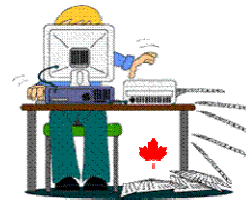


## Media Watch...

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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Compiled & Annotated by Barry R. Ashpole

Technology and end-of-life care: Scroll down to [Specialist Publications](#) and 'Telecare, remote monitoring and care' (p.7), published in *Bioethics*.

## Canada

### McGill's mindfulness meditation teaches doctors coping skills

QUEBEC | *Montreal Gazette* – 19 April 2012 – It's not easy to work with critically ill children and stressed-out parents. Doctors who work in pediatric-palliative care do it every day. Conversations with parents are often tense; frustrations can boil over – on both sides. Pediatrician Stephen Liben knew he needed to figure out how to cope better with the stress. The director of pediatric-palliative care at the Montreal Children's Hospital was finding himself angry or defensive in heated moments with parents. A calm doctor is a better doctor. He knew he could do better as a physician. So he decided – reluctantly – to try mindfulness meditation. McGill University offers such a program for healthcare professionals, and colleagues had spoken highly of it. Liben was skeptical, but willing. "If you're finding yourself reacting out of anger

or frustration and it has brought neither you nor others around you any happiness or understanding, you start asking yourself: Is there any other way to be in the world other than this reactive way?" Liben said.

<http://www.montrealgazette.com/health/Physicians+healing+themselves/6482206/story.html>

#### Extract from *Montreal Gazette* article

The Mindfulness-Based Medical Practice program is part of McGill University's Whole Person Care program, which educates physicians on how to treat not only the physical, but also the psychosocial and spiritual aspects of a person, while also dealing with their own well-being.

## Corrections & Clarifications

Noted in Media Watch, 26 March 2012 (p.2), was publication of the report of the Quebec National Assembly's Select Committee on Dying with Dignity ('La Commission spéciale sur la question de mourir dans la dignité dépose son rapport). An English translation of the Committee's twenty-four recommendations is available at: <http://www.cspcp.ca/english/DWD%20Recommendations.pdf> (Source: Canadian Society of Palliative Care Physicians.)

## Assisted (or facilitated) death

Representative sample of recent news media coverage:

- MANITOBA | *Winnipeg Free Press* (Letter to the Editor) – 19 April 2012 – **'An inhumane argument.'** In the current discussion about whether physician-assisted suicide should be legalized for the terminally ill, an oft-heard argument is what I call the "we put down pets so let's put down people" argument. I have three reasons for thinking this isn't a good one. First, it's simply not the case that we treat people more humanely when we put them down when they suffer. The humane, compassionate response to a human being who is suffering pain and his or her prognosis is not good is care – palliative care. Second, withdrawing or withholding extraordinary, burdensome, or medically useless treatment from a terminally ill patient is already both a legal and ethical part of palliative care. It does not require the legalization of physician-assisted suicide. Third, the legal acceptance of physician-assisted suicide signals the culture's embrace of death as a solution to medical, social and psychological problems. [http://www.winnipegfreepress.com/opinion/letters\\_to\\_the\\_editor/an-inhumane-argument-148056115.html](http://www.winnipegfreepress.com/opinion/letters_to_the_editor/an-inhumane-argument-148056115.html)
- BRITISH COLUMBIA | *Kelowna Capital News* – 17 April 2012 – **'Kelowna's assisted suicide debate to run before courts decide issue.'** A West Kelowna woman who has signed on to a right-to-die case before the B.C. Supreme Court must wait for one more hurdle before the courts decide her fate and the future of terminally ill patients who want to choose when they die. On 16 April, both sides in Carter *et al*, on which West Kelowna's Gloria Taylor is a co-plaintiff, were asked to provide more evidence in light of the recent Bedford decision. The Bedford case decided the constitutionality of Canada's laws against bawdy houses and communicating for the purposes of prostitution, and considered matters of exploitation and harm, which are also considerations in the context of assisted death decisions, according to Justice Lynn Smith, the judge presiding over the Carter case. <http://www.kelownacapnews.com/news/147786475.html>

