Te Kaunihera Rata o Aotearoa

Medical Council of New Zealand

Annual Report 2018

Contents

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

The Medical Council of New Zealand is pleased to submit this report for the year ended 30 June 2018 to the Minister of Health. The report is presented in accordance with section 134 of the Health Practitioners Competence Assurance Act 2003 and includes a report on activities of the Health Practitioners Disciplinary Tribunal for doctors only.

Te Kaunihera Rata o Aotearoa

Te tiaki i te iwi whānui me te whakatairanga pai i te mahi e pā ana ki te taha rongoā

Medical Council of New Zealand

Protecting the public, promoting good medical practice

Facts at a glance

Doctors newly registered →

(1 July 2017 to 30 June 2018)

1,056
International medical graduates

469
Trained in New Zealand

662
Doctors newly registered with vocational scopes

84
Candidates who sat NZREX Clinical

45
Candidates who passed NZREX Clinical

30
Referrals to a professional conduct committee

21

Referrals to a performance assessment committee

7

Education programme ordered after a performance assessment

60

Referrals to the Health Committee

16,343

Total practising doctors at 30 June 2018

Medical Council of New Zealand's strategic goals 2017/18

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

Goal two Improve Council's relationship and partnership with the public, the profession and stakeholders to further Council's primary purpose – to protect the health and safety of the public.

Goal three Promote good regulation of the medical profession by providing standards of clinical competence, cultural competence and ethical conduct and ensuring that the standards reflect the expectations of the public, the profession and stakeholders.

Goal four Improve medical regulatory and workforce outcomes in New Zealand by the registration of doctors who are competent and fit to practise and their successful integration into the health service.

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

Council is working in five strategic directions to achieve its goals.

→ Strategic direction 1

Accountability to the public and stakeholders

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

→ Strategic direction 2

Promoting competence

Council applies the principles of 'right touch' regulation to ensure all doctors maintain competence, have up-to-date knowledge and are fit to practise throughout their medical career. The key outcome of this strategic direction is to continually improve the current high quality of medical practice in New Zealand. Council will continue to provide leadership to the profession and work collaboratively and constructively with key stakeholders to achieve this outcome.

→ Strategic direction 3

Cultural competence, partnership and health equity

Council expects that doctors will be culturally competent and deliver culturally safe care. Council is encouraging doctors and health organisations to establish and strengthen their partnerships with Māori organisations, with the aim of including Māori participation within their governance structures. The aim of these endeavours is to improve Māori health outcomes and reduce health inequity.

→ Strategic direction 4

Medical education

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

Following an independent review of the implementation of the prevocational medical training programme for interns undertaken in 2016, Council proceeded to implement the 35 subsequent recommendations made in the final report. The changes included improving processes for how interns record their learning outcomes and goals, improvements to the functionality of the intern electronic portfolio (ePort), appropriate supervision of interns and ensuring the focus of the two prevocational years is on their education.

The recommendations from the report have now been completed and all actions addressed.

→ Strategic direction 5

Research and evidence-based regulation

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

Chairperson's report

Appointment of new Chief Executive

In December 2018, Council appointed Mrs Joan Simeon as Chief Executive of the Medical Council of New Zealand. Mrs Simeon previously held roles at Council as Strategic Programme Manager and Registration Manager. Mrs Simeon's appointment followed the resignation of Mr Philip Pigou who had served as Chief Executive for 12 years. Mr Pigou resigned to take up the role of Chief Executive with the Australian Medical Council.

Mrs Simeon has extensive knowledge of the role and functions of Council and the wider health sector, as well as a vision for ensuring effective regulation for the years to come. In addition, her ability to build long-term relationships with stakeholders is vital to the strategic work and direction of Council.

Council member changes

Council membership will change considerably in the next 12 months as 10 members' terms expire between June 2018 and June 2019.

- Dr Jonathan Fox – June 2018
- Dr Pamela Hale – June 2018
- Dr Martin Searle – June 2018
- Dr Curtis Walker – June 2018
- Dr Tailulu (Lu'isa) Fonua-Faeamani – September 2018
- Ms Kim Ngārimu – September 2018
- Mr Andrew Connolly – December 2018
- Ms Laura Mueller – December 2018
- Ms Susan Hughes – June 2019
- Professor John Nacey – March 2019

The loss of a number of long-serving Council members poses some challenges to Council with the significant loss of institutional knowledge. We will need to ensure there is a smooth transition.

Dr Jonathan Fox and Ms Laura Mueller have each served 9 years on Council, the maximum amount of time a member can serve in this role. Dr Martin Searle, who was appointed to Council for a 9-month term in August 2017, did not stand for re-election and retired from Council on 30 June 2018. Ms Joy Quigley retired from Council on 29 April 2018 after serving two terms as a lay member.

I am also completing my time on Council with a new Chairperson to be elected in February 2019.

I would like to acknowledge the contribution that both Ms Quigley and Dr Searle made to Council. Ms Quigley has been a strong advocate for health consumers around the Council table over the past 6 years, while Dr Searle's advice during his short term has been invaluable. Dr Fox and Ms Mueller have given extraordinary service to Council, and the contribution of all retiring members is formally acknowledged.

In February 2018, Ms Mueller, layperson, and I were again re-elected Deputy Chairperson and Chairperson of Council respectively – positions we have both held since February 2014.

2018 Medical Council of New Zealand election

In March 2018, doctors voted four doctors to be elected to Council.

The successful candidates in alphabetical order were:

- Dr Stephen Child
- Dr Ainsley Goodman
- Dr Pamela Hale
- Dr Curtis Walker

Two existing Council members, Drs Pamela Hale and Curtis Walker, were re-elected.

The names of the four highest-polling candidates have been forwarded to the Hon Dr David Clark, Minister of Health, and we expect they will take up their positions for a 3-year term sometime after 1 July 2018.

Health Practitioners Competence Assurance Amendment Bill 2018

In May 2018, Council made submissions to the Health Select Committee (the committee) on the Health Practitioners Competence Assurance Amendment Bill 2018. Council highlighted several key areas of concern:

- **Power to suspend doctors in urgent cases**

  Council has long argued for power to act immediately to prevent a doctor from continuing to practise in circumstances of clear risk to patients. Council believes that a power to immediately suspend a practitioner (or to impose conditions) in some cases is essential.

- **Referral of convictions to professional conduct committee (PCC)**

  Council advocated for a degree of discretion on whether to refer to a PCC a notice of conviction relating to certain acts listed in section 67(b) but urged the committee to extend that discretion to convictions generally. PCCs require significant resources, with Council drawing heavily on the profession to provide PCC members. The costs of PCCs are significant and are passed on to the profession.

- **Telehealth**

  Council's view is that the Act must protect the health and safety of all patients in New Zealand, regardless of where that care is provided from. Council commented that the Act needed to be clear not only on expectations for the regulation of practitioners based overseas but also on providing telehealth services to the New Zealand public.

  Greater flexibility may be needed to allow registration authorities to use alternative measures to ensure that practitioners who are located in another country are competent and fit to practise and there is no risk of harm to New Zealanders receiving telehealth services.

Thanks

I would like to extend my thanks to Council members and staff for their support and for meeting the challenges and demands of medical regulation in New Zealand.

Andrew Connolly
Chairperson
Medical Council of New Zealand

Chief Executive's report

It is with pleasure that I present my first report as Chief Executive Officer (CEO), covering the 7 months since I took up this role.

I would like to acknowledge the huge contribution that Mr Philip Pigou made to the work and leadership of Council over the past 12 years until the end of November 2017. His work and vision for Council has left the organisation in good shape for the challenges ahead.

I would like to express special thanks to our committed staff who are dedicated to achieving the purpose of Council and are always focused on protecting the health and safety of the public. Our people are our greatest asset, and I am proud to lead such a wonderful team.

We are extremely fortunate to have members of numerous committees, panels and advisory groups who make a huge contribution to Council's strategic programmes of work. We are appreciative of the contribution these groups make, and I thank them for their time and commitment to Council's work.

I would also like to extend my thanks to Mr Andrew Connolly, Council Chairperson, who demonstrates tremendous leadership. It has been a privilege to work alongside Andrew and a committed group of Council members.

I am very much looking forward to the next year. We are well placed to build on the strategic and operational areas of our work.

The Council office

Since the Kaikoura earthquake in November 2016, we have moved our office because of concerns about the building we were in. In the 7 months I have been CEO, I have strongly believed that it is my responsibility, and that of Council, to make sure that everyone working for Council is safe in their work environment.

Our accommodation has created many challenges, not least maintaining business continuity. We are currently working in temporary office accommodation that has been less than ideal and testing for everyone. I would like to pay tribute to all staff for their resilience, understanding and tolerance of their temporary working conditions. Everyone's 'can do' attitude while we work through these challenges has been very much appreciated.

5-year strategic plan: *Towards 2022*

Early in 2018, we reviewed and refined our strategy and released our 5-year strategic plan *Towards 2022*. The plan outlines our vision, purpose, values, principles, goals and strategic directions.

Council has five strategic goals that drive our activities for the benefit of the public, profession and stakeholders. This work is achieved by five directions that sit beneath our strategic goals.

A summary of key activities undertaken within each strategic direction follows.

Strategic direction 1 – Accountability to the public and stakeholders

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

We do this in a number of ways including seeking input and feedback in multiple forms, for example:

- our Consumer Advisory Group
- holding annual meetings with medical colleges
- our stakeholder engagement plan to ensure we meet regularly with all of our stakeholders
- having memoranda of understanding with numerous stakeholders, defining roles and responsibilities.

