CMOA

CMO Bulletin

Newsletter of the Career Medical Officers Association Inc

December 1997 Volume 1 No 4

President's Address

Happy Birthday!

This edition of the CMO ***Bulletin*** marks our 1st Anniversary as an association and it's a good time to reflect on our progress to date:

1. We exist as a legitimate special interest group in the medical field and now have over 100 members—a large increase over the 28 doctors who attended the inaugural meeting on 13 November, 1996.

2. We have an energetic committee who work hard for the membership bringing CMO issues to the fore in publications such as this, and representing you at meetings, conferences etc relevant to CMOs. Two people I would like to point out for special mention are Mary Webber—Editor of this publication, Secretary of the CMOA and full-time director of the Orange Base Hospital Emergency Dept—she does a power of work (Super CMO!!), and Stephen Delprado—Education Officer of the Association and one of the new breed of private hospital based CMOs, who is constantly looking for ways to bring quality education for CMOs onto the agenda and into the mainstream of CMO practice.

3. We have a quarterly bulletin, newsletters and a Website on the internet.

4. We have had official and unofficial representation on various committees, conferences and medical groups that may impact on CMO practice, including; Medical Training Review Panel (HMO subcommittee), AMA - Medical Careers 2000 Workshop & Doctors in Training Organisations Caucus, Australian Salaried Medical Officers Federation, Australasian Society for Emergency Medicine, and 2nd Forum on the Integration of General Practice and NSW Health.

A pleasing aspect of this high profile is the invitations we are now getting as an organisation to attend and voice our concerns at these meetings.

5. We have commenced detailed discussions both within the Association and with outside institutions concerning the provision of quality education to CMOs.

As impressive as this list is for a "neonatal" group, there is no cause for complacency and Warwick Barnes has brought up some important issues in the last edition of the ***Bulletin*** (in "*The Future for CMOs*"). Have we arrived too late, emerging from the "primordial swamp only to be greeted by the Medicare Ice Age?" Will many of our positions evaporate when staff specialists (such as FACEMs in EDs) come on board in increasing numbers?

There are no easy answers to these questions and much depends on medical manpower numbers and deployment factors decided in the main by Governments (especially Federal) with issues sometimes political rather than health-related involved in the equations. What does seem to be apparent is that there is no chance of controlling our own working environment without organisation, and I believe for us that means the CMOA.

I feel that it is highly unlikely that FACEMs will ever displace all or even most of the CMOs that now work in EDs (how often are you asked to do more shifts than you want?) and there are increasing requirements for CMOs in private hospitals (in ED and general ward work). There is also the possibility of CMOs setting up their own

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President's Address

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private "acute care" centres that could manage most of what now attends the public hospital Emergency Departments.

There are, to my mind, too few doctors rather than the reverse, and opportunities are always opening up for the experienced "generalist"—both in hospitals (such as in intensive care units, psychiatric in-patient units, neonatal units, private hospital general wards etc) and in the community (sexual health and sexual assault, developmental disability, drug and alcohol, mental health etc).

Our flexibility is one of the great attractions of the CMO life-style and is also one of the great strengths of the Association. To continue the evolutionary analogy, our generalist nature and our flexibility will almost certainly give us the competitive edge when it comes to finally crawling out of the primordial swamp and lying exhausted but happy on the green grass (perhaps sparing a sad thought for our too specialised contemporaries, still fighting for enough oxygen in the quagmire behind).

One final point, survival needs commitment—we need to be motivated and to be self-starters. To quote Warwick one more time "Decide for yourself - but don't take too long....."

John Egan
President

Committee

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Next Meeting.....

The Inaugural AGM of the CMOA

at

The Novotel
Brighton-Le-Sands

on

Saturday 28th of February 1998.

Full day programme featuring both keynote and guest speakers on a variety of topics of both industrial and general interest.

Progress and Prospects report by John Egan.
Election of Officers and Councillors.
Delightful lunch on the terrace.

Cost $52.00 includes Lunch, and morning & afternoon tea.

It would be appreciated if this money could be prepaid, but cash and personal cheques (with ID) will be accepted on the day.
RSVP to: John Egan, Michael King or Mary Webber.
You can be assured of good company and spirited conversation, because we always do enjoy ourselves.

