President's Address

Continued From Page 1

time, and directed at short-term, immediate goals. For reasons that are becoming more pressing (***by the minute -Ed***) and that will be obvious to most of you, this state of affairs cannot continue. By and large, ***we*** must have an idea of how we intend to gain our postgraduate education and then discuss this with the Colleges, the Universities and the Federal and State Governments. If we don't act now, these bodies will dicate to us what standards we must have to work in a hospital ED, to work in a community setting, to apply for a post at a pychiatric institution etc. Far better that we come to the table well-prepared and as equals, than that we come as reluctant parties or, worse, that we are not invited to come at all.

There are many options for the format of education - degrees from the Universities (such as Masters of Medicine), diplomas or similar from the Colleges (such as the Dip Obs and Gynae), self-directed learning and use of log-books etc. for CME points. However, whatever method, or combinations of methods is used will require acceptance from the other medical bodies and Australia-wide recognition. These educational units could be provided by the above institutions and could concievably be used as bridging courses to specialist qualifications by those CMOs who want to go on and specialise. Our education officer, is about to go in to bat for the right to trial a critical care program for RMOs who want to become CMOs, and there are other pilot programs underway in Newcastle, Toowoomba, Brisbane, and elsewhere. If this area interests you (and it should) then please contact us with your ideas so that we have as complete a picture as possible of CMO educational requirements.

3. ***Subscriptions***

As an association, we are only as strong as our membership makes us—basically this means numbers. The more CMOs that subscribe, the more powerful is the organisation. Currently we have more than 50 paid up members and a database of over 130 CMOs. We know that there are least 400 CMOs in NSW and probably 1000 Australia-wide. Nobody would be too surprised if there were about double that number. Two problems: one, to get the names and addresses of all CMOs—not as easy as it might sound—so that we can inform them of our group, and secondly to encourage those who are aware of us to join the association.

Adverising is very important and the most important aspect of this is certainly word of mouth. Those of you who are members need to encourage others to join and also to advertise in your place of work - hospital notice board, community news bulletin etc. The "flyer" sent out with this publication should help in this regard. Please feel free to photocopy, display and do whatever else is necessary to spread the word.

Enough preaching. I hope to see as many of you as can make it to the next meeting in early May, at Bankstown Hospital.

John Egan

Committee

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Next Meeting.....

Tuesday 6th May
at 5.00 pm
Conference Rooms
Bankstown Hospital
Eldridge Rd, Bankstown

Follow the signs from the main foyer.

Editorial

Better Ponds and Gardens, or, The Shape of Things to Come...

Well, there was definite interest out there as a result of our fledgling efforts with the last publication of *The Bulletin*. Sadly though, this particular little black duck isn't getting any more organised as it wobbles cheerfully along its scenic and self-appointed path, so those admittedly bird-brained dreams of full colour supplements and glossy photo spreads are still just that - an editor's dream of the future—mostly indulged after one too many grasshoppers, while hanging out down at the murky end of the pond!

And speaking of worms and early avian life-forms ...

Finding myself facing the production task of getting a second issue together led inevitably to the personal observation that nothing new gets done unless some Dodo with more enthusiasm than sense makes the commitment to do it themselves. While avoiding the obvious remarks about editors and extinction, it must nevertheless be conceded that Systems inevitably decay to entropy unless energy is applied from the outside to sustain them and make them grow.

What a bore, I thought, the way that the world is arranged! So many of us are so very busy reacting rather than acting. Reacting to the demands of our jobs and our lives and our other interests. We have relatively little spare energy left over to be pro-active — that is, to push that barrow uphill against the incline of entropy and apathy and fatigue, for long enough to create something new and worthwhile and sustainable that wasn't there before. Primary action looks too hard and fails to come naturally.

