ASCMO Times

Newsletter of the Australasian Society of Career Medical Officers

www.ascmo.org.au Number 1

President's Address

Welcome to 2002 all CMOs in Australasia. It is that time of year again, as the AGM approaches to reflect on the year that has been and the year to come.

In 2001 many things were achieved. Newsletters went out. Successful meetings were held in Sydney, Tweed Heads and Alice Springs. The website continued to be an invaluable resource (thanks Dave). NSW Industrial concerns continued to have our presence felt via our input into ASMOF. The CME Diary continued to provide a reliable, sensible tool to reflect. All in all, we achieved maintenance of our core concerns throughout a year that was personally challenging to many of us—not a mean feat in a world trying to knock out the smaller players.

However...

The last six months of 2001 proved to me the challenges and difficulties of having a group for CMOs. Whilst we have a cause or issue to rally around, be that an award concern, or an article to write, we cluster together and strive for the good cause, utilising the last morsels of our energy. However, when things are in status quo, we maintain awareness of the tasks arising and requiring attention, but are overwhelmed by the service and survival requirements of our daily lives within the health sector.

This has definitely been the case in the last six months for myself. I started off 2001 with great gusto and good intentions, intending to encourage CMO's around Australia to support each other and record their CME in accordance with new legislative requirements coming through. Then, mid year my employment prospects and life requirements took over, and my zest focussed on survival, working long hours, and trying to keep a sinking ship together.

So where to in 2002? We need to decide whether we regroup and re-energise OR simply say it is all too hard. If we are to re-energise, which would be my preferred option, we need to create a team approach, rather than a single person captaincy.

The ship floundered on rocks this year because while I was busy falling on my sword no structure existed which could pick up and continue—no deputies came to the helm until I could stand again. I am not suggesting that the old stalwarts are beaten to an early grave—many of the founding parents of CMOA continue to give their wisdom and effort, but we need new blood working, functioning and carrying oxygen through the organisation.

We will be ASCMO in 2002—The Australasian Society of Career Medical Officers. We already have a very able assistant in Jacqui. We have dedicated industrial and web site expertise in David, and ongoing educational expertise in John. We have enthusiasm and wisdom in Mary, Ken, Mark, and the Michaels of the Executive. What we need from here is to work closer and more consistently. We need to re assess our objectives, and set multiple little goals to move forward.

We can meet the challenge of another year.
We can find that untapped energy.
We can regroup and refocus and begin to assist each other in this struggle of life in the health sector.

But....We can only do it if we all work together and work as a team. As captain/president, I am sorry I floundered through the year. We still achieved a lot - now it is time to move on and achieve a bit more.

See you all at the AGM.

Gabrielle

Inside This Issue...

Executive

Committee

The Fellowship of the Nose-Ring

Ring 911 - it's an emergency

Opinion

On a day of infamy 5,000 die, 20,000 mourn their loved ones, a city-state cries and a nation weeps while the world watches, too stunned even to take a breath.

A small village in Bangladesh yet again slides beneath angry waves and terrifying wind, while the families of the dead make plans to rebuild—again.

A governor general says sorry, while heads of state throw Truth overboard.

Famine, War, Pestilence and Death ride roughshod over the world while Kaos reigns and Terry Pratchet turns in his recent grave, decomposing his similitudes.

And a little lost child called Seymour Askmore wanders, lost, bereft, wondering of his relevance in the world and of the need for his existence.

Get real everyone.

It is undeniable that the nation's and world's events have paralyzed many thoughts, actions and plans. It is also undeniable that our own important needs for job and personal security and happiness take precedence over our group need for sustenance.

The point—that it is not surprising that we do not manage to achieve all we set out to. Sometimes things just fall apart. Sometimes we need to just get on with it—in spite of the setbacks.

That is what we as a group are more than good at.

In fact we are THE experts at this.

We are lucky enough to have an elected leader who knows when to apologize.

We have a child in need of sustenance and encouragement.

Need I say more?

Editorial

Michael Boyd

Welcome to the first epidose of the ASCMO Times - same size same shape same colour!

This issue has some great reviews of jobs and courses, some diatribe, some pathos , some humour and some sense. What more could you want ?

Enjoy!

Drug & Alcohol Medicine

A CMO Perspective

Firstly, the term is now ADDICTION MEDICINE. (Sorry everyone, but alcohol is a drug, too!)

