ASCMO Times

Newsletter of the Australasian Society of Career Medical Officers

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ASCMO encourages the use of human social intelligence and application of the capacity for free speech and debate. The opinions expressed here are those of the authors. Think about what is said and respond with courtesy.

The Presidents View

Michael Boyd

The Road goes ever on (or) Diversity is Strength
(apologies to both Orwell and Buffet)

What a year!

First there was the tumultuous phone call: "Hi Mike. It's Dave here." (microsecond pause)… "We've done it!!!!" Usually phlegmatic of temperament, here was Dave almost shouting his excitement down the phone . Marshalling the efforts of our own organisation, of ASMOF, HSU, some helpful departmental types and the industrial court, we had - against all expectations - inveigled, explained, pushed, prodded, out-thought and out flanked, those arrayed against us - exhausting ourselves in the process but emerging triumphant with a new award for CMOs in NSW.
Everyone involved deserves a fantastic Thank You!!!! from our organisation. But of course one guy stands out in this process, and is the deserved recipient of the inaugural David Brock Award for excellence in persistence . That would be – well, - Dave! A huge Thanks will come your way from anyone reaping these benefits into the future but especially from those of us who fully appreciate the skill with which you pursued the prize.
And then comes the news that out of the blue the other raison d'etre of the organization – education and career enhancement, is finally being recognised in the form of the nascent Hospitalist project.
It seems that our diversity is now regarded as our strength. Of course we always knew it was – but showing the world is a different matter.
What is new about this ? The most amazing thing is that all of a sudden the opinion of the CMO matters. Always, in the past, people who know an individual CMO would come to value his or her opinion, but suddenly it is not just the individual but the body of CMOs who are being seen as having something to give, something recognised as important for the ongoing health of the system.
So congratulations are due for all the effort – ten years old and Seymour is about to become a teenager.
Yea!
What a pity we can't sit back and enjoy it all – not just yet anyway.
As we can see from Queensland report, NSW is not the only place where our particular and peculiar outlook is of use. Then there are the other States……
One of the things to come out of the AGM were the similarities to problems faced by those across the pond from us – those Enzedder s from AMPA who have faced most of the challenges that we face and who have come out in a very strong position made possible by their hard work and the particular political environment over there. In many ways they have much to teach us, but also we have quite a bit that we can help them with .
ASCMO's strength lies in its diversity, in its inclusiveness. Like any good multicultural society, we get to dip into the pool of support and expertise and come up with expert information. It never ceases to surprise me how, when we need information about something or other, there seems to be someone who knows someone who can bring a novel thought or idea to the table .

So let us celebrate our diversity, revel in robust discussion, actively promote differing views. And orient ourselves to the challenges ahead.

Committee

President
Michael Boyd
Vice President
Maria Nittis
Secretary
Mary Webber
Tresurer
Ken Wilson
Public Officers
Tom Salonga
Virgina Noel
Committee Members
Virginia Noel
Michele Meltzer
Louise Delaney
Tom Salonga
Education Officer
Gabrielle du Preez-Wilkinson
Industrial Officer
Ross White
ASMOF Repr/Website
David Brock/HSU Rep
AMA Contact Person
Danny Briggs

WIN !!

Come up with a new motto for our organisation and win!

(Have fun with it.Dont be afraid to be creative!)

Post your entry on ASCMO-talk@yahoogroups.com.Atten to Mary Webber.

QUEENSLAND REPORT

Perfect one day, cataclysmic disaster the next....

Gabrielle du Preez-Wilkinson

Dear Colleagues and Friends,

Queensland Health – perfect one day, cataclysmic disaster the next… Well, maybe not in days… The entire scenario in Queensland has been brewing for years, with a bonfire ignited last year, and the smouldering ruins being recognised only now.

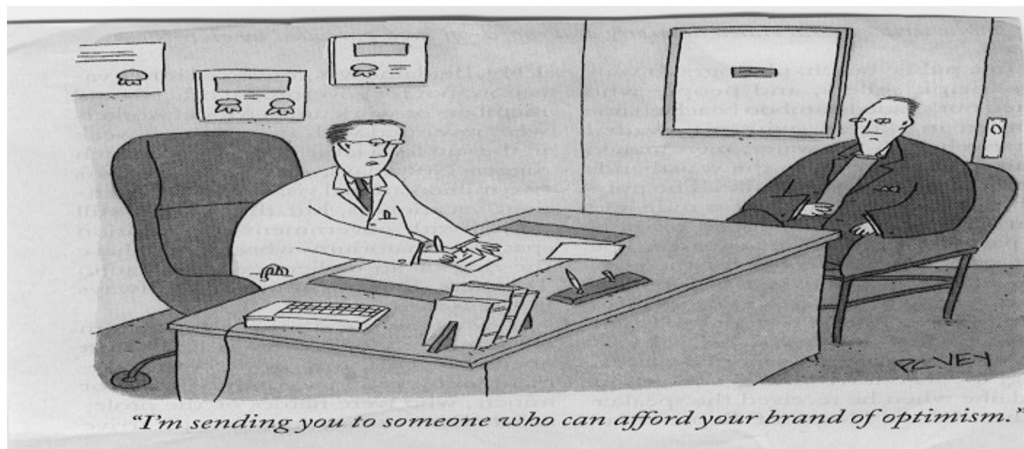
A tad dramatic, one may think. But the situation here in many hospitals is quite desperate… So how did we go from slightly dysfunctional and dependent on overseas trained graduates (like the rest of the country) to simmering cess pool of media glee in just over twelve months?

