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PALLIATIVE CARE: A TASK FOR EVERYONE

Rodger Charlton is absolutely correct in saying end-of-life care is a generalist domain and always has been.¹ The challenge is to accept that it always will be. Specialist palliative care is now 20 years old, a recognised speciality to which we can take our complex patients with difficult problems. The bulk of palliative care, however, is rooted in general practice, and we need to take ownership of what is a complicated, emotional, and ultimately very rewarding part of our job.

The first question to ask is: who are the generalists in end-of-life care? Much of the care given at the end-of-life is by district nurses (DNs), as part of their core competencies. They are the foundation of end-of-life care at home. A close working relationship between GPs and DNAs is essential, and is threatened by the 'corporatisation' of DNAs into area teams, instead of practice teams working together from the same building.

In hospital, generalist nurses and junior doctors are key providers of end-of-life care. With 58% of all deaths and 50% of cancer deaths occurring in hospitals,² these generalists are major providers of end-of-life care. It has been estimated that the average foundation-year 1 doctor during his/her first year of practice will care for 40 patients who die while in hospital, and 120 in the last 6 months of life.³ They have to balance the concepts of 'cure' and 'care', seeking to sustain life without engaging in futile interventions.

The change in working patterns has greatly affected the working lives of hospital doctors. All doctors now coming out of vocational training schemes will have been subjected to the hospital shift system, and most will be glad to leave it behind in search of the truly rewarding part of general practice: continuity of care. That continuity is no longer about 24/7 personal availability, but about good in-hours care liaising closely with good out-of-hours (OOH) care.⁴

High quality OOH care costs PCTs upfront and then saves money in reduced admissions. There are some excellent examples of OOH providers who have worked hard to liaise with cancer networks, build up protocols, train their OOH GPs, and make end-of-life issues part of the core competencies of all their staff. This costs money. Many services are now under

considerable pressure to reduce costs and compromise quality, or lose the contract.

In a recent study of OOH contacts with palliative patients across four providers, only 2% of patient contacts resulted in admission to a hospice, and 9% were admitted to hospital. (S Forrest, unpublished report, 2007). There is a growing impetus to prevent hospital admission using tools such as the Gold Standards Framework⁵ to increase the chances of patients dying in their preferred place of care.⁶

Sixteen per cent of deaths occur in care homes² where considerable improvement in end-of-life care provision is needed. The Care Homes Inspectorate examines only basic care provision, which does not include palliative care. There is wide inequality of provision of hospice care, specialist nurses, provision of 24/7 specialist advice, and hospice at home care.⁷ Specialist services are expensive, and the NHS has relied on charitable funding of these for too long, resulting in patchy provision nationally.

The skills required to give good end-of-life care are the ones we use at all phases of life: information gathering through good communication, examination and diagnosis, shared management plans, good handover, and review, which are supported by specialist advice, ongoing learning, and good OOH care. The relationship between GPs and patients remains central. If GPs are fortunate enough to have all these in place in their practice area, they may not need to give patients their home or mobile number but, for many of us, our altruism means we will continue to do so.

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REFERENCES

1. Charlton R. The demise of palliative care. *Br J Gen Pract* 2007; **57**(536): 247.
2. Office for National Statistics. *Mortality Statistics: review of the Registrar General on deaths in England and Wales, 2004*. London: The Stationery Office, 2006.
3. Faull C, Woolf R. *Palliative Care: an Oxford core text*. Oxford: Oxford University Press, 2002.
4. Worth A, Boyd K, Kendall M, et al. Out-of-hours palliative care: a qualitative study of cancer patients, carers and professionals. *Br J Gen Pract* 2006; **56**(522): 6–13.
5. Thomas K. The Gold Standards Framework in community palliative care. *Eur J Palliat Care* 2006; **10**(3): 113–115.
6. Pemberton C, Storey L, Howard A. The preferred place of care document: an opportunity for communication. *Int J Palliat Nurs* 2003; **9**(10): 439–441.
7. Munday D, Dale J, Barnett M. Out-of-hours palliative care in the UK: perspectives from general practice and specialist services. *J R Soc Med* 2002; **95**(1): 28–30.