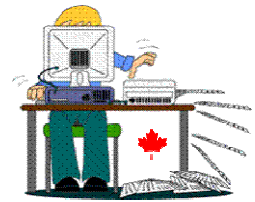


Media Watch...

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

Geriatric medicine and end-of-life care: Scroll down to Specialist Publications and 'Guidance at the juncture of palliation and old age' (p.11) in *The Gerontologist*.

Canada

Health region introduces new resuscitation policy

SASKATCHEWAN | *The Star Phoenix* (Saskatoon) – 6 June 2015 – What happens when a long term care resident collapses and it isn't clear what to do next? To help health care staff, residents and their families navigate that thorny issue, the Saskatoon Health Region has adopted a new resuscitation policy. The Ministry of Health has said resuscitation should be offered at long term care homes. So while staff have been performing CPR at long term care homes since last year, a 2009 policy didn't reflect that and needed to be updated. The trick was to develop a sequence of care between acute and long term care settings, the region's bioethicist, Dr. Qaiser Fahim said. Specifically, it now requires that when a patient moves from a hospital to long term care, their resuscitation care plan goes with them to inform any later resuscitation decision... <http://www.thestarphoenix.com/health/Health+region+introduces+resuscitation+policy/1114766/story.html>

Specialist Publications

'Predictors of place of death for those in receipt of home-based palliative care services in Ontario, Canada' (p.15), in *Journal of Palliative Care*.

'Impact of palliative care consultations on resource utilization in the final 48 to 72 hours of life at an acute care hospital in Ontario, Canada' (p.15), in *Journal of Palliative Care*.

'Palliative care costs in Canada: A descriptive comparison of studies of urban and rural patients near end of life' (p.15), *Palliative Medicine*.

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.

When is aggressive cancer treatment too aggressive?

THE GLOBE & MAIL | Online – 4 June 2015 – Last week, it was the coming surge in cancer cases: According to Canadian Cancer Statistics 2015, compiled by the Canadian Cancer Society and other sources, the projected number of new diagnoses is expected to rise 40% over the next 15 years.¹ That's in addition to the estimated 50-per-cent increase in dementia, especially Alzheimer's disease, over the same time period.² Some unlucky people will develop both, along with heart disease, arthritis and any number of other chronic ailments. The culprit behind these gloomy statistics, of course, is something for which there is no cure: aging. Not only are we getting older, but we are living longer because of medical advances. Blame the baby boom, the swaggering generation born between 1946 and 1965. Boomers turn 69 this year and will be approaching 85 in 2030, the year pegged as ground zero by the Cancer Society. Here's the question: Should we be treating older cancer patients

as aggressively as we do younger ones? <http://www.theglobeandmail.com/life/health-and-fitness/health/when-is-aggressive-cancer-treatment-too-aggressive/article24807595/>

Extract from *The Globe & Mail* article:

As well, there are relatively few geriatricians in this country – Dr. [Shabbir] Alibhai, [a geriatrician and geriatric oncologist at University Health Network in Toronto] puts the number at about 200. That means they are often not part of the assessment team in making treatment decisions for older cancer patients. He thinks that should change with the development of geriatric assessment tools and the inclusion of health care practitioners trained in palliative care (not necessarily doctors) who can talk with patients about their hopes and fears regarding proposed treatment plans, and about the significance to them of quality versus quantity of life.

1. 'Canadian Cancer Statistics 2015: Predictions of the Future Burden of Cancer in Canada,' Canadian Cancer Society, Statistics Canada. [Noted in Media Watch, 1 June 2015, #412 (p.2)] <https://www.cancer.ca/~media/cancer.ca/CW/cancer%20information/cancer%20101/Canadian%20cancer%20statistics/Canadian-Cancer-Statistics-2015-EN.pdf>
2. 'Dementia Statistics,' Alzheimer's Disease International. As of 2013, there were an estimated 44.4 million people with dementia worldwide. This number will increase to an estimated 75.6 million in 2030, and 135.5 million in 2050. Much of the increase will be in developing countries. [Noted in Media Watch, 9 December 2013, #335 (p.9)] <http://www.alz.co.uk/research/statistics>

N.B. A June 2015 report from Alzheimer's Disease International, 'Women and Dementia: A global research review,' reveals how women are much more likely to be affected by dementia than men. The majority of people living with the disease and those most at risk of developing dementia are women, and women account for an overwhelming majority of caregivers and health professionals. <http://www.alz.co.uk/news/new-report-reveals-disproportionate-impact-of-dementia-on-women>

Second group submitting bid for hospice

ONTARIO | *The Nugget* (North Bay) – 1 June 2015 – There are at least two hospice proposals in the running to become the preferred model for this district. The North Bay & Area Community Hospice went public with its plans, indicating it will be submitting a proposal to the North East Local Health Integration Network (LHIN) in response to a call for expressions of interest for the creation of a residential hospice in Nipissing District. The proposal is separate from that of Nipissing Serenity Hospice, which has been actively seeking a suitable site in the city for a 10-bed facility, and is also expected to submit its proposal to the LHIN. Because the North Bay & Area proposal would be located at the health centre campus ... capital costs for renovations are pegged at about \$1 million... The Nipissing Serenity plan calls for the construction a \$5.8-million stand-alone building with 10 private rooms... North Bay council adopted a motion ... supporting a hospice in the city. A majority of members, however, agreed to remove a reference to the Serenity proposal from the motion in order remain neutral on the matter. <http://www.nugget.ca/2015/06/01/second-group-submitting-bid-for-hospice>

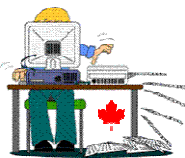
A national strategy is needed for unpaid caregivers in the workplace

