2022 RACGP curriculum and syllabus for Australian general practice

Palliative care

Rationale

Instructions

This section provides a summary of the area of practice for this unit and highlights the importance of this topic to general practice and the role of the GP.

Palliative care provides support and treatment for distressing symptoms and experiences of illness rather than focusing on disease-modifying treatments. It addresses the physical, psychosocial and spiritual health needs of patients, their families, friends and carers.[1] It is estimated that about 1% of general practice consultations in Australia involve palliative care, advance care planning or end-of-life care.[2]

Palliative care priorities patient comfort, affirms dying as a natural and inevitable part of life and addresses the adverse impact of grief and loss that death brings.[1] The cultural and spiritual significance of death and grief is important, and diversity of practices and customs around end of life and bereavement need to be recognised and respected.[3] Sensitivity in language and clinical approach is required.[4] Respecting culture and kinship is particularly important when caring for Aboriginal and Torres Strait Islander peoples and their communities.[5] Experiences of colonisation and discrimination should be also considered when caring for Aboriginal and Torres Strait Islander peoples and communities.[6] Care is also required to ensure that every effort is made to allow people to have their end-of-life decisions respected and honoured wherever possible, including being able to return to Country or being in the communities they consider their home.[7]

In the past, palliative care was often not introduced until late in a patient's illness trajectory, frequently in the last few days or weeks of life when symptoms had become severe.[1] It is now recognised that introducing palliative care earlier has a beneficial effect in improving outcomes from a symptom perspective. The scope of illness recognised as benefiting from palliative care has also broadened in recent years, including non-cancer diagnoses such as human immunodeficiency virus (HIV) and cerebrovascular and neurological disease.[8] The demand for palliative care services has grown with this broader scope of application.

In 2018–19, there were over 83,000 palliative care-related hospitalisations in Australia.[9] Over half of these were for people aged 75 and over,[9] and the number of people who need end-of-life palliative care is expected to increase in coming years.[10] The increased rate of comorbidity will be a significant factor for general practitioners (GPs) to manage. Palliative care commonly involves multimorbidity, chronic progressive illnesses with protracted disease courses and diseases with complex symptoms and high symptom burden.[11]

There are no dedicated Medicare Benefits Schedule items specific for advance care planning and palliative care in general practice,[12] however the increased demand to provide high quality palliative care and the introduction of voluntary assisted dying laws in Australian jurisdictions[11] has seen an expansion of the supports available to general practice and primary care services in providing palliative care.[13] It is important for GPs and general practice registrars to maintain and build their skills in palliative care so that they can assist with addressing symptoms and navigating the complexities of services and care for people with palliative care needs.

