



Interdisciplinary End of Life Symposium

**ESMO Initiatives in Palliative Care and World Health Organization
Recommendations for Palliative and End-of-Life Care**

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Disclosures

- I do not have any relevant financial relationships.

This presentation and/or comments will provide a balanced, non-promotional, and evidence-based approach to all diagnostic, therapeutic and/or research related content.

Cultural Linguistic Competency (CLC) & Implicit Bias (IB)

STATE LAW:

The California legislature has passed [Assembly Bill \(AB\) 1195](#), which states that as of July 1, 2006, all Category 1 CME activities that relate to patient care must include a cultural diversity/linguistics component. It has also passed [AB 241](#), which states that as of January 1, 2022, all continuing education courses for a physician and surgeon **must** contain curriculum that includes specified instruction in the understanding of implicit bias in medical treatment.

The cultural and linguistic competency (CLC) and implicit bias (IB) definitions reiterate how patients' diverse backgrounds may impact their access to care.

EXEMPTION:

Business and Professions Code 2190.1 exempts activities which are dedicated solely to research or other issues that do not contain a direct patient care component.

This presentation is dedicated solely to research or other issues that do not contain a direct patient care component.



Content:

WHO recommendation for palliative care end of life

European medical societies involved in end of life management
ESMO guideline for end of life

EAPC recommendation for sedation in end of life

End of life and Centers of integration medical oncology and
palliative care





**World Health
Organization**

<https://www.who.int/>

Key facts

- Palliative care improves the quality of life of patients and that of their families who are facing challenges associated with life-threatening illness, whether physical, psychological, social or spiritual.
- Each year, an estimated 56.8 million people, including 25.7 million in the last year of life, are in need of palliative care.
- Worldwide, only about 14% of people who need palliative care currently receive it.
- Unnecessarily restrictive regulations for morphine and other essential controlled palliative medicines deny access to adequate palliative care.



World Health Organization

- Adequate national policies, programmes, resources, and training on palliative care among health professionals are urgently needed in order to improve access.
- The global need for palliative care will continue to grow as a result of the ageing of populations and the rising burden of noncommunicable diseases and some communicable diseases.
- Early delivery of palliative care reduces unnecessary hospital admissions and the use of health services.
- Palliative care involves a range of services delivered by a range of professionals that all have equally important roles to play – including physicians, nursing, support workers, paramedics, pharmacists, physiotherapists and volunteers – in support of the patient and their family.



World Health Organization

Pain and difficulty in breathing are two of the most frequent and serious symptoms experienced by patients in need of palliative care. For example, 80% of patients with AIDS or cancer, and 67% of patients with cardiovascular disease or chronic obstructive pulmonary disease will experience moderate to severe pain at the end of their lives. Opioids are essential for managing pain

