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The picture on the cover: "*Roof tails*" from Bartl, Hungary

EDITORIAL

Palliative care for European citizens

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In Europe the need of palliative care is growing, related to the ageing of the population and changes in morbidity. In most European countries palliative care is developing. The European Association of Palliative Care (EAPC) has constructed a benchmark to assess the level of palliative care in each country. The maximum score is 100 and one country is defined as the golden standard, i.e. the United Kingdom. The decision of EAPC to define the UK as golden standard maybe seen as a successful neo-colonialism of the hospice movement. Ireland, Sweden and the Netherlands have a score in the eighties, while countries like Romania, Malta, Greece and Portugal score 40 or lower.

In Romania – as in many other European countries – people with a terminal disease prefer to die at home. Not hospices or ‘specialised dying wards’ in hospitals are the priority of palliative care, but palliative care provisions at home, where palliative care is delivered by the family doctor and the district nurse and supported by family members and volunteers. And indeed, that what is missing in many European countries, especially in Central-Eastern and Southern European countries.

In various European countries like Bulgaria, Estonia, Romania and Slovakia palliative care is stimulated by the support of charity organisations from abroad. Most of these organisations have given much attention to the development of hospice care and less to palliative care services at home. The role of such organisations may be questioned for two reasons. On the one hand they promote an idea about palliative care, which may fit in their ‘home culture’, but not for example in the Romanian culture and tradition. So, they develop care provisions based on ‘important values and beliefs’. On the other hand, they hinder the development of a palliative care policy by the citizens themselves and their policy makers. Many Central-Eastern countries are ‘over- hospitalised’. Building up more in-patient based facilities is not what citizens need neither what policy makers want.

A workshop in October 2009 in Bucharest, Romania, discussed the need of palliative care in Romania and what solutions are preferred. The workshop was not only attended by experts and health care professionals, but – which is not seen often – also by representatives of patient organisations, volunteers, insurance organisations and policy makers. The conclusions of the workshop as well as the analysis may serve as an example for other countries. Therefore, this issue of PALIATIA is reporting the details of this workshop.

The resolution of the Assembly of the Council of Europe, drafted by Dr. Wolfgang Wodarg, adopted in January 2009, states ‘palliative care is a model for innovative health and social policy’. The resolution makes a plea for European countries to take this opportunity to make palliative care available for their citizens. Already in 2003 the Council of Europe called the governments of member states ‘to adopt policies, legislative and other measures necessary for a coherent and comprehensive national policy framework for palliative care.’

There is no doubt, that palliative care is a service, which has to be available and accessible for all European citizens, with guarantees for quality of care. But these palliative care services should respect the values, beliefs and customs of the citizens of the country, where the service is delivered. The workshop in Bucharest indicates that different types of palliative care services are needed through Europe. There is no golden standard yet.

ORIGINAL PAPERS

Palliative care in Romania: the state of the art

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Presentation on the workshop "*Palliative care for Romanian citizens: a plan for action*",
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Abstract

Palliative care is a relatively new development in health care. However, it is believed to become more and more important. In some countries it is the fast growing new health care provision.

WHO defined palliative care in 2002 as '... an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.'

This presentation describes the present situation on palliative care provisions in Romania. In Romania, a fast majority of family doctors reports a need for palliative services in their region. Also, they report the need for more information and training in palliative care, especially on pain treatment, communication issues and treatment of depression/anxiety.

Using calculations from international data, since Romanian data are lacking, it is calculated that the total number of patients who need palliative care annually is 73.000. Palliative care is at home is needed by 46.000 patients on average per year, while institutional palliative care (special units in hospitals, hospices, nearly home houses) is needed by 27.000 patients on average per year.

The numbers of patients taken care for on an annual basis is not known, but some data are available about the number of facilities for palliative care patients. These have increased between 2002 and 2006 but recently no increased further because of lack of funding. Sixty eight provisions for palliative care were functioning in 2006, the majority financed by foreign humanitarian or religious foundations. On average, based on the number of patients in need for palliative care in Romania, each of these palliative care services had to take care for over 1000 terminal patients per year.

It is calculated that in 2006 about 2700 patients in need for palliative care are really helped by all palliative care services together. So the shortage of palliative care is enormous.

Research shows the need among terminal patients for palliative care is very large. The number of symptoms patients have when they enrol in a palliative care service – only for the lucky ones – is much higher than the same type of patients have in other countries. This finding and the large differences in average visits per week for patients, taking care for at home, indicates a large variety in quality of palliative care. Romanian citizens with a terminal disease suffer a lot from pain, nausea, dyspnoea and also from anxiety and depression. Not only the patients suffer, also their families.

Several projects have shown that palliative care of good quality may be delivered in Romania. However, there is a shortage in palliative care expertise. This growing medical services is not taught at medical schools.

There are discrepancies and obscurities in the present legislation and regulations. However, legislation and financial regulations may be relatively easily adopted. Therefore, decisions are needed, to be taken by the Romanian policy makers, to realise sufficient palliative care provisions in Romania.

Such adaptation of legislation and financial regulations is not difficult. The question is: do our representatives and policy makers care about fellow citizens with a terminal disease, suffering and in need for care?

Keywords: *palliative care, pain, need for care, legislation*

Introduction

WHO defined palliative care in 2002 as ‘... an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual’(1).

Palliative care has two major goals: symptom control and maintenance quality of life. And palliative care is not only dealing with physical symptoms and aspects, but includes early identification, assessment and treatment of psychosocial and spiritual problems. The consequences are that interdisciplinary care arrangements have to be available to deliver palliative care (2). As Dr. W. Wodarg and the resolutions of the Assembly of the Council of Europe have indicated, palliative care has to be a part of regular health care. And it is one of the fast growing new care arrangements in western health care systems (3,4).

The question in this article is: what is the state of the art of palliative care in Romania? The need for palliative care in Romania will be analysed and an inventory of palliative care provisions will be presented. This will be followed by an overview of legal arrangements which may stimulate or hinder the development of palliative care in Romania.

Methodology

To answer that central question different resources will be used. The *need for palliative care* will be analysed from the perspective of health care professionals as well as based on epidemiological data. In 2004 a survey was executed among a sample of family doctors and nurses, working in primary health care, about their opinions and experiences with palliative care in Romania (5). The most important findings will be presented. Based on an international literature search it was possible to estimate how much people are in need for

palliative care in Romania (2,6). The urgency of this need is analysed based on a survey among terminal patients, who enrolled in palliative care as part of the PACARO project (7). In 2002 and 2006 an inventory was made of *palliative care provisions* in Romania (8,9). The changes in health care provisions will be analysed and presented. But also, in the survey among family doctors and nurses we asked for the possibilities of delivering palliative care in Romania.

