

National Consultative Ethics Committee for Health and Life Sciences

Opinion n°108

Opinion on ethical issues in connection with the development and funding of palliative care

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Jean Leonetti, M.P., rapporteur of the mission for the evaluation of law n° 2005-370, dated April 22, 2005, on patients' rights and the end of life, addressed the Committee asking "...how to set up a system for funding health care with due regard to avoiding the unreasonable obstinacy prohibited by article L.1110-5 of the Code of Public Health and to facilitating palliative care".

In Opinion n° 101, "Health, ethics and money", the Committee addressed the ethical issues arising out of economic constraints on our health system, particularly hospitals. In this earlier Opinion, the Committee drew attention to the dangers inherent in the current system in France for hospital funding based on price per activity (called 'T2A'). In fact, this pricing system gives precedence to codified diagnostic and therapeutic acts to the detriment of caring activities which are not codified. This is true of palliative care and of the long-term management of chronic diseases or of mental health. Palliative care tries to provide not only the relief of symptoms but also the counselling, guidance and support that can help to make life as comfortable as possible but which cannot easily be quantified or codified.

The funding system can be a serious obstacle to the kind of flexibility required for satisfactory care to be given in particularly difficult circumstances. The adverse effects of the T2A method were quickly noticeable in hospital departments for the management of patients needing palliative care: admissions selected on the basis of the foreseeable length of hospital stay, discrimination against certain medical conditions, for instance those that are slow to progress and also against certain patients, in particular those with social integration problems, together with managerial considerations being foremost in decisions to move patients from one institution to another. In agreement with health professionals, managers modified the pricing system in an attempt to attenuate its negative impact¹.

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B. Devalois USP CH Puteaux . "Tarification à l'activité : ses questions pour les soins palliatifs" (Price per activity: issues as regards palliative care). Congrès National d'accompagnement et de soins palliatifs 18-20 June 2009 CNIT La Défense Paris (Conference on counselling and palliative care).

This presentation refers to better valuation of long hospital stays thereby refuting arguments in favour of the need for shorter hospital stays and for selecting patients expected to stay less time.

In this Opinion, the Committee will be evaluating to what extent financial considerations enter into care practices and culture in connection with unreasonable obstinacy and during the terminal phase of disease. Are ethics and physicians' decisions significantly influenced by the reimbursement system? Are reimbursement systems in phase with the ethical expectations of health professionals and society?

The death of a human being raises issues which may seem incompatible with financial concerns. In both symbolic and cultural terms, it is difficult to achieve a reasonable degree of impartiality when there is a need for economic concerns to encroach on tragic circumstances. And yet, there is a connection between reality and economics which cannot be ignored. This aspect of the problem will be discussed.

This referral raises the issue of difficulties in implementing regulations and laws on the very sensitive matter of the end of life. Since accounting problems are not the only reasons for delay in enforcing the 2005 legislation, we shall be considering other factors that seem to play as important a role.

Preliminary considerations: the cultural context

A confrontation with death is one of the most violent ordeals human beings have to endure; it is, obviously, a reminder of the boundaries of their own existence but also, in particular for health professionals, that their science and power are not unlimited. It is in this emotionally destabilising context that "unreasonable obstinacy" enters the scene. It could be defined as the continuation of futile investigation and therapy instead of moving on to palliative care. Such "obstinacy" also points to the limits of medical competence in terms of both technique and human relations². But the subject of unreasonable obstinacy also involves patients and their loved ones; their expectations of the health care system, which health professionals have to contend with, cannot be ignored.

The interdependence of financial concerns and human dimensions at this particular point in time are ethical issues in terms of autonomy and responsibility: how much of the community's resources can society commit without exceeding the bounds of their fair allotment and to what extent can next of kin be prepared to devote their personal sympathy and attention? Limited resources involve both collective and

²Let us not forget the prayer attributed to Rabbi Moshe ben Maimon, Maimonides, (1135-1204) born in Cordoba, physician, in the traditional Jewish equivalent of the Hippocratic Oath. He asks God to forgive him, since as a physician his powers are limited, "Never allow the thought to arise in me that I have attained to sufficient knowledge".

individual commitment. Devoting time to the dying is of course the personal and private concern of those involved, but this experience takes place within a certain social and cultural framework. In this context, it is the task of competent authorities to define the rules of good practice and make sure they are complied with.

