



# ASCMO Times

Newsletter of the Australasian Society of Career Medical Officers

**JULY 2008 ISSUE**

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*Michael Boyd*

## PRESIDENT'S REPORT

### *The Art of the Possible*

What a journey, what an adventure!

From small beginnings a group of die hard persistent folk have managed some really quite amazing things! It does not seem very long since we sat trying to work out what we should call ourselves, where we thought we would like to go - we decided that we would have 2 parts to our association - industrial and educational and that we should be lobbying for a general and sustainable improvement in the conditions and career opportunities of CMO's. We wanted the three R's - Recognition, Remuneration and to Reconfigure the educational and career pathways available to CMO's.

Now into our second decade we can begin to count some achievements and note that there are still a few crocodile infested waters to navigate and cliffs to climb!

Recognition has now in part come our way - (not all of it wanted...) and we are now increasingly seen to be an important part of the workforce. Those of us more used to with bifrontal migraines from bashing our heads against the brick wall or the glass ceiling are quite astounded that, at last, people take our views seriously rather than just dismissing them. To have been invited as a peak body to discuss the future of the health system was indeed one of those "how did we get here?" moments. CMO's are still having some difficulties in the local jungle but slow gains are being made.

Remuneration has vastly improved in NSW and the more egregious parts of the old award have been dispensed with. Ongoing relationships with both of the unions representing CMO's continuing to produce needed outcomes. Queensland continues to be ahead of the rest of Australia as regards the integration of the CMO workforce into the industrial framework. Other States have greater degrees of difficulty with their generalist workforces.

**Cont p2**

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*Whilst there is mounting pressure towards becoming a college to support the CMO, the need to maintain inclusivity and cooperative support has never been greater.*

Reconfiguring the educational and career pathway has proven a little harder. Our AGM due at the end of this week is all about the provision of a career pathway that can be designed to be inclusive and flexible. We have seen our colleagues in New Zealand become Acute Medical Practitioners - recognised as a separate branch of urgent care medicine. We have seen our rural colleagues gain from the recognition that rural medicine does need specific support. The premier of NSW has decided that all CMO's are Hospitalists and NSW Health is working toward a structure of "Career Hospitalists" leading to a "Staff Hospitalist" position.

Whilst there is mounting pressure towards becoming a college to support the CMO/MOSS/Hospitalist/SHO/ (etc), the need to maintain inclusivity and cooperative support has never been greater. However It seems clear that if we let others control our future the decisions made will not necessarily fulfill our goals and to continue to have some influence over our futures we may need to evolve.

So well done Seymour - you appear to be growing well Like all preteens there are changes ahead.

The adventure continues.

**COMMITTEE 2007**

- President :** Michael Boyd
- Vice President :** TBA.....
- Secretary :** Mary Webber
- Treasurer :** Ken Wilson
- Education Officer :** Gabrielle du-Preez Wilkinson
- Industrial Officer :** Ross White
- ASMOF Rep :** Ron Strauss
- Website Moderator :** David Brock
- Journal Editor :** Mary Webber
- Membership Secretary :** Ron Strauss
- AMA Contact Person :** Gabrielle du-Preez Wilkinson
- Committee Members :** Virginia Noel, Michelle Meltzer, Irene Adby, Louise Delaney



## GARLING INQUIRY

*Mary Webber: Secretary ASCMO*

*Despite an  
initial  
scepticism, the  
scope and sheer  
persistence of  
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impressed  
us.....*

Following the death of Vanessa Anderson in RNSH in 2005 and other difficulties since then, the State Government of NSW appointed Peter Garling SC in January 2008 to head up a Special Commission of Inquiry into the state of acute care services in NSW. See [http://www.health.nsw.gov.au/news/2008/20080125\\_00.html](http://www.health.nsw.gov.au/news/2008/20080125_00.html) for more details.

Commissioner Garling has toured the state of NSW for months talking to all and sundry on the ground and taking submissions from interested parties. Upwards of 20,000 pages of testimony have been garnered, generating at the very least a unique resource and snapshot of the condition of the health care network in 2008.

Despite an initial scepticism, the scope and sheer persistence of the enquiry's efforts impressed us greatly and ASCMO decided to put a document together at short notice and submit it privately.

Our effort paid off well beyond our expectations when we received in return a short notice invitation to come to the offices of the enquiry and meet with the Commissioner and his team privately to discuss our submission and the concepts that CMOs have for the health of the system as a whole. On the 24 June we (Ross, Michael and Mary) put on our best suits (well, Michael put on his best jumper) and presented ourselves. You know what we said - the same things CMOs have been saying since the beginning of our life as an organisation. But we were met with courtesy and listened to with attention and enjoyed a spirited discussion, and that is <not> how it has always been when CMOs speak out. In fact, we found Mr Garling to be actually ahead of us in some respects, and that was unique in our experience - they have (not ) been sleeping through all that testimony. We thoroughly enjoyed it



Ross White: Industrial Officer ASCMO

## INDUSTRIAL REPORT 2008

I must acknowledge David Brock's continued involvement in the Industrial are of our organisation. Those of us employed in NSW Health and who have benefited from revision of the CMO award appreciate the work that David has done as the CMO rep on the ASMOF NSW Council, reminding AMSOF that CMOs are an independent group of professionals who need consideration and should not be expected to provide additional industrial muscle to push for better conditions and pay for staff specialists.

When I was unexpectedly hospitalised in early June, David advised the ASCMO talk group about the 3.9% increase from 1<sup>st</sup> July offered by NSW Health. The group decided to accept that offer rather than undergo protracted negotiations which may not have had any backdating to 1<sup>st</sup> July. There has been some trade-offs with limits accumulation of ADOs – this has not been applied to CMOs only, but to many others in the NSW Public Service. Those CMOs who do get ADOs should take them before losing them.

