



Australian College of
Rural and Remote Medicine

Annual Report 2004 - 2005

Recognising Rural and Remote Medicine

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ISBN 0-9750537-4-4

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ACRRM's Annual Report is intended to provide a brief introductory overview of ACRRM for the financial year 2004 - 2005.

Australian College of
Rural and Remote Medicine

A.C.N 078 081 848

ANNUAL REPORT
2004 - 2005

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I President's Report

This year for ACRRM has been an intense and exciting one. Our College continues to mature and develop with increasing membership, member services and influence. ACRRM is also close to a recommendation from the AMC about our application for specialist recognition – a decision that will have far-reaching consequences for Rural and Remote Medicine (RRM), rural communities and for the AMC itself. It is with some regret that I finish my term with this line in site.

This year's AGM is my handover to Dr David Campbell, an extremely capable Rural Medical Practitioner from Lakes Entrance in Victoria. ACRRM can look forward to a solid future with David's leadership and our talented staff and board.

Over the past two years of my presidency, the board has been very supportive of our agenda - securing the future of RRM. Despite all the past initiatives aimed at assisting rural and remote communities, RRM has two remaining barriers – recognition and workforce. Over the last few years we have striven to address this by promoting RRM as a career our next generation may aspire to. To replace our 'dad's army' of self-taught, self-made rural doctors, we need to train the next generation as the 'SAS' of medicine – an elite group with the skills to work and achieve at the edge. I make no apologies for this. I am so pleased to hear student representatives saying that Rural and Remote Medicine has changed from the last thing a student would do to the most popular.

In pursuing our agenda, we have had to be positive and persistent, firm and frank, energetic and effective. We need to model how RRM can stand alone as the next generation emerges if we are to have an adequate workforce. There are many signs that workforce initiatives we have instituted with government are coming to fruition - 25% rural intakes into medical school, oversubscribed rural clinical schools, the General Practice Education and Training (GPET) rural pathway numbers increasing by 60%, keen Medical Rural Bonded Scholar doctors and existing doctors enthusiastically embracing procedural medicine incentives.

On the political front, the last year in particular has been dominated by the AMC application for specialist recognition. The concept of another college in the generalist area has been a threat to some. I was extremely disappointed, but not surprised, that some organisations with large urban constituencies or a large investment in the status quo were unable to support our bid for speciality status. Equally, I was overwhelmed by the heartfelt support of the rural sector for our bid. We hope that we can repay their support by the benefits of our program. ACRRM will be able, if successful, to tailor our program to meet the needs of rural communities, unencumbered by urban caveats.

The introduction of the Enhanced Rural Training Framework with GPET, within the current system, has begun this process but there is much work still to be done.

Our next step is the refinement of assessment. We have a strong basis for this with our primary curriculum. It will be vital that we complete this process in the near future so that rural doctors, communities and the registrars themselves can be confident that they are trained, tested and certified in the skills needed to effectively look after a rural community. There will be a strong need for Fellows of ACRRM to be involved in this process.

Our staff continues to promote the College and its activities. At the heart of this are the member services that so effectively link together our members. I have had frequent comments about the responsive and personal service provided by the office. The IT services, especially RRME0, provide a fabulous platform to complement this. The ACRRM CD – (Training towards FACRRM), released this year, has brought together so many of the things we do into one very valuable resource.

The continuing success of Tele-Derm has recently been complemented by Radiology Online - which attracted one hundred participants in its first few weeks on-line. For the working Rural or Remote Medical Practitioner, the PDA Emergency Medicine guidelines are a godsend. Rural doctors see clinical presentations infrequently, and to have this resource available at the bedside can only help to provide quality care for patients.



“Rural and Remote Medicine has two remaining barriers – recognition and workforce. Over the last few years we have striven to address this by promoting RRM as a career our next generation may aspire to.”



ACRRM Board Members

A major watershed occurred before my term as President - the recognition of ACRRM's Professional Development Program (PDP). We have bedded this down over the last two years in discussions at our Joint Committee with the Royal Australian College of General Practitioners (RACGP). Thanks to the Australian Government's Department of Health and Ageing for their support in this process. Our PDP infrastructure has been decentralised with regional staff offering valuable support to members over a wide geographical area.

A raft of financial initiatives has flowed over the last two years through Medicare. We are proud that the well organised advocacy on behalf of procedural medicine by the Rural Doctors Association of Australia (RDAA) and ACRRM has resulted in the budget initiatives of up to \$15,000 per annum to enable rural and remote proceduralists to access procedural training and upskilling. ACRRM leads a collaborative implementing this procedural grants program, and has received numerous compliments about the no-fuss nature of our process. We have recently, after discussion with RDAA and RACGP, applied for an extension of this program to those doctors undertaking emergency care.

Another groundbreaking ACRRM initiative has been the Rural and Remote Area Placement Program (RRAPP), which has now been expanded to form the broader Prevocational General Practice Placement Program (PGPPP). It is yet another excellent chance to expose young doctors to rural practice in their early postgraduate years.

ACRRM has also been successful in obtaining contracts for the support of Medical Rural Bonded Scholars and John Flynn Scholars. We spent much time engaging medical students through collaboration with the Australian Medical Students Association (AMSA), Australian Medical Association Council of Doctors in Training (AMACDT) and rural orientated registrars through Doctors in Rural and Remote Training Australia (DIRRTA). This next generation is our future and has shown a marked turnaround in attitude. We also have better communication with General Practice Registrars Australia (GPRA) who, despite their commitment to existing GP training, has increasingly engaged with us

on training for Rural and Remote Medicine. We have also reached agreement with Queensland Health to train rural generalists in Queensland Hospitals towards Fellowship of ACRRM.

The future for rural and remote medical practice lies in the adequate and rigorous recognition of rural and remote clinical skills. Part of this is the clinical privileges project which aims to implement the Australian Council for Safety and Quality Health Care (ACSQHC) guidelines in rural practice Australia-wide.

We continue to work with specialist colleges on joint training curricula, recognition of prior learning and dual qualifications so that rural doctors may pursue careers in many areas.

Government activity in the form of Medicare reform, election policy and reviews of the Rural, Remote, Metropolitan Areas classification, workforce agencies and the Productivity Commission review and many more mean a continually changing environment for us to work in. We continue to work with rural medical organisations, especially the RDAA and the workforce agencies on these matters.

In travelling around Australia during my time as President, I have been struck by the dedication and expertise of our Fellows who provide such quality services to rural and remote communities.

Rural and Remote Medicine is coming of age, and with recognition and increased interest from the next generation of rural doctors, I am optimistic that the hurdle of workforce shortage can be overcome and sustainable services delivered.

Thank you for your support.

Bruce Chater
President

I CEO's Report

Maintaining the Momentum

Preceded by our reputation as the 'can do' college, ACRRM has maintained trademark momentum over 2004 – 2005. Continued increase in membership, the high rate of re-subscription and our ongoing expansion confirm the need for ACRRM and the relevance of our products and services to the rural and remote medical workforce.

In forging new education and training pathways specifically for rural and remote doctors, ACRRM has focused on developing high quality services and delivering these in a practical way, free from red tape. It has been gratifying to see pathways to enable training towards Fellowship of ACRRM (FACRRM) gain traction so quickly over 2004 - 2005:

- within six months of General Practice Education and Training (GPET) formally recognising training towards FACRRM, all rural Regional Training Providers had registered to deliver our training pathway; and
- in the same timeframe more than 50 Registrars were training towards FACRRM and this number continues to increase each day.

While we are still constrained by the requirement to integrate our training pathway within the limits of general practice requirements, the numbers of Registrars pursuing FACRRM is living proof of the real need for formal acknowledgement of the separate end point for Rural and Remote Medicine. Only when this is in place will Registrars be offered a truly competitive environment for training and a real choice in pursuing a rural medical career that doesn't have to detour through General Practice training procedures to get there.

This year also marked the end of the first triennium for ACRRM's Professional Development Program (PDP) in which we achieved 99.7% compliance for our nearly 1000 Vocational Registered (VR) PDP participants. This is a particularly impressive result and much credit for this result must go to our outstanding national and regional PDP staff members who spent many hours assisting members with their educational plans and points.

As demand for ACRRM services continues to grow, so too do our programs and services. This year we expanded significantly to provide a regional support network. ACRRM now has Regional Support Officers available in each state and territory providing local, face to face support and assistance to our members and service providers.

ACRRM's curriculum and delivery mechanisms for the management of our Vocational Training and Professional Development provide a sound basis for extension to other aspects of rural and remote medical education and training. We have also started the work required to train rural generalists in Queensland hospitals towards FACRRM.

At the more formative end of the education continuum ACRRM administers a suite of student and junior doctor programs to support rural recruitment. It has been satisfying to have it externally confirmed that ACRRM runs this part of our business well. In the past year:

- External evaluations of both the John Flynn Scholarship Program and the Medical Rural Bonded Scholarship Scheme Support Pilot Project confirmed the positive impact these programs are having on rural recruitment and acknowledged ACRRM's contribution to their success;
- ACRRM has also secured the management of the junior doctor placement program Prevocational General Practice Placement Program in rural and remote regions for a further two years to June 2007.

The use of our online learning platform, Rural and Remote Medical Education Online - RRMEO, continues to grow. Subscriptions to the system have increased as has content, with an ever expanding inventory of online resources available. The collaborative working relationship



“Continued increase in membership, the high rate of re-subscription and our consequent expansion confirm the need for ACRRM and the relevance of our products and services...”

