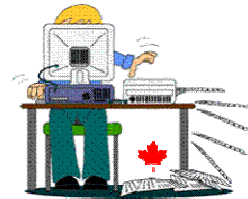


Media Watch...

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

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Compiled & Annotated by Barry R. Ashpole

Referral to palliative care: Scroll down to [Specialist Publications](#) and 'Should a hip fracture in a frail older person be a trigger for assessment of palliative care needs?' (p.6), published in *BMJ Supportive & Palliative Care*.

Canada

Hospice plans approved despite residents' objections

BRITISH COLUMBIA | *Globe & Mail* (Vancouver) – 8 June 2011 – The University of British Columbia's Board of Governors has approved a 15-bed hospice on a campus location, even as some residents of a neighbouring high-rise condominium continue to object to the facility on what they say are cultural grounds. The approval, at a board of governors' meeting ... followed an approval last week by the board's planning committee. The \$10-million, 15-bed facility, is a joint venture of the university's Faculty of Medicine and the Order of St. John and would be operated by Vancouver Coastal Health. It would provide hospice care and also serve as a research and teaching facility. <http://www.theglobeandmail.com/news/national/british-columbia/ubc-hospice-plans-approved-despite-residents-objections/article2052151/>

U.S.A.

Doctors going home

FLORIDA | *Tampa Tribune* – 12 June 2011 – The house call is as old as medicine itself, but it has fallen out of favor in recent decades as doctors have grown more specialized and health care has moved to medical offices and hospitals. Now, Medicare and private insurers are turning back to house calls as a way of putting the brakes on escalating health care costs, particularly for chronically ill people with complex health problems. With millions of baby boomers coming onto Medicare rolls in the near future, house-call doctors could play an important role in keeping a lid on costs, medical experts say. Advocates say house calls eliminate the expensive, specialized transportation many patients with serious health problems need to get to the doctor. House calls also help doctors catch health problems before they turn into costly trips to the emergency room or, in the worst cases, life in a nursing home on the government's tab. <http://www2.tbo.com/news/news/2011/jun/12/MENEWSO1-doctors-going-home-ar-236838/>

Cont.

From Media Watch dated 25 April 2011:

- *AMERICAN MEDICAL NEWS* | Online report – 25 April 2011 – **'House call practice attracts \$11.5 million investment.'** With house calls becoming more common – and better paying – at least one medical practice that specializes in this area has attracted investor interest. <http://www.ama-assn.org/amednews/2011/04/25/bisb0425.htm>

From Media Watch dated 18 April 2011:

- *GLOBE & MAIL* (Toronto, Canada) | Online article – 11 April 2011 – **'Canada's seniors: The doctor will see you now.'** Few medical students see the elderly at their best... Instead they are often tended to in a full-fledged medical crisis in an emergency room or chronic care ward. The answer for the future may be the past. Reviving the old-fashioned house call is one way to entice more doctors – and improve the system. <http://www.theglobeandmail.com/news/national/canadas-seniors-the-doctor-will-see-you-now/article1981281/>

Would you pay \$93,000 to live four months longer?

CBS (BNET) | Online OpEd – 10 June 2011 – Here's a \$173 billion question. Literally. Should a physician order expensive chemotherapy drugs and tests even if there is virtually no chance they will work or provide answers? If your answer is "yes." then get ready for a price tag to treat cancer of \$173 billion by 2020 – up from \$104 billion in 2006. The cost spike could be even greater as a raft of new cancer treatments come online with price tags of \$5,000 to \$10,000 a month. And here is the kicker: many of these drugs don't work very well for most patients, adding at best a few extra weeks or months of life. <http://www.bnet.com/blog/biotechnology-science/would-you-pay-93000-to-live-four-months-longer/115>

