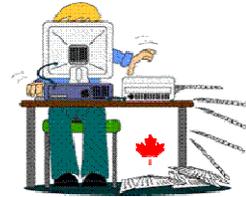


Media Watch...

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

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

Compiled & Annotated by Barry R. Ashpole

Navigating the bureaucratic maze: Scroll down to **Specialist Publications** and 'Patient-centered palliative care often elusive' (p.5), published in *The Clinical Advisor*.

Canada

National Advance Care Planning Day

Few Canadians plan for life's final days: Poll

BRITISH COLUMBIA | *Vancouver Sun* – 4 April 2012 – Death, we all hope, is a long way off. But health care experts say too few Canadians are thinking about the kind of care they'll need as the inevitable nears. In an Ipsos-Reid poll of 1,000 Canadians, 86% of respondents said they were not aware of what advance care planning was. Dr. Daren Heyland, a professor of medicine at Queen's University in Kingston, Ontario, who commissioned the poll, says a lack of care planning can cause a worsened experience during the months leading towards death. Heyland says patients who have end-of-life conversations with their doctors and family members are more likely to be satisfied with their care and require fewer medical resources. "Canadians haven't really thought about it," said Heyland. "Many people have

thought about their funeral, but interestingly not planned for those final days where medical care is needed. This leads to an over-utilization of life-sustaining technologies and overall prolongs the dying experience."

<http://www.vancouversun.com/health/Canadians+plan+life+final+days+Poll/6412086/story.html>

Specialist Publications

Of particular interest:

'The barriers encountered by community-based palliative care teams in Ontario, Canada' (p.8), published in *Health & Social Care*.

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.

Why we buy off-the-shelf dying

COLORADO | *Daily Camera* (Boulder) – 8 April 2012 – Ninety percent of us say that we want to die in peace, at home. Most end-of-life guidance suggests only that we express our wishes to our loved ones and medical proxy, writing directives via two (of seven primary) related legal documents: an Advance Directive and a Durable Medical Power of Attorney. These challenging actions are presented as, and believed to be, sufficient to secure a peaceful demise. It ain't necessarily so. Conversations and directives are crucial steps everyone should take. Nonetheless, it's easy to overshoot one's exit to a peaceful demise due to chance, shifting events, errors, even design. To increase the likelihood of dying peacefully we must know things about which medicine knows but does not, perhaps cannot, advise us. http://www.dailycamera.com/opinion-columnists/ci_20342249/guest-column-why-we-buy-off-shelf-dying

To die as he wanted

His neighbor's keeper – and chronicler

NEW YORK TIMES | Online photo-essay – 4 April 2012 – When [Clyde] Day turned 104 in February 2011, [Michael] Keating started photographing his friend in earnest. He had never done a project that was so intimate – or long term. Mr. Keating brought some turkey to Mr. Day and his caretaker on Thanksgiving Day 2011. Two days later, Mr. Keating got a call at 4 in the morning from the caretaker and rushed right over. Mr. Day had died in his sleep. "I was sad, but I was happy that he was able to die as he wanted – at home, not in a hospital room hooked up to a machine." <http://lens.blogs.nytimes.com/2012/04/04/his-neighbors-keeper-and-chronicler/?hp>

Many medical tests and procedures aren't needed – doctors' groups

WALL STREET JOURNAL | Online report – 4 April 2012 – Many medical tests and procedures are performed when they aren't needed, a new campaign by several doctors' groups says. The initiative, coordinated by the foundation affiliated with the American Board of Internal Medicine, will initially focus on 45 medical services – five each produced by nine different doctor-specialty societies. It will later add future lists from other specialties. "We're not saying they should never be done, we're saying these are often unnecessary, and therefore the patients should ask the doctor, 'Gee, do I need this?'" says Dr. Christine Cassel [CEO of the foundation]. The campaign, dubbed 'Choosing Wisely,' comes amid intense pressure to rein in growing health care costs. Doctors are trying to take the initiative from insurers. "We're better positioned to do this than insurance companies," Cassel says. Many of the ex-

Extract from *Daily Camera* article

Failure to recognize medical milestones derails our wishes. During our last decades we utilize medicine repeatedly to restore quality of life and save life. When we understand that we've already engaged in heroic measures over 5-20 years we might not feel impelled to do so again at the risk of ruining our chance to die peacefully. You don't have to slog through curative treatment to wait for a doctor to reluctantly suggest a palliative consult; you can ask for one anytime.