A brief review of my work in addiction medicine will give an insight into how some of you might choose to enter a field that is extremely challenging yet extraordinarily satisfying.

Eight years out of Med School I was working at a variety of Emergency Departments, both public and private, when a colleague asked me to apply for a position at a Methadone Clinic one day per week. Gaining my License to prescribe Methadone (and more recently, Buprenorphine.) I now review over one hundred clients. Three years after commencing work at the clinic I joined the team at Westmead Hospital (in Sydney's western suburbs), looking after all aspects of treatment, including detoxification, abstinence maintenance, coordination of other services (especially psychiatry, gastroenterology and obstetrics), ward consultations and monitoring the various pharmacotherapies. I am fortunate to work with a wonderful team that includes a staff specialist, 3 CMOs, 3 CNCs, 4 psychologists, 15 or more caseworkers, 3 social workers, a medical registrar, and an RMO (the last two on rotation). We routinely review 60 to 80 clients per day in the outpatients department, as well as a 4 bed inpatient ward.

The other Teaching Hospitals in Sydney have varying levels of commitment to Addiction Medicine, and you would have to make enquiries as to the CMO positions at each hospital. I would like to note The Langton Centre (south of Sydney's CBD) as also being a centre of excellence.

There are too many lessons to share in this brief article, but I want to exemplify the deep reward, through treating the patient as an individual and with sound medical practice, that one experiences in assisting that person to achieve a more normal, fulfilling life. Whereas job satisfaction in settings such as the ED can be measured over minutes and hours, in the treatment of an addict one may only see improvements over months or years. Frustration is tempered with the knowledge that addictions can be viewed as chronic relapsing brain diseases, and cycles of abuse and remission are to be expected. Many clinicians believe that if people want to use drugs then they will, if they don't want to use, then they won't, and those who present to treatment services are often ambivalent (especially in the public hospital setting where many clients are under pressure to stop using by their partner/ family, or an impending court appearance, or are referred after a recent overdose/ crisis).

I can not fail to mention how complex these patients can be, with the majority (80%+) having a conjoint mental illness, poor previous primary health care and often desperate histories of abuse, neglect and criminality. This is where CMOs can play a major role, with their wide knowledge gained from working in various fields of medicine. The three CMOs at Westmead, for example, have backgrounds

"Prosperity doth best discover vice; but adversity doth best discover virtue."

Francis Bacon (1561-1626)

Life As An Orthopaedic CMO

Peter Garrett

I am a CMO in orthopaedics. I have been an orthopaedic CMO for 10 years. I was unable to pass my surgical primaries and was working as an orthopaedic registrar at Liverpool Hospital. The prospect of reapplying for registrar positions each year did not appeal to me.

At the same time Campbelltown hospital was unable to fill their orthopaedic registrar position and the orthopaedic surgeons would not work without registrar cover. “Gosh, imagine having to come in and treat a public NOF!”

I approached the medical superintendent, and suggested that they employ me as an orthopaedic CMO. The administration jumped at the offer and I started working in this capacity. The position suited me. I have been able to treat most patients that present to the hospital, except the multi-traumas and spinal patients. Campbelltown is on Trauma bypass—so multi traumas are sent to the trauma centres. I find job satisfaction high. I am responsible for operating on the public patients.

Nietzche said, "What doesn't kill us will make us stronger."

With the daily workout I'm getting, I'm the strongest bitch on the block.

The workload was reduced when an orthopaedic registrar was seconded from Liverpool hospital. Most of these registrars are junior—they can cause problems if they disregard advice and instruction. The relationship between myself as a CMO, and the seconded registrar, varies greatly. I think most of the problems come from the registrar’s desire to get onto the training scheme. It is not uncommon for the registrars to stay back to be seen, and to assist in cases to learn when the orthopaedic VMO comes in. But when I invite them to see an interesting or difficult procedure of mine, their response is “ I’ll see it some other time”. One example that sticks in my mind involves Dr P who is on the AOA selection committee. His orthopaedic surgeon had to do another case at another hospital and asked me to do his elective list. I started his list and the registrar joined me. As the end of the first case he asked “Is Dr P delayed?” When I told him that he was not coming and I was doing the cases his reply was that “there was no point in me staying here”. He left, and the staff burst out laughing.

I find that I’m treated very well by the other hospital staff. This is probably due to my length of service and availability. Hardly a day goes by without a corridor consultation/2nd opinion being sought.