Palliative Care Information Act

Law on end-of-life care rankles doctors

NEW YORK TIMES | Online article – 6 June 2011 – I shouldn't be surprised when doctors object to laws telling them how to practice medicine, as does New York State's new Palliative Care Information Act – not surprised, but in this instance, distressed. Vehemently opposed by the Medical Society of the State of New York, the law ... took effect in February. The legislation was written in collaboration with Compassion & Choices of New York, an organization that advocates for informed choices and greater physical and emotional comfort at the end of life. The act ... states that when patients are found to have a terminal illness or condition, health care practitioners must offer to provide information and counseling about appropriate palliative care and end-of-life options. Patients or their surrogates are entirely at liberty to refuse an offer to discuss these options. California passed a similar law in 2009, and other states are considering them. These measures promise

to reduce the cost of care at the end of life, as well as the suffering often associated with it; palliative care is meant to reduce the severity of disease symptoms, pain and stress. Although there are penalties for violation, it is not the specter of punishment that raises the hackles of some physicians. Rather, they say the new requirement interferes with how they choose to deal with their patients and does not take into account the nuances of a doctor-patient relationship. <http://www.nytimes.com/2011/06/07/health/07brody.html? r=1>

Specialist Publications

Of particular interest:

'Dying cancer patients talk about physician and patient roles in DNR decision making' (p.5), published in *Health Expectations*.

Cont.

From Media Watch dated 7 March 2011:

- *ELDER LAW ATTORNEY* (New York State Bar Association), 2011;21(1):32-39. **'Hospice and palliative care in New York: Changing landscape for patients, families and providers in health decision making.'** In New York State, the integrated approach that has already begun to the implementation of the FHCDA [Family Health Care Decisions Act], the PCIA [Palliative Care Information Act] and the MOLST [Medical Orders for Life-Sustaining Treatment] program aligning patient goals with policy goals, systems objectives and professional training will facilitate adjustments to these changes at all levels. <http://www.redlig.com/Dec10-nysba.pdf#page=32>

International

Plot to reuse Queensland graves every 40 years to free up burial space

AUSTRALIA (QUEENSLAND) | *Courier Mail* – 13 June 2011 – Graves could be dug up and reused every 40 years under a radical plan to free up space in fast-filling urban cemeteries. The State Government is considering drastic options to overhaul burial and cremation techniques as projections reveal Queensland's death rate will double in 30 years. Western Australian cemeteries already impose a 25-year limited tenure on plots and the gravesite can be excavated and reused if families choose not to pay a renewal fee. Independent Funeral Directors Association president Esther Swanborough feared the move would be "distressing" for families. <http://www.couriermail.com.au/news/queensland/plot-to-reuse-queensland-graves-every-40-years-to-free-up-burial-space/story-e6freoof-1226073963667>

Word-play keeps essential care from cancer patients

SOUTH AFRICA | *Personal Finances* – 12 June 2011 – The prescribed minimum benefits (PMBs) do not give medical scheme members who have cancer the protection they deserve, because they are neither well defined nor is the minimum treatment detailed. Leading oncologists say that the PMBs for cancer do not cover either the treatment of all curable cancers or palliative care for people whose illnesses cannot be cured. Medical schemes are using the vagueness of the PMB regulations to deny benefits – particularly for more expensive treatments – to members, they say. <http://www.iol.co.za/business/personal-finance/word-play-keeps-essential-care-from-cancer-patients-1.1081990>

Hospice Friendly Hospitals

New hospice resources should help bring dignity to dying

IRELAND | *Irish Times* – 11 June 2011 – The Hospice Foundation do death well. They are not frightened of it. They see it as a moment of profound significance. Although this was the official launch [of a range of resources designed to bring sensitivity and compassion to the experience of dying], some of the resources have been in use for a number of years. Hospitals are busy places, so part of the aim is to provide discreet symbols, such as an "end of life" sign depicting a triple spiral, to alert everyone in a ward that someone has died or is dying. As a student, I worked in a hospital and sometimes got the impression any death was viewed as a failure by some doctors, rather than a natural part of life. People were so rushed ... sometimes grieving families were told tragic news in corridors, or held the hand of a dying person as other families chatted and laughed beyond a curtain. The end-of-life spiral on display in a ward protects people from such unintended insensitivity. <http://www.irishtimes.com/newspaper/opinion/2011/0611/1224298736034.html>

