to the Council on behalf of the Auditor-General. The total amount recognised for audit fees is $29k (2018: $32k). No non-audit services have been provided by the auditor.

7 Receivables

	2019 (000's)	2018 (000's)
GST receivable	247	35
Interest receivable	7	25
Prepayments	100	32
Receivables	421	1,072
Provision for doubtful debts	(329)	(854)
Total receivables	**446**	**310**

8 Intangible assets

	Developed Software (000's)	Purchased Software (000's)	Total (000's)
2019			
Cost	10,652	30	10,682
Less: Accumulated amortisation and impairment	(6,375)	(3)	(6,378)
Net book value	**4,277**	**27**	**4,304**
2018			
Cost	9,976	28	10,004
Less: Accumulated amortisation and impairment	(5,300)	(1)	(5,301)
Net book value	**4,676**	**27**	**4,703**

Reconciliation of the carrying amount at the beginning and end of the period:

2019	Developed Software (000's)	Purchased Software (000's)	Total (000's)
Opening balance	4,676	27	4,703
Additions	676	2	678
Disposals	-	-	-
Amortisation	(1,075)	(2)	(1,077)
Impairment	-	-	-
Closing balance	**4,277**	**27**	**4,304**

9 Work in progress

	2019 (000's)	2018 (000's)
Developed Software	482	-
Total work in progress	**482**	**-**

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand
Notes to the financial statements
For the year ended 30 June 2019

10 Property, plant and equipment

	Computer Hardware (000's)	Furniture & Fittings (000's)	Office Alterations (000's)	Office Equipment (000's)	Artwork (000's)	Total (000's)
2019						
Cost	946	558	2,482	297	7	4,290
Less: Accumulated depreciation and impairment	(818)	(358)	(812)	(242)	-	(2,230)
Net book value	**128**	**200**	**1,670**	**55**	**7**	**2,060**
2018						
Cost	886	416	783	244	7	2,336
Less: Accumulated depreciation and impairment	(715)	(344)	(302)	(238)	-	(1,599)
Net book value	**171**	**72**	**481**	**6**	**7**	**737**

Reconciliation of the carrying amount at the beginning and end of the period:

	Computer Hardware (000's)	Furniture & Fittings (000's)	Office Alterations (000's)	Office Equipment (000's)	Artwork (000's)	Total (000's)
2019						
Opening balance	171	72	481	6	7	737
Additions	60	142	1,698	53	-	1,953
Disposals	-	-	-	-	-	-
Depreciation	(103)	(14)	(106)	(4)	-	(227)
Impairment	-	-	(403)	-	-	(403)
Closing balance	**128**	**200**	**1,670**	**55**	**7**	**2,060**

12

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand
Notes to the financial statements
For the year ended 30 June 2019

11 Payables	2019 (000's)	2018 (000's)
Creditors	1,676	453
Accrued expenses	113	273
	1,789	**726**

12 Employee entitlements	2019 (000's)	2018 (000's)
Current portion		
Accrued salaries and wages	200	185
Annual leave	314	382
Long service leave	39	32
Total current portion	**553**	**599**
Non-current portion		
Long service leave	71	51
Total non-current portion	**71**	**51**
Total employee entitlements	**624**	**650**

13 Provisions	2019 (000's)	2018 (000's)
Current portion		
Onerous lease	605	-
Total current portion	**605**	**-**
Non-current portion		
Onerous lease	1,781	-
Total non-current portion	**1,781**	**-**
Total provisions	**2,386**	**-**

Onerous lease

The provision recognises a non-cancellable premises lease at 80 The Terrace, Wellington where the unavoidable costs of meeting the lease contract exceed the economic benefits to be received from it. The Council continues to met its obligations under the lease which expires in July 2023. At the end of the lease the Council is required to make-good any damage caused to the premises and to remove any fixtures and fittings installed. It is expected that the timing of the make good cash flow will occur at the expiry of the lease. Additional information is provided in Note 17.

