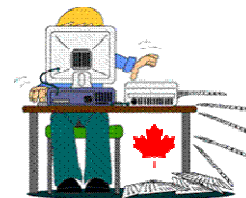


## Media Watch...

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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Compilation of Media Watch 2008-2018 ©

Compiled & Annotated by Barry R. Ashpole

**Leadership issues in end-of-life care: Scroll down to [Specialist Publications](#) and 'Whose job? The staffing of advance care planning support in twelve international healthcare organizations: A qualitative interview study' (p.7), in *BMC Palliative Care*.**

## Canada

### **“A gaping hole” in Ontario Health Insurance Plan for dying Canadians seeking end-of-life-care**

ONTARIO | CBC News (Toronto) – 22 May 2018 – Laval Picard's last days were comfortable – because Wellington Hospice officials decided to take him under their care even without Ontario Health Insurance Plan (OHIP) coverage. The 66-year-old Quebec City man moved to Guelph, Ontario, in late April to be closer to his family after receiving his advanced stage 4 cancer diagnosis. He had been recovering in hospital after bowel surgery at the time. On his way to Guelph, Picard had to get a blood transfusion in a Montreal hospital. But when he finally got to Ontario, the Picards found out the province wouldn't pay the hospice bills until Laval had been in the province for 90 days – or three months. And at that time he was only given less than three months to live. “[Wellington Hospice] thankfully took him *pro-bono*,” his son Jonathan Picard told CBC News... Laval Picard passed away ... on 17 May. Picard said he wrote to the OHIP Eligibility Review Committee twice. Both times the committee said they wouldn't be able to do anything. “The Ontario Health Insurance Act provides no discretion for the ministry to grant an earlier effective date of coverage for persons not exempt from the waiting period, either on compassionate grounds or to relieve financial hardship,” an email from the committee said. <https://goo.gl/9FY8nD>

Noted in Media Watch 7 May 2018 (#562, p.2):

- ONTARIO | *The Globe & Mail* (Toronto) – 1 May 2018 – ‘**Ontario to plug gap in home-care coverage for patients who move provinces.**’ The Ontario [provincial] government is closing a gap in medicare that temporarily denies home-care coverage to Canadians who relocate from other provinces, including terminally ill patients who are not expected to live past the three-month waiting period for an Ontario Health Insurance Plan card. <https://goo.gl/HCJH1y>



### 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 beginning on p.16.

## Assisted (or facilitated) death

Representative sample of recent news media coverage:

- THE CONVERSATION | Online – 23 May 2018 – **“Suicide tourism” and understanding the Swiss model of the right to die.** Cases of “suicide tourism” presented in the media typically say little about the functioning of the Swiss model. Instead, the coverage of “suicide tourism” speaks more to the state of the public debate in a given country on assistance in dying. The fact that citizens of one country make the decision to die in another country, far from their home and family, has a powerful effect on the public. It provides convincing evidence of determination and suffering. It also shows that other possibilities for regulating assistance in dying exist. In Switzerland, assisted suicide has been tolerated since 1942 provided that the person assisting has no selfish motive. Moreover, the person requesting such assistance must self-administer the lethal drug and must have decision-making capacity. Compared to the comprehensive Canadian federal and provincial laws on medical assistance in dying (MAiD), Swiss regulation and safeguards can be perceived as lacking. However, this misses the meaning of assisted suicide in Switzerland. Unlike in Canada, assisted suicide is an act of citizenship in Switzerland, not a health-care intervention. Switzerland proposes a much less medicalized approach to assisted dying. <https://goo.gl/iyJngP>

## U.S.A.

### Delayed hospice care common for dialysis patients

MASSACHUSETTS | Reuters (Boston) – 23 May 2018 – Very few Medicare patients on dialysis receive hospice care at the end of life (EoL), and when they do, they’re often enrolled too briefly to fully benefit from these services, a U.S. study suggests.<sup>1</sup> Medicare, the U.S. health insurance program for the elderly that also covers Americans with kidney failure, will not pay for dialysis and hospice at the same time. This forces terminally ill patients to choose between continuing on dialysis or accessing hospice care, which may provide more comfort and support at the EoL... Researchers examined data on more than 770,000 dialysis patients covered by Medicare who died between 2000 and 2014. Overall, just one in five were receiving hospice services when they died. Among patients who did receive hospice care, 42% were enrolled for three or fewer days. Compared with dialysis patients who didn’t receive hospice care, those enrolled in hospice for three or fewer days were more likely to have been hospitalized or admitted to intensive care units in the last month of life. But they were less likely to die in the hospital or undergo invasive procedures. <https://goo.gl/Uirvfh>

1. ‘Association between hospice length of stay, health care utilization, and Medicare costs at the end of life among patients who received maintenance hemodialysis,’ *JAMA Internal Medicine*, published online 30 April 2018. [Noted in the 7 May 2018 issue of *Media Watch* (#562, p.12)] **Abstract:** <https://goo.gl/pc2kPg>

### Specialist Publications

**‘Capacity for preferences: Respecting patients with compromised decision-making’** (p.9), in *The Hastings Report*.

**‘Centenarians’ end-of-life thoughts and plans: Is their social network on the same page?’** (p.10), in *Journal of the American Geriatrics Society*.

**‘Metastatic pancreatic cancer: American Society of Clinical Oncology Clinical Practice Guideline update’** (p.11), in *Journal of Clinical Oncology*.

**‘Can growing popular support for physician-assisted death motivate organized medicine to improve end-of-life care?’** (p.15), in *Journal of General Internal Medicine*.

**‘Will the American Medical Association heed its own ethics council, regarding assisted suicide?’** (p.16), in *Psychiatric Times*.

## The U.S. “futile-care” debate: How are cases like Alfie Evans’ handled here?

*THE NATIONAL CATHOLIC REGISTER* | Online – 23 May 2018 – The tragic case of Alfie Evans, the British toddler who died 28 April from a degenerative neurological condition after his parents were prevented by the European courts from taking him to a hospital in Italy, raised widespread concerns about government usurping parental rights. In the U.S., little Alfie’s story also casts a spotlight on so-called medical futility laws, which are designed to protect hospitals and physicians from legal action if they decide, against a family’s wishes, to discontinue medical care they consider inappropriate or excessive for a terminally ill patient. While some pro-life groups have opposed such legislation, other medical specialists and Catholic officials say that the laws in some American states – such as Texas’ Advance Directives Act – contain safeguards that include giving families the opportunity to find hospitals willing to provide the disputed care. Besides Texas, only Virginia and California have laws that explicitly allow physicians and health care facilities, after a series of steps that include ethics committee evaluations, to discontinue treatment in cases where it is considered “medically inappropriate” to continue care. <https://goo.gl/9P1k7T>

**N.B.** Selected articles, reports, etc., on the Alfie Evans’ case noted in the 7 May 2018 issue of Media Watch (pp.7, 14).

