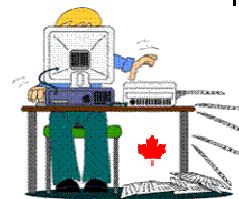


Media Watch...

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

Measuring what matters: Scroll down to [Specialist Publications](#) and 'Top-ranked quality indicators for hospice and palliative care from the American Academy of Hospice & Palliative Medicine and [U.S.] Hospice & Palliative Nurses Association' (p.11), *Journal of Pain & Symptom Management*.

Canada

Canada failing on palliative care

THE TORONTO STAR | Online – 17 February 2015 – Despite the impressive strides palliative care has taken – in areas such as pain and symptom management, and sensitivities to the psychosocial, existential and spiritual challenges facing dying patients and their families – at their time of licensure, physicians have been taught less about pain management than those graduating from veterinary medicine. Once in practice, most physicians have knowledge deficiencies that can significantly impair their ability to manage cancer pain. Doctors are also not generally well-trained to engage in end-of-life conversations, meaning that goals of care often remain unclear; and patients may not receive the care they want or the opportunity to live out their final days in the place they would want to die. In light of the [recent] Supreme Court's decision, these issues have never been more important, nor the need to resolve them ever more pressing. We are about to become a country that extends patients the right to a hastened death, but offers no legislative guarantees or assurances that they will be well looked after until they die. As Canada deliberates its response to the court's decision, federal and provincial governments will need to make substantive

investments in hospice and palliative care in order to offer patients and families choices that are equitable, compassionate and real. <http://www.thestar.com/opinion/commentary/2015/02/18/canada-failing-on-palliative-care.html>

[Specialist Publications](#)

'The Supreme Court of Canada ruling in *Carter v. Canada: A new era of end-of-life care for Canadians*' (p.16), in *Bioéthique*.

End-of-life care in Canada

Nine reports, published between 1995 and 2014, on the need to improve end-of-life care in Canada are listed in Media Watch dated 22 December 2014, #389 (p.4). See also the sidebar on p.3 of this issue of the weekly report on estimates of the access to palliative care in Canada.

N.B. The Economist Intelligence Unit rated Canada 9th of 40 countries surveyed in 'The Quality of Death: Ranking End-of-Life Care Across the World' (2010). http://graphics.eiu.com/upload/QOD_main_final_edition_Jul12_toprint.pdf

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- CTV NEWS | Online – 18 February 2015 – **'Liberals seek national debate on doctor-assisted suicide.'** The federal Liberals want the Harper government to launch a national debate on doctor-assisted suicide in the wake of this month's landmark Supreme Court decision. Liberal Leader Justin Trudeau says it's time for parliamentarians to tackle the thorny issue now that the high court has given Parliament 12 months to come up with a new law. Two weeks ago, the Supreme Court unanimously struck down the ban on providing a doctor-assisted death to patients who are mentally competent but suffering irremediable ailments. The high court suspended its judgment, giving Parliament a year to recognize the right of consenting adults with intolerable physical or mental suffering to seek medical help in ending their lives. At least six reform bills on right-to-die

issues have been defeated over the past two decades. Last fall, the Harper government said it would not support changing the *status quo*. <http://www.ctvnews.ca/politics/liberals-seek-national-debate-on-doctor-assisted-suicide-1.2242057>

[Corrections & Clarifications](#)

A Canadian Society of Palliative Care Physicians' position statement on "euthanasia and assisted suicide," dated February 2015, was noted in Media Watch of 9 February 2015 (#396, p.4) and of 16 February 2015 (#397, p.3). Between publication of the two issues of the weekly report, the Society posted on its website 'Position Statement: Following Supreme Court Judgement Re: Carter.' <http://www.cspcp.ca/wp-content/uploads/2014/10/CSPCP-Position-Following-SCC-Judgment-12-Feb-2015.pdf>

[U.S.A.](#)

Doctors strive to do less harm by inattentive care

THE NEW YORK TIMES | Online – 17 February 2015 – Suffering. The very word made doctors uncomfortable. Medical journals avoided it, instructing authors to say that patients "'have' a disease or complications or side effects rather than 'suffer' or 'suffer from' them," said Dr. Thomas H. Lee, the chief medical officer of Press Ganey, a company that surveys hospital patients. But now, reducing patient suffering – the kind caused not by disease but by medical care itself – has become a medical goal. The effort is driven partly by competition and partly by a realization that suffering, whether from long waits, inadequate explanations or feeling lost in the shuffle, is a real and pressing issue. It is as important, says Dr. Kenneth Sands, the chief quality officer at Harvard's Beth Israel Deaconess Medical Center in Boston, as injuries, like medication errors or falls, or infections acquired in a hospital. The problem is how to measure it and what to do about it. Dr. Sands and his colleagues decided to start by asking their own patients what made them suffer. They found several categories. Communications – for example, a doctor blurting out, "Oh, it looks like you have cancer." <http://www.nytimes.com/2015/02/18/health/doctors-strive-to-do-less-harm-by-inattentive-care.html?ref=health&r=0>

[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.

Hospice "end-of-life" care bill moves along in the Kentucky General Assembly

KENTUCKY | WKMS News (Murray) – 16 February 2015 – Legislation to make end-of-life decisions clear to all pertinent care givers is moving through the Kentucky general assembly. This is the third time the matter has come before state lawmakers. The medical orders for scope of treatment or MOST document is similar to a living will. The bill passed the Kentucky Senate last week. <http://wkms.org/post/hospice-end-life-care-bill-moves-along-ky-general-assembly>

When grief won't relent

THE NEW YORK TIMES | Online – 16 February 2015 – Grief is a normal human reaction, not a disease, and there is no one right way to get through it. Most often, within six months of a death, survivors adjust and are more or less able to resume usual activities, experience joy, and remember their loved ones without intense pain. But sometimes, even when the loss is neither sudden nor unexpected ... survivors close to the deceased can experience extremely disruptive grief reactions that persist far longer. In a [recently published] report¹ ... Dr. M. Katherine Shear presents a composite portrait of what is known as complicated grief, an extreme, unrelenting reaction to loss that persists for more than six months and can result in a serious risk to health. <http://well.blogs.nytimes.com/2015/02/16/when-grief-wont-relent/?ref=health&r=0>

1. 'Complicated grief,' *The New England Journal of Medicine*, 2015;372(2):153-160. Psychotherapy directed at the loss and at restoring activities and effective functioning is recommended. <http://www.nejm.org/doi/pdf/10.1056/NEJMcp1315618>

