

Media Watch...

is intended as an advocacy tool and change document. The weekly report is international in scope and distribution – to 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 inform discussion and encourage further inquiry.

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Compiled & Annotated by Barry R. Ashpole

Psychosocial aspects of end-of-life care: Scroll down to [Specialist Publications](#) and 'Why is spiritual care infrequent at the end of life? Spiritual care perceptions among patients, nurses, and physicians and the role of training' (p.7), in *Journal of Clinical Oncology*.

Canada

Statistics Canada

Home care for seniors falls largely on friends, family

CBC NEWS | Online report – 19 December 2012 – More than half of Canadians aged 65 and older who received home care in 2009 said they relied on family, friends and neighbours for the support.¹ <http://www.cbc.ca/news/health/story/2012/12/19/home-care-seniors.html>

1. 'Seniors' use of and unmet needs for home care, 2009,' Statistics Canada, December 2012. <http://www.statcan.gc.ca/pub/82-003-x/2012004/article/11760-eng.pdf>

Rasouli case may make doctors reluctant to start life support in "borderline" cases

BRITISH COLUMBIA | *Vancouver Sun* – 17 December 2012 – If doctors do not have the right to take patients off life support they feel has become useless or harmful, they may never try to revive some patients in the first place, well-known critical care doctors warn. The Supreme Court of Canada deliberates whether doctors alone can decide when to halt life prolonging treatments. The case is seen as crucial in conflicts of end-of-life care, because modern medicine now allows us to keep people biologically alive indefinitely, even when someone is "trying to die in front of you," experts say. Some intensive care doctors say that if the country's top court rules against them, it could make doctors more reluctant to begin aggressive life

support in cases where there is little hope of recovery – especially if they could be forced to continue indefinitely once it starts.

<http://www.vancouversun.com/news/national/Rasouli+case+make+doctors+reluctant+start+life+support/7711197/story.html>

[Specialist Publications](#)

Of related interest:

'Making "ethical safe space" in the translation of contested knowledge: The role of community debate in defining end-of-life decision ethics' (p.6), in *Palliative & Supportive Care*.

U.S.A.

Help for when grief gets 'complicated'

MASSACHUSETTS | WBUR News (Boston) – 21 December 2012 – Even after all the funerals in Newtown are over, the mourning will long go on. If experience is any guide, the heartbreak there will slowly heal with time. But for some who lost loved ones, the pain of bereavement may remain intense and constant, even years afterward. Psychiatry calls this 'complicated grief.' 'Complicated' meaning not complex but that the healing process that normally occurs, after even a sudden and terrible loss, goes somehow awry. It develops a complication, like an infection in a wound. Complicated grief is under consideration to become a new official diagnosis, and psychiatrists have developed specific therapy to help patients who become "stuck" for years in their grief.

<http://commonhealth.wbur.org/2012/12/complicated-grief-help>

End-of-life care and the economy

Louisiana hospice cuts worse than previously announced

LOUISIANA | WAFB News (Baton Rouge) – 20 December 2012 – Louisiana's health department is acknowledging that planned cuts in the state's Medicaid program will eliminate hospice care for all Medicaid recipients beginning in February. Hospice care aims to make dying people more comfortable in their final months of life. In announcing reductions to hospice care funding last week, officials with Governor Bobby Jindal's administration said hospice care at nursing homes would not be eliminated. Kathleen Meyers, a spokeswoman for the state health agency, confirmed there will be no reimbursement for hospice services beginning 1 February.

<http://www.wafb.com/story/20398600/la-hospice-cuts-worse-than-previously-announced>

First facility of this kind

Unveiled: Palliative care center

NEW YORK | *The Architects Newspaper* – 18 December 2012 – Known as the National Center for Palliative Care Innovation, the project will be an assisted-living community for both low-income and market-rate tenants. Palliative care focuses on relieving terminally ill patients' suffering with a holistic approach that includes psychological, physical, and multi-faith spiritual approaches. Commissioned by The HealthCare Chaplaincy ... the building will be the first facility of this kind in New York City. The design team also worked to blur the line between indoor and outdoor space by incorporating green roofs into the project as well as a semi-public passageway that cuts through the lower floors of the building. In addition to accommodating 120 assisted-living units, the project will include a geriatric and palliative care outpatient medical practice, as well as educational, research, and administrative spaces. <http://www.archpaper.com/news/articles.asp?id=6411>