## U.S.A.

### Hospice care comes too late to many in North Jersey

NEW JERSEY | *The Record* (Woodland Park) – 23 April 2012 – Hospice is designed to provide end-of-life care that helps keep terminal patients comfortable – if possible in their own homes – while providing emotional support for their families. But even as a new hospice service is getting off the ground ... providers are finding that in North Jersey getting people into the programs in a timely fashion is a major problem. At ... Holy Name Hospital's hospice residential-care facility ... at least some of its 20 beds is unused "a significant amount of the time," said Jean Leone, executive director of the hospital's hospice and palliative services. The problem, hospice administrators say, is that terminally ill patients are referred to their care at way too late a stage in their disease. [http://www.northjersey.com/news/148472385\\_Benefits\\_of\\_hospice\\_often\\_are\\_complicated\\_by\\_delays.html](http://www.northjersey.com/news/148472385_Benefits_of_hospice_often_are_complicated_by_delays.html)

### To aid patients, Sutter Health employees queried about end-of-life care wishes

CALIFORNIA | *Modesto Bee* – 20 April 2012 – In the past week, palliative care teams at the region's seven Sutter Health hospitals have spent time promoting their "Having the Talk" program among Sutter employees, educating them on the importance of talking to their families about their end-of-life care wishes and then putting in place the appropriate documents that set out those preferences. The campaign hasn't targeted patients but rather the employees and medical professionals themselves and their families. Not only will that allow employees to get their documents in order so that their families can be prepared, said Catherine McGregor, Sutter Auburn Faith Hospital palliative care nurse coordinator, but they'll also gain valuable insight into the difficult decisions that patients face every day. <http://www.modbee.com/2012/04/20/2165735/to-aid-patients-sutter-health.html>

## How Judaism differs in life-death issues

*NEW JERSEY JEWISH STANDARD* | Online report – 20 April 2012 – The boy was 17 years old and he urgently needed an operation. As a Jehovah's Witness, however, he would rather die than receive a blood transfusion, believing it to be a transgression of the biblical prohibition against eating blood. His parents ... agreed with him. The doctors of the UCLA [University of California, Los Angeles] Medical Center, however, would not agree to perform a blood-free operation. They were not willing to risk losing a patient's life because of his religious beliefs. As a member of the medical center's ethics committee, Rabbi Elliott Dorff was among those consulted. Dorff, Conservative Judaism's leading expert on medical ethics and chairman of the Rabbinical Assembly's Committee on Jewish Law & Standards, says that under halachah, or Jewish law, the case would be open-and-shut. First, halachah does not consider a blood transfusion to be at all akin to the forbidden act of eating blood. Secondly, even eating blood would be permitted under Jewish law to save a life. American law, however, presented the UCLA Medical Center with a more complicated picture. An adult has the legal right to refuse medical treatment. The patient, however, was a minor. And parents do not have the right to refuse medical treatment on behalf of their children. [http://www.jstandard.com/content/item/how\\_judaism\\_differs\\_in\\_life-death\\_issues/22840](http://www.jstandard.com/content/item/how_judaism_differs_in_life-death_issues/22840)

## In defense of 'death panels'

*NEWSDAY* | Online OpEd – 20 April 2012 – As a former health fraud and patient abuse investigator with expertise in Medicare and health insurance, I was better prepared than most to advocate for my elderly father in the last few months of his life. But still, it was heartbreaking to watch this proud man, who then weighed less than 125 pounds, hold out false hope for recovery because his doctors sidestepped telling him that he had months, not years, to live. Granted, doctors are faced with a dreadful dilemma. If they tell their patient that there is little hope for a cure, then what? Do they delay seeing the patients in the waiting room in order to spend enough time discussing treatment options with a single gravely ill individual? Or do they postpone the uncomfortable discussion by scheduling the next appointment for three months in the future and prescribing an improbable treatment? In my father's case they chose the latter. There could have been another choice for my father and his physicians if doctors had the option to refer patients for a Medicare covered end-of-life consultation. This proposed benefit would have allowed a health care provider to talk with a patient about important advanced directive issues such as living wills, as well as palliative care and hospice services covered by Medicare. But that benefit was removed from the health care reform law due to the hysteria caused by false and reckless rumors that a voluntary consultation by a physician about end-of-life options was a "death panel." <http://www.newsday.com/opinion/oped/cassidy-in-defense-of-death-panels-1.3673417>

