MJA Careers

Career overview — Breast physicians

Centre of care

Breast physicians are the linchpins of breast cancer management

When breast physicians first began working in Australia more than 20 years ago, their work centred around screening and diagnosis, mostly in breast screening or diagnostic clinics including BreastScreen services that were being implemented at the time.

Now breast physicians oversee or coordinate a woman's care, not only helping to bind the work of the multidisciplinary team, but to be the bridge between a woman's general practitioner and her surgeon.

"We coordinate everything", says Dr Pfeiffer, who is medical director of BreastScreen on the Sunshine Coast in Queensland."We see the women when they first come in, we examine them, and we decide what investigations they need. Once they've had those investigations, we give them the diagnosis and make the referral to the appropriate specialist. Depending on the settings in which we work, we might be involved in their ongoing follow-up, in liaison with their GP."

Dr Pfeiffer is one of 50 Fellows of the Australasian Society of Breast Physicians, a small but passionate organisation that links the network of breast physicians in Australia and New Zealand who are involved in breast screening clinics or breast diagnostic centres. Many are clinical directors or program managers of screening programs.

Associate Professor Nehmat Houssami, who started work as a breast physician 21 years ago when the profession was in its infancy, now works as a consultant clinician at the NSW Women's Breast Centre at the Royal Hospital for Women in Sydney, among other roles.

"I started when [the specialty] was very much centred on breast screening or seeing symptomatic women attending dedicated breast clinics", she says."Most breast physicians are still working in a screening environment and in symptomatic clinics, but some also collaborate with surgeons, in theatre and in immediate post-op follow-up."

Associate Professor Houssami, who is also a public health physician, now mostly sees high-risk patients, such as women who have had breast cancer or women who have breast cancer gene mutations.

She recalls that her main reason for becoming a breast physician was the opportunity to spend time with women after screening for breast cancer to discuss results.

"For most women, I could give them good news, but for women who had cancer, I could spend time discussing the results with them and providing as much information as they needed", she says."I often had more time than the surgeon to counsel them about their treatment options."

The role also allowed her to pursue her interest in breast medicine more broadly without confining herself to one conventional specialty.

"In my intern year, breast cancer work appealed to me, but I didn't really want to be a surgeon, radiologist or oncologist", she says."When a job came up at the Sydney Breast Clinic, it gave me the chance to learn various skills and to have a broad role across breast medicine. That's still part of the appeal for me."

Conversely, Associate Professor Houssami says the field may suit young

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In this section

> “We have just revised our training document, which we hope will be a major asset in gaining recognition from a specialist college”
>
> Dr Deborah Pfeiffer

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doctors who want to specialise in one aspect of breast cancer but are not sure which specialty to choose.

“Working as a breast physician exposes you to a lot of different aspects of care: you see the diagnosis side and you see patients after surgery, so it’s a good grounding”, she says.“I have trained a couple of doctors who started working as a breast physician and then specialised in radiology.”

The big issues

The biggest issue facing breast physicians in Australia is that their profession is not recognised as an independent medical specialty, Dr Pfeiffer says.

“We have just revised our training document, which we hope will be a major asset in gaining recognition from a specialist college”, she says.“It is comparable in depth and breadth to the training documents of other colleges recognised by the Australian Medical Council and sets out our training curriculum.”

Associate Professor Houssami says that while breast physicians work closely with others as part of the multidisciplinary team, the lack of recognition as a specialty can be professionally challenging and may deter doctors from joining their ranks.

“Working as a breast physician may be perceived as not as secure as other specialties”, she says.“Although jobs do come up on a regular basis, there aren’t guaranteed training posts, so that can be quite difficult, particularly if you’re a young doctor looking to train in a specialty.”

Marge Overs

Becoming a breast physician: the inside story

The Australasian Society of Breast Physicians is working hard to have its profession recognised by a specialist college as an area of advanced training, Dr Deborah Pfeiffer says. Until that happens, though, there are no dedicated registrar training positions in Australia.

“Training positions tend to be opportunistic and become available in state-run screening programs, private diagnostic breast clinics and private radiology clinics, and some large public hospital outpatient departments”, she says.

Dr Pfeiffer suggests that doctors interested in becoming breast physicians should contact breast screening and diagnostic services in their area. They can also make inquiries through the Society’s website.

