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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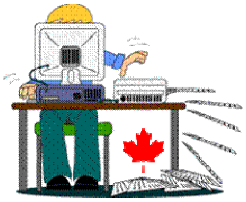


Compiled & Annotated by Barry R. Ashpole

Living with a life-limiting illness; Scroll down to Specialist Publications and 'Existential concerns for people with motor neurone disease: Who is listening to their needs, priorities and preferences?' (p.10) in *British Journal of Occupational Therapy*.

Canada

International Consortium for End-of-Life Research

End-of-life care in Canada more hospital-centric than in U.S., Europe

CBC NEWS | Online – 19 January 2016 – Canada has the highest proportion of people with cancer dying in hospital among seven developed countries, despite a mismatch with the type of end-of-life care many Canadians say they want, the author of a new study says. [See inset right] The study was conducted using administrative records for people over age 65 who died with cancer in Canada, Belgium, England, Germany, The Netherlands, Norway and the U.S. Canada had proportionately the highest number of people dying in acute-care hospital settings, at 52.1%, followed by: Belgium, 51.2%; England, 41.7%; Germany, 38.3%; Norway, 44.7%; The Netherlands, 29.4%; and, U.S., 22.2%: "Countries like The Netherlands and England tend to spend much less but generally have a much greater capacity to deliver palliative care and hospice care than countries like Canada and the U.S. that spend much more," said study author Dr. Robert Fowler, an intensive-care physician at Toronto's Sunnybrook Hospital and a scientist at the Institute for Clinical Evaluative Sciences. No country has it right, but there are fewer opportunities to keep people out of hospital in Canada and the U.S. compared with the hospice movement's established roots in the U.K., he said. http://goo.gl/UZ7g3g

Specialist Publications

'Comparison of site of death, health care utilization, and hospital expenditures for patients dying with cancer in 7 developed countries' (p.14), in *Journal of the American Medical Association.*

N.B. Canada was ranked 11th 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

Committee begins look at complexities of assisted-dying legislation

THE OTTAWA CITIZEN | Online – 18 January 2016 – The opening session of the special joint House of Commons-Senate committee on physician-assisted dying heard from two senior Justice Canada officials. For two hours, the lawyers explained the complexities of assisted-dying laws in other countries, the fuzzy, confusing language of terms like voluntary euthanasia and assisted suicide, and the maze of federal-provincial jurisdictional boundaries tangling the issue. They then noted that the unanimous 2015 Supreme Court of Canada "Carter" judgment allowing physician-assisted dying – for which Parliament must now race to enact Charter-compliant legislation by June 6 – leaves many additional and vital questions unanswered. Including, for starters, whether the court judgment applies to just the terminally ill or anyone with an incurable medical condition that causes "intolerable" suffering. Just as important will be the need for the committee to carefully spell out how government will reduce the risk inherent in authorizing people to deliberately and purposely take the lives of others with impunity. 461-page-thick binders were thumped down before each committee member. The just-released report by the External Panel on Options for Legislative Response to *Carter v. Canada*, which conducted extensive research and expert consultations, was commissioned last spring by the previous Conservative government. The panel also heard from nearly 15,000 Canadians who responded to a sophisticated online questionnaire [see panel below]. http://goo.gl/klyNeu

Findings of the External Panel on Options for Legislative Response to *Carter v. Canada*

More than...

70% support a national oversight body for physician assisted dying

76% want a national strategy on palliative and end-of-life care

78% support a comprehensive national home-care strategy

80% want a national strategy on disability supports

84% support palliative care education for all health care providers

Expert Panel report (dated 15 December 2015): http://goo.gl/5DBe2f

Specialist Publications

'Canadian Pharmacists Association surveys pharmacists on physician-assisted dying' (p.16), in *Canadian Pharmacists Journal.*

'Physician-assisted death in Canada' (p.17), in *Journal of the American Medical Association*

Related

- BRITISH COLUMBIA | CHQR 770 News (Calgary, Alberta) – 22 January 2016 – **'British Columbia doctors given "road map" on physician-assisted suicide for patients.'** The College of Physicians & Surgeons of British Columbia has released its "Interim Guidance" that covers the 4-month extension granted by the Supreme Court of Canada. That extra time is supposed to give the federal government a chance to update assisted dying laws. The guidance lets doctors know they have a right not to participate in the process, due to their values and beliefs. http://goo.gl/RitwKu

  N.B. College of Physicians & Surgeons of British Columbia, Standards & Guidelines (scroll down to 'Physician-Assisted Dying'): https://goo.gl/swuk3r

- *THE GLOBE & MAIL* | Online – 21 January 2016 – **'Provincial consensus unlikely on assisted-dying rules.'** Canadian health ministers are working on a common approach to doctor-assisted dying, but it is unlikely provinces and territories will totally agree on what those rules will be. Federal Health Minister Jane Philpott, in ... to meet with her provincial and federal counterparts, said the group reviewed two recent reports and discussed the concerns of individual provinces. She said there is a general hope that individual provinces will come up with legislation that is as similar as possible, but it is too soon to say if that can be done. "Those are decisions that provinces and territories will have to make," she said. http://goo.gl/MdXsgg

Cont.

- *iPOLITICS* | Online – 21 January 2016 – **'Physicians should be allowed to refuse referrals to doctor-assisted death.'** The Canadian Medical Association has released a document suggesting that in designing framework for assisted-dying, physicians who ethically object to providing the service should be allowed to do so, including refusing referrals.[1] But it also says doctors should still be charged with giving patients information on all of the options available. "Physicians are expected to provide the patient with complete information on all options available," it reads. "There should be no discrimination against a physician who chooses not to provide or participate in assisted-dying." It also says a patient should submit "at least two oral requests for assisted dying to the attending physician over a period of time that is proportionate to the patient's expected prognosis." Dr. Cindy Forbes, head of the CMA, said such a delay would allow for "sober second thought and the ability for patients to change their mind." http://goo.gl/giqTvc

    1. 'Principles-based Recommendations for a Canadian Approach to Assisted Dying,' Canadian Medical Association, January 2016. https://goo.gl/1V5cvn