Medicare to cover more home care

THE WALL STREET JOURNAL | Online report – 16 December 2012 – For years, Medicare recipients with chronic conditions have had difficulty qualifying for home health services administered by nurses and therapists. Now, a legal settlement between consumer advocates and the federal government has paved the way for patients with chronic conditions to receive such services both at home and in skilled-nursing and outpatient facilities. The settlement, which covers those enrolled in both original fee-for-service Medicare and private Medicare Advantage plans, requires Medicare to end a long-standing practice of denying coverage for skilled-nursing services and physical, speech and occupational therapy to patients whose conditions are unlikely to improve. "You can no longer be denied simply because you aren't going to improve," says Judith Stein, founder of the non-profit Center for Medicare Advocacy, which represented the plaintiffs. <http://online.wsj.com/article/SB10001424127887323339704578171511894763322.html>

Cont.

Of related interest:

- FAMILY CAREGIVER ALLIANCE | Online report – Accessed 21 December 2012 – **'Family Care-giving & Transitional Care: A Critical Review.'** This review and critical synthesis demonstrates that promising approaches and tools exist to make family caregivers integral partners with professionals during transitions between health care and community settings. However, it finds that engaging family caregivers deserves higher priority in most transitional care programs. It makes a case for greater coordination between medical services and long-term services and supports in transitional care. It concludes with recommendations for research, quality measurement, and public policy to more meaningfully engage family caregivers as partners in transitions across settings. http://caregiver.org/caregiver/jsp/content/pdfs/FamCGing_TransCare_CritRvw_FINAL10.31.2012.pdf
- FAMILY CAREGIVER ALLIANCE | Online report – Accessed 21 December 2012 – **'Selected Caregiver Assessment Measures: A Resource Inventory for Practitioners.'** Given the current interest in caregiver assessment across health and social service settings, it seemed fitting to update the caregiver assessment measures for the next generation of deployment in the field. As health care continues to move into home setting, it is important to assess not only the knowledge, skills and capacity of the caregiver to provide care but also to address caregiver well-being and health in order to prevent more serious health problems for families in the long-term. http://caregiver.org/caregiver/jsp/content/pdfs/SelCGAssmtMeas_ResInv_FINAL_12.10.12.pdf

International

[Legislative] Speaker puts focus on hospice care

TAIWAN | *Taipei Times* – 22 December 2012 – Legislative Speaker Wang Jinpyng signed a letter of intent to choose hospice palliative care to raise public awareness about hospices, after the legislature significantly relaxed the threshold needed to suspend treatment for terminal illnesses. Under the approved amendment to the Hospice Palliative Care Act, a decision not to perform cardiopulmonary resuscitation on a terminally ill patient or not to provide life-sustaining treatment to such a patient can be made when two doctors confirm a terminal diagnosis and when the individual has signed a letter of intent. Such a letter may be replaced by a statement of consent given by the patient's nearest family member when the individual is unconscious and is not able to provide informed consent, while consent from a parent or a legal guardian is required in case of children or adolescent patients, the amendment stipulated. In the case of a patient whose letter of intent is not available, who cannot clearly express his or her wishes and who has no relatives, a hospital's hospice medical team can make a decision in the best interests of the patient, it stated. At any rate, any decision made by other people to terminate medical care for a terminally ill patient may not go against the wishes expressed by the patient before he or she became unconscious, the law said. <http://www.taipeitimes.com/News/taiwan/archives/2012/12/22/2003550737>

Court blocks judicial review over 'do not resuscitate' orders

U.K. | *The Guardian* – 21 December 2012 – A family's attempt to force the government to adopt a policy requiring hospitals to consult patients and relatives before making "do not resuscitate" orders has been blocked by a high court judge. Mrs. Justice Nicola Davies said a judicial review ... on the legal issues in the case of 63-year-old Janet Tracey, who had a DNR notice put on her file without her knowledge, would be neither "appropriate nor proportionate." Tracey was admitted to hospital with a broken neck following a car accident two weeks after she had been diagnosed with terminal lung cancer. Eight days later, after she was transferred to Addenbrooke's Hospital in Cambridge, a DNR notice was put on her medical record without either Tracey or her family being consulted. When the family objected, it was removed. A second DNR notice went on the file three days later, after talks with the family, but not with the patient, who they felt too ill to discuss it. <http://www.guardian.co.uk/society/2012/dec/21/court-blocks-judicial-review-dnr>

Cont.