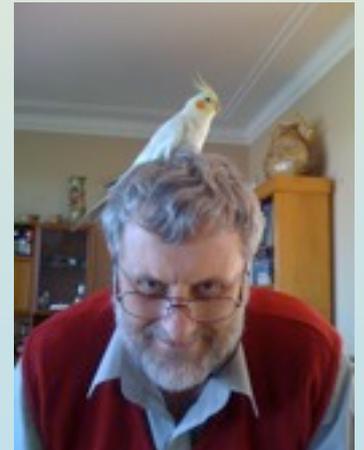
Payment of conference and course expenses has been an ongoing concern for NSW CMOs. As we are not staff specialists, there is no hospital or Area Health TESL office to handle our claims for payment in advance or refunds of expenditure. Some areas have got their act together and it is all straight forward to arrange payment, while other hospitals require multiple submissions of forms with approved non-order vouchers. When payment does happen, it can happen serendipitously and trying to get the system to work in the same fashion again frequently results in disappointment.

There was some discussion in ASCMO-Talk that there should be an annual amount specified in the Award for each CMO's education and conference expenses. It was felt that this could be held over rather than delay the pay increase. As Industrial Officer, I would appreciate any information about successful applications with details regarding forms used and the key AHS contacts. Also if you are having problems getting funding to attend suitable conferences and courses, please let me know. In the 2008 reprint of the NSW Medical Board's Code of Professional Conduct, Standard 1.3.1 requires of doctors "In order to maintain your competence (knowledge and skill), you must participate in educational activities, relevant to your area of practice, which develop and maintain your performance throughout your working life..".

NSW Health has indicated that it would be looking at a new award or section of the CMO award to cover the Hospitalist and Staff Hospitalist posts. What NSW Health eventually does offer is awaited with keen interest seeing that that the Hospital Skills Program is going ahead with curricula for emergency, aged care and mental health being developed.

*Area of Need Positions.* ASMO is frequently asked to support AoN applications where there have been no local applicants for a CMO job. The employer than advertise overseas and put an international medical graduate in the post, and that doctor is tied to that post. I have looked at some of the advertisements and these are clearly needing a very experienced doctor with years of experience and a high level of clinical skills yet the employer is looking for a CMO 1 or 2, being the cheapest option. I have rung the contacts for several of these posts and have asked them why they did not advertise the position as being open to Senior CMOs. They said that they would be very happy to accept a Senior CMO but were worried that putting in Senior CMO in the advertisement would discourage those applicants early in their CMO careers. I have suggested that in future, they should include "...up to and including Senior CMO.." as there may those in our ranks looking for a change of workplace but not wanting a reduction in pay rates. This would save the new employer the costs in checking applicants overseas, arranging AMC and NSWMB recognition, and sponsoring them.

I was thinking of writing to all AHS Directors of Workforce saying that unless the original advertisements contained mention of the possibility of a Senior CMO appointment, then ASCMO could not offer support from 1<sup>st</sup> Jan 2009. This may backfire and they may ignore ASCMO and just apply for AoN without our support. These key people in each AHS may not want much to do with us in the future and we will need to work with them.



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*Gabrielle duPreez-Wilkinson*

## EDUCATION : WHEREFORE ART THOU?

As often as the world turns, so changes the times and fortunes of CMOs... Once the cornerstone of the health system, especially in the hospital, for a long time, we were left as merely moss growing on the buildings – adding in some mysterious way that people couldn't define, occasionally scraped away, but mostly just left alone to add our own ethereal beauty, strength and quiet peace..

Suddenly, now, it has been discovered that this moss is the only thing holding some structures together, with the underlying cement decaying years ago.. Organic is often best..

### ***The Beginnings***

Similarly, our education from whipper snappers into saplings and then matured oaks has been an ongoing evolution. Once, the rotations and terms required for generalist training were easily come by – flexibility was the essence of clinical care.. Then, the twin evils of restricted provider numbers and sub sub specialisation induced a suffocating hysteria, where each term was fiercely guarded by the specialists charged with the training, only for their young... And now, we are reinventing a wheel that was smashed in the past – trying to re establish the broad basis of education that allows for a depth of understanding required by generalist clinical care.

The auspices for these revolutions are the rural generalist/ generalist in ... (emergency, forensics etcetera) in Queensland, and the hospitalist model in New South Wales. Under these revivals are the true value of the CMO being re recognised, and the old training pathways rebooted under new guises, and modernised a little, just to keep the trend setters happy that things have really changed..

But even more has changed. In Queensland, the generalist models are being adopted, accredited, credentialed, and revitalised in conjunction with ACRRM (Australian College of Rural and Remote Medicine). Individual CMOs are having their CVs reviewed and individual training plans developed to move people to Fellowship in ACRRM.. So CMOs will be able to get provider numbers!!! AND we are starting conversations with people in NSW to follow suit..

### ***The Continuation***

Now that we have re established that a wheel is good and should be round, how do we keep it rolling? In fact, how have we kept it rolling for so long..

Continuing Education for CMOs to date has been variable and multi variate. They could join a Royal College program as a member or associate, and keep track through that. They could keep their own diary and report back to Medical Board as they see fit. They could participate in University programs of any sort. They can join the ASCMO program for documentation and certification. There have been many roads to the same place.

The ASCMO CPD program to date has been essentially a record of activities. As Education Officer for ASCMO, I have just checked that a minimum of fifty hours activity per year has occurred in activities that seem appropriate to the person's position. These activities have been quite wide ranging – from classic journals and conferences through to case discussions with peers and specialists, and everything in between. Considerations have been given to contracts, where education is proactively planned, rather than reactively being stumbled across, but this has been difficult to manage with resources and technology..

The future is very exciting. RRMEO – the on line education module for ACRRM – has many possibilities.. Obviously, if a permanent and concrete alignment with ACRRM is formed, this will provide an option through RRMEO to record and look for educational activities – and options for different certification through the College. If ACRRM remains only a support, but not integral, there are options to still access RRMEO through a different portal – and various options for RRMEO access exist, including the potential for a CMO only portal and community – with our own curriculum and learning objectives, if we want. This technology will allow us to do whatever we want with our own education – and make learning contracts, and print off our own certificates once authorised.. The world is our oyster – our time has come, for both perpetuation of the species and maintenance of the species in a healthy, safe manner. Vive Le Revolution!!

