Change and age

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October is a month of change for *Australian Family Physician*. After nearly a decade as medical editor, and then Editor in chief, with both *AFP* and the **check** Program, Dr Jenni Parsons is leaving us to take up new challenges.

Jenni has always been a passionate advocate for making sure *AFP* delivers accessible, relevant, evidence based information to Australian general practitioners. In her time as Editor in chief, *AFP* received its much anticipated first impact factor and has been given an Excellence in Research for Australia (ERA) ranking of B, both of which will promote *AFP* to Australian GP researchers as a place to publish research and reach GPs in clinical practice. Confirming this is the most recent Medical Publications Readership survey,[1] which ranked *AFP* as Australia's leading medical journal, 'read by more GPs, more often and in greater depth'.

Jenni has also been a valued and respected mentor to *AFP* medical staff, in particular, her involvement over the years with helping *AFP* Publications Fellows come to grips with the world of medical editing.

Jenni's sound advice, thought-provoking editorials, and passion for *AFP* will be missed. We wish her every success into the future.

The *AFP* team is very fortunate to be able to welcome back Dr Kathryn O'Connor as a medical editor. Kath was *AFP*'s inaugural Publications Fellow, and under the mentorship of both Associate Professor Steve Trumble and Jenni Parsons, made the transition to medical editor of *AFP* and then the **check** Program.

Dr Rachel Lee, also a Publications Fellow mentored by Jenni, will continue in her role as medical editor. Both Kath and Rachel will help maintain *AFP*'s quality and relevance into the future.

Change also comes with age, and the focus of this month's issue of *AFP* is aged care. While aged care often invokes images of residential aged care and very frail people, the general practice reality is more than that. This is consistent with a study of people aged 85 years in the Newcastle region of the United Kingdom.[2] Only about 10% of people in the study were in Australia's equivalent of residential aged care. The most common conditions reported were hypertension, osteoarthritis and hearing impairment, all documented at between 50 and 60%. There were also lower levels of disability than we may have expected with almost 1 in 5 reporting no disabilities. As a group they also self rated their health highly, compared to others their age, with 78% rating it as good to excellent. This group of patients do see GPs, with 93% having GP contact in the preceding 12 months and 95% taking some medication. However, only 22% had spent a night in hospital in the past year.

When our aging patients do go to hospital, sometimes the first the GP knows about it is when they come to see us afterward – in the worst case scenario, to ask you to explain what happened! An Australian study[3] of Department of Veterans' Affairs Gold card holders, with a mean age of 80 years, found that the median time from discharge to GP visit was 12 days, but 25% of patients saw their GP within 4 days of discharge. They also had a median of 6 days to medication dispensing from a community pharmacy, but 25% had a prescription filled within 2 days. In contrast, in the 30 days after discharge only 44% saw a specialist, even though two-thirds of the admissions were to private hospitals. This data provides the hard facts behind the belief we have of the importance of timely communication, and perhaps a sense of worry about the risks in the current health system.

This 'old old' group includes many subjectively and objectively very healthy people, as well as some very frail people. General practitioners manage them both, from the prevention and health maintenance focus when needed, to the managing of multiple comorbidities and competing priorities that often conflict and need a true patient centered approach.

The articles in this month's *AFP* are designed to help GPs with the entire spectrum of aged care. The article by Yee on aging and sexuality reminds us to think of and raise this issue in consultations with our aging patients. The article by Workman, Dickson and Green on dementia aims to provide up-to-date information on this condition, which increases in prevalence with age. The article on prescribing in the elderly by Yates and Holbeach offers some ways of analysing and managing issues around prescribing and comorbidities. While it may not be immediately relevant, beginning discussions on end of life care preferences is best done before this time, and the article by Bloomer, Tan and Lee covers these issues.

While reading *AFP*, the research article by Inderjeeth and Smeath may also prompt us to consider our screening and management for osteoporosis in the aged. We hope that the articles in this issue of *AFP* provide thought, and possibly change, in our consultations with the aged.

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