Rural Palliative Care Resource Kit

Adelaide Hills
Division of General Practice Inc.

Experiences of Establishing and Managing a Clinical Multidisciplinary Team Meeting

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Introduction

Regular multidisciplinary team (MDT) meetings were established in many of the 8 projects within the Rural Palliative Care Program (RPCP). Experiences within this program have shown that, certainly within the rural context[1], there is not a 'one size fits all' model for these meetings.

This document examines:

- the benefits and disadvantages of MDT meetings
- the establishment and format of meetings
- case conferencing
- some of the experiences from within the RPCP.

The information contained here is aimed at enabling those considering implementing clinical MDT meetings to build on the lessons learned from within the literature and from practical experience.

Important points

- A lack of coordination of care and communication increases stress for patients and families.
- MDT meetings can ensure smooth transition between services, avoiding duplication of services.
- MDT meetings can become a means of facilitating staff support.
- MDT meetings also serve as a vehicle for education, and a means to widen skills.
- Geography and distances to travel can be a barrier to attendance at meetings (but teleconferencing can address this).
- MDT meetings can help provide insight into the awareness of the roles of others.
- Case conferencing, GP Care Planning and Team Care Arrangements can be undertaken within an MDT meeting.
- GP funding can be a barrier to participation, but claiming EPC item numbers for above arrangements helps address this.

Background, benefits and barriers

Palliative care is in itself multidimensional, multi-professional and complex[2]. Palliative care should then by definition be team care, as no one practitioner has the skills or time to care for all patients needs[3].

Multidisciplinary working practices cannot therefore be emphasised enough, this has been previously well documented in the literature (see further reading section) and referenced within

National Policies and Strategies, including the *National Palliative Care Strategy,* and within the National '*Standards for Providing Quality Palliative Care for all Australians*'[45].

There have traditionally been issues regarding primary care and palliative care service delivery. These include lack of continuity of care, poor communication, co-ordination of services and blurring of responsibility[6,7,8]. A lack of co-ordination of care, along with poor communication increases stress for patients and families, and the alleviation of this can add significantly to quality of life with overall benefit to patient, carer and family[2,8,9,10]. These issues can arguably be facilitated by the coordination of care via regular meetings attended by members of the multidisciplinary team. Team-working is seen as a way to tackle fragmentation of care; a means to widen skills; and a way to generally improve quality for the patient[9].

There is often a lack of awareness between health professionals of the activities or contribution of others, what services they can provide, and how they can interface effectively[71112]. Collaborative partnerships can be formed or improved within a common forum, such as a regular MDT meeting, allowing acceptance and recognition of team members' roles, building of trust, clear communication, shared team goals, and a perception of the long- term benefits[13].

General practitioners have been reported as being wary of sharing care with specialist teams, feeling excluded once referral to specialist palliative care services has been made[14]. Including GPs in the MDT and/or case conferencing process can be one way of ensuring that they are still closely involved with the specialist services and wider MDT, promoting the concept of shared management of care[14].

Some health professionals can be firmly entrenched in their existing working practice[15]. There are those who will contribute their expertise in isolation from others, those who will work autonomously while saying they're part of a team, and those who may not have been trained to collaborate in a team approach[2,16,17,18,19]. Emphasising multidisciplinary collaboration and service provision in preference to locally or regionally mandated protocols is required, as well as promoting the long-term benefits of working collaboratively in this way[20].

Each discipline and each health professional brings a different perspective to MDT meetings, along with a different history or interaction with the patient and their carers or family. These unique experiences when shared within this forum enable a clearer picture of all the variables and in turn enable a more holistic approach to care by the team. The collaborative interdisciplinary team should consist of diversely trained individuals working toward a common goal of improving the quality of life of the patient[21].

A common motivator of networking within palliative care is when a particularly confronting or challenging case is encountered[8]; in other words, triggered by specific needs rather than by design. These and other so-called 'crisis' situations could potentially be avoided by pre-empting them within a regular multidisciplinary forum[21]. Contingency planning can in turn, prevent inappropriate admissions to hospital, or periods where symptoms remain uncontrolled while appropriate interventions are sought.

