ASCMO Times

Newsletter of the Australasian Society of Career Medical Officers

OCTOBER 2010 ISSUE

PRESIDENT'S REPORT 2010

Michael Boyd

Springtime for CMO's in Paradise...!...?...

Has everyone heard about sunspots? The Solar Tsunami which is supposed to be bringing disruption and consternation to the word with an unusually high solar flux? The coronal ejection events that will bathe the earth with Death Rays?

Intruth, past large solar fluxes led to ruinous storms and disrupted communications. It might indeed even be reasonable to have more concern now because so much of our society depends on satellite communication. Our very way of life feels threatened. The Death Rays are coming!

But
During these maxima we managed to put the first man in space.
Modern Australia was re-discovered. Some of the greatest light shows from the northern and southern lights radiated beauty in such places as Rome, Mexico and even Tahiti.

So
Should Seymour be afraid of the Rays?

Seymour the child shielded his eyes so he didn't go blind
Seymour the teenager went to a rave party, dared to look at the light and changed the rules of the game
Is Seymour the adult in danger of losing it all by being afraid to look?

There remain many challenges for the CMO. Our hard won increased profile has not led to a wave of new CMO's, and people still do not 'get' the idea that the *specialised, integerated, generalist has something to offer that the partialist can not*. There are still many times when the term CMO/SMO/SHO etc are used pejoratively. CMO's with high level critical care skills are treated as low level residents simply because they do not have the specialist appellation. Will we 'wither and die' if not protected by a specialist framework? *(see opinion piece p 19)*

...specialised, integerated, generalist has something to offer that the partialist can not...

We were able to teach the ex-Prime Minister new word - Hospitalist...

In a surreal moment last year we were able to teach the ex Prime Minister a new word - Hospitalist. As he was becoming distracted by the throng he asked ?are you a specialist - only really interested if we were able to say that we were. The public, our peers, the GP's (most who are now called specialists), all do not take seriously anyone who merely says "I am good at my job". To them you are not good at your job unless you specialise in that job. The funny thing is that we do. We are specialists at the job we do. We do spend lots of time and effort maintaining the skills and knowledge in order to do that job. We are specialists in everything but name.

When we developed ASCMO we had dual objectives of the industrial and the educational. It is clear now that the two cannot be extwined easily - without the industrial recognition there would be no possibility for education. Without the educational pathways there will be no reason to employ us. Without the recognition that there is something different and fantastic about doing the job we do we will not attract new people. Without new people we cannot gain new industrial aims.

Through the hard work of the association, we have changed the industrial framework, have changed people's opinion, have generated new possibilities. The Hospital Skills Program would simply not have existed if members and like minded people had not pushed for it - and been understood and supported by friends. The Masters of Medical Practice now offered at Macquarie University shows that our scope of practice can lead to recognition of the integrated nature of our work.

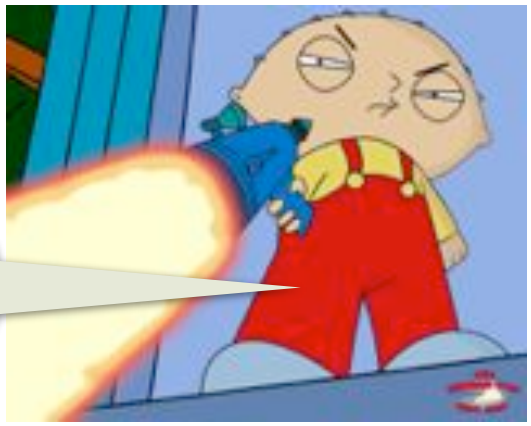
Why have others, such as ACCRM, been able to pursue a rural generalist pathway and have achieved near specialist recognition? How come our folks over the ditch not only have a new generalist college but have recently defined the Hospital generalist to have a specialised scope of practice?

Have we been guilty of acting locally and thinking locally only daring to dream globally?

Perhaps Seymour should look at the stars.

See you on 19th & 20th November at Macquarie for an Educational Experience and for our AGM!

Michael Boyd



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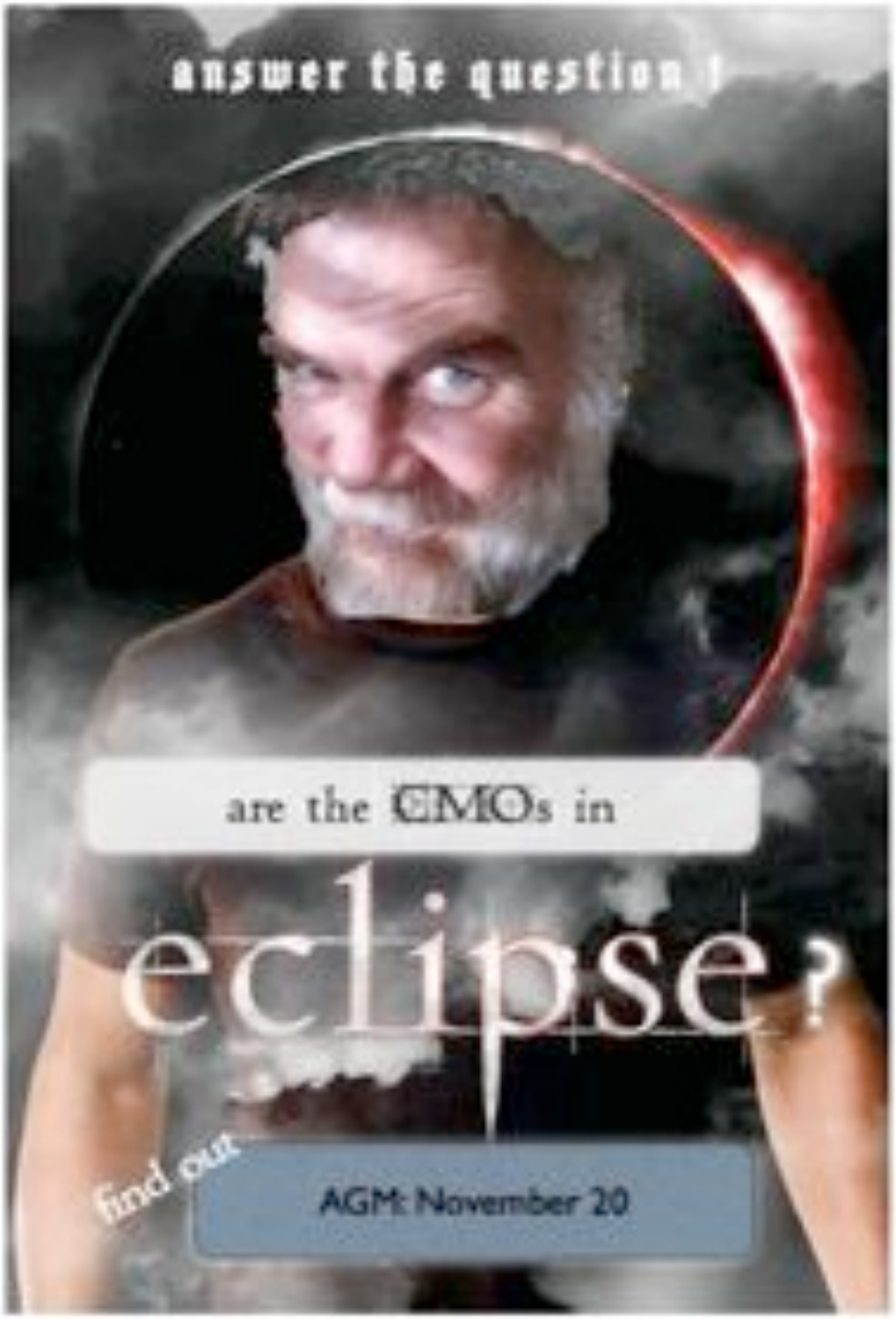


Editor's Report 2010

Wow - that was a crazy year. Now in our fourth year at Ryde, the proof of concept phase is complete, and we're still running on 1.75 FTE and no hope of any more, and the health dollar is shrinking faster than I can keep up with.

Meantime, I live for the moments I get to play with the cartoons for the journal. I long for the day when the readers send me fascinating insights into their myriad lives and non-medical activities. I sigh for the chance to hand the whole thing on to the next generation.

But then, I used to long for the tech that would let us work on the journal from across time and space without a tardis, and we've got that now, so things do change, they can get better - and all we have to do is walk a little further.

INDUSTRIAL REPORT 2010

Ross White

Vice President ASCMO- Industrial Officer

There has not been a lot of activity across the state. I have heard that more CMOs have gone to VMO GP classification in some outer urban hospitals.

I have spoken to a Senior Industrial Officer at ASMOF who said that the only recent issue was in SWAHS where incorrect contracts were sent to CMOs. New contracts have been issued in the past few days and ASMOF will be contacting members of ASMOF about these soon.

The ASMOF Officer said that there were no Senior CMO gradings pending at present. If you are waiting on a Senior CMO grading, please let me know so I know how many are waiting.

The HSU has no major CMO issues at present. There are some issues such as missing ADOs that need attention at times. HSU is planning to negotiate a new pay agreement with NSW Health by the time the current one expires in July next year.

HSU has recently formed a Medical Officers Council. They are seeking CMOs who are HSU members to be part of it and nominations close next week – contact HSU if you would like to be nominated.

If you have any industrial matters causing you concern, please let me know.

