

Media Watch...

is intended as an advocacy, research and teaching tool. The weekly report is international in scope and distribution – to colleagues who are active or have a special interest in **hospice** and **palliative care**, and in the quality of **end-of-life care** in general – to help keep them abreast of current, emerging and related issues – and, to inform discussion and encourage further inquiry.

29 May 2017 Edition | Issue #514



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Compiled & Annotated by Barry R. Ashpole

Spiritual care: Scroll down to [Specialist Publications](#) and ‘Evaluation of a chaplain residency program and its partnership with an in-patient palliative care team’ (p.10), in *Journal of Health Care Chaplaincy*.

Canada

Better health care means fixing bureaucratic failings

NOVA SCOTIA | *The Globe & Mail* – 22 May 2017 – Two years after Nova Scotia “de-regionalized” – merged its nine health regions into a single provincial health authority – an informal, blue-ribbon group has offered up a scorching analysis of the exercise.¹ It concluded that the Nova Scotia Health Authority, which has 23,400 employees and a budget of \$2.1 billion, is a “non-system – disconnected, not communicating, non-agile, non-‘people-centred’ as well as [having] front-line staff and managers who feel helpless and unable to effect the changes they know have to happen.” That is, sadly, a description that applies to many provincial and regional health administrative bodies around the country. In fact, the small group that wrote this *cri de coeur* – including former deputy health minister Kevin McNamara, emergency doctor John Ross, geriatric psychiatrist Jeanne Ferguson, palliative care specialist Robert Martel [see sidebar right], and family physician Dr. Ajantha Jayabarathan – serve up a timely reminder that virtually all the problems in our health-care system are engineering and administrative failings, not failures of medical care. Mercifully, they do not suggest the classic Canadian solution of throwing more bodies into a mismanaged system but, rather, call for the system to be better

structured and managed so we can allow the health professionals we have to do their work unencumbered by seemingly never-ending bureaucratic hurdles. This is a knowledgeable quintet and they have good ideas. While the solutions are specific to Nova Scotia, again, the advice would be well-heeded in all regions of the country. <https://goo.gl/hwJX7D>

Richmond County palliative care doctor pulls services, blames slow provincial action

NOVA SCOTIA | *The Cape Breton Post* (Sydney) – 7 July 2016 – Dr. Bob Martel will no longer provide palliative care (PC) services for the Strait-Richmond area. Martel said Richmond is one of three counties in the province without PC nursing services on weekday evenings and on weekends. Other than Martel working as a full-time PC doctor, medical PC consultations are only available from out-of-town physicians every three to four weeks. There are other resources lacking such as a full-time social worker, dedicated field-based PC nurses, physicians, and nurse practitioners. Provincial PC co-ordinator Cheryl Tschupruk admitted there are gaps in PC service, but the [province’s] strategy is working to build capacity in a primary health-care setting. [Noted in Media Watch 11 July 2016, #470 (p.1)] <http://goo.gl/hFuijC>

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- ONTARIO | *The Toronto Sun* – 20 May 2017 – **‘Why is Ontario forcing docs to participate in euthanasia?’** Canada’s assisted dying law does not require doctors to provide medically assisted death personally. But in Ontario, they must refer the patient to a doctor who will do it, known as effective referral, which many medical professionals say violates their conscience rights not to participate in the euthanasia process. All the Ontario doctors who oppose assisted dying are asking is that their conscience rights not to be forced to give effective referrals to their patients requesting a medically assisted death be recognized in law. But for some reason, the Liberal government is balking at this request. They haven’t legally recognized the third-party process in Bill 84 and have rejected requests both from doctors and nurses who have asked for it. Along with the New Democratic Party, the Liberals voted down a private member’s bill (Bill 129), which would have amended Bill 84 to recognize doctors’ conscience rights with regard to euthanasia. <https://goo.gl/Dc1lvo>

Specialist Publications

“‘It’s not just the word care, it’s the meaning of the word...(they) actually care”: Caregivers’ perceptions of home-based primary care in Toronto, Ontario’ (p.8), in *Ageing & Society*.

‘Barriers to home death for Canadian cancer patients: A literature review’ (p.8), in *Journal of Pain Management*.

‘Finding a home (somewhere) for medical aid in dying’ (p.16), in *Journal of Pain Management*.

‘Medical assistance in dying: Implementing a hospital-based program in Canada’ (p.5), in *New England Journal of Medicine*.

U.S.A.

Can comfort care at the ER help older people live longer and suffer less?

NATIONAL PUBLIC RADIO | Online – 26 May 2017 – As baby boomers age, more of them are visiting the emergency room, which can be an overcrowded, disorienting and even traumatic place. Adults 65 and older made 20.8 million emergency room visits in 2013, up from 16.2 million in 2000, according to the most recent hospital survey by the Centers for Disease Control & Prevention. The survey found 1 in 6 visits to the ER were made by an older patient, a proportion that’s expected to rise. Half of adults in this age group visit the ER in their last month of life, according to a 2012 study.¹ Of those, half die in the hospital, even though most people say they’d prefer to die at home. The influx is prompting more clinicians to rethink what happens in the fast-paced emergency room, where the default is to do everything possible to extend life. Hospitals across the country – including in Ohio, Texas, Virginia and New Jersey – are bringing palliative care, which focuses on improving quality of life for patients with advanced illness, into the emergency department. <https://goo.gl/0A1PL3>

1. ‘Half of older Americans seen in emergency department in last month of life; most admitted to hospital...’ *Health Affairs*, 2012;31(6):1277-1285. <https://goo.gl/96R6GW>

Specialist Publications

‘Exploring the utilization of end-of-life documentation among an online sample of sexual- and gender-minority individuals in the U.S.’ (p.10), in *Journal of Gay & Lesbian Social Services*.

‘End-of-life care for glioblastoma patients at a large academic cancer center’ (p.11), in *Journal of Neuro-Oncology*.

‘Community-based models of care delivery for people with serious illness’ (p.15), National Academy of Science discussion paper.

Cont.

Selected articles on end-of-life care in the emergency department

- *JOURNAL OF PALLIATIVE MEDICINE* | Online – 16 February 2017 – ‘**Using the surprise question to identify those with unmet palliative care needs in emergency and inpatient settings: What do clinicians think?**’ Modest study participants reported that the surprise question (SQ) influenced care delivery as well as goals of care. At least some advance care planning discussions were prompted by the SQ. [Noted in Media Watch 20 February 2017, #500 (p.13)] <https://goo.gl/cjh58n>
- *AMERICAN JOURNAL OF HOSPICE & PALLIATIVE MEDICINE* | Online – 30 November 2016 – ‘**“They shouldn’t be coming to the ED, should they?”: A descriptive service evaluation of why patients with palliative care needs present to the emergency department.**’ There is no international agreement on which patients are best cared for in the emergency department, compared to the primary care setting or direct admission to the hospital. [Noted in Media Watch 5 December 2016, #490 (p.5)] <https://goo.gl/qQL7qS>
- *JOURNAL OF PALLIATIVE MEDICINE* | Online – 26 April 2016 – ‘**Effectiveness of emergency department based palliative care for adults with advanced disease: A systematic review.**’ Emergency departments are seeing more patients with palliative care needs, but evidence on best practice is scarce. [Noted in Media Watch 2 May 2016, #460 (p.7)] <http://goo.gl/J18JG6>

N.B. Additional articles on end-of-life care in the emergency department are noted in the 18 April 2016 issue of Media Watch (#458, p.10).