The *legislation* on social and medical care for severe ill patients as well as legislation on human rights and patients rights is analysed and the main results will be summarised (10).

Results

The need for palliative care

A fast majority of family doctors (82%) reports a need for palliative services in their region. Also, they report the need for more information and training in palliative care, especially on pain treatment, communication issues and treatment of depression/anxiety (5).

An international review distinguishes between the need for palliative care between cancer patients and non-cancer patients. Otherwise than often thought, the need for palliative care is about equal between cancer and non-cancer patients. And even more important, the need for palliative care is growing more rapidly among non-cancer patients, because of changes in morbidity patterns.

For Romania, looking at international data, the total number of patients who need palliative care annually, is estimated to be 73.000. For Romania, it can be calculated, that palliative care is at home is needed by 46.000 patients on average per year, while institutional palliative care (special units in hospitals, hospices, nearly home houses) is needed by 27.000 patients on average per year. Family care and taking care for dying people at home are more common in Romania, as compared to the international data these calculations come from. So, the need for palliative care at home will be somewhat higher for Romania and the institutional palliative care somewhat lower than the presented figures.

Another indication of the high need of palliative care is the number of symptoms terminal patients had in enrolling in a palliative care service. These Romanian data may be compared to research results from other, i.e. western European countries (7). The Romanian data show, that patients enrolled in the palliative care services had over 12 symptoms. The number of symptoms is almost as twice as high as compared to studies from abroad. This indicates that patients have to wait much longer and have to suffer much more before there is a change to receive the needed palliative care.

Palliative care provisions

Accordingly to family doctors, the possibilities for delivering palliative care in Romania are bad (52%) or even very bad (37%).

The inventory in 2002 and 2006 gave the following overview (Tabel1) (8,9)

Tabel 1 - Palliative care facilities in Romania in 2002 and 2006 and number of patients cared for in 2006

Type of units	2002	2006	Estimated palliative care patients in 2006
Hospital unit/hospice	1	5	300
Hospice (free standing)	4	9	400
Mobile teams connected with	0	7	1200

hospice/hospital			
Teams for palliative care at home	10	24	800
Day care centres for palliative care	11	23	?
Total	29	68	

The number of palliative care provisions doubled in 4 years. There are a few specific palliative care services for children. The numbers of patients taken care for on an annual basis is not exactly known. On average, based on the number of patients in need for palliative care in Romania, these palliative care services had to take care for over 1000 terminal patients per year.

The PACARO project showed, that teams for palliative care at home, took care for on average 15 terminal patients per year. However, the study also showed that the teams could take care for more patients if needed to a maximum of about 30 patients a year. This figure comes close to an inventory of patients taken care for in 2006 (9). In 2006 the number of patients receiving palliative care at home was about 2000, while the need is estimated to be 23 times higher.

In 2006 the number of patients to be taken care for in hospice and special wards in hospitals was about 700 per year. The number of patients in need for palliative care in hospices will be almost 40 times higher.

Recent data on palliative care provisions are not available. The impression is, based on a search on internet and information of the Ministry of Health, that the number of palliative care provisions did not increase in the last years.

Another finding from the inventory in 2006 is, that the intensity of the care given varies largely. Some palliative care teams at home visit their patients 3-4 visits per week on average, while others report one visit per month on average. Research data from abroad show, that 3-4 visits per week are 'normal'. This large variation is an indication that the quality of palliative care may be very different.

Legislation

Legislation in palliative care is developed from 1999 on. The legislation may be divided in three parts:

- *Teaching, training and specialisation in palliative care.* Palliative care is recognised as a medical, special competence in 1999, 2000 and 2001. In 2002 and 2003 training centres for 'specialisation' in palliative care competence were recognised; there are two centres now. Last year the Ministry of education mentioned palliative care as a topic for teaching palliative care in under graduate medical training. (Order nr. 390/2008 Ministry of Education. March 2002 Health Ministry Study Center "Casa Sperantei" Hospice. November 2003 Health Ministry Recognition of other centers for training in competence. Health Ministry Order no. 772/1999 recognizing the competency of palliative care. Health Ministry Order no. 254/2000 recognizing the palliative care as a specialization. Health Ministry Order no. 923/December 2001 palliative care is recognized as a supplemental competency in the Specialty Classification Book);
- *The provisions in palliative care.* Related to the reorganisations of hospitals palliative care services were mentioned as 'new activity' in 2002 and confirmed as possible 'hospital activity' in 2006. Direct and concrete measures are not taken. Related aspects are the formalisation of home care services in 2003, including the role of volunteers in 2005. In 2006 home medical services were mentioned. The law on opioids of 2005, effective in 2007, enlarged the possibilities for management on

symptoms in palliative care patients. (Government Decision no. 826/2002 – National Strategy regarding the reorganization in institutions with beds. Order no. 318 of April 7, 2003 approving the rules for organization and functioning of home care services. Law of the opioids / 2005 with rules to application in June 2007. DECISION nr.1317 of October 27, 2005 on support for voluntary activities in home care services. Law no. 95/2006, Hospital law – mentions palliative care among the other hospital services. Order Nr. 1211/325 of 4 October 2006 Regulations to assess the providers of medical services, medical devices, medicines and sanitary materials, assessment standards, and rules methodology for health care providers, medical devices, medicines and sanitary materials);

- *The right for palliative care.* Right to receive care at home was formulated in 2002, followed by the right to receive terminal care in 2003. (Emergency Ordinance no. 150/2002 adjusts the Health Care Law, emphasizing the patients rights to receive care at home in any situation. Law no. 46/2003 – Law of patients rights; the right of patients to get terminal care, to die in dignity.

There are various discrepancies in the order and completeness of legislation in palliative care. The most remarkable consequences are:

- the late recognition of palliative care as a subject for medical education; as a consequence, palliative care is rarely taught at medical schools;
- the number of expertise centres and post graduate training centres is insufficient in numbers as well as in regional distribution;
- the absence of clear regulations on content and reimbursement of palliative care services at home and in hospices;
- the right of patients to receive palliative care without taking measures to assure accessible and qualitative palliative care provisions. So Romanian citizens are unable to use their right on terminal care;
- currently, the social health insurance law of the National Health Insurance House provides no list of distinct palliative care services in addition community health care services to patients at home. These citizens are not treated medically although they are terminally ill. Even the care is limited to 3 months. On the other hand, Order no. 318 of 2003, the Ministry of Health provides a distinguish list of palliative care services for both physicians and for nurses with competence and specifies the method of payment to home care providers. This order is not applied by the Health Insurance House.

