

End-of-life decisions: *Israeli perspective*

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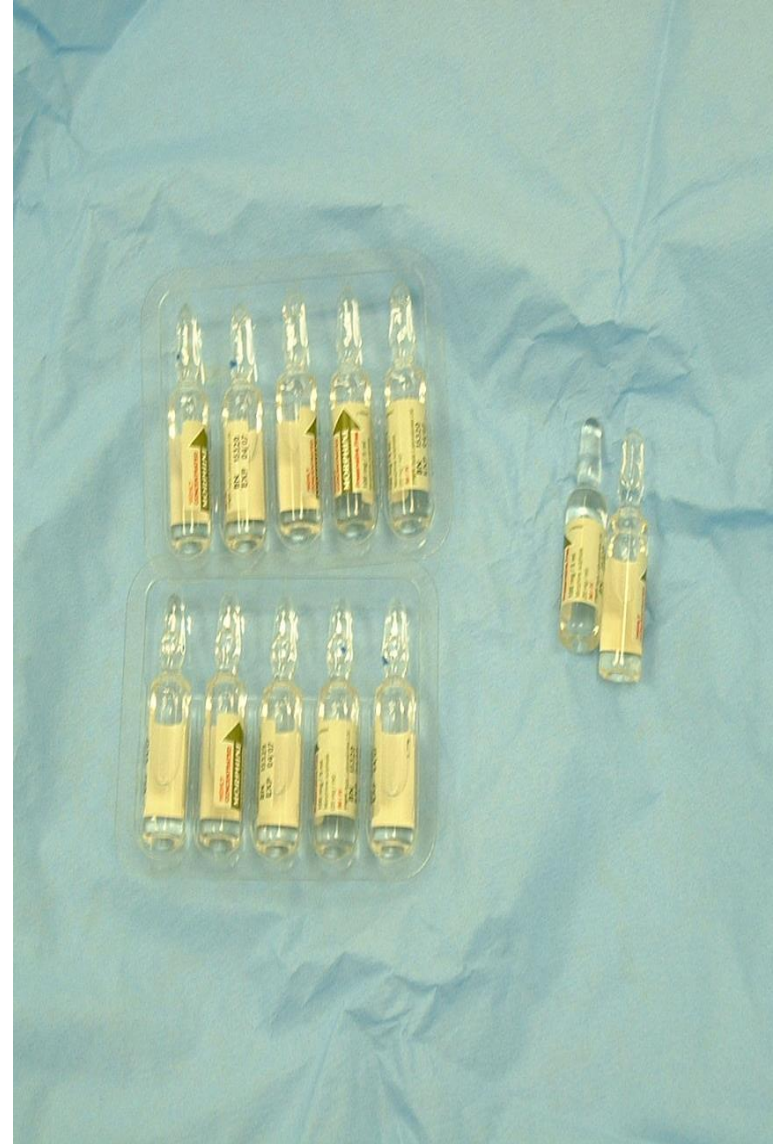


