January 2001

Vol 4 No3

Scream 3

The Search For New Blood

As the end of the year 2000 frantically rushes towards us, I must confess myself one of those for whom the exact delineation of the millennium, this year or last, or three years ago if that monk really did make a mistake on the Gregorian calendar, is a matter of the profoundest indifference. All the time I care about is that wretched stream of seconds flowing away, faster and faster under my feet.

How comes this about? Dammed if I know. Ghandi once wrote, "There is more to life than increasing its speed." Of course he was a man with his sandals on the ground and who knew a thing or two about this and that. All I know is that I have a new puppy, Seamus, and not enough time to play with him.

Well, that was the year that was. Despite the demands of competing schedules, the sudden shifts, the journeys to and fro and overseas, the unexpected family ills, and the death, breakdown and/or theft of various computers at various times, we have made some progress.

We looked forward to raising our profile a little, and have conducted a number of meetings outside Sydney, placed one committee member as an ASMOF Branch Councillor, and another as NSW secretary of ASEM. We published an article on Hospitalists in the MJA, and have now an international correspondence proceeding on that topic. We have written to the College of General Practice to solicit recognition of the CPDP as CME for their purposes. We even had a letter from the College of Emergency Medicine, welcoming us to participate in their MOPS programme.

We have now been in existence for approaching four years. Despite the fact that the NSW Medical Registration Board still lumps us in their OMPs section and doesn't recognise our existence outside a salaried hospital position, nevertheless we have grown in confidence and slowly in numbers. Our web site is a fabulous E presence and finds us new members we would not have otherwise located. We continue to stick our hands up at meetings, and invite important educational institutions to provide material that we say is relevant to us.

But it is basically the same six people giving their precious time, doing all the work year after year. Hence the title of this piece.

The time has come for the bold and foolish to step forward and put up their hands. The CMOA committee needs new nominations for next year. It's (modestly) a great bunch of people who get along great and actually share a common vision, that this is a viable alternative career, that diversity is to be celebrated and supported, and that a cold beer is a fine accompaniment to a spirited discussion.

But we need more people people to bring forward their particular skills to grow the organisation. Are you, for example, one of those born with a phone grafted to one ear and an insatiable need to network? We'd love to incorporate a membership secretary. Is counting and organising your thing? We're looking to develop formal feedback loops for the CPDP. And so on.

We need more PersonPower if we are to expand and grow strong and increase in effectiveness.

Continued on

Inside This Issue...

Committee

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President's Address

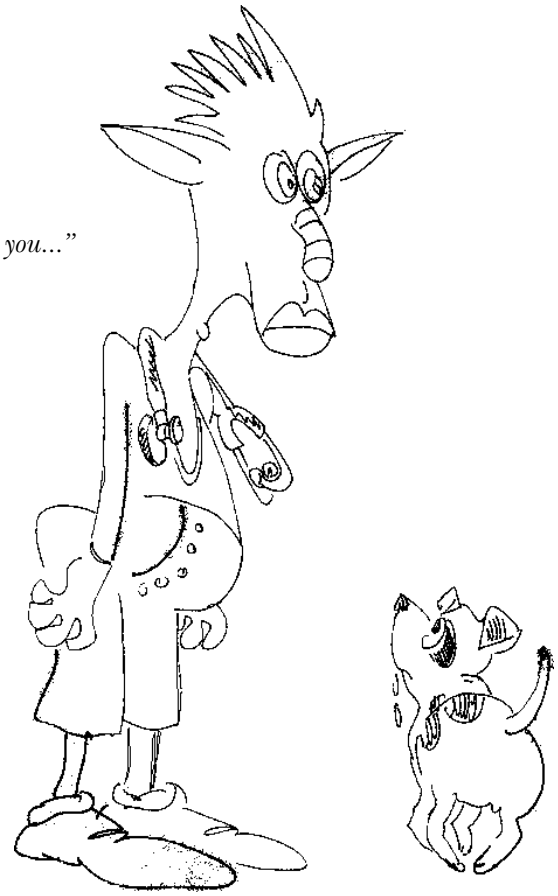
Continued from page 1

I will not be standing for President next year. We all agree that two years is enough for that particular job. And I have a puppy to play with. Anyone interested? You will receive nomination forms with the relevant information re the AGM in the New Year sometime. Think about it, and remember that decisions tend to get made by those who bother to show up.

