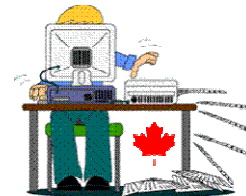


Media Watch...

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

Creating a basis for new practice: Scroll down to [Specialist Publications](#) and 'Preserving dignity in end-of-life nursing home care: Some ethical challenges' (p.7), in *Nordic Journal of Nursing Research*.

Canada

Home-care coverage gap remains for patients who move provinces

ONTARIO | *The Globe & Mail* – 24 October 2016 – When Dan Duma found out he had incurable liver cancer, he wanted to die at home. For the Alberta oil-sands worker, that meant moving back to Windsor, Ontario, where he and his wife lived for more than 15 years before the closing of the local General Motors plant pushed them west, and where their two grown daughters live now. Unfortunately for Mr. Duma, crossing provincial lines left him with no access to publicly funded home care for three months, making it impossible for the 48-year-old to be at home when he died on 18 July. Mr. Duma fell through one of the biggest cracks in Canada's fractured home-care system... The problem is that home care is not covered in the first two to three months after a patient moves to a new province. The federal, provincial and territorial health ministers made home care a priority at their meeting in Toronto last week, and the Liberal government has singled it out as the only area of health care in line to receive new money from Ottawa.

Duma did not qualify for any services provided by his local Community Care Access Centre (CCAC), the public agency that co-ordinates home care in Ontario. That meant no nursing care, no help from personal support workers, and no access to publicly funded equipment, such as a hospital bed. <https://goo.gl/R8V79Z>

Extract from *The Globe & Mail* report

Darren Cargill, the palliative care leader for the Erie St. Clair Regional Cancer Program, found out about Mr. Duma's dilemma from his daughters. He did his best to help, asking nurse educators from the Hospice of Windsor & Essex County to support the family by phone, and rummaging through the hospice's basement to find used equipment to donate to Mr. Duma. In the end, Dr. Cargill bent the rules to secure a bed for Mr. Duma at a hospice in Leamington, about 45 minutes from Windsor. Hospice services are also excluded from the interprovincial billing agreement.

N.B. The articles in *The Globe & Mail's* series that investigated Ontario's home care system are listed in Media Watch 11 April 2016, #457 (p.1).

U.S.A.

Where the elderly die can vary by region, study shows

THE WALL STREET JOURNAL | Online – 26 October 2016 – How much time people spend in hospitals or nursing homes in the final months of life, instead of at home, varies widely depending on where they live, new research shows.¹ Across the Rockies and regions of the Gulf Coast, the dying spend more than two additional weeks hospitalized or in other facilities, on average, compared with those at the end of life in the Midwest and Montana, researchers report. In other parts of the country, the picture is more mixed, but still differs sharply from one community to another. Understanding why that is could help reduce medical care that goes against patients' wishes to be home, according to the researchers who led the study. "Being home at the end of one's life will never be a universal goal," the researchers wrote, "but our experience and academic research suggests that all else being equal, patients would rather be at home than in health-care facilities." The variation may also point to unnecessary medical care that drives up costs at the end of life, said researchers not involved in the study. <https://goo.gl/Tel8C2>

1. 'Days spent at home – a patient-centered goal and outcome,' *The New England Journal of Medicine*, 2016;375(17):1610-1612. <https://goo.gl/yQ2vW8>

Noted in Media Watch 26 September 2016, #487 (p.8):

- *JOURNAL OF THE AMERICAN GERIATRICS SOCIETY* | Online – 19 September 2016 – '**Predictors of place of death of individuals in a home-based primary and palliative care program.**' Home-based primary and palliative care results in a high likelihood of nonhospital death, although certain demographic characteristics are strong predictors of death in the hospital. For Mount Sinai Visiting Doctors Program participants, home visits in the last month of life were not associated with death outside the hospital. <https://goo.gl/yJBIUU>

Noted in Media Watch 19 September 2016, #480 (p.10):

- *JOURNAL OF THE AMERICAN GERIATRIC SOCIETY* | Online – 9 September 2016 – '**Factors associated with transition from community settings to hospital as place of death for adults aged 75 and older: A population-based mortality follow-back survey.**' There is an apparent reliance on hospitals to provide end of life (EoL) care for older people, particularly those living at home, who accounted for 71.9% of those who transitioned. Very few (4.7%) transitioned to an inpatient hospice unit at the EoL. <http://goo.gl/6KVloz>