“In forging new education and training pathways specifically for rural and remote doctors, ACRRM has focussed on developing high quality services and delivering these in a practical way...”

continues with Regional Training Providers as well as other specialist colleges in the use of this system in recording and organising trainee and online learning activities. Work to improve aspects of the system has also progressed over the past year and once complete RRME0 will be even faster and cheaper for users.

ACRRM's growth relies on the sustained energy and loyalty of a group of people who continue to drive the agenda of rural and remote health forward, often in uncharted territories. The close collaborative working relationship between staff, board and members generates ACRRM's distinctive work culture and it is a privilege to be part of such a committed and forward thinking team.



Marita Cowie
CEO

I Professional Development Program Report

Introduction

The last twelve months have seen organisational, operational and policy changes in the Professional Development Program (PDP). This has facilitated an improved and more effective service to ACRRM members.

Changes in operations within the PDP Department include implementation of a new Quality Assurance program that will ensure a superior standard in accreditation and processing of educational activities. Improvements in processing of attendance lists and PDP certificates will give higher levels of time efficiency and accuracy in allocation of PDP points into member's statements.

Membership

The calibre of members ACRRM attracts was reflected last Triennium (2002-2004) with a compliance rate by our doctors of 99.8% for Vocational Recognition. Participants of the Professional Development Program have increased from 1496 as at December 2004 to 1609 in June 2005.

RRMEO

RRMEO is currently undergoing a rebuild that will make it increasingly user friendly for staff and members. The PDP staff are liaising with IT staff to ensure that the rebuild responds to the requirements of the program.

Committee

Dr Steve Holmes continues to Chair the PDP Committee, which has ten active members. Consideration regarding the operational structure of the PDP Committee has been undertaken to ensure committee activities are targeted towards improving PDP activities.

Staff

The last year has seen the introduction of 12 Regional Support Officers (RSOs) across the states and Northern Territory. The aim of the PDP Regional Support role is to assist in implementing the ever growing Professional Development Program (PDP) throughout Australia.

There is currently a team of five full-time PDP staff at Central Office.

Future Direction

To support the ongoing development of PDP within the college the PDP Committee is reviewing the program and developing a strategic direction that will continue the growth seen this year.





Vocational Training Report

2004 - 2005 has been an important and defining year for ACRRM - not only for our work with the AMC in presenting our case for the recognition of Rural and Remote Medicine as a new discipline, but also for the recognition of our vocational training program by the Commonwealth agency (GPET).

The Commonwealth agency responsible for managing the training of General Practitioners (GPs) (GPET) now provides the opportunity for a nationally distributed network of Regional Training Providers (RTPs) to provide a pathway to competency in rural medicine (Fellowship of ACRRM [FACRRM]) for potential rural doctors.

In October 2004 the GPET board endorsed the motion that:

“medical practice in specific rural contexts requires knowledge and skills in addition to the FRACGP and that such knowledge and skills are embodied in such programs as the Graduate Diploma Rural General Practice and the Fellowship of the Australian College of Rural and Remote Medicine”.

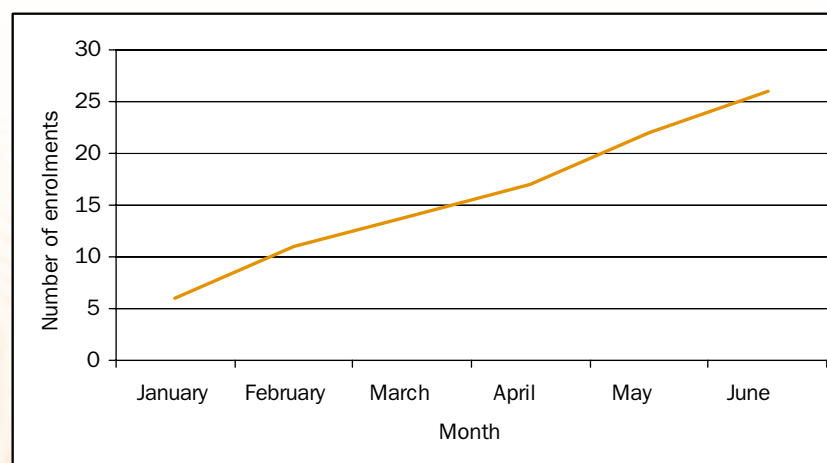
This board recognition provided the catalyst for introducing the FACRRM pathway via the GPET network.

In 2004 - 2005, processes and accreditation procedures were developed to ensure quality of training against ACRRM standards within the RTP network. GPET formally recognised these ACRRM standards and processes for the accreditation of Practices and Posts and incorporated the ACRRM Standards for Recognition of RTPs as an option for rural RTPs within the GPET accreditation process. The Enhanced Rural Training (ERT) Framework was also introduced by GPET to provide RTPs with advice and additional resources to fully support Registrars seeking the FACRRM and/or the Graduate Diploma in Rural Medicine.

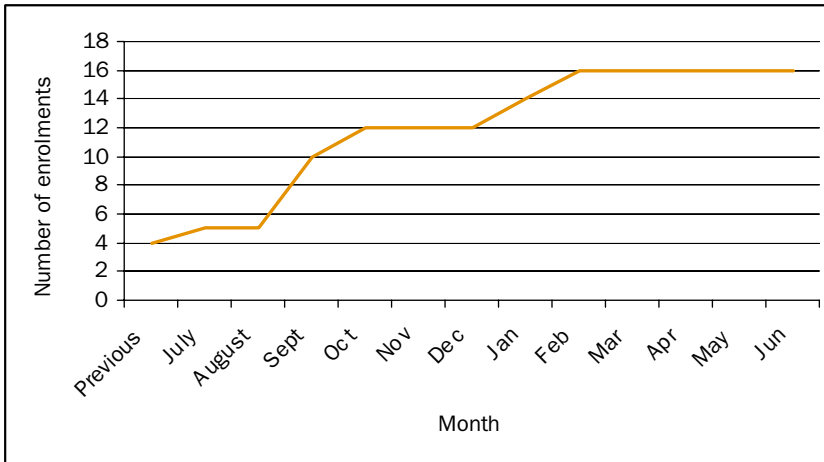
ACRRM has established models/pathways providing ACRRM candidates with three options for meeting FACRRM requirements. These models are documented in the ACRRM Vocational Training Handbook (www.acrrm.org.au) and are designed to ensure that the skill set defined in the ACRRM curriculum can be achieved.

The number of registrars formally enrolled in ACRRM pathways increased significantly in 2005 with ongoing and continued increases anticipated. As at June 2005, 11 registrars were training towards FACRRM via the Remote Vocational Training Scheme (RVTS)

Growth in enrolments in Vocational Preparation Pathway (Parallel Pathway GPET) (Jan-June 2005)



Growth in enrolments in Independent Pathway (July 2004 to June 2005)



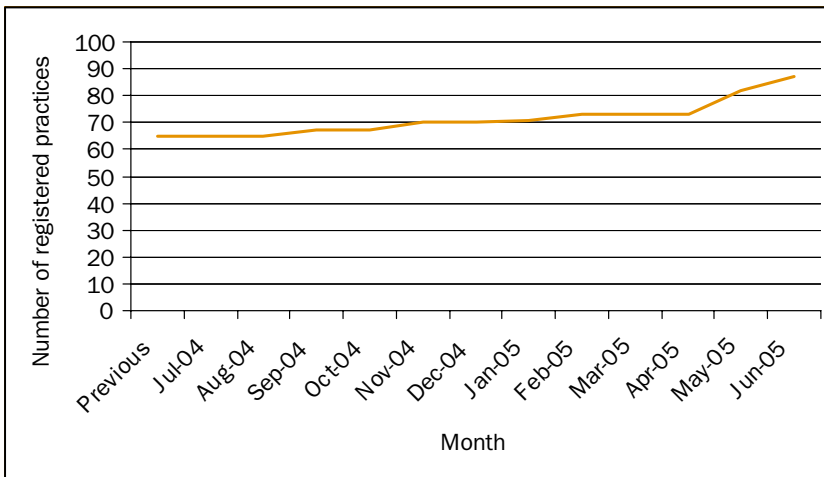
ACRRM Accreditation of Teaching Posts and Practices

ACRRM developed policies and processes for ensuring the quality of training for FACRRM candidates. A key component of the ACRRM models for education relates to the quality of the clinical setting and supervision. ACRRM has developed accreditation standards which make explicit the characteristics of the training environment (including supervision) and the scope of practice which define an ACRRM training post.

In the period 2004-2005, 87 teaching practices have been involved in the various stages of ACRRM accreditation. As of 30 June 2005:

- 36 posts have been fully accredited
- 37 are provisionally accredited - awaiting accreditation visit
- 14 have registered / pending further information regarding scope of practice.

Growth in training post applications (July 2004 to June 2005)



These numbers are increasing exponentially as the Regional Training Providers become recognised by ACRRM to deliver the FACRRM.

ACRRM Recognition of Regional Training Providers (RTPs)

ACRRM has also developed standards, with specific criteria and indicators, which define the required characteristics of an RTP seeking accreditation to deliver the FACRRM in their region. RTPs seeking ACRRM recognition are required to register with ACRRM, complete a self assessment against ACRRM standards, and participate in the accreditation process managed by GPET and demonstrate compliance with ACRRM Standards.