Pain

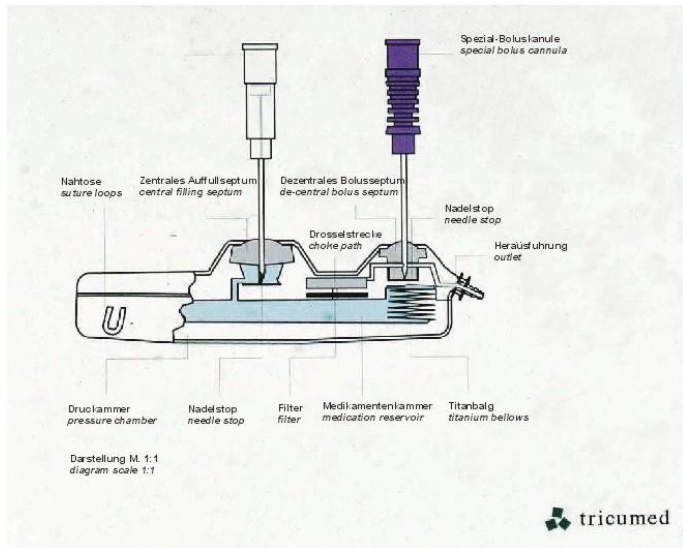
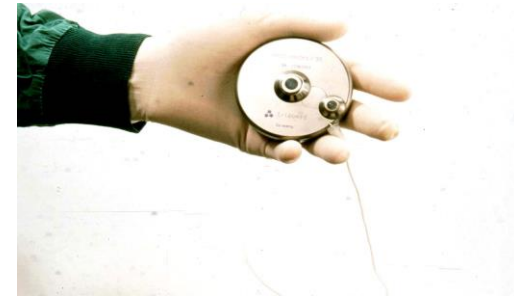
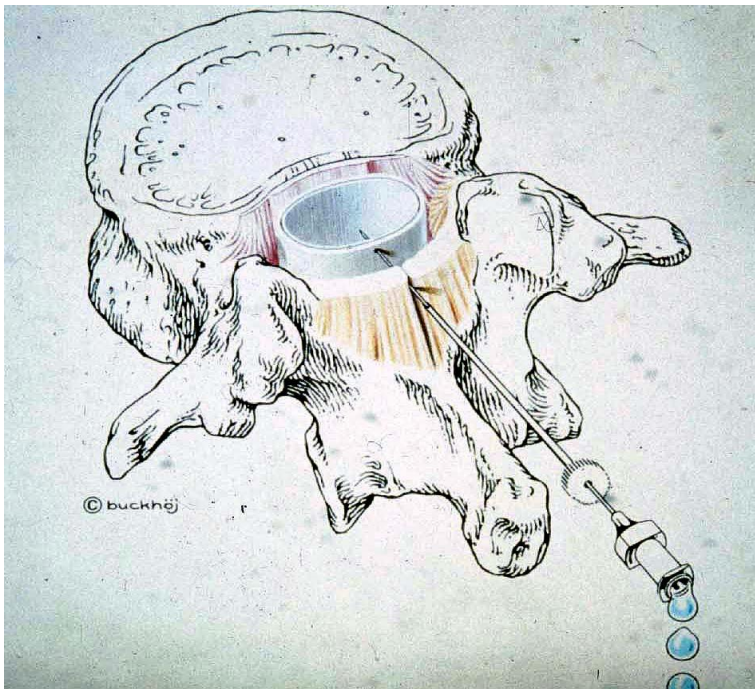
“An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.”