Philosophical and spiritual stances regarding end-of-life situations may be in conflict with the usual priorities and purposes of medical practice, which are themselves, to some extent, defined by the expectations of users. Controversies, such as whether to continue providing nutrition and hydration, are emblematic of the ambivalence inherent to the trials prevailing as life ends. In this particular situation, time must be allowed for reason to prevail over emotions, sentiments and the imagination. Attention must be given to all these aspects without encroaching on society's obligation to solidarity and the welfare of all its members.

Although most health professionals are by now well aware of the laws on palliative care, some time is needed for the cultural changes which they imply to be put into practice. The population as a whole is also concerned by these changes and gradually, awareness and integration are increasing. The new legislation is not as yet implemented in all the medical institutions throughout the land, but management constraints peculiar to public hospitals are not the only cause.

1. The practices at issue

The care culture upheld by both professional and voluntary actors of palliative care is now recognised both institutionally and legally. It concerns those who are affected by a progressive disease from which they will not recover and which will end in death in the longer or shorter term. But the global care concept which is at the heart of this culture may be applicable to people with incurable diseases long before they are terminally ill. Such care is not a systematic substitute for curative therapy and can be delivered simultaneously. The purpose is relieve patients' physical symptoms as well as the emotional distress they and their families endure. Successive laws have gradually codified these practices: June 9, 1999 - Palliative Care; March 4, 2002 - Patients' Rights; April 22, 2005 - End-of-life. Some of these laws include statements to the effect that palliative care can be delivered at any time in the course of a serious disease or infirmity.

1.1. Resistance to palliative care

Although the beneficial effect of palliative care is not in dispute, it would seem that health professionals do not always find it easy to pinpoint when it should

begin³ and when a disease is entering its terminal phase. Not accepting "the fact that current treatment is no longer of any use" could explain the resistance to rational argument, for which there may also be other causes⁴.

Should this resistance give reason to believe that more than half of the dying, according to a study involving health professionals, do not receive the care appropriate to their pain and distress? Two thirds of them apparently consider that the quality of their patients' end-of-life would be unacceptable if it applied to themselves or their loved ones⁵.

Could it be that society, health carers included, has an idealistic perception of a "good death", while clinical practice confronts health professionals with a much less acceptable reality?

1.2. On the topic of unreasonable obstinacy

Obstinacy is not unreasonable *per se*. It contributes to medical progress and the improvement of care; it leads to increasing life spans and even to seeking a cure in seemingly hopeless cases. It becomes "unreasonable" and, as such, condemned by law⁶, when it allies illusion and futility in procedures which are detrimental to the

384% of doctors are aware that palliative care is not solely confined to terminally ill patients, but most of them consider that it cannot be very helpful before that phase. "Représentations médicales autour de l'équipe mobile de soins palliatifs du centre hospitalier Lyon Sud." (Medical perceptions of the palliative care mobile team in the Lyon Sud Medical Centre.). A. Laurent, C. Deslandres, M. Ruer, M. Filbet, W. Rondalith, M. Barmaki ; *médecine palliative* 2008, vol 7, n° 2.

4Cf N. Barthélémy et al. **Résistance des soignants à la mise en pratique des soins palliatifs : construction d'un modèle causal.** *Médecine palliative* 2008, vol. 7, n° 5 : pp. 251-259 (Health carer resistance to the onset of palliative care: construction of a causal model.) The authors of this Belgian study demonstrate that this resistance is connected to "the problem of having to choose, confrontation with finiteness, feelings of powerlessness."

5E. Ferrand et al. Circumstances of death in hospitalized patients and nurses' perceptions : French multicenter Mort-à-l'Hôpital survey. *Archives of Internal Medicine* 2008, vol. 168, n° 8 : pp. 867-875.