Review of Council's statements

Over the past year, we engaged widely with medical colleges, the profession, the Consumer Advisory Group, employers, including District Health Boards, and a wide range of other stakeholders on the following Council statements:

- *Complementary and alternative medicine.*
- *Safe practice in an environment of resource limitations.*
- *Professional boundaries in the doctor-patient relationship.*
- *Sexual boundaries in the doctor-patient relationship.*

I would like to thank all those who contributed feedback, which helped strengthen the content of the revised statements.

Strategic direction 2 – Promoting competence

Council applies the principles of 'right touch' regulation to ensure all doctors maintain competence, have up-to-date knowledge and are fit to practise throughout their medical career. The key outcome of this strategic direction is to continually improve the current high quality of medical practice in New Zealand. Council will continue to provide leadership to the profession and work collaboratively and constructively with key stakeholders to achieve this outcome.

Recertification requirements for vocationally registered doctors

A significant focus for us this year has been on strengthening recertification. Our vision is that recertification should ensure that each doctor is supported by education that provides for their individual learning needs and is delivered by effective, efficient and reflective mechanisms that support maintenance of high standards and continuing improvement in performance.

We consulted in early 2017 on a proposal for a strengthened approach to recertification. We proposed a model building on continuing professional development that is already in place. We also proposed the use of a professional development plan and a greater component of reflection and peer review activities. The direction proposed is to increase emphasis on the value of recertification activities, based on evidence, ensuring that these are appropriate for a doctor's individual learning needs. This will not be a big change – rather, it will strengthen what we already do.

In the coming year, we will be continue our focus on this important work that builds on Council's *Vision and principles for recertification*.

Review of collegial relationships

Doctors registered within a general scope of practice who are not participating in a vocational training programme are required to establish a collegial relationship with a doctor who is registered within a vocational scope in the same or a closely related area of medicine in which they work. The main purpose of the collegial relationship is to ensure that the doctor's professional development plan and CPD activities are appropriate for and focused on the actual work that the doctor is undertaking.

Over the past year, Council carried out a review of the effectiveness of collegial relationships, which considered the strengths, weaknesses and opportunities for improvement. A working group developed a range of recommendations for improvements, and Council will consider these in July 2018.

Strategic direction 3 – Cultural competence, partnership and health equity

Council expects that doctors will be culturally competent and deliver culturally safe care. Council is encouraging doctors and health organisations to establish and strengthen their partnerships with Māori organisations, with the aim of including Māori participation within their governance structures. The aim of these endeavours is to improve Māori health outcomes and reduce health inequity.

We have worked closely in partnership with Te Ohu Rata o Aotearoa Māori Medical Practitioners Association (Te ORA) on initiatives within this strategic direction.

We have commenced a review of our statements and resources focused on cultural competence, cultural safety and health equity to make sure they are current and reflect best practice.

Linked to this work, I have been keen to encourage staff to attend workshops and take part in training in tikanga Māori and te reo Māori, and we commenced training workshops for all staff through the year. In November 2017, Associate Professor Papaarangi Reid (Head of Department of Māori Health, University of Auckland) ran a workshop for all Council staff. She discussed cultural competence, cultural safety and conscious and unconscious bias and how these contribute to health inequities.

Strategic direction 4 – Medical education

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

Medical education is a key part of our work as we develop the skills needed by doctors today and in the future.

Evaluation of all changes to prevocational medical training requirements

We initiated an evaluation of the changes made over the past 3 years to prevocational medical training to ensure it is providing a quality training experience for interns and delivering against the intended outcomes.

Malatest International was contracted to undertake this work, and their evaluation work began in June 2018. The first findings from the evaluation are expected in November 2018.

New Zealand Curriculum Framework (NZCF) for prevocational medical training

A steering group, led by Professor John Nacey (Council member and Education Committee Chairperson), was established in 2017 to review the NZCF. The steering group has membership from a wide range of key stakeholders, including the national DHB Chief Medical Officer group, universities, clinical directors of training, prevocational educational supervisors, interns and the New Zealand Resident Doctors' Association.

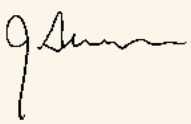
The review of the NZCF will continue through the coming year.

Strategic direction 5 – Research and evidence-based regulation

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

We are committed to undertaking and publishing evaluations of all strategic initiatives to determine if they deliver the outcomes we set out to achieve. Evaluations undertaken or planned include those related to regular practice review, prevocational medical training, cultural competence, cultural safety and health equity.

We are considering how data and other information gained through evaluation programmes and other sources could be used to improve our processes, inform our standards and help develop new initiatives over time.



Joan Simeon
Chief Executive
Medical Council of New Zealand

Audit Committee report

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

In June 2018, Dr Jonathan Fox completed his term on Council and therefore stood down as Chairperson of the Council's Audit Committee, and I was appointed Chairperson by Council.

Terms of reference

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

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

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

Fees review

During 2015, a complete review of all fees charged was completed using activity-based costing methodology. This resulted in changes to fees where there had previously been cross-subsidisation. Due to the amount of the fee changes combined with the change in the methodology compared to the way fees had been calculated in the past, the calculation of the fee workings was peer reviewed by KPMG.

Using the same activity-based costing methodology that was applied in 2015, the fees that Council charges have been reviewed during this financial year. The calculations have been updated to take into account the changes to the budget since 2015 as well as changes to processes and the time taken to undertake certain functions.

Health and safety

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

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

Premises

The Council office premises experienced earthquake damage. Following this, an independent engineer's report identifying potential safety risks necessitated us moving out of our permanent accommodation at 80 The Terrace in Wellington in mid-February 2017 to temporary accommodation at Plimmer Steps.

The Medical Council's concerns related to the safety of the building were not resolved over the course of the year and remained unresolved at the close of the financial year.

Therefore, at 30 June 2018, we remain in temporary accommodation.

The Audit Committee and Council engaged a number of strategies to work through the issues, but they remain unresolved at the end of the year.

Risk management programme

The Audit Committee this year continued to monitor key risks to Council. The risk impact assessment Council uses has been useful in managing issues including business disruption, allowing both Council and staff to anticipate and proactively mitigate and manage issues.

The Audit Committee monitored risks around the property issues facing Council due to the relocation of Council from its premises at 80 The Terrace as a result of earthquake damage to the building.

Annual financial statements

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

Finally, I would like to thank Dr Jonathan Fox for his stewardship and oversight of the Audit Committee over the past 3 years.

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

Education Committee report

The Education Committee is a standing committee of Council.

Accreditation of prevocational medical training providers

Under the Health Practitioners Competence Assurance Act 2003 (HPCAA), Council is required to accredit and monitor educational institutions that deliver medical training for doctors and to promote medical education and training in New Zealand. The purpose of the accreditation of prevocational training providers is to ensure that minimum standards have been met for the provision of education and training for postgraduate year 1 and 2 (PGY1 and PGY2) interns.

The following training providers have been assessed by a Council-appointed accreditation team as part of their requirement to meet Council's accreditation standards:

Prevocational medical training

- Lakes District Health Board (DHB) – site visit conducted in October 2017.
- Taranaki DHB – site visit conducted in July 2017.
- Waikato DHB – site visit conducted in August 2017.
- Waikato DHB (follow-up) – site visit conducted in April 2018.

Vocational medical training and recertification programmes

- Royal New Zealand College of Urgent Care – site visit conducted in August 2017.
- New Zealand Dermatological Society Incorporated (NZDSi) – site visit conducted in November 2017.
- Division of Rural Hospital Medicine – site visit conducted in April 2018.
- Family Planning and Reproductive Health College of the New Zealand Sexual and Reproductive Health Educational Charitable Trust – site visit conducted in March 2018.

Accreditation of Specialist Medical Training and Recertification Programmes: Standards and Procedures for New Zealand Training Providers (2014) was used to assess the vocational medical training and recertification programmes for New Zealand-based training providers and colleges.

2017 prevocational educational supervisor meetings

Three annual prevocational educational supervisor meetings were held in Wellington and Auckland in August and September 2017.

The agenda for each meeting followed a similar format. The meetings included a workshop from Connect Communications about supporting interns having to deal with burnout and stress in the workplace as well as how to manage the disengaged intern. Updates on Council's processes and initiatives were shared, and prevocational educational supervisors were able to provide feedback about any challenges they faced the previous year. Each meeting also concluded with a question and answer session led by the Council Chairperson.

Protocols for the appointment of members to Council's Education Committee and members to prevocational and vocational accreditation teams

At its October 2017 meeting, Council approved the *Protocol for the appointment of members to Council's Education Committee* and the *Protocol for the appointment of members to prevocational and vocational accreditation teams*.

This followed resolutions from Council in 2016 and 2017 to amend the composition of the Education Committee as well as clarification of its processes for the appointment of members to the Education Committee. Similarly, Council resolved to make amendments to the composition of accreditation teams that assess prevocational medical training providers as well as vocational medical training and recertification programmes. At this time, Council also clarified the process for appointing interns and trainees to accreditation teams.

A review of the role and efficacy of the ePortfolio in prevocational training

The Education Committee undertook a review of ePortfolio (ePort) software in its effectiveness to accurately record the clinical education experiences of PGY1 and PGY2 interns during their prevocational medical training in New Zealand as well as medical students in their final year (6th year) of medical school.

The implementation of the ePort system has encouraged a strong focus towards standardisation of intern clinical education and acquisition of essential skills and experiences leading to proficient and safe patient care by New Zealand's interns. The review found there are several aspects of the ePort system that could benefit from further evaluation and amendments. Additionally, there is excellent potential for the ePort system to also act as a tool to monitor the quality, quantity and consistency of intern education, and further development will be considered.