References

1. World Health Organization. National cancer control programmes: Policies and managerial guidelines. 2nd edn. Geneva: WHO, 2002.
2. Australian Government Department of Health. Final report: research into awareness, attitudes and provision of best practice advance care planning, palliative care and end of life care within general practice. Canberra, ACT: Department of Health, 2017 (http://www.health.gov.au/resources/publications/gp-best-practice-research-project) [Accessed 29 September 2021].
3. Palliative Care Australia. Improving access to quality end of life care for Aboriginal and Torres Strait Islander Australians. Canberra, ACT: PCA, 2015 (https://palliativecare.org.au/wp-content/uploads/2015/08/PCA-Palliative-care-and-Indigenous-Australians-position-statement-updated-16-8-11.pdf) [Accessed 29 September 2021].
4. Reconciliation Australia. RAP good practice guide. Kingston, ACT: Reconciliation Australia, 2018 (http://www.reconciliation.org.au/wp-content/uploads/2018/05/language-guide.pdf) [Accessed 30 July 2021].
5. Indigenous Program of Experience in the Palliative Approach (IPEPA). Cultural considerations: Providing end-of-life care for Aboriginal peoples and Torres Strait Islander peoples. Brisbane, Qld: Queensland University of Technology, 2020 (https://pepaeducation.com/wp-content/uploads/2020/12/PEPA_CulturalConsiderationsFlipbook_Web.pdf) [Accessed 29 September 2021].
6. Queensland Health. Sad News, Sorry Business: Guidelines for caring for Aboriginal and Torres Strait Islander people through death and dying (version 2). Brisbane, Qld: Queensland Health, 2015 (http://www.health.qld.gov.au/__data/assets/pdf_file/0023/151736/sorry_business.pdf) [Accessed 29 September 2021].
7. Advance Care Planning Australia. Health professionals: Roles and responsibilities. Kew, Vic: Advance Care Planning Australia, 2021 (http://www.advancecareplanning.org.au/understand-advance-care-planning/health-professionals-roles-and-responsibilities) [Accessed 30th July 2021].
8. Worldwide Hospice Palliative Care Alliance. Global Atlas of Palliative Care. 2nd edn. London, UK: WHPCA, 2020 (http://www.thewhpca.org/resources/global-atlas-on-end-of-life-care) [Accessed 29 September 2021].
9. Australian Institute of Health and Welfare. Palliative care services in Australia. Canberra, ACT: AIHW, 2021 (http://www.aihw.gov.au/reports/palliative-care-services/palliative-care-services-in-australia) [Accessed 5 June 2021].
10. Brito M, Etkind S, Nkhoma K, Guo P, Higginson I, et al., The escalating global burden of serious health-related suffering: projections to 2060 by world regions, age groups and health conditions, Lancet Global Health, 2019; 7(7):E883-892. (https://doi.org/10.1016/S2214-109X(19)30172-X)
11. Palliative Care Australia. Palliative Care 2030: Working towards the future of quality palliative care for all. Canberra, ACT: PCA, 2018 (https://palliativecare.org.au/wp-content/uploads/dlm_uploads/2019/02/Palliative-Care-2030-public.pdf) [Accessed 29 September 2021].
12. Advance Care Planning Australia. Advance care planning in general practice. Kew, Vic: Advance Care Planning Australia, 2021 (http://www.advancecareplanning.org.au/understand-advance-care-planning/advance-care-planning-in-specific-health-settings/advance-care-planning-in-general-practice) [Accessed 29 September 2021].
13. Australian and New Zealand Society of Palliative Medicine. Workforce Strategy: Meeting the palliative medicine needs of patients in Australia 2011-2015 and beyond. Canberra, ACT: ANZSPM, 2011.

Competencies and learning outcomes

Instructions

This section lists the knowledge, skills and attitudes that are expected of a GP for this contextual unit. These are expressed as measurable learning outcomes, listed in the left column. These learning outcomes align to the core competency outcomes of the seven core units, which are listed in the column on the right.

Communication and the patient–doctor relationship	
Learning outcomes	Related core competency outcomes
The GP is able to:	

Communication and the patient–doctor relationship	
• communicate in a sensitive and compassionate manner when discussing palliative care options with patients, their families and carers	1.1.1, 1.1.2, AH1.3.1
• identify relevant values and cultural systems that influence the care and treatment decisions of people with palliative care needs and the communities around them	1.1.1, 1.3.1 1.4.1
• discuss and facilitate advance care planning in relation to a patient's culture, health issues, condition, treatment options and prognosis	1.1.4, 1.1.6, RH1.1.1
• discuss with a patient and their family when referral to palliative care services would be appropriate	1.4.2
• provide supportive care for people dealing with grief and bereavement, while recognising the ubiquitousness of grief and loss and the normal grieving process	1.1.3, 1.4.2, AH1.4.1, RH1.4.1, 1.4.3
• identify those whose grief reaction is complex or abnormally severe and may need referral to specialist bereavement and mental health services	1.1.1, 1.1.2, 1.1.3, 1.3.1