- *IRISH HEALTH* | Online report – 7 June 2011 – **'Resources to enhance dignity of dying patients.'** The [Irish Hospice Foundation] has launched a range of practical resources [developed by the Hospice Friendly Hospitals programme in partnership with the Health Service Executive and hospitals around the country]. <http://www.irishhealth.com/article.html?id=19270>

National Framework on Advance Care Directives

Experts call for reform of living wills

AUSTRALIA | ABC News – 10 June 2011 – There are growing calls to change the law around living wills ... that allow people to set out their wishes for end of life care in advance. As people near death, many lose the ability to communicate, and senior legal officers in New South Wales and Victoria say reform is sorely needed at a state and national level. Victoria's former public advocate, Julian Gardner, says the current law is so complex that doctors may not follow a patient's wishes to stop life-prolonging treatment. "Many doctors have a muddled understanding of what the law is and are often guided by their ethical principles of preserving life where possible, of curing where possible," he said. "I think sometimes that their concept of ... clinical best interests can override what somebody would have wanted." There are other reasons doctors are not respecting end of life wishes. They include hospitals being geared up to resuscitate not palliate, big advances in life-saving technology and doctors not wanting to make the difficult decision of when to move from life-prolonging treatment to palliative care. A new National Framework on Advance Care Directives is due to be released. It wants to harmonise different laws in each state and territory. <http://www.abc.net.au/news/stories/2011/06/09/3240299.htm>

Same-day transfer into palliative care

Palliative care: Maroondah Hospital's new path

AUSTRALIA (VICTORIA) | *Maroondah Weekly* – 7 June 2011 – A new service at Maroondah Hospital [Ringwood East] aims to help dying patients avoid often busy and noisy emergency departments. The public hospital began its Fast Track Pathway service late last month, which has streamlined the process of transferring patients between the emergency department and a quieter, palliative care ward. Director of palliative services Dr. Sonia Fullerton said that before the program started, patients would wait up to a week to be transferred into palliative care. <http://www.maroondahweekly.com.au/news/local/news/general/palliative-care-maroondah-hospitals-new-path/2186227.aspx>

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- U.K. (SCOTLAND) | *Sunday Herald* (OpEd) – 12 June 2011 – **'Please, can we let the Godless die in peace.'** In a world full of people who would rather not die badly, prematurely, in misery or in pain, the right just to choose the manner of one's passing is contested. In most places, it is denied outright, and anyone found to have assisted in the choice is liable to face the full weight of the law. This is God's territory: No Trespassing. There are other reasons to reject assisted dying, of course, and a few of them are respectable. Sick and old people might fall prey to greedy relatives with funny ideas about what is sensible. Individuals pushed to the edge of reason by pain, exhaustion or incapacity might be unable to give informed consent. The person thinking of ending it all might be better off in a decent hospice, with good palliative care. All of these objections can be answered in most cases by the creation of a living will, properly managed and validated. It still wouldn't satisfy those who hold that the gift of life is non-returnable. In their books, if God wills it, we stick it out, no matter the agonies, and no matter the reservations we might have about religions that outlaw suicide but tolerate agonies. What's worse, it makes no odds if you don't share the faith in question. <http://www.heraldsotland.com/comment/ian-bell/please-can-we-let-the-godless-die-in-peace-1.1106406>

Media Watch posted on Palliative Care Network-e Website

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

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

Transition from curative efforts to purely palliative care for neonates: Does physiology matter?

