

## Media Watch...

is intended as an advocacy and research tool. The weekly report is international in scope and distribution – to colleagues who are active or have a special interest in hospice and palliative care, and in the quality of end-of-life care in general – to help keep them abreast of current, emerging and related issues – and, to inform discussion and encourage further inquiry.

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Informed decision making: Scroll down to [Specialist Publications](#) and 'Prognosis terminal: Truth-telling in the context of end-of-life care' (p.10), in *Cambridge Quarterly of Healthcare Ethics*.

## Canada

### National dialogue starts...

NEWFOUNDLAND | *The Telegram* (St. John's) – 19 February 2014 – The Canadian Medical Association [in association with the Canadian Society of Palliative Care Physicians and the Canadian Hospice Palliative Care Association] is partnering with a national publication for a cross-country series of public town halls focused on end-of-life care. St. John's hosted the first event as part of 'In Conversation with *Maclean's*' series. <http://www.thetelegram.com/News/Local/2014-02-21/article-3622879/National-dialogue-on-end-of-life-care-kicks-off-in-St.-John%26rsquo%3Bs/1>

### [Specialist Publications](#)

'Canada needs a "dialogue about death" says CMA president' (p.10), in *Canadian Medical Association Journal*.

### Earlier palliative care helps patients with advanced cancer to cope

ONTARIO | CBC News – 18 February 2014 – Giving advanced cancer patients earlier access to palliative care services improves their quality of life and their satisfaction with the care they are getting, a new study suggests.<sup>1</sup> The researchers got the 461 patients in the study to assess their care and quality of life using questionnaires that are standardly used in this type of research. Assessments at three months found few real differences between the two groups, but by four months those who had early access to palliative care scored higher for quality of life, symptom control, and satisfaction with their care. Lead researcher Dr. Camilla Zimmermann, head of the palliative care program at [Toronto's] Princess Margaret Hospital, says there is a misconception about what palliative care is. Many people believe it is the type of care hospitals offer when they have exhausted all medical options. They think it means that the oncology teams, having run out of cancer fighting tools, then hand off patients to people specialized in helping ease the final days of a dying person's life. <http://www.cbc.ca/news/health/earlier-palliative-care-helps-patients-with-advanced-cancer-to-cope-1.2542457>

1. 'Early palliative care for patients with advanced cancer: A cluster-randomised controlled trial,' *The Lancet*, 19 February 2014, [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(13\)62416-2/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)62416-2/abstract)

## Ontario needs to improve working conditions for home care workers

ONTARIO | *The Toronto Star* (OpEd) – 15 February 2014 – Ontario Health Minister Deb Matthews' promise to increase wages for personal support workers in the home care industry is a good step forward, but in this increasingly important sector more than a salary bump is needed. If Matthews wants the struggling home care sector to succeed, front-line health care workers must be treated and trained like professionals. Nothing less will do. Even with a hike to home-care's minimum wage of \$12.50, the industry's working conditions, not to mention benefits, are dismal. And despite the fact that personal support workers (PSWs) are being asked to handle more complicated medical procedures, only basic training is required, leaving many scared of the jobs they're told to perform. And that puts vulnerable patients at risk. Indeed, as Ontario's population ages, care for the elderly and infirm will increasingly shift away from hospitals and long-term care, creating a pressing need to attract more PSWs who will dedicate their careers to the home care industry, instead of seeking better wages and benefits in hospitals or nursing homes. [http://www.thestar.com/opinion/editorials/2014/02/16/ontario\\_needs\\_to\\_improve\\_working\\_conditions\\_for\\_home\\_care\\_workers\\_editorial.html](http://www.thestar.com/opinion/editorials/2014/02/16/ontario_needs_to_improve_working_conditions_for_home_care_workers_editorial.html)

## Assisted (or facilitated) death

Representative sample of recent news media coverage:

- *THE NATIONAL* | Online – 21 February 2014 – **'The Conservatives' selective interest in protecting human life.'** Quebec is poised to legalize what it calls "medical aid in dying." And needless to say, the Conservative government in Ottawa is not on board. It appealed the 2012 decision by the B.C. Supreme Court striking down Canada's euthanasia laws. The Supreme Court in Ottawa is set to consider it some time this year. In the meantime, Justice Minister Peter MacKay said in a statement last month, "it is our government's position that the Criminal Code provisions prohibiting assisted suicide and euthanasia are in place to protect all persons, including those who are most vulnerable in our society ... The Supreme Court of Canada acknowledged the state interest in protecting human life and upheld the constitutionality of the existing legislation 20 years ago in the [Sue] Rodriguez decision." Unusually for this government on a Criminal Code issue, however, its message is free of moral judgment. <http://fullcomment.nationalpost.com/2014/02/21/chris-selley-the-conservatives-selective-interest-in-protecting-human-life/>

Of related interest:

- QUEBEC | *Macleans* – 19 February 2014 – **'Good news, bad news.'** Quebec is on the verge of introducing historic legislation that strikes the best possible balance: institutionalizing extensive palliative care while still allowing the gravely ill, in certain circumstances, to end their unbearable suffering with a lethal injection. Although no system is perfect, especially when the issue is literally life and death, a patient deserves that ultimate choice – not the state. <http://www2.macleans.ca/2014/02/19/good-news-bad-news-18/>
- QUEBEC | CBC News – 17 February 2014 – **'Quebec's "dying with dignity" law would set new standards.'** Should Quebec's national assembly pass ... the proposed legislation to allow medical aid in dying, it will be setting in place a law that appears to take much of its key inspiration from Europe. While a small number of North American jurisdictions, such as the U.S. states of Washington, Oregon and Vermont, have laws allowing physician-assisted suicide, Quebec's proposed Bill 52 follows Europe's lead in particular by extending the law's reach to those experiencing "unbearable suffering," but who may not be within months of dying, which is the U.S. criteria. <http://www.cbc.ca/news/canada/quebec-s-dying-with-dignity-law-would-set-new-standards-1.2537259>
- QUEBEC | *The Globe & Mail* – 14 February 2014 – **'Why euthanasia and assisted suicide must remain legally prohibited.'** Bill 52, which defines euthanasia as palliative care and proposes adding it to end-of-life decision-making options, could be voted on later this month by the Quebec Legislative Assembly. Much ink has already been spilled on the pro- and anti-euthanasia arguments relevant to these initiatives, but there has been little discussion in the public square on the content of the "life concepts" that are informing this debate. <http://www.theglobeandmail.com/globe-debate/why-euthanasia-and-assisted-suicide-must-remain-legally-prohibited/article16893616/>

## U.S.A.

### Study affirms need for hospice in state Medicaid programs

MISSOURI | *The St. Louis Post-Dispatch* – 19 February 2014 – The recent Missouri Hospice Medicaid Study clearly indicates that hospice actually reduces spending for Medicaid beneficiaries as well as reduces total costs to Medicaid.<sup>1</sup> Those dying while under the care of hospice had total Medicaid costs that were 45% lower than that of patients who died in the hospital. Hospice users spent a total of \$126,000 whereas those dying in a hospital spent \$284,000, respectively. <http://interact.stltoday.com/pr/local-news/PR021914093416007>