Conclusions

The need for palliative care is tremendous in Romania. There is a enormous shortage on palliative care provisions. And the few palliative care provisions are unequally distributed. Romania is at the back in taken care for terminal ill patients in Europe.

There is a discrepancy between the legislation on palliative care and the patients' rights to receive palliative care. The Romanian law on 'patients rights' stipulates the right to receive specialised medical care till the last moment of life and to die in dignity. This legislation is in line with European norms. However, most patients do not receive such care. Those who receive palliative care get it from nongovernmental organisations providing this care.

The reason why most patients do not receive palliative care they need and are entitled to accordingly the Patients' rights Law, is the discrepancy in legislation and regulations between the Ministry of Health and the Ministry of Social Affairs and between the Ministry of Health and the Health Insurance House.

It is recommended to adapt the existing regulations to a coherent set and to start a stimulation programme for the development of palliative care in Romania.

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Regional Expertise Centres for Palliative Care: experiences and possibilities

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Abstract

As the resolution of Dr. W. Wodarg, adopted by the General Assembly of the Council of Europe, in January 2009, states palliative care is an integrated part of health care and a model for innovative health and social policies. European countries are urged to create sufficient and qualitative palliative care services, since the need for such services is increasing rapidly because of the ageing of the population.

Romania has experts in palliative care and medical doctors and nurses may be accredited with 'competence in palliative care'. The number of experts is, however, limited and the maintenance of expertise asks for additional training and support. This is special the case if palliative care is delivered at home.

In the project PALLiative CARE in ROMania (PACARO) it was shown, that Romanian citizens have need for palliative care at home. Also it demonstrated, that palliative care can be delivered at home with good quality in Romania, if resources (infrastructure, expertise and finances) are available. And even more important palliative care at home is highly preferred and appreciated by Romanian citizens. Romania, however, has an enormous shortage in palliative care services.

The question is: how palliative care services with guaranteed quality and with sufficient expertise can be build up in Romania? This question is highly relevant since Romania is scoring very low on the benchmark for palliative care in the EU: 22nd out of 27 countries.

In Slatina an experiment was started in 2007 to build up a regional expertise centre for palliative care. It has shown, that such a regional expertise centre can build up and that it plays a pivotal role in ensuring accessibility and quality in palliative care. Romania may learn from its own experiment as well as from experiences abroad, where regional expertise centres on palliative care have been build up in the last years. But more is needed.

To build up palliative care in the next five years a national stimulation programme for palliative care is needed. Such national programmes were realised in various other EU countries in the last decade and were very successful in realising qualitative and sufficient palliative care services.

A national stimulation programme on palliative care encloses *all* diseases (dementia, HIV, cancer etc.) as well as *health* and *social* care. Palliative care starts in the primary health care system; *continuity of care* is an essential part of the service. The programme includes the establishment of regional expertise centre, information and training, national guidelines for

palliative care and research. Legislation has to be analysed and possible adapted to implement the national programme and extra resources have to be put available.

Regional expertise centres are needed to support health and social care workers in palliative care, to stimulate the quality of the services and to inform citizens and palliative care workers on the possibilities of palliative care. Romanian citizens are poorly informed about palliative care, on what it is and what it may perform. Also these regional expertise centres will play an important role in training of volunteers, in post graduate training for health care workers and in research and innovation in palliative care.

It is up to the Romanian politicians to take the proper action now. These days, ten thousands of Romanian citizens suffer because of the lack of palliative care provisions. Proper action, as proposed, will reduce the suffering and pain of many terminal ill patients and their families.

Keywords: *palliative care, expertise centre, benchmark, national programme*

Introduction

Accessibility of health care for citizens is a basic human right. And as the resolution of Dr. W. Wodarg, adopted by the General Assembly of the Council of Europe, in January 2009, states palliative care is an integrated part of health care and a model for innovative health and social policies (1).

Accessibility to palliative care means, that palliative care facilities have to be sufficiently available. The first question is: does Romania have sufficient palliative care services available? The answer is 'NO' as is shown and concluded by Dr. L. Dumitrescu (2). And the need for such services is growing (3,4).

Another prerequisite, when a health care service is offered to citizens, is that the quality of that service is guaranteed and controlled for (5). The question 'how can the quality of palliative services be guaranteed and controlled in Romania?' is even more important if such services have to be built up. Yes, Romania has experts in palliative care and medical doctors and nurses may be accredited with 'competence in palliative care'. The number of experts is, however, limited and the maintenance of expertise asks for additional training and support. This is special the case if palliative care is delivered at home.

In the project PAlliative CAre in ROmania (PACARO) the need for and possibilities of palliative care at home were demonstrated (4). Palliative care at home can be delivered with good quality in Romania, if resources (infrastructure, expertise and finances) are available. And even more important palliative care at home is highly preferred and appreciated by Romanian citizens.

This article will explore how palliative care services with guaranteed quality and with sufficient expertise can be built up in Romania. I will start by showing, that Romania is behind other countries in this field. Next I will explain why regional expertise centres are needed, referring to recent experiences in Slatina with the experiment to build up a regional expertise centre for palliative care.

In looking for answers how to build up qualitative and sufficient palliative care services in Romania I will use experiences and studies from abroad and describe the outline of a national stimulation plan for palliative care.

Building up palliative care services

The European Association of Palliative Care (EAPC) has developed a benchmark for palliative care in Europe. The benchmark combines various parameters for palliative care like: the level of care provisions in palliative care, availability of special drugs, training facilities, the existence of national association and coordination (6). The ideal score is 100. Countries like Ireland, Sweden and the Netherlands score over 80 (see Table 1). Most Eastern European countries score below 50 with the exception of Poland, which scores 77. Romania scores 40 and takes the 22nd place in the EU according to this benchmark (7).

Such a benchmark at least indicates that some work has to be done and especially about the resources.