ADVANCES IN NEONATAL CARE, 2011;11(3):216-222. The study aim was to identify the physiology involved in coming to the end of life and indicating a transition need for palliative care. Although the respondents were able to identify physiological factors or lethal conditions leading to a transition to purely palliative care, they stated that these factors were not how the goals of care were established. Parental agreement was the determinant to palliative care transition, and, regardless of neonatal physiological condition, without agreement, curative technological efforts continued. http://journals.lww.com/advancesinneonatalcare/Abstract/2011/06000/Transition_From_Curative_Efforts_to_Purely.15.aspx

Of related interest:

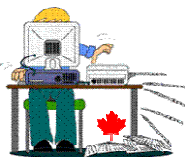
- *NEONATOLOGY*, 2011;100(20):215-216. 'A time to be born and a time to die: Ethical challenges in the neonatal intensive care unit.' <http://content.karger.com/ProdukteDB/produkte.asp?Aktion=ShowAbstract&ArtikelNr=329089&Ausgabe=255009&ProduktNr=224215>

Ethics and palliative care: Which consultant and when?

AMERICAN JOURNAL OF HOSPICE & PALLIATIVE MEDICINE | Online article – 10 June 2011 – Over the past 30 years, and increasingly over the past decade, palliative care services characteristically address the complexity of communication, decision making, and management of end-of-life issues for patients and families of all ages. Clinical ethics services have a parallel 30-plus year history in the U.S. – so much so that some have offered that clinical ethics has "cut its teeth" on issues attendant to the beginning and end of life. The authors propose considerations necessary in determining the appropriateness of consultation with palliative care, clinical ethics, or both, and when either may be necessary but perhaps not sufficient for patient and family management. <http://ajh.sagepub.com/content/early/2011/06/03/1049909111410560.abstract>

Of related interest:

- *HEALTH EXPECTATIONS*, 2011;14(2):147-158. 'Dying cancer patients talk about physician and patient roles in DNR decision making.' [Study] participants' descriptions of appropriate patient or physician roles in decisions about CPR appeared related to how they conceptualized the decision: as a personal or a medical issue, with patient and doctor respectively identified as appropriate decision makers; or alternatively, both medical and personal, with various roles assigned embodying different versions of a shared decision-making process. Participants' endorsement of physicians as decision makers rested upon physicians' enactment of the rational, knowledgeable and compassionate expert, which legitimized entrusting them to make the DNR decision. Where this was called into question, physicians were positioned as inappropriate decision makers. <http://onlinelibrary.wiley.com/doi/10.1111/j.1369-7625.2010.00630.x/abstract>



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>

End-of-life issues in caring for patients with dementia: The case for palliative care in management of terminal dementia

AMERICAN JOURNAL OF HOSPICE & PALLIATIVE MEDICINE | Online article – 10 June 2011 – The problem of end of life care for patients suffering from dementia though spoken of and written about, does not get the attention and system support as for example patients suffering from cancer receive. This article attempts to revisit the issues, and the reasons, that may contribute to this. Some guidelines on palliative management in cases of patients suffering from severe dementia exist; the evidence base for these guidelines though is relatively weak. <http://ajh.sagepub.com/content/early/2011/06/03/1049909111410306.abstract>

Palliative care for older people: Better practices

WORLD HEALTH ORGANIZATION (Regional Office for Europe) | Online report – Accessed 12 June 2011 – This publication aims to provide examples of better palliative care practices for older people to help those involved in planning and supporting care-oriented services most appropriately and effectively. Examples have been identified from literature searches and from an international call for examples through various organizations... The publication is intended for policy-makers, decision-makers, planners and multi-disciplinary professionals concerned with the care and quality of life of older people. http://www.euro.who.int/_data/assets/pdf_file/0017/143153/e95052.pdf

Should a hip fracture in a frail older person be a trigger for assessment of palliative care needs?

BMJ SUPPORTIVE & PALLIATIVE CARE, 2011;1(1):3-4. One in five people sustaining a hip fracture die within 4 months. A palliative care approach is appropriate for people with advanced non-malignant as well as malignant disease. Thus a hip fracture in a frail older person could reasonably trigger a palliative care approach: anticipating and planning for physical, social, psychological and spiritual needs and end of life care. This might result in better care planning, help avoid futile treatment, and decrease healthcare costs in the last year of life. Annually there are around 75,000 hip fractures in the U.K. and 300, 000 in [the] U.S. This is projected to rise to 101,000 in the U.K. annually by 2020, with associated health and social costs of £2.2 billion. <http://spcare.bmj.com/content/1/1/3.extract>

Media Watch Online

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

Canada

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

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

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

U.S.A.

