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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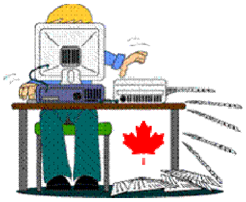

Compiled & Annotated by Barry R. Ashpole

'Perspectives of people with dementia and carers on advance care planning and end-of-life care: A systematic review and thematic synthesis of qualitative studies' (p.13), in *Palliative Medicine*.

Canada

Care gaps contribute to undignified palliative deaths in ER

ONTARIO | *The Hamilton Spectator* – 8 November 2018 – Palliative patients should not end up dying in a busy, noisy hospital emergency room (ER), say caregivers. And yet a 2016 Canadian Cancer Society report says that while palliative patients often want to die at home, about 45% of all cancer deaths in Canada occur in hospitals – a substantial portion of them in the emergency or intensive care departments.[1] In the Local Health Integration Network (LHIN) that includes Hamilton, it's 40% says Martina Rozsa, LHIN vice-president of Home & Community Care. The complex issue of accessing dignified, quality palliative care (PC) was highlighted last week when the April death of terminally-ill cancer patient Donna Jones in a busy Hamilton hospital emergency department was brought up in the Ontario legislature. Jones, 66, wanted to die at home, but when a home care nurse visited that day, she advised Jones' husband and family caregiver, David, to call an ambulance to take her to the ER. She was placed in St. Joseph's hospital's ER hallway and later died in an ER room shortly after being moved there. "It is a failure that Donna died in the ER," says Clare Freeman, executive director of the Dr. Bob Kemp Hospice. "Hospital emergency departments are not meant for PC patients. If someone is palliative in the ER, they are not going to be the priority." https://goo.gl/7xY465

Specialist Publications

'Evaluating an initiative to promote entry-level competence in palliative and end-of-life care for registered nurses in Canada' (p.11), in *Journal of Hospice & Palliative Nursing*.

'Does end-of-life care differ for Anglophones and Francophones? A retrospective cohort study of decedents in Ontario, Canada' (p.12), in *Journal of Palliative Medicine*.

'Medical assistance in dying for cancer patients one year after legalization: A collaborative approach at a comprehensive cancer centre' (p.15), in *Current Oncology*.

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1. 'Right to Care: Palliative care for all Canadians,' Canadian Cancer Society, December 2015. [Noted in 18 January 2016 issue of Media watch (#445, p.1)] **Download/view at:** http://goo.gl/f3iFEB

Cont.

Noted in Media Watch 4 June 2018 (#566, p.9):

- *INTERNATIONAL JOURNAL OF NURSING STUDIES* | Online – 23 May 2018 – **'Exploring the quality of the dying and death experience in the emergency department: An integrative literature review.'** Sixteen articles are included. Eight themes emerged: 1) Care in the emergency department (ED) is about living not dying; 2) Staff perceive that death is a failure; 3) Staff feel underprepared to care for the dying patient and family in this environment; 4) There is limited time for safe standards of care; 5) Staff stress and distress; 6) Staff use of distancing behaviours; 7) The care of the dying role is devolved from medics to nurses at the end of life; and, 8) Patients and staff perceive that the ED is not the preferred place of death. **Abstract (w. link to references):** https://goo.gl/5dwLLz

N.B. Additional articles on PC in emergency medicine noted in 30 July 2018 issue of Media Watch (#574, p.6).

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- ALBERTA | *The Globe & Mail* – 6 November 2018 – **'How do we balance rights in cases of medically assisted dying?'** A disturbing story featuring the clash of health-care ethics and the rights of faith-based healthcare facilities recently came to light. We tend to think of such episodes unfolding in courtrooms, hospital boardrooms and university classrooms. This one played out on an Edmonton sidewalk. In May, 2017, Doreen Nowicki was suffering from amyotrophic lateral sclerosis and receiving care in the Edmonton General Continuing Care Centre. The Centre describes itself as providing "long term care, sub-acute care and hospice care to a diverse population in downtown Edmonton." For Ms. Nowicki and her family, it was also the only available bed for the palliative care (PC) she needed. The Centre began its life as the Edmonton General Hospital over a century ago. Founded in 1895 by the Grey Nuns of Montreal, the Centre has since converted into a long-term care facility and is run by Covenant Health, a publicly-funded Catholic organization operating 17 hospitals across Alberta (and a third of the province's PC beds). Covenant Health is dedicated "to continue the healing ministry of Jesus by serving with compassion, upholding the sacredness of life in all stages and caring for the whole person – body, mind and soul." But caring for the whole person in all medical circumstances is not always easy for healthcare institutions guided by religious teachings. https://goo.gl/scMouJ

  N.B. Additional articles, reports, etc., on faith-based hospitals *vis-à-vis* medical assistance in dying noted in 29 October 2018 issue of Media Watch (#587, p.2).

- CBC RADIO | Online – 4 November 2018 – **'Canadian doctors grapple with how to approach assisted dying for young patients.'** The federal government is about to wade into an emerging controversy: How to respond to requests from children for medical assistance in dying (MAiD). "We had discussed that there may be a time in the future that MAiD would be available for patients under the age of 18, or a group called 'mature minors,'" said Dr. Adam Rapoport, director of the Pediatric Advanced Care team at Toronto's Hospital for Sick Children. The possibility that assisted dying could become an option for that demographic will be addressed next month in a report to Parliament from the Canadian Council of Academies. Rapoport was part of a group of bioethicists, palliative care doctors and others who drafted a preliminary policy on medically assisted dying for the handful of patients at Sick Kids who continue care at the hospital after they turn 18. It also explored how the hospital might respond if youth under 18 could choose assisted death. The group published the article about their "in-progress thinking" ... in September.[1] According to the Canadian Paediatric Society, doctors are increasingly being asked by children, teens and parents about medically assisted death. In a survey, 35 pediatricians said they had "exploratory discussions" about assisted dying with youth under age 18, while 45 reported receiving explicit requests for MAiD from parents.[2] https://goo.gl/yVmxjW

  1. 'Medical assistance in dying at a paediatric hospital,' *Journal of Medical Ethics*, published online 21 September 2018 [Noted in 24 September 2018 issue of Media Watch (#582, p.18)] **Abstract:** https://goo.gl/VEoqod
  2. 'Medical assistance in dying: A paediatric perspective' (Canadian Paediatric Society position statement), *Paediatrics & Child Health*, 2018;23(2):125-130. [Noted in 23 April 2018 issue of Media Watch (#560, p.23)] **Full text:** https://goo.gl/FPQSTb

U.S.A.