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- *THE WASHINGTON POST* | Online – 24 October 2016 – "'**Death with dignity**" laws and the desire to control how one's life ends.' Supporters of "death with dignity" have succeeded in legalizing what is also known as physician-aid-in-dying in five states by convincing voters, lawmakers and courts that terminally ill patients have the right to die without suffering intractable pain in their final days or weeks. Yet the latest research shows that terminally ill patients who seek aid in dying aren't primarily concerned about pain. Those who have actually used these laws have been far more concerned about controlling the way they exit the world than about controlling pain. The research suggests that patients' motivations are more complicated than they're often portrayed and could affect how people vote on the issue in other cities and states. <https://goo.gl/jQCaO4>

Specialist Publications

'**Death with dignity in Washington patients with amyotrophic lateral sclerosis**' (p.9), in *Neurology*.

International

Children’s Ombudsman: No system of palliative care in Ukraine

UKRAINE | Ukrinform (Kyiv) – 29 October 2016 – Ukrainian Children’s Ombudsman Mykola Kuleba has stated that Ukraine has no palliative care (PC) system... “Thousands of children and their parents suffer from unbearable torments every day because of this,” Kuleba said. As noted, there are more than 17,000 children in need of PC annually in Ukraine. However, as estimated by UNICEF, there are more than 40,000 such children in Ukraine. “Timely and appropriate care for terminally ill children is our test of humanity and the ability to be the civilized society,” the Ombudsman added and urged to “unite all efforts to provide children in need with timely medical and social assistance.” <https://goo.gl/2okrxR>

Noted in Media Watch 20 May 2013, #306 (p.6):

- UKRAINE | Reuters – 15 May 2013 – ‘**New breakthrough for incurably ill.**’ Ukraine’s cabinet of ministers’ approval of new regulations on access to pain medicines will dramatically expand healthcare services for patients with incurable illnesses and reduce unnecessary suffering. A Human Rights Watch report in 2011 concluded that tens of thousands of cancer patients in Ukraine die every year in severe pain because they cannot get adequate palliative care services.¹ <https://goo.gl/9bW0i5>

1. *Uncontrolled Pain: Ukraine’s Obligation to Ensure Evidence-Based Palliative Care*, Human Rights Watch, 12 May 2011. [Noted in Media Watch, 16 May 2011 #201 (p.4)] <https://goo.gl/SGQ7kD>

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

Don’t obey orders in a living will, judge orders doctors: Ruling means patients in an unconscious state cannot die without the case going before a court

U.K. | *The Daily Mail* – 24 October 2016 – Living wills – the documents by which desperately sick patients can give advance orders to doctors to end their lives – must no longer be obeyed by the medical profession, judges have ordered. They have declared that no one who is in a coma or an unconscious state should be allowed to die without the case first being considered by a court. The instructions set out by judges of the Court of Protection effectively strike down the 2005 Mental Capacity Act. Under a living will, people can instruct doctors to withdraw their medical treatment if they become incapacitated and unable to make decisions for themselves. This means that doctors should remove tubes providing them with nourishment and fluids, because in law artificial nutrition and hydration counts as treatment. The incapacitated patient then dies of hunger and thirst. <https://goo.gl/v6Vvu4>



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.¹ 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>

1. Ashpole BR. ‘Communications with the Public, Politicians, and the News Media,’ *Oxford Textbook of Palliative Medicine*, 5th Edition (pp.357-359), Oxford University Press, 2015. <https://goo.gl/Vi07RS>.

Too much needless National Health Service treatment says Royal College, as it draws up list of those with little or no benefit

U.K. (England, Northern Ireland, Scotland & Wales) | *The Daily Telegraph* – 24 October 2016 – Doctors are giving too many patients tests and drugs they do not need, senior medics have warned, as they published a list of 40 treatments which should no longer be in routine use. The unprecedented intervention by the Academy of Medical Royal Colleges (AMRC) follows research which found doctors commonly ordering X-ray, scans and drugs, in cases they believed to be pointless. More than six in 10 medics said their decisions had been driven by a fear of litigation, with just as many saying they ordered interventions because they felt under pressure from patients. The Academy – which represents all 21 medical royal colleges in the U.K. – has today drawn up a list of 40 treatments and procedures which it says are of little or no benefit to

patients. Professor Dame Sue Bailey, AMRC chairman, said doctors and patients should question whether interventions were “really necessary” before embarking on tests and treatments. Dame Sue said the changes were not primarily about saving the NHS money, but about having an “intelligent conversation” with patients. <https://goo.gl/O8ljnC>

Extract from *The Daily Telegraph* report

Most controversially, it suggests chemotherapy for advanced cancer should be carefully considered, as “benefit is likely to be small, and the harm may be great,” the report says. It also recommends against regular scans for terminally ill patients...

