Très chère fin de vie

Lucas Morin, PhD

27ème Congrès de la SFAP (22–24 septembre 2021)
Déclaration de liens d’intérêt

Je n’ai participé à aucune activité et je n’ai reçu aucun avantage matériel ou immatériel susceptibles de mettre en cause mon indépendance, mon impartialité ou mon objectivité vis-à-vis des travaux présentés ici.
Données de santé
Dépenses de santé « socialisées »

200 milliards d’€uros

80% remboursés
Dépenses de santé « socialisées »

200 milliards d’euros

95 Mds €  Soins hospitaliers
55 Mds €  Soins de ville
32 Mds €  Médicaments
16 Mds €  Optiques, prothèses, matériel…
5 Mds €   Transport sanitaire
Defining Death

Medical, Legal and Ethical Issues in the Determination of Death

President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research
The use and costs of Medicare services in the last 2 years of life

This study reports on the use of Medicare services by Medicare enrollees who died in 1976. The results are presented for the last 2 years of life for all Medicare enrollees and for those who had Medicare expenditures in the last 2 years of life. The study was conducted by the authors to determine the use of Medicare services and the costs associated with these services. The results show that a large proportion of Medicare expenditures occur in the last 2 years of life, and that a substantial portion of these expenditures are for inpatient hospital care. The study also found that the use of Medicare services is influenced by several factors, including age, gender, and prior health status. The study's findings have important implications for policymakers and health care providers, as they suggest that strategies to reduce Medicare expenditures and improve the quality of care for the elderly should focus on the last 2 years of life.
Pour réduire le déficit de l’assurance maladie, ne convient-il pas de s’attaquer aux dépenses de fin de vie ? Selon les données disponibles, elles représentaient 13% des dépenses remboursées et sont appelées à augmenter. Cette approche « comptable » peut se parer de la vertu de l’éthique, en dénonçant l’inutilité et la cruauté d’un acharnement thérapeutique qui ne tiendrait pas compte d’un besoin de mourir dans la dignité. Une analyse des données disponibles fait apparaître une tout autre vision de la question : il ne semble pas que la part prise par ces dépenses ait augmenté au cours du temps, les efforts les plus coûteux sont engagés pour les personnes âgées de moins de 65 ans, les dépenses les plus importantes sont liées aux pathologies chroniques lourdes, soignées depuis longtemps, où la partie de la fin de vie ne représente qu’une petite part des efforts consentis. Questionner les efforts héroïques des équipes de soins dans les derniers jours de la vie n’est donc peut-être pas une question économique, celle de la remise en cause de la rentabilité collective de l’acharnement thérapeutique, mais bien une question éthique : affirmer à chacun le choix de finir sa vie comme il l’entend.

**Les dépenses en fin de vie, un zombie ?**

Dans le culte vaudois, un zombie est un mort que convoque le prêtre du culte au cours d’une cérémonie pour le mettre à son service, mort qui ne cesse donc de revivre pour servir les intérêts des vivants. Robert Evans, économiste de la santé canadien, utilise ce terme pour évoquer les arguments et idées qui reviennent régulièrement dans le débat sur les dépenses de santé et
« Indéniablement, les dépenses en toute fin de vie pèsent un poids considérable dans les dépenses remboursées »
Coût moyen des soins hospitaliers
The Myth Regarding the High Cost of End-of-Life Care

Health care reform debate in the United States is largely focused on the highly concentrated health care costs among a small proportion of the population and policy proposals to identify and target this “high-cost” group. To better understand this population, we conducted an analysis for the Institute of Medicine Committee on Approaching Death using existing national data sets, peer-reviewed literature, and published reports. We estimated that in 2011, among those with the highest costs, only 11% were in their last year of life, and approximately 13% of the $3 trillion spent on personal health care costs in the United States was devoted to care of individuals in their last year of life. Public health interventions to reduce health care costs should target those with long-term chronic conditions and functional limitations. [Am. J. Public Health. Published online ahead of print October 15, 2011: e1-e10. doi:10.2105/AJPH.2011.302899]

In 2011, the United States spent $1.7 billion on health care more than double what was spent in 2000. It is projected that by 2040, 1 out of every 3 dollars spent in the United States will be spent on health care. Health care reform debates frequently highlight highly concentrated health care costs among a small proportion of the population and propose policy proposals to identify this “high-cost” group and significantly reduce its costs. Indeed, a wide range of programs are attempting to target chronically ill and complex patients with cost-effective interventions. Yet, these exist at the national, regional, and patient level. The health care expenditures of the US population from which to estimate the costs of the high-cost group. Lack of comprehensive data on the primary reason detailed analyses of the high-cost group have not been conducted and why some may be more common.

