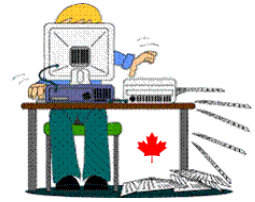


Media Watch...

is intended as an advocacy, research and teaching tool. The weekly report is international in scope and distribution – to colleagues who are active or have a special interest in **hospice** and **palliative care**, and in the quality of **end-of-life care** in general – to help keep them abreast of current, emerging and related issues – and, to inform discussion and encourage further inquiry.

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Compilation of Media Watch 2008, 2009, 2010, 2011, 2012, 2013, 2014 ©

Compiled & Annotated by Barry R. Ashpole

Results of a Delphi Study: Scroll down to Specialist Publications (p.10) and 'Components and principles of a pediatric palliative care consultation,' in *Journal of Palliative Medicine*.

N.B. Several additional articles on different aspects of paediatric palliative care are noted.

U.S.A.

A new era of cost reporting for hospices

HEALTHCARE FINANCE NEWS | Online – 11 July 2014 – Historically, the Centers for Medicare & Medicaid Services [CMS] hasn't put a lot of emphasis on tracking costs in the hospice industry. In the late 1990s, there wasn't even a requirement to file the reports. However, CMS later decided it did need some kind of information on the sector and required hospices to file. Organizations can now lose Medicare payments if they don't file the reports, and yet, because there are no penalties for inaccurate reporting, there is little motivation to spend much time on them. In the current climate, in fact, a hospice could claim something as inconsistent as providing care for inpatient days, but not associating any cost for inpatient stays. There is no mechanism used to catch even big, easily apparent errors. Judi Lund Person, vice president of compliance and regulatory leadership for the National Hospice & Palliative Care Organization [NHPCO], said that an internal NHPCO analysis of cost re-

ports showed that the cost per day of nursing care reported by hospices ranged from 6 cents to \$55,000 – neither of which was right. These kinds of discrepancies, she said, "affect the reputation for validity of the cost reports." But hospices ability to turn in unchecked reports will soon be changing. <http://www.healthcarefinancenews.com/new/new-era-cost-reporting-hospices>

Specialist Publications

'Interventions to improve hospice and palliative care referral: A systematic review' (p.11), in *Journal of Palliative Medicine*.

'End-of-life health care utilization in hospitals with compared to those without palliative care programs' (p.12), in *Journal of Palliative Medicine*.

Medicare and Medicaid services may soften paperwork requirements for home health care

THE WASHINGTON POST | Online – 9 July 2014 – Doctors may not have to write a narrative summary for patients needing home health care if a proposed rule by the Centers for Medicare & Medicaid Services is finalized. For Medicare to pay for a home health visit ... the patient must be seen by a doctor either 90 days prior to the start of the home health care or 30 days after the start of the services. Currently, Medicare requires physicians certify these patients are under their care and they have trouble leaving home without the help of a walker or special transportation because of an illness or injury. To do so, doctors have to fill out what's referred to as a face-to-face document, which states when the doctor saw the patient, and includes a narrative summary stating why the patient is homebound. Home health agencies have pushed back against these requirements, saying Medicare contractors have denied them payments if physicians' summaries are too short and not descriptive enough. And physicians have little incentive to do it a second time since the patient has already received care. Hospital physicians may also not have enough of a full picture of the homebound status of a patient to write detailed summaries, and primary care physicians might not be in the know if a patient becomes homebound after a hospitalization. http://www.washingtonpost.com/national/health-science/cms-may-soften-paperwork-requirements-for-home-health-care/2014/07/09/ec6be446-07a3-11e4-9ae6-0519a2bd5dfa_story.html

State Prison Health Care Spending

THE PEW CHARITABLE TRUSTS | Online – 8 July 2014 – This report finds state spending on prisoner health care increased from 2007 to 2011, but began trending downward from its peak in 2009. Nationwide, prison health care spending totaled \$7.7 billion in fiscal 2011, down from a peak of \$8.2 billion in 2009. In a majority of states, correctional health care spending and per-inmate health care spending peaked before 2011. A steadily aging prison population is a primary challenge that threatens to drive costs back up. The National Institute of Corrections pegged the annual cost of incarcer-

ating prisoners age 55 and older with chronic and terminal illnesses at two to three times the expense for all other inmates... <http://www.pewtrusts.org/~media/Assets/2014/07/StatePrisonHealthCareSpendingReport.pdf>

Quotable Quotes

The degree of civilization in a society can be judged by entering its prisons. Fyodor Dostoevsky (1821-1881)

N.B. The provision and delivery of end-of-life care in the prison system have been highlighted in Media Watch on a regular basis. A compilation of articles, reports, etc., on this public health issue noted in the weekly report in recent years is available online at the Palliative Care Community Network website: <http://www.pcn-e.com/community/pg/file/read/3389844/end-of-life-care-in-prisons>.

Hospice closure

Hospice Care Team to provide continuity of patient care

TEXAS | *The Citizen* (The Woodlands) – 8 July 2014 – Houston Hospice will step in to provide patient care and employment as Galveston County's only not-for-profit hospice organization [Hospice Care Team (HCT)] ceases operations. To ensure continuity of care for their current roster of patients, the operators of HCT reached out to Houston Hospice – the oldest and largest non-profit hospice in the Houston area. Houston Hospice will not only oversee patient care, they also anticipate hiring the majority of HCT's clinical staff and essential support personnel. http://www.yourhoustonnews.com/bay_area/news/hospice-care-team-to-provide-continuity-of-patient-care/article_4d089dcb-abdc-5693-8f03-bddb30e593ee.html

N.B. Hospice Care Team announced last month that it would shut down due to a lack of funds.

East Bay facility first in nation to offer palliative and hospice care to families with terminally ill children

CALIFORNIA | *The Contra Costa Times* (Walnut Creek) – 6 July 2014 – When it opened ... in 2004, George Mark was the first free-standing facility in the nation to offer palliative and hospice care to terminally ill children. It remains one of the few examples in this country of an approach to children's care more common in Europe. George Mark provides transitional and end-of-life care mostly for children from birth to age 21, who usually stay from one day to several months. Of eight beds, four to five are occupied daily. Insurance covers about 22% of the center's \$4 million annual operating budget. The rest is covered through partnerships, donations, grants or through fundraising. Relying on

donations means that it is sometimes tough to stay afloat. When the recession hit in 2007, money dried up and the facility laid off staff. In 2010, it closed for six months. http://www.contracostatimes.com/news/ci_26093827/george-mark-childrens-house-offers-solace-families-terminally

Specialist Publications

'Components and principles of a pediatric palliative care consultation' (p.10), in *Journal of Palliative Medicine*.