The New Zealand Curriculum Framework for prevocational medical training was established to ensure PGY1 and PGY2 interns develop and demonstrate a range of essential skills required to work effectively and safely within a general scope of practice prior to undertaking vocational training.

I would like to acknowledge the excellent contribution of the Education Committee and Council staff towards ensuring the best possible learning experience for our interns and vocational trainees.

Professor John Nacey
Chairperson
Education Committee
Medical Council of New Zealand

Members of the Medical Council

During the period 1 July 2017 to 30 June 2018

Mr Andrew Connolly

BHB 1984, MB ChB 1987 Auckland, FRACS 1994

Appointed to Council in November 2009, Mr Connolly was elected Deputy Chairperson of Council in February 2012 and as Chairperson from February 2014. Mr Connolly was re-elected as Chairperson again in February 2018.

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

He has a strong interest in governance, education and clinical leadership and has been the Head of Department of General and Vascular Surgery since 2003. He served on the Ministerial advisory group that was responsible for the *In Good Hands* document. In 2016, he was part of the Ministry of Health Capability and Capacity Review of the Health Sector.

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

He has previously held the role of Presiding Member of the Lotteries Health Research Distribution Committee, he chaired a Ministerial review of the impact of the elective waiting times policy and he was a member of the review panel of the New Zealand Cancer Registry. Mr Connolly currently also serves on the Southern Partnership Group for the redevelopment of Dunedin Hospital.

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

As Council Chairperson, Mr Connolly is an ex officio member of Council's Audit, Education and Health Committees.

Dr T Lu'isa Fonua-Faeamani

MB ChB 1998 Otago, FRNZCGP 2007

Appointed to Council in July 2015, Dr Fonua-Faeamani is a GP and clinical director for The Fono – Health and Social Services based in West Auckland. The Fono provides affordable healthcare services including medical, dental, pharmacy, health awareness and community support services and delivers a combination of these services across four Auckland locations.

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

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

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

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

Dr Jonathan Fox

MB BS 1974 Lond, MRCS Eng LRCP Lond 1974, MRCGP 1981, FRNZCGP 1998 (Dist), FRACGP 2010 (Hon) C MinstD

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

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

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

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

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

He came to New Zealand in 1990 with his GP wife and their children. Over the last 27 years, their practice grew and is now a seven-doctor practice in Meadowbank, Auckland. Dr Fox retired from general practice in mid-June 2018.

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

Dr Pamela Hale

MB ChB Otago 1982, FRACP 1991

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

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

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

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

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

She is Chairperson of Council's Health Committee.

Ms Susan Hughes QC

BA, LLB, GDip Bus Studs, MMgt

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

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

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

Ms Hughes is Chairperson of Council's Audit Committee.

Dr Paul Hutchison

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

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

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

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

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

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

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

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

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

Ms Laura Mueller

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

Appointed to Council in October 2009, Ms Mueller is a lay member of Council and has been Council's Deputy Chairperson since February 2014.

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

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

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

Ms Mueller is on the board of trustees for the Tauranga Community Foodbank and was elected to the board of Consumer NZ in June 2018.

Professor John Nacey

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

Professor Nacey was appointed to Council in March 2010.

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

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

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

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

Professor Nacey is Chairperson of Council's Education Committee.

Ms Kim Ngārimu

BBS

Ms Ngārimu is a director of Tāua Limited, a consulting company specialising in the provision of public policy and management advice, and is a member of a number of government-appointed statutory boards.

She held the position of Deputy Secretary Policy with Te Puni Kōkiri from March 2007 until December 2013. Ms Ngārimu has also held positions as Acting Chief Executive of the Ministry of Women's Affairs and Acting Director for the Waitangi Tribunal.

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

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

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

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

Ms Joy Quigley JP

QSO (2008)

Ms Quigley was appointed to Council as a lay member in 2011.

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

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

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

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

Dr Martin Searle

BM 1976 Soton, MRCP (UK) 1980, FRACP 1990

Dr Searle was appointed to Council in August 2017 by the Minister of Health.

Dr Searle recently retired as a nephrologist with Canterbury District Health Board (1998–2015) where he was also Chair of the Mortality Review Committee and Member of the Credentials Board. He continues locum practice as a nephrologist in Australia and New Zealand.

Dr Searle graduated in the first class from the new Southampton University Medical School in 1976 and undertook physician training in nephrology and general medicine in the Wessex Region.

He came to New Zealand in 1987 as the first full-time nephrologist with what was then South Auckland Health.

While working at Middlemore Hospital, Dr Searle chaired the Division of Medicine, Senior Medical Staff Association, New Zealand Nephrology Group and Renal Advisory Committee to the Ministry of Health and was a member of the Australian and New Zealand Society of Nephrology Council.

Dr Searle was awarded Fellowship on the basis of his overseas qualifications. Soon after, he organised the first Fellow of the Royal Australasian College of Physicians' (RACP) clinical examination at Middlemore Hospital followed by 20 years as a RACP examiner. His roles with the New Zealand branch of the RACP included Chair of Committee of Exams, Board of Censors and RACP President for New Zealand.

He helped formulate RACP's advice to Council on the Health Practitioners Competence Assurance Act and processes of assessment of overseas-trained physicians. In addition, he advised the Parliamentary Select Committee when it considered moving responsibility for assessing overseas-trained physicians from Council to the New Zealand Education Authority.

Dr Searle has been a member of Council's Performance Assessment Committee and has carried out a number of individual assessments for Council.

Dr Curtis Walker

MB ChB 2007 Auckland, FRACP 2015

Dr Walker was first elected to Council in 2015 and re-elected in March 2018.

Ko Whakatōhea rāua ko Ngāti Porou ngā iwi.

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

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

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

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

Registration of doctors and practising certificates

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

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

Confirmation of eligibility for doctors seeking registration in general and special purpose scopes of practice is provided within 20 working days of receiving a completed application. Eligibility for registration within a vocational scope of practice is provided after consultation with the relevant vocational education and advisory body and takes, on average, 4–6 months.

Table 1: Scopes of practice – summary of registration status[1]

At 30 June 2018

Provisional general	3,804
General	9,052
Provisional vocational	256
Vocational	12,077
Special purpose	226
Total on register	**25,415**
Total practising	16,343
Suspended	12

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

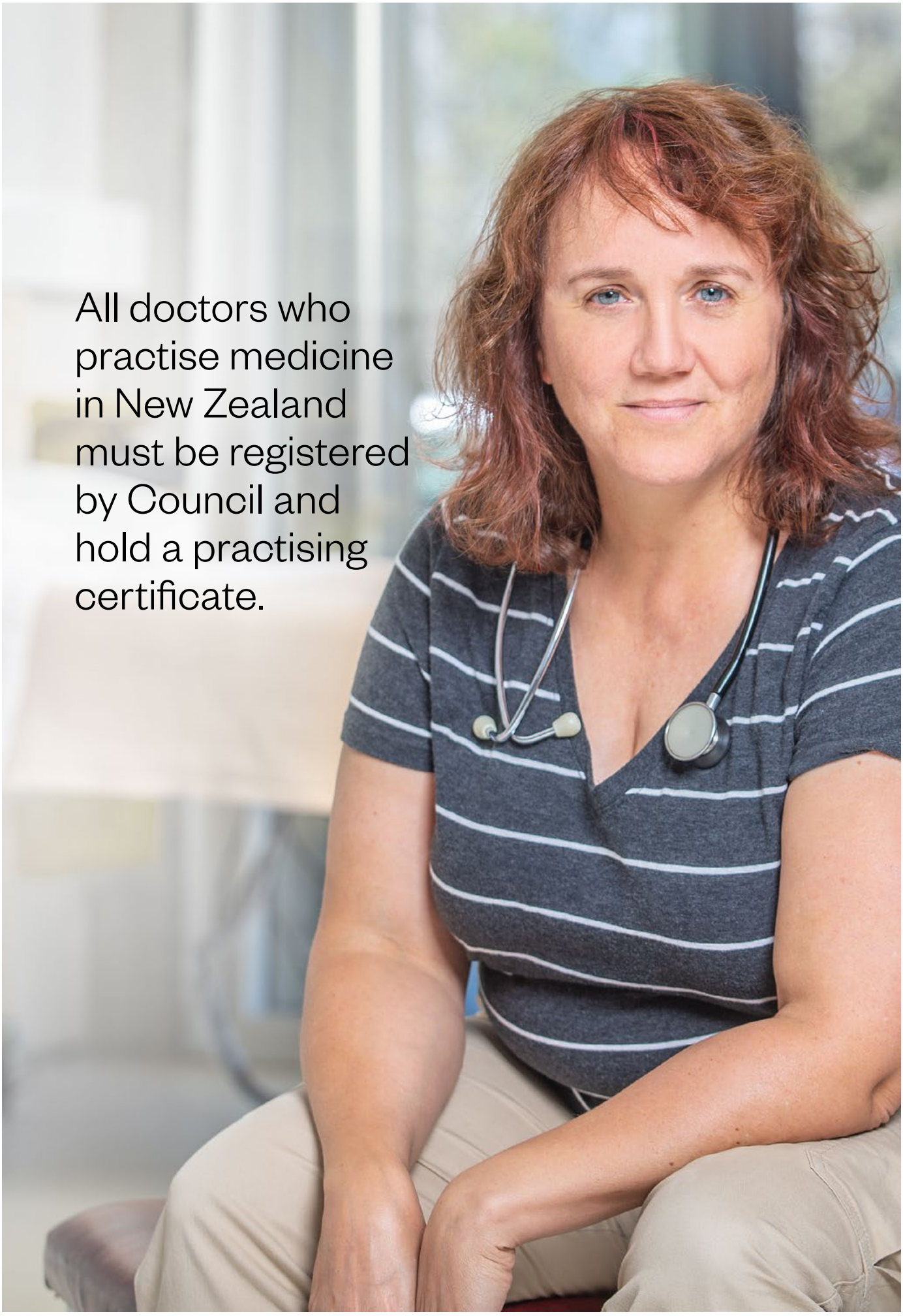

All doctors who practise medicine in New Zealand must be registered by Council and hold a practising certificate.

