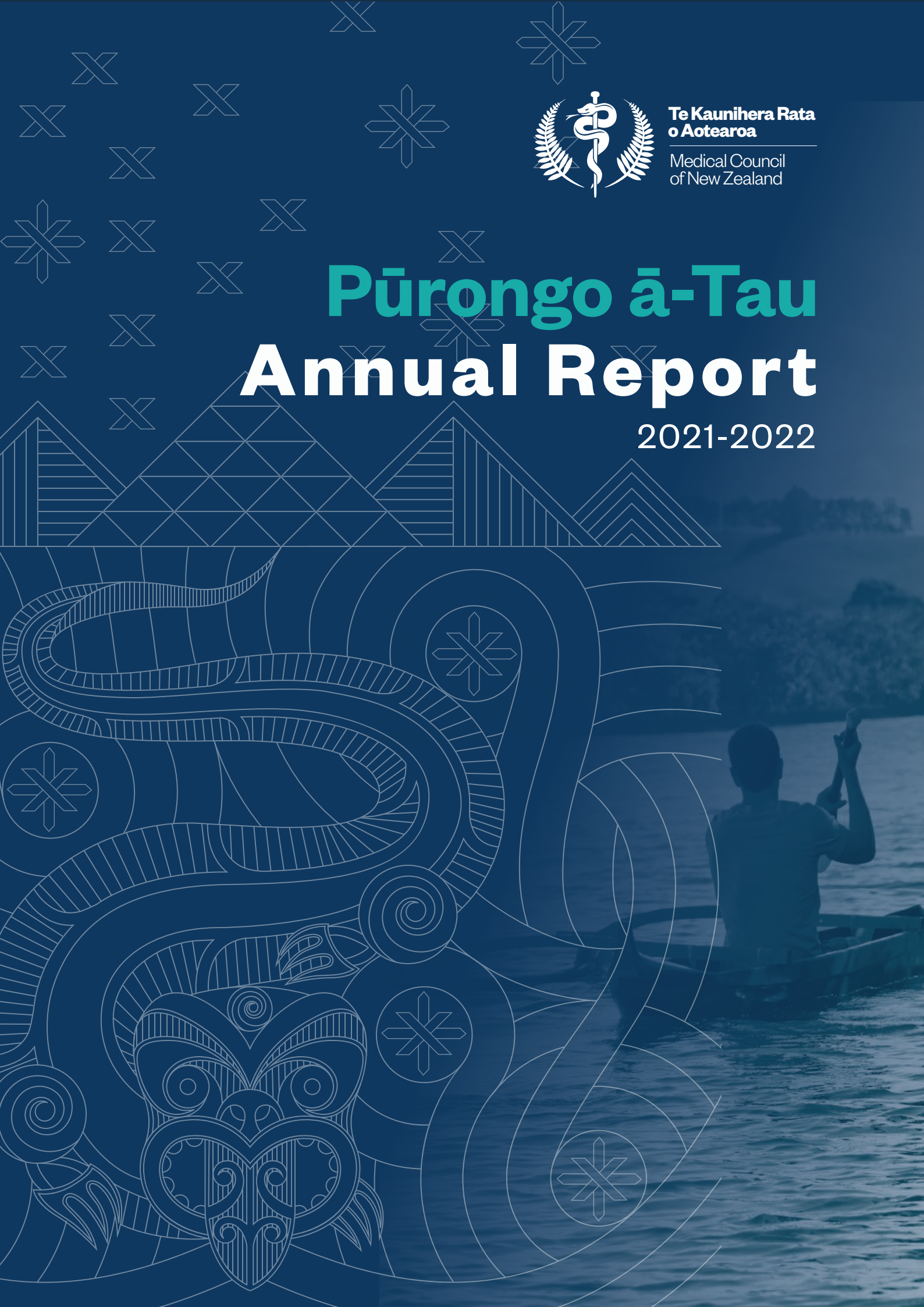
Te Kaunihera Rata o Aotearoa
Medical Council of New Zealand

Pūrongo ā-Tau
Annual Report
2021-2022



Pūrongo ā-Tau 2022

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand, is pleased to submit this report, for the year ending 30 June 2022, to the Minister of Health.

The report is presented in accordance with section 134 of the Health Practitioners Competence Assurance Act 2003.

He Tirohanga Whānui o te Tau
Our Year at a Glance

(1 July 2021 to 30 June 2022)

18,784

Upward trend in the number of registered doctors

In comparison to the year prior, practising doctors on the register increased from 18,250 to 18,784 in 2021/2022.

583

New Zealand trained doctors registered

There was a slight increase in the number of new NZ graduates in 2021/2022 - up from 537 the prevous year.

748

New specialists registered

New specialists registered increased by 40 in 2021/2022 in comparison to the year prior.

237

Notifications related to doctors' performance and conduct

237 notifications were received by Council in 2021-2022. A decrease of 5.2% in comparison to the year prior.

942

International medical graduates (IMGs) registered

IMGs made up over 60% of the new registrations for the year.

99%

IMG applications processed in 20 working days

Our committment to service standards resulted in 99% of applications for IMG's seeking registration in the general or special purposes scopes of practice being processed within 20 working days.

33

Notifications referred to a Professional Conduct Committee (PCC)

Public health and safety is the touchstone against which the Council considers every decision about individual doctors. Council referred 33 notifications to a PCC in 2021-2022, up from 30 during the previous year.

Mai i te Tumuaki
From the Chairperson

Te Kaunihera rata is pleased to present our annual report, Pūrongo ā-Tau 2022.

Te Kaunihera rata is pleased to present our annual report, Pūrongo ā-Tau 2022.

Firstly, I would like to acknowledge and thank you – the people of Aotearoa – for the trust and confidence which you place in us as we regulate the medical profession on your behalf.

Secondly, I would like to thank the medical profession for your continued dedication through the COVID-19 pandemic and in facing up to the many challenges in providing healthcare across our communities.

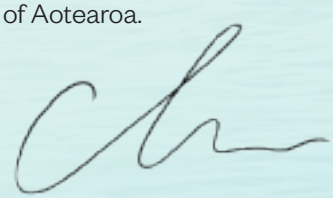
Practising under resource constraints and with workforce shortages, while dealing with the effects of climate change and daily clinical pressures, are enormously difficult. As a practising hospital specialist, I am all too aware of these realities. Nōreira kia manawanui me ngā manaakitanga ki a tātou katoa.

The Medical Council continues to work hard to ensure we are playing our part in addressing these challenges and supporting better, more equitable health outcomes for all New Zealanders. I am thankful that we have been able to register so many new doctors in the past year, both from overseas and locally trained.

Further, we are constantly reviewing our registration processes to ensure they are as timely and "right touch, human touch" as possible at all times, and have made a number of changes to support more doctors to enter practice in Aotearoa.

I am pleased that we have maintained Council's strong financial position while at the same time keeping the annual practising certificate increase under the rate of inflation. This result could not have been achieved without discipline, efficiency, and effective control of our expenses.

Finally, I want to thank Joan and the amazing team of staff for their mahi and values. To Council members past and present, thank you also for your guidance and wisdom in service of the people of Aotearoa.



Dr Curtis Walker
Tumuaki | Chair

Mai i te Manukura
From the Chief Executive Officer

Tēnā koutou katoa

I would like to thank the medical profession for their unfailing focus on the health and safety of the public while dealing with the impact of another year of COVID-19. We recognise that the extraordinary events of the past couple of years have placed a huge strain on the health system and the people who work within it.

Our primary focus has continued to be on public safety. The ongoing challenges for the health system, all health professions, and the regulators of those professions have emphasised the importance of us all working together with agility and responsiveness.

It is the collegiality and strong relationships with others in the sector that have enabled us to continue to support and promote standards of good medical practice.

18,784

We have more doctors than ever before.

Workforce

We have more doctors than ever before. There were 18,784 practising doctors on the register at 30 June 2022, an increase of 534 doctors since last year.

However, this was not sufficient to alleviate current workforce pressures.

60%

of new registrations were International medical graduates.

International medical graduates (IMGs) play a crucial and substantial role in the medical workforce, making up over 60 percent of new registrations for the year and over 40 percent of the overall number of doctors.

Recognising this, we have commenced a review and refresh of pathways to registration to ensure they are fit for purpose and do not pose barriers for IMGs looking to gain registration.

We also approved a pilot scheme to support IMGs who have passed NZREX to work in primary care for the majority of their two-year internship.

As part of our ongoing COVID-19 response, in liaison with the Director-General of Health, we extended our pandemic special purpose scope of practice to allow doctors who were no longer on the register to gain registration quickly.

Additional flexibility was also extended to enable interns to support the COVID-19 response in a range of settings.

We continue to work closely with our new national health authorities;

- Te Whatu Ora – Health New Zealand, and
- Te Aka Whai Ora – Māori Health Authority

on matters relating to workforce.

This includes a review of our prevocational medical training framework (that guides the training and education of interns over their first two years of practice) and will take into account the changes underway in the health system.

Strategic plan 2022 – 2027

Over 2021/2022, Council reconfirmed its strategic direction and developed a strategic plan that lays out our strategic intentions for the next 3–5 years and details our outputs for the next 1–2 years.

The strategic priorities focus on;

- accountability
- equity
- right-touch regulation.

Our commitment to Te Tiriti o Waitangi is an overarching principle and key priority for all our work.

Te Tiriti o Waitangi and Health Equity

Addressing health equity and embedding cultural safety have remained a high priority across all of our regulatory functions. This includes embedding Te Tiriti principles within all of our processes.

We have initiated the development of a Te Tiriti framework to guide our work, and we are grateful for the support we have received from Te Ohu Rata o Aotearoa – Māori Medical Practitioners Association in this important mahi.

In addition, our strengthened standards for recertification ensure that there is a clear focus on cultural safety and health equity for all doctors, through their continuing professional development and lifelong learning.

An organisational cultural capability framework has been embedded within our overarching organisational capability framework.

Training in Te Tiriti, te ao Māori, te reo Māori, unconscious bias and cultural safety continued to be rolled out to all staff.

Collaborative working

We have continued to work closely with the other Regulatory Authorities (RAs). For example, we contributed to the establishment of an inter-RA Māori leads group and actively support it. This group meets monthly to consider matters relating to Te Tiriti, cultural safety and health equity.

We have also been co-leading a project (with the Pharmacy Council) to develop a joint prescribing standard across the seven RAs whose professions prescribe.

In responding to COVID-19, we collaborated closely with the Ministry of Health, other agencies and regulatory colleagues in New Zealand and internationally.

This included changes to a number of standards for the profession, such as prescribing and telehealth, to support new ways of working.

We continued to maintain close strategic alignment with international regulatory colleagues and ensured that international regulatory best practice informs all of our strategic, policy and operational work.

I hold the position of Chair-elect on the International Association of Medical Regulatory Authorities (IAMRA) and members of Council's Executive Leadership team sit on IAMRA Committees.

Regulatory Authority Review 2021

An amendment made to the Health Practitioners Competence Assurance Act 2003 (HPCA Act) in April 2019 requires all regulatory authorities operating under the Act to undergo a review of how effectively and efficiently they are performing their functions. Our performance review was undertaken August–December 2021.

The independent reviewer, BSI Group NZ Ltd, assessed the Council's performance against a full set of core performance standards. These standards were established by the Ministry of Health for all the authorities that align with the functions under section 118 of the HPCA Act. The final report can be found on our website.

The review confirmed that the Council complies with the functions set out in the HPCA Act. There was only one recommendation for improvement.

BSI noted the Council's initiative in employing our new senior leadership position, Kaitiaki Mana Māori, to support the principles of equity and Te Tiriti o Waitangi and to provide cultural support with the strategic direction.

BSI recommended that the Council 'continue this positive mahi with the Kaitiaki Mana Māori providing the leadership to further build the organisational commitments for Te Tiriti o Waitangi and the capacity and capability in te ao Māori.'

The Council accepted the recommendation and has implemented it. The Council's strong organisational commitment to Te Tiriti o Waitangi and building capacity and capability within Council in relation to te ao Māori remains ongoing.

Recognition and thanks

I would like to recognise our staff team for their diligence and dedication through increased COVID-19 related workloads while also experiencing personal ill-health and disruption due to COVID-19. I am privileged to lead such an outstanding team.

I would also like to recognise Kath Fox, who was Deputy Chair of Council and sadly passed away on 9 January 2022. Kath made a significant contribution to Council's work and is missed very much by me and all of the staff.

Finally, a thank you to our Chair, Dr Curtis Walker and Deputy Chair, Kim Ngarimu and all Council members for their ongoing support, their commitment to public safety, and their professionalism in dealing with the tremendous workload over the past year.

Joan Simeon
Manukura | Chief Executive

He Rārangi Upoko
Contents

Mō Mātou
About Us

Council's primary purpose is to protect the public health and safety of New Zealanders by ensuring doctors are competent and fit to practise.

Whether it's assessing a doctor's performance or omoting good medical practice that reflects the expectations of New Zealand communities, all our decisions are based on the principles of right touch regulation – an internationally tried and tested decision-making model for regulators.

How we make our decisions

Proportionate
- We will identify risk. Decisions will be proportionate to the risk posed.