Please feel most welcome to join us.

Editorial

Busy, busy, busy....

Hi all, and greetings from the over-worked, but not entirely unappreciated.

Well, Orange has turned out to be quite an experience—no wonder they wanted an old doctor (I mean ***experienced***, yes of course that's what I meant....). Between the escalating case load, writing the teaching, dealing with the extreme youth of the staff (five baby docs last term, four of which had never worked in an Australian ED), and the sheer amount of pushing needed to move us towards what other departments take for granted, like sticky labels and unique medical record numbers for every patient and a white board to tell us where they all are and what's happening to them, it's been well—***interesting***.

I hope that we're getting part of the way there, but it's taken a great deal of time, and little has been left over for attending to other important things—like mail for the CMOA. If you haven't heard from me, I simply beg your indulgence and promise to do better.

El Presidente says I can have a little secretarial support, and I am grateful, not to mention eternally indebted to the buddies who helped me finally to put the database together. There is an astonishing amount of work goes into reaching you, and your patience in waiting for it to happen is appreciated. We are just one year old. The best is still ahead of us. (Anyone want to stuff envelopes this Friday?)

May your Deity be with you this holiday season and bring you safely and with joy into the next year.

See you at the AGM.

Mary G T Webber
Secretary / Editor

Industrial Update

John went to the last meeting of ASMOF - and noted that there will be a 16% pay rise for CMOs over the next two years.

Other current industrial isses include:
The way our overtime is paid,
The move to introduce a CMO IV level,
The $15 per day on-call rate.

ASMOF perserveres. So does John. (*All hail - El Presidente! - Ed*.)

Education Officer's Report

Greetings for the coming season.

... Education has been largely put on hold awaiting the "Medical Training Review Panel" decisions.

... "El Presidente" and I have put a submission to the panel in an approach to medical education which discusses leaving portfolios and structured units. I personally had a discussion with the sub-section of the panel involved in entry to the colleges, and their attitudes that CMOs did not fit into their frames of reference.

... On a more positive note, the Emergency Life Support (ELS) is an exciting new development, being piloted in NSW at the moment, before going national next year. This course is forseeable as a prerequiste for senior emergency doctor practise within the next five years.

... Vocational registration as a general practioner is a touchy subject for many CMOs. After discussion with the censor for the RACGP, it may be possible to develop a special group concession. Any CMO who fulfills the following categories should contact me for further discussion.

1. Greater than 9 years post-graduation.
2. Works in Emergency medicine
3. Has been refused vocational registration as a General Practioner.

The ***Bulletin*** would also love to publish anyone's views on vocational registration and how it was executed.

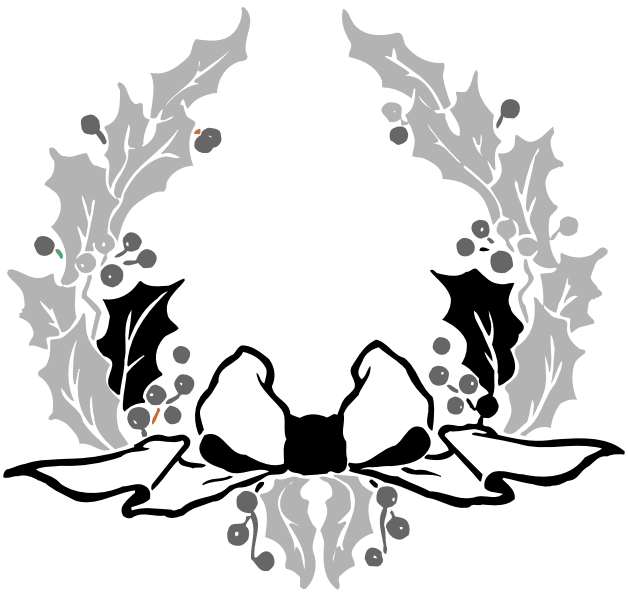
See you at the AGM.

Steve Delprado

And girls in slacks remember Dad,
And oafish louts remember Mum,
And sleepless children's hearts are glad,
And Christmas morning bells say "Come!"
Even to shining ones who dwell
Safe in the Dorchester Hotel.

