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.*

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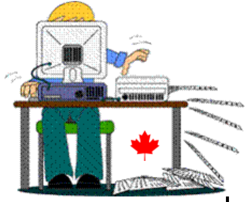

Compiled & Annotated by Barry R. Ashpole

The illness experience: Scroll down to Specialist Publications and 'Examining end-of-life case management: Systematic review' (p.12), in *Nursing Research & Practice*.

Canada

End of life health services on Vancouver Island are improving ... slowly

BRITISH COLUMBIA | *The Campbell River Mirror* – 28 August 2014 – Coordination between the Province, regional health authorities, various hospice societies, and communities is helping improve the availability and quality of end of life services for Vancouver Island residents. A priorities update report from Island Health (formerly the Vancouver Island Health Authority) regarding Island Health's End of Life Pogram was released in June, which analyzes and makes recommendations on data regarding EOL care in the region.[1] "Unfortunately, many people who are dying may end up in acute care during the last weeks of life when that is neither their care preference, nor their need," according to the report, and it re-evaluates the program's priorities to mitigate that fact. Based on the report's findings, 45% of the approximately 6,000 people per year who die on Vancouver Island of natural causes die in an acute care location, such as a hospital, compared to 27% who end their lives in "residential services," and 19% who die at home, "with support from Home and Community Care." Seven per cent pass away in a palliative care facility or hospice. http://www.campbellrivermirror.com/news/273093431.html

1. 'Island Health's End of Life: Priorities Update,' June 2014. http://www.viha.ca/NR/rdonlyres/C5CDC971-A3B6-4899-AF88-ECBB1A4601A5/0/ENDOFLIFEPROGRAM_01Aug14_WEB.pdf

Noted in Media Watch, 1 April 2013, #299 (p.2):

- BRITISH COLUMBIA | 1130 Radio News (Vancouver) – 25 March 2013 – **'Province introduces plan to improve end-of-life care.'** Dying-with-dignity is the goal of a new plan by the province to improve end-of-life care.[1] http://www.news1130.com/2013/03/25/bc-introduces-plan-to-improve-end-of-life-care/

    1. 'The Provincial End-of-Life Care Action Plan for British Columbia: Priorities & Actions for Health System & Service Redesign,' British Columbia Ministry of Health, March 2013. http://www.health.gov.bc.ca/library/publications/year/2013/end-of-life-care-action-plan.pdf

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- *THE GLOBE & MAIL* | Online – 27 August 2014 – **'Assisted suicide: It happens, but in a grey legal area.'** End-of-life decision making is once again in the national spotlight. Psychotherapist Gillian Bennett passed, leaving an eloquent argument for choice; Justice Minister Peter McKay labelled the issue "emotional and divisive" and stayed the course; and Conservative MP Steven Fletcher called for a parliamentary debate. As the national discussion evolves, it will be helpful to appreciate the broader legal context in which it sits. Right now, federal law is clear: No doctor-assisted death, period. However, due to several structural features deliberately built into the Constitution and legal process, what appears to be a rigid ban is actually far more nuanced. And this built-in nuance is necessary to manage the inevitable conflict between static laws, evolving social values, and the fluid moral messiness of everyday life. http://www.theglobeandmail.com/globe-debate/assisted-suicide-it-happens-but-in-a-grey-legal-area/article20217770/

- CANADA.COM | Online – 26 August 2014 – **'Doctor-assisted death appropriate only after all other choices exhausted, Canadian Medical Association president says.'** Doctor-hastened death would only be appropriate after all other reasonable choices have been exhausted, says the head of the country's largest doctors' group. Dr. Chris Simpson, newly installed president of the Canadian Medical Association, made the comments in advance of a landmark Supreme Court of Canada hearing expected to add fuel to the emotional end-of-life debate gaining urgency across Canada. Simpson said there are enough doctors in Canada willing to perform doctor-hastened death, if the federal ban outlawing euthanasia were lifted. But doctors first need safeguards to protect the vulnerable and a strategy to urgently shore up palliative care "so that this is not seen as a first, or second or even third choice, but a choice that's appropriate for people after all other reasonable options are exhausted," he said. http://o.canada.com/news/national/doctor-assisted-death-appropriate-only-after-all-other-choices-exhausted-cma-president-says

U.S.A.

Coverage for end-of-life talks gaining ground

THE NEW YORK TIMES | Online – 30 August 2014 – Five years after it exploded into a political conflagration over "death panels," the issue of paying doctors to talk to patients about end-of-life care is making a comeback, and such sessions may be covered for the 50 million Americans on Medicare as early as next year. Bypassing the political process, private insurers have begun reimbursing doctors for these "advance care planning" conversations as interest in them rises along with the number of aging Americans. People are living longer with illnesses, and many want more input into how they will spend their final days, including whether they want to die at home or in the hospital, and whether they want full-fledged life-sustaining treatment, just pain relief or something in between. Some states ... recently began covering the sessions for Medicaid patients. But far more significant, Medicare may begin covering end-of-life discussions next year if it approves a recent request from the American Medical Association [AMA], the country's largest association of physicians and medical students. http://www.nytimes.com/2014/08/31/health/end-of-life-talks-may-finally-overcome-politics.html

Cont. next page

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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.16.

Of related interest:

- NATIONAL PUBLIC RADIO | Online – 27 August 2014 – **'Hello, may I help you plan your final months?'** Imagine you're at home. You have cancer. You just had another round of chemo, and the phone rings. "My name is Kate. I'm a health care counselor," the gentle voice of the caller says from her cubicle in Cherry Hill, New Jersey. This is not a typical telemarketing call. She wants to talk with you about your serious illness and, eventually, if you're ready to think about it, what you'd like to have happen at the end of your life. Kate Schleicher, 27,is a licensed clinical social worker. At the start of the call, she knows almost as little about you as you know about her. Except she has your phone number, she knows the name of your insurance carrier (the insurance company provided your phone number), and she knows that you're pretty sick. http://www.npr.org/blogs/health/2014/08/27/339861118/hello-may-i-help-you-plan-your-final-months

