



General principles

- Palliative care is a fundamental component of general practice.
- Most people die from chronic diseases that progress along one of three typical illness trajectories to the end of life, which are:
 - cancer (short decline)
 - non-malignant organ failure (intermediate decline with acute episodes)
 - frailty, dementia (gradual dwindling).
- Patient care along the illness trajectory can ideally transition smoothly from chronic disease management to treatment of advanced illness, to a palliative approach, end-of-life care and terminal phase:
 - A palliative approach shifts the primary focus from life-prolonging treatments towards symptom treatment and quality of remaining life.
 - End-of-life care is focused on providing increased services and support for the person's physical, emotional, social and spiritual/existential issues as they approach death.
 - The GP's role in end-of-life care includes a terminal care plan, care after death and bereavement support for patients and their families.
 - GP self-care and support of colleagues is important to prevent stress, burnout and compassion fatigue.

Practice points

Practice points	References	Grade
Initiate advance care planning early when patients have capacity to express their wishes and directives for care if they become too ill or cognitively impaired to make decisions	28–31, 38	Consensus-based recommendation
General practitioners (GPs) can use a proactive, systematic approach to anticipate and provide person-centred care to the end of life and a 'good death' by: <ul style="list-style-type: none"> • initiating advance care planning early to document patient wishes and directives • anticipating and assessing escalating palliative care needs early along the illness trajectory • establishing clinical care goals and treatment decisions with the patient/medical decision maker • reviewing clinical care plans frequently to address symptoms and physical, psychosocial and spiritual/existential issues • coordinating and participating in the provision of team-based end-of-life care. 	–	Consensus-based recommendation
Early identification, assessment and management of escalating palliative care needs are important to relieve symptoms, avoid suffering, reduce need for hospital care, and improve quality of remaining life and the death experience	13	Consensus-based recommendation
Recognise escalating palliative care needs at major transition points along the illness trajectory to initiate timely: <ul style="list-style-type: none"> • palliative approach • end-of-life care • terminal care, including after-death and bereavement support 	13	Consensus-based recommendation
Indicators such as the 'surprise question' and the Supportive and Palliative Care Indicators Tool (SPICT) can help identify patients early when considering whether a person may benefit from a palliative approach	5, 6, 44, 47	Consensus-based recommendation
Consider using symptom assessment tools, which can be valuable in identifying symptoms, scoring their severity and monitoring the effectiveness of treatments	34	Consensus-based recommendation

Introduction

An Australian man aged 65 years in 2009 could expect to live an average of 8.2 years without disability, and another 10.5 years with disability, including 3.5 years with severe or profound activity limitation. An Australian woman aged 65 years in 2009 could expect to live an average of 9.7 years without disability, and another 12.1 years with disability, including 5.6 years with severe or profound activity limitation.¹

About two-thirds of Australians die between 75 and 95 years of age.¹ In 2005, 54% of people aged >65 years died in hospital, 32% in residential aged care facilities (RACFs), and 14% elsewhere (eg home).²

Chronic diseases are responsible for 90% of deaths,³ and about 70% of deaths are 'expected' due to advanced disease,⁴ predominately cardiovascular diseases (eg coronary heart disease, stroke), dementia and Alzheimer's disease, chronic respiratory disease and lung cancer.

Death is often preceded by a period of significant disability, interspersed by life-threatening events. Patients with advanced diseases have an average of eight hospital admissions in their last year of life.⁵ Many of these involve

treatments that are of little or no benefit, or may cause more harm than benefit,⁶ and patients often do not have the capacity or opportunity to discuss their wishes for care.⁷

Clinical context

The current Australian healthcare system does not meet patient preferences for care at the end of life.⁴ For instance, the low proportion of people dying at home is at odds with the stated preferred place of death of patients; and is half that of comparable countries such as New Zealand, the US, Ireland and France.⁴ Place of death is a key indicator of quality end-of-life care.⁸ Preferred place of death is influenced by many factors, including:⁹

- connectedness to community
- family
- availability of services and equipment
- complexity of caregiving and decision making.

