

General practitioner, specialist providers case conferences in palliative care



Lessons learned from 56 case conferences

Geoffrey Mitchell, FRACGP, FChPM, is Associate Professor, Discipline of General Practice, School of Medicine, University of Queensland.

Margaret Cherry, BA, MPH, is Research Assistant, Centre for Military and Veteran's Health, University of Queensland.

Rosemary Kennedy, BA, PhD, is Research Assistant, Townsville Division of General Practice.

Karen Weeden, MSc, BSc, is Research Assistant, Discipline of General Practice, School of Medicine, University of Queensland.

Letty Burridge BN, MPH, is PhD candidate, School of Population Health, University of Queensland.

Alexandra Clavarino, BA, PhD, is Senior Research Fellow, School of Population Health, University of Queensland.

Peter O'Rourke, BSc, PhD, is Associate Professor, School of Population Health, University of Queensland.

Chris Del Mar, MD, FRACGP, is Dean, Faculty of Health Science and Medicine, Bond University, Queensland.

OBJECTIVE

To describe the utility and acceptability to general practitioners and palliative care staff of case conferences in palliative care.

METHOD

Research focussed on case conferences conducted between GPs and staff of three specialist palliative care units (in an inner urban, outer metropolitan and regional setting), at the time of referral of patients to the service. Telephone interviews were conducted with all GPs who participated in a case conference, and focus groups were conducted with palliative care staff.

RESULTS

For most GPs, case conferences by teleconference were a time effective and immediate means of information transfer. The best instances for a conference were at time of patient referral, time of discharge to the community, or where the case was complex. General practitioners appreciated access to multiple professionals simultaneously. Workload pressures were a

drawback of participation for both GPs and specialists. Palliative care team members thought case conferences gave GPs an appreciation of a team approach, and reduced professional isolation. The usefulness of the case conferences depended on the willingness of the GP to participate. General practitioners would participate again provided they did not have to organise the case conference. Specialist staff were concerned by the financial cost of organising case conferences.

DISCUSSION

Case conferences provide useful information exchange between GPs and specialist staff, and are acceptable to both parties. Much depends on the individual GP's attitude toward participation, as well as the timing of the conferences in the course of the patient's illness. Organisation needs to be a task of the specialist units, who would need administrative support to organise them, as most GPs do not have the capacity to do this.

The management of patients with chronic and complex conditions relies heavily on cooperation between disciplines. Specialist services frequently use multidisciplinary team meetings to determine management. When patient care is shared between secondary or tertiary carers and community carers, there can be significant problems in

team coordination, in particular in ensuring the general practitioner is part of the management team.

Formal teamwork between specialists and GPs has the potential to improve patient outcomes. A systematic review found that when formal specialist-GP management programs are in place, there are

improvements in patient adherence to follow up, and in physicians' clinical behaviour; and there are marginal improvements in patient health outcomes which could be long term.¹

Few areas of medicine require more coordination between specialist services and primary care than palliative care.² But there are institutional barriers to

coordinated care which must be overcome. The commonwealth government introduced the Enhanced Primary Care program in 1999 which includes item numbers to reimburse GPs and specialist physicians for time spent organising and participating in multidisciplinary case conferences and care planning.³ The administration procedures required to claim Medicare reimbursement for this participation is complex, and uptake has been slow: in 2003 there were 20 716 claims for case conferences, compared with 228 250 care plan claims.⁴

There is little understanding of the process of case conferences and whether they deliver enough benefits to warrant the cost of participation.⁵⁻⁹ Perhaps the reason for poor uptake is due to perceived barriers to participation outweighing perceived promoters of their use.⁹

