

Nursing home patients

This month's theme is particularly relevant to general practitioners (GPs) who visit residential aged care facilities, but many of the principles are applicable to aged patients who continue to reside in their own homes with various levels of support. How to best care for the elderly in a modern society is a question that resonates not only with Australian GPs in varied spheres of practice, but also with our overseas colleagues. This month we invited Margaret McCartney, a practising Scottish GP and published author, to share her perspectives on end-of-life care. Here she argues for a central role for general practice in improving the process of dying for our patients.

Margaret McCartney

How to define the work of general practice? Here in the UK we are paid in fits and starts for piecemeal work (flu vaccination, cervical smear and blood pressure targets, smoking advice). I hate ticking boxes when I should be doing our core work of listening and conversing, reaching understandings, and trying to balance between benefit and harm.

This is general practice: the person who asks for a new inhaler but is really concerned about how their chronic disease is affecting their quality of life; the daughter whose father not only has a cough but an erratic memory and he is, she fears, increasingly unsafe at home; the woman with terminal cancer who has not yet been given the space to articulate how distressed she is at her multiple recent hospital admissions and wants to know, 'please, can't I just stay at home from now on?'

However obvious it is that death is inevitable, we frequently sacrifice quality for quantity of life on the altar of medicalisation. Most patients receiving palliative chemotherapy do not know it will not cure them.¹ Most of the general population rate cardiopulmonary resuscitation (CPR) as likely to be successful against the far starker odds of reality.² We know that CPR in people who are expected to die from metastatic cancer is overwhelmingly unlikely to be successful.³ And 87% of the time, doctors recognise when people are in the last hours of life in hospital but there is a documented discussion about

it less than half of the time.⁴ This matters because most people want to die at home or in a hospice.⁵ We cannot fulfill wishes if we do not acknowledge the possibility that death is near. We GPs are quite good at predicting who will die but not very accurate at predicting when death will occur.⁶

This uncertainty means we will sometimes get it wrong. More certain, though, is the facility for medicine to do harm at the end of life. Palliative care, as opposed to typical oncological care for metastatic non-small-cell lung cancer, prolongs quality and quantity of life.⁷ Patients with cancer who had discussions with their doctor about their future care had less chemotherapy, less ventilation, less resuscitation and a higher quality of life in their last days. Additionally, after the patients' deaths, families felt more prepared and had less regret, compared with those who did not have such conversations with their doctor.⁸

How to manage uncertainty when we work in an environment often intolerant of it? It will only be possible to better plan for death by accepting that the diagnosis of dying might be wrong sometimes. We need to make room to talk about death – in the consulting room and out of it. Families, communities and care homes should be able to make plans and practical steps such as appointing legal proxies. For GPs, listening for the time to raise conversations about the future is hard, emotional work, especially when time-pressed and overwhelmed with other demands. Care of people in the last days and weeks of their lives is the fulfilling, vocational stuff that makes the heartland of

our work sing. Only when the highly skilled, professional relationships inherent to general practice are allowed to take centre stage and be cherished for their proper value will we be able to make the process of dying better. Talking about death is not about the application of protocols. It is about taking the time to listen and hear.

Author

Margaret McCartney MbChB MRCP is a general practitioner in Glasgow, Scotland. She writes a weekly column for the British Medical Journal, contributes regularly to Radio 4's Inside Health, and is the author of two books, *The Patient Paradox*, and *Living with Dying*.

References

1. Weeks JC, Catalano PJ, Cronin A, et al. Patients' expectations about chemotherapy for advanced cancer. *N Engl J Med* 2012; 367:1616–25.
2. Marco CA, Larkin GL. Cardiopulmonary resuscitation: knowledge and opinions among the US general public. *Resuscitation* 2008;79:490–98.
3. Ewer SW, Kish SK, Martin CG, Price MD, Feeley TV. Characteristics of cardiac arrest in cancer patients as a predictor of success after cardiopulmonary resuscitation. *Cancer* 2001;92:1905–12.
4. Royal College of Physicians. National Care of the Dying Audit of Hospitals. London: RCP, 2014. Available at www.rcplondon.ac.uk/sites/default/files/ncdah_national_report.pdf [Accessed 26 February 2015].
5. Gomes B, Calanzani N, Gysels M, Hall S, Higginson IJ. Heterogeneity and changes to preferences for dying at home: a systematic review. *BMC Palliat Care* 2013;12:7.
6. Barnes S, Gott M, Payne S, et al. Predicting mortality among a general practice-based sample of older people with heart failure. *Chronic Illn* 2008;4:5–12.
7. Temel JS, Greer JA, Muzikansky A, et al. Early palliative care for patients with metastatic non-small-cell lung cancer. *N Eng J Med* 2010;363:733–42.
8. Wright AA, Zhang B, Ray A, et al. Associations between end-of-life discussions, patient mental health, medical care near death, and caregiver bereavement adjustment. *JAMA* 2008;300:1665–73.