14 Categories of financial assets and liabilities

The carrying amounts of financial instruments presented in the Statement of Financial Position relate to the following categories of assets and liabilities:

	2019 (000's)	2018 (000's)
Financial assets		
Cash and cash equivalents	1,730	229
Short term investments	2,500	4,750
Receivables	446	310
Total financial assets	**4,676**	**5,289**
Financial liabilities		
Payables	1,789	726
Employee entitlements	2,334	599
Total financial liabilities	**4,123**	**1,325**

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand
Notes to the financial statements
For the year ended 30 June 2019

15 Related party transactions

These expenses relate to all the activities of Council members.

Council member fees and expenses	2019 (000's)	2018 (000's)
Council meeting fees	589	611
Council expenses	248	214
Total Council member fees and expenses	**837**	**825**

The total fees earned by Council members for attending Council, committee, working party meetings and participating in other forums are disclosed below:

	2019 (000's)	2018 (000's)
A Connolly ^	63	88
A Connolly ^ (Counties Manukau DHB)	50	81
T Fonua-Faeamani	42	29
K Fox	14	-
J Fox	22	39
A Fraser	-	3
A Goodman	44	1
P Hale	48	46
S Hughes **	32	28
P Hutchison	31	33
L Mueller ^^	50	67
J Nacey	45	54
K Ngarimu	54	43
J Quigley	3	31
M Searle	-	27
C Walker *	62	41
C Walker * (MidCentral DHB)	29	-
Total fees paid to Council members	**589**	**611**

*/ ** denotes the current Chairperson / Deputy Chairperson elected in February 2019 respectively.
^ / ^^ denotes the former Chairperson / Deputy Chairperson through to February 2019 respectively.

There were no other related party transactions (2018: None).

Key management personnel

The key management personnel of the Council include Council members, the Chief Executive and Executive Management Team. The aggregate remuneration of Council members is set out above. The aggregate remuneration of key management personnel and the number of individuals, determined on a full-time equivalent basis, receiving remuneration are as follows:

	2019 (000's)	2018 (000's)
Total remuneration	1,828	1,700
Other long-term benefits	17	28
Total key management personnel compensation	**1,845**	**1,728**
Number of persons	12	11
Full time equivalents basis (FTE)	11.3	10.7

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand
Notes to the financial statements
For the year ended 30 June 2019

16 Capital commitments

The Council has no capital commitments at the reporting date (2018: None).

Non cancellable operating lease commitments

As at the reporting date, the Council has entered into the following non-cancellable operating leases:

Premises Leases	2019 (000's)	2018 (000's)
Not later than 1 year	1,075	605
Later than 1 year no later than 5 years	4,298	2,231
Later than 5 years	4,119	-
Total minimum premises lease payments	**9,492**	**2,836**

During the year the Council entered into a long term lease on premises at 1 Willis Street, Wellington. The lease expires on 30 April 2028 with a right of renewal for a further three years.

As outlined in Note 13, the Council has recognised a provision for the onerous lease on premises at 80 The Terrace, Wellington.

17 Effects of the Kaikōura earthquake

The 14 November 2016, magnitude 7.8 Kaikōura earthquake caused damage to the premises leased by the Council at 80 The Terrace, Wellington. The Council vacated these premises on 12 February 2017 due to the uncertainty around the building safety and the extent of the remedial work required.

In December 2017, following the completion of remedial works, the Council sought independent advice to consider the safety of the building. As a consequence the Council permanently vacated these premises and has recognised an onerous lease provision (Note 13) and impaired existing office alterations at the premises (Note 10).

18 Contingent assets and liabilities

The Council had business interruption insurance at the time of the Kaikōura earthquake. The Council has been working with insurance broker Marsh and loss adjustors Crawford and Company New Zealand to progress the claim. At the reporting date a claim has been submitted for the insurers' review. On 26 August 2019, the Council received a proposed settlement offer for $147k excluding GST, however this has yet to be agreed by Council. It is expected this matter will be resolved in the next financial year.

There are no other contingent assets or liabilities at the reporting date (2018: None).

19 Events after the reporting period

There are no significant events after the reporting period to be disclosed.

Auditor's Report

Baker Tilly Staples Rodway Audit Limited
Level 6, 95 Customhouse Quay, Wellington 6011
PO Box 1208, Wellington 6140
New Zealand

T: +64 4 472 7919
F: +64 4 473 4720
E: wellington@bakertillysr.nz
W: www.bakertillysr.nz

INDEPENDENT AUDITOR'S REPORT
TO THE READERS OF
MEDICAL COUNCIL OF NEW ZEALAND'S FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2019

The Auditor-General is the auditor of the Medical Council of New Zealand (the Medical Council). The Auditor-General has appointed me, Chrissie Murray, using the staff and resources of Baker Tilly Staples Rodway Audit Limited, to carry out the audit of the financial statements of the Medical Council on his behalf.