Medicare reimbursements drive crowding in the hospice space

NORTH CAROLINA | *Triad Business Journal* (Greensboro) – 9 November 2018 – For-profit hospice providers now outnumber community-based non-profits that for the better part of the last century prided themselves on caring for their own. Many today are keeping a watchful eye on the ever-changing health care landscape and what the future might bring. https://goo.gl/cCcXny

Palliative care needs survey results

NATIONAL HOSPICE & PALLIATIVE CARE ORGANIZATION (NHPCO) | Online – 5 November 2018 – Respondents represent palliative care (PC) services in 48 states. The NHPCO report summarizes the results for all who answered the question "Do you provide formal PC services…?" The results include the services these programs are providing, the challenges they are experiencing... While the primary location of services provided is community-based (home, assisted living facility, and long-term care), most organizations are providing care in multiple settings, including the hospital and clinic. Over 70% of respondents have served PC patients for three or more years; 63% served 101 or more patients, with 29% of these organizations serving 501 to 5,000 patients in 2017. The highest identified services are goals of care discussions, patient/family education, symptom management, comprehensive assessment, advance care planning, care coordination and transition management, medication management... Other notable services provided by some include bereavement and volunteers. **Download/view at:** https://goo.gl/SL7bVD

Specialist Publications

'Wrongful living' (p.10), in *Iowa Law Review*.

'Palliative care improves quality of life and symptoms' (p.12), in *Managed Care*.

International

Belarus among founders of Association of Children's Palliative in Eastern Europe & Central Asia

BELARUS | *Belarus News* (Minsk) – 9 November 2018 – Belarus was among the driving forces spear-heading the establishment of the Association of Children's Palliative in Eastern Europe & Central Asia... "Each country has its own model of palliative care (PC), its achievements and challenges. With this in mind, Belarus, Latvia and Ukraine put forward an initiative to set up this association ... designed to train doctors and social workers to provide PC. There will be a group of consultants who will help countries work out their own models of PC," Anna Gorchakova, Director of the Belarusian Hospice explained. The association is expected to be up and running next year. At this moment, work is underway to select consultants (medical advisors) who will provide assessments and consultations to participating countries in palliative treatment, Gorchakova added. Children's PC in Belarus is advancing to a new level; however, there is still room for improvement. "Thanks to public-private partnership people can already get medical assistance in hospital and at home. Such a model is not common in other countries. This model is used mostly in Minsk. We should work towards establishing PC facilities in the regions and think of ways to make this care convenient and inexpensive." The Belarusian Children's Hospice takes care of about 250 children a year. A register of children in need of palliative treatment has been compiled in Belarus. At present it features 1,200 children. https://goo.gl/2MFPTe

N.B. Belarusian Children's Hospice website: https://goo.gl/fYZVNr

Living wills should not be legally binding, say doctors

IRELAND | *The Irish Times* (Dublin) – 8 November 2018 – Doctors in Ireland don't want to see a new legally binding regime introduced which would allow people predetermine the medical treatment they would wish for in the event that they become incapacitated. Doctors argue there is a "disconnect" between so-called living wills and their own professional ethics, and say a non-legally binding regime may better serve patients. Living wills, or advanced healthcare directives (AHDs), were provided for by The Assisted Decision-Making (Capacity) Act 2015. These documents allow someone to set out the type and extent of medical or surgical treatment they may want at some point in the future should they become incapacitated and unable to communicate their own wishes. For example, such a document could include information on treatment given to prolong or limit life, and may include a do not resuscitate order. Putting a legislative framework on living wills was seen as necessary, because while someone can create an enduring power of attorney, this does not allow for the making of healthcare decisions by another person. Now however, doctors argue that there is a "disconnect" between part eight of the Act, which deals with AHDs, and the professional ethics that guide the work of doctors. The Irish Medical Organisation doesn't want people drawing up such living wills without the input of medical professionals. https://goo.gl/GY7irq

Specialist Publications

'Who gets to decide for the older patient with a limited decision-making capacity: A review of surrogacy laws in the European Union' (p.13), in *European Geriatric Medicine*.

End-of-life care in Australia

Why greater investment in palliative care could lead to economic benefits

AUSTRALIA (Victoria) | *The Mandarin* (Melbourne) – 6 November 2018 – The new Aged Care Standards recently released by the Australian Government could have helped reduce the costs of end-of-life (EoL) support and help more elderly people deal with a terminal illness, but did not mention the role of palliative care (PC) in aged care facilities.[1] The omission is a lost opportunity. According to Palliative Care Australia, 35% of all deaths in Australia occurred in residential aged care between 2014-2015. Of all the permanent residents who died, only a small number received a formal assessment noting that they required PC. PC can make a big and positive difference to the lives of elderly people and their families and carers, helping them live more fully and as comfortably as possible until death. What may be less known is that PC has major economic benefits, too.[2] Specialist PC services have resulted in less spending on medical treatment, and other associated costs. The savings from PC could help to reduce pressure on Australian aged and healthcare systems, while better supporting the elderly. Greater investment in PC may be essential for more cost-effective, medically sound and compassionate EoL care in Australian aged care facilities. https://goo.gl/vtSevz

Specialist Publications

'Evaluation of a toolkit resource package to support positive workplace behaviours in relation to quality end-of-life care in Australian hospitals' (p.7), in *BMJ Open Quality*.

'Variations in hospital inpatient palliative care service use: A retrospective cohort' (p.8), in *BMJ Supportive & Palliative Care*.

'Palliative and end-of-life care is everyone's business: A mapping study to guide a palliative approach in far west New South Wales, Australia' (p.14), in *Rural & Remote Health*.

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1. 'New Aged Care Quality Standards,' Australian Aged Care Quality Agency, Australian Government. **Download/view at:** https://goo.gl/dhk4ad

2. 'The Economic Value of Palliative Care & End-of-Life Care,' Palliative Care Australia, July 2017. **Download/view at:** https://goo.gl/rUowgg

New atlas of variation for palliative and end-of-life care in England

U.K. (England) | Public Health England – 5 November 2018 – The National Health Service (NHS) atlas presents a series of maps of variation selected from the topics which National Clinical Directors from the Department of Health and others have identified as being of importance to their clinical specialty. The aim is to put variations in activity, expenditure, quality, outcome, value, and equity firmly on the health service agenda for the next decade, and to stimulate the NHS to search for unwarranted variation and, by extension, to tackle the causes and drivers of that variation. Each individual and every population is unique, and, although affected by the same modern epidemics, the priorities for each individual and for each population, and the values they hold, will be unique. For these reasons, the occurrence of some variation is not only inevitable but also necessary in both clinical practice and healthcare commissioning. However, unwarranted variation is cause for concern. Variation in the level of quality is likely to persist as services seek to improve. This variation is understandable and explicable, especially as each service strives to reach the level achieved by the best, while the best themselves will have moved on. **Download/view at:** https://goo.gl/3fM4WV

