ASCMO Times

Newsletter of the Australasian Society of Career Medical Officers

July 2017 ISSUE

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The World Has Changed …

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Is it possible for CMOs to Prosper?

2017 - The year we recognise that Burnout is not a symptom of Mindfulness Deficiency …

President's View

by Michael Boyd

Hi Guys,

We have had yet another interesting year - industrially in helping to save yet another bureaucratic snafu, assisting the the unions to fix the CMO overpayments scandal, in continued involvement in educational matters - and Oh Yes - in coming the realisation that the world has changed, and we can no longer afford not to support the birth of a College of Hospital Medicine.

We need this to help the guys coming behind who want to do the work of a CMO and who need to get the training and support in a very different environment than when we trained. We need this for continued jobs. We need this for all our own continued support. What we also need to find a voice and structure that lets us do it in our own fashion - and you will read some exciting ideas and analysis inside this journal.

Welcome to another year!

On Being a CMO - the art of the Journeyman

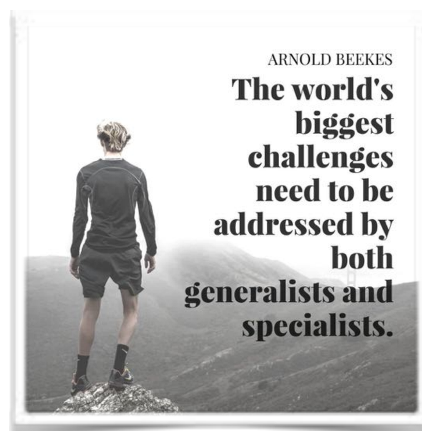
In older parlance the journeyman was someone, who having served their apprenticeship, was able to cease indentured labour and earn a daily wage. They had transferred from being a trainee to a trusted craftsman, needing minimal supervision and able to manage their own day to day work. Much of medical practice fits the journeyman model and some elderly retirees may remember this to have be the norm rather than the exception in how doctors learned their craft. The Guilds that controlled this process sooner or later morphed into the Learned Colleges, who now control the process though a series of barrier exams and gated access.

One of the major differences for the CMO is that we still regard the journey as being of major importance - the overall attitude remains that learning never stops and expertise continues to develop on the job.

Also of basic tenants is that the answer to difficult questions - the capacity to deal with the moment of great import is often already "in the room" - that is a team approach with whatever team is about, often provides a solution that is novel and appropriate.

It is very exciting to be on the cusp of a new venture. As we wend our way slowly and thoughtfully towards to the need for a more collegiate existence we are well served by these approaches to Practice - the solutions suggested are both novel and appropriate without forgetting to give a nod to our deep past and highlight the journey as much as the destination.

Yes it may be rather daunting and potentially tiring. To do this will need not just determination and strength of purpose but also a body capable of giving time and labour. But this is now the task we must do and like any good CMO, we will do it in true journeyman fashion with a combination of skill, goodwill, new ideas and - dare I say it - a collegiate approach!



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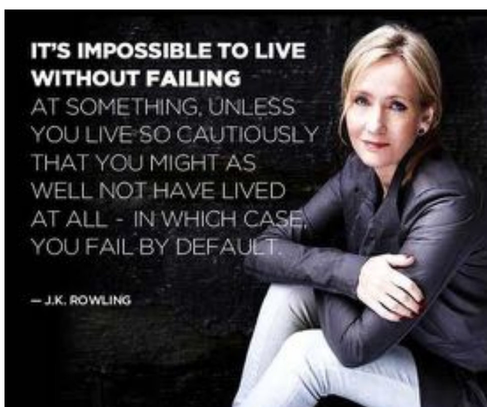


Editor's Personal View

by Mary G.T.Webber

Harry Potter is 20 years old this year - and so are we.

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

Yet the task continues to feel incomplete - as if the two steps forward are inevitably programmed for the one step back. The technological solutions we dreamed of - the technical capacity to bridge distance and separation - are now a reality. One of my consultants teaches trauma systems in another hemisphere using You Tube. Doctors use WhatsApp to provide encrypted co-ordination for their major incident responses, cutting waste and duplication, and promoting cohesion when it absolutely matters most. These days we all carry that spare brain in our back pockets, so we can follow the airway debate at Das SMACC on Twitter. We don't have to miss a thing - and yet… and yet…

While teaching tools we fantasised about are all around, It seems time for meaningful purposeful action is in ever shorter supply. I know I feel over committed. Over connected. Over stimulated. Under engaged. Atomised. And I don't think I'm alone.

I suspect that we in health are now so overwhelmed by the demand to go faster go faster, that we switch off in self defence, using the flow of distraction to anaesthetise our discomfort. I now see people at work on their phones during the orientation, during teaching, during a handover, in theatre. I pass ward rounds where the intern stands at a screen on the other side of the room, typing like a crazy person, trying to catch up, in a total vacuum of bedside teaching because the emr2 made everything slower and the network keeps freezing and losing the notes, and something had to give.

And here comes e-prescribing. Lordy me.

Or it is time to take the biggest riskiest step of all and declare that working on the system itself is a legitimate task for doctors? To declare that we've thought about it and that Hospital Medicine really is a Thing. The thing that bridges all the different professional silos, that values collaboration over all, that knows the special patients as they cross between their community and the hospital. That supports the junior doctors who will never make it through a barrier college exam to find their feet and develop their dedication and practical knowledge into a recognised, valuable part of keeping the place running safely.

Is it time to step up with a completely different notion of what a College could be?

I don't know. I truly don't.

So we invited some opinion pieces from our longest serving members. And here they are. As CMOs we have dared to be different. We just get on with it. We are not usually 'political', and although many of us have fellowships, we don't often join conventional medical hierarchies.

So if there is a different future to be made for such as we, what should it look like? And would you come too?

