ANNUAL REPORT / 2005

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

ANNUAL REPORT / 2005

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

COLLEGE COUNCIL

Left row up
Dr Kerry Brandis
Dr Margaret Cowling
Professor Garry Phillips
Dr Leona Wilson
A/Prof Tony Weeks
Dr Lindy Roberts
Dr Rod Westhorpe
Professor Alan Merry
Dr Mike Richards

Centre row up
Associate Professor Kate Leslie
Dr Jack Havill
Associate Professor Milton Cohen

Right row up
Dr Diana Khursandi
Dr Walter Thompson
Dr Frank Moloney
Professor Michael Cousins

CONTENTS

PRESIDENT'S REPORT 4
DISASTER RESPONSE IN 2005 10
TRAINEE TEACHING AT THE ROYAL CHILDREN'S HOSPITAL 15
CEO'S REPORT 16

ANZCA ANNUAL REPORT 2005 20
ACCREDITATION 21
EDUCATION AND TRAINING 21
TRAINING AND ASSESSMENT 22
TRAINEES' COMMITTEE 23
EXAMINATIONS 23
MAINTENANCE AND PROFESSIONAL STANDARDS 24
CONTINUING MEDICAL EDUCATION 26
RESEARCH GRANT AWARDS 27
WORKFORCE 29
ANZCA AWARDS 30
COLLEGE COUNCIL 30
ORGANISATIONAL CHART 31

DEAN'S REPORT JFICM 32
DEAN'S REPORT FPM 34
PANEL OF EXAMINERS 37

HONORARY TREASURER'S REPORT 38
REVENUE AND EXPENSES 40
INDEPENDENT AUDITOR'S REPORT 41
FINANCIAL STATEMENT 42
NOTES TO THE CONCISE FINANCIAL REPORT 46

PRESIDENT'S REPORT

PROFESSOR MICHAEL J COUSINS AM
ANZCA PRESIDENT

Time for a major effort by all Fellows

ANZCA and other Colleges face enormous challenges posed by the current interest of both the State and Federal Governments in medical colleges activities – ACCC/AHWOC Implementation, The Productivity Commission, The Morris and Forster inquiries, OTS Area of Need Programs etc.

It is vital that all Fellows become well informed about the issues and what ANZCA is doing about them. Also, a large number of Fellows are needed to participate in this process.

All Fellows need to become part of the major effort by ANZCA, and its two Faculties, to maintain our mission to serve the community with safety and quality patient care in anaesthesia, intensive care and pain medicine. We must all engage in an ongoing dialogue with state and national governments, with universities and with other bodies, including the general public, in order to play a key role in the future of our specialty – a good example of this is excellent work by ANZCA Fellows in New Zealand with respect to Nurse Practitioners over the past few years.

We have a strong organisation, and the Fellows who graduate from our training and examination process are second to none. But currently less than 10% of our Fellows are fully informed and strongly involved in the issues I have described – this needs to change to 100% involvement. The taskforces are the first move in this direction – and the response has been very positive.

If this increased involvement does not occur, the current unmatched professional milieu and standards of patient care will suffer in a way that may be irreparable. We owe it to our patients not to let this happen.

This is not going to be a matter of a few exchanges on TV or in the newspapers. What is needed is a carefully planned strategy that is executed over many months in a persistent and credible manner.

Ongoing Challenges to ANZCA

In addition to the need to comply much more closely with the Australian Corporations Act via the Australian Securities and Investment Commission (ASIC) and the Australian Competition and Consumer Commission (ACCC), ANZCA has also recently been heavily involved with ongoing discussions with the Australian Government concerning the Overseas Trained Specialists/Area of Need Program and with the Australian Medical Council (AMC) regarding training, examinations and specialist recognition.

There is an increasing interest of state governments and the Australian Government in our training programs, with a desire to have a much greater involvement. This will require very careful management in order to preserve quality and independence. The Council of Australian Governments (COAG) commissioned the Productivity Commission to undertake a study of health professional workforce issues, including training and education. The report made wide ranging recommendations to increase competition in all aspects of healthcare.

ANZCA responded in an effective manner to these bodies and received positive feedback. Fellows will appreciate that this has entailed an order of magnitude increase in work for the College and also placed the College under much greater scrutiny than ever before. This is one reason why ANZCA needs the participation of a much larger number of Fellows and needs to strengthen and streamline the governance of the College.

Quite clearly there is a need for a completely new strategy for our interface with government and the general public. ANZCA is taking a proactive and continuous approach to this area.

Major Changes to ANZCA Governance

On the 10th February 2005, ANZCA Council and key administrative staff were involved in a Strategic Planning Day, facilitated by former Chairman of ASIC, Mr Henry Bosch AO.

Some major changes to ANZCA governance were developed during this day and then passed by ANZCA Council on 11th February:

1. A major reduction in the size of the Executive to comprise the President, Vice President, Director of Professional Affairs and CEO.
2. A reduction in the decision making role of the Executive, to that of conducting essential business between Council Meetings.
3. An increase in the number of Council Meetings per annum to at least six per year. This has enabled Council to take on increased responsibilities, previously vested in the Executive, and to have adequate time to meet all of the requirements of a company Board; these were previously difficult to address because of the demands of ANZCA specific business. Such activities include: regular review of a strategic plan; review of performance indicators and performance arrangements; review of College risk management process; review of organisation structure; review of accounting policies; other ongoing review of Council Governance.
4. Approval of a Council Charter which provides a detailed description of the Role and Responsibilities of Council, delegations, composition of the Council and guidelines for meetings of Council.
5. A Council Protocol which gives a detailed statement of what is expected of individual Councillors, acting as directors of a Board. There are a number of appendices to the Protocol which include: Induction of New Council Members; a Council Handbook; President's Responsibilities and Authorities; Role and Responsibilities of the College Council Secretary.
6. The Executive Committee Charter, which clearly defines the revised role of the Executive.
7. Finance, Audit and Risk Management Committee Charter.
8. Role and Responsibilities of the Chief Executive Officer.
9. Role and Responsibilities of the Director of Professional Affairs.

All of these new governance measures were passed unanimously by Council, and it is the view of Council that they represent a major step forward in the operations of our College.

The new arrangements for Council came into action from June 2005.

ANZCA Taskforces

The members of all ten ANZCA Taskforces were appointed, and meeting of all Taskforces by teleconference occurred. At these meetings, individual Taskforce members outlined their areas of expertise in order for the Taskforce to become aware of the range of expertise available to it. Also, key resource documents were identified and circulated to all Taskforce members. Terms of Reference were refined and nominations for the Chairperson were provided to me from whom a Chair was appointed. (See Taskforces Composition and Terms of Reference)

eCommunity websites were set up for all Taskforces and all members of the Taskforces had access to all of the information on the ten Taskforce websites in order to facilitate cross-fertilisation of information.

I am delighted by the depth and strength of the more than 100 individuals who agreed to participate in this important work, which will have major implications for the future of ANZCA. It has been extremely encouraging to learn of the willingness of such accomplished individuals to contribute at a time when all medical Colleges need to harness more resources to meet the challenges that they face. I tried very hard to identify young Fellows and individuals who have not previously contributed to the work of ANZCA and this was certainly reflected in the Taskforce composition.

At the September and November 2005 Council Meetings, reports were received and considered by Council on the following Taskforces:

- Private Practitioners Involvement in ANZCA
- Integrated Approach to Quality and Safety
- Professionalism – A Code of Professional Conduct
- Relationship of Regional/National Committees with ANZCA
- Taskforce on Data
- Name of the Specialty

Council was broadly in agreement with the Recommendations made by these Taskforces and asked for comments from the Regional/National Committees in a timely manner, so that Council could move ahead with implementation of the Recommendations. Fellows were encouraged to visit the ANZCA website and examine the Recommendations of these and other Taskforces.

In December 2005 the reports of a further three Taskforces were received:

- Perioperative Medicine
- Non-Medical Members of the Anaesthesia Care Team
- Relationship of Younger Fellows to ANZCA

At the February 2006 Council Meeting, the final taskforce report was received:

- Disaster Reponse

In view of the unprecedented changes that are currently mooted in healthcare, the work of these Taskforces is providing crucial input to ANZCA Council.

Productivity Commission Report "Australia's Health Workforce"

In September 2005, the Productivity Commission published its Position Paper which was prepared "for further public consultation and input". ANZCA identified a number of significant errors which were carefully rebutted in the response. I once again repeat my advice from ANZCA Bulletins, that individual Fellows should channel all of their responses through ANZCA. Regional/National Committees were also asked to maintain close contact with ANZCA headquarters if discussions are required with State Health Departments or other bodies.

The Conduct of Anaesthesia is a Specialised Medical Practice

ANZCA'S submissions to the Productivity Commission and the Morris and Foster inquiries included 15 core statements:

1. Modern and complex surgery has been made possible and safe for patients by the advances in anaesthesia which over the last 45 years has become a highly specialised area of medical practice.
2. In Australia the specialty of anaesthesia founded on the education and training program of ANZCA has also initiated and embraced improved patient medical treatment in pre, intra and postoperative care, intensive care and in pain medicine.
3. Specialist anaesthetists are doctors who undergo a total of 13 years training, comprising 6 years of medical school, 2 years as an intern or junior hospital doctor, and then 5 years involving specialist training and rigorous assessment and examination leading to a Fellowship (FANZCA) for successful graduates. It takes this length of time to learn all that a specialist anaesthetist needs to know. (This training provides knowledge in general medicine and surgery plus specialised knowledge and expertise in physiology, pharmacology and anaesthesia related subjects, including the specialised skills that are required.)
4. The training which Australian and New Zealand specialist anaesthetists receive, and their continuing commitment to maintaining their knowledge and skills, has resulted in a standard of care which is equal to the best in the world (the AMC has accredited this program with very favourable comments).
5. Having an anaesthetic in 1940 carried a 1:1000 risk of death. In 1960, the risk was 1:5,000. In 1970 the risk was 1:10,000. In 1999, the risk of anaesthesia related death was less than 1:80,000 for all patients, including the very old and the very sick.
6. The people of Australia and New Zealand expect and deserve to continue to receive the best anaesthesia care in the world. Any decision to use less well trained providers would threaten the maintenance of this high standard.
7. Overall workforce figures (eg. AMWAC) indicate a small shortage of Specialist Anaesthetists in Australia and New Zealand, being rapidly made up by increased graduation of ANZCA Fellows via: (1) increased throughput through the ANZCA training program; (2) increased output through the ANZCA OTS assessment process.
8. ANZCA has no restrictions on the number of training positions.
9. The OTS/AON program is in place for areas where a regional maldistribution exists. This program is under revision by Federal/State Governments, with ANZCA's participation.
10. In Australia, a tripartite program of ANZCA, the Royal Australian College of General Practitioners and ACRRM, trains and supports General Practitioners to provide anaesthesia

11 Nurses are already involved in collaboration with medical specialist anaesthetists: as Assistants to Anaesthetists in Operating Theatres, as Recovery Room Nurses, as Intensive Care Nurses and as nurses in multidisciplinary Pain Management teams. Even in these roles they are in short supply.

12 Australian Surgeons and Anaesthetists have developed a team approach which has resulted in a very high standard of pre, intra and post operative care with the lowest mortality rates in the world.

13 In some countries where nurses or non-medical personnel provide anaesthesia care, they have to be supervised by the surgeon. Australian and New Zealand surgeons are not trained for this role, nor do they wish to have their attention diverted from the increasingly more complex surgery they perform.

14 The training required to provide safer anaesthesia in remote areas, without the support of fully qualified specialist anaesthetists, is higher than that required in a major metropolitan centre because of the variety of clinical situations which might arise and because of the lack of help if things go wrong in what was expected to be a straightforward anaesthetic.

15 There are a number of possible solutions to the shortage of anaesthetists in remote areas, and ANZCA is working with State and Federal Governments to address the issue.

One of the important areas of contention in the Productivity Commission Report was the data on the Specialist Anaesthetist Workforce, which were not up to date. We are now exceeding the AMWAC Recommendations and there is new evidence that there has been a significant increase in the number of trainees, the number of successful candidates at examinations and a significant increase in the success rate in the OTS examination process. Also, our tripartite JCCA Program for General Practitioner Anaesthetists in remote areas continues to be a strong point that is not available in countries such as the USA. This was all drawn to the attention of the Productivity Commission.

The Changed Environment of Healthcare

Medical specialties are now under greater scrutiny than ever before. Thus the highest levels of professionalism and ethical behaviour must be scrupulously maintained. At the most fundamental level, this includes a caring and empathetic relationship with our patients, continuing to foster the mutual regard and strong teamwork that we enjoy with our surgical and nursing colleagues, and the high level of vigilance that is the hallmark of the quality and safety of the care that we provide to our patients. There is no room for Fellows to tolerate behaviour that falls short of these standards.

Acute Pain Management Guideline

I am delighted to Report that the document "Acute Pain Management: Scientific Evidence, Second edition 2005" has been published and is available on the ANZCA website. This is a magnificent effort on behalf of the Faculty of Pain Medicine and ANZCA, and I warmly congratulate Dr Pam Macintyre and her Working Party. This evidence-based document has been endorsed by all of the medical specialist colleges participating in the Faculty of Pain Medicine, by the Royal College of Anaesthetists and by the International Association for the Study of Pain. It is approved by the NHMRC. It will be used worldwide and will stand as the most comprehensive analysis of the scientific basis of treatment for all forms of acute pain. The College and the Faculty of Pain Medicine should be extremely proud of this achievement.

