

# PALIATIA

journal of palliative care



Volume 3, Number 3, July 2010



[www.paliatia.eu](http://www.paliatia.eu)

**CONTENT**

**EDITORIAL**

**Palliative care: a challenge for Europe**

Holmerová I

**ORIGINAL PAPERS**

**Terminal phase of life - Whishes and reality in our district**

Németh F

**The communication of bad news in oncology**

**1. General considerations. Opinions of patients an professionals regarding bad news communication in oncology**

Omer I

**CLINICAL LESSONS**

**Palliative procedures in prostate cancer**

Aurelian J

**MANAGEMENT**

**About being volunteer in Romania**

**2. Health care volunteer. Palliative care volunteer**

Staicu DG, Dumitrescu L

**Organisations active in palliative care**

**COMMENTS, DISCUSSION**

**Palliative care in geriatrics as seen by international organisations**

Bogdan C

**LETTER TO THE EDITOR**

**Is euthanasia an option?**

Astărăstoae V

**NEW PUBLICATION**

**Care need in dementia and digital interactive information provisioning**

Roest H van der

**NEWS**

**The picture on the cover: *Destination (1996)* from Fritz Föttinger, Germany**

# EDITORIAL

## Palliative care: a challenge for Europe

Holmerová Iva, MD, PhD, geriatrician, associated professor, president of the Czech Society of Gerontology and Geriatrics

Address for correspondence:  
e-mail: iva.holmerova@gerontocentrum.cz

For many decades Czech Republic as well as other Central-Eastern European countries have been part of a different societal system, i.e. different from the other parts of Europe. These Central-Eastern European states were called socialistic or people's republics; however many of their policies were neither by nor for the people. The most striking difference for me (after the opening of frontiers to „Western Europe“) was the integration of persons with disabilities, even with very severe disabilities, into the society and the enabling environment for persons who are sick, frail and disabled.

More than two decades ago reintegration between East and West has started and both Czech Republic and Romania became member of European Union. Now, two decades later we can look back into the previous decades of the socialistic system in our countries – I believe – without emotions. We may see that not all in this system, especially in the health care system, was bad. Health care was well organized, focused on prevention, was very cheap (cost-effectiveness was not bad at all) and accessible to all. Indeed, the system needed investments into modern technologies, drugs and other developments. These modern achievements came available soon after the political changes and during last two decades acute medical care has improved in many fields. We have top acute centres, hospitals with top technologies... However, the improvements in the health status of the population are not so brilliant. Heroic medicine seems only heroic in acute wards, but also there it has its limits. Human life has its limits itself and diseases are not always curable. But we may state, that we have managed to improve our acute medical care within the last two decades focusing on the modern knowledge and technology.

I think that now it is the time to change the paradigm: to focus on the individual person and his/her complex needs and wishes (instead of only considering medical treatment, which has its limits). We have caught up Europe in many ways, but in between developments in health care went further and the society changed as did morbidity patterns. The methods of modern medicine are similar in European countries, west or east from the former iron curtain. However we find still very important differences in the care for persons with chronic diseases, for people with terminal diseases, for frail old and for persons who need palliative care between European countries.

Therefore, a new international effort is important, as stated by the General Assembly of the Council of Europe, to exchange experiences, good practices especially in the field of care for chronically ill, terminal ill and frail old, i.e. palliative care. And let us face it: care for the frail old and palliative care are still much underestimated in countries like Czech Republic and Romania. In this issue of PALIAȚIA the discrepancy between wishes and reality, when old people die, is illustrated for a Slovak district.

Palliative care is a broad and humanistic concept of person-centred care that reflects not only biological but also social, psychological and spiritual needs. Palliative care reflects the

attitude that values human life despite its limits and supports human dignity. In my opinion, palliative care is a broad field of different activities, it includes not only palliative medicine but also nursing care, different other therapeutic attitudes, hospice movement, palliative efforts in different settings including hospitals and long-term care institutions, home care and social care providers and last but not least general practitioners. This issue describes among others the development of palliative services in Romania, giving palliative care in hospitals and mobile palliative care services as example.

Persons in need for palliative care may show a wide variety of diseases. Very often, especially in countries like Czech Republic and Romania, we put – wrongly – palliative care identical with oncological diagnoses. This is incorrect for two reasons. Oncological diagnoses are often curable, so patients with cancer do not need palliative care per se. Many persons die because of other diseases, who need palliative care, especially neurodegenerative diseases, chronic cardiac failure, frailty of old age. These conditions have to be addressed in the new concept of „paliatia“. The first steps have been realised in this field. Alzheimer Europe issued its recommendations on end-of-life care for persons with dementia. Palliative care in geriatrics is a topic, which deserves special attention as is mentioned in this issue of PALIAȚIA.