Ross White
riwhite@nsccahs.health.nsw.gov.au

To all NSW members : Do you realise that the NSW CMO Award runs out in July next year? It will continue to cover NSW CMO's but if you want to change anything - NOW is the chance!!!

Union reps will be at the AGM

Report From:
Gabrielle du Preez-Wilkinson
Subject: PhD Progession

Assessment of Competence - CMO Research

So what I derived is an electronic, potentially web based tool, capable of.....

It is fascinating that in an era of patient safety and increasing accountability - and scapegoating in various health circles - that our assessment forms for junior doctors, and even for Registrars, generally have terms like "consistent with level", without any clear description of the "level" being available or known..

This has been the focus and driving force for my PhD in Medical Education.. The biggest challenge I found in this area - of designing a validated, anchored assessment form for clinical competence - was finding meaningful data and useful validated theory.. There is some, but much of the literature consists of expert opinion - which is level 5 on an evidence based process..

So, what I have derived is an electronic, potentially web based tool, capable of assessing from junior medical student through to senior consultant (I believe)..

The assessment starts with global assessment, as there is lots of literature to support this as validated and reliable, and then assessment in three domains: knowledge; thinking; and translation. The reasons for these domains, which obviously will be (hopefully) validated during my research, rather than the traditional KSA (knowledge skills attitudes) is that knowledge is obvious; skills doesn't encompass all of the translation aspects very comfortably and people tend to focus on technical skills; and I don't believe you can actually really assess attitudes as most intelligent people will present whatever mask of attitude that they think you want.. Also, there is lots of literature and personal experience to validate that thinking, or critical reasoning, is what often rate limits progression and capacity for doctors..

At each level of these four areas, you can mark the candidate as one of excellent, proficient, competent, borderline, struggling, from junior medical student through to senior consultant..

The next screens of the assessment tool goes through the sub domains of each domain.. Knowledge, for example, has scientific theory, human theory, system issues, and other theory as the subdomains.. Thinking has data/ experience interface, thinking processes and reflection as subdomains. Translation has both global and specific subdomains. The global are expected of all professionals - neat writing, polite communication, clean and neat dress, punctual, ethical behaviour etcetera.. The specific components are where the growth occurs during the professional career. The subdomains for translation are written communication, oral communication, team interactions, patient focus, work management, and professionalism, with procedural skills and clinical skills only have specific components in the sub domains..

Each point on tool has a speech bubble with a description come up as you put your mouse over the point, so that you understand and know what you are actually saying by marking people. Therefore, I have developed a matrix of development in each sub domain throughout the career span of a doctor..

You can save your assessment at any time and go back to it to complete it, if you are called away. Also, you have the option to upgrade someone in a subdomain above the level the achieved for the overall domain. As an example, if you have a candidate that has a PhD in medical science, but has only just graduated and never worked in a hospital before, their knowledge may be that of a competent intern, but their scientific knowledge may be that of a competent senior registrar or junior consultant.. The aim is to move to competency based assessment in the real world - and give junior doctors direction as to the next milestones in their competency development, even if they are excellent clinicians for their stage..

Interestingly, I think that the thinking domain is going to end up being the time limiting factor for many junior doctors, as some of the data/ experience and reflection can only occur after significant clinical exposure.. This is one of the interesting aspects of the data analysis yet to occur.

I have also ensured not to specify clinical or procedural skills for registrars or consultants. These are sub domains that the Colleges can fill in at a later time, after the tool is validated, if they want to use it.. The dream is to have a life long record of progression in clinical competence from medical student through to CME - not much to want from a research project, really!!

So, the hard work is now on- to trial the tool, validate it, and do the stats analysis. More fun to come!!

I have presented this theory building for the PhD at two international conferences this year and have had very positive responses, as well as lots of collaborators interested in helping me trial the data..

So, the hard work now is on - to trial the tool, validate it, and do the stats analysis.. More fun to come!!

If you want more information about this project, please come along to the ASCMO AGM and Educational Days, as I will be presenting the information, and (if my son can finish tweaking the software) hopefully showing off the tool.. If I can't show the tool, I can at least show you the dummy screens and development matrix, so you can get a better idea :)


Screen Images for CAT (Clinical Assessment Tool)
Medical Officer Clinical Attainment Tool

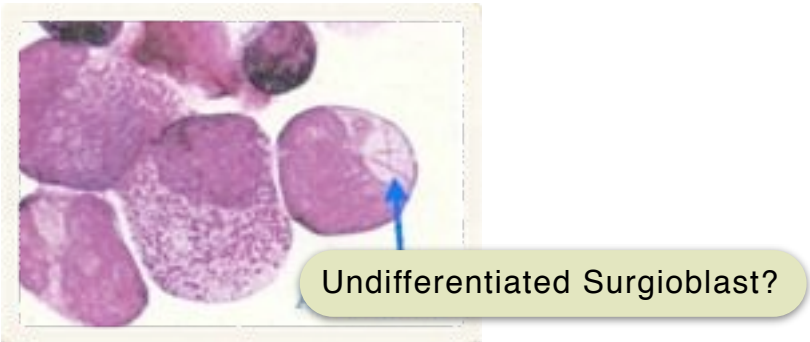
On Being a Locum Surgical Registrar in 2010 – a CMO's Narrative

Due to the incumbent *(the one and only - Ed)* surgical registrar suddenly taking two weeks sick leave, our urban district hospital would not have a surgical registrar on-site.

No suitable surgical locums were available as the RACS exams were on in a fortnight. If there was no registrar level cover, there would have been no on-site supervision of the surgery intern and RMO for 2 weeks. This could have affected the validity of the term for the intern's progression from conditional to full registration if the intern had to be withdrawn from the term for lack of supervision. *(Once a DPET, always a DPET - Ed)*

I agreed to act as surgical registrar for the two weeks as there was no alternative that could be arranged quickly. No on-call duties were involved as the surgical registrar had some time earlier arranged for the two teaching surgical registrars who share the after hours on-call roster at our hospital to cover that period. *(Hmmm - Ed)* My rostered ED shifts were covered by my colleagues there.

In our surgical service, there are two teams. Team A has a PGY2 RMO on rotation from the teaching hospital and this includes providing support to the gynaecological VMOs and sometimes ENT and Ophthalmology VMOs. There are no Gynae or ENT registrars at our hospital, so the Team A RMO communicates directly with the consultants. Team B has an intern on rotation from the teaching hospital and the intern and RMO together look after the general surgical patients of Team A and B. As the incumbent Team A RMO was keen on a surgical career, it was decided that he would do the theatre assisting and I would manage the ward surgical patients and the initial surgical consultations in the ED and wards, and supervise the intern.



Complicating the arrangements was the term changeover of the RMO and intern that was to happen the Monday of the second week.

Each afternoon I would ring the on-call surgical registrar and give a handover of the surgical patients that might need review during the evening and any patients being admitted from ED who may be going to theatre that evening. In the mornings, the on-call registrar would call me and hand over any patients who were admitted overnight.

INCIDENTS AND OBSERVATIONS:

1. Surgeons have varying means of being contacted. Most were readily available on their mobiles or their reception staff knew exactly where the surgeon could be found, often with the direct line into the theatre of a private hospital. However one surgeon only had a rooms and mobile number known to the hospital and when I rang the rooms about an urgent matter, the reception staff had no way of contacting the surgeon other than the mobile which I had tried to ring first. Some receptionists had no idea of what other rooms were used by the surgeon. One said that the surgeon was operating that afternoon in a private hospital. I rang the theatres there and they said that surgeon no longer operated there.

2. There does not appear to be a sharing arrangement among our surgeons whereby if Dr X is unavailable, Dr Y is contacted next about his patients. If an inpatient is deteriorating and needs to have surgery urgently and the admitting surgeon is not contactable, the surgeon on-call for the day has to be called.

In one instance, a post-operative patient deteriorated and needed urgent laparotomy and the surgeon could not be contacted via mobile or rooms. However, the on-call surgeon responded quickly to my call and was cancelling his patients at his rooms to come in straightaway when the original surgeon called back and came in.

3. Patients can wait a long time for surgery, particularly appendicitis and I saw at least one patient who would have had a shorter admission if the operation was done more promptly.

4. Transfers to other hospitals as always can take hours of phone calls trying to find someone who will accept the transfer. There was one particular seriously ill, immuno-compromised, but non-malignancy post-surgical middle aged patient. Her surgeon, and two VMO physicians who had been consulted about the patient, all felt that her only chance of surviving was to be in the teaching hospital where the full gamut of services and consultants would be available to manage her. I spent about 8 hours over three days (as the surgical RMO was doing the assisting in theatre, I was able to do this). Each time I would speak to a registrar at the teaching hospital, the transfer was knocked back by the registrar immediately, or by the consultant when the registrar checked with the consultant. One registrar advised me that the patient should have a bronchoscopy done at our hospital, when our respiratory, who had actually seen the patient, and had already said that the patient was too sick to have the procedure here. Eventually I spoke directly to the on-call general physician who kindly accepted the patient who a few days later need to be admitted to ICU with acute pulmonary oedema and eventually went home a couple of months later.

In one instance, post-operative patient deteriorated and needed urgent laparotomy....

5. I actually went to theatre on the last day to drain a very painful abscess under GA on the thigh of a young patient. I had contacted the on-call consultant who asked me to do it as he was in theatre elsewhere and would not be able to do it till late that day, which would have meant an overnight admission. I checked with the DMS about my credentialing to do this procedure and it is included in my appointment details among the procedures I am expected to do in my ED and ward work. I scrubbed up and did the procedure uneventfully.

