Personal choice about the place of death

Background
In 2004 most (73%) of the Dutch population preferred to die at home; yet only 32% were able to do so. Since then, the number of palliative terminal beds and public information about the possibilities of palliative care, increased significantly.

Aims
This study explored shifts in the selection of places of death from 2004 to 2013 and the meanings assigned to individual agency and illness that play a part in those shifts. The purpose of this study is to contribute to the dialogue between healthcare professionals, scientists and policymakers regarding the concept of autonomy and personal choice about the place of death.

Mixed methods
Quantitative
• National survey (n = 1881)
• Palliative care patients in hospices (n = 41)
• Mortality statistics of people with chronic illnesses
Qualitative
• Retrospective study: semi-structured interviews with relatives of deceased patients (n = 20)

Analyses
Quantitative
• Chi-square test; the Spearman Rank Correlation Coefficient
Qualitative
• Open and axial coding, using a reiterative process

Results
The gap between desire to die at home and reality has decreased in the last 10 years. 68% wish to die at home but only 36% succeed. The current gap seems to be partly due to different definitions of ‘home’. Those, in the last phase of life, attached more importance to ‘feeling at home’ than ‘being at home’. Atmosphere, time and attention, commitment and security were mentioned as feelings associated with ‘home’. Feeling in control of dying was more a relational process of sense making than an individual act. Dialogue and making sense about the meaning of dying preceded and were considered more important than decision-making.

Places of death in non-acute mortality in 2012 (source: CBS 2014)

Conclusions
• The process leading to the realization of the place of death is not linear but complex.
• Patients’ wishes and decisions can change over time.
• Professionals should attach more importance to wishes of patients instead of influencing their decision-making.
• Relational care requires dialogue between all participants in the dying process.

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