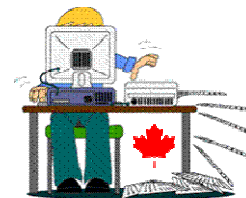


Media Watch...

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

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Compiled & Annotated by Barry R. Ashpole

The illness experience: Scroll down to [Specialist Publications](#) and 'Making space for empathy: Supporting doctors in the emotional labour of clinical care' (p.9), in *BMC Medical Ethics*.

Canada

Home care not keeping up with seniors' population growth in British Columbia, advocate finds

BRITISH COLUMBIA | *The Vancouver Sun* – 27 January 2016 – Health authorities throughout the province are trimming hours and the types of work they fund that helps seniors stay at home, advocate Isobel Mackenzie said... "The data do support that we're providing less care, per person, province-wide." The result is that the elderly are ending up in long-term nursing facilities before the limits of extra assistance at home have been exhausted, Mackenzie said in releasing a monitoring report on the province's services to seniors.¹ It found the portion of British Columbia's population over the age of 75 has increased by 4% in the past year, but the number of hours of home support services fell in three of five provincial health regions. "It's counter-

intuitive that they should be going down," says Mackenzie. Government policy supports keeping seniors in their own homes as long as possible with the dual goal of maintaining their quality of life and reducing health care costs from unnecessary hospital stays. <http://goo.gl/OSxL1q>

[Specialist Publications](#)

'Evidence of increasing public participation in advance care planning: A comparison of polls in Alberta between 2007 and 2013' (p.10), in *BMJ Supportive & Palliative Care*.

1. 'Monitoring Seniors' Services 2015,' Office of the Seniors' Advocate, British Columbia, January 2016. <https://goo.gl/WCE4QD>

Noted in Media Watch, 21 September 2015, #428 (p.3):

- BRITISH COLUMBIA | *The Vancouver Sun* – 14 September 2015 – '**Caregivers in B.C. have high levels of anger and worry: Report.**' One-third of family caregivers in British Columbia are stressed out and may give up on keeping a loved one at home unless they get relief, the province's Seniors Advocate warned.¹ <http://goo.gl/H67nTi>

1. 'Caregivers in Distress: More Respite Needed,' Seniors Advocate, British Columbia, September 2015. <https://goo.gl/FePNCt>

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- CBC NEWS | Online – 27 January 2016 – **‘Doctors with moral objections to assisted dying should be able to opt out, committee hears.’** Doctors who morally object to physician-assisted dying should not be obligated to refer patients to a doctor who will provide the service, a joint Commons-Senate committee studying the issue heard... Dr. Cindy Forbes, president of the Canadian Medical Association told the panel doctors shouldn’t have to refer a patient, but they must “advise the patient on all of their options ... including physician assisted dying, and make sure the patient has the information they need to access that service.” Dr. Monica Branigan, a board member of the Canadian Society of Palliative Care Physicians, told the committee currently the quality of palliative care (PC) a patient receives depends on their postal code and any new assisted-dying legislation should be coupled with an increase in funding to, and national standardization of PC across the country . Branigan stressed the importance of palliative care by pointing out that while only three per cent of Canadians will seek a physician assisted-death, all Canadians can benefit from improved funding to PC. <http://goo.gl/mXDFbU>
- ONTARIO | CBC News – 26 January 2016 – **‘Ontario doctors get interim guidelines for providing assisted death.’** Ontario doctors will be permitted to provide assistance in dying to eligible patients within Canada who qualify for publicly funded health care as the federal government works to legislate doctor-assisted suicide. The College of Physicians & Surgeons of Ontario ... approved its interim guidelines for doctors who are approached by patients seeking help in dying before doctor-assisted suicide becomes legal nationwide on 6 June. The guidelines were amended following 30 days of consultations with doctors and Ontario residents. An earlier draft limited physicians to providing the service only to Ontario residents. Other changes include a clarification that conscientious objectors do not have to assess whether a patient is eligible for doctor-assisted death before referring them to another physician. <http://goo.gl/pHnG34>

U.S.A.

Signed consent for DNR not universally required

MASSACHUSETTS | *The Boston Herald* – 29 January 2016 – Some of the Bay State’s largest hospitals don’t require signed written consent from patients or their relatives before labeling patients as ‘Do Not Resuscitate’ in a state regulatory vacuum that led to what one hospital executive called a “misunderstanding” after an elderly man died at Melrose-Wakefield Hospital. Hospitals must honor so-called Medical Orders for Life Sustaining Treatment and DNR forms – if patients fill them out – but the Department of Public Health (DPH) doesn’t require hospitals to use the state-approved signed documents to record DNR requests, according to a DPH spokesman. <http://goo.gl/bHKN5j>

The disappearance of a distinctively Black way to mourn

THE ATLANTIC | Online – 26 January 2016 – Black funeral traditions are distinctive from other burial rituals in American culture. Funeral directors have long preserved the African American tradition of homegoings, as these Christian ceremonies are often called: Bodies are typically viewed in an open casket, and a richly adorned one at that, with large floral arrangements and ornate fabrics. There are limousines and nice cars to escort families, which lends a sense of pride and pageantry to the lengthy rituals. Homegoings can offer black Americans the respect in death that they don’t always receive in life. Black funeral spaces also provide refuge for the living: A family in mourning can be comforted and understood within a community institution, away from an often-racist world. Mourners can feel at home during an otherwise disorienting moment, knowing their traditions will be honored without question. Untimely death and dying marked the African American experience at its beginning – from mortality-plagued transatlantic voyages to the violence of forced labor and the privation of the slave quarters. Surrounded by these unnecessary deaths, funeral ceremonies were an urgent and central rite in slave communities. They also formed the foundation of the black church tradition. <http://goo.gl/EteKX2>

As population ages, where are the geriatricians?

OREGON | *The New York Times* – 25 January 2016 – Geriatrics is one of the few medical specialties in the U.S. that is contracting even as the need increases, ranking at the bottom of the list of specialties that internal medicine residents choose to pursue. “One of the greatest stories of the 20th century was that we doubled the life expectancy of adults,” said Terry Fulmer, president of the John A. Hartford Foundation [New York, NY], which funds programs to improve the care of older adults. “Now we need to make sure we have all the supports in place to assure not just a long life but a high quality of that long life.” Here in Oregon, there is approximately one geriatrician for every 3,000 people over 75. The shortage will grow more acute as the state’s population continues to age. Oregon’s problem is mirrored across the U.S. According to projections based on census data, by the year 2030, roughly 31 million Americans will be older than

75, the largest such population in American history. There are about 7,000 geriatricians in practice today in the U.S. The American Geriatrics Society estimates that to meet the demand, medical schools would have to train at least 6,250 additional geriatricians between now and 2030, or about 450 more a year than the current rate. <http://goo.gl/Lny4xy>

Specialist Publications

‘Management of Diabetes in Long-term Care & Skilled Nursing Facilities: A Position Statement of the American Diabetes Association’ (p.10), in *Diabetes Care*.

