Letter from . . . Dunedin

The best laid schemes o' mice an' men

A G HOCKEN

It is singularly fitting that Robbie Burns should be able to provide a piece appropriate to my current thoughts. For not only was his uncle, the Reverend Thomas Burns, the spiritual founding father of this Edinburgh of the south when he led his flock here in 1848, but the poet himself has a bronze statue in the centre of the town—lauded with the salutations of countless generations of gulls.

In 1968 a series of commission reports and studies resulted in a synthesised message which said, of and to the University of Otago, "Yes, you may have the improved facilities which you require in order to attract the standard of clinicians and teachers needed that you may maintain the excellence of your medical school. However, in exchange, you will contribute to certain moves to remedy the present underdoctoring of New Zealand by increasing, by stages, the intake into Otago University Medical School by up to 200 students per annum. You will furthermore co-operate in the establishment, in due course, of clinical medical schools of the University of Otago in Christchurch and Wellington." Thus in early 1981 the nine-storey, 500-bed, ward block of Dunedin Hospital will be occupied. The use of one wing by students and faculty represents that side of the bargain, which has over the decade massively enriched the medical faculty of the University of Otago. Movement of patient services into the block was initiated in anticipation of the formal opening by the Duke and Duchess of Kent on 10 November 1980.

It is about this present time in history that Burns's philosophy comes to the fore. It is the numbers game that has, as it has so often in the past, gang a-gley. In 1974 Auckland University Medical School released its first class of medical graduates. In 1975 the preclinical intake to Dunedin rose to 200, most of whom have matured this November to preregistration doctors through the clinical schools of Dunedin, Wellington, and Christchurch. Thus this nation of 3m people will have to accommodate 320 new doctors from 1980. Since 1968, however, the rest of the world's doctor producers have apparently done the same mathematics, reaching similar answers. Now, therefore, not only is there a superfluity (800-1000 New Zealand doctors in 1985 we are assured) but there is nowhere for them to go.

What to do with these young superfluities in the middle 1980s is taxing people's minds. A spokesman for the Department of Health Management Unit is reported to have "blamed" the decisions of the 1960s for the present problems and is reported further as saying, "they overreacted a little." The speaker was reported as going on to tell of similar problems in nursing, occupational therapy, and physiotherapy. Preregistration and first and second years of house service seem secure, initially at least, but from 1983 there may be some rub—unless graduates

can be dissipated by reason or persuasion into neglected rurality or community medicine, provided training can be found.

A publication that should make an impact on New Zealand medical thinking is a further report by the Advisory Committee on Medical Manpower entitled *Specialist Medical Manpower in New Zealand*.¹ In 1979 the committee had already concluded that within five years there would be a superfluity of doctors, not only to the needs of the health service, but to that which the country's economy could support. They recommended then a stringent limitation on medical immigration. The importance of this consideration may be gauged by the fact that since 1971 an average of 100 overseas trained doctors have come to New Zealand each year, so that about one-third of the current medical work force is trained overseas. In particular, nearly half of those in community medicine, psychiatry, and radiotherapy are from abroad. The committee went on in 1979 to recommend a 25% reduction of student intake to both Auckland and Otago (Dunedin) Medical Schools at the earliest opportunity. At that time, in addition to Otago's annual intake of 200 Auckland took 120. Late in 1979 the Government agreed to a cut of 12.5% in the February 1980 intake. Any further reduction the Government said, with the politician's eye on those of its remote rural electorates who already claimed to have too few doctors, would be sanctioned only if the profession—that is, the New Zealand Medical Association—were to offer constructive advice on the problem of the maldistribution of general practitioners within the nation.

In September it was announced that the Government had agreed to cut a second 12.5% from the national student intakes for 1981, thus reducing the overall intake from 320 two years ago to 250 in February 1981. The price the profession paid for this resolution was to provide some constructive ideas on the redistribution of general practitioner service. In fact the contribution of the New Zealand Medical Association, which satisfied the minister, was a suggestion, as the *Otago Daily Times* reported, "... to ensure that a mechanism is available to provide general practitioner services in localities of special short-term need." A national "night call service" in other words.

What is a specialist?

As to specialists and their numbers and distribution the first problem the committee found was a definition. The specialist register maintained by the Medical Council of New Zealand is incomplete. Qualifications related to practice are not specified, and there is room for disagreement between employers and colleges as to "what is a specialist?" The confusion is compounded by the staff of medical schools where non-clinical medically registered workers, who may be employed exclusively in teaching and research, are counted as specialists.

Within this ill-defined cadre, a population explosion has occurred that has exceeded not only the predicted but by even more the actual general population growth from 1973 to 1979. The latter increased by 5.4% while the working medical

population expanded by 32.2%. In particular the growth of all specialists has exceeded the population from the low of the ENT doctors increasing by 7% to the junior hospital staff by over 50%. An intriguing snippet is the number of people that have leapt on to the medical administration bandwagon, whose numbers have increased by 46.5%. The pattern in this group is late recruitment and early retirement. Interestingly, although the number of women in current clinical classes in Dunedin has reached 35%, there is no increase—possibly “yet”—in their numbers among the specialties, where they tend to continue to take posts in anaesthetics, obstetrics and gynaecology, paediatrics, and now community medicine.