The discussion regarding the high-cost population in the United States has often focused on the population at the end of life, during which evidence suggesting that those at the end of life drive health care spending. This evidence is biased, however, in that most studies have examined only Medicare enrollees and, therefore, only the Medicare population. Although health care for older adults is generally more costly and the majority of costs in the last year of life are paid by Medicare, such analyses exclude the substantial health care costs paid by Medicaid, private insurers, and individuals themselves. Furthermore, whereas an individual loses the last year of life may be significantly more expensive than preceding years, between individuals, differences in health care costs at any stage in life outweigh individual differences. These substantial limitations of the existing evidence characterizing the high-cost population in the United States may have hindered policymakers’ attempts to rein in health care costs.

Here we address this important gap in our understanding of the high-cost population in the United States by providing estimates of total spending among those in the last year of life and describing 3 distinct subgroups within the “high-cost” patient population. Our analysis contains contributions to a more comprehensive set of payments from those included in prior studies. Because “total spending” data representing all payments do not exist in a single population-based source, we estimate the data from existing national data sets (including the Medical Expenditure Panel Survey (MEPS) and the Health and Retirement Study), peer-reviewed literature, and published reports. We also describe the persistence of health care spending across 3 major subgroups within the high-cost group. In our opinion, the ability to design policy solutions that target individuals with exceptionally high health care costs is contingent on understanding the characteristics that define this population and, thus, how and why they incur such high costs.

The high cost population is 18.2 million. The end-of-life population is 2 million. The overlap is 0.5 million. Source: Total population and health care costs were obtained from 2011 Medical Expenditure Panel Survey data adjusted to include the nursing home population. The estimate of total costs for the end of life population was estimated from Health and Retirement Study data linked to Medicare claims data, adjusted to include non-Medicare payers and adjusted to 2011 dollars via the Bureau of Labor Statistics Consumer Price Index.

Figure 1—Estimated overlap between the population with the highest health care costs and the population at the end of life: United States, 2011.
Les dépenses de soins remboursés durant la dernière année de vie, en 2008, en France

Reimbursed health expenditures during the last year of life, in 2008, France

P. Ricci *, M. Mezzarobba, P.O. Biolière, D. Polton

Direction de la stratégie, des études et des statistiques, Caisse nationale de l’assurance maladie, 50, avenue du Pr. André-Lesanier, 75856 Paris cedex 20, France
Reçu le 9 septembre 2011 ; accepté le 16 avril 2012

Abstract

Background. – To measure the reimbursed health expenditures in the last year of life and the proportion it represents in total reimbursement costs in 2008, to analyse the structure of such expenditures and to identify costs by cause of death.

Methods. – Data were obtained from the French national insurance information system (SNIFRAMES). Data from the national hospital discharge database were linked to the outpatient reimbursement database for patients covered by the general health insurance scheme (n = 49 million persons). The cost of the last year of life was calculated for the exhaustive population (361,528 deaths in 2008). The supposed cause of death was mainly derived from the primary diagnosis of the last hospital stay during which the patient died.

Results. – The average reimbursed expenses during the last year of life were estimated at 22,000 € per person in 2008, with 12,500 € accounting for public hospital costs. Reimbursed health expenditures varied according to different medical causes of death: 52,300 € for HIV disease and about 40,000 € for tumors. A negative effect of age on the expenditure during the last year of life was observed. Health care spending increased with shorter time before death, the last month of life corresponding to 28% of reimbursed expenditures during the last year of life. Health care use in the last year of life represented 10.5% of the total health expenditures in 2008.

Conclusion. – This study found results similar to those observed in the past or in other countries. Our results show in particular that the weight of health expenditures during the last year of life on total health expenditures remains stable over the years.

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22 000 à 26 000 euros / pers

13,5 milliards €
22 000 à 26 000 euros / pers

68% soins hospitaliers
17% soins de ville
15% médicaments
22 000 à 26 000 euros / pers

68% soins hospitaliers
17% soins de ville
15% médicaments

21 000 € maladies cardiovasculaires
35 000 € cancers solides
93 000 € insuffisance rénale chronique
Evolution of health care utilization and expenditure during the year before death in 2015 among people with cancer: French sneds-based cohort study

Audrey Tanguy-Melac¹ · Dorian Verboux¹ · Laurence Pestel¹ · Anne Fagot-Campagna¹ · Philippe Tuppin¹ · Christelle Gastaldi-Ménager¹

Received: 7 July 2020 / Accepted: 26 March 2021 / Published online: 7 June 2021
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Abstract

Background Cancer patients have one of the highest health care expenditures (HCE) at the end of life. However, the growth of HCE at the end of life remains poorly documented in the literature.