Preference for receiving care at home is stronger for end-of-life care during the last months of life than for death at home. Transfer from home may occur in the last few days due to rapidly escalating patient care needs, patient safety risks or carer exhaustion.

Principles of a 'good death' have been summarised from surveys of people approaching death and their relatives. Patient priorities for end-of-life care include:^{10,11}

- knowing when death is coming and what to expect
 - reasonable control of what happens
 - ensure wishes are respected
 - choice to leave when it is time
 - avoid prolonging dying
- choice and control over where death occurs
 - who is present and who shares the end
 - time to say goodbye
 - arrange important affairs
- access to
 - 'hospice-style' quality care in any location
 - necessary information and expertise
 - control of pain and other symptoms
 - dignity and privacy
 - spiritual or emotional support
- strengthening of relationships, and relieving burdens placed on the family.

Australia's healthcare system is facing the challenge of shifting away from a hospital-centric provision of treatment at the end of life towards better support for people who wish to receive care within their community during their last months of life.^{4,12}

Palliative care

Palliative care, while originally associated with cancer care, is appropriate for anyone with life-limiting illnesses, including non-malignant degenerative diseases, and dementia (refer to Part A. Dementia). In the past decade, palliative care has become available within almost every healthcare setting, including general practices, RACFs, acute hospitals and generalist community services.¹²

Each year in Australia, about 160,000 people die, and around 100,000 of these deaths are predictable. Of those, 40,000 patients receive specialist palliative care and 60,000 do not. Patients may receive palliative care for years, months, weeks or days before death.¹

People receiving palliative care have fewer episodes of hospitalisation, shorter lengths of stay when they are hospitalised, and reduced visits to emergency departments. Those who receive palliative care at home have been shown to have increased quality of life and reduced need for hospital-based care.¹²

Box 1 provides definitions of palliative care; there is no clear demarcation point between curative and palliative intent, or at the transition between phases of palliative care.

Box 1. Definition of phases of palliative care

Palliative care:

- World Health Organization – Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems – physical, psychosocial and spiritual.¹³
- Palliative Care Australia – Palliative care is person-centred and family-centred care provided for a person with an active, progressive, advanced disease, who has little or no prospect of cure and who is expected to die, and for whom the primary goal is to optimise the quality of life.¹⁴

Palliative approach:

- A palliative approach recognises that death is inevitable and focuses on the care rather than cure of a person with multiple chronic conditions, frailty and/or a life-threatening or life-limiting illness. The goal of a palliative approach is to improve or optimise a person's level of comfort and function and to offer appropriate treatment for any distressing symptoms. A palliative approach addresses a person's psychological, spiritual, social, emotional and cultural needs. Families are welcomed as partners in this approach. A palliative approach recognises that for older people with multiple chronic conditions, frailty and/or a life-threatening or life-limiting illness, that this is often the last chapter of their life, the length of which is unknown.¹⁵

End-of-life care (and terminal phase):

- End-of-life care is the last few weeks of life in which a patient with a life-limiting illness is rapidly approaching death. The needs of patients and carers are higher at this time.
 - This phase of palliative care is recognised as one in which increased services and support are essential to ensure quality, coordinated care from the healthcare team is delivered.
 - This takes into account the terminal phase or when the patient is recognised as imminently dying, death and extends to bereavement care.¹⁴
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For definitions and up-to-date information on legal issues that can arise with palliative medicine (eg double jeopardy) and end-of-life decision making, refer to [End of Life Law in Australia](#).

At the time of writing, euthanasia is illegal in all Australian states and territories. Since 19 June 2019, voluntary assisted dying (VAD) became legal in Victoria and is being considered in other states. VAD involves administering a medication for the purpose of causing death in accordance with the steps and processes set out through legislation. VAD must be voluntary, and will usually be self-administered by the individual.

