ASCMO Times

Newsletter of the Australasian Society of Career Medical Officers

August 2015 ISSUE

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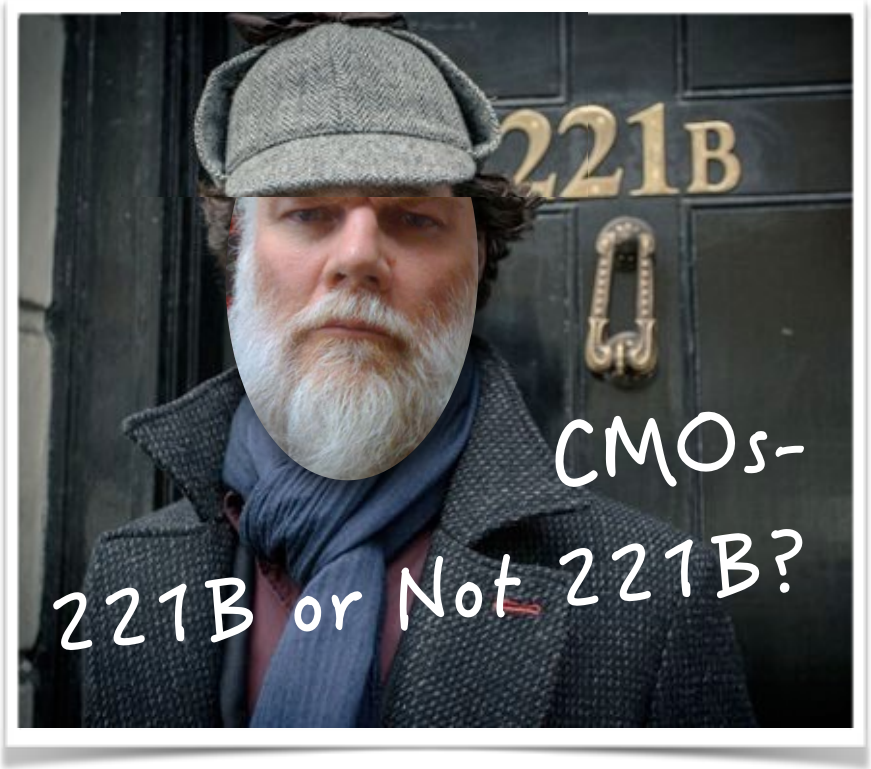
President's Report - From the Art to the Improbable

Dear Sherlock,

As requested I have been down under under cover. I have been masquerading as a deceased naturalist in order to answer the questions you have set for me. I do hope that this is intelligible to you because much that happens down here does not make even elementary sense to me.

I will return on the next steamer,

Yours etc J/W



"When one has eliminated the impossible, whatever remains, however improbable, must be the truth."

S. Holmes

Preliminary report from the colonies
Searching for clues.....Somewhere around here .....Maybe under the hat..... They are really so good at hiding....

Gotcha !

The Spotted Seymour is a crafty little animal, more accustomed to hiding from the light, burrowing industriously, and creating networks of tunnels that communicate via especially strong memes.

Yes - shine a light on these little critters and they run for cover licketty ssplit - probably with good reason, since the reporting of known numbers of wild Seymours has recently diminished.

Their natural predators are paradoxically also their greatest collaborators in the excretion of a quality ecosystem and this is the improbable reason why they still exist. Their greatest survival tool is the ability to interbreed with species usually thought to be anathemous to life - indeed they have been described as polygenic, sharing some 80% of introns with several other species, such as *Physicus genericum, Surgicus expletivum, Orthopedicus siloitum, Psychuss psychius* and especially *Emergicus aneatus*.

Uniquely Australian, they have at least one prepared shell always in readiness should their primary shell be disturbed. It has been reported that some have an amazing 6 to10 shells up their sleeves whilst up to 4 is relatively common.

Their language is often guttural, but they have been known to utter multiple grunts and polysyllabic itterings - but what they actually mean by these statements is not well established.

It is simply amazing how these little creatures gain nourishment. They do not react well to the spoon or the teat, but seem to prefer foraging for themselves![1] Thus it is difficult to ascertain how much they metabolise and we are left to the rather crude scale of clinical outcome. Of course this makes them terribly terribly hard to measure and especially difficult to micro-measure! Some of the greater beings have decided that the only way to achieve this aim is to starve them out, weighing the ecosystem before and after.
It remains to be seen just how the Seymours will react but the unfortunate result my well be an irreversible change in the ecosystemic microbiota and the invasion of *closemouthicus diffcicultium*.

The evolutionary background of the Spotted Seymour has been relatively well described in the literature. They started life as the *PeterPannicus genericum*. By the process of multiple evolutionary stimuli, stemming from multiple baiting programmes of the last century, their accelerated development has made them into ubermedica, and the classification has recently been revisited. They are now widely being known as *Hospitalium seniorium.* This nomenclature is not yet widely accepted and much discussion is taking place in the hallowed places of the greater beings.

A recent change in their behavioural characteristics is quite noteable. Some of these have been seen FOAMing and twittering but whether this is a short term phase only time will tell.

I must admit that despite my initial foreboding I have become rather fond of these spiny little critters and it is to be hoped that these important denizens of the macromedica will not disappear or hide too well. I cannot help but conclude that their loss would be to the detriment of the overall biosphere.

JHW

[1](though up to 700 of these creatures have reportedly been seen ingesting regularly from similar sources)

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Belief is a powerful tool…

The incipience of the idea that there should be a defined role for the "Doctor That Does", in whom experience, seniority and corporate knowledge worked together to produce quality care and efficiency, came at a time when there were fewer and fewer doctors willing to stay in the hospital environment. The role developed in multiple places around Australia as an 'idea whose time had come'. Various industrial moieties were used, and a varied approach to training occurred. Whilst many trained themselves, some lucky ones were able to attach themselves in an ad hoc way to specialist training schemes. Some even luckier folk were able to take the opportunity provided by the early proto-training schemes based on defined experience in one workplace.

From these early demonstrations and experience was born the view that the trained CMO was more than just a gap filler, but an integral part of the health service with an ability to treat patients, make high level decisions and help to provide a systems approach to the provision of healthcare.

There were problems - leading to a difficult and pejorative environment. One was that the label of CMO/SHO/SMO etc was used as an industrial codicil for folk who were not well trained for the job required. This allowed the criticism of the whole for the performance of the few. The second was that a blinkered view from each of the 'partialist' colleges was that CMO's did not have the level of training demanded by that particular specialty - notwithstanding that outside the narrow view the CMO's advice is is often sought. Industrial anomalies such as 3/8 normal pay as the overtime rate poured salt on wounds.