MDT forums can also become a means of facilitating staff support, and a way of coping with the tensions of palliative care[6,12,15,22]. Many health professionals such as GPs, will often work in isolation, especially in the more rural and remote areas. They have less support, and there can be issues of getting too close to patients with an absence of debriefing opportunities[23].

Time and work constraints are an often quoted reason for not convening or attending meetings, although the lack of direct communication with many professionals involved, is probably taking up more time[24]. Since teamwork of this description does require time set aside for meetings, there are

manpower complications that managers may become involved in[25]. Sometimes, even those who have shown support for the venture may then opt - out when they realise the impact on their current working practices[26].

Potential sources of conflict can be inherent in the values and approaches professionals of different disciplines bring to multidisciplinary interaction[27]. However, when a multidisciplinary team is established and members are committed to the same goals, the identity of the team takes priority over individual and professional identities[21]. It comes down to the benefits care has for the patient, not so much whether each discipline is performing to its' full potential[25].

Establishing a multidisciplinary meeting

It is worth considering the work undertaken in change management over recent years, when planning to establish a MDT meeting. Introducing anything new is introducing change, and much needs to be taken into consideration before trying to alter things that may have been in place for many years, despite the demonstrated need or participants' enthusiasm. Bringing about change can be difficult and sound reasons for the change do not automatically translate into a change in behaviour or practice[28].

It is important to identify those staff who participate in making changes in practice, and those who advocate for change[29]. Finding champions for the process enabled at least one RPCP meeting to continue and to eventually be valued by all concerned. There is a need to build consensus and commitment to the new venture, and while the time and effort required for good communication seems costly in the early stages of working together, it is invaluable[2].

The composition of an interdisciplinary team will vary depending on the stage of development of the program, the objectives of the program, or the particular needs of a given patient[15]. Most programs will include doctors, nurses, social workers, chaplains and volunteers. However, in view of the complex challenges for most patients, carers and families, it is ideal that other personnel are involved regularly or on an as needed basis such as occurred within the Adelaide Hills Division of General Practice (AHDGP) project where many core personnel remained unable to commit to a regular meeting. Occupational therapists, speech therapists, dieticians, pharmacists and music and art therapists are examples of other disciplines that could be involved, as are care assistants, physiotherapists, pain specialists, psychologists and psychiatrists[3031]. In many rural areas this should also include Aboriginal liaison officers[32]. (See box one)

Box One: Culturally appropriate multidisciplinary care for Indigenous Australians

Excerpt from the **Providing Culturally Appropriate Palliative Care to Indigenous Australians Resource**

Multidisciplinary teams are structured around a collaborative approach to service provision. Depending on the Indigenous person's needs this team could also include indigenous Australian personnel such as health workers, liaison officers, cultural support officers, interpreters, and both government and non-government agencies or departments.
http://www.health.gov.au/internet/wcms/publishing.nsf/Content/palliativecare-pubs-indig-resource.htm

The logistical steps to be taken when establishing a meeting are found in Box Two. This list has been adapted from the checklist for planning an MDC meeting, Multidisciplinary meetings for cancer care: a guide for health service providers (National Breast Cancer Centre). http://www.nbcc.org.au/bestpractice/mdc/

Box Two: Establishing a multidisciplinary team meeting[33]

Adapted from the checklist for planning an MDC meeting, *Multidisciplinary meetings for cancer care: a guide for health service providers (National Breast Cancer Centre).*

Issues to be considered:

Management

- There may be a need to get commitment and support at managerial level for the meeting to take place and to be attended
- It may also require a commitment regionally rather than just locally, to cross institutional and discipline boundaries
- Memorandums of Understanding may need to be put in place
- Who will chair or lead the meeting? Will this be a rotating role?
- Plan the process/ format for the meetings

Name

- Decide who should be a part of the multidisciplinary team meeting
- Decide what the meeting will be called

Agree time, location and resources

- Establishing the date, timing and regularity of meetings may be difficult. There is a need to prioritise who needs to be there (e.g.: a visiting Palliative Care Consultant)
- Where will the meetings be held? Are privacy/ confidentiality ensured?
- Does catering need to be provided?
- Is there access to teleconferencing phone or videoconferencing equipment if required?

