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New Zealand Medical Association
Annual Report 2011
NZMA Mission Statement

The New Zealand Medical Association provides leadership of the medical profession and promotes:

• professional unity and values, and
• the health of all New Zealanders.

Roles of the NZMA

• to advocate on behalf of members and their patients
• to develop and maintain the profession’s Code of Ethics
• to provide support and services to our members
• to publish the New Zealand Medical Journal.
The New Zealand Medical Association (NZMA) strengthened its high profile and influence in 2011, taking a leadership role to raise awareness of health inequity. There was widespread support from the medical profession and wider health sector in response to our Health Equity Position Statement. It has been pleasing to see our position statement regularly referenced and incorporated into the language of various health sector documents.

In 2011 the NZMA published the Role of the Doctor Consensus Statement, which was developed by the medical profession, and began with a seminar that brought together 80 leaders from throughout medicine in New Zealand. The Statement defines what it is that doctors do, and how we bring value to New Zealand’s health system. It outlines the key skills and attributes of our profession, and ultimately aims to ensure that in the context of a changing health sector we deliver the highest quality care to patients. Endorsed by the majority of medical colleges and published in the New Zealand Medical Journal, the statement will underpin our advocacy, as well as provide medical schools with a platform for selecting and training future doctors. I would like to extend a special thank you to Drs Andrew Old, Harvey White and Peter Foley for their leadership and commitment in developing and publishing the statement.

There was significant progress made on medical workforce issues, with Health Workforce New Zealand (HWNZ) implementing a range of initiatives and projects to improve the recruitment and retention of New Zealand doctors. The NZMA can take some of the credit for this progress, based on its long-term advocacy on medical workforce issues. For many years we urged the Government to demonstrate leadership and implement a national health workforce strategy to ensure we have a fit for purpose, self-sufficient workforce to guarantee the provision of quality healthcare.

The Government has continued to reiterate its commitment to make primary care the cornerstone of our health system to alleviate pressure on hospitals, and to attain a more cost-effective and responsive health service for our patients. The integration of hospital and community-based care and stronger primary/secondary relationships is essential to achieve this goal. The NZMA supports moves towards integration with more care delivered in community settings. We would like to see processes in place to speed up integration of health services to achieve the vision of multi-disciplinary co-located teams of health professionals, but full engagement with doctors and the wider health sector is essential. Health professionals must be involved in decision-making to ensure integration is workable.

The year was one of celebration for the NZMA as it commemorated its 125-year anniversary. We held two events, one in Wellington and Auckland respectively, to showcase the Association’s history and achievements, including a timeline of key
milestones. Before the NZMA was established in 1886, organisations for doctors existed on a regional basis but it was soon recognised that doctors needed a strong, united voice on the national stage to effectively advocate for the medical profession and for patients. I am encouraged that more doctors are joining the NZMA, with the major motivation being to demonstrate commitment to our profession, and in recognition of the need for a strong national association to advocate for doctors.

The 125-year celebrations highlighted both the NZMA’s proud history and its proactivity as we anticipate changes to the profession, health sector and our patients. As an organisation with a steadily increasing membership, particularly among younger doctors, we are only too aware that the work we do now will impact our profession in the years to come – and our country’s ability to respond to the health needs of our changing population.

The NZMA’s strategic plan for 2011-2016 serves as an excellent document to guide the NZMA’s advocacy priorities, and keep our work on course, to respond to the needs of the profession and patients.

**Advocacy**

The NZMA has an effective working relationship with the Government and our opinions and knowledge are regularly sought. We have supported moves to address medical workforce shortages and have provided feedback to HWNZ. We are strongly supportive of HWNZ’s goals but we have expressed concerns about implementation of some projects, particularly where there has been a lack of adequate engagement with the profession.

The NZMA is also supportive of the National Health Board (NHB) which oversees all District Health Boards (DHBs) to achieve greater coordination of services. As a long-time critic of the huge discrepancies in the quality of health services across different parts of the country, we are supportive of the NHB’s aims to achieve greater uniformity of healthcare delivery.

The recession and growing demand for health services has had considerable influence on governments in New Zealand and overseas, looking at how to achieve best value in health expenditure. Moves towards greater integration of health services are supported by the NZMA, although we continue to seek appropriate funding of primary care, greater engagement with clinicians and more rapid progress.

**Workforce**

To ensure that health services are sustainable and that our patients have the health services they require, we must continue to work towards achieving a self-sufficient, fit for purpose medical workforce. There are too few doctors, across all specialties, and we are losing too many to overseas opportunities while heavily dependent on overseas trained doctors to bridge the shortfall.

In 2011 there was continued focus on initiatives to reduce medical, and wider health workforce, shortages. HWNZ has continued to work on leading and coordinating the development of our workforce to meet health needs. It has numerous projects underway such as the development of Regional Training Hubs, health workforce reviews, the Physician Assistant trial and the Advanced Training Scheme (ATS) scholarship. HWNZ is working in collaboration with training providers and professional bodies such as the NZMA to achieve its goals. While we have had some concerns about the implementation of some of these projects, we do value
the relationship we have with HWNZ and its willingness to listen to our concerns and make changes that are needed to secure buy-in from the profession. While the NZMA is active on many issues, it is anticipated that workforce issues will always be at the forefront of NZMA advocacy. Ensuring a strong, self-sufficient medical profession is an essential prerequisite in delivering quality health services to all New Zealanders.

Health equity
The NZMA took a proactive stance to raise awareness of the social determinants of health and health equity. We published our Health Equity Position Statement which was based on strong evidence from New Zealand and overseas, such as the World Health Organization’s report on the Social Determinants of Health, that highlighted the policies that have been successful in reducing health disparities. It was encouraging that so many of our members expressed their strong support for the NZMA’s work and that doctors who were not members were motivated to join as a result of the NZMA’s advocacy on health equity. It highlighted that doctors do see their role as going beyond individual patient care to encompass responsibility for improving public health, particularly as it effects our most vulnerable populations.

The NZMA hosted the visit of Sir Michael Marmot, a world-leading advocate on health equity. Sir Michael was the keynote speaker at two fully booked symposia held in Auckland and Wellington. The visit was a pivotal point in raising awareness of health equity and promoting policies that could make a real difference. The argument for a solution to the problem is multifaceted: cost savings for the health system, better health outcomes throughout peoples’ lives leading to a more cohesive and productive society, and the principle of social justice. There is growing recognition from our politicians, and the wider community, that action is urgently needed. The NZMA was pleased with a number of government policies, such as free after hours care to under-sixes, the programme to eradicate rheumatic fever, and the home insulation project. We were also very supportive of the Government’s Green Paper on Vulnerable Children that seeks to address the neglect and abuse of our children. There is still a great deal that needs to happen to reduce health disparities and turn around the negative statistics. The NZMA will continue to raise awareness and advocate for policies to effect change.

ACC
The NZMA has a strong working relationship with ACC. The NZMA’s priority is to ensure that ACC’s actions do not compromise patient care. We were concerned about the debate over ‘degeneration’ and expressed our concern that patients should continue to have access to the care they need. While the NZMA does not have a specific position on the decision to open up the Work Account to competition, we believe any changes must not compromise the services required by ACC claimants.

Public health
The NZMA continued to have significant input into policies and legislation, including submissions on major public health issues such as alcohol and tobacco. We supported bold proposals to reduce smoking rates and alcohol related harm (banning tobacco retail displays, increasing the price of alcohol), and these will continue to be priorities for our public health advocacy in the coming year. We are pleased with the progress made in smoking cessation but would like to see stronger measures in place to curb excessive alcohol consumption that is so detrimental to health outcomes and social cohesion.
NZMA councils
The NZMA Auckland Council held a number of events which promoted greater collegiality within our medical profession. Events comprise a valuable mix of debate on medico-political issues, with guest speakers and discussion, and the opportunity to socialise with colleagues. Attendance at these events is high and the positive feedback we receive reinforces the importance of NZMA regional events for the profession. The success of the Auckland Council is now being emulated by the reinvigorated NZMA Wellington Council, which held events in the latter half of 2011. Both Councils are now planning their events calendar for 2012. I would encourage all NZMA members to attend events in their regions and to encourage other doctors, who may not be members, to also come along and find out more about what the NZMA does for the medical profession.

General Practice
The NZMA GP CME conferences (Rotorua and Dunedin) continue to grow in reputation and size each year. The conferences meet the needs of general practice – doctors, nurses and practice managers – providing relevant clinical content and opportunities for networking and socialising with colleagues.

The Primary Health Care Strategy has led to improvements in General Practice and made it more affordable for patients to access a GP. The focus has now turned to strengthening clinical services, particularly in light of government policy to improve integration of primary and secondary services. The future delivery of healthcare is increasingly in a non-hospital setting as primary care looks at different, innovative ways of delivering services. The NZMA has advocated for appropriate funding to meet this goal, as well as engagement of doctors from both sectors.