1. 'Missouri Hospice Medicaid Study,' Missouri Hospice & Palliative Care Association, February 2014. <http://www.mohospice.org/library/MH212-MO%20Hosp.%20Leg.e-VERS.pdf>

### Maine inmates find redemption through hospice care

MAINE | *The Charlotte Observer* (Charlotte, North Carolina) – 16 February 2014 – Steve Carpentier, a wiry man with blue eyes, has served 28 years in prison for murder, but he and other violent offenders volunteering for hospice duty at the state's maximum security prison are finding an untapped reservoir of empathy by caring for their fellow inmates in their final hours. The program is part of a trend at prisons where inmate populations are aging along with the rest of America. There are now more than 60 hospice or end-of-life programs in prisons across the country, but this is the only one in Maine. <http://www.charlotteobserver.com/2014/02/16/4699016/maine-inmates-find-redemption.html#.UwluhGJdX8k>

#### Specialist Publications

**'Both sides of the fence: Methodological challenges in undertaking research into end-of-life care for prisoners'** (p.10), in *BMC Supportive & Palliative Care*.

**N.B.** Articles and reports focused on the provision and delivery of end-of-life care for prison inmates have been highlighted in Media Watch on a fairly regular basis. A compilation of these articles and reports in a single document is available on request. Contact information at foot of p.17.

### Assisted (or facilitated) death

Representative sample of recent news media coverage:

- NEW JERSEY | NJ Spotlight – 19 February 2014 – **'Fine print: Legislators reintroduce measure allowing assisted suicides.'** With Governor Christie still opposed, debate over emotional and controversial issue may be all that's possible in this session. A bill that would allow terminally ill patients to receive a lethal dose of medication ignited one of the most emotionally charged debates of the last legislative session – and that could happen again with reintroduction of the controversial measure. The New Jersey Death with Dignity Act, S-382 and A-2270, lays out a series of steps intended to guarantee that terminally ill patients who want to end their life are acting voluntarily. <http://www.njspotlight.com/stories/14/02/18/fine-print-legislators-revive-measure-reintroduce-allowing-assisted-suicides/>

#### Barry R. Ashpole

My involvement in hospice and palliative care dates from 1985. As a communications consultant, I've been involved in or responsible for a broad range of initiatives at the community, regional, provincial and national level. My current work focuses primarily on advocacy and policy development in addressing issues specific to those living with a 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 college courses on different aspects of end-of-life care, and facilitating issue specific workshops, primarily for frontline care providers. Biosketch on the International Palliative Care Resource Center website at: <http://www.ipcrc.net/barry-r-ashpole.php>



## International

### **Kenya faces shortage of palliative care**

AFRICA (Kenya) | *Coast Week* (Nairobi) – 21 February 2014 – Kenya is facing a shortage of facilities and experts who can take care of patients with life-threatening illness, the National Aids Control Council (NACC) said. NACC Deputy Director Dr. Sobhie Mulindi told journalists in Nairobi that government is currently in the process of implementing guidelines for the management of life limiting illnesses. "The need for palliative care is enormous, not only in Kenya and the region," Mulindi said. The leading causes of death in Kenya include pneumonia, HIV, cancer and heart disease. The ministry of health estimates that 22,000 Kenyans die from cancer annually. <http://www.coastweek.com/3708-latest-news-Kenya-faces-shortage-of-palliative-care.htm>

Noted in Media Watch, 17 February 2014, #345 (p.8):

- *BMC PALLIATIVE CARE* | Online – 15 February 2014 – '**Public preferences and priorities for end-of-life care in Kenya: A population-based street survey.**' This first population-based survey on preferences and priorities for end-of-life care in Africa revealed that psycho-social domains were of greatest importance to the public, but also identified variations that require further exploration. <http://www.biomedcentral.com/content/pdf/1472-684X-13-4.pdf>

### End-of-life care in the U.K.

#### **Too many people are being denied their wish to die at home or a hospice**

U.K. (England) | *The Yorkshire Post* (Leeds) – 21 February 2014 – Too many people are dying on trolleys and cubicles in hospitals while waiting to be transferred to a ward or back home, a report into end of life care in the East Riding has found. Although the vast majority of people want to die at home or a hospice, only one in five do so. Nearly 60% cent die in hospital, although most people say it is their least preferred place to die. A review panel, made up of East Riding councillors, heard "time and time again" of "serious issues" with the out of hours GP service, which has just two GPs and two "contract practitioners" for a population of 300,000 people spread over more than 900 square miles. The report found that when people got into distress after 11 p.m. and the out of hours service was called, doctors were not available and ambulances had to be called. <http://www.yorkshirepost.co.uk/news/main-topics/general-news/too-many-people-are-being-denied-their-wish-to-die-at-home-or-a-hospice-1-6455780>

#### **Have the British forgotten how to grieve?**

U.K. | *The Daily Telegraph* – 20 February 2014 – Some countries "celebrate" the loss of a loved one, others have prolonged mourning rituals. In Britain, we rush back to work after a funeral. Have we got death all wrong? <http://www.telegraph.co.uk/lifestyle/10639359/Have-the-British-forgotten-how-to-grieve.html>

#### [Media Watch Online](#)

Media Watch (or a link to the weekly report) is posted on a number of websites that serve the hospice and palliative care community-at-large. Complete listing p.16.

#### [Media Watch posted on Palliative Care Network-e Website](#)

Palliative Care Network-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, exchange of ideas, information and materials. <http://www.pcn-e.com/community/pg/file/owner/MediaWatch>

## Ensure palliative care to cancer patients past treatable stage: Experts

INDIA (Tamil Nadu) | *The New Indian Express* (Chennai) – 17 February 2014 – Even as cancer continues to post alarming rise in incidence, the tendency to subject patients to unnecessary treatment protocols, inflicting huge economical as well as psychological drain on them and their family has begun to gall experts. There should be a stop to over-diagnosis and over-treatment when the disease is past treatable stage. Patients should be brought into palliative care so they can enjoy improved quality of life ... WHO Emeritus and Chief, Cancer & Palliative Care [sic], Jan Stjernsward said. Every doctor knows when the disease becomes untreatable. He should be sensitive enough to decide against continuing treatment when it ceases to have any meaningful effect. By ending treatment and starting palliative care, the doctor can not only stem further economical burden on the patient but also ensure peace and comfort in the last remaining time. [http://www.newindianexpress.com/states/odisha/Ensure-Palliative-Care-to-Cancer-Patients-Past-Treatable-Stage-Ex-](http://www.newindianexpress.com/states/odisha/Ensure-Palliative-Care-to-Cancer-Patients-Past-Treatable-Stage-Experts/2014/02/17/article2061199.ece#.Uwlz-WJdX8k)  
[perts/2014/02/17/article2061199.ece#.Uwlz-WJdX8k](http://www.newindianexpress.com/states/odisha/Ensure-Palliative-Care-to-Cancer-Patients-Past-Treatable-Stage-Experts/2014/02/17/article2061199.ece#.Uwlz-WJdX8k)

