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
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 MEDICINE 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 APPROACH 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

Integration of curative and palliative medicine

Death

CURATIVE

PALLIATIVE

Integration of curative and palliative medicine

Integration of curative and palliative medicine
CONCEPT OF TOTAL PAIN

SOMATIC SOURCE

Cancer
AIDS

DEPRESSION

ANXIETY

Anger

Trauma
Surgical
Medical
CONCEPT OF TOTAL PAIN

SOMATIC SOURCE
- Cancer
- AIDS
- Trauma
- Surgical
- Medical

DEPRESSION
- Loss of social position
- Loss of prestige and income
- Loss of role in family
- Chronic fatigue and insomnia
- Sense of helplessness
- Disfigurement
- Fear of hospital
- Worry about family
- Fear of death
- Spiritual unrest

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

ANXIETY
- Fear of pain
- Family finances
- Loss of dignity or body control
- Uncertainty about future
- Spiritual unrest
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 PALLIATIVE 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
<table>
<thead>
<tr>
<th>Diagnosis in ward</th>
<th>Team Findings</th>
<th>Ward Prescription</th>
<th>Team Prescription</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post traumatic neuralgia</td>
<td>Neuropathic pain</td>
<td>Doxyphene 2 tabs tds</td>
<td>Stopped doxyphene Give Amitriptylene 50mgs nocte &amp; Carbamazepine 200mgs tds</td>
<td>Patient was relieved after 48 hours</td>
</tr>
<tr>
<td></td>
<td>Not nociceptive pain.</td>
<td>Panado 2 tabs tds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Osteoarthritis of rt knee</td>
<td>Severe pain in rt arm where patient was</td>
<td>Pethidine IMI into rt arm 4</td>
<td>Stopped Pethidine IMI Oral Morphine (10mgs/5ml) then changed to MST 30mgs bd</td>
<td>Patients pain improved in 24 hours. Discharged home.</td>
</tr>
<tr>
<td></td>
<td>being injected with pethidine and epigastic pain</td>
<td>hourly and Brufen 400mgs tds</td>
<td>when dose required established Lactulose 20mgs nocte Ulsanic 10mls tds</td>
<td></td>
</tr>
<tr>
<td>RVD (HIV/AIDS) Sore mouth</td>
<td>Sores in mouth, pain confused</td>
<td>Tramal 50mg po tds</td>
<td>Stop Tramal Give morphine syrup 10mg/5mls 4 hrly Panado syrup 5mls 8 hrly</td>
<td>Pain controlled Mouth sores healed No longer confused Discharged home.</td>
</tr>
<tr>
<td>For pain control and referral to hospice</td>
<td></td>
<td>Clexane 20mg s/c dly</td>
<td>Lactulose 20mls nocte Chlorhexidine mouthwash tds</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>AZT 300mg dly</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3TC 75mg dly</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>EFV 600 mg dly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ca Pancreas with liver mets.</td>
<td>++ constipated, nausea and vomiting</td>
<td>Coversyl 4mg daily Mast 20</td>
<td>Lactulose 20mls po nocte Senokot 2 tabs nocte</td>
<td>Patient passed stool Nausea and vomiting stopped</td>
</tr>
<tr>
<td>CVA</td>
<td></td>
<td>mg po bd.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For symptom control - nausea and vomiting</td>
<td></td>
<td>Morphine Syrup 10 mg/5ml prn</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnosis + Reason for referral</td>
<td>Ward Prescription</td>
<td>Team Prescription</td>
<td>Results</td>
<td></td>
</tr>
<tr>
<td>--------------------------------</td>
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</tr>
<tr>
<td>Orthopaedic</td>
<td>Fracture of humerus, Referred for pain control.</td>
<td>Doxyphene 2tds Pethidine 50mg IMI 6hrly</td>
<td>SEVERE PAIN IN BOTH ARMS FROM IMI PETHEDINE. PATIENT NEVER STOPPED CRYING. Stopped Pethidine &amp; 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</td>
<td>Pain controlled in 24hrs PATIENT NEVER STOPPED SMILING and patient discharged home</td>
</tr>
<tr>
<td>Gastro-enterology Clinic</td>
<td>Ca Oesophagus Referred for Pain Control</td>
<td>DF118 30mg 8 hrly (Step 2) Doxyphene 2 tds, patient on assessment still had pain score 8/10</td>
<td>Stopped DF118 &amp; Doxyphene Prescribed Morphine syr 10mg/5ml 4 hrly Lactulose 20ml nocte</td>
<td>Pt was discharged home on telephonic follow up. Pain was controlled &amp; she will see the Team on her next visit.</td>
</tr>
<tr>
<td>Ward of Referral</td>
<td>Diagnosis + Reason for referral</td>
<td>Ward Prescription</td>
<td>Team Prescription</td>
<td>Results</td>
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</tr>
<tr>
<td>Orthopaedic</td>
<td>Septic Arthritis, Pain score 8/10</td>
<td>Ridaq 25mg, Prexium 4mg dly, Maxolon 10mg tds</td>
<td>Retained ward prescription, Added MST 30mg BD, Morphine Syrup 10mg/5ml for breakthrough pain, Indomethacin supp 100mg tds, Lactulose 10mg nocte</td>
<td>Patients pain score improved from 8/10 to 4/10 after 24hrs. Patient very happy.</td>
</tr>
<tr>
<td>Medical Ward</td>
<td>Parkinsons disease, Sacral Bed Sores</td>
<td>Madopar 1/2tab tds, Tryptanol 25mg nocte, Normal Saline dressing</td>
<td>Patient was elderly and had an offensive bedsore. Prescribed retain Madopar &amp; Tryptanol, Add Flagyl 400mg tds p.o. Flagyl dressing on bedsore. Paracetamol 1g qid</td>
<td>After 2 days the wound was less offensive &amp; beginning to granulate. Pain relief obtained. Patient transferred to Mother Terressa Hospice.</td>
</tr>
</tbody>
</table>
Ignorance of what is legal, moral or ethical is often a cause of inadequately relieved suffering.