

Tips for GP trainees working in palliative care

INTRODUCTION

Trainees are faced with dying and death throughout their training. In hospital jobs the emphasis is not always on good palliative care. GPs spend a significant amount of their time with patients and their families as they embark on the journey from symptoms to diagnosis, via more symptoms, ultimately to death. Many people, doctors included, find the prospect of hospices a dark and depressing thought. Withhold judgement! Working in palliative medicine can be an overwhelmingly positive experience that will leave you feeling more confident managing patients in the community while knowing when to ask for support from the specialist palliative care team.

It is hoped that this advice will prove useful when thinking about palliative medicine whether you are fortunate enough to have a rotation in it or not.

SYMPTOM CONTROL

1. Examine your patient. Physical contact is reassuring even if just to check a pulse.
2. Nausea and vomiting are common and often managed poorly. Think carefully about likely causes and target your treatment. Not all antiemetics are equal.
3. Understand 'total pain' that encompasses physical, psychosocial, and spiritual domains. Analgesia alone is not always the answer.
4. Bowel dysfunction, not to be confused with bowel obstruction, is a common symptom. Constipation, distension, nausea, and vomiting are features. This is a diagnosis of exclusion once other conditions (for example, opioid-induced constipation, hypercalcaemia, and renal failure) have been ruled out.
5. It is acceptable to refer hospice patients to an acute ward. Bowel obstruction, spinal cord compression, and superior vena cava obstruction are some conditions that may warrant imaging and acute management.

6. Leave your sceptical views regarding complementary therapy at home. Whether there is evidence or not, they may leave patients feeling better. Spending time with a caring person who is interested in them and their symptoms may be therapeutic in itself. If not costly and unlikely to do harm, why deny patients this opportunity?
7. Shadow a specialist pain team ward-round and observe any anaesthetic procedures you can. You may be able to apply this knowledge as a GP.
8. Know what to do in the case of massive haemorrhage. Where are the surgical towels?
9. Differentiate between getting and feeling better.

COMMUNICATION

10. Learn how to discuss prognosis. Ask patients what they think; they are often very insightful. It is not helpful to say 'you have X months to live' as patients and families may take this as gospel and be upset, angry, or disappointed if your prediction is incorrect. Consider talking in terms of rate of change. For example, when a patient is deteriorating by the month, their prognosis is likely to be measured in months. If they are more unwell by the week, their prognosis is likely to be weeks. Likewise, if they are frailer by the day or hour, their life expectancy is likely to be days or hours. Make sure it is clear that these are estimates.
11. Spend time with patients. They like to talk about football and gardening as well as their symptoms. Informal chats offer brief periods of respite and have the potential to be valuable therapeutic tools.
12. Read: Not TLC but FPI (friendly professional interest). *J R Soc Med* 1990; **83(3)**: 172-175.
13. Do not condemn other professionals for poor communication skills. Patients may

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say 'Dr Bloggs never told me I was going to die'. Dr Bloggs may have told them. Did they understand and were they ready to accept this news? Consequently, always check understanding of important information that has been discussed.

14. Obtain consent to communicate with third parties. Families may not know as much as you hoped. Document these conversations concisely but accurately.
15. Do not be afraid to break bad news. Patients have often anticipated that they may have cancer or are dying.
16. Although patients are your primary focus, their friends and relatives need your attention too. Be empathetic to their situation and think about sources of support that could be useful for them. For example, the chaplain, psychosocial team, or GP.
17. Silence is a communication skill. Use it!

PRESCRIBING

18. There is no maximum dose of opioid if the pain is opioid sensitive and side effects are tolerable.
19. Make use of the *Palliative Care Formulary*.
20. Prescribe modified-release morphine by brand name.
21. Patients with impaired renal function require less morphine. Reduce the dose, prolong the interval between doses, or use an alternative such as fentanyl.
22. Use a book entitled *The Syringe Driver*. It contains information on drugs used, drivers, their indications, dosages, and compatibility with other medications.
23. Consult an opioid conversion chart when changing opioids or routes. Do not try to learn conversions and never rush this task. If in doubt, ask.
24. Learn how to prescribe breakthrough analgesia properly. Again, refer to the conversion chart or ask.
25. Check blood sugars of patients taking high dose steroids.
26. Do not fear morphine or midazolam. Used correctly, they do not hasten death.
27. Medicines are only efficacious if absorbed. If vomited, oral medicines will not work. Patches only work if they adhere.

TEAM WORK AND ORGANISATIONAL

28. Understand the different funding arrangements for patients who require care at home.
29. Listen to the nurses and auxiliaries. They are often very experienced and spend

more time with your patients than you do. If they are concerned, there is something wrong (not necessarily what they think is wrong, but nevertheless, there is something wrong).

30. Attend a Gold Standards Framework meeting. You will be fundamental in these as a GP.
31. Participate in multidisciplinary team meetings. Your views really matter (as do those of the nurses, auxiliaries, chaplains, physiotherapists, occupational therapists, complementary therapists, and social workers).
32. Become familiar with your hospice's referral criteria. Patients with diagnoses other than cancer may be accepted.
33. Maintain good communication with hospital and GP colleagues. Inform them promptly of discharges and deaths.
34. Do some home visits with another doctor and clinical nurse specialist.
35. The Liverpool Care Pathway. What is it and what are the indications for using it?
36. Watch experienced colleagues at work. They will all do it differently. Take the aspects of their work that you like and integrate them into your own style.

ETHICS AND LEGAL

37. Mental Capacity is decision specific.
38. Complete death certificates and cremation forms promptly.
39. Check patients and their notes for the presence of hazardous implants before completing question 23 of the Cremation 4 form.
40. Focus on ethics. There will be countless resuscitation, capacity, and consent issues, as well as advanced decisions to refuse treatment.
41. Not everyone in the hospice is 'Do not attempt cardiopulmonary resuscitation'. Some patients should still be resuscitated in the event of cardiopulmonary arrest. If in doubt, discuss resuscitation status with your seniors at the time of admission. Relatives and staff should be resuscitated so know where the defibrillator is!
42. People make eccentric decisions. This does not mean that they lack mental capacity.
43. Remember you are the doctor. Nurses may be experienced but do not be persuaded to prescribe or administer medicines unless you can justify it. It does not look good in court when your defence is 'the nurse told me to'!

Provenance

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