Noted in Media Watch 25 September 2018 (#531, p.5):

- **TEXAS** | *The Huston Chronicle* – 22 September 2017 – ‘**Judge lets one-of-a-kind “futile care” law stand.**’ In a victory for Texas’ medical community, a Harris County state district judge Friday rejected a lawsuit challenging the constitutionality of a state law that allows doctors to withdraw life-sustaining treatment against the wishes of the patient or guardian. Judge Bill Burke said it would be “a case of throwing the baby out with the bath water” to repeal the controversial 1999 law, enacted in response to doctors’ push to eliminate care they believe prolongs suffering in terminal patients. The law, which is unique to Texas, has drawn criticism from some families who say it gives doctors too much power. <https://goo.gl/i8PCN3>

## Palliative care training helps doctors steer cancer patients away from major surgery

CALIFORNIA | Reuters (Sacramento) – 22 May 2018 – Doctors who don’t have palliative care (PC) training are more likely to recommend aggressive surgery for patients with life-limiting diseases, a study suggests.<sup>1</sup> Researchers surveyed 102 surgeons, oncologists, intensive care specialists, and PC doctors ... asking how they would respond to four different surgical conditions in patients with very advanced cancers. Overall, regardless of doctors’ age, years of experience or medical specialty, those with less than 40 hours of palliative care training were more likely to recommend major operations as opposed to less aggressive procedures... In one scenario, someone with advanced colon cancer had a bowel obstruction. In another, someone with advanced breast cancer had been injured in a car accident. The other two scenarios involved a patient with late-stage lung cancer and recurrent gastrointestinal bleeding and a patient with advanced prostate cancer and a groin hernia. In general, there wasn’t much consensus on the treatment decisions, regardless of the doctors’ specialties. <https://goo.gl/ovmxoW>

1. ‘Palliative care training and decision-making for patients with advanced cancer: A comparison of surgeons and medical physicians,’ *Surgery*, published online 27 April 2018. The findings of this study highlight the need for greater efforts system wide in palliative care education among surgeons, including incorporation of a structured palliative care training curriculum in graduate and continuing surgical education. **Abstract (w. link to references):** <https://goo.gl/eWtu5A>

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

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

## House passes “right-to-try” bill for experimental drugs

NATIONAL PUBLIC RADIO | Online – 22 May 2018 – The bill ... has patient advocates divided. Patient groups including the American Cancer Society Cancer Action Network and the American Lung Association opposed the bill. They say it could do more harm than good by giving patients access to drugs that may, in the end, shorten their lives. Advocates say the bill would make it easier for patients to get access to experimental drugs that have completed the first phase of clinical trials and are in the midst of additional testing. It eliminates the role of the Food & Drug Administration (FDA) in the approval process and reduces the threshold for patients to receive the medicines. Critics say that removing the FDA from the process could raise the risks for patients. <https://goo.gl/4wPtqe>

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

## The hospice that hurried death? Texas courts to weigh criminal charges

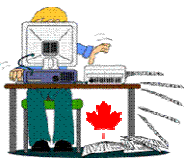
TEXAS | *The Pilot* (Dallas) – 22 May 2018 – In a legal case that includes allegations of death-hastening drug use and falsified do-not-resuscitate orders, a former hospice executive has admitted speeding the deaths of patients to boost the company’s profits. The case concerns Novus Health Services... The company’s leaders allegedly worked a scheme that billed Medicaid and Medicare \$60 million from 2012-2015, resulting in payments to Novus for over \$35 million. <https://goo.gl/Thp9u9>

**N.B.** Additional articles on Medicare fraud in the U.S. in the context of hospice care noted in the 26 June 2017 issue of Media Watch (#518, pp.3-4).

## Assisted (or facilitated) death

Representative sample of recent news media coverage:

- CALIFORNIA | National Public Radio (Sacramento) – 24 May 2018 – ‘**Court upholds ruling against California’s assisted suicide law.**’ An appeals court has let stand a lower court ruling overturning a California law that allows physicians to prescribe life-ending drugs to the terminally ill. California’s Fourth District Court of Appeals ... refused to stay last week’s decision by the Riverside County Superior Court, which ruled that state lawmakers should not have passed the law during a special session on health care funding. However, the constitutionality of the law itself – passed nearly three years ago – was not challenged. California Attorney General Xavier Becerra had sought to block the earlier ruling in order to allow terminally ill people to access life-ending drugs while the issue works its way through the courts. <https://goo.gl/mKaR8j>



### Barry R. Ashpole

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

## International

### Palliative care in Australia

#### **Palliative care need in hospitals soars**

AUSTRALIA (New South Wales) | SBS News (Crows Nest) – 23 May 2018 – The use of palliative care (PC) in Australian hospitals is rising at a faster rate than any other hospital service. New data released by the Australian Institute of Health & Welfare (AIHW) shows the number of Australians admitted to hospital for PC has soared by 28%, rising from about 57,600 in 2011-2012 to almost 74,000 in 2015-2016.<sup>1</sup> Over the same period, the total number of hospitalisations in Australia rose by 15%. The rise was seen across all age groups over this period, AIHW spokesperson Matthew James said. “Although it’s difficult to be definitive about the reasons for this rise, Australia’s growing and ageing population – paired with a rise in chronic and incurable illnesses – has broadened the type of patients requiring palliative care,” Mr. James said. In 2015-2016, cancer was responsible for about half of all PC hospital admissions and deaths among PC patients. <https://goo.gl/L9misy>

1. ‘Palliative care services in Australia,’ Australian Institute of Health & Welfare, May 2018. **Download/view at:** <https://goo.gl/aQffoh>

#### **Report finds promises to bring more patient care closer to home via National Health Service community services have fallen flat**

U.K. (England) | Practice Business – 21 May 2018 – A report by NHS Providers says promises to bring more patient care closer to home by prioritising National Service (NHS) community services have fallen flat.<sup>1</sup> National strategies under successive governments have concluded that the NHS must do more to help people stay well in their own homes and communities, avoiding the need for hospital treatment, if the health service is going to be financially sustainable. This commitment was set out most recently in the Five Year Forward View, which envisaged a significantly expanded role for community services, such as community specialist nurses and physiotherapy. The report presents striking examples of good practice where community service providers have successfully developed new ways of working, collaborating with other services to improve care for patients. But it con-

1. ‘National Health Service Community Services: Taking Centre Stage,’ NHS Providers, May 2018. **Download/view at:** <https://goo.gl/GfqUiK>

### Specialist Publications

‘Approaches to parental demand for non-established medical treatment: Reflections on the Charlie Gard case’ (p.11), in *Journal of Medical Ethics*.