While running around, planning to beat submissions out of people (when I get the time, she added, grinnning) I was led to the futher philosophical reflection that this is hardly surprising. It is, after all, built into the very nature of this medical business. After all, you're almost always behind the pathological process by the time it reaches you. You get sort of used to the back view, to the demands of playing catch-up, to picking up the mess. This fundamental reality must shape to some extent our psychological approach to other situations. One is forced to the question. Do we actually wait for the mess to declare itself before we see the need to do anything about it?

At this turbulent time, in the face of increasing pressures on the individual's time from within and without the profession, we're looking further and further away from being in control of our professional destinies. I don't know about your little corner of the pond, but in mine, the mess is getting bigger and uglier. I can see the wave coming at me, I'm just too busy dealing with it to see myself as able to do anything to design a better pond. The profession, and we individuals within it, are being forced onto the back (webbed) foot by these events outside our control.

Mind you, if we don't get up off our collective nest-egg, shake our tails and get involved, none of us will get the chance to find out what we could have achieved, and our opinions will be left where The Powers That Be think they belong - in the tea room. We're smart. We'll figure it out. I hope.

Much of the space in this issue has been given to the pressing matter of the Junior Doctors Dispute. I take the liberty of bringing you information as to what is happening and to whom it refers. Surprisingly little is actually known by the general medical community as to what is going on and why, and so a report is appropriate.

Mary G T Webber

Next Issue...

The Internet for Health Professionals

Blueprint for the Australian Medical Workforce

Error in Medicine

CMO Education: A Personal View

From Steve Delprado, Education Officer

Education....Well, we all have our opinions about it, but how about expressing them? I have yet to hear from any of our otherwise vocal members (excepting El Presidente, of course) with their views on Education. Consider this a hint and a reminder to feel free to drop me a line.

Therefore, having no-one else's views to present, we will start the discussion with my views and questions and thoughts ....

The education process should be life-long. However—

1. There is a distinct lack of formal on-going education processes relevant to CMOs in most hospitals.
2. There is no uniformity between hospitals in the provision of paid conference/study leave for CMOs.
3. If you wished to become a CMO, where would you even start?
4. There is no current formal career structure for CMOs. A structured career would generate an education process

For on-going education, there are several available models :

1. The Module

Consists of a short course (2-4 days), similar to the Early Management of Severe Trauma course. But in topics relevant to CMO work eg. Anaesthetics/ Paediatrics.

2. Self-directed learning

Using computer programmes in paid time.

3. The Lecture

Most colleges use CME points for turning up to lectures. In my opinion this fails, because people turn up for the points, not the information.

My favoured approach would be a combination of the module and computer-based training.

I have put a submission into the Commonwealth Department of Health for funding for the creation of an education process in the South Western Area Health Service of Sydney (SWAHS) and to create a model of a structured career path. This encompasses ongoing education and the training of new CMOs. The aim is not to "re-invent the wheel" but to examine programmes that exist for RMOs in the creation of a programme for CMOs. If sucessful, in about a year or so it would go to other areas in the state and then nationwide. The submission has been examined and approved by your committee and the SWAHS, and I will keep you informed as to its progress and eventual outcome.

Please forward your own suggestions, articles or information to myself or Mary Webber for inclusion in the next issue.

Autism: Issues in Diagnosis and Management

A one day conference presented by The Association of Doctors in Developmental Disability (ADIDD)

Friday 30th May 1997

Registration from 8.30am. Programme: 9.00am - 5.30pm Cost: $30.00 at the door

The Norman Nock Lecture Theatre

Royal North Shore Hospital, Pacific Highway St Leonards

Speakers will address recent advances in the understanding of autism and their practical applications in the assessment and management of individual children with this diagnosis.

Morning Session: The nature and extent of autism with viewpoints presented from speakers in child psychiatry, psychology, and speech therapy, as well as parents. The differential diagnoses of autism, Asperger's syndrome and various language disorders will be examined.

Afternoon Session: The mangament issues with input from the Autistic Association, the Lovaas Programme and the Giant Steps Programme, and also Nutrition and Drug Treatment.