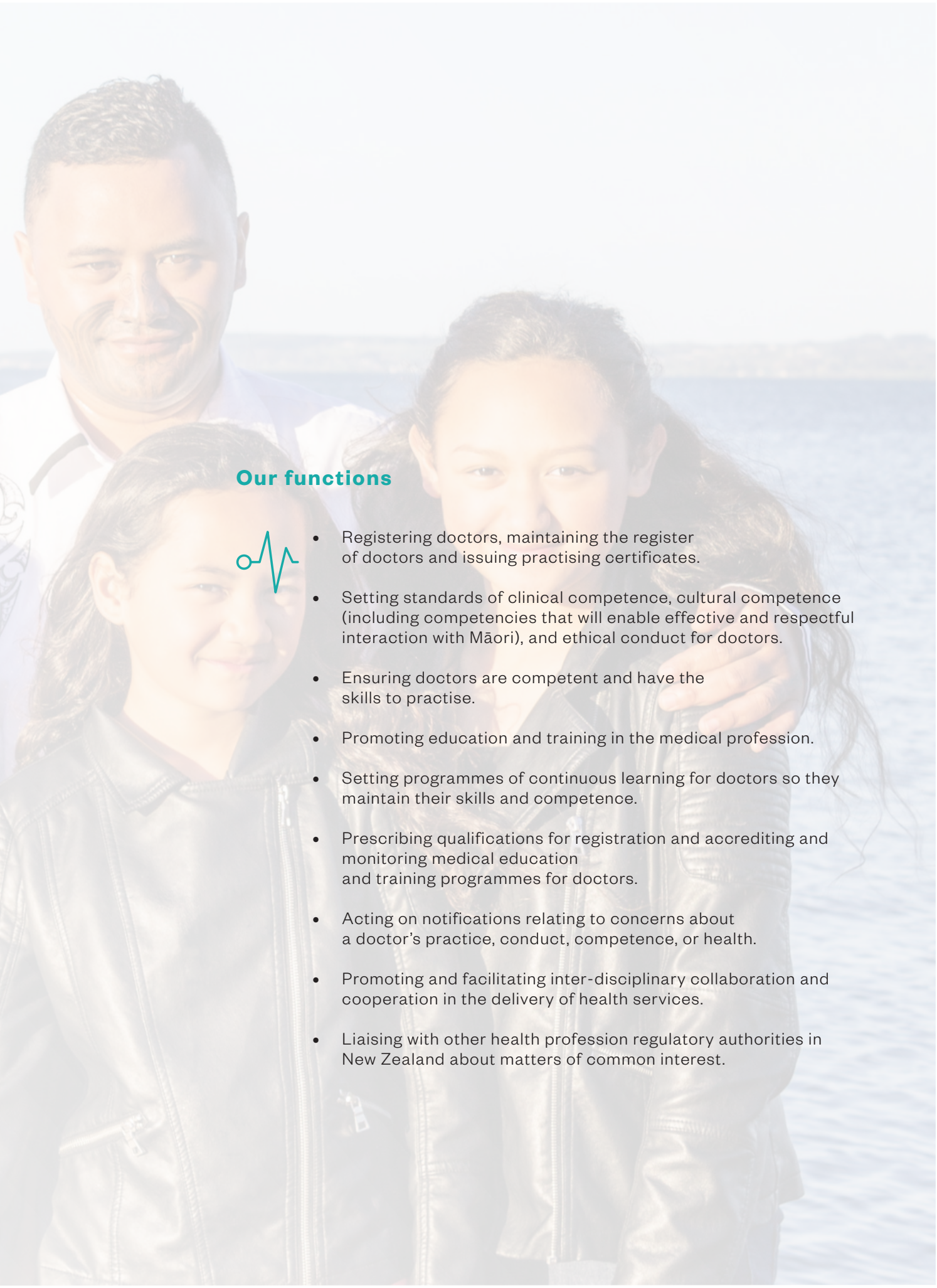
Consistent
- Our policies, standards and decisions will be based on the principles of fairness and consistency.

Targeted
- We will focus on the problem and minimise the side effects.

Transparent
- We will be open and transparent and keep our regulations simple and user-friendly.

Accountable
- We make sure our decisions and actions are robust and stand up to scrutiny.

Agile
- We will be forward thinking and adapt to and anticipate change.



Our functions

- Registering doctors, maintaining the register of doctors and issuing practising certificates.
- Setting standards of clinical competence, cultural competence (including competencies that will enable effective and respectful interaction with Māori), and ethical conduct for doctors.
- Ensuring doctors are competent and have the skills to practise.
- Promoting education and training in the medical profession.
- Setting programmes of continuous learning for doctors so they maintain their skills and competence.
- Prescribing qualifications for registration and accrediting and monitoring medical education and training programmes for doctors.
- Acting on notifications relating to concerns about a doctor's practice, conduct, competence, or health.
- Promoting and facilitating inter-disciplinary collaboration and cooperation in the delivery of health services.
- Liaising with other health profession regulatory authorities in New Zealand about matters of common interest.

Ngā Tumu o Te Kaunihera
Our Council Members

Richard Aston
(Lay Member)

Dr Stephen Child
MD 1986 Ottawa, FRCP(C) 1991, FRACP 1995

Dr Kenneth (Ken) Clark
MB ChB 1981 Otago, FRANZCOG 1989, FRACMA 2012

Dr T. Lu'isa Fonua-Faeamani
MBChB 1998 Otago, FRNZCGP 2007

Dr Ainsley Goodman
MB ChB 1994 Otago, FRNZCUC 2006, FRNZCGP 2017

Dr Pamela Hale
MBChB Otago 1982, FRACP 1991

Dr Charles Hornabrook
MBChB Otago 1985, FRANZCP 1999

Dr Rachelle Love
MB ChB 2002 Auckland, FRACS 2017

Giselle McLachlan
LLB, CFInstD (Lay Member)

Kim Ngārimu
BBS (Lay Member)
Tumuaki Tuarua | Deputy Chair

Dr Curtis Walker
MB ChB 2007 Auckland, FRACP 2015
Tumuaki | Chair

Ms Joan Simeon
MPM
Manukura | Chief Executive Officer

Mr David Dunbar
LLB, B.Com
Pouroki | Registrar

He Paetae Matua
Key Achievements

> *'Relationships throughout the sector are well established and the Council applies a continuous improvement approach that is informed by changes in the sector and ongoing developments in its regulatory functions.' MCNZ RA Review, 2021, p2.*

Accountability

- Our Responsible Authority (RA) performance review (conducted by BSI Group NZ Ltd and overseen by the Ministry of Health) took place in August 2021 and is published on our website.

  We were pleased to receive only one recommendation as an outcome of the review. This related to our intention to establish a new senior position to support the principles of equity and Te Tiriti o Waitangi. The Kaitiaki Mana Māori has now been appointed and sits on the Executive Leadership Team.

- In December 2021, a memorandum of understanding between Council and the district health boards was signed to commit the two bodies to work together across several areas, including intern training, to ensure doctors are safe and competent to practise, and the public is protected.

- As in previous years, we provided relevant, useful and timely information to the medical profession and the health sector.

For example:

We published our 2021 Medical Workforce Survey report providing medical workforce demographics and insights.

We provided guidance via our newsletter MCNews and our website on 'Informed consent and providing care in a teaching environment'; COVID-19 response guidance about doctors' duty of care in relation to positive test results; and on the End of Life Choice legislation and implications for doctors.

- The Consumer Advisory Group contributed to our strategy and policy development as well as providing valuable input into the revision of several professional standards for the profession.

> *'Policies, statements, standards and processes consistently recognise the Council's principal "purpose to protect public safety and demonstrate the principles of right-touch regulation.'*
> *MCNZ RA Review, 2021, p1.*

> *'The Council is currently employing a new senior leadership position, Kaitiaki Mana Māori, to support the principles of equity and Te Tiriti o Waitangi. This role will be able to provide cultural support with the strategic direction.'*
> *MCNZ RA Review, 2021, p2.*

Equity

- We ensured that there is a clear focus on cultural safety and health equity for all doctors in strengthened standards for recertification and lifelong learning (effective 1 July 2022).

  These recertification standards drive quality lifelong learning for the profession, providing assurance of competence.

- We ensured that Māori medical graduates are well supported when they transition from medical student to intern.

- We provided training to our Professional Conduct Committee, Professional Assessment Committee and Vocational Practice Assessment members to build their knowledge of cultural safety, Te Ao Māori world view and Te Tiriti o Waitangi.

- We developed a pilot series of 'Welcome to practice in Aotearoa New Zealand' workshops for IMGs new to practice in this country.

  The workshops were designed to improve understanding of cultural safety and health equity, and ethical issues to support safe integration to medical practice in Aotearoa New Zealand. We are now considering how these workshops can be sustainably rolled out to all IMGs beginning practice.

Right-touch regulation

- We set up a new Policy Working Group comprising three Council members and senior staff to support the development of Council statements and standards.

  This group provided invaluable support and direction throughout the year. We consulted on and published the following updated statements:

  1. Responsibilities of doctors in management and governance
  2. Use of internet and electronic communication
  3. Conducting medical assessments for third parties
  4. What to do when you have concerns about another doctor
  5. When another person is present in a consultation.
  6. Advertising

- We made submissions on a range of consultations, including the draft consumer/whānau code of engagement and the Pae Ora (Healthy Futures) Bill.

- Council appeared before the Royal Commission of Inquiry on Abuse in Care on matters relating to the Lake Alice Child and Adolescent Unit hearing. We apologised and acknowledged the pain and suffering of all survivors who experienced abuse while in State care, including those at Lake Alice Hospital.

Te Mahere Rautaki
Strategic Plan 2022-2027

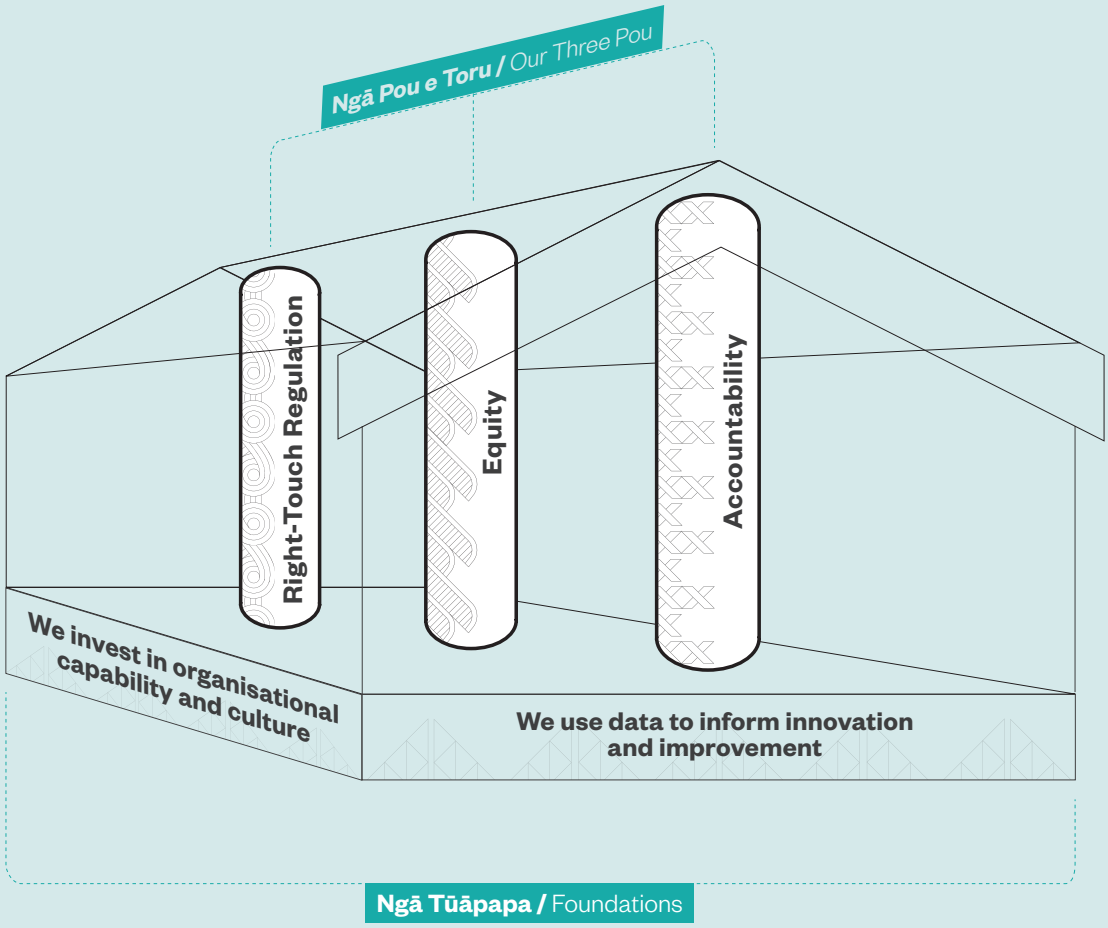
Te Moemoeā / Vision

Kia whakawhirinakitia ngā rata katoa i Aotearoa.
A medical profession all New Zealanders can trust.

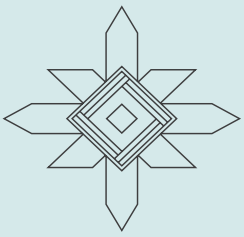
Tō Mātou Kaupapa / Our Purpose

Kia tūhauora, kia haumaru ai te iwi, mā te whakatū, whakatuarā ngā paerewa mo ngā rata i Aotearoa.