Fears of addiction keep cancer patients from getting pain relief

REUTERS | Online – 29 August 2014 – Fears of opioid abuse and addiction might be keeping patients with advanced cancer from getting enough pain medicine, researchers say. "At the end of life, we should feel comfortable providing whatever necessary to control pain," said Joel Hyatt, assistant regional director at Kaiser Permanente. Concerns about overdose and addiction ... should not prevent terminally ill patients from obtaining relief. Opioid overuse and abuse are a widespread problem that gets lots of attention in the news media – and that may keep cancer patients and doctors from using them appropriately. http://uk.reuters.com/article/2014/08/29/us-cancer-pain-addiction-idUKKBN0GT27H20140829

When medical care is futile, other patients pay the hidden price

NATIONAL PUBLIC RADIO | Online – 26 August 2014 – Every day in intensive care units across the country, patients get aggressive, expensive treatment their caregivers know is not going to save their lives or make them better. California researchers now report this so-called "futile" care has a hidden price: It's crowding out other patients who could otherwise survive, recover and get back to living their lives. Their study[1] ... shows that patients who could benefit from intensive care in UCLA's teaching hospital are having to wait hours and even days in the emergency room and in nearby community hospitals because ICU beds are occupied by patients receiving futile care. http://commonhealth.wbur.org/2014/08/cost-futile-care

1. 'The opportunity cost of futile treatment in the ICU,' *Critical Care Medicine*, 2014;42(9):1977-1982. Although futile treatment is acknowledged as a misuse of resources ... no study has evaluated ... how it affects care for others. [Noted in Media Watch, 25 August 2014, #372 (p.9)] http://journals.lww.com/ccmjournal/Abstract/2014/09000/The_Opportunity_Cost_of_Futile_Treatment_in_the.2.aspx

Healthcare fears, end-of-life decisions loom large in same-sex marriage cases

INDIANA | Associated Press – 25 August 2014 – When Niki Quasney felt a piercing pain in her ribcage in March, the oncologist treating her advanced ovarian cancer told her to get to an emergency room immediately. But instead of making the short drive to a hospital near her home in Munster, Indiana, she drove alone for more than 40 minutes to one in neighboring Illinois. Quasney said she was "terrified" her local hospital might not allow her and her partner of more than 13 years, whom she wed last year in another state, to be together if she suffered a health emergency. Quasney and her partner, Amy Sandler, are among dozens of couples challenging Indiana's and Wisconsin's gay marriage bans in a case being heard in the 7th U.S. Circuit Court of Appeals in Chicago. Looming large in the case is the issue of medical emergencies faced by same-sex couples. The couples are suing for the right to marry or to have their out-of-state marriages recognized in their home states. They argue that powers of attorney and domestic partner registries don't guarantee they'll be allowed to make critical end-of-life or life-saving decisions. http://www.lgbtqnation.com/2014/08/healthcare-fears-end-of-life-decisions-loom-large-in-same-sex-marriage-cases/

Hospice oversight may come from rare bipartisan health bill

FORBES | Online – 24 August 2014 – Bipartisan congressional legislation designed to bring more frequent surveys to hospice providers in hopes of increasing quality, transparency and accountability has emerged in the U.S. House of Representatives with the backing of the industry and both political parties. The legislation ... comes following criticism in government watchdog reports. Last year, for example, a report by the U.S. Department of Health & Human Services' Office of Inspector General [OIG] found that frequency of surveys of hospice were inconsistent and it was common that facilities would go years without an evaluation.[1] A *Washington Post* series running this month called the 'Business of Dying' has also outlined problems.[2] Many of those with infrequent surveys were cited for quality and other violations of inadequate care. In 12 states, the OIG said, "more than 25% of hospices had not been recertified within the previous six years." But the new proposed legislation, known as the Hospice Act, would create a three-year recertification cycle compared to the current six to eight-year cycles, according to Reed's office. http://www.forbes.com/sites/brucejapsen/2014/08/24/hospice-oversight-may-come-from-rare-bipartisan-health-bill/

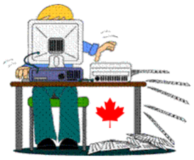
1. 'Frequency of Medicare recertification surveys for hospices is unimproved,' Office of the Inspector General, Department of Health & Human Services, 29 August 2013. [Noted in Media Watch, 9 September 2013, #322 (p.11)] http://oig.hhs.gov/oei/reports/oei-06-13-00130.asp

2. 'Is that hospice safe? Infrequent inspections mean it may be impossible to know,' *The Washington Post*, 26 June 2014. [Noted in Media Watch, 30 June 2014, #364 (p.3)] http://www.washingtonpost.com/business/economy/is-that-hospice-safe-infrequent-inspections-means-it-may-be-impossible-to-know/2014/06/26/e258e880-eaa4-11e3-b98c-72cef4a00499_story.html

N.B. *The Washington Post* series is noted in Media Watch, 25 August 2014, #372 (p.11).

Medicare star ratings allow nursing homes to game the system

THE NEW YORK TIMES | Online – 24 August 2014 – The Medicare ratings, which have become the gold standard across the industry, are based in large part on self-reported data by the nursing homes that the government does not verify. Only one of the three criteria used to determine the star ratings – the results of annual health inspections – relies on assessments from independent reviewers. The other measures – staff levels and quality statistics – are reported by the nursing homes and accepted by Medicare, with limited exceptions, at face value. The ratings also do not take into account entire sets of potentially negative information, including fines and other enforcement actions by state, rather than federal, authorities, as well as complaints filed by consumers with state agencies. Widespread acceptance of the ratings is leading to their use beyond the elder-care industry. http://www.nytimes.com/2014/08/25/business/medicare-star-ratings-allow-nursing-homes-to-game-the-system.html



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://www.ipcrc.net/barry-r-ashpole.php

International

End-of-life care in Australia

Indigenous patients face too many barriers to seeing specialists, say doctors

AUSTRALIA | *The Guardian* (U.K.) – 27 August 2014 – Access to government-subsidised medical specialists for Aboriginal and Torres Strait Islander people is piecemeal and rife with barriers, according to the leading organisation representing physicians and paediatricians in Australia. Indigenous Australians used specialists 178 times less per 1,000 people compared to the general community, the president of the Royal Australasian College of Physicians, Professor Nicholas Talley, told a national forum of indigenous health experts... This was despite Indigenous people having greater health needs. "Clearly the college and many other health organisations are concerned about closing the gap, and there is still a very significant gap," he said. Following the forum, the college will present the federal assistant health minister, Fiona Nash, with a proposal for a national specialist access plan that could be included in the national Aboriginal and Torres Strait Islander health plan...[1] http://www.theguardian.com/society/2014/aug/27/indigenous-patients-too-many-barriers-specialists-doctors