The NZMA’s GP Council provides a political voice for GPs and is also a key member of the General Practice Leaders Forum (GPLF). The GPLF provides a united voice for General Practice but also enables individual voices to have influence.

General Election
It was disappointing that there was a lack of policy debate during the election campaign and that health received so little media coverage. As part of the NZMA’s election strategy we sent the political parties health policy questions on a wide range of health issues. The responses we received were positive in some respects (such as all politicians acknowledging the need to address health inequities) but did not adequately articulate the political parties’ vision for health.

The National Party was re-elected to government and the NZMA will continue to have regular contact with government representatives to advocate on priority issues for the medical profession and patients.

Christchurch earthquake
The Canterbury region faced huge challenges in the wake of the February earthquake with dramatic implications for health services. There were 185 lives lost and thousands of people injured. Many in the health sector were personally affected by the earthquake, but showed remarkable resilience by working tirelessly and selflessly to help their fellow Cantabrians. Doctors, nurses, and other health professionals rose to the challenge and demonstrated what can be achieved when the sector works together and harnesses its skills.
The primary and secondary sectors worked collaboratively, and showed us what the future of integration can look like. We saw health care teams throughout the country providing much needed assistance in a multitude of ways, including the transfer of patients to hospitals outside the region and free consultations at GP clinics. The ‘whole of system’ response in Canterbury has served to illustrate optimal health care models to enhance patient care. It was with great pleasure that the annual Chair’s Award – the NZMA’s highest standing award – was bestowed to Canterbury DHB CEO David Meates and his team, for their superlative response in mobilising health services in Canterbury. Ultimately we saw the best of New Zealand in response to the earthquake, and the best of our health services.

International affairs
There were numerous opportunities for attending and presenting at national and international conferences. A regular theme I spoke about at conferences was the urgent need for action to address health equity. From an international perspective, attending the World Medical Association (WMA) conference in Montevideo, Uruguay was certainly enlightening and highlighted the breadth of global issues the WMA covers. The NZMA was very supportive of the WMA’s call for better protection of medical personnel in places of conflict and warfare, following the trial of health workers in Bahrain who treated anti-government protestors. It is important for the NZMA to have input into global health issues and to be aware of issues affecting the medical profession in other parts of the world.

Summary
The NZMA is strongly committed to strengthening our profession and delivering a quality health service to our patients, particularly at a time of financial constraints and health sector changes.

We will continue to press for greater involvement of clinicians in leadership and decision making across the spectrum of DHB activity, from community health to hospitals; for progress in integration of primary and secondary services so that patient care is enhanced; and implementing more regional collaboration between DHBs. The Association is ideally placed, as the pan-professional organisation for doctors, to provide input and facilitation to assist in achieving these goals.

Through effective leadership and promoting professional unity and values, the NZMA enhances the reputation of the profession and strengthens its presence in the sector. We also encourage two-way communications with our members, seeking their feedback about the issues that concern them and giving us valuable insight about what is happening at the coalface.

I would like to acknowledge the support of our Chief Executive, Lesley Clarke, her predecessor Cameron McIver who served in the role for 15 years, and my colleagues on the NZMA Board. I would also like to thank the loyal staff in the National Office for their work.

In a year when we celebrated 125 years of the NZMA, I would like to express my gratitude to the past chairs of the NZMA who have made such a tremendous contribution and particularly those past chairs who continue to provide guidance and advice.
To our members, thank you for your ongoing support and commitment which enables the NZMA to advocate more strongly for the profession and the health of all New Zealanders.

Paul Ockelford  
Chair

NZMA Board Members  
Dr Mark Peterson (Deputy Chair)  
Professor Harvey White  
Dr Kate Baddock  
Dr Jonathan Foo  
Dr Don Simmers  
Dr Sandra Hicks  
Dr Maria Poynter  
Dr Stephen Child  
Ms Lesley Clarke (Ex Officio)
Ms Lesley Clarke

Introduction
I am pleased to submit my first annual report as the incoming Chief Executive Officer. When I took up the position in June 2011 I was impressed by the work undertaken by the NZMA in representing the interests of the profession and the way in which the Association actively provides leadership through the promotion of professional unity and values and advocating for the health of New Zealanders.

With the support and guidance of the Board, and the assistance of the National Office team, I have been able to navigate through the first few months on the job and come up to speed with membership and advocacy issues as well as dealing with the inevitable learning curve required when joining a new organisation.

Governance and planning
During 2011 the NZMA Board undertook a major review of governance policies. These policies are based on the principles of good governance but also reflect that the NZMA Board’s role extends to policy development and advocacy. This work saw the establishment of an Audit, Finance and Risk Assessment Committee to assist the Board in its duties around legal compliance, financial reporting, risk management and investments. The CEO Assessment and Board Performance Committee was also formed.

The NZMA also took the opportunity with the commencement of a new CEO to develop a new five-year Strategic Plan. As part of this exercise we gave some thought to the NZMA’s organisational values to underpin our purpose and the way in which we work. The statement comprises the core values of: integrity; respect; quality and excellence; fairness, inclusiveness; care and nurturing; responsible and responsive.

The Strategic Plan is dedicated to the ideals of our mission statement and provides direction to shape our priorities and as well as goals against which to measure our success.

The six strategic priorities that form the basis of our Strategic Plan are:

- improve the health of New Zealanders
- lead the medical profession in New Zealand
- a strong and integrated membership
- influence the environment in which doctors practise
- be a champion of quality
- be a learning organisation.
Membership

While the NZMA continues to enjoy membership growth it is important that we continue to work on strategies to retain existing members and attract new members. This includes strategies to improve awareness of the NZMA, what we do and stand for, and a focus on leadership activities to raise our profile in the sector through proactive evidence-based advocacy on matters of importance to our members and the wider community.

Engagement is a critical factor for any membership based organisation and the NZMA recognises the importance of collegiality and the need to connect with our members directly as well as pursuing the collective goals of the profession. This is achieved via good communication channels, such as the revamped Vital Signs weekly newsletter, and the opportunity for members to come together at regional NZMA events.

Resource management and operational performance

The NZMA’s largest asset is the NZMA building at 26 The Terrace, Wellington which we have owned and occupied since 1938. In recent years however the building has not performed well as a working asset due to low rental income and significant maintenance expenditure. The building is also poorly configured to achieve a good working environment for staff and space utilisation is not optimal. In these circumstances the prospect of improving rental income was unlikely.

Before undertaking any work to resolve these issues it was agreed that a seismic assessment of the building should be conducted. Unfortunately, engineers found that the building is between 10-15% compliant of the new building standard for earthquake strength, which required the Board to consider the future of the building.

The annual accounts are attached to this report and while a deficit has been recorded for the 2010/11 financial year the overall financial position of the NZMA remains strong.

The National Office team continues to operate very effectively. It is a small team with significant and wide ranging responsibilities. The expertise and skills of these individuals enables the NZMA to achieve the required deliverables of the organisation.

I would like to thank the staff, the Board and the wider membership for your ongoing support.

Lesley Clarke
Chief Executive Officer
### NZMA OFFICE BEARERS

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<tr>
<td>Board Chair</td>
<td>Dr Paul Ockelford</td>
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<td>Immediate Past Chair</td>
<td>Dr Peter Foley</td>
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<td>President</td>
<td>Dr Aine McCoy</td>
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<td>Professor Harvey White</td>
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<td>GP Council Chair</td>
<td>Dr Kate Baddock</td>
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<td>Specialist Council Chair</td>
<td>Professor Harvey White</td>
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<td>DIT Council Chair</td>
<td>Dr Jonathan Foo</td>
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<td>Ethics Committee Chair</td>
<td>Dr Tricia Briscoe</td>
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<td>Chief Executive Officer</td>
<td>Ms Lesley Clarke</td>
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<td>NZMJ Editor</td>
<td>Professor Frank Frizelle</td>
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NZMA STAFF

Operations Manager: Anna Phipps
Senior Policy Advisor: Lucille Curtis
Communications Manager: Daphne Atkinson
EA to CEO: Robyn Fell
Marketing Co-ordinator: Sokmanea Foo
Communications Co-ordinator: Falyn Edlin
Membership and Database Administrator: Susan Holt
NZMJ Production Editor: Brennan Edwardes
NZMJ Administration Assistants: Sally Bagley/Wendy Edwardes

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Dr Kate Baddock

It was this time last year that I took on the mantle of the General Practitioner Council (GPC) chairmanship. The last 12 months have therefore been a steep learning curve, as I had no preconceived notion of how the GPC functioned and how it could best fulfil its role.

The GPC is an advisory council to the NZMA Board but it would be wrong to think that it is merely a conduit for information from GPs to the Board and back again. While it is of great importance that we support individual GPs who seek our help and support – provided it falls within the mandate of the NZMA – it behoves the GPC to be more active in seeking and gathering GP opinion on a variety of matters. These matters may be political, they may be workforce-based or they may be about the business of General Practice. I believe we have a singular capability in representing GPs and their views – and ensuring that their voice is heard.

