Letter from . . . Victoria

Medical manpower

JOHN KNIGHT

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Forecasting the need for doctors in the future is a form of crystal gazing, usually carried out with dark glasses on. Recently Dr R McEwin, chairman of the Health Commission of New South Wales (NSW), wrote to the *Medical Journal of Australia* about medical manpower.¹ In NSW registration has to be renewed yearly. With the 1976 renewal notices went a questionnaire asking for details about the type of practice and so on. Some 90% of these questionnaires were returned. Using these figures Dr McEwin calculated the patient-doctor ratio for general practitioners and 17 different specialist groups. He then compared these ratios with the Commonwealth (Federal Government) Department of Health's "desirable levels in 1991." He found that only five of the 18 categories were below the hypothetical desirable level. These were GPs, ENT surgeons, pathologists, ophthalmologists, and radiologists. All the other groups were already above the 1991 desirable levels. Despite the figures there are current shortages in some specialties—for instance, anaesthetists' posts are vacant in some NSW hospitals despite the oversupply according to the 1991 desirable levels. Dr McEwin's letter ended with a plea to those responsible for medical training, both undergraduate and postgraduate, to consider the implications of his figures as the new graduates from the universities in NSW will more than maintain the numbers of doctors in the State.

Three weeks later the Director-General of the Department of Health, Dr Glyn Howells, suggested in a further letter² that Dr McEwin's conclusions might be premature—"It is difficult to determine the size and composition of the medical work force. It is even more difficult to determine what would represent either a shortage or a surplus." He metaphorically patted the Health Commission of NSW on the back for its ability to produce a clear picture of the NSW medical work force. He believed that more needed to be done, much more than his department had yet done, to establish whether there is a shortage or a surplus. He doubted that "Dr McEwin's analysis properly interprets my department's recent internal paper giving primary consideration to desirable supply levels for doctors in each of the specialties."

How many doctors?

It seems to me that the first thing to establish is how many doctors are at work, and what sort of work they do, now. Then this information, which could be extracted from the various medical registers and specialist registers in the separate states, could be correlated with evidence of oversupply or undersupply.

The state registers would have to be cross-checked against each other as many doctors are registered in more than one state, so appearing on two or more registers. There are over 4000 doctors in Victoria, so at a guess there are about 16 000 or more doctors in Australia. Cross-checking this number with the seven registers (one for each state and one for the Territories) open in front of him should usefully employ a public servant for a week or two and give the Department of Health a base from which to plan.

The next step, obtaining evidence of oversupply or undersupply, is more difficult. As so much of Australia's medical care is given by the private sector the public hospital waiting lists give a false impression of needs. I can see no way of deciding the question from the information already being gathered. In any case what do we mean by an oversupply or undersupply of doctors? Do we measure the patients' waiting time in the doctor's waiting room? Or do we measure the time between the request for a visit and the visit to the home? This is probably how patients assess the adequacy of their doctor's practice. Should we measure the number of hours worked each week and consider all those hours over 40 (or perhaps 35, which is the Australian public servant's working week) as evidence of undersupply? Should we ask the Medibank computers³ for the incomes of doctors, setting an arbitrary figure as a desirable level of income and count those above and those below the magic figure? Perhaps this information could be interpreted as evidence that the scale of fees was or is too high. Whatever measures of adequacy are finally chosen new information will have to be gathered and collated.

About five years ago the medical course in NSW was cut from six to five years. The next graduation will see the first of the new five-year graduates and the last of the six-year ones. Some will probably have to find their first job outside NSW. This may raise problems as the hospital system in all states is suffering from a cut in finance, inflicted by the Commonwealth (Federal) Government. One way of coping that appeals to hospital administrators is to reduce the number of resident and registrar posts.

Whatever the figures show in the way of an oversupply of medicos there are areas in each state that have too few doctors. These are mostly in country areas but also in the poorer suburbs. How to attract doctors to the smaller country towns is an unsolved problem. In every state most doctors practise in the metropolitan area of the capital city. After all that is where most people live. The further one goes from the capital cities the fewer the doctors—though this may not apply to Queensland's northern coast, where the climate, beaches, and lack of death duties combine to lure doctors to the area.