However, there remain many other important issues to be dealt with and discussed and I am personally very pleased that PALIAȚIA offers a friendly, skilled and modern platform for these discussions. Indeed, palliative care invites to cooperate, between disciplines, within countries and within Europe.



# ORIGINAL PAPERS

## Terminal phase of life - Whishes and reality in our district

Németh Frantisek, MD, PhD, geriatrician, chief doctor at the Pažínková Monika Department of Geriatrics, Faculty Hospital J.A. Reiman, Faculty of Medicine of Presov University, Prešov, Slovakia,

Address for correspondence:  
e-mail: feronemeth@yahoo.com

### Abstract

Dying not death is an essential problem. The more we believe that death ends everything, the more we fear death. A human spirit hardly copes with this fact. All religions want to cut this fear. They highlight that present life continues and human spirit lives further on, in another postmortem dimension.

The author evaluated death of 142 patients, among which 45 (32 %) died at home, 74 (52 %) in hospital, 34 (24 %) died among close relatives and 56 (39 %) without the presence of any relative.

Most of the dying patients wish to stay with their family or relatives at the end of life. If this wish cannot be fulfilled, then a palliative care facility seems to be the most suitable alternative for an individual in terminal stage in modern society.

In the Prešov region (East Slovakia), there is a lack of hospices and palliative care does not cover the needs of terminally ill patients.

Key words: *dying, place of death, palliative care*

### Introduction

Recent changes of life style and values in Slovakia have revealed old and new phenomenon in the field of dying and death. The developments require professionally trained medical and social workers, who will be motivated, beside expert skills, by human principles and effort to support patients to live usefully and meaningfully till the end. At present, with the technology penetrating all areas of medicine and civil life, humanization of the health system should be a high priority.

The last phase of human dying is characteristic by the fact, that none has its own experience and cannot pass it to others, so both professionals and general population miss the experience (1). Most people fear more from dying than from death itself (2).

Insufficient attention is paid to the last moments of human life in Slovak Republic as well as abroad (3, 4). It is certainly a paradox, that while the medical specialization on coming to life - obstetrics - is regularly developing together with other medical disciplines, medical specialization on leaving life - thanatology – is covered by individuals and practical knowledge in health care workers is generally insufficient (5, 6).

Dignified death means that even in the most difficult hours of the life the dying person should not be alone and without open personal interest (7).

Accompanying to death is the most difficult task for every-one (8). The same is true for the clinical geriatrist. This difficult part of work can be successfully managed only by the one who really and without reservations loves people, who is balanced with his own finality and own mortality. He also needs to know how to add not only his energy and power but also his love and sensitivity in daily praxis. From the patient's view, kindness and sensitivity in the attitude of the health care professional create the faith and expectation that the result will be good not bad. Compassion and support to dying subjects takes a lot of energy but add a lot of wisdom and maturity (9).

At present, no common view exists on the place of the end of life. Subjective wish of each individual should determine the place to die and could be considered as optimum (10). But what is optimal if a subjective wish cannot be guaranteed?

An important factor, which influences the place of death, is the development of one-generation family. Children become relatively young independent, socially and economically, and both old and young families live separately (11). In Slovakia, this process is markedly supported by the small size of apartments (10).

At present, health care professionals should take care of both psychical and social comfort of the patient, including the choice of help to an old, immobile or dying individual.

Patients must be informed about all possibilities. In the literature, it is called the "new social role of a doctor" (12). It means that the doctor working mostly with geriatric patients should be a coordinator of all types of help.

### **Aim of the study**

The aim of the study was to evaluate the place of death and the presence of accompanying people of the dying patients in the Presov region in Slovakia and to describe the place of dying. Knowledge of the actual situation may create a social pressure for necessary development and reaching the optimum in the site of death and way of life at the end in our region.

### **Methods**

The district Lemešany was chosen as a sample, because it is a typical district in Prešov region (Slovak Republic). The District Lemešany with a private outpatient facility for adults, children and dental clinic is located southeast in the Prešov region. The region is mostly agricultural, without a bigger factory or other source of environmental pollution. In the district live 2296 inhabitants; 13% are 65 years and over and 2% 80 years and over.

A 10-year pilot prospective study was conducted in the period from January 1, 1998 to December 31, 2007, during which the death of every district inhabitant aged 65 year or older was evaluated according to criteria set in advance. The following parameters were recorded: age, sex, date and site of death, causes of death, family relationships and a presence of relatives at the time of dying. The deaths of individuals, who died at different institutions (hospital, social care institutions, and private nursing clinics), were also evaluated.

