

cess to multidisciplinary palliative care teams.

In conclusion, rather than more research, we may need more education, more practical solutions and more compassion.

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The recent study by Daren Heyland and associates¹ provides excellent insight into the wishes and priorities of seriously ill patients and their family members. The authors note that the perception of "what matters most" in end-of-life care varies widely between different patient groups and their family members, which indicates the need for individualized care.

In our own medical oncology practice we find that this variability in "what matters most" exists not only between patient groups but also at different stages of a patient's illness. The large discrepancy between desired and actual place of death for patients with metastatic breast cancer may be an example of this. Our data for patients who died with this disease revealed that 71% wished to die at home, but only 33% were able to do so.² This difference probably reflects a complicated combination of the difficulties in coordinating palliative care services and changing perceptions of and decisions

about end-of-life care by patients and their caregivers as the patients' condition deteriorates. Therefore, decisions and communication about end-of-life care not only need to be individualized, but also need to be reassessed frequently.

Hopefully, through awareness of these key issues, we can improve the quality of end-of-life care for all terminally ill patients.

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[Three of the authors respond:]

Katharina Manassis seems to take exception to our call¹ for more research in the area of end-of-life care, suggesting that "more education, more practical solutions and more compassion" are what are required to fix the problem. Although this is true, we believe it is not sufficient. Most of the patients we serve at the end of life (and their families) are very dissatisfied with the care they receive.² Overall, we do agree that more educational and clinical resources need to be applied to caring for patients with terminal and chronic diseases. In this regard, we are pleased that Associated Medical Services of Ontario has stepped forward to fund fellowships in end-of-life care in Ontario teaching hospitals.³ The fellows will endeavour to promote excellent care of the terminally ill, quality improvement initiatives and curriculum developments that will ultimately translate into improved care for these patients.

However, as a discipline, palliative and end-of-life care, relative to other medical disciplines, stands on a weak

evidentiary basis informing us about best practice and how it is optimally achieved in various circumstances. We think it is misguided to assume that we now have all the solutions to quality-of-care problems in our health care system. Accordingly, the Canadian Institutes of Health Research (CIHR) has allocated over \$14 million to establish end-of-life research teams across the country and has recently dedicated a specific committee to review all grants in this area.⁴ These positive developments increase the likelihood that future educational and clinical interventions will be supported by substantial research evidence.

We agree with Christine Simmons and Mark Clemons that communication and decision-making at the end of life are best viewed as a process, not an event, which requires frequent reassessments. Unfortunately, our fragmented, discontinuous health care system makes this kind of care challenging. We hope that future research by the Canadian Researchers End-of-Life Network and other CIHR-funded teams will illuminate the strategies needed to optimize communication and decision-making for dying patients and their families.

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