Enquires: Dr David Starte at The Chatswood Assessment Centre
Phone: 02 9414 0218 Fax: 02 9413 4574

6th International Conference of Emergency Medicine

Sydney 17-22 November 1996: *Review by Lisa Bell CMO Mt Druitt.*

Held at the Darling Harbour conference facilities, this was my first formal Emergency Medicine Conference experience, and overall, was an enjoyable one.

Topics covered were very broad-ranging, from the irksome horrors of our Native Toxic species through to the sombre issues of International Health. The conference started with a plenary session on violence - domestic, child, elderley, and in the Emergency Dept. Much of the first day was dedicated to this topic and I found it well-presented and a good focal point to begin with.

Other topics for the week included recent research into the treatment of AMI and asthma: advances in the managment of Paediatric trauma, the wonders of Wilderness Medicine and the inevitable sessions devoted to administrative issues (which I avoided.) In its sheer diversity the conference helped to highlight the spectrum of roles Emergency Medicine has to offer us, as well as to promote the advances in skills and technology.

The treatment dilemmas we face were probably best exemplified by the plenary session on fluid resusitation, where we found that the crystalloid-colloid debate continues. Colin Myers of Royal Brisbane Hospital presented his paper, 'Fluid Resusitation - Which Fluid?'. At the end of the day the question, it seems, remains unanswered, although the general consensus seemed to be that massive IV fluid loading in uncontrolled haemorraghic shock could be harmful and 2 studies showed patients with better outcomes in haemorraghic shock if fluid was withheld or given at minimal volume. The possibility exists that these results reflected the need for a more aggressive approach to dealing with the source of blood loss, rather than having a false sense of security because the blood pressure has improved.

Dr Jim Ducharme presented on the pathophysiology of shock, further reinforcing our impressions of a limited understanding of the process, and emphasising the need to get back in touch with the basics of patient care. In response to a German delegate's glowing description of the high-tech mobile ICU's that now respond to the carnage of the autobahns, Dr Ducharme intimated that perhaps we need to focus on getting the simple things right first, and not forget about them while searching for more exciting and spectacular options.

Amoung the diverse paediatric presentations was a useful discussion of paediatric sedation from Dr P. Younge of the Frenchay Hospital, Bristol, U.K., comparing the use of oral midazolam and oral ketamine in children requiring sedation for local anaesthetic injection and wound repair. The Midazolam dose was 0.7mg/kg (slightly higher than previously used) and of Ketamine, 10mg/kg. The study showed very favourable results with both these agents, with ketamine being the preferred option for more painful procedures, on account of its powerful analgesic effects. Patient and parent tolerance was good and in 52 patients, no emergence phenomenae were demonstrated with Ketamine.

Dr N Kisson presented on the "Golden Hour" of trauma as it applies to the paediatric patient. He emphasised that the primary risk areas in the child versus the adult were respiratory as opposed to circulatory, since major trauma in childhood prominently features the CNS and the thoracic region.

The links between the Energency Department and Primary Health Care were touched on, as were the differences in practice between the developed countries and the Third World, (*What? No autobahns all ready for the high-tech mobile ICU's in Banglasdesh, eh? - Ed*) with some excellent presentations on Emergency health care in Africa and PNG. Dr Symmons' presentation on Tinsley District Hospital in PNG well demonstrated the schisms between worlds. The daily adversity faced by his patients becomes compounded at times of medical crisis by the extraordinary distances travelled and the determination required to locate medical help. The resultant morbitity and mortality reminds us all of how lucky we are to have convenient access to good care.

Continued on Page

The Health Insurance Act Amendments

Highlights From: The Health Insurance Amendment Act (No.2) 1996.

~~Junior~~ Doctors Dispute Coverage Part 1.

Short title. Big trouble.
Frequently more than slightly obscure.
Contains many puzzling examples of Beaurocratese.
One can twist oneself into pretzels trying to figure out the concealed implications.
Will have significant effects on the medical workforce. Listen up.

