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MJA Careers

THE MEDICAL JOURNAL OF AUSTRALIA



# The doctor at the end of life's journey

**"PALLIATIVE CARE** is often thought to be synonymous with terminal care, but there is a lot more to it than that. It is not so much about the dying, but about how we can help patients to cope with life-limiting illnesses."

So says Dr Anil Tandon, a palliative care physician at Sir Charles Gairdner Hospital in Perth, Western Australia, and the WA director of advanced training for palliative medicine.

Dr Tandon agrees it's a confronting career path, as unlike patients treated in other specialities, palliative care patients are in the terminal phase of their lives and a cure is, by definition, not possible. This makes palliative care unique among specialties.

In a sense, it's a "specialist's specialty". Often doctors are attracted to palliative care after having worked in some other field — usually general practice, pain medicine or oncology, he says.

Given that the aim of the medical profession is to cure illness and maintain health, what kind of doctor would be suited to palliative care? "As clichéd as it may sound, you need a genuine desire to help people at their time of greatest need," he says.

"You certainly need empathy and a caring nature — qualities that aren't easy to learn but are intrinsically more highly developed in some individuals than in others. A great deal of patience is also required. Good communication skills are essential since so much of the work is conducted at a very personal, one-to-one level."

The ability to work well in a team is important, he says, as palliative care specialists work best within a multidisciplinary team involving oncologists, physicians, geriatricians and general practitioners, as well as nurses, allied health professionals and others.

But the inevitability of the death of one's patients does pose challenges not faced by other specialities to the same extent.

"The hardest part of the job is when you're not able to relieve a person's suffering as much as you would like to. As you'd expect, it can be emotionally challenging with younger patients — as they often have so much to live for.

"It's also difficult looking after patients with whom you closely identify, either because they are similar to yourself or your loved ones."

It can be frustrating because modern medicine doesn't give palliative care the consideration and attention it deserves. "So often, we are asked to see patients who have been in terrible pain — or some other uncontrolled symptom — for days, weeks or even longer, when there is no need for them to have been left in such a state," Dr Tandon says.

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Editor: Dr Peter Lavelle • plavelle@ampco.com.au • (02) 9562 6666

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| Locum Junior Positions | | | |
|---|---|---|---|
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| Medical Registrar | 27 Mar to 27 Apr | $140 ph | ACT |
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| Permanent Nurse Positions | | | |
|---|---|---|---|
| Scrub Scout | Immediate | Post Graduate | Metro VIC |
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Medical Recruitment

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| Locum GP Positions | | | |
|---|---|---|---|
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|---|---|---|---|
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| FACEM | Immediate | $neg | VIC |
| RMO Position | Immediate | $neg | ACT |
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But the job has huge rewards — being able to help people at one of the most important phases of their lives.

In other respects, the work is not so different from other specialities.

Palliative care specialists can work as salaried staff specialists in the public hospital system or as visiting medical officers (VMOs) in the public or private hospital system (many palliative care units are run by private hospitals or charitable organisations). It's uncommon, however, for palliative care specialists to work exclusively as VMOs.

Palliative care specialists work in a mix of acute hospital, inpatient palliative care unit (or hospice) and community settings. A typical day involves a mix of ward rounds, outpatient clinics and multidisciplinary meetings.

As with any other specialty, many of the challenges involve non-clinical problems such as high workload and administration pressures.

On-call work is definitely a requirement with any palliative care service. "During the week, this is usually just being available by phone; but patients will frequently need to be reviewed both on Saturdays and Sundays, if they are unstable with uncontrolled symptoms (especially severe pain)."

It is a specialty that is very well suited to women with families; part-time appointments come up frequently and more than 50% of trainees in palliative care are women.

Remuneration is the same as for any other non-procedural specialist, ranging from $150,000 to $275,000 depending on age and experience. "The rewards are not necessarily in the money, but in the ability to provide excellent end-of-life care," Dr Tandon says.

## Training

There are two different pathways for advanced training in palliative care: via the Royal Australasian College of Physicians Basic Training Program, or as a Fellow of one of a number of other Colleges (such as the Royal Australian College of General Practitioners).

Both pathways involve 3 years of advanced training, which is the same for all trainees and is made up of 6-month rotations in each of the following: a hospice setting, an acute hospital and a community setting. They must then do an additional 6 months in one of these three sites, plus 6 months of oncology training (which can be medical oncology, radiation or haematology) and 6 months in another relevant specialty (eg, pain medicine, psychiatry, general medicine, respiratory medicine) or in a research post. In addition, the trainee needs to complete two satisfactory written assessments (a case report and a research project). On graduation, there is generally no need to complete a "Fellowship" or subspecialty training as is the case in many other specialties.