Overseas doctors

Besides the spectre of an overproduction of doctors in Australia, a large number of overseas doctors are on the medical register in some states. It has been said that in five to ten years there will be a glut of doctors in Australia and the law of supply

Grey Street Anaesthetic Group, East Melbourne, Victoria, Australia
JOHN KNIGHT, FFARCS, specialist anaesthetist

and demand will bring down medical fees. I wonder. It appears that most young doctors wish to specialise and avoid general practice. Surgeons' fees varied a bit some ten years ago when there was a glut of general surgeons, but no one lowered his fees to attract the customers; more usually they charged what they could (or what they needed to stay in business). Some three years ago the Australian Medical Association emerged as the fee-setting organisation for the whole profession, and the various specialist groups' fees were brought together in one book. The Government chose a lower scale of fees on which to base the patients' rebates. Since then the passing years have added to the fees but not as much as inflation has eroded their value. On each occasion this has happened the Government congratulated the Australian Medical Association for its self-sacrificing nobility, which hardly makes up for the fact that my standard of living is slowly going down. But I must not grumble as I am still much better off than my opposite numbers in the UK.

The overseas doctors on the registers of some states are there because Australia has no overall general medical council. Each

state has its own medical register, with different conditions. South Australia has hundreds of doctors who live and work in the countries to the north of Australia. There is fear that the state might be swamped by overseas doctors if things go wrong abroad. NSW has much wider registration possibilities than does Victoria. This was publicised recently when a small country town was unable to obtain the services of an Indian doctor who was willing to move from NSW, where he was registered, to Victoria. This was not to be, as his qualifications, acceptable in NSW, were not acceptable in Victoria. It is said that last year the NSW Medical Board registered more foreign than Australian graduates. Perhaps NSW is oversupplied in some specialties as a result of an influx of foreigners.

References

- ¹ McEwin, R, *Medical Journal of Australia*, 1977, **2**, 288.
- ² Howells, G, *Medical Journal of Australia*, 1977, **2**, 341.
- ³ Knight, J, *British Medical Journal*, 1978, **1**, 93.

Dynamic Approach to Adolescence

Treatment

K S PERINPANAYAGAM

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The dynamic approach to adolescent disturbances, taking account of the patient's total personality and total situation, can be based on outpatient or residential treatment.

Outpatient treatment

Two frequently used methods for treating disturbed adolescents as outpatients are individual psychotherapy and family therapy.

INDIVIDUAL PSYCHOTHERAPY

Adolescents generally long for a one-to-one relationship. They have secrets that confuse and worry them, they have many questions for which they want answers, and they often feel misunderstood, lonely, and unloved. They are ripe and ready to relate to an adult whom they can trust.

Nevertheless, they are also wary of adults and angry with them and usually begin by displacing these feelings on to the therapist. They are also ashamed of their need and wish for a dependent relationship with the therapist and want to deny it. If the therapist is aware of the adolescent's confusion, his ambivalence, and his underlying wish to make a relationship, and

approaches him sensitively and with empathy, a good relationship can be easily established. Within such a context many different techniques can be used to help the adolescent with his difficulties.

FAMILY THERAPY

Simply getting all the family together for discussions can solve many an adolescent problem. Often parents do not realise that their teenage son or daughter is having some serious worries. Parents tend to believe that their little children have all they need—a good home, food and clothing, and opportunities to study and make friends—and that any worries they have must be very minor ones. Anxieties and worries that children attempt to convey to their parents, sometimes directly and clearly and at others indirectly and in disguised form, are often minimised and dismissed. For the adolescent to see his whole family getting together—perhaps at great personal sacrifice of time, money, and leisure—for his sake, thinking and discussing what he feels to be his personal difficulties, and to hear his parents' anxieties and concerns about him is often a unique experience. He realises for the first time that he is indeed cared for and is a member of a caring family and, in fact, not alone. He feels better about himself and better able to cope and to deal with his problems and feelings constructively. The actual sharing of his feelings with the family lightens his burden.

Parents often attend these family interviews with reluctance because they feel considerable guilt about being the cause of their children's problems. They are sensitive to such suggestions, defend themselves, over-react, never relax, and finally stop coming if their guilt is not handled with sensitivity. Many potentially useful family discussions are destroyed by the therapist's attempts to make "clever" and facile interpretations that seem to be aimed at displaying his competence rather than

Brookside Young People's Unit, Goodmayes, Essex IG3 8XJ

K S PERINPANAYAGAM, MB, MRCPsych, consultant psychiatrist and medical director