President's Address

Continued from page 1

community that state quite openly that CMOs are lazy, worthless, not clinically reliable and should get off their butts and either do the exams or get out and drive a taxi. Of course the same people are writing the rosters that relegate CMOs to unsocial undesirable and unsupervised shifts and duties on the grounds that.... well, it's early in the year, best not to get started on the topic of fallacious and self-serving logic. Anyway, the point is that we must take the responsibility of documenting what we know to be true.

Also on a good note ASEM has expressed considerable interest in increasing it's holding and representation of CMOs and has put its money where its mouth is with an offer of free membership for the first months of the year. This is a generous gesture and an offer too good to refuse, so details are at the back of this issue.

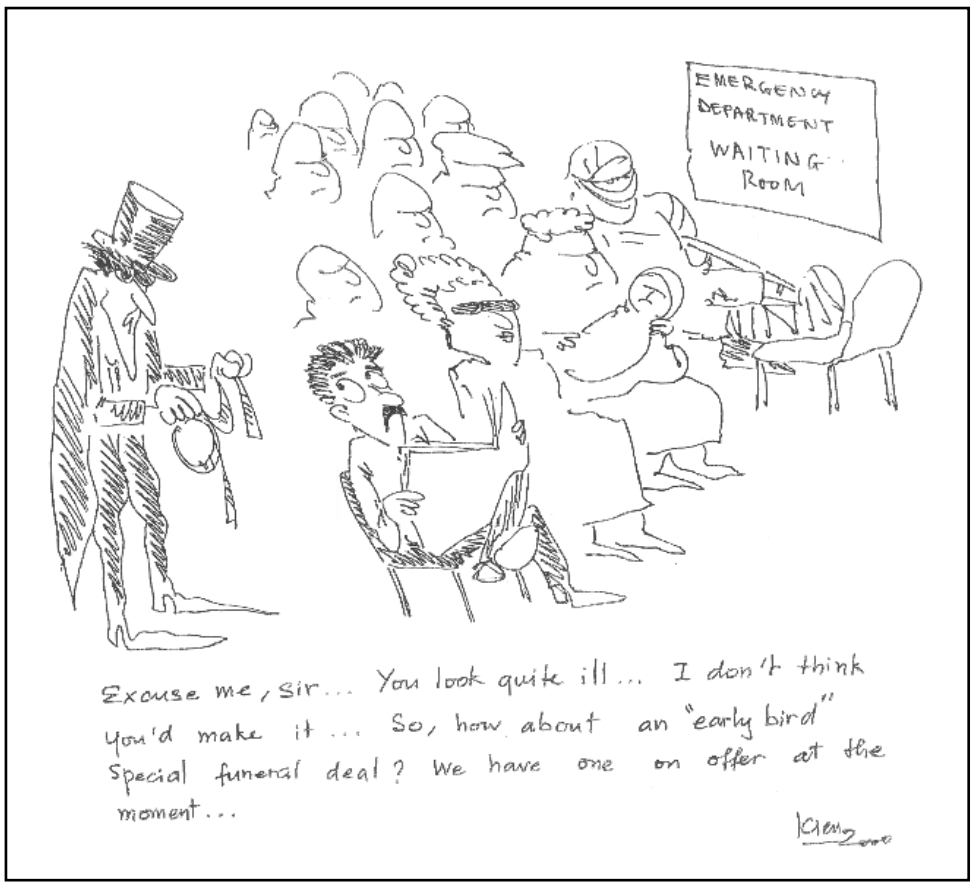
Towards the end of the year a debate has started to emerge in the MJA with regard to the evolution of "Hospitalist" as yet another desirable speciality within the hospital system and the physician, anaesthetists and FACEMs are all weighing into the discussion. For obvious reasons we too have put forward our own view that CMOs are already performing similar functions to those under discussion, and details will be published in the Bulletin at a later date.

