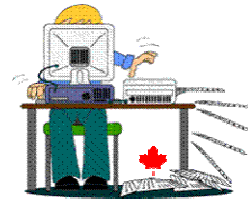


Media Watch...

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

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

Compiled & Annotated by Barry R. Ashpole

Do no harm: Scroll down to [U.S.A.](#) and 'When saving a life conflicts with Hippocratic Oath' (p.4), published in the Nebraska newspaper *Columbus Telegram*.

Canada

The view from here

A town that thinks about dying

BRITISH COLUMBIA | *The Province* (Vancouver) – 25 October 2011 – Almost every adult in [the North-Central U.S. town of] La Crosse, Wisconsin, has pondered their death. In this small town on the eastern bank of the Mississippi River, where the two largest employers are medical centres, planning for one's death happens with a frequency that would be considered morbid elsewhere. Do you want a ventilator when your lungs fail? What about aggressive antibiotics pumped into your bloodstream? How do you feel about feeding tubes? The questions need asking because the answers are important, says Dr. Michael Dolan, at Gundersen Lutheran, the hospital that spearheaded an end of life planning initiative [Respecting Choices®] ... two decades ago. <http://www.theprovince.com/health/town+that+thinks+about+dying/5601541/story.html>

Extract from *The Province* article

By 2008, 92% of hospitalized patients who died had an advanced directive that identified the patient's choices about treatments at the end of life. The majority – about 65% – opt for a mixture of life-prolonging procedures ... while the rest elect to have everything done.

From Media Watch dated 23 November 2009:

- WISCONSIN | National Public Radio – 9 November 2009 – **'Why this Wisconsin City is the best place to die.'** Sandra Colbert sits propped up in a hospital bed at Gundersen Lutheran Hospital ... connected by tubes to oxygen and IV fluids. Doctors have told her she didn't have a heart attack. But it sure felt that way when she collapsed at the gym a few hours earlier. "It felt like my heart exploded," she says, then adds. "I thought I was going to die." She's not going to die, the doctor reassured her. But now nurses are asking her to think about dying. Or, more specifically, they've asked her to fill out a living will. <http://www.npr.org/templates/story/story.php?storyId=120346411>

N.B. Respecting Choices® website: <http://respectingchoices.org/>

Home care, not health care

ONTARIO | *Ottawa Citizen* – 25 October 2011 – Providing the help that seniors need to stay in their own homes is universally acknowledged as a good idea. All the major provincial parties favour it. Study after study has shown that it is much more cost effective than hospital or long-term care and provides a better quality of life for seniors. Given that, you'd think there would be some real progress made in this area. That hasn't been the case in Ontario. A new study from the Institute for Research on Public Policy¹ finally offers a way to look at the problem that might result in a solution, if government has the will to act. The fundamental problem for home care is that it has been lumped in with health care, although the two services are actually quite distinct.
<http://www.ottawacitizen.com/life/Home+care+health+care/5600177/story.html>

1. *Population Aging and the Evolving Care Needs of Older Canadians: An Overview of the Policy Challenges*, Institute for Research on Public Policy, Montreal, 19 October 2011.
http://www.irpp.org/pubs/IRPPstudy/IRPP_Study_no21.pdf

From Media Watch dated 5 September 2011:

- BRITISH COLUMBIA | CBC News – 29 August 2011 – **"Cost of aging population on health care 'overblown.'**" Fears that Canada's aging population could lead to soaring health-care costs may be greatly exaggerated, say researchers, who suggest that the predicted "grey tsunami" may turn out to be more like a "grey glacier."^{1,2}
<http://www.cbc.ca/news/health/story/2011/08/29/grey-tsunami-aging-population.html>
1. *HEALTHCARE POLICY*, 2011;7(1):68-79. 'Population aging and the determinants of healthcare expenditures: The case of hospital, medical and pharmaceutical care in British Columbia, 1996 to 2006.' There is a gap between rhetoric and reality concerning healthcare expenditures and population aging.
<http://www.longwoods.com/content/22525>
 2. *HEALTHCARE POLICY*, 2011;7(1):41-54. 'Diagnosing senescence: Contributions to physician expenditure increases in British Columbia, 1996/97 to 2005/06.' Physician services in Canada present a puzzle with major implications for access to and costs of medical care, as well as for physician supply policy.
<http://www.longwoods.com/content/22527>

