

## 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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Special journal issue on palliative care in dementia: Scroll down to [Specialist Publications](#) and 'Complexity and gaps: The high-hanging fruit of dementia and palliative care research' (p.13), in *Palliative Medicine*.

## Canada

### Medical Assistance in Dying (MAiD)

#### Formal network of docs offering medical assistance in dying is in the works for northeastern Ontario

ONTARIO | CBC News (Sudbury) – 15 March 2018 – About 40 doctors and nurse practitioners in the region are now trained to offer Medical Assistance in Dying (MAiD), after they had specialized training ... from the Canadian Medical Association. The Supreme Court of Canada ruled in June 2016 that medical assistance in dying is a constitutional right... Between then and now, there has only been an informal network for people seeking medically assisted death, said Dr. Paul Preston, Vice President of Clinical for the North East Local Health Integration Network (LHIN), and an advocate for access for those seeking a doctor's help with dying. Referrals happen when family practitioners who may be uncomfortable with the request direct the patient to another doctor. He adds that many doctors and nurses who help people with dying don't want their names on a published list, nor do they want to provide service outside their catchment area. The LHIN still needs to work out the details for how the network will operate or who will have access to it. <https://goo.gl/dhSbzc>

### Specialist Publications

'Provider tools for advance care planning and goals of care discussion: A systematic review' (p.7), in *American Journal of Hospice & Palliative Medicine*.

'What are healthcare providers' understandings and experiences of compassion? The healthcare compassion model: A grounded theory study of healthcare providers in Canada' (p.8), in *BMJ Open*.

'Medical assistance in dying: Journey to medical self-determination' (p.14), in *Alberta Law Review*.

### Journal Watch

'Poor quality, predatory conferences prey on academics' (p.15), in *University Affairs*.

## U.S.A.

### **Hospitals are confronting a new opioid crisis: An alarming shortage of pain meds**

MASSACHUSETTS | Stat (Boston) – 15 March 2018 – The incident command system kicked in at Brigham & Women’s Hospital about a week ago. A team of doctors, pharmacists, and nurses began assembling every morning to confront an emerging crisis with the potential to severely undermine care for patients. The challenge was different than it was during the Boston Marathon bombing, another event that triggered the command response. This one wasn’t rushing toward caregivers as fast. But it was similarly daunting and logistically demanding. Amid a nationwide crisis caused by too-easy access to medical painkillers, hospitals are now struggling to find enough of that same class of drugs to keep their patients’ pain controlled. That is the reality now facing Brigham & Women’s and other medical providers across the country. Production of injectable opioids has nearly ground to a halt due to manufacturing problems, creating a shortage of staple medications used to treat a wide array of patients <https://goo.gl/ors4cr>

#### **The other opioid crisis: Hospital shortages lead to patient pain, medical errors**

*KAISER HEALTH NEWS* | Online – 16 March 2018 – Even as opioids flood American communities and fuel widespread addiction, hospitals are facing a dangerous shortage of the powerful painkillers needed by patients in acute pain, according to doctors, pharmacists and a coalition of health groups. As a result, hospital pharmacists are working long hours to find alternatives, forcing nurses to administer second-choice drugs or deliver standard drugs differently. That raises the risk of mistakes – and already has led to at least a few instances in which patients received potentially harmful doses, according to the non-profit Institute for Safe Medication Practices, which works with health care providers to promote patient safety. <https://goo.gl/qNdcv8>

Noted in Media Watch 5 March 2018 (#553, p.3):

- OREGON | *The Bulletin* (Bend) – 24 February 2018 – ‘**Opioid limits hit hospice, cancer patients.**’ New strategies to rein in the overprescribing and misuse of opioid pain medications have almost universally excluded patients with end-of-life or cancer pain from those limits. But doctors treating such patients are increasingly reporting challenges getting medications for patients who truly need them. St. Charles Bend has experienced sporadic shortages of intravenous morphine and intravenous hydromorphone over the past year. <https://goo.gl/7nZUnC>

### **Long miles, lonely roads: In rural Texas, dying at home means little is easy**

TEXAS | Stat – 15 March 2018 – Texas has nearly 500 hospice providers, but 60% of its counties do not have a single provider, according to 2015 data – the latest available – compiled by Cordt Kass of Hospice Analytics. Use of hospice by eligible patients is only slightly less in rural counties than in urban ones, but Kassner’s data make clear that rural residents enter hospice much later than those living in or near cities. The average length of stay for rural residents is 63 days. For urban residents, it’s 81. Overall, about half the people who are eligible for hospice services in the state actually use them, which is slightly higher than the national average of 46%. “Texas, as a whole, in my opinion, has

many more hospices than are needed,” said Kassner. There are 254 counties in the state of Texas, and the largest five, by population, have more than 40% of the state’s providers. “The distribution of those hospices is not necessarily appropriate.” <https://goo.gl/hDEMGT>

#### **Specialist Publications**

‘**Evaluating the feasibility and acceptability of a telehealth program in a rural palliative care population: TapCloud for palliative care**’ (p.10), *Journal of Pain & Symptom Management*.

**N.B.** Additional articles on the provision and delivery of hospice and palliative care in rural and remote regions of the U.S. noted in the 6 November 2017 issue of Media Watch (#537, p.9).

## House defeats “right-to-try” legislation to allow expanded use of experimental drugs

*THE WASHINGTON POST* | Online – 14 March 2018 – In a major setback for Republicans, the House rejected “right-to-try” legislation Tuesday evening that would have allowed seriously ill patients to bypass the Food & Drug Administration (FDA) to get access to experimental treatments. The vote came after a spirited debate in which Republican Party lawmakers portrayed the measure, which was strongly backed by President Trump and Vice President Pence, as a last chance at survival for desperately ill patients. Democrats said the bill would weaken critical FDA protections without addressing the fundamental obstacles to experimental drugs. Republican backers brought up the measure under a suspension of the rules, which does not allow for amendments and requires approval from two-thirds of those present to pass. The legislation failed on a vote of 259 to 140. <https://goo.gl/unSDBb>

### Related

- MASSACHUSETTS | *Stat* (Boston) – 12 March 2018 – **“Right-to-try” law threatens patient safety and rational drug development.** A number of states have already passed such “right-to-try” laws. The Senate has passed a federal version, and a revised version is now under consideration in the House. The House Energy & Commerce Committee has shown its commitment to terminally ill patients by working to make some important changes to the Senate right-to-try bill. Yet even the House proposal retains key elements that will undoubtedly be harmful. Right-to-try legislation would create a pathway to remove FDA oversight of experimental, unproven therapies. <https://goo.gl/HyuDdQ>

