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Grampians Regional Palliative Care Team

"HEY SPIRO, YOU'RE IN GANDARRA. IS EVERYTHING OK?"

A week or so after beginning my sabbatical in Palliative Care Medicine, I received an email from Stacey Vincent asking me, "Why are you in Gandarra?" (*paraphrasing).* Although all humans have a beginning, middle and a terminal end, the last time I checked I'd yet to be formally diagnosed with a terminal illness to officially be there as a patient, (although with the current COVID restrictions, I'm overdue for my inevitable prostate exam all 50+ years old males can look forward to). Having worked at BHS for more than eight years, I was entitled to take a 6-month sabbatical from the Emergency Department to pursue an area of clinical interest. With a personal interest in death, legal drugs, spirituality and psychedelics, I thought I would give Palliative Medicine a go, and attempt the Diploma of Palliative Medicine at the same time.

My medical career began pre-Y2K. A graduate of University of Melbourne, Austin-Repat alma mater 1990, I completed my internship and HMO years predominately at the Austin Hospital, with sojourns to Maroondah and Box Hill.

Early in my medical career, I was drawn to the raw humanity exposed in the Emergency Department (ED) ward. I was attracted to the drama, the vulnerability and implicit trust patients placed on the medical and nursing staff. Ultimately, nobody makes an appointment to come to ED, so most patient-doctor relationships develop hastily and often under some duress; something I relish and am good at. As a consequence, I endeavoured to train as an Emergency Physician.

In 1995 I became an advanced trainee with the Australasian College for Emergency Medicine (ACEM). Spending most of my training at the Austin Hospital ED, I rotated through the Austin Acute Spinal unit, the Royal Children's Hospital and the Victorian Institute for Forensic Medicine as a 'Police Surgeon' registrar. In the year of the Sydney Olympics (and Cathy Freeman's 400m Gold Medal race, in a body suit that only she could pull-off), I became a fellow of ACEM.

Shortly afterwards, my young family and I moved to New Zealand. I worked in Palmerston North (witnessing the destruction of the 2nd Twin Tower, in New York, on the TV whilst organising a helicopter evacuation of a subarachnoid haemorrhage patient to the Wellington Hospital), and then Wellington Hospital Emergency Department for nearly three years; returning to Australia in 2003. I worked in Warrnambool for a year, and then Ballarat Heath Services (BHS) since late 2004. My family moving to Ballarat in 2007. August 2020 saw the completion of my 16th year at BHS ED.

In my 20-year career as an Emergency Physician I've figured on a number of home-truths. Namely, patients demand two main qualities from their health professionals:

1) fidelity to their profession; and
2) compassion for their predicament and vulnerability.

The first is dependent on the healthcare provider's efforts; the second is greatly impacted on by the available funding and resources, especially within a stressed public healthcare system.

The ED has suffered (and continues to suffer) from an identity crisis stemming from its origins as the 'casualty ward' of the hospital: a place you come to get stitches and plasters; a tetanus shot; and where you must negotiate past the junior doctor to see the 'real' doctors from upstairs.

Over the past 35+ years, ED has evolved into a specialty that manages specific and unique conditions, such as resuscitation, toxicology, multi-trauma and the provision of time-sensitive medical conditions. In recent times, modern EDs operate within over-subscribed and under-resourced public health systems that frequently force them to be the main 'safety net' for many patients who deteriorate at home waiting to be seen in outpatient clinics; surgical waiting lists; and even admission to specialty sub-acute wards such as Gandarra.

The Emergency Physician frequently becomes the 'jack-of-all-trades-and-master-of-none'. The majority of patients attending the BHS ED are elderly, with significant complex co-morbid conditions, which not infrequently include terminal conditions requiring palliative medical expertise and sensitivity. There have been at least half a dozen times in my 16 years at BHS where patients have attended ED to receive a palliative-level care for their symptoms for the first time ever, often within the few short hours prior to their

death. The need to provide high quality palliative care to such patients has been a major motivation for me to seek formal training in Palliative Care medicine.

On a personal note, (and because I've only written approx. 650 words of a 1,500-word article), I have an interest in the pathophysiology of chronic disease, as well as the pharmacology of the drugs used to treat those conditions. Understanding the 'science' of medical treatment is very important, especially when traversing complex medical conditions such as diabetes, stroke, heart disease, cancer and pain etc. BUT, equally as important, in my opinion, is the influence of the 'art of medicine' on disease expression and healing; the 'placebo effect' (having its own Wikipedia page) being an extreme (and largely unethical) manifestation.

How a healthcare provider approaches and engages a patient, and their loved ones, during their most vulnerable time, can greatly influence the patient's wellbeing; even when the outcome results in the patient's death. It has been my experience in the ED that a genuine, honest and compassionate encounter with a patient in extremis, even when in the dying process, has frequently yielded more anxiolysis than boluses of midazolam could ever have achieved alone, (although knowing the right dose of midazolam is a bonus). Experiencing the patient's trust in me as their provider of medical care (as a patient), and feeling respected by me (as a fellow human), has always yielded the most memorable moments of my medical career, and the highest degree of job satisfaction.

As an Emergency Physician, I've become more aware of the influence consciousness, psychological factors and spirituality have on particular disease processes. In particular, I'm interested in research emerging over the past 5-10 years involving cannabis, ketamine and psychedelics in the management of specific conditions of the 'soul', such as drug addiction, PTSD, grief and other 'psychiatric' conditions.

Within the Emergency Medicine world, research is emerging that ketamine may confer long-term suicide prevention (link to article). Although evidence is conflicted, CBD and THC derivates may eventually be proven useful in the treatment of chronic and acute-on-chronic pain. Within the Palliative Care literature, I am excited by research published by the Center for Psychedelic and Consciousness Research (John Hopkins University) and the Centre for Psychedelic Research, Imperial College London, utilising psychedelic agents such as psylocibin (the active component of 'magic mushrooms') for end-of-life anxiety and existential re-alignment; research ear-marked for replication by St Vincent's Hospital Melbourne Palliative Care Unit in 2020 (link to article).

As an Emergency Physician, I believe there are elements of Palliative Care with significant crossover with Emergency Medicine. Both specialties frequently deal with people at the end of life; often with severe disabling symptoms; and complex psychological, spiritual and existential needs.

My hope during the six months is to bring skills back into the ED that seek to treat palliative patients (and their loved ones) as persons with end-of-life needs, and not just a 'diagnosis in cubicle 13'. In addition, I intend to 'test the waters' with regard to completing the Fellowship in Palliative Medicine through the RACP, although that is a work in progress at this stage.

Having returned to ward-based registrar work [and those dreaded drug charts] for the first time in over 20 years, I've eaten enough humble pie the past few weeks to make re-writing drug charts a major substituted 'food group'. I'm hoping at 53 this old-dog can still relearn old tricks and go on to complete the fellowship, because I really enjoy the medicine.

Well, I best be making that appointment with my GP, although I guess telemedicine and a prostate check don't mix! :)

Cheers

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