York County physicians, patients join push for better communication with goal of improving treatment

PENNSYLVANIA | *The York Daily Record* – 6 July 2014 – [Dr. Mark] Goedecker joined Aligning Forces for Quality's patient partner program in its infancy as a "physician champion" to help work with patients and the internal structure of his practice to change the cycle of miscommunication. York County practices sign up to be part of patient partners and go through a one-year program, learning an extensive curriculum created by Goedecker and his team. Each practice is called a medical home, made up of doctors, nurses, administrative staff and patients. When the medical home finishes the program, they graduate, Goedecker said. But data showed even after learning how to change, the medical homes began to slide into their old ways. Goedecker leads the

Learning & Innovating for Transformation Collaborative, where graduate medical homes continue to meet through webinars and annual dinners to discuss progress and new initiatives. New is the introduction of medical neighborhoods, as specialists and emergency room staff join the movement. http://www.ydr.com/local/ci_26094432/york-county-physicians-patients-join-push-better-communication

Specialist Publications

'Managing oncology patients: Communication is key to improving quality of care' (p.8), in *Medical Economics*.



Barry R. Ashpole

My involvement in hospice and palliative care dates from 1985. As a communications consultant, I've been involved in or responsible for a broad range of initiatives at the community, regional, provincial and national level. My current work focuses primarily on advocacy and policy development in addressing issues specific to those living with a 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 college courses on different aspects of end-of-life care, and facilitating issue specific workshops, primarily for frontline care providers. Biosketch on the International Palliative Care Resource Center website at: <http://www.ipcrc.net/barry-r-ashpole.php>

Affordable Care Act

Let's talk about "death panels"

POLITICO MAGAZINE | Online – 6 July 2014 – A health-care system that promiscuously reimburses proton beam cancer therapies can finance a 45-minute conversation about your advanced-care directives. Some private insurers and state Medicaid programs already reimburse such consultations. So it's no surprise that the Illinois medical society, geriatricians, policymakers and advocacy groups are quietly pushing both private insurers and Medicare to reconsider the idea, this time through regulatory and administrative actions rather than new legislation. The American Medical Association ... will submit information to the Centers for Medicare & Medicaid Services concerning the mechanics of reimbursing such services. There's nothing inherently ideological about these services, either. Donald Taylor of Duke University, one of the nation's leading palliative care policy experts, notes that "prior to the Affordable Care Act, hospice policy and discussions around advanced directives and the like tended to have broad bipartisan support." Indeed, it was a Republican senator ... who co-sponsored 2007's Medicare End-of-Life Planning Act to expand coverage for voluntary care counseling in cases of serious illness. A very similar provision was included in the House version of what became the Affordable Care Act. Section 1223 would have paid physicians for discussing advanced-care planning with their patients. Then came the "death panel" bomb. <http://www.politico.com/magazine/story/2014/07/death-panels-108553.html#.U7rGiZRdX8k>

Noted in Media Watch, 9 June 2014, #361 (p.4):

- WASHINGTON, DC | *Stateline* – 2 June 2014 – **'Feds to consider paying doctors for end-of-life planning.'** The federal government may reimburse doctors for talking to Medicare patients and their families about advance care planning ... and end-of-life treatment options potentially rekindling one of the fiercest storms in the Affordable Care Act debate. <http://www.pewstates.org/projects/stateline/headlines/feds-to-consider-paying-doctors-for-end-of-life-planning-85899545989>

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- OHIO | WOSU News (Columbus) – 7 July 2014 – **'Assisted suicide: Legality and ethics.'** Proponents say that assisted suicide – or dying – gives the power to the patient to take control of his or her life in the end. Opponents say that such laws could be used to coerce frail or elderly people who have become burdens – financially or otherwise – on their family or caretakers. Still others warn that insurance companies may turn to such policies to avoid expensive treatments. Mildred Solomon, president of non-profit bioethics research institute The Hastings Center, said that having the option to take their own lives gives some people the sense of some form of control that helped them accept death peacefully. "Part of the argument that proponents have given, is that this is meant to also be psychologically reassuring, to help people feel that they are in control," she said. "And once they know they have this ability, they can relax and enjoy the time they do have." Solomon also said that not everyone who requests the medication use it. <http://wosu.org/2012/allsides/assisted-suicide-legality-ethics/>

[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>

International

End-of-life care in the U.K.

Dying wishes going unfulfilled

U.K. (England) | *The Daily Mail* – 10 July 2014 – Only a third of people nearing the end of their lives who want to die in the comfort of their own homes are able to do so, new figures suggest.¹ Thirty-five per cent of people who expressed a preference to die at home had their wishes fulfilled in 2013, the Office for National Statistics (ONS) said. The ONS's national survey of bereaved people, based on the views of almost 50,000 respondents on the quality of care provided to a friend or relative in the last three months of life in England, also found that quality of care was rated significantly lower for people who died in a hospital, compared to those dying at home, in a hospice or care home. Almost half of those included in the survey died in hospital, which the ONS states "indicates the importance of providing high quality care in this setting." But it said hospitals were still "lagging behind" other care settings. <http://www.dailymail.co.uk/wires/pa/article-2687310/DYING-WISHES-GOING-UNFULFILLED.html>

1. National Survey of Bereaved People (VOICES), Office for National Statistics, July 2014. <http://www.ons.gov.uk/ons/rel/subnational-health1/national-survey-of-bereaved-people--voices-/2013/stb---national-survey-of-bereaved-people--voices-.html>

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 and research tool.

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.

Media Watch Online

Media Watch (or a link to the weekly report) is posted on a number of websites that serve the hospice and palliative care community-at-large. Complete listing p.13.