She says the work would suit doctors with a good background in general medicine and in women’s health.

“If you are working in screening, an understanding of population health and epidemiology is an asset”, Dr Pfeiffer says. “If you are working in a diagnostic clinic, you need excellent communication skills and to be a team player, because multidisciplinary care is so important in breast care. It also helps to be obsessive and methodical in paying attention to detail.”

To become a Fellow of the Australasian Society of Breast Physicians, doctors are required to complete a curriculum that covers five areas of competence: clinical expertise, breast imaging interpretation, counselling/communication skills, interventional procedures and administration.

They are also required to work in breast medicine for five years (full-time equivalent), to have a mentor and to complete oral and written exams.

For more information about working as a breast physician, go to the Society’s website: http://breastphysicians.org.

Trainee Q&A

Dr Naomi MacIntyre is training to become a breast physician at Sydney Breast Clinic

Why did you decide to become a breast physician?
I had been away from general practice for 5 years travelling overseas. When I returned to Australia in 2004, I knew the upskilling I would need to re-enter general practice was significant and felt I would rather learn something new. A friend had applied for a job as a breast physician, something I had never heard of. It involved working in the field of breast cancer screening and diagnosis as part of a multidisciplinary team, doing imaging, procedures and coordinating patient care. Training was on the job and part-time, and no after-hours, on-call or weekend work was required. My friend couldn’t take the job so I jumped at the opportunity to work at Sydney Breast Clinic. A year later, she was so impressed by how much fun I was having, she reapplied and we are both still loving it 7 years on.

What do you enjoy about the training?
I enjoy the atmosphere of the multidisciplinary clinic. It’s very busy in a collegial way. I enjoy the procedures and the imaging work. I received excellent supervision from the senior breast physicians and other doctors over the first several years and gradually increased in independence. We have 30–40 patients a day (for three clinicians) and by the end of the day everyone is sorted.

What have been the main obstacles/challenges?
Breaking bad news is always sad, and it is a regular part of the job. Coming from general practice, the imaging component was new to me. It takes a while to develop a sense of what you are looking at. I’m not good with technology, and that is a challenge with the high-level imaging equipment we use. Other challenges are harder to describe — they are to do with boundaries. Breast physicians are not recognised as a subspecialty group. As you are not a surgeon or a radiologist, you need to be careful that your clinical decisions are consistent with what these other groups would do.

What advice do you have for doctors interested in working as a breast physician?
This job is suited to someone with a strong interest in women’s health, who enjoys procedures and feels they could learn to love imaging. You need to be able to balance the opinions of a group of health professionals with the needs of the patient for a result that keeps everyone happy. I find it works well with my family commitments. Many doctors hold a fellowship of the Royal Australian College of General Practitioners before they begin training as a breast physician. It’s probably best to spend time observing in a breast screening or diagnostic clinic to get a sense of whether it’s something you could enjoy. The pay is not great and the job market is small. I earn more than what I earned as a GP registrar but less than what I earned as a qualified GP. Once qualified, I will still earn less than my GP colleagues but there are other breast physician jobs that pay better.

What do you plan to do when you finish training?
At the moment I am happy where I am and have no other plans!

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Vital cog in the wheel

Dr Sue Fraser describes the privilege of being a breast physician

Dr Sue Fraser is president of the Australasian Society of Breast Physicians. After working as Clinical Director of BreastScreen in Cairns for 15 years, Dr Fraser now works in various roles in breast medicine in Queensland and New South Wales. She also lectures at James Cook University in Cairns.

I worked as a general practitioner for 14 years, including 10 years as a solo GP in Cairns. When I sold my practice, good friends who were radiologists and a breast surgeon asked if I wanted to run a breast clinic they were starting in Cairns. I trained for three months at the Wesley Breast Clinic in Brisbane before the Cairns clinic opened in 1992 as a multidisciplinary private diagnostic clinic. We had wonderful support from radiologists, surgeons and pathologists. It took a while for GPs to get used to the idea of referring women to the clinic, but they came around. In 1994, our clinic landed the contract for BreastScreen in Cairns. We were the only private facility doing public screening and we had a one-stop shop — a screening program and a diagnostic program sharing all staff and equipment.