Goals

- Identify the teams' goals, priorities, expectation, commitment – short term and long term
- How much fit is there between individual, team and organisational goals (Cummings, 1998)
- Terms of Reference, including review dates need to be established

Practicalities

- Establish what happens about interruptions, phone calls
- Ensure that clinical notes are available when discussing patients
- Ensure anyone teleconferencing has correct time and phone number

Documentation

- What notes are to be taken and by who?
- If case conferences are to be undertaken who will organise them?
- What data is to be collected and who will take responsibility?

Format of multidisciplinary team (MDT) meetings

The format of meetings differs according to local need[34].

In the GAPS model a one hour agenda is set[34].

- New referrals are considered for acceptance to the service and cases already in the service are reviewed.
- A minimal data set is recorded each week for each patient on PalCIS, a palliative care database, which includes phase of care, Karnofsky, current needs and a treatment plan.
- Case conferences are also undertaken, and paperwork distributed by admin personnel.

(Information on PalCIS can be found in the resource kit within the patient records section. There is a document on using electronic records and electronic communication)

This is the format chosen by many of the RPCP projects, with variations on data collection strategies. The GAPS program very early on identified the benefits of linking in incentives for GP participation. These are the enhanced primary care (EPC) and chronic disease management (CDM) items that allow Medicare claims by GPs for participation in case conferences and care plans (see links below within case conferencing).

Others have used these meetings to discuss bereavement issues, business items, clinical education and relevant local issues[35]. In the AHDGP model the Palliative Care Volunteer Coordinator attends and then liaises with the volunteers, and the Bereavement Coordinator takes referrals (on occasion to see patients) and follows up carers and families afterwards.

Distance, especially for those in more rural and remote areas, can be a barrier to this type of collaborative working practice. Within the RPCP case conferencing has taken place within this multidisciplinary forum, with some participants teleconferencing in to the meeting if they are unable to attend. While teleconferencing has its benefits, it also has its disadvantages, as some GPs have found it difficult to participate from a distance, feeling disadvantaged in not knowing the participants[36]. Videoconferencing is also an option that can be used for teaching, consultation and support, and may overcome in part this barrier, as face-to-face is the preferred option[20].

Case conferencing

Care plans and case conferences can be held for people with chronic and complex illnesses requiring care from two or more care providers in addition to their GP[37]. A case conference has also been described as a tool for coordinating care across a multidisciplinary team. Both can and have taken place within the MDT meetings discussed here.

GP funding has also been a barrier to participation in that they have not traditionally been compensated for organising or participating in these conferences[13]. It has been important in our experiences to streamline the process for GPs to claim EPC items.

The Enhanced Primary Care Package (link 1) recognises the importance of adequate reimbursement for GPs, for example encouraging a more active role within the multidisciplinary team, and allowing for non-contact time spent planning and discussing patient management with other professionals[38]. Case conferences were employed in the different projects, with General

Practitioner Management Plans (GPMP) and Team Care Arrangements (TCA) now also available (link 2)

1. http://www.health.gov.au/internet/wcms/publishing.nsf/Content/pcd-programs-epc-chronicdisease

2. http://www.health.gov.au/internet/wcms/publishing.nsf/Content/648DE4B114E3370BCA257019007DB5C3/$File/CDM%20items%20-%20Checklist%20GPMPs%20and%20TCAs.pdf

The achievements of case conferencing have been identified as improved patient understanding of their condition, increased patient satisfaction, improved communication with other health professional and more comprehensive and consistent care[39]. Case conferencing can also serve as a vehicle for education and an opportunity for healthcare providers to get to know each other, thereby building capacity and strengthening the team approach[40].