- ALBERTA | *The Calgary Herald* – 19 January 2016 – **'Alberta doctors divided on assisted death for minors.'** A proposal that would give teenagers the right to die by euthanasia has divided Alberta doctors, months before the federal government introduces legislation on the thorny issue of doctor-assisted suicide. The College of Physicians & Surgeons of Alberta, the provincial regulator for the health care profession, has attracted criticisms for its position that there should be no age limit for terminally ill patients eligible to end their lives early. The college argues that age is largely irrelevant in considering whether patients are competent enough to make decisions about their health care. Instead, the college says doctors should consider other factors when handling requests for assisted death, including that patients have enough information, that they're not under coercion or pressure and that they're competent. http://goo.gl/42tVSr

    N.B. College of Physicians & Surgeons of Alberta, 'Physician-Assisted Dying'): http://goo.gl/FeKTae

- YUKON TERRITORY | CBC News (Whitehorse) – 19 January 2016 – **'Yukon working on guidelines for assisted dying.'** Yukon doctors and government officials are busy developing guidelines around assisted suicide, even as the deadline for federal legislation is pushed back. http://goo.gl/OQhYlf

U.S.A.

Don't get trapped by the myth of the "good death"

FORBES | Online – 22 January 2016 – ...there is an enormous risk to creating impossible expectations about death. By defining an ideal "good death" we run the risk of leaving survivors with deep, needless guilt. It is hard enough losing a loved one, why add to the burden by measuring families against some often-unachievable benchmark? You know, the one where decades of familial loose ends are tied up and mom dies with a smile on her face, listening to the hits of her youth... Of course, there is an upside to this trendy death business. Patients – and doctors – are paying more attention to end of life care. Fewer specialists are writing off terminally-ill patients who reject aggressive treatment in favor of comfort care. Palliative care is slowly gaining traction, though it remains a poorly understood specialty. Half of older adults participate in hospice before they die, though the system still ghettoizes the dying. We are thinking harder about how we want to die, and where. http://goo.gl/PFOJcf

Mother, school district reach agreement on terminally ill student

ALABAMA | *The Decatur Daily* – 21 January 2016 – Limestone County Schools has reversed its previous position and reached an agreement with the mother of a terminally ill student that allows the mother and the student's hospice nurse to be on campus with him. Rene Hoover, whose 14-year-old son, Alex, is autistic and has a terminal heart condition, said she will meet with school officials next week to finalize the details about her son's individualized education plan. The school district has never denied Alex, a freshman, access to school, but the district refused to comply with an advanced directive prepared by the family's attorney, which essentially requested Alex not be provided lifesaving medical care if he had medical problems at school. http://goo.gl/KxOIxd

Cont.

Noted in Media Watch, 16 November 2015, #436 (p.3):

- ALABAMA | AL.com – 12 November 2015 – **'Limestone County case shows gaps in Alabama's end-of-life policies, expert says.'** Rene Hoover, mother of a terminally-ill special education student in Limestone County, has been waging a public battle to allow her son to attend public school with a do-not-resuscitate order. But if she and her son lived just over the state line in Tennessee it wouldn't be an issue... http://goo.gl/1Sepmg

Americans are living longer

U.S. NEWS & WORLD REPORT | Online – 21 January 2016 – A new report from the Centers for Disease Control & Prevention shows that the number of Americans older than 100 has increased more than 43% from just one decade ago. The report looked at mortality trends among centenarians from 2000 through 2014, with consideration for sex and ethnic group. Key findings show that death rates for centenarians increased from 2000 through 2008 and then decreased through 2014 for both males and females. What's more, death rates for centenarians increased from 2000 through 2006 for the Hispanic population and from 2000 through 2008 for white and black populations, and decreased through 2014 for all ethnic groups. The top five causes of death among those older than 100 in 2014 include: heart disease, Alzheimer's disease, stroke, cancer, influenza and pneumonia. The report specifically links Alzheimer's disease to a 119% increase in death rates for centenarians between 2000 and 2014. http://goo.gl/OUn7Dt

1. 'Mortality Among Centenarians in the United States, 2000–2014 , Centers for Disease Control & Prevention, January 2016. http://goo.gl/HOqUE2

Unequal lives, unequal deaths

THE NEW YORK TIMES | Online (OpEd) – 20 January 2016 – When I began my career, I had naïvely assumed that, if time were short, who wouldn't prefer the familiarity of home and palliative medicine's focus on quality of life to the chaotic mess of the hospital? But I've learned that even when my patients accept hospice services, the proverbial "good death at home" is often out of their reach. Fully experiencing the benefits of home hospice requires resources: involved, dedicated family members. Money to afford caregivers, particularly in the absence of involved family members. A neighborhood whose local pharmacy actually stocks opiate medications for severe pain. Insurance that covers stays in nursing homes so that family members can simply be family members instead of caretakers. Without these luxuries, which so many others take for granted, dying at home could actually be less comfortable than dying in the hospital. Over this past year, I have stepped across the wide gap between my idealistic conception of hospice care and the reality of providing it amid life circumstances that shape the circumstances of dying. http://goo.gl/n53Xjr

Many doctors choose end-of-life care differently than the general population, two studies show

ABC NEWS | Online – 19 January 2016 – The way many doctors face end-of-life care differs from the approach of the general public, according to two new studies ... that suggest doctors are actually less inclined to seek heroic medical care in those circumstances. In the first study, researchers found physicians were slightly less likely to die in a hospital, get surgery shortly before their death or be admitted to the intensive care unit compared with the general population.[1] One reason may be that doctors understand extra procedures do not always mean better quality of life... The second study ... also found physicians were less likely to die in a medical facility than the general population.[2] http://goo.gl/Bn4ZkB

1. 'End-of-life care intensity for physicians, lawyers, and the general population,' *Journal of the American Medical Association*, 2016; 315(3):303-305. http://goo.gl/TdqUx8

2. 'Association of occupation as a physician with likelihood of dying in a hospital,' *Journal of the American Medical Association*, 2016; 315(3):301-303. http://goo.gl/nCrpJ8

Cont.