International Association for the Study of Pain (IASP) 1994



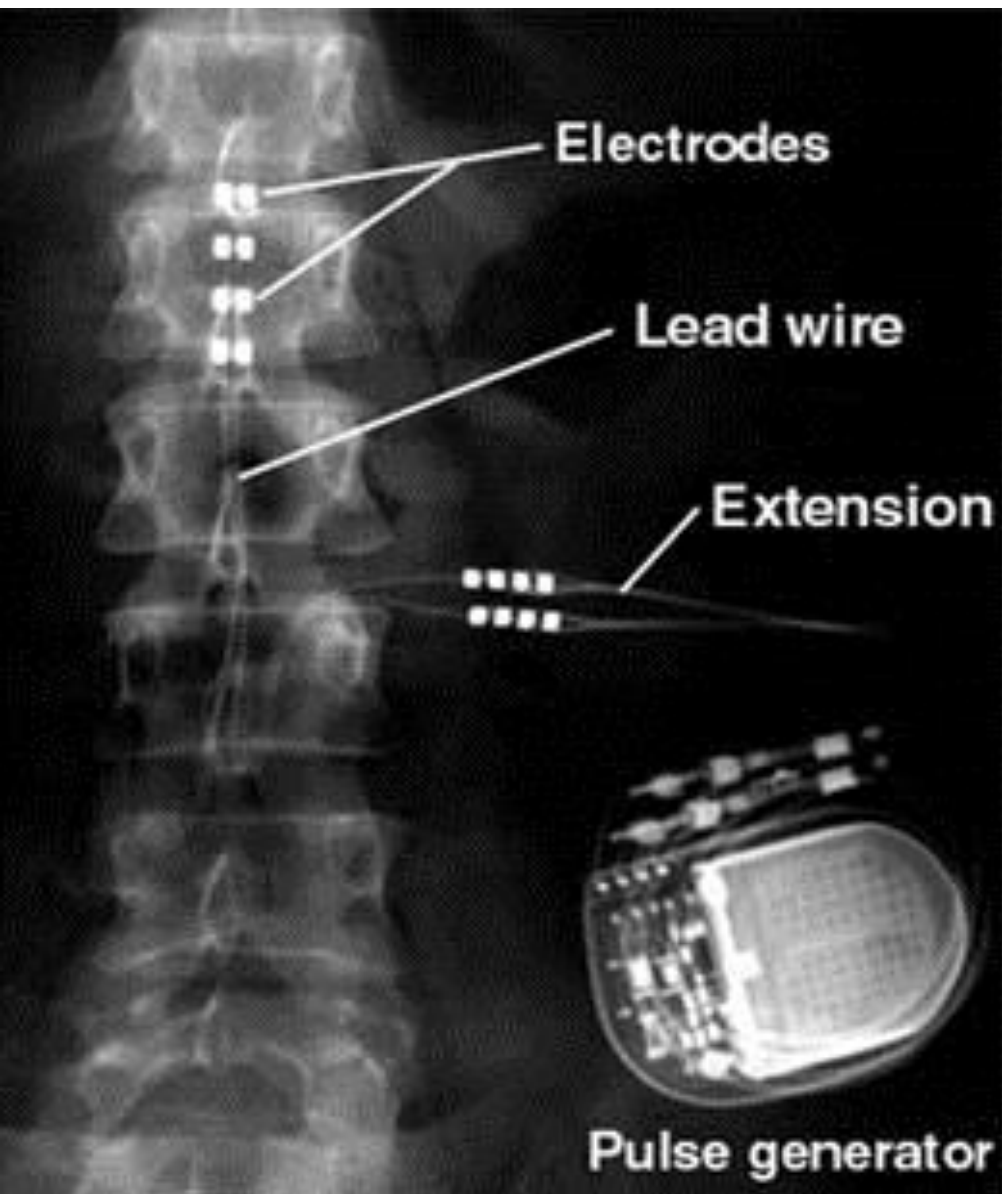








Spinal cord stimulation



The 2015 Quality of Death Index

Ranking palliative care across the world

A report by The Economist Intelligence Unit

Everyone hopes for a good death, or rather, “a good life to the very end”

Good death vs. good life to the very end

What causes patients to seek end-of-life?

- ✓ Pain
- ✓ Depression
- ✓ Dyspnea
- ✓ Nausea and vomiting
- Frailty, fatigue

✓ - treatable

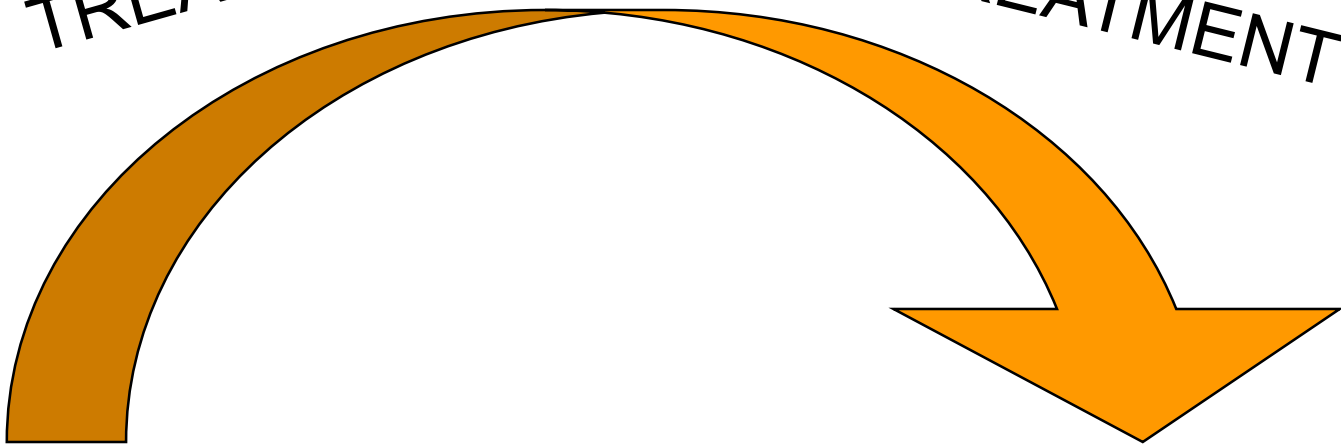
What causes physicians to seek end-of-life of a patient?