Noted in Media Watch 24 October 2016, #484 (p.15):

- *SUPPORTIVE CARE IN CANCER* | Online – 13 October 2016 – ‘**The role of palliative care in the last month of life in elderly cancer patients.**’ The purpose of this study was to evaluate the administration of chemotherapy in the last month of life (CLML) and to evaluate the impact of the palliative care consult (PCC) in the elderly patients. Overall, PCC failed to decrease CLML administration... <https://goo.gl/nDDJON>

N.B. Additional articles on chemotherapy towards the end of life noted in this issue of Media Watch.

Specialist Publications

Resuscitation orders in acute hospitals: A point prevalence study

AUSTRALIAN JOURNAL OF AGEING | Online – 19 October 2016 – One thousand nine hundred and thirty-four patient records were reviewed, and 230 resuscitation orders and 15 advance care plans found. Significantly, more resuscitation orders were found at public hospitals. Patients admitted to private hospitals were older, with shorter admissions. A further 24 orders were written following Medical Emergency Team (MET) calls for 97 patients. Only 16% of patients aged 80+ years had a resuscitation order written within 24 hours of admission. Fewer resuscitation orders were written at admission for older adults than might be expected if goals of care and resuscitation outcome are considered. MET continue to have a prominent role in end-of-life care. <https://goo.gl/r9xCrJ>

Related

- *CRITICAL CARE MEDICINE* | Online – 20 October 2016 – ‘**A randomized trial of palliative care discussions linked to an automated early warning system alert.**’ This study suggests that automated early warning system alerts can identify patients potentially benefitting from directed palliative care discussions and reduce the number of ICU transfers. Advanced directive documentation was significantly greater prior to discharge in the intervention group ... as were first-time requests for advanced directive documentation. Documentation of resuscitation status was also greater... <https://goo.gl/tEVmpM>

Cont.

- *SUPPORTIVE CARE IN CANCER* | Online – 22 October 2016 – ‘**Do-not-resuscitate orders in cancer patients: A review of literature.**’ Do-not-resuscitate (DNR) orders are often placed late in the disease process. This may be a cause for disagreements between doctors and between doctors and patients, and may cause for unnecessary treatments and admissions. DNR orders ... may influence the rest of the medical treatment for patients. The authors present recommendations for discussing DNR orders and medical futility in practice through shared decision-making. <https://goo.gl/A97NDO>

All Ireland Institute of Hospice & Palliative Care

Protocol for a thematic synthesis to identify key themes and messages from a palliative care research network

BMC RESEARCH NOTES | Online – 21 October 2016 – Research networks that facilitate collaborative research are increasing both regionally and globally and such collaborations contribute greatly to knowledge transfer particularly in health research. The Palliative Care Research Network is an Irish-based network that seeks to create opportunities and engender a collaborative environment to encourage innovative research that is relevant for policy and practice. The current review outlines a methodology to identify cross-cutting messages to identify how dissemination outputs can be optimized to ensure that key messages from this research reaches all knowledge users. <https://goo.gl/cguzZX>

Selected articles on research priorities in the context of end-of-life care

- *BMC PALLIATIVE CARE* | Online – 24 March 2016 – ‘**Developing research priorities for palliative care of people with intellectual disabilities in Europe: A consultation process using nominal group technique.**’ The proposal of four major priority areas and a range of minor themes for future research in intellectual disability, death, dying and palliative care will help researchers to focus limited resources and research expertise on areas where it is most needed and support the building of collaborations. [Noted in Media Watch 28 March 2016, #455 (p.9)] <http://goo.gl/fNxm6x>
- *BMJ SUPPORTIVE & PALLIATIVE CARE*, 2016;6(1):2-4. ‘**Research challenges in palliative and end-of-life care.**’ A review of end-of-life care in the U.K. expressed concerns about a lack of research in this field and underuse of existing research. However, research in this area is underfunded compared with studies into the prevention and cure of life-limiting conditions. Less than 0.3% of the £500 million spent on cancer research is allocated to palliative care, with funding for non-cancer conditions likely to be even less. [Noted in Media Watch 22 February 2016, #450 (p.10)] <http://goo.gl/WNJeLB>
- *EUROPEAN JOURNAL OF PALLIATIVE CARE*, 2015;22(3):114-117. ‘**Identifying palliative and end-of-life care research priorities: A U.K. approach to consult end users.**’ Launched in 2013 the Palliative and End-of-Life Care Priority Setting Partnership (PeolcPSP) has enabled end users of research – patients, carers and clinicians – to identify their priorities in order to inform future end-of-life care research. [Noted in Media Watch 11 May 2015, #409 (p.8)]

