One aspect of the medical workforce that was not discussed is that of locum doctors, who, in metropolitan and rural New South Wales, are increasingly called upon to staff public hospitals.

Under this system, a doctor registers with a locum agency, hospitals advise the agency (often multiple agencies) of the shifts they need filled, and the agency then sends to all the doctors on their books a list of shifts available. Doctors then choose which shift(s) they would like to work and the agencies supply their names to the hospitals. They are paid by the hospital — the current rate for all doctors, Post Graduate Year (PGY) 1 and upwards, being a minimum of $70–$80 an hour — and the agency receives a 10%–15% commission. In contrast, the base hourly rate for a full-time PGY 1 doctor is $23.11, with a loading of 75% on Sundays and 100% for any hours worked beyond a 10-hour shift.

The only barrier to locum work is that a doctor is unable to have two rates of pay within the one Area Health Service. There is thus a strong incentive for full-time employees to refuse extra overtime work at their own hospital and do locum work at other hospitals. The number of shifts needing to be filled increases as Junior Medical Officers choose this option. The current rate for all doctors, Post Graduate Year (PGY) 1 and upwards, being a minimum of $70–$80 an hour — and the agency receives a 10%–15% commission. In contrast, the base hourly rate for a full-time PGY 1 doctor is $23.11, with a loading of 75% on Sundays and 100% for any hours worked beyond a 10-hour shift.

The snapshot: Halloween CT cholangiogram

A 35-YEAR-OLD WOMAN presented with symptoms suggestive of gallstones. These were confirmed on a computed tomography cholangiogram (see picture), the contrast clearly defining their outline. However, their unique “jack-o’-lantern” configuration also serves as a seasonal reminder that, like the present-day association with Halloween, the word “gall” derives from an Old English word meaning “something unpleasant to experience”!

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Cosmetic surgery

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To the Editor: It was most enlightening to read the articles on cosmetic surgery in the 17 June 2002 issue of the Journal. In particular, the Clinical Update by Castle et al on psychosocial wellbeing and cosmetic surgery¹ is pertinent to everyday practice. The warning given that cosmetic specialists should be concerned about patients who have had numerous procedures, in particular patients who have previously sued physicians, is a poignant one.

Psychological testing of patients who wish to have plastic and cosmetic surgery is not routine, and plastic or cosmetic surgeons cannot be expected to carry out such testing. Liaison with psychologists and psychiatrists can be conducted on a case-specific basis, but not routinely. The aim is to screen for body dysmorphic disorder, but this can be quite difficult, as the presentation is often obscure.²

In reality we live in a world where appearance is very important, and self-esteem is related to appearance. Age discrimination is a reality, and cosmetic surgery has been shown to improve a patient’s psychosocial wellbeing.³ The issue of advertising of cosmetic surgery services is a vexed one, as is the issue of where cosmetic surgery should be performed. As it is usually not performed in public hospitals,