And is it true? And is it true?
This most tremendous tale of all,
Seen in a stained glass window's hue,
A Baby in an ox's stall?

From "Christmas"
John Betjeman



The CMOA wishes all Members and friends
a happy and safe Christmas,
and a prosperous New Year.

The Emergency Life Support Course: ELS

Bringing the CMO population information about what rescources are out there for self-education is one of our major goals and so we are delighted to bring the existence of this significant new course to your attention, not only because it offers an overview of the field, but because it is specifically aimed at doctors who already know something about what they're doing.

From
Geoff Marshall
Education consultant: ELS
ED Director, Bathurst
ASEM

The practice of Emergency Medicine has altered dramatically since the early 1980s. The Australian Society of Emergency Medicine (ASEM) and the Australian College of Emergency Medicine (ACEM) have both worked since that time to develop the body of knowledge and range of skills required for the practice of Emergency Medicine.

Within larger hospitals, specialists in Emergency Medicine mostly work in conjunction with a body of others including CMOs, general practitioners and the junior medical workforce. Away from these centres the role of care of seriously ill patients is usually by the latter groups often in isolation and with less backup.

The ELS course was first run in 1997 with four very successful courses. It has been developed by a series of authors but the driving and co-ordinating force has been Dr Phil Hungerford FACEM from Tamworth.

The ELS course has been designed to address a need for knowledge of emergency skills by teaching a systematic approach to the management of the seriously ill patient. The ELS course has minimal trauma content and does not aim to duplicate the objectives of the Royal Australian College of Surgeons EMST course.

It is aimed at CMOs and general practitioners who have a significant role in emergency care.

The specific topics and objectives of the course can be found in a separate section on page 6 of the ***Bulletin***.

It is a two day course which is very intensive—early start to evening finish. It is mostly workshop orientated using mannequins for practice in groups of three with one tutor.

There is a pre-course multi-choice exam and an end-of-course viva.

There is no animal lab.

The course is limited to eighteen candidates each time.

The cost of the course is $1200.00.

CME points will be available.

The next course is to be held at Westmead on 7th and 8th Feb 1998.

The other courses for next year (in the second half of the year) are in Mudgee, Melbourne, New Zealand, Tasmania, and Townsville.

For further information including registration of interest or enrolment, please contact:

Sandra Guider
Tamworth Base Hospital
Phone: (02) 6768 3559
Fax: (02) 6766 6638

The Australian Society of Emergency Medicine will be providing us with brochures for this course in the next few weeks. They will be included in the next full issue of the ***Bulletin****. Meanwhile for comments from two CMOs who have attended the course, please read on...*

The Emergency Life Support Course:

1. From Stephen Delprado

Late in July I had the pleasure to attend the Second Pilot of the Emergency Life Support Course at Westmead Hospital, Sydney. The course is two full days long and consists of lectures and skill stations. Prior to commencing, a pre-course manual is provided for preparatory reading.

The manual is one of the best emergency medical books I've seen and would suffice as an Emergency Department manual for any department in the state. It has up to date information on diagnostic approaches and theraputic measures including drug dosages.

The lectures were accurate and informative regardless of your personal level of knowledge.

The skill stations were by far the best part of the course, teaching very practical measures such as CPR, advanced airways control, ECG interpretation and the methodical approach to the emergency patient.

The idea—and its creation—comes from the Australasian Society for Emergency medicine whose members put in may hours "gratis" into its development for the benefit of critical care medicine as a whole.

The course is designed to cover all aspects of the critically ill patient, without going into excessive detail, and without covering trauma—which is well covered in the EMST course. A set of systematic managment principles is put forward which can be applied across a broad range of medical emergencies.

It is anticipated that the course will be available from1998, and I strongly recommend that anyone working in critical care consider doing this course.

Course Objectives for the ELS

1. Apply systematic managment principles and a uniform standard of care in the treatment of a broad range of emergencies.

