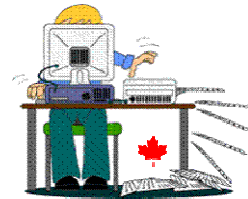


Media Watch...

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

Research deficit: Scroll down to [Specialist Publications](#) and 'Balancing benefit and harm in palliative care: The difficult position of palliative medicine in view of the promises of curative medicine' (p.9), published in *Zeitschrift fur Evidenz, Fortbildung und Qualitat im Gesundheitswesen*.

Canada

University of Victoria study challenges notion of "grey tsunami" swamping health care system

BRITISH COLUMBIA | *Times Colonist* (Vancouver Island) – 2 May 2011 – The capacity to live alone happily, with just a small amount of support around the house, is the real issue now facing Canadian seniors' health care, a new ... study contends.¹ The popular, existing notion of a demographic "grey tsunami" that threatens to swamp the health care system is false. "The persistent belief that the increasing size of our older population will overwhelm Canada's health care system is not true. The rising cost of high-tech, acute care is what's really behind steadily increasing health costs. And those acute care interventions are applied to all ages, not just seniors. The report noted even the national Canadian Health Services Research Foundation, has concluded only about one per cent of the yearly total increase in health care costs can be attributed to a population growing demographically older. Seniors, said Chappell and Hollander, actually have health care needs resulting more from the health problems that just normally accompany old age. And these conditions, like diabetes or asthma or general frailty, are best described as "chronic." Chronic conditions can generally be managed, as opposed to acute incidents which require intensive medical intervention, like an operation. Like most people with chronic conditions, seniors can manage quite effectively on their own, in their own homes with just a little bit of help. What makes seniors unique is the help required is often, not even medical. <http://www.timescolonist.com/health/UVic+study+challenges+notion+grey+tsunami+swamping+health+care+system/4712960/story.html>

1. 'An evidence-based policy prescription for an aging population,' *HealthcarePapers*, 2011;11(1):8-18.

[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/pg/file/world/world/>

U.S.A.

U.S. rules require clearance for long hospice stays

PENNSYLVANIA | *Philadelphia Inquirer* – 5 May 2011 – New government rules ... require hospices to send doctors or nurse practitioners for face-to-face visits with Medicare patients who have been on hospice more than six months to certify that the patients are really sick enough to need the program. The new rules came in response to lengthening hospice stays as services expanded beyond cancer patients to those with slower-moving and less predictable illnesses like heart failure, Alzheimer's, and chronic obstructive pulmonary disease. Government spending on hospice grew from \$2.9 billion in 2000 to \$10 billion in 2007, according to a 2009 report from ... the Medicare Payment Advisory Commission [MedPac] that recommended the tougher stance on long stays. During those years, the number of hospice providers rose from 2,300 to 3,200, with most of the growth in for-profits. MedPac said that hospice is most profitable during long stays, which "may have led to inappropriate utilization of the benefit among some hospices." While the median length of stay has remained steady at about two weeks, the longest stays have gotten longer. The agency estimated that, in about 6% of hospices, 40% or more of stays exceed 180 days. The longer stays, MedPac said, blur the distinction between true hospice and long-term care. http://www.philly.com/philly/health_and_science/121302158.html

From Media Watch dated 4 April 2011:

- **LONG TERM CARE NEWS** | Online report – 4 April 2011 – '**Centers for Medicare & Medicaid Services implements new law on hospice, home health.**' The Centers for Medicare & Medicaid Services [CMS] has begun implementing a new law that requires physicians to meet face-to-face with individuals looking to be certified for Medicare home health services and Medicare hospice services. <http://www.mcknights.com/cms-implements-new-law-on-hospice-home-health/article/199830/>

Caregivers need government help or they'll go broke

USA TODAY | Online OpEd – 3 May 2011 – Family caregivers are the largest caregiver group in the workforce – 65 million Americans who provide unpaid care for a chronically ill, disabled or aged family member. The value of the services they give free to our society is estimated to be \$375 billion a year. That is almost twice as much as the government spends on home care and nursing home services combined (\$158 billion). <http://yourlife.usatoday.com/parenting-family/new-passages/story/2011/05/Caregivers-need-government-help-or-theyll-go-broke-/46729532/1?csp=34news>

