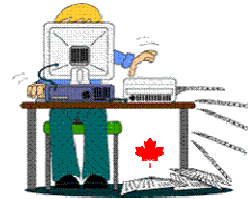


Media Watch...

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 and research.

4 June 2012 Edition | Issue #256



Compilation of Media Watch 2008, 2009, 2010, 2011, 2012 ©

Compiled & Annotated by Barry R. Ashpole

Issues in end-of-life care: Scroll down to [Specialist Publications](#) and 'Why do palliative care patients present to the emergency department? Avoidable or unavoidable?' (p.7), published in the *American Journal of Hospice & Palliative Care*.

Canada

Ontario oncologists struggle with grief when patients die, study shows

ONTARIO | *Toronto Star* – 30 May 2012 – They are the bearers of bad news, those who guide patients through painful cancer treatments and often help families say goodbye. But a new Ontario-based study suggests that oncologists struggle with grief of their own when patients die, an issue that researchers say affects both their personal lives and the quality of care they provide. The peer-reviewed study¹ ... conducted last year on 20 oncologists at three hospitals in Toronto and Hamilton. Many of those surveyed said they felt not just grief when a patient died, but also a sense of powerlessness, self-doubt and failure – and those feelings often go untreated, as they remain taboo within the profession, said lead researcher Leeat Granek. "There is this really strange paradox about the fact that we know oncology is riddled with loss and yet there isn't a lot of opportunity to talk about it," said Granek, a health psychologist ... at Toronto's Hospital for Sick Children. More than half of those surveyed said grief could affect their treatment decisions – say, for example, providing aggressive chemotherapy treatment when palliative care is a better option. <http://www.healthzone.ca/health/article/1203206--ontario-oncologists-struggle-with-grief-when-patients-die-study-shows>

1. 'Nature and impact of grief over patient loss on oncologists' personal and professional lives,' *Archives of Internal Medicine*, published online 22 May 2012 (noted in Media Watch, 28 May 2012. <http://archinte.jamanet-work.com/article.aspx?articleid=1160665>

Specialist Publications

Of particular interest:

'**Doctor house calls part of Ontario plan to keep seniors at home longer**' (p.11), published in *The Medical Post*.

'**The house call: Past, present and future**' (p.11), published in the *University of Toronto Medical Journal*.

Corrections & Clarifications

Last week's issue of Media Watch was incorrectly numbered #254 (dated 28 May 2012). It should have been numbered #255.

U.S.A.

End-of-life medical advice: Devaluing patients in name of greater good?

FORBES | Online article – 1 June 2012 – Sarah Palin's "death panel" description polarized the nation; it was dismissed by proponents of the Patient Protection & Affordable Care Act (PPACA) as "pure demagoguery," and taken up by PPACA critics as a cudgel with which to pound "Obamacare." I'd like to offer an intermediate perspective of sorts – one that recognizes PPACA isn't calling for death panels, but also acknowledges why that concern seems especially salient. The idea that our healthcare system can make dying with dignity difficult has been effectively communicated^{1,2} ... One take-away is that proactive discussions about end-of-life care, coupled with the ability of the health system to more effectively and more willingly implement these wishes, could be an unarguably good thing for patients and families. Moreover, in response to the "death panel" uproar, a provision for "voluntary advanced care planning" ... was removed as an element of the annual wellness visit for Medicare patients, even though it's hard to see ... why this discussion in itself would be objectionable. The anxiety about "death with dignity" comes when you start to layer in costs. <http://www.forbes.com/sites/davidshaywitz/2012/06/01/why-we-shouldnt-dismiss-death-panels-as-pure-demagoguery/>

1. 'What should medicine do when it can't save your life?' *The New Yorker*, 2 August 2010 (noted in Media Watch, 2 August 2012). http://www.newyorker.com/reporting/2010/08/02/100802fa_fact_gawande?currentPage=all
2. 'A life worth ending,' *New York Magazine*, 20 May 2012. <http://nymag.com/news/features/parent-health-care-2012-5/>

"an amulet to ward off overly aggressive care"

Discovered: The magic word

NEW YORK TIMES | Online article – 30 May 2012 – The word "hospice" usually evokes a shift, a pivot from trying to cure to providing comfort and support at the end of life. Hospice workers help people through the final weeks and months of terminal illness, easing dying people's pain and fear, bolstering their exhausted families. But in one case I heard about recently, the word served a different function: It became a kind of magic shield. Simply saying it could protect against unwanted medical treatments for a vulnerable old woman who possibly wasn't dying at all. <http://newoldage.blogs.nytimes.com/2012/05/30/discovered-the-magic-word/>

Mourning becomes electric: Tech changes the way we grieve

USA TODAY | Online report – 30 May 2012 – In this new era, the bereaved readily share their sorrow via Facebook comments. They light virtual candles on memorial websites, upload video tributes to YouTube and express sadness through online funeral home guest books. Mourners affix adhesive-backed "QR code" chips to the tombstones of their beloved, so visitors can pull up photos and videos with a scan of a Smartphone. Those in need of consolation can replay the streaming video of a funeral service to hear a cleric's comforting words. Those who want help remembering a yahrtzeit – the anniversary of death in the Jewish faith – can get e-mail reminders from websites such as ShivaConnect.com. <http://www.usatoday.com/tech/news/story/2012-05-07/digital-mourning/55268806/1>

From Media Watch, 5 March 2012:

- *OMEGA – JOURNAL OF DEATH & DYING*, 2012;64(4):275-302. 'Does the Internet change how we die and mourn?' The article outlines the issues that the internet presents to death studies. http://baywood.metapress.com/app/home/contribution.asp?referrer=parent&backto=issue_1_6:journal_1_255:linkingpublicationresults_1:300329_1

Idaho leads the nation at helping people die their way

IDAHO | *Statesman* – 27 May 2012 – The Legislature this year passed a bill to prevent physicians from denying patients' requests for food, fluids and medicine. Opponents of the legislation said doctors already honor the wishes of their patients and the change was unnecessary. Proponents said an earlier law allowed physicians to deny treatment if they made a goodwill effort to find another doctor willing to administer the treatment. The change ... closed that loophole. The Legislature also approved one other change, allowing nurse practitioners and physician assistants to sign a POST form [giving] better access for people ... without regular access to a physician. <http://www.idahostatesman.com/2012/05/27/2132423/ida-ho-leads-at-helping-people.html>