Of related interest:

- AFRICA (Kenya) | Standard Media (Nairobi) – 16 February 2014 – **'Prioritise prevention and treatment of cancer, government told.'** The government has been urged to prioritise treatment and care of cancer patients. Nairobi Hospice Chairman Sobbie Mulindi said the rising number of cancer patients is an indication that there is need for enhancement of proper treatment and palliative care. He noted the government has set aside Sh32 million [under the National Cancer Control Strategy] to fund the fight against cancer and integrate palliative care into the healthcare delivery system. Statistics from the health ministry reveal 28,000 new cases of cancer are diagnosed annually while 22,000 cancer-related deaths occur during the same period. [http://www.standardmedia.co.ke/?articleID=2000104815&story\\_title=Kenya-prioritise-prevention-and-treatment-of-cancer-government-told](http://www.standardmedia.co.ke/?articleID=2000104815&story_title=Kenya-prioritise-prevention-and-treatment-of-cancer-government-told)
- U.K. | *The Telegraph* – 16 February 2014 – **'Experts criticise restriction on life-prolonging prostate cancer drug.'** Prostate cancer experts are pleading with NHS [National Health Service] rationing bodies to reverse their "outrageous" decision to deny drugs to men in the advanced stages of the disease. Three months ago NICE [National Institute for Health & Clinical Excellence's] ruled that the drug [enzalutramide] would be made available to those with cancer which has spread beyond the prostate, and who have stopped responding to treatment, after the manufacturers agreed a discount on the £25,000 per patient price. But last month the rationing body issued new restrictions – which meant that the NHS will only fund the drug if men have not tried the only other drug that is available for such cases, called abiraterone. <http://www.telegraph.co.uk/health/healthnews/10641472/Experts-criticise-restriction-on-life-prolonging-prostate-cancer-drug.html>

### India: Major breakthrough for pain patients

INDIA | Human Rights Watch – 21 February 2014 – The Rajya Sabha, the upper house of parliament, approved amendments to the Narcotic Drugs & Psychotropic Substances Act (the Drug Act) that the lower house had approved a day earlier. The amendments eliminate archaic rules that obligated hospitals and pharmacies to obtain four or five licenses, each from a different government agency, every time they wanted to purchase strong pain medicines. As Human Rights Watch documented in a 2009 report this resulted in the virtual disappearance of morphine, an essential medicine for strong pain, from Indian hospitals, including most specialized cancer centers. <http://www.hrw.org/news/2014/02/21/india-major-breakthrough-pain-patients>

1. 'Unbearable Pain: India's Obligation to Ensure Palliative Care,' Human Rights Watch, October 2009. [Noted in Media Watch, 2 November 2009, #121 (p.4)] <http://www.hrw.org/reports/2009/10/28/unbearable-pain-0>

### Specialist Publications

'Affordable cancer care: Pipedream or achievable reality?' (p.13), in *The Lancet Oncology*.

## **Ireland: Public quizzed on living wills**

IRELAND | *The Independent* (Dublin) – 17 February 2014 – Members of the public are invited to give their views on plans to bring in legislation for living wills, where people can set out the medical treatments they would like in the event of becoming very ill. A draft general scheme has been approved by the Government. Health Minister James Reilly said: "Advance healthcare directives represent an important means by which people can exercise their autonomy, which is an integral component of a patient-focused model of health care. Given that there is currently no specific legislation pertaining to advance healthcare directives in Ireland, incorporating provisions for advance healthcare directives into the Assisted Decision-Making (Capacity) Bill 2013 represents an efficient and practical method of consolidating the law." <http://www.independent.ie/lifestyle/public-quizzed-on-living-wills-30012685.html>

## **Does CPR usually bring people around?**

U.K. | BBC News – 17 February 2014 – In studies of medical dramas, resuscitation was shown to be successful 75% of the time on U.S. television,<sup>1</sup> whereas there was a more realistic 25% success rate in British dramas.<sup>2</sup> Even that 25% rate is higher than many places actually achieve. The success of CPR depends a lot on where you live and how fast you can get medical help. A review of studies across many countries found a survival rate of just 5.35% in New York compared with 37% in the German city of Heidelberg.<sup>3</sup> <http://www.bbc.com/future/story/20140217-does-cpr-usually-work>

1. 'Cardiopulmonary resuscitation on television – miracles and misinformation,' *New England Journal of Medicine*, 1996, 334(24):1578-1582. [Noted in Media Watch, 18 March 2013, #297 (p.13, under 'Worth Repeating')] <http://www.nejm.org/doi/full/10.1056/NEJM199606133342406>
2. 'As seen on TV: Observational study of cardiopulmonary resuscitation in British television medical dramas,' *British Medical Journal*, 1998;317(7161):780-783. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC28667/>
3. 'An outcome study of out-of-hospital cardiac arrest using the Utstein template – a Japanese experience,' *Resuscitation*, 2002;55(3):241-246. [http://www.resuscitationjournal.com/article/S0300-9572\(02\)00207-1/abstract](http://www.resuscitationjournal.com/article/S0300-9572(02)00207-1/abstract)

**N.B.** The abstract of the article in *Resuscitation*, cited by the BBC, does not mention survival rates in other countries. Access to the full article requires a subscription.

## **Scottish social care watchdog promises to make services "transparent"**

U.K. (Scotland) | *Homecare* – 17 February 2014 – Scotland's social care watchdog, the Care Inspectorate, has announced a drive to provide better information about poorly performing care services, as well as highlight those services that demonstrate leading-edge practice. The body, which inspects and regulates some 14,000 care homes and home care providers ... says those that fall below adequate standards and don't improve sufficiently fast will be highlighted on the Care Inspectorate website as well as those that regularly excel. Every care service in Scotland is regularly inspected by the Care Inspectorate, mostly unannounced ... and is graded on a scale from 1 (unsatisfactory) to 6 (excellent). Results for 2012/2013 showed that 4.8% of registered services scored 3 (adequate) or less, an increase of 1% on the previous year. Where services cause concern, the watchdog inspects much more frequently, to ensure care users are protected. The Care Inspectorate also has legal powers to enforce change, and close a service where necessary. [http://www.homecare.co.uk/news/article.cfm/id/1562540/scottish\\_social\\_care\\_watchdog](http://www.homecare.co.uk/news/article.cfm/id/1562540/scottish_social_care_watchdog)

## Assisted (or facilitated) death

Representative sample of recent news media coverage:

- AUSTRALIA (Australian Capital Territory) | *The Canberra Times* – 22 February 2014 – **'Time to talk about how we die, says MLA Mary Porter.'** Labor backbencher Mary Porter intends moving a motion in the Australian Capital Territory Assembly on "dying with dignity" and end-of-life issues, an action sure to reignite the euthanasia debate. Ms. Porter stressed that her aim was not to discuss euthanasia exclusively – her motion doesn't mention the word and, in fact, goes much wider to include palliative care and the pressures on the health system from the city's ageing population. <http://www.canberratimes.com.au/act-news/time-to-talk-about-how-we-die-says-mla-mary-porter-20140221-337zi.html>
- RUSSIA TODAY TV NETWORK | Online – 17 February 2014 – **'Russian adoption ban could expand to countries with legalized child euthanasia.'** Lower House MPs have asked the Foreign Ministry to study the recently passed law allowing child euthanasia in Belgium in order to decide if its citizens should be legally banned from adopting Russian kids. The initiative comes from Deputy Roman Khudyakov of the Liberal Democratic Party of Russia. The politician told the mass circulation daily *Izvestia* that he wrote to Foreign Minister Sergey Lavrov asking him to investigate the situation. "Before we continue cooperation with Belgium allowing our children to be adopted by their citizens we should understand on what grounds a child can be killed in this country and if there is a danger for our kids to lose their lives in a foreign country," the lawmaker said. Khudyakov added that the majority of Russian children's rights groups and religious organizations would support the ban on adoption of Russian children by Belgians. <http://rt.com/politics/child-euthanasia-ruaaisn-adoption-352/>

Noted in Media Watch, 17 February 2014, #345 (p.7):

- BELGIUM | BBC News – 13 February 2014 – **'Belgium's parliament votes through child euthanasia.'** The parliament in Belgium has passed a bill allowing euthanasia for terminally ill children without any age limit, by 86 votes to 44, with 12 abstentions. When, as expected, the bill is signed by the king, Belgium will become the first country in the world to remove any age limit on the practice. <http://www.bbc.co.uk/news/world-europe-26181615>
- JAPAN | *The Japan Times* (Tokyo) – 15 February 2014 – Euthanasia is an emotionally charged issue for people on both sides of the debate. Proponents of euthanasia argue that a person suffering from terminal illness should be given the freedom to choose how and when they die. Such discourse is given weight by the Japanese term for the practice – *anrakushi*, which literally means "peaceful death." On the other hand, opponents generally argue that euthanasia is nothing short of murder, and the use of palliative care can often give a terminally ill person a more comfortable, dignified death. In some cases, they say, a desire to die prematurely is merely rooted in depression. The government has enacted no specific legislation on euthanasia and the Supreme Court has only ruled on the matter once without providing any specific guidance. Instead, the basic framework of Japan's euthanasia policy to date has been laid out in two local court cases, one in Nagoya in 1962, and another after an incident at Tokai University in 1995. The judgments in these cases established a legal framework and a set of conditions within which euthanasia could be legal. In both cases, however, the defendants were found guilty of violating these conditions when hastening the deaths of their patients. <http://www.japantimes.co.jp/life/2014/02/15/general/euthanasia-the-dilemma-of-choice/#.UwlInjGJdX8k>
- U.K. | *The Daily Mail* – 15 February 2014 – **'Terminally sick children have been secretly given deadly overdoses by British doctors in illegal mercy killings, claims retired GP.'** British doctors have secretly killed terminally sick children by giving them "huge" overdoses of painkillers, it was claimed. Hours after Belgium became the first country in the world to allow the euthanasia of children, a retired GP [Dr. Michael Irwin] suggested it was already happening, informally, in Britain. He added: "It has been done under the pretext of what we call double effect where the child has been given huge doses of painkillers and so on, in order to relieve discomfort, pain and other symptoms." Jeremy Hunt, the Health Secretary, vowed to investigate but said he was not aware of specific cases. <http://www.dailymail.co.uk/news/article-2560014/Terminally-sick-children-secretly-given-deadly-overdoses-British-doctors-illegal-mercy-killings-claims-retired-GP.html>

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

### **Care of terminally-ill patients: An opinion survey among critical care healthcare providers in the Middle East**

*AFRICAN HEALTH SCIENCES*, 2013;13(4):893-898. Modern medicine has allowed physicians to support the dying terminally-ill patient with artificial means. However, a common dilemma faced by physicians in general, and intensivists in particular, is when to limit or withdraw aggressive intervention. The authors studied the effect of training background and seniority on do not resuscitate (DNR) decisions in the Middle East. Most of the responders to an anonymous questionnaire were Muslim (86%) and consultants (70.9%). The majority of the responders were trained in western countries. Religion played a major role in 59.3% for making the DNR decision. DNR was considered equivalent to comfort care by 39.5%. In a futile case scenario, do not escalate therapy was preferred. The likelihood of a patient, once labeled DNR, being clinically neglected was a concern among 46.5%. Admission of DNR patients to the ICU was acceptable for 47.7%. Almost one-half of the responders (46.5%) wanted physicians to have the ultimate authority in the DNR decision. Training background was a significant factor affecting the interpretation of the term no code DNR. <http://www.ajol.info/index.php/ahs/article/viewFile/100195/89457>

Noted in Media Watch, 11 April 2011, #196 (p.10):

- *JOURNAL OF PEDIATRIC HEMATOLOGY/ONCOLOGY*, 2011;30(Supple1-80). **'Palliative care in Middle-Eastern countries.'** The focus of this article is on palliative care in Cyprus, Egypt, Israel, Pakistan, the Palestinian Authority and Turkey. <http://journals.lww.com/jpho-online/toc/2011/04001>

### **End-of-life care beliefs among Muslim physicians**

*AMERICAN JOURNAL OF HOSPICE & PALLIATIVE MEDICINE* | Online – 13 February 2014 – Physicians' religiosity affects their approach to end-of-life care (EOLC) beliefs. Studies exist about end-of-life care beliefs among physicians of various religions. However, data on Muslim physicians are lacking. This study explores the beliefs centering on aspects of end-of-life care among Muslim physicians in the U.S. and other countries. A total 461 Muslim physicians responded to the authors' survey. The primary end point was if the Muslim physicians thought that making a patient do not resuscitate (DNR) is allowed in Islam?. Nearly 66.8 % of the respondents replied yes as compared to 7.38 % of the respondents who said no. Country of origin, country of practice, and if physicians had talked about comfort care in the past had the most impact on the yes vs. no response. Muslim physicians' beliefs on EOLC issues are affected more by the area of practice, country of origin and previous experience in talking about comfort care than the religious beliefs. <http://ajh.sagepub.com/content/early/2014/02/12/1049909114522687.abstract>

Noted in Media Watch, 28 March 2011, #194 (p.10):

- *JOURNAL OF MEDICAL ETHICS* | Online – 23 March 2011 – **'Disclosure of terminal illness to patients and families: Diversity of governing codes in 14 Islamic countries.'** Codes for 14 Islamic countries were located. Five codes were silent regarding informing the patient, seven allowed concealment, one mandated disclosure and one prohibited disclosure. Five were silent regarding informing the family, four allowed disclosure and five mandated/recommended disclosure. The Islamic Organization for Medical Sciences code was silent on both issues. <http://jme.bmj.com/content/early/2011/03/22/jme.2010.038497.abstract>