Prognosis

Figuring the odds

CALIFORNIA | *New York Times* – 2 May 2011 – Three ... palliative care specialists ... are developing a Web site that offers individual prognoses based on 18 to 20 different geriatric prognostic indexes. These serve different purposes: Some are meant for nursing home residents, for example, while others target patients being discharged from hospitals. "These scores and indices are meant to help guide decision-making," explained Dr. Sei Lee. "They let us say, 'This person is at higher risk, so maybe we should be more aggressive with statins.' Or, 'Maybe we shouldn't focus energy on cancer screenings that may not be useful here.' Or, 'Maybe we should start discussing end-of-life issues.'" <http://newoldage.blogs.nytimes.com/2011/05/02/figuring-the-odds/>

International

Kerala shows the way

INDIA | *The Hindu* – 7 May 2011 – Kerala has broken new ground with a palliative care policy that aims at covering every bedridden citizen in the State – rich or poor, down to the last rung. The Arogya Keralam Palliative Care project is being touted as India's first, and the only government initiative of its kind in entire Asia. Flagged off Statewide in 2008, the project got off to a good start in Kozhikode and Malappuram districts in North Kerala. Three years down the line, North Kerala still scores over the rest of the State because of the active involvement of the community there, points out Dr. Anju Miriam John, Medical Officer of the programme in the Kottayam district hospital. "An initiative of this nature can succeed only with people's participation," she stresses. The Arogya Keralam Palliative Care project is aided partly by the National Rural Health Mission (NRHM). Every district has a core team of a programme co-ordinator, medical officer, nurses and helpers. Smaller teams fan out at the panchayat levels. <http://www.thehindu.com/arts/magazine/article1999145.ece>

The promise of total care

INDIA | *The Hindu* – 7 May 2011 – Palliative care is mistakenly understood to be terminal care to alleviate pain when the treatment itself has failed. Treating the 'whole person' for relief from distress and pain should be the goal from the beginning of the treatment itself.

<http://www.thehindu.com/arts/magazine/article1999138.ece>

From Media Watch dated 10 January 2011:

- INDIA | BBC 4 (U.K.) – 6 January 2011 – **'A model to treat the dying that could be rolled out in other nations.'** Kerala ... has more palliative care centres than the rest of the country put together. Is this a model to treat the dying that could be rolled out in other nations, as well as other parts of India? http://www.bbc.co.uk/iplayer/episode/b00wr9v8/Crossing_Continents_Palliative_Care_in_India/

N.B. India was rated 40th in *The Quality of Death: Ranking End-of-life-Care Across the World*, commissioned by the Lien Foundation, Singapore, and published by the Economist Intelligence Unit, July 2010. http://graphics.eiu.com/upload/QOD_main_final_edition_Jul12_toprint.pdf

Islamic way of treating dead bodies

SAUDI ARABIA | *Arab News* – 5 May 2011 – The Islamic tradition is to respect the dead bodies of both Muslims and non-Muslims. The body should not be abused, the face should not be disfigured and it should be given a dignified burial. Ritual washing and burial should not be delayed unnecessarily. The body should be buried under the soil on land. Throwing a body into the sea is not permitted except in exceptional circumstances, such as if the death occurs while the person is on a voyage and land is too far away or there is a possibility of the decomposition of the body if kept until landfall. <http://arabnews.com/lifestyle/islam/article383269.ece>

East End Hospice now visiting area nursing homes

U.K. | *Suffolk Times* – 5 May 2011 – [East End Hospice] ... has spread its wings beyond its core mission of offering end-of-life care to individuals and is now bringing its services to terminal patients and their families in area nursing homes. San Simeon by the Sound Center for Nursing & Rehabilitation ... is the latest local facility to invite hospice workers to train staff and work with terminal patients. Although San Simeon hasn't yet had a patient who opted for hospice care, staff there have been trained by hospice workers, who stand ready to offer specific patient plans of care should the need arise. That can include visits by hospice nurses, social workers, aides and hospice volunteers. <http://suffolktimes.timesreview.com/2011/05/12301/east-end-hospice-now-visiting-area-nursing-homes/>

Paediatric palliative care

Palliative care funding review must involve social care

U.K. | *Children & Young People Now* – 4 May 2011 – The government is being urged to put social care at the heart of its review of funding for palliative care. As part of the Department of Health-led review of services for adults and children, charities Children's Hospices U.K. and Act want the Department for Education to be closely involved to ensure the social care needs of children and families are met. According to the groups, 23,500 children and young people in the U.K. will die before they reach adulthood and will therefore require palliative care. Lizzie Chambers, chief executive of Act, said: "As good children's palliative care depends on joined-up health and social care, it is essential that the review encompasses social care funding. [The two charities] have urged the Department for Education to engage actively with the review." Research is currently being undertaken ... to ascertain where children's hospices get their funding, looking at both local authority and health sources. <http://www.cypnow.co.uk/Health/article/1067787/palliative-care-funding-review-involve-social-care/>