Studies have shown, that palliative care staff believe case conferences help GPs better understand both a team approach to care and a systematic approach to the management of palliative care, thereby helping to reduce professional isolation[36]. Case conferences also increase specialist team appreciation of the patient-GP relationship and provide an insight into the quality of care offered to the patient.

Time and work constraints for GPs have traditionally meant that it is has been almost impossible to incorporate these meetings into their daily practice, finding it hard to justify the time and effort involved in organising and participating in case conferences[14,17]. The experience within some of the RPCPs, has been for the project managers to organise the meetings, with GPs invited to attend. If they cannot attend in person, appointments for teleconferencing are booked formally in their diary.

Encouraging specialist services to initiate these conferences with GPs may be an effective way to get GPs involved[41,3,17,36,42,43]. Practice nurses and / or practice managers may also play a role in co-ordinating these conferences if the GP is to initiate them. In more rural areas, primary care professionals can play a crucial role in both organising and delivering palliative care[44]. Box Three (below) details steps for organising a case conference.

Box Three: Steps to organise a case conference

Organising a case conference

There are certain steps to be taken and support mechanisms to be put in place when organising a case conference. These include:

- decide who needs to be involved, and when and where it will be held
- contact participants to inform of the arrangements – some may need to teleconference
- book an appointment in the GPs diary
- establish who will take responsibility for communicating with and supporting the patient and/or carer. The patient can indicate if there is anything they don't wish to be discussed. The patient must give consent.
- keep a record of the case conference
  - document who was responsible for gaining consent from the patient and /or carer
  - indicate whether a case conference has been held before and when
  - write up the proceedings of the case conference
  - verify any actions from the case conference, along with responsibilities
  - ensure a distribution/ communication strategy is in place, enabling all involved to receive the documentation
  - establish a mechanism for supportive feedback to the patient and carer if they aren't directly involved. They also need to receive a copy of the case conference summary.
- discuss when a review will be undertaken.

Work undertaken on family conferences, shows experiences similar to that of the case conferences undertaken within this program. These meetings enable patients, family members, and providers to discuss together the illness experience, care options, and end-of-life decision making[45]. They are an important way of sharing information and involving the family in the decision-making process[32].

Patient and carer attendance and inclusion needs to be in a supportive environment[24]. Responsibility needs to be taken for ensuring that patients and carers are included and that the proceedings have been understood. They may need some time after the meeting to facilitate this. Family can find 'medical' meetings anxiety-provoking with so many health professionals present, and it is important to be clear beforehand what form the meeting will take[24]. Often other cultural considerations will need to be made (see Box Four for Indigenous Australians)

Case conferences within the RPCP have not necessarily included patients and carers, although this is obviously the preferred option (see personal reflection from the Adelaide Hills Project). The GAPS model saw back to back case conferences undertaken within a short period of time, which was successful in this setting, but not seen as feasible by some teams.

Box Four: Family centred care for Indigenous Australians

Excerpt from 'Providing culturally appropriate palliative care to indigenous Australians'

"Family centred care is important to empower both patient and family to state their needs. Consideration may need to be given to those with a different cultural heritage where family networks can be extensive, and members who need to be involved in the conference may need to be brought from a distance. This can delay decision making considerably. Some indigenous Australians may also not feel it is their place or their right, or they may feel shame to question medical staff. "Indigenous people do not feel comfortable about saying how they feel or questioning the system and require a person to help inform and advocate in certain situations". **Aboriginal Health Worker**
http://www.health.gov.au/internet/wcms/publishing.nsf/Content/palliativecare-pubs-indig-resource.htm

Multidisciplinary team review

The effectiveness of each team, and arguably the team meetings as well, needs to be continually evaluated to ensure that all the relevant disciplines are able to participate in the clinical management of patients[46]. Issues of time management, for example, could also be addressed, as restricted resources also require efficient practice[15]. Recording and monitoring of the outcomes of MDT meetings would highlight any problems or unmet needs, demonstrating how effective in practice a MDT approach could be, justifying the costs of such meetings in terms of the resulting benefits to clients[47].

