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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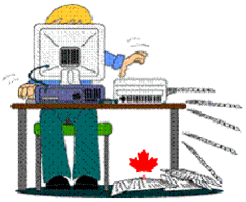


Compiled & Annotated by Barry R. Ashpole

Different perspectives on discussing end of life care: Scroll down to Specialist Publications and 'Talking it out: Helping our patients live better while dying' (p.6), published in *Annals of Internal Medicine*. Footnoted are four additional, related journal articles (p.7).

Canada

Ontario health care needs more integration: Report

ONTARIO | CBC News – 20 June 2011 – Ontario needs a better planned and more integrated approach to health care if it wants to improve patient services and outcomes while trimming a huge deficit, concludes a special report from hospitals and community care centres. The Liberal government wants to limit the increase in annual health spending to three per cent – down from an average of 6.5% annually since 2003 – to help eliminate a $16.3 billion deficit. Health eats up over 40 cents of every program dollar the government spends. A joint report from the Ontario Hospital Association [OHA] and the Ontario Association of Community Care Access Centres [OACCAC] admits spending on health care can't keep growing at the old rate, but also calls for funding of 3.5% a year plus inflation to beef up community care.[1] Creating more capacity in the community for services such as home care, assisted living, long-term care and day programs, are "critical," said Margaret Mottershead, CEO of the Ontario Association of Community Care Access Centres.http://www.cbc.ca/news/canada/ottawa/story/2011/06/20/ottawa-ontario-health-care-report.html

Extract from OHA & OACCAC report

Patients who have complex needs and utilize different providers – sometimes at the same time – require smooth handoffs and improved communication between those providers. In Ontario, there is no standardized way that this occurs, but the authors acknowledge that the [province's] Local Health Integration Networks (LHINs) and Community Care Access Centres (CCACs) are working toward this goal. An example of this can be found in the Hamilton Niagara Haldimand Brant LHIN, where palliative care physicians, CCACs, pharmacies, hospitals, community support services and long-term care homes have created a network to improve the consistency of end-of-life care.

1. *Four Pillars: Recommendations for Achieving a High Performing Health System*, June 2011. http://www.oha.com/KnowledgeCentre/Library/Documents/Four%20Pillars%20-%20FINAL%20FULL.pdf

Cont.

Of related interest:

- CBC NEWS | Online report – 21 June 2011 – **'Hospital waits: Is investing in home care and long-term care the answer?'** A new report on hospital wait times says about one in six hospital beds is occupied by patients who should be receiving care elsewhere.[1] The report from the Wait Time Alliance estimated that when an acute-care bed is occupied, about four patients per hour are denied access to emergency care. The patients occupying hospital beds that could be cared for somewhere else tended to be older, with an average age of 80. They often have dementia and other chronic conditions. http://www.cbc.ca/news/yourcommunity/2011/06/hospital-waits-is-investing-in-home-care-and-long-term-care-the-answer.html

    1. *No Time for Complacency: Report Card on Wait Times in Canada*, June 2011. http://www.waittimealliance.ca/media/2010reportcard/WTA2010-reportcard_e.pdf

From Media Watch dated 11 April 2011:

- ONTARIO | *Chronicle Journal* (Thunder Bay) – 5 April 2011 – **'Home care in bad shape: Report.'** Huge waiting lists, unequal access to care and high administrative costs continue to plague Ontario's home care system, the Ontario Health Coalition claims. Those are some of the findings in *Still Waiting: An assessment of Ontario's Home Care System After Two Decades of Restructuring*.[1] http://www.chroniclejournal.com/content/news/local/2011/04/05/home-care-bad-shape-report

    1. *Still Waiting: An assessment of Ontario's Home Care System After Two Decades of Restructuring*, April 2011. http://www.web.net/~ohc/homecare2011finalreport.pdf