As with most other specialties, demand exceeds supply, particularly so with palliative medicine as it is still a young speciality. Positions come up regularly in cities and regional centres throughout Australia, Dr Tandon says.

*By Dr Peter Lavelle*

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# Q&A

MJA *Careers* profiles interesting and important jobs and the people who do them

**Dr Scott Blackwell has been a general practitioner for 40 years in Scarborough, a seaside suburb of Perth. He has a special interest in palliative care. He is president of the Palliative Care Association of Western Australia and of Palliative Care Australia, and lead clinician of the Primary Health Care Network of WA. He is a keen hockey player who also enjoys art and going to the theatre, ballet and concerts.**

***What got you interested in palliative care?***

My interest in palliative care developed naturally during the course of my career. Somehow, earlier interests in obstetrics and anaesthetics faded and palliative care and aged care moved in. Perhaps it was as much that I felt comfortable in the death and dying space and saw the need for this part of clinical life to be done well, and not avoided.

***In Australia, there is great inconsistency in care provided to people at the end of life. Some people receive the care they need, many do not. Some experience excellent care in hospitals, hospices and at home, while others may not. Why is there this discrepancy?***

I believe this inconsistency has its basis in the mindset of the modern clinician. There is such good ability to cure and control disease that this has become the all-consuming mindset of clinicians of all types. The ability to recognise that life is nearing its end, indeed that it should be allowed to end, is lacking. Therefore, the opportunity of preparing for a good death is lost. Some say we live in a death-denying society; I believe we have a death-denying health industry. The clinicians hold the key to how our society thinks about death and dying. They can and should be leaders in this, the important third great stage of life. Palliative care is still about life — it is a simple change in emphasis from all-out disease management to considering how the person feels. The two can coexist.

***Are our existing models of care adequate to meet the needs of the dying?***

Palliative care from its inception has worked in a multidisciplinary model of care. This recognises the diverse needs of people at the end of life and that a wide variety of skills are needed to meet them. The problem is that not all Australians get the privilege of care in this multidisciplinary environment where body, mind and spirit have equal consideration. So it is really about access.



***Is there a particular problem for residents in aged care homes?***

Indeed there is. Residential aged care facilities (RACFs) are really the hospices of today. The average life expectancy of people entering RACFs in Australia is less than 18 months. Over 80% of residents in RACFs are cognitively impaired and many facilities have dementia-specific units. It is time to recognise that dementia, in most cases, is a progressive neurological degenerative disease that leads to death. It not only affects the mind but also affects the whole body. It can be associated with pain, especially towards the end of life, and recognition of this can be difficult for the inexperienced. A multidisciplinary approach to this is emerging and will make a difference … but how soon? Residential aged care is way overdue for this approach to become the norm.

***Should palliative care be the concern of the whole health system? Or just aged care?***

Palliative care is the concern of the whole health system. It is as important in paediatrics as it is in aged care. Specialist palliative care is well established and capable of caring for those whose needs are greatest. Recognition of the approaching death and appropriate referral is the main limiting factor. Whatever the age at which people may die, their care should be of high standard. Multidisciplinary models of care are emerging across all sectors, and it is hoped this will expand into the future.

***Is palliative care sufficiently well recognised as a mainstream discipline within the Australian health system?***

Yes it is. It is work in progress, but there is recognition of its importance from politicians and bureaucrats as well as in the clinical world. We do have national and state palliative care strategies, which are being better funded as we go, but there is a long way to go to meet the unmet need.

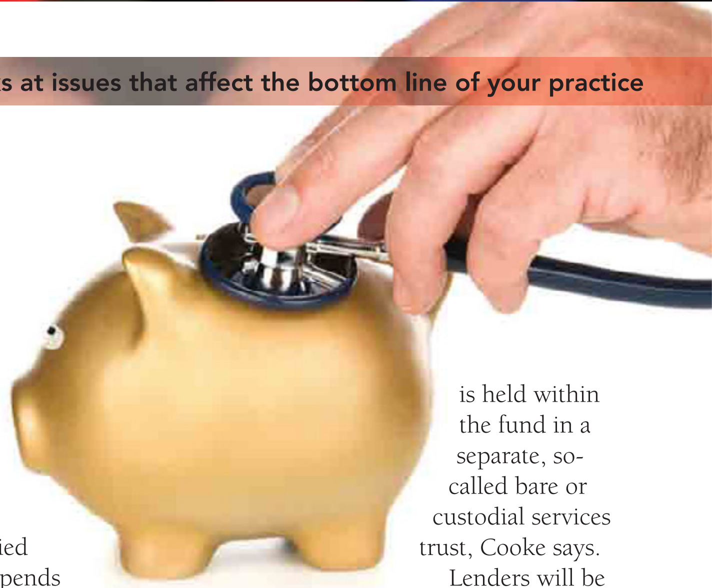
***What are "advanced care plans", why are they important, and how should they be implemented?***

Advanced care planning is most important as it engages people and their families in the conversation of their preferences for end-of-life care. It also engages the professions in that conversation. Indeed, it is the conversation that Australia should have at all levels. In the end, it is easier to achieve one's preferences if there is an advanced care plan and perhaps, more importantly, someone appointed to speak for you on these matters when you can no longer speak for yourself. ■

## Money and Practice

MJA *Careers* looks at issues that affect the bottom line of your practice

# Borrowing to create wealth



**DOCTORS** have an advantage over many other professionals; their incomes tend to be higher than those of people in other professions and they have better job security than many others.

