Palliative Care Management Challenges in Rural Settings

Workshop

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Disclosure

In relation to this presentation, I declare that
I have no conflicts of interest

A conflict of interest is any situation in which a speaker or immediate family members have interests, and those may cause a conflict with the current presentation. Conflicts of interest do not preclude the delivery of the talk, but should be explicitly declared. These may include financial interests (eg. owning stocks of a related company, having received honoraria, consultancy fees), research interests (research support by grants or otherwise) or organisational interests

www.shpa.org.au
Outline the session

- This is an interactive session

- Form large groups.....

- Discuss the topics & one representative of each group give us your group’s views.....

- Finally, we will look at the issues & Challenges in Palliative Care Services in general and in rural region
Question (1)

What are the challenges....... in Palliative care (now)?

(10 minutes Discussion)
5 KEY CHALLENGES
(Scott Murray, PCC 2010)

1. All end stage illnesses

2. Earlier than later

3. All dimensions

4. All nations

5. All settings
Impact is Huge...

on Palliative care Services!
1. All end stage illnesses

- Increased referral rate! with end-stage non-malignant diseases

- Unlike malignancies, longer term life span with acute episodes – intermittently!

- During the acute episode, they may need hospital care, under palliative care label (how much to treat... ?)


www.palliativedoctor.net
Dilemmas in providing specialist palliative care for all!

(Sheila Payne, UK - “On our own terms: the challenges of providing palliative care beyond cancer”)

- ‘flood-gates’ argument – services are being overwhelmed
- Skills of specialist Palliative care Practitioners
- Do patients with other conditions have needs and levels of symptom burden that merit palliative care?
- Do palliative care interventions benefit those with other conditions?
- When should patients be referred? when prognostication is uncertain?
- Are hospice and specialist palliative care services acceptable to those with other conditions?
- Funding and resources........

(Field and Addington-Hall 1991; Addington-Hall 2004)
Figure 1. Vision for the future of Palliative Medicine

Scott Murray, Et al. 2010 Int. J. Pall Nursing: 316-319

- Organ failure
- Cancer
- Acute
- Dementia, frailty and decline

GP has 20 deaths per list of 2000 patients per year
2. Earlier than later

![Diagram showing the comparison between old and better concepts of care.](chart.png)
Early integration of palliative care services with standard oncology care for patients with advanced cancer

3. Multidimensional Care

The availability of MDT Support

- Unlike cities, it is difficult to provide all dimensions of palliative care in rural areas!
- Unlike in-patient facility, the MDT members have to travel all over the region.
- The rural care provider (Doctor / nurse) may have to use different hats as needed as a medic, nurse, counsellor, social worker or chaplain to support the patient / family
4. All Nations

- Reaching to all in need in economically poorer countries. (e.g.: Africa has only 4 countries with any comprehensive palliative care services: in all other 52 countries there is very little access to morphine or any other strong analgesia! - (Scott Murray, Et al. 2010 Int. J. Pall Nursing: 316-319)

- How to provide Palliative care services... to Multi-cultural background?

- We professionals have to learn... what is accepted in the culture & what is not? (e.g.: Providing culturally appropriate palliative care to Indigenous Australians or Overseas refugees)
5. All settings

- Providing patients’ preferred place of care with limited institutional (in-patient) facility or limited end of life care services patient at home

- Issues in managing the End of life care at home
  - Limited number of medics / specialist nurses to cover larger rural area
  - Rapid changes in the level of care & unable to provide when needed
  - No out of hour service Pharmacy
  - Social worker / Counsellor support
Question (2)

What are the issues & challenges of providing Palliative care in Rural Australian Population?

(10 minutes)
Some Australian Statistics -1

- 1/3 of Australians live in the regional & rural area but significantly fewer specialists & GPs work in Rural Australia compare to Metropolitan area.
  - Australian Government Department of Health & Aging Report on the Audit of Health work in Rural & Regional Australia 2008

- The seven million who people lives outside the cities have shorter lives, higher level of some illnesses & health risks than the rest of the people in the major cites. Mortality rates increase with increasing remoteness.
  - COCG Reform Council’s Healthcare 2010-11: Comparing outcomes by remoteness
Standardised index of the ratio doctors, nurses & midwives by Remoteness Area (Australia) – 2009

“Health Workforce 2025” volume 1, figure 35
Some Australian Statistics -2

- Only 22% of regional Hospitals had dedicated Palliative care doctor & 59% had a dedicated Palliative care nurse.
  - Clinical Oncological Society of Australia Mapping rural & Regional Oncology Services in Australia Sydney COSA 2006

- 25% of the Australian GP Workforce chooses not to administer Palliative care
Rural Palliative Care Challenges

Patient Factors / Challenges

- Palliative care awareness / Perception:
  - Negative Perception of Palliative care
  - Denial of the severity of the illness
  - Conflicting emotions (anger / guilt / low mood)
  - The Prognosis of Diseases
  - Decision making / Conflicting views within family

- Poor socio-economic status
- Lower level of Education
- Patients wishes (Preferred Place of Care/ Death)