Further Evidence-Based-Medicine Documents

Numerous Fellows have commented to me that the College should be producing more documents which provide an evidence base for our professional practice. I strongly agree with this approach, and I have suggested that the next evidence-based document for the College should be "Cardiovascular Support During and After Anaesthesia". I welcome suggestions for a Chairperson and members of a Working Party to produce this document.

Trainee Representatives on ANZCA Committees

ANZCA and its two Faculties have been progressively increasing trainee involvement in Committees and other aspects of the College work. All trainee representatives on ANZCA Committees are members of the ANZCA Trainee Committee which was set up to consolidate the input of trainees to ANZCA Council. ANZCA Council sees a progressive increase in involvement of trainees in most aspects of the work of the College.

Transition from Trainee to Fellowship

The Committee of Presidents of Medical Colleges (CPMC) has agreed to ANZCA's proposal that it develop an Intercollegiate New Fellows' Conference with the aim of addressing issues that are important to Fellows across different Colleges. One aspect of this is the need to improve strategies for helping trainees in the transition from trainee to Fellowship. Other aspects will be pursued by the ANZCA Committee on Education and Training.

Research and the ANZCA Foundation

Fellows will be pleased to hear that there were 51 applications for research support for 2006. Because of the high standard of these applications, Council made special arrangements to be able to support 20 of these applications. However there were still a number of good quality applications that could be supported if ANZCA funds were available. As I have previously emphasised in the *Bulletin*,there are many "good news stories" about important new developments in clinical management which come about as a result of high quality research. Thus I once again urge Fellows to respond to the call for donations to the ANZCA Foundation. So far just over $200,000 has been raised. Some of our Fellows have given extremely generously, while others have not yet contributed. I ask such individuals to please reconsider – it is in your interest, and that of your patients.

FARM Committee

The College has set up a Finance, Audit and Risk Management (FARM) Committee. We have been fortunate to gain the participation of Mr Henry Bosch AO, former Chairman of The National Companies and Securities Commission – the predecessor to ASIC, Australia's principal corporate regulator, as a Committee Member. Former Head of the accounting firm Ernst and Young, Mr Tom O'Brien AM, has agreed to chair the FARM Committee. These individuals together with the Vice President, Honorary College Solicitor Mr Michael Gorton and Honorary Treasurer take a wide ranging view of the College finances, and examine risks to the College across a very broad range. Company law that is now being applied to all Specialist Colleges, requires such a body. We have been fortunate to be able to assemble such high quality individuals.

Death of ANZCA's First CEO

Council and Fellows were saddened by the news of the death of ANZCA's dedicated and long-serving CEO, Joan Sheales. ANZCA Council bestowed Honorary Fellowship of ANZCA on Joan in November 2005.

CEO Position

ANZCA had an excellent response to the advertisement for a new CEO. The appointment of Dr Mike Richards to the CEO position is an excellent outcome for ANZCA. I am sure that all Fellows join me in welcoming Mike to the College and we look forward to an exciting new phase in our development.

ANZCA Awards

Our Director of Professional Affairs, Professor Garry Phillips was awarded the Orton Medal. Professor Phillips has provided exemplary service to the College over an extremely broad range of areas and continues to be of enormous assistance to the President and ANZCA.

An Orton Medal was awarded to Dr Pamela Macintyre from South Australia. Fellows will be aware of Dr Macintyre's major contribution in producing the document "Acute Pain Management: Scientific Evidence".

National Honours for ANZCA Fellows

I would particularly like to express my pleasure at the award of the following Honours to ANZCA Fellows in 2005:

- Professor Garry D Phillips, Director of Professional Affairs – Member of the Order of Australia (AM)
- Dr Jack H Havill, Dean of the Joint Faculty of Intensive Care Medicine – Officer of the New Zealand Order of Merit (ONZM)
- Associate Professor Victor I Callanan, Member of ANZCA Taskforce on Perioperative Medicine – Member of the Order of Australia (AM)
- Dr George M Boffa – Medal in the Order of Australia (OAM)

It is good to see recognition of these senior Fellows of our College who have made such a major and sustained contribution, far above the call of duty.

DISASTER RESPONSE IN 2005

Again in 2005 many Australian and New Zealand College of Anaesthetists (ANZCA) Fellows volunteered their valuable time and critical expertise to victims of natural disasters and war.

Key destinations included Iraq and areas ravaged by natural disasters - Banda Aceh, Indonesia (the 26 December 2004 tsunami), Bali, Indonesia (the October 2005 Jimbaran Bay bombings) and Pakistan (the October/November 2005 earthquake and its aftershocks).

ANZCA Fellows - Anaesthetists and Intensive Care specialists - are the essential core of every disaster medical team. Their unique skills in the medical management of victims range from acute on-site resuscitation and safe patient transport to hospitals through to the intensive care and recovery phases.

In the year in review ANZCA responded to the growing need for disaster medicine by creating the ANZCA Australian Disaster Response Taskforce. Comprised of 13 ANZCA Fellows from throughout Australia, its members are all anaesthetists with experience in military and/or disaster zone anaesthesia, ICU and retrieval work.

Typical 2005 Disaster Response Challenges

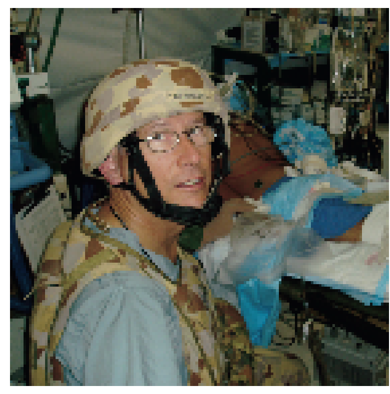
Delivering medical services in disaster situations holds many challenges, as the following quotes from ANZCA Fellows describe. To begin with, logistics are difficult, as disasters usually occur without warning, and often in remote places.

ANZCA's Wing Commander David Scott (Lismore Base Hospital, NSW) began emailing colleagues to identify volunteers on 26 December 2004, as soon as he heard about the Asian tsunami. By December 28 two of the ANZCA volunteers, Dr Allan MacKillop (Tweed Hospital, NSW) and Group Captain Bill Griggs (Royal Adelaide Hospital) arrived in Banda Aceh to help establish RAAF aero-medical evacuation services (AME).

On December 29 Dr Scott and a multidisciplinary team including ANZCA's Brigadier Brian Pezzutti (Lismore Hospital), Commander Paul Luckin (Redcliffe, Queensland) and Lieutenant Commander Paul Dunkin (St Vincents Hospital, Sydney) - all reservists working as civilians - flew from Brisbane via Darwin to Jakarta where they stayed overnight before flying to Banda Aceh.

It took far longer for Australian medical help to reach the Pakistan earthquake zone in December 2005. ANZCA's Squadron Leader Haydn Perndt (Royal Hobart Hospital) recalls it took a week to organize the Australians' trip as "Christmas and New Year complicated the logistics". A whole day was needed for the team to travel from Melbourne to Islamabad before the 150 km four-hour drive to Muzafferabad in the mountains.

ANZCA's Squadron Leader Dianne Stephens (Royal Darwin Hospital) heard about the Jimbaran Bay Bali, bombings at 11pm on Saturday October 1, two hours after the event. At 11am on Sunday she attended her hospital's first 'command and control meeting', part of



'2005 was a landmark year in terms of the College's involvement in emergency situations at home and abroad. The continuing commitment and sense of service amongst Fellows prompted us to consolidate our collective experience into a new ANZCA Australian Disaster Response Taskforce to ensure our immediate and co-ordinated response to future crises.'

Professor Michael Cousins

Disaster Response Taskforce Chairman, Group Captain George Merridew in Iraq

RDH's successful and still evolving disaster plan. At 2 pm she attended a RAAF briefing. By 7pm - with one of two RAAF AME teams and equipment from Sydney - she was aboard a Hercules on its 3.5 hour flight to Denpasar from Darwin.

On arrival at disaster areas anaesthetists often have to unload equipment as well as immediately treat the wounded. Dr Scott recalls how, on arriving at Banda Aceh, they spent a couple of hours unloading 17 tonnes of stores and then helping load displaced locals into the plane. After a meal of army rations they "fell, hot and exhausted onto our camp stretchers" in tents next to the airport for a few hours' sleep, before being trucked to the Fakinah Private Hospital. At the hospital, "deserted following the quake," they again unloaded their stores and "lugged them upstairs".

Hospitals in disaster areas are often short of equipment. Dr Scott arrived with Dr Luckin at the Kesdam TDI Military Hospital in Banda Aceh on January 1, 2005. "We set up the operating theatre with two tables in the same room MASH-style ... with no suction, air-conditioning, intermittent electricity, basic anaesthesia machines, one oxygen cylinder and oxygen concentrator". Despite this, and "our surgeons" having only basic equipment and no diathermy, "all the surgery was life-saving", and mostly successful.

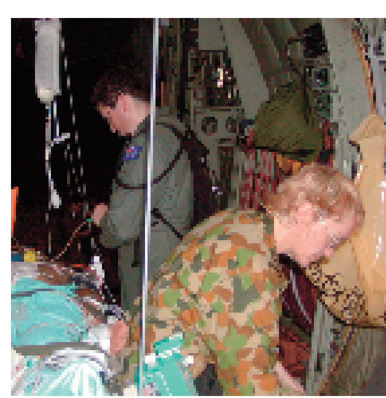
Recalling work at the US military hospital in Balad, 50 miles north of Baghdad in Iraq, in August and September 2005, ANZCA's Squadron Leader Bruce Paix (Flinders Medical Centre, South Australia) described conditions as "surreal, with a constant kaleidoscope of MASH-style loudspeakers, helicopter rotors and 'incoming' alarms."

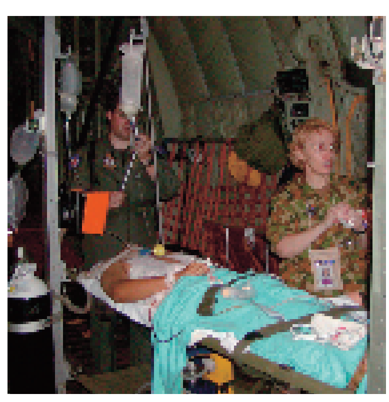
In the completely new 70-bed Abbas hospital in Muzafferabad, Pakistan - commissioned because the major local hospital had been destroyed by the quake - Dr Perndt and his team had to meet the needs of several hundred people. He recalls how "it had essential equipment including a CT scanner" but, being new, had no organisational routine. Further, "most of the local medical staff had lost family, friends and colleagues in the disaster ...so much personal tragedy!"

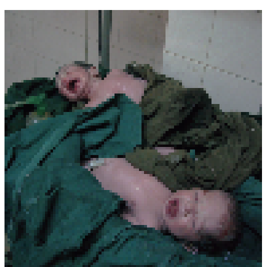
Dr Perndt's Australian team - himself, a surgeon and two nurses - shared the emergency 'On Call' with Cuban surgeons and their anaesthetists. "We were very busy from the start," he says. "Most the work was emergency life saving surgery. About a third of the cases were obstetrics. Anaesthetic challenges included an Isoflurane vaporiser filled with Sevoflurane, a single laryngoscope borrowed between theatres, drug ampoules of indeterminate content, a lack of water in the theatres for three days and the intense cold."

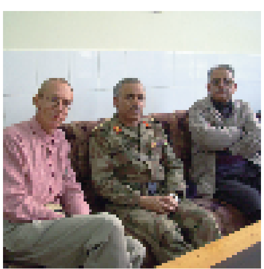
As well as the heavy work, the number and horrific nature of many injuries are another challenge. In Jakarta on his way to Banda Aceh, Dr Scott encountered Dr MacKillop. "He had just returned from Banda Aceh and I will never forget the haunted look on his face," Dr Scott recalls. Dr Scott's own memory of Banda Aceh was that" the heat, humidity, stench from rotting flesh and grossly infected wounds and the horrific nature of the injuries made working there very difficult."

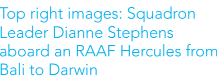
Working at Balad in Iraq in November and December 2005, Dr Pezzutti said the hospital's three theatres frequently had "two tables going at once". "How often in Australia would you see in one afternoon the arrival of six patients with burns ranging from 35 percent to 95 per cent? How many could provide a place in the ICU to ventilate six in a room as hot as 42











Top right images: Squadron Leader Dianne Stephens aboard an RAAF Hercules from Bali to Darwin

Left column images: Urgent supplies reach Banda Aceh; Pakistani twins born during the earthquake; Cementing relationships – Squadron Leader Haydn Perndt with Pakistani officials

Right column images: Pakistan earthquake victims; Squadron Leader Bruce Paix in Iraq; Brigadier Brian Pezzutti in Iraq (right) with young patient and father

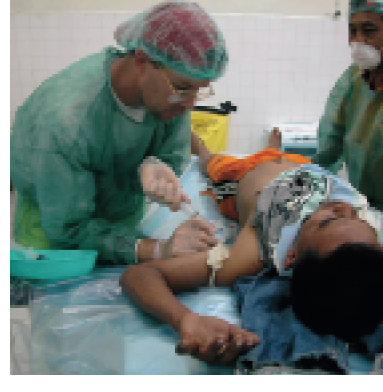
degrees centigrade? How many could provide six operating theatres and the skilled staff to manage the escarotomies as required and prepare patients for very long journeys and have them all arrive in a fair clinical state? All this and continue to take other high need trauma patients!"