- ☐ Pain
- ☐ Depression
- ☐ Frailty, fatigue
- ☐ Dyspnea
- ☐ Nausea and vomiting
- ☐ Cough
- ☐ Fever
- ☐ Bleeding
- ☐ Agitation/delirium/ terminal anguish/restlessness (e.g. thrashing, plucking, or twitching)
- ☐ Secretions accumulated in the oropharynx and upper airways when patients become too weak to clear their throat
- Rationing and the allocation of resources

OPTIONS AT THE END OF LIFE

WITHHOLDING
TREATMENT

WITHDRAWING
TREATMENT



FULL CONTINUED
CARE

ACTIVE LIFE
ENDING
PROCEDURES

INTENT TO RELIEVE SUFFERING OR HASTEN DEATH?

Ethicus study:

doses of opioids and benzodiazepines reported for active shortening of the dying process (SDP) with the intent to cause death were in the same range as those used for symptom relief in earlier studies and that times to death were similar for SDP and withdrawal patients, demonstrate that the distinction between treatments to cause death and to relieve suffering in dying patients may be unclear.

Sprung C et al. End-of-life practices in European intensive care units: the Ethicus Study.

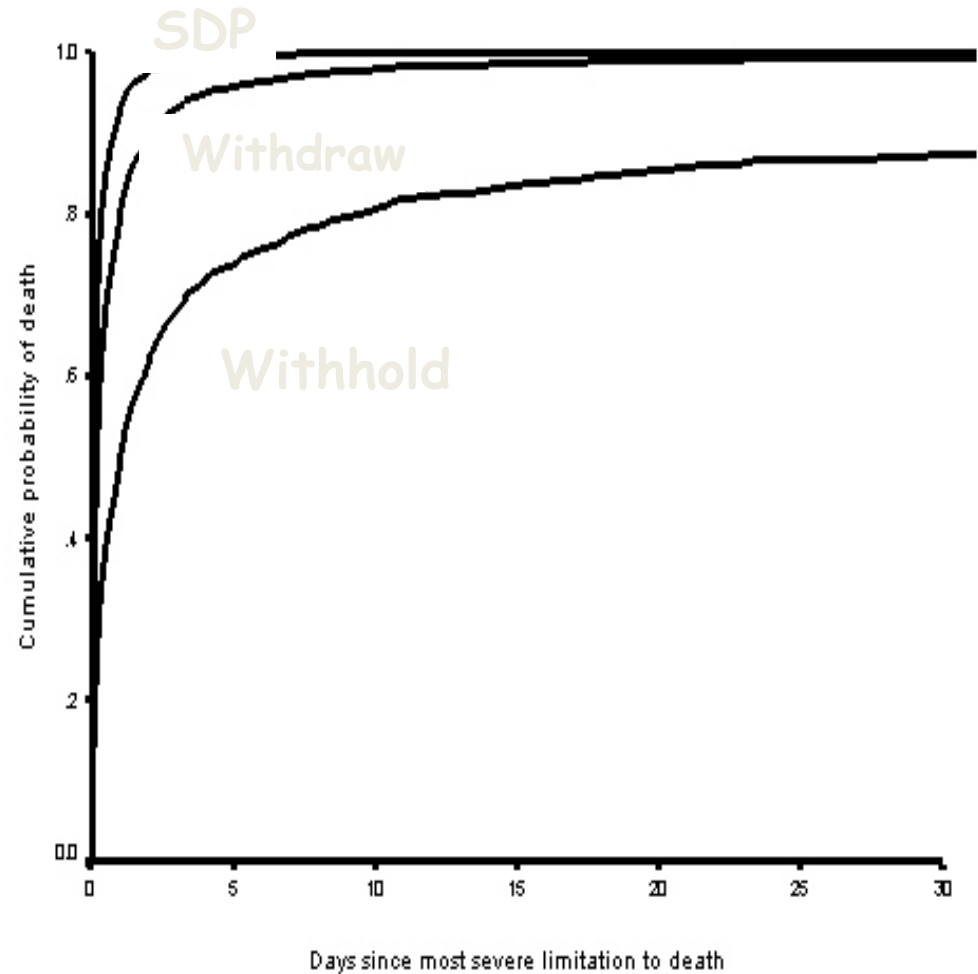
JAMA. 2003 Aug 13;290(6):790-7.

