

Facing death alone: An exploration of terminally ill individuals living alone in palliative care

Paul Bashyam¹ MCouCFT, Ching Sian Yap¹ BA (Hons) Philosophy, XiangYi Chen¹ BSocSci, Zhi Zheng Yeo¹ MPH

Dear Editor,

Home palliative care clinicians provide end-of-life care for patients from diverse social and economic backgrounds. They include patients who live alone—a single-person household.¹ Auon et al. found that 7–12% of patients under palliative care lived alone for more than a year.³ Demographic trends increasingly highlight this group to be a growing population with pressing concerns (e.g. the number of single-person households in Singapore has almost doubled between 2012 and 2022).² With the greying population, the trend of patients living alone is expected to grow.

Understanding the characteristics and behaviours of patients living alone is important for clinicians to better identify their needs and provide appropriate and timely care. Coordination between healthcare and social service providers can also be strengthened. However, information about this group remains fragmented and insufficiently documented. Hence, we aimed to conduct an exploratory study on the prevalence and service experience of terminally ill patients who live alone.

A systematic retrospective review of electronic medical records was conducted for patients who were deceased or discharged between December 2021 and May 2022. Of the 1412 patients, 1079 (76.4%) had their living and care arrangements documented. These patients were then categorised by whether they lived: (1) alone, (2) with family members, (3) with only 1 family member or (4) with non-family members. Statistical tests (i.e. chi-squared, Fisher's Exact and t-tests) were performed to test for demographic differences between patients living alone and those living with family who represented the typical patient archetype supported by home palliative care.

Table 1 summarises the results of the analyses. Among 52 patients, 4.8% lived alone, 62.9% lived with family members and 32.3% stayed with 1 family caregiver or with non-family.

Compared to patients who lived with family, patients who lived alone were not significantly different in terms of sex, age, disease type and

number of contacts with the clinical team ($P \geq 0.05$). However, there were significant differences ($P < 0.05$) by (1) race: more Chinese patients tended to live alone than other ethnicities; (2) marital status: patients who lived alone were more likely to be widowed, divorced/separated or single. Interestingly, 19% of patients were married, but their spouses did not stay in the same household and were not present; (3) means test categories: nearly 80% of patients were means tested to be eligible for subsidies of up to 80% of expenses; (4) death/discharge location: patients were more likely to be discharged or deceased in locations other than their own homes; and (5) length of stay in home palliative care: patients received support for a shorter period.

In addition, a narrative review of medical and social work case notes of 2 patients who lived alone was conducted to describe their service experience. Initially, the patients were resistant towards the home palliative care service, exhibiting avoidant behaviours and refusing visits. They also did not regularly update on their health conditions, leading to untimely care rendered. While the number of contacts they received did not differ from patients who have family support, clinicians often documented that they faced difficulties engaging the patients.

Throughout their illness trajectory, patients demonstrated a strong desire to maintain independence. Safety concerns often conflicted with their preference to remain at home and to decline healthcare or social work support. They rejected clinical advice to be admitted into care facilities and would request to remain at home. Mobility aids were accepted as their conditions deteriorated.

Clinicians needed to exercise continual efforts to engage with the patients while respecting their preferences to stay at home alone. This eventually fostered rapport building, and patients eventually became more receptive to more frequent contacts with care providers.

As the patients' conditions deteriorated, they gradually explored alternative care arrangements through consultations with the clinicians. The

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¹ HCA Hospice Limited, Kwong Wai Shiu Hospital, Singapore

Correspondence: Mr Paul Bashyam, Psychological Services, HCA Hospice Limited, 705 Serangoon Road, #03-01 Block A @ Kwong Wai Shiu Hospital, Singapore 328127.

Email: paulb@hcahospicecare.org.sg

Table 1. Demographics data of loner patients.

Demographics	Staying alone (n=52)	Staying with family (n=679)
Sex, no. (%)		
Male	26 (50)	317 (46.6)
Female	26 (50)	362 (53.3)
Age, mean (SD), years	75.8 (13.8)	74.9 (13.5)
Race, no. (%)		
Chinese	44 (84.6)	493 (72.6)
Malay	5 (9.6)	135 (19.9)
Indian	1 (1.9)	31 (4.6)
Others	2 (3.8)	20 (2.9)
Disease, no. (%)		
Cancer	35 (67.3)	522 (76.8)
Non-cancer	17 (32.7)	157 (23.1)
Marital status, ^a no. (%)		
Married	10 (19.3)	449 (66.1)
Widowed	19 (36.5)	169 (24.9)
Divorced/separated	11 (21.1)	23 (3.4)
Single	12 (23.1)	38 (5.6)
Means test category, ^{ab} no. (%)		
0%	9 (17.3)	19 (28.3)
15–30%	2 (3.9)	77 (11.3)
40–50%	0	21 (3.1)
55–60%	1 (1.9)	129 (19.0)
75–80%	40 (76.9)	260 (38.3)
Length of stay in home hospice, ^a mean (SD), days	112 (113.9)	125 (180.2)
Contacts with clinical team		
Median no. of phone calls	9	10
Median no. of home visits	6	7
Death/discharge location, ^a no. (%)		
Hospital	11 (21)	202 (29.8)
Nursing home or hospice	26 (50)	44 (6.5)
Others/blank	4 (7.7)	24 (3.5)
Own home	11 (21.2)	409 (60.2)

SD: standard deviation
^a Significant at $P<0.05$
^b Used as a measure of socioeconomic status by evaluating an individual's or household's financial means, including income and assets, to determine eligibility for medical and healthcare subsidies.

patients also sought out estranged relationships for reconciliation or closure. They were more likely to share information about themselves due to closer rapport with the clinicians.

The patients desired a good death. They wished to live independently and to reconcile with estranged relationships. Their measure of a good death was not determined by the place where they spent their last days, but how and with whom they spent the days with.

Patients who live alone constitute a small but significant proportion of patients in home palliative care. Our study observed that these patients may be more socially isolated or disadvantaged, whether by choice or by circumstance. Financial struggles appeared to be a common challenge; more than 80% were found to be eligible for substantial subsidies. Moreover, they are often estranged from families and friends. The absence of informal support at home compounded by poor care coordination and safety surveillance⁴ makes this group of patients vulnerable. This reveals the urgency for socioeconomic support where scheduled and regular visits can act as a safety net.

Patients who live alone demonstrate a strong preference for independence and tendency to reject support from clinicians. This presented a challenge to healthcare workers who must balance the tension of safeguarding safety and respecting patients' autonomy. Regular attempts at engagement without imposing instructions on patients have shown to help develop rapport and trust with them, increasing their likelihood to accept clinical advice and support in future.

Findings highlight other factors that influence patients' living arrangement. For example, there is a higher proportion of Chinese patients who lived alone compared to other ethnic groups, suggesting

differences in cultural values that shape a patient's living and care arrangements.

The results suggest the need for an empathetic approach that is sensitive to patients' desire for autonomy and tailored care that addresses their unique health, psychological, emotional and cultural needs. Due to limited studies conducted on values and cultural factors influencing care preferences of patients who live alone, this study highlights the importance of further research to explicate the psychosocial and cultural complexities of this patient group. We intend to explore the experiences and needs of these patients in greater depth, and share findings that can enable providers to better support more patients like them in future.

Declaration

The authors declare they have no affiliations or financial involvement with any commercial organisation with a direct financial interest in the subject or materials discussed in the manuscript.

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