ASCMO was brought into being by belief. We believed that we could not only fix some of the more egregious industrial anomalies, but lobby for an educational pathway that could help to train and define the CMO.

How are we doing?

> The most difficult industrial setting , NSW, has largely been fixed.
>
> We have produced enhanced educational pathways and created new job opportunities as Hospitalists. The CMO educational ideals, that we own our own learning, can learn new skills quickly and efficiently, and that medical learning is a lifelong event are reflected in the HSP and by Masters Courses broadly similar to our original proposals. We are well placed to utilise the exciting current and future opportunities.

Why then do we suddenly find ourselves in an environment that seems perfectly suited for the CMO to wane?

Root causes are likely to be found in older strongly held belief systems intersecting with difficulties in resource allocation plus our own difficulties with marketing our strengths and dealing effectively with our weaknesses.

We now work in in an age where new graduates may not have a job, let alone adequate training. This political and financial pressure defines itself upward, leading to a general decrease in both experience and overall seniority of the medical workforce at a time when complexity of care is growing. While all staff are vulnerable, the CMO is uniquely poised to be viewed as either too expensive a junior or as an undertrained senior.

However, increasing costs for an increasingly complex case load requires a systematic team-based approach, which we are well based to provide.

The pejorative milieu, whilst remaining for some a thorny if not 'wicked' problem, has the potential to be solved by continuing to have high level conversations in support of the notion that the CMO is not an expensive junior staff member but a senior clinician who adds value and efficiency, and who brings high level decision support and a systems approach to the changing needs of healthcare - and that putting resources and effort into training such medicos is both necessary and worthwhile.

Magical Thinking would have us disappear. We are the impossible doctors who should not, by all things traditionally sensible, exist. By believing in our future we exemplify Doyle's theory of improbability.

Its simply elementary!

Michael Boyd

Root causes are likely to be found in older strongly held belief systems intersecting with difficulties in resource allocation plus our own difficulties with marketing our strengths and dealing effectively with our weaknesses.

Editor's View

by Mary G.T.Webber

It's been a very long time since we embarked on the journey to a CMO culture, meaningful education opportunities, an industrial structure that recognised and supported that, and a career path that allowed non-streamed, senior doctors to be recognised for their value to continuity and care at the coal face and beyond.

So many good and wonderful things have happened in the last few years. The Great Learning Event at Macquarie in Nov 10, to the assemblage and actual delivery of not one but 2 self-directed Masters courses that recognise the CMO skills set. the HSP behind it all. CMOs writing the first ever curriculum in Hospital Medicine and phrasing it in terms of what we do in the real world - our Entrustable Professional Activities. The award has survived its review. We have articles published in the MJA (bless them). We have set up and promoted and delivered on the promise of Hospitalists as a career option for CMOs, and seen new blood and smart new people come in to the room. And we are told that our activities have forced the learned Colleges to adapt and offer Diplomas etc.

Still, It feels both as if we have really accomplished those goals, but that we are only at the beginning of a larger task. It is difficult to find time from our jobs and our lives and our studies to reflect on how we do things, and what that reveals of who we are a s individuals and a group (however loosely affiliated), but the Journal is that moment, so here we go.

Is there even such a thing as CMO culture?

A worthwhile question, I believe that there is. Indeed Michael and I sat down after one particularly annoying meeting a couple of years ago, and attempted to define what made CMOs different and how that is reflected in the particular character of the Hospital Skills Programme. See page —- and see what you think.

Did you step off a recognised path deliberately, or did you just slide into CMO-dom by accident? Did you just want a job, or did some poorly supported, unconventional aspect of modern medicine fascinate you so much that you had to follow your nose and go only where it lead you?

What ever the answer, we would hope you continue to find a welcome and a fellowship here.

INDUSTRIAL REPORT August 2015

Ross White

Vice President ASCMO - Industrial Officer

NSW CMOs can apply to be regraded as senior CMOs:

Career Medical Officers can, on application, be regraded to Senior Career Medical Officer status in accordance with the provisions of the *Public Hospital Career Medical Officers (State) Award* (the 'CMO Award')

Details are at: http://www.asmofnsw.org.au/latest-news/guidelines-for-regrading-senior-career-medical-officers

I like to hear from anyone doing such an application.

Annual Pay Increase in NSW:

The annual NSW pay rise from 1 July 2015 has taken effect. There is the ongoing argybargy about whether the 2.5% should be reduced to 2.27% with the increase in compulsory superannuation rate.

Meal Allowances:

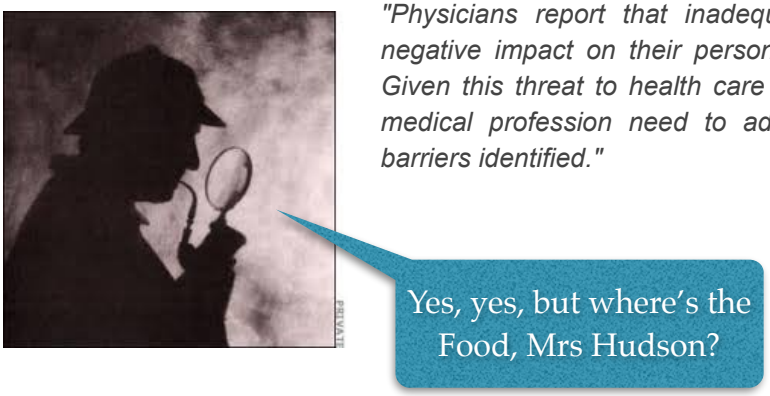
The current NSW Public Hospital CMO Award http://www.health.nsw.gov.au/careers/conditions/Awards/hsu_ph_career_med_officers.pdf

In section 10 (Overtime) has this:

(iii) An employee who works authorised overtime and was not notified on or prior to his/her previous shift of the requirement to work such overtime shall be paid in addition to payment for such overtime the meal allowance as determined by the Director of Public Employment from time to time: (a) for breakfast when commencing such overtime work at or before 6.00 am; (b) for an evening meal when such overtime is worked for at least one hour immediately following his/her normal ceasing time, exclusive of any meal break and extends beyond or is worked wholly after 7.00 pm; (c) for luncheon when such overtime extends beyond 2.00 pm on Saturdays, Sundays or holidays; or shall be provided with adequate meals in lieu of such payments.