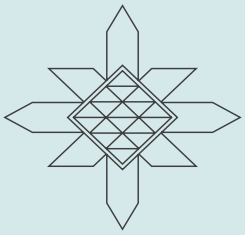
We serve Aotearoa New Zealand by protecting public health and safety through setting and promoting standards for the medical profession.



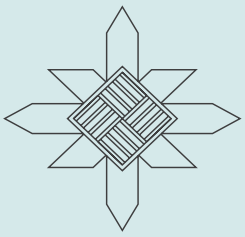
Ā Mātou Uara
Our Values



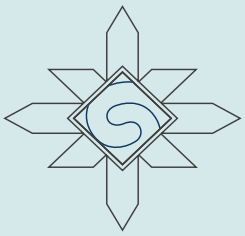
Whakapono
We act with integrity



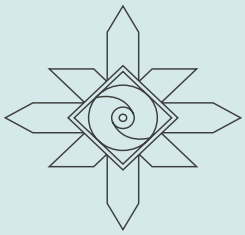
Whakamārama
We lead by listening



Kotahitanga
We are a team



Manaakitanga
We support each other



Kaitiakitanga
We protect the public

'Mā ēnei whakaarotau rautaki, me whakatutuki te moemoeā, me whakamahia te kaupapa, me whakamana Te Tiriti o Waitangi, a, kia toitū te rōpū.'

'We will achieve our vision, deliver on our purpose, uphold the mana of Te Tiriti o Waitangi, and be a sustainable organisation through our strategic priorities.'

Te Whakaurunga
Registration

He Tirohanga Whānui o te Tau
Our Year at a Glance

(1 July 2021 to 30 June 2022)

Increase in total number of registered doctors

There were 18,784 practising doctors on the register at 30 June 2022, an increase of 534 doctors on the year prior. This increase reflects a greater number of international medical graduates (IMGs) as well as New Zealand graduates gaining registration and holding current practising certificates.

The number of new registrations rebounded

The number of new registrations dipped in 2020/21, mainly due to COVID-19 travel restrictions. This is beginning to rebound in 2021/22, most notably amongst provisional general registrations for IMGs.

40% of practising doctors are International medical graduates (IMGs)

IMGs make up over 40 percent of practising doctors in New Zealand. We registered 942 new IMGs in 2021/22, compared to 851 in 2020/21, through a range of different pathways. This is an increase of 91 IMG registrations, compared to last year.

Increase in specialist IMGs

There has been an increase in specialist IMGs gaining provisional vocational registration. This is a positive sign for New Zealand's healthcare system and may suggest that more specialist IMGs are interested in making a long-term commitment to practising medicine in New Zealand.

Te Rōpū Whakaurunga Registration Committee

Dr Curtis Walker (Chair)
MB ChB 2007 Auckland,
FRACP 2015

The Registration Committee (the Committee) was established in November 2019.

Its role is to consider applications for registration from medical students identified by medical schools' Fitness to Practise Committees as having missed several weeks of elective practice.

The Committee did not meet during this reporting period.

Dr Curtis Walker
Chair
Registration Committee

Principal activities

- All doctors who practise medicine in New Zealand must be registered by Council and hold a practising certificate. Registration ensures that a doctor is fit to practise medicine and is competent to practise safely.
- Practising doctors must comply with Council's recertification requirements including continuing professional development to demonstrate that doctors are maintaining competence and staying up to date.
- Council's registration team considers applications for registration, renews practising certificates, issues certificates of professional status (good standing), and develops registration policy.

Service standards

99%

IMG general and special purpose registration applications processed in

We are committed to processing applications for doctors seeking registration in the general and special purpose scopes of practice within 20 working days of receiving a completed application.

We achieved this goal in 99 percent of cases in 2021/22.

It takes longer to process applications for registration within a vocational scope of practice. These require a more detailed assessment.

For this assessment we must consult the relevant specialist college. On average, it takes four to six months to confirm a doctor's eligibility for registration.

We processed 84 percent of applications within our six-month service standard in 2021/2022.

IMG retention rate is low

40%

Many IMGs only stay in New Zealand for a short period, with less than 40% remaining two years after gaining registration.

While we register a significant number of IMGs each year, many IMGs do not remain practising in New Zealand long term.

Just over 60 percent of IMGs remain in New Zealand one year after they are registered. This drops to less than 40 percent after two years, and then continues to drop more gradually until around 25 percent remain after 10 years.

The retention rate is considerably higher for new NZ graduates. Almost all NZ graduates are retained for two years after initial registration (98.9 percent).

As with IMGs, there are then more gradual drops each year. After 10 years, over three quarters of doctors who are New Zealand graduates are still retained (76.3 percent).

He Raraunga Kaimahi
Workforce Data

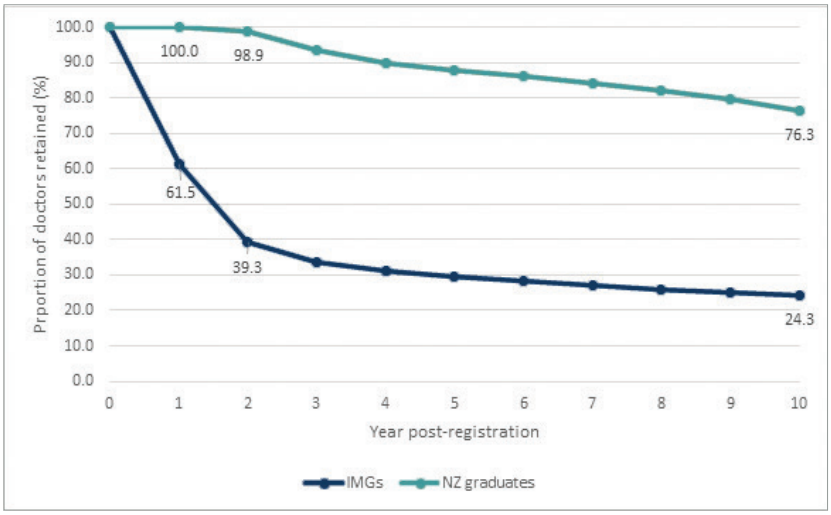
New registrations issued by year and scope (1 July 2018 to 30 June 2022)				
Broad scope	2018/19	2019/20	2020/21	2021/22
General	90	88	75	90
Provisional general (IMGs)	742	679	499	631
Provisional general (NZ and Australian graduates)	508	521	527	566
Provisional vocational (IMGs)	103	110	154	152
Special purpose	178	178	132	109
Vocational (VOC1)[1]	421	481	491	465
Vocational (VOC2)[2]	46	80	91	111
Total	2,088	2,137	1,969	2,124

[1]VOC1 applications are made by doctors who are already registered within the general scope of practice; typically, they have recently completed a NZ/Australasian college vocational training programme.

[2]VOC2 applications are made by doctors who are not registered; typically, they are made by doctors who have completed an Australasian college vocational training programme in Australia.

Retention

Retention of IMGs and NZ graduates after initial registration between 2000 and 2021



See more workforce data at pages 64 - 86

Mātauranga | Ngā Whakamatautau
Education | Examinations

Te Rōpū Mātauranga
Education Committee

Dr Kenneth (Ken) Clark (Chair)
MB ChB 1981 Otago, FRANZCOG 1989, FRACMA

The Education Committee is a standing committee of Council. Its primary purpose is to accredit and monitor medical education providers, including medical schools, prevocational medical training providers and vocational training providers (medical colleges).

This ensures medical students and doctors receive high-quality education and training across the education continuum for their primary medical qualification, prevocational training as interns, and vocational training.

Our mahi over the last 12 months has focused on adapting our accreditation framework to ensure accreditation remains robust and fit for purpose.

We aim to:

- ensure the accreditation system aligns with the changes to the new health system, reflecting Te Whatu Ora | Health New Zealand, Te Aka Whai Ora | Maori Health Authority and the other new health structures
- use the opportunity to further develop and emphasise key aspects of prevocational medical training, for example the focus on cultural safety and health equity
- ensure that interns continue to receive high-quality medical education and training.

Over the last year, we have been pleased to welcome two new members to the Education Committee: Dr Karleigh O'Connor as the PGY1 intern member, and Professor Phillippa Poole as the medical academic member. Our new and existing members bring a wealth of knowledge and experience to the Committee.

We farewelled Dr Fraser Jeffery, who served as the intern member from 2020 and was a valued member of several prevocational assessment teams.

I would like to recognise the ongoing contribution made by all those committed to medical education in Aotearoa New Zealand.

He Paetae Matua
Key Achievements

(1 July 2021 to 30 June

Education

- We assessed three prevocational medical training providers against the accreditation standards: Northland, Waikato and Lakes. All three providers either met or substantially met the standards.
- We assessed one medical college against the accreditation standards for New Zealand training providers of vocational medical training and recertification programmes: the NZ College of Public Health Medicine (NZPHM), who substantially met the standards.
- We held three virtual meetings for prevocational educational supervisors (PES) in 2021, providing vital training and networking opportunities. Topics discussed included community-based attachments, Te Tiriti o Waitangi, learning activities and multi-source feedback for interns.

We implemented an annual reporting process for prevocational medical education providers to better monitor their training programs. The first reports were due on 30 June, 2022.

- We appointed 26 new prevocational educational supervisors from 12 regions. PESs are vocationally registered doctors appointed by Council to provide educational supervision, pastoral care, and support to a group of up to 10 interns over a year.
- We accredited 35 clinical attachments, 11 of which were community-based, to provide quality learning, supervision, and assessment for interns during their PGY1 and PGY2 years. These clinical attachments offer a range of clinical training and experience, and each attachment is accredited by Council.

Examinations

- In June 2022, the New Zealand Registration Examination (NZREX) was held, with 28 candidates taking the examination and 78% passing.
- We consulted on NZREX eligibility requirements, inviting stakeholders to consider the introduction of a 'clinical practice' requirement.
- We strengthened the verification of applicants' credentials by requiring applicants to complete primary source verification of their qualifications through the Educational Commission for Foreign Medical Graduates (ECFMG) EPIC system.
- We supported the development of a pilot programme at Waikato DHB for a primary care-focused internship for doctors who have passed NZREX.

He Waka Eke Noa
Travelling Forward Together

Australian and New Zealand Prevocational Medical Education Forum

Council hosted the 25th Australian and New Zealand Prevocational Medical Education Forum (ANZPMEF or Forum), held virtually on 18 and 19 October 2021.

The ANZPMEF is an annual trans-Tasman conference that is hosted in turn by members of the Australasian Confederation of Postgraduate Medical Education Councils (CPMEC).

ANZPMEF provides the opportunity to support and further develop high-quality prevocational medical education, and for Aotearoa New Zealand and Australian colleagues to share the latest innovations, research, and initiatives.

The Forum theme was 'Travelling forward together – he waka eke noa'. The three subthemes were Transitions and Innovations, Health Equity and Cultural Safety, and Professionalism and Wellbeing.

We were thrilled to have high calibre keynote addresses delivered by Dr Jason Frank (Canada), Professor Trudie Roberts (UK) and Dr Rhys Jones (Aotearoa). The additional panel presentations ncouraged thought-provoking discussion. We were fortunate to have panellists who have extensive expertise and a depth of medical education knowledge and experience and they reflected trans-Tasman perspectives.

The Forum programme was very well received by the almost 400 delegates.

See more workforce data at pages 64 - 86

Te Hauora Health

He Tirohanga Whānui o te Tau
Our Year at a Glance

(1 July 2021 to 30 June

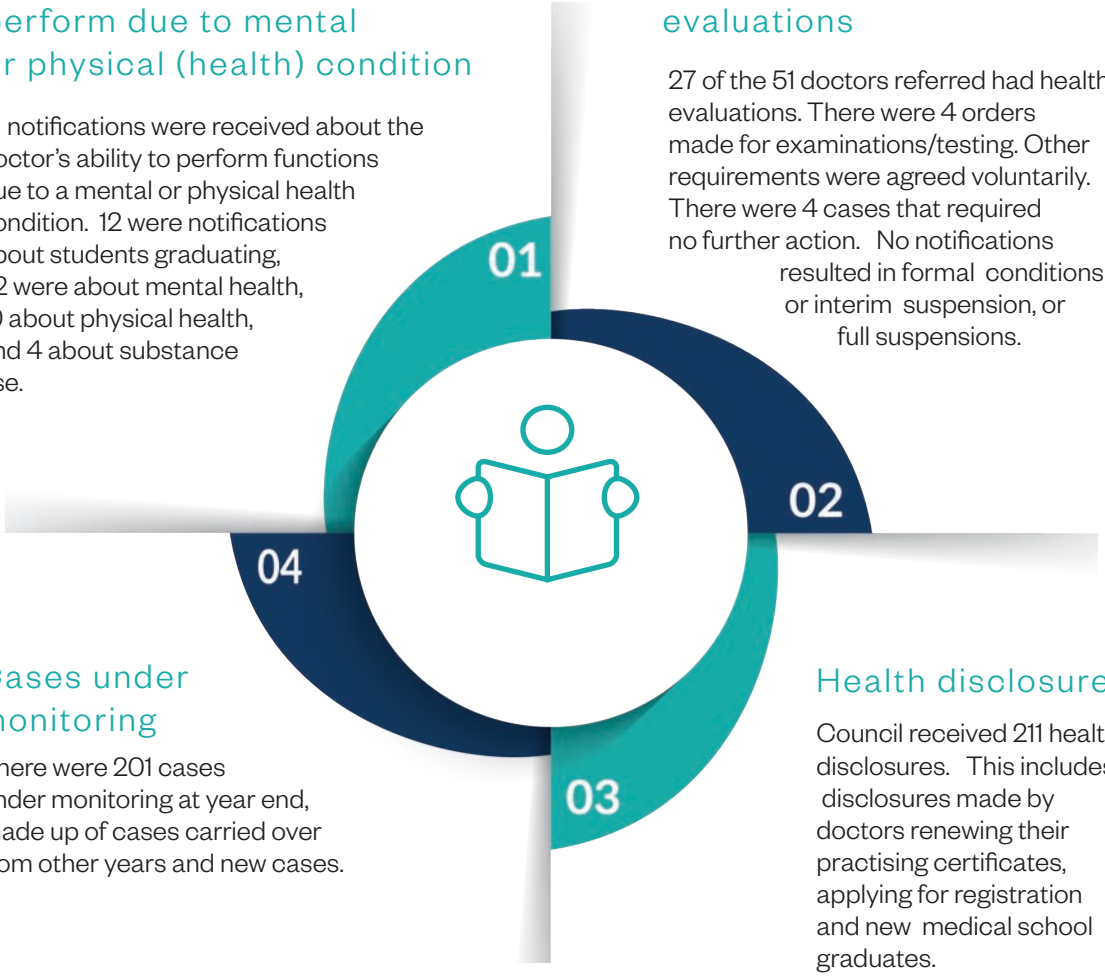
463 cases related to doctors' health were overviewed in 2021/2022

Notifications of inability to perform due to mental or physical (health) condition

51 notifications were received about the doctor's ability to perform functions due to a mental or physical health condition. 12 were notifications about students graduating, 22 were about mental health, 10 about physical health, and 4 about substance use.