Probability of death over time after a limitation

Median time from most active limitation of therapy until death:

- All patients: 6.6 hours (IQR: 30.2 hours)
- Withholding: 14.3 hours (IQR: 64.6 hours)
- Withdrawal: 4.0 hours (IQR: 16.2 hours)
- SDP: 3.5 hours (IQR: 7.0 hours)

$p < 0.001$



End of life care services aim to support those with advanced, progressive, incurable illness to live as well as possible until they die.

In England, approximately half a million people die each year, almost two-thirds of whom are aged over 75 years.

Around three quarters of deaths are 'predictable' and follow a period of chronic illness, such as cancer or heart disease, where people may need access to end of life care.[

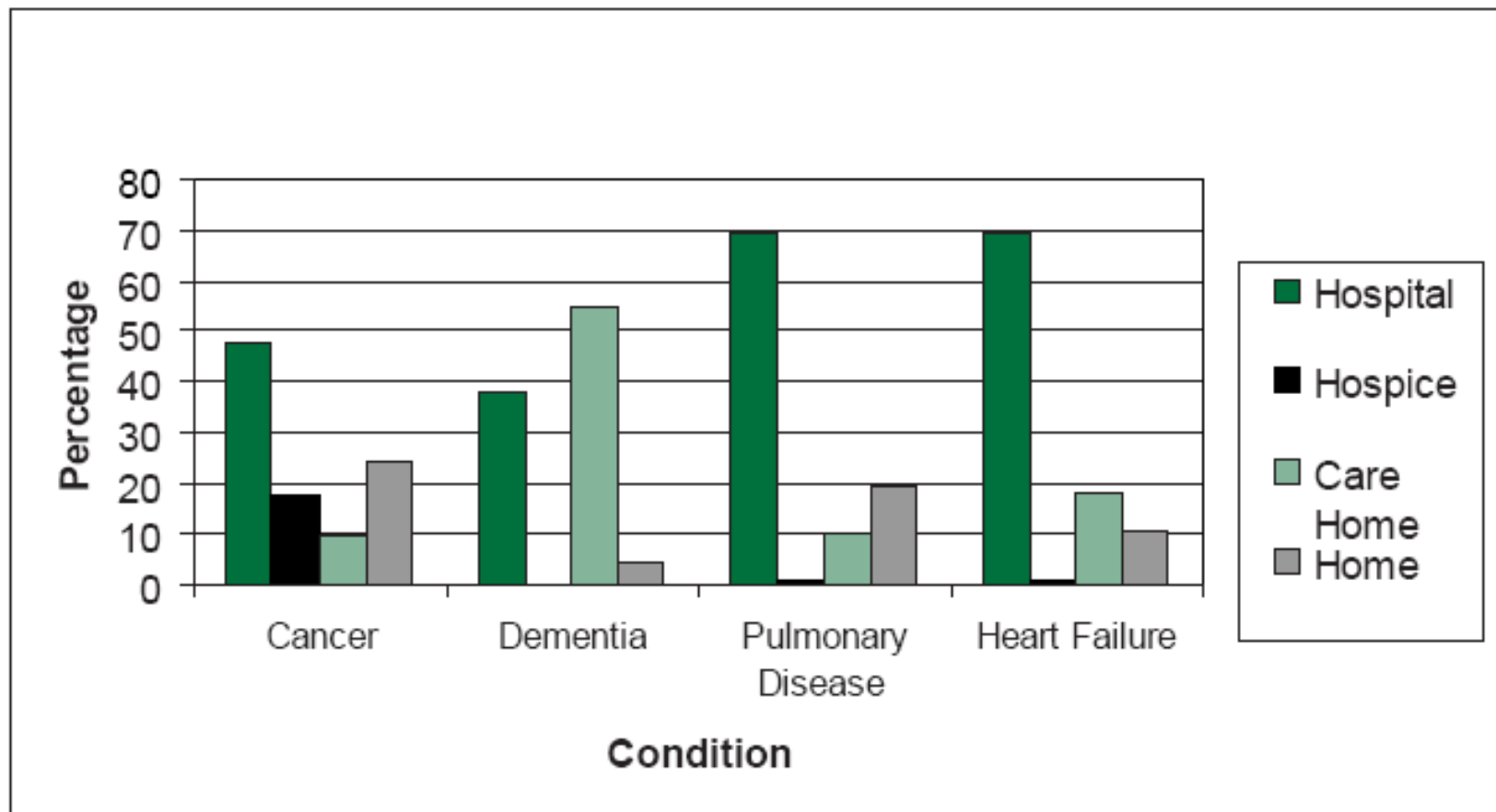
The majority of people (between 56% and 74%) express a preference to be cared for and die in their own home, which for some will be a care home, and to avoid dying in an acute hospital.