Opinion
We have audited the financial statements of the Medical Council, that comprise the statement of financial position as at 30 June 2019, the statement of comprehensive revenue and expenses, the statement of changes in net assets 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 Medical Council, present fairly, in all material respects:

- its financial position as at 30 June 2019; 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 Public Benefit Entity Standards – Reduced Disclosure Regime

Our audit was completed on 8 October 2019. 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 relating to the financial statements, and we explain our independence.

Basis of opinion
We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the Professional and Ethical Standards and International Standards on Auditing (New Zealand) issued by the New Zealand Auditing and Assurance Standards Board. Our responsibilities under those standards are further described in the Responsibilities of the Auditor section of our report.

We have fulfilled our responsibilities in accordance with the Auditor-General's Auditing Standards.

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

Responsibilities of the Council for the financial statements
The Council is responsible for preparing financial statements that are fairly presented and that comply with generally accepted accounting practice in New Zealand.

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.

In preparing the financial statements, the Council is responsible on behalf of the Medical Council for assessing the Medical Council's ability to continue as a going concern. The Council is also responsible for disclosing, as applicable, matters related to going concern and using the going concern basis of accounting, unless there is an intention to liquidate the Medical Council or to cease operations, or there is no realistic alternative but to do so.

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

Baker Tilly Staples Rodway Audit Limited, incorporating the audit practices of Christchurch, Hawkes Bay, Taranaki, Tauranga, Waikato and Wellington.

Baker Tilly Staples Rodway Audit Limited is a member of the global network of Baker Tilly International Limited, the members of which are separate and independent legal entities.

bakertilly
STAPLES RODWAY

Responsibilities of the auditor for the audit of the financial statements
Our objectives are to obtain reasonable assurance about whether the financial statements, as a whole, are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion.

Reasonable assurance is a high level of assurance, but is not a guarantee that an audit carried out in accordance with the Auditor-General's Auditing Standards will always detect a material misstatement when it exists. Misstatements are differences or omissions of amounts or disclosures, and can arise from fraud or error. Misstatements are considered material if, individually or in the aggregate, they could reasonably be expected to influence the decisions of readers taken on the basis of these financial statements.

We did not evaluate the security and controls over the electronic publication of the financial statements.

As part of an audit in accordance with the Auditor-General's Auditing Standards, we exercise professional judgement and maintain professional scepticism throughout the audit. Also:

- We identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

- We obtain an understanding of internal control relevant to the audit 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.

- We evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the governing body.

- We conclude on the appropriateness of the use of the going concern basis of accounting by the governing body and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Medical Council's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Medical Council to cease to continue as a going concern.

- We evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with the Council regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Our responsibility arises from the Public Audit Act 2001 and section 134(1) of the Health Practitioners Competence Assurance Act 2003.

Independence

We are independent of the Medical Council in accordance with the independence requirements of the Auditor-General's Auditing Standards, which incorporate the independence requirements of Professional and Ethical Standard 1(Revised): *Code of Ethics for Assurance Practitioners* issued by the New Zealand Auditing and Assurance Standards Board.

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

Chrissie Murray
Baker Tilly Staples Rodway Audit Limited
On behalf of the Auditor-General
Wellington, New Zealand

Whakahaumaru i te iwi whānui, whakatuarā te kounga o te tikanga rata.

We protect the public and promote good medical practice.

Bankers

ASB Bank Limited

PO Box 11966
Wellington 6011

Auditors

Baker Tilly Staples Rodway

PO Box 1208
Wellington 6140

Office of the Auditor-General

Private Box 3928
Wellington 6140

Te Kaunihera Rata o Aotearoa

Medical Council of New Zealand

Medical Council of New Zealand

Level 24
1 Willis St
PO Box 10509
Wellington 6011

+64 4 384 7635
0800 286 801

mcnz@mcnz.org.nz
www.mcnz.org.nz