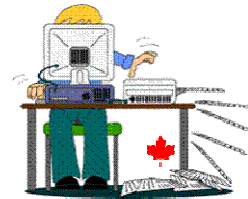


Media Watch...

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

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

Compiled & Annotated by Barry R. Ashpole

Undergraduate medical education: Scroll down to [Specialist Publications](#) and 'Why are newly qualified doctors unprepared to care for patients at the end of life? (p.10), published in *Medical Education*.

Canada

Gravely ill man's wishes for life must be respected, panel finds

ONTARIO | *Toronto Star* – 20 March 2011 – A provincial panel has ordered doctors at Oakville Trafalgar Memorial Hospital to act against their own wishes and provide him with aggressive, life-saving treatment if his health falls into crisis. The finding by the [provincial] Consent & Capacity Board resolves a high-profile dispute ... between the hospital's medical team and the family of the 87-year-old – a dispute increasingly playing out in hospitals across the country [see next page]. After 14 months of treating him for dementia, pneumonia, bed sores and other ailments, Desmond's medical team recently sought permission from his wife Maria to remove heroic measures from their treatment plan and care for him as a palliative patient. Desmond's wife and two of his daughters firmly opposed that hands-off approach, insisting the devout Catholic would have wanted to be given every chance at life despite any suffering he may be enduring.
<http://www.thestar.com/living/article/957080--gravely-ill-man-s-wishes-for-life-must-be-respected-panel-finds>

- ONTARIO | *Toronto Star* – 18 March 2011 – **'Wife grapples with perplexing minefield of end of life debate.'** The life-and-death issues at stake with Desmond Watson are an early distant warning for what lies ahead for many of us, our families and our already strained medical system. In many cases, we, the ill or dying, won't be the ones making our own final call. A lack of legal and ethical clarity around the end-of-life question in Canada has made the decision-making process a perplexing minefield. There are no clear provincial, federal or medical protocols to break the deadlock when the wishes of patients and their families come into conflict with the medical judgment of physicians.
<http://www.thestar.com/news/canada/article/956704--wife-grapples-with-perplexing-minefield-of-end-of-life-debate?bn=1>

Extract from *Toronto Star* (of 18 March 2011)

Dr. David McConachie ... and nurse Rebecca Franks told the panel that they had no knowledge of Desmond's values and beliefs when it comes to end-of-life care. Asked if he had ever asked Mrs. Watson about her husband's beliefs and values, McConachie said in testimony, "I have no idea what Mr. Watson's personal beliefs are." He never asked.

Cont.

From Media Watch dated 25 October 2010:

- ONTARIO | *Toronto Star* – 25 October 2010 – **'Family, doctors battle over 'do not resuscitate' order.'** As Mann Kee Li lies in hospital fighting dire prospects, his family is engaged in a life-or-death struggle, not with the cancer spreading through his body, but with the doctors treating it. <http://www.thestar.com/news/article/880422--family-doctors-battle-over-do-not-resuscitate-order>

From Media Watch dated 6 September 2010:

- ONTARIO | *Toronto Star* – 4 September 2010 – **'Lawsuit could set precedent about end-of-life decisions.'** While [Joy] Wawrzyniak and her father, Douglas (Dude) DeGuerre, had repeatedly requested he receive life-saving treatment in case of a medical emergency, doctors unilaterally overruled those wishes without consent or consultation ... [a \$1 million] lawsuit [against Sunnybrook Health Sciences Centre] claims. <http://www.thestar.com/news/gta/article/856741--lawsuit-could-set-precedent-about-end-of-life-decisions?bn=1>

From Media Watch dated 29 March 2010:

- *NATIONAL POST* | Online report – 29 March 2010 – **'Crisis in the ICU.'** The doctor for a dying Jewish man at the heart of an emotional court battle has spoken out about the case for the first time, calling for a public inquiry to help clear up the growing debate over who should decide the care of gravely ill patients.¹ <http://www.nationalpost.com/news/canada/story.html?id=2738063>