6Article L1110-5. *All patients, taking into account their state of health and the urgency of treatment that it requires, are entitled to receive the most appropriate treatment and to benefit from therapies of recognised efficacy and guaranteeing the best possible medical safety in the view of tested medical knowledge. Preventive, investigative and health caring procedures must not, to the best of current medical knowledge, present dangers which are disproportionate to the expected benefits. **These procedures must not be continued because of unreasonable obstinacy. When they appear to be futile, disproportionate or not having any other effect beyond the artificial continuation of life, they may be discontinued or dispensed with altogether.** In this event, the physician respects the dignity of the dying and ensures the dying patient's quality of life by delivering the care specified in article L. 1110-10.*

quality of life and increase patient discomfort. Unreasonable obstinacy is not confined to sophisticated technical and aggressive procedures; it is defined by the absence of proportionality between the means and the expected outcome. Such everyday practices as nasogastric tubes, for example, may not meet patient needs, lead to discomfort and loss of autonomy. They can also be costly.

"Unreasonable" obstinacy is not always initiated by carers. For patients themselves and their families, it may be difficult to abandon the hope that continuation of curative treatment represents. For relatives, refusing the prospect of imminent death is often a form of loyalty to the loved one and a wish to continue hoping beyond hope for life to persist. Moreover we should not forget that, despite the best possible attentive care, to be moved to the palliative care unit or to have the hospital's mobile palliative care team take over, may provoke feelings of apprehension in the patient, the patient's family and carers themselves. In most cases, the team's appearance in the terminal phase of the disease spells the loss of hope of recovery and that time is running short.

Therapeutic sobriety is more readily acceptable when patients are old and/or their quality of life has seriously deteriorated. When, however, a patient is young and eager to fight for life, there is a tendency on the part of health professionals to consider, and on the part of families to request, unreasonable therapy. Experience has shown⁷ that the validity and acceptability of such medical decisions are improved when they are the outcome of a consensus involving the entire medical team. These situations can be stressful, particularly when members of the medical team or of the family do not agree among themselves.

1.3. Between obstinacy and abandonment: the right road

Progressive and severe illness involves increasingly distressing episodes affecting patients and their families. The support they are given must not add the pain of abandonment to all the other losses and privations brought about by the disease itself. Whenever treatment ceases to be "caring", it is less effective. The issue of whether treatment is reasonable or not and avoiding any form of "unreasonable abandonment" can only be addressed in a situation of mutual trust between health professionals, patients and their families.

This trust is built on recognition and respect of the rights of patients — including the right to refuse treatment — and their capacity to take informed decisions. But patients are not always aware that they are entitled to refuse. Some patients may

7 Audition of Doctors Régis AUBRY, Bernard DEVALOIS, Jean-Marc LAPLANA.

be fearful that, should they express unwillingness, they might disappoint their loved ones or be abandoned by their doctors. Fear of excessive medicalisation at the end of life and distaste for prolonged artificial life support are the root causes of certain stances regarding euthanasia, as was underlined by CCNE in its Opinion n° 63, dated January 27, 2000 "End of life, ending life, euthanasia". If the obligation to abstain from unreasonable obstinacy, as prescribed by law and recently clarified in the *Code de déontologie médicale* (Code of Medical Deontology), is integrated in practice, mutual trust may contribute to reducing the frequency of such a situation⁸.

Clinical experience shows that citizens' expectations of medicine are not confined to diagnosis and therapy, but that health care also includes a human dimension of solicitude, support and attention. With this in mind, legislators in France decided on a number of changes for the better in medical practice. Such changes can only be put into effect in a financial context which adjusts the means to the objectives and which, furthermore, integrates them in a more pronounced and formal manner in both initial and continuing training for physicians and health carers generally.

2. Health care and its price: complexity of an exclusively quantitative pricing system

France devotes over 10% of its GDP to healthcare. The share borne by public financing (the State and social contributions) is large and the margin left for possible growth is limited, even though some sources of income are still exempt from social levies⁹. Keeping a check on health care expenditure so as to optimise the use of resources is an ethical necessity.