3GA Register of Approved Placements

1. The purpose of this section is to provide for registration of certain medical practicioners in approved placements.
2. The Commission is to establish and maintain a Register of Approved Placements.
3. The regisiter may be maintained in any form, including as a computer record.
4. A medical practicioner may apply to the Commission for registration under this section.
5. If a medical practioner makes an application and—
   a) a body specified in the regulations (*What regulations? - Ed*) gives the Managing Director of the Commision written notice stating:
   i) that the applicant is enrolled in, or undertaking, a course or program of a kind specified in the regulations; and,
   ii) the period over which, and the location in which, the applicant will be undertaking the course or pro gram;
   or
   b) the applicant is, in accordance with the regulations, eligible for registration under this section;

the Managing Director must, within the required period under subsection (6), enter the applicant's name in the Register, together with the period in respect of which and the location in respect of which the applicant is registered.

Followed by another long section (section 6) about how rapidly the Commision is obligated to notify the applicant....

7. The Managing Director must give the applicant written notice of the day on which the applicant's name is to be entered into the Register.

8. The Commission may give a body specified in regulations made for the purposes of paragraph (5)
(a) information about the following matters to the extent that those matters relate to persons about whom the body has given a notice under paragraph (5) (a):
   a. the current state of the Register
   b. additions to the Register
   c. Deletions from the Register

I point this section out to you because it boils down to the fact that they can decide that a placement in the Kimberleys would be an educational experience for you, and they will register you in circumstances defined by "the regulations", and you are then, regardless of your date of graduation, potentially exempt from the provisions of the infamous Section 19AA. See below. In fact, it seeems to me that this is the little kicker that could be interpreted as allowing for Geographical Provider Numbers, but I could be wrong.

Anyway, on to 19AA, then we'll pause for breath and reflection.....

19AA Medicare Benfits not payable in respect of services rendered by certain medical practioners.

1. A Medicare benefit is not payable in respect of a professional service, rendered after the commencement of this section and before January 2002, if the person who rendered this service:
a. first became a medical practioner on or after 1 November 1996; and
b. was not, at the time the service was rendered:
   i) a specialist (whether or not the service was rendered in the performance of the specialist's speciality); or
   ii) a consultant physician (whether or not the service was rendered in the performance of the consultant physican's speciality); or
   iii) a general practitioner: or
   Note; For general practioner see subsection 3 (1)
   iv) subject to subsection (3), a person registered under section 3GA; or
   v) a person to whom a determination under subsection 3J (1) applied.

Note: Subsection 5. gives a restricted meaning to the term professional service for the purposes of this section.

Section 2. repeats the contents of 1. but instead of the medical practioner themselves , refers to "if the medical practioner on whose behalf the service was rendered" and enters into confusing detail about whether a service can be rendered on behalf of a medical practioner if it is rendered by another medical practioner (it can't, but do I care?)

3. Subparagraphs 1.b.iv) and 2.b.iv) only apply in relation to a professional service that was rendered:

a) during the period in respect of which, and in the location in respect of which, the person is registered under Section 3GA; or

b) in such circumstances (which may include circumstances relating to the period during which, or the location in which, services are rendered) as are specified in the regulations.

4. For the purposes of this section, a medical practioner who, on 1 Nov 1996:

a) was a medical practioner who had not commenced, or who had not completed, training as an intern; or

b) was not an Australian citizen or a permanent resident within the meaning of the Migration Act 1958;

is taken to have first become a medical practioner on 1 November 1996.