INDUSTRIAL REPORT 8th July 2017

Ross White. Vice President ASCMO and Industrial Officer - News and Views

1. Update from the NSW Senior CMO Grading Committee: approx. 30 applications have been received in the past year. Most are from northern NSW. Applications are usually successful if information for criteria are correctly supplied, so some applications are sent back to be revised by the applicant. The Committee meets by teleconference depending on availability of MoH staff. ASMOF has Bob Morgan on the committee.

(Career Medical Officers can, on application, be regraded to the 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, as the process can be a long one.)

2. Employment opportunities. Currently www.adzuna.com.au has 85 NSW CMO positions advertised as of 18 June 2017.

   Many are locum positions paying $145/hr plus fares and accommodation for short term ED/Wards/HDU. Some jobs are up to $170/hr. The adverts describe a lot of the jobs at the level of senior registrar/CMO without specifying senior CMO. Some are for rural public hospitals EDs/ wards for up to 12 months contract at award rates with no mention of possible senior CMO grading. There are private hospitals looking for ward and HDU CMOs. With only two private EDs in Sydney, one being The San which now gets its own interns and trainees, there are certainly fewer opportunities for CMOs in the NSW metropolis.

   Adzuna also lists 12 CMO vacancies in Victoria, 2 in Tasmania, 1 in Qld and 9 in WA. None currently advertised in SA on Adzuna.

   In SA - in 2015 the SA government announced plans to reduce the 6 EDs in Adelaide to 3, but all are still open and the QEH is to get a new ED as part of a $250 million dollar upgrade being announced in a pre-election budget.

3. The privatisation of NSW public hospitals. The 488-bed Northern Beaches Hospital at Frenchs Forest is to replace the Manly and Mona Vale hospitals and is slated to open in 2018, with some staff to migrate there this year. A huge development is happening in and around the site. Mona Vale will stay open for some non-urgent services but the Manly site will close. The private operator of the Beaches has not given much information about how the hospital will be staffed after the first 2 years when the staff transferring will continue under their current awards.

   The Government is promoting the privatisation of several other hospitals and the local communities and unions are opposing the move. While there could be opportunities for groups of CMOs to contract medical services to private hospitals, like groups of intensivists do now, such a group could be hard to implement and manage, and there would be strong opposition from other medical organisations re loss of training positions and changes to the structures of teams.

4. **The vexed question of the 17.5% annual leave loading for NSW CMOs**. Someone in MoH decided that it would be a good idea to no longer pay the shift loading on penalty rates for CMOs who worked regular after hours shifts, and in fact to demand repayments of up to $30,000 from individual doctors. This caused a lot of distress to those affected. The MoH had not though it through very well, as a lot of CMOs were not aware that they were even eligible to receive the 17.5%, and had never received it on the grounds that their employers changed the roster during the leave periods. After forceful representations *(and some maths homework - ed.)* by individual CMOs and ASMOF, the MoH has now retreated and delayed any enforcement of the repayments. The MoH wants to change the award to clarify the leave loading. The MoH has indicated that only ASMOF members would be eligible not to repay the alleged overpayments. So it appears that the MoH is encouraging CMOs to join the union if they want to avoid the large repayments. ASMOF is not obliged to act on behalf of issues arising before the taking out of membership, but probably will in this case.

5. As I am now in my 67th year and facing some medical procedures myself in the next few months, I would like to hand over the industrial officer position to a younger enthusiastic CMO from our ranks.

6. My apologies for not presenting this report in person but there is an important family gathering on 8 July which cannot be changed.