6. On the first Friday in the late afternoon, there was a surgical patient in ED who needed an urgent CT but the hospital CT scanner had broken down. There was heavy rain at the time and the patient, and a medical patient who needed a CT scan too, would face several hours of waiting and travel to another crowded hospital for their scans. I found out the private radiology practice adjacent to the hospital was willing to scan the patients but wanted them at the practice in a few minutes or they would have to close for the day. The rain was too heavy for the patients to be transported in wheelchairs. The Patient Transport Service ambulance was parked in the hospital but the crew had gone home. The PTS supervisor gave permission for the wardsman to drive the ambulance, but he was not able to drive it as it was a manual. The quickest way to get the patients to the scanner was for me to drive them there and back. The scans were done and the patients were able to managed locally and the hospital did not have an escort nurse away for hours, nor had to pay for two patients to have ambulance transport, and the films were reported by the radiologist immediately.

Our surgical registrars are rotated every six months from a teaching hospital which is different to the one that administers our district hospital. The registrar's Allocated Days Off are usually taken on quiet surgical days so there is usually no replacement sent from the surgical trainee's teaching hospital, but there is cover provided for any annual leave. That replacement takes some time to be orientated to the hospital yet has to spend a large amount of the day in theatre.

I would recommend that several of our permanent CMOs and SRMOs do a week or two when the surgical registrar takes annual or study leave. As our surgical registrars are fairly junior, they do not do or start cases in the absence of the VMO surgeon, so advanced surgical skills are not required. Having someone who is familiar with our hospital and knows how to work in with our other medical and allied health staff would be better for patient care. Often the surgical intern and/or RMO have an interest in surgical training and are very happy to spend more time in theatre assisting, which is what the registrar usually does. Supervising the management of surgical patients in the ward needs the medical skills of someone more experienced than PGY2. A replacement for the surgical registrar can contribute to improving patient care and flow by continually monitoring the progress of inpatients during the day rather than trying to see patients before or after theatre.

('On Ya, Ross - Ed)

Hospital Skills Program Update

Area Health Services Implementation Activities

Hunter New England AHS held a successful HSP Emergency Medicine Education Day on Thursday 3 June 2010. The day included skills workshops on Airways Management in ED and Arrhythmia Management in ED as well as Non-Invasive Ventilation and Venous Access. This workshop was attended by 34 doctors from across the AHS who all provided positive feedback on the skills workshops.

HNEAHS will also be holding HSP Paediatric Emergency Department Education Day in late October 2010.

SouthEastSydneyIAHS has conducted an Emergency Medicine Workshop at Sutherland Hospital on Tuesday 11 May 2010. This workshop was attended by 21 doctors from across the AHS who participated in skills development workshops on Venous Access Using Ultrasound Guidance and Advanced Facial Suturing as well as sessions in ECG Interpretation and the Aged Care Module: Falls and Advanced Life Directives in the ED Context. The feedback received was very positive.

SESIAHS has also been organising airway/intubation training for interested HSP participants in the Shoalhaven and Shellharbour operating theatres. Other planned activities for 2010 include Central Lines Training in late August and September 2010 as well as a Dental Trauma Workshop in November 2010. SESIAHS will also be holding their annual HSP Forum on 7 December 2010 which a focus on paediatric emergencies.

SESIAHS Mental Health doctors have been invited to participate in the Hunter New England Area Health Service Psychiatry Training Program via videoconference on Wednesday afternoons from 1445 until 1630.

Enrolments

All AHS have received completed HSP modules and enrolment forms. AHS have been requested to enrol all interested doctors into the program. More than 200 doctors have been enrolled in the program to date.

Module Development

The completed modules in Emergency Department, Aged Care, Mental Health and HSP Core Skills have been distributed to Area Health Services and are also available via the IMET website www.imet.health.nsw.gov.au. Module development in progress for Hospital Medicine (including pre-post operative surgical care, hospital therapeutics and trauma), Child and Adolescent Health and Women's Health. Module development is on track for completion by end of 2010.

Following IMET's analysis of workforce data on current roles of non specialist doctors working in NSW hospitals, funding for further module development has been requested under the NSW Government's *Caring Together* response to the Special Commission of Inquiry.

HSP
HOSPITAL SKILLS PROGRAM

The funding received includes supporting the delivery of medical education activities to non-specialist doctors in four modules: Sexual Health, Drug and Alcohol Medicine, Indigenous Health and Rural Medicine.

Funding has also been received to identify learning resources and activities that will promote participants' achievement of HSP workplace competencies/capabilities via online e-learning development work which may involve:

- The creation of properly configured online courses and tutorials
- Conversion of content provided by the Curriculum Developer into finished online tutorials. This will involve editing video, graphics, photographs for use in online pages, formatting text, and creating the instructional flow of tutorials and question pages
- Linking and uploading of ancillary resources such as pdf files and other documents, html pages and websites
- Creation of other online activities such as forums, calendars and coordinating the development of assessment items.

Principles for the Implementation of the HSP

IMET is developing principles for the implementation of the HSP to guide HSP implementation across Area Health Services. These principles are being developed with the overarching goal of recognising that patient safety and quality care is paramount and that the professional development of non specialist doctors is a core business activity of Area Health Services.

IMET is also developing a HSP Strategic Plan 2010 – 2013 which will give the Area Health Services, the HSP State Training Council and CETI some key performance indicators and goals for achievement. The document provides a work plan for the Hospital Skills Program and its planned achievements over the next three years.

HSP Assessment Resources:

IMET submitted a request for funding under the Caring Together initiative proposed by Workforce Development and Innovation Branch to provide statewide assistance in the form of a 'train the trainer' package to support the HSP assessment. This funding has been provided and work has commenced on developing DVDs as part of the package for HSP assessment. Workshops will be run within all the Area Health Services for HSP assessment by the end of the current financial year. Some of these workshops will be videotaped so that this can be provided as an online resource for review by assessors at a later date.

HSP Education Strategy Forum

The HSP Education Strategy Forums are held to provide an opportunity for HSP Area Directors and ESOs to meet, network and inform sustainable, effective educational strategies developed by IMET with input from HSP participants. The HSP Education Strategy Forums will be held three times a year with two one-day meetings and one two-day meeting.

The Education Strategy Forum will include all the HSP Area Directors and ESOs as well as 2 HSP participants from each Area Health Service, IMET staff; and co-opted members, as required.

The first Education Strategy Forum will be held during the third week of November 2010 with a firm date to be confirmed shortly.

The Word from the Top: Clinical Education and Training Institute

The Clinical Education and Training Institute (CETI) was established on the 1st July 2010 as a Chief Executive led Statutory Health Corporation, as part of the NSW Health response to the special commission of inquiry into acute care services in NSW public hospitals. CETI will work with many organisations including those identified by Commissioner Garling (ACI, BHI and CEC) to develop clinical workforce capacity, capability and skills while supporting safe, high quality, patient centred care.

CETI will lead the development and delivery of clinical education and training across NSW. A high level of partnering and collaboration with health services, clinicians and other stakeholders will support the development and delivery of clinical education and training, and associated services, for medical, nursing and midwifery, allied health, pharmacy and clinical support staff.

Although CETI is a new organisation, within its areas of responsibility sit programs and services historically administered by other organisations, including the Institute of Medical Education and Training (IMET) and the Institute of Rural Clinical Services and Teaching (IRCST). IMET and IRCST's programs of work and staff have been transitioned to the CETI Division of the NSW Health Service and are operating as CETI's Medical and Rural divisions.

Within CETI's immediate objectives is the review of two programs allocated to the organisation, namely the ***GP Procedural Training Program*** and ***Basic Physician Training***. CETI staff has commenced consultation with stakeholders to renew these programs and to develop three others, including:

- **New Starter Multidisciplinary Program**, which aims to build effective multidisciplinary clinical teams providing safe, high quality patient centred care;
- RACMA ***Medical administrator*** training;
- ***On-line learning***, providing content and delivery support for the NSW Health eLearning platform.

In addition to CETI's vision of leading, facilitating and building sustainable capacity of the clinical workforce to support and improve patient health, an on-line Centre of Excellence is envisaged with expertise in adult and on-line learning. To be pedagogically effective however, CETI will support blended, discipline specific and interprofessional learning and practice.

CETI's values of Collaboration, Excellence, Transparency and Innovation will guide decision making, methods of working, strategic focus and stakeholder engagement and will assist the organisation to meet its mission of building capacity and improving quality in clinical education and training across New South Wales.

CETI staff looks forward to partnering, collaborating and consulting with clinicians, clinical support staff, clinical managers, health services, patients, the tertiary sector and other stakeholders to ensure CETI's new and established programs of work and resources are useful, relevant, targeted and strategic.

Further information about CETI and its programs of work can be obtained by contacting Dr Gaynor Heading, General Manager, CETI by email gheading@ceti.nsw.gov.au or Ph: 02 98446579.

There's LIFE Jim, but not as we know it.....

The Australian School of Advanced Medicine

Underpinng our education, research and clinical care is a strong team approach....

