

Palliative care: promoting general practice participation

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Specialist palliative care services and services involved in the pre-palliative phase of a patient's disease must accept GPs as an integral part of the care team

The number of Australians requiring palliative care is set to rise as the population ages. Although specialist palliative care services now cover most regions of Australia, rationing will be inevitable. Addressing the gaps and shortfalls to enable successful care of dying people will always require general practitioners to shoulder most of this clinical load.

Unfortunately, specialist palliative care services report that some GPs are disinclined to continue to care for patients who need palliative care. They also report variability in the palliative care skills GPs possess, and struggle to work out how to support the GP colleagues whose care they perceive to be suboptimal.

In 2002, the Commonwealth Department of Health and Ageing commissioned research to identify the barriers and propose solutions to this perceived problem. The outcome of this exercise provides a series of options for managing the engagement of GPs in palliative care.¹

Most of the barriers to GP participation in palliative care are complex structural factors that will take some time to address (Box 1). GPs are increasingly opting for part-time work and there is a rising proportion of female GPs. In view of family responsibilities and safety issues, female GPs may have to consider their willingness to undertake home visits and after-hours work.² For some GPs, regardless of gender, performing the time-consuming services involved in palliative care is becoming socially, financially and professionally non-viable.¹ Practice costs, and the pressures arising from them, continue to increase.

Several interim measures may improve GP participation in palliative care. Financial incentives (in the form of palliative-care-specific item numbers, or a substantial Special Incentives Program payment that recognises the intense work required in palliative care) may help. Items within the Enhanced Primary Care Program that encourage multidisciplinary care need to be simplified if they are to be used more often.³

For some GPs, exposure to only a small number of palliative care patients each year,^{4,5} combined with rapid advances in the evidence base for palliative care,

undermines their confidence in managing patients appropriately. Given these disincentives, GPs may well ask, “Why should I be involved when there is a specialist palliative care unit in the district?”.

Education providers, specialist palliative care services, governments and GPs themselves can all play a part in reinforcing the central role of GPs in palliative care.

Defining a minimum set of palliative care skills to be taught to all doctors at undergraduate and intern level would ensure that all GPs have the knowledge and confidence to manage most common problems in palliative care. Medical schools should accept the challenge of embedding the national undergraduate palliative care curriculum⁶ into their programs. Currently, neither the national intern training curriculum⁷ nor the Royal Australian College of General Practitioners vocational training curriculum⁸ includes palliative care as a distinct entity. Many parts of both curricula could be covered by structured teaching of palliative care.

Educational strategies aimed at established GPs should take into account the variable level of their skills and interest in palliative care. Such strategies include:

reinforcing the core skill set, especially during vocational training;

opportunistic case-based education, based on adult learning principles;

accessible and available local teaching;

financial support to attend educational sessions (including locum fee support); and

funded longer-term placements for GPs interested in making palliative care a major part of their practice.

Both specialist palliative care services and services involved in the pre-palliative phase of a patient’s disease (when the focus is on curative measures) must accept GPs as an integral part of the care team and work towards integrating GP input into patient care planning, patient review and management.

Maintaining clear lines of communication between hospitals and GPs is important, but, unfortunately, not always done well.¹ When patients are discharged from curative care, GPs need to be informed and their responsibilities delineated. Direct transfer of patients to palliative care units without keeping GPs informed and without giving them a defined role sends a message that they are not valued in this setting. Case conferences at the point of transfer can be useful. Furthermore, offering GPs responsibility during care planning and seeking their involvement in routine surveillance of patients during the pre-palliative phase (with clear protocols in place)⁹ might facilitate their involvement when patients enter the palliative phase of the illness.

Specialist palliative care services should not take on the role of finding an alternative GP or acting as primary care provider for patients whose GP will not or can not accept this responsibility — rather, this role should be referred back to the GP.¹⁰ GPs, in turn, should accept this responsibility and embrace or initiate shared-care models

(Box 2). Such models have been established successfully here and overseas.¹¹⁻¹³ Divisions of General Practice could play a key role (not yet well exploited) in encouraging formal shared-care arrangements — only 9% of Divisions were involved in palliative care shared-care projects in 2002.¹⁴

A significant proportion of Australians are from minority ethnic backgrounds, including Indigenous Australians. Many GPs who care for people from minority cultural groups require cross-cultural training relating to issues of death and dying. Many GPs who care for people of their own cultural group, while understanding the barriers to care that different cultural beliefs may pose, nevertheless have difficulty reducing the impact of these beliefs. Some GPs and communities require assistance in participating in and benefiting from mainstream models of palliative care.

Palliative care should be a rewarding part of general practice,¹⁵ and indeed the skills of good palliative care closely mirror those of good general practice care. It is essential that this core task is not diminished by, or lost in, the current rapid evolution of consumer needs, financial uncertainties, structural changes and increasing training imperatives.

1: Barriers to greater general practitioner participation in palliative care

Structural barriers

GP undersupply and uneven distribution

Time constraints for adequate service provision

Changing demographics (eg, increased proportion of female and part-time GPs)

Safety fears around home visits

Cost inefficiencies of providing quality palliative care

Rising practice costs and related pressures

Knowledge barriers

Sporadic patient load

Rapidly expanding knowledge base of palliative care

Competing educational priorities

Practical barriers to undertaking training (eg, time, cost, availability of locum support)

Lack of structured basic training

undergraduate curricula

national intern training curricula

culturally specific palliative care

Service barriers

Suboptimal planning of palliative care provision after attempted curative measures

Lack of active GP involvement in care during curative phase or in transition from curative to palliative care

“Specialisation” of palliative care

Unclear role definition for GPs in specialist palliative care service environment or among multiple service providers with palliative care brief

2: Roles of general practitioners and specialist palliative care services in palliative care

General practitioners

Provision of contextual knowledge of patient, family dynamics, history of illness to team’s care plan

Routine medical surveillance

Early intervention to prevent or control symptoms

Medical care of carers

Specialist teams

Provision of specialist advice on symptoms and treatment to team’s care plan

Nursing and allied health services

Pastoral care

Access to inpatient admission

Either GPs or specialist teams (by negotiation)

Care coordination

After-hours emergency care

Bereavement surveillance of carers

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