Financials 2016 -2017: Speaking of Money

By Ken Wilson

ASCMO 2016-2017 Accounts at June 16th

Opening Assets	2016-2017	2015-2016	2014-2015	2013-2014	2012-2013	2011-2012	2010-2011	2009-2010	Jan-Jun 09	2008	2007	2006	2005	2004
Westpac A/C Initial balance	$17,517.01	$19,845.65	$21,081.89	$21,631.16	$21,756.30	$18,942.90	$16,325.47	$17,933.46	$14,470.63	$13,999.06	$11,567.13	$17,951.54	$14,405.78	$16,498.20
Income														
Memberships +/- CPDP	$360.00	$1,549.00	$2,676.00	$2,735.00	$4,125.00	$4,100.00	$1,794.00	$6,939.00	$6,339.00	$6,708.00	$6,617.00	$7,512.00	$5,798.00	$5,715.00
CPDP		$55.00								$930.00	$1,045.00	$1,045.00	$1,210.00	
Annual meeting		$100.00					$7,560.00			$800.00	$450.00	$420.00	$315.00	
Website ads	$300.00	$2,200.00	$1,800.00	$450.00	$300.00	$2,100.00	$1,300.00	$1,100.00	$700.00	$1,800.00	$2,025.00	$2,125.00	$875.00	$2,400.00
Repayment dishonour fee												$9.50		
Interest	$13.19	$18.23	$56.50	$56.61	$79.37	$76.90	$63.41	$52.09	$30.30	$90.43	$91.04	$65.70	$103.35	$82.85
Advertising										$450.00	$150.00			
Total Income	$673.19	$3,922.23	$4,532.50	$3,241.61	$4,504.37	$6,276.90	$10,717.41	$8,091.09	$7,069.30	$10,778.43	$10,378.04	$11,177.20	$8,301.35	$8,197.85
Expenses														
Secretarial services													0	$1,109.11
Julie Woods												$4,075.79		
Cathy Cordi	$180.00	$510.00	$315.00	$285.00	$705.00	$480.00	$1,755.00	$2,008.00	$1,080.00	$2,917.50	$1,642.50	$4,800.50		
Insurance	$588.36	$576.84	$556.14	$543.76	$533.10	$522.66	$512.40	$512.40	$512.40	$512.40	$512.00	$488.00	$470.10	$470.10
Office Rent	$2,000.00	$1,333.28	$2,499.94	$2,000.00	$1,499.99	$2,166.55	$2,166.64	$1,833.30	$833.33	$999.97				
accountant/FairTrading fees			$86.00	$336.00			$48.00	$75.00		$45.00				$297.00
Stationary/mail/computing	$100.00	$43.48	$615.00	$39.70	$185.25	$197.95	$625.68	$872.05	$257.25	$853.94	$455.07	$948.31	$149.88	$459.00
Printing												$282.50	$852.00	
committee expenses														$476.00
Bank Expenses												$9.50		
Phone industrial officer										$90.00	$115.00	$390.42		$207.25
Executive travel													$302.00	$241.00
teleconferencing		$328.61	$272.15	$17.60	$26.40	$120.35	$109.60			$50.34		$338.59		$2,277.34
Website expenses	$1,083.10	$168.06	$683.10	$743.10	$133.10	$855.00	$762.50	$1,428.50	$423.50	$1,078.50	$1,673.50	$1,978.50	$423.50	$1,642.82
conference expenses/sponsorship		$800.00	$1,500.00		$750.00	$750.00	$750.00	$750.00		$750.00	$2,343.75	$112.00	$750.00	$750.00
Annual meeting		$1,502.00					$1,790.18	$2,219.83		$3,509.20	$1,203.89	$4,142.36	$1,808.11	$2,360.35
Refund Membership + CPD			$175.00		$230.00									
Total Expenses	$3,951.46	$5,262.27	$6,702.33	$3,965.16	$4,062.84	$5,092.51	$8,520.00	$9,699.08	$3,106.48	$10,806.85	$7,944.71	$17,566.47	$4,755.59	$10,289.97
Net Profit	-$3,278.27	-$1,340.04	-$2,169.83	-$723.55	$441.53	$1,184.39	$2,197.41	-$1,607.99	$3,962.82	-$28.42	$2,433.33	-$6,389.27	$3,545.76	-$2,092.12
Closing Assets														
Westpac A/C Final Bal Cal	$14,238.74	$18,505.61	$18,912.06	$20,907.61	$22,197.83	$20,127.29	$18,522.88	$16,325.47	$18,433.45	$13,970.64	$14,000.46	$11,562.27	$17,951.54	$14,406.08
Westpac A/C Final Bal Actu	$14,238.74	$17,517.01	$19,907.30	$21,081.89	$21,631.16	$21,756.30	$18,942.90	$16,325.47	$17,933.46	$14,470.63	$13,999.06	$11,567.13		
Discrepancy	$0.00	$988.60	-$995.24	-$174.28	$566.67	$1,629.01	$420.02	$0.00	-$499.99	$499.99	$1.40	-$4.86		
		Cheques for $61.65, $666.64, $266.95, = $995.24 presented from last year	Cheques for $61.65, $666.64, $266.95, = $995.24 not yet presented	Cheque for $610 not presented yet	Cheque $1000.00 late from last year. Cheque $333.33 not yet presented	Cheque $420 late from last year. Cheque $1,000.00 not yet presented	Cheque $420 presented late		*Cheque $499.99 presented from previous accounting period	*Cheque $499.99 presented after accounting period				
Finacial Members	4	27 at AGM	?21	20	29	42	52	52		58	55	63	28	
CPDP users	0	7 at AGM in July	?6	7						?17		18	19	

But wait - there's more - the MOH supported the Masters of Clinical Management at Newcastle Uni for CMOs - but no-one seems to have been re-graded as a result…

A CMO College : A SWOT becomes a Call to Arms - Opinion Piece

by Tom Salonga

The melting iceberg is now an icecube- has the water reached boiling point for the frogs in the pot?

I was asked to write a SWOT analysis about the formation of a CMO College.

2011-
I am reminded that Dr Steve Markowskei wrote about this question in 2011, published in this journal.

I summarise his points below:

1- Training without recognition is pointless
2- The Commonwealth Government is making fellowship mandatory
3- There will be little incentive to employ and train CMOs
4- Nationalisation of Registration

"Without a specialty college the viability of the CMO/Hospitalist as career choice will end. Despite a significantly more robust training system now being woven around us, CMOs will become increasingly marginalised and remain the non-formally trained and unaccredited members of the health community… I believe this will happen surprisingly rapidly, perhaps in the next 5-8 years, as the above pressures prove unrelenting."

Now (6 years later):

The Masters Programmes for Hospital Medicine has now seen 6 years of alumni- perhaps attesting to the interest among non-specialists in the value of scholarly learning.
The Hospital Skills Program was another initiative for CMOs to be supported in ongoing learning and credentialing.

Although this has translated to better outcomes for the patients under our care, and advantaged the organisations we are employed by, the actual CMOs are not as clearly benefited.

There are no new Medicare item numbers for "Hospitalist" consultations, yet there are now a whole slew of "nurse practitioner" item numbers that exceed the non-VR GP medicare rebate.

We face the reality that it is expected that HETI (the Education arm of NSW Health) will soon truncate its focus and support to the "unprecendented numbers of local graduates" (as Markowskei previously predicted) that are now needing to be accommodated within the NSW Health System.

And still there have been no responses to how the "thereafter" (5 years and above post graduate) will be supported.

An HSP program trial being run in a peripheral Southern Sydney hospital was terminated as that hospital decided to phase-out CMOs from their hospital.

The maximum CMO grade 3 has been severely rationalised within health services, and there is no longer any uneasiness about discussing how we can replace thereafter CMOs with RMO2s (even if we have to source from the Asia-Pacific regions suitably qualified practitioners).

Who validates and credentials the generalist proficiencies of CMOs to the satisfaction of AHPRA?

Not to mention the other CMOs/ senior non-specialists in other states?

THERE'S NO DEBATE. CMO's ARE BEING SCREWED AND WE NEED TO DO SOMETHING TOGETHER TO STOP THIS… WE NEED A COLLEGE.

It does not matter where you work in the Health System - CMOs impact the care of patients and consequently affect your work.

From the doctors who work the evening and night shifts in ED, when the FACEMs are unavailable. To the doctors that are willing to be the first-on call for neonates after hours this week – and to be on the

Yet despite local recognition of the vital role they play, there is no equity in how CMO's are treated compared to other doctors and workers that have a more organised industrial/ professional representation.