Doctors referred to health evaluations

27 of the 51 doctors referred had health evaluations. There were 4 orders made for examinations/testing. Other requirements were agreed voluntarily. There were 4 cases that required no further action. No notifications resulted in formal conditions or interim suspension, or full suspensions.



Cases under monitoring

There were 201 cases under monitoring at year end, made up of cases carried over from other years and new cases.

Health disclosures

Council received 211 health disclosures. This includes disclosures made by doctors renewing their practising certificates, applying for registration and new medical school graduates.

Te Rōpū Hauora
Health Committee

Dr Pamela Hale (Chair)
MBChB Otago 1982, FRACP

The Health Committee (Te Rōpū Hauora) acts on behalf of Council by reviewing all notifications/concerns about a doctor's health that may affect their ability to safely practise medicine. It comprises up to five members of Council representing different medical specialties, including a minimum of one lay person. Ideal medical members include a psychiatrist, GP and a hospital specialist to get a broad understanding of the work undertaken by different types of doctors.

Over the last year we have been saddened by the loss of Kath Fox our lay person member. We are very pleased to have Kim Ngārimu now contributing in this role, which is necessary to be quorate.

We usually receive notifications from the doctor with the health problem themselves, or alternatively from concerned colleagues. There were 51 new referrals in the year ending 30 June 2022 .

Our role is to decide whether the doctor's health condition could adversely impact their work. If concerned about this, we will arrange for an assessment by an independent practitioner in a specialty relevant to the illness of concern.

This independent doctor is nominated by the Committee, but also agreed to by the referred doctor. The assessors' conclusions and advice, particularly around enabling the doctor to work safely, informs our decision making.

We are grateful for the quality of these assessments and the professionalism of our regular assessors. It is unusual that a doctor may be required to stop work until their health improves.

We meet monthly to discuss doctors who have been referred, and to regularly review the progress of doctors under our supervision. The Committee also considers applicants' health disclosures on applications for registration, as well as practising certificates, and gives advice to Council's Registrar and Council on these. In total, there were 211 disclosures reviewed.

Conditions most likely to require the Committee's oversight include mental illnesses such as severe depression and bipolar illness, drug and alcohol dependence, neuropsychiatric conditions such as dementia, head injuries, and progressive physical conditions such as Parkinson's disease.

We are very fortunate to have a highly skilled team in the office to support the Committee. They perform their work with sensitivity, compassion, and professionalism. The work can be stressful especially when dealing with vulnerable and distressed doctors, anxious to maintain their careers. The team liaises directly with the doctors, organising assessments, coordinating treatment and any work supervision needed. They may need to arrange drug and alcohol screening, respond to any concerns or health crises; and keep the Committee informed.

We carefully balance any risks to patient safety with compassionate management of the doctor, encouraging and facilitating treatment of their health condition.

2022 has been another challenging year with only a few meetings being held face-to-face. The rest occur by videoconferencing, which is functional but does not facilitate the same level of rapport.

Our fundamental role is public safety, ensuring doctors are not impaired at work, but it is also very rewarding for the team when we are able to assist doctors to carry on or return to their profession.

Notifications

Zero

There were no health related notifications in 2021/2022 that resulted in formal conditions, interim suspension, or full restrictions.

The Health Committee had an overview of 463 cases related to doctors' health in the 2021–2022 year.

51 notifications were received outlining concerns about the doctor's ability to perform the required functions due to a mental or physical health condition. Just under 40 percent of those were from the doctor themselves.

The Universities of Auckland and Otago (education programmes) made 12 notifications about students graduating in 2021 or early 2022. Of these 11 had mental or psychological problems, and one had a physical issue. All were able to be registered.

Of the other 39 notifications, 22 were about mental health, ten about physical health, and four about substance use.

The remaining three were alcohol-related convictions referred under section 67A (the Health Evaluation pathway). There were 22 doctors who were not practising and were on sick leave when the notification was received.

27 of the 51 doctors referred had health evaluations. There were four orders made for examinations/testing under s49(1) of the HPCAA. Other requirements of the Committee were agreed voluntarily. The process where doctors agree to medical examination closely aligns to that in section 49 of the HPCAA. 66 reports were obtained from treating clinicians, occupational physicians, and other health professionals.

Four cases required no further action. There were no notifications in 2021/2022 that resulted in conditions, interim suspension, or full suspention.

Where the Committee imposes formal requirements, we usually implement these through a confidential agreement with the doctor, unless it is in the interests of the public to have conditions published.

Disclosures

211

Council received 211 health disclosures in 2021/2022.

Disclosures were made by doctors renewing their practising certificates, doctors applying for registration (usually IMGs), and new medical school graduates applying to begin their PGY1 year.

Most issues disclosed by new graduates were psychological rather than physical, reflecting their comparatively young age. This was also true for disclosures from doctors applying for registration, but the gap between psychological and physical was smaller.

Applicants for registration will have a wider age spread compared to new graduates. For disclosures made on practising certificate renewals, physical issues outnumbered psychological ones. This group will have the widest age spread, including doctors at all stages of their careers.

Monitoring

There were 201 cases under monitoring at year end, made up of cases carried over from other years and new cases.

He Raraunga Kaimahi
Workforce Data

Notifications of inability to perform required functions due to mental or physical health condition (1 July 2019 to 30 June 2022)				
Source	2019	2020	2021	2022
Health service	2	2	2	0
Health practitioner	29	29	31	20
Employer	7	7	16	6
Medical Officer of Health	-	-	-	0
Other person	2	2	-	1
Education programme[1]	2	2	2	12
Council	-	-	0	5
Ordered health evaluation	-	-	-	3
Treating doctor	-	-	-	4
Total	42	42	62	51

Outcomes of health notifications[1]				
Outcome	2019	2020	2021	2022
No further action	4	4	9	4
Order medical examination section 49(1)[2] HPCAA	-	-	-	4
Interim suspension section 48(1)(a) HPCAA	24	0	34	0
Conditions section 48(1)(b) HPCAA[3]	-	24	-	0
Restrictions imposed section 50(3) or (4)	-	-	1	-

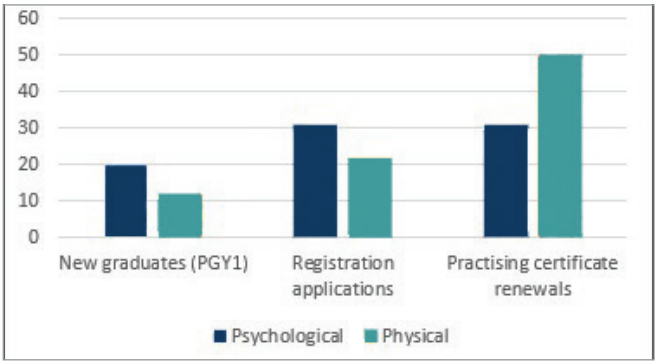
[2] 21 assessments were agreed voluntarily.

[1] A health notification may result in more than one outcome. For example, a doctor subject to 'interim suspension' will also have an assessment to ensure fitness to practise.

[3] Achieved through voluntaryagreement.

Health disclosures by source and type

(1 July 2021 to 30 June 2022)



Te Āheinga me te Whanonga Performance and Conduct

He Tirohanga Whānui o te Tau
Our Year at a Glance

(1 July 2021 to 30 June 2022)

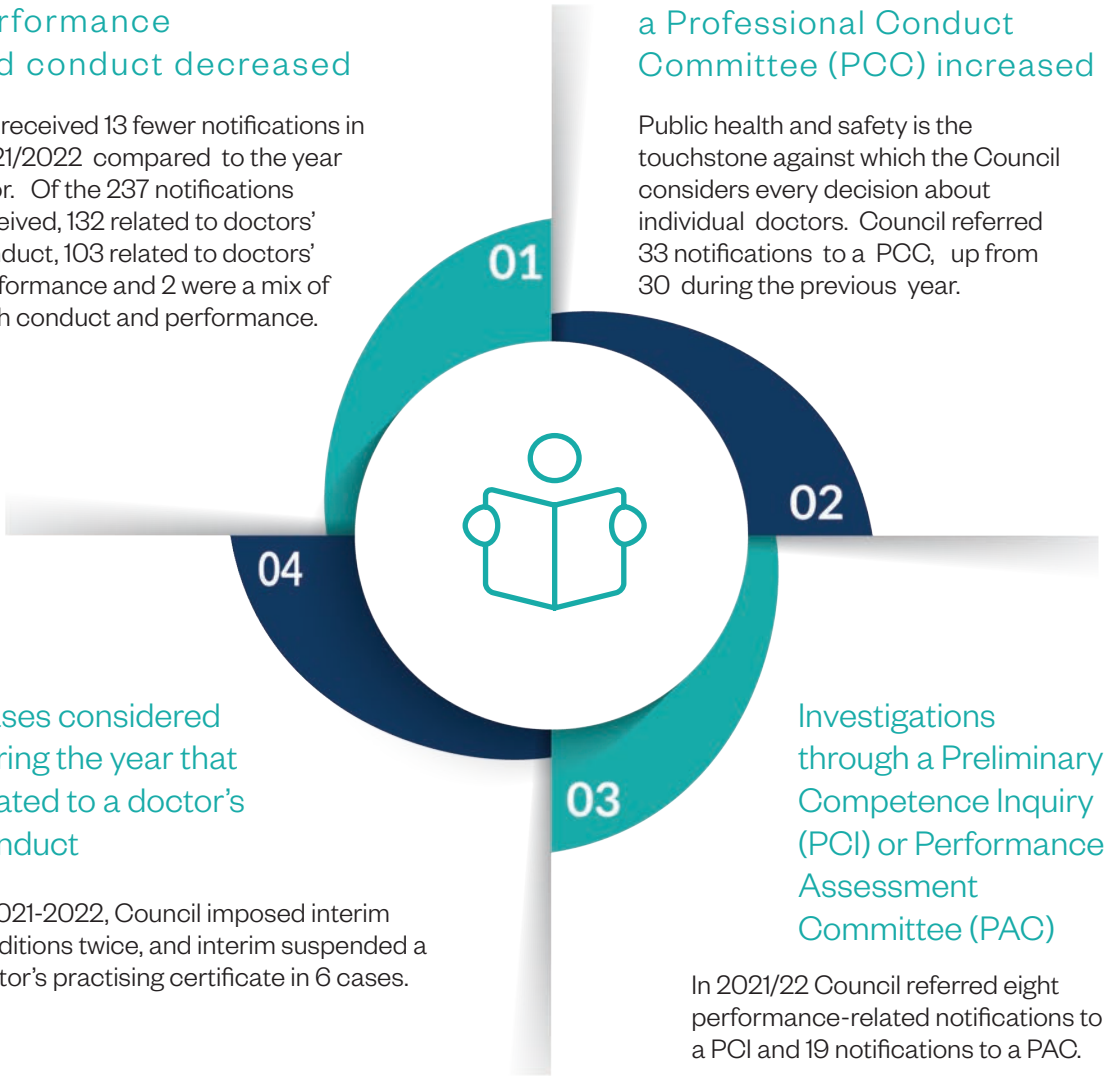
We received 237 notifications in 2021/2022

Notifications about performance and conduct decreased

We received 13 fewer notifications in 2021/2022 compared to the year prior. Of the 237 notifications received, 132 related to doctors' conduct, 103 related to doctors' performance and 2 were a mix of both conduct and performance.

Notifications referred to a Professional Conduct Committee (PCC) increased

Public health and safety is the touchstone against which the Council considers every decision about individual doctors. Council referred 33 notifications to a PCC, up from 30 during the previous year.