This can make it easier for them to save to acquire investment assets.

To make the situation even sweeter, this financial security is attractive to lenders. Hence doctors have a much greater capacity to borrow to acquire investments — a much more effective way of generating wealth than saving.

So says Paul Cooke, a Canberra-based financial planner with Centric Wealth Advisers, an independent fee-for-service financial planning group that has many doctors as clients.

Providing the returns are greater than the costs of borrowing to acquire and hold these assets, the result is the accumulation of wealth over time, Cooke says.

In Australia, unlike in most other countries, if the cost of financing the investment(s) exceeds the income from the assets, the difference is tax deductible and can be used to offset the tax paid on the investor's personal income. This is called "negative gearing".

"So in the case of property, if the interest costs (plus other costs such as agent's fees, and repairs and maintenance) exceed rental income, the difference can be deducted from personal income (eg, salary or practice income) to reduce the tax payable on that income. In the case of shares, it is the difference between the interest needed to finance the share portfolio and the dividend stream from the shares that is tax deductible. The higher a person's marginal tax rate, the more significant the value of this deduction becomes," Cooke says.

If the assets gain in value, they can then be sold for a capital gain (provided they are held for more than 12 months). Capital gains tax (CGT) is only applied to 50% of the capital gain. The rest is CGT free.

The amount of CGT applied on the 50% that is taxable depends on a person's marginal tax rate at the time of the sale of the asset(s). So if the assets are sold when a doctor's marginal tax rate is low (eg, after retirement), the overall tax paid on the accumulated capital gains over the years may be low or minimal.

> Quality assets will rise in value when the market recovers, but if investors panic and sell at a low point, they will turn paper losses into real ones

### Managing risks

But for this strategy to make sense, the assets must increase in value (ie, capital gain) by more than the costs of borrowing (offset by the tax deductions). Doctors need to invest in quality property and/or a diversified portfolio of blue-chip shares to produce solid capital growth over the long term. One should never gear to invest in speculative investments, or simply to reduce a tax bill, Cooke says.

To make sure they can keep making the interest payments on the amount borrowed, doctors must have a secure income protected by income protection insurance.

They must be prepared to hold on to the assets, even if their value falls in a stock or property market slump. "Quality assets will rise in value when the market recovers, but if investors panic and sell at a low point, they will turn paper losses into real ones," he says.

One strategy that has become attractive for doctors is to borrow to invest via a self-managed super fund, which is now possible thanks to changes in superannuation legislation over the past 18 months.

Super funds may now borrow to invest in property, provided the property is held within the fund in a separate, so-called bare or custodial services trust, Cooke says.

Lenders will be more conservative in their approach to lending to a self-managed super fund, requiring a loan-to-valuation ratio of 65%–70% (compared to the normal 80%), and will require that there is sufficient income from the property and other assets in the super fund to cover the interest repayments (they won't allow the interest payments to be met simply by future member contributions). However, a big advantage of doing it this way is that when the super fund is converted into a pension fund, there is no capital gains tax applied to the subsequent sale of the property.

One strategy that Cooke is reluctant to recommend is margin lending. This is an arrangement whereby the lender provides financing for a share portfolio on condition that if the value of the share parcel falls below a certain loan-to-valuation ratio (typically 65%), the borrower agrees to pay a portion of the loan to keep the ratio at this level. The lender will require this so-called "margin call" to be done at very short notice — often within 24 hours. If the borrower does not comply, the bank will sell some of the shares — at fire-sale prices — to maintain the loan-to-valuation ratio. The investor must have sufficient cash to cover a margin call to prevent this happening. Hence, it is much more sensible to borrow against the equity in the family home. It is also cheaper — home equity loan interest rates are currently around 7% compared to about 9% for margin loans.

Regardless of which gearing strategy a doctor adopts, it's important to get advice from an independent financial planner before embarking on it.

*By Dr Peter Lavelle*

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Criteria for this award and the approved nomination form are available at www.ama.com.au/node/6482 or email awards@ama.com.au

Closing date for nominations is Thursday 21 April 2011.

