Medical Council
of New Zealand

Te Kaunihera Rata
o Aotearoa

Medical Council of New Zealand

Annual Report 2013

TE KAUNIHERA RATA O AOTEAROA
MEDICAL COUNCIL OF NEW ZEALAND

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

CONTENTS

The Medical Council of New Zealand is pleased to submit this report for the year ended 30 June 2013 to the Minister of Health. The report is presented in accordance with section 134 of the Health Practitioners Competence Assurance Act 2003 (HPCAA) and includes a report those activities of the Health Practitioners Disciplinary Tribunal relating to doctors.

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FACTS AT A GLANCE

1 JULY 2012–30 JUNE 2013

Doctors registered (1 July 2012–30 June 2013)	
– Trained in New Zealand	366
– International medical graduates	1,146
Total practising doctors at 30 June 2013	14,150
Doctors registered with vocational scopes	9,800
Candidates who sat NZREX Clinical	137
Candidates who passed NZREX Clinical	81
Referrals to professional conduct committees	31
Referrals to competence	47
Education programme ordered after a reference assessment	12
New health referrals	56

CHAIRPERSON'S REPORT

This report covers the period 1 July 2012 to 30 June 2013.

SINGLE SECRETARIAT FOR ALL HEALTH REGULATORY AUTHORITIES

Health Workforce New Zealand (HWNZ) began consulting in 2011 about a shared secretariat for all health regulatory authorities. The ultimate shape of any such secretariat has since been the subject of plenty of work, but remains unclear.

The original vision proposed by HWNZ included:

- introducing a single secretariat to provide back-office functions (including regulatory functions) for all 16 health regulatory authorities (such as the Medical Council, Nursing Council, Dental Council); and
- reducing the numbers of board members on the different boards and councils, as their terms expire.

The main arguments for the proposal were greater efficiency and cost savings, more consistent accountancy processes, more consistent policy and processes, and a single database of health practitioner workforce information and knowledge.

The Council believes collaboration among regulatory authorities already occurs and increased collaboration may provide further benefits. Council however continues to have concerns about retaining capability, the security of existing financial resources and managing risk. Any sharing of back-office functions would need to show financial and quality benefit for the sector, including a clear cost-benefit for the Council.

The Council retains an open mind on the shared administrative secretariat. Despite the change management work and financial modeling that continues, there is uncertainty about the shape of any shared secretariat and what it will mean for doctors and other health practitioners in the long term.

COUNCIL MEMBER CHANGES

There was one change to Council membership during the year. The Council was sad to lose longstanding lay person Ms Liz Hird who was first appointed in June 2005. Ms Hird has made a significant contribution to Council over the past 9 years and will be remembered for becoming the first lay member in February 2011 to become the Council's deputy chairperson.

Ms Susan Hughes, QC was appointed in May 2013 to replace Ms Hird.

Mr Andrew Connolly, Ms Laura Mueller and Mr Jacob Te Kurapa were all reappointed for further 3 year terms in October 2012.

RECERTIFICATION

Ensuring the ongoing competence and fitness to practise of doctors is one of the Council's key responsibilities. One way that the Council achieves this is by setting standards for recertification and recognising specific recertification programmes.

The first year of the implementation of a strengthened recertification programme for doctors registered in a general scope of practice is complete. They have been required to enrol in the *Inpractice* recertification programme administered by bpac^{nz} on behalf of the Council.

During each 12 month programme cycle participants must complete 50 hours of Continuing professional development including:

- A professional development plan.
- 20 hours of Continuing Medical Education (CME).
- 10 hours of peer review.
- An audit of medical practice.
- Meetings with a nominated collegial relationship provider (six in the first year and four in subsequent years).

In addition to the annual requirements participants must complete:

- The Essentials Test in the first year and then once every 3 years.
- Multisource Feedback once in every 3 year period.
- A Regular Practice Review visit when scheduled (not required in the first 3 years after gaining a general scope).

EVALUATION OF REGULAR PRACTICE REVIEW

One of the components of the *Inpractice* programme administered by bpac^{nz} is Regular Practice Review (RPR).

RPR is a quality improvement process with the primary purpose of maintaining and improving the standards of the profession. The goal of RPR is to help individual doctors identify areas where aspects of their performance could be improved, benefiting not only their own professional development but also the quality of care that their patients receive.

The Council, in June 2013, invited individuals or groups to submit an expression of interest to manage an evaluation programme that looks at the effectiveness of RPR as implemented through the bpac^{nz} *Inpractice* programme. The purpose of the evaluation is to determine the effectiveness of RPR and the outcomes it has on a doctor's future performance and practice.

REVIEW OF PREVOCATIONAL EDUCATION

A major continuing strategic initiative during the year has been the redevelopment of expectations and assessment in the first 2 years of practice after graduation. There has been a substantial consultation process and Council has made some innovative and exciting decisions that will, on implementation, create an excellent training environment and help ensure fit for purpose doctors and improved quality of care in years to come. The changes are detailed in the Education Committee report, and I want to thank the staff team involved in the project and Professor Nacey as chairperson of the Education Committee for the huge amount of work so far.

THANKS

I would like to thank Council members for bringing an independent view that ensures vigorous and robust debate from both a medical and public perspective. I would also like to thank Philip Pigou and all Council staff for their professionalism in meeting the demands placed on them.

Dr John Adams
Chairperson

AUDIT COMMITTEE REPORT

It is with pleasure, that I write this on behalf of the Medical Council of New Zealand's Audit Committee.

The Audit Committee is a standing Committee of the Medical Council.

TERMS OF REFERENCE

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

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

INTERNAL AUDIT

During the year KPMG undertook several internal audits as part of the Council's 2012-13 Internal Audit Programme.

The first audit was undertaken in August 2012 to identify areas of risk to the Council's IT systems. The report concluded that *'Overall the process has effective controls. We identified two moderate risk findings that relate to monitoring access to the systems. As these systems hold confidential data, security and access to the systems is a primary risk to Council. Implementing the suggested recommendations will help strengthen the security of the systems and reduce the possibility of inappropriate access.'*

Another audit undertaken by KPMG in October was of case management (competence and conduct) to provide assurance to the Council that our processes align with current legislation and good practice; and identify efficiency gains within the processes. The audit found that *'Overall the process has effective controls, is in compliance and aligned with legislative requirements and is aligned with Cole's'.*

Following these internal audits, Council staff implemented the recommendations made by KPMG.

RISK MANAGEMENT

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

I would like to acknowledge the dedication and professionalism of Committee members, auditors and staff alike.

Jacob Te Kurapa JP
Chairperson
Audit Committee

EDUCATION COMMITTEE REPORT

PREVOCATIONAL TRAINING

In February 2013, council released a second consultation paper *A review of prevocational training requirements for doctors in New Zealand: Stage 2.* A comprehensive national road show took place during March and April 2013 to provide an opportunity to discuss the proposed changes outlined in the consultation paper. The meetings were very well attended, with over 550 attendees, and the feedback has been reassuringly positive.

The feedback was considered by Council in July 2013 Council. It made the following decisions. Each of these are described in detail in Council's *Report on the feedback and decisions following the consultation of: A review of prevocational training requirements for doctors in New Zealand: Stage 2.*

The Council's decisions were:

- **Curriculum Framework**
  The *New Zealand Curriculum Framework for Prevocational Medical Training* will be implemented.
- **Standards for accreditation of clinical attachments**
  Standards for accreditation of clinical attachments will be developed and implemented, ensuring that each attachment provides a quality learning experience.
- **Professional development plan (PDP)**
  There will be a requirement for a professional development plan (PDP) that is to be completed during postgraduate year 2.
- **Framework for assessment**
  A framework for assessment which will include Multisource feedback will be implemented for the intern years (postgraduate years 1 and 2).
- **E-portfolio**
  A record of learning in the form of an e-portfolio will be implemented. This will ensure a nationally consistent means of tracking and recording skills and knowledge acquired during the Intern years.
- **Training for supervisors**
  A framework for training of supervisors will be developed. Training will focus on the needs of both intern supervisors as well as supervisors of individual clinical attachments.
- **Community based experience will be included**
  Interns will be required to spend at least 12.5 percent of their time in community based and outpatient settings. This is equivalent to completing one attachment over the 2 year period, or alternatively a selection of attachments, each of which has a portion of time allocated to the community or outpatient setting.
- **Evaluation**
  An evaluation programme will be developed to consider the effectiveness of the changes, and this will be informed by an expert advisory group.
- **Communications plan**
  A communication plan has been developed. This will ensure relevant stakeholders are informed of Council's decisions about changes, and to ensure ongoing communication during the design, development, and implementation period.
- **Implementation plan**
  A transitional implementation plan has been developed to phase in changes, with the first changes taking effect in November 2014 and others taking effect in November 2015.

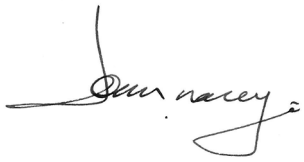
HOSPITAL ACCREDITATION

We have a 3 year accreditation cycle. Council visits all New Zealand hospital accredited for International medical graduate (NZREX) training. It meets with the hospital education teams and reviews their training programmes to ensure interns receive appropiate education, training and supervision, and that supervision and supervision facilities for interns meets Council standards.