QUEBEC | *The Montreal Gazette* – 1 June 2015 – A year ago, the federal government established the Employer Panel for Caregivers, which consulted with employers to help them find ways to better support their employee caregivers¹. The consultation was premised on the (realistic) assumption that unpaid care will remain the main source of long-term care in Canada. The most significant insight it gained is this: There might not be a business case for many employers to voluntarily engage in supporting employee caregivers. Put another way, moral appeal and compassion will not translate into a massive, spontaneous movement in the Canadian workplace to address the issue any time soon. What else is needed? Should the costs of caregiving and reduced productivity belong uniquely to caregivers and their employers? It is becoming increasingly difficult for Canadian policy-makers to ignore their own essential role – beyond that of offering limited support – to address the issue. Confronted with a similar situation, the U.K., Australia and New Zealand have adopted national strategies. At home, Manitoba and Nova Scotia are leading in many ways, but efforts across the country remain fragmented. First, Canada's workplace legislation, which is primarily a provincial jurisdiction, needs to ensure minimum standards to protect workers with caregiving commitments. Second, we also need a comprehensive set of financial instruments – possibly a combination of private or public programs – to better protect workers' incomes and their employers' productivity losses. Third, more substantial coverage of home care, nursing care and supportive services for the disabled is an essential component. <http://montrealgazette.com/news/national/opinion-a-national-strategy-is-needed-for-unpaid-caregivers-in-the-workplace>

1. 'Give family caregivers a break,' *The Globe & Mail*, 30 June 2014. [Noted in Media Watch, 30 June 2014, #364 (p.2)] <http://www.theglobeandmail.com/globe-debate/editorials/give-family-caregivers-a-break/article19301566/>

Of related interest:

- BRITISH COLUMBIA | *The Vancouver Sun* – 3 June 2015 – '**Report calls for more home care workers...**' Basic services to help seniors stay in their homes are now more difficult than ever to access, according to a report released by the British Columbia (BC) Health Coalition¹ ... [that] ... recommends investing in home care to hire more workers in the short term and also create a plan on how to keep seniors independent as their numbers grow in the coming decades. <http://www.vancouversun.com/health/Report+calls+more+home+care+workers+seniors/11103981/story.html>
 1. 'Living Up to the Promise: Addressing the high cost of underfunding and fragmentation in BC's home support system,' Health Coalition and Integrated Care Advocacy Group, June 2015. <http://www.bchealthcoalition.ca/sites/default/files/uploads/Living%20Up%20to%20The%20Promise%20-%20Full%20Report%20-%20press%20-%20new%20appendixA.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>

U.S.A.

How to let go when a loved one is dying

NATIONAL PUBLIC RADIO (NPR) | News-hour – 5 June 2015 – Many recent news stories have focused on right-to-die issues – what options might we want, and what control can we exert, as we approach the end of life? When death is sudden and unexpected, there are few choices, and if there has been no preparation for this moment, events will unfold as medical and emergency staff see fit. But when illness is chronic or prolonged, or when pain, frailty and old age impact the quality of life, there are measures we can take to have our wishes respected, to share those wishes with others, and to request a dignified, comfortable death. An NPR story

last year examined why some health care providers are hesitant to discuss end-of-life measures, even with seriously ill patients.¹
<http://www.pbs.org/newshour/updates/letting-go-honoring-choices-end-life/>

Specialist Publications

'Talking about sensitive topics during the advance care planning discussion: A peek into the black box.' (p.9), in *Palliative & Supportive Care*.

1. 'Doctors hesitate to ask heart patients about end-of-life plans,' NPR Health News, 4 June 2014.
<http://www.npr.org/sections/health-shots/2014/06/04/318772558/doctors-hesitate-to-ask-heart-patients-about-end-of-life-plans?ft=1&f=>

N.B. The 4 June 2014 NPR article was based on a study reported in *Medical Daily*, 'End-of-life care: Doctors reluctant to discuss issue with chronic heart condition patients.' [Noted in Media Watch 9 June 2014, #361 (p.15)] <http://www.medicaldaily.com/end-life-care-doctors-reluctant-discuss-issue-chronic-heart-condition-patients-286324>

Noted in Media Watch, 5 January 2015, #391 (p.6):

- *ARCHIVES OF PSYCHIATRIC NURSING* | Online – 27 December 2014 – '**An emerging concept: Peaceful letting go.**' The concept of peaceful letting go emerged to describe the emotional, transitional and decision making processes that family members experience in losing an older adult loved one with a life-limiting illness. [http://www.psychiatricnursing.org/article/S0883-9417\(14\)00179-4/abstract](http://www.psychiatricnursing.org/article/S0883-9417(14)00179-4/abstract)

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

- *SOCIAL SCIENCE & MEDICINE* | Online – 15 November 2012 – '**The art of letting go: Referral to palliative care and its discontents.**' While medical specialists are expected to ease patients' transitions to specialist palliative care ... few have received training in such interpersonal complexities. <http://www.sciencedirect.com/science/article/pii/S0277953612007575?v=s5>

In question of public or private hospice, commissioners go with public

NORTH CAROLINA | *The Sun Journal* (New Bern) – 5 June 2015 – The Craven County Board of Commissioners was faced with a philosophical dilemma when planning for next year's budget. Questions arose over whether county government should continue with its hospice program or allow the private sector to meet patient needs. Director Scott Harrelson of the Health Department asked for the county to continue its funding and stated that the program should sustain itself over the next year. Hospice services, which have been offered through the county since 1980, provide palliative comfort and help to families of terminally ill patients who are referred mainly from Carolina East Medical Center, he said. The latest available data on the average daily census was for the month of May in which 30 patients were served, Harrelson added. Prior to beginning his presentation to the board, Harrelson passed around a document describing the differences between

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for-profit and non-profit hospice agencies. In the article, it seemed clear from the discussion between board members and the director that a non-profit agency has benefits not afforded by those offered in the open market. <http://www.newbernsj.com/news/local/in-question-of-public-or-private-hospice-commissioners-go-with-public-1.487743>