Noted in Media Watch, 17 August 2015, #423 (pp.5-6):

- U.S. | CNN News – 11 August 2015 – **'How doctors want to die is different than most people.'** A Stanford University study shows almost 90% of doctors would forgo resuscitation and aggressive treatment if facing a terminal illness.[1] http://goo.gl/QN6YzZ

  1. "Do unto others": Doctors' personal end-of-life resuscitation preferences and their attitudes toward advance directives,' *PLoS One*, 28 May 2014. [Noted in Media Watch, 2 June 2014, #360 (p.11)] http://goo.gl/TBNL8w

N.B. This issue of Media Watch lists several articles on doctors' preferences in terms of their own end-of-life care.

International Consortium for End-of-Life Research

The U.S. is not as bad at end-of-life care as most people think

THE WASHINGTON POST | Online – 19 January 2016 – One of the most pervasive ideas about death in America is that we don't do it well, dying in hospital beds after enduring unnecessary medical procedures instead of at home. It's our uncomfortable relationship with death, the thinking goes, that's pushing the relentless rise of our health-care spending to the highest in the world. A new study of cancer patients over age 65 complicates that notion, finding that while pieces of the story are right, much of it is not. [See inset right] Among the seven countries studied, American cancer patients were the least likely to die in a hospital bed. They spent the fewest days in the hospital during the final six months of life. Hospital spending during that period was high, but trailed Canada and Norway. "When I tell people the results – we have the lowest deaths in the hospital and we're not the most expensive – there isn't a single person who isn't surprised and shocked," said Ezekiel J. Emanuel, the leader of the study and an architect of the Affordable Care Act who now heads the medical ethics and health policy department at the University of Pennsylvania Perelman School of Medicine. "We've spent two years going over this data meticulously precisely because we were shocked." The notion that Americans die in an expensive, intrusive way that is contrary to most patients' wishes is entrenched, Emanuel said. After he left the White House and gave public talks about health care, end-of-life care constantly came up as a major factor in spiraling health-care costs. The idea follows from two powerful data points. Roughly a quarter of the Medicare budget is spent on health care during people's last year of life. At the same time, the U.S. spends much more per person on health care than any other developed nation. To many people, those facts seem likely to explain one another, fertilized by the power of anecdote; everyone knows a story about someone who passed away after a needless last-minute surgery or suffered the side effects of drugs that never had a chance of curing them. https://goo.gl/DpfGMk

Specialist Publications

'Comparison of site of death, health care utilization, and hospital expenditures for patients dying with cancer in 7 developed countries' (p.14), in *Journal of the American Medical Association.*

'Trends in end-of-life cancer care in the Medicare program' (p.14), *Journal of Geriatric Oncology.*

N.B. The U.S. was ranked 9th 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

Media Watch: Online

Media Watch (or a link to the weekly report) is posted on a number of websites that serve the hospice and palliative care community-at-large. Complete listing p.17.

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- CALIFORNIA | *The Los Angeles Times* – 19 January 2016 – **'Guidelines issued for California's assisted suicide law.'** With the state's assisted death law taking effect in months, the California Medical Association issued guidelines to physicians on writing prescriptions of lethal doses of drugs for terminally ill patients. The 15-page guide[1] details the complicated legal and medical path that doctors must take before they can authorize medication to hasten a patient's death, and helps physicians understand their legal rights to participate or not participate based on their own moral or religious values. http://goo.gl/jTc3oJ

    1. 'The California End of Life Option Act,' California Medical Association, January 2016. http://goo.gl/5ZEmv5

International

Louis Dundas Centre for Children's Palliative Care attempt to revolutionise the care of children with life-threatening illnesses

U.K. | *The Independent* – 22 January 2016 – A unique centre for palliative care (PC) is bringing together doctors and academics to create a "deeper body of research" to transform care for seriously ill children across the country. Specialists at the Louis Dundas Centre for Children's Palliative Care (LDC), based at Great Ormond Street Hospital, are attempting to revolutionise the care of children with life-limiting and life-threatening illness. Myra Bluebond-Langner, lead professor and researcher at the centre, said the LDC was dedicated to breaking down the misconception that paediatric PC was only focused on end-of-life care in children. "PC is not about end-of-life care," she said. "It's about living with the illness." That is why the professor and her team work to try to control symptoms and help children and their families to make decisions that yield the longest life with the best quality of life, whether it be a few weeks or many years. Research and practice at the LDC follows three main guidelines, says Professor Bluebond-Langner. These are to "listen to the child," to take their "concerns and wishes into account" and to make sure the difficult decisions are "not the child's alone to make." Researchers have historically shied away from publicly discussing the harrowing subject of PC for young children, but the LDC ... is dedicated to kick-starting a revolution in research and sharing this with hospices and hospitals across the country and beyond. http://goo.gl/4bJVlg

Specialist Publications

'A survey of key opinion leaders on ethical resuscitation practices in 31 European Countries' (p.16), in *Resuscitation.*

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

- *PROGRESS IN PALLIATIVE CARE* | Online – 15 October 2012 – **'The child's voice in pediatric palliative and end-of-life care.'** Although much is asked clinically and emotionally of children and adolescents who are receiving treatment for a life-threatening illness, they are not routinely asked how they experience the treatment that is intended to save or prolong their lives. Without their subjective reports (the "child's voice"), the treatment risk/benefit ratio cannot be fully known. http://goo.gl/holpr1

Media Watch: Back Issues

Back issues of Media Watch are available on the International Palliative Care Resource Center website at:
http://goo.gl/frPgZ5

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- THE NETHERLANDS | *Dutch News* – 20 January 2016 – **'Euthanasia requests for severe dementia patients rejected.'** None of the 26 requests for euthanasia for people with very severe dementia made to a special Dutch clinic were carried out, according to a report in medical magazine *Medisch Contact*. Between 1 January 2012 and 1 May 2015, official guardians made requests to help 26 patients who had become incapable of asking for themselves, the report says. All the patients had signed a euthanasia declaration before they became seriously ill. Euthanasia is allowed in the Netherlands under strict conditions. The patient must be suffering unbearably and the doctor must be convinced the patient is making an informed choice. http://goo.gl/N9g5TZ

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

Palliative care for patients dying in the ICU with chronic lung disease compared to metastatic cancer