Contrast between high cost of hospital care and the wish to die at home should make us pause

BRITISH COLUMBIA | *The Province* (Vancouver) – 25 October 2011 – Getting older often means needing more health care. It is precisely this relationship between age and need that creates boomerangst: the fear that the boomers are going to bankrupt our health-care system. This fear is out of proportion to reality, for two reasons. First, study after study in Canada and elsewhere over the past 30 years shows that population aging adds a small and predictable amount of pressure on the health-care system each year. It is one of the least important among the many different cost drivers in the health-care system. Increasing use of laboratory testing and imaging, for example, adds twice as much in costs each year to physician services than does aging.
<http://www.theprovince.com/health/Essay+Contrast+between+high+cost+hospital+care+wish+home+should+make+pause/5525897/story.html>

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>



Committee on assisted suicide likely to recommend more palliative care

QUEBEC | Canadian Press (*Winnipeg Free Press*) – 24 October 2011 – Quebec's committee examining physician-assisted suicide is running behind schedule and wants more time to reach a consensus on its recommendations to the provincial government. But The Canadian Press has learned the report of the committee will likely focus on urging the government to increase the amount of palliative care and training of doctors who are caring for the dying. There would also be suggestions to amend physicians' codes of ethics accordingly and better inform Quebecers of their rights, including the right to refuse medical treatment. The committee wants to ensure the patient's wishes are respected in the end. The commission, set up two years ago, was to report this fall. It received 300 submissions and heard from 400 witnesses. <http://www.winnipegfreepress.com/canada/breakingnews/committee-on-assisted-suicide-likely-to-recommend-more-palliative-care-132495373.html>

Other reports pending on end-of-life care in Canada

Parliamentary Committee on Palliative & Compassionate Care: http://www.pcpsc-cpspsc.ca/index_files/Page300.htm

Royal Society of Canada Expert Panel on End-of-Life Decision Making: http://www.rsc-src.ca/documents/WorkingTOR_EndofLifePanel_Feb24_10000.pdf

N.B. Quebec Select Committee on Dying with Dignity: <http://www.assnat.qc.ca/en/actualites-salle-presse/nouvelle/Actualite-21205.html>

Specialist Publications

Of particular interest:

'Canada develops models of teleoncology' (p.9), published in the *Journal of the National Cancer Institute*.

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>

U.S.A.

The journey from life to death: Students participate in end-of-life simulation

MINNESOTA | *International Falls Daily Journal* – 29 October 2011 – After learning about hospice in the community, [Rainy River Community College] students were given 12 pieces of paper on which they wrote the names of three important people in their lives, three prized possessions, three favorite activities and three attributes about themselves of which they were most proud. After being told they had a life-threatening illness with six months to live, they were given thirty seconds to rip up three pieces of paper, signifying things they had to give up. Later, one-by-one, they had torn up all their papers except two. [Gale] Gagnier then circulated among the students and took one of each of their last squares of paper at random. The exercise is intended to show students that when your life is ending, you can't always control what you lose first. http://www.ifallsdailyjournal.com/view/full_story/16198444/article-The-journey-from-life-to-death--Students-participate-in-end-of-life-simulation

Health care model that saves money

Palliative approach cuts hospital admission costs, economist says

NEW YORK | *Times Union* (Albany) – 27 October 2011 – Hospitals can save more than \$2,000 per admission for patients who receive palliative care, according to an economist. About 150 doctors, hospital administrators and community health workers gathered in Saratoga Springs at the first palliative care conference sponsored jointly by the Healthcare Association of New York State and the Hospice & Palliative Care Association of New York State. The conference focused on advancing palliative initiatives, a model of care in which health professionals discuss with patients and families quality of life, medical treatment risks and the patient's wishes. Palliative care is aimed at people who have serious chronic illness, but are not necessarily terminal.
<http://www.timesunion.com/business/article/Health-care-model-that-saves-money-2240113.php>

From Media Watch dated 24 October 2011:

- CALIFORNIA | *Los Angeles Times* – 24 October 2011 – **'The costs of palliative care teams.'** Despite early research suggesting there are eventual cost savings in palliative care, setting up a palliative care team does require an investment. And in a medical care

system that largely rewards doctors and hospitals for performing procedures, many financially strapped hospitals ask whether and how palliative care teams will pay for themselves.

