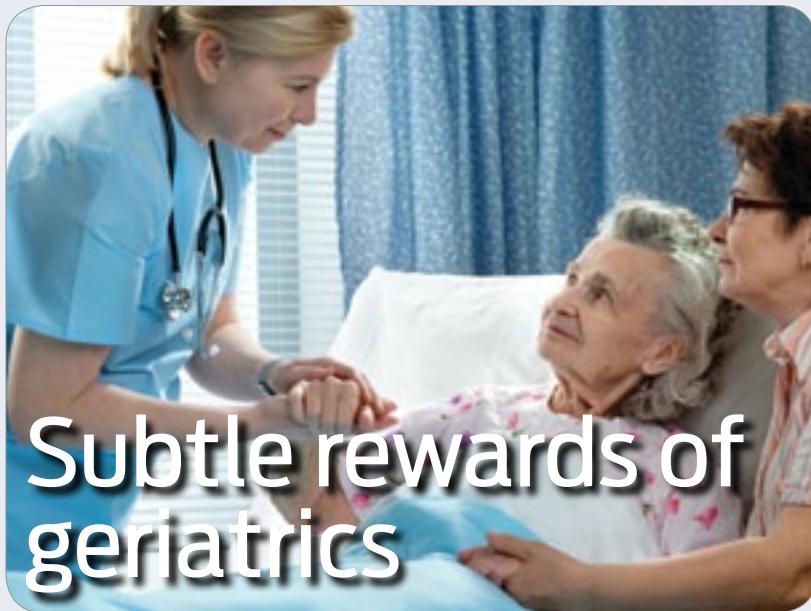


MJA Careers

Career overview



Subtle rewards of geriatrics

As Australia's population ages, demand for geriatricians is set to further increase

Geriatricians treat older people with often complex comorbid medical conditions. The specialty includes the medical management of the full range of older people's illnesses, and it is this variety of practice that often attracts doctors to the specialty.

Dr Robert Prowse, president of the Australian and New Zealand Society for Geriatric Medicine, says he chose the specialty because of this breadth.

"I always enjoyed all the specialties in physician training, but I never found one that I liked more than another. One of the things about geriatric medicine is that it provides an opportunity to be quite broad in your practice", he says.

"It's a way of keeping general but, because of the contact with older people and their needs, there's a lot

of specialist knowledge which sets it apart from general medicine", he adds.

Some geriatricians choose to focus on a particular area within geriatric medicine, such as rehabilitation or dementia, but most manage a range of comorbidities in older people.

Dr Prowse, who is a geriatrician at Royal Adelaide Hospital, says patients also tend to be very different from one another in this age group.

"As people get older, they deal with the effects of ageing and acquired illness very differently. They have different life experiences and social circumstances ... that increased heterogeneity as we age means that no one presentation is the same. It's very difficult to get bored in geriatric medicine."

Traditionally, geriatric medicine was

considered to involve patients aged 65 years and over, but Dr Prowse says the average age of geriatricians' patients has tended to increase as older people's health has improved. Now, he says, his typical patient would be an 82-year-old woman with complex comorbidities.

"Most geriatricians are looking after patients in their 80s, and increasingly in their 90s and above", he says.

In addition to the variety of presentations, geriatric medicine also offers a range of working environments, from hospital inpatient care to ambulatory services or rehabilitation clinics.

Private sector work opportunities are increasing, as the fee-for-service environment becomes more financially rewarding and private hospitals increasingly recognise the importance of geriatric medicine.

Dr Prowse says there is substantial scope for geriatricians to change the mix of working options over the course of their career, which again keeps things interesting.

Part-time work is common and valued by most specialists in the field, says Dr Prowse. As such, the specialty is well suited to doctors who want to combine their professional responsibilities with raising a family and attracts a lot of female trainees.

Dr Prowse says the specialty also tends to attract people with "a lot less ego" than some specialties.

"When I go to conferences, there are always a lot of like-minded people. They all have views but they respect other people's views as well. The camaraderie is very strong and that makes for a nice specialty."

