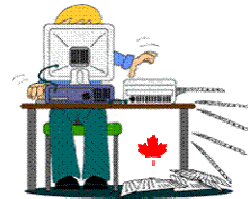


Media Watch...

is distributed weekly to my colleagues who are active or have a special interest in **hospice, palliative care** and **end-of-life issues** – to help keep them abreast of current, emerging and related issues, and to also inform discussion and to encourage further inquiry.

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Compilation of Media Watch 2008, 2009, 2010, 2011 ©

Compiled & Annotated by Barry R. Ashpole

National conversation about end-of-life care: Scroll down to U.S.A. and 'Americans choose quality over quantity at the end of life, crave deeper public discussion of care options' (p.2), for the findings of a country-wide opinion poll.

Canada

National standard eyed for care providers

NEW BRUNSWICK | *Telegraph-Journal* (Saint John) – 11 March 2011 – The number of unregulated health care workers is increasing rapidly in Canada – providing care in retirement homes, long-term care institutions, hospitals and palliative care facilities. The Canadian Association of Continuing Care Educators is leading an initiative to develop a set of basic competencies that could become a national educational standard for personal care providers. <http://telegraphjournal.canadaeast.com/news/article/1387705>

Former senator Pat Carney weighs in on ... hospice dispute

BRITISH COLUMBIA | Straight.com (Vancouver) – 10 March 2011 – The controversy over a proposed University of British Columbia hospice isn't about to die anytime soon. A position taken by the University Neighbourhood Association [UNA] – which functions like a municipal council on campus – on the planned 15-bed palliative-care facility has sparked a revolt among local residents. Retired Canadian senator Pat Carney, a campus resident, has written the UNA board to express her concern about the "inappropriate action" the association has taken by supporting a group of Asian residents of the upscale Promontory condominium tower who oppose having the St. John Hospice built next door. Citing traditional beliefs, the Promontory residents have claimed that living near a hospice brings bad luck to its neighbours. But this has been discredited by prominent members of the Chinese Canadian community as a misrepresentation of Chinese culture. <http://www.straight.com/article-379927/vancouver/pat-carney-weighs-ubc-hospice-dispute>

From Media Watch dated 24 January 2011:

- *GLOBE & MAIL* | Online report – 18 January 2011 – '**Hospice critics don't speak for us, Chinese community says.**' Distancing themselves from condo owners who have opposed a hospice on cultural grounds, Chinese community representatives say that while residents' concerns may reflect some aspects of Chinese folklore, it is false to claim that living next door to a hospice is incompatible with Chinese culture. <http://www.theglobeandmail.com/news/national/british-columbia/hospice-critics-dont-speak-for-us-chinese-community-says/article1875103/>

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- CTV NEWS | Online report – 8 March 2011 – '**Latimer: No regrets about killing disabled daughter.**' Saskatchewan farmer Robert Latimer didn't spend much time thinking about the personal consequences he would face for killing his severely disabled daughter in 1993 – her daily pain and suffering, he says, were the only things on his mind. Latimer told CTV ... he certainly didn't expect that his decision to end Tracy's life would trigger a storm that would envelop his own life for years to come. <http://calgary.ctv.ca/servlet/an/local/CTVNews/20110307/latimer-ctv-interview-1100307/20110307/?hub=CalgaryHome>
- BRITISH COLUMBIA | *Vancouver Sun* – 7 March 2011 – '**Assisted suicide shrouded in secrecy.**' Nearly 20 years ago Sue Rodriguez asked: "Who owns my life?" In a 5-4 ruling, the Supreme Court of Canada answered with a blunt "Not you." Nevertheless, Rodriguez ended her life in the compassionate presence of Member of Parliament Svend Robinson and with the assistance of an anonymous physician who broke the criminal law prohibiting assisted suicide. The Farewell Foundation for the Right to Die ... is asking that question in the form of a constitutional challenge. <http://www.vancouversun.com/news/Assisted+suicide+shrouded+secrecy/4394180/story>

U.S.A.