The challenges of palliative care for children

THE WALL STREET JOURNAL | Online – 16 February 2015 – Palliative care is increasingly used to help seriously ill adults and seniors. Now medical centers are creating teams that specialize in a more challenging task: delivering palliative care for young children. Despite a popular misconception, palliative care isn't just about keeping patients comfortable until they die. Rather, palliative-care teams complement the usual array of physicians, specialists and clinicians, helping patients by managing pain, treating symptoms and ensuring that they have the best possible quality of life. Pediatric palliative care is modeled on the principles of adult palliative care. But because so much about treating seriously ill children is different from caring for adults, it presents its own unique set of challenges. In contrast with adult palliative-care patients, the major-

ity of whom have cancer, about half of children in palliative care have complex genetic and neurological diseases that in previous generations would have been fatal. Because medical advances have extended these children's lives, pediatric palliative care is often delivered for far longer, and with a wider range of specialists, than adult palliative care. <http://www.wsj.com/articles/the-challenges-of-palliative-care-for-children-1424145655>

Specialist Publications

'Family functioning as a constituent aspect of a child's chronic illness' (p.12), in *Journal of Pediatric Nursing*.

Back Issues of Media Watch

Back issues of Media Watch are available on the International Palliative Care Resource Center website at: <http://www.ipcrc.net/archive-global-palliative-care-news.php>

End-of-life care can buy misery, Cornell expert says

STATE OF NEW YORK | *The Ithaca Journal* – 15 February 2015 – Much of life follows a basic economic principle: the more you pay, the higher the quality, and the better the outcome. Not so in death, at least not when it comes to terminal cancer, as costs in money and suffering skyrocket in the last few months of life, according to Holly Prigerson, director of the Center for Research on End-of-Life Care at Weill Cornell Medical College. In fact, dying of cancer in America flips the usual notion of cost-benefit on its head. "The more spent, the worse the patient's quality of life," Prigerson said. Delaying the inevitable comes with a cost in both medical payments and the toll experienced by the patient and their family. Prigerson pointed to increased rates of late-stage cancer patients receiving chemotherapy and the number of people dying in intensive care

units as evidence of a more aggressive – and, in the end, futile – tact toward prolonging life with palliative chemotherapy. <http://www.ithacajournal.com/story/news/local/2015/02/15/ithaca-end-life-talk/23376837/>

Specialist Publications

'Public health imperative of the 21st Century: Innovations in palliative care systems, services, and supports to improve health and well-being of older Americans' (p.9), in *Gerontologist*.

'Top-ranked quality indicators for hospice and palliative care from the American Academy of Hospice & Palliative Medicine and Hospice & Palliative Nurses Association' (p.11), in *Journal of Pain & Symptom Management*.

'Iolani School offers hospice course to students

HAWAII | KITV 4 News (Honolulu) – 10 February 2015 – 'Iolani School is offering a hospice course to students. It's to help them experience empathy and compassion. The one-of-a-kind course has seventeen students who are instructed by Bob Kane. As a teacher, he began pondering ways he could use the subjects of death and terminal illness to boost the self-esteem of his students. He devised a year-long hospice course where students could be trained in caring for those facing life-limiting illnesses. <http://www.kitv.com/news/-Iolani-School-offers-hospice-course-to-students/31188258>

Noted in Media Watch, 31 October 2011, #225 (p.3):

- U.S. (Minnesota) | *International Falls Daily Journal* – 29 October 2011 – **'The journey from life to death: Students participate in end-of-life simulation.'** After learning about hospice in the community, Rainy River Community College students were given 12 pieces of paper on which they wrote the names of three important people in their lives, three prized possessions, three favorite activities and three attributes about themselves of which they were most proud. After being told they had a life-threatening illness with six months to live, they were given thirty seconds to rip up three pieces of paper, signifying things they had to give up. Later, one-by-one, they had torn up all their papers except two. The exercise is intended to show students when your life is ending, you can't always control what you lose first. http://www.ifallsdailyjournal.com/view/full_story/16198444/article-The-journey-from-life-to-death--Students-participate-in-end-of-life-simulation

Noted in Media Watch, 8 August 2011, #213 (p.9, under 'Worth Repeating'):

- THE NETHERLANDS | *TheAge.com.au* – 14 February 2007 – **'Lesson in life and death: Pupils build dying teacher's coffin.'** Eri van den Biggelaar has just a few weeks to live after being diagnosed with an aggressive form of cervical cancer. She asked the woodwork teacher, a friend, to build a coffin for her. "Why don't you let the children make it?" he replied. Now pupils ... have been helping with the finishing touches. "Life and death belong together," van den Biggelaar said. "The children realised that when I explained it to them. I didn't want to be morbid about it; I wanted them to help me. None of the children considered it creepy ... and nobody felt traumatised. Parents of the children involved all gave their consent. <http://www.theage.com.au/news/world/lesson-in-life-and-death-pupils-build-dying-teachers-coffin/2007/02/13/1171128974213.html>

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- MONTANA | CBS News – 17 February 2015 – **'Right-to-die bill allowing doctor prosecution fails in house.'** A bill that would allow doctors to be criminally prosecuted for prescribing life-ending medication to terminally ill patients who ask for it failed by a narrow vote in the House. House Bill 328 was rejected 51-49 after a lengthy debate. The Legislature has struggled to clarify that the practice is specifically legal or illegal since the Montana Supreme Court ruled in 2009 that nothing in state law prohibits physicians from giving aid in dying. The high court also said at the time that doctors could use a patient's request for the medication as a defense against any criminal charges. <http://seattle.cbslocal.com/2015/02/17/right-to-die-bill-allowing-doctor-prosecution-fails-in-house/>
- STATE OF NEW YORK | *The Observer* (New York) – 17 February 2015 – **'Death With Dignity legislation ... introduced in Albany.'** Legislation seeking to give terminally ill New Yorkers the choice to end their life under a doctor's care ... has been introduced into the State Senate in Albany. The New York End-of-Life Options Act ... is modeled off the law in Oregon. It would allow adults to obtain a prescription from a physician for a lethal dose of medication that a patient can take on her own to end her life. <http://observer.com/2015/02/death-with-dignity-legislation-inspired-by-brittany-maynard-introduced-in-albany/>
- CALIFORNIA | *The Los Angeles Times* (OpEd) – 16 February 2015 – **'A new reason to support California's "death with dignity" bill.'** For the first time in close to a decade, the California Legislature is considering a bill that would grant terminally ill patients the right to seek a prescription from a physician for a lethal dose of medicine, giving them the ability to die peacefully rather than suffer severe mental anguish or unbearable physical pain. But just as the Legislature is beginning to consider the bill, a lawsuit has been brought in an effort to move the process along more quickly, contending that terminally ill Californians already have an inherent right to end their own lives. This is a matter that would be better resolved by legislation than by the courts. <http://www.latimes.com/opinion/editorials/la-ed-right-to-die-lawsuit-lethal-drugs-20150217-story.html>
- OREGON | Oregon Health Authority – Accessed 16 February 2015 – **'Dying with Dignity Act – 2014 Report.'** As of 2 February 2015, prescriptions for lethal medications were written for 155 people during 2014 under provisions of the Death With Dignity Act (DWDA), compared to 121 during 2013. Since the law was passed in 1997, 1,327 people have had DWDA prescriptions written and 859 patients have died from ingesting medications prescribed under the Act. <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf>