As regards hospitals and other medical institutions, each successive financing system has had perverse outcomes. Until 1983, the system was on a price-per-day basis which led to lengthening hospital stays. From 1983 onwards, with the global endowment system, a hospital's best interest was to take on fewer patients so as to spend less and benefit from the largest possible margin between actual expenditure and the amounts allocated.

In 2004, global endowment was replaced by remuneration calculated on the basis of Price per Activity (T2A), a system already in use in other countries, including the United States and Belgium. This financing system is complemented by a scale of charges based on the definition of "*Groupes Homogènes de Malades*" (GHM)" (Homogeneous Patient Groups), inspired by the World Health Organization's

⁸*Idem*

⁹References to the 2004 OECD study quoted in Opinion 101.

international classification of diseases. To each GHM is attributed an average cost (depending on the number and price of medical acts necessary to treat the patient) and an average length of stay (*durée moyenne de séjour - DMS*). These components are used to define the amount which will be paid to the hospital by the national health insurance system, in payment for the treatment of a patient of a given GHM. The T2A system was controversial and increasingly so as this management procedure was extended progressively to all clinical sectors. It was found that these new criteria were difficult to reconcile with the irreducible variety of patient needs, depending on whether their treatment is confined to purely diagnostic and therapeutic purposes or extends further to palliative – and also preventive and psychosocial – dimensions.

Remuneration based on clinical acts is an inducement to perform more of them or to choose better paid ones. Furthermore, the difference between the amount paid by the health insurance system and the actual cost of treatment varies from one GHM to another. Some may be more lucrative for a hospital. Generally speaking, the shorter the stay, the more "profitable" it is. Short stays are therefore preferred by managers whose mission includes making their facilities more cost-effective. Such hospital policies are a source of insistent pressure on doctors who are blamed, in particular, for what is always judged to be excessively long stays in hospital.

Despite its failings, T2A did add value to palliative care and end-of-life support. Payment for stays in palliative care, all classified within the same GHM, is now satisfactory and more attractive. But the *Cour des Comptes'* (Court of Auditors) report and the evaluation report on the laws relating to palliative care have already emphasised the inherent dangers of this system¹⁰. Henceforth, one of the perverse effects of T2A may be that palliative care becomes too attractive. Palliative care practices may be distorted by a financing system which, since it has added value to this activity, could lead to excessive classification of care into the "palliative" category, even when such care does not provide people nearing the end of their lives with the kind of counselling and attention they really need.

Other factors, besides the current reimbursement system applicable in hospitals, contribute to less effective functioning of beds set aside for palliative care and of palliative care units. The excessive importance attached to the number of operational beds and the correlative reduction in necessary health carers may lead to admitting preferentially to the palliative care wards those patients whose life expectancy is not too different from the "average length of stay in palliative care" (as defined in the current scale of charges), or to organising patient nomadism from

¹⁰Using the average length of stay (DMS), i.e. 3 days and 30 days combined with standard fixed amounts means that a bed occupied for one 15-day stay "earns" three times less for the hospital than three 5-day stays; beyond the 35th day, the daily fixed amount paid to the hospital is less than the daily cost of the patient.

one unit to another, or from home to palliative care and back again. In summary, whereas the 1999 and 2005 laws were imbued with the desire to encourage quality support for patients at the end of life, the insufficiency of beds "dedicated" to palliative care and the shortage of health carers are such that the present situation does not satisfy the legitimate expectations of society. Financing palliative care proportionately to the length of stay must not obviate the need for qualitative appreciation criteria.

3. Economics and ethics

The relationship between health carers and patients cannot be totally separated from the cultural, social and financial context in which it operates. But economics and ethics are not at odds.

Three facts with economic implications are frequently put forward to illustrate an unsatisfactory situation:

- Of the hundreds of thousands of people who die every year in this country, the vast majority die in a hospital or institution.
- If, as the Council of Europe reports, it is in the last weeks of life that health care is most expensive, even though it does not always fully meet people's needs, how can the ethics of the means and the ethics of the ends be matched?
- Alternatives to end-of-life medicalisation have been implemented in other countries¹¹. Perhaps some of them could serve as an example?