**N.B.** Additional articles on “right-to-try” laws noted in 12 February 2018 issue of Media Watch (#550, p.5).

## Oregon medical students face tough test: Talking about dying

OREGON | *Kaiser Health News* (Portland) – 13 March 2018 – The distraught wife paced the exam room, anxious for someone to come and tell her about her husband. She’d brought him to the emergency department that afternoon when he complained about chest discomfort. Sophia Hayes, 27, a fourth-year medical student at the Oregon Health & Science University (OHSU), entered with a quiet knock, took a seat and asked the wife to sit, too. Softly and slowly, Hayes explained the unthinkable: The woman’s husband had had a heart attack. His heart stopped. The intensive care team spent 45 minutes trying to save him. Then Hayes delivered the news dreaded by doctors and family members alike. “I’m so, so sorry,” she said. “But he died.” The drama ... was a scene staffed by actors and recorded by cameras, part of a nerve-wracking exam for Hayes and 143 other would-be doctors. OHSU officials say they’re the first medical students in the U.S. required to pass a tough new test in compassionate communication. By graduation this spring, Hayes and her colleagues must be able to show that, in addition to clinical skills, they know how to admit a medical mistake, deliver a death notice, and communicate effectively about other emotionally and ethically fraught issues. <https://goo.gl/6rp7s1>

Noted in Media Watch 19 February 2018 (#551, p.3):

- MASSACHUSETTS | *Kaiser Health News* (Boston) – 12 February 2018 – **‘Doctors learn how to talk to patients about dying.’** Hundreds of clinicians at Massachusetts General Hospital in Boston are getting trained to talk to seriously ill patients about their goals, values – and prognoses – while there’s time to spare. At the hospital, Dr. Juliet Jacobsen, a palliative care physician, serves as medical director for the Continuum Project, a large-scale effort to quickly train clinicians to have these conversations, document them and share what they learn with one another. <https://goo.gl/wd6ge4>

## Judge rules that spouse has authority to remove partner's life support if there's no directive

CALIFORNIA | *The Los Angeles Times* – 12 March 2018 – A Los Angeles judge has ruled that a spouse in California is the presumptive healthcare decision maker when the partner is in a persistent vegetative state. Ruling in the case of a San Gabriel Valley man, Los Angeles Superior Court Judge Mary Thornton House said that in the event that there is no advance directive for a someone in a vegetative state, their partner can decide for them. California law, House noted in her ruling, has left “a gap” when it comes to this issue. The case involves Juan Fernando Romero, who suffered a lack of oxygen to the brain in May 2015 that left him in a persistent vegetative state at a San Gabriel Valley hospital. <https://goo.gl/veejon>

### Specialist Publications

**'End-of-life plans for African American older adults with dementia'** (p.13), in *American Journal of Hospice & Palliative Medicine*.

**'An actual advance in advance directives: Moving from patient choices to patient voices in advance care planning'** (p.6), in *Asian Bioethics Review*.

**'Implementing the MOLST (Medical Order for Life-Sustaining Treatments): Challenges faced by nursing home staff'** (p.9), in *Geriatric Nursing*.

## Assisted (or facilitated) death

Representative sample of recent news media coverage:

- HAWAII | *The Star Advertiser* (Honolulu) – 16 March 2018 – **'Bill to legalize medically assisted death moves forward in state Senate.'** Hawaii moved another step closer to legalizing medical aid in dying with a key Senate committee unanimously advancing House Bill 2739, known as the 'Our Care, Our Choice Act.' The Senate Commerce, Consumer Protection & Health Committee voted 6-0 in favor of the measure after hearing about two hours of public testimony in favor and against the bill. The committee did not make any amendments to the bill, which would allow terminally ill patients to request prescriptions for lethal doses of medication. The bill still needs the approval of the Senate Judiciary Committee and a full Senate vote. The Senate last year passed out a similar measure, but the bill was tabled by a House committee and was never put to a House floor vote. <https://goo.gl/fetJLK>
- CALIFORNIA | *The Sacramento Bee* – 14 March 2018 – **'Don't play politics with dying Californians.'** Lawmakers have to strike a balance between rules that safeguard patients and excessive regulations that make it difficult for patients to access health care. Adding more rules sometimes does more harm than good, and new legislation to amend California's End of Life Option Act is a classic example. The law gives mentally capable adults with six months or less to live the option to request prescription medication so they die peacefully if their suffering becomes unbearable. During recent hearings, patients, doctors, health system representatives and others confirmed that the law is helping terminally ill Californians. Concerns about abuse and coercion have proved to be completely unfounded. In fact, the consensus was that the process for obtaining the medication is too complicated and burdensome. It's difficult to find a doctor who will prescribe. There's too much paperwork, and the waiting period is too long. There are, quite simply, too many hoops for a dying person to get through. <https://goo.gl/MxKzgs>



### Barry R. Ashpole

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

## International

### End-of-life care in Australia

#### **Do not resuscitate laws introduced in Victoria**

AUSTRALIA | *The Age* (Melbourne) – 18 March 2018 – Victorians, including those with dementia, now have the power to refuse medical treatment or resuscitation even after they lose consciousness or forget who they are. New laws that quietly came into effect this week mean families can no longer overturn such instructions, as has happened in the past. The introduction of the Medical Treatment Planning & Decisions Act 2016 means people with dementia still can have a say about how they are treated, long after their memory starts showing signs of failing. People can also leave instructions asking they receive treatment in certain circumstances, such as a young person with a severe disability who wants to make it clear they do want to be resuscitated to save their life. Significantly, new “instructional directives” providing specific in-

structions about the treatments a person consents to or refuses will not be able to be overruled by family members. <https://goo.gl/XgC4Fw>

#### **Specialist Publications**

**‘Palliative sedation in Germany: Factors and treatment practices associated with different sedation rate estimates in palliative and hospice care services’** (p.12), in *BMC Palliative Care*.

**‘Italy’s new advance directive law: When in Rome...’** (p.7), in *JAMA Internal Medicine*.

**‘Patient’s orders: Patient’s rights and the doctor’s obligations under the Claeys-Leonetti Law of 2016 in France’** (p.12), in *Statute Law Review*.