International

Good communication is essential to successful integration of health and social care

U.K. (England) | *The Guardian* – 17 February 2015 – Most people involved in delivering health and social care are committed to making integration happen. They know it's a good thing and can see the benefits for care and for the people who use services. But like any complex reform involving multiple agencies, they often struggle to see what it actually means for them and what they need to do differently to make it happen. This has to change if integration is to become a reality and not just a pipe dream. Better training, including joint training for social care and health staff, can help us to move forward. Pooled budgets, plus clear joint delivery and governance structures, involving those who lead both health and social care will also help. However, these changes alone will not be enough: communication and engagement with staff, people who use services and the public will play an essential role in the ultimate success of integration. <http://www.theguardian.com/social-care-network/2015/feb/17/good-communication-integration-health-social-care>

Cont.

1. The £5.3 billion Better Care Fund was announced by the Government in the June 2013 spending round, to ensure a transformation in integrated health and social care. Website: <http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/>

Selected articles on the integration of health and social services noted in past issues of Media Watch:

- U.K. (England) | Commission on the Future of Health & Social Care in England – 4 September 2014 – **'A new settlement for health and social care.'** The final report from the commission discusses the need for a new settlement for health and social care to provide a simpler pathway through the current maze of entitlements. It proposes an approach that redesigns care around individual needs regardless of diagnosis, and with a graduated increase in support as needs rise, particularly towards the end of life. [Noted in Media Watch, 8 September 2014, #374 (p.3)] <http://www.kingsfund.org.uk/publications/new-settlement-health-and-social-care>
- *INTERNATIONAL JOURNAL OF INTEGRATED CARE* | Online – 20 March 2014 – **'Integrated end-of-life care: The role of social services.'** If palliative care must be holistic, then it should include the social nature of the aid. [Noted In Media Watch, 31 March 2014, #351 (p.7)] <http://www.ijic.org/index.php/ijic/article/view/URN%3ANBN%3ANL%3AUI%3A10-1-114777/2376>
- *BMJ SUPPORTIVE & PALLIATIVE CARE*, 2014;4(18). **'Benefits of health and social care integration.'** Scotland's health boards and local authorities are moving towards integrated funding and service provision. [Noted in Media Watch, 24 March 2014, #350 (p.8)] <http://spcare.bmj.com/content/4/1/118.1.short>

Elder and home care in the U.K.

Misguided priorities and a lack of resources: Why the Care Act is set to fail

U.K. | *The Guardian* – 16 February 2015 – The number of people living longer is growing, as are the numbers of those who will need help and support in their 80s and 90s. There is also an increasing expectation that care will be provided at home, with fewer people needing to go into residential and nursing care. To accommodate these changes the government has been trumpeting last year's Care Act as the way forward. On the ground, however, the feeling is one of crisis. Much of the hype about the act focused on a new deal on residential and nursing home fees. But already only a minority of people go into care, and this proportion should decline further as better and more flexible care at home becomes standard. Only those with very high needs and/or severe dementia are likely to need residential and nursing care. What most of us want is better support and care at home, but reductions in budgets have led local authorities to concentrate solely on those in severe need. The knock-on effect has meant the number of people receiving care at home has gone down from over a million to 850,000 in the last three years, as a recent [*sic*] report by Age UK identified.¹ <http://www.theguardian.com/social-care-network/2015/feb/16/care-act-set-to-fail-meg-munn>

1. 'Care in Crisis: Causes and Solutions,' Age UK, May 2011. The report predicted that by 2014, England would be spending £250 million less on older people's care than a decade previously. Even before the cuts began spending was only £40 million higher than in 2004. At the same time the number of people aged over 85 who most often need care had risen by 630,000. <http://www.ageuk.org.uk/Documents/EN-GB/Campaigns/Care%20in%20Crisis%20-%20FINAL.pdf?dtrk=true>

Of related interest:

- U.K. (England) | *The Telegraph* – 15 February 2015 – **'More than 500,000 home care visits last less than five minutes.'** [Minister of Care & Support] Norman Lamb has called for a "fundamental" overhaul of home help services after an investigation [based on figures obtained under the Freedom of Information Act] exposed more than half a million visits that lasted less than five minutes each. <http://www.telegraph.co.uk/news/health/news/11302534/Revealed-more-than-500000-home-care-visits-last-less-than-five-minutes.html>

End-of-life care in Ireland

It's time we provide couples with perinatal hospices

IRELAND | *The Irish Times* (Dublin) – 15 February 2015 – The hospice movement is highly regarded in Ireland. But just like virtually every other vital service, it is under-funded, and in some areas, does not exist at all. For example, there is only one children's hospice, LauraLynn, but it has to constantly battle for funding. But one form of hospice does not exist formally at all in Ireland, even though there is a great need for it. In other countries, when a couple hears the shattering news that the baby they are expecting has a life-limiting condition, they will be offered the services of perinatal hospice, which will wrap them around with care at a time of devastation. It is one of the least expensive forms of hospice, because it is more a mind-set than a place. It fits perfectly with the idea of hospice-friendly hospitals, and could be operated in any maternity hospital. The news that the child you are carrying may not make it to birth, or will only live for a short time, perhaps only hours, days, weeks, months, or in rare cases, years, splinters parents' hearts. <http://www.irishtimes.com/opinion/breda-o-brien-it-s-time-we-provide-couples-with-perinatal-hospices-1.2103297>