‘Current research status of palliative care in Mainland China’ (p.13), in *Journal of Palliative Care*.

‘Mapping the scope of occupational therapy practice in palliative care: A European Association for Palliative Care cross-sectional survey’ (p.14), in *Palliative Medicine*.

‘Directing citizens to create advance directives’ (p.8), in *Swiss Medical News*.

cludes that in practice, support on the ground has failed to match the rhetoric, leaving many providers marginalised, underfunded and short staffed. The report highlights findings from a survey of NHS trust leaders – including more than half of those providing community services... <https://goo.gl/15LVah>

#### **Extract from NHS Providers report**

Pressures on the acute sector have led to more patients being discharged into the community with increased levels of acuity and a greater range of medical and support needs. For example, patients who used to be looked after in nursing homes are now being looked after in residential care, and nursing homes are doing the job of palliative services.

## Assisted (or facilitated) death

Representative sample of recent news media coverage:

- NEW ZEALAND | *New Zealand Herald* (Auckland) – 21 May 2018 – ‘**Deadline for End-of-Life Choice Bill extended due to interest.**’ A deadline for an assisted dying law change has been pushed back again because of a record level of interest. Public hearings begin on the End of Life Choice Bill, and so far 35,000 submissions have been received. Justice Committee chair Raymond Huo said submissions were still being processed, but it was already believed to be a record number. The last high-profile conscience issue, the legalisation of same-sex marriage in 2012, attracted around 22,000 submissions. The committee was initially given nine months to hear the submissions, an extension on the usual six months. It has now pushed the deadline back another three months, to March, to cope with the huge workload. <https://goo.gl/A8WtPC>

## Specialist Publications

### Dignity impact as a primary outcome measure for dignity therapy

*AMERICAN JOURNAL OF HOSPICE & PALLIATIVE MEDICINE* | Online – 24 May 2018 – Feasibility of dignity therapy (DT) is well established in palliative care. Evidence of its efficacy, however, has been inconsistent and may stem from DT’s primary effects differing from the outcomes measured in previous studies. The authors proposed that DT effects were in the spiritual domain and created a new outcome measure, Dignity Impact Scale (DIS), from items previously used in a large randomized controlled trial . They found that, compared to both other groups, patients who received DT reported significantly higher DIS ratings, which is consistent with the DT focus on meaning-making, preparation for death, and life completion tasks. The authors propose that the DIS be used as the primary outcome measure in evaluating the effects of DT. **Abstract:** <https://goo.gl/dQF2k3>

### Palliative care in the U.S.

### Identifying palliative care needs among older adults in non-clinical settings

*AMERICAN JOURNAL OF HOSPICE & PALLIATIVE MEDICINE* | Online – 23 May 2018 – Though palliative care (PC) is appropriate for patients with serious illness at any stage of the illness and treatment process, the vast majority of PC is currently delivered in inpatient medical settings in the past month of life during an acute hospitalization. PC can have maximal benefit to patients when it is integrated earlier in the illness trajectory. The goal of this study was to assess the rates of unmet PC needs in older adults who attend New York City-based senior centers. The results revealed that 28.8% of participants screened positive for unmet PC needs. Lower education and living alone were predictors of positive PC screens, but age, gender, marital status, and race were not. This study determined that the rate of unmet PC needs in community-based older adults who attend senior center events was high and that living arrangement and education level are both correlates... Screening ... in community settings is a promising approach for moving PC upstream to patients who could benefit from the additional supportive services prior to an acute hospitalization. **Abstract:** <https://goo.gl/PMAk4j>



New Link

Closing the Gap Between Knowledge & Technology

<http://goo.gl/OTpc8l>

## The death debate: Penumbra conundrum

*AMERICAN JOURNAL OF HOSPICE & PALLIATIVE MEDICINE* | Online – 21 May 2018 – Determination and declaration of death by neurologic criteria, brain death, is an established and legally accepted clinical practice with profound implications. Concerns regarding the accuracy of this diagnosis raise important clinical, ethical, and legal issues. A recent magazine article highlights these concerns by describing a poignant example of a patient meeting accepted clinical and ancillary testing criteria for brain death in the setting of post cardiac arrest hypoxic ischemic encephalopathy (CA-HIE). With continuation of ventilatory and nutritional support, this patient not only survived but over time demonstrated findings that were no longer consistent with brain death. Offered here is a review of the course of events described in the article, an overview of the variable clinical implications of CA-HIE and their relationship to the diagnosis of brain death, a proposed pathophysiologic correlation, and recommendations for palliative clinicians providing consultation with regard to goals of care and intervention options in cases of CA-HIE with severe neurologic injury. **Abstract:** <https://goo.gl/cKA2Wo>

**N.B.** Additional articles on defining “brain death” noted in the 23 April 2018 issue of *Media Watch* (#560, p.11).

## Whose job? The staffing of advance care planning support in twelve international healthcare organizations: A qualitative interview study

*BMC PALLIATIVE CARE* | Online – 24 May 2018 – This research highlights the need, in the absence of significant new funding or a professional lead role, for intensive and committed organizational leadership, both at a strategic and day-to-day level. The intractability of time constraints, however, remains a significant challenge, particularly for facilitating advance care planning (ACP) conversations and, while there may be some scope for absorbing ACP support into existing health and care provision, there is likely to remain a need for some new resource. Physician leadership and involvement are key, and approaches to developing ACP need to work with physicians’ concerns while, at the same time, balancing this against the risk of ACP becoming entirely physician-led, with ACP limited in scope and occurring late in the illness trajectory. Team-based frameworks embedded in evolving models of care for chronic illness and end of life are likely to help to achieve this balance, manage costs and maximize quality of care. The importance of ensuring strong links with external healthcare providers in care homes is emphasized for equity of care. While the full consideration of transferability issues is beyond the scope of this study, the consistency of findings across the four countries (U.S., Canada, Australia & New Zealand) provides some confidence that lessons drawn may have relevance in a range of socio-economically similar countries. **Full text:** <https://goo.gl/XaX24N>

