Workforce challenges in orthogeriatrics

Faye Wilson has worked as a consultant orthogeriatrician in Sunderland since 2014. She completed both her undergraduate and postgraduate training in London and prior to taking up her consultant post completed a fellowship in orthogeriatric medicine at Imperial College London and a Masters degree in Cardiff.

Shvaita Ralhan trained in Geriatric and General Internal Medicine in London, and is now a Consultant in Perioperative Medicine at the John Radcliffe Hospital. She is interested in major trauma in older patients and has set up the Major Trauma Geriatrics service in Oxford. She is passionate about teaching, has completed a Masters in Clinical Education, and runs the Perioperative Medicine fellowship programme in Oxford.

Faye Wilson and Shvaita Ralhan

The rapid expansion of orthogeriatric services in England and Wales over the past decade is remarkable. National benchmarking, real-time outcome feedback and linked financial incentives have led to specialist multidisciplinary care becoming routine and seen outcomes improve[1].

The benefit of having embedded senior geriatric input on the trauma ward was highlighted during the peak of the COVID-19 pandemic. Risk factors conferring poor prognosis in SARS-CoV-2, such as increasing age and co-morbid burden, are common in those with fragility fractures, making early senior medical input and escalation decisions key[2]. Orthogeriatricians are uniquely well placed and experienced in both making and communicating these difficult decisions, yet in some units services were reduced or substituted.

As well as the obvious clinical roles orthogeriatricians fulfil, they can also provide other benefits to orthopaedic departments. These include: providing consistent ward level leadership; promoting clear lines of communication between patients, relatives and staff; involvement in service development and quality improvement; helping to embed geriatric principles into routine ward care; and education and pastoral support to medical and ward staff. These all help to change the culture of a trauma ward to one which is focussed on providing high quality care to older frail patients routinely. Despite the many potential benefits, many trauma services have not been able to employ dedicated integrated geriatric support. So, why is that and what could we do to try to change it?

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Medical workforce vacancies

Surveys of junior doctors leaving Foundation training show declining numbers are choosing to progress directly into specialist training programmes. Despite this change to the traditional career pathway, fill rates for Core Medical Training (CMT) remain high nationwide, with 100% of posts filled in 2019[3].

Sufficient recruitment into ST3 posts, however, shows worrying trends in terms of long-term workforce planning across all medical specialities. The number of trainees completing core training >>

and choosing to apply for Higher Specialist Training (HST) are currently insufficient to fill available ST3 posts. Geriatric medicine programmes filled 69% of their ST3 posts in 2019, with regional variation of between 25 and 100%[4]. However, even if all ST3 posts were full, this would not be enough to fill all current consultant vacancies. 2018 data from the Royal College of Physicians (RCP) shows that 43% of advertised consultant posts went unfilled across all specialities[5].

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Work-life balance whilst a medical registrar is particularly relevant in geriatric medicine, as 15% of trainees work less than full time (LTFT), around two thirds are female, and, unlike some other medical specialities, most trainees continue with acute general medical on-calls for their entire training period[7].

Orthogeriatric recruitment

On completion of training, geriatric trainees are in a strong position, with a surplus of available consultant posts. More geriatricians complete training every year than any other medical speciality and geriatric medicine has the highest fill rate of advertised consultant posts. Despite this, over 50% go unfilled due to lack of a suitable candidate, with figures probably an underestimation due to unadvertised posts[5].

In addition, more than half of advertised geriatric jobs are new posts, often in innovative sub-speciality areas such as acute frailty or perioperative medicine. These may have significant draw for trainees and orthogeriatrics may not always compare favourably[7].

Poor on-call experiences on surgical wards as a medical registrar due to previously mismanaged clinical situations or difficult interactions with surgical staff can lead to the misconception that working relationships will be challenging or clinical work will be unrewarding. There may also be concerns about being responsible for frail older patients on non-geriatric wards, with out of hours medical support provided by disinterested or inexperienced junior surgical trainees.