Members of the GPC provide ongoing representation for the NZMA on a wide and expanding variety of external organisations, advisory groups and committees. These include observer status on the Royal New Zealand College of General Practitioners (RNZCGP), PHO Alliance and General Practice New Zealand (GPNZ); and sitting on advisory groups for the Ministry of Social Development, Accident Compensation Corporation and the Primary Care Information Management Group.

Over the past 12 months, the GPC has met approximately every two months and has covered a wide variety of issues. Some of the more significant ones are outlined below.

- Patient eligibility, DHB audits and clawback. This is a perennial issue which has been addressed by the PHO Service Agreement Amendment Protocol Group (PSAAP) at the national level and still remains unresolved. With General Practice not having access to some of the information which would determine eligibility, and an expectation by DHBs that the process is more black and white than it actually is, this has meant the issue of clawbacks has been particularly painful for some GPs. We continue to advocate for national consistency regarding the rules governing eligibility, as well as consistency in their application by DHBs.

- After hours issues. This continues to cause unrest and the GPC, in conjunction with the GPLF, has been calling for some agreed national principles regarding, particularly, the application of the free under sixes and subsidised visits by those in high needs categories.
• Pharmacy issues and the role of pharmacists and pharmacies in the primary care team. The Warfarin pilot and the development of unsubsidised influenza vaccinations being available through community pharmacies have raised the greater question of how pharmacy and the primary care team can engage positively. Again, the GPC has been advocating for the development of some agreed principles of engagement so that all parties can move forward together.

• Career pathway for General Practitioners. Acknowledging that the career structure for GPs has been flat, there has been a renewed call to develop a structure that more accurately reflects and rewards the differences between newly qualified GPs and their much more experienced and wiser colleagues – who may also be teachers and have a variety of other roles in their professional lives. A consultation paper has been prepared by the RNZCGP and is currently circulating for comment.

The NZMA GP CME conferences in Rotorua and in Dunedin attract enormous numbers of GPs and are very well received by GPs in both islands. The NZMA is focusing on workforce issues for the Rotorua conference in June, and professionalism for the Dunedin conference in August 2012.

We are looking at new ways of engaging and gauging GP opinion on a variety of different issues, so that our position on issues continues to be well informed and supported by GP views.

Kate Baddock
Chair
GPC

GP Council Members
Dr Tim Baiy-Gibson
Dr Peter Chapman-Smith
Dr Jan White
Professor Murray Tilyard
Dr David Wilson
Dr Bev O’Keefe (GPNZ Rep)
Dr Harry Pert (RNZCGP Rep)
Dr Paul Ockelford (Ex Officio)
Ms Lesley Clarke (Ex Officio)
I would like to begin by thanking the members of the Specialist Council (SPC) for their ongoing support and contribution.

It has been gratifying to see the Specialist Council take on a greater role within the NZMA, especially in light of the membership of the Council being significantly broadened. This has enabled the NZMA to better represent the views of specialists and to provide a strong political voice for specialists.

The SPC met on the 16 March 2011, 22 June 2011, and 28 September 2011 in Wellington. The following is a list of significant activities undertaken in 2011 as SPC Chair.

1. Attended a Workforce Debate hosted by the NZMA Auckland Council on 6 July 2011.

2. Attended the Symposium on Health Equity and the Social Determinants of Health hosted by the NZMA, in conjunction with the Heart Foundation and The University of Auckland School of Population Health on 12 July 2011. The guest speaker was Sir Michael Marmot, a world leading advocate on health equity and previous chair of the WHO Commission on the Social Determinants of Health.

3. Attended a Special Paediatric Grand Round at Starship on 29 July 2011 which focused on the Green Paper, the Auckland Plan, the Child Health Scorecard and an annual State of the Nation’s Children report with a presentation by the Child Health Commissioner Dr Russell Wills.


5. The Role of the Doctor Consensus Statement was published on 4 November 2011 in the New Zealand Medical Journal.
6. Presented on the Role of the Doctor at the Physicians Grand Round held in the Clinical Education Centre of Auckland City Hospital on 30 October 2011.

Harvey White
Chair
SPC

Specialist Council Members
Dr Deborah Greig
Dr Wayne Miles
Dr Andrew Tie
Dr Howard Clentworth
Dr Graham Sharpe
Dr Ian Page (RANZCOG Rep)
Dr Rob Carpenter (NZSA rep)
Dr Cathy Ferguson (RACS rep)
Dr Paul Ockelford (Ex Officio)
Ms Lesley Clarke (Ex Officio)
DOCTORS-IN-TRAINING COUNCIL (DiTC)

Dr Jonathan Foo

Introduction
The Doctors-In-Training Council (DiTC) is a standing committee of the NZMA and operates under the delegated authority of the Board. The DiTC comprises nine elected members, the President of the New Zealand Medical Students’ Association (NZMSA) and the Chair and CEO of the NZMA (Ex Officio).

Summary of business
The DiTC is focused on making a positive difference for our members. We have had a productive year with the usual mix of submissions, advocacy and representation. This year we have taken major steps in representation and have been invited to participate at Medical Council of New Zealand (MCNZ) and Health Workforce New Zealand (HWNZ) committees on a variety of topics. We have also added a Facebook page to contact our members and better engage with them.

The DiTC was principally involved in two major submissions in 2011 – General Practice Education Programme (HWNZ) and Prevocational Registration (MCNZ). I believe we contributed well to these two key issues but the goal is continued engagement with these national agencies.

The DiTC hosted the fifth annual Trainee Forum in September. This has been a platform for trainees around the country to discuss medical training concerns at a national level. Trainees from nearly every college attended this meeting and we were able to debate a variety of concerns with our two invited speakers, Professor Des Gorman, Chair of HWNZ and Dr John Adams, Chair of the MCNZ.

Working groups/committees
The DiTC has been invited to participate as a member, on a number of national working groups/committees in 2011-12:

- MCNZ Medical Student Registration Working Group
- MCNZ Prevocational Training Working Group
- MCNZ Credentialing Framework DHB/SMO Working Group
- MCNZ/CPMEC Prevocational Forum Scientific Committee
- HWNZ Advanced Training Fellowship Selection Committee
- HWNZ Regional Training Hub Reference Group
- ACE Reference Group.

Evidenced based advocacy
The Prevocational Registration discussion document generated a great deal of interest, and following more than 200 responses to our survey we have drafted a manuscript for submission to the New Zealand literature.
Following discussion at the Trainee Forum, we have completed a survey of all vocational trainees in New Zealand to determine their views on the quality of training received in New Zealand. With more than 25% of all vocational trainees responding to this survey, we look forward to issuing a report on this and submitting a further manuscript to contribute to the New Zealand literature.

Elections

I would like to begin by thanking Drs Anu Shinnamon and Anna Choi for their committed service and hard work over the last year as members of our council. The elections resulted in Drs Ciaran Thrush and Emily Gill returning for a further term. We also welcomed Drs Kathryn Hagen, Richard Pole and Sally Eyers in 2012 along with Mr Michael Chen-Xu (NZMSA) onto Council. We thank Mr Oliver Hansby, as immediate past president of NZMSA, for his excellent work on the DiTC.

Jonathan Foo
Chair
DiTC

---

DiTC Members
Dr Emily Gill (Deputy Chair)
Dr Jesse Gale
Dr Ciaran Thrush
Dr Anu Shinnamon
Dr James Blackett
Dr Kathryn Hagen
Dr Anna Choi
Mr Oliver Hansby (President, NZMSA)
Dr Paul Ockelford (Ex Officio)
Ms Lesley Clarke (Ex Officio)
THE NEW ZEALAND MEDICAL JOURNAL AND DIGEST

Professor Frank Frizelle

The online eNZMJ and printed NZMJ Digest have survived another year of turmoil. In February 2011 I had just submitted the previous report when we had the February 22nd earthquake here in Christchurch. Despite one staff member being trapped in our office at Christchurch Hospital by falling equipment, all staff were unharmed and we published the next edition of the eNZMJ three days later (though we did drop most of the letters).

This resilience has been the hallmark of the staff as they strove to cope with the ongoing aftershocks, and disturbed work environment that was Christchurch in 2011. As a result of these difficulties many planned changes did not occur as we moved from “going forward” to “trying to stand still.”

Despite all this, the Journal came out with more published articles than most years with the table below outlining what we published in 2011; in addition, the Journal includes Methuselah (abstracts from other journals), 100 years ago (in the NZMJ), obituaries, medico-legal disciplinary notices, proceedings (abstracts) from scientific meetings, book reviews, errata, and notices (mostly applications for academic awards/scholarships or notifications of award recipients).