N.B. Access to the contents of the *European Journal of Palliative Care* requires a subscription. Contents page: <http://goo.gl/63tZAn>

End-of-life practices in France under the Claeys-Leonetti Law: Report of three cases in the oncology unit

CASE REPORTS IN ONCOLOGY, 2016;9(3):650-654. On 2 February 2016, the French government enacted the Claeys-Leonetti law introducing the right to deep and continuous sedation and forbade euthanasia for end-of-life patients. This article reports the first descriptions of this kind of intervention at the final stage of life of three patients and highlights the need of patient-centered goals and the importance of close collaboration between the patient, family, and medical and paramedical team to achieve a higher quality of final palliative care. <https://goo.gl/PWRDzs>

Noted in Media Watch 11 January 2016, #444 (p.14):

- *SOINS: LA REVUE DE RÉFÉRENCE INFIRMIÈRE*, 2015;60(801):49-51. ‘**The decision to withhold and withdraw active treatments, an ethical approach.**’ Intensive care medicine is confronted with situations of suffering and dependence experienced as the appropriation of the body or medical futility. In this context, withholding and withdrawing active intensive care must be given a framework. The ethical challenge is to decide to continue or not with care considered vain or futile. The ‘Leonetti Law,’ in particular, helps to clarify the situation for professionals and families. <http://goo.gl/mWYjJj>

N.B. French language article. The Léonetti Law Act (2005) established the right to “let die.” The law opposes the “unreasonable obstinacy” of undertaking or continuing “unnecessary or disproportionate” treatment, “with no other effect than maintaining life artificially.”

Develop and test a palliative care screening tool for rural patients with serious chronic illnesses: a study protocol

INTERNATIONAL JOURNAL OF CLINICAL TRIALS, 2016;3(4):210-216. Delayed admission to palliative and hospice services is prevalent and, especially in rural areas, contributing to poor quality of care, caregiver stress and burden, reducing patients’ and their caregivers’ quality of life and increasing healthcare costs. A reliable and sensitive screening tool would help clinicians identify patients in need of palliative care (PC) services. The purpose of the study is to develop and test a screening tool to be used by healthcare professionals in rural clinics and hospitals to identify patients with progressive, multiple chronic illnesses in need of primary PC services. The implication of this project is to 1) Reduce healthcare disparities; 2) Improve quality of care for rural patients with chronic serious illness; 3) Inform the development of a hybrid

(both inpatient and outpatient) screening tool for identifying PC needs that can be integrated into primary PC programs; and, 4) Enhance our understanding of mechanisms and relevant variables related to PC in rural patients living with chronic serious illness, leading to future program research in this field. <https://goo.gl/HhLOFI>



RURAL ONTARIO
INSTITUTE

End-of-life Care in Rural Communities:
<http://goo.gl/WPJvBI>

Survey: Urban vs. Rural Palliative Medicine:
<http://goo.gl/GEJL4u>

Related

- *JOURNAL OF TRANSCULTURAL NURSING* | Online – 21 October 2016 – ‘**At the grave we make our song: A palliative care study in rural Guatemala.**’ The overarching theme was “relief from suffering,” reinforced by three support systems: 1) The family; 2) Community *rezadora*; 3) and, Priest. The family made decisions and provided physical care. The *rezadora* sang prayers and prepared the home altar. The priest provided traditional sacraments. The role of the *rezadora* should be considered in providing palliative care (PC) to Guatemalans. Some Guatemalans are unfamiliar with or have difficulty understanding the role of the nurse in palliative and end-of-life care (EOLC). The authors suggest training opportunities using international resources to enhance the role for Guatemalan nurses in EOLC. <https://goo.gl/o1Vq1H>

N.B. An estimated 1.3 million Hispanics of Guatemalan origin resided in the U.S. in 2013, according to a Pew Research Center analysis of the Census Bureau’s American Community Survey.

