Media Watch...

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

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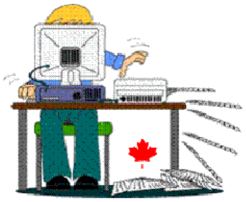


Compiled & Annotated by Barry R. Ashpole

Mourners' health risks: Scroll down to International and 'You really can die of a broken heart say scientists' (p.4), published in the *Daily Telegraph.*

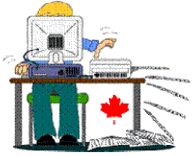
Canada

Navigating the health care system

Ailing boy gets 24-hour care

ONTARIO | *Toronto Star* – 9 January 2012 – Mark Rumsby, the 17-year-old boy who was denied entry to hospices that said they were unable to treat his life-threatening disorder, has been given 24-hour in-home care. This assistance, offered as a stopgap by the Community Care Access Centre until long-term hospice care can be provided, comes in the wake of a *Toronto Star* story last week[1] about the Rumsby family's troubles navigating Ontario's healthcare system maze. Round-the-clock support for the family started Sunday when a personal support worker arrived at the family's Leslieville house during the day. There was a "no-show" on Sunday evening between 4 and 11 p.m., and a nurse came in after that to monitor Mark throughout the night until Monday morning, said Wayne Rumsby, Mark's father. "It is a huge relief," Rumsby, 52, said. "The article brought attention." http://www.thestar.com/news/article/1113057

1. 'Hospice care out of reach for dying teen,' *Toronto Star*, 3 January 2012 (noted in Media Watch dated 9 January 2012). http://www.thestar.com/news/article/1110182--hospice-care-out-of-reach-for-dying-teen



Barry R. Ashpole

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

U.S.A.

Hospice: Care, not profit

CALIFORNIA | *The Enterprise* (Davis) – 12 January 2012 – "Apparently, the marketplace has joined hands with Death itself to defraud the taxpayer and cheat the truly terminally ill." So wrote Thomas P. Lowry[1] in response to a *Washington Post* ... article, 'The big payoff of pushing patients into hospice.'[2] This is just one of a rapidly accumulating number of studies and news articles investigating the explosive growth of for-profit hospices in the U.S. Lowry's response is understandable, particularly when you consider the origins of the hospice movement as non-profit agencies focusing on a mission versus the current growth of for-profit hospices whose focus is, apparently, a business plan. How did we get to this point? The simple answer is that Medicare pays the majority of hospice bills, with reimbursement for most hospice care. Hospice agencies then choose whether to invest their reimbursements into enriched patient services, or into shareholder pockets. Since the mid-1970s, hospices have endeavored to raise awareness about their compassionate services for those facing the end of life. And these non-profit originators of the movement in the U.S. have been successful.http://www.davisenterprise.com/opinion/opinion-columns/hospice-care-not-profit/

Extract from *The Enterprise* article

Because of the intimate nature of hospice care and its delivery by compassionate clinicians whose work is more of a calling than a profession, hospice has established a spiritual sense of purpose and has long enjoyed admiration and respect from the communities it serves.

1. 'Truths and myths about hospice care' (letters to the Editor of the *Washington Post,* undated). http://www.washingtonpost.com/opinions/truths-and-myths-about-hospice-care/2011/12/20/gIQA3BPMEP_story.html

2. 'The big payoff of pushing patients into hospice,' *Washington Post*, 18 December 2011. http://www.pressdisplay.com/pressdisplay/viewer.aspx

From Media Watch dated 9 January 2012:

- FLORIDA | *Palm Beach Post* – 7 January 2012 – **'Hospice for profit: Business of dying is booming.'** Three decades after becoming a Medicare benefit, hospice care has emerged as its fastest-growing cost – and more than one federal investigation is targeting the nation's largest provider. http://www.palmbeachpost.com/money/hospice-for-profit-business-of-dying-is-booming-2087926.html

  N.B. Footnoted are several articles on the topic of for-profit hospice in the U.S. that have been included in past issues of Media Watch.