Noted in Media Watch, 19 January 2015, #393 (p.2):

- **THE WASHINGTON POST** | Online – 14 January 2015 – **‘How the drive for profits is shaping end-of-life care.’** A federal watchdog has warned ... that financial incentives in Medicare may be warping the ways that hospice care works in the U.S.¹ The new findings follow others that indicate that financial incentives provided by the Medicare payment system leads some hospices to target patients with easier to handle diagnoses because they are more profitable. <http://www.washingtonpost.com/blogs/wonkblog/wp/2015/01/14/how-the-drive-for-profits-is-shaping-end-of-life-care/>

1. ‘Medicare Hospices Have Financial Incentives to Provide Care in Assisted Living Facilities,’ Office of the Inspector General, Department of Health & Human Services, January 2015, <https://oig.hhs.gov/oei/reports/oei-02-14-00070.pdf>

N.B. *The Washington Post* series the ‘Business of dying’ has been noted in Media Watch. See 15 December 2014, #388, issue of the weekly report (p.4) for a listing to that date. The most recent instalment, ‘Dying and profits: The evolution of hospice,’ is noted in Media Watch, 29 December 2014, #390 (p.3).

A new snapshot of America’s 44 million family caregivers: Who they are and what they do

FORBES | Online – 4 June 2015 – A landmark study paints a dramatic picture of family caregivers.¹ Nearly 44 million adults in the U.S. are providing personal assistance for family members with disabilities or other care needs. That’s more than one out of every six adults. More than 34 million care for frail elders and nearly 4 million help children with disabilities. About 6.5 million care for both. The typical family caregiver is a 49-year-old woman who is assisting a parent or in-law and working at a paid job. She reports spending an average of about 24 hours-a-week providing personal assistance such as bathing or dressing or helping with activities such as shopping or rides. Almost six in 10 say they perform nursing or other complex care tasks, such as giving oral medicines or injections, wound care, or operating medical equipment. The typical caregiver has been helping a parent or spouse for four years. Most work full-time but six in 10 say caregiving has affected their ability to do their jobs. About half say they’ve had to take occasional time off, 15 percent have taken leaves of absences, and 14% have had to reduce work hours or change jobs as a result of their caregiving. <http://www.forbes.com/sites/howardgleckman/2015/06/04/a-new-snapshot-of-americas-44-million-family-caregivers-who-they-are-and-what-they-do/>

1. ‘Caregiving in the U.S. 2015,’ National Alliance for Caregiving and American Association of Retired Persons, June 2015. <http://www.caregiving.org/caregiving2015/>

Of related interest:

- **UTAH** | *The Standard-Examiner* (Ogden) – 2 June 2015 – **‘Survey says, support Utah’s caregivers.’** The state has approximately 382,000 family caregivers at any one time, representing \$4.2 billion in unpaid service to the economy for the staggering 365 million hours of service they provide each year. <http://www.standard.net/Guest-Commentary/2015/06/03/Survey-says-support-Utah-s-caregivers.html>

[Media Watch posted on Palliative Care Network-e Website](#)

The website promotes education amongst health care providers in places around the world where the knowledge gap may be wider than the technology gap ... to foster education and interaction, and the exchange of ideas, information and materials. <http://www.pcn-e.com/community/pg/file/owner/MediaWatch>

Medicare's next half-century

THE NEW YORK TIMES (OpEd) | Online – 3 June 2015 – The 50th anniversary of Medicare ... is an opportunity to consider what the goals of medicine should be in our aging society and how we want to live in relation to medicine's evolving tools. There has been a revolution in medicine and in patient expectations since President Lyndon B. Johnson signed Medicare health insurance into law in 1965, setting off the often contentious debates about cost control, rationing and privatization now dominating the public conversation about health care. To craft Medicare's best possible future, however, it may be more productive to focus on the kinds of health care older Americans are actually receiving and are claiming to want. Our aging population has become increasingly medically sophisticated, risk aware, and demanding about treatments. The paternalistic physician who knew the patient and family and "made the decisions" into the 1960s has been succeeded by a culture of patient autonomy, hospital-centered medicine and new importance of medical teams. http://opinionator.blogs.nytimes.com/2015/06/03/medicares-next-half-century/?_r=0

Extract from *The New York Times* article:

Our nation, in which individual rights remain the supreme value, finds itself in the midst of a perfect storm comprising an aging society, an astounding array of high-tech, exorbitantly costly treatments and a powerful, profit-driven drug and device industry that churns out new therapies at an unprecedented rate. In this light, Medicare's original reimbursement strategy – to pay for acute care services loosely labeled "reasonable and necessary" – now seems glaringly misguided.

[Specialist Publications](#)

'Preliminary study shows dramatic trend of cost savings in lay navigation program for cancer patients' (pp.13-14), in *Medical Express*.

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- CALIFORNIA | Associated Press – 4 June 2015 – '**California Senate passes right-to-die bill.**' California lawmakers have advanced a right-to-die bill... The state Senate passed the measure on a 23 to 14 vote, ahead of a legislative deadline. The measure heads to the Assembly. <http://www.nbcsandiego.com/news/local/Brittany-Maynard-Right-to-Die-Bill-California-306128581.html>

[International](#)

Painless access to narcotic drugs cheers palliative care community

INDIA | *The Times of India* – 4 June 2015 – Five essential narcotic drugs will now be made available to registered medical institutions on a single licence issued by the state drug controller's office. This has put an end to a situation where opioids were inaccessible for pain management and palliative care for patients because six different licences were needed to be allowed to procure, stock and prescribe them. Five essential narcotic drugs will now be made available to registered medical institutions on a single licence issued by the state drug controller's office. This has put an end to a situation where opioids were inaccessible for pain management and palliative care for patients because six different licences were needed to be allowed to procure, stock and prescribe them. <http://timesofindia.indiatimes.com/india/Painless-access-to-narcotic-drugs-cheers-palliative-care-community/articleshow/47535646.cms>