1999 was also the year that the NSW CMO award was up for potential re-shaping. ASMOF undertook as survey which seemed to point out what we already knew which was that CMOs are senior doctors, largely Oz graduates and pursuing this course by choice. Then we are told that there is no money for alterations to the award. Then we see that a deal has been struck about which we knew nothing. This has turned out to be a very interesting situation and has not unfolded to the full even yet. Dave Brock has been our active and committed Industrial Officer and there is a preliminary note from him a little later in these pages. Suffice it to say that we will be looking forward to developments with rather a jaundiced eye and inviting ASMOF along to the AGM to answer some questions.

So, there is another AGM coming up. March 4th at the Novotel, Brighton-Le-Sands. Another opportunity for everyone to front up and engage in some active discussion and head counting and food and fluid. I hope very much that you will come and put forward your views then put up your hand to help us make those views a reality. Dr Allen Hewson, of Newcastle University is our major speaker and is seeking serious input from CMOs with regard to desirable further educational opportunities. And what I say is, come along.

The future will not be user friendly. So be involved. Money where your mouth is. Put up or shut up. And so on and so on. Welcome to our Brave New World. See you at the AGM.

Mary GT



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CMO Continuing Medical Education: The Next Frontier

By Gabrielle du Preez-Wilkinson

On 3rd December, 1999, I was privileged to be invited to the University of Queensland Medical School for a meeting. Yes, I can hear you all groan, another meeting. However, this was a meeting with a difference. Not only were highly esteemed colleagues present, but I believe the meeting may have achieved an outcome—or at least proposed a direction for an outcome— and not merely been a talkfest. Only time will tell if this optimism is misplaced. But now, **WE NEED YOU** to help reality occur.

Just to set the scene—another article in this Bulletin discusses the nexus between MTRP, PGMEC and CMO's (see Provider Number Legislation Update). As we are tuned in and pro-active individuals, who like to be in control of our own destiny, our Education Officer, Dr John Egan, has worked long and hard to negotiate the CPDP (Continuing Professional Development Program) to ensure that we can document and have our CME appropriately accredited. For our younger colleagues, there has always been the question, how do I become a CMO— what kind of training should I do? And each of us have had times when the convenience or practicality of CME has required huge expenditure, inconsistent with our level of earnings. So, for some time, some of us have dreamed of access to flexible, realistic, useful CME.

With this in mind, and with the blessing of the CMOA Executive, I went along to this meeting. The meeting was with Dr Peter Livingstone, Director of Queensland Medical Education Centre, Dr Bryan Campbell, Director of Queensland PGMEC, Professor John Hamilton, Assistant Dean Postgraduate Coursework Studies, Medical School, University of Newcastle, and Dr Alan Hewson, Assistant Dean CME University of Newcastle. As well as myself, Dr Michael Catchpole - Queensland Health Medical Adviser, Dr Stephen Brierley - Director Ipswich Hospital Emergency Department, and Dr Pat Naidoo - Director Redcliffe Hospital Emergency Department, were also in attendance—all of the latter three being CMO's in reality or heart.

We talked for many hours, but the summarised version of the discussion is looking towards an option for university based education for CMO's who choose it. There were concepts of a consortium being formed between University of Queensland and University of Newcastle to develop this program. This program was seen (at least by myself) as being complementary to, and having the capacity to work with, the CPDP already in existence. It was seen as essential that whatever education was developed, through the University consortium, that it was flexible, clinically based, has multiple entry points and recognition of prior learning and experience. It is currently being envisaged as being in a modular form, and having the potential to use distance education principles to allow access to CMO's in rural and remote areas. It was recognised as being essential that the education was driven by the individual CMO's, with variety and flexibility being stressed. It was also seen as essential that this process was voluntary, an option for CME or training, and NOT the compulsory or only method. (Given that CME is a life long process, and that university courses by their nature are time limited, this should not be difficult to maintain.) It was seen that many resources are already available, and that these should be integrated where possible, rather than re-inventing the wheel. The industrial issues and issues surrounding recognition by the Commonwealth for Provider Numbers were also briefly mentioned.

The most exciting aspect of the entire meeting wasn't just the brain storming and intellectual buzz associated. It was that these educationalists valued the input of the CMO's to develop a nationally recognised education process for the CMO's. There are funding issues and proposals that need to be developed and sorted through in the oncoming months. However, this is a genuine opportunity for us to ensure that we have educational options available to us that are useful, practical and palatable.