Table 1 - Score EAPC benchmark palliative care

Country	Resources index (max 135)	Vitality index (max 10)	EAPC index (max 100)
Ireland	111	7	85
Sweden	114	6	84
Netherlands	105	7	81
Poland	102	6	77
Hungary	65	2	44
Romania	41	6	40

Already in 2003 the Committee of Ministers of the Council of Europe adopted the recommendation for *common rules* in the health care field, including the provision of equitable access and appropriate quality in health care, for all member states (3). Especially, attention was asked for the *development of palliative care*, considering the growing number of people in need for palliative care. And the recommendation emphasised the differences in availability and quality of palliative care throughout Europe, calling for co-operation between countries.

Six years later the picture has not really changed for Romania. Therefore, new actions are needed. One is the establishment of regional expertise centres on palliative care.

The importance of regional expertise centres

As known, only a few expertise centres exists in Romania and are mainly focused on training (2). A policy to really implement palliative care expertise in health care is not realised yet.

Other countries have had the same problem. For example, in the Netherlands the development of regional expertise centres in palliative care has been an explicit policy to stimulate palliative care and to guarantee the quality of palliative care. The role of these regional expertise centres have been evaluated (8). The independent evaluation committee concluded, that the regional expertise centres were very functional in giving information, training, network building between disciplines/different care professionals and in delivering individual consultations/advice when care became unexpectedly complicated.

Also some interesting recommendations were made by the evaluation committee. One is, that palliative care is *generalist care*. It means, that palliative care has not to be delivered by specialists of special institutions, but by all health care professionals, advised by a group of experts (working as a *consultative team in the regional expertise centres*). Special attention

should be given to the importance of palliative care at home, delivered by family doctors and home care organisations. This plea for generalist palliative care is not typical Dutch, but also heard in UK, Belgium and Austria (9).

Another recommendation was, that regional palliative care centres should not be part of a cancer centre, but independently and open for all kind of patients. If they are part of cancer centres less attention is given to palliative care for non-cancer patients.

The Regional Expertise Centre on Palliative Care in Slatina (REPACARO or CREIP) was build up in 2007 with support of the Dutch Ministry of Foreign Affairs. Build up means, a infrastructure has to be created (place, bureau, phone lines, information systems, leaflets, developing courses and information sessions etc.) and volunteers had to be trained to execute the work. In Slatina enough volunteers (most individual involved in health and social care were found) to follow the training and to execute the various activities. CREIP started in January 2008. In Table 2 an overview is presented of the various activities and the number of people involved.

Over 140 persons have attended information sessions on palliative care. Five courses were given for nurses; the courses were accredited and attended by in total 281 nurses. Information and training sessions for General Practitioners were attended by 288 GPs. The figures indeed show the large interest in palliative care among health care professionals and the public.

Also mass media showed a clear interest in palliative care.

Patients in need for palliative care and their families could ask for information and consultation at the regional expertise centre. Also, here the interest to get help, support or advice is evident. Consultations of patients and their families was requested 29 times; these consultations were dome at home of the patients and often included family members. Phone calls to the expertise centre were less frequent as expected in a year period; 32 calls from patients/families and 6 calls by care professionals. Most frequently patients/families asked for help with care at home (by lay person or by nurse), for pain drugs and for symptom treatment.

Table 2 - Overview of activities of new regional expertise centre, started in January 2008, in 19 months.

Activity	Number of persons involved or attending	Number of sessions
Accredited courses for nurses	281	5
Information sessions on palliative care for public	140	2
Information and training General Practitioners	288	2
Courses for assistant nurses	51	2
Information session for oncologists and neurologists	38	1
Training on consultation in palliative care	16	1
Consultation at home of patients	48	29
Phone calls by patients/families	32	32
Phone calls by health care professionals	6	6
Mass media articles/interviews etc.	23	5

Family care givers feel better since they know they may call the expertise centre for advices in case of questions or uncertainties, additionally to their own health care professionals. Such need for information or advice is found also in western countries (10).

Through the courses, information sessions and consultations a network is developing.

Indeed, CREIP starts to fulfil the functions like the regional expertise centres in the Netherlands, contributing to more accessibility of palliative care and to better quality. CREIP could be build up with special support (money and expertise) of the Dutch Ministry of Foreign Affairs. This support will end this month, but CREIP will continue its activities since various institutions in the region, including clinics, patient organisations and the municipality, have noticed the added value of such a regional expertise centre.

With this project it was demonstrated how palliative care teams at home and palliative care workers (family doctors, nurses, social workers) may be supported in delivering good quality of palliative care by the regional expertise centre. So, we know what infrastructure is needed and how to implement it.

National stimulation programme for palliative care

However, regional expertise centres have to be part of an overall plan, a national programme to stimulate palliative care in Romania. By such a *national stimulation programme* Romanian citizens may get access to palliative care services at European level in Romania, as the Council of Europe has asked for (3).

So, first a national stimulation programme for palliative care has to be adopted by the Parliament. By a national stimulation programme I mean a *real* national plan, which is build up and agreed on by all relevant stakeholders. This means that it is not limited to oncology neither to hospices. The programme foresees in the provision of palliative care services for *all patients* in need for such care. As epidemiological data show the biggest challenge for the future here is for patients with dementia.

Essential in palliative care and so in the programme to define how to build up *continuity* in palliative care, starting with primary health care. Dr. D. Doyle, an international expert on palliative care, states, that there are 5 models of palliative care, varying from hospice care to day care centres (11). It is, however, a mistake to think in such models. Palliative care provisions have to be linked with each other; a chain of palliative care provisions is needed to ensure continuity and quality of palliative care. *And* palliative care has to integrate health and social care arrangements.

The national stimulation programme foresees in the establishment of regional expertise centres to support and stimulate (the quality of) palliative care services, including the role of family members and volunteers.

Expertise in palliative care has to be developed. Palliative care has to be part of the undergraduate curricula of medical and nursing schools in all universities. Professors in palliative care have to be appointed in medical schools for teaching, research and for the development of better and innovative palliative care services. Of course, such a research programme will be part of an European network of palliative care research (6,8).

Related to the academic expertise regional expertise centres are needed. On the one hand these regional expertise centres will support health care professionals and other workers in

the field of palliative care. On the other hand these centres will cooperate with the academic centres for research and training.

Despite the high need for palliative care Romanian citizens are poorly informed about palliative care. The PACARO project showed, that people were surprised that support, relief of pain and nursing care at home were possible and they were grateful for it (12). This also shows that people do not know what to expect and what their rights are, especially in rural areas.