Methods

The study was approved by the Ethics Committee of the University of Queensland and the three participating health districts. The trial included patients referred to three palliative care specialist services in Queensland (inner urban, outer metropolitan, and regional) from 1 July 2001 to 1 May 2003. Participants met the following inclusion criteria: their estimated life expectancy was more than 30 days, they understood English, they were not confused or demented, their GP and primary carer (if present) consented, and they provided informed consent. They were randomised to either have their GP participate in a case teleconference at the their admission or to usual care. General practitioners whose patients were randomised to the intervention were invited to join routine palliative care team meetings by telephone.⁹

Of the 592 eligible patients, 159 (27%) patients were randomised into the trial. Of these, 80 were randomised to case conferences. Fifty-six case conferences were conducted with 52 GPs. Reasons for nonconduct included early patient death, withdrawal from study, patient or

GP moving away, and GP inability or refusal to participate.

General practitioners who participated in case conferences were interviewed by telephone using a semistructured interview guide.¹⁰ They were asked about their recall of the case conference, the amount and nature of information gained by them or imparted to the specialist team, and for their comments on the case conference process – particularly with regard to perceived barriers to and promoters of the process. Of the 52 GPs who participated in case conferences, 41 (79%) participated in a telephone interview about the experience.

Specialist palliative care providers were also interviewed in two focus groups (inner urban area and regional centre). The focus groups were conducted by independent facilitators, with the project staff acting as note takers. They were asked questions similar to those asked of the GPs. Sixteen palliative care staff participated in the focus groups: two medical specialists, 10 nurses, two social workers, one volunteer coordinator, and one pharmacist.

Interviewers' notes of the interviews with GPs were analysed thematically. After open coding, the data codes were sorted electronically, and distributed into final categories. This process was undertaken independently by two of the research group to check the reliability of ratings. Transcripts of the focus group discussions and the interviews were analysed manually for relevant themes by one of the research group, again identifying categories and subcategories which were mutually exclusive.

Results

Both palliative care team members and GPs reported potentially useful exchanges of information. General practitioners reported being better informed about their patient's progress as an inpatient. Case conferences made discharge planning easier and allowed for clear role delineation between the GP and the palliative care service. Although some GPs learnt something new (eg. available drugs and treatment modalities),

many did not (*Table 1*).

Palliative care staff thought case conferences helped GPs better understand both a team approach to care and a systematic approach to the management of palliative care, and helped to reduce professional isolation. They also felt that case conferences increased the flow of information.

Case conferences increased specialist team appreciation of the patient-GP relationship and insight into the potential quality of care offered to the patient. Particular insight was provided as to evidence of the GP's willingness to provide after hours care and house calls, and whether the GP had a high level of knowledge of palliative care treatments. This allowed the negotiated management plans to accommodate the capacity of the GP to contribute to the patient's care.

Both GPs and specialists thought routine case conferences were less useful than those held at critical points in the patient's illness: at admission to the service, before discharge home, or when there were complex issues to discuss. Most GPs were impressed by the time effectiveness and immediacy of information transfer of case conferences. Some GPs felt more a part of the care team, and appreciated the input of more than one practitioner and discipline. However, some found them less effective than routine communication, because they were not face-to-face they felt at a disadvantage as they may not have been familiar with all the team members. Specialist teams viewed case conferences as vehicles for building rapport with their general practice colleagues.

Participation in case conferences was limited by workload pressures. Some GPs found the process inefficient. The need for a clear agenda for the conference was identified; also for current patient information to be forwarded to the GP beforehand. General practitioners would participate in case conferences again, provided they did not have to organise them personally. Palliative care staff found that case conferences required extra administrative