One could reasonably suppose that the situation began with Bundaberg Hospital and Dr Patel. But that is the common media version, and leaves out boring details like facts. The entire scenario has been painted as hero nurse (who kept personal log of issues, but never completed an incident report, nor followed up her initial complaint to Medical Superintendent – three weeks after his commencement - at any subsequent time), disastrous surgical outcomes, terrible management and system gone mad. The last of these points seems extremely evident, but the rest is all open to interpretation. Yes, mistakes were made and some outcomes were substandard. It appears that the surgeon was over confident, and the management poorly advised. The perverse funding incentives, where surgical output is rewarded with money, especially more complex surgery, were never attacked. Political interference in individual patient management was never considered as one of the contributing factors. Patient autonomy was dismissed – individuals aware of mortality risks and prepared to wear them, obviously needed to have discussed this more fully with their families.

The Morris Enquiry has had substantial impact on Queensland Health staffing – through the Premier reacting to the interim report of the Morris Enquiry and shutting down the Medical Board registering overseas trained doctors through all of June and most of July 2005 – the peak immigration sorting time for UK doctors. So the rest of the country and New Zealand took advantage of our annual pilgrimage of 300 + doctors from the UK as we were forced to turn them away from Queensland's door…. I remember hearing on one report that we were about 360 doctors short across the state… the maths is very interesting.

So, we started on a spiral… Our annual reprieve in August and September, when all the local graduates are fading and wearing out, never came. Our floods of UK graduates have turned into a drought. The weary locals have been asked to just keep going and push on – with no end in sight. Tempers have become frayed, resignations have fuelled the fire of discontent, increasing patient demands, summer heat and summer holidays where you don't see your family compounded the frustration and weariness. The spiral is in place, and there is no clear end.

So, we started on a spiral…



"I'm sending you to someone who can afford your brand of optimism."

Continued over page.

Queensland Report cont'

The imminent disaster of 2006 began to be mooted by medical managers in July and August 2005, as their relief staff did not arrive to replenish the stocks from those who went home from their working holiday. Contingency plans were discussed. Closing inpatient beds ,amalgamating hospital functions, moving staff from inpatient areas to emergency department areas—all were discussed, but no consensus was reached. It would have been easy to blame the medical managers– and I am sure that not all are without blame, Many of the medical managers function within an environment that would kill an ordinary person.
Political interference in management decisions is generally expected and anticipated. The ability to fix things or set up self sustaining processes has been diluted by the reactive nature of media management as a primary principle of managing health care.

Surely , there have been some lessons learnt from all this stress and chaos.

Surely, there have been some lessons learnt from all of this stress and chaos. The first lesson would appear to be to ensure that clinicians work within the scope of their credentials and that facilities function within the resources and service profile allocated. This self evident statement, however, may conflict with the second lesson, which is to react to any and all complaints at all times with maximum effort. So, if a patient is unhappy or a staff member doesn't like the limitations of their credentials, and either chose to complain to the politicians directly, then a series of paperwork cascades from the mountain in a land that smothers all life out of any potential survivors.

One of my colleagues, a non medical manager, has not been able to spend time with her staff in the last seven weeks, due to the pure volume of ministerial complaints and questions that she has had to answer – and this is only one person…

On the ground, most things are continuing as usual. If you have full medical registration in Australia and want a job in Queensland, please let me know. Much of the thunderclouds brewing in the sky have minimal impact and rain on the people actually covering the work on the ground. Some locations have significant problems, but many sites just lack actual people power. The locations with problems have the advantage of apparent fountain of eternal funds, where doctors are being granted almost anything they want – sometimes even if unreasonable – but this is to balance the stress and lack of numbers of the roster. Greed and avarice is alive and well in some sections of the medical community in Queensland, but most of us soldier on – realising that fountains always run dry in the end, and that a steady and reliable stream with industrial support will have more sustainability.

All is not lost, in my opinion. All that is required is genuine ACTION to move culture – instead of words and documents. In my humble opinion, the genuine bullies (ie those not being bullied into bullying) need to be removed – not create extra positions to manage them. The culture of the organisation needs to go back to maintenance of high quality care for patients and staff through appropriate training, education and support – funded and rostered for within Queensland Health time and facilities. The politicians need to butt out and let the clinicians manage the patients. Accountability needs to be fostered through clinicians talking to patients when there are concerns, managers talking to clinicians when they are unsure, and senior bureaucrats trusting their district managers, when they are trustworthy (see above for management of untrustworthy). Extra staff will come when it appears that they will be cared for, and are part of a vibrant, educationally sound organisation – with aspirations beyond the next election and towards better health for all in the longer term… In the meantime, we have lots of jobs, and I can tell you the best places .

Gabrielle

CMO AWARD WINNER !!!

Awarded to David Brock, We thank you for your efforts..Well done!!

CONGRATULATIONS DAVID

Industrial Report 2006

David Brock

After 7 years of politicking and some rocky moments during final negotiations, ASCMO finally got some runs on the board with the NSW Industrial Commission implemented a new award for NSW CMOs on 26th May 2006. This award not only provided significant pay increases, but also identified CMOs as a distinct group of medicos with a more navigable career pathway that included the new classification 'Senior CMO'. The penalty, public holiday and overtime barrier was removed, and an entitlement was put in place for fully funded Continuing Medical Education leave. (Full details on ASCMO's website: www.ascmo.org.au).

Well done ASCMO !

Although the final offer from NSW Health had some deficiencies (such as minimal On-Call rates), it was considered by ASCMO and our representative unions that overall benefits outweighed any disadvantages and the offer was probably better than what might be achieved if our full case proceeded before the IRC.