1. 'Idaho Physician Orders for Scope of Treatment,' Department of Health & Welfare, Idaho, 2007. http://www.idahoendoflifecoalition.wildapricot.org/Resources/Documents/WebRCRT16Section4_POSTForm_pg37.jpg

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- LOUISIANA | KATC News (Lafayette) – 29 May 2012 – **'Bill would strengthen ... ban on euthanasia.'** A bid to strengthen Louisiana's ban on euthanasia is headed to the governor's desk after receiving final legislative passage. The state has a prohibition in criminal law against euthanasia and assisted suicide. House Bill 1086 ... will add the prohibition to the state's medical consent law. <http://www.katc.com/news/bill-would-strengthen-la-ban-on-euthanasia-244949/>

Specialist Publications

Of particular interest:

'What influences African American end-of-life preferences?' (p.10), published in the *Journal of Health Care for the Poor & Underserved*.

'Palliation for dying undocumented immigrants' (p.12), published in the *New England Journal of Medicine*.

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.

International

National Confidential Enquiry into Patient Outcome & Death

Do not resuscitate orders 'ignored' as doctors try to revive patients suffering cardiac arrest

U.K. | *Daily Mail* – 1 June 2012 – Doctors are ignoring 'do not resuscitate' orders and attempting to revive hospital patients suffering a cardiac arrest. A report found every one of 52 patients who had made an explicit request to be allowed to die had their wishes flouted. Other terminally ill patients were also given cardio-pulmonary resuscitation even though it was not in their best interests. The report investigated the care of 526 patients who had suffered a cardiac arrest in NHS [National Health Service] hospitals in England & Wales over a two-week period in 2010, and underwent a resuscitation attempt. In seven out of ten cases their care was 'less than good' with a failure to recognise warning signs that they might arrest or to contact senior doctors. In one-third of these cases, poor care was judged to have contributed to the patient's death, the report by the National Confidential Enquiry into Patient Outcome & Death said. Worryingly, nine out of ten patients were never asked about their wishes should they suffer an arrest despite many having chronic disease and being at risk. Professional and NHS guidelines recommend doctors discuss with seriously patients and their families what to do in advance, including whether to put on their records DNACPR (do not attempt CPR). <http://www.dailymail.co.uk/health/article-2153013/Do-resuscitate-orders-ignored-doctors-try-revive-patients-suffering-cardiac-arrest.html>

1. 'Time to Intervene? A review of patients who underwent cardiopulmonary resuscitation as a result of an in-hospital cardiorespiratory arrest,' A report by the National Confidential Enquiry into Patient Outcome & Death, 2012. http://www.ncepod.org.uk/2012report1/downloads/CAP_fullreport.pdf

From Media Watch, 12 March 2012:

- U.K. | *The Guardian* – 9 March 2012 – **'Human rights watchdog intervenes in 'do not resuscitate' case.'** <http://www.guardian.co.uk/society/2012/mar/09/watchdog-intervenes-do-not-resuscitate-case>

From Media Watch, 20 February 2012:

- U.K. | *Daily Mail* – 15 February 2012 – **'National Health Service accused of putting 'do not resuscitate' notices on patients with learning disabilities without consulting with their families.'** <http://www.dailymail.co.uk/health/article-2101445/NHS-accused-letting-patients-learning-disabilities-die-consulting-families.html>

From Media Watch, 30 January 2012:

- U.K. | *Daily Mail* – 25 January 2012 – **'GPs told to quiz elderly with serious health problems about 'how they want to die.'** <http://www.dailymail.co.uk/news/article-2091377/GPs-told-quiz-elderly-want-die.html>

From Media Watch, 29 August 2011:

- U.K. | *The Guardian* – 26 August 2011 – **'Do not resuscitate: Final word is with medical staff, whatever patient feels.'** <http://www.guardian.co.uk/society/2011/aug/26/do-not-resuscitate-medical-patient>

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/owner/MediaWatch>

Palliative care in the U.K.

£60 million boost for hospices

U.K. (ENGLAND) | Department of Health – 29 May 2012 – Hospices are to benefit from up to £60 million of funding to help improve the quality of care for people nearing the end of their lives. The funding – which is open to all adult and children's hospices in England – will help improve care for patients and families by enhancing the hospice environment, as well as supporting the care hospices provide to people in their own homes. <http://mediacentre.dh.gov.uk/2012/05/29/60m-boost-for-hospices/>

Of related interest:

- 'U.K. (ENGLAND) | National End of Life Care Intelligence Network – 28 May 2012 – **'New end-of-life care Primary Care Trust profiles.'** The Network has launched new End of Life Care Profiles for each Primary Care Trust to help commissioners and providers to understand the specific needs and characteristics of their local population to help with service planning. http://www.endoflifecare-intelligence.org.uk/end_of_life_care_profiles/primary_care_trust_profiles.aspx

Palliative care in Australia

A commitment to quality care

AUSTRALIA | *Aged Care Insite* – Accessed 28 May 2012 – Not everyone who needs good end-of-life care is able to receive it. Perhaps it is because it is such a young discipline that palliative care engages in a lot of self-analysis. Unlike some other forms of navel gazing, this has positive ramifications for patient care and results in significant improvements in quality. A major reason for Australia being awarded the interesting accolade of being the second-best place in the world to die¹ is due to the federal government's policy support for palliative care. This is represented in the National Palliative Care Strategy² and various related funding initiatives, but significantly in the support for quality improvement initiatives. The three programs aimed at improving quality in the sector itself – the National Standards Assessment Program, the Palliative Care Outcomes Collaborative and Caresearch – work closely and collaboratively to drive sector-wide improvement. <http://www.agedcareinsite.com.au/pages/section/article.php?s=Clinical&ss=Palliative+Care&idArticle=23814>