Two individuals, who died due to severe injury during accident and one individual who committed suicide, were also included in the study. One individual who died abroad while visiting relatives was excluded from the study.

In case of death in the hospital, the attending doctor, attending nurse and eventually pathologist were contacted and "reports on death" were evaluated simultaneously. Information on deaths in social care institutions were obtained from the head nurse and relatives or from the head of the institution.

Every death was evaluated by the general practitioner within 3 working days and then summarized for the calendar years, so the records may be considered accurate.

Due to transparency, 2-year intervals are given in the tables.

## Results

In total 142 persons died in 10 years in the district. The average age at death was 79 years. One third (32%) of the persons died at home, over half (52%) in a hospital (Table 1).

Deaths due to cardiovascular disorders dominate. Stroke, which also belongs to the cardiovascular disorders are depicted separately, because these patients died at the departments of neurology.

Table 1 - Number of deaths, gender, average age, place of death and cause of death

| Year<br>(Percentage)   | 1998-99 | 2000-01 | 2002-03 | 2004-05 | 2006-07 | Total |       |
|------------------------|---------|---------|---------|---------|---------|-------|-------|
| Number of deaths       | 20      | 36      | 28      | 27      | 31      | 142   |       |
| Males                  | 12      | 17      | 16      | 17      | 16      | 78    | (55%) |
| Females                | 8       | 19      | 12      | 10      | 15      | 64    | (45%) |
| Mean age at death      | 78.1    | 80.0    | 78.9    | 77.3    | 81.8    | 79.2  |       |
| <i>Place of death</i>  |         |         |         |         |         |       |       |
| Home                   | 6       | 14      | 7       | 8       | 10      | 45    | (32%) |
| Hospital               | 10      | 18      | 16      | 14      | 16      | 74    | (52%) |
| Social care institute  | 1       | 3       | 2       | 3       | 3       | 12    | (8%)  |
| Other                  | 3       | 1       | 3       | 2       | 2       | 11    | (8%)  |
| <i>Causes of death</i> |         |         |         |         |         |       |       |
| Cardiovascular         | 10      | 16      | 13      | 12      | 14      | 65    | (46%) |
| Malignancy             | 4       | 4       | 6       | 7       | 6       | 27    | (19%) |
| Stroke                 | 3       | 5       | 3       | 2       | 6       | 19    | (13%) |
| Other                  | 3       | 11      | 6       | 5       | 31      | 31    | (22%) |

As shown in Table 2, 35 % of seniors were living with partner during the last 6 months before their death. Living together with children and other relatives (40 %) is difficult to arrange in current economic situation. Up to 25 % of the seniors has lived alone.

Table 2 - Living situation of the deceased persons (n=142)

| Year                 | 1998-99 | 2000-01 | 2002-03 | 2004-05 | 2006-07 | Total |       |
|----------------------|---------|---------|---------|---------|---------|-------|-------|
| Living alone         | 4       | 10      | 6       | 10      | 6       | 36    | (25%) |
| With partner         | 8       | 8       | 8       | 16      | 10      | 50    | (35%) |
| With other relatives | 4       | 20      | 8       | 12      | 12      | 56    | (40%) |

At the moment of the death fifty six patients (39 %) were dying without the presence of any relatives or any other close person, just thirty four patients (24 %) died at the presence of close relative (Table 3).

Table 3 - Presence of close person(s) at the time of death (n=142)

| Year                   | 1998-99 | 2000-01 | 2002-03 | 2004-05 | 2006-07 | Total    |
|------------------------|---------|---------|---------|---------|---------|----------|
| With close relatives   | 5       | 8       | 10      | 5       | 6       | 34 (24%) |
| Without relatives      | 11      | 16      | 8       | 14      | 7       | 56 (39%) |
| With distant relatives | 4       | 12      | 10      | 14      | 12      | 52 (37%) |

## Discussion

The data show, that the average age of death (79 years) is approximately 3 years lower compared to some developed countries (13). Over half of the people died in the hospital, which might be considered relatively high as compared to neighbor countries. Only a quarter of the patients died at home. The percentage of dying due to malignancy is comparable to other countries (8). The number of patients dying in the presence of close family is relatively low (24%), which is related with the place of death. These data may indicate that end of life is accompanied by an unnecessary distress, loneliness and loss of dignity as is found in other studies (3). Such negative situation may be compensated when professional expertise on dying and death are present (14).

From our clinical experience we have observed that fear from death and dying is smaller in old age compared to middle age and in men as compared to women. Education, occupation, income, place of living etc. are not so important regarding fear from death and dying. Regarding acceptance of dying and death, life experience plays a crucial role together with basic personal attributes. An individual can accept death and dying process as a transport to other life or as an outcome of existence or just as a simple fact. Most of old, chronically ill people wish to die at home, but as the data show they actually die in the hospital.

