CMOA Meeting Report

Third Meeting Tuesday 6th May, 1997 Bankstown Hospital

Committee

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One of the most important functions of the CMOA is to keep the members in touch with each other and informed on issues of mutual concern. Therefore a coverage of each meeting will be published in the following issue of the *Bulletin*. Our meetings tend to be both informal affairs and spirited in the flow of talk, and so the gist of discussion is here presented.

Guest Speakers

We had two special guests at the third meeting. Dr Keith Edwards, National President Australian Society of Emergency Medicine (ASEM) and Russell Noud, Industrial Officer of the National AMA.

Keith Edwards, recently elected National President of ASEM spoke about the origins of ASEM in 1981 with the forming of a grouping of interest, out of which grew the College of Emergency Medicine in 1984. He admitted that as the College has grown in importance, so ASEM has assumed a less prominent role. He regards his own brief as being one of re-invigorating the society and broadening its membership base, specifically in the areas of trainees and CMOs, and making best use of its seat on the College committee to represent the interests of its members. Interestingly, he was emphatic that the CMOs would be most welcome in the Society, and to participate in ASEM sponsored activities such as the Emergency Life Support course, which is owned by the Society and about to enter the pilot phase.

The first course is due to be held on 26/27 July at Westmead under the guidance of Rob Edwards, NSW President of ASEM. Priority registration will be given to members of the Society.

Keith also told us that ASEM suppports an annual Winter Symposium, held this year in NZ, and also an annual Rural Meeting—held last year at Terrigal. Sessions are held at annual scientific meetings, this year focusing on continuing education.

Meetings of ASEM are held on the third Tuesday of every second month at 3pm, at Concord Hospital. They are joint meetings with the college. Membership of ASEM is a modest $145 including receipt of the society journal *Emergency Medicine*.

We had some general discussion at this point and the CMOA, as represented by the persons present, thought it was all a damn good idea, and as an Association we should work to develop links to ASEM.

The second speaker, Russell Noud is our contact in the AMA, and spoke about the state of play for the CMOs in the medical work force. Russell made the suggestion that we might profitably tap into the AMA networks—seek representation on various committees and form a special interest group. After discussion, the consensus was that at some point in the future the CMOA may enter into formal discussion about possible con-joint membership between CMOA and the AMA. Russell also reminded us that the AMA co-sponsored the Brennan report, together with the PSA and ASMOF. They then convened the Medical Workforce 2000 meeting to look at that report. As you will recall from previous issues of the *Bulletin*, CMOs were the hot item on the agenda, and there is now national acceptance and recognition of the notion. The previously prevailing perception of CMOs as failed specialists is not the reality and such comments are based on out-dated perceptions.

Other initiatives the AMA has been involved in, such as the Hospital Pilot Restructuring Programme—which was funded federally—to examine ways to either increase the supply, or decrease the demand on doctors in hospitals are at a halt now and everyone is wondering what comes next. (6-8 projects got through to stage 2 - including Caboolture / Mater/

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Next Meeting.....

Albury Base Hospital Tuesday 19th August

Please contact Michael King if you plan to attend:
Phone: 060 584 55 Fax: 060 584 528

Editorial

Moving on...

Well, the last three months have been an excellent example of why the CMOs have had such a low profile for so long - too damn flat out like a lizard drinking getting on with their own lives and careers to have time to do much else. Sigh.