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<td>351</td>
<td>342</td>
<td>385</td>
<td>513</td>
<td>505</td>
<td>494</td>
<td>512</td>
<td>452</td>
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<tr>
<td>Editorials</td>
<td>38</td>
<td>44</td>
<td>41</td>
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<td>43</td>
<td>36</td>
<td>42</td>
<td>47</td>
</tr>
<tr>
<td>Original articles</td>
<td>123</td>
<td>126</td>
<td>117</td>
<td>100</td>
<td>114</td>
<td>105</td>
<td>106</td>
<td>122</td>
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<tr>
<td>Viewpoints</td>
<td>17</td>
<td>21</td>
<td>8</td>
<td>18</td>
<td>17</td>
<td>24</td>
<td>25</td>
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<tr>
<td>Review articles</td>
<td>8</td>
<td>5</td>
<td>3</td>
<td>7</td>
<td>10</td>
<td>8</td>
<td>7</td>
<td>10</td>
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<tr>
<td>Special articles</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>3</td>
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<tr>
<td>Case reports</td>
<td>23</td>
<td>42</td>
<td>32</td>
<td>43</td>
<td>44</td>
<td>59*</td>
<td>71*</td>
<td>56*</td>
</tr>
<tr>
<td>Letters</td>
<td>64</td>
<td>90</td>
<td>96</td>
<td>80</td>
<td>85</td>
<td>80</td>
<td>94</td>
<td>113</td>
</tr>
</tbody>
</table>

* Now called clinical correspondence — case reports and medical images combined since May 2008 as clinical correspondence. Reported separately for 2008, however for 2009 medical images are included along with case reports.
The NZMJ Editorial Board in 2011 remained as Jennie Connor, Richard Beasley, Roger Mulder, Tim Buckenham, Jim Reid, and myself. The production staff also remains unchanged with Brennan Edwardes (Production Editor), Sally Bagley (part-time Administrative Assistant; 16 hours), and Wendy Edwardes (part-time Administrative Assistant; 6 hours).

We expect some changes over the next 12 months, many of which I had planned earlier but didn’t occur due to the events of last year. One of the most urgent changes is to move the Journal to a commercial online manuscript management system, which will allow remote editing. This should speed up manuscript handling, and make it easier for editorial staff to work anywhere as we expect increased demands for office space in Christchurch, including our own.

In 2011, the International Committee of Medical Journal Editors (ICMJE) met in Ottawa, Canada. Editors from the main journals discussed issues of common interest and work on developing the “uniform requirements of medical publishing.” Considerable work went into developing new uniform requirements of medical publishing (the rules for medical publishing). An updated version of this document will likely be published this year.

The NZMJ Digest continues to be well received and continues to attract advertising. Indeed, the Digest is enjoyed by many readers and appears to be filling a gap that the NZMJ in electronic form doesn’t fill.

The Journal continues to receive considerable media coverage. So far this year we have avoided some of the controversies that have been an issue in past years. I am hoping for a less shaky year ahead.

Frank Frizelle
Editor
NZMJ

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NZMA Services Limited
Dr Don Simmers (Chair)
Dr Sandra Hicks
Dr David Kerr
Ms Lesley Clarke (Ex Officio)
NZMA ETHICS COMMITTEE

Dr Tricia Briscoe

The NZMA Ethics Committee has had an interesting and varied year.

In March 2011, the Ethics Committee provided comment to the NZMA Board regarding a World Medical Association draft document on End of Life Care. The document was generally in line with NZMA policy. However, it was the Committee’s opinion that the paper should clearly state that in end of life care there is no ethical impediment to giving whatever analgesics are necessary to relieve pain, even if this may have the effect of shortening the life of the patient.

In May the NZMA Ethics Committee provided comments to the MCNZ (at their request) on the ethics of holding incompetent patients against their will. The ethical use of restraints, both physical and chemical (with medications) for incompetent patients should be driven primarily by the patient’s needs, and ensuring that harm is avoided. Other management techniques should be considered first, and restraints should be of the minimum level to ensure safety for the patient and those who will have contact with the patient. Documentation, training, regular review and discussion with those people who hold responsibility for the incompetent patient are also important guiding principles.

The Ethics Committee also provided advice in May to the Board regarding the ethics of CPR. The NZMJ published a paper by McLennan et al (21-January-2011, Vol 124 No 1328), which was a comprehensive statement concerned with the legal aspects of Do Not Resuscitate (DNR) orders and discrepancies between current practice and the law. The NZMA Code of Ethics is clear in its advice that withholding treatment when such treatment would not be to the benefit of the patient’s wellbeing is correct ethically. It emphasises the importance of death with dignity (which would not be provided in a terminal setting by active resuscitation measures).

In August, the Committee provided comment to the NZMA Board on the proposed revision of The Physiotherapy Board of New Zealand’s Code of Ethics and Professional Conduct. The Committee felt the document was comprehensive and appropriate, but provided some comments on specific issues.

In October, the Committee commented on an interesting query from a potential patient, regarding the ethical issues around his proposed request to a surgeon to undertake a novel (and experimental) procedure on his chronic spinal cord injury. Our thoughts were that if the procedure is not compliant with medical ethics, then the surgeon should not be involved, despite the patient’s request. The treatment has to be within the bounds of that endorsed by a reasonable body of medical
opinion, put the patient’s safety, health and wellbeing as the first consideration, and
be agreed to by a responsible and suitably qualified practitioner who fairly explains
the nature and risks of the procedure to the patient. The practitioner must also
ensure the patient is under no inappropriate duress to consent.

I also provided comment to the NZMA Chair in regard to a query from the National
Ethics Advisory Committee, seeking NZMA’s feedback on the principle of “first
do no harm” in industrial situations. The NZMA position is well explained in
recommendation 67 of the NZMA Code of Ethics, added at the time the Code was
last revised.

In November, the Committee provided comments to the Board regarding the
MCNZ’s review of its standards in relation to doctors and financial conflicts of interest.
The Ethics Committee felt the statement by the World Medical Association (WMA)
concerning the Relationship between Physicians and Commercial Enterprises to be
particularly useful: gifts from Health Related Commercial Organisations (HRCOs) to
physicians must be of minimal value, not designed to influence clinical practice, not
for personal benefit, nor of cash or cash equivalent. In relation to conference funding,
in an ideal world funding provided by health related commercial organisations for
conferences should be channelled through an independent third party. However,
while ideally a doctor should never receive funding directly from an HRCO, that
position is impractical at present in New Zealand in respect of assistance for travel
to overseas conferences and may mean that New Zealand doctors are unable
to attend overseas conferences that are costly to travel to. Key principles of any
funding should be transparency and independence.

The committee also felt the MCNZ paper should cover physician endorsement of
commercial products, and drew attention to the NZMA’s 2007 policy statement on
this matter. The MCNZ’s proposed standards relating to research were regarded as
appropriate but inadequate. As a minimum the Medical Council should refer to the
Declaration of Helsinki, and should elaborate on the issue of ensuring that negative
results are always made available.

Outside of the specific issues the MCNZ mentioned, we felt that there also needed
to be an acknowledgment of the necessity of there always being some relationship
between doctors and HRCOs. Pharmaceutical and technological development
has been driven, made and paid for by private companies. Having interests and
promoting them is a basic freedom in a society provided it is not at the expense of
others. Medical practitioners must be able to talk and to cooperate with all partners
in the health care field including companies. Again, the major principles we should
adopt in regard to this are transparency and independence.

In January I provided some comments on an NZMA Board document, a resource
for members regarding CPR and DNR orders.

In February, the Ethics Committee provided feedback to the Board regarding the
Nursing Council draft Code of Conduct. The Committee noted that, while the
document was comprehensive and appropriate, there was very little about working
with other health professionals, and it lacked any guidelines for the situation when
a nurse is acting for a third party.
My thanks to my fellow committee members, Dr Grant Gillett, Dr Brian Linehan and Dr Philip Rushmer for their valued input to these various topics, and also to the NZMA National Office staff, particularly Lucille Curtis, for their indispensable help and assistance.

Dr Tricia Briscoe
Chair
NZMA Ethics Committee

Ethics Committee Members
Dr Grant Gillett
Dr Brian Linehan
Dr Philip Rushmer
Dr Paul Ockelford (Ex Officio)
Ms Lesley Clarke (Ex Officio)
Submissions made by the NZMA national office during 2011 are listed below.