In various countries different outcomes are found, but study outcomes may also vary within countries (13,15). The main difference in care at home and in hospital is an overall approach. Hospital care is intended to save the life therefore the patient undergoes various examinations until the last moment. In such environment there are fewer places for family. For the dying, the laboratory parameters are not substantial, substantial is how he feels, whether main symptoms like pain, dyspnoe and anxiety are managed and whether beloved ones are close. At home, although without laboratory and various catheters, patient is less isolated, has more privacy and his actual problems are solved more quickly (16,17). In several publications it is stated that for seniors above 65 years (without cognitive impairment), some situations like life depended on devices, loss of mental abilities, loss of self-sufficiency, permanent pain are worse than death (13,18).

How to overcome the discrepancy between the desire of patient to die at home, with relatives, and the present reality? A highly qualified and differentially developed service exists, i.e. palliative care. Its aim is not to lengthen the life in quantity but to add quality of life even in the terminal phase. It is a worldwide developing type of care offering help to the dying person and his relatives when 'common' treatment approaches fail (19). The World Health Organization defines palliative care as complex care of patients where the "disease does not respond to the curative treatment". A typical institute for palliative care is the hospice as 'bed institution'; a palliative home care program may provide complex palliative care at home or in an alternative social environment. The World Health Organization declares palliative care as one of the prior fields of health care and social care development (1). Palliative care has also ethic aspects to counter weight various motions and views to euthanasia (8).



In Prešov region, there is one hospice with 24 beds; palliative care at home is rare, provided insufficiently and unsatisfactory by home nursing care agencies (36). Also care of dying person in the setting of specialized nursing institutes with developed palliative care expertise is hardly available in the network of health or social care institutions in Slovakia.

## Conclusion

The way and place of dying of geriatric patients in Prešov region are determined by the present possibilities and life style. At home dies nearly one third of the aged; most elderly die in institutions. Only one fourth of them die in the presence of close family.

Palliative care is rare in the Slovak Republic. It should be included into the present system of health and social care services. Economical problems in building hospices might be overcome by creating a palliative care at home service, which could provide, besides visits and consulting, the availability of 24 hours services and – if necessary – by taking care for the patient in an adequate institution. Family member who decide to take care of their terminally ill relatives till the end should be supported, granted from social sources and provided help and adequate education.

It is needed to include thanatology in the curricula at the schools of medicine and nursing. As in developed countries, it is necessary to create a positive social atmosphere for solving problems of dying in the Slovak Republic.

## References

1. Berns R, Colvin ER. The final story: events at tile bedside of dying patients as told by survivors. ANNA J 1998; 15 (6): 583 -7.
2. Schel W. Dying and euthanasia. Hannover Brigitte Kunz Verlag 2002; 728 – 34.
3. Byock I. Dying well. The Prospect for Growth at the End of Life. Riverhead Books 1997; 45 – 57.
4. Fried TR, Pollack DM, Drickamer MA et al. Who dies at home? Determinants of site of death for community-based long-term care patients. J Amer Geriat Soc 1999; 47 (1): 25 – 9.
5. Sakuyama T, Takamura S, Nakamura Y et al. Death at home, home care for terminal cancer patients. Gan To Kagaku Ryoho, 1998; 25 (Suppl 4): 675 – 78.
6. Abrams WB et al. Merck manual of geriatrics. Merck and Co 1995; 238 – 44.
7. Kalvach Z et al. Palliative care in the Czech Republic. Projekt 'Promotion of the development of palliative care in Czech Republic' Prague, Open Society Foundation 2004; 62 – 98.
8. Morisson RS, Mccier DE. Palliative Care. J Amer Geriat Soc 2004; 12: 25 - 42
9. Kubešová H, Weber P, Holík J. Seventy-two hours of the life of patients: what do professionals?. Bratislava Geriatria 2003; 2: 68-72.
10. Seale C, Addington Halí J, McCarthy M. Awareness of dying: prevalence, causes, consequences. Soc Sci Med 1997; 45 (3): 477 – 85.
11. Topinková E. Care of the old in the family. Praha Prakt Lék 1995; (7): 366 – 9.
12. Steinhauer KE, Christakis NA, Clipp EC et al. Factors considered important on the end-of-life by patients, family, physicians and other care providers. J Amer Med Ass 2000; 284: 24 – 6.
13. Campion EW. Specialized care for elderly patients. New Engl. J Med 2002; 346: 874 – 5.
14. McCarthy M, Halí JA, Ley M. Communication and choice in dying from heart diseases. JR Soc Med 1997; 11 (3): 128 – 31.
15. Pompey H. Dying. Mainz Matthias-Grunewald-Verlag; 1996.
16. Pritchard RS, Fisher ES, Teno JM et al. Influence of Patient Preferences and local System Characteristics on the Place of Death. J Amer Geriat Soc 1998; 46 (10): 1242 – 50.
17. Kalvach Z et al. Geriatrics and gerontology. Praha Grada Publishing; 2004.