<http://www.latimes.com/health/la-he-palliative-care-side-20111024,0,6155818.story>

As more use hospice, Medicare sees sharp rise in costs, problems

FLORIDA | *Orlando Sentinel* – 29 October 2011 – On the final day Elly Barton worked as a hospice nurse last spring, she quit in disgust. The 74-year-old Winter Park woman had been hired as a "crisis care" nurse, assigned to patients considered so frail that they required around-the-clock medical supervision. Instead, Barton said, she wound up "baby-sitting" a nursing-home patient who needed nothing more than someone to make sure she didn't "jump out of bed and fall over." Because of Barton's presence, though, the hospice organization for which she worked could bill Medicare at the highest reimbursement level, a practice Barton thinks was a big waste for taxpayers.
<http://www.orlandosentinel.com/health/os-hospice-medicare-costs-20111028,0,2736520.story>

Do no harm

When saving a life conflicts with Hippocratic Oath

NEBRASKA | *Columbus Telegram* (OpEd) – 25 October 2011 – Being a hospitalist, I often have to take care of patients that are literally struggling between life and death. As a physician, my foremost duty is to save the lives of my patients. But, today, I will tell you about a situation when the duty to save life conflicts with the Hippocratic Oath of "doing no harm." Yes, there are times when you may harm someone by saving his/her life. It mainly depends upon what "life" means to a particular patient. Every individual has complete control over what they would want when they are suffering from a life threatening illness. For some, being alive at any cost is the definition of life. For others, the quality of life is more important than being alive. Quality of life also means different things to different patients. Being able to breathe on their own without being hooked up to a machine may be the most important consideration for some patients; being able to think and communicate may be the most important one for others. When a patient with serious illness deteriorates rapidly in the hospital, it triggers our duty to save life by doing certain things. I am talking about those situations when doing nothing will almost certainly result in a natural death.
http://columbustelegram.com/news/local/article_910caafe-ff0e-11e0-9591-001cc4c03286.html

Informed patient: Advance directives cut unwanted hospitalizations

WALL STREET JOURNAL | Online article – 24 October 2011 – Frail elderly patients who have advance directives through a program to communicate treatment preferences have fewer unwanted hospitalizations, according to a new study.¹ The program uses a form known as POLST – Physician Orders for Life-Sustaining Treatment – which allows patients to document their preferences about certain treatments. Signed by both patient and doctor, the form spells out choices including whether a patient wants to be on a breathing machine or feeding tube. The program launched in Oregon almost 20 years ago, but remains controversial to some groups that feel life-sustaining treatment should always be administered. Efforts to expand use of the forms, currently in use in about 14 states, with about 20 programs in development were the subject of an Informed Patient column earlier this year.² <http://blogs.wsj.com/health/2011/10/24/informed-patient-advance-directives-cut-unwanted-hospitalizations/>

1. 'The consistency between treatments provided to nursing facility residents and orders on the Physician Orders for Life-Sustaining Treatment form,' *Journal of the American Geriatric Society*, published online 22 October 2011. <http://onlinelibrary.wiley.com/doi/10.1111/j.1532-5415.2011.03656.x/abstract>
2. 'New efforts to simplify end-of-life care wishes,' *Wall Street Journal*, 15 March 2011 (noted in Media Watch dated 21 March 2011). <http://online.wsj.com/article/SB10001424052748703327404576194942197661606.html>

From Media Watch dated 10 October 2011:

- *U.S. TODAY & WORLD NEWS* | Online report – 4 October 2011 – '**Advance directives might curb cost of end-of-life care.**' Depending on where you live, having an advance directive may raise the odds that you'll receive hospice services and reduce the overall cost of your end-of-life care, a new study indicates.¹ <http://health.usnews.com/health-news/managing-your-healthcare/healthcare/articles/2011/10/04/advance-directives-might-curb-cost-of-end-of-life-care>
 1. 'Regional variation in the association between advance directives and end-of-life Medicare expenditures,' *Journal of the American Medical Association*, 2011;306(13):1447-1453. <http://jama.ama-assn.org/content/306/13/1447.abstract>