During the year accreditation visits were made to:

- Hawke's Bay Hospital – September 2012
- Palmerston North Hospital – November 2012
- Dunedin Hospital – November 2012
- Canterbury Hospitals (revisit to general surgical department in Feb 2013)
- Wairau and Nelson Hospitals – May 2013
- Middlemore Hospital – May 2013

I would like to thank all members of the Education Committee and staff for their contributions during the year.



Professor John Nacey
Chairperson
Education Committee

MEMBERS OF THE MEDICAL COUNCIL

DURING THE PERIOD 1 JULY 2012 TO 30 JUNE 2013

DR RICHARD (RICK) H ACLAND

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

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

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

DR JOHN B ADAMS

MB ChB 1976 Otago, M 1984 F 1986 RANZCP

Dr Adams is a psychiatrist, and currently Associate Dean of Student Affairs in the Dunedin School of Medicine and Faculty of Medicine, University of Otago. He has recently completed 10 years as the Dean of the Dunedin School of Medicine, having been appointed in 2003.

He graduated from the University of Otago and subsequently trained in psychiatry, gaining his Fellowship of the Royal Australian and New Zealand College of Psychiatrists in 1986. Until his appointment as Dean of the Dunedin School, he worked at the Ashburn Clinic in Dunedin, where he was appointed medical director in 1988.

He has had extensive involvement with the New Zealand Medical Association (NZMA), initially as a Council delegate, then a board member, and subsequently NZMA Chairman from 2001 to 2003.

Apart from his duties monitoring the academic progress and pastoral care of the undergraduate medical students in Dunedin, Dr Adams teaches in the professional development programme in the undergraduate course in Dunedin. He maintains clinical practice with one of the Southern District Health Board community mental health teams. He is a trustee for the Ashburn Hall Charitable Trust.

Since joining the Council as an appointed member in 2008, Dr Adams has participated as a member of the Health Committee and chairperson of the Education Committee. As elected chairperson since 2010, Dr Adams is ex-officio on all Council committees.

MR ANDREW B CONNOLLY
MB ChB 1987 Auckland, FRACS 1994

Mr Connolly is deputy chairperson of the Council and a general and colorectal surgeon, employed full time at Counties Manukau District Health Board.

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

He has a strong interest in governance and clinical leadership and has been the Head of Department of General and Vascular Surgery since 2003. He has served on the ministerial advisory group that was responsible for the *'In Good Hands'* document.

Mr Connolly has served on various district health boards and national committees, including the National Guidelines Group for the screening of patients with an increased risk of colorectal cancer. He is the Presiding Member of the Lotteries Health/Research Distribution Committee. He has a strong interest in surgical education and training and acute surgical care, as well as taking an active role with surgical research into enhanced recovery.

Mr Connolly is a member of the Council's Audit and Education Committees.

DR JONATHAN E M FOX
MB BS 1974 Lond, MRCS Eng LRCP Lond 1974, MRCGP 1981, FRNZCGP 1998

Dr Fox is a general practitioner (GP) based in Auckland. He is a past president of the Royal New Zealand College of General Practitioners (RNZCGP) and immediate past chair of the Council of Medical Colleges in New Zealand. He is a board member of ProCare Health Limited, the Auckland Independent Practitioners Association. He is also a member of various charitable and research trusts in the Auckland region.

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

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

Dr Fox qualified from Guys Hospital Medical School, London, in 1974. He then spent 7 years working as a medical officer in the Royal Navy, before completing his vocational training in the United Kingdom (UK). 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 children. Over the last 20 years, their practice has grown and is now a five-doctor practice in Meadowbank, Auckland.

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

Dr Fox is chairperson of the Council's Health Committee and a member of the Audit Committee.

DR ALLEN R FRASER

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

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

He has been involved in many local, national, and international professional organisations, including the Royal Australian and New Zealand College of Psychiatrists (RANZCP), since 1980. Dr Fraser was Chair of the RANZCP's New Zealand Committee for 4½ years. He was a union leader (President of the Association of Salaried Medical Specialists for 4 years and is now a life member), and a chief medical officer.

His current clinical work is in private practice in Auckland where he concentrates on mood disorders and medico-legal assessments.

Dr Fraser is a member of the Council's Health and Education Committees.

MS LIZ HIRD

LLB (Hons) 1983

Ms Hird is a lay member who has been a barrister since 1987 and has a wide ranging commercial and administrative law practice.

She has had a long involvement in community health, beginning with the founding of the Otaki Women's Health Group in 1987. She was also an initial member of the Otaki Community Health Committee of the Area Health Board and founding trustee, and is the current chairperson of the Otaki Community Health Trust, which provides community grants for health projects.

Ms Hird was a member of the Otaki PHO steering committee that established the Otaki Community PHO. Ms Hird is also national contractual legal adviser to HealthCare Aotearoa (Inc), a network of community primary health providers.

In 2011, Ms Hird was appointed a District Inspector of Mental Health Services for Manawatu, Wairarapa, Tairawhiti and Wellington, and a District Inspector for Intellectually Disability Services for the lower half of the North Island.

MS SUSAN HUGHES
BA, LLB, GDip. Bus Studs, MMgt, QC

Appointed in May 2013 as a Council 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.

Her practice is 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; such practice has honed her interest in matters of process and the effective resolution of disputes.

MS LAURA MUELLER
BA Psych (Calif) 1992, Juris Doctor (Calif) 1996

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

With a keen interest in governance and leadership, Ms Mueller serves on the Disputes Tribunal's National Education Committee and as a mentor for new Referees. She has served as treasurer on the Disputes Tribunal's Referees Association Executive.

Ms Mueller was appointed to the Medical Council in October 2009 and is a member of the Council's Health and Education Committees, as well as being the Council's liaison member on its Consumer Advisory Group.

PROFESSOR JOHN N NACEY

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

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

With an interest in prostate disease, Professor Nacey has published extensively on this subject. He acts as referee for several major international journals and has chaired the recent Government Taskforce on prostate cancer. 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 including the position of President of the Wellington Medical Research Foundation and Chairman of the Board of Management. He remains a strong advocate for promoting men's health.

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

MS JOY QUIGLEY

QSO (2008) JP

Ms Quigley was appointed to the Medical Council in 2011.

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

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

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

Ms Quigley is a member of the Council's Audit and Education Committees.

DR PETER ROBINSON LVO

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

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

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

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

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

PROFESSOR RICHARD (DICK) SAINSBURY

MB ChB 1972 Otago, FRACP 1981, MA 2011, Post Grad Dip Arts 2011

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

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

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

MR JACOB TE KURAPA
JP

Ko Mataatua te Waka; Ko Manawaru te Maunga; Ko Ohinemataroa te Awa; Ko Mataatua te Marae; Ko Ngati Tawahaki te Hapu; Ko Tuhoe te Iwi; Ko Hakopa Te Kurapa taku ingoa. Tihei Mauri Ora!

Mr Te Kurapa worked in health as the Health Promotions Team Leader and the Community Action Youth and Drugs Service Coordinator; a position dedicated to finding alternative and positive solutions for young people in Murupara and the surrounding districts.

Mr Te Kurapa is currently the Chairperson of the Murupara Community Board and was the youngest elected representative during his 9-year term (2001-2010) in Office to the Whakatane District Council. He is also the Chairperson of the newly established Murupara Area School and a Justice of the Peace.

Mr Te Kurapa is a Ministerial appointee to the National Ethics Advisory Committee (NEAC), and a former member of the Health Practitioners Disciplinary Tribunal.

In 2013, Mr Te Kurapa was appointed to the Bay of Plenty District Health Board.

Mr Te Kurapa is the Chairperson of the Council's Audit Committee.

CHIEF EXECUTIVE'S REPORT

Our five strategic goals are to:

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

GOOD MEDICAL PRACTICE - UPDATED

In April, the Council released an updated version of *Good Medical Practice* after consultation with the profession, stakeholders and the Council's Consumer Advisory Group.

The publication is addressed to doctors, but is also intended to let the public know what they can expect of doctors. The document outlines the duties of a good doctor in a simple and direct style. It aims to help doctors monitor their own conduct and the conduct of their colleagues. We are also aware that *Good Medical Practice* is often referred to by patients who are uncertain about the quality of care they have received. We have tried to make the resource accessible to patients, doctors and stakeholders, and tried to ensure that the standards outlined are clear and easy to follow.

CONSUMER ADVISORY GROUP

The Council's Consumer Advisory Group (CAG), made up of Pacific, disability, health and iwi consumer advisers continues to provide valuable feedback and suggestions to the Council on issues such as the review of *Good Medical Practice,* sexual boundaries, cultural competence, the use of social media and professional standards.

TRAINING WORKSHOPS FOR SUPERVISORS OF INTERNATIONAL MEDICAL GRADUATES (IMGS)

The Council's registration team organised four workshops. Most attendees have found it useful in helping them learn different methods of dealing with cultural competence, communication issues and addressing concerns that may arise with the performance of IMGs. The workshops also provide supervisors with a forum to meet with other supervisors to share ideas and experiences and form networking groups.

The training workshops for supervisors of IMGs were first introduced in 2009, and there have now been 17 workshops held, with over 400 supervisors attending the training.

APPROVED PRACTICE SETTINGS (APS)

Accreditation as an APS demonstrates that appropriate support and supervision is available and provided to IMGs within a particular medical service. This ensures their safe integration into medical practice in New Zealand, and demonstrates there is ongoing assessment being provided. Benefits of being accredited as an APS include:

- Recognition of a service or practice that spans more than one site and providing a mechanism to streamline their internal processes and policies.
- Simplified application process for services, for example individual supervision plans and supervision reports do not need to be submitted to Council.