18. Haškovcová H. Thanatologie. Praha Galén 1994: 112 – 24.

19. Malacrida R, Bettelini CM, Degrate A et al. Special not different:, general practitioners account of their care of dying people. Soc Sci Med 1997; 26 (7): 1111 – 20.

**Conflict of interest:** none

**Received;** 18 January 2010

**Accepted:** 16 April 2010

## **The communication of bad news in oncology**

### **1. General considerations. Opinions of patients and professionals regarding bad news communication in oncology**

Omer Ioana, psychologist, PhD, Hospital for chronic diseases "St. Luke", Bucharest, Romania

Address for correspondence:  
omer\_ioana@yahoo.com

#### **Abstract**

In the present article we studied 355 oncological patients in advanced stages of disease (stage III and IV) and 125 therapists (doctors, medical assistants, social assistant, psychologists). In this article we present some aspects related to bad news communication in oncology.

#### *Objectives:*

- to find out the factors which stimulate/inhibit the communication between patient and doctor;
- to find out opinions and attitudes of the doctors and patients about the communication of the diagnosis of cancer.

#### *Methods:*

- observation, registered interviews with patients, questionnaires completed by doctors.

#### *Results and conclusions:*

The study revealed that the majority of therapists believe that the diagnosis must be communicated to patients because cancer must be treated for a long period with many secondary adverse reactions, sometimes very mutilating for the patient, but necessary for saving their lives. The patients also want to know the truth, the results being a balanced mood, positive attitude and behaviour with disease a better therapeutic relation with the doctor; the patient realize that he is helped physically and psychologically and motivated for accepting the correct treatment.

*Key words: bad news, depression, communication, cancer, compliance*

(Full text in Romanian)

# CLINICAL LESSONS

## Palliative procedures in prostate cancer

Aurelian Justin, MD, resident in urology, Clinical Hospital „Prof.dr. Th. Burghel”, Bucharest , Romania

Address for correspondence:  
e-mail: justin.aurelian@gmail.com

### Abstract

The article describes shortly the development of prostate cancer. It continues by presenting procedures to deliver palliative care to these patients when needed.

Although in the last years the detection rate of prostate cancer has increased, still a large proportion of elderly men have clinically unidentified prostate cancer. Prostate cancer is a heterogeneous and multifocal disease. It is slowly unfolding, as it needs 25 years to develop from a focal lesion till an aggressive malignant form.

Like in other terminal diseases, palliative treatment of symptoms and maintaining an adequate quality of life are the important goals in the treatment of patients with terminal prostate cancer.

Palliative care procedures to be used include: bladder drainage, hormonal therapy, chemotherapy and radiotherapy. In patients who are in an advanced stage of prostate cancer a series of palliative treatments may improve their quality of life. Early evaluation of painful or disabling symptoms can preserve quality of life of these patients.

Key words: *prostate cancer, palliative procedures, metastases*

(Full text in Romanian)

# MANAGEMENT

## About being volunteer in Romania

### 2. Health care volunteer. Palliative care volunteer

Staicu George(a), jurist  
Dumitrescu Luminița (b), MD, PhD, general practitioner

(a): Foundation RainCAare, Slatina, Romania  
(b): District Hospital Slatina, Romania

Corresponding author :  
George Staicu  
e-mail: staicupol@yahoo.com

#### Abstract

##### *Objectives:*

This article describes the development and organization of volunteers in Romania. It presents the legal regulation of voluntary support in home care for the elderly. The article contains the main legal regulations of the Romanian Government Decision no. 1317/27.10.2005, published in Official Gazette no. 997/10.11.2005. Also experiences of the Foundation for Integrated Care in Romania, RainCare, are presented for volunteering in palliative care.

##### *Material and method:*

The Romanian legislation on volunteering is studied and the results of volunteering in palliative care in one region are analyzed.

##### *Results:*

Legal rules regulate socio-medical care of volunteers. These volunteers may be engaged under a contract with a provider of home care services for older persons. The need for care and the type of problems, the elderly have, have to be assessed by care professionals of the home care provider. Also the obligations and responsibilities of volunteers have to be specified by the provider. Facilities by state institutions are available to train volunteers in home care services.