From a professional development perspective, the hospital and VMOs don’t know what to do. There are no meetings on orthopaedics directed at me. I have to travel to other hospitals for orthopaedic education. The Campbelltown hospital has a monthly education day for Emergency CMOs and I have to join this newly started program.

I have found that because I am senior and on the premises, I am vicariously liable for most orthopaedic problems—this is from past experiences when patients have complaints. I have since ensured that I always follow hospital procedures about admitting and consenting and informing VMOs prior to operating on any patients. I have learned from past experience that I can make a convenient fall guy. A case in point occurred when a patient that I did not look after, or operate on, suffered bad pressure sores under a cast. When blame was being attributed, both administration and the VMO pointed to me. I easily vindicated myself.

The orthopaedic hierarchy is very conservative and favours like minded people and thinking. I am occasionally viewed with some suspicion. I have heard suggestions that I am trying to become an orthopaedic surgeon via another route than by their selection and college training—I am not. I am a CMO. I am very happy with my present position. I get great satisfaction from the job and have no desire to become an orthopaedic surgeon and build a practice. I have other needs outside my profession—family, children and other interests.

I think I offer a lot to the public and give high quality care to the patients at my hospital. I have seen many mistakes made by registrars and residents, both past and present - mainly due to inexperience and lack of supervision. I know I can deliver constant quality orthopaedic care in my position as an orthopaedic CMO.

A Commentary

John Egan

The accompanying article makes for interesting and thought-provoking reading for CMOs. Its major points could be repeated with little change for those working in emergency, psychiatry, anaesthetics and almost any other area of medicine as a Career Medical Officer.

The significant messages that I take from this tale, and that I believe can be generalised, are;

1. There is a high level of expertise / experience among CMOs.
2. This expertise is not always appreciated by colleagues or administration.
3. CMOs are a very cost effective way of filling in the gaps in patient service.
4. CMOs are not a threat to the medical colleges or their graduates.
5. CMOs have high public service ideals, and last, but certainly not least,
6. CMOs are really interesting people!

These attributes were the major reason that I and others formed the CMOA (now ASCMO) in 1996. There was a great need for an association, meeting place, industrial advocacy and educational initiatives that related primarily to CMOs. These needs have not lessened, in fact, as the article highlights, they are more pressing than ever. We can be proud of what we have achieved, but we have really only just begun – we are the early dawn in the bright day of CMO affairs.

It is with some sadness that I write these lines as I will shortly be leaving full time CMO work to take up a position in a local General Practice. A large part of me will always be a "CMO" (it's a state of mind rather than a job description) and I plan to do the occasional shifts in the Emergency Department. However the strain of constant shift work (especially nights) and family considerations make the change in role necessary.

My parting advice, for what it's worth, is to regularly *use* and *add to* the resources of the Association. The best example that I can think of is Dave Brock's outstanding work on two major fronts – the development and maintenance of the Association's web site and his untiring efforts on the industrial front. A hard act to follow, but a wonderful role model for CMOs.

I also believe that we should think laterally and not be so in awe of the classical educational models – university and college. These institutions have their place but, as the above article shows, there is considerable expertise already among CMOs. We currently give certification for CMO continuing medical education (Continuing Professional Development Program) and I see no reason why we should not certify CMOs in emergency, orthopaedics, psychiatry etc.– not as specialists in these areas, but to the level that a competent CMO should attain before stand alone practice. If energy (mea culpa) and time had allowed, there are two areas that I personally would have liked to develop;
1. A program to prepare CMOs commencing ED practice.
2. The CMO in the role of the hospitalist. I feel that this also could (and should) be successfully developed.

If you believe you can do something, you will almost always succeed with hard work and enthusiasm, and I think perhaps that enthusiasm is the more important.

Well, when you start to give advice unasked for, it's time to go ……

"Adversity is the first path to truth."

Lord Byron

The Inaugural

PERIPHERAL HOSPITALS

EMERGENCY MEDICINE CONFERENCE

2-4 October 2002

Cypress Lakes Resort

This is a conference whose time has come—so much so that ASCMO has agreed to sponsor it—and one of our members is the headline speaker!! (See the enclosed insert).

As a special service to ASCMO members, the deadline after which it will cost $100 more has been extended for around two weeks—just mention you're a member when you send in your application.