More Americans with Alzheimer’s are dying at home

ASSOCIATED PRESS | Online – 25 May 2017 – U.S. health officials say 1 in 4 Alzheimer’s deaths are now occurring at home¹ – a startling increase that marks a shift away from hospitals and nursing homes. Over 15 years, Alzheimer’s deaths in hospitals, nursing homes or other long-term care facilities shrank from more than 80% to 60%. Meanwhile, those dying at home rose from 14% to 25%. Experts say it’s not clear why the shift is happening and say more research is needed. Alzheimer’s disease is a progressive brain disorder that’s most common in the elderly. The Alzheimer’s death rate has risen 55% since 1999 and the disease is the nation’s sixth leading cause of death. There’s no known cure. <https://goo.gl/IUZqij>

1. ‘Deaths from Alzheimer’s Disease – United States, 1999-2014,’ Centers for Disease Control & Prevention, May 2017. <https://goo.gl/Mghlnu>

Noted in Media Watch 13 March 2017, #503 (p.3):

- *FORBES* | Online – 7 March 2017 – ‘**Alzheimer’s staggering \$259 billion cost could break Medicare.**’ 5.5 million Americans are living with Alzheimer’s dementia and most of them are over the age of 65.¹ Meanwhile, the disease is taking a financial toll on a U.S. healthcare system that provides more Americans healthcare coverage given the lack of treatments to reduce the prevalence and severity of the disease. Medicare and Medicaid pay for about two-thirds, or \$175 billion, of the “total healthcare and long-term care payments for people with Alzheimer’s and other dementias,.” <https://goo.gl/EbKfD3>

1. ‘Alzheimer’s Disease Facts & Figures,’ Alzheimer’s Association, Chicago, Illinois, March 2017. <https://goo.gl/bndlll>

N.B. Additional articles on end-of-life care for people living with Alzheimer’s and other forms of dementia are noted in the 9 January 2017 issue of Media Watch (#494, p.8).

Extract from Centers for Disease Control report

Most Alzheimer’s decedents died in a nursing home or long-term care facility in 1999 (67.5%) and 2014 (54.1%). The percentage who died in a medical facility declined from 14.7% in 1999 to 6.6% in 2014. In contrast, the percentage who died at home increased from 13.9% in 1999 to 24.9% in 2014, with an additional 6.1% who died in a hospice facility in 2014.

Putting a lid on waste: Needless medical tests not only cost \$200 billion – they can do harm

KAISER HEALTH NEWS | Online – 24 May 2017 – It's common knowledge in medicine that doctors routinely order tests on hospital patients that are unnecessary and wasteful. There are plenty of opportunities to trim waste in America's \$3.4 trillion health care system ...but, it's often not as simple as it seems. Some experts estimate that at least \$200 billion is wasted annually on excessive testing and treatment. This overly aggressive care also can harm patients, generating mistakes and injuries believed to cause 30,000 deaths each year. <https://goo.gl/E3xqL3>

Specialist Publications

'Making recommendations for limiting care in the ICU based on sound prognosis' (p.9), in *Journal of the American Medical Association*.

N.B. The author of the *Kaiser Health News* article cites a recent study from Massachusetts' The Lowin Institute. The study reads, in part: "Many patients at the end-of-life (EoL) receive very intense treatment in the hope of extending their lives. However, that treatment is often futile, and it can be painful, undignified, and expensive. Patients and clinicians are often reluctant to have frank conversations about what patients want at the EoL, but those conversations are crucial to avoid causing unnecessary suffering for dying patients." <https://goo.gl/DyURco> **BRA**

Study finds fewer blood cancer patients get hospice care

UNITED PRESS INTERNATIONAL | Online – 22 May 2017 – A study by the Dana-Farber Cancer Institute examined the cause for why hematologic oncologists refer their patients to hospice at significantly lower rates.¹ Findings in a national survey suggest concerns about the efficacy of hospice may be preventing blood cancer specialists from referring patients to hospice. Researchers surveyed a national sample of 349 hematologic oncologists from the clinical directory of the American Society of Hematology and found that 46% of oncologists believed home hospice care was inadequate for the needs of blood cancer patients compared to inpatient hospices with round-the-clock care, despite more than 68% of hematologic oncologists strongly agreeing that hospice care in general is helpful for patients with blood cancers. More than half of respondents said they would be more likely to refer patients to hospice if red cell and/or platelet transfusions were available. Research showed blood cancer patients are not only less likely to receive hospice care but when they enroll, they spend less time in hospice care compared to patients with other types of cancer. <https://goo.gl/hAKHsC>



1. 'Why are patients with blood cancers more likely to die without hospice?,' *Cancer*, published online 22 May 2017. <https://goo.gl/PNT020>

Noted in Media Watch 18 July 2016, #471 p.10):

- *JOURNAL OF CLINICAL ONCOLOGY* | Online – 11 July 2016 – '**Barriers to quality end-of-life care for patients with blood cancers.**' In this national survey of [U.S.] hematologic oncologists, standard end-of-life (EoL) quality measures were highly acceptable. The top barrier to quality EoL care reported was unrealistic patient expectations, which may be best addressed with more timely and effective advance care discussions. <http://goo.gl/ZrtxyJ>

Noted in Media Watch 28 December 2015, #442 (pp.3-4):

- *U.S. NEWS & WORLD REPORT* | Online – 21 December 2015 – '**End-of-life talk often comes too late for blood cancer patients.**' Many doctors wait too long to have end-of-life (EoL) discussions with blood cancer patients, a new study finds.¹ The lack of a clearly defined point when there is no remaining hope for blood cancer patients may contribute to delays in EoL. The findings show that blood cancer specialists are aware of gaps in EoL care for their patients, but are uncertain how to tackle the issue.² <http://goo.gl/01tJ87>

1. 'Timeliness of end-of-life discussions for blood cancers: A national survey of hematologic oncologists,' *JAMA Internal Medicine*, published online 21 December 2015. <http://goo.gl/kuEIHb>
2. 'Addressing end-of-life quality gaps in hematologic cancers: The importance of early concurrent palliative care,' *JAMA Internal Medicine*, published on 21 December 2015. <http://goo.gl/VlnSBt>

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- **THE WASHINGTON POST** | Online – 25 May 2017 – **‘It’s not pain but “existential distress” that leads people to assisted suicide, study suggests.’** Allowing assisted dying to come into the open has helped us gain insights about one of the most fundamental questions of our existence: where humans draw the line between choosing life and choosing death. But a [recent] ... suggests the answers may be surprising: The reasons patients gave for wanting to end their lives had more to do with psychological suffering than physical suffering.¹ Canada's Medical Assistance in Dying law, or MAiD, allows for adults with serious and incurable diseases in an advanced state to seek help. At the University Health Network, which operates four large hospitals, patients must go through several levels of evaluations, and if they meet the criteria, they can come to the hospital to receive a lethal medication intravenously. For many people, death from a terminal illness may be synonymous with pain. Much of the discussion about assisted suicide focuses on compassionate palliative care for cancer patients and about suffering that can't be controlled by even the strongest opioids. But that's not what the people in the new study report. <https://goo.gl/w9Vuul>