Volunteering in palliative care is realized in several (experimental) programs. These programs show, that volunteers have an important role in information and training on palliative care issues to health care professionals and to patients and their families in a lesser extent.

##### *Conclusions:*

Legal arrangements of volunteering are available in Romania, despite frequent additions and changes in legislation, including volunteering in home care for the elderly. Volunteers may be trained.

The performances of RainCare in palliative care show, that volunteering in palliative care is a new area of services, which has to be developed further in Romania.

*Key words: volunteering legislation, medical volunteering and volunteer organizations, palliative care*

(Full text in Romanian

## Organisations active in palliative care

### Association for Mobile Palliative Care Services



The Association for Mobile Palliative Care Services (Asociatia pentru Servicii Mobile de Ingrjire Paliativa- SMIP) helps people with cancer and their families to cope with their life threatening disease. The organization is delivering palliative care services: symptom control, social and emotional support, information, supportive care during oncological treatment.

The association is providing palliative care services since March 2009, both as consultative palliative care team for Coltea Hospital in Bucharest (due to a partnership contract) and in home care. The team includes an oncologist, specialized in palliative care, a registered nurse and a social worker. They work as a team for 6 years; the medical coordinator has 13 years experience in providing palliative care.

The association is the one of the few organizations in Romania that provides palliative care services in a hospital setting as well as at home. The team is working according to the international recommendation in evaluation of patients' need for palliative care and in implementation of the care plan. SMIP collaborates with general practitioners, oncologists and other specialists involved in patients' care during specific oncological treatments (supportive care) and also when these treatments are no longer indicated.

Palliative care in hospital setting: the team is active in different departments of the hospital: oncology, haematology, internal medicine, ENT department. The patients are referred to the association by their doctors when facing uncontrolled symptoms (pain, nausea, vomiting, anxiety and depression), social and emotional problems or they are entering the terminal phase.

Palliative home care is based on referrals from patients, families or attending physicians. The care encompasses symptom control (pain, breathlessness, anxiety, insomnia, nausea so on), nursing interventions, wound and stoma care, emotional support, useful information about nutrition, hygiene, available support sources in community and so on. Besides, the association has developed specific projects to stimulate a friendly environment for patients and to train professionals in palliative care. Some examples are given.

The International Women's Association of Bucharest funded a project for improving the quality of life for people with cancer and limited mobility who are admitted in the Coltea Hospital (oncology department). The project consisted in purchasing TV sets for every room of the oncology department and mobility aids and special mattresses for the patients cared for at home.

Creating a friendly environment for patients admitted in the various departments of Coltea Hospital (oncology, hematology, radiotherapy, internal medicine) on Easter and Christmas.

*"Symptom Control in Palliative Care"* is an educational programme (40 CME) in palliative care (postgraduate level) for physicians, developed in partnership with the National Centre of Training for doctors. Also the same programme is used for training of junior physicians.

*"The nurse and the oncological patient"* is an educational programme (30 CME) for nurses working in oncology/ haematology/ radiotherapy departments developed in partnership with The National Authority for Nurses and with the financial support of GlaxoSmithKline Oncology.

Website: [www.smip.ro](http://www.smip.ro)



## **Hospital for chronic diseases “ St. Luke “ Bucharest Oncology– Palliative care Department**

The oncology department of ‘St Luke’ has been accredited in oncology since 1995, and in palliative care since 2003. The activity of the department (60 beds) is dedicated to palliative care. The team work is based on principles of palliative care, and respond of the needs of patients and their families.

The palliative care team is composed by 13 registered nurses, 2 medical specialist, 1 psychologist and 1 priest.

The palliative care services includes:

- palliative chemotherapy, hormone therapy, immunotherapy,
- pain and other symptoms treatment
- psychotherapy
- spiritual assistance

Patients admission is based on the recommendation of other physician (family doctor, medical specialist)

In 2008, 2213 patients were admitted, in 2009 this number was 3022. The median hospitalization days were 7 in 2008 and 9 in 2009. Till May 2010 the median was 7. The department also has 10 beds for day care and is building up a palliative care team to deliver palliative care at home.

Besides patient care, the department also presents scientific communications in the field of palliative care. It also has a palliative care training centre for physicians and nurses.

# COMMENTS, DISCUSSION

## Palliative care in geriatrics as seen by international organisations

Bogdan Constantin, MD, PhD, geriatrician, president of Romanian Society of Palliatology and Tanathology, Romania

Address for correspondence:  
e-mail: c\_bogdan34@yahoo.com

### Abstract

Palliative care was originally developed and mainly applied in oncological pathology. In the last years the palliative area has been extended, in order to respond to the demographic reality and morbidity, to what is considered as non-oncological palliative care, which includes mainly elderly patients with incurable illnesses.