Applied knowledge and skills	
Learning outcomes	Related core competency outcomes
The GP is able to:	
• assess and manage the impact of treatment and symptoms on activities of daily living	2.1.3, 2.1.7, 2.1.9, 2.1.10
• assess and manage acute deterioration of symptoms	2.1.3, 2.1.9, 2.3.2, AH2.3.1, RH2.3.1
• explain the clinical indications for introducing palliative care services, including appropriate timing in someone's illness trajectory	2.1.3, 2.1.7, 2.1.8

Population health and the context of general practice	
Learning outcomes	Related core competency outcomes
The GP is able to:	
• advocate for the role of the general practitioner in palliative care	3.2.1, 3.2.4, RH3.2.1

Professional and ethical role	
Learning outcomes	Related core competency outcomes
The GP is able to:	
• maintain self-care strategies and avenues for debriefing when caring for those who are terminally ill	4.2.2, 4.2.5, RH4.2.1
• recognise own beliefs and values in relation to death and dying and how these might impact on care for others with differing beliefs or from different cultures	4.2.2, 4.2.4, AH4.2.1, AH4.2.2

Professional and ethical role	
• provide leadership to reduce fragmentation of care across coordinating services, including locum services, residential aged care facilities (RACFs), non-GP specialists, ambulance services and hospitals	4.1.2, AH4.2.3, RH4.2.2

Organisational and legal dimensions	
Learning outcomes	Related core competency outcomes
The GP is able to:	
• establish clinical triggers in the management of patients with advanced chronic disease to inform anticipatory care planning and promote consideration of adopting advance care planning or a palliative care approach	AH5.1.2, AH5.2.1
• explain and obtain informed consent in a manner of shared decision-making with the patient, their family and substitute decision-maker in a private and confidential manner	5.2.2
• coordinate care to ensure people with palliative care needs understand how and where to seek help after hours	5.2.1, 5.2.3
• ensure access to clear documentation about a patient's wishes to their entire treating team and the processes required in the event of an expected death	5.1.3, 5.2.1, 5.2.3, RH5.1.1

Words of wisdom

Instructions

This section includes tips related to this unit from experienced GPs. This list is in no way exhaustive but gives you tips to consider applying to your practice.

Extension exercise: Speak to your study group or colleagues to see if they have further tips to add to the list.

1. Palliative care is not restricted to those with cancer. Sometimes the most important step is to recognise when a patient is dying. Ask yourself, would I be surprised if this patient passed away in the next 12 months? If the answer is no, consider goals of treatment and keep your patient's experience at the centre of any decisions or recommendations you might be making. To help you do this, ask yourself, will this improve the person's ability to enjoy life at the present time, or not?
2. 'Don't just do something… Sit there!' Often our first instinct is to try and *do something* to help people when we see them suffering. Often, however, the first and most powerful thing that we can do to alleviate someone's suffering is to have *empathic presence*. Simply by sitting with someone in their suffering, not speaking, not acting, just *being there*, we can create a powerfully therapeutic space in which healing can occur.
3. Living with cancer or other terminal and/or serious illness can be a terrifying and lonely time for people, even those with a lot of people around them. Having someone available to share their struggles with and share the journey can transform that person's experience of terminal illness.
4. Often with common symptoms, such as pain or nausea, it is easy to fall into the trap of treating only the symptom using the same medications every time. Instead, try to understand the aetiology of the symptom and tailor treatments to the underlying cause. Learning how classes of medication work differently depending on the underlying cause can help to treat symptoms more effectively.
5. Avoid using phrases like 'I know what you're going through' or 'I know how you're feeling' when speaking to patients or their loved ones. Even if you have experienced something similar, everyone's experience can be very different, and we never actually know what another person is feeling. Instead, try less assuming phrases, such as 'I've known people in similar circumstances to sometimes feel …' If you become distressed in the process of caring for someone because of your previous experiences or for any other reason, seek support from a colleague.
6. When making a caring and empathic statement, such as 'I imagine this is a very distressing thing for you', try to avoid the trap of immediately following it up with a question or a further comment. Instead, learn to be comfortable with brief silences, to let your empathic statements sit and be absorbed and have their therapeutic effect. The beneficial effect on the patient–doctor relationship and the therapeutic effect of the consultation may surprise you!