*But even more  
has changed.  
In  
Queensland,  
the generalist  
models are  
being adopted,  
accredited,  
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and revitalised  
in conjunction  
with  
ACRRM .....*

*The future is  
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## WEBSITE REPORT 2008

*David Brock : website co-ordinator ASCMO*

**www.ascmo.org.au** continues to be a valuable resource for CMOs across Australasia. The site provides a host of information for CMOs including various awards and salary scales for CMOs across Australia and on-line Application forms for ASCMO membership and ASCMO's "Continuing Professional Development Program" (CPDP). You can also find advertisements for permanent CMO positions on this site.

A restricted "Members-Only" area provides access to a large amount of industrial and politically related information. You will need to enter the following username/password combination to access relevant salary schedules and various industrial awards, etc.

*username = **ascmo**  
password = **member02***

Elsewhere on the site you'll continue to find past copies of "ASCMO-times" and "CMO Bulletins". You'll even find a selection of CMO related cartoons. (try doing a search for "cartoons"). Our most popular pages continue to be our "Links", "What's New" and "Industrial" pages, although there were quite a few visitors curious enough to visit ASCMO Committee's photo. Some of us could be famous.

The "Open forum" on our website remains under-utilised. So why not put in a message and get it going again.

Remember this website is provided for **YOUR information and participation**.

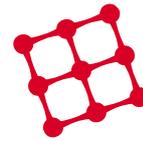
**ASCMO-talk@yahoogroups.com** is ASCMO's main discussion forum. Currently 30 CMOs belong to this (ASCMO only) email discussion group, where ideas are tossed around for general comment or perusal. All ASCMO members are welcome to join this free group, by simply sending a request to me at [davbrock@ozemail.com.au](mailto:davbrock@ozemail.com.au)

*The "Open forum" on our website remains under-utilised. So why not put in a message and get it going again.....*



*David Brock is the proud holder of the inaugural Brick award for his persistence at breaking glass ceilings*





**IMET**  
NSW Institute of  
Medical Education  
and Training

## Background to, and summary of, the Hospital Skills Program

In July 2005 a proposal was submitted to the NSW Minister for Health that a blueprint of a “Hospital Skills Program” (HSP) be developed that would provide structure for the training and education needs of the non-specialist medical workforce, and ensure that the capabilities of individuals are appropriately matched with roles and responsibilities for the delivery of care.

The non-specialist medical workforce is a heterogeneous group not supported by a coherent training system. Though there is potential for significant risk in relation to patient safety, there is little or no professional regulation. However, many such doctors have become highly skilled but are poorly recognised for such skills within the health system.

The Hospital Skills Program (HSP) is a program designed to:

- **Recognise skills** already attained by the non-specialist medical workforce in public hospitals throughout NSW.
- Provide mechanisms(s) to **increase the skills** needed by this cohort to fulfil these roles, particularly in emergency departments and other acute and critical care areas, but also in new roles such as mental health and aged care.
- Provide a system which **records skills** acquired by all doctors in NSW public hospitals and a mechanism for employers and employees to **match these skills** against those needed for a particular hospital position.

This program will then become a training framework as practitioners identify skills and abilities they require in order to function in roles across the levels. The program will provide opportunities for non-specialist medical staff to participate within a training program in order to develop and provide evidence of capability, allowing them to fill a role at a higher level.

This will be presented as a modular training program with the first three areas of focus to be Mental Health, Aged Care and Acute & Critical Care.

### Conceptual basis:

- The framework is a modular system aimed at developing capability and providing evidence of that capability which is transferable and recognised between different employers.
- The framework is structured in levels describing level of independent practice that would be appropriate for the level of capability attained in each level.

Level 0 (New graduate)	Level 1 (Supervised practice)	Level 2 (Competent practice)	Level 3 (Independent practice)
Intern/ Resident	<ul style="list-style-type: none"> <li>• Junior registrar</li> <li>• MMO 1</li> <li>• CMO Grade 1</li> </ul>	<ul style="list-style-type: none"> <li>• Junior registrar</li> <li>• MMO 2</li> <li>• CMO Grade 1</li> </ul>	<ul style="list-style-type: none"> <li>• Advanced registrar</li> <li>• MMO 3</li> <li>• CMO Grade 2</li> </ul>
This reflects the JMO Core Curriculum requirements for content, supervision and assessment	<ul style="list-style-type: none"> <li>• Competently functions independently** for components of care especially common and simple cases</li> <li>• Consults† for all cases before disposition or definitive management decided</li> <li>• Requires direct supervision# overall, for the majority of presentations</li> </ul>	<ul style="list-style-type: none"> <li>• Competently functions independently** for common and simple cases</li> <li>• Consults† for uncommon and complex cases</li> <li>• Requires direct supervision# for less common, complex and life threatening presentations</li> </ul>	<ul style="list-style-type: none"> <li>• Competently functions independently** for majority of presentations</li> <li>• Consults† for uncommon and complex cases</li> <li>• Does not require direct supervision#</li> </ul>

\*\* “Independent in” means the clinician can on most occasions perform safely and effectively at this level without direct supervision or intervention from a clinician with more specialised training and experience.

† Consults with medical officer at next highest grade. Level 2s use good judgment to consult specialists. Admitting consultants are also consulted if patients are inpatients on wards.

# Direct supervision implies supervisor is available in person at short notice



-The framework provides individuals with a guide that helps them to identify future training and education needs

-The framework helps supervisors to identify areas of skills requiring development

-The framework provides employers with a set of skills that can be used to ensure that a role is appropriately defined

-The framework closely links with the Hospitalist Pilot Project ensuring an education and training program for their ongoing educational needs

**The framework has underlying principles of:**

-Integration of training and evidence of capability activities (vertical integration allowing development of capabilities on continuum of learning from medical school through the career; horizontal integration allowing learning outcomes to be achieved from a variety of sources e.g. simulation, clinical experience, online learning and professional integration with other doctors)

-Mutual recognition of prior learning

-Flexibility regarding entry to employment

**The key components of the training plan are:**

-Adequate clinical experience. This includes capabilities assumed to be developed during relevant clinical placements.

-Off ward-training relevant to clinical duties. This incorporates opportunities to develop capabilities outside of clinical experience.

