Coordinating death: Exploring healthcare professional interactions in the hospital admissions of patients close to the end of life

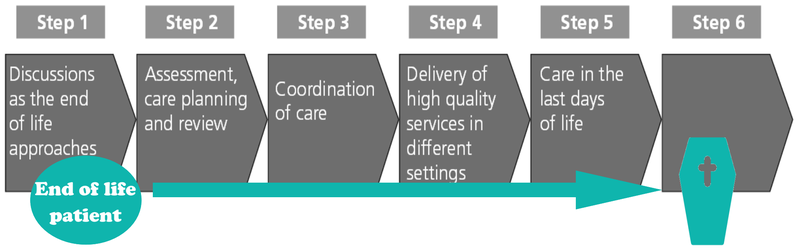
*seh91@medschl.cam.ac.uk

Sarah Hoare,* Stephen Barclay, Michael P Kelly. Department of Public Health and Primary Care, University of Cambridge School of Clinical Medicine, Forvie Site, Cambridge Biomedical Campus, Cambridge. CB2 0SR

End of life (EOL) care policy aims to ensure patients die in their preferred place of care; home. Admissions where EOL patients die in hospital are described as "inappropriate", anti-choice and expensive.

Method: Interviews with healthcare workers involved in the care of a patient who died shortly after admission to hospital. Thematic analysis ongoing.

EOL policy suggests caring for dying patients is a linear process.



'The End of Life Care Pathway' Department of Health (2008)

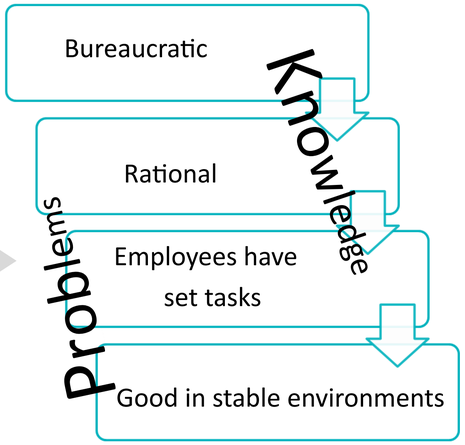
Healthcare professionals accounts suggest it is more complicated than this.

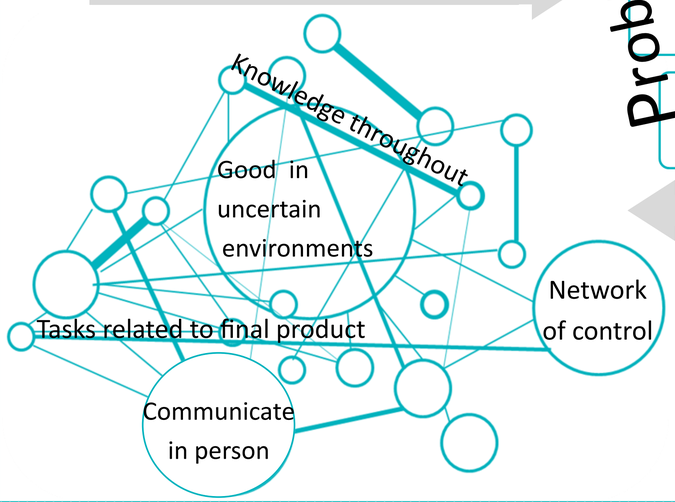
E.g. prognosticating death difficult, services not available, incomplete information.

Department of Health (2008) *End of Life Care Strategy – promoting high quality care for all adults at the end of life* London

Burns and Stalker's (1961) dichotomy between different ways of organising work is useful for understanding how EOL care is organised.

Policy appears to organise care in a **mechanical** way.

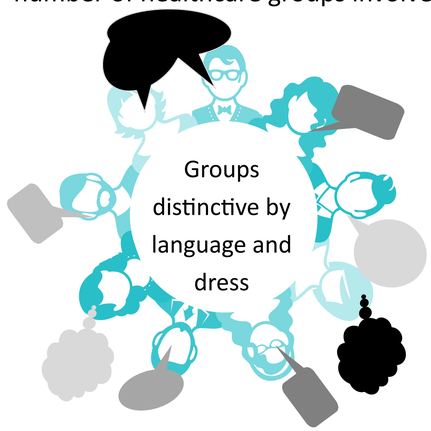




Healthcare professionals seem to organise care in a **organic** way.

Burns, T. and Stalker, G. (1994) *The management of innovation.* Oxford: Oxford University Press

Organic organisation practical because of number of healthcare groups involved.



Cooperation between groups can become difficult if each does not share the same values or practices.

One reason for these differences is the amount of professionalism.

Using the ideas of Etzioni (1964) and Johnson (1972) the most senior professional roles have:

· Long training periods

· Responsibility for making life or death decisions

· High status patients

Those in more professional roles have:

. Autonomy (versus supervision)

Professional judgement (versus rules)

These differences could affect how care of the dying is organised.

Etzioni, A. (1964) *Modern organizations* Englewood Cliffs: Prentice-Hall
Johnson, T. (1972) *Professions and power* London: Macmillan.

As such, hospital may become a default location because:

Available to all without discussion

"Things like hospice, it depends on bed availability and so, it can be quite frustrating, you know what you want to do…. [but]"

GP, AD001c

Universally accepted place of care

"And also when they're in hospital or in a hospice or something like that they're more like to have more staff, so people, you know, sitting with them, keeping them comfortable, coming in, you can call on people."

AD002d paramedic

Requires few inter-group negotiations

"it took us a number of hours, me and a crew with an out of hours GP who refused to come out, and her manager and her manager and then her manager, so went up four rungs of the ladder, even spoke to our manager, spoke to the clinical support desk, you know literally we have to lots of people in [so the patient could die at home]

AD002d paramedic

All have the authority to send a patient to hospital

"it was obvious that she wasn't going to make it, but because of our protocol we have to kind of just take her in"

Paramedic ADOO3b

. Other important factors; analysis ongoing.

. Recognising that group has its own identity, values and practices which are not always complementary is important for understanding EOLC is carried out.

UNIVERSITY OF CAMBRIDGE

Acknowledgements: This research was funded and led by the National Institute of Health Research (NIHR) Collaborations for Leadership in Applied Health Research and Care (CLAHRC) East of England. The views expressed are those of the authors and not necessarily those of the NHS, NIHR, or the Department of Health.

NHS National Institute for Health Research