Table 2: Registration activities

1 July 2017 to 30 June 2018

Registration activities	Number
Provisional general/vocational issued	
New Zealand graduates (interns)	466
Australian graduates (interns)	13
Passed NZREX Clinical (interns)	43
Graduate of competent authority accredited medical school	460
Worked in comparable health system	199
New Zealand and international medical graduates reregistration (following cancellation)	-
Transitional	-
Non-approved postgraduate qualification – vocational assessment	91
Non-approved postgraduate qualification – vocational eligible	82
Special purpose scope issued	
Visiting expert	37
Research	2
Postgraduate training or experience	42
Locum tenens in specialist post	93
Emergency or other unpredictable short-term situation	-
Teleradiology	-
General scope after completion of supervised period	
New Zealand/Australian graduates (interns)	462
Passed NZREX Clinical	22
Graduate of competent authority accredited medical school	329
Worked in comparable health system	92
Transitional	-
Vocational scope after completion of supervised period	
Non-approved postgraduate qualification – vocational assessment	54
Non-approved postgraduate qualification – vocational eligible	84
Approved vocational education and advisory body (VEAB) training programme	-

Table 2 continued

Registration activities	Number
General scope issued	
New Zealand graduates	9
Overseas graduates	85
Restorations	15
Vocational scope issued	
Approved postgraduate qualification	478
Suspensions	
Suspension or interim suspension	5
Revocation of suspension	-
Conditions	
Imposed	232
Revoked	155
Cancellations under the Health Practitioners Competence Assurance Act 2003	
Death – section 143	23
Discipline order – section 101(1)(a)	3
False, misleading or not entitled – section 146	1
Revision of register – section 144(5)	98
At own request – section 142	167

Table 3: Doctors registered in vocational scopes

1 July 2017 to 30 June 2018

Vocational scope	Vocational registration at 30/6/2017[1]	Added 2017/18	Removed 2017/18	Net change	Vocational scope at 30/6/2018[1,2]
Anaesthesia	974	53	7	46	1,020
Cardiothoracic surgery	40	2	1	1	41
Clinical genetics	16	3	-	3	19
Dermatology	76	8	-	8	84
Diagnostic and interventional radiology	627	38	6	32	659
Emergency medicine	355	38	3	35	390
Family planning and reproductive health	34	-	-	-	34
General practice	4,240	170	46	124	4,364
General surgery	377	21	1	20	397
Intensive care medicine	109	8	1	7	116
Internal medicine	1,322	76	6	70	1,392
Medical administration	38	4	-	4	42
Musculoskeletal medicine	25	-	-	-	25
Neurosurgery	29	1	-	1	30
Obstetrics and gynaecology	387	26	2	24	411
Occupational medicine	68	2	-	2	70
Ophthalmology	175	11	1	10	185
Oral and maxillofacial surgery	24	4	1	3	27
Orthopaedic surgery	338	15	2	13	351
Otolaryngology head and neck surgery	133	7	-	7	140
Paediatric surgery	26	3	-	3	29
Paediatrics	461	25	6	19	480
Pain medicine	28	3	-	3	31
Palliative medicine	78	7	-	7	85
Pathology	368	23	-	23	391
Plastic and reconstructive surgery	82	5	1	4	86

Table 3 continued

Vocational scope	Vocational registration at 30/6/2017[1]	Added 2017/18	Removed 2017/18	Net change	Vocational scope at 30/6/2018[1,2]
Psychiatry	777	63	2	61	838
Public health medicine	215	8	1	7	222
Radiation oncology	81	3	-	3	84
Rehabilitation medicine	29	2	-	2	31
Rural hospital medicine	119	6	-	6	125
Sexual health medicine	24	-	-	-	24
Sport and exercise medicine	31	-	-	-	31
Urgent care	215	22	-	22	237
Urology	84	2	-	2	86
Vascular surgery	41	3	1	2	43
Total	**12,046**	**662**	**88**	**574**	**12,620**

1 Includes doctors who may currently be inactive (have no practising certificate).
2 Includes 521 doctors with registration in two vocational scopes and 10 doctors with registration in three vocational scopes.

Table 4: Registrations issued, by country of primary qualification

1 July 2017 to 30 June 2018

Country	Provisional general	Provisional vocational	Special purpose	Total
England	286	31	23	**340**
United States of America	62	34	68	**164**
Scotland	98	10	4	**112**
Ireland	47	1	1	**49**
India	13	11	12	**36**
Australia	13	-	22	**35**
South Africa	7	24	2	**33**
Canada	15	4	8	**27**
Netherlands	25	1	-	**26**
Wales	23	-	1	**24**
Germany	12	9	2	**23**
Pakistan	10	1	2	**13**
Sweden	11	1	-	**12**
Denmark	10	-	-	**10**
Poland	4	3	2	**9**
Northern Ireland	7	1	-	**8**
Belgium	5	2	-	**7**
Malaysia	3	1	3	**7**
Fiji	1	-	5	**6**
Hungary	4	2	-	**6**
Spain	2	2	2	**6**
Other[1]	57	30	16	**103**
New Zealand	466	2	1	**469**
Total	**1,181**	**170**	**174**	**1,525**

1 Other represents 48 countries that had fewer than six registrations in the reporting period.

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

1 July 2017 to 30 June 2018

Vocational scope	New Zealand	Overseas	Total
Anaesthesia	22	31	**53**
Cardiothoracic surgery	1	1	**2**
Clinical genetics	2	1	**3**
Dermatology	3	5	**8**
Diagnostic and interventional radiology	11	27	**38**
Emergency medicine	13	25	**38**
General practice	97	73	**170**
General surgery	12	9	**21**
Intensive care medicine	4	4	**8**
Internal medicine	37	39	**76**
Medical administration	2	2	**4**
Neurosurgery	1	-	**1**
Obstetrics and gynaecology	14	12	**26**
Occupational medicine	-	2	**2**
Ophthalmology	6	5	**11**
Oral and maxillofacial surgery	1	3	**4**
Orthopaedic surgery	8	7	**15**
Otolaryngology head and neck surgery	2	5	**7**
Paediatric surgery	1	2	**3**
Paediatrics	21	4	**25**
Pain medicine	3	-	**3**
Palliative medicine	3	4	**7**
Pathology	15	8	**23**
Plastic and reconstructive surgery	1	4	**5**
Psychiatry	16	47	**63**
Public health medicine	2	6	**8**
Radiation oncology	3	-	**3**
Rehabilitation medicine	-	2	**2**

Table 5 continued

Vocational scope	New Zealand	Overseas	Total
Rural hospital medicine	5	1	**6**
Urgent care	12	10	**22**
Urology	1	1	**2**
Vascular surgery	-	3	**3**
Total	**319**	**343**	**662**

Table 6: Outcomes of applications for vocational assessments

1 July 2017 to 30 June 2018

	Incomplete applications	Pending	Withdrawn/ lapsed	Vocational eligible	Vocational assessment	NZREX	Total
Anaesthesia	10	3	8	1	6	2	**30**
Cardiothoracic surgery	1	1	-	-	-	-	**2**
Clinical genetics	2	-	-	-	-	-	**2**
Dermatology	1	-	2	3	2	-	**8**
Diagnostic and interventional radiology	9	1	11	13	3	-	**37**
Emergency medicine	11	-	1	5	8	-	**25**
General practice	9	1	4	-	4	-	**18**
General surgery	7	-	5	5	-	1	**18**
Intensive care medicine	1	-	-	-	2	-	**3**
Internal medicine	25	3	9	20	7	2	**66**
Neurosurgery	1	-	-	-	2	-	**3**
Obstetrics and gynaecology	7	2	3	3	3	-	**18**
Occupational medicine	2	-	-	4	-	-	**6**
Ophthalmology	5	-	1	1	1	1	**9**
Oral and maxillofacial surgery	1	1	-	2	-	-	**4**
Orthopaedic surgery	12	3	2	2	2	1	**22**
Otolaryngology head and neck surgery	7	1	5	1	2	2	**18**
Paediatric surgery	-	-	-	-	1	-	**1**
Paediatrics	5	-	4	4	2	-	**14**
Pain medicine	1	-	-	-	-	-	**1**
Palliative medicine	1	-	-	6	-	-	**7**
Pathology	13	-	-	4	-	-	**17**
Plastic an reconstructive surgery	2	-	-	1	1	2	**6**

Table 6 continued

	Incomplete applications	Pending	Withdrawn/ lapsed	Vocational eligible	Vocational assessment	NZREX	Total
Psychiatry	25	1	10	17	7	-	**60**
Public health medicine	1	-	1	2	1	-	**5**
Radiation oncology	2	-	1	1	1	-	**5**
Rehabilitation medicine	1	-	-	1	-	-	**2**
Sport and exercise medicine	-	-	2	-	-	-	**2**
Urology	2	-	-	-	1	-	**3**
Vascular surgery	2	-	1	-	-	2	**5**
Total	**165**	**17**	**70**	**96**	**56**	**13**	**417**
Percentages based on total number of outcomes (%)				58.2	33.9	7.9	