As well as ill distribution in relation to the needs among specialties on the national scale, there is also an inequitable distribution among hospital centres within the country. A particular example is that of specialists among the teaching centres of Auckland, Wellington, Christchurch, and Dunedin. Nationally there are 56.5 specialists per 100 000 head of population. Christchurch supports 9% and Auckland 7% below this figure. Wellington is in credit by 7%, while Dunedin is reported to have 51% greater than average population of specialists. Similar apparent inequalities apply to the distribution of registrars. Only 54% of the public live in the “four main centres,” but these centres employ 80% of the registrar cadre, and Dunedin has twice the number of registrars per population density as do the other three centres. While the committee recommends that these figures should be explored, possibly some measure of accountability could be extracted from the differing nature of the centres. Auckland has a relatively small school complete in its preclinical and clinical curriculum in a single urban area. On the other hand, Christchurch and Wellington each take 33% of Dunedin’s 200 students for clinical education. This large group of students enters a mature and multifacultied university. This last will relate to the committee’s earlier comments about the importance of a loading of pure academics contributing to apparent maldistribution. Indeed, we note that while the more northern centres have 9–12% of academics among their specialists, Dunedin supports 39%. Furthermore, it would appear that the committee may not have considered the figures for the population served, as opposed to the hospital board area population figures on which the teaching hospitals are centred. Consideration of the concept of regional services may amend these discrepancies, and would possibly be a beginning toward the explanation that the committee demands, in the absence of which it somewhat pointedly advocates, rational planning “must start with critical examination of these sort of data.” In particular, overall review must be critical of the provision of services related to the type of hospital centre and the relative levels of manpower between specialties within centres.

Feast or famine

While one has over many years wondered at the international ineptitude that has led to the recurrent feast or famine phenomenon of medical manpower, it may be that this “ineptitude” is unavoidable and that the errors are associated with, quantitatively at least, varying factors that cannot be predicted over the middle term. In this report¹ we have this conclusion—should it be “admission”?—stated thus: “The availability of health care resources including medical manpower has never, and never will be determined by an objective assessment of the need . . . resources . . . appear to be determined by a variety of complex sociopolitical systems which no one has yet been able to unravel.” The statement goes on to comment that the full use of whatever facilities are provided is matched by a parallel pool of unmet demands. This has been further referred to by the spokesman of the New Zealand Medical Association who commented on the increase in both population and medical manpower leaving the waiting lists unaffected. In the context of this whole subject, and in particular the very sane statement of

our manpower committee on the proved impossibility of accurate forecast, I was interested to read a very forthright and well-reasoned plea from the senior members of the British colleges that a moratorium be placed on any increase in student numbers in that country; that the Secretary of State should be dissuaded from his present course of increasing student intake in Britain by 12½% by 1990 because output already exceeds career posts by 50%. Currently, Britain is graduating one student per 13 750 head of population while New Zealand’s anxiety is centred on a rate of graduating one per 9375 population. I note incidentally that the British Government is still muttering about using consultants to do junior doctors’ work in order to let there be less of the latter so that they may swell the ranks of the former. That was proposed as a logical use of manpower ten years ago, I recall.

Convincing international data can be produced to show that, “wealth rather than need seems to be the prime determinant of the availability of health care.” In 1979 the New Zealand Planning Council, reflecting on the relationship between the growth of health expense and the national economy, recommended a limit of 2% annual growth. The minister is aiming at, or at least “it is his belief that” this will be pared to nearer 1% annual growth in his department’s expenses over the next decade. From this, in view of the direct relation between doctor population and health expense—either salaries or our technical aspirations, or both, I presume—it has been suggested that over the coming decade the specialist cadre should not be permitted to grow by more than 2% a year. This proposed economy is underlined by the earlier overestimates of the general population growth, the misjudgment being attributed to lowered fertility and emigration. Already the staffing of medical schools has been frozen to 1979 levels, a restraint that was considered a logical sequel to reduced student intake. As a simple sequence this is probably arguable.

The present state of affairs between major specialty disciplines seems to indicate that general internal medicine has in training (that is, those concerned in Royal Australasian College of Physicians training programmes) about 20 people a year to meet the calculated need for 17 positions annually over the period 1979–86. Again, however, the peculiarities of our medical population befog the issue in so far as the check provided by those New Zealand graduates who are currently working in training abroad is balanced by the proportion of those in training positions in New Zealand who are overseas graduates. Generally, the surgeons seem to have their affairs best in order, but the radiologists are in a parlous state of minimal recruitment, and community medicine has no programme for recruitment and training at present. The arithmetical crunch is spelt out in the table. By 1986 it is predicted that New Zealand will have 1000 head of medical manpower superfluous to its needs.