1. ‘Medical assistance in dying: Implementing a hospital-based program in Canada,’ *New England Journal of Medicine*, 2017;376(21):2082-2088. <https://goo.gl/f8WVhf>

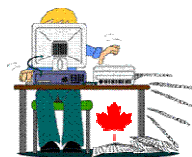
- **MAINE** | *The Portland Herald* – 23 May 2017 – **‘Maine House rejects ‘death with dignity’ bill.’** The bipartisan 85-61 vote against the bill followed lengthy and oftentimes emotional debate among lawmakers sharing personal stories of watching loved ones battle terminal diseases. The so-called “death with dignity” bill had passed the Maine Senate by a single vote last week, but faced a potential veto from Governor Paul LePage even if it had passed the House. <https://goo.gl/OXRIKP>
- **NEVADA** | *Reno Gazette-Journal* – 23 May 2017 – **‘Senate passes bill permitting doctor-assisted suicide.’** The Senate voted 11-10 to approve a physician-assisted suicide bill that gives terminally-ill patients the option to end their life. The bill would allow doctors to prescribe terminally-ill residents of the state at least 18-year-old with pharmaceuticals intended to end the patient’s life. Patients would have to be diagnosed with a terminal disease by two doctors and be found competent. Next of kin would have to be notified before the final decision as well. Doctors would not be required by law to prescribe the drugs if they have reservations. The bill now moves to the Assembly. <https://goo.gl/YbQyQr>

Specialist Publications

‘Early experience with the California End-of-Life Option Act: Balancing institutional participation and physician conscientious objection’ (p.15), in *JAMA Internal Medicine*.

‘Reconsidering physician aid-in-dying’ (p.16), in *Minnesota Medicine*.

‘Evaluating the American Nurses Association’s arguments against nurse participation in assisted suicide’ (p.16), in *Nursing Ethics*.



Barry R. Ashpole

My involvement in hospice and palliative care dates from 1985. As a communications consultant, I’ve been involved in or responsible for a broad range of initiatives at the community, regional, provincial and national level. My current work focuses primarily on advocacy and policy development in addressing issues specific to those living with a terminal illness – both patients and families. In recent years, I’ve applied my experience and knowledge to education, developing and teaching on-line and in-class college courses on different aspects of end-of-life care, and facilitating issue specific workshops, primarily for frontline care providers. Biosketch on the International Palliative Care Resource Center website at: <http://goo.gl/5CHoAG>

International

End-of-life care in Saudi Arabia

Dying well

SAUDI ARABIA | *Saudi Gazette* (Jeddah) – 25 May 017 – End-of-life (EoL) choices are considered a recent development in medicine, in general, and can still engender heated debates and discussions worldwide. In Saudi Arabia, it is a very culturally sensitive subject in addition to the fact that there is an absolute absence of national regulations regarding EoL options in hospitals. Instead, EoL options are governed by a fatwa, religious decree, issued in 1988 by the Presidency of the Administration of Islamic Research and Ifta, which states that: “If three knowledgeable and trustworthy physicians agree that the patient’s condition is hopeless, the life-supporting machines can be withheld or withdrawn. The opinion of family members is not included in the decision making as they are unqualified to make such decisions.” The fatwa includes specifications of hopeless cases and considers the option of refraining from treatment as well as do not resuscitate, which occurs when the patient’s heart stops and doctors attempt to revive it, as it is equivalent to life-supporting machines. As for euthanasia or assisted suicide, it is not an option because it is forbidden in Islam. It is understood that regulations, in general, in Saudi Arabia are based on Islamic teachings, but there must be nationally enacted regulations in the first place to avoid confusion and misunderstandings. <https://goo.gl/IJsduS>

Noted in Media Watch 10 April 2017, #507 (p.10):

- *AVICENNA JOURNAL OF MEDICINE*, 2017;7(2):35-45. ‘**Do not resuscitate, brain death, and organ transplantation: Islamic perspective.**’ Muslim patients and families are often reluctant to discuss and accept fatal diagnoses and prognoses. In many instances, aggressive therapy is requested by a patient’s family, prolonging the life of the patient at all costs. Islamic law permits the withdrawal of futile treatment, including life support, from terminally ill patients allowing death to take its natural course. “Do not resuscitate” is permitted in Islamic law in certain situations. <https://goo.gl/NW9OkG>

N.B. Additional articles on the Islamic perspective on end-of-life and end-of-life care are noted in the 14 November 2016 issue of Media Watch (#487, p.11).

Australian Institute of Health & Welfare

Palliative care need rising in Australia

AUSTRALIA | Special Broadcasting Service – 24 May 2017 – A higher proportion of the Australian population is going to hospital for end-of-life care than ever before. New data ... shows that palliative care (PC) hospitalisations are growing faster than all other hospitalisations – increasing to 19% between 2010-2011 to 2014-2015. This is greater than the 15% increase recorded for hospitalisations for all reasons over the same period. In 2014-2015, about 155,600 people died in Australia, and almost half died as an admitted patient in hospital. Just over half of PC patients were aged 75 and over, and a similar proportion involved cancer as the main diagnosis. <https://goo.gl/GNPJfg>

1. ‘Palliative care services in Australia,’ Australian Institute of Health & Welfare, Canberra, Australian Capital Territory, May 2017. <https://goo.gl/nstjoi>

Related

- AUSTRALIA (New South Wales) | *The Northern Daily Leader* (Tamworth) – 22 May 2017 – ‘**Palliative care roundtable comes to Tamworth for answers.**’ She’s charged with looking after the state’s regional health system, but Leslie Williams came to Tamworth with no solutions for the region’s cries for better palliative care services. But the parliamentary secretary was willing to listen. While the MP said things could be done better, what exactly will be done will remain unclear until mid-to-late June, when a discussion paper will be released and more public comment is sought. <https://goo.gl/AXdV3v>

Cont.