This opportunity has only been available to RTPs since 2005, however, as of June 2005, all 18 rural or regional RTPs (of the 22 RTPs nationally) have formally registered with ACRRM to be assessed to deliver the FACRRM.



I Pre-vocational General Practice Placements Program

The Pre-vocational General Practice Placements Program (PGPPP) is part of the Australian Government's Strengthening Medicare initiative. The PGPPP is similar to the Rural and Remote Area Placement Program (RRAPP) which was designed and managed by ACRRM from 2000-2004. The extended version of the program managed by ACRRM provides well-supervised placements for junior doctors in remote, rural and small regional locations.

The aim is to fill an important gap in the vertical integration of rural training, between the rural student initiatives and regional vocational pathways. Junior doctors have had few opportunities to experience rural community practice in their intern and resident years, and the PGPPP effectively fills this gap.

In the PGPPP, junior doctors join accredited training practices as working colleagues in well supervised and supported placements, where training and experience can be blended. The PGPPP rates as a positive and inspirational experience in the view of most participants and can be highly effective in allowing young doctors to make an informed decision about careers in primary care, remote medicine, aboriginal health and community practice.

ACRRM is responsible for the recruitment and management of rural and remote placements through a number of training collaborations, which consist of a fund holder, a training practice and a feeder hospital.

ACRRM has fulfilled the duties outlined in the Agreement with the Commonwealth of July 2004 in regard to the three principal areas required, these being:

- the provision and management of general practice placements in rural, remote and regional areas through the training collaborations;
- the establishment of contracts with fund holders on behalf of training collaborations, which will be responsible for the administrative / funding arrangements of Training Collaborations in relation to their role in the Program; and
- the provision of a secretariat function for the National Advisory Committee (NAC) to the Pre-Vocational General Practice Placements Program and arrangement of NAC meetings as required.

ACRRM has been highly effective in the management of the PGPPP, being awarded up to 65% of the available placements in the program exclusively for experience in rural medicine. The program capacity has been increased to offer 320 rural and remote placements to June 2007.

The PGPPP currently operates in all states and territories, including sites at: Smithton, Scottsdale, George Town and New Norfolk in Tasmania; Warrnambool, Stawell, Bendigo, Wonthaggi, Lakes Entrance and Wodonga in Victoria; Bingara and Murwillumbah in New South Wales; Bamaga/Thursday Island in Queensland; Clare, Kadina, Whyalla, Jamestown, Kapunda, Murray Bridge, Victor Harbor and Crystal Brook in South Australia; Albany, Busselton, Kalgoorlie and Broome in Western Australia and various communities across the Northern Territory.

In terms of the quality of clinical training, professional experience, teaching excellence and personal and family support, the ACRRM PGPPP rates in the 90% levels of effectiveness and over 60% of participants have moved into community practice through the Regional Training Providers. More than 90% of participants indicate that they would like further involvement in rural training and/or careers and more than 75% of participants state that the PGPPP has positively influenced their choice of further training.

The ACRRM PGPPP management team would like to take the opportunity to thank the doctors, practices, hospitals and rural organisations that play such an important role in this national program.

John Flynn Scholarship Scheme

The John Flynn Scholarship Scheme (JFSS) provides financial support to enable medical students form a long-term relationship with a rural or remote community and gain a better understanding of rural and remote medical practice and non-metropolitan health care services. Funded by the Department of Health and Ageing and administered by ACRRM, the JFSS is part of a long-term strategy to increase the number of doctors in rural and remote communities.



2004 - 2005 saw the successful intake of 158 new scholars to the scheme and the smooth, ongoing organisation of 514 scholar placements. Towards the end of 2004, the Department of Health and Ageing commissioned an external evaluation of the JFSS:

- to report on the effectiveness of the Scheme in encouraging students to consider a medical career in rural and remote Australia; and
- to determine how participation in the Scheme is influencing the career choices of JFSS scholars.

The evaluation report confirmed the positive impact of the JFSS and recommended that the scheme continue to be offered to medical students studying in Australia. ACRRM successfully submitted three proposals to carry forward some of the report's key recommendations, comprising:

1. Designing, piloting and implementing a tracking system for JFSS scholars;
2. Building Host Communities; and
3. Making the most of the JFSS experience via a revised planning and evaluation system.

ACRRM would like to take this opportunity to thank all stakeholders involved in organising and contributing to the JFSS over the past year including scholars, mentors, community contacts, panel members, the National Advisory Committee and university contacts among many others. Throughout 2004 – 2005, the JFSS continued to be an extremely rewarding learning experience for all involved - in the words of one JFSS scholar on return from their placement:

Since returning to university, I feel incredibly privileged to have had the opportunity I was given. I have learned an enormous amount, and somehow theoretical studies now seem more relevant and useful than ever before. After seeing the needs and responsibilities of the medical profession in a small country town, I have been inspired to make the most of my learning opportunities in order to use these skills down the track.



Medical Rural Bonded Support

ACRRM started the Medical Rural Bonded Support Pilot Project 'MRB Support' in July 2003. Funded by the Department of Health and Ageing, the program provides support, communication and networking mechanisms to Medical Rural Bonded Scholarship Scheme (MRBSS) scholars, enabling them to access a range of support activities, including attendance at conferences and events.

During 2004 - 2005, participation in the program grew from 271 to 332 scholars, representing approximately 66% of the total MRBSS scholar community. The RRMEO virtual community, established in July 2004 to facilitate information sharing between scholars, has proved to be extremely popular with 247 scholars actively participating in this forum by June 2005. Further development of both the website (<http://www.mrbssupport.com.au>) and the mentoring network has been ongoing.

Demand for the conference program has also continued to increase with ACRRM organising a total of 201 scholar places during the 2004 – 2005 period:

- ACRRM Scientific Forum, Alice Springs NT, July 2004 (27 places);
- 8th National Undergraduate Rural Health Conference, Tanunda SA, September 2004 (45 places);
- RDAA / ACRRM Annual General Meeting, Launceston Tas, November 2004 (21 places);
- 8th National Rural Health Conference, Alice Springs NT, March 2005 (63 places); and
- ACRRM Orientation to Rural and Remote Medicine Brisbane Qld, April 2004 (45 places).

An external evaluation of MRB Support commissioned by the Department of Health and Ageing in October 2004, concluded that the pilot project is having a positive effect in supporting MRBSS scholars by:

- assisting them to access existing rural and remote health education, communication, networking and conference opportunities; and
- increasing their commitment to an extended career in rural and remote medicine, in many cases beyond the period required by their bond.

Gratifyingly, the pilot was extended for a further 12 months to June 2006, while the longer-term future of the program is decided.

ACRRM successfully submitted two proposals to the Department to carry forward key recommendations arising from the evaluation:

- To develop a framework of mentorship for implementation within MRB Support; and
- To plan and identify appropriate support arrangements for MRBSS graduate doctors.

Both projects are due for completion in January 2006.

ACRRM would like to take this opportunity to thank all stakeholders who have contributed to the success of the MRB Support Pilot Project, including scholars, mentors and the MRB Management Committee.

Training for Rural & Remote Procedural GPs Program

The Training for Rural and Remote Procedural GPs Program (TRRPGP) is one of the initiatives included in the Australian Government's Strengthening Medicare package. The program provides training support in the form of a grant of \$15,000 per doctor per financial year, based on 10 days training at \$1,500 per day. The program is jointly administered by ACRRM and the Royal Australian College of General Practitioners (RACGP), with the Health Insurance Commission (now Medicare Australia) making payments to the doctors.

Officially launched in July 2004, TRRPGP supports rural and remote proceduralists in RRMA 3-7 for skills maintenance and upskilling in obstetrics, anaesthetics and surgery. This training can be in the form of a course/workshop/conference or supervised clinical attachment. To be eligible to register for the program doctors are required to hold current clinical privileges in anaesthetics, obstetrics or surgery.

Doctors that have qualifications in these disciplines that have recently stopped practicing and wish to re-enter medicine, but require just a few days or weeks of refresher training, can claim the grant retrospectively once they have re-gained their clinical privileges.

A condition of ACRRM's contractual agreement with the Department of Health and Ageing was the establishment of a joint ACRRM / RACGP collaboration. This consists of seven proceduralists; three from each College, with ACRRM's Dr Bruce Chater as the Chair. The Terms of Reference, developed by ACRRM, were approved by the RACGP and the Department of Health and Ageing.

This group monitors the accreditation of educational activities and clinical attachments as well as addressing any eligibility issues or appeals. There are rigorous auditing and reporting requirements set down for the program with a list of designated objectives and outcomes to be measured. The ACRRM Research and Evaluation team developed a monitoring tool for this purpose and results from the first survey, conducted in May 2005, indicated that doctors participating in the program:

- increased levels of skills and knowledge;
- increased levels of confidence in undertaking procedures;
- increased opportunities for the acquisition of new procedural skills; and
- demonstrated a clear connection between these opportunities and their perceived degree of encouragement to continue in procedural rural practice.

The fact that rural and remote proceduralists now have an incentive to regularly participate in quality educational events has, in turn, encouraged the education providers to offer quality training and courses on a more frequent basis. To enable quicker access to activities that are accredited for this program, ACRRM's Rural and Remote Medical Education Online (RRMEO) website has been modified to include new search tools. It has, however, become obvious that some doctors are finding it difficult to attend courses due to the time and distances involved with travel. Online or distance education activities would be beneficial for these doctors and ACRRM is currently looking at possible delivery models that may fulfil this need.