OK- SO WHY HAS A COLLEGE NOT HAPPENED YET?
OR…WHAT ARE OUR WEAKNESSES?

There are many reasons for why a College has not yet been formed.

Some of the reasons are intuitive-
IT TAKES A LOT OF MONEY, TIME AND NEEDS TRULY DRIVEN PEOPLE TO CLIMB TOWARDS THIS SUMMIT!

BUT HEY!- we all passed our medical courses!
So we have shown that we can be driven people- and are willing to spend the energy, time and money (albeit a lot of us were community funded) to reach a summit!

It is possible that a major reason lies in why we are CMOs to begin with-
To try to motivate the comfortable, easily gratified, elitism-eschewing portfolio-lifestyle driven crowd (not to mention ageing…) who are more interested in direct patient care and who wish to spend their non-working time on their families or making the greater (non-medical) world a better place …
To give up precious time and energy to tilt at windmills- may seem an impossible task.

Besides- what is our turf? What is our territory in the medical landscape that is "CMO" specific when there are numerous ivory towers that mark out other specialties?

Can nomadic tribes really claim a territory as their own ?

How can we avoid the destiny of the Bedouin tribes of the Holy Land whose nomadic lifestyle which has been defiant for 3000 years is predicted to die out in a generation due to the effects of climate change rendering their grazing lands arid, and geographical marginalisation wrought by sprawling urban settlements forcing them from traditional territories.

The THREATS-
Akin to the Bedouins, a lot of the threats to CMOs are political.

The threat posed by the adversarial stance of established national specialist colleges are obvious.
In the absence of a peak national body, CMOs are not able to assert a seat on the table when discussions take place on national issues despite our input being just as relevant and useful as other organisations.

Less readily appreciated are the threats posed by CMO segmentation and the internal political naivety and inertia of the CMOs specifically as it relates to activism,.

Audience segmentations - or the reason why if you've met one CMO - then you have met only one CMO.

The pluralistic, pleomorphic nature of CMOs mean that there are differing experiences of each and every CMOs, and different motivators and dissuaders exist for different CMOs for organising to a College.

There is no one-size fits all reason for organising to form a College, there are plenty of strategies and plans, and each has a pearl embedded in them.

CMOs have learned to be resilient and adopt a strategy of remaining under the radar (do your work well so nobody complains, do not make a fuss, be liked by everybody because then they are more likely to feel bad if they have to do something unpleasant- like making you redundant, or deny your entitlements).
This stance has even been manifested to pockets of CMOs declining outreach from ASCMO - they are happy to exist in their own pockets hidden from the exposure involvement in a larger organisation would create - UNLESS THEY HAD A PROBLEM.

SO NOW WE ALL HAVE A PROBLEM AS UNPLEASANT THINGS ARE HAPPENING EVERYWHERE - and maybe, CMOs are beginning to sort of care/ worry about THIS ISSUE OF A COLLEGE, but hey- leave it to somebody else with more time and interest. Maybe go looking at other career and livelihood options.

Or maybe experience a low level feeling of dread while continuing to ignore the issue. Or get too wrapped up in that dread and suffer from anxiety. Then maybe just resign to fate and go on with life.

However, to paraphrase Aragorn - "That day is NOT THIS DAY"!

HOW DO WE TALK ABOUT THIS STUFF - OUR OPPORTUNITIES

As a result of the efforts over the past 15-20 years on the part of certain esteemed CMOs, there now exists a reasonable basis to claim our patch of the medical landscape.

The Masters degree curriculum may form the basis of a scholarly requirement for inclusion into a college.

There are still involved CMOs that have experience, skills and interest in forming a College.

We need to agree on a clear purpose for the College, its reason to exist, and an achievable goal the College can aspire towards that we can communicate again and again.

We should talk to everybody:

CMOs -those that are currently working as CMOs or will work as CMOs in future (but do not know it yet) who are concerned about the future

Doctors with a Techy bent and start-up character -type streaks- especially recent medical graduates or students who may have had other careers prior to medicine.

Doctors who may have wished to join a CMO College that are currently fellows of other Colleges.

Established Specialist Doctors who value you as a CMO colleague as well as a person .

Opportunistic comfortable CMOs who might care (AKA- everyone else). CMO's significant others and home managers

Health system bureaucrats and Health Educators and Academics. Angel investor types (individuals or organisations)

Health journalists/ bloggers/writers, creatives, and marketing types

We do not know if one of these groups provide the tipping point and turn this idea into a large groundswell that finally jolts CMOs into action. Maybe.

But we need to start soon, and start to approach it from all angles.

BTW- if you have read this and feel that a CMO College is something you would like to see happen- or think that you have just wasted your time PLEASE- muck in, comment, add more detail, supply corrections, explain why this is a fantasy- WHATEVER.

A CMO College : A Brave New World at Last - Opinion Piece

by Gabrielle du Preez Wilkinson

… Traditionally medical services have self-organised either by craft group (cardiologist , gastroenterologist, etc), or by geographic location - e.g. General Practice, Emergency Medicine, Anaesthetics - which all exist in predefined physical spaces. But who bridges the whole clinical/organisational spaces in hospitals? Who grows the local systems for clinical conditions that need a system response, like delirium and end of life, conditions that occur in many different teams without being the business of the specialist team? When/where there may not even be a specialist team to consult? Who is there long enough to be the maestro of your local systems and the keeper of the expert workaround? It's time to develop a specialty to bring it all together, Hospital Medicine. (ed.)

After some (more) spirited conversations, a revived plan to advocate for an Australasian College of Hospital Medicine (ed) is back on the agenda. Membership could include current CMOS, SMOs, and SRMOs in non-training jobs in public and private hospitals across Australasia. Pretty much everyone who currently doesn't belong to a college with their interests at heart, is welcome here. The option of interest groups within the College will likely develop over time.