Noted in Media Watch 30 May 2016, #464 (p.6):

- AUSTRALIA | ABC News – 24 May 2016 – ‘**Ageing population blamed for 80% increase in palliative care spending.**’ In 2013-2014, \$5.3 million in palliative care (PC) medicine services was paid from the Medicare Benefits Schedule, up from \$3 million five years prior, according to a new report.¹ Spending remained relatively steady in 2014-2015, at just over \$5.3 million. The report also revealed a nation-wide increase in the number of people admitted to both private and public hospitals to receive PC. <http://goo.gl/odQDIK>

1. ‘Palliative Care Services in Australia 2016,’ Australian Institute of Health & Welfare, Canberra, Australian Capital Territory, May 2016. <http://goo.gl/aA60BK>

Elder care in England & Wales

National Health Service faces staggering increase in cost of elderly care, academics warn

U.K. (England & Wales) | *The Guardian* – 24 May 2017 – The National Health Service and social care system in the U.K. is facing a staggering increase in the cost of looking after elderly people within the next few years, according to new research which shows a 25% increase in those who will need care between 2015 and 2025.¹ Within eight years, there will be 2.8 million people over 65 needing nursing and social care, unable to cope alone, says the research – largely because of the toll of dementia in a growing elderly population. The research ... says that cases of disability related to dementia will rise by 40% among people aged 65 to 84, with other forms of disability increasing by about 31%. <https://goo.gl/a0ZLQu>

1. ‘Forecasted trends in disability and life expectancy in England and Wales up to 2025: A modelling study,’ *Lancet Public Health*, published online 23 May 2017. <https://goo.gl/Q0vkYp>

Doctors [in Ireland] added by do not resuscitate orders

IRELAND | *The Sunday Times* (London, England) – 21 May 2017 – One-third of doctors do not fully understand what is meant by a “do not resuscitate” (DNR) order, according to a study by the School of Medicine at University College Cork.¹ The survey of hospital physicians working in Cork teaching hospitals found that 35% of those questioned demonstrated an incorrect understanding of DNR orders that relate solely to non-resuscitation of a patient during cardiopulmonary arrest. The study suggests that some of the confusion arises out of the lack of guidelines in Ireland on DNRs. Many doctors believed that DNRs relate to the complete withdrawal of care, with no further effort to be made to preserve life. The research concluded that a “substantial proportion” of hospital doctors have an “incomplete understanding” of the issue. Of the 103 doctors interviewed, 45.9% stated they had the knowledge to draft a DNR but almost half of this same group, 48.7%, chose an incorrect definition when provided with three options. Neither clinical specialty nor experience had any bearing on this level of understanding. The survey also revealed considerable confusion about whether a doctor had the right to overrule a DNR. When asked this question, 33.3% said they believed they had this right. <https://goo.gl/2wuh5K>

1. ‘Doctors’ attitudes towards the introduction and clinical operation of do not resuscitate orders (DNRs) in Ireland,’ *Irish Journal of Medical Science*, published online 16 May 2017. <https://goo.gl/QON9Yr>

Noted in Media Watch 1 February 2016, #447 (p.12):

- *IRISH MEDICAL TIMES* | Online – 27 January 2016 – ‘**Guide on consent law due.**’ In July 2015, legislative provisions relating to advance healthcare directives were incorporated into the Assisted Decision-Making (Capacity) Bill 2013. The policy states that decisions about CPR must be made on a case-by-case basis and not based on, for example, age, disability, the subjective views of healthcare professionals regarding the individual’s quality of life or whether they live in the community or in long-term care. In addition, it states that such decisions should be made in the context of the individual’s overall goals and preferences for treatment and care as well as the likelihood of success and potential risks. <http://goo.gl/KQHnEV>

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- AUSTRALIA (Tasmania) | ABC News – 24 May 2017 – ‘**Tasmania votes down voluntary euthanasia bill for third time in 10 years.**’ Tasmania's Lower House has voted down voluntary euthanasia legislation that would have allowed people to end their own lives in certain medical circumstances. MPs were allowed a conscience vote on the Voluntary Assisted Dying Bill, with eight voting for, and 16 voting against the bill. Premier Will Hodgman said he remained concerned about the vulnerable and suggested it was not the end of the debate. <https://goo.gl/GwD01A>

Specialist Publications

“It’s not just the word care, it’s the meaning of the word...(they) actually care”: Caregivers’ perceptions of home-based primary care in Toronto, Ontario

AGEING & SOCIETY | Online – 18 May 2017 – The frail and homebound older adult populations currently experience difficulties accessing primary care in the medical office. Given this fundamental access to care problem, and the questionable care quality that arises when navigating a labyrinthine health-care system, these populations have typically been subject to inadequate primary care. To meet their needs better, growing research stresses the importance of providing comprehensive home-based primary care (HBPC), delivered by an inter-professional team of health-care providers. Family caregivers typically provide the majority of care within the home, yet their perceptions of HBPC remain under-researched. Findings [of this study] suggest that, compared to the standard office-based care model, HBPC may better support unpaid caregivers, providing them assistance with system navigation and offering them the peace of mind that they are not alone, but have someone to call should the need arise. The implications of this research suggest that HBPC could be a model to help mitigate the discontinuities in care that patients with comorbid chronic conditions and their attendant unpaid caregivers experience when accessing fragmented health, home and social care systems. <https://goo.gl/kZCUnl>

Related

- *JOURNAL OF PAIN MANAGEMENT*, 2017;10(1):107-115. ‘**Barriers to home death for Canadian cancer patients: A literature review.**’ This paper reviews the literature to identify barriers experienced by Canadian cancer patients and families when trying to arrange for or achieve a home death. A comprehensive literature search was performed across several databases to locate relevant studies. Barriers were defined as amendable determinants which may be changed with appropriate resources and policies. Four major barriers were identified: 1) Inadequacy of support services; 2) Insufficiency of family caregivers; 3) Inadequacy of home locations and sizes; and, 4) Discontinuity of care by family physicians. <https://goo.gl/o6DIM7>
 1. ‘Palliative Care at the End of Life,’ Health Quality Ontario, June 2016. [Noted in Media Watch 4 July 2016, #469 (p.2)] <http://goo.gl/GW0Xh9>
- *MÉDECINE PALLIATIVE* | Online – 23 May 2017 – ‘**Gap in end-of-life medical care at home.**’ The causes of medical abandonment in at home end of life situations are numerous: 1) Patients are not informed of the end of curative possibilities, preventing the anticipation of the palliative care needs at home; 2) Default of communication between hospital and city-based professionals; 3) Absence or weak involvement of the general practitioner; 4) Withdrawal of the hospital physician when there is no longer a curative possibility; and, 5) Lack of financial resources of the local actors. This article suggests a few recommendations to improve the situation. <https://goo.gl/RXxLvX>

N.B. French language article.

Making recommendations for limiting care in the ICU based on sound prognosis

JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION | Online – 21 May 2017 – A revolution in psychologic research in the latter half of the 20th century upended the notion of human decision making as essentially rational, with choices driven by calculation and optimization. Rather, humans are decision makers highly influenced by how choices are framed, by their prior experience, and by many other influences not readily apparent at the time decisions are made. Decision making is particularly complex in and around care of critically ill patients, given the quantity and complexity of data being collected as well as the rapid-time course of events. Such patients are often incapacitated, with the added complexity that many decisions are therefore made by family members. Even when clinicians frame likely outcomes as best they can, families may be subject to optimism bias when interpreting the information.¹ Regrettably, much more effort has been spent considering how to improve the quality of the decision making and less on how to improve the accuracy of prognostic information used in the decisions. <https://goo.gl/mBVwU5>

1. 'Surrogate decision makers' interpretation of prognostic information,' *Annals of Internal Medicine*, 2012; 12(156):360-366. [Noted in Media Watch 12 March 2012, #244 (p.9)] <https://goo.gl/tdVv29>