Five services have been accredited so far as an APS. These are:

- Medicross Accident and Medical Clinic, New Plymouth.
- East Tamaki Healthcare, Auckland (nine sites).
- South Island Neurosurgical Service, Christchurch and Dunedin.
- Radius Medical, The Palms, Palmerston North.
- Pegasus Health, 24 Hour Surgery, Christchurch.

MEMORANDUMS OF UNDERSTANDING (MOUs)

MoU between the Medical Council and the District Health Boards (DHBs) of New Zealand

A revised MoU between the Medical Council and the District Health Boards (DHBs) of New Zealand was signed in May 2013. The objective of the MoU is to enable DHBs and the Council, working in a collaborative and equal relationship, to clarify our respective roles and responsibilities related to the regulation of doctors in New Zealand, including the registration of doctors and the management of any competence, performance, conduct and health issues.

The Medical Council and Southern Cross Hospitals Limited signed a MoU in December 2012.

The MoU formalises and sets out protocols for the exchange of information between the two organisations relating to doctors practising in Southern Cross Hospitals. The objective of the MoU is to clarify the two organisation's respective roles and responsibilities related to the management of any competence, performance, conduct and health issues, and to enable Southern Cross Hospitals and the Council to work collaboratively in the interests of public health and safety.

CONSULTATIONS

The Council consulted the profession and other stakeholders on a wide variety of issues including:

- A proposal to amend the Council's *Interim policy for doctors registered in a general scope or a vocational scope of general practice who wish to perform tumescent liposuction*
- A proposed amendment to the Medical Council's active clinical practice requirement for the comparable health system pathway
- A proposed change to the prescribed qualification for special purpose (locum tenens) scope of practice
- A proposed framework for the regulation of 'special interests'
- *A Review of Prevocational Training Requirements for doctors in New Zealand*
- *Good medical practice*
- Medical certification
- Proposed name change to the accident and medical practice scope of practice
- Standards and processes for recognition and accreditation of New Zealand Vocational education and advisory bodies
- Vocational recognition for addiction medicine
- Vocational recognition for pain medicine.

My thanks go to Dr John Adams, all Council members and staff for their support and professionalism this year.

Philip Pigou
Chief Executive

REGISTRAR'S REPORT

NEW SCOPE OF PRACTICE

The Council has accredited pain medicine as a scope of practice in New Zealand, giving formal recognition to this medical specialty and its associated qualification. The new scope and qualification came into effect in December 2012. The accreditation follows a lengthy application process undertaken by the Faculty of Pain Medicine (FPM) of the Australian and New Zealand College of Anaesthetists.

David Dunbar
Registrar

REGISTRATION OF HEALTH PRACTITIONERS AND PRACTISING CERTIFICATES

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

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

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

1.

SCOPES OF PRACTICE – SUMMARY OF REGISTRATION STATUS

As at 30 June 2013

Provisional general	3,589
General	8,120
Provisional vocational	255
Vocational	9,800
Special purpose	208
TOTAL ON REGISTER	**21,972**
Total practising	14,150
Suspended	11

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

2.

APPLICATIONS FOR REGISTRATION

1 July 2012–30 June 2013

	HPCAA Section	Number	Outcomes		
			Registered	Registered with conditions	Not registered
Total	15	–	–	–	[1]
Reasons for non-registration					
Communication including English language requirements	16 a and b	–	–	–	–
Conviction by any court for 3 months or longer	16 c	–	–	–	–
Mental or physical condition	16 d	48	44	–	4
Professional disciplinary procedure in New Zealand or overseas, otherwise under investigation	16 e,f,g	–	–	–	–
Other – danger to health and safety	16 h	–	–	–	–

[1] Includes those occasions when Council resolved to decline an application to change scope because requirements had not yet been met

3.

APPLICATIONS FOR PRACTISING CERTIFICATES (PCs)

1 July 2012–30 June 2013

	HPCAA Section	Number	Outcomes			
			PC	PC with conditions	Interim	No PC
Total		14,119	13,269	–	–	850 [1]
Reasons for non-issue of a PC						
Competence	27 (1) a	–	–	–	–	–
Failed to comply with a condition	27 (1) b	–	–	–	–	–
Not completed required competence programme satisfactorily	27 (1) c	–	–	–	–	–
Recency of practice	27 (1) d	–	–	–	–	–
Mental or physical condition	27 (1) e	–	–	–	–	–
Not lawfully practising within 3 years	27 (1) f	–	–	–	–	–
False or misleading application	27 (3)	–	–	–	–	–

[1] Notified as not practising in New Zealand, rather than declined

4.

REGISTRATION ACTIVITIES

1 July 2012–30 June 2013

Provisional general/vocational issued	
New Zealand graduates (interns)	363
Australian graduates (interns)	5
Passed NZREX	57
Graduate of competent authority accredited medical school	522
Worked in comparable health system	219
New Zealand and overseas graduates reregistration (following erasure)	–
Transitional	–
Non-approved postgraduate qualification – vocational assessment	108
Non-approved postgraduate qualification – vocational eligible	46
Special scope issued	
Visiting expert	19
Research	–
Postgraduate training or experience	30
Locum tenens in specialist post	139
Emergency or other unpredictable short-term situation	–
Teleradiology	2
General scope after completion of supervised period	
New Zealand/Australian graduates (interns)	387
Passed NZREX Clinical	63
Graduate of competent authority accredited medical school	223
Worked in comparable health system	82
Transitional	3
Vocational scope after completion of supervised period	
Non-approved postgraduate qualification – vocational assessment	57
Non-approved postgraduate qualification – vocational eligible	48
Approved Vocational Education and Advisory Bodies (VEAB) training programme	–

Continued...

General scope issued	
New Zealand graduates	6
Overseas graduates	41
Restorations	13
Vocational scope issued	
Approved postgraduate qualification	449
Suspensions	
Suspended or interim suspension scope	5
Revocation of suspension scope	2
Conditions	
Imposed	215
Revoked	129
Cancellations under the HPCAA	
Death – s 143	52
Discipline order – s 101(1)(a)	1
False, misleading, or not entitled – s 146	–
Revision of register – s 144(5)	190
At own request – s 142	305

5.

DOCTORS REGISTERED IN VOCATIONAL SCOPES

1 July 2012–30 June 2013

Vocational scope	Vocational registration at 30/6/2012[1]	Added 2012/2013	Removed 2012/2013	Net change	Vocational scope at 30/6/2013[1,2]
Anaesthesia	774	50	14	36	810
Cardiothoracic surgery	34	1	-	1	35
Clinical genetics	11	2	-	2	13
Dermatology	65	4	-	4	69
Diagnostic & interventional radiology	452	37	6	31	483
Emergency medicine	209	25	1	24	233
Family planning & reproductive health	31	1	-	1	32
General practice	3,426	199	47	152	3,578
General surgery	331	20	11	9	340
Intensive care medicine	81	5	1	4	85
Internal medicine	1,049	70	15	55	1,104
Medical administration	26	3	-	3	29
Musculoskeletal medicine	24	-	1	-1	23
Neurosurgery	22	1	-	1	23
Obstetrics & gynaecology	337	19	6	13	350
Occupational medicine	60	-	1	-1	59
Ophthalmology	157	3	3	-	157
Oral & maxillofacial surgery	19	-	-	-	19
Orthopaedic surgery	292	19	3	16	308
Otolaryngology head & neck surgery	124	4	5	-1	123
Paediatric surgery	20	-	-	-	20

Vocational scope	Vocational registration at 30/6/2012[1]	Added 2012/2013	Removed 2012/2013	Net change	Vocational scope at 30/6/2013[1,2]
Paediatrics	390	16	13	3	393
Pain medicine	-	4	-	4	4
Palliative medicine	52	6	-	6	58
Pathology	337	16	11	5	342
Plastic & reconstructive surgery	69	4	1	3	72
Psychiatry	687	48	11	37	724
Public health medicine	211	4	5	-1	210
Radiation oncology	74	3	4	-1	73
Rehabilitation medicine	24	-	1	-1	23
Rural hospital medicine	54	17	-	17	71
Sexual health medicine	21	-	1	-1	20
Sports medicine	24	2	-	2	26
Urgent care	144	9	5	4	148
Urology	69	2	1	1	70
Vascular surgery	34	3	-	3	37
TOTAL	**9,734**	**597**	**167**	**430**	**10,164**

NOTES: [1] Includes doctors who may currently be inactive (have no practising certificate).
[2] Includes 355 doctors with registration in two vocational scopes and three doctors with registration in three vocational scopes

6.

REGISTRATIONS ISSUED, BY COUNTRY OF PRIMARY QUALIFICATION

1 July 2012–30 June 2013

Country	Provisional general	Provisional vocational	Special purpose	Total
England	355	33	10	398
United States of America	85	25	97	207
Scotland	74	12	5	91
Ireland	59	7	2	68
India	25	14	15	54
Wales	29	-	1	30
Germany	10	14	5	29
Canada	12	4	10	26
Netherlands	22	4	-	26
Australia	6	2	8	16
South Africa	3	3	6	12
Belgium	7	2	1	10
Pakistan	5	3	2	10
Sri Lanka	5	2	3	10
Sweden	6	4	-	10
Other[1]	100	25	24	149
New Zealand	363	2	1	366
Total	**1,166**	**156**	**190**	**1,512**

NOTES: [1] Other represents 57 countries which had fewer than 10 registrations in the reporting period.

