

Palliative Care in Australia - the Story So Far.

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‘Professor Maddocks will discuss his role’.

Accidental
Opportunistic
Timely
Fortunate

Built on the important preparations by others

Before the 80s

Early developments

1980s Increasing Interest from

Government

Universities

Established Medicine

Pharmaceutical Companies

Before the 1980s

Influence of overseas advocates and exemplars –

- Cicely Saunders: The St. Christopher's Model
- Derek Doyle: Intellectual Content (Palliative Medicine)
- Balfour Mount: In Established Hospitals
- Eric Wilkes: Day Care

There were some Australian attempts to follow models outside of established medicine: Mary Potter, City Mission, Theresa Plane

Early government recognition gave different emphasis – eg SA 1990: 'Palliative Care is an integral part of health care', therefore a government responsibility for funding.

SOME AUSTRALIAN PIONEERS (very selective!)

DAVID ALLBROOK: ACADEMIC, MRA

ROSALIE SHAW: PERTH AND ASIA

DOUG BRIDGE: PHYSICIAN, ASIA

ROGER HUNT: NEW GRADUATE JOB?

DAVID THORNE: GP

NARELLE LICKISS: ONCOLOGY, RELIGIOUS

TREVOR BANKS: GEELONG GP

MARGUERITE ROBERTSON: BRISBANE

SHIRLEY SUTTON: CANBERRA

RUTH REDPATH: RADIO THERAPY

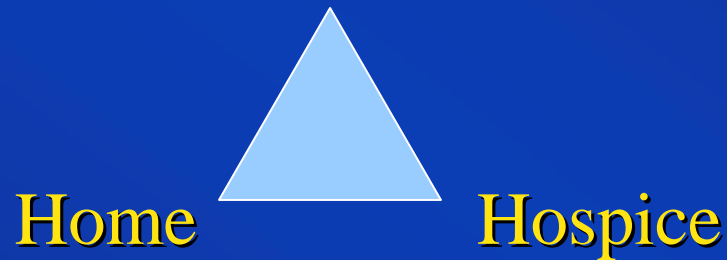
Different backgrounds, Common themes

- cancer, religious conviction, maverick??

WA: Silver Chain an innovative Australian model.

The value of an integrated service

South Australia: Hospital



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Finding that accepted place in established medicine:

- Recruiting established individuals
- Establishing training programs with University status
- Providing a useful, used service

Tertiary Education

University Chairs

1988 Flinders University, then
Newcastle: Peter Ravenscroft
Monash: Michael Ashby

NSW: The Sydney Institute

AWARDS

Grad. Cert., Grad. Dip., Master. Doctorate

ANZSPM created collegiality

College of Physician recognition: FACHPM

SOME CURRENT ISSUES:

Recognition and Government Funding -
gained/lost something?

Medications, especially Opioids
too many Opioids?

Privately-funded palliative care -
discrimination?

Cancer/Non-cancer - Palliative Aged Care?

Evidence - a valuable tension?

ISSUE 1. GOVERNMENT RECOGNITION

Designated Funding for States, Federal.

Emphasis on Data collection, Accreditation criteria -

What are they doing, what does it cost?

Cautious support for NGO Bodies - PCA ++

- Generous recent support for research projects, surveys, position papers on standards, training etc.
- Ready support for opioids and some special drugs; but concern re diversion/non-malignant pain.
- Relatively frugal support for expanding services - understandable but sometimes frustrating.
- Worrying example of Aged Care Facilities paperwork.

ISSUE 2. Medications

Australia has as good availability of opioids as almost anywhere,

Partly through a new recognition of how to use them effectively,

Partly through research and marketing by the drug companies,

A small part through research from within the discipline,

Much through effective advocacy eg for special PBS listings

BUT?

Common Opioids in Use in Australia

Morphine Syrup: 1, 2, 5, 10, 20mg/ml [200ml]

Morphine tablets 10, 15, 30mg

(Morphine suppository 10, 20, 30mg)

CR Morphine:

5,10,15,20,30,50,60,90,100,120,200mg

Morphine inj. 1, 5, 10 15, 30 120mg

Fentanyl oral stick 200,400, 600 800µg

Fentanyl patch 2.5, 5, 7.5, 10mg each 3 days

Fentanyl inj. 100, 500,1000µg

Tramadol caps 50mg

Tramadol SR 100mg

Tamadol inj 100mg/2ml

Dextropropoxyphene 32.5 + paracetamol 500

Oxycodone tab/caps 5, 10, 20mg

Oxycodone liquid 5mg/ml

Oxycodone suppository 30mg

CR Oxycodone 5,10, 15, 20, 30, 40, 80mg

(Oxycodone amp.5mg, 10mg)