Americans choose quality over quantity at the end of life, crave deeper public discussion of care options

NATIONAL JOURNAL & THE REGENE FOUNDATION | Press release – 8 March 2011 – A national poll ... finds that more than 70% of Americans believe enhancing the quality of life – not just extending the length of it – should be a priority at the end of life. The poll ... shows over-whelming majorities also want a more open public dialogue about the issues and options surrounding end-of-life care ... and that Americans believe such discussions should be fully covered by both Medicare and private insurance. And at a time when much of the national conversation about end-of-life care has taken on the pitched rhetoric of a political battle, the poll shows notably little difference of opinion across political

affiliations. <http://www.sys-con.com/node/1744606>

Specialist Publications

Of particular interest:

'Mandatory screening increases palliative care, cuts costs,' (p.6) published in *Internal Medicine News*; **'Palliative care consultation teams cut hospital costs for Medicaid beneficiaries'** (p.6), published in *Health Affairs*; and, **'Rethinking hospice eligibility criteria'** (p.7), published in the *Journal of the American Medical Association*.

- NATIONAL JOURNAL | Online article – 8 March 2011 – '**Dancing around death (panels).**' A *National Journal*-sponsored study ... reveals that 93% of Americans believe conversations about care at the end-of-life should be a top priority of the U.S. health care system. But when the opportunity arose in 2009, many politicians wavered in their stance on who should be instigating these conversations, whether they're among family members, patient and doctor, or insurance providers. Here's what's been said – and often taken back – about end-of-life care during the health care debate. <http://www.nationaljournal.com/dancing-around-death-panels--20110308>

Media Watch posted on Palliative Care Network-e Website

Palliative Care Network-e (PCN-e) promotes education amongst health care providers in places around the world where the knowledge gap may be wider than the technology gap ... to foster teaching and interaction, and the exchange of ideas, information and materials. <http://www.pcn-e.com/community/>

Reimbursements cuts will negatively affect hospice care – particularly in rural America

CALIFORNIA | *Sacramento Bee* – 7 March 2011 – A ... study focusing on the projected margins of the hospice community found that, as a result of two recent cuts to Medicare reimbursement ... the overall median Medicare profit margin for the hospice community could decrease from minus 2% in 2008 to minus 14% by 2019. Hospices caring for Americans in rural areas would be the most severely affected, with median profit margin decreases ranging from minus 2% in 2008 to minus 19% by 2019. The National Hospice & Palliative Care Organization released the results of the study commissioned as part of its ongoing work to protect patient access to hospice in America.¹ <http://www.sacbee.com/2011/03/07/3455440/reimbursement-cuts-will-negatively.html>

1. National Hospice & Palliative Care Organization press release, 7 March 2011. <http://www.nhpc.org/i4a/pages/index.cfm?pageid=6459>

House passes bill to resolve conscience conflict

IDAHO | Press Association – 7 March 2011 – Under a bill passed by the Idaho House [of Representatives], doctors who object to their patients' dying wishes must make a good-faith effort to refer them to another physician who is willing to provide the treatment. Monday's 51-17 vote sending the bill to the Senate seeks to resolve what Republican supporters called a "narrow conflict" between a 1988 law governing living wills and last year's measure allowing health care workers to bow out of providing care that violates their ethics. Democrats and some GOP [Grand Old Party, i.e., Republican] lawmakers alike agreed that the 2010 law could interfere with a person's end-of-life wishes, but how to resolve the conflict remained in dispute. Republicans said their bill remedies the problem, but groups such as AARP [American Association for Retired Persons] and Democratic legislators argued that it puts people's dying wishes in limbo. <http://washingtonexaminer.com/news/2011/03/house-passes-bill-resolve-conscience-conflict>

Of related interest:

- *JOURNAL OF MEDICAL ETHICS* | Online article – 9 March 2011 – '**Conscientious refusals to refer: Findings from a national physician survey.**' Data suggest there is no uncontroversial way to resolve conflicts posed when patients request interventions that their physicians cannot in good conscience provide. <http://jme.bmj.com/content/early/2011/03/09/jme.2010.041194.abstract>