The many roles I have are an indication of the variety and opportunities in the work of a breast physician. Last year I started working with a very busy breast surgeon on the Gold Coast, Dr Daniel de Viana. It is a very different role to the diagnostic work I was used to. I assist him in surgery and do postoperative follow-up. When I was a diagnostician, I gave the patient good or bad news and handed them back to their GP for further management. With specialised follow-up, I have an ongoing role and can get to know my patients. I also have several other roles, including working as a breast physician two days a fortnight in Cairns; as a senior medical officer for the public breast surgeon in Cairns; and reading films for St George Hospital in Sydney. I also work for BreastScreen in Cairns and on the Gold Coast.

> “It’s a great privilege to work as a breast physician. I have no plans to retire — I get up every day and look forward to work”

With the increasing incidence of breast cancer, the role of breast physicians is becoming more important. Women with breast cancer are followed for a minimum of five years and some for longer. Women with breast cancer have a lot of post-treatment issues. The surgeons are so busy seeing all the new patients with breast cancer, they don’t always have time to manage all the follow-ups and women presenting with benign breast conditions. Breast physicians have the time and expertise to manage these women.

Breast physicians play a key role in multidisciplinary teams. The role varies according to the location in which the breast physician works. In most services, in addition to taking a breast history and doing a clinical breast examination, breast physicians are responsible for coordinating the team and correlating the results of imaging, examination and pathology. After being a solo GP for years, I love the team aspect of breast medicine. The patient knows they have all these people managing their care.

The Australasian Society of Breast Physicians is a bit like the orphan who is looking for a home. Our society has been around for more than 20 years and we have about 50 Fellows. We have had many obstacles to gaining professional recognition by a specialist college, but we are working hard to achieve this goal. We have a revised training document, which we think stands up to scrutiny, and we’re working to have that validated by one of the colleges in the future.

Breast surgeons who work with breast physicians say they couldn’t manage without them. In my work I have had the amazing experience of diagnosing women, being the assistant in the operating theatre, and being involved in their follow-up care. Breast physicians know a lot about many aspects of breast medicine. We are the generalists of breast medicine and pull it all together for the patient in a holistic way.

It’s been a privilege to help build the profession of breast physicians in Australia. Our profession has been able to develop within the multidisciplinary team, and our work has added to holistic care. Our society has been a tight-knit and unified group — unified by our passion for our work. It’s a great privilege to work as a breast physician. I have no plans to retire — I get up every day and look forward to work.

Interview by **Marge Overs**

Road less travelled

Taking a stand

Surgeon Dr Kingsley Faulkner makes his mark away from the operating table, advocating for public health

Dr Kingsley Faulkner ... Wittenoom fired up his interest in preventive medicine

Early in his medical career, Dr Kingsley Faulkner spent just over a year as a district medical officer with the Royal Flying Doctor Service in Western Australia's Pilbara region.

At the time the region, which included the Wittenoom blue asbestos mine, was being developed as a major iron ore mining area.

It was an experience that made its mark: "It fired up my interest in preventive medicine and the need for doctors to fearlessly stand up and be counted when there is powerful evidence to support that stand", he says.

"Wittenoom is probably the greatest mining and industrial disaster in Australia's history because early medical warnings were repeatedly ignored and that mine has contributed to so many preventable deaths. Many more will die in the future because of it."

Throughout his career Dr Faulkner has combined clinical roles as a surgeon with this interest in preventive medicine.

He has held a number of senior surgical positions, including head of general surgery at the Sir Charles Gairdner Hospital in Perth. He was also president of the Royal Australasian College of Surgeons from 2001 to 2003.

He has a long history of health advocacy, including being chair of the Australian Council on Smoking and Health (ACOSH) from 1983 to 1990. Dr Faulkner says ACOSH has had a 30-year history of working with other health organisations to successfully lobby governments to introduce policies aimed at reducing tobacco use.

Now vice-president of ACOSH, Dr Faulkner has been pleased to see the plain packaging legislation pass through the Federal Parliament with bipartisan support, and the recent High Court decision supporting that legislation. "Other countries are now looking closely at Australia's example", he says.

Dr Faulkner says he is attracted to health advocacy roles because of the chance to improve the health of many more people than just the patient in front of him in a consulting room or operating theatre.

"If you are serious about being a doctor, then you should also be serious about preventive medicine", he says.