The Curriculum so far is based on the NSW Hospital Skills Program, which sees our skills in wholistic terms - in Entrusbable Professional Activities rather than as tick boxes in lists of unrelated tasks. This real world approach was initially advocated and published by ASCMO members, and recognises a 3 tiered format of skills based opportunities to advance across as is needed/wanted/relevant. We are thinking these often neglected doctors are in fact the versatile conductors of the hospital system, coordinating across specialties, bringing back generalism/system thinking into the hospital component of the heath care system, whilst respecting the super specialists including our GP colleagues, with whom we would also coordinate. *(And we'll never, never use the words 'please chase" on our discharge letters. Promise - ed)* As well as providing practical support for juniors, we are versatile, and provide capacity fill for the holes in the organisation's clinical and management fabric, including clinical governance and educational roles.

The Australasian College of Hospital Medicine, thus defines Hospitalism as an inclusive philosophy of clinical medicine that incorporates the art of differential diagnosis and diagnostic reasoning, as well as the sciences of network theory, and human factors, and the arts of collaboration, implementation and innovation. Its practitioners are experts in understanding and problem - solving in their local environment. It is a philosophy that may lead the interested clinician on an often meandering pathway, covering many disciplines, seeking different perspectives across a lifetime. Hospital Medicine works collaboratively with other disciplines. Hospitalists are not competitive with other specialties, and seek and value the specialist knowledge of colleagues from other colleges. It is a college with a 'servant leader' mentality, advocating for juniors in the after hours, acting to provide the putty in the mosaic of modern medicine, filling gaps in the health system that can cause clinical harm to patients and staff alike. Hospitalism putty provides strength, support and ensures smoothness and aims to provide continuity for patients in a chaotic, busy and often fragmented system.

This College would work on a portfolio system of credentialing and assessment. Thus, academic parts of portfolio could include Hospital Skills Program, Masters programs of various hues, and formal training in network theory, human factors, patient safety and understanding the other medical Colleges. Clinical parts of their personal portfolios could review the lessons of different clinical exposures and terms. CPD should be self-directed and should reflect your areas of expertise and training, and be based on minimum 50 hours per year, through a variety of online, face to face, and practical maintenance of skills.

There is an opportunity to create a brave new world through our usual leadership and uniqueness. Bring on the future!

BTW How to comply with AHPRA

There are two levels to this situation.

AHPRA compliance (in my understanding) requires appropriate qualifications, honesty, maintenance of skills (either through College or self regulation), medical indemnity insurance, and working within personal competence or credentialling limits.

If one is in self regulating education, generally 50 hours per year of appropriate education is seen as appropriate. None of this means that one is safe from patient or colleague complaints. Good record keeping and data will protect you to a degree if/ when a complaint arises. And, unfortunately, professionals are still assumed to be guilty until proven innocent by regulatory bodies of all colours.. Call a friend if this happens, and keep your own sanity at all costs.

ASCMO's Website Report for 2017 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.

usename = ***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 <u>YOUR</u> benefit and <u>PARTICIPATION.</u>

David Brock
ASCMO Website Co-ordinator

Best Conference that I Need to Tell You About Award - Outside the Box

by Gabrielle du Preez Wilkinson

When it was necessary to go to Las Vegas in March, to support one of my family, I decided I would find a conference to attend whilst there. So, after trawling through the Internet for a while, I found something that seemed appropriate about Chronic Health Issues, aimed at generalists, run by an organisation called Contemporary Forums. Booked a ticket and headed out there.

This was the best decision I have made for ages...
Officially, it blew my mind!!

So, the first day I attended two half day intensives: the first was in diabetes; and the second on obesity. These were amazing. The 'Diabetes Intensive' actually explained a whole new model of looking at diabetes and its complications, as well as explaining all the different classes of diabetes drugs and WHAT THEY DO in a manner that I actually retained it. Mind blown. In the afternoon, the 'Obesity Intensive' highlighted that obesity is a disease, not a moral failing, not just laziness and eating too much food; that it is a sub speciality in US; and that there are lots of billing options in US (maybe I didn't need to know this?).

The other thing I found out on this first day is that in America even generalism is sub specialised. Most of the generalists present were Nurse Practitioners, with some Physician Assistants, GPs, and general physicians scattered in the crowd. It appears that, probably due to economies of scale, most of the GP type work in Australia is actually done by NPs in USA, sometimes in a piecemeal manner, and sometimes more holistically, especially in more rural areas.

The attendees were all very welcoming, open, interested in different perspectives and helpful in answering queries. The absolute numbers of medications available in America, for diabetes and obesity on this day (and other areas on other days), was amazing, and many of them I had never heard of. However, each of the drug classes mostly had a representative drug available in Australia. Also, all the presentations were obsessive about being evidence based, being current, and declaring any possible biases, to a level I have rarely seen in Australia. One of the sessions was seen to be too commercial and not adequately evidence based, so those points were deducted from the conference, and online options to make up points were made available to us all.

Day two and three were this amazing blur of intensive information. Essentially, over the main part of the conference, there were updates on virtually every clinical area of medicine, based on best evidence available. Even the break out sessions, one was able to download the presentations for all the break outs, and get information from the presenters later. Every session was first data on updated information from the journals, and then question/ discussion time to highlight real life challenges. It as like doing an update on my medical degree, with best current evidence available, over a few days. I was exhausted at the end!

I would like to encourage people to think outside the square. Contemporary Forums have lots of online stuff that I am exploring also. Learning with other professionals, and being one of two Australians at the conference, also provided some unique perspectives and learning opportunities. LAs VAegas

AGM REPORT - 8TH AUGUST, 2015

We gathered at our traditional haunt at the Novotel Brighton-le-Sands, to both regroup to the business of ASCMO after another tumultuous yeard.