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

As at 30 June 2018

Country	Provisional general	General	Provisional vocational	Vocational	Special purpose	Total	Number with practising certificates
England	1,207	1,588	25	1,530	27	**4,377**	2,122
United States of America	550	144	65	351	118	**1,228**	392
Scotland	304	444	12	436	3	**1,199**	607
South Africa	65	166	25	777	3	**1,036**	726
Australia	17	547	-	447	1	**1,012**	529
India	68	216	17	453	18	**772**	484
Ireland	179	325	1	85	4	**594**	246
Germany	87	85	17	155	1	**345**	186
Wales	119	136	2	70	2	**329**	115
Canada	135	27	8	74	12	**256**	82
Sri Lanka	12	66	2	170	1	**251**	124
Netherlands	115	51	11	56	-	**233**	103
Iraq	6	55	-	109	-	**170**	109
Pakistan	23	64	1	49	2	**139**	79
Northern Ireland	32	46	-	34	1	**113**	57
China	4	42	-	61	-	**107**	78
Sweden	58	15	11	19	-	**103**	23
Bangladesh	4	28	2	68	-	**102**	43
Egypt	13	18	2	52	1	**86**	45
Fiji	1	15	-	46	11	**73**	66
Russia	9	33	1	24	-	**67**	53
Poland	16	20	3	22	2	**63**	35
Denmark	35	15	2	9	-	**61**	21
Belgium	25	16	4	12	-	**57**	23
Philippines	2	24	2	29	-	**57**	42
Singapore	10	19	-	23	-	**52**	28
Zimbabwe	2	3	-	40	-	**45**	36

Table 7 continued

Country	Provisional general	General	Provisional vocational	Vocational	Special purpose	Total	Number with practising certificates
Italy	11	5	6	18	-	**40**	24
Nigeria	8	16	1	14	-	**39**	14
Romania	6	13	1	17	-	**37**	19
Serbia	-	9	-	24	-	**33**	21
Spain	6	9	-	16	1	**32**	26
Switzerland	12	7	3	9	-	**31**	13
Austria	10	11	4	5	-	**30**	13
Hungary	10	6	-	14	-	**30**	22
Czech Republic	5	12	-	11	-	**28**	15
France	7	11	2	8	-	**28**	17
Malaysia	5	8	1	11	3	**28**	24
Myanmar	2	9	-	13	-	**24**	16
Ukraine	3	14	-	7	-	**24**	17
Israel	4	6	2	6	1	**19**	14
Bulgaria	2	7	1	8	-	**18**	13
Iran	2	8	1	5	-	**16**	8
Croatia	1	4	-	10	-	**15**	10
Finland	4	7	2	1	1	**15**	5
Mexico	5	2	-	6	2	**15**	7
Sudan	2	6	2	5	-	**15**	14
Argentina	2	4	4	3	-	**13**	12
Brazil	3	4	-	6	-	**13**	7
Syria	2	6	1	4	-	**13**	8
Zambia	-	7	-	6	-	**13**	9
Norway	3	1	1	7	-	**12**	6
Colombia	1	4	-	5	1	**11**	6
Papua New Guinea	1	1	-	9	-	**11**	6

Table 7 continued

Country	Provisional general	General	Provisional vocational	Vocational	Special purpose	Total	Number with practising certificates
Dominica	6	2	-	1	1	**10**	4
Grenada	7	1	-	2	-	**10**	4
Sint Maarten	8	2	-	-	-	**10**	1
Other[1]	37	76	10	86	8	**217**	134
New Zealand	531	4,566	1	6,539	1	**11,638**	9,380
Total	**3,804**	**9,052**	**256**	**12,077**	**226**	**25,415**	**16,343**

1 Other represents 61 countries with fewer than 10 registered doctors

Professional standards

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

Table 8: Referral sources to full Council meeting for performance processes

1 July 2017 to 30 June 2018

ACC	8
Employer (DHB)	3
Employer (private hospital or general practice)	3
Health and Disability Commissioner (HDC)	23
Medical practitioner colleague	4
Health practitioner colleague	1
Member of public or patient	3
Other	2

Performance

Council seeks to implement mechanisms to ensure doctors are competent to practise. When receiving referrals that relate to a doctor's competence to practise, Council does not investigate specific incidents (that is the Health and Disability Commissioner's role) but considers whether the circumstances raise questions about deficiencies in the doctor's performance.

Table 10 shows the number of cases considered by Council during the year that related to a doctor's competence to practise and Council's decisions as to how those cases should be addressed. The table shows the number of Council's processes during the year rather than the number of individual doctors. Many doctors will have been the subject of more than one decision or process. The numbers include processes that commenced before the year commencing 1 July 2017 and processes that continued after 30 June 2018 and illustrates the volume of Council's work during the year in this area.

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

1 July 2017 to 30 June 2018

Employer (DHB)	4
Employer (private hospital or general practice)	5
Member of public or patient	6
HDC	4
Internally referred within Council	5
Medical practitioner colleague	9
Health practitioner colleague	5
Ministry of Health	2
Media	2
Other	4

Table 10: Competence-related Council processes

1 July 2017 to 30 June 2018

No further action or educational letter on first consideration	11
Await HDC after first consideration	4
Defer – request further information after first consideration	5
Recertification programme ordered on first consideration	4
Referral to a performance assessment committee (PAC)[1]	21
Doctor meets required standard of competence following PAC	11
Doctor does not meet required standard of competence following PAC	7
Recertification programme ordered after PAC (section 41)	3
Educational programme ordered after PAC (section 38)	7
Conditions ordered after PAC (section 38)	3
Educational programme completed satisfactorily	7

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

Conduct

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

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

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

When a doctor is convicted of any offence punishable by imprisonment for a term of 3 months or longer or of an offence under certain specified Acts, the doctor is automatically referred to a PCC. It is not a Council decision. Table 12 shows the PCCs that were commenced as a result of a conviction.

Table 11: Conduct-related Council processes

1 July 2017 to 30 June 2018

No further action or educational letter on first consideration	23
Recertification programme ordered on first consideration	1
Referral to professional conduct committee (PCC)[1]	30
Refer new information to existing PCC	3
Interim conditions ordered (section 69)	4
Interim suspension ordered (section 69)	1
PCC determined charge be brought in the Health Practitioners Disciplinary Tribunal	10
PCC recommended no further action and Council endorses	3
PCC recommended counselling or mentoring and Council endorses	9
PCC recommended review of fitness to practise and Council endorses	4
PCC recommended review of competence to practise and Council endorses	–

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

Table 12: PCC as a result of a conviction

1 July 2017 to 30 June 2018

Professional conduct committee as a result of a conviction	10

Doctors' health

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

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

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

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

1 July 2017 to 30 June 2018

Source	Health Practitioners Competence Assurance Act	Existing	New	Closed	Still active
Health service	section 45(1)a	–	-	-	2
Health practitioner	section 45(1)b	–	31	1	33
Employer	section 45(1)c	–	13	1	11
Medical Officer of Health	section 45(1)d	–	-	-	-
Any person	section 45(3)	–	15	4	9
Person involved with education	section 45(5)	–	1	1	-
Total		**–**	**60**[1]	**7**	**55**[2]

1 31 of the 60 were self-referred.
2 Six of the 55 are in abeyance.

Table 14: Outcomes of health notifications

1 July 2017 to 30 June 2018

Outcomes	HPCAA	Number[1]
No further action	–	9
Order medical examination	section 49(1)	63[2]
Interim suspension	section 48(1)(a)	17[3]
Conditions	section 48(1)(b)	-
Restrictions imposed	section 50(3) or (4)	See note [4]

1 There may be more than one outcome.
2 31 assessments agreed voluntarily (seven of which are pending), and 32 reports from treating clinicians, occupational physicians and so forth.
3 Achieved through voluntary agreement.
4 Requisite monitoring for 55 doctors still active achieved through informal agreement without use of statutory provisions of the Health Practitioners Competence Assurance Act 2003.

Examinations

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

New Zealand Registration Examination – NZREX Clinical

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

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

The prerequisites for applying to sit NZREX Clinical are:

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

Table 15: Cadidates sitting and passing NZREX Clinical

1 July 2017 to 30 June 2018

Country	Number sitting	Attempts					Number passed	Passes				
		1	2	3	4	5		1	2	3	4	5
Bangladesh	3	2	1	-	-	-	-	-	-	-	-	-
Belarus	2	2	-	-	-	-	-	-	-	-	-	-
China	9	8	1	-	-	-	2	2	-	-	-	-
Egypt	3	3	-	-	-	-	1	1	-	-	-	-
Fiji	4	3	1	-	-	-	3	3	-	-	-	-
France	1	1	-	-	-	-	-	-	-	-	-	-
Georgia	1	1	-	-	-	-	1	1	-	-	-	-
Hungary	1	1	-	-	-	-	-	-	-	-	-	-
India	13	11	2	-	-	-	7	6	1	-	-	-
Iran	2	2	-	-	-	-	2	2	-	-	-	-
Iraq	3	2	1	-	-	-	3	2	1	-	-	-
Kyrgyzstan	1	-	1	-	-	-	1	-	1	-	-	-
Malaysia	4	4	-	-	-	-	3	3	-	-	-	-
Netherlands	1	1	-	-	-	-	1	1	-	-	-	-

Table 15 continued

Country	Number sitting	Attempts					Number passed	Passes				
		1	2	3	4	5		1	2	3	4	5
Nigeria	2	2	-	-	-	-	2	2	-	-	-	-
Pakistan	10	9	1	-	-	-	6	5	1	-	-	-
Philippines	6	5	1	-	-	-	3	2	1	-	-	-
Russia	6	5	-	1	-	-	4	4	-	-	-	-
Samoa	1	-	1	-	-	-	1	-	1	-	-	-
Serbia	1	1	-	-	-	-	1	1	-	-	-	-
South Africa	3	3	-	-	-	-	3	3	-	-	-	-
Sri Lanka	3	3	-	-	-	-	-	-	-	-	-	-
Tanzania	1	1	-	-	-	-	-	-	-	-	-	-
Ukraine	1	-	1	-	-	-	1	-	1	-	-	-
United Arab Emirates	2	2	-	-	-	-	-	-	-	-	-	-
Total	**84**	**72**	**11**	**1**	**-**	**-**	**45**	**38**	**7**	**-**	**-**	**-**

Health Practitioners Disciplinary Tribunal (HPDT)

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

Medical charges before the Health Practitioners Disciplinary Tribunal

During the year, the HPDT received 17 charges relating to 13 doctors – 16 charges were received from a professional conduct committee (PCC) and one from the director of proceedings.