Certainly there have been some teething problems since implementation of the new award. Some CMOs were incorrectly translated across to the new salary scale. The process for approving Senior CMO applications has proved to be troublesome. NSW Health representatives refused to accept original applications when it re-issued guidelines for applicants to re-submit their applications. After almost a year less than one third of the initial 160 applications have been processed. At 12 May 06, I'm told by ASMOF's Sim Mead that approx 40 CMOs should be receiving the news that they have been awarded Senior CMO grading. Over 100 initial applications remain to be processed by the Senior CMO Grading committee.

The Staff Specialists in NSW have recently had their award updated. ASCMO could benefit from studying this document, as we modelled the NSW CMO claim on sections from their previous award. ie: aligned ourselves towards the needs of senior and experienced medical staff rather than junior staff undergoing specialist training.

The next opportunity to refine pay and conditions for NSW CMOs occurs when the current award 'expires' on 26th May 2008. Debate would need to begin 1-2 years before this date to allow a credible claim to be developed and put before the commission at the time of expiry. If not, then expect the unions in NSW to agree to percentage increases that will be subject to a 'no extra claims' clause lasting a further 3 yrs.

Finally, Awards provide a floor to working conditions, rather than a ceiling. So all groups benefit whenever award conditions improve. After 7 years as ASCMO's Industrial Officer, with a new Award in place for NSW CMOs, I intend to step back from this role. I would like to acknowledge the support of numerous CMOs in past years. Especially Ron Strauss and Michael Boyd for attending so many ASMOF meetings in Sydney and ensuring that CMO issues never left the table. I would also like to thank the steady stream of feedback from ASCMO's committee members and everyone belonging to ASCMO-talk (ASCMOs email discussion forum). Thank you and well done.

Website Report 2006

ASCMO-talk@yahoogroups.com is ASCMO's main discussion forum. Currently 28 CMOs belong to this (ASCMO only) email discussion group, where ideas are tossed around for general comment or perusal. For example, 'ASCMO-talk' allowed CMOs to debate and discuss the evolving claim put forward by ASCMO to the unions, that led to a new Award for NSW CMOs. All ASCMO members are welcome to join this free group, by simply emailing davbrock@ozemail.com.au Recent discussion have been focussed on difficulties faced by CMOs that have applied for Senior CMO re-grading, and the pilot program for Hospitalist CMOs in Area Health Services close to Sydney.

www.ascmo.org.au continues to be a valuable resource for CMOs across Australasia. The site provides 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.

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". You'll even find a selection of CMO related cartoons. (try doing a search for "cartoons"). Our most popular pages continue to be our "Links", "What's New" and "Industrial" pages, although there were quite a few visitors curious enough to visit ASCMO Committee's photo. Some of us could be famous.

The "Open forum" on our website remains under-utilised. So why not put in a message and get it going again.

Remember this website is provided for <u>YOUR</u> information and participation.

David Brock
ASCMO Website Co-ordinator

Credit : The Cartoons are either stolen or created by the twisted mind of Mary G.T.Webber using Comic Life and her groovy new MacBook.

Meet our new Vice President

I joined ASCMO at the recommen-dation of a current member…..

Maria Nittis

My name is Maria Nittis and I graduated from the University of NSW in 1989. I completed 2 ½ years in the public hospital system before venturing overseas for 18 months of travel (Alaska to Tierra Del Fuego). I arrived back and got a job in General Practice and remained in this field for 12 years.

I applied and was accepted as a CMO in Sexual Assault (2002). The job required the provision of services for sexually assaulted children and adults in a region extending from Bowral to Bankstown. During the four years in this position I completed my Masters in Forensic Medicine at Monash University. At the beginning of this year I left because of lack of career opportunities in the field. I was also disgruntled by the lack of foresight of those who had political control over the future development of Forensic Medicine in NSW. (NB "Turkey slapping" does not qualify as a sexual assault!)

….and have found that it has provided the Industrial and peer support that has previously been lacking.

February this year I started work in Sydney South West as a CMO in Drug Health, where I am currently. I average 33 hours per week between two Opioid Treatment Services at Campbelltown and Liverpool Hospital. I intersperse this with a job at Macarthur Private Hospital where I assist a Gynaecologist and a Urologist in theatre on a weekly basis.

I am currently completing a Masters in Legal Medicine (Griffith Uni) and a short course in Drug and Alcohol and Health (Sydney Uni). I have applied for the training scheme for Addiction Medicine and am waiting to hear whether or not I have been accepted.

I am a single, mother of two (9 and 5) and live in the Camden area of Sydney. I joined ASCMO at the recommendation a current member of ASCMO and have found that it has provided the industrial and peer support that had previously been lacking.

WELCOME!!

Meet our new Industrial Officer

Ross White

Ross White is the newly-appointed ASCMO Industrial Officer with David Brock still providing advice from his many years of experience in the role.

Ross was a rural GP for 16 years before returning to Sydney where he worked as an ICU CMO at The Hills Private Hospital for 4 years, before becoming a part-time CMO in the Drug and Alcohol Service of the Sydney West Area Health Service where he still works 5 sessions a week.

Ross also works once a fortnight as a CMO in the Emergency Department of The Hills Private Hospital, and as the Hospital Liaison Officer for WentWest GP Training.

He practices as a GP three afternoons a week in Beecroft.

Ross was involved in the planning of the Spring Seminar on Emergency Medicine for several years.

The Hospitalist Project: Pathway to a Career, or Highway to Hell?