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- IDAHO | *Spokesman-Review* (Boise) – 12 March 2011 – '**Idaho Senate passes bill to make assisted suicide a felony.**' The Idaho Senate voted overwhelmingly ... to make assisted suicide a felony, revoke the licenses of doctors who violate the law and allow people to get injunctions to block anyone they think might be planning an assisted suicide. Sen. Russ Fulcher ... said several of Idaho's surrounding states, including Washington, permit assisted suicide, and he doesn't think Idaho should go that way. <http://www.spokesman.com/stories/2011/mar/12/idaho-senate-passes-bill-to-make-assisted-suicide/>
- WASHINGTON | *Seattlepi.com* – 10 March 2011 – '**87 people got assisted-suicide drugs in Washington in 2010.**' Eighty-seven people received medication to end their lives last year with the help of 68 doctors and 40 pharmacists, the state Department of Health reported. Of the people who got drugs under Washington's Death with Dignity Act, 51 are known to have died from the medication. http://www.seattlepi.com/local/436911_death.html?source=myspi
- VERMONT PUBLIC RADIO | Online report – 8 March 2011 – '**Vermont faces emotional debate over "death with dignity" bill.**' Supporters call it "death with dignity" and opponents call it "physician-assisted suicide." For both sides, the debate over whether physicians should be able to help people die is emotional and contentious. And new legislation introduced last month in the Vermont House [of Representatives] is bringing the issue back to the forefront. Already advocacy organizations on both sides are coming out in force. http://www.vpr.net/news_detail/90248/

International

Study into coma patients

U.K. (SCOTLAND) | *Scotsman* – 10 March 2011 – Pioneering brain-imaging techniques are being developed by Scottish scientists to gain a fresh insight into patients who have been left in a coma. The new Coma Science Group at Aberdeen University aims to discover to what extent coma patients and those in a persistent vegetative state may be aware of their surroundings. Christian Schwarzbauer, professor of neuro-imaging at Aberdeen University, is leading the research. <http://news.scotsman.com/health/Study-into-coma-patients-6731407.jp>

From Media Watch dated 1 November 2010:

- CANADA | *Globe & Mail* – 29 October 2010 – **'Vegetative patients may be aware, newly-recruited researcher says.'** [Neuroscientist] Adrian Owen [recently relocated from the U.K. to the University of Western Ontario] ... has pioneered a new way to communicate with seemingly unconscious patients by putting them in a brain imager and asking them to think particular kinds of thoughts. <http://www.theglobeandmail.com/news/national/vegetative-patients-may-be-aware-newly-recruited-researcher-says/article1779227/>

Funerals and the environment

The latest in eco-funerals: Terminator-style nitrogen shattering

SWEDEN | *DVICE* – 8 March 2011 – Traditional funerals are apparently pretty bad for the environment. Embalming fluid is toxic stuff. Coffins are often made of metal, which doesn't biodegrade, or wood finished with nasty chemicals. And even the cremation route uses scads of energy and releases mercury into the atmosphere. A Swedish company ... has come up with a crazy new way of handling the remains of the deceased, and it's straight out of science fiction. <http://dvice.com/archives/2011/03/the-latest-in-e.php>

From Media Watch dated 15 March 2010:

- *SCIENCE & RELIGION* | Online article – 12 March 2010 – **'Do green graves change the way we mourn?'** Research provides little support for the notion that there is a "right" or "wrong" way to respond to significant losses. <http://www.scienceandreligiontoday.com/2010/03/12/do-green-graves-change-the-way-we-mourn-roxane-cohen-silver-answers/>

Soul midwives: Rethinking a good death

U.K. | *Eulogy* – 8 March 2011 – In a utopian world, perhaps disease and old age would be non-existent, but such is currently not the case; there comes a point at which medicines and machinery can no longer provide a chance of recovery from illness. When death is approaching, the emotional responses of the dying and their loved ones may be vast and complex, ranging from denial to fear. <http://www.eulogymagazine.co.uk/article/features/detail/id/110>



Barry R. Ashpole

My involvement in palliative and end-of-life care dates from 1985. As a communications specialist, I've been involved in or responsible for a broad range of initiatives at the community, regional, provincial and national level. My work focuses primarily on advocacy, capacity building and policy development in addressing issues specific to those living with a life-threatening or 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 courses, and facilitating issue specific workshops, for frontline care providers.