The HPDT sat during the year to hear 12 charges relating to 12 doctors over 31 days. Three of the 12 charges were received in 2016/17. Eight charges received during 2017/18 are yet to be heard.

Table 16: Medical charges before the Health Practitioners Disciplinary Tribunal

As at 30 June 2018

Nature of charges	
Professional misconduct 2016/17	3
Professional misconduct 2017/18	13
Conviction 2017/18	4
Total	**20**

Source	
Prosecution of charges brought by a PCC 2016/17	3
Prosecution of charges brought by a PCC 2017/18	9
Charges brought by a PCC yet to be heard	8
Total	**20**

Outcome of hearings	
Guilty – professional misconduct 2016/17	3
Guilty – professional misconduct 2017/18	6
Guilty – conviction 2017/18	3
Yet to be heard 2017/18	8
Total	**20**

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

Corporate governance

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

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

Council membership

Council aims to have members who represent:

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

Council committee structure

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

Links with medical regulatory bodies

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

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

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

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

Council committees[1]

Council standing committees as at 30 June 2018

Chairperson – Mr Andrew Connolly
Deputy Chairperson – Ms Laura Mueller

Audit Committee

- Ms Susan Hughes QC (Chairperson)
- Ms Laura Mueller
- Ms Kim Ngārimu
- Mr Roy Tiffin

Health Committee

- Dr Lu'isa Fonua-Faeamani
- Dr Pamela Hale (Chairperson)
- Dr Charles Hornabrook
- Ms Laura Mueller (Deputy Chairperson)
- Ms Kim Ngārimu

Alternative layperson: Vacant

Education Committee – Council members

- Ms Laura Mueller
- Professor John Nacey (Chairperson)
- Ms Kim Ngārimu
- Dr Curtis Walker

Education Committee – non-Council members

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

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

Council office

Office of the Council at 30 June 2018

Chief Executive	Joan Simeon
Registrar	David Dunbar
Deputy Registrar	Aleyna Hall
Executive Assistant	Dot Harvey
Human Resources Manager	Bernadine Lynch
Project Manager	Sidonie
Senior Legal Adviser	Emma Coburn
Legal Adviser	Vacant
Junior Legal Adviser	Elliot Foxall
Legal Administrator	Jacqueline van Schalkwyk

Adviser group

Communications Manager	George Symmes (part-time)
Medical Adviser	Dr Steven Lillis (part-time)
Medical Adviser	Dr Kevin Morris (part-time)
Senior Policy Adviser	Kanny Ooi

Corporate services

Chief Financial Officer	Peter Searle
ICT Team Leader	Bill Taylor
Business Process Analyst	Carolyn Berry (part-time)
Senior ICT Systems Analyst	Andrew Cullen
ICT Systems Analyst	Alecia Thompson (part-time)
ICT Systems Analyst	Ray van der Veen
Accountant	Jim Peebles
Assistant Accountant	Atish Pathak
Finance Officer	Marika Puleitu
Senior Office Administrator	Dianne Newport
Office Administrator	Suzi Bryce
Office Administrator	Jennifer Porter

Health

Health Manager	Lynne Urquhart
Health Case Manager	Meredith Baron
Health Case Manager	Jo Hawken
Health Case Manager	Hollie Bennett
Health Case Manager	Jasmine Walker
Health Case Manager	Garth Wyatt
Health Administrator	Erin O'Brien

Health Practitioners Disciplinary Tribunal (HPDT) for Medical Practitioners

HPDT Manager	Gay Fraser
Legal Officer HPDT	Kim Davis
Executive Officer HPDT	Debra Gainey
Personal Assistant to HPDT Manager	Deborah Harrison

Registration teams

Manager Registration	Nisha Patel
Team Manager – General Registration	Kylie Johnston
Registration Coordinator – General	Anastasia Appleyard
Registration Coordinator – General	Alastair Gibbons
Registration Coordinator – General	Prakash Joseph
Registration Coordinator – General	Harinderjeet Gill
Registration Coordinator – General	Devan Menon
Registration Coordinator – General	Trudy Rook
Registration Coordinator – General	Lucy Tregidga
Registration Coordinator – General	Rachel Warren
Team Manager – Practising Certificate	Helen Vercoelen
Practising Certificate Coordinator	Bronwyn Courtney
Practising Certificate Coordinator	Brady Miller
Practising Certificate Audit Coordinator	Isabella Greenwood-Reeves
Team Manager – Vocational Registration	Laura Lumley
Registration Coordinator – Vocational	Sandra Clark
Registration Coordinator – Vocational	Francesca Dalli-Niven
Registration Coordinator – Vocational	Imojini Kotelawala
Registration Coordinator – Vocational	Patrick McKane
Registration Coordinator – Vocational	Geethanjali Raghunath
Registration Coordinator – Vocational	Sandra Tam
Manager, Professional Standards and Accreditation	Emily Douglas
Professional Standards Team Manager	Charlotte Provan
Professional Standards Coordinator	Maria Bernal
Professional Standards Coordinator	Nadia Hampton
Professional Standards Coordinator	Danielle Hubbard
Professional Standards Coordinator	David Agnew
Professional Standards Coordinator	Rajwinder Kaur
Professional Standards Coordinator	Nikita Takai
Professional Standards Coordinator	Ancari van Niekerk
Professional Standards Coordinator	Anna Yardley
Education Coordinator	Elmarie Stander

Finances

MEDICAL COUNCIL OF NEW ZEALAND
Statement of financial position
as at 30 June 2018

	Notes	2018	2017
Current assets			
Petty cash		600	600
Bank accounts		228,253	221,609
Receivables	6	250,557	518,156
Interest accrued		24,887	35,424
Investments	7	4,750,000	5,250,000
GST		34,498	(27,666)
Total current assets		$5,288,795	$5,998,123
Term assets			
Property, plant and equipment	8	737,388	819,738
Intangibles	9	4,702,273	4,089,326
Total term assets		$5,439,661	$4,909,064
Current liabilities			
Sundry creditors		726,425	938,955
Employee entitlements		598,033	430,039
Lease rent free liability		34,927	34,927
Payments received in advance		376,960	343,237
Total current liabilities		$1,736,345	$1,747,158
Term liabilities			
Employee entitlements		51,201	41,681
Lease rent free liability		140,511	175,438
Total term liabilities		$191,712	$217,119
TOTAL NET ASSETS		**$8,800,399**	**$8,942,910**
CAPITAL ACCOUNT			
General Fund		6,813,213	7,103,430
Complaints Investigation and Prosecution Fund		1,557,616	1,376,000
Examination Fund		429,570	463,480
Total capital account		**$8,800,399**	**$8,942,910**

Authorised for issue for and on behalf of the Council.

Andrew Connolly
Chairperson
23 November 2018

Joan Simeon
Chief Executive
23 November 2018

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

Page 1

MEDICAL COUNCIL OF NEW ZEALAND
Statement of comprehensive income
for the year ended 30 June 2018

	Notes	2018	2017
Income			
Exchange Income			
Fees received		1,807,771	1,914,514
Vocational registration income		446,099	663,935
Interest received		176,291	170,854
Recovery of staff costs		112,909	89,008
Other income		2,084	1,718
		2,545,154	2,840,029
Non Exchange Income			
APC Fees		11,330,830	10,765,842
Recovered legal costs		334,414	217,526
Fines received		25,500	5,000
		11,690,744	10,988,368
		$14,235,898	$13,828,397
Expenditure			
Advice and consultancy		163,627	123,730
Archives		66,600	65,506
Audit fees		31,545	30,820
Council and standing committee meeting costs		636,439	637,717
Debt collection costs and debt impairment expense		237,604	140,833
Depreciation and amortisation	10	1,091,014	1,061,050
Employee benefits		6,537,265	6,074,115
Health Practitioners Disciplinary Tribunal fees and expenses		401,195	419,450
Intern supervisors payments		721,146	688,226
Legal prosecutor		240,250	612,116
Medsys service level agreement		695	51,957
Office relocation	17	503,020	152,586
Performance Assessments and other costs		370,120	302,016
Plimmer Towers office fitout	17	149,623	0
Professional Conduct Committee costs		363,445	451,133
Rent		496,890	434,062
Repairs and maintenance office equipment		136,697	78,995
Reports and health assessments		191,912	152,225
Strategic directions		184,552	91,980
Vocational registration expenses		477,690	442,614
Other administrative costs		1,377,080	1,349,473
		$14,378,409	$13,360,604
Net surplus / (deficit) for year		($142,511)	$467,793
Other comprehensive income		0	0
Total comprehensive income		($142,511)	$467,793