Objective To describe monthly reimbursed expenditure during the last year of life among cancer patients, by performing detailed analysis according to type of expenditure and the person’s age.

Method Data were derived from the Système national des données en santé (SNDS) [national health data system], which comprises information on ambulatory and hospital care. Analyses focused on general scheme beneficiaries (77% of the French population) treated for cancer who died in 2015.

Results Average reimbursed expenditure during the last year of life was €34,300 per person in 2015, including €21,100 (62%) for hospital expenditure. “Short-stays hospital” and “rehabilitation units” stays expenditure were €14,700 and €2000, respectively. Monthly expenditure increased regularly towards the end of life, increasing from 12 months before death €2000 to €5200 1 month before death. The highest levels of expenditure did not concern the oldest people, as average reimbursed expenditure was €50,300 for people 18–59 years versus €25,600 for people 80–90 years. Out-of-pocket payments varied only slightly according to age, but increased towards the end of life.

Conclusion A marked growth of HCE was observed during the last 4 months of life, mainly driven by hospital expenditure, with a more marked growth for younger people.
ABSTRACT Although end-of-life medical spending is often viewed as a major component of aggregate medical expenditure, accurate measures of this type of medical spending are scarce. We used detailed health care data for the period 2009–11 from Denmark, England, France, Germany, Japan, the Netherlands, Taiwan, the United States, and the Canadian province of Quebec to measure the composition and magnitude of medical spending in the three years before death. In all nine countries, medical spending at the end of life was high relative to spending at other ages. Spending during the last twelve months of life made up a modest share of aggregate spending, ranging from 8.5 percent in the United States to 11.2 percent in Taiwan, but spending in the last three calendar years of life reached 24.5 percent in Taiwan. This suggests that high aggregate medical spending is due not to last-ditch efforts to save lives but to spending on people with chronic conditions, which are associated with shorter life expectancies.
EXHIBIT 1

Mean per capita medical spending (in 2014 US dollars) in 9 countries in the last 12 months of life, by category of spending.
EXHIBIT 1

Mean per capita medical spending (in 2014 US dollars) in 9 countries in the last 12 months of life, by category of spending

Countries with complete data

- Denmark
- Germany
- Netherlands
- US
- Taiwan

Countries with limited data

- England
- France
- Japan
- Quebec

Categories:
- Long-term care
- Home help
- Pharmaceuticals
- Professional services
- Hospital
1/ Quel est le contrefactuel ?
Chronic condition
(Rank)

01. Hypertension
02. Ischemic heart disease
03. Heart failure
04. Solid neoplasm
05. Depression or mood disease
06. Cataract, lens disease
07. Atrial fibrillation
08. Cerebrovascular disease
09. Dementia
10. Diabetes
<table>
<thead>
<tr>
<th>Chronic condition (Rank)</th>
<th>Prevalence rate (%)</th>
<th>Prevalence by number of comorbidities % of all deceased individuals</th>
</tr>
</thead>
<tbody>
<tr>
<td>01. Hypertension</td>
<td>71.5%</td>
<td></td>
</tr>
<tr>
<td>02. Ischemic heart disease</td>
<td>40.7%</td>
<td></td>
</tr>
<tr>
<td><strong>03. Heart failure</strong></td>
<td><strong>39.3%</strong></td>
<td></td>
</tr>
<tr>
<td>04. Solid neoplasm</td>
<td>37.7%</td>
<td></td>
</tr>
<tr>
<td>05. Depression or mood disease</td>
<td>35.3%</td>
<td></td>
</tr>
<tr>
<td>06. Cataract, lens disease</td>
<td>31.5%</td>
<td></td>
</tr>
<tr>
<td>07. Atrial fibrillation</td>
<td>30.3%</td>
<td></td>
</tr>
<tr>
<td>08. Cerebrovascular disease</td>
<td>27.3%</td>
<td></td>
</tr>
<tr>
<td>09. Dementia</td>
<td>26.3%</td>
<td></td>
</tr>
<tr>
<td>10. Diabetes</td>
<td>22.8%</td>
<td></td>
</tr>
</tbody>
</table>

Number of co-occurring conditions:
- ≤1
- 2
- 3
- 4
- 5
- ≥6
<table>
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<td><strong>70%</strong></td>
</tr>
<tr>
<td>04. Solid neoplasm</td>
<td>37.7%</td>
<td></td>
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<tr>
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</table>