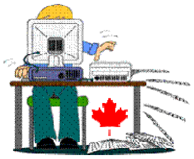
ANNALS OF THE AMERICAN THORACIC SOCIETY | Online – 19 January 2016 – Palliative care (PC) has focused largely on patients with cancer and yet patients with chronic lung diseases also suffer from high morbidity and mortality. The majority of deaths in intensive care units (ICUs) follow decisions to withhold or withdraw life-sustaining treatments, suggesting PC is critically important in this setting. The authors explored differences in receipt of elements of PC for patients with interstitial lung disease (ILD) and chronic obstructive pulmonary disease (COPD) who die in ICUs compared to patients with cancer. Among patients who die in the ICU, patients with ILD and COPD receive fewer elements of PC and have longer lengths of stay compared to patients with cancer. These findings identify areas for improvement in caring for patients with chronic lung diseases. http://goo.gl/1GvhiR

Noted in Media Watch, 11 January 2016, #444 (p.8):

- *ANNALS OF THE AMERICAN THORACIC SOCIETY* | Online – 5 January 2016 – **'Inadequate palliative care in chronic lung disease: An issue of healthcare inequality.'** Patients with chronic lung diseases (CLD) suffer higher symptom burden, lower quality of life, and greater social isolation compared to patients with other diagnoses, such as cancer. These conditions may be alleviated by palliative care (PC), yet PC is utilized less by patients with CLD compared to patients with cancer. http://goo.gl/KlLylP

Noted in Media Watch, 27 May 2013, #307 (p.8):

- *THE LANCET RESPIRATORY MEDICINE* | Online – 17 May 2013 – **'Palliative care for lung disease: Start early, stay late.'** Unfortunately, at the end of life when all reasonable curative interventions have failed, many patients with end-stage lung disease still die in pain after much suffering. http://goo.gl/dVhUON



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

The needs, models of care, interventions and outcomes of palliative care in the Caribbean: A systematic review of the evidence

BMC PALLIATIVE CARE | Online – 22 January 2016 – This review has revealed that the peer reviewed literature offers little evidence on palliative care (PC) needs of the Caribbean population. The available evidence was broadly divided into health care practitioner's needs, patients' needs and health care institutional needs. They included patients' needs for access to analgesia, preferred place of care /death and multi-dimensional aspects of support needed for patients and their caregivers. Health care practitioners spoke about their need for health policy and education in PC. In addition, needs of more trained staff and the services in PC were cited as institutional needs. The models of care existent in the Caribbean were not well described in the peer reviewed literature. There were no intervention studies. It is timely to now develop and evaluate evidence-based PC services in the Caribbean. http://goo.gl/oaQ4OV

Noted in Media Watch, 2 June 2014, #360 (p.6):

- *CAMBRIDGE QUARTERLY OF HEALTHCARE ETHICS* | Online – 27 May 2014 – '**Hospice and palliation in the English-speaking Caribbean.**' This article presents empirical data on the limited availability of hospice and palliative care to the 6 million people of the English-speaking Caribbean. Ten of the 13 nations responded to a survey and reported employing a total of 6 hospice or palliative specialists, and having a total of 15 related facilities. The evolving socioeconomic and cultural context in these nations bears on the availability of such care, and on the willingness to report, assess, and prioritize pain, and to prescribe opiates for pain. http://goo.gl/KnErWF

Compassion: A scoping review of the healthcare literature

BMC PALLIATIVE CARE | Online – 19 January 2016 – 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 over the past quarter century. 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. As a result, compassion is arguably one of the most referenced principles of quality care for which there is little empirical evidence. Compassion is inextricably linked to the inherent qualities of clinicians being actualized through acknowledgment, engagement and action in response to patient suffering. Clinicians' capacity for compassion is largely determined by their baseline qualities, qualities that can be either nurtured or eroded within clinical and educational settings. While this review has identified a multiplicity of directions for future research, two directions seem paramount. First, there is a need to reset the empirical foundation of compassion research by establishing its conceptual specificity, thereby providing a scientific base to conduct future research on the topic that is marked by validity and rigor. Second, there is a pressing need for applied research, investigating compassion within the clinical setting, as it is at the bedside that compassion seems to either flourish or falter. Above all, future research on the nature of compassion and its application in clinical practice needs to incorporate the perspective of patients, who desperately desire and increasingly expect compassion to be a core component of their healthcare experience. http://goo.gl/CoL1EU

Quotable Quotes

How far you go in life depends on your being tender with the young, compassionate with the aged, sympathetic with the striving and tolerant of the weak and strong. Because someday in your life you will have been all of these. **George Washington Carver (1864-1943)**

Cont.

Noted in Media Watch, 9 November 2015, #435 (p.14):

- *JOURNAL OF MEDICAL ETHICS* | Online – 3 November 2015 – **'Smiling through clenched teeth: Why compassion cannot be written into the rules.'** The discourse on the failings of the National Health System [in the U.K.] often cites lack of compassion as an important factor. This has resulted in proposals to enact rules which aimed at enforcing compassion in healthcare workers so as to improve the quality of healthcare and avoid future scandals. This paper argues that compassion cannot be enforced by any rule. http://goo.gl/hAb8Fn

Noted in Media Watch, 30 March 2015, #403 (p.14):

- *INTERNATIONAL JOURNAL OF HEALTH POLICY & MANAGEMENT*, 2015;4(4):199-201. **'Why and how is compassion necessary to provide good quality healthcare?'** In this editorial, the author argues why and how compassion might become a foundation of ethics guiding health professionals and a basis for ethics of care in health service organisations. http://goo.gl/nvHF60

Conceptual foundations of a palliative approach: A knowledge synthesis

BMC PALLIATIVE CARE | Online – 15 January 2016 – Much of what we understand about the design of healthcare systems to support care of the dying comes from the experiences with providing palliative care (PC) for dying cancer patients. It is increasingly recognized that in addition to cancer, high quality end-of-life care should be an integral part of care that is provided for those with other advancing chronic life-limiting conditions. A "palliative approach" has been articulated as one way of conceptualizing this care. However, there is a lack of conceptual clarity regarding the essential characteristics of a palliative approach to care. The authors conducted a knowledge synthesis of empirical peer-reviewed literature. Three overarching themes were conceptualized to delineate a palliative approach: 1) Upstream orientation towards the needs of people who have life-limiting conditions and their families; 2) Adaptation of PC knowledge and expertise; and, 3) Operationalization of a palliative approach through integration into systems and models of care that do not specialize in PC. http://goo.gl/1GqayC