A joint ACRRM, RACGP and RDAA proposal has recently been submitted to the government, recommending the inclusion of a new support stream for Emergency Medicine within the current program.

With the success of the program after the first year of operation, the Australian Government must be applauded for its innovative approach to ensuring the development of rural procedural medicine in Australia.





I Rural & Remote Medical Education Online

Re-build of RRMEO

One of the major projects during 2004 - 2005 was the substantial re-build of ACRRM's Rural and Remote Medical Education Online (RRMEO) web site. The new generation RRMEO will move towards a Distributed Learning System (DLS) that will, over time, allow for greater flexibility regarding where RRMEO servers can be placed. It will allow institutions to have their own RRMEO server for faster local connectivity, and their own local branding of the system as required.

The re-build has provided ACRRM with an opportunity to respond to the feedback provided by members and users to have a more intuitive and user friendly system. In addition, features such as the choice to have discussion forums emailed to users, and greater flexibility around Learning Planners for different education programs are elements a redeveloped RRMEO hopes to provide.

As part of the re-build, ACRRM will be able to develop key aspects of RRMEO based on the lessons we have learned so far. Some of the advantages of the new system will include:

- Improved design and ease of use, which will enable the system to be more intuitive and improve user friendliness;
- The 'back end' of the new system will be more flexible and enable ACRRM to provide further RRMEO features (such as different Learning Planners for different programs); and
- An increased variety of subscription and costing options, which depend on the number of users per system, to meet the needs of smaller and lower resourced organisations

Tele-Derm

ACRRM's popular addition to RRMEO, Tele-Derm, achieved national coverage during the year, with The Minister for Health and Ageing, the Hon. Tony Abbott MP, officially launching the new feature in March 2005.

Since going national, Tele-Derm enrolments quickly exceeded 500, and recorded more than 10,000 hits during the first six months of 2005. Previously, only medical practitioners from Queensland could access the site; but since this development, Tele-Derm users across Australia can submit their dermatology cases for review.

I Research and Evaluation



Throughout 2004 – 2005, ACRRM's Research and Evaluation team continued to provide a range of services to the organisation. Within ACRRM's program activity a series of internal evaluations, based on rigorous research approaches, was undertaken to provide each program with advice on refinements to program activity, input to data reports and objective outcomes testing for reporting to funding bodies. In addition, the team provided technical advice and writing services for funding submissions, grants and project designs requiring a research base.

The team also designed and developed the academic program for ACRRM in terms of its Scientific Forum in 2004: Recognising Rural Medicine and its second symposium in partnership with the RDAA: Obstetric Services in Small Rural Hospitals.

In 2004, ACRRM, in partnership with the Rural Workforce Agencies of Victoria and Queensland, conducted research into the mentoring needs of young women doctors and the means to attract, recruit and support mentors. A working version of mentor guidelines was developed.

Also in 2004, ACRRM research on the priorities of women doctors and their support needs was published and used as a basis for planning the further support work for ACRRM's female membership and for the activity of the Women in Rural Practice (WIRP) Group.

One of the priorities identified by these means was the need to understand the Continuing Professional Development (CPD) preferences and learning styles of female doctors and the factors and issues associated with their capacity to access CPD.

In supporting the role of women in education, further work was undertaken on the role of mentors in rural and remote practice, and the establishment of discussion groups, networks and access to locum support.

The results of these two areas of research provide both a current needs assessment on the requirements of women doctors in terms of their professional development, and a current audit of the capacity of education providers to deliver the necessary programs. The research also provides the basis for argument, on behalf of education providers, for further resources to support the special needs of women doctors' CPD.

In addition, guidelines for both CPD provision and mentoring for women doctors have been developed to assist education providers in the development of programs and to encourage doctors to undertake support roles for their rural colleagues. Additional resources developed through the research include online support services, discussion groups and locum registers to encourage rural and remote women doctors to access and advocate for appropriate CPD for their practice profiles.

These research findings provide the basis for the development of guidelines for regional education providers. They focus on relevant, affordable and achievable solutions to the strategic issue of supporting Australia's increasing proportion of female doctors. Many of the issues identified as relevant by women doctors are becoming of equal concern to their male counterparts; the principles within these guidelines are relevant to the design and delivery of CPD.

Prospective work includes submissions to examine women's health needs in rural and remote communities and to develop, with the RDAA and other partners, action on reaching a consensus position on the delivery and support for rural maternity services.



I ACRRM Ultrasound Program

During 2004 - 2005, ACRRM held ultrasound workshops in: Brisbane, Townsville and Cairns (Qld); Newcastle (NSW); Broome & Geraldton (WA). Eighty-nine doctors attended these workshops that covered obstetric ultrasound and emergency medicine ultrasound.

Since the ACRRM ultrasound program commenced in 2002, the College has run eleven basic obstetric ultrasound workshops and seven intermediate obstetric ultrasound/emergency medicine ultrasound workshops. The College will be running five more intermediate obstetric ultrasound/emergency medicine ultrasound workshops during 2005-2006.

These workshops were developed after educational needs assessments research showed that ultrasound was an area in which rural and remote doctors wanted education. The ultrasound programs have been very popular and successful and have contributed to some of the unmet educational needs in this area.

Rural doctors that have attended any of the workshops have been able to put their new skills into practice immediately. A few examples include:

- a rural doctor in Victoria who was able to diagnose an ectopic pregnancy on ultrasound at 2am in his small rural hospital;
- doctors in remote Western Australia who were able to diagnose internal bleeding from a ruptured spleen on ultrasound using the FAST test within days of attending a workshop.

As articulated by one workshop participant:

'I have used my improved skills on many occasions since the workshop, and found it to be one of the most useful education events I have attended'

The College also developed ultrasound education resources including manuals, CD ROMs, Videos and DVDs. ACRRM now sells these resources in every Australian state, and internationally including Canada, Saudi Arabia, South Africa, Yemen, Denmark, New Zealand, Turkey, and North America. We have also had enquiries from Hong Kong to buy multiple licence products for libraries in Hong Kong, Singapore, Korea, and Taiwan.

I Censor's Report



Overview

Over the past 12 months there has been continued development of the Censorial processes of ACRRM. This has involved the progression of the various committees and working groups of the panel and a reorganisation of the committee structure to realign the committees more with the active functions of the College. This has been in response to the need to develop appropriate standards, as well as a culture, that assists ACRRM's Australian Medical Council application and emergent national issues of quality, safety and standards of practice.

While much of the work has now been completed, there are a number of areas that will continue to develop in the short and medium-term. These include refinement of an appropriate assessment process and development of a Quality and Safety in Practice framework to overlay the entire censorial program.

The job has been a busy one with the Censor taking on board a number of new roles, including that of advisor to ACRRM staff and Board. This role will now be taken over by the various State and National Medical Advisors and RTP Rural Educators as they are appointed.

Representative Roles

There have been many representative roles, particularly to GPET, NGOs and Government in 2004-2005. These activities have helped the College to develop an excellent working relationship with these organisations, and have increased the profile of ACRRM as a legitimate voice of rural and remote medical training. Further details are provided below regarding committees and reference groups involving the ACRRM Censor.

GPET Committees

- Academic and Research Registrar Working Group: Determines the allocation of Academic Registrar positions in universities and the allocation of research project funds to registrars. This has been a very positive experience for this Censor as well as for the other members of the committee. Appropriate processes are now in place and the standards of applications have reached such a high standard that competition is quite fierce for the dollars allocated. The quality of applications has been reflected in the fact that two from the current group were successful in obtaining National Health and Medical Research Council (NHMRC) research grants.
- Policy Working Group: A revision of the policies that govern the General Practice Education and Training (GPET) Training program will be completed in the latter part of 2005. Program simplification and a new degree of flexibility for Regional Training Providers (RTPs) will hopefully allow for a more innovative education program to meet the needs of Registrars. There have also been substantial gains in the area of rural and remote training, with additional innovation grants now available to this area.
- Selection Review Committee: A review of the selection guidelines and processes is now completed with the final meeting held in October 2005.
- GP Standards Liaison Group: This committee is a joint GPET, RACGP and ACRRM Committee and has met three times in the past 12 months.

Other Committees

- Evaluation of GPET: (DoHA). The final report from Acil Tasman on the review of GPET has been received and comments passed on to the Commonwealth.
- National Prescribing Service: Quality Use of Medicine Curriculum Working Group.

- Medical Specialist Outreach Assistance Program (MSOAP) Reference Groups, DoHA, Queensland.
- Queensland Medical Education Committee, Queensland Health. This group includes all the University Medical Schools in Queensland and a number of medico-political groups and Professional Colleges. Its purpose is to advise on the management of the increasing numbers of interns resulting in the growth of medical student places in Queensland (from 240 in 2000 to over 500 by 2012).
- Royal Australasian College of Physicians (RACP) / ACRRM, Fellowship of Australian Public Health Medicine (FAPHM) Joint Training Pathway Working Group.

Censorial Programs

Considerable progress has also been made within the censorial portfolio, both from the point of view of working with individuals in the attainment of FACRRM and work done by our censorial sub-committees. A brief synopsis follows.