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- QUEBEC | *Montreal Gazette* – 23 June 2011 – **'Quebec delegation headed to Europe to research assisted suicide.'** A Quebec delegation is heading to Europe ... to further study the thorny question of euthanasia and assisted suicide. The four provincial legislators taking part in the mission are members of a special parliamentary commission on end-of-life issues that wrapped up public hearings this winter. They are in the process of writing their report and decided to travel to European countries that have grappled with the perplexing questions involving life and death in recent years. "It is imperative that a delegation go witness firsthand the reality on the ground in these countries," said a statement from the president of the commission, Liberal Maryse Gaudreault. Many of the emotional testimonies heard during the commission pitted people battling terminal illnesses pleading to be delivered from their sufferings against more philosophical and clinical arguments about the sanctity of life and the importance of improving end-of-life care in Quebec.http://www.montrealgazette.com/news/Quebec+delegation+headed+Europe+research+assisted+suicide/4995246/story.html

    From Media Watch dated 7 February 2011:

    - QUEBEC | *Montreal Gazette* – 5 February 2011 – **'Focus on care, not death, hearing told.'** As hearings on "dying with dignity" wrapped up in Montreal, two groups representing some of society's most vulnerable raised concerns about legalizing euthanasia and assisted suicide. The Association quebecoise de gerontology called instead for the expansion of palliative care services to provide comfort to the terminally ill. The Association de spina-bifida et d'hydrocephalie du Quebec argued that a debate on euthanasia is premature, given that health services for the disabled are lacking everywhere.http://www.montrealgazette.com/news/Focus+care+death+hearing+told/4228482/story.html

Media Watch posted on Palliative Care Network-e Website

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

U.S.A.

Oregon's end-of-life care far from norm

OREGON | *The Oregonian* (Portland) – 22 June 2011 – During the last six months of life, an Oregon resident dying of cancer, diabetes or heart disease is likely to spend seven days in the hospital, and receive about two days of intensive care. In New Jersey, the same patient could expect to be hospitalized more than 16 days and receive more than 6 days of intensive care. Medical care at the end of life continues to vary drastically across the U.S. As far as researchers can tell, extreme use of hospitals and specialists in some regions doesn't improve survival or quality of life. On the contrary, some studies have found that less hospital care at the end of life gives patients more satisfying experiences, and suggest that many people continue to receive aggressive medical interventions that they don't want or need. [The chart below] shows how Oregon compares to the national average and New Jersey, the most hospital intensive state, in measures reported by Dartmouth University's Dartmouth Atlas Project.[1] Researchers compared treatment and spending per person during the last six months of life among chronically ill Medicare enrollees. http://www.oregonlive.com/health/index.ssf/2011/06/oregons_end-of-life_care_far_f.html

Specialist Publications

Of particular interest:

'Quality of palliative care at U.S. hospices: Results of a national survey' (p.9), published in *Medical Care*.

	U.S.	**New Jersey**	**Oregon**
Total medical spending (final 2 two years):	$53,441	$65,436	$41,502
Time spent in the hospital:	11 days	16 days	7 days
Time in intensive care:	4 days	6 days	2 days
Chance of dying in a hospital:	30%	37%	25%
Share of patients receiving are from 10 or more physicians:	34%	51%	17%
Share receiving palliative hospice care:	37%	33%	44%
Amount of hospice care provided:	15 days	12 days	17 days

1. *Trends and Variation in End-of-Life Care for Medicare Beneficiaries with Severe Chronic Illness*, a report of the Dartmouth Atlas Project, Dartmouth Institute for Health Policy & Clinical Practice, Dartmouth, Massachusetts, April 2011 (noted in Media Watch dated 18 April 2011, pp.3,4). http://www.dartmouthatlas.org/downloads/reports/EOL_Trend_Report_0411.pdf

From Media Watch dated 6 June 2011:

- OREGON | *Mail Tribune* (Medford) – 2 June 2011 – **'Could Oregon's end-of-life care standard save Medicare?'** Oregon has consistently ranked in the bottom 5 to 10% in cost per Medicare beneficiary. How are we different from areas that spend so much more than we do? One area of clear difference is our approach to end of life. Although Oregon developed a reputation for allowing physician-assisted suicide, few ... have availed themselves of that service. Instead, we have developed a medical culture that encourages both physicians and patients to openly discuss end-of-life-care.http://www.mailtribune.com/apps/pbcs.dll/article?AID=/20110602/OPINION/106020306/-1/NEWSMAP

Many boomers not prepared for elder care: Survey

CBS NEWS | Online report – 20 June 2011 – While most of the 76 million baby boomers are no longer caring for their children, more and more of them are playing the role of caretaker for an older generation: their parents. A new survey ... shows that an alarming number of those caring for their aging parents are under-prepared. Almost half of those surveyed said they couldn't name a single drug their parents took. Also, 34% said they don't know whether their parents have a safe deposit box, and 36% said they don't know where their parents' financial information is located. http://www.cbsnews.com/stories/2011/06/20/earlyshow/main20072534.shtml

Of related interest:

- METLIFE MATURE MARKET INSTITUTE | Online report – Accessed 21 June 2011 – **'Caregiving costs to working caregivers: Double jeopardy for baby boomers caring for their parents.'** A new study has found that the percent of adult children caring for their aging parents has tripled in the last 15 years, and that providing this care costs the caregivers $3 Trillion in lost wages, pension, and Social Security benefits. http://www.caregiving.org/wp-content/uploads/2011/06/mmi-caregiving-costs-working-caregivers.pdf

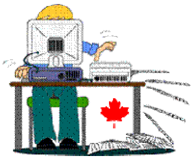
Tapping life insurance when you're terminally ill

NASDAQ | Online Q&A – 23 June 2011 – Many life insurance policies offer "accelerated death benefits," which allow policyholders who have been diagnosed with a terminal illness to access a portion of the policy's death benefit while they are still alive. These benefits may be available for both term life insurance policies, which last for a certain number of years but have no cash value, and permanent life insurance policies (such as whole life), which remain in force for as long as you pay the premiums and build cash value that you can withdraw or borrow against. The money you receive early is subtracted from the death benefit your heirs will receive when you die. http://community.nasdaq.com/News/2011-06/tapping-life-insurance-when-youre-terminally-ill.aspx?storyid=82178

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- *CRISIS MAGAZINE* | Online report – 21 June 2011 – **'Bishops betrayed on assisted suicide.'** Last week, the U.S. Conference of Catholic Bishops approved a statement describing assisted suicide as "a terrible tragedy, one that a compassionate society should work to prevent." But as with so many moral issues, the bishops need look no further than our Catholic institutions to find that the "nationwide campaign" in opposition to Church teaching has been ongoing for many years. http://www.crisismagazine.com/2011/bishops-betrayed-on-assisted-suicide



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

International

National Health Service failed my dying father, reveals health secretary Andrew Lansley

U.K. | *Daily Mail* – 26 June 2011 – Health Secretary Andrew Lansley has told of his grief after his dying father was left in a hospital observation bay for several days because there were no beds available. Thomas Lansley, a distinguished National Health Service pathologist, died last year from cancer after spending the last six months of his life as an NHS patient. The health secretary, who was drawing up plans for NHS reforms at the time, said there were significant shortcomings in the way his father was treated especially during the final stages of the illness. Highlighting a lack of co-ordination between the many doctors and departments, he said he had been unable to work out who was in charge of caring for his father. http://www.dailymail.co.uk/news/article-2008311/Health-secretary-Andrew-Lansley-slams-NHS-way-dying-father-treated.html?ito=feeds-newsxml

National Institute for Health & Clinical Excellence (NICE) consults on new end of life care draft quality standard

U.K. | NICE press release – 24 June 2011 – The draft quality standard contains twenty statements for the care of adults with advanced, progressive, or life-limiting conditions who are approaching the end of their life, and for adults who die suddenly or after a very brief illness, in settings where care is provided by health and social care staff. It also covers support for the families and carers of people in these groups. The statements include ensuring people in such settings are offered comprehensive and regular assessments, which include the opportunity to discuss their current physical, psychological, social and spiritual needs and preferences. It also states that people approaching the end of life, and their families and carers, are communicated with in a timely, sensitive and honest way responsive to their needs and preferences. http://www.nice.org.uk/newsroom/pressreleases/EndOfLifeCareDraftQS.jsp

