

Letters

The importance of having general practitioners in youth services

Co-located services are important for adolescents with mental health disorders. Indeed, risks cluster for young people, and there is often risk on many fronts: disengagement from school and community, family conflict, socioeconomic disadvantage, substance abuse, sexual risk-taking, unequal relationships, and physical and mental health issues. Each risk can affect future wellbeing, and young people facing multiple challenges are unlikely to go from service to service. Hetrick et al¹ and McGorry² have written that ‘one stop shops’ are the preferred model, and primary care is at the core of the model. General practitioners (GPs) who can engage with young people; provide physical, sexual, and mental healthcare; and who can coordinate management – and even devote time to prevention – should be seen as an essential part of youth services. They need to be available on site, especially at services such as headspace.

Yet many headspaces still do not have GPs. Attraction and retention remains an issue, just as it was 10 years ago, when headspace commenced. The reasons for this are manifold: inconsistent funding and supports, reliance on bulk billing with frozen rebates that are not particularly favourable to very long consultations, high rates of non-attendance and the stressful nature of the work. The latter is partly due to increasing numbers of young people with complex needs presenting to a service set up for early intervention. Youth health is immensely rewarding work, but the aforementioned issues detract from it being a chosen career pathway. It really

is time to walk the walk and ensure that the identified best practice model can be implemented and is sustainable.

headspace GP funding models vary across the country; however, there is little doubt that GP attraction and retention would improve if there was dedicated funding available at every centre to support (for example) non-attendance, long appointments, participation in team meetings and supervision. Ensuring GPs are funded and supported will increase the likelihood that young doctors choose youth health as a career and that they stay in the sector. Such a step would go some way towards improving the overall wellbeing of this very vulnerable group of young people.

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Patient focus in end-of-life care: Palliative care does not have all the answers

We write to comment on the article ‘Multidisciplinary management of motor neurone disease’ (*AJGP* September 2018).¹

The article suggests that palliative care physicians can ‘allay fears’ held by patients with motor neurone disease (MND). If only that were true.

Palliative care physicians and neurologists can explain the condition, outline their approach to management and try to prolong and improve patients’

lives, using a multidisciplinary approach.^{2,3} They offer understanding, comfort and support. Just like general practitioners (GPs). The research into the success of these interventions in relation to mental health outcomes is of poor quality and inconclusive.⁴

However, patients’ distressing symptoms and unbearable existential suffering cannot always be adequately relieved. Physicians who have managed patients with MND will attest to the extreme suffering that some experience. Many of our colleagues have witnessed end-of-life phases where symptoms are not adequately alleviated, even with optimal medical and nursing input.

Despite careful airway toilet, drying medications and procedures as well as the use of narcotics and benzodiazepines, dyspnoea is very difficult to treat.

In fact, the Palliative Care Outcomes Collaboration report published by the Australian Department of Health in 2016 noted that 5.2% of all palliative care patients did not have adequate resolution of all symptoms during their treatment.⁵ That is one patient in every twenty!

It is incorrect for the authors to assert or imply that their specialty can control distressing symptoms, when their own research does not bear this out. In fact, if this were true, palliative care would be the first medical specialty to address all its patients’ needs.

Also, the article does not include GPs (its target audience) in the ‘multidisciplinary team’. This is disappointing, because the GP offers continuity of care to patients and their families. We are often the doctor most available to help in the community, especially in rural areas. GPs see the

reality of end-of-life care. They know that end-of-life care needs more than subcutaneous morphine. Many patients require additional midazolam or ketamine, or both, to relieve dyspnoea and choking.

Faced with this frightening prospect, some patients actually elect to take their own lives before the final phase of the disease. It is hard to imagine a sadder end for patients and their families, but this tragic reality was outlined by the Victorian Coroner in his powerful submission to the Parliamentary inquiry into end-of-life care in 2016–17.⁶

There is no evidence to support the claim that palliative care will stop desperate patients from taking this step. If we truly support patient autonomy, we must learn to truly respect the patient's right to choose. We must also accept the limitations of our profession. It has, in fact, been found that managing withdrawal of treatment requests for palliative care physicians is very difficult.⁷ Patient-focused treatment needs to be a greater priority for our profession.

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Reply

We thank the correspondents who wrote in response to our article 'Multidisciplinary management of motor neurone disease'.¹ We wish to make several points in response. The authors are correct that motor neurone disease (MND) is extremely challenging. The central question of management is how these challenges can best be met. The disease is incurable, so we are already in a domain of relief, rather than elimination, of debility and symptoms. Palliative care is the discipline of medicine that is forensically focused on the care of patients with incurable illnesses. So, while the authors are correct to state that palliative care cannot guarantee the management of symptoms, the discipline is certainly dedicated to their amelioration. We cannot guarantee perfection. But we can strive with perfectionism to do our best.

The authors are correct to highlight the role of the general practitioner (GP). Our article noted, at several points, the crucial role of the GP. The enumerated list of health professionals was purely in relation to the members of the polyclinic itself. We certainly did not mean to diminish the role of the GP in the overall care of the patients. Indeed, from our perspective, as clinicians working in such a polyclinic, we constantly correspond with and value the role of the GP for all the reasons the author of the letter notes.

For the authors to characterise the experience of MND as unadorned suffering is incorrect. Yes, suffering occurs, but it is joined with expressions of love and gratitude, enlightenment, reflection on the past, reconciliation and kindness. We see this regularly.

The authors point to the level of comfort of palliative care physicians in withdrawal from non-invasive ventilatory support. We cannot speak for the broad community of these physicians, but those working closely with MND patients do have both the comfort and expertise to organise and guide patients and families through this process. Indeed, other clinicians look to these physicians in this regard.

The authors state that patient-focused management needs to be the greatest priority. We completely agree. In our experience, this is precisely the perspective of clinicians working in this area.

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