During specialist training, exposure to different models of orthogeriatric care will vary. Some trainees will experience only liaison services, attending the trauma ward infrequently to see new or unwell patients. For geriatricians, trained to provide individualised, multifaceted care as part of a multidisciplinary team, this model can seem unappealing or unsatisfactory. Conversely, some trainees will see an integrated service with daily early morning consultant input as less amenable to juggling childcare and working LTFT.

Orthogeriatrics is a relatively new sub-speciality, and for many more experienced geriatricians there will have been no specific orthopaedic training as a registrar. This may result in some highly skilled but not specialist geriatricians feeling uncomfortable working in this area.

Potential solutions

Improving recruitment and retention

CMT has now been redesigned into the longer three-year Internal Medicine Training (IMT) programme. This aims to provide a more structured preparation for taking on the role of medical registrar, with a more supportive transition period and a widening of clinical experience to include geriatric medicine and critical care.

Alongside this, the RCP has worked to support trainees by introducing a chief registrar scheme and flexible portfolio training[8]. These aim to improve conditions on the acute take, increase support within acute hospitals for this grade and allow development of other professional skills such as management, research, medical education and quality improvement.

At consultant level, orthogeriatric job plans need to be flexible, with opportunities to job share, incorporate other interests and avoid excessive out of hours commitments given the number of LTFT and female geriatricians.

Promoting trauma geriatrics

There is much in orthogeriatrics to generate enthusiasm. If we want to encourage trainees, whether medical, anaesthetic or surgical, to return as our consultant colleagues it is up to all of us, whatever our own specialism, to showcase positive aspects. Observing skilled professionals with mutual respect collaborating to deliver high quality care or education is a powerful incentive, and the opposite is also true.

The wealth of data easily available from the NHFD, allowing individuals and services to audit outcomes following changes, is a significant positive not always appreciated amongst geriatric trainees. When highlighted this can provide the basis for interdisciplinary collaboration on quality improvement and research projects.

Regional trauma networks are well established to share orthopaedic best practice. Orthogeriatric networks and specialist interest groups (SIG) are operational in some areas, but expanding trauma networks to encompass local geriatricians could provide the impetus needed for these to become more widespread. From geriatricians, the formation of a dedicated national orthogeriatrics SIG is perhaps long overdue.

Reshaping services

Geriatricians learn to manage medically complex, frail patients during a lengthy and costly training period. Given the current deficit in orthogeriatric numbers and rapidly expanding older trauma population we are unlikely to solve workforce issues solely through employing geriatricians. However, by getting creative we can expand services without diluting the quality of care delivered.

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By designing trauma services that have good geriatric care embedded within them (such as cognitive assessment, nutritional supplementation, early mobilisation and pressure area care) departments can allow busy geriatricians to focus on the more complex aspects of patient care. Ensuring reliable clinical ward support, adequate inpatient therapy provision and outpatient follow-up from a fracture liaison service also helps to relieve pressure on consultant time and make services more sustainable.

We need to look at who delivers routine daily care, much of which is straightforward, especially under direct supervision from a consultant geriatrician. Advanced nurse practitioners (ANPs), clinical nurse specialists (CNs) and physician associates (PAs) can successfully deliver some aspects of care with a model of training that is shorter and less costly. Furthermore, they can improve clinical continuity on the ward, provide mentoring for less experienced team members, and help nursing retention by providing a rewarding role with an enhanced career path. In some hospitals support from anaesthetists with a specialist interest in perioperative medicine may also be available.

We are not proposing these individuals replace geriatricians, but act to redistribute the workload and complement the existing team. Many centres already have success in this area in the form of hip fracture specialist nurses.

Understandably there are concerns that this reshape of the workforce could threaten quality of care with less experienced staff delivering care to a group of complex frail patients. However, we feel the key to success of use of this extended workforce is underpinned by careful role design and expansion of practice that is jointly developed, supervised and appraised by senior nursing staff and orthogeriatricians.

Summary

Orthogeriatric care has been shown to improve outcomes following hip fracture but services are variable in design and geriatric consultant input, at least in part due to the growing burden of workforce issues. Perceived challenges in the medical registrar role impact upon recruitment and are being addressed by medical colleges, but there is much that orthopaedic departments can do to attract geriatricians by extending roles and redesigning services. ■

References

References can be found online at www.boa.ac.uk/publications/JTO.