Geriatricians need to be excellent

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Plotting a path to the PCEHR

It's very difficult to get bored in geriatric medicine

”

Dr Robert Prowse

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communicators, particularly as the specialty involves considerable teamwork with other medical and allied health professionals.

Dr Prowse says that, as the population ages, other hospital departments are increasingly relying on the skills of geriatricians. Opportunities for collaboration are increasing, for instance, between oncologists and geriatricians.

Geriatricians also need great listening skills and, crucially, need to value and respect older people.

For instance, Dr Prowse relishes the chance to hear his older patients discuss the twists and turns of their lives.

"I always find those life stories tremendously fascinating ... what brought them to be the person they are now", he says.

Professor Len Gray, professor of geriatric medicine at the University of Queensland, says his favourite aspect of the specialty is its complexity.

"Some people may see it as messy, but the complexity is what makes it interesting. Geriatricians generally like the complexity and the people aspects of the specialty."

"The challenges are complex from a medical perspective, but also because of the difficulties older people and their families experience."

Professor Gray says solutions are often subtle and focus on a "whole

“

Some people may see it as messy, but the complexity is what makes it interesting

”

Professor Len Gray

person" approach to care. For instance, for a person with mobility difficulties, geriatricians may be involved in everything from stabilising their blood pressure to organising a walking aid or someone to help them at home.

Professor Gray says the rewards of geriatric medicine are also often more subtle.

"Surgery, for instance, is a different style; you can fix a lot with one action. With geriatrics you don't weave magic at any one moment, but over time you get a lot of rewards seeing gratified older people and their families", he says.

Professor Gray says the specialty therefore suits doctors who don't need immediate results to gain professional satisfaction.

Training as a geriatrician

To become a specialist geriatrician, trainees first need to complete 3 years of basic training through the Royal Australasian College of Physicians, followed by 3 years of advanced training in geriatric medicine. More information is available from the Australian and New Zealand Society for Geriatric Medicine (www.anzsgm.org).

Sophie McNamara

Registrar Q+A

Dr Anthony French, Advanced Trainee in Geriatric Medicine, Princess Alexandra Hospital, Brisbane.

Why did you decide to specialise in geriatric medicine?

I chose geriatric medicine because it offers a wide spectrum of practice opportunities. Geriatric medicine specialists are in high demand in both the public and private systems, giving great scope for innovation and career development. Geriatricians can modify and refine their practice to suit their interests and desired work-life balance. Geriatricians are also a very close-knit professional group and a nice bunch of people, so collegiality was an important factor in my choice.

What do you enjoy about the training and specialty?

The care of the elderly is very rewarding and challenging for those not afraid of complexity and lack of clarity. My training is very enjoyable because there are so many opportunities to sample different areas of geriatric medicine and to explore potential practice preferences before committing to them.

What do you dislike or find challenging?

The most challenging thing is time constraints and deciding which areas of geriatric medicine to focus on and which to leave out. Career planning and strategic networking can also prove challenging.

What do you want to do once you've completed training?

I plan to go into private practice as a consultant geriatrician with a focus on a few subspecialty areas, specifically orthogeriatrics, perioperative geriatrics and geriatric rehabilitation. I also intend to work towards developing private practice as a more viable and desirable practice model in geriatric medicine overall. If private practice was less daunting, more rewarding and more lifestyle-friendly, hopefully we could increase geriatrician numbers overall and improve the provision of aged care services.

Do you have any mentors?

I have been lucky enough to have spent significant time during my basic and advanced training working with a number of prominent geriatricians who have provided formal and informal mentorship. Through membership of various committees of the Australian and New Zealand Society for Geriatric Medicine, I have met many inspiring geriatricians. I have also been involved in developing practice guidelines, government policy, funding models and future directions for aged care provision through the society.

Have you done (or are you planning) any overseas work or training?

We are lucky in Australia to have the opportunity to practise world-class geriatric medicine with world-class geriatricians, so I have always felt I have more to gain by training here than I could hope to gain overseas. However, I would love the opportunity during my specialty practice to spend time overseas as a researcher and geriatrician.