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Noted in Media Watch, 30 May 2015, #403 (p.13):

- *INDIAN JOURNAL OF MEDICAL ETHICS* | Online – Accessed 24 March 2015 – ‘**Access to controlled medicines for palliative care in India: Gains and challenges.**’ India has witnessed robust advocacy efforts which push for the consideration of palliative care and pain management as a human right. Central to this paper is India’s Narcotic Drugs & Psychotropic Substances (NDPS) Act, 1985: its genesis, its critique, and the amendments aimed at enhancing access to the NDPS for medical care and research. The author refers to the advocacy efforts in India ... which led to the amendments to the NDPS Act in February 2014; and the contribution of the global and local human rights discourse on palliative care to these efforts. <http://www.issuesinmedicalethics.org/index.php/ijme/article/view/2197/4701>

Elder care in the England

Appalling care for elderly in their homes is revealed

U.K. (England) | *The Times* – 4 June 2015 – It is virtually impossible to recruit carers for the elderly in some parts of the country, with staff quitting to stack shelves in supermarkets where the pay is better, council chiefs have warn.¹ In their annual report on elderly care, they warned there would be cuts of £1.1 billion this year, further damaging the recruitment and retention of staff; and said that without well-paid, well-trained staff, thousands of older people living at home or in residential care would be in jeopardy. <http://www.thetimes.co.uk/tto/news/uk/article4459992.ece>

1. ‘Budget Survey 2015: Report,’ Association of Directors of Adult Services, June 2015. http://www.adass.org.uk/uploadedFiles/adass_content/policy_networks/resources/Key_documents/ADASS%20Budget%20Survey%202015%20Report%20FINAL.pdf

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

Rise in patient numbers for specialist palliative care

U.K. (England, Northern Ireland & Wales) | National Council for Palliative Care – 3 June 2015 – Increasing numbers of people are accessing specialist palliative care across all settings – especially community-based services – according to a new report...¹ Latest figures show that the average number of patients per service has risen for all specialist palliative care settings and service types since 2008. Community care specialist palliative services in particular are seeing increasing numbers of people, in line with moves to enable more people to be cared for at home. Dementia is becoming an increasing issue for community care specialist palliative care teams, with five times as many people with dementia accessing community services in 2013/2014 compared with 2008/2009. The proportion of older people (aged 85 and older) seen by community teams has also continued to increase, as it has for hospital support teams. However, the report shows that not everyone yet has equal access to specialist palliative care. <http://www.ncpc.org.uk/MDS-2013-14>

1. ‘National Survey of Patient Activity Data for Specialist Palliative Care Services: Minimum Data Set for Specialist Palliative Care (MDS) for 2013-14,’ National Council for Palliative Care, Public Health England, and Hospice UK. <http://ncpc.org.uk/sites/default/files/MDS-2013-14-Summary-report-and-all-settings.pdf>

Noted in Media Watch, 13 April 2015, #405 (p.5):

- U.K. (England, Northern Ireland & Wales) | BBC News – 8 April 2015 – ‘**End-of-life care for terminally ill “needs major overhaul.”**’ The U.K.’s care system for dying patients with terminal illnesses is lacking and needs a major overhaul, says a damning new report.¹ According to London School of Economics researchers, more than 100,000 people a year who would benefit from palliative care are not getting it. Patients are being left without sufficient pain relief and respite. The report found inequalities in access to good care, with certain groups of patients more likely to miss out. <http://www.bbc.com/news/health-32201594>

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1. 'Equity in the provision of palliative and end of life care in the U.K.: Review,' Personal Social Services Research Unit, London School of Economics & Political Science, April 2015. <https://www.mariecurie.org.uk/globalassets/media/documents/policy/campaigns/equity-palliative-care-uk-report-full-lse.pdf>

Of related interest:

- U.K. | *The Times* – 1 June 2015 – '**Doctors to be trained on care for the dying.**' All doctors and nurses would be trained in end-of-life pain relief and how to discuss death openly and sensitively with their patients under a bill presented in the House of Lords. The bill would make it a failure of duty of care if appropriate pain relief were not given in the final stages of life. <http://www.thetimes.co.uk/tto/health/news/article4456715.ece>

Why doctors get it wrong about when you will die

U.K. | *The Guardian* – 2 June 2015 – One of the largest reviews ... systematically reviewed survival predictions in terminally ill patients with cancer.¹ Eight studies were analysed in three countries over 30 years. Overall, doctors' predictions were correct to within one week in 25% of cases, correct to within two weeks in 43%, and correct to within four weeks in 61%. The study found doctors tended to overestimate survival. The very measure of a doctor lies in their predictive abilities, their grasp of the crystal ball: "How long have I got, doctor?" The *Corpus Hippocraticum* of early Greek medicine underlined just that: "I hold that it is an excellent thing for a doctor to practise forecasting. For indeed, if he discover and declare unaided by the side of his patients their present, past and future circumstances, he will be able to inspire greater confidence that he knows about illness, and thus people will decide to put themselves in his care." Why is it so difficult to prognosticate? Every patient is different, every disorder is different, every disorder within a disorder is different. People are unpredictable, their illness even more so. But there exist other subtleties that are harder to admit to. <http://www.theguardian.com/lifeandstyle/2015/jun/02/doctors-predict-patient-die-prognosis-wrong>

1. 'A systematic review of physicians' survival predictions in terminally ill cancer patients,' *British Medical Journal*, 24 July 2003. <http://www.bmj.com/content/327/7408/195>