Related

- *HEC FORUM* | Online – 22 May 2017 – '**Assessing decision making capacity for do not resuscitate requests in depressed patients: How to apply the "communication" and "appreciation" criteria.**' A patient's decision-making capacity may come under question when distortions in thinking and understanding due to illness, delirium, depression or other psychiatric symptoms are identified or suspected. Physicians and other healthcare professionals working in hospital settings where medical illness is frequently co-morbid with depression, adjustment disorders, demoralization and suicidal ideation, can expect to encounter ethical tension when medically sick patients who are also depressed or suicidal request do not resuscitate orders. <https://goo.gl/3eV1uL>

Providing end-of-life care in disability community living services: An organizational capacity-building model using a public health approach

JOURNAL OF APPLIED RESEARCH IN INTELLECTUAL DISABILITIES | Online – 25 May 2017 – There is broad consensus within the disability field that the end-of-life care (EoLC) offered to people with intellectual disabilities should be of a quality consistent with that advocated by contemporary palliative care (PC). In practice, however, various barriers are encountered when applying PC strategies to the EoLC of people with intellectual disabilities, particularly those in disability community living services. There is a strong relationship between organizational structure and culture, and both influence end-of-life practice in community living services. Barriers to good practice arise from the differing attitudes of paid carers involved, and from uncoordinated approaches reflecting misaligned service systems in the disability and PC fields. Organizational reorientation is crucial to achieving sustainable change that will support healthy dying. The authors outline an organizational model they have developed from public health principles to manage EoLC in community living services. <https://goo.gl/Dbb5qV>

Related

- *JOURNAL OF APPLIED RESEARCH IN INTELLECTUAL DISABILITIES* | Online – 25 May 2017 – '**Emergency medical services providers' perspective of end-of-life decision making for people with intellectual disabilities.**' Emergency medical services (EMS) providers are often called to rapidly determine and act upon patients' wishes for end-of-life care (EoLC). People with intellectual disabilities are living increasingly longer with complex conditions leading to international calls for person-centred advance care planning. Yet, best estimates suggest that very few people with intellectual disabilities document their wishes. Findings of this study indicate that 62.7% had treated a person with intellectual disability who had medical orders directing EoLC. Three themes (provider familiarity, organizational processes, socio-cultural context) offer insights about how medical orders inform EMS providers during calls involving people with intellectual disabilities. <https://goo.gl/2im9Sm>

N.B. Additional articles on end-of-life care for people living with intellectual and developmental disabilities are noted in the 22 May 2017 issue of Media Watch (#513, p.15).

Exploring the utilization of end-of-life documentation among an online sample of sexual- and gender-minority individuals in the U.S.

JOURNAL OF GAY & LESBIAN SOCIAL SERVICES | Online – 19 May 2017 – Lesbian, gay, bisexual, transgender, and queer (LGBTQ) persons often receive end-of-life (EoL) care incongruent with wishes. Evidence with heterosexual samples supports associations among EoL documentation (e.g., do not resuscitate [DNR] orders, durable power of attorney for health care orders [DPOAH], living wills [LW]), and care consistent with wishes. However, little is known about the knowledge, attitudes, and willingness regarding utilization of these documents among LGBTQ persons. Of 107 participants, most had heard of each document (95% DNR, 91% DPOAH, 97% LW), but had not procured them (26% DNR, 50% DPOAH, 51% LW). Approximately one-third of respondents believed documents would be enforced more for heterosexual persons than themselves. This result indicates sexuality or gender minority-related stigma may be a barrier to document utilization. <https://goo.gl/IXIz8n>

N.B. Additional articles on end-of-life care for LGBT communities are noted in the 22 May 2017 issue of Media Watch (#513, pp.18-19).

Evaluation of a chaplain residency program and its partnership with an in-patient palliative care team

JOURNAL OF HEALTH CARE CHAPLAINCY | Online – 23 May 2017 – In 2009, a consensus conference of experts in the field of spiritual care and palliative care (PC) recommended inclusion of board-certified professional chaplains with at least 1,600 hours of clinical pastoral education as members of PC teams. This study evaluates a clinical pastoral education residency program's effectiveness in preparing persons to provide spiritual care for those with serious illness and in increasing the PC team members' understanding of the chaplain as part of the PC team. Chaplain residents felt the program prepared them to provide care for those with serious illness. It also showed that chaplain residents and PC team members view spirituality as an integral part of PC and see the chaplain as the team member to lead that effort. Suggested program improvements include longer PC orientation period, more shadowing with PC team members and improved communication between PC and chaplain residents. <https://goo.gl/VVwQZc>

Cultural and religious considerations in cancer care. Where do desires for life-sustaining care and miracles come from

JOURNAL OF PAIN MANAGEMENT, 2017;10(1):49-57. A scoping review of the literature found that stronger religious beliefs are associated with a greater desire for and use of life-sustaining treatments, but that this use can be mitigated when medical teams provide spiritual support to their patients. Furthermore, relative to Caucasian, Hispanic and Swiss populations, African American and Indian cultures have increased desires for life-sustaining treatments. No studies provided empirical evidence on the desire for miracles in varying religious/cultural cohorts in the palliative cancer population, and thus this is an area for future research. <https://goo.gl/Z0oPwe>

N.B. Additional articles on religious coping in the context of end-of-life care are noted in the 13 March 2017 issue of Media Watch (#503, p.12).

Noted in Media Watch 8 May 2017, #511 (p.14):

- *JOURNAL OF PALLIATIVE MEDICINE* | Online – 7 April 2017 – **'Hooray for chaplains! How do we prove their value.'** From a brief perusal of the literature, it appears proving the obvious – chaplains help patients and families – is both hard research to do and hard research to fund. The importance of understanding and proving the sacred work of chaplains is only becoming more important lest we risk losing them as members of the team. <https://goo.gl/nejtQ2>
- *JOURNAL OF PALLIATIVE MEDICINE* | Online – 6 April 2017 – **'In the chaplain's shadow.'** I saw the chaplain in a different light, saw how he – not the doctors – had positioned himself to help the man at the very crux of his suffering. He was in the right place. And the clearer the light, the sharper the shadow. For the first time, I recognized that for many patients, we doctors, whether we perceive it or not, live in the chaplain's shadow. <https://goo.gl/qov69w>

Cont.