Number of co-occurring conditions:

- ≤1
- 2
- 3
- 4
- 5
- ≥6
2/ Payer quoi, pour qui ?
Traitements curatifs
Médicaments de prévention secondaire
Médicaments de prévention primaire
Cascade thérapeutique
Confort, soulagement des symptômes
— Hé bien ! Messieurs, vous l’avez vu, cette opération qu’on disait impossible a parfaitement réussi
— Mais, Monsieur... la malade est morte...
— Qu’importe ! Elle serait bien plus morte sans l’opération
End-of-life care for hospitalized patients with metastatic melanoma in France: a nationwide, register-based study

I. Gallais Sérézal, Y. Beaussant, P. Rochigneux, C. Tournigand, R. Aubry, B. Lindelöf and L. Morin

Department of Dermatology, Karolinska Hospital and Department of Medicine, Karolinska Institutet, Stockholm, Sweden
2Department of Palliative Care and INSERM CIT808, Besançon University Hospital, Besançon, France
3Medical Oncology, Institut Paoli-Calmettes, Marseille, France
4Oncology Department, Hôpital Henri Mondor, Assistance Publique Hôpitaux de Paris, Créteil, France
5Paris-Est Créteil University, Créteil, France
6Aging Research Center, Karolinska Institutet and Stockholm University, Gåvleatan 16, 11330 Stockholm, Sweden
5300 € l’administration

140–240 000 € / patient
Mélanome métastatique: taux de survie à 5 ans

![Graph showing survival rates over years with specific percentages at 18.3%, 21.7%, and 36.6% for different years.](image-url)
Patients with Metastatic Melanoma Receiving Anticancer Drugs: Changes in Overall Survival, 2010–2017

Florence Poizeau, Sandrine Kerbrat, André Happe, Caroline Rault, Erwan Drezen, Frédéric Balusson, Philippe Tuppin, Bernard Guillot, Anne Thuret, Lise Boussemart, Monica Dinulescu, Marc Pracht, Thierry Lesimple, Catherine Droitcourt, Emmanuel Oger and Alain Dupuy

Immune checkpoint inhibitors and targeted therapies have profoundly altered the management of several cancers over the past decade. Metastatic melanoma has been at the forefront of these changes. We provide here a nationwide overview and an assessment of changes in survival in France. We included 10,936 patients receiving a systemic treatment for metastatic cutaneous melanoma between 2010 and 2017 using the French National Health Insurance database (Système National des Données de Santé). Over the study period, there was a doubling of the number of new patients receiving a systemic treatment. Cytotoxic chemotherapy was progressively replaced by targeted therapy and immune checkpoint inhibitors. Patients having initiated a first-line treatment since June 2015 gained 46% overall survival compared with those initiating treatment before 2012. Overall survival at 24 months rose from 21% to 44%. We provide real-world evidence for the improvement of overall survival in the past decade among patients with metastatic melanoma. Although the characteristics of the patients treated can vary across periods, this type of exhaustive real-world data provides evidence from broader populations than those included in clinical trials.

Figure 3. Comparative OS across the four cohorts of patients with advanced melanoma in France (2010–2017). Kaplan-Meier curves for OS are shown per cohort. Cohorts 1–4 correspond to patients receiving a first-line systemic treatment for metastatic melanoma from January 2010 to December 2011, January 2012 to October 2013, November 2013 to May 2015, and June 2015 to December 2017, respectively. As there was no loss to follow-up, all censored patients were individuals who were still alive on 31 December 2017. The 2-year OS was computed for each cohort. OS, overall survival.

Survival probability

2015-2017

24%

21%

36%

44%

0.00

0.25

0.50

0.75

1.00

0

12

24

36

48

60

72

84

96

Time (months)

Number at risk

Cohort 1
1808 699 384 294 254 236 213 97 0
Cohort 2
2069 826 493 383 339 161 1 0 0
Cohort 3
2334 1180 841 455 33 0 0 0 0
Cohort 4
4725 1662 424 0 0 0 0 0 0

2010-2011
Choosing Wisely: Measuring the Burden of Medications in Older Adults near the End of Life: Nationwide, Longitudinal Cohort Study

Lucas Marti, MS,† Davide L. Vitarelli, MD,
Deborah Riscica, PhD,‡ Amalia Goldstein-Larrea, PhD,*‡
Johan Gustafson, MD, PhD,§ Kristina Johneil, PhD*

†Aging Research Center, Karolinska Institutet, Stockholm, Sweden. Department of Geriatrics, Catholic University of Rome, Italy.
‡Research Group on Chronic Diseases, Aegon Health Sciences Institute, SS Ligure, Miguel Servet University Hospital, Zaragoza, Spain.
§Department of Geriatrics, Aegon Health Sciences Institute, SS Ligure, Miguel Servet University Hospital, Zaragoza, Spain.