#### **Revealed: Postcode lottery – burial plots in Northern Ireland cost from £261 to staggering £3,116**

U.K. (Northern Ireland) | *The Belfast Telegraph* – 17 March 2018 – An investigation, which examined the cost and causes of dying as well as the impact of changes in bereavement benefit payments, was carried out against a backdrop of austerity as well as rising funeral costs, with services last year 88% more expensive than they were in 2004. Investigators also looked into the variations in charges for children’s burials, with most councils offering discounts. Investigators found that in the five years to 2016-2017 there were 18,219 applications for a Funeral Payment, which provides financial assistance for benefits claimants “towards a simple, respectful, low-cost funeral.” The average payment was £1,037 – leaving families on low incomes with a shortfall of around £2,000... The research has prompted calls for a full overhaul of Government financial support and regulation of the funeral industry. Citizens Advice Northern Ireland, Marie Curie and the National Association of Funeral Directors believe a public health campaign is needed to address the issue. <https://goo.gl/1XTa32>

#### **Marie Curie to end palliative care service in Fife**

U.K. (Scotland | *The Courier* (Dundee) – 14 March 2018 – Marie Curie has announced it is ending its palliative care (PC) services in the region at the end of May amid fears the rates being offered in a new contract would not allow it to deliver the same level of quality care. The organisation said the rates quoted by Fife Health & Social Care Partnership were “unrealistic and restrictive.” Richard Meade, Marie Curie head of policy and public affairs in Scotland, predicted the contract would result in reduced quality of care and warned the impact would extend beyond patients. Health & Social Care Partnership, jointly run by National Health Service Fife and Fife Council, had incorporated PC into a much larger contract dominated by social care. He cautioned against such a move, despite potential efficiencies. <https://goo.gl/fqqVvi>



#### **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.

## Scots living in poverty “twice as likely” to experience complicated grief

U.K. (Scotland) | *The Scotsman* (Edinburgh) – 14 March 2018 – Having bereavement counselling to cope with grief improves wellbeing in adults, a new study has found. The five-year research study of more than 300 adults also discovered higher rates of complicated grief among bereaved people who are at or below the poverty threshold. Scottish charity Cruse Bereavement Care Scotland said around 10-20% of the general population is at significantly increased risk of suffering complicated grief which is associated with a higher risk of earlier death, including heart disease, and suicide as well as increased absence from work. <https://goo.gl/a3wFJj>

## Genes have a role in empathy, study says

U.K. (England) | BBC News – 12 March 2018 – It helps us to make close connections with people, and influences how we behave in a range of situations... Now scientists say empathy is not just something we develop through our upbringing and life experiences – it is also partly inherited. A study of 46,000 people found evidence for the first time that genes have a role in how empathetic we are.<sup>1</sup> And it also found that women are generally more empathetic than men. <https://goo.gl/6Ntoz9>

1. ‘Genome-wide analyses of self-reported empathy...’ *Translational Psychiatry*, published online 12 March 2018. **Full text:** <https://goo.gl/mY1Ekj>

## Assisted (or facilitated) death

Representative sample of recent news media coverage:

- INDIA | *The Telegraph* (Calcutta) – 12 March 2018 – ‘**Experts line up euthanasia dictionary.**’ The Indian Council of Medical Research (ICMR) has released a document that clarifies medical terminology relevant to end-of-life care (EoLC), with the idea of guiding families and doctors facing decisions to withhold or withdraw life support from terminally ill patients. The document is meant to address long-standing concerns that a lack of clarity on the terminology at times burdens patients and their families with indiscriminate and aggressive medical intervention and blocks patients’ right to die with dignity, doctors and health officials said. Senior ICMR officials say the document is expected to improve the public’s understanding of EoLC issues and facilitate the implementation of the recent Supreme Court ruling that provides legal guidance and prescriptions for decisions to withdraw or withhold life support. <https://goo.gl/xJKWUs>

**N.B.** Download/view ‘Definition of terms used in limitation of treatment and providing palliative care at end of life,’ at the ICMR website: <https://goo.gl/q9vnYN>

## [Specialist Publications](#)

### **An actual advance in advance directives: Moving from patient choices to patient voices in advance care planning**

*ASIAN BIOETHICS REVIEW* | Online – 14 March 2017 – Since the concept of the living wills emerged nearly 50 years ago, there have been practical challenges in translating the concept of an advance directive (AD) into documents that are clinically useful across various healthcare settings and among different patient populations and cultures. Especially, challenging has been the reliance in most ADs on pre-selected “choices” about specific interventions which either revolve around broad themes (e.g., “prolong life /do not prolong life”) or whether or not to utilize particular interventions (e.g., CPR, mechanical ventilation), both of which about most laypersons know little and, more importantly, lacking context, prove to be of limited meaningfulness. Moreover, whether by foundational frame, decade-long misunderstanding in

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medicine and bioethics, or different societal customs, these ADs present decision-making responsibility for initiating, continuing, or withdrawing medical interventions as a patient responsibility – creating a burden for which most patients are unprepared – and hence reducing healthcare providers' responsibility to mere technical application or customer service. At the Center for Healthcare Ethics, Cedars-Sinai Medical Center, Los Angeles, California, significant efforts have focused on embracing the unique and complementary responsibilities of patients (articulating their goals, values, and preferences) and physicians (using medical expertise to reach patient goals) for enabling appropriate plans of care. This includes restructuring its AD form to more accurately represent patient's values as the frame within which physicians are responsible for determining appropriate care. Rather than specifying interventions, the AD makes patients responsible for specifying what matters to them as well as what they value in terms of function, interaction, and level of acceptable burden, thus providing clear goals for clinicians to pursue – or when goals are not reachable by available medical interventions, to acknowledge and allow for logical shifts to what may be achieved, including, in end of life contexts, care focused on respect and dignity. **Full text:** <https://goo.gl/75S3LQ>