Noted in Media Watch, 12 November 2012:

- U.K. | ITV News – 5 November 2012 – **'Resuscitation case begins: Case to examine 'do not resuscitate' policies.'** <http://www.itv.com/news/story/2012-11-05/janet-tracey-resuscitation/>

Hospice care 'threatened by NHS reforms'

U.K. | *The Daily Telegraph* – 19 December 2012 – Hospices should be allowed to get on with caring for dying patients with kindness and compassion but face being obstructed by a new layer of burdensome regulation... Jeremy Hunt, the Health Secretary, is facing calls to ease the imposition of new rules under NHS [National Health Service] reforms and is expected to meet Lord Howard of Lympne, former Tory leader, to be told about the concerns. It is feared that hospices, which are already governed by hundreds of different rules, will be saddled with even more red tape under the shake-up. Dr. Ros Taylor, chief executive of St Francis Hospice in Hertfordshire, told BBC Radio 4's Today programme: "My concern is that hospice care is based on close engagement

with patients. "The more our nurses, doctors and social workers have to spend filling in forms and phoning and faxing, that is less time with patients. We perhaps need a ministry of common sense to look at that."

<http://www.telegraph.co.uk/health/healthnews/9754840/Hospice-care-threatened-by-NHS-reforms.html>

Extract from *The Daily Telegraph* report

Dr. Taylor said that 16 years ago when she started at the hospice there were three policies governing its running, which had now increased to 233.

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- BELGIUM | Agence France-Press – 18 December 2012 – **'Belgium looks at euthanasia for minors, Alzheimer's sufferers.'** Belgium is considering a significant change to its decade-old euthanasia law that would allow minors and Alzheimer's sufferers to seek permission to die. The proposed changes to the law were submitted to parliament by the Socialist party and are likely to be approved by other parties, although no date has yet been put forward for a parliamentary debate. The draft legislation calls for "the law to be extended to minors if they are capable of discernment or affected by an incurable illness or suffering that we cannot alleviate." Belgium was the second country in the world after The Netherlands to legalise euthanasia in 2002 but it applies only to people over the age of 18. <http://www.france24.com/en/20121218-belgium-looks-euthanasia-minors-alzheimers-sufferers>
- FRANCE | Radio France Internationale – 18 December 2012 – **'No to euthanasia in France, says report.'** A report commissioned by president François Hollande ... will recommend that euthanasia remain illegal in France, while leaving the door open to assisted suicide. Professor Didier Sicard concludes after his study of the issue, that assisted suicide could be considered in certain cases of progressive incurable illnesses. Under current French legislation, enshrined in the 2005 so-called Leonetti Law, it is illegal to give patients medication which will kill them, but legal to administer pain relief, which might have the side effect of shortening life. <http://www.english.rfi.fr/europe/20121218-no-euthanasia-france-says-new-report>
- AUSTRALIA | *Western Australia Today* – 17 December – **'Resounding 'yes' for terminally ill.'** More than 80% of Australians support voluntary euthanasia for terminally ill patients, and almost a quarter say they would change their parliamentary vote if their preferred candidate opposed euthanasia reform. <http://www.watoday.com.au/national/resounding-yes-for-terminally-ill-20121216-2bhm6.html>

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

A cross-sectional survey of the activity of palliative care teams in Portugal

AMERICAN JOURNAL OF HOSPICE & PALLIATIVE MEDICINE | Published online – 21 December 2012 – Of the 21 teams identified, 10 accepted to participate in the study. A total of 164 patients were included with a median of 15.5 per team: 60 (37%) were identified as inpatients in palliative care units; 59 (36%) by an intra-hospital support team; 26 (16%) as outpatients; and 19 (12%) at home. The median age was 71 years (16-95). Fifty-one percent were females. The diagnosis was cancer in 151 (92%) patients. The most common cancer was colorectal in 22 (15%) patients, followed by gastric 17 (11%), head and neck 17 (11%), breast 15 (10%), and lung cancers 14 (9%). All patients were treated by doctors and nurses experienced in palliative care.
<http://ajh.sagepub.com/content/early/2012/12/20/1049909112469718.abstract>

Noted in Media Watch, 18 April 2011:

- *THE PORTUGAL NEWS* | Online report – 16 April 2011 – '**Portugal makes progress in palliative care.**' <http://www.theportugalnews.com/cgi-bin/article.pl?id=1108-14>

Noted in Media Watch, 20 December 2010:

- *THE PORTUGAL NEWS* | Online report – 18 December 2010 – '**New dawn, new choices for palliative care patients.**' <http://www.theportugalnews.com/cgi-bin/article.pl?id=1092-5>