Minutes of Last Meeting

27th July 2001, Alice Springs Base Hospital

First of all, many thanks are due to Clare McGrath for setting this meeting up and organising the meeting space and the attendance. It was a great opportunity to pack the bags and go talk in person to doctors practicing on the front line of contemporary industrial reality. Also The Alice is simply an extraordinary place and landscape to visit. Highly recommended.

Present by phone or in person were:
John Egan, Mike Pearson, Dave Brock, Mary Webber, Gabrielle du Preez- Wilkinson, Clare McGrath, Jenny Yee, Dr Anjou, Dr Kumar, Ken Wilson, Michael Boyd and a fluctuating cast of interested people dropping in from work or tutorials as opportunity offered.

Apologies were received from Kien Caoxuan, Steve Delprado and Andrew Ebinger.

Minutes of the last CMOA meeting were accepted as a true and accurate record by those who had been present and actually read them afterwards.

Introduction
Firstly Gabrielle restated the familiar history and aims of CMOA, with a small update and forward glance towards…

1. Mandatory CME is being anticipated, so we need to have access to a specifically CMO-relevant, flexible system which we ourselves will offer and control for the benefit of CMOs. The CPDP (Continuing Professional Development Programme) of the College of Pathologists not only meets our needs, but meets the requirements of at least the NSW Medical Board, a hopeful sign for the other states.

2. Industrial equity for CMO's is a continuing concern. Dis-equity across states remains unaddressed. Award changes in NSW are looking at basic rates, but conditions are still occasions of debate. When talking to Powers That Be we emphasise a complex formal definition of CMO-hood. CMOs are CMOs under 3 qualifications 1. Long term and by specific Choice. 2. As a more fluid group of people on the way somewhere else. 3. As individuals with speciality qualifications not currently working those areas.

For CMOs in any location a set of recognised Career pathways are the ultimate goal. These are the years of outreach. Marketting the CME programme gives us an opportunity/excuse to make or renew contacts in many locations. Gabrielle fond of getting out and about.

Issues Specific to Alice Springs
Issues of CME persist in what is regarded as an entire set of 'service' jobs. Perennial problem of recognition of pre-existing qualifications and Level 2-1 or above is not available without recognition. OSTDs are used as effectively 'slave labour' and moreover the FACCRM is not being recognised in Physicians or Anaesthetics. RAMA 4-7 can charge at the higher fee. To add to the general industrial joy, and recognising the captive nature of its audience, the NT Govt also does not accept that Alice Springs is actually a remote location although the Federal Govt does – as does anyone with a damn map. The hospital does not feel the need to assist the AMCs to complete their studies, and requires long hours of unrostered overtime etc. It also practices conditional registration of specialists. ASMOF has been approached but appears to be capable of doing, um, diddly squat. Placement and payment of skills level at resident/ registrar level is at the discretion of the DMS. Recognition of ACCRM. The Medical Board recognises ACCRM. A letter from Medical Board of QLD exists saying that they will recognise it. The next step remains elusive. Recipocal rights looming in the offing with Australia wide registration.

Project underway. OTDs – need hospital-based bridging courses for AMC – possibility of linking with bridging courses for QMEC. Some movement on this might be achieved with sponsored movement to allow people to go to bridging courses. ? Needs a deal between QLD and NT govt for reciprocal rego for a little work to pay the bills during bridging course.

Tennant Creek.
Two MOs. One trying to get AMC through College of GPs. Mike is already VRd. Rural area service for five years and 18 months in an approved General Practice and successful completion of the Fellowship in General Practice can have unrestricted registration. Happily the time is coming when the FACCRM will be enough.

ASMOF NSW and ASMOF QLD may be encouraged to support pay at specialist rates but the RMOs are stuck at junior levels of pay.

CME/ CPDP – Legislative Changes
Background was provided from John Egan about the CPDP Diary. Flexibility in use is its characteristic as well as self-direction. The electronic version is best but the College also offers a broad spectrum Manual version with photocopied sheets for delayed data entry.

Enquiry about how this would fit in with the CME of ACCRM – so far we have a heads up agreement – that they will recognise CMO work on the way to accreditation. College of GPs are now saying that there is no need for a rural stream at all (dispute over funding, of course). So

Minutes

Continued

ACCRM is now having discussions for MACCRM recognised (CMO people – documentation of CPDP would be useful) en route to further accreditation. Two main characteristics of our CPDP support it – it's already available and its cheap. And in NSW the Medical Board will accept the self-directed CPDP as it's requirement. We now accredit through our Education Officer.