Mary G.T. Webber

PS. Turns out we didn't need the ABN after all. It took me a total of four attempts to get through the waiting list on the Advice Line to finally confirm that, and the last involved 38 minutes of sitting on hold. If I never talk to the Tax department again, it will be too soon.

"Having a dog changes you..."



Publishers Apology

Dear Members

Mary in her role as Editor, provided copy for this edition in December, I hoped to have it out by Christmas. However, my computer's primary hard drive, nearly new and under warranty, turned up its toes and refused to co-operate any further. The retailer says—go to the manufacturer, and the manufacturer says go through the retailer, and no one is prepared to accept responsibility. Finally, they took it back. But the timing could not have been worse. Ever tried to get anything fixed two weeks before Christmas?

Fortunatley, we recovered most of the data, and are now operating on standby drives while we await the manufacturer's pleasure. Therefore, please accept my apology for this unforseen delay in the publication of this edition.

Update on Rural Training and CMO's

By Gabrielle du Preez-Wilkinson

Great news is at hand... If you are an OMP (Other Medical Practitioner - non VR'ed doctor etcetera), and work in RAMA 4 - 7, then you are eligible to bill Medicare as a VR doctor.... RAMA 4 - 7 is a rural classification, and basically it means small to remote hospitals. The catch is that ACRRM (Australian College of Rural and Remote Medicine) will then help organise a CME program to maintain your VR status. (And who said medicine was full of acronyms!!) What this means in reality is that the Federal Government is finally recognising the extra skills that rural doctors bring to their practice, and are prepared to financially reimburse them.

ACRRM is also progressing full steam ahead with finessing their Primary Curriculum document, their training program, and eventually their exam and entry requirements. This is all developing at the same time as the new direction in General Practice training is gestating. Basically, RACGP has had its last intake of a program totally under their control. From 2002, GP training will be run by Training Consortia. The idea of a Consortia is that a group of interested parties (including Divisions of General Practice, University Departments of GP, RACGP, ACRRM, Health Departments, local training units et cetera) get together to design a holistic approach to training for GP. There will be a concurrent emphasis on rural attachments with over 70% of all GP attachments having to occur in rural or remote settings. So the world of GP training is moving, into a new cooperative multi-focussed direction, with the possibility of rural pseudo-conscription—And we thought the good ole days were good!!

The aim of this little update is to warn you, inform you, and encourage you to be involved whereever you see fit. Our proposed Masters of Clinical Medicine could also fit in here, with some units possibly being able to be accredited for RPL (Recognition of Prior Leaning) for ACRRM at least. So the world will continue to revolve, evolve, and self destruct concurrently still.....

Education Report

1. CPDP

Problems, Feedback, Accreditation
Need for formal articulation of learning needs.

The Continuing Professional Development Programme (CPDP), developed by the Royal College of Pathologists of Australasia and used by approximately one quarter of our Association as a means of certifiable CME, has not been without problems. The major drawback seems to be that of actually logging on and putting down the relevant learning experience. I must admit that this is one of my own difficulties even though I use the computer at least once a week. This is probably more a matter of developing good habits than any problem with the programme per se. Other problems are with transferring data entered to a new computer, backup or making up reports for employers or the CMOA. I believe the overall programme is excellent and well worth the support of the CMOA. If people do experience difficulties they can contact myself, or the RCPA directly (02 8356 5825 email: cpdp@rcpa.edu.au). Incidentally, the RCPA is quite happy to provide the paper version of the CPDP for those who would feel more comfortable with this. Simply make a note of this preference when you apply for the programme.

One method to make CME more relevant is to provide regular feedback during the year in the form of newsletters from the Education Officer CMOA, and quarterly or half yearly reports from the members. This will be done during the coming year.

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Industrial Update

October 2000 *David Brock*

AWARD NEGOTIATIONS
A lot of this may sound familiar, as things have only "progressed by NOT progressing". Turning negatives into positives, ASMOF has also been frustrated by a lack of forward response from HAREA and is now prepared to prepare and lodge a CMO claim before the NSW Industrial Commission, with or without HAREA's assistance. ASMOF would be interested to hear our renewed support for this action.

BACKGROUND
(skip this if you are familiar with developments over the past 2 years):

1. NSW salaried CMOs paid under the NSW CMO Award have dual industrial representatives before the NSW Industrial Commission, namely HAREA & ASMOF. HAREA probably has more political clout than ASMOF, yet ASMOF prides itself on exclusively representing Doctors. We are dependent upon both organisations as we are unable to directly represent ourselves, because we are not entitled to (we are not "parties" to the NSW CMO Award), and do not have sufficient funds or resources.