**Other expected outcomes include:**

-Improved patient safety and an anticipated improvement in the equity of outcome;

-The portability of skills and knowledge between public health organisations;

-Increased ease with which prior learning and assessment can be recognised;

-Improvements in the 'transfer' of training best practice between organisations (i.e. making sure that lessons are not lost);

-Improved cross professional recognition of training and skills;

-A framework that facilitates local work practice reform.

The Hospital Skills Program identifies an initial training plan with an emphasis on the 'hands-on' skills required within priority modules. This recognises prior clinical experience as well as completion of recognised off-ward training courses and activities such as simulation.

As a general principle, the HSP allows for existing training, provided by vocational Colleges and affiliated training agencies, to be recognised according to standards outlined by the an Education and Training Committee. However, it is envisaged that the majority of training will take place in the workplace within a hospital setting.

The education program and training plan identifies learning outcomes, pre-requisites for learning, minimum requirements for training and evidence of capability at each of the four levels that roles will be graded at for non-specialist medical staff in relevant modules. The modules require evidence of capability in both 'hands-on skills' such as airway management as well as cognitive skills such as communication and crisis management. It also identifies the different pathways through which this training can be obtained:

-Local training;

-Formal courses;

-Recognition of prior learning;

-Skills centre training.

The purpose of the first workshop is to start to identify relevant skill sets (those that are core to any module) and those that are specific to modules as well as considering non-clinical skills. This work will be further progressed at the second and third workshops.

**IMET Contacts:**

Ms Erin Mulvey, 9844 6565

Ms Alix Brown, 9844 6541



ASCMO Meeting 3<sup>rd</sup> October 2007 —

Alice Springs, 1.30pm

Attendance: Michael Boyd, Claire McGrath, Mary G. T Webber, Gabrielle duPreez Wilkinson, Peter Smith AMPA NZ, Michael King, Ross White, Robyn Carey AMPA NZ, Ken Wilson, Ramy Mezrami

Apologies: David Brock (insincere)

AGM minutes — “look okay”

Comments on AGM minutes:

- Unsure when membership lapse — and some confusion of when financial or not
- 70 financial members as of 2 weeks ago
- Relationship with unions is currently calm as focus has moved elsewhere in NSW
- Qld award changes noted — study pay into routine pay, as well as C2 levels that will allow equivalence with specialists
- In NSW, CMOs now the flower of the day

Agenda:

1. AMPA relationship
2. Alice Springs loop
3. College relationship
4. Hospitalists
5. On line CME

Ratify continued support of this conference at same level — \$750 per year

Deal with ASEM for discount in registration for next year

1. Suggest similar support for AMPA conference in March 2008, at approximately same level as with ASEM, and possible similar level of discount for their conference  
AMPA is somewhere between GP and ED, in facilities that are not physically in existence in Australia

2. Alice Springs loop - need to re establish contact

3. College — still problem with some of specialist colleges

All training in ACRRM can be done in hospitals — potential links with ACRRM

Multiple pathways with integration into ASCMO

Need to continue working in this area

4. Hospitalists is starting to fly up the wall, as the churning of the rest of the organization uncovers the gaps and hospitalists are being thought of as the putty fill  
Senior permanent, with strong peripheral vision with links back to the real world in as many ways as possible.

Port Macquarie has just one new appointment from own funds

3 x hospitalist bodies here at present...

5. Demonstration of RRMEO trial site — continue matrix and website development and trial for next year meeting — early in year — trial group

**Apologies:  
David Brock  
(insincere)...**

**THE HEART.  
THE SOUL.**



**THE CENTRE.**

**Report on AMPA Conference on Urgent Care Auckland  
8-9 February 2008 by Ross White (Industrial Officer, ASCMO).**

Michael Boyd and I attended this conference. In addition to the sessions on clinical management, there was a lively plenary session where speakers from NZ, USA, Ireland and Australia and here is my recollection of the discussions:

**NZ:** Dr David Gollogly spoke about NZ. NZ is the most developed in having doctors and centres that specialise in urgent care.

New Zealand is on a per capita basis the biggest exporter of their own medical graduates and the biggest importer of foreign medical graduates to make up the deficiency by the exports.

Three factors coincided:

1. In 1987, the Government through the District Health Boards encouraged the establishment of Accident and Medical (A&M) centres to provide comprehensive care to people with acute conditions not requiring hospital care. They have on-site xray (often now with digital imaging and remote short turnaround reporting), no appointments, and extended hours. Most are owned by companies but I did meet an IMG who owned a couple in South Auckland A few are co-located with hospitals and at least one clinic in Christchurch has some beds for people to be observed and treated (eg IV rehydration) for up to about 6 hours.
2. The Accident Compensation Commission was established providing free medical treatment and rehabilitation for accident victims regardless of cause. (I was at a RNZCGP Medical Education Convention in 2006 and I heard how GP teachers actively train the GP trainees in the correct filling out of ACC forms as this is such an important part of practice income).
3. The revision of the Medical Practitioners Act in the 1990s. AMPA, established in 1991, became a body with equal footing as the learned colleges in being able to vocationally register doctors working in these clinics. Some doctors work as GPs and also in A&M clinics. While there were some initial suggestions that the RNZCGP would include the A&M doctors, there was opposition from some in the RNZCGP about the relevance of A&M doctors. So AMPA went ahead independently and became able to vocationally register doctors working in that field. AMPA developed its standards and a system to examine candidates – the entry exam is called AMPEX and the exit exam is the Diploma of Community Emergency Medicine run by the University of Auckland which can be done by distance learning. An alternative to the AMPEX for entry is to have passed part 1 exam of ACEM. There is a non-compulsory preparation course for AMPEX available by distance learning. AMPA has 3 roles: education, industrial, and vocational registration. AMPA has a Board of Censors, an Education Committee, and a Professional Standards Committee. It is now looking at setting Standards for A&M Clinics.

David has a vision that urgent care should become international so that that doctors who work overseas have portable recognition of skills, and there would be a common curriculum and shared teaching materials and exams. He would like there to be an International Journal of Urgent Care.