When the CMO Association [i] published on this topic in the MJA in 2000, *http://www.mja.com.au/public/issues/172_07_030400/egan/egan.html*, we little thought that just a few short years later we would be invited to the 'Big Table' to give a CMO perspective on the implementation and marketing of some of the very same ideas we had thrown into the ether half a decade previously. A strange experience, some suggesting that it raises the spectre of being careful what we were wishing for …. On the other hand, perhaps the re-birth of the Generalist is simply an idea whose time has now become apparent to anyone with half a br… -ahem, to anyone giving the issues of complexity in health care delivery their serious consideration.

It might be worthwhile at this point to re-iterate and explore how some of this came about, and voice to the CMO community some of the thoughts driving these developments. According to Tony O'Donnell at the DOH, the concept of rebirthing the Generalist arose from a number of initiatives and a variety of sources with a common interest in quality health care and patient safety (*so who **isn't** interested? - ed*).

In 2004, *A Review of future Governance Arrangements for Safety and Quality in Health Care* by Bernie Johnston www.achs.org.au/content/screens/file_download/Future%20Governance%20Review%20submission%20(Nov).doc - points out that, *'ACHS has nearly 1000 member organisations in both the public and private sectors and as such has a major capacity to influence the behaviour of individual and organisational performance; the opportunity this presents has not been fully exploited.*' ie – important, smart people with a lot of resources are having trouble effecting positive evolutionary change on the shop floor.

Further, the term 'silo' makes an appearance in this report, a term which one hears frequently used in meetings to describe the character of inevitable disconnects in complex systems. In short medical evolution has been vertical and hierarchical, and - '*Some projects have been very slow in making progress or have not been driven to implementation, for example, monitoring of sentinel events, open disclosure and the feasibility study of implementing a nationally coordinated standards development and accreditation program. In others, such as the safe use of medications, 'silos' of the disciplines involved appear to have emerged limiting the potential gains.*'

Mr O'Donnell cited the Maggie Project – arising out of the Access Block Improvement Project for John Hunter Hospital - as significant in increasing the system's understanding of the complex issues involved. The Maggie Project followed a theoretical patient through their patient 'journey' across the system and considered the potential dis-connects in her care. This business re-engineering approach revealed 200-300 identified issues that were then refined down to 24 possible solutions. 10 or so high impact / low cost changes (eg. check the fax machine in xray for the requests more than three times a day) were then used as intervention levers to improve systematised care.

By leaving no sacred cow unturned an institution the sheer size of JHH has managed to decrease their length of stay, increase their patient satisfaction and decrease their access block while dealing with an increase in demand- in much the same way that a smaller institution might have done so with a lot of personal contact and some corridor consultations.

There seems now to be some recognition that 'silos' are an inevitable result of vertical specialization, and now hyper-specialization, coupled with high turnover of trainees and increased numbers of patients having more interventions in shorter stays. Perhaps this has led in turn to the realisation that there is a need for doctors to stick around on the floor permanently and help to 'MacGyver' the clinical care in the hospital, to have patient safety and managing a system of care as their primary focus.

There are a number of drivers behind the piloting of a hospitalist doctor classification. These include

* Changes in workforce numbers and hours,
* the increasing use, expense and the occasional professional unpredictability of the locum workforce *(admit it – you know they're out there – ed.),*
* the above mentioned evolution of highly skilled but un-integrated 'silos' of medical expertise,
* the oft-bruited aging of the population and a need to keep people cared for and resident in the community.
* The slow painful demise of the general physician.
* Care is diagnosis-based rather than patient-centric care model
* The move toward hospital in the home, requiring more rather than less acute expertise.

To give the medical and DOH establishment its due, many clever and good-willed people have been giving this their serious attention of late. Medical focus groups have been used to diagnose the problem rather than merely to identify reactions to a defined solution. Getting together through the CSRP (Clinical Skills Redesign Project), IMET (Institue of Medical Education and Training) MTEC (Medical Training and Education Council)and GMCT (Greater Metropolitan Clinical Taskforce), and no doubt other acronymic groups has, according to Mr O'Donnell, identified the same concerns from multiple sources.

There is a need for a highly trained generalist, since specialisation as a sole response to a problem would appear to be counterproductive. –

Thus was born the idea a hospitalist-but not in the same form as the overseas model. CMOs will recognise some resonance in the DOH definition. '*In the Australian context, a Hospitalist will be a medical practitioner employed by an Area Health Service who is* ***not*** *in a training position and is* ***not*** *working towards a Fellowship in any of the Learned Colleges. The Hospitalists' principle focus will be the provision of quality clinical services to patients both in and out of the hospitals, to ensure that the patient's journey is co-ordinated and as effective, efficient and as safe as possible.*'[iii] (Their bold type, not ours – ed.)

To their credit, the Steering Committee has, from the beginning, invited CMO participation, both formally and informally. The CMOA and later ASCMO can be justifiably proud of its efforts to bring this need to the attention of health planners. We were one of the first organisations to publish on the matter (eight years ago!) and have maintained solid efforts in lobbying since. We have made no bones about our professional diversity and this has proven at long last to bebonus.

Professor Katherine McGrath, whose baby this is, came with Professor Mark Brown to our AGM this year on a fact finding mission and, since some of us didn't quite appreciate that they were Very Important Folk, told them facts of all descriptions and in no uncertain terms. (*Michelle Metzler from Community Mental Health Ryde was particularly eloquent about her relationship with the Learned College – it was good to see – ed.*). Frankly it also introduced them to the concept that CMOs themselves might be able to show them how to make this work.

