Case studies
(these patients have given permission for their story to be told but their detail have been altered to protect anonymity nonetheless)

JW
78 year old male with a history of gallstones and cognitive impairment. 2 years previously he had been admitted with obstructive jaundice and admitted to hospital. He was treated with antibiotics and awaited an ERCP after bloods showed deranged LFT and an US showed dilated ducts.

A week into his admission, whilst JW was awaiting his ERCP he developed a delirium and became very difficult to manage. He became aggressive and fell several times. He injured himself and a staff member. He was then sedated and developed a hospital acquired pneumonia. His ERCP was cancelled 3 times as he was too unwell. His daughter was told that he would be unlikely to survive the admission. After 4 months he managed to have his ERCP and he was discharged home. His daughter was terrified of him ever having to go to hospital again.

2 years later JW was referred by the GP after complaining of some abdominal pain and dark urine. When he attended SDEC his daughter was tearful and frightened. JW was content and compliant with blood tests. These once again showed an obstructive picture and an ultrasound performed the same day confirmed dilated ducts. JW's daughter was extremely keen to avoid admission.

The SDEC team worked with the hepatologists and the ERCP co-ordinator to arrange an OP ERCP as an urgent procedure (using the same timescale as inpatient). The hepatology team were concerned regarding risk of infection, but agreed that the risk of an inpatient admission was significant. He was sent home with oral antibiotics and a planned ERCP 13 days later. He had two visits to SDEC in the meantime for a clinical review and to check his bloods to ensure he was remaining stable.

The ERCP was successful and he was managed as a day case. A planned review on the SDEC 2 days later showed markedly improved bloods and the patient was well. The daughter was keen for us to share this story which outlined how different her dad's experience had been.

MR
MR was a 45 year old lady who was a carer for her husband who was terminally ill. She had been getting increasingly tired which she had put down to the stress of her home situation, but her friend thought she looked pale and persuaded her to see her GP. A full blood count revealed a Hb of 56. She was phoned by the GP and told to attend urgently. She arrived at the hospital at 9pm and had a NEWS score of 0. When she was seen she reported increasingly heavy menstruation for the last 8 months. She had been noticing some fatigue and shortness of breath on exertion but otherwise felt well. She was extremely reluctant to

be admitted as “I want to spend every possible hour I can with my husband whilst I still can, and I need to be there for my children”.

She was discharged that evening and returned for 2 units of blood the following day and then discharged with oral iron and an urgent OP gynaecology appointment.

Her Hb was maintained on oral iron and tranexamic acid and an MRI (organised by the gynae team) showed a large fibroid. She wanted to hold off surgery to be with her husband and was very grateful to be able to do this. Her husband died one month later. She had a hysterectomy 2 months later.

What both of these cases have in common is the patient (and their advocate) wanting to be kept out of hospital where possible. There are many reasons for this but the most common we hear are caring responsibilities for family, friends, and often pets or concern regarding hospital related complications.

What these cases also had in common was that the patient (and their advocate) were both able to bring this up and ask for alternatives to be considered. However, many patients feel unable to do this and all too often clinicians do not ask what a patient wants or dismiss the idea that they could be managed at home. We know that doctors will often make different decisions for themselves than their patients and this is due to fear of litigation[i].

SDEC offers a way of managing patients at home that would otherwise have been admitted and can sometimes be a safer alternative when the true risk of admission is balanced against the risk of a co-ordinated and supervised discharge.

---

[i] Garcia-Retamero R, Galesic M. On defensive decision making: how doctors make decisions for their patients. Health Expect. 2014 Oct;17(5):664-9. doi: 10.1111/j.1369-7625.2012.00791.x. Epub 2012 May 31. PMID: 22646919; PMCID: PMC5060905.