The Australian School of Advanced Medicine has an ethos of patient-centred care and competency-based learning, and sees the development of the hospital generalist pathway across Australia as part of its core business. Our primary purpose as a medical school is to educate and to innovate, in line with national goals for the Australian tertiary sector. Because we have a teaching hospital, we can achieve broad goals in a setting that values the direct care of patients and the advancement of medical science. We are committed to bringing together the best people and the most advanced technology to fight disease and improve the quality of life of all Australians.

Underpinning our education, research and clinical care is a strong team approach. This approach sees scholars working alongside highly qualified experts – and in close contact with patients – to determine the best treatment plan for every patient. The Australian School of Advanced Medicine is careful integrated into both the hospital's infrastructure and its operation. Operating suites, wards, consulting rooms and a collaborative team environment replace traditional lecture theatres and allow medical and health care workers to perform effectively and to reflect on how they are delivering the best possible care, we tirelessly pursue the best outcomes for our patients through teaching, research and advanced clinical care.

Our Faculty offer a very high level of skills and knowledge in this area of medicine, and in relation to complex public health systems and education program. The academic rationale for this proposal is based on the need to provide a modern, constructively aligned, competency-based education for the hospital care Physicians of the future. This education must not only assure technical excellence, but a thorough grounding in the scientific, clinical, professional and personal underpinning of hospital practice, together with the intellectual tools and the desire to be effective lifelong learners.

Educational rationalism is an approach to the recognition of prior learning based on assessment of participants' current state of clinical competence. It requires the initial assessment of the performance of a participant, followed by feedback on that performance, and re-assessment as necessary until there is consistent evidence of a competent performance of the Learning Outcome.

Master of Medical Practice in Hospital Care
at The Australian School of Advanced Medicine

The Master of Medical Practice in Hospital Medical Care (MMP) is suitable for doctors who wish to acquire a university qualification which denotes advanced expertise and competence in the care of patients who have been hospitalised for specialist medical or surgical treatment. It aims to build capacity for advanced care within the non-specialist workforce, by identifying and developing the skills and competencies required for the safe, effective and efficient management of care to ultimately improve the safety, quality and continuity of patient care.

To be effective, a Senior Hospitalist will have to meet the needs of the individual hospital, and therefore each learning program will be adapted for the local hospital or medical care setting. The proposed program will combine workplace practice, face-to-face learning, online learning, self-directed learning, workshops, group discussion, private study and simulation training; it will focus on both the clinical activities and the cognitive requirements of the role. The Units of Study are hands-on, competency-based, and are rigorously assessed, requiring work in consulting rooms, hospital wards, operating rooms, and other facility locations. Scholars who are enrolled in the program will also develop the capacity to enhance the functioning of their healthcare facility by acquiring skills in protocol design and review, patient flow management, and administration.

To be effective,a Senior Hospitalist will have to meet the needs of the individual hospital, and therefore.....

Scholars who enrol in this degree program will be undertaking paid clinical practice in hospitals throughout the State (and possibly further afield). Many of the assessment tasks in the program will be workplace performance-based assessments of the Scholars as they go about their clinical work. The rationale for this is that it confers a high degree of *validity* on the assessments since, for the most part, they will assess what Scholars *actually* do, rather than what they *can* do, or merely what they *know*.

The MMP in HMC will provide recognition for each completed Unit of Study, with the following milestones and expected timelines

Postgraduate Certificate (3 Units) 1 year part time
Postgraduate Diploma (6 Units) 1 to 2 years part time
Postgraduate Master (8 Units) 2 to 3 years part time

Recruitment of physicians with international reputations is important. In subspecialty training, prospective Scholars study the.....

Campus: recognising that, for doctors, the workplace is their classroom, Macquarie University Hospital will be a crucial (but not exclusive) campus for our Scholars.

Australian Centre for Educational Studies: ASAM collaborates with ACES for the learning and teaching components for its programs as well as the development of the evaluation strategies for the programs. ASAM faculty are strongly encouraged to enrol in ACES programs for their own professional development and lifelong learning.

Philosophy and Law: ASAM is collaborating with staff of the Department of Philosophy and the Department of Law for the development of units of study of Ethics Law and Professionalism. The proposed appointment in the Department of Philosophy will facilitate this collaboration.

Library: Participants will require on-line access to medical journals and this will be available to enrolled participants through the Macquarie University Library. Working relationships with the Liaison Librarians assigned to ASAM are proving most positive.

Information Technology: Learning and teaching will be contained within the resources of ASAM. This includes the development of the IT e-portfolio, which will be supported on the Macquarie University Hospital patient database.

People: Recruitment of physicians with international reputations is important. In subspecialty training, prospective Scholars study the reputation of individual physicians with whom they will be identifying as Advanced Scholars. Macquarie is recruiting such a faculty.

Australian School of Advanced Medicine

Course Review - Date 27 - 28 April 2010

Emergency Medicine Crisis Management Training:
The Kolling Institute RNSH campus - ongoing

This was a 2 day workshop held at the new SIM centre at RNSH and on this occasion made available free of charge to new enrollees to the Hospital Skills Program in the local area.

I waded through well, the majority of the manual during an incredibly busy week prior, and arrived anxious as always that I was under-prepared: but right from the beginning it was clear that this was a course more about developing my skills to a new level and reflecting on how I did things, than on just ticking a box that I knew the correct dose of adrenaline and the ventilation:compression ratio.

For more senior doctors and nurses, tips and tricks from colleagues in the skills workshops, discussion about difficult cases, and of course, experiencing and watching scenarios is the most rewarding way to learn, and the EMCM delivers that in spades.

EMCM also emphasizes training in teams in a realistic way, and it was great to gather a group from our hospital who work, but do not usually train, together, and to explore each other's thoughts and skills outside the department. Rotating the leadership role in scenarios is a great way to learn about your colleagues, and how different people bring different senses of pace and different styles of decision making to the same situation.

The course organizers do a great job of creating a climate of warmth and openness to promote a free exchange of ideas, and everyone is encouraged to have their voices heard. Swapping stories with people coming in from other hospitals and from various grades of seniority is also one of the great pluses of a course like this.

Since organising doctors in particular has all the usual rewards of herding cats, I must commend the work that Joanne and the team at HSP put in to transform the opportunity into the reality for me, and have no hesitation in commending the EMCM course for both its intellectual content and for its warm and lively style of delivery.

Good one, guys!

Future tech? - The H Bus - out in the world - making it happen

ASCMO Extraordinary General Meeting
30th September 2010, Coffs Harbour

Attendance:

Mary Webber (Ryde), Michael Boyd (Ryde), Gabrielle dPW (Bne/ SE Qld), Sue Phillips (Broome), Helen Flavell (Armadale, WA), Joy Treasure (Adelaide), Emile Chakty (Manly)

Commenced 1215hrs...

General Business

A) *AGM Dates* - Options in November – either 13th or 19th with attached education event
B) *Macquarie Proposition* - Educational options available through hospitalist training; Dip/ Grad Dip/ Masters of Medical Practice in Hospitals; Dip/ Grad Dip very structured; final year of masters is mostly elective; issues in process, capacity to be involved as CMOs; tendering for university component of Hospital Skills Program – which is currently in tendering process;
C) *Support of the CMO* - Raison d'etre for ASCMO; Alburn hospitalist positions without support or structure and at inappropriate pay level; always need a broader base of membership and leaders for ASCMO than available; new ideas are needed
D) *Local Issues* - Hospital Skills Program in NSW; Adelaide issues; Need for multi skilling capacity in Broome, so can work across entire organisation; Armadale values continuity and high quality staff who can do the job; Armadale also looking at being ACEM diploma site (as is TPCH); QE in Adelaide has hospitalists; Lyle-McEwin has some CMOs; Norlunga has senior CMOs; Adelaide not employ CMOs at present (but has in past);
E) *New Award in NSW* - deferred to AGM
F) *Role with General Practice* - need capacity to cross train, and come back to other disciplines;
G) *Rural CMO*- need to reach out to GP VMOs in these areas
H) *Role of ACRRM* - capacity to create faculty; capacity for RPL for rural streaming, including ED substitute for GP; need to explore further, so that can organise formal College qualifications
I) *Other General Business* -

Issues with forming College – not independent section of knowledge for all CMOs
Potential for College of Hospital Medicine, but then exclusive not inclusive
Possibility of Faculty within ACRRM
Stability of workforce and qualification recognition

Australian School of Advanced Medicine at Macquarie University....
Diploma ACEM – safe practice, looking at rotations for some of it..

Opinion Piece: Steve Markowskei

The cohort of medical practitioners who call themselves CMOs are the largest group of medical officers who remain without the potential for membership of a recognised College.

There is a College of Sports Physicians and College of Medical Administrators. There are the various Chapters of the Royal College of Physicians (Sexual Health, Addiction and Palliative Care Medicine)- all of which can be entered via FRACGP. The College of Sports Physicians achieved recognition in November 2009 by the Hon Nicola Roxon MP, Minster for Health and Aging.

Yet our association remains unaccredited with no formal recognition. The need for the CMO association to comprehensively pursue a CMO or Hospitalist college and fellowship for our members has never been so great, and I believe several factors are driving this requirement;

1. Training without recognition remains pointless. The new hospital skills program (HSP) being run by the NSW Health Department and the new Masters in Hospital practice at Macquarie University demonstrate that there is a definable body of knowledge that must be assimilated by the non specialist hospital medical officer. Diplomas (e.g. in emergency medicine) enable the CMO to further stratify their speciality and achieve workplace specific qualifications. Paradoxically, despite this acceptance and development of a CMO knowledge base, there will be little point in pursuing a rigorous training program or, for example, a two year (part time) Masters degree if it has no outside recognition and no potential for progression to a college membership;

there is a definable body of knowledge that must be assimilated...