## Cancer patients rarely speak up about care problems

REUTERS | Online report – 19 April 2012 – Many cancer patients who'd had problems with their treatment never said anything to the doctor they thought was responsible – and almost none formally reported the problems to the hospital, according to a survey of cancer patients. In the study<sup>1</sup> ... patients cited delays in treatment, surgical complications and other issues related to medical care, in addition to communication barriers or breakdown between them and their doctors, as the most common potentially harmful problems. Lead author Kathleen Mazor, from Meyers Primary Care Institute and the University of Massachusetts Medical School in Worcester, said there may be many reasons for this. "Sometimes there's a situation where they're really still thankful for the care that they got, and so they don't want to hurt anybody by saying, 'Everything was great, except...' Or they don't want to do harm to their relationship with their doctor," she added. <http://www.reuters.com/article/2012/04/19/health-cancer-care-idUSL3E8FJ0AI20120419>

1. 'Toward patient-centered cancer care: Patient perceptions of problematic events, impact, and response,' *Journal of Clinical Oncology*, published online 16 April 2012. <http://jco.ascopubs.org/content/early/2012/04/11/JCO.2011.38.1384.abstract?sid=b35e8278-8b1a-49d0-95c7-5bbceeb0cc3d>

## Where the oldest die now

*NEW YORK TIMES* | Online Commentary – 18 April 2012 – Always alert for a bit of good news about the sorry way so many older Americans die, I noticed a recent report from the Centers for Disease Control [CDC] & Prevention.<sup>1</sup> The agency's statisticians looked at the deaths of people over 85 – 700,000 of them in 2007 – and where they occurred, and pointed out some encouraging trends. The proportion of those very old people who died as hospital patients dropped to 29% in 2007 from 40% in 1989. During the same time period, the proportion who died at home climbed to 19% from 12%. The full CDC report shows similar trends in the broader population over age 65: a steadily declining proportion of deaths in hospitals (just over one-third in 2007, down from nearly half in 1989), and a rising proportion of deaths at home (24% in 2007, up from 15% in 1989). That's still a very low percentage, given how many people say they want to die in their homes. But it shows improvement, doesn't it? Not so fast, said Dr. Joan Teno, professor of community health and medicine at the Brown Medical School. She pointed out ... that the rates of very old people dying in nursing homes and other long-term care facilities have also increased, reaching 40% of those over age 85. If they were actually residents of the nursing homes in which they died, that may not be unhappy news. <http://newoldage.blogs.nytimes.com/2012/04/18/where-the-oldest-die-now/#>

1. 'Location of death for decedents aged ≥85 years – U.S., 1989-2007,' Centers for Disease Control & Prevention, September 2011. <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6037a9.htm>

## State budget cuts could take away hospice care for poor

ILLINOIS | CBS (Chicago) – 17 April 2012 – [State] Governor Pat Quinn says the state's Medicaid system is on the verge of collapse, and to save it, billions of dollars in spending must be cut. One service that could end on the chopping block is hospice care for the poor ... that would be devastating for many people who have a terminal illness. <http://chicago.cbslocal.com/2012/04/17/state-budget-cuts-could-take-away-hospice-care-for-poor/>

## High-tech medicine and the elderly don't mix well, says geriatrician

FLORIDA | *Herald-Tribune* (Sarasota) – 16 April 2012 – Most people say they don't want to die in an intensive-care ward, hooked up to machines, and yet this is the experience many patients and their families get by default. One doctor who has studied the quality of that experience is calling for a new approach to treating the elderly. "We have an aging society, access to advanced technology, a very high expectation of what health care can accomplish, and a culture that denies that we won't live forever," says Bruce J. Naughton, associate professor of medicine at the University at Buffalo and a specialist in geriatrics. "It turns out that more care and more technology doesn't necessarily translate to the best care." Preliminary data from a study at the university's Geriatric Center of Excellence shows that people over

the age of 80 who spend more than four days in a medical intensive-care unit have up to a 75% chance of dying in the hospital. High-tech care for seriously ill patients of an advanced age is associated with "markers of poor care," Naughton says, such as too-late admission to hospice programs and stressful transfers of the patient within three days of death. <http://health.heraldtribune.com/2012/04/16/high-tech-medicine-and-the-elderly-dont-mix-well-says-geriatrician/>