In Victoria, the *Voluntary Assisted Dying Act 2017* (Vic) (the Act) sets legal criteria for an individual to be eligible for VAD, for health practitioners to be involved with VAD, and for the VAD processes overall. The Act provides for, and regulates, access to VAD, defined as 'the administration of a voluntary assisted dying substance, and includes steps reasonably related to such administration'.¹⁶ Health practitioners can conscientiously object to being involved with VAD, and in Victoria, cannot raise the issue of voluntary assisted dying with patients (even indirectly).

The process for an individual to request and access VAD is separate from, and cannot be included in, advance care planning or palliative care. Once a person requests information about VAD, knowledge of best practice for end-of-life discussions is an important part of communicating about VAD. A patient receiving palliative care, if eligible, can concurrently request and have access to VAD through a separate pathway.

Further information on Victoria's VAD is available on the [Department of Health and Human Services website](#).

The National Palliative Care Strategy (the Strategy) highlights a focus on 'living well with chronic illness' and maximising quality of life, and six guiding principles:¹²

- Palliative care is person-centred care
- Death is a part of life
- Carers are valued and receive the care they need
- Care is accessible
- Everyone has a role to play in palliative care
- Care is high quality and evidence based

Specialist palliative care services usually include doctors, nurses, physiotherapists, occupational therapists, social workers, clinical pharmacists, dietitians, speech therapists and pastoral care workers. Specialist palliative care services may be available to support general practitioners (GPs) and patients by providing help with:¹⁸

- complex problems, symptom control, admission to hospice or hospital
- advice on ethical dilemmas (eg nutrition, hydration)
- spiritual issues, concerns held by the patient or carers, sense of therapeutic partnership
- resources for bereavement management.

The Strategy recognises that GPs play an essential role in advance care planning and providing palliative care for patients with terminal illnesses living in the community and RACFs.¹²

GPs' role at the end of life

As patients approach the end of life, the GP's role is to apply the principles and approach to care of older people presented throughout this Silver Book. There is a sharper focus on:

- person-centred care to support wellbeing and quality of remaining life, and to respect the person's values, goals and treatment choices
- proactive clinical care planning to anticipate and provide care as the person's clinical condition deteriorates, and as goals of care shift from treating illness towards comfort and managing death.

All GPs who care for older people are engaging with issues their patients face towards the end of life. Even small shifts in emphasis towards anticipating and planning to minimise the effect of predictable problems can improve the care offered, and the quality of life experienced by patients and carers. For example, a high-quality handover to the GP who will care for the patient on admission to an RACF can enhance continuity of care and future care planning.

Rural GPs can often continue providing care for patients as they move between home, RACFs or rural hospitals. They may also be required to fill in for lack of patient access to community nursing, specialist palliative care services and equipment for home care.

Chronic disease prevention and management are already established as major routine parts of general practice. The rationale is compelling for GPs to extend management of progressive chronic diseases to meet patients' needs for community-based end-of-life care and a 'good' death.

The number of patients seeking GP care at the end of life is increasing because of multiple interacting factors, including:

- an ageing population
- technological advances that prevent premature death and extend life
- a growing number of general practice patients with progressive chronic life-limiting diseases, and associated disability and cognitive impairment
- patients seeking to avoid medical and hospital treatments that are of limited benefit and not wanted at the end of life
- a greater proportion of the population selecting palliative care at home or in RACFs
- the current gaps in services for end-of-life care in the community (ie inequality of access and service provision, lack of integration and communication between services)

The focus of care in the terminal phase is on enabling a 'good death' with dignity, relief from pain and other symptoms, and respecting the person's preference of place of death and who is present. Terminal care priorities are as follows:

- Provide support and communicate diagnosis of dying and likely course to the patient, family and service providers
- If the patient lives in an RACF, commence residential aged care end-of-life (terminal) pathway
- Monitor and address symptoms with nursing care and medications
- Cease non-essential medications, review anticipatory prescribing and ensure appropriate medications are available
- Discuss what to do after death
 - carers and family can have time alone with the person before contacting person to certify death, and the funeral director
 - arrangement of death certificate
 - bereavement support
 - document bereavement follow-up plan

