Promoting Palliative Care Is Prerequisite to Future Integrity of a Comprehensive Humane Medicine

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Palliative care means authentic care of the oncologist and his team for any physical, mental and spiritual needs of the handicapped and disabled – it is not just a regular service to be ordered by insurance companies! Politicians and health authorities stress and demand medical ethics whenever in need for unlimited and cheap medical support and enduring performance. For chronically ill cancer patients causal, cancer directed interventions, though effective for symptom control, were recently defined as inefficient and no longer financially affordable for the German health system if they did not extend life beyond 6–8 weeks [1]. This call for prioritization with neglect of the chronically ill is economically intended triage and feared to be one of the driving forces behind recent political claims for promoting palliative care. Palliative care, however, is not limited to professional duties. Palliative care describes the basic ethical attitudes and moral obligations of any physician caring for the terminally ill and the dying.

The growing commercialization of the health system compromises our traditional ethical and moral values. It incurs the danger of opening health care for economic contest, and drives hospitals and private practices to pseudo-competition, thus leading to the rationing of services. Clinics should be conducive to the common welfare, instead of being sold to profit oriented companies. Privatization is feared to lead to the revocation of common public interest and thereby public control over institutions no longer supported by our communities. The imminent problem is that it may force the medical profession into the wrong direction of good economic performance rather than comprehensive individual care. This results in the economization of ethics.

We have to revoke this dangerous trend in the future development of public welfare because it results in depressing moral consequences, such as already practiced in various European countries, particularly in the Netherlands, Great Britain and Scandinavia, countries with centralized governmental health systems. They follow utilitarian aims, legalize euthanasia and physician assisted suicide and prioritize according to the medieval triage favoring socially acceptable pre-

mature death ('sozialverträgliches Frühableben' [2]) by withholding benefits for the handicapped, aged, and chronically sick – services until now unchallenged in Germany. The statement of Belgian participants at the Congress of the European Association for Palliative Care (EAPC) (Vienna, 9.5.2009) that 'euthanasia is part of good palliative care' is considered irresponsible and not compatible with the Helsinki Declaration of Human Rights.

Following the intervention of German delegates, euthanasia in the form of 'terminal sedation' leading to death within 19 h by 'slow sedation' [3] was not included into the 2010 EAPC S3 guidelines for palliative care as a means to reduce human suffering. This issue and activities of 'Dignitas' for 'physician assisted suicide' were clarified in an editorial to the EAPC Congress: 'It is our responsibility to promote care, not killing' [4].

It is with sorrow that we follow tendencies which enforce end-of-life home-care at the expense of patients, for whom costly hospital or specialist cancer care are to be withheld [5]. We have to preserve dignity for the terminally ill, allowing when necessary, specific cancer treatment and giving temporary 'palliative' symptom oriented, instead of 'terminal' death precipitating 'sedation'. Keeping end-of-life palliative care free from euthanasia is an essential task for German physicians [6]. We have to continuously keep in our consciousness the hundred thousands of handicapped children and adults who were killed by our medical forefathers, sanctified by the philosophy of a 'healthy nation' (Gesunder Volkskörper) of the Nazi regime.

To achieve the assigned objective, competent evidence based palliative care is a highly effective defense against the dictate of managers, business economists, sociologists, and officials who, realizing the forthcoming demographic and sociologic constraints, see no other means but to economize our fundamental ethical values, and place them under the heading of cost efficiency. Cost efficiency dominating treatment effectiveness risks going down a slippery ethical road: the renaissance of a philosophy of life with oppressing closeness to the concept of 'worthless' – or in former times 'unworthy' – life.

Such strong conviction does not close our eyes to the current discussion led in public, parliament, and our ethic commission (Zentrale Ethik-Kommission der Deutschen Bundesärztekammer, ZEKo) about the individual's request to actively end their life because of unbearable suffering without a way out of the impasse or any perspective for life [7]. The decision of the responsible attending physician not to prolong life – passive euthanasia – or to seek palliative sedation in rare cases to cope with otherwise untreatable somatic or spiritual conditions, may be accepted. Physician assisted suicide may in certain conditions indeed be empathetic, conserving of the individuals integrity and dignity – but it is by no means a general way out difficult clinical situations, such as practiced in neighboring countries.

What Are the Concrete Objectives of Conjointly Liable Countermeasures?

As far as our economic resources, support from national welfare, and our general social service is concerned, the public has to be familiarized with the imminent limitations of our health system. The medical profession, especially under the guidance of the German Cancer Society (Deutsche Krebsgesellschaft, DKG) and the German Society of Palliative Care (Deutsche Gesellschaft für Palliativmedizin, DGP), and assisted by patients' self-help groups (Bundesvereinigung der Selbsthilfeorganisationen) and organizations of the handicapped (Bundesvereinigung Lebenshilfe e.V.) has to be active in the decision-making body of the Gemeinsamer Bundesausschuss (gBA) of the ministry of health. Oncologists have to be consulted whenever measures of prioritization are envisaged. The advocacy for guaranteeing appropriate medical requirements for the individual, and protecting our patients from triage is up to the DKG and DGP.

We therefore request

- a permanent seat for the DKG and the DGP in the board of IQWiG (Institut für Qualitätssicherung und Wirtschaftlichkeit im Gesundheitswesen), a government institute for the evaluation of medical studies, to safeguard humanitarian values when validating diagnostic and therapeutic interventions in the frame of cost effectiveness calculations,
- to establish a regional public ethics and health forum to supervise insurance companies, clinic management, and

health authorities and reject possible commercially justified trespassing (off label use of drugs, limiting budgets, insurance claims etc.) directed against the physician's individual patient care,

- to accept the recommendation of the regional multiprofessional tumor board or palliative care conference for specific interventions addressing the patients needs, even if 'off label',
- recollection of the ethical values of the medical profession in a world with loosening religious beliefs, and introduction of ethics teaching courses for medical students and post-graduates, such as currently practiced intensely in the training for palliative care,
- to strongly develop ideal and financial support for clinical trials and scientific projects covering evidence based patient and palliative care (e.g. the interdisciplinary working group for palliative care (Arbeitsgemeinschaft Palliativmedizin, APM) of the DKG,
- to establish and financially support interprofessional palliative care team conferences on a weekly schedule with the participation of representatives of all professions relevant to palliative care in the hospital and ambulatory setting, and finally the
- training of lay personnel to serve in a honorary capacity e.g. for the regional Cancer Societies (Landeskrebssgesellschaften), the municipal General Ambulatory Palliative Care (Allgemeine ambulante Palliativversorgung, AAPV) and the Specialized Ambulatory Palliative Care (Spezielle ambulante Palliativversorgung, SAPV) teams to help with the nursing of solitary cancer patients in preterminal conditions at home.

Economically sound medical care for our population is our critical responsibility. However, strictly cost efficient care, based on material efficiency and profit, ignoring the individual's fate for economic reasons, will compromise ethical standards and burden the sick and the old. We have to become aware of this trend and oppose it.

Conflict of Interest

The author is chairman of the Working Group Palliative Care (Arbeitsgemeinschaft Palliativmedizin, APM), chairman Landeskrebssgesellschaften, and board member of the German Cancer Society DKG e.V.

The author affirms having no industrial or financial relations pertaining to the contents of this article.

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