

Whither general practice palliative care?

Palliative care is one of the most important tasks a general practitioner can undertake. Most GPs will care for 5–7 deaths per annum,¹ and many of these will take a palliative course. This number will rise as the population ages. Ninety percent of the care in the last year of life takes place at home.² However, the care of these patients is intense for a relatively short time: whether a GP chooses to undertake this care is an important decision.

Palliative care and general practice have similar aims – comprehensive whole person care to the patient, and carer in the context of family and their community.³ The only difference between standard general practice and palliative care is the intense nature of the problem and the short timeframe.

About a quarter of GPs will not take palliative patients on.⁴ The reasons are not known; but are probably discomfort at dealing with symptom control – especially with a specialist service in the area; concern at doing house calls, competing priorities such as family commitments, personal discomfort in dealing with dying patients, and changing out of hours arrangements and expectations.

General practitioners most comfortable dealing with palliative patients are those who have been in practice for some time.⁵ How does a young GP get enough experience to be comfortable with palliation if they don't trust their ability or for whatever reason choose not to get involved? A deliberate choice needs to be made, knowing that the first few times a GP does this will provide a very steep learning curve.

Yet GPs must get involved. There will never be enough specialist services to care for all dying patients. Palliative patients and their carers⁶ value GP care and can feel betrayed when their GP does not perform when the need is greatest. Bereaved carers are at high risk of morbidity and have a higher mortality in the 12 months after a spousal death. Someone has to care for those left behind – who if not the GP? In a recent study, nine out of 65 surviving spouses changed GP as a result of the poor care their loved one received.⁷ The therapeutic relationship had to be re-formed at a critical life juncture.

Palliative care services don't want to usurp the GP role, but what choice do they have when patients don't have access to a primary medical carer when needed? The ball

is in our court. Some would say that if the GP doesn't get involved, it should be their responsibility to determine which of their colleagues will do it for them.

Palliative care also is by definition team care. No one practitioner has the skills or time to care for all patient needs. Someone has to be the 'team leader' to ensure that no task falls between professional cracks. This scenario is ideal for application of the Enhanced Primary Care scheme. General practitioners can provide contextual knowledge to enrich specialist services content knowledge. Indeed, there is emerging evidence that case conferences can improve some aspects of quality of life, particularly in the last month of life.⁷

This issue of *Australian Family Physician* examines various aspects of palliative care. Pain and symptom control are at the centre of good palliative care and are well within the capacity of general practice to achieve for most cases. Good clinical assessment is essential, as defining the source of the problem often determines the type of treatment to be offered. Excellent national clinical guidelines⁸ exist and should be on the desk of every practitioner. Palliative care does not stop at the death of the ill person. The culture and beliefs of people can have a profound impact on the nature of the care they want from GPs.

Walking with a patient known for many years is a privilege. We must not let the opportunity slip. If standards in this area fall, specialist services will have to by default pick them up, and everyone will be the poorer for the passing of general practice palliative care.

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Geoffrey K Mitchell

MBBS, PhD, FRACGP, FACHPM, is Associate Professor of General Practice, Discipline of General Practice, University of Queensland Medical School, Queensland.



CORRESPONDENCE email: afp@racgp.org.au