2. Demonstrate at a number of skill stations the ability to:
   - Perform Basic/ Advanced Cardiac Life Support,
   - Interpret cardiac arrhythmias and abnormal ECGs,
   - Perform airway assessment and management,
   - Use pocket masks for expired air respiration,
   - Use bag-valve-mask,
   - Use pulse oximetry,
   - Perform capnometry,
   - Perform pump priming,
   - Perform a routine or a difficult entubation,
   - Use IV fluids appropriately,
   - Perform an interosseous needle insertion,
   - Perfom a needle thoracostomy,
   - Perform the pressure immobilisation technique for the first aid care of envenomation,
   - Interpret common emergency chest X Rays.

3. Successfully manage a series of mock medical emergencies:
   - Basic airway management / routine or difficult entubation,
   - The unconscious patient,
   - The patient in cardio-respiratory arrest,
   - The child with upper airways obstruction,
   - The patient with seizures,
   - The febrile mottled child,
   - The patient with severe asthma,
   - The envenomated patient.

Two Views

2. From Mary G T Webber

I managed to weasel/cajole/grovel my way onto the third pilot of the ELS in August in Wagga Wagga.

Being further down the development track, the organisers had varied the approach a little away from the lecturing format to take advantage of the fact that many of the participants already had a grasp on a deal of the material. They added IGLOOS - Interactive Group Learning Objective something-or-others. These were sessions that basically came down more to group discussion and working through cases on a given topic. I must say that one of our learned FACEM's interpretations of an extremely drunken, foolish bushwalker bitten on the knee by a "bloody big brown snake, Doc," was quite distinguished and entirely carried the acting day. Our equally distinguished convener was also seen to keel over as an example of chest pain and arrhythmia while coming up for air and occasional refreshing bites of an apple, presumably supplied for him in his role as teacher. Amusement and conversation and comparison of different experiences ensued, going some way towards breaking down any undue formality between the members of the learned colleges and well, us out here. As a member of the species of CMO, I felt that this was quite a refreshing approach. In fact the overall atmosphere of the weekend was relaxed and enjoyable while still clearly moving right along with the material at hand.

My group were a varied bunch including quite a number of rural GPs and a smattering of CMOs and the odd observer, and showed some considerable variation in the amount of critical care experience. However, there was something for everyone, with even the old and jaded amongst us picking up tips and filling in holes in the spectrum of their knowledge and experience. I confess to being totally startled to find that my CPR technique, which I teach to younger colleagues while seldom being called upon to actually perform, could actually be improved upon in practice. Oops.

A point which the course strongly makes is the need for periodical retraining as knowledge and skills naturally decay. On the other hand it was reassuring to know that I knew more than I thought I did and that common sense could still weasel me out of a tricky question.

If I have a criticism, it was that the information could have been a touch more dense in the lectures. I would have liked sample sets of ABG's in the discussion of severe asthma, and I think that the toxicology could have taken two sessions and/ or covered at least one class of drugs in more depth. An update on the approach to antiarrhythmics is always welcome as well. I realise that the organisers are more interested in teaching the approach rather than the specifics, but I felt that slightly more challenging information could be offered in some areas to the more experienced participants. I also felt that some form of written assessment and feedback would have been helpful, but I recognise that these details are still being refined.

As Steve says, the manual is just *superb,* and in fact quite revolutionary—this is the first time a systematic overview has been presented for Emergency practice in this country. The manual is a "must have" for any department's reference shelf and an instant baseline for teaching and discussion.

Assessment was by way of pre and post course multiple-choice papers, and by two (live) mock patient scenarios. I must admit, being the um, wiseguy (?) that I am, I walked up to the supposedly unconscious 14 year old outside my surgery door first thing in the morning, took one look at this pink, comfortably breathing, well-perfused and hydrated and well-nourished specimen of young womanhood on the bench, bounced up to her, flicked an eyelash to establish a present blink reflex, turned to the examiners and announced: "Nope. She's faking it!"— which was of course, quite correct. Take some advice—don't make jokes in exams—they just grin at you, share the joke, then throw in some airways obstruction and a bit of hypothermia and that BSL of 18, just to keep you on your toes.....Hmm. Oh, well, no way to learn but the hard way, I guess. (But I was right, she ***was*** faking it.)