"As a surgeon I can treat a certain number of people in my professional lifetime. You try to do so as well as you can. But when around 20 000 Australians were dying every year from smoking-related diseases and I could join others in doing something about it, then that seemed a good use of some of my professional time", he says.

Much of his health advocacy work focuses on the health impacts of environmental challenges. For the past year he has been chair of Doctors for the Environment Australia, an organisation that aims to alert people to the health consequences of environmental threats, including climate change.

He says these threats range from direct health impacts, such as the respiratory, cardiac and even neurological consequences of mining and burning coal, to the increase in vector-borne diseases, such as dengue fever and malaria, as temperatures rise.

Dr Faulkner, who grew up on a farm in the Porongurup region in Western Australia, has witnessed the effect of environmental degradation, including increased salinity and reduced rainfall, in many of the state's agricultural regions.

> "If you are serious about being a doctor, then you should also be serious about preventive medicine"

"An editorial in *The Lancet* in 2009 named climate change as the greatest threat to health in the 21st century. You cannot ignore something like that."

Dr Faulkner is concerned that Australia's media and politicians often trivialise, manipulate and politicise discussion on climate change, when the vast majority of informed scientists agree on the need for urgent action.

He says Doctors for the Environment Australia support a carbon pricing mechanism. "If this country is really serious about reducing fossil fuel usage, then we need some economic mechanism to help drive it."

Dr Faulkner also tries to make a wider contribution to medicine through his involvement in teaching a new generation of doctors. He is a professor in the School of Medicine at the University of Notre Dame Australia and an honorary clinical professor with the Department of Surgery at the University of Western Australia.

He is encouraged by the enthusiasm, intelligence and drive of his students.

"The next generation of doctors is going to be not only more electronically skilled but also more aware of future environmental and other community-wide health problems", he says. "They will assess the evidence, demand and help draft effective policies, and assist in the research and development of new technologies to tackle the challenges which undoubtedly lie ahead."

Sophie McNamara

Money and practice

Creating your safety net

Income protection insurance can help fill the coffers when fate steps in — but it pays to choose the right policy

It's an obvious question but one that's easy to ignore: who will pay the bills if illness or an accident leaves you unable to work?

For doctors, the issue is particularly pressing. Typically they have high financial obligations, which means a stint without cash can pack a bigger punch.

Chris Wren, of Highland Financial, says doctors tend to need to service a debt that requires a high cash flow. If they have no income, they can't meet the repayments on their loans, he says.

Mr James Gerrard, a financial adviser at PSK Financial Service, agrees. "There's such a large amount of money at risk if something happens and a doctor is unable to work", he says.

Mr Gerrard estimates, however, that only half of Australian doctors have income insurance.

Medical Benevolent Association of NSW social worker, Ms Meredith McVey, says a lack of income protection insurance leads many doctors to the Association's door seeking financial assistance.

Even if a doctor has income protection insurance, it's often not enough to cover their obligations and there can be long waiting periods before payments kick in, she says.

Income protection insurance is not cheap. This type of insurance will set you back between $800 and $12 000 a year, depending on your age and income, although premiums are tax deductible.

The statistics show the need for income protection insurance, Mr Wren says. Men have a one-in-four chance of claiming for a major health event, such as heart attack, stroke or cancer, during their working life, while women have a one-in-three chance.

There are many different policies, so what should you look for? Financial advisers point to some of the key differentiators and offer their tips choosing a policy that suits your needs.

Waiting period

When you make a claim, a waiting period must be served before payments start. The longer the waiting period, the cheaper the premium.

Many policies have a 30-day waiting period, but if you can survive without an income for 3 months, the policy will be around 40% cheaper, Mr Gerrard says.

"The 90-day waiting period offers the best value of money, but you need to make sure have sufficient cash reserves to get by before the policy kicks in", he says.

Mr Chris Wren

One option is an offset facility on your mortgage to draw down on for a couple of months.

Terry McMaster, of McMasters' Accounting, Financial Planning and Legal, says many companies try to sell a policy with a 30-day waiting period, but premiums are much less with a 90-day waiting period. "Very few doctors would be wiped out if they weren't paid for 60 days", he says.

Policy type

There are two types of premiums: stepped and level. With a stepped premium, the cost of the policy goes up as you age, in line with the rising statistical risk of making a claim.

