

# Palliative Care Journal Watch

A partnership between Pallium Canada and several Divisions of Palliative Care and Medicine across Canada and Internationally:

McMaster University, University of Calgary, University of Alberta, Queens University, University of Toronto, McGill University, University of Manitoba, Hadassah-Hebrew University Medical Center

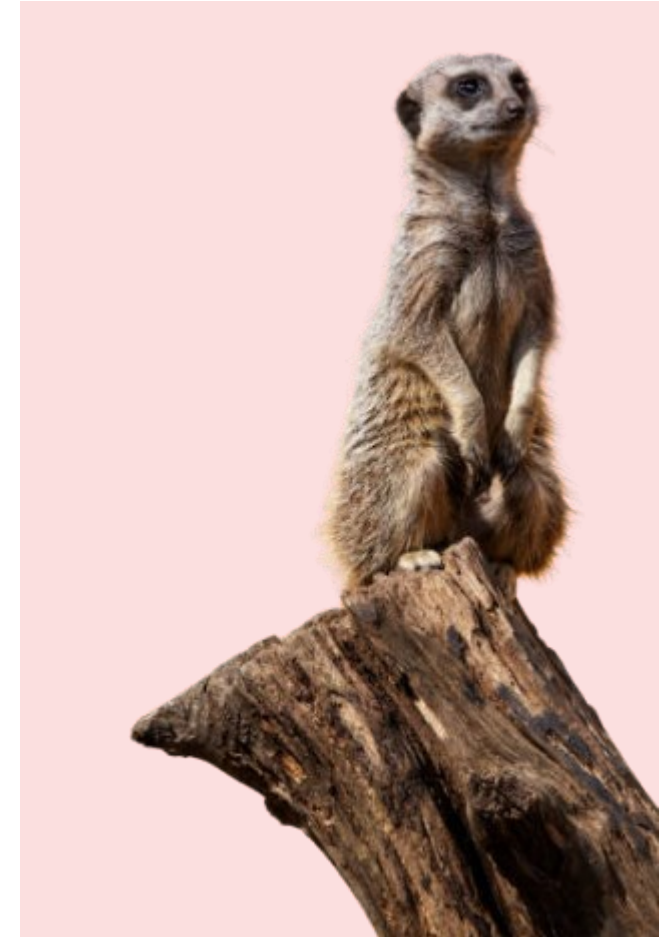


**Hosts & Panelists:** Dr. Jose Pereira, Dr. Leonie Herx, Dr. Sharon Watanabe, Dr. Aynharan Sinnarajah

**Date:** April 7th, 2025

# Welcome to the Palliative Care Journal Watch!

- Keeps you up to date on the latest peer-reviewed palliative care literature.
- Led by palliative care experts from several divisions of palliative care/medicine across Canada and internationally.
  - McMaster University
  - Queen's University
  - McGill University
  - University of Toronto
  - University of Manitoba
  - University of Calgary
  - University of Alberta
  - Hadassah-Hebrew University Medical Center in Israel.
- We regularly monitor over 30 journals and highlight articles that challenge us to think differently about a topic or confirm our current practices.



# The Palliative Care ECHO Project

The Palliative Care ECHO Project is a 5-year national initiative to cultivate communities of practice and establish continuous professional development among health care providers across Canada who care for patients with life-limiting illness.

The Palliative Care ECHO Project is supported by a financial contribution from Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.



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# What to expect from today's session

- We will present and discuss our featured selections and provide a list of honourable mentions.
- Please submit questions through the Q&A function.
- This session is being recorded and will be shared with registrants within the next week.
- This 1 credit-per-hour Group Learning program has been certified by the College of Family Physicians of Canada for up to **8 Mainpro+ credits** (each 1-hour session is worth 1 Mainpro+ credit).

# Introductions

**Dr. José Pereira, MBChB, CCFP(PC), MSc, FCFP, PhD**

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Clinical Professor, Division of Palliative Care, Department of Family Medicine, McMaster University, Hamilton, ON, Canada

Scientific Advisor and Co-Founder, Pallium Canada

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Cross Cancer Institute, Edmonton Zone, Alberta Health Services

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# Disclosures

## Pallium Canada

- Not-for-profit.
- Funded by:
  - Health Canada (through contribution agreements 2001-2007, 2013-2018), Patrick Gillin Family Trust (2013-2016), Li Ka Shing Foundation (2019 to current), CMA (2019 to 2022), Boehringer Ingelheim (dissemination of LEAP Lung courses 2019 to current).
  - Partnerships with some provincial bodies.
  - Revenues from LEAP course registration fees and licenses, sales of Pallium Palliative Pocketbook.