2. The Commonwealth Government is making fellowship mandatory. Whilst most of our members are salaried, the fixed non VR renumeration to those who actually have a provider number, and the inability for newer members to obtain a provider number in any format, gives some measure of the importance of accreditation and fellowship. Over time it will become apparent (if it isn't already) that it is only possible to practice medicine without college membership within a severely limited framework;

3. **There will be little incentive to employ and train CMOS.** Unprecedented numbers of local graduates are expected to graduate from 2012. Unless the CMO association is able to create a recognised college it will, particularly as time passes, be difficult to know where the Senior Resident Medical Officer (SRMO) skill set stops and the CMO skill set starts. There may be large numbers of SRMOs awaiting training positions remaining in the system. In this environment hospitals would have little incentive to utilise CMOS; and

Without a speciality college the viability of the CMO/ Hospitalist as career choice will end. Despite.....

4. **Nationalisation of Registration.** This will allow the ongoing centralisation and standardisation of accreditation and CME. The CMOs working in their current guises as 'ad hoc' health workers will find it increasing difficult to format their training in an acceptable nationally recognised way. A college membership will provide proof of this training and CME. Ultimately it may be the only acceptable proof.

Without a speciality college the viability of the CMO/ Hospitalist as career choice will end. Despite a significantly more robust training system now being weaved around us, CMOs will become increasingly marginalised and remain the non-formally trained and unaccredited members of the health community. Providing ongoing training to CMOs whilst keeping us in a situation where we never obtain professional recognition will have little ultimate point. Our services will become less sought after. I believe this will happen surprisingly rapidly, perhaps in the next 5-8 years, as the above pressures prove unrelenting.

A CMO college could be modelled on the RACGP model allowing for significant diversity and training backgrounds for Fellows, but we need to get the college up and running, rather than endlessly discussing suitable models. These can be incorporated later. The Australian Medical Council website (http://www.amc.org.au/) clearly details the requirements for specialist registration - we as an association need to meet or exceed these requirements and achieve registration. A call on the members to pay for a part time officer to work up our application would not be unreasonable.

I strongly call on the board to make this their 100% goal in 2011: That the ASCMO creates a recognised college of CMOs.

AGM - Report of AGM and Meeting 22nd August 2009 Novotel Brighton Beach

In Attendance:

Michael Boyd (el Presidente), Mary G.T. Webber, John Egan (founding el presidente), Ross White, Ken Wilson, Louise Delaney, (Simon Leslie), Ron Strauss, Michael Goss, (Tilman Boesal), (Cathy Hull), (Peter Davy), Gabrielle du PreezeWilkinson - typist extraordinaire

() = invited speakers or part thereof, but not the AGM proper

By Phone Conference :

David Brock, Tom Salonga – both at times

Apologies:

Michelle Metzler; Virginia Noel

Welcome:

Michael Boyd - reviewing what the year has brought, reflecting on the long journey to get here and welcoming the friends who, for better or worse, have been along for the ride. Special welcome to John Egan, whose righteous anger at the way CMOs were being spoken about in the corridors of power, set off this entire process, proving that individuals really can make a difference. General chat greetings and introductions and a shared pleasure in meeting up again, often after a whole year of just frantically scrambling through our daily lives. Welcome also, and introductions for our invited speakers - here to share in our usual spirited discussions.

INVITED SPEAKERS

National Registration: by Gabrielle dPW - Education Officer, ASCMO

* See presentation available as pdf on website ascmo.org.au
* Will hopefully provide consistent pathways for registration
* Evaluation might add a PESCI - preemployment structured clinical interview - recognition that theory knowledge is not necessarily competence, includes mandatory standardised orientation
* CA/ Std re terms for general reg (12 mo supervised anything vs 10/10/8-10 Med/ Surg/ ED)
* We anticipate lots of problems with implementation

Macquarie University Masters in Hospital Medicine:

* The first university private hospital – Australian School of Advanced Medicine
* 183 beds / 20 ICU or CCU / 15 chemo / sleep apnoea / 2 angio / 12 digital OT / radiotherapy & stereotactic radiosurgery/ interventional radiology & PET and CT scan
* Post grad med school for advanced medicine – masters for surgical subspecialties
* Challenge: creation of robust process that links learning and assessment to standards
* Hospital Care Physician (Hospitalist) stream – a Medical Expert in general care of the hospitalised patient
* Core Units of Study (credit points): Hospital Therapeutics (4); Safety & Quality in Hospital Medical Care (4); Patient Assessment & Communication (4); Hospital Medicine (4) ((40 hr per credit point, need 32 CP over 2 years, extended semesters))

* Elective Units of Study: Ethics, Law & Professionalism (4); Basic concepts in education & critical appraisal of medical literature (4); Health systems & management (4); Resuscitation & procedures (4); Critical care (4); Surgical Care (4)
* Grad Cert (12 CP: 3 core subj); Grad Dip (24 CP: 4 core + 2 elect); Masters (32 CP: 4 core + 4 elect)
* Recognition of Prior Learning offered – assessment tasks only; if you fail, then repeat unit…
* Discussion – move from 1 FTE to 3 – 4 FTE on educational component of faculty (to oversee teaching and assess); distance education not yet worked out; clinical professorship or fellowship; interaction with ACRRM; assessment work-place based; Rufus Clarke is the Professor of Medical Education
* Pricey but potientially worth it - roughly $30 000 for entire course with no RPL
* Target group – anyone post grad 2 years, pre retirement; cross accreditation with QUT Grad Cert subjects or leadership courses for some CP; Peri-operative service is another model as well; neurosurg and research departments are currently active; core subjects for RACMA missing

IMET & HSP – Snapshot:

- Peter Davy – Curriculum writer/ Developer for HSP
- There are currently 8 components of curriculum (emergency, mental health, aged care, medicine, surgery, O&G, paeds, core curriculum underneath); ACF 3 curriculum domains – clinical management, communication, professionalism with HSP additional for service management;
- Eg of ED domain of clinical Mx; then learning activities and resources; supported by education support officer and director for hospitalists to allow people to be actually doing what is required;
- Assessment – outcomes based education, evidence about workplace performance against standards; standards or required capabilities are defined in HSP curriculum; the focus is on assessing competence and performance, not identifying modes of learning or time of learning
- "Toolbox" of proven workplace assessment methods
- Curriculum working groups have developed approved modules; Resources for each module;
- Future curriculum development for paeds; O&G; hospital medicine
- At least 5 members including clinical facilitator and curriculum developer, with 3 meetings to draft capabilities and identify suitable stuff
- MOODLE review – adds information to CV, constructs web page, add information
- MOODLE – separate or combine back into NSW Health
- Garling supportive of HSP/ CMOs
- Supervisor training money from Commonwealth will be looked for U Syd to provide service for IMET; mentor training and supervisor training is available in a number of different areas (GP, psych etc); PD for education support officers;
- Forums for HSP; steering committee structure;

CMOs and the Future:

- Generalists will have their day – the large pool will become obvious with increasing numbers of medical graduates
- Increase number of medical schools from 12 to 20 from 5 years ago until now
- Generalists likely to come from new graduates; major role for us is to be mentors and advocates
- Perspective of what new graduates are like – some more female, potentially more mature and maintain external interests, wanting PT work, want to fit into current lifestyle, do not want to run their own business/ practice, have other responsibilities
- Accident of history have become CMOs
- Not Australian phenomenon – but worldwide
- Patients more complex and older, more social fragmentation
- Experience generalists run better service than specialists and more cost effective
- Recent study in US that shows efficiency of generalists
- Department of Health – tag hospitalist now – potential opposition; prefer hospital medical practitioner or senior hospital medical practitioner; hospital generalist…
- Influence of national medical registration – potential to use ACRRM Rural Generalist model
- Risk of movement with national registration across state boundaries
- Payment for increase juniors? – Training will be required for these people – CMOs could do this
- AHS still have right to employ as they want; Issues with getting phone numbers; Critical mass needed for success
- Hawkesbury – link CMO with RMO rotations, not seen as perpetuating workforce

ASCMO & RRMEO:

- Demonstration of options available – potentially can go to Hawkesbury if needed
- Need to decide if want to use as ASCMO – in theory agreement, for about $125 per person per year with full access via CMOK

ASCMO Annual General Meeting Proper

President's Address:

See ASCMO Times

Minutes Previous Meeting:

See ASCMO Times

Minutes accepted – nominated Ross, seconded Ken, approved all

ELECTION OF OFFICE BEARERS 2009

	Nominated	*Seconded*	*Vote*
President			
Michael Boyd	Ross	Ron	Unanimous
Vice President			
Ross White	Michael	Mary	Unanimous
Secretary			
Mary Weber	Ross	Louise	Unanimous
Treasurer			
Ken Wilson	Ross	Mary	Unanimous
Education Officer			
Gabrielle dPW	Ross	Mary	Unanimous
Industrial Officer			
Ross White	GdPW	Ken	Unanimous
ASMOF Rep			
Ron Strauss	Not required		
Website/ASCMO Moderator			
David Brock	Not required		
AMA contact person			
Louise Delaney	Not required		
Journal Editor			
Mary Weber	Not required		
Membership Secretary			
Ron Strauss	Michael	Ken	Unanimous
Public Officer			
Ken Wilson	Mary	GdPW	Unanimous
Committee members			
	Not required for these positions		
Virginia Noel			
Michelle Metzler			
Sunil Misir			
Louise Delaney			
Tom Salonga			

