Guest Editorial

Palliative care

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All doctors encounter patients with advanced life-threatening illness and it is important that we develop competence in managing these patients throughout the progression of their illness and in caring for patients who are dying. General practitioners are at the front line of this care and although hospice care is becoming more accessible to patients in South Africa, patients rely on their GPs to provide continuity of care and support. This edition of *CME* provides an update of some key aspects of palliative care for the GP.

Good communication skills are the foundation to clinical care and are particularly important when discussing end-of-life issues. The GP is frequently the person who has to break bad news or has to elaborate on the diagnosis, prognosis and care plans for patients with life-threatening or life-limiting illness. Linda Ganca and Alan Barnard have written about these challenging conversations and how to develop communication skills to be prepared for these discussions. In addition to good communication, a sound knowledge of bioethics assists the doctor during end-of-life discussions and in making decisions about end-of-life care. As in all palliative care, management at the end of a patient's life should be tailored to that patient's circumstances, the illness, the patient preferences and family resources and wishes. It is important to elicit the patient's and family's understanding and expectations of care as unrealistic expectations influence this decision-making. Honesty and truth-telling support the patient and family with realistic hope, as does the commitment to continued care.

This edition of *CME* also considers some key clinical skills in palliative care. Rene Krause and Janet Stanford are both hospice doctors with considerable experience in palliative care. They explore new developments in pain management based on the WHO guidelines for management of pain. They have taken knowledge from research into pain physiology and management of neuropathic pain to give us further insight into the rationale for the use of anticonvulsants which act as calcium channel blockers in pain management and tricyclic antidepressants to block sodium channels at nerve synapses to reduce pain. Pain is still under-diagnosed and undermanaged in South Africa, resulting in significant suffering and limitation to activity. It is an ethical imperative to keep up to date with such advances in patient care.

David Cameron writes on delirium – a common symptom in palliative care affecting up to 80% of cancer patients towards the end of life. Diagnosis of delirium, identifying the cause of delirium and treating the cause as well as the symptomatic treatment of confusion and agitation require attention to detail and a structured approach to the problem. Delirium causes great distress to patients, family members and staff and the relief of delirium provides comfort to patient and family and the sense of a job well done to professional staff. Professor Cameron also provides guidance in the event of opioid-induced neurotoxicity.

Spiritual care is a neglected part of palliative care but to recognise that patients find comfort in their doctor 'being there' and listening, providing a safe space to discuss issues beyond physical concerns is a first step towards spiritual care. Charmaine Blanchard explores this further as well as the concept of total pain and the role of the doctor in addressing spiritual pain.

And so to the issue of when to start palliative care, referring to the World Health Organization's statement that 'palliative care is applicable early in the diagnosis in conjunction with other therapies that are implemented to prolong life'. In general practice we are familiar with providing active care while recognising that cure may not be possible for patients with life-threatening illness. In fact this is the basis of much chronic care including management of HIV with antiretroviral medication. GPs are well placed to take an active role in palliative care both while patients are still receiving treatment with curative intent and also at a time when the disease progresses and the patient is now seen as terminally ill. Hospice care is invaluable in supporting the GP at this time of a patient's life when more intense care is required with hospice staff undertaking frequent visits to a patient's home, supporting the family, ensuring good symptom management and comfort for the patient. A partnership between hospice and GP ensures the most effective care for the patient and family.

A number of training opportunities are available to the GP to improve knowledge and skills to provide palliative care and I would encourage GPs to take advantage of these to ensure that patients with life-threatening illness have the care required to experience good quality of life even at the end of life.