Interestingly, the other brick (*snicker–ed*) in this edifice of CMO involvement comes from our success in the industrial arena: an outcome of our previously um, combative? encounters with the DOH which, though some felt would follow eventually, no-one anticipated would happen quite this quickly. We thus appeared on their radar on two flanks. I quote - '*The Career Medical Officer (CMO) award has provided an industrial framework for doctors not in a training program; they are not seen as a mainstream part of the workforce.*' [iv]

It has been clear in meetings that the availability of a structured award in a skills-based model for advancement is a crucial element of formulating this proposal at this time. The DOH needed a way of advancing the participants in this project that the old award would not have met (eg. no study leave, etc) and their intention to keep Hospitalists outside a College structure would have met with a big conceptual block without the new award.

Of course, whether these good ideas, into which a great deal of time and effort has gone, will play in the Areas as anything other than some new opportunities for CMOs to find themselves providing canon fodder for the night shift remains to be seen. However, we can say directly that the Steering Committee and the Workshops appear to welcome the CMO and Important People have been seen to be wrapping their heads around the fact that very experienced doctors bringing a depth and variety of clinical experience back to the floor might be able in turn to help them to make this work. We have made suggestions and comments that we have seen incorporated into their ideas in real time. It has been an altogether remarkable experience for this particular punter.

There has been discussion and concern that the emergence of this role might actually lead inevitably to just another College, with all that entails. Our organisation faces challenges in this regard – for all the posturing that this is not going to be a specialty or a college, one can all too easily see the route towards a college developing in the future. . We will need to work hard to differentiate ourselves in appropriate and recognisable ways.

Ultimately decisions will be made by those who show up. Spirited discussion and advocacy for CMOs has always been our special ability, and our averred goal.

So here we are, at the dawn of another day in the course of these 'interesting times'.

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[i] The hospitalist: a third alternative. The role of hospitalist is already evolving in Australia, being filled by Career Medical Officers, John M Egan, Mary G T Webber, Michael R D King, Michael Boyd,
Gabrielle du Preez-Wilkinson and David Brock, *MJA* 2000; 172: 335-338
[ii] A Review of future Governance Arrangements for Safety and Quality in Health Care, Bernie Johnston

[iii] 'Hospitalists' - A proposal for the implementation of a Pilot to assess the feasibility of a new category of medical professional in Sydney West, Sydney South West, South Eastern Sydney and Illawarra and Central Coast Area Health Services, Dr Linda MacPherson, Dr Siun Gallagher, Mr Paul Gavel, Mr Abd Malek Ms Phillipa Blakey, Adj/Prof Jenny Becker, Ms Jane Street, Professor Katherine McGrath
[iv] ibid.

AGM Minutes 2006

ASCMO AGM: 20th May, 2006
Novotel Hotel, Brighton Beach, Sydney

Attendance: Virginia Noel, Mary G. T Webber, Michele Metzler, Michael Boyd, Gabrielle du Preeze Wilkinson, Maria Nittis, Ross White, Danny Briggs, Virginia Noel, Cathy Cordi.
Teleconference attendance: Dave Brock, Ken Wilson
Guests: Julie Josie, Carl Kennedy, from QLD.
Alistair Sullivan from New Zealand.
Apologies: Harmon Lightfoot, Louise Delaney, Tom Salonga, Ron Strauss, Kien Ciaoxuan. Claire McGrath

1. Opening Address: Happy 10th Birthday to US!
Meeting declared opened at 0838
Congratulations to Michelle Metzler who has finally been appointed a Senior CMO!
The news from the trenches at this time is that 72 people have been approved as Senior CMOs, though we do not know how many of them are being paid that way. Twenty more listed for further information. Another 60 in the works.

2. Previous Minutes:
Minutes accepted as accurate and correct and reflective of meeting. Nominated Gabrielle , Seconded Michael Boyd. Unanimous acceptance

3. Reports from Reps
President – Michael Boyd: The Society is now 10 years old and finally, having traversed the difficult years of early childhood, finding its feet and looking forward to having a real life. It was formed with the twin intentions of providing mutual support and advancing the recognition and opportunities of the CMO. We all knew of the need for the highly experienced generalist. In the last year we have had some success in this regard, and are right in feeling satisfied with our accomplishment. After monumental and persistent effort we have secured the passage of the new award. There have been some Industrial successes in NSW and QLD. We look forward to having an increased educational focus as our new goal. A few pats on the back.

Cathy has been the new office manager since Nov 05. She reports of member ship – 102 member currently financial, and 51 renewed so far for this year, of which 13 are registered for CPDP. The CDs have been sent out. Cathy manages mailouts and updating the data base. Several rejoining and several new members are responding to the web site.

Vice President: Main activity has been AMA representation – to discuss later.

Secretary: Danny Briggs is currently a GP Anaesthetist in the Blue Mountains – and now being paid as a VMO. As are the senior ED people in Nepean. Staff Specialists are also rumoured to be being paid as VMOs – not sure wether this simply represents a workforce reality or a longer term trend.

Treasurer: Ken Wilson: Same as previous years financially. $14,405.78 to start, income $8500, expenses $4075.75. Pretty much ISQ - continue.

There are still outstanding bills, as per the usual financial year. Balance sheet is presented and to be attached to minutes. Main expenses – annual conference and teleconference costs and secretarial absorbs around 50% of total costs. Membership price has never risen. We suggest a memory stick as an additional cost, but a most convenient way of storing CPDP….

Ken adds that he is unable to attend in person, having just changed jobs secondary to some difficulty with implementing the senior CMO position at Canterbury, and unable to shift his roster at the new job. Sydney South West also reports there are games afoot. Some candidates have been offered recurrent 3 month contracts and are thereby inhibited in applying for a senior position. Dave Brock has challenged his own employer – and this has led to some further trouble. The climate has become somewhat oppressive.