Measurement and feedback can also be a useful form of communication when team relationships become strained[9]. With differing occupational cultural values, and other stressors arising out of the varying organisations, conflict within teams is perhaps inevitable[1548]. It affects team functioning only if it is not dealt with and can be managed to enrich the program as long as it is not allowed to become destructive[915].

Some teams have defined outcome criteria and measure their performance against these criteria[15]. Any goals set for the meeting need to be reviewed and updated, with a view to measuring achievements. The questions that could inform any review would ask: What does success look like? How does the MDT meeting make the team members work differently? What is the impact on their practice? What is the outcome for the patient?

Personal reflections of RPCP experiences with MDT meetings

The following are from some of those involved with the RPCP, and give differing views and experiences on these meetings.

Establishing a MDT Meeting and case conferencing in the Adelaide Hills

A main aim was to engage GPs in Palliative Care and facilitating a clinical multidisciplinary Palliative Care forum was an ideal way to do this. The end result would be increased communication, and a better understanding for them of each of the Allied Health Services and how they work together. It would also help to address low referral patterns of GPs to Palliative Care Services, the issue of the difficulty that the nurses had in getting hold of GPs to discuss patient issues, and looking at how to best collaborate in patient care.

Establishing a meeting sounded fairly straightforward in theory, but in practice was difficult to initiate. Time and work constraints for all disciplines was an issue, even for something as simple as deciding what day and time to hold the meeting. Suddenly the ad hoc referrals and meetings in the corridor didn't seem so bad! Even with the support of the EO of the Health Service in meeting individually with team leaders, many chose not to attend.

Case conferencing was proposed as a means of discussing patient care, engaging GPs via teleconference. However, there was great difficulty in demonstrating the value of case conferences, as unfortunately the rationale behind organising them within this forum was never fully understood or appreciated, despite repeated attempts to explain.

The nurses preferred family meetings in the home, with patient and carer present. While this is the ideal scenario, it occurred only occasionally and did not engage as many GPs in multidisciplinary care planning as could be facilitated via the proposed process. The role of the GP Advisor in these meetings was never fully realised, and necessitated a change of direction and focus for the role.

Meetings were attended regularly by Occupational Therapists, the nursing representative from the local Hospital, the Social Worker, Project Officer, GP Advisor, Palliative Care Nurses, Bereavement Co-ordinator and Palliative Care Volunteer Coordinator. Community nurses attended when able, as did students from different disciplines.

Deb Rawlings
Palliative Care Project Manager, Adelaide Hills DGP

Running an MDT Meeting in Coffs Harbour

A GP advocate attends each meeting, with up to 2-3 other GPs attending, (usually via teleconference for their patients' case), but GP participation is variable. There are many regular supporters of the meeting; however, consideration had been given to changing the meeting to lunchtime which more GPs would have found accessible. Unfortunately, the Oncologist is only available from 8-9am, and in the absence of a palliative care specialist this input is considered vital. If circumstances change, the meeting time will be reviewed.

When the team reviewed the terms of reference, they changed the chairperson from the nurse to become a shared role between the hospital chaplain and Palliative Care Social Worker, which has worked well. Part of the review included an undertaking by the team to case conference 70% of new admissions. Giving regular feedback in the form of graphs has been helpful.

Getting started on time and keeping each case to 15mins is important. Using the time well and having an agreed structure and consistency to the discussion helps with routine and flow. The meeting coordinator takes notes and does the letters; with GPs responsible for claiming an EPC item number if they participated. At the end of the 15 minutes, the discussion content and plan are read out to ensure it accurately reflects the case discussion which is a good way to summarise and to move on.

