

ELECTIVE (SSC5b) REPORT (1200 words)

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

What are the prevalent conditions among hospice patients and how do these compare to the rest of Europe?

The vast majority of patients cared for by St Joseph's Hospice have advanced cancer, often with additional comorbidities. This is also the case amongst patients cared for in the community. This finding is reflected in hospices throughout the UK with 79% of patients cared for having advanced cancer. However, anyone with a life limiting condition, who has specialist palliative care needs could be cared for by the palliative care team within the hospice or in the community.

How is palliative care organised and resourced in East London, and how does this compare to the rest of the Europe?

According to HospiceUK, there are 17 adult hospices in London. The majority are run by charitable organisations but there are some fully publicly funded organisations. St Joseph's Hospice receives 50% of its funding through the NHS and 50% through donations and fundraising activity. The proportions of public and charitable funding does vary for different hospices within the different London boroughs.

Funding systems for palliative care vary considerably across Europe. In Hungary, each day the community team visits a patient is reimbursed by a single payment. These payments are limited to 150 per patient and the payment does not change to reflect the complexity of care or length of visits. In Hungary and Poland, funding is restricted to specified conditions rather than all life-limiting illnesses. This results in hospices relying on charitable funding to meet the needs of patients whose condition is not on the specified list and ultimately unequal access to care based on diagnoses.

St Joseph's Hospice offers a wide range of services on site and in the community which means greater accessibility and choice for patients. However, some vulnerable groups seem to have poorer access to hospice care. There is evidence from the UK and Italy that people living in the poorest areas, who have higher death rates from some cancers are more likely to die in hospital rather than home or hospice. The marginalised groups of people that are hard for all services to reach (for example; homeless, travelers, asylum seekers, migrants) are also difficult for palliative care and hospice teams to reach. I am particularly interested in how services can best reach and care for these often vulnerable groups of people and is something I will continue to explore in my future practice.

To gain a greater understanding about how different cultural views affect people's choices around end of life care.

The time I have spent at the hospice has allowed me to observe some different approaches to the end of life. I have seen how important religious faith can be for patients and their families, particularly in bringing a calming influence to their situation. I learnt more about complementary therapies and how they can support the spiritual needs of patients. This aspect of hospice care is one that I find really interesting and think is important not only in meeting some of the patient's spiritual needs, but also allowing them time to come-to-terms with, accept and even improve the severity of symptoms. In all cases, it has been apparent to me that the family and friends of a person and their relationships have a huge impact on views about, and plans for, the end of life.

I have also learnt more about the practical issues surrounding death, post-death rituals and care, as well as funeral arrangements for different faiths and cultures. For example, the muslim faith needs to turn the dying person to face Mecca and to bury the body within 24hrs of death. The team caring for someone with these or similar beliefs need to be aware in order to support families to achieve this and limit additional anguish suffered when grieving families are unable to fulfill their spiritual and cultural rituals. The need for open communication and advanced care planning between the patient and the hospice team was highlighted to me.

To develop my confidence and understanding of palliative care medicine, particularly around what to prescribe and how to stop medication.

I have gained a much greater understanding of palliative care and what it can offer patients and their families. I would be able to give a good account of the long and short-term services and clinics available in palliative care to future patients and their families.

Spending time on the wards has allowed me to become more familiar with drugs commonly used at the end of life. I was also able to consider the importance of route of administration towards the end of life when oral medicines might not be tolerated. In a number of cases, medications had to be reconsidered with creative prescribing to find an effective drug which could be administered in each case and tolerated by the patient. I have learnt more about the terminal and dying phases of life and the importance of recognising these to help focus care and support.

The key learning point that I will take from this placement for my future practice, is the importance of an individualised approach to care, particularly at the end of life. Establishing and reviewing the patient's priorities and concerns should inform care and treatment rather than the agenda of a health professional or a 'one size fits all' approach.