Case consultation example

Instructions

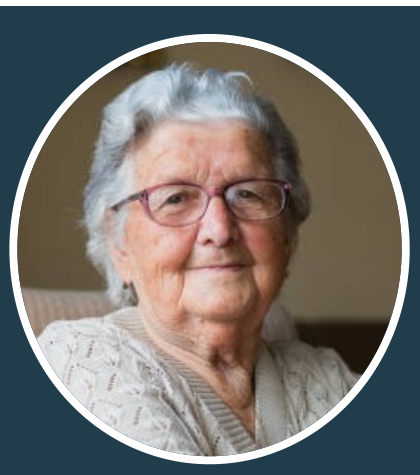
1. Read this example of a common case consultation for this unit in general practice.
2. Thinking about the case example, reflect on and answer the questions in the table below.

You can do this either on your own or with a study partner or supervisor.

The questions in the table below are ordered according to the RACGP clinical exam assessment areas (https://www.racgp.org.au/getmedia/f93428f5-c902-44f2-b98a-e56d9680e8ab/Clinical-Competency-Rubric.pdf.aspx) and domains, to prompt you to think about different aspects of the case example.

Note that these are examples only of questions that may be asked in your assessments.

Extension exercise: Create your own questions or develop a new case to further your learning.



Pamela is 74 years old and comes to see you with her son. She has recently moved to your area from interstate, to be closer to family.

Pamela was diagnosed with breast cancer seven years ago, which was treated with bilateral mastectomy and adjuvant chemotherapy and radiotherapy. She was in remission until two years ago when she was diagnosed with metastatic recurrence in her liver and multiple bone metastases. At her follow-up telehealth oncology appointment a few days ago, Pamela was told by her oncologist that her cancer had progressed, and 'no further treatments were available'. She was advised to see her new GP to 'arrange palliative care'. Pamela is concerned that she's getting a lot of back pain, and says she feels quite tired and 'like life is not worth living anymore'. Her son is also concerned about his mother's recent weight loss, as she has been struggling to eat much lately.

Questions for you to consider		**Domains**
How might Pamela be feeling after her recent consultation with the oncologist? What about her son? What communication skills might be useful to support Pamela and develop a trusting therapeutic relationship in this first consultation with her?	1. Communication and consultation skills	1,2,5
What information from Pamela would help you create a management plan for her main symptoms? What information would be useful to gather from her treating oncologist? What about from Pamela's family?	2. Clinical information gathering and interpretation	2
What might be causing Pamela's loss of appetite, weight loss and pain? How might knowing the cause help you manage those symptoms? Are there any investigations that might help in this assessment?	3. Making a diagnosis, decision making and reasoning	2
How might the way you manage Pamela's appetite and weight loss change, depending on what the cause is? What options could you consider to manage Pamela's back pain? How might these options change as Pamela's symptoms evolve over the coming weeks or months? If Pamela lived in a rural or remote area, with limited access to tertiary palliative care services, how might this affect her goals of care and the treatment options for complex symptoms?	4. Clinical management and therapeutic reasoning	2
When and how would it be appropriate to involve substitute decision-makers in treatment and care decisions? If Pamela was an Aboriginal or Torres Strait Islander, how might this affect decisions about treatment and where she might want to receive end-of-life care? Where might you obtain further knowledge about communicating with Aboriginal and Torres Strait Islander peoples and their communities in a palliative setting, and information on the culture and practices that may be relevant?	5. Preventive and population health	1,2,3