**Accident Compensation Corporation (ACC)**
- Consultation on Proposed Increase to Cost of Treatment Regulations

**Auckland City Council**
- Auckland City Plan

**Advertising Standards Authority**
- Consultation on the review of the code for advertising liquor

**Australasian Faculty of Occupational and Environmental Medicine**
- Consensus Statement on Health Benefits of Work

**Christchurch City Council**
- Draft City Plan

**Christchurch City Laboratory Consult**
- Christchurch Laboratory Service Level Alliance Report: A Whole of System Approach to Laboratory Services

**Law Commission**
- Final words – Death and Cremation Certification in New Zealand

**Medical Council of New Zealand (MCNZ)**
- Reaccreditation of the College of Intensive Car Medicine
- Proposed changes to fees for assessment of documents and interview of international medical graduates applying for provisional vocational registration
- Prevocational Training Requirements for Doctors in New Zealand
- Prevocational Training Requirements for Doctors in New Zealand – Supplementary Letter
- Statement on Cosmetic Procedures – Tumescent Liposuction
- Revision of MCNZ Statement on Telemedicine
- Review of the Comparable Health System pathway to registration in a (provisional) general scope of practice
- Proposed Changes to the Special Purpose (Locum Tenens) Scope of Practice
- Recognition of the Vocational Scope of Pain Medicine

**Medical Council of New Zealand (MCNZ) / Health Workforce New Zealand (HWNZ) / Royal New Zealand College of General Practitioners (RNZCGP)**
- Workforce Requirements for New Models of Service Delivery: Proposed Changes to the General Practice Education Programme
Minister of Health
• Report of Health Select Committee on inquiry into improving New Zealand’s environment to support innovation through clinical trials

Ministry of Health (MOH)
• Draft Maternity Standards
• Proposal for a Shared Secretariat and Office Function for all Health-Related Regulatory Authorities together with a Reduction in the Number of Regulatory Authority Board Members
• Proposal that Traditional Chinese Medicine Become a Regulated Profession under the Health Practitioners Competence Assurance Act 2003
• Report to the Ministry of Health – New Models of Care for Medical Oncology
• High Use Health Card checklist

MOH – Consult by Allen and Clark
• Proposed amendments to the Maternity Referral Guidelines and processes for the transfer of care

MOH – Consult by Siggens Miller
• Evaluation of Physician Assistant Trial

MOH – HWNZ
• Career Planning Guiding Principles
• Health Workforce New Zealand Draft Investment Plan Prioritisation Criteria

MOH – National Health IT Board
• Information Governance in the New Zealand Health Sector

National Ethics Advisory Committee (NEAC)
• First “do no harm” principle and industrial action.

New Zealand Guidelines Group
• Draft Resources for the Management of Type 2 Diabetes

Pharmac
• Proposal to amend the Special Authority restrictions applying to fluconazole capsules
• Supply of Services to Promote the Responsible Use of Pharmaceuticals
• Proposal to tender certain pharmaceuticals for sole supply

Physiotherapy Board
• Code of Ethics and Professional Conduct

Parliamentary Select Committees
Health
• Smoke-free environments (controls and enforcement) amendment bill

Justice and Electoral
• Alcohol Law Reform Bill

Royal Australasian College of Physicians (RACP)
• Position Statement of the AFRM/NZRA Rehabilitation Strategy Working Group – A New Zealand Rehabilitation Strategy
NZMA Affiliates 2011

- Accident and Medical Practitioners Association
- Association of Catholic Doctors
- Australasian College for Emergency Medicine
- Australasian Faculty of Public Health Medicine
- Australian and New Zealand Association of Urological Surgeons
- Australian and New Zealand College of Anaesthetists
- Aviation Medical Society of Australia and New Zealand
- Cardiac Society of Australia and New Zealand
- Doctors for Sexual Abuse Care
- Institute of Australasian Psychiatrists
- Medical Acupuncture Society of New Zealand
- New Zealand Association of Musculoskeletal Medicine
- New Zealand Association of Pathology Practices
- New Zealand College of Appearance Medicine
- New Zealand Dermatological Society
- New Zealand Doctors for Life
- New Zealand Family Planning Association
- New Zealand Orthopaedic Association
- New Zealand Pain Society
- New Zealand Rheumatology Association
- New Zealand Society of Anaesthetists
- New Zealand Society of Gastroenterology
- New Zealand Society of Otolaryngology/Head and Neck Surgery
- New Zealand Venereological Society
- Pasifika Medical Association
- Royal Australasian College of Physicians
- Royal Australasian College of Surgeons
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists
- Royal Australian and New Zealand College of Psychiatrists
- Royal Australian and New Zealand College of Radiologists
- Royal Australian and New Zealand College of Ophthalmologists
- Royal College of Pathologists of Australasia
- Royal New Zealand College of General Practitioners
- Rural General Practice Network
- Sports Medicine New Zealand
We record with regret the deaths of the following members of the NZMA.

<table>
<thead>
<tr>
<th>Name</th>
<th>Surname</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr William Ward</td>
<td>AKROYD</td>
</tr>
<tr>
<td>Dr Colin Graeme</td>
<td>ANDERSON</td>
</tr>
<tr>
<td>Dr Peter</td>
<td>APTHORP</td>
</tr>
<tr>
<td>Dr Jacob</td>
<td>BECK-JAFFURS</td>
</tr>
<tr>
<td>Mr Ross Lewis</td>
<td>BOHM</td>
</tr>
<tr>
<td>Dr David Charles</td>
<td>BRIDGE</td>
</tr>
<tr>
<td>Dr Ian Sinclair De Berri</td>
<td>BROADFOOT</td>
</tr>
<tr>
<td>Dr Stuart Hawksworth</td>
<td>BROWN</td>
</tr>
<tr>
<td>Dr George Shannon</td>
<td>CHISHOLM</td>
</tr>
<tr>
<td>Dr Robin Macfarlane</td>
<td>CHRISP</td>
</tr>
<tr>
<td>Dr Geoffrey Bolton</td>
<td>CLARKE</td>
</tr>
<tr>
<td>Dr Thomas Nigel</td>
<td>ELLISON</td>
</tr>
<tr>
<td>Dr Robert Burton</td>
<td>FISHER</td>
</tr>
<tr>
<td>Dr Ian Calderwood</td>
<td>FLEMING</td>
</tr>
<tr>
<td>Mr Zachary</td>
<td>GRAVATT</td>
</tr>
<tr>
<td>Dr Lindsay Franklin</td>
<td>HAAS</td>
</tr>
<tr>
<td>Dr Roy Douglas</td>
<td>HARRIS</td>
</tr>
<tr>
<td>Dr Alan Bernard Howard</td>
<td>HOWES</td>
</tr>
<tr>
<td>Dr Bruce Irving</td>
<td>HUNTER</td>
</tr>
<tr>
<td>Dr Marjorie Elizabeth</td>
<td>MacREADY</td>
</tr>
<tr>
<td>Dr Alan</td>
<td>MITCHELL</td>
</tr>
<tr>
<td>Dr Charles Stuart</td>
<td>MOORE</td>
</tr>
<tr>
<td>Dr John Murray</td>
<td>NEUTZE</td>
</tr>
<tr>
<td>Dr Brian Eden</td>
<td>OLDHAM</td>
</tr>
<tr>
<td>Dr Anthony</td>
<td>QUINN</td>
</tr>
<tr>
<td>Dr Bernard Harold</td>
<td>ROSA</td>
</tr>
<tr>
<td>Major Brian Walter</td>
<td>SCOTT</td>
</tr>
<tr>
<td>Dr Marion Anne</td>
<td>UPSDELL</td>
</tr>
<tr>
<td>Dr Roland John</td>
<td>WILSON</td>
</tr>
<tr>
<td>Prof James Lawrence</td>
<td>WRIGHT</td>
</tr>
<tr>
<td>Dr Samuel Philip</td>
<td>WRIGHTSON</td>
</tr>
</tbody>
</table>
In 2011 the NZMA continued to support and provide advice to practices covered by the Primary Health Care Multi Employer Collective Agreement (PHC MECA), which sets pay rates and term and conditions of employment for practice nurses, other registered nurses working in primary care, midwives, enrolled nurses, medical receptionists and administration staff.

There were minor changes in employment legislation in 2011, and our resources were updated to incorporate these changes.

In 2011, the NZMA entered a partnership with FearFree Security and Safety Management to offer workshops specifically for medical staff, to help them deal with conflict and difficult patients. These workshops have proved to be very successful, and they will continue to be run throughout the country in 2012.

The NZMA continues to offer comprehensive advice on a variety of issues, ranging from staff employment to running your practice. More information on the NZMA Advisory Service, and copies of our publications, are available in the members only section on the NZMA website.

Financial benefits

The following is a list of current NZMA financial membership benefits.

**Air New Zealand Koru Club**
Pay corporate rates for Koru Club individual membership.

**American Express – Merchant Rate**
 Preferential Merchant of 1.99% to NZMA members who hold personal or business American Express cards.

**ACP Magazines Discount**
Offers an exclusive discount rate to NZMA members for a selection of consumer and trade magazines. NZMA members can receive up to 40% discount on the normal retail subscription rates.

**Cherrytree – the Club for Smart Shoppers**
Reduced membership fee, reduced renewal fee and an account credit when joining Cherrytree.

**Goodyear Dunlop Tyres and Co**
10% off all tyres and batteries at Beaurepaires, Frank Allen Tyres and Goodyear stores.
HotelClub.com
Save up to 12% discount on the already discounted prices of accommodation listed on the HotelClub website.

MSIG Pre-Employment Screening and Theft Investigation
Discounted comprehensive pre-employment screening and theft investigation service through Morley Security and Investigation Group (MSIG).