#### Related

- *AMERICAN JOURNAL OF HOSPICE & PALLIATIVE MEDICINE* | Online – 12 March 2018 – '**Provider tools for advance care planning and goals of care discussion: A systematic review.**' Although several studies report positive findings, there is a lack of consistent patient outcome evidence to support any one clinical tool for use in advance care planning (ACP) or goals-of-care discussions. Effective ACP conversations at both the population and the individual level require provider education and communication skill development, standardized and accessible documentation, quality improvement initiatives, and system-wide coordination to impact the population level. There is a need for research focused on goals of care discussions, to clarify the purpose and expected outcomes of these discussions, and to clearly differentiate goals of care from ACP. **Abstract:** <https://goo.gl/BEmJEM>
- *GERONTOLOGY & GERIATRICS EDUCATION* | Online – 12 March 2018 – '**Begin with the end in mind: A three-part workshop series to facilitate end-of-life discussions with members of the community.**' This article describes a community-level intervention that facilitates those necessary conversations among elders who have at least begun to talk with others about their wishes. A free, three-part educational workshop series on end-of-life (EoL) planning was developed at a U.S. mid-western university. Findings from [a survey of] 33 participants suggest a concern about making plans and ensuring others would follow their wishes. In conclusion, this article offers a roadmap for gerontologists and others to use in engaging the community to think about and act on EoL public health issues. **Abstract:** <https://goo.gl/YmTYso>
- *JAMA INTERNAL MEDICINE* | Online – 12 March 2018 – '**Italy's new advance directive law: When in Rome...**' Although all human beings share the same biology, the political context of medical practice, like all politics, is notoriously local. So, while some might be surprised to learn that Italy only adopted its first advance directive legislation in the closing days of 2017, such surprise would reflect a kind of naive parochialism. Rome is not Washington DC. The bill, which passed the Italian Senate in December 2017 after three decades of debate, assumed the force of law on 6 January 2018. The law establishes a right to refuse tests and treatments, a right to palliative care, and provides for living wills and the naming of medical proxies... The protracted legislative course reflects a complex amalgam of culture, religion, language, politics, ethics and medicine. **First page preview:** <https://goo.gl/WEhcNy>

#### Developing and testing a nursing home end-of-life care chart audit tool

*BMC PALLIATIVE CARE* | Online – 15 March 2018 – Auditing the care provided in the resident's last month of life aims to improve care through the identification of ineffective practices, enhance the quality of training provided to staff, and ensure the effective use of resources; all of which have the potential to change practice. This study is significant since assessing the quality of care is an important activity for health care institutions to regularly undertake, yet there is a general recognition for the need to develop

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brief, quality measures for end-of-life care (EoLC). Also, gathering timely information is needed in order to monitor and improve the quality of EoLC, including valid and reliable data about the care provided, the recipients, the facilities, and the caregivers. By developing a brief chart audit tool that captures best practices derived from expert consensus and the research literature, nursing home facilities will be equipped with a valid means for monitoring and assessing the care delivered to residents in the last month of life. These assessments will help drive improvements in care by providing direction for staff education, the development of initiatives aimed at reducing ineffective practices, ensuring the optimal use of resources. These improvements will lead to a culture of care that aims to deliver the highest quality of care in the last phase of a resident's life. **Full text:** <https://goo.gl/1NXaMH>

### **What are healthcare providers' understandings and experiences of compassion? The healthcare compassion model: A grounded theory study of healthcare providers in Canada**

*BMJ OPEN* | Online – 14 March 2018 – Healthcare providers (HCPs) are considered the primary conduit of compassion in healthcare. Although most healthcare providers desire to provide compassion, and patients and families expect to receive it, an evidence-based understanding of the construct and its associated dimensions from the perspective of healthcare providers is needed. This study provides HCPs, educators, researchers and policymakers with a multidimensional model of compassion. It identifies the knowledge, skills, behaviours and qualities which underpin delivery of compassionate healthcare at the bedside. The systematic nature of the Healthcare Provider Compassion Model characterises the components of compassion and their inter-relatedness. There is also an element of flexibility within these domains that recognises that true compassion comes from within the person, through a dynamic human interaction with a patient and the patient's needs. While mastery may be unattainable, the multidimensional facets of compassion can potentially be nurtured in individual HCPs and throughout the cultures they work within. **Full text:** <https://goo.gl/EwFWZY>

Noted in Media Watch 19 February 2018 (#551, p.13):

- *MEDICAL HUMANITIES* | Online – 10 February 2018 – '**A moment for compassion: Emerging rhetorics in end-of-life care.**' "Compassion" has become the flagship concept to be fostered in the delivery of end-of-life care (EoLC), and a rallying call for social action and public health intervention. The authors examine the emerging rhetorics of compassion as they relate to EoLC and offer a critique of the expanding discourse around it. They argue, even where individuals "possess" compassion or are "trained" in it, there are difficulties for compassion to flow freely, particularly within Western society. **Full text:** <https://goo.gl/VGPT1C>

Noted in Media Watch 4 December 2017 (#541, p.6):

- *BMC PALLIATIVE CARE* | Online – 1 December 2017 – '**Compassionate collaborative care: An integrative review of quality indicators in end-of-life care.**' Compassionate collaborative care (CCC) is an emerging, complex concept. Although limited by a lack of strong empirical evidence, it is of growing importance for healthcare quality. This integrative review suggests that CCC is inextricably linked to the inherent values, needs and expectations of patients, families and healthcare providers. Communication, shared decision-making and goal setting comprise the overarching processes, while development and satisfaction are overarching outcomes. **Full text:** <https://goo.gl/smV1xn>

Noted in Media Watch 25 January 2016 (#446, p.8)

- *BMC PALLIATIVE CARE* | Online – 19 January 2016 – '**Compassion: A scoping review of the healthcare literature.**' The importance of compassion within healthcare, while seemingly self-apparent and frequently referenced in the literature, has received little in the way of empirical attention. Important clinical studies are emerging and are collectively contributing to a body of evidence that brings insight to compassion in clinical care. However, these studies often rely on preconceived theoretical definitions of compassion that lack specificity, clinical applicability, conceptual validity, and fail to adequately incorporate the understandings and experiences of patients. **Full text:** <http://goo.gl/CoL1EU>

## Interdisciplinary pediatric palliative care team involvement in compassionate extubation at home: From shared decision-making to bereavement

*CHILDREN*, 2018;5(3). Little is known about the role of pediatric palliative care (PPC) programs in providing support for home compassionate extubation (HCE) when families choose to spend their child's end of life at home. Two cases are presented that highlight the ways in which the involvement of PPC teams can help to make the option available, help ensure continuity of family-centered care between hospital and home, and promote the availability of psychosocial support for the child and their entire family, health care team members, and community. Though several challenges to realizing the option of HCE exist, early consultation with a PPC team in the hospital, the development of strategic community partnerships, early referral to home-based care resources, and timely discussion of family preferences may help to make this option a realistic one for more families. The cases presented demonstrate how families' wishes with respect to how and where their child dies can be offered, even in the face of challenges. By joining together when sustaining life support may not be in the child's best interest, PPC teams can pull together hospital and community resources to empower families to make decisions about when and where their child dies. **Full text:** <https://goo.gl/GuiZcW>



**N.B.** This article is one of a number in a special issue of *Children* focussing on pediatric palliative care. Journal contents page (to access the full text of each article): <https://goo.gl/k1rMXe>.