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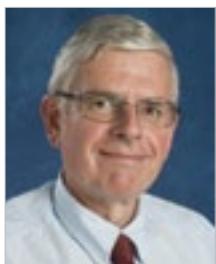
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Medical mentor

Associate Professor Michael Woodward reflects on his career in geriatric medicine

Associate Professor Michael Woodward is head of aged and residential care services at Austin Health, and a geriatrician in private practice at Donvale Rehabilitation Hospital. He is director of the Austin's wound management clinic, editor of *Wound Practice and Research* and a past president of the Australian Wound Management Association. He is director of the memory clinic at the Austin and sits on numerous boards for dementia organisations.

"When I was a physician registrar at the Royal Melbourne Hospital in the early 80s, I was working in a ward that, like most wards, even back then, was full of older people. I asked my boss, Professor Ian Mackay, for advice on choosing a specialty. Straight away he said, 'geriatric medicine'. Even though he is a well known immunologist, I think he was a bit of a frustrated geriatrician.

What I liked then and what I still like is that geriatric medicine involves treating the whole patient. You treat the patient's physical symptoms as well as their psychological, cognitive and mental status, in the context of their social environment. It's looking at whole systems of functions such as their mobility, their ability to look after their finances and their ability to eat.

As director of aged care at Austin Health I have a mix of inpatient and ambulatory responsibilities, as well as running a big department. The department has over 100 beds, a consultative service and a community service for people in their own homes. We also have specialty clinics such as memory, wound management, continence and falls. It's one of the most comprehensive, hospital-based aged care services in Australia. I've been a consultant at the Austin since 1988.

Throughout my career, I've been very involved with professional organisations. I was chair of the Royal Australasian College of Physicians Committee for Physician Training for 6 years and deputy chair for 6 years before that. This group oversaw training for all physician specialties including the assessment process, accreditation, supervision of training, etc.

If we don't pay full attention to the ageing of society, it's extremely likely it will be to our detriment

At any one time we had about 1000 basic and advanced trainees so it was a big job. I'm proud of my work there.

Immunisation of older people is a major interest of mine. I sit on several global and national immunisation boards and recently revised the guidelines of the Australian and New Zealand Society for Geriatric Medicine for immunisation of older people. Older people need to be vaccinated against preventable diseases like pneumococcal disease, flu and shingles, but there's not enough awareness about the importance of vaccinating this population. The kids have hijacked the agenda!

I also have a particular interest in cognitive disorders. I'm on the board of Alzheimer's Australia Victoria, and am involved with several other professional associations. I've done a lot of research into developing drugs for Alzheimer disease, as part of international, multicentre trials. I'm also proud of some of the clinical dementia research I'm doing, including trying to gain a better understanding of what I call the 'frontal variant' of Alzheimer disease. This involves people with Alzheimer who present early on with frontal features such as behavioural problems. My MD research degree, which I completed last year, focused on this topic.

Wound management is also an area of interest. A key achievement of my presidency of the Australian Wound Management Association, from 2006 to 2010, was my involvement in developing guidelines for treating and preventing chronic venous leg ulcers, and similar guidelines for pressure injuries.

Although it's increasingly being recognised as an important area to resource, geriatric services are often housed in second-rate facilities, in what some regard as second-rate hospitals. I think that's ageism. Some people seem to believe that older people don't mind being in the ward that's been abandoned by, say, orthopaedics. It's often a case of, 'what can we do with this old, leftover ward? Hey, we'll turn it into a nursing home'. It's never the other way round, where a brand new building is filled with geriatric medical wards. The Austin is among the more enlightened hospitals but we are still pushing uphill nationally.

I think that ageism is changing. The so-called baby boomers are becoming old people, and they regard appropriate health care as a right. Also, the population explosion is not young babies in China, it's people over age 80 in every country. If we don't pay full attention to the ageing of society, it's extremely likely it will be to our detriment. We need to fund more Alzheimer research, to develop drugs. We need to fund older persons' vaccination. We need more appropriate residential care facilities and hospitals. We need to train hospital staff to deal better with confused older people and prevent falls and pressure injuries. All this has to happen soon or we'll have millions of people with chronic wounds, including pressure ulcers, who are demented and living for years in second-rate facilities.

