PC15 Palliative care

Rationale and general practice context

1. Palliative care requires a multidisciplinary approach, with the general practitioner playing a central and increasing role, especially in the management of domiciliary care. For example, in 2002, of the approximate 134,000 deaths that occurred in Australia, about 64,000 (almost 50%) of patients would have been cared for by a GP several times during their last 12 months of life. 4

2. Most patients who die an easily predictable death from a diagnosed terminal illness want to be cared for at home (>50%). However, only about 16% are able to exercise this option, as most patients now die in hospital; only 20% of people die in hospices and 10% in nursing homes.5

3. The community sector is increasingly caring for people at home rather than in hospital, and GPs often coordinate sometimes fragmented and competing community services and advocate on behalf of patients, their families and carers for community based palliative care.6,7

4. Like other doctors, GPs are largely trained to work with curative or life prolonging models of health and many GPs have identified that they require further education in the skills that underpin the practice of palliative care, such as basic communication skills, symptom control and management skills, and skills for dealing with ‘death and dying’.8,9

5. The provision of good general practice and community based palliative care requires GPs to organise their practices appropriately to help build and configure best use of community based health networks (eg. specialist hospital based to community based teams) to meet the palliative care needs of their patients, and their families and carers, for quality, comprehensive healthcare at the end-of-life in the setting of their choice.9

6. Like any other area of medicine, GPs need to utilise evidence based clinical decisions when providing general practice palliative care and access current palliative evidence bases such as CareSearch10 and Therapeutic guidelines – palliative care.11

7. There are government initiatives in palliative care, and GPs need to work in conjunction with government health priorities and other organisations toward better palliative care services.

Related curriculum areas

- Oncology
- Pain management

References


# Learning outcomes and criteria

## Domain 1 Communication and the doctor-patient relationship

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<tr>
<td><strong>Pre-general practice</strong></td>
<td><strong>General practice under supervision</strong></td>
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<tr>
<td>PC1.1 Establish and foster effective and empowering and therapeutic relationships with patients, carers and families.</td>
<td>PC1.1.1a Describe the issues specific to working with patients, carers and families. PC1.1.2a Describe the difference between caring and curing. PC1.1.3a Identify diversity between patients within families and cultures. PC1.1.4a Describe specific communication skills to enable the best care for patients and their families/carers at the end-of-life. PC1.1.5a Illustrate how spiritual, religious and cultural issues affect patient perception of illness and death, and treatment decisions.</td>
</tr>
<tr>
<td>PC1.2 Assist patients and their carers to maintain their quality of life.</td>
<td>PC1.2.1a Describe ways of managing patient expectations PC1.2.2a Identify interventions for people with life-limiting illnesses and their families PC1.2.3a Describe the experience and consequences of terminal illness from the perspective of the patient and their family. PC1.2.4a Analyse the impact of caregiving on family and carers.</td>
</tr>
<tr>
<td>PC1.1.1c Manage end-of-life issues for patients and their families/carers. PC1.1.2c Review and revise procedures that address end of life care.</td>
<td>PC1.2.1c Co-ordinate patient care to ensure that all members of the team are cognisant of the patient’s views</td>
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</table>
| PC1.3 Identify, evaluate and manage grief and bereavement. | PC1.3.1a Describe grief processes for families/carers.  
PC1.3.2a Describe how personal and cultural beliefs can impact on the provision of care. | PC1.3.1b Prepare carers for bereavement  
PC1.3.2b Provide support during the bereavement process.  
PC1.3.3b Manage bereavement issues for families/carers.  
PC1.3.4b Coordinate services when ongoing care and support is required. | PC1.3.1c Evaluate and build on skills in assisting patients, carers and family manage their grief and bereavement. |
| PC1.4 Facilitate communication with relevant healthcare professionals. | PC1.4.1a Identify essential components of effective referrals.  
PC1.4.2a Explain *multidisciplinary* inter-professional communication. | PC1.4.1b Identify appropriate healthcare professionals that can support patients, carers and families.  
PC1.4.2b Establish high quality referral systems to enable comprehensive care of all aspects of required care. | PC1.4.1c Establish and nurture networks of health professionals to enable comprehensive care of complex palliative patients |
### Domain 2 Applied professional knowledge and skills