‘Academic study shows how racial bias may impact end-of-life care’ (p.12), in *Journal of Blacks in Higher Education*.

Noted in Media Watch, 28 September 2015, #429 (p.6):

- *THE NEW YORK TIMES* | Online – 22 September 2015 – ‘An aging population, without the doctors to match.’ Most health care professionals have had little to no training in the care of older adults. Currently, 97% of all medical students in the U.S. do not take a single course in geriatrics. Recent studies show that good geriatric care can make an enormous difference. Older adults whose health is monitored by a geriatrician enjoy more years of independent living, greater social and physical functioning and lower presence of disease. <http://goo.gl/5OtEli>

Selected articles on geriatrics and palliative care

- *THE GERONTOLOGIST*, 2015;55(3):503-505. ‘Guidance at the juncture of palliation and old age.’ 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 (PC) providers have advanced health care practices to maximize comfort, function, and quality of life for persons (of all ages) who are living with life-threatening diagnoses. There is no guarantee, however, that these specialists possess the necessary knowledge to provide comprehensive PC for geriatric patients. [Noted in Media Watch, 8 June 2015, #413 (p.11)] <http://goo.gl/7fJYeF>
- *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 (PC) are frequently disregarded as individuals and may experience discrimination because of their age. PC for older patients relates particularly to multiple treatments for various conditions. [Noted in Media Watch, 3 Mar 2014, #347 (p.10)] <http://goo.gl/bo4i2i>
- *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. [Noted in Media Watch, 24 February 2014, #346 (p.9)] <http://goo.gl/U2GhgM>

International

Home care in England

Short home care visits “plague system”

U.K. (England) | BBC News 29 January 2016 – Unacceptably short 15-minute home care visits to elderly and disabled people are still plaguing the care system in England, a report suggests. Research by Unison found “distressing” cases of care being compromised after surveying councils and care workers. Ministers have been demanding councils which are in charge of care services stop using the so-called “flying visits.” And guidance issued last year by the National Institute for Health & Care Excellence said visits should last at least 30 minutes unless it was for a quick check-up as part of a wider package of care,¹ such as calling in to make sure someone has taken medication. Unison received responses to a Freedom of Information request from all 152 councils with responsibility for social care, just as the guidance was being introduced and received feedback from 1,100 care staff via an online survey. <http://goo.gl/PZm4qE>

1. ‘Delivering Personal Care and Practical Support to Older People Living in Their Own Homes,’ National Institute for Health & Care Excellence, September 2015. [Noted in Media Watch, 28 September 2015, #429 (p.8)] <https://goo.gl/kEQM0z>

Noted in Media Watch, 2 February 2015, #395 (p.7):

- U.K. (England) | *The Daily Mail* – 31 January 2015 – ‘**Indignity, a dearth of compassion, terrible suffering and utter chaos...**’ A *Daily Mail* investigation has revealed a catalogue of failings – inadequate training, call times of 15 minutes or even less in which carers must meet their clients’ most basic needs; carers asked to be literally in two places at once because they are allocated insufficient travelling time. It all adds up to a grim picture, according to the former care minister Paul Burstow.¹ <http://goo.gl/F9x1hV>

1. ‘Key to Care: Report of the Burstow Commission on the Future of the Home Care Workforce,’ Local Government Information Unit, December 2014. Paul Burstow was Minister of Care Services 2010-2012. <http://goo.gl/TOKTzq>

End-of-life care in South Korea

80 percent of elderly say no to palliative care

SOUTH KOREA | *The Korea Times* (Seoul) – 28 January 2016 – Eight out of 10 elderly people in Korea would refuse palliative care, a survey shows. The Korea Institute for Health & Social Affairs published the results this month, after surveying 300 citizens aged 65 and above. Eighty percent of people in care facilities said they would accept their death, while 17.3% said they would continue to receive treatment. For those living at their homes, the figure was higher – 85.3% said they would accept their fate, while 12.7% said they would be treated to prolong their life. There was also a difference in the two categories in what people believed was necessary for a “comfortable death.” Those in facilities cited pain relief as the

main factor, while those at home said psychological stability. <http://goo.gl/uytCTA>

Top court orders expenses to be paid for treatment after decision to die with dignity

SOUTH KOREA | *The Korea Herald* (Seoul) – 28 January 2016 – South Korea’s top court ruled in favor of a hospital, ordering family members of a now deceased patient who had refused life-extending treatments to pay for related medical expenses. The Supreme Court ruled the family of the patient – the first allowed to “die with dignity” in South Korea – should pay medical expenses totalling 86.4 million (\$71,500). <http://goo.gl/6TvqTV>

Cont.

Noted in Media Watch, 18 January 2016, #445 (p.5):

- SOUTH KOREA | *The Korea Times* (Seoul) – 10 January 2016 – “**Death with dignity**” approved in parliament.’ How much pain would you endure in order to stay alive if you had an incurable illness and no prospect of leaving hospital? With the National Assembly passing the “well-dying” bill, from 2018 patients with no hope of recovery will be able to end their lives by refusing life-sustaining treatment. <http://goo.gl/MEMl65>

N.B. South Korea was ranked 18th of 80 countries surveyed in ‘2015 Quality of Death Index: Ranking Palliative Care Across the World,’ The Economist Intelligence Unit, October 2015. Commissioned by the Lien Foundation of Singapore [Noted in Media Watch, 12 October 2015, #431 (p.6)] <http://goo.gl/bT3PV5>

French lawmakers vote on terminal sedation, not euthanasia

FRANCE | Associated Press – 27 January 2016 – France’s lower house of parliament has approved a bill that could let doctors keep terminally ill patients sedated until death comes but stops short of legalizing euthanasia or assisted suicide. After years of tense debate over the issue and a long journey through Parliament, the bill is now facing a final vote at the Senate... If adopted, it would allow patients to request “deep, continuous sedation altering consciousness until death,” but only when their condition is likely to lead to a quick death. Doctors would be allowed to stop life-sustaining treatments, including artificial hydration and nutrition. Sedation and painkillers would be allowed “even if they may shorten the person’s life.” The bill would also apply to patients who are unable to express their will, following a process that includes consultation with family members. The methods can involve medicating patients until they die naturally of their illness or until they starve. Some doctors, however, say it may be more human to euthanize. <http://goo.gl/5SZbb0>