N.B. Portugal was rated 31st (of the 40 countries surveyed) in *The Quality of Death: Ranking End-of-life-Care Across the World*, commissioned by the Lien Foundation, Singapore, published by the Economist Intelligence Unit, July 2010. http://graphics.eiu.com/upload/QOD_main_final_edition_Jul12_toprint.pdf

Many pain clinics fail to offer multidisciplinary care, says audit

BRITISH MEDICAL JOURNAL | Online report – 18 December 2012 – Many pain clinics in England & Wales fall well below the minimum requirements for an effective multidisciplinary pain service, the first national pain audit has concluded.¹ The audit was commissioned ... in response to the chief medical officer for England's report *Pain: Breaking through the Barrier*. The audit found high variation in patients' access to multidisciplinary care – considered to be the essential requirement for specialist chronic pain services. <http://www.bmj.com/content/345/bmj.e8577>

1. National Pain Audit, Final Report 2010-12, Health Quality Improvement Partnership, December 2012. <http://www.hqip.org.uk/assets/NCAPOP-Library/NCAPOP-2012-13/Pain-National-Audit-Report-pub-2012.pdf>

Of related interest:

- *PAIN PRACTICE* | Published online – 14 December 2012 – '**Palliative medicine update: A multidisciplinary approach.**' Considering the complexity of care for incurable patients, a multidisciplinary approach is a prerequisite to balance curative and palliative intervention options. <http://onlinelibrary.wiley.com/doi/10.1111/papr.12025/abstract;jsessionid=09DEAD8CB59618C1F673B7997C9BB39D.d02t04?deniedAccessCustomisedMessage=&userIsAuthenticated=false>

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>

End-of-life care in the treatment of advanced heart failure in the elderly

CARDIOLOGY IN REVIEW, 2013;21(1):9-15. Heart failure presents its own unique challenges to the clinician who desires to make excellent and humane care near the end of life a tangible reality. Accurate prediction of mortality in the individual patient is complicated by both the frequent occurrence of sudden death, both with and without devices, and the frequently chronic course that is punctuated by recurrent and more prominent acute episodes. A significant literature demonstrates that healthcare providers continue to have difficulty communicating effectively with terminally ill patients and their caregivers regarding end-of-life care preferences, and it is clear from the prognostic uncertainty of advanced heart failure that this kind of communication, and discussions regarding palliative care, need to occur earlier rather than later. This article discusses various means of providing palliative care, and specific issues regarding device therapy, cardiopulmonary resuscitation, and palliative sedation, with concurrent discussion of the ethical ramifications and pitfalls of each. Above all, clinicians ... need to confront the existential reality of death in themselves, their loved ones, and their patients so as to best serve those remanded to their care. http://journals.lww.com/cardiologyinreview/Abstract/2013/01000/End_of_Life_Care_in_the_Treatment_of_Advanced.2.aspx

Noted in Media Watch, 1 October 2012:

- *EUROPEAN JOURNAL OF AGEING* | Published online – 22 September 2012 – **"Who is going to explain it to me so that I understand?" Health care needs and experiences of older patients with advanced heart failure.** <http://www.springerlink.com/content/4001j18092105526/>
- *JOURNAL OF PAIN & SYMPTOM MANAGEMENT* | Published online – 26 September 2012 – **"Understanding palliative care on the heart failure care team: An innovative research methodology."** [http://www.jpmsjournal.com/article/S0885-3924\(12\)00354-5/abstract](http://www.jpmsjournal.com/article/S0885-3924(12)00354-5/abstract)

Elements of an engaged clinical ethics: A qualitative analysis of hospice clinical ethics committee discussions

CLINICAL ETHICS, 2012;7(4):175-182. Social, legal and health-care changes have created an increasing need for ethical review within end-of-life care. Multiprofessional clinical ethics committees (CECs) are increasingly supporting decision-making in hospitals and hospices. This paper reports findings from an analysis of formal summaries from CEC meetings, of one UK hospice, spanning four years. Using qualitative content analysis, five themes were identified: timeliness of decision-making, holistic care, contextual openness, values diversity and consensual understanding. The elements of an engaged clinical ethics in a hospice context is not generally acknowledged nor its elements articulated. Findings from this study have the potential to explain some of the most challenging ethical problems and to contribute to their resolution. It may also guide future deliberation and raise CEC members' awareness of the recurrent issues and values of their CEC practice. <http://ce.rsmjournals.com/content/7/4/175.abstract>

Of related interest:

- *PALLIATIVE & SUPPORTIVE CARE* | Published online – 23 December 2012 – **"Making "ethical safe space" in the translation of contested knowledge: The role of community debate in defining end-of-life decision ethics."** Contested policy and ethical frameworks for making decisions about withdrawing and withholding life supporting treatment may influence both the perspectives of palliative care providers and patients referred to palliative care facilities. An innovative model for knowledge translation using a public forum that enabled stakeholders with conflicting perspectives to engage with ethical and professional policy issues asserting the physician's authority in contested decisions involving withdrawing or withholding life-supporting treatment, was a successful way to engage stakeholders supporting alternative positions on the impact of the policy statement and to discuss ethical, legal, and disability rights issues identified in the public debate. <http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=8793385&fulltextType=RA&fileId=S1478951512000806>

Anger: A common form of psychological distress among patients at the end of life

INTERNATIONAL JOURNAL OF PALLIATIVE NURSING, 2012;18(12):592-596. Although a certain level of psychological distress such as anger is expected in terminally ill patients owing to their situation, such responses may also be dysfunctional. This paper aims to highlight the challenges and complexities of adequately assessing and supporting palliative care patients who are presenting with psychological distress in the form of anger, in order to relieve their suffering and assist them in resolving their issues and improving their quality of life. Anger can be difficult to treat, and for some patients can be more distressing than some physical symptoms. Hence this paper also aims to offer anger management guidance to palliative care practitioners.

http://www.ijpn.co.uk/cgi-bin/go.pl/library/article.html?uid=95986;article=IJPN_18_12_592_596

Why is spiritual care infrequent at the end of life? Spiritual care perceptions among patients, nurses, and physicians and the role of training

JOURNAL OF CLINICAL ONCOLOGY | Published online – 17 December 2012 – Most patients with advanced cancer [i.e., study participants] had never received any form of spiritual care [SC] from their oncology nurses or physicians. Majorities of patients indicated that SC is an important component of cancer care from nurses and physicians. Most nurses and physicians thought that SC should at least occasionally be provided. Most nurses and physicians had not received SC training. <http://jco.ascopubs.org/content/early/2012/12/13/JCO.2012.44.6443.abstract>

Of related interest:

- *JOURNAL OF PASTORAL CARE & COUNSELLING*, 2012;66(4): 'Spiritual/cultural competency: Methods in diversity education.' This article describes group educational methods with case examples that foster spiritual/cultural competency, each member a person in context with the opportunity to be distinct and connected, a threshold for all other dimensions of diversity learning in pastoral practice. <http://journals.sfu.ca/jpcp/index.php/jpcp/article/view/642>

Noted in Media Watch, 19 November 2012:

- *NURSING OUTLOOK*, 2012;60(6):370-375. 'Psychosocial, cultural, and spiritual health disparities in end-of-life and palliative care: Where we are and where we need to go?' [http://www.nursingoutlook.org/article/S0029-6554\(12\)00237-0/abstract](http://www.nursingoutlook.org/article/S0029-6554(12)00237-0/abstract)

Noted in Media Watch, 29 October 2012:

- *JOURNAL OF NURSING MANAGEMENT* | Published online – 20 October 2012 – 'A health services framework of spiritual care.' <http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2834.2012.01482.x/abstract?deniedAccessCustomisedMessage=&userIsAuthenticated=false>

Noted in Media Watch, 24 September 2012:

- CANADA (MANITOBA) | *Metro Winnipeg* – 20 September 2012 – 'Manitoba takes 'step forward' with spiritual health-care strategic plan.' <http://metronews.ca/news/winnipeg/376929/manitoba-takes-step-forward-with-spiritual-health-care-strategic-plan/>



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>

U.S. Department of Veterans Affairs

Providing support through life's final chapter for those who made it home

MILITARY MEDICINE, 2012;177(12):1498-1501. Military personnel are exposed to unique environmental hazards and psychological stressors during their service to our nation. As a result, military service personnel are at high risk not only for physical injury but for psychological trauma as well that may result in post-traumatic stress disorder, depression, substance abuse, and homelessness. These medical and psychosocial issues may hasten the development of life-limiting illnesses and may complicate the delivery of end-of-life care. Community-based hospice agencies often lack the resources and expertise to address the special needs of veterans.