Noted in Media Watch, 29 December 2014, #390 (p.10):

- *INTERNATIONAL JOURNAL OF PALLIATIVE NURSING*, 2014;20(3):143-148. **'Perinatal palliative care: A developing specialty.'** Neonates and babies have the highest death rate in the paediatric population. Perinatal palliative care aims to enhance the quality of life of babies with a life-limiting condition and their families. However, very little data is available on perinatal palliative care and its impact on babies and families along their journey. End-of-life decision-making for babies with an adverse prognosis also remains ethically challenging. <http://www.magonlinelibrary.com/doi/abs/10.12968/ijpn.2014.20.3.143>

National Health Service private health provider accused of U.S. hospice fraud

U.K. (England) | *The Guardian* – 14 February 2015 – One of the private health firms awarded the chance to earn contracts worth up to £5 billion to provide back-office services to National Health Service (NHS) doctors is being pursued through the courts over allegations of a major fraud of the American hospice system.¹ Optum, one of 12 organisations given the preferred status by NHS England, is accused by the U.S. federal government of falsely claiming American taxpayers' cash for looking after people in hospices who were not terminally ill. According to a lawsuit ... an investigation by the government found that patients whom the company claimed were terminally ill were living for up to four years in hospices run by Optum. By packing their hospices across 13 American U.S. states with patients who were not coming to the end of their lives, the firm was able to cut the most expensive costs that come with admitting people and dealing with their deaths, the lawsuit claims. The company is also accused of making it hard for patients who were not terminally ill to leave. <http://www.theguardian.com/society/2015/feb/14/nhs-private-contractor-optum-hospice-fraud>

1. 'Medicare fraud case claims Optum put patients in hospice care who weren't terminal,' Westword, Denver, Colorado, 3 September 2014. A federal law suit against Optum Palliative & Hospice Care claims the company offered hefty bonuses to employees who kept the numbers of patients up and fired those who attempted to weed out patients who weren't eligible for hospice benefits. <http://www.westword.com/news/medicare-fraud-case-claims-optum-put-patients-in-hospice-care-who-werent-terminal-5868287>

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>

Judge refuses mother's plea to treat terminally-ill son, saying he should be allowed to die

U.K. (England & Wales) | *The Telegraph* – 14 February 2015 – Doctors believe that a terminally-ill teenager who has a brain tumour will die within weeks after a judge gave them permission to withhold treatment. The 18-year-old man's parents wanted chemotherapy to continue and his mother had launched a "passionate" fight "for his life" at a fraught late-night hearing at the Court of Protection... She said her son was "absolutely adored" and a "miracle child" and urged judge Mrs. Justice Hogg not to rule that he "has to die." The judge described the case as "tragic," but decided specialists could lawfully stop providing chemotherapy, end "neuro-surgical intervention," and not resuscitate, after analysing evidence at a hearing which lasted more than eight hours. <http://www.telegraph.co.uk/news/health/news/11412861/Judge-refuses-mothers-plea-to-treat-terminally-ill-son-saying-he-should-be-allowed-to-die.html>

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- U.K. (Scotland) | *The Daily Record* (Glasgow) – 21 February 2015 – '**Assisted suicide wins approval from Scots...**' Most Scots are in favour of legalising assisted suicide, according to a poll commissioned by the *Daily Record*. Sixty-four of those questioned backed proposals first championed by late Member of the Scottish Parliament Margo MacDonald to allow doctors to help terminally ill people take their own life. Only 14% of those in the poll opposed the plans. <http://www.dailyrecord.co.uk/news/scottish-news/assisted-suicide-wins-approval-scots-5202374>
- NEW ZEALAND | 3 News (Auckland) – 20 February 2015 – '**Nearly half of GPs back euthanasia – survey.**' Nearly half of Kiwi doctors are in favour of euthanasia, or physician-assisted dying (PAD), according to a [new] survey... This lags well behind public support for PAD, which was measured at 82% in January by researchers at the University of Auckland. <http://www.3news.co.nz/nznews/nearly-half-of-gps-back-euthanasia---survey-2015021913#axzz3SJTP7Cya>
- COLUMBIA | *PanAm Post* – 19 February 2015 – '**Colombia to finalize euthanasia law in March.**' On 17 February, the Colombian Constitutional Court gave the Ministry of Health 30 days to implement a number of protocols pertaining to euthanasia, setting guidelines for all health care providers in the Andean country. During this time, health agencies are tasked with forming interdisciplinary committees to advise patients and their families on their decision to resort to euthanasia, in order to prevent such a decision being made as a result of mood or depression. The Court said that "without clear rules and precise procedures, doctors do not know exactly when they are committing a crime and when they are contributing to the realization of a fundamental right." <http://panampost.com/sabrina-martin/2015/02/19/colombia-to-finalize-euthanasia-law-in-march/>
- U.K. (Scotland) | BBC News – 17 February 2015 – '**Final arguments on Assisted Suicide Scotland bill heard.**' The politician championing the Assisted Suicide Scotland bill said it is fit for purpose and he did not intend to make any "radical changes." But, during the final day of evidence, Green MSP Patrick Harvie told Holyrood's health committee changes could be made to strengthen the bill. Supporters said the plan had widespread public backing, but critics have argued a change in the law would be unethical. The Scottish government does not support a change in the law. <http://www.bbc.com/news/uk-scotland-scotland-politics-31505627>
- THE NETHERLANDS | *NL Times* – 12 February 2015 – '**Euthanasia cases leap 73% at cautioned clinic.**' The Levensindekliniek (Life Clinic) helped 232 people with their request to die in 2014, 98 more than in 2013. The clinic also had 1,035 requests for euthanasia last year, substantially more than the previous year. The Regional Euthanasia Review Committee reprimanded the clinic last month for the euthanasia of a woman with severe tinnitus (ringing in

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the ears), without performing a psychiatric examination. In August the clinic was also reprimanded for assisting in the suicide of an elderly woman without sufficient motivation. Just over a third of the people who requested euthanasia did so because of a psychiatric disorder; 17 psychiatric patients received euthanasia. Most of the 232 people who were given euthanasia by the Levenseindekliniek last year were suffering from physical conditions such as MS, ALS or effects of a stroke. Slightly less than a quarter had cancer and 20% suffered from an accumulation of old age complaints. About 30% of the more than a thousand requests were honored. A quarter was rejected, 30% withdrew their requests and the rest died before the investigation was completed. Most of the people who received euthanasia were older than 70 years old. The youngest patient last year was 24 years old and the oldest patient was 103 years old. <http://www.nltimes.nl/2015/02/12/euthanasia-cases-leap-73-cautioned-clinic/>