**N.B.** Additional articles on end-of-life care and Islam law are footnoted in this issue of Media Watch.

## **Health care professionals' perceptions towards lifelong learning in palliative care for general practitioners: A focus group study**

*BMC FAMILY PRACTICE* | Online – 19 February 2014 – The majority of palliative patients prefer their general practitioner (GP) to organize their palliative home care. General practitioners need a range of competences to perform this task. However, there has been no general description so far of how GPs keep these competences up-to-date. The present study explores current experiences, views and preferences towards training and education in palliative care among GPs, palliative home-care professionals and professionals from organizations who provide training and education. The effectiveness of undergraduate education might be enhanced by adding practical experience. Providers of continuing medical education should look to organize interactive, practice-based and interprofessional sessions. Therefore, teachers need to be trained to run small group discussions. In order to optimize workplace learning, health care professionals should be trained to monitor each other's practice and to provide effective feedback. Further research is needed to clarify which aspects of interprofessional teamwork (e.g., professional hierarchy, agreements on tasks and responsibilities) influence the effectiveness of workplace learning. <http://www.biomedcentral.com/content/pdf/1471-2296-15-36.pdf>

Of related interest:

- *JOURNAL OF GENERAL INTERNAL MEDICINE* | Online – 21 February 2014 – '**Regardless of age: Incorporating principles from geriatric medicine to improve care transitions for patients with complex needs.**' This article provides a framework for incorporating geriatrics principles into care transition activities by discussing the following elements: 1) identifying factors that make transitions more complex; 2) engaging care "receivers" and tailoring home care to meet patient needs; 3) building "recovery plans" into transitional care; 4) predicting and avoiding preventable readmissions; and, 5) adopting a palliative approach, when appropriate, that optimizes patient and family goals of care. <http://link.springer.com/article/10.1007/s11606-013-2729-1>
- *PALLIATIVE MEDICINE* | Online – 17 February 2014 – '**Early identification of palliative care needs by family physicians: A qualitative study of barriers and facilitators from the perspective of family physicians, community nurses, and patients.**' Barriers and facilitators found relate to communication styles, the perceived role of a family physician, and continuity of care. Family physicians do not systematically assess non-acute care needs, and patients do not mention them or try to mask them from the family physician. This is embedded within a predominant perception among patients, nurses, and family physicians of the family physician as the person to appeal to in acute and standard follow-up situations rather than for palliative care needs. <http://pmj.sagepub.com/content/early/2014/02/14/0269216314522318.abstract>

### End-of-life care in The Netherlands

#### **The effect and process evaluations of the national quality improvement programme for palliative care: The study protocol**

*BMC PALLIATIVE CARE* | Online – 21 February 2014 – The nationwide integration of palliative care best practices into general care settings is challenging but important in improving the quality of palliative care. This is why the Dutch National Quality Improvement Programme for Palliative Care has recently been launched. This four-year programme consists of about 70 implementation trajectories of best practices. A large evaluation study has been set up to evaluate this national programme and separate implementation trajectories. This mixed-method evaluation study gives more insight into the effects of the total programme and the separate implementation trajectories. However, evaluation of large quality improvement programmes is complicated due to changing, non-controlled environments. Therefore, it is important that an effect evaluation is combined with a process evaluation. <http://www.biomedcentral.com/content/pdf/1472-684X-13-5.pdf>

## **Both sides of the fence: Methodological challenges in undertaking research into end-of-life care for prisoners**

*BMJ SUPPORTIVE & PALLIATIVE CARE*, 2014;4(1):105. The number of older prisoners in the U.K. has more than doubled in the last decade, with the greatest increases amongst those over 70. Around 40% of older prisoners are sex offenders, many of whom are in prison for the first time due to historic abuse. Longer sentences and more stringent release criteria mean that increasing numbers of anticipated deaths in prison are predicted. Prison staff experience tensions between care and custody and demands for considerable emotional labour in delivering palliative care to such prisoners. This paper presents some of the methodological challenges encountered during the early stages of the "Both sides of the fence" study, which uses action research to develop a transferable model of integrated palliative care for prisoners. A prison with a large population of older and disabled prisoners was identified as the research site, and access was granted following ethical and governance approvals. Engagement of diverse groups of staff in the research required multiple meetings, extensive networking and the visible on-site presence of the researcher; this engagement led to an important protocol amendment to include focus groups with prisoners who provide informal care to fellow prisoners. Establishing effective connections with a wide range of prison staff has been key to overcoming the methodological challenges and progressing the research. <http://spcare.bmj.com/content/4/1/105.1.abstract>

## **Prognosis terminal: Truth-telling in the context of end-of-life care**

*CAMBRIDGE QUARTERLY OF HEALTHCARE ETHICS*, 2014;23(2):209-219. Recent contributions to the medical literature have raised yet again the issue of whether the term "terminal" is an intelligible one and whether there is a consensus view of its meaning that is sufficient to justify or even require its use in discussing end-of-life care and treatment options with patients. Following a review of the history and development of informed consent, persistent problems with the communication of prognosis and the breaking of bad news are analyzed. The author argues that candid, but compassionate, communication between physicians and patients about prognosis is essential to informed decisions about both disease-directed (curative) and palliative therapies. <http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=9173735&fulltextType=RA&fileId=S0963180113000741>

Of related interest:

- *AMERICAN JOURNAL OF HOSPICE & PALLIATIVE MEDICINE* | Online – 13 February 2014 – 'Use of the word "cure" in the oncology literature.' Twenty-nine articles used the word cure in their title in 2012. Nearly half used the term in situations currently considered incurable. <http://ajh.sagepub.com/content/early/2014/02/18/1049909114524477.abstract>

## **Canada needs a "dialogue about death" says CMA president**

*CANADIAN MEDICAL ASSOCIATION JOURNAL* | Online – 20 February 2014 – Canada is facing a severe crisis surrounding end-of-life care due to the stigma surrounding it and funding concerns, Dr. Louis Hugo Francescutti, president of the Canadian Medical Association [CMA] told the Economic Club of Canada in Ottawa. The end of life is difficult to face at the best of times, but Canadians need to open a "dialogue about death," said Francescutti. This is particularly important in light of the upcoming vote on Quebec's Bill 52: An Act respecting end-of-life care. With terms like palliative care, physician-assisted suicide and advanced care directives coming into play there's plenty of room for confusion. "We all need to be comfortable talking about the latter days of life because we're all going to get there," said Francescutti. Palliative care "puts quality into the end of a life, "for both patients and families, said Francescutti. Unfortunately, palliative care is currently only available to 15-30% of Canadians. Yet, the Canadian Hospice Palliative Care Association reports that 73% of people who will die this year could benefit from an improved quality of life before death. [http://www.cmaj.ca/site/earlyreleases/20feb14\\_Canada-needs-a-dialogue-about-death-says-CMA-president.xhtml](http://www.cmaj.ca/site/earlyreleases/20feb14_Canada-needs-a-dialogue-about-death-says-CMA-president.xhtml)