After death

After the death of a patient, the GP can ensure practical tasks are performed:¹⁸

- Oversee completion of legal requirements
 - death is to be verified by an authorised person – medical practitioner, nurse or paramedic
 - if the body is to be cremated, inform funeral director of hazards to be removed (eg implanted pumps, cardiac devices, radioactive isotopes, implants)
 - some deaths must be reported to the coroner; if in doubt, contact the state or territory coroners' office to discuss
 - death certificate is to be completed by medical practitioner (requirements vary by state or territory)
- Make sure carers and family are aware they can have time alone with the person before contacting the practitioner to certify death
- Offer to contact a funeral director or minister of religion (may be done by family member or RACF staff)
- Offer bereavement support
- Inform community nursing team or palliative care team; they can organise support for the family
- Organise collection of equipment, removal of medications, including Schedule 8 drugs and sharps
- Inform relevant health providers and health services

Symptom control

Patients with life-limiting illness frequently develop symptoms because of progression, relapse or exacerbation of chronic diseases, treatments and/or intercurrent illness. Early identification, assessment and management are important to relieve symptoms and improve quality of life. Assess each symptom, its impact, cause and effect of previous treatments, and consider priorities for the patient.¹⁸

In a systematic review of general practice end-of-life symptom control, most GPs expressed confidence in identifying end-of-life care symptoms. However, they reported lack of confidence in providing end-of-life care at the beginning of their careers, and improvements with time in practice. They perceived emotional support as the most important aspect of end-of-life care that they provide. GPs felt most comfortable treating pain, and least confident with dyspnoea and depression. Observed pain management was sometimes not optimal. More formal training, particularly in the use of opioids, was considered important to improve management of both pain and dyspnoea.⁵³

Symptom assessment tools can be valuable to identify symptoms, score their severity and monitor the effectiveness of treatments. A useful tool for GPs is the [Symptom Assessment Scale \(SAS\)](#), which is available in 15 languages for

completion by patients, their carer or RACF staff. It lists and scores severity on a scale of 0–10 for seven common symptoms (with ability to add extra symptoms) in palliative care:

- Difficulty sleeping
- Appetite problems
- Nausea
- Bowel problems
- Breathing problems
- Fatigue
- Pain (refer to Part A. Pain)

Physical issues and symptoms to be considered in palliative care for people with dementia include monitoring for non-verbal pain behaviours, falls (refer to Part A. Falls), vision, oral health, swallowing difficulties, seizures and withdrawal effects of deprescribing medication.

Refer to clinical guidelines (eg eTG Palliative Care,¹⁸ CareSearch)⁵⁴ for detailed assessment and management of common physical symptoms and problems at the end of life, including pain, fatigue, gastrointestinal, respiratory, neurological and neuromuscular, psychological, dermatological, haematological, genitourinary, and emergencies.¹⁸

Many of the troubling symptoms of the terminal phase can be remembered under the mnemonic PANERO:⁵²

- **P**ain
- **A**gitation
- **N**ausea (and vomiting)
- **E**mergencies (eg acute severe):¹⁸
 - vomiting
 - dyspnoea
 - airway obstruction
 - superior vena cava obstruction
 - agitation and altered mental state
 - haemorrhage
 - seizures
 - spinal cord compression
- **R**espiratory symptoms (eg noisy breathing)
- **O**ther symptoms (related to the specifics of the terminal illness)

Principles of symptom management include the following:¹⁸

- Closely monitor patients' symptoms and individualise treatment as needed
- Minimise the burden of treatment and number of medications
- Communicate and document plan to patient, carer and treating health providers
- Frequently review symptom and management

Medication management in palliative care

Principles

Issues to consider for safe use of medicines in palliative care include:⁵⁵

- monitoring for effectiveness and adverse effects
- minimising burden on patients
- polypharmacy (refer to Part A. Polypharmacy)
- deprescribing (refer to Part A. Deprescribing)
- safety of opioid use and disposal
- complexities of opioid prescribing.