Mr Gerrard says stepped premiums go up substantially for people in their 40s and mid 50s. "Because of this, doctors often stop or cut back their policies, yet statistically that's when they are most likely to make a claim."

The alternative is to choose level-premium insurance, which allows you to lock in your premium at the outset. You pay more initially, Mr Gerrard says, but you will pay less over the longer term.

"For the first 8 years, a stepped policy will be cheaper than a level policy but in year 8,

Medical history matters

If you've had an illness in the past, you can still get income protection insurance by excluding that illness from your policy, says Mr Terry McMaster of McMasters' Accounting, Financial Planning and Legal. A word of warning: if there's a hint of depression, he says, insurers may knock you back. He says he's seen a couple of cases of this over the years.

> "There's such a large amount of money at risk if something happens and a doctor is unable to work"
>
> James Gerrard

the stepped premium should equal the level policy in overall cost. After 13 years, you'll see a net benefit from a level policy", Mr Gerrard says.

You can also index the sum for which you're insured every year to ensure it doesn't diminish with inflation, he says.

Benefit period

Once you've served your waiting period, you get a monthly benefit for a set period, with the duration varying from policy to policy.

Mr McMaster says sometimes doctors are sold cheap "useless" policies that only pay out for 2 years.

"We want income to kick in on the 90th day, to be indexed to inflation and to go to your 65th birthday", he says.

Mr Gerrard agrees. "The benefit period could be 6 months, 2 years or 5 years, but the most comprehensive policies go to age 65 or 70, so I always choose those for health professionals."

The longer the benefit period, the higher the premiums, but you can balance this a little by tweaking the policy and making trade-offs, such as extending your waiting period, he says.

Income upfront

Guaranteed income (otherwise known as agreed value) means that you and your insurance company agree on your income up-front. If you make a claim, they will pay you accordingly — even if your income has fallen.

Indemnity cover, which means that you are paid according to your income at the time of the claim, tends to be 15% cheaper.

According to Mr Wren, when you're flat on your back, it's not an ideal time to try to prove what you earn. "We always advise you get guaranteed income", he says.

Mark Morcos, head of Wealth Journey, says the insurer will ask for your past 2 years' of tax returns to verify your income up-front.

"You want to know how much you are being insured for", he says. "You definitely want to go for an agreed-value policy."

Premium vehicle

Some people pay their policy personally as premiums — and these are tax deductible — while others pay through their super fund, through salary sacrifice.

Mr Gerrard says the tax advantage is about the same. While some consider the superannuation option to be more convenient, it is a less favourable option for those who are trying to maximise their super contributions, he says.

Also, when the insurance policy is held in a super fund, if you do make a claim, it can be trickier to get your money, Mr Morcos says. As well as proving you are unable to do your normal job, you have to meet the *Superannuation Industry (Supervision) Act 1993* definition of incapacity.

Mr McMaster agrees. "Because there are rules about getting the money out, it can get locked up in your super policy, so it's not something we recommend", he says.

Proportion covered

Once you do make a claim, most policies will cover around 75% of your income. Mr McMaster says it's important to be insured for an appropriate, but not excessive, amount, to minimise premiums.

"This may not represent a bonanza if you happen to get sick", he says. "For instance 50% of doctors are married to other doctors or high-income earners and they provide a natural hedge to each other."

Doctors need to decide if they really need to earn $420 000 a year if they are unable to work when, for a quarter of the price, they could still get $120 000 a year through an income protection policy, he says

Mr McMaster also advises doctors who think they are in better-than-average health to consider cutting back on their cover once they get older and their premiums start to skyrocket.

"Income protection insurance is a bet and the probabilities are that you will lose the bet: you will pay your premiums and not get ill", he says.

"While young doctors with all their financial commitments can't afford to not to make the bet, it's different for older doctors with grown-up kids, super and who own their home. In those circumstances we say cut back, often to the screams of insurance advisers."

Amanda Bryan

Tips and traps

Chris Wren of Highland Financial offers a few extra tips:

- If you are working overseas, make sure your income protection policy will still cover you, as some don't. Also check to see if they pay to get you home if you fall ill.
- Make sure your policy includes superannuation. Insurers' quotes often don't include superannuation, but this is usually offered as an optional extra.
- If you opt for a 3-month waiting period, your claim will take time to be processed so you may have to wait 4 months before you see your money.
- One or two insurers have created policies that include return-to-work clauses. These let you return to work for up to 10 hours a week while still being paid.
- Make sure the definitions for serious diseases are clearly spelt out in your policy, especially in relation to cancer, as this can be a significant grey area.