In Attendance: Michael Boyd (President), Ken Wilson (Treasurer), Ross White (Industrial officer), Simon Leslie, Mary Webber, Michelle Metzler, Gabrielle du Preez-Wilkinson (Education Officer), Hannah Rose, Haroon Mohamed, Ron Strauss, Tom Salonga (on phone), Cathy Cordi (Office manager)

Guests: Glen Pead and Dr Mani Senthil (from HSU from 1430pm), Clayton Spencer (via phone 1500)

Apologies: David Tree, David Brock, Virginia Noel, Rami Mezrani

General introductions

The Minutes from August 2015 were reviewed and accepted. Moved acceptance by Ross White, seconded by Gabrielle dPW, unanimously accepted.

Agenda

President's Report - as read. An interesting year, and a challenging year, but still holding the belief that there is a need fro an organisation like us. The industrial issues continue but there is a need for interpretation and information dissemination for new CMOs who do not realise they need a union. Lots of issues with CMOs being pushed out of their jobs and positions then being advertised at a lower rate. When organisations like ACEm do their numbers, it appears that there are not enough FACEMs/ other specialists or CMOs for either group to provide a complete staffing complement — so need both to survive. However there is a need to change the organisation's focus for a CMO to be considered as senior replacement, not junior replacement. Finally, our belief that lots of people are not being supported is not reflected in our membership numbers.

Financial report - Moved by Ken Wilson, Seconded by Ross White, Unanimously accepted.
Started the year with $21, 000 in bank, and details are on the spread sheet (attached)
Finished year with $18 900 Again, a slowly reducing membership numbers, losing small amounts of money every year. Our insurance is public liability insurance to protect the committee
We endorsed attendance by Graham Still to the MABEL conference – receipt yet to be presented.

Secondary discussion to Finance Report:
Membership — clearly the next transition is to blogging and social media issues to increase membership base by more outreach and discussion? Do we want to re-design/ pay for/ outsource to a website to extend to blogging capability.

Membership Report /Office Manager Report - Cathy Cordi - has been in this position for 10 years,
We wish to express our collective and formal appreciation for her ongoing involvement. Unanimously supported.
100 currently on the database, with 27 memberships paid so far this year and multiple new memberships
CPD – 7 renewed this year from 27; and the certificates need to be updated; new process being trialled
Need to clean up database — possibly look at whether need to resign
For office manager to consider: Alternate methods of paying – respond electronically via Paypal – need to investigate costs and benefits this year. BPay could also use some refinement.

Secondary discussion Office Manager Report:
Many people want information but are not actually joining ASCMO. We may need new approaches — multiple options of individuals and sites who can successfully contribute. Simplest thing may be to produce a brochure for information… for prospective people
We strongly scourge people from resigning as CMOs, so not lose ongoing entitlements — some people have changed to VMO positions but then have been fired/ made redundant.
Joint memberships with other organisations need to be considered

Education Report - Remaining in a holding pattern — about 10 people continue to produce their CPD diary with Gabrielle's support. Alternately we may need to bite the bullet develop a College-type concept which is recognisable but still relevant to CMOs. (Requires significant/staggering amount of energy)
Main issues with CMOs — is that they view work in the real world, where it's not about education but learning — an organic process to acquire functional knowledge rather than theoretical. Actually needs a different paradigm. The current paradigms of curricula and assessment of MCQs, barrier exams, research requirements, etc are not real world.

Secondary Discussion to Education Report:

Joanna Flynn – has been talking about Work Based Assessments (WBA) - CMOs may be able to help consultants train for the job. eg Consultant not knowing about Between the Flags protocols.
Look at CEC discussions The system works because of CMO type doctors off bring local knowledge and continuity roles in positions trust.
However in small organisations — this value is not recognised by organisation, nor by CMOs themselves.
Kerry Parnell — Docs for Docs — interested in solutions. Option of blog with video podcasts — Tom does have a blog, which has been present for years.
There has been lots of talk about WBA and other options, but not much action in Australia to date. This may change quickly.
The HSP — Hospital Skills Program — has always been based on WBA. The Sutherland trial of professional portfolios ended up bastardised for other purposes, including pushing out CMOs!
Revalidation is also hovering - may hang on WBA and 360 degree assessments
App being developed to assess doctors in workplace…
Not in Colleges' agendas to support non specialists
Ways to explore trainees and Fellows to credential their skills
System does not provide opportunities to train and maintain many skills (Though more than it used too - thanks to the hard fought Award efforts by CMOs over the years.)
HSP and Masters should be independent of workplace… crucial to revalidation
Certificate in ED was developed by ACEM to get money for education, which was being diverted to ACRRM in QLD for industrial recognition — but now need ACRRM for money and ACEM for specialists to allow you to get job.
Industrial and education need to go hand in glove - as always. And recall that the RACGP has 20 -30 thousand members.

Industrial report - From Around the Traps: Moved by Ross White, Seconded by Mary Weber, unanimously accepted. Ross continues to attend every ASMOF meeting by teleconference — our appreciation for this effort was noted by the whole group.
Please note that on the ASMOF website one can apply for recognition as senior CMO — therefore recognition by managers of need for ability to work at that level.
Pre- emptive joining of a union is important — as they naturally won't cover if you make contact after the serious problem starts. HSU or ASMOF are both options for seniors and juniors — most juniors in ASMOF. CMOs (us) are therefore kept in the loop industrially.
HSU will be attending this afternoon.
Friends in industrial space — improving industrial profile through increasing membership
Linking ASMOF to ASCMO may be an option

- Medical intern review for COAG — individual submissions by several CMOs in the mix.
- Revalidation is coming … but no-one can say when or what it will cost.
- Pay increase about 2 percent.
- Meal allowances — in. conditions of employment review — the current allowance allows you after hours access to your non existent cafeteria; meal vouchers should be to the value of $27.70, but Drs instead may receive tokens for vending machines; difficult to get adequate food on a long shift; inadequate workplace nutrition is identified in literature as detrimental to performance.
- Tsunami of medical graduates has arrived — apparently flooding RMO positions, with no Registrar nor consultant jobs for them to go into.
- Observer ships for IMGs have been terminated
- If you have been de -registered or suspended — you will need a position as an RMO2 with a supervisor to come back to work, chaperone on some occasions. Almost impossible to find such a position.