2. After repeated letters from the CMOA (April 1999 through to Mar 2000) to both representative unions, ASMOF agreed with our suggestions that the NSW CMO Award is in need of urgent revision. HAREA has not replied to any letters I have sent as the Industrial Officer for the CMOA. In fact, senior members of HAREA have stated to me that it has no obligation to anyone other than its members, therefore it doesn't have to acknowledge or respond to letters from the CMOA.

3. HAREA has put forward a proposed "amalgamated award" before the NSW Industrial Commission. It proposes that approx 28 individual NSW awards affecting NSW hospital workers will be replaced by a single "Public Health Industry (State) Award". This amalgamated award fails to properly address issues of concern to CMOs, merely bringing CMOs into a single document encompassing all public hospital workers except Nurses and Specialists.

4. The CMOA has written to both HAREA and ASMOF stating that we want the NSW CMO Award retained as a distinct document, but not be disadvantaged by this action. HAREA, of course, hasn't replied. ASMOF, however, has responded with a letter they wrote to HAREA in May 2000 suggesting that ASMOF & HAREA "jointly develop a comprehensive log of claims for a new CMO Award for submission to the Department of Health. Such an approach would require an amendment to exclude CMOs from your existing application for a new Public Health Industry (State) Award". Five months later, ASMOF hasn't received a reply from HAREA, who are still "considering their position".

5. As a member of HAREA and armed with a copy of ASMOF's letter to HAREA, I have repeatedly approached HAREA for some action. No one in HAREA appears capable of acknowledging that this letter from ASMOF was received, even though I have provided various people who are supposed to represent CMOs with copies.

RECENT DEVELOPMENTS:
While the NSW Govt has been preoccupied with all things Olympic, NSW ASMOF has been preoccupied by all things GST. Nonetheless ASMOF is concerned about HAREA's lack of response to their letter. As ASMOF wants to demonstrate that it can achieve things for salaried doctors in NSW, it is now willing to prepare a claim for CMOs, and take it before the Industrial commission with or without HAREA's assistance.

The no extra claims clause (that is part of the current 16% pay rises rolling in over the next 3 years for all public NSW health workers) does not appear to be an impediment as a claim currently put forward by the NSW nurses appears to be progressing.

I have also spoken with HAREA's senior negotiator Bob Hull. He states that HAREA has no fundamental opposition to CMOs being removed from the amalgamated claim. Furthermore he accepts that the penalty/overtime barrier clause, unique to CMOs, should have been removed from their proposed amalgamated award,

referring to it as a "typographical error", and will need to be deleted from future copies.

HAREA is also negotiating an outstanding 20% pay claim for "selected groups" within HAREA, which was lodged prior to the recent 16% agreement. For reasons not clear to me CMOs were never included as one of these selected groups. (Pharmacists, Allied Health workers, purchasing officers, etc. were). HAREA says that we may indirectly benefit from this claim as it may be used to argue for the removal of the CMO penalty & overtime barrier. Discussions will have to take the existing 16% pay increases into account.

COMMENTS
We need to work with both representative organisations, even if one refuses to formally recognise our Association. In my opinion, any actions that would trigger a demarcation dispute between HAREA & ASMOF would be counter-productive, as this would distract everyone from the issues at hand.

We need to consider our position and reaffirm that ASMOF & HAREA work to retain CMOs as a distinct group with a new log of claims to be negotiated with the Department of Health. HAREA & ASMOF wish to see the general conditions award as a basis for our claim. HAREA is holding discussions with NSW Department of Health representatives today. I have asked that issues relating to CMOs are included in their discussions and should get an indication of the Departments attitudes before Goulburn meeting.

WHAT WE NEED TO DECIDE
I believe we need to send a clear message to ASMOF and HAREA to strongly reaffirm that the CMOA wants the NSW CMO Award to be retained and developed as a distinct document. The alternative is to sit quietly and be passively absorbed into HAREA's general conditions award.

MOST RECENT UPDATE
I had a further chat with Bob Hull from HAREA today (5th Oct 2000). He had a meeting with Dept of Health representatives today and mentioned that HAREA was considering removing CMOs from their general conditions award and putting in a renewed claim for CMOs. He asked what the Departments response might be to such an arrangement. The DOH representatives stated that they were unable to say at this stage and would have to refer the matter to their superiors. Nonetheless it did appear that the department would probably oppose any new claim, due to the current "no extra claims" clause associated with 16% pay rise which is currently rolling in over 4 years ..