1. *The Quality of Death: Ranking End-of-life-Care Across the World*, commissioned by the Lien Foundation, Singapore, published by the Economist Intelligence Unit, July 2010. http://graphics.eiu.com/upload/QOD_main_final_edition_Jul12_toprint.pdf
2. 'Supporting Australians to Live Well at the End of Life,' National Palliative Care Strategy, 2010. [http://www.health.gov.au/internet/main/publishing.nsf/Content/533C02453771A951CA256F190013683B/\\$File/NationalPalliativeCareStrategy.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/533C02453771A951CA256F190013683B/$File/NationalPalliativeCareStrategy.pdf)

Of related interest:

- AUSTRALIA | *Aged Care Insite* – Accessed 28 May 2012 – **'Push for advanced care plan law.'** Delivering advanced care planning (ACP) to every aged care facility in Australia would save about \$330 million from the health budget each year. ACP was important because 85% of people die after a chronic, often lengthy illness, not a sudden event. Nearly half are not in a position to make their own decisions when near death, and family are unlikely to know their views without a discussion. <http://www.agedcareinsite.com.au/pages/section/article.php?s=News&idArticle=23795>
- AUSTRALIA | *Aged Care Insite* – Accessed 28 May 2012 – **'Broadband to help palliative care.'** The government hopes the ability to harness technology to support palliative care in home or aged care settings could deliver economic benefits, while responding to patient preferences regarding their ability to die in their own homes. A report by Palliative Care Queensland found it cost \$900/day per patient compared with an average cost of \$63/day to deliver community-based palliative care. <http://www.agedcareinsite.com.au/pages/section/article.php?s=Technology&idArticle=23811>

Economic trends

No help for the aged: Home carers axed for our old and most vulnerable

U.K. | *Sunday Mirror* – 27 May 2012 – For our most vulnerable pensioners, home care visits are the lifeline that allows them to live with dignity. But ... they have become the latest service to fall victim to the Government's funding axe. A fresh wave of cuts has led to the price of having a carer visit a sick or elderly person soaring by 10% [£1billion]. <http://www.mirror.co.uk/news/uk-news/home-carers-axed-for-our-old-and-most-848960>

Of related interest:

- U.K. | *Daily Mail* – 27 May 2012 – '**Soaring toll of elderly starving in their homes: Hospital admissions up 50% as councils cut back care.**' The number of people hospitalised because they are malnourished has soared by 50% in five years. Ten patients a week end up in hospital, half of them aged over 60. <http://www.dailymail.co.uk/news/article-2150883/Soaring-toll-elderly-starving-homes-Hospital-admissions-50-councils-cut-care.html?ito=feeds-newsxml>

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- SWITZERLAND | *The Local* – 1 June 2012 – '**Swiss canton to vote on assisted suicide.**' The people of the canton of Vaud will vote in June on whether to require nursing homes and hospitals to accept assisted suicide on their premises. The referendum taking place in Vaud on June 17th 2012 may result in the first ever law on assisted suicide being passed in Switzerland. The issue concerns whether or not nursing homes and hospitals should be made to accept the practice of assisted suicide. <http://www.thelocal.ch/3433/20120601/>
- SPAIN (BASQUE COUNTRY) | Zee News (India) – 30 May 2012 – '**People scared of dying badly rather than actually dying.**' A new study has shed light on how perception about euthanasia and dying has changed since the 1970s. Inaki Olaizola interviewed all kinds of people in Basque society and has been able to conclude that the fear of dying badly is widespread. He stresses the need to guarantee a dignified death by means of legislation. http://zeenews.india.com/news/health/health-news/people-scared-of-dying-badly-rather-than-actually-dying_17204.html

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

Patients views on failure to gain expected clinical beneficial outcomes from participation in palliative medicine clinical trials

AMERICAN JOURNAL OF HOSPICE & PALLIATIVE CARE | Online article – 28 May 2012 – This study aims to understand patients' views on failing to gain expected beneficial outcomes from palliative medicine clinical trials. Despite loss of initial hope in benefiting themselves in terms of better disease or symptom control, patients [i.e., study participants] interviewed still found joining clinical trials meaningful experience in terms of benefiting future patients and being valuable life experience. Experience in interacting with research staff partly formulated final impressions on clinical trial participation experience. Joining well-designed clinical trials unlikely causes harm to patients. Caring attitudes of researchers and maintaining good researcher-patient relationships can help patients in meaning-finding process, especially if they have failed to gain anticipated clinical benefits. <http://ajh.sagepub.com/content/early/2012/05/25/1049909112447673.abstract>

From Media Watch, 9 March 2009:

1. *JOURNAL OF PALLIATIVE MEDICINE*, 2009;12(3):215-217. '**The culture of research in palliative care...**' <http://online.liebertpub.com/doi/abs/10.1089/jpm.2009.9662>

Why do palliative care patients present to the emergency department? Avoidable or unavoidable?

AMERICAN JOURNAL OF HOSPICE & PALLIATIVE CARE | Online article – 23 May 2012 – Presentations by patients with advanced illness to the emergency department (ED) towards the end-of-life can be distressing for both patients and caregivers. With an understanding of why patients present, interventions to avoid these presentations close to the end-of-life may be possible. Appropriate sharing of information to on-call doctors, creating confidence in carers and providing extra practical supports is necessary. A comprehensive, coordinated specialist palliative care approach across community and acute services may help ensure patients are not sent to the ED inappropriately. <http://ajh.sagepub.com/content/early/2012/05/18/1049909112447285.abstract>

Consequences of cancer treatment: A new challenge for supportive and palliative care

BMJ SUPPORTIVE & PALLIATIVE CARE, 2012;2(2):82-83. Prevention and treatment of cancer are improving. There are now 2 million people living in the U.K. after a cancer diagnosis. This will rise to 4 million by 2030. More survivors are now living long enough to develop treatment related conditions. The current estimate is that at least one in five of those who survive cancer can expect ongoing physical and psychological problems. These can include persistent fatigue, breathlessness, neuropathy, cognitive impairment, poor bowel and urine control, skin necrosis, bone fracture and endocrine failure as well as an increased risk of common chronic illnesses such as heart failure, osteoporosis and second primary cancer. Symptoms may persist after initial therapy or they may develop months or years later, after a period of normal health, when neither the patient nor their health professional links them to previous cancer. For a significant minority, the ongoing impact of cancer treatment can be devastating. Most consequences of cancer treatment do not have to be disabling and after appropriate specialist assessment and diagnosis can be managed effectively, often by patients themselves. However, a minority will have more complex problems requiring specialist multidisciplinary management. Recent estimates suggest that this will involve 5-10% of patients with the common cancer types over a 20-year period. <http://spcare.bmj.com/content/2/2/82.extract>