The current meal allowance for the JMOs is $27.70 and seeing few hospitals have decent staff cafeterias these days, hospitals have been using various ways to show some compliance, or they don't bother paying a meal allowance at all. One hospital required the doctors to get a token from the after hours nurse manager to use in the vending machines. There have been reports that being hungry affects clinical performance and there will be some action coming up soon.

The effect of poor nutrition on JMO's performance has been reported in Lemaire et al. Nutrition Journal 2011, 10:18 (full text available at http://www.biomedcentral.com/content/pdf/1475-2891-10-18.pdf) which concludes:



"Physicians report that inadequate workplace nutrition has a significant negative impact on their personal wellness and professional performance. Given this threat to health care delivery, health care organizations and the medical profession need to address both the practical and professional barriers identified."

Please let me know if you experience non-payment or only having access to junk food in machines.

The recently reappointed chair of the Medical Board of Australia has said revalidation will be coming.

Medical Intern Review is in progress at present for COAG, and there is a report due out soon. A couple of CMOs have made individual submissions. According to Michael Hannan who is running the administration of the review, there will be a second phase where ASCMO may make a formal submission.

http://www.coaghealthcouncil.gov.au/MedicalInternReview

Revalidation:

The recently reappointed chair of the Medical Board of Australia has said revalidation will be coming. Most of this will be through the Colleges. I think that ASCMO should get in contact with the Medical Board of Australia to explore ways for revalidation for doctors who are not a trainees or fellows.

http://www.medicalboard.gov.au/News/Newsletters/June-2015.aspx#revalidation

The Tsunami of Medical Graduates:

There appears to be many applicants for medical jobs in NSW hospitals. Many are by people just not wanting to miss out so they apply everywhere in case they don't get their preferred positions. Some hospitals have reduced their CMO ED workforce and have more PGY3s and 4s. Anecdotal reports from ED physicians at those places are that the reduction in CMO numbers is noticeable.

ASMOF:

ASMOF has significant numbers of JMO members after HSU lost their exclusive cover for JMOs. Consequently the balance in the Council has changed as the numbers of councillors is proportional to the number of members form each group. Michael Boyd and I are the CMO representative members on the Council, being the only nominees at the last elections. Anyone who applies to join ASMOF is asked if they have any previous or current industrial issues and usually will only be offered general advice for such existing issues. Any new situations that arise would be covered. There is quite good travel insurance included in the subscriptions for members, partners, and dependent children.

As I expect to retire in the next year or two, I would hope that another CMO ASMOF member would be prepared to go onto Council. There are monthly meetings at 6.30pm on the third Tuesday of each month and the teleconference/Skype links seem to work quite well.

Doctors re-entering the workforce after suspension/deregistration:

Some doctors in this situation are ordered by the Medical Council of NSW to work as PGY2 doctor in a public hospital before they can apply for working in medical practices. With NSW offering two year contracts to new medical graduates, there are few PGY2 positions that come up by resignation, and they usually have a lot of doctors from interstate (often NSW citizens who did their medical degrees in other states) who apply. Despite the re-registering doctors having many years experience, they may not have practised any medicine for 5 years and no hospital experience for decades, which makes a fully registered new PGY2 more attractive, especially when there may be conditions on re-registering doctors such as being always under direct supervision of senior doctor, or not seeing female or child patients at all or only with an approved chaperone, which is almost impossible to arrange in a hospital.

Education Update: Hospital Skills Program

Guest Editorial - by Toni Vial

With its high participation rate and breadth of targeted education across the state, the Hospital Skills Program (HSP) has been a successful and valued program for HETI and NSW Health. This success arises from the hard work and dedication of our HSP Directors of Training and Education Support Officers. The easy part is to define the procedures and processes. The hard part is to make them happen. Your value to our health service and to patients is reinforced (in this time of austerity) by the Ministry's generous commitment to recurrent funding to HSP training networks.

During this period of transition for the Medical Portfolio at HETI, I would like to reassure everyone that, as long as there are doctors working in our Health Service who do not have oversight of their professional development by a medical college, we will have work to do. It is imperative that all doctors develop learning plans and have at least an annual evaluation of the extent to which they have achieved their learning goals and maintained the competencies required of their roles. HSP's expertise to date has been largely in the design, delivery and facilitation of educational opportunities to doctors, but we need to further our aims of multidisciplinary engagement in our activities and facilitating and delivering the Professional Development Process. Defining the degree to which doctors in HSP meet expected performance outcomes is vital to both clinical governance and meeting professional and community expectations of HSP.

Recent reports from around the NSW Networks indicate that there are over 700 participants currently enrolled in the HETI HSP or engaged in HSP endorsed activities!

This includes 195 NSW doctors who have completed or are currently progressing through the Australasian College of Emergency Medicine Certificate and Diploma courses!

Toni Vial

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HSP Emergency Medicine Workshop @ The Sutherland Hospital on Wednesday 25th March 2015. Dr Con Glezos facilitated the 'closed reduction & management of common fractures' workshop

Emergency Diagnostic Ultrasound Workshop at The Sutherland Hospital on Wednesday the 6th on May 2015.

There were 4 stations: Peripheral Vascular Access (Dr Andrea Bell); Focused Assessment with Sonography for Trauma (FAST) (Dr Sharif Elgafi); Central Line (Dr Gina Watkins / Dr John Mackenzie); Regional Nerve Block (Dr Andrew Fincke / Dr John Mackenzie)

The Hospital Skills Program

The Elevator Explanation 😎

The Hospital Skills Program (HSP) provides a life-long pathway for self-directed education across three levels of agreed expertise, utilising a variety of traditional and non-traditional resources and methods appropriate to the working environment of the participant, resulting in the acquisition of a skills portfolio useful to an employer and appropriate to the local patient community.

The HSP recognises the heterogenous nature of the skills and circumstances of the CMO equivalent medical practitioner, their value in the delivery of Health Services to the population of NSW and their right to meaningful education opportunities in a mode appropriate to their working lives and geographic locations .

HSP recognises that self-directed education is the realm and property of the adult learner and that accountability for learning remains with the individual. There fore HSP exists firstly to identify, co-coordinate and facilitate the delivery of learning opportunities and to assist the individual to evaluate their progress across the three levels of the HSP and to plan for their own future needs.

THE ELEVATOR EXPLANATION : A SUMMARY SO CONDENSED AND PERSUASIVE THAT YOU CAN DELIVER IT BETWEEN THE SECURITY ENTRANCE AND THE MEETING ROOM LEVEL OF THE MOH - ED.