Noted in Media Watch 6 February 2017, #498 (p.11):

- *JOURNAL OF PALLIATIVE MEDICINE* | Online – 1 February 2017 – ‘**Chaplains working in palliative care: Who they are and what they do.**’ Half of survey respondents reported frequently participating in palliative care rounds. Primary chaplain activities were relationship building, care at the time of death, and helping patients with existential issues or spiritual distress. Over half reported addressing goals of care 60% of the time or more. <https://goo.gl/hpZOyu>

Hospice-appropriate universal precautions for opioid safety

JOURNAL OF HOSPICE & PALLIATIVE NURSING, 2017;19(3):256-260. Universal precautions for opioid safety... is one approach to managing the epidemic of prescription pain medication misuse that has been used in pain clinics, primary care practices, and in some hospices. In this project, a set of hospice-appropriate universal precautions was designed, drawing on hospice nursing strengths, and implemented in a mid-size hospice agency. <https://goo.gl/7Wg1TE>

End-of-life care for glioblastoma patients at a large academic cancer center

JOURNAL OF NEURO-ONCOLOGY | Online – 20 May 2017 – Glioblastoma (GBM) is a universally fatal disease, complicated by significant cognitive and physical disabilities, inherent to the disease course. The purpose of this study was to retrospectively analyze end-of-life care (EoLC) for GBM patients at an academic center and compare utilization of these services to national quality of care guidelines, with the goal of identifying opportunities to improve EoLC. Using electronic medical records and hospice records, of 100 patients, 76 were referred to hospice. Despite the poor survival and changes in mental capacity associated with this disease, only 40% of individuals had documentation of code status and only 17% had any documentation of advance directives (ADs). None had documentation by a health care provider of a formal symptom, psychosocial, or spiritual assessment at greater than 50% of clinic visits. Only 17% used chemotherapy in their last month of life. 37% were hospitalized in the last month of life for an average of 9 days. Documentation of palliative care and end-of-life (EoL) measures could improve quality of care for GBM patients, especially in the use of ADs, symptom, spiritual, and psychosocial assessments, with earlier use of hospice to prevent EoL hospitalizations. <https://goo.gl/LOk4Eu>



Noted in Media Watch 19 November 2012, #280 (p.11):

- *NEURO-ONCOLOGY*, 2012;14(Suppl 4):iv3-iv7. ‘**Neuro-oncology and palliative care: A challenging interface.**’ For patients with end-stage Glioblastoma, a palliative care (PC) cost-effectiveness study of 141 patients who died during an observation period demonstrated a reduction in need for re-hospitalization prior to death for those receiving home-based PC of 8.3% compared with 26.8% of those not receiving support, despite a similar median survival time in both groups of 13 and 11 months, respectively. Costs associated with hospitalization per patient dying were found to be substantially different, with those for home-based PC costing 2% of those for non-PC (€517 vs €24,076 per patient hospitalization). <https://goo.gl/urC0Z0>

Palliative Care Network Community

Closing the Gap Between Knowledge & Technology

<http://goo.gl/OTpc8I>

Best practices in children's bereavement: A qualitative analysis of needs and services

JOURNAL OF PAIN MANAGEMENT, 2017; 10(1):119-126. Themes are divided into two major sections: 1) Unique aspects of children's grief; and, 2) Recommended practices. Experts noted that children may experience grief in short spurts and then return to their daily activities, that some children may grieve at each developmental stage and milestone, and that children may try to console their parents at the expense of addressing their own grief. Recommendations include using proper medical terminology and avoiding euphemisms, normalizing grief, peer support with other bereaved children, and therapies in addition to one-on-one counselling such as art therapy and play therapy, among others. There is consistent evidence throughout the lit-

erature and agreed upon by experts regarding how children experience grief and what services should be available to them. Expert knowledge and recommendations can be situated in theoretical knowledge on grief, the dual process model of coping, and the chronic sorrow model. <https://goo.gl/zm4nRO>



Related

- *PALLIATIVE & SUPPORTIVE CARE* | Online – 22 May 2017 – ‘**The emergence of personal growth amongst healthcare professionals who care for dying children.**’ The positive effects of caregiving constitute a newly emerging outcome that has been relatively unexplored in the pediatric literature, and yet they may play an important role in contributing to the satisfaction and well-being of the healthcare professionals who care for children who have a life-limiting illness. Three dimensions of personal growth were most consistently reported [in this interview-based study]: 1) New or altered life perspectives; 2) Enhanced personal resources; and, 3) Benevolence. A deeper understanding of the phenomenon of personal growth could help healthcare organizations to implement innovative approaches that would counterbalance compassion fatigue, and thereby enhance both healthcare provider well-being and child and family outcomes. <https://goo.gl/2GgBsi>
- *DEATH STUDIES* | Online – 25 May 2017 – ‘**Siblings’ voices: A prospective investigation of experiences with a dying child.**’ Sibling relationships reflect a unique childhood bond, thus the impact on a sibling when a child is seriously ill or dying is profound. The authors conducted a study over two years using interpretive descriptive methodology to understand siblings’ perspectives when a brother or sister was dying at home or in hospital. The insights from the 10 siblings revealed complex experiences, both personal and with the ill child, their families, and peers. These experiences were paradoxically sources of strain and of support, revealing the importance of validation and normalization in assisting siblings to successfully navigate the experience. <https://goo.gl/059E9o>

Palliative care in the Flemish Region of Belgium

Improving comfort around dying in elderly people: A cluster randomised controlled trial

THE LANCET | Online – 16 May 2017 – Over 50% of elderly people die in acute hospital settings, where the quality of end-of-life care is often sub-optimum. The authors assessed the effectiveness of the Care Programme for the Last Days of Life (CAREFuL) at improving comfort and quality of care in the dying phase in elderly people. 451 (11%) of 4,241 beds in ten hospitals were included in the analyses. Five hospitals were randomly assigned to standard health care practice and five to the CAREFuL programme; 118 patients in the control group and 164 in the CAREFuL group were eligible for assessment. Assessments were done for 132 (80%) of 164 patients in the CAREFuL group and 109 (92%) of 118 in the control group by nurses, and 48 (29%) in the CAREFuL group and 23 (19%) in the control group by family carers. Implementation of CAREFuL compared with control significantly improved nurse-assessed comfort... Although a continuous monitoring of the programme is warranted, results suggest that implementation of CAREFuL might improve care during the last days of life for patients in acute geriatric hospital wards. <https://goo.gl/m39U83>

Cont.

Related

- *NEUROLOGY* | Online – 24 May 2017 – ‘**Early transition to comfort measures only in acute stroke patients: Analysis from the Get With The Guidelines – Stroke registry.**’ Among 963,525 patients from 1,675 hospitals, 54,794 (5.6%) had an early comfort measures only (CMO) order... Early CMO use varied widely by hospital (range 0.6%-37.6% overall) and declined over time (from 6.1% in 2009 to 5.4% in 2013). In multivariable analysis, older age, female sex, white race, Medicaid and self-pay/no insurance, arrival by ambulance, arrival off-hours, baseline non-ambulatory status, and stroke type were independently associated with early CMO use (vs no early CMO). <https://goo.gl/29NVrI>

Noted in Media Watch 22 May 2017, #513 (p.11):

- *BMC PALLIATIVE CARE* | Online – 19 May 2017 – ‘**Improving hospital-based end-of-life care processes and outcomes: A systematic review of research output, quality and effectiveness.**’ Publications examining end-of-life care (EoLC) in hospitals are predominately descriptive in nature, with few rigorous trials of interventions aimed at improving the care of the dying. More high-quality intervention trials in hospitals are required to make clear recommendations about which strategies are most effective in improving EoLC processes, and whether these improvements translate to improved end-of-life outcomes. Interventions targeting both the patient and their substitute decision maker, and those strategies with the potential to change practice patterns at a system level should be explored. <https://goo.gl/2sVJun>

A review of specialist palliative care provision and access across London – mapping the capital