7.

VOCATIONAL SCOPES GRANTED TO DOCTORS, BY VOCATIONAL SCOPE PRACTICE

1 July 2012–30 June 2013

Vocational scope	Overseas	New Zealand	Total
Anaesthesia	26	24	50
Cardiothoracic surgery	1	-	1
Clinical genetics	-	2	2
Dermatology	2	2	4
Diagnostic & interventional radiology	21	16	37
Emergency medicine	20	5	25
Family planning & reproductive health	-	1	1
General practice	126	72	198
General surgery	6	14	20
Intensive care medicine	1	4	5
Internal medicine	36	34	70
Medical administration	2	2	4
Neurosurgery	1	-	1
Obstetrics & gynaecology	11	8	19
Ophthalmology	1	2	3
Orthopaedic surgery	10	9	19
Otolaryngology head & neck surgery	1	3	4
Paediatrics	9	7	16
Pain medicine	4	-	4
Palliative medicine	4	2	6
Pathology	11	5	16
Plastic & reconstructive surgery	2	2	4
Psychiatry	37	11	48
Public health medicine	-	4	4
Radiation oncology	2	1	3
Rural hospital medicine	8	9	17
Sports medicine	-	2	2
Urgent care	4	5	9
Urology	-	2	2
Vascular surgery	1	2	3
Total	**347**	**250**	**597**

8.

OUTCOMES OF VOCATIONAL REGISTRATION ASSESSMENTS

1 July 2012–30 June 2013

Branch	Incomplete applications	Pending	Withdrawn/ lapsed	Vocational eligible	Vocational assessment	NZREX	Total
Anaesthesia	6	8	2	20	18	1	55
Cardiothoracic surgery	–	–	–	–	1	1	2
Dermatology	1	–	–	1	–	–	2
Diagnostic & interventional radiology	19	7	2	12	7	–	47
Emergency medicine	18	5	1	11	3	–	38
General practice	3	–	–	–	6	1	10
General surgery	1	4	1	2	4	–	12
Intensive care medicine	1	1	–	–	–	–	2
Internal medicine	16	14	3	15	15	5	68
Medical administration	1	–	–	–	–	–	1
Neurosurgery	1	–	–	2	3	–	6
Obstetrics & gynaecology	16	5	1	9	1	1	33
Occupational medicine	1	–	–	–	1	–	2
Ophthalmology	3	2	2	2	1	1	11
Orthopaedic surgery	1	2	2	5	3	2	15
Otolaryngology head & neck surgery	2	3	–	2	–	–	7
Paediatric surgery	–	–	–	1	2	–	3
Paediatrics	5	2	1	3	5	–	16
Palliative medicine	2	1	–	2	1	–	6
Pathology	2	–	1	5	1	–	9
Plastic & reconstructive surgery	3	1	–	–	1	1	6
Psychiatry	13	16	2	26	7	3	67
Public health medicine	–	–	2	–	1	–	3
Radiation oncology	3	–	–	–	–	–	3
Rehabilitation medicine	1	–	–	–	–	–	1
Urology	2	1	–	–	–	–	3
Vascular surgery	–	1	1	–	–	–	2
TOTAL	**121**	**73**	**21**	**118**	**81**	**16**	**430**
Percentages based on total number of outcomes				54.9%	37.7%	7.4%	

9.

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

As at 30 June 2013

Country	Provisional general	General	Provisional vocational	Vocational	Special purpose	Total	Number with practising certificate
England	1,198	1,146	31	1,189	15	**3,579**	1,885
South Africa	69	286	18	715	7	**1,095**	737
Scotland	296	339	14	340	2	**991**	535
United States of America	510	92	63	216	93	**974**	341
Australia	11	544	2	318	1	**876**	365
India	86	246	23	340	19	**714**	468
Ireland	213	133	9	67	2	**424**	176
Germany	92	72	24	111	2	**301**	181
Sri Lanka	13	85	-	177	10	**285**	148
Wales	116	99	-	50	1	**266**	106
Canada	119	24	6	61	13	**223**	68
Iraq	9	72	2	91	-	**174**	108
Netherlands	84	22	7	29	-	**142**	75
Bangladesh	6	46	1	65	-	**118**	60
Pakistan	19	59	3	28	1	**110**	65
China	9	35	-	54	-	**98**	74
Sweden	62	13	12	10	-	**97**	16
Egypt	10	30	2	47	1	**90**	53
Fiji	1	17	-	44	21	**83**	72
Northern Ireland	27	25	-	25	1	**78**	36
Philippines	6	25	3	25	4	**63**	39
Russia	7	31	1	17	1	**57**	45
Poland	14	20	2	12	-	**48**	29
Zimbabwe	2	6	4	32	1	**45**	40
Yugoslavia; Federal Republic of	1	17	1	23	-	**42**	23
Nigeria	15	14	1	7	1	**38**	20
Singapore	5	9	-	22	1	**37**	22
Belgium	16	8	1	9	-	**34**	19
Romania	8	11	1	12	-	**32**	23
Italy	8	9	4	9	-	**30**	19
Denmark	14	9	1	5	-	**29**	8
Austria	19	4	1	1	-	**25**	8

Continued...

Country	Provisional general	General	Provisional vocational	Vocational	Special purpose	Total	Number with practising certificate
Myanmar	2	9	-	13	-	**24**	14
Hungary	8	6	-	8	-	**22**	14
Switzerland	11	3	-	8	-	**22**	11
Czech Republic	7	8	-	5	-	**20**	13
Ukraine	5	12	1	2	-	**20**	18
Spain	5	3	2	7	1	**18**	14
Croatia	1	6	-	9	-	**16**	10
Malaysia	3	6	1	4	2	**16**	14
France	4	5	1	5	-	**15**	9
Bulgaria	-	6	-	8	-	**14**	11
Iran	-	6	1	4	1	**12**	6
Zambia	1	6	1	4	-	**12**	8
Mexico	5	-	1	5	-	**11**	4
Finland	4	4	1	1	-	**10**	5
Norway	2	-	-	8	-	**10**	8
Papua New Guinea	1	-	-	9	-	**10**	7
Sudan	3	5	-	2	-	**10**	9
Other	67	71	9	69	7	**223**	132
New Zealand	395	4,416	-	5,478	-	**10,289**	7,979
TOTAL	**3,589**	**8,120**	**255**	**9,800**	**208**	**21,972**	**14,150**

[1] Other represents 61 countries with fewer than 10 registered doctors.

PROFESSIONAL STANDARDS

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

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

10.

SOURCE OF ALL NEW REFERRALS - THESE MAY RELATE TO A DOCTOR'S COMPETENCE AND/OR CONDUCT

1 July 2012–30 June 2013

Source	Number
ACC	13
Vocational education advisory body	2
Consumer complainant	23
Courts (notices of conviction)	18
Employer	20
HDC	82
Legal counsel	1
MCNZ (from information in public sphere)	2
Medicines control	1
Ministry of Health	3
Other health agency	4
Other health professional	15
Peer	19
Police	3
Public	3
Self referral	1

PERFORMANCE

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

The table below shows the number of cases considered by Council during the year that related to a doctor's competence to practise and Council's decisions as to how those cases should be addressed. The table shows the number of Council's processes during the year rather than the number of individual doctors. 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 2012 and processes that continued after 30 June 2013 and illustrates the volume of Council's work in this area.

The table does not include cases that were determined by Council's complaints triage committee and which were not considered fully by Council (other than in a summary report).

11.

NUMBER OF COUNCIL PROCESSES

1 July 2012–30 June 2013

Outcomes	Number
No further action or educational letter on first consideration	22
Recertification programme ordered on first consideration	1
Referral to a Performance Assessment Committee (PAC)	30
Education Programme after a PAC	12
Recertification programme ordered after a PAC.	5
Doctor found competent by PAC therefore no further action	6
Education or recertification programme completed satisfactorily	11
Follow up PAC after completion of education programme	5
Order for interim suspension made	2
Order for conditions on practice imposed	12
Other actions	5
Total	**111**

CONDUCT

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

The table below shows the number of cases considered by Council during the year that related to a doctor's conduct and Council's decisions as to how those cases should be addressed. The table shows the number of Council's processes during the year rather than the number of individual doctors. 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 2012 and processes that continued after 30 June 2013 and illustrates the volume of Council's work in this area. The table does not include cases that were determined by Council's complaints triage committee and which were not considered fully by Council (other than in a summary report.

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

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

12.

NUMBER OF CASES CONSIDERED THAT RELATE TO A DOCTOR'S CONDUCT AND COUNCIL'S DECISIONS AS TO HOW THESE CASES SHOULD BE ADDRESSED

1 July 2012–30 June 2013

Outcomes	Number
No further action or educational letter on first consideration.	10
Referral to Professional Conduct Committee (PCC)	31
Order made imposing conditions on doctor's practice	4
PCC recommended no further action	2
PCC recommended counselling or mentoring	6
PCC determined charge be brought in the HPDT	4
Other considerations (mainly applications to remove conditions)	9

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, promoting doctors' health.

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

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

13.