Medical staff urged to ensure end-of-life carers get full support

U.K. (Scotland) | *The Scotsman* (Edinburgh) – 5 November 2018 – Marie Curie and Macmillan Cancer Support are urging early identification of people caring for those at the end of their lives. Authors of the report from the charities spoke to bereaved people who gave palliative care to relatives and found early provision of information and support was vital.[1] The report found many carers were not identified as such and recommended all healthcare staff – but particularly GPs and district nurses – to do more to remedy this. Other recommendations include speedy assessments and support plans for palliative carers, readily available respite care, and the carer's details forming part of key medical information. The report said there are "many missed opportunities" in end-of-life care. "Ensuring that those caring for someone in the last six months of life gets the support they need as quickly as possible is crucial if they are to effectively carry out the caring role they have taken on," it continued. "A lack of support leaves both the carer and the cared-for person at risk of a breakdown in the care provided, which may lead to much greater complexities in the care provision needed, and quality of life available to the cared-for person and carer, beyond death and into bereavement." https://goo.gl/iYVQ5H

1. 'Getting it right for carers supporting someone at the end of life,' Marie Curie and Macmillan Cancer Support, October 2018. **Download/view at:** https://goo.gl/Qci6Dg

Specialist Publications

The best interests of infants and families during palliative care at the end of life: A review of the literature

ADVANCES IN NEONATAL CARE | Online – 31 October 2018 – This article examines what neonatal palliative care (PC) entails, how parents perceive healthcare providers' actions, what they potentially need at the end of their infant's life, and what bereavement interventions are most supportive for parents. Healthcare providers should consider alleviation of the infant's pain and suffering when discussing whether to provide or continue aggressive medical interventions. The timing of these discussions is important. Parents appear to be most comforted by compassionate, caring healthcare providers who show competence and knowledge in the provision of medical/nursing and PC. Healthcare providers working in neonatal intensive care units (NICUs) require specific training in bereavement/PC for infants. Families facing the death of their infant must receive support from qualified providers both during and after that death. Furthermore, the infant's quality of life must be considered when discussing withholding or withdrawing care. There is a need for further research investigating the specific types of training required by healthcare providers in NICU settings who are providing bereavement/PC to neonates, in order to best support the families' needs in these situations. **Abstract:** https://goo.gl/fKjxpV

Cont.

Related

- *THE NEW ENGLAND JOURNAL OF MEDICINE* | Online – 8 November 2018 – **'Ethical problems in decision making in the neonatal ICU.'** Technological advances have altered the boundary between viable and nonviable newborns and increased the need to consider quality of life in intervention decisions. An approach to decision making that accounts for the complexity of family and physician values is described. **Summary:** https://goo.gl/crHBVv

- *PEDIATRICS* | Online – 8 November 2018 – **'Child abuse, incarceration, and decisions about life-sustaining treatment.'** The authors present the case of an infant with severe hypoxic-ischemic encephalopathy at birth whose mother was incarcerated shortly after delivery. They explore clinical and legal challenges that the medical team faces in determining best interests for the infant in this context and difficulties in deciding what therapies to provide and for how long. **Abstract:** https://goo.gl/ecDT73

End of life and palliative care in neurology: Does autonomy matter?

ANNALS OF INDIAN ACADEMY OF NEUROLOGY, 2018;21(4):239-241. The recent supreme court of India judgment on autonomy makes it necessary for all practicing neurologists to appraise themselves of the changing legal framework for end-of-life decision-making in India. A pathway has been prescribed for advance care planning and medical futility decision-making. This is an evolving landscape and in a diverse country may vary substantially by geography. Living wills and advance medical directives can be prepared by our patients, and we will be required to honor these instruments. Catastrophic brain injury and life-limiting neurologic illness both require us to maintain our commitment to care when cure is no longer possible. **Full text:** https://goo.gl/d5CKB4

Related

- *JOURNAL OF PALLIATIVE MEDICINE* | Online – 7 November 2018 – **'Providers' perspectives on palliative care in a neuro-medicine intensive care unit: End-of-life expertise and barriers to referral.'** Three perspectives were identified: 1) Foundational; 2) Comfort care; and, 3) Holistic. Regression analysis shows that providers' perspectives are differentially related to their end-of-life expertise. Frequencies of provider-reported barriers to referring patients to palliative care (e.g., lack of care coordination) were determined. **Abstract:** https://goo.gl/cyzDwx

Noted in Media Watch 22 October 2018 (#586, p.16):

- *SEMINARS IN NEUROLOGY*, 2018;38(05):569-575. **'Neuropalliative care: A practical guide for the neurologist.'** While specialty-level palliative care (PC) training is available to interested neurologists, all neurologists can strive to provide primary PC for their patients. The authors describe the scope of neuropalliative care, define patient populations who may benefit from PC, and explore the communication and symptom management skills essential to PC delivery. **Abstract:** https://goo.gl/mjj32k

N.B. Additional articles on PC in neurology noted in this issue of Media Watch.

Experiences of Dutch general practitioners and district nurses with involving care services and facilities in palliative care: A mixed methods study

BMC HEALTH SERVICES RESEARCH | Online – 8 November 2018 – Services and facilities in palliative care can help meet the multidimensional needs of patients and relatives. The authors' finding that psychological, social, and spiritual services are involved less often suggests that the classic care model, with the primary focus on somatic issues, is still well entrenched. While involvement of all available services and facilities is certainly not always needed or desired by patients and relatives, it may be beneficial to involve these services more often. More familiarity with services that can provide additional healthcare in these areas, both with regard to availability and added value, could improve the quality of life for patients and relatives at the end of life. **Full text:** https://goo.gl/AWMf5J

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Pediatric palliative care in the U.S.