Development of quality indicators to address abuse and neglect in home-based primary care and palliative care

JOURNAL OF THE AMERICAN GERIATRICS SOCIETY | Online – 27 October 2016 – The literature review yielded 4,371 titles and abstracts; 25 publications met final inclusion criteria and informed development of nine candidate quality indicators (QIs). The technical expert panel rated all but one of the nine candidate indicators as having high validity and feasibility. Translating the complex problem of addressing abuse and neglect into QIs may ultimately serve to improve care delivered to vulnerable home-limited adults who receive home-based medical care. <https://goo.gl/UalrIj>

Development of a palliative approach in neonatology

MÉDECINE PALLIATIVE | Online – 28 October 2016 – To discuss the question of unreasonable, futile or inappropriate treatment and neonatal end-of-life in cases with multiple complications in which all possible medical treatment has been attempted but has failed to relieve symptoms that are considered to be intolerable. Questions on the meaning of care as well as ethical issues that arise in these situations are analyzed. In these situations, it is necessary to define whether the goal of the clinical plan for treatment and care is to maintain life for the short, intermediate or long-term, or if this life can no longer exist because it is physiologically impossible and death will occur rapidly. If life is physiologically possible, we can speak of a life project and a plan for adapted care. In the latter case, speaking of a life project creates ambiguity and it is more appropriate to speak of an adapted care plan for the baby's comfort. It is important to go beyond moral principles and be pragmatic about what can be done socially and materially so that the time alive of this life is not to the detriment of other lives. The decisions should be made following one or several pluridisciplinary meetings. The reasons for this decision should be recorded in the newborn's file by the physician who is responsible for the case. <https://goo.gl/Bmc7mS>

N.B. French language article.

Preserving dignity in end-of-life nursing home care: Some ethical challenges

NORDIC JOURNAL OF NURSING RESEARCH | Online – 21 October 2016 – The aim of this study was to investigate how healthcare workers are influenced by and deal with ethical challenges in end-of-life care in nursing homes. Researchers and clinical staff, as co-researchers, collaborated to shed light on clinical situations and create a basis for new practice. The analysis resulted in the main theme, “dignity in end-of-life nursing home care,” and the sub-categories “challenges regarding life-prolonging treatment” and “uncertainty regarding clarification conversations.” The authors' findings indicate that nursing homes do not provide necessary organizational frames for the team approach that characterizes good palliation, and therefore struggle to give dignified care. Ethical challenges experienced by healthcare workers are closely connected to inadequate organizational frames. <https://goo.gl/qguHPu>

Family caregivers' conceptualisation of quality end-of-life care for people with dementia: A qualitative study

PALLIATIVE MEDICINE | Online – 25 October 2016 – Three over-arching themes were derived from the interviewees, including maintaining the person within, fostering respect, and dignity and showing compassion and kindness. End-of-life care for people with dementia does not differ from care through-out the dementia trajectory. Throughout the findings, there is an implicit underlying theme of conflict: conflict between family caregivers and an increasingly systematised service of care and conflict between family caregivers and professionals. This study has in particular demonstrated the importance of the psychosocial aspects of care, aligning with the holistic definition of palliative care. <https://goo.gl/TYqx0x>

Finding evidence about the costs of palliative care: CareSearch's suite of search tools

PALLIATIVE MEDICINE | Online – 25 October 2016 – Access to reliable current information about the costs of palliative care (PC) is crucial to provide evidence to underpin service provision, to assist in clinical and policy decision making and to inform ongoing research. The vast and growing quantity of information about the costs of PC can be hard to navigate; it is stored in many different databases, across disciplines, and indexed on a variety of platforms with differing terminology. Health practitioners, policymakers and researchers in PC may not readily have the time or expertise needed to frame the detailed searches required to search the many different sources effectively. This paper describes the development of a resource that facilitates the retrieval of current high quality literature about economic aspects of PC. This paper highlights the importance of searching in multiple and appropriate databases for economics literature. The paper outlines the identification, testing and evaluation of existing search filters and other sources of information to determine the best resources to use and the best terms to use for each one. <https://goo.gl/QdzZqb>