### Related

- *BMC PALLIATIVE CARE* | Online – 24 May 2018 – ‘**Feasibility of hospital-initiated non-facilitator assisted advance care planning documentation for patients with palliative care needs.**’ This study shows that providing an advance care planning document to palliative patients discharged from hospital, initiated by the clinical healthcare team treating the patient, is feasible, both in terms of uptake and in terms of the quality of documentation. However, palliative issues regarding non-physical domains are underreported, except where palliative care trained staff are involved as part of a patient’s healthcare team. Education and training in “palliative reasoning” might improve this knowledge gap. **Full text:** <https://goo.gl/WwgVY9>
- *JOURNAL OF THE AMERICAN GERIATRIC SOCIETY* | Online – 23 May 2018 – ‘**Physicians’ views on advance care planning and end-of-life care conversations.**’ Ninety-nine percent of survey respondents agreed it is important to have end-of-life conversations, yet only 29% reported they have formal training for such conversations. Those most likely to have training included younger physicians and those caring for a racially and ethnically diverse population. Patient values and preferences were the strongest motivating factors in having advance care planning conversations... The biggest barrier mentioned was time availability. Other barriers included not wanting a patient to give up hope and feeling uncomfortable. **Abstract:** <https://goo.gl/ixXi96>

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- *JOURNAL PAIN & SYMPTOM MANAGEMENT* | Online – 25 May 2018 – ‘**Overview of systematic reviews of advance care planning: Summary of evidence and global lessons.**’ The high volume and disparate nature of advance care planning (ACP) research make it difficult to grasp the evidence and derive clear policy lessons for policymakers and clinicians. Preliminary evidence highlights several elements that influence the ACP process and provides a variety of features that could support successful, effective and sustainable ACP implementation. Further studies evaluating ACP as a unified program and assessing the impact of ACP for different populations, settings and contexts are needed to develop programmes able to unleash ACP’s full potential. **Abstract:** <https://goo.gl/rT9qUu>
- *SWISS MEDICAL NEWS* | Online – 16 May 2018 – ‘**Directing citizens to create advance directives.**’ This article describes the Swiss law on advance directives (ADs)... For various reasons the drafting of ADs is not yet widespread in Switzerland, and many resources might be put to better use if this became a common practice. A recent proposal ... to make the discussion, although not the actual drafting, of ADs mandatory was rejected by the Swiss Federal Parliament, and the proposal was written off after having been pending for 2 years. The authors consider that the rejection of this proposal was not justified and that discussion of ADs should become mandatory, so that individuals can fully assume their role as responsible citizens taking proactive decisions. **Full text:** <https://goo.gl/6FaYW8>

### End-of-life doulas: What we can offer at the most difficult time of life

*EUROPEAN JOURNAL OF PALLIATIVE CARE*, 2018;25(7):64-67. Birth doulas provide support and guidance to mothers and mothers-to-be at the start of life; end-of-life doulas provide practical and emotional support for people who are dying and the loved ones they will ultimately leave behind. Our job is to help make the ostensibly unbearable situation of living with life-limiting more bearable. “Doula-ing” is about the quality of the relationship with the person you’re working with; it’s about making them feel safe, comfortable and perhaps most importantly, heard. If “doula-ing,” as a verb, ever makes it into the dictionary, it will be defined as the act of listening – really listening. It’s about not feeling alone. Doulas spend time with people who are dying. We can facilitate those difficult and necessary conversations with loved ones. After death, we’re there for the bereaved. We sometimes help with funeral arrangements and if you want to keep your loved one at home after they’ve died, we can support you to do that, too. Sometimes we only work with the person who is dying, other times we only work with family and friends. Some doulas ... provide a structure of support for professionals who are impacted by death and dying. We might also go into schools to open up the discussion around this fundamental subject. The role is flexible and person-centred, tailored to the individual, altering and evolving to accommodate ever-changing needs. **Journal contents page:** <https://goo.gl/9Xq5UZ>.

**N.B.** Access to this journal requires a subscription.

Noted in Media Watch 1 January 2018 (#544, p.14):

- *INTERNATIONAL JOURNAL OF PALLIATIVE NURSING*, 2017;23(12):612-619. ‘**A holistic view from birth to the end of life: End-of-life doulas and new developments in end-of-life care in the West.**’ The relatively newly-developed profession of birth doulas ... has been in existence since the 1990s. End-of-life (EoL) doulas are another emerging profession... Doulas provide non-medical support for both childbearing women and people at the EoL, as well as their families. Although birth and death would appear to be opposites, they share common characteristics and challenges... **Abstract (w. link to references):** <https://goo.gl/gVmXBN>

**N.B.** Additional articles on “death doulas” noted in the 20 November 2017 issue of Media Watch (#539, p.4).



## The timing and circumstances of the implementation of pediatric palliative care in Hungarian pediatric oncology

*EUROPEAN JOURNAL OF PEDIATRICS* | Online – 21 May 2018 – There is an international consensus that palliative care (PC) should commence at the diagnosis of a pediatric malignant disease regardless of illness outcome. Despite the continuous improvement of pediatric PC barriers to the early implementation of PC in pediatric oncology involve resource-based and attitudinal factors. In Hungary, where pediatric oncologists are sole decision-makers, early implementation of PC is rare. There is a strong preference among physicians for working within a team, while also asserting that presence of team members may decrease the level of intimacy. **Abstract (inc. list of references):** <https://goo.gl/EyLBrK>

### Related

- *BMC PALLIATIVE CARE* | Online – 22 May 2018 – ‘**Building bridges, paediatric palliative care in Belgium: A secondary data analysis of annual paediatric liaison team reports from 2010 to 2014.**’ A Royal Decree issued in 2010 provides the legal framework that defines the paediatric liaison teams’ mission as ensuring continuity of curative and palliative care between the hospital and home for children diagnosed with life-limiting conditions. This national study describes how these teams ensure continuity of care by describing their activities and the characteristics of the children they cared for... **Full text:** <https://goo.gl/3thHdK>

