FACULTY OF MEDICINE AND HEALTH SCIENCES

DEPARTMENT OF GERIATRIC MEDICINE

DEALING WITH EUTHANASIA ON GERIATRIC WARDS

Nele Van Den Noortgate, MD, PhD / Ghent, 17 January 2020

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CONTENT

- Part 1: Good medical decision-making at the end-of-life: based on good prognostication
- Part 2: Advance care planning and DNR
- Part 3: Terminal care
- Part 4: Euthanasia

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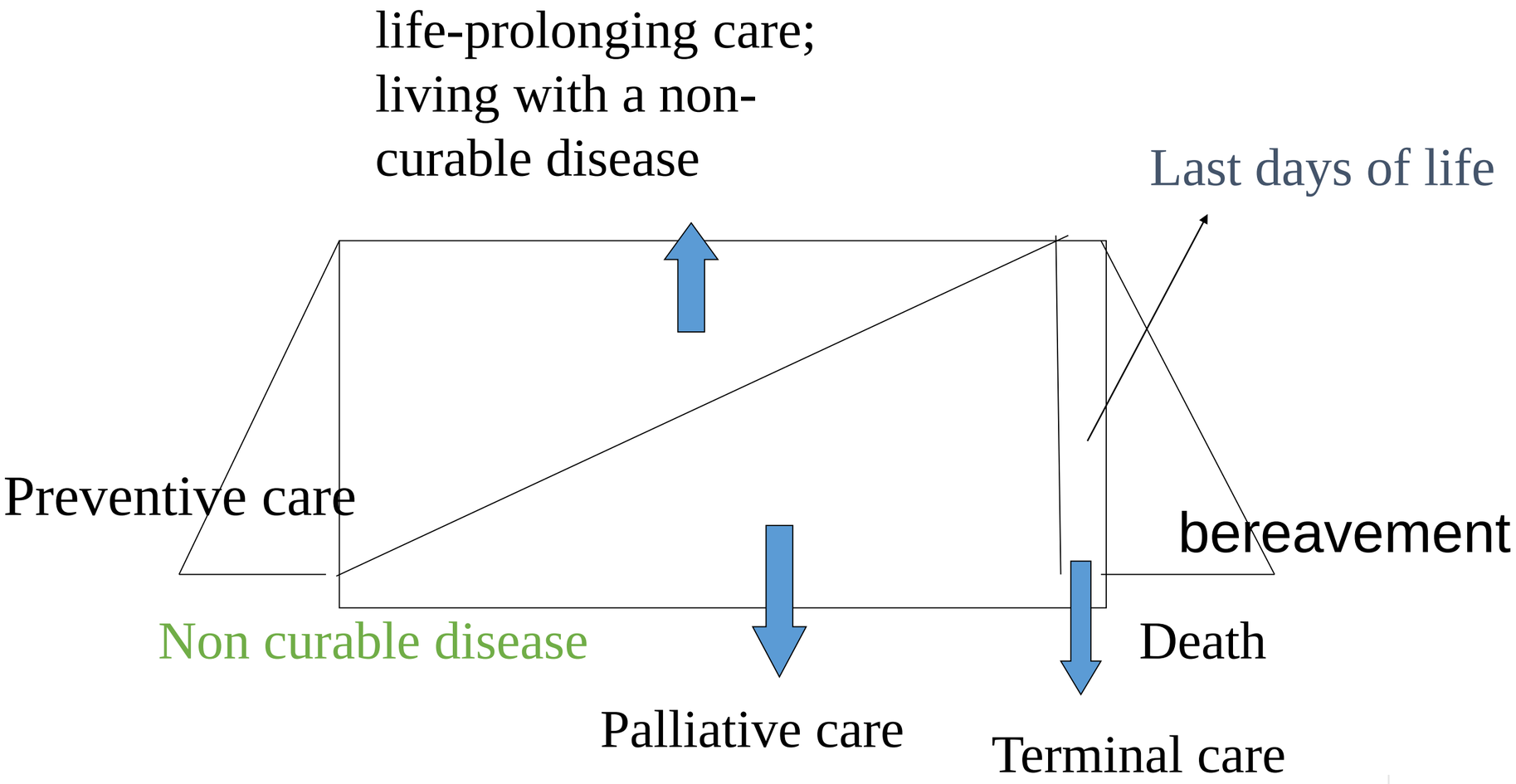
MODEL OF INTEGRATED PALLIATIVE CARE



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IDENTIFICATION OF DYING PATIENT

- Moment of identification of the dying patient in relation to death
  - Last day of life: 30%
  - Last 2-7 days: 33%
  - Last 8-30 days: 19.5%
  - Last 31-90 days: 13%
  - Last 91-210 days: 4.5%

Jakobsson et al. J Pall Med 2006;9:1348-1358

IDENTIFICATION OF DYING PHASE

Attitude to see dying as a natural phase of life

and not as a medical failure

can help to identify the point of no return

and to avoid prolongation of the dying phase

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IDENTIFICATION OF DYING PHASE

- Signs and symptoms in the terminal phase
  - Very little/no fluid intake
  - Generalized weakness
  - Very little/no nutritional intake
  - Respiratory problems/dyspnea
  - Somnolence
  - Recurrent fever

Brandt HE et al. Arch Intern Med 2005;165:314-20

CLINICAL SYMPTOMS LAST 72 HOURS

- Cold, white nose
- Death ratlle
- Oliguria (<300 ml/24h)
- Cyanotic lips
- Cold extremities – blue/red color
- Apnoe > 15 sec
- sleep (> 15h /24h)

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SMALL GROUP DISCUSSION

A is becoming more and more restless, stupor, rattling, breathless

R/ Statin – aspirine – diuretics – gliclazide – LMWH – bètalytics

What would you do?

- non-pharmacological
- pharmacological treatment

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TERMINAL PHASE

- Stop every treatment not necessary for symptom control
  - Consider stopping artificial nutrition/hydratation (discuss in time with family)
  - Stop taking bloodpressure, oxygensaturation, pulse rate …
  - Consider stopping oxygen so comfortable

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Essential drugs- review route	**Previously essential- consider stopping**	**No longer essential- stop**
Analgesics	Steroids	Antihypertensives Statins
Anti-emetics	Replacement hormones	Antidepressants
Sedatives	Hypoglycaemics	Laxatives
Anxiolytics	Diuretics Antiarrhytmics Anticonvulsants	Antiulcer drugs Anticoagulants Longterm antibiotics Iron, vitamins

TERMINAL PHASE

- Treat and anticipate for common symptoms
  - Restlessness, pain, dyspnoea, delirium, death rattle

- Medication often used (syringe driver)
  - Opioids (morphin)
  - Benzodiazepines: (midazolam)
  - Anticholinergic drug

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TERMINAL PHASE: DEATH RATTLE

- In 25 to 90% of the dying patients
- Try non-pharmacological interventions
- Pharmacological treatment
  - Anticholinergic drug
    - Hyoscine hydrobromide (scopolamine ®) SC
      - 0.5 mg/4h (max 3 à 4 mg/24h)
    - Hyoscine butylbromide (buscopan ®) SC/IV
      - 20 mg/4à6h
    - Glycopyronium (Robinul®) SC
      - 200 - 400 µg (max 2.4 mg/24h)

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PAIN/DYSPNOEA

Opioids

- Start with 2,5 mg morphine SC as bolus
  - continue infusion of 20 mg morphine SC over 24h

- It depends on the dose opioids (also weak opioids) already used

RESTLESSNESS/DELIRIUM

- Midazolam (Dormicum®) easy to use SC
  - Start 2.5 mg SC ; consider depending on the purpose
    - 5 à 15 mg SC over 24h (if symptom control is the intention like anxiety, dyspnoea, nausea ..)
    - 50 mg to 120 mg SC over 24h (if deep sedation is needed)
- Lorazepam (Temesta®) PO, SC
  - 1 à 2.5 mg PO; 2 à 4 mg SC

BENEFICENCE OF ANH IN TERMINAL ILLNESS?