Media Watch posted on Palliative Care Network-e Website

Palliative Care Network-e (PCN-e) promotes education amongst health care providers in places around the world where the knowledge gap may be wider than the technology gap ... to foster teaching and interaction, and the exchange of ideas, information and materials. http://www.pcn-e.com/community/pg/file/owner/MediaWatch

State first to launch electronic advance directive registry

WEST VIRGINIA PUBLIC BROADCASTING | Online report – 12 January 2012 – West Virginia is about to be the first in the nation to implement a state-wide electronic registry for advance directives. Officials at the West Virginia Center for End of Life Care in Morgantown say the e-Directive Registry project that they have shepherded for 2 years will be online 2 March 2012. This will allow West Virginians' advance directives including Living Wills, medical powers of attorney, Do Not Resuscitate Orders, and Physicians Orders for Scope of Treatment, to be available online and accessible to treating health care providers according to project director Alvin Moss, MD. http://www.wvpubcast.org/newsarticle.aspx?id=23486

Specialist Publications

Of particular interest:

'The need for safeguards in advance care planning' (p.7), published in the *Journal of Internal General Medicine.*

Dying Americans using hospice care remains stable but new report reveals drop in length of service

NATIONAL HOSPICE & PALLIATIVE CARE ORGANIZATION (NHPCO) | Online posting – 11 January 2012 – The NHPCO's annual report[1] on hospice facts and figures released this week shows the number of patients served remains fairly constant at 1.58 million in 2010 (a slight rise from 1.56 million served in 2009). Yet a statistic of concern to hospice and palliative care professionals is the drop in both median and average length of service. The median (50th percentile) length of service in 2010 was 19.7 days, a decrease from 21.1 days in 2009. The average length of service dropped to 67.4 days in 2010 from 69 days in 2009. "What's important to recognize here is that half of hospice patients received care for less than twenty days," said J. Donald Schumacher, NHPCO president and CEO. "With drops in both the median and average length of service, there is concern that hospice providers are not reaching the patients and family caregivers who need hospice support in a timely manner." http://www.prnewswire.com/news-releases/dying-americans-using-hospice-care-remains-stable-but-new-report-reveals-drop-in-length-of-service-137085193.html

1. 'Facts & Figures: Hospice Care in America,' NHPCO, January 2012 (noted in Media Watch dated 9 January 2012). http://www.nhpco.org/files/public/Statistics_Research/2011_Facts_Figures.pdf

International

Hospital may 'withhold treatment'

IRELAND | *Irish Times* – 11 January 2012 – A hospital may withhold life-saving treatment from a child permanently disabled after a near-drowning incident if his condition deteriorates to an extent requiring invasive treatment which doctors advise against, the High Court has ruled. The President of the High Court, Mr Justice Nicholas Kearns, said he believed ventilation of the six-year-old boy in the circumstances of this case would involve undue pain and suffering to him and merely prolong his life with no prospect of improvement. The boy is severely disabled with severe spastic quadriplegic cerebral palsy, blind, incontinent and totally dependent with no prospect of recovery after a near drowning incident which occurred when he was aged almost two. http://www.irishtimes.com/newspaper/breaking/2012/0111/breaking35.html

Specialist Publications

Of particular interest:

'The courts, futility, and the ends of medicine' (p.6), published in the *Journal of the American Medical Association.*

Mourners' health risks

You really can die of a broken heart say scientists

U.K. | *Daily Telegraph* – 9 January 2012 – A "perfect storm" of stress, lack of sleep and forgetting to take regular medication puts mourners at increased risk in the days after losing a loved one. Scientists showed that after a significant person's death, heart attack risks increased to 21 times higher than normal within the first day, and were almost six times higher than normal within the first week.[1] Dr. Murray Mittleman, a preventive cardiologist and epidemiologist at Harvard Medical School in the U.S., said: "Caretakers, healthcare providers, and the bereaved themselves need to recognise they are in a period of heightened risk in the days and weeks after hearing of someone close dying." The study is the first to focus on heart attack risk during the first few days and weeks after someone close died. http://www.telegraph.co.uk/health/healthnews/9002263/You-really-can-die-of-a-broken-heart-say-scientists.html

1. 'Risk of acute myocardial infarction after death of a significant person in one's life: The determinants of MI [myocardial infarction] onset study,' *Circulation*, published online 9 January 2012. http://circ.ahajournals.org/content/early/2012/01/09/CIRCULATIONAHA.111.061770.abstract?sid=6144679d-201b-41a9-8c3e-61d1f687b1c9

Of related interest:

- U.S. | *New York Times* (OpEd) – 13 January 2012 – **'Mourning in a digital age.'** I have found myself in a season of loss. Every few weeks for the last six months, friends in the prime of life have suffered the death of a close family member. These deaths included a mother, a father, a sister, a brother, a spouse and, in one particularly painful case, a teenage child who died on Christmas morning. The convergence of these passings brought home an awkward truth: I had little idea how to respond. http://www.nytimes.com/2012/01/15/fashion/mourning-in-the-age-of-facebook.html

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.hpcconnection.ca/newsletter/inthenews.html

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

U.S.A.