A Modern Masters for the Hospital Skills Program

September 19, 2013 was a proud day in the annals of HETI and the Hospital Skills Program for some of the founding members of the HSP. We had the occasion to prove our capacities as learners and teachers in a modular, meaningful qualification that we had pushed for for over a decade.
My Masters of Hospital Medicine makes a very nice addition to my HSP portfolio.

Everything you learn that's relevant to your work is material for your HSP portfolio. That's what's so remarkable - a format to recognise your inexhaustible capacity to improve. So not about the barrier exams. The HSP never ends - you can't graduate from it, or sign it off, or leave it behind. *(This aspect really freaks lots of traditional thinkers out. - ed)* True life long learning for doctors working in hospitals - therefore your Diplomas, Masters, Fellowships, weekend courses, self-directed reading and small group teaching - all are part of a life portfolio in the Hospital Skills Program.

On September 19, the first cohort of HSP members graduated from Macquarie University, Australian School of Advanced Medicine, (ASAM) with the title Masters of Medical Practice in Hospital Medical Care. I had the privilege to be one of them. It has been a remarkable experience being part of that attempt to broaden and deepen the educational opportunities available for post grad doctors working in hospitals.

The ASAM ethos, which recognises only Scholars and Advanced Scholars in its not-actually-a-hierarchy, has particular appeal to CMO-equivalent doctors, and being involved in the development and reviewing of the Masters, as well as in participating, has been one of the true highlights of my professional career.

The clinical emphasis on Sim Skills, Emergency Medicine, Resuscitation and Procedures and Clinical Therapeutics complimented the more strategic subjects in Education, Communication, Leadership, Hospital Management and Ethics and Professionalism. Patient Safety and Quality with Professor John Cartmill was a personal favourite in understanding the concept of Emergence in systems. All the subjects were consciously tailored to make use of real world work topics and projects, tackling problems we always wanted to get too but couldn't, (eg; therapeutic guidelines in feeding, pain service pathways, rapid response systems evaluation). I especially valued being assigned a Liaison Librarian, the amazing Mary Simons, to help me update my education and critical appraisal skills. I can honestly say that not a week goes by without me using and being grateful for those skills.

Steve Markowski, Mary G.T. Webber, Ross White, Vice Chancellor Bruce Dowton, Michael Boyd, and our honoured HSP Clinical Director, Simon Leslie

And Simon won the course award for his ethics works, which doesn't actually surprise anyone who knows him …

What a pleasure it has been to encounter those willing minds and talents, and to stretch our individual horizons. But it was hard challenging work to complete the course material and submit it to our satisfaction, while not neglecting our many other obligations. It was only looking back, on that proud moment processing through the doors across campus to the reception that I realised that the aspirations of more than a decade had just borne fruit.

We always said there should be flexible, responsive further qualifications for CMO type doctors. We said if they came to pass we would take the challenge on, and see where it led. Regardless of any other consideration, to be better educated, more knowledgeable and more competently equipped for the job at hand has tremendous intrinsic value.

To the many visionary and energetic people at who are opening these new doors and sticking their feet in the space to keep them open, we give thanks.

Mary G.T.Webber
Hospitalist
Ryde Hospital

ed - And can I just say that the amazing Steve Markowskei achieved the first crossed over ACCRM fellowship at the same time while working full time! Our congratulations on his extraordinary persistence and determination.

Word map from our last journal - what we care about and how often

But wait - there's more - the MOH now supports the new Masters of Clinical Management at Newcastle Uni for CMOs - as in, supports with actual money!

Whoo Hoo!

From - Brent Steeves

Hear Brent speak about the Masters of Clinical Medicine (Leadership and Management) - http://gradschool.edu.au/programs/overview/master-clinical-medicine-leadership-management-12263

I completed the Masters of Clinical Medicine (Leadership & Management) at Newcastle University with the degree's first cohort in 2013.
It was hard work and didn't result in any immediate tangible benefit for my career (such as a college fellowship would) but I'm happy to have done it, both for the broader professional skill set it has given me and for the strengthening of my CV. The course is delivered by online learning using web media tools for academic discussion forums, which works surprisingly well. All of the projects are work based which allowed me to fit in with my schedule and made them relevant to my clinical context.
The focus of the course is non-clinical and this causes some confusion among colleagues, who thought that I was studying medical admin. The philosophy of the course is that in our complex, compartmentalised health system, doctors need more than clinical knowledge to navigate that system and that clinical leadership is best exercised by those at the coalface, by clinicians. So the skills taught in this course address this: quality management and clinical practice improvement; teaching, work based assessment, supervision and performance management; the Australian health system and funding; organisational change management; clinical service provision; the anatomy of the hospital; and more.
While my clinical role hasn't changed, I have become more deeply involved in all aspects of my hospital's organisation, including becoming chair of our resuscitation committee. In the end, the professional skills the course has given me have helped raise my profile, differentiate me from my peers and, most importantly, make a real positive impact on our hospital's systems and patient care.

Brent Steeves
Senior Hospitalist

Sponsorship

Candidates applying from NSW may be eligible to apply for sponsorship in the Masters of Clinical Medicine (Leadership and Management)
Visit the Health Education & Training Institute (HETI)

THE UNIVERSITY OF NEWCASTLE AUSTRALIA

ASCMO's Website Report for 2015 Annual General Meeting

ASCMO-talk@yahoogroups.com continues to be ASCMO's main discussion vehicle. Currently 35 CMOs belong to this private (ie: ASCMO members only) email discussion group, where ideas are tossed around for general comment or perusal. All ASCMO members are welcome to join this free group, by simply emailing a request to me at davbrock@ozemail.com.au

Meanwhile www.ascmo.org.au continues to be a valuable resource for CMOs across Australasia.
With a new hosting arrangement costs are minimal (less than $150/yr) for providing a host of information for CMOs including various awards and salary scales for CMOs across Australia and on-line Application forms for ASCMO membership and ASCMO's "Continuing Professional Development Program" (CPDP). You can also find advertisements for permanent CMO positions on this site and links to various Locum agencies. Proceeds from these advertisements and banner adverts flow back into ASCMO's coffers and indirectly help to keep members subscription costs at a minimum.

To maintain and increase traffic to ASCMO's website we continue to develop strategic links with other active sites on the internet such as ASMOF, AMA and various locum agencies that provide reciprocal links. In this way we continue to achieve headline positioning whenever anyone searches for "Career Medical Officers" on GOOGLE's search engine! (Have had the number 1 spot for over 10 yrs !!).

