

Palliative care

Brendon Evans

IN MY FIRST TERM OF TRAINING, I approached my supervisor with a problem. June, a delightful woman aged in her 80s who had been given a diagnosis of lung cancer, had progressively become weaker and now struggled to make it into the practice for her appointments. I asked my excellent supervisor how I could coordinate the palliative care service to take over her care entirely. His response surprised me: ‘why don’t you visit her at home yourself?’

What followed was an experience that I will never forget. Over the next several months, I had the privilege of visiting her daughter’s meticulously neat home where June lived. Together, we reviewed and removed medications, added others, and coordinated with community services. When her needs exceeded the care her family could provide, she was admitted to her local hospital where she soon passed away under the care of a different rural general practitioner (GP). What had begun for me as routine consultations had become a sobering education in the context and sanctity of the human experience of life and death, and I am profoundly grateful to June for allowing me to be a part of it.

Every day in Australia, GPs contribute significantly to the palliative care of patients. They can be found relieving suffering in clinics, homes, hospices and hospitals. Their positions might be rural or urban, leading or supportive, but their knowledge, skills and – perhaps most importantly – their compassion have an understated impact on individuals at the close of their lives. What could be more

appropriate than the clinician who has been with them – ageing alongside them – through sickness and injury, child-rearing and middle age, continuing to be with them when the curtain begins to fall?

However, circumstances within our medical system make providing care, including home visits, progressively difficult. Increased cost of practice, coupled with a static rebate, has resulted in rates of these visits dropping to less than one-third of what they were 15 years ago.¹ It is our frail and palliative who suffer the most from this problem, and although ongoing funding for telehealth consultations is welcome, they cannot replace the benefit of home visits. Changes need to occur to assist our most vulnerable.

I have found our subspecialist palliative care colleagues to be consistently very supportive of general practice palliative work. In this spirit, *AJGP* has commissioned a group of palliative care specialists to address commonly encountered topics in palliative care. Most of these authors hold a FRACGP and have worked significantly within general practice prior to subspecialty training. Within this *AJGP* issue, the reader can find tips to better help our palliative patients experiencing breathlessness,² depression³ or refractory constipation.⁴ Advice for how to manage diabetes in advanced cancer⁵ is addressed along with a nuanced discussion about some common pitfalls of medications used in the palliative context.⁶ We trust that both highly experienced GPs and those beginning their journeys into palliative care will find the content relevant and practical.

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