## This ECHO program has received financial support from:

- Health Canada in the form of a contribution program.

## Disclosures of Hosts/Guest Panelists:

- Dr. José Pereira: Scientific Advisor, Pallium Canada.
- Dr. Leonie Herx: No conflicts of interest to declare.
- Dr. Sharon Watanabe: No conflicts of interest to declare.
- Dr. Aynharan Sinnarajah: No conflicts of interest to declare.

## Mitigating Potential Biases:

- The scientific planning committee had complete independent control over the development of course content.

# Featured articles

- Yamaguchi T, Matsuda Y, Watanabe H, et al. **Treatment Recommendation for Dyspnea in Patients with Advanced Disease: Revised Clinical Guidelines from the Japanese Society for Palliative Medicine.** Journal of Palliative Medicine. 2024;27(10):1404-1414. [10.1089/jpm.2023.0667](https://doi.org/10.1089/jpm.2023.0667)
- Smallwood NE, Pascoe A, Wijsenbeek M, et al. **Opioids for the palliation of symptoms in people with serious respiratory illness: a systematic review and meta-analysis.** Eur Respir Rev. 2024;33(174):230265. doi:10.1183/16000617.0265-2023
- Grudzen CR, Siman N, Cuthel AM, et al. **Palliative Care Initiated in the Emergency Department: A Cluster Randomized Clinical Trial.** JAMA. 2025;333(7):599-608. doi:[10.1001/jama.2024.23696](https://doi.org/10.1001/jama.2024.23696)
- Zhang Y, Kesler SR, Dietrich J, Chao HH. **Cancer-Related Cognitive Impairment: A Practical Guide for Oncologists.** JCO Oncol Pract. Published online March 5, 2025:OP-24-00953. doi [10.1200/OP-24-00953](https://doi.org/10.1200/OP-24-00953)

# Featured Articles



# Treatment Recommendation for Dyspnea in Patients with Advanced Disease: Revised Clinical Guidelines from the Japanese Society for Palliative Medicine

## Article Reference:

Yamaguchi T, Matsuda Y, Watanabe H, et al. Treatment Recommendation for Dyspnea in Patients with Advanced Disease: Revised Clinical Guidelines from the Japanese Society for Palliative Medicine. Journal of Palliative Medicine. 2024;27(10):1404-1414. doi:10.1089/jpm.2023.0667

**Selected by:** Dr. Jose Pereira

**Presented by:** Dr. Jose Pereira

## Background

- Dyspnea common symptom in pts with advanced diseases
  - Prevalence of 50%–70% in advanced cancer, and up to 90%) in other advanced noncancer diseases (e.g., COPD, HF)
  - Related to poor QOL
- The Japanese Society for Palliative Medicine (JSPM) published clinical guidelines for respiratory symptoms in cancer pts in 2011. Revised in 2016.

## Objective

- Update of guidelines given growing importance of palliative care for noncancer patients,

# Treatment Recommendation for Dyspnea in Patients with Advanced Disease: Revised Clinical Guidelines from the Japanese Society for Palliative Medicine

## Article Reference:

Yamaguchi T, Matsuda Y, Watanabe H, et al. Treatment Recommendation for Dyspnea in Patients with Advanced Disease: Revised Clinical Guidelines from the Japanese Society for Palliative Medicine. Journal of Palliative Medicine. 2024;27(10):1404-1414. doi:10.1089/jpm.2023.0667