Dr Stephens says of her work at Denpasar's Sanglah Hospital that of the 15 Newcastle patients evacuated to the RDH, six ended up at RDH's ICU" with blast injuries reminiscent of what I had seen all too often in my three months in Iraq" earlier that year.

She says that, while there were no burns as the blasts occurred in the open, there were eye, lung, abdominal and multiple soft tissue injuries. "These patients required 52 hours of surgery in the first two days, including surgery for cardiac tamponade, tracheostomy for airway compromise and removal of shrapnel," she said.

Language was another challenge. In Banda Aceh at one stage, Dr Scott purloined a *New York Times* reporter's interpreter. But, despite the hardships, the ANZCA Fellows found the work rewarding. Dr Pezzutti says of his Balad, Iraq, experience that "the striving for excellence was palpable and the patients ever grateful" and that it was a "very exhilarating but tiring and emotionally draining experience."

Recalling Pakistan, Dr Perndt "felt privileged to have been able to help, even though it seemed to be such small assistance as to be almost inconsequential." He also said that the emotional support of professional colleagues in such situations "cannot be underestimated". The fact that unpaid Australian medical volunteer doctors were there, funded by the Australian Government through an Australian Muslim NGO "had a significant impact on our Pakistani colleagues, contacts and hosts."



Above left: Wing Commander David Scott at work in Banda Aceh

Above right: Responding to the crisis in Banda Aceh; a rare pause for the team

Dr Scott found his Banda Aceh patients "overjoyed" when they realised they were not to be billed for their medical care. He believes being there "helped build bridges between Australia and Indonesia." So would he return? "Yes."

Sadly noting that "as interventionists we now need to be expert in the planning of the response to terrorist attacks as well as natural disasters," Dr Stephens says the key is to have efficient and effective systems in place – one of the reasons ANZCA created its Disaster Response taskforce.

YEAR AHEAD

ANZCA's Australian Disaster Response Taskforce

In September 2005 ANZCA Council decided to create the ANZCA Australian Disaster Response Taskforce to develop the most effective disaster response capability.

The Taskforce is chaired by Group Captain George Merridew (Launceston General Hospital) who has had numerous military deployments and is a previous chairman of the Australian Defence Force's Anaesthesia Consultative Group (ADF AnCG). The Taskforce's deputy chair is Wing Commander David Scott (Lismore Base Hospital, NSW) who has also worked in many disaster situations and currently chairs the ADF AnCG.

The Taskforce aims include to:

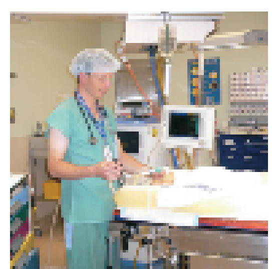
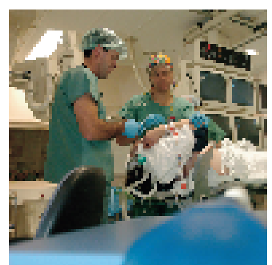
- create a disaster response database of available ANZCA Fellows,
- specify field anaesthetic apparatus and
- provide disaster-related organisational advice to key government groups.

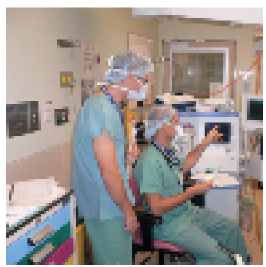
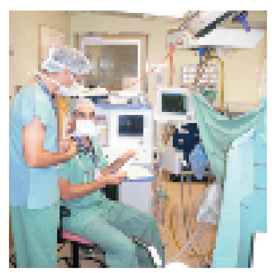
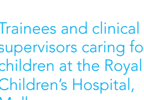
The Taskforce has input from Australian military personnel, non-government aid organisations such as Médecins Sans Frontières (MSF) and the International Committee of the Red Cross (ICRC), and civilian retrieval specialists such as CareFlight.

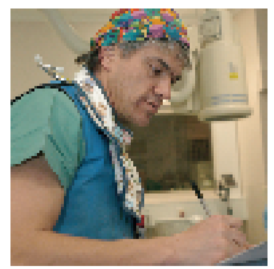
The other Taskforce members, who all share experience in disaster medicine, most of it abroad, are: Kevin Baker (Liverpool Hospital, NSW; ICRC and MSF), Roger Capps (Royal Adelaide Hospital; ADF), Ken Harrison (Westmead Hospital, Sydney; Careflight), Bernard Hanrahan (Liverpool Hospital; Careflight and ADF,) Allan MacKillop (Tweed Hospital, NSW; Careflight and ADF) Geoff Mullins (Princess Margaret Hospital, Perth), Blair Munford (Liverpool Hospital, Sydney; CareFlight; Chair of the ANZCA SIG for Critical Care in Unusual and Transport Environments), William O'Regan (Liverpool Hospital; ADF), Brian Pezzutti (Lismore Base Hospital; ADF), Dianne Stephens (Royal Darwin Hospital; ADF), and Peter Tralaggan (Prince of Wales Hospital, NSW; ADF).

TRAINEE TEACHING AT THE ROYAL CHILDREN'S HOSPITAL

Sub-specialty experience is an integral part of the ANZCA training program




Trainees and clinical supervisors caring for children at the Royal Children's Hospital, Melbourne



During the third year of their specialist training, many anaesthesia trainees spend either four or six months at the Royal Children's Hospital, Melbourne. With 20,000 anaesthetics being administered each year, there are many opportunities for trainees to gain expertise in caring for children and families.

Patients range from tiny premature infants weighing less than 1000g to large adolescents, undergoing a huge variety of surgical and investigative procedures. Anaesthesia and monitoring equipment needs to be adaptable to the range of ages and sizes, and particular attention must be paid to maintaining body temperature and fluid requirements, especially in the very young and the very sick.

The Royal Children's Hospital is accredited for anaesthesia training as well as for training in intensive care, and pain medicine. Currently there are 13 anaesthesia trainees, with a further one to be appointed shortly. Apart from two overseas Fellows in training, all are accredited trainees with ANZCA or recently graduated FANZCAs. A recent report indicates that a further seven trainees are needed to fulfill the required service commitments, however further funding from government is necessary before appointments can be made. Once funded, all additional trainees would be accommodated by the ANZCA training program, as the College has no limitation on the numbers of accredited trainees.

CEO's REPORT

DR MIKE RICHARDS
CHIEF EXECUTIVE OFFICER

This is my first Report as chief executive officer of ANZCA since joining the College in mid-November 2005. My appointment followed the resignation through ill-health of Mrs Joan Sheales, who had been administrative officer of the Faculty of Anaesthetists, then Registrar and finally CEO of the College for the past 25 years. Joan's untimely death in January 2006 brought the end of an era. Her dedicated service to ANZCA and significant achievements in advancing the standing of the College and the profession will be her lasting legacy.

The internal challenges – streamlining administration

A key early priority for me has been streamlining the administration of the College, which supports the work of the many activities of ANZCA. Late in 2005 I commissioned an effectiveness review of our administration. The consultants were asked to examine:

- The current organisation structure of the College and its interfaces with the Council, management and regional offices;
- Key administrative and operating systems, especially IT systems, to assess their effectiveness and skill requirements, and to maximize their efficient use;
- Operating expenditure levels and efficiency;
- Key resource issues and priorities, and any existing capability deficits; and
- Budget, financial management and management reporting issues.

The key findings of the Report—which were circulated to Council and staff for comment—relate to organisation structure, management, processes and systems issues. The recommendations relating to organisation structure issues are intended to address deficiencies with the current structure including:

- The split of education and quality assurance activities (the core activities of the College) distributed between the Education Unit and Professional Areas Unit, and resulting in diffused focus and unclear responsibilities;
- The existence of capability gaps in some areas of the College, particularly in IT, organisation development, and communications (both internal—with staff, Fellows and trainees—and external stakeholders, including government at all levels in Australia and New Zealand, and the media); and
- The very broad span of control of the Chief Executive Officer, with some reports of an operational nature requiring the CEO to become involved in the detail of daily operations.

As a consequence of these findings, I propose the following steps to streamline our administration:

- Establishing a new Education & Training Unit by combining the Education unit with the education and training functions of the current Professional Areas Unit.
- Establishing a Quality and Accreditation Unit to group these functions from the current Professional Areas unit, together with the new position of Administrative Officer-Quality and Safety.
- Creating an Office of the CEO comprising staff responsible for organisation development, and communications.
- Creating an additional position of Director of Professional Affairs to strengthen the advice going to the CEO and the Council on the many professional and jurisdictional issues facing the College.
- Changing the reporting lines for the Library and Museum from the CEO to the Executive Officer, Corporate, to form a knowledge resources group that also includes Archives.
- Creating a new position of Manager, Information Technology while eliminating the currently vacant position of Administrative Assistant–IT.

Other recommendations of the Review address a wide range of management, process and systems issues, including:

- The need for Council to consider developing a strategic plan that can be used by management to prioritise and direct activities undertaken by the College.

- The development of management skills and practices through management training, improved internal communications, continued adherence to the new performance appraisal framework, better work scheduling, and putting in place a career and succession planning framework.
- Addressing deficiencies in the clarity and frequency of management reporting.
- Adopting a new approach to budget formulation by linking budget development and accountability for achieving budget results in the roles of Unit managers.
- Requiring all proposals for major new initiatives to be supported by a business case.
- Clarifying the roles and responsibilities of managers within the changed organisation structure.

In addition to recommendations on management processes, the consultants have also developed a number of recommendations relating to operational systems, processes and procedures. One characteristic feature of the College is its heavy reliance on manual processes. Despite technological advances and the growth in online functionality and usage, the College remains very much a paper-based organisation. This generates a great deal of manual work for staff, many of whom are aware of the inefficiencies of the current processes and feel frustrated by them. Solutions to this issue generally affect both processes and systems. The Report's main recommendations in this regard include:

- The streamlining of processes, making as much use as possible of available information technology and communications systems to facilitate College interactions with Fellows, Trainees and other key stakeholders.
- Implementing new, standardised, streamlined processes across the College (including the regional offices) wherever possible, with clear documentation of each process easily accessible by all staff.
- Changes to the College's IT systems, designed and phased within an overall strategic development framework.
- Updating the functionality of the College's websites to support relevant process improvement initiatives, including allowing the staff responsible for each area to make changes to that content directly.

The main aim of the Review was to strategically position the College to be better able to respond to the administrative demands placed upon it in a rapidly changing external landscape of increased requirements for anaesthetists' services, greater public accountability and increased service expectations. The College administration serves to support the College and its Trainees in all the educational, training, and professional development activities in which they are engaged. The proposed organisational, process and systems changes will ensure an efficient and effective organisation with the resources, process improvements and systems needed to meet the College's core goals of providing training, setting professional standards and promoting the practice of anaesthesia, intensive care medicine and pain medicine in Australia and New Zealand.

I expect that these administrative changes will be progressively implemented through 2006. (The proposed functional organisation chart is shown on page 31.)

The external challenges – workforce issues

One of the key challenges facing governments at the national and state level (and their agencies) is dealing with the workforce issues that result in the maldistribution of specialist medical services in Australia and New Zealand. Whilst governments have an obligation and an interest in the provision of a safe and a readily accessible medical workforce, they find themselves in a position of increased pressure between the supply and the quality of that workforce. Whilst they strive to maintain standards and therefore manage risk as effectively as possible, they are sometimes swayed into making trade-off decisions between quality standards and service. Increasingly, governments are looking to provide a doctor of perhaps a lesser standard, often to work in an isolated area of high service requirement—with little, if any, support, and with little scope of further educational opportunities—in order to provide a solution to a workforce shortage.

There is little doubt that there is unmet community need in many medical specialities, including anaesthesia, but it turns less on numbers of specialists than their distribution through the population, particularly in rural and remote areas. The College has been responsive to this issue, and while the Australian Medical Workforce Advisory Committee set a target

of 128 for 2011, (Australia only) the College actually graduated 233 Fellows in 2005, of whom 196 were from Australia. In fact, between 2000 and 2005, the number of anaesthetists annually admitted to Fellowship effectively doubled, rising from 95 to 196 (Australia only). In addition, in 2005, there were 28 Fellows approved via the Overseas Trained Specialist pathway.

A further continuing issue is the requirement by governments for more and more data from the Colleges. In the context of the government's provision of a suitable medical workforce and presumably as a measure of addressing the current imbalance between the quality and supply of a medical workforce, information and explanation of College processes is increasingly being sought by a complex mix of government bodies on its training and assessment processes and, particularly, on the assessment of overseas trained anaesthetists.

