Is a terminally ill non-cancer patient really forced to stay at the hospital?

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Dear Editor,

for many years the National Health Service has taken care of terminal illness in its clinical, ethical, and legal aspects. The expert doctor has learned to recognize the moment of the end of life thanks to his professional experience, the help of the specialist, and using the predictive scores.[1] Assistance to the terminally ill patient takes place in different care settings, such as hospitals, hospices, and homes, depending on the intensity of care/assistance.[2] Pain therapy, terminal sedation, and the prohibition of unreasonable obstinacy in treatment are legally recognized and are now a matter of competence of every healthcare professional.[3]

Despite this knowledge, however, a gap remains between care for terminally ill cancer patients and that reserved for terminally ill patients for non-oncological causes.

Due to the lower predictability of the prognostic curve for non-cancer patients, various scores have been introduced.[4-7] Despite these efforts, there is still no homogeneity in their use. In recent years, the National Health Service has invested economic resources to build a healthcare system in the territory. However, we have recorded a poor use of resources towards non-oncology end-stage patients.

The lack of propensity toward the treatment of terminally ill non-cancer patients has various educational, ethical, and economic reasons. During studies for the medical degree and medical specialization, the subject of palliative care is little stressed. The therapeutic choices of some health workers are still influenced by religious education. The number of end-stage patients by organ function is constantly increasing due to the average age and the effectiveness of treatments, but economic resources do not seem to be able to cure this trend.

Reports from the World Palliative Care Association and the World Health Organization since 2017 inform us that the need for palliative care is greater for end-stage non-cancer patients (70%), regardless of age and the income resources/wealth of the country. In the same report, terminally ill patients suffered from infectious diseases (22%), cardiocerebrovascular disease (15%), dementia (12%), cardiopulmonary disease (5%), and hepatorenal disease (3%).[8]

The recent regional normative, DGR nr. 553 of 30 April 2018, on the "Palliative Care Network" has not yet been better interpreted for non-cancer patients. In daily hospital work, we experience the difficulty of finding the right allocation for terminally ill non-cancer patients. The result is that most of the time, the patient dies in the Medicine and Geriatrics Wards, as in the experience of the Medicine Department of the *Ospedale dell'Angelo* in Mestre, Venezia, Italy. When we consider the first five diagnoses on the hospital discharge form during 2023, we can record 672 deaths from non-oncological causes and 173 deaths from oncological causes. The trend is the same during the first seven months of 2024 (Tables 1 and 2). This entails not only a lengthening of the average hospital stay but also the risk of inappropriate treatment. The lack of propensity to take care

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of these patients has also induced the physicians of the Medicine Department of *Ospedale dell'Angelo* to keep palliative care consultations low over the years. In fact, the requests for palliative care consultancy concerned non-oncological terminally ill patient only 2% in 2023 and 7% in the first seven months of 2024 (Table 3).

One of the reasons for the lack of transfer out of the hospital towards the "Palliative Care Network" lies in the fact that the regional result indicators do not provide for the care of non-oncology end-stage patients.[2] Another reason is that the standards of the "Palliative Care Network", which is one home palliative care unit per 100,000 inhabitants and one hospice with 8/10 beds per 100,000 inhabitants, are lower than the growing needs of the terminally ill. For all these reasons, only 22 non-cancer patients out of a total of 463 and 7 non-cancer patients out of a total of 233 died in the hospice beds of the "Palliative Care Network" during 2023 and in the first 6 months of 2024, respectively. Too few.

How can we effectively allocate resources and provide appropriate care to non-oncology terminal patients outside of the hospital? We think we need to act on several fronts: i) the tools for identifying the end-stage patient must be complete, understandable, rapid, and repeatable; they must consider health, social, and welfare aspects; ii) once the prognosis of these patients has been identified, a report to the "Palliative Care Network" must provide the right intensity of care and assistance; iii) palliative care must be widespread among doctors who work in the various healthcare structures (general practitioners, free choice paediatricians, primary care, residential doctors and healthcare, hospice, community hospital, community home); iv) the resources of the *Piano Nazionale di Ripresa e Resilienza*, thanks to Next Generation Europe funds, must focus on the "Palliative Care Network" and mainly to palliative home care; v) telemedicine tools (tele-visit, tele-assistance, tele-monitoring, tele-consultancy) must help healthcare workers in assisting the terminally ill by allowing the patient and the caregiver to interact in real-time with all the actors involved.

Only in this way will it be possible to guarantee the terminally ill patients for non-oncological causes an adequate transfer to the "Palliative Care Network" and assistance by competent personnel with the appropriate equipment, avoiding continuous returns to the hospital in the last phase of their life.

Table 1. Deaths of end stage patients due to non-oncological/oncological causes.

Department of Medicine and Oncohematology with Urgent Care activities, *Ospedale dell'Angelo*, Mestre, Venezia (year 2023 and January-July 2024).				
Ward	**n**	**Average hospital stay 2023**	**n**	**Average hospital stay 2024 (Jan-Jul)**
Non-oncological				
Hematology	2	29.0	3	3.0
Gastroenterology	12	7.3	4	3.3
Geriatrics	338	8.1	184	7.2
Infectious Diseases	10	11.3	2	18.5
General Medicine	292	8.8	155	10.5
Nephrology	18	20.8	14	18.7
Total	672	8.8	362	9.1
Oncological				
Hematology	19	1.,5	6	26.7
Gastroenterology	6	10.5	2	30.5
Geriatrics	35	9.1	14	4.9
General Medicine	112	9.2	65	8.4
Nephrology	1	20.0	0	0
Total	173	10.2	87	9.6

Table 2. Main diagnosis of non-oncology hospitalizations resulting in death.

Main diagnosis	2023	Jan-Jul 2024
Renal failure	38	19
Lung failure	169	94
Heart failure	96	52
Liver failure	37	18
Dementia, Alzheimer	55	30
Cerebral hemorrahage/stroke	35	30
Intestinal disease	6	7
Sepsis	200	102
COVID-19	36	10
Total	672	362

Table 3. Requests for palliative care for non-oncology and oncology end-stage patients who died in hospital.

Department of Medicine and Oncohematology with Urgent Care activities, *Ospedale dell'Angelo*, Mestre, Venezia (year 2023 and January-July 2024).		
Ward	**2023**	**Jan-Jul 2024**
Non-oncological		
Cardiology	1	-
Geriatrics	4	9
General medicine	7	14
Nephrology	1	3
Total requests	13	26
No requests	659	336
Overall total	672	362
% requests for palliative care	2	7
Oncological		
Gastroenterology	1	1
Geriatrics	17	4
General medicine	41	27
Total requests	59	32
No request	114	55
Overall total	173	87
% requests for palliative care	34	37

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