ACRRM Fellowship Program: All potential fellowship applications have been viewed and assessed against the Fellowship of ACRRM (FACRRM) Criteria. This has progressed to the extent that the majority of applications now have a turnaround of little more than 30 days. A number of successful candidates have been approved while advice has been provided to the unsuccessful candidates. Trainees in the Independent Pathways have received advice on how to progress and implement their learning plans.

Censorial Sub-Committees

Vocational Training

Censor Vocational Training: Tom Doolan

The staff of ACRRM have been working towards a training program for rural and remote medical practice with GPET and RTPs. In addition, it has maintained the Independent Training pathway for FACRRM. The Censor's role in this has been advisory to staff and candidates and will become a part of the medical advisor roles in the near future.

Professional Development Committee

Censor PDP: Steve Holmes

This committee reports through the CEO as it is a separately funded program by the Commonwealth.

Safety and Quality in Practice Committee

Censor SQiP: Fred McConnell

The SQiP committee has developed a number of papers that describe and outline a framework that is being developed to meet the requirements of ACRRM to provide a safe working standard for its members and communities. It has been a complex and difficult area but the committee, under the chairmanship of Fred McConnell, has accepted the ongoing challenge. In doing so, the Chairman of this committee has sat across most of the Censorial Committees to ensure the linkage with safety and quality is not lost.

Assessment Working Group

This new committee has been taken on by Bruce Cameron, who is currently working with staff and other board members to develop a process for the assessment of Fellows. The principles of flexibility, validity and reproducibility are being applied and a process of assessment of rural procedural skills has provided a challenge for our college. In order to address this, an audit tool is currently under development. This will act as an expansion of the practice analysis tool to provide a viable audit process, including a 360 degree audit tool for procedural practice.

Documents prepared for ACRRM Board:

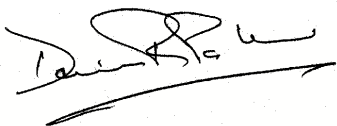
1. Fellowship Criteria, Training for FACRRM
2. Draft Guidelines for Overseas Trained Rural and Remote Medical Practitioners seeking Recognition and/or Registration or Fellowship in Australia
3. Discussion Paper on Assessment of Experience in Practice
4. Discussion Paper on Expiration of Fellowship
5. SQiP in Rural and Remote Practice.

Conclusion

As this will be my last report as Censor, I would like to thank the members of my panel and committees for their hard work in meeting the challenges of our College. I would especially like to thank the staff and CEO of ACRRM for their patience, intelligence, support and efforts in supporting me and the Committees. Their good humour and affability, in what are often tight and busy circumstances, has made my work a pleasure.

The future of the Censorial process rests with further developing a number of processes. These are based upon the general principles, exhibited in the past, of appropriateness to rural and remote practice, flexibility, quality and safety for our communities, fairness and transparency, innovation and responsiveness to the needs of Rural and Remote Medicine.

The reorganisation of the Censorial Committees has given us a structural framework which will allow us to manage the tasks ahead. There are many other innovations I would have liked to have implemented but will leave for my successor. I do feel, however, that the groundwork has been laid to facilitate this ongoing process.



Dr Dennis Pashen
Censor

04-05

Australian College of
Rural and Remote Medicine

A.C.N 078 081 848

FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2005

I Directors' Report

The Directors submit the following report for the year ended 30 June 2005 made in accordance with a resolution of the Board of Directors.

DIRECTORS

The names of the Directors of Australian College of Rural and Remote Medicine Limited in office at any time during the year or since the end of the year:

Dr Alan Chater
 Dr David Campbell
 Dr Elizabeth Dodd
 Dr Stephen Holmes
 Dr Bruce Cameron
 Dr Ruth Stewart
 Professor John Murdoch (resigned 20 November 2004)
 Dr Ian Kamerman
 Dr Fred McConnel
 Associate Professor Elizabeth Chalmers
 Dr Pat Giddings
 Dr Myrle Gray (resigned 20 November 2004)
 Dr John Heinrich (resigned 20 November 2004)
 Dr Robert Seton (appointed 20 November 2004)
 Dr Megan Rathbone (appointed 20 November 2004)
 Dr James McLennan (appointed 21 November 2004)
 Dr Louis Peachey (appointed 21 November 2004)
 Dr Timothy Wootton-Leeuwenburg (appointed 20 November 2004)

PRINCIPAL ACTIVITIES

The principal activity of the Company during the year ended 30 June 2005 was the provision of medical education and training services to doctors in rural and remote areas.

No significant changes in the nature of the above activity occurred during the year.

REVIEW AND RESULTS OF OPERATIONS

The surplus from ordinary activities for the year ended 30 June 2005 amounted to \$1,915,690 (2004: \$1,335,794). This surplus is made up of a College surplus of \$435,962 and a project surplus of \$1,479,728.

The project surplus of \$1,479,728 is a direct result of timing differences between the receipt of grant funding and expenditure of these funds and where these fall in relation to the end of financial year cutoff. Over the life of the projects budgets will be met without any deficits resulting.

DIVIDENDS AND OPTIONS

The company is limited by guarantee and consequently no dividends have been paid or options issued.

LIKELY FUTURE DEVELOPMENTS AND EXPECTED RESULTS

ACRRM anticipates a continuation in 2005 - 2006 of its positive performance and growth with a focus on providing high quality education and training services to rural and remote medical practitioners in Australia.

The College will complete the Australian Medical Council assessment process to have Rural and Remote Medicine recognised as a new medical specialty. It is anticipated that specialty status will bolster the developments already underway toward integrating Rural and Remote Medicine into Australia's medical administrative and educational processes.

It will expand its role in developing and maintaining professional standards for Rural and Remote Medicine and work with key stakeholders to support relevant training that responds to the needs of practitioners and their communities. A formal assessment process for Fellowship of ACRRM will continue to be developed and trialed as a matter of priority.

SIGNIFICANT CHANGES IN STATE OF AFFAIRS

There were no significant changes in the state of affairs of the company during the year.

INFORMATION OF DIRECTORS

The following persons were Directors of the Australian College of Rural and Remote Medicine during this financial year. No payments (financial or otherwise) were made for their services.

Dr Alan Bruce Chater

MBBS Hons (Qld), DRAZCOG (Advanced), FRACGP, FACRRM

Dr Bruce Chater was the Vice President of ACRRM before becoming President of ACRRM on 26 October 2003. He is a founding member and Fellow of ACRRM with more than 20 years' experience as a solo procedural practitioner in small community of Theodore in Central Queensland. Dr Chater has a longstanding involvement in the medico-political and educational policy arena in Australia. He has held a range of positions including President of the Rural Doctors Association of Queensland and Vice President of Rural Doctors Association of Australia, Chair of the National Rural Health Alliance and Rural Faculty representative on the Council of the RACGP. He is currently the Australian delegate to the WONCA International Rural Working Party and a Director on the Board of the National Institute of Clinical Studies. He is a Senior Lecturer in Rural Medicine at University of Queensland, Honorary Senior lecturer at Monash University and Adjunct Associate Professor at James Cook University.

Dr David Campbell

MBBS, Dip RACOG, FRACGP, DCH, FACRRM

Dr David Campbell was the Victorian Director on the ACRRM Board before being elected as Vice President on 26 October 2003. He has practised as a rural doctor in Lakes Entrance, Victoria since 1983 and is a foundation member and Fellow of ACRRM. He is currently Director of the East Gippsland Regional clinical School with Monash University. He is a Director and Board member of the Rural Workforce Agency, Victoria and a member of the Committee of Management of Rural Doctors' Association of Victoria. Dr Campbell is a Director of the Gippsland Education and Training for General Practice consortium. He chairs the ACRRM Accreditation Committee and National Emergency Medicine Teacher Training Committee and is a member of the Remote Vocational Training Scheme Committee between ACRRM and RACGP.

Dr Elizabeth Dodd

MBBS (Syd), FRACGP, FACRRM

Dr Elizabeth Dodd is ACRRM's Treasurer. She has been a rural doctor since 1980 and is now in fulltime rural practice. Working now in Griffith NSW, she has worked in rural and remote Queensland and New South Wales as a procedural rural doctor. She has been involved in medical education since 1985 and currently is a mentor on the Remote Vocational Training Scheme.

Dr Stephen Holmes

MBBS (Adelaide), FRCPA, DRACOG, FACRRM

Dr Stephen Holmes is the South Australian Director on the ACRRM Board. Dr Holmes has worked in rural medicine for 16 years and has been in solo practice in Clare, South Australia and surrounding regions since 1986. He chairs ACRRM's Professional Development Committee and IMIT Committee and represents the College on the Quality Use of Pathology Committee, General Practice Computing Group Management Committee and chairs the SA GP Forum. Dr Holmes is a member of the Executive Committee and Lower MidNorth representative on the MidNorth Medical Practitioners Association and MidNorth Division of General Practice. He is a lifemember of South Australian PostGraduate Medical Education Association.

Dr Bruce Cameron

FACRRM, DRANZCOG, BSc Hons (Geophysics)

Dr Bruce Cameron is the Queensland Director on the ACRRM Board. Dr Cameron is a foundation member and Fellow of ACRRM and practises in Atherton, Far North Queensland. Dr Cameron is the ACRRM representative on Queensland's General Practice Advisory Committee. Dr Cameron has previously held positions as President of the Rural Doctors Association of Queensland, Vice President (Education) of Rural Doctors Association of Australia, and Board member of the Queensland Rural Medical Support Agency (now known as Health Workforce Queensland).