Any doctor who doesn't do geriatric medicine is losing an opportunity to do an incredibly fulfilling job. You're never going to run out of work, we need more geriatricians and it's more conducive to the achievement of work-life balance than some specialties. Most importantly, it's very satisfying to look after the whole of the patient in their social context, rather than being a super-specialist in one small part of the body."

Interview by Sophie McNamara

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Road less travelled

Gold medal medicine

From rural GP to head of the Olympic medical team



says Dr Baquie, adding that he was pleased there were few problems relating to the conditions in China, such as major asthma or gastrointestinal cases.

In the lead-up to London, athletes will be advised on strict infection control to prevent the spread of bugs, plus most athletes have already been screened for any cardiovascular abnormalities.

In London, as in Beijing, Dr Baquie and most other medical staff will stay in the athletes' village, with other doctors and athletes from around the world.

"It's pretty exciting, it's a real buzz. It's an amazing, multinational experience", he says.

Dr Baquie did not begin his medical career in sports medicine, although he had always played a lot of football and cricket.

He was a rural general practitioner in Foster, in Victoria's Gippsland region for 11 years, a job he really enjoyed. He moved back to Melbourne when his kids reached high school, and began working as a suburban GP.

"Being a GP in Melbourne was very different. I was a bit underwhelmed", he says.

An old friend from medical school, Dr Peter Brukner, had established the Olympic Park centre, and suggested Dr Baquie try sports medicine.

"I took the plunge and re-skilled, went through the training program when I was 40. Trying to do physiology and anatomy again was a nightmare!"

However, he loved his new specialty, and soon began combining clinical consultations with sporting team work, initially as doctor for a junior basketball team.

He later worked with the Carlton Australian Football League (AFL) club for 3 years, and then spent 7 years as doctor for the Australian men's hockey team, culminating in their gold-medal performance at the Athens Olympics in 2004.

When Australia's Olympic athletes head to London next month, they will be accompanied by an entourage of doctors, nurses, psychologists, masseurs and physiotherapists.

At the medical helm will be Dr Peter Baquie, a sports physician usually based at Olympic Park Sports Medicine Centre in Melbourne.

Dr Baquie describes his role as medical director for the Australian Olympic Team as the link between the Team medical staff and the Team Executive. He is also supported by a Medical Commission of five doctors, plus other allied health practitioners, who advise the whole Team on medical matters.

Team medical care is provided by sport-nominated and sport-specific medical personnel, while Dr Baquie is part of the medical headquarters group that provides care to smaller sports that do not have their own doctors, plus to support staff such as administrators, officials and media.

London will be Dr Baquie's second Olympics as medical director, and he says it poses fewer health and security challenges compared with Beijing 4 years ago.

"For Beijing, there were concerns about water safety, food safety and air quality. Despite the uncertainty, we were able to prepare the team sufficiently",

After Athens, he decided to return to football, and has spent the past 8 years as team physician with the Hawthorn AFL club.

He successfully applied for the Olympic medical director role in 2006 and now manages his working life between his Melbourne practice, Hawthorn team physician role and Olympic responsibilities.

Dr Baquie says he loves the "diagnostic challenge" of sports medicine, regardless of whether he is looking after an amateur or Olympic athlete.

He also enjoys the responsibility of making the judgement call about whether an athlete should keep playing.

"When is a guy safe enough to return to the field? What happens if you push physiology a little? I enjoy living on the edge a bit", he says.

He enjoys the multidisciplinary approach, where he works with allied health professionals including psychologists and physiotherapists, as well as non-health staff such as coaches.

Dr Baquie also loves the "peripheral" aspects of sports medicine; the camaraderie of working with a sporting team and the excitement of the Olympic Village.

"I've been incredibly lucky, going from being a small-time country GP, to now travelling the world with sports teams ... it's been a very fortunate and special journey", he says.