ABSTRACT

BACKGROUND: The burden of medications near the end of life has mostly come under scrutiny, because several studies suggested that people with life-limiting illness receive potentially futile therapies.

METHODS: We launched 73,840 older adults (>65 years who died in Sweden between 2007 and 2013 and reconciled their drug prescription history for each of the last 12 months of life through the Swedish Prescribed Drug Register. Electronic characteristics at time of death were assessed through record linkage with the National Patient Register, The Social Insurance Register, and the Swedish Education Register.

RESULTS: Over the course of the final year before death, the proportion of individuals exposed to ≥10 different drugs was from 30.3% to 47.2% (p < 0.001 for trend). Although older adults who died from cancer had the largest number of the number of drugs (median difference, 33.3% vs 39.9% difference median; 33.9% vs 33.5% incidence proportion), associated with a higher median (42.0 vs 38.5), the most commonly used drugs were benzodiazepine (55.6%), non-opioid analgesics (53.5%), analgesics (51.1%), antidepressants (50.8%), and respiratory drugs (49.4%).

CONCLUSION: Polypharmacy increased throughout the last year of life of older adults. It is not only by symptomatic medications but also by long-term prescription of questionable benefit. Clinical guidelines are needed to ensure physicians to their decision to continue or discontinue medication near the end of life.

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KEYWORDS: Elderly; End of Life; Medications; Polypharmacy

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Polypharmacy (≥10 prescription drugs)

- Total cohort
- Institutionalized
- Community-dwelling

Proportion of decedents, %

0 10 20 30 40 50 60

12 11 10 9 8 7 6 5 4 3 2 1

Months before death

Available interested researchers can access the aggregated data from the Swedish Prescribed Drug Register (http://www.sdataakut.se/utrustning/sverigespreskrivning)

Requests for review should be addressed to Lucas Marti, MS, Karolinska Institutet, Aging Research Center, Gustav Adolfs torg, 5, 10513 Stockholm, Sweden. E-mail: lucas.marti@ki.se

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Original Article

Preventive Drugs in the Last Year of Life of Older Adults

With Cancer: Is There Room for Desperation?

Lolita Mooney, MD, Adam Toul, MPH, PhD, Stephen Buesing, MA, FRCP, MD, Thomas F. Whitaker, MD, PhD, James M. Whitaker, MD, PhD, and Kristin Linfield, MPH, PhD

BACKGROUND: The use of preventive drugs among older patients with advanced cancer has been debated recently because these drugs are expected to deliver their clinical benefit during the patient’s remaining lifetime.

METHODS: A systematic review and meta-analysis was conducted to assess the evidence for preventive drugs in older patients with advanced cancer. We performed a search of the PubMed, EMBASE, and Cochrane CENTRAL databases from inception to November 2018,

RESULTS: We identified 328 trials involving 199,682 patients. The median age was 70 years. Thirteen drugs were included in the analysis, including aspirin, vitamin D, vitamin E, sirtuin activators, bisphosphonates, and LHRH agonists. The median follow-up was 9 months.

CONCLUSIONS: Preventive drugs have the potential to reduce adverse outcomes in older patients with advanced cancer, but the evidence is limited. Further research is needed to determine the optimal use of these drugs.

KEYWORDS: Preventive drug, preventive drug in the last year of life, Advanced care planning, Palliative care
Médicaments au cours de la dernière année de vie