Dr Ruth Stewart

MBBS, DRANZCOG, FACRRM

Dr Ruth Stewart is the Women in Rural Practice Director on the ACRRM Board and a parttime procedural rural practitioner in Camperdown, in South West Victoria. Making life better for rural women practitioners is a high priority for Ruth who is a member of the ACRRM executive committee, the assessment subcommittee, is a representative on the ACRRM RACGP Committee on Professional Development, chairs the steering committee for the Office for the Status of Women project held by ACRRM and represents ACRRM on the National Female Rural General practitioner Network. Dr Stewart is ACRRM's representative on the Board of the Victorian Metropolitan Alliance and sits on the Maternity Services Advisory Committee which reports to the Victorian Minister for Human Services. She is a GP obstetrician with Caesarean skills and she joins in the weekend on-call roster for Camperdown hospital. She is currently conducting research evaluating a model of maternity service demonstrating high quality outcomes in a low volume rural context for her PHD.

Professor John Murdoch

MD PhD, FRACGP, FRCGP, FACRRM

Professor John Campbell Murdoch is the Western Australia Director on the ACRRM Board. Professor Murdoch is Professor of Rural and Remote Medicine and Head of Rural Clinical School at the University of Western Australia. He was a family physician in rural practice in Winterton, Southland, New Zealand. He was also Professor and Chair of the Department of General Practice, Dunedin School of Medicine from 1983 to 1992 and a pioneer in research and clinical management of chronic fatigue syndrome at the time when the syndrome had a high prevalence in New Zealand. He has also worked in both the Middle East and the United Kingdom.

Dr Ian Kamerman

MBBS, DRANZCOG, DA, FACRRM

Dr Ian Kamerman is the New South Wales Director on the ACRRM Board. Dr Kamerman is a foundation Fellow of the College and wellknown advocate for Rural and Remote Medicine. He has worked in the Bingara and Junee in NSW, but has also practiced in rural Victoria. Dr Kamerman represents ACRRM on the NSW Ministerial Advisory Committee on General Practice and the New England Area Training Service, of which he is currently Chair. He is also Chair of the National GP Supervisors' Association and a Senior Lecturer at the University of Newcastle School of Medical Practice and Population Health.

Dr Frederic McConnel

MBBS (UQ), Dip RACOG, FAFPH, MPH, FACRRM

Dr Frederic McConnel is the Northern Territory Director on the ACRRM Board. Dr McConnel has worked in rural and remote regions of Australia for more than 30 years. He is currently the Medical Workforce Adviser to Northern Territory Department of Health and Community Services. His long career in remote and Indigenous health in northern Australia has encompassed all aspects of remote health care delivery from procedural medicine to health service management. He has been a mentor to many younger doctors helping them gain the skills to deliver effective primary health care in Aboriginal communities. He has also worked abroad in Vietnam, Hong Kong, China and Indonesia. Dr McConnel is a Public Health Physician, and represents ACRRM on the committee overseeing the Public Health Medicine and General Practice joint training model.

Associate Professor Elizabeth Chalmers

MBChB, MPH, FAFPHM, FACHAM, FACRRM

Associate Professor Elizabeth Chalmers is the ACRRM Academic Director. She has spent seven years as District Medical Officer in remote Aboriginal communities and Northern Territory Air Medical Services. She has also spent seven years in remote private general practice in the mining town of Nhulunbuy; Royal Flying Doctor Service Practitioner for remote women's program. Additional to her work in rural medicine, Associate Professor Chalmers has been Director of the Alcohol and Drug Unit, Royal Darwin Hospital for seven years, Medical Officer with Darwin Sexual Assault Service, consultant to the Northern Territory Government and Miwatj Aboriginal Health Service. She is currently Chair of the Remote Vocational Training Scheme Committee.

Dr Pat Giddings

MBBS, FRACGP, DRANZCOG, FACRRM, Grad. Dip. Fam. Med

Dr Pat Giddings is the Victorian Director of ACRRM Board. He lives in Bright in North Eastern Victoria and has fifteen years experience in fulltime rural medicine practice. He has ten years experience as a board member of the North East Victorian Division of General Practice, including three years as Chair. He is a member of the Board of Management of the Rural Doctors Association of Victoria. Dr Giddings is the Program Manager for the Remote Vocational Training Scheme and the Regional Director, Bogong Regional Training Network. He has had a key role in the development of the ACRRM Curriculum and Teaching Standards for rural and remote practice. He is also an instructor for the Advanced Paediatric Life Support course.

Dr Myrle Gray

MBBS, FACRRM

Dr Myrle Gray is the Tasmanian Director on the ACRRM Board. She has been involved in Rural Doctors Association of Australia both in Tasmania and federally for many years. In 1978, she commenced her residency at Mt Isa Base Hospital in rural Queensland. In 1980, she was rural medical practitioner in Savage River, a rural remote opencut mining community on the

west coast of Tasmania. In 1982, she was family doctor in a regional town of Warners Bay near Newcastle, New South Wales. From 1985 until the present day she is based at Oatlands, Tasmania, which is a farming community in central Tasmania. Her interests include emergency medicine, environmental issues, bush walking and family.

Dr John Heinrich

MBBS (Qld), Graduate Certificate in Family Medicine (Monash), FRACGP, FACRRM

Dr John Heinrich is a solo rural medical practitioner and Medical Superintendent of the Mundubbera hospital in Central Queensland. He has practised in Blackall, Queensland as a solo rural medical practitioner and has been an enthusiastic participant in the Pilot Remote Vocational Training Scheme. He has been the ACRRM Registrar Director since October 2002. Dr Heinrich is also the ACRRM representative on the General Practice Registrars Association Board and ACRRM's representative on the Board of the Rural and Regional Queensland Training Consortium.

Dr Robert Seton

MBCHB, FACRRM

Dr Robert Seton is a Fellow of ACRRM and was elected as Western Australian Director on the ACRRM Board on 20 November 2004. Robert is in full time rural practice in Narrogin, Western Australia.

Dr Megan Rathbone

MBBS, FACRRM

Dr Megan Rathbone is a Fellow of ACRRM and was elected as Tasmanian Director on the ACRRM Board on 20 November 2004. Dr Rathbone's experience consists of 23 years in rural practice in North-West Tasmania as both a group and sole practitioner. She has been the Executive Director of the North-West Tasmanian Director of General Practice and also as Board Member and Chairman between 1994 and 2000.

Dr Rathbone is a part-time senior lecturer at the Tasmanian Rural Clinical School. She is also the ACRRM nominee on the Board of General Practice Training in Tasmania, and teaches students and registrars in her General Practice. She has started a support group for female practitioners in the North-West of Tasmania, which has met for the last four years.

Dr James McLennan

MBBS, Dip RACOG, Dip FCA, FACRRM

Dr McLennan has been a partner in a rural practice for 16 years, performing anaesthetics and obstetrics. He is the immediate past president the Rural Doctors Association of South Australia (RDASA) and the Educational Vice President of the Rural Doctors Association of Australia (RDAA). Dr McLennan is a founding member and Fellow of the Australian College Rural and Remote Medicine and is currently a board member representing the RDAA. He is also a member of the South Australian Health Minister's Rural Health Advisory Panel.

Dr Louis Peachey

BMed, Cert Rural, FACRRM

Dr Louis Peachey is the Chair, Indigenous Chapter on the ACRRM Board. Louis was appointed to the ACRRM Board on 21 November 2004. Louis is ACRRM's representative and current Chair on the Joint Consultative Committee for Aboriginal and Torres Strait Islander Health. Louis is employed as a Medical Educator at the Mt Isa Centre for Rural and Remote Health.

Dr Timothy Wootton-Leeuwenburg

MBBS

Dr Timothy Wootton-Leeuwenburg is a Registrar at Kangaroo Island, South Australia and was appointed to the ACRRM Board as Registrar Director on 20 November 2004. An OTD by virtue of his undergraduate medical degree, he has undertaken postgraduate training in emergency medicine, anaesthetics and general practice with a view to a long term future in rural and remote medicine via the FACRRM pathway.

Ms Marita Cowie

BA (Psych), BBus (Com), MEd (T&D)

Marita Cowie was appointed Company Secretary of the College in 1998. She is also the foundation Chief Executive Officer of ACRRM. Marita has more than 12 years experience in medical education, training and company administration. She is also a Director on the Board of Genex Pty Ltd and Company Secretary of MMB Investments.