**USA:** Dr Lee Resnick from University Hospitals Urgent Care in Orange Village, Ohio and is the President of the Urgent Care Association of the America which was founded in 2004. Its website is [www.ucaoa.org](http://www.ucaoa.org) and states that there are over 17,000 urgent care centres in the USA. These centres “meet the need for convenient access for minor injuries and illnesses” Dr Resnick said that some US Emergency Departments charge a premium for patients who have low acuity illnesses and injuries to discourage their attendance. UCAOA represent centre owners as well as doctors employed there. Dr Resnick mentioned that some pharmacy chains have nurse practitioners to provide limited care and one chain has the line “You’re sick, we’re quick!” ([www.mintecclinic.com](http://www.mintecclinic.com)). They have fixed prices and refer patients to primary care physicians, urgent care centres, and emergency departments if the patient is not within their defined scope of practice.

*..... has a vision  
that urgent care  
should become  
international so  
that that doctors  
who work  
overseas have  
portable  
recognition of  
skills.....*



*The AMPA conference did not deal much about inpatient care after admission and there appears to be a gap in medical education/standards in the care of inpatients .....*

Dr Resnick defined urgent care as a collage of emergency medicine, general practice and orthopaedics. Urgent care centres were established because of convenience for patients and cost-effectiveness. They started appearing in the late 1970s and early 1980s but then faded until a resurgence in the 1990s. UCAOA has 2,500 doctors and 1,000 clinic owners/administrators as members. They have a monthly journal and a fellowship training programs eg in Case Western University in Cleveland.

Dr Resnick said some of the US specialty colleges are unhappy with urgent care centres as a departure from what they were used to working with. Specialists who disagree with the concept of urgent care can decide not to accept referrals from the clinics.

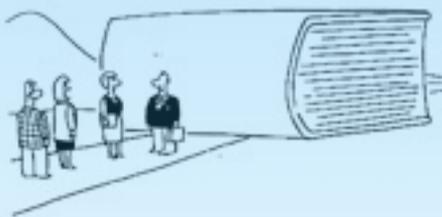
**Ireland:** Dr Ainsley Goodman is an NZ gradute who has worked in general practice and A&M clinics but now works in Swiftcare, a private urgent care clinic in Dublin. In Dublin it costs 60 Euros to see a GP or to go to a hospital ED. Swiftare charges the patient 120 Euros plus extra for imaging and path. A simple suturing is another 50 Euros. There is a lot of opposition from doctors and hospitals. Some ED doctors refuse to talk to her about patients that she is sending to emergency. There is lot of pressure with costs – most blood tests are sent to France and can take weeks to get results but imaging including CT is much more readily available.

**Australia:** Adam Janson from Melbourne talked about Australia and the opposition of ACEM to anything less than FACEM and Emergency trainees providing emergency care. The reality Lee reminded is that many FACEMs are burnt out by the training and don't want to work more than 20 hours a week. Some FACEMS are moving to other specialities (they can do a 2 year training program and become intensive care specialists nowadays), and fewer junior doctors are willing to undertake the training program when they look at the rigours and length of the training program and the lower professional satisfaction and income compared to other specialties. Adam also reminded the audience that a lot of doctors like to vary their careers and the rigid nature of many specialty training programs does not attract some doctors who head to locum work. A comment from one senior FACEM/FRACGP in the audience, now administering three emergency departments ( 2 private and 1 public), is that the newly graduated FACEMs compared the older FACEMs, are less tolerant of the non-specialist medical staffing in ED.

**Conclusion:** The Hospitalist model in NSW is more aimed at working in current hospitals whereas the NZ, US and Irish models of urgent care are more for standalone urgent care/A&M centres specifically to provided appropriate urgent care for patients who don't need the facilities of a full ED but are too acute for a general practice, or they cannot get an appointment at short notice.

Many small suburban general practices in Australia used to have signs saying "Casualty" but most GPs these days are swamped with their chronic care patients and have great difficulty fitting in urgent cases, particularly if the patient is not a regular patient of the practice. This will only increase as more suburban GPs retire and general practices close.

The AMPA conference did not deal much about inpatient care after admission and there appears to be a gap in medical education/standards in the care of inpatients apart from specific operations and procedures and immediate post-op care and ICU.



"It appears that our path is blocked by a giant procedural manual."

## ASCMO —

*Meet the Members : Virginia Noel*

Virginia is a long—term member and fiercely independent soul, famous in CMO circles for always going her own way, her great laugh, reading encyclopedias in boring meetings, bringing her offspring to conferences to give shoulder massages for free, and always winning the Trivia evenings.

In 2006 she also won the Einstein Factor, and at SSEM she showed us the tattoo to prove it!

*The last question on the grand final was "What was the name of the hidden valley in the novel of the same name by James Hilton?" and the answer (which I almost forgot in the excitement) was of course Shangri-La: that hidden environment where CMOs have only the most interesting patients, and there are no ignorant, inexperienced consultants, registrars or interns trying to boss them around..*

The Einstein Factors self-styled goal is to find the person who "knows everything about something and something about everything". To that end, contestants with specially nominated subjects appear each week. The show is also noted for Peter Berner's offbeat manner and humorous approach to being a quizmaster. The program has proved quite popular with a wide audience, unusually so for a program broadcast on the ABC. (ref: Wikipedia, of course)

A season of *The Einstein Factor* can be divided into three parts of 13 episodes each plus the series grand final, bringing the total number of episodes in a season to 40. The winners of each programme's heats compete at the end of the series in a series of "Play-Offs", the winners of which compete in a "Series Final". The three winners of the "Series Finals" compete in "*The Einstein Factor* Grand Final" to determine the series overall winner. Specialised subjects remain the same throughout. The following list is the typical structure of the last third of every season, usually commencing in early to mid-August:

3 heats / 1 Play-Off / 3 heats / 1 Play-Off / 3 heats / 1 Play-Off / 1 Series Final / 1 Grand Final

**Grand Final Winner — Series 3—[12 November 2006](#)**: Virginia Noel, special subject of [Classical Greek Mythology](#)

Virginia submitted the following 'quirky bits' about her topic to the ABC — reproduced here for your delectation

2200 points Virginia is a 55 y/o Prison Medical Officer/Doctor. She has 3 children, likes to sing and has lots of shoes. She would love to be able to give up work and sing all day.