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- IRELAND | *Breaking News* (Lapps Quay, Cork) – 5 May 2011 – **'Women prevented from travelling to Switzerland for assisted suicide.'** Two Irish women have been prevented from travelling to Switzerland for assisted suicide, after intervention by the Gardaí [Ireland's national police force]. The women, one of whom is in the final stage of multiple sclerosis, were forced to cancel their planned visit to the Dignitas clinic ... after officers became aware of their plans, radio station Newstalk has reported. Assisted suicide is legal in Switzerland but is a criminal offence in Ireland, punishable by up to 14 years imprisonment. <http://www.breakingnews.ie/ireland/women-prevented-from-travelling-to-switzerland-for-assisted-suicide-503786.html>
- AUSTRALIAN AGEING AGENDA | Online report – 3 May 2011 – **'The floor is open for debate.'** Alzheimer's Australia has released the second half of a two-part report¹ ... focusing on providing information about both sides of the complex and contentious euthanasia debate. "Alzheimer's Australia does not have a position on euthanasia," [Ita] Buttrose [President of Alzheimer's Australia] said. "We take the view that the debate on euthanasia is clouded in confusion. The intention of this paper is not to tell people what view they should take but rather to provide clear information about the debate and to provide an overview of the complex issues dementia raises in respect of euthanasia." <http://www.australianageingagenda.com.au/2011/05/03/article/The-floor-is-open-for-debate/BFTTSATHLC>

1. *Planning for the End of Life for People with Dementia* (Part Two), Alzheimer's Australia, May 2011. http://www.alzheimers.org.au/common/files/NAT/20110428_Nat_Paper_EOLP2.pdf

N.B. *Planning for the End of Life for People with Dementia* (Part One), Alzheimer's Australia, March 2011. http://www.alzheimers.org.au/common/files/NAT/20110331_Nat_Paper_23_EndofLife.pdf



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. Biosketch on the International Palliative Care Resource Center website at: <http://www.ipcrc.net/barry-r-ashpole.php>

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

End-of-life care at an academic medical center: Are attending physicians, house staff, nurses, and bereaved family members equally satisfied? Implications for palliative care

AMERICAN JOURNAL OF HOSPICE & PALLIATIVE MEDICINE | Online article – 5 May 2011 – End-of-life care is deemed to be poor in the U.S. – particularly in large teaching hospitals. Via a brief survey, the authors examined satisfaction with end-of-life care for those patients who died in their academic medical center from provider and family perspectives. Overall satisfaction was high, but there was discordance among different providers. Continuity of care was limited. Age and location of death alone did not significantly affect satisfaction with end-of-life care. Implications of this type of research for improving end of life care at academic centers are discussed. <http://ajh.sagepub.com/content/early/2011/05/05/1049909111407176.abstract>

Of related interest:

- *JOURNAL OF PALLIATIVE MEDICINE* | Online article – 6 May 2011 – '**Intensity of acute care services at the end of life: Nonclinical determinants of treatment variation in an older adult population.**' The study results reveal that effects of age, minority status, health plan, and hospital characteristics all affect hospital utilization and intensity of care above and beyond clinical factors. <http://www.liebertonline.com/doi/abs/10.1089/jpm.2010.0360>

Survey of consumer informatics for palliation and hospice care

AMERICAN JOURNAL OF PREVENTIVE MEDICINE, 2011;40(5):S173-S178. Online information about palliation is available, although identifying trustworthy sources can be problematic. More attention to literacy levels, instructional principles, and needs of special populations would improve products. Research to measure usage of such tools, ability to influence behavior, and cost/benefit issues is needed.