Key principles for medication management at the end of life are as follows:¹⁸

- Assess and closely monitor patients and individualise treatment as needed
- Continue current medicines if needed for symptom control
- Stop unnecessary, burdensome or harmful medicines
- Consider anticipatory prescribing
- Prescribe regular medicines for ongoing symptoms and as required for intermittent or breakthrough symptoms
- Keep the patient comfortable by ensuring adequate doses
- Administer medicines subcutaneously or sublingually
- Consider practical aspects of subcutaneous administration (eg injection volumes, medicine compatibility, skill of carers)
- Monitor effects and adjust dose
- Seek palliative care advice if a patient is distressed or does not settle despite adequate doses

Alleviating suffering and ensuring a patient can maintain their dignity and some sense of control as their life comes to an end is the essence of good palliative care.¹⁸ However, in the terminal phase, GPs may be concerned that they could prescribe or administer a medicine that will unintentionally lead to a patient's death.²⁵

In Australian law, the 'doctrine of double effect' recognises that giving medicines (usually by a health professional) to a patient to relieve pain is lawful, even if it could hasten death. The two critical elements of 'double effect' are intention and that the patient's death is imminent. If the primary intention is to relieve pain and symptoms, not cause death, the person who gave the medicine will not be criminally responsible for a death which follows, even if it is foreseen. For further information, refer to 'Palliative Medicine' on the [End of Life Law in Australia](#) website.

Deprescribing

Deprescribing is the withdrawal of medicines that are no longer beneficial. It is a key component of palliative care. For current medicines prescribed for long-term effects, assess risks, short-term benefits and potential withdrawal effects, including:

- medicines for cardiovascular disease (ie hypertension, angina, dyslipidaemia), diabetes, cancer, epilepsy, neurological diseases, psychiatric illness
- anticoagulants and antiplatelet medications, thyroid replacement, antivirals (human immunodeficiency virus [HIV], hepatitis), corticosteroids.

Changes should occur gradually unless the patient is close to death, has minimal oral intake and is unable to take their usual medicines.

Prescribing

Medications used in palliative care are available as no script ('over the counter'), private script, Pharmaceutical Benefits Scheme (PBS) script, PBS Authority script and PBS Authority (Palliative Care). Medicines listed in the PBS Palliative Care Schedule are 'authority required'; larger quantities can be prescribed, reducing burden in terms of costs and need for repeat prescriptions.

'Off-label' medications are often prescribed as private scripts for palliative care patients for a different indication or route than the one for which they are approved by the Therapeutic Goods Administration (TGA). Palliative care services can provide advice to GPs based on considerable clinical experience with common off-label uses of medications in palliative care, such as:

- antipsychotics or antihistamines for nausea
- antidepressants or anticonvulsants for neuropathic pain
- administration of intravenous (IV) preparations by the subcutaneous route.

Anticipatory prescribing is prescribing medicines in advance for anticipated symptoms or problems, or to avoid crisis or urgent hospital transfer. GPs can promote effective symptom management in the community by anticipatory prescribing for common end-of-life symptoms and involving carers in symptom management.

Table 2 is a consensus-based list of eight palliative care medicines suitable for managing terminal symptoms in the community. It has been endorsed by the Australian and New Zealand Society of Palliative Medicine (ANZSPM).

Table 2. Consensus-based list of eight palliative care medicines suitable for managing terminal symptoms in the community

Medication	Ampoule strength	Stock
Clonazepam drops (PBS-listed for seizures only)	2.5 mg/mL	1 bottle (10 mL)
Fentanyl citrate injection (not listed on PBS)	100 mcg / 2 mL	10 ampoules
Haloperidol injection	5 mg/mL	10 ampoules
Hydromorphone injection	2 mg/mL	5 ampoules
Hyoscine butylbromide injection	20 mg/mL	5 ampoules
Metoclopramide injection	10 mg/ 2 mL	10 ampoules
Midazolam injection (not listed on PBS)	5 mg/mL	10 ampoules
Morphine sulphate injection	10 mg/mL	5 ampoules

Details on prescribing these medicines with doses for patients' symptoms are available in the Resources section.