N.B. NICE, Centre for Clinical Practice, Quality Standards Programme, draft quality standard: http://www.nice.org.uk/media/B7C/43/EoLCDraftQSForConsultation.pdf

Of related interest:

- U.K. | National End of Life Care Intelligence Network press release – 21 June 2011 – **'Respiratory deaths report sheds light on services.'** Earlier discussion and planning of end of life care could result in more people dying in their place of choice, according to a [new] report. It notes that 69% of people with respiratory conditions other than lung cancer die in hospital – compared to an average of 58% of all deaths. Reducing the percentage of deaths that take place in hospital is a key goal of the 2008 national End of Life Care Strategy. Research suggests two-thirds of people would prefer to die at home. http://www.endoflifecare-intelligence.org.uk/news/default.aspx

  N.B. Scroll down to 'Respiratory deaths report sheds light on services' and 'Download report' for a pdf version of *Deaths from Respiratory Diseases: Implications for End of Life Care in England*.

The heartache of caring for 'vegetative state' patients

U.K. | BBC News – 21 June 2011 – It is difficult to find precise figures for the numbers affected, but experts believe there could be as many as 5,000 people in the U.K. enduring what has been described as a "living death." And, because of advances in medical science meaning that more people survive what would previously have been fatal injuries, the figures are set to continue to grow. Expert clinicians have highlighted a number of concerns about the care of vegetative state patients and their families. They believe some are being misdiagnosed as a result of inconsistencies in assessment across the country. There is also evidence families are not routinely being told of all the options open to them. http://www.bbc.co.uk/news/health-13469346

Cont.

- U.K. | Royal College of Physicians press release – 13 June 2011 – **'Patients in the vegetative state – updated guidelines.'** The Royal College of Physicians has updated its 1996 guidelines on diagnosis and management of patients in the vegetative state in response to requests for clarification from the Official Solicitor. For the first time [the guidelines] include information on the vegetative state for relatives, carers and friends. http://www.rcplondon.ac.uk/news-media/press-releases/patients-vegetative-state-updated-guidelines

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- THE NETHERLANDS | Radio Netherlands Worldwide – Online report – 26 June 2011 – **'Dutch doctors wary of euthanasia for dementia.'** Just 33% of Dutch doctors are willing to use euthanasia in cases of early dementia, a national survey conducted by three university hospitals shows. People with dementia are only able to give their consent to euthanasia in the early stages of the disease. In the later stages, patients are too disoriented to make informed decisions. The number of people with dementia who have resorted to euthanasia has risen from three in 2006 to 21 in 2010. http://www.rnw.nl/english/bulletin/dutch-doctors-wary-euthanasia-dementia

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

Palliative and end-of-life care in psychogeriatric patients

AGING HEALTH, 2011;7(3):395-408. A rapidly growing number of elderly persons and their families are burdened by one or more terminal illnesses in the later years of their life. How best to support their quality of life is a major challenge for healthcare teams. Palliative and end-of-life (PEOL) care is well positioned to respond to this challenge. While the evidence of PEOL is just beginning, much of the suffering can be relieved by what is already known. PEOL care for the elderly needs to go beyond the focus on the patient and should rest on a broad understanding of the nature of suffering that includes family and professional caregivers in that experience of suffering. The dissemination of PEOL care principles should be a public health priority. http://www.futuremedicine.com/doi/abs/10.2217/ahe.11.20

Of related interest:

- *EXPERT REVIEW OF PHARMACOECONOMICS & OUTCOMES RESEARCH*, 2011;11(3):265-266. **'The public health approach to palliative care: Sharing practice on a global level.'** The aims of the Second International Conference on Public Health & Palliative Care were firstly to bring together practice examples that involve a public health approach to palliative care from around the world ...and, second, to promote and support the nascent palliative care scene in Bangladesh. http://www.ingentaconnect.com/content/ftd/erp/2011/00000011/00000003/art00005

Talking it out: Helping our patients live better while dying

ANNALS OF INTERNAL MEDICINE, 2011;154(12):830-832. Although dying is an inevitable part of the life cycle, there has been extensive political debate over end-of-life care. Participating in end-of-life care conversations can be emotionally challenging for everyone involved. Messages about serious or terminal illnesses can be very hard for patients and their families to hear, and physicians frequently struggle with the burden of delivering these messages. Still, evidence shows that conversations about end-of-life care options between physicians and patients can improve the quality of life of dying patients and help to relieve the emotional burden on surviving loved ones. Legislation [in the U.S.] to support these discussions by consistently reimbursing physicians for their time spent performing this service has been blocked on multiple occasions. Overcoming political divides to support end-of-life care conversations is needed to promote care that is consistent with patients' values and needs and is a key step in encouraging better quality of life for dying patients. http://www.annals.org/content/154/12/830.abstract

Cont.

Of related interest:

- *INTERNATIONAL JOURNAL OF PALLIATIVE NURSING*, 2011;17(6):278-284. **'Anticipating emotion: A qualitative study of advance care planning in the community setting.'** The findings [of this study] clearly depict two of the challenges faced by the GPs and DNs in the community: emotional labour, and balancing patients' and families' expectations about care provision in the community with the limited resources available. http://www.ijpn.co.uk/cgi-bin/go.pl/library/article.html?uid=84759;article=IJPN_17_6_278_284

- *PALLIATIVE MEDICINE* | Online article – 22 June 2011 – **'An uncertain future: The unchanging views of care home residents about living and dying.'** Core to the older person's ability to discuss end-of-life care is their acceptance of being in a care home, the involvement of family members in making decisions, and the extent to which they believed they could influence decision making within their everyday lives. Advance care plans should document ongoing dialogue. http://pmj.sagepub.com/content/early/2011/06/22/0269216311412233.abstract

- *SUPPORTIVE CARE IN CANCER* | Online article – 19 June 2011 – **'Awareness of dying: It needs words.'** Being aware of dying is associated with acceptance of dying, which supports the idea that open communication in the dying phase can contribute to the quality of the dying process. However, views on whether or not patients are aware of the imminence of death diverge between different caregivers. http://www.ncbi.nlm.nih.gov/pubmed/21688164

- *PALLIATIVE MEDICINE* | Online article – 16 June 2011 – **'Recording patient preferences for end-of-life care as an incentivized quality indicator: What do general practice staff think?'** The most appropriate time to ask a patient about end-of-life care is subjective and patient specific and therefore does not lend itself to an inflexible single indicator. Focusing on one isolated question simplifies and distracts from a multi-faceted and complex issue and may lead to patient harm. http://pmj.sagepub.com/content/early/2011/06/16/0269216311406990.abstract

A randomized trial of the effect of patient race on physicians' intensive care unit and life-sustaining treatment decisions for an acutely unstable elder with end-stage cancer

CRITICAL CARE MEDICINE, 2011;39(7):1663-1669. In this exploratory study, hospital-based physicians did not make different treatment decisions for otherwise identical terminally ill black and white elders despite believing that black patients are more likely to prefer intensive life-sustaining treatment. They grossly overestimated the preference for intensive treatment for both races.http://journals.lww.com/ccmjournal/Abstract/2011/07000/A_randomized_trial_of_the_effect_of_patient_race.9.aspx

From Media Watch dated 1 June 2009:

- JOURNAL OF GENERAL INTERNAL MEDICINE, 2009;24(6):695-701. **'Racial and ethnic differences in preferences for end-of-life treatment.'** Greater preference for intensive treatment ... among minority elders is not explained fully by confounding socio-cultural variables. Still, most Medicare beneficiaries in all race/ethnic groups prefer not to die in hospital, to receive life-prolonging drugs that make them feel worse all the time, or to receive mechanical ventilation. http://www.springerlink.com/content/e85620l2hq12h181/?p=2072358fb24c4d8180df2041956c47a8&pi=0

