PATIENT CENTRED MEDICINE

COMBINING THE ART AND SCIENCE OF MEDICINE

ACHIEVED BY INTEGRATING THE ETHOS AND SKILLS OF PALLIATIVE CARE INTO THE MAINSTREAM CURRICULA FOR DOCTORS AND NURSES

HISTORY

HSTORY OF PALLIATIVE CARE

Doctors expertise 70 years ago very limited.
But knew how to care for and help their patients.

1960s - Explosion of science and technology of medicine – ability to cure and artificially prolong life – often prolongs or causes suffering.
The excitement of this lead to Disease Centred Medicine replacing patient centred medicine.

Hospice Movement founded in late 1960's
therefore Palliative Care associated with incurable or life threatening illnesses
Suffering exists in all medical and surgical conditions
It is overdue to change the perception of Palliative care.

PALLIATIVE MEDICNE INSTITUTE

ESTABLISHED in 1998 FOR
THE TRAINING OF
DOCTORS AND NURSES
IN THE
EXPANDED APPROACH TO PALLIATIVE CARE

WHO DEFINITION OF PALLIATIVE CARE (abbreviated)

Active comprehensive care for:

The Physical, Emotional, Psychosocial
and Spiritual needs of the patient
and the family
with the aim of relieving suffering

FOR WHOM CURE IS NO LONGER POSSIBLE
FOR THOSE WITH LIFE-THREATENING ILLNESS

EXPANDED APROACH TO PALLIATIVE CARE

Active comprehensive care for the physical, emotional, psychosocial and spiritual needs of the patient and the family with the aim of relieving distress.

It starts at the moment of first contact with

ANY patient with ANY illness OR condition and continues for its duration(an hour,a day, week/s)

If and when cure is no longer possible, palliative care plays the major or the total role.

AWARENESS IS GROWING

- SUFFERING EXISTS IN ALL MEDICAL AND SURGICAL CONDITIONS
- NEEDS TO BE ADDRESSED FOR BOTH SCIENTIFIC AND COMPASSIONATE REASONS.
- THE OUTCOME OF ANY ILLNESS OR SURGICAL PROCEDURE AND ICU HAS BEEN REPORTED TO BE IMPROVED BY COMPREHENSIVE MANAGEMENT
- IT OFTEN SHORTENS HOSPITAL STAY
- COST EFFECTIVE.

TWO OTHER NGO'S WERE ESTABLISHED
UNDER THE INSTITUTE OF PALLIATIVE MEDICINE

1.THE CM JBG ACADEMIC HOSPITAL PALLIATIVE CARE TEAM

2.COMMUNITY ACTION – STREET BASED PRIMARY CARE MODEL

FUNDED BY THE GATES FOUNDATION

THE HOSPITAL PALLIATIVE CARE TEAM

Established in 2001 as an NGO in the CM JHB Academic Hospital.

Takes referrals from any ward or unit

The results prove the necessity of

the integration of the ethos and skills of Palliative Care into the management of all patients in any setting.

