ELECTIVE (SSC5b) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

St. Elizabeth Hospice

Objective 1

- **Describe the types of patient and conditions that are making use of palliative care services, and consider how this may change in the future.**

During my time working with and shadowing the team at St Elizabeth Hospice in Ipswich, I have seen a wide range of patients making use of the palliative care services. Even though one would think that as everyone dies, everyone will attempt to access hospice and palliative care, I have seen that there are certain groups of patients who are referred far more readily to these services than others. The most common patient group who use the service here, matches the patient group who most frequently used the service during my time at St Helena Hospice. This patient group is those who are suffering from diagnoses of terminal cancers. During my time here, about three quarters of the inpatients on the IPU had diagnoses of oncological malignancies. This is likely to be because of the high levels of awareness around cancer means that more patients get referred to the palliative service than other, equally fatal but less well known (or less feared), conditions.

During my time here, the majority of patients to be inpatients on IPU were elderly, although this is more likely due to the fact that fewer younger people develop terminal conditions, and therefore fewer younger people require hospice care. It is not because younger patients have less access to the service if required.

By shadowing the doctors in outpatient clinics and other similar environments, I also got to see other aspects of palliative medicine. As well as end of life care, the palliative team here are often responsible for pain control in patients with severe pain, which is beyond the abilities of the hospital teams. Therefore, being a doctor in the specialty of palliative care does not mean that you only work in end of life medicine and palliation, but also in patients with good prognoses or even who are in remission.

I believe that the demand for hospice care will only increase in the future. As the population of Britain ages, the prevalence of cancer and other diseases of old age will increase, and therefore we will be likely to see an increase in the number of referrals to the palliative services. I also think that as people become more distanced from the realities of death, combined with becoming more aware of the available services, that palliative medicine will see an increase in referrals from patients with diseases other than cancer, as it is a fantastic resource to have access to.

Objective 2

- **How are end of life care services in the UK organised in comparison with other countries**

In the UK, end of life care services, such as hospices, receive a proportion of their funding from the NHS. The rest of the funding has to come through charitable donations, legacies and gifts, and other similar fundraising strategies. There are few, if any, privately established palliative care physicians. Patients do not expect to have to pay at the point of care for end of life services.

In other countries such as Argentina, where advanced healthcare is seen to be more of a private sector service, as opposed to a free public sector right, the model is different. There is less state funding of hospice services, and instead there is a private hospice sector, where wealthier patients (or their families) can pay an institution roughly similar to a hospice to provide the care, at a daily rate, much the same as privately funding a stay in a care home. If you are unable to afford this rate, there are much (much) longer waiting lists for the available charitable hospice spaces, and a far higher proportion of patients die either at home or in hospitals.

Objective 3

- **To increase my awareness of the demands for palliative care in relation to changing UK demographics**

Globally, trauma is the biggest cause of death in patients aged between 1 and 51. Patients who die from fatal trauma usually do not utilise palliative care services. This means that they do not have an effect on palliative care demand. However, with the aging population in the UK, a larger percentage of people in the country will be over the age of 51, so proportionally fewer people should statistically die from major trauma. This means that it is likely that there will be more people dying of the diseases common in later life, many of which (for example cancers or heart failure) will require access to palliative services. This will therefore increase demand placed on the palliative care teams in the community, hospice and hospital.

What is more, for a number of years, there has been a trend away from the traditional model of a multi-generational nuclear family, where children continue to live at home and care for their parents in their old age. This mean that family structures now-a-days are less geared up to be able to provide support and care for individual members themselves. This means that as people's care needs increase towards the end of their lives, this support is less likely to be provided by the families. This means that they may develop an increased reliance on the hospice support teams in the end of life phase, from medical care, right through to the holistic psychosocial support also offered at St. Elizabeth.

Between these two factors, combined with the better awareness of the services now available to people, I believe that in the future, the changing demographics of the UK will contribute to an increase in demand for palliative care, and especially hospice medicine, in the future.

Objective 4

- **To increase my understanding of, and knowledge about, the health issues associated with end of life, and to improve my future practice as a result**

My time at the hospice, combined with the excellent teaching available to me, has contributed to increase my understanding of, and knowledge about, the health issues associated with end of life, and I believe that my future practice will therefore be improved as a result. I have seen patients who have a wide variety of terminal illnesses, and I have also realised that palliative medicine is a specialty which does not only deal with patients with limited prognoses. My time in the outpatient clinic and on the day-care unit made me realise palliative specialists also provide pain management and general psychosocial support, amongst many other things! By integrating the examples of good communication and active listening that I have seen during my time here into my personal practice, should hopefully improve my future practice, and the experience of my future patients.