ABS (2011); National Rural Health Alliance (2013)
Service / System Barriers -1

1. Underfunded Services
2. Poor access to specialist palliative care
3. No or much less training & expertise
4. Geographical disadvantages:
   - Population Clusters / Distances & Long travels
   - Weather /climate issues,
   - Poorly maintained Roads

National Rural Health (2013)
Service / System Barriers -2

5. Obtaining supplies, advice about the use and disposal of the medications for palliative care can be challenging for rural population

Palliative care Australia (Oct 2012)

- End stage non-malignant & malignant disease patients are on multiple drugs....
  ➨ De-prescribing rarely done!
#### Unequal distribution of professionals

**Table 2.8: Employed medical practitioners, number by Remoteness Areas, 1997(a), 2001 and 2005**

<table>
<thead>
<tr>
<th>Type of practitioner</th>
<th>Major Cities</th>
<th>Inner Regional</th>
<th>Outer Regional</th>
<th>Remote/Very Remote</th>
<th>Not stated</th>
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<td>585</td>
<td>52</td>
<td>550</td>
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<td>Specialist-in-training</td>
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<td>221</td>
<td>99</td>
<td>16</td>
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<td>Non-clinicians</td>
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<td>290</td>
<td>133</td>
<td>32</td>
<td>206</td>
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<td><strong>Total</strong></td>
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<td>2,619</td>
<td>541</td>
<td>2,133</td>
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<td>2,014</td>
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<td>6,63</td>
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<td>74</td>
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<td>19,94</td>
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<td>89</td>
<td>17</td>
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(a) 1997 is the earliest year for which comparable estimates to 2005 are available, due to changes in estimation processes.

Professional Barriers / Challenges:

Currently the provision & teaching of palliative care in rural areas frequently depending on Palliative care specialist Nurses who advice GPs on Pain & other symptom control.

There are reports of GPs refusing to take advice from these ‘nurses’ & not using pain /symptom control correctly…!

- Joint submission to the senate community Affairs Committees inquiry into Palliative care in Australia by the COSA & CVA March 2012
Rural Primary Care Practitioners

- Poor Training opportunities & More working hours compare to metropolitan Practitioners

- “Ownership” issues are more significant among the rural primary providers!
Model of Care to Rural & Remote Region..?

- Many research work were published & still many to be published.... and some new models have been started & tried out.... But

- **A few Rural Models in practice:**
  - ‘Traditional ‘ healthcare model
  - ‘Clinical Nurse Consultant’- model
  - Formal multi-disciplinary team model
  - Visiting Consultative Services –model
  - “Hospice without walls” –Model
    (Currently we are using in NW Tasmania ➔ Mixture of different models !)
Cultural Challenges

- More than 41% of doctors working in the rural & remote areas have trained overseas
  - Australian Government Department of Health & Aging Report on the Audit of Health work in Rural & Regional Australia 2008

- Cultural differences that may exist between these Overseas-trained doctors & their community are sometimes evident in their approach to Palliative care
  - Joint submission to the senate community Affairs Committees inquiry into Palliative care in Australia by the COSA & CVA March 2012
Cultural Challenges:

- Remember! Our indigenous Australians mainly live in the regional & remote area...

Family/community based palliative care Model:

- A standard principle of Aboriginal health policy is that *there should never be a one-size-fits-all model* for any health program, and end of-life care is no exception.

- We have to remember the patient’s link with the land and sense of community / family, acknowledging cultural & spiritual beliefs about illness, dying & death.
Discuss the role of the Palliative care Pharmacist in a Rural Palliative care MDT...?

(10 minutes)
Open Discussion.....
Role of the Palliative Pharmacist in a Rural Palliative MDT

1. As a MDT member, he/she can advise the appropriate drug for palliative patients’ symptom management (specially with renal/liver impairment).

2. We have to find a way to get the palliative drugs/injections in the rural community for emergencies. Palliative Pharmacist may be able to check the availability of palliative drugs in the rural pharmacies, co-ordinate hospital & community pharmacies & provide information to rural practitioners (E.g.: S/driver drugs).

3. Education (as a “Rural Palliative Clinical Pharmacist”) to rural practitioners & new palliative care staff (Registrars/training nurses/community nurses).

4. De-prescribing advice: Check the community palliative patients & advice the GPs/Palliative care doctors regarding de-prescribing unnecessary drugs.

5. Check the community palliative patients’ drug charts/syringe driver charts periodically!
“The positives”

My 18 months experience in the Rural Palliative Care

1. **Tele-Health is GREAT... for rural Palliative Care!**
   
   » **“face-to-face” Consultation (GP / Patient/Family)**
   (Work well for Kings Island Patients’ combined consultation with GP + family)
   
   » **Rural Teaching for Hospital / Community nurses**
   (Protected Teaching time for Nursing staff by myself: Every 1st Tuesday of the month 14.00 hours for the whole Northwest Tasmania! The Hospitals & community team feel that they are supported & they select the topics!)

2. **PEPA Training Program:**

   Through this Program, We train the local Community Nurses & GPs

3. **Rural Clinical School Teaching:**

   Our ‘future doctors’ (final year Medical students – UTAS) are doing clinical attachment in Palliative care, NW-THO, Tasmania.

17/07/2014
I strongly belief.....

We can build strong palliative care foundation to Tasmania through education!
Thank You