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

MEDICAL COUNCIL OF NEW ZEALAND
Statement of movements in equity
for the year ended 30 June 2018

	Notes	2018	2017
A) ACCUMULATED FUNDS AND RESERVES			
Balance brought forward		8,942,910	8,475,117
Total comprehensive income		(142,511)	467,793
Closing balance		$8,800,399	$8,942,910
B) ANALYSIS OF INDIVIDUAL FUNDS			
1) General Fund			
Balance brought forward		7,103,430	6,193,497
Total comprehensive income	2	(290,217)	909,933
Closing balance		$6,813,213	$7,103,430
2) Complaints Investigation and Prosecution Fund			
Balance brought forward		1,376,000	1,855,330
Total comprehensive income	3	181,616	(479,330)
Closing balance		$1,557,616	$1,376,000
3) New Zealand Registration Examination Fund			
Balance brought forward		463,480	426,290
Total comprehensive income	4	(33,910)	37,190
Closing balance		$429,570	$463,480

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

MEDICAL COUNCIL OF NEW ZEALAND
Statement of cash flows
for the year ended 30 June 2018

	Notes	2018	2017
Cash flows from operating activities			
Cash was provided from:			
Receipts pertaining to statutory functions		14,254,504	13,559,874
Cash was distributed to:			
Council fees, disbursements and office expenses		(13,313,077)	(12,342,786)
Net cash flows from operating activities		941,427	1,217,088
Cash flows from investing activities			
Cash was provided from:			
Interest received		186,828	170,980
Short-term investments		1,000,000	1,250,000
		1,186,828	1,420,980
Cash was applied to:			
Purchase of assets		(1,621,611)	(1,538,739)
Short-term investments		(500,000)	(2,000,000)
		(2,121,611)	(3,538,739)
Net cash flows from investing activities		(934,783)	(2,117,759)
Net increase / (decrease) in cash and cash equivalents		6,644	-900,671
Opening cash brought forward		222,209	1,122,880
Ending cash carried forward		$228,853	$222,209
Represented by:			
Petty cash		600	600
ASB bank account		9,253	29,609
ASB call account		219,000	192,000
		$228,853	$222,209

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

MEDICAL COUNCIL OF NEW ZEALAND

Notes to and forming part of the financial statements
For the year ended 30 June 2018

1. Statement of accounting policies

Basis of preparation

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

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

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

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

- Reconciliation of Plant, Property and Equipment movements for the prior year (Note 8)
- Reconciliation of Intangible Assets for the prior year (Note 9)
- The nature and extent of exposures to credit risk, liquidity risk and market risk (Note 14)
- Capital management note (Note 16).

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

Statement of compliance

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

Measurement base

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

Specific accounting policies

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

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

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

Vocational registration income is recognised at the time of invoicing. However a value equivalent to 2.4 month's invoicing (2017: 3.0 months) (the average time taken to process applications) is assessed and held in payments made in advance.

(b) **Depreciation** – Property, plant and equipment have been depreciated on a straight line basis at the following rates:

Furniture and fittings 10%pa
Office alterations 10%pa
Office equipment 20%pa
Computer hardware 33%pa

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

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

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

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

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

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

(i) **Payments received in advance** – The outstanding balance at 30 June 2018 represents payments in advance or deposits made by debtors for services to be provided but not yet completed by the Council at balance date.

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

(k) **Leases –** The value of the leases are recognised in the statement of commitments at the current negotiated value of a number of current leases. The Council has a long term lease on premises at 80 The Terrace, Wellington. Refer to Note 13 for full details of lease commitments at balance date.

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

Intangible assets have a finite useful life and are amortised on a straight line basis at 10% on Medsys internal software development and 33% per annum on software licences, electronic data management and disaster recovery software systems.

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

(n) **Statement of cash flows**

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

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

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

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

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

Significant changes in accounting policies

The ASB call account ($219,000 (2017 $192,000)) has been reclassified as part of the Council's operating cash balance. Comparative figures in the Statement of Financial Position and the Statement of Cashflows have been amended for comparability.

Critical accounting estimates and assumptions

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

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

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

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

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

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

Estimating the doubtful debt provision
At each balance date each debtor is reviewed and an assessment is made on the likelihood of collection of the amount owed. Where this assessment indicates that impairment exists, a further assessment is made of the amount of that impairment and a provision is created. Any receivable that is uncollectible is written off

against the provision. An impairment will be assessed to exist where there has been no payment received, no payment schedule has been entered into, an existing payment programme is breached or information is received that would indicate the likelihood of collection is diminished.

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

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

2.
General Fund
Statement of comprehensive income
for the year ended 30 June 2018

	Notes	2018	2017
REVENUE			
Exchange Income			
Fees received	1	1,476,032	1,493,863
Vocational registration income		446,099	663,935
Interest received		153,487	145,267
Administration charge - Complaints Investigation and Proscecution Fund	1	790,000	790,000
Administration Charge - Examination Fund	1	160,000	160,000
Workforce survey and other income		46,000	46,000
		3,071,618	3,299,065
Non Exchange Income			
APC Fees		9,250,067	8,789,066
		9,250,067	8,789,066
		$12,321,685	$12,088,131
ADMINISTRATION AND OPERATING EXPENSES			
Communications		117,483	94,737
Depreciation		1,091,014	1,061,051
Legal expenses and other consultancies		163,627	123,730
Office relocation		503,021	152,586
Plimmer Towers office fitout		149,623	0
Rent		496,889	434,062
Staff costs including recruitment and training		6,155,154	5,687,238
Other administration and operating expenses		797,705	853,968
Total administration and operating expenses		$9,474,516	$8,407,372
COUNCIL AND COMMITTEE EXPENSES			
Council			
- Fees and expenses		647,865	572,125
- Conference and liaison costs		71,566	88,344
- Strategic directions		184,552	91,981
Audit committee			
- Fees and expenses		13,164	13,986
Health committee			
- Fees and expenses		45,650	48,864
- Independent assessment reports, Doctors' Health Advisory Service, other costs		191,912	152,225
Education committee			
- Fees and expenses		86,180	79,775
- Intern supervisor contracts		675,927	644,134
- Hospital visits and other costs		190,094	178,346
Professional standards			
- Performance assessments and other costs		370,120	302,016
Registration			
- Workshops and other costs		660,356	599,030
Total Council and committee expenses		**$3,137,386**	**$2,770,826**
TOTAL EXPENDITURE		$12,611,902	$11,178,198
Net surplus/(deficit) for year and total comprehensive income		($290,217)	**$909,933**

3.
Complaints Investigation and Prosecution Fund
Statement of comprehensive income
for the year ended 30 June 2018

	Notes	2018	2017
Revenue			
Exchange Income			
Recovery of staff costs		112,909	89,008
Interest received		16,144	19,105
		129,053	108,113
Non Exchange Income			
APC Fees		2,080,764	1,976,776
Recovered costs		334,413	217,526
Fines received		25,500	5,000
		2,440,677	2,199,302
Total revenue		$2,569,730	$2,307,415
ADMINISTRATION AND OPERATING EXPENSES			
Administration charge	1	790,000	790,000
Debt impairment expense relating to unpaid penalties and costs		237,604	140,833
General administration and operating expenses		355,620	373,213
Total administration and operating expenses		$1,383,224	$1,304,046
COUNCIL AND TRIBUNAL EXPENSES			
Legal Prosecutor costs		240,250	612,116
Professional conduct committee costs			
- Members fees and other expenses		363,445	451,133
Health Practitioners Disciplinary Tribunal			
- Administration fee		125,915	179,810
- Fees and other hearing expenses		275,280	239,640
Total Health Practitioners Disciplinary Tribunal costs		401,195	419,450
Total Council and Tribunal expenses		$1,004,890	$1,482,699
TOTAL EXPENDITURE		$2,388,114	$2,786,745
Net surplus/(deficit) for year and total comprehensive income		**$181,616**	**($479,330)**

4.
New Zealand Registration Examination Fund
Statement of comprehensive income
for the year ended 30 June 2018

	Notes	2018	2017
Revenue			
Exchange Income			
NZ Rex candidate fees		283,700	372,838
Interest received		6,660	6,481
Other income		4,123	3,530
		$294,483	$382,849
ADMINISTRATION AND OPERATING EXPENSES			
Administration charge	1	160,000	160,000
Centre costs		27,879	72,312
Examiners' fees and expenses		47,967	64,336
Honorarium, staff costs and other administrative expenses		92,547	49,011
Total administration and operating expenses		$328,393	$345,659
Net surplus/(deficit) for year and total comprehensive income		**($33,910)**	**$37,190**

5. **Taxation**

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

6. Receivables

	2018	2017
Debtors	1,070,458	1,243,296
Provision for impairment	(854,188)	(782,434)
	216,270	460,862
Payments in advance	34,287	57,294
Total debtors and other receivables	**$250,557**	**$518,156**

Fair Value

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

Impairment

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

	2018			2017		
	Gross	Impairment	Net	Gross	Impairment	Net
Not past due	56,239	0	56,239	140,460	0	140,460
Past due 1-30 days	23,416	0	23,416	79,122	0	79,122
Past due 31-60 days	19,536	0	19,536	17,871	0	17,871
Past due 61-90days	8,470	(424)	8,047	28,299	(1,415)	26,884
Past due >90 days	962,797	(853,764)	109,033	977,544	(781,019)	196,525
Total	**$1,070,458**	**($854,188)**	**$216,270**	**$1,243,296**	**($782,434)**	**$460,862**