Examples of recent Australian government initiatives that have sought College input are the ACCC College reviews and the Productivity Commission Review of Health Workforce. It seems that the Australian government is particularly interested in the College's adaptability to the changing workforce environment in its training and assessment of its own trainees (for example, seeking a better alignment of medical specialist training curricula with an expanded range of training settings), and of overseas trained anaesthetists (for example, the recent agreement with the Commonwealth to fund a Rapid Assessment Unit for overseas trained specialists within this and several other specialist medical Colleges). The government seeks rapid training and assessment that is cost effective and delivers a high quality medical workforce in areas where it is required.

There are government-developed provisions in Australia for the rapid assessment of overseas trained anaesthetists—such as the Area of Need program—as a short-term, interim solution for areas of workforce shortage. However, despite ANZCA's strict adherence to agreed government guidelines for the declaration and administration of the Area of Need process, some jurisdictions have seen fit to ignore those guidelines. The result—as we have seen—has been processes that have caused serious compromises to standards of public health. A glaring example, of course, occurred in Queensland where government's failure to seek the advice of the peak accreditation body, may have made more likely the tragedy of Bundaberg and 'Dr Death'.

While jurisdictions are increasingly dependent upon overseas trained doctors, they are independently developing and applying rules and requirements to the provision of health services by overseas trained doctors, a situation that increases complexity not only for the applicants and the Colleges but also for those at the coal-face in terms of matters such as supervision and recruitment. The College seeks not only to understand and work efficiently within these varied requirements but also to assist in reaching common agreement between jurisdictions for the equitable and transparent assessment of overseas trained doctors.

These issues are likely to provide the specialist medical sector with continuing challenges going forward, and we are putting a major effort into ensuring that ANZCA's commitment to quality standards—while acknowledging and responding to the legitimate requirements of governments to provide appropriate levels of community service—is well understood and accepted among jurisdictional decision-makers.

Resources

The continued financial good health of the College is highlighted in the Treasurer's report. The success of the Council and management in maintaining a secure financial base has allowed a modest increase in our staff resources to meet the capability gaps identified in the Effectiveness Review. I expect that there will be an additional four staff—including a further Director of Professional Affairs—join the organisation in the coming months. (The highlights of the revenue and expenditure of the College are shown in the chart overleaf.)

Finally, I would like to thank all staff for their hard work and commitment during 2005. This was a difficult year in many ways, and staff have responded well to the additional demands on their work, as well as coping with the loss of a much loved CEO in Joan Sheales. An intensive period of review and restructure has also required staff to make significant adjustments to their work processes. I am pleased to say that they have responded positively and enthusiastically to the changes, and to the many challenges we face ahead.

ANZCA ANNUAL REPORT 2005

ACCREDITATION

Hospitals and Training Programs

ANZCA accredits Hospital Departments and other organisations which comply with its requirements for recognition. Accredited Departments and organisations must be associated with other accredited Departments in a rotational training scheme of two or more hospitals, so that the required amount of sub-specialty training can be provided to trainees. There must be the opportunity for experience in a rural centre. A grouping of hospitals providing such a program of specialty and subspecialty training constitutes a training program.

In 2005 the Hospital Accreditation Committee reviewed and approved accreditation procedures and documentation, and instituted training for its visitors.

In 2005, a total of 52 hospitals were inspected in Australia, New Zealand, Singapore and Malaysia.

New hospitals accredited for training were:

- Casey Hospital (Vic)
- Peter MacCallum Cancer Centre (Vic)

EDUCATION AND TRAINING

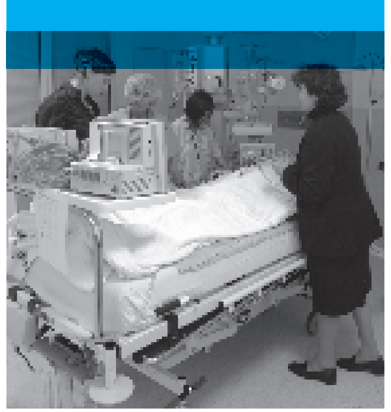
A number of issues regarding the roll-out of the modular training system introduced in 2004 were raised by the Trainee Committee and discussed at the Education and Training Committee. Council agreed to the following changes:

- Module 3 'Anaesthesia for Major and Trauma Surgery' cannot be commenced until Module 1 "Introduction to Anaesthesia and Pain Management" has been running for six months and the structured assessment to move beyond Level 1 supervision has been successfully completed.
- That the requirements to complete "at least five of Modules 4-10 by the date of the written examination" of the Final examination be removed.
- That the College monitors the completion rates for the modules, with the possibility of modifying the minimum required clinical experience, to be reviewed by mid-2006.
- That trainees must have completed all the requirements for any of the clinical modules 3-10 no longer than 10 years from the date of completing all the other requirements for the awarding of Fellowship.
- Following a survey of trainees and supervisors regarding the In-Training Assessment, there was agreement that the overall aims of the formative process were being met. The need for a summative process is being explored.
- Concern has been expressed that abolition of posts, and a consequent perceived increase in trainee numbers, may exacerbate bottlenecks in paediatric, cardiac and neuroanaesthesia training. The College is monitoring this situation.

The Clinical Teaching Course is now being delivered to Supervisors, and to Fellows and senior trainees interested in trainee education. There are four modules:

- Assessment in the Workplace
- How to teach effectively in small groups
- Assisting the trainee with difficulties
- Teaching in the operating theatre

The annual supervisors' workshop held at the 2005 Annual Scientific Meeting was on the In-Training Assessment.



TRAINING AND ASSESSMENT

Trainees are selected in a process which complies with College guidelines, based on the Medical Training Review Panel Report 'Trainee Selection in Australian Medical Colleges, 1998' (Brennan).

After 24 months general hospital experience, training can begin at the date of commencement of supervised training within an Approved Hospital Department. The five-year training program is divided into Basic (24 months) and Advanced Training (36 months) with structured progression through a series of learning experiences organised into 12 Modules. These include major anaesthesia subspecialty areas, pain medicine, intensive care, professional attributes and practice, and a Formal Project which advances skills in scientific enquiry.

Trainee aims, learning objectives, required knowledge, skills, attitudes and behaviours, and assessments for each Module are outlined in the document 'ANZCA Curriculum Modules for the Diploma of Fellowship of the Australian and New Zealand College of Anaesthetists'.

Assessment is by means of:

- Regular formative in-training assessment
- Satisfactory completion of Modules
- The Primary Examination (see 'Syllabus for Examination in the Basic Sciences in Anaesthesia and Intensive Care')
- The Final Examination which assesses the theory and practice of clinical anaesthesia, intensive care medicine and pain medicine, and relevant aspects of clinical medicine
- Completion of either the Early Management of Severe Trauma (EMST) or the Effective Management of Anaesthetic Crises (EMAC) course.

The College supports part-time and interrupted training, and recognises prior experience in anaesthesia-related disciplines.

Trainee Numbers

At the end of 2005, the following number of financial Trainees was registered with the College:

Australia	883
New Zealand	187
Hong Kong	84
Singapore	58
Malaysia	18
Overseas	20
	1050

More detailed figures are provided annually to the Medical Training Review Panel. In the Ninth Report (November 2005), ANZCA reported that there were a total of 795 registered financial trainees in Australia, of whom 64% were male, 36% female.

TRAINEES' COMMITTEE

The ANZCA Trainee Committee consists of the chairs of the ANZCA Regional Trainee Committees. The Committee met three times during the year via teleconference. It was chaired by Annabel Orr (Vic), who brought valuable continuity to the committee, having been on the committee the previous year. The other members were Corinne Bennett-Law (NZ), Angela Ralph (Tas), David Duke (NSW), Ben Lloyd (Qld), Andrew Beinssen (SA), Alan Millard (WA), Wanling Leong (Singapore), Rafidah Atan (Malaysia), and Assad Hussain (Hong Kong). Leona Wilson, Chair of the Education and Training Committee, was an ex-officio member and provided a valuable sounding board for trainee discussions.

The Committee felt its primary roles were as a platform to have trainee concerns expressed in a formal and collective way to the College, and as a representative group that the College could consult to gauge trainee opinion. In this regard the most significant ongoing issue was undoubtedly that of the Revised FANZCA Program.

The regional representatives reported widespread concern from trainees that the goalposts had been shifted after they had commenced training. Of particular concern was access to subspecialty training in order to complete modules, specifically paediatric, cardiac and neuroanaesthesia. In some cases registrars were unable to sit final examinations as they had not completed a sufficient number of modules. The Committee felt that Leona Wilson had taken on-board the concerns it expressed and it was able to report back to trainees in each state the feedback on these issues.

Other issues discussed included:

- the status of rural training rotations (being compulsory or not);
- trainee involvement in the hospital accreditation process;
- a proposal for a compulsory provisional fellow year after completing the final examination and all modules;
- a survey of trainee experiences conducted by the College
- a proposal for College regulations to recognize that oversupervision of senior trainees is an issue in some institutions; and
- reasons for the low traffic on the College-run trainee "e-Communities"website.

In all, the Committee felt it had provided an important link in communication between trainees in each region and the College Education and Training Committee. May that liaison continue and enrich in 2006.

EXAMINATIONS

The examinations co-ordinated by the General Examinations Committee (GEC) are the ANZCA Primary Examination, the ANZCA Final Examination, the Overseas Trained Specialist Performance Assessment and the Examination for the Certificate in Diving and Hyperbaric Medicine.

The courts of Examiners, the Final Examination Committee (FEC) and the Primary Examination Committee (PEC) report to Council via the GEC. A/Professor David Cottee and Dr Noel Roberts chaired the PEC in 2005. Dr Michele Joseph was the Chair of the FEC in 2005.

ANZCA Primary Examination

Two Primary Examinations were held in 2005 as follows:

March/April 2005
One hundred and sixty two candidates presented for the Pharmacology section and of those 123 were approved. One hundred and forty five candidates presented for the Physiology section and of those 110 were approved. In total 119 candidates satisfied the requirements of the Primary Examination.

The Renton Prize for the half year ended 30th June 2005 was awarded to Drs Daniel J Faulke (NZ), Pedro Diaz (SA) and Luke E Torre (WA).

Merit Certificates were awarded to Drs Benjamin G Freeman (VIC), Ivan Ward (SA), Justin A Burke (VIC), Gabriel L Snyder (VIC), Kong Hang Sze Amy (HKG), Warrick A G Wrightson (NZ), Andrew K Lansdown (NSW) and Mark A Fairley (QLD).

July/August 2005
One hundred and ninety six candidates presented for the Pharmacology section and of those 133 were approved. Two hundred and seven candidates presented for the Physiology section and of those 158 were approved. In total 143 candidates satisfied the requirements of the Primary Examination.

The Renton Prize for the half-year ended 31st December 2005 was awarded to Dr Shannon J Matzelle (WA).

The following candidates were awarded Merit Certificates:

Dr Elspeth L Alfredson (NSW)
Dr Nathan J Kershaw (NZ)
Dr Cambell G Bennett (NZ)
Dr Kay-Lip Khoo (NZ)
Dr Matthew D J Chacko (NZ)
Dr Christopher H Mitchell (WA)
Dr Chin-Wern Chan (WA)
Dr Louise M Munro (QLD)
Dr John J P Dally (SA)
Dr Angela J Palumbo (WA)
Dr Paul G Davies (QLD)
Dr Andrew A Udy (NZ)
Dr Yi-Feng Cindy Ding (QLD)
Dr Peik Fei Yau (VIC)
Dr Jack Shao-Cheng Huang (QLD)
Dr Benjamin M Zugai (QLD)

ANZCA Final Fellowship Examination

Two Final Fellowship Examinations were held in 2005 as follows:

May 2005
One hundred and fifteen candidates presented for the examination and 93 were approved.

The Cecil Gray Prize for the half year ended 30 June 2005 was awarded to Drs Amber Chisholm (NZ) and Peter Chong (NSW).

Merit Certificates were awarded to Drs James King (NZ), Kar Soon Lim (NSW), Simon Patullo (NSW) and Nicholas Barrett (NSW).

September 2005
One hundred and twelve candidates presented for the examination and 100 were approved.

The Cecil Gray Prize for the half year ended 31st December 2005 was awarded to Dr Victoria Eley (QLD).

Merit Certificates were awarded to Drs. Stephen Berrill (NZ), Tamara Culnane (WA), Bojidar Manasiev (NSW) and Manu Narayanaswamy (NSW).

The total number of candidates who passed the Final Fellowship Examination in 2005 was 193.

Overseas Trained Specialist Performance Assessment

Two assessments were held in 2005.

May 2005
Twenty eight candidates presented for assessment and eleven were approved.

The OTS Certificate of Excellent Performance was awarded to Dr Indu Kapoor (NZ).

September 2005
Thirty three candidates presented for assessment and 17 were approved.

The OTS Certificate of Excellent Performance was awarded to Dr Katherine Hames (QLD).

The total number of candidates who passed the OTS Performance Assessment in 2005 was 28.

Certificate in Diving and Hyperbaric Medicine

October 2005
Two candidates presented for the certificate examination and both were approved.