The extension of the palliative care and assistance was stimulated by international organizations such as UN/ONU, WHO/OMS, regional such as UNECE, COUNCIL OF EUROPE, EUROPEAN UNION and non-governmental such as EURAG, ECEPT (palliative care organization for Eastern Europe located in Poznan – Poland).

The paper presents these organizations' positions in favor of palliative care that must be offered to the elderly, as it results from different documents, studies, recommendations.

Key words: *palliative care, geriatrics, international organizations*

(Full text in Romanian)

# LETTER TO THE EDITOR

## Is euthanasia an option?

Astărăstoae Vasile, MD, PhD, professor, president of The Romanian College of Physician

Address for correspondence :  
e-mail: colegium@iasi.mednet.ro

The January issue of PALIAȚIA has paid extensively attention to euthanasia. This is indeed an important issue to be discussed, also in the context of palliative care. I would like to add some considerations and arguments to the euthanasia debate. My contributions is based on general developments on human rights and international legislation on the one hand and on values and norms people in different countries or with different religions considered as essential in relation to euthanasia on the other hand.

Euthanasia is a highly complex concept that lies at the crossroads between life and death, between free will and medical, societal and religious norms. Euthanasia is about therapeutic and deliberate action to induce death.

There are various assumptions – philosophical, medical and legal – which underlie the concept of euthanasia.

According to *philosophical assumptions*, any person dies. The value of human life is measurable. Human life can be approached the same as life of other creatures. It is assumed that pain is without any benefit. Request for euthanasia are considered rationally and based on compassion.

From a *medical point of view assumptions* include, that medical diagnosis and prognosis are always certain and can a realistic degree of suffering of people. Implicitly it is assumed, that effective alternatives to treat pain are not available. For doctors, euthanasia is a responsibility that is seen as justified, based on these assumptions.

*Legal assumptions* are that legal regulation of euthanasia will be able to control abuse of euthanasia, i.e. unjustified killing for material profit (organs, inheritance) will be prevented. So, through legislation a clear distinction may be made between between euthanasia and murder.

There are regardless the assumptions, arguments in favour of euthanasia:

1. Compassion;
2. The right to die;
3. Social progress;
4. Economic necessity.

Of course arguments against euthanasia exist as well:

1. Euthanasia is too radical: destroy a problem rather than solve;
2. Euthanasia has no ethical justification: reverse the "can destroy an entire party to save" does not exist;
3. Euthanasia is not legally admissible: to eliminate the possibility of abuse, most countries have not legalized euthanasia;
4. Euthanasia is hard to put into practice: we do not find enough doctors to want to play the role of "executioner" in front of patients because it could alter their relationship with patients;
5. Euthanasia is becoming less necessary because there are alternatives (eg palliative treatment).

A different aspect in the euthanasia debate is the role of religion. Various religions have explicitly mentioned there points of view towards euthanasia.

Christian moral principle reject euthanasia on the grounds sanctity of life. Is there an explicit commandment that says "do not kill." For believers, human life is a gift from God. Life comes from God, and belongs Him only.

The Roman Catholic Church states the right to life thus: "God is the creator and owner of human life and no one can take without his permission". The Roman Catholic Church's attitude on active euthanasia is clear: "He is guilty of manslaughter practice."

In 2001 the Romanian Orthodox Church council explicitly declared the prohibition of euthanasia for both believers and for physicians. The Lutheran Church Episcopal Church in Romania have also a strong position against assisted suicide.

In Islam, euthanasia and assisted suicide are prolonged interrogations.

Looking at the legislation and behavioural codes as these are developed in the last decades a fundamental change may be observed as compared to religious beliefs as well as former legislation.

Euthanasia was prosecutable according to ethical views and documents. The points of views, expressed at the Nürnberg trial were used as the base for international codes: the World Medical Association Oath of 1950, the Helsinki Declaration of 1964 and the 1975 Tokyo Declaration. All documents rejected euthanasia.

As example we may look at the Code of Conduct College of Physicians in Romania:

Article 120: "The doctor is designed to minimize patient suffering from incurable and ensure the dignity of dying."

Article 121: "Euthanasia is forbidden, namely use of products and resources in order to cause the death of a patient, regardless of severity and prognosis, although this was expressly requested by a patient fully conscious."

Article 122: "doctor will not help and will not recommend suicide or self-mutilation through advice, recommendations or offer means. Your doctor will refuse any explanation or help in this regard."

As indicated legal regulations have changed and become more diverse. Worldwide, there are countries that prohibit euthanasia/assisted suicide, but there are also countries that have legalized euthanasia/assisted suicide. This is an ongoing debate.