Cases considered during the year that related to a doctor's conduct

In 2021-2022, Council imposed interim conditions twice, and interim suspended a doctor's practising certificate in 6 cases.

Investigations through a Preliminary Competence Inquiry (PCI) or Performance Assessment Committee (PAC)

In 2021/22 Council referred eight performance-related notifications to a PCI and 19 notifications to a PAC.

Professional Standards Team principal activities (performance and conduct)

The Professional Standards Team will:

- receive notifications and referrals of concerns
- support the Notifications Triage Team
- maintain assessment tools and policy on performance assessment
- establish Performance Assessment Committees (PACs) and Professional Conduct Committees (PCCs)
- establish individual education programmes and recertification programmes, following performance assessments
- monitor doctors who are subject to conditions arising from competence and conduct concerns and disciplinary action.

Notifications

34

The team experienced a surge in enquiries and questions relating to COVID-19 . 34 notifications were received in 2021/2022.

In 2021/22 the team experienced a surge in enquiries and questions relating to COVID-19 vaccinations, vaccination certificates, mandates, prescribing and misinformation. In addition, here were 34 notifications related to COVID-19 in 2021/2022.

Notifications are broadly categorised into whether they relate to a doctor's competence or conduct. Some cases will include a combination of competence and conduct concerns.

We received 237 notifications in 2021-2022. Of these, 132 related to doctors' performance (competence) or conduct. 103 related to doctors' performance and two were a mix of both conduct and performance.

Performance

19

Council referred 19 notifications to PACs during 2021–2022.

When receiving notifications or referrals that relate to a doctor's competence to practise, we consider whether the circumstances raise questions about deficiencies in the doctor's competence.

Investigating doctors' competence (PCIs and PACs)

Where questions are raised about a doctor's competence, Council will investigate through either a Preliminary Competence Inquiry (PCI) or Performance Assessment Committee (PAC).

In 2021/22 Council referred eight performance related notifications to a PCI and 19 notifications to a PAC. PACs are ordered more often for males than females.

The 2019–2020 year is a notable exception where the proportions were even.

Females make up around 46 percent of the overall workforce, so are relatively underrepresented amongst PACs ordered.

Overlap with the Health and Disability Commissioner (HDC)

There is some overlap between the roles of Council and the HDC. The HDC is responsible for investigating specific incidents in the first instance, but sometimes notifications are made to both organisations. In these cases, Council will often await the outcome of the HDC's investigation. This outcome occurred for 50 performance-related notifications in 2021-2022.

Table 3 (page 41) shows the number of cases considered by Council during the year that related to a doctor's competence to practise, and our decisions as to how those cases should be addressed. The table shows the number of processes during the year rather than the number of individual doctors, as many doctors may have been the subject of more than one decision or process. The numbers include processes that commenced before 1 July 2021 and processes that continued after 30 June 2022.

Conduct

33

Council referred 33 notifications to a PCC, up from 30 the previous year.

Council's Conduct team handles notifications that relate to the appropriateness of a doctor's conduct, or the safety of a doctor's practice.

Council refers these notifications to a Professional Conduct Committee (PCC) where further investigation is required.

Council referred 33 notifications to a PCC in 2021/2022, up from 30 the previous year. Covid-19 concerns were the most common type amongst PCCs ordered in 2021/2022, followed by prescribing concerns, and unprofessional behaviour.

As with performance-related notifications, there is some overlap between Council's role and that of the HDC. With conduct-related notifications, Council is not legally allowed to take action against a doctor under Part 4 of the Act (conduct-related action) while the Health and Disability Commissioner is conducting their investigation.

Council may take interim action where it considers the doctor poses a risk of harm to the public while an HDC, PCC or criminal investigation is undertaken. This can include imposing conditions on the doctor's practice or suspending the doctor's practising certificate. In 2021/2022, Council imposed interim conditions twice, and interim suspended a doctor's practising certificate in six cases. See table four (page 42) for more information.

In 2021-2022, Council imposed interim conditions twice, and interim suspended a doctor's practising certificate in six cases.

He Raraunga Kaimahi
Workforce Data

Notifications

Table 1 : Total notifications received by type [1] (1 July 2021 to 30 June 2022)				
Type	2018/19	2019/20	2020/21	2021/22
Performance	-	130	146	103
Conduct	-	59	104	132
Mixed	-	-	-	2
Total	203	189	250	237

[1] This only includes matters where Council processes were commenced. It does not include queries outside Council's jurisdiction or internally managed inquiries that did not proceed to NTT or Council.

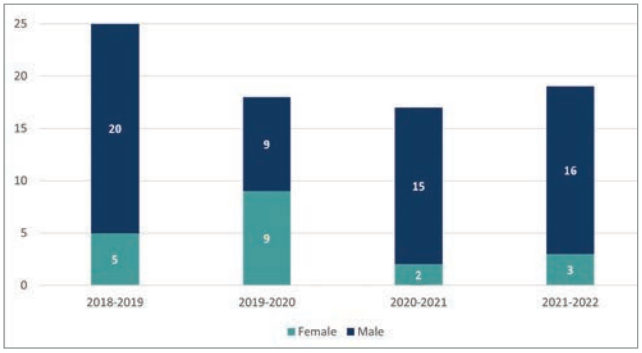
Notifications

Table 2 : Competence and conduct processes ordered (1 July 2021 to 30 June 2022)				
Process	2018/19	2019/20	2020/21	2021/22
Performance assessment (PAC)	12	23	18	19
Preliminary competence inquiry (PCI) [2]	-	9	21	8
Professional conduct committee (PCC)	27	35	30	33

[2] Council only holds data for PCIs ordered from partway through the 2019-2020 FY.

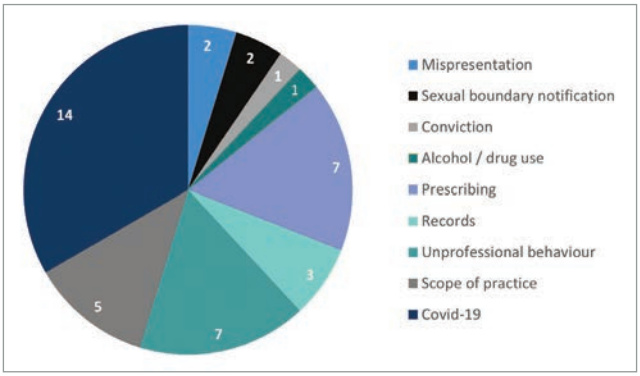
Performance

PACs ordered by gender by year
1 July 2018 to 30 June 2022



Conduct

PCC investigations by concern type
(1 July 2021 to 30 June 2022)



Note: Some PCCs involve multiple concern types. As a result, the combined categories may be higher than the number of PCCs ordered for the same period.

Performance

Table 3 : Performance-related Council processes [3]	
(1 July 2021 to 30 June 2022)	
No further action or educational letter after first consideration	28
Await outcome from HDC after first consideration	50
Request a Preliminary Competence Inquiry (PCI)	8
No further action after Preliminary Competence Inquiry	4
Recertification programme ordered on first consideration	2
Referral to Performance Assessment Committee (PAC)	19
Doctor meets standard of competence (PAC assessment category 1)	1
Doctor doesn't meet standard of competence (PAC assessment category 2 or 3)	8
Educational programme ordered after PAC assessment (section 38, category 2)or 3)	8
Conditions imposed after PAC assessment (section 38)	3
Educational programme completed satisfactorily	3
Educational programme completed unsatisfactorily	0
Recertification programme completed satisfactorily	0
Follow up performance assessment ordered after educational programme	1
Conditions ordered after unsuccessful completion of educational programme	0
Referral to health team	0

[3] Table 10 includes decisions made in current reporting year – including those made by Council (full board meeting), by the Notification Triage Team (NTT) and by the Registrar/Deputy Registrar under delegation..

Conduct

Table 4 shows the number of cases considered during the year that related to a doctor's conduct and our decisions as to how those cases should be addressed. It shows the number of processes during the year rather than the number of individual doctors, as many of these doctors will have been the subject of more than one decision or process. The numbers include processes that started before 1 July 2021 and processes that continued after 30 June 2022.

Table 4 : Conduct-related Council processes [4]	
(1 July 2021 to 30 June 2022)	
No further action or educational letter on first consideration	28
Referral to PCC[5]	37
New information received referred to existing PCC	8
Interim conditions ordered (section 69)	2
Interim suspension ordered (section 69 or section 69A)	6
PCC determined charge in the Health Practitioners Disciplinary Tribunal	8
PCC recommended no further action	1
PCC recommended counselling	13
PCC recommended review of fitness to practise (referral to Health Committee)	2
Referred to the Health Committee	5
PCC charges heard in the HPDT	9
PCC charges proved in the HPDT	9
PCC charges withdrawn prior to hearing	2

[4] This only includes matters where Council processes were commenced. It does not include queries outside Council's jurisdiction or internally managed inquiries that did not proceed to NTT or Council.

[5] 5 The difference between the two PCC totals in table 2 and table 4 is due to additional referrals to existing PCCs i.e. if new information is received that is outside the original terms of reference.

When we receive notice that a doctor is convicted of any offence punishable by imprisonment for a term of three months or longer, or of an offence under certain specified Acts, the Council must consider whether to refer the notice of conviction to a PCC, or alternatively refer the doctor to the Health Evaluation Pathway. This can involve ordering the doctor to undergo any specified medical or psychiatric examination or treatment, counselling, or therapy (with the doctor's consent). Table 5 shows the PCCs that were commenced as a result of a conviction, and the number of doctors referred to the Health Evaluation

See more workforce data at pages 64 - 86

Table 5 : Notice of Convictions	
(1 July 2021 to 30 June 2022)	
Notices of conviction referred to PCC[6]	2
Doctor referred to Health Evaluation Pathway (section 67A)	2

[6] This does not include ongoing PCC processes during which a conviction is received.

Addressing Competence Concerns

Dr K's Educational Programme

In mid-2019 the Health and Disability Commissioner (HDC) notified the Council that it had begun an investigation into Dr K, related to the care he provided to a patient in 2018.

Concerns had been raised about Dr K's assessment of this patient's cardiac and pulmonary condition in the days leading up to their unexpected death.

The HDC was critical of the adequacy of Dr K's assessment of his patient.

As a result, in early 2020, Council resolved that Dr K was required to undergo a performance assessment (assessment). This assessment was delayed due to the COVID-19 lockdown and a family bereavement, and eventually took place at the end of 2020.

Following the assessment, the Performance Assessment Committee (PAC) provided Council with a report. While the PAC noted Dr K's cooperation throughout the assessment process, its report detailed concerns about Dr K's:

a) Management plans
b) Documentation of consultations and communication skills
c) Ensuring continuity of care
d) Undertaking thorough examination
e) Critical thinking and clinical knowledge

Council considered the PAC's report and Dr K's response, which included that the assessment process had been a beneficial way to reflect on work and obtain feedback from colleagues.

Council found that Dr K did not meet the required standard of competence, and as a result ordered Dr K was to undertake a 12-month educational programme (programme), under professional supervision, designed to address the PAC's concerns.

The programme commenced in early 2021 with the first meeting between Dr K and the supervisor. Council's Medical Adviser monitored the reports from the supervisor, and noted that Dr K had a positive approach to the programme, he had engaged well, and had made good progress with all objectives.

By mid 2022, the Medical Adviser was satisfied that Dr K had achieved each of the programme's objectives and that Dr K was practising at the required standard of competence.

On the basis of that advice the Deputy Registrar, acting under delegation from Council, determined the educational programme was complete and that no further action was required. Dr K has been practising without restriction since.

Names have been removed to protect privacy. Identifying letters are assigned randomly and bear no relationship to the person's actual name.'


MUSIC
MUSIC • PEOPLE • LEGACY

Te Pūrongo Pūtea ā-Tau
Annual Financials

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bakertilly
STAPLES RODWAY

INDEPENDENT AUDITOR'S REPORT TO THE READERS OF THE MEDICAL COUNCIL OF NEW ZEALAND'S FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2022

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

Opinion

We have audited the financial statements of the Medical Council, that comprise the statement of financial position as at 30 June 2022, the statement of comprehensive revenue and expenses, the statement of changes in net assets and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information.

In our opinion the financial statements of the Medical Council,

- present fairly, in all material respects:
  - its financial position as at 30 June 2022; and
  - its financial performance and cash flows for the year then ended; and
- comply with generally accepted accounting practice in New Zealand and have been prepared in accordance with Public Benefit Entity Standards – Reduced Disclosure Regime.

Our audit was completed on 7 December 2022. This is the date at which our opinion is expressed.

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

Basis of opinion

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

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

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

Responsibilities of the Council for the financial statements

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

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

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

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

Responsibilities of the auditor for the audit of the financial statements

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

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

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

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

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

- We obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Council's internal control.