REPORTS

Secretary:

Crazy year – did lots of things outside of official role; profoundly grateful to Cathy Cordi for stabilisation office function and providing essential back up

Office Manager:

Typed report to be included in minutes;

Highlights: great year; group effort; current state of organisation is stable; in role since 2005; cleanup database; deceased ex member; move on to other careers;

85 names in current database with 52 current paid members; CPDP 34 on list

Treasurer:

Handout to be included; financially stable

Vote of thanks to Ken Wilson for ongoing support

Industrial Officer:

See ASCMO Times

Highlights: CMO rates went up; CMO versus GP VMO is also documented;

ASMOF Officers:

Ross co-opted on for David, but then lost contact through time; will re establish contact

Ron is involved also – degree of discretionality in representation

Website:

See ASCMO Times

Journal:

Only possible with Cathy Cordi; only 1 journal this year; attempt to get more regular issues out

Plan to put things out more frequently; Set up for forum in February;

Advances in technology has made it easier to get out journal, including better access to graphics

Look at options after SSEM in Broome

Education Officer:

* See ASCMO Times

* Cathy Cordi sending list with email addresses for CPDP, so I can follow up with people interested but not compliant

Other Business:

* Review of motion re Office space from 2008 – Michael abstains from vote; annual review concurred and continuation of current situation is approved
* Review of motion re debit card account for office expenses – never happened, but need to get sorted; either through bank or as pre paid debit card
* New version of file maker database programme endorsed and supported by entire body
* Industrial issues related to higher levels of qualifications – being left to forum in February
* Louise attempted to resign but decline by all body, as CMO is in spirit and wanting to belong rather than in narrow limits of current employment, so Louise was accepted to remain as active member with thanks
* AON position has evaporated – we have been removed from this role
* Reimbursement David Brock – approximately $700 + $250 costs – income $2400 from website – total reimbursement support
* Access to carer's leave – Ron discussed – can take up to 3 years sick leave without problems, but have to apply for more accumulated leave beyond this, which can be discretionary – independent lawyer involvement was very expensive
* Retirement rates for ASCMO – honorary life membership or reduced fees
* Network for Forensic Medicine is another networking opportunity
* Subsidy to SSEM still occurring

Closing Notes: Our ambitions

? Interest in a Forum in February/ March 2010 – educational and research focus – define CMO/ Specialist interface – late February – regional (Tweed Heads) – 6th and 7th March
AGM – 21st/ 22nd August 2010

FINISH
and progress to fabulous dinner by the water...

TREASURERS REPORT -Ken Wilson

ASCMO 2008 Accounts and Jan-Jun2009							
Opening Assets		2009 - 2010	Jan-Jun 2009	Jan-Dec 2008	Jan-Dec 2007	Jan-Dec 2006	Jan-Dec 2005
	Westpac A/C Initial balance	$17,933.46	$14,470.63	$13,999.06	$11,567.13	$17,951.54	$14,405.78
Income							
	Memberships	$6,939.00	$6,339.00	$6,708.00	$6,617.00	$7,512.00	$5,798.00
	CPDP			$930.00	$1,045.00	$1,045.00	$1,210.00
	Annual meeting			$800.00	$450.00	$420.00	$315.00
	Website ads	$1,100.00	$700.00	$1,800.00	$2,025.00	$2,125.00	$875.00
	Repayment dishonour fee					$9.50	
	Interest	$52.09	$30.30	$90.43	$91.04	$65.70	$103.35
	Advertising			$450.00	$150.00		
	Total Income	$8,091.09	$7,069.30	$10,778.43	$10,378.04	$11,177.20	$8,301.35
Expenses							
	Secretarial services						0
	Julie Woods					$4,075.79	
	Cathy Cordi	$2,008.00	$1,080.00	$2,917.50	$1,642.50	$4,800.50	
	Insurance	$512.40	$512.40	$512.40	$512.00	$488.00	$470.10
	Office Rent	$1,833.30	$833.33	$999.97			
	accountant/FairTrading fees	$75.00		$45.00			
	Stationary/mail/computing	$872.05	$257.25	$853.94	$455.07	$948.31	$149.88
	Printing					$282.50	$852.00
	committee expenses						
	Bank Expenses					$9.50	
	Phone industrial officer			$90.00	$115.00	$390.42	
	Executive travel						$302.00
	teleconferencing			$50.34		$338.59	
	Website expenses	$1,428.50	$423.50	$1,078.50	$1,673.50	$1,978.50	$423.50
	conference expenses/sponsorship	$750.00		$750.00	$2,343.75	$112.00	$750.00
	Annual meeting	$2,219.83		$3,509.20	$1,203.89	$4,142.36	$1,808.11
Total Expenses		$9,699.08	$3,106.48	$10,806.85	$7,944.71	$17,566.47	$4,755.59
Net Profit		-$1,607.99	$3,962.82	-$28.42	$2,433.33	-$6,389.27	$3,545.76
Closing Assets							
	Westpac A/C Final Balance Calculated	$16,325.47	$18,433.45	$13,970.64	$14,000.46	$11,562.27	$17,951.54
	Westpac A/C Final Balance Actual	$16,325.47	$17,933.46	$14,470.63	$13,999.06	$11,567.13	
	Discrepancy	$0.00	-$499.99	$499.99	$1.40	-$4.86	
CPDP users 2005=19, 2006=18, 2008=?17			*Cheque $499.99 presented after accounting period				
	2010=13						
Financial Members	2010=50						

OCCASIONAL SERIES: THE STATE OF PLAY

Excerpt from Presentation at SSEM 10 : *What Emergency Medicine Doctors Need to Know About General Practice in 2010 and the Years to Come.*

Dr Chris Mitchell, Currently President RACGP

(Ed: This was an informative and enjoyable presentation and Dr Mitchell was quite willing to acknowledge that the College has been less than welcoming of older postgraduates wishing to cross-train etc, though he said this was being looked at. Time will Tell ... We thank him for providing some of his notes for this article.)

"The aim of GP training in part is to allow us to feel comfortable stepping away from guidelines when it's appropriate without consulting a specialist or lawyers."

General Practice is a Medical Specialty recognised by the AMC and Medical Board of Australia. We aim to train people to deal with complexity of primary care.

While GPs are specialists, that doesn't mean we restrict our scope of practice to a particular disease or procedure - it means that in order to be a GP, doctors need special skills, training, and assessment.

Since 1996 all Australian Graduates who wish to ender general practice must go through a 3 to 4 year training program and submit themselves to a formal examination. The RACGP Assessment was developed in 1968 and in 1974 it became an assessment to Fellowship. Fellowship of the Royal Australian College of General Practice has never been 'grandfathered'.

We have looked at data on GP training and fellowship.

Evaluation of the benefits of Fellowship certification are rare nationally and internationally - however we have looked at the quality outcomes of Fellows of the RACGP in comparison to vocationally recognised GPs.

Fellows prescribe significantly less medications and recommend significantly more non-pharmacological treatments. After adjusting for GP and patient characteristics and for morbidity, Fellows less often prescribe or provide:

- broad spectrum antibiotics ,
- compound analgesics,
- sedatives, hypnotics and
- Non-steroid anti-inflammatory drugs in older patients.

Source: Miller G, Britt H, Pan Yet al. *Relationship between general practitioner certification and characteristics of care.* Med Care. 2004;42(8):770-778

The benefits of a training program for general practice has also been assessed.

Using administrative data from the *Health Insurance Commission* - there are significant differences between graduates of the RACGP's training program and non-graduates in terms of their cost to the community.

When all costs were considered - that is the Medical Benefits Schedule, the Pharmaceutical Benefits Schedule and measured secondary costs, GPs who have gone through the RACGP training program, cost the government $64.13 per consultation compared to $76.59 for vocationally recognised non-training program GPs. That's per consultation - on a per patient basis over the year. GPs that have gone through the RACGP training program's costs including referrals and medication costs are considerably lower

So we have evidence that our training program offering cost savings of 16% per consultation and 34% per patient over a year.

Source: Outcomes Evaluation unit of May 2001: Britt H, Miller G, Valenti L. *Comparison of practice patterns of GPs who completed the RACGP Training Program*

Training

Since 2000 the training has been delivered by GPET (General Practice Education and Training) to RACGP or ACRRM endpoints through 17 Recognised Training Providers.

- FRACGP
- FARGP
- FACRRM

The FRACGP is a 3 year program with an optional 12 months Advanced Rural Skill Post leading to a Fellowship in Advanced Rural General Practice or a FAR-GP.

The ACRRM program is a 4 year program that includes a 12 month Advanced Rural Skills Post – ACRRM calls this "Rural Specialised Training" or an RST.

Advanced skills or Advanced Rural Skills may include the typical rural procedural general practice skills of Obstetrics, Anaesthetics and Surgery. By far the most popular Advanced Skills Posts are anaesthetics and obstetrics, closely followed by emergency medicine.