However, increasing the number of people who die at home, reducing the number of treatment prescriptions for them and encouraging alternatives to medicalisation at the end of life, would not perhaps be sufficient to support the claim that the quality of life of patients has improved and their specific needs have been met. The 2008 - 2012 palliative care development plan insists on the creation and extension of Mobile Palliative Care Units, on the setting up of networks comprising the Establishments for the Care of Elderly Dependants, Home Hospitalisation systems and more generally, the Social and Medico-Social Establishments for the Elderly. Such developments may not suffice to reduce expenses significantly since, for the most part, technological resources would be replaced by costly human resources (professional help or the patient's family). A sick person's desire to end life at home cannot always be supported by families despite the assistance provided by private health carer networks. This difficulty should not, however, prevent

¹¹Only 30% of the French population dies at home, whereas in the Netherlands this figure is around 80%. While the private-public medical information communications networks and voluntary associations favour dying at home, this is not easy to implement because health carers are not always available, people are often isolated and families are not always able to help. Although the new scale of charges may be an incentive to return home, it must be because it is wanted, not because there is no alternative.

patients from staying in their own home as long as possible and as their families can shoulder the burden. Hospitalisation as life ends makes available to patients and their carers technical assistance and reassuring human presence. The availability of doctors and paramedics is a barrier against isolation and a source of more immediate remedy in the event of uncomfortable symptoms.

3.1. Quality indicators

As methodologies vary and queries are numerous, it would seem desirable and necessary for palliative care to be provided with quality indicators so that, over a given time period, progress in the management of patients can be measured. Furthermore, as such indicators are evaluated by an external authority, they should play a practical role in the allocation of resources.

One of the tasks of the *Haute Autorité de Santé* (National Authority for Health), is to ensure the quality of care using three types of indicators: structures (number of institutions or of medical teams, number of health professionals, etc.); processes (training provided and received by the health carers) and results.

The first two of these indicators can be quantified and are obviously much easier to set up than an evaluation of results. For example, staying on at home as long as possible is not necessarily an indication of the quality of management. Hospitalisation can be a respite needed by families and even by patients; it can also be a place where people feel more secure. Staying on at home often has a financial cost which is largely paid for by family. Some steps have been taken to provide, for example, paid leave from work for carers, and their implementation will be very welcome.

Multiple short hospital stays, which hospitals strongly encourage doctors to prescribe, may be a sign of poor quality support but sometimes, they can put an end to long stays in hospitals when possibilities of returning home may have been missed.

The concept of unreasonable obstinacy is still difficult to evaluate since, the same step, depending on whether it is due to medical decision or patient choice, may be viewed differently. When treatment offered to patients is mutilating, painful or emotionally disturbing, it can be considered that prolonging life must not be to the detriment of quality of life. It is not just a matter of sparing the patient physically and mentally distressing surgery (amputations for examples) or treatment with taxing side effects, but also uncomfortable examinations (waiting on a gurney for yet another scan or MRI), and innumerable painful procedures (transfusions, injections, nasogastric tubes, etc.). The obligation on doctors to prescribe

appropriately should always be inseparable from the obligation to question the purpose of the investigation and evaluate the expected outcome.

In palliative care, while avoiding any kind of unreasonable obstinacy, once the patient has been made comfortable and symptoms dealt with, the essential components are time, attention, availability, therapeutic sobriety and relational skills.

Increasing the number or the capacity of palliative care units, or the number of beds reserved for palliative care in other clinical departments, is not the only way of responding to the full range of needs at the end of life. It has been estimated that less than 10% of end-of-life situations require the use of palliative care facilities. As regards the mobilisation of human resources, one palliative care unit is worth one resuscitation unit. Giving all patients the possibility of being looked after in the unit where they were treated, or at home, is important as is making sure that whatever they choose to do, the support they and their loved ones receive is of high quality.