Bob also stated (raised the issue) that HAREA had removed overtime provisions relating to hospital managers & hospital scientists in an effort to provide a common overtime provision. He told them that HAREA believed it was a typographical error that the current version of the general conditions award includes an overtime clause relating to CMOs, and that this would need to be removed.

He also added that despite HAREA[1]s failure to respond to letters from the CMOA, he was apparently the 4th person to be entrusted to "all things CMO", and there was a box of all related information located somewhere in HAREA.

So we need to maintain our links with HAREA, as it appears HAREA is still wanting to do the right thing by us.

Dave

Stop Press

Having attended the last ASMOF Meeting I am happy to report that HAREA and ASMOF are finally having discussions about separating CMOs from the proposed amalgamated health workers award. Which implies that the award will be reassessed in the New Year. Great work David!

I would also take this moment to point out that improvements to awards in one state can subsequently be usefully employed in seekign improvements in similar awards in other states. So these issues are not of interest only to NSW CMOs.

Mary GT

The Hospitalist: An Australian Perspective

John Egan

The article we published in the MJA has drawn international attention! If you have not read it, it is available on the website at http://www.cmoa.ican.net.au. This is an article I sent to John Nelson MD, one of the founders of the hospitalist movement in the USA. At the end of the article is a letter received from Scott Flanders, which is self explanatory.

The term "hospitalist" is new to Australian medicine and at the present time there is no-one who is officially practicing in this capacity. All this may be about to change following three recent articles in the Medical Journal of Australia (1,2,3). The first of these by Ken Hillman (1), an intensivist from Liverpool Hospital (20 km south-west of Sydney), brought the concept to the attention of Aussie doctors and made the suggestion that this person be chosen from the ranks of intensive care medical specialists. The next two articles explored the concept in general terms and made the counter-claims that the doctor be either a specialist physician (2) (internist) or a career medical officer (3) (probably no American equivalent but a variety of doctor employed in Australia in rural and urban hospitals to maintain experienced medical staff within the hospital system). This doctor is used predominantly in the more populous eastern states.

The medical staffing of Australian hospitals has generally followed British tradition with patients admitted under a consultant doctor (medical, surgical, gynaecological, paediatric or other)—the visiting medical officer (VMO). This doctor will normally run private or outpatient rooms and attend hospital patients on ward rounds with junior medical staff. The day to day medical care of inpatients is left to these junior medical staff - in order of increasing experience and seniority - intern, resident medical officer (RMO) and registrar. The registrar is a specialist in training. In spite of having a good track record in the past, there are increasing problems with delivery of a high standard within the hospital system (4).

One part of this problem is the relative inexperience of the doctors who are working "at the coal face" on the hospital wards. This has been exacerbated with the entry into the regular hospital routine of highly experienced physicians in emergency departments and intensive care units. The advanced training and activities that nurses undertake in a modern hospital further highlights the deficiencies of having apprenticeship level medical cover at the front line.

One surprising aspect of the debate is the general lack of criticism of the concept of the "hospitalist". There has been a little negative reaction among the wider medical community, "why do we need to change?", however much positive reaction from both specialist physicians (internists) and career medical officers - "that's what we're doing now" or "that's what I would like to doing" being typical responses among both groups. The fact that the uptake of this concept has been almost "powder-keg" explosive in the USA suggests that the energy for change was there, waiting to be released by those one or two with the lighted match of insight and initiative. This may also prove to be the case in Australia. One problem that is being considered is that of the "major" or "minor" hospitalist options. Should we have a full hospitalist role, with the doctor taking up all inpatient responsibility from admission to discharge (as appears to be the case in the USA), or should the role be complementary and integrated with the visiting medical officer having overall control but relying on the active support and expertise of the inpatient physician?

There is obviously still a lot of debate that needs to be undertaken in Australia before we match the major revolution that seems to be well underway in the American hospital, but the following questions seem relevant to an Australian doctor with an interest in the process:

1.What are the basic requirements for acceptance onto the training programme for a hospitalist?

The Hospitalist: continued

2.What does the training programme consist of in terms of rotations, knowledge base and time?

3.What would be the "Job Description" for a typical hospitalist position?

4.If you could reinvent the "hospitalist", how could you do it better, what mistakes would you avoid?