Of related interest:

- MISSOURI | KCUR News (COLUMBIA) – 24 October 2011 – '**End-of-life decisions: Family consent law proposed.**' 44 states have so-called "family consent laws," which help determine which family member should make health care decisions. Missouri is one of six states with no such law, putting families and doctors in legal limbo. A bill headed for the ... legislature could change that. <http://www.publicbroadcasting.net/kcur/news.newsmain/article/1/0/1866837/KCUR.News/End-of-Life.Decisions.Family.Consent.Law.Proposed>

Still no relief in sight for long-term needs

WASHINGTON DC | *New York Times* – 24 October 2011 – The law that many Americans had hoped would transform the nation's dysfunctional system of long-term care for the swelling ranks of people with disabilities and dementia quietly died this month... More than 10 million people in the U.S. already have long-term care needs, and two-thirds of the costs are paid for by government programs, mostly Medicaid. Studies estimate that unpaid family members deliver an even larger share of the care, and the cost of nursing home care averages \$72,000 a year. http://www.nytimes.com/2011/10/25/health/25seniors.html?_r=1

From Media Watch dated 17 October 2011:

- REUTERS | Online report – 14 October 2011 – '**U.S. suspends home-care program from healthcare law.**' U.S. health officials said they were suspending a program to provide home care for the elderly and disabled. <http://www.trust.org/alertnet/news/us-suspends-home-care-program-from-healthcare-law/>

International

Near-death experience 'all in the mind'

U.K. | BBC News – 30 October 2011 – Near-death experiences are simply "manifestations of normal brain functions gone awry", researchers say. Psychologists from Edinburgh University and the Medical Research Council in Cambridge reviewed existing research. They say phenomena such as out-of-body experiences or encounters with dead relatives are tricks of the mind rather than a glimpse of the afterlife. One of the researchers, Dr Caroline Watt, said: "Our brains are very good at fooling us." <http://www.bbc.co.uk/news/health-15494379>

Policy development

To live well is to die well

AUSTRALIAN AGEING AGENDA | Online report – 27 October 2011 – The Minister for Mental Health & Ageing, Mark Butler, has stressed the key role that quality palliative care services should play in the reformed aged care sector of the future, during a presentation at the 9th Asia/Oceania Regional Congress of Gerontology & Geriatrics in Melbourne earlier this week. Minister Butler fronted conference attendees and ageing experts ... to offer a brief overview on the Australian situation and emphasises the importance of "dying well." The minister publically stated that the sector can only allow older people to live well if individuals are enabled to also die well. His comments about the importance of integrating quality palliative with aged care

services, hints at the minister's support for palliative care to become the "core business" of aged care, as suggested by the Productivity Commission's (PC) in its recent *Caring for Older Australians* report. <http://www.australianageingagenda.com.au/2011/10/27/article/To-live-well-is-to-die-well/MHBGYAPZTV.html>

Specialist Publications

Of particular interest:

'Exploring barriers to the provision of palliative care in Australia' (p.8), published in the *Australian Medical Student Journal*.

From Media Watch dated 12 September 2011:

- AUSTRALIAN AGEING AGENDA | Online report – 6 September 2011 – **'Choice and control over life and death.'** The Productivity Commission [PC] has taken up the palliative care cause, recommending that the aged care system "should aim to be consumer-directed, allowing older Australians to have choice and control over their lives and to die well." Behind those words – "to die well" – is a much greater emphasis placed on palliative care in the final version of the PC's report.¹ <http://www.australianageingagenda.com.au/2011/08/16/article/Choice-and-control-over-life-and-death/PCZVWNMNLJ.html>

1. *Caring for Older Australians*. Productivity Commission, 2011. <http://pc.gov.au/projects/inquiry/aged-care/report>

Of related interest:

- AUSTRALIA (AUSTRALIAN CAPITAL TERRITORY) | *Canberra Times* – 26 October 2011 – **'Palliative care to focus on allowing terminally ill to die at home.'** Health Minister Katy Gallagher says she wants to see more palliative care beds throughout the city [of Canberra] ... and more support for those wishing to end their days in their own homes. Ms. Gallagher ... [said] ... that work had already begun on a strategy for palliative care in the territory for the next several years. <http://www.canberratimes.com.au/news/local/news/general/palliative-care-to-focus-on-allowing-terminally-ill-to-die-at-home/2335929.aspx>

Office for National Statistics launches new survey to measure care at end of life

U.K. (ENGLAND) | Office for National Statistics (ONS) – 25 October 2011 – A first ever national survey to measure experiences of care at the end of life has been launched by the ONS. It will provide important information for the key services – the National Health Service, care homes and hospices – that care for people at the end of their lives, to help improve people's experiences at this sensitive time. The survey, which has been commissioned by the Department of Health is being sent to 49,000 people across England – one in seven of all those who registered a death between November 2010 and June 2011 – seeking their views on the care that their loved one received, as well as the care and support they were given themselves. This survey will provide an opportunity for those who have cared for a loved one at the end of their life to make a real contribution to improving services for others. <http://www.ons.gov.uk/ons/rel/mro/news-release/national-survey-of-bereaved/index.html>

- *GP* (U.K.) | Online report – 28 October 2011 – **'National review launched into GP role in end-of-life care.'** End-of-life care run by GPs will be reviewed for the first time as part of a survey that will feed into developing the National Health Service Outcomes Framework. The survey of 49,000 people's end-of-life care experiences in England will be run by the Office for National Statistics... <http://www.gponline.com/News/article/1101318/national-review-launched-gp-role-end-of-life-care/>

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- U.K. (SCOTLAND) | *Herald* (Glasgow) – 26 October 2011 – **'MacDonald moves on right to die.'** Margo MacDonald has taken the first step in re-introducing a Bill to give Scots the right to assisted suicide. The independent Member of the Scottish Parliament submitted the proposed consultation document for a new, streamlined piece of legislation to be called the Assisted Suicide (Scotland) Bill. <http://www.heraldsotland.com/news/politics/macdonald-moves-on-right-to-die-1.1131223>
- RADIO NETHERLANDS WORLDWIDE | Online report – 25 October 2011 – **'Dutch doctors still reserved about euthanasia.'** Abortion, the suicide pill and euthanasia. In the Netherlands, life and death are both individual choices. That may be the image the Netherlands has abroad but euthanasia is not, in practice, carried out on any major scale. Dutch doctors are often reticent. <http://www.rnw.nl/english/article/dutch-doctors-still-reserved-about-euthanasia>

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/owner/MediaWatch>

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>

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

Exploring barriers to the provision of palliative care in Australia

AUSTRALIAN MEDICAL STUDENT JOURNAL, 2011;2(2):25-28. Most [study participants] agreed that palliative care was essential in the community, hospital and aged care setting. Four major themes [i.e., barriers] were identified: 1) education and stigma; 2) communications; 3) aged care; and, 4) general practice. Inadequate prescriptions of pain medication were a significant issue. Knowledge of palliative care was poor in both aged care staff and GPs, only 8.3% and 38.5% respectively answering all palliative care questions correctly, compared to 64.2% amongst South East Palliative Care staff. The study addresses a deficit in previous research, identifying barriers to palliation in aged care. http://www.amsj.org/wp-content/uploads/files/articles/amsj_v2_i2/pg25-28.pdf

Piloting the role of a pharmacist in a community palliative care multidisciplinary team: An Australian experience

BMC PALLIATIVE CARE | Online article – 31 October 2011 – The pharmacist screened most patients (88.4%) referred to the palliative care service to assess their risk of medication misadventure, and undertook 52 home visits. Medication reviews were commonly conducted at the majority of home visits (88%), and a variety of drug related problems (113) were detected at this point, the most common being "patient requests drug information" (25%) and "condition not adequately treated" (22%). The pharmacist made 120 recommendations in relation to her interventions. Fifty percent of online survey respondents had interacted 10 or more times with the pharmacist for advice. All felt that the pharmacist's role was helpful, improving their knowledge of the different medications used in palliative care. The six team members who participated in the focus group indicated that there were several benefits of the pharmacist's contributions towards medication screening and review. <http://www.biomedcentral.com/content/pdf/1472-684x-10-16.pdf>

Palliative care – what, who and when?