amples on the initial lists, such as imaging scans, focus on services and situations that have long drawn concern about overuse. <http://blogs.wsj.com/health/2012/04/04/many-medical-tests-and-procedures-arent-necessary-doctors-groups-say/>

Extract from *Wall Street Journal* report

Likely to be touchier is the recommendation ... that doctors should typically steer away from chemotherapy or radiation therapy for patients with solid tumors who aren't doing well, don't qualify for a research trial, haven't responded to multiple past treatments and show no strong evidence that they will benefit from new ones. Instead, such patients may do better with palliative care aimed at easing their pain and other symptoms...

Hospice of Michigan pilot program expands services to patients in last two years of life

MICHIGAN LIVE | Online report – 3 April 2012 – Hospice of Michigan has tested a home care program for patients who have an advanced illness – but aren't ready for hospice care – and found it cut costs [for one group by more than \$3,000 per month] and reduced hospital visits. It is run separately from the organization's hospice services, which are geared toward patients with a life expectancy of six months or less. The program uses the same interdisciplinary approach ... but it includes increased emphasis on meeting the needs of caregivers who are coping with the long-term challenges of caring for a loved one with a chronic illness. The program includes 24/7 access to a hospice nurse who answers questions, provides advice and, when needed, dispatches a nurse to the home. http://www.mlive.com/business/west-michigan/index.ssf/2012/04/hospice_of_michigan_pilot_prog.html

International

Aged fear rip-offs to fund their care

THE AUSTRALIAN | Online report – 7 April 2012 – Older Australians are worried about the opaque system they face when it comes time to pay for aged-care accommodation, and they want greater control over their own death, including access to high-quality palliative care, a four-month national consultation has found. The Council on the Ageing report collates the views of more than 3,400 people who attended "conversations" on aged care around the country. <http://www.theaustralian.com.au/news/nation/aged-fear-rip-offs-to-fund-their-care/story-e6frg6nf-1226320744779>

A salve soon, for cancer patients in terminal pain

INDIA | *Times of India* (Indore) | 6 April 2012 – An Indo-American non-government agency has come forward to set up pain and palliative care centre across the country, for cancer patients. The Jiv Daya Foundation has announced that two of these would be at the Cancer Hospital attached to Mahatma Gandhi Medical College in Indore and the Jawaharlal Nehru Cancer Hospital in Bhopal. The centres would provide free morphine medication and care to the patients. <http://timesofindia.indiatimes.com/city/indore/A-salve-soon-for-cancer-patients-in-terminal-pain/articleshow/12552744.cms>

Tomb-sweeping goes digital

CHINA.ORG.CN | Online report – 4 April 2012 – Although she was thousands of miles away, Beijing-based accountant Yang Jingjing was still able to "visit" her father's gravestone and offer virtual sacrifices with a few clicks of her mouse. The ritual performed on a government-sponsored website brought some comfort to Yang, who was unable to pay a personal visit to her father's resting place in southern China's Guangxi as part of this year's Qingming Festival. "It's hard for me to make that long journey, but I felt relieved and a lot less guilty when I saw his headstone," Yang said. The Festival ... is an important occasion for mourning the dead, but observing the annual ritual of tomb sweeping is becoming harder for the country's younger generations, many of whom now live and work far from their hometown. The website Yang visited is just one pilot project initiated by the government of the Guangxi Zhuang autonomous region to digitalize its cemeteries for online mourning. http://www.china.org.cn/china/2012-04/04/content_25060333.htm

From Media Watch, 2 April 2012:

- *CHINA DAILY* | Online report – 30 March 2012 – '**Live expensively, die expensively?**' The Chinese government's new regulations to clamp down on rocketing funeral and burial prices has prompted heated discussion online in the run-up to China's traditional day of honoring ancestors... http://www.chinadaily.com.cn/china/2012-03/30/content_14954536.htm