Treaty Bodies

Committee on Economic, Social and Cultural Rights



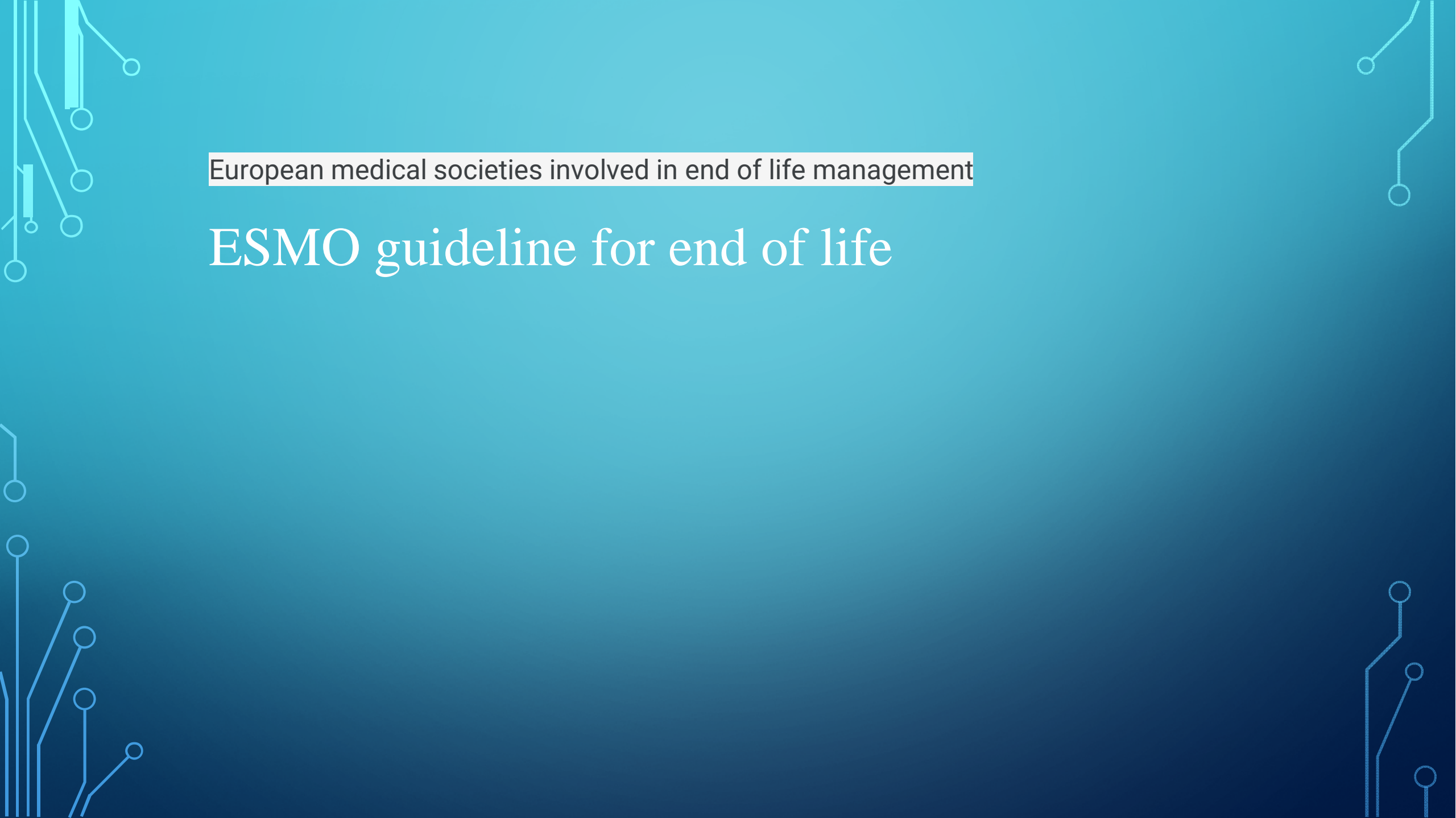
JOINT DECLARATION AND STATEMENT OF COMMITMENT ON PALLIATIVE CARE AND PAIN TREATMENT AS HUMAN RIGHTS

and

The Universal Declaration of Human Rights recognizes the rights of everyone “*to life*” and to freedom from “*torture*” and “*cruel, inhuman or degrading treatment*” (Art. 5), and “*to a standard of living adequate for health and well-being*.”

The United Nations Committee on Economic, Social and Cultural Rights specifically states that parties are “*under the obligation to respect the right to health by, inter alia, refraining from denying or limiting equal access for all persons . . . to preventive, curative and palliative health services*”⁴;

The Committee on Economic, Social and Cultural Rights affirmed the importance of “*attention and care for chronically and terminally ill persons, sparing them avoidable pain and enabling them to die with dignity*”⁵;

The background is a solid teal color with a gradient from light to dark. In the four corners, there are decorative white line-art elements resembling circuit boards or neural networks, with lines and small circles connecting them.

European medical societies involved in end of life management

ESMO guideline for end of life

Death in Hospitals from European countries

Proportion of deaths in hospital in European countries: trends and associations from panel data (2005-2017)

Jingjing Jiang ¹, Peter May ^{1 2}

PMID: 34557918 DOI: 10.1093/eurpub/ckab169

Healthcare provision for people at end of life has attracted major policy interest in developed countries over the last three decades

Analytic dataset included 30 countries accounting for over 95% of Europe's population. Average national proportion of deaths occurring in hospital in the study period ranged from 26% to 68%, with a median of 52%. Trends vary markedly by region and wealth, with low and decreasing rate in the North-West, and high and increasing prevalence in the South and East. Controlling for demographic and economic factors, strong palliative care provision and generous government finance of long-term care were associated with fewer hospital deaths.