Noted in Media Watch, 12 May 2014, #357 (p.6):

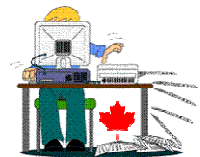
- *AMERICAN JOURNAL OF HOSPICE & PALLIATIVE MEDICINE* | Online – 7 May 2014 – ‘**Palliative sedation: Analysis of international guidelines and position statements.**’ Guidelines, etc., have been published by the American College of Physicians-American Society of Internal Medicine (2000), Hospice & Palliative Nurses Association (2003), American Academy of Hospice & Palliative Medicine (2006), American Medical Association (2008), Royal Dutch Medical Association (2009), European Association for Palliative Care (2009), National Hospice & Palliative Care Organization (2010), and National Comprehensive Cancer Network (2012). <http://goo.gl/T8c6y8>

Challenge over bereavement benefits

U.K. | BBC News – 27 January 2016 – Each year, an estimated 7,000 newly-bereaved partners receive nothing in bereavement benefits when their partner dies, as they are not married. Insurance company Royal London calculated that £82 million a year would be paid if the benefits were extended. A committee of MPs has challenged the government on why benefits for bereavement are limited to those married and in civil partnerships. A growing number of people in the U.K. – now six million – are living together without being married. If one partner dies, a surviving partner does not qualify for bereavement benefits, even if they have been together for years and have children <http://goo.gl/6kQOKt>

[Barry R. Ashpole](#)

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



Can good cheer and honest talk change our gloomy perspective on death?

THE ECONOMIST | Online – 26 January 2016 – Death is a hard thing to sell. People shrink away from the declarations of life insurance companies and funeral-planning services (“you’re guaranteed to be accepted for a funeral plan if you’re 50 or over”), dismissing them as unpleasant and, unsurprisingly, morbid. Attempts to bring death into the public domain have been largely unsuccessful; last year, IDEO, a leading global design firm, sought to “redesign death” in the form of a slick app to help put one’s affairs in order. It was abandoned, with few prospects for uptake. Another “Death-Positive Movement” wants to “teach our repressed society how to explore its relationship with death”; one advocate runs a website called ‘Ask A Mortician’ so that fears, thoughts, and feelings can become

part of the wider “cultural conversation.” It has found cult popularity, but the movement has not been able to break death’s commercial taboo. <http://goo.gl/M17moJ>

Specialist Publications

‘Providing palliative care for cardiovascular disease from a perspective of socio-cultural diversity: A global view’ (p.11), in *Current Opinion in Supportive & Palliative Care*.

‘Family caregivers who would be unwilling to provide care at the end of life again: Findings from the Health Survey for England Population Survey’ (p.15), in *Plos One*.

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- INDIA | DNA India (Mumbai) – 29 January 2016 – **‘Government says it favours passive euthanasia.’** Joining other countries legalising passive euthanasia for terminally ill patients, the Narendra Modi government has told Supreme Court ... that draft legislation, The Medical Treatment of Terminally Ill patient (protection of patients and medical practitioners) Bill, is prepared. The health ministry told the court that it is not in favour of active euthanasia, but favours the passive euthanasia and living will of the patient. <http://goo.gl/3Oh0p1>

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

Defining a good death (successful dying): Literature review and a call for research and public dialogue

AMERICAN JOURNAL OF GERIATRIC PSYCHIATRY | Online – 22 January 2016 – There is little agreement about what constitutes good death or successful dying. The definitions found were categorized into core themes and sub-themes and the frequency of each theme was determined by stakeholder (patients, family, health care providers [HCP]) perspectives. The authors identified 11 core themes of good death: 1) Preferences for a specific dying process; 2) Pain-free status; 3) Religiosity/spirituality; 4) Emotional well-being; 5) Life completion; 6) Treatment preferences; 7) Dignity; 8) Family; 9) Quality of life; 10) Relationship with HCP; and, 11) Other. The top three themes across all stakeholder groups were: 1) Preferences for dying process (94% of reports); 2) Pain-free status (81%); and, 3) Emotional well-being (64%). However, some discrepancies among the respondent groups were noted in the core themes e.g., family perspective articles included dignity (70%), life completion (80%), and presence of family (70%) more frequently than did patient perspective articles regarding those items (55% for each of these three themes). Religiosity/spirituality was reported more often in patient articles (65%) than in HCP (59%) and family (50%) articles. While there was agreement among stakeholders in the importance of many aspects of dying well, the presence of discrepancies in certain areas suggests a need for research on the impact of divergent perspectives on end-of-life care. Dialogues among the stakeholders for each individual must occur to ensure a good death from the most critical viewpoint – the patient’s. <http://goo.gl/u7GyUy>

Cont.

Selected articles on defining “a good death”

- *PALLIATIVE & SUPPORTIVE CARE* | Online – 6 January 2016 – ‘**The “good death”: An integrative literature review.**’ Evolving in response to prominent social attitudes and values, the contemporary “good death” is a powerful, constraining discourse that limits spontaneity and encourages one way to die. [Noted in Media Watch, 11 January 2016, #444 (p.13)] <http://goo.gl/NCthtU>
- *JOURNAL OF PALLIATIVE CARE*, 2015;31(3):158-165. ‘**Defining a good death: A deliberative democratic view.**’ The authors ... paint a picture that differs from those painted by the previous research, which focused mainly on individual and idealized views of a good death. [Noted in Media Watch, 7 September 2015, #426 (p.14)] <http://goo.gl/lcpZRT>
- *AMERICAN JOURNAL OF HOSPICE & PALLIATIVE MEDICINE* | Online – 23 February 2012 – ‘**Concept analysis of good death in terminally ill patients.**’ The findings of this study describe the evolution of the good death concept over time from the prehistoric era followed by pre-modern, modern, and post-modern times. [Noted in Media Watch, 27 February 2012, #242 (p.9)] <http://goo.gl/LuncFG>

A service evaluation of an integrated model of palliative care of cystic fibrosis