## Implementing the MOLST (Medical Order for Life-Sustaining Treatments): Challenges faced by nursing home staff

*GERIATRIC NURSING* | Online – 6 March 2018 – This study examined how the Medical Order for Life-sustaining Treatment (MOLST) is implemented in two nursing homes in Massachusetts; one had primarily long-term care residents and high hospice utilization, the other had low hospice utilization and a high proportion of post-acute care residents. Staff at both nursing homes described benefits of the MOLST such as providing guidance for staff and family. Yet, they also gave detailed accounts of challenges they face in implementing the form. They reported problems with the form itself such as confusing language and conflicting categories as well as a set of procedural challenges that undermined the timely completion of the form. The nursing home with more post-acute care residents faced more challenges with transferability of the MOLST to and from hospitals. **Abstract (w. list of references):** <https://goo.gl/sr1YvJ>

Noted in Media Watch 10 April 2017 (#507, p.7):

- *JOURNAL OF PALLIATIVE MEDICINE*, 2017;20(9):939-945 (first published online 4 April 2017). **'Maryland's Medical Orders for Life-Sustaining Treatment form use: Reports of a state-wide survey.'** Few patients [i.e., patient population studied] or surrogates declined discussing Medical Orders for Life-Sustaining Treatment orders, and few orders were written based on medical ineffectiveness criteria defined in Maryland law. **Abstract:** <https://goo.gl/b09YIO>

Noted in Media Watch 3 October 2016 (#482, p.14):

- *JOURNAL OF POST-ACUTE & LONG-TERM CARE MEDICINE*, 2018;18(1):35-39 (first published online 27 September 2016). **'Decisions by default: Incomplete and contradictory MOLST in emergency care.'** Inconsistencies were found in patient wishes among a subset of patients, wherein their desire for "comfort measures only" seemed contradicted by a desire to be sent to the hospital, receive IV fluids, and/or receive antibiotics. **Abstract (w. list of references):** <https://goo.gl/2Ew9LH>

## Can the ethical best practice of shared decision-making lead to moral distress?

*JOURNAL OF BIOETHICAL INQUIRY* | Online – 14 March 2018 – When healthcare professionals feel constrained from acting in a patient's best interests, moral distress ensues. The resulting negative sequelae of burnout, poor retention rates, and ultimately poor patient care are well recognized across healthcare providers. Yet an appreciation of how particular disciplines, including physicians, come to be "constrained" in their actions is still lacking. This paper examines how the application of shared decision-making may contribute to the experience of moral distress for physicians and why such distress may go under-recognized. Appreciation of these dynamics may assist in cross-discipline sensitivity, enabling more constructive dialogue and collaboration. **Abstract (w. list of references):** <https://goo.gl/xw8PkE>

## Donation after the circulatory determination of death: Some responses to recent criticisms

*JOURNAL OF MEDICINE & PHILOSOPHY*, 2018;43(2):211-240. This article defends the criterion of permanence as a valid criterion for declaring death against some well-known recent objections. The authors argue that it is reasonable to adopt the criterion of permanence for declaring death, given how difficult it is to know when the point of irreversibility is actually reached. They claim that this point applies in all contexts, including the donation after circulatory determination of death context. The authors also examine some of the potentially unpalatable ramifications, for current death declaration practices, of adopting the irreversibility criterion. **Full text:** <https://goo.gl/W6gPMb>

## Evaluating the feasibility and acceptability of a telehealth program in a rural palliative care population: TapCloud for palliative care

*JOURNAL OF PAIN & SYMPTOM MANAGEMENT* | Online – 15 March 2018 – This is one of the first papers to describe a telehealth palliative care (PC) program and to demonstrate acceptability, feasibility, and usability as well as describe symptom outcomes and hospice transitions. One-hundred and one PC patients in rural Western North Carolina were enrolled in the program. The mean age of patients enrolled was 72, with a majority (60%) being female and a pulmonary diagnosis accounting for the largest percentage of patients (23%). Remote patient monitoring using TapCloud resulted in improved symptom management and patients in the model had a hospice transition rate of 35%. Patients, caregivers, and providers reported overwhelmingly positive experiences with telehealth with three main advantages: 1) Access to clinicians; 2) Quick responses; and, 3) Improved efficiency and quality of care. **Abstract (w. list of references):** <https://goo.gl/5EVkM6>

## Spiritual distress within inpatient settings: A scoping review of patient and family experiences

*JOURNAL OF PAIN & SYMPTOM MANAGEMENT* | Online – 13 March 2018 – Within the 37 articles meeting inclusion criteria, the authors identified six themes: 1) Conceptualizing spiritual distress (SD); 2) Diagnosis and prevalence; 3) Assessment instrument development; 4) Experiences; 5) Associated variables; and, 6) Barriers and facilitators to clinical support. The majority of studies focused on patients; two studies focused on family caregivers. The most common clinical settings were oncology and advanced disease. Terminology to describe SD varied amongst studies. The prevalence of at least moderate SD in patients was 10-63%. SD was experienced in relation to self and others. Associated variables included demographic, physical, cognitive and psychological factors. Barriers and facilitators were described. Patient and family experiences of SD in the inpatient setting are multifaceted. Important gaps in the literature include a narrow spectrum of populations, limited consideration of family caregivers, and inconsistent terminology. Research addressing these gaps may improve conceptual clarity and help clinicians better identify SD. **Abstract (w. list of references):** <https://goo.gl/JguF67>

## **Top 10 tips palliative care clinicians should know when caring for patients with endometrial cancer**

*JOURNAL OF PALLIATIVE MEDICINE* | Online – 13 March 2018 – Endometrial cancer incidence has been increasing over the last two decades, likely due to the obesity epidemic. The majority of these cancers are confined to the uterus at diagnosis and can be cured with surgery. Overall, five-year disease-specific survival is about 80%, but some patients have locally advanced or metastatic disease that is not amenable to control with radiation and/or chemotherapy. Disease-related symptoms are most common in this subset of patients with endometrial cancer, although women with early-stage disease may also experience side effects related to surgical menopause or adjuvant treatment. In recent years, professional societies have been increasingly vocal about the importance of incorporating palliative care (PC) early in a patient's disease course. As these calls increase, PC clinicians will likely increasingly co-manage patients with advanced or recurrent endometrial cancer. The authors brought together a team of gynecologic oncology and PC experts to assemble practical tips for the care of women with endometrial cancer. In this article, they use a "Top 10" format to highlight issues that may help PC physicians understand a patient's prognosis, address common misconceptions about endometrial cancer, and improve the quality of shared decision making and goals of care discussions. **Abstract:** <https://goo.gl/dNDSsP>