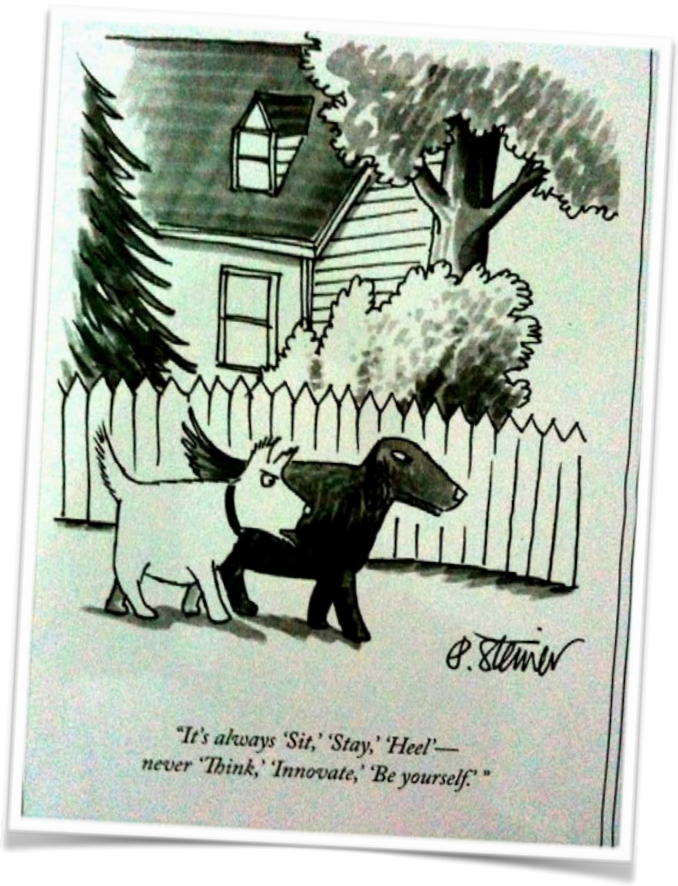
A restricted "Members-Only" area provides access to a large amount of industrial and politically related information. You will need to enter the following username/password combination to access relevant salary schedules and various industrial awards, etc.

username = ***ascmo***
password = ***member02***

Elsewhere on the site you'll continue to find past copies of "ASCMO-times" and "CMO Bulletins". Our most popular pages continue to be our "Links", "What's New" and "Industrial" pages.

Remember ASCMO-talk@yahoogroups.com **and** www.ascmo.org.au **have been created and maintained for** **YOUR** **benefit and** **PARTICIPATION.**

David Brock
ASCMO Website Co-ordinator



SOCIAL MEDIA and the CMO - A personal view - Mary G.T. Webber

If you want to know how we practiced medicine 5 years ago, read a textbook.
If you want to know how we practiced medicine 2 years ago, read a journal.
If you want to know how we practice medicine now, go to a (good) conference.
If you want to know how we will practice medicine in the future, listen in the hallways and use FOAM.

— from International EM Education Efforts & E-Learning by Joe Lex 2012

One of the major barriers we faced early in the CMO journey - and still face in many places, is the tyranny of distance. This takes many forms - the distance between us and the August Bodies who oversee the health system, between the worlds of service delivery and academe, and simply between us as individuals - as the members of our own fraternity.

I recall how we dreamed of teleconferencing and how it might change the educational environment for colleagues in the bush. But we see in short horizons, and I wasn't thinking it through. A dubious grainy connection to a poorly presenting speaker in another part of the state, projected in a room you cant get to because of your shift patterns, was an answer that consumed vast amounts of money and commitment without meeting the end point - learning and professional connection wherever you are.

Now I can barely remember a time without my iPhone, and there is and there is Twitter, and there is FOAM - Free Online Accessible Meducation (#FOAMed), and I can dip into conversations about retrieval, @ketaminh, and rural general practice, @broomedocs and @KangarooBeach, and I get sent great links by lots of people in Paeds like @PEMDocSyd.

Simplicity, speed of delivery, variety of content.

There seems to be a flattening of hierarchy, a broadening of the range of voices to be heard, and for the moment, a care of how to nurture this space for far flung humans. People come and go, and opinion flows much as you would expect. Care should be exercised. Courtesies are required, even in 140 characters.

The effect is that I now dip into my professional education almost every day of my life, instead of when I can get to it, and I bump thoughts with an entire planet of generous minds who are passionate about a lot of the same things I care about (esp human factors and patient safety). I can attend learning moments at the time It suits me. And since I hear about things constantly, when they come up at work, I'm more ready to translate information into action. And I poke around in areas I would never read in a journal like the intricacies of research in to infection control. And of course, there's an endless supply of humour, philosophy, and Star Wars memes. One's follow list becomes a strange little externalisation of one's mind.

Recommendations

@openculture
@philosophybites
@Radiopaedia
@timsenior
@cliffreid
@LizCrowe2
@doctorcaldwell
@I_C_N
@bunnybuddhism

On the other hand, unlike many people, I don't care for Facebook. I don't trust their privacy settings and advertising policies. And as for its content and purpose - it is strangely, inexplicably not my thing. Must be the attention span thing. 140 characters is about my limit these days.

Stephen Fry is reputed to have said that Twitter felt like strolling down the street bumping into interesting people, and Facebook felt like Homework. Yep. Could not agree more.

Twitter feels like strolling down a street bumping into interesting people, and Facebook feels like homework.

There are caveats.

- Think it through before you post. Anything you post to the internet or write in an email can be found and taken out of context. There is no natural boundary to this process. Posting is a FOREVER thing. If you wouldn't want it read aloud to the panel at a job interview - DON'T POST IT.
- The usual standards of patient privacy apply. Do not identify a case or a patient, ever.

> *The use of social media is expanding rapidly. Individuals and organisations are embracing user-generated content, such as social networking, personal websites, discussion forums and message boards, blogs and microblogs.*
>
> *Whether an online activity is able to be viewed by the public or is limited to a specific group of people, health professionals need to maintain professional standards and be aware of the implications of their actions, as in all professional circumstances. Health professionals need to be aware that information circulated on social media may end up in the public domain, and remain there, irrespective of the intent at the time of posting.*

- From the AHPRA website and their policy March 2014 at http://www.ahpra.gov.au/News/2014-02-13-revised-guidelines-code-and-policy.aspx

- Think about your own behaviour and words. The world has truly changed. Covert recording of your conversations and your actions is easy, and customer reviews of a doctor's behaviour be reviewed to *Yelp* in less time than it takes to order Chinese take out. Having material removed from the internet is almost impossible. Codes of conduct take on entire new dimensions.

- Verify the sources of material you may use in your practice. FOAM is no substitute for doing the research.