Questions for you to consider		Domains
As you support people moving into end-of-life care, what personal reflections and challenges might come up about your own history and family? In what ways do your views, beliefs, values and cultural attitudes towards death and dying impact on and influence how you approach palliative and end-of-life care?	6. Professionalism	4
What are the legal and professional requirements for drawing up an advance care directive? How could you obtain specialist palliative care medications (eg medicinal cannabis, levomepromazine) through the Therapeutic Goods Administration Special Access Scheme?	7. General practice systems and regulatory requirement	5
Where might you find out which medications are, or are not, compatible within the same syringe driver? If your practice were in a rural or remote location, would you know how to set up a syringe driver? How could you improve your skills?	8. Procedural skills	2
How would you discuss prognosis with Pamela and her family? What information would be helpful for such a discussion? How would you manage Pamela's symptoms if you were unsure of their underlying cause?	9. Managing uncertainty	2
How would you discuss with Pamela and her family the most appropriate care and treatments should she become more unwell? How might you discuss goals of care with Pamela and her family? Are there situations where Pamela would want to be assessed and treated in an emergency department, and others where she might not? What signs or symptoms would suggest that you need to refer Pamela to a specialist inpatient palliative care service, such as a hospice or palliative care unit at a hospital?	10. Identifying and managing the significantly ill patient	2

Learning strategies

Instructions

This section has some suggestions for how you can learn this unit. These learning suggestions will help you apply your knowledge to your clinical practice and build your skills and confidence in all of the broader competencies required of a GP.

There are suggestions for activities to do:

- on your own
- with a supervisor or other colleague
- in a small group
- with a non-medical person, such as a friend or family member.

Within each learning strategy is a hint about how to self-evaluate your learning in this core unit.

On your own

Use practice software to identify one of your patients who is in need of palliative care support. Read through the notes and explore who is in that person's support network. Review the management of this patient and any symptoms that have been reported to the clinical team recently.

- *Does the person have any symptoms that are being treated, and any that are not being fully managed? If so, what do treatment guidelines recommend as alternative or additional therapeutic options?*
- *Who's missing from 'the team'? Are there allied health practitioners that might be helpful in treating and supporting the person's symptoms? What psychological and spiritual support people are involved in this person's care, and who else might be able to offer support? Who is supporting the family and caregivers? Are they also patients of your practice? What peer and community support groups might be suitable for the patient and their caregivers?*

Register for a free account on Cancer Council Victoria's website (http://www.cancervic.org.au/for-health-professionals/training-education/elearning-modules), and complete the free *End of Life Conversations* e-learning module.

- *Which skills and techniques are discussed that you are already aware of and using in your practice? Which additional skills will you try to incorporate into your practice?*
- *Were there any skills or advice that you're not going to use? If so, why not? Do you have alternative skills or ideas of your own?*
- *What's the evidence base for some of the skills and strategies that are discussed in the module?*

Complete two of the following RACGP *gplearning* activities:

a. AJGP Clinical Challenge – Palliative care
b. Advance care planning in general practice
c. Approach to timely palliative care conversations
d. Living longer, dying better: A framework for palliative care in community-based aged care
e. AJGP Clinical Challenge – Oncology

- *What areas or topics did you find most challenging?*
- *Are there any medical science topics that you might benefit from revising; for example, pharmacology or oncology?*
- *Were there aspects of palliative care that were different for terminal illnesses other than cancer?*

What legal aspects were discussed that would need to be clarified in respect to your state or territory?

With a supervisor

Identify a patient who you or your supervisor has seen who had pain or nausea that was difficult to manage. Discuss the case and explore the various things that were tried, and consider what else might be worth considering.

- *Why were this person's symptoms so difficult to manage? Why do you think the treatments didn't work in this situation? Was it something about the type of pain or nausea? Or were there things about this person's life, body, context or current situation that were complicating or undermining the treatment?*
- *Was the treatment plan carried out as it was intended? Did the patient understand the treatments and how they usually worked?*
- *Was the initial assessment of the aetiology of the pain or nausea accurate, or did it need to be revised or updated?*
- *Were the initial treatment choices evidence-based? What do treatment guidelines recommend?*

Select a small sample of patients over the age of 75 at your practice, ideally that both you and your supervisor have treated. Both of you go through this list of patients independently and ask yourselves if you would be surprised if the patient passed away in the next six months. Then compare your results. For those patients who you wouldn't be surprised if they passed away in the next six months, check whether there is a record in the notes about an advance care planning discussion and/or an advance care directive being in place.