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- AUSTRALIA (NEW SOUTH WALES) | *Sydney Morning Herald* – 11 March 2011 – **'Support for voluntary euthanasia at 85%.'** Support for voluntary euthanasia ... is running at 83%, with only 10% of people implacably opposed, according to a Newspoll. The result ...shows the level of support unchanged since the last survey two years ago. <http://www.smh.com.au/nsw/state-election-2011/support-for-voluntary-euthanasia-at-85-20110310-1bpsm.html>
- INDIA | *Hindustan Times* – 9 March 2011 – **'Families struggle to care for walking dead.'** The families of 10 out of 200 patients in a vegetative state with no hope of recovery ask for active euthanasia, shows data from the All India Institute of Medical Sciences' Trauma Centre. <http://www.hindustantimes.com/Families-struggle-to-care-for-walking-dead/Article1-671109.aspx>
- AUSTRALIA (TASMANIA) | *The Australian* – 8 March 2011 – **'State to push for mercy killing.'** Tasmania is poised to become the first state to legalise voluntary euthanasia and to allow "death with dignity" clinics to operate. Premier Lara Giddings ... [said] ... she was committed to working ... to prepare a private member's bill for voluntary euthanasia. <http://www.theaustralian.com.au/news/nation/state-to-push-for-mercy-killing/story-e6frg6nf-1226017319925>

Three-point leeway in mercy verdict

INDIA | *The Telegraph* (Calcutta) – 9 March 2011 – The Supreme Court appears to acknowledge that certain actions followed in certain critical care situations are "considered normal medical practice." These actions include stopping or not starting medically futile treatment, stopping or not starting a treatment at the patient's request, and speeding up death as a side-effect of treatment necessary for alleviating serious suffering. http://www.telegraphindia.com/1110309/jsp/frontpage/story_13688812.jsp

Media Watch Online

The weekly report can be accessed at several websites, among them:

Canada

Ontario | Hamilton Niagara Haldimand Brant Hospice Palliative Care Network: <http://www.hnhbhpc.net/Resources/UsefulLinks/MediaWatch/tabid/97/Default.aspx>

Ontario | HPC Consultation Services: <http://www.hpconnection.ca/newsletter/inthenews.html>

Ontario | Mississauga Halton Palliative Care Network: <http://www.mhpcn.ca/Physicians/resources.htm>
(Scroll down to 'Newsletters/Media Updates')

U.S.A.

Prison Terminal: <http://www.prisonterminal.com/news%20media%20watch.html>

International

Global | Palliative Care Network Community: <http://www.pcn-e.com/community/search/?tag=Media+Watch>

U.K. | Omega, the National Association for End of Life Care: <http://www.omega.uk.net/news.htm>

Specialist Publications (e.g., in-print and online journal articles, reports, etc.)

Mandatory screening increases palliative care, cuts costs

INTERNAL MEDICINE NEWS | Online article – 7 March 2011 – Within a year of implementation, mandatory palliative care screening significantly increased palliative care consults at St. John Hospital and Medical Center in Detroit. The increased use of palliative care services saved the hospital about \$700,000 in fiscal year 2008, because of shorter lengths of stay and patients opting for less-heroin care, among other factors. St. John Providence Health System now screens patients admitted to St. John and its other four hospitals for palliative care needs, and is incorporating screening into its electronic health record system. A multi-disciplinary working group developed [and tested] a ... checklist... After a year, they streamlined the checklist down to nine items, any one of which triggered a consult. In 2006, before it was implemented, there were 444 palliative care consults; the number increased to 742 in 2007 and to 952 in 2008. The time from admission to consult dropped from about 9 days to about 6. The success led to a system-wide rollout of palliative care screening, with the nine triggers (see sidebar right) now assessed in patients admitted to the health system's five hospitals. <http://www.internalmedicineweb.com/news/geriatric-medicine/single-article/mandatory-screening-increases-palliative-care-cuts-costs/1a386c46ab.html>