On the whole, it was fun and worthwhile, particularly for senior doctors in fairly isolated practice — I checked a bunch of stuff I wanted to ask about, picked up some pointers from folks who knew, played with the truly cool toys in the skill stations, and got the chance to thoroughly show off in the X-ray interpretation session. Who could ask for anything more?

SWAN V

South Western Sydney Area Health Service Trauma Management Network
5th Trauma Seminar

Report by
Michael Boyd

MAIN TOPICS:
HEAD INJURIES management, and prevention of complications

PAEDIATRIC TRAUMA

HEADLINE SPEAKERS:
Dr Anne Kolbe:
Paediatric Surgeon, Director of Trauma Services at STARSHIP (you read it right!!!) Hospital Auckland, who showed great *enterprise* in organising a well funded and structurally well designed trauma service.

Prof Larry Marshall:
Chief of Neurosurgery UCSD San Diego

Prof Danny Cass:
Paediatric Surgeon, New Childrens Hospital Westmead

Trish McDougall:
Trauma Co-ordinator, Westmead Hospital

MAIN SURPRISE:
Holistic surgeons exist!!!

MAIN TAKE HOME MESSAGES:

a) **HEAD INJURIES:**
Don't even let one episode of significant HYPOTENSION occur, as watershed infarcts can be very debilitating in otherwise mildly injured patients.

b) Ensure that children with significant head injuries (be careful of the diagnosis of "significant") get adequate hand over to the educational system. This involves intervention by doctors in the educational realm.

Such patient's performance at school work may be significantly slower or involve different work practices after head injuries. Simply changing the parameters of the assessment procedures can make all the difference.

An example given was of a child who was performing poorly after head injury on time-limited tests but who, after intervention by the neurosurgeon, was given a non-time-limited test and performed to his usual exceptional standard. He is now the head of multinational companies (no narking comments about getting your head kicked, please.)

c) Beware of **DEPRESSION** after even minor or moderate head injuries as this is extremely common.

d) Prevention is better than cure and more effort is needed in this direction.

e) Non operative (ie "conservative") management of abdominal trauma in children can pay great dividends, but there is an art to knowing just how long to wait. To combat this, guidelines have been developed to help in the decision tree.

f) It is still all too easy to **miss** injuries on the secondary survey, more emphasis needs to be placed on the full examination within the first 24 hours.

BIGGEST POINT OF ARGUMENT:
None of the assembled cognoscenti could agree on what was hypotension in a paediatric trauma exercise!

PRACTICAL ASPECTS:
For those who don't see much paediatric trauma, having all the implements and drugs assembled in paediatric roll where the appropriate utensils are placed according to the length of the child can speed up the response.

OTHER AREAS OF INTEREST:
Good debate was created by Martin Jones, surgeon at Nowra who stated plainly the difficulties of head trauma in a country hospital - unfortunately the assembled neurosurgeons could not come up with a solution to his problems.

FINAL ASSESSMENT:
A worthwhile conference, perhaps a little on the "samish" side for those seeing lots of trauma, but well organised and well worth attending for the broader construct it purveyed.

The Doctors in Training Meeting

On June 24, 1997 I attended a special meeting organised by the AMA Industrial officers to address the providor number issue. I attended as CMOA member.

(*At least we're getting invited! - Ed)*

Present at the meeting were representatives of every major medical industrial association, including:

- AMA National
- AMA NSW
- ASMOF
- PSA
- RMOs Association - 3 Representatives
- CMO's Association
- Queensland Industrial Union

It was the first time these union representatives had ever met at the same table. It was —***amazing****(?)* to watch them in action.

Beauracy was at its best when, after the meeting was opened, the agenda was changed so that we would discuss further meetings first, before having discussed anything beneficial to anyone. For 45 minutes everyone congratulated themselves on having turned up and how it should be a yearly conference at a major venue (not AMA House where the parking is appalling).

The only dissenting voice was the ASMOF representative who pointed out that there was little reason to have a meeting unless you have something to discuss.