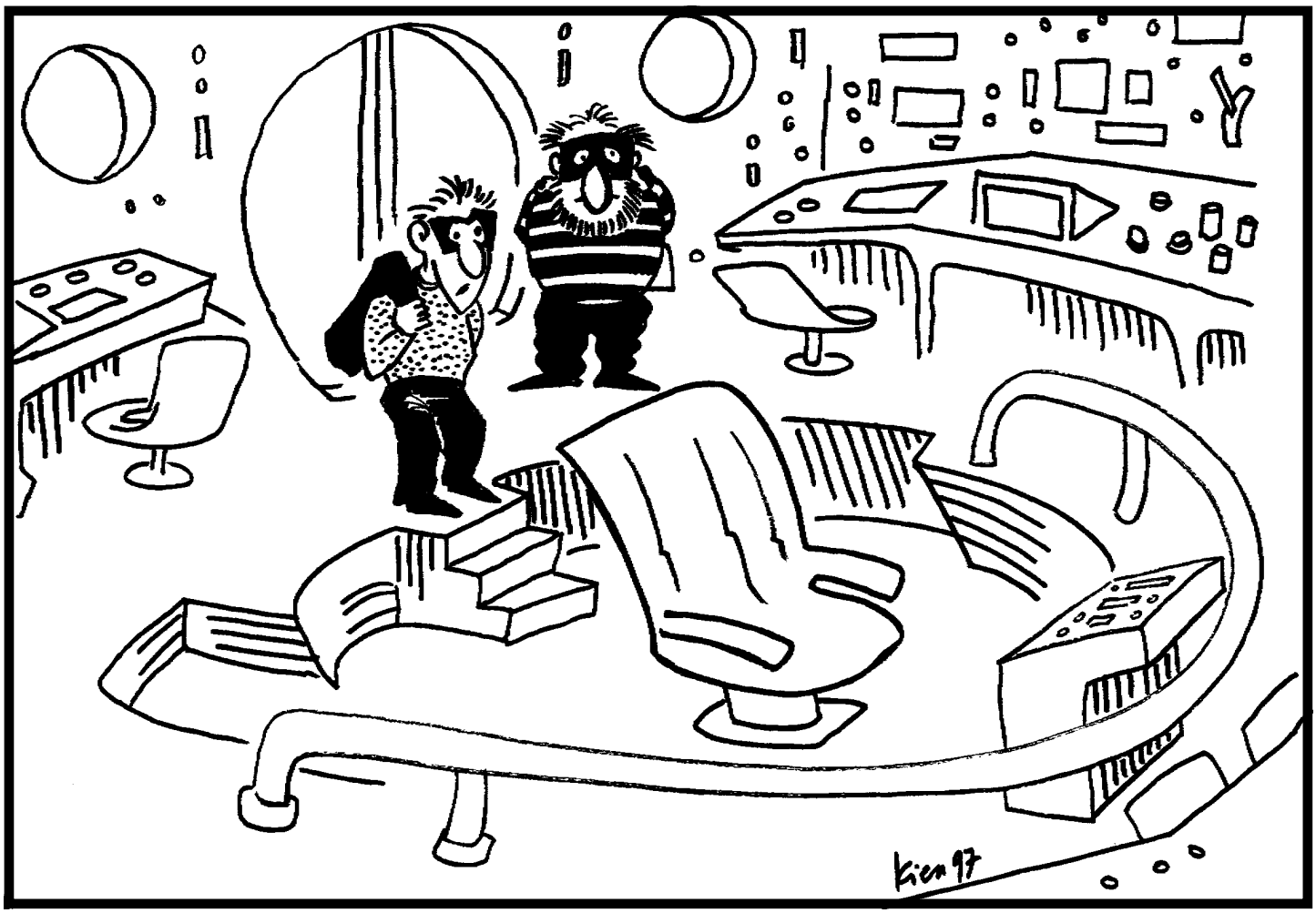
My apologies to all and sundry for the delay in producing this issue of the Bulletin. Goodies have been awaiting attention for months, but as well as many and demanding involvements in extra-curricular activities of great personal import and enjoyment, I was foolish (?) enough to accept the CMO-in-charge position in the ED at Orange.

Surprisingly enough this involves a gob-smacking amount of work (PGMC accreditation coming up), as well as packing and transporting 80-odd boxes of books to the country. It took some weeks to even identify which particular box contained the CMO stuff. Challenge is good for a person, I'm almost sure.

If we owe you a membership receipt or a membership card it should follow closely on the heels of this issue. If it doesn't, you can now call me on (063) 605 227 in the ED at Orange Base Hospital, or on 015 906 105, and I'll sort it out.