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- FRANCE | BBC News – 5 June 2015 – '**Right to die: Court backs France in Vincent Lambert case.**' The European Court of Human Rights has upheld the decision of a court in France to allow a paralysed man to be taken off life support. Vincent Lambert, 39, has been in a coma for seven years after a motorcycle accident left him tetraplegic. His family have been split over whether he should be kept alive. The case was taken to the European court last year after France's highest court had ruled in favour of ending his life support. It sparked fierce debate in France where euthanasia is illegal, although doctors can withdraw care under a 2005 passive euthanasia law. The court in Strasbourg ruled that the decision to stop intravenously feeding Mr. Lambert did not violate European rights laws. <http://m.bbc.com/news/world-europe-33018506>
- COLUMBIA | *PanAm Post* (Miami, Florida) – 4 June 2015 – '**Colombian public doctors must now provide euthanasia by law.**' A new ruling by Colombia's Constitutional Court means that public health institutions, and all the doctors who work in them, will be unable to refuse a patient's request for assisted suicide – forcing them to carry out the procedure, or transfer the patient to an institution that will. <http://panampost.com/maria-suarez/2015/06/04/colombian-public-doctors-must-now-provide-euthanasia-by-law/>

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- U.K. | *The Guardian* – 1 June 2015 – ‘**Lord Falconer: Government must clean up assisted dying legal mess.**’ The government must make parliamentary time available to reform the law on assisted dying, Lord Falconer, the sponsor of a private member’s bill on the issue, has urged. The new shadow justice secretary is warning that the existing law – which criminalises those helping the terminally ill end their lives – is in a mess and no longer capable of being enforced. His assisted dying bill, which includes legal and medical safeguards, made significant progress in the last parliament but ran out of debating time. He will reintroduce it this session. <http://www.theguardian.com/society/2015/jun/01/lord-falconer-government-assisted-dying-legal-mess>
- U.K. | *The Mirror* – 30 May 2015 – ‘**More than half of U.K. GP’s would help a patient die if it was legal, survey reveals.**’ Just a year ago a poll showed far fewer – 19% – would be prepared to assist in a suicide. The new survey also found that, for the first time, a majority of doctors do not oppose an Assisted Dying Bill. Of 1,000 doctors who participated in the poll by MedeConnect medical researchers, 54% said they would be prepared to be involved in assisted dying. The British Medical Association – the doctors’ union – opposes a change in the law. <http://www.mirror.co.uk/news/uk-news/more-half-uk-gps-would-5794574>

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

Relinquishing or taking control? Community perspectives on barriers and opportunities in advance care planning

AUSTRALIAN HEALTH REVIEW | Online – 1 June 2015 – There is a lack of awareness about ACP [advance care planning] in Australia, compounded by issues in the accessibility of ACP information, forms and support in completing the often complex documentation. Further, studies have indicated health practitioners tend to avoid assisting patients with ACP decision making and formalisation of their wishes for health care should they lose testamentary capacity. This paper contributes further understanding of the experiences and perceptions of people, particularly older Australians, in relation to ACP, including the motivating and discouraging factors for people in the uptake of advance healthcare directives and enduring power of

attorney. People felt discomfort and mistrust about ACP, and lacked understanding of its relevance regardless of age or health status. <http://www.publish.csiro.au/paper/AH14152.htm>

***Australian Health Review* article:
What are the implications for practitioners?**

It is now clear that people require improved provision of information and support around ACP-related activities. Without discussion of death and dying, and the role of ACP, people will continue to feel a mistrust and avoidance towards formalising their healthcare wishes in advance.

Of related interest:

- *AUSTRALIAN HEALTH REVIEW* | Online – 1 June 2015 – ‘**Advance care planning in 21st century Australia: A systematic review and appraisal of online advance care directive templates against national framework criteria.**’ Fourteen online ACD templates were included, all of which were available only in English. Templates developed by Southern Cross University best met the framework criteria. One ACD was found to be biased against medical treatment – the Dying with Dignity Victoria Advance Healthcare Directive. <http://www.publish.csiro.au/paper/AH14187.htm>
- *PALLIATIVE & SUPPORTIVE CARE* | Online – 2 June 2015 – ‘**Talking about sensitive topics during the advance care planning discussion: A peek into the black box.**’ Analysis indicates that during discussions about sensitive end-of-life issues the healthcare professional will be able to pose and explore sensitive questions in a straightforward manner, if the voices that express empathy and seek to empower the patient in different ways are emphasized. <http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=9740808&fulltextType=RA&fileId=S1478951515000577>

Early palliative care – health services research and implementation of sustainable changes: The study protocol of the EVI project

BMC CANCER | Online – 29 May 2015 – International medical organizations ... recommend early palliative care as the “gold standard” for palliative care in patients with advanced cancer. Nevertheless, even in comprehensive cancer centers, early palliative care is not yet routine practice. The main goal of the EVI project is to evaluate whether early palliative care can be implemented – in the sense of “putting evidence into practice” – into the everyday clinical practice of comprehensive cancer centers. In addition, the authors are interested in 1) describing the type of support patients would like from palliative care; 2) gaining information about the effect of palliative care on patients’ quality of life; and, 3) understanding the economic burden of palliative care on patients and families. <http://www.biomedcentral.com/content/pdf/s12885-015-1453-0.pdf>

Noted in Media Watch, 30 March 2015, #403 (p.15-16):

- *HEMONC TODAY* | Online – 25 March 2015 – ‘**Palliative medicine under the microscope: Not every patient with cancer needs palliative care.**’ A litany of studies have shown conclusively active treatment is an expensive option that affords little benefit ... to the dying patient, and is effectively and appropriately replaced by timely referral for palliative and then hospice care. That said, the thought all patients with cancer should receive palliative care ... just doesn’t make sense to me as clinician with 40 years of experience. <http://www.healio.com/hematology-oncology/palliative-care/news/print/hemonc-today/%7B6e166b0e-604b-47a1-ae4-6ed28bcb5bf4%7D/palliative-medicine-under-the-microscope-not-every-patient-with-cancer-needs-palliative-care>