Baby Joseph to get tracheotomy by the end of the week: U.S. doctors

ONTARIO | *Vancouver Sun* (British Columbia) – 14 March 2011 – A terminally ill Ontario baby at the centre of a heated debate over end-of-life medical care will undergo a tracheotomy ... in hopes he could be transferred to a nursing facility closer to home, said the Missouri hospital that accepted Joseph Maraachli. Joseph was airlifted there "in serious but stable condition" from the London Health Sciences Centre, where specialists recommended the child be taken off life support because he suffers from a fatal neurological disorder and is in a vegetative state. <http://www.vancouversun.com/life/Baby+Joseph+tracheotomy+week/4435461/story.html>

From Media Watch dated 7 March 2011:

- *GLOBE & MAIL* | Online article – 1 March 2011 – **'Hospital confronts social media uprising over care of dying baby.'** One of Canada's most prestigious medical institutions has made the bold decision to go public with details of a highly emotional tug-of-war over a dying infant in an attempt to defend itself against a slew of threats, condemnations and criticisms playing out in social media. <http://www.theglobeandmail.com/news/national/ontario/hospital-confronts-social-media-uprising-over-care-of-dying-baby/article1925978/>

Specialist Publications

Of particular interest:

'Income inequities in end-of-life health care spending in British Columbia, Canada: A cross-sectional analysis, 2004-2006' (p.10), published in the *International Journal for Equity in Health*.

'Trends in the aggressiveness of end-of-Life cancer care in the universal health care system of Ontario, Canada' (p.10), published in the *Journal of Clinical Oncology*.

'A shared care model pilot for palliative home care in a rural area: Impact on symptoms, distress, and place of death' (p.8), for the findings of a Canadian study published in the *Journal of Pain & Symptom Management*.

'Family physician-provided end-of-life care assessed in ongoing study' (p.8), for the findings of a Dalhousie University study reported in *The Medical Post*.

[U.S.A.](#)

[Japan earthquake and tsunami](#)

Plight of ailing, elderly quake victims renews questions from Katrina

MSNB | Online OpEd – 18 March 2011 – In the wake of the devastating earthquake and tsunami in Japan, rescue workers found 128 elderly people abandoned by medical staff at a hospital six miles from the damaged Fukushima Dai-ichi nuclear power plant. The tsunami also killed nearly half the 113 residents at a retirement home in Kesennuma. Eleven of those who lived died of exposure, and the other 53 are in a shelter with only kerosene heaters to keep them warm in near-freezing condition. For the most part, help can't get to the ailing and injured. Doctors without Borders says it may pull out of the area near the nuclear plant. In Japan, where nearly one in four residents is over 65, the disaster will likely take the largest toll on the elderly. "We're trying to comfort and help them, but we can't do too

much," Keiko Endo, a nurse at the Kesennuma shelter told the Associated Press. http://www.msnbc.msn.com/id/42156972/ns/health-health_care/

Extract from MSNB

The crisis calls to mind America's devastating natural disaster of 2005 – Hurricane Katrina. In the aftermath, workers in New Orleans hospitals were left frantically trying to care for ailing patients without electricity, water, supplies – or anyone to rescue them. The ethical questions raised during that national disaster about what should be done for those left helpless and dying are so difficult that Americans never directly answered them.

End-of-life care in Massachusetts needs improvement, panel says

MASSACHUSETTS | *Patriot Ledger* (Quincy) – 16 March 2011 – State officials and health care experts want people talking about an issue that affects everyone: If you fall ill, how do you want to spend the last days of your life? It's a heavy topic, but one that has been inching to the forefront of national and local health care discussions as medical advances allow people to live longer with cancers and other diseases. Nearly 70% of Americans say they want to die at home, surrounded by family, but in Massachusetts, fewer than 25% die at home. The majority die in hospitals and nursing homes, often hooked up to life support. That's according to a report ... examining what it's like to die in Massachusetts, whether patients' last wishes are followed, and what can be done to improve their quality of life in those final months, weeks or days. The report was prepared by the state's Panel on End of Life Care, a 40-plus group made up of doctors, hospital leaders, lawmakers and hospice and social work experts assigned by the Legislature to examine the issue. http://www.patriotledger.com/lifestyle/50_plus/x32326773/End-of-life-care-in-Massachusetts-needs-improvement-panel-says