Mary G.T.Webber
Harassed Editor

"Where the hell are we... The bridge of the Starship Enterprise?"
"Nah, its just Mary Webber's house."



The Future for CMOs

From Warwick Barnes. Former Emergency Department CMO

Over the next few years CMOs will be gradually squeezed out.

CMOs have been in existence as a group for most of this decade, but until the recent embryogenesis of the CMOA, this heterogeneous group of doctors have all been out there doing their own thing, without any common voice.

Now with the CMOA, there may at last be a way for this group to have a say in the health system, and to lobby the Government for better contracts etc. etc. But has it all occurred too late?

Traditionally, (if you can develop traditions in a group that has only been in existence for less than 10 years) most CMOs have worked in Emergency Departments in "areas of special need". Though I have no hard data to back me up, I suspect that this is still the case, though some percentage so work as registrars outside the ED.

Recent changes to the Emergency Department where I work have highlighted to me the rapidly changing nature of the role of the CMOs, and presented the very real possibility that CMOs as a species are headed for extinction, or at least relegation to the more inhospitable corners of the medical workforce.

The first changes at any given hospital may be subtle - change of pay scales, or re-arranging of rosters in favour of the permanent or training staff. This is, in my opinion, the thin end of the wedge that will be sledge-hammered home with force over the next 5-10 years.

Emergency Departments of the future will be staffed with an abundance of staff specialists and training registrars topped up with the junior RMOs and Interns. This is almost inevitable. Over the next few years CMOs will be gradually squeezed out.

The first step is likely to be a change from the more costly casual awards onto the less costly permanent awards. Next comes the roster re-arranging, where the CMOs are "asked" to cover the shifts that the registrars and specialists don't want. Then, as the number of these full-time FACEMs and registrars increases, so the shifts available to the CMOs will decline, and are likely to be removed altogether.

It won't happen overnight, but it will happen... So where does that leave CMOs and the CMOA? Those of us lucky enough to have some diversification in our work may be able to continue in our non-Emergency Department positions. Those who work part time in General Practice as well as in the public hospitals may be forced to re-think their careers, and switch to the RACGP. The rest of us may be forced out into the mulga.

Also, it is not just the restructuring of the Emergency Departments that will impact negatively on the future of the CMOs. The recent changes to the general practice training and vocational registration, combined with the provider number changes will see an increasing number of RMOs effectively trapped in the hospital system awaiting a training position in general practice or a specialty. These RMOs are an easy target for budget conscious administrators to slot into ED rosters as cheap labour, further decreasing the availability of CMO shifts.

Have CMOs finally emerged from the primordial swamp only to be greeted by extinction in the Medicare Ice Age? Decide for yourself—but don't take too long .....

Submitting Items For CMOA Bulletin

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

All items submitted should be either sent on disc, or e-mail to the Editor, whose mail and e-mail addresses are on page 2. Just about any PC or Mac Word Processing format is OK. When submitting items on disc, please label your disc, and provide a printed copy if possible. Please contact the Editor if you wish to submit material generated in other types of software applications. Illustrations should be in black ink, on plain white paper with nothing on the back. Photographs can be either black & white or colour.

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

Next issue will appear in September.
Closing date for submissions: 31 August.

Master of Psychological Medicine

UNSW School of Psychiatry at St Vincent's Hospital

A two year part-time masters program for general practitioners (currently in practice) focused on the mangement of patients with Psychological and Psychiatric problems. Course begins February 1998 on Tuesdays from 7.30 am -12.30 pm. Class limit is 20. Currently accreditated with 25 Practice Assessment points and 70 CME points per semester in the RACGP QA & CE Program. Fees: $1875 per semester (4 semesters)

Semester 1 - February to May
Aims to provide an overview of diagnosis and epidemiology of mental disorders. Students are taught the tenets of good diagnostic interviewing and good clinical care and acquire the skills of micro counselling and structured problem solving techniques. This semester provides the groundwork for learning the specific therapeutic skills that are utilised in following semesters.

