Letters

The medical workforce in 2025: what's in the numbers?

To the Editor: Joyce contends in her recent article that "medical workforce supply levels follow a predictable, if lengthy, cycle between phases of shortage and surplus".[1] If this is the case, the scramble by the Australian Health Ministers' Advisory Council (AHMAC) to find internships for graduating medical students[2] represents a stunning lapse in workforce planning.

Marked growth in student numbers has occurred since the early 2000s, and the approximate size of the 2012 graduating cohort has been known since 2009.[1,3] Despite the expansion of intern places in recent years,[1] a significant shortfall is predicted for 2013.[4,5] Commonwealth-supported-place students are guaranteed an internship after graduation, but domestic and international full-fee-paying students might miss out.

AHMAC is attempting to identify new intern placements.[2,5] However, capacity issues exist along the workforce continuum,[1] and the cannibalisation of senior prevocational and vocational positions to allow expansion of intern training will only shift the bottleneck. The shortfall of intern places is symptomatic of a much larger problem.

This situation reflects the lack of explicit national policy regarding the contribution of former international full-fee students to the medical labour force. It also disregards Australia's strategic objective of a self-sufficient health workforce.

The Council of Australian Governments must take a leadership role and agree on a robust mechanism to better manage the entire training pipeline, linking input, throughput and output. The federal–state blame game needs to end.

These issues are complex, but the lack of coordination has real-world consequences; not just for the future careers of these medical students, but also for the health care of Australians.

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1 Joyce CM. The medical workforce in 2025: what's in the numbers? *MJA Open* 2012; 1 Suppl 3: 6-9.
2 Australian Health Ministers' Advisory Council. Communique. 18 June 2012. Perth: AHMAC, 2012. http://www.amsa.org.au/advocacy/internship-crisis/ (accessed Jul 2012).
3 Australian Government Department of Health and Ageing. Medical Training Review Panel twelfth report. Canberra: DoHA, 2009.
4 Australian Medical Students' Association. National internship crisis updates [webpage]. 2012. http://www.amsa.org.au/internship-crisis (accessed Jul 2012).
5 Newton K. Govt vows to expand intern places. *Australian Doctor* 2012; 24 Jul. ❑

Adverse effects of adult topical androgen use on children

To the Editor: We read with interest the report by Handelsman describing an increase in Australian testosterone prescriptions, including a particular increase in prescribing of topical testosterone gel.[1]

The topically applied formulation of testosterone has a unique adverse-effect profile because of inadvertent exposure to it via direct skin contact. We report progressive virilisation in a 2-year-old girl who presented in 2011 with an 18-month history of body odour and pubic hair development, associated with her father having administered testosterone gel on his forearms. The child's virilisation resolved when her father changed his method of androgen administration. He had not been informed of the risk to children of inadvertent androgen exposure, and he did not know the indication for his treatment with testosterone.

Some of the growing population of men who are prescribed testosterone are of childrearing age, and possible paediatric exposure should be considered when selecting an androgen formulation. We are aware of five similar cases nationally, involving virilisation of children due to topical androgen use by their parents on locations such as the anterior chest wall. Inadvertent exposure of children to topical androgens can lead to irreversible skeletal maturation, intrauterine virilisation of unborn children, and significant enlargement of the clitoris in young girls.[2,3]

Patients should be routinely warned of this potential adverse effect when testosterone gels are prescribed. Furthermore, the Therapeutic Goods Administration should consider imposing a boxed warning for this formulation of testosterone, as occurs in the United States,[4] to reduce the incidence of this serious adverse effect in children.

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1 Handelsman DJ. Pharmacoepidemiology of testosterone prescribing in Australia, 1992–2010. *Med J Aust* 2012; 196: 642-645.
2 Patel A, Rivkees SA. Prenatal virilization associated with paternal testosterone gel therapy. *Int J Pediatr Endocrinol* 2010; 2010: 867471.
3 Kunz GJ, Klein KO, Clemons RD, et al. Virilization of young children after topical androgen use by their parents. *Pediatrics* 2004; 114: 282-284.
4 Voelker R. Children's exposure to testosterone gel spurs FDA to order boxed label warning. *JAMA* 2009; 301: 2428. ❑

> "The authors acknowledge that rescreening rates varied ... but failed to include this in a multivariate analysis"
>
> Dunn

Effect of false-positive screening mammograms on rescreening in Western Australia

To the Editor: In their recent article on false-positive screening mammograms and their effect on rescreening rates within the BreastScreen WA (BSWA) program, Sim and colleagues posit that an absolute reduction in future rescreening of 3 percentage points can be seen among women who are recalled for assessment but do not have breast cancer.[1]

The analysis presented did not adjust for other factors known to influence