This is where WE NEED YOU. Dr Alan Hewson will be attending the AGM on 4th March, 2000, in Sydney, to discuss with us

Continued on page 9

Provider Number Legislation: Update

By Gabrielle du Preez-Wilkinson

The reasons that many of us chose to be Career Medical Officers are wide and varied. All of us enjoy career flexibility and self-determination in career objectives and ongoing education. The Medical Training Review Panel, set up to monitor medical workforce issues subsequent to the introduction of the Provider Number Legislation, is aware of the fact that we do not have a mandatory system of reporting and maintaining continuing medical education. The current view being touted is that CMO's should report to the relevant Post-Graduate Medical Education Council for their state, presumably through the Directors of Clinical Training, similar to Interns and PGY1 and PGY2.

There are obvious issues with this scenario – first and foremost, PGMEC's are set up to manage initial training issues for Resident Medical Officers, and have no experience to date with senior clinicians, such as CMO's. Secondly, the wide area of special interest and expertise amongst CMO's means that the training requirements and standards are wide and varied, and will require significant influx of funds to PGMEC's to develop this expertise. Another issue is that in many locales, the DCT is actually a CMO, so the people will be reporting to themselves.

For all of these reasons, and for the younger CMO's who may be caught in the Provider Number Legislation, an abridged version of the Executive Summary of the Mid Term Review of the Provider Number Legislation follows. The Minister for Health and Aged Care, Dr Michael Woolridge, tabled this Mid Term Review in the Federal Parliament on 8 December, 1999. The italic commentary, as well as the abridging, is by the author of this article. The aim of these is to decrease the amount of jargon, as well as the length. If anyone would like a full version of the Executive Summary, please contact me.

Mid Term Review of Provider Number Legislation

Commonwealth Government, December 1999
Executive Summary

In summary, the review found as follows:

Section 19AA
There is overwhelming agreement with the objective that General Practice be recognised as a vocational speciality (ie graduates without further training should not be practising unsupervised). Claims made at the time the bill was passed that there was a lack of training positions that would result in young doctors being unemployed or 'stranded' in hospitals have not materialised. This legislation is underpinning other quality and workforce packages that have been put in place.

Comment
Inadequate time has passed to allow this to eventuate.

Section 3GA
This section is being used effectively to approve training courses and to address workforce shortages. However the following issues need to be resolved:

- the quality and training objectives of the legislation are being weakened by the necessary emphasis on addressing workforce shortages;
- the objectives for and implementation of community terms in early post-graduate years; and
- there is a continuing low rate of Australian trained doctors taking positions in rural and remote communities.

Comment
This is in line with the Government's belief that no genuine medical workforce shortage exists, and that rural practice should be STRONGLY encouraged.

Section 3GC
The work and effectiveness of the MTRP in producing much needed information on training issues, and in bringing together stakeholders to resolve training issues, was

well recognised and positively regarded by the industry. Given that much of its initial work is done, the Panel should continue to address the growing challenges in the medical workforce environment.

Recommendations

Recommendation No 1
Approval to work in the emergency departments of private hospitals is a quality, workforce and patient service issue affecting private hospitals in both urban and rural areas which needs to be addressed. The Commonwealth should undertake discussions with the relevant parties to resolve this problem.

Recommendation No 2
Paraphrase – Encourage more General Practice training for rural communities, using colleges and funding as a mechanism.

Recommendation No 3
Paraphrase – Urgent review of the Queensland Country Relieving Program is required to maintain consistency with the intent of the legislation.

Recommendation No 4
As it is inappropriate for doctors without the relevant training to provide home visits, serious consideration should be given to repealing the regulations that established the Approved Medical Deputising Services Program.

Recommendation No 5
This review recommends that the role of the Rural Workforce Agencies as a body matching doctors and placements be considered in the context of the national evaluation of the Agencies.

Recommendation No 6
Given the apparent inconsistencies between the name of this program and its objectives, this review recommends that the name 'Rural Locum Relief Program' be changed to more accurately reflect its role.