### Quote from *Herald-Tribune* report

*The reliance on overly aggressive, often high-tech treatments in elderly patients with multiple illnesses ends up providing, in the end, poor care: the exact opposite of what physicians are trained to do.*

## Assisted (or facilitated) death

Representative sample of recent news media coverage:

- *JURIST* | Online OpEd – 18 April 2012 – '**Georgia's assisted suicide ban lacks patient safe-guards.**' Guest Columnist Valerie Vollmar of Willamette University College of Law says the Georgia legislature seems to have acted hastily without thinking through the potential consequences of its new assisted suicide law, which differs dramatically from the legislative schemes in states that allow the practice. <http://jurist.org/forum/2012/04/valerie-vollmar-assisted-suicide.php>

## International

### Eldercare

#### **Shake-up will help the aged stay at home**

AUSTRALIA | *Wellington Times* – 21 April 2012 – Elderly Australians with means will pay more for their aged care under a \$3.7 billion overhaul of the system which seeks to rid it of inconsistency and keep it sustainable as the population ages and the workforce shrinks. The package – of which \$577 million is new money – will introduce means tests for people being cared for either in their home or a nursing home and will inject \$1.2 billion towards redressing the shortfall of aged-care workers and the low wages they are paid. The reforms ... include establishing an aged care financing authority, which will

approve the bonds and fees charged by providers to prevent people being ripped off. <http://www.wellingtontimes.com.au/news/national/national/general/shakeup-will-help-the-aged-stay-at-home/2529489.aspx>

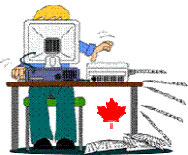
#### **Specialist Publications**

Of particular interest:

**'Transitional care for older adults: The need for new approaches to support family caregivers'** (p.8), published in the *Journal of Gerontology & Geriatric Research*.

Of related interest:

- IRELAND | *Independent* (Dublin) – 17 April 2012 – '**€17m lying unclaimed by elderly in home care fund.**' Thousands of elderly people are due as much as €17m in unclaimed arrears under the state scheme which subsidises nursing home care. The back money is due to thousands of people who were unable to get funds for many months after the Fair Deal scheme was introduced, due to a backlog in dealing with their applications. <http://www.independent.ie/national-news/17m-lying-unclaimed-by-elderly-in-home-care-fund-3082232.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>

## Nurses want more training in palliative care

IRELAND | *Irish Times* (Dublin) – 17 April 2012 – Just one in three staff working in three public long-stay care units for elderly patients in Dublin had been educated in palliative care at the beginning of an Irish Hospice [Foundation] sponsored study.<sup>1</sup> Some 98% had expressed an interest in such training. The results arose from a project which aimed to identify current practice in end-of-life care, and to develop a programme to improve it. Of the sixty nurses [who responded to the survey], just 8% said they had a specific qualification in palliative care or palliative nursing, while 30% had attended study days in palliative care. Among healthcare assistants, 40% indicated they had attended in-service, study or lecture

days relating to palliative care, but 100% of those surveyed said they would be interested in pursuing such a planned education course. <http://www.irishtimes.com/newspaper/health/2012/04/17/1224314815269.html>

### Extract from *Irish Times* report

...the report found that of 37 residents who died in the year prior to the project taking place, just six had a documented chaplaincy referral in the 48 hours prior to their death. Among its recommendations, the report found that there "is a need to review the manner in which residents' spiritual care needs are addressed."

## Hospice New Zealand standards for palliative care...

NEW ZEALAND | Community Scoop – 12 April 2012 – Development of the Standards involved 18 months work and collaboration between Hospice New Zealand, Maori hospice and health workers, experts from palliative care, aged care, management and audit. There has been a conscious effort to capture the spirit of palliative care in the document with inclusion of the many faces of New Zealanders, and whakatoki (Maori sayings), gifted to Hospice New Zealand by Maori elders associated with Hospices across the country. <http://community.scoop.co.nz/2012/04/hospice-nz-standards-for-palliative-care-launch/>

From Media Watch, 22 March 2010:

- NEW ZEALAND | University of Waikato online posting – 15 March 2010 – **'Study looks at dying, death, bereavement among Māori.'** University of Waikato researchers are embarking on a three-year study of dying, death and bereavement among contemporary Māori. The Kia Ngawari study aims to increase knowledge and understanding of Māori palliative [care] needs, both within the healthcare system and among whānau [the extended family]. <http://www.waikato.ac.nz/news-events/media/2010/03Study%20looks%20at%20dying,%20death,%20bereavement%20among%20M%C4%81ori%20.shtml>

## Assisted (or facilitated) death

Representative sample of recent news media coverage:

- U.K. | BBC ('Heart & Soul') – 16 April 2012 – **'Choosing Life'** In the U.K., the campaign to legalise assisted dying so that an adult with a terminal illness could be helped to take their own life, is gathering momentum. In the country that pioneered holistic end-of-life care through the hospice movement, why have people lost their faith in the possibility of dying well without intervention? [http://www.bbc.co.uk/iplayer/episode/p00qdrpg/Heart\\_And\\_Soul\\_Choosing\\_Life\\_Episode\\_2/](http://www.bbc.co.uk/iplayer/episode/p00qdrpg/Heart_And_Soul_Choosing_Life_Episode_2/)

### [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>

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

### **Trends in services among pediatric hospice providers during 2002 to 2008**

*AMERICAN JOURNAL OF HOSPICE & PALLIATIVE MEDICINE* | Online article – 19 April 2012 – The medical complexities involved in caring for children at end of life have increased during the past few decades. This study sought to understand what hospice services were offered for these children and to examine service trends among pediatric hospice providers over a 7-year time-frame. The number of core hospice services diminished in 2003 and 2004; however, by 2008 there was an increase in offering core, non-core, and other hospice services among pediatric providers. <http://ajh.sagepub.com/content/early/2012/04/18/1049909112444001.abstract>

Of related interest:

- *MEDICAL INDEPENDENT* (Ireland) | Online report – 20 April 2012 – '**National budget must be ring fenced for children home nursing care.**' Having no national paediatric home nursing care budget in Ireland today is causing major challenges as funding is *ad hoc* and difficult to track while tremendous resources are being spent chasing up scarce resources. There are inconsistent practices between regions, hidden costs to the taxpayer and a greater burden on acute services, as well as greater stresses to parents who want their children at home, but need good support to do so... [http://www.medicalindependent.ie/page.aspx?title=national\\_budget\\_must\\_be\\_ringfenced\\_for\\_childr\\_en\\_home\\_nursing\\_care\\_\\_jack\\_and\\_jill](http://www.medicalindependent.ie/page.aspx?title=national_budget_must_be_ringfenced_for_childr_en_home_nursing_care__jack_and_jill)

### **Technology and end-of-life care**

#### **Telecare, remote monitoring and care**

*BIOETHICS* | Online article – 16 April 2012 – Telecare is often regarded as a win/win solution to the growing problem of meeting the care needs of an ageing population. In this paper the authors call attention to some of the ways in which telecare is not a win/win solution but rather aggravates many of the long-standing ethical tensions that surround the care of the elderly. It may reduce the call on carers' time and energy by automating some aspects of care, particularly daily monitoring. This can release carers for other caring activities. On the other hand, remote and impersonal monitoring seems to fall short of providing care. Monitoring may be used to help elderly users retain independence. But it may also increase the amount of information which flows from users to carers, which can result in a form of function-creep that actually undermines independence. <http://onlinelibrary.wiley.com/doi/10.1111/j.1467-8519.2012.01961.x/abstract>

From Media Watch, 2 January 2012:

- *JOURNAL OF TELEMEDICINE & TELE CARE* | Online article – 23 December 2011 – '**Organizational factors associated with the use of telehospice.**' The authors investigated organizational factors associated with the use of telehospice (defined as the use of video technology by hospices). <http://jtt.rsmjournals.com/content/early/2011/12/22/jtt.2011.110803.abstract>

#### **Pulmonary rehabilitation and palliative care in COPD: Two sides of the same coin?**

*CHRONIC RESPIRATORY DISEASE* | Online article – 12 April 2012 – Pulmonary rehabilitation and palliative care ... are remarkably similar in many respects. Both utilize a multidisciplinary team that focuses on the specific needs of the individual patient. Care in both is goal defined and includes relief of symptoms and improvements in functional status and quality of life. Pulmonary rehabilitation is commonly given in a specific setting, such as a hospital-based outpatient setting, while palliative care is often hospital based extending into the home setting in the form of hospice. Components of pulmonary rehabilitation and palliative care should be administered as part of good medical care. <http://crd.sagepub.com/content/early/2012/04/03/1479972312441379.abstract>

Cont.