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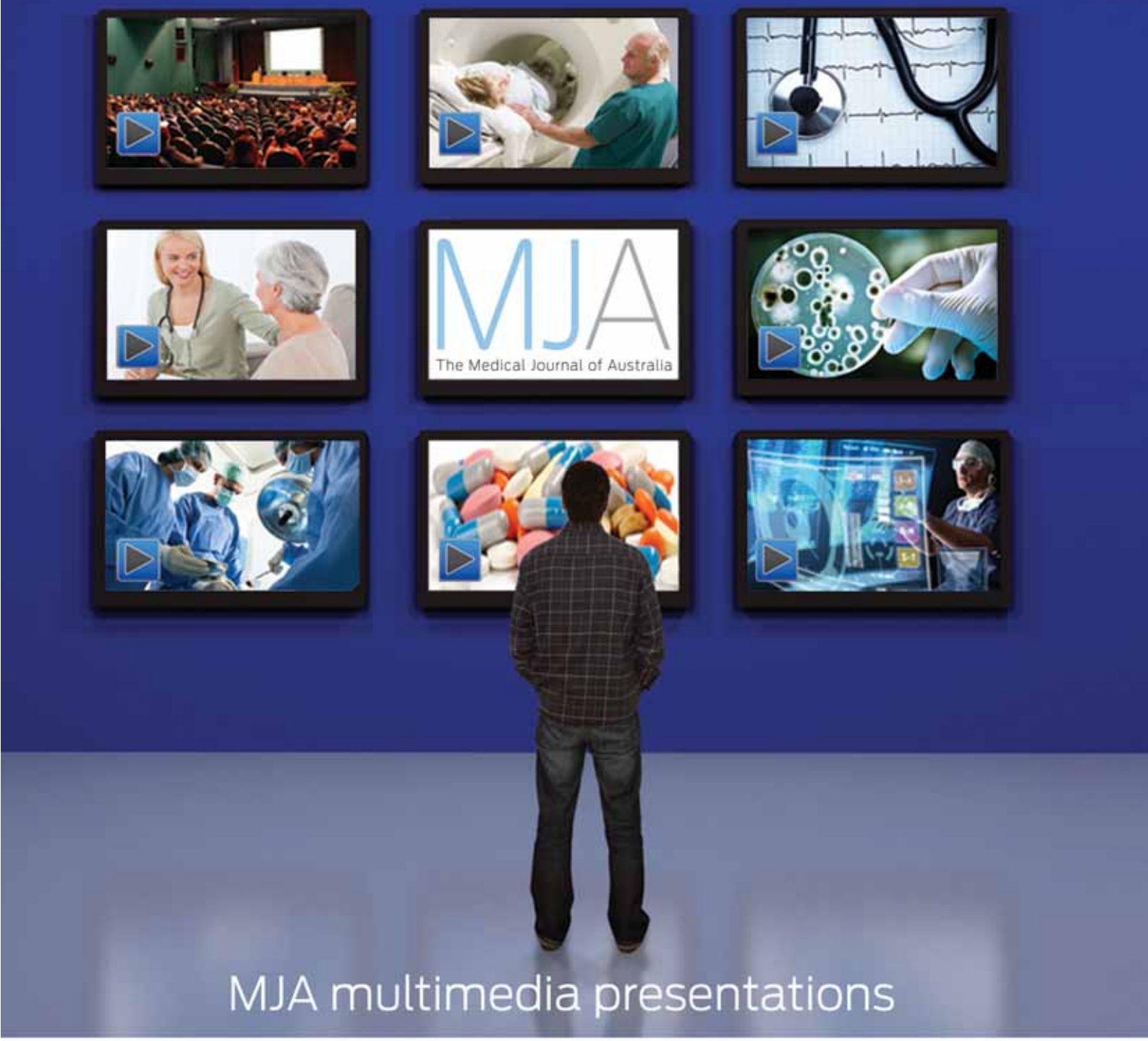

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