Of related interest:

- *JOURNAL OF ONCOLOGY PRACTICE* | Online article – 29 May 2012 – '**The rising cost of cancer care: Physicians take charge.**' No abstract available. <http://jop.ascopubs.org/content/early/2012/05/28/JOP.2012.000654.full.pdf+html>
- *ONCLIVE* (U.S.) | Online article – 30 May 2012 – '**The rising cost of cancer care in the era of individualized therapy.**' Emerging targeted therapies are extending survival in many cancers, but the cost of these new treatments is often high. For example, sipuleucel-T (Provenge, Dendreon) for metastatic castration-resistant prostate cancer costs \$93,000 [U.S.] a year. Ipilimumab (Yervoy, Bristol-Myers Squibb), the first treatment for metastatic melanoma to improve overall survival in more than 10 years, costs \$120,000 [U.S.] for four infusions over a span of just three months. Everolimus (Afinitor, Novartis), for renal cell carcinoma and pancreatic cancer, costs \$10,000 [U.S.] a month. <http://www.onclive.com/publications/targeted-therapy-news/2012/June-2012/The-Rising-Cost-of-Cancer-Care-in-the-Era-of-Individualized-Therapy-A-QandA-With-Thomas-J-Smith-MD>



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>

On the emotional connection of medical specialists dealing with death and dying: A qualitative study of oncologists, surgeons, intensive care specialists and palliative medicine specialists

BMJ SUPPORTIVE & PALLIATIVE CARE | Online article – 31 May 2012 – Participants [in this study] took different positions about the emotional connection that should develop with their dying patients and their families. Although there was agreement about finding a balance between objectivity and connection, their strategies for achieving this seem to be subjective and prescribed by individual notions. By sharing perspectives and learning how other colleagues deal with similar issues, there is an opportunity for medical practitioners to develop a well-rounded approach to dealing with death and dying, which may enhance personal and professional relationships and may ultimately influence future generations of medical practitioners.
<http://spcare.bmj.com/content/early/2012/05/31/bmjspcare-2012-000208.abstract>

Of related interest:

- *JOURNAL OF PALLIATIVE MEDICINE* | Online article – 24 May 2012 – '**Negotiating uncertain terrain: A qualitative analysis of clinicians' experiences of refractory suffering.**' In palliative care, the witnessing of unrelieved (refractory) suffering takes its toll on all concerned; however, the effect on experienced palliative clinicians of witnessing such suffering has largely been unexplored.
<http://online.liebertpub.com/doi/abs/10.1089/jpm.2011.0442>

Pediatric palliative care

Living life to the fullest: Early integration of palliative care into the lives of children with chronic complex conditions

CURRENT PEDIATRIC REVIEWS, 2012;8(2):152-165. In light of their medical fragility and unpredictable trajectories, children with chronic complex conditions are ideal candidates for palliative care. Integration of palliative care concurrently with curative or life-prolonging therapies results in improved outcomes and is widely endorsed as the most appropriate model of care for this population of children. This paper dispels common misconceptions about pediatric palliative care and outlines the benefits realized by children living with chronic complex conditions, and their families, when palliative care is introduced early in the course of their illness. Practical suggestions to facilitate difficult conversations and to manage challenging clinical situations are provided.
<http://www.ingentaconnect.com/content/ben/cpr/2012/00000008/00000002/art00007>

Of related interest:

- *BMJ SUPPORTIVE & PALLIATIVE CARE* | Online article – 31 May 2012 – '**Paediatric palliative care: A survey of paediatricians and family practitioners.**' The results of the survey will guide the paediatric palliative care community to design programmes that will better educate practicing physicians and future physicians about paediatric palliative and end of life care, healthcare services and family communication and support. <http://spcare.bmj.com/content/early/2012/05/31/bmjspcare-2011-000058.abstract>

If I paint a rosy picture, will you promise not to cry?

JOURNAL OF CLINICAL ONCOLOGY | Online editorial – 29 May 2012 – The urge to reassure can get us into trouble. It is a major impediment to caring for our patients empathically, although it seems like such a caring and benign impulse. Soothe people, make them less upset, show them great confidence to maintain their hope and peace of mind. But reassurance can also be a gesture to minimize their concerns, to snuff out their expressions of suffering so that we don't have to deal with it, an exit strategy from a more difficult, truthful, and empathic conversation.
<http://jco.ascopubs.org/content/early/2012/05/29/JCO.2012.42.8920.full.pdf+html>

Cont.

- *JOURNAL OF PEDIATRIC ONCOLOGY NURSING*, 2012;29(3):141-150. **'Palliative care after-hours: A review of a phone support service.'** Families caring for a child with incurable cancer require access to support and advice round the clock. In Brisbane, Australia, an after-hours phone service was established to support these families. This service is operated by oncology clinical nurse consultants experienced in pediatric palliative care. This is the first review of 8 years of activity, totaling 106 patients and 1,954 calls. <http://jpo.sagepub.com/content/29/3/141.abstract>
- *PALLIATIVE & SUPPORTIVE CARE* | Online article – 22 May 2012 – **'Cultural and religious considerations in pediatric palliative care.'** Recommendations for providing culturally sensitive end-of-life care are offered through the framework outlined in the Initiative for Pediatric Palliative Care Quality Improvement Project of 2002. Cultural traditions are dynamic, never static, and cannot be generalized to all families. Guidelines to aid in approaches to palliative care are provided, and providers are encouraged to define these important differences for each family under their care. <http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=8594419&fulltextType=RA&fileId=S1478951511001027>

N.B. Initiative for Pediatric Palliative Care Quality Improvement Project website:
<http://www.ipcweb.org/initiative.asp>

The effectiveness of telehealth care on caregiver burden, mastery of stress, and family function among family caregivers of heart failure patients: A quasi-experimental study

INTERNATIONAL JOURNAL OF NURSING STUDIES | Online article – 24 May 2012 – Family caregivers in both groups had significantly lower burden, higher stress mastery, and better family function at one-month follow-up compared to before discharge. The total score of caregiver burden, stress mastery and family function was significantly improved for the family caregivers in the experimental group compared to the comparison group at post test. The results provide evidence that telehealth care combined with discharge planning could reduce family caregiver burden, improve stress mastery, and improve family function during the first 30 days at home after heart failure patients are discharged from the hospital. Tele-nursing specialists cared caregivers with the concepts of providing transitional care to help them successfully cross the critical transition stage. <http://www.sciencedirect.com/science/article/pii/S0020748912001514>

The hospitalized prisoner with a life-threatening illness: Criminal first and patient second?