LONDON JOURNAL OF PRIMARY CARE, 2017;9(3):33-37. This is the first time London-wide data has been collected about specialist palliative care (SPC) services. It demonstrates that SPC services are available across London at home, in hospital, and in hospices in weekday working hours. However, SPC out-of-hours service availability falls short of national guidance and accepted best practice. London SPC services see a disproportionate number of people with cancer ... although the data analysed show that London SPC services are seeing more patients with non-malignant disease than the national average. The analysis of this data is limited by the fact that the authors were not able to collect patient level data. They were also unable to report on quality outcome measures outside service availability and diagnoses as there are no nationally accepted measures of SPC outcomes or service quality to act as benchmarks. The anticipated launch of a national individual-level data-set in 2017 of SPC services including demographic details, activity information and patient outcomes data will be an important milestone towards providing evidence on outcomes, and (in the longer term) facilitating genuine equity of access across London. <https://goo.gl/cl1db8>

Noted in Media Watch 14 March 2016, #453 (p.7):

- U.K. (England) | London Assembly Health Committee – 8 March 2016 – ‘**Dying well depends on where you live.**’ The London Assembly Health Committee has investigated the issue of end-of-life care (EoLC) and found that only 8 out of 33 London Clinical Commissioning Groups scored above the national average for EoLC quality indicators and fewer than half of local authorities include EoLC within their health and wellbeing strategies. <https://goo.gl/2HIQzo>

Noted in Media Watch 26 October 2015, #433 (p.6):

- U.K. (England) | Pan-London End-of-Life Alliance – 19 October 2015 – ‘**Is London the worst place to die?**’ A report by the Economist Intelligence Unit ranked the U.K. as the best country in the world for end-of-life care (EoLC) services.¹ However, the quality of EoLC received in London currently underperforms against national averages.² The London Assembly Health Committee will examine EoLC in the capital and the barriers certain groups face. <http://goo.gl/rMvweZ>

1. ‘2015 Quality of Death Index: Ranking Palliative Care Across the World,’ Economist Intelligence Unit, October 2015. [Noted in Media Watch 12 October 2015, #431 (p.6)] <http://goo.gl/wcwa0I>

2. ‘A review of specialist palliative care provision and access across London,’ London Cancer Alliance, PallE8 & Marie Curie, 18 September 2015. [Noted in Media Watch 21 September 2015, #428 (p.5)] <https://goo.gl/Gacy6g>

The Supportive Hospice and Aged Residential Exchange (SHARE) programme in New Zealand

NURSE EDUCATION IN PRACTICE | Online – 22 May 2017 – Research indicates that staff in aged residential care may be unprepared for their role in palliative care (PC) provision. In collaboration with a local hospice, the project piloted an innovative problem-based experiential learning intervention ... to enhance aged residential care staff PC skills. Results from the SHARE pilot indicate that the intervention overall is seen as a success, especially in relation to advanced care planning documentation. Relationships between hospice and facility staff, and consequently facility staff and residents are seen as the key to the success of the project. Staff survey results indicated increased confidence in PC delivery and decreased depression. Key lessons learnt from the development of any PC intervention within aged residential care include the importance of reciprocal learning, as well as the necessity of a strong partnership with key stakeholders. <https://goo.gl/18YYg3>

Children's hospice in the U.K.

One in four people are unaware of role of children's hospices

NURSING STANDARD | Online – 24 May 2017 – One in four people show a “worrying” lack of understanding about children's hospices and palliative care (PC), a survey shows.¹ U.K. charity Together for Short Lives asked people how they which words or phrases they would associate with children's hospices and PC and 26% said they did not know how to answer the question. The survey of more than 1,500 adults ... showed that over one in three people would not feel comfortable talking to a friend whose child had been diagnosed with a life-limiting or life-threatening condition. More than a third of those surveyed have had, or know someone who has had, some experience of serious childhood illness or a child dying young, the survey found. The survey shows there are still unhelpful myths about children's hospice care with people associating it with negative words or phrases like: “pain,” “suffering,” “tragic” and “distressing.” There are at least 49,000 children and young people in the U.K. living with a condition which means they may not reach adulthood. <https://goo.gl/p5KH2c>

1. ‘Taboos could be leaving families feeling isolated,’ Together for Short Lives, May 2017. Survey conducted by YouGuv.UK. <https://goo.gl/mshdb3>

Family members' experiences with intensive care unit diaries when the patient does not survive

SCANDINAVIAN JOURNAL OF CARING SCIENCES | Online – 19 May 2017 – Nine participants who read/wrote eight diaries in total were interviewed. The analysis revealed an overall theme “the diary was experienced as a bridge connecting the past with the future,” which was a metaphor referring to the temporal aspect where there was the period with the diary up until the patient's death and then the post-bereavement period. The diary contributed to both a rational and emotional understanding of the death of the patient and disclosed glimmers of light that still existed before the illness deteriorated. Further, the diary bridged the space between family members themselves and between family and nursing staff. It helped to maintain a feeling of togetherness and engagement in the care of the patient which family members found comforting. Family members of non-survivors had a need to have the intensive care unit time explained and expressed. The diary might work as a form of “survival kit” to gain coherence and understanding; to meet their needs during the hospital stay; and, finally, to act as a bereavement support by processing the death of the patient. <https://goo.gl/Fzi3z>



Media Watch Online

Media Watch (or a link to the weekly report) is posted on a number of websites that serve the hospice and palliative care community-at-large. Complete listing p.17.

Discussion Paper

Community-based models of care delivery for people with serious illness

U.S. NATIONAL ACADEMY OF SCIENCE | Online – 13 April 2017 – An expert panel recently convened by Pew Charitable Trusts and others concluded that a very small number of performance measures exist to assess care for the very final stage of life¹ – and even fewer to evaluate the care received by those struggling with serious illnesses over longer periods of time. Serious illness care programs serve some of the most vulnerable populations, including frail elders, people with physical and cognitive disabilities, those with life-threatening medical diagnoses, and those nearing the end of life. Proper oversight and transparency are key to early detection and remediation of barriers to access, as well as avoiding poor-quality care, including inappropriate under-treatment, unsafe environments, and excessive out-of-pocket expenditures. Further thought should be given to how best to ensure access to safe, high-quality care for all people in a geographic community, especially those who lack health insurance, have limited financial resources, or have no family members to serve as caregivers and advocates. There is a need to define the roles and responsibilities of health care organizations providing serious illness care to a specified patient population and social service and support organizations that serve an entire geographically-defined community. For many people, serious illness care requires a careful blend of health care and social supports. <https://goo.gl/XkWP7s>

1. 'Building additional serious illness measures into Medicare programs,' Pew Charitable Trusts, Washington DC, March 2017. <https://goo.gl/y4R4ju>

Noted in Media Watch 15 May 2017, #512 (p.8):

- *JOURNAL OF THE AMERICAN GERIATRIC SOCIETY* | Online – 9 May 2017 – '**A moving target: Medicare beneficiaries coming to the end of long lives.**' Few outpatient physicians manage their hospitalized patients. New specialists in palliative care consult to settle goals-of-care and advise about symptom management, but they rarely provide ongoing primary care around the clock. Hospice promises to stay with the individual and family through death and bereavement – but hospice serves most enrollees only for 1 or 2 weeks. Hospice programs often discharge very sick and disabled individuals when they live too long, thereby abrogating the promise of continuity. <https://goo.gl/lmQSmC>