Australians are watching your (amazingly rapid) development with great interest. We suspect that we may well go down the same road in the near future.

John Egan,
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References:

(1) Hillman K. *The changing role of acute-care hospitals.* Med J Aust 1999; 170: 325-328

(2) Scott IA, Phillips PA. *Hospitals and hospitalists: an alternative view.* Med J Aust 1999; 171: 312-314

(3) Egan JM, Webber MG, King MR, et al, *The hospitalist: a third alternative*. Med J Aust 2000 172: 335-338

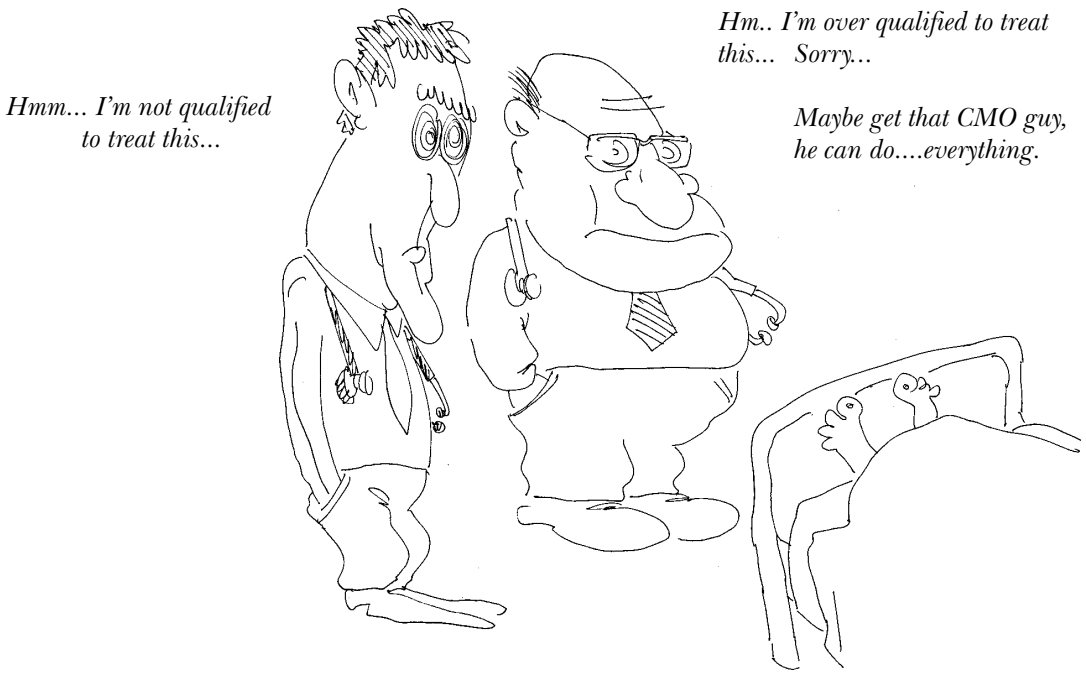
(4) Wilson RMcL, Runciman WB, Gibberd RW, et al. *The quality in Australian Health Care Study*. Med J Aust 1995; 163: 458-471

Dear John,

I am the editor of **The Hospitalist** (the newsletter for the National Association of Inpatient Physicians) here in the U.S. I read with interest your article on the hospitalist movement in Australia that you sent to John Nelson.

I plan on publishing it in our next newsletter and would love to get any updates you may have over the following months. Thanks for you submission and keep us posted.

Scott Flanders, MD
University of California, San Francisco



12th Meeting of the CMOA

July 15th 2000 Prince Charles Hospital, Chermside, Brisbane

Guests:
Rupert Titmarsh - ASMOFQ
Brian Mann - QPSU
Jennifer Harlen - University of QLD

Apologies:
John Egan, Micheal Boyd, Michael King, Steve Delprado, Kien Caouxuan, Murray Byrne

Present: Gabrielle DuPreez Wilkinson, Mary G.T. Webber, Mark Davie (Anasethetics), Paul de Jong from Gladstone Hospitalist , Stefan Golsfetter - D&A, Maria Markovska - D&A, Dave Brock by phone link up.

Opening and General Business
Our first true interstate meeting. Also a chance to introduce ourselves to people. Thanks to Stefan and Maria for coming along and giving us a hearing. Also a valuable chance to compare interstate notes on the industrial situation. The minutes of our last meeting were accepted as a true record of proceedings.