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<th>General practice – lifelong learning</th>
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</thead>
<tbody>
<tr>
<td><strong>PC2.1 Identify a broad range of illnesses requiring palliative care</strong></td>
<td>PC2.1.1a List a variety of malignant and non-malignant illnesses that may require palliative care.</td>
<td>PC2.1.1b Recognise common symptoms seen in palliative care.</td>
<td>PC2.1.1c Review and apply new and emerging evidence in palliative care to ensure best practice standards are met.</td>
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<td>PC2.1.2b Use symptom checklists and screening tools as diagnostic support tools.</td>
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<td>PC2.1.3b Organise a prioritised management checklist.</td>
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<td>PC2.1.4b Implement diagnostic and treatment algorithms.</td>
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<td><strong>PC2.2 Determine Indicators of disease progression.</strong></td>
<td>PC2.2.1a Describe the pathology of the symptoms of terminal illness.</td>
<td>PC2.2.1b Undertake an effective assessment of a palliative patient to establish a comprehensive management plan.</td>
<td>PC2.2.1c Promote quality care and optimise palliative care health outcomes.</td>
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<td>PC2.2.2a Describe prognosis and quality of life issues.</td>
<td>PC2.2.2b Organise appropriate investigations in a palliative patient.</td>
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<td>PC2.2.3b Differentiate disease pathways in malignant and non-malignant terminal illnesses and the impact this has on patients and their families.</td>
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<tr>
<td><strong>PC2.3 Evaluate and manage end-of-life symptoms</strong></td>
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<td>PC2.3.1a Describe types of pain and other symptoms.</td>
<td>PC2.3.1b Organise appropriate investigations in palliative emergencies.</td>
<td>PC2.3.1c Reflect on the identified symptomatology and ensure that treatment reflects the patient’s priorities.</td>
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<td>PC2.3.2a Describe potential end-of-life emergencies.</td>
<td>PC2.3.2b Identify treatments for specific diseases and symptom control.</td>
<td>PC2.3.2c Commit to ongoing professional development that promotes the best available evidence based practice.</td>
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<td>PC2.3.2a Explain the management principles for common symptoms and health problems associated with life-limiting illnesses.</td>
<td>PC2.3.3b Utilise a range of palliative care interventions.</td>
<td>PC2.3.3c Use this knowledge to provide patients with the best management.</td>
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</table>

<p>| <strong>PC2.4 Accurately prescribe medications commonly used in palliative care.</strong> | <strong>Pre-general practice</strong> | <strong>General practice under supervision</strong> | <strong>General practice – lifelong learning</strong> |
| | PC2.4.1a Describe the drugs commonly used in palliative care and their indications, doses and routes of administration. | PC2.4.1b Describe the prescribing implications of renal and hepatic impairment. | PC2.4.1c Refer to available databases to advise patients on the available evidence of efficacy, safety and adverse interactions. |
| | PC2.4.2a Describe dose equivalence of opioids | PC2.4.2b Manage possible interactions between prescribed drugs and any complementary and alternative medicines. | |
| | PC2.4.3a Outline signs of opioid toxicity. | PC2.4.3b Use appropriate subcutaneous infusion devices in palliative care. | |
| | | PC2.4.4b Effectively apply the PBS palliative care section. | |</p>
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<tr>
<td><strong>PC3.1 Co-ordinate relevant community services</strong></td>
<td><strong>Pre-general practice</strong>&lt;br&gt;PC3.1.1a Describe the role of the GP in the palliative care setting.&lt;br&gt;PC3.1.2a Describe the role of GPs operating within a multidisciplinary team</td>
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<td><strong>PC3.2 Effectively utilise available healthcare resources.</strong></td>
<td>PC3.2.1a Describe palliative care budgetary and human resource limitations.</td>
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<td><strong>PC3.3 Manage palliative care for Aboriginal and Torres Strait Islander people.</strong></td>
<td>PC3.3.1a Describe palliative care issues specific to Aboriginal and Torres Strait Islander people.</td>
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4 Professional and ethical role

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<tr>
<td>PC4.1 Maintain professional standards of behaviour when managing palliative patients.</td>
<td>Pre-general practice: PC4.1.1a Discuss the unique emotional and spiritual issues that arise for a palliative patient.</td>
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<tr>
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<td>General practice under supervision: PC4.1.1b Manage patient wishes to decline treatment. PC4.1.2a Advocate strongly for patient needs, including accessing best practice resources.</td>
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<td>General practice – lifelong learning: PC4.1.1c Apply current and best practice palliative care knowledge to all patients.</td>
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<td>PC4.1.3b Manage ethical issues and conflicts in patient care. PC4.1.4b Identify and manage personal beliefs that impact on interactions with patients and their care.</td>
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## 5 Organisational and legal dimensions