MEETINGS OF DIRECTORS

During the 2004-2005 financial year, 12 meetings of directors were held, with attendance as follows:

DIRECTORS	Directors Meetings	
	<i>Eligible to attend</i>	<i>Attended</i>
Dr Alan Chater	12	11
Dr David Campbell	12	12
Dr Elizabeth Dodd	12	12
Dr Stephen Holmes	12	11
Dr Bruce Cameron	12	12
Dr Ruth Stewart	12	8
Professor John Murdoch	5	5
Dr Ian Kamerman	12	6
Dr Fred McConnel	12	11
Associate Professor Elizabeth Chalmers	12	12
Dr Pat Giddings	12	12
Dr Myrle Gray	5	3
Dr John Heinrich	5	5
Dr Robert Seton	7	6
Dr Megan Rathbone	7	5
Dr James McLennan	6	3
Dr Louis Peachey	6	6
Dr Timothy Wootton-Leeuwenburg	7	1

ATTENDANCE OF EX OFFICIO BOARD MEMBERS AT THE MEETING OF DIRECTORS

EX OFFICIO MEMBERS	Directors Meetings	
	<i>Eligible to attend</i>	<i>Attended</i>
Professor Ian Wronski, Immediate Past President	12	8
Dr Tom Doolan, Hon. Director of Education	12	9
Associate Professor Dennis Pashen, Censor	12	10
Ms Marita Cowie, Chief Executive Officer (maternity leave – November 2004-January 2005)	9	9
Ms Evie Cuthbertson, Acting Chief Executive Officer	3	3

There is one formally constituted committee of the Board being the Executive Committee. During the financial year, 3 meetings of the Executive Committee were held, with attendance as follows:

EXECUTIVE MEMBERS

	Executive Meetings	
	<i>Eligible to Attend</i>	<i>Attended</i>
Dr Alan Chater, President	3	2
Dr David Campbell, Vice President	3	3
Dr Elizabeth Dodd, Treasurer	3	3
Dr Ruth Stewart, Women in Rural Practice Director	3	3
Ms Marita Cowie, Chief Executive Officer	3	3

The Audit Committee during the financial year had one (1) meeting on 6 October 2004, with attendance as follows:

AUDIT COMMITTEE MEMBERS

	AUDIT COMMITTEE MEETINGS	
	<i>Eligible to attend</i>	<i>Attended</i>
Dr Elizabeth Dodd, Treasurer, Chair	1	1
Dr David Campbell, Vice President	1	1
Dr Stephen Holmes, South Australian Director	1	0
Dr Ruth Stewart, Women in Rural Practice Director	1	1
Ms Marita Cowie, Chief Executive Officer, Ex Officio Member	1	1

SIGNIFICANT AFTER BALANCE DATE EVENTS

No matters or circumstances have arisen after the end of the financial year that have significantly affected or may significantly affect the operations of the company, the results of those operations, or the state of affairs of the company, in subsequent financial years.

ENVIRONMENTAL REGULATIONS

There has been no matter, either during or since the end of the financial year, which in the opinion of the directors, would give rise to any conflict with the provisions of existing environmental regulation.

INDEMNIFICATION OF OFFICERS

During or since the financial year the company has paid premiums to insure each of the directors and officers against liabilities for the costs and expenses incurred by them in defending any legal proceedings arising from a wrongful act while acting in their capacity of officer of the company. The policy prevents the company from disclosing premiums paid.

PROCEEDINGS ON BEHALF OF THE COMPANY

No proceedings have been entered into on behalf of the company.

Signed in accordance with a resolution of the Board of Directors.

Director 

Dated at Griffith, New South Wales this 5th day of October, 2005.

AUDITOR'S INDEPENDENCE DECLARATION UNDER SECTION 307C OF THE CORPORATIONS ACT 2001 TO THE DIRECTORS OF AUSTRALIAN COLLEGE OF RURAL AND REMOTE MEDICINE LIMITED

I declare that, to the best of my knowledge and belief, during the year ended 30 June 2005 there have been:

- (i) no contraventions of the auditor independence requirements as set out in the Corporations Act 2001 in relation to the audit; and
- (ii) no contraventions of any applicable code of professional conduct in relation to the audit.

BENTLEYS MRI
Brisbane Partnership
Chartered Accountants

R J Forbes
Dated at Brisbane this 5th day of October 2005

DIRECTORS' DECLARATION

In the opinion of the Directors of the Australian College of Rural and Remote Medicine Limited:

- (a) the accompanying financial statements and notes are in accordance with the Corporations Act 2001, comply with the accounting standards and give a true and fair view of the company's financial position as at 30 June 2005 and its performance for the year ended on that date.
- (b) at the date of this declaration there are reasonable grounds to believe that the company will be able to pay its debts as and when they become due and payable.

Signed in accordance with a resolution of the Directors.

Director

Dated at Griffith, New South Wales this 5th day of October, 2005.

STATEMENT OF FINANCIAL PERFORMANCE FOR THE YEAR ENDED 30 JUNE 2005

	Notes	2005 \$	2004 \$
Revenues from Ordinary Activities	2	9,343,627	6,063,511
Expenses from Ordinary Activities	3	(7,427,937)	(4,727,717)
Surplus/(Deficit) from Ordinary Activities		1,915,690	1,335,794
Income Tax Expense		-	-
Net Surplus/(Deficit)		1,915,690	1,335,794

*The above Statement of Financial Performance should be read in conjunction with the attached notes

STATEMENT OF FINANCIAL POSITION AS AT 30 JUNE 2005

	Notes	2005 \$	2004 \$
CURRENT ASSETS			
Cash Assets	5	7,158,671	5,539,835
Receivables	6	1,514,546	1,211,120
Other Assets	7	354,308	36,203
TOTAL CURRENT ASSETS		9,027,525	6,787,158
NON-CURRENT ASSETS			
Intangible Assets	8	-	83,033
Property, Plant and Equipment	9	170,794	176,253
TOTAL NON-CURRENT ASSETS		170,794	259,286
TOTAL ASSETS		9,198,319	7,046,444
CURRENT LIABILITIES			
Payables	10	1,192,075	986,741
Provisions	11	90,900	62,913
TOTAL CURRENT LIABILITIES		1,282,975	1,049,654
NON-CURRENT LIABILITIES			
Provisions	11	21,545	18,681
TOTAL NON-CURRENT LIABILITIES		21,545	18,681
TOTAL LIABILITIES		1,304,520	1,068,335
NET ASSETS		7,893,799	5,978,109
EQUITY			
Retained Surplus	12	7,893,799	5,978,109
TOTAL EQUITY		7,893,799	5,978,109

*The above Statement of Financial Position should be read in conjunction with the attached notes

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

1. SUMMARY OF ACCOUNTING POLICIES

The Australian College of Rural and Remote Medicine is not a reporting entity because in the directors' opinion, there are unlikely to exist users who are unable to command the preparation of reports tailored so as to satisfy specifically all of their information needs. These financial statements constitute a Special Purpose Financial Report which have been drawn up in accordance with Accounting Standards, other authoritative pronouncements of the Australian Accounting Standards Boards, Urgent Issues Group Consensus Views and the Corporations Act 2001 except for the inclusion of the statement of cash flows and the recognition of oncosts on employee benefits.

Basis of Accounting

The statements are prepared on the accrual basis of accounting using the historical cost assumption and except where stated, do not take into account changing money values nor current valuations of non-current assets and their impact on operating results.

Income Tax

The entity is exempt from income tax under provisions of the Income Tax Assessment Act.

Property, Plant and Equipment

Property, plant and equipment are brought to account at cost, less, where applicable, any accumulated depreciation.

Depreciation is calculated on the Diminishing Value Method so as to write the assets off over their estimated useful lives. The average depreciation rate for office equipment ranges between 20 and 40%. New assets are depreciated from the date of commissioning.

Revenue Recognition

- (a) Grants received are brought to account as revenue where:
- The company has control over the contribution;
 - It is probable that the economic benefit comprising the contribution will flow to the company; and
 - The amount of the contribution can be reliably measured.
- (b) Interest Revenue is recognised on a time proportionate basis that takes into account the effective yield on the financial asset.
- (c) Subscriptions are recognised on an accrual basis proportionate to when the service is provided.

Concentration of Credit Risk

The Company has one significant concentration of credit risk being the Department of Health and Ageing amounting to \$1,410,415. This is equivalent to 93.05% of the total debtors balance.

Employee Benefits

The following liabilities arising in respect of employee entitlements are measured at their nominal amounts:

- wages and salaries, annual leave and sick leave regardless whether they are expected to be settled within twelve months of balance date.
- other employee entitlements which are expected to be settled within twelve months of balance date.

Long service leave liabilities are determined after taking into consideration years of service, current level of wages and salaries and past experience regarding staff departures.

Leases

Lease payments for operating leases, where substantially all the risks and benefits remain with the lessor, are charged as expenses in the periods in which they are incurred.

Intangible Assets

The cost of creating a website has been capitalised under the conditions set out in UIG37. The expense was amortised over a period of three years and any further expenses incurred for maintenance will be expensed to the Statement of Financial Performance.

Credit Risk Exposure

Credit risk represents the risk of counterparty default. The maximum credit risk exposure is represented by the carrying amount of assets in the statement of financial position net of any provisions for losses.

Receivables

Trade receivables represent the principal amounts outstanding at balance date, are non interest bearing and are usually settled within 30 days.

Payables

Payables represent the principal amounts outstanding at balance date, are non interest bearing and are usually settled within 30 days.

Net Fair Value

The net fair value of all financial assets and liabilities are represented by their book value unless otherwise stated.

Impact of Adoption of Australian Equivalents to International Financial Reporting Standards

The company is preparing and managing the transition to Australian Equivalents to International Financial Reporting Standards (AIFRS) effective for the financial years commencing 1 January 2005. The adoption of AIFRS will be reflected in the company's financial statements for the year ending 30 June 2006. On first time adoption of AIFRS, comparatives for the financial year ended 30 June 2005 are required to be restated. The majority of AIFRS transitional adjustments will be made retrospectively against retained earnings at 1 July 2004.

The company's management, along with its auditors, have assessed the significance of the expected changes and are preparing for their implementation. The impact of the alternative treatments and elections under AASB1: First Time Adoption of Australian Equivalents to International Financial Reporting Standards has been considered where applicable.

It is not expected that there will be any significant impacts on the carrying value of assets or liabilities due to the AIFRS nor, accordingly, surplus and company equity balances in the year ending 30 June 2006.