Poor policy to blame for problems in health sector

AUSTRALIA | *The Australian Financial Review* – 8 July 2014 – While the federal government tells us we're living beyond our means and the health system is unsustainable, the real problem lies in policy development or, more pertinently, lack of policy according to ... [the recent Healthy Ageing Round Table] ... participants. Health policy adviser and former director general of New South Wales and Queensland Health, Mick Reid, put it most succinctly when he said: "The crisis has been overstated and the policy response has been disproportionate to the circumstances." Reid worries unnecessary fear has been engendered in the community and as a result we're starting to lose our sense of fair play and egalitarianism and that's flowing through into areas such as health policy development. Chairman of the Western Sydney Local Health District Professor Stephen Leeder agrees much of the federal government's health policy seems to disproportionately affect those from lower socioeconomic backgrounds and seems to have been made on the run. Maddocks and [Health program director at the Grattan Insti-

tute Stephen] Duckett agreed that we tend to demonise the aged and focus on their dependency when the health system is geared to look after people from birth through to death, it's not designed to drop off just because people cost more. What's needed is a redesign of the hospital system where there is a focus on more personalised care and on consumer-directed care. http://www.afr.com/p/business/healthcare2-0/poor_policy_to_blame_for_problems_XrERIWkzfBSEwNldpCTjyO

Extract from *The Australian Financial Review* report

Palliative care specialist ... Ian Maddocks says we should keep people out of the hospital system to start with. "It's the only way in which the state governments are going to save money. You have to keep elderly people at home with some kind of good care, whether we've got nurse practitioners and visiting nurses and doctors who can respond to a given situation," Maddocks says.

We Irish are great at death but – unlike Bob – we still don't know how to grieve

IRELAND | *The Herald* (Dublin) – 8 July 2014 – Bob Geldof [Irish singer-songwriter, author and political activist] has revealed that he gets assailed by waves of grief in public in the aftermath of the death of his 25-year-old daughter, Peaches. In doing so he's shone a light on how we, and how men in particular, are expected to put a stiff upper lip on expressions of loss. "In this life, nothing is said to be certain, except death and taxes." So wrote Benjamin Franklin in 1789, and yet 225 years later, we still haven't become comfortable about talking about and dealing with death. We expect tears when someone dies – actually, we almost demand it, and woe betide a chief mourner who doesn't openly weep over the loss of a loved one. Society tolerates women crying better than men, though. After all, women are allowed to be emotional at the best of times. But our poor bereaved men must stay stoic and strong, and mourn their losses in private. <http://www.herald.ie/opinion/we-irish-are-great-at-death-but-unlike-bob-we-still-dont-know-how-to-grieve-30412733.html>

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- SOUTH AFRICA | *The Observer* (Commentary by Desmond Tutu) – 12 July 2014 – '**Desmond Tutu: A dignified death is our right – I am in favour of assisted dying.**' The manner of Nelson Mandela's prolonged death was an affront. I have spent my life working for dignity for the living. Now I wish to apply my mind to the issue of dignity for the dying. <http://www.theguardian.com/commentisfree/2014/jul/12/desmond-tutu-in-favour-of-assisted-dying>

Cont.

- U.K. (England & Wales) | BBC News – 12 July 2014 – '**Assisted dying: Church of England seeks inquiry.**' The Church of England has called for an inquiry into assisted dying. It follows a U-turn by former Archbishop of Canterbury Lord Carey, who said he would back legislation to allow the terminally ill in England & Wales get help to end their lives. The current Archbishop of Canterbury Justin Welby says the Assisted Dying Bill is "mistaken and dangerous." But the Church said an inquiry would include expert opinion and carefully assess the arguments. <http://www.bbc.com/news/uk-28278324>

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

Palliative care development in the Asia-Pacific region: An international survey from the Asia Pacific Hospice Palliative Care Network (APHN)

BMJ SUPPORTIVE & PALLIATIVE CARE | Online – 10 July 2014 – Of the 14 member countries/regions of the APHN, 12 (86%) responded. Some form of specialist palliative care services had developed in all the responding countries/regions. Eight member countries/regions had physician certifications for palliative care. Most essential drugs for palliative care listed by the International Association for Hospice & Palliative care were available, whereas hydromorphone, oxycodone and transmucosal fentanyl were unavailable in most countries/regions. Six member countries/regions required permission to prescribe and receive opioids. The development of palliative care is in different stages across the surveyed countries/regions in the Asia-Pacific region. Data from this survey can be used as baseline data for monitoring the development of palliative care in this region. <http://spcare.bmj.com/content/early/2014/07/10/bmjspcare-2013-000588.abstract>

Is religion harmful or beneficial at the end of life?

EUROPEAN JOURNAL OF PALLIATIVE CARE, 2014;21(4):188-192. Religious coping is commonly used by people approaching the end of life to help them face the challenges of terminal illness. Scholars seem to agree that religion has a profound influence on health; however, the role of religion/spirituality in coping with illness has received relatively little attention. A literature search highlighted studies showing both positive and negative influences of religion on health and the end of life. Understanding the impact of spiritual and religious beliefs on people can help clinicians overcome their own reluctance to discuss disease progression and prognosis with their patients.

N.B. Access to this article requires a subscription to the journal. Contents page of current issue: http://www.haywardpublishing.co.uk/year_search_review.aspx?JID=4&Year=2014&Edition=512

Representative sample of articles noted in past issues of Media Watch on religious faith and end-of-life care:

- *JOURNAL OF SURGICAL RESEARCH* | Online – 2 June 2014 – '**Religiously affiliated ICU patients receive more aggressive end-of-life care.**' Religiously affiliated patients [i.e., study participants] incurred 23% more hospital charges, 25% more ventilator days, 23% more hospital days, and 30% longer time until death than their non-affiliated counterparts. [Noted in Media Watch, 9 June 2014, #361 (p.14)] [http://www.journalofsurgicalresearch.com/article/S0022-4804\(14\)00540-X/abstract](http://www.journalofsurgicalresearch.com/article/S0022-4804(14)00540-X/abstract)
- *SOCIAL FORCES* | Online – 10 August 2012 – '**Religion and end-of-life treatment preferences: Assessing the effects of religious denomination and beliefs.**' Fundamentalist Catholics and fundamentalist Protestants were more likely than their non-fundamentalist counterparts to desire life-extending treatments... [Noted in Media Watch, 20 August 2012, #267 (p.7)] <http://sf.oxfordjournals.org/content/early/2012/08/09/sf.sos061.abstract>