...1. Virginity, for the Olympians, was a bit of a moveable feast. After a particularly unpleasant experience, a goddess could renew her chastity by bathing in a sacred stream. If only we could wipe out our bad love affairs like that.

2. For stabbing their husbands on their wedding night, the fifty Danaids were condemned to spend the rest of eternity trying to carry water in a sieve. A bit like housework, really.

3. Several women in Greek legend, when seduced by a god in animal form, were required to put up with a lot of bull. Nothing has changed in 2000 years.

4. Ancient Greek men were a gullible lot. They believed their women when they claimed impregnation by

- a swan
- a horse
- a god who appeared to Alcmene in the shape of her husband while the said husband was still away on the battlefield.

5. Women were just as bad. Odysseus took ten years to get home from the Trojan War, and his wife allegedly believed him when he told her, with a straight face, that for eight of those years he had been held captive on a secret island - completely against his will - by a beautiful nymph. If he'd had GPS, the Odyssey would never have been written.

*Virginia is a 55 year old Prison Medical Officer/ Doctor. She has 3 children, likes to sing and has lots of shoes.....*

*Virginity for the Olympians was a bit of a moveable feast. After a particularly unpleasant experience....*



## AGM MINUTES

28<sup>th</sup> July 2007**Novotel – Brighton Le Sands, Sydney**

**Present:** Mary Webber, Michael Boyd, Ken Wilson, Michelle Metzler, Louise Delaney, Cathy Cordi, Ross White, Virginia Noel, Gabrielle duPreez Wilkinson, Irene Advy, Ron Strauss

**On Telephone:** David Brock from Tweed heads

**Apologies:** Maria Nittis, Danny Briggs, Sunny Misir, Cathy Hull

**Opening Address**

Dr Michael Boyd welcomed members and guests, new and old. It's been a very interesting year, where we've been able to capitalise on previous hard and persistent work and get some continuing and real movement on the role and place of Hospitalists as a career option for CMOs, and to get the attention of the AMA and ASMOF as we never have before. 2007/2008 look like continuing in the same vein, with doors opening and challenges in every direction. One of the especially significant questions for our members is to understand the relationships and difference between CMO and hospitalists from our perspective. Is this another opportunity the CMOs are well placed to take up, or is this going to turn into a college program by stealth and limit our freedom to work in the diverse ways we currently enjoy or otherwise. We also confront the challenges of how others – in government, and Health administration view the same questions, since that will shape the resources and opportunities that are made available. We continue to push for an open—structured continuing education as the medical world increases its attention to the credentialing situation. Overall, it's been a pretty good year, and while there hasn't been time to be very active in this organisation, we've put energy into activity in other spheres – welcome and thanks for coming.

**Confirmation of Previous Minutes**

Moved: GdPW,

Seconded : All.

Passed: unanimously

**Reports**

**Office Manager: Cathy Cordi**

Our current state is stable, with good response from membership when they talk to us. A few new members continue to trickle in – much as we have seen over the years, with members appearing and disappearing as their interests meet ours, and a core of long term members committed to this organization. We have a new and updated database, which is now running well. Presently we have about 100 names current in the database – and so far 55 have paid full subscription for 2007, with more to follow from this meeting.

Ongoing education – 23 CPDP members currently, and several renewed so far – 5 new names in 2007 – and hopefully this will increase in 2007. As always with such a busy and scattered membership, we simply have to press on, to spread ASCMO word into the future.

It's a pleasure to be part of this organisation and to be organising today.

*Our current state  
is stable....  
and a core of  
long term  
members  
committed to the  
organisation.....*

**Vice President**

**Absent** – no report

**Secretary: Mary G. T Webber**

I strongly support Cathy's endeavours – For myself, I have a hate:hate relationship with my email and much prefer the corridor consultation – to show up and actually talk to people . I am deeply grateful to Cathy for doing what would otherwise be my job.

**Treasurer: Ken Wilson**

Financial reports have been distributed – our total income \$11000, and total expenditure was \$17000, though this downturn in income is partly related to bill distribution throughout the year – ie, there was no secretarial services paid for in 2005, but these were caught up in 2006. In reality we are probably only 1 – 2 thousand down at present, though lots of nice new members would be good.

There were a few other expenses from 2005 including web expenses that ended up piled into 2006, but I can report that we now up to date and current with finances and we should stay closer to breaking even in the future.

There is \$11 500 in the bank at present – though there will likely be more expenses to be presented today.

Financially we remain fairly stable. Our major costs are for this conference (AGM) fees and for secretarial services – both slowly increasing over time. We also make a regular contribution to aid SSEM and this will continue this year...

The contribution to SSEM money is well worth it, and gets us a meeting venue and occasion for no cost, a seat of their central committee, and raises our profile in the ED community, and gives us opportunity to present papers at conference level. We also engage with them co-operatively in such projects as sharing the cost of a proper conference phone, which SSEM and ASEM and ASCMO are all able to use

Task for Mary – check with Denby re the whereabouts of the invoice for said conference phone

At this current meeting - \$1050 with 15 people + \$25/ head extra for buffet lunch – we are paying \$45 per head

Income:

Website generates income – could get significant income stream from this over time.

Ad for 3 months: \$125/ ad - \$50 set up = \$75 profit

Banner ad for year: \$250/ ad - \$50 set up = \$200 profit

Overall – we run a quite lean organization and would prefer to avoid the need to put fees up at this time.

**Education Officer: Gabrielle du Preez Wilkinson**

15 – 20 people getting certificates for CPDP through diary

For the future – we will need to look at the next iteration of this process and decide how the future looks: ? electronic ? web based

We also need to look at developing contracts with learning objectives and looking at a more formal structure around CPDP.

A very large task to get to that level.





**Industrial Officer: Dave Brock**

As at 17/7/07: Gradings for senior CMOs discussed: 102 approved; 7 provisionally approved; 12 requesting further information (+ Balmain Casualty GPs); 15 have been rejected (+ 2 withdrawn); 16 are still being considered.