Extract from *Internal Medicine News*

Triggers for palliative care consult:

- Code status changed to "do not resuscitate"
- Conflict about starting or stopping life-prolonging treatment
- Discussion about goals of care or code status, and/or surrogate distress about decision making
- A marked decrease in functional status within 2 months
- Uncontrolled symptoms, such as pain or nausea, interfering with quality of life
- Consideration of percutaneous endoscopic gastrostomy tube placement
- Admission from an extended-care facility with dependence for activities of daily living
- Non-ambulatory dementia with no speech, or with recurrent aspiration pneumonia
- A patient or family request for palliative care

Of related interest:

- *HEALTH AFFAIRS*, 2011;30(2):3454-3463. **'Palliative care consultation teams cut hospital costs for Medicaid beneficiaries.'** On average, patients who received palliative care incurred \$6,900 less in hospital costs during a given admission than a matched group of patients who received usual care. These reductions included \$4,098 in hospital costs per admission for patients discharged alive, and \$7,563 for patients who died in the hospital. Consistent with the goals of a majority of patients and their families, palliative care recipients spent less time in intensive care, were

less likely to die in intensive care units, and were more likely to receive hospice referrals than the matched usual care patients. The authors estimate that the reductions in Medicaid hospital spending in New York State could eventually range from \$84 million to \$252 million annually (assuming that 2% and 6% of Medicaid patients discharged from the hospital received palliative care, respectively), if every hospital with 150 or more beds had a fully operational palliative care consultation team. <http://content.healthaffairs.org/content/30/3/454.abstract>

Cont

- *JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION*, 2011;305(10):1031-1032. **'Rethinking hospice eligibility criteria.'** In 2009 there were approximately 5000 hospices in the U.S. compared with 4,160 in 2005. Despite this growth, access to hospice care is still constrained by the eligibility requirements that patients have a prognosis of 6 months or less without life-sustaining treatment and that they forgo life-sustaining treatment related to their hospice admitting diagnosis. <http://jama.ama-assn.org/content/305/10/1031.extract>

End of life care in Bangladesh

Palliative care: We should begin to think

JOURNAL OF BANGLADESH COLLEGE OF PHYSICIANS & SURGEONS, 2011;29(1):1-2. More than a million people die in Bangladesh every year. Approximately 0.6 million of them are estimated to be in need of PC [palliative care] service. More than 4% of the population are aged 65 and above and the number of elderly are on a steady rise. Most of these people are in need of care routinely offered by a palliative care services. To ensure that PC is available and accessible to the majority of the needy, a community-based approach should get appropriate consideration. <http://www.banglajol.info/index.php/JBCPS/article/viewFile/7163/5419>

Of related interest:

- *BMC PALLIATIVE CARE* | Online article – 9 March 2011 – **'End of life care in sub-Saharan Africa: A systematic review of the qualitative literature.'** End of life (EoL) care in sub-Saharan Africa still lacks the sound evidence-base needed for the development of effective, appropriate service provision. This article aims to synthesize qualitative research on EoL care in sub-Saharan Africa to inform policy, practice and further research. It seeks to identify areas of existing research; describe findings specifically relevant to the African context; and, identify areas lacking evidence. <http://www.biomedcentral.com/content/pdf/1472-684x-10-6.pdf>

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 tool or change document.

Distribution

Media Watch is distributed at no cost to colleagues active or with a special interest in hospice, palliative care and end of life issues. Recipients are encouraged to share the weekly report with *their* colleagues. The distribution list is a proprietary one, used exclusively for the distribution of the weekly report and occasional supplements. It is not used or made available for any other purpose whatsoever – to protect the privacy of recipients and also to avoid generating undue e-mail traffic.