<table>
<thead>
<tr>
<th></th>
<th>12\textsuperscript{th} month before death</th>
<th>Last month before death</th>
<th>Absolute change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Percent</td>
<td>Percent</td>
<td>Percent points (95%CI)</td>
</tr>
<tr>
<td><strong>Antithrombotic agents</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vitamin K antagonists</td>
<td>7.7%</td>
<td>5.6%</td>
<td>-2.1 (-2.3 to -1.9)</td>
</tr>
<tr>
<td>Heparin group</td>
<td>2.7%</td>
<td>10.0%</td>
<td>+7.3 (7.1 to 7.5)</td>
</tr>
<tr>
<td>Platelet aggregation inhibitors</td>
<td>37.7%</td>
<td>36.2%</td>
<td>-1.5 (-1.8 to -1.2)</td>
</tr>
<tr>
<td><strong>Drugs used in the treatment of hypertension</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low-ceiling diuretics</td>
<td>6.3%</td>
<td>5.2%</td>
<td>-1.1 (-1.3 to -0.9)</td>
</tr>
<tr>
<td>Potassium-sparing agents</td>
<td>7.3%</td>
<td>11.2%</td>
<td>+3.9 (3.7 to 4.1)</td>
</tr>
<tr>
<td>Beta blocking agents</td>
<td>37.5%</td>
<td>38.2%</td>
<td>+0.7 (0.4 to 1.0)</td>
</tr>
<tr>
<td>Calcium channel blockers\textsuperscript{d}</td>
<td>18.9%</td>
<td>15.9%</td>
<td>-3.0 (-3.3 to -2.7)</td>
</tr>
<tr>
<td>ACE inhibitors</td>
<td>20.3%</td>
<td>18.5%</td>
<td>-1.8 (-2.1 to -1.5)</td>
</tr>
<tr>
<td>Angiotensin II antagonists</td>
<td>11.7%</td>
<td>9.9%</td>
<td>-1.8 (-2.0 to -1.6)</td>
</tr>
<tr>
<td><strong>Lipid modifying agents</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HMG CoA reductase inhibitors</td>
<td>21.0%</td>
<td>16.3%</td>
<td>-4.7 (-5.0 to -4.4)</td>
</tr>
</tbody>
</table>

\textsuperscript{d} Calcium channel blockers include calcium channel blockers of the calcium entry and calcium channel blockers of the calcium release.
Médicaments au cours de la dernière année de vie

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<td>60.4%</td>
<td>60.1%</td>
<td>-0.3 (-0.6 to 0.0)</td>
</tr>
<tr>
<td>Low-ceiling diuretics</td>
<td>6.3%</td>
<td>5.2%</td>
<td>-1.1 (-1.3 to -0.9)</td>
</tr>
<tr>
<td>Potassium-sparing agents</td>
<td>7.3%</td>
<td>11.2%</td>
<td>+3.9 (3.7 to 4.1)</td>
</tr>
<tr>
<td>Beta blocking agents</td>
<td>37.5%</td>
<td>38.2%</td>
<td>+0.7 (0.4 to 1.0)</td>
</tr>
<tr>
<td>Calcium channel blockers(d)</td>
<td>18.9%</td>
<td>15.9%</td>
<td>-3.0 (-3.3 to -2.7)</td>
</tr>
<tr>
<td>ACE inhibitors</td>
<td>20.3%</td>
<td>18.5%</td>
<td>-1.8 (-2.1 to -1.5)</td>
</tr>
<tr>
<td>Angiotensin II antagonists</td>
<td>11.7%</td>
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</tr>
<tr>
<td>Lipid modifying agents</td>
<td>21.5%</td>
<td>16.8%</td>
<td>-4.7 (-5.0 to -4.4)</td>
</tr>
<tr>
<td>HMG CoA reductase inhibitors</td>
<td>21.0%</td>
<td>16.3%</td>
<td>-4.7 (-5.0 to -4.4)</td>
</tr>
</tbody>
</table>
### Médicaments au cours de la dernière année de vie

<table>
<thead>
<tr>
<th></th>
<th>12&lt;sup&gt;th&lt;/sup&gt; month before death</th>
<th>Last month before death</th>
<th>Absolute change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Percent</td>
<td>Percent</td>
<td>Percent points (95%CI)</td>
</tr>
<tr>
<td><strong>Antithrombotic agents</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vitamin K antagonists</td>
<td>46.6%</td>
<td>48.1%</td>
<td>+1.5 (1.1 to 1.9)</td>
</tr>
<tr>
<td>Heparin group</td>
<td>7.7%</td>
<td>5.6%</td>
<td>-2.1 (-2.3 to -1.9)</td>
</tr>
<tr>
<td>Platelet aggregation inhibitors</td>
<td>2.7%</td>
<td>10.0%</td>
<td>+7.3 (7.1 to 7.5)</td>
</tr>
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<sup>d</sup>Calcium channel blockers data not available.
Prevalence, symptom burden, and natural history of deep vein thrombosis in people with advanced cancer in specialist palliative care units (HIDDen): a prospective longitudinal observational study

The Science of Choosing Wisely — Overcoming the Therapeutic Illusion

David Casarett, M.D.

In recent years, the United States has seen increasing efforts to reduce inappropriate use of medical treatments and tests. Perhaps the most visible has been the Choosing Wisely campaign, in which medical societies have identified many tests, medications, and treatments that are used inappropriately. The result is recommendations advising against using these interventions or suggesting that they be considered more carefully and discussed with patients.