- MASSACHUSETTS | WGBH News (Boston) – 17 March 2011 – **'Report offers new recommendations for end-of-life care.'** A report ... by a panel convened by Massachusetts health officials says that all too often, doctors don't discuss end of life care with their patients. And, as a result, patients are likely to receive costly and unwanted hospitalization and medical interventions. <http://www.wgbh.org/articles/index.cfm?tempid=2282>

[Corrections & Clarifications](#)

Ireland's funeral industry was the focus of a report in *Irish Health* noted in Media Watch dated 21 February 2001. At the time, online access to *The Funeral Industry in Ireland: The Road to Reform* was unavailable. The National Council of the Forum on End of Life discussion document can now be downloaded at: <http://www.endoflife.ie/news/updates.aspx?article=abdd119-6763-44c4-b1c8-2d275c5478f3>

University of Texas Medical Branch research: Artificial nutrition not best

TEXAS | KHOU TV News (Houston) – 16 March 2011 – In a new study looking at people with terminal illnesses ... researchers ... said the medical profession might have swung the pendulum too far in its efforts to keep patients alive. End-of-life medical care often leads to that conflicting intersection of personal, medical, legal and policy issues that frequently spill over into the public arena. The medical profession, in concert with other interests, should focus more on what is best for a patient – prolonging a life might not be the most compassionate medical course of action... Looking at ethical concerns, case studies, legal and medical discourse spanning 60 years, researchers said it might be time to reconsider artificial nutrition and hydration for end-of-life patients. "We seem to have forgotten the difference between people who died because they stop taking in food and water and people who stop taking in food and water because of the natural dying process," Dr. Howard Brody, lead author of the study ... said. "There seems to be a growing disconnect between popular ethical conceptions and the palliative care medical community." <http://www.khou.com/news/health/UTMB-Research-Artificial-nutrition-not-best-118076864.html>

Specialist Publications

Of particular interest:

'Making sense of the Roman Catholic directive to extend life indefinitely' (p.9), published in *The Hastings Report*.

'Artificial nutrition and hydration: The evolution of ethics, evidence, and policy' (p.9), published *Journal of General Internal Medicine*.

Of related interest:

- GÉNÉTHIQUE | Online report – 7 March 2011 – **'Italy: Food and hydration in the end of life law.'** The text [of a bill on end of life care] provides for the obligation to nourish and hydrate the patient; nutrition and hydration constitute not "therapy" but a "life support" for the person. They cannot be halted unless they are "no longer effective or suitable to the patient's living conditions." http://www.genethique.org/En/press/press/2011/March/07_11.html#4

Media Watch Online

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

Canada

Ontario | Hamilton Niagara Haldimand Brant Hospice Palliative Care Network: <http://www.hnhbhpc.net/Resources/Usefullinks/MediaWatch/tabid/97/Default.aspx>

Ontario | HPC Consultation Services: <http://www.hpconnection.ca/newsletter/inthenews.html>

Ontario | Mississauga Halton Palliative Care Network: <http://www.mhpcn.ca/Physicians/resources.htm>
(Scroll down to 'Newsletters/Media Updates')

U.S.A.

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

International

Global | Palliative Care Network Community: <http://www.pcn-e.com/community/search/?tag=Media+Watch>

U.K. | Omega, the National Association for End of Life Care: <http://www.omega.uk.net/news.htm>

Physician Orders for Life-Sustaining Treatment

New efforts to simplify end-of-life care wishes

WALL STREET JOURNAL | Online report – 15 March 2011 – Advance directives ... can be too vague to cover many medical situations. Now, a growing number of states are promoting another program to help guide physicians with a patient's specific instructions. The programs are known as Physician Orders for Life-Sustaining Treatment, or POLST ... which is signed by both the patient and the doctor, spells out such choices as whether a patient wants to be on a mechanical breathing machine or feeding tube and receive antibiotics. POLST programs are currently in use in 14 states and regions ... and another 16 states and six regions are developing programs. The programs train health-care providers to

discuss end-of-life treatment choices with patients...<http://online.wsj.com/article/SB10001424052748703327404576194942197661606.html>