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- GERMANY | United Press International – 4 April 2012 – **'German doctors can assist terminally ill.'** An administrative court in Berlin has given German doctors the power to use their own judgment in cases involving terminally ill patients who want to die. The court lifted a physician's association ban on assisted suicide that included fines of up to \$65,722 on doctors who provided their patients with enough drugs to kill themselves. Court spokesman Stephan Groscurth said the judges found the ban "too general." Euthanasia is currently illegal in Germany. However, if a doctor is certain a dying patient wishes to end his or her life, a physician can provide that patient with the means to commit suicide. http://www.upi.com/Top_News/World-News/2012/04/04/German-doctors-can-assist-terminally-ill/UPI-30661333545713/

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

Developing and testing a strategy to enhance a palliative approach and care continuity for people who have dementia: Study overview and protocol

BMC PALLIATIVE CARE | Online article – 2 April 2012 – This project trialed a strategy intended to support a consistent, high quality, palliative approach for people with dementia drawing close to death. The strategy was to implement two communities of practice, drawn primarily from service provider organizations across care sectors, supporting them to address practice change. Communities comprised practitioners and other health professionals with a passionate commitment to dementia palliative care and the capacity to drive practice enhancement within partnering organizations. Project aims were to document: 1) changes driven by the communities of practice; 2) changes in staff/practitioner characteristics during the study (knowledge of a palliative approach and dementia; confidence delivering palliative care; views on death and dying, palliative care, and a palliative approach for dementia); 3) outcomes from perspectives of family carers, care providers, and community of practice members; 4) the extent to which changes enhanced practice and care continuity; and, 5) barriers to and facilitators of successful community of practice implementation. <http://www.biomedcentral.com/content/pdf/1472-684X-11-4.pdf>

From Media Watch, 2 April 2012:

- *AGING WELL*, 2012;5(2):18. **'Integrating palliative medicine with dementia care.'** Healthcare professionals should offer a gradually changing blend of restorative, maintenance, and palliative care services as a patient's function and the goals of care shift. Familiarity with disease terminal trajectories is essential to know when to commence palliative care. It is preferable to request specialist advice early, especially when considering potentially invasive and possibly harmful diagnostics and therapeutic interventions. <http://www.agingwellmag.com/archive/031912p18.shtml>

[Web-based technologies and social media](#)

From Cork to Budapest by Skype: Living and dying

BMJ SUPPORTIVE & PALLIATIVE CARE | Online article – 31 March 2012 – The use of Skype, blogging and webcams by patients in our hospitals and hospices is increasing. As illustrated in this case, the availability of such technology enables patients and families to communicate across wide geographical boundaries. This has particular advantages in situations where family members cannot routinely attend at the hospital because of other commitments or distance. The authors report on the varying use of Skype video-telephony over the course of a cancer patient's illness from the initial treatment phase through to the final days and hours of life. The benefits and challenges of using such technologies in a hospital setting and particularly in end-of-life circumstances are discussed. <http://spcare.bmj.com/content/early/2012/03/31/bmjspcare-2012-000210.abstract>

Stressors experienced by nurses providing end-of-life palliative care in the intensive care unit

CANADIAN JOURNAL OF NURSING RESEARCH, 2012;44(1):18-39. The major organizational stressors were lack of a palliative care approach, interprofessional difficulty, lack of continuity in life-support and treatment plans, and conflicting demands. Professional stressors included lack of end-of-life palliative care (EoL/PC) competencies and difficulty communicating with families and collaborating with the medical team. Emotional stressors were described as value conflicts, lack of emotional support, and dealing with patient and family suffering. Education and support programs should be developed to ensure quality EoL/PC in the critical care environment. <http://www.ingentaconnect.com/content/mcgrill/cjnr/2012/00000044/00000001/art00003>

Of related interest:

- JOURNAL OF PALLIATIVE MEDICINE | Online article – 3 April 2012 – 'Barriers to end-of-life care in the intensive care unit: Perceptions vary by level of training, discipline, and institution.' <http://online.liebertpub.com/doi/abs/10.1089/jpm.2011.0261>