Interprofessional palliative care education for pediatric oncology clinicians: An evidence-based practice review

BMC RESEARCH NOTES | Online – 7 November 2018 – Although pediatric oncology clinicians care for patients with life-threatening illnesses, there is great variation in their formal palliative care (PC) training. Essential components for successful pediatric PC educational programs include: 1) Establishing effective modalities and teaching strategies for content delivery; 2) Developing an interprofessional PC curriculum; and, 3) Evaluating programs. Despite limited evidence of the effects on pediatric oncology practice, suggested evaluation methods are: 1) Eliciting patient and family feedback; 2) Standardizing care delivery measures; and, 3) Evaluating outcomes of care. To the authors' knowledge, this was the first study addressing PC education for pediatric oncology clinicians through an interprofessional lens. Given the ongoing debate in Congress, the findings are both timely and relevant to the national health policy agenda. Limitations stem from the lack of high-level evidence available on this topic... Studies utilized clinician self-report measures and there was no systematic evaluation of educational intervention impact on care delivery. Only one study was multi-modal, with all others consisting of a single modality and time-limited interventions. One program incorporated all core competencies, with only one study utilizing an internationally validated pediatric curriculum. Further longitudinal and multi-site studies are needed to standardize clinician education and develop psychometrically tested tools to establish best practice recommendations. **Full text:** https://goo.gl/Fv8aN8

Evaluation of a toolkit resource package to support positive workplace behaviours in relation to quality end-of-life care in Australian hospitals

BMJ OPEN QUALITY | Online – 10 November 2018 – This study aimed to determine the effectiveness of an action-orientated toolkit in supporting behaviour change in relation to quality end-of-life care (EoLC) in acute hospital settings. The toolkit was developed to complement a programme of online EoLC education. The toolkit has been well received by users, with many recommending the resource to colleagues. The evaluation data demonstrate that the toolkit had resulted in self-reported changes to workplace practice, with the vast majority of toolkit users reporting that the toolkit made them feel more confident in addressing end-of-life issues with patients and their families. While the toolkit was intended as a resource for individual use in acute hospital settings, the authors noted that the toolkit has had broader appeal both in terms of its applicability in other settings and to other user groups. Some extension of materials would be expected to broaden the appeal of toolkit to other groups such as aged care workers, who represent a significant workers' population providing care to Australians ageing and nearing the end of life. The toolkit has also been used as an education tool in numerous settings. Finally, the toolkit provides a new resource within the sector, and the Australian-specific nature of the resource has been highly valued by users. **Full text:** https://goo.gl/gkAd2m

Improving resuscitation decisions: A trust-wide initiative

BMJ OPEN QUALITY | Online – 1 November 2018 – Treatment escalation plans (TEPs) can be an effective way of formalising timely clinician decision-making and communicating ceilings of care for patients and have now become a national initiative. A correctly documented TEP form is an important resource for both the medical and surgical team, particularly in the case of a deteriorating patient in the acute setting. This quality improvement project has increased the use of TEP forms. The authors believe this had a positive impact on appropriate do not attempt cardiopulmonary resuscitation decision-making and documentation, as they helped to remind doctors to consider the escalation plans for their patients. In particular, there was also a noticeable increase in the proportion of escalation plans that had been discussed with patients or relatives. Although, TEPs have improved awareness and decision-making in the authors trust regarding ceilings of care, they have

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not yet achieved our goal of 100% TEP completion. Engagement and education of senior decision-makers is key. Some of senior staff continue to be reluctant to make these important decisions and the authors have focused on education and communication in order to improve this. They are targeting junior doctors' teaching and induction to emphasise the importance of resuscitation decisions and to escalate to their seniors. Increasingly, hospitals are looking to the community and general practitioners to hold these conversations with their patients prior to being admitted to hospital and this is what the authors plan as the next cycle of this project. **Full text:** https://goo.gl/QJGxhL

Noted in Media Watch 27 August 2018 (#578, p.12):

- *JOURNAL OF PUBLIC HEALTH*, 2018;40(2):404-408. '**"One day I will find the right words, and they will be simple" – Rethinking DNACPR at a national level.**' Evidence has shown a diversity of practices and terminology concerning the implementation and documentation of do not attempt cardiopulmonary resuscitation (DNACPR) notices across different hospital trusts in England & Wales, and the Resuscitation Council (U.K.) has proposed a standard approach for how DNACPR notices can be better incorporated into overall care plans. However, the Council can only make recommendations for good practice. This discussion reviews current practices and suggests that the time has come for a national standardized approach to the process of initiating and documenting DNACPR, along with a dedicated programme to increase public understanding of what is involved. **Abstract:** https://goo.gl/jVLK7g

Variations in hospital inpatient palliative care service use: A retrospective cohort study

BMJ SUPPORTIVE & PALLIATIVE CARE | Online – 8 November 2018 – The authors examined rate and time of in-hospital palliative care (PC) use and associated interhospital variations. They used admissions from all hospitals in New South Wales within a 12-month period, for a cohort of adults who died in 73 public acute care hospitals between July 2010 and June 2014. Receiving PC and its timing were based on recorded use. Among 90,696 adults who died, 27% received PC, and the care was initiated 7.6 days ... before death. Over the 5-year period, the PC rate rose by 58%... The duration of PC before death declined by 7%. Despite an increase over time in the PC rate, its initiation was late and of brief duration. PC use was associated with patient and hospital characteristics; however, half of the between hospital variation remained unexplained. **Abstract:** https://goo.gl/VuWpXA

Related

- *HEART FAILURE REVIEWS* | Online – 3 November 2018 – '**The use of hospital-based services by heart failure patients in the last year of life: A discussion paper.**' The aim of this discussion paper is to determine chronic heart failure (CHF) patients' use of acute hospital-based services in their last year of life and to discuss the potential for palliative care (PC) to reduce service utilisation. A systematic search of the literature was conducted. There were 12 studies that evaluated the use of hospital-based services by CHF patients at the end of life. In all studies, it was found that CHF patients used acute hospital-based services as death approached. However, only two studies examined if PC consultations were obtained by patients, and neither study assessed the impact that these consultations had on service utilisation in the last year of life. **Abstract (inc. list of references):** https://goo.gl/GV3Muc

- *SOCIETIES* | Online – 2 November 2018 – '**What Is the "right" number of hospital beds for palliative population health needs?**' Highly diverse citizen to hospital and citizen to hospital bed ratios were found across 9 Canadian provinces and 15 developed countries. These differences are an enigma for palliative care. Most governments are currently seeking new ways to better meet the wide range of healthcare needs of citizens. The findings of this report should focus attention to the concern that hospitals and hospital beds are also needed for palliative populations. Excess hospital accessibility is a macro-level problem, as hospitals are costly both directly and indirectly as hospital utilization improvements and community-based care innovations may be delayed. Inadequate hospital accessibility is of major significance at both the individual and family level. **Full text:** https://goo.gl/kgLTNU

We are caregivers: Social identity is associated with lower perceived stress among rural informal caregivers

CANADIAN JOURNAL ON AGING | Online – 8 October 2018 – Informal caregivers often experience high stress levels with little support, especially in rural settings. With a mixed-methods approach, this research explored experiences of rural informal caregivers, including how social identification as a caregiver, social interactions, and formal and informal coping support related to perceived stress. Major focus group themes included lacking available services, balancing challenges, unmet practical needs, and strong community identity. Survey data revealed that perceived coping support (e.g., having someone to turn to), social interactions, and caregiver identity (e.g., perceiving the role as important to one's self-concept) were associated with lower life upset stress, but only caregiver identity was associated with managing the personal distress and negative feelings associated with caregiving stress. Results suggest that, although available rural services may fall short, other options might alleviate caregiver stress, including facilitating access to coping support, encouraging social interactions, and enhancing caregiver social identity. **Abstract (inc. list of references):** https://goo.gl/qt9agf

Is access to intensive care equitable?