- *What were the differences between your answers? Why did you choose your answer, and why might it have been different to your supervisor's?*
- *Did you find information about advance care directives for those patients who you wouldn't be surprised about passing away in the next six months?*
- *Has there been a discussion about goals of care with the patients or their caregivers?*
- *Have palliative care services been engaged with?*

In a small group

Revise your study of the pharmacological action of the main classes of anti-emetic drugs, including antipsychotics and adjuvant anti-emetics like corticosteroids. Remind yourself how they work in treating nausea and reflect on various common causes of nausea. Match each cause with an anti-emetic that might work well in that situation.

- *Discuss your ideas together as a group and decide on the answers by consensus.*
- *Reflect on where you had differences of opinion, but also seek to learn from each other's different knowledge and experiences.*

With permission, record yourself role-playing a consultation with a peer who is pretending to receive bad news; for example, that their cancer has progressed despite treatment. Then watch a supervisor/another doctor/video exemplar of a similar consultation. (Ensure that whoever agrees to take part is aware that this can be a challenging issue to role-play and can sometimes trigger painful memories or deep-seated anxieties.)

- *Compare the two consultations. What were the differences? Think beyond the clinical information. Were there differences in body posture, communication, jargon used, etc?*
- *What could you improve on?*

On pieces of card, write down the name of a specific opioid, and a route of administration. For example, write 'oxycodone, oral' or 'fentanyl, topical (patch)'. Shuffle the cards, and then put each card on the floor or on a table, spread out and face down so that none of you can see which card is which. Each person picks up a card and holds on to it. Leave at least one card on the floor or table. Once everyone has picked a card, choose one of the leftover cards and decide on a reference dose for that opioid and its route of administration. Then, everyone works out the opioid conversion (oral morphine equivalent dose) for the opioid and route of administration that is written on their chosen card. Come back together and discuss your answers.

- *Refer to whatever reliable and validated opioid conversion charts or tables are available to you. Safer Care Victoria has an [opioid conversion resource (http://www.bettersafercare.vic.gov.au/clinical-guidance/palliative/opioid-conversion)](http://www.bettersafercare.vic.gov.au/clinical-guidance/palliative/opioid-conversion).*

With a friend or family member

Invite a trusted friend or family member to share a brief story about an event or experience that they found challenging or embarrassing. Sit in silence together for at least 30 seconds afterwards, without doing or saying anything. Then you do the same, and again, sit in silence for 30 seconds. After both of you have shared your story or experience, and sat in silence after both, then either of you can talk more about your experiences.

- *How difficult did you find sitting in silence for 30 seconds? Did you want to say something? Were you uncomfortable?*
- *Did you feel more or less uncomfortable when you were the one to share your experience, compared to when you were the one listening?*
- *What was the therapeutic effect of the silence?*

Discuss attitudes and beliefs about death and dying with a friend from a different culture and/or religious perspective to your own.

- *What differences were there between your attitudes and beliefs? What was similar?*
- *How might these differences in attitude and belief affect practices around death?*
- *How might these affect how palliative care is both provided and received?*
- *How might awareness of cultural diversity impact on how you deliver palliative care to your patients?*

Talk to a very close friend, partner or family member about what they would like to happen if they become very unwell and unable to make or communicate decisions themselves. Have they spoken to their loved ones and their doctors about their preferences? Do they have an advance care directive? Have they thought about, or appointed a formal substitute decision-maker (eg Medical Power of Attorney)? Do they have a preference for what should happen to their body when they die? Do they have any special religious or cultural belief or practice that is important to consider when they are approaching death or when they die?