- Practice Infection Control for your device and it's content. Physically keep it clean.

- Require a passcode to access the device. Record the verbal consent to send that Xray to the Kids Hospital in the notes. Then make the removal of clinical photos from your phone part of your normal day - end of shift routine - because if you leave the damn thing in a taxi …

-Check the policies at your institution for their Bring Your Own Device guidance if you use the local network for access.

UPDATE on MABEL

MABEL (Medicine in Australia: Balancing Employment and Life) is Australia's national longitudinal survey of doctors funded by the NHMRC. From interns to those nearing retirement, the aim of the survey is to examine the working lives of doctors. Each year, around 10,000 doctors respond, with the research focussed on career transitions, workforce participation, and rural medical workforce. Understanding the factors influencing doctors' decisions in these areas is important in designing medical workforce policy. The survey examines the role of job satisfaction, working environment, family circumstances, and financial issues on career decisions. Recent papers have examined rural mobility, non-clinical activities, job satisfaction, and the determinants of working hours. MABEL was used in the development of the new 'Modified Monash Model' to allocate rural incentives to GPs, and is being used by a range of researchers, professional organisations, and government. A summary of completed and ongoing research is on our website www.mabel.org.au, or you can find out about the latest research results by following us on Twitter @MabelSurvey, liking our Facebook page, or joining our group on Linkedin.

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AGM REPORT -10TH MAY, 2014

We gathered at our traditional haunt at the Novotel Brighton-le-Sands, to both regroup to the business of ASCMO after a tumultuous couple of years, and to celebrate with our friend and colleague, Tom Salonga, who had just completed his Masters.

Present - Ron Strauss, Ross White, Michael Boyd, Graham Still, Ken Wilson, Cathy Cordy, Simon Leslie, Tom Salonga, Mary G.T.Webber, Gabrielle Du Preez Wilkinson

The Minutes from Sept 2011 were reviewed and accepted

From Business arising

Financial report - on where we are. Holding our own - outstandings are flights to the Mabel conference and the last, colour journal for which we are still awaiting the bills. Changes in the administration at Macquarie are delaying this.

M**embership Report** - from Cathy - 30 recent renewals - and the EFT option is being used by about 50%. In our perfect world we would have staffing and structures to contact each new members for that official welcome.

We recognise Ron Strauss for his unswerving contribution to finding new members

Our first formal resignation has been received. Louise Delaney has departed from the obstetric CMO role as her GP practice is consuming her, and naturally we recognise her long contribution with our first Life Membership as CMO emeritus - Ross nominates, Ron seconded - certificate to be sent.

Fees will remain the same, with an option for Senior membership at reduced rate.

Education Report - Gabrielle continues to support the approx 10 people who currently use the CPDP database system. This information gets to Cathy via Gabrielle and may be delayed. This entire system needs review in the upcoming year.

From APHRA - they are still trying to get through the bulk of the colleges registration requirements and not yet up to specifying the CMOs. Overall the consensus minimum is about 1 hour/week defensible - relevant to the field you are working in. these are matters which will be in flux in the next few years.

Industrial report - Around the Traps

VR for hospital doctors is not established. There is a trend emerging of displacement of CMOs etc in spite of continuing deficiencies in seniority and cover - the NSW rural doctors network has 101 vacancies.

Medicare Plus for OMPs - eg Wyong is only willing to pay for permanent nights Dr - conditions - PGPPP - people are pulling out of the positions - some spaces still exist under this arrangement at present. See Ross for advice.

From Sutherland - ED had been half staffed by CMOs - a number of SAC2s in the face of changes in medical admin and staff move from St George. A FACEM who was extremely supportive to pioneering the HSP skills portfolio development process has been pushed sideways and now it is FACEM led department with more junior doctors - ASMOF delayed and negotiated an exit package - note lack of clout from CMOs in ASMOF, in spite of Ross and Michael regularly attending to fly the flag.

From Hawkesbury - the hospital has recognised that there are no regular supply hospitalists in the pipeline - has turned to a JMO rotation model - various people have been redeployed to other areas in the hospital to facilitate registrar rotations form Nepean - market forces meet contextual forces. Nights will still be nights and after hours.

From Canterbury - the previous director - not going to recruit any more CMOs - we can now have regs at a cheaper rate.

From The San - Regs and JMOs cheaper. Had to maintain workforce - tap into speciality to supervise the registrars on duty. Interesting developments in supervision there - now a teaching hospital - need to maintain that credibility by rotating through ED etc.

From Psych - Ron has been co-opted to be on the on-call consultant after hours - in D&A - consultant behind him somewhere - he's covering the call for $2/hour - (remote recall by technology precedent in radiology - for payment). Still doesn't have admitting rights at those 3 hospitals - 2 days a week - weak point in the award - in consultant level roles - back up to a full time nurse. We must be due for another round of negotiation and needs to be updated …

Industrial from ASMOF - 'potted report' - Award up for negation - ongoing problem with superannuation contribution - 2.5% increase for 3 years - increased employer contribution - went to Supreme Court - knocked back by the arbitration commissioner - 2.7% increased. Only a relative capacity to argue in the courts. Appeals to follow.
QLD specialists situation continues to emerge - following closely .
ASMOF and northern beaches, and another wretched public private partnership ….

With interest we note that the AMA is stepping back from its industrial role - won't join the arbitration at this time. Interesting.

Website report
Web Site Report - still getting a trickle of adverts - which offsets the cost.
$133/yr for hosting and a token fee for the URL. It comes up in top 10 positions on google search for career medical officers
Since it is a .org = non profit
Dave willing to continue with it. (Ron - login is on some pages only.)

Election of Officers
All officers elected unopposed who were willing to continue in their roles.

Free Wheeling Discussion on the topic of possible futures

We have had links of a transient type with ACCRM int he past and much of their philosophy resonates with the self determining nature of CMO as a career.
There was strong interest in ACCRM membership at one stage - However Geoff Adien president changed to Richard Murray, who has more of an academic bent and not apparently as responsive to our experiences. Steve Markowsi achieved ACCRM - proving that the very difficult process can be navigated, but then perhaps they now have enough applicants.

ACCRM - Gabrielle will be seeing Richard Murray and keeps on friendly relations - has a lot of links in QLD in the public service space.

The College options - sounds good - we have now established that there is an intellectual property and way of working that defines us - in The skills of system thinking and in the CanMed domain of Collaboration, however it is several million $ to run College programs, which are funded from government and membership fees.