JONA'S HEALTHCARE LAW, ETHICS, & REGULATION, 2012;14(2):43-47. It is generally accepted the Patient's Bill of Rights applies to all patients including prisoners. Yet, a prisoners' ... status generally prohibits inmates from making any decision that may shorten his/her life and the *de facto* medical decision maker becomes the medical director of the state correctional facility. This case study highlights challenges that arise when the ethically appropriate response to a hospitalized prisoner's terminal medical condition warrants decisions that are in conflict with that advocated by the correctional facility. http://journals.lww.com/jonalaw/Abstract/2012/04000/The_Hospitalized_Prisoner_With_a_Life_Threatening.3.aspx

Prison hospice

Articles and reports focused on the provision and delivery of end of life care for prison inmates have been highlighted in Media Watch on a fairly regular basis. A compilation of these articles and reports in a single document is available on request. Contact information at foot of p. 16.

Of related interest

- *JOURNAL OF THE AMERICAN GERIATRICS SOCIETY* | Online article – 29 May 2012 – **'Addressing the aging crisis in U.S. criminal justice health care.'** This article provides an overview of aging in the criminal justice system. <http://onlinelibrary.wiley.com/doi/10.1111/j.1532-5415.2012.03962.x/abstract>

What influences African American end-of-life preferences?

JOURNAL OF HEALTH CARE FOR THE POOR & UNDERSERVED, 2012;23(1):28-58. There are well documented differences in preferences for end-of-life care and utilization of services between non-Hispanic Whites and African Americans. African Americans do not use advance care planning documents or hospice to the same extent as non-Hispanic Whites, and, even after controlling for income and access, the difference is significant. Many African Americans choose aggressive life-sustaining treatment at the end of life, even if that treatment seems likely to confer great burden with little chance of benefit. The reasons for this are multi-faceted and include knowledge of/access to services, historical mistrust of the health care system, and spiritual beliefs. http://muse.jhu.edu/login?auth=0&type=summary&url=/journals/journal_of_health_care_for_the_poor_and_underserved/v023/23.1.wicher.html

From Media Watch, 7 May 2012:

- *HOWARD JOURNAL OF COMMUNICATION* | Online article – 27 April 2012 – '**African Americans and decisions about hospice care: Implications for health message design.**' <http://www.tandfonline.com/doi/abs/10.1080/10646175.2012.667724>

From Media Watch, 10 October 2011:

- U.S. | Reuters – 5 October 2011 – '**Downsides of cancer care rarely seen in black media.**' Historically, African Americans with advanced cancer have been more likely than whites to opt for aggressive treatment, and less likely to want hospice care.¹ There's also evidence that hospice care ... does not speed death – and in some cases, may help people live longer than aggressive cancer treatment would. <http://www.reuters.com/article/2011/10/05/us-downsides-cancer-care-idUSTRE79455V20111005>

1. 'Is public communication about end-of-life care helping to inform all? Cancer news coverage in African American versus mainstream media,' *Cancer*, published online 22 September 2011 (noted in Media Watch, 3 October 2011). <http://onlinelibrary.wiley.com/doi/10.1002/cncr.26499/full>

Teaching end-of-life care via a hybrid simulation approach

JOURNAL OF HOSPICE & PALLIATIVE NURSING | Online article – 21 May 2012 – A single-group pre-experimental design was deployed to evaluate the impact of a hybrid simulation experience on a [nursing] student's knowledge and emotional readiness to provide care for a dying patient. Students [i.e., study participants] reported a higher level of stress for providing care to a patient after the simulation experience. This may be due to students having limited exposure to this content during their nursing education. Educators need to ensure they sufficiently cover this content in nursing curricula while ensuring students are competent in providing end-of-life care. http://journals.lww.com/jhpn/Abstract/publishahead/Teaching_End_of_Life_Care_Via_a_Hybrid_Simulation.99991.aspx

Of related interest:

- *BMJ SUPPORTIVE & PALLIATIVE CARE* | Online article – 31 May 2012 – '**Hospice inpatients' views on physical examination by medical students: Is it acceptable?**' Hospice inpatients generally wish to be involved in medical student teaching, but many are concerned about being physically examined, and some feel a sense of obligation to participate. There are implications for hospices that teach students. Further research is necessary to investigate the frequency and severity of these concerns. <http://spcare.bmj.com/content/early/2012/05/31/bmjspcare-2012-000202.abstract>
- *JOURNAL OF THE AMERICAN GERIATRICS SOCIETY* | Online article – 30 May 2012 – '**Palliative care teaching in medical residency.**' This is a comparison review of GeriaSims and Care of the Aging Medical Patient modules addressing issues in palliative and hospice medicine found in the Portal of Geriatric Online Education, a free on-line repository of geriatric educational materials for medical educators. <http://onlinelibrary.wiley.com/doi/10.1111/j.1532-5415.2012.03964.x/abstract>

Direct observation of prognosis communication in palliative care: A descriptive study

JOURNAL OF PAIN & SYMPTOM MANAGEMENT | Online article – 30 May 2012 – Participants [in this study] communicated prognoses regarding quality of life more frequently than survival; focused prognosis estimates on the unique patient more frequently than on a general population; and, framed prognosis using pessimistic cues more frequently than optimistic ones. Prognoses were more commonly spoken by palliative care clinicians than by patients/families. The following two factors demonstrated an association with the rate of prognostic communication and with the pessimistic framing of that information: whether the patient, family, or both participated in the conversation, and shorter expected survival (as estimated by the attending physician). The rate and characteristics of prognosis communication differ based on the length of time the patient is expected to live. <http://www.sciencedirect.com/science/article/pii/S0885392412001522>