Interactional communication challenges in end-of-life care: Dialectical tensions and management strategies experienced by home hospice nurses

HEALTH COMMUNICATION | Online – 3 July 2014 – Hospice nurses experience both interpersonal and organizational dialectics during hospice interactions: authoritative-non-authoritative, revelation-concealment, independence-collaboration, and quality of care-business of care. Dialectics often resulted as a by-product of a) responding to expectations and care choices of patients and families particular to the emotionally charged home context; b) obtaining authorization from health care providers who are not members of the interdisciplinary team; and, c) pressures associated with providing quality patient care while fulfilling organizational role requirements. Strategies used to negotiate tensions included segmentation, balance, recalibration, and spiraling inversion. Nurses employed strategies such as ascertaining family/patient acceptance, using persuasive tactics when communicating with external health care providers, relying on effective time management, and working off the clock to provide more in-person care. <http://www.tandfonline.com/doi/abs/10.1080/10410236.2013.868966#.U7vpFZRdX8k>

Managing oncology patients: Communication is key to improving quality of care

MEDICAL ECONOMICS | Online – 8 July 2014 – It's no secret that the U.S. cancer care delivery system is in crisis. Care is often not patient-centered, appropriate palliative care is lacking, and medical decisions often are not evidence-based. But when primary care physicians are closely involved during a patient's cancer treatment, quality of care can improve. New cancer diagnoses are expected to rise by 45% by 2030, even as severe shortages of both oncologists and primary care physicians (PCPs) are projected. Costs in cancer care are rising faster than other areas of medicine—annual costs are projected to reach \$173 billion by 2020, up from \$104 billion in 2006, according to the American Society of Clinical Oncology. Meanwhile, the rollout of the Affordable Care Act will bring more patients into the healthcare system. Traditionally, the role of the PCP in treating cancer patients has been ill-defined, and PCPs might easily lose track of their patients with cancer during the treatment phase. <http://medicaleconomics.modernmedicine.com/medical-economics/news/managing-oncology-patients-communication-key-improving-quality-care>

Of related interest:

- *HEALTH COMMUNICATION*, 2014;29(10):962-973. **'Relational dialectics theory: Disentangling physician-perceived tensions of end-of-life communication.'** Existing literature evidences the centrality of interpersonal communication during end-of-life care, but several barriers currently compromise its effectiveness. One of them is a common lack of communication skills among physicians in this challenging context. Several strategies have been suggested to enhance end-of-life interactions; however, a solid theoretical framework is needed for the development of effective systematic guidelines and interventions that can facilitate this goal. <http://www.tandfonline.com/doi/abs/10.1080/10410236.2013.815533?queryID=%24%7BresultBean.queryID%7D#.U7vrWpRdX8k>

Noted in Media Watch, 5 May 2014, #356 (p.13):

- *JOURNAL OF PAIN & SYMPTOM MANAGEMENT* | Online – 28 April 2014 – **'Contradictions and dialectics in the palliative dialogue: Enhancing the palliative dialogue by dialectical principles.'** Accepting the principles of dialectics, in which the existence of contradictions is seen as an inherent part of a reality that is undergoing constant change, give the caregiver the flexibility to interpret dichotomic thoughts and emotions as a dialectic failure and, in accordance, to move towards a synthesis of the ideas of living and dying. This approach provides caregivers the means to promote the palliative dialogue, to implement varied communication skills to clarify the patient's goals, and to implement a therapeutic plan to realize them. [http://www.jpmsjournal.com/article/S0885-3924\(14\)00222-X/abstract](http://www.jpmsjournal.com/article/S0885-3924(14)00222-X/abstract)

Palliative sedation in nursing homes: A good death?

JOURNAL OF THE AMERICAN MEDICAL DIRECTORS ASSOCIATION | Online – 4 July 2014 – The proportion of nursing home deaths is expected to increase in the upcoming years. International differences exist in the role of nursing homes in end-of-life care. Indeed, the proportion of residents dying in the nursing home ranges from 45% in Japan, to 68% in the U.S. and 90% in Belgium. [http://www.jamda.com/article/S1525-8610\(14\)00342-9/abstract](http://www.jamda.com/article/S1525-8610(14)00342-9/abstract)

Conflicts in goals of care at the end of life: Are aggressive life-prolonging interventions and a "good death" compatible?

JOURNAL OF HOSPICE & PALLIATIVE NURSING, 2014;16(6): 330-335. Recent medical literature reports increased utilization of the ICU at the end of life, even for patients who are considered terminally ill, and that the overall ICU adult mortality rate ranges from 10% to 29%. At times, ongoing aggressive life-prolonging interventions for a terminally ill patient can create ethical conflicts and moral distress for nurses. This leads to the question: Can this level of treatment be compatible with a "good death?" Medical recommendations are made based on the patient's goals of care, appropriate treatment options, and associated benefits and burdens. http://journals.lww.com/jhpn/Abstract/2014/08000/Conflicts_in_Goals_of_Care_at_the_End_of_Life_Are.3.aspx

Losing a parent: Analysis of the literature on the experiences and needs of adolescents dealing with grief

JOURNAL OF HOSPICE & PALLIATIVE NURSING, 2014;16(6):362-373. The aims of this study were to describe the reactions, experiences, and needs of adolescents who lose a parent as a result of a chronic illness, and to identify the factors that have proven to be useful in helping them deal with grief. The analysis of fourteen publications ... led to the identification of four key factors: 1) response to parent loss; 2) the teenagers' life after the death of their parent, of their needs, coping strategies and the factors influencing the grieving process 4) and, relations with context. http://journals.lww.com/jhpn/Abstract/2014/08000/Losing_a_Parent_Analysis_of_the_Literature_on_the.9.aspx

Representative sample of articles noted in past issues of Media Watch on young people and grief:

- *JOURNAL OF FAMILY COMMUNICATION*, 2014;14(3):208-229. **'Exploring children / adolescents' final conversations with dying family members.'** Four overarching themes emerged: 1) everyday communication; 2) messages of love; 3) messages of individual identity; and, 4) messages related to religion/spirituality. [Noted in Media Watch, 23 June 2014, #363 (p.12)] <http://www.tandfonline.com/doi/abs/10.1080/15267431.2014.908198#.U6BHbJRdX8k>
- *END OF LIFE JOURNAL*, 2013;3(2). **'Encouraging / supporting dying parents to talk to their children.'** This article provides an overview of the main factors for nurses and other health professionals to consider when supporting dying parents to communicate with their children ... to improve the confidence of practitioners in relation to encouraging dying parents to undertake such difficult conversations. [Noted in Media Watch, 15 April 2013, #301 (p.12)] <http://endoflifejournal.stchristophers.org.uk/clinical-skills/encouraging-supporting-dying-parents-to-talk-to-their-children>
- *JOURNAL OF PALLIATIVE MEDICINE* | Online – 14 September 2012 – **'How do we talk to the children? Child life consultation to support the children of seriously ill adult inpatients.'** Adult interdisciplinary palliative medicine teams often feel unprepared to facilitate the open communication with these children that has been shown to reduce anxiety, depression, and other behavioral problems. [Noted in Media Watch, 17 September 2012, #271 (p.11)] <http://online.liebertpub.com/doi/abs/10.1089/jpm.2012.0019>

Results of a Delphi Study

Components and principles of a pediatric palliative care consultation

JOURNAL OF PALLIATIVE MEDICINE | Online – 7 July 2014 – Nineteen experts participated and prioritized 34 components and principles in the first survey round, and 36 statements in the second survey round. There was consensus from all participants that the first priority of a consultation was to establish rapport with the family, and examples of how to achieve this were defined. Other components of a consultation included: establishing the family's understanding of palliative care; symptom management; an emergency plan; discussion of choices for location of care, and a management plan. Components considered suitable to defer to later consultations, or appropriate to address if initiated by family members, included: spiritual or religious issues; discussion around resuscitation and life-sustaining therapies; end-of-life care; and the dying process. <http://online.liebertpub.com/doi/abs/10.1089/jpm.2014.0121>

Of related interest:

- *AMERICAN JOURNAL OF HOSPICE & PALLIATIVE MEDICINE* | online – 9 July 2014 – **'Why palliative care for children is preferable to euthanasia.'** Recent laws in Europe now allow for pediatric euthanasia. The author reviews some rationale for caution, and addresses why ensuring the availability of pediatric palliative care is an important step before allowing pediatric euthanasia. <http://ajh.sagepub.com/content/early/2014/07/08/1049909114542648.abstract>
 - *ARCHIVES DE PÉDIATRIE* | Online – 30 June 2014 – **'Pediatric palliative care: A national survey of French pediatric residents' knowledge, education, and clinical experience.'** Ninety-six percent of all French pediatric residents encountered a PPC [pediatric palliative care] situation during their residency. That 77% had experienced PPC during their first year of residency shows the importance of early training in PPC. There is a significant lack in PPC training, however, since 40% of all residents in the study received no specific PPC training. <http://www.sciencedirect.com/science/article/pii/S0929693X1400219X>
- N.B. French language article.
- *JOURNAL OF CHILD HEALTH CARE* | Online – 30 June 2014 – **'Care in the home for seriously ill children with complex needs: A narrative literature review.'** The literature search revealed three major themes, namely the increasing acuity of child illness, the evolving role of the parent as care provider, and the health professional as care provider. While there is much known about the complexity of care of children and the role of family in that care, little is known about what families require in terms of support and sustenance during the long years of care provision. <http://chc.sagepub.com/content/early/2014/06/26/1367493514538327.abstract>
 - *JOURNAL OF EMERGENCY NURSING*, 2014;40(4):e83-e101. **'Death of a child in the emergency department.'** This revised technical report and accompanying policy statement reaffirm principles of patient- and family-centered care. Recent literature is examined regarding family presence, termination of resuscitation, bereavement responsibilities of emergency department [ED] clinicians, support of child fatality review efforts, and other issues inherent in caring for the patient, family, and staff when a child dies in the ED. Appendices are provided that offer an approach to bereavement activities in the ED, carrying out forensic responsibilities while providing compassionate care, communicating the news of the death of a child in the acute setting, providing a closing ritual at the time of terminating resuscitation efforts, and managing the child with a terminal condition who presents near death in the ED. <http://www.sciencedirect.com/science/article/pii/S0099176714002049>
 - *NURSING CHILDREN & YOUNG PEOPLE* | Online – 8 July 2014 – **'Innovative approach to providing 24/7 palliative care for children.'** This study outlines an innovative, English hospice-based service that provides 24/7 care for children with life-limiting conditions and their families. Operational objectives were: symptom management; open access to families and professionals; choice in place of care and of death; and collaboration to develop shared pathways and management plans. <http://rcnpublishing.com/doi/abs/10.7748/ncyp.26.6.27.e445>

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- *NURSING CHILDREN & YOUNG PEOPLE* | Online – 8 July 2014 – **'Family-focused children's end of life care in hospital and at home.'** This article describes how nurses working with children and families in home, hospital and community settings used the principles of practice development methodology to develop end of life care provision and follow-up bereavement support. It outlines the 'ways of knowing' that informed developments and how parents' priorities were kept central to the process. Finally, it discusses how the approach taken to practice development reflected the value of compassion in nursing practice. <http://rcnpublishing.com/doi/abs/10.7748/ncyp.26.6.35.e451>
- *PAEDIATRICS & CHILD HEALTH*, 2014;24(8):343-350. **'Palliative care for disabled children and young people.'** Systems are being piloted across the U.K. to collect data about who and where children and young people with palliative care needs are and to ensure robust funding mechanisms are established for provision of care in an equitable way. <http://www.sciencedirect.com/science/article/pii/S1751722214000213>
- *PEDIATRICS* | Online – 7 July 2014 – **'Pediatric advance directives: Parents' knowledge, experience, and preferences.'** Among 307 participants surveyed, previous AD [advance directives] experience was low, with 38.1% having heard of an AD, 17.6% having discussed one, and 25.1% having known someone who had an AD. Furthermore, 8.8% participants had an AD or living will of their own, and 2.6% reported their chronically ill child had an AD. Interest in creating an AD for the child was reported by 49.2% participants, and was significantly more likely among families who had more frequent emergency department visits over the previous year. <http://pediatrics.aappublications.org/content/early/2014/07/01/peds.2013-3124.abstract>
- *SYMBIOSIS* | Online – 12 June 2014 – **'Bereaved parent's satisfaction with home-based pediatric palliative care: Finding from Poland.'** Asked about their fears connected with decision to use hospice care most respondents frequently said they wouldn't cope with home care. The main expectation connected with hospice care was minimizing the feeling of helplessness. Value of children's families satisfaction with hospice care was classified "very good." <http://symbiosisonlinepublishing.com/palliative-medicine-care/palliative-medicine-care13.pdf>