An information sheet is provided to patients to ensure they understand the purpose and membership of the MDT. The local private hospital is looking at including MDTs in the routine consent obtained from all patients. At present for Residential Aged Care Facility (RACF) residents, consent by the resident or substitute decision maker consent is obtained and documented.

The specialist MDT meeting doesn't involve patient/family but this may be incorporated over time. Some RACF have involved resident and families but it is not a regular occurrence. The staff tend to have a meeting with the resident and family, and then care staff, separately in preparation for the MDT.

Julie Mildenhall
Rural Palliative Care Project, Mid North Coast NSW DGP

The West Vic Experience

Strategic directions for rural palliative care, especially in the area of service enhancement, are state driven. WVDGP was unsuccessful in implementing the GAPS model of multidisciplinary team meetings as this did not match existing practice.

The project managed to have one team meeting that included the patient, carer, GP, practice nurse, palliative care nurse and palliative care specialist. The meeting was a two hour case conference. The GP found this a very valuable experience as he was retiring and was concerned about ensuring that the patient would be managed well. The practice could only be remunerated for a case conference. The palliative care team and the specialist, though committed to the process, found it impractical in terms of capacity and time. This is in the context that the palliative care team covers a large geographical area; they have proven methodologies that include the specialist meeting and reviewing the patient, and the involvement of the multidisciplinary team.

"The Griffith model was one intervention to achieve the palliative care approach and service enhancement. Multidisciplinary team (MDT) meetings are a tool (a gold standard tool) but not the only mechanism to disseminate the palliative approach and promote service enhancement, and we had to identify other interventions to achieve this goal. Divisions need to be outcome focused on what is achievable in their area. MDT meetings may, or may not, be a mechanism to achieve this."
Jane Measday
Palliative Care Project Manager, West Victoria DGP

Primary Health Care Team – Case Conferences in South Burnett (Queensland)

One of the key highlights of RPAC Program was the implementation of case conferences across the region. Case vonferences were used as a mechanism to engage health professionals and services providers, to coordinate care for palliative patients and to ensure communication of pertinent information in a suitable environment. All stakeholders agreed to a single set of policies, procedures and clinical guidelines for the management of patients registered in the RPAC Program.

RPAC Program Coordinator extensively consulted with local GPs to identify the most appropriate method of facilitating Case Conferences, while also raising the Program's profile and increasing the level of GP/stakeholder involvement. During Program implementation the Enhanced Primary Care Items were changed under new Medicare Initiatives into Chronic Disease Management Items (CDM). RPAC was able to meet the requirements for issuing a CDM item that allows the GP to be remunerated for the time spent attending case conferences. GPs have indicated that this is not the primary driver for participation. Case Cconferences have encouraged a coordinated approach to clinical care among service providers. A single management plan is now considered essential. This mechanism has also assisted with meeting National Palliative Care Standards for patient care within the South Burnett region.

Initially referrals were instigated by GPs, until benefits and engagement were recognised by the majority of service providers in the region and broadened the referral base. In conjunction with this, while referrals to RPAC are generally from within the local community, a number of referrals have also been received directly from Metropolitan Centres.

Case conferences are attended by GPs, Specialist Palliative Care Nurse, Directors of Nursing, Domiciliary Nurses, Community Health Nurses, Social Worker, Volunteers and Pastoral Care Workers. There were issues with limited availability of time that impeded local Hospital staff from attending; as such a Case Note file with current public patients was made available on the ward and in Accident & Emergency sections of these Hospitals.

It is imperative that this multidisciplinary approach continues, to allow for holistic planning – reviewing issues of not only symptom control but also financial, psychosocial and family care needs. Case Conferences have been one of the major successes of the RPAC Program with a strong buy-in from all sectors of the health fraternity – with monthly Case Conferences held in both Kingaroy and Murgon. Fifty-eight (58) Case Conferences have been facilitated through RPAC over a twenty-two (22) month period, with seventy-eight (78) palliative patients provided with individual assistance through this mechanism and seventy (70) EPC/CDM Medicare Items issued to GP practices. Thirteen (13) patients passed away or were transferred to a RACF before reviews could be conducted at Case Conferences. The purchase of teleconference phones allowed GPs to participate when unable to attend in person.