European Recommendations for End-of-Life Care in Departments of Emergency Medicine (European Society For Emergency Medicine)

<https://eusem.org/wp-content/uploads/2017/10/EuSEM-Recommendations-End-of-life-care-in-EDs-September2017.pdf>

- Patients and their families should be involved, whenever possible, in end-of-life care decisions. All discussions should be documented, with details of those who took part in the discussions.
 - doctors should endeavor to determine whether end-of-life care plans have already been made by asking the patient and their family.
 - Discussions regarding patient treatment preferences should be communicated to family doctors, care homes and inpatient teams to enable continuity of care and end-of-life care planning.
- If the end of life is imminent, it may be appropriate to consider interdisciplinary discussions, leading eventually to a “Do not Attempt Resuscitation” (DNAR) order

Summary of Recommendations

(End-of-Life Care in Departments of Emergency Medicine)

- It is recommended that all European countries accept the concept of DNAR orders. It is advisable that such orders should be interdisciplinary and not based solely on the opinion of one doctor.
- Establishing a DNAR order does not exclude other care. A checklist or other end-of-life care document aition may be useful so that all necessary aspects of care are considered.
- All DNAR decisions should be discussed with the patient, if he/she is competent and/or with the family if appropriate.
- Organ and tissue donation should be considered as part of end-of-life care in the Emergency Department.
- All Emergency Departments should have adequate facilities for caring for bereaved relatives

ESMO definition of End of Life care

In palliative care (PC), the term 'end of life' (EoL) is commonly used but inconsistently defined.

The European Society for Medical Oncology (ESMO) Clinical Practice Guideline (CPG) refers to EoL:

as care for people with advanced disease once they have reached a point of rapid physical decline, typically the last few weeks or months before an inevitable death as a natural result of a disease

. This guideline will only consider the last weeks and days of life for the adult patient with advanced cancer.

ESMO guideline of End of Life care

At EoL, the goal of care is focused towards comfort, offering a tailored and individualised management of quality of life (QoL) and approaching death of the patient.

Thus, early integration of supportive care and PC in oncology is essential

Comfort care is holistic and person-centred, focusing on the interrelationship between physical, psychosocial and spiritual issues.

ESMO guideline of End of Life care

Early integration warrants the cessation of cancer-modifying treatments and disproportionate interventions, focusing on symptom relief and 'whole person' or 'total care'.

It is well documented that PC teams improve symptom control, satisfaction and psychological support for patients and families in hospitals, hospices and community settings, particularly at EoL.

ESMO guideline of End of Life care

In the absence of multiprofessional PC teams, and to enhance better collaboration, oncologists need skills to intervene beyond oncological therapies.

Communication with the patient and their family becomes a priority to ascertain the therapeutic choices available. Furthermore, the care setting at EoL needs careful evaluation so that monitoring of overall well-being enables the best QoL and a dignified death.

EoL provides specific challenges in clinical management of oncology patients, which can be addressed through a multiprofessional and collaborative approach.

Oncologists have a responsibility to ensure the smooth transition of the patient and family from living to dying and to coordinate the necessary resources for effective and timely intervention

The main issues addressed by the ESMO guideline

COMMUNICATION AND THE FAMILY

- Patients who are parents of young children

NURSING CONSIDERATIONS

PROGNOSTIC FACTORS IN ADVANCED CANCER

- Diagnosis of dyin

RATIONALISING TREATMENTS

- Anticancer therapies

ROUTES OF DRUG ADMINISTRATION

NUTRITION AND HYDRATION

The main issues addressed by the ESMO guideline

MEDICATION AND INTERVENTION REVIEW

- Anticoagulation
- Antibiotics
- Blood transfusion

SYMPTOM MANAGEMENT

PSYCHOLOGICAL ISSUES

SPIRITUAL DISTRESS

BEREAVEMENT CARE

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EAPC recommendation for sedation in end of lief

European Association for Palliative Care (EAPC)

Some aspects of End of Life

“Recommendation REC (2003) 24 of the Committee of Ministers to member states on the organisation of Palliative Care”.

A document like this may give us an opportunity to put palliative care on the national agenda, a recommendation like this without any national initiative will stay in the drawer of the bureaucrats.

Ref:

European Association for Palliative Care (EAPC) framework for palliative sedation: an ethical discussion

• [Niklas Juth](#), [Anna Lindblad](#), [Niels Lynøe](#), [Manne Sjöstrand](#) & [Gert Helgesson](#) *BMC Palliative Care* volume 9,

Article number: 20 (2010) [Cite this article](#)

Ethically controversial issues in end of life decisions.

More specifically, we will focus on the themes in the text that are relevant to so-called continuous deep sedation, i.e. continuing to alter patient consciousness without specifically intending to discontinue sedation, when this is done at the end of life.

More specifically still, we think there are two particular questions where the framework would have gained by being more precise: regarding **intolerable suffering and refractory symptoms** and regarding the relation **between continuous deep sedation at the end of life and euthanasia**.