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

Public health imperative of the 21st Century: Innovations in palliative care systems, services, and supports to improve health and well-being of older Americans

GERONTOLOGIST | Online – 17 February 2015 – A primary aim of federal aging and health policy must be promoting innovations in palliative care systems, services, and supports that improve the experience of growing old in America. Older adults must contend today with increasing burden over the life course often as the result of life-limiting chronic pain and chronic illnesses as well as social and economic factors beyond their control. These burdens are frequently shared with unpaid family caregivers who provide significant uncompensated medical care and social support to their loved ones. Enjoyment of the highest attainable standard of physical and mental health, recognized as a fundamental human right under international law, remains a goal for all older adults and encompasses the right to palliative care. For many older Americans, especially vulnerable subgroups who face health and pain disparities, however, this goal remains elusive. A public health strategy for implementing palliative care policy interventions will help to build age-friendly environments, assure the availability and accessibility of palliative systems of care, essential medicines, and an adequate generalist-level workforce, and sustain diffusion of innovation across all levels of health and social provision. The 2015 White House Conference on Aging must make these realignments a policy priority in order to foster social and economic development for... <http://gerontologist.oxfordjournals.org/content/early/2015/02/16/geront.gnu178.abstract>

Of related interest:

- *CLINICS IN GERIATRIC MEDICINE* | Online – 17 February 2015 – '**Palliative care in the era of health care reform.**' Research shows that early access to palliative care can significantly improve the quality of care for patients with chronic and advanced illnesses and reduce the overall costs of care. However, factors such as poor provider reimbursement mechanisms; inadequate formal education and training; workforce shortages; and low provider acceptance and patient engagement have created barriers to the widespread uptake of palliative care. [http://www.geriatric.theclinics.com/article/S0749-0690\(15\)00004-X/abstract](http://www.geriatric.theclinics.com/article/S0749-0690(15)00004-X/abstract)

Improving policies for caregiver respite services

GERONTOLOGIST | Online – 15 February 2015 – This paper provides a template for the decade ahead regarding the delivery, supply, and funding of caregiver respite services. Policy changes are needed to address these issues as concerns about our country's ability to meet future caregiving needs are growing along with our aging population. Federal initiatives and state-level policies and programs affecting respite are reviewed and directions for policy advancement are highlighted. Much work is needed to educate caregivers and the general public about the necessity for respite beginning early in the caregiving career to prevent burnout and other adverse effects. Because it is unlikely that there will be a sufficient number of direct-care workers to replace unpaid caregivers, improved policies are needed to ensure that their situation is sustainable through increased availability of high-quality respite and other services vital to caregiver health and well-being. <http://gerontologist.oxfordjournals.org/content/early/2015/02/14/geront.gnu120.short>

Palliative care experiences of adult cancer patients from ethno-cultural groups: A qualitative systematic review protocol

JBI DATABASE OF SYSTEMATIC REVIEWS & IMPLEMENTATION REPORT, 2015;13(1). Globally, over 20.4 million people need palliative care services annually. The majority of these people (19 million) are adults, with 34% of them being patients diagnosed with cancer. With the current increase in the aging population, especially in developed countries, the number of adults requiring palliative care is expected to rise. Furthermore, how palliative care is offered and received continues to be shaped by culture and ethnicity. Likewise [these] influence how palliative care patients experience diseases like cancer, and seek and utilize palliative care services. Also, healthcare providers sometimes find it challenging to address the palliative care needs of patients from different ethno-cultural groups. Sometimes these challenges are believed to be due to cultural incompetence of the care provider. When palliative care patients and their providers differ in their perception of care needs and how to address them, negative palliative care experiences are likely to ensue. <http://www.ioannabriggslibrary.org/index.php/jbisrir/article/view/1809/2334>

Of related interest:

- *CANCER* | Online – 11 February 2015 – '**Patient beliefs that chemotherapy may be curative and care received at the end of life among patients with metastatic lung and colorectal cancer.**' A third of the patients [i.e., study participants] recognized chemotherapy was "not at all" likely to cure their cancer. Such patients were no less likely than other patients to receive end-of-life chemotherapy; they were more likely than other patients to enroll in hospice. <http://onlinelibrary.wiley.com/doi/10.1002/cncr.29250/abstract.jsessionid=E2816D4B492DD0AE0210D55FDC22D0E0.f04t04?deniedAccessCustomisedMessage=&userIsAuthenticated=false>
- *SUPPORTIVE CARE IN CANCER* | Online – 14 February 2015 – '**How well is palliative care integrated into cancer care? A MASCC, ESMO, and EAPC Project.**' One hundred eighty-three different institutions completed this survey, 28 % of ESMO designated centers. Most institutions had palliative care programs and most programs consisted of an inpatient consult service and outpatient clinics. A minority had inpatient palliative care beds and institution supported hospice services. Barriers to palliative care were largely financial. Integration of palliative care into oncology was highly desirable but only a minority of respondents felt that their institution would financially support expanded services and additional palliative care personnel. Designated centers were more likely to have expanded palliative care services. <http://link.springer.com/article/10.1007/s00520-015-2630-z>

N.B. MASCC: Multinational Association of Supportive Care in Cancer; ESMO: European Society for Medical Oncology; EAPC: European Association for Palliative Care.