AMERICAN JOURNAL OF HOSPICE & PALLIATIVE MEDICINE | Online – 26 January 2016 – Patients with advanced cystic fibrosis (CB) ... are often awaiting lung transplantation and many die without receiving specialist palliative care (PC). The authors introduced an integrated model whereby palliative specialists joined the CB team to provide PC in parallel with standard care. The CB team rated this model highly, felt that PC should be members of the team, and thought that patients had found it helpful. The palliative specialists gained knowledge of CB, found it beneficial to meet patients earlier in the disease, and identified unmet needs in managing bereavement and the effects of deaths on other patients with CB. <http://goo.gl/VCVEoD>

Noted in Media Watch, 14 September 2015, #427 (p.10):

- *JOURNAL OF CYSTIC FIBROSIS* | Online – 8 September 2015 – ‘**Cystic fibrosis healthcare workers feel unprepared in providing suitable end-of-life care and desire more education: Results of a nationwide survey.**’ The majority of non-physician cystic fibrosis (CF) care providers [i.e., survey respondents] reported that they felt “somewhat” or “very” involved in palliative or end-of-life care in their current role. Yet ... only 18% reported that they were “fully prepared” and 45% felt that they were only “minimally” or “not” prepared. <http://goo.gl/pBBKtc>

N.B. Selected articles, reports, etc., on end-of-life care for people living with cystic fibrosis noted in past issues of Media Watch are listed in this issue of the weekly report.

End-of-life care in The Netherlands

Hospice assist at home: Does the integration of hospice care in primary healthcare support patients to die in their preferred location – A retrospective cross-sectional evaluation study

AMERICAN JOURNAL OF HOSPICE & PALLIATIVE MEDICINE | Online – 26 January 2016 – Hospice assist at home service [a Dutch model of general/specialised palliative care within primary care, collaboratively built by general practitioners and a hospice] supports patients to die in their preferred place of death. Shared responsibility of proactive care in primary care collaboration enable patients to express preferences. A total of 130 patients [i.e., study participants] ... were enrolled... Preferred place of death was known for 101/107 (94%) patients of whom 91% patients died at their preferred place of death. <http://goo.gl/8qJVHw>

Related

- *BMC HEALTH SERVICES RESEARCH* | Online – 28 January 2016 – ‘**Hospice care in The Netherlands: Who applies and who is admitted to inpatient care?**’ This study suggests that when applying for inpatient hospice care, patients who seem most urgently in need of inpatient hospice care are more frequently admitted. However, non-cancer patients seem to be an under-represented population. <http://goo.gl/ROF7IF>

Exploring sensory experiences and personalization in an inpatient residential hospice setting

AMERICAN JOURNAL OF HOSPICE & PALLIATIVE MEDICINE | Online – 25 January 2016 – This study explored the ambient and sensory experience of residents and families in a residential hospice. Hospice users participated in personalizing environments and experiences, adapting and developing rituals, and enjoying the experience (including smells and sounds) of communal spaces and private rooms. Opportunity for developing new rituals, in particular, suggests an environment supportive of sense of control, social support, and positive distracters. <http://goo.gl/BHME5j>

Noted in Media Watch, 24 December 2012, #285 (p.12) (under 'Worth Repeating'):

- *JOURNAL OF HOUSING FOR THE ELDERLY*, 2009;23(1-2):66-91. '**Creating a place for dying: Gerontopia.**' The author reports on how the environment negatively impairs or positively enables and empowers patients through individual meaning, control/preference, and sensory perception. Of application for designers, health care providers, and families, this study of caregivers provides specific attributes and examples of place making for palliative care environments. <http://goo.gl/HF2fvv>

An observational study to explore the feasibility of assessing bereaved relatives' experiences before and after a quality improvement project to improve care of dying medical inpatients

AMERICAN JOURNAL OF HOSPICE & PALLIATIVE MEDICINE | Online – 25 January 2016 – Although hospitals are the most likely place of death, the quality of care received by dying inpatients remains variable. This is of concern for both the dying person and their relatives, with poorer bereavement outcomes likely for those who perceived their family member suffered unduly. There is a real need to consider how this situation can be improved. This work was conducted with the aim of exploring the feasibility of including bereaved relatives' experiences as part of a larger project exploring the use of a care bundle to improve care of the dying inpatients. Although all families [i.e., study participants] who agreed to be interviewed completed the session, with regard to the quality of dying and death, some families indicated that they would rather talk than provide numeric scores. When invited to share their experiences, without prompting, families spoke of consistent concerns that included communication, place of death, and symptom control. <http://goo.gl/P0CyPA>

Related

- *AMERICAN JOURNAL OF HOSPICE & PALLIATIVE MEDICINE* | Online – 26 January 2016 – '**Differences in palliative care quality between patients with cancer, patients with organ failure and frail patients: A study based on measurements with the Consumer Quality Index Palliative Care for bereaved relatives.**' Compared with the bereaved relatives of patients with cancer, bereaved relatives of patients with organ failure or frailty were more likely to negatively assess the palliative care provided to both the patient and themselves. <http://goo.gl/S4XPyy>

Noted in Media Watch, 13 April 2015, #405 (p.9):

- *INTERNATIONAL JOURNAL OF PALLIATIVE CARE* | Online – Accessed 10 April 2015 – '**Concordance between experiences of bereaved relatives, physicians, and nurses with hospital end-of-life care: Everyone has their "own truth."**' To achieve improvements in care in the dying phase, more emphasis should be put on the collaboration between health care professionals and relatives in the therapeutic alliance with patients. Physicians should be more willing to timely discuss a poor prognosis and to check whether the patient and relative's understanding align with the physician. <http://goo.gl/1IWtz0>

Noted in Media Watch, 16 March 2015, #401 (p.10):

- *JOURNAL OF PALLIATIVE CARE*, 2015;31(1):13-20. '**Dying in the hospital: Perspectives of family members.**' Although most patients express a preference to die at home, many (30% in the U.S.) still die in hospital. Families do not interpret clinical cues leading up to death in the same way that health-care providers do; families need clear and direct explanations from providers. Clinicians should assess patient and family understandings of prognosis and communicate clearly and directly. Family members value being with their loved one at the time of death. <http://goo.gl/RdNgrv>

Making space for empathy: Supporting doctors in the emotional labour of clinical care