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<tr>
<td><strong>PCS.1 Coordinate multidisciplinary teamwork.</strong></td>
<td><strong>Pre-general practice</strong>&lt;br&gt;PCS.1.1a Outline role of team care and care planning for palliative patients.&lt;br&gt;PCS.1.2a Identify sources of support for people with life-limiting illnesses and their families/carers.&lt;br&gt;PCS.1.3a Describe relevant models of healthcare and service delivery.&lt;br&gt;<strong>General practice under supervision</strong>&lt;br&gt;PCS.1.2b Apply appropriate Medicare items relevant to palliative care.&lt;br&gt;PCS.1.2b Identify and use local medical, nursing, allied health, community and respite services.&lt;br&gt;PCS.1.3b Facilitate access to relevant appliances and aids to daily living for palliative patients.&lt;br&gt;PCS.1.4b Negotiate the implementation of appropriate services for palliative patients.&lt;br&gt;PCS.1.5b Coordinate the ongoing provision of services.&lt;br&gt;PCS.1.6b Outline barriers to the provision of coordinated services.&lt;br&gt;<strong>General practice – lifelong learning</strong>&lt;br&gt;PCS.1.1c Identify gaps in knowledge, skills and attitudes in relation to evidence based palliative care.&lt;br&gt;PCS.1.2c Monitor the effectiveness of the team to assist in developing strategies to address identified gaps in knowledge, skills and attitudes.&lt;br&gt;PCS.1.3c Structure the clinic/practice to accommodate palliative patients.&lt;br&gt;PCS.1.4c Undertake regular audits of management practices in dealing with palliative care patients and their families/carers.</td>
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<tr>
<td><strong>PCS.2 Apply relevant legislative and administrative requirements.</strong></td>
<td><strong>Pre-general practice</strong>&lt;br&gt;PCS.2.1a Describe state legal issues associated with end of life care&lt;br&gt;<strong>General practice under supervision</strong>&lt;br&gt;PCS.2.1b Describe identification and certification of death, and surrounding legal issues.</td>
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<td>Requirements for competence</td>
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</table>
| **Required knowledge** | Role of palliative care within the healthcare system  
Disease trajectories for malignant and non-malignant terminal illness  
Common symptoms in end of life care  
Grief process | Dynamics within families of terminally ill patients  
Range of clinical resources  
Comprehensive knowledge of available pharmacologic interventions  
The Australian healthcare system  
Health promotion theory and practice  
Referral methods and sources  
Universal precautions  
Duty of care theory and practice  
Availability of a range of resources related to supporting patients and their families  
Interpreting demographic data  
Access and equity in the context of the patient and the setting |
| **Required skills** | Good communication skills | Delivering bad news  
History taking - bio-psycho-social  
Performing physical examinations  
Negotiation and problem-solving  
Communication skills (verbal and non-verbal) appropriately applied in a range of contexts  
Managing emergence of long repressed memories  
Advocacy  
Developing management plans with patients, their family/carers and other providers.  
Essential procedural skills  
Diagnostic skills  
Managing complications and emergencies  
Clinical decision-making  
Prescribing appropriately and cost effectively |
| **Required attitudes** | Empathy  
Inquisitiveness | Empathy  
Patience  
Resilience  
Rapport and empathy  
Dealing with uncertainty and ambiguity  
Collegiality  
Self-awareness  
Consistency | Professionalism  
Self-directedness |
| **Evidence required to demonstrate competence** | Case studies  
Supervisor reports  
Symptom lists  
Record of palliative care attachments or electives | Log book  
Case histories  
Records of visits to palliative care facilities  
Lists of support services and how to access them etc | CDP records of workshop and course attendance. |
| **Methods of assessment** | Small group projects  
Literature review  
Reflective essays | Report writing  
Clinical notes including referral letter review  
Observations  
Simulations  
Role-play  
Third party reports | 360 feedback  
Clinical audit |
Range statement

1 Communication and the doctor/patient relationship

Interventions
Can include those that will optimise physical, psychological and social function for people with life-limiting illnesses and their families

End-of-life issues can include giving bad news, developing realistic expectations and maintaining hope, managing grief processes for families/carers which progress beyond the patient’s death during their bereavement phase dealing with unfinished business

Multidisciplinary
Encompasses the shared care of the patient between a number of different health, allied health and community professionals and organisations.

2 Applied professional knowledge and skills

Appropriate investigations
Need to take into consideration the context of the patient’s illness and quality of life concerns.

Terminal illnesses
Can include cancer, neurological degenerative disease (eg. motor neurone disease, end stage dementia), organ failure (eg. chronic obstructive pulmonary disease, congestive cardiac failure), frailty and dementia, and HIV/AIDS

Symptom control
Can include palliative surgery, radiotherapy and chemotherapy, nutrition and hydration, mouth care, pressure area care

Symptoms
can include pain (nociceptive, visceral, neuropathic and complex); nausea and vomiting; constipation; anorexia; hiccoughs; fatigue, weakness and lethargy; delirium and confusion; dyspnoea; depression and anxiety; existential distress; malignant effusions; peripheral lymphoedema.

3 Population health and the context of general practice

Community services
Can include nursing, allied health, domiciliary services, pastoral care. Coordination of community services can include care of the patient, health beyond that of the individual patient, advocacy regarding community needs, needs of disadvantaged groups, cross-cultural partnerships.

4 Professional and ethical role

Professional standards of behaviour
Can include negotiating and agreeing on treatment modalities, priorities and goals of treatment in partnership with patient/family/carers; resource allocation to best serve the health needs of the population on the basis of need and equity of access to care and support; recognition of personal emotional stress and seeking assistance appropriately; understanding of patient and community perspectives on a ‘good death’; the need to complete ‘unfinished business; the issues surrounding relief of suffering and euthanasia.

5 Organisational and legal dimensions

Barriers to the provision of coordinated services
These can include intra-practice issues, time management and financial constraints.

**Legislative and administrative requirements** can include death certificates, advanced health directives, medical power of attorney, enduring guardianship requirements, carer’s allowance applications, will preparation, testamentary capacity

**Structure**
Can include accommodating home visits for palliative patients, when appropriate, arranging adequate clinical handover to partners or preferred after hours providers to ensure continuity of care at all hours for palliative care patients and their families.