CRITICAL CARE | Online – 3 November 2018 – Patients with life-threatening illness often require admission to intensive care units (ICUs) to receive life sustaining interventions. This is an expensive health care resource with specialized physical space, equipment and healthcare worker expertise. Due to constraints imposed by a limited resource, various guidelines for admission to the ICU have been proposed, including triage decisions if demand exceeds supply. Institutions likely have their own more specific admission and discharge criteria for individual ICUs. These guidelines are subject to interpretation and, especially when combined with individual treatment decisions, introduce the possibility of subjectivity and bias. Whether such inequities in access to ICU care exist is not clearly known, or easy to study. To ensure that healthcare access is equitable for all members of our populations, it is important to have valid methods to measure this. This is not a simple task, since the admission process is complex. ICU admissions usually come from the ward, operating room or emergency department and require a referral from the appropriate physician to the intensivist, who must then assess if the patient meets the ICU admission criteria. Critical care rapid response or medical emergency teams may influence this process in hospitals where they exist. **Full text:** https://goo.gl/Yn3Vgj

Noted in Media Watch 29 October 2018 (#587, p.6):

- *JAMA INTERNAL MEDICINE* | Online – 22 October 2018 – **'Does the term *intensive care unit* promote aggressive treatment?'** Six million Americans are admitted to an intensive care unit (ICU) each year. Many receive aggressive efforts to return them to health that are appropriate and consistent with their values. Others are treated aggressively, despite a poor prognosis, even though many people indicate that they would not want burdensome treatment in such a situation. The term *intensive care unit* and its abbreviation, ICU, may contribute to this discrepancy by implying a default option of aggressive life-sustaining therapy. **Abstract:** https://goo.gl/UNKpm8

Noted in Media Watch 20 august 2018 (#577, p.5):

- *BMC ANESTHESIOLOGY* | Online – 16 August 2018 – **'Palliative care in intensive care units: Why, where, what, who, when, how.'** Palliative care (PC) in the ICU encompasses symptoms control and end-of-life management, communication with relatives and setting goals of care ensuring dignity in death and decision-making power. However, effective application of PC in ICU presupposes specific knowledge and training which anesthesiologists and critical care physicians may lack. Moreover, logistic issues such protocols for patients' selection, application models and triggers for consultation of external experts are still matter of debate. **Full text:** https://goo.gl/3Grs6g

Palliative care in lung cancer: When to start

CURRENT ONCOLOGY REPORTS | Online – 9 November 2018 – Despite recent advances in the care of patients with advanced non-small cell lung cancer (NSCLC), significant morbidity and mortality remains. Symptoms caused by the cancer and its treatments can be profoundly debilitating. In this review, the authors discuss the definition, purpose, benefits, and optimal timing of palliative care (PC) in advanced NSCLC. Several studies evaluating the value of early PC for patients with advanced NSCLC and other advanced malignancies have identified benefits for patients, caregivers, and health systems**. Abstract (w. list of references):** https://goo.gl/7dypem

Being acknowledged by others and bracketing negative thoughts and feelings: Frail older people's narrations of how existential loneliness is eased

INTERNATIONAL JOURNAL OF OLDER PEOPLE NURSING | Online – 7 November 2018 – Being acknowledged by others, that is, being the focus of others' concern, [in this qualitative study] eased the experience of existential loneliness (EL), as did encountering intimacy and having meaningful exchanges of thoughts and feelings. Further, EL was pushed into the background and eased when participants could bracket negative thoughts and feelings, that is, when they could adjust and accept the present situation, view life in the rear-view mirror, be in contact with spiritual dimensions and withdraw and distract themselves. Frail older peoples' opportunities to ease EL may be facilitated by health care staff providing person-centred care and create possibilities for solitary time and meaningful togetherness. **Abstract:** https://goo.gl/Atm25u

Noted in Media Watch 11 June 2018 (#567, p.8):

- *INTERNATIONAL JOURNAL OF QUALITATIVE STUDIES ON HEALTH & WELL-BEING* | Online – 5 June 2018 – **'Encountering existential loneliness among older people: Perspectives of health care professionals.'** Encountering existential loneliness (EL) is experienced by health care professionals as both challenging and meaningful, and it is important to talk about it and highlight its role in providing good-quality care to older people. The effects of facing EL do not seem to be limited to the caring situation, but rather to affect health care professionals both personally and professionally. **Full text:** https://goo.gl/s1yNW9

Noted in Media Watch 26 February 2018 (#552, p.4):

- *RESURGENCE & ECOLOGIST*, 2018, Issue #307. **'Tackling loneliness and isolation reduces health bill.'** A "compassionate community" scheme aimed at tackling the connection between loneliness and ill health has helped cut emergency hospital admissions in its area by 17%, official figures reveal. At a time when hospital overcrowding and the future of the National Health Service are becoming a major political issue in Britain, the small town of Frome in Somerset, south-west England, is bucking the trend with a scheme that may have international implications for health policy. **Full text:** https://goo.gl/68ngwg

N.B. Additional articles on the potential detrimental effect on health of loneliness and isolation noted in 22 May 2017 issue of Media Watch (#513, pp.3-4). On a related subject, articles on decision-making for "unbefriended" or "unrepresented" patients noted in 18 September 2017 issue of Media Watch (#530, p.14).