BMC MEDICAL ETHICS | Online – 27 January 2016 – Empathy is an important aspect of clinical care, but the emotional labour it requires is not negligible. The ability for empathy, namely the joining into someone else's feelings and emotions, presupposes a high level of self-awareness of one's own emotions. Physicians are routinely trained to remain detached from their own as well as their patients' emotions, perpetuating the ideal of the skilled and cool-minded professional. They have to deal daily with distressing situations, heavy workload, and strict time constraints. Such an environment is not conducive to the development of empathy in the contact with patients. Although a certain degree of detachment is important for doctors, over-detachment characterised by emotional neglect and denial can have serious consequences for both physicians and patients. A variety of support groups and courses are already available for doctors to help them develop emotional self-awareness and self-reflection, but only few make use of them. Until the stigma of the "unprofessional" and "weak" doctor who needs support is removed and the work conditions improve, these tools will remain unutilised. Empathy should not only be expected from doctors but should be actively promoted, assisted and cultivated in the medical profession. <http://goo.gl/r1uRKt>

Related

- *BRITISH JOURNAL OF GENERAL PRACTICE* | Online – 1 February 2016 – '**Clarifying empathy: The first step to more humane clinical care.**' Currently, empathy and the "humanisation" of medical care are of particular concern in the wake of high-profile reports. These include the Mid Staffordshire National Health Service Foundation Trust public inquiry;¹ 'Dying Without Dignity,' a report by the Health Service Ombudsman into end-of-life-care;² and, the Leadership Alliance for the Care of Dying People report, 'One Chance to Get it Right.'³ These reports all pointed to an empathy deficit in clinical care. A disheartening aspect of the current situation is that empathy deficit is not a new phenomenon. <http://goo.gl/KbVku0>
 1. 'Report of the Mid Staffordshire National Health Service Foundation Trust Public Inquiry,' February 2013. [Noted in Media Watch, 11 February 2013, #292 (p.5)] <http://goo.gl/XPLTU>
 2. 'Dying with Dignity: Investigations by the Parliamentary & Health Service Ombudsman into Complaints About End-of-Life Care,' May 2015. [Noted in Media Watch, 25 May 2015, #411 (p.6)] <http://goo.gl/w3CSPm>
 3. 'One Chance to Get it Right: Improving people's experience of care in the last few days and hours of life,' Leadership Alliance for the Care of Dying People, 2014. [Noted in Media Watch, 30 June 2014, #364 (p.7)] <https://goo.gl/HF6Krt>

Selected articles on empathy in end-of-life care:

- *EUROPEAN JOURNAL OF PALLIATIVE CARE*, 2014;21(2):69-71. '**The art and science of empathy.**' In palliative care ... healing can be facilitated by the establishment of a therapeutic relationship in which empathy plays a crucial role, helping to release the innate potential of the sufferer towards reintegration and wholeness. [Noted in Media Watch, 17 March 2014, #349 (p.10)]

N.B. Access to this article requires a subscription. Contents page: <http://goo.gl/RI5Msl>
- *JOURNAL OF PALLIATIVE MEDICINE* | Online – 17 December 2013 – "'**Yes it's sad, but what should I do?': Moving from empathy to action in discussing goals of care.**" The authors discuss: 1) How affect provides a spotlight that illuminates what is important; 2) How empathy affords a way to connect with patients and families that engages deep values; 3) How clinicians can infer deep values through an associative process with patients; and, 4) How clinicians can then design actions with patients and families and nurture their commitment to the actions. [Noted in Media Watch, 23 December 2013, #337 (p.14)] <http://goo.gl/eGwJwp>
- *BRITISH JOURNAL OF COMMUNITY NURSING*, 2013;18(7):358. '**Empathy in palliative care: A biological inheritance.**' Empathy ... is a central and sensitive aspect of community nursing. Empathy is a critical component of the social intelligence needed for such support and is popularly associated with the ability to identify with the emotional experiences of others. [Noted in Media Watch, 15 July 2013, #314 (p.6)] <http://goo.gl/vxHBTY>

Evidence of increasing public participation in advance care planning: A comparison of polls in Alberta between 2007 and 2013

BMJ SUPPORTIVE & PALLIATIVE CARE | Online – Raw data from three independently conducted public polls on advance care planning (ACP) engagement ... were analysed to assess whether participation in ACP activities changed over 6 years. Statistically significant increases were ... in: recognising the definition of ACP (54.8% to 80.3%), discussions about healthcare preferences with family (48.4% to 59.8%) and with healthcare providers (9.1% to 17.4%), written ACP plans (21% to 34.6%), and legal documentation (23.4% to 42.7%). These remained significant after adjusting for age, education and self-rated health status. The authors discuss factors that may be responsible for the increase and provide suggestions for healthcare systems or other public bodies seeking to stimulate engagement in ACP. <http://goo.gl/FIUMup>

Diabetes management at end of life

Management of Diabetes in Long-term Care & Skilled Nursing Facilities: A position statement of the American Diabetes Association

DIABETES CARE, 2016;39(2):308-318. This position statement provides a classification system for older adults in long term care (LTC) settings, describes how diabetes goals and management should be tailored based on co-morbidities, delineates key issues to consider when using glucose-lowering agents in this population, and provides recommendations on how to replace sliding scale insulin (SSI) in LTC facilities. As these patients transition from one setting to another, or from one provider to another, their risk for adverse events increases. Strategies are presented to reduce these risks and ensure safe transitions. This article addresses diabetes management at end of life and in those receiving palliative and hospice care. The integration of diabetes management into LTC facilities is important and requires an interprofessional team approach. To facilitate this approach, acceptance by administrative personnel is needed, as are protocols and possibly system changes. It is important for clinicians to understand the characteristics, challenges, and barriers related to the older population living in LTC facilities as well as the proper functioning of the facilities themselves. Once these challenges are identified, individualized approaches can be designed to improve diabetes management while lowering the risk of hypoglycemia and ultimately improving quality of life. <http://goo.gl/e5k80D>

Noted in Media Watch, 9 December 2013, #335 (p.13):

- *PRACTICAL DIABETES*, 2013;30(90):355-356. 'End of Life Diabetes Care: A Strategy Document': Where are we one year on in the light of the review of The Liverpool Care Pathway?' Access to this article requires a subscription. <http://goo.gl/XAihMI>

N.B. End of Life Diabetes Care: A Strategy Document Commissioned by Diabetes U.K., July 2012. <http://goo.gl/7OZ3Of>

Media Watch: Back Issues – <http://goo.gl/frPgZ5>

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Please feel free to share this weekly report with your colleagues.
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MW 444: Prognosis, treatment benefit and goals of care: What do oncologists discuss with patients who have incurable cancer?
Download the complete issue (PDF 540 KB)