## Care of the dying cancer patient in the emergency department: Findings from a national survey of Australian emergency department clinicians

*INTERNAL MEDICINE JOURNAL* | Online – 16 February 2014 – Although 83.8% [of survey respondents] found caring for the dying a reasonable demand on their role as clinician, 83.8% also agreed that the emergency department [ED] is not the right place to die. Respondents demonstrated a wide range of views regarding caring for this patient group in ED... In addition, 64.5% reported that futile treatment is frequently provided in the ED, the main reasons reported were that limitations of care were not clearly documented or discussed with the patient or their family. Almost all respondents agreed advance care plans assist in caring for dying patients in the ED.  
<http://onlinelibrary.wiley.com/doi/10.1111/imj.12379/abstract>

## Factors associated with initiation of advance care planning in dementia: A systematic review

*JOURNAL OF ALZHEIMER'S DISEASE* | Online – 14 February 2014 – A variety of factors with ... involved in initiating advance care planning [ACP]. Family factors dominated, with family's initiative or lack of it, and willingness or reluctance to engage in initiating ACP, identified in a series of studies. Professional caregivers' initiative or lack of it and patient's health status were important factors that facilitated or hindered initiating ACP. Ethnic minority status of those involved and family distance may be barriers. Continuity of care and health care system factors also affected initiating of ACP. Professional caregivers may initiate ACP early if strategies ... consider timing and family and patient receptiveness or reluctance, and are family and patient-centered. Interventions should address the complexity of interrelated system and personal factors affecting initiation...  
<http://iospress.metapress.com/content/a3m66l7k78112131/?p=c6c8950827674d7e8a570dfbd1e2817&pi=1>

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### 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 and research tool.

### 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

1. Links are checked and confirmed as active before each edition of Media Watch is distributed.
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.

Noted in Media Watch, 6 May 2013, #304 (p.13):

- *PALLIATIVE MEDICINE*, 2013;27(5):387-388. **'Planning a personalised future with dementia: "the misleading simplicity of advance directives."'** Given the paucity of disease modifying treatment, it has been suggested that one benefit of diagnosis is that it allows the person to plan for their future care while they still have capacity. Louise Robinson and colleagues explore key issues of advance care planning for people with dementia in a large representative sample of professionals...<sup>1</sup> <http://pmj.sagepub.com/content/27/5/387.extract>
- 1. *PALLIATIVE MEDICINE* | Online – 21 November 2012 – **'Professionals' experiences of advance care planning in dementia and palliative care, "a good idea in theory but ..."** The majority [of participants] expressed uncertainty over the general value of advance care planning, whether current service provision could meet patient wishes, their individual roles and responsibilities and which aspects of advance care planning were legally binding; the array of different advance care planning forms and documentation available added to the confusion. In dementia care, the timing of when to initiate advance care planning discussions was an added challenge. [Noted in Media Watch, 26 November 2012, #281 (p.7)] <http://pmj.sagepub.com/content/early/2012/11/15/0269216312465651.abstract>

### **Risk factors for potentially avoidable re-admissions due to end-of-life care issues**

*JOURNAL OF HOSPITAL MEDICINE* | Online – 14 February 2014 – In a medical population, the authors identified risk factors significantly associated with 30-day potentially avoidable readmission due to end-of-life care issues, producing a model with very good to excellent discrimination. Patients with these risk factors might benefit from palliative care consultation prior to discharge to improve end-of-life care and possibly reduce unnecessary re-hospitalizations. <http://onlinelibrary.wiley.com/doi/10.1002/jhm.2173/abstract>

### **What justifies a hospital admission at the end of life? A focus group study on perspectives of family physicians and nurses**

*PALLIATIVE MEDICINE* | Online – 17 February 2014 – Study participants indicated that although they considered death at home or in the nursing home of residence the most preferable outcome, there are a number of scenarios that they considered to justify a hospital admission at the end of life: when the patient prefers a hospital admission, when the caring capacity of the care setting is considered to be inadequate and when one of a number of acute medical situations occurs. <http://pmj.sagepub.com/content/early/2014/02/14/0269216314522317.abstract>

Representative sample of articles on avoidable hospital readmissions of hospice or palliative care patients noted in past issues of Media Watch:

- *PALLIATIVE MEDICINE* | Online – 23 December 2013 – **'Economic impact of hospitalisations among patients in the last year of life: An observational study.'** Of 483 admissions, 35 were classified as potentially avoidable. Avoiding these admissions and caring for the patients in alternative locations would save the two hospitals [involved in the study] £5.9 million per year. Reducing length of stay in all 483 patients by 14% has the potential to save the two hospitals £47.5 million per year; however, this cost would have to be offset against increased community care costs. [Noted in Media Watch, 30 December 2013, #338 (p.12)] <http://pmj.sagepub.com/content/early/2013/12/23/0269216313517284.abstract>
- *JOURNAL OF PALLIATIVE MEDICINE* | Online – 9 November 2013 – **'Acute hospital admissions of hospice patients.'** The authors of this study found these previously unreported factors that are associated with elevated acute hospital admissions [AHA] rates: 1) hospice diagnoses of terminal heart and lung disease compared with other diagnoses; and, 2) the home care setting compared with the nursing home setting. Moreover, previous studies had not looked in detail at the timing of AHA over the course of hospice care or related the timing of AHA to the reason for AHA. [Noted in Media Watch, 25 November 2013, #333 (p.14)] <http://online.liebertpub.com/doi/abs/10.1089/jpm.2013.0033>

## Affordable cancer care: Pipedream or achievable reality?

*THE LANCET ONCOLOGY* | Online – 14 February 2014 – The oncology community needs to take greater responsibility for our own practice patterns, especially when using expensive tests and treatments with marginal value: we cannot continue to accept novel therapeutics with very small benefits for exorbitant prices. Patients, payers, and pharmaceutical communities should be constructively engaged to communicate medically and economically possible goals, and eventually, to reduce use and costs. Diagnostic tests and treatments should have to show true value to be added to existing protocols. In this article, the authors discuss three key drivers of costs: end-of-life care patterns, medical imaging, and drugs. They propose health-care models that have the potential to decrease costs and discuss solutions to maintain clinical benefit at an affordable price. [http://www.thelancet.com/journals/lanonc/article/PIIS1470-2045\(14\)70062-2/fulltext](http://www.thelancet.com/journals/lanonc/article/PIIS1470-2045(14)70062-2/fulltext)

Of related interest:

- *JOURNAL OF CANCER POLICY* | Online – 15 February 2014 – '**Dispelling the myths around cancer care delivery: It's not all about costs.**' Costs of cancer care grow exponentially. It has been argued that there is a linear relation between costs and outcome: the more a country spends on cancer care, the better the outcome. The authors try to dispel this myth... <http://www.sciencedirect.com/science/article/pii/S2213538314000022>

## Emerging subspecialties in neurology: Palliative care

*NEUROLOGY*, 2014;18;82(7):640-642. As we work to find cures for so many devastating neurologic injuries and diseases, our patients suffer tremendously on a daily basis. Individuals with conditions including stroke, multiple sclerosis, Parkinson disease, muscular dystrophies, amyotrophic lateral sclerosis, and nervous system malignancies share a host of physical, emotional, and existential symptoms that can be difficult to treat. In addition, patients and their families face the realities of loss of function, loss of ability to communicate, and life spans limited by the neurologic diagnosis or complications related to it... We may not always be able to reverse damage to the nervous system, but we can optimize quality of life for our patients by providing expertise in communicating difficult news, in pain and symptom management, and in advance planning and end-of-life care. <http://www.neurology.org/content/82/7/640.extract>

Representative sample of articles on palliative care for people living with a neurology condition or disorder noted in past issues of Media Watch:

- *DEMENTIA*, 2014;13(1):96-110. '**Palliative care services for people with dementia: A synthesis of the literature reporting the views and experiences of professionals and family carers.**' What emerges is a range of perspectives that provide contrasting views of the heterogeneity of carers and professionals. This may be helpful for professionals and policy makers to consider when planning end-of-life care strategies for people with dementia and insights drawn from hearing directly from carers may be powerful learning tools. [Noted in Media Watch, 30 December 2013, #338 (p.8)] <http://dem.sagepub.com/content/13/1/96.abstract>
- *PALLIATIVE MEDICINE* | Online – 9 July 2013 – '**Palliative care for Parkinson's disease: A summary of the evidence and future directions.**' An integrated model of care, promoting collaboration between specialist palliative and neurological services, is discussed, along with specific palliative care interventions. [Noted in Media Watch, 15 July 2013, #314, (p.11)] <http://pmj.sagepub.com/content/early/2013/07/05/0269216313495287.abstract>
- *REVUE NEUROLOGIQUE* | Online – 28 February 2013 – '**Mobile team of palliative care in a department of neurology: Value of two multidisciplinary and professional groups' fruit of a joint distribution of the palliative approach and ethical support.**' This article describes how a mobile team of palliative care and a department of neurology learned to cope with many complex end-of-life situations. [Noted in Media Watch, 18 March 2013, #297 (p.12)] <http://www.sciencedirect.com/science/article/pii/S0035378713000350>

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- *JOURNAL OF MEDICAL ETHICS* | Online – 22 December 2012 – '**A plea for end-of-life discussions with patients suffering from Huntington's disease: The role of the physician.**' Talking about end-of-life wishes with an Huntington's disease patient is part of the legal, professional and moral responsibility of the physician. [Noted in Media Watch, 24 December 2012, #285 (p.11)] <http://jme.bmj.com/content/early/2012/12/21/medethics-2011-100369.abstract>
- *JOURNAL OF NEUROLOGY, NEUROSURGERY & PSYCHIATRY*, 2012;83(3):e1. '**Attitudes towards end of life issues among people with multiple sclerosis.**' Results highlight a need for better patient education and openness about end of life options ... and a greater exploration of these issues on a wider scale. [Noted in Media Watch, 12 March 2012, #244 (p.12)] <http://jnnp.bmj.com/content/83/3/e1.78.abstract?sid=2d78f642-d629-4e9d-a43d-5561f4889829>
- *JOURNAL OF NEUROLOGY, NEUROSURGERY & PSYCHIATRY* | Online – 5 February 2011 – '**Palliative care in amyotrophic lateral sclerosis: Review of current international guidelines and initiatives.**' Despite an international consensus ... integration of palliative care varies considerably across health care systems. Late referral to palliative services in amyotrophic lateral sclerosis is not uncommon and may impact negatively on the quality of life of these patients and their caregivers. [Noted in Media Watch, 14 February 2011, #188 (p.8)] <http://jnnp.bmj.com/content/early/2011/02/04/jnnp.2010.232637.abstract?sid=2fb2379c-b7d2-419d-8a3b-bf6f757148c3>

### **Knowledge is *not* power for patients: A systematic review and thematic synthesis of patient-reported barriers and facilitators to shared decision making**

*PATIENT EDUCATION & COUNSELING*, 2014;94(3):291-309. Many barriers are potentially modifiable, and can be addressed by attitudinal changes at the levels of patient, clinician/health-care team, and the organization. The results support the view that many patients currently *can't* participate in substitute decision making, rather than they *won't* participate because they do not want to. Future implementation efforts should address patient-reported factors together with known clinician-reported barriers and the wider organizational context. [http://www.pec-journal.com/article/S0738-3991\(13\)00472-2/abstract](http://www.pec-journal.com/article/S0738-3991(13)00472-2/abstract)

Of related interest:

- *JOURNAL OF MEDICINE & PHILOSOPHY* | Online – 19 February 2014 – '**The surrogate's authority.**' The authors identify two problems with contemporary understandings of the surrogate's role: the assumption that knowledge of the patient entails knowledge of what the patient's choice of treatment would be; and, the assumption that a good decision reproduces the content of that choice. If the authors are right, then the Patient Preference Predictor, helpful though it might be in guiding surrogates' decisions, nevertheless would hold them to the wrong standards and in that way could add to, rather than relieve, the stress they experience as they try to do their job. <http://jmp.oxfordjournals.org/content/early/2014/02/18/jmp.jhu003.abstract>

Noted in Media Watch, 17 February 2014, #345 (p.10):

- *JOURNAL OF MEDICINE & PHILOSOPHY* | Online – 13 February 2014 – '**Use of a patient preference predictor to help make medical decisions for incapacitated patients.**' This paper proposes to incorporate the use of a Patient Preference Predictor into the shared decision-making process between surrogates and clinicians. <http://jmp.oxfordjournals.org/content/early/2014/02/12/jmp.jhu001.abstract?sid=33063f86-0c8c-48c5-9b57-c56409d8ac66>

## On Goldilocks, care coordination, and palliative care: Making it "just right"

*PRIMARY CARE RESPIRATORY JOURNAL* | Online – 19 February 2014 – Hospice/palliative care is not just end-of-life care, it is specialised medical care for patients with serious illness. Although definitions of "serious illness" may vary, it is clear that far more patients could benefit from hospice/palliative care than we can actually serve, given the existing workforce challenges and the lack of clarity in how to pay for specialist palliative care throughout the world. The needs of patients and caregivers are similar regardless of the underlying life limiting illness. Appropriate timing of referrals is key, but this timing must be clearly defined for each disease group, with differences to be expected between cancer and chronic obstructive pulmonary disease. Not every patient needs to see a palliative care specialist, and the timing matters greatly when resources are limited. Thus, as palliative care continues to move further upstream in a patient's journey, these limitations necessitate that we be better able to match the right type of care with the right patient at the right time. Models of "care coordination" offer one potentially promising strategy for addressing this problem. In this issue of the *Primary Care Respiratory Journal*, Epiphaniou and colleagues report the results of a longitudinal qualitative study of patients' experiences with end-of-life care coordination in the U.K.<sup>1</sup> These results highlight several important truths about the current state of care coordination. [http://www.thepcrj.org/journ/view\\_article.php?article\\_id=1103](http://www.thepcrj.org/journ/view_article.php?article_id=1103)