Advance care planning among patients with heart failure: A review of challenges and approaches to better communication

JOURNAL OF CLINICAL OUTCOMES MANAGEMENT, 2015;22(2):73-82. Although most patients with heart failure prefer to receive thorough and honest information about their health condition and prognosis, the unpredictability of the heart failure trajectory coupled with physician barriers including discomfort with emotionally-laden topics and difficulty identifying the "right" time to engage in advance care planning, and systems barriers such as inadequate clinic time and limited reimbursement, impede timely engagement in advance care planning discussions. Approaches to effective advance care planning communication include using open-ended questions to stimulate patient engagement, evaluating how much information the patient wants to ensure patient-centeredness, and using empathic language to demonstrate support and understanding. While successful models of advance care planning communication have been identified, replication is limited due to the resource intense nature of these approaches. http://www.turner-white.com/pdf/jcom_feb15_heart.pdf

Measuring What Matters

Top-ranked quality indicators for hospice and palliative care from the American Academy of Hospice & Palliative Medicine and Hospice & Palliative Nurses Association

JOURNAL OF PAIN & SYMPTOM MANAGEMENT | Online – 16 February 2015 – Measuring quality of hospice and palliative care is critical for evaluating and improving care, but no standard U.S. quality indicator set exists. The 'Measuring What Matters' project aimed to recommend a concise portfolio of valid, clinically relevant, cross-cutting indicators for internal measurement of hospice and palliative care. The authors narrowed the initial 75 indicators to ... 10. These include one in the National Consensus Project domain Structure & Process (comprehensive assessment), three in Physical Aspects (screening for physical symptoms, pain treatment, dyspnea screening and management), one in Psychological & Psychiatric Aspects (discussion of emotional or psychological needs), one in Spiritual & Existential Aspects (discussion of spiritual/religious concerns), and three in Ethical & Legal Aspects (documentation of surrogate, treatment preferences, and care consistency with documented care preferences). The list recommends a global indicator of patient/family perceptions of care, but does not endorse a specific survey instrument. [http://www.jpsmjournal.com/article/S0885-3924\(15\)00073-1/abstract](http://www.jpsmjournal.com/article/S0885-3924(15)00073-1/abstract)

Rawlsian justice and palliative care

BIOETHICS | Online – 17 February 2015 – Palliative care serves both as an integrated part of treatment and as a last effort to care for those we cannot cure. The extent to which palliative care should be provided and our reasons for doing so have been curiously overlooked in the debate about distributive justice in health and healthcare. We argue that one prominent approach, the Rawlsian approach developed by Norman Daniels, is unable to provide such reasons and such care. This is because of a central feature in Daniels' account, namely that care should be provided to restore people's opportunities. Daniels' view is both unable to provide pain relief to those who need it as a supplement to treatment and, without justice-based reasons to provide palliative care to those whose opportunities cannot be restored. The authors conclude this makes Daniels' framework much less attractive. <http://onlinelibrary.wiley.com/doi/10.1111/bioe.12156/abstract>

N.B. See 'From Healthcare to Health: An Update of Norman Daniels's Approach to Justice,' *International Journal of Health Policy & Management*, 2014;2(3):151-153. http://www.ijhpm.com/article_2828_602.html

Of related interest:

- *AGE & AGING* | Online – 16 February 2015 – '**Use of the MMRI-R prognostic tool for older patients discharged to nursing homes from hospital: A prospective cohort study.**' The Minimum Dataset Mortality Risk Index–Revised can be used at the acute hospital/nursing home interface, and can help predict 3-month and 6-month mortality. It had not been validated in the U.K... <http://ageing.oxfordjournals.org/content/early/2015/02/16/ageing.afv012.abstract>

Selected articles on quality indicators for the provision and delivery of end-of-life care noted in past issues of Media Watch:

- *BMC HEALTH SERVICES RESEARCH* | Online – 17 September 2014 – '**Consensus on quality indicators to assess the organisation of palliative cancer and dementia care applicable across national healthcare systems and selected by international experts.**' A multidisciplinary, international panel of professionals participated in a modified RAND Delphi procedure to compose a set of palliative care quality indicators (QIs) based on existing sets of QIs on the organisation of palliative care. [Noted in Media Watch, 22 September 2014, #376 (p.10)] <http://www.biomedcentral.com/content/pdf/1472-6963-14-396.pdf>

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- *PROGRESS IN PALLIATIVE CARE* | Online – 8 January 2014 – '**Improving the organization of palliative care by implementing quality indicators and national and setting-specific interventions: Study protocol of the IMPACT project.**' There is a wide gap between knowledge about palliative care and its application in everyday clinical practice, affecting many patients in our ageing population. [Noted in Media Watch, 13 January 2014, #340 (p.13)] <http://www.maneyonline.com/doi/abs/10.1179/1743291X13Y.0000000080>
- *PALLIATIVE MEDICINE* | Online – 16 July 2013 – '**Validation of quality indicators for the organization of palliative care: A modified RAND Delphi study in seven European countries.**' No international set of quality indicators to measure organizational aspects of palliative care settings exists. Five were rated as useful [by the authors]. These ... concerned: definition of a palliative care service, accessibility to palliative care, specific infrastructure to deliver palliative care, symptom assessment tools, specific personnel in palliative care services, documentation methodology of clinical data, evaluation of quality and safety procedures, reporting of clinical activities, and education in palliative care. [Noted in Media Watch, 22 July 2013, #315 (p.13)] <http://pmj.sagepub.com/content/early/2013/07/15/0269216313493952.abstract>

Family functioning as a constituent aspect of a child's chronic illness

JOURNAL OF PEDIATRIC NURSING | Online – 11 February 2015 – This study explored how family functioning may contribute to trace a child's illness trajectory. The authors conducted semi-structured interviews with 33 parents of children in care at a hospice in northern Italy. They also examined the medical records of the children, and interviewed the physician who cared for them. Different illness progressions corresponded to the different ways with which families experienced the illness: possibility, focus on illness, denial, and anger. Clinical interventions should involve the whole family and take into account their role in the construction of illness trajectories. [http://www.pediatricnursing.org/article/S0882-5963\(15\)00030-5/abstract](http://www.pediatricnursing.org/article/S0882-5963(15)00030-5/abstract)

Limitation of the therapeutic effort: Ethical and legal justification for withholding and/or withdrawing life sustaining treatments

MULTIDISCIPLINARY RESPIRATORY MEDICINE, 2015;10:5. Life sustaining treatments – ranging from resuscitation techniques, assisted ventilation, to artificial nutrition and hydration – represent valued and irreplaceable devices in the context of modern medicine. However, we should not lose sight of their aim, which consists in recovering vital compromised functions, or at least in controlling suffering and in maintaining a level of quality and dignity of life which the patient considers acceptable, and not in prolonging the death process of individuals who cannot benefit from lifesaving treatments because of their critical health state. With regard to these patients, health care workers are not always morally, deontologically, and legally obliged to initiate or to continue lifesaving treatments. Instead, limitation of the therapeutic effort may rather represent the needed premise to give the kind of assistance, in the palliative care's perspective, whose main purpose is to preserve ill persons from unnecessary suffering, granting them their dignity until the end of life. <http://www.mrmjournal.com/content/pdf/s40248-015-0001-8.pdf>