Other options include:

- Aboriginal Health
- Mental Health
- Paediatrics
- Adult Internal Medicine
- Sports Medicine
- Palliative Care
- Drug and Alcohol

Academic Terms have also been popular for many years and its interesting that now 40% of Australia's Medical Dean's were trained as GPs.

Thank you.

One CMO's response to bullying in the workplace. (anon)

Some years ago I was part of a CMO workforce undergoing some structural changes, facilitated by a new manager. During this process I came in for some special attention and some surprising disciplinary action. It soon became apparent to myself and my colleagues that some of us were being subjected to bullying behaviours by this manager. In the view of my colleagues I was being singled out for "slow crucifixion" by this manager.

I tried the usual avenues to address my concerns with higher levels of management and found this only triggered powerful responses that described me as 'undeniably vindictive' and a 'troublemaker' demanding that I put myself before some extremely troublesome proceedings that were considered to be illegal by my union representatives. After a second round of surprising disciplinary action was launched against me, I decided to explore new ways to address bullying and harassment in my workplace.

In that process I surfed the net and spoke to numerous experienced unionists, lawyers and even some architects of various anti-bullying policies, etc. It became apparent that bullying and harassment was endemic within hierarchical systems and the best advice I could receive when strongly targeted by an organization was to simply move to greener pastures.

I decided to battle on and solve this problem for myself before I moved on. At best I thought I could become an agent for change (if possible) within my workplace. To better position myself to deal with this manager and the wider management supporting his behaviours I joined the Occupational Heath and Safety Committee as an OHS representative as I thought this would help protect me against any reprisals when raising issues about health and safety in my workplace.

Over the subsequent months and years I made numerous notifications to the CEO of my Area Health Service advising him of my concerns that there was an ongoing foreseeable risk to health and safety in my workplace, namely the behaviour of my immediate manager and all those supporting his behaviours, including local and regional managers (which naturally including the CEO I was providing these notifications to !) I merely invited the CEO to ensure that a relevant OHS risk assessment take place so that all risks to health and safety could be addressed, minimised and / or eliminated from my workplace.

These requests were politely received but never acted on in the manner in which I requested. This did not concern me, as I was merely creating a paper trail that would provide evidence of inaction on their part, that could make the wider organization and the CEO personally liable to prosecution if any one suffered from their failure to fully address issues raised by an employee or a member of the OHS committee.

I had become aware of various provisions within the NSW OHS Act and Regulation.

Specifically the Act states (in Part 1, 3 Objects) that the employer must:

> **"ensure that risks to health and safety at a place of work are identified, assessed and eliminated or controlled**,"
>
> **"promote a safe and healthy work environment for people at work that protects them from injury and illness and that is adapted to their physiological and psychological needs"**
>
> **"protect people at a place of work against risks to health or safety arising out of the activities of persons at work**,"

In section 8 Duties of Employers it states:

> **"An employer must ensure the health, safety and welfare at work of all the employees** of the employer."

That duty extends (without limitation) to .. **ensuring that systems of work and the working environment of the employees are safe and without risks to health**,

The OHS Regulation in **Section 9 Employer to identify hazards** states:

(1) **An employer must take reasonable care to identify any foreseeable hazard that may arise from the conduct of the employer's undertaking and that has the potential to harm the health or safety of:**

(a) any employee of the employer, or

(b) any other person legally at the employer's place of work,

or both.

(2) **In particular** (and without limiting the generality of subclause (1)), **the employer must take reasonable care to identify hazards arising from**:

(a) the work premises, and

(b) work practices, work systems and shift working arrangements

(**including** hazardous processes, **psychological hazards** and

fatigue related hazards), and

Furthermore the Act specifically states in Section 23 **Unlawful dismissal or other victimisation of employee:**

An employer must not dismiss an employee, injure an employee in his or her employment or alter an employee's position to his or her detriment because the employee:

(a) **makes a complaint about a workplace matter that the employee considers is not safe or is a risk to health**

The regulation outlines various penalties if an employee is dismissed or victimised when reporting concerns about OHS risks in their workplace

Again in section 23

Maximum penalty (**where each penalty unit = $110 in 2010**):

(a) in the case of a corporation (being a previous offender)—375 penalty units, **(= $41,250 fine)** or

(b) in the case of a corporation (not being a previous offender)—250 penalty units, **(= $27,500 fine)** or

(c) in the case of an individual (being a previous offender)—225 penalty units, **(= $24,750 fine)** or

(d) in the case of an individual (not being a previous offender)—150 penalty units. **(= $16,500 fine)**

Therefore all I did was provide recurrent notifications of a potential OHS risks within my workplace and asked the individual ultimately responsible for ensuring compliance all aspect of the OHS Act and Regulation, which was the CEO of the local area health service.

Furthermore I reminded the CEO that I was merely fulfilling my employee designated responsibility to take reasonable care for health and safety in my workplace by reporting potential workplace hazards to my employer to allow him/her ample opportunity to address, minimise or eliminate these risks. I was reporting these in the same manner that I should be expected to report other workplace hazards such as faulty electrical wiring, leaking pipes, loose tiles or equipment that could fall and injure someone. However since this involved serious bullying and harassment by tiered levels of management, I had to report the matter direct to him. This was my interpretation of fulfilling the requirements in Section 28 (of the NSW OHS Regulation) **"Employees to disclose certain matters."**

> (1) **An employee must take reasonable steps to prevent risks to health and safety at work by notifying the employee's employer or supervisor of any matter that, to the knowledge of the employee, may affect the capacity of the employer to comply with the requirements of this Regulation.**

The Act requires employees to comply with the employer's direction in Section
20 Duties of employees

> (2) An employee must, while at work, co-operate with his or her employer or other person so far as is necessary to enable compliance with any requirement under this Act or the regulations that is imposed in the interests of health, safety and welfare on the employer or any other person.

However, in my view, I could not be expected to co-operate in proceedings that might cause me further harm or injury. Hence when the CEO suggested I lodge my concerns as a formal grievance, I replied that to do so was likely to cause me further harm and/or injury, as grievance proceedings were heavily biased against me and were no longer considered to be appropriate in cases of serious bullying and harassment. Subsequent NSW policy guideline documents have now supported this view.

Instead, I offered to provide full information ONLY to someone who was well qualified and widely recognised to be an expert in the assessment and correct identification of all forms of overt and covert workplace bullying. Furthermore, I could only agree to proceedings that could not cause me any further harm or injury. Naturally this was never provided.

So I established a pattern of recurrent notifications to the CEO that triggering recurrent inaction on their part till it was finally decided to provide educational sessions on bullying and harassment in my workplace that appeared to benefit non-medical staff as well.

At the same time I drafted a potential survey instrument to gauge the level of bullying and harassment within my workplace. I hoped that this could be used on a recurrent basis. The premise behind this was, that providing a survey instrument with 'non-judgemental awareness raising questions' would not only ascertain the level of coercive behaviours in my workplace but also raise awareness, so that it would become far more difficult for bullying behaviours to occur. This survey was passed around to as many staff as possible during its development and also passed up to higher levels of management on the premise that it could be used to enter a regional Quality Award.

Five years later bullying and harassment essentially seems to have disappeared from my workplace where most of that time the original perpetrator and I co-existed within the same workplace. Sure bullying occurs spasmodically at times but never in any sustained fashion. And should it ever reappear in

that manner, it would simply require recurrent OHS notifications to the CEO and the re-circulation of the draft version of this survey to "further refine & develop it" prior to implementation in an official capacity or unofficially to seek recognition as a quality initiative.

Perhaps this might be useful to other CMOs finding themselves being subjected to bullying & harassment.

A copy of the NSW OHS Act can be found on the internet at
http://www.legislation.nsw.gov.au/fullhtml/inforce/act+40+2000+FIRST+0+N

A copy of the NSW OHS Regulation 2001 with Margin Notes can be found at:
http://www.bees.unsw.edu.au/ohs/OHSRegulation2001withMarginNotes.pdf

Quality Project
Bullying, Harassment and Intimidation in the Workplace

Bullying Survey Instrument –

NB: THIS IS A DRAFT DOCUMENT ONLY
It is strongly suggested that it be passed widely around staff to further develop and refine questions that are best suited to your local workplace and circumstances before any implementation.

The following questionnaire will be issued to all staff within The **XYZ** Hospital's **ABC** Department on a 3 monthly basis for a period of one year. Participation is entirely voluntary.

Completed questionnaires will be collated by an independent 3rd party and presented back to the department in a de-identified and generalized manner at the end of the 12 month period.

Please confine all answers to your experiences within The XYZ Hospital's ABC Department during the previous 3 months.

1. Please enter Today's Date: . . / . . / . .

2. I am a
   - ☐ Registered Nurse
   - ☐ Enrolled Nurse
   - ☐ Student Nurse (RN or EN)

- ☐ Dr (Specialist)
- ☐ Dr (CMO)
- ☐ Dr (Registrar)
- ☐ Dr (RMO)
- ☐ Administration staff member (eg: Clerical staff)
- ☐ Wardsperson
- ☐ Cleaner
- ☐ Allied Health Worker
- ☐ Other . . . . . .

3. I work

- ☐ Full-time (Permanent)
- ☐ Part-time (Permanent)
- ☐ Contract (Full-time)
- ☐ Contract (Part-time)
- ☐ Casual
- ☐ Other . . . . . .