Semester Two - July to November
Aims to cover the recognition and management of the more common disorders seen in general practice; the anxiety and depressive disorders. Students are trained in cognitive behavioural management techniques and taught about pharmacotherapy for these disorders.

Semester Three - February to May
Aims to cover the recognition and management of cognitive impairment, dementia, developmental disability, schizophrenia, personality disorders, and other chronic disorders. Students are taught about crisis resolution and good clinical care for such patients and, in addition, are trained in specific management strategies where evidence exists for their effectiveness.

Semester Four - July to Novemeber
Aims to cover the problems of childhood, adolescence, the elderly, and problems arising within the marriage and family. Students are taught specific effective management strategies appropriate to the general practice setting and when and where specialist consultation can be sought.

Project Report
A project report, begun in Semester 3 and completed in Semester 4, is a requirement of the programme. The project can either be an account (in about 20 000 words) or cases from the students own clinical practice that shows the student's ability to integrate the research literature and clinical practice (and must include an evaluation of the patient's progress in treatment), or, it can be a research project relating to psychiatry in general practice. Regular supervision sessions will be scheduled.

Faculty
Gavin Andrews (Professor of Psychiatry), Caroline Hunt (Lecturer in Psychiatry), the staff of the School of Psychiatry, and visiting lecturers and tutors who are expert on particular topics.

Enquiries
Professor Gavin Andrews or Judy O'Rourke
Phone: 02 9332 3097

This information very kindly submitted by Mary T Nagle, CMO, Morrisett, NSW

Neat Stuff from the Internet

Well the first thing you're going to need if you're about to embark the brave new world of the information superhighway is a good book.

Amazon Books at: http://www. amazon.com

However if you're on the Net to do some work, then check out:

Paediatric Radiology at: http://www2.hawaii.edu/medicine/paediatrics/pemxray/pemxray.html

Visible Human Project: http://www.nlm.nih.gov/research/visible/visible_human.html

The Interactive Patient: http://medicus.marshall.edu/medicus.html

If you need to send the Interactive Patient flowers after a difficult consultation, you can order them from:

The Virtual Florist at: http://www.virtualflorist.com/index.html.

Of course the ultimate medical site is Emory University's public health MedWeb site at:
http://www.gen.emory.edu/medweb/medweb.ph.html/#Sites

And if you can't find it there you can Blow Yer Brains Out at:
http://www.islandnet.com/~moron/deterrent/roulette.html

Our own Internet site, with a really useful bunch of links can be found at: http://www.gis.net.au/CMOA

Medical Training Review Panel HMO Working Group

Report by John Egan

The Medical Training Review Panel (MTRP) is a body set up by the Federal Government as a spin-off from the Provider Number Legislation. In association with State Departments of Health and many of the major players in the medical arena (including the colleges and most of the political and industrial bodies), this organisation has as its brief the wide field of ***Medical Training***. Committees were formed to investigate particular areas of interest and to make submissions to the parent body.

The committee that is of most interest to CMOs is the Hospital Medical Officer Working Group, under the chairmanship of Dr Alan Sandford of the Victorian Department of Human Services and now includes the following members:

Dr Chris Baggoley
Australian College of Emergency Medicine
Prof Richard Smallwood
Royal Australasian College of Physicians
Dr Sam Lees *GP Divisions' Strategy Group*
Dr Brian Jardine *PSA NSW*
Mr Duncan Inverarity *ASMOF*
Dr Kate Hillier *Doctors in Training AMA*
Mr Bob Wells
Commonwealth Dept of Health & FamilyServices
Dr Sue Phillips *DH&FS*
Ms Justine Curnow *DH&FS*
Mr Chris Lyon *DH&FS*
Prof Nick Saunders
Committee of Deans of Australian Medical Schools
Dr Julie Hudson *Qld Dept of Health*
Mr Russell Noud
Industrial Officer AMA (observer)
Dr John Egan *CMOA*

Terms of Reference

1. Develop and recommend a limited number of proposals for a National Training Model for Hospital Medical Officers. (HMO in this sense includes second and third year post-graduate medical officers and post-graduate experience beyond the third year for doctors wishing to pursue non-specialist career pathways within the hospital. (That is, RMO1 & 2 and CMOs in the NSW scene.)