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

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

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

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

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

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

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

Chrissie Murray
Baker Tilly Staples Rodway Audit Limited

On behalf of the Auditor-General
Wellington, New Zealand

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand
Statement of Comprehensive Revenue and Expenses
For the year ended 30 June 2022

	Notes	2022 (000's)	2021 (000's)
Revenue from non-exchange transactions			
Practising certificate (PC) fees and disciplinary levies		14,897	14,109
Disciplinary recoveries		251	288
Total non-exchange revenue		**15,148**	**14,397**
Revenue from exchange transactions			
Fees received		3,737	3,419
Interest income		67	26
Other income		726	565
Total exchange revenue		**4,530**	**4,010**
Total revenue		**19,678**	**18,407**
Expenses per schedules	**5**		
Administration expenses		10,980	10,137
Council and profession expenses		3,639	3,300
Disciplinary expenses		2,119	2,325
Examination expenses		101	140
Total expenses		**16,839**	**15,902**
Results before reversal of onerous lease provision		**2,839**	**2,505**
Reversal of onerous lease provision		-	(665)
Total surplus for the year		**2,839**	**3,170**
Other comprehensive revenue and expense for the year		-	-
Total comprehensive revenue and expense for the year		**2,839**	**3,170**

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand
Statement of Changes in Net Assets
For the year ended 30 June 2022

	General Reserve (000's)	Disciplinary Reserve (000's)	Examination Reserve (000's)	Total Equity (000's)
Opening equity balance 1 July 2021	6,730	2,154	289	9,173
Total surplus / (deficit) for the year	1,822	1,167	(150)	2,839
Closing equity balance 30 June 2022	**8,552**	**3,321**	**139**	**12,012**
Opening equity balance 1 July 2020	4,010	1,725	268	6,003
Total surplus for the year	2,720	429	21	3,170
Closing equity balance 30 June 2021	**6,730**	**2,154**	**289**	**9,173**

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand
Statement of Financial Position
As at 30 June 2022

	Notes	2022 (000's)	2021 (000's)
Current assets			
Cash and cash equivalents		1,707	2,093
Short term investments		7,000	3,000
Prepayments		194	115
Receivables from exchange transactions	7	252	141
Receivables from non-exchange transactions	7	36	117
Total current assets		**9,189**	**5,466**
Non-current assets			
Intangible assets	8	3,520	3,789
Work in progress	9	40	229
Property, plant and equipment	10	1,563	1,680
Total non-current assets		**5,123**	**5,698**
Total assets		**14,312**	**11,164**
Current liabilities			
Payables	11	1,231	1,246
Employee entitlements	12	511	400
Revenue received in advance		500	269
Total current liabilities		**2,242**	**1,915**
Non-current liabilities			
Employee entitlements	12	58	76
Total non-current liabilities		**58**	**76**
Total liabilities		**2,300**	**1,991**
Net assets		**12,012**	**9,173**
Equity			
General reserve		8,552	6,730
Disciplinary reserve		3,321	2,154
Examination reserve		139	289
Total Equity		**12,012**	**9,173**

Authorised for issue for and on behalf of the Council on 6 December 2022.

Curtis Walker
Chair

Kim Ngarimu
Deputy Chair

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand
Statement of Cash Flows
For the year ended 30 June 2022

	2022 (000's)	2021 (000's)
Cash flows from operating activities		
Receipts		
Receipts from PC fees (non-exchange)	11,009	11,016
Receipts from disciplinary levies (non-exchange)	3,888	3,090
Receipts from other non-exchange transactions	566	258
Receipts from exchange transactions	4,596	3,710
Payments		
Payments to suppliers and employees	(15,736)	(15,307)
Net cash flows from operating activities	**4,323**	**2,767**
Cash flows from investing activities		
Receipts		
Interest received	30	36
Redemption of investments	5,250	6,000
Payments		
Purchase of property, plant and equipment	(199)	(76)
Purchase of intangible assets	(540)	(566)
Investments in short term deposits	(9,250)	(7,750)
Net cash flows from investing activities	**(4,709)**	**(2,356)**
Net (decrease)/increase in cash and cash equivalents	**(386)**	**411**
Cash and cash equivalents at 1 July	2,093	1,682
Cash and cash equivalents at 30 June	**1,707**	**2,093**
Represented by:		
ASB Bank Account - General	107	93
ASB Bank Account - Call	1,600	2,000
	1,707	**2,093**

1 Reporting entity

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

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

These financial statements have been approved and were authorised for issue by the Council on 6 December 2022.

2 Statement of compliance

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

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

3 Summary of Accounting Policies

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

3.1 Basis of measurement

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

3.2 Functional, presentational currency and rounding

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

3.3 Revenue

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

Revenue from non-exchange transactions

Practicing certificate (PC) fees and disciplinary levies

PC fees are recognised in full upon the commencement of the practising year to which it relates. Revenue from the provision of other services is recognised when the service has been provided. Where provision of services is extended over a period of time the stage of completion is estimated and revenue recognised when the degree of service has been provided.

Disciplinary recoveries

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

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

Revenue from exchange transactions

Fees received

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

- New Zealand registration examination fees which are recognised when the examination is held.
- Vocational registration income is recognised at the time of invoicing, however a portion equivalent to 3 months (2021: 3 months) is assessed and held as payments in advance.

Interest income

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

Other income

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

3.4 Financial instruments

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

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

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

Financial assets

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

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

Impairment of financial assets

During the year $179k was written off from the provision for doubtful debts. Additional amounts were recovered from specific debtors during the year which were previously doubtful as outlined in Note 3.7. This resulted in the impairment provision reducing $55k. There were no other impairments of financial assets for the year.

Financial liabilities

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

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

3.5 Cash and cash equivalents

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

3.6 Short-term investments

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

3.7 Receivables

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

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

A provision has been made in the Statement of Comprehensive Revenue and Expense for those receivables that are deemed impaired. Impairment has been provided for on the following basis:

Age of debt	**Rate**
1 month or less	0%
2 months	2%
3 months	5%
4 months	10%
5 months	20%
6 months	40%
7 months	60%
8 months	80%
9 months or more	100%

3.8 Property, plant and equipment

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

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

- Furniture and fittings 0% - 20% p.a.
- Office alterations 10% p.a.
- Office equipment 20% p.a.
- Computer hardware 33% p.a.

Depreciation methods, useful lives and residual values are reviewed at each reporting date and are adjusted if a change occurs in the expected pattern of consumption of the future economic benefits or service potential embodied in the asset.

3.9 Intangible assets

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

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

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

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

3.9 Intangible assets (continued)

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

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

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

- Developed software 10% - 20% p.a.
- Purchased software 10% p.a.

3.10 Leases

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

3.11 Work in progress

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

3.12 Employee entitlements

Short term employee entitlements

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

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

Long term employee entitlements

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

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

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

3.13 Provisions

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

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

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

3.14 Income tax

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

3.15 Goods and services tax (GST)

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

The net amount of GST recoverable from, or payable to, the Inland Revenue is included as part of receivables or payables in the Statement of Financial Position.

Cash flows are included in the Statement of Cash Flows on a net basis, and the GST component of cash flows arising from investing and financing activities, which is recoverable from, or payable to, the Inland Revenue is classified as part of operating cash flows.

3.16 Equity

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

General reserve

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

Disciplinary reserve

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

Examination reserve

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

4 Significant accounting judgements, estimates and assumptions

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

Judgements

In the process of applying the Council's accounting policies, management have not made any significant judgements that would have a material impact on the financial statements.

Estimates and assumptions

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

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

Useful lives and residual values

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

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

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

4 Significant accounting judgements, estimates and assumptions (continued)

Recoverability of receivables

The recoverability of receivables is a significant estimate. For information on how these are assessed refer to 3.7 above.

Long service leave

The measurement of long service lease was based on a number of assumptions. An assessment of 76 employees employed at 30 June 2022 was undertaken as to which employees would reach the long service criteria. 7 employees had entitlements and this is reflected as the current portion. The non-current portion reflects the assessment of the probability of employees earning long service leave in the future. Due to the number of employees affected and relatively low length of service, discount rates and salary inflation factors were not incorporated into the calculation.

5 Expenses

2022	Administration (000's)	Council and profession (000's)	Disciplinary (000's)	Examination (000's)	Total (000's)
Administration	307	-	-	-	307
Amortisation	1,000	-	-	-	1,000
Communication	43	-	-	-	43
Council	-	447	-	-	447
Depreciation	316	-	-	-	316
Disciplinary and legal	-	493	772	-	1,265
Education committee	12	39	-	-	51
Education general	-	969	-	-	969
Health committee	-	49	-	-	49
Health general	-	217	-	-	217
HPDT disciplinary	-	-	452	-	452
Insurance	65	-	-	-	65
IT & systems	927	-	-	-	927
NZRex clinical	-	-	-	38	38
Premises	1,224	-	-	-	1,224
Professional standards	-	275	-	-	275
Registration	-	1,054	-	-	1,054
Staff general	344	-	12	-	356
Staff remuneration	6,742	-	883	63	7,688
Strategy	-	96	-	-	96
Total expenses	**10,980**	**3,639**	**2,119**	**101**	**16,839**

5 Expenses (continued)

2021	Administration (000's)	Council and profession (000's)	Disciplinary (000's)	Examination (000's)	Total (000's)
Administration	306	-	-	-	306
Amortisation	975	-	-	-	975
Communication	62	-	-	-	62
Council	-	505	-	-	505
Depreciation	290	-	-	-	290
Disciplinary and legal	-	169	1,025	-	1,194
Education committee	9	42	-	-	51
Education general	-	830	-	-	830
Health committee	-	54	-	-	54
Health general	-	264	-	-	264
HPDT disciplinary	-	-	492	-	492
Impairment expense	100	-	-	-	100
Insurance	60	-	-	-	60
IT & systems	807	-	-	-	807
NZRex clinical	-	-	-	110	110
Premises	1,180	-	-	-	1,180
Professional standards	-	372	-	-	372
Registration	-	968	-	-	968
Staff general	217	-	12	-	229
Staff remuneration	6,131	-	796	30	6,957
Strategy	-	96	-	-	96
Total expenses	**10,137**	**3,300**	**2,325**	**140**	**15,902**

6 Auditor's remuneration

Baker Tilly Staples Rodway Audit Limited provide audit services to the Council on behalf of the Auditor-General. The total amount recognised for audit fees is $32k (2021: $30k). No non-audit services have been provided by the auditor.

7 Receivables

	2022 (000's)	2021 (000's)
Interest receivable - exchange	41	4
Receivables from exchange transactions	239	164
Provision for doubtful debts - exchange	(28)	(27)
Receivables from exchange transactions	**252**	**141**
Receivables from non-exchange transactions	88	403
Provision for doubtful debts - non-exchange	(52)	(286)
Receivables from non-exchange transactions	**36**	**117**
Total receivables	**288**	**258**

8 Intangible assets

2022	Developed Software (000's)	Purchased Software (000's)	Total (000's)
Cost	12,749	30	12,779
Less: Accumulated amortisation and impairment	(9,236)	(23)	(9,259)
Net book value	**3,513**	**7**	**3,520**
2021			
Cost	12,018	30	12,048
Less: Accumulated amortisation and impairment	(8,237)	(22)	(8,259)
Net book value	**3,781**	**8**	**3,789**

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

2022	Developed Software (000's)	Purchased Software (000's)	Total (000's)
Opening balance	3,781	8	3,789
Additions	731	-	731
Disposals	-	-	-
Amortisation	(999)	(1)	(1,000)
Impairment	-	-	-
Closing balance	**3,513**	**7**	**3,520**

9 Work in progress

	2022 (000's)	2021 (000's)
Developed Software	40	229
Total work in progress	**40**	**229**

10 Property, plant and equipment

2022	Computer Hardware (000's)	Furniture & Fittings (000's)	Office Alterations (000's)	Office Equipment (000's)	Total (000's)
Cost	1,270	629	2,509	297	4,705
Less: Accumulated depreciation and impairment	(1,087)	(453)	(1,324)	(278)	(3,142)
Net book value	**183**	**176**	**1,185**	**19**	**1,563**
2021					
Cost	1,102	598	2,509	297	4,506
Less: Accumulated depreciation and impairment	(989)	(419)	(1,151)	(267)	(2,826)
Net book value	**113**	**179**	**1,358**	**30**	**1,680**

10 Property, plant and equipment (continued)

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

2022	Computer Hardware (000's)	Furniture & Fittings (000's)	Office Alterations (000's)	Office Equipment (000's)	Total (000's)
Opening balance	113	179	1,358	30	1,680
Additions	168	31	-	-	199
Disposals	-	-	-	-	-
Depreciation	(98)	(34)	(173)	(11)	(316)
Impairment	-	-	-	-	-
Closing balance	**183**	**176**	**1,185**	**19**	**1,563**

11 Payables

	2022 (000's)	2021 (000's)
Creditors	173	456
Accrued expenses	925	698
GST payable	133	92
	1,231	**1,246**

12 Employee entitlements

	2022 (000's)	2021 (000's)
Current portion		
Accrued salaries and wages	58	27
Annual leave	426	352
Long service leave	27	21
Total current portion	**511**	**400**
Non-current portion		
Long service leave	58	76
Total non-current portion	**58**	**76**
Total employee entitlements	**569**	**476**

13 Categories of financial assets and liabilities

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

	2022 (000's)	2021 (000's)
Financial assets		
Cash and cash equivalents	1,707	2,093
Short term investments	7,000	3,000
Prepayments	194	115
Receivables from exchange transactions	252	141
Receivables from non-exchange transactions	36	117
Total financial assets	**9,189**	**5,466**
Financial liabilities		
Payables	1,231	1,246
Employee entitlements	511	400
Total financial liabilities	**1,742**	**1,646**

14 Related party transactions

These expenses relate to all the activities of Council members.