5. In this section: 'intern' means a medical practioner who is undertaking:

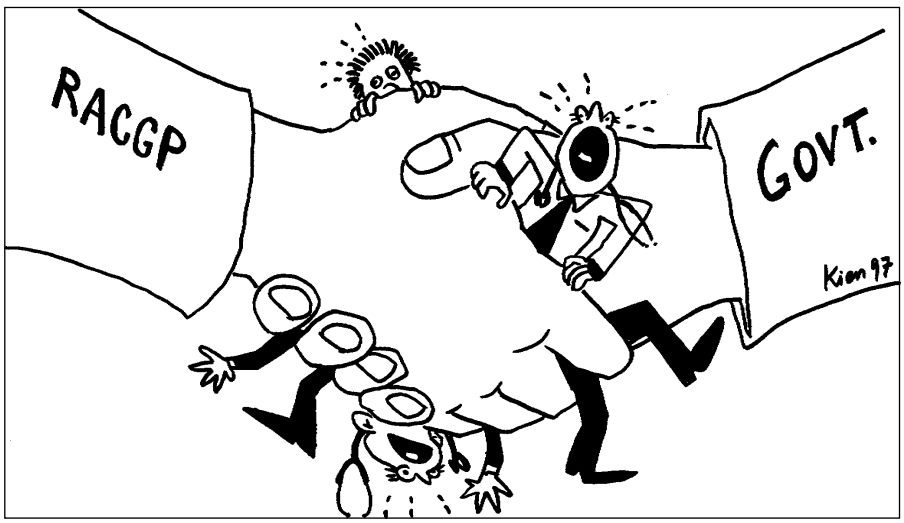
a) a period of internship (by what ever name called); or

b) a period of supervised training (by whatever name called);

under a law of a State or Territory specified in the regulations (whether or not the medical practioner is a resident in a hospital for some or all of that period).

I might also point out to you that under section 19C it is actually an offence (incurring 1 penalty unit, what ever that is) to provide a service for which a benefit is not payable because of section 19AA, without having first made "all reasonable attempts" to inform the patient of your lowly status.

Well, wasn't that fun?



6th ICEM Report

Continued from page 5

On a less serious note, the Social Schedule was quite entertaining, and the venue for the conference dinner a splashing success - the Sydney Olympic Aquatic centre. Part of the evening's entertainment was provided by the up and coming Olympic diving team. You will be reassured to learn that when a few of the conference delegates attempted to emulate the diver's skill, there were no casualties, despite the ETOH level. However, stern words were drawn from the militant aquatic Centre officials.

So yes, despite the passage of time, a bunch of doctors collected together still seem to be able to get themselves into trouble. And sadly there were no toxic sea-creatures provided by the venue for us to try out our new-found Hot-Water-Denaturing-Of-Toxin trick, so that too will have to wait for another time.

Overall, an informative and entertaining conference. I'll be back.

Lisa Bell

The HIA Amendments:

Implications for CMOs A Purely Personal Response

~~Junior~~ Doctors Dispute Coverage Part 2.

With thanks to Dr Chung Yong from the PSA and Mr Russell Noud from the AMA for talking to me....

A letter arrived on my desk a few weeks ago from Bruce Shepherd, inviting me to send money to the Australian Doctors Fund. It included the following snippet from the Australian Financial Review 4th February, which I share with you ...

> *The Health Minister, Dr Michael Wooldridge, is convinced that the way to tackle the problems of the private-public mix and the pressures for cost increases in the health system is by attacking the supply side rather than the demand side. He is adamant that it is doctors who over-service - however unconsciously, rather than patients, and, for that reason, numbers of doctors have to be reduced rather than patient co-payments introduced to reduce the fee-for-service incentive for cost blowouts.*

The amendments to the Health Insurance Act were presented in August 1996 as part of a package designed to decrease the cost of Medicare to the tune of $500 million dollars. They received a second reading in The House of Representatives on 17 October and the Senate on 18 November and then passed the Lower House again on December 13 at 0300 in the morning, received Royal Assent three days later and have therefore become law.

These alterations are blatantly a cost-cutting measure. Alarmingly, there are two pages only of Amendments Relating to the Level of Medicare Benefit, covering things like the 'greatest permissible gap', mutliple diagnostic imaging services and repealing the increased fee in complex cases. Sixteen of the eighteen pages are Amendments Relating to Medical Practioners. The theory is that if you reduce the number of doctors you reduce the number of practioners billing Medicare and you reduce the Medicare bill. You've done nothing to change the amount of illness in the community, or the perception of the public that their health service is "free" and/or paid for out of their taxes and medicare levy—which the minister now assures us, is not actually collected for the purposes of funding Medicare, but rather is a sort of general revenue catcher—but we won't worry about that right now.