Patient-centered palliative care often elusive

THE CLINICAL ADVISOR | Online OpEd – 3 April 2012 – The [U.S.] Patient Self-Determination Act (PSDA) became effective in 1990, a federal mandate affording people the right to determine how they will die. The PSDA requires institutions to provide patients the opportunity to put their wishes in writing. In 1995, the SUPPORT study [...to Understand Prognoses and Preferences for Outcomes and Risks of Treatments] found that practitioners were not adequately trained in communication techniques regarding end-of-life care.¹ This study incited the palliative care movement and standards that hospitals are now required to meet for Joint Commission on Accreditation of Healthcare Organizations accreditation. We have, however, a layer of bureaucracy in health care: insurance regulators determining where a patient will die based on information from well-intentioned but inexperienced case managers. We also have the artful sublimi-

nal messages of the extreme right and the media blitz of "death panels/offing granny/pulling the plug." In the midst of this, the most important voice is lost – that of the patient who lies in an ICU losing precious days at home, where he or she wants to die in peace. <http://www.clinicaladvisor.com/patient-centered-palliative-care-often-elusive/article/234853/>

Extract from *The Clinical Advisor* article

A year before he was appointed head of the Centers for Medicare & Medicaid Services, Donald Berwick proposed the following definition for patient-centered care: "The experience (to the extent the informed, individual patient desires it) of transparency, individualization, recognition, respect, dignity and choice in all matters, without exception, related to one's person, circumstances and relationships in health care."²

1. 'A controlled trial to improve care for seriously ill hospitalized patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT),' *Journal of the American Medical Association*, 1995;274(20):1591-1598. <http://jama.ama-assn.org/content/274/20/1591.abstract>
2. 'What 'patient-centered' should mean: Confessions of an extremist,' *Health Affairs*, 2009;28(4): w555-w565. <http://content.healthaffairs.org/content/28/4/w555.abstract>

End-of-life care for gay, lesbian, bisexual and transgender people

CULTURE, HEALTH & SEXUALITY | Online article – 2 April 2012 – There is little understanding in Australia of the special issues faced by gay, lesbian, bisexual and transgender people in end-of-life care and advance care planning. Participants [in this exploratory study] reported barriers to health care service access due to discrimination, inappropriate care and lack of knowledge among both consumers and health care workers of legal rights at the end of life. While advance care planning can assist with improving end-of-life care, respondents reported a number of obstacles. These included a lack of knowledge and absence of perceived need and the additional obstacle of social isolation, leading to difficulties identifying alternative decision-makers. The study highlighted the need for education for gay, lesbian, bisexual and transgender people and health and aged care providers on existing legal provisions to prevent discrimination in end-of-life care. <http://www.tandfonline.com/doi/abs/10.1080/13691058.2012.673639>

From Media Watch, 19 March 2012:

- U.K. | National Council for Palliative Care report – 15 March 2012 – **'End of life care services letting down lesbian, gay, bisexual and transgender people say leading charities.'** 'Open to all? Meeting the needs of lesbian, gay, bisexual and transgender people nearing the end of life,' draws on a survey of over 700 hospices, care homes and hospitals, as well as clinicians and service users. With more than 3.7 million lesbian, gay and bisexual people and at least 12,500 transgender people in Britain, the report expresses concerns that a significant proportion of the population are not accessing appropriate care when they are dying because of their sexuality or gender identity. <http://www.ncpc.org.uk/news/87>

From Media Watch, 6 February 2012:

- *INTERNATIONAL JOURNAL OF PALLIATIVE NURSING*, 2012;18(1):29-34. **'End-of-life care considerations for gay, lesbian, bisexual, and transgender individuals.'** Negative social attitudes, discrimination, and homophobia affect gay, lesbian, bisexual, and transgender individuals during their lifetimes. These experiences can affect how these individuals access health services and interact with health professionals, resulting in adverse outcomes compared with their heterosexual counterparts. End-of-life experiences can also be shaped by these factors. http://www.ijpn.co.uk/cgi-bin/go.pl/library/article.html?uid=89126:article=IJP_N_18_1_29_34

Do grief self-help books convey contemporary perspectives on grieving?