- *How about you? Have you spoken to your loved ones and doctors about your preferences? Do you have an advance care directive or plan? Have you thought about appointing a substitute decision-maker? Do you have any religious or cultural beliefs that will affect what happens when you are approaching death or when you die?*
- *Think about any of your patients who have advance care directives or are considering creating one, and reflect on what might be included in one.*

Guiding topics and content areas

Instructions

These are examples of topic areas for this unit that can be used to help guide your study.

Note that this is not a complete or exhaustive list, but rather a starting point for your learning.

- Have a comprehensive understanding of important medico-legal issues concerning palliative care, end-of-life care and terminal illness relevant to your state or territory, including:
  - advance care planning and advance care directives
  - informed consent and substitute decision-makers
  - substitute decision-makers and processes of healthcare decision-making
  - medical certification of cause of death (death certificates) and cremation certificates
  - prescription, administration and storage of Schedule 8 medications (eg opioids).
- Initiate advance care planning conversations with patients, to empower patients to have autonomy and dignity throughout their lives, wherever possible, and to have a say in what happens to their bodies after and around death.
- Perform an assessment of a person living with a serious, life-limiting illness to identify their care needs, and using shared decision-making, design and document a care plan, including (but not limited to):

    - community palliative care
    - pastoral care
    - tertiary palliative care services
    - allied health
    - other appropriate non-GP specialist care; for example, oncology services, renal services
    - grief and bereavement services.
- Perform a comprehensive pain assessment of a person with palliative care needs, including identifying the likely mechanisms underlying the pain, and any aetiological, precipitating and exacerbating factors. And identify potential management and treatment options for the pain, and collaboratively decide on a treatment plan with the patient. These options may include:
    - opioid medication
    - non-opioid and adjuvant medication
    - physical therapies
    - psychological treatments and therapies
    - radiotherapy and other disease-modifying treatments.
- Assess a person receiving palliative care experiencing agitation, anxiety and/or existential distress or suffering, including identifying any possible predisposing, precipitating and perpetuating factors for the distress, and also what self-coping and protective/supportive factors are being employed or are already in place.
    - Be mindful of and consider the person's cultural, spiritual and religious beliefs, values and background and their community context, appreciating the difference between religion and spirituality and the wide diversity of cultural perspectives between and within communities.
    - Identify potential management and treatment options for the distress, including both pharmacological and non-pharmacological strategies, and collaboratively decide on a treatment plan with the patient, involving their support network where appropriate and with consent.
- Assess a person receiving palliative care experiencing nausea or vomiting, including identifying the likely underlying mechanisms involved, and any aetiological, precipitating and exacerbating factors that can be ascertained.
    - Identify potential management and treatment options for the nausea/vomiting, including both pharmacological and non-pharmacological strategies, and collaboratively decide on a treatment plan with the patient.
- Assess a person receiving palliative care experiencing other symptoms, including those that are complex and difficult to treat, and identify when to refer to specialist palliative care services. These other symptoms might include:
    - dyspnoea or shortness of breath
    - restlessness or agitation
    - cough
    - cachexia and anorexia
    - fatigue
    - excessive secretions
    - pruritis/itch
- Develop an understanding of foundational palliative medicine skills and knowledge when caring for children with terminal illness, and an awareness of paediatric palliative care services.
- Demonstrate effective and advanced communication skills using compassion, empathy and respect for human dignity, privacy and autonomy, and involve family and caregivers appropriately and sensitively, with consent. This includes challenging and difficult conversations and consultations in palliative care; for example:
    - shared decision-making (eg advance care planning)
    - discussing prognosis
    - breaking 'bad news'
    - facilitating end-of-life decisions
    - supporting people experiencing grief and loss
    - supporting people experiencing existential distress or anxiety.

Learning resources

Instructions

The following list of resources is provided as a starting point to help guide your learning only and is not an exhaustive list of all resources. It is your responsibility as an independent learner to identify further resources suited to your learning needs, and to ensure that you refer to the most up-to-date guidelines on a particular topic area, noting that any assessments will utilise current guidelines.

Journal articles

The role of the GP in paediatric palliative care.