## Humor assessment and interventions in palliative care: A systematic review

*FRONTIERS IN PSYCHOLOGY* | Online – 15 May 2018 – The central goal of palliative care (PC) is to optimize the quality of life of patients suffering from life-limiting illnesses, which includes psychosocial and spiritual wellbeing. Research has demonstrated positive correlations between humor and laughter with life satisfaction and other aspects of wellbeing, and physiological symptoms can be improved by humorous stimuli. Two studies on humor interventions and 11 on humor assessment were included in this systematic review. Most of these studies were about the patients’ perspective on humor in PC. Findings showed that humor had a positive effect on patients, their relatives, and professional caregivers. Humor was widely perceived as appropriate and seen as beneficial to care in all studies. Even though humor interventions seem to be potentially useful in PC, descriptions evaluating their use are scarce. Overall, research on humor assessment and interventions in PC has remained limited in terms of quantity and quality. **Abstract:** <https://goo.gl/RzEMwe>

Noted in Media Watch 2 April 2018 (#557, p.8)

- *AMERICAN JOURNAL OF HOSPICE & PALLIATIVE MEDICINE* | Online – 27 March 2018 – ‘**The use of humor in palliative care: A systematic literature review.**’ Humor plays an unquestionable role in palliative care, but its use needs training and appropriate use. A total of 156 studies were identified, which were then filtered in pairs by means of an established hierarchy, selecting studies that discussed the use of humor specifically in palliative care (PC) from all perspectives and designs... Five main topics were identified: 1) Definition of humor; 2) Use and functions of humor in PC; 3) How to use humor; 4) When not to use humor; and, 5) Humor before and after the diagnosis of terminal illness. **Abstract:** <https://goo.gl/Qp8nP1>

## Capacity for preferences: Respecting patients with compromised decision-making

*THE HASTINGS REPORT*, 2018;48(3):31-39. When a patient lacks decision-making capacity, then according to standard clinical ethics practice in the U.S., the health care team should seek guidance from a surrogate decision-maker, either previously selected by the patient or appointed by the courts. If there are no surrogates willing or able to exercise substituted judgment, then the team is to choose interventions that promote a patient’s best interests. The authors argue that, even when there is input from a surrogate, patient preferences should be an additional source of guidance for decisions about patients who lack decision-making capacity. Their proposal builds on other efforts to help patients who lack decision-making

Cont.

capacity provide input into decisions about their care. For example, “supported,” “assisted,” or “guided” decision-making models reflect a commitment to humanistic patient engagement and create a more supportive process for patients, families, and health care teams. But often, they are supportive processes for guiding a patient toward a decision that the surrogate or team believes to be in the patient’s medical best interests. **Abstract:** <https://goo.gl/pV2u5s>

#### Related

- *THE HASTINGS REPORT*, 2018;48(3):40. ‘**You can’t always get (or give) what you want: Preferences and their limits.**’ People who lack decision-making capacity may be able to communicate preferences, which can and should inform surrogate decision-making on their behalf. It is unclear whether making a further distinction about “capacity for preferences” ... would improve the process of surrogate decision-making. Anyone who is regularly involved in surrogate decision-making or who has worked to articulate decision-making standards and processes can think of cases in which a patient’s voice was ignored or his or her preferences and ability to communicate them overlooked. However, we can also think of cases in which it was unclear whether information provided by a patient, recently or in the past, should have been characterized as a preference relevant to a medical decision that the patient lacked the capacity to make. **Abstract:** <https://goo.gl/8R8Sx2>
- *THE HASTINGS REPORT*, 2018;48(3):41-42. ‘**In the balance: Weighing preferences of decisionally incapacitated patients.**’ The authors of ‘Capacity for preference...’ ... argue that patients without decisional capacity can still have relatively stable wishes or inclinations toward one treatment option over another and that these preferences are “not devoid of moral weight and might therefore guide or at least influence treatment decisions when they cannot be defeated by other considerations.” This position is not controversial among most bioethicists. The hard work comes in sussing out the details of this position. How much moral weight do these preferences have? When should preferences be defeated by other considerations? How should we identify actual preferences, and how should preferences be differentiated and weighed against one another? **Abstract:** <https://goo.gl/qTqn5a>

#### Centenarians’ end-of-life thoughts and plans: Is their social network on the same page?

*JOURNAL OF THE AMERICAN GERIATRICS SOCIETY* | Online – 22 May 2018 – In nearly half of cases [i.e., study participants], proxies misjudged whether the centenarian thought about end of life (EoL). Although only few centenarians perceived the EoL as threatening, and approximately one-quarter reported longing for death, proxies overestimated centenarians’ reports on the former and underestimated the latter. Proxies reported more centenarian EoL planning than centenarians themselves. Even though enrolled proxies were mostly persons very close to the centenarian, many of them did not seem to be well informed about the centenarians’ thoughts and plans regarding the EoL, suggesting a lack of communication between centenarians and social network members in this respect. Healthcare professionals should be aware that, even for very old adults approaching the end of their lives, discussions about EoL and EoL planning may need to be actively encouraged and supported. **Abstracts:** <https://goo.gl/Hqshg9>

**N.B.** Additional articles on social/support networks in the context of end-of-life care noted in the 30 April 2018 issue of *Media Watch* (#561, pp.7-8).

#### A mixed-methods approach to understanding the palliative needs of Parkinson’s patients

*JOURNAL OF APPLIED GERONTOLOGY* | Online – 22 May 2018 – Parkinson’s disease (PD) is the second-most common age-related neurodegenerative disorder. Despite recommendations for a palliative approach, little is known about what palliative needs are unmet by standard care. PD patients and neurologists were recruited for a survey on palliative need; a subset of patients was interviewed. Significant differences between physicians and patients were found in physical, psychological, social, financial, and spiritual domains. Physical and Psychological needs predicted health-related quality of life. Primary themes across interviews included: 1) Lack of healthcare education; and, 2) Need for care coordination. Secondary themes included: 1) The importance of support groups; 2) The role of spirituality/religion; and, 3) The narrow perceived role of the neurologist. Findings highlight the importance of coordinated individualized care. **Abstract (inc. list of references):** <https://goo.gl/z5dmND>

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Noted in Media Watch 9 October 2017 (#533, p.14):

- *MAYO CLINIC PROCEEDINGS*, 2017;92(10):1592-1601. '**Palliative care in neurology.**' Patients with a variety of neurologic conditions such as Parkinson disease, dementia, amyotrophic lateral sclerosis, brain tumors, stroke and acute neurologic illnesses have substantial unmet needs that can be addressed through a combination of primary and specialty palliative care. The complex needs of these patients are ideally managed with an approach to care that addresses the physical, psychological, social and spiritual aspects of care in an effort to reduce suffering. **Full text:** <https://goo.gl/Zk4adw>