1. 'Coordination of end-of-life care for patients with lung cancer and those with advanced COPD: are there transferable lessons? A longitudinal qualitative study,' *Primary Care Respiratory Journal*, 29 January 2014. [http://www.thepcrj.org/journ/view\\_article.php?article\\_id=1096](http://www.thepcrj.org/journ/view_article.php?article_id=1096)

## The instrument 'Sense of Security in Care – Patients' Evaluation': Its development and presentation

*PSYCHO-ONCOLOGY* | Online – 14 February 2014 – The preliminary instrument was based on a literature review and analysis of qualitative interviews with patients about their sense of security. The SEC-P ['Sense of Security in Care – Patients'] provides a three-component assessment of palliative home care settings using valid and reliable scales. These were associated with other concepts in ways that were expected. The SEC-P is a manageable means of assessment that can be used to improve quality of care and in research focusing on patients' sense of security in care. <http://onlinelibrary.wiley.com/doi/10.1002/pon.3502/abstract;jsessionid=346A360A992574D035DB027397E5CEDA.f01t02?deniedAccessCustomisedMessage=&userIsAuthenticated=false>

Noted in Media Watch, 9 May 2011, #200 (p.9):

- *PSYCHO-ONCOLOGY* | Online – 6 May 2011 – **'What is a "secure base" when death is approaching? A study applying attachment theory to adult patients' and family members' experiences of palliative home care.'** Informants [i.e., study participants] expressed the relevance of sensing security during palliative home care because death and dying were threats that contributed to vulnerability. Palliative home care could foster a feeling of security and provide a secure base. <http://onlinelibrary.wiley.com/doi/10.1002/pon.1982/abstract>

## Hydration at the end of life

*ZEITSCHRIFT FÜR PALLIATIVMEDIZIN*, 2014;15(1):22-27. Hydration at the end of life is controversial. Due to the fact that no internationally valid recommendations and guidelines exist and the evidence is uncertain, the decision is made not only on the basis of medical but also on ethical and emotional points of view. With the help of a case report the approach and the meaning of hydration at the end of life are discussed. Complete hydration was stopped in a patient with a cerebral bleeding and poor prognosis. This approach was decided because of the advanced directives and presumed will of the patient. Nevertheless she died only 21 days after stopping hydration. This time was a difficult process of accepting for her husband. In this context it becomes clear that in palliative care the approach and the treatment must be met on the basis of biological, psychological, social and spiritual aspects. <http://cat.inist.fr/?aModele=afficheN&cpsid=28068542>

## Media Watch Online

### **International**

INTERNATIONAL ASSOCIATION FOR HOSPICE & PALLIATIVE CARE: <http://hospicecare.com/about-iahpc/newsletter/2014/2/media-watch/>

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>

PALLIMED (Hospice & Palliative Medicine Blog): <http://www.pallimed.org/2013/01/the-best-free-hospice-and-palliative.html> [Scroll down to 'Aggregators' and Barry Ashpole and Media Watch]

### **Asia**

ASIA PACIFIC HOSPICE PALLIATIVE CARE NETWORK: <HTTP://APHN.ORG/CATEGORY/MEDIA-WATCH/>

SINGAPORE | Centre for Biomedical Ethics (CENTRES): <http://centres.sg/updates/international-palliative-care-resource-center-media-watch/>

### **Australia**

WESTERN AUSTRALIA | Palliative Care WA Inc: <http://palliativecarewa.asn.au/site/helpful-resources/> [Scroll down to 'International Websites' and [www.ipcrc.net/archive-global-palliative-care-news.php](http://www.ipcrc.net/archive-global-palliative-care-news.php) to access the weekly report]

### **Canada**

ONTARIO | Central Regional Hospice Palliative Care Program: <http://www.centralrhpcp.ca/Physicians/resources.htm?mediawatch=1>

ONTARIO | Central West Palliative Care Network: [http://cwpcn.ca/Health\\_Practitioners/resources.htm?mediawatch=1](http://cwpcn.ca/Health_Practitioners/resources.htm?mediawatch=1)

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.acclaimhealth.ca/menu-services/palliative-care-consultation/resources/> [Scroll down to 'Additional Resources']

### **Europe**

EUROPEAN ASSOCIATION FOR PALLIATIVE CARE: <http://www.eapcnet.eu/Themes/Organization/Links.aspx> [Scroll down to International Palliative Care Resource Center – IPCRC.NET]

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>

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

Representative sample of recent articles, etc:

- *INNOVAIT* | Online – 14 February 2014 – '**Assisted suicide: Would you participate?**' One cannot fail to notice the media interest surrounding the emotive subject of assisted dying. Multiple, high profile cases, celebrity commentary and legal proceedings are underpinned by tragic personal stories involving individuals who find themselves in the unimaginable position of wanting to end their lives but being unable to do so without assistance. As GPs, patients may come to us to discuss the issue of assisted dying. We need to be prepared for these difficult consultations. <http://ino.sagepub.com/content/early/2014/02/13/1755738014523737.abstract>

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- *INTERNATIONAL JOURNAL OF EPIDEMIOLOGY* | Online – 18 February 2014 – **'Suicide assisted by right-to-die associations: A population based cohort study.'** In both age groups [that were studied], assisted suicide was more likely in women than in men, those living alone compared with those living with others, and in those with no religious affiliation compared with Protestants or Catholics. The rate was also higher in more educated people, in urban compared with rural areas, and in neighbourhoods of higher socio-economic position. In older people, assisted suicide was more likely in the divorced compared with the married; in younger people, having children was associated with a lower rate. <http://ije.oxfordjournals.org/content/early/2014/02/17/ije.dyu010.short?rss=1>
- *JOURNAL OF INTERPROFESSIONAL HEALTHCARE*, 2014;1(1):Article 10. **'Are veterinarians kinder than physicians? A veterinary oncologist's interprofessional perspective of euthanasia.'** This commentary concerns the ethics and rationale of compassionately using kind and gentle techniques for euthanasia of terminally ill companion animals and how these concepts may benevolently crossover to helping terminally ill humans die with dignity. On the other hand, what are the ethics and rationale for those pet owners and veterinarians, who allow a prolonged and often miserable death for pets due to their beliefs or preferences to apply the principles of human hospice ("true" hospice) by eschewing euthanasia? <http://www.jihonline.org/jih/vol1/iss1/10/>

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