The General Practitioner and the Care of the Dying Patient

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SUMMARY

As far as the general practitioner is concerned, the care of the dying patient can begin at birth, or even earlier.

Important aspects of treatment at the deathbed of the aged patient are discussed in broad outline, as are the psychological aspects of terminal illness and the alleviation of pain and discomfort.

S. Afr. Med. J., **48**, 708 (1974).

For everything its season, and for everything under heaven its time:
a time to be born and a time to die;
a time to plant and a time to uproot;
a time to kill and a time to heal;
a time to pull down and a time to build up;
a time for mourning and a time for dancing;
a time for silence and a time for speech.

Ecclesiastes, chapt. 3, i-vii

Of all the ways of dealing with death, the one most surely doomed to failure is the attempt to ignore it.[1] Part of the picture is ugly, and part of it is painful, but a great deal can be done to mitigate the suffering which accompanies terminal illnesses. We are afraid to be frank with those who are dying because we do not wish to make it more difficult for them. Yet we need this discussion to help them.

The general practitioner has to deal with dying patients in all stages of life.

A TIME TO BE BORN

Death may occur before birth *in utero*, for example. from erythroblastosis or toxaemia. It may be suspected if uterine growth stops, fetal movements cease, and heart tones become inaudible. It can be verified by ECG tracings and X-ray signs. Early diagnosis may save the fetus and prevent much heartbreak. The incidence of congenital malformation has not diminished and remains an unsolved problem. Death may occur during birth, possibly due to a tight, short cord around the neck. Checking the fetal heart every 5 minutes or more in the 2nd stage of labour will save babies. The general practitioner who undertakes obstetrical treatment must be prepared to deal with a dying infant, especially an asphyxiated one.

A TIME TO BUILD UP

Children from 5 to 14 years old have the lowest mortality. Death may occur in early childhood, e.g. from leukaemia and acute infectious diseases. A preventable cause of death is the inhalation of small objects, which can often be dislodged by turning the child upside down and administering a slap on the back. Peanuts in particular should be withheld from young children. Throttling may be prevented by not having cords or drawstrings around the necks of garments of small children.

Children may be afraid of dying. They should be given the opportunity to show their fears and to talk about them. The parents also need sympathy and understanding, and must have confidence in their doctor.

A TIME FOR DANCING

The years of adolescence and early adult life are the ones during which most has been achieved. Death in the age group 15 - 44 years is largely due to accidents and cancer. Drug addiction has lately also assumed great importance. Tuberculosis is no longer such a feared killer. Death in the relatively young is always particularly tragic—it is not the time to die and there is sorrow and resentment at the injustice of it.

A TIME TO DIE

From the age of 45 years, we are more familiar with death and dying—this may be the time to die. Cancer and diseases of the circulatory system are the chief causes. since diabetes and pernicious anaemia no longer take their high toll. Senescence as a cause of death has been described and the theories on death from senescence are varied, but it is generally agreed that there is a failure to replace damaged specialised cells.

We are faced with cases where the process of dying is inevitable, or thought to be so. A wrong diagnosis may be the result of attempting to save expense and discomfort for the patient.

The living body depends on the integrity of its 3 principal interdependent systems: circulation, respiration and innervation. Failure of any one of these will eventually cause failure of the rest.

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How then do we determine that a patient is dying? It may be defined as the stage of an illness in any one of these systems in which there is no hope of recovery or any prospect of improvement. Recognition of this is often easy — widespread cancer or investigations indicate from experience the course that the disease will take. Uncertainty comes when the diagnosis is not established or the course of the disease is uncertain. At times the powers of recovery are unpredictable, so that there are no universal criteria which can separate those with a fatal illness from those who will survive.[2] In practice there is generally a reasonable certainty.

A TIME TO HEAL

Let us separate these dying patients into two categories: the unconscious and the conscious.

The Unconscious Patient

The patient is in a state of insensibility without sensory impressions and subjective experiences. It may be transient or prolonged and may vary in depth from semiconsciousness (stupor) to coma. The cause will lie mainly in the innervation system—through suppression of neuronal function or damage to the brain directly, or secondary to increased intracranial pressure. In aged or cachectic patients coma is a frequent terminal event, regardless of the nature of the disease. A serious pitfall in practice is the alcoholic who has a head injury, when it must be remembered that he is not immune to other causes of coma. Over-sedation by drugs, or coma in the elderly from causes other than a stroke, may also lead to misdiagnosis.

After attending to the airway and the blood pressure a case history and identification is attempted. The patient is examined as a routine, catheterised and a full urinalysis and blood studies done. Gastric lavage, X-ray films and lumbar puncture are performed as indicated. Treatment is then directed at the cause determined.

The Conscious Patient

In cases of rapid death, e.g. cerebral haemorrhage, there is often little to be done. Cardiac massage may save a patient with cardiac arrest, and with cardiac arrhythmias the general practitioner must understand the correct treatment.