- Length of survival? NO
  - ANH is not a significant determinant of survival
- Increasing comfort level? NO
  - 75% no changes; 6% more discomfort
- Decreasing symptoms like thirst, renal insufficiency, delirium? NO

Raijmakers et al. Annals of Oncology 2011;dci10.1093
Mitchell et al. Arch Intern Med 1997;157;327-32
Sampson E et al. Cochrane 2009; 2: CD007209

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HYDRATION

- Thirst
  - No clear relation between thirst sensation and hydration of the patient
  - No studies could prove that hydrating patients is decreasing thirst sensation

Burge; J Pain Symptom Manage 8;454
Musgrave; J Palliat Care 11:17-21

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HYDRATION

- Delirium
  - One study where delirium was reduced with 3% tot 10% after hydration; also reduction of neuroleptics and benzodiazepins
    - Study-design? Also opioid reduction
  - Is still point of discussion
    - In case of severe doubt, a trial could be considered

Faisinger et al. J Palliat Care 9;4-8

HYDRATION

- Controlling electrolyte disorders and renal function
  - No evidence that renal function is diminishing or that a severe electrolyte function appears at the end of life
  - No difference in diuresis at the end of life in hydrated or non-hydrated patients
  - Oliguria is occurring at the end of life

Dunphy et al; Palliat Med 9;221-228.
Oliver et al. Arch Intern Med 155:1258-63
Am J Hospice Palliat Care 11:22-27

MALEFICENCE OF ANH IN TERMINAL FASE

- ANH give raise to:
  - Increased production of GI fluids/ascites
  - Higher incidence of pulmonary secretes, death rattle
  - Presence of oedema

All causing discomfort

Morita et al. J Pain Symptom Manage 2006;31: 306-16 & 130-9

ANH: A MEDICAL TREATMENT?

ANH is a medical act that can cause damage

⇩

Consider alternative ways of giving care

- Mouth care
- Oral drips of fluids
- Music , story telling …

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PRACTICE OF HYDRATION AT THE END OF LIFE

- Try to inform the family about the facts/evidence and not the feelings
- Try to assess the importance of the topic for the family and why. Confirm you understand the feeling and explain how they can replace this feeling by other forms of care
- If the opposition of the family is to great, or you cannot convince them of the futility, careful hydration at the end of life isn't harming too much the patient and can give the family the possibility to say goodbye in peace.

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PALLIATIVE SEDATION

- Medical technique (variable stages of sedation) to treat intractable symptoms in patients with an advanced terminal disease
  - Discuss with palliative care team

- Symptom control – once symptoms controlled not necessary to augment medication

- Mean duration to death ~ 72 hours

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END-OF-LIFE CARE RESEARCH GROUP

UNIVERSITEIT GENT VUB

JOBS OUR TEAM PRESS COLLABORATIONS LOG IN AS MEMBER

NEWS & EVENTS PROJECTS OUTPUT ABOUT US CONTACT PALLIATIEVE ZORG IN VLAANDEREN (DUTCH) >

Home > Projects > CAREFuL - Implementing the Care Programme For the Last Days of Life in acute geriatric hospital wards in Flanders, Belgium

CAREFuL - Implementing the Care Programme For the Last Days of Life in acute geriatric hospital wards in Flanders, Belgium

last updated07-06-2018

Improving the quality of end-of-life care in acute geriatric hospital wards in Flanders

Domain: Older people and dementia

Period: 05-2018 to 04-2021

Status: Current

Website: http://www.endoflifecare.be/zorgprogramma

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GUIDELINE FOR LAST DAYS OF LIFE IN G- WARD

baseline data collection
10 hospitals
1 year

320 eligible deaths
92% assessed by nurses
37% assessed by family carers

Control	Intervention
Standard care 5 hospitals	CAREFuL implementation 5 hospitals 6 months
Post intervention data 1 year 118 eligible deaths *92% assessed by nurses* *20% assessed by family carers*	Post intervention data 1 year 164 eligible deaths *81% assessed by nurses* *29% assessed by family carers*

Beernaert K et al. Lancet 2017;390:125-134

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METHODOLOGY

- Cross-sectional descriptive study
  - In 23 acute geriatric wards - 13 Flemish hospitals
  - Patients hospitalized for more than 48 hours between October 1st 2012-September 30th 2013
- 290 structured after-death questionnaires filled out by the treating geriatricians (RR 85%) within one week after death
  - List of PIM based on the Good Palliative-Geriatric Practice algorithm
- Data analysis performed with SPSS vs 20

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AIM

To describe

- the anticipatory prescription of symptomatic medication
- The deprescription of potentially inappropriate medication (PIM)

During the last 48 hours of life

In frail old people admitted to an acute geriatric ward

Van Den Noortgate N et al. J Pain Symptom Manag 2

ANTICIPATORY PRESCRIPTION IN THE TERMINAL PHASE

- Anticipatory prescription was present in 65,4% (83% vs 23% of those where death was expected versus not expected)
  - 45,5% morphine
  - 15,5% benzodiazepine
  - 13,8% scopolamine hydrobromide

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N Van Den Noortgate et al. J Pain Symptom Manage. 2016;51(6):1020-6.

ANTICIPATORY PRESCRIPTION IN THE TERMINAL PHASE

- Likelihood of having anticipatory medication after adjustment:

	OR	95% CI	P-value
Expected vs not expected death	19	9-40	< ,0001
Dementia vs no dementia	0,35	0,16-0,74	<,006

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N Van Den Noortgate et al. J Pain Symptom Manage. 2016;51(6):1020-6.

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DEPRESCRIPTION OF PIM ON G-WARDS

	% patients treated at admission	% patients treated until death
Inhalation betamimetics and/or steroids (n=262)	58.4	32.1
Antihypertensive (n=270)	71.5	26.7
Anti-ulcer drugs (n=260)	59.2	26.5
Diuretics (n=266)	61.3	23.3
Antibiotics (n=264)	63.6	21.2
Laxatives (n=256)	44.5	15.2
Anticoagulants (n=250)	33.6	14.8
Aspirin (n=264)	45.5	13.3
Corticosteroids (n=247)	30.8	13.0
Bisphosphonates (n=256)	23.4	8.6
Lipid Lowering Drugs (Statins) (n=251)	21.5	8.8
Acetyl cholinesterase inhibitors (n=244)	14.0	5.7
Anti-diabetics **Oral (n=244)** **Subcutaneously (n=245)**	 13.1 12.2	 4.5 2.9

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N Van Den Noortgate et al. J Pain Symptom Manage. 2016;51(6):1020-6.

DEPRESCRIPTION OF PIM ON G-WARDS

– Likelihood of deprescription of PIM after adjustment:

	OR	95% CI	P-value
Expected vs not expected death	21	10-43	< ,0001
Oncological disease vs frailty or dementia	7,0	1,1-45,6	=,042

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N Van Den Noortgate et al. J Pain Symptom Manage. 2016;51(6):1020-6.

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GUIDELINE FOR LAST DAYS OF LIFE IN G- WARD

CAREFuL was developed using the MRC framework

- Care guide for the Last Days of Life – assessing symptoms and guiding interventions
- Supportive documentation for family members
- Training manual ; Implementation guide

Implemented with support of the palliative teams

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Verhofstede R; BMC Pall Care 2016;15:27 –
BMC Pall Care 2015:;4:24; BMC Geriatr 2015;15:13