N.B. The author cites the Oncology Nursing Society’s palliative care for people with cancer “position” (December 2014) that recommends “palliative care be provided throughout the treatment continuum” from diagnosis. <https://www.ons.org/advocacy-policy/positions/practice/palliative-care>

- *JOURNAL OF CLINICAL ONCOLOGY* | Online – 23 March 2015 – ‘**Palliative care: If it makes a difference, why wait?**’ In 2014, a landmark resolution was passed unanimously at the World Health Assembly that called for all state members to strengthen palliative care as a component of integrated treatment within the continuum of care. When to initiate is central to this hoped-for integration. <http://jco.ascopubs.org/content/early/2015/03/23/JCO.2014.60.5386.full>

Workings of the human spirit in palliative care situations: A consensus model from the Chaplaincy Research Consortium

BMC PALLIATIVE CARE | Online – 1 June 2015 – The model uses modestly adapted existing definitions and models. It describes the human experience of spirituality during serious illness in three renditions: 1) visual; 2) mathematical; and, 3) verbal so that researchers can use whichever is applicable. The visual rendition has four domains: 1) spiritual; 2) psychological; 3) physical; and, 4) social with process arrows – and permeable boundaries between all areas. The mathematical rendition has the same four factors and is rendered as an integral equation, corresponding to an integrative function postulated for the human spirit. In both renditions, the model is notable in its allowance for direct spiritual experience and a domain or factor in its own right, not only experience that is created through the others. The model does not describe anything beyond the human experience. The verbal rendition builds on existing work to describe the processes of the human spirit, relating it to the four domains or factors. Implications of the model for how the human spirit functions and how the chaplain can care for the patient or family caregiver’s spiritual coping and well-being are discussed. The next step is to generate researchable hypotheses, results of research from which will give insight into the human spirit and guidance to chaplains caring for it. <http://www.biomedcentral.com/content/pdf/s12904-015-0005-3.pdf>

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Of related interest:

- *JOURNAL OF HEALTH PSYCHOLOGY* | Online – 28 May 2015 – ‘**Spirituality in patients with advanced illness: The role of symptom control, resilience and social network.**’ Statistically significant correlations were found [in this study] between some dimensions of spirituality and poor symptomatic control, resiliency, and social support. Three variables predicted spirituality: 1) having physical symptoms as the main source of discomfort; 2) resiliency; and, 3) social support. <http://hpg.sagepub.com/content/early/2015/05/28/1359105315586213.abstract>

Selected articles on spirituality, in the context of end-of-life care, noted in past issues of Media Watch:

- *WESTERN JOURNAL OF NURSING RESEARCH* | Online – 25 May 2014 – ‘**Describing spirituality at the end of life.**’ The authors’ analysis of the literature identified five attributes that most commonly described the essence of spirituality: 1) meaning; 2) beliefs; 3) connecting 4) self-transcendence; and, 5) value. [Noted in Media Watch, 2 June 2014, #360 (p.12)] <http://wjn.sagepub.com/content/early/2014/05/23/0193945914535509.abstract>
- *JOURNAL OF SOCIAL WORK IN END-OF-LIFE & PALLIATIVE CARE*, 2013;9(2-3). ‘**Spirituality in end-of-life and palliative care: Theory, research, and practice dimensions for social work.**’ The theme of this issue of the journal is “theoretical and practice perspectives in which spirituality plays a key role in end-of-life care.” [Noted in Media Watch, 24 June 2013, #311 (p.12)] Journal contents page: <http://www.tandfonline.com/toc/wswe20/current>
- *ARCHIVE FOR THE PSYCHOLOGY OF RELIGION*, 2012;34(1):63-81. ‘**Six understandings of the word “spirituality” in a secular country.**’ A common understanding of the term does not exist, at least in a modern secular setting. Six understandings of spirituality were identified in this study: 1) positive dimensions in human life and well-being; 2) New Age ideology; 3) an integrated part of established religious life; 4) a vague striving, opposed to religion; 5) selfishness; and, 6) ordinary inspiration in human activities. [Noted in Media Watch, 25 June 2012, #259 (p.9)] <http://www.ingentaconnect.com/content/brill/arp/2012/00000034/00000001/art00005>

Is it appropriate to use Western guidelines for breaking bad news in non-Western emergency departments? A patients’ perspective

CLINICAL ETHICS | Online – 3 June 2015 – The patients’ [i.e., study participants] preferences in 9 out of 19 statements were similar to the guidelines. “Using the maternal language” received the strongest agreement. The strongest disagreement was on “encouraging the patients to talk after receiving bad news.” The summative scores ... indicated strong agreement for cultural issues, followed by communication skills, breaking bad news session, and privacy. The patients’ preferences were not completely consistent with the guidelines. The authors could not determine if it was a situational or cultural issue. However, it is reasonable to design a new guideline for breaking bad news, considering these factors. <http://cet.sagepub.com/content/10/1-2/13.abstract>

Geriatric medicine and end-of-life care

Guidance at the juncture of palliation and old age

THE GERONTOLOGIST, 2015;55(3):503-505. Although older persons are living longer and more active lives, it is inevitable that advancing age will be accompanied by a growing risk for chronic conditions that increase morbidity and undermine quality of life. Gerontologists often have promoted lifestyle behaviors to prevent disease or improve physical, social, or cognitive function among older adults. Notwithstanding their expertise in caring for persons in the final decades of life, some gerontologists remain unfamiliar with the effective palliation of symptoms for older adults with life-limiting or chronic, debilitating conditions. Similarly, palliative care providers have advanced health care practices to maximize comfort, function, and quality of life for persons (of all

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ages) who are living with life-threatening diagnoses. There is no guarantee, however, that these specialists possess the necessary knowledge to provide comprehensive palliative care for geriatric patients. <http://gerontologist.oxfordjournals.org/content/55/3/503.extract?sid=119d934a-164b-4f3c-9605-cdd457d6bc56>