- Armitage N, Trethewie S. Paediatric palliative care – the role of the GP (https://www.racgp.org.au/afp/2014/april/paediatric-palliative-care/). Aust Fam Physician 2014;43(4):176–80.

This article describes and explains terminal sedation, often provided in tertiary palliative care settings.

- Patel C, Kleinig P, Bakker M, Tait P. Palliative sedation (https://www1.racgp.org.au/ajgp/2019/december/palliative-sedation). Aust J Gen Pract 2019;48(11/19):838–45.

Outlines aspects of providing palliative care to people with kidney failure.

- So S, Brennan F, Li K, Brown M. End stage kidney disease: The last 12 months (https://www1.racgp.org.au/ajgp/2021/april/end-stage-kidney-disease-the-last-12-months-1). Aust J Gen Pract 2021;50(03/23):193–98.

Textbooks

Evidence-based treatment options for managing clinical problems or situations that can arise in palliative care.

- Therapeutic Guidelines (http://www.tg.org.au)

(http://www.tg.org.au)Online resources

The roles and responsibilities for GPs in advance care planning.

- Advance Planning Australia. Health professionals: Roles and responsibilities (http://www.advancecareplanning.org.au/understand-advance-care-planning/health-professionals-roles-and-responsibilities).

Evidence-based palliative care information, resources and guidelines.

- CareSearch: Palliative Care Knowledge Network (https://www.caresearch.com.au/tabid/7015/Default.aspx).

Important considerations and recommendations for doctors providing palliative care to Aboriginal and Torres Strait Islander peoples.

- IPEPA Project team. Cultural considerations providing end-of-life care for Aboriginal peoples and Torres Strait Islander peoples (https://pepaeducation.com/wp-content/uploads/2020/12/PEPA_CulturalConsiderationsFlipbook_Web.pdf).

Resources and links, including providing palliative care in different settings, for Aboriginal and Torres Strait Islander peoples, paediatrics, LGBTIQ+ community and residential aged care.

- Palliative Care Australia (https://palliativecare.org.au/im-a-health-professional/).

Learning activities

eLearning modules on the topics of palliative and end-of life care.

- The Royal Australian College of General Practitioners. *gplearning* (https://www.racgp.org.au/education/professional-development/online-learning/gplearning):
  - Advanced care planning for general practice.
  - Approaches to timely palliative care conversations.

This webinar explores palliative care for rural GPs.

- The Royal Australian College of General Practitioners. Palliative care for rural GPs (http://www.racgp.org.au/education/professional-development/online-learning/webinars/rural-health/palliative-care-for-rural-gps).

This module looks at communication skills for GPs when having end-of-life discussions.

- Cancer Council Victoria. End of life conversations (http://www.cancervic.org.au/for-health-professionals/training-education/elearning-modules).

Other

A useful guide for converting opioid doses when switching between different opioids or different modes of delivery.

- Safer Care Victoria. Opioid conversion (http://www.bettersafercare.vic.gov.au/clinical-guidance/palliative/opioid-conversion).

This reference guide provides information on combining multiple medications in the same syringe for use in terminal care.

- Safer Care Victoria. Syringe driver compatibility (http://www.bettersafercare.vic.gov.au/clinical-guidance/palliative/syringe-driver-compatibility).

This free smart phone app gives information on medication used in palliative care and includes an opioid conversion calculator.

- PalliMEDS app (http://www.caringathomeproject.com.au/tabid/5159/Default.aspx).

This contextual unit relates to the other unit/s of:

- Domain 3. Population health and the context of general practice (https://www.racgp.org.au/curriculum-and-syllabus/units/domain-3)
- Mental health (https://www.racgp.org.au/curriculum-and-syllabus/units/mental-health)
- Older persons' health (https://www.racgp.org.au/curriculum-and-syllabus/units/older-person-s-health)
- Pain management (https://www.racgp.org.au/curriculum-and-syllabus/units/pain-management)