Of related interest:

- *JOURNAL OF GENERAL INTERNAL MEDICINE* | Online article – 13 April 2012 – **'Palliative care and rehabilitation for stroke survivors: Managing symptoms and burden, maximizing function.'** The role of rehabilitation ... is critical for optimizing functional outcomes and symptomatic relief, particularly in more severe strokes. Like palliative care, rehabilitation services are best incorporated across the continuum of care, starting in the acute post-stroke period as soon as the patient is medically stable. <http://www.springerlink.com/content/k0j249h15qw24452/fulltext.pdf>

From Media Watch, 21 February 2011:

- *GERIATRIC REHABILITATION*, 2011;27(1):229-235. **'Geriatric rehabilitation and palliative care: Opportunity for collaboration or oxymoron?'** There has been much collaboration among clinicians in ... palliative care and several medical specialties, including physical medicine and rehabilitation ... [which focuses] ... on restoring function, coping with disability, and decreasing the illness burden of chronic disease. There is a natural compatibility between these two fields, which provide increasing opportunities for clinical interface in the comprehensive treatment of seriously ill patients. [http://journals.lww.com/topicsingeriatricrehabilitation/Abstract/2011/01000/Geriatric\\_Rehabilitation\\_and\\_Palliative\\_Care\\_.5.aspx](http://journals.lww.com/topicsingeriatricrehabilitation/Abstract/2011/01000/Geriatric_Rehabilitation_and_Palliative_Care_.5.aspx)

### **Are there several kinds of palliative care?**

*CURRENT OPINION IN ONCOLOGY* | Online editorial – 15 April 2012 – It seems that we are witnessing a new concept of psychosocial care for patients with advanced cancer and receiving palliative anticancer therapy. It is actually a new dimension added to the general supportive care to be necessarily provided to these patients; it should be introduced early during the course of the disease and, probably, it merges with terminal care, at some point. The importance of this early palliative care or psychosocial supportive care is likely to be essential for the well being and autonomy of many patients. Therefore, it is important that this activity be identified among the expertises required for a comprehensive supportive care and be implemented as a necessary part of optimal cancer care. [http://journals.lww.com/co-oncology/Citation/publishahead/Are\\_there\\_several\\_kinds\\_of\\_palliative\\_care\\_.99699.aspx](http://journals.lww.com/co-oncology/Citation/publishahead/Are_there_several_kinds_of_palliative_care_.99699.aspx)

### **Transitional care for older adults: The need for new approaches to support family caregivers**

*JOURNAL OF GERONTOLOGY & GERIATRIC RESEARCH* | Online article – Accessed 22 April 2012 – Improving the quality of transitional care that elders receive has the potential to limit adverse events and reduce avoidable hospital readmissions. Many factors contribute to the problems that older adults face when they move between care settings and levels. It is increasingly recognized that, one approach to improving transitional care is implementing interventions to support and train family members to be skilled and knowledgeable caregivers. In particular, it is known that interventions which involve building skills to solve problems are the most effective. The venue in which interventions are offered is also important. Technology-based approaches, such as web-based training and online messaging, are new venues to help caregivers get the right information and support at the right time and in the right place. These technologies have the potential to revolutionize the healthcare delivery system and provide new avenues for healthcare providers to interact with, teach, and support families in their critical roles as caregivers of older patients. <http://www.omicsgroup.org/journals/JGGR/JGGR-1-e107.pdf>

Of related interest:

- *NEURODEGENERATIVE DISEASE MANAGEMENT*, 2012;2(2):173-181. **'Supportive care to family caregivers is not supportive enough: Moving towards an equitable approach to dementia home care.'** <http://www.futuremedicine.com/doi/abs/10.2217/nmt.11.83>