Recommendation No 7
Paraphrase – Suggests consistent use of terminology, and prefers use of "area of need" terminology as this has been previously defined.

Recommendation No 8
Paraphrase – States community term for PGY2 needs to be further reviewed and analysed by MRTP.

Recommendation No 9
It is recommended that a body such as AMWAC undertake a longitudinal study, aimed toward filling in the gap in medical workforce knowledge of what Australian medical graduates do and why.

Comment
An acknowledgment of well known lack of knowledge, without which it was previously argued that the provider number legislation was pre-emptive and unlikely to produce the desired effects.

Recommendation No 10
Paraphrase – Abolish sunset clause and enshrine legislation for eternity.

There is one thing even more vital to science than intelligent methods; and that is, the sincere desire to find out the truth, whatever it may be.

Charles Sanders Pierce

It is interesting to note in this context, that the AMWAC report on Emergency Medicine training did not recognise that CMO's existed, and all workforce projections were based on Emergency Departments being entirely staffed by Specialists and trainees. Queensland Health, through the office of the Principal Medical Adviser, reviewed the reality of this in Queensland, and has produced two reports about Senior Medical Officers in Emergency Departments in Queensland. Needless to say, Senior Medical Officers (CMO's by another name) are alive and well in most provincial hospitals in Queensland, and are unlikely to disappear by the time the Emergency Registrars have finished their training. What nexus this will lead to only time can tell.

Advanced Paediatric Life Support

Course reviewed by David Brock

Having had the experience of EMST and Advanced Life support courses, I managed to secure a place in the APLS course held on the Gold Coast in October 1999. This proved to be a rewarding combination of numerous lectures, practical skill stations and "scenario" based teaching held over 3 days. The course manual, issued 6 weeks earlier, was comprehensive and is a useful resource for any emergency department.

The aim of the course is to provide an educational package for all health care personnel working with acutely ill and injured children. Our group of 30 included 2 CMOs, 2 GPs, 9 Paed & Emerg Regs, 3 Paeds, 2 Emerg Specs, 2 House officers, and 9 Nurses (who didn't do the final day's scenarios, but did everything else).

Education was enthusiastically provided by 11 voluntary instructors: 4 Paeds, 4 Emerg, 1 GP, 1 Anaes and 1 Emerg Reg. The repeated theme, was that it was no good having advanced life support skills without a firm foundation in basic life skills. These were repeatedly tested and the familiar "ABCs" were drilled into us through all teaching scenarios, allowing us to feel pretty confident when confronted with any sick plastic dummy. Instructors focussed on our positive achievements with each situation, whilst we agonised over all the negatives.

My final case involved minimal information as a "blue child" was delivered to me with an obstructed airway. All attempts to ventilate this child were unsuccessful, eventually demanding needle cricothyroidotomy, and adrenalin for asystole. Final diagnosis: acute epiglottitis. The course managed to provide (& remind) me with a firm structure to handle the potential chaos in dealing with such situations.

CMO rating: 5/5 stars *****

Application form for this course is also available from the CMOA Website www.cmoa.ican.net.au

APLS Australia is committed to improving the early management of acutely ill and injured children. The course has been brought to Australia, from England, with the support of the Australasian College for Emergency Medicine, Australian College of Paediatrics and the College of Rural and Remote Medicine. Courses are conducted throughout Australia on a regular basis.

CONTENT

1. Life support - basic and advanced
2. Serious illness
3. Serious injury
4. Practical procedures, including radiology and pain management

FORMAT

Core Knowledge

Candidates are provided with a manual at least four weeks in advance of the course. The manual contains all the core material required to successfully complete the course. Entry knowledge is tested, key issues are reinforced throughout the lecture and workshop programme and knowledge is again tested at the end.

Skills

The course is practically based and taught in small groups. All of the relevant practical skills are covered and are tested at the end of the course.

PRACTICALITIES

The course is of three days duration and runs from approximately 0800 - 1900 hours on each day of the course. The cost of the course is $950.00. Participants are expected to pay their own travel and accomodation costs. All teaching materials, meals, and refreshments are included in the cost. Applicants names will be placed on a waiting list and positions will be filled from that list. Participants will be offered a place as these become available.