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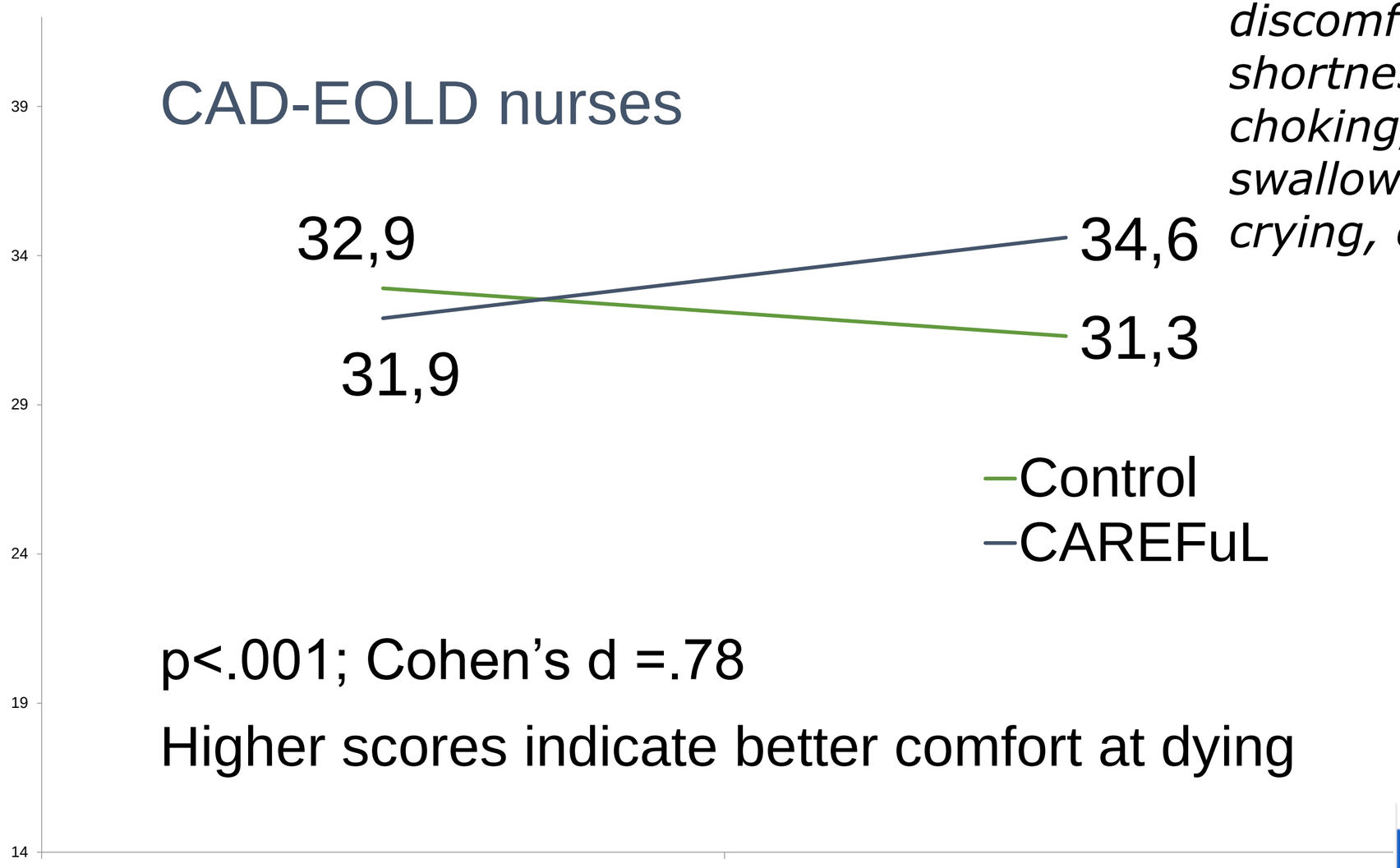
Beernaert K et al. Lancet 2017;390:125-134

RESULTS: PRIMARY OUTCOME

<u>scale items CAD-EOLD</u>: discomfort, pain, shortness of breath, choking, difficulty swallowing, anxiety, crying, calm etc



p<.001; Cohen's d =.78

Higher scores indicate better comfort at dying

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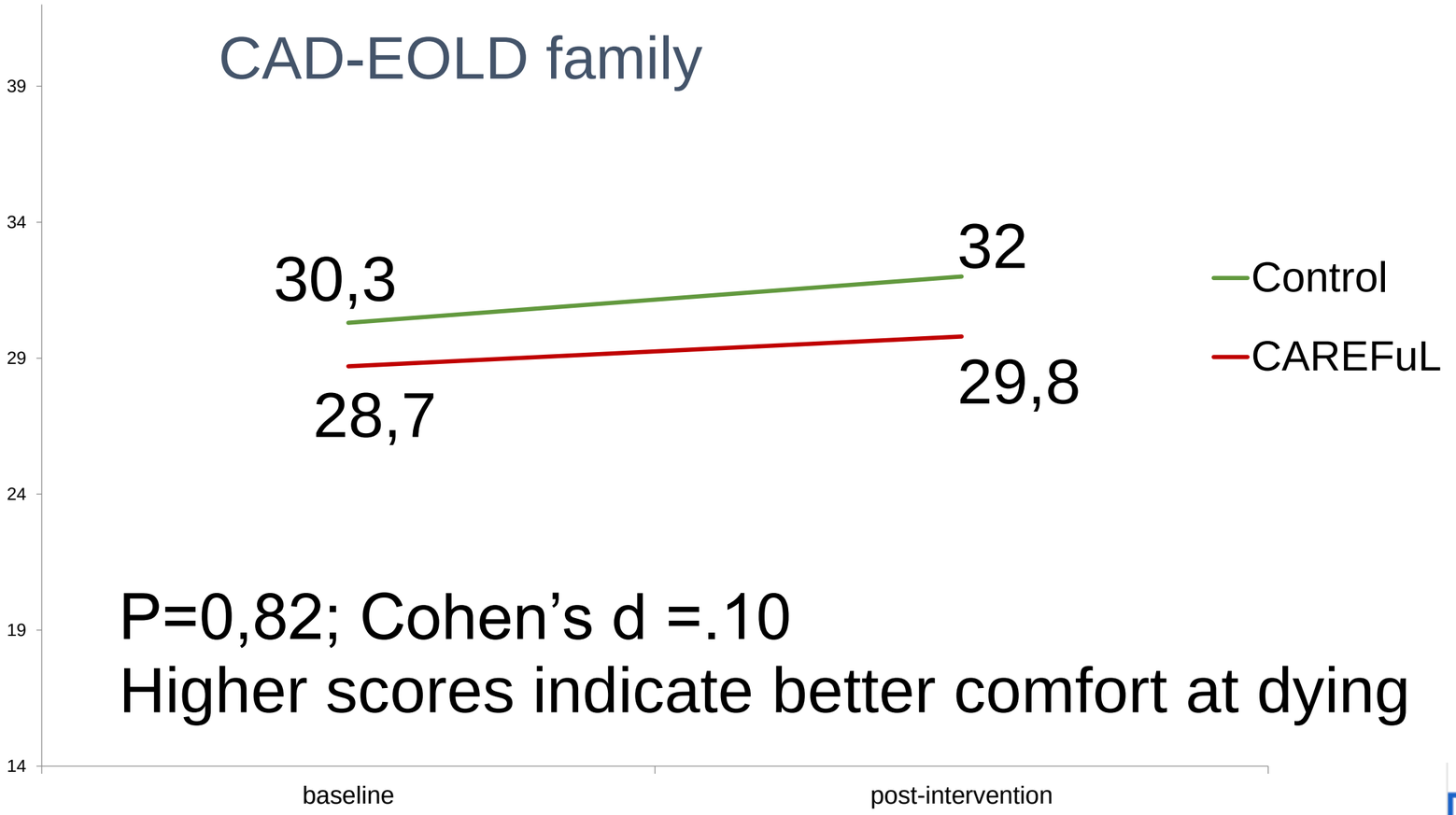
Beernaert K et al. Lancet 2017;390:125-134

RESULTS: PRIMARY OUTCOMES



P=0,82; Cohen's d =.10
Higher scores indicate better comfort at dying

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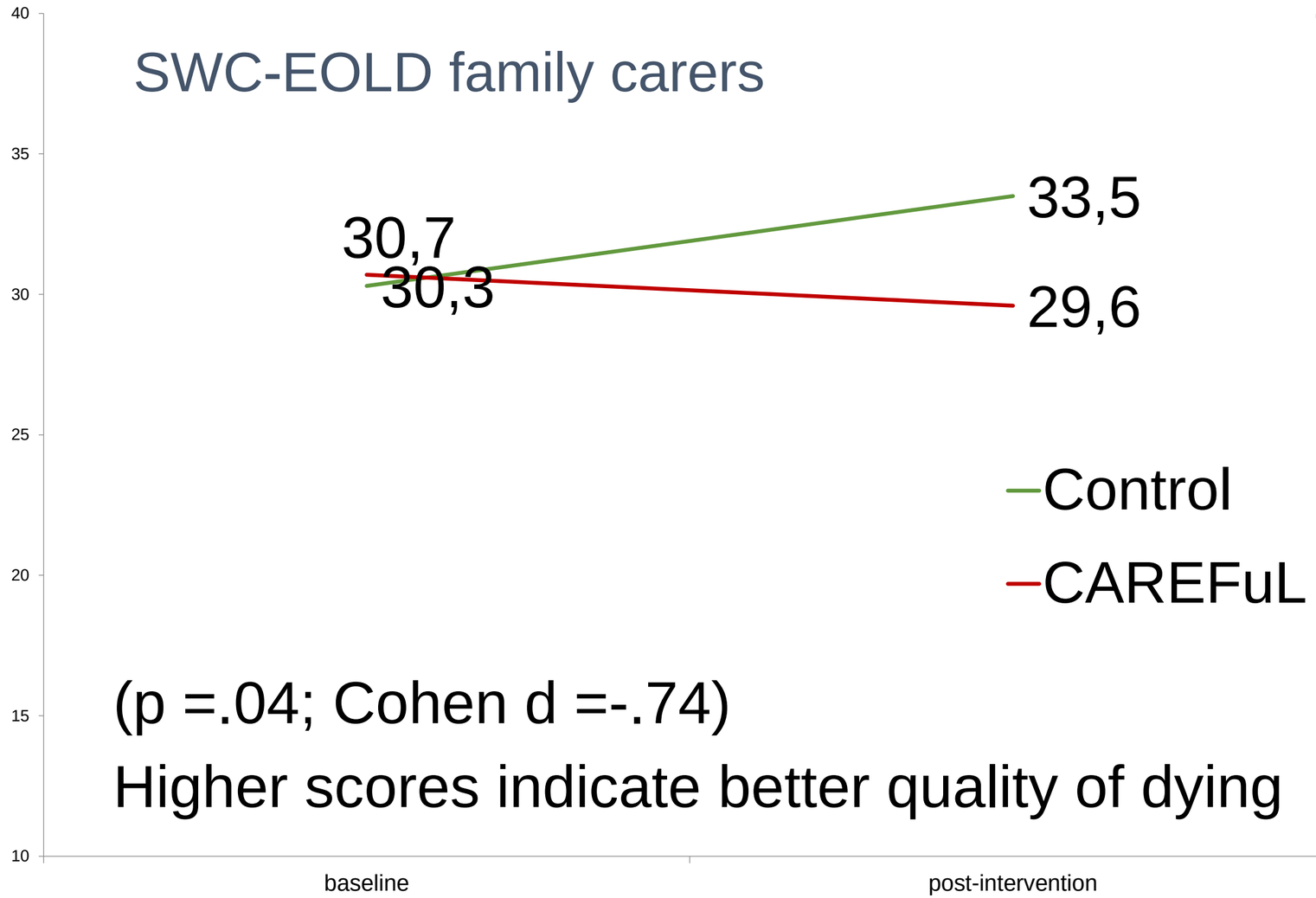
Beernaert K et al. Lancet 2017;390:125-134