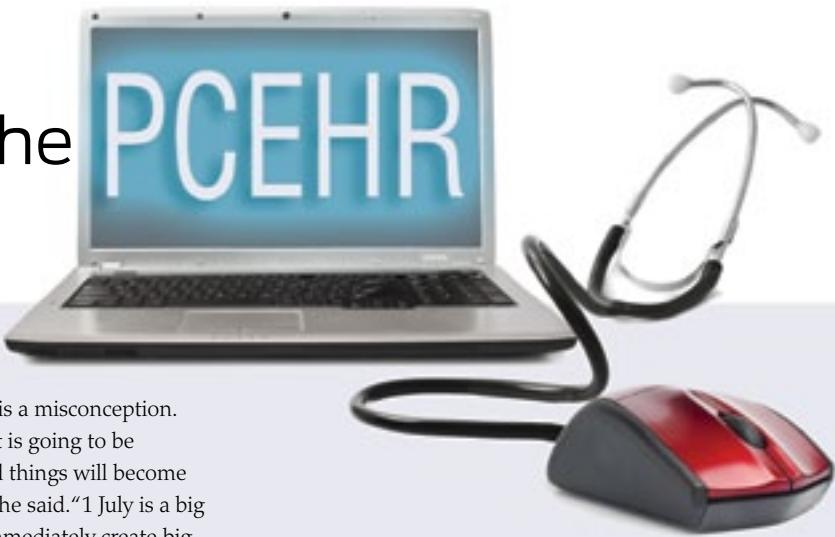
Sophie McNamara



Plotting a path to the PCEHR

Electronic health records go "live" on 1 July.

Will everything change?



The much trumpeted personally controlled electronic health record (PCEHR) officially launches on 1 July, but if you're feeling a little under-prepared, you're not alone.

The \$467 million project to provide a seamless source of patient health data has hit a few obstacles along the way.

As a result the PCEHR "go-live" date is likely to pass by quietly and without fanfare - something most medical practitioners will be grateful for.

There are a few hoops to jump through to participate in the PCEHR: once a practice is registered, doctors will need to familiarise themselves with the web-based system, upgrade their clinical software to integrate with the system and, ultimately, create and manage patients' shared health summaries.

If that sounds daunting, it's worth noting that doctors are not actually obliged to participate. There is a catch though — those who don't will not be eligible for the eHealth Practice Incentive Payment.

The end goal, however, is a worthy one: boosting patient safety by reducing errors, improving health care delivery, and cutting waste and duplication from the system.

According to industry commentators, that end goal will only be achieved when PCEHR-capable clinical systems have been developed, doctors are suitably compensated for their extra work and potential legal risks have been addressed.

However, Dr Mike Civil, a general practitioner and e-health spokesperson for the Royal Australian College of General Practitioners says there's no need for panic.

"Lots of doctors are feeling the pressure. They think that they're going to have to be ready from day one and are worried that they'll appear to be behind

the eight ball. This is a misconception. The PCEHR rollout is going to be incredibly slow and things will become clearer over time", he said. "1 July is a big step but it won't immediately create big changes in what we do."

As with any new journey, it helps if you have a map to follow. Here's a basic blueprint of what will be involved:

Registration

At the moment, all patients can register their interest at the government's PCEHR site at ehealth.gov.au.

Once the shared health summaries are up and running, this is also the portal where practices will access them but, to do so, they will need a health care organisation identifier from Medicare Australia.

Practices will also be obliged to keep a tight rein on exactly who's authorised to access their patients' PCEHRs, as employees come and go, with stiff penalties for privacy breaches.

Only doctors and other health workers with a health care provider identifier will be able to add information to the PCEHR system.

If a patient asks who's accessed their record, practices are obliged to provide them with a list. Industry bodies have noted that these additional tasks will add extra layers of administration for practices.

Dr Civil says his practice may opt to help patients with the registration process once there's more clarity around what will be involved.

"The consumer registration system is a little clunky at present. We may be able streamline that process for patients, depending on how many are interested", he says.

“

If a patient asks who's accessed their record, practices are obliged to provide them with a list

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Software

The PCEHR will be viewed, at least initially, via a government-run web-based "provider portal".