to ensure optimum patient management

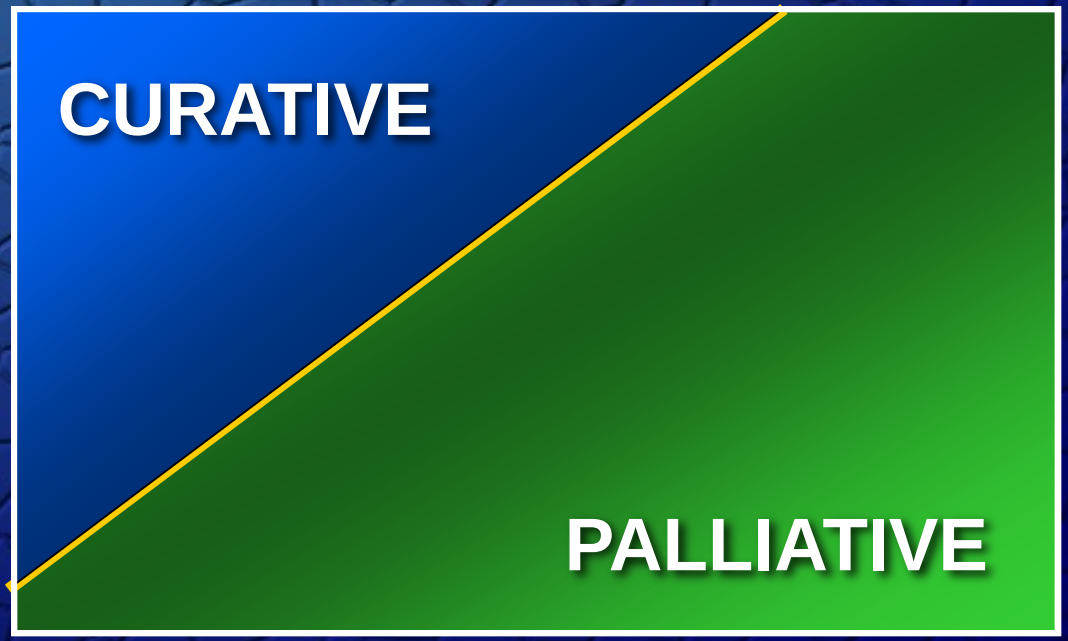
ie GOOD MEDICINE

TRAJECTORY OF CARE

Acute

Continuing pain
And/or suffering

Incurable
Terminal

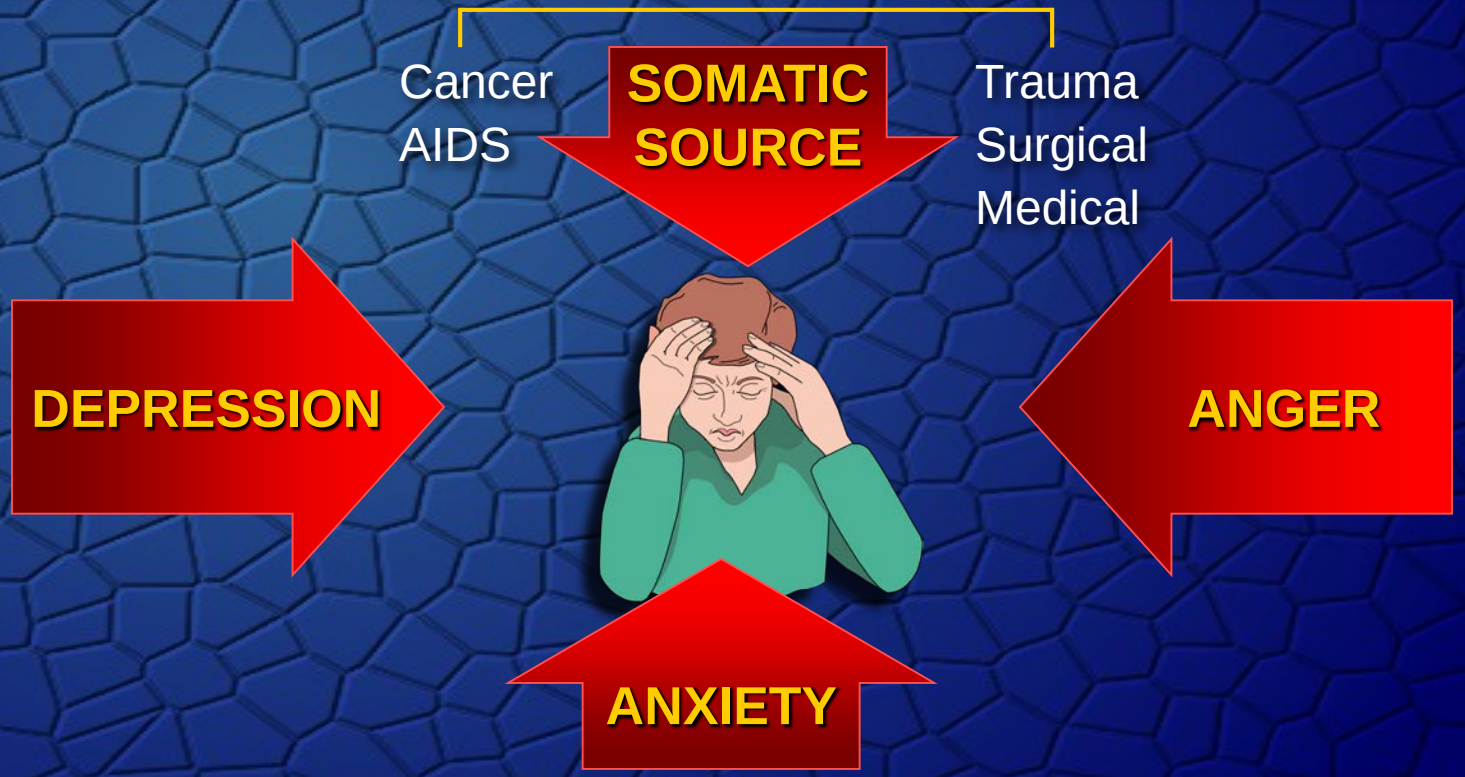


First contact With patient

Death

Integration of curative and palliative medicine

CONCEPT OF TOTAL PAIN



CONCEPT OF TOTAL PAIN

Cancer
AIDS

SOMATIC SOURCE

Trauma
Surgical
Medical

DEPRESSION

ANGER

Loss of social position
Loss of prestige and income
Loss of role in family
Chronic fatigue and insomnia
Sense of helplessness
Disfigurement

ANXIETY

Fear of hospital
Worry about family
Fear of death
Spiritual unrest

Fear of pain
Family finances
Loss of dignity or body control
Uncertainty about future

Bureaucratic bungling
Friends who do not visit
Delays in diagnosis
Unavailable doctors
Irritability Therapeutic failure

SKILLS AND ETHOS OF PALLIATIVE CARE

PALLIATIVE CARE IS PATIENT CENTRED
Medical and nursing students should be taught the basics within their main stream curricula or after qualifying even if many years later.
Includes Full History and Full examination which makes 75 % of diagnoses and limits expense of unnecessary expensive blood and Scans
A SPECIALIST PALL IATIVE CARE TEAM MUST BE AVAILABLE FOR PROBLEMS

ETHOS

A Doctor/Nurse/Patient relationship –
Patient-orientated not disease-orientated

- Believe the patient
- Listen to the patients narrative
- Talk to the patient.
- Assess the emotional and psychosocial state of the patient.
- Non judgemental attitude.
- Talk to the family .