RESULTS: SECONDARY OUTCOME



(p =.04; Cohen d =-.74)

Higher scores indicate better quality of dying

Scale items SWC-EOLD

Information

Involvement in decisions

Listening to needs

Idea that everything was done to feel comfortable

….

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Beernaert K et al. Lancet 2017;390:125-134

CONTENT

- Part 1: Good medical decision-making at the end-of-life: based on good prognostication
- Part 2: Advance care planning and DNR
- Part 3: Terminal care
- Part 4: Euthanasia

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EUTHANASIA/ PALLIATIVE SEDATION

- If a patient knows he is going to die within a few days and he wants to hasten death and asks for sedative medication, who will consider to give it?
- If a patient knows he is going to die within a few days and he wants to hasten death and asks for euthanasia, who will consider to give it?

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MAID WORLDWIDE

- **Switzerland**: “Assisted Suicide”
- **USA**: Oregon “Physician-assisted death” or "aid in dying" (1997), followed by Washington (2008), Montana (2009), Vermont (2013), California (2015), Colorado (2016), District of Columbia (2016), Hawaii (2018)
- **Columbia**: mercy killing or euthanasia (1997)
- **BENELUX**: “euthanasia” & PAS (NL/BE2002 and Luxemb. 2009)
- **Canada**: MAID – “Medical Assistance In Dying” (2016)
- **Australia**: Victoria VAD ”Voluntary Assisted Dying” (2018)

EUTHANASIA

‘Euthanasia’

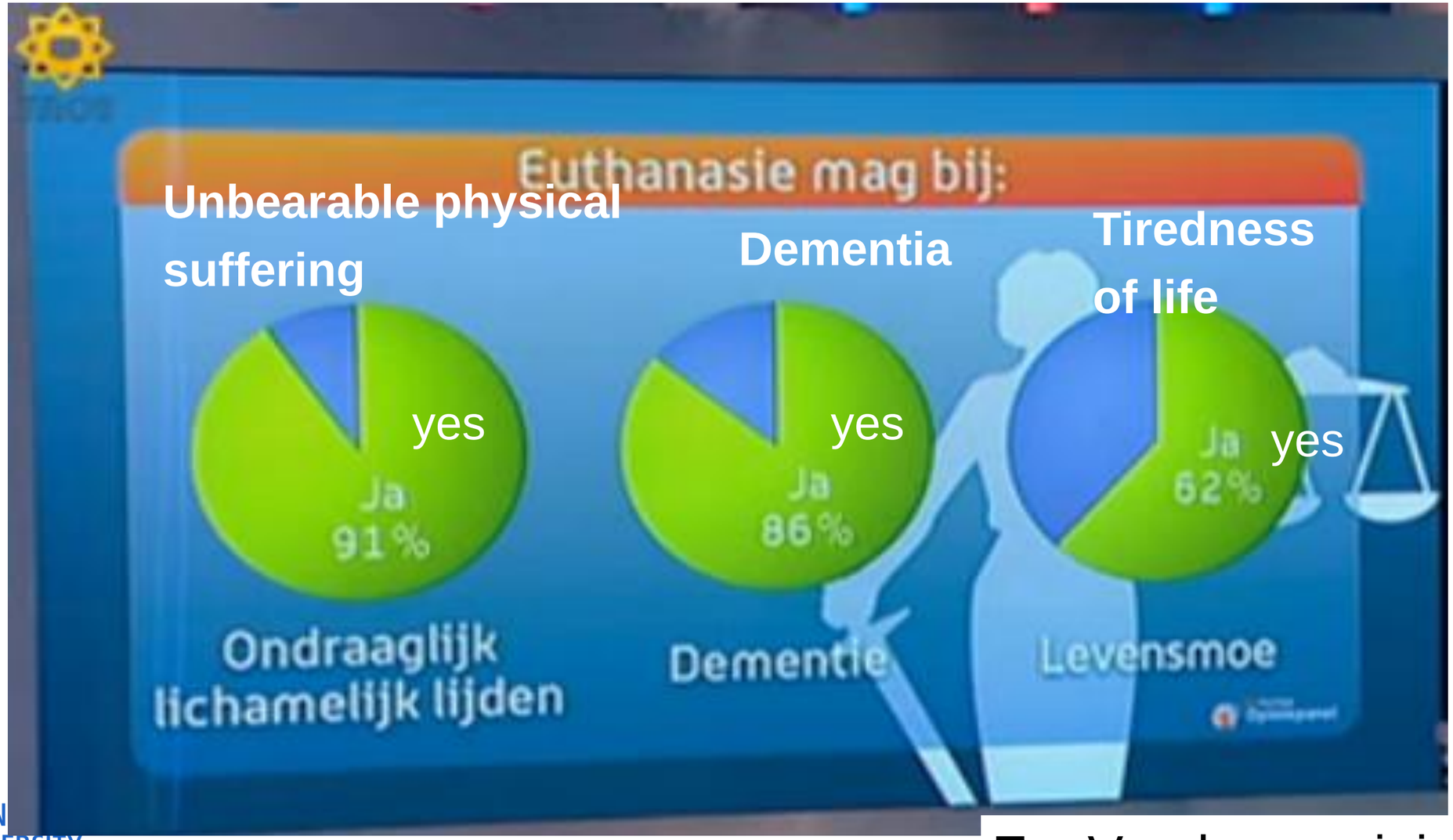
- ‘eu’ meaning ‘well’
- ‘thanatos’ meaning ‘death’

ETHICAL CONSIDERATIONS

- ‘Good death’: termination of life for merciful purposes
  - The doctor’s duty to relieve pain and suffering
  - A dignified and peaceful death at time&place of choice
  - ‘Euthanasia’ = ultimate way; complementary to palliative care

- ‘Right to die’: Keeping control/autonomy of a person even in situation of no underlying disease
  - *Controversial*
  - *Risk of the ‘Right to die’ being normalized and becoming to the ‘Duty to die’ ?*
    - *Protecting vulnerable people ?*

PUBLIC OPINION REGARDING EUTHANASIA - NETHERLANDS



EenVandaag opiniepanel NL 2013

PUBLIC OPINION REGARDING MAID -NL

Table 2 Opinions of the respondents regarding assistance in dying in different circumstances

In my opinion...	% agree	% neutral	% disagree
... everybody should have a right to euthanasia	57	20	23
... euthanasia should be allowed for people who are tired of living, without having a serious disease	21	27	52
... every human being has the right to determine their own life and death	53	25	23
... the oldest old should be able to get medications that enable them, if they wish, to end their life	36	30	35

Agree, sum of agree and totally agree. Disagree, sum of disagree and totally disagree.