Then on to the nitty gritty. The Federal AMA representatives produced a paper they wished us to agree on, concerning definitive places for RMOs in FMP, including rural placements. The paper was well written with bright ideas and showing significant work by the AMA. Unfortunately, in my humble opinion, it fell short of what was actually needed. After discussion with the major players at lunch it appeared the attitude was "If the Health Minister takes a mile we're doing well to get a foot back." My immediate reaction was that this was not adequate. After lunch discussions became more heated with the RMOs association and myself insisting that more should be done, and the unions insisting nil further can be done.

The PSA produced a paper on alternative routes to general practice via hosptitals, which is an altogether obvious solution which the minister has already failed to act on. (There was a previous "very expensive" study done by an English group in Australia indicating that this was the way to go and the Minister appears to have ignored this advice.)

At the end of the day precisely ***no*** definite actions had been sanctioned by the whole group. On the whole an entertaining but frustrating day. My compliments to the Federal and NSW AMA industrial officers for their restraint. I am looking forward to the next meeting but doubt there will ever be one.

Steve Delprado

(*Masterly political inactivity - how unusual - Ed*)

If you think this sounds like a potential script for another series of "Yes (Health) Minister", read on...

And on the subject of meetings ...

"Well, it's clear that the committee has agreed that the new policy is a really excellent plan but in view of some of the doubts being expressed, may I propose that I recall that after careful consideration, the considered view of the committee was that while they considered that the proposal met with broad approval in principle, that some of the principles were sufficiently fundamental in principle and some of the considerations so complex and finely balanced in practice, that, in principle, it was proposed that the sensible and prudent practice would be to submit the proposal for more detailed consideration, laying stress on the essential continuity of the new proposal with existing principles, and the principle of the principal arguments which the proposal proposes and propounds for their approval, in principle."

Sir Humphrey Appleby
His longest recorded sentence.

Meeting Report

4th Meeting at Albury Base Hospital: 19th August 1997

This was our first meeting, "away from home", so to speak, and it is clearly most important that we maintain our commitment to representing and reaching out to country doctors as well as metropolitan ones.

Opening and welcome and tour of the facility was by our treasurer and local representative in the Riverina, the inestimable Dr Michael King.

Apologies:
Peter Tait, Steve Delprado, Martin Werry

Previous Minutes:
Accepted

Business Arising:
ASEM - the last meeting was attended by El Presidente. CMO's mentioned supportively by newly elected Councillor for the College of Emergency Medicine, Dr Janet Talbot-Stern, and by our own FACEM member of the CMOA, Dr Peter Roberts. Discussion re policy on position of CMOs.

Industrial and Mt Druitt:
ASMOF tells us that the action (involuntary shuffling of shifts and conditions on the grounds that the personnel were technically casual) was ill-advised but not illegal. They can't stop it.

Database:
Mary to get moving on this, and has located a Mac guru to set the thing in motion. The database is needed for such things as the free mail out by the College of Pathologists etc. Also needed to check up on people who haven't paid etc, and update the information on those who have.

Education:
Mary is still waiting for feedback from Newcastle re Master's Program proposal. Two levels of education need noted - Junior and Senior.

Nothing of note from the MTRP yet.

The AMA had a meeting to which Steve Delprado went - seek a report.

Peter Brennan still in the mix somewhere. *(— over the Rainbow? - Ed.)*

Our own profile for the character of how we would wish formal CMO-style education to take place -

1. Flexibility of character and content
2. Independence, and a voice in content and form.
3. Modular quality, portability and a mix of experience and formal qualifications.
4. Inclusive education - non barrier education.
5. Use the existing infrastructure.
6. CMO is a career path in its own right - worthy of its own qualification.

Issues still to be resolved: VR and Provider Numbers. — Who controls them?

Since PGMC looks after early education, who looks after us? (*Us, of course- Ed.*)

MTRP - The HMO subcommittee of the MTRP say that VR is only through the learned colleges.

General Business:
Meeting upcoming for Interns for next year at Randwick - can we get a flyer to them? Do we have a flyer? Can we get a flyer done in time? John will speak to Sue Atherton.
Website material is still needed.

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 processor.

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 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 regular issue: March. Closing date for submissions: 28 February.