My own question runs something like this...

Is it not rather difficult to imagine ***how*** reducing the number of medical practioners by the mere one hundred per year that the minister insists will be caught in these provisions—who can, we have heard, always become CMOs and cost-shift back onto the States through the public hospital system—will reduce the overall cost of Medicare by $500 million dollars over the next four years?

Is it possible that the Minister of Health is being, er, economical with the truth here? Is it possible that the bottom line is that your providor number has just become a political tool useful for the control of your profession? Bloody oath it is. For myself, I smell a testing of the waters to see how much oppostion is really out here. Anyone who thinks that the Minister assuring the RMOs three times in a recent meeting that geographical provider numbers are merely a myth has clearly never found themselves playing a losing hand at poker. The evidence is before you. A group of fully-qualified medical practicioners have just been excluded from any practice of their profession outside the confines of a government designated area of work.

Look around. Work it out. The group in question were those outside the power play —those newly qualified and not already dancing to the College's tune. The most vulnerable and obvious targets in fact.

Will they be the only targets? Can you save $500 million dollars over four years by keeping a hundred of them per year in the public hospital system?

No, you can't.

So. Who's next?

HIA - The Campaign

A brief synopsis of Meeting at UNSW on March 14.

~~Junior~~ Doctors Dispute Coverage Part 3.

So, given that this nasty little piece of legislation is now law, what can be done about it? Simple—the relevant sections can be amended or repealed.

To this end the RMOs and their allies started lobbying the Democrats in October, subsequent to which an additional 50 'safety-net' training places were added to the 400 total Australian GP training places. However, these places are only available to doctors who have exhausted all other options and no guarantee is given as to the nature or location (even the State) of the training position. It is important to realise also, that under the new provisions, a training provider number refers to the job you're in, not to you inside it. You can no longer take that provider number with you when you walk out in disgust from your placement 1000kms from your spouse and children. (Don't laugh, it happens).

Of course the real difficulty in this process has been the Minister's refusal of acknowledge letters, return phone calls or be willing to meet with the RMOs, on the curious grounds that, "There's nothing to talk to doctors about." The other difficulty has been rousing the other state RMO bodies to action in the face of political intimidation (esp Vic.) and outright threats of $1000 personal fines (ACT). At the time of the major RMOs meeting on Friday March 14, at which point the industrial action—withdrawal of non-emergency services—was already a week old, QLD was attempting a separate deal, which wasn't working, the NT was out and SA and WA were wavering. Rural hospitals were invited to teleconferencing and the entire committee of the RMOs had dents in their ears from being stuck on the phone for hours on end. The State Health Dept were in support of the dispute, to the point where a doctor representing the PSA and the RMOs was actually invited to travel to Tamworth where she addressed the State Parliament in its rural sitting. As ever, the NSW Branch of the AMA, ASMOF and the PSA were unwavering in their efforts, and the meeting and its speakers were well-informed, responsible and highly organised. The matter is too serious for anything less.

At that point, March 14, instead of waning, support was actually starting to snow-ball, helped along by a some sterling media performances from the Minister, including the deathless gems, "Even if it turns out we're wrong, we're going ahead with it anyway," and his suggestion that the RMO's could always "drive a taxi". Possibly the most boggling of his utterances was the suggestion that one did not have to be a doctor to profitably employ a medical degree, after all, look at him.

Happily, the dispute had attracted a certain amount of attention, with 170 media references on its first day alone. It was still a third page SMH topic a week later. Opinion was mixed, as would be expected in so complex a case, but the effect was what was required, of declining to let the issue die. The VMOs had a meeting at RNS on March 9 and passed a number of motions in support of the RMOs, and the NSW Branch of the AMA was considering on March 18 a motion calling for "a challenge in the High Court to the Federal legislation which restricts Medicare Provider numbers on the grounds that the legislation affects civil conscription of doctors which is outlawed by the Constitution." (Section 51. Paragraph 23a).