**Selected by:** Dr. Jose Pereira

**Presented by:** Dr. Jose Pereira

## Methods

- Clinical questions developed by consensus meeting of taskforce members
  - 6 palliative care physicians, 1 nurse specialist, 1 pharmacist, 1 epidemiologist.
  - Included patient-family representatives
- Nonpharmacological treatments (O<sub>2</sub>, HFNC, fan t) included for any advanced diseases,
- For pharmacological treatments (opioids, BDZ, and CS): only cancer
- Systematic reviews (SRs) conducted for each CQ
  - Searched Cochrane Central Register of Controlled Trials, MEDLINE, Embase, and Ichushi-web; articles published before September 23, 2019.
- For CQs re pharmacological interventions: RCTs, non-RCTs, and observational studies with control groups were evaluated.
- Selection strategy:
  - (1) if there were at least two RCTs, inclusion was completed;
  - (2) if there was no or only one RCT, non-RCTs or observational studies with control groups were included;
  - (3) if there were no RCTs, non-RCTs, or observational studies with control groups, single-arm observational studies were included.
  - Case reports and case series were excluded
- Assessed risk of bias (Minds Manual 2020)
- Draft recommendations:
  - Drafted by taskforce group
  - Then modified Delphi process (taskforce members + reps of 8 stakeholder societies)
  - Consensus after 3 rounds
  - Then external peer review (7 reviewers: pall care, primary care, resp therapist)
  - Mind's grading system: Strength of recommendation & level of evidence

# Treatment Recommendation for Dyspnea in Patients with Advanced Disease: Revised Clinical Guidelines from the Japanese Society for Palliative Medicine

## Article Reference:

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**Selected by:** Dr. Jose Pereira

**Presented by:** Dr. Jose Pereira

## Key Results

### • O2 therapy

- CQ 1-1: *Is supplemental oxygen useful for dyspnea in patients with advanced disease with hypoxemia at rest?*
- CQ 1-2: *Is supplemental oxygen useful for dyspnea in patients with advanced disease without hypoxemia at rest?*
- **Supplemental oxygen during exertion (22 RCTs, etc)**
  - *Recommendation 1-2a: Supplemental oxygen during exertion is suggested for dyspnea in patients with advanced disease without hypoxemia at rest (2B).*
- **Short-burst oxygen**
  - *Recommendation 1-2b: Short-burst oxygen is not suggested for dyspnea in patients with advanced disease without hypoxemia at rest (2B).*
- **High-flow nasal cannula oxygen therapy**
  - *Recommendation 2: High-flow nasal cannula oxygen therapy is suggested for dyspnea in patients with advanced disease with hypoxemia that is refractory to standard oxygen therapy (2C).*

### • Opioids

- CQ4-1: *Is systemic morphine useful for treating dyspnea in patients with advanced cancer?*
- 7 RCTs
  - *Recommendation 4-1: Systemic morphine is recommended for dyspnea in patients with advanced cancer (1B).*
- CQ4-2: *Is systemic oxycodone useful for treating dyspnea in patients with advanced cancer?*

### • Read article for recommendations re other interventions

## **Treatment Recommendation for Dyspnea in Patients with Advanced Disease: Revised Clinical Guidelines from the Japanese Society for Palliative Medicine**

### **Article Reference:**

Yamaguchi T, Matsuda Y, Watanabe H, et al. Treatment Recommendation for Dyspnea in Patients with Advanced Disease: Revised Clinical Guidelines from the Japanese Society for Palliative Medicine. Journal of Palliative Medicine. 2024;27(10):1404-1414. doi:10.1089/jpm.2023.0667

**Selected by:** Dr. Jose Pereira

**Presented by:** Dr. Jose Pereira

## **Key Discussion Points**

- “These guidelines are derived from a combination of the best available evidence and expert consensus.”
- “It is crucial to acknowledge that the evidence levels for most recommendations remain low, primarily owing to the challenges of conducting high-quality clinical research in vulnerable advanced disease patients, including ethical conflicts.”
- Need to consider pharmaco-economic outcomes and the availability of devices and medications.
- Consider patient’s preferences.
- Useful flow diagram in paper to help decision making

## **Strengths and Limitations**

- Extensive and large process
- Limitations: excluded non-cancer illnesses for pharmaceutical approaches.
- Selection process in systematic review?