The proposed models should include consideration of:

i) The Hospital Pilot Restructuring Program.
ii) The Brennan Report into non-specialist hospital career paths.
iii) Alternative modes of training delivery such as those contained in the Holsgrove Report.

The HMO Working Group is also instructed to comment on infrastructure features such as planning and coordination of training, providers of training, recognition and portability of training etc.

2. Formally establish a national network of stakeholders for the purpose of consultation.

3. To advise the MTRP on a dissemination strategy for proposals arising from the HMO Working Group.

Comments

When I became aware of this body I felt strongly that representation of our organisation was essential. There is no doubt that the impetus for establishing the MTRP was to mollify the criticism that junior medical officers were, on the one hand, to be denied access to provider numbers (and therefore the ability to practice as GPs), and on the other, to be faced with no organised program of training or accreditation. The Federal Government could be seen to be aware of this problem by forming the review panel and therefore addressing criticism of the legislation.

CMOs, most of whom work in the hospital system, are likely to be caught up in any changes in practice that result from this process and should, at the very least, be informed of current negotiations. However even more importantly, CMOs should contribute actively to this discussion as we are one of the main targets of any recommendations and we are also the people with the most experience in the non-specialist hospital medical officer role.

The HMO Working Group met at Melbourne Airport on the 14 May. My overall impression: These are people with the ability, educational background and positions of power in the medical organisation to impact in a positive way on CMO

matters, especially in educational and industrial areas. The major problem was the lack of ***direct*** knowledge of CMO experience, utilisation and aspirations.

The main positive outcome was the unanimous agreement to look into the first two years of medical practice, to suggest the NSW model (and the QLD counterpart) as the "state of the art" position to emulate, and to present these suggestions to the major body of the MTRP.

Those who work in NSW & QLD may be surprised to find that their current system of well organised attention to the recent graduates (under the control of the Post-Graduate Medical Councils) is not available in most other states, where the newly qualified doctors have to look after themselves - in most cases to their disadvantage.

The major negative outcome was the group's inability to come to grips with the specifically CMO issues. It seems to be in the "too hard" basket and I had the strong impression that most of the group would not address these issues unless forced to do so—this I see as my role over the next few months. To this end I have already presented the CMOA view on our training and accreditation (at the same time taking the opportunity to give out extra copies of the ***Bulletin*** to all the delegates!).

Watch this space for futher developments.

Latest HIA Amendments

The Act as pertaining to the Medical Training Review Panel

Section 3GC: Medical Training Review Panel

(1) The Minister must, by instrument in writing, establish a Medical Training Review Panel.

(2) The functions of the Panel are:

(a) to compile such information relating to:
(i) courses and programs of a kind specified in regulations made for the purposes of subparagraph 3GA (5)(a)(i); and
(ii) medical practitioners who are enrolled in or undertaking, or who are available to enrol in or under take, those courses and programs;

(b) to publish the information in such a manner as the Minister determines in writing; and

(c) to establish and maintain a register of employment opportunities for medical practitioners, in such a form and containing such information as the Minister determines.

(3) The Minister may make written determinations relating to:
(a) appointment of persons as members of the Panel; and
(b) nomination of persons for such appointment.

(4) The Panel must, as soon as practicable after 30 June in each year, prepare and give to the Minister a report on its operations during the financial year that ended on that day.

(5) The Minister must cause a copy of each report to be laid before each House of Parliament within 15 sitting days of that House after the Minister receives the report.

(6) Determinations under this section are disallowable instruments for the purposes of section 46A of the *Acts Interpretation Act 1901*.

(7) This section ceases to be in force on 1 January 2002.