PALLIATIVE CARE TEAMS ARE NECESSARY IN ALL HOSPITALS

ideally a multidisciplinary team

Palliative care trained nurses &doctor

& dedicated social worker.

physiotherapist and relevant health professionals to be available for the team when necessary

EXAMPLES OF THE MANY RESULTS OF THE HOSPITAL PALLIATIVE CARE TEAM

Diagnosis in ward	Team Findings	Ward Prescription	Team Prescription	Results
Post traumatic neuralgia	Neuropathic pain Not nociceptive pain.	Doxyphene 2 tabs tds Panado 2 tabs tds	Stopped doxyphene Give Amitriptylene 50mgs nocte & Carbamazepine 200mgs tds	Patient was relieved after 48 hours
Osteoarthritis of rt knee	Severe pain in rt arm where patient was being injected with pethedine and epigastric pain	Pethidine IMI into rt arm 4 hourly and Brufen 400mgs tds	Stopped Pethidine IMI Oral Morphine (10mgs/5ml) then changed to MST 30mgs bd when dose required established Lactulose 20mgs nocte Ulsanic 10mls tds	Patients pain improved in 24 hours. Discharged home.
RVD (HIV/AIDS) Sore mouth For pain control and referral to hospice	Sores in mouth, pain confused	Tramal 50mg po tds Clexane 20mg s/c dly AZT 300mg dly 3TC 75mg dly EFV 600 mg dly	Stop Tramal Give morphine syrup 10mg/5mls 4 hrly Panado syrup 5mls 8 hrly Lactulose 20mls nocte Chlorhexidine mouthwash tds	Pain controlled Mouth sores healed No longer confused Discharged home.
Ca Pancreas with liver mets. CVA For symptom control – nausea and vomiting	++constipated, nausea and vomiting	Coversyl 4mg daily MST 20 mg po bd. Morphine Syrup10 mg/5ml prn	Lactulose 20mls po nocte Senokot 2 tabs nocte	Patient passed stool Nausea and vomiting stopped

	Diagnosis + Reason for referral	Ward Prescription	Team Prescription	Results
Orthopaedic	Fracture of humerus, Referred for pain control.	Doxyphene 2tds Pethidine 50mg IMI 6hrly	SEVERE PAIN IN BOTH ARMS FROM IMI PETHEDINE. PAAOTENT NEVER STOPPED CRYNG. Stopped Pethidene & Doxyphene. Prescribed Morphine syr 10mg/5mg 4 hrly then change to MST 20mg BD when know dose of morphine reqd. with Morphine syr for breakthrough pain only. Lactulose 20mg nocte Panado 1g qid for headache	Pain controlled in 24hrs PATINET NEVER STOPPED SMILING and patient discharged home
Gastro-enterology Clinic	Ca Oesophagus Referred for Pain Control	DF118 30mg 8 hrly (Step 2) Doxyphene 2 tds, patient on assessment still had pain score 8/10	Stopped DF118 & Doxyphene Prescribed Morphine syr 10mg/5ml 4 hrly Lactulose 20ml nocte	Pt was discharged home on telephonic follow up. Pain was controlled & she will see the Team on her next visit.

Ward of Referral	Diagnosis + Reason for referral	Ward Prescription	Team Prescription	Results
Orthopaedic	Septic Arthritis Pain score 8/10	Ridaq 25mg Prexium 4mg dly Maxolon 10mg tds NO PAIN MEDICATION PRESCRIBED	Retained ward prescription Added MST 30mg BD Morphine Syrup 10mg/5ml for breakthrough pain Indomethacin supp 100mg tds Lactulose 10mg nocte	Patients pain score improved from 8/10 to 4/10 after 24hrs Patient very happy.
Medical Ward	Parkinsons disease Sacral Bed Sores	Madopar 1/2tab tds Tryptanol 25mg nocte Normal Saline dressing	Patient was elderly and had an offensive bedsore. Prescribed retain Madopar & Tryptanol Add Flagyl 400mg tds p.o. Flagyl dressing on bedsore. Paracetamol 1g qid	After 2 days the wound was less offensive & beginning to granulate. Pain relief obtained Patient transferred to Mother Terressa Hospice

LEGAL AND ETHICAL ISSUES

Ignorance of what is legal, moral or ethical is often a cause of inadequately relieved suffering