The proportion of people expressing a preference to die at home has, however, been shown to change as death approaches

<https://publications.parliament.uk/pa/cm200809/cmselect/cmpubacc/99/9905.htm>

Prepared 14 May 2009

Figure 1: Place of death varies by condition



Source: National Audit Office analysis of 2006 Mortality Statistics for England

<https://publications.parliament.uk/pa/cm200809/cmselect/cmpubacc/99/9905.htm>

Prepared 14 May 2009

Over 50% of elderly people die in acute hospital settings, where the quality of end-of-life care is often suboptimum.

Suggesting CAREFuL programme: care guide for the last days of life, training, supportive documentation, and an implementation guide.

Improving comfort around dying in elderly people: a cluster randomised controlled trial.

Beernaert K et al.

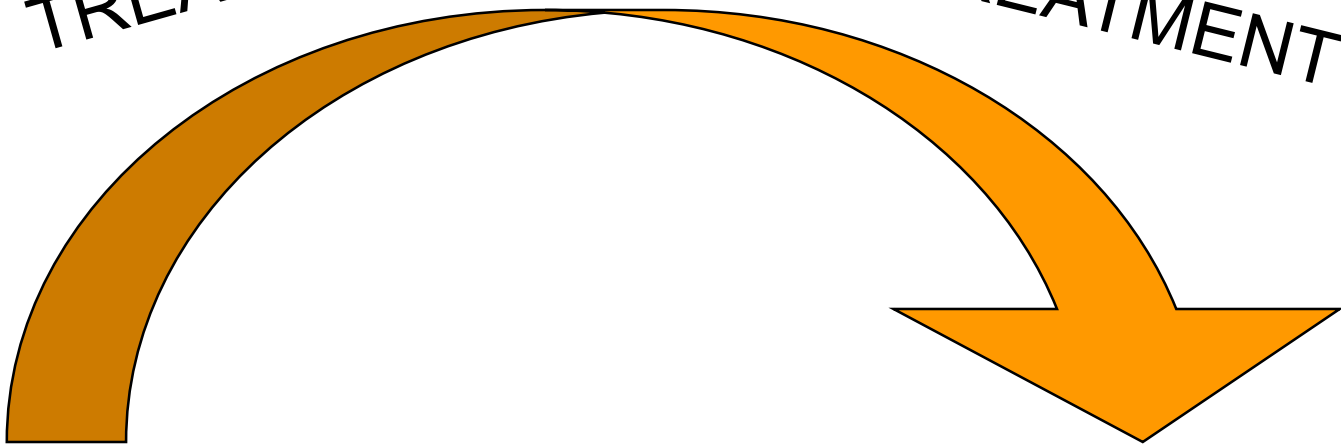
(acute geriatric wards in ten hospitals in Flemish Region, Belgium)

Lancet. 2017 May 16. S0140-6736(17)31265-5.