AMA Rep Report: Harmen Lightfoot: has represented us on teleconferences during the year, which participation have revealed that the AMA remains keen to recognise and represent CMOs. Their work, life balance workshop recognised CMOs as a distinct membership within the AMA. Options for enhancing CMO status were reviewed by salaried officers committee of AMA who seem keen on developing increased status for CMOs. The AMA wants to start a postgraduate program – Masters of Clinical Medicine – and reviewing award issues. Strategies really involve campaign status, career structure, and increased profile of CMOs within the AMA.

There was a vigorous discussion, (as there often is at our meetings), about the viability of a Masters of Clinical Medicine – and its possible variations, especially in Emergency Medicine. A potential linking into the Critical Care Training Steering Committee was noted. Ongoing credentialing is as always an issue being considered at present. **The discussion moved to a debate about whether we want to be seen to encourage more barriers and examination requirements for CMOs. To which the answer is probably a resounding "NO!"**

ASMOF Rep Report: Ron Strauss: CMO Advertisements are tending to be looking for casual jobs, rather than permanent positions – the ASMOF response depends on how long the employer keeps people in the job, and whether it contravenes award. Ron has attended several meetings and increased the profile of CMOs in ASMOF.

Education Officer Report: Gabrielle dPW: Main activity for 2004 and 2005 was the conference last year. CPDP continues with not many members (eleven, about 50%), but several people find it very useful and use for Medical Board requirements. The main direction for the future is to look to individual learning plans on annual or biannual basis… Longer-term we need to look at computer linking with CME number for meetings attended, etc. (Potential links with RACGP and ACRRM to get this information is possible.) We can also look at transforming education program to palm pilot version. We can maybe develop a draft in excel and word and circulate it for comment. If she is continuing in this position, a topic for the conference next year would be appreciated.

Another interesting topic is : Are we in the place where we can do the actual teaching or educating by teleconferencing. Eg: EM Reviews and Perspectives – www.EMRAP.us updates. Modes include CD and mp3 download, or are we best placed to facilitate rather than provide. We could certainly offer podcast via the website. Or PDF. Or bit-torrent. Share site on the web site. Something like - CMO Web Reviews and Perspectives .www.

Website Report: David Brock: Generally doing well with lots of hits. We run about one ad per month for CMO positions, as well as lots of other material of interest. Some income is occurring.

Costs of website is $440 per year, with additional minimal costs for David's time for writing and setting the ads. This is still a useful communication avenue, with minimal cost impact and generally positive finances.

There have been several people contacting for password in order to access more information. Running itself basically. Cathy gets occasional requests for restricted areas. Generating a few new memberships this way. We generate some income = about 5-6000 grand. Also Ken took the Sydney Hospital job that was advertised there. Per $125/ ad - $50 to Dave – takes about an hour to place it. Traffic diminished a little. Dave wants to learn to do more HTML.

Industrial Report:

David Brock - 1. **The Process of Getting Here** : Somewhat to our surprise, we finally find ourselves on the evolving threshold of significant improvements in the Award.

This is the result of seven years of politicing and agitation for a boost in fairness to the baseline. The aim was to raise the floor for all CMOs. As you recall, the original driver was simply to remove the overtime barrier

and address some weird stuff out of the DOH. Our negotiation position took a while to be established and eventually we embarrassed ASMOF into action via the HSU, who showed glimmers of interest at the right times.

Michael and Ron spent considerable time with ASMOF – a small organization with a high opinion of itself. Then Michael and David went on to develop a good cop and bad cop approach – (we invite you to guess which one was which - ed). There was much saying of one thing and doing of nothing – endless drafts going around in circles – through ASCMO-talk@yahoogroups.com – and with continuing feedback via the list we were able to push lots of input and channelling onto Sim Mead and so on.

When it finally made it to a Court representation to develop a credible claim suddenly there was a flurry of offers. Danya and Michael met with the DOH and Dave at meeting in Sydney to make an offer. The DOH was not too sure about the senior CMO situation and reneged on that offer.

Many strange moments followed as the players basically invented as convoluted process a process as they could well manage.

Eventually they were all pushed into it by the Commissioner on 26 May 2005. The decision was then retrospective to April 2005.

A new debacle has, of course, since followed with the tangled appointments process for Senior – and now there's no CMO rep on the committee. The areas have started to process applications and become bogged down only half way through the process. At least we have now identified the CMO as a distinct animal: a more mature role in the work force, if not yet a force to be reckoned with. The Department of Health doesn't like anything to be decided by the Industrial Commission – in case of creating a precedent, and this can create some odd industrial distortions, for good or bad. Eg: the unique position for the staff specialists to receive loading for special shifts, while they may not actually be required to do anything.

We will be revisiting the award in 2008. Since the lead time is two years, perhaps we had best start now.

2. Award the Senior – recognition should be back-dated to 20 April 2005. Further pay increases apply from 2006 and 2007. If you have any queries please email them to ASCMOtalk for latest in CMO gradings. At this time of the 92 who have applied 72 have been approved. Of those enquiring, 20 have been referred back to their Areas for further information. 4 have been rejected because of Area of Need service – which apparently don't meet the criteria – this odd glitch is probably worthy of a challenge. Perhaps it just represents an opportunity to allow the commission to reject some applications. The Committee has reviewed 4 applications that have been back and forth to the Area, then back to the CMO for comment and then back again to Committee. Two have been approved. One was rejected as Area of Need and one is currently in abeyance. We should consider asking to be one of the represented Union in the deliberations – eg as the HSU rep, perhaps? ASMOF has been given the name of every successful candidate – (Anyone who gets it and doesn't join ASCMO is officially considered to be a bum – ed.) – so we need the names. Dave is a member of ASMOF Council – he knows that the list exists. Should we push the point? Dave drops emails to the members with selective CCs about what's going on.