CLINICAL ONCOLOGY | Online – 14 December 2015 | The authors describe documentation of prognosis, treatment benefit and goals of care discussions in outpatients with advanced cancer. [read more...](#)

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- 2014, January - June
- 2013, July - December
- 2013, January - June
- 2012, July - December
- 2012, January - June
- 2011, July - December
- 2011, January - June
- Current

Magical thinking around end of life: An editorial on 'Implantable cardioverter defibrillator deactivation discussions – Reality vs. recommendations'

EUROPEAN JOURNAL OF CARDIOVASCULAR NURSING, 2016;15(1):8-9. Discussing deactivation with a patient is difficult and requires skill and empathy. The ability to hold these conversations is not innate, but requires training and practice. The literature suggests that simulation and role play are more effective than simple knowledge acquisition. Shifting the paradigm of healthcare professionals will require that training programs incorporate training on communication in the setting of serious illness and that experienced healthcare professionals model these behaviors for the trainees they mentor. A tool to assist healthcare providers specifically with discussions around implantable cardioverter defibrillator (ICD) deactivation has been developed and tested in Swedish and testing of an English language translation is ongoing. Despite our preconceptions about the challenges of these discussions, the reality is that we do not know patient preferences until we explore them. We need to talk to patients about their values, preferences and choices because it turns out that we are not that good at predicting what they would want. Hill and colleagues' finding that patients who had endured a shock were more likely to keep their ICDs active at death is contrary to intuition.¹ But it also suggests a real possibility: that getting a shock is not as bad as we think it is. Maybe the real lesson for us is that the only

way we will know how painful it is to engage in these discussions is to actually have them – maybe the “shock” will not be so bad after all. <http://goo.gl/SmlFdi>

Providing palliative care for cardiovascular disease from a perspective of socio-cultural diversity: A global view

CURRENT OPINION IN SUPPORTIVE & PALLIATIVE CARE | Online – 22 January 2016 – The burden of cardiovascular disease is increasing globally and access to palliative care for individuals and populations is inconsistent and largely driven by policy, funding models, center-based expertise and local resources. Culture is an important social determinant of health and moderates health outcomes across the life trajectory. Along with approachability, availability, accommodation, affordability and appropriateness, culture moderates access to services. Health disparities and inequity of access underscore the importance of ensuring services meet the needs of diverse populations and that care is provided by individuals who are culturally competent. In death and dying, the vulnerability of individuals, families and communities is most pronounced. The authors consider the evidence from the literature in regard to the interaction between the individual, interpersonal relationships, community and society in promoting access to individuals with cardiovascular disease. <http://goo.gl/92Xcjl>

1. 'Implantable cardioverter defibrillator deactivation discussions: Reality vs. recommendations,' *European Journal of Cardiovascular Nursing*, 2016;15(1):20-29. [Noted in Media Watch, 4 May 2015, #408 (p.10)] <http://goo.gl/vlj8KR>

Selected articles on defibrillator deactivation in the context of end-of-life care

- RESUSCITATION COUNCIL (U.K.), BRITISH CARDIOVASCULAR SOCIETY & NATIONAL COUNCIL FOR PALLIATIVE CARE | Online – March 2015 – '**Cardiovascular implanted electronic devices in people towards the end of life, during cardiopulmonary resuscitation and after death.**' Challenges arise when people with an implanted device approach or reach the end of their life. Receiving treatment as they are dying may provide no benefit but may cause them pain and may cause distress both to them and to those who care about them. [Noted in Media Watch, 23 March 2015, #402 (p.11)] <https://goo.gl/D7iISb>
- *PACING & CLINICAL ELECTROPHYSIOLOGY* | Online – 14 February 2015 – '**Defibrillator deactivation against a patient's wishes: Perspectives of electrophysiology practitioners.**' Survey respondents were from Europe, Asia, Australia, South American and Africa. The majority 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. [Noted in Media Watch, 23 February 2015, #398 (p.14)] <http://goo.gl/QuxgL3>

Cont.

- *INTERNATIONAL JOURNAL OF CARDIOLOGY* | Online – 5 January 2015 – ‘**Defibrillator patients should not be denied a peaceful death.**’ A descriptive analysis of 65 deceased ICD patients, all of whom had a written DNR-order before death, is presented. More than half still had shock treatment active at time of death with a median of four days or more between DNR decision and death. Patients with therapy deactivated, two days or more elapsed in more than a third from DNR decision to deactivation of therapy, exposing patients to a high risk of painful shocks before death. [Noted in Media Watch, 12 January 2015, #392 (p.9)] <http://goo.gl/ZYRsTT>

Managing hope in palliative care

HUISARTS EN WETENSCHAP, 2016;59(1):14-16. Hope is important to people receiving palliative care, but it can put general practitioners in an awkward situation, especially when the patient has false hope. However, patients and their caregivers approach the concept of “hope” not only from a realistic perspective, but also from a functional perspective (hope helps to cope with the situation) or a narrative perspective (hope fits with someone’s narrative). Communication in the last phase can be improved substantially if GPs bear these three perspectives in mind. The balance between hope, hopelessness, and despair – the dynamics of hope – is affected by changes in the patient’s physical condition, and GPs can make use of these changes during the palliative phase to raise the topic of “hope.” Lastly, from a relational-ethical point of view GPs have to find a balance between appealing to hope-giving aspects (empowerment) on the one hand and recognizing suffering and loss (compassion) on the other. A relational ethics of hope requires that GPs recognize their own hopes and suffering. <http://goo.gl/QxcjeO>

N.B. Dutch language article

Related

- *AMERICAN JOURNAL OF HOSPICE & PALLIATIVE MEDICINE* | Online – 25 January 2016 – ‘**Hope, symptoms, and palliative care: Do symptoms influence hope?**’ Anxiety, depression, fatigue, and pain are reported to impair hope. The objective of this study was to determine whether age, gender, marital status, duration of cancer, symptoms, or symptom burden ... correlated with hope as measured by the Herth Hope Index. This study found a correlation between symptom burden and hope was not clinically relevant, but was so for depression. <http://goo.gl/zj7Mki>