Noted in Media Watch 31 July 2017 (#523, p.7):

- *AMERICAN JOURNAL OF HOSPICE & PALLIATIVE MEDICINE* | Online – 26 July 2017 – '**Severely affected by Parkinson disease: The patient's view and implications for palliative care.**' People severely affected by Parkinson disease/atypical parkinsonism comprise a heterogeneous group with distinct needs, which so far remain largely unexamined. Most common reasons for feeling severely affected were mobility impairment, coordination problems, speech problems, and limited day-to-day activities. <https://goo.gl/LBKK6X>

**N.B.** Additional articles on the palliative care (PC) needs of patients and families living with Parkinson's disease noted in this issue of Media Watch, including guidelines released in England in July 2017 by the National Institute for Health & Care Excellence, which includes a section (1.9) on PC.

### **Metastatic pancreatic cancer: American Society of Clinical Oncology Clinical Practice Guideline update**

*JOURNAL OF CLINICAL ONCOLOGY* | Online – 23 May 2018 – In 2016, American Society of Clinical Oncology (ASCO) published a guideline to assist in clinical decision making in metastatic pancreatic cancer for initial assessment after diagnosis, first- and second-line treatment options, palliative and supportive care, and follow-up. The purpose of this update is to incorporate new evidence related to second-line therapy for patients who have experienced disease progression or intolerable toxicity during first-line therapy. ASCO convened an expert panel to conduct a systematic review of the literature on second-line therapy published between June

2015 and January 2018. Recommendations on other topics covered in the 2016 Metastatic Pancreatic Cancer Guideline were endorsed by the expert panel. **Full text:** <https://goo.gl/Jv5buB>

#### **Palliative Care: ASCO recommendation**

Patients with metastatic pancreatic cancer should have a full assessment of symptom burden, psychological status, and social supports as early as possible, preferably at the first visit. In most cases, this assessment will indicate a need for a formal palliative care consult and services.

### **Approaches to parental demand for non-established medical treatment: Reflections on the Charlie Gard case**

*JOURNAL OF MEDICAL ETHICS* | Online – 18 May 2018 – The opinion of Mr. Justice Francis of the English High Court, which denied the parents of Charlie Gard, who had been born with an extremely rare mutation of a genetic disease, the right to take their child to the U.S. for a proposed experimental treatment occasioned world wide attention including that of the Pope, President Trump, and the U.S. Congress.<sup>1</sup> The case raise anew a debate as old as the foundation of Western medicine on who should decide and on what standard when there is a conflict between a family and the treating physicians over a possible treatment. As carefully crafted as the opinion of Justice Francis in the Gard case proved to be, it left commentators unsatisfied. A widespread criticism, captured in an article by Michael Dougherty ... was for the state to "get out of the way of the parents trying to act in the best interests of the child."<sup>2</sup> Although he conceded the parents could be adding to the suffering of the child by taking Charlie to America for an experimental therapy and agreed that such a choice "may be the wrong decision," in Dougherty's view, it should still be "their decision." Dougherty's stand was the popular response to the question of 'Who should decide?' It fails, however, to propose any rationale for the decision. It provided no norms, no standards and no guidelines for the parents. **Abstract:** <https://goo.gl/PxZcVQ>

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1. 'Great Ormond Street Hospital -v- Yates and Gard judgment, 24 July 2017,' High Court of Justice, Family Division. **Download/view at:** <https://goo.gl/JEychB>
2. 'The Vatican's statement on the Charlie Gard case is a disgrace,' *The National Review*, 30 June 2017. <https://goo.gl/SPgpH8>

**N.B.** Additional articles on the Charlie Gard case noted in the 9 May 2018 issue of Media Watch (#564, p.9).

### Language used by health care professionals to describe dying at an acute care hospital

*JOURNAL OF PAIN & SYMPTOM MANAGEMENT* | Online – 22 May 2018 – The authors conducted a retrospective chart review of the final admission of 150 patients who died on an inpatient internal medicine unit. Conventional and summative content analysis was performed of the language used to describe, either directly or indirectly, that the patient's death was imminent. A total of 45% of 150 deaths were from cancer, and 66% occurred with prior palliative care (PC) team involvement. There was no documentation of the dying process in 18 (12%) of charts. In the remainder, clinicians' documentation of imminent death fell into three categories: 1) Identification of the current state using specific labels, e.g., "dying" (24.7%), or "end of life" (15.3%), or less specific language, "unwell" or "doing poorly" (6.0%); 2) Predicting the future state using specific or more vague predictions: e.g., "hours to days" (7.3%) or "poor or guarded prognosis" (26.0%); 3) Using care provided to the patient to imply patient status: e.g., PC (49.3%) or comfort care (28.7%). PC involvement, but not a malignant diagnosis, was associated with more frequent use of specific language to describe the current or future state.

Death and dying in hospital is inadequately documented and is often described using unclear and vague language. PC involvement is associated with clearer language to describe this process. **Abstract (w. link to references):** <https://goo.gl/Ha16WN>

#### Do patients need to know they are terminally ill?

'No.' Patients do not need to be told that they are terminally ill. However, this does not mean we should pretend we can cure them of incurable illnesses or that we should withhold prognostic information from those who want it. **Introductory paragraphs:** <https://goo.gl/QH3HoY>

'Yes.' Informed consent, and the process of balancing risks and benefits of treatment, is a fundamental ethical principle. This principle is no less relevant for a patient with a terminal illness. **Introductory paragraphs:** <https://goo.gl/nXZKzT>

**N.B.** Published online in the *British Medical Journal* 24 April 2013. [Noted in Media Watch 29 April 2013 (#303, p.4).

### "The thing that really gets me is the future": Symptomatology in Older Homeless Adults in the HOPE HOME Study

*JOURNAL OF PAIN & SYMPTOM MANAGEMENT* | Online – 18 May 2018 – Homelessness causes and exacerbates physical and psychological distress. Interventions should address multiple interconnected dimensions of suffering. Health systems that care for homeless patients should adapt palliative care practices using a stepwise approach. Homeless shelters should adopt policies and modifications that increase privacy and autonomy while promoting community-building. Housing interventions should promote community-building. All who work with people experiencing homelessness should avoid stigmatizing language and recognize homeless individuals' sources of strength and coping. **Abstract (w. link to references):** <https://goo.gl/3hGdf3>

**N.B.** Additional articles on palliative care for the homeless in the U.S. noted in the 12 February 2018 issue of Media Watch (#550, p.3).