MAINTENANCE OF PROFESSIONAL STANDARDS

The Maintenance of Professional Standards Program (MOPS) aims to foster continuing scholarship of Fellows after graduation in order to maintain a high standard of clinical practice.

The Program validates continuing medical education, quality assurance, and other self-improvement educational activities.

The Program is voluntary, but participation is being increasingly mandated by regulatory authorities and hospital clinical privileging bodies. A return is required to be submitted annually so that a Certificate of Participation can be issued. Random audits of participation are conducted each year.

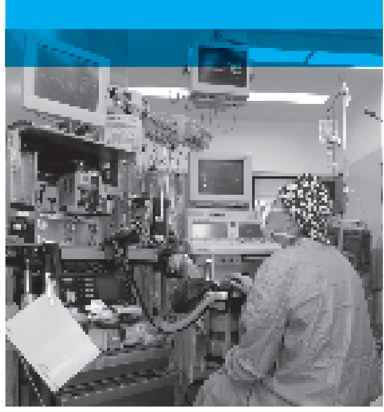
A review of the MOPS Program will be completed in 2006.

The Audit Report of 2004 returns is set out below:

The participation rate in MOPS among the Fellows over the past 12 months has increased to 50% (cf 45% in 2003). New Zealand stands out at 81%. South Australia and Western Australia who have traditionally had low participation rates both increased in 2004. South Australia increased from 32% in 2003 to 38%. Western Australia increased from 25% to 31% in 2004. Of those returns submitted 91% met all criteria.

The number of non-fellows continues to increase with 130 participants in 2004. Sixty percent of these are from New Zealand.

1 Forty participants were randomly selected for auditing. One participant had been selected the previous year and had been given provisional approval pending receipt of further documentation which was supplied after the



participants had been selected. This participant then became exempt from audit in 2004. Thirty seven returned the documentation supporting their 2004 Annual Returns. Returns from the other two are still expected. The participants audited came from NSW (9), NZ (13), QLD (6), SA (3), TAS (1) and VIC (7). Of those selected the average number of CME/TTR points was 189 and the average number of QA points was 63.

2 The members of the CE & QA committee who are also Councillors performed the audit.

3 The returns were audited according to the criteria set out in the programme manual, which are the accuracy of returns and the relevance of activities to the participants practice.

4 Results: (thus far)

- 24 were satisfactory
- 2 were given Provisional Approval. Both were asked to provide further documentary evidence
- 0 returns had significant errors in documentation.

5 The auditors were pleased to see the range of activities that participants had taken part in. It was noted that several participants had under claimed, in that when reviewing the documentation, it was apparent that they could have claimed for more activities to be credited in their return, particularly in the area of Local CME and QA Meetings.

6 Errors noted:

- Evidence of attendance at hospital / practice CME (Code 1.2) and QA meetings (Code 2.2) was variable in quality, with only some practices providing annual attendance certificates.
- Some participants claimed CME and QA activities that they could not provide supporting documentation for.
- A few participants used the incorrect QA Committee Work Code for claiming activities in this area.
- Claiming QA Supervisor of Training points when they were not the designated SOT at the hospital.
- Claiming ANZCA approved Hospital Accreditation Reviews when they were not approved reviewers.
- Providing documentary evidence for activities not listed on the annual return.
- A tendency to provide documentary evidence to satisfy the minimum number of CME and QA points rather than all the activities listed on the annual return.

7 The auditors considered that the activities that the participants recorded were relevant to their practice.

8 Recommendations (many of these are repeated from previous audits):

- The documentation of attendance at local CME and QA meetings should be improved; I would recommend that an attendance register is kept for such meetings, and if possible, annual statements of attendance issued,
- Participants will be reminded of the definitions of local QA meetings, QA committee meetings and major QA meetings, and that there are separate points for participants and presenters / instructors for the activities,
- The same format and timetable should be used for next year. Selected Councillor members of CE & QA will be asked to perform the audit of 40 randomly selected returns,

9 The auditors made a note of any outstanding issues with each participant’s returns, and these were notified to the participant when the material was returned to them.

CONTINUING MEDICAL EDUCATION

ANZCA, JFICM, FPM Annual Scientific Meeting (ASM), Auckland, 7-11 May 2005

The premiere event of the College and Faculties' continuing education calendar was held at the Aotea Centre in Auckland. The Meeting themed 'Improving Outcomes', was convened by Dr Charles Bradfield, with the Scientific Program organised by Dr Brian Anderson. Faculty programs were co-ordinated by Dr Tony Williams (JFICM) and Drs Bob Large and Mike Butler (FPM). The Meeting attracted 534 full registrants, 107 Faculty registrants, 263 exhibitor registrants, and 161 day registrants. The Professional Conference Organiser was The Conference Company.

World-class visitors included Professor David Menon from England (ANZCA Foundation Visitor), Professor Warwick Ngan Kee from Hong Kong (ANZCA Australasian Visitor), Professor Keith Walley from Canada (JFICM Foundation Visitor), Associate Professor Mark Sullivan (FPM Foundation Visitor), and Professor John Murkin (NZ Invited Visitor). In addition, Dr Jacques Creteur from Belgium and Dr Carol Ball from England participated as the ANZICS New Zealand Medical Visitor and Nursing Visitor respectively.

The 2005 Named Lectures were:

The Australasian Visitor's Lecture
Professor Warwick Ngan Kee
Lies, Damn Lies and Obstetric Anaesthesia: searching for evidence in obstetric anaesthesia practice

The Michael Cousins Foundation Lecture
Associate Professor Mark Sullivan
Chest Pain and the Mind

The Ellis Gillespie Lecture
Professor David Menon
Academic Anaesthesia: irrelevant luxury or a valuable resource?

The Mary Burnell Lecture
Professor David Menon
The Impact of Critical Care on Outcome in Head Injury

The Dr Gwen Wilson Memorial Lecture
Dr Anthony Newson – *Aspects of Early NZ Anaesthesia*
Dr Basil Hutchinson – *Bibliographies of Early Anaesthetists in Australia and New Zealand*

The New Zealand Visitor's Lecture
Professor John Murkin
Improving Outcomes

The ANZICS New Zealand Lecture
Dr Jacques Creteur
pCO2 Monitoring to Elevate Tissue Oxygenation

The ANZICS New Zealand Nursing Visitor
Dr Carol Ball
Realising the Potential of the Critical Care Nurse

The 2005 Prize Winners were:

Gilbert Brown Prize: Dr Paul John Wrigley (NSW) - *Spinal mechanism of thermal nociceptive processing*

Formal Project Prize:Dr Ian Duncan McKay (NZ) - *Pharmacokinetic-pharmacodynamic modelling of the hypnotic effect of sevoflurane using the spectral entropy of the electroencephalogram*

The ASM was supported by a large health Care Industry Exhibit, and successful liaison with local, national and overseas media. The social program, organised by Dr Karen Smith, included the College Ceremony held at the Auckland Town Hall, with College Orator, Sir Paul Reeves, GCMG, GCVO, QSO, and presentation of new Fellows of the College and its Faculties.

The ASM was preceded by the annual New Fellows' Conference, held at The Grand Chateau, Tongariro National Park, and the Faculty of Pain Medicine Refresher Course day held at the Aotea Centre prior to the commencement of the ASM.

RESEARCH GRANT AWARDS

The following Research Grants for 2006 were awarded by Council:

FELLOWSHIP GRANT APPLICANT	PROJECT	FUNDING
Dr Jeremy COHEN	Unravelling the metabolic syndrome in critical illness: Role of tissue cortisol and 11-beta hydroxysteroid dehydrogenase	$24,000

RESEARCH GRANTS APPLICANT	PROJECT	FUNDING
A/Prof Michael PAECH	The Australasian survey on obstetric general anaesthesia for caesarean section	$5,585
Dr John WILLIAMSON	Comparing the latest 2000 incidents with the first 2000 to track progress and devise safety strategies for new problems	$35,000
Dr Russell VICKERS	Analysis of dental pulp from extracted teeth to identify dental pain mechanisms	$50,000
A/Prof Kate LESLIE	B-Aware Trial long-term follow-up study	$50,000
Prof Andrew BERSTEN	Prevention of ventilator-induced lung injury: could dynamic factors also play a role?	$50,000
Prof Laurie MATHER	Pharmacological consequences of general anaesthesia on local anaesthetic cardiovascular effect and pharmacokinetics	$50,000
Dr Andrew DAVIDSON	MAC-awake in children	$8,500
A/Prof Carlos SCHEINKESTEL	An analysis of temporally distributed medical and nursing team coordination in the intensive care unit	$16,860
Dr Pam MACINTYRE	Efflux transporter activity in the blood brain barrier in vivo - a method of application to opioids	$45,000
Prof Rinaldo BELLOMO	A study of the nature and mechanisms of tubular injury in experimental septic acute renal failure	$40,860
Prof Rinaldo BELLOMO	A pilot randomized open label pilot study of the efficacy of dexmedetomidine and haloperidol in ventilated patients with ICU-associated agitation and delirium	$9,000
Prof Jeffrey LIPMAN	Pharmacokinetic modeling of various B-lactam antibiotics in critically-ill patients using microdialysis	$30,000
A/Prof Tony QUAIL	The effect of propofol on cardiovascular and respiratory control mechanisms during severe arterial hypoxia in the rabbit	$43,000
Dr Peter MCCALL	"Salvage Use" of recombinant activated factor VII after inadequate haemostatic response to conventional therapy in complex cardiac surgery – a randomised placebo controlled trial	$18,000
Dr Christopher THOMPSON	Anaesthesia auditory alarm design and evaluation recommendation for alarm standards	$22,000
Dr Philip FINCH	Mechanism and treatment for pain evoked by touch in patients with chronic pain after traumatic limb injury	$40,000
Dr Dean COWIE	The IMASH trial: Does intravenous magnesium sulphate improve outcome after aneurismal subarachnoid haemorrhage?	$40,000
Dr Andrew DAVIDSON	The influence of age on Bispectral Index as a predictor of anaesthetic depth in infants and children	$8,500
Prof Stephan SCHUG	Psychological factors that predict patient satisfaction and response to multidisciplinary treatment for chronic pain	$17,000
Dr Peter KRUGER	The biology of HMG CoA Reductase Inhibitors in patients with sepsis	$30,000
A/Prof Johan MYBURGH	A comparison of the effects of noradrenaline and adrenaline in critically ill patients	$20,000

The Harry Daly Research Award was awarded to Dr Rinaldo Bellomo for his project 'A study of the nature and mechanisms of tubular injury in experimental septic acute renal failure'.

The Organon Research Award was awarded to Professor Laurie Mather for his project 'Pharmacological consequences of general anaesthesia on local anaesthetic cardiovascular effect and pharmacokinetics'.

The John Boyd Craig Bursary was awarded to Dr Phillip Finch for his project 'Mechanism and treatment for pain evoked by touch in patients with chronic pain after traumatic limb injury'.

Overseas Trained Specialists

In 2005, the College assessed 49 overseas-trained specialists (OTS) according to the process outlined in the document 'Overseas Trained Specialists – Assessment Process' (available at www.anzca.edu.au). Assessments were made by four member panels which included community representation, and were held in February, March, April, June, July, September, November and December. Criteria assessed included training in comparison with ANZCA, specialist qualification and practice as a specialist, experience as a specialist, and participation in continuing education and quality assurance activities.

Countries of OTS origin included India (18), United Kingdom (8), Germany (7), South Africa (7), Czech Republic (2), Sweden (2) and one each from Croatia, Egypt, Iran, United States, Kuwait, Malta, Pakistan, Philippines, Sri Lanka and China.

Of these applicants, 29 were determined to require a clinical practice assessment period of 12 months plus successful completion of the OTS Performance Assessment, and 14 were determined to require 24 months, plus successful completion of the OTS Performance Assessment. Four applications were rejected, on the basis that the gap between their training and that required for FANZCA was too great for the OTS process. One applicant was able to proceed directly to Election to Fellowship and one was required to undertake the examination only.

Overseas Trained Specialist Performance Assessment

Overseas Trained Specialist Performance Assessments were held in April/May and July/September. At the April/May sitting, 28 candidates presented and, of these, 11 (39%) were successful. Dr Indu Kapoor received the OTS Certificate of Excellence for the April/May OTS Performance Assessment. At the July/September examination, 33 candidates presented and 17 (51%) were successful. Dr Katherine Hames was the winner of the OTS Certificate of Excellence at the conclusion of the July/September examination.

Area of Need Assessments

During 2005, 40 Area of Need (AON) assessments, including applications for extension, were undertaken by the Assistant Assessor, according to the College document 'Anaesthesia Services for Areas of Need in Australia' (available at www.anzca.edu.au). Of the 30 primary applications, 26 commenced in positions, and 11 have commenced the OTS process.

During the year, 12 AON extensions were approved.

WORKFORCE

At the end of 2005 there were 3925 active and retired Fellows of the College.

Of these 3046 (77.6%) were male and 879 (22.4%) female. The geographical distribution was as follows:

2005	FELLOWS	NEW FELLOWS
Australia	2954	196
ACT	*48*	*4*
NSW	*977*	*58*
QLD	*543*	*40*
SA/NT	*303*	*20*
TAS	*80*	*9*
VIC	*730*	*53*
WA	*265*	*12*
New Zealand	458	24
Hong Kong	163	6
Malaysia	51	2
Singapore	57	5
United Kingdom	89	
United States of America	49	
Canada	13	
Other	18	
TOTAL	3925	233

A detailed Workforce Survey was carried out by the Australian Medical Workforce Advisory Committee and published in 2001.