Palliative & End of Life Care:
A Blueprint for Improvement

AUSTRALIA (New South Wales) | Agency for Clinical Investigation Palliative Care Network – September 2014 – This report has been developed to provide a flexible guide for health services to meet the needs of people approaching and reaching the end of life, their families and carers. It emphasises the need for an integrated approach to care whereby relationships between specialist palliative care providers and care providers across all settings of care are fostered. It seeks to enhance networks of support, to build skills and competence in providing care to those approaching and reaching the end of their lives across all care settings, and to better support patients, families and carers along the way ... [and] ... guide services and Local Health Districts in constructing ... localised models of care. http://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0007/240100/progress-report-palliative-and-end-of-life-care-a-blueprint-for-improvement.pdf

1. 'National Aboriginal & Torres Strait Islander Health Plan, 2013-2023,' Department of Health. The Plan provides a long-term, evidence-based policy framework as part of the overarching Council of Australian Governments' approach to closing the gap in indigenous disadvantage. http://www.health.gov.au/internet/publications/publishing.nsf/Content/oatsih-healthplan-toc

Noted in Media Watch, 13 May 2013, #305 (p.16):

- *RURAL & REMOTE HEALTH* | Online – 8 May 2013 – **'Considering Aboriginal palliative care models: The challenges for mainstream services.'** Aboriginal people in Australia account for a very small proportion of the population, have poorer health outcomes and their culture demonstrates a clear resistance to accessing mainstream health services which are viewed as powerful, isolating and not relevant to their culture, way of life, family and belief systems. Aboriginal people regard their land as spiritual and their culture dictates that an Aboriginal person needs to know their origins, emphasising the value placed on kin and also demonstrating a strong desire to remain within their own country. Currently Aboriginal people tend to not access palliative care services in mainstream facilities; and there is very little data on Aboriginal admissions to palliative care centres. Over the last two decades only two models of palliative care focusing on and developed in Aboriginal communities have been implemented. http://www.rrh.org.au/articles/subviewaust.asp?ArticleID=2339

End-of-life care in New Zealand

Patient numbers overtake hospice funding

NEW ZEALAND | *Bay of Plenty Times* (Tauranga) – 26 August 2014 – The number of patients under Waipuna's Hospice care has increased by more than 100% over the past four years and funding has not kept up with the rapid increase. Chief executive Dr. Richard Thurlow said in 2010 it had 140 patients on its books "at any one time" compared to 292 now. Its funding model with the Bay of Plenty District Health Board had also dropped from 70% received in 2009 to 56% funding. The hospice has adapted by adopting smarter strategies. http://www.nzherald.co.nz/bay-of-plenty-times/news/article.cfm?c_id=1503343&objectid=11314293

Noted in Media Watch, 30 September 2013, #325 (p.5):

- NEW ZEALAND | *The Waikato Times* – 27 September2013 – **'Hospice hit hard by "double-whammy."'** In its 2012-2013 report Hospice Waikato revealed while referrals to its services had gone up by 28%, income from grants had gone down by $177,000 over the same period. http://www.stuff.co.nz/waikato-times/news/9215575/Hospice-hit-hard-by-double-whammy

End-of-life care Scotland

Percentage of end of life spent at home or in a community setting

U.K. (Scotland) | National Services Scotland – 26 August 2014 – In total, for all people dying in Scotland during 2012-203 the percentage of the last 6 months of life spent at home or in a community was 91.2% continuing the trend of marginal increases year on year since 2008-2009 when the rate was 90.4%. Across health boards the percentage of the last 6 months of life spent at home or in a community setting varied between 89.0% and 93.9% in part reflecting the different use of community hospitals in different parts of the country. The percentage of the last 6 months of life spent at home or in a community setting does not vary greatly but tends to be slightly lower among those in most deprived areas (89.9%) compared to less deprived areas (91.8%) and lower in large urban areas (90.2%) compared to remote areas (93.9%). There is little difference between males and females in the percentage of the last 6 months of life spent at home or in a community setting, while the oldest patients aged 85+ had the highest percentage at 92.2%. https://isdscotland.scot.nhs.uk/Health-Topics/Health-and-Social-Community-Care/Publications/2014-08-26/2014-08-26-End-of-Life-Care-Report.pdf?15012758971

Easing the pain and fears of dying children

SOUTH AFRICA | *The Times* (Johannesburg) – 25 August 2014 – "Am I going to die?" The first time a child asked paediatrician Michelle Meiring this question she was shocked. "Sometimes doctors lie," not wanting to tell the child the truth, says Meiring. In her opinion the correct response is: "What makes you think that?" And then to explore their fears... Meiring works with children who have incurable illnesses. Based at the Sarah Fox Convalescent Hospital in Athlone, Cape Town, she was last week awarded a Discovery Foundation fellowship to complete her PhD on paediatric palliative care. http://www.timeslive.co.za/thetimes/2014/08/25/easing-the-pain-and-fears-of-dying-children

Specialist Publications

'On the child's own initiative: Parents communicate with their dying child about death' (p.13), in *Death Studies*.

Cont.

Noted in Media Watch, 22 October 2012, #276 (p.9):

- *PROGRESS IN PALLIATIVE CARE* | Online – 15 October 2012 – **'The child's voice in pediatric palliative and end-of-life care.'** Although much is asked clinically and emotionally of children and adolescents who are receiving treatment for a life-threatening illness, they are not routinely asked how they experience the treatment intended to save or prolong their lives. http://www.ingentaconnect.com/content/maney/ppc/pre-prints/1743291X12Y.0000000035

Elder care in the U.K.