So an *information plan for palliative care* has to be implemented to inform citizens about the objectives and possibilities of palliative care and about their rights to receive palliative care. It also will open the possibilities to involve family members and volunteers more intensively in palliative care. As the president of the EAPC was stating: 'the lack of understanding the key concepts of palliative care has been a major barrier to the development of palliative care in Europe' (6). Maybe such information campaign is also needed for the professionals and for the members of Parliament.

The importance of information on palliative care for the public is demonstrated in an Italian study, which shows that lack of information and knowledge among caregivers and its consequences for unnecessary hospital admission and unequal distribution of palliative care facilities (13).

To assure the quality of the palliative care given, *training of health and social care professionals and volunteers* is important. In countries like Austria and the Netherlands volunteers play a significant role in palliative care at home and in hospices. For example, in the Netherlands over 8000 volunteers participate in palliative care (14).

Guidelines on palliative care are available in most Western European countries. It is important to adopt these to the Romanian context and to implement these. Implementation of guidelines is one of the task of regional expertise centres. The use of guidelines also enables the quality control by the Ministries of Health and of Social Affairs.

Last but not least the plan specifies the *legal and financial arrangements*, which has to be added to the existing legislation (2).

I have depicted the main elements of a national stimulation programme for palliative care in Romania. In several European countries (like Belgium (Flanders), Ireland and the Netherlands) such national plans have been executed in the last ten years (7,8). Romania could learn from it. And as mentioned, these countries score high on the EAPC benchmark.

Conclusions and recommendations

Palliative care is hardly needed in Romania. Terminal ill patients suffer unnecessary because of lack of information on palliative care and lack of services. There is a shortage in expertise in Romania. The need for palliative care is increasing and internationally an appropriate level of palliative care is seen as a matter of civilisation and development.

Palliative services with high quality may be build up in a 5 years programme. Therefore, it is urgent, that the Romanian Parliament takes action and approves a national stimulation programme for palliative care.

The programme covers palliative care for all patients in need for such care, it builds a network for continuity of palliative care and establishes regional expertise centres, a research

programme and a national information plan. Legal and financial arrangements will be clarified and implemented.

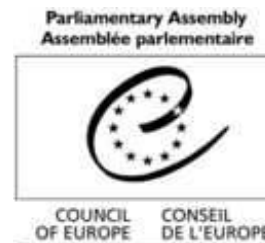
The citizens of Romania – especially the terminal ill patients – will benefit from such a national stimulation programme. In a period of five years such a programme – with enough resources, experts from abroad and financial support from the Romanian government – might realise palliative care provisions in Romania at European level. Why should Romanian citizens not have the same rights as other EU citizens?

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MANAGEMENT

Parliamentary Assembly
Assemblée parlementaire



Resolution 1649 (2009)(1)

Palliative care: a model for innovative health and social policies

1. The Parliamentary Assembly notes that palliative care is a substantial and socially innovative addition to curative, highly scientific medicine, where the subjective wellbeing of the patient comes after the goal of curing an illness and which involves therapy-related restrictions and sometimes massive side effects.
2. In this connection, the Assembly builds its position on the 2002 World Health Organization (WHO) definition: palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.
3. The Assembly nevertheless underlines that the innovative potential of the approach is not given sufficient emphasis in this definition, which could lead public opinion to believe that palliative care is a humanitarian luxury which we can no longer afford in the current difficult economic situation.
4. The Assembly notes that, especially in the final stages of life and in spite of the high standards and huge costs involved, contemporary medical care fails to meet the basic needs of many people (seriously ill, chronically ill, patients requiring high levels of individual care). Against the background of the increasing domination of health and social policies by economics, growing numbers of people do not have a strong enough lobby to defend their basic rights.
5. The Assembly regards palliative care as a model for innovative health and social policies, as it takes account of the changes in our perceptions of health and illness and does not assume that curing diseases is the precondition for self-determination and participation in society. Autonomy is accordingly the requirement for a subjective form of “health”, which includes people’s freedom to decide for themselves how to deal with illness and death.
6. The Assembly notes that palliative care enables people who have serious illnesses, are suffering pain or are in a state of great despair, to exercise self-determination. The approach is not, therefore, just based on need, but contributes directly to human, civic and participation rights being asserted right up to death.

7. The Assembly believes that there is an urgent need to extend the scope of this innovative treatment and care method. In addition to the terminally ill, palliative care should be available to the seriously ill and chronically ill and all those requiring high levels of individual care who may benefit from the approach.

8. Palliative care can be seen as an approach to an appropriate type of care developed on a practical level, which involves patient-oriented integration of medicine and care, as well as the provision of other health-related services and social resources. For instance, this includes the successful involvement of voluntary helpers and the possibility of including social, psychological and spiritual support if necessary.

This can be more important for individual patients than medical care in the stricter sense.

9. With the above, the Assembly also draws conclusions from the debate on the subject of euthanasia, which showed that liberal constitutional states cannot leave ethical questions concerning the life and death of individuals unanswered¹⁰. Sticking to ethical pluralism does not ensure maximum individual freedom in ethical issues, but, in society it gives precedence to randomness, relativism and practical nihilism over properly founded ethical positions. This results in general disorientation and ultimately in the erosion of the liberal constitutional state.

11. In this connection, the Assembly refers to the relevant recommendations on dealing with the terminally ill as set out in the European Health Committee's report (1980) "Problems related to death: care for the dying" and in its Recommendation 1418 (1999) on protection of the human rights and dignity of the terminally ill and the dying.

12. It recognises that the limits of any medical intervention are determined by the autonomy of the individual patients in so far as they express their will not to receive curative treatment or, regardless of any medical assessment of their state of health, have done so explicitly in a living will, for instance.

13. The Assembly hopes that palliative care also offers individuals who have given up hope the prospect of dying in dignity if they are allowed to turn down curative medicine but accept pain relief and social support.

14. It therefore regards palliative care as an essential component of appropriate health care based on a humane concept of human dignity, autonomy, human rights, civic rights, patient rights and a generally acknowledged perception of solidarity and social cohesion.

15. It underlines that Recommendation Rec(2003)24 of the Committee of Ministers to member states on the organisation of palliative care already provides a good basis for strengthening the palliative care approach.

16. The Assembly endorses the four applications of palliative care listed in Recommendation Rec(2003)24 following the WHO definition – namely symptom control; psychological, spiritual and emotional support; support for the family; and bereavement support – and accordingly, specifically recommends that member states:

16.1. establish a consistent and comprehensive healthpolicy approach to palliative care at national level;

16.2. promote international cooperation between the various organisations, institutions, research institutes and other players in the palliative care movement.