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

1 July 2012–30 June 2013

Source	HPCAA	Number			
		Existing	New	Closed	Still active
Health service	45 (1) a	–	1	–	1
Health practitioner	45 (1) b	–	34[1]	8	26
Employer	45 (1) c	–	14	4	10
Medical Officer of Health	45 (1) d	–	–	–	–
Any person	45 (3)	–	6	1	5
Person involved with education	45 (5)	–	1	-	1
Total			**56**	**13**	**43**

[1]30 of the 34 were self referred

14.

OUTCOMES OF HEALTH NOTIFICATIONS

1 July 2012–30 June 2013

Outcomes	HPCAA	Number [1]
No further action	45 (3)	2
Order medical examination	49 (1)	64 [2]
Interim suspension	48 (1) (a)	7 [3]
Conditions	48 (1) (b)	–
Restrictions imposed	50 (3) or (4)	See note [4]
Total		**56**

[1] There may be more than 1 outcome

[2] 20 assessments agreed voluntarily and 44 reports from treating clinicians

[3] Achieved through voluntary agreement

[4] Requisite monitoring for 43 doctors still active achieved through informal agreement, without use of statutory provisions of the HPCAA.

EXAMINATIONS

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

NEW ZEALAND REGISTRATION EXAMINATION – NZREX CLINICAL

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

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

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

The prerequisites for applying to sit NZREX Clinical are:

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

15.

CANDIDATES SITTING AND PASSING NZREX CLINICAL

1 July 2012–30 June 2013

	Number sitting	Attempts				Number of passes	Passes on attempts			
Country		**1**	**2**	**3**	**4**		**1**	**2**	**3**	**4**
Belarus	1	1	-	-	-	1	1	-	-	-
Belize	1	1	-	-	-	-	-	-	-	-
Brazil	1	-	1	-	-	1	-	1	-	-
Bulgaria	4	2	2	-	-	1	-	1	-	-
China	9	9	-	-	-	8	8	-	-	-
Dominica	2	2	-	-	-	2	2	-	-	-
Egypt	4	4	-	-	-	1	1	-	-	-
Fiji	3	3	-	-	-	3	3	-	-	-
Finland	1	1	-	-	-	1	1	-	-	-
France	1	1	-	-	-	1	1	-	-	-
Germany	1	1	-	-	-	1	1	-	-	-
Greece	1	1	-	-	-	1	1	-	-	-
Hungary	1	1	-	-	-	1	1	-	-	-
India	33	29	3	1	-	16	15	1	-	-
Iran	3	2	1	-	-	-	-	-	-	-
Iraq	3	3	-	-	-	3	3	-	-	-
Jordan	2	2	-	-	-	2	2	-	-	-
Malaysia	1	1	-	-	-	1	1	-	-	-
Nepal	6	4	2	-	-	3	2	1	-	-
Netherlands Antilles	1	1	-	-	-	-	-	-	-	-
Nigeria	4	4	-	-	-	4	4	-	-	-
Pakistan	19	15	2	2	-	11	7	2	2	-
Peru	1	1	-	-	-	-	-	-	-	-
Philippines	9	6	3	-	-	4	3	1	-	-
Russia	3	3	-	-	-	1	1	-	-	-
Samoa	2	2	-	-	-	2	2	-	-	-
Seychelles	2	2	-	-	-	1	1	-	-	-
Singapore	1	1	-	-	-	-	-	-	-	-
South Africa	3	3	-	-	-	3	3	-	-	-
Sri Lanka	4	2	2	-	-	3	1	2	-	-
St Kitts and Nevis	1	1	-	-	-	-	-	-	-	-
Sudan	2	2	-	-	-	1	1	-	-	-
Ukraine	4	4	-	-	-	1	1	-	-	-
Venezuela	1	1	-	-	-	1	1	-	-	-
Yugoslavia	1	-	-	-	1	1	-	-	-	1
Zimbabwe	1	1	-	-	-	1	1	-	-	-
TOTAL	**137**	**117**	**16**	**3**	**1**	**81**	**69**	**9**	**2**	**1**

MEDICAL CHARGES BEFORE THE HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL

Principal activities: Disciplinary proceedings brought against doctors are heard and determined by the both the Medical Practitioners Disciplinary Tribunal (Medical Practitioners Act 1995) and the Health Practitioners Disciplinary Tribunal (Health Practitioners Competence Assurance Act 2003).

During the year the Health Practitioners Disciplinary Tribunal (HPDT) received eight charges relating to eight doctors. Four of these charges were received from a professional conduct committee and four were received from the Director of Proceedings.

The HPDT sat during the year to hear six charges relating to six doctors over 11 days and one one-day rehearing of a penalty decision. One of the six charges was received in 2011/2012. The other five charges were received in 2012/2013. All but three of the eight charges received during 2012/2013 have been heard. The rehearing of a penalty decision related to a charge received during the 2010/2011 year and was ordered by the High Court following an appeal by the practitioner.

Note: The Medical Practitioners Disciplinary Tribunal (MPDT) has now ceased to exist and all outstanding legal appeals have been resolved.

MEDICAL CHARGES BEFORE THE HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL

1 July 2012–30 June 2013

Nature of charges	
Professional misconduct 2011/2012	1
Conviction 2012/2013	1
Professional misconduct 2012/2013	7
Total	**9**
Source	
Prosecution of charges brought by professional conduct committee 2011/2012	1
Prosecution of charges brought by director of proceedings 2012/2013	2
Prosecution of charges brought by professional conduct committee 2012/2013	3
Charges brought by professional conduct committee yet to be heard	1
Charges brought by director of proceedings yet to be heard	2
Total	**9**
Outcome of hearings	
Guilty – professional misconduct 2011 /2012	1
Guilty – conviction 2012/2013	1
Guilty – professional misconduct 2012/2013	4
Yet to be heard 2012/2013	3
Total	**9**

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

MEDICAL WORKFORCE SURVEY

Each year the Council collects workforce data through the practising certificate process. The data is used by the New Zealand Health Information Service to analyse workforce needs.

16.

FACTS AT A GLANCE[1]

FACTS AT A GLANCE[1]	2007	2008	2009	2010	2011	2012
Size of the workforce	12,643	12,949	13,408	13,883	14,333	14,686
Doctors per 100,000 population	299.0	303.4	310.7	317.9	325.4	328.7
Proportion of IMGs (%)	38.4	38.9	40.6	41.1	41.5	41.4
Proportion of females (%)	37.8	38.6	39.1	39.6	40.4	41.3
Average age of workforce	44.6	44.7	44.9	45.1	45.2	45.4
Average weekly workload (hours)	44.8	44.7	44.2	43.9	43.7	43.9
Average proportion of new IMGs retained after 1 year	48.4	50	50.8	51.7	52.7	53.5

[1] These figures are taken directly from Council's report, *The New Zealand Medical Workforce in 2012*. More detailed information about these figures and how they were calculated can be found in the report which is available from our website at www.mcnz.org.nz.

CORPORATE GOVERNANCE

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

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

COUNCIL MEMBERSHIP

The Council aims to have members who represent:

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

COUNCIL COMMITTEE STRUCTURE

The Council operates three standing committees: Audit, Health and Education. Members of these committees are listed on page 43. The Council receives committee meeting minutes at its formal meetings and, in approving those minutes, confirms the decisions made. Delegation limits are established.

LINKING WITH STAKEHOLDERS

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

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

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

- the Accident Compensation Corporation
- Vocational Education and Advisary Bodies (VEABs)
- chief medical advisers of DHBs
- the Council of Medical Colleges
- District Health Boards New Zealand
- the Health and Disability Commissioner
- the Independent Practitioners Association Council of New Zealand
- the Medical Protection Society
- the Minister of Health
- the Ministry of Health
- the New Zealand Medical Association
- members of the profession, other regulatory authorities, medical students, and community groups.

COUNCIL COMMITTEES

COUNCIL STANDING COMMITTEES AT 30 JUNE 2013

AUDIT COMMITTEE

Dr Richard Acland
Mr Andrew Connolly
Ms Joy Quigley
Mr Roy Tiffin (co-opted member)
Dr John Adams (ex-offico)[1]
Dr Peter Robinson
Mr Jacob Te Kurapa (Chairperson)

EDUCATION COMMITTEE – COUNCIL MEMBERS

Dr John Adams (ex-offico)[1]
Dr Allen Fraser
Ms Laura Mueller
Mr Andrew Connolly
Professor John Nacey (Chairperson)
Ms Joy Quigley

EDUCATION COMMITTEE MEMBERS APPOINTED BY COUNCIL

Professor Peter Ellis
Medical Council of New Zealand representative of Medical Schools Accreditation Committee

Professor Cindy Farquhar
Nominee of appropriate College or vocational education and advisory body (VEAB)
The Royal Australian and New Zealand College of Obstetricians and Gynaecologists

Dr Alice Febery *(until December 2012)*
Active consumer of education

Dr Liza Lacks
Nominee of appropriate College or VEAB – The Royal New Zealand College of General Practitioners

Dr Alex Lee
Resident medical officer representative

Dr Oliver Hansby
Resident medical officer representative (from February 2013)

Dr Greg Russell
Nominee of appropriate College or VEAB or – College of Urgent Care Physicians

Dr John Thwaites
Intern supervisor representative

Dr Sally Ure
Nominee of appropriate College or VEAB or – The Australian and New Zealand College of Anaesthetists

HEALTH COMMITTEE

Dr John Adams (ex-offico)[1]
Dr Allen Fraser
Ms Laura Mueller
Dr Jonathan Fox (Chairperson)
Professor Dr Richard Sainsbury
Alternative lay person: Ms Joy Quigley

[1] The Chair 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 lay person must sit on each committee.