Hydromorphone liquid 1mg/ml [476ml]

Hydromorphone tablets 4mg

Hyromorphone inj. 1, 2,10,50,500mg

CR hydromorphone

Codeine tab 30mg (also + paracetamol 500mg)

Codeine inj 50mg/ml

Methadone tablet 10mg

Methadone injection 10mg

Available but less used

Dextromoramide tab 5mg

Pentazocine tab. 25,50mg

Pentazocine inj 60mg

Buprenorphine 0.2mg subl. tab

Buprenorphine inj. 0.3mg/ml

Buprenorphine patch 5,10,20 µg/hr. each 7 days

Pethidine inj 50, 75,100,500mg

Diamorphine (UK only)

Do we have TOO MANY opioids?

Company Competition continues - How do GPs cope?

Mixing Opioids - A Mixed blessing!

Oxycontin: Example from Korea (naughty!)

ISSUE 3: Private Palliative Care

Government initiatives encourage private health insurance.

Private hospitalisation, private agencies are variably supported by the health funds.

Liaison with publicly-funded care teams varies also.

In most countries for any kind of health care you need money and very often the poor miss out.

In Australia, there has been a phase in the development of palliative care when privately-insured patients were missing out.

Send not the rich empty away!

The emphasis on the organization of palliative care remains on the public agencies. A recent review of palliative care in South Australia (Palliative Care Services in South Australia 2009 - 2016) makes no mention of the work of private hospitals and the liaison between private consultants, private work by palliative care physicians, or by privately -funded nursing services.

ISSUE 4: Palliative Care for Non-Cancer.

WA study indicated Non-cancer not being referred.

Referrals are increasing

WHY?

Greater recognition of PC?

Just part of the referral dance between specialists?

Discomfort with 'failure'?

Grateful hand-over to someone more interested?

AGED CARE a special issue: WHO document 'Palliative Care for Older People: Better Practice' promises a new deal for the elderly by bringing palliative care attitudes and practices into aged care - but that will surely need increased funding per client, and numbers are scary.

ISSUE 5: Evidence

Much 'research' is concerned with process, not care

Mix enthusiasm for research with scepticism.

Be innovative, rigorous in recording, not too expectant.

What works, what pleases, what is accepted and what is simple, seems often the best approach.

What is the most important knowledge in palliative care?

Often the best knowledge is patient-centred:

- what discomfort matters most to the patient
- what drug seems best tolerated by the patient
- what dose, route of drug administration suits the patient
- what words are best understood by the patient
 - given the education, cultural background, language.
- what resources are needed to meet patient needs,
- where they can be accessed, what they cost etc.

Knowing when to seek help!

This might be called Personal, Situational and Practical Knowledge, rather than Scientific Knowledge

Celibidache (Romanian composer/conductor)
on music:

*“What is written in the score
is everything -
except what is important”*



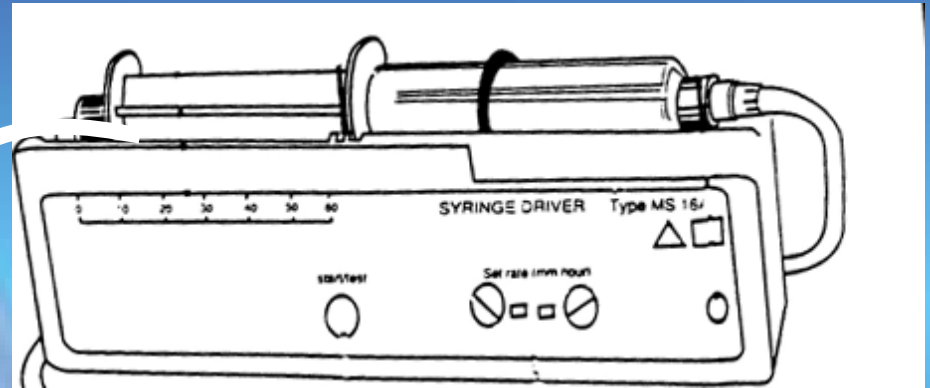
This also applies to Palliative Care?
There is often no right answer, and
how care is delivered may matter more
than exactly what is delivered.

After 25 years - Where are we going?

It is an uncertain world, and there are greater reasons than ever before to consider that the world itself is terminally ill. What can palliative care offer? What form of Graseby syringe-driver can we prescribe for a dying planet?

I wrote in an editorial for Progress in Palliative Care:

'Palliative Care offers an example of what can be won from a anxious situation of impending demise. It acknowledges a hope founded in love and courage and patience rather than desperate survival, and so it proclaims a still small message for a terminal world.'



WHAT PALLIATION FOR
A TERMINALLY-ILL WORLD?