## **Surgeons' perceived barriers to palliative and end-of-life care: A mixed methods study of a surgical society**

*JOURNAL OF PALLIATIVE MEDICINE* | Online – 13 March 2018 – Nearly 20% of colorectal cancer patients present with potentially incurable (Stage IV) disease, yet their physicians do not integrate cancer treatment with palliative care (PC). Compared with patients treated by primary providers, surgical patients with terminal diseases are significantly less likely to receive palliative or end-of-life care. Participants [in this study] were all current, non-retired members of the American Society of Colon & Rectal Surgeons. Among 131 survey respondents, 76.1% reported no formal education in PC, and specifically noted inadequate training in techniques to forgo life-sustaining measures (37.9%) and communication (42.7%). Over half (61.8%) of surgeons cited unrealistic expectations among patients and families as a barrier to care, which also limited discussion of palliation. At the system level, absence of documentation, appropriate processes, and culture hindered the initiation of PC. Thematic analysis of open-ended questions confirmed and extended these findings through the following major barriers to palliative and end-of-life care: 1) Surgeon knowledge and training; 2) Communication challenges; 3) Difficulty with prognostication; 4) Patient and family factors encompassing unrealistic expectations and discordant preferences; and; 5) Systemic issues including culture and lack of documentation and appropriate resources. **Abstract:** <https://goo.gl/2qXbeV>

Noted in Media Watch 11 December 2017 (#542, p.13):

- *JOURNAL OF PAIN & SYMPTOM MANAGEMENT* | Online – 5 December 2017 – '**Characterizing the role of U.S. surgeons in the provision of palliative care: A systematic review and mixed-methods meta-synthesis.**' Four major themes affected receipt of palliative care (PC) for surgical patients: 1) Surgeon experience and knowledge; 2) Surgeons' attitudes; 3) Surgeons' preferences and decision-making for treatment; and, 4) Perceived barriers. Surgeons overall demonstrated insight into the benefits of PC, but reported limited knowledge and comfort as well as a multitude of challenges to introducing PC to their patients. **Abstract (w. list of references):** <https://goo.gl/L7i7wa>

**N.B.** Additional articles on palliative care in surgery are noted in the 8 May 2017 issue of Media Watch (#511, p.6).

**Palliative Care Network**

Closing the Gap Between Knowledge & Technology

<http://goo.gl/OTpc8I>

## Palliative sedation: The end of heated debate?

*PALLIATIVE MEDICINE* | Online – 13 March 2018 – The long list of publications on palliative sedation (PS) in this journal demonstrates that research in the past decades has come a long way in describing and comparing its practice. However, several questions remain. How can we explain its rather high frequency in some countries? Also, in an era of increased emphasis on shared decision-making, how can patients or their representatives be adequately involved in the decision-making process? How should we deal with patients who suffer unbearably from refractory symptoms, but have a life expectancy of more than 1-2 weeks? Future work should critically evaluate whether PS guidelines still reflect and support current clinical and societal views on a good death. It should also focus on education about PS in medical and nursing curricula and informing the general public about what PS is and when it can be used. Such education would facilitate informed debates about the circumstances in which PS can be an acceptable procedure to support a good death. **Full text:** <https://goo.gl/69zm7f>

### Related

- *BMC PALLIATIVE CARE* | Online – 13 March 2017 – ‘**Palliative sedation in Germany: Factors and treatment practices associated with different sedation rate estimates in palliative and hospice care services.**’ Clinical practice of palliative sedation (PS) varies between institutions worldwide and sometimes includes problematic practices. Little available research points at different definitions and frameworks which may contribute to uncertainty of healthcare professionals in the application of PS. This analysis investigates what demographic factors and characteristics of treatment practices differ between institutions with high versus low sedation rates estimates in palliative and hospice care in Germany. **Full text:** <https://goo.gl/3zmJfP>
- *JOURNAL OF PAIN & SYMPTOM MANAGEMENT* | Online – 13 March 2018 – ‘**Palliative sedation in terminal cancer patients admitted to hospice or home care programs: Does the setting matter? Results from a national multicenter observational study.**’ Few studies regarding palliative sedation (PS) have been carried out in the home care (HC) setting. A comparison of PS rate and practices between hospice (HS) and HC is also lacking. Results of this study show the feasibility of PS in HC and HS, and suggests setting differences in rates, indications and practice of PS are possibly related to patients selection or care organization. **Abstract (w. list of references):** <https://goo.gl/zHGvAb>
- *STATUTE LAW REVIEW* | Online – 14 March 2018 – ‘**Patient’s orders: Patient’s rights and the doctor’s obligations under the Claeys-Leonetti Law of 2016 in France.**’ France enacted the Claeys-Leonetti law in 2016, becoming one of the first countries to legalize terminal sedation as a medico-legal practice in the world. The focus of this short paper is to highlight the limitations imposed by Claeys-Leonetti on the doctor to fulfil his or her ethical duties under the Hippocratic Oath to act “for the benefit of my patient,” but to act only according to the “wishes of the patient,” to eliminate all forms of pain and suffering. A legislative commentary will be provided for the first five pertinent articles followed by proposals for reform. **Full text:** <https://goo.gl/fzDzf5>

Noted in Media Watch 5 February 2018 (#549, p.13):

- *JOURNAL OF PAIN & SYMPTOM MANAGEMENT* | Online – 27 January 2018 – ‘**Palliative sedation for existential suffering: A systematic review of argument-based ethics literature.**’ While unanimity exists on using palliative sedation for controlling refractory physical suffering in end-of-life situations, using it for controlling refractory existential suffering is controversial. Complicating the debate is that definitions and terminology for existential suffering are unclear, ambiguous, and imprecise, leading to a lack of consensus for clinical practice. **Abstract (w. list of references):** <https://goo.gl/XpswZQ>

**N.B.** Additional articles on palliative sedation noted in the 27 November and 17 July 2017 issues of Media Watch (#540, p.17 and #521, p.16, respectively).