On Friday March 14 the State Health Dept lodged a Notice of Dispute with the Industrial Relations Comission. On Monday the 17th March Justice Fischer appointed a judge to hear the case and cordially "invited" the Minister to come to the table for discussions. Apparently an invitation too good to refuse, at last.

And should you still be of the opinion that all this has nothing to do with you, remember that on the meeting day itself, a further Amendment was put before Senate providing for the loss of control of their medical records by doctors, despite the victory on this issue in the High Court a year previously.

So hang onto your hats, this isn't over yet.

CMOA Website

Peter Tait Webmaster

http://www.gis.net.au/CMOA.

Any organisation worth it's salt has it's own World Wide Web site. The CMOA is no exception —we are now on the web!

Just before Easter, the CMOA Homepage made it's debut on the net. Admittedly it is still in it's embryonic stages, but the possibilities for the future are endless. There are a myriad of potential applications for members of the CMOA on the web, including continuing medical education, discussion groups, rapid dissemination of news and information of importance to CMOs, and of course the convenience of email. The uses of the internet in general and the website in particular will develop as the CMOA develops.

At this stage the website consists essentially of general information about the Association and a collection of links that should be of interest to CMOs. ***The Bulletin*** is also published online. Plans are afoot to develop the site substantially over the next few months, and any ideas from members about other ways to improve the site would be very much welcomed. In particular, if any net savvy members have stumbled across websites of interest, let us know the URLs for inclusion on the links page.

For those who have not yet discovered the potential of the internet, a series of articles about how to use the net to greatest advantage will appear in future issues of ***The Bulletin.***

The URL for the CMOs Association website is **http://www.gis.net.au/CMOA**. Any ideas or suggestions should be sent to Mary or myself, our email addresses appear on page 2.

To whet your appetite, here a few sites to interest CMOs, especially those working in emergency medicine.

http://www.trauma.org/resus/moulage/moulage.html
This site has a series of interactive trauma moulages, allowing the user to make decisions regarding the management of major traumas. If you make a wrong decision, the program will quite bluntly inform you that you've killed the patient!

http://www.embbs.com/
This is the Emergency Medicine and Primary Care Home Page. It features an enormous array of resources, including a radiology library, an ECG library, clinical reviews, more trauma simulations, and a net forum for emergency physicians.

http://rmstewart.uthscsa.edu/default.html
This the University of Texas trauma site. It has an excellent list of links to many other websites dealing with trauma and emergency medicine.

ASMOF and Career Medical Officers

This, just to hand from the February Neswletter of ASMOF....
Reprinted with permission

A proposal to re-name the old Public Health group as the Career Medical Officer's Group and for the group to concentrate its activities on representation of CMOs is likely to be put forward at the Federation's Annual General Meeting. Separate representation on Council for CMOs would allow a single, consistent voice mirroring the arrangements for Hospital Specialists, Specialist Medical Managers and Clinical Academics. At the same time, with the introduction of Groups based on Area Health Services, individual or local issues can be pursued on behalf of CMOs through those groups.

Recently, the Federation has held discussions with Dr John Egan from the Career Medical Officer's Association with a view to more effective representation of industrial and professional issues relevant to CMOs. The discussions have been both informative and productive and the Federation anticipates that co-operation between the organtisations can only lead to benefits for CMOs generally. The recent restrictions to Medicare providor numbers will increase the ranks of the Career Medical Officers. the federation is committed to working on a number ofissues with the Career Medical Officers during the course of 1997.

CMOA Meeting Report

Second Meeting Tuesday February 11, 1997 Bankstown Hospital

One of the most important functions of the CMOA is to keep the members in touch with each other and with issues of mutual concern. Therefore a coverage of each meeting will be published in the following issue of *The Bulletin*.