Of related interest:

- *BMJ SUPPORTIVE & PALLIATIVE CARE* | Online article – 31 May 2012 – **'Patients' reports or clinicians' assessments: which are better for prognosticating?'** A prognostic model derived using observer-rated data was more accurate at predicting survival than a similar model derived using patient self-report measures. <http://spcare.bmj.com/content/early/2012/05/31/bmjspcare-2012-000216.abstract>

Doctor house calls part of Ontario plan to keep seniors at home longer

THE MEDICAL POST (Canada) | Online report – 25 May 2012 – The Ontario [provincial] government has outlined the next step in its strategy to keep seniors in their homes longer. Health Minister Deb Matthews says proposed measures include more house calls by doctors, more access to home care for seniors in need, and special co-ordinators to ensure seniors receive the right care. It also includes a home-renovation tax credit for seniors to adapt their homes as they get older. <http://www.canadianhealthcarenetwork.ca/physicians/news/professional/doctor-house-calls-part-of-ontario-plan-to-keep-seniors-at-home-longer-22712>

From Media Watch, 30 January 2012:

- *CANADIAN FAMILY PHYSICIAN*, 2012;58(1):114-116. **'Teaching end-of-life care in the home.'** <http://www.cfp.ca/content/58/1/114.full>

From Media Watch, 13 June 2011:

- U.S. | *Tampa Tribune* (Florida) – 12 June 2011 – **'Doctors going home.'** Advocates say house calls eliminate the expensive, specialized transportation many patients with serious health problems need to get to the doctor. <http://www2.tbo.com/news/news/2011/jun/12/MENEWSO1-doctors-going-home-ar-236838/>

The house call: Past, present and future

UNIVERSITY OF TORONTO MEDICAL JOURNAL, 2012; 89(3):175-177. Physicians for millennia have performed house calls. It allows for the opportunity of the physician to develop a connection with a patient while they are their most vulnerable. This established profound physician-patient relationships, as both the time spent with the patient was longer and the frequency of visits were higher. This article will examine the early history of the house call, how it became nearly extinct in the 20th century and its recent resurgence. The house call will be examined as a tool of improving patient outcomes and as a method to decrease health care expenditures in wake of the aging population with increased co-morbidities. <http://utmj.org/ojs/index.php/UTMJ/article/view/1429/1252>

Amyotrophic lateral sclerosis and palliative care: Where we are, and the road ahead

MUSCLE & NERVE, 2012;45(3):311-318. Patients with amyotrophic lateral sclerosis (ALS) have high symptom burdens, including pain, fatigue, dyspnea, and sialorrhea, and they must make difficult decisions about the use of life-prolonging therapies, such as long-term mechanical ventilation. The impact of ALS is felt by family caregivers who often struggle to meet the heavy physical, financial, and emotional demands associated with the illness. Expert multidisciplinary care may improve both quality and length of life of patients with ALS. However, although advances have been made in the treatment of some symptoms, others, including pain management, remain poorly studied. Involvement of palliative care ... as part of the ALS multidisciplinary team is recommended as we continue to work toward improving the quality of life for patients and their families. <http://onlinelibrary.wiley.com/doi/10.1002/mus.22305/abstract?userIsAuthenticated=false&deniedAccessCustomisedMessage=>

From Media Watch, 14 February 2011:

- *JOURNAL OF NEUROLOGY, NEUROSURGERY & PSYCHIATRY* | Online article – 5 February 2011 – '**Palliative care in amyotrophic lateral sclerosis: Review of current international guidelines and initiatives.**' Despite an international consensus ... integration of palliative care varies considerably across health care systems. Late referral to palliative services in ALS is not uncommon and may impact negatively on the quality of life of ALS patients and their caregivers. <http://jnnp.bmj.com/content/early/2011/02/04/jnnp.2010.232637.abstract?sid=2fb2379c-b7d2-419d-8a3b-bf6f757148c3>

From Media Watch, 7 June 2010:

- *AMYOTROPHIC LATERAL SCLEROSIS* | Online article – 17 March 2010 – '**Meaning in life in patients with amyotrophic lateral sclerosis.**' The aim of this study was to investigate 'meaning in life' in patients with amyotrophic lateral sclerosis and compare the findings with a ... sample of the German population. <http://informahealthcare.com/doi/abs/10.3109/17482961003692604>

Palliation for dying undocumented immigrants

NEW ENGLAND JOURNAL OF MEDICINE | Online article – 31 May 2012 – At first glance, sending dying patients home at their request may appear to be an approach that would please advocates on both sides of the debate over illegal immigration. But it does raise some concerns. Would helping a dying immigrant to get home lead to the use of emergency Medicaid funds for palliative purposes? (If so, evidence suggests that hospice services for undocumented immigrants, as with all health care services, would cost significantly less than those for the native born.) Are we, by not providing dying patients the standard of care, coercing immigrants to return home? These are valid concerns, but they should not detract from the principal issue: in a system in which emergency care for immigrants is being limited and adequate palliation for dying patients is not possible – a system in which dying people feel compelled to return to the hospital immediately after discharge – sending the right patients home may be ethically necessary. <http://www.nejm.org/doi/pdf/10.1056/NEJMp1201768>

"A sound track of your life": Music in contemporary U.K. funerals

OMEGA – JOURNAL OF DEATH & DYING, 2012;65(1):33-54. Music contributes to the public ceremony and the personal existential quest of the bereaved. It is important to both the content and process of the contemporary funeral, an event of deep cultural significance in our response as individuals and communities to death and the loss of a significant relationship. There is evidence that for many people, the music chosen and used also evokes and conveys their spirituality. <http://baywood.metapress.com/app/home/contribution.asp?referrer=parent&backto=issue,3,5;journal,1,256;linkingpublicationresults,1:300329,1>

Progress towards systems of quality measurement that capture the essence of good palliative care