Meeting Report

5th Meeting at Bankstown Hospital: 11th November 1997

This was the first anniversary meeting and was suitably celebrated with choclate biscuits and a defrosting cheesecake with a single candle. I don't remember if we sang, but we certainly applauded and felt generally pleased.

Steve gave us a report from the AMA doctors in training group on 27 June at AMA House, which meeting (partly covered elsewhere in this issue) was intended to canvass issues such as VR, provider numbers and training issues.

What was striking was not only their inability as a group to make any decisions of substance, but also the schism between the residents and the unions that purport to represent them. The unions took the position that you should be grateful if you get an inch back after the Minister takes a mile away from you. The PSA produced a document on alternate pathways to VR via hospital training—rehash of the original London Report—(available from Murray Barrell or John Egan if you're interested).

In essence, the meeting was unproductive. Steve admitted he may have even started to raise his voice at them.

We now understand that further meetings have been cancelled due to lack of interest —or possibly because Steve raised his voice? *(Native lack of tolerance for beauro-cratic BS—it's practically on the CMO Bill of Rights.*)

Steve suggests that realistically looking forward we have to consider the push for dialogue with the colleges themselves re VR for special interest CMO groups. The determining feature of VR will be an on-going commitiment to a given field and a commitment to continuing education in that field.

Steve also spoke to someone from Brennan Associates, who are putting out a report for the MTRP about trainee selection in Australian Medical colleges. The conversation was sympathetic but concluded that the prospects were poor for the MTRP to see us as an integral part of the structure of medical manpower.

It would appear that the MTRP is also stalled in these issues. We are represented in the HMO working party, where everyone agrees that the first two years should follow the PMC route. So what? - the PMC has been up and running in NSW for eight years, and even if the model needs to be applied in other states, it's well worked out and can be followed with minimal preparation. That will be the easy part. Everyone is reluctant to go onto the next step—us. The MTRP, of course, is organised by the Commonwealth Department of Health, who, although they are interested in following it on, have produced nothing since August and so it remains....

The whole concept to VR = experience + education applies to whatever field you may work in. Sarita Sachdev was able to tell us about her difficulties in working as a CMO in DD and meeting the same difficulties as non-VR GPs.

On other matters it was noted that the market demand for experienced CMOs remains strong, and the **Bulletin** has made a commitment to providing some in-group advertising of what's around.

Discussion also noted that the secretary/ editor is more than slightly snowed under and said she could have some secretarial support is she could find some willing fingers for the keyboard to track memberships. Also it was decided that membership cheques dated after the 1st September are good for the following year as well.

The AGM was on the agenda and we agreed upon the desirability of a short programme of speakers to enliven the need to conduct some business between-times. It was also agreed that at least one speaker should be on a non-medical topic, to continue to assert our CMO/generalist tendencies.

More on this in a special issue in January. See advert for the AGM in this issue....

Industrial Update - see separate column.

Then we all went home with long lists of things to do.

CMO Positions Vacant

Orange Base Hospital

Emergency Department

The Emergency Department at Orange Base Hospital is seeking to increase the seniority and permanency of its medical staffing. To this end we are looking to recruit Career Medical Officers with a minimum of three to four years postgraduate experience and an established interest and experience in Emergency Medicine.

The successful CMO should be able to function as in-charge-of-shift of the medical staff on the floor and sustain a day-to-day administrative role, take admitting calls and liase with both registrars and consultants and local and regional GPs, stay in contact with the bed state, redispose medical resourses according to need, and provide close supervision and support to junior staff.

Familiarity with all aspects of the ED's function is assumed. Teaching and education will be given a high priority and opportunities exist within hospital and regional educational services, such as ELS and EMST placements for commited applicants. It is anticpated that the CMO will also take part in all aspects of the regional road retrieval service and in-house additional training will be offered if necessary.

The Emergency Department at OBH is a busy and growing service, and we are looking for medical officers willing and able to take an active part in realising its potential.

Please contact Dr Karen Mahlo on 02 6362 1411 for details.

WANTED!

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Please apply either in writing or by phone to:

Dr Trish Saccasan-Whelan
Director ED, Goulburn Base Hospital
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GOULBURN NSW 2580

phone: 02 4827-3111

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