*Please address nominations to:*

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Public Health Policy Section
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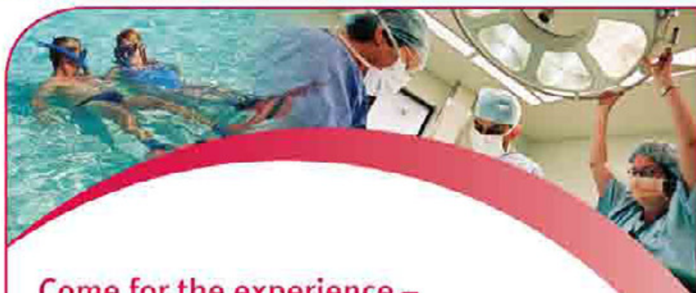

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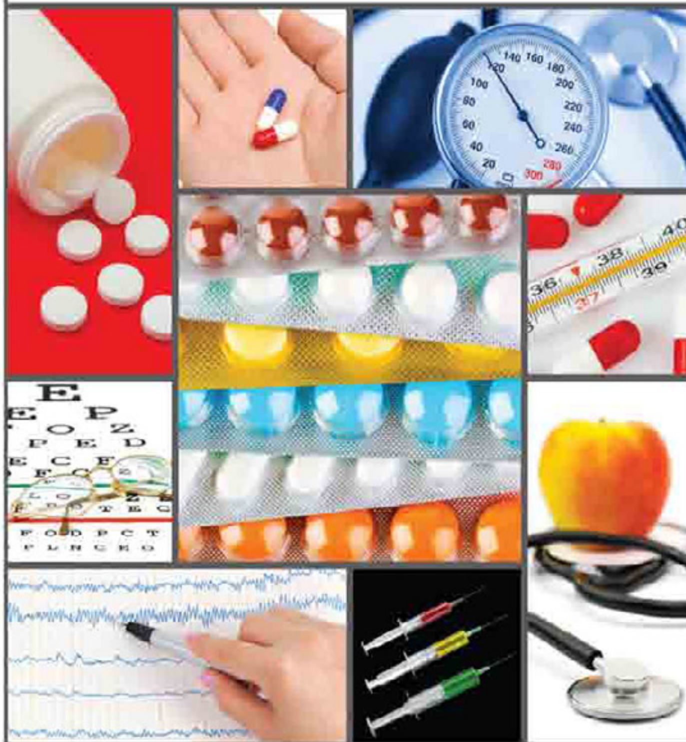

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The successful candidate will make a significant contribution to Sir Charles Gairdner Hospital activities and state-wide Neuroscience and play a significant role within the discipline of Neurology in the University, Sir Charles Gairdner Hospital, other tertiary hospitals and the wider community. The appointee will be expected to demonstrate a visionary perspective to the discipline providing academic leadership to the University and the State of WA in undergraduate and postgraduate education and be actively involved in clinical practice, providing clinical leadership to the hospital in the delivery of clinical service. The candidate will spend half of their time on clinical duties. The successful candidate must also be able to show evidence of a strong record of published research, be actively involved in research productivity, and possess the ability to foster the research of others in the state. The appointee must possess exemplary interpersonal skills and show evidence of his/her ability to enthuse staff and students at all levels.

**For further information please contact:** Winthrop Professor Fiona Lake, Head of School, on (08) 9346 3928, or email fiona.lake@uwa.edu.au, Associate Professor Brendan McQuillan, Head of Sir Charles Gairdner Hospital Unit, on (08) 9346 7908, or email brendan.mcquillan@uwa.edu.au. Alternatively please contact Clinical Professor William Carroll, Head of the Department of Neurology, Sir Charles Gairdner Hospital, on (08) 9346 3088, or email William.Carroll@health.wa.gov.au.

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ANNOUNCEMENTS

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## 2011 AMA AWARD FOR EXCELLENCE IN HEALTH CARE

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This award is for an individual who has made a significant contribution to improving health or health care in Australia.

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Nominations may be submitted by any member of the community.

Criteria for this award and the approved nomination form are available at www.ama.com.au/node/6482 or email awards@ama.com.au

Closing date for nominations is Thursday 21 April 2011.

*Please address nominations to:*

'Excellence in Health Care Award'
Ms Sophia Habib
Public Health Policy Section
Australian Medical Association
PO Box 6090
KINGSTON ACT 2604

Email: awards@ama.com.au

Fax: 02 6270 5499

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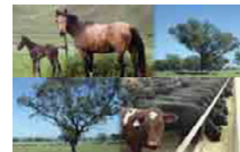

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**k.mason@qldcardiology.com.au**

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*For further information please contact:*
**Mr Philip Reasbeck, Executive Director Medical Services on +61353204278 or pgr@bhs.org.au**

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