Dr. Ron Speechley, Medical Superintendant, Orange Base Hospital, was our first ever guest speaker, and having clearly heard about our existence, (yea! - Ed.) dropped by to say Hi and point out an employment opportunity that has emerged in Orange Base Hospital for a senior CMO to run their Emergency Dept. We will be adding him to the mailing list and wishing him luck in his quest.

We also had interstate representation from the irrepressible Dr Gabrielle DuPreeze-Wilkinson, visiting from QLD and ready to share her skills and experience in dealing with administrators everywhere. Gabrielle is presently Deputy Medical Superintendant at Toowomba Base Hospital and heavily involved in both industrial issues and in the development of a Master Of Medicine pilot programme, incorporating the astonishing and ground-breaking concept that working in the field of your choice increases your expertise in that field. She promises to bring the CMOA and our cause to the attention of CMOs and residents throughout QLD on her upcoming regional hospital tour.

Present: Murray Barrell, Michael Boyd, Steven Delprado, Seeta Dursurvalla, Gabrielle du Preez -Wilkinson, John Egan, Mary McGinty, Tony Moynham, Jenny Virgona, Mary G.T.Webber

1. Business arising from previous meeting: included the push for paid-up memberships, which approach 50 but need to be twice that at least for us to be able to stick up our hands anywhere near a government body and be heard. Our mailing list is closer to 150, who will get freebies and lots of encouragement to cough up the cash for a while yet. We came up with several notions of information sources to scunge for further names and faced the fact squarely that it will be up to us to take the message to the people, emphasising the personal touch, since the issues of income and employment and professional autonomy are nothing if not personal. Volunteers were identified to search out CMOs everywhere.

2. Incorporation - We are incorporated as of the 19th Dec 1996. Insurance policy No. SB2709996 / GIO. As an organisationn we follow the NSW Model Rules for Incorporation of Associations. The President is responsibile for the relevant papers, and will pass them along, come election time, to his sucessor.

3. Education Officer's Report - Steve pointed out that his submission to the Federal Department of Health and Family Services was ready, so he tabled it for discussion, whereupon we went over it and rendered various parts into Beaurocratese for the benfit of the common-sense impaired. Words on its fate in the next newsletter, stay tuned.

4. Research. We seek a way to bring all the relevant databases together, and sort out the fascinating question of who and where we all are, but maybe not this week.

5. Advertising. We spent an extraordinary amount of money ($1344) on a half-page ad with an AMA publication to very little effect, so that was a learning experience. Advertising will go to notice boards, mail-outs, word of mouth and Kien Caoxuan's already-negotiated deal swapping cartoons for ad-space in the journal of his choice.

6. *The CMOA Bulletin* - we decided to acccept adverts for conferences and employment opportunities and generally expand the notion of *The Bulletin* to include educational articles and profiles of the members and generally to stay in touch and share the interesting information that comes our way. A motion of thanks went to Mary G.T.Webber and *Flying Colours Printing* for the great job in minimal time.

7. Treasurers Update. Michael King sent apologies and submitted a report on where the money goes and we universally

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Submitting Items For CMOA Bulletin

This is your journal. You are welcome to submit letters, articles, papers, photos, cartoons, quotable quotes, in fact just about anything that its legal to print. ***CMOA Bulletin*** will only be as good as your contributions make it, so get to your word processors.

All items submitted should be either sent on disc, or e-mail to the Editor, whose mail and e-mail addresses are on page 2. Just about any PC or Mac Word Processing format is OK. When submitting items on disc, please label your disc, and provide a printed copy if possible. Please contact the Editor if you wish to submit material generated in other types of software applications.

Illustrations should be in black ink, on plain white paper with nothing on the back. Photographs can be either black & white or colour.

Typed copy is acceptable only if you have no other means available, and we can't seriously expect our publisher to read doctors' handwriting - so don't even think about it.

Next issue will appear in June.

Closing date for submissions: 15th May.