Decisional conflict among Chinese family caregivers regarding nursing home placement of older adults with dementia

JOURNAL OF AGING STUDIES | Online article – 12 June 2011 – Factors influencing caregivers' decisional conflict included the Chinese value of filial piety, limited financial resources and information, placement willingness of the older adult, family disagreement, distrust of nursing home care quality, and limited nursing home availability. It is important to provide appropriate decision support beginning before admission and across the trajectory of the older person's nursing home stay in order to decrease decisional conflict and facilitate a more positive decision making process for caregivers, family members, and older adults with dementia. http://www.sciencedirect.com/science/article/pii/S0890406511000545

Hospital do-not-resuscitate orders: Why they have failed and how to fix them

JOURNAL OF GENERAL INTERNAL MEDICINE, 2011;26(7):791-797. This article highlights the persistent problems with today's use of inpatient DNR [do-not-resuscitate] orders. DNR discussions do not occur frequently enough and occur too late in the course of patients' illnesses to allow their participation in resuscitation decisions. Furthermore, many physicians fail to provide adequate information to allow patients or surrogates to make informed decisions and inappropriately extrapolate DNR orders to limit other treatments. Because these failings are primarily due to systemic factors that result in deficient physician behaviors, the authors propose strategies to target these factors including changing the hospital culture, reforming hospital policies on DNR discussions, mandating provider communication skills training, and using financial incentives. http://www.springerlink.com/content/1175n7538010103m/

When should conscientious objection be accepted?

JOURNAL OF MEDICAL ETHICS | Online article – 20 June 2011 – This paper makes two main claims: first, that the need to protect health professionals' moral integrity is what grounds the right to conscientious objection in health care; and second, that for a given claim of conscientious objection to be acceptable to society, a certain set of criteria should be fulfilled. The importance of moral integrity for individuals and society, including its special role in health care, is advocated. Criteria for evaluating the acceptability of claims to conscientious objection are outlined. The precise content of the criteria is dictated by the two main interests that are at stake in the dilemma of conscientious objection: the patient's interests and the health professional's moral integrity. http://jme.bmj.com/content/early/2011/06/20/jme.2011.043646.abstract

From Media Watch dated 9 May 2011:

- *JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION*, 2011;305(17):1804-1805. **'Would accommodating some conscientious objections by physicians promote quality in medical care?'** Moral pluralism is a valuable aspect of a free society but sometimes creates conflicts in medical care when individual physicians object to providing certain legal but morally controversial services, such as abortion, physician-assisted suicide (where it is legal), and palliative sedation to unconsciousness. http://jama.ama-assn.org/content/305/17/1804.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.hpcconnection.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

Quality of palliative care at U.S. hospices: Results of a national survey

MEDICAL CARE | Online article – 16 June 2011 – The National Quality Forum (NQF) identified hospice services as a national priority area for health care quality improvement and endorsed a set of preferred practices for quality palliative and hospice care. This study [i.e., findings of a random, cross-sectional survey] reports the first national data regarding hospices' self-reported implementation of the NQF preferred practices and identifies hospice characteristics associated with more comprehensive implementation. Twenty-one percent of hospices reported having implemented all patient-centered preferred practices, 26% all family-centered preferred practices, and 10% all patient and family-centered preferred practices. In adjusted analyses, large hospices (100 or more patients per day) were significantly more likely than small hospices to report having implemented all patient-centered preferred practices and all family-centered preferred practices. Similarly, chain-affiliated hospices were significantly more likely than free-standing hospices to report having implemented all patient-centered preferred practices and all family-centered preferred practices.http://journals.lww.com/lww-medicalcare/Abstract/publishahead/Quality_of_Palliative_Care_at_US_Hospices__Results.99551.aspx