## Complexity and gaps: The high-hanging fruit of dementia and palliative care research

*PALLIATIVE MEDICINE*, 2018;32(3):591-593. Healthcare teams have been looking after people dying from the dementias for aeons. But research on dementia and palliative care has only emerged as a specific field in the last 30 years. It was back in 1986 that the *Journal of the American Medical Association* published a paper on the development and evaluation of the first dementia-specific hospice programme aimed at comfort.<sup>1</sup> Since then, many more researchers from all around the world have entered the field. The submissions to this special issue show the breadth and innovative nature of the work that is being done and demonstrates the richness of that work and confirms the international nature of the research endeavour. Reviewing the papers published in this issue (as well as those submitted), or published elsewhere recently, suggests two observations. First, that the work still to be done is becoming more complex; and, second, that some important areas are relatively under-represented. Both observations could be summed up by saying that the low-hanging fruit has been harvested! The high-hanging fruit that remains is marked by its complexity and is required to fill the gaps in research that persist. **Full text:** <https://goo.gl/ozzQv3>

Palliative Medicine

1. 'Hospice approach to the treatment of patients with advanced dementia of the Alzheimer type,' *Journal of the American Medical Association*, 1986;256(16):2210-2213. **Abstract:** <https://goo.gl/wRZ8DH>
2. Journal contents page: <https://goo.gl/FvxBFu>

### Related

- *AMERICAN JOURNAL OF HOSPICE & PALLIATIVE MEDICINE* | Online – 14 March 2018 – '**End-of-life plans for African American older adults with dementia.**' The findings of this study reflect more end-of-life planning in this population than previous studies reported and could improve the quality of end-of-life (EoL) outcomes in this population by giving health-care providers increased understanding of African American EoL planning preferences. This may, in turn, help the providers to inform and educate these care recipients and their family caregivers. **Abstract:** <https://goo.gl/1qUajp>
- *ST. CHRISTOPHER'S END-OF-LIFE JOURNAL* | Online – Accessed 18 March 2018 – '**Advance decisions to refuse treatment in cases of dementia.**' This article discusses the ethical and legal frameworks for approaching decision-making processes in relation to a complex case of an adult with dementia who, before its onset, drew up an advance decision to refuse treatment to be implemented in the event that she lost mental capacity for decision-making. However, when the time came her family and carers wanted her GP to ignore the advance refusal document. **Abstract:** <https://goo.gl/m1ZyTb>

**N.B.** Additional articles on palliative care for people living with Alzheimer's and other forms of dementia noted in the 5 March 2018 issue of Media Watch (#553, p.7).

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

#### Assessing best interests in end-of-life care for a patient in a minimally conscious state

*ST. CHRISTOPHER'S END-OF-LIFE JOURNAL* | Online – Accessed 18 March 2018 – The legal basis and principles for the lawful withholding of life-sustaining treatment from people in a minimally conscious state have been laid out in the Supreme Court judgment in *Aintree University Hospitals National Health Service Foundation Trust (Respondent) vs James (Appellant)*... This was the first case under the Mental Capacity Act 2005 to come before the Supreme Court and hence it is of legal importance. The case involved a 68-year-old man who had multiple physical co-morbidities and who was diagnosed as being in a minimally conscious state. This article discusses the Supreme Court case and the approach taken by the Court of Protection and the Court of Appeal in applying the Mental Capacity Act 2005 when assessing whether withholding life-sustaining treatment is ever in a person's best interests. It also outlines two similar cases from 2014. In so doing it demonstrates how the courts assess best interests in end-of-life care for people in minimally conscious states and how this differs legally from those in a persistent vegetative state. **Abstract:** <https://goo.gl/XtHr8o>

## The barriers to organ and tissue donation in palliative care

*ST. CHRISTOPHER'S END-OF-LIFE JOURNAL* | Online – Accessed 18 March 2018 – Discussions about organ/tissue donation are now expected to become part of end-of-life care discussions, when appropriate. It is commonly perceived that terminally ill people are not eligible to donate their organs/ tissues. However, that is not the case. Palliative care (PC) patients can donate various tissues, including corneal tissue, and in some cases organs. Donation rates from PC patients are low as a result of a variety of factors, e.g., the family not knowing the deceased's wishes, negative attitudes to organ/tissue transplantation among relatives and clinicians, fears of disfiguring the body and wanting to protect the deceased person from further harm. Health professionals can be reluctant to broach the topic of tissue donation with patients and/or their families/next of kin. This article explores the involvement of PC patients in decisions about donating their tissues, why families may be reluctant to consent to donating organs/tissues of deceased loved ones and reasons why nurses are wary of discussing the possibility of donation with patients and/or their next of kin. Recommendations for practice are also made. **Abstract:** <https://goo.gl/cJRvou>

**N.B.** Articles on organ transplantation in the context of palliative and end-of-life care noted in the 18 December and 9 October 2017 issues of *Media Watch* (#543, p.11 and #533, p.9, respectively).

## Knowledge and skills needed by informal carers to look after terminally ill patients at home

*ST. CHRISTOPHER'S END-OF-LIFE JOURNAL* | Online – Accessed 18 March 2018 – The aim of this study was to explore the lived experiences of informal carers providing care for an adult receiving palliative care at home. It explored carers' experiences about what they need to know in order to provide care and the practical skills that carers believe they need for their role. Two main themes emerged, with associated sub-themes: 1) Knowing the right thing to do (sub-themes: need for knowledge and practical skills, managing symptoms and administering medications, knowing what is best for the person); and, 2) Personal experiences of caring (sub-themes: impact of caring on health, the need to accept help, and experiencing a sense of satisfaction). Participants suggested that carers require adequate preparation for the caring role, in terms of the necessary skills, the provision of timely information and knowledge, assessment and provision of practical and emotional support. **Abstract:** <https://goo.gl/DJg31g>

### Related

- *JOURNAL OF RELIGION & HEALTH* | Online – 9 March 2018 – '**Helping carers care: An exploratory study of factors impacting informal family carers and their use of aged care services.**' Several themes emerged regarding carer well-being, carer decision-making and carer relationships – particularly with respect to the various authorities and organisations ostensibly responsible for supporting carers. Although this research was isolated to a particular locality, carers in similar situations globally have indicated comparable stresses and challenges further indicating that greater accountability and improved organisation are required for the support of carers internationally. Recommendations are suggested for how service providers can support carers – most importantly, the need for ongoing government assessment and government service improvement in order to help carers care into the future. **Abstract (w. list of references):** <https://goo.gl/3nQGa3>

## Assisted (or facilitated) death

Representative sample of recent journal articles:

- *ALBERTA LAW REVIEW*, 2018;55(3):777-803. '**Medical assistance in dying: Journey to medical self-determination.**' We have come a long way from the time where the Law Reform Commission of Canada wrote that "[a] country like Canada could not, without violating its social traditions and history, tolerate and give a legal veneer to [this] policy." By 2016, a major shift in social mores and norms culminated in the setting aside of a prohibitive criminal law and the development of a permissive regime. Canadians, with certain exceptions as dictated by legislation, can now alleviate their suffering, mentally