Homely touches vital in residential care, says Care Quality Commission

U.K. (England) **|** *Lexology* – 25 August 2014 – Care providers for the elderly will have to offer personalised environments with home comforts such as residents' own furniture and choice of decor, thanks to a new ruling. From October, any residential or care home deemed to be too institutional and impersonal will be downgraded in tougher inspections by the Care Quality Commission (CQC), which recently admitted being lax in its care home ratings.[1] Research has shown the distress caused by moving into a residential or care home can be eased with familiar belongings and homely surroundings, especially for people with dementia. The homeliness of the residents' environment will be just one of the comprehensive inspection criteria. The CQC's new system is its way of stepping up its inspections and reports, following its admission this month of failure to report adequately on care homes. http://www.lexology.com/library/detail.aspx?g=44e81b77-25d4-4abe-8fd3-f4df43db4cda

1. 'We failed elderly because we were too scared care home owners would sue us, watchdog admits,' *The Daily Telegraph*, 9 August 2014. [Noted in Media Watch, 18 August 2014, #371 (p.5)] http://www.telegraph.co.uk/health/healthnews/11021374/We-failed-elderly-because-we-were-too-scared-care-home-owners-would-sue-us-watchdog-admits.html

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- U.K. | *The Daily Telegraph* – 27 August 2014 – **'Is assisted suicide for the terminally ill all its supporters believe it to be?'** A common reason for supporting AS [assisted suicide] is because of a relative or friend who experienced a protracted distressing death. Publicity associated with several high-profile cases over the past few years has probably confirmed these beliefs. People often associate terminal cancer and/or dying with intractable pain and suffering. However, this need not be the case: leading palliative care doctors tell me that in 95% of cases the pain can be relieved, and significantly reduced in the remainder. Another reason for supporting AS is the incidence of death prolongation by overzealous medical interventions at the end of life. But this would seem to be a call for health professionals to better recognise when illness is terminal, and to switch from curative treatment to palliative care. We need to start asking questions such as: Is it appropriate to give antibiotics to a terminally ill patient who develops a chest infection? Or, as in the past, can pneumonia be regarded as the dying patient's friend? Palliative care is expensive. The average costs of inpatient hospice care is £3000-£4000/week. AS equates to a one-off payment of less than £500. The ongoing costs of long-term medical conditions are huge. In an age of austerity legalising AS may seem a good fiscal choice. http://www.telegraph.co.uk/health/11056235/Is-assisted-suicide-for-the-terminally-ill-all-its-supporters-believe-it-to-be.html

- CZECH REPUBLIC | Radio Prague – 25 August 2014 – **'Health minister reacts to suspected mercy killing, ruling out any legalization of euthanasia.'** Murder charges filed against a nurse suspected of aiding the death of a terminally-ill patient ... has refocused attention on the issues of euthanasia, palliative health care, and controls in the health sector. http://www.radio.cz/en/section/curraffrs/health-minister-reacts-to-suspected-mercy-killing-ruling-out-any-legalization-of-euthanasia

Cont.

- IRELAND | *The Independent* (Dublin) – 24 August 2014 – **'Assisted suicide bill to come before Dáil.'** Left Alliance TD [Teachta Dála] John Halligan will introduce a new bill on assisted suicide when the Dáil [i.e., the lower house of the Irish parliament] returns in the autumn. The Bill is being drafted with the assistance of Tom Curran, the widowed partner of Marie Fleming who lost a high profile Supreme Court case on the right-to-die.[1] The Supreme Court ruled that Ms. Fleming did not have the Constitutional right to die, or to be assisted to do so, but it said that there was nothing to prevent the introduction of legislation to deal with similar cases. http://www.independent.ie/irish-news/politics/assisted-suicide-bill-to-come-before-dail-30531625.html

    1. 'Marie Fleming loses Supreme Court right-to-die case,' *The Independent* (Dublin), 29 April 2013. [Noted in Media Watch, 6 May 2013, #304 (p.6)] http://www.independent.ie/irish-news/courts/marie-fleming-loses-supreme-court-righttodie-case-29228686.html

- U.K. (England) | *The Daily Mail* – 23 August 2014 – **'Most doctors oppose assisted dying.'** Fewer than one in five doctors would be willing to help patients end their lives, according to a new poll. Lord Falconer's Assisted Dying Bill – which is being considered by Parliament – would offer the chance of assisted dying to terminally ill patients deemed mentally capable and within six months of likely death. But a survey of 600 doctors by the Medix found that 60 % are against a change in the law to allow physician-assisted suicide. This is a rise of 17 points from the last time the same question was asked – just 43% were against a change in 2004. http://www.dailymail.co.uk/wires/pa/article-2732548/Most-doctors-oppose-assisted-dying.html

Specialist Publications (e.g., in-print and online journal articles, reports, etc.)

Student reflections from an online death and dying course

AMERICAN JOURNAL OF HOSPICE & PALLIATIVE MEDICINE | Online – 29 August 2014 – This study describes nursing students' reflections on taking an online course on death and dying. In a semi-structured paper, students described fears of caring for clients at end of life (EOL), important content learned, and remaining discomforts. Student reflections on the knowledge they gained closely followed initial fears. Several students appreciated the ability to reflect on their experiences in a non-judgmental setting. The data showed that nursing students can become more confident in EOL care through online education. Knowledge gains and continued fears about the same topics suggest EOL confidence lies along a continuum and may require ongoing education. http://ajh.sagepub.com/content/early/2014/08/28/1049909114549182.abstract

Noted in Media Watch, 26 November 2012, #281 (p.8):

- *BMJ SUPPORTIVE & PALLIATIVE CARE*, 2012;2(4):292-293. **'Can e-learning be used to teach end-of-life care?'** E-learning has been around for quite some time, but in terms of learning about end-of-life care, it is a relatively "new kid on the block." Many clinicians and educators regard e-learning with scepticism, especially in relation to a subject as personal and sensitive as end-of-life care. http://spcare.bmj.com/content/2/4/292.extract

Seeking worldwide professional consensus on the principles of end-of-life care for the critically ill: The Welpicus Study

AMERICAN JOURNAL OF RESPIRATORY & CRITICAL CARE MEDICINE | Online – 27 August 2014 – No abstract available. Subscription to the journal is required to access the article. http://www.atsjournals.org/doi/abs/10.1164/rccm.201403-0593CC

Media Watch posted on Palliative Care Network-e Website

Palliative Care Network-e (PCN-e) promotes education amongst health care providers in places around the world where the knowledge gap may be wider than the technology gap ... to foster teaching and interaction, and the exchange of ideas, information and materials. http://www.pcn-e.com/community/pg/file/owner/MediaWatch