Interventions to improve hospice and palliative care referral: A systematic review

JOURNAL OF PALLIATIVE MEDICINE | Online – 7 July 2014 – Hospice and palliative care are underutilized among patients at the end of their lives despite evidence that they improve patient satisfaction and reduce costs. The authors' search strategy yielded 419 studies, of which only six met their eligibility criteria. Three studies included nursing home populations; one included home care patients, one targeted care managers, and one reported on heart failure patients. Three studies had a cohort design, two were pre-post, and only one was randomized. Two studies evaluated a process to identify eligible subjects. Two evaluated the impact of advance care planning programs and two only provided education. Interventions that only provided education showed a median increase in referral of 5% while interventions that identified hospice candidates showed a median increase in hospice referral of 19.5%. Interventions of different levels of complexity can improve the use of hospice services among subjects with high mortality risk. <http://online.liebertpub.com/doi/abs/10.1089/jpm.2013.0503>

Of related interest:

- *JOURNAL OF PALLIATIVE MEDICINE* | Online – 9 July 2014 – **'The power of advance care planning in promoting hospice and out-of-hospital death in a dialysis unit.'** Comprehensive and systematic advance care planning among patients with end-stage renal disease on dialysis promotes greater hospice utilization and may facilitate the chance that death will occur out of hospital. <http://online.liebertpub.com/doi/abs/10.1089/jpm.2014.0031>
- *JOURNAL OF PALLIATIVE MEDICINE*, 2014;17(7):753-760. **'Engaging heart failure clinicians to increase palliative care referrals: Overcoming barriers, improving techniques.'** Better models to integrate palliative care earlier in the disease trajectory and a stronger evidence base for the role of palliative care for these patients are desperately needed. Because the course of heart failure is complex and unpredictable, the focus of palliative care offered must fit this different paradigm. <http://online.liebertpub.com/doi/full/10.1089/jpm.2013.0675>

End-of-life care in the U.S.

End-of-life health care utilization in hospitals with compared to those without palliative care programs

JOURNAL OF PALLIATIVE MEDICINE | Online – 7 July 2014 – Evaluations of palliative care frequently use end-of-life health care utilization as a key outcome. Hospitals that are early adopters of palliative care programs may differ systematically from U.S. hospitals overall factors such as hospital size, ownership, and baseline utilization that may affect programs' effectiveness. The object of this study was to describe key characteristics of U.S. hospitals with early palliative care programs compared with those without, including differences in end-of-life utilization. <http://online.liebertpub.com/doi/abs/10.1089/jpm.2014.0079>

N.B. The prevalence of palliative care in U.S. hospitals with 50 or more beds has increased by 157.1% over the past 11 years. In 2000, less than one-quarter of these hospitals (658) had a palliative care program, compared with more than two-thirds (1,692) in 2011. If current trends continue, by 2014, eight in ten U.S. hospitals with 50 or more beds will have a palliative care program. **Source:** Center to Advance Palliative Care <http://www.capc.org/capc-growth-analysis-snapshot-2013.pdf>

Of related interest:

- *NEWS-MEDICAL* | Online – 11 July 2014 – **'Palliative care delivered early during hospitalization can cut costs for critically ill patients.'** Palliative care delivered early during hospitalization can help cut costs for critically ill patients, finds a new study... "Palliative care programs are increasingly prevalent in U.S. hospitals but the financial incentives for hospitals to deploy them are not well-understood," explains Ian McCarthy, PhD, an assistant professor of economics at Emory. Today, 88% of large hospitals have palliative care teams and, said McCarthy, palliative care programs have proven "highly effective at addressing a wide range of needs felt by...patients and their families." <http://www.news-medical.net/news/20140711/Palliative-care-delivered-early-during-hospitalization-can-cut-costs-for-critically-ill-patients.aspx>
- *PALLIATIVE MEDICINE*, 2014;28(7):917-918. **'Avoidable for whom? Hospital use at the end of life.'** The worst global recession since the Second World War has focused international attention on ensuring efficient, and crucially cost-effective, health service usage. Given that most people consume the bulk of their lifetime health spend in the last year of life, it is unsurprising that the use of health services by people with palliative care needs has come under particular scrutiny. Indeed, a policy concern in many countries is reducing the number, and length, of acute hospital admissions among people who are at the end of life. <http://pmj.sagepub.com/content/28/7/917.full>

Literature review

Informal caregiving of hospice patients

JOURNAL OF PALLIATIVE MEDICINE | Online – 7 July 2014 – This study synthesized 58 articles pertaining to informal hospice caregiving, focusing on caregivers' satisfaction with hospice services, the physical and psychological well-being of caregivers, the predictors of caregivers' well-being, the direct impact of hospice services on caregivers, and the effectiveness of targeted interventions for hospice caregivers. The studies reviewed found hospice caregivers to experience clinically significant levels of anxiety, depression, and stress; however, results for caregiver burden and quality of life were mixed. Caregivers' perceptions regarding the meaningfulness of care as well as their levels of social support were associated with enhanced psychological outcomes. Beyond satisfaction with hospice services, the direct impact of standard hospice care on caregivers remains uncertain. Caregiver intervention studies have demonstrated promising outcomes signifying a need for additional investigations into hospice-specific interventions that improve caregiver outcomes. <http://online.liebertpub.com/doi/abs/10.1089/jpm.2013.0196>

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Of related interest:

- **HEART & LUNG** | Online – 7 July 2014 – '**Dignity in the older critically ill adult: The family member's perspective.**' Three major themes were identified in this study: 1) the older patient's health status and ICU experiences; 2) family roles, relationships, and goals; and 3) staff interactions with family members. Insight into the concerns of family members related to the dignity of the older critically ill patient may be useful in guiding nurses as they provide care in what are often fast-paced, highly technical environments. Meeting well established family needs as well as attending to the unique concerns identified in this study will assist nurses in supporting the older, critically ill patient's dignity. [http://www.heartandlung.org/article/S0147-9563\(14\)00186-1/abstract](http://www.heartandlung.org/article/S0147-9563(14)00186-1/abstract)
- **ONCOLOGY NURSING FORUM**, 2014;41(4):e248-e255. '**Effect of an Integrated Cancer Support Team on caregiver satisfaction with end-of-life care.**' Although the emotional impact of an impending loss of a loved one may not change with the provision of support, perception a loved one was well cared for in the terminal phase of illness may have long-range benefits...<http://ons.metapress.com/content/j7h841270423p330/?p=b5e571e69725441e91edeac29872c6c8&pi=2>

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Media Watch Online

International

INTERNATIONAL ASSOCIATION FOR HOSPICE & PALLIATIVE CARE: <http://hospicecare.com/about-iahpc/newsletter/2014/5/media-watch/>

INTERNATIONAL PALLIATIVE CARE RESOURCE CENTER: <http://www.ipcrc.net/archive-global-palliative-care-news.php>

PALLIATIVE CARE NETWORK COMMUNITY: <http://www.pcn-e.com/community/pg/file/owner/MediaWatch>

PALLIMED (Hospice & Palliative Medicine Blog): <http://www.pallimed.org/2013/01/the-best-free-hospice-and-palliative.html> [Scroll down to 'Aggregators' and Barry Ashpole and Media Watch]

Asia

ASIA PACIFIC HOSPICE PALLIATIVE CARE NETWORK: <HTTP://APHN.ORG/CATEGORY/MEDIA-WATCH/>

SINGAPORE | Centre for Biomedical Ethics (CENTRES): <http://centres.sg/updates/international-palliative-care-resource-center-media-watch/>

Australia

WESTERN AUSTRALIA | Palliative Care WA Inc: <http://palliativecarewa.asn.au/site/helpful-resources/> [Scroll down to 'International Websites' and www.ipcrc.net/archive-global-palliative-care-news.php to access the weekly report]

Canada

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

ONTARIO | Palliative Care Consultation Program (Oakville): <http://www.acclaimhealth.ca/menu-services/palliative-care-consultation/resources/> [Scroll down to 'Additional Resources']

Europe

EUROPEAN ASSOCIATION FOR PALLIATIVE CARE: <http://www.eapcnet.eu/Themes/Organization/Links.aspx> [Scroll down to International Palliative Care Resource Center – IPCRC.NET]

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/media-watch-hospice-palliative-care-and-end-of-life-news-n-470.htm?PHPSESSID=b623758904ba11300ff6522fd7fb9f0c>

- *PALLIATIVE & SUPPORTIVE CARE* | Online – 8 July 2014 – 'What constitutes quality of family experience at the end of life? Perspectives from family members of patients who died in the hospital.' Sixty-four attributes of quality of family experience [were identified] constituting 8 domains: completion, symptom impact, decision making, preparation, relationship with healthcare providers, affirmation of the whole person, post-death care and supportive services. <http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=9297662&fulltextType=RA&fileId=S1478951514000807>
- *PSYCHO-ONCOLOGY* | Online – 4 July 2014 – 'Reducing the psychological distress of family caregivers of home based palliative care patients: Longer term effects from a randomised controlled trial.' Results of this study are consistent with the aim of the intervention and support existing evidence demonstrating relatively short psycho-educational interventions can help family caregivers who are supporting a dying relative. The sustained benefit during the bereavement period may also have positive resource implications, which should be the subject of future inquiry. <http://onlinelibrary.wiley.com/enhanced/doi/10.1002/pon.3610>

Palliative care: More than one chance to get it right

THE LANCET, 2014;384(9938):103. In today's *Lancet* are the first two papers in the Every Newborn Series, campaigning to ensure that every baby has a healthy start in life through improved quality of care at birth. Equally important, and an area that often receives much less attention, is improvements in quality of care for people who are dying. This week sees the phasing out in the U.K. of The Liverpool Care Pathway (LCP), a set of guidelines developed in the 1990s intended to ensure comfort and dignity for patients at the end of their life, but one that has been widely criticised by the U.K. media and some patients and their relatives for failing to provide appropriate care.¹ The LCP was popular with many health-care professionals, and indeed with many patients' families. It offered a clear framework for clinical staff who were not experts in caring for patients in the last days of life, providing a structure for physical, psychological, social, and spiritual care, with an emphasis on comfort and symptom control. Last year's report on the LCP by Baroness Neuberger, 'More Care, Less Pathway,' was broadly supportive, but identified several problems with its implementation. The report found that communication around the LCP was often poor, with patients and families frequently feeling they had not been consulted or informed when the decision to focus on comfort rather than cure had been made by the medical team. In environments where care was generally poor, care of the dying patient on the LCP was no better: the issue

was the organisational culture, rather than the pathway. The response to Baroness Neuberger's report commissioned by the Department of Health was One Chance to Get it Right, published last month.² [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(14\)61144-2/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(14)61144-2/fulltext)

Case study

Thoughts occasioned by the dying of my mother-in-law

BC MEDICAL JOURNAL, 2014;56(6):276-277. Much of our preventive care and therapeutic work is designed to enable people to live fulfilling lives for longer. This practice fails to acknowledge that the quality of death should be given due consideration. We are educators for our patients. We focus on clearly defined health benefits (treating high blood pressure will help avoid a heart attack), and we are good at describing long-term threats to the quality of life (losing weight will help avoid diabetes, arthritis, and hypertension). However, we are not good at describing long-term threats to the quality of death. We do not tell elderly patients that getting a flu vaccination, taking a statin, or taking anti-hypertensives may increase their chances of an unpleasant death. Neither I nor anyone else advised my mother-in-law of this. It is not part of the common currency of health care decision making. And as a result we ensure that more people, as Joan said, "die a death I would not wish on a dog." <http://bcmj.org/premise/thoughts-occasioned-dying-my-mother-law>