Following on from the last isue.... More important HIA amendments affecting CMOs

Integration?

2nd Forum on the Ingegration of General Practice and NSW Health Services

Report by Julian Egan

My brief was to press the flesh, raise the profile of the CMOA and interact with the delegates on matters pertaining to the CMOA.

The idea behind the forum is that if GPs and NSW Health Services can work together then the public will have a better health service, and things will run more smoothly for the deliverers of health care. There are some obvious examples of intelligent cooperation between the GPs and hospitals, e.g. shared ante-natal care; the DOCFACS system, whereby GPs are notified by fax of patient admissions, discharges, after discharge home care facilities, etc.

It all sounded great and the opening feelgood pep talk from Dr Refshauge made us all feel we were involved in something ***really important***. This Integration idea may or may not have legs, but if it does get up and running, everyone involved in health care is going to be affected—so you'd better understand what's going on, and be involved in its formation, or have it rudely thrust upon you from a great height.

It's important to state here just who the players were at the forum. Apart from a few peripherals like myself, the majority of the 150 people there were representatives of GP Divisions across the state. The balance was made up of 20 representatives of NSW Health, mainly Area Health Service (AHS) CEOs. For those who came late, local GP Divisions have been operating for about six years, and usually an AHS will have about four GP Divisions within its boundaries.

Some GP Divisions operate on multi-million dollar budgets (courtesy of federal funding), and collectively they have the potential to usurp all existing GP organisations to become the most powerful GP player in health politics. At present they are all democratically constituted local bodies dealing with local issues.

After representatives from the Divisions and the AHS gave their rendition of what Integration means to them, we were divided up into workshops and I signed up for "Setting up the team and the game", feeling that there I could put in the CMOA's two bob's worth, especially as hospital staff were going to be involved in this process.

Fifteen of us sat around in a circle and we each said who we felt ought to be involved in the Integration process. My argument that the CMOA ought to be a player since CMOs were likely to be the originators of the DOCFACS transmissions and would also play a coordinating role in integrating health services for early discharge patients such as temporary home care, didn't wash with the convenor. There was even outright hostility from a Sydney Division GP who flatly said that he didn't consider CMOs a part of the team. I said that they should be, and reiterated my argument. After an awkward silence the nonplussed convenor said "OK. Put CMOs on the board." So up on the whiteboard when CMO under GP and AHS.

But it was a hollow victory and I was beginning to feel like a just-discovered gatecrasher at a private party when, God bless her, a pensioner from the Consumers Health Forum, TED stockings and all, said she reckoned her organisation ought to be on the team as well. I felt so relieved. And then the convenor did a very intelligent thing: with gusto he said: "RIGHT! Who else should be on the team?"

Well, we all began babbling and pretty soon we'd filled up that whiteboard with nurses, pharmacists, physiotherapists, podiatrists and anyone else we could think of. "Right!" said the convenor, "Now who are the CORE players on the team?" Of course he got the answer he wanted: GPs and AHS. "Right! Lets go to lunch!"

I was as happy to be out of that room as the rest of them, and realized that if I had been a stick in the mud I would have done the CMOA more harm than good.

Over lunch I had a friendly discussion with the GP who hadn't considered CMOs part of the team and he went away with a better understanding of the CMOA. I also gave Dr Tim Smyth, chief spokesman for the AHS, the CMOA website address, as in his

speech he had stressed the need for getting onto the information technology bandwagon.

After lunch the real power game began. All the workshops were to report back to the forum on their deliberations, and then we were to agree on a set of guidelines for furthering the establishment of Integration.

Eventually the discussion centered on how to improve liaison between GPs and AHS. Someone suggested that GPs be appointed to the boards of AHS. Immediately Tim Smyth jumped to his feet and courageously opposed the suggestion. We all have to work in our own spheres and I could undertand his objection to being 'infiltrated' by a potentially very powerful organization. However he was hopelessly outnumbered and the most important resolution of the forum was to send a request to Dr Refshauge to allow GPs positions on AHS boards. (Board members are appointed by the minister).