Mandatory On lIne Training.
Currently required for CMOs and junior doctors for all 40 available modules every year — plus face to face opportunities — this clearly needs options for streamlining and sorting out — and clearly needs to be paid time — btw - unable to validate who actually performs the test if not in paid time.
HETI reviewing the situation for consultants. Stay tuned. ASMOF is quite active in this space. (HSU — the Williamstown problem pretty much killed Council of Medical Officers but interested in rekindling flames and interest)
Strategic option may be to join HSU as ASMOF has lots of juniors and consultants. The ACCC limits the Industrial Commission capacity to stop union involvement, but happy to allow extra unions representative rights.
- Hospitalists admitting rights will create thorny issues and cost a lot of energy to work through…
- The looming Australian abolition of penalty rights might be an option to increase union involvement. *(watch them coming out of the woodwork like little lemming beetles, then (ed.))*

Website report — by David Brock
A valuable resource, still available for job advertising
ASCMO—Talk Yahoo group is still the main communication for ages — and keeps communication and connectivity together — attachments help
ASCMO wishes to thank David for his constancy and maintenance and managing the ongoing funding and allowing it to be self—sufficient. Thank You.

Discussion from Website report:
Wordpress may be an option to upgrade with ASCMO—Talk Yahoo group. As for all of us, time and energy remain the issue. We note that Spring Seminar and other websites have progressively upgraded over time. Tom and Haroon both have blogs — persistent and maintenance of ASCMO website
Graham Still has most contact and information in this space.
We also own hospitalist.net.au and hospitalist.org.au. Individual columnists and blogs can fall under same umbrella.
There are now programs like SLACK that helps people do projects together.
Blogs not existent in other disciplines — and no connection between people
Issue in visibility — organisational branding will help with visibility and recognition and start conversations. Medical students don't know about CMOs. CMOs continue to be considered a dinosaur waiting to become extinct… but we still won't die. Yet.
Haroon's offer — to produce an explanation video on hospitalists and CMOs, and start the conversations. Reality is that CMOs need consultant specialised expertise and input, and consultants needs CMOs to functionalise the system. And we all need to provide mentorship needed of younger CMOs in our areas. Should the organisation happen to approve any …

NSW report covered
Qld report discussed verbally
WA not want involved
Victoria mostly in RMO sphere
SA imploding
NT and NZ and Tas — all lost contact with people
There is some talk about Generalism - which to us looks like CMOs across the system and the shifts and the out of hours and the system continuity roles, but General Physicians, General Surgeons, Intensivists, Emergency physicians all claim the title. The Rural Generalist Pathway in QLD seems to be the closest thing to getting the message out there.

Election of Office Bearers

Our Public Officer takes over the meeting — Ken Wilson offers to remove all officer positions. Accepted. Suggest all people remain in positions if they are willing. They are willing.

Therefore the 2015/ 2016 Committee Officers:
President — Michael Boyd
VicePresident – Ross White for only one more year
Treasurer — Ken Wilson
Public Officer — Ken Wilson
Education Officer — Gabrielle du Preez-Wilkinson
Website convenor — David Brock
Journal editor — Mary Webber
Office manager — Cathy Cordi
HSP representative — Simon Leslie
Ordinary Members — Ron Strauss, Michelle Metzler, Tom Salonga, Simon Leslie, Haroon Mohamed (happy to be mentored into role)
Hannah Rose would like to be an ordinary member also

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

Rate for membership - leave at $125
Contacts for different areas/ disciplines — Michelle volunteers for psychiatry, Ron volunteers for Drug and Alcohol, Tom is volunteered for Emergency, Mary volunteers for Hospital Medicine.

Things we support -
Sponsoring Spring Seminar – continue to support
Hope to have meeting for ASCMO there in September at least informally
Next meeting – around July/ August 2016
Advanced notice — there is the first Geriatrics in Emergency Medicine Seminar on April 16 in Sydney

Meeting closed 1230pm

POST AGM GENERAL DISCUSSION AND RESOLUTIONS

The MABEL report — the conference was attended by Graham Still - v useful. Graeme remains a staunch friend of the CMOs. Haroon, Mary and Michael have designed a workforce survey via MABEL.
Lots of people keen to participate in survey. HETI was asked to be involved but unable to make decision about this. They are processing data from survey. Tony Scott from MABEL has approved our survey so far.
Roles and actions of HETI more complex over time - eg CMO psychiatry survey from HETI did not go to CMOs, probably went to Directors of Service, who may not have known they had any CMOs on the books… ($1.5 million in Southern NSW for HSP, not one cent spent on CMO education). Try multiple approaches via unions, HSP directors, AMA, friendly med supers
Need governance around how we use any data that eventually arises.
Validity questions to compare with other surveys may need reframing if going solo rather than with HETI. This is a more complex question than it appears. We may (in a perfect world) be able to assist MABEL with contribution from CMOs to potentially obtain long-term data.
No one can make the non clinical time appear…

LUNCH

RECONVENE 14:30 post Lunch

1430 HSU Discussion — Guests Dr Mani Senthil and Glen Pead.

Mani has a long history in th eIndustrial sphere and used to attend with David Brock when looking at the Award in the past.
The HSU staff has changed significantly in recent years — currently 20 industrial staff - here to promote a little stakeholder engagement. Trying to rebuild union and rebuild liaison and stakeholder involvement with CMOs
Industrial expertise — award negotiated by HSU — vigorously debated in the meeting.
Encapsulate concepts with award terms and conditions; previously, if one worked 7 years continuously publicly, one could become a senior CMO with agreement both unions and department.
CMOs need understanding and support. And to be aware that federal campaigning against overtime and weekend penalty rates seems to be looming — union support and campaigns against that will be needed.
There are continuing issues with accessing the provisions of award — not due to award, but due to implementation, such as accessing conference leave and access to senior CMO status.
the HSU sees itself as a boutique union versus larger union — with more expertise in running large campaigns — currently focussed on opposing privatisation of health and other government services.
For example - currently, privatisation of childcare centre at Ryde Hospital — being campaigned against.
Campaigns are won through community engagement, leading the politicians along the way.
Risk of losing focus in big union on smaller professional groups (previously at least).
Small needs from small group of people will be taken seriously.
One main issue is to allow CMOs to be promoted to senior CMOs — maybe use this as a test case - as opposed to moving CMOs to junior positions.