[http://www.ajpmonline.org/article/S0749-3797\(11\)00109-7/abstract](http://www.ajpmonline.org/article/S0749-3797(11)00109-7/abstract)

Understanding death attitudes: The integration of movies, positive psychology, and meaning management

DEATH STUDIES, 2011;35(5):387-407. The portrayal of death is one of the most common themes in movies and is often unrealistic, promoting misconceptions to the public. However, there are also many films that portray death acceptance in an instructive way. Such films depict the development of character strengths useful in embracing life and lessening death anxiety, namely zest, curiosity, self-regulation, and humor. Moreover, the role of meaning in films is pivotal for understanding death attitudes. The authors discussed key elements in a number of popular, independent, and international films and

emphasized the use of films as an important adjunct for both teachers and clinicians addressing death attitudes with students and clients. <http://www.informaworld.com/smpp/content~db=all~content=a937207477~frm=abslink>

Can we overcome the effect of conflicts in rendering palliative care? An introduction to the Middle Eastern Cancer Consortium

CURRENT ONCOLOGY REPORTS | Online article – 2 May 2011 – The Middle East has been experiencing an ongoing political conflict for the past several decades. This situation has been characterized by hostility often leading to violence of all sources. At times, such a conflict led to the outbreak of a military war, which was followed by an enmity between religious, ethnic, cultural, and national populations. In such environmental situations, palliative care professionals often confront major challenges including bias, mistrust, and mutual suspicion between patients and their treating clinicians. In order to overcome such obstacles, while rendering palliative care services, all professionals involved need careful planning and execution of their treatment plans. The latter is however possible, and sometimes successful even across lines of conflict, thereby promoting understanding, mutual respect, and tolerance between the involved communities and individuals. <http://www.springerlink.com/content/a222x2w44r7l8r58/>

Spiritual care in palliative care

EUROPEAN JOURNAL OF PALLIATIVE CARE, 2011;18(2):86-89. The WHO [World Health Organization] defines palliative care as 'an approach that improves the quality of life of patients and their families facing the problem[s] associated with life-threatening illness, through the prevention and relief of suffering.' The definition specifies that palliative carers attempt to achieve this outcome through 'early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.' However, despite working with a definition that makes mention of the 'spiritual,' despite the reports which state that many patients have spiritual needs, and despite evidence that attending to such spiritual needs directly benefits patients, many healthcare professionals would feel hard-pressed to describe their assessment and treatment of spiritual problems as 'impeccable.' The aspiration embodied by the WHO's definition is

contradicted by the evidence, since healthcare professionals report difficulty in addressing their patients' spiritual issues. http://www.vgvz.nl/userfiles/files/nieuws/2011/EJPC_febr_2011_Towards_taskforce.pdf

Extract from *European Journal of Palliative Care*

As one experienced British palliative nurse expresses it, 'I ... sometimes find it difficult to offer spiritual help and support to my patients and their families. I am not sure what my role is, and fear invading a private part of their lives. I hold back and offer only the rudiments of spiritual care. I am relieved when I am told that they are either non-practising or have their own minister or priest. I have also made the mistake of thinking that religion and spiritual care are one and the same ... I understand that if my patients' spiritual needs are not met, this can have an effect on their pain and suffering.'

Patient-physician communication

JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, 2011;305(17):1802-1803. The last few decades have witnessed incredible progress in the scientific underpinnings of medicine. New discoveries and innovations have created sophisticated tools and technologies that have changed the way diseases are diagnosed and managed. Ironically, some of these technologies have taken precedence over one of the most important skills of the compassionate physician – the art of listening to the patient. Patients often experience physicians as being too busy to listen and too distant to care. Consumer Web sites abound with criticisms about physicians' deficiencies in communication skills. This appears equally true in Canada and in the U.S., despite the major differences in their health care systems. Concerns about physicians' communication skills are not really new. For decades, there have been calls for physicians to pay greater attention to the person with the disease rather than to the disease itself.

<http://jama.ama-assn.org/content/305/17/1802.extract>

Quotable Quotes

Dying is one of life's central and undeniable consequential events, and yet we devote little careful attention to it. We don't investigate or discuss how to prepare for death, the actual process of dying, or how to make decisions that will allow us to die in a distinguished, meaningful way that agrees with our wishes and values.

*When we do talk about dying, it is usually to discuss how to avoid death or beat the odds. We make birth plans and dinner plans, but we do not discuss the expectation of death that is associated with frailty. Speak openly about the possibility of dying and try to avoid treatments that will cause unbearable suffering at the end of life. **Laurie Mallery MD**, author of *The Salami Salesman & His Daughter Falafel* (Indiana: Author House, 2011)*

N.B. With Dr. Paige Moorhouse, Dr. Mallery is founder of the Palliative & Therapeutic Harmonization Clinic at Queen Elizabeth II Health Centre, Halifax, Nova Scotia, Canada (see Media Watch dated 27 December 2010, 'A place to find comfort,' p.2).

Cont.