For further information, or to place your name on the list, contact:

Sandra Willis
Course Co-ordinator - APLS Australia
P.O. Box 907
Parkville VIC 3052
Tel: 03 9345 6158
Fax: 03 9345 5938
email: williss@cryptic.rch.unimelb.edu.au

Latest Developments in the CMO Award

By David Brock, Industrial Officer

The "GOOD" News:
It appears that the representative unions for CMOs in NSW (=HAREA + ASMOF) are about to agree to a 4 1/2 year deal, "secretly" struck between the various health unions and the NSW State Govt. This deal reportedly involves a 16% payrise, over the 4 1/2 yrs, beginning with 2% on Jan 1st 2000, 2% on Jan 1st 2001, 3% Jan 1st 2002, 4% Jan 1st 2003 and a final 5% from July 1st 2003. Treasury will fund 10% and the remaining 6% will be achieved through "efficiency savings", that latter were withheld by the government. This agreement expires on 30th June 2004.

We are somewhat peripheral to these arrangements (for >150,000 Health care workers) as they have apparently been made to avert impending strike action by NSW Nurses, etc.

The "Not-so-GOOD News"
Agreements of this nature tend to prevent further development of Awards. Associated "no extra claims" clauses allow the Department of Health to refuse to discuss any other issues during the period of these agreements.

As we have a "representative democracy" in process here, individual CMOs (and the CMOA) have no direct say in these discussions as we are not a "party" to the "CMO Award". (The relevant parties for us are ASMOF and HAREA and they may choose to only discuss this agreement with their councils rather than their membership.)

ASMOF believes a 4 1/2 year deal is unprecedented and a 16% payrise is worthy of their consideration. Peter Somerville, from ASMOF, has not seen the full details of the no extra claims clause, and believes that its wording may not exclude ASMOF from discussing CMO issues with the Department of Health (DOH), however the DOH could argue that it is within its agreed rights to refuse to talk till 2004.

Hence, the numerous NSW CMO Award issues outlined by the CMOA to ASMOF, HAREA and the DOH will all be pushed to one side for another 4 years. (This includes improving access & financial support for CMOs to attend appropriate educational conferences, removal of the overtime barrier unique to the CMO Award, increasing on-call allowances, improving mechanisms for re-grading CMOs, etc, etc)

We do have a couple of other choices. Senior members of the DOH have told me that they do take pride in looking after small groups which can be "swallowed up by the "greater good". Relatively recently, the DOH responded to repeated cries from the Clinical Academics and improved their conditions, as a special case.

So, our current options include:
1. Do nothing .. allow our representative unions to make decisions on our behalf. (The easiest option by far)
2. We could approach the DOH in a similar fashion to the Clinical Academics. Either: a) before this agreement occurs .. to signal our discomfort with prolonged neglect of our award conditions. (My preference)
Or: b) after agreement occurs .. to signal our ongoing discomfort with the way we have been repeatedly denied opportunities to revise our award.
3. Make complicated proposals such as accepting 13% payrise with additional 3% specifically directed towards making funding available for education, etc.
4. Your ideas.....

Hope you had an enjoyable Xmas & Good luck for the New Year.

4th Annual General Meeting of CMOA

Saturday 4th March 2000
Novotel Hotel
Brighton - Le - Sands, Sydney
Commencing at 1000

Principle guest: **Dr Allan Hewson**
Assistent Dean, Continuing Medical Education, University of Newcastle
Director of Studies for the Hunter Post-graduate Medical Institute.

We will also be conducting talks on the CPDP and using it, on Evidence Based medical practice, and we are seeking to have a non-mainstream guest speaker. Oh, and we will be handing out jobs for the next year, but that's nothing to be afraid of.....full agenda soon.

Evidence Based Clinical Practice

Research Workshop Report *By Gabrielle duPreez-Wilkinson*

Location:
Melbourne Business School, Carlton, VIC
Time:
9am 16/12/99 until 3pm 17/12/99
Activity:
Evidence Based Clinical Practice Research Workshop
Sponsored by: NH&MRC
National Health & Medical Research Council
Purpose:
To provide feedback on fourteen research projects funded by NH&MRC into clinical use of EBM in Australia.
Reason for Attendance:
CMOA were invited, and I was chosen.