<http://www.ingentaconnect.com/content/amsus/zmm/2012/00000177/00000012/art00023>

Noted in Media Watch, 20 August 2012:

- *POLITICAL & MILITARY SOCIOLOGY* | Published online – Accessed 15 August 2012 – **'Spillovers of veteran's hospice care: The economic and social impact of palliative care.'** http://works.bepress.com/bruce_mcdonald/9/

Noted in Media Watch, 27 February 2012:

- U.S. (NORTH CAROLINA) | *News Observer* (Durham) – 19 February 2012 – **'At hospice, military vets help other fighters face end of life.'** <http://www.newsobserver.com/2012/02/19/1867475/at-hospice-military-vets-help.html>

Noted in Media Watch, 3 January 2011:

- U.S. (CALIFORNIA) | *Los Angeles Times* – 28 December 2010 – **'Helping the brave fight their final battle.'** <http://www.latimes.com/health/sc-fam-1228-senior-health-veteran-20101228,0,7667701.story>

Media Watch: Editorial Practice

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

Distribution

Media Watch is distributed at no cost to colleagues active or with a special interest in hospice, palliative care and end of life issues. Recipients are encouraged to share the weekly report with *their* colleagues. The distribution list is a proprietary one, used exclusively for the distribution of the weekly report and occasional supplements. It is not used or made available for any other purpose whatsoever – to protect the privacy of recipients and also to avoid generating undue e-mail traffic.

Links to Sources

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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.

National Health Service to implement Chief Nursing Officer vision of compassionate care

NURSING IN PRACTICE | Online report – 18 December 2012 – The NHS [National Health Service] will drive forward a culture of compassionate care as set out by the NHS Commissioning Board's [CB] chief nursing officer. According to *Everybody counts: Planning for patients 2013/14*,¹ the NHS CB has pledged to play its part in encouraging safe and dignified care "that does not fall below acceptable standards." <http://www.nursinginpractice.com/article/nhs-implement-cno-vision-compassionate-care>

1. *Everybody counts: Planning for patients 2013/14*, National Health Service Commissioning Board, December 2012. <http://www.commissioningboard.nhs.uk/everyonecounts/>

Noted in Media Watch, 10 December 2012:

- U.K. (ENGLAND) | BBC News – 4 December 2012 – **'Nurses in drive for 'compassionate care.'** <http://www.bbc.co.uk/news/health-20583115>

Palliative care pushing into outpatient settings

ONCOLOGY TIMES, 2012;34(24):24-27. The non-profit Center to Advance Palliative Care has launched a new initiative to improve palliative care in cancer care clinics and other outpatient settings. Improving Palliative Care-Outpatient [IPAL-OP] brings together tools, including needs assessment worksheets, case studies, and a "getting started" guide, to help integrate palliative care into medical clinics and home care settings. The project is designed to help oncologists meet the new standards of care that have emerged this year. The provision of palliative care services either on-site or by referral was added to the Commission on Cancer's new Cancer Program Standards, which went into effect in January 2012. http://journals.lww.com/oncology-times/Fulltext/2012/12250/Palliative_Care_Pushing_into_Outpatient_Settings.6.aspx

N.B. See Media Watch, 16 July 2012 (p.6), for a listing of articles noted in past issues of the weekly report on palliative care in the emergency department.

Of related interest:

- *NATURE REVIEWS CLINICAL ONCOLOGY* | Published online – 18 December 2012 – **'Palliative care reduces morbidity and mortality in cancer.'** A growing body of evidence supports the integration of palliative care into routine cancer care ... in inpatient, outpatient, and home-based settings. <http://www.nature.com/nrclinonc/journal/vaop/ncurrent/abs/nrclinonc.2012.211.html>
- *ONCOLOGY TIMES*, 2013;35(1):5-6). **'How oncologists are bending the cancer cost curve.'** A pilot study has found oncology practices that use cancer care pathways, proactive nurse-initiated support calls throughout a patient's course of treatment, and end-of-life planning can significantly reduce the need for emergency department and inpatient care. http://journals.lww.com/oncology-times/Fulltext/2013/01100/How_Oncologists_Are_Bending_the_Cancer_Cost_Curve.2.aspx

Characteristics of hospice patients utilizing hospice inpatient/residential facilities

AMERICAN JOURNAL OF HOSPICE & PALLIATIVE MEDICINE | Published online – 21 December 2012 – Given the increasing popularity of a hospice inpatient/residential facility (HIRF) among hospice patients and their family members, examining who uses HIRFs has been of increasing importance. Using the 2007 National Home & Hospice Care Survey, the authors found that about 14% of the hospice patients received care in an HIRF in 2007. Characteristics of patients associated with HIRF use largely match the industry norm for a general inpatient level of care and include having no caregiver or having an incapable caregiver; having imminent death; and being directly admitted to a hospice after discharge from a hospital. Given a recent stricter enforcement of reimbursement rules, however, the authors call for close monitoring of any change in the number of HIRF beds – particularly in rural and low-income urban areas. <http://ajh.sagepub.com/content/early/2012/12/20/1049909112469717.abstract>