Congratulations to Michelle Metzler who has finally been appointed a Senior CMO!

The news from the trenches at this time is that 72 people have been approved as Senior CMOs, though we do not know how many of them are being paid that way. Twenty more listed for further information. Another 60 in the works.

3. The Future - A lot of area of need positions – is ASCMO a stake holder in area of need positions? – the

applications have to be flicked to all stakeholders. Not willing to support unless the conditions are met. Very few contacts made in spite of the overall need. Dave doesn't mind.

4. The David Brock Memorial Award Brick Wall. Watch this space…

Queensland Report/Education Report: Gabrielle dPW: People sent us stuff, and we sent them certificates. Amemory stick looks like excellent an solution to moving personal information around, given the difficulty of firewalls. We've decided to trial a group with them, in QLD, free with membership as a spot of research. What about organising some video conferencing? Watch this space

What's Happening in QLD Health? The Highlights – Health remains chaotic – the medical board remains obstructive – the DOH remains paranoid and hysterical – the lines of reporting are ridiculous on medical staffing which goes via the district manager on a virtually daily basis – however no useful data is coming out of it.

Their new initiative – Come Work for Us – has unfortunately no idea of workforce. Industrial –medical administration has gone over to the specialist award – but candidates have to get the fellowship and lots of over-worked people are struggling. The SMO award is linked to the IBB interest-based-bargaining. Everyone went up except the SMOs. Have created new levels because the staffers have gone up 20-30k. New C2 (?rate) and above. C3 and working on C4. Currently folks are looking at the C2 skills – eg: rural generalist obstetrics and emergency etc. Hopefully this will create an opportunity to progress – perhaps a chance to get ASCMO represented here and to push the CPDP.

Developed a rural generalist pathway at Dennis Lennox. Talk of generalist pathway. – car and fuel card on offer. QLD Health is also, ahem, preparing for the increase of interns from intakes of 286 to 682/year. It is, to say the least, not clear who's going to teach them. There will need to be an increase the clinical service staff.

There have been some advances in pay and conditions – conference and study leave. Previously these were delivered through the employer and at their discretion – now you just get an aliquot per year. Will place a copy of these on the website when available.

Office Manager: Cathy Welcome and thanks for joining us. Your new manager is actively working on sorting out the many incarnations of the database and then will look at recruitment, as well as generally keeping the wheels turning.

4. Office Bearers:

Position	Nominee	Nominated	Seconded	Vote
President	Michael B	GdPW	MaryGT	Unanimous
Vice President	Maria Nittis	Michael B	David B	Unanimous
Secretary	Mary Webber	David B	Virginia	Unanimous
Treasurer	Ken Wilson	Michael B	Michael	Unanimous

Continued over page

Honorary Positions – All passed unanimously

ASMOF Rep Dave Brock/ HSU rep

AMA Rep Danny Briggs

Website Editor David Brock/

Industrial Rep Ross White/ Dave Brock – publicity officer 02 99809696

Education Officer Gabrielle dPW – we need a training disc – formal training can we schedule a session at Byron Bay ?

Public Officer Tom Salonga/ Virginia Noel

Gen Members Virginia

Michele

Louise/ Tom

Journal Editor Approach Mary Webber if she isn't cranky…

4a. Employees:

Cathy to continue as office manager, on request of executive committee.

ASCMO 2005 ACCOUNTS

Opening Assets				
	Westpac A/C initial balance			**$14,405.78**
Income				
	Memberships		$5,798.00	
	CPDP		$1,210.00	
	Annual Meeting	$315.00		
	Website Ads		$875.00	
	Donations			
	Interest	$103.35		
	Total Income		————-	
			$8,301.35	
Expenses				
	Secretarial Services			
	Insurance		$470.00	
	Mail			
	Stationary		$149.88	
	Printing	$852.00		
	Executive Travel	$302.00		
	Phone			
	Website Ads		$423.50	
	Conference Sponsorship	$750.00		
	Annual Meeting	$1,808.11		
	Total Expenses	————-		
			$4,755.59	
Net Profit				**$3,545.76**
Closing Assets				
	Westpac A/C Final Balance		—————	**$18,793.16**

Note:Final balance does not include outstanding secretarial fees, executive expenses and AGM expenses.

Aunty Gabrielle's Guide to Acronyms for the *Un-Initiated*

Dr Robyn Mason, Secretary-General of the AMA, writing of the frustrations of medical politics in *Australian Medicine* back in April 2006, provides us with the following useful illustration. "As you will no doubt have noticed, a lot of our time is spent creating, exchanging and interpreting acronyms. In Canberra circles this is known as PARANOIA – Producing A Really Amazing New Original Inventive Acronym."

Says it all really. For those of us who were watching paint dry through the 90s and have come late to this discussion, working out whom is whom and how they inter-relate is a daunting task, yet power is devolved to distinct loci in the system and it behoves us to attempt the challenge of working it all out. So here is a status update of a few the players.