PALLIATIVE MEDICINE, 2012;26(4):291-293. Quality measurement in palliative care usually involves health care utilization indicators, such as number of hospitalizations at the end of life; medical record review for issues such as pain management; or survey data, such as after-death surveys for families of hospice patients. However, although many tools have recently been developed, quality measurement in this area is limited by challenges of assessment in vulnerable populations and lack of consistent documentation of many key aspects (such as pain management or end-of-life decision-making) in medical records. Many palliative care indicators have not been well evaluated; in particular, there is little good evidence for correlation between indicators ... and patient outcomes. In addition, most indicators only address processes of care that are a small part of the complex and varied issues necessary for high-quality end-of-life care, and none collect data directly from patients. <http://pmj.sagepub.com/content/26/4/291.full>

Of related interest:

- *BMJ SUPPORTIVE & PALLIATIVE CARE* | Online article – 31 May 2012 – '**Defining the palliative care patient: Its challenges and implications for service delivery.**' Major themes suggested GPs [i.e., study participants] found it difficult to define the palliative care patient. Patients not identified as 'palliative' were often discussed unofficially if care requirements were significant or prognosis uncertain. <http://spcare.bmj.com/content/early/2012/05/31/bmjspcare-2012-000220.abstract>

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/CurrentNewsandEvents/tabid/88/Default.aspx> (Click on 'Current Issue' under 'Media Watch')

ONTARIO | HPC Consultation Services (Waterloo Region/Wellington County): <http://www.hpcconnection.ca/newsletter/inthenews.html>

ONTARIO | Mississauga Halton Palliative Care Network: <http://www.mhpcn.ca/Physicians/resources.htm?mediawatch=1>

ONTARIO | Palliative Care Consultation Program (Oakville): <http://www.palliativecareconsultation.ca/?q=mediawatch>

U.S.A.

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

Europe

HUNGARY | Hungarian Hospice Foundation: <http://www.hospicehaz.hu/en/training/> (Scroll down to 'Media Watch')

U.K. | Omega, the National Association for End of Life Care: <http://www.omega.uk.net/news.htm> (Scroll down to 'International End of Life Roundup')

Asia

SINGAPORE | Centre for Biomedical Ethics (CENTRES): <http://centres.sg/> (Scroll down to 'What's New: Reading List Update')

International

Australasian Palliative International Link: <http://www1.petermac.org/apli/links.htm> (Scroll down to 'Media Watch')

Palliative Care Network Community: <http://www.pcn-e.com/community/pg/file/owner/MediaWatch>

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

Extent of palliative care need in the acute hospital setting: A survey of two acute hospitals in the U.K.

PALLIATIVE MEDICINE | Online article – 22 May 2012 – In common with international health policy, The End of Life Care Strategy¹ for England has highlighted the delivery of high quality palliative care in the acute hospital setting as an area of priority. The aim of this study was to explore the extent of palliative care need in the acute hospital setting, and to explore agreement between different sources in the identification of patients with palliative care need. 36.0% of patients were identified as having palliative care needs according to GSF criteria. Medical staff identified 15.5% of patients as having palliative care needs, and nursing staff 17.4% of patients. Patient self-report data indicated that 83.2% of patients meeting GSF criteria had palliative care needs. The results reveal that according to the GSF prognostic guide, over a third of hospital in-patients meet the criteria for palliative care need. Consensus between medical staff, nursing staff and the GSF was poor regarding the identification of patients with palliative care needs. This has significant implications for patient care, and draws into question the utility of the GSF in the hospital setting. <http://pmj.sagepub.com/content/early/2012/05/18/0269216312447592.abstract>

1. 'End of Life Care Strategy...' Department of Health, 2008. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_086345.pdf

From Media Watch, 5 March 2012:

- 'Transforming end of life care in acute hospitals: The route to success 'how to' guide,' National End of Life Care Programme, National Health Service (NHS), February 2012. <http://www.endoflifecareforadults.nhs.uk/publications/acute-rts-howtoguide>

N.B. The guide builds upon 'The route to success in end of life care – achieving quality in acute hospitals,' NHS, 2010. <http://www.endoflifecareforadults.nhs.uk/publications/route-to-success-acute-hospitals>

Breaking bad news in China – the dilemma of patients' autonomy and traditional norms. A first communication skills training for Chinese oncologists and caretakers

PSYCHO-ONCOLOGY | Online article – 27 May 2012 – Current practice of breaking bad news in China involves disclosure of information first to family members who then decide whether the patient should receive this information. Recently, however, patients' right to be informed has been regulated by law. This represents a dilemma for oncologists who now have to balance traditional practice with new legal requirements. A communication skills training was developed for Chinese practice. It addresses this issue and may help participants find individual solutions within these conflicting requirements. Participants stated that in most cases (78%), they inform family members first. Contrary to this practice, participants think that about 75% of patients would like to be informed first, independent of family. Overall, the workshop received a very good rating. After the workshop, the participants rated their performance significantly higher in all areas, for example, talking about diagnosis, prognosis and death with the patient and the family. <http://onlinelibrary.wiley.com/doi/10.1002/pon.3112/abstract>

'I don't want to talk about it.' Raising public awareness of end-of-life care planning in your locality

INTERNATIONAL JOURNAL OF PALLIATIVE NURSING, 2012;18(5):241-247. The U.K. Department of Health's (End of Life Care Strategy) highlighted the need for greater public awareness around planning and the choices available as people approach the end of their life. Despite efforts to 'normalise' death and dying and recognise that they are an inevitable part of life, a taboo persists and open communication about these issues is often limited or restricted to periods of crisis. Translating national policy into meaningful local dialogue requires creative interventions that are adaptable to each community. This article explores these key themes and reports on the responses of the first 304 people to complete an end-of-life survey as part of local engagement with the general public in South West Essex regarding issues around death and dying. http://www.ijpn.co.uk/cgi-bin/go.pl/library/article.html?uid=91967;article=IJPN_18_5_241_247

Cont.