The Report recommended that to meet projected anaesthesia service requirements in Australia for the period 2001 – 2011 of 2.2% per year, the average number of graduates from the Anaesthesia training program should increase to 128 per year.

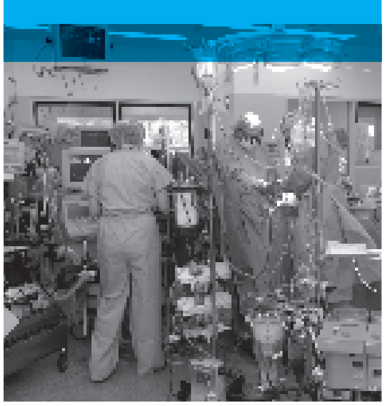
The number of anaesthetists admitted to Fellowship by training and examination in 2005 was 233. There were also 28 Fellows approved via the Overseas Trained Specialist pathway.

At the end of 2004 the ANZCA Workforce Committee undertook a survey of all Fellows of the College on issues relating to their practice.

The results of the survey were published in the December 2005 edition of the Bulletin.

Several statistical reports can also be accessed on the College website at http://www.anzca.edu.au/publications/reports/workforce/index.htm

It is intended to continue to conduct regular surveys in the future, to determine Fellows' ongoing practice profiles, and monitor workforce trends.



ANZCA AWARDS

Orton Medal

The Robert Orton Medal is the highest honour the College can bestow on its Fellows in Anaesthesia. The award is made at the discretion of Council, the sole criterion being distinguished service to Anaesthesia.

The Orton Medal was awarded to Dr Graham Chudleigh Fisk (NSW) (accepted on his behalf by his sons), and Professor John Raymond Archdall Rigg (WA) during the College Ceremony at the 2005 Annual Scientific Meeting.

The award to Dr Fisk recognised his enormous contributions to paediatric anaesthesia and intensive care, in which he was a pioneer. He was an innovator who undertook both clinical and laboratory research to underpin advances in the care of infants and children.

Professor Rigg was recognised for his services to anaesthesia, especially in the introduction of multicentre clinical trials in anaesthesia which were recognised internationally for their rigor and scientific merit.

During 2005, an Orton Medal was awarded to Professor Cindy Aun (HK), Dr Pamela Macintyre (SA) and Professor Garry Phillips (SA). These medals recognise Professor Aun's contributions to training and education in Hong Kong, Dr Macintyre's efforts in the field of Pain Medicine, particularly in relation to the Acute Pain Guidelines, and Professor Phillips's contributions to education and training, particularly in the Asia Pacific, and his outstanding service to the College over a long number of years. They will be presented during the College Ceremony at the 2006 ASM in Adelaide.

ANZCA Council Citation

The ANZCA Council Citation award is made at the discretion of Council in recognition of significant contributions to activities of the College, particularly in education.

Citations were awarded to the following in 2005:

- Dr Rupert McArthur (SA)
- Mrs Lorna Berwick (NZ)

COLLEGE COUNCIL

In accordance with the provisions of the Constitution, nominations were called for three vacancies on Council. Five nominations were received. Kerry Brandis and Kate Leslie were re-elected for a period of three years, along with new Councillor Alan Merry (NZ).

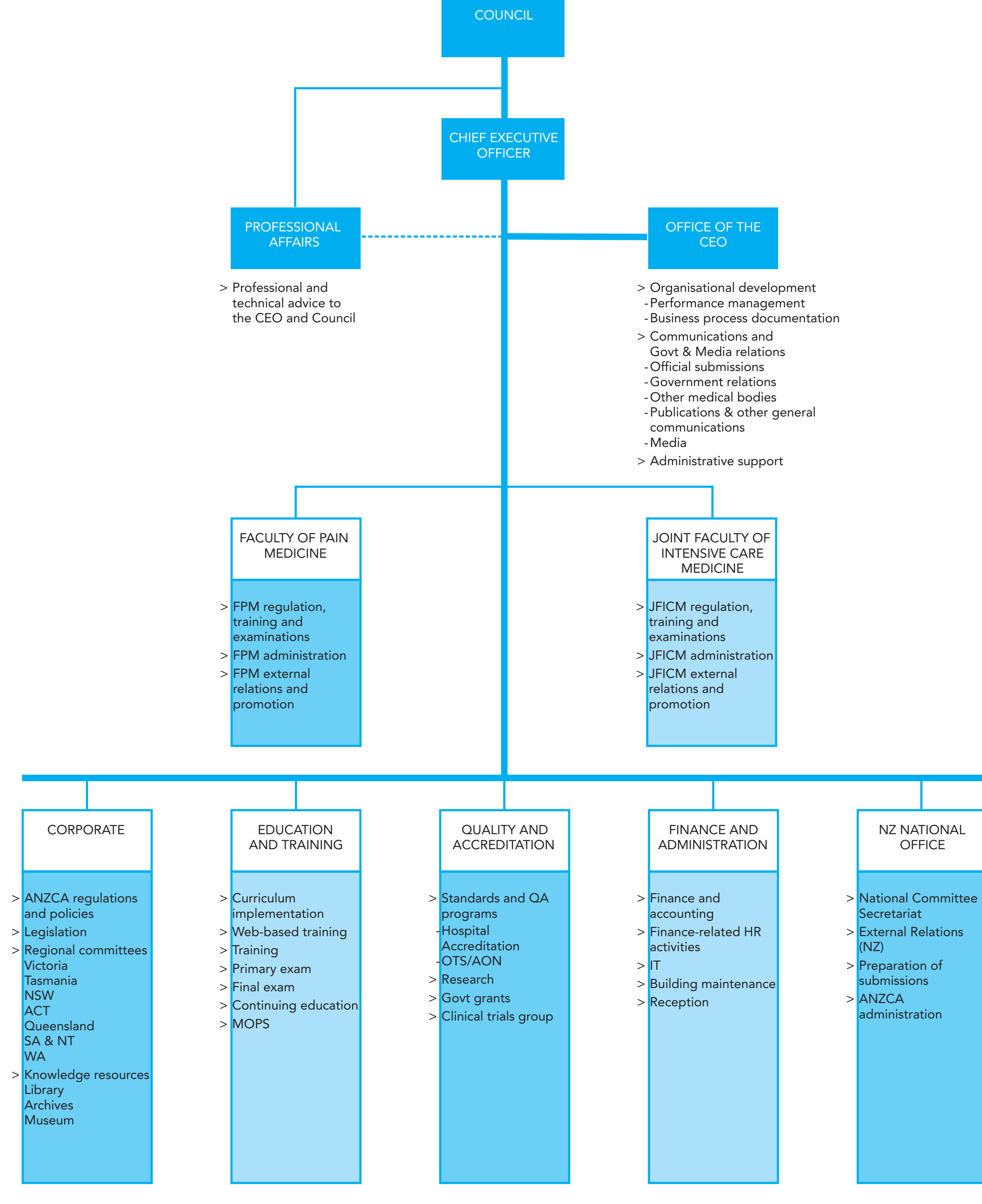
The following is the result of the Ballot:

1	LESLIE, Kate	845
2	BRANDIS, Kerry James	767
3	MERRY, Alan Forbes	720
4	WALDRON, Richard John	481
5	GATT, Stephen Paul	421

Following the resignation of Neil Maycock in June 2005, Frank Moloney was elected by Council to fill the resulting casual vacancy.

In accordance with Clause 10 (b) (i) of the Constitution, Richard Waldron was co-opted to represent Tasmania.

ORGANISATIONAL CHART



DEAN'S REPORT
JOINT FACULTY OF INTENSIVE CARE MEDICINE

2005 was a very busy and satisfying year for the Joint Faculty. Many new challenges were met as numbers of Fellows and Trainees continued to grow. JFICM now has 517 Fellows and 337 active trainees. In 2005, Fellowship was awarded to 33 candidates.

Dr Jack Havill, Dean of the Joint Faculty of Intensive Care Medicine

Education and Training

The highlights of progress included:

- New courses and workshop forums were held for:
  - training of examiners,
  - a Supervisors Workshop for assisting trainees with difficulties
  - a one day workshop on the new format of the Examination for trainees.
- The agreement to elect a 'New Fellow' to the JFICM Board.
- Ongoing definition of a curriculum for trainees which links assessment to training.
- With greater numbers of Trainees sitting the Examination, some significant changes were made to the format. These included the requirement for candidates to pass the Written Examination in order to present for the Oral Sections. The format was changed, with essays replacing Short Answer Questions, and the Clinical section was revised.
- Fellowship examination: At the first examination in April/May 2005, 34 candidates presented, and 19 were approved. At the second examination in August/September 2005, 43 candidates presented and 12 were approved. At the paediatric examination in August/September 2005, two candidates presented and one was successful.
- Development of an Intensive Care Primary Examination to be held in 2007. Trainees will still be able to utilize the ANZCA and RACP Examinations and other accepted Primary Examinations to access dual certification, and complete basic training as a pathway to advanced training in intensive care.
- Criteria for accreditation of Units for Basic Training were developed.

Hospital Accreditation

In 2005 seven Hospitals were accredited. Wesley Hospital (QLD) was newly accredited.

Professional

Following agreement with the Australasian Academy of Critical Care Medicine, our Journal "Critical Care and Resuscitation" was recently indexed by the National Library of Medicine.

A focus on Rural Intensive Care resulted in a conjoint committee being established with ANZICS which aims to investigate ways of attracting intensivists to rural practice.

In reviewing its policies, the JFICM promulgated the following professional documents:

- 'Intensive Care Specialist Practice in Hospitals Accredited for Training in Intensive Care Medicine' (formerly 'Duties of an Intensive Care Specialist').
- 'Guidelines for the Relationship between Fellows, Trainees, and the Healthcare Industry'.

Meanwhile, on broader fronts, the Joint Faculty provided input to the European Society of Intensive Care Medicine (ESICM) curriculum and established useful liaison. It was also agreed to establish a Hong Kong Training Committee to enhance relationships with Fellows and trainees there.

Meetings and Conferences

During 2005, the Joint Faculty made successful contributions to the Annual Scientific Meetings of ANZCA (May 2005 in Auckland) and RACP (May in Wellington). The Annual New Fellows Conference was held at Tongariro and some excellent feedback from our newer Fellows was received.

Undoubtedly the highlight of the year was the Joint Faculty's first Annual Scientific Meeting (in association with ANZICS), held in Sydney in June. The meeting was very well received, with over 300 registrations. The presentation of new Fellows held during the Conference Dinner was also very well supported.

The Dinner provided a unique opportunity to recognise some of our greatest contributors, with the Inaugural Felicity Hawker Medal being presented to Dr Peter J. Victor for the best Formal Project paper. Professor Napier Thomson presented the John Sands Medal to Dr Ray Raper, and Dr Geoff Clarke received the Inaugural JFICM Medal. Dr Timothy Stanley, of Newcastle NSW was awarded the G.A. (Don) Harrison Medal for 2005, for his performance at the Fellowship Examination.

Board Affairs

Dr Ray Raper, Co-ordinator of Advanced Training for Intensive Care since 1995, stepped down from the Board. He has played a very significant role in the development of the Joint Faculty, particularly in the previous Joint Specialist Advisory Committee - Intensive Care. He was instrumental in maintaining a smooth transition for physician trainees wishing to achieve dual certification. Jonathan Gillis also retired in June, and his contributions as an RACP representative and to our paediatric program were highly valued.

A promising new resource will be created, with the development of the role of a Director of Professional Affairs. This part-time role will be filled by a Fellow with experience in Board affairs and will assist the Dean and the Board as a whole in representation to government and other organizations, preparation of data and reports to such bodies, and will assist in the development of strategies.

In October, the Board held a planning day to examine issues such as governance, relationships with parent colleges, CPD and recertification issues, educational modules including courses and use of simulation, plus a lengthy review of our assessment procedures.

I would like to acknowledge the staff and Fellowship for their ongoing contributions.

Board of Faculty 2005

Dr Jack Havill FANZCA, FJFICM (Dean)

Dr Richard Lee FANZCA, FJFICM (Vice-Dean, Censor, Chair OTS Committee)

Dr Vernon van Heerden FANZCA, FJFICM (Treasurer, Assistant Censor)

Dr Peter Morley FANZCA, FJFICM (Chairman, Fellowship Examinations Committee)

Dr Neil Matthews
FANZCA , FJFICM (Immediate Past Dean, Chairman, Hospital Accreditation Committee)

Dr David Ernest FJFICM, FRACP (Education Officer)

Dr Ross Freebairn FANZCA, FJFICM (Rural Focus Officer)

Associate Professor John Myburgh
FANZCA, FJFICM (Research Officer)

Dr Megan Robertson FANZCA, FJFICM FRACP (MOPS Officer,ASM Officer)

Associate Professor Bala Venkatesh
FJFICM (Assistant Education Officer)

Professor Garry Phillips AM
FANZCA, FJFICM (Co-opted Member of ANZCA Council)

Professor Napier Thomson
FRACP (Co-opted Member of RACP Council)

Dr John Gowardman
FJFICM (Co-opted Representative, Tasmania)

Dr Ian Jenkins
FANZCA, FJFICM (Observer, ANZICS President)

DEAN'S REPORT
FACULTY OF PAIN MEDICINE

A landmark year for ANZCA in 2005 with the Australian Government acknowledging Pain Medicine as a medical specialty.