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

7. Investments

	2018	2017
Current Investments		
ASB - Matures 8 Aug 2018 - 3.05%	250,000	250,000
ASB - Matures 9 Aug 2018 - 3.05%	250,000	250,000
ASB - Matures 10 Aug 2018 - 3.10%	250,000	250,000
ASB - Matures 16 Aug 2018 - 3.19%	500,000	500,000
BNZ - Matures 23 Mar 2019 - 3.25%	250,000	250,000
BNZ - Matures 7 Aug 2018 - 3.30%	250,000	250,000
Westpac - Matures 3 Oct 2018 - 3.45%	250,000	250,000
Westpac - Matures 28 Sept 2018 - 3.05%	250,000	250,000
Westpac - Matures 16 Oct 2018 - 3.45%	250,000	250,000
ASB - Matures 26 July 2018 - 3.10%	500,000	500,000
ASB - Matures 26 Oct 2018 - 3.50%	1,000,000	1,000,000
ASB - Matures 8 Sept 2018 - 2.75%	250,000	250,000
New Investments		
Westpac - Matures 19 July 2018 - 3.05%	250,000	0
Westpac - Matures 20 Aug 2018 - 3.05%	250,000	0
Closed Investments		
ANZ - Matured 18 Oct 2017 -3.00%	0	250,000
Westpac - Matured 18 April 2018 - 3.45%	0	250,000
Westpac - Matured 18 Apr 2018 - 3.45%	0	250,000
ASB - Matured 28 June 2018 - 3.05%	0	250,000
	$4,750,000	**$5,250,000**
Current	4,750,000	5,250,000
Term	0	0
	$4,750,000	**$5,250,000**

8. Property, plant and equipment

	Computer Hardware	Furniture and Fittings	Office Alterations	Office Equipment	Artwork	TOTAL
Cost						
Balance at 1 July 2016	645,708	397,991	760,608	242,288	7,138	2,053,733
Additions	138,209	11,729	22,496	875	0	173,309
Disposals		0	0		0	
Balance at 30 June 2017	783,917	409,720	783,104	243,163	7,138	2,227,042
Balance at 1 July 2017	783,917	409,720	783,104	243,163	7,138	2,227,042
Additions	102,483	5,874	0	1,041	0	109,398
Disposals						0
Balance at 30 June 2018	886,400	415,594	783,104	244,204	7,138	2,336,440
Accumulated depreciation and impairment losses						
Balance at 1 July 2016	514,328	313,748	148,911	231,372	0	1,208,359
Depreciation expense	102,263	15,967	77,021	3,694	0	198,945
Impairment losses					0	0
Disposals					0	0
Balance at 30 June 2017	616,591	329,715	225,932	235,066	0	1,407,304
Balance at 1 July 2017	616,591	329,715	225,932	235,066	0	1,407,304
Depreciation expense	98,515	14,056	76,163	3,014	0	191,748
Impairment losses					0	0
Disposals					0	0
Balance at 30 June 2018	715,106	343,771	302,095	238,080	0	1,599,052
Carrying amounts						
At 30 June and 1 July 2017	167,326	80,005	557,172	8,097	7,138	819,738
At 30 June 2018	171,294	71,823	481,009	6,124	7,138	737,388

9. Intangibles

Cost	
Balance at 1 July 2016	7,126,129
Additions	1,365,430
Disposals	0
Balance at 30 June 2017	8,491,559
Balance at 1 July 2017	8,491,559
Additions	1,512,213
Disposals	0
Balance at 30 June 2018	10,003,772
Accumulated amortisation and impairment losses	
Balance at 1 July 2016	3,540,128
Amortisation expense	862,105
Impairment losses	0
Disposals	0
Balance at 30 June 2017	4,402,233
Balance at 1 July 2017	4,402,233
Amortisation expense	899,266
Impairment losses	0
Disposals	0
Balance at 30 June 2018	5,301,499
Carrying amounts	
At 30 June and 1 July 2017	4,089,326
At 30 June 2018	4,702,273

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

10 Depreciation

	2018	2017
Depreciation on Plant, Property and Equipment	191,748	198,945
Depreciation on Intangible Assets	899,266	862,105
Total Depreciation	**$1,091,014**	**$1,061,050**

11. Related party transactions

Key management personnel compensation

	2018	2017
Salaries and other short-term employee benefits	1,700,168	1,534,242
Other long-term benefits	28,451	28,179
Total key management personnel compensation	**$1,728,619**	**$1,562,421**

Key management personnel include the Chief Executive and the other 10 members (2017 9) of Council's management team.

Council member's fees and expenses

	2018	2017
Council members - fees	612,920	605,276
Council members - other expenses	210,612	184,175
Total Council members fees and expenses	**$823,532**	**$789,451**

There were no other related party transactions.

12. Statement of contingent liabilities

There are no known contingent liabilities (2017: Nil).

13. Statement of commitments

Lease commitments under non-cancellable operating leases.

	2018	2017
Less than one year	605,390	920,245
Between 1 and 5 years	2,231,026	2,821,239
Greater than 5 years	0	15,177
	$2,836,416	**$3,756,661**

The Council has a long term lease on premises at 80 The Terrace, Wellington. The Council has vacated these premises as a result of earthquake damage sustained in the November 2016 earthquake. At balance date, the Council occupied leased office space at Plimmer Towers, Wellington. The re occupation of 80 The Terrace is currently under dispute. However the Council's obligations under this lease are included in the statement of commitments. The Council has signed leases in respect of Levels 20 and 28 Plimmer Towers, Wellington and these values are also included in the statement of commitments.

14. Financial instruments

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

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

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

Market Risk
The Council is exposed to interest rate risk as interest rate movements will affect the returns generated from investments and related cash flows. At year end the interest rates on term deposits ranged from 2.75% to 3.50% (2017: 2.75% to 3.65%).

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

	2018	2017
Receivables	$275,444	$553,580
Bank balances	$228,253	$221,609
Investments	$4,750,000	$5,250,000
Sundry creditors	($1,103,385)	($1,282,192)

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

15. Council members' fees and allowances

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

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

	2018	2017
Attendance allowance:		
Daily	$960.00	$960.00
Hourly	$120.00	$120.00
Communication allowance:		
Quarterly	$161.37	$161.37
Total fees and allowances paid to members of Council	**$612,920**	**$605,276**

16. Capital management

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

Council's equity is largely managed as a by-product of managing revenues, expenses, assets, liabilities, investments and general financial dealings.
The objective of managing Council's equity is to ensure that the Council effectively achieves its objectives and purpose whilst remaining a going concern.

17. Earthquake disruption contingencies and post balance date events

The Council has a long term lease on premises at 80 The Terrace, Wellington until 10 July 2023.

The Council vacated these premises from 12 February 2017 as a result of earthquake damage sustained in the November 2016 earthquake due to uncertainty around the building safety and the extent of remedial work required on the building. At balance date, the Council occupied alternative leased office space at Plimmer Towers, Wellington. The additional costs of this relocation have been separately disclosed as 'Office relocation' and 'Plimmer Towers office fit out'.

The Council had business interruption insurance at the time of the earthquake and is in the process of negotiating an insurance claim. The Council is expected to receive a settlement for this claim in the 2019 financial year however no reliable estimate of the settlement can be made at the present time.

Subsequent to balance date the Council resolved to relocate and negotiate a termination of the lease on 80 The Terrace. This may incur significant early termination costs and potentially require impairment of the fit out assets (carrying value $481,009).
The ultimate resolution of this situation cannot be reliably estimated at the time of signing the financial statements. The Council's obligations under this lease are included in the statement of commitments (refer Note 13).

Level 6, 95 Customhouse Quay
Wellington 6011
New Zealand

PO Box 1208
Wellington 6140
New Zealand

T +64 4 472 7919
F +64 4 473 4720
W staplesrodway.com

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CHARTERED ACCOUNTANTS

INDEPENDENT AUDITOR'S REPORT TO THE READERS OF MEDICAL COUNCIL OF NEW ZEALAND'S FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2018

The Auditor-General is the auditor of the Medical Council of New Zealand (the Medical Council). The Auditor-General has appointed me, Stuart Signal, using the staff and resources of 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 on pages 1 to 18, that comprise the statement of financial position as at 30 June 2018, the statement of comprehensive income, the statement of movements in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information.

In our opinion the financial statements of the Medical Council on pages 1 to 18, present fairly, in all material respects:

- its financial position as at 30 June 2018; 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 23 November 2018. This is the date at which our opinion is expressed.

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

Basis of opinion

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

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

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

Responsibilities of the Council for the financial statements

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

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

In preparing the financial statements, the Council is responsible on behalf of the Medical Council for assessing the Medical Council's ability to continue as a going concern. The Council is also responsible for disclosing, as applicable, matters related to going concern and using the going

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CHARTERED ACCOUNTANTS

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.

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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.

Stuart Signal
Staples Rodway Audit Limited
On behalf of the Auditor-General
Hastings, New Zealand

Te tiaki i te iwi whānui me te whakatairanga pai i te mahi e pā ana ki te taha rongoā

Protecting the public, promoting good medical practice

Bankers

ASB Bank Limited
2 Hunter Street
PO Box 11966
Wellington 6011

Auditors

Staples Rodway
PO Box 1208
Wellington 6140

Office of the
Auditor-General
Private Box 3928
Wellington 6140

Te Kaunihera Rata o Aotearoa

Medical Council of New Zealand

Medical Council of New Zealand

Level 28
2–6 Gilmer Terrace
PO Box 10509
Wellington 6143

+64 4 384 7635
0800 286 801

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