

15/6/2020

Inquiry into Palliative Care Submission.

Dr Mark Monaghan MBBS FACEM AFRACMA

Director of Medical Services SW Coastal.

Thankyou for the invitation to submit to the Inquiry.

My comments and observations will be both general ones and others specific to the rural setting / SW coastal region.

General Comments.

I am a strong advocate for both a more comprehensive palliative care system and the existence of the Voluntary Assisted Dying Legislation. The two should and not only co-exist, but in fact can complement and enhance one another.

I believe that there is still a gap between the realm of active treatment focus and palliative symptom control. This gap is often a temporal one, in that we do what we can with a treatment/curative focus, and then when failing we switch. A continued gradual changing of perceptions of palliative care (both medical and societal), to an enhanced symptom control discipline that is not all about preparation for death and can run in parallel with active treatment, could save an enormous amount of suffering.

In practice this might mean palliative care physicians working alongside oncologists or geriatricians, so that on initial diagnosis, a patient is referred to both as a comprehensive care model.

In my experience, symptom control, including emotional support, is often not adequately managed by oncologists alone.

The role of the GP is obviously an important potential option as a source of palliative care in it's broader sense here, but this requires both the skill set, training and time allocation to the patient, which may be hampered by financial constraints such as long consult remuneration.

Many rural GPs provide palliative care for their patients and consider it one of the most enjoyable and rewarding parts of their job. Investment in both opportunities for training and specialist support 24/7 are important to ensure the patients receive the level of care that they should.

I will add an anecdote here.

A year or so ago in Margaret River, an elderly couple, who had been together since their teens, and had lived in the region all their lives, were both in their late 80s and terminally ill. They were much loved by the community. The local hospital nursing and medical staff set up an unpaid roster to keep them both at home where they wanted to be, providing an around the clock home care service. In the final stages they were managed on nikki pumps at home, with staff in attendance multiple times every day. They passed away in their bed, comfortably, alongside each other and several hours apart. This was as lovely for the staff as it was for the patients and their family.

Having the skills, the specialist support if required and the capacity to provide care of this level, whether it be at home, in a hospital or a hospice would encapsulate what I think we should be aiming for.

I have worked in a metro hospital hospice, it was a wonderful service and provided great care.

For the SW coastal region, I want to see a robust hospice model, as well as an increased capacity community based palliative care model.

We have some degree of each, but neither is yet where it should be.

In my view the palliative care nursing FTE allocated to providing home support remains inadequate, and as with many services where people are invested in their patients, it only manages to do the good it does by individuals working beyond what should be expected because of the relationships they form with their patients.

The other area where palliative care is commonly administered is the general hospital ward setting.

In the tertiary sites there are good models with palliative care teams on site.

In regional rural centres, and smaller hospitals, it is not the same, and may be left medically to senior medical officers, GPs and nursing staff, many of whom who have no training in palliative care. For example, a Health Campus in the SW that I am aware of has nominal hospice beds and a dedicated volunteer model, but cannot always guarantee hospice trained nursing staff for that area as they are part of the general nursing pool. The issue is recognised and is being worked on, but is not as yet resolved.

The other tricky area here is the daily occurrence of shifting treatment focus from active to palliative management, and the supports available to support best decision making. This often requires the navigation through ethical dilemmas. There is no obvious or easily accessible resource for our staff to seek expert advice on ethico-legal frameworks in real time.

GPs, particularly country GPs, make these decisions every day with patients and their families. But I worry about the consistency and rigour around the decision making, even though I am sure that almost all are well motivated and reasonable.

As an aside, I recently looked into doing a graduate degree in medical ethics to help provide that resource locally. Thus far the time investment required to study this formally and the \$25-30,000 cost of the course has stopped me from progressing with this.

There is real progress at a WACHS level to enhance regional palliative care resources, with sessional allocations for doctors to provide palliative care expertise. This is being lead by Dr Kirsten Auret, who is an excellent advocate for the profession.

In conclusion, my sense as the medical director for my rural region, is that we have a way to go to get to a situation where we have both the capacity and supported skill set to provide consistent, excellent palliative care for our region.

Having said this, I was very recently covering the medical director role for the Kimberley, and the palliative care for that region is significantly less advanced than that in the SW, and would seem a priority to address.

Best wishes for your Inquiry.

Mark Monaghan