17. In view of the great differences in developments in this area in the various countries in Europe, the Assembly is aware that, although rapid implementation in existing healthcare structures is desirable with a view to sustainable funding arrangements, the funding arrangements themselves may involve serious obstacles for such a flexible care and treatment approach.

18. It therefore believes there is a need for detailed analysis of structural obstacles and accurate analysis of needs on the basis of a minimum data set of the kind called for in the appendix to Recommendation Rec(2003)24 in order to achieve sustainable, effective changes in existing health systems.

19. It notes that wide-ranging discussion in society on the priorities of health care based on sensible health objectives is necessary if fundamental rights are to take precedence over further patient rights in the health system. As the protection of fundamental rights is a government task, this must not be left to pressure group politics.

20. The Assembly believes that ethics therefore have a fundamental role to play as a practical philosophy in shaping the discussion of health objectives and care priorities in society.

21. Therefore, with regard to general recommendations, the Assembly recommends that member states:

21.1. focus on ethics not only in application issues but as a matter of principle, as only the clarification and typological classification of fundamental positions will enable a stable consensus to be reached in society about controversial ethical issues and a fair allocation of resources;

21.2. seek to ensure improved rewards for non-product related services both in health and in economic and financial policies so that social policy can draw on economic policy and fiscal incentives and to counter more effectively the increasing domination of society by economics
21.3. in general, seek to strengthen primary health care so as to protect patients against inappropriate medical intervention and place greater emphasis again on the importance of communication between doctor and patient as the basis for rational, patient-oriented medicine;

21.4. given governments' capacity for influence, promote an approach to medicine in society which highlights palliative care as a key pillar of care provision to which patients are entitled.

22. Moreover, with regard to practical recommendations, the Assembly recommends that member states:

22.1. consider effective symptom control for seriously ill patients as a key requirement for the doctor-patient relationship and patient self-determination and promote this view, thereby also bringing the innovative potential of the palliative care method into the domain of curative medicine;

22.2. within a consistent health policy approach for the specific strategy of improving palliative health care provision, identify practical indicators that can be used to check what progress has been made in patient care over a given period;

22.3. draw up annual reports so that shortcomings can be analysed as quickly as possible and dealt with appropriately;

22.4. react promptly, for instance through special arrangements for the funding of palliative care, if it becomes apparent that the appropriate use of painkillers is not taking place as desired or the standardisation of hospital treatment (through diagnosis related groups – DRGs) is having a negative impact on existing structures and practices;

22.5. with regard to legal regulations on living wills:

22.5.1. avoid creating legal arrangements which could lead to interpretation problems in practice;

22.5.2. conduct a comprehensive assessment of the legal consequences, taking account of possible legal side effects such as asset liability (“care as a financial loss”).

1. Assembly debate on 28 January 2009 (6th Sitting) (see Doc. 11758, report of the Social, Health and Family Affairs Committee, rapporteur: Mr Wodarg). Text adopted by the Assembly on 28 January 2009 (6th Sitting).

COMMENTS, DISCUSSION

The voice of old people in Europe*

Cluzel A. AGE Platform, Member of E.D.E. the European Association for Directors of Residential Care Homes for the Elderly

*This is not a scientific paper; it is just the expression of older people.

Abstract

We are all living until the End of Life and dying will be our last act of life.

"I shall want those who will be looking after me to know how I feel about this, to look at me as I am, old and frail and unable to do anything myself and to respect my ageing mind and body."

Not only myself speaking on behalf of AGE, but also the leaders of the European Union, underline the necessity at all times in long term care to respect the dignity of the person cared for, young or old, but especially the very frail older old.

'Please respect who I am. I may not speak your language, have your beliefs, but respect my choices. And I do hope you will look after my dearest family and help them through any distressing times." To my knowledge this is what older people are calling for.
"What I want is End of Life Care".

AGE, the European Older People's Platform, through its members, hears the voice of older citizens in Europe;
and AGE, through its collaboration with the European Commission has early access to E.C. reports, communications, keeping us informed of ageing questions, demographic projections, enabling Member States to prepare for changes.

AGE's members, who are in majority Pensioners Associations or Organizations of Professionals giving services to the elderly, speak of the situation in their country. AGE's staff officers make surveys and summaries of the major desires and wishes of older people in Europe.

What do older people ask for most from their national policy makers?

- (a) They want to stay at home for as long as possible, they want to receive long-term care at home. After a period of time where the place of death shifted from one's domicile to hospital the request is coming back to end life at home, and to be able to receive medical acts of comfort at home in the same way as can be found at hospital.
- (b) They do not want to be left in pain. They believe that today we can be relieved from suffering.
- (c) They hope to be cared for by professionals in number wherever they choose to live – trained nurses and doctors in sufficient number and who are sufficiently informed of the needs of older people and the end of their lives.
- (d) They ask for Member States to provide the funds for this, not only for medical care and pain relief treatment but equally for social services and institutions if needed; they ask for assistance in daily needs too if next-of-kin or family are not available.

These four points clearly justify the place for Palliative care for Older Persons in Europe. To give relief and to accompany gravely ill patients in this period of approach to dying is now becoming more widespread in Europe. Many more people are aware that they can claim this support to help them through the time that they have left.

Earlier on I quickly mentioned the demographic projections that are diffused by the Europe Commission. These have indeed an influence on the provision of care that Member States are going to have to provide and adapt accordingly. I quote from the Commission's 2006 Demographic Report "Demographic ageing, i.e. the increase in the proportion of older people, is above all the result of significant economic, social and medical progress giving Europeans the opportunity to live a long life in comfort and security that is without precedent in our history."

Let me give two examples of the repercussion of these projections:

(1) Increased longevity has and will bring about additional demands for long-term care; formal hospital settings are going to have difficulty in coping and long-term care services will inevitably be directed to informal at-home settings.

(2) Fertility rates below the replacement level and demographic ageing translate in a greater proportion of old and very old people in the future. The family members in the household will decrease and so there should be put in place alternatives to the accompanying role in ultimate long-term care.

A patient's perspective.

(Today, in France, palliative care is given through a team organization or a "unité")

One patient, Gabriela, is 82 and has been diagnosed with cancer of the gullet. She has been put under chemotherapy and in hospital she is concerned about her family; she realizes that her time before dying is short. She was not told as much but she had read about her illness. She asked to be discharged and go back home.