The success of such efforts, however, may be limited by the tendency of human beings to overestimate the effects of their actions. Psychologists call this phenomenon, which is based on our tendency to infer causality where none exists, the “illusion of control.” In medicine, it may be called the “therapeutic illusion” (a label first applied in 1978 to “the unjustified enthusiasm for treatment on the part of both patients and doctors”). When physicians believe that their actions or tools are more effective than they actually are, the results can be unnecessary and costly care. Therefore, I think that efforts to promote more rational decision making will need to address this illusion directly.

The best illustration of the illusion of control comes from studies in which volunteers were asked to figure out how to press a button in order to cause a panel to light up. The volunteers searched enthusiastically for strategies and were generally confident that they would succeed. They didn’t know, however, that their success was determined entirely by chance.

The phenomenon has since been described in widely varied settings. Gamblers, for example, consistently overestimate the control they have over outcomes, both in gambling and in everyday life. Their belief leads them to engage in seemingly bizarre or ritualistic behaviors such as throwing dice in a certain way or wearing specific colors. But the illusion of control is widespread, and its effects may be enhanced when people are placed in posi-
L’illusion thérapeutique

La tendance à croire que nos actions sont plus efficaces qu’elles le sont réellement

(et de sous-estimer l’influence des facteurs sur lesquels nous n’exerçons aucun contrôle)
Arthroscopic subacromial decompression for subacromial shoulder pain (CSA): a multicentre, pragmatic, parallel group, placebo-controlled, three-group, randomised surgical trial

David J Beard
University of Oxford

Summary
Background Arthroscopic subacromial decompression (decompressing the sub-acromial space by removing bone spurs and soft tissue arthroscopically) is a common surgery for subacromial shoulder pain, but its effectiveness is uncertain. We did a study to assess its effectiveness and to investigate the mechanisms for surgical decompression.

Methods We did a multicentre, randomised, pragmatic, parallel group, placebo-controlled, three-group trial at 32 hospitals in the UK with 51 surgeons. Participants were patients who had subacromial pain for at least 3 months with intact rotator cuff tendons, who were eligible for arthroscopic surgery, and had previously completed a non-operative management programme that included exercise therapy and at least one steroid injection. Exclusion criteria included a full-thickness rotator cuff tear. We randomly assigned participants (1:1:1) to arthroscopic subacromial decompression, investigational arthroscopy only, or no treatment (attendance at a routine appointment with a specialist shoulder clinician 3 months after study entry, but no intervention). Arthroscopy only was a placebo as the essential surgical element (bone and soft tissue removal) was omitted. We did the randomisation with a computer-generated minimisation system. In the surgical intervention groups, patients were not told which type of surgery they were receiving (to ensure masking).

Findings Between Sept 14, 2012, and June 14, 2015, we randomly assigned 533 patients to treatment groups (506 to decompression surgery, 235 to arthroscopy only, and 104 to no treatment). 512 (96%) of the decompression, arthroscopy only, and no treatment groups, respectively, did not receive their assigned treatment by 6 months. At 6 months, data for the Oxford Shoulder Score were available for 90 patients assigned to decompression, 94 to arthroscopy, and 90 to no treatment. Mean Oxford Shoulder Score did not differ between the two surgical groups at 6 months (decompression mean 33-7 points (SD 11-4) vs arthroscopy mean 34-2 points (9-1), mean difference −1·3 points (95% CI −3·9 to 1·3, p=0.340). Both surgical groups showed a small benefit over no treatment (mean 29·4 points (SD 11·9), mean difference 2·4 points (95% CI 0·5–4·3), p=0.034, mean difference vs arthroscopy 4·2 (1·8–6·6), p=0·004) but these differences were not clinically important. There were six study-related complications that were all frozen shoulders in two patients in each group.

Interpretation Surgical groups had better outcomes for subacromial pain and function compared with no treatment but this difference was not clinically important. Additionally, surgical decompression appeared to offer no extra benefit over arthroscopy only. The difference between the surgical groups and no treatment might be the result of, for instance, a placebo effect or postoperative physiotherapy. The findings question the value of this operation for these indications, and this should be communicated to patients during the shared treatment decision-making process.