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

Europe

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

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

International

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

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

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

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- IRELAND | *Irish Examiner* (Cork) – 11 January 2012 – **'Proper debate on controversial issue is a matter of life and death.'** Contrary to popular belief, the right to die has been enshrined in Irish case law – but only for those who are physically incapable of voicing their desire to end their own lives. This week's recommendation of the U.K.'s Commission on Assisted Dying, that terminally ill adults should be allowed end their lives with the help of their doctor, has again raised the controversial issue of euthanasia. The Supreme Court has ruled that patients in a permanent vegetative state can be allowed to die following applications being made on their behalf by family members but has drawn a clear line of demarcation between this "natural death" and physician-assisted death. According to our courts, removing the feeding tube from a comatose patient and allowing them to starve to death constitutes a natural death while the autonomous decision of a terminally-ill patient, living in agony, to end their own life at a time of their own choosing cannot be countenanced. http://www.irishexaminer.com/opinion/columnists/colette-browne/proper-debate-on-controversial-issue-is-a-matter-of-life-and-death-179758.html

    1. *The current legal status of assisted dying is inadequate and incoherent...*, Commission on Assisted Dying, January 2012 (noted in Media Watch dated 9 January 2012). http://www.demos.co.uk/files/CoAD_-_web.pdf?1325710486

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

Should I stay or should I go: A study of hospice palliative care volunteer satisfaction and retention

AMERICAN JOURNAL OF HOSPICE & PALLIATIVE MEDICINE | Online article – 12 January 2012 – Forty-one hospice palliative care volunteers ... participated in informal group discussions regarding what aspects of their work provide them with the most (and least) satisfaction; why they continue to volunteer; and, why they might stop. In 5 of the 9 programs, volunteers said that feeling appreciated by the patients/families they support gave them great satisfaction. Boundary issues and/or role ambiguities were among the least satisfying aspects of their work, mentioned by volunteers in 4 programs. Volunteers in all 9 programs mentioned that they continue to volunteer because it makes a difference/helps others/meets a need in other people's lives. Among the reasons given for potentially stopping volunteering were family crisis, burnout, old age, and other commitments. http://ajh.sagepub.com/content/early/2012/01/04/1049909111432622.abstract

From Media Watch dated 14 February 2011:

- *AMERICAN JOURNAL OF HOSPICE & PALLIATIVE MEDICINE* | Online article – 10 February 2011 – **'Boundary issues for hospice palliative care volunteers: When to say "yes" and when to say "no."'** http://ajh.sagepub.com/content/early/2011/02/08/1049909110397926.abstract

Literature review

Medical students talking to hospice patients

THE CLINICAL TEACHER, 2012;9(1):9-13. Medical students have increasing opportunities to learn about palliative care from talking to patients in a hospice. This resource is not fully utilised, in part because of concerns about patient and student welfare. These concerns are not supported by current research findings, including a qualitative interview study of patients and staff. http://onlinelibrary.wiley.com/doi/10.1111/j.1743-498X.2011.00513.x/full

Rural-urban differences in end-of-life nursing home care: Facility and environmental factors

GERONTOLOGIST | Online article – 9 January 2012 – Compared with nursing homes [NHs] located in urban areas, facilities in smaller towns and in isolated rural areas have significantly worse end-of-life [EOL] quality for in-hospital death and hospice use. Whereas the differences in these QMs are statistically significant between facilities located in large versus small towns, they are not statistically significant between facilities located in small towns and isolated rural areas. http://gerontologist.oxfordjournals.org/content/early/2012/01/08/geront.gnr143.abstract

The courts, futility, and the ends of medicine

JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, 2012;307(2):151-152. On 13 August 2010, the Appellate Division of the Superior Court of New Jersey declined to rule in the matter of *Betancourt v Trinitas Hospital*, a case that raised questions about the limits of medicine in patients with advanced illness. In declining to rule, the judges wrote that resolving such issues in "the context of overheated rhetoric in the battlefield of active litigation" would not positively contribute to the policy debate around medical futility. These comments raise important questions about whether there is a role for the courts in helping to shape the boundaries of medical practice near the end of life. One view is that courts should not provide guidance on medical futility disputes. Texas has formalized this belief into law. The Texas Advance Directives Act bars substantive judicial review when intractable conflict arises between clinicians and patients or their surrogate decision makers. http://jama.ama-assn.org/content/307/2/151.extract