## **Practice Impact**

- Useful for clinical practice

# Discussion

# Opioids for the palliation of symptoms in people with serious respiratory illness: a systematic review and meta-analysis

## Article Reference:

Smallwood NE, Pascoe A, Wijsenbeek M, et al. Opioids for the palliation of symptoms in people with serious respiratory illness: a systematic review and meta-analysis. Eur Respir Rev. 2024;33(174):230265. doi:10.1183/16000617.0265-2023

**Selected by:** Dr. Jose Pereira

**Presented by:** Dr. Jose Pereira

## Background

- People living with serious respiratory illness experience a high burden of distressing symptoms, including dyspnea.
- Serious illness = “a condition that carries a high risk of mortality, negatively impacts quality of life and daily function, and is burdensome in terms of symptoms, treatments or caregiver stress”
- Breathlessness = subjective experience of breathing discomfort
  - Can vary in intensity and quality
- Opioids are recommended when breathlessness chronic and distressing despite optimizing disease modifying treatments
  - But “their benefits are unclear”

## Study Objective

- Study the effectiveness (efficacy) and safety of opioids for symptom management in people with serious respiratory illness

# Opioids for the palliation of symptoms in people with serious respiratory illness: a systematic review and meta-analysis

## Article Reference:

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**Selected by:** Dr. Jose Pereira

**Presented by:** Dr. Jose Pereira

## Methods

- Systematic review and meta-analysis
- Embase, MEDLINE and the Cochrane Central Register of Controlled Trials
- Searched up to 11 July 2022
- Inclusion criteria
  - Serious respiratory illnesses (COPD, IDL, etc)
  - RCTs of opioids to treat symptoms in people with serious respiratory illness
- Exclusion criteria
  - <80% of participants having a nonmalignant lung disease
- Primary outcome (breathlessness) & secondary outcomes (QoL, cough, arterial blood gas parameters): validated instruments,
- Risk of bias assessed (Cochrane Risk of Bias tool V1)
- Stats
  - Standardised mean differences (SMDs) for continuous data or odds ratios for dichotomous data (adverse events)
  - Estimates interpreted with effect sizes (Cohen)



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**Selected by:** Dr. Jose Pereira

**Presented by:** Dr. Jose Pereira

## Key Results

- 17 studies included
  - 6 laboratory-based exercise trials (n=70)
  - 10 home studies measuring breathlessness in daily life (n=788)
  - One (n=18) conducted in both settings.
- “Home studies”: ≥ 4 days consecutively on opioid
- Laboratory studies:
  - All were small ( $n \leq 20$ )
  - Some only single or limited doses (x5)
- All except 1 opioid compared to placebo
- “Overall certainty of evidence was “very low” to “low”.”
  - “five had a high risk of bias in one domain and an additional 10 had an unclear risk of bias in up to three domain”
  - “12 studies deemed unclear risk due to a lack of prospectively registered outcome reporting plans”
- Opioids reduced breathlessness during laboratory exercise testing (SMD -0.37), but not breathlessness measured in daily life (SMD -0.10).
- No effects on HRQoL or cough found.
- Side effects
  - In at-home studies, opioids led to increased frequency of nausea/vomiting (OR 3.32), constipation (OR 3.08) and drowsiness (OR 1.37)
  - “Some serious adverse events identified (hospitalisation and death)”
    - Reported in 1 RCT (33% of participants)



# Opioids for the palliation of symptoms in people with serious respiratory illness: a systematic review and meta-analysis

## Article Reference:

Smallwood NE, Pascoe A, Wijsenbeek M, et al. Opioids for the palliation of symptoms in people with serious respiratory illness: a systematic review and meta-analysis. Eur Respir Rev. 2024;33(174):230265. doi:10.1183/16000617.0265-2023

**Selected by:** Dr. Jose Pereira

**Presented by:** Dr. Jose Pereira

## Key Discussion Points

Authors write:

- “This systematic review and meta-analysis identified that opioids, when compared to placebo, had no statistically or clinically significant effect on breathlessness outcomes measured pragmatically in daily life at home in people with nonmalignant serious respiratory illness.”
- “The treatment-emergent adverse events reported in the included studies were often mild and self-limiting on withdrawal of opioids, though it should be noted that even low-grade adverse events can be detrimental to quality of life ...”
- Mechanisms of action of opioids to reduce breathlessness poorly understood.

## Strengths and Limitations

- Strengths
  - 2 settings (home and lab) and RCTs
- Limitations: homogeneity of participants

## Practice Impact

- Absence of evidence is not evidence of absence
- As per authors: “There are limited data on the use of opioids to treat breathlessness in people with nonmalignant serious respiratory illness who are at the very end of life. Given that many physicians consider prescribing opioids only in an end-of-life, palliative care setting, it is important to not rule out a potential beneficial treatment effect in this circumstance.”
- Some patients may still benefit (where benefits outweigh burdens).
- Be more selective and prudent when considering opioids in these cases

# Discussion

# Palliative Care Initiated in the Emergency Department: A Cluster Randomized Clinical Trial

## Article Reference:

Grudzen CR, Siman N, Cuthel AM, et al.

