Letter from . . . Brisbane

Play it again Sam

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When I worked in England in the 'fifties one of my colleagues was a time-expired senior registrar. Being highly esteemed by the hospital chief, he remained on the staff on a grace and favour arrangement. He was well qualified to work as a consultant, and, like so many others, job hunting. After many refusals he found a position in a provincial city, and so far as I know he is still there. Those were the days of the great wave of medical migration from Britain, so well documented in the *BMJ* by Dr John Seale. Most emigrants went to North America, many came to Australia. Simple arithmetic demonstrated the problem. A consultant appointed at the age of 35 could expect to work for 30 years, during which time seven or eight senior registrars would pass through his unit. As only one could replace him, and as expansion of services was strictly controlled by the State, some at least of the others had to leave their specialty or leave the country. The problem would have been worse had it not been for the large number of "colonial" doctors working in Britain. It was generally thought that a "colonial" had a better chance than a local of obtaining a registrar appointment (the few pre-eminently brilliant local graduates could expect an appointment on the staff of their teaching hospital), as the return of a registrar to his country of origin prevented further crowding of the promotion ladder.

Things seem better now. Indeed, the pendulum may have swung the other way, as notices of new appointments—at least in the less popular specialties—often contain the names of doctors who have graduated outside Britain. Official spokesmen bewail the fact that a country can train a doctor, at considerable public expense, only to see him leave for ever and spend his working life elsewhere; but, in the absence of medical conscription, and with everybody quite rightly looking for a place to work which best suits his talents and aspirations, this is an inevitable result of inequalities of opportunity.

Twenty years on

In spite of these clear lessons, Australia is making similar mistakes—though, as often happens in our derivative culture, 20 years later. When I joined the staff of my hospital the specialties, particularly in internal medicine, were not very well developed. A few registrars could fill the service needs of the hospital, and some of them are now back as consultants. Over the years the specialties have flourished, and we have become the major referral hospital for half of the city of Brisbane. As each new department has opened a registrar has been appointed, and with the growth of the departments some now have two, the total number rising steadily each year. The Royal Australasian

College of Physicians has calculated that in ten years' time Australia will probably have trained twice as many consultant physicians as it needs. Few of the trainees come from outside Australia, as the excellent medical schools and hospitals in neighbouring countries such as Singapore provide adequate scope for their own graduates, while opportunities for emigration from Australia are limited. The same arithmetic applies in Australia as in Britain, and so it seems inescapable that many physicians in training will be unable to find work in their chosen specialty.

This state of affairs has been complicated by the attitude of our College of Physicians to training. While expressing a belief in the need for flexibility, it has forced an unprecedented rigidity on to medical training over the whole of Australasia. It is almost essential for the aspiring physician to commit himself to this specialty in his second postgraduate year. A fairly strict timetable controls his study for the primary fellowship examination, and, while passing the old membership examination was always a major objective for the candidate, the new style examination, with its multiple choice questions on medical minutiae, distracts the trainee's attention to the point where hospital work tends to suffer.

As an example, a few years ago registrars were willing to write papers based on their clinical experience, some being published in the hospital newsbulletin, a few in medical journals. Such is the preoccupation of registrars with their examination that this custom has all but been abandoned—to the detriment of both the hospital and the registrars themselves. Further, it is no longer practicable for the aspiring physician to take appointments in physiology, pathology, or even in surgery—again a loss to the practice of medicine. Once the candidate has passed his primary he has to undertake a course of training in approved posts, so again he must commit himself fairly early. Though the training he receives may be guaranteed to be of high quality, loss of flexibility must restrict his educational horizons and his employment potential.

Unofficially college spokesmen have suggested that the imbalance between training posts and consultant opportunities may be redressed by "dis-accreditation" of several positions. Such an attitude seems to show a lack of awareness of the service obligations of hospitals, as a post not accredited for specialty training is unlikely to attract applicants—yet the service must go on. Some years ago I suggested to members of the college council that it was high time an attempt was made to rationalise the conflicting demands of the community for medical specialists, the hospitals for a work force to provide service needs, and the legitimate aspirations of young doctors, with the requirements of the college for specialty training. The response was unvarying: a total lack of interest. Now that a crisis is almost on us, the college has realised that it is time to take action—but it cannot do so unilaterally with any hope of success. Dr Roderick McEwin, Chairman of the Health Commission of New South Wales, has produced figures suggesting that there is already an oversupply of doctors in that State,¹ and with large numbers of students already in medical schools, and pressure of would-be

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immigrant doctors, this state of affairs is likely to get worse before it gets better. But sense has not altogether flown: plans to build three new medical schools have been shelved.

The new technology

Another tune being played again here is that of the new technology. Doctors in private practice earn their living on a fee for service basis, the level of fees being negotiated periodically between the Australian Medical Association, the Commonwealth Government, the medical insurance organisations, and a tribunal which sets the level at which benefits for each item of service are to be paid. The politicians and bureaucrats failed to realise that the output of autoanalysers and other modern laboratory equipment far exceeds that of the technician doing each test by hand. Around Australia there are many highly efficient private laboratories, whose gross income has risen both legitimately and considerably as a result of technological advances. So the basis of payment for laboratory tests has had to be reviewed. Moreover, one of the anomalies of the health insurance system is that public hospital laboratories can and do earn millions of dollars from tests on private and intermediate patients—perhaps not a bad thing, as hospitals' incomes are augmented beyond their normal expectations.