Integration may not amount to much, but I get the feeling that the type of power play I saw at the meeting was of such intensity that there was some big prize they were all playing for. Perhaps they were playing for control of mult-imillion dollar AHS budgets. Perhaps I'm too cynical. Perhaps anyone who has done their sums knows the power of Integration.

As far as the CMOA is concerned, we are definitely minnows in this world of whales and the policy of being non-ideological, friendly to all and not aligned with any other health group is essential. Also, and I know its only very early days, if we are going to be an effective association we must have profile. No one at the forum had heard of us. Hopefully at next year's forum people will know where we're coming from.

Whispering Pectoriloquy

By Ian Biggs... with apologies to Big Bill Shakespeare

On a lighter note, and for those who, like your Editor, spent a good deal of time admiring Branagh's full-text Hamlet in 70mm .....
from an irreverent soul amongst us...

TB or not TB; that is the question:
Whether 'tis nobler in the lung to suffer
The nodes and foci of primary disease,
Or to take arms against a sea of bacilli,
And by opposing, kill them?
To die, to sleep;
No more; and by a sleep to say we end
The cavitation and thousand miliary foci
That flesh is heir to, 'tis a consumption
Fibrotically to be ended. To die, to sleep;
To sleep; perchance to live: ay, there's the best.
For in that sleep of death what result may come
When we have shaken off this mortal cough,
Must give us hope. There's the malaise
That makes haemoptysis of so long disease;
For who would bear the scars and risks of time,
The bacilli's wrong, the rifampicin's success,
The pain of pleural disease, the BCG's delay,
The insolence of spread, and the drugs
That the patient in bed 46 - he's unworthy but takes,
When he himself might his recovery make
With nought but a bare X-Ray?
And who would reactivations bear,
To cough and sweat a weary course,
But that the hope of relief after death,
The undiscovered treatment from whose course,
All sufferers recover, puzzles the profs,
And makes us rather bear those ills we have
Than fly to others we that we come to know of.
Thus Tuberculosis does make patients of us all;
And thus the native hue of life
Is sicklied o'er with the pale cast of death
And treatment of great drugs and many
With this illness, their lives turn awry,
And lose the organs called lungs....

Education: A Personal View

Steve Delprado

EMST & Beyond

In the last newsletter I told you about a submission to the Federal Department of Health on Education. This has been rejected awaiting the decisions of the newly formed Medical Training Review Panel of which our president is now a member. (*To the pushy the spoils - Ed.)*

By the way, I have still had precisely zero direct input on the pressing issue of continuing education from the CMO membership. *(Except from Mary G.T.Webber, who is briefly engaged in some fascinating discussions with the University of Newcastle about the possibility of development of a Masters in Clinical Practice programme specifically aimed at furthering the flexibility and relevance of the CMO experience. - Ed.)*

EMST Course

The Early Management of Severe Trauma (EMST) is an intensive two and half day course (Friday to Sunday) in the management of injury victims in the first one to two hours following severe injury. Its empasis is on life-saving skills and a systematic clinical approach.

It was adapted by the Royal Australasian College of Surgeons in 1988 from the Advanced Trauma Life Support (ATLS) course of the American College of Surgeons. EMST courses are sponsored by the Trauma Committee of the Royal Australasian College of Surgeons.

EMST is designed for all doctors who are involved in the early management of serious injuries in urban or rural areas no matter how sophisticated or otherwise, the available emergency facilities may be. These doctors include:

* Surgeons
* Emergency Physicians
* Rural General Practitioners
* Anaesthetists
* Intensivists
* Doctors in the Armed Forces
* Trainees in the above specialties (surgery, anaesthetics, emergency)
* Resident Medical Officers

Once they have completed the EMST course, a participant should be able to:

* Demonstrate concepts and principles of primary and secondary patient assessment.
* Establish primary and secondary priorities in a trauma situation.
* Initite primay and secondary management of unstable patients.
* Demonstrate skills used in initial assessment and management.