2. REVENUES FROM ORDINARY ACTIVITIES

	2005	2004
	\$	\$
Operating Revenue		
Rendering of Services	1,079,082	766,891
Grant Income	7,903,488	5,089,495
Sponsorship	9,731	-
Sundry Income	38,612	9,328
Non Operating Revenue		
Interest	312,714	197,797
	<u>9,343,627</u>	<u>6,063,511</u>

3. EXPENSES FROM ORDINARY ACTIVITIES

	2005	2004
	\$	\$
<i>Classification of Expenses by Function:</i>		
College Services & Admin Expenses	956,864	835,000
Publication & Communication Services	47,313	47,374
RRAPP Grant Expenses	913,450	786,599
Radiology Grant Expenses	31,971	11,188
Professional Development Program Grant Expenses	1,250,199	760,696
John Flynn Scholarship Scheme Grant Expenses	1,665,599	1,290,210
Rural Training Grant Expenses	-	645,158
Obstetric Ultrasound Grant Expenses	159,704	210,190
Medical Rural Bonded Scholarship Grant Expenses	476,864	141,302
GP Procedural Grant Expenses	92,411	-
PGPPP Grant Expenses	1,833,562	-
	<u>7,427,937</u>	<u>4,727,717</u>

4. SURPLUS/(DEFICIT) FROM ORDINARY ACTIVITIES

<i>Surplus/(Deficit) from Ordinary Activities includes:</i>		
Net (Gain)/Loss from sale of Plant and Equipment	5,225	12,788
Net Expense resulting in movements in provisions:		
Depreciation	57,035	33,872
Amortisation	83,033	165,984

5. CASH ASSETS

Cash on Hand	100	100
Cash at Bank	903,119	782,591
Cash on Deposit	6,255,452	4,757,144
	<u>7,158,671</u>	<u>5,539,835</u>

6. RECEIVABLES

Trade Receivable	1,514,546	1,211,120
	<u>1,514,546</u>	<u>1,211,120</u>

Included in the above, are aggregate amounts receivable from the following related parties:

Directors (other than loans to directors)	108	1,842
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7. OTHER ASSETS

Prepayments	132,485	36,203
Accrued Income	221,823	-
	<u>354,308</u>	<u>36,203</u>

8. INTANGIBLE ASSETS

Website Development	498,000	498,000
Accumulated Amortisation	(498,000)	(414,967)
	<u>-</u>	<u>83,033</u>

9. PROPERTY, PLANT AND EQUIPMENT

	2005 \$	2004 \$
Office Equipment	314,637	283,791
Accumulated Depreciation	(143,843)	(107,538)
	170,794	176,253
Movement Schedule		
Opening Balance	176,253	93,121
Additions	56,742	129,792
Disposals at Written Down Value	(5,166)	(12,788)
Depreciation Expense	(57,035)	(33,872)
Closing Balance	170,794	176,253

10. PAYABLES

(i) Current		
Trade and Sundry Creditors	214,810	299,833
Unearned Income	679,665	477,820
Accruals	219,447	106,306
GST Payable	78,153	102,782
	1,192,075	986,741

Included in unearned income, are amounts from directors:

4,000	3,875
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11. PROVISIONS

(i) Current		
Employee Benefits	90,900	62,913
	90,900	62,913
(ii) Non-Current		
Employee Benefits	21,545	18,681
	21,545	18,681

Aggregate liability arising from employee benefits:

Current		
Provision for Annual Leave	90,900	62,913
Employee Benefit Accruals	21,766	14,229
	112,666	77,142
Non-Current	21,545	18,681
	134,211	95,823

12. RETAINED SURPLUS

Retained Surplus at the beginning of year	5,978,109	4,642,315
Net Surplus/(Deficit)	1,915,690	1,335,794
Retained Surplus at the end of year	7,893,799	5,978,109

13. AUDITORS REMUNERATION

	2005	2004
	\$	\$
Audit and review of Financial Statements	5,000	5,000
Other Project Audit Services	5,000	-
	10,000	5,000

14. COMMITMENTS FOR EXPENDITURE

Non-cancellable operating lease for lease of premises with a term of more than one year.

Commitments not provided for:

No later than 1 year	80,770	80,770
Later than 1 year but no later than 5 years	80,770	161,540
	161,540	242,310

15. MEMBERS GUARANTEE

The company is limited by guarantee. If the company is wound up, the Articles of Association state that each member is required to contribute a maximum of \$10 each towards meeting any obligations of the company.

16. CORPORATE INFORMATION

Australian College of Rural and Remote Medicine Limited is an Australian Company whose principal activities are the provision of medical education and training services to rural and remote areas. The principal place of business and registered office of the Australian College of Rural and Remote Medicine Limited is Level 4, 410 Queen Street, Brisbane, Queensland. There are 28 employees (2004: 22) at the end of the reporting period.

17. SEGMENT INFORMATION

The company's sole business segment is the provision of medical, education and training services to rural and remote areas in Australia.

18. ECONOMIC DEPENDENCY

The project operations of the Australian College of Rural and Remote Medicine are dependent upon ongoing funding, which, to date, has been predominantly through agreements with the Department of Health and Ageing.

19. RELATED PARTY TRANSACTIONS

The directors of the company pay membership fees under normal terms and conditions. They are not remunerated by the company. The names of persons who held office during the year are as follows:

2005

Dr Alan Bruce Chater
 Dr David Campbell
 Dr Elizabeth Dodd
 Dr Stephen Holmes
 Dr Bruce Cameron
 Dr Ruth Stewart
 Professor John Murdoch (resigned 20/11/04)
 Dr Ian Kamerman
 Dr Fred McConnel
 Associate Professor Elizabeth Chalmers
 Dr Pat Giddings
 Dr Myrle Gray (resigned 20/11/04)
 Dr John Heinrich (resigned 20/11/04)
 Dr Robert Seton (appointed 20/11/04)
 Dr Megan Rathbone (appointed 20/11/04)
 Dr James McLennan (appointed 21/11/04)
 Dr Louis Peachey (appointed 21/11/04)
 Dr Timothy Wootton-Leeuwenburg
 (appointed 20/11/04)

2004

Professor Ian Wronski
 Dr Alan Bruce Chater
 Dr David Campbell
 Dr Stephen Holmes
 Dr Bruce Cameron
 Dr Ruth Stewart
 Dr Jane Greacen (resigned 26/10/03)
 Dr Brian Bowring (resigned 26/10/03)
 Dr John Heinrich
 Professor John Murdoch
 Dr Ian Kamerman
 Professor Paul Worley (resigned 26/10/03)
 Dr Fred McConnel (appointed 14/08/03)
 Associate Professor Elizabeth Chalmers
 (appointed 26/10/03)
 Dr Elizabeth Dodd (appointed 26/10/03)
 Dr Pat Giddings (appointed 26/10/03)
 Dr Myrle Gray (appointed 14/04/04)

20. FINANCIAL INSTRUMENTS

Credit Standby Facilities

The company had no credit standby facilities as at 30 June 2005.

Unused/Used Financing Facilities

The company had no financing facility as at 30 June 2005.

Interest Rate Expense

The company does not engage in any transactions which are speculative in nature. Financial assets and liabilities other than cash disclosed in financial statements are noninterest bearing in nature.

I Independent Audit Report

To the members of Australian College of Rural and Remote Medicine Limited

Scope

We have audited the attached financial report, being a special purpose financial report, of Australian College of Rural and Remote Medicine Limited for the year ended 30 June 2005. The members of the Board are responsible for the financial report and have determined that the accounting policies used and described in Note 1 to the financial statements are appropriate to meet the requirements of the Corporations Act 2001 and are appropriate to meet the needs of the members. We have conducted an independent audit of the financial report in order to express an opinion on it to the members of Australian College of Rural and Remote Medicine Limited. No opinion is expressed as to whether the accounting policies used, and described in Note 1, are appropriate to the needs of the members.

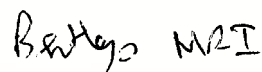
The financial report has been prepared for distribution to the members for the purpose of fulfilling the reporting requirements under the Corporations Act 2001. We disclaim any assumption of responsibility for any reliance on this report or on the financial statements to which it relates to any person other than the members, or for any purpose other than that for which it was prepared.

Our audit has been conducted in accordance with Australian Auditing Standards. Our procedures included examination, on a test basis, of evidence supporting the amounts and other disclosures in the financial statements and the evaluation of significant accounting estimates. These procedures have been undertaken to form an opinion as to whether, in all material respects, the financial statements are presented fairly in accordance with the accounting policies described in Note 1 to the financial statements so as to present a view which is consistent with our understanding of the College's financial position and performance as represented by the results of its operations. (These policies do not require the application of all Accounting Standards and other professional reporting requirements.)

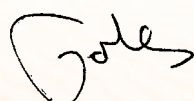
Audit Opinion

The audit opinion expressed in this report has been formed on the above basis.

In our opinion, the financial report of the Australian College of Rural and Remote Medicine Limited presents a true and fair view of the financial position of the College as at 30 June 2005 and the results of its operations for the year then ended in accordance with the accounting policies described in Note 1 to the financial statements.



BENTLEYS MRI
Brisbane Partnership
Chartered Accountants



RJ Forbes
Dated at Brisbane this 5th day of October 2005.



acrrm



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Medicine

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