From Media Watch dated 23 August 2010:

- NEW JERSEY | *Star-Ledger* (OpEd) – 17 August 2010 – **'New Jersey court rightly urges legislature to act on end-of-life issues.'** The case of Ruben Betancourt will not set a legal precedent on who has final say on whether a hospital can discontinue life-sustaining medical treatment over a family's objections. A state appeals court has ruled the case moot due to the patient's death. http://blog.nj.com/njv_editorial_page/2010/08/nj_court_rightly_urges_legisla.html

Literature review

Prognostic indices for older adults

JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, 2012;307(2):182-192. The authors reviewed 21,593 titles to identify 16 indices that predict risk of mortality from 6 months to 5 years for older adults in a variety of clinical settings: the community, nursing home, and hospital. They identified several indices for predicting overall mortality in different patient groups; future studies need to independently test their accuracy in heterogeneous populations and their ability to improve clinical outcomes before their widespread use can be recommended. http://jama.ama-assn.org/content/307/2/182.abstract

From Media Watch dated 2 January 2012:

- *NEW YORK TIMES* | Online article – 27 December 2011 – **'The unspoken diagnosis: Old age.'** In a recent article[1] ... [researchers] suggested offering to discuss "overall prognosis," doctor-speak for probable life expectancy and the likelihood of death, with patients who don't have terminal illnesses. The researchers favor broaching the subject with anyone who has a life expectancy of less than 10 years or has reached age 85. http://newoldage.blogs.nytimes.com/2011/12/29/the-unspoken-diagnosis-old-age/

    1. 'Discussing overall prognosis with the very elderly,' *New England Journal of Medicine*, 2011;365(26): 2149-2151. http://www.nejm.org/doi/full/10.1056/NEJMp1109990

The need for safeguards in advance care planning

JOURNAL OF INTERNAL GENERAL MEDICINE | Online article – 12 January 2012 – The recent uproar about Medicare "death panels" draws attention to public and professional concerns that advance care planning might restrict access to desired life-sustaining care. The primary goal of advance care planning is to promote the autonomy of a decisionally incapacitated patient when choices about life-sustaining treatments are encountered, but the safety of this procedure has not received deserved scrutiny. Patients often do not understand their decisions or they may change their mind without changing their advance care directives. Likewise, concordance between patients' wishes and the understanding of the physicians and surrogate decision makers who need to represent these wishes is disappointingly poor. A few recent reports show encouraging outcomes from advance care planning, but most studies indicate that the procedure is ineffective in protecting patients from unwanted treatments and may even undermine autonomy by leading to choices that do not reflect patient values, goals, and preferences. Safeguards for advance care planning should be put in place, such as encouraging physicians to err on the side of preserving life when advance care directives are unclear, requiring a trained advisor to review non-emergent patient choices to limit life-sustaining treatment, training of clinicians in conducting such conversations, and structured discussion formats that first address values and goals rather than particular life-sustaining procedures. http://www.ncbi.nlm.nih.gov/pubmed/22237664

Of related interest:

- *AUSTRALIAN JOURNAL OF PRIMARY HEALTH* | Online article – 10 January 2012 – **'It's just too hard! Australian health care practitioner perspectives on barriers to advance care planning.'** Findings suggest multiple barriers exist, from practitioners' perspectives, which can be divided into three major categories, namely: patient-centred, practitioner-centred and system-centred barriers. http://www.publish.csiro.au/?paper=PY11070

- *JOURNAL OF PALLIATIVE MEDICINE* | Online article – 12 January 2012 – **'Advance directive discussions: Lost in translation or lost opportunities?'** Previous studies have shown that minority populations have low rates of documented advance directives and express preferences for more life-prolonging interventions at the end of life. We sought to determine the impact of Latino ethnicity on patients' self-report of having an advance directive discussion and having a completed advance directive in the medical record at an index hospitalization for serious medical illness. http://www.liebertonline.com/doi/abs/10.1089/jpm.2011.0328

- *JOURNAL OF PALLIATIVE MEDICINE* | Online article – 10 January 2012 – **'The POLST program: A retrospective review of the demographics of use and outcomes in one community where advance directives are prevalent.'** http://www.liebertonline.com/doi/abs/10.1089/jpm.2011.0178

From Media Watch dated 9 January 2012:

- OREGON | *The