COUNCIL OFFICE

OFFICE OF THE COUNCIL AT 30 JUNE 2013

Chief Executive	Philip Pigou
Registrar	David Dunbar
Senior Legal Adviser	Alison Mills
Legal Adviser	Rachel Kent
Executive Assistant	Dot Harvey
Strategic Programme Manager	Joan Crawford
Project Coordinator	Adeline Cumings
Project Coordinator	Andrea Flynn

ADVISER GROUP

Communications Manager	George Symmes (p/t)
Human Resources Adviser	Rachel Martin (p/t)
Medical Adviser	Dr Steven Lillis (p/t)
Medical Adviser	Dr Kevin Morris (p/t)
Senior Policy Adviser and Researcher	Michael Thorn

CORPORATE SERVICES

Corporate Services Manager	Peter Searle
ICT Team Leader	Bill Taylor
Senior Information Systems Analyst	Andrew Cullen
Information Systems Analyst	Ray van der Veen
Business Analyst	Diane Latham
Senior Office Administrator	Dianne Newport
Office Administrator	Casey Dalton
Office Administrator	Jenny Porter
Office Administrator	Jenny Rickit (p/t)

FINANCE

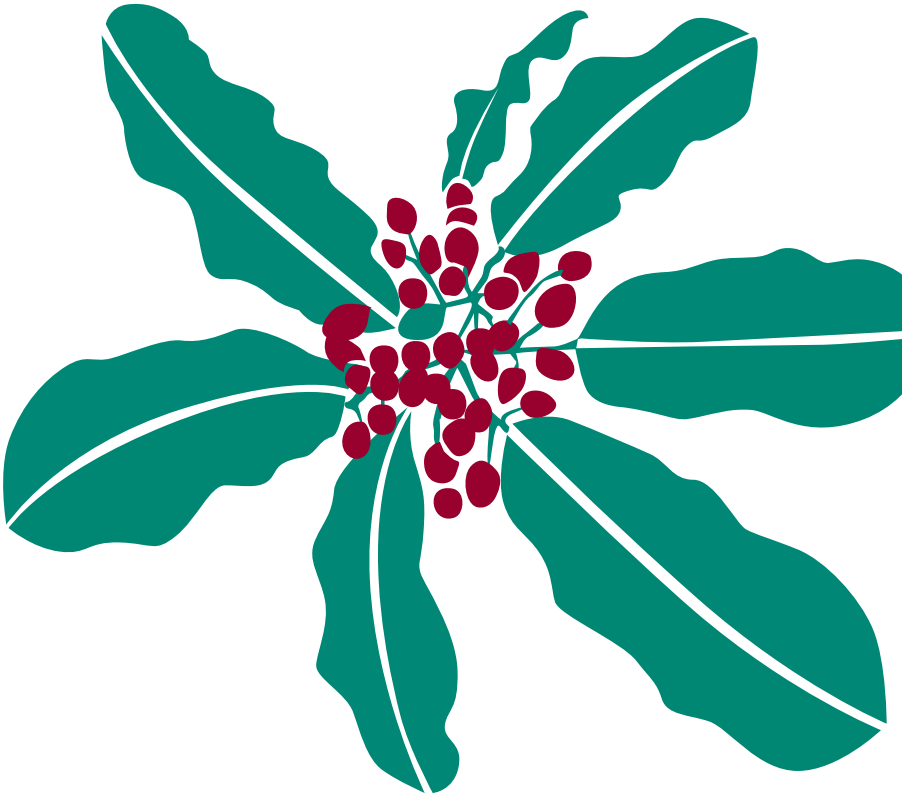
Finance Officer	Atish Pathak
Finance Officer	Marika Puleitu (p/t)
Finance Officer	Raewyn Travers

HEALTH

Health Manager	Lynne Urquhart
Health Administrator	Viv Coppins
Health Case Manager	Helen Arbuckle
Health Case Manager	Constance Hall
Health Case Manager	Jo Hawken
Health Case Manager	Jude Kindley
Health Case Manager	Garth Wyatt

HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL FOR MEDICAL PRACTITIONERS

HPDT Manager	Gay Fraser
Executive Officer	Debra Gainey
Legal Officer	Kim Davies (p/t)
Personal Assistant to Executive Officer	Deborah Harrison



REGISTRATION

Registration and Human Resources Manager	Valencia van Dyk
Senior Registration Coordinator	Gyllian Turner
Registration Team Leader – General	Anastasia Appleyard
Registration Coordinator – General	Trudy Clarke
Registration Coordinator – General	Prakash Joseph
Registration Coordinator – General	Kylie Johnston
Registration Coordinator – General	Patrick McKane
Registration Coordinator – General	Devan Menon
Registration Coordinator – General	Sandra Tam
Registration Coordinator – General	Madeline West
Registration Team Leader – Vocational	Laura Lumley
Registration Coordinator – Vocational	Sandra Clark
Registration Coordinator – Vocational	Imojini Kotelawala
Registration Coordinator – Vocational	Geetha Raghunath
Registration Coordinator – Vocational	Daniel Smith
Registration Coordinator – Vocational	Simon Spence
Practising Certificate Team Leader	Helen Vercoelen
Practising Certificate Coordinator	Bronwyn Courtney
Practising Certificate Coordinator	Sharon Mason (p/t)
Practising Certificate Audit Administrator	Elaine Pettigrew

PROFESSIONAL STANDARDS

Professional Standards Manager	Susan Yorke
Senior Professional Standards Coordinator	Charlotte Wakelin
Professional Standards Coordinator	Gina Giannios
Professional Standards Coordinator	Krystiarna Jarnet
Professional Standards Coordinator	Angela Pigott
Professional Standards Coordinator	Heather Roblin
Professional Standards Coordinator	Nikita Takai
Professional Standards Coordinator	Anna Yardley

APPENDICES - FINANCE

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Wellington 6011
New Zealand

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Wellington 6140
New Zealand

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info@staplesrodway.com
www.staplesrodway.com

staplesrodway
CHARTERED ACCOUNTANTS

INDEPENDENT AUDITOR'S REPORT TO THE READERS OF THE MEDICAL COUNCIL OF NEW ZEALAND'S FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2013

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

We have audited the financial statements of the Council on pages 1 to 16, that comprise the statement of financial position as at 30 June 2013, the statement of comprehensive income, statement of movements in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information.

Opinion

In our opinion the financial statements of the Council on pages 1 to 16:

- comply with generally accepted accounting practice in New Zealand; and
- fairly reflect the Council's:
  - financial position as at 30 June 2013; and
  - financial performance and cash flows for the year ended on that date.

Uncertainty about the delivery of office functions in future

Without modifying our opinion, we draw your attention to the disclosure on page 8 regarding a proposal for combining the secretariat and office functions of the Council with other health-related regulatory authorities. We considered the disclosure to be adequate.

Our audit was completed on 15 October 2013. This is the date at which our opinion is expressed.

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

Basis of opinion

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

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

An audit involves carrying out procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the financial statements whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the preparation of the Council's financial statements that fairly reflect the matters to which they relate. We consider internal control 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.

staplesrodway
CHARTERED ACCOUNTANTS

An audit also involves evaluating:

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

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

We have obtained all the information and explanations we have required and we believe we have obtained sufficient and appropriate audit evidence to provide a basis for our audit opinion.

Responsibilities of the Council

The Council is responsible for preparing financial statements that:

- comply with generally accepted accounting practice in New Zealand; and
- fairly reflect the Council's financial position, financial performance and cash flows.

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

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

Responsibilities of the Auditor

We are responsible for expressing an independent opinion on the financial statements and reporting that opinion to you based on our audit. Our responsibility arises from section 15 of the Public Audit Act 2001 and section 134(1) of the Health Practitioners Competence Assurance Act 2003.

Independence

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

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

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

MEDICAL COUNCIL OF NEW ZEALAND
Statement of financial position
as at 30 June 2013

	Notes	2013 $	2012 $
Current assets			
Petty cash		1,293	1,327
Bank accounts		823,467	2,237,419
GST	7	165,142	5,462
Receivables	7	342,609	325,881
Interest accrued		106,807	22,259
Investments	8	3,750,000	1,250,000
Total current assets		$5,189,318	$3,842,348
Term assets			
Receivables	7	4,160	14,080
Property, plant and equipment	9	334,608	385,657
Intangibles	10	3,407,062	3,518,329
Total term assets		$3,745,830	$3,918,066
Current liabilities			
Sundry creditors		574,989	362,326
Employee entitlements		339,044	391,086
Payments received in advance		459,775	482,723
Total current liabilities		$1,373,808	$1,236,135
Term liabilities			
Employee entitlements		87,467	96,407
TOTAL NET ASSETS		**$7,473,873**	**$6,427,872**
CAPITAL ACCOUNT			
General fund		5,628,601	6,050,162
Complaints investigation and prosecution fund		1,454,055	104,567
Examination fund		391,217	273,143
Total capital account		**$7,473,873**	**$6,427,872**

Authorised for issue for and on behalf of the Council.