Industrial Issues/ Progress

The CMOA set up an industrial convention in 1998 to discuss the various inequities of the current system – eg. if you're in a non-training position you can't get study leave unless you're in the training scheme but you can't – etc etc Catch 22. The NSW Award is currently in its 6th or 7th re-write. Relying on ASMOF and HAREA to represent us. The current draft is out on the ASMOf website – and calling for comments. Dave Brock is now a Branch Councillor to push this forward. They will put general membership funds into running the case. In QLD CMO equivalents are allowed the lower levels of the specialists awards but no provisions for fatigue leave etc.

Note : Website resources and email discussions for the July 18 version – asking for final comments by 3rd August then the document will go to negotiation with the team – anticipated they will fail to secure an agreement on this draft. Then we will have to go to arbitration later in the year, and hopefully have some changes in place early next year. ASMOF also run the rural incentive and safe hours provisions. 25% loading on salary and extra weeks leave and full salary packaging. Apparently the EBA for NT will be the EBA across the board for Professional Training. (Mick Saunders is the industrial officer in ASMOF/ territory in Canberra.) Electronic version from Mick.

DIRRTA

The College of GPs and ACCRM have had a falling out. The GP registrar association asked for a comment on the conjoint training pathway – initially everyone was impressed and willing. At the point where they asked if they could vote on it, the metropolitan people kept everyone quiet. Ensuing, um, debate, was enough to make the president resign and DIRRTA arise from the ashes. To get their ideas onto their training programme – and we should support them - rural OTDs and rural OMPs, CMOs and GP rurals should support each other. Generalist training is in fact, a good thing. We look forward to developments with a cynical interest.

Business Arising

MTRP – seeks changes to amend definition of CMO – Gabrielle will provide.

Interviews for SMH – Gabrielle medical career options. Supplement – September 9.

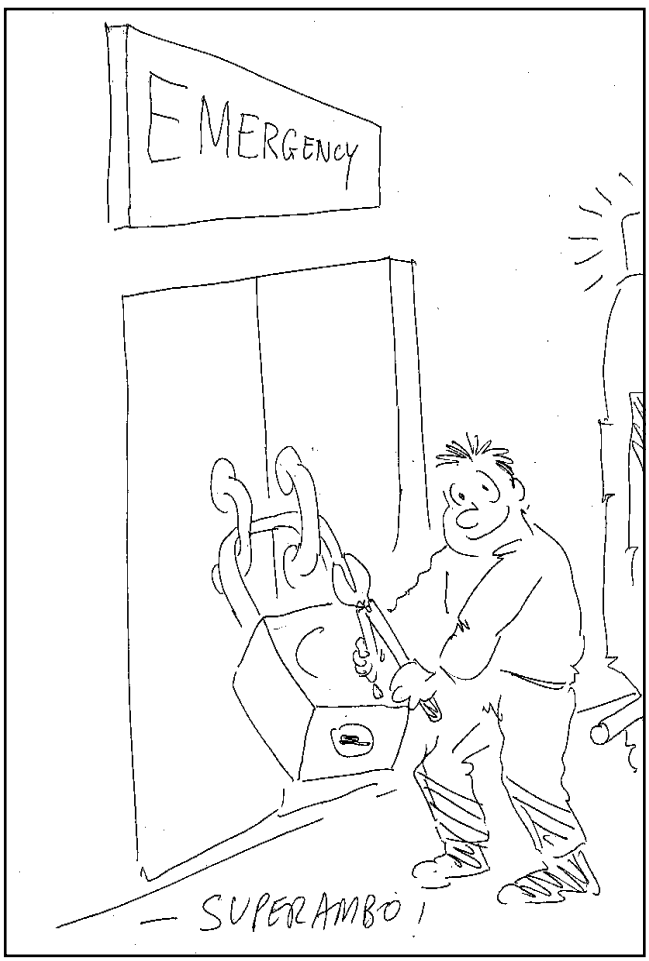
Michael Boyd has been contacted through the web site and naturally expressed our interest .

Next Meeting and Action Plan

After a longish and as usual, vigorous meeting, there is additional understanding of conditions in hospital-based remote practice. Gabrielle looks to bring such issues to meetings of ACCRM, Dave to place the EBA on the Websaite. Gabrielle also to look into the possibility of reciprocal bridging course registrations, though this will obviously be a mid-to-long term goal. Look to ASMOF to consider our rates of pay.

There is a conference in Hobart in October? Anyone interested in meeting there? Meet on the CMOAtalk in the meantime.