End-of-life care in Ireland

Guide on consent law due

IRISH MEDICAL TIMES | Online – 27 January 2016 – An implementation guide to support the Health Service Executive National Consent Policy is in the final stages of development and will be aligned with recent and forthcoming legislation and will be rolled out, the Minister for Health has said. In July 2015, legislative provisions relating to advance healthcare directives were incorporated into the Assisted Decision-Making (Capacity) Bill 2013. The guiding principle underpinning the AHD provisions is that an adult with capacity is entitled to refuse treatment, including resuscitation, for any reason. The 2013 Bill was passed by the Dáil [i.e., Assembly of Ireland] in October. <http://goo.gl/KQHnEV>

Academic study shows how racial bias may impact end-of-life care

JOURNAL OF BLACKS IN HIGHER EDUCATION | Online – 25 January 2016 – A new study by research at the University of Pittsburgh Medical Center and Purdue University found physician treat dying Black and White patients differently. The researchers conducted an experiment with emergency room physicians and put them in simulations where they had to interact with patients who were dying and their family members. The results showed that physicians were more likely to stand right next to the White patients’ bedside when telling them the bad news and what treatments were available. Doctors were also more likely to touch White patients sympathetically. Senior author of the study, Amber Barnato, an associate professor of clinical and translation medicine at the University of Pittsburgh, said that “although we found

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that physicians said the same things to their Black and White patients, communication is not just the spoken word. It also involves nonverbal cues, such as eye contact, body positioning and touch. Poor nonverbal communication – something the physician may not even be aware he or she is doing – could explain why many Black patients perceive discrimination in the health care setting.” Dr. Barnato went on to say “body language is a significant tool in building trust – or mistrust. To help Black patients and their families feel welcome and encouraged to be partners in medical decision-making, it is critical that doctors be aware of their verbal and nonverbal communication and any unintentional biases.” <https://goo.gl/kbJf1B>

1. ‘Differences in physicians’ verbal and non-verbal communication with black and white patients at the end of life,’ *Journal of Pain & Symptom Management*, 2016;51(1):1-8. [Noted in Media Watch, 24 August 2015, #424 (p.13)] <http://goo.gl/klBrNh>

Noted in Media Watch, 24 August 2015, #424:

- U.S. | National Public Radio – 20 August 2015 – ‘**Can health care be cured of racial bias?**’ Even as the health of Americans has improved, disparities in treatment and outcomes between white patients and black and Latino patients are almost as big as they were 50 years ago. A growing body of research suggests doctors’ unconscious behavior plays a role in these statistics, and the Institute of Medicine of the National Academy of Sciences has called for more studies looking at discrimination and prejudice in health care.¹ <http://goo.gl/JUZvwn>

1. ‘Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,’ Institute of Medicine of the National Academy of Sciences, 2003. <http://goo.gl/C4A9bv>

Physicians’ and nurse practitioners’ level of pessimism about end-of-life care during training: Does it change over time?

JOURNAL OF PAIN & SYMPTOM MANAGEMENT | Online – 27 January 2016 – The authors examined changes in trainee pessimism about end-of-life care over the course of one academic year and to explore predictors of pessimism among residents, fellows, and nurse practitioners. There was a significant decrease in pessimism between baseline and follow-up assessments. Age had a significant inverse effect on baseline pessimism, with older trainees being less pessimistic. There was a direct association of race/ethnicity on pessimism at follow-up, with greater pessimism among minority trainees. The model suggests that between baseline and follow-up, pessimism among younger white non-Hispanic trainees decreased, whereas pessimism among younger trainees in racial/ethnic minorities increased over the same time period. Pessimism about end-of-life care among minority trainees may reflect the influence of culture on clinician attitudes about communication with seriously ill patients. <http://goo.gl/9js5Tp>

Ethical dilemmas at the end of life: Islamic perspective

JOURNAL OF RELIGION & HEALTH | Online – 22 January 2016 – Many Muslim patients and families are often reluctant to accept fatal diagnoses and prognoses. Not infrequently, aggressive therapy is sought by the patient or his/her family to prolong the life of the patient... Islamic law permits the withdrawal of futile treatment, including all kinds of life support, from terminally ill patients leaving death to take its natural course. However, such decision should only take place when the physicians are confident that death is inevitable. All interventions ensuring patient’s comfort and dignity should be maintained. This topic is quite challenging for the health care providers of Muslim patients in the Western World. <http://goo.gl/9QCq9d>

Cont. next page

[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.

Related

- *CLINICAL JOURNAL OF ONCOLOGY NURSING*, 2016;20(1):11-12. **‘Providing culturally appropriate care to American Muslims with cancer.’** The population of Muslims in the U.S. is projected to dramatically increase in the next few decades. Understanding the role of Islam for people who believe in and follow Islam will provide nurses with important perspectives that affect health behaviors, cancer screening, treatment decision-making, and end-of-life care. <https://goo.gl/OxOV04>

Noted in Media Watch, 16 February 2015, #397 (p.10):

- *GLOBAL BIOETHICS* | Online – 9 February 2015 – **‘Islam and palliative care.’** This investigation is steered by two overriding questions. First, if pain and suffering could, as highlighted in the primary sources of Islamic Law, lead to the expiation of sins, can pain relief be taken? Second, is it religiously permissible to choose pain treatment options that could bring about iatrogenic addiction, the hastening of death and the impairment or obliteration of consciousness? <http://goo.gl/hoFnWt>

Noted in Media Watch, 12 January 2015, #392 (p.7):

- *AMERICAN JOURNAL OF BIOETHICS*, 2015;15(1):3-13. **‘Ethical obligations and clinical goals in end-of-life care: Deriving a quality-of-life construct based on the Islamic concept of accountability before God (Taklif).’** End-of-life medical decision making presents a major challenge to patients and physicians alike. In order to determine whether it is ethically justifiable to forgo medical treatment in such scenarios, clinical data must be interpreted alongside patient values, as well as in light of the physician’s ethical commitments. <http://goo.gl/NZXlJy>

N.B. This issue of the *American Journal of Bioethics* includes several articles on end-of-life care from the Islamic perspective. Journal contents page: <http://goo.gl/vw9Lxq>. Additional articles on the subject are noted in the issues of Media Watch of 15 December 2014, #388 (pp.11-12), 16 June 2014, #362 (p.11), and 28 March 2011, #194 (p.10).

