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Preferred Place of Death

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With increasing technological advances, modern medicine has been accused of 'medicalising' many of our normal life events, in particular, the key ones of birth and death. While there are merits in the arguments both for and against such medical intrusions into what is sometimes considered natural milestones on the human journey, there is little data on people's preferences, and even less data on how these preferences may change with changing social attitudes and availability of support services. A welcome inclusion into medical literature, and especially to our local database, is the paper by Lee et al in this issue of the Journal (pg xxx), which describes the preferred place of care and place of death of cancer stricken in-patients at a local hospital. This is the first report of preferences of patients in Singapore who have been diagnosed with cancer. The latter is important because asking healthy people for their preference, whether of treatment or other choices, is fraught with inaccuracies, as people's perceptions change with changing life circumstances. An earlier study on the preferred place of death in Singapore by Merriman and Lau Ting[1] in 1986, was done on groups of medical students, nurses and doctors attending lectures on hospice care and geriatric care. On average, 73% of these indicated that they wanted to die at home. This proportion increases with increasing exposure of these healthcare personnel to the medical circumstances surrounding death.

There is great discordance between the place where terminally-ill patients spend the last phase of their lives, and their preferred and actual place of death. According to studies done in the UK in the late 1980s, 81% of patients with terminal illness spent most part of their last year at home[2]. In patients seen by a hospital palliative care team, 53% preferred to die at home, 29% at a hospice and only 14% wanted to die in hospital. The actual place of death of these patients were 26% at home, 12% at a hospice and 63% in hospital[3].

In the present study of our local patients, out of those who indicated a preference between home and hospital, 83% of patients aged 65 years and above wanted to die at home, compared to only 50% of patients under 65 years. Interestingly, 71% of male patients compared to 52% of female patients preferred to die at home. These preferences are likely to be related to the availability of a caregiver, as 69% of those with a caregiver preferred to die at home, compared to 17% of those who did not have a caregiver.

In comparing this to the wishes of relatives, there was little difference in preference between relatives of the different groups of patients. Fifty-six percent of relatives of patients aged 65 and above wanted them to die at home, as compared to 48% of relatives of patients younger than 65. Of the relatives of male patients, 50% wanted them to die at home, as compared to 54% of relatives of female patients. As expected, for those patients who had no caregiver at home, none of the relatives wanted them to die at home, while 60% of the relatives with caregivers wanted them to die at home. Direct comparisons cannot be drawn because the group of relatives interviewed were not all relatives of the patients who were interviewed. There was also no indication as to which relative was interviewed, whether it was the chief caregiver or only onlookers, as their preferences may well be different.

One issue that was only briefly touched on by this study was distinguishing between the preferred place of care and the preferred place of death. People in the business have observed the phenomenon of two types of patients. There are those who want to be in a hospital or hospice while care needed to be given, whether in the form of medical intervention or nursing care, but when death is imminent, they want to go home to die because of beliefs that the soul will get lost while trying to return to the body if the body is moved. A different group of patients want to be cared for at home while they are able to enjoy the company and care of their families, but do not wish death to take place in the home because of the inconvenience to the relatives and beliefs that it would bring bad luck to the house, particularly if it is a new one, as this would affect resale value of the property. For these, arrangements have to be made to transfer the patient to hospital or hospice as soon as death seems imminent. As part of the assessment in palliative care practice, such preferences are documented to enable the wishes of patient and family to be followed as far as possible. It would be interesting to document the frequency of these happenings and how far they are attributable to religious beliefs or common superstitions.

One of the tenets of palliative care is to provide the patient with choices. In drawing near to death, the patient often loses control over areas of his life – the functions of his body, his body image, his social role, his financial integrity. Palliative care tries to allow the patient as much control over his life as is still

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possible, so that availability of choices is central to the philosophy of care. In response to patient preferences to be at home, hospice home care services in Singapore started as a tentative volunteer effort in 1987. Over the years, these have grown into professionally run but still largely charitably funded services which presently, serve over 50% of patients dying of cancer in Singapore. Statistics on the place of death of patients under hospice home care showed that in 1993, 74% of patients supported by such a service managed to die at home[4]. At the time, there were few alternatives from home other than hospital, and the overall cancer deaths occurring at home was 34%[5]. With increasing availability of in-patient hospice care in recent years, death at home has dropped to the present 48%, while death at in-patient hospices among those referred for hospice home care rose from less than 1% in 1993 to 18.6% in 1997[4,6] with over 800 hospice admissions. As more services and more choices become available, further study of the change in patient preferences would be profitable to guide the development of future services for this group of patients.

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Corrigendum

The Editor of the SMJ wishes to apologise for inadvertently omitting Respiratory Medicine in the write-up on Tan Tock Seng Hospital in the September issue of the Journal (Singapore Med J 1998; 39 (9): 389).

The amended write-up is printed herein:

Tan Tock Seng Hospital – A Legacy of Caring

Tan Tock Seng Hospital (TTSH) was founded in 1844 as the first and only local hospital for the sick poor. Today, TTSH is an acute care general hospital with 19 medical and surgical disciplines. Much effort has been put into the development of TTSH's special strengths: • Geriatric Medicine • Infectious Disease • Neurosciences • Rehabilitation Medicine • Respiratory Medicine • Rheumatology and Immunology

Having stood at its current premises for close to a century, groundbreaking for the new TTSH took place in September 1993 and topping out was achieved in May 1997. Almost six years later, we look forward to the completion of the new building at the end of 1998. The new 14-storey hospital complex has a gross floor area of 171,000 m^2 and will accommodate 1,211 beds and an ambulatory medical centre. It is designed with our patients in mind, adopting the "one-stop" service concept where inpatient and outpatient facilities are consolidated under one roof. Patients benefit from the cost-effectiveness and convenience of numerous one-stop multidisciplinary programmes, many of which are pioneering programmes in Singapore. The new hospital will also upgrade its current Information Technology system to improve the overall information delivery and communications network.

TTSH values her dedicated staff as the greatest asset, and we will continue to harness on our strong spirit of teamwork to build on our traditional strengths as well as new areas of service. While striving to practise cutting-edge medicine, we will not forget our objective to deliver affordable and cost-effective healthcare to our patients.

Ms Lena Wan
Dr Loh Keh Chuan