Coping with parental death as seen from the perspective of children who attended a grief camp

QUALITATIVE SOCIAL WORK | Published online – 11 December 2012 – In this qualitative case study, researchers interviewed parentally bereaved children and their surviving parents in order to conceptualize the emotional impact of losing a parent to death and to understand the possible influence of one bereavement program's attempt to address these issues. Themes presented ... are discussed in terms of the emotional impact of the death and the influence of the program on each issue: sadness, anger, being set apart, worries, trauma, and contemplation of suicide. <http://qsw.sagepub.com/content/early/2012/11/27/1473325012465104.abstract>

International palliative care experts' view on phenomena indicating the last hours and days of life

SUPPORTIVE CARE IN CANCER | Published online – 15 December 2012 – The phenomena associated with approaching death were generated using Delphi technique. The Delphi process was set up in three cycles to collate a set of useful and relevant phenomena that identify and predict the last hours and days of life. The first Delphi cycle of 252 participants (health care professionals, volunteers, public) generated 194 different phenomena, perceptions and observations. In the second cycle, these phenomena were checked for their specific ability to diagnose the last hours/days of life. Fifty-eight phenomena achieved more than 80% expert consensus and were grouped into nine categories. In the third cycle, these 58 phenomena were ranked by a group of palliative care experts in terms of clinical relevance to the prediction that a person will die within the next few hours/days. Twenty-one phenomena were determined to have "high relevance" by more than 50% of the experts. Based on these findings, the changes in the following categories (each consisting of up to three phenomena) were considered highly relevant to clinicians in identifying and predicting a patient's last hours/days of life: "breathing," "general deterioration," "consciousness/cognition," "skin," "intake of fluid, food, others," "emotional state" and "non-observations/expressed opinions/other." <http://link.springer.com/article/10.1007/s00520-012-1677-3/fulltext.html>

Of related interest:

- *JOURNAL OF HOSPITAL MEDICINE* | Published online – 19 December 2012 – '**Mortality predictions on admission as a context for organizing care activities.**' The probability of 30-day mortality provides health systems with an array of prognostic information that may provide a common reference point for organizing the clinical activities of the many health professionals involved in the care of the patient. <http://onlinelibrary.wiley.com/doi/10.1002/jhm.1998/abstract>

End-of-life care in Germany

Care of critically ill and dying people of advanced old age in nursing homes

ZEITSCHRIFT FÜR PALLIATIVMEDIZIN, 2012;13(6):284-292. The German Association for Palliative Medicine and the German Hospice & Palliative Association have convened a joint working group to support the implementation of palliative care. The working group has worked out this policy paper on the care of seriously ill and dying people of advanced age in nursing homes. The purposes of this paper are closely related with the further implementation process of the 'Charter for the care of the critically ill and the dying people in Germany.' The policy paper describes the current stage of provision of palliative care in nursing homes, the objectives for the integration of hospice culture and palliative care provision, as well as the measures needed to achieve these aims. Hospice culture and palliative nursing should become integral parts of the care program in every facility. <http://cat.inist.fr/?aModele=afficheN&cpsidt=26563303>

Cont.

N.B. This article is published in German. Germany was rated 8th (of the 40 countries surveyed) in *The Quality of Death: Ranking End-of-life-Care Across the World*, commissioned by the Lien Foundation, Singapore, published by the Economist Intelligence Unit, July 2010.
http://graphics.eiu.com/upload/QOD_main_final_edition_Jul12_toprint.pdf

Noted in Media Watch, 8 October 2012:

- *PUBLIC HEALTH* | Published online – 2 October 2012 – '**Population, mortality and place of death in Germany (1950–2050) – Implications for end-of-life care in the future.**'
<http://www.sciencedirect.com/science/article/pii/S003335061200234X>

Noted in Media Watch, 6 February 2012:

- *BUNDESGESUNDHEITSBLATT - GESUNDHEITSFORSCHUNG - GESUNDHEITSSCHUTZ*, 2012;55(2):231-237. '**Palliative care in the light of legal and regulatory requirements in Germany.**' <http://www.springerlink.com/content/3457017t5130nt1p/>