3.2. Ensuring equitable access to quality care

It is easy to view the control of health expenditure as a threat to the fundamental right of access to health care. A system which gives financial value to care for as short a while as possible must not be allowed to generate in effect an absence of effective care. However, appropriate use of resources is one of the duties the medical professions owe society. Let us remember that in the Code of Medical Deontology, the physician is designated as "an actor of public health". There is no incompatibility between quality care and concern for equitable distribution of limited resources. Health professionals — like users — are citizens concerned by the issue of funding our health system. The financial efficacy of this system cannot be a taboo subject. Ethical reflection shows that sobriety can be a sign that the art of medicine is competently mastered. It reconciles the respect owed to a person and that which must be given to society, since competence cannot be disconnected from collective solidarity.

4. The need for training and research

Palliative care is fully a component of medical practice and must, like all others, be founded on the acquisition of scientific and technical competence, although it does rely on specific qualifications. But the courses which make it possible to acquire the relational competence, awareness of the importance of interdisciplinarity and the background for ethical reflection, are not given the weight they deserve in the medical curriculum. The lack of interconnection between these various components in medical training explains, to some extent, why it is so difficult to implement palliative practices and the excessive slowness with which the care culture they represent are developing. The hurdles in the path of implementation of the end-of-life and palliative care laws are in part, the result of these gaps in the initial and continuing training given to health carers.

In current society, life's end is not by any means a subject which people like to dwell on. Death is all too often left out of contemporary reflection. Medical training should be more inclined to respond to social and cultural issues of an ethical nature so that professionals would be better prepared to cope when death, with its inherent problems, is close at hand. They would also be more inclined to enter into the kind of critical analysis which is needed to progress beyond a simple assimilation of knowledge.

Although it may be necessary for certain patients to be admitted to specialised units, all health carers in all the clinical departments must be trained so that they can provide both the medical and the human care and attention that patients need at the end of their lives. Including in the curriculum a course on "pain control and palliative care" is obviously not sufficient. Furthermore, there is an urgent need for enhancing the image of physicians and medical teams specialising in palliative care so that they can aspire to acceptance by society at a good level in the scale of medical and surgical specialities.

Finally, as regards fundamental and clinical scientific data, there is evidence that while physiological mechanisms of pain are now correctly identified, the pharmacological tools needed to control them did not benefit to any great extent from this identification of the targets. The neurosciences have now developed fundamental and clinical means of investigation which should provide greater insight

of the cerebral impact of pain and its awareness as a function of states of consciousness and sub-consciousness. Research in these domains should be encouraged by national research organisations and public financing sources.

5. Proposals and recommendations

No funding system will ever prevent unreasonable obstinacy. Nevertheless, with the aim of increasing dissemination of the palliative care culture, the Committee recommends:

- **making sure that the palliative care tariffing system** continues to be reviewed and that such revisions be applied taking into consideration the specific quality indicators that need to be put into effect.

- **disseminating information on practices**, and so contribute to avoiding unreasonable obstinacy, in compliance with the April 22, 2005 law, and give more value to palliative care. Giving more importance to multidisciplinary meetings where several different medical specialities are represented and through which the opinions of all those involved (medical and paramedical professionals, those close to the patient and, above all, the views of patients themselves can be voiced, since the March 4, 2002 and April 22, 2005 laws give them pride of place). Unreasonable obstinacy is often the result of an individual decision and consultation is a way of avoiding it, specifically because through collegial discussion the barrier of isolated decision is breached and the fear of making a mistake is removed. The first priority, therefore, is to guide health professionals, physicians in particular, in these procedures, so that they are no longer seen as peripheral and incidental, but as an essential component of medical efficiency and complying with law. In the event of divergent opinions, mediation or clinical ethics practices, bringing in outside expertise, may help to arrive at an acceptable and calm decision.