Raijmakers NJH, et al. J Med Ethics 2015;41:145–150

CONTENT

Introduction

Law on euthanasia in Belgium

Challenges in geriatric medicine

Opinion of health care professionals

THOM’s

BELGIAN LAW ON EUTHANASIA 2002

On 28 May 2002, the Belgian House of representatives, the lower house of Parliament, passed the Act Concerning Euthanasia

MINISTERIE VAN JUSTITIE

N. 2002 — 2141 [C − 2002/09590]

28 MEI 2002. — Wet betreffende de euthanasie (1)

ALBERT II, Koning der Belgen,
Aan allen die nu zijn en hierna wezen zullen, Onze Groet.
De Kamers hebben aangenomen en Wij bekrachtigen hetgeen volgt :

Artikel 1. Deze wet regelt een aangelegenheid als bedoeld in artikel 78 van de Grondwet.

HOOFDSTUK I. — *Algemene bepalingen*

Art. 2. Voor de toepassing van deze wet wordt onder euthanasie verstaan het opzettelijk levensbeëindigend handelen door een andere

MINISTERE DE LA JUSTICE

F. 2002 — 2141 [C − 2002/09590]

28 MAI 2002. — Loi relative à l'euthanasie (1)

ALBERT II, Roi des Belges,
A tous, présents et à venir, Salut.
Les Chambres ont adopté et Nous sanctionnons ce qui suit :

Article 1er. La présente loi règle une matière visée à l'article 78 de la Constitution.

CHAPITRE Ier. — *Dispositions générales*

Art. 2. Pour l'application de la présente loi, il y a lieu d'entendre par euthanasie l'acte, pratiqué par un tiers, qui met intentionnellement fin

DEFINITION OF EUTHANASIA IN BELGIAN LAW

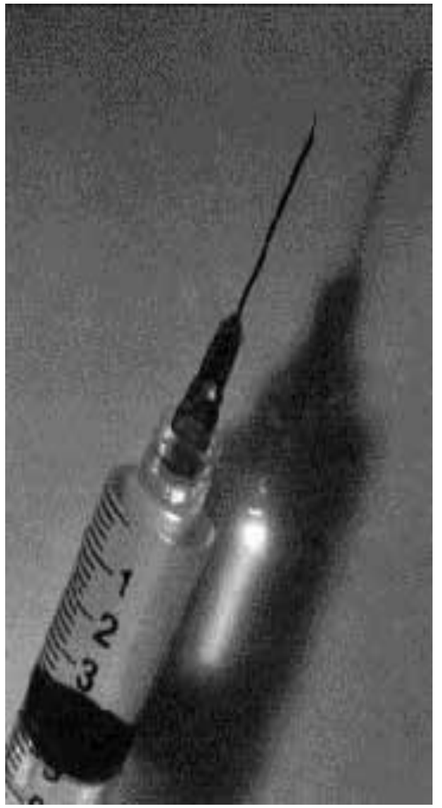
- Intentionally terminating life by someone other than the person concerned, at the latter's request
  - Can only be requested by the PATIENT, not by others
  - Can only be provided by a PHYSICIAN
    - Physician has the right to refuse
- 'Passive' euthanasia is not used in Belgium
  - Withdrawing/withholding treatment = non-treatment decision

NOT INCLUDED IN BELGIAN LAW

(Physician) Assisted suicide

- Is the intentional helping of somebody to terminate his or her life at his or her explicit request

- Oral intake is possible but as an alternative method within the law on euthanasia
  - Physician should be present until death



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NO CRIMINAL OFFENCE IF FOLLOWING CRITERIA

- Patient
  - Reached age of majority (since 2014 also for minors-terminal)
  - Competent and conscious at moment of making request
- Two ways of request
  - Written actual request (name, date and signature)
  - Advance directive – 5 years (parliament)
    - Incurable disorder caused by illness or accident
    - Unconsciousness
    - This situation should be irreversible …

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NO CRIMINAL OFFENCE IF FOLLOWING CRITERIA

- Medically futile condition
- Constant and unbearable physical or mental suffering that cannot be alleviated

    Resulting from a serious and incurable disorder caused by illness or accident

PROCEDURE TO FOLLOW

- Inform the patient about
  - His condition and life expectancy
  - Possibilities of treatment ; of palliative care

- After different conversations, together with the patient, the physician must come to the belief that
  - There is no reasonable alternative
  - Request is written, repeated, completely voluntary and without external pressure
  - That the patient is subject of unbearable suffering

PROCEDURE TO FOLLOW

- Discuss the request of patient with the nursing team and if patient agree with his next of kin

- In case death will be expected in ‘a reasonable time’
  - Consult another independent physician

- In case the patient is ‘not expected to die in a reasonable time’
  - Allow at least one month between the request and the act
  - Consult a second independent physician (psychiatrist or expert in the underlying illness)

PROCEDURE TO FOLLOW

- Intravenous = fast procedure
  - Barbiturate (Sodium Thiopental 20 mg/kg)
    - Midazolam until deep coma
  - Neuromuscular blocker (Curare - Cisatracurium 20mg)
  - (Potassiumchloride)
- Oral = slow procedure
  - Sodium pentobarbital 9 gram in 100 ml mixture
  - If no death after 8h: neuromuscular blocker IV
- Special legalisation and procedure for pharmacist to deliver the medication

PROCEDURE TO FOLLOW

- After the patients death, the physician has to
  - Declare a natural death on the death certificate
  - Send a registered letter within 4 days, to a committee for judgement (Federal Evaluation Commission)
    - Anonymous part – report of criteria
    - Closed part with the names (patient/physicians) to open in case of discussion
  - In case of discussion
    - The physician can be asked for further information
    - The file can be send to the court

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CONTENT

Introduction

Law on euthanasia in Belgium

Challenges in geriatric medicine

Opinion of health care professionals

THOM’s

CASE IRMA: 93 YEAR OLD

- Widow since 20 years
- No kids, only a niece
- Independent living
- Hospitalization due to a fall on the street
  - No fractures, painkillers and short rehabilitation
  - Send home two days later
  - Calls her GP with a request for euthanasia
    - Life if futile; loneliness; no one to live for; a cost for the society
    - Anxious to loose control; to be dependent/to end up in nursing home

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MENTIMETER

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CASE OF LOUIS 85 YEARS OLD

- Lives alone since 20 years
- One grandchild, involved in his care
- Living at home with maximal support
- Medical record
  - Arterial hypertension – well controled
  - Osteo-arthrosis resulting in limited mobility (with walking aid)
  - Bad sighting and hearing (limiting daily communication with surrounding)
  - One suicidal attempt a few years ago
- Increasing mental suffering due to loss of mobility and communication with a wish to die daily repeated to the professional caregivers

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MENTIMETER

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FIGURES IN BELGIUM

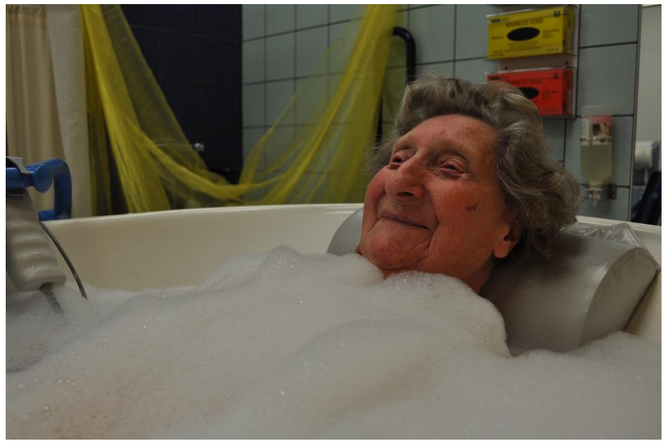
Age	2003 N (%)	2009 N (%)	2017 N (%)
< 60 y	81 (34)	198 (24)	321 (16)
60-79 y	115 (49)	420 (51)	995 (49)
≥ 80 y	39 (17)	204 (25)	705 (35)
	235	822	2309

Report Federal evaluation commission

FACTS IN BELGIUM

Underlying disease	2003 N (%)	2009 N (%)	2017 N (%)
Maligne	195 (83)	641 (78)	1417 (61,4)
Neuromuscular	32 (12)	58 (7)	179 (7,8)
Non-maligne organ	9 (3)	66 (9)	149 (6,4)
Neuropsychiatric	0 (0)	21 (2)	40 (1,7)
Others	4 (2)	34 (4)	82
Poly-pathology	NA	NA	442 (19,1)

CASE : ANNA 83 YEARS OLD



- Widow since 5 years
- 1 son, strongly involved in the care
- Since 3 years in a nursing home: a wish to die

  Very unhappy, feels maltreated, nothing to live for, burden to her son…
- Medical history
  - Bad vision (right eye is blind, left 10%); nearly deaf
  - Cerebral benign tumor since 5 years already treated with radiotherapy- complicated by a right paresis

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CASE: ANNA 83 YEARS OLD

Current hospitalization:

- Increasing concentration and
  memory problems, increase in paresis on the right sight

Question for euthanasia (more prominent during hospitalization)

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EXPLORATION OF REQUEST

- Is the patient **competent to take the decision** ?
  - Especially in older patients with neurodegenerative diseases or cerebral tumours this can be difficult to evaluate
  - Repeated discussions with the patient
    - Try to place the request in the life-history
    - How long is the request present? Repeated request?