Of related interest:

- *CHEST*, 2011;139(5):1081-1088. **'A call for high-quality advance care planning in outpatients with severe COPD or chronic heart failure.'** Despite the fact that patients are able to indicate their preferences regarding life-sustaining treatments, based on burden of treatment, outcome of treatment, and likelihood of outcome, these preferences are rarely discussed with their physician specialist. <http://chestjournal.chestpubs.org/content/139/5/1081.abstract>
- *ONCOLOGY NURSING FORUM* | Online article – 29 April 2011 – **'Nurses' perceptions and experiences with end-of-life communication and care.'** On average, nurses [i.e., participants in this study] cared for more than seven terminally ill patients during a three-month period while only discussing hospice care with a third of these patients and their family members. <http://ons.metapress.com/content/h522r42x428279w5/>
- *ONCOLOGY NURSING FORUM*, 2011;38(3):307-313. **'Lack of communication and control: Experiences of distance caregivers of parents with advanced cancer.'** Two major themes, communication and control, and five sub-themes, benefits and burdens of distance caregiving, dealing with uncertainty, direct action through information seeking, protecting, and staying connected, emerged ... [in this qualitative study]. <http://www.ons.org/Publications/ONF/Features/media/ons/docs/publications/may2011onfpodcast.pdf>
- *PALLIATIVE & SUPPORTIVE CARE* | Online article – 4 May 2011 – **'Experiences of truth disclosure in terminally ill cancer patients in palliative home care.'** Patients [i.e., participants in this study] identified three different modes of truth: 1) the absolute objective truth that they are dying; 2) the partial truth about their condition including some facts but not all of the details; and, 3) the desired truth, originating in the patient's own beliefs about a healthy or better life. <http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=8268200&fulltextType=RA&fileId=S1478951511000046>

[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.

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[Something Missed or Overlooked?](#)

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

Would accommodating some conscientious objections by physicians promote quality in medical care?

JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, 2011;305(17):1804-1805. Moral pluralism is a valuable aspect of a free society but sometimes creates conflicts in medical care when individual physicians object to providing certain legal but morally controversial services, such as abortion, physician-assisted suicide (where it is legal), and palliative sedation to unconsciousness. Genuine conscience-based refusals (CBRs) are refusals in which a physician believes that providing the requested service would violate his or her core moral beliefs (religious or secular), thereby causing personal moral harm. Conscience-based refusals should be a "shield" to protect individual physicians from being compelled to violate their core moral beliefs rather than a "sword" to force their beliefs onto patients. This partially explains why many physicians who invoke CBRs refer their patients to physicians willing to provide the requested care. <http://jama.ama-assn.org/content/305/17/1804.extract>

From Media Watch dated 14 March 2011:

- PRESS ASSOCIATION | Online report – 7 March 2011 – **'House passes bill to resolve conscience conflict.'** 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. <http://washingtonexaminer.com/news/2011/03/house-passes-bill-resolve-conscience-conflict>
- *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>

Family involvement, independence, and patient autonomy in practice

MEDICAL LAW REVIEW | Online article – 4 May 2011 – The legal debate about patient autonomy focuses mainly on mental capacity and provision of information. The influence of the family on the decisions of the competent adult patient has scarcely been discussed in English medical law. Dominated by the bioethical principle of individual autonomy, the law concentrates on the patient and takes an exclusionary stand regarding relatives. The aim of this article is to examine the attitude of English law towards the involvement of relatives when patients make decisions, and to investigate the views and experiences of patients and their relatives in reality. The findings [of this qualitative study] reflect a relational approach to patient autonomy. When making decisions about treatment, patients needed to know that their relatives would support them no matter what they decided. However, exceptional cases which demonstrated substantial familial influence suggest that the law should secure the patient's interest in making their own decisions. <http://medlaw.oxfordjournals.org/content/early/2011/05/03/medlaw.fwr008.abstract>

Of related interest:

- *THE HASTINGS REPORT*, 2011;41(3):24-27. **'Surrogate health care decisions and same-sex relationships.'** Early in 2011, Illinois joined the ranks of states that recognize civil unions between both same-sex and opposite-sex couples. Despite the fact that Illinois and most other states still reserve marriage for opposite-sex couples, the option of civil unions will make it easier for some couples to make health care decisions for one another should one of them become incapacitated. <http://www.thehastingscenter.org/Publications/HCR/Detail.aspx?id=5358>

What is a 'secure base' when death is approaching? A study applying attachment theory to adult patients' and family members' experiences of palliative home care

