

THE WORLD MEDICAL ASSOCIATION, INC.

WMA DECLARATION ON END-OF-LIFE MEDICAL CARE

Adopted by the WMA General Assembly, Montevideo, Uruguay, October 2011

INTRODUCTION

All people have the right to high-quality, scientifically-based, and humane healthcare. Therefore, receiving appropriate end-of-life medical care must not be considered a privilege but a true right, independent of age or any other associated factors. The WMA reaffirms the principles articulated in the WMA Declaration on Terminal illness and the WMA Declaration on Euthanasia. These Declarations support and complement the Declaration on End of Life Medical Care.

Palliative care at the end of life is part of good medical care. The need for access to improved quality palliative care is great, especially in resource-poor countries. The objective of palliative care is to achieve the best possible quality of life through appropriate palliation of pain and other distressing physical symptoms, and attention to the social, psychological and spiritual needs of the patient.

Palliative care may be provided at home as well as in various levels of health care institutions.

The physician must adopt an attitude to suffering that is compassionate and humane, and act with empathy, respect and tact. Abandonment of the patient when he or she needs such care is unacceptable medical practice.

RECOMMENDATIONS

1. Pain and symptom management

- 1.1 It is essential to identify patients approaching the end of life as early as possible so that the physician can perform a detailed assessment of their needs. A care plan for the patient must always be developed; whenever possible, this care plan will be developed in direct consultation with the patient.

For some this process may begin months or a year before death is anticipated. It includes recognising and addressing the likelihood of pain and other distressing symptoms and providing for patients' social, psychological and spiritual needs in the time remaining to them. The primary aim is to maintain patients' dignity and their freedom from distressing symptoms. Care plans pay attention to keeping them as comfortable and in control as possible and recognise the importance of supporting the family and treating the body with respect after death.

- 1.2 Important advances in the relief of pain and other distressing symptoms have been made. The appropriate use of morphine, new analgesics, and other measures can suppress or relieve pain and other distressing symptoms in the majority of cases. The appropriate health authorities must make necessary medications accessible and available to physicians and their patients. Physician groups should develop guidelines on their appropriate use, including dose escalation and the possibility of unintended secondary effects.
- 1.3 In a very limited number of cases, generally in the very advanced stages of a physical illness, some symptoms may arise that are refractory to standard therapy. In such cases, palliative sedation to unconsciousness may be offered when life expectancy is a few days, as an extraordinary measure in response to suffering which the patient and clinician agree is intolerable. Palliative sedation must never be used to intentionally cause a patient's death or without the agreement of a patient who remains mentally competent. The degree and timing of palliative sedation must be proportionate to the situation. The dosage must be carefully calculated to relieve symptoms but should still be the lowest possible to achieve a benefit.

2. Communication and consent; ethics and values

- 2.1 Information and communication among the patient, their family and members of the health care team is one of the fundamental pillars of quality care at the end of life. The patient should be encouraged to express his or her preferences regarding care, and his or her emotions and existential angst must be taken into consideration.
- 2.2 Ethically-appropriate care at the end of life should routinely promote patient autonomy and shared decision-making, and be respectful of the values of the patient and his or her family.
- 2.3 Physicians should directly discuss a patient's preferences with the patient and/or the patient's substitute health care decision maker, as appropriate. These discussions should be initiated early and routinely offered to all patients and should be revisited regularly to explore any changes patients may have in their wishes, especially as their clinical conditions change. Physicians should encourage their patients to formally document their goals, values and treatment preferences and to appoint a substitute health care decision maker with whom the patient can discuss in advance his or her values regarding health care and treatment. Patients who are in denial about the implications of their condition may not want to engage in such discussion at some stages of their illness, but should know that they can change their minds. Because documented advance directives are often not available in emergency situations, physicians should emphasize to patients the importance of discussing treatment preferences with individuals who are likely to act as substitute health care decision makers.
- 2.4 If a patient is capable of giving consent, care should be based on the patient's wishes as long as preferences can be justified medically, ethically and legally. Consent needs to be based on sufficient information and dialogue, and it is the physician's obligation to make sure that the patient is adequately treated for pain and discomfort before consent is obtained in order to assure that unnecessary physical and mental suffering do not interfere with the decision-making process.
- 2.5 The patient's next-of-kin or family should be informed and involved in the decision-making process, provided the patient is not opposed to this. If the patient is unable to express consent and an advance directive is not available, the views of the health care substitute decision maker, appointed by the patient on care and treatment, must be considered.

3 Medical records and medico-legal aspects

- 3.1 Physicians caring for a patient in the final stages of life must carefully document treatment decisions and the reasons for choosing particular procedures, including the patient's and family's wishes and consent, in the progress notes of the medical records. An adequate medical record is of the utmost importance for continuity and quality of medical care in general and palliative care in particular.
- 3.2 The physician must also take into account that these notes may serve a medico-legal purpose, e.g., in determining the patient's decision-making capacity.

4. Family members

It is necessary to acknowledge the importance of the family and the emotional environment of the patient. The needs of the family and other close caregivers throughout the course of the illness must be recognized and attended to. The health care team should promote collaboration in the care of the patient and provide bereavement support, when required, after the patient's death. Children's and families' needs may require special attention and competence, both when children are patients and dependents.

5. Teamwork

Palliative care is usually provided by multiprofessional and interdisciplinary teams of healthcare and non-healthcare professions. The physician must be the leader of the team, being responsible, amongst other obligations, for diagnosis and medical treatment. Continuity of care is very important. The team should do all it can to facilitate a patient's wish to die at home, if applicable and possible.

6. Physician training

The increasing number of people who require palliative care and the increased availability of effective treatment options mean that end-of-life care issues should be an important part of undergraduate and postgraduate medical training.

7. Research and education

More research is needed to improve palliative care. This includes, but is not limited to, general medical care, specific treatments, psychological implications and organization. The WMA will support efforts to better educate physicians in the skills necessary to increase the prevalence and quality of meaningful advance care planning.

Conclusion

The care that a people give to dying patients, within available resources, is an indication of their degree of civilisation. As physicians representing the best humanitarian tradition, we should always commit ourselves to delivering the best possible end-of-life care.

The WMA recommends that all National Medical Associations develop a national policy on palliative care and palliative sedation based on the recommendations in this declaration.