This portal can be accessed from any computer that meets the technical requirements and has an internet connection. Authorised users will be able to check whether a patient has a PCEHR, seek permission to access a PCEHR, view and search a PCEHR and download and print clinical documents and views.

To upload patient data or documents, though, practitioners will need to use clinical software that's compatible

E-health exposure

Medical defence organisation MDA National has pinpointed some potential legal hazards as the personally controlled electronic health record (PCEHR) rolls out:

Sharing data

The shared health summary could be a potential source of legal liability for practitioners when inaccurate and outdated information is uploaded by other health providers accessing it.

Patient control

The patient's ability to set access controls and control their content has a number of medicolegal implications for practitioners. For instance, the practitioner will not know if a patient has prevented them from accessing certain information.

Parental control

Parents have control of their children's PCEHR from 0 to 14 years. From 14 to 18 years this could provide a challenging situation for practitioners when patients request certain information not be included in their PCEHRs.

Use of pseudonyms

The use of pseudonyms by patients could provide a significant basis for inconsistent clinical decision making. Patients' motivation for using pseudonyms could include fear of being traced when escaping family violence or fear of exposure due to the public nature of their work.

with the new system — and this area remains a work in progress.

The software programs are under development and, over the coming months, upgrades that enable practices to create and update shared health summaries are expected to be released.

This software capability will be crucial to practitioners who want to create and manage PCEHRs, according to Dr Civil.

Ultimately it's hoped that clinical software will automate much of this work so as to reduce double handling of patient data between the clinician's records and the PCEHR.

Once this occurs, the most crucial factor would be the extent to which doctors keep their own summaries up to date, according to a spokesperson for the National E-Health Transition Authority (NEHTA).

According to NEHTA, a few sites have already deployed elements of the e-health infrastructure and standards. They are now moving to the next stage: integrating these with the national PCEHR system.

There will be a call centre to provide support in accessing the system and to answer general questions about it.

The record

The PCEHR will run in parallel to the health records held by health care providers. It will include a summary of key information such as basic demographic data, allergies, regular medications, vaccinations and health conditions.

It will also include an indexed summary of specific health care events, dubbed "event summaries". These may include referral letters and test results.

Specialists can also upload information when needed - event summaries and test results, for example - provided they also implement clinical software. Otherwise, they will largely be restricted to viewing records.

When it comes to their creation and ongoing management, however, most of the work will fall to GPs. GP groups also say the onus will be on them to ensure the accuracy and completeness of the PCEHR.



This remains a controversial area, with much of the debate surrounding what rebates, if any, would be claimable for the substantial legwork involved.

Although Health Minister Tanya Plibersek has announced that GPs can claim MBS items B, C or D when creating or changing a shared health summary, depending on the length of time it takes, there are caveats.

"I want to confirm that use of the longer consultation items will be seen as appropriate by the Medicare Australia Practitioner Review Process and the Professional Services Review in circumstances where there is clear evidence of patient complexity and there is documentation of substantial patient history", she said in a speech in March.

The Australian Medical Association, meanwhile, has developed its own item numbers for doctors preparing and managing a shared health summary for guidance purposes. These items, which apply to all the medical professions, are time-tiered and can be billed in addition to any consultation that is provided to the patient on the same day. Whether these ultimately attract a Medicare rebate is yet to be seen.

Dr Civil says that although everyone would like some clarification around incentives, it is important to remember that doctors are unlikely to be suddenly swamped with patients requesting PCEHRs.

"I think we just have to get the ball rolling, and adapt and accommodate things as it all rolls out", he says.

Amanda Bryan

PCEHR on trial

Sydney general practitioner, Dr Kean-Seng Lim, has had a sneak peak at what the personally controlled electronic health record (PCEHR) may look like.

He's been involved in HealtheNet, a Greater Western Sydney PCEHR trial that was tasked with testing some of the PCEHR components such as shared health summaries, discharge summaries and the mother-and-child "Blue Book".