Intolerable suffering and refractory symptoms

Intolerable suffering from refractory symptoms is generally conceived of as an indication for palliative sedation therapy. According to the EAPC framework, in the absence of refractory symptoms, the use of palliative sedation in the end of life is characterised as "abuse"

"This [abuse of palliative sedation] may occur by the deliberate use of deep sedation in patients who have no refractory symptoms"

According to the EAPC framework, the presence of refractory symptoms is a necessary condition for an ethically defensible initiation of sedation at the end of life, in particular when there is no intention of discontinuing sedation before the patient dies.

Cherny NI, Radbruch L, The Board of EAPC: European Association for Palliative Care (EAPC) recommended framework for the use of sedation in palliative care. *Palliat Med.* 2009, 23: 581-593. [10.1177/0269216309107024](https://doi.org/10.1177/0269216309107024).

EAPC conclusion for intolerable suffering, refractory symptoms , continuous deep palliative sedation and euthanasia

EAPC framework would have benefited from taking a clearer stand on the ethically controversial issues regarding intolerable suffering and refractory symptoms and regarding the relation between continuous deep palliative sedation at the end of life and euthanasia.

It is unclear what constitutes refractory symptoms and what the relationship is between refractory symptoms and intolerable suffering, which in turn makes it difficult to determine what are necessary and sufficient criteria for palliative sedation at the end of life, and why.

Authors conclude with a message about the spirit in which we would like to see frameworks on palliative sedation at the end of life written: that the best interest and autonomous decisions of the patients should be the primary concerns.

Saskia Siderow, MPH, Managing Director, Ormond House LLC and Allison Silvers, Vice President Payment & Policy, CAPC



The benefits of palliative care concurrent with oncology treatment are well-documented: lower symptom burden, fewer emergency department visits and hospitalizations, and less caregiver distress.^{[i],[ii]}

In short, higher-value cancer care. In fact, these outcomes are so consistent that both the American Society of Clinical Oncology and the National Cancer Institute recommend combining standard oncology care with palliative care for patients with advanced cancer or high symptom burdens

Criteria for “Designated Centers”

- 1. The Center provides closely integrated oncology and palliative care clinical services**
- 2. The Center is committed to a philosophy of continuity of care and non-abandonment**
- 3. The Center provides high level home care with expert backup and coordination of home care with primary cancer clinicians**
- 4. The Center incorporates programmatic support of family members.**



Criteria for “Designated Centers”

5. The Center provides routine patient assessment of physical and psychological symptoms and social supports and has an infrastructure that responds with appropriate interventions in a timely manner
6. The Center incorporates expert medical and nursing care in the evaluation and relief of pain and other physical symptoms
7. The Center incorporates expert care in the evaluation and relief of psychological and existential distress



Criteria for “Designated Centers”

8. The Center provides emergency care of inadequately relieved physical and psychological symptoms
9. The Center provides facilities and expert care for inpatient symptom stabilization
10. The Center provides respite care for ambulatory patients for patients unable to cope at home or in cases of family fatigue



Criteria for “Designated Centers”

- 11. The Center provides facilities and expert care for inpatient end-of-life care and is committed to providing adequate relief of suffering for dying patients**
- 12. The Center participates in basic or clinical research related to quality of life of cancer patients**
- 13. The Center is involved in clinician education to improve the integration of oncology and palliative care**



The main types of centers:

1. Comprehensive centers for cancer treatment (such as major centers in European capitals).
2. Hematology centers that require strict and often long-term surveillance of patients.
3. Centers of specific cancer treatment, for example lung cancer.
4. Hospices in collaboration with the department of medical oncology.
5. Medical oncology departments in collaboration with hospices.

Ref:

How to integrate medical oncology and palliative care?

Alexandru C. Grigorescu

Teodorescu Laura Mihaela

Integr Cancer Sci Therap, 2019

DOI: 10.15761/ICST.1000322

Institute of Oncology Prof. Dr. Alexandru Trestioreanu

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- 1. [ESMO Designated Centres of Integrated Oncology and Palliative Care](#)
- 2. [ESMO Accredited Designated Centres](#)

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Current Period of Accreditation

2022 - 2025

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CONCLUSIONS:

EoL is an important problem of humanity that must be solved not only by medical professional but by the whole society

WHO, United Nations, ASCO, ESMO .EAPC, CAPC fight for implementation of all countries of the treatment of pain and other symptoms that define unacceptable suffering.

Paliative care departments and hospices mainly deal with EoL

ESMO recommends the integration (education facilities etc.) of the therapy of serious symptoms and EoL in the oncology senters , the emergency departments and whenever the patient may die.