## Current research status of palliative care in Mainland China

*JOURNAL OF PALLIATIVE CARE* | Online – 18 May 2018 – Fifty-four studies found to be relevant were included for the analysis. Three studies on “palliative care (PC) education and training” asserted that education and training programs were scant in Mainland China and that only one program had been devised within the healthcare context of Shanghai. Five studies on “PC screening and timely identification” highlighted the absence of early screening criteria or checklists and referral procedures for PC. Thirty-one studies on “PC needs assessment and implementation were identified, and various methodological flaws were observed in most of these included studies. Twelve studies on “advanced decision-making” were identified, all of which focused on investigating the attitudes of patients with cancer, their families, and/or health-care professionals toward advanced decision-making only. The percentage of patients, family members, and health-care professionals who held positive attitudes toward advanced decision-making were varied and suboptimal, particularly for family members. Five studies on “caring for patients at the end of life” were identified, and the experience of healthcare professionals in caring for those patients was explored. No studies relating to “death and bereavement care” and “psychological support for PC providers” were identified. The current research status of PC in Mainland China remains at an early stage with minimal PC services used. Although several knowledge gaps were identified, the first step, which should be addressed, is assessing the PC needs. **Abstract:** <https://goo.gl/Kyorw4>

**N.B.** Additional articles on palliative care in China noted in the 15 January and 14 May 2018 issues of Media Watch (#546, pp.7-8 and #563, p.3, respectively).

## National impact of the EPEC-Pediatrics Enhanced Train-the-Trainer Model for delivering education on pediatric palliative care

*JOURNAL OF PALLIATIVE MEDICINE* | Online – 21 May 2018 – Lack of pediatric palliative care (PPC) training impedes successful integration of PPC principles into pediatric oncology. The authors examined the impact of an enhanced implementation of the Education in Palliative & End-of-Life Care for Pediatrics (EPEC®-Pediatrics) curriculum on the following: 1) Knowledge dissemination; 2) Health professionals' knowledge; 3) Practice change; and, 4) quality of PPC. Seventy-two trainers taught 3,475 learners; the majority (96.7%) agreed that their PPC knowledge improved. In addition, 10/15 sites achieved practice change quality improvement goals. The only improvements in care quality were an increased number of days from referral to PPC teams until death ... and from first documentation of advance care planning until death..., after adjusting for background variables. While improvements in care quality were only seen in two areas, the authors approach was highly effective in achieving knowledge dissemination, knowledge improvement, and practice change goals. **Abstract:** <https://goo.gl/U8FGTp>

### Related

- *NURSE EDUCATION TODAY* | Online – 19 May 2018 – ‘**A one hour teaching intervention can improve end-of-life care.**’ Aggressiveness of nursing care scores decreased significantly for all end-of-life (EoL) patients and students reported similar behavioral intentions for all EoL patients, regardless of patient age or code status. Student age was marginally related to change in behavior following the lecture. Prior experience in caring for a dying patient or relative did not have a significant effect on aggressiveness of care scores before or after the lecture. **Abstract (w. link to references):** <https://goo.gl/6x1hCX>

## Health-related suffering: From Lancet Commission to DeclarAction

*THE LANCET* | Online – 18 May 2018 – As the world unites to achieve universal health coverage (UHC) and we strive to measure, adopt, adapt, and account for progress, awareness of the most basic of health-care needs and intrinsic goals of health systems has been obliterated: the prevention and alleviation of suffering. Suffering is a state of distress that manifests in physical, psychological, social, and spiritual forms. The alleviation of suffering ... is a core component of medicine and public health. Yet, remarkably,

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the need to alleviate health-related suffering has been largely ignored by health professionals. This omission is unacceptable in any conception of a decent society. Most of the more than 61 million people worldwide who experience serious health-related suffering have almost no access to the palliative care (PC) and pain relief that could alleviate their symptoms. Poor countries and poor people lack even the most basic of medicines – oral immediate release and injectable morphine—to relieve their pain in moments of need. Indeed, the poorest 50% of the world live in countries that have only 1% of this essential medicine. The Lancet Commission on Global Access to Palliative Care and Pain Relief, in 2017, drew attention to this access abyss,<sup>1</sup> created a novel framework to measure the burden of serious health-related suffering, and proposed an inexpensive essential package of PC and pain relief to include as part of UHC. **Full text:** <https://goo.gl/iiBGvD>

1. 'Alleviating the access abyss in palliative care and pain relief: An imperative of universal health coverage,' *The Lancet*, published online 12 October 2017. [Noted in the 16 October 2017 issue of *Media Watch* (#534, p.14)] **Full text:** <https://goo.gl/i7r9M1>

### **Palliative care may reduce suicide risk in veterans with advanced lung cancer**

*MEDICALXPRESS* | Online – 21 May 2018 – “Suicide is a significant national public health problem, especially among lung cancer patients and among veterans,” said Donald R. Sullivan, assistant professor of medicine at Oregon Health & Science University... “We wanted to see if palliative care (PC), which has been shown to improve quality of life, reduced suicides among veterans with stage IIIB and IV lung cancer.” The researchers found that among 20,900 lung cancer patients in a Veterans Affairs cancer registry, 30 committed suicide – a rate more than 5 times greater than the average in veterans of a similar age. However, those lung cancer patients who had at least one PC encounter after their diagnosis were 82% less likely to die by suicide. The authors believe their study is the first to explore the relationship between PC and suicide risk in cancer patients. According to Dr. Sullivan, several medical societies recommend PC for all patients with advanced stage lung cancer; however, there is a gap between those recommendations and practice. **Full text:** <https://goo.gl/UdCNLd>

### **Deadlines: Doing times in (Dutch) hospice**

*MORTALITY* | Online – 18 May 2018 – For a person to enter a Dutch hospice as resident, a clearly articulated deadline is needed: a life expectancy of three months or less. The author argues that this institutional timeframe of a singular, clock-timed period of more or less linearly approaching death (the end of time), affords life to unfold in hospice as a relatively clockless multitude of temporal orderings enacted by staff and residents (the time of the end). Based on a period of ethnographic fieldwork in hospices and focus group interviews with hospice staff, the author analyses how temporal orderings manifest and intersect in different ways. **Full text:** <https://goo.gl/SwRUVB>