The great tragedy of science— the slaying of a beautiful hypothesis by an ugly fact.

Thomas Huxley

This workshop was full of information, with the capacity for serious information overload for the uninitiated. Evidence Based Medicine – referred to as EBM from now – is seen as the way forward for medical practice, a method of ensuring quality and maintaining standards. The presenters were finding the workshop wearying by the end of the second day, with each principal researcher needing to present information from their project on at least three different occasions, each with a slightly different view. Needless to say, much was learned, excellent contacts were made, and generally this was much as one would expect from a national conference-type event.

Enough of the overview, now for the nitty gritty. Just what is EBM!! Well, I had been fortunate enough to have had brief contact with EBM through my contact with the Australian Association for Quality in HealthCare and through attending a previous session on EBM at a previous conference. Without this prior knowledge, I am afraid that I would have spent half the conference lost without the appropriate lingo and jargon. In essence, Evidence Based Medicine involves searching the literature for the best evidence available on the efficacy of a treatment or intervention in a clinical setting. Level 1 Evidence refers to a meta-analysis of Random Control Trials in the relevant topic. Level 2 Evidence refers to at least one well-structured Random Control Trials. Subsequent levels of evidence then refer to various other research methodologies with less reliability in a hierarchical manner.

The majority of research presented looked primarily at applying Level 1 and Level 2 Evidence in a variety of clinical settings.

The most well known database of Evidence Based Medicine is the Cochrane Collaboration, although there are other sources for such information. The Cochrane Collaboration is an internationally recognised database collecting EBM about a wide variety of clinical scenarios. The Cochrane Collaboration was referred to repeatedly during the workshop, especially as the CD ROM version of the database was distributed to a variety of sites (as part of one of the research projects).

The workshop actually presented information at two levels. The actual results of the EBM Clinical Practice Research were presented tangentially, and the change management issues related to implementation were focussed on as the major topic of the workshop.

The management issues discussed at length included differentiating between Quality Assurance and Clinical Research, the role of Ethics Committees, and issues surrounding confidentiality. Discussion about the relationship between actual clinical practice and research evidence, consumer sovereignty issues, and specific issues surrounding EBM for aged communities and rural and remote communities filled the first day. On the second day, the importance of ownership and opinion leaders, the challenges of coordination and communication between and within disciplines, and organisational/ structural issues were discussed at length. In essence, the majority of the focus of the discussions centred on organisational issues and professional issues that assisted and impeded the implementation of EBM. The workshop looked at many of the change management issues that surround any move in organisational culture, or change in professional practice.

The actual clinical evidence presented, and used as the basis for the (implementation of EBM) research, was varied, as were the facilitators and impediments to implementation. Several of the projects were in the

area of respiratory medicine. The salient EBM principles that were being implemented included using puffers rather than nebulisers (as evidence has proven equal efficacy at less cost), reviewing use of home oxygen for those requiring it (as survival is related to hours per day using oxygen), and developing clinical practice guidelines for COPD. Heart disease also featured in a couple of presentations. These researchers looked at the gap between knowledge of heart disease risk factors and monitoring of same, and another group looked at improving communication to GP's of profiles for heart disease patients at an individual level. Risk factors for stroke of hypertension and atrial fibrillation in the elderly are well known, and one research team ventured into aged care institutions to review monitoring and treatment, and provide subsequent education.

Sustainability of projects was considered in reviewing the longevity of improvement of a previous study aiming to decrease youth suicide rates. One research team looked at discouraging neonatal- maternal separation in hospital. Educational dissemination of EBM material surrounding clinical practice guidelines for prevention of neonatal group B streptococcal infections was another project's focus. The rationale for hysteroscopy for dysfunctional uterine bleeding was also brought under scrutiny through one project.

Diabetes in the Torres Strait, looking at implementing EBM guidelines for monitoring and treatment, was the most challenging presentation. The logistics, inaccessibility of appropriate groceries or footwear, and the high cost of failure (shown in leg amputations!!) impressed the need for the persistence and enthusiasm shown by these particular researchers.