Wrongful living

IOWA LAW REVIEW | Online – 31 October 2018 – Executing an advance directive (AD) that specifies a patient's wishes regarding end-of-life (EoL) medical care is an exercise of self-determination – a conscious choice about the degree and type of medical intervention one wishes to receive under EoL circumstances. Empirical studies, however, consistently report that healthcare professionals fail to comply with ADs; violations of a patient's interest in self-determination are alarmingly common. From a practical per-

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spective, the conduct of either patients or healthcare professionals may make an AD unavailable, which results in non-compliance. Legally, courts have historically rejected claims for "wrongful living" associated with the prolongation of life that results from unwanted medical intervention. As a result, healthcare professionals fear the liability threatened by a wrongful death claim more than the legal exposure risked by keeping an individual alive despite a contrary mandate in an AD. Full text: https://goo.gl/s9LJk5

End-of-life care in Italy

Transforming end-of-life care by implementing a patient-centered care model: Findings from an action research project

JOURNAL OF HOSPICE & PALLIATIVE NURSING, 2018;20(6):531-541. Studies have revealed the difficulty of adopting patient-centered care in daily practice and of sharing its meaning within the interdisciplinary team. The aim of this study was to report the process of transforming end-of-life care by implementing a patient-centered model of care in an Italian hospice. The following phases were performed: 1) "Looking" phase: the diagnosis was established by collecting data through semi-structured interviews in the field study and through the administration of the Frommelt Attitude Toward the Care of the Dying Scale Form B – Italian Version; 2) "Thinking" phase: staff members, guided by a research team, redesigned practice by identifying priorities in improvements and actions through multi-professional focus groups; 3) "Acting" phase: actions identified in the previous phase were implemented; and, 4) "Relooking" phase: the same data collection processes used in the looking phase were applied to evaluate the outcomes achieved. Three areas of improvement have been established: 1) Symptoms were intensively audited through patient self-reports by using validated tools; 2) Patients' family needs were also regularly collected, documented in clinical records, and addressed; 3) Patients' family members were involved in the plan of care through support and education. Inpatient hospice health carers in this study were aware of the concept of patient-centered care. However, its actual implementation was lacking. An action research approach helped them to implement expected changes. **Abstract:** https://goo.gl/XPE2HT

Evaluating an initiative to promote entry-level competence in palliative and end-of-life care for registered nurses in Canada

JOURNAL OF HOSPICE & PALLIATIVE NURSING, 2018;20(6):568-574. Numerous competency statements have been developed for the purpose of guiding nurse educators and clinicians. Rarely, though, are there evaluations of the use of these competency statements in practice. In this cross-sectional descriptive study, nurse educators were surveyed to determine how the Canadian Association of Schools of Nursing (CASN) Palliative & End-of-Life Care Entry-to-Practice Competencies and Indicators are used in schools of nursing in Canada. Twenty-four respondents consented to participating in this study. Findings supported that some version of palliative and end-of-life care (P&EoLC) education was offered at each school of nursing in Canada, and it was most commonly threaded throughout existing undergraduate courses. Data also suggested that if nurse educators were interested in P&EoLC and had existing knowledge or expertise in P&EoLC, the CASN P&EoLC competency document was used to integrate content into curricula. **Abstract:** https://goo.gl/6pf9x9

Beyond right or wrong: Attitudes and practices of physicians, nurses, psychologists, and social workers regarding attendance at patient funerals

JOURNAL OF PALLIATIVE MEDICINE | Online – 9 November 2018 – Australian health practitioners from medicine, nursing, psychology, social work, and other allied health professions participated in a cross-sectional nationwide online survey of attitudes and practices toward attendance at patient funerals based upon data from interviews with health professionals. Attendance at patient funerals was predicted by age, telling colleagues about own funeral attendance practices, having discussions with colleagues about funeral attendance, having long relationships with patients, and having a majority of patients at the end of life. Non-attendance was predicted by believing that if they cannot attend all funerals, they prefer not to

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attend any, feeling that colleagues disapprove of funeral attendance, believing that attending funerals is crossing the line between the personal and the professional, and being a psychologist. The study's findings emphasize the need for more open discussions and reflection among individuals and groups of health practitioners regarding attendance at funerals. Understanding the motivations of physicians, nurses, social workers, and other allied health practitioners to attend or not attend patient funerals is an important first step in working toward policies, protocols, and guidelines to support best practice. **Abstract:** https://goo.gl/2BDqx5

Noted in Media Watch 11 June 2018 (#567, p.15):

- *PEDIATRICS PERSPECTIVE* | Online – 5 June 2018 – '**The importance of attending patient funerals.**' In my career as a pediatrician, I have gone to many funerals. I have cared for 28 children with recessive dystrophic epidermolysis bullosa in both primary care and hospital inpatient settings and attended 12 of their funerals. Attending these funerals provided a valuable perspective on the lives of chronically ill children with a terminal illness. They also helped us cope with our frustration. Why could we not have done more to alleviate our patients' suffering and delay the deaths of these children? We gained a deeper understanding that these children, despite their terrible disease and suffering, brought enormous joy to their parents and friends. **Introduction:** https://goo.gl/mRKbnj

N.B. Selected articles on the topic of attending patient funerals noted in 19 September 2016 issue of Media Watch (#480, p.9).

Does end-of-life care differ for Anglophones and Francophones? A retrospective cohort study of decedents in Ontario, Canada

JOURNAL OF PALLIATIVE MEDICINE | Online – 3 November 2018 – In this retrospective cohort study data from two regions with higher representations of Francophones were examined, with the final distribution by primary language being 75% Anglophone, 18% Francophone, and 7% other languages. Compared with Anglophones, Francophones were more frequent users of long-term care (LTC) – 47.6% vs. 37.1% – and less frequent users of home care – 71.3% vs. 76.3%. In adjusted models, the number of days spent in hospital in the last 90 days of life was similar between Anglophones and Francophones, although the odds of dying in hospital were significantly higher among the latter. The mean total health care cost in the last year of life was slightly lower among French ($62,085) compared with English ($63,814) speakers. There are statistically significant differences in end-of-life (EoL) outcomes between linguistic groups in Ontario, namely more institutionalization in LTC, less home care use and more deaths in-hospital among Francophones. Future research is needed to examine the cause of these differences. Strategies to ensure equitable access to quality EoL care are required. **Abstract:** https://goo.gl/TfpwBX

Palliative care improves quality of life and symptoms

MANAGED CARE | Online – 4 November 2018 – There's now a body of evidence to support the provision of palliative care (PC) services, especially in hospitals. A review of the evidence in 2017 found that PC interventions soon after a diagnosis of advanced cancer have beneficial effects on quality of life and symptom intensity, although the effects on extending life were uncertain.[1] The reviewers noted the limited evidence available and looked forward to ongoing trials to shed more light on outcomes. A meta-analysis published in 2016 came to about the same conclusion.[2] The reviews noted that end-of-life care is often complex and hard to study. Evidence points to PC reducing expenditures among inpatients, although the studies so far are fairly narrow and small; sweeping statements will have to wait. Research results reported in 2011 showed that Medicare patients who received palliative hospital care incurred $6,900 less in hospital costs than patients who received usual care.[3] Another inpatient-specific study of cancer patients published in 2017 compared a PC intervention group with controls and found declines in hospital readmissions and chemotherapy use and an increase in hospice referrals.[4] The researchers concluded it improved the value of cancer care. A 2017 study found reduced length of stay and reduced intensity of treatment with use of PC among advanced cancer patients.[5] **Full text:** https://goo.gl/eXqj5z