Bereavement support

Support for carers and family

Most bereaved people do not require counselling or specialist support. Simple reassurance, acknowledgment of their loss and access to information may be all that is required. Reactions commonly seen as part of normal grief include:⁵⁰

- physical – hollowness in stomach, tightness in the throat or chest, oversensitivity to noise, sense of depersonalisation, breathlessness, dry mouth, muscle weakness, lack of energy
- behavioural – crying, sighing, sleep disturbance, restlessness and overactivity, appetite disturbances, absentmindedness, social withdrawal, dreams of the deceased, avoiding reminders, searching and calling out, visiting places associated with the deceased, carrying reminders
- mental – disbelief, confusion, preoccupation
- emotional – anxiety, fear, sadness, anger, guilt, inadequacy, hurt, relief, loneliness.

Bereavement has a significant effect on the health of surviving family members. Grief can cause poorer health outcomes, depression, and alcohol and drug dependency in some people. Mortality of the surviving spouse doubles in the 12 months after the death. Issues to consider in bereaved people include:⁵⁰

- sleep problems and fatigue, worsening memory
- clinically significant depression – this may occur in 10–20% of bereaved people (refer to Part A. Mental health)
- changed social circumstances – this can affect the bereaved person’s physical activity levels, nutritional status, and self-management of chronic health problems
- social isolation and changes in other important relationships.

Strategies to actively follow up recently bereaved people in general practice may include:⁵⁰

- offering an appointment to talk about what happened with a GP; this may be appreciated, particularly if the GP cared for both deceased and bereaved
- flagging bereaved patients for the practice nurse to contact by condolence letter or a phone call with an offer of a check-up
- offering to review the bereaved person’s overall health status and medical conditions when they attend the clinic
- identifying bereaved persons who need specialist support.

Support for healthcare professionals

GP self-care and support of colleagues is important to prevent stress and burnout from accumulated losses and grief associated with providing palliative care, especially in a solo practice or rural setting. Measures for self-care include:¹⁸

- education, training, and skills development for palliative care, including communication skills
- self-awareness and realistic expectations
- workload and work–life balance
- expressing grief and sharing experiences of loss (eg of long-term or close patients)
- peer and professional support with colleagues, mentors, professional supervision
- debriefing with colleagues, multidisciplinary case conferences.

Resources

Professional development

GPs are encouraged to develop palliative care skills and experience early in their career. This can be built on and enhanced by:

- using tools and resources (listed below) to supplement palliative care practice
- shared care with local team-based support services, including community home-based and RACF services; informal care networks, service groups and Compassionate Community organisations; specialist palliative care services and hospice care
- peer support and training, including
 - GP palliative care interest groups (eg primary health networks [PHNs], The Royal Australian College of General Practitioners [RACGP])
 - membership of the [ANZSPM](#), which provides professional development to support and educate Australian and New Zealand medical practitioners with an interest in palliative medicine
 - the [Program of Experience in the Palliative Approach \(PEPA\)](#), which is a clinical attachment and e-learning program
 - web-based and group training programs in advance care planning, communications skills, advanced chronic disease, palliative care

- [Advance Project](#), which is a toolkit and training package to help GPs and practice nurses initiate advance care planning, assess likely end-of-life care needs, and provide team-based palliative care in everyday clinical practice
- [CareSearch](#)
- [end-of-life law for clinicians](#).