N.B. The Joint Commission accredits and certifies more than 19,000 health care organizations and programs in the U.S. Website:http://www.jointcommission.org/certification/palliative_care.aspx

Embracing the value of palliative medicine

ASSOCIATION OF AMERICAN MEDICAL COLLEGES REPORTER | Online commentary – June 2011 – Chronic conditions, such as heart disease, cancer, and diabetes, are the leading causes of death and disability in the U.S., accounting for 70% of all deaths in the country. The U.S. population also is aging, with nearly one in five Americans expected to be age 65 or older by 2030. With both chronic disease and higher rates of health care utilization associated with aging, and more Americans having access to regular health care through the Affordable Care Act, the need for palliative care is only likely to increase.https://www.aamc.org/newsroom/reporter/june2011/250904/word.html

End-of-life care in Hungary

Important aspects of end-of-life care: Survey of patients visiting the primary care office

ORVOSI HETILAP (Hungarian medical journal), 2011;152(27):1082-1092. Death and dying are still taboo topics in Hungary. The care of the dying, the adequate relief of their symptoms and the psychosocial support of both patients and their caregivers are not yet well addressed. More than two thirds (69%) of respondents [i.e., study participants] would like to receive end of life care in their home. Only 19% of respondents would prefer to die in a hospital. Respondents' greatest fear was to lose their autonomy (55%). The second most noted concern was fear from pain (38%). According to 93% of the participants, truth telling is very important in the event of terminal illness. http://www.akademiai.com/content/b7hwu3u4212366v0/?p=8803e46b6d07407492bc99b70cc1f3a9&pi=0

From Media Watch dated 9 November 2009:

- *JOURNAL OF PAIN & SYMPTOM MANAGEMENT* | Online article – 5 November 2009 – **'Physicians' beliefs and attitudes about end-of-life care: A comparison of selected regions in Hungary and the U.S.'** The aim of this study was to assess, compare, and contrast beliefs and practices of end-of-life care held by primary care physicians practicing in selected regions of the U.S. and Hungary. http://www.jpsmjournal.com/article/S0885-3924(09)00789-1/abstract

N.B. Hungary was rated 11th in *The Quality of Death: Ranking End of-life-Care Across the World*, July 2010. http://graphics.eiu.com/upload/QOD_main_final_edition_Jul12_toprint.pdf

Worth Repeating

Judgements about fellow professionals and the management of patients receiving palliative care in primary care: A qualitative study

BRITISH JOURNAL OF GENERAL PRACTICE, 2008;58(549):264-272. Policies emphasise the importance of collaborative working in community palliative care. Collaborations are generally formed through formal and informal referral processes, but little is known about what influences professionals' decisions to refer to such services. Judgements – positive and negative – about aspects of fellow professionals' performances appeared to influence referral decisions and ongoing collaboration and care. Attributes upon which these judgements were based included professional responsiveness and communication, respect, working and workload management practices, perceived expertise, and notions of elite practice. The effects of such judgements on referral and healthcare practices were altered by professional 'game playing' to achieve professionals' desired outcomes. Palliative care policies and protocols need to take account of these complex and subtle influences on referrals and collaboration. In particular, teamwork and partnership are encouraged within palliative care work, but critical judgements indicate that such partnerships may be difficult or fragile. It is likely that such judgemental attitudes and practices affect many aspects of primary care, not just palliative care.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2277112/

N.B. National Gold Standards Framework website: http://www.goldstandardsframework.org.uk/

Media Watch: Editorial Practice

Each listing in Media Watch represents a condensed version or extract of what is broadcast, posted (on the Internet) or published; in the case of a journal article, an edited version of the abstract or introductory paragraph, or an extract. Headlines are as in the original article, report, etc. There is no editorializing ... and, every attempt is made to present a balanced, representative sample of "current thinking" on any given issue or topic. The weekly report is issue-oriented and offered as a potential advocacy tool or change document.

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Something Missed or Overlooked?

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

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