RPAC coordinated case conferences over the Program's duration; the Domiciliary Service has assumed the coordination role as part of an existing full time position. The coordination role involves:

- receipt of referrals
- notification to the referee of acceptance into the RPAC Program and confirmed time for GP to attend or receive teleconference call
- reviewing Case Notes for disseminating to stakeholders – taken by participating Link Nurse
- providing files for dissemination by SQRDGP Liaison Officer.

Southern Queensland Rural Division of General Practice has implemented a short-term sustainability plan, developed by stakeholders, and has funded 2 GPs to Chair meetings and provided administrative assistance through the Liaison Officer. Meetings have continued on a monthly basis but there has been a steady decline in the number of referrals.

Linda Rudorfer,
RPAC Coordinator, SQRDGP

GP Adviser Role within the Adelaide Hills Palliative Care Project

"The general consensus today is that palliative care services are best delivered within a multidisciplinary format. An integral part of the multidisciplinary team is a medical practitioner. In a large hospital setting, this works more easily with full time salaried medical practitioners, but a community setting poses difficulties with this model of care. Medical practitioners involved in palliative care in the community are usually local GPs in private practice, working on a fee for service basis.

Two teams often occur simultaneously, but are often not well coordinated. One of these teams is the community health multidisciplinary team, and the other is a team comprising the patient, the carer, the GP, and the community nurse. The GP Adviser to a community palliative care service or to a palliative care project has a role to link these two teams.

A GP Adviser is ideally a local GP who has:

- a special interest and expertise in palliative care
- a good relationship with local allied health services and community nursing
- a mutually respected working relationship with other local GPs
- an interest in teaching
- a knowledge and good relationship with specialist palliative care services.

A GP Adviser is able to attend the multidisciplinary meetings, and bring a GP perspective to the discussion. Medicare funding, through case conferencing and care planning, now offers the opportunity for GPs to be better remunerated for treating patients with complex medial conditions, such as palliative care patients. Care planning and case conferencing can be facilitated by a GP Adviser within the multidisciplinary meetings, and the GP Adviser is ideally placed to chair these conferences. These can be teleconferenced, resulting in better outcomes for the individual patient, in addition to enhanced relationships between local GPs and allied health. The case conferences also offer educational opportunities for the GP.

Following a case conference, a GP Adviser is well placed to follow up clinical issues with the GP concerned. This can be in the form of clinical handouts, guidelines, or references. A GP Adviser can also connect the GP with the appropriate palliative care specialist or service, if necessary. A GP Adviser can also be involved with more structured educational activities, such as CPD activities for local GPs, and talks to hospital nurses and link nurse groups and so on. The GP Adviser can also be involved in community educational activities.

The success of this model will vary between regions. The introduction of a GP Adviser within a community health service is a significant change of work practice to the service, and is potentially confronting. Patience and mutual respect is required. Equally, if the GP Adviser does not have a good relationship with other local GPs, the service model will not work. Any professional tensions or sense of competition between GPs would be a major difficulty.

During the 3 year project just completed in the Adelaide Hills, many features of the model described worked very well. The most disappointing aspect from my point of view was the difficulty the multidisciplinary team had in embracing the concept of case conferencing. The team was more familiar with occasional case conferences in the patient's home, with the GP leaving the surgery to attend. Regular teleconferencing was not generally adopted, and I believe many of the potential positive outcomes of the project were lost as a result of this.

Other aspects of the GP Advisers role, in particular educational activities and multidisciplinary meetings, worked sufficiently well for me to believe a GP Adviser can have a positive contribution to a community palliative care service".

Dr Graham Hughes,
GP Adviser, Adelaide Hills Palliative Care Project

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