Opening the doors a crack wider: Palliative care research data in the public domain

BMJ SUPPORTIVE & PALLIATIVE CARE | Online – 18 January 2016 – This report builds further on OPCARE9, an European Union 7th framework project aiming to identify knowledge gaps in care provision in the last days of life. This study began with curiosity about new ways of generating research questions to meet future challenges in palliative care (PC) and how to better engage disciplines not generally included in PC research. The authors describe an innovative methodological approach to generating data; put data relevant for PC research in the public domain; and, raise issues about open access in PC research. They aimed to compile research questions from different disciplines, based on raw data consisting of approximately 1,000 descriptions of non-pharmacological caregiving activities (NPCAs), generated through previous research. 53 researchers from different fields were sent the full list of NPCAs and asked to generate research questions from their disciplinary perspective. Responses were received from 32 researchers from 9 countries, generating approximately 170 research topics, questions, reflections and ideas, from a wide variety of perspectives, which are presented here. Through these data, issues related to death and dying are addressed in several ways, in line with a new public health approach. http://goo.gl/F93wCo

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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

Selected articles on evidenced-based end-of-life care

- *THE ASCO POST* (American Society of Clinical Oncology) | Online – 10 December 2015 – **'Evidence-based practice needed in end-of-life care.'** Over the past several decades, the oncology community has advanced the implementation of guidelines and other assessment tools to further integrate solid clinical evidence into daily practice, from diagnosis to treatment. However, the delivery of equitable, high-quality end-of-life care has suffered from a lack of study-based evidence. [Noted in Media Watch, 14 December 2015, #440 (p.6)] http://goo.gl/eudgG7

What's wrong with evidence-based medicine?

HASTINGS CENTER REPORT, 2016;46(1):IBC. Medicine in the last decades of the twentieth century was ripe for a data sweep that would bring systematic analysis to treatment strategies that seemingly had stood the test of time but were actually unvalidated. Coalescing under the banner of evidence-based medicine, this process has helped to standardize care, minimize error, and promote patient safety. But with this advancement, something of the art of medicine has been lost. http://goo.gl/9Fc8Xt

- *NEW ENGLAND JOURNAL OF MEDICINE* | Online – 14 October 2015 – **'Toward evidence-based end-of-life care.'** The disquieting patterns of end-of-life care in the U.S. have been well documented. One of the most sobering facts is that no current policy or practice designed to improve care for millions of dying Americans is backed by a fraction of the evidence the Food & Drug Administration would require to approve even a relatively innocuous drug. [Noted in Media Watch, 19 October 2015, #432 (p.14)] http://goo.gl/qH3rMQ

- *JOURNAL OF PALLIATIVE CARE*, 2015;31(3):133-140. **'Evidence-based palliative care 13 years on: Has anything changed?'** There is a paucity of data on whether interventions in individual palliative care (PC) units are evidence-based. Results show the evidence base for interventions in PC continues to evolve, but that there are still areas for which further high-quality studies are needed. [Noted in Media Watch, 7 September 2015, #426 (p.12)] http://goo.gl/4VJ90P

Existential concerns for people with motor neurone disease: Who is listening to their needs, priorities and preferences?

BRITISH JOURNAL OF OCCUPATIONAL THERAPY | Online – 14 January 2016 – People living with motor neurone disease (MND) are told at the time of their diagnosis that they have a life-limiting illness, and depending on the type of MND diagnosed they may have only months or years to live. The Motor Neurone Disease Association practice guidelines recommend that multidisciplinary health and social care professionals should focus upon psychological, functional and medical management. A referral to the palliative care team is recommended as the disease progresses, if a person experiences a loss of speech or respiratory insufficiency. People living with MND have existential concerns from the time of their diagnosis. Valuable opportunities may be lost to discuss and document their needs, priorities and preferences for end-of-life care before a person loses their ability to communicate by any means. Occupational therapists working as a member of a multidisciplinary team have an important role to play in this area of practice, as people newly diagnosed with MND are often referred to occupational therapy services because of their loss of function. http://goo.gl/fCY8b3

Noted in Media Watch, 10 November 2014, #383 (p.7):

- IRISH HOSPICE ASSOCIATION | Online – 3 November 2014 – **'New report highlights deficiencies in palliative care needs of people with advancing neurological disease.'** 'The Palliative Care Needs of People with Advancing Neurological Disease in Ireland' is calling for protocols and pathways to be developed, and increased resourcing and training opportunities for neurology and specialist palliative care services to support people with advancing neurological disease. [Noted in Media Watch, 10 November 2014, #383 (p.7)] http://goo.gl/sGlT4l

Cont.

Noted in Media Watch, 9 June 2014, #361 (p.15):

- *MEDSCAPE MEDICAL NEWS* | Online – 3 June 2014 – **'New European consensus on palliative care in neuro disease.'** A consensus paper for palliative care (PC) for patients with progressive neurologic disease emphasizes the special needs of these patients and how neurologists and PC specialists can work together to fulfil them. The paper is the product of a joint effort of the European Federation of Neurological Societies and the European Association for Palliative Care. http://goo.gl/1TAwqH

Sexuality and aging: A focus on lesbian, gay, bisexual, and transgender needs in palliative and end of life care

CURRENT OPINION IN SUPPORTIVE & PALLIATIVE CARE | Online – 15 January 2016 – To date, there has been relatively limited scholarly research on sexual health needs of people in palliative care (PC) and near end of life, and an even greater paucity of data specifically about sexual minorities. Forms of sexual expression may change with advancing age and illness. Physical intimacy and emotional connection may take on greater roles compared with more traditional concepts of sexual activity. Several recent studies have examined sexual health in PC and a few have examined lesbian, gay, bisexual, and transgender (LGBT) cohorts. Advances in public policy, including the recent U.S. Supreme Court decision regarding marriage equality, have continued to shape the cultural landscape for LGBT people. This article reviews recent literature with considerations for future research. Sexuality and intimacy remain important for many people facing terminal illness. LGBT people face unique challenges with regard to sexuality during PC. Clinicians should work to avoid heteronormative stereotypes and focus on goals of care to enhance quality of life for all patients. http://goo.gl/uOiKq7