OPTIONS AT THE END OF LIFE

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- Public interest in euthanasia
- The arguments propounded for and against euthanasia in the 20th century are identical to those in 19th century.
- Such similarities suggest that
 - 1) is not linked with advances in biomedical technology;
 - 2) flourishes in times of economic recession, in which individualism and social Darwinism are invoked to justify public policy;
 - 3) arises when doctor authority over medical decisions is challenged;
 - 4) occurs when terminating life-sustaining medical interventions become standard medical practice and interest develops in extending such practices to include euthanasia.

Emanuel EJ. Ann Intern Med 1994;121:793-802

End-of-Life Decisions in the Netherlands over 25 Years (1990-2015)

In the Netherlands, physician assistance in dying has been legally regulated since 2002:

- physician-assisted suicide
 - euthanasia (physician administers lethal medication at the explicit request of a patient)
-
- Both types of assistance are allowed only for patients who are “suffering unbearably” without any prospect of relief

Table 1. Frequency of Physician Assistance in Dying and Other End-of-Life Practices in the Netherlands (1990–2015).*												
Variable	1990		1995		2001		2005		2010		2015	
	No. of Cases	Percent (95% CI)	No. of Cases	Percent (95% CI)	No. of Cases	Percent (95% CI)	No. of Cases	Percent (95% CI)	No. of Cases	Percent (95% CI)	No. of Cases	Percent (95% CI)
Total no. of cases studied	5197		5146		5617		9965		6861		7761	
End-of-life decisions												
All categories	2361	39.4 (38.1–40.7)	2604	42.6 (41.3–43.9)	2899	43.8 (42.6–45.0)	2580	42.5 (41.1–43.9)	3685	57.8 (56.7–59.0)	4379	58.1 (57.0–59.2)
Euthanasia†	141	1.7 (1.4–2.1)	257	2.4 (2.1–2.6)	310	2.6 (2.3–2.8)	294	1.7 (1.5–1.8)	475	2.8 (2.5–3.2)	829	4.5 (4.1–5.0)
Physician-assisted suicide	18	0.2 (0.1–0.3)	25	0.2 (0.1–0.3)	25	0.2 (0.1–0.3)	17	0.1 (0.0–0.1)	21	0.1 (0.1–0.2)	22	0.1 (0.1–0.2)
Ending of life without explicit patient request	45	0.8 (0.6–1.1)	64	0.7 (0.5–0.9)	42	0.7 (0.5–0.9)	24	0.4 (0.2–0.6)	13	0.2 (0.1–0.3)	18	0.3 (0.2–0.4)
Intensified alleviation of symptoms	1166	18.8 (17.9–19.9)	1161	19.1 (18.1–20.1)	1312	20.1 (19.1–21.1)	1478	24.7 (23.5–26.0)	2202	36.4 (35.2–37.6)	2469	35.8 (34.7–36.8)
Forgoing of life-prolonging treatment	991	17.9 (17.0–18.9)	1097	20.2 (19.1–21.3)	1210	20.2 (19.1–21.3)	767	15.6 (15.0–16.2)	974	18.2 (17.3–19.1)	1041	17.4 (16.6–18.3)
Continuous deep sedation‡	NA		NA		NA		521	8.2 (8.8–8.6)	789	12.3 (11.6–13.1)	1288	18.3 (17.4–19.2)

* Absolute numbers are unweighted, but percentages are weighted for sampling fraction, nonresponse, and random-sampling deviations to make them representative for all deaths in the year studied. Therefore, the percentages cannot be derived from the unweighted absolute numbers. CI denotes confidence interval, and NA not available.

† In 2005, 5.2% of all deceased patients had requested euthanasia; this percentage was 6.7% in 2010 and 8.4% in 2015. The number of requests is not available for 1990, 1995, and 2001.

‡ The use of continuous deep sedation may overlap with end-of-life decisions. It coincided with intensified alleviation of symptoms in 11% of all deaths and with forgoing life-prolonging treatment in 5%.