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

International

Global | Palliative Care Network Community: <http://www.pcn-e.com/community/pg/file/world/world/>

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

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

What questionnaires exist to measure the perceived competence of generalists in palliative care provision? A critical literature review

BMJ SUPPORTIVE & PALLIATIVE CARE, 2011;1(1)19-32. The increase in the numbers of patients requiring palliative care input prior to death, and a global economic situation where few countries are able to invest further in specialist palliative care services, has meant an increased focus upon 'generalist palliative care provision.' The goal of the present review is to ascertain what questionnaire tools exist to measure the perceived competence of generalists in palliative care provision. 19 of the 1361 articles met the inclusion criteria. Overall, a lack of validation and a focus upon the physical aspects of symptom management was apparent. No single validated questionnaire to measure perceived competence in palliative care management among health professionals involved in generalist palliative care management could be identified. The rising prominence paid to generalist care provision points to an urgent need for further development of comprehensive and validated perceived competence measurement tools.

<http://spcare.bmj.com/content/1/1/19.abstract>

Of related interest:

- *NURSING TIMES* (U.K.) | Online article – 6 June 2011 – **'End-of-life care manifesto won't succeed without community nurses.'** The government must invest "energy and real money" into the district nursing workforce, one of the authors of a new initiative to improve palliative care in primary care settings has warned. The Royal College of Nursing and the Royal College of General Practitioners ... jointly launched a seven-point "charter for end of life care" detailing what patients should be able to expect from practice nurses and GPs. <http://www.nursingtimes.net/nursing-practice/clinical-specialisms/end-of-life-and-palliative-care/end-of-life-care-manifesto-wont-succeed-without-community-nurses/5030682.article>

From Media Watch dated 6 June 2011:

- U.K. | BBC News – 31 May 2011 – **'GPs and nurses launch charter for end of life care.'** Health staff have made seven pledges to patients at the end of their lives ... to ensure patients' remaining days are as comfortable as possible. <http://www.bbc.co.uk/news/health-13601446>

End-of-life care and barriers for female inmates

JOURNAL OF OBSTETRIC, GYNECOLOGIC & NEONATAL NURSING | Online article – 3 June 2011 – The number of female inmates is growing, and their average age is increasing. As a result, end-of-life care is situated in a highly restrictive environment with a focus on security rather than comfort. The authors describe the need for and potential barriers to humane care and provide care strategies that can be useful in a complex organizational system. Frontline workers such as nurses who understand the balance between care and control must promote change in the women's prison system. <http://onlinelibrary.wiley.com/doi/10.1111/j.1552-6909.2011.01260.x/full>

Of related interest:

- *JOURNAL OF ELDER ABUSE & NEGLECT*, 2011;23(2):169-189. **'Adult protective services workers' experiences with serious illness and death.'** A national survey of adult protective services (APS) workers examined encounters with serious illness, injury, death, and bereavement and how these situations were handled professionally and personally. APS workers often encountered clients and caregivers with life-threatening illnesses, and clients receiving hospice services. <http://www.informaworld.com/smpp/content~db=all~content=a935891961~frm=abslink>

N.B. 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.9).

Approaching patients and family members who hope for a miracle

JOURNAL OF PAIN & SYMPTOM MANAGEMENT | Online article – 6 June 2011 – A clinical problem may arise when caring for patients or their surrogates who prefer continued aggressive care based on the belief that a miracle will occur, despite a clinician's belief that further medical treatment is unlikely to have any meaningful benefit. An evidence-based approach is provided for the clinician by breaking this complex clinical problem into a series of more focused clinical questions and subsequently answering them through a critical appraisal of the existing medical literature. Belief in miracles is found to be common in the U.S. and is an important determinant of how decisions are made for those with advanced illness. There is a growing amount of evidence that suggests end-of-life outcomes improve with the provision of spiritual support from medical teams, as well as with a proactive approach to medical decision making that values statements given by patients and family members. [http://www.jpsmjournal.com/article/S0885-3924\(11\)00243-0/abstract](http://www.jpsmjournal.com/article/S0885-3924(11)00243-0/abstract)