Table 1. Themes identified

Theme	Comments
Transfer of information	
GP awareness of other team member's role	I was aware of inpatient care and outpatient expectations when discharged – <i>GP</i>
New treatment knowledge	The main thing I learned was the use of durogesic patches in preference to morphine – <i>GP</i>
Presented structured approach to palliative care patients	Maybe what they got out of it was an organisation of the issues which were being discussed, in a way they might not have known before – <i>team member</i>
Defining role of GP in team	Maybe part of that is to help the GP know that they are supported in their role, but also to define their role. A lot of the time we say we have to have a GP, but we don't actually manage to negotiate a 'contract' between the GP and the patient – <i>team member</i>
Information transfer in case conferences – little difference to normal communication methods	I'm not sure that there would be a lot of difference between those patients who had case conferencing and those who didn't, [due to] the formal pathways of communication that we have anyway, writing to them – <i>team member</i>
Team assessment of GP palliative care capacity	
Willingness to do house calls and be available after hours	It is hard on the family that death is not acknowledged until office hours – <i>team member</i>
Assessment of GP knowledge of palliative care	If it wasn't for the teleconferencing we probably would miss out on a lot of what their home care plan was like, and where the GPs are up to with their pain and symptom management – <i>team member</i>
Timing of case conferences	
Best at key points in illness	When the patient is deteriorating is the most useful time to case conference – sharing knowledge about changing circumstances and treatment – <i>GP</i>
	Isn't it just as valid to have that case conference at the beginning?... We all know what we're working toward – <i>team member</i>
Advantages of case conferences	
Time effective and efficient	I thought the teleconference was good, helpful. Otherwise we would never get to talk to the specialist. Often the letter we get is later, after other things have happened – <i>GP</i>
Building relationships with the specialist team	We tend to contact our GPs on referral, so there may be no issues then, but it's building rapport – <i>team member</i>
Disadvantages	
Workload pressures	Nerve wracking, people coming in the waiting room, never empty, feel I should be looking after patients greater than 15 minutes behind, a nausea, sickening feeling... If I had three patients per hour it [participating in case conferences] would be okay, rather than eight – <i>GP</i>
Case conferences by teleconference not ideal	It didn't appear to be as useful as I had first imagined and I don't know why. Whether it was the teleconferencing component, we always seemed to be... trying to speak to clinicians who were obviously very busy and were trying to fit us in and it obviously wasn't perhaps the most convenient time – <i>team member</i>
	I found that when we had the teleconferencing it was not as free flowing, and I think that we were always waiting with bated breath for the GP to participate – <i>team member</i>
	Doing [the case conference] by phone and being so far away, didn't know who else was there to ask questions of – only a brief introduction – <i>GP</i>

effort to organise. They thought the willingness of the GP to participate was important. Although palliative care staff allowed for case conferences in their schedule, others appeared to be participating in addition to normal duty.

Discussion

The low response rate of GPs to the telephone interviews is consistent with other trials.^{11,12} The triangulation from collecting information from different sources increases the confidence that these data reflect the issues well. However, the views of participating GPs may be influenced positively as a result of participation in a trial.

It may be difficult to extend these findings as a generalisation to other specialist settings. However, the issues identified in this study that make participation difficult for general practice will be the same for other specialties that attempt systematic use of case conferences.

Case conferences appear to improve information transfer, which surely improves patient care. The appreciation by specialists of the ability of some GPs to deliver high quality palliative care may reap benefits in the longer term. It may also allow for targeted education for those GPs whose knowledge is suboptimal, relevant to the patient on hand. Education of this type improves clinical performance.¹³

Responsibility for successful case conferences appears to be shared by both GPs and specialist teams. Most GPs lack the infrastructure and organisational capacity to organise case conferences. Until they do, case conferences will have to be organised by specialist teams. To make this investment, they will need to be convinced that GPs have an important and definable role to play in the ongoing care of the patient. The availability of Medicare rebates for specialists participating in case conferences may allow some of the administrative costs to specialist teams to be offset.

Conflict of interest: none declared.

Acknowledgments

We would like to acknowledge the cooperation of the staff of the Mater Hospital Palliative Care Service, Logan and District Palliative Care Service, Townsville and District Palliative Care Service, and the Townsville Division of General Practice.

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The medical editor responsible for this article was Dr Steve Trumble.

AFP

Correspondence

Email: afp@racgp.org.au