DEATH STUDIES, 2012;36(5):393-418. Grief therapy and psychology literatures of the modern Western world conceptualized bereavement and grief as processes to be "worked through" so that other relationships could be pursued. In the last decade or so, however, grief theorists have endorsed the value of attaining new meaning(s) and continuing bonds with our lost loved ones instead of "moving on from," "letting go of," or "achieving closure from" them. This article tracks the evolution of thought pertaining to this shift and examines its relevance to grief self-help books... <http://www.tandfonline.com/doi/abs/10.1080/07481187.2011.553326>

"I'm not trying to be cured, so there's not much he can do for me": Hospice patients' constructions of hospice's holistic care approach in a biomedical culture

DEATH STUDIES, 2012;36(5):419-446. The hospice philosophy was founded on a mission to provide comprehensive and holistic services to individuals at the end of life. Hospice interdisciplinary teams work together to offer therapies such as spiritual services, comfort care, and massage therapy to meet patients' physical, psychological, emotional, and spiritual needs. Although the hospice philosophy is guided toward patient-centered care, limited research has examined how patients understand holistic care services. The authors examined hospice patients' understandings of holistic care and argue that these perceptions of care are constructed through the biomedical model of medicine. <http://www.tandfonline.com/doi/abs/10.1080/07481187.2011.584024>

Cont.

Of related interest:

- *CURRENT OPINION IN SUPPORTIVE & PALLIATIVE CARE* | Online article – 6 April 2012 – '**An existential approach to oncology: Meeting the needs of our patients.**' Oncologists should consider expanding their role and involving themselves in the more holistic aspects of cancer care. As a result of the bonds that they develop with patients, these professionals often find themselves in a position of being able to help and counsel cancer patients who are coping with feelings of isolation, loneliness, and fear. <http://journals.lww.com/co-supportiveandpalliativecare/toc/publishahead>

Telling a child that her dad is dying

END OF LIFE JOURNAL, 2012;2(1). Palliative care practitioners can sometimes find themselves in a situation where there is an urgent need to communicate with a family member or friend of a terminally ill patient. Nurses working in hospitals, care homes and community settings are often involved in end-of-life conversations and thereby play an important role supporting families facing loss. There is a paucity of information in the palliative care literature on how to talk to children when a parent is dying. According to Chowns (2009), healthcare professionals are often reluctant to engage in such conversations because: the forthcoming death of a parent challenges the perception that childhood is a time of innocence and their instinct is to protect children from painful experiences; they lack confidence when it comes to relating to a child's conception of the world; and, they worry that talking to a child about death will potentially cause more harm to the child. <http://endoflifejournal.schristophers.org.uk/clinical-skills/communication-vignettes-telling-a-child-that-her-dad-is-dying>

Pediatric palliative care – when quality of life becomes the main focus of treatment

EUROPEAN JOURNAL OF PEDIATRICS | Online article – 3 April 2012 – Pediatric palliative care (PPC) focuses on children and adolescents with life-limiting diseases. It may be initiated at various points of the disease trajectory, if possible early enough to support living with the best possible quality of life despite a limited lifespan. From birth to adolescence, children with a broad spectrum of diseases may benefit from PPC. Since 50% of deaths in childhood occur within the first year of life, PPC is just as relevant to neonatology. Causes of death in the neonate and young infant are due to perinatal conditions such as preterm birth and congenital disorders and syndromes; in older children, external causes, such as traumatic injuries, outweigh disease-related causes of death. PPC may last from a few hours or days for neonates to many years for children with complex chronic conditions. For neonates, PPC often has the character of end-of-life (EOL) care followed by bereavement care for the family. For older children, PPC can clearly be differentiated from EOL care;

its indications include progress or deterioration of disease, marked instability of the child's condition, increase in the need for technical or medical support, increase in suffering, or failure of treatment. If a child's need for palliative care is established, useless and potentially harmful treatments may be withheld and informed choices can be made about treatment, care, and the remaining life of the child. <http://www.ncbi.nlm.nih.gov/pubmed/22476440>

Conclusion to the *European Journal of Pediatrics* article

This review aims to provide knowledge for clinicians who care for children and adolescents at risk of dying from their disease. Pediatric palliative care can improve the child's remaining life-time by focusing on quality of life and goals that are defined by the child and his or her family.

Cont.