1. The PGMC The Post Graduate Medical Training Council – this was the one we recognised, the venerable granddaddy of Med Ed. Alas it is no more and Gabrielle tells us that PGMC ceased to exist sometime last year. Apparently they needed to extend their brief to include PGY3 and beyond – and in fact to everyone who didn't have a fellowship. Quite the task. Not sure what happened about that, but they are no more. They went to MTEC via NSW government in NSW – other states are considering this model. MTEC dropped into the space where current fellowship training programmes weren't successful in their outreach, starting with the physican's programme. MTEC then comes under the umbrella of IMET. MTEC is the implementation end and was incorporated into IMET and the purpose of IMET is for non trainees and to support the college training programmes – to promote equity of trainng across the state – have developed the Hospital Skills Programme.

2. MTEC – The Medical Training and Education Council – ***www.mtec.nsw.gov.au***

   Established in 2001 by the NSW Department of Health to …'work with stakeholders to develop a sustainable and high quality medical workforce by enhancing the efficiency and effectiveness of service based training in NSW.'
   And if you think that was complicated – these are the materials they drew on –

   1988 Doherty Report
   1995 AMWAC established
   1996 Medical Training Review Panel established
   2002 AHMAC Working Party on Specialist Training Outside Teaching Hospitals
   2003+ ACCC RACS determination and subsequent reviews
   2004 AHMAC Specialist Training Taskforce
   2004 National Health Workforce Strategic Framework
   2004 ACCC College reviews
   2005 COAG Review of Health Workforce (Productivity Commission)

3. IMET – Institute of Medical Education and Training

   What is NSW IMET?

   The NSW Institute of Medical Education and Training (NSW IMET) was established by the Minister and Director-General of Health to develop and support medical education and training provided in NSW Health services.
   We are driven by the pursuit of excellent patient care through the delivery of high quality medical education and training in NSW.

4. General practice General Practice Education and Training – this is run by a quasi-independent body with Boards appointed by the Federal Department of Health and Aging – a potential GP applies to GPET – then contacts the consortia – three in QLD and 6-7 in NSW – a group of colleges of RACGP ACRRM, and the divisions of general practice – who provide administrative support to the GPs in a given area, the university rural health schools, and interested GPs. Different consortia have different alignments with the colleges but have approval on which terms have accreditation for special skills terms etc. There may not be consistency in application – each general practice who wants a trainee has to be accredited by AGPAL – who are a group who accredits the practice – the federal govt? and the college the trainee wants to be in, and by which ever consortia the trainee wants to be part of. The accreditation process is something of a Hydra. Shall we say.

Me – I just want a job….

Minutes of ASCMO Meeting, Canberra Hyatt Hotel

SSEM 28th September 2005

Present

Dr M.G.T.Webber
Dr Virginia Noel =Justice Health
Dr Jennifer Delima =Northern Territory
Dr Jeremy Smilie - Hunter New England
Dr Tom Salonga
Dr Ross White - Sydney West
Dr Harmon Lightfoot
Dr Stephen Delprado =Blue Mountains
Dr David Tree =Tweed Health
Dr Michael Boyd
Dr Ken Wilson =South West =Canterbury
Dr Michael King =North Coast
Dr Brett Letchford =North Coast

An informal gathering of the troops was called on the verandah of the Hyatt during an academic papers session of the SSEM, and was well attended by CMOs from widely scattered locations, once more commending the usefulness of this conference as a venue for networking CMOs.
The meeting was called specifically to inquire into the progress of the various Areas in the implementation of the new CMO award structure, which passed the NSW process as of the first pay period on or after 26 May 2005.
In short the award contains much of what we asked for the overtime penalty barrier has come down, there is establishment of a category of Senior CMO, pay rises, capacity for study leave and conference leave including relevant expense etc. The award is up on the website. Overall a fantastic result.
However there is some doubt that the Health Department has activated the necessary committee structure to actually implement the award changes. Applications for Senior CMO grades have not been actioned (Northern Area in Sydney, Sydney West etc). We understand that the Transitional Grade has been given to Justice Health.
The process as we understand it is that the proposal has to come from the Areas Health for Senior Grade. Application has to be supported by comment from the employer, but then has to go to a committee which is thought not to exist yet. A reply should have been expected within four weeks.
Applications for back pay, which should go back to 1 July 2004, should have been paid. It is not clear that back pay has been paid beyond the transitional grade.
Report has it that Northern Area Health claimed not to have read the award, and certainly havent paid according to its provisions. Tweed on the other hand, are paying penalty rates and the back pay is coming through.
It is very clear that we need to support and encourage people to apply for the conditions to which they are now entitled. It may be that the DOH never planned to notify CMOs that the award has changed. Not surprising since it is doubtful that they know where all of us are, or what we're actually doing.
Of note also is that the Staff Specialist award is also under negotiation, and they are looking for compensation for the After hours clause. Reportedly negotiations are somewhat stalled. We wish them all the best. And welcome to our world, guys.

Meetings Happening Around the Place

The issue of who CMOs are and what they do is still on the agenda Has anyone asked anyone whether the apparent current shortage of doctors has anything to do with the Provider No Legislation???
Various committees of alphabet soup GMTT, IMET that was MTEC which is the state version of MTRAA /PGMC are all still noticing that VMOs no longer engage in a great deal of 1:1 teaching, that there is inequity of skills distribution, and that locums are an unsatisfactory way to staff normal hours of work in busy hospitals. Talk still continues of developing a clinical skills program. There is concern that city based training will continue to ignore the realities of the rural workforce.

One of the agenda items for the next year would be to sort out where the overall scenario is up to as meetings about CMOs do not necessarily include CMO input. An update of CMO affairs is in order.

There should probably be a CMOs advisory Committee similar to the Gps
Advisory structure Ross might be able to look into this possibility through Cumberland.

See you next year for another spirited debate and a couple of cold ones….. M