Noted in Media Watch, 3 Mar 2014, #347 (p.10):

- *JOURNAL OF GERIATRIC ONCOLOGY* | Online – 24 February 2014 – ‘**Cancer in the elderly: Is it time for palliative care in geriatric oncology?**’ Elderly who need palliative care are frequently disregarded as individuals and may experience discrimination because of their age. Palliative care for older patients relates particularly to multiple treatments for various conditions. [http://www.geriatriconcology.net/article/S1879-4068\(14\)00036-8/abstract](http://www.geriatriconcology.net/article/S1879-4068(14)00036-8/abstract)

Noted in Media Watch, 24 February 2014, #346 (p.9):

- *JOURNAL OF GENERAL INTERNAL MEDICINE* | Online – 21 February 2014 – ‘**Regardless of age: Incorporating principles from geriatric medicine to improve care transitions for patients with complex needs.**’ This article provides a framework for incorporating geriatrics principles into care transition activities by discussing the following elements: 1) identifying factors that make transitions more complex; 2) engaging care “receivers” and tailoring home care to meet patient needs; 3) building “recovery plans” into transitional care; 4) predicting and avoiding preventable readmissions; and, 5) adopting a palliative approach, when appropriate, that optimizes patient and family goals of care. <http://link.springer.com/article/10.1007/s11606-013-2729-1>

Social work assessment notes: A comprehensive outcomes-based hospice documentation system

HEALTH & SOCIAL WORK | Online – 28 May 2015 – The system was developed to guide the assessment of patients’ and caregivers’ needs related to end-of-life psychosocial issues, to facilitate collaborative care plan development, and to measure patient- and family-centered outcomes. Goals established with the patient and the caregiver are documented in the plan of care and become the foundation for patient-centered, strengths-based interventions. The documentation system was developed for use in an electronic health record but can be used for paper charting. <http://hsw.oxfordjournals.org/content/early/2015/05/28/hsw.hlv033.abstract>

Of related interest:

- *ILLNESS, CRISIS & LOSS* | Online – 29 May 2015 – ‘**Embracing life: The gift of a day program.**’ The Gift of a Day program seeks to celebrate life with each individual client by providing a customized client-centered event that encompasses activities that are enjoyable and important to them. Results [of this study] suggest that participating in activities that are pleasurable and personally meaningful may improve clients’ emotional well-being at the end of life. <http://icl.sagepub.com/content/early/2015/05/28/1054137315587635.abstract>

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MW 456: Palliative care in advanced lung disease: The challenge of integrating palliation into everyday care
Download the complete issue (PDF 452 KB) [R]

CHEST | Online - 5 March 2015: The tendency toward "fatherly" thinking (either care or control) in traditional biomedical care paradigms does little to optimize care in advancing chronic illness. Calls for improved palliation in chronic lung disease mandate a review of related care gaps and current clinical practices. [Read more...](#)



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<http://www.ipcrc.net/archive-global-palliative-care-news.php>

Campaign to highlight grieving fathers

IRISH HEALTH | Online – 2 June 2015 – The #Daddyandme campaign has been launched by Anam Cara, a Irish charity that works with families who have experienced the death of a child. Almost two-thirds of people know someone who has lost a child and it is estimated that [in Ireland] in 2014 alone, around 2,100 families lost a son or daughter. However ... the grief a father experiences is often overlooked, with many people asking how a mother is coping, but not offering the same degree of support to fathers. <http://www.irishhealth.com/article.html?id=24693>

Of related interest:

- *JOURNAL OF AMERICAN MEDICAL ASSOCIATION*, 2015;313(21):2172-2173. **'Increasing support for the treatment of complicated grief in adults of all ages.'** Complicated grief (CG) is ... most prevalent in elderly persons. However, to the authors' knowledge, no full-scale randomized clinical trial has studied CG in this population. Results [of this randomized clinical trial] strongly support the need for physicians and other health care providers to distinguish CG from depression. <http://jama.jamanetwork.com/article.aspx?articleid=2300584>

Mobile palliative care teams

End of life in the hospital: Practical and organizational challenges

MÉDECINE PALLIATIVE | Online – 1 June 2015 – This article presents an analysis of a national qualitative study on mobile palliative care teams and beds specifically oriented toward palliative care. Important progresses were observed but they are irregular and uncertain. Without exerting any authority, a mobile palliative care team has to demonstrate its expertise and its capacity to support the other specialized hospital departments and to develop a joint relation with them. The effectiveness of beds specifically oriented toward palliative care changes from one hospital to another because of organizational choices. Specific financing and collegiality are the most important factors for this organization. The diffusion of the palliative approach in non-palliative departments requires the incorporation of technical actions. One of the problems is the risk to forget the time needed to decide when the patient requires a palliative approach. This moment may be a breaking one. <http://www.sciencedirect.com/science/article/pii/S1636652215000628>

N.B. French language article.

Noted in Media Watch, 18 March 2013, #297 (p.12):

- *REVUE NEUROLOGIQUE* | Online – 28 February 2013 – **'Mobile team of palliative care in a department of neurology: Value of two multidisciplinary and professional groups' fruit of a joint distribution of the palliative approach and ethical support.'** This article describes how a mobile team of palliative care and a department of neurology learned to cope with many complex end-of-life situations. After a brief introduction to inter-team cooperation, clinical work of the mobile team with patients and families and its cooperation with the neurology team are presented. <http://www.sciencedirect.com/science/article/pii/S0035378713000350>

N.B. French language article.