So, I had an educational trip, made contacts and the research continues, but what does this mean for CMO's. Well, firstly, NH&MRC is talking about a second round of funding looking at implementing EBM in clinical settings. Perhaps, we could look at a multi-state conglomerate (or just the CMOA itself) putting up a bid to look at realities of implementing EBM for CMO's —a joint educational and research opportunity. Or perhaps one of you out there is inspired with an incongruence you are aware of between research data and clinical practice, and want to change the world (or get us to try and change it for you). Secondly, the Federal Government is very interested in EBM, as could be seen by Dr Woolridge's presence for almost half the first day, and the encouragement with funding. So, EBM will be sneaking into hospital and clinical vocabulary—along with quality management, best practice, economic rationalism, value for money, and the rest of the buzzwords that fill the meetings at our various organisations. It is better to be informed than to have to catch up later on. Thirdly, for my sins, I will be doing a brief presentation on EBM and the workshop at the AGM—another excellent reason to come along, and I will see if I can snaffle a copy of Cochrane Collaboration CD ROM to show off there. So, be there and find out more.

CMO Continuing Medical Education: continued

Continued from page 3

the preliminary ideas. They want our feedback, and brain storming, to facilitate the process moving forward. We can make a genuine difference. The session will be run in a workshop manner for one of the sessions of the AGM. If you have any intention to seek formal recognition of our years of experience, if you want to shape the educational opportunities for future CMO's, if you have something you believe needs an educational module developed oravailable (especially through distance education), then PLEASE BE THERE!! For CMO's to input into this process of educational development for the future, to access the wealth of intelligence, experience and ideas out there, we really need you to come along to the AGM and put your ideas out there. So, please come and help us help these Uni people help us with our CME.

Report - 10th Meeting of CMOA

Coffs Harbour Base Hospital Education Centre 9th October 1999

In keeping with our inclusionist philosophy we schedule a meeting or two per year out of the capital cities, and this year we made the trek north to Coffs Harbour to gather the faithful and spread the news. True to traditional CMO form, the faithful were mostly still at work and mostly couldn't get away, but we were able to cover a lot of ground and get a sense of the issues on the ground in the mid north coast. Michael King had prepared an excellent Power Point presentation of the beautiful Coffs Harbour and surrounds highlighting local issues of staffing and retention, and the demand for and the cross-linkage of servise in the area. The area continues to employ significant overseas doctors who continue to make valuable contributions. Food, fluids and discussion ensued.

Apologies:

Steve Delprado, Dave Brock, Kien Couaxuan, Ron Strauss

Correspondence :

- From John Davis Hamilton - Faculty of Medicine UNSW—discussing the need for options for CMO education—possibly course work based. John Egan to follow up.
- From Medical Board re recognition of CMO's - forwarded to NSW Health Department for follow up - Gabrielle to contact Mick Catchpole and find out who NSW contact is and re Qld survey
- To RACGP re recognition of CPDP for VR and ongoing accreditation - no response since 10 August - John Egan to follow up.

Local Issues Arising:

The Health Services Area remains short of medical staff, requiring some secondment of staff from Coffs Harbour. This situation is unlikely to change in the near future. There was soome discussion that the OS doctors are in fact a target group for the CMOA since they experience a number of the same difficulties of marginalisation and limited industrial strength. Perhaps a prospect for the future.

General Business:

a. Report from Office Manager:

A small numbers of people are not renewing membership to CMOA, reasons not clear. Again, the need for grass roots promotion by existing members and followup of contacts etc. 93 financial members at present. 200 on the database, but this includes old information, and will need to include some new contacts in the next few months and when the keeper of the database gets it organised. (Sigh from Dr Webber)

b. Finances

Current balance is circa $9000. Outstanding bills - $3000 (office expenses, Bulletin etc.) These are paid in full today. Will we have the dosh to fund the AGM in full?

c. Taxation Issues.

Do we need to put in tax returns since we are effectiveky a non-profit organisation, and how will the GST affect us. Do we need an Australian Business Number? This needs to be clarified and sorted out - Mary to follow up.