Dave Brock is now a Branch Councillor in ASMOF, pursuing the fact that the CMO award is falling into disuse. This is of considerable significance since the shelter of an award structure may be something we might all be glad to have available some day. Private agreements are vulnerable to being changed unilaterally, and contracts can be terminated .

One of our aims for the year is to start to raise our profile generally. ASMOF is one of the targets of this process and we make efforts now to have at least one committee memeber either physically present or attending meetings by phone. A frustrating business since their main issues continue to be tax, and Staff Specialists. ASMOF continues to be willing to work with CMOA for the preservation and improvement of the NSW award and willing to retain it in the face of the the threat of a combined award that HAREA has put forward. ASMOF sent letter of protest at the highest level but no reply has been received. Information seems poorly disseminated and it is difficult to identify how decisions are being taken, or not as the case may be. However HAREA will need to agree with ASMOF in order to implement the changes, so there might be some play there. The proposed amalgamation of 28 awards into 1 award makes a 220 page document with no actual improvements in the pre-existing problems, does not seem to be an improvement. CMOs who are members of HAERA individually need to contact and protest.

Time frame for implementing the amalgamation: almost a fait acompli? No notice to HAREA members that we know of.

Web Site - still getting hit. Difficulty counting who is hitting it - 8 -10/ day. Dave is happy to add a link for ASMOFQ. Pursuing it.

Gabrielle[1]s Presentation. For the benefit of guests and new members, Gabrielle outlined the evolution of the CMO in practice. The difficulties with nomenclature were discussed, as was the ongoing need for constant re-skilling to meet changing roles and the struggle to control that ourselves. Forseeable that documented CME will become a condition of registration, as it is in NZ and South Africa. The familiar industrial issues were summarised, and the variety and flexibilty of career paths to address the real world demand were once more noted.

Reports from office bearers - President / Editor and Secretary present. Both pooped and pressed for time.

Local Industrial Issues

Redlands - Pursuant to a loophole in the QLD award the 1st tem hours of overtime doesn't count as overtime. The local admin seems to think that SMOs etc actually don't get paid for it at all and they are juggling those hours to reduce the number of people employed.

Long term QLD provision of a 90 hours / fortnight—and so far unable to establish a specific clause reflecting unpaid overtime. SMOs/RMOs are also required to undertake paeds or resus without training. This is a significant medico-legal risk situation.

12th Meeting: continued

Hopefully the admin can be taken up on this as their duty of care implies a binding arrangement to provide trained staff.

From Simone Evans - concerned for conditions under which doctors provide services to private hospital. Private practice should carry option A or B allowance for private practice. Additional to normal duties. However this is running up against local issues of difficulty with attracting staff at all. SMOs etc are doing necessary private work without being appropriately remunerated.

Recent industrial action in QLD. Complaints were received that communication from QPSU to the floor about the progress of the dispute was poor. During a planned stop work - RMOs didn't know and couldn't find out what was going on.

Report - QPSU took reasonably low key approach. Part of a day of action. Apparently the Government is a touch toey that the negotiaions are still under way after the previous agreegment has actually expired. The current offer is 9% over 3 years, and the date of operation will be projected back to 1st April. The union is still trying to include allowances - training adminstration levels upwards, remote raiography allowance, salary sacrificing etc. A number of clauses still outstanding.

When these are finalised there will be consultation and a ballot - over soon. Activity has been continuous since March.

Master of Clinical Medicine Update
Discussions re options for staff development - start small and layer later on. Such a model works well in the school of Continuing Ed. Currently being drafted is a proposal to Federal Government for a seeding grant from the Dept of Commonwealth. Appointment in Canberra later this year.

For the benefit of, and to canvass the opinions of, those unfamiliar with our previous discussions we outlined the usual agreed profile of such a degree, featuring a modular approach using local rescources, and utilizing integration with existing programmes and administrative structures, for flexibility and contained costs.

Happy to report some considerable interest form the floor, which was great since it was a cold audience previously unsubjected to our persistence on this topic.

13th Meeting of the CMOA

Saturday 7th October 2000, Goulburn Hospital

Attendance: Mary Webber, Steven Myers, Ruth Edwards, John Egan, Dave Brock, Gabrielle du Preez Wilkinson, Michael Boyd.