Clinical applications

- [SPICT app](#)
- [palliAGEDgp](#) – this is available as an app or online for GPs to support care of older palliative patients living at home or in RACFs. An offline capacity makes it practical for use in remote and rural settings. It provides free, accessible, evidence-based information to help clinical decision making for each phase of palliative care:
 - [Advance care planning](#)
 - [Case conferencing](#)
 - [Terminal care management](#)
 - [Prescribing guidance](#)
- [palliMEDs](#) – this app is useful for anticipatory prescribing at end of life. It was developed by NPS MedicineWise for [caring@home](#) as a guide to prescribing eight palliative care medicines, was endorsed by the ANZSPM for management of terminal symptoms, and covers off-label prescribing and medico-legal issues
- [Opioid Calculator](#) – this tool simplifies the calculation of equianalgesia expressed as total oral morphine equivalent daily dose (oMEDD), and was developed by the Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists.

Clinical tools

- [SPICT](#)
- NAT-C or NAT-CC [Caregiver needs assessment](#) – these are needs-assessment tools for carers of people dying with cancer and non-cancer. They are available as self-completed checklists for carers, which allows them to identify their own major concerns. These are available online and can be discussed in a GP consultation
- [Palliative Care Outcomes Collaboration \(PCOC\)](#) – PCOC uses five clinical assessment tools to help identify and manage common symptoms, evaluate effectiveness of treatments, and help patients, carers and families to communicate their experiences and preferences. Specific useful tools for GPs are:
 - [SAS](#) (clinical assessment tools to help identify and manage common symptoms, available in 15 languages)
 - [Australia-modified Karnofsky Performance Status \(AKPS\)](#) (score of physical abilities across activity, work and self-care).

Guidelines and resources

- [Localised palliative care and advance care planning pathways](#) are divided by area in Australia and available from local PHNs. The pathways are designed and written for use during the consultation and provide clear concise guidance for patient assessment, management, and referral to local health services. Included are pathways that contain information specific to Aboriginal and Torres Strait Islander peoples and culturally and linguistically diverse communities.
- [Therapeutic Guidelines: Palliative care](#) provides practical detailed clinical guidelines, including palliative care and symptom management, decision making and ethical challenges, communication, support for carers and families, medications and prescribing, terminal care, and bereavement support.
- [CareSearch](#) – the GP section provides easy-to-navigate guidance at all points along the patient's pathway of care, including patient assessment, planning care, symptom assessment and management, clinical decisions, the dying patient, bereavement, use of the PBS and MBS, and professional practice (ongoing education and self-care). It also provides advice on prescribing and symptom-management advice, psychosocial complexity and

- Department of Health. MBS Online – Note AN.0.49. Available at www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=AN.0.49&qt=noteID&criteria=Case%20Conference [Accessed 14 August 2019].
- palliAGED. Terminal care – Synthesis. Adelaide: Flinders University, 2018. Available at www.palliaged.com.au/tabid/4466/Default.aspx [Accessed 14 August 2019].
- Australian Commission on Safety and Quality in Health Care. National Consensus Statement: Essential elements for safe and high-quality end-of-life care. Sydney: ACSQHC, 2015. Available at www.safetyandquality.gov.au/publications/national-consensus-statement-essential-elements-for-safe-high-quality-end-of-life-care [Accessed 14 August 2019].
- CareSearch. Bereavement. Adelaide: Flinders University, 2019. Available at www.caresearch.com.au/tabid/11/Default.aspx [Accessed 14 August 2019].
- Mitchell GK, Girgis A, Jiwa M, Sibbritt D, Burrige LH, Senior HE. Providing general practice needs-based care for carers of people with advanced cancer: A randomised controlled trial. *Br J Gen Pract* 2013;63(615):e683–90.
- Ellershaw J, Wilkinson S, editors. *Care of the dying – A pathway to excellence*. New York: Oxford University Press, 2003.
- Mitchell G, Senior H, Johnson C, et al. Systematic review of general practice end-of-life symptom control. *BMJ Support Palliat Care* 2018;pii:bmjpcare-2017-001374.
- CareSearch. Symptoms. Adelaide: Flinders University, 2019. Available at www.caresearch.com.au/tabid/11/Default.aspx [Accessed 14 August 2019].
- CareSearch. Prescribing. Adelaide: Flinders University, 2019. Available at www.caresearch.com.au/Wabid/4/Default.aspx [Accessed 14 August 2019].