A qualitative study exploring use of the surprise question in the care of older people: Perceptions of general practitioners and challenges for practice

BMJ SUPPORTIVE & PALLIATIVE CARE | Online – 28 August 2014 – The question "Would you be surprised if this patient were to die in the next 6-12 months?" has been included in U.K. palliative care guidance with the aim of supporting the identification and care planning of those nearing the end of life. Little is known about how the surprise question is utilised in the care of older people within primary care. This study sought to explore the perceptions and experiences of general practitioners (GPs). Data discussing 22 clinical cases revealed the difficulties experienced by GPs when assessing prognosis for older people with non-malignant conditions, despite their recognition of multiple mortality risk factors and high symptom burden. GPs did not appear to include the surprise question within their usual practice and expressed concerns regarding its use to facilitate discussion of advance care plans. These concerns highlighted the subjective nature of the surprise question and potential barriers to conducting discussions of preferences for future care. http://spcare.bmj.com/content/early/2014/08/28/bmjspcare-2014-000679.abstract

Of related interest:

- *INNOVAIT* | Online – 26 August 2014 – **'Primary care management of palliative care emergencies.'** There are relatively few true emergencies in palliative care, but an ability to deal with those that do occur is crucial. Managing major haemorrhage, superior vena cava obstruction or terminal agitation may be a daunting prospect for GPs, and equipping ourselves with the necessary skill set in advance of needing to apply it is vital. In situations where immediate action is required, the goal is usually to prevent a sudden or catastrophic worsening in the patient's quality of life or symptoms, or to manage a potentially unpleasant mode of death. http://ino.sagepub.com/content/early/2014/08/20/1755738014545898.abstract

End-of-life treatment preferences: A key to reducing ethnic/racial disparities in advance care planning?

CANCER | Online – 21 August 2014 – Preferences against life-prolonging care differ dramatically by race/ethnicity, but they have a uniform significant association with DNR order completion rates across racial/ethnic groups of patients with advanced cancer. Non-Latino white patients were significantly more likely to have a DNR order (45%) than black (25%) and Latino (20%) patients. Advance care planning interventions that target preferences associated with DNR orders across racial/ethnic groups may reach a broad patient population and reduce end-of-life care disparities. http://onlinelibrary.wiley.com/doi/10.1002/cncr.28970/abstract;jsessionid=388BDAD169F97B024A56002CD8A15F26.f02t02?deniedAccessCustomisedMessage=&userIsAuthenticated=false

Of related interest:

- *CANCER* | Online – 21 August 2014 – **'Are patient preferences for end-of-life care socially influenced? Examining racial disparities in advance care planning.'** Future research should continue empirical investigations into the social influences and additional factors responsible for the modification of preferences among racially/ethnically diverse patients with terminal cancer... http://onlinelibrary.wiley.com/doi/10.1002/cncr.28969/abstract

How does involvement of a hospice nurse specialist impact on the experience on informal caring in palliative care? Perspectives of middle-aged partners bereaved through cancer

EUROPEAN JOURNAL OF CANCER CARE, 2014;23(5):701-711. Five main themes emerged [in this study] regarding the impact of the hospice nurse specialist (HNS) on informal caring: 1) "the ambivalence of caring"; 2) "the HNS as a 'confidante' in caring"; 3) "the HNS as a 'champion' in support"; 4) "the work of the HNS – an unseen benefit"; and, 5) "being prepared for death and bereavement." Findings offer insights into how involvement of a HNS impacts on the ability of carers to perform their role as an informal caregiver. They highlight a crucial need for carers to have a clear understanding of all aspects of the HNS role so that full benefit is derived from their input. http://onlinelibrary.wiley.com/doi/10.1111/ecc.12183/abstract

Reduction in the number of hospital beds in a super-aging society: An upsurge in isolation deaths

JOURNAL OF THE JAPAN HOSPITAL ASSOCIATION, 2014;(33):35-43. Local governments should do what they can to facilitate the opening of more specialized nursing homes. It is essential to provide hospital beds to elderly patients with the imminent risk of dying to prevent them from isolation deaths because it is a human right to die with dignity. In order to accommodate elderly patients who need extensive medical treatments and to provide an appropriate place for the point of death, more convalescent beds are needed. Collaboration with hospitals, local governments, and integrated community care support centers is the key to solving this problem. http://europepmc.org/abstract/med/25145114

Characteristics, interventions, and outcomes of lung transplant recipients co-managed with palliative care

JOURNAL OF PALLIATIVE MEDICINE | Online – 27 August 2014 – Lung transplantation (LT) recipients carry a high symptom burden. Palliative Care (PC) is a field of medicine focused on symptom control and psychosocial support, but transplant recipients are often referred to PC very late in the disease course, if at all. In authors' institution, the LT service has increasingly consulted PC to co-manage LT recipients with end-stage graft dysfunction or other terminal conditions. They present the characteristics, PC interventions used, and outcomes of these patients. LT recipients referred for PC ... [they] ... typically receive comfort medications and avoid the aggressive end-of-life care usually reported for this population. PC interventions on patient quality of life requires further study. http://online.liebertpub.com/doi/abs/10.1089/jpm.2014.0167

Noted in Media Watch, 27 January 2014, #342 (p.10):

- *EUROPEAN JOURNAL OF PALLIATIVE CARE*, 2014;21(1):30-33. **'More palliative care involvement is needed for transplant patients.'** Patients who have already received a transplant, as well as those who are on a waiting list for an organ transplant, have large unmet needs for high-quality palliative and end-of-life care.