End-of-life care in Canada: Multi-centre study

Dignity and distress towards the end of life across four non-cancer populations

PLOS ONE | Online – 25 January 2016 – Study subjects included patients with advanced amyotrophic lateral sclerosis (ALS), chronic obstructive pulmonary disease (COPD), end stage renal disease (ESRD); and, institutionalized alert frail elderly. 404 participants were recruited (ALS, 101; COPD, 100; ESRD, 101; and frail elderly, 102). Depending on group designation, 35% to 58% died within one year of taking part in the study. While moderate to severe loss of sense of dignity did not differ significantly across the four study populations, the number of Patient Dignity Inventory items reported as problematic was significantly different... Each of the study populations also revealed unique and distinct patterns of physical, psychological and existential distress. <http://goo.gl/szA5HL>

Related

- *SUPPORTIVE CARE IN CANCER* | Online – 27 January 2016 – **‘Detrimental social interactions predict loss of dignity among patients with cancer.’** Loss of dignity was a frequent problem in the authors’ mixed cancer patient sample. Detrimental interactions that weaken the sense of dignity may result from discrepancies with patients’ needs for autonomy and security. Tailoring social support to attachment-related patient needs may help to conserve patients’ sense of dignity. <http://goo.gl/7lvu2Z>

[Media Watch: 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://goo.gl/8JyLmE>

Family caregivers who would be unwilling to provide care at the end of life again: Findings from the Health Survey for England Population Survey

PLOS ONE | Online – 25 January 2016 – Most people who have provided end-of-life care for someone close to them would be prepared to provide care again. However, a significant group would not. Younger age of caregiver and use of palliative care services were associated with willingness to care again highlighting the need for appropriately skilled support for patient and their families while in this role and subsequently. Barriers preventing access for disadvantaged groups need to be actively overcome. <http://goo.gl/SX1gqS>

Related

- *AMERICAN JOURNAL OF HOSPICE & PALLIATIVE MEDICINE* | Online – 26 January 2016 – ‘**Gender and family caregiving at the end-of-life in the context of old age: A systematic review.**’ Palliative family caregiving for older adults is gendered. Gender affects why people care and the consequences of providing care (PC). PC literature needs to incorporate a greater gender focus for future research and policy makers need to be aware of the gendered ramifications of providing more PC in the community. <http://goo.gl/Cx9qge>

Living and dying with frailty: Qualitative interviews with elderly people in the domestic environment

ZEITSCHRIFT FÜR GERONTOLOGIE UND GERIATRIE | Online – 15 January 2016 – From the patients’ perspective frailty is perceived as a process of increasing complexity of health problems, increased vulnerability and reduced ability to perform tasks. Frailty is experienced as various deficits including the physical, psychological, social and existential dimensions. Living and dying in a familiar environment and maintaining autonomy was identified as a core category. Key determinants were access to and quality of healthcare services as well as various individual and social resources. A palliative bio-psychosocial care approach should be established early in the process of frailty, including advance care planning in order to meet the patients’ needs of staying in a familiar environment. <http://goo.gl/PPIDJ9>

N.B. German language article

Selected articles on frailty at end of life

- *FRAILITY IN AGING: BIOLOGICAL, CLINICAL & SOCIAL IMPLICATIONS*, 2015;41:151-160. ‘**End-of-life care in frailty.**’ The ability of health care systems to recognize and respond to acute health issues in frail patients using a holistic understanding of health and prognosis will play a central role in ensuring their effective and appropriate care, including that at the end of their lives. The authors review the history of palliative care (PC) and the elements of frailty that require the modification of current models of PC. [Noted in Media Watch, 3 August 2015, #421 (p.8)] <http://goo.gl/zNXy1B>
- *JOURNAL OF THE AMERICAN MEDICAL DIRECTORS*, 2013;14(6):392-397. ‘**Frailty consensus: A call to action.**’ A consensus group consisting of delegates from six major international, European and U.S. societies created four major consensus points on a specific form of frailty. For the purposes of optimally managing individuals with physical frailty, all persons older than 70 years and all individuals with significant weight loss due to chronic disease should be screened for frailty. [Noted in Media Watch, 24 June 2013, #311 (p.11)] <http://goo.gl/JmWQQp>
- *JOURNAL OF NURSING EDUCATION & PRACTICE*, 2013;3(7):75-91. ‘**When frailty should mean palliative care.**’ The aim of this work is to assist physicians in providing proper care for the frail elderly. It consists in a systematic review of the literature available, intended answer the following questions: 1) Is frailty an appropriate indication for the instatement of palliative care (PC)? 2) When is the right moment to instate PC for the frail elderly subject? 3) What tools are available to assist care teams? 4) Are there efficient organisational models that integrate the frail elderly into PC? There are answers to these questions. But the level of evidence is low. It can be concluded that frailty is an indication for the instatement of PC. [Noted in Media Watch, 21 January 2013, #289 (p.8)] <http://goo.gl/55Gj9e>

Worth Repeating

Hospice patient evacuation: A case for using a checklist for safe disaster response

AMERICAN JOURNAL OF HOSPICE & MEDICINE, 2014;31(3):260-268. This study provides lessons learned from the experience of a small, rural hospice care organization of an actual crisis that required evacuation of the facility. A framework using emergency response certification guidelines was used to first provide details of the incident, second analyze the effectiveness of disaster planning and response to an actual crisis, and third discuss the post-event review, lessons learned, and process improvement. [Noted in Media Watch, 1 April 2013, #299 (p.8)] <http://goo.gl/Wr36hN>

Palliative care considerations in mass casualty events with scarce resources

BIOSECURITY & BIOTERRORISM: BIODEFENSE STRATEGY, PRACTICE & SCIENCE, 2009;7(2):199-210. Planning to provide palliative care (PC) during mass casualty events [in the U.S.] should be part of the current state and local disaster planning/training guidelines, protocols, and activities. The authors identify five domains of concern, along with guidance: 1) The role of PC in a mass casualty event with resulting scarce resources; 2) The triage and ensuing treatment decisions for those “likely to die”; 3) The critical PC services to provide, along with the personnel and settings; 4) The pragmatic plans needed for ensuring training, supplies, and organizational or jurisdictional arrangements; and, 5) Unusual issues affecting PC under mass casualty event scenarios. [Noted in Media Watch, 17 August 2009, #110 (p.7)] <http://goo.gl/20WLTc>

Media Watch: Online

International

INTERNATIONAL ASSOCIATION FOR HOSPICE & PALLIATIVE CARE: <http://goo.gl/qeiOX9>

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

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

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

Asia

ASIA PACIFIC HOSPICE PALLIATIVE CARE NETWORK: [HTTP://GOO.GL/JNHVMB](http://goo.gl/JNHVMB)

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

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Europe

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

HUNGARY | Hungarian Hospice Foundation: <http://goo.gl/5d1l9K>

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

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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.

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