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 patterns of palliative care in neuro-oncology: A survey of physician members of the Asian Society for Neuro-Oncology, the European Association of Neuro-Oncology, and the Society for Neuro-Oncology

NEURO-ONCOLOGY PRACTICE | Online – 16 February 2015 – The most significant differences were found between Asia-Oceania (AO) and Europe as well as AO and U.S./Canada (US-C). US-C providers had more subspecialty training in neuro-oncology, but most providers had received no or minimal training in palliative care independent of region. Providers in all 3 regions reported referring patients at the onset of symptoms requiring palliation, but US-C and European responders refer a larger total proportion of patients to PC. Physicians in AO and Europe (both 46%) as well as 29% of US-C providers did not feel comfortable dealing with end-of-life issues. Most US-C patients (63%) are referred to hospice compared with only 8% and 19% in AO and Europe, respectively. <http://nop.oxfordjournals.org/content/early/2015/02/16/nop.npu037.abstract>

Nursing concerns with palliative care and at the end-of-life in patients with heart failure

NURSING: RESEARCH & REVIEWS | Online – 12 February 2015 – Patients with chronic heart failure (HF) suffer from numerous symptoms and quality-of-life (QOL) concerns, and thus, palliative care ... is needed. The transition to hospice care is made when HF is refractory to medical therapy or when the potential harm of treatment outweighs the potential benefits. Nurses are key persons for patients with HF as they may initiate and support palliative and hospice care, focus on delivering patients' goal-directed, well-coordinated care, champion patients' and caregivers' needs, and facilitate optimal QOL. This paper addresses the nurses' role in determining for whom, and when palliative and hospice care is appropriate; where and how palliative and hospice care should be provided; and the communication needs of

patients and their families regarding referral to hospice, emergencies, implantable cardioverter-defibrillator therapy, ventricular assist devices, and continuous intravenous inotropic or vasoactive support at the end-of-life. file:///C:/Users/Barry/Downloads/NRR-45298-nursing-concerns-with-palliative-care-and-at-the-end-of-life_021215.pdf

Extract from *Nursing: Research & Reviews* article

Despite the inclusion of palliative and hospice care for HF patients in published guidelines, health care providers are frequently unfamiliar with palliative and hospice care and the needs of HF patients and their families.

Of related interest:

- *JOURNAL OF PAIN & SYMPTOM MANAGEMENT* | Online – 19 February 2015 – '**Preparedness for resident death in long-term care: The experience of front-line staff.**' Certified nursing assistants (CNAs) who reported that their resident was "aware of dying" or "in pain" expressed higher levels of both emotional and informational preparedness. CNAs who endorsed an EOL care preference of wanting all possible treatments regardless of chances for recovery were likely to report lower emotional preparedness. More senior CNAs, both in regard to age and tenure, reported higher preparedness levels. Greater support from co-workers and hospice involvement also were associated with higher levels of both facets of preparedness, the latter in particular when hospice care was viewed positively by the CNA. [http://www.jpsmjournal.com/article/S0885-3924\(15\)00081-0/abstract](http://www.jpsmjournal.com/article/S0885-3924(15)00081-0/abstract)
- *NURSE PRESCRIBING* | Online – 13 February 2015 – '**Are nurse prescribers issuing prescriptions in palliative care?**' Prescribing in palliative care was an "early candidate" area for the extension of nurse prescribing authority, but has failed to meet expectations. The low number of nurse prescribers working in palliative care, and the impact of the lack of this kind of professional, has received little attention. This paper gives details of an "in-depth service evaluation project" relating to the prescribing activity of specialist palliative care nurse independent prescribers in one community palliative care team to ascertain the volume of their prescribing activity as well as identifications of the outcomes and influences to their prescribing activity. <http://www.magonlineibrary.com/doi/abs/10.12968/npre.2015.13.2.98>

Defibrillator deactivation against a patient's wishes: Perspectives of electrophysiology practitioners

PACING & CLINICAL ELECTROPHYSIOLOGY | Online – 14 February 2015 – Though the sample included [survey] respondents from Europe, Asia, Australia, South American and Africa, the majority were from North American (78%), were academically affiliated (64%), and practiced in an urban setting (67.8%). Deactivation of implantable cardioverter-defibrillators (ICD) shock function in agreement with patient wishes and a pre-existing DNR was not considered physician assisted suicide. However, a majority of the sample responded that it was not ethical/moral for doctors to deactivate ICDs against patients' wishes or against family/surrogates' wishes, even in the context of medical futility. <http://onlinelibrary.wiley.com/doi/10.1111/pace.12614/abstract>

N.B. See Media Watch dated 12 January 2015, #392 (p.9), for a listing of selected articles on defibrillator deactivation and end-of-life care noted in past issues of the weekly report.

"Less ticking the boxes, more providing support": A qualitative study on health professionals' concerns towards the Liverpool Care of the Dying Pathway

PALLIATIVE MEDICINE | Online – 17 February 2015 – Despite being widely used, research into the effectiveness of the Liverpool Care of the Dying Pathway (LCP) and associated cases of malpractice does not match dissemination.¹ No study exists focusing on concerns voiced by professionals. The authors explore the views of professionals who, during the hospital implementation of the Italian version of the LCP, voiced or showed concerns towards it. A total of 12 categories were identified, referring to four topics: the Implementation Programme, the LCP clinical documentation, the hospital environment, and the educational and professional background of hospital healthcare staff. Issues raised by participants concerned both "real" characteristics of the LCP

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[Media Watch: Editorial Practice](#)

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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.

and a misinterpretation of the LCP approach and clinical documentation. Furthermore, difficulties were reported which were not linked to the programme but rather to end-of-life care. A more comprehensive approach to professional training in palliative care is needed and may envisage the development of new interventions aimed at improving the quality of care throughout the illness trajectory. <http://pmj.sagepub.com/content/early/2015/02/14/0269216315570408.abstract>

1. *Independent Report: Review of Liverpool Care Pathway for dying patients* [in England), Department of Health, July 2013. [Noted in Media Watch, 22 July 2013, #315 (p.6)] <https://www.gov.uk/government/publications/review-of-liverpool-care-pathway-for-dying-patients>

Noted in Media Watch, 13 May 2013, #305 (p.12):

