

End-of-Life Care and the GP:

From cradle to ...

Text by Dr Rina Nga

In the time serving the community in palliative home care, there were many heart-warming moments where I saw the faith the elderly place in their GPs. These moments were especially obvious when I would attempt to “deprescribe” near the end of life. Taking patients off their statins, vitamins and iron tablets would be met with fierce resistance as they retort: “Dr Tan said that I *cannot* stop this medicine!” To which I would respectfully concede and wait for another opportune moment to bring up the subject.

This also happened on other occasions when one’s blood pressure would be dropping and I would try to take off anti-hypertensives. I would then have to resort to calling up Dr Tan, the patient’s beloved GP, to speak to him/her personally.

There have also been cases where as I instruct the family on the procedure for getting a doctor to sign the Certificate of Cause of Death (CCOD) in the event of death, they would reply confidently: “Don’t worry, our Dr Wong will come and sign it. He is a very good doctor. He has promised to sign the CCOD.”

Bringing in the GPs

So I ask myself: “Where are the ‘Drs Tan and Wong’ at the end of their patients’ journeys?” These GPs have built up a rapport with their patients and their families which cannot be shaken. Yet here I am, another GP (with special interest, hence termed GPSIs), trying to build up my rapport with these same patients and their families from scratch, just so I can provide “good” end-of-life care. I had to ask them questions like: “What are your interests/favourite foods/favourite music/favourite people?”, whereas their regular GPs already *know* their every quirk.

Let me outline the typical trajectory of a terminal cancer patient. For example, Mr Lim has been seeing his neighbourhood GP, Dr Tan, since he moved to the area 20 years ago. Dr Tan has also been seeing his entire family. When Mr Lim notices his sudden weight loss, he goes to see Dr Tan who conducts some screening tests for him. Suspecting something sinister, Dr Tan refers Mr Lim to the oncologist. Mr Lim is confirmed to have cancer. *Dr Tan doesn’t see Mr Lim anymore.* Mr Lim goes back and forth

from home to the hospital, for unending rounds of chemotherapy, radiotherapy and admissions for complications. After one year, the oncologist decides to call in the help of the palliative care team, as Mr Lim’s cancer does not seem to be responding to treatment. The family decides that it would be best for Mr Lim to spend the rest of his days in the comfort of his home, and he is referred to a hospice home care team. They take over management and look after Mr Lim in his familiar surroundings, as he wishes. One month later, Mr Lim’s wife goes to see their GP, Dr Tan, and tells him the sad news that Mr Lim passed away at home a week ago.

I see this as a waste of a precious doctor-patient relationship. It is a truncation of a complete “cradle-to-grave” follow-up. I asked myself: “Can the ‘Drs Tan’ step back in and be involved in their patients’ care at the end-of-life stage?”

Identifying the obstacles

If the concern is regarding skills and expertise, I can attest to the fact that palliative care is hardly rocket science.

In fact, the greatest struggle our modern-day doctors have with palliative care is in communication skills – communication of bad news, discussion of choices and crafting of advance care plans – these are the aspects that challenge doctors nowadays. But these are the skills that GPs are already equipped with. It is heartening to see more GPs register interest in palliative care through attendance at the Singapore Hospice Council's Postgraduate Course in Palliative Medicine and in the recently launched Graduate Diploma in Palliative Medicine.

The greater concern I see is the "how". Once equipped with suitable training in palliative medicine, how does the GP penetrate the system, such that they can once again be the primary physician when their patient with a life-limiting condition is channelled back into the community healthcare service? Some concerns that GPs have voiced so far include:

1. Carriage and prescription of controlled drugs

Unfortunately, many patients with life-limiting disease require some form of opioid for the control of pain or breathlessness at some point. Many GPs get very nervous at the thought of having to keep pristine records of controlled drugs.

2. 24-hour coverage

GPs usually operate alone and palliative patients need to have access to care around the clock. It would be humanly impossible, not just unsustainable, to be providing care whenever the need arises, if the GP were to operate solo.

3. Remuneration

Current hospice home care providers do not charge for their services. It is unlikely that patients would want to switch out of a service that is free to them. How would a private GP get reimbursed for his/her services then?

The Ministry of Health has put in place a provision for the use of Medisave for home palliative care.¹ However, the definition of home palliative care providers currently includes only the six recognised players (HCA Hospice Care, Assisi Hospice, Dover Park Hospice,

Singapore Cancer Society Hospice Care, Agape Methodist Hospice and Metta Hospice Care). These rely on Government subsidies and charity dollars, and currently do not charge patients (through Medisave or cash) for their services.

This situation makes it difficult for the GP (who doesn't receive charity dollars) to penetrate the "market". Families would often be cash strapped by the time their loved one requires palliative care and might not be able to pay for house calls provided by their GPs.

4. House calls

These are termed "home visits" in palliative home care. GPs generally avoid making house calls because it takes them out of their comfort zone and a controlled environment. House calls are also conducted alone, without the help of a nurse or assistant, unlike in home visits. However, speaking from personal experience, it is really a matter of getting used to it, and an accompanying nurse is definitely an added advantage. I have always preferred to see the patient in his/her natural environment than in a clinic where we have no idea if what we advise and prescribe is actually being (or can be) adhered to at home. For example, you can prescribe all the laxatives in the world for constipation, but if the patient cannot get to the toilet in time because he cannot negotiate the kerb getting into the toilet, he will just refuse to take those laxatives!

Concluding words

In conclusion, this matter is far from reaching a conclusion. I still advocate that community-based palliative care should be handled by the GP, so that continuing care can be provided for our patients and their families. But in order to come to some resolution, the following have to be achieved first:

1. Buy-in from GPs – awareness of the importance of including palliative care in the scope of GPs' work.
2. Training – conducting training courses in a framework that appeals to the majority of GPs.

3. System changes – perhaps a partnership between GPs and existing palliative home care providers, so that the issues with opioid carriage, remuneration and nursing support can be addressed.

It is only then that the GPs in Singapore can truly be involved in the care of their patients from the proverbial "cradle to grave". ♦

References

1. Ministry of Health. Medisave Uses and Withdrawal Limits. Available at: https://www.moh.gov.sg/content/moh_web/home/costs_and_financing/schemes_subsidies/medisave/Withdrawal_Limits.html.

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