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1. ‘Early palliative care for adults with advanced cancer,’ *Cochrane Reviews*, published online 12 June 2017. [Noted in 19 June 2017 issue of Media Watch (#517, p.14)] **Full text:** https://goo.gl/Nxer8u

2. ‘Association between palliative care and patient and caregiver outcomes: A systematic review and meta-analysis,’ *Journal of the American Medical Association*, 2016;316(20):2104-2114. [Noted in 28 November 2016 issue of Media Watch (#489, p.1)] **Full text:** https://goo.gl/cb3x8N

3. ‘Palliative care consultation teams cut hospital costs for Medicaid beneficiaries,’ *Health Affairs*, 2011; 30(3):454-463. [Noted in 14 March 2011 issue of Media Watch (#192, p.6)] **Full text:** https://goo.gl/36LwVL

4. ‘Standardized criteria for palliative care consultation on a solid tumor oncology service reduces downstream health care use,’ *Journal of Oncology Practice*, published online 17 March 2017. [Noted in 20 May 2017 issue of Media Watch (#504, p.11)] **Full text:** https://goo.gl/xaPCP5

5. ‘Cost analysis of a prospective multi-site cohort study of palliative care consultation teams for adults with advanced cancer: Where do cost-savings come from?’ *Palliative Medicine*, published online 3 February 2017. [Noted in 6 February 2017 issue of Media Watch (#498, p.7)] **Abstract:** https://goo.gl/KoKFSw

Perspectives of people with dementia and carers on advance care planning and end-of-life care: A systematic review and thematic synthesis of qualitative studies

PALLIATIVE MEDICINE | Online – 8 November 2018 – Advance care planning (ACP) aims to ensure that care received during serious and chronic illness is consistent with the person’s values, preferences and goals. However, less than 40% of people with dementia undertake ACP internationally. From 84 studies involving 389 people with dementia and 1864 carers, five themes were identified: 1) Avoiding dehumanising treatment and care (remaining connected, delaying institutionalisation, rejecting the burdens of futile treatment); 2) Confronting emotionally difficult conversations (signifying death, unpreparedness to face impending cognitive decline, locked into a pathway); 3) Navigating existential tensions (accepting inevitable incapacity and death, fear of being responsible for cause of death, alleviating decisional responsibility); 4) Defining personal autonomy (struggling with unknown preferences, depending on carer advocacy, justifying treatments for health deteriorations); and, 5) Lacking confidence in healthcare settings (distrusting clinicians’ mastery and knowledge, making uninformed choices, deprived of hospice access and support at end of life). People with dementia and their carers felt uncertain in making treatment decisions in the context of ACP and end-of-life care. Strategies that attend to people’s uncertainty in decision-making may help to empower people with dementia and carers and strengthen person-centred care in this context. **Abstract:** https://goo.gl/8QDxL2

N.B. Additional articles on ACP for patients living with Alzheimer’s and other forms of dementia noted in 27 August 2018 issue of Media Watch (#578, p.9).

Related

- *EUROPEAN GERIATRIC MEDICINE* | Online – 29 October 2018 – **‘Who gets to decide for the older patient with a limited decision-making capacity: A review of surrogacy laws in the European Union.’** Family members of older incompetent patients are increasingly playing an essential role in the decision-making process relating to medical treatment. Furthermore, rights of patients and carers and the extent of their legal involvement vary widely across the European Union (EU). Starting with an illustrative case within the Italian legal framework, this review focuses on statutory laws in the EU to analyse the role and the rights of surrogates on behalf of older incompetent patients. The authors have identified two main essential areas of surrogate’s law in Europe, in the absence of the advance directives: 1) The role of family members automatically accepted as surrogates by law; and, 2) A legal representative appointed by a court. **Abstract (inc. list of references):** https://goo.gl/6PwV8Y

Research prioritisation exercises related to the care of children and young people with life-limiting conditions, their parents and all those who care for them: A systematic scoping review

PALLIATIVE MEDICINE | Online – 8 November 2018 – There is limited high-quality research in many aspects of care for infants, children and young people with life-limiting conditions. The authors provides a unique overview of where and by whom a wide range of research priorities for infants, children and young people with life-limiting conditions have been agreed. The research priorities identified are mapped in the context in which they were agreed, while common topics and themes are highlighted. This article presents an overview of consensus derived research priorities for infants, children and young people with life-limiting conditions, providing the opportunity for a coherent approach to improving the evidence base for this area of practice. The authors highlight the need for broader consideration of stakeholder perspectives when undertaking research prioritisation exercises. However, further identification of research priorities cannot be justified at this time unless ascertaining the perspectives of children and young people and their families. **Full text:** https://goo.gl/evQF4G

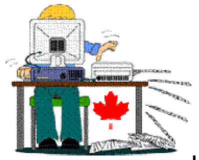
Related

- *BMC PALLIATIVE CARE* | Online – 7 November 2018 – '**Bereaved parents' experiences of research participation.**' Despite ongoing research demonstrating that bereaved parents may find research participation beneficial rather than harmful, it can be difficult to design and gain approval for such emotionally laden studies. In part, this difficulty is caused by a lack of empirical evidence that explores how and when to approach bereaved parents in a way that promotes autonomy and safety whilst minimising harm and distress. The authors' findings offer suggestions for appropriate research contact timeframes, contact methods, and interview locations. **Full text:** https://goo.gl/K391Ch

Palliative and end-of-life care is everyone's business: A mapping study to guide a palliative approach in far west New South Wales, Australia

RURAL & REMOTE HEALTH | Online – Accessed 10 November 2018 – All healthcare providers can influence the delivery and outcome of a palliative approach to care, ensuring that everyone has "equitable access to quality care based on assessed need as they approach and reach the end-of-life." The vast network [within the region studied] demonstrates extensive long-term involvement in palliative care (PC) as well as established connections and opportunities for improving communication between the services and providers involved in PC. Palliative practice is varied and challenging; challenges include communication, early identification, and education. Mapping the existing networks, resources, and relationships proved invaluable to guide the implementation of a palliative approach to care. The implementation of a palliative approach, as with any service model, requires agreement and engagement across relevant healthcare organisations, services, and providers. Mapping and understanding the network of providers (and organisations) that support health care delivery before implementing new models of care will identify strengths and gaps within the network. This knowledge will then support new and integrated connections that enhance the provision of care so that it is acceptable, fit for purpose, and regionally responsive. **Abstract:** https://goo.gl/vxqBcU

N.B. Additional articles on the provision and delivery of palliative and end-of-life care in rural and remote regions of Australia noted in 24 September 2018 issue of Media Watch (#582, p.14).



