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Gwyther graduated from UCT in 1979 with MB ChB. She worked as a GP in Zimbabwe and Somerset West and died for MFGP in 1993. She has been involved in hospice care on a voluntary basis from 1993 and obtained the Diploma in Palliative Medicine from the University of Wales, College of Medicine (UWCM) in 1998 and the MSc in Palliative Medicine (UWCM) in 2002. She has been active in palliative care training and education and in hospice development programmes. She is a member of the education sub-committee of the Hospice Palliative Care Association of South Africa (HPCA) and member of the HPCA Board. She is also a convenor for the postgraduate programmes in palliative medicine at the University of Cape Town.



**MARK
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Dr Hosking gained an interest and skills in palliative care at St Luke's Hospice, working as a full-time medical officer for 3 years. His chief interest is in family medicine but he plays an active volunteer role as medical officer to Helderberg Hospice in Somerset West, Cape Town.

Palliative care

Palliative medicine is a relatively new discipline in South Africa and the fact that palliative care has, until recently, been available only in our hospices has led to a view that palliative care is synonymous with terminal care.

However, it is clear that palliative care is appropriate from the moment of diagnosis of a life-threatening illness and can be effectively integrated into the care of the patient and family alongside disease-specific care.

There came a point in traditional oncology care when patients were told that there was nothing more to be done for them, and that they should enter a palliative care phase. This has given way to the more compassionate and true concept that there is always something more that can be done for our patients. Oncologists skilled in palliative care practise effective management of symptoms and recognise the value of holistic care. In HIV care it is particularly important that palliative care principles are instituted early in the management of the patient. Early in the illness the psychosocial support is vital as well as essential nutritional advice, lifestyle management, early recognition and aggressive treatment of intercurrent infections to maintain a good state of health for as long as possible.

Kathy Mngadi's article discusses the difficulty of diagnosing the 'terminal phase' of HIV illness; even a low CD4 count (under 50) can be reversed with good management of the illness.

Modern palliative care was established in the UK in the early 1960s through the efforts and example of Dame Cecily Saunders and her colleagues and became recognised as a full medical specialty in the 1980s in the UK. In South Africa, our first hospices opened in the early 1980s.

Palliative care is defined by the World Health Organisation (WHO) as an approach that improves the quality of life of patients and their families facing problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Palliative care:

- provides relief from pain and other distressing symptoms
- affirms life and regards dying as a normal process
- intends neither to hasten nor postpone death
- integrates the psychological and spiritual aspects of patient care
- offers a support system to help patients live as actively as possible until death
- offers a support system to help the family cope during the patient's illness and in their own bereavement
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated
- will enhance quality of life, and may also positively influence the course of illness
- is applicable early in the course of illness, in conjunction with other

therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

Palliative medicine is the study and management of patients with active, progressive, far-advanced disease for whom the prognosis is limited and the focus of care is the quality of life.

A unique feature of palliative care is that care of a patient and family is achieved through the working of an interdisciplinary team. Irene Tanchel's article gives a comprehensive description of the psychosocial aspects of palliative care.

Much has been written in medical journals regarding basic pain management principles. Good knowledge and clear understanding of pain control are essential for good palliative care, and Mark Hosking writes about the use of opioids in palliative care.

The other articles in this issue deal with difficult situations that may arise in the terminal phase of palliative care. It is at this stage that the management team may be faced with difficult decisions to make and it is useful to have a sound ethical framework on which to base these decisions.

Terminal restlessness is a challenging clinical problem to manage, not least the challenge of achieving calm and dignity in the patient's experience but also to attempt to achieve lucidity so that the patient continues to interact meaningfully with family and loved ones. David Cameron gives us a good strategy in approaching this problem.

Dyspnoea is a relatively common and always distressing symptom for patients, families and carers.

Sarah Fakroodeen describes interventions that can allow the patient some relief from this distress.

Palliative medicine has given us new insights into other medical problems including that of intestinal obstruction.

Traditionally the choices available to medical practitioners and their patients were surgery (which in advanced disease carries high risk of morbidity and mortality) or prolonged treatment with nasogastric tube and intravenous fluids. Marietta van den Berg describes the assessment and management of a patient with malignant intestinal obstruction.

In end-of-life care, medical practitioners are often faced with patients with reduced oral intake and the emotional issues that result within the family, as nourishment is a basic need. Hilton Horsley examines the current knowledge around the natural progression of illness and the question of whether there is a need for rehydration in end-of-life care.

The message in all palliative care is that the team managing the patient's care looks at the patient as a whole and formulates an indi-



vidual care plan for that patient and family. The situation and care plan are reviewed and revised as often as necessary bearing in mind the changes that occur in a patient's condition in the palliative care setting. In the general practice setting, doctors feel that they do not have a 'team' to assist in patient care but if they look around they will find that there are non-governmental organisations, community-based organisations or faith-based organisations which can be a part of a care team together with the GP and other professionals. The goal of palliative care is the best possible quality of life for patients and their families and this can be achieved through sound knowledge and implementation of palliative care skills.