Associate Professor Milton Cohen, Dean of the Faculty of Pain Medicine

Pain Medicine Recognised as a Medical Specialty

In November 2005, the Minister for Health and Ageing, the Hon Tony Abbott, advised the Australian Medical Council that a case had been made for Pain Medicine to be recognised as a medical specialty, thus completing Stage 1 of the AMC's process for such assessment. Stage 2, assessment by the AMC of the education and training programs available for the medical speciality, was also completed and accreditation of the Faculty's programs has been given to 31 December 2008, in line with the next accreditation review of ANZCA.

American Academy of Pain Medicine and its Journal, *Pain Medicine*

The agreement with the AAPM for its journal *Pain Medicine* to be adopted as the Faculty's publication vehicle came into effect in January 2005 and will stand for two years. The Faculty has nominated a Senior Editor to the Board of that Journal. The FPM Senior Editor has negotiated on behalf of the Faculty to have abstracts from the Faculty's Annual Scientific Meeting published in *Pain Medicine*.

Education

The Education and Training Committee has been actively engaged in developing a number of initiatives. Resource materials produced by the Committee in 2005 include Psychosocial Assessment, Guide to the History of the Patient in Pain and Epidemiology for the Pain Physician. A revised Prospectus for trainees was completed. A major project to support Supervisors of Training is in train.

Professional Document PM4 Guidelines for Patient Assessment and Implantation of Intrathecal Catheters, Ports and Pumps for Intrathecal Therapy was accepted for promulgation.

The second edition of Acute Pain Management: Scientific Evidence was finalised with the input of a number of Faculty Fellows and was launched by the Federal Minister for Health at the IASP Congress in Sydney in August and has been distributed to Fellows and Trainees.

The Faculty of Pain Medicine 2005 Refresher Course Day "Pain and the Brain" was held in Auckland on 6 May 2005 and attracted 109 delegates. Regional meetings were held in Brisbane and Melbourne. The Faculty contributed a two-day Scientific Program to the ANZCA Annual Scientific Meeting in Auckland in May 2005, to which the Foundation Visitor, Professor Mark Sullivan, contributed significantly. The Faculty also contributed a session on pain medicine to the RANZCP Congress. A move towards offering questions on pain medicine for first part examinations of the Faculty's participating bodies is progressing.

Examinations

The Faculty Examination was held in Sydney on 19, 20 and 21 October. Nineteen of the twenty-four candidates were successful. Successful candidates were from the following disciplines: anaesthesia (15), internal medicine (1) and rehabilitation medicine (3).

Training Unit Accreditation

In 2005, Nepean Hospital (NSW), Royal Adelaide Hospital and the Auckland Regional Pain Service were reaccredited. There are now 16 accredited Pain Medicine Training Units in Australia and New Zealand.

Research

The Board sees research as a core business of the Faculty. Since its inception in February 2004, the FPM Research Committee has been addressing a number of important issues including roles, linkages, infrastructure

and various specific projects (such as a Pain Medicine Prize, PhD Scholarship, publication of FPM ASM abstracts etc).

The Research Committee of the FPM Board plans to develop a suitable framework to address a number of fundamental issues and a framework is under consideration. Input has been sought from the Fellowship and trainees.

Workforce Survey

The Faculty conducted its first Workforce Survey early in 2005 with the assistance of the Australian Medical Association and Access Economics in collating, presenting and interpreting the data. The response rate was 49.4%. Despite the lowish response rate, the demographics, gender, age and specialty mix matched the Faculty's population very well.

At the end of 2004, of the 192 Fellows, 155 were domiciled in Australia, 13 in New Zealand and 24 in other countries. For the Australian respondents to the survey the range of practice in Pain Medicine was wide, from less than 1, to up to 10 sessions per week, with an average of 4.5 sessions per week. Fellows saw on average 22 patients per week each.

Admission to Fellowship

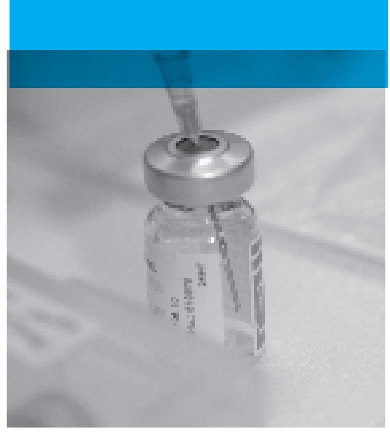
During 2005 nine Fellows were admitted by training and examination, four by election and one Honorary.

Total Fellowship as at December 2005 numbered 206, of whom seven are Honorary. Sixty-four have been admitted through training and examination. Of the 199 active Fellows, 158 were domiciled in Australia, 14 in New Zealand and 27 in other countries. Those whose primary specialty is anaesthesia make up just over 60% of the Fellowship. Although the majority of trainees have been anaesthetists by primary specialty, neurosurgeons, psychiatrists and rehabilitation physicians have taken up the challenge of training in pain medicine.

Intercollegiate Relationships

The Faculty has sought to broaden opportunities for entry into training in Pain Medicine. Previously Fellowship of one of the participating Colleges (AFRM, ANZCA, RACP, RACS, RANZCP), or equivalent, was required. It has now been determined that acceptable qualifications include Fellowship of the Australian or New Zealand Colleges of General Practitioners, or Fellowship of a Faculty or Chapter of a participating College, such as the Faculty of Occupational Medicine (RACP), the Faculty of Public Health Medicine (RACP), the Australasian Chapter of Palliative Medicine (RACP), the Australasian Chapter of Addiction Medicine (RACP) or the Joint Faculty of Intensive Care Medicine (ANZCA/RACP). The training period for such practitioners is three years, two years of which must be undertaken in a prospectively approved structured training program in a Faculty-accredited Pain Medicine Unit.

Progress in realising intercollegiate connections arising out of the Forum held in July 2004 has been gratifying. Our congenital relationship with the Faculty of Rehabilitation Medicine (RACP) has been strengthened. Links have been established with the Chapter of Addiction Medicine (RACP) and the Division of Consultation Liaison Psychiatry (RANZCP). Approaches are in train to the Australian Rheumatology Association, the Australian Association of Neurologists and the Neurosurgical Society of Australasia. The Faculty has offered to facilitate pathways for trainees in those disciplines, and to contribute curricular teaching material and examination materials. Mutual presentations at Annual Scientific Meetings have occurred.



BOARD AND COMMITTEES

The Faculty Board comprises:

A/Prof Milton L Cohen FRACP (Dean)

Dr C Roger Goucke FANZCA (Vice Dean)

A/Prof R Leigh Atkinson AO, FRACS (Immediate Past Dean)

Dr Penelope A Briscoe FANZCA (Chair, Examination Committee)

Dr David Jones FANZCA (Censor)

Prof Robert D Helme, (Chair, Education and Training Committee)

Dr Geoffrey Booth, FAFRM (RACP), (Chair, Research Committee)

Dr Brendan J Moore, FANZCA

Dr Frank J New, FRANZCP

Professor Edward A Shipton, FANZCA

Professor Garry Phillips AM, FANZCA, FJFICM (Co-opted Representative)

Committees:

Education and Training Committee

Examination Committee

Training Unit Accreditation Committee

Research Committee

PANEL OF EXAMINERS 2005

JOINT FACULTY OF INTENSIVE CARE MEDICINE

Dr Nicholas Andrew Barnes

Professor Andrew Bersten

Dr Marianne Jean Chapman

Associate Professor David James Cooper

Dr Charles Frederick Corke

Dr Stephen Arthur Edlin

Dr Athanasios Flabouris

Dr Leslie Henry Galler

Dr Christopher John Joyce

Dr Stephen Richard Keeley

Dr Bruce Gregory Lister

Dr Imogen Mitchell

Dr Thomas John Morgan

Dr Peter Thomas Morley

Associate Professor John Alexander Myburgh

Dr Anthony John O'Connell

Dr Sandra Lois Peake

Dr John Hamilton Reeves

Dr Megan Sue Robertson

Dr Martin Peter Rowley

Dr Edward Richard Stachowski

Dr John M. Torrance

Dr Peter Vernon van Heerden

Associate Professor Bala Venkatesh

Dr Robert John Young

FACULTY OF PAIN MEDICINE

Dr Penny A Briscoe

Dr Meredith J Craigie

Dr Matthew R Crawford

Dr Julia A Fleming

Dr C Roger Goucke

Dr David W Gronow

Dr David Jones

Dr Lindy J Roberts

Dr Pamela E Macintyre

Dr Bruce F Rounsefell

Dr Michael J Butler

Associate Professor Richard W Chye

Associate Professor Milton L Cohen

Dr Ray Garrick

Professor Robert D Helme

Professor George Mendelson

Dr Frank J New

Associate Professor R Leigh Atkinson

Dr Carolyn A Arnold

Dr Kok Eng Khor

Professor J E (Ben) Marosszeky

Dr Allan R Molloy

HONORARY TREASURER'S REPORT

ASSOCIATE PROFESSOR KATE LESLIE
HONORARY TREASURER

This is my second report as Honorary Treasurer. I am pleased to report that the College remains in a robust financial position, despite the abolition of the subscriptions-in-advance scheme for the 2006 subscription.

The Financial Report for 2005, in the format required by the Australian Securities and Investments Commission (ASIC), has been circulated to all Fellows. This report has undergone external independent audit and has been discussed and accepted by Council.

Income Statement

This is a summary of the revenue, expenses and surplus from the activities of the College. The overall revenue for the year ended 2005 of $11,770,714 was 9.9% greater than that for 2004 ($10,705,139). Total expenses increased by 8.1% to $9,998,087 leaving a surplus of $1,772,627. This surplus equates to 15.1% of the total revenue. Amongst the revenue items, income from investments increased to $914,820 (from $535,374 in 2004); subscriptions increased to $3,419,069 (from $3,179,500 in 2004) and Training and Examination fees increased to $3,465,596 (from $3,133,695 in 2004) reflecting higher numbers of Fellows and Trainees. In addition, the ANZCA Foundation received donations totalling $129,260 by 31 December, 2005. Within the 2005 expenses, Trainee and Examination expenses increased to $3,464,688 (from $3,069,848 in 2004) and administration expenses increased to $3,628,751 (from $2,950,825 in 2004). Research grants paid decreased to $621,739 (from $1,119,110 in 2004 when a change in accounting policy occurred).

Balance Sheet

This is a summary of the assets, liabilities and equity position of the College. The net assets of the College increased by 8.2% to $23,322,995. This includes investments of $14,042,067 (accounted for at fair market value). Total assets of $29,780,513 include property, plant and equipment of $11,035,862 (accounted for at cost minus depreciation and not at market value). The total liabilities of $6,457,518 have increased from $5,552,141 in 2004.

Cash Flow Statement

There was a decrease in cash held at 31 December 2005 ($836,838; a decrease from $2,243,678) due to the abolition of subscription in advance.

Notes

The remaining section of the Financial Report provides accounting policies, further breakdowns to the actual statements and financial instruments.

Comments

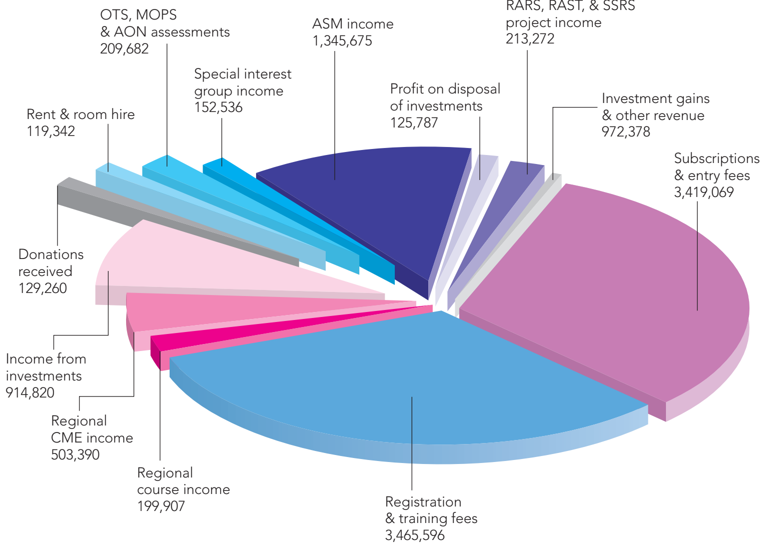
The College remained in a sound financial position during the period of this report. The College's assets increased in value and revenue from fees, investments and educational activities increased. These were accompanied by an increase in expenses, but overall left a healthy surplus.