  N.B. Access to the *European Journal of Palliative Care* requires a subscription: http://www.haywardpublishing.co.uk/ejpc.aspx

Noted in Media Watch, 8 July 2013, #313 (p.10):

- *PULMONARY & RESPIRATORY MEDICINE* | Online – 24 June 2013 – **'Barriers to the provision of optimal palliative care in a patient awaiting lung transplantation.'** This case report describes palliative and end of life care in a patient with end stage pulmonary fibrosis listed for lung transplantation and discusses the transition from curative restorative care and palliative care to end-of-life care. http://www.omicsonline.org/2161-105X/2161-105X-3-151.pdf

Burnout and death anxiety in hospice social workers

JOURNAL OF SOCIAL WORK IN END-OF-LIFE & PALLIATIVE CARE, 2014;10(3):219-239. Hospice work has been regarded as particularly stressful due to the complexity inherent in the provision of end-of-life care. Burnout and death anxiety are especially relevant to hospice social workers because they regularly function in a high-stress, high-loss environment. Key themes [to emerge in this study]: a) personal interest in hospice social work; b) although death anxiety decreased from exposure and understanding of the death process, there was increased anxiety surrounding working with certain patients; and, c) burnout was related to workload or difficult cases. http://www.tandfonline.com/doi/abs/10.1080/15524256.2014.938891?journalCode=wswe20

Team-based volunteerism with the seriously ill: A qualitative analysis from 10 volunteers' perspectives

JOURNAL OF SOCIAL WORK IN END-OF-LIFE & PALLIATIVE CARE, 2014;10(3):282-295. This study explored the experience of volunteers on teams organized initially as a grassroots movement in response to stigmatized and often socially isolated people with HIV/AIDS dying in the community. Volunteer care teams later expanded to individuals with other serious illnesses. This model spread as a means of meeting the growing need for practical support for seriously ill homebound individuals. Yet, little has been reported in the scientific literature about the interworkings of these teams and their optimal level of functioning. The volunteers [interviewed] discussed balance between positive life meaning gained from volunteer work, lessons learned, and negative aspects of a volunteer team approach to caring for the seriously ill in the community. http://www.tandfonline.com/doi/abs/10.1080/15524256.2014.938893#.U_yHM8VdX8k

Of related interest:

- *INTERNATIONAL JOURNAL OF NURSING STUDIES* | Online – 23 August 2014 – **'Does involving volunteers in the provision of palliative care make a difference to patient and family wellbeing? A systematic review of quantitative and qualitative evidence.'** This review identified some limited evidence that volunteers in direct care roles improve the wellbeing of patients and their families. More research is recommended to draw out more clearly the benefits and limitations of the involvement of volunteers in care. This is important as appropriate and effective deployment of volunteers may be a key part of the resources needed to enable future growth to match growing worldwide demand for palliative care. http://www.sciencedirect.com/science/article/pii/S0020748914002107

Spiritual needs of cancer patients important part of care

MEDSCAPE MEDICAL NEWS | Online – 21 August 2014 – After asking a patient if she would like to be prayed for, Caroline Petrie, a community nurse working in the U.K., was suspended from her job. Petrie faced disciplinary action and the possible loss of her job. At the time of the incident, she was told that she had to "demonstrate a personal and professional commitment to equality and diversity" and that she could not use her "professional status to promote causes that are not related to health." Petrie insisted that she never tried to force her religious beliefs on any of her patients, but simply asked if the patient wanted her to pray for her. Although she was reinstated, the incident highlights the "line in the sand" that is often drawn when it comes to mixing religion and medicine. The intersection between faith, science, and healing is still hazy for many practitioners, and some are uncomfortable bringing spiritual practice into the care paradigm. But in this era of increasingly holistic care, it has become clear religious and spiritual beliefs and practices are important to many patients. This can be particularly pronounced in people facing a potentially terminal disease ... where one's own mortality suddenly becomes very real. http://www.medscape.com/viewarticle/830317?nlid=63813_1842&src=wnl_edit_medp_wir&uac=213000DZ&spon=17

Noted in Media Watch, 9 February 2009, #83 (p.4):

- U.K. (England) | *The Daily Telegraph* (Editorial) – 3 February 2009 – **'National Health Service religion guidelines are bad for the nation's health.'** While I wasn't the reporter who broke the story of Caroline Petrie ... I am going to try to take some credit for being the first to write about the National Health Service's bizarre staff guidelines on religion.[1] http://blogs.telegraph.co.uk/martinbeckford/blog/2009/02/03/nhs_religion_guidelines_are_bad_for_the_nations_health

  1. 'Religion or belief: A practical guide for the National Health Service,' Department of Health, 2009. http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093133

Cont.

Of related interest:

- *JOURNAL OF RELIGION & SPIRITUALITY IN SOCIAL WORK*, 2014;33(3-4):353-376. **'The role of spirituality at end of life in Nova Scotia's black community.'** The purpose of this research was to examine the issue of spirituality from the perspective of family caregivers, and spiritual leaders... The authors explored how spirituality is expressed and how it serves as a coping mechanism during times of suffering and hardship at the end of life. http://www.tandfonline.com/doi/abs/10.1080/15426432.2014.930622#.VAIneMVdX8k

- *PAIN MEDICINE* | Online – 26 August 2014 – **'Spirituality: What is its role in pain medicine?'** Many authors and consensus panels have explored the concept and formulated a conceptual framework and an approach that is inclusive, accessible, relevant, and applicable to people with a wide range of health conditions. In addition, there is accumulating evidence that interventions that address the issue of spirituality have benefits for physical and emotional health. http://onlinelibrary.wiley.com/doi/10.1111/pme.12511/abstract

Examining end-of-life case management: Systematic review

NURSING RESEARCH & PRACTICE | Online – Accessed 25 August 2014 – Case management was initiated in the 1970s to reduce care discontinuity. A literature review focused on end-of-life (EOL) case management identified 17 research articles, with analysis revealing two themes: 1) seeking to determine or establish the value of EOL case management; and, 2) identifying ways to improve EOL case management. The evidence ... suggests that EOL case management is helpful to dying individuals and their families. http://www.hindawi.com/journals/nrp/2014/651681/

End-of-life care in the U.K.