Council member fees and expenses	2022 (000's)	2021 (000's)
Council fees	495	542
Council travel	20	47
Council expenses	11	25
Council development	3	2
Total Council member fees and expenses	**529**	**616**

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

Fees paid to Councillors	2022 (000's)	2021 (000's)
R Aston	23	37
K Clark	43	37
S Child	29	24
T Fonua-Faeamani	32	35
K Fox	24	46
A Goodman	41	40
P Hale	44	36
C Hornabrook	32	36
S Hughes	7	30
P Hutchison	-	5
R Love	26	22
G McLachlan	29	32
J Nacey	-	8
K Ngarimu (Deputy Chair)	35	24
C Walker (Chair)	65	65
C Walker (MidCentral DHB)	65	65
Total fees paid to Council members	**495**	**542**

There were no other related party transactions (2021: Te Ohu Rata o Aotearoa (Te Ora) provided services to the Council related to the jointly published Cultural Safety Baseline Data Report (October 2020). Te Ora is a related party as the Chair of Council is also the Deputy Chair of Te Ora. The value of services provided was $6k).

Key management personnel

The key management personnel, as defined by PBE IPSAS 20 *Related Party Disclosures,* are the members of the governing body comprising Council members, the Chief Executive Officer, Deputy Chief Executive, Registrar, Deputy Registrar, Chief Financial Officer, Manager - Strategy and Policy, Health Manager and Kaitiaki Mana Māori.

The remuneration paid to Council members is set out above. The aggregate remuneration of key management personnel and the number of individuals, determined on a full-time equivalent basis, receiving remuneration are detailed below.

	2022 (000's)	2021 (000's)
Total key management personnel remuneration	**1,427**	**1,296**
Number of persons	8	7
Full time equivalents basis (FTE)	6.62	6.65

15 Capital and other commitments

During the reporting period, the Council has renewed a contract with an IT vendor to support and develop our information systems. The Council is committed to incur $838k (2021: $820k) during the financial year ending 30 June 2023.

The Council has no other capital commitments at the reporting date (2021: None).

Non cancellable operating lease commitments

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

	2022 (000's)	2021 (000's)
Not later than 1 year	1,207	1,155
Later than 1 year no later than 5 years	4,806	4,611
Later than 5 years	993	2,087
Total minimum lease payments	**7,006**	**7,853**

The non cancellable operating lease relates to the lease of Level 24 and 25, AON Centre, 1 Willis Street, Wellington, and Fuji Xerox printing equipment. The building lease expires in April 2028, with one right of renewal and an escalation clause allowing for annual rent increases of 2.25% and market rent reviews in 2025 and 2028 (if the lease is renewed).

16 Contingent assets and liabilities

There are no contingent assets or liabilities at the reporting date (2021: None).

17 Events after the reporting period

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

He Raraunga Kaimahi
Workforce Data

Table 1: Scopes of practice – summary of registration status (1 July to 30 June of the year)					
	2018	2019	2020	2021	2022
Provisional general–NZ graduates	508	547	558	582	670
General–international medical graduates	570	494	443	445	530
General	5,355	5,681	6,082	6,206	6,311
Provisional vocational	131	133	129	191	200
Vocational	9,646	9,948	10,332	10,713	11,002
Special purpose	81	104	108	110	71
Total on register					
Total practising	16,291	16,907	17,652	18247	18,784
Suspended	11	11	11	10	12

Note: Doctors holding more than one scope of practice concurrently have been counted once for this table. To achieve this, doctors are allocated to the first scope they hold in this order of priority:

1. Suspended
2. Vocational
3. General
4. Provisional vocational
5. Provisional general
6. Special purpose

Table 2: Registration activities (1 July to 30 June of the year)					
	2018	2019	2020	2021	2022
Provisional general/vocational registrations					
New Zealand graduates (interns)	466	507	521	527	566
Australian graduates (interns)	13	4	1	2	3
Passed NZREX Clinical (interns)	43	26	30	18	38
Australian general registrants	-	2	8	4	8
Graduate of competent authority accredited medical school	460	527	493	325	402
Worked in comparable health system	199	186	150	160	182
New Zealand and international medical graduates reregistration (following cancellation)	-	-	-	-	-
Non-approved postgraduate qualification – vocational assessment	91	81	77	118	125
Non-approved postgraduate qualification – vocational eligible	82	74	95	108	92
Special purpose scope registrations					
Visiting expert	37	21	10	-	2
Research	2	3	1	5	2
Postgraduate training or experience	42	43	45	19	15
Locum tenens in specialist post	93	111	109	92	63
Emergency or other unpredictable short-term situation	-	-	5	-	-
Pandemic	-	-	8	15	23
Teleradiology	-	-	-	2	5
General scope registrations, after completion of supervised period					
Australian general registrant	-	-	1	2	2
New Zealand/Australian graduates (interns)	462	483	506	502	478
Passed NZREX Clinical	22	33	33	20	26
Graduate of competent authority accredited medical school	329	442	398	250	244
Worked in comparable health system	92	94	75	82	62

	2018	2019	2020	2021	2022
Vocational scope registrations, after completion of supervised period					
Non-approved postgraduate qualification–vocational assessment	54	50	40	45	66
Non-approved postgraduate qualification–vocational eligible	84	74	86	74	92
General scope registrations					
New Zealand graduates	9	5	3	2	6
Overseas graduates	85	85	85	72	83
Restorations	15	22	12	19	8
Vocational scope registrations					
Approved postgraduate qualification (VOC1)	478	421	481	491	465
Approved postgraduate qualification (VOC2)	-	-	-	2	1
Suspensions of registration					
Suspension or interim suspension	5	2	7	4	7
Revocation of suspension	-	1	3	2	7
Numbers of doctors who had conditions imposed on scope of practice[1]					
Imposed	109	82	91	114	124
Revoked	40	59	52	100	79
Cancellations under the HPCAA					
Death–section 143	23	43	36	43	43
Discipline order–section 101 (1)(a)	3	2	3	1	3
False, misleading or not entitled–section 146	1	-	1	-	-
Revision of register–section 144(5)	98	147	256	527	2
At own request–section 142	167	188	120	80	148

Table 3: Doctors registered in vocational scopes of practice (1 July 2021 to 30 June 2022)					
Vocational scope	Vocational registration at 30/6/2021[1]	Added 2020/22	Removed 2020/22	Net change	Vocational scope at 30/6/2022[1,2]
Anaesthesia	1,154	48	1	47	1,201
Cardiothoracic Surgery	51	2	-	2	53
Clinical Genetics	20	2	-	2	22
Dermatology	91	3	2	1	92
Diagnostic & Interventional Radiology	853	120	2	118	971
Emergency Medicine	503	32	2	30	533
Family Planning & Reproductive Health	43	-	-	-	43
General Practice	4,742	167	36	131	4,873
General Surgery	426	21	3	18	444
Intensive Care Medicine	134	6	-	6	140
Internal Medicine	1,632	95	13	82	1,714
Medical Administration	47	2	1	1	48
Musculoskeletal Medicine	26	4	-	4	30
Neurosurgery	30	3	-	3	33
Obstetrics & Gynaecology	467	27	3	24	491
Occupational Medicine	77	2	1	1	78
Ophthalmology	203	10	2	8	211
Oral & Maxillofacial Surgery	34	4	-	4	38
Orthopaedic Surgery	385	18	3	15	400
Otolaryngology Head & Neck Surgery	151	9	1	8	159
Paediatric Surgery	33	-	-	-	33
Paediatrics	543	28	4	24	567

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

[2] Includes 634 doctors with registration in two vocational scopes and 17 doctors with registration in three vocational scopes.

Vocational scope	Vocational registration at 30/6/2021[1]	Added 2021/22	Removed 2021/22	Net change	Vocational scope at 30/6/2022[1,2]
Pain Medicine	39	1	1	1	40
Palliative Medicine	101	3	-	3	104
Pathology	433	25	1	24	457
Plastic & Reconstructive Surgery	93	7	1	6	99
Psychiatry	917	50	5	45	962
Public Health Medicine	231	5	-	5	236
Radiation Oncology	96	6	-	6	102
Rehabilitation Medicine	33	1	-	1	34
Rural Hospital Medicine	141	11	-	11	152
Sexual Health Medicine	26	1	-	1	27
Sport and Exercise Medicine	39	2	-	2	41
Urgent Care	301	27	2	25	326
Urology	94	4	1	3	97
Vascular Surgery	46	2	-	2	48
Total	14,235	748	84	664	14,899

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

[2] Includes 634 doctors with registration in two vocational scopes and 17 doctors with registration in three vocational scopes.

Table 4: Doctors registered in vocational scopes of practice (1 July to 30 June of the year)					
Vocational scope	2018	2019	2020	2021	2022
Anaesthesia	1,020	1,057	1,110	1,154	1,201
Cardiothoracic Surgery	41	45	48	51	53
Clinical Genetics	19	20	20	20	22
Dermatology	84	85	87	91	92
Diagnostic & Interventional Radiology	659	694	772	853	971
Emergency Medicine	390	419	453	503	533
Family Planning & Reproductive Health	34	38	40	43	43
General Practice	4,364	4,482	4,621	4,742	4,873
General Surgery	397	408	417	426	444
Intensive Care Medicine	116	120	128	134	140
Internal Medicine	1,392	1,466	1,549	1,632	1,714
Medical Administration	42	44	46	47	48
Musculoskeletal Medicine	25	25	27	26	30
Neurosurgery	30	31	31	30	33
Obstetrics & Gynaecology	411	426	447	467	491
Occupational Medicine	70	75	76	77	78
Ophthalmology	185	195	205	203	211
Oral & Maxillofacial Surgery	27	30	33	34	38
Orthopaedic Surgery	351	365	375	385	400
Otolaryngology Head & Neck Surgery	140	146	148	151	159
Paediatric Surgery	29	31	31	33	33
Paediatrics	480	497	521	543	567
Pain Medicine	31	32	35	39	40

Vocational scope	2018	2019	2020	2021	2022
Plastic & Reconstructive Surgery	86	90	90	93	99
Psychiatry	838	867	910	917	962
Public Health Medicine	222	223	230	231	236
Radiation Oncology	84	88	93	96	102
Rehabilitation Medicine	31	32	32	33	34
Rural Hospital Medicine	125	128	135	141	152
Sexual Health Medicine	24	25	25	26	27
Sport and Exercise Medicine	31	33	36	39	41
Urgent Care	237	256	277	301	326
Urology	86	87	89	94	97
Vascular Surgery	43	45	46	46	48
Total	12,620	13,112	13,705	14,235	14,899

Table 5: Registration granted, by country of primary qualification (1 July 2021 to 30 June 2022)				
	Provisional general	Provisional vocational	Special purpose	Total
New Zealand	566	3	14	583
England	244	37	13	294
United States of America	46	58	33	137
Scotland	75	14	5	94
South Africa	7	31	9	47
Ireland	42	2	2	46
India	23	4	8	35
Wales	32	0	0	32
Netherlands	25	6	0	31
Canada	11	10	3	24
Germany	9	6	2	17
Belgium	10	2	0	12
Northern Ireland	9	1	2	12
Spain	5	3	1	9
Egypt	3	3	2	8
Philippines	7	1	0	8
Pakistan	7	0	0	7
Other[1]	78	35	16	129
Total	1,199	216	110	1,525

[1] Other represents 46 countries that had fewer than seven registrations in the reporting period.

Table 6: Registration granted, by country of primary qualification (1 July to 30 June of the year)					
	2018	2019	2020	2021	2022
New Zealand	470	512	530	537	583
England	341	375	359	258	294
United States of America	163	161	145	171	137
Scotland	112	119	87	61	94
South Africa	33	31	51	65	47
Ireland	49	95	79	48	46
India	38	36	36	45	35
Wales	24	17	22	15	32
Netherlands	26	31	30	19	31
Canada	27	30	26	20	24
Germany	23	19	12	7	17
Belgium	7	7	9	11	12
Northern Ireland	8	7	7	10	12
Spain	6	7	5	3	9
Egypt	3	4	4	2	8
Philippines	2	2	2	1	8
Pakistan	13	7	18	9	7
Other[1]	184	127	127	107	129
Total	1,529	1,587	1,549	1,389	1,525

[1] Other represents countries who had less than 6 registrations in 2021/2022.