A similar problem is about to appear with body scanning. While only two of Brisbane's four major public hospitals have computed tomography brain scanners, radiologists in private practice have installed two whole-body scanners. Because of the cost of the machines, their accommodation, servicing, and maintenance, scans will be expensive—and there will be a legitimately rising demand for their use. It is highly likely that the increase will outstrip the predictions of the bureaucrats, so that we can expect accusations of "rip-offs" by radiologists (true, a few doctors in various forms of practice have been convicted of defrauding Medibank, but which profession does not have its quota of rogues?). and further attacks on the medical profession by those who would prefer a nationalised service.

A similar rapid expansion has occurred in cancer chemotherapy. As cytotoxic drugs are costly, and as most require careful laboratory control, this is a highly expensive form of treatment. As an example, a paper was presented at a recent meeting of the Thoracic Society of Australia claiming increased length of survival of patients with small cell cancer of the lung. All patients in the series had had two brain, lung, and liver scans; all had received radiotherapy and combination chemotherapy; and all had been assessed by a team of doctors and

paramedicals. Certainly the lives of these patients were prolonged, and certainly chemotherapy research must go on, but no dollar can be spent twice, and one wonders if some of the money could have been better used for improving the treatment of, say, handicapped children.

Futile effort?

Every doctor has an obligation to provide the best available care for his patients. The corollary in the technological age is that doctors continue to be accused of careless prescribing, wasteful investigations of patients, unnecessary hospital admissions, unnecessary surgery, rip-offs, and other abuses. Prompted by the Federal Minister for Health, the AMA has established a committee to study peer review, medical audit, delineation of privileges, and related topics. Two members toured the United States, Canada, and West Germany and presented a report of their findings to a special meeting of representatives of all branches. But where will all this effort lead? The AMA has no part to play in the management of private or public hospitals, while the problem of evaluating the work of general practitioners and specialists in their consulting rooms appears so formidable that it is likely to be placed in the "too hard" basket.

In hospitals the necessity for improvement in medical records; employment of more filing clerks and records librarians; appointment of suitable people to cull information from charts; and payment of doctors to attend meetings to discuss the data so collected will add considerably to running costs before one dollar is saved—and this at a time when hospitals have been instructed to reduce spending. The peer review song, a number requested by the politicians, is unlikely to be heard here in the near future, but the AMA will need better skill at public relations than it has shown so far if doctors are to avoid the label of self-interested obstructionists.

To this rather cheerless letter I must add a further sad note. One tune will not be played again. Sir Albert Coates, the famous prisoner-of-war surgeon, died recently. In Australia's Valhalla Bert Coates has an honoured place, seated near that other great Melbournian Sir William Johnston, both well above the salt.

Reference

- McEwin, R, *Medical Journal of Australia*, 1977, 2, 228.

In the Sherlock Holmes story "The Adventures of the Devil's Foot" Sir Arthur Conan Doyle wrote, "All three of them, the dead woman and the two demented men, retained upon their faces an expression of the utmost horror." I have never seen a corpse that retained anything that could be called an expression. Sir Arthur was well known as a keen observer and a doctor but did his imagination overcome his medical experience?

The short answer is yes, for Conan Doyle was not averse to using a little licence for the sake of colour. The face can reflect physical states such as pallor, turgid engorgement—as when the eyes bulge in strangling or become hollow in dehydration—but not emotional states like horror, disgust, or amusement. Death is indeed the great smotherer of anxious brows.

Does canned or carton-packed orange juice contain vitamin C, and does the vitamin survive storage in a refrigerator?

A little of the vitamin C in orange juice is destroyed during canning, almost none in freezing. There is also very little deterioration in the can and virtually none in the frozen orange juice. Even after opening

or reconstituting, orange juice loses vitamin C very slowly in the refrigerator. This is partly because of the acidity and partly because there are natural substances in the orange juice that retard oxidation.

If a piece of meat is cut in half and one half cooked right away all the juices are cooked in the meat. If the other half is deep-frozen and later thawed out before use some juice is lost in the thawing-out. What beneficial properties are lost in this thawing-out?

The first part of this statement is not correct, since cooking meat invariably results in some shrinkage and thus the exudation of juices into the cooking water or the baking tray, or to the surface of grilled meat—where it may dry. This juice, like the juices exuded from thawing frozen meat, does contain small amounts of water-soluble vitamins and salts. The total loss is on average about 20% of these substances, but may be rather more if cooking is prolonged. Less than this is lost on thawing frozen meat, but this would partly be made up by a decrease in the amount of juices that are later lost in the cooking. One way to prevent even this wastage is to use the juices in soup or gravy, if that is possible.