Reasons for rejection given as: 1. Applicant occupies AON position and not minimal supervision requirement; 2. Applicant on a training program, therefore not in meeting the minimal supervision requirement; 3. Not able to show applicant is doing work that would otherwise be done by a specialist... Some hospitalists got senior CMO status only through severe negotiation... *(ed: is that like in Star Wars where the Jedi engage in 'aggressive negotiations' – with light sabres?)*

We are unsure when 'specialist equivalence' component was slipped into equation – and we need to address this with the unions, as to when and how it came in – especially as this point is a probable reason for AMA salaried specialist complaints about the hospitalist role.

Currently both the job and the person need approval for senior CMO status – but if the person changes their job they will need to take a pay cut for 6/12 until the new position gets senior approval. This also is a new invention since award and represents a change without endorsement. Portability that was promised through the award negotiations appear to be lost.

*( ed: Robust discussion followed about senior CMO grading, processes, individual versus position applicability, and individual experiences explored at length. Love it.)*

Award statement: Not recommend unless meets 3 criteria

- Has at least 7 years PG experience;

- Has a demonstrated capacity to perform clinical duties and responsibilities at a senior level, with minimal clinical supervision, in one or more areas of medical specialty; and

- Is to perform clinical duties and responsibilities, at a senior level, with minimal clinical supervision, in one or more areas of medical specialty, as required by the employer

The loophole is the third criteria, where employers can chose to interpret as either.

We note with disgust that there is no CMO input into Senior CMO Status Committee occurring which raises questions about the validity of their industrial process. A lack of peer representation on the grading committee is not in line with due industrial process, as recognised across world.

The other major issue arising is the Study Leave Entitlement. In NSW this is being quibbled over at length, there is debate about Section 16, paragraph 4, whether there should be a money entitlement or automatic variable amount – TESL arrangement versus training funds also needs to be clarified – ASMOF needs to create form to comply with conditions of award...

In contract – the Brief Update on Queensland shows that the – C1 level is now automatic, study leave, car and petrol card all included, C2 still being worked out but will be back paid eventually...

**AMA Contact Person**

For discussion later re documents to date

*The other major issue arising is the Study Leave Entitlement. In N.S.W this is being quibbled over at length.....*





**ASMOF Rep**

NSW Health is developing policy directive about senior CMO status, with input from ASMOF.

Task – 6.30pm near Wentworth Park, third Tuesday of the month – need to delegate between people – 21<sup>st</sup> August – need follow up as well

**Website**

Included in financial discussions

David Brock maintaining it in ongoing manner – just ticking over

Few advertising agencies are interested in maintaining presence

ASCMO talk – about 32 people – drop people off for a while – continuing discussions – could be more active – more discussions – provided to membership, if they are interested

**Election of Office Bearers**

	<b>Nominated</b>	<b>Seconded</b>	<b>Election</b>
<b>President</b>			
Michael Boyd	Ross White	Ken Wilson	Unanimous
<b>Vice President</b>			
Maria Nittis	Michael Boyd	Ron Strauss	Unanimous
	pending Maria accepting – confirmed 1224 md		
<b>Secretary</b>			
Mary Weber	Gabrielle dPW	Michelle Metzler	Unanimous
<b>Treasurer</b>			
Ken Wilson	Michael Boyd	Mary Weber	Unanimous
<b>Education Officer</b>			
Gabrielle dPW	Virginia Noel	Ross White	Unanimous
<b>Industrial Officer</b>			
Ross White	Ron Strauss	Ross White	Unanimous
<b>ASMOF Rep</b>			
Ron Strauss	Ross White	David Brock	Unanimous
<b>Website/ AON moderator/ ASCMO moderator</b>			
David Brock	Mary Weber	Gabrielle dPW	Unanimous
<b>AMA Contact Person</b>			
Gabrielle dPW	Louise Delaney	Michael Boyd	Unanimous
	to talk to Danny Briggs		
<b>Journal Editor</b>			
Mary Weber	Michelle Metzler	David Brock	Unanimous
<b>Membership Secretary</b>			
Ron Strauss	David Brock	Louise Delaney	Unanimous
<b>Public Officer</b>			
Kien Caouxuan	Mary Weber	Gabrielle dPW	Unanimous
<b>Committee members</b>			
Virginia Noel	Ron Strauss	Ken Wilson	Unanimous
Michelle Metzler	Virginia Noel	David Brock	Unanimous
Irene Adby	Michelle Metzler	Virginia Noel	Unanimous
Louise Delaney	Ken Wilson	Michael Boyd	Unanimous



## outstanding Business

Monthly electronic newsletter – discussed as concept – web newsletter. Mary volunteers to explore this issue. Biggest issue is content – prepared to consider options. Could add charge to current ads.

Task list – Mary to ring Hiliary today.

Finish 1045am

## TASK LIST

Everyone

- ASMOF meetings – 6.30pm near Wentworth Park, third Tuesday of the month – need to delegate between people – 21<sup>st</sup> August – need follow up as well
- Continue delegated jobs/ tasks/ responsibilities of positions
- Keep track of doctors working below award
- Need to create database of CMOs – each member presenting info for own area
- Start recording on database for aberrance on pay rates for CMOs
- Suggest CMO support officer from ASMOF
- Consider volunteering to be buddy or mentor to new CMO

Mary

- Ring Hiliary today
- Check with Denby re invoice for conference phone
- Consider creating a video of real ED to show DOH people

Ron

- Distribute posters and fliers (and help Cathy and friends to create)

Gabrielle

- Approach medical managers in other areas for database of CMOs if problems in accessing data
- Approach Danny Briggs about AMA role
- Approach Tom D about wine for meetings
- Send various teaching sessions on to Mary and Michael and Ross
- Talk to David Brock about weblinks to and from ASMOF
- Suggest website comment to look for buddy or mentor, can contact me as Education Officer, then I recommend joining ASCMO and possibly link with support person
- Get ASCMO friendly version of RRMEO ready – have demonstrable by SSEM
- Consider talking to Mark Brown re CMOK version of RRMEO ...