N.B. China was rated 37th (of forty countries surveyed) in *The Quality of Death: Ranking End-of-life-Care Across the World*, commissioned by the Lien Foundation, Singapore, published by the Economist Intelligence Unit, July 2010. http://graphics.eiu.com/upload/QOD_main_final_edition_Jul12_toprint.pdf

Palliative care in Taiwan

Family experience with difficult decisions in end-of-life care

PSYCHO-ONCOLOGY | Online article – 23 May 2012 – The purpose of this study was to determine the frequency and difficulty of decisions experienced in end-of-life care and to identify related factors. The most difficult decisions commonly encountered [among study participants] in both hospice and non-hospice wards related to truth telling, place of care, and alternative treatments. Older age, not being the main family caregiver, and less perception of burdens regarding the Natural Death Act [Hospice Palliative Medicine Act, 2000] were negatively correlated with the difficulty of decisions. Families frequently encountered difficult decisions while caring for terminally ill loved ones. Better communication with family members, particularly the main caregiver, to diminish negative perceptions ... could help to decrease psychological distress. <http://onlinelibrary.wiley.com/doi/10.1002/pon.3107/abstract>

N.B. Taiwan was rated 14th (of forty countries surveyed) 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

Diabetes and end of life: Ethical and methodological issues in gathering evidence to guide care

SCANDINAVIAN JOURNAL OF CARING SCIENCES | Online article – 23 May 2012 – The aim of this paper is to discuss the ethical and methodological issues encountered when undertaking research to develop guidelines for managing diabetes at the end of life and the strategies used to address the issues. Key themes were vulnerability of the sampling population; methodological issues included recruiting participants and ensuring rigor, ethical issues concerned benefit and risk, justice, autonomy, privacy, professional boundaries and informed consent. Researcher-related issues were identified such as managing participant distress and their own emotional distress. People were willing to discuss end of life diabetes management preferences. Undertaking research with people at the end of life is complex because of their vulnerability and the ethical issues involved. However, the ethical principles of autonomy and justice apply and people should be given the relevant information and opportunity to decide whether to participate or not. <http://onlinelibrary.wiley.com/doi/10.1111/j.1471-6712.2012.01016.x/abstract>

From Media Watch, 21 May 2012:

- *JOURNAL OF HOSPICE & PALLIATIVE NURSING*, 2012;14(4):293-302. 'The experiences and care preferences of people with diabetes at the end of life: A qualitative study.' [http://journals.lww.com/jhpn/Abstract/2012/06000/The Experiences and Care Preferences of People.10.aspx](http://journals.lww.com/jhpn/Abstract/2012/06000/The_Experiences_and_Care_Preferences_of_People.10.aspx)

Integration of palliative and supportive cancer care in Asia

THE LANCET ONCOLOGY, 2012;13(5):445-446. Good cancer care should aim to prevent or relieve suffering caused by cancer and its treatment. This approach can have quantifiable outcomes for patients, including prolonged and improved quality of life. Palliative and community-based supportive care are necessary components and need to be fully integrated into any multidisciplinary health-care plan. Asia's ageing population presents challenges to the sustained organisation and delivery of comprehensive care for patients with cancer, and several important ethical issues need to be considered. [http://www.thelancet.com/journals/lanonc/article/PIIS1470-2045\(12\)70141-9/fulltext](http://www.thelancet.com/journals/lanonc/article/PIIS1470-2045(12)70141-9/fulltext)

Dignity therapy

Creating discursive order at the end of life: The role of genres in palliative care settings

WRITTEN COMMUNICATIONS, 2012;29(2):111-141. This article investigates an emerging practice in palliative care: dignity therapy ... a psychotherapeutic intervention that its proponents assert has clinically significant positive impacts on dying patients. Dignity therapy consists of a physician asking a patient a set of questions about his or her life and returning to the patient with a transcript of the interview. The authors use a rhetorical genre studies framework to explore what the dignity interview is doing, how it shapes patients' responses, and how patients improvise within the dignity interview's genre ecology. Findings suggest that these patients appear to be using the material and genre resources ... associated with dignity therapy to create discursive order out of their life events. This process of genre negotiation may help to explain the positive psychotherapeutic results of dignity therapy. <http://wcx.sagepub.com/content/29/2/111.short>

Assisted (or facilitated) death

Representative sample of recent articles, etc:

- *BRITISH MEDICAL JOURNAL* | Online article – 29 May 2012 – **'What's wrong with assisted dying.'** Within a relatively recent historical context ... the apparently burgeoning enthusiasm for assisted dying seems perhaps a little surprising. The common assertion is that allowing doctors to help people to die, within a carefully regulated framework of strict safeguards, will relieve more suffering than it causes. I am not so sure, and I can identify two main reasons for my discomfort. The first is a deep concern that it will be impossible to draft a law robust enough to protect the vulnerable. <http://www.bmj.com/content/344/bmj.e3755.short>
- *HEALTH POLICY*, 2012;105(2):296-302. **'Empathy and the application of the 'unbearable suffering' criterion in Dutch euthanasia practice.'** Results show that doctors follow different 'cognitive routes' when assessing a patients suffering in the context of a euthanasia request. Sometimes doctors do this imagining how she herself would experience the situation of the patient ('imagine self'). Doctors may also try to adopt the perspective of the patient and imagine what the situation is like for this particular patient ('imagine other'). Besides this the authors found that the (outcome of the) assessment is influenced by a doctor's private norms, values and emotions considering (the performance of) euthanasia. [http://www.healthpolicyjrn.com/article/S0168-8510\(12\)00015-2/abstract](http://www.healthpolicyjrn.com/article/S0168-8510(12)00015-2/abstract)
- *JOURNAL OF AGING STUDIES* | Online article – 8 May 2012 – **'Alzheimer's disease and euthanasia.'** Employing the tenets of philosophical materialism, this paper discusses the ethical debate surrounding assisted suicide for persons suffering end-stage Alzheimer's. It first presents a classification of the dissociative situations between "human individual" and "human person." It then moves on to discuss challenges to diagnosed persons and their caregivers in relation to the cardinal virtues of Spinozistic ethics – strength of character (*fortitudo*), firmness (*animositas*) and generosity (*generositas*). <http://www.sciencedirect.com/science/article/pii/S089040651200028X>
- *THE LANCET NEUROLOGY*, 2012;11(5):392-393. **'U.K. High Court case to reignite debate over assisted death.'** A paralysed man has won the right to argue in court that he should be able to request lawful euthanasia, in a hearing that could have repercussions for patients with dementia. The debate about the rights and wrongs of assisted death is never far from the headlines, and so far 2012 has been no exception. [http://www.thelancet.com/journals/laneur/article/PIIS1474-4422\(12\)70086-8/fulltext](http://www.thelancet.com/journals/laneur/article/PIIS1474-4422(12)70086-8/fulltext)

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