The hospital's mobile unite of palliative care was informed and within a month Gabriela entered the service and the team set up her medical and social care plan.

Her family doctor was involved, the district nurses, the local service of nursing at home, her family was informed and the team contacted the local association of voluntary palliative care visitors. The specialist doctor and the family practitioner followed in particular the pain reliefment treatment and gave close attention to undesirable side-effects. The social worker was informed and ensured that the documents and formalities were in place for the coverage and payment of the care. Gabriela was appeased. She said "this team is able to come together coherently to look at my illness and what it needs and to look at my loved ones and their needs."

Futile medical treatment at the end of life

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The field of futile medical treatments gains more and more relevance due to constant increase in mortality and aging of population worldwide.

Framework to address issues of futile treatments experienced radical changes in recent decades due to advances in medicine in general and in reanimatology in particular, which has created false myths and belief that "medicine has unlimited power". Meanwhile, the doctor-patient relationship has become one of collaboration, partnership, based on patient's autonomy, which meant a radical change from the paternalistic attitude that has ruled for thousands of years medicine. In this context, medicine shifted from the attitude of excessive use of innovations to the definition of "futile treatment".

The concept of futile medical treatment is addressed relatively recently in the literature, after 1988, superimposed on a socio-political context, particularly focusing on the rationalization of resources and increased patient decision-making authority regarding her/his life and health. If in the years 1960-1980 we have seen an excess of unnecessary treatments and patients' demand to be recognized right to dignified death, in recent years a real pressure has been created in medical field against unnecessary treatments and demand of patients and their families to it further.

The approach of defining the futile treatment is a difficult and even the American Medical Association says "can not develop a fully objective and concrete definition of futility for medical treatment". However, over time, professional medical associations and many authors have different definitions tempted.

For instance, Lawrence J. Schneiderman & al., in 1990, developed a definition with a qualitative component based on the patient's ability to assess the results of medical treatment or the ability of treatment to offer the patient the possibility to live an independent life away from of ICU and a qualitative component bounding treatment as futile if successful is likely less than 1%.

The controversy regarding the possibility of defining and delimiting unnecessary medical treatment and issues of appropriateness and morality of acceptance of this concept is outdated. A number of the arguments most frequently mentioned are:

1. Effect versus benefit, which claims that the patient is a whole and the scope of medicine is not only to treat certain parts of the human body but to obtain a benefit for the body as a whole (Eg. cardio-respiratory resuscitation is without any benefit to a cancer patient with multiple metastases). Opponents stress that are not developed criteria for characterizing the whole concept so that it can reach the view that a person suffering from a chronic disease not well as a whole!
2. Medical treatment, to be legitimate, must ensure patient's survival for achieving a minimum scope other than concern for the disease
3. Unnecessary treatments create a false hope in the doctor-patient relationship
4. Unnecessary treatments create a false hope in the doctor-public relationship
5. The application of medical treatment must take into account professional standards
6. Patient's autonomy versus physician's autonomy

7. Field unnecessary treatment is ambiguous, based on its own definition.

Even if the field of futile treatments strikes many controversies and uncertainties, there is a consensus among specialists on a number of items useful in evaluating medical treatment as useless:

1. The patient has a fatal prognosis or impending death
2. Treatment can not achieve its physiological purpose
3. Treatment will not achieve the goals of the patient or family
4. Treatment will not increase patient's life expectancy
5. Treatment will not improve the quality of patient's life.

Beyond the scope of controversy, the decision to continue or discontinuation of futile treatment must be derived from the partnership between the doctor and patient. The physician set up her/his opinion based on professional standards, weighing risks and benefits of treatment and material constraints and application data to streamline resources as well. Patient's decision is based on personal values and principles and promote their autonomy. In this way, communication becomes the basis of the best decisions. Whatever the decision, the physician has a moral and ethical obligation to not abandon the patient and to move from unnecessary, incisive treatments in providing palliative care in order to give quality end of patient's life.

The ethics of caring for terminal ill patients

Prof. dr. Vasile Astărăstoae, President of the Romanian College of Physicians

The presence of palliative care services indicates whether we are a society in which vulnerable persons are respected or not. A clerk in the Ministry can calculate how much palliative care for a terminal ill persons costs. Based on such calculations policy makers may conclude that it is a lot of money and that the society cannot afford it. So far in such a process, there is no involvement from a medical institution with expertise in palliative care which may take into consideration what palliative care may add to quality of medical care and to quality of life.

In Romania, there is only one unit of palliative care within the hospital in Pascani, set up with money from Switzerland. In Slatina there is a regional palliative care expertise centre set up by the REPACARO Foundation. These and other palliative care services are conceived by NGO's which apply for money from abroad.

The fact is, that the terminally-ill person is abandoned from the Romanian health care system by the policy makers. This is against our tradition: a family has never abandoned its old family member in Romania. This situation calls for ethical considerations on palliative care.

The care of terminally-ill patients is a concept, much more than a "specialty" in itself. It is meant mainly to relieve human suffering in the last stages of the irreversible disease, by therapeutic methods which address first to pain relief as well as other symptoms, ensuring nutrition, together with the psychological and spiritual support at the end of life.

The underlying concept in ethics of care for terminal ill patients is the autonomy of each human being supported by the natural right to life, bodily integrity and health. All these concepts relate to human and patients' rights.

Doctors have several ethical dilemmas in caring for the terminal ill patient: How is the case selection made? Who is the person who provides care for this patient? By following the path of cost-effectiveness and declaring some drugs as being useless, we may open the way of an economic euthanasia. Is the terminal ill patient still a human being? Should the terminal ill patient receive complex care, i.e. not only medical, but also social, psychological and spiritual support assuring his quality of life? Who is taking care of the terminal ill patients in Romania? Who takes the decisions to continue with specific treatment and care or not? When do we stop giving specific therapy or measuring sustaining vital functions?

Nowadays, this type of care is poorly developed in Romania, because of financial reasons. In case of terminal ill patients, beyond the intensive care therapy, palliative care is in itself not expensive. Palliative care aims to prevent unnecessary suffering and to maintain quality of life to persons who will have no hope for recovering life is.

We have discussed that, within the Frame-Contract for 2010, the financing of the palliative care should be reintroduced but this will very much depend on the budget allocated to the health system and unfortunately, it seems that the budget for the next year will be less than the one for this year. Does it mean that terminal ill patients are not treated accordingly the standards of the medical knowledge in Romania? Indeed, the question arises: how civilized is our society.