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1. *Independent Report: Review of Liverpool Care Pathway for dying patients* [in England), Department of Health, July 2013. [Noted in Media Watch, 22 July 2013, #315 (p.6)] <https://www.gov.uk/government/publications/review-of-liverpool-care-pathway-for-dying-patients>
2. 'One chance to get it right: Improving people's experience of care in the last few days and hours of life,' Leadership Alliance for the Care of Dying People, June 2014. [Noted in Media Watch, 30 June 2014, #364 (p.7)] <https://www.gov.uk/government/publications/liverpool-care-pathway-review-response-to-recommendations>

Of related interest:

- *EUROPEAN JOURNAL OF PALLIATIVE CARE*, 2014;21(4):180-183. **'The Global Atlas of Palliative Care at the End of Life: An advocacy tool.'** Advocating palliative care without the basic facts about the global situation is difficult. The first *Global Atlas of Palliative Care at the End of Life*, jointly published by the WHO and Worldwide Palliative Care Alliance, provides some hard data. The *Global Atlas* contains crucial data, such as a list of diseases that require palliative care and an estimate of the number of people who need palliative care worldwide. The *Atlas* uses the WHO public health model for palliative care to make recommendations for palliative care development.

N.B. Access to this article requires a subscription to the journal. Contents page of current issue: http://www.haywardpublishing.co.uk/year_search_review.aspx?JID=4&Year=2014&Edition=51
 2. An article on the 'Global Atlas of Palliative Care at the End of Life' was noted in Media Watch, 3 February 2014, #343 (p.5)] <http://www.thewpca.org/resources/global-atlas-of-palliative-care/>

Palliative care and neurology: Time for a paradigm shift

NEUROLOGY | Online – 2 July 2014 – As neurologists care for patients with chronic, progressive, life-limiting, and disabling conditions, it is important that they understand and learn to apply the principles of palliative medicine. In this article, the authors aim to provide a practical starting point in palliative medicine for neurologists by answering the following questions 1) What is palliative care and what is hospice care? 2) What are the palliative care needs of neurology patients? 3) Do neurology patients have unique palliative care needs? (4) How can palliative care be integrated into neurology practice? They cover several fundamental palliative care skills relevant to neurologists, including communication of bad news, symptom assessment and management, advance care planning, caregiver assessment, and appropriate referral to hospice and other palliative care services. The authors conclude by suggesting areas for future educational efforts and research. <http://www.neurology.org/content/early/2014/07/02/WNL.000000000000674.short>

Noted in Media Watch, 9 June 2014, #361 (p.15):

- *MEDSCAPE MEDICAL NEWS* | Online – 3 June 2014 – **'New European consensus on palliative care in neuro disease.'** In the face of little evidence-based information in this area, a joint task force of the European Federation of Neurological Societies and the European Association for Palliative Care has issued what it called a consensus document "based on the available evidence" rather than a guideline. <http://www.medscape.com/viewarticle/826100>

N.B. Noted in this issue of Media Watch is additional articles noted in recent issues of the weekly report on end-of-life care for people living with a neurological condition or disorder.

[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>

Assisted (or facilitated) death

Representative sample of recent articles, etc:

- *EUROPEAN SCIENTIFIC JOURNAL*, 2014;2(June):185-188. **'Euthanasia in Islamic views.'** Islamic jurisprudence, based on a convincing interpretation of the holy Koran, does not recognize a person's right to die voluntarily. According to Islamic teachings, life is a divine trust and can't be terminated by any form of active or passive voluntary intervention. All the Islamic scholars regard active euthanasia as forbidden ... and there is no difference between Sunni and Shiite schools. <http://www.eujournal.org/index.php/esj/article/viewFile/3707/3506>

Of related interest:

- *EUROPEAN SCIENTIFIC JOURNAL*, 2014;2(June). **'Euthanasia: An Islamic ethical perspective.'** The popular Egyptian scholar Sheikh Yusuf al-Qaradawi, recently issued a fatwa, or religious ruling, equating euthanasia with murder, but allowing the withholding of treatment that is deemed useless. <http://eujournal.org/index.php/esj/article/view/3709>
- *JOURNAL OF NURSING* | Online – Accessed 8 July 2014 – **'Euthanasia, assisted suicide, and nursing.'** According to Robley "nurses in Oregon, and now Washington, don't assist with suicide, but care for patients who elect assisted suicide in the same way they care for all patients, with dignity and compassion" (Robley, 2011 [sic], p.15).¹ Many nurses choose to work with patients who are at the end of their lives. Often these are home health care and hospice nurses. Nurses who work in any of the four [U.S.] states where physician assisted suicide is legal need to take time to consider their personal values and beliefs about being involved in the care of a patient who chooses this form of care. Nurses in Oregon are allowed to refuse to provide care for a patient who chooses physician assisted suicide, as with all healthcare professionals (Dunn *et al*, 2008).² The nurse who chooses to continue to provide care to this patient population should provide compassionate care to the patient and the family during the dying process. Nurses should be aware that this is a current ethical issue within healthcare. It is important to understand what euthanasia and assisted suicide are because four states have legalized these forms of care. Equally important, nurses need to know what type of care and actions are legal for nurses to assist with or provide for this patient population. As stated by the American Nurses Association, "participation by nurses in assisted suicide and euthanasia is strictly prohibited" (Association position statement, 2013, p.9).³ <http://rnjournal.com/journal-of-nursing/euthanasia-assisted-suicide-and-nursing>
 1. 'Reigniting the debate over assisted suicide,' *Nursing Critical Care*, 2009;4(5):15-17. http://www.nursingcenter.com/lnc/pdfjournal?AID=933010&an=01244666-200909000-00005&Journal_ID=&Issue_ID=
 2. 'The Oregon Death with Dignity Act: A Guidebook for Health Care Professionals,' The Greenwall Foundation, March 1998. <http://www.ohsu.edu/xd/education/continuing-education/center-for-ethics/ethics-outreach/upload/Oregon-Death-with-Dignity-Act-Guidebook.pdf>
 3. 'Euthanasia, Assisted Suicide, and Aid in Dying,' American Nurses Association, April 2013. <http://www.nursingworld.org/MainMenuCategories/Policy-Advocacy/Positions-and-Resolutions/ANAPositionStatements/Position-Statements-Alphabetically/Euthanasia-Assisted-Suicide-and-Aid-in-Dying.pdf>

Barry R. Ashpole
Guelph, Ontario CANADA

'phone: 519.837.8936
e-mail: barryashpole@bell.net