Original Article

Reasons for End-of-Life Hospital Admissions: Results of a Survey Among Family Physicians

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Abstract

Context. Although the acute hospital setting is not considered to be an ideal place of death, many people are admitted to hospital at the end of life.

Objectives. The present study aims to examine the reasons for hospital admissions that result in an expected death and the factors that play a role in the decision to admit to hospital.

Methods. This was a survey among family physicians (FPs) about those of their patients who had died nonsuddenly in an acute university hospital setting in Belgium between January and August 2014. Questions were asked about the patient's health situation, care that the patient received before the admission, the circumstances of the hospital admission, the reasons necessitating the admission, and other factors that had played a role in the decision to admit the patient to hospital.

Results. We received 245 completed questionnaires (response rate 70%), and 77% of those hospital deaths were considered to be nonsudden. FPs indicated that 55% of end-of-life hospitalizations were for palliative reasons and 26% curative or life-prolonging. Factors such as the patient feeling safer in hospital (35%) or family believing care to be better in hospital (54%) frequently played a role in the end-of-life hospitalization. When patients were admitted with a limited anticipated life expectancy, FPs were more likely to indicate that an inadequate caring capacity of the care setting had played a role in the admission.

Conclusion. To reduce the number of hospital deaths, a combination of structural support for out-of-hospital end-of-life care and a more timely referral to out-of-hospital palliative care services may be needed. J Pain Symptom Manage 2016;■:■−■.

Key Words

Hospitalization, palliative care, terminal care, family physician, hospital admission

Introduction

A large number of frail older people and patients with a life-limiting illness are admitted to hospital at the end of life,[1−6] and the acute hospital setting is a frequent and persistent place of death in many Western countries.[7−9] However, the acute hospital setting is considered not to be an ideal setting for end-of-life care, or as a place of death.[10−12] Care in the acute hospital setting is predominantly focused on cure and life prolongation[10,11,13−15] and is perceived to be inadequate in meeting the needs of dying patients.[11,16] Moreover, research shows that most people prefer not to die in a hospital.[17−24] As a result, end-of-life care policies in a number of countries such as Belgium and England advocate for dying at home or in familiar surroundings.[25,26]

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In Belgium, out-of-hospital end-of-life care is, in principle, provided by the treating health care professionals and family carers, coordinated by the patient's family physician (FP).[26] They can be supported in this by specialized palliative care professionals (e.g., multidisciplinary home care team). Several measures have been set out to ensure that they would not be restricted from receiving high-quality care (e.g., palliative status) or to avoid an admission to the acute hospital setting (e.g., palliative day care centers).[26] For those patients who cannot be cared for at home and for whom an admission to the acute hospital setting might be considered unnecessary, palliative care units have been established in or near some hospitals.[26] However, the availability of palliative care unit beds is very limited, with 379 beds for the whole of Belgium.[27]

Several studies show that preferences for place of death may change from home to hospital as death approaches,[24,28–30] and in some situations, an end-of-life hospital admission might be considered justified.[31] However, studies exploring the reasons for admissions which result in an expected death and factors that influence the decision to admit to hospital at the end of life are scarce.[32] More evidence regarding the reasons for and factors that necessitate end-of-life admissions to the acute hospital setting is needed. The present study aims to examine the reasons for end-of-life hospital admissions—that is, hospital admissions that result in an expected death—and the factors that play a role in the decision to admit to hospital.

Methods

Design

A cross-sectional survey was conducted among the FPs of all patients who died in a large (+/− 1000 beds) university hospital in Belgium between January and August 2014, to collect data on the circumstances of the admission.

In Belgium, almost 95% of the population have an FP whom they consult regularly (78% at least once a year).[33] FPs are considered to have a pivotal role in providing out-of-hospital end-of-life care[34] and are expected to be well informed about the patient's medical and social situation. Consequently, their perspectives are considered crucial when examining circumstances related to the hospital admission.

Study Population

All patients who died in an acute hospital in the sampling period were identified in the hospital medical record system. Those aged less than 18 years; those not residing in Belgium; and those who died on a specialized palliative care unit, maternity ward, or psychiatric ward were excluded as they were not the focus of this study.

Data Collection

A research assistant was involved in the data collection procedure as intermediary between FPs and the university hospital. The assistant received an extract of the hospital records of all deaths, including the patient's gender, postal code, date of birth, date of death, timing of admission, hospital ward where they died, and their FP's contact information. A questionnaire was sent to the FP of every death that met the inclusion criteria. The accompanying letter included the gender of the deceased patient, postal code of the municipality of residence, date of birth, and date of death so as to enable the FPs to identify the patient when filling out the questionnaire.

Deaths were identified on a weekly basis during the study period. Two weeks after the patient's death, a four-page questionnaire was sent to the FP, so as to limit the time between the death and the completion of the questionnaire and to limit recall bias. The Total Design Method was used to maximize the response to the questionnaire.[35,36] In cases where there was no response, a reminder was sent after three weeks, a second questionnaire as a reminder after five weeks, and another reminder after seven weeks. After 10 weeks, a brief nonresponse questionnaire was sent to those FPs who had not responded to elicit their reasons for not completing the questionnaire. FPs received questionnaires for a maximum of three patients to limit the workload.

From the returned questionnaires, the research assistant coded all data and ensured that the research data could not be linked to the patient or the FP. The questionnaire data were linked to the extract of hospital records, using a unique case number, whereas the patient's postal code and the FP's contact information were deleted to ensure anonymity.

Questionnaires

The questionnaire was designed by a research team (five medical sociologists and an FP) with experience in survey methodology and knowledge of the subject. Its design was based on the results of three previous qualitative studies and on similar surveys that had been used in The Netherlands and Belgium.[3,5,11,31,34,37] We tested the questionnaire among five FPs, and it was modified wherever necessary.

FPs were asked to continue completion of the questionnaire if they considered the death of their patient not to be sudden and not totally unexpected. Questions were asked about the patient's health situation, care that the patient received before the admission,