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EXPLORATION OF LEGAL CRITERIA

HOOFDSTUK II. — *Voorwaarden en procedure*

Art. 3. § 1. De arts die euthanasie toepast, pleegt geen misdrijf wanneer hij er zich van verzekerd heeft dat :

— de patiënt een meerderjarige of een ontvoogde minderjarige is die handelingsbekwaam en bewust is op het ogenblik van zijn verzoek;

The patient is in a medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated, resulting from a serious and incurable disorder caused by illness or accident

en hij de in deze wet voorgeschreven voorwaarden en procedures heeft nageleefd.

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MEDICALLY FUTILE CONDITION ?

= Objective, this requires a medical expertise

- What are treatment options?
- Is there a reasonable chance that treatment is going to make a difference?

The patient is in a medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated, resulting from a serious and incurable disorder caused by illness or accident

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WHAT IS SERIOUS?

Different interpretation among caregivers

- Serious = life-threatening

Versus

- Serious= incurable and causing suffering for people
  - Age related polypathology

⇨ No consensus among physicians, lawyers, ethicists;
To be discussed for every individual case

EXPLORATION OF LEGAL CRITERIA

HOOFDSTUK II. — *Voorwaarden en procedure*

Art. 3. § 1. De arts die euthanasie toepast, pleegt geen misdrijf wanneer hij er zich van verzekerd heeft dat :

— de patiënt een meerderjarige of een ontvoogde minderjarige is die handelingsbekwaam en bewust is op het ogenblik van zijn verzoek;

The patient is in a medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated, resulting from a serious and incurable disorder caused by illness or accident

en hij de in deze wet voorgeschreven voorwaarden en procedures heeft nageleefd.

UNBEARABLE PHYSICAL OR MENTAL SUFERING?

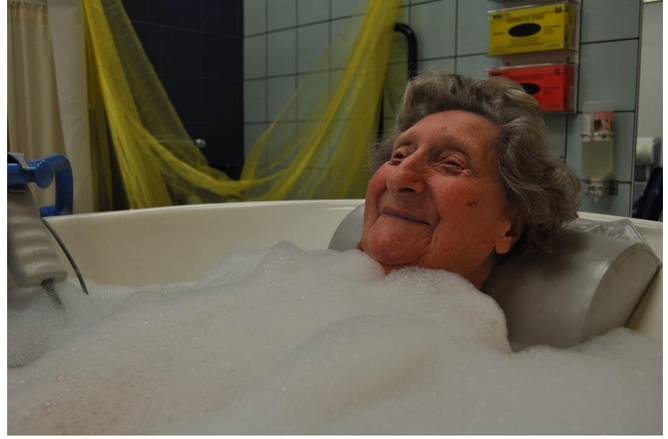
Unbearable = Subjective feeling

– It is what the patient tells you it is

Is compassion/agreement of the physician with the suffering needed?

– Not legally, not for ‘right to die’ movement
– Well for most of the physicians…

CASE : ANNA 83 YEARS OLD



Are the unbearable suffering and wish to die the result of the disease, the completed life, the feeling of being a burden, or the living situation in the nursing home?

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UNBEARABLE SUFFERING IN OLDER PATIENTS

- Often complex
- Combination of physical, mental & societal issues
- Not always easy to define what is manageable, changeable?

IS A WISH TO DIE VOLUNTARY?

Moral “duty to die” - the feeling to be a burden for the society (physical, economical, social)

Do older people have the feeling that their life is completed

or

Rather the feeling that the society/ the next of kin is completed with them?

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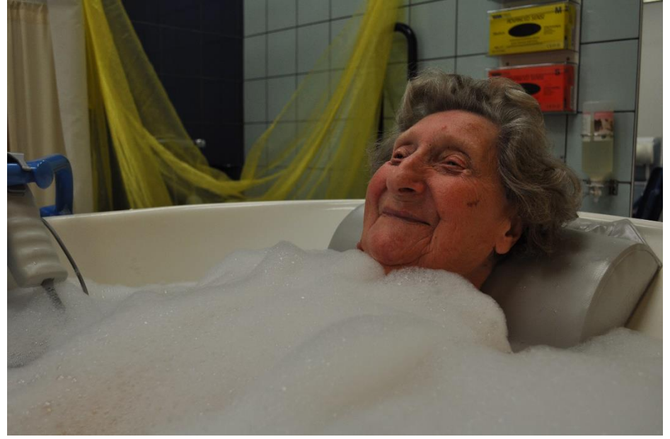
CASE : ANNA 83 YEARS OLD



Decision after team discussion :

- One month observation on the palliative care unit to look at the influence of another environment on the suffering

Medical condition get worse during the following weeks

The request was more and more clear

Request was granted after six weeks

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CHALLENGES IN DEALING WITH EUTHANASIA IN OLDER POPULATION

- Competent ?
- Unbearable suffering physical and/or mental
  - Complex & often multiple underlying reasons in older population not always related to the underlying disease
  - Mercifulness of the physician?
- “Duty to die” – societal debate & responsibility?
- What is a Serious illness?
- What if the patient refuses a possible treatment?
- What is a ‘reasonable’ time to die?

Evaluation of legal criteria

Legal criteria - absent

No medical condition
and/or
No unbearable suffering

Legal criteria - unclear

Legal criteria - present

Take time

Collegial/interdisciplinary consultation

Ethical rounds/reflection

What if there are still treatment options?

Why does someone refuses alternatives?

Su

neen

- ethisch advies

zorgvuldigheidscriteria
aanwezig ?

ja

tart
euthanasia
procedure

DEBATE IN BELGIAN COMMITTEE FOR BIO-ETHICS 2018

– No discussion that to approve euthanasia – even when there is unbearable suffering - an underlying medical condition is required.

⇨ NOT legal in case of ‘completed life’ / ‘Tiredness of life’ without underlying medical condition

– There is **no consensus** how to interpret ‘a medical underlying condition’

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LAW ON EUTHANASIA AND DEMENTIA

- Only possible in competent patients
  - Early phase of dementia (case of Hugo Claus)
- Ongoing ethical debate on broadening the law to patients with an advance directive in case of dementia
  - No consensus among HCP; only few cases in NL
  - Broad public support (recently a digital petition started)
  - No political support so far

ONGOING DEBATE

Open VLD-voorzitster Gwendolyn Rutten: euthanasie moet ...

https://www.vrt.be › vrtnws › 2019/10/29 › rutten-over-euthanasie ▾

4 dagen geleden - Open VLD-voorzitster Gwendolyn Rutten vindt dat **euthanasie** ook ...

parlement of de S

‘Completed’ life

Euthanasie voor mensen die levensmoe zijn, moet dat kunnen ...

https://www.vrt.be › vrtnws › 2019/10/29 › euthanasie-experts ▾

4 dagen geleden - Moeten mensen die vinden dat hun leven rond is, **euthanasie** kunnen ...

opnieuw op de agenda, en wil een debat in het federaal **parlement**.