Nexus Data Security
Receive 10% discount off the normal subscription rates for secure online backup of your medical practice.

Noel Leeming
Exclusive prices for members on everything in store, at Noel Leeming and Bond & Bond stores.

NRC Debt Collecting Package
Offers a competitive rate per debtor and easy online access service with National Revenue Corporation.

NZMA GPCME Conference
Members receive $150 discount on full registration to the NZMA GPCME Conferences in Rotorua and Dunedin.

NZMA Wine Club
Discounts on selected quality NZ and imported wines through the NZMA online wine club.

OfficeMax Stationery Discounts
Discounts on everyday stationery and business consumables through OfficeMax.

Petals online florist
Members receive 10% discount on the flower value and 8% discount on the product value for all gift orders through Petals online florist.

Telecom
Telecommunication packages at special member rates through Total Network.

Westpac Banking Package
Competitive member rates on merchant credit card processing rates, eftpos terminals and day-to-day banking through Westpac.

Wilkinson Legal Expenses Insurance
15% discount off premiums for legal expenses insurance through Wilkinson Insurance Brokers (policy underwritten by Lumley’s)

American Express - Credit Cards*
Competitive interest rates and additional benefits offered on the NZMA Gold, Platinum and Business Cards.
*this service is available to all doctors, including non-members.

The NZMA is committed to continuous improvement and we regularly develop services and advice packages that will benefit our members and add value to your membership with us.
Acknowledgement

The Association acknowledges the valued contribution of its Corporate Partners:

American Express
Conference Matters
Medical Assurance Society
Westpac Banking Corporation
Wilkinson Insurance Brokers
National Revenue Corporation

Other organisations whose support also assists us in providing enhanced services to our members:

ACP Media
Air New Zealand Koru Club
Cherrytree
Fear Free Security & Safety Management
HotelClub
Morley Security and Investigation Group
Nexus Data Security
Noel Leeming Group
OfficeMax
Petals
South Pacific Tyres
Telecom
Primo Vino
**A message to NZMA members**

Please share this Annual Report with any colleague who is not yet a member of the NZMA.

**A message to non-members**

The NZMA fosters unity within the profession. Only the NZMA, with membership extending from students to retired doctors, can represent medical practitioners in a pan-professional way.

The NZMA's ability to influence issues at a political level is strongest when we have a high level of membership.

You owe it to yourself and your profession to belong. By joining the NZMA, you are heard and supported, and you help enhance the collective strength of the profession.

Acknowledge the success and commitment of the NZMA and its focus on members. For a membership application form contact the National Office on 04 472 4741 or visit our website: www.nzma.org.nz/membership/join.html.
# New Zealand Medical Association Inc.
## Consolidated Statement of Financial Performance
### For the Year Ended 30th September 2011

<table>
<thead>
<tr>
<th>Note</th>
<th>2011 Group</th>
<th>2011 Parent</th>
<th>2010 Parent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>REVENUE</strong></td>
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<tr>
<td>Subscriptions</td>
<td>1,189,688</td>
<td>1,109,702</td>
<td>1,064,208</td>
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<tr>
<td>Investment Income</td>
<td>108,156</td>
<td>107,638</td>
<td>171,500</td>
</tr>
<tr>
<td>Member Benefit Income</td>
<td>86,649</td>
<td>86,849</td>
<td>68,486</td>
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<tr>
<td>GPCME Conference</td>
<td>73,038</td>
<td>73,038</td>
<td>72,740</td>
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<tr>
<td>MEGA Negotiations</td>
<td>70,005</td>
<td>70,065</td>
<td>55,000</td>
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<tr>
<td>Other Income</td>
<td>108,951</td>
<td>106,906</td>
<td>133,980</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td><strong>1,677,527</strong></td>
<td><strong>1,594,198</strong></td>
<td><strong>1,585,914</strong></td>
</tr>
<tr>
<td><strong>Less Expenses</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administration, Support and Finance</td>
<td>971,454</td>
<td>958,229</td>
<td>892,098</td>
</tr>
<tr>
<td>Advocacy and Policy</td>
<td>139,107</td>
<td>139,107</td>
<td>115,282</td>
</tr>
<tr>
<td>Audit Fees</td>
<td>18,180</td>
<td>14,180</td>
<td>14,540</td>
</tr>
<tr>
<td>Board and Advisory Councils</td>
<td>392,274</td>
<td>399,392</td>
<td>341,285</td>
</tr>
<tr>
<td>Depreciation</td>
<td>36,728</td>
<td>36,728</td>
<td>37,405</td>
</tr>
<tr>
<td>Doubtful Debt Expense</td>
<td>3,023</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Grants</td>
<td>-</td>
<td>143,478</td>
<td>-</td>
</tr>
<tr>
<td>Loss on Disposal of Assets</td>
<td>18,440</td>
<td>18,440</td>
<td>2,959</td>
</tr>
<tr>
<td>Membership Services and Marketing</td>
<td>75,334</td>
<td>75,334</td>
<td>90,308</td>
</tr>
<tr>
<td>New Zealand Medical Journal &amp; Digest (Net)</td>
<td>201,948</td>
<td>-</td>
<td>83,871</td>
</tr>
<tr>
<td><strong>Total Expenses</strong></td>
<td><strong>1,847,388</strong></td>
<td><strong>1,744,878</strong></td>
<td><strong>1,577,748</strong></td>
</tr>
<tr>
<td><strong>OPERATING DEFICIT FOR YEAR</strong></td>
<td><strong>(169,861)</strong></td>
<td><strong>(150,680)</strong></td>
<td><strong>(11,834)</strong></td>
</tr>
<tr>
<td>Fair Value Movements in Investments</td>
<td>(60,712)</td>
<td>(60,712)</td>
<td>-</td>
</tr>
<tr>
<td><strong>NET SURPLUS/(DEFICIT) FOR YEAR</strong></td>
<td><strong>(230,573)</strong></td>
<td><strong>(211,392)</strong></td>
<td><strong>(11,834)</strong></td>
</tr>
</tbody>
</table>

The accompanying notes form part of these financial statements. These financial statements have not been subject to audit or review, and should be read in conjunction with the attached Audit Report.
## New Zealand Medical Association Inc.
### Consolidated Statement of Movements in Equity
**For the Year ended 30 September 2011**

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2011</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Group</td>
<td>Parent</td>
<td>Parent</td>
</tr>
<tr>
<td>ACCUMULATED FUNDS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opening Balance as at 1 October 2010</td>
<td>2,457,715</td>
<td>2,457,715</td>
<td>2,469,549</td>
</tr>
<tr>
<td>Net Surplus for the Year</td>
<td>(230,573)</td>
<td>(211,392)</td>
<td>(11,834)</td>
</tr>
<tr>
<td>Closing Balance as at 30 September 2011</td>
<td>2,227,142</td>
<td>2,246,323</td>
<td>2,457,715</td>
</tr>
<tr>
<td>RESERVES AND TRUSTS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opening Balance as at 1 October 2010</td>
<td>667,866 667,866</td>
<td>647,299</td>
<td></td>
</tr>
<tr>
<td>Transfer to Building Maintenance Fund</td>
<td>-</td>
<td>-</td>
<td>8,500</td>
</tr>
<tr>
<td>Unrealised Gain/(Loss) on Investments</td>
<td>12</td>
<td>12</td>
<td>12,057</td>
</tr>
<tr>
<td>Closing Balance as at 30 September 2011</td>
<td>667,878</td>
<td>667,878</td>
<td>667,866</td>
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<tr>
<td>Total Equity</td>
<td>2,895,020</td>
<td>2,914,201</td>
<td>3,125,581</td>
</tr>
</tbody>
</table>

The accompanying notes form part of these financial statements. These financial statements have not been subject to audit or review, and should be read in conjunction with the attached Audit Report.
New Zealand Medical Association
Consolidated Statement of Financial Position
As at 30th September 2011