Recommendation 1418/1999 of the Council of Europe on protection of human rights and dignity of the dying and incurable patients mentions various considerations:

- The right to life is guaranteed and national laws must do so, conform to Article 2 of the European Convention on Human Rights. The European Convention on Human Rights expressly stipulates "death is not caused anyone intentionally" ;

- Expressed desire to die because of a incurably illness may be a legal justification for actions that can lead to death, but not a legal basis to kill another person.

The European Court of Human Rights (ECHR), applying the Human Rights Convention accepts that a person may refuse treatment that will prolong or maintain life, but rejects the use of lethal forces leading to the death of the person.

In Romania, the old Penal Code Article 468 regulating the "murder of pity." The current Penal Code contains no provision for euthanasia.

Societal attitudes also differ between European countries.

In Romania there is a traditional conception of death and euthanasia. This is shown by several studies about public perception of euthanasia. Also medical students and medical doctors share the perception of the public. A study from Sibiu in 2003 showed, that 71% of the students were against euthanasia, 20% would accept euthanasia but under certain conditions, and 4% only if the law requires it.

A study in Iași among 400 students analysed their views on euthanasia/assisted suicide before and at the end of a course in medical bioethics. Before, one third of students disagreed with euthanasia. After the course only 11% of students accepted euthanasia. Another study shows that 29% of medical doctors, just finishing medical school, believed in future passive euthanasia only acceptable in exceptional circumstances; 4% accept voluntary active euthanasia. Two third of these young doctors did not accept euthanasia.

I hope this analysis has shown the large differences in points of view on euthanasia in Europe. Attitudes to human rights, culture and religion all play a role in this ongoing debate.

## **NEW PUBLICATION**

### **Care need in dementia and digital interactive information provisioning**

H van der Roest

Dissertation Free University Amsterdam, the Netherlands, 2009

This dissertation studies the need for care of people with dementia from the perspective of the patients with dementia as well as their family members. Based on this study, solutions to meet these care needs are looked for by the support of information communication technology (ICT).

To identify the care needs of dementia patients the Camberwell Assessment of Need for the Elderly (CANE) was used. CANE is a validated assessment instrument, looking for physical, social and psychological care needs in 24 domains of activities in daily life (including activities like medication, incontinence, cleaning, meals, mobility, social relationships). The questionnaire was filled in by 236 patients with dementia, living at home, and 322 central carers.

Central carers indicate as most frequently needed: coping with memory loss of the patient, emotional burden and structuring activities during the day. Patients mention most frequently the need more information about the disease process.

Patients and central carers (most family members) differ in the type of need as well as the intensity of need. Patients indicate a lower intensity of need for care as compared to central carers.

As might be expected the intensity of need for care increases with the severity of the disease. Central carers with a high education level and/or high income are able to realise more care needs as compared to central carers with low education and/or income.

To meet the needs of this study group a Dementia-specific Digital Interactive Social Chart (DEM-DISC) was developed. The DEM-DISC supports the central carer to clarify the type of need by asking specified questions about the type, frequency, intensity of support/help needed. Based on the answers a personal advice is given as well as how and where the needed support may be found.

A prototype of the DEM-DISC is evaluated by central carers (14 central carers received the prototype, 14 not). After two months the central carers with the prototype showed to cope better with the care needs of themselves as well of the patients. Also, they indicated to feel more competent to deal with their job as carer for a patient with dementia.

The DEM-DISC is expected to be evaluated in a randomised trial to study the effect of the DEM-DISC more systematically, including prevention of institutional admission and health care costs.



## **NEWS**

### **Palliative care services in the new framework agreement in Romania**

In April 2010 the new framework agreement between health professionals and health insurance is at force. It is regulated that patients can receive up to 90 days of medical care at home. A novelty is that the recommendation can be done by family physicians. Also palliative care services were introduced in the package. Annexes 24, 25, 26 and 27 specify who may receive this care and what are the conditions in which this type of care is given. Although, this is a new possibility for delivering palliative care, the number of institution which apply for this possibility, is limited.

### **Eleventh Conference of the National Association for Palliative Care**

#### **"Palliative Care - An Invitation to Collaboration"**

28-30 October 2010, Cluj-Napoca, Romania

#### *CONFERENCES THEMES:*

Symptom control in palliative care  
Communication with patient, family and professionals - a continuing challenge  
Organizing palliative care services - news, needs and perspectives  
Integrated model of palliative care  
Work in palliative care nursing  
Decisions and ethical dilemmas in palliative care  
Engaging the community and authorities in palliative care  
The role of social support in palliative care  
Spirituality - an integral part of palliative care services  
Palliative care team: challenges, needs and activities

More information at: [www.anip.ro](http://www.anip.ro)