Related

- *CURRENT ONCOLOGY REPORTS* | Online – 15 January 2016 – **'Communication about sexuality in advanced illness aligns with a palliative care approach to patient-centered care.'** Palliative care providers, while not expected to be sexual health experts, can provide comprehensive patient-centered care by including sexual health as part of their evaluation. They can explore how sexual dysfunction can impair functioning and utilize an interdisciplinary approach to manage symptoms. Principles on addressing sexuality in the palliative setting and practical ways of incorporating sexual history into the palliative care assessment are provided. http://goo.gl/SshIrL

Selected articles on sexuality and intimacy in terminal illness

- *PALLIATIVE MEDICINE* | Online – 21 January 2014 – **'Experiences of sexuality and intimacy in terminal illness: A phenomenological study.'** When someone is living with a life-limiting illness, their coupled relationship is also dying. In their being-towards-death-of-the-couple, patients and partners of patients ... experienced connecting and disconnecting within their coupled relationship. [Noted in Media Watch, 27 January 2014, #342 (p.16)] http://goo.gl/yUWWA6

- *JOURNAL OF PALLIATIVE MEDICINE* | Online – 28 March 2013 – **'An integrative review of sexual health issues in advanced incurable disease.'** The loss of sexual health can impact a person's overall quality of life and well-being. Studies regarding the sexual health of patients with life limiting illnesses are generally narrative reviews, expert opinions, or exploratory in nature. [Noted in Media Watch, 1 April 2013, #299 (p.14)] http://goo.gl/fZyigf

- *NURSING STANDARD*, 2010;24(52):35-39. **'Importance of sexual needs assessment in palliative care.'** Guidance states to support and improve the lives of adults with life-limiting illness, health professionals must address care in the social, psychological, spiritual and physical domains, yet no mention is made of the sexual domain. [Noted in Media Watch, 27 September 2010, #168 (p.10)] http://goo.gl/q7E9Kg

End-of-life care in a case of severe anorexia nervosa and end-stage liver disease

END OF LIFE JOURNAL | Online – 20 January 2016 – This article reviews a [U.K.] Court of Protection case involving a woman, Ms X, with two severe medical conditions: anorexia nervosa and end-stage liver cirrhosis due to alcohol dependence. Each of these conditions alone warranted end-of-life care planning. When combined, they provided a far more unique and complex presentation because of the way they were intertwined. Ms X's life was in imminent danger. The Court implemented methodically the principles of the Mental Capacity Act 2005. Ms X was assessed as lacking capacity to make decisions in relation to treatment for her anorexia. However, she retained capacity to make decisions regarding treatment for her liver disease and the continued harmful use of alcohol. The Court ruled that it was not in Ms X's best interests to be subject to further compulsory treatment for her anorexia, even though this may have prolonged her life. http://goo.gl/fEbaEj

Noted in Media Watch, 18 June 2012, #258 (p.6):

- U.K. | *The Daily Telegraph* – 17 June 2012 – **'Anorexia court ruling could affect living wills, lawyers say.'** A court ruling which concluded that a severely anorexic woman should be force-fed could render living wills invalid for those believed to lack capacity, barristers warned. Such wills could be overturned if the subject's mental capacity is subsequently questioned, meaning that a doctor must assess them at the time they make their decisions. http://goo.gl/HyBNvn

Noted in Media Watch, 15 June 2009, #101 (p.6):

- *INTERNATIONAL JOURNAL OF EATING DISORDERS* | Online – 14 May 2009 – **'Palliative care and hospice care as a last resort in the treatment of refractory anorexia nervosa.'** Although circumstances requiring its use are rare, palliative care (PC) may play a role in the treatment of long suffering, treatment refractory patients. For poor prognosis patients who are unresponsive to competent treatment, continue to decline physiologically and psychologically, and appear to face an inexorably terminal course, PC and hospice may be a humane alternative. http://goo.gl/07S0kN

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.

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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.

Supporting children facing a parent's cancer diagnosis: A systematic review of children's psychosocial needs and existing interventions

EUROPEAN JOURNAL OF CANCER CARE | Online – 18 January 2016 – This review aimed to 1) summarise the psychosocial needs of children/adolescents (0-18 years) with a parent with cancer across the illness trajectory (diagnosis to bereavement); and, 2) Evaluate existing interventions for this population. Of 98 full text articles retrieved, 12 reported on children's psychosocial needs, and 12 intervention studies were identified. Three factors emerged as critical to consider in future intervention development: 1) Children need age-appropriate information about their parent's cancer; 2) Children require support communicating with parents, family members and health professionals; and, 3) Children need an environment where they feel comfortable sharing positive/negative emotions and can have their experiences normalised among peers. All intervention studies reported at least one positive outcome, however, only five reported significant improvements in child/family functioning based on validated quantitative measure/s. Variability in study design and quality, combined with considerable heterogeneity in intervention characteristics and outcome variables limited the conclusions, which could be drawn. Therefore, further carefully designed and scientifically evaluated interventions for children facing a parent's cancer diagnosis are clearly warranted. http://goo.gl/VbnXLv

Online Resources

A literature search was undertaken in 2015 for the Children & Youth Grief Network of the Region of Peel. International in scope, it focused on key articles, reports, etc., published between 2010 and 2015, reflecting "current thinking" on the many different aspects of grief and bereavement support among children and young people:

Support Services for Grieving or Bereaved Children – Literature Search (annotated): http://goo.gl/FDvgk3

Helplines, Online Support, Social Media – Supplement to Literature Search (annotated): http://goo.gl/QzVV96

Learning about dying and living: An applied approach to end-of-life communication