Tom - the experience in palliative care physicians was investing in undergraduate teaching to develop interest in their craft group. *(ed -Hospital medicine as an emerging speciality is all about doing the critical stuff that no-one else wants too..)*

Tom - change management - deferring the question does nothing - need for a 10 year strategic plan - things are very fluid at the moment.

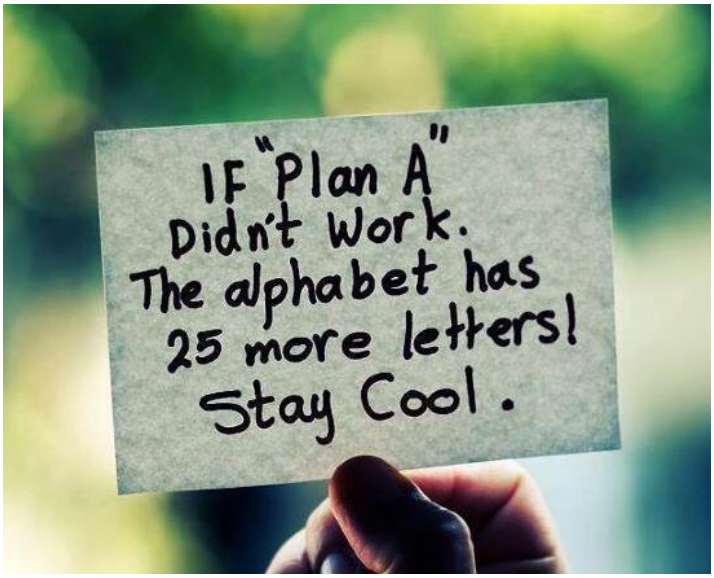
Michael - when consolidate - under whose umbrella? - discussions with college of physicians - possibility of alignment - need to make a decision - intensive process - what do we want to achieve - and how to set about it - threat of other entities - appropriating the assists you have .

Gabrielle - other option is as clinician managers in RACMA - unless doing clinical medicine - debate and division about this direction in the college - applicability to their domains are as using adult learning principles - training to demand - understanding local needs - define us as adaptable - as team players - Entrustable Professional Activities.

Simon - we have a cultural barrier - makes us reluctant to start telling our colleagues what to do - we are fundamentally not like the other colleges, we are about inclusion, local learning, collaboration and systems thinking. Even when working in special fields we have the upstream/downstream perspective that continuity roles naturally engender.

New name - Continuity Medical Officers?

Looking for the next iteration.



From Haroon

ASCMO Life of CMO study

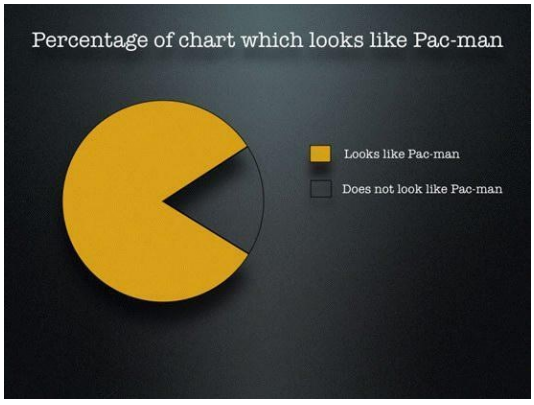
We have been having discussions about doing a bespoke survey to look into the current workforce contribution composition and career aspirations of the CMO's / Hospitalists.

It has been some time since this was attempted, and as we have seen , the environment has changed dramatically for both better and worse.

The editing of material is almost complete and the details of distribution, sponsorship and evaluation are being worked on at the moment.

We want to better understand and represent the views and experience of our professional group - so this will be an opportunity to have your voice heard.

Please participate as fully as you can when the invitation reaches you.



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Opinion Editorial : Mohamed Haroon

Transforming Healthcare Delivery through the Hospitalist Model of Care - A Call to Action

Introduction

An ageing population with an increase in prevalence of chronic diseases, funding constraints in the light of burgeoning healthcare expenditure and demands for greater accountability for safety, quality and healthcare efficacy underline the need for generalists who will be able to provide comprehensive continuity of care across institutional silos and enable safety and quality within our healthcare systems. A new category - Senior Hospitalists - have been created (NSWHealth, 2011) to have a system wide perspective on patient care and a strong training background in quality and safety. However major challenges preclude their meaningful adoption within the Australian healthcare system.

This article seeks to highlight the current challenges that preclude implementation of the Senior Hospitalist model of care within our healthcare systems and offers possible solutions that would enable greater uptake of this role.

The need for a transformation in models of healthcare delivery

In their article (Swensen et al., 2010) posit that the healthcare system today is broken as a consequence of being a cottage industry of non-integrated dedicated artisans. Autonomy is hard wired into such systems and consequently patient care is variable, largely unmeasured and standardised processes regarded skeptically.

Over emphasis on local autonomy in the face of an explosion of medical knowledge has led to an increasing gap between current practice and established science. Consequently, there is overuse of diagnostic services - such as radiology (Shaw, 2012), pathology (Pathology, 2012).

Despite evidence that compliance with evidence-based care processes can lead to improved clinical outcomes (NICS, 2006), studies (Grol & Buchan, 2006) clearly show that availability, dissemination, and even awareness of evidence-based approaches do not guarantee their application.

All of the above, have contributed to significant variations in clinical practice (Kennedy, Leathley, & Hughes, 2010) resulting in avoidable complications and costs.

In addition, a metastatic culture of medical specialisation in the context of an increasingly ageing population with multiple chronic diseases has resulted in care that is inefficient and fragmented (Schoen et al., 2004) (Collins, 2014). This is turn has contributed to redundancies and inefficiencies that continue to exert disproportionate pressures on our ailing healthcare systems.

For instance, patients in emergency departments, may need to be referred in-turn to several suspecialties before being accepted for management (Newnham, Thompson, Jenkins, & O'Brien, 2009). The resulting delays in bed allocation and consequent overcrowding of ED have been shown to be associated with increased mortality. (Peter C Sprivulis, 2006)

Consequently, we need doctors today, who, as generalists, will be to provide personalised and comprehensive continuity of care across medical specialities (Barnett et al., 2012). Their strong background in safety and quality should help them promote standardisation, minimise clinical practice variation and enable explicit strengthening of governance within our hospitals and healthcare systems.