1500 - Clayton Spencer - DMS Greater West -

Is doing a pilot out west in places, like Orange.
Has been exploring hospitalism and generalism for some time.
30 smaller hospitals and several bigger hospitals. Also talking to U of Syd and looking at integrated care also — demonstration site for this. Looking at 20% patients using 80% resources. The wheels fall off when patient comes into hospital, as not looking at all of these issues. Has a vision of a hospitalist as focussing on high risk patients and complex patients — helicopter view and link all resources together — focus on gaps on quality and safety as well.
U Syd is looking at academic support — what does a hospitalist look like in Australia, and then looking at whether it makes a difference… Has sourced funding from the Ministry — awaiting confirmation.
Combined with reinvigorating HSP and manners to integrate better with rural generalist model — promoting on it out west as survive on this.. Generalist stream for entire District
U Newcastle already doing survey along those lines.
Need to look at Ryde at horizontal model of hospitalism rather than vertical inside single unit
Lots of happiness that messages are finally being heard — would like to help and make sure it work

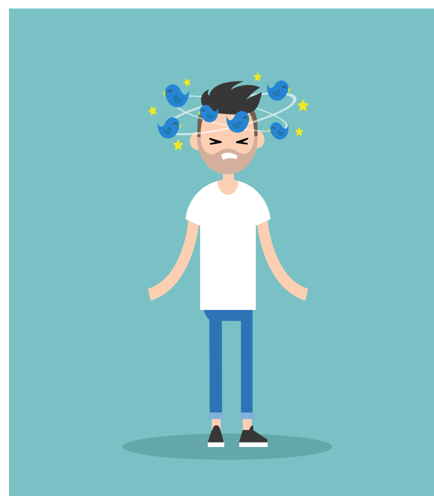
1515pm: Back to Industrial Issues

Mt Druitt has offered redundancies to all 3 CMOs Issues at Auburn and other hospitals…
Ward based team probably needs hospitalists — need to be collaborators and cement relationships to achieve efficiencies. Admitting rights is probably a furphy - will draw a lot of antibody response, soak up a decade of debate - and distract from moving freely about the system.

Opposition for hospitalists — from staff specialists, junior doctors, junior managers
Perhaps we should consider Career Medical Officer as Continuity Medical Officer — will provide ongoing support to ensure system works…
Ministry and patients and DMS all interested in safety and nurses are our supports
One does not win a war emotionally, but win a war with numbers — from Mani
How could we work with ASMOF and why join which one? — want to work with community of doctors (or others) to help moving forward; will work with other unions as much as possible;
Strategy to move forward involves plan and SWOT analysis on how to move forward
Potential conflict between favouring one or other union – more about working together as much as possible
Consultative meetings on site, and escalation methods from local to district to ministry
Before start on major campaign, maybe trial case with Haroon
Look at planning day in the future and involvement with HSU at that time

HSP and the Mr Collins review:

HSP is very successful within HETI - recently engaged a review of all medical programs
Review basically says that specialists can look after all doctors, which is clearly wrong… Specialist colleges are the ones that should certify doctors, not HETI.
HSP should be coalesced into prevocational training and after year 5, they will all be in a specialist training program and not need ongoing support. Also wrong.
Rest of organisation, including Ministry, do not believe HSP can go away
Implementation of this report has been delayed for at least 2 years
Plan to coalesce with surgery training as well — Surgery pulled out of all HETI training due to allegations of restricting trade
HETI took over pre surgical training — 150 paid supervisors at 0.2 FTE — the trainees in SET running through HETI and then go into surgical training
Psych HSP — Northern Sydney – program written by Emergency Doctor and completely inappropriate and unsuitable — emergency room skills for which Psych CMOs have no use and then scenarios, which were also insulting
Model of education and force-feeding versus learning skills that are actually needed



Asking what people want versus giving people what is perceived as being needed
Response for Collins review
Looking for CMO rep for Psychiatry State Training Council run by HETI
Still need that HSP annual learning plan..

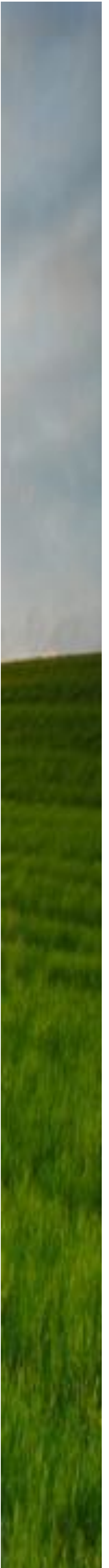
Discussions about joint membership
AMA and ASCMO — a craft group option in AMA, Sim Mead noted two Uni Newcastle graduates are on AMA State Council in NSW — consider options and explore
HSU and ASCMO —Transition to Senior CMO, sort out TESL as proof of pudding
ASMOF and ASCMO — expansion in hospitalist may leave CMOs ostracised by juniors and specialists

Urgent Care model — emergent practice with either CMO or GP models, may be options for provider number to be on agenda, could be included in training

CPD — tick box by AHPRA
Plan to look at non-compliers first, and then look at quality
Need to consider issues regarding peer feedback and input
Resistance for achieving leave for conferences

Email trail for meeting for future of Hospitalists

Meeting closed 1630



In Memoriam

Ramy Mezrani, who was with us from the beginning
Departed this Life in October 2016
We still miss you