HEALTH COMMUNICATION | Online – 20 January 2016 – The purpose of this article is to expand on prior research in end-of-life communication and death and dying communication apprehension, by developing a unique course that utilizes a hospice setting and an applied, service-learning approach. Therefore, this essay describes and discusses both students' and my experiences over a 7-year period from 2008 through 2014. The courses taught during this time frame provided an opportunity to analyze students' responses, experiences, and discoveries across semesters/years and co-cultures. This unique, 3-credit, 14-week, service-learning, end-of-life communication course was developed to provide an opportunity for students to learn the theories related to this field of study and to apply that knowledge through volunteer experiences via interactions with dying patients and their families. The 7 years of author's notes, plus the 91 students' electronically submitted three reflection essays each (273 total documents) across four courses/years, served as the data for this study. According to the students, verbally in class discussions and in numerous writing assignments, this course helped lower their death and dying communication apprehension and increased their willingness to interact with hospice patients and their families. Furthermore, the students' final research papers clearly demonstrated how utilizing a service-learning approach allowed them to apply classroom learnings and interactions with dying patients and their families at the hospice, to their analyses of end-of-life communication theories and behaviors. The results of these classes suggest that other, difficult topic courses (e.g., domestic violence, addiction, etc.) might benefit from a similar pedagogical approach. http://goo.gl/GIYLlj

Related

- *PATIENT EDUCATION & COUNSELING* | Online – 20 January 2016 – **'The relationship between physician humility, physician-patient communication, and patient health.'** The results of this study suggest that humble, rather than paternalistic or arrogant, physicians are most effective at working with their patients. http://goo.gl/Ayqpd6

International Consortium for End-of-Life Research

Comparison of site of death, health care utilization, and hospital expenditures for patients dying with cancer in 7 developed countries

JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, 2016;315(3):272-283. This is the first international comparative study to the authors' knowledge of site of death, health care utilization, and hospital expenditures at the end of life. All 7 nations had high rates of hospital admissions and hospital days near the end of life. The U.S. had the lowest proportion of decedents with cancer dying in acute care hospitals. Norway and England had higher rates of in-hospital deaths, hospital admissions, and hospital days, and Norway had among the highest hospital expenditures, but England had among the lowest. The authors found similar patterns in the larger cohort of decedents of any age and the more homogeneous cohort of decedents older than 65 years with lung cancer, suggesting that the differences observed are likely driven more by end-of-life care practices and organization rather than differences in cohort identification. Four points are worth emphasizing. First, three broad patterns of end-of-life care emerged in the 7 countries examined. Decedents in Belgium, Canada, Germany, and Norway received more hospital-centric care with correspondingly high expenditures for hospitalizations, where hospital-centric implies higher rates of death in acute care hospitals and other measures of inpatient utilization. End-of-life care in England was hospital-centric but at a lower cost. Decedents in the U.S. and The Netherlands received care in acute care hospitals less often and for fewer days, although hospital expenditures near the end of life in the U.S. were higher (commensurate with expenditures in Canada and Norway), while hospital expenditures in The Netherlands were lower. Second, the U.S. had the lowest proportion of patients dying in the hospital. Third, the U.S. was prominent in its use of expensive, resource-intense services at the end of life. Fourth, this study collected a wide variety of data on decedents across 7 developed countries. http://goo.gl/UWG881

JAMA The Journal of the American Medical Association

The focus of the current issue of *JAMA* is end-of-life care. Topics include end-of-life care in the ICU, physician orders for life-sustaining treatment, duties of care in life-limiting illness, family perspectives on aggressive care near the end of life, and physician-assisted dying. Journal contents page: http://goo.gl/vslRnb

Related

- *BMC PALLIATIVE CARE* | Online – 20 January 2016 – **'The determinants of home and nursing home death: A systematic review and meta-analysis.'** Place of death may not be a very good indicator of the quality of end-of-life/palliative care since it is determined by multiple factors and is therefore dependent on individual circumstances. http://goo.gl/lCNIGk

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

Trends in end-of-life cancer care in the Medicare program

JOURNAL OF GERIATRIC ONCOLOGY | Online – 15 January 2016 – Despite growing focus on providing appropriate end-of-life care, there has not been an improvement in aggressive end-of-life cancer care in the Medicare program. The proportion of beneficiaries receiving at least one potentially aggressive end-of-life intervention increased from 48.6% in 2006 to 50.5% in 2011. From 2006 to 2011, increases were apparent in repeated hospitalization (14.1% vs. 14.8%), repeated emergency department visits (34.3% vs. 36.6%), ICU admissions (16.2% vs. 21.3%), and late hospice enrollment (11.2% vs. 12.9%), whereas in-hospital death declined (23.5% vs. 20.9%). End-of-life chemotherapy use (4.4% vs. 4.5%) did not change significantly over time . The use of potentially aggressive end-of-life care varied substantially across hospital referral region (HRRs), ranging from 40.3% to 58.3%. Few HRRs had a decrease in aggressive end-of-life care during the study period. http://goo.gl/3tJbRI

Cont.

Related

- *AMERICAN CRIMINAL LAW REVIEW* | Online – Accessed 19 January 2016 – **'Life, death and Medicare fraud: The corruption of hospice and what the private public partnership under the Federal False Claims Act is doing about it.'** On 17 October 2013 ... a federal jury in the U.S. District Court for the Eastern District of Pennsylvania returned a guilty verdict on all thirty five counts against Matthew Kolodesh for various forms of healthcare fraud, mail fraud, money laundering, aiding and abetting, and conspiracy, related to his ownership and operation of Home Care Hospice of Philadelphia, Pennsylvania. The indictment alleged that Kolodesh and his co-conspirators fraudulently billed Medicare to the tune of an estimated $12.8 million for end-of-life care for patients who were not at the end of their lives. https://goo.gl/K5b9Bi

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

  - U.S. | *The Washington Post* – 14 January 2015 – **'How the drive for profits is shaping end-of-life care.'** A federal watchdog has warned that financial incentives in Medicare may be warping the ways that hospice care works in the U.S.[1] http://goo.gl/iU8z2O

    1. 'Medicare Hospices Have Financial Incentives to Provide Care in Assisted Living Facilities,' Office of the Inspector General, Department of Health & Human Services, January 2015, https://goo.gl/bxxkA0