Meeting closed.



Industrial Report

David Brock - Industrial Officer

ASCMO has been endeavouring to get changes to NSW CMO Award for the past three years. We currently have a comprehensive claim before the NSW Department of Health. We are currently being represented by both ASMOF and HREA and have formed the basis of a negotiation team. Several members of ASCMO are on the negotiation team led by Sim Mead from ASMOF.

It has been made clear to us that the NSW Health Department is likely to only agree to changes that are cost neutral. To this end I have had discussions with senior Departmental officers, suggesting that there may be significant savings for the Department if we can put in place an award capable of attracting and maintaining skilled CMOs as permanent employees rather than the current situation that is dependent upon more expensive and transient locum employees.

Without doubt, negotiations are unlikely to be successful unless we work towards an award that works well for both CMOs and employing Area Health Services. We continue to invite input from all CMOs and interested parties.

At the time of writing this report, the Department of Health was endeavouring to organise their negotiation team and attempting to identify areas within this document that the Department is able to agree on. We expect that the first face to face meeting may occur within the month.

Recently the Department asked Sim Mead for his view on the relationship between our claim and the "no extra claims" clause in the Memorandum of Understanding [MOU] that provides the current round of pay increases (totalling 16%). The MOU states that: "... *there will be no new salaries or condition claims arising from negotiation of productivity and efficiency improvements covered by this agreement*." Sim expressed the view that our claim does not arise from the "negotiations covered by the MOU". ASMOF expects further contact once the Department has digested this view (which is consistent with the view taken by the NSW Nurses' Association, which allowed changes to their conditions).

Further details including a copy of the proposed NSW CMO award are available from our website at **www.ascmo.org.au**

NSW Payrise

NSW CMO's can expect a 3% payrise from Jan 2002. Future rises are also detailed.

		2001	1/1/02 (3%)	1/1/03(4%)	1/7/03(5%)
GRADE 1	**Year 1**	60171	61976	64455	67678
	Year 2	64935	66883	69558	73036
	Year 3	69476	71560	74422	78143
	Year 4	74874	77120	80204	84214
GRADE 2	**Year 1 ***	78151 *	80495	83715	87901
	Year 2	80789	83213	86542	90869
	Year 3	83981	86500	89960	94458
	Year 4	87210	89826	93419	98090
GRADE 3	**Year 1**	89921	92619	96324	101140
	Year 2	95192	98048	101970	107069
	Year 3	103568	106675	110942	116489

*The NSW CMO Award has a "Penalty, Holiday payment and Overtime barrier" that requires all Penalty, Overtime and Public Holiday loadings for CMOs above Grade 2 Yr 1 to be calculated from the salary associated with Grade 2 Year 1. (The ASCMO has asked that this limitation be removed.)

Salary Packaging will be available to all NSW CMOs working in Public Hospitals from 1st Jan 2002 .. contact your Pay Office personnel for more details. ***NB: As the Salary Packaging year runs March - March .. the full $17,000 per year is available for packaging in the 3mths to March 2002.*** Furthermore, the CMOA recommends that all CMOs seek independent financial advice before entering into any salary packaging arrangements with their employers.

Website Report

David Brock

With the CMOA re-inventing itself as ASCMO, we now have re-vamped our website, and moved it to a new location: **www.ascmo.org.au**

[All visits to the old website, **www.cmo.asn.au** are taken directly to **www.ascmo.org.au**].

You will now find a navigable menu on the left hand margin of most pages. Some sections are only accessible to members. Therefore you will need to enter the following information to access certain pages such as salary schedules and industrial awards:

usename = **ascmo**
password = **member02**

The new website continues to provide a detailed resource for CMOs throughout Australasia and beyond. You'll find detailed educational, political and industrial information relevant to CMOs. We have past copies of our "CMO Bulletins" and a "Guestbook" to pose questions or leave comments for your CMO colleagues to read and respond to. Our "Links" page continues to be one of our most popular pages. To make it easier to access over 100 pages of information relevant to CMOs, we now have an "intra-site" search engine to allow you to readily access information from this site.

Application forms for membership to both the CMOA and our Continuing Professional Development Program (CPDP) can also be found on our website. And keep an eye on our jobs for CMOs, where hospitals can place advertisements for CMO positions which also provides additional income to ASCMO.

So remember this website continues to be there for your information and participation.