Of related interest:

- *ARCHIVES OF PEDIATRICS & ADOLESCENT MEDICINE* | Online article – 2 April 2012 – '**Patterns of care at end of life in children with advanced heart disease.**' Infants and children who die of advanced heart disease frequently succumb in the intensive care setting with multisystem organ failure and exposure to highly technical care. <http://archpedi.ama-assn.org/cgi/content/short/archpediatrics.2011.1829v1?rss=1>

The barriers encountered by community-based palliative care teams in Ontario, Canada

HEALTH & SOCIAL CARE | Online article – 31 March 2012 – By establishing shared care models in the community setting, teams support primary healthcare providers such as family physicians and community nurses who often have little exposure to palliative care in their training. As a result, palliative care teams strive to improve not only the end-of-life experience of patients and families, but also the palliative care capacity of primary healthcare providers. The aim of this qualitative study was to explore the views and experiences of community-based palliative care team members and key-informants about the barriers involved using a shared care model to provide care in the community. <http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2524.2012.01060.x/abstract>

A guide to regulating the home care market

IRISH MEDICAL TIMES | Online report – 5 April 2012 – Healthcare organisations and rights campaigners have long demanded statutory regulation and standards to protect the thousands of vulnerable older people who are cared for in their homes by voluntary organisations or private service providers. Now the Law Reform Commission (LRC) – which is tasked with recommending the enactment of legislation to clarify and modernise the law – has added its voice to the clamour for tighter controls. The Commission believes the Health Information & Quality Authority (HIQA) should be given additional regulatory and inspection powers to ensure that appropriate legal standards are in place in the home care sector. Under the Health Act 2007, HIQA is the regulatory and standard-setting body for the residential

nursing home setting. This Act should be extended to broaden HIQA's powers over the provision of professional home care. <http://www.imt.ie/features-opinion/2012/04/a-guide-to-regulating-the-home-care-market.html>

Extract from Law Reform Commission report

GPs and public health nurses are the main providers of palliative care in the home. However, there is no formal framework to support the delivery of palliative care by primary care teams in Ireland.⁹⁰ The palliative care team, also known as the home care team, provides specialist support to patients, families and to community based health care professionals.

1. 'Legal Aspects of Professional Home Care,' Law Reform Commission, January 2012 (noted in Media Watch, 30 January 2012). http://www.rte.ie/news/2012/0130/lrc_homecare.pdf

Individuals' goals for surrogate decision-making

JOURNAL OF THE AMERICAN GERIATRIC SOCIETY | Online article – 3 April 2012 – Individuals have three primary goals with respect to making treatment decisions for them during periods of incapacity: involve their family, treat them consistently with their own treatment preferences, and reduce the burden on their family. Unfortunately, prior systematic reviews have found that family members often are not able to determine which treatment patients want, and family members frequently experience substantial distress when acting as surrogates. These findings suggest that current practice frequently fails to promote individuals' primary goals for treatment decision-making. <http://onlinelibrary.wiley.com/doi/10.1111/j.1532-5415.2012.03937.x/abstract>

Cont.

Of related interest:

- *SWISS MEDICAL WEEKLY* | Online article – 5 April 2012 – **'To speak, or not to speak – do clinicians speak about dying and death with geriatric patients at the end of life?'** Discussing and preparing (the patient) for an end-of-life decision early enough is a prerequisite of good palliative care. It is an ethical obligation on the side of the healthcare professionals to support openness, respect for autonomy, and dignity by addressing issues of dying and death with the patient in order to help facilitate advance care planning. <http://www.smw.ch/content/smw-2012-13563/>

Liars, medicine, and compassion

JOURNAL OF MEDICINE & PHILOSOPHY | Online article – 6 April 2012 – This paper defends an account of compassion and argues for the centrality of compassion to the proper practice of medicine. The argument proceeds by showing that failures of compassion can lead to poor medical treatment and disastrous outcomes. Several case studies are discussed, exemplifying the difference between compassionate and non-compassionate responses to patients seeking help. Arguments are offered in support of approaching reports of persistent pain with a trusting attitude, rather than distrust or skepticism. The authors suggest educational improvements to encourage compassion. <http://jmp.oxfordjournals.org/content/early/2012/04/06/jmp.jhs007.abstract>

Of related interest:

- *JOURNAL OF PALLIATIVE MEDICINE* | Online article – 4 April 2012 – **'"Tu Souffres, Cela Suffit": The compassionate hospital.'** The authors propose that the characteristics of personal ... compassion may be extrapolated to the concept of corporate ... compassion. Modern health care facilities attract staff members who are able to exercise varying degrees of compassion in their busy daily routines. <http://online.liebertpub.com/doi/abs/10.1089/jpm.2011.0378>

Media Watch Online

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

Canada

ONTARIO | Hamilton Niagara Haldimand Brant Hospice Palliative Care Network: <http://www.hnhbhpc.net/CurrentNewsandEvents/tabid/88/Default.aspx> (Click on 'Current Issue' under 'Media Watch')

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

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

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

U.S.A.