- *PALLIATIVE MEDICINE* | Online – 7 May 2013 – '**The Liverpool Care Pathway for cancer patients dying in hospital medical wards: A before-after cluster phase II trial of outcomes reported by family members.**' These results provide the first robust data collected from family members of a preliminary clinically significant improvement, in some aspects, of quality of care after the implementation of the Italian version of Liverpool Care Pathway programme. The poor effect for symptom control suggests areas for further innovation and development. <http://pmj.sagepub.com/content/early/2013/05/03/0269216313487569.abstract>

Choosing the place of death: Empowering motor neurone disease/amyotrophic lateral sclerosis patients in end-of-life care decision making

PALLIATIVE MEDICINE | Online – 17 February 2015 – Motor neurone disease/amyotrophic lateral sclerosis (MND/ALS) is a fatal neurodegenerative disease that requires special attention at the end-of-life, particularly because disability is relentlessly progressive and death generally occurs in a predictable fashion. In the absence of a cure, palliative care and advance care planning (ACP) are key management strategies. The quality of care provided throughout the illness profoundly influences the end-of-life care (EOLC). The [U.K.] 'End of Life Care Strategy' aims at promoting excellence in EOLC. The central aspect of this strategy concerns patients' preference for place of death. There is little in the literature about enabling MND/ALS patients to make choices about their EOLC, particularly relating to the preferred place of death (PPD). Honouring patient's choice for PPD is important, and this can be achieved through ACP. The Preferred Priorities for Care document is a patient-held dynamic record that can be used as an ACP tool... <http://pmj.sagepub.com/content/early/2015/02/14/0269216315570412.extract>

Selected articles on end-of-life care for people living with a neurological condition noted in past issues of Media Watch:

- *IRISH HOSPICE ASSOCIATION* | Online – 3 November 2014 – '**New report highlights deficiencies in palliative care needs of people with advancing neurological disease.**' 'The Palliative Care Needs of People with Advancing Neurological Disease in Ireland' is calling for protocols and pathways to be developed, and increased resourcing and training opportunities for neurology and specialist palliative care services to support people with advancing neurological disease. [Noted in Media Watch, 10 November 2014, #383 (p.7)] <http://hospicefoundation.ie/wp-content/uploads/2014/11/NAI-IHF-report1.pdf>
- *MEDSCAPE MEDICAL NEWS* | Online – 3 June 2014 – '**New European consensus on palliative care in neuro disease.**' A new consensus paper for palliative care for patients with progressive neurologic disease emphasizes the special needs of these patients and how neurologists and palliative care specialists can work together to fulfil them. [Noted in Media Watch, 9 June 2014, #361 (p.15)] <http://www.medscape.com/viewarticle/826100>

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- *EUROPEAN JOURNAL OF PALLIATIVE CARE*, 2014;21(2):57. **'Reflections on neurological palliative care.'** Neurological palliative care has led the authors to consider new aspects of care, new interventions, different symptoms and challenging issues, setting an example for how palliative care services should deal with non-cancer diagnoses. [Noted in Media Watch, 17 March 2014, #349 (p.10)]

N.B. Access to this article requires a subscription. <http://www.haywardpublishing.co.uk/ejpc.aspx>
- *NEUROLOGY*, 2014;82(7):640-642. **'Emerging subspecialties in neurology: Palliative care.'** Individuals with conditions including stroke, multiple sclerosis, Parkinson disease, muscular dystrophies, amyotrophic lateral sclerosis, and nervous system malignancies share a host of physical, emotional, and existential symptoms difficult to treat. [Noted in Media Watch, 24 February 2014, #346 (p.13)] <http://www.neurology.org/content/82/7/640.extract>

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- *JOURNAL OF MEDICAL ETHICS* | Online – 17 February 2015 – **'Can physicians conceive of performing euthanasia in case of psychiatric disease, dementia or being tired of living?'** This study shows that a minority of Dutch physicians find it conceivable that they would grant a request for euthanasia and physician-assisted suicide (EAS) from a patient with psychiatric disease, dementia or a patient who is tired of living. For physicians who find EAS inconceivable in these cases, legal arguments and personal moral objections both probably play a role. <http://jme.bmj.com/content/early/2015/01/30/medethics-2014-102150>
- *BIOÉTHIQUE* | Online – 13 February 2015 – **'The Supreme Court of Canada ruling in Carter v. Canada: A new era of end-of-life care for Canadians.'** With this historic judgment, Canada has become the second country in the world, after Colombia, to have allowed for PAD on constitutional grounds. Reading media reports published soon after the release of the decision, bioethicists might be forgiven for thinking that this case is concerned only with physician-assisted suicide. Many national and international media refer to assisted suicide in their headlines and bodies of texts when discussing the practice at the heart of this case. But make no mistake: the SCC decriminalized both euthanasia and physician-assisted suicide, practices that many bioethicists have long recognized to be ethically related but which may be distinguished in practical terms. The American Medical Association's Code of Medical Ethics, for example, defines physician-assisted suicide (PAS) as "when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act." Euthanasia is distinguished from PAS in that another person – a physician in places that have legalized euthanasia – administers the life-ending act. Specifically, the SCC decriminalized "physician-assisted death" or "physician-assisted dying" and it accepted the claimants' definition of this term as a "situation where a physician provides or administers medication that intentionally brings about the patient's death, at the request of the patient." <http://bioethiqueonline.ca/4/4>
- *MÉDECINE PALLIATIVE* | Online – 19 February 2015 – **'Assisted suicide: The individual's or society's choice?'** Confronted on a daily basis with issues relating to the end of life in a palliative care medical centre in Geneva, the authors, who come from different European cultures, put forward their conclusions to the following specific question, "Is assisted suicide considered a medical treatment in palliative care?" After reviewing the different laws and current situation in Switzerland neighbouring countries and without denying the cultural and historical issues facing society in this respect, their unanimous response was "no". However, they recognize that this position is contrary to the current trend to associate physicians with this assistance in self-determination, which is authorized or under debate in many European countries. They are convinced they have daily proof that relieving symptoms and suffering is an integral part of their job and find it paradoxical to entrust carers with a role that is completely contradictory to their commitments to society and the oaths they may have taken. They accordingly maintain their conviction that it is their duty to escort their patients from life towards death, rather than shifting care towards the illusion of mastering life and its end. <http://www.sciencedirect.com/science/article/pii/S1636652215000045>

N.B. French language article.

Media Watch Online

International

INTERNATIONAL ASSOCIATION FOR HOSPICE & PALLIATIVE CARE: <http://hospicecare.com/about-iahpc/newsletter/2015/02/media-watch/#CHINESE>

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

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]

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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