## **Development of a content valid tool for assessing end-of-life communication in acute care settings**

*JOURNAL OF PALLIATIVE MEDICINE*, 2012;15(4):381-387. Literature review identified five domains: 1) seek information; 2) assess life values; 3) educate family; 4) extend care in a consistent manner; and, 5) respond to family questions and concerns. Within each domain, the expert panel identified sub-domains with related behavioral examples that were consistently rated as important to end-of-life care for emergency practitioners. The resulting assessment tool provides a list of skill domains with specific descriptors and clear behavioral examples that can be used as both a teaching and assessment tool. This represents an essential first step that will allow further validation of the assessment tool, ultimately producing a valid and reliable measure of physician skill in emergency medicine end-of-life care. <http://online.liebertpub.com/doi/abs/10.1089/jpm.2011.0427>

## **Availability of services in Ontario hospices and hospitals providing inpatient palliative care**

*JOURNAL OF PALLIATIVE MEDICINE* | Online article – 18 April 2012 – Most Canadians die in inpatient settings. The authors' aim was to determine the availability of medical services, programs, and care for common palliative procedures, in hospices, palliative care units (PCUs), and hospital medical wards (MWs) providing inpatient palliative care in Ontario, Canada. Of 128 surveys sent, 102 (80%) were completed and returned, from 58 MWs, 31 PCUs, and 13 hospices. MWs were the most common location of palliative care overall, particularly in rural areas. PCUs were most likely to provide care for common procedures (e.g., tracheostomy, nephrostomy); methadone for pain management; and palliative radiation. MWs were most likely to offer intravenous chemotherapy and antibiotics. Transfusions were available in most PCUs and MWs, but only in one hospice. Hospices were most likely to provide complementary therapies. Lack of financial support and human resources were the most frequent perceived barriers to providing quality palliative care. <http://online.liebertpub.com/doi/abs/10.1089/jpm.2011.0453>

### **Media Watch: Editorial Practice**

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

### **Distribution**

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2. Links often remain active, however, for only a limited period of time.
3. Access to a complete article, in some cases, may require a subscription or one-time charge.
4. If a link appears broken or inactive, try copying/pasting the URL into the address bar of your browser or, alternatively, Google the title of the article or report, and the name of the source.
5. Due to its relevance, an article may be listed but for which a link is not available; access, therefore, may only be possible directly from the source (e.g., publication) or through the services of a library.

### **Something Missed or Overlooked?**

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

## Palliative care in New Zealand

### **Staff perceptions of end-of-life care following implementation of the Liverpool Care Pathway for the dying patient in the acute care setting**

*JOURNAL OF PALLIATIVE MEDICINE* | Online article – 13 April 2012 – The authors report on the post-implementation findings of a mixed methodology study into staff perceptions of EOL [end-of-life] care following the pilot implementation of the LCP [Liverpool Care Pathway]<sup>1</sup> into two acute wards. Study results suggest that within acute settings staff perceive that the LCP improves EOL care overall, assists interdisciplinary communication around death and dying, and that is a useful tool to positively influence decision making and care delivery. Further research into aspects of staff communication, diagnosing dying, changing direction of care, and the physical environment is warranted. <http://online.liebertpub.com/doi/abs/10.1089/jpm.2011.0375>

From Media Watch, 25 October 2010:

- *BRITISH MEDICAL JOURNAL* | Online letter – 19 October 2010 – '**Good death for all remains distant goal.**' Ellershaw and colleagues again defend their Liverpool Care Pathway.<sup>1,2</sup> The pathway has obvious appeal, but it has proved controversial, and reports of misuse remain disturbingly frequent. Despite decades of research in the care of patients with cancer, the accurate prediction of dying ... remains difficult. <http://www.bmj.com/content/341/bmj.c5815.extract>
- 1. *BRITISH MEDICAL JOURNAL* | Online article – 16 September 2010 – '**Achieving a good death for all.**' <http://www.bmj.com/content/341/bmj.c4861.extract>

### **End-of-life quality-of-care measures for nursing homes: Place of death and hospice [in the U.S.]**

*JOURNAL OF PALLIATIVE MEDICINE* | Online article – 13 April 2012 – The Centers for Medicare & Medicaid Services (CMS) publishes a web-based quality report card for nursing homes. The quality measures (QMs) do not assess quality of end-of-life (EOL) care, which affects a large proportion of residents. This study developed prototype EOL QMs that can be calculated from data sources available for all nursing homes nationally. The study included approximately 1.5 million decedents residing in 16,000 nursing homes during 2003-2007, nationally. This study offers two QMs specialized to EOL care in nursing homes that can be calculated from data that are readily available and could be incorporated in the Nursing Home Compare (NHC) report card. <http://online.liebertpub.com/doi/abs/10.1089/jpm.2011.0345>