Cont.

and physically, while awaiting their “natural” death. Yet, this is far from the final chapter; while the criminal law establishes the general rules of conduct of what society permits, it cannot alone provide a comprehensive clinical guide for decision-making. Accordingly, the new legislation is part of the ongoing dialogue between multiple participants, including physicians, nurses, pharmacists, lawyers, politicians, and the greater public. Over time, the new medical assistance in dying (MAiD) regime will evolve, cases will vary, and individual assessments and subjective decisions will have to be made. For all Canadians, but especially those currently precluded from seeking MAiD, the journey continues. **Full text:** <https://goo.gl/uBWVrT>

- **NEDERLANDS TIJDSCHRIFT VOOR GENEESKUNDE** | Online – Accessed 14 March 2018 – ‘**Discuss the relationship between physicians and pharmacists in the context of euthanasia.**’ Physicians are regularly confronted with pharmacists who refuse to provide euthanasia drugs. They do not always understand that the provision of euthanasia drugs is not a normal professional activity for pharmacists. It is a lot less clear that pharmacists are also allowed to have fundamental objections. In addition, professional standards lack clarity for pharmacists who do not have such objections to the provision of euthanasia drugs. The relationship between physicians and pharmacists in the context of euthanasia presents problems overlooked by researchers of the third evaluation of the Termination of Life on Request & Assisted Suicide (review procedures) Act (WTL). The professional bodies of physicians and pharmacists should address these as soon as possible. **Abstract:** <https://goo.gl/2uYaex>

**N.B.** Dutch language article.

## Journal Watch

### **Poor quality, predatory conferences prey on academics**

*UNIVERSITY AFFAIRS* (Ottawa, Ontario, Canada), April 2018. Many publishers of deceptive or poor-quality academic journals have created a big sideline business organizing equally questionable academic conferences. Yet some professors don’t seem to be getting the message to stay away. McGill University professor Eduardo Franco discovered last year, to his dismay, that OMICS International, one of these publishers, listed 220 McGill professors whom the company claimed had served as “editors, contributors and speakers” for OMICS journals and conferences. Dr. Franco, who is the James McGill Professor in the departments of oncology, and epidemiology and biostatistics, said OMICS organizes some 3,000 conferences of questionable quality and publishes about 700 journals, many of which are considered “predatory” – a term first coined by librarian Jeffrey Beall at the University of Colorado Denver. Mr. Beall had created a much-used online list of bogus journals which he claims he had to take down last year due to harassment from predatory publishers. Most of the 220 McGill professors listed on the OMICS site likely had nothing to do with the company and didn’t know that the company was using their names in this way, said Dr. Franco. Still, he was concerned. Many academics have likely received spam emails – complete with vague promises, and glaring spelling and grammar mistakes – for bogus conferences. Organizers of predatory conferences claim to properly peer review conference speakers and papers, but attendees may arrive at a venue only to discover that this isn’t true and, worse, that the event contains bizarre or irrelevant topics and has few or no conference staff on site. **Full text:** <https://goo.gl/h5G9ed>



**N.B.** The OMICS publications include the *Journal of Palliative Care & Medicine*: <http://goo.gl/ieTbLZ>

Noted in Media Watch 15 January 2018 (#546, p.16):

- **CANADA** | *The Ottawa Citizen* – 5 January 2018 – ‘**Predatory journal has firm grip on universities in Ottawa and Canada.**’ Scientists from the University of Ottawa, The Ottawa Hospital and other top-tier institutions across Canada keep publishing their results in fake science journals, tainting the work despite years of warnings. Until recently, the scope of the problem of “predatory” journals has been hard to measure. <https://goo.gl/vt697s>

**N.B.** In November 2017, a U.S. federal court granted a preliminary injunction against OMICS requested by the Federal Trade Commission “temporarily halting the deceptive practices” of the publisher. [Noted in the 27 November 2017 issue of Media Watch (#540, p.18)] See Retraction Watch: <https://goo.gl/XrocPi>

## Media Watch: Online

### International



INTERNATIONAL ASSOCIATION FOR HOSPICE & PALLIATIVE CARE: <https://goo.gl/38NX5H>

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

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

PALLIMED: <http://goo.gl/7mrgMQ>

[Scroll down to 'Aggregators' and 'Media Watch by Barry Ashpole'; see also 'Media Watch: Behind the Scenes' at <https://goo.gl/6vdk9v>]

### Asia

ASIA PACIFIC HOSPICE PALLIATIVE CARE NETWORK: <https://goo.gl/ZRngsv>

[Scroll down to 'Resource Collection' and 'Media Watch Barry Ashpole']

### Canada



CANADIAN SOCIETY OF PALLIATIVE CARE PHYSICIANS: <https://goo.gl/BLgxy2>

[Scroll down to 'Are you aware of Media Watch?']

ONTARIO | Acclaim Health (Palliative Care Consultation): <https://goo.gl/wGi7BD>

[Scroll down to 'Additional Resources']

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

ONTARIO | Mississauga Halton Palliative Care Network: <https://goo.gl/ds5wYC>

[Scroll down to 'International Palliative Care Resource Center hosts Media Watch']

### Europe



EUROPEAN JOURNAL OF PALLIATIVE CARE: <https://goo.gl/ijCHez>

[January/February 2018 issue (Scroll down to 'Paediatric palliative care; the patient's voice')]

HUNGARY | Magyar Hospice Alapítvány: <http://goo.gl/5d1I9K>

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

### South America



Academia Nacional de Cuidados Paliativos (Brazil): <https://goo.gl/b5CV31>

## Media Watch: Editorial Practice

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

## Distribution

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

## Links to Sources

1. Short URLs are used in Media Watch. Links to pdf documents, however, cannot always be shortened.
2. Links are checked and confirmed as active before each edition of the weekly report is distributed.
3. Links often remain active, however, for only a limited period of time.
4. Access to a complete article, in some cases, may require a subscription or one-time charge.
5. If a link appears broken or inactive, try copying/pasting the URL into the address bar of your browser or, alternatively, Google the title of the article or report, and the name of the source.
6. Due to its relevance, an article may be listed but for which a link is not available; access, therefore, may only be possible directly from the source (e.g., publication) or through the services of a library.

## Something Missed or Overlooked?

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

[Search Back Issues of Media Watch @ http://goo.gl/frPgZ5](http://goo.gl/frPgZ5)

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