He found that for everyday care of the patient, some components, such as the electronic discharge summaries, represented a big step forward. However, because underlying systems were still in development, he says the project's key challenges revolved around integrating all the different systems such as the GP Hospital communication interface.

He says some of these problems have required interim solutions and it has often been a case of

learning as they go.

"From what we've seen so far, ensuring PCEHRs are kept up to date is not going to be a simple one-click task. It will require time and cognitive effort on the part of the practitioner, to review all the new information that may become available at each visit", he says.

Some practices would also need to re-examine their current record-keeping format in order to facilitate the creation of a shared health summary, according to Dr Lim.

On the positive side, he says, practitioners will have access to much more information than in the past.

"This system has huge benefits in terms of patient care but it does appear to offer fewer benefits for GPs", he says.



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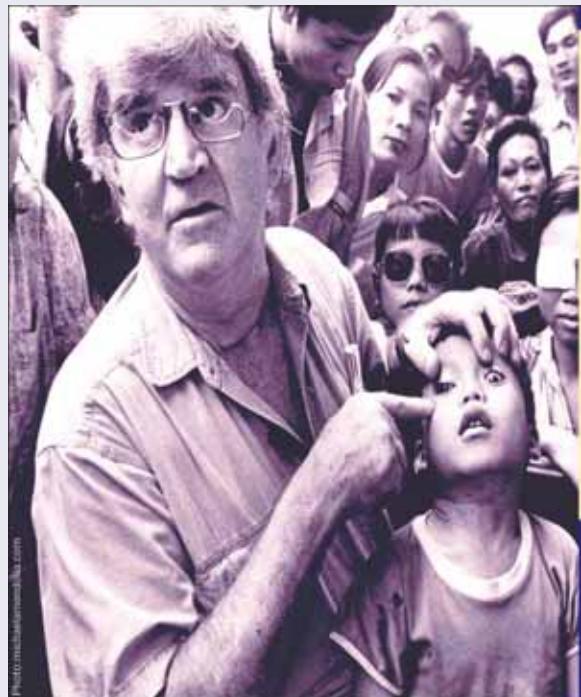
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Non-Specialist Appointments

Sonographers needed for Medical Imaging Dept at GV Health, Shepparton, VIC

2 Positions available, Permanent Full Time

Reference: 32482/ Applications must be received by 2 July 2012

Enquiries: Olasunbo Olalere, Manager & Chief Medical Imaging Technologist on 03 5832 3433 or 0419550971.

There are currently two positions available for a qualified Sonographer to become part of an innovative and dynamic team. Our Medical Imaging Department at GV Health is fully accredited by NATA until Jan 2015. All full time permanent GV Health employees are entitled to salary packaging opportunities.

The Department fosters the pursuit of excellence and offers a full range of modalities, including X-ray (Out-patient, In-patient, Theatre, Mobile and Emergency), 64 slice CT scanning with Cardiac Angiography, Ultrasound (including echocardiography), Digital fluoroscopy and 3.0T MRI. All images are acquired and stored digitally using Agfa Digital Imaging System PACS and Promedicus RIS. We are equipped with new Philips IU22, GE Logiq E9, Toshiba Aplio and Xario ultrasound units. A replacement plan of four years is applicable to all ultrasound units at GV Health Medical Imaging Department.

Ongoing professional development will be provided. Opportunities for further specialised training in other modalities will be available.

Applicants will be required to be eligible for membership of appropriate Professional bodies and accredited by the Australian Sonographers Registry.

All new employees of Goulburn Valley Health are required to undergo a National Police Record Check.

Register and apply online at www.gvhealth.org.au. Key selection criteria and position description available online. Applications that do not address the key selections criteria will not be considered. GV Health is an equal opportunity employer who provides a smoke free environment.



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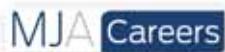
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The post holder will undertake some clinical work but will focus on leading the medical team whilst contributing to the clinical management of UKSH South West in conjunction with the Registered Manager and senior team.

To apply for this position please email your CV to Neil Andrews, Recruitment Manager, to: swrecruitment@uk-sh.co.uk

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