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

Current role of palliative interventions in advanced pancreatic cancer

WORLD JOURNAL OF GASTROINTESTINAL SURGERY, 2018;10(7):75-83. Pancreatic cancer is an extremely aggressive disease with a five-year survival of only 8.5%. When a curable operation is not possible, treatment decisions should focus on reducing morbidity and improving quality of life. The success of a palliative treatment to provide durable symptom resolution should be at the forefront of the discussion among physicians, patients and their families. The role of surgical palliation has evolved over the past several decades as there have been advances in non-operative palliative interventions. Regional neurolysis of celiac plexus can serve as an adjunct for better tumor-related pain control. Regardless of the palliative procedure performed, all physicians involved must be adequately trained in end of life management to ensure appropriate and compassionate care for patients. **Full text:** https://goo.gl/Zcj5mL

American Society of Clinical Oncology
Clinical Practice Guideline: Palliative Care

JOURNAL OF CLINICAL ONCOLOGY | Online – 23 May 2018 – 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. [Noted in 28 May 2018 issue of Media Watch (#565, p.11)] **Full text:** https://goo.gl/Jv5buB

Assisted (or facilitated) death

Representative sample of recent journal articles:

- *CURRENT ONCOLOGY*, 2018;25(5):e486-e489. **'Medical assistance in dying for cancer patients one year after legalization: A collaborative approach at a comprehensive cancer centre.'** Medical assistance in dying (MAiD) is a new medical service in Canada. Access to MAiD for patients with advanced cancer can be daunting during periods of declining health near the end of life. In this report, the authors describe a collaborative approach between the centralized coordination service and a regional cancer centre as an effective strategy for enabling interdisciplinary care delivery and enhancing patient-centred care at the end of the patient's cancer journey. **Abstract:** https://goo.gl/NgbQh9

  N.B. Click on pdf icon to access full text.

Publishing Matters

Peer review: The worst way to judge research, except for all the others

U.S. | *The New York Times* – 5 November 2018 – Even before the recent news that a group of researchers managed to get several ridiculous fake studies published in reputable academic journals, people have been aware of problems with peer review. Throwing out the system – which deems whether research is robust and worth being published – would do more harm than good. But it makes sense to be aware of peer review's potential weaknesses: 1) Reviewers may be overworked and underprepared; 2) There is evidence that reviewers are not always consistent; 3) Peer review may be inhibiting innovation; and, 4) An even bigger issue is that peer review may be biased. https://goo.gl/4QBgXV

Noted in Media Watch 15 October 2018 (#585, p.18):

- *NATURE* | Online – 8 October 2018 – **'How to write a thorough peer review.'** Scientists do not receive enough peer-review training. To improve this situation, a small group of editors and the author developed a peer-review workflow to guide reviewers in delivering useful and thorough analyses that can really help authors to improve their papers.[1] **Full text:** https://goo.gl/u5V8zn

  1. 'A Peer Review Process Guide,' **Download/view at:** https://goo.gl/2AnGC1

Suspended British Columbia professor who exposed fake journals welcomes investigation

CANADA (British Columbia) | *The Vancouver Sun* – 3 November 2018 –The association representing Canadian university faculty [i.e., the Canadian Association of University Teachers] has launched an investigation to determine whether Thompson Rivers University (TRU) has violated the academic freedom of economics professor Derek Pyne. He had gained international attention for his peer-reviewed research into the way faculty in his own department were advancing their careers by publishing in deceptive academic journals, also known as "predatory" publications.[1] Pyne was suspended without pay in July by administrators at the Kamloops university. However, TRU restored his pay in August when *The Vancouver Sun* researched and wrote an article about his work.[2] He remains banned from teaching and going to the TRU campus, except in a few circumstances. There has been a dramatic rise around the world in such deceptive academic journals and conferences, which offer to publish or present scholars' papers for significant fees, without putting their work through the rigour of peer review by fellow experts or other checks for validity. https://goo.gl/jTfxhT

1. 'The rewards of predatory publications at a small business school,' *Journal of Scholarly Publishing*, 2017;48(3):137-160. [Noted in 15 May 2017 issue (#512, p.9)] **Abstract:** https://goo.gl/a56XiU

2. 'British Columbia economist in grim battle against deceptive scholarship,' *The Vancouver Sun*, 12 August 2018. [Noted in 20 August 2018 issue of Media Watch (#577, p.17)] https://goo.gl/WY8vYs

Noted in Media Watch 19 March 2018 (#555, p.15):

- CANADA | *University Affairs* – 5 March 2018 – **'Poor quality, predatory conferences prey on academics.'** Many publishers of deceptive or poor-quality academic journals have created a big sideline business organizing equally questionable academic conferences. Yet some professors don't seem to be getting the message to stay away. McGill University professor Eduardo Franco discovered last year, to his dismay, that OMICS International, one of these publishers, listed 220 McGill professors whom the company claimed had served as "editors, contributors and speakers" for OMICS journals and conferences. **Full text:** https://goo.gl/h5G9ed

  N.B. OMICS publications include the *Journal of Palliative Care & Medicine*: http://goo.gl/ieTbLZ. In November 2017, a U.S. federal court granted a preliminary injunction against OMICS requested by the Federal Trade Commission "temporarily halting the deceptive practices" of the publisher.

Media Watch: Editorial Practice

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

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2. Links are checked and confirmed as active before each edition of the weekly report is distributed.
3. Links often remain active, however, for only a limited period of time.

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4. Access to a complete article, in some cases, may require a subscription or one-time charge.
5. If a link appears broken or inactive, try copying/pasting the URL into the address bar of your browser or, alternatively, Google the title of the article or report, and the name of the source.
6. Due to its relevance, an article may be listed but for which a link is not available; access, therefore, may only be possible directly from the source (e.g., publication) or through the services of a library.

Something Missed or Overlooked?

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

Search Back Issues of Media Watch @ http://goo.gl/frPgZ5

Media Watch: Access on Online

International

INTERNATIONAL ASSOCIATION FOR HOSPICE & PALLIATIVE CARE: https://goo.gl/RoL82M

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

PALLIATIVE CARE NETWORK: https://goo.gl/YBP2LZ

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']

Canada

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

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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/lOSNC7

Europe

HUNGARY | Magyar Hospice Alapítvány: https://goo.gl/L7D2hw

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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