Two major decisions were made in 2004 that have had an impact on the financial statements. The first was the Council's decision to abolish subscriptions in advance for ANZCA Fellows. This decision resulted in a decrease in the cash flow for 2005, but also a decrease in liabilities. The second was the decision to account for research grants on an accrual, rather than a cash, basis. This resulted in a larger than usual research expense in 2004, which returned to normal levels in 2005. Funds available for research were augmented by a pleasing level of donations by Fellows to the ANZCA Foundation.

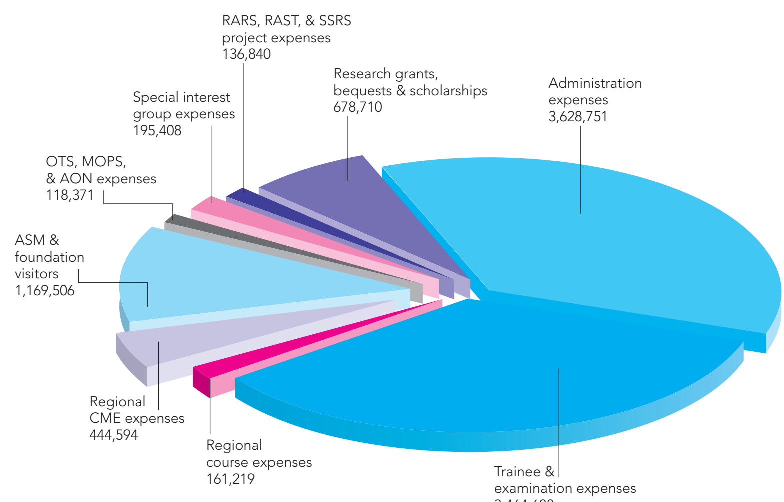
It should be noted that the College's property, plant and equipment are accounted for on a cash basis (minus depreciation), whilst its cash and managed fund investments are accounted for on a fair market value basis. The College's ASGARD wrap account continues to perform well. Due to the strength of domestic and international share markets, the market value of this investment had grown to over $14M by 31 December 2005, as well as producing substantial interest income.

The solid financial position of the College has resulted from the commitment of Councillors, Committee Members, Fellows and staff throughout Australia, New Zealand and South East Asia. They all deserve recognition for their efforts. This particularly relates to the generosity of Fellows in making donations to the Foundation and participating in the subscriptions-in-advance scheme between 1986-2005.

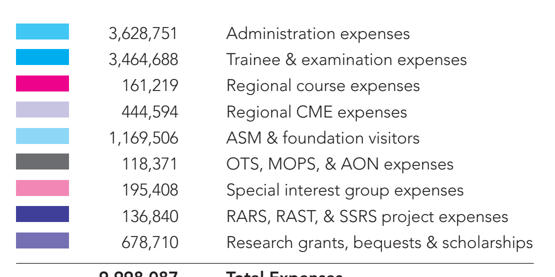
REVENUE



EXPENSES



Amount	Item
3,419,069	Subscriptions & entry fees
3,465,596	Registration & training fees
199,907	Regional course income
503,390	Regional CME income
914,820	Income from investments
129,260	Donations received
119,342	Rent & room hire
209,682	OTS, MOPS & AON assessments
152,536	Special interest group income
1,345,675	ASM income
125,787	Profit on disposal of investments
213,272	RARS, RAST, & SSRS project income
972,378	Investment gains & other revenue
11,770,714	**Total Revenue**



Amount	Item
3,628,751	Administration expenses
3,464,688	Trainee & examination expenses
161,219	Regional course expenses
444,594	Regional CME expenses
1,169,506	ASM & foundation visitors
118,371	OTS, MOPS, & AON expenses
195,408	Special interest group expenses
136,840	RARS, RAST, & SSRS project expenses
678,710	Research grants, bequests & scholarships
9,998,087	**Total Expenses**

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS ABN 82 055 042 852 AND CONTROLLED ENTITY

AUDITOR'S INDEPENDENCE DECLARATION UNDER SECTION 307C OF THE CORPORATIONS ACT 2001 TO THE DIRECTORS OF AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

I declare that, to the best of my knowledge and belief, during the year ended 31 December 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.

Impact McDonald Carter

IMPACT MCDONALD CARTER
Chartered Accountants

G S Parker
Partner
Melbourne
Dated 31 March 2006

DISCUSSION AND ANALYSIS OF THE FINANCIAL STATEMENTS

Information on Australian and New Zealand College of Anaesthetists Concise Financial Report

The financial statements and disclosures in the concise financial report have been derived from the 2005 Financial Report of the Australian and New Zealand College of Anaesthetists and Controlled Entities.

A copy of the full financial report and auditor's report will be sent to any member, free of charge, upon request.

The discussion and analysis is provided to assist the members in understanding the concise financial report. The discussion and analysis is based on the Australian and New Zealand College of Anaesthetists and Controlled Entities consolidated financial statements and the information contained in the concise financial report has been derived from the full 2005 Financial Report of the Australian and New Zealand College of Anaesthetists and Controlled Entities.

Income Statement

The operating surplus from ordinary activities for the financial year was $1,772,627 which is $314,533 higher than the result in 2004. Total revenue increased by 9.1% to $11,770,714 whilst total expenses increased by 8.1% to $9,998,087. The College is a Company Limited by Guarantee which has no share capital and declares no dividends. The College is exempt from income tax pursuant to Section 50–5 of the Income Tax Assessment Act 1997.

Balance Sheet

Total assets increased by $2,722,673 to $29,825,152 representing an increase of 10%. This increase was mainly attributable to a trading investments individually valued at fair market value. Total liabilities increased by $950,406 to $6,502,187 representing an increase of 17%.

Cash Flow Statement

Cash flows decreased in 2005 due to the abolition of subscriptions in advance.

CONSOLIDATED INCOME STATEMENT FOR THE YEAR ENDED 31 DECEMBER 2005

	Note	Economic Entity	
		2005 $	2004 $
Revenue			
Subscriptions and entry fees		3,419,069	3,179,500
Registrations, training and exam fees		3,465,596	3,133,695
Regional CME & course income		703,297	584,693
Investment income		914,820	535,374
Donations received		129,260	104,394
ASM income		1,345,675	1,051,898
OTS & AON assessments, MOPS fees		209,682	206,972
Special interest group income		152,536	163,211
RARS, RAST & SSRS project income		213,272	468,586
Other income		158,332	139,394
Profit on disposal of investment securities		125,787	89,731
Gains on growth in value of investments		933,388	1,047,691
Total revenue		11,770,714	10,705,139
Expenses			
Administration expenses		3,628,751	2,950,825
Registrations, training and exam expenses		3,464,688	3,069,848
Regional CME & course expenses		605,813	546,778
ASM and foundation visitor costs		1,169,506	879,811
OTS & AON assessments, MOPS expenses		118,371	124,797
Special interest group income costs		195,408	212,575
RARS, RAST & SSRS project costs		136,840	297,506
Research grants, bequests & international scholarships		678,710	1,164,855
Total expenses		9,998,087	9,246,995
SURPLUS FROM ORDINARY ACTIVITIES		1,772,627	1,458,144

CONSOLIDATED BALANCE SHEET AS AT 31 DECEMBER 2005

	Note	Economic Entity	
		2005 **$**	2004 **$**
CURRENT ASSETS			
Cash assets		836,838	574,987
Receivables		3,616,250	1,368,003
Other financial assets		14,042,067	13,244,439
Other		294,165	334,767
TOTAL CURRENT ASSETS		18,789,320	15,522,196
NON CURRENT ASSETS			
Property, plant and equipment		11,035,862	11,580,313
TOTAL NON CURRENT ASSETS		11,035,862	11,580,313
TOTAL ASSETS		29,825,182	27,102,509

CONSOLIDATED BALANCE SHEET AS AT 31 DECEMBER 2005

	Note	Economic Entity	
		2005	2004
		$	$
CURRENT LIABILITIES			
Payables		1,296,904	1,326,966
Provisions		482,040	675,980
Other		4,691,735	3,446,750
TOTAL CURRENT LIABILITIES		6,470,679	5,449,696
NON CURRENT LIABILITIES			
Provisions		31,508	102,445
TOTAL NON CURRENT LIABILITIES		31,508	102,445
TOTAL LIABILITIES		6,502,187	5,552,141
NET ASSETS		23,322,995	21,550,368
EQUITY			
Share capital		2	2
Retained earnings		23,322,993	21,550,366
TOTAL EQUITY		23,322,995	21,550,368

CONSOLIDATED CASH FLOW STATEMENT FOR THE YEAR ENDED 31 DECEMBER 2005

	Note	Economic Entity	
		2005 $	2004 $
CASH FLOW FROM OPERATING ACTIVITIES			
Receipts from fellows and trainees		7,934,835	6,927,470
Other receipts		707,821	821,214
Payments to suppliers and employees		(8,876,620)	(8,179,409)
Interest received		908,804	527,791
Research grants, bequests and scholarships paid		(621,739)	(530,915)
Net cash provided by (used in) operating activities		53,101	(433,849)
CASH FLOWS FROM INVESTING ACTIVITIES			
Proceeds from sale of investments		200,000	1,686,709
Proceeds from sale of property, plant and equipment		38,440	-
Purchase of investments		(1,607,144)	(11,887,950)
Purchase of property, plant and equipment		(91,237)	(297,485)
Net cash used in investing activities		(1,459,941)	(10,498,726)
Net decrease in cash held		(1,406,840)	(10,932,575)
Cash at 1 January 2005		2,243,678	13,176,253
Cash at 31 December 2005		836,838	2,243,678

NOTES TO THE CONCISE FINANCIAL REPORT FOR THE YEAR ENDED 31 DECEMBER 2005

NOTE 1: BASIS OF PREPARATION OF THE CONCISE FINANCIAL REPORT

The concise financial report has been prepared in accordance with Accounting Standard AASB 1039: Concise Financial Reports, and the Corporations Act 2001.

The financial statements, specific disclosures and other information inlcuded in the concise financial report are derived from and are consistent with the full report of Australian and New Zealand College of Anaesthetists and Controlled Entity. The concise financial report cannot be expected to provide as detailed an understanding of the financial performance, financial position and financing and investing activities of Australian and New Zealand College of Anaesthetists and Controlled Entity as the full financial report.

The accounting policies have been consistently applied by the entities in the economic entity and are consistent with those of the previous financial year.

COUNCILLORS' DECLARATION

The councillors of Australian and New Zealand College of Anaesthetists declare that the concise financial report of the Australian and New Zealand College of Anaesthetists and Controlled Entity for the financial year ended 31 December 2005, as set out in pages 1 to 4:

a. complies with Accounting Standard AASB 1039: Concise Financial Reports; and
b. has been derived from and is consistent with the full financial report of Australian and New Zealand College of Anaesthetists and Controlled Entity.

This declaration is made in accordance with a resolution of the Councillors.

Professor M J Cousins AM
PRESIDENT

Associate Professor K Leslie
HONORARY TREASURER

Dr M J Richards
CHIEF EXECUTIVE OFFICER
Dated this 20th day of March 2006

INDEPENDENT AUDIT REPORT TO THE MEMBERS OF AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS AND CONTROLLED ENTITY

Scope

We have audited the concise financial report of Australian and New Zealand College of Anaesthetists and Controlled Entity for the financial year ended 31 December 2005 as set out on pages 1 to 4. In order to express an opinion on it to the members of the disclosing entity. The disclosing entity's directors are responsible for the concise financial report.

Our audit has been conducted in accordance with Australian Auditing Standards to provide reasonable assurances as to whether the concise financial report is free of material misstatement. We have also performed an independent audit of the full financial report of the Australian and New Zealand College of Anaesthetists and Controlled Entity for the year ended 31 December 2005. Our audit report on the full financial report was signed on 31 March 2006 and was not subject to any qualification.

Our procedures in respect of the audit of the concise financial report included testing that the information in the concise financial report is consistent with the full financial report, and examination on a test basis, of evidence supporting the amounts, discussion and analysis, and other disclosures which were not directly derived from the full financial report. These procedures have been undertaken to form an opinion whether, in all material respects, the concise financial report is presented fairly in accordance with Accounting Standard AASB 1039: Concise Financial Reports.

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

Independence

In accordance with ASIC Class Order 05/83, we declare to the best of our knowledge and belief that the auditor's independence declaration set out on page 1 of the financial report has not been changed as at the date of providing our audit opinion.

Audit Opinion

In our opinion the concise financial report of Australian and New Zealand College of Anaesthetists and Controlled Entity complies with Accounting Standard AASB 1039: Concise Financial Reports.

Impact McDonald Carter

IMPACT MCDONALD CARTER
Chartered Accountants

G S Parker
Partner
Melbourne
Dated 31 March 2006

PHOTOGRAPHY CREDITS
Page 13: Image of Orphan's tent courtesy of ICRC
Page 2: Photograph by Andrew Curtis

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

JOINT FACULTY OF INTENSIVE CARE MEDICINE

FACULTY OF PAIN MEDICINE

ANZCA HOUSE
630 St Kilda Road
Melbourne Victoria 3004 Australia
Telephone (03) 9510 6299
Email ceoanzca@anzca.edu.au.

ANZCA MISSION STATEMENT

To serve the community by fostering safety and quality patient care in anaesthesia, intensive care and pain medicine