INNOVAiT | Online article – 20 October 2011 – Palliative care is a speciality which has grown considerably in recent years gaining recognition as its own subspecialty of medicine by the Royal College of Physicians in 1987. GPs have always had a role in providing palliative care, and as our ageing population increases, the number of people living with incurable illnesses will continue to rise. This article aims to provide an understanding of palliative care medicine, the role of the GP in the palliative care team, guidance to help identify those patients who may benefit from palliative care services and when referral to specialist services may be needed. The authors have also highlighted key documents pertaining to palliative care applicable to general practice. <http://rcgp-innovait.oxfordjournals.org/content/early/2011/10/20/innovait.inr154.abstract>

Of related interest:

- *MEDICINE*, 2011;39(11):636-638. **'Evolution and change in palliative care around the world.'** Palliative care attracts increasing attention as an aspect of the public health system and there are calls for access to it to be recognized as a human right. Yet around the world, palliative care is not uniformly developed and it needs to press hard to secure full integration with prevailing health policies. <http://www.sciencedirect.com/science/article/pii/S135730391100226X>

N.B. This issue of *Medicine* includes several articles on different aspects of palliative care. Journal contents page: http://www.sciencedirect.com/science?_ob=PublicationURL&_hubEid=1-s2.0-S1357303911X00117&_cid=273575&_pubType=JL&_view=c&_auth=y&_acct=C000228598&_version=1&_urlVersion=0&_userid=10&md5=811275b5acab8e21eff2ebddc0d100a9

Analysis of a network-wide specialist palliative care out-of-hours advice and support line: A model for the future

INTERNATIONAL JOURNAL OF PALLIATIVE NURSING, 2011;17(10):494-499. The number of calls to the out-of-hours Mount Vernon Cancer Network telephone advice line increased by 13% over the 3-year period. The primary reason for the calls was symptom management, and 79% were made by patients' relatives. 66% of callers appeared to have a high rate of satisfaction, and 67% of patients were not admitted to hospital. It appears that the advice line is providing a highly valued service, with calls being managed by experienced nurses. Increasingly, local commissioners are placing greater emphasis on supporting care at home and reducing unnecessary hospital admissions, and advice lines seem to be an effective way of facilitating this. http://www.ijpn.co.uk/cgi-bin/go.pl/library/article.html?uid=87291;article=IJPN_17_10_494_499

Professional tears: Developing emotional intelligence around death and dying in emergency work

JOURNAL OF CLINICAL NURSING | Online article – 21 October 2011 – Emergency nurses develop expertise in end-of-life care giving by progressing through three stages of development: 1) investment of the self in the nurse–patient relationship; 2) management of emotional labour; and, 3) development of emotional intelligence. Barriers that prevent the transition to expertise contribute to occupational stress and can lead to burnout and withdrawal from practice. Despite the emotional impact of emergency deaths, nurses who invest their therapeutic self into the nurse-patient relationship are able to manage the emotional labour of caring for the dying and their relatives through the development of emotional intelligence. They find reward in end-of-life care that ultimately creates a more positive experience for patients and their relatives. <http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2702.2011.03860.x/full>

End-of-life care in ICU: A practical guide

JOURNAL OF INTENSIVE CARE MEDICINE, 2011;26(5):295-303. Proper critical care training and management rests on 3 pillars – evidence-based patient care, proficient procedural skills, and compassionate end-of-life (EOL) management. The purpose of this manuscript is to provide a practical guide to EOL management for all bedside practitioners. The manuscript outlines not all but some fundamentally important ethical concepts and provides helpful rules and steps on end-of-life management based on the author's own personal experience and practice. Moreover, nowhere in the rigorous training of critical care or hospitalist physicians do we teach the procedure for removal of life-sustaining measures. Like any other procedure in medicine, it requires preparation, implementation and conclusion, as well as supervision and repetition to become proficient. <http://jic.sagepub.com/content/26/5/295.short?rss=1&ssource=mfr>