Chief nurse orders review of DNR questionnaire after media outcry

NURSING STANDARDS | Online – 27 August 2014 – England's chief nurse Jane Cummings has promised to review the content of a form that prompts district nurses to discuss do-not-resuscitate orders with older patients during home visits. Ms. Cummings said that patients and clinical staff would help review the questionnaire after hearing "disturbing" accounts that nurses are asking the question in a "blunt and impersonal" way. http://rcnpublishing.com/doi/full/10.7748/ns.28.52.7.s2

Noted in Media watch, 25 August 2014, #372 (p.9):

- U.K. (England) | *The Daily Telegraph* – 20 August 2014 – **'Elderly patients asked during home visits by nurses: Would you want to be resuscitated?'** Nurses who have met the patients for the first time have questioned them about sensitive medical issues including whether they would want doctors to restart their heart if it stopped beating. http://www.telegraph.co.uk/health/nhs/11044923/Elderly-patients-asked-during-home-visits-by-nurses-Would-you-want-to-be-resuscitated.html

The *International Charter for Human Values in Healthcare*: An interprofessional global collaboration to enhance values and communication in healthcare

PATIENT EDUCATION & COUNSELING, 2014;96(3):273-280. The human dimensions of healthcare – core values and skilled communication necessary for every healthcare interaction – are fundamental to compassionate, ethical, and safe relationship-centered care. The objectives of this paper are to: describe the development of the *International Charter for Human Values in Healthcare*, which delineates core values, articulate the role of skilled communication in enacting these values, and provide examples showing translation of the Charter's values into action. The authors' identified five fundamental categories of human values for every healthcare interaction – compassion, respect for persons, commitment to integrity and ethical practice, commitment to excellence, and justice in healthcare – and delineated sub-values within each category. They have disseminated the Charter internationally and incorporated it into education/training. http://www.pec-journal.com/article/S0738-3991(14)00272-9/abstract

Characteristics of a pediatric hospice palliative care program over 15 years

PEDIATRICS | Online – 25 August 2014 – Pediatric palliative care has seen the adoption of several service provision models, yet there is minimal literature describing them. Canuck Place Children's Hospice (CPCH) is North America's first freestanding pediatric hospice. This study describes the characteristics of and services delivered to all children on the CPCH program from 1996 to 2010. The study cohort included 649 children. The majority of diagnoses belonged to cancers (30%), and diseases of the neuromuscular (20%), and central nervous systems (18%). The majority of deaths occurred among the cancer (45%), central nervous system (15%), and metabolic disease (14%) groups. By study end date, 24% of children were still alive, 61% died, and 15% transitioned to adult services (more than half of whom were cognitively competent). On average, 1024 days were spent on the CPCH program. The majority of inpatient hospice discharges were for respite (82%); only 7% were for end-of-life care. Location of death was shared between CPCH (61%), hospital (22%), and home (16%). Diagnostic groups largely determine the nature and magnitude of services used. Involvement with pediatric life-threatening conditions is increasing. http://pediatrics.aappublications.org/content/early/2014/08/19/peds.2014-0381

On the child's own initiative: Parents communicate with their dying child about death

DEATH STUDIES | Online – 25 August 2014 – Open and honest communication has been identified as an important factor in providing good palliative care. However, there is no easy solution to if, when and how parents and a dying child should communicate about death. This paper reports how bereaved parents communicated about death with their child dying from a malignancy. Communication was often initiated by the child and included communication through narratives such as fairy-tales and movies and talking more directly about death itself. Parents reported their child prepared for death by giving instructions about his or her grave or funeral and... http://www.tandfonline.com/doi/abs/10.1080/07481187.2014.913086?queryID=59%2F7515270

Of related interest:

- *ZEITSCHRIFT FÜR PALLIATIVMEDIZIN*, 2014;15(4):166-173. **'The perspective of children and youth with life-limiting conditions in research on pediatric palliative care: A literature review.'** This study discusses how the perspective of children and adolescents with a life-limiting condition is represented in paediatric palliative care research. The spectrum of diseases reached from oncological diseases to neurodegenerative disorders and HIV infections. Seven central aspects have been identified: 1) subjective experience; 2) to go through relationships and dying; 3) decision-making; 4) advance care planning; 5) communication; and, 6) family perspective. Affected children have a very differentiated view of their situation, which can differ from a third-party view. Future research should strongly focus on children's subjective beliefs and competencies. http://cat.inist.fr/?aModele=afficheN&cpsidt=28570018

  N.B. German language article.

Futility and orthotanasia: Medical practices from the perspective of a private hospital

REVISTA BIOÉTICA, 2014;22(2). Futility means therapeutic obstinacy to delay imminent death. Orthothanasia means death in its natural process, not prolonging treatment. The aim of this study was to analyze the perception of patients' family members in private general hospital on orthotanasia and futility... This was a cross-sectional, observational study, in which 190 families were interviewed... Most respondents (64.2 %) opted for the realization of futility as a conduct for their relative. Of the 122 participants who did not know the meaning of "terminal condition," 85.9% would choose futility. However, among those who knew what they meant, 70,9% would choose orthotanasia. The study indicates that this topic needs to be discussed by society, encouraging them to understand the individual and collective implications of life prolongations when suffering. http://www.scielo.br/scielo.php?pid=S1983-80422014000200018&script=sci_arttext

N.B. Portuguese language article.

Teaching communication skills: Using action methods to enhance role-play in problem-based learning

SIMULATION IN HEALTHCARE, 2014;9(4): 220-227. Role-play methods can be enhanced by techniques that are not widely used in medical teaching, including warm-ups, role-creation, doubling, and role reversal. The purposes of these techniques are to prepare learners to take on the role of others in a role-play; to develop an insight into unspoken attitudes, thoughts, and feelings, which often determine the behavior of others; and to enhance communication skills through the participation of learners in enactments of communication challenges generated by them. In this article, the authors describe a hypothetical teaching session in which an instructor applies each of these techniques in teaching medical students how to break bad news using a method called SPIKES (Setting, Perception, Invitation, Knowledge, Emotions, Strategy, and Summary). They illustrate how these techniques track contemporary adult learning theory through a learner-centered, case-based, experiential approach to selecting challenging scenarios in giving bad news, by attending to underlying emotion and by using reflection to anchor new learning. http://journals.lww.com/simulationinhealthcare/Fulltext/2014/08000/Teaching_Communication_Skills__Using_Action.2.aspx

Creating the final conversations scale: A measure of end-of-life relational communication with terminally ill individuals

JOURNAL OF SOCIAL WORK IN END-OF-LIFE & PALLIATIVE CARE, 2014;10(3):257-281. Final conversations (FCs) are defined as the communicative interactions, both verbal and non-verbal, that occur between terminally ill patients and relational partners. In this study, the Final Conversations Scale was developed and tested. A total of 152 participants that had engaged in final conversations with individuals that were terminally ill completed the newly developed instrument. Factor analysis produced a five-factor structure, including: 1) messages of spirituality/religion; 2) expressions of love; 3) proactive difficult relationship talk; 4) everyday communication; and, 5) talk about illness/death. Participants' perceptions of the relational closeness and difficulty with the deceased significantly influenced the individuals' recalled frequency of FCs messages. Practical and scholarly implications focus on the needs of the family members regarding their communication with terminally ill individuals, as well as directions for future research with the FCs Scale. http://www.tandfonline.com/doi/abs/10.1080/15524256.2014.938892#.U_yQQcVdX8k