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

The meaning of occupation for patients in palliative care when in hospital

PALLIATIVE & SUPPORTIVE CARE | Online – 22 January 2016 – The aim of this study was to describe how patients in palliative care (PC) relate to occupation during hospitalization and to define the meaning it has for them. Patients experience occupations as meaningful when in hospital during the last period of their lives. They would like to be able to handle their own needs as much as possible. Staff behavior, the design of the environment, the lack of accessible occupations, and the degree to which patients can decide whether to receive or decline visits affect the possibility to make their wishes a reality. The authors results also revealed that patients experience a sense of loss of their role, as well as a lack of control and participation. http://goo.gl/flmzUr

Physician perspectives on palliative care for children with neuroblastoma: An international context

PEDIATRIC BLOOD & CANCER | Online – 19 January 2016 – Studies have shown that children with cancer globally lack access to palliative care (PC). Little is known regarding physicians' perceptions of (PC), treatment access, and self-reported competence in providing PC. Members of the Global Neuroblastoma Network were surveyed. Most respondents trained in high-income countries (HIC), but practice in low- and middle-income countries (LMIC), and care for more than five patients with neuroblastoma annually. WHO Essential Medicines in PC varied in availability, with incomplete access across LMIC centers. Non-pharmacologic therapies were inconsistently available. Contrary to international definitions, 17% of respondents inappropriately considered PC as that initiated only after curative therapy is stopped. Mean physician competence composite score in providing symptomatic relief and PC across phases of care was 2.93. Physicians reported significantly greater competence in symptom management during cure-directed therapy than during end-of-life or when patients are actively dying. Practicing in HIC, prior PC training, having access to radiotherapy, and not having to turn patients away due to bed shortages were significantly predictive of perceived competence in providing PC at end of life. http://goo.gl/R9CFcn

End-of-life care in Italy

"Dignity" at the end of life: Ethical and deontologic reflections

RECENTI PROGRESSI IN MEDICINA, 2015;106(12):593-596. According to the liberal tradition, human dignity is especially expressed in the autonomy of every human being. The Italian and the German Constitutions recall the value of human dignity. In Article 32 of the Italian Constitution, the concept of dignity is taken into account when stating the autonomy of the individual decision-making about health treatment. This is confirmed by the Code of Medical Ethics (2014): the right to self-determination and the right of patients to decide for themselves in accordance with their own life plans, are at the core of the concept of "human dignity." For this reason, doctors should support and encourage the full right of every patient to be considered as an autonomous person until the end of life, affirming his dignity. http://goo.gl/CKwQqB

N.B. Italian language article.

A survey of key opinion leaders on ethical resuscitation practices in 31 European Countries

RESUSCITATION | Online – 14 January 2016 – Europe is a patchwork of 47 countries with legal, cultural, religious, and economic differences. A prior study suggested variation in ethical resuscitation/end-of-life practices across Europe. This study aimed to determine whether this variation has evolved, and whether the application of ethical practices is associated with emergency care organisation. A questionnaire covering four domains of resuscitation ethics was developed based on consensus: 1) Approaches to end-of-life care and family presence during cardiopulmonary resuscitation; 2) Determinants of access to best resuscitation and post-resuscitation care; 3) Diagnosis of death and organ donation; and, 4) Emergency care organisation. There is need for harmonised legislation, and improved, education-based interpretation / application of bioethical principles. http://goo.gl/me0mUy

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- *BMJ OPEN* | Online – 18 January 2016 – **'Caught between intending and doing: older people ideating on a self-chosen death.'** The authors findings show that the in-between period emerges as a considerable, existential challenge with both rational and non-rational concerns and thoughts, rather than a calculative, coherent sum of rational considerations. This study highlights the need to take due consideration of all ambiguities and ambivalences present after a putatively rational decision has been made in order to develop careful policy and support for this particular group of older people. http://goo.gl/flZOkf

- *CANADIAN PHARMACISTS JOURNAL*, 2016;149(1):54-55. **'Canadian Pharmacists Association surveys pharmacists on physician-assisted dying.'** In certain jurisdictions where assisted dying is legal, pharmacists are not only asked to dispense lethal drugs, but can be expected to offer advice to patients and physicians. Consistent with this approach, the Canadian Pharmaceutical Associations survey found that Canadian pharmacists favour such a requirement for pharmacist counselling to the patient, physician or patient's family as part of dispensing lethal medication. http://goo.gl/Npxtqi

- *INTERNAL MEDICINE JOURNAL* | Online – 13 January 2016 – **'Exploring the interface between palliative care and "physician assisted dying": Data from the Australasian context.'** Legalisation of physician assisted dying (PAD) remains a highly contested issue. In the Australasian context, the opinion and perspective of palliative care (PC) specialists has not been captured empirically, and is required to better inform the debate around this issue moving forward. Important findings of a survey of Australasian specialists in PC include: 1) PC specialists are largely opposed to the legalisation of PAD; 2) The proportional titration of opioids is not understood by any PC specialist studied to be "voluntary euthanasia"; and, 3) There is a wide variation in frequency of requests, and one third of PC specialist express discomfort in dealing with requests for assisted suicide or euthanasia. Key areas for future research at the interface between PAD and best practice end-of-life care are identified, including exploration into why PC specialists are largely opposed to PAD, and consideration of the impact "the opioid misconception" may have on the literature informing this debate. http://goo.gl/5G2sNn

Cont.

- *JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION*, 2016;315(3):253-254. **'Physician-assisted death in Canada.'** This Viewpoint describes efforts in Canada to explore the complexities of physician-assisted death after a 2015 Canadian Supreme Court ruling against its prohibition. Physicians whose patients disclose a wish to die must always be listening for underlying deep sorrow, the source of which may or may not be self-evident or readily accessible. For some patients, requesting a hastened death may be the ultimate assertion of individual autonomy. The impulse of physicians to pursue these conversations, to try to unravel the etiology of a desire for death, can sometimes be temporized by the uncertainty of where those discussions might lead and the question of how best to respond. In countries having or about to have legislation allowing for death-hastening options, these conversations are now simply unavoidable. http://goo.gl/kLd0HI

JAMA The Journal of the American Medical Association

The focus of the current issue of *JAMA* is on end-of-life care and includes several articles on physician-assisted death. Journal contents page: http://goo.gl/vslRnb

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

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

Canada

ONTARIO | HPC Consultation Services (Waterloo Region Wellington County): http://goo.gl/AhlqvD

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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