- **investing in research, primary training and continuing education for health professionals**, this being a direct consequence of the above proposal:

 - by **creating posts in teaching hospitals, under the heading of Internal Medicine - Palliative Care**, so that palliative medicine is given the standing it deserves in medical training and its visibility and appeal are enhanced. Investment in human effort, prestige, education and financial

resources is generally to be observed in domains which are thought to be of importance. If professorial posts were created in the fields of pain relief and solace, this would help to gain general recognition for palliative care and also for the technical expertise required in certain extreme and particularly complex situations, for which specialised training is needed. It would also be useful if each medical and surgical speciality (cardiology, pneumology, infectious diseases, urology, neurology, etc.) were to set out the palliative specifics required in its discipline.

. **by stimulating research**, in particular through the same kind of call for tenders procedure that was used in the *Programme Hospitalier de Recherche Clinique 2010* (2010 Clinical Research Hospital Programme).

. **by including palliative care and its practices in the education given to all health professionals**, in particular nursing auxiliaries, physiotherapists and occupational therapists; nursing training courses have been providing this kind of training for many years.

- **developing mobile palliative care units**. In health caring institutions, these teams raise awareness of the palliative care culture, focused on interdisciplinarity, involvement of all those concerned, counsel and discussion, ethical concern. Far from posing as experts, palliative care teams are a friendly source of further expertise. Their support within a hospital environment is of irreplaceable pedagogical value.

In conclusion

Ethical concern in matters related to the life and death of human beings touches upon the permanence of the social bond. The issue of the financing and cost of medical services as life ends cannot be abstracted from that of responsibility for the welfare of the whole community. If this dimension of care were to be omitted, it would mean that a part of the population would be sacrificed and excluded from it. Palliative care is not a luxury that only prosperous societies are allowed to enjoy. It is an "innovative potential" of the health caring activity. The reflection and action that it prompts qualify it as a "sensible health objective"¹².

Bearing this in mind, efforts to inform society generally and associations in particular, should be given full support. Associations are working on raising the

¹²*Recommendations of the Committee of Ministers to member states of the Council of Europe on the organisation of Palliative Care, on November 12, 2003.*

social body's awareness of the need for care at the end of life to remain embedded in interpersonal, inter-generational and collective bonds of solidarity.

November 12, 2009

Documents

Report of the taskforce for evaluation of law n° 2005-370, dated April 22, 2005, on patients' rights and end-of-life.

Presented by Jean Leonetti, M.P., December 2008

French National Assembly, document 1287.

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

Rapporteur Wolfgang Wodarg

Parliamentary Assembly, Council of Europe, November 2008, document 11758

Final report of the *Comité National du suivi du développement des soins palliatifs et de l'accompagnement*. (National Committee on the Development of Palliative Care and counselling) Régis Aubry, Chairman of the Committee

French Ministry of Health, Youth and Sports, November 2008

French National Auditors' annual report, February 2007.

Progress of health indicators

Bulletin n° 7, May-June 2007, issued by the French National Authority for Health,

Note on T2A in palliative care for the attention of the Parliamentary Commission for the evaluation of the April 2005 law.

Dr B. Devalois, member of the monitoring committee and of the working group on the difficulty of financing palliative care.

Publications

Barthélémy, Andrien et coll, *Résistance des soignants à la mise en pratique des soins palliatifs : construction d'un modèle causal* (Health carer resistance to implementation of palliative care: construction of a causal model).

Medecine palliative n°5 volume 7 October 2008 Elsevier Masson

Boumédiane Pascale **la tarification à l'activité T2A en soins palliatifs : un calcul éthique ?**

(T2A pricing per activity in palliative care: an ethical calculation?) Memoir DU on palliative care, Paris Medical School, 2007-2008 school year.

E. Ferrand **Mort à l'hôpital Survey, Circumstances of Death in Hospitalized Patients and Nurses' Perceptions:** French multicentric study. Archives of Internal Medicine 2008

A. Laurent, C. Deslandres, M. Ruer, M. Filbet, W. Rondalith, M. Barmaki, **Medical perceptions of the palliative care mobile team in the Lyon Sud Medical Centre.** médecine palliative 2008, vol 7, n° 2 .