Nursing homes can honor do not resuscitate

GEORGIA | Associated Press – 14 March 2011 – Currently patients who go into cardiac arrest in a nursing home must be resuscitated, even if they have signed an order saying they do not want such life-sustaining measures to be taken. http://www.necn.com/03/14/11/House-Nursing-homes-can-honor-do-not-res/landing_health.html?&blockID=3&apID=a062581450ff4950b5f23ef7db1a1d2f

From Media Watch dated 5 July 2010:

- *JOURNAL OF THE AMERICAN GERIATRICS SOCIETY*, 2010;58(7):1241-1248. **'Comparison of methods to communicate treatment preferences in nursing facilities.'** Residents with POLST forms were more likely to have treatment preferences documented as medical orders than those who did not. <http://www3.interscience.wiley.com/journal/123572530/abstract>

From Media Watch dated 16 February 2009:

- *JOURNAL OF PALLIATIVE MEDICINE*, 2009;12(2):133-141. **'Use of the Physician Orders for Life-Sustaining Treatment Paradigm Program in the hospice setting.'** The POLST Paradigm Program was designed to ensure the full range of patient treatment preferences are honored throughout the health care system. <http://www.liebertonline.com/doi/abs/10.1089/jpm.2008.0196>

N.B. POLST website: <http://www.ohsu.edu/polst/>

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- GEORGIA | *Sun Sentinel* (Fort Lauderdale, Florida) – 17 March 2011 – **'Don't even talk about assisted suicide in Georgia, or risk a felony.'** Legal in Oregon, Montana and Washington, other states like California, Michigan and Maine have rejected attempts to legalize physician-assisted suicide, even though the majority of the country, according to various polls, leans in support of professional attempts to help disease sufferers end their lives with dignity. The author of this article explains how states like Georgia are going even further – making it a felony to even discuss such options. http://www.sun-sentinel.com/health/fl-nbc-ol-end-of-life-info-brochu-031720110317_0_6369536.column

[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/>

International

Leading health charity in calls to make learning about dying and death part of school curriculum

U.K. | Dying Matters press release – 16 March 2011 – All secondary school pupils in England should be taught about issues relating to dying and death as part of the national curriculum... The National Council for Palliative Care, which leads the Dying Matters Coalition, is leading calls for learning about death and dying to be part of the wellbeing curriculum in all schools, so that people of all ages can feel supported in discussing difficult health, care, emotional and practical issues. <http://www.dyingmatters.org.uk/documents/Schools%20Lesson%20Plan%20Press%20Release%2014%2003%2011.pdf>

Palliative Care Funding Review launches response tracker

U.K. | Palliative Care Funding Review online posting – 16 March 2011 – The palliative care funding review team have launched an online tracker. The tracker provides a picture of which dedicated palliative care services people think should be funded by the state and which should be supported by society. The responses will inform the final report ... to the Government on what the dedicated palliative care services that would be funded by the NHS [National Health Service] are. http://palliativecarefunding.org.uk/2011/03/palliative-care-funding-review-launches-response-tracker/?utm_source=feedburner&utm_medium=email&utm_campaign=Feed%3A+Palliativecarefundingorguk+%28palliativecarefunding.org.uk%29

Paediatric palliative care

Making dying 'a little bit easier'

IRELAND | *Irish Times* – 15 March 2011 – Caring for a child who is dying is one of the most heartbreaking experiences that life can bring. Most families with children who have life-threatening conditions say they would prefer that they are nursed for and cared for at home. Currently, the services available to make that possible are seriously inadequate. In recognition of this, the Irish Hospice Foundation has set out a plan to put in place eight outreach nurses throughout the State who will be available to help families cope when their child has a life-limiting illness. Bevan Ritchie is the first of these. Based in Children's University Hospital in Temple Street, Dublin, for the past three years, he sees families with children right through from the initial diagnosis and coping with the illness to the final months, weeks and days of the child's life. Ritchie says that a large part of his job is to link with services that already exist near the child's home and to be the point of contact for the family when they need to access these community-based

services. <http://www.irishtimes.com/newspaper/health/2011/03/15/1224292151112.html>

Specialist Publications

Of particular interest:

'Pediatric palliative care provision around the world: A systematic review' (p.11), published in *Pediatric Blood & Cancer*.

