

## section 4.4: communicating with General Practitioners

### palliative care and General Practitioners

General Practitioners are the primary providers and coordinators of community based medical care and in a full-time capacity will undertake approximately 5,000 consultations per year.<sup>1</sup> Only a small number of these consultations will be for palliative patients (on average 5-7 patients annually, although wide variations occur<sup>2</sup>). The majority of patients prefer to have their care provided at home, whether this be in their private residence or a residential or other supported care facility. An involved and informed GP is essential to support the patient, their family and caregivers in making this preferred option for care a reality.

In their working career GPs are likely to see larger numbers and a wider diversity of presenting medical complaints and clinical situations than any other health care provider. Accordingly GPs have developed flexible and practical management strategies. Palliative patients may present with complex issues including unrelieved physical, psychosocial or existential symptoms which may be very challenging and time consuming in a hectic work schedule of competing patient needs.

In general GPs work autonomously and do not commonly take part in team-based or collaborative models – an awareness of this in palliative care settings is critical. Recognising that the GP can be the palliative patient's strongest ally in managing community care and providing a smooth transition between acute hospitals and the community is crucial. Equally important is the support the GP may require and the benefit of a shared management approach which may utilise input from several specialist teams, including the specialist palliative care team.

#### What you need to know from the GP

A simple phone call to the GP may be the most useful part of the discharge planning process and can provide information about the context of the patient's disease, the history of illness and relevant family dynamics.<sup>3</sup>

This conversation may be as straightforward as:

- is now a good time to tell you about Mrs X?
- do you know Mrs X well, and are you aware of her situation?
- we are planning to discharge Mrs X home on Wednesday, are you able to provide home visits?
- have you worked with the palliative care team before and do you know how to reach them in an emergency?

#### What do General Practitioners (GPs) need?

Typically GPs need the following:

- information about the patient
  - current status, likely future problems or complications
  - recent treatments or significant changes to the treatment plan
  - medication changes
  - likely symptom issues, particularly if complex symptoms are present
- a clear outline of what the patient and family have been told about disease status and management plans

- a clear understanding of the involvement of other community providers (eg RDNS or other community nursing and allied health input)
- the patient to be provided with adequate medication supplies from the hospital to last until a visit to the GP can be arranged (or a home visit if they are too unwell to travel to the surgery)
- a clear understanding of how non-PBS listed medications will be supplied, if they are ordered eg subcutaneous fentanyl
- access to inpatient care or specialist community support to manage acute changes to the patient's condition

Only those discharges that have been planned well in advance and where there is prearranged GP cover should occur on a Friday afternoon or prior to a long weekend.

## **Planning for community care**

### **Using case conferences**

GPs are now able to use designated Medicare items (Enhanced Primary Care) for interactive, multidisciplinary care planning for patients with a chronic or terminal illness. This provides a valuable opportunity for case-conferences and in streamlining communication and care planning involving both acute care teams and the GP. Checking with the GP about the usefulness of a case conference may be helpful.

### **Access to home visits**

As the condition of a palliative patient deteriorates it may not be possible for them to manage a visit to the GP's surgery. Encouraging the caregivers/family to explore the option of home visits with the GP in advance may allow the GP the opportunity to plan for these visits, rather than having to respond to a crisis situation.

Should the GP not be able to offer home visits, then exploring alternative options with him/her at that time will be valuable. Would he or she consider another GP becoming involved?

### **After-hours support**

Access to after hours medical cover or a locum service also requires exploration. Support in the form of telephone advice for the GP is available both during and after hours from the local specialist palliative care service. A review by the specialist team, if required, can be negotiated at that time.

## **related resources and information**

### **AMA Safe Handover Guide Will Help Keep Patients In Safe Hands**

A new publication called *Safe Handover: Safe Patients* is available to assist hospitals, doctors, and other health professionals improve patient safety, particularly at times when there is a transfer of responsibility for patient care.

[www.aushealthcare.com.au/news/news\\_details.asp?nid=8347](http://www.aushealthcare.com.au/news/news_details.asp?nid=8347).

### **GP Online Training in Opioid Medication in Palliative Care**

See <http://www.pallcare.org.au/>

## references

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- <sup>1</sup> Sturmberg J (2002) General practice-specific care categories: a method to examine the impact of morbidity on general practice workload. *Family Practice*, 19: 85- 92.
- <sup>2</sup> Wakefield MA, Beilby J, Ashby M (1993) How well do general practitioners deliver palliative care? A systematic review. *Palliative Medicine*. 7:117-126.
- <sup>3</sup> Mitchell G, Reymond E, McGrath B (2004) Palliative Care: promoting general practice participation. *MJA* 180(5) 207-208.