AGENDA
1. Opening and apologies
Apologies from Ron Strauss, Kien Caouxuan, Steve Delprado.
In keeping with our policy of recognizing the scattered and various nature of CMO work by having meetings out of the Sydney metropolitan area, this time we ventured forth to Goulburn to sample some southern highlands hospitality and meet the locals. These meeting are always an interesting chance to meet people who have neither time nor facility to come to Sydney, to discuss issues local to the area, such as staffing concerns, and to put faces to the names on the mailing list. Ruth was able to inform us as to the educational requirements of the College of Rural and Remote Medicine, and Stephen was eloquent on the topic of life as a member of the very first generation of doctors without a provider number. John Egan, education officer extraordinaire suggested extending our usual agenda to include an educational session and inviting local GPs and RMOs to participate. This was an excellent opportu

13th Meeting

Continued from page 9

nity to raise the profile of CMOs in the area and John's suggestion of Trauma Workshop conducted by Dr Tom Lyttle, trauma surgeon and EMST Instructor was very well received and attended. Special Thanks to John and Lyn for putting the meeting together, and keeping us fed, watered and entertained. And particular thanks to Dr Lyttle who gave up his precious Saturday off to share tips, tricks and timely reminders with us.

2. Minutes of last meeting were reviewed and accepted as a true record of proceedings. Discussed the differing industrial situation in QLD, and agreed that the effort to stage our first interstate meeting had been entirely worthwhile. Maybe Alice Springs next year?

3. Business arising from last meeting:
Having acted under the advice available at the time and so as to avoid possible complications and/or penalty we are now registered for the GST and have received our ABN. Of course no-one precisely knew where non-profit professional organisations will fit into this new schema, exactly. Advice over the advice line said go ahead and register. However we will NOT be passing this expense onto the members at this time, until the situation is clearer, and probably not then.

Post-Graduate education designed for CMOs, see Gabrielle's update elsewhere.

4. Treasurers report.
Michael King is rumoured to be off doing something with RFDS. Last time we heard we were still solvent and able to pay our bills for publishing, postage, web site, travel for speakers, phone conferences and so on. Solvent but not wealthy. Its a good thing all the envelope licking and stapling is still provided gratis.

5. Industrial Officer's report.
As ever Dave's extensive report is available elsewhere in this bullletin.

6. Education Officer's report.
See separate article by John in this bulletin. Discussed the pressure to provide documentable CME (again) and the prospects and labor involved in providing our own on a six monthly basis. A project for the coming year and one that will require more input from the members. Looking for volunteers soon, we thought. As ever we suffer from a small actual work force none of whom is overburdened with free time. The sorts of time commitments, for example, involved in developing the educational requirements for ACCRM are far beyond our modest rescources.

Once more we discussed the long term desirablity and possible formats for an independent training programme for prospective CMOs. CPDP membership will have to be emphasised to the members next year.

7. Correspondence.
The hospitalist role article has raised some interest in unexpected quarters. John has had correspondence from John Nelson, MD one of the founding memebers of the newly formed US College. More on that elsewhere in this issue.

8. General business
We continue to raise our level of involvement with ASMOF. This year has also brought the opportunity to raise our profile with ASEM, which we are taking.

9. Next meeting and close.
We did discuss having meeting in Dec, but the tidal wave of life, its inconveniences and complications has overtaken us again!

The business part of the meeting was followed by a Trauma Workshop given by Dr Tom Lyttle. Extraordinary thanks to John for setting it up and finding the relevant bits of sheep and chook, and to Dr Lyttle for his enthusiasm and excellent teaching.

Education Report

Continued from page 3

One further method is to formally articulate your own learning needs and goals for a specific period (eg one year).

Accreditation and verification of CME is becoming mandatory in many areas of medicine and there is no doubt that this will be the case for CMOs in the near future. With this in mind the CMOA will start certification of CME this year—all those who have the programme will be notified and a certificate supplied on receipt of a report (however much or little is on the report for this first year). In future there will be minimum standards and for the coming year this will be one hour per week reported CME.

While we are on this topic it is worth noting the principles underlying the Professional Development Programme put out by the Australian College of Rural and Remote Medicine (ACRRM) - brought to my attention by Ruth Edwards who is now a Fellow. These principles are similar to those underlying the CPDP.