Irish Hospice Foundation

Design and dignity at end of life, single rooms and spaces for important conversations

Recipient of the Nobel Prize for Literature, Seamus Heaney, and actor and filmmaker Gabriel Byrne discuss the quality of end of life care. <http://www.youtube.com/watch?v=zr4hSAVdNwU>

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- AUSTRALIA | *Sydney Morning Herald* – 15 March 2011 – '**40% support euthanasia: Poll.**' More than 40% of Australians would "take the option of euthanasia if available" if they were terminally ill with just weeks to live, a poll has indicated. The research, commissioned by Alzheimer's Australia, also suggests strong support for the permitted, though legally fraught, option of refusing treatment "even if this means they would die sooner." <http://news.smh.com.au/breaking-news-national/40-per-cent-support-euthanasia-poll-20110315-1bvck.html>

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

Validation study of an end-of-life questionnaire from the Swedish Register of Palliative Care

ACTA ONCOLOGICA | Online article – 10 March 2011 – The Swedish Register of Palliative Care is a national quality register that focuses on the last week of life. The results in this study [based on medical data of 169 patients] will be used to improve and further develop the register. Consensus on quality issues in end-of-life care would simplify the work of writing and answering the questionnaire. <http://informahealthcare.com/doi/abs/10.3109/0284186X.2011.554434>

N.B. Sweden rated 16th in *The Quality of Death: Ranking End of-life-Care Across the World*, commissioned by the Lien Foundation, Singapore, and published by the Economist Intelligence Unit, July 2010. http://graphics.eiu.com/upload/QOD_main_final_edition_Jul12_toprint.pdf

Spiritual feasts: Meaningful conversations between hospice volunteers and patients

AMERICAN JOURNAL OF HOSPICE & PALLIATIVE MEDICINE | Online article – 10 March 2011 – Conversations between hospice volunteers and patients provide patients with emotional and social support, and they are meaningful and satisfying to volunteers. Prominent themes [identified in this study based on questionnaires and interviews] were the meaning of life, experiences and life stories, talk about death and spirituality, discussions of families and relationships, and shared interests. <http://ajh.sagepub.com/content/early/2011/02/11/1049909111398238.abstract>

Interventions for improving palliative care for older people living in nursing care homes

COCHRANE COLLECTION | Online article – Accessed 18 March 2011 – The aim of this review was to see how effective palliative care interventions in care homes are and to describe the outcome measures used in the studies. The authors found only three suitable studies ... all from the U.S. There was little evidence that interventions to improve palliative care for older people in care homes improved outcomes for residents. There is a need for more high quality research. <http://onlinelibrary.wiley.com/doi/10.1002/14651858.cd007132/frame.html>



Barry R. Ashpole

My involvement in palliative and end-of-life care dates from 1985. As a communications specialist, I've been involved in or responsible for a broad range of initiatives at the community, regional, provincial and national level. My work focuses primarily on advocacy, capacity building and policy development in addressing issues specific to those living with a life-threatening or terminal illness – both patients and families. In recent years, I've applied my experience and knowledge to education, developing and teaching on-line and in-class courses, and facilitating issue specific workshops, for frontline care providers.

Death, the home and palliative care

Whose business is dying?

CULTURAL STUDIES REVIEW, 2011;17(1):15-30. The home setting as a death scene is not, and cannot become, an institutional place of care, fully regulated by expert professionals. The home – in all its varying forms – is a place considered 'normal' by its occupants, where ownership of, and control over, its boundaries rests with those considered as subject to the paternalistic practices of conventional approaches to palliative care. By extension, the networks formed by the linking of these homes and their occupants create a community that 'owns' the business of dying amongst its members. A model of palliative care that integrates the principles and practices of health promotion and public health is proposed as one approach to normalising the conceptualisation of dying and the responses of communities to their dying members. Whose business is dying? <http://epress.lib.uts.edu.au/ojs/index.php/csrj/article/viewFile/1971/2159>

Of related interest:

- *JOURNAL OF PAIN & SYMPTOM MANAGEMENT* | Online article – 14 March 2011 – '**A shared care model pilot for palliative home care in a rural area: Impact on symptoms, distress, and place of death.**' Symptom and emotional distress were maintained below high severity, and a high rate of home death compared with population norms was observed. Shared care models build on family physician capacity and as such are promising in the development of palliative home care programs to improve access to quality palliative home care and foster health system integration. [http://www.jpmsjournal.com/article/S0885-3924\(11\)00031-5/abstract](http://www.jpmsjournal.com/article/S0885-3924(11)00031-5/abstract)
- *THE MEDICAL POST* (Canada) | Online report – 18 March 2011 – '**Family physician-provided end-of-life care assessed in ongoing study.**' In Nova Scotia, about one-third of patients get home visit, but only 18% receive information about symptom management. There is little or no palliative care [in the province] and many patients remain at home during the months leading up to final hospitalization <http://www.canadianhealthcarenetwork.ca/physicians/clinical/fp-provided-end-of-life-care-assessed-in-ongoing-study-14924>

A jurisprudence of ambivalence: Three legal fictions concerning death and dying

CULTURAL STUDIES REVIEW, 2011;17(1):52-80. The advent of artificial ventilation and other life-sustaining technologies has produced death scenes of a particular sort. When a person would rather die than endure these treatments, the death scene may be the subject of prior discussion, debate or demand. A person may insist that they no longer wish to live if there is no hope for improvement, or that they want doctors to remove the technology upon which their continued life depends. They might even request that withdrawal occur in one way rather than another. Accordingly, these death scenes usually require some planning, and they are necessarily contingent on the involvement and cooperation of others. This article will explore the death scene following treatment withdrawal, drawing upon *Ms B. v An NHS Hospital Trust* and *Brightwater Care Group (Inc.) v Rossiter*. The former is the leading English decision in which a conscious patient's choice to die was upheld. The latter is the first such decision of an Australian supreme court.

<http://utsescholarship.lib.uts.edu.au/epress/journals/index.php/csrj/article/viewFile/1973/2138>

Can we mandate compassion?

THE HASTINGS REPORT, 2011;41(2):20-23. The absence of compassion in health care is increasingly remarked upon. In 2009, it led to a campaign to broaden New Zealand's Code of Patients' Rights to include the legal right "to have services provided with compassion, including a prompt and humane response to suffering." As health and disability commissioner in New Zealand for the past decade, I was in the midst of the country's debate over this change.

<http://www.thehastingscenter.org/Publications/HCR/Detail.aspx?id=5162>

'Death panels'

Rationing: Theory, politics, and passions

THE HASTINGS REPORT, 2011;41(2):23-27. As did almost everyone else of a certain persuasion, I recoiled when Sarah Palin invoked the notion of a "death panel" to characterize reform efforts to improve end-of-life counseling. That was wrong and unfair. But I was left uneasy by her phrase. Had I not been one of a handful of bioethicists over the years who had pushed to bring the need for rationing of health care to public attention and proposed ways to carry it out? And was not a common thread running through the latter efforts the likely necessity of some kind of committee or other public mechanism to make the hard decisions? Were we not in other words talking about a "death panel," even if none of us has been so imprudent to use such a phrase? And did we not regularly bemoan the fact that politicians, left and right, would not go near the word "rationing"? <http://www.thehastingscenter.org/Publications/HCR/Detail.aspx?id=5163>

Making sense of the Roman Catholic directive to extend life indefinitely

THE HASTINGS REPORT, 2011;41(2):28-29. In November 2009, the U.S. Conference of Catholic Bishops issued *Ethical & Religious Directives for Catholic Health Care Services*, requiring that all patients – including those in the so-called persistent vegetative state – be provided with artificial hydration and nutrition if such care could extend life indefinitely. The directives ... prompted outcry from death-with-dignity movements and confusion within hospital ethics committees. Some hospital ethics committees debated whether their hospitals would be obliged to accept patients who refused such treatment as transfers from local Catholic hospitals. <http://www.thehastingscenter.org/Publications/HCR/Detail.aspx?id=5164>

From Media Watch dated 28 June 2010:

- *NEUROLOGY TODAY*, 2010;10(2):30. **'Should feeding tubes always be continued in terminal illness? Not necessarily, according to new guidance from the Catholic Church.'** Bioethicists highlight aspects of a revised directive on artificial nutrition and nutrition from the Catholic Church that would apply to neurologists working in Catholic hospitals. *Ethical & Religious Directives for Catholic Health Care Services* says that there is a general moral obligation to provide patients with nutrition and hydration if it would prolong their lives, but there are exceptions to that obligation. http://journals.lww.com/neurotodayonline/Fulltext/2010/06170/Should_Feeding_Tubes_Always_Be_Continued_in.14.aspx

Of related interest:

- *JOURNAL OF GENERAL INTERNAL MEDICINE* | Online article – 5 March 2011 – **'Artificial nutrition and hydration: The evolution of ethics, evidence, and policy.'** The debate over use of artificial nutrition and hydration ... in terminal illness ... remains contentious despite extensive ethical and empirical investigation. The history of the debate ... results from a complex interplay of ethical concerns, a growing empirical database, legal changes, public opinion, and financial as well as institutional concerns. <http://www.springerlink.com/content/1p45g41805014834/>

Reassure dying patients about discontinuing drugs

INTERNAL MEDICINE NEWS | Online report – 15 March 2011 – Withdrawing medications at the end of life is often the right thing to do clinically, but it can make hospice patients feel abandoned, according to nurse Beverly Lunsford. "People have it hammered in their heads to take their diabetes medications, their hypertension medications, and have done it faithfully for [decades]. Now you're telling them to stop. They may have a real sense that isn't right. Families may perceive medication discontinuation as substandard care or lack of care," said Dr. Lunsford, who coordinates the graduate program for palliative care nurse practitioners at George Washington University in Washington. <http://www.internalmedicineneeds.com/news/geriatric-medicine/single-article/reassure-dying-patients-about-discontinuing-drugs/4515698712.html>

Cont.

Of related interest:

- *CANADIAN FAMILY PHYSICIAN*, 2011;57(3):291-295. **'Withdrawing medication: Managing medical co-morbidities near the end of life.'** Family physicians need to initiate discussions about medication withdrawal and goals of care with patients with limited life expectancy. Patients' decision making about declining treatment or withdrawing medication might occur all at once or might take place over time, with specific treatments, medications, and devices being gradually withdrawn. <http://www.cfp.ca/cgi/reprint/57/3/304>

Income inequities in end-of-life health care spending in British Columbia, Canada: A cross-sectional analysis, 2004-2006

INTERNATIONAL JOURNAL FOR EQUITY IN HEALTH | Online article – 16 March 2011 – Despite the universal health care system in British Columbia, the authors found patterns of inequity in spending by income in the last year of life, even for fully publicly covered services. These results ... suggest persistent income-related inequities in the health care Canadians receive throughout their lives. <http://www.equityhealthj.com/content/pdf/1475-9276-10-12.pdf>

Trends in the aggressiveness of end-of-Life cancer care in the universal health care system of Ontario, Canada

JOURNAL OF CLINICAL ONCOLOGY | Online article – 14 March 2011 – Among 227,161 patients, 22.4% experienced at least one incident of potentially aggressive EOL [end of life] cancer care. Multivariable analyses showed that with each successive year, patients were significantly more likely to encounter some aggressive intervention. Multiple emergency department (ED) visits, ICU [Intensive care Unit] admissions, and chemotherapy use increased significantly over time, whereas multiple hospital admissions declined. Patients were more likely to receive aggressive EOL care if they were men, were younger, lived in rural regions, had a higher level of co-morbidity, or had breast, lung, or hematologic malignancies. Chemotherapy and ICU utilization were lower in Ontario than in the U.S. [The authors conclude] aggressiveness of cancer care near the EOL is increasing over time in Ontario, Canada, although overall rates were lower than in the U.S. <http://jco.ascopubs.org/content/early/2011/03/14/JCO.2010.31.9897.abstract>

Of related interest:

- *PHARMACY PRACTICE NEWS* | Online article – 18 March 2011 – **'Palliative chemotherapy: When is enough too much?'** Between 15% and 20% of people with cancer receive chemotherapy within 14 days of their death – at a point when the treatment has virtually no chance of extending survival or the quality of their life. It's referred to as "palliative" chemotherapy, but it frequently "palliates" very little – indeed, it often causes more discomfort and burden on the patient and family. http://www.pharmacypracticenews.com/ViewArticle.aspx?d=Hem%2FOnc%2BPharmacy&d_id=439&i=March%2B2011&i_id=716&a_id=16868

Why are newly qualified doctors unprepared to care for patients at the end of life?