Agnes van der Heide, et al. (Erasmus MC, Utrecht Univ., Amsterdam)
N Engl J Med 2017; 377:492-494

About half of all requests for physician assistance in dying were granted in 2015

End-of-life decision had preceded death:

1990 39%

2015 58%, mostly intensified alleviation of symptoms, continuous deep sedation or forgoing of life-prolonging treatment.

However, reported 829 cases (4.5%) of euthanasia and 18 cases of ending of life without explicit patient request

“Such assistance is provided predominantly to patients with severe disease but increasingly involves older patients and those with a life expectancy of more than a month”

Agnes van der Heide, Johannes J.M. van Delden, Bregje D. Onwuteaka-Philipsen

End-of-Life Decisions in the Netherlands over 25 Years. NEJM2017;377:492

End-of-Life Decisions in the Netherlands over 25 Years (1990-2015)

- 1990: 1.7% of all deaths were the result of euthanasia
- 2015: 4.5%
- 1990: 0.1% - physician-assisted suicide
- 2015: 0.2%

Agnes van der Heide, et al. (Erasmus MC, Utrecht Univ., Amsterdam)
N Engl J Med 2017; 377:492-494

End-of-Life Decisions in the Netherlands over 25 Years (1990-2015)

- Ending of life without an explicit patient request
 - 1990: 0.8%
 - 2015: 0.3%

End-of-Life Decisions in the Netherlands over 25 Years (1990-2015)

In 2015 had:

- early stage of dementia - 3%
- psychiatric problems - 3%

Reporting of euthanasia in medical practice in Flanders,
Belgium: cross sectional analysis of reported and unreported cases.
T. Smets et al. BMJ 2010;341:c5174

... the incidence of euthanasia was estimated as
1.9% of all deaths (95% CI 1.6% to 2.3%).

Approximately half (549/1040 (52.8%, 95% CI 43.9%
to 60.5%)) of all estimated cases of euthanasia were
reported to the Federal Control and Evaluation
Committee

patients' rights. The Canadian Society of Palliative Care Physicians says that most of its members do not want to aid patients in dying;

The American Psychiatric Association (APA) has taken a strong stand against euthanasia. In a **formal position statement** approved by its board of trustees this month, it says:

The American Psychiatric Association, in concert with the American Medical Association's position on Medical Euthanasia, holds that a psychiatrist should not prescribe or administer any intervention to a non-terminally ill person for the purpose of causing death.

This implies that it is not ethical for a psychiatrist to help a non-terminally ill person to commit suicide, either by providing the means or by direct lethal injection, as is being currently practiced in The Netherlands and Belgium.

Although this binds only APA members, the APA is one of the world's most influential professional bodies. The World Psychiatric Association (WPA) is considering a similar statement.

Why physicians shouldn't be involved in physician assisted death- euthanasia?

- Many requests disappear with symptom control and psychological support.
- Patients should be sure about medical professionalism: physicians are trying to heal and relieve suffering and they are never intentionally causing harm
- The danger of a slippery slope
 - Administration of lethal drugs without absence of terminal illness, untreated psychiatric diagnoses and patient consent

Euthanasia and physician assisted suicide

Improve palliative care at the end-of-life

- Patients with severe pain can benefit from better palliative care as almost all patients can be made physically comfortable.

Lorenz K, Lynn J. JAMA 2003;289:2282

Euthanasia and physician assisted suicide

Improve palliative care at the end-of-life

- Many suicidal individuals do not want to die; they want to escape what they perceive as intolerable suffering. When relief is offered in the form of adequate treatment for depression, better pain management and palliative care, the desire for death wanes.

Kheriaty A. First Things. 2015

Euthanasia and physician assisted suicide

Improve palliative care at the end-of-life

- The International Association for Hospice & Palliative Care stated that no country or state should consider the legalization of PAS-E until it ensures universal access to palliative care services and to appropriate medications, including opioids for pain and dyspnea.

De Lima L. J Palliat Med 2017;20:8-14

Alternatives to physician assisted death- euthanasia

- Palliative care
- Social support
- Psychological support