Palliative care via telemedicine

Canada develops models of teleoncology

JOURNAL OF THE NATIONAL CANCER INSTITUTE | Online article – 18 October 2011 – Want to get oncology care to a small population spread over a large area? Canada is a case in point of a country rising to that challenge. In Canada, with a land mass spanning more than 3.8 million square miles and a population of only 34 million tucked mainly into a few urban centers, telemedicine is just about the only economically feasible option for delivering quality health care to the hundreds of small communities scattered throughout its northern regions. (By contrast, the U.S. has a population of 314 million people on 3.7 million square miles.) Perhaps not surprisingly, Canada has spawned one of the world's largest telemedicine networks, and oncology is a big part of that. <http://jnci.oxfordjournals.org/content/early/2011/10/17/jnci.djr449.extract>

Cont.

Of related interest:

- *INFORMATICS FOR HEALTH & SOCIAL CARE* | Online article – 21 October 2011 – **'Information technology and hospice palliative care: Social, cultural, ethical and technical implications in a rural setting.'** Twenty priority issues were identified at a roundtable session. This paper provides the results of a needs assessment for health information technology to support hospice palliative care delivery in rural settings. <http://informahealthcare.com/doi/abs/10.3109/17538157.2011.613553>

Israel's Dying Patient Law

Fatal choices and flawed decisions at the end of life: Lessons from Israel

PERSPECTIVES IN BIOLOGY & MEDICINE, 2011;54(4):578-594. This article presents a recent disconcerting event that took place at a rehabilitative nursing home in Tel Aviv in light of Israel's Dying Patient Law, which came into effect in 2005. It probes the double effect doctrine as it is relevant to the case at hand and the role of the medical profession and of the family in making decisions at the end of life, and it argues that patients who express a wish to die should receive a comprehensive care assessment that addresses their physical and mental condition before rushing to provide lethal medication. The article concludes by offering some guidelines to help practitioners address the intricate questions they face when patients ask to die.

http://muse.jhu.edu/login?uri=/journals/perspectives_in_biology_and_medicine/v054/54.4.cohen-almagor.html

The clock on the wall: On dying, denying, and the search for hope

PSYCHOLOGY TODAY | Online article – 29 October 2011 – Sometimes, it seems that when people talk about denial, they are referring to a theory that relates courage simply to the ability to stare death in the face. But denial and courage are complicated business. Sometimes, courage takes the form of knowing what you want, or simply of having a sense of humor, or of admitting you're afraid. And, sometimes, it takes the form of recognizing when you don't have the strength to see the facts plainly, and need to be distracted. In the end, perhaps the bravest thing we do is simply to go on however we can, staying connected and finding beauty in a world that so casually goes on without us.

<http://www.psychologytoday.com/blog/the-flip-side/201110/the-clock-the-wall-dying-denying-and-the-search-hope>

Extract from *Psychology Today* article

Where does hope end and denial start? More important, does it matter? The answer is complicated. I could have begun this discussion with any of the following statements:

Denial helps cancer patients cope better.

Denial is a function of giving up, and gets in the way of coping and survival.

Denial will help cancer patients live longer.

Denial has no effect on survival at all.

Denial is a necessary element of a fighting spirit and is essential for the battle ahead.

Every single one of those statements can be supported by citations from the research literature.

End of life care in France

The National Observatory on End of Life Care

SOINS; LA REVUE DE RÉFÉRENCE INFIRMIÈRE, 2011;Sep(758):50-51. Created in 2010, the French National Observatory on End of Life Care is responsible for drawing up an overview of existing knowledge in order to gain a better understanding of the conditions of end of life. It must contribute to the dissemination of the palliative culture and the development of training and research. Its work must also throw light on the choices made in the area of health policies. <http://www.ncbi.nlm.nih.gov/pubmed/22003797>

Of related interest:

- *SOINS; LA REVUE DE RÉFÉRENCE INFIRMIÈRE*, 2011;Sep(758):52-53. **'The main missions of the National Palliative Care Resource Centre.'** The French National Palliative Care Resource Centre (CNDR) provides people impacted by the end of life, death and bereavement with a range of constantly evolving services. Spreading the palliative approach in order to enable everyone to benefit from it and appropriate it constitutes the main mission of the CNDR. <http://www.ncbi.nlm.nih.gov/pubmed/22003798>
- *SOINS; LA REVUE DE RÉFÉRENCE INFIRMIÈRE*, 2011;Sep(758):47-49. **'Role and missions of the French Society of Support & Palliative Care.'** The French Society for Support & Palliative Care brings together professionals and volunteers working in the area of palliative care and signed up to its social project. It is a learned society which develops and passes on practices, knowledge and research. It is the mouthpiece for people concerned by and involved in palliative care and support. <http://www.ncbi.nlm.nih.gov/pubmed/22003796>

N.B. Articles in French

Assisted (or facilitated) death

Representative sample of recent articles, etc:

- *JOURNAL OF MEDICAL ETHICS* | Online article – 29 October 2011 – **'Distress from voluntary refusal of food and fluids to hasten death: What is the role of continuous deep sedation?'** There is a growing trend to practice physician-assisted dying (death) [PAD] under the premise of providing quality palliative care in consensual and non-consensual life-ending situations. Voluntary refusal of food and fluids is a legal method of PAD, although medical and societal acceptability is uncertain. <http://jme.bmj.com/content/early/2011/10/29/medethics-2011-100278.extract>
- *BRITISH MEDICAL JOURNAL* | Online report – 24 October 2011 – **'Legalisation of assisted dying does not harm palliative care, study concludes.'** The legalisation of assisted dying does not undermine the provision of good palliative care, a report comparing six European countries concludes. Palliative care is as well developed in countries that have legalised assisted suicide or euthanasia as in those that haven't, says the report from the European Association of Palliative Care. <http://www.bmj.com/content/343/bmj.d6779.extract>
- *MEDICINE, HEALTH CARE & PHILOSOPHY* | Online article – 23 October 2011 – **'Euthanasia and end-of-life practices in France and Germany. A comparative study.'** The objective of this paper is to understand from a sociological perspective how the moral question of euthanasia, framed as the "right to die," emerges and is dealt with in society. It takes France and Germany as case studies, two countries in which euthanasia is prohibited and which have similar legislation on the issue. The paper ... seeks to understand how requests for the "right to die" emerge in each society, through both the debate (analysis of daily newspapers, medical and philosophical literature, legal texts) and the practices (ethnographic work in three French and two German hospitals) that elucidate the phenomenon. <http://www.springerlink.com/content/7h1338714q26255x/>

Cont.

- **SWISS MEDICAL NEWS** | Online article – 20 October 2011 – **'The impact of forensic investigations following assisted suicide on post-traumatic stress disorder.'** In Switzerland, all deaths through assisted suicide are reported as unnatural deaths and investigated by a forensic team (police, medical examiner, and state attorney). However, there is limited knowledge concerning the impact these forensic investigations have on the development of post-traumatic stress disorder, complicated grief, or depression in those who have lost a loved one. The data suggest that the diagnosis of post-traumatic stress disorder is significantly related to having experienced the forensic investigation as emotionally difficult. Thus, the way the forensic investigation is conducted immediately after an unnatural death is evidently associated with the development of post-traumatic stress. <http://www.smw.ch/content/smw-2011-13284/>

Worth Repeating

Patient navigation: A culturally competent strategy to address disparities in palliative care

JOURNAL OF PALLIATIVE MEDICINE, 2007;10(5):1023-1028. There is growing acceptance and increasing application of patient navigation in the care of underserved populations. Navigators (also called *promotoras*, *comadres*, ambassadors, community health workers, lay health workers) work with patients and families to empower them to overcome barriers in the health care system and enjoy better health and health care. The roles of navigator vary across programs but usually include some degree of case management, patient education, social work, and advocacy. However, to the best of the authors' knowledge, patient navigators have not been utilized in palliative care. In this paper they describe patient navigation in the traditional medical model and then illustrate how the patient navigator model applies to palliative care, using as an example their recently funded project to demonstrate the feasibility of a patient navigator to improve end of life outcomes for seriously ill Latinos. <http://www.liebertonline.com/doi/abs/10.1089/jpm.2007.0070>

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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