From Media Watch, 26 March 2012:

- *QUALITY IN AGEING & OLDER ADULTS*, 2012;13(1):60-70. '**Guidelines for nursing homes delivering end-of-life care to residents with dementia across the island of Ireland.**' Findings [of this study] showed that the end of life care delivered was deemed by most elderly spouses to be of high quality, with person centred, individual, kind, professional care highly valued. Areas of dissatisfaction noted included poor communication, lack of involvement in key decision making, and poor symptoms control. <http://www.emeraldinsight.com/journals.htm?articleid=17021848&show=abstract>

From Media Watch, 16 January 2012:

- *GERONTOLOGIST* | Online article – 9 January 2012 – '**Rural-urban differences in end-of-life nursing home care: Facility and environmental factors.**' Facilities in smaller towns and in isolated rural areas have significantly worse end-of-life quality for in-hospital death and hospice use. <http://gerontologist.oxfordjournals.org/content/early/2012/01/08/geront.gnr143.abstract>

Cont.

From Media Watch, 9 January 2012:

- **PALLIATIVE MEDICINE** | Online article – 4 January 2012 – **'The effect of policy on end-of-life care practice within nursing care homes: A systematic review.'** [The objective of this study was] to identify the impact of implementing end of life care policy with regard to the use of the Gold Standards Framework in Care Homes<sup>1</sup> programme, the Liverpool Care Pathway<sup>2</sup> ... and educational/training interventions to support the provision of end of life care within nursing care homes within the U.K. <http://pmj.sagepub.com/content/early/2012/01/03/0269216311432899.abstract>
  1. Gold Standards Framework in Care Homes: <http://www.goldstandardsframework.org.uk/GSFCareHomes>
  2. Liverpool Care Pathway: <http://www.liv.ac.uk/mcpil/liverpool-care-pathway/>

From Media Watch, 18 April 2011:

- **AGEING & SOCIETY**, 2011;31(4):529-544. **'A discourse of silence: Professional carers reasoning about death and dying in nursing homes.'** The [study's] findings show that the discourse had three characteristics: a) dying was silent and silenced; b) emotions were pushed into the background; and, c) attentiveness to death arose after the moment of the elderly person's death. <http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=8235355&fulltextType=RA&fileId=S0144686X10000905>

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#### 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')

#### **Asia**

SINGAPORE | Centre for Biomedical Ethics (CENTRES): <http://centres.sg/> (Scroll down to 'What's New: Reading List Update')

#### **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.ipcr.net/archive-global-palliative-care-news.php>

## **Palliative care in gynaecological oncology**

*OBSTETRICS, GYNAECOLOGY & REPRODUCTIVE MEDICINE*, 2012;22(5):123-128. Gynaecological malignancy accounts for significant patient morbidity and mortality. Clinical aims focus upon palliative management and supportive care when potentially curative treatment options are exhausted. Patients with recurrent, advancing or terminal disease may suffer severe and distressing physical and psychological effects associated with both cancer diagnosis and treatments. It is of paramount importance that patients, families and carers are provided with the assistance they need to have as high a quality of life as possible. This review focuses upon the provision of relief from pain and other distressing symptoms commonly associated with gynaecological malignancy. <http://www.sciencedirect.com/science/article/pii/S175172141200036X>

## **Assisted (or facilitated) death**

Representative sample of recent articles, etc:

- *AMERICAN MEDICAL NEWS* | Online report – 17 April 2012 – '**5 Hawaii doctors offer assisted suicide to terminally ill patients.**' A group of Hawaii physicians is offering to write lethal prescriptions for terminally ill patients in a bid to test whether doctor-assisted suicide is allowed under state law. Unlike Oregon and Washington, the only two states where writing such a prescription is explicitly allowed and regulated, Hawaii has no law authorizing physician-assisted suicide. Moreover, Hawaii Attorney General David M. Louie issued an opinion in December 2011 saying that manslaughter charges could be brought against physicians who write prescriptions with the intention of causing death. <http://www.ama-assn.org/amednews/2012/04/16/prsd0417.htm>

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