Dementia

donderdag
31/10/2019

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CONTENT

Introduction

Law on euthanasia in Belgium

Challenges in geriatric medicine

Opinion of health care professionals

THOM’s

OPINION OF HEALTH CARE PROFESSIONALS

Pilot study

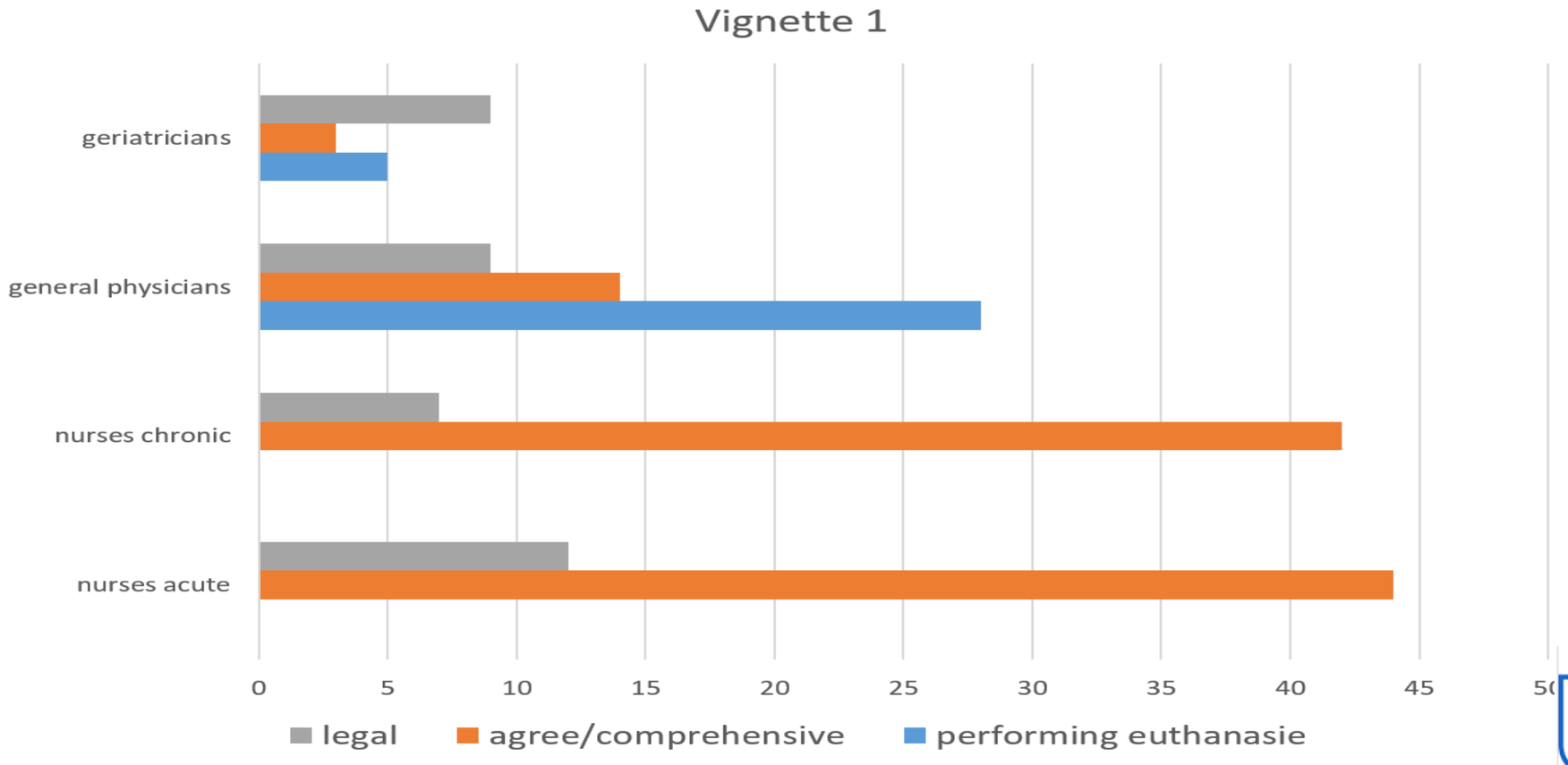
Quantitative survey with 4 case vignettes

Study population – randomly selected – peer review groups

- 151 Nurses (76 on chronic and 75 on acute wards)
- 190 Physicians (133 GP and 57 geriatricians)

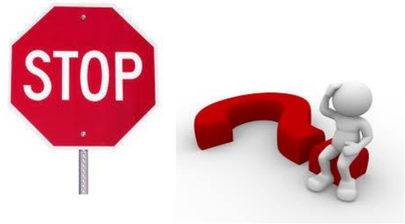
RESULTS: CASE VIGNETTE 1= IRMA

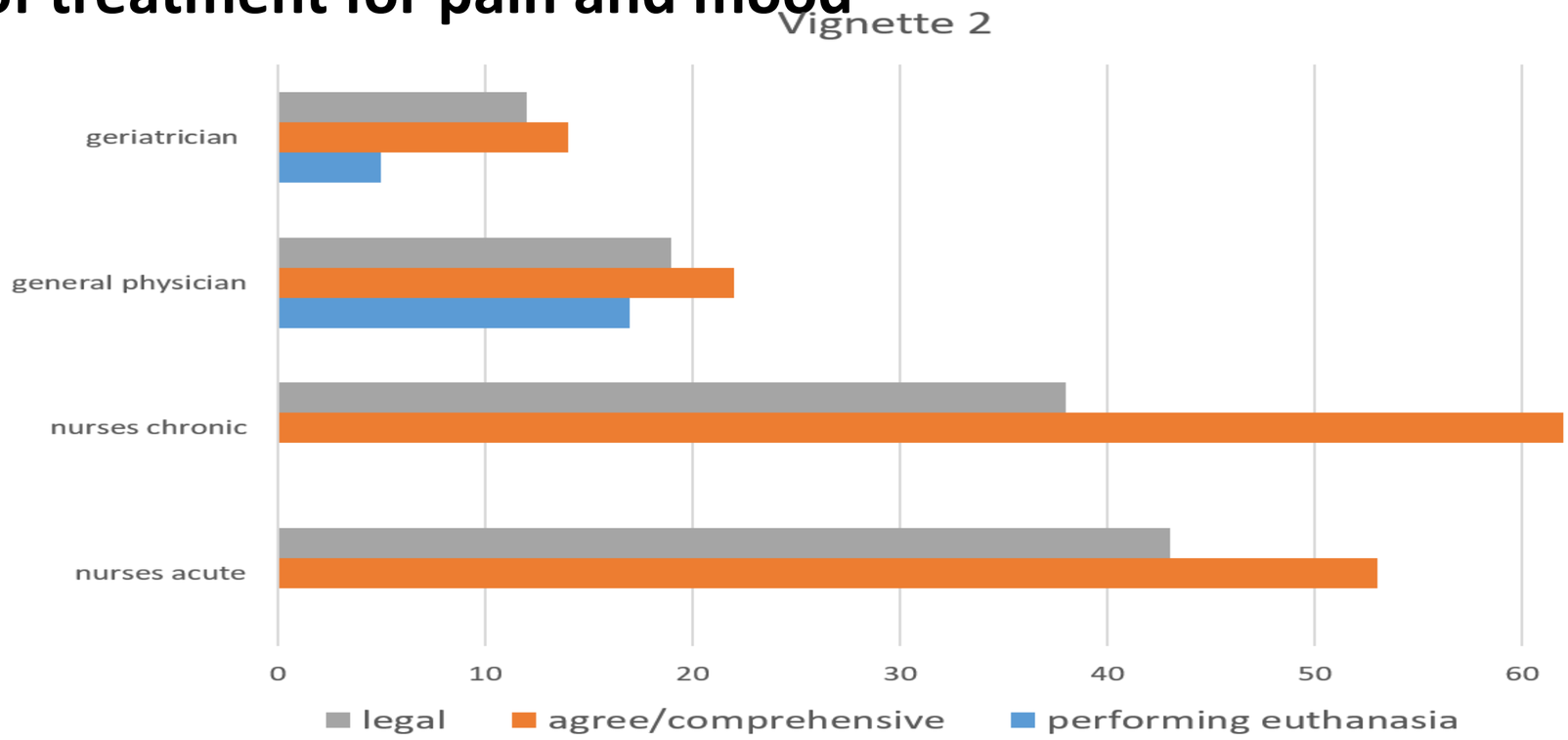
- Woman 93 years old; Be widowed since 31 years
- Lives independently
- **No comorbidity** ; CIRS-G 1; SI 1



RESULTS: CASE VIGNETTE 2 MARIE

- 88 years old; No children, 2 nieces
- Lives independently; ToL since more than 3 years
- Osteoporosis; arterial hypertension; CIRS-G 3; SI 1,5
- Crushing fracture of spine
- **Refusal of treatment for pain and mood**