### **Mapping the scope of occupational therapy practice in palliative care: A European Association for Palliative Care cross-sectional survey**

*PALLIATIVE MEDICINE*, 2018;32(5):960-968. This study is the first to examine the provision of occupational therapy in palliative care (PC) in Europe. It shows there is a shared core content of occupational therapy services in direct and indirect patient care and that priority is given to clinical care activities over teaching, service development or research. Occupational therapists (OTs) understand and value their role in making it possible for people facing dying to participate as fully as they wish and are able in their everyday lives – from managing the basic fundamentals of personal hygiene to digging the flowerbeds or continuing to work – but do not feel that this role is used to its full potential. The ability of OTs to use the full range of their skills and expertise to support patients to live well while dying appears to be significantly influenced by their colleagues' and employing organisations' expectations and understanding of the scope of their role. This needs to be addressed in partnership between OTs, patients and carers, the MDT and PC service providers. **Full text:** <https://goo.gl/E6HiCd>

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Noted in Media Watch 25 September 2017 (#531, p.17):

- *SCANDINAVIAN JOURNAL OF OCCUPATIONAL THERAPY* | Online – 22 September 2017 – ‘**What is important to patients in palliative care? A scoping review of the patient’s perspective.**’ Seventeen articles were included and each were based on interviews. The theme “continuing occupational participation is important for people at the end of life” was identified. This included five sub-themes: maintaining previous occupational patterns; feeling needed; being involved in the social environment; leaving a legacy; and, living as long as you live. The results show that continued occupational participation is important for people in palliative care. **Abstract:** <https://goo.gl/W3mQvJ>

**N.B.** Additional articles on the role of occupational therapy in palliative care noted in the 28 November 2016 issue of Media Watch (#489, p.6).

### **The colours and contours of compassion: A systematic review of the perspectives of compassion among ethnically diverse patients and healthcare providers**

*PLOS ONE* | Online – 17 May 2018 – Synthesis of the literature identified the perspectives, facilitators and barriers of compassion in healthcare within different ethnic groups. Compassion was described as being comprised of healthcare provider virtues (honesty, kindness, helpful, non-judgment) and actions (smile, touch, care, support, flexibility) aimed at relieving the suffering of patients. The importance and impact of providing compassion to ethnically diverse patients was identified, which included overcoming cultural differences, alleviating distress at end-of-life, promoting patient dignity and improving patient care. This review also identified the need for more contextual studies exploring the topic of compassion from the perspectives of individuals within diverse ethnic groups, rather than superimposing a pre-defined, enculturated and researcher-based definition of compassion. **Full text:** <https://goo.gl/LyayzV>

#### 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)***

### **Assisted (or facilitated) death**

Representative sample of recent journal articles:

- *JOURNAL OF GENERAL INTERNAL MEDICINE* | Online – 18 May 2018 – ‘**Can growing popular support for physician-assisted death motivate organized medicine to improve end-of-life care?**’ Modern medicine has experienced tectonic shifts over the last several decades from a technological, ethical, and sociological perspective, particularly around care at the end of life (EoL). The confluence of these transformations has shaped the public discourse around the way we die and has given rise to the debates we see today surrounding physician-assisted death (PAD). Through personal stories and stories in the popular press regarding overly aggressive treatments at the EoL, some Americans are fearful that they too might die what is often portrayed as a dehumanizing death. The increasing momentum towards legalization of PAD is in part a reaction to this public perception embedded in a clinical reality and motivated by a desire to regain personal control. This, it can be assumed, would counteract a perceived helplessness to resist the overwhelming array of choices within a system that defaults to aggressive care at the EoL. **Full text:** <https://goo.gl/QmGdkP>

Noted in Media Watch 28 August 2017 (#527, p.4):

- U.S. (California) | *The Los Angeles Times* – 21 August 2017 – ‘**There’s an unforeseen benefit to California’s physician-assisted death law.**’ Many healthcare systems designed protocols for screening people who say they’re interested in physician-assisted death, including some that were meant to dissuade patients from taking up the option. But physicians across the state say the conversations that health workers are having with patients are leading to patients’ fears and needs around dying being addressed better than ever before. <https://goo.gl/gesxpi>

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- *PSYCHIATRIC TIMES* | Online – 22 May 2018 – ‘**Will the American Medical Association heed its own ethics council, regarding assisted suicide?**’ It seemed like a major statement on physician-assisted suicide (PAS) by the American Medical Association (AMA), and several media websites trumpeted the story in just such terms; for example, ‘The AMA continues to oppose physician-assisted suicide’ and ‘AMA rebuffs advocates of physician-assisted suicide.’ However, more cautious observers quickly pointed out that the Council on Ethical & Judicial Affairs Report 5-A-18 merely put forward the recommendation of the Council and that “...the AMA House of Delegates has not yet taken action on this report [which]...does not represent adopted policy of the AMA at this time.”. Indeed, it is far from clear how the delegates will actually vote this June. **Full text:** <https://goo.gl/jM1iR2>

### [Media Watch: Access on Online](#)

#### International



INTERNATIONAL ASSOCIATION FOR HOSPICE & PALLIATIVE CARE: <https://goo.gl/T2tCWF>

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

#### New Link

PALLIATIVE CARE NETWORK: <https://goo.gl/fjNsZN>

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

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

#### Asia

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

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

#### Australia

PALLIATIVE CARE WESTERN AUSTRALIA: <https://goo.gl/fCzNTL>

[Scroll down to ‘International Websites’]

#### Canada

BRITISH COLUMBIA HOSPICE PALLIATIVE CARE ASSOCIATION: <https://goo.gl/gw5ti8>

[Click on ‘National Resources,’ scroll down to ‘Palliative Care Network Community’]



CANADIAN SOCIETY OF PALLIATIVE CARE PHYSICIANS: <https://goo.gl/BLqxy2>

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

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

[Scroll down to ‘Additional Resources’]

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

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

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

SASKATCHEWAN | Saskatchewan Medical Association: <https://goo.gl/5cftPV>

[Scroll down to ‘Palliative Care Network Community’]

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## Europe



EUROPEAN JOURNAL OF PALLIATIVE CARE: <https://goo.gl/KjrR6F>

[March/April 2018 issue (Scroll down to 'The homeless: A vulnerable population with poor access to palliative care.')

HUNGARY | Magyar Hospice Alapítvány: <https://goo.gl/3jnH7K>

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

## South America



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

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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.

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