Education Report

John Egan - Education Officer

It's probably a good time to recap on what we have accomplished to date.

The Royal College of Pathologists of Australasia's (RCPA), Continuing Professional Development Programme (CPDP) was officially launched in September 1996 and made available to Fellows in January 1997. The Programme is based on self-directed learning through the documentation of educational activities in a Learning Diary and it was apparent that this was an ideal mechanism by which CMOs could participate in CME.

The CMOA was granted the use of this programme for its members in 1999 and this is the method by which many CMOs now log their CME in a verifiable manner. We currently have at least 40 doctors enrolled in this program and those who fulfil certain minimum criteria—ie enrolment in the program and notification of the education officer of their yearly CME activities—will receive certification to this effect. The cost of the program is $55-00/yr for the electronic version and $110-00/yr for the manual version.

The medical registration board has made it clear that it expects all doctors to have a demonstrable CME program in place in the future and it is clear that this will very soon be compulsory. The medical registration board has further indicated that it accepts the CPDP, authenticated by the CMOA, as valid CME for the purpose of continuing registration.

So …… we have done the hard work and have a very user-friendly CME program in place – accepted by the major medical colleges and the medical registration board – and all you have to do is contact Jacqui Riding, our Office Manager, or log onto the CMOA internet site, details below, and enrol. So…….. what are you waiting for?

There have been no other major educational endeavours this year but we are open to suggestions for any undertakings or areas of educational need in the coming year – please contact John Egan at email or postal address below.

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UNSW Masters of Professional Ethics

Course Review by Mary G T Webber

Course conveners:
Assoc. Prof. Stephen Cohen
Dr Damien Grace

The word 'ethics', derived from the Latin 'ethos', originally referred to 'the way we do things around here', a cultural starting point that seems far, far removed from the complexities of ethical pluralism, feminist moral discourse, and the implications of the precautionary principle in the science of GM foods.

Professional ethics differs from what doctors traditionally conceive of as the appropriate realm of medical ethics in so far as it focuses on the actions, decisions and capabilities of professionals (quintessentially in medicine and law, but encompassing an increasingly nebulous and flexible domain of activity) in their specific capacities as professionals.

The Masters comprises five theory subjects and a thesis, and costs in the neighbourhood of $9000.

Moral Theory and Moral Reasoning – the foundation subject – introduces the basic concepts and conflicts in the western moral universe. Kant, Hobbes, virtue ethics, utilitarianism, moral relativism and ethical pluralism etc.

The Professions and Society introduces and examines the progress of the professional project with guest speakers across a range of professions – accounting, law, medicine, teaching, business etc, and considers their successes, failures and changing status.

Ethics in Organisations is concerned with Responsibility in Organisations and developing and working with a model of how flows of information, resources and beliefs are incorporated into and affect the capacities of organisations to realise the goals for which they are created. Elements such as organisational culture, the quality of resources available, and the interaction between the organisation its environment and society at large are as influential as the ethics of the individuals involved. Groups generate problems of incentive structures, limits to knowledge, the sanitizing of information and the problem of 'many hands'—in complex organisations there is fragmentation of knowledge, responsibility and implementation across many decision makers and the outcome of actions of individuals—coordinated in an organisational structure—can lead to a wrong outcomes without the individuals acting unethically. Failures of capability, defective information, poor governance systems and the like make the problem more complex than it may appear. Individual moral culpability only arises once other causes are removed, such as ignorance of cause and effect being washed away by later knowledge—eg the stolen generations.

This was a tricky subject to wrap the brain around, but deeply and pragmatically worthwhile. The term paper required us to identify and characterise a responsibility issue for an organisation then examine how it was playing out. This led to lots of waiting for the penny to drop and numerous sheets of butcher's paper liberally dappled with arrows. All good clean fun.

Ethical Issues in Business and the Professions felt a bit like more of the same, in more detail looking at issues like the development of codes of ethics and the difference between codes of ethics and codes of conduct, the progress and fate of whistle blowers, and the precautionary principle.

Which leaves the self-directed study in Supervised Readings and the wait for inspiration for the thesis. Wish me luck.

At all points one is encouraged to pursue one's own projects and concerns, and self-determination is the key. Although the Masters is available on Web-teach in a distance learning mode, I greatly enjoyed the class time and in fact would regard the hanging out with non-medical thinking persons as the best part of the course to date. Classmates from teaching, HR, business, law, financial services and patient advocacy make my thinking, and indeed my little world, richer and more interesting. It has certainly confirmed my suspicion that Medicine is an insular universe much inclined to think that it already has a lock on the old moral progress issue.