Table 7: Vocational registration granted, by vocational scope of practice (1 July 2021 to 30 June 2022)			
Vocational scope	New Zealand	Overseas	Total
Anaesthesia	21	27	48
Cardiothoracic Surgery	1	1	2
Clinical Genetics	1	2	3
Dermatology	2	1	3
Diagnostic & Interventional Radiology	13	107	120
Emergency Medicine	4	28	32
General Practice	102	65	167
General Surgery	11	10	21
Intensive Care Medicine	2	4	6
Internal Medicine	43	52	95
Medical Administration	2	-	2
Musculoskeletal medicine	3	1	4
Neurosurgery	-	3	3
Obstetrics & Gynaecology	11	16	27
Occupational Medicine	-	2	2
Ophthalmology	4	6	10
Oral & Maxillofacial Surgery	1	3	4
Orthopaedic Surgery	9	9	18
Otolaryngology Head & Neck Surgery	1	8	9
Paediatrics	11	17	28
Pain Medicine	-	1	1
Palliative Medicine	2	1	3
Pathology	11	14	25

Vocational scope	New Zealand	Overseas	Total
Plastic & Reconstructive Surgery	5	2	7
Psychiatry	8	42	50
Public Health Medicine	4	1	5
Radiation Oncology	4	2	6
Rehabilitation Medicine	-	1	1
Rural Hospital Medicine	10	1	11
Sexual Health Medicine	-	1	1
Sport and Exercise Medicine	-	2	2
Urgent Care	13	14	27
Urology	3	1	4
Vascular surgery	-	2	2
Total	301	447	748

Table 8: Outcomes of applications for vocational registration assessments (1 July 2021 to 30 June 2022)							
Branch	Pending					NZREX*	Total
Anaesthesia	33	2	13	9	10	0	67
Cardiothoracic Surgery	4	-	1	-	-	-	5
Clinical Genetics	-	-	1	-	-	-	1
Dermatology	3	-	1	1	3	-	8
Diagnostic &	29	1	25	15	4	-	64
Emergency Medicine	17	-	5	5	10	1	38
General Practice	14	-	9	1	5	-	29
General Surgery	14	-	8	-	2	3	27
Intensive Care Medicine	6	-	1	1	2	-	10
Internal Medicine	33	-	21	13	23	2	92
Neurosurgery	6	-	1	-	1	1	9
Obstetrics & Gynaecology	10	2	6	5	6	2	31
Occupational Medicine	1	-	1	1	-	-	3
Ophthalmology	13	-	6	3	1	1	24
Oral & Maxillofacial Surgery	-	-	-	1	-	-	1
Orthopaedic Surgery	14	-	9	2	1	2	28
Otolaryngology Head & Neck Surgery	7	-	3	5	2	4	21
Paediatrics	13	-	8	3	1	1	26
Pain Medicine	-	-	1	-	-	-	1
Palliative Medicine	-	-	-	1	-	-	1
Pathology	13	-	6	-	2	1	22
Plastic & Reconstructive Surgery	2	-	2	3	-	2	9
Psychiatry	29	1	12	5	24	2	73

Branch	Pending					NZREX*	Total
Public Health Medicine	2	-	2	-	-	-	4
Radiation Oncology	4	-	1	-	-	-	5
Rehabilitation Medicine	-	-	1	-	-	-	1
Sexual health Medicine	-	-	1	-	1	-	2
Sport & Exercise Medicine	1	-	1	1	-	-	3
Urology	2	-	2	-	-	-	4
Vascular Surgery	1	-	-	-	-	-	1
Total	271	6	138	75	98	22	610
Percentages based on total number of outcomes (%)				38.5	50.3	11.3	

* Doctors who are assessed as not meeting the required standard for registration within a vocational scope must apply

Table 9: Practising doctors on the NZ medical register, by country of primary qualification (1 July 2021 to 30 June 2022)						
Country	General				Special purpose	Total
New Zealand	670	4,047	1	6,149	-	10,867
England	170	706	22	1,421	7	2,326
Australia	3	341	1	457	-	802
South Africa	7	73	35	653	8	776
Scotland	49	184	5	393	1	632
India	25	119	7	374	9	534
United States of America	47	74	56	269	23	469
Ireland	32	189	1	87	1	310
Germany	8	43	5	132	1	189
Wales	24	54	-	63	-	141
Netherlands	26	32	8	67	-	133
Sri Lanka	3	22	1	92	3	121
Iraq	1	22	-	84	-	107
Pakistan	10	45	-	42	-	97
China	7	29	2	45	-	83
Canada	7	10	7	53	3	80
Fiji	4	10	-	46	4	64
Northern Ireland	12	21	1	27	-	61
Russia	2	28	2	23	-	55
Philippines	7	18	1	27	-	53
Egypt	3	11	1	36	2	53
Bangladesh	3	9	-	32	-	44
Poland	3	9	-	32	-	44
Singapore	4	15	-	17	-	36

Country	Provisional general	General	Provisional vocational	Vocational	Special purpose	Total
Belgium	10	9	2	15	-	36
Zimbabwe	-	1	1	32	-	34
Spain	7	9	1	15	1	33
Israel	5	7	5	11	1	29
Italy	5	3	1	18	-	27
Malaysia	3	12	-	11	-	26
Romania	1	8	3	13	-	25
Czech Republic	3	7	2	12	-	24
France	3	9	2	9	-	23
Hungary	1	6	2	12	-	21
Serbia	-	2	-	17	-	19
Sweden	3	4	1	10	-	18
Nigeria	1	8	1	7	-	17
Ukraine	1	7	-	9	-	17
Myanmar	2	6	-	9	-	17
Austria	1	7	1	7	-	16
Brazil	2	2	3	9	-	16
Iran	2	7	1	5	-	15
Sudan	-	6	1	7	-	14
Argentina	2	3	2	6	-	13
Bulgaria	-	4	-	8	-	12
Hong Kong	-	1	2	9	-	12
Libya	-	4	2	6	-	12
Other[1]	21	68	10	132	5	236
Total	1,200	6,311	200	11,002	71	18,784

[1] Other represents 71 countries with fewer than 12 registered doctors.

Table 10: Doctors on the New Zealand medical register, by country of primary qualification (1 July to 30 June of the year - Doctors with a current practising certificate)					
	June 2018	June 2019	June 2020	June 2021	June 2022
New Zealand	9,370	9,731	10,180	10,567	10,867
England	2,102	2,189	2,289	2,289	2,326
Austalia	528	575	651	708	802
South Africa	724	738	746	767	776
Scotland	604	617	620	623	632
India	480	509	519	536	534
United States of America	389	385	410	461	469
Ireland	245	290	322	317	310
Germany	183	191	193	187	189
Wales	113	115	121	131	141
Netherlands	103	115	122	130	133
Sri Lanka	124	115	117	120	121
Iraq	109	109	105	106	107
Pakistan	79	78	89	92	97
China	75	75	78	78	83
Canada	82	85	79	84	80
Fiji	68	64	65	63	64
Northern Ireland	57	54	57	59	61
Russia	52	53	54	53	55
Egypt	45	43	49	49	53
Phillippines	42	44	45	46	53
Bangladesh	43	44	44	43	44

	June 2018	June 2019	June 2020	June 2021	June 2022
Sinapore	28	30	31	33	36
Belgium	23	28	29	34	36
Zimbabwe	36	36	33	33	34
Spain	25	28	30	30	33
Israel	14	16	17	25	29
Italy	24	23	24	23	27
Malaysia	24	22	23	25	26
Romania	19	18	22	24	25
Czech Republic	15	19	18	22	24
France	17	20	19	20	23
Hungary	22	20	20	22	21
Serbia	21	23	30	18	19
Sweden	23	20	14	19	18
Myanmar	15	16	14	15	17
Nigeria	14	13	14	16	17
Ukraine	17	16	17	17	17
Austria	13	13	14	13	16
Brazil	7	10	12	15	16
Iran	8	11	10	11	15
Other[1]	274	268	280	286	299

[1] Other represents countries with less than 15 registered doctors in 2021/2022.

Table 11: Candidates sitting and passing NZREX Clinical (1 July 2021 to 30 June 2022)						
		Attempt			Attempt	
Country	# sitting Provisional general	1	2	# passed	1	2
Bangladesh	2	-	2	1	-	1
Brazil	2	2	-	2	2	-
China	3	3	-	2	2	-
Egypt	1	-	1	1	-	1
India	6	4	2	3	2	1
Iraq	1	1	-	1	1	-
Korea (Republic of)	1	1	-	1	1	-
Pakistan	3	1	2	3	1	2
Philippines	1	-	1	1	-	1
Russia	3	2	1	1	-	1
Serbia	1	1	-	1	1	-
South Africa	1	1	-	1	1	-
Sri Lanka	1	1	-	1	1	-
Ukraine	1	-	1	1	-	1
Total	27	17	10	20	12	8

Table 12 : Referral sources for performance-related notifications	
(1 July 2021 to 30 June 2022)	
ACC	9
Colleague[1]	6
College	1
Employer (DHB/GP)	1
Employer	5
HDC	64
Internally referred within Council (Health)	1
Notifier[2]	15
Other health agency	1
Other health professional	2
Total	105

[1] Includes colleagues and peers

[2] Includes notifiers who were members of the public

Table 13 : Referral sources for conduct-related notifications	
(1 July 2021 to 30 June 2022)	
ACC	1
Colleague[1]	19
College	3
Employer	1
HDC	19
Media/public information	3
Other Health Agency	26
Ministry of Health	4
Notifier[2]	38
Other Health Professional	8
PCC	2
PAC	1
Pharmacist	2
Police	2
Self-referral	4
Other	1
Total	134

[1]Includes categories formerly reported as colleague, other doctors, peers

[2]Includes categories formerly reported as notifier, member of the public and patient's family or friend

Table 14 : Performance-related Council processes [1]	
(1 July 2021 to 30 June 2022)	
No further action or educational letter after first consideration	28
Await outcome from HDC after first consideration	50
Request a Preliminary Competence Inquiry (PCI)	8
No further action after Preliminary Competence Inquiry	4
Recertification programme ordered on first consideration	2
Referral to Performance Assessment Committee (PAC)	19
Doctor meets standard of competence (PAC assessment category 1)	1
Doctor doesn't meet standard of competence (PAC assessment category 2 or 3)	8
Educational programme ordered after PAC assessment (section 38, category 2)or 3)	8
Conditions imposed after PAC assessment (section 38)	3
Educational programme completed satisfactorily	3
Educational programme completed unsatisfactorily	0
Recertification programme completed satisfactorily	0
Follow up performance assessment ordered after educational programme	1
Conditions ordered after unsuccessful completion of educational programme	0
Referral to health team	0

[1] Table 10 includes decisions made in current reporting year – including those made by Council (full board meeting), by the Notification Triage Team (NTT) and by the Registrar/Deputy Registrar under delegation..

Table 15 : Conduct-related Council processes[1]	
(1 July 2021 to 30 June 2022)	
No further action or educational letter on first consideration	28
Referral to PCC	39
New information received referred to existing PCC[2]	8
Interim conditions ordered (section 69)	2
Interim suspension ordered (section 69 or section 69A)	6
PCC determined charge be brought in the Health Practitioners Disciplinary Tribunal	8
PCC recommended no further action	1
PCC recommended counselling	13
PCC recommended review of fitness to practise (by referral to Health Committee)	2
Referred to the Health Committee	5
PCC charges heard in the HPDT	9
PCC charges proved in the HPDT	9
PCC charges withdrawn prior to hearing	2

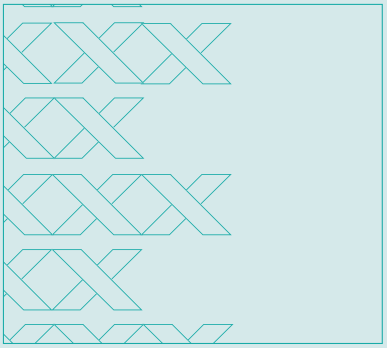
[1] This only includes matters where Council processes were commenced. It does not include queries outside Council's jurisdiction or internally managed inquiries that did not proceed to NTT or Council.

[2] Council's processes can extend over 12 months, so the number of referrals to PCCs, and PCC outcomes, may not necessarily correlate with outcomes within the same year (or outcomes from the previous year.

Table 16 : Notice of Convictions	
(1 July 2021 to 30 June 2022)	
Notices of conviction referred to PCC[1]	2
Doctor referred to Health Evaluation Pathway (section 67A)	2

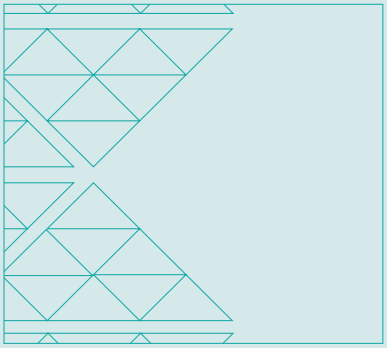
[1] This does not include ongoing PCC processes during which a conviction is received.

He Kupu Whakamārama
Words of Explanation



Purapura Whetū / Stars in the Night Sky

The stars in the sky are based on Purapura Whetū, a tukutuku pattern that represents the stars and the great numbers of people of a nation. We have used this to represent the people of Aotearoa, and also the people within Te Kaunihera Rata o Aotearoa. Five of the stars represent our organisation's values; Whakapono, Whakamārama, Kotahitanga, Manaakitanga, and Kaitiakitanga.



Niho Taniwha / Teeth of the Taniwha

The sawtooth tāniko and tukutuku pattern of Niho Taniwha is used to depict the hills around Whanganui-a-Tara, and represents whānau and hapū, chiefly lineage, the communities in which we live, and the organisations we rely on. Niho Taniwha also speaks to community empowerment and self-determination.

Tangaroa / God of the Seas

Beneath the hills lies Tangaroa, the source and foundation of all life, both bountiful and dangerous. This motif depicts the waters that the people of Aotearoa must navigate; here it represents our own health and our health system - wai ora, the waters of life.

Kiri Taniwha / Skin of the Taniwha

This motif depicts the skin of the taniwha, and represents the qualities of Te Āraihaumaru – strength, guardianship, protection, and safe navigation.

Te Āraihaumaru / The Guardian Protector

The taniwha represents Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand as the kaitiaki, the guardian and protector of the people. The taniwha swims beside the reflection of Purapura Whetū in the sea of Tangaroa, guiding the people safely through. The stars themselves are also used in navigation, so both the people and the taniwha work alongside each other.

The name we have given the taniwha, Te Āraihaumaru, translates as The Defender of Safety.

Te Kaunihera Rata
o Aotearoa

Medical Council
of New Zealand