Lancet 2019; 393: 529–38
2,075 patients assessed for eligibility

2,154 ineligible
81 eligibility unclear

740 eligible for inclusion

427 not randomised
232 took part in an observational cohort for patients with a strong preference
195 did not partake but no information provided

313 randomised

106 assigned to decompression

6 months 12 months
Received ASAD 76 80
No surgery 32 17
RCS including ASAD 4 5
Other including ASAD 2 2
Other excluding ASAD 2 2

101 assigned to arthroscopy only

6 months 12 months
Received arthroscopy 60 68
No surgery 32 23
RCS including ASAD 4 4
ASAD 3 3
Other including ASAD 1 1
Other excluding ASAD 2 2

104 assigned to no treatment

6 months 12 months
Received no treatment 93 78
RCS including ASAD 1 1
ASAD 8 18
Other including ASAD 2 6
Withdrawal 1 1

6 withdrawn

2 withdrawn

7 withdrawn

88 with 12-month OSS data and included in intention-to-treat analyses
12 no response
76 included in per-protocol analyses

94 with 6-month OSS data and included in intention-to-treat analyses
7 no response
57 included in per-protocol analyses

93 with 12-month OSS data and included in intention-to-treat analyses
7 no response
65 included in per-protocol analyses

84 with 12-month OSS data and included in intention-to-treat analyses
13 no response
61 included in per-protocol analyses

Decompression  Arthroscopy only  Nosurgery
**Figure 2: Oxford Shoulder Score in the intention-to-treat analyses**

Data are mean (95% CI) shown at follow-up timepoints. OSS=Oxford Shoulder Score.
Dépenses liées aux soins palliatifs

Soins palliatifs « de recours » : 1,7 milliards €

dont Unités de Soins Palliatifs: ~340 millions €
dont Lits Identifiés de Soins Palliatifs: ~800 millions €
dont Equipes Mobiles de Soins Palliatifs: ~140 millions €

Auxquels il faut ajouter les soins palliatifs intégrés…
Les soins palliatifs allègent-ils la dépense?

Malheureusement pour nous… pas vraiment.
Economics of Palliative Care for Hospitalized Adults With Serious Illness
A Meta-analysis

Peter May, PhD; Charles Normand, DPhil; J. Brian Cassel, PhD; Egido Del Fabbro, MD; Robert L. Fine, MD; Reagan Menz; Corey A. Morrison; Joan D. Penrod, PhD; Chessie Robinson, MA; R. Sean Morrison, MD

**IMPORTANCE** Economics of care for adults with serious illness is a policy priority worldwide. Palliative care may lower costs for hospitalized adults, but the evidence has important limitations.

**OBJECTIVE** To estimate the association of palliative care consultation (PCC) with direct hospital costs for adults with serious illness.

**DATA SOURCES** Systematic searches of the Embase, PsycINFO, CENTRAL, PubMed, CINAHL, and EconLit databases were performed for English-language journal articles using keywords in the domains of palliative care (eg, *palliative*, *terminal*) and economics (eg, *cost*, *utilization*), with limiters for *hospital* and *consultation*. For Embase, PsycINFO, and CENTRAL, we searched without a time limitation. For PubMed, CINAHL, and EconLit, we searched for articles published after August 1, 2013. Data analysis was performed from April 8, 2017, to September 16, 2017.

**STUDY SELECTION** Economic evaluations of interdisciplinary PCC for hospitalized adults with at least 1 of 7 illnesses (cancer, heart, liver, or kidney failure; chronic obstructive pulmonary disease; AIDS/HIV; or selected neurodegenerative conditions) in the hospital inpatient setting vs usual care only, controlling for a minimum list of confounders.

**DATA EXTRACTION AND SYNTHESIS** Eight eligible studies were identified, all cohort studies, of which 6 provided sufficient information for inclusion. The study estimated the association of PCC within 3 days of admission with direct hospital costs for each sample and for subsamples defined by primary diagnoses and number of comorbidities at admission, controlling for confounding with an instrumental variable when available and otherwise propensity score weighting. Treatment effect estimates were pooled in the meta-analysis.
The effectiveness and cost-effectiveness of hospital-based specialist palliative care for adults with advanced illness and their caregivers (Review)

Sur 13 essais randomisés qui ont comparé le coût des services de soins palliatifs hospitaliers:

- 9 études ne trouvent aucune différence de coût
- 2 études rapportent des dépenses plus faibles avec les soins palliatifs
- 1 étude donne des résultats non-concluants
- 1 étude rapporte des coûts d’hospitalisation plus faible mais des coûts totaux similaires
La question n’est pas tant de savoir si l’accompagnement de la fin de vie coûte cher que de savoir ce que l’on propose aux patients avec les ressources dont on dispose.
Questions ouvertes
lucas.morin@inserm.fr
lucasmorin_eolc