Dying the ‘good death’

By JENNIE LEE

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the Ministry of Health’s pledge to review and improve the whole framework for home-based care is welcome.

But a system where you come home with the last rites on your chest is no place for home palliative care. And the patient may actually die at a hospital if doctors insist on operating.

A home death may sound like the most natural outcome of a long and steadily declining illness such as cancer or progressively worsening heart failure. But while two-thirds of terminally-ill patients want to die at home, only one-quarter actually do so.

Why this happens?

At least four factors contribute to this.

The first is the death of “de-legitimation.” This began, popularised by the Lien Foundation, with conversations about death and dying. New end-of-life care policies are becoming accepted, and families are not prepared for the impending death because these die-logues have not occurred.

The second factor that leads to death in hospital, and not at home, is the view that disease and death are battles to be fought for the better.

And, American author Sharon Kaufman describes how “...death moved out of the home and into medical institutions” in the 20th century. In Singapore, too, deaths in hospitals have increased over the decades.

Once open to a time, death was seen as “natural”, a consequence of passing and hence, not-upset-able but not noted. Today, too, for too many doctors tend towards still treating death as an admission of failure, and not in the profoundness of modern medicine to control disease. If illness is a battle, then the hospital becomes a bastion of resistance, and the Intensive Care Unit the last stand.

The first is the dearth of “die-logues”. This is a factor....the dying.

And for those who see loved ones into the dark night, the last few moments and days are precious. According to the Singapore Hospice movement, once famously remarked: “Love people the memories of those who live on.”

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The pernicious effects of such a policy are two-fold: Firstly, hospices need to spend large amounts of time raising funds to cover the shortfall, detracting from clinical services. Secondly, the amount of time spent with any single patient is limited, with the “rotation of the clock” nursing service. The charge is typically $60 per day, or higher than what public hospitals charge for hospital admissions.

The perverse outcome? It becomes cheaper for families to send their loved ones to hospital to die than to spend a good death at home.

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Resolving the financing incongruities may be easier said than done. But it is worth pursuing in the interest of the patient and the family.

The key to the equation is to look at what is currently being done and see it as the barest of minimums. The MOH has stipulated that home palliative care must cost only $800 per month, the low end of the $800-$1,200 per month commonly charged by hospices. But at $800 per month, it is not enough to support nurses and doctors into palliative care services.

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