NEW PUBLICATION

Getting Started: Guidelines and Suggestions for those Starting a Hospice / Palliative Care Service

2nd Edition

Derek Doyle, OBE, MD
IAHPC Press Houston 2009
ISBN - 0-9758525-7-4

This is the second, up-dated handbook for professionals, policymakers and volunteers, who intend to start a palliative care service. It contains 12 chapters, which lead the reader through the most important issues related with setting up palliative care services. The book deals with the principles of palliative care, management of a new palliative care service and important issues like communication, documentation and training.

Five organisations of palliative care are described: a hospital palliative care unit, a hospital palliative care team, a free standing Inpatient unit (hospice), a palliative care day care unit and a community palliative care services. In the book is rather much emphasis on institutional palliative care, which is relevant in some health care systems, but not in most. It is stated, that 'palliative care' and 'hospice' are the same and the difference is said to be related to the different knowledge of the public and of professionals. In many countries, however, Hospice, is an institution, where patients are taken care of outside their home, which may be a big difference.

The book starts with a 'practical' description of palliative care: is "Palliative care is the care of patients with active, progressive, far-advanced disease with a limited life expectancy, for whom the focus of care is the quality of life." Palliative care includes not only the patient but also has to involve the family.

Palliative care is not disease-specific, is not restricted to a defined number of months or weeks of life, and is centred on quality rather than quantity of life.

Specialist palliative care is care, that is provided by a service where the principal clinicians (doctors, nurses, social worker and other team members) have all had advanced training in the principles of modern palliative care. In a few countries where palliative medicine and palliative care nursing are recognised as medical and nursing specialties the services in which they work are essentially secondary or tertiary referral services. Specialist palliative care services may serve as expertise centres for palliative care delivered at home.

It is clearly stated, that for palliative care a multidisciplinary team to assess the need and do the treatment is mandatory. "Failure to do this often results in unrelieved pain and unrelieved psychosocial suffering. No one professional can deal with the many problems encountered in palliative care. An integrated team is essential".

Given the situation in many Central-Eastern European countries, the chapter which deals with *Community Palliative Care Services* may be special relevant. These are services caring for terminally ill patients in their own homes or the home of relatives, or care homes for the frail or aged – patients not in a hospital or in-patient palliative care unit.

Strong evidence from many countries suggests that almost everyone says that when they come to the end of their lives they want to remain at home as long as possible and in a country like Romania to die there.

Three models of community palliative care are described:

1. Advisory Service. This assists GPs and community nurses who invite the advisory team to visit and advice on the care of patients at home. The staff of the advisory service does not accept invitations to become involved from anyone except the family doctor and community nurse. The advisory team consists of a palliative medicine physician and a community palliative care nurse (and can usually call on the services of a social worker, an occupational therapist and other allied health professionals in the hospice / palliative care service).

The benefits of such a service are that the patient (and often some relatives) remains under the care of doctors and nurses they know well but, at the same time, they are getting specialist advice on the one hand and that there is no threat to the authority or autonomy of the family doctor and community nurse on the other hand.

2 Practical ('hands-on') Palliative Nursing Service. Nurses, specially trained in palliative as well as community nursing, provide all the practical nursing a terminally ill patient needs, and demonstrate basic nursing care to the relatives. They may visit once or many times each day, depending on needs; often lending equipment from the palliative care service. These nurses have to work together with a family doctor, knowledgeable about palliative care. Such service is mostly rather expensive. Also training may fail here.

3 Comprehensive Community Palliative Care Service

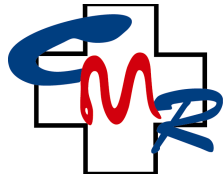
This service provides a team of specially trained palliative medicine physicians and nurses who provide all care for the terminally ill patient in his home. Any necessary equipment is loaned from the palliative care expertise service base.

The patient is guaranteed to receive high quality specialist medical and nursing care round-the-clock in his own home, with his well-supported family around him. Such as service is thought to enable more to die at home if that is what they wish.

In all cases, it is essential, that family doctors and community nurses need to know their 'limitations'. They may need special expertise advices and consultations how to deal with complications and rare symptoms like extreme breakthrough pain, hypercalcaemia, haemorrhage, spinal cord compression, sudden dyspnoea, pathological fracture, oesophageal obstruction etc.

This handbook is a must for those who want to build up a palliative care service, but also for them who work in the palliative care field. Even experienced palliative care professionals may learn to rethink some of their 'daily routines'.

NEWS



**Koninkrijk
der Nederlanden**

Workshop on: “Palliative care for Romanian citizens : a plan for action”

Date: Thursday, 8 October 2009

Location: Athenee Palace Hilton (The Diplomat), Bucharest, Romania

Time: 10.00-14.00

Chair: Prof. Dr. V. Astarastoe, President of the Romanian College of Physicians, Romania

Co-chair: Prof. Dr. W.J.A. van den Heuvel, University of Groningen, the Netherlands

10.00-10.15: Coffee

10.15-10.30

Welcome

- Prof. Dr. V. Astarastoe, President of the Romanian College of Physicians, Romania
- Mrs. M.W.J.A. Van Gool, Ambassador of the Netherlands in Romania, the Netherlands
- Mrs. M. Nitelea, Director Office of Council of Europe in Romania, Romania

10.30-11.45

Presentations

Palliative care: the European perspective

- Wolfgang Wodarg, MD, PhD, Member of the German Parliament and Chairman of the Health Commission of the Assembly of Council of Europe, Germany

Palliative care in Romania: the state of the art

- Luminita Dumitrescu, MD, PhD, Regional Expertise Centre for Palliative Care in Romania (REPACARO), Romania

The voice of Older Citizens in Europe

- Angela Cluzel, The European Older People's Platform (AGE Platform), Executive Board Member of The European Association for Directors of Residential Care Homes for the Elderly (E.D.E.), France

Regional Expertise Centres for Palliative Care: experiences and possibilities

- Marinela Olaroiu-van den Heuvel, MD, PhD, Regional Expertise Centre for Palliative Care in Romania (REPACARO), the Netherlands

Futile medical treatment at the end of life

- Beatrice Ioan, MD, PhD, Medical Faculty, University of Iasi, Romania

11.45-12.15

Invited discussants

12.15-12.45

Plenary discussion

12.45-13.00

Conclusions

Presented by Prof. Dr. V. Astarastoe, President of the Romanian College of Physicians, Romania

13.00

Press conference

13.00-14.00

Lunch