In cases of slow death we are faced with terminal illness and all its facets. It is usually not longer than 3 months that special care is required.[3] It is usually obvious to all that there is deterioration, and medical help is mostly palliative.

In order to relieve pain, distress, anxiety and depression, consideration must be given to prescribing drugs to dull perception, and measures to interrupt conduction by pain fibres from diseased parts to the brain, e.g. by regional block with local anaesthesia.

Severe pain can be controlled by the doctor's favourite drug. Persistent pain must and will always be relieved by the opiates. Morphine allays distress and causes addiction and we have to judge when to start. Mild pain can be controlled by the simple analgesics.

Physical discomfort must be relieved by drugs and other means, e.g. surgery, radiotherapy and blood transfusion. Attention must be given to breathlessness, nausea and vomiting, catheterisation by indwelling catheter, and prevention of bedsores. Odours must be prevented.

Insomnia may respond to soporifics, tranquillisers or alcohol, and these may also help relieve pain, anxiety and distress.

Psychotherapy may be necessary for patient and relatives.

A TIME FOR SILENCE AND A TIME FOR SPEECH

Should the Patient Know?

About one-quarter of patients already know that they are going to die. It is important here that the question 'Will I die?' may never be asked. Must we tell him if he does not ask? I think not. Suicide may be contemplated, or religious beliefs may weaken or strengthen. Cramond[4] believes that seriously-ill patients think of death as a possible relief, and welcome the chance to discuss this. Patients do not fear death as much as they do the process of dying. Saunders says 'I find that the truth dawns gradually on many of the dying even when they are not told.'[5]

Do the Relatives Know?

It is my experience that if those who care for a dying patient know, their care is not what it should be because they fear being questioned. Even doctors may be so plagued and this may bring about a barrier between relatives and friends and the patient at a time when he needs them most. Hinton[6] says that if we do not care adequately for the dying we have contributed to their misery.

Frances Wilson[7] maintains that the social isolation and loneliness of an old person are best treated by support given at this time of greatest grief, ensuring that they do not become cut off from their family and friends.

The relatives usually want only the best for the patient. A question frequently asked is whether the patient should be hospitalised. Gibson[8] points out that patients with terminal illness can be cared for in their own homes provided that they are thoroughly investigated and that home care has been agreed upon by the patient and his family. In hospital the patient is confronted with others like him and this may aggravate his depression. Home

care cannot always cope with all the complications and hospital care is easier, especially towards the end.

The relatives may not agree, of course. Thorough and frequent communication between the doctor and the patient and the relatives is of great importance.

A TIME TO KILL

As regards euthanasia I agree with the BMA Panel of 1970 which stated that what was needed was not legislation but more resources for the care of the elderly and chronically sick, and a change in attitude towards them. We cannot accept the responsibility of such legislation, as no adequate safeguards can be provided. The report says that to be a trusted physician is one thing but to appear as a potential executioner is quite another.[9]

A TIME TO PLANT AND A TIME TO UPROOT

We are at present, and will even more in the future, be faced with the question of providing organs for transplantation. We must acquaint ourselves with the law in this regard.

A TIME FOR MOURNING

Medicolegally

There is the importance of the dying declaration when laws regarding hearsay evidence may be waived, as the dying declaration is always hearsay. The requirements are that the patient must have died; the declaration is permissible in certain criminal cases such as murder; the declarer must have known that death was imminent; it must be complete; and the declarer must have been a competent witness had he lived.[10] In regard to these declarations, the doctor may be summoned to give evidence.

The Doctor's Part

In this situation between a doctor and his patient the factors involved are: their relative ages, the patient's will to live, a full realisation of the situation, the presence of reason on the part of the patient, the doctor's experience of deathbeds, and their personal relationship.

One of the important requisites of a good doctor is psychological balance and emotional stability. He dare not be caught in a web of emotions, because he may be needed to save another life and his diagnostic acumen may be affected. Let us take the example of the middle-aged general practitioner and the middle-aged dying patient, acquainted but not intimate friends. The doctor will do his duty towards the patient, even in these last moments, to prevent death if possible. The patient can be expected to want to still live and he expects help. How constant is the doctor's approach and treatment of dying patients? Routine treatment can be ruled out, and after death the drama of the bedside is soon forgotten, but we must remember that the deceased did not want to die. What did he desire before death? Did we come up to his expectations? Is the doctor concerned with this, and is he satisfied that his diagnosis and decisions were correct? Or can it be that he accelerated the moment of death, or caused it, by wrong diagnosis?

We must make honest and objective observations of our dying patients from time to time to refresh our memories, so that, if there was a shortcoming on our part, we can prevent similar mistakes. This will relieve our consciences. We are all human, and all have our appointment with death. What will we expect from the doctors at our deathbeds? What we expect we must be prepared to give.

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