No bloody chance mate.

"Adversity is the trial of principle. Without it man hardly knows whether he is honest or not."

Henry Fielding (1707-1754)

Drug & Alcohol Medicine

Continued from page 3

in emergency medicine, anaesthetics, obstetrics, general practice and rehab medicine between us, allowing for energetic academic debate.

Traditionally, in the public hospital setting, the D+A baton was reluctantly passed to the gastroenterology team, who would treat the complications of alcohol abuse, but would offer few services to patients with other drug problems. A heterogenous and poorly coordinated group of government and non-government organisations and individuals would look after the remaining patients, each with varying success. In more recent times, health professionals with an interest in this field have combined clinical expertise with academic research to offer an evidenced-based approach.

Well-publicised developments such as Naltrexone-based abstinence from opiates and the Injecting Room at Kings Cross, and the newer pharmacotherapies such as Acamprosate (for alcohol cravings), Buprenorphine (for opiate withdrawal or maintenance) and the new generation of antipsychotics (such as Olanzapine) give the clinician more power for intervention.

The Royal Australian College of Physicians have created an Australasian Chapter of Addiction Medicine (based on 3 years of advanced level training), further evidence of an increased commitment to evidence-based management of addicted individuals.

What is the relevance of this to CMOs? As the RACP website (racp.edu.au) emphasises, this area fails to attract and retain young doctors, and I feel CMOs will play an increasingly larger role in clinical and research practice as each Area Health Service develops its service. CMOs will offer the flexibility and experience that hospital trainees cannot deliver. I'm sure many of you will agree that our enthusiasm is maintained with the variety of two or more part-time jobs.

Apart from Teaching Hospitals, opportunities for CMOs exist in the other sectors, eg private practices (usually offering opioid maintenance eg methadone), private hospitals (usually offering detoxification and initial rehabilitation) and various government departments eg those involved with the Prisons and Judicial systems. I invite other CMOs to contribute to future newsletters with other employment opportunities and their experiences.

For more information please investigate:

APSAD: Australian Professional Society on Alcohol and other Drugs

NDARC: National Drug and Alcohol Research Council (www.med.unsw.edu.au/ndarc)

Pharmaceutical Services Branch of the NSW Department of Health

and, consider the Methadone (and Buprenorphine) Prescribers' Accreditation Program.

"However, never daunted, I will cope with adversity in my traditional manner ... sulking and nausea."

Tom K. Ryan

For Comment

Why not write to us—burning issues, brevity, wit, even some diatribe will be gratefully accepted. To kick us off here is an interesting snippet.

OPEN COLA
The great giveaway.

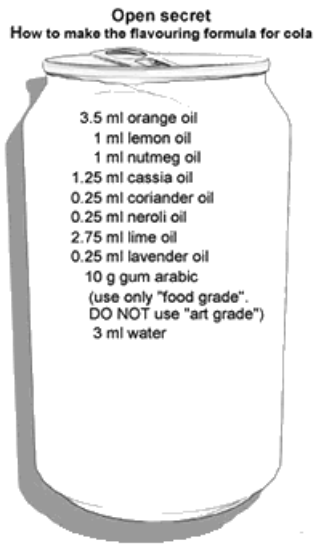
A report by the New Scientist Magazine gives this recipe for cola, noting that it is the first open source consumer product—anyone can use the recipe, anyone can modify it and distribute it—provided that this is done in agreement with the open source fundamental—that it remains free to utilise and distribute.

This had it's genesis in the open source computer software movement (some will recognize Linux as being the archetypal program using this method of distribution and development). The report notes other attempts—such as open law—where new legislation is put out to tender so that everyone can "iron out the bugs"

What is of interest is the similarities of this argument to the promulgation of medical research. There are many moves to limit the open nature of medical research - the increasing need for external funding leaves many researchers with an agreement that some or all of their findings not be published, or will only be published after patents are applied.

One could argue that the free flow of medical information is what ensures patient safety—one does not have to think hard to come up with examples where closet research has remained closeted until brought out in legal proceedings—research which may have saved lives if put to appropriate use.

Thus the question is begged—Do we need an open source agreement for medical research?



For details on finishing the recipe, including crucial safety information, you must read:
http://www.opencola.com/products/3_softdrink/formula.shtml