7. Continuing Business:

a. CPDP Report

17 members are already on the database,a nd this is an area we should be heavily promoting to the membership and publicising in any discussion about the CMOA in the wider arena. Some private hospitals will develop a requirement for continuing Ed, eg. to be involved in CPDP as a condition of employment. For the future we will need to ask if RACGP if it will accept CPDP for ongoing education instead of other VR requirements. CME rears its persistent head. We note on-going interest in CPDP from the website visits including at least one OS enquiry.

b. ASMOF Report

10% of CMOA members on database are noted members of ASMOF According to NSW Health—no salary changes in the foreseeable future—no formal negotiations, tidying up award possible—we need to get more detailed information to find out exactly what is happening, but this seems fuzzy at best. What is going on behind the scenes that we don't know about? We note that one of the award difficulties in rural hospitals is that contracting is better option than CMO Award for most MO's. Suggestion that CMO Award should be linked to Staff Specialist Award rather than linked to RMO's. Need to contribute to survey participation. Is there time or impetus to mail out to all CMOA members with ASMOF survey.

Dave Brock coming to Sydney next week for industrial issues - ?? Need for CMOA to talk directly to NSW Health?? Need to recruit non-training RMO's into CMOA - ?? Craft group of AMA. Decision to investigate AMA Craft Group - Gabrielle to investigate

c. MTRP Report

Last minute notification for MTRP - HMO Working party has disbanded—CMO's now have no voice in the process—Mary attempting to get onto Justine Curnow to fix —intention for us to be included in loop— next meeting MTRP in November. Submission is posible, maybe after data collection working party info available in November.

d. Queensland Report

The SMO Workforce Report now available - this supports the need for SMO's into the longer term and recognises the invaluable service provided by them—this report is going to the Director General Queensland Health. Recommendations to be circulated in due course. Get Mick Catchpole to send us a copy - Need to formally commend recognition of SMO's and object to recommendation of CME being fixed up by PGMEC, both to Queensland and MTRP. Gabrielle to contact SMO's in Queensland toward Christmas or in New Year.

Business Arising:

a. Database: All members and contacts have been allocated numbers. Email query script may be possible via Mary's Email OR find host for File Maker Pro database for external queries via password. Gavan Schneider is looking into this. Or Mary may just update to the new version of Filemaker that supports Web based queries and intends to improve functionality.

General Discussion:

URGENT need to join ACCRM NOW !!!! Need membership of ASEM as well—need to pend resolution of other issues.

Phone conferences of committee between meetings - once per month. Next meeting is in Sydney in December.

11th Meeting CMOA - Brief Report

December 14 1999 The Hills Private Hospital

Present: (including phone conference) Emile Chatky, Jenny Clark, Steve Delprado, Dave Brock, John Egan, Michael Boyd, Gabrielle du Preez-W, Mary Webber
Apologies: Seeta Durvasula, Ron Strauss, Bing Brotohusodto, Anna Ramquist.

Of interest was our apparent failure to obtain feedback about what was actually happening on the award front. We discussed the desirability of forming an AMA craft group as part of raising our profile. It is very clear that this would not represent any move towards forming yet another college, nor any surrender of our independence.

Gabrielle reported on a meeting on 3 Dec in Brisbane between Uni Q, Uni Newcastle and QMEC, following the recommendations of the MTRP, about future education models for the CMOs, and interest was expressed in workshopping with CMOs as to what their needs are. Enthusiasm followed as we had prelimnary similar talks about two years ago with Prof Shane Carney, and this might represent the follow up. Gabrielle to pursue.

The CMOA has also been invited by the NHMRC to send a rep to the Evidence Based Medical Practice seminar and workshop in Melbourne in Dec and Gabrielle, who has a background in such matters is the chosen one. She will report in the next Bulletin and give a talk at the AGM. We will cover her basic costs. Unanimously agreed.

Mary reported that her accountant doesn't think we need to lodge tax returns as a non-profit organisation. GST guidelines for small associations are not clear as yet.

Tha AGM looms, looking for a guest speaker, either non-medical or non-mainstream medical. Everyone think about it.