They would encourage flexible thinking in designing new work practices that embrace technological innovations (e.g. mHealth and integrated digital healthcare platforms) that enable measurement of patient centred outcome measures (Gabriel & Normand, 2012) and facilitate innovations in care that would be preventive, personalised and cost efficient (Varnfield et al., 2014). And by virtue of their leadership skills they will promote linkages and connectedness across inter-departmental silos and empower action. (Dowton, 2004)

The NSW Health Senior Hospitalist Initiative: The Leaders are here

The NSW Health Senior Hospitalist Initiative was designed to proactively support the growth of a such a highly skilled generalist workforce which would respond to the changing profile and care needs of the patient by providing 'coordinated and efficient care across disciplines'. (NSWHealth, 2011). The Initiative is supported by the Master of Clinical Medicine (Leadership and Management) (UoN, 2013).

The Senior Hospitalist Initiative is a two-year part time program for experienced non-specialist doctors which seeks to leverage their corporate knowledge through a substantial workplace component and (UoN, 2013) equips them with advanced leadership skills to help interpret complexity lead successfully in uncertain times (Dowton, 2004) provides them with a hospital wide perspective to help them provide personalised and comprehensive continuity of care across medical specialties (Barnett et al., 2012) trains them to be effective communicators to empower them to co-ordinate care by building linkages across silos both within and external to their healthcare systems (Dowton, 2004) gives them the skills to conduct research based system redesign to enable safety, quality and minimise clinical practice variation with institutions.(Dowton, 2004) teaches them the skills required to enhance the education experience of the junior doctors (Gleason, Daly, & Blackham, 2007)

The Medical Portfolio Program Review (Collins, 2014) highlighted the need for greater emphasis of generalism and generalists in an era of increasing demands from the healthcare system from an ageing population with multi-morbid conditions and changing expectations of professionalism from the general public. (Cruess, Johnston, & Cruess, 2002)

Professor Dowton (Dowton, 2004) in defining such generalist leaders emphasises the fact that "clinical mastery or eminence in discipline-specific research does not necessarily translate into an ability to lead". He further underlines the urgent need for a medical leadership that "would be able to create effective linkages with other healthcare professionals healthcare system managers and the stakeholders in the general public at large. Such leaders should be able to interpret complexity so that their institutions can operate successfully in uncertain times."

Consequently, the Senior Hospitalists with their hospital wide perspective on patient care that enables them to provide comprehensive continuity of care across medical specialties, their ability to coordinate care by building linkages across the acute/community care settings, and their understanding of organisational culture ,networks and infrastructure that helps conduct research based system redesign towards designing innovative work practices - -- remain the natural claimants to the role of Generalist leaders that the system desperately needs.

Hospitalists in Australian Hospital Practice - Challenges in implementation

Despite the above, significant misconceptions preclude the implementation of a Senior Hospitalist Role within our health system in any meaningful way.

In their article Macdonald et al (MacDonald, 2006) view the Hospitalist initiative as being "born out of a workforce crisis in the provision of healthcare" and express concerns about the potential "dumbing down of the hospital medical workforce" that would be comprised of "potentially unsuitable medical practitioners". In addition, they view hospitalists as "practitioners of a lower standard" (MacDonald 2006) requiring supervision from their physician colleagues.

Such perceptions offer little recognition of the fact that the candidates in the course were practising non-specialist doctors within our hospitals, emergency departments and intensive care units who were involved in many years of unsupervised practice, often under demanding conditions. It also ignores the strong training background of Hospitalists in enabling safety and quality in comparison to their specialist colleagues. Sadly, such fallacies continue to inform the debate around Hospitalists in clinical practice.

Consequently, the current career pathways for the Senior Hospitalist are limited to working in roles in rural and smaller metropolitan hospitals under the supervision of physicians who have little in the way of training in change management or fostering a culture of quality and safety. This makes any form of meaningful leadership role in enabling quality and safety both improbable and unrealistic.

And finally, such misconceptions have led to denial of full specialist awards to this group and this deprives them of the benefits of pursuing continuing education in the form conferences that their specialist colleagues are privy to.

All of the above make it unlikely that the Hospitalist Pathway will be viewed as an attractive career pathway.

Transforming Healthcare Delivery: Implementing the Hospitalist Model of care

Whilst the Garling Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals (Garling, 2008) recognised that 'Hospitalists have an important role in co-ordinating the care of a patient who has needs which cross the boundaries of individual specialties. The aforementioned challenges highlight the need for a better informed and thoughtful discourse on developing frameworks that would allow implementation of the hospitalist role, better define their part within our health systems and establish ongoing mechanisms for their accreditation.

This should include

° institution of workflow modelling assessments to quantify the contribution of current hospitalists to patient care and offer recognition of the fact that most hospitalists are involved in unsupervised work often under demanding conditions

. leveraging the training of the hospitalists in having a hospital wide perspective on patient care to facilitate partnership between the LHD and the Ministry of Health in the implementation and ongoing monitoring of Ministry of Health initiatives such as Whole of Hospital Program (NSWHealth, 2015) . using their understanding of organisational culture, leadership and management skills to foster robust relationships between the LHD and the NSW Pillars of Health towards establishing best practices and developing innovative models of care. This would be consistent with recommendations of the Medical Portfolio Review Program. (Collins, 2014)

. leveraging their strong training in quality, safety and management in facilitating implementation of National Safety and Quality Health Service Standards within the LHD's (ACSQHC, 2011)

. utilizing their strong their training in teaching and consider them for positions like DPET towards enhancing the learning experience of our junior doctors . enabling ongoing accreditation mechanisms of hospitalists through multisource feedback and regular practice review by measuring their performance in enabling safety and quality within their healthcare systems. Such forms of accreditation would be superior to CPD based recertification methods followed by the colleges and ensure the highest standards of healthcare delivery. (Paterson, 2012)

. appreciating the contribution of hospitalists to enabling cost efficient healthcare systems by applying remunerations that would mirror those of their specialist colleagues. It is unlikely that being a hospitalist will be seen as an attractive career without a wage structure similar to the staff specialist.

Epilogue: A Call to Action

It is nearly a decade since the untimely passing of 16-year-old Vanessa Anderson as a consequence of respiratory arrest from the depressant effect of opiates administered to her. The subsequent damning indictment of our healthcare system by NSW Deputy Coroner Carl Milovanovich (Milovanovich, 2008) led to the recommendations of the Garling report advocating the establishment of a Hospitalist Role - to enable quality and safety within our healthcare systems. It is indeed sad that the implementation of this role has been bedeviled by misinformed debates and political point scoring.

This highlights the urgent need for a better informed discourse that would recognise the need for Senior Hospitalists towards enabling cost efficient high quality care within our healthcare systems and make the greater adoption of this role possible.

In Professor Dowton's words (Dowton, 2004) "This important work awaits us -- let us begin”.

We owe it ourselves and our healthcare systems.

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