Of related interest:

- AMERICAN SOCIETY FOR CLINICAL ONCOLOGY CONFERENCE | University of Chicago Medical Center abstract – 7 June 2011 – **'Many patients with advanced cancers get treatments that won't help.'** A study of more than 1,000 patients with colon cancer that had spread to distant sites found that one in eight was treated with at least one drug regimen that was not recommended. Those patients were exposed to significant risk without proven benefits, at an estimated cost – just for the drugs – of more than \$2 million. The study ... focused on three chemotherapy regimens that were not supported by evidence from prior clinical studies or clinical practice guidelines. <http://www.newswise.com/articles/many-patients-with-advanced-cancers-get-treatments-that-won-t-help>

Assisted (or facilitated) death

Representative sample of recent articles, etc:

- *ETHNICITY & HEALTH*, 2011;16(3):259-278. **"We are (not) the master of our body': Elderly Jewish women's attitudes towards euthanasia and assisted suicide.'** The research reveals diverse views among women in the community on intentionally terminating a patient's life. Absolute rejection of every act which deliberately terminates life is found among the overwhelming majority of ... Orthodox (Hasidic and non-Hasidic) women, as they have an unconditional faith and trust in God's sovereign power over the domain of life and death. On the other hand, the views of secularised Orthodox women – mostly irreligious women, who do not consider themselves Orthodox, thus not following Jewish law, yet say they belong to the Orthodox Jewish community – show an acceptance of voluntary euthanasia and assisted suicide but non-voluntary euthanasia is approached more negatively. As they perceive illness and death as merely profane facts, they stress a patient's absolute right towards self-determination, in particular with regard to one's end of life. Among non-Hasidic Orthodox respondents, more openness is found for cultivating a personal opinion which deviates from Jewish law and for the right of self-determination with regard to questions concerning life and death. In this study, these participants occupy an intermediate position. <http://www.informaworld.com/smpp/content~db=all~content=a938335475~frm=abslink>
- *JOURNAL OF THE AMERICAN GERIATRICS SOCIETY* | Online article – 7 June 2011 – **'Advance directives for euthanasia in dementia: How do they affect resident care in Dutch nursing homes?'** Advance directives for euthanasia are never adhered to in the Netherlands in the case of people with advanced dementia, and their role in advance care planning and end-of-life care of people with advanced dementia is limited. Communication with the patient is essential for elderly care physicians to consider adherence to an advance directive for euthanasia of a person with dementia. <http://onlinelibrary.wiley.com/doi/10.1111/j.1532-5415.2011.03414.x/full>

Worth Repeating

Ideals and compromises in palliative care

JOURNAL OF PALLIATIVE MEDICINE, 2006;9(6):1339-1347. This qualitative study explores the concept of ideal palliative care as it broadens its field of application from terminal care to include people earlier in the course of an illness. Palliative care professionals have clear views of what constitutes ideal care that include: establishing a relationship, setting goals, communication, acceptance, advocacy, flexibility, symptom relief, and recognising the identity of each person. There was agreement [among study participants] upon the nature of obstacles that prevented ideal care being achieved including obstacles created by families, other health professionals, administrative structures, and conflicts between the aims of care for a particular patient. Finally, each clinician has a well-developed set of personal views of the acceptable limits to practice, although these views vary widely. The clusters of ideas emerging in this study describe three objects of different ontologic status. The elements of ideal care are conceptual in nature, highlighting the aspirations for workers. The obstacles reflect the real world palliative care professionals must negotiate each day, giving rise to a form of care that was good enough.
<http://www.liebertonline.com/doi/abs/10.1089/jpm.2006.9.1339?prevSearch=allfield%253A%2528advocacy%2529&searchHistoryKey=>

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.

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