Related

- *PHYSICIAN LEADERSHIP JOURNAL*, 2016;September/October:8-11. '**Cost savings and palliative care referrals from the emergency department.**' The number of patients with end-of-life care needs who present to emergency departments (EDs) continues to grow. Increasingly, emergency physicians seek to provide care and comfort to patients with serious illnesses and others with sudden, unanticipated catastrophic events. Many present to EDs due to refractory pain, increasing symptom burden or failing support systems. Palliative care (PC) consultation has been shown to provide benefits to patients and families. These benefits include optimal pain control, enhanced shared decision-making and reductions in unnecessary and futile tests and treatments. Additionally, early PC consultation has been shown to decrease hospital length of stay (LOS). Historically, emergency physicians have considered obtaining PC consultation to be a role best suited for the inpatient teams. Time pressures, lack of longitudinal relationships, complex family dynamics, emergency physician discomfort and lack of education have all contributed to avoiding discussions focused on end-of life issues. Additionally, it has been shown that relatively few patients received ED-initiated PC consults even though early consultation has been shown to decrease LOS and increase referrals to home hospice.

N.B. Access to articles in the *Physician Leadership Journal* requires a subscription: <https://goo.gl/gr1ckf>

Noted in Media Watch, 2 May 2016, #460 (p.7):

- *JOURNAL OF PALLIATIVE MEDICINE* | Online – 26 April 2016 – '**Effectiveness of emergency department based palliative care for adults with advanced disease: A systematic review.**' Emergency departments (EDs) are seeing more patients with palliative care (PC) needs, but evidence on best practice is scarce. There is yet no evidence ED-based PC affects patient outcomes except for indication from one study of no association with 90-day hospital readmission, but a possible reduction in length of stay if PC is introduced early at ED rather than after hospital admission. <http://goo.gl/J18JG6>

N.B. Additional articles on end-of-life care in the emergency department noted in Media Watch 18 April 2016 issue of Media Watch, #458 (p.10).

Social death

QJM | Online – 20 October 2016 – The idea of social death is used to analytically represent how someone can be identified and treated as if they are ontologically deficient – meaning that they are not seen as being “fully human.” This impacts on their position within society and how they are interacted with. This review considers three examples of social death – often distinguished from physical or biological death – that are important for clinical practice: 1) Loss of agency and identity; 2) Treating people as if they are already dead; and, 3) Rituals and bereavement. Recognising that a distinction between social and biological death may not always be helpful, this review suggests ways in which healthcare practitioners can minimise the likelihood of inadvertently treating someone as “socially dead.” <https://goo.gl/LgV9DH>

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- *NEUROLOGY* | Online – 21 October 2016 – ‘**Death with dignity in Washington patients with amyotrophic lateral sclerosis.**’ In Washington State, 39 patients with amyotrophic lateral sclerosis (ALS) requested dying with dignity (DWD) from the University of Washington, Virginia Mason [Hospital & Medical Center], and Swedish Medical Centers [Seattle] beginning in 2009. The median age at death was 65 years (range 46-86). Seventy-seven percent of the patients used the prescriptions. All of the patients who used the medications passed away without complications. The major reasons for patients to request DWD as reported by participating physicians were loss of autonomy and dignity and decrease in enjoyable activities. Inadequate pain control, financial cost, and loss of bodily control were less commonly indicated. These findings were similar to those of the 92 patients who sought DWD in Oregon. In Washington and Oregon, the percentage of patients with ALS seeking DWD is higher compared to the cancer DWD cohort. Furthermore, compared to the all-cause DWD cohort, patients with ALS are more likely to be non-Hispanic white, married, educated, enrolled in hospice, and to have died at home. <https://goo.gl/PFzjfK>

Worth Repeating

Be known, be available, be mutual: A qualitative ethical analysis of social values in rural palliative care

BMC MEDICAL ETHICS | Online – 28 September 2011 – The values identified in this study offer the opportunity to better understand common ethical tensions that arise in rural healthcare and key differences between rural and urban palliative care (PC). In particular, these values shed light on problematic health system and health policy changes. When initiatives violate deeply held values and hard won rural capacity to address the needs of their dying members is undermined, there are long lasting negative consequences. These findings offer one way to re-conceptualize healthcare decision making through consideration of critical values in order to support ethically good PC in rural settings. <https://goo.gl/0GDvVr>

Media Watch: Online

International

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

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): <https://goo.gl/JL3j3C>

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]

Cont.

HUNGARY | Hungarian Hospice Foundation: <http://goo.gl/5d1I9K>

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

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.

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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.

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