**Palliative Care Initiated in the Emergency Department: A Cluster Randomized Clinical Trial.** *JAMA*. 2025;333(7):599-608.  
doi:[10.1001/jama.2024.23696](https://doi.org/10.1001/jama.2024.23696)

## Selected by:

Dr. Aynharan Sinnarajah

## Presented by:

Dr. Aynharan Sinnarajah

## Background

- Emergency department (ED) offers an opportunity to initiate palliative care for older adults with serious, life-limiting illness
- US: 50% visit ED in last month of life; 75% in last 6 months of life
- Prior study showed Palliative care consultation for patients with advanced cancer improved QoL at 12 weeks
- Effectiveness of primary palliative care delivered by emergency clinicians needs to be tested

## Study Objective

- Primary outcome: Effect of a multicomponent primary palliative care intervention in the ED on **hospital admission** in older adults with serious, life-limiting illness
- Secondary outcome: Effect of the intervention on subsequent health care use and survival (6 months) in this population

## Methods

- Cluster randomized, stepped-wedge design
- 29 EDs across the US (36 EDs initially assessed)
- Physicians, NPs, PAs, Nurses
- Intervention (4): Education (1hr), training (4h simulation workshop on SIC), clinical decision support, and audit and feedback for ED clinical staff
- May 1, 2018 – Dec 31, 2022
- Patients aged  $\geq 66$  yo
- Gagne comorbidity score  $> 6$ , representing a risk of short-term mortality greater than 30%
- Excluded: Nursing home patients, prior hospice patients

# Palliative Care Initiated in the Emergency

## Department: A Cluster Randomized Clinical Trial

### Article Reference:

Grudzen CR, Siman N, Cuthel AM, et al.  
**Palliative Care Initiated in the Emergency Department: A Cluster Randomized Clinical Trial.** *JAMA*. 2025;333(7):599-608.  
doi:[10.1001/jama.2024.23696](https://doi.org/10.1001/jama.2024.23696)

### Selected by:

Dr. Aynharan Sinnarajah

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## Key Results

- 98,922 ED visits
- No difference in hospital admission rates between the preintervention and postintervention periods, even after adjusting for temporal trends and the COVID-19 pandemic (64.4% vs 61.3%; OR 1.03 (0.93 – 1.14))
- No differences in secondary outcomes like ICU admission (7.8% vs 6.7%), ED revisits (34.2% vs 32.2%), hospice use (17.7% vs 17.2%), home health use (42.0% vs 38.1%), or hospital readmissions (41.0% vs 36.6%) between the two periods.
- No difference in death at 6 months (28.1% vs 28.7%); Average: 17d

## Strengths and Limitations

- Results of pre-intervention palliative care skills / knowledge assessment not presented
- The stepped-wedge design is vulnerable to external factors that could influence the primary outcome
- COVID-19 pandemic significantly impacted ED care, making it difficult to distinguish the effects of the intervention from the effects of the pandemic
  - E.g. Many home / hospice agencies refused to accept patients with COVID-19, or short on staffing
- No communication skills training to trainees
- High staff turnover (nurses) → No palliative training

## Palliative Care Initiated in the Emergency Department: A Cluster Randomized Clinical Trial

### Article Reference:

Grudzen CR, Siman N, Cuthel AM, et al.  
**Palliative Care Initiated in the  
Emergency Department: A Cluster  
Randomized Clinical Trial.** *JAMA*.  
2025;333(7):599-608.  
doi:[10.1001/jama.2024.23696](https://doi.org/10.1001/jama.2024.23696)