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

Europe

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

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

International

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

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

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

Bioethics, cultural differences and the problem of moral disagreements in end-of-life care: A terror management theory

JOURNAL OF MEDICINE & PHILOSOPHY | Online article – 4 April 2012 – Cultural differences in end-of-life care and the moral disagreements these sometimes give rise to have been well documented. Even so, cultural considerations relevant to end-of-life care remain poorly understood, poorly guided, and poorly resourced in health care domains. Although there has been a strong emphasis in recent years on making policy commitments to patient-centred care and respecting patient choices, persons whose minority cultural worldviews do not fit with the worldviews supported by the conventional principles of western bioethics face a perpetual struggle in getting their care needs met in a meaningful, safe, and healing way. In this essay, attention is given to exploring why cultural differences exist, why they matter, and how health care providers should treat them in order to reduce the incidence and impact of otherwise preventable harmful moral outcomes... <http://jmp.oxfordjournals.org/content/early/2012/04/04/jmp.jhs009.abstract>

Of related interest:

- *PLoS ONE* | Online article – 3 April 2012 – '**Culture and end of life care: A scoping exercise in seven European countries.**' This ... is the first comparative exploration of the cultural differences in the understanding of end of life (EoL) care in these countries. The diverse body of evidence that was identified on socio-cultural issues in EoL care, reflects clearly distinguishable national cultures of EoL care... <http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0034188>

Characteristics of emergency department patients who receive a palliative care consultation

JOURNAL OF PALLIATIVE MEDICINE | Online article – 2 April 2012 – A large gap exists between the practice of emergency medicine and palliative care. At an urban academic medical center with a well-developed palliative care service, the majority of palliative care consultations were for patients who arrive via the emergency department. Despite this, only a small minority of consultations originated from emergency providers and consultation was on average initiated days into a patient's hospital stay. <http://online.liebertpub.com/doi/abs/10.1089/jpm.2011.0376>

What we learned from medical student reflections on a palliative care experience

JOURNAL OF PALLIATIVE MEDICINE | Online article – 29 March 2012 – Two broad thematic categories were identified [in this study]: what the students learned and what the students experienced. Student writings revealed learning about palliative care (pain management, family meetings, goals of care, patient-family centered care, timing of palliative care, and delivering bad news); being a doctor (knowledge, communication, presence, empathy, not giving false hope, and person-focused care); the patient (importance of family, the experience of dying, and the uniqueness of each patient); and themselves (need to be non-judgmental, ability to do palliative care, self-limitations, becoming a better physician, and dealing with death). Student reflections centered on encounters with patients and families, internal emotional responses, and self-transformation. <http://online.liebertpub.com/doi/abs/10.1089/jpm.2011.0391>

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>

Worth Repeating

How to attract more males to community-based hospice palliative care volunteer programs

AMERICAN JOURNAL OF HOSPICE & PALLIATIVE MEDICINE, 2009;26(6):439-448. Two separate studies were conducted to better understand why so few middle-aged and older men volunteer in hospice palliative care; only about 10% of the patient/family care volunteers in New Brunswick's community-based hospice palliative care volunteer programs are men. In study 1, 15 (22%) of the 68 men who read a brief description about the kinds of things that hospice palliative care volunteers do expressed an interest in this type of volunteerism. The main reasons given for their lack of interest included "being too busy" and "not being able to handle it emotionally." At least one third of the men who said "No" to becoming a hospice palliative care volunteer expressed an interest in 10 of 13 other common volunteer activities (e.g., driving). In study 2, 59 men were presented with a list of 25 tasks that hospice palliative care volunteers might perform when providing emotional, social, practical, and administrative support. The men were asked to indicate which tasks they would be willing to perform if they were a hospice palliative care volunteer. The men were least willing to serve on the board of directors (28%), provide hands on patient care (38%), and work in the volunteer program's office (42%); they were most willing to talk to the patient (97%), share hobbies and interests with the patient (92%), listen to the patient's memories and life stories (90%), and provide friendship and companionship (88%). The results of these studies may have implications for the recruitment of male volunteers to work with dying patients and their families. <http://ajh.sagepub.com/content/26/6/439.abstract>

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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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