<table>
<thead>
<tr>
<th>Note</th>
<th>2011 Group</th>
<th>2011 Parent</th>
<th>2010 Parent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2011</td>
<td>2011</td>
<td>2010</td>
</tr>
<tr>
<td></td>
<td>Group</td>
<td>Parent</td>
<td>Parent</td>
</tr>
<tr>
<td>Bank</td>
<td>58,736</td>
<td>40,058</td>
<td>717,406</td>
</tr>
<tr>
<td>GST Refund Due</td>
<td>4,207</td>
<td>8,214</td>
<td>-</td>
</tr>
<tr>
<td>Accounts Receivable</td>
<td>147,521</td>
<td>122,341</td>
<td>123,700</td>
</tr>
<tr>
<td>Advance</td>
<td>-</td>
<td>17,391</td>
<td>-</td>
</tr>
<tr>
<td>Investments</td>
<td>2,674,362</td>
<td>2,674,362</td>
<td>2,282,886</td>
</tr>
<tr>
<td>Payments in Advance</td>
<td>4,320</td>
<td>4,320</td>
<td>47,595</td>
</tr>
<tr>
<td><strong>Total Current Assets</strong></td>
<td>2,880,148</td>
<td>2,866,688</td>
<td>3,171,686</td>
</tr>
<tr>
<td>Fixed Assets at Cost</td>
<td>1,042,988</td>
<td>1,042,988</td>
<td>1,049,609</td>
</tr>
<tr>
<td>Less Accumulated Depreciation</td>
<td>(962,744)</td>
<td>(962,744)</td>
<td>(847,462)</td>
</tr>
<tr>
<td><strong>Total Non Current Assets</strong></td>
<td>180,244</td>
<td>180,244</td>
<td>202,147</td>
</tr>
<tr>
<td><strong>Total Non-Current Assets</strong></td>
<td>180,244</td>
<td>180,244</td>
<td>202,147</td>
</tr>
<tr>
<td><strong>TOTAL ASSETS</strong></td>
<td>3,069,390</td>
<td>3,046,930</td>
<td>3,373,833</td>
</tr>
<tr>
<td>GST Due for payment</td>
<td>-</td>
<td>-</td>
<td>7,895</td>
</tr>
<tr>
<td>Accounts Payable</td>
<td>129,350</td>
<td>101,505</td>
<td>125,119</td>
</tr>
<tr>
<td>Provision for Holiday Pay</td>
<td>45,020</td>
<td>31,224</td>
<td>36,210</td>
</tr>
<tr>
<td>Receipts in advance</td>
<td>-</td>
<td>-</td>
<td>59,028</td>
</tr>
<tr>
<td><strong>TOTAL LIABILITIES</strong></td>
<td>174,370</td>
<td>132,729</td>
<td>248,252</td>
</tr>
<tr>
<td><strong>NET ASSETS</strong></td>
<td>$2,885,020</td>
<td>$2,914,201</td>
<td>$3,125,581</td>
</tr>
</tbody>
</table>

Represented by:

**EQUITY**

**RESERVES AND TRUSTS**
- JPS Jamieson/GP Society Trust: 7,425
- Building Maintenance Fund: 42,500
- Memorial Oration Fund: 16,004
- Guest Speaker Fund: 23,000
- Building Replacement Fund: 578,949
- Investment Revaluation Reserve: -

**Total Reserves and Trust** | 667,878 | 667,878 | 667,866 |

Accumulated Funds | 2,227,142 | 2,246,323 | 2,467,715 |

**TOTAL EQUITY** | $2,895,020 | $2,914,201 | $3,125,581 |

For and on behalf of the Board:

Chairperson: [Signature]  
Date: 12.03.2014  
Chief Executive: [Signature]
1. STATEMENT OF ACCOUNTING POLICIES

Nature of Entity
The financial statements presented here are for the entity New Zealand Medical Association Inc. (the Association), an Incorporated Society registered under the Incorporated Societies Act 1908. They are also registered as a Charity under the Charities Commission as at 30 June 2008.

The Association is a voluntary body directly representing the majority of practising medical practitioners in New Zealand. The Association is dependent on receiving subscriptions from its members on an annual basis.

The financial statements of the Association as at and for the year ended 30 September 2011 comprise the separate financial statement of the Association being the ‘Parent’ and the consolidated financial statements of the Parent and its subsidiary being NZMA Services Limited as from 1 October 2010.

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, with the exception of certain items for which specific accounting policies have been identified.

Changes in Accounting Policies
There have been no changes in accounting policies. All policies have been applied on bases consistent with those used in previous years.

Specific Accounting Policies:

(a) Depreciation
All fixed assets, other than vehicles, are depreciated on a straight line basis to write off the various assets over their expected useful lives. The entity has the following classes of Property, Plant & Equipment:

<table>
<thead>
<tr>
<th>Class</th>
<th>Depreciation Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buildings</td>
<td>1%</td>
</tr>
<tr>
<td>Building Renovations</td>
<td>10%</td>
</tr>
<tr>
<td>Furniture, Fittings and Office Equipment</td>
<td>20 - 25%</td>
</tr>
<tr>
<td>Computer Equipment and Website</td>
<td>20 - 25%</td>
</tr>
<tr>
<td>Membership Database</td>
<td>12.5%</td>
</tr>
</tbody>
</table>

(b) Goods & Services Tax
These financial statements have been prepared on a GST exclusive basis with the exception of accounts receivable and accounts payable which are shown inclusive of GST.

(c) Taxation
No provision for Income Tax has been made as there is no current or deferred tax payable. New Zealand Medical Association is registered as a charity under the Charities Commission and is therefore exempt from income tax. NZMA Services Limited are subject to income tax but have no tax to pay in the current year.

(d) Differential Reporting
The Association is a qualifying entity in terms of the framework for Differential Reporting by virtue of it not being publically accountable and not being deemed large. All differential reporting exemptions available have been applied.

(e) Revenue
Membership subscriptions and dividends are recognised on a cash basis. Interest income on term deposits is recognised on an accrual basis all other interest income is recognised on a cash basis.
New Zealand Medical Association Inc.
Consolidated Notes to the Financial Statements
For the Year Ended 30th September 2011

(f) Investments
Share investments in listed companies are stated at their fair value. Initially they are recorded at cost, and are then valued at market bid price at the Statement of Financial Position date in subsequent periods. Any gains or losses generated as a result of revaluation is recognised in the Statement of Financial Performance.

Other investments are stated at cost less any amortisation. Amortisation is recognised in the Statement of Financial Performance.

(g) Operating Leases
Operating leases are those which all the risks and benefits are substantially retained by the lessee. Operating lease payments are expensed in the periods the amounts are payable.

(h) Receivables
Receivables are stated at their estimated realisable value. Bad debts are written off in the year in which they are identified. Dividends are recorded on a cash received basis.

2. AUDIT
These financial statements have been subject to audit, please refer to Auditor’s Report.

3. BUILDING REPLACEMENT FUND
From 1985 until 1 October 2005 members of the Association were levied for the replacement of Association premises. No levy has since been charged.

4. LAND AND BUILDINGS
The latest Government valuation on land and buildings, dated 1 September 2000 was $1,775,000.
The New Zealand Medical Association Inc. building was assessed late 2011 and found to be earthquake prone. The NZMA is considering the option of redeveloping the site.

5. RELATED PARTIES
On 3 May 2010 the Association established a company ‘NZMA Services Limited’. The Association retained 100% of the shares in this company at balance date. The Association has entered into a Service Level Agreement with NZMA Services Limited for the purposes of operating the Medical Journal. The Association has agreed to provide a Grant per annum for the provision of these services. The grant given for 2011 was $143,478. (2010: Nil)

6. BANK

<table>
<thead>
<tr>
<th></th>
<th>2011 Group</th>
<th>2011 Parent</th>
<th>2010 Parent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash on Hand</td>
<td>200</td>
<td>200</td>
<td>200</td>
</tr>
<tr>
<td>Westpac Current Account</td>
<td>35,713</td>
<td>18,035</td>
<td>50,888</td>
</tr>
<tr>
<td>Westpac On Call account</td>
<td>1,700</td>
<td>1,700</td>
<td>646,334</td>
</tr>
<tr>
<td>Westpac Management Account</td>
<td>22,123</td>
<td>22,123</td>
<td>22,073</td>
</tr>
<tr>
<td>Total</td>
<td>38,728</td>
<td>40,088</td>
<td>717,484</td>
</tr>
</tbody>
</table>

7. CONTINGENT LIABILITIES
At balance date there are no known contingent liabilities (2010: $0). New Zealand Medical Association Inc. has not granted any securities in respect of liabilities payable by any other party whatsoever.
New Zealand Medical Association Inc.
Consolidated Notes to the Financial Statements
For the Year Ended 30th September 2011

8. OPERATING LEASE COMMITMENTS

Lease of Photocopier
The photocopier is leased for a term of 60 months commencing in December 2010 and includes a minimum volume amount in each payment.

<table>
<thead>
<tr>
<th></th>
<th>2011 Group</th>
<th>2011 Parent</th>
<th>2010 Parent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Year</td>
<td>14,100</td>
<td>14,100</td>
<td>10,024</td>
</tr>
<tr>
<td>1-5 years</td>
<td>44,650</td>
<td>44,650</td>
<td>31,742</td>
</tr>
<tr>
<td>Total</td>
<td>58,750</td>
<td>58,750</td>
<td>41,766</td>
</tr>
</tbody>
</table>

9. INVESTMENTS

Investment Portfolio
All investments are held by New Zealand Medical Association Inc. and therefore the numbers represent both parent and group.

