Lessons from Family Medicine in the care of dying people
Lessons from our peers

• “Looking after dying patients is a very special part of family medicine care.”

• “We need to know what care our patients want and where they want it delivered. We need to be honest about what is happening and what is possible.”
Lessons from our peers

• “Doctors have the obligation and opportunity to manage their dying patients as they would hope to be managed themselves – with humanity.”

• “When the time comes that I am dying, I want my family doctor, as my advocate, by my bedside at all times.”
Fundamentals of palliative care

- Caring honesty
- Good communication
- Management planning
- Symptom control
- Emotional, social and spiritual support
- Counseling and education
- Patient involvement in decision making
- Support for carers

From John Murtagh’s “General Practice”
The six big questions our patients ask us …

• What is wrong?
• What can you do?
• Will I suffer?
• Will you look after me?
• How long will I live?
• Can I be looked after at home?

*From John Murtagh’s “General Practice”*
10 Golden Rules for Family Doctors

1. Honesty early
2. Know your patient’s history
3. Do a proper physical examination
4. Consider referral to an oncologist
5. Avoid precise prognostic predictions
6. Manage common problems
7. Think about differential diagnosis of symptoms
8. Visit at the time of death
9. Contact the family soon after a bereavement
10. Permit death with dignity
Three months ago Paul Haddad had a laparotomy for undiagnosed abdominal pain, constipation and weight loss. Carcinoma of the colon with widespread omental secondaries was found and a palliative procedure was performed.

His wife requested that Paul should not be told he has incurable cancer.

Paul’s condition deteriorated since the surgery and he is now aggressively complaining of being unwell with persisting abdominal discomfort and nausea.

What do you do?

Was this predictable?
Golden rule

“Honesty early”

- If asked by a relative not to disclose the diagnosis, explore the reason for the request.
• Genevieve Suleiman is 53 years old and presents with pain in her right shoulder.

• This fails to respond to NSAIDS and paracetamol. An xray is reported as normal.

• Genevieve was referred to an orthopaedic surgeon whose letter back to you says:

• “Repeat x-ray and bone scan disclosed a metastatic erosion from carcinoma of the breast from ten years earlier.”
Golden Rule

“Know your patient’s history”

• Anticipate the natural history of the disease

• This will permit earlier diagnosis of complications and allow earlier management
Clara Khoury is 58 years old and underwent laparotomy for an acute small bowel obstruction thought to be due to adhesions following a hemicolecctomy for carcinoma of the caecum 18 months earlier.

At operation Clara had widespread metastases. A short circuit anastomosis relieved the obstruction. The surgeon advised Clara and her family that “no further treatment would be of value.”

Clara made a surprisingly rapid recovery but presented three months later with a large hard lower abdominal mass.

She was referred for radiotherapy, the mass reduced in size and she survived a further 18 months.
Golden rule

“Consider referral to an oncologist”

• Medicine is rapidly changing, especially in cancer care.

• The referral may just be a simple phone call for advice.

• Our patients deserve the best possible care and knowledge of all treatment options.
• George Malouf is 62 years old and has inoperable carcinoma of the lung.

• He recently developed headaches and some personality changes.

• He has an appointment with his hospital oncologist next week. His daughter made a request for an ambulance to take him to his hospital outpatient appointment.

• The request was denied on the grounds that he was not sick enough.

• He died two days before the appointment.
Golden Rule

“Avoid making precise prognostic predictions”

• Even very experienced clinicians cannot predict the time of death

• But it is important to provide our patients with as much accurate information as possible
• David Bashir had a palliative choledochoduodenostomy twelve months ago for painless jaundice due to an inoperable carcinoma of the head of the pancreas.

• He now presents with epigastric pain and a palpable mass above the umbilicus. FBE showed a hypochromic microcytic anaemia of 9.6.

• At the request of his family doctor, John was reviewed by his surgeon who felt that no further treatment was indicate.

• You visit him at home. He complains of “vomiting black stuff” last night. He feels weak and dizzy and has a marked tachycardia. His pallor has increased and he looks very ill.

• What do you do?
• Management options were discussed with David and his family.

• David was transferred to hospital by ambulance where he received a blood transfusion.

• Gastroscopy the next day showed a benign gastric ulcer.

• He was treated with medication and discharged home.

• He survived another 18 months.
Golden Rules

“Manage common problems”

“Think about the differential diagnosis”

• Offer appropriate investigation and treatment options
• George Hanna is 88 years old and is being cared for at home by his family. His death has been expected for several days.

• You are phoned by his daughter during a fully booked clinical session.

• “Father is in a coma and looks dreadful. Can you come as soon as possible?”

• What do you think might have happened?

• What do you do?
Golden Rules

“Visit at the time of death”

“Contact the family soon after a bereavement”

• Relatives should not be expected to diagnose death

• Early contact with the family following bereavement is an important part of assisting family members
• Tony Kaddoura is a 68 year old man who, when first seen, had an inoperable carcinoma of the lung with metastases above the right clavicle.
• He deteriorated rapidly over the next month, becoming gravely ill but was cared for at home. Six days ago he developed an incomplete paraplegia.
• He was admitted to a local hospital and, after two days, was transferred to a teaching hospital for spinal decompression. Three days later he was transferred to a specialist cancer hospital for radiotherapy. He died the next day.
• His family are dismayed and bewildered about the three hospital admissions in five days, the number of clinicians involved in his care, the complexities of his treatments, the pain and distress he experienced and his eventual predictable death.
Golden Rule

“Permit death with dignity”

• In retrospect this was medicine gone mad. This man was dying.
• The basic error was a failure to identify his rapid downhill course, and a failure to stop and say “what are we really doing?”
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Cum scientia caritas

With scientific knowledge and tender loving care