John Adams
Chairperson
Dated: 15 October 2013

Philip Pigou
Chief Executive
Dated: 15 October 2013

MEDICAL COUNCIL OF NEW ZEALAND
Statement of comprehensive income
for the year ended 30 June 2013

	Notes	2013 $	2012 $
Income			
Fees received		9,619,715	9,338,324
Interest received		176,199	145,796
Additional Disciplinary Levy (2012/13)		960,303	0
Other income	6	553,258	812,955
		$11,309,475	$10,297,075
Expenditure			
Employee benefits		4,968,269	4,880,140
Legal prosecutor		131,224	234,739
Depreciation and amortisation	9,10	642,366	607,522
Fees paid to members of Council and standing committees		576,745	597,009
Medsys service level agreement		154,892	57,676
Debt collection costs and debt impairment expense	7	77,591	69,718
Rent		400,544	392,757
Intern supervisors payments		352,245	290,597
Health Practitioners Disciplinary Tribunal fees		128,025	89,280
Vocational registration expenses		184,278	334,644
Reports and health assessments		141,455	169,539
Credit card fees and commissions		29,454	175,961
Professional Conduct Committees fees		141,610	177,570
Other legal & advisors		2,043	3,785
Advice and consultancy		220,856	82,850
Repairs and maintenance office equipment		113,322	171,813
Legal assessors		0	52,219
Archives		59,591	76,471
Information brochures and notices		43,058	11,177
Audit fees		32,851	30,223
Council election		0	60,110
Other administrative costs		1,863,054	1,832,907
		$10,263,474	$10,398,707
Net surplus / (deficit) for year		$1,046,001	($101,632)
Other comprehensive income		0	0
Total comprehensive income		**$1,046,001**	**($101,632)**

MEDICAL COUNCIL OF NEW ZEALAND
Statement of movements in equity
for the year ended 30 June 2013

	Note	General Fund	Note	Complaints Investigation and Prosecution Fund	Note	New Zealand Registration Examination Fund	Total
2012							
Balance brought forward		6,089,202		149,599		290,703	6,529,504
Total comprehensive income	2	(39,040)	3	(45,032)	4	(17,560)	(101,632)
Closing balance		$ 6,050,162		$ 104,567		$ 273,143	$6,427,872
2013							
Balance brought forward		6,050,162		104,567		273,143	6,427,872
Total comprehensive income	2	(421,561)	3	1,349,488	4	118,074	1,046,001
Closing balance		$5,628,601		$1,454,055		$391,217	$7,473,873

MEDICAL COUNCIL OF NEW ZEALAND
Statement of cash flows
for the year ended 30 June 2013

	Notes	2013 $	2012 $
Cash flows from operating activities			
Cash was provided from:			
Receipts pertaining to statutory functions		11,331,180	10,333,574
Cash was distributed to:			
Council fees, disbursements and office expenses		(9,856,769)	(9,874,973)
Net cash flows from operating activities	12	1,474,411	458,601
Cash flows from investing activities			
Cash was provided from:			
Interest received		96,894	167,186
Short-term investments		1,750,000	3,325,576
		1,846,894	3,492,762
Cash was applied to:			
Purchase of assets		(485,291)	(782,020)
Short-term investments		(4,250,000)	(1,250,000)
		(4,735,291)	(2,032,020)
Net cash flows from investing activities		(2,888,397)	1,460,742
Net increase / (decrease) in cash and cash equivalents		**(1,413,986)**	**1,919,343**
Opening cash brought forward		2,238,746	319,403
Ending cash carried forward		$824,760	$2,238,746
Represented by:			
Petty cash		1,293	1,327
ANZ bank account		715	2,237,419
ASB bank account		822,752	0
		$824,760	$2,238,746

MEDICAL COUNCIL OF NEW ZEALAND
Notes to and forming part of the financial statements
For the year ended 30 June 2013

1. Statement of accounting policies

Basis of preparation

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

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

The principle place of business is in Wellington. The Council undertakes operations to register doctors in New Zealand and carries responsibilities in the area of standards, conduct and competence.

Statement of compliance

These financial statements are a general purpose financial report as defined in the External Reporting Board's Framework and have been prepared in accordance with NZ IFRS.

The financial statements have been prepared in accordance with the New Zealand equivalent to the International Financial Reporting Standards (NZ IFRS) and in accordance with Generally Accepted Accounting Practice in New Zealand (NZGAAP).

The Council is a public benefit entity.

Measurement base

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

Specific accounting policies

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

(a) **Revenue** – Practising certificate (PC) revenue is recognised in full upon the commencement of the practising year to which it relates.

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

(c) **Property, plant and equipment** – is shown at cost less accumulated depreciation (Note 10).

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

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

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

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

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

(i) **Payments received in advance** – Doctors who have received their training overseas and who are seeking registration in New Zealand pay a fee for documentation review and an interview process with the appropriate College. Once the process is complete the money is either paid to the College or refunded to the doctor if the application does not proceed or an interview is not required.

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

(k) **Leases** – The Council leases the property occupied at 139–143 Willis Street. The value of the lease is recognised in the statement of commitments at the current negotiated value of the annual lease.

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

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

(m) **Provisions** – A provision is made for the amount of accounts receivable that are expected not to be received. This provision is created by reviewing all outstanding amounts at the end of the year and assessing the likelihood of payment. Where a payment plan is in place, amounts scheduled to be recovered after 5 years are provided in full and other balances are provided for after assessment of the likelihood of collection.

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

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

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

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

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

Changes in accounting policies

There have been no changes in accounting policies and these accounting policies have been applied on bases consistent with those used in the previous year.

Standards, amendments and interpretations issued that are not yet effective and have not been early adopted

Standards, amendments and interpretations issued but not yet effective that have not been early adopted, and which are relevant to the Council, are:

- NZ IFRS9 – Financial instruments. This specifies how an entity should classify and measure financial assets. NZ IFRS9 is intended to replace NZ IAS39. The new standard is required to be adopted for the year ended 30 June 2016. However, as a new Accounting Standards Framework is likely to be apply before this date, there is no certainty when as equivalent standard to NZ IFRS9 will be applied by public benefit entities.

The Minister of Commerce has approved a new Accounting Standards Framework (incorporating a Tier Strategy) developed by the External Reporting Board ('XRB'). Under this Accounting Standards Framework, the Medical Council is likely to elect to be a Tier 2 reporting entity and it will be required to apply Public Benefit Accounting Standards adopting the Reduced Disclosure Regime ('PAS RDR'). These standards are being developed by the XRB based on current international Public Sector Accounting Standards. The effective date for the new standards for public sector entities is expected to be for reporting periods beginning on or after 1 July 2014. This means the Medical Council expects to transition to the new standards in preparing its 30 June 2015 financial statements. As the PAS RDR are still under development, the Medical Council is unable to assess the implications of the new Accounting Standards Framework at this time.

Due to the change in the Accounting Standards Framework for public benefit entities, it is expected that all new NZ IFRS and amendments to existing NZ IFRS will not be applicable to public benefit entities. Therefore, the XRB has effectively frozen the financial reporting requirements for public benefit entities up until the new Accounting Standards Framework is effective. Accordingly, no disclosure has been made about new or amended NZ IFRS that exclude public benefit entities from their scope.

Critical accounting estimates and assumptions

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

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

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

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

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

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

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

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

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

Uncertainty about the delivery of office functions in future

In February 2011, Health Workforce New Zealand (HWNZ), on behalf of the Minister of Health (the Minister), issued a consultation document proposing a single shared secretariat and office function for all 16 health regulatory authorities.

In late 2012 HWNZ funded a detailed business case for the establishment of a shared secretariat organisation. This is being considered by each of the 16 health regulatory authorities.

The proposals, if they proceeded, would likely have a significant effect on the Council. We have not quantified the possible effect.

Until a decision is made, there is uncertainty about the form in which our office functions will be delivered in future.

2.
General Fund
Statement of financial performance
for the year ended 30 June 2013

	Notes	2013 $	2012 $
REVENUE			
Annual practising certificates and other fees	1(a)	7,612,494	7,460,584
Administration fee - Complaints Investigation and Prosecution Fund		406,662	739,318
Administration fee - Examination Fund		103,147	187,334
Interest received		141,584	117,574
Workforce survey and other income		368,426	582,471
Total revenue		$8,632,313	$9,087,281
ADMINISTRATION AND OPERATING EXPENSES			
Communications		87,912	79,455
Council election		0	60,110
Legal expenses and other consultancies		220,856	83,626
Debt impairment expense relating to unpaid charges		0	8,795
Administration and operating expenses		2,151,719	2,390,024
Staff costs including recruitment and training		4,630,650	4,606,974
Total administration and operating expenses		$7,091,137	$7,228,984
COUNCIL AND COMMITTEE EXPENSES			
Council			
- Fees and expenses		560,657	587,844
- Conference and liaison costs		65,872	20,496
- Strategic directions		51,322	103,162
Audit committee			
- Fees and expenses		23,991	25,497
Health committee			
- Fees and expenses		43,365	44,155
- Independent assessment reports, Doctors' Health Advisory Service, other costs		141,455	169,539
Education committee			
- Fees and expenses		65,606	69,862
- Hospital visits, intern supervisor contracts and other costs		452,954	373,797
Professional standards			
- Performance assessments and other costs		394,292	385,293
Registration			
- Workshops and other costs		163,223	117,692
Total Council and committee expenses		**$1,962,737**	**$1,897,337**
TOTAL EXPENDITURE		**$9,053,873**	**$9,126,321**
Net surplus/(deficit) for year and total comprehensive income		**($421,561)**	**($39,040)**

The purpose of the general fund is to allow Council to maintain operations for the organisation.