Noted in Media Watch 24 April 2017, #509 (p.7):

- *AMERICAN JOURNAL OF HOSPICE & PALLIATIVE MEDICINE* | Online – 20 April 2017 – '**Expanding the palliative care domains to meet the needs of a community-based supportive care model.**' The current framework of palliative care domains in the National Consensus Project Guidelines for Quality Palliative Care offers an opportunity to reassess the domains of care delivered at home, earlier in the course of illness. The results of this study were used to inform a home-based, upstream model of supportive care for serious illness. <https://goo.gl/0zk9A3>

Assisted (or facilitated) death

Representative sample of recent journal articles:

- *JAMA INTERNAL MEDICINE* | Online – 22 May 2017 – '**Early experience with the California End-of-Life Option Act: Balancing institutional participation and physician conscientious objection.**' Effective since 9 June 2016, the California End-of-Life Option Act allows physicians to provide prescriptions for a lethal dose of medication to patients with a terminal illness, decision-making capacity, and a prognosis of less than 6 months to live. The patient can ingest the medication and end his or her life. The act outlines specific processes for physicians, patients, and health care systems to ensure that patients to whom the law applies receive all needed information regarding their options for end-of-life care and are neither impaired nor coerced into making such a profound decision. Although similar to laws in Oregon and Washington, the California law will sunset in 10 years if the state takes no further action. <https://goo.gl/1Oq4B5>

Cont.

- *JOURNAL OF PAIN MANAGEMENT*, 2017;10(1):9-13. **'Finding a home (somewhere) for medical aid in dying.'** Recent alterations to the criminal code following the passing of Bill C-14 have made Medical Aid in Dying (MAiD) legal in Canada. With the new legislation in place, institutional questions arise concerning how MAiD should be provided within the health care system. Alternatively, what are the limitations of conscientious objection to MAiD? Palliative Care Units (PCUs) are in dire need of the answers to these questions, as they face contrary obligations towards patients requesting MAiD. MAiD seems to contradict some of the principle values of palliative care (PC), while PC patients are also in a condition where they more likely to be eligible for MAiD. Yet, examining some of these value contradictions more closely, there are more commonalities between MAiD and PC than it would first seem. As a result, if PCUs conscientiously object to MAiD as departments, then they are neglecting to fulfill their responsibility to honor their own missions and values. These commonalities in value between MAiD and PC have clinical implications, as many of the patients who would prefer PC are also patients who would consider pursuing MAiD concurrently. Three cases where patients could request both MAiD and PC are outlined. They reveal a risk that a departmental conscientious objection to MAiD in the PCU comes at the expense of patients receiving necessary PC. <https://goo.gl/44qo50>

- *MINNESOTA MEDICINE* | Online – Accessed 27 May 2017 – **'Reconsidering physician aid-in-dying.'** The Oregon experience has proven that control of physician aid-in-dying is possible with appropriate restrictions, guidelines and monitoring, and that there has been no demonstrable harm to society or the medical profession. We must strengthen the doctor-patient relationship with our commitment to create an environment of trust and communication based on our deep understanding of the patient's beliefs, values and goals. We do so by no longer defining ourselves as healers; we can't focus just on life but on the reality of the individual's life experiences in the context of the human life cycle, which includes death. If the suffering, terminally ill person has mental capacity and finds their life to be no longer meaningful, we physicians should be legally allowed to medically help them achieve a gentle death <https://goo.gl/vTj7wi>

- *NURSING ETHICS* | Online – 23 May 2017 – **'Evaluating the American Nurses Association's arguments against nurse participation in assisted suicide.'** This discussion paper critically assesses the American Nurses Association's stated arguments against nurse participation in assisted suicide... Seven distinct arguments can be gleaned from the Association's statement, based on: 1) The Association's Code of Ethics with Interpretive Statements and its injunction against nurses acting with the sole intent to end life; 2) The risks of abuse and misuse of assisted suicide; 3) Nursing's social contract or covenant with society; 4) The contention that nurses must not harm their patients; 5) The sanctity of life; 6) The traditions of nursing; and, 7) The fundamental goals of nursing. Each of these arguments is evaluated, and none are found to be convincing. <https://goo.gl/bj4HSO>

- *SINGAPORE ACADEMY OF LAW JOURNAL* | Inprint – 19 May 2017 – **'The case against physician-assisted suicide and voluntary active euthanasia: A jurisprudential consideration.'** Twenty years after the Advance Medical Directive Act came into force in Singapore, the issue of the legalisation of physician-assisted suicide and voluntary active euthanasia remains live. By examining jurisprudential arguments, this article makes a case against legalisation. In particular, it is important to address the points raised in the [2010] article by Toh Puay San and Stanley Yeo¹ ... as it is possibly the most comprehensive local article on this subject... As the authors also consider the arguments often raised in debates on euthanasia, it is apposite to approach the jurisprudential consideration by countering their arguments. <https://goo.gl/ZSMKLS>
 1. 'Decriminalising physician-assisted suicide in Singapore,' *Singapore Academy of Law Journal*, 2010; 22(1):379-412. <https://goo.gl/8K8lzk>

[Media Watch: Editorial Practice](#)

Each listing in Media Watch represents a condensed version or extract of what is broadcast, posted (on the Internet) or published; in the case of a journal article, an edited version of the abstract or introductory paragraph, or an extract. Headlines are as in the original article, report, etc. There is no editorializing ... and, every attempt is made to present a balanced, representative sample of "current thinking" on any given issue or topic. The weekly report is issue-oriented and offered as a potential advocacy, research and teaching tool.

Cont.

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Something Missed or Overlooked?

If you are aware of a current report, article, etc., relevant to hospice, palliative care or end-of-life issues not mentioned, please alert this office (contact information below) so that it can be included in a future issue of Media Watch. Thank you.

Media Watch: Online

International

INTERNATIONAL ASSOCIATION FOR HOSPICE & PALLIATIVE CARE: <https://goo.gl/JXsJtr>

INTERNATIONAL PALLIATIVE CARE RESOURCE CENTER: <http://goo.gl/frPgZ5>

PALLIATIVE CARE NETWORK COMMUNITY: <http://goo.gl/8JyLmE>

PALLIMED: <http://goo.gl/7mrgMQ> [Scroll down to 'Aggregators' and Barry Ashpole and Media Watch]

Asia

ASIA PACIFIC HOSPICE PALLIATIVE CARE NETWORK: <HTTP://GOO.GL/JNHVMB>

SINGAPORE | Centre for Biomedical Ethics (CENTRES): <https://goo.gl/JL3j3C>

Canada

ONTARIO | HPC Consultation Services (Waterloo Region Wellington County): <https://goo.gl/IOSNC7>

Europe

EUROPEAN ASSOCIATION FOR PALLIATIVE CARE: <http://goo.gl/o7kN3W> [Scroll down to International Palliative Care Resource Center – IPCRC.NET]

HUNGARY | Hungarian Hospice Foundation: <http://goo.gl/5d1I9K>

U.K. | Omega, the National Association for End-of-Life Care: <http://goo.gl/UfSZtu>

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