Assisted (or facilitated) death

Representative sample of recent articles, etc:

- *DEATH STUDIES*, 2013;37(1):89-98. '**Validation of the Chinese Expanded Euthanasia Attitude Scale.**' A 4-stage validation process included a pilot survey of 119 college students and a randomized household survey with 618 adults in Hong Kong. Confirmatory factor analysis confirmed a 4-factor structure of the scale, which can therefore be used to examine attitudes toward general, active, passive, and non-voluntary euthanasia. The scale considers the role effect in decision-making about euthanasia requests and facilitates cross-cultural comparison of attitudes toward euthanasia. The new Chinese scale is more robust than its Western predecessors conceptually and measurement-wise. <http://www.tandfonline.com/doi/abs/10.1080/07481187.2011.623214>
- *FRONTIÈRES*, 2012;24(1-2):36-44. '**L'euthanasie et l'aide au suicide: Enquête sur la position des travailleurs sociaux du Québec.**' This article presents a synthesis of a survey conducted online to learn about the perspective of social workers from Quebec regarding voluntary euthanasia (VE) and assisted suicide (AS). The results corroborate listed studies where social workers reports being in favor of both practices. The respondents, however, expressed a higher consideration for VE than for AS. They insist that appropriate care must be accessible to people in the first place. So if the VE or AS would be allowed by the law, the respondents wishes that criteria's would be put in place to set boundaries around those practices. The difficulties social workers encounter in their practice concerning the requests of VE or AS can be summarized by the difficulty to intervene in certain contexts of suffering and end of life. <http://www.erudit.org/revue/fr/2012/v24/n1-2/1013083ar.html?vue=resume&mode=restriction>

N.B. French language article.

- *JOURNAL OF MEDICAL ETHICS* | Published online – 22 December 2012 – '**A plea for end-of-life discussions with patients suffering from Huntington's disease [HD]: the role of the physician.**' From a qualitative study based on interviews with 15 physicians experienced in treating HD, several ethical issues emerged. Consideration of these aspects leads to a discussion about the professional role of a physician in relation to the personal autonomy of a patient. Such a discussion can raise awareness that talking about end-of-life wishes with an HD patient is part of the legal, professional and moral responsibility of the physician, and that a letter of intent on behalf of the physician can improve active participation in the process. Discussion of these issues can help to advance the debate on euthanasia and PAS in HD and other neurodegenerative diseases. <http://jme.bmj.com/content/early/2012/12/21/medethics-2011-100369.abstract>
- *SOCIOLOGY OF HEALTH & ILLNESS* | Published online – 20 December 2012 – '**The 'window of opportunity' for death after severe brain injury: Family experiences.**' The authors show how the medico-legal 'window of opportunity' for allowing the patient to die structures family experience and fails to deliver optimal outcomes for patients. They end with some suggestions for change. <http://onlinelibrary.wiley.com/doi/10.1111/1467-9566.12020/abstract>

Worth Repeating

Creating a place for dying: Gerontopia

JOURNAL OF HOUSING FOR THE ELDERLY, 2009;23(1-2):66-91. The place chosen by palliative care patients for dying is typically examined according to functional aspects of practical equipment and housing modification. The author reports on how the environment negatively impairs or positively enables and empowers patients through individual meaning, control/preference, and sensory perception. Of application for designers, health care providers, and families, this study of caregivers provides specific attributes and examples of place making for palliative care environments. <http://www.tandfonline.com/doi/full/10.1080/02763890802664646>

N.B. This article appears in a special issue of the *Journal of Housing for the Elderly* on palliative care. Contents page: <http://www.tandfonline.com/toc/wjhe20/23/1-2>

Media Watch Online

Asia

SINGAPORE | Centre for Biomedical Ethics (CENTRES): <http://centres.sg/> (Scroll down to 'Palliative Care Network: Media Watch')

Australia

AUSTRALASIAN PALLIATIVE INTERNATIONAL LINK: <http://www1.petermac.org/apli/links.htm> (Scroll down to 'Links,' then to 'Media Watch')

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>

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/media-watch-hospice-palliative-care-and-end-of-life-news-n-470.htm?PHPSESSID=b623758904ba11300ff6522fd7fb9f0c>

International

INTERNATIONAL PALLIATIVE CARE RESOURCE CENTER: <http://www.ipcrc.net/archive-global-palliative-care-news.php>

PALLIATIVE CARE NETWORK COMMUNITY: <http://www.pcn-e.com/community/pg/file/owner/MediaWatch>

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