<table>
<thead>
<tr>
<th></th>
<th>Westpac</th>
<th>JG Were</th>
<th>ANZ</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2011</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Zealand Equity</td>
<td>-</td>
<td>168,534</td>
<td>238,643</td>
<td>406,177</td>
</tr>
<tr>
<td>Australian Equity</td>
<td>-</td>
<td>121,007</td>
<td>75,648</td>
<td>196,655</td>
</tr>
<tr>
<td>Offshore Equities</td>
<td>-</td>
<td>86,377</td>
<td>-</td>
<td>86,377</td>
</tr>
<tr>
<td>Bonds</td>
<td>-</td>
<td>568,958</td>
<td>941,891</td>
<td>1,510,849</td>
</tr>
<tr>
<td>Cash / Term Deposits</td>
<td>380,267</td>
<td>81,074</td>
<td>33,993</td>
<td>476,304</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>380,267</td>
<td>1,065,960</td>
<td>1,288,145</td>
<td>2,674,362</td>
</tr>
<tr>
<td><strong>Income derived from Investments</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dividends</td>
<td>-</td>
<td>3,224</td>
<td>19,743</td>
<td>22,967</td>
</tr>
<tr>
<td>Interest</td>
<td>23,981</td>
<td>44,823</td>
<td>57,816</td>
<td>126,620</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>23,981</td>
<td>48,047</td>
<td>77,559</td>
<td>149,537</td>
</tr>
<tr>
<td><strong>2010</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Zealand Equity</td>
<td>-</td>
<td>176,735</td>
<td>223,810</td>
<td>400,546</td>
</tr>
<tr>
<td>Australian Equity</td>
<td>-</td>
<td>144,717</td>
<td>77,617</td>
<td>222,334</td>
</tr>
<tr>
<td>Bonds</td>
<td>-</td>
<td>560,570</td>
<td>786,971</td>
<td>1,366,541</td>
</tr>
<tr>
<td>Cash / Term Deposits</td>
<td>165,195</td>
<td>108,381</td>
<td>273,576</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,077,217</td>
<td>1,205,679</td>
<td>2,282,894</td>
<td></td>
</tr>
<tr>
<td><strong>Income Derived from Investments</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dividends</td>
<td>-</td>
<td>9,376</td>
<td>91,897</td>
<td>71,273</td>
</tr>
<tr>
<td>Interest</td>
<td>43,988</td>
<td>17,675</td>
<td>61,663</td>
<td>132,323</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>43,988</td>
<td>17,675</td>
<td>61,663</td>
<td>132,323</td>
</tr>
</tbody>
</table>
# New Zealand Medical Association Inc.
## Consolidated Notes to the Financial Statements
### For the Year Ended 30th September 2011

## 10. BOARD FEES

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>194,614</td>
<td>194,614</td>
<td>185,800</td>
</tr>
</tbody>
</table>

## 11. FIXED ASSETS

All fixed assets are held by New Zealand Medical Association Inc. and therefore the numbers represent both parent and group.

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Freehold Land</td>
<td>6,579</td>
<td>6,570</td>
</tr>
<tr>
<td>Buildings</td>
<td>56,092</td>
<td>56,092</td>
</tr>
<tr>
<td>Less Accumulated Depreciation</td>
<td>(24,866)</td>
<td>(24,127)</td>
</tr>
<tr>
<td>Building Renovations</td>
<td>252,706</td>
<td>252,706</td>
</tr>
<tr>
<td>Less Accumulated Depreciation</td>
<td>(200,403)</td>
<td>(180,241)</td>
</tr>
<tr>
<td>Furniture, Fittings &amp; Office Equipment</td>
<td>478,607</td>
<td>471,500</td>
</tr>
<tr>
<td>Less Accumulated Depreciation</td>
<td>(459,323)</td>
<td>(452,323)</td>
</tr>
<tr>
<td>Computer Equipment and Website</td>
<td>249,004</td>
<td>225,851</td>
</tr>
<tr>
<td>Less Accumulated Depreciation</td>
<td>(178,207)</td>
<td>(167,020)</td>
</tr>
<tr>
<td>Motor Vehicles</td>
<td>-</td>
<td>36,880</td>
</tr>
<tr>
<td>Less Accumulated Depreciation</td>
<td>-</td>
<td>(14,782)</td>
</tr>
<tr>
<td>Total Fixed Assets</td>
<td>180,244</td>
<td>202,145</td>
</tr>
</tbody>
</table>

## DEPRECIATION

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buildings</td>
<td>561</td>
<td>561</td>
</tr>
<tr>
<td>Building Renovations</td>
<td>11,164</td>
<td>11,164</td>
</tr>
<tr>
<td>Furniture &amp; Fittings, Office Equipment</td>
<td>7,092</td>
<td>6,024</td>
</tr>
<tr>
<td>Computer Equipment and Website</td>
<td>14,282</td>
<td>12,460</td>
</tr>
<tr>
<td>Motor Vehicles</td>
<td>3,089</td>
<td>7,370</td>
</tr>
<tr>
<td>Total Depreciation</td>
<td>35,728</td>
<td>37,405</td>
</tr>
</tbody>
</table>
12. RESERVES AND TRUSTS

<table>
<thead>
<tr>
<th>Trust</th>
<th>2011 Group</th>
<th>2011 Parent</th>
<th>2010 Parent</th>
</tr>
</thead>
<tbody>
<tr>
<td>JPS Jamieson/GP Society Trust</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opening Balance</td>
<td>7,425</td>
<td>7,425</td>
<td>7,425</td>
</tr>
<tr>
<td>CLOSING BALANCE</td>
<td>7,425</td>
<td>7,425</td>
<td>7,425</td>
</tr>
<tr>
<td>Building Maintenance Fund</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opening Balance</td>
<td>42,500</td>
<td>42,500</td>
<td>42,500</td>
</tr>
<tr>
<td>CLOSING BALANCE</td>
<td>42,500</td>
<td>42,500</td>
<td>42,500</td>
</tr>
<tr>
<td>Memorial Oration Fund</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opening Balance</td>
<td>16,004</td>
<td>16,004</td>
<td>16,004</td>
</tr>
<tr>
<td>CLOSING BALANCE</td>
<td>16,004</td>
<td>16,004</td>
<td>16,004</td>
</tr>
<tr>
<td>Guest Speaker Fund</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opening Balance</td>
<td>23,000</td>
<td>23,000</td>
<td>23,000</td>
</tr>
<tr>
<td>CLOSING BALANCE</td>
<td>23,000</td>
<td>23,000</td>
<td>23,000</td>
</tr>
<tr>
<td>Building Replacement Fund</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opening Balance</td>
<td>578,949</td>
<td>578,949</td>
<td>578,949</td>
</tr>
<tr>
<td>CLOSING BALANCE</td>
<td>578,949</td>
<td>578,949</td>
<td>578,949</td>
</tr>
<tr>
<td>Investment Revaluation Reserve</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opening Balance</td>
<td>-</td>
<td>-</td>
<td>(12,079)</td>
</tr>
<tr>
<td>Movement for the Year</td>
<td>-</td>
<td>-</td>
<td>12,067</td>
</tr>
<tr>
<td>CLOSING BALANCE</td>
<td>-</td>
<td>-</td>
<td>(12)</td>
</tr>
<tr>
<td><strong>TOTAL RESERVES AND TRUSTS</strong></td>
<td>687,878</td>
<td>687,878</td>
<td>687,866</td>
</tr>
</tbody>
</table>
AUDITOR’S REPORT

Independent Auditor’s Report

Grant Thornton

To the Members of New Zealand Medical Association Incorporated and Group

Report on the Financial Statements
We have audited the financial statements of New Zealand Medical Association Incorporated (the “Parent”) and Group comprising its subsidiaries on pages 1 to 8, which comprise the statement of financial position as at 30 September 2011, and the statement of financial performance, statement of changes in equity for the year then ended, and a summary of significant accounting policies and other explanatory information.

Board Members’ Responsibilities
The Committee members are responsible for the preparation of financial statements in accordance with generally accepted accounting practice in New Zealand and for such internal control as the committee members determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor’s Responsibilities
Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with International Standards on Auditing (New Zealand). Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor’s judgement, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity’s preparation of financial statements that present fairly the matters to which they relate 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 entity’s internal control.
An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates, as well as evaluating the presentation of the financial statements.

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

Other than in our capacity as auditor we have no relationship with, or interests in the New Zealand Medical Association Incorporated or its subsidiaries.

Opinion
In our opinion, the financial statements on pages 1 to 8 present fairly, in all material respects, the financial position of New Zealand Medical Association Incorporated and Group as at 30 September 2011, and its financial performance, for the year then ended in accordance with generally accepted accounting practice in New Zealand.

Emphasis of Matter
We draw your attention to Note 4 to the financial statements describing the earthquake prone condition of the building. The condition is such that the building is likely to require significant modification or redevelopment. No financial impairment has been made to the carrying value of land and building as the current fair value of the site exceeds the carrying value reported in the Statement of Financial Position. Our opinion is not qualified in respect of this matter.

Other Matter
The financial statements of the Association for the year ended 30 September 2010 were audited by another auditor who expressed a modified opinion on those financial statements on 27 April 2011.

Grant Thornton
Wellington, New Zealand
12 March 2012