4. Workplace bullying, harassment and/or intimidation has been an important issue for me in the past three months?

Strongly Disagree	**Mostly Disagree**	**Neutral**	**Mostly Agree**	**Strongly Agree**
☐	☐	☐	☐	☐

3. a) In the past three months have you witnessed, experienced or been involved in incidents involving bullying, harassment or intimidation in your workplace. (ie: as a target, witness or perpetrator)

☐ **No** ☐ **Yes**

If you have answered 'No' please move to Q 12

b) with regard to any **single incident that appears most prominent to you** during the last three months, who was **doing** the bullying / harassing / intimidating (ie: '**perpetrator**')?

- ☐ Yourself
- ☐ Patient
- ☐ Relative
- ☐ Visitor
- ☐ Doctor
- ☐ Registered Nurse
- ☐ Enrolled Nurse
- ☐ Wards-person
- ☐ Cleaner
- ☐ Supervisor
- ☐ Manager
- ☐ Administration staff member (eg: Clerical staff)
- ☐ Other . . . . . .

c) with regard to this incident, who was the **target** of the bullying / harassment / intimidation (ie: '**victim**') ?

- ☐ Yourself
- ☐ Patient
- ☐ Relative
- ☐ Visitor
- ☐ Doctor
- ☐ Registered Nurse
- ☐ Enrolled Nurse
- ☐ Wards-person

- ☐ Cleaner
- ☐ Supervisor
- ☐ Manager
- ☐ Administration staff member (eg: 'Ward clerk')
- ☐ Other . . . . . .

d) with regard to this incident, please indicate the type of bullying / harassment / intimidation that occurred ?

(you may tick more than one box if needed)

- ☐ Verbal abuse
- ☐ Unwarranted criticism
- ☐ Physical (non-sexual)
- ☐ Sexual harassment
- ☐ Discrimination
- ☐ Unfair demands on your time
- ☐ Unfair demands on your clinical/professional skills or abilities – or refusal to pay you for the work you have done (including alteration of time sheets or non-payment of overtime)
- ☐ Unfair rostering
- ☐ Professional belittling, patronising or condescending behaviours
- ☐ Negative comments in front of other staff members
- ☐ Negative comments in front of patients
- ☐ Threats of disciplinary action/dismissal
- ☐ Threats of violence
- ☐ Overlooking praise whilst at the same time over-emphasising negative criticism
- ☐ Other forms of bullying/harassment/intimidation

. . . . . .
. . . . . .
. . . . . .
. . . . . .

e) with regard to this incident, do you think the target found this personally distressing.

Strongly Disagree	**Mostly Disagree**	**Neutral**	**Mostly Agree**	**Strongly Agree**
☐	☐	☐	☐	☐

f) with regard to this incident, do you think the incident allowed the protagonist some benefits.

Strongly Disagree	**Mostly Disagree**	**Neutral**	**Mostly Agree**	**Strongly Agree**
☐	☐	☐	☐	☐

g) with regard to this incident, what did you do about this?

(you may tick more than one box)

- ☐ Nothing
- ☐ Ignored it
- ☐ Felt startled or overwhelmed by it
- ☐ Approached the bully
- ☐ Approached the target
- ☐ Approached bully's supervisor
- ☐ Approached senior hospital management
- ☐ Approached Area level management
- ☐ Approached Department of Health
- ☐ Took concerns to Union

- ☐ Took concerns to lawyer
- ☐ Took concerns to Media
- ☐ Left employment or transferred to another area with the same employer
- ☐ Sought revenge (eg: behaved in a passive aggressive manner towards the bully[s])
- ☐ Other . . . . . .

4. If you did do something about it, was there a favourable outcome?
   - ☐ No
   - ☐ Yes (the bullying stopped)
   - ☐ Partially (please explain)

     .....
     .....
     .....

5. Do you think more should or could have been done?
   - ☐ No
   - ☐ Yes If Yes , what should or could have been done

     .....
     .....
     .....

6. If experiencing or witnessing bullying, did this have any effects upon your general health, well-being, or ability to do your normal work related duties

   No ☐ **Yes** ☐

   If Yes , did this adversely affect

   (you may tick more than one box)

   - ☐ your sleep
   - ☐ your mood
   - ☐ your concentration
   - ☐ your interest in your work
   - ☐ your relationships at work
   - ☐ your relationships at home
   - ☐ your level of self confidence
   - ☐ your confidence in your clinical abilities
   - ☐ your levels of enjoyment
   - ☐ your ability to focus on other issues in your life
   - ☐ other . . . . . .

7. If experiencing or witnessing bullying, did you receive support from your manager or supervisor.

   ☐ **No** ☐ **Yes**

   If Yes , did this involve
   - ☐ personal support
   - ☐ education
   - ☐ advice and encouragement to receive counselling
   - ☐ information about the employee assistance program
   - ☐ other . . . . . .

8. If experiencing or witnessing bullying, did you receive any form of professional support.

   ☐ **No** ☐ **Yes**

   If Yes , did this involve the services of a
   - ☐ counsellor
   - ☐ psychologist

- ☐ general practitioner
- ☐ psychiatrist
- ☐ employee assistance program
- ☐ other . . . . . .

9. If experiencing or witnessing bullying, did you have time off work using sick leave or workers compensation leave.

☐ **No** ☐ **Yes**

If Yes , did the total period extend for

- ☐ less than one week
- ☐ between one week and one month
- ☐ more than one month

10. If experiencing or witnessing bullying, did you gain anything from the experience.

☐ **No** ☐ **Yes**

If Yes , did you

- ☐ learn more about the requirements of your position
- ☐ learn more about the opinions and attitudes of others
- ☐ learn more about what is acceptable and unacceptable behaviour within this department
- ☐ other . . . . . .

11. Do you believe that there have been occasions when you have inadvertently or deliberately bullied, harassed or intimidated others within the past three months

☐ **No** ☐ **Yes**

a) If Yes, do you believe this relates to

(you may tick more than one box)

- ☐ part of normal working relationships
- ☐ expected behaviour for your particular role at the time
- ☐ needing to behave in this manner in order to ensure that the job at hand was completed in a time effective manner
- ☐ justified behaviour because you were acting in the interest of better patient care
- ☐ part of my strong personal style
- ☐ to do otherwise would be a sign of weakness
- ☐ being inadequately resourced
- ☐ being inadequately trained
- ☐ frustration with hospital's inability to meet the needs of patients
- ☐ frustration with bed block
- ☐ frustration due to other issues at work
- ☐ frustration due to issues at home
- ☐ repeating a learned pattern of behaviour
- ☐ expecting others to do more than they feasibly could under the circumstances
- ☐ justified behaviour
- ☐ protecting yourself from perceived criticism
- ☐ enjoying watching other people cringe
- ☐ other reasons . . . . . .

b) If Yes, were you subjected to any form of disciplinary action, complaint or investigation

☐ **No** ☐ **Yes**

c) If Yes, did you require time off work

☐ **No** ☐ **Yes**

d) If Yes , did this extend for a period

☐ less than one week
☐ between one week and one month
☐ more than one month

12. Bullying, Harassment and Intimidation is largely within the eye of the beholder.

Strongly Disagree	**Mostly Disagree**	**Neutral**	**Mostly Agree**	**Strongly Agree**
☐	☐	☐	☐	☐

13. Bullying, harassment and intimidation is the only way to guide and control some people.

Strongly Disagree	**Mostly Disagree**	**Neutral**	**Mostly Agree**	**Strongly Agree**
☐	☐	☐	☐	☐

14. Bullying, Harassment and Intimidation is stressful.

Strongly Disagree	**Mostly Disagree**	**Neutral**	**Mostly Agree**	**Strongly Agree**
☐	☐	☐	☐	☐

15. Some stress is good for you.

Strongly Disagree	**Mostly Disagree**	**Neutral**	**Mostly Agree**	**Strongly Agree**
☐	☐	☐	☐	☐

16. There is a place for some Bullying, Harassment and Intimidation in the workplace.

Strongly Disagree	**Mostly Disagree**	**Neutral**	**Mostly Agree**	**Strongly Agree**
☐	☐	☐	☐	☐

17. Are you aware of that NSW Health has issued a policy on bullying, harassment and discrimination within the workplace?

☐ **No** ☐ **Yes**

18 Are you aware that this policy states that managers are obliged to ensure that all forms of Bullying, Harassment and Discrimination are eliminated from the workplace and must not model this behaviour themselves.

☐ **No** ☐ **Yes**

19. Bullying, harassment and discrimination is tolerated within my workplace?

Strongly Disagree	**Mostly Disagree**	**Neutral**	**Mostly Agree**	**Strongly Agree**
☐	☐	☐	☐	☐

20. I currently possess the skills to confidently deal with any Bullying, Harassment and Intimidation that may arise within my workplace.

Strongly Disagree	Mostly Disagree	Neutral	Mostly Agree	Strongly Agree
☐	☐	☐	☐	☐

21. Are you aware that NSW Health provides the Employee Assistance Program offering free counselling to employees and their families for personal and/or work related issues ?

☐ **No** ☐ **Yes**

22. Please provide any additional comments and / or suggestions below:

. . . . . .
. . . . . .
. . . . . .
. . . . . .
. . . . . .

23. Completing this survey has been useful.

Strongly Disagree	Mostly Disagree	Neutral	Mostly Agree	Strongly Agree
☐	☐	☐	☐	☐

Thank you for your time.

source: www.sangrea.net/hjkdjjbix/bullying_mr-sosipath_&_mr_.jpg