RESULTS: CASE VIGNETTE 3: LOUIS

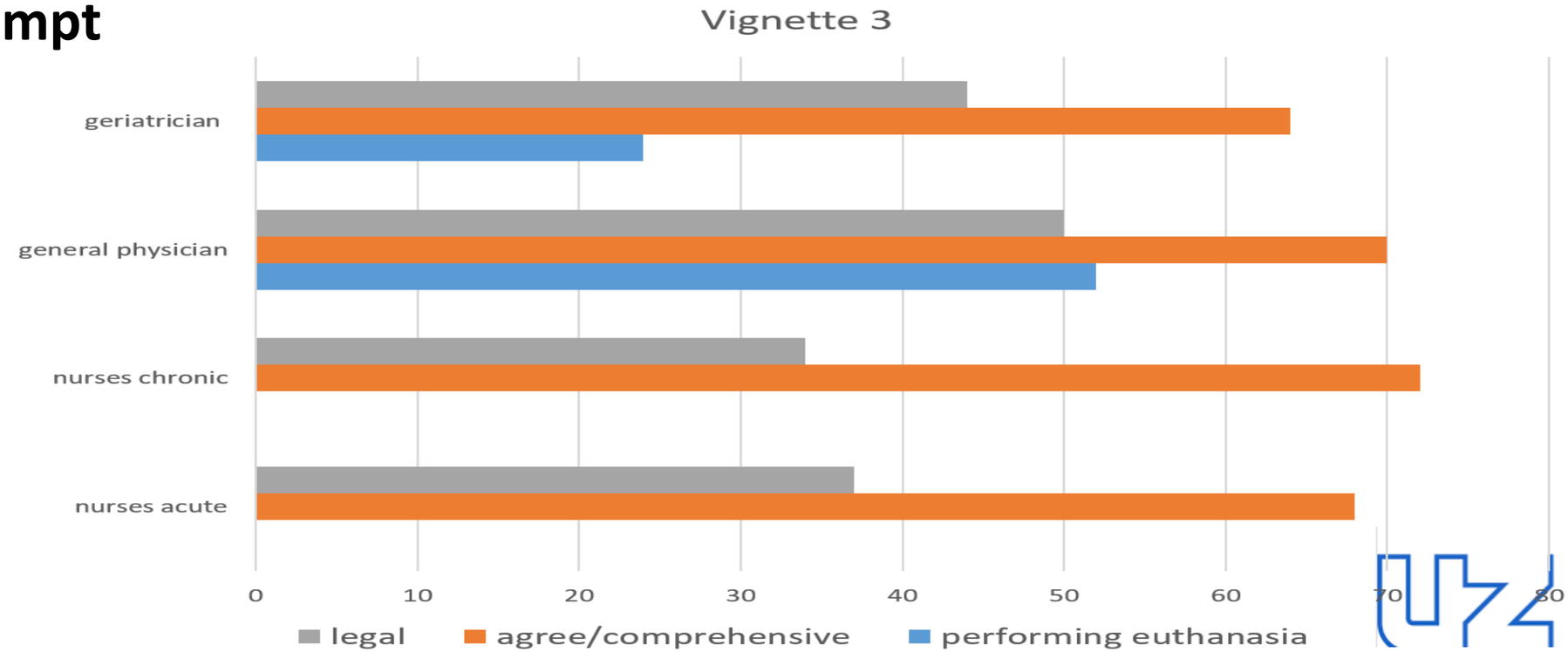
-97 years old; Be widowed since 7 years

-**death of a daughter 2 years ago**

-Antidepressive treatment: no effect on mood

-**Chair-bound, low ADL, hearing and vision impairment ;** CIRS-G 7; SI 2,3

-**Suicide attempt**



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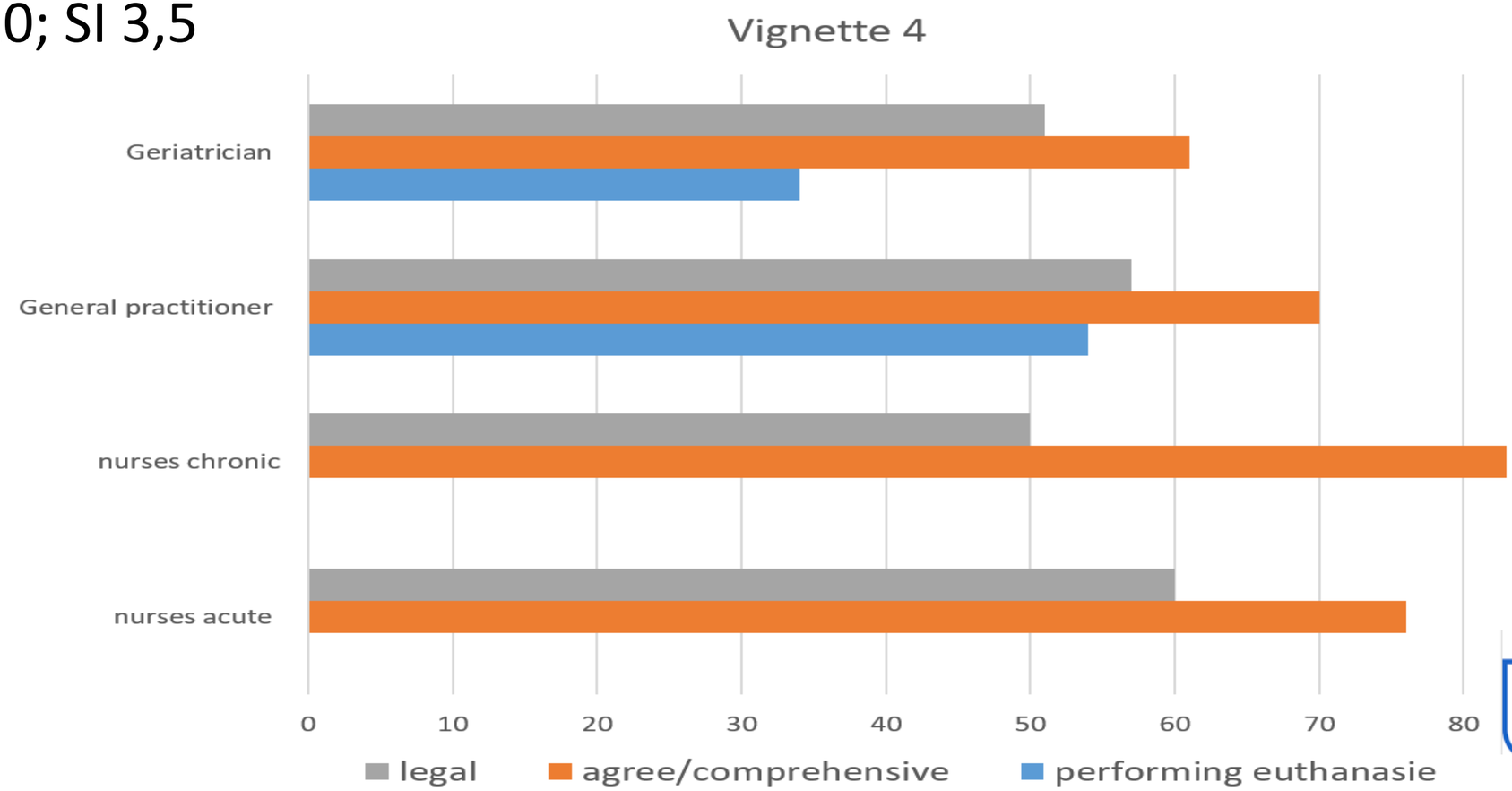
RESULTS: CASE VIGNETTE 4: ARTHUR

- 79 years old ; Married, two children
- **Severe stroke (aphasia, dysphagia, hemiplegia)**
- **Tube-fed, no rehabilitation possibilities**: admission to nursing home 3 month ago ; CIRS-G 10; SI 3,5



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CONCLUSION PILOT STUDY

- Uncertainty about the legal aspects among HCP in Belgium

- Nurses empathize more often with the ‘existential suffering of patients’ being tired of life
  - Physicians only ‘empathize’ the suffering if there is also (severe) functional decline

- Willingness to perform euthanasia is different among medical specialties
  - Geriatricians more restrictive than GP’s
  - GP’s more restrictive than nurses in cases of ‘existential suffering’

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TAKE HOME MESSAGE ON EUTHANASIA

- ‘Law’ = decriminalization under ‘well?’ defined criteria
  - For some criteria in Belgian Law: an absence of consensus between HCP, ethicists and lawyers

⇨ Challenges in Geriatric Medicine
Pressure on HCP induced by public media

- Two mainstreams leading the debate
  - A ‘Good death’ - ‘mercifulness’ in terminal care
  - ‘Right to die’ in patients without underlying (serious) illness

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Let no one walk alone

World Health Organization
REGIONAL OFFICE FOR Europe

PALLIATIVE CARE FOR OLDER PEOPLE: BETTER PRACTICES

KING'S College LONDON
University of London
WHO Collaborating Centre for Palliative Care and Older People

Healthy Cities 21st Century

FONDAZIONE MARUZZA LEFEBVRE D'OVIDIO ONLUS

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