Cathy with friends

- Need posters and fliers
- Bottles of wine for speakers for future meetings and for this year
- Investigate roll up demonstrate board
- Chat forums for separate discipline groups?!? – or through RRMEO



<b>ASCMO 2006 FINANCIAL REPORT</b>	
DEPOSITS INTO BANK	\$8,986.50
EXPENSES	\$10,895.05
	<b>-\$1,908.55</b> loss

<b>ASCMO 2006 EXPENSES</b>		<b>DEPOSITS</b>	
AGM COSTS	\$4,357.61	11/01/2006	\$1,070.00
STATIONARY/PRINTING	\$478.99	24/01/2006	\$1,665.00
POSTAGE	\$250.00	30/01/2006	\$1,255.00
TELECONFERENCING	\$237.13	09/02/2006	\$1,189.50
COMPUTER SOFTWARE	\$501.82	06/03/2006	\$240.00
SPRING SEMINAR EXPS	\$112.00	16/03/2006	\$523.00
WAGES as at 12/11/06	\$4,957.50	10/04/2006	\$295.00
		08/05/2006	\$295.00
		10/05/2006	\$271.00
	<b>\$10,895.05</b>	30/05/2006	\$300.00
		30/05/2006	\$480.00
		28/06/2006	\$127.00
		15/07/2006	\$192.00
		18/07/2006	\$350.00
		25/07/2006	\$247.00
		04/08/2006	\$120.00
		19/09/2006	\$36.00
		18/10/2006	\$91.00
		01/11/2006	\$120.00
		12/12/2006	\$120.00
			<b>\$8,986.50</b>



<b>DEPOSIT BREAKDOWN</b>	
Memberships	\$7,512.00
CPDP	\$1,045.00
AGM Payments	\$420.00
Dis Fee repaid	\$9.50
	<b>\$8,986.50</b>



## ASCMO Forum

at the AGM: 28<sup>th</sup> July 2007

In keeping with our long—standing philosophy of polite but vigorous discussion we moved onto a forum of discussing relevant issues — a time when it has never been more clear that CMOs need and profit from the voice that ASCMO provides.

11am – **Professor Mark Brown**, who has attended our meetings with great interest in the past discussed the nascent Hospital Skills Program and gave a powerpoint presentation — (*please see insert —ed*)

In short —there are a number of converging factors giving rise to the need to urgently reevaluate the delivery of education needs to doctors: the saturation of the existing training programs, the alternate world view of Generation Y, and rising doubts that the traditional training model will work for the future, especially given the oncoming rush of new graduates we expect over the coming decade – and whether hospitalists can take some of this educational and mentoring role.

FAQ: The Hospital Skills Program— how is it different to a College –

A: The HSP is neither hierarchial NOR exclusionary, there are no college fees for training, as well as 3 listed fundamental criteria of the design — (not specialist – but generalist, not rigidly time based, no exam-based barrier).. They aim to provide the ability to ‘bank’ your skills, so that both you and an employer can easily decide what you can do, and where you can pursue your interests further

Will be able to just enter or look at information in the HSP database...

( —followed by vigorous discussion re marketing of program to CMOs and how to move on with this. — ed)

### TASK LIST

- Need posters and fliers .... Keep track of doctors working below award...
- Need to create database of CMOs – each member presenting info for own area, and Gabrielle happy to approach medical managers in other areas for this...
- Award issues – up payments and down payments....

Lunch — 1230 – 1345

2pm - **John Pardy and Louise Delaney** – Obstetrics program – **presentation** on Michael’s computer. ‘The Future of Maternity Service in (semi) Rural Settings’

Discussion of the advantages of role delineation, of standardised roles, the importance of ongoing support from the employing organization and willingness of the learned colleges to give such a model support and a fair go. (*Woh! — subversive to the max — ed*)

Supporting video link options with VICU in NSW, and ICU/ psych/ derm/ ophthalmology/ paed in Qld discussed.

One of major issue is relationship between CMO and specialist/ rest of hospital versus registrar and specialist/ rest of hospital. However, in situations where the CMO service becomes established, these issues usually become theoretical after a time. Services that have taken up this model eg anaesthetics at Nepean where Danny works, usually embrace it with both hands for the stability it offers.



3pm – **AMA discussion** – a letter is apparently circulating from AMA Salaried Doctors Committee, whose next meeting is 6<sup>th</sup> August 2007, that is apparently less than enthusiastic about recent developments. They have received information through channels, (much as we do) and they do not understand r like what is happening. We need to get our act together and submit something in writing to AMA NSW or Federal AMA or Queensland AMA or all of them. We need to consider our approach and explain Hospitalists and the Queensland rural generalist program in an illuminating way.

3.05pm – Mary Webber – **presentation** for hospitalists – explaining the characteristics of the senior position, how the steering committee process works, the progress from Maggie program to where we are now. Quite hopeful htat if we make the effort to stay engaged, and show up constantly at the top table, some good things will follow.

3.30pm – Michelle Meltzer – discussion about new CMOs, especially IMG ones, and their risk and capacity to get lost in the system and not have enough support or educational opportunity.

Wide ranging discussions about options – including the desirability of a mentor/ buddy system, of links between the ASCMO and the ASMOF websites (and need for ASMOF to tell new CMOs about ASCMO), and possible phone or email systems set up to support people – actions to task list of AGM minutes

3.45pm – Gabrielle dPW – Review of CME across the colleges – **presentation** and demonstrate ACRRM/ RRMEO system and explanation of the potential of an ASCMO window into RRMEO

4.20pm – Tim Shaw by proxy – CPD **presentation** to be inserted – UNSW are willing partners – happy to be involved in process and ongoing developments.

**Names we have thought of when having a spirited discussion on whether to become a college.....**

**Australasian College of Hospitalists Trainees and Undifferentiated New Graduates : ACHTUNG**

**Experienced Medical Officers : EMO**

**Experienced Medicos Undifferentiated : EMU**

**Overworked, Stressed, Terribly Remunerated Independent Career Hospitalists : OSTRICH**

**Lack Of A Career Medical Officers : LOCMO**

**College of Institutional Generalists : CIG. ( Those with Special interests could be CIGS. Add Australasia to it and you would have ACIG )**

**Senior Undifferentiated Medical Officers : SUMO**

**Australasian College of Community, Hospital and Urgent Medicine Practioners - ACHUMP**

**Specialists in Integrated medicine working i n the Department of Intergrated Medicine : DIMSIM's**

