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Viewpoint

THE DEMISE OF PALLIATIVE CARE

Palliative or end-of-life care is very much the domain of the generalist and not the specialist. This is not a bold statement, but rather reality as less than 10% of people die in hospices. It is the generalist, therefore, who oversees the care of the dying mainly in hospitals and, to lesser extent, in the community.

There are three main reasons for a demise. First, hospices receive limited NHS funding as end-of-life care is not a priority thus relying heavily on charitable giving. Secondly, the sad fact is that when GPs relinquished responsibility for out-of-hours care in 2004 through the new GP contract, they also finally severed the continuity of care by the 'personal' doctor necessary to adequately care for someone who is dying. It may be anecdotal, but crises in the dying seem to occur out-of-hours and frequently lead to hospital admissions where the acute environment of their care is not appropriate. Thirdly, an evidence-based statement; only 6 out of 1000 quality indicator points of the second Quality and Outcomes Framework of the current new GP contract are devoted to palliative care which does not reflect the average GP's workload.

As we train a generation of office-bound '9 to 5 salaried doctors' one of the many areas they often do not experience is the follow-up and anticipatory care that a dying patient requires. This trend is set in the new and short rotations and shift systems of foundation year doctors. These limit continuity, where the remit of palliative care is seen as that of the specialist nurse after completion of the 'necessary' multi-page referral form. And yet for years GPs have looked after patients with progressive life-threatening illnesses as a usual part of their practice. It was only recently that palliative medicine specialists recognised that cancer patients were just the tip of the iceburg for GPs and suddenly palliative care was seen as applicable to non-cancer patients too. But, it is often forgotten that it is the GP who is the expert and coordinator of such care.

House visits are declining and an anathema to our 'apprentices'. However, they are pivotal for dying patients. Many GPs with considerable innovation set up cooperatives for out-of-hours care, but sadly these are being franchised out to more 'cost-effective' commercial alternatives as deemed by the ever changing, reconfiguring and cash-strapped primary care organisations (PCOs). A home visit to a palliative care patient out-of-hours may in some circumstances now consist of a paramedic on a motorcycle followed quickly by an ambulance and assessment in the setting of an acute hospital casualty unit geared to resuscitation and cure. Requests for the details of one's 'palliative care' patients by these new out-of-hours providers are dwindling, so how will their needs be met in these crisis situations? Some hospices have reacted and set up rotas to provide out-of-hours advice but interestingly, often with a dedicated GP workforce.

The real providers of end-of-life care have always been district nurses and not the specialist palliative care nurses who make brief infrequent assessment visits to advise, but rarely provide 'hands on' care. District nurses bridge the gulf between the GP practice and the home, or at least they did until their workforce numbers were threatened by some PCOs. In many areas 'modernising' and the restructuring of services has meant that the district nurse who provided continuity to one GP practice may be regularly seconded to other GP practices. Furthermore, resignation and retirement do not necessarily result in replacement as funding is scarce and so input for end-of-life care will inevitably suffer.

Altruism is the unselfish devotion to the welfare of others and is greedy of the demands it makes on the individual. It emphasises the point that medicine is a vocation and not just a job. This is at odds with the shift systems in medical training, which adversely effect continuity of care. And yet, one of the great skills we have as GPs is being able to listen, provide symptom relief and follow up where a patient has an illness that cannot be cured. The plight of dying patients has reached a watershed in the UK despite all the valiant efforts of the late Dame Cicely Saunders, founder of St Christopher's Hospice in 1967. We need to reflect on our role as GPs where the ultimate challenge remains the care of someone who is terminally ill. Without a vast increase in the number of hospices and associated specialists, palliative care remains in the hands of GPs. How many of you would give your mobile or home number to the family of a dying patient?

Rodger Charlton