PSYCHO-ONCOLOGY | Online article – 6 May 2011 – Informants [i.e., participants in this study] expressed the relevance of sensing security during palliative home care because death and dying were threats that contributed to vulnerability. Palliative home care could foster a feeling of security and provide a secure base. This was facilitated when informants had trust in staff (e.g., due to availability and competence in providing symptom relief), felt recognised as individuals and welcomed to contact the team in times of needs. Being comfortable, informed and having an everyday life also contributed to a perception of palliative home care as a secure base. Family members stressed the importance of being relieved from responsibilities that were too heavy.
<http://onlinelibrary.wiley.com/doi/10.1002/pon.1982/abstract>

Balancing benefit and harm in palliative care: The difficult position of palliative medicine in view of the promises of curative medicine

ZEITSCHRIFT FUR EVIDENZ, FORTBILDUNG UND QUALITAT IM GESUNDHEITSWESEN, 2011;105(3):171-175. The significance of palliative care as an interdisciplinary and multi-professional approach to treating patients with extremely severe medical conditions should be investigated using the same methodological standards as for clinical medicine in general. Clinical studies in palliative medicine show that certain standards, e.g., in pain therapy, have still not been sufficiently implemented. There is also a lack of methodologically appropriate studies to investigate palliative medicine as a complex intervention. This research deficit is all the more regrettable as ... it can be demonstrated that the benefit provided by the services of palliative care teams is very large, especially for patients with a particularly unfavorable course of the disease.
[http://www.unboundmedicine.com/medline/ebm/record/21530905/abstract/\[Balancing_benefit_and_harm_in_palliative_care:_The_difficult_position_of_palliative_medicine_in_view_of_the_promises_of_curative_medicine](http://www.unboundmedicine.com/medline/ebm/record/21530905/abstract/[Balancing_benefit_and_harm_in_palliative_care:_The_difficult_position_of_palliative_medicine_in_view_of_the_promises_of_curative_medicine)

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?mediawatch=1>

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/pg/file/world/world/>

International Palliative Care Resource Center: <http://www.ipcrc.net/archive-global-palliative-care-news.php>

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

Assisted (or facilitated) death

Representative sample of recent articles, etc:

- *PALLIATIVE MEDICINE* | Online article – 4 May 2011 – '**Dying cancer patients' own opinions on euthanasia: An expression of autonomy? A qualitative study.**' The informants [i.e. participants in the study] expressed different positions on euthanasia, ranging from support to opposition, but the majority were undecided due to the complexity of the problem. The informants' perspectives on euthanasia in relation to autonomy focused on decision making, being affected by 1) power, and 2) trust. Legalization of euthanasia was perceived as either a) increasing patient autonomy by patient empowerment, or b) decreasing patient autonomy by increasing the medical power of the health care staff, which could be frightening.
<http://pmj.sagepub.com/content/early/2011/05/04/0269216311404275.abstract>
- *PALLIATIVE & SUPPORTIVE CARE* | Online article – 4 May 2011 – '**Attachment styles of Oregonians who request physician-assisted death.**' Patients' attachment styles may be an important factor in requests for PAD. Recognition of a patient's attachment style may improve the ability of the physician to maintain a constructive relationship with the patient throughout the dying process.
<http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=8268185&fullTextType=RA&fileId=S1478951510000660>

Worth Repeating

The view from 18 years ago

Patient control over dying: Responses of health care professionals

SOCIAL SCIENCE & MEDICINE, 1993;36(6):757-765. The findings [of this study] ... suggest that while health care professionals are generally in favour of the principle of patient control over dying, they have reservations about accommodating patients' wishes in actual clinical situations. Key factors that underly their ambivalence on this point are: 1) specific patient circumstances, such as age, severity of illness and mental competence; 2) moral and legal concerns; and, 3) the type of intervention requested by patient. The results indicate that patient control over dying represents a challenge to the clinical judgement of health care professionals; that it runs counter to their perception of their role as healers and supporters; that it raises crucial concerns about their personal ethics and legal liability and that it poses a challenge to their professional autonomy and power. It is likely that health care practitioners will increasingly be pressured to concede their autonomy and enter into a partnership with patients in the decision-making process.
http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6VBF-465D4R9-BJ&_user=10&_coverDate=03%2F31%2F1993&_alid=1741575729&_rdoc=12&_fmt=high&_orig=search&_origin=search&_zone=rslt_list_item&_cdi=5925&_sort=r&_st=13&_docanchor=&view=c&_ct=1251&_acct=C000050221&_version=1&_urlVersion=0&_userid=10&md5=98acd8c56e217a3ed311a6bb2837081c&searchtype=a

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