Of related interest:

- *AMERICAN JOURNAL OF HOSPICE & PALLIATIVE MEDICINE* | Online – 27 August 2014 – **'Does the approach of disclosing more detailed information of cancer for the terminally ill patients improve the quality of communication involving patients, families, and medical professionals?'** This study revealed that disclosing more detailed information of cancer for terminally ill cancer patients contributed to improving the quality of communication... http://ajh.sagepub.com/content/early/2014/08/26/1049909114548718.abstract

Noted in Media Watch, 20 January 2014, #341 (pp.1-2):

- CANADA | *The National Post* – 14 January 2014 – **'Breaking bad news is never easy, but for doctors, there are better ways to do it.'** A 2000 study ... revealed just how frequently one slice of the medical profession has to do it: about 60% of the respondents, all oncologists, broke bad news between five and 20 times per month.[1] Another academic article ... speculates that a link, not yet clinically proven, may exist between doctor communication skills and better results for their patients.[2] http://life.nationalpost.com/2014/01/14/dr-aw-breaking-bad-news-is-never-easy-but-for-doctors-there-are-better-ways-to-do-it/

    1. 'SPIKES – A six-step protocol for delivering bad news: Application to the patient with cancer,' *The Oncologist*, 2000;5(4):302-311. http://theoncologist.alphamedpress.org/content/5/4/302.full.pdf+html

    2. 'Communication skills training for oncology professionals,' *Journal of Clinical Oncology*, 2012;30(11):1242-1247. http://jco.ascopubs.org/content/30/11/1242.abstract

Life-threatening illness in popular movies: A first descriptive analysis

SPRINGERPLUS | Online – 5 August 2014 – Thirty-five movies could be identified and were analyzed in detail and investigated the presentation of illness and death. The number of movies focusing on terminal illness, dying, and death has increased since 1991. The total number of movies that made the yearly German Federal Film Board hit list and included a focus on terminal illness, dying, and death increased from 1991 (1 movie) to 2011 (6 movies). The gender of the main characters suffering from terminal illness was distributed equally; three movies portrayed terminally ill children. The number of movies dealing with terminal illness continues to increase and a considerable audience has shown interest in these films. Due to a limited true-to-life performance in the films, a presentation closer to reality could be a major public educational resource. http://www.springerplus.com/content/3/1/411/abstract

Extra from *SpringPlus* article

More than one third of the terminally ill characters died in hospital. The terms "palliative" or "hospice care" were not mentioned once in any films.

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 and research tool.

Distribution

Media Watch is distributed at no cost to colleagues active or with a special interest in hospice, palliative care and end of life issues. Recipients are encouraged to share the weekly report with *their* colleagues. The distribution list is a proprietary one, used exclusively for the distribution of the weekly report and occasional supplements. It is not used or made available for any other purpose whatsoever – to protect the privacy of recipients and also to avoid generating undue e-mail traffic.

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5. Due to its relevance, an article may be listed but for which a link is not available; access, therefore, may only be possible directly from the source (e.g., publication) or through the services of a library.

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.

World hospice &
palliative care day

11 October 2014

Who Cares? We Do!

Home page: http://www.worldday.org/
Materials: http://www.worldday.org/materials/

Media Watch Online

International

INTERNATIONAL ASSOCIATION FOR HOSPICE & PALLIATIVE CARE: http://hospicecare.com/about-iahpc/newsletter/2014/5/media-watch/

INTERNATIONAL PALLIATIVE CARE RESOURCE CENTER: http://www.ipcrc.net/archive-global-palliative-care-news.php

PALLIATIVE CARE NETWORK COMMUNITY: http://www.pcn-e.com/community/pg/file/owner/MediaWatch

PALLIMED (Hospice & Palliative Medicine Blog): http://www.pallimed.org/2013/01/the-best-free-hospice-and-palliative.html [Scroll down to 'Aggregators' and Barry Ashpole and Media Watch]

Asia

ASIA PACIFIC HOSPICE PALLIATIVE CARE NETWORK: http://aphn.org/category/media-watch/

SINGAPORE | Centre for Biomedical Ethics (CENTRES): http://centres.sg/updates/international-palliative-care-resource-center-media-watch/

Australia

WESTERN AUSTRALIA | Palliative Care WA Inc: http://palliativecarewa.asn.au/site/helpful-resources/ [Scroll down to 'International Websites' and www.ipcrc.net/archive-global-palliative-care-news.php to access the weekly report]

Canada

ONTARIO | Central Regional Hospice Palliative Care Program: http://www.centralrhpcp.ca/Physicians/resources.htm?mediawatch=1

ONTARIO | Central West Palliative Care Network: http://cwpcn.ca/Health_Practitioners/resources.htm?mediawatch=1

ONTARIO | HPC Consultation Services (Waterloo Region/Wellington County): http://hpcconnection.ca/general-resources/in-the-news/

ONTARIO | Mississauga Halton Palliative Care Network: http://www.mhpcn.ca/Physicians/resources.htm?mediawatch=1

ONTARIO | Palliative Care Consultation Program (Oakville): http://www.acclaimhealth.ca/menu-services/palliative-care-consultation/resources/ [Scroll down to 'Additional Resources']

Europe

EUROPEAN ASSOCIATION FOR PALLIATIVE CARE: http://www.eapcnet.eu/Themes/Organization/Links.aspx [Scroll down to International Palliative Care Resource Center – IPCRC.NET]

Updated HUNGARY | Hungarian Hospice Foundation: http://hospicehaz.hu/alapitvanyunk/irodalom/nemzetkozi-kitekintes

U.K. | Omega, the National Association for End-of-Life Care: http://www.omega.uk.net/media-watch-hospice-palliative-care-and-end-of-life-news-n-470.htm?PHPSESSID=b623758904ba11300ff6522fd7fb9f0c

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