

Provisional edition

## Palliative care: a model for innovative health and social policies

Resolution 1649 (2009)<sup>1</sup>

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

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

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

9. With the above, the Assembly also draws conclusions from the debate on the subject of euthanasia, which showed that liberal constitutional states cannot leave ethical questions concerning the life and death of individuals unanswered.

10. Sticking to ethical pluralism does not ensure maximum individual freedom in ethical issues but in society it gives randomness, relativism and practical nihilism precedence over properly founded ethical positions. This results in general disorientation and ultimately in the erosion of the liberal constitutional state.

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

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

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

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

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

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

16.1. establish a consistent and comprehensible health-policy approach to palliative care;

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

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

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

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

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

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

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

21.2. seek to ensure improved rewards for non-product-related services both in health and in economic and financial policies so that social policy can draw on economic-policy and fiscal incentives and do more to counter the increasing domination of society by economics;

21.3. in general, seek to strengthen primary health care so as to protect patients against inappropriate medical intervention and place greater emphasis again on the methodical significance of communication between doctor and patient as the basis for rational, patient-oriented medicine;

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

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

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

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

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

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

22.5. with regard to legal regulations on living wills:

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

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

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