Links to Sources

1. Links are checked and confirmed as active before each edition of Media Watch is distributed.
2. Links often remain active, however, for only a limited period of time.
3. Access to a complete article, in some cases, may require a subscription or one-time charge.
4. 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.
5. 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.

Addressing inappropriate care provision at the end-of-life: A policy proposal for hospitals

JOURNAL OF MEDICINE & LAW | Online article – Accessed 13 March 2011 – This paper reviews several aspects of medical futility. The concept of medical futility is presented initially, with its challenges associated with vagueness and ambiguity. Advanced directives in their various forms are then discussed. These directives can provide some guidance to hospital facilities, but also have inherent weaknesses. Law also provides some guidance, but can conflict with other principles such as medical ethics determinations. The empirical experience in jurisprudence involving withholding and withdrawing treatment in two [American] states with competing philosophies, Texas and Ohio, is also reviewed, and indicates benefits but also unintended consequences that provide additional insight as to addressing medical futility in the hospital context. On the basis of these assessments, a model policy is provided guiding institutions to best address the challenges of medical futility at the end-of-life. These guidelines can be adapted to the specific hospital circumstance for best use to ensure hospitals and patient needs are fulfilled. <http://anesthesia.ucsd.edu/research/faculty-research/Documents/LiangStandleyFutility.pdf>

Of related interest:

- *JOURNAL OF MEDICAL ETHICS* | Online article – 10 March 2011 – **'How is informed consent related to emotions and empathy? An exploratory neuroethical investigation.'** This study shows an empirical relationship between decision-making and informed consent, on the one hand, and emotions and empathy on the other. The findings of a relationship between informed consent, emotions and empathy raise important neuroethical questions with regard to an emotional-social concept of informed consent and potential clinical implications for testing informed consent. <http://jme.bmj.com/content/early/2011/03/09/jme.2010.037937.abstract>

Development and evaluation of a staff training program on palliative care for persons with intellectual and developmental disabilities

JOURNAL OF POLICY & PRACTICE IN INTELLECTUAL DISABILITIES | Online article – 9 March 2011 – This paper reports on a three-phase project undertaken to develop, implement, and evaluate a palliative care curriculum and educational program that is responsive to the unique learning needs of staff providing services and supports for individuals with I/DD [intellectual and developmental disabilities] living in long-term care settings. Participants' ratings of their levels of preparation and confidence to provide palliative care improved from pre-training to post-training. Post-training use of materials and practice changes in palliative care occurred. When training is developed in partnership with the staff who will use these training resources, it has the potential to sustain its use and to alter the care practices to address the palliative care needs of persons with I/DD. <http://onlinelibrary.wiley.com/doi/10.1111/j.1741-1130.2011.00288.x/full>

An advance directive in two questions

JOURNAL OF PAIN & SYMPTOM MANAGEMENT | Online article – 14 March 2011 – It has been two decades since advance directives have become an integral part of health care. Impediments to their optimal usage are common and multifactorial. Decisions commonly have to be made when patients are unable to participate in decision making, often at the end of life. The use of two questions, 1) "If you cannot, or choose not to participate in health care decisions, with whom should we speak?" and 2) "If you cannot, or choose not to participate in decision making, what should we consider when making decisions about your care?" may accomplish the major goals of an advance directive. [http://www.jpsmj.com/article/S0885-3924\(11\)00047-9/abstract](http://www.jpsmj.com/article/S0885-3924(11)00047-9/abstract)

Cont.

From Media Watch dated 21 June 2010:

- *PALLIATIVE MEDICINE* | Online article – 17 June 2010 – '**An exploration of the experience, confidence and attitudes of staff to the provision of palliative care to people with intellectual disability.**' Both palliative care and intellectual disability services staff lacked confidence in their ability to provide palliative care. Staff were challenged by perceived 'differences' and 'difficulties' in the provision of care. They endorsed a partnership approach to care but focus group discussions revealed that a shared desire to co-operate was insufficient to guarantee effective collaboration. <http://pmj.sagepub.com/cgi/content/abstract/0269216310371413v1>

From Media Watch dated 15 March 2010:

- *INTERNATIONAL JOURNAL OF PALLIATIVE NURSING*, 2010;16(2):93-98. '**Exploring the needs of hospice staff supporting people with an intellectual disability.**' This article defines the population involved, explores the literature which provides a contextual backdrop against which the research sits, introduces the methods and procedures used, and describes and discusses these findings in relation to the palliative care provision for people with an ID from a hospice perspective. http://www.ijpn.co.uk/cgi-bin/go.pl/library/article.html?uid=46755;article=IJP_N_16_2_93_98

Effects of death education program on family caregivers of disabled individuals

KOREAN JOURNAL OF HOSPICE & PALLIATIVE CARE, 2011;14(1):20-27. The purpose of this study was to investigate the effects of Death Education Program which had been provided to family caregivers of disabled individuals. The subjects' conception of the meaning of life and resilience did not significantly change. The median scores for the burden of family caregivers declined, while those for the subjects' attitude towards death increased, after attending the education program. The findings showed that Death Education Program has an affirmative effect on the burden of family caregivers of disabled individuals and their attitude towards death. <http://www.koreamed.org/SearchBasic.php?RID=0155KJHPC/2011.14.1.20&DT=1>

Ending the life of the act/omission dispute: Causation in withholding and withdrawing life-sustaining measures

LEGAL STUDIES | Online article – 24 February 2011 – The aim in this paper is to challenge the increasingly common view in the literature that the law on end-of life decision making is in disarray and is in need of urgent reform. The argument is that this assessment of the law is based on assumptions about the relationship between the identity of the defendant and their conduct, and about the nature of causation, which, on examination, prove to be indefensible. A clarification of the relationship between causation and omissions is provided which proves that the current legal position does not need modification, at least on the grounds that are commonly advanced for the converse view. <http://onlinelibrary.wiley.com/doi/10.1111/j.1748-121X.2011.00193.x/abstract>

Of related interest:

- *PALLIATIVE MEDICINE* | Online article – 10 March 2011 – '**Attitudes of U.K. doctors towards euthanasia and physician-assisted suicide: A systematic literature review.**' U.K. doctors oppose the introduction of active, voluntary euthanasia [AVE] and physician-assisted suicide [PAS] in the majority of studies. Top three themes: the provision of palliative care, adequate safeguards in the event of AVE or PAS being introduced, and a profession to facilitate AVE or PAS that does not include doctors. <http://pmj.sagepub.com/content/early/2011/02/20/0269216310397688.abstract>

Worth Repeating

Good and bad dying from the perspective of terminally ill men

ARCHIVES OF INTERNAL MEDICINE, 2004;164(9):977-981. Because individuals define good and bad deaths differently, clinicians may want to ask each patient to describe each of these. To truly understand a patient's views about the end of life, the clinician will need to probe certain answers to find out what "suffering" means to that individual, for example. Clinicians may not want to assume that wanting to avoid suffering equates to wanting to avoid pain. Clinicians may also want to ask patients about the presence of others at the very end of life and preferred place of death. Once the clinician has obtained information about a patient's preferences for the end of life, the discussion then can focus on how a patient's clinical course may fit with the stated preferences. Situations that might preclude a patient from being able to attain his preferred death, for instance, could be discussed and alternative options reviewed. If a patient without family, who lives alone, states that a good death would be one in

which he or she dies at home, the clinician's response might include a review of alternative settings for care if adequate in-home care could not be arranged. Engaging in these conversations before death is imminent may help patients achieve a better quality of life while they are dying and may reduce emotional stress on loved ones.

<http://archinte.ama-assn.org/cgi/reprint/164/9/977?maxtoshow=&hits=10&RESULTFORMAT=&fulltext=terminal+illness&searchid=1&FIRSTINDEX=20&resourcetype=HWCIT>

Extract from *Archives of Internal Medicine*

Participants voiced multiple reasons for why dying in one's sleep led to a good death and why prolonged dying or suffering led to a bad death. Participants did not hold uniform views about the presence of others at the very end of life or preferred location of dying

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