The content of the EMST course comprises lectures, practical skills, case studies, written tests, videos and sessions in Initial Assessment Practice and Test.

Lecture subjects cover: Initial Assessments; clearing the Airway; treating Shock; treating Chest, Abdomen, Head and Spine injuries; tending to Burns and Extremities; ensuring Stabilisation for Transport.

Practical skills subjects include: Airway control; IV/Shock therapy; Head injury assessment; Limb splinting; Spine protection; MAST suit; venous cutdown; Chest tubes; Peritoneal lavage; Perdicardiocentesis and Cricthyroidotomy

Approximately 16 doctors participate in evey course, which is in turn overseen by seven to eight specifically trained course instructors.

Approximately 45 provider courses are held each year in all capitals and some regional centres across both Australia and New Zealand. The current cost of the course is $980 and applications may be obtained from:

Damian Christie
EMST Administration Assistant
EMST Office
Royal Australasian College of Surgeons
College of Surgeons Gardens
Spring St
MELBOURNE VIC 3000

Tel:(03) 9249 1297
Fax:(03) 9249 1298

Please note that because of the small number of participants for each course (16), there is currently a waiting list of 12 months from the date of application.

EMST Refresher & Instructor Courses
For successful EMST participants, there are refresher courses held four times a year. This is a one and a half day program (usually Fridays and Saturdays) in which successful participants can refresh their knowledge and skills four years after the expiraton of the initial EMST certificate.

EMST Instructor courses are conducted twice yearly. Applicants must have completed an EMST course, be actively involved in trauma care and have an interest and involvement in teaching. These courses include expert instruction in teaching techniques.

For further information, see the contact name, address and number above.

Comments on EMST Course
From a personal perspective, having completed the course, I would say that it is well worth the money. For practicioners in acute care it will improve your approach to the day to day management and confidence in your skills with all patients, not just those victims of trauma.

Up and Coming....
A new course is being piloted by the ASEM. The Emergency Life Support course will focus on the managment of acute medical emergencies and will make a nice pairing with the EMST for trauma. We have at least one and maybe more CMOs going through the pilot programmes and will be back to you with an opinion and further information in the next issue.

I have moved my place of work to:
The Hills Private Hospital
499 Windsor Rd
Baulkham Hills 2153
02 9639 3333
Please forward ideas/ book reviews/ meeting reviews to me at that address, for possible publication to the membership.

The Internet For Health Professionals

University of Sydney Centre for Continuing Education

Reviewed by
Mary G T Webber

So, you couldn't tell a search engine from a fire engine, and wouldn't know how to start it anyway? So you don't have time to wade through a book and you couldn't find the examination practice site at Birmingham University with both hands in a thunderstorm? You don't have time or *patience* for this stuff? This is just the course for you. The one-day course costs $235, includes a dandy brown paper bag lunch like mum used to make, and covers the basics in a comprehensible format. If the group going through already know what client software does and the difference between Hypertext Transfer Protocol and Hypertext Markup Language, and that email addresses are not case-sensitive even though the URL is, then the instructors will move you right along to the information that you don't have to type "http" in www if you're using Netscape. (Well, I didn't know that.) Netscape E-mail is covered in reasonable depth, and the course is platform independent, just like the Net.

Mind you, I have to say that when it comes to elegance of use, Mac leaves IBM and this browser business standing when it comes to digging out the mail you sent yourself. The course covers the pros and cons of the whole deal, pointing out what a time sink a Net connection can be and reminding you that the multi-media wonderful world out there is largely inaccessible unless you have a fast connection and a reasonably powerful computer *and* you need to virus check any free software you import before you decompress it.

But the real deal of this course is access to John's own collection of health-related bookmarks, and making the whole wonderful, confusing mess look remarkably like something that could actually be usefully employed to find information that you *need*, out here in the Real World.

Course rating : ****
(Lost a star for being expensive, even with the baggie lunch.)