### Selected by:

Dr. Aynharan Sinnarajah

### Presented by:

Dr. Aynharan Sinnarajah

## Key Discussion Points

- No impact found
- Education (1 + 4 hrs), Clinical decision support, Audit/feedback: Not enough
- Is hospital admission an acceptable outcome? (considering mortality risk as low as 30%)
  - What if stratify by mortality risk?
- High mortality that's short → Too late to have impact?
- integration with community resources / palliative care?
- Some ED sites had lower hospital admission → Random vs Site specific facilitators?
- Was intervention targeted based on pre-assessment skills / knowledge?
- Editorial: *“Large-scale supportive care interventions designed to enhance care should not presume that palliative care education is the primary deficit, especially while neglecting new or additional resources that may be required to deliver adequate palliative care”*

## Practice Impact

- Still awaiting high quality primary palliative care evidence
- Is it time to focus on advocating for more specialist palliative care workforce?
- Continue to support EDs in palliative consultation and mentoring / advocacy

# Discussion

# Cancer-Related Cognitive Impairment: A Practical Guide for Oncologists

## Article Reference:

Zhang Y, Kesler SR, Dietrich J, Chao HH.  
JCO Oncol Pract 2025; 00:1-5,  
DOI. <https://doi.org/10.1200/OP-24-00953>

**Selected by:** Sharon Watanabe

**Presented by:** Sharon Watanabe

## Background

- Cancer-related cognitive impairment (CRCI) is caused by cancer or its treatment
- Affects 60-70% or more of patients with cancer
- Significantly impacts wellbeing
- Often not recognized

## Publication Objective

- Raise awareness of CRCI and provide recommendations on screening and management

## Key Discussion Points

- Diagnostic challenges
  - Cognitive tests often normal/slightly impaired
  - Comorbidities may also affect cognition
  - Do not dismiss (“medical gaslighting”)
- Lack of standardized and evidence-based interventions

## Practice Impact

- Routine screening: “Have you had any changes in your thinking, memory, or attention? Have these changes affected your daily life?”
- Most robust data supports physical exercise
  - Alternatives: yoga, mindful meditation/relaxation exercises
- Compensatory strategies e.g. taking notes
- Referrals (depending on resources)

# Discussion



# Honourable Mentions

- Feliciano DR, Reis-Pina P. **Enhancing End-of-Life Care With Home-Based Palliative Interventions: A Systematic Review.** *J Pain Symptom Manage.* 2024;68(5):e356-e372. doi:10.1016/j.jpainsymman.2024.07.005
- Brown A, Yardley S, Bowers B, et al. **Multiple points of system failure underpin continuous subcutaneous infusion safety incidents in palliative care: A mixed methods analysis.** *Palliat Med.* 2025;39(1):7-21. doi:[10.1177/02692163241287639](https://doi.org/10.1177/02692163241287639)
- Austin PD, Lee W, Keall R, Lovell MR. **Efficacy of spiritual interventions in palliative care: An umbrella review of systematic reviews.** *Palliat Med.* 2025 Jan;39(1):70-85. doi: 10.1177/02692163241287650. Epub 2024 Oct 16. PMID: 39412883; PMCID: PMC11673315.
- Sachs GA, Johnson NM, Gao S, Torke AM, Hickman SE, Pemberton A, Vrobel A, Pan M, West J, Kroenke K. **Palliative Care Program for Community-Dwelling Individuals With Dementia and Caregivers: The IN-PEACE Randomized Clinical Trial.** *JAMA.* 2025 Jan 29:e2425845. doi: 10.1001/jama.2024.25845. Epub ahead of print. PMID: 39878993; PMCID: PMC11780502.
- Lau WK, Fehnel CR, Macchi ZA, et al. **Research Priorities in Neuropalliative Care: A Consensus Statement From the International Neuropalliative Care Society.** *JAMA Neurol.* 2025;82(3):295. doi:10.1001/jamaneurol.2024.4932
- Jones KF, Liou KT, Ashare RL, et al. **How Racialized Approaches to Opioid Use Disorder and Opioid Misuse Management Hamper Pharmacoequity for Cancer Pain.** *JCO.* 2025;43(1):10-14. doi:10.1200/JCO.24.00705

# Wrap-up

- Please fill out our feedback survey a link has been shared in the chat!
- A recording of this webinar and a copy of the slides will be e-mailed to registrants within the next week.
- To listen to this session and previous sessions, check out the **Palliative Care Journal Watch** podcast.



NOTE: recordings, slides and links to articles from all our sessions are available at [www.echopalliative.com/palliative-care-journal-watch/](http://www.echopalliative.com/palliative-care-journal-watch/).

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# Thank You



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