Number of specialists in training in 1979 and the predicted need in 1986

	RMO	Specialist	General Practitioner	Others	Total available
1979 (in post)	1000	1650	1780	70	4500
1986 (need)	1200	1900	1900	—	6000

Suggestions made in this latest report¹ as to steps towards a solution will be regarded as radical, with the shedding of parochial life blood by some groups and areas. The first seems rational and innocuous but is not really as procrastinatory as it looks. It is just to watch events over the next couple of years or so, monitoring closely. But to do that usefully there must be avid and accurate data collection that would include the rationalisation of those to whom the title specialist shall be applied and their accurate registration. The intentions of New Zealanders currently abroad must be lobbied and taken into the calculations and immigration should be limited to the very precise needs of those areas into which recruitment is not available from inside New Zealand.

The second point, the proper function of doctors and how they should be used, may also cause a little anxiety. Which of us is confident that he "constitutes a good buy for the public"? The advocated structuring of postgraduate training is probably already in hand. I speak from knowledge of internal medicine training and the activities of the Royal Australasian College of Physicians in New Zealand. Whether it is advocated, or indeed whether such training *should* be used to manipulate the senior manpower availability, is a moot point. But just reading the words, one must agree that there can be no doubt than "an effective planning mechanism must for the first time be developed." And last, but no longer least—although it probably has been for too long—the voice of the people of whose careers and aspirations we are speaking must be heard. The Student Association is on record as raising the spectre

of high pressure competition in family medicine as an alternative to unemployment, and of making an eloquent plea with rational positive suggestions on deployment of the superfluity of manpower to the benefit of the public. This latest report¹ says that junior doctors are unhappy—"disillusioned" is the word used—that while they are a clear-thinking body with viable and vital ideas, for too long they have been channelled by an authoritarian seniority to which they have been allowed no material voice—sic transit gloria?

Reference

- ¹ New Zealand. Advisory Committee on Medical Manpower. *Specialist medical manpower in New Zealand*. Wellington: Management Services and Research Unit, Department of Health, 1980.

Dealing with the Disadvantaged

Overweight patients

PAMELA GIBBONS

The attitude of a doctor may make or break the confidence a fat person has in him or her, so perhaps one who has experienced this may be permitted to make some observations.

Diet

(1) For many people, sensible dieting is a straightforward way to lose weight, but there are those who do not respond to the accepted norm of diet sheets. Please do not greet them with that awful cliché, "Nobody fat ever came out of Belsen," or suggest that they must be cheating.

(2) Do not offer a negative diet. One only has to read the forbidden list to yearn for something on it. A positive list is far more helpful, however short.

(3) Perhaps one week you could try the diet you prescribe for yourself—and prepare it yourself. Dieting is much more difficult when one is cooking for a family than it is when someone else prepares, weighs, and cooks the meal and just sets it on the table.

(4) Do not be afraid to suggest far less food than many so-called balanced diets. After years of following them, interspersed with crash diets (milk, banana, Mayo—eggs and grapefruit), then Weight Watchers, I steadily gained weight. It is only now, on a diet of two Oxo cubes, two yoghurts, and up to two pints of skimmed milk per day, that I am losing weight and feeling better than I have for the past 20 years. That, plus a Multivite and a ferrous sulphate tablet, was worked out for me by the medical research unit at a London hospital during a three-week stay and after many tests. I would digress here to beg for more centres for the overweight to be attached to provincial hospitals.

(5) Apart from the fact that only trial and error can establish the right diet, the ways in which the right amount of calories can be taken or absorbed vary enormously. Suggest, therefore, that the patient is weighed weekly by your nurse and has a monthly check up by you to monitor a particular diet.

(6) Try to appear reasonably sympathetic if you feel the patient has really tried, even if the result is disappointing. Just imagine how depressed the dieter is feeling.

General points

(1) Do not suggest enlisting the help of one's friends. It just does not work. Friends will offer false platitudes, and tell you they like you as you are, usually adding, "If you get thin you wouldn't be you—it suits you to be well covered."

(2) Some experts advise telephoning a hostess before going to dinner and asking her not to offer any forbidden food—do not suggest this. The modern hostess is adventurous, often extravagant, and she would rather her invitation was refused (with the reason) than be expected to modify her menu or provide plain alternatives.

(3) Please do not refer to a fat person to his face as obese or grossly obese. To the layman the word has a different connotation; it sounds like obscene, and many fat people really feel obscene.

We asked Dr John Garrow, who specialises in treating the overweight, for any additional comments. He writes:

The objective of treatment is to make life more tolerable for the patient. The doctor must inform himself about the mortality and morbidity associated with obesity, especially in young people, to enable him to give an honest analysis of the relative risks and inconveniences of dieting on the one hand or of remaining obese on the other. Unless the balance is in favour of dieting why should the patient diet? Doctors should be aware that it is more difficult and less profitable for the patient to lose weight as he gets older. It is, therefore, a good plan to