Preliminary study shows dramatic trend of cost savings in lay navigation program for cancer patients

MEDICAL EXPRESS | Online – 4 June 2015 – Based on the premise that coordinated cancer management leads to decreased overall cost, the Patient Care Connect Program (at the University of Alabama Comprehensive Cancer Centre) is designed to pair a trained non-clinical lay navigator with a cancer patient to help them through their cancer journey. The program has about 40 lay navigators who work across 12 Health System Cancer Community Network associate sites

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located in Alabama, Florida, Georgia Mississippi and Tennessee. The study evaluated health care utilization with hospitalizations, ER visits, ICU admissions and hospice admissions for all eligible Medicare patients. In addition, during implementation, the study analyzed the cost to Medicare for the overall medical care received by these patients. The results of the study indicate a dramatic trend toward a clinically significant reduction in health care utilization and Medicare costs, with substantial impact during initial phase, survivorship and the last six months of life. <http://medicalxpress.com/news/2015-06-preliminary-trend-cancer-patients.html>

An excerpt from *Dying For Dummies*

NATURE | Online – 27 May 2015 – It used to be that choosing how to die involved no complicated menu of alternatives. You waited for it to happen or you took your own life – and that was it. And if you didn't want to decide on how to dispose of the material remains, you didn't have to – you could just leave that choice to your next of kin. But scientific advances have created more interesting and much more positive post-mortem modes to choose from. That's the good news. The bad news is that making the choice requires sophisticated technological knowledge that is beyond what the average person is likely to have. You must understand that the choice is, in effect, the most crucial one you have to make, not merely in your life but potentially for ever. And you need to realize that the consequences will not be assured, that post-mortem existence is not a matter of certainty, but a bet on the odds that each mode currently seems to offer. So the purpose of *Dying For Dummies* is to allow the public at large to make this choice in an enlightened and informed manner by explaining those odds and the costs of each post-mortem mode of existence. <http://www.nature.com/nature/journal/v521/n7553/full/521556a.html>

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.

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Something Missed or Overlooked?

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

End-of-life care in Canada

Palliative care costs in Canada: A descriptive comparison of studies of urban and rural patients near end of life

PALLIATIVE MEDICINE | Online – 3 June 2015 – Significant gaps in the evidence base on costs in rural communities in Canada and elsewhere are reported in the literature, particularly regarding costs to families. However, it remains unclear whether the costs related to all resources used by palliative care patients in rural areas differ to those resources used in urban areas. This study aimed to compare both the costs that occurred over 6 months of participation in a palliative care program and the sharing of these costs in rural areas compared with those in urban areas. The mean total cost per patient was CAD\$26,652 in urban areas, while it was CAD\$31,018 in rural areas. The family assumed 20.8% and 21.9% of costs in the rural and urban areas, respectively. The rural families faced more costs related to prescription medication, out-of-pocket costs, and transportation while the urban families faced more costs related to formal home care. <http://pmj.sagepub.com/content/early/2015/06/03/0269216315583620.abstract>

Of related interest:

- *JOURNAL OF PALLIATIVE CARE*, 2015;31(2):69-75. '**Impact of palliative care consultations on resource utilization in the final 48 to 72 hours of life at an acute care hospital in Ontario, Canada.**' This study shows that patients who receive palliative care consultations are associated with significantly lower costs in the final 48 to 72 hours of life than their non-palliative counterparts. Another finding was the degree of cost reduction at the very end of life appears to be relative to how soon after the patient's admission the palliative care consultation was initiated. <http://www.ingentaconnect.com/content/iug/jpc/2015/00000031/00000002/art00002>
- *JOURNAL OF PALLIATIVE CARE*, 2015;31(2):76-88. '**Predictors of place of death for those in receipt of home-based palliative care services in Ontario, Canada.**' Patients with high nursing costs and patients with high personal support worker costs were more likely to die at home than those with low costs. Patients who lived alone were less likely to die at home than those who cohabitated, and those with a high propensity for a home-death preference were more likely to die at home than those with a low propensity. An understanding of the predictors of place of death may contribute to the development of effective interventions that support home death. <http://www.ingentaconnect.com/content/iug/jpc/2015/00000031/00000002/art00003>

Noted in Media Watch, 13 April 2015, #405 (pp.1-2):

- *PlosOne* | Online – 26 March 2015 – '**The health care cost of dying: A population-based retrospective cohort study of the last year of life in Ontario, Canada,**' The study is descriptive in nature and does not directly address quality of care; nevertheless, it can be inferred that a proportion of health care utilization near the end of life, such as certain emergency room visits, hospital admissions and medications, are potentially preventable and burdensome for the patient. <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0121759>

Legal and ethical issues in end-of-life care: Implications for primary health care

PRIMARY HEALTH CARE, 2015;25(5):34-41. Increasing numbers of patients are achieving their wish to die in the familiar surroundings of their own homes, which means that providing high quality, person-centred end of life care is likely to be an important part of the primary health care nurse's role. Care at the end of life may present a number of legal and ethical challenges, as nurses manage the requirement to achieve effective palliation of pain and other distressing symptoms, while recognising that a point may be reached where active treatment, such as artificial hydration and nutrition, is no longer appropriate. This article provides nurses with an opportunity to consider the challenges that may arise when caring for a dying patient in the community... <http://journals.rcni.com/doi/abs/10.7748/phc.25.5.34.e1032>

Dreaming of home: Long-term residential care and (in)equities by design

STUDIES IN POLITICAL ECONOMY | Online – Accessed 2 June 2015 – An ideal of “home” as the best site for living and dying in old age has become embedded in residential care policies and practices in many countries, often in tandem with neoliberal restructuring. This article compares the ways that two Canadian jurisdictions have approached this and identifies contradictions in the effects this policy direction has had for direct care workers and residents [and] reveals challenges and possibilities for gender equity. <http://spe.library.utoronto.ca/index.php/spe/article/view/22671>

Media Watch Online

International

INTERNATIONAL ASSOCIATION FOR HOSPICE & PALLIATIVE CARE: <http://hospicecare.com/about-iahpc/newsletter/2015/05/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 | 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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