MEDICAL EDUCATION, 2011;45(4):389-399. Undergraduate medical education is currently failing to prepare junior doctors for their role in caring for dying patients by omitting to provide meaningful contact with these patients during medical school. This lack of exposure prevents trainee doctors from realising their own learning needs, which only become evident when they step onto the wards as doctors and are expected to care for these patients. Newly qualified doctors perceive that they receive little formal teaching about palliative or end-of-life care in their new role and the culture within the hospital setting does not encourage learning about this subject. <http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2923.2010.03873.x/abstract>

Pediatric palliative care provision around the world: A systematic review

PEDIATRIC BLOOD & CANCER | Online article – 17 March 2011 – Pediatric palliative care is recommended by many organizations. Yet, there is no information available on the progress that has been made in providing this care or the gaps that still exist in provision around the world. The systematic review identified 117 peer-reviewed and non-peer reviewed resources. Based on this information, each country was assigned a level of provision; 65.6% of countries had no known activities, 18.8% had capacity building activities, 9.9% had localized provision, and 5.7% had provision that was reaching mainstream providers.

<http://onlinelibrary.wiley.com/doi/10.1002/pbc.23100/abstract>

Of related interest:

- *BMJ SUPPORTIVE & PALLIATIVE CARE* | Online article – 10 March 2011 – **"Holding the baby at the end of life."** Although there are obvious differences in caring for people at the extremes of life (newborns and the dying), there are many principles that can be applied to both – for example, the theory-practice gap, dealing with distress, 'We're only human,' 'It's easier with experience' and 'It doesn't have to be complicated.' <http://blogs.bmj.com/spcare/2011/03/10/%e2%80%98holding-the-baby%e2%80%99-at-the-end-of-life/>

Assisted (or facilitated) death

Representative sample of recent articles, etc:

- *JOURNAL OF PALLIATIVE MEDICINE* | Online article – 18 March 2011 – **'Quality of death and dying in patients who request physician-assisted death.'** Physician-assisted death (PAD) was legalized in 1997 by Oregon's Death with Dignity Act (ODDA). Through 2009, 460 Oregonians have died by lethal prescription under the ODDA. The quality of death experienced by those who received lethal prescriptions is no worse than those not pursuing PAD, and in some areas it is rated by family members as better. <http://www.liebertonline.com/doi/abs/10.1089/jpm.2010.0425>

Media Watch: Editorial Practice

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

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Something Missed or Overlooked?

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

Worth Repeating

Daughters caring for dying parents: A process of relinquishing

QUALITATIVE HEALTH RESEARCH, 2007;17(7):932-944. Caring for elderly, dying parents is challenging for daughters as they try to balance other obligations and responsibilities. The purpose of this ... study was to explain the domain of daughters' caregiving experiences in Newfoundland & Labrador, Canada. The primary author interviewed 12 women whose parents had died. Three types of turmoil (emotional, relational, and societal) emerged as the central issue for these women. The authors discovered a substantive theory of relinquishing with inter-dependent processes of keeping vigil, navigating systems, facing loss, and an end process of coming to terms. In moving through ... relinquishing, social conditions of personal ideals, family expectations and societal demands determine strategies employed by any one daughter to manage her turmoil. Findings fill a gap in knowledge related to daughters' caregiving for dying parents by contributing a theoretical framework that will inform women, health care providers, researchers and health policy makers. <http://qhr.sagepub.com/content/17/7/932.abstract>

Barry R. Ashpole
Beamsville, Ontario CANADA

'phone: 905.563.0044
e-mail: barryashpole@bellnet.ca