~ Reflection on own practice

~ Self-directed learning based on individual and practice needs

~ A formal articulation of learning needs

~ Greater credit given for educational strategies shown to be more effective

~ Need to accumulate points in order to direct learning towards proven strategies and to demonstrate participation in the programme

~ Flexibility

2. Training Programme

This is something for the future, but there appears to be a need to develop a training programme specifically in hospital medicine. Perhaps this could be done as part of the involvement of the CMOA in the "Hospitalist" debate and any move to formalise this area as a legitimate career. This will need a lot of discussion and input from interested CMOs. My own personal idea would be to make a programme over several years that included

Coursework eg EMST, ELS, APLS
Procedural skills
Formal training programme (University or other)

Needs lots of thought and debate.

3. Postgraduate Programme

Report from Gabrielle– anyone to start? See the article by Gabrielle elsewhere in this Bulletin.

4. Further issues

Similarly to the Training Programme mentioned above, these two items need a great deal of thought and debate but, to my mind, should be considered now rather than later. Just briefly here, but possibly for debate in the next issue of the Bulletin (or at the next AGM)

1. Should the CMOA form a College?

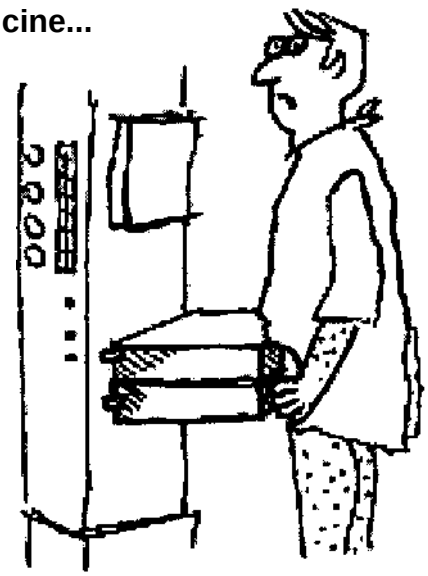
2. Should the CMOA become involved in development of an Australian Hospitalist?

John Egan

Some Humour for the Holidays

If Women Controlled Medicine...

The Manogram



More humour on the back page...

Mammograms

Many women are afraid of their first mammogram, but there is no need to worry. By taking a few minutes each day for a week preceding the exam and doing the following practice exercises, you will be totally prepared for the test, and best of all, you can do these simple practice exercises right in your home.

EXERCISE 1:

Open your refrigerator door and insert one breast between the door and the main box. Have one of your strongest friends slam the door shut as hard as possible and lean on the door for good measure. Hold that position for five seconds. Repeat again in case the first time wasn't effective enough.

EXERCISE 2:

Visit your garage at 3 AM when the temperature of the cement floor is just perfect. Take off all your clothes and lie comfortably on the floor with one breast wedged under the rear tire of the car. Ask a friend to slowly back the car up until your breast is sufficiently flattened and chilled. Turn over and repeat for the other breast.

EXERCISE 3:

Freeze two metal bookends overnight. Strip to the waist. Invite a stranger into the room. Press the bookends against one of your breasts. Smash the bookends together as hard as you can. Set an appointment with the stranger to meet next year and do it again.

You are now properly prepared.

A Parable For Our Times....

In the beginning, God created Heaven and Earth....
And the Earth was without form, and void, and darkness was upon the face of the deep.
And the Devil said, "It doesn't get any better than this."
And so God created Man in His own image; male and female He created them.
And God looked upon Man and Woman and saw that they were lean and fit.
And God populated the earth with broccoli and cauliflower and spinach, and green and yellow vegetables of all kinds, so Man and Woman would live long healthy lives.
And so the Devil created McDonald's.
And McDonald's brought forth the double cheeseburger.
And the Devil said to Man, "You want fries with that?"
And Man said, "Yea, super size them."
And Man gained five pounds.
And so God created the healthful yogurt, that Woman might keep her figure.
But the Devil brought forth chocolate.
And Woman gained five pounds.
And God said, "Try my crispy fresh salad."
And the Devil brought forth Ben and Jerry's.
And Woman gained 10 pounds.
And God said, "Why doth thou eatest thus? I have sent thee heart-healthy vegetables and olive oil with which to cook them."
But the Devil brought forth chicken fried steak so big it needed its own platter.
And Man gained 10 pounds.
And his bad cholesterol went through the roof.
And so God brought forth running shoes.
And Man resolved to lose those extra pounds.
And the Devil brought forth cable TV with remote control so Man would not have to toil to change channels.
And Man gained another 20 pounds.
And so God brought forth the potato, a vegetable naturally low in fat and brimming with nutrition.

It is our sincere hope that this does not offend any of our readers, we thought it an interesting comment on the almost religious and puritanical approach to food, and besides, it's funny.