3.
Complaints Investigation and Prosecution Fund
Statement of financial performance
for the year ended 30 June 2013

	Notes	2013 $	2012 $
REVENUE			
Disciplinary levy received	1(a)	1,543,888	1,507,668
Additional Disciplinary Levy (2012/13)		964,545	0
Fines and costs recovered		96,006	161,440
Interest received		30,652	20,829
Other revenue		84,824	64,484
Total revenue		$2,719,915	$1,754,421
ADMINISTRATION AND OPERATING EXPENSES			
Administration fee		406,662	739,318
Debt impairment expense relating to unpaid penalties and costs		77,591	60,923
General administration and operating expenses		311,855	293,517
Total administration and operating expenses		$796,108	$1,093,758
COUNCIL AND TRIBUNAL EXPENSES			
Complaints assessment committee costs			
- Fees		0	0
- Expenses		2,297	0
Total complaints assessment committee costs		2,297	0
Professional conduct committee costs			
- Fees		141,610	177,570
- Expenses		218,405	381,530
Total professional conduct committee costs		360,015	559,100
Medical Practitioners Disciplinary Tribunal			
- Fees and other hearing expenses		0	650
Total Medical Practitioners Disciplinary Tribunal costs		0	650
Health Practitioners Disciplinary Tribunal			
- Administration fee		83,982	56,665
- Fees and other hearing expenses		128,025	89,280
Total Health Practitioners Disciplinary Tribunal costs		212,007	145,945
Total Council and Tribunal expenses		$574,319	$705,695
TOTAL EXPENDITURE		**$1,370,427**	**$1,799,453**
Net surplus/(deficit) for year and total comprehensive income		**$1,349,488**	**($45,032)**

The purpose of the Complaints investigation and prosecution fund is to investigate, and where appropriate, apply sanctions to practitioners who are not meeting the required standards of competence or conduct.

4.
New Zealand Registration Examination Fund
Statement of financial performance
for the year ended 30 June 2013

	Notes	2013 $	2012 $
REVENUE			
NZREX candidate fees		463,333	370,072
Interest received		3,963	7,393
Other income		4,003	4,560
Total revenue		$471,299	$382,025
ADMINISTRATION AND OPERATING EXPENSES			
Administration fee		103,147	187,334
Centre costs		79,255	67,333
Examiners' fees and expenses		77,314	63,392
Honorarium, staff costs and other administrative expenses		93,509	81,526
Examination review costs		0	0
Total administration and operating expenses		$353,225	$399,585
Net surplus/(deficit) for year and total comprehensive income		**$118,074**	**($17,560)**

The purpose of the New Zealand Registration Examination fund is to examine the fitness for registration of those practitioners who do not meet any other Medical Council of New Zealand pathway to registration.

5. Taxation

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

6. Other Income

	2013 $	2012 $
Workforce NZ	46,100	46,200
Vocational registration fees	192,882	355,212
Prevocation forum	17,585	58,402
Other General	111,858	122,657
Fines and Costs	180,830	225,924
Other Exam	4,003	4,560
	$553,258	**$812,955**

7. Receivables

	2013 $	2012 $
Debtors	1,013,663	965,502
Provision for impairment	(810,752)	(733,161)
GST	165,142	5,462
	368,053	237,803
Payments in advance	143,859	107,620
Total debtors and other receivables	**511,911**	**345,423**

Fair Value

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

Impairment

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

	2013			2012		
	Gross	Impairment	Net	Gross	Impairment	Net
Not past due	254,421	0	254,421	24,134	0	24,134
Past due 1-30 days	8,321	0	8,321	10,190	0	10,190
Past due 31-60 days	55,196	0	55,196	6,933	0	6,933
Past due 61-90days	4,268	(425)	3,843	75,779	(71,630)	4,149
Past due >90 days	856,599	(810,327)	46,272	925,345	(700,627)	224,718
Total	**1,178,805**	**(810,752)**	**368,053**	**1,042,381**	**(772,257)**	**270,124**

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

8. Investments

	2013 $	2012 $
ANZ - Matures 24 Oct 2013 -4.30%	750,000	0
ASB - Matures 12 Aug 2013 - 4.50%	1,000,000	500,000
BNZ - Matures 29 Jan 2014 - 4.41%	1,000,000	0
TSB - Matures 20 Aug 2012 - 4.55%	0	250,000
TSB - Matures 11 Sep 2012 - 4.35%	0	500,000
Westpac - Matures 12 Aug 2013 - 4.30%	500,000	0
Westpac - Matures 24 Oct 2013 - 4.30%	500,000	0
	$3,750,000	**$1,250,000**
Current	3,750,000	1,250,000
Term	0	0
	$3,750,000	**$1,250,000**

9. Property, plant and equipment

	Computer Hardware	Furniture and Fittings	Office Alterations	Office Equipment	Artwork	TOTAL
Cost						
Balance at 1 July 2011	605,345	312,057	695,409	253,417	7,138	1,873,366
Additions	6,321	4,230	4,336	8,554	0	23,441
Disposals	0	0	0	0	0	0
Balance at 30 June 2012	611,666	316,287	699,745	261,971	7,138	1,896,807
Balance at 1 July 2012	611,666	316,287	699,745	261,971	7,138	1,896,807
Additions	111,734	3,907	4,948	3,766	0	124,355
Disposals	0	0	0	-930	0	-930
Balance at 30 June 2013	723,400	320,194	704,693	264,807	7,138	2,020,232
Accumulated depreciation and impairment losses						
Balance at 1 July 2011	421,857	232,159	460,916	196,911	0	1,311,843
Depreciation expense	90,699	19,286	69,686	19,636	0	199,307
Impairment losses	0	0	0	0	0	0
Disposals	0	0	0	0	0	0
Balance at 30 June 2012	512,556	251,445	530,602	216,547	0	1,511,150
Balance at 1 July 2012	512,556	251,445	530,602	216,547	0	1,511,150
Depreciation expense	78,220	18,743	62,632	14,940	0	174,535
Impairment losses	0	0	0	0	0	0
Disposals	0	0	0	-61	0	-61
Balance at 30 June 2013	590,776	270,188	593,234	231,426	0	1,685,624
Carrying amounts						
At 1 July 2011	183,488	79,898	234,493	56,506	7,138	561,523
At 30 June and 1 July 2012	99,110	64,842	169,143	45,424	7,138	385,657
At 30 June 2013	132,624	50,006	111,459	33,381	7,138	334,608

10. Intangible assets

	2013 $	2012 $
Cost		
Opening Balance 01 July	4,534,417	3,775,838
Additions	356,565	758,579
Disposals	0	0
Closing Balance 30 June	$ 4,890,982	$ 4,534,417
Accumulated depreciation and impairment losses		
Opening Balance 01 July	1,016,088	607,873
Additions	467,832	408,215
Impairment losses	0	0
Disposals	0	0
Closing Balance 30 June	$ 1,483,920	$ 1,016,088
Carrying amounts		
Opening Balance 01 July	$ 3,518,329	$ 3,167,965
Closing Balance 30 June	$ 3,407,062	$ 3,518,329

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

11. Related party transactions

Key management personnel compensation

	2013 $	2012 $
Salaries and other short-term employee benefits	1,344,117	1,312,454
Post-employment benefits	0	0
Other long-term benefits	32,006	34,868
Termination benefits	0	0
Total key management personnel compensation	**$1,376,123**	**$1,347,322**

Key management personnel include the Chief Executive and the other 8 members (2012: 8) of Council's management team.

There were no other related party transactions.

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

	2013 $	2012 $
Surplus / (deficit) for year	1,046,001	(101,632)
Less items classified as investing activity – interest	(176,199)	(145,796)
Add non-cash items:		
Depreciation and amortisation	642,366	607,522
Employee entitlements	(60,982)	31,913
Provision for Doubtful Debts	77,591	69,718
	658,975	709,153
Add movements in working capital items:		
(Increase) / decrease in receivables	(84,399)	21,435
(Increase) / decrease in GST	(159,680)	101,315
Increase / (decrease) in receipts in advance	(22,948)	148,812
Increase / (decrease) in sundry creditors	212,661	(274,686)
	(54,366)	(3,124)
	1,650,610	604,397
Net cash flows from operating activities	**$1,474,411**	**$458,601**

13. Statement of contingent liabilities

There are no known contingent liabilities (2012: Nil).

14. Statement of commitments

Lease commitments under non-cancellable operating leases;

	2013 $	2012 $
Less than one year	394,383	394,383
Between 1 and 5 years	328,655	723,038
Greater than 5 years	0	0
	$723,038	**$1,117,421**

The lease expires on 30 April 2015 and the Medical Council of New Zealand has no right of renewal.

15. Financial instruments

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

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

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

Market Risk
The Council is exposed to interest rate risk as interest rate movements will affect the returns generated from investments and related cash flows. At year end the interest rates on term deposits ranged from 4.30% to 4.50% (2012: 4.35% to 4.55%).

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

	2013 $	2012 $
Receivables	618,719	367,682
Bank balances	823,467	2,237,419
Investments	3,750,000	1,250,000
Sundry creditors	**($1,034,764)**	**($845,049)**

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

16. Council members' fees and allowances

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

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

	2013	2012
Attendance allowance:		
Daily	$ 908	$ 896
Hourly	$ 113.50	$ 112.00
Communication allowance:		
Quarterly	$300	$300
Total fees and allowances paid to members of Council	**$ 576,745**	**$599,148**

17. Capital management

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

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

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

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