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## **Avoidable for whom? Hospital use at the end of life**

**Merryn Gott**

The worst global recession since the Second World War has focused international attention on ensuring efficient, and crucially cost-effective, health service usage. Given that most people consume the bulk of their lifetime health spend in the last year of life<sup>1</sup>, it is unsurprising that the use of health services by people with palliative care needs has come under particular scrutiny. Indeed, a policy concern in many countries is reducing the number, and length, of acute hospital admissions amongst people who are at the end of life.<sup>2</sup> This is typically presented as a ‘win-win’ situation as a ‘good death’ is viewed as hard to achieve in a hospital setting. However, papers in this edition add to a growing body of evidence which indicates that, whilst this argument may appear both appealing and straightforward on paper, the realities of dying are much more complex and unpredictable.

Reyniers and colleagues<sup>3</sup> explore Belgian nurse and family physician perspectives on ‘what justifies a hospital admission’ at the very end of life. They focus attention on patient and family preference, an issue purportedly at the heart of palliative and end of life care provision. However, the role preference plays in end of life hospital admissions has not been researched in any detail. Participants reported that patients often request a hospital admission: they, and/or, their family caregiver often feel fearful and anxious about their impending death; the hospital environment can represent a familiar, safe space to them; and they are often not fully informed about the advanced stage of their illness, or ready or able to absorb that news. Ultimately, the health care professionals identified that they could not, and indeed believed they should not, prevent an admission if a patient requests it. In a similar vein, De Korte-Veroef and colleagues<sup>4</sup> examined with GPs their most recent patient’s final hospital

admission, reporting that 24% felt that this admission could have been avoided. However, again it was apparent that avoiding these admissions would not have been straightforward. Whilst we have tended to think that investing in community health services is the key to reducing hospitalisations, this study identified that services themselves could only have prevented approximately one quarter of the admissions. Rather, the authors concluded that what is needed is a better understanding by patient and family that death is imminent and that hospital can confer little clinical benefit.

Both pieces of research indicate that, for people who are nearing the end of their life and their families, going into hospital may be a logical step, even when it is not seen as ‘appropriate’ or ‘justified’ from a clinical perspective; even if hospital isn’t the preferred place of care, or indeed, death. This finding is in line with research which points to the role that medicalization plays in determining hospital use in the final stages of a life limiting illness. We are socialised into reacting to illness by seeking medical treatment.<sup>5</sup> For those who are not immersed in palliative care culture, hospitals represent ‘cure’, or at least a temporary reprieve from death. Unless policy-makers, and the researchers whose evidence they draw upon, acknowledge this wider social context and think only in terms of health services, attempts to prevent end of life hospitalisations are unlikely to succeed.

It is also important to acknowledge that there are wider motivations at play in attempts to reduce hospital use for people who are dying; this agenda is not driven merely by a desire to act in their best interests. Costs savings in this area are believed to be high<sup>6</sup>, although the shifting of costs onto family caregivers and voluntary community service providers has not been factored into current thinking. The role ageism plays in underpinning attitudes towards

appropriate hospital use has also not been considered, even though the majority of people dying with palliative care needs in acute hospitals are in their 70s and 80s. Rockwood and Hubbard<sup>7</sup> highlight why this is pertinent, arguing that rather than trying to adapt the hospital environment to accommodate these patients' complex needs, decision-makers instead 'want the frail old people to go away to some more appropriate place'. Similarly, a recent study exploring dignity in the care of older people in hospital identified an implicit ageism in the assumption of many staff they interviewed that hospitals are not the 'right place' for older people to be.<sup>8</sup> The authors argue that, as older people are by far the highest users of hospital services, it is the hospital environment that should be changed, not the patient group. This argument could equally be applied to the palliative care context. Maybe it is now time to spend less time thinking about how to keep people with palliative care needs out of hospital and more time thinking about how to make hospitals nicer places to be for people who are dying and their families.

How to do this is complex, particularly given the constraints of the physical environment and the wider context of resource limitations. However, one way to move forward is to think more critically about what individuals, and the palliative care community more widely, value about 'home' dying. In particular, I would argue that there is a need to extend this debate beyond thinking about 'home' in terms of a single discrete physical location. We have evidence to show that home is a malleable concept within an end of life context. Research has demonstrated the ways in which 'home' can become institutionalised when care is delivered there, as well as the converse – institutions such as hospitals and care homes can become 'homely' when the space becomes familiar and good, in some cases 'family-like', relationships are established with staff.<sup>9</sup>

Patient/professional relationship building has not been the focus of much research within palliative care, but a good example of an initiative with the potential to effect huge change in this area is the ‘#hellomynameis’ campaign initiated by Dr Kate Granger, an Elderly Medicine Registrar and terminally ill cancer patient. She observed that not all health professionals caring for her during an inpatient admission introduced themselves, but that so doing is important because ‘it is the first rung on the ladder to providing compassionate care and often getting the simple things right, means the more complex things will follow more easily and naturally’.<sup>10</sup> This seems like a very practical and sensible place to start thinking about how, in the challenge of optimising palliative and end of life care to which we are all committed, hospitals can become part of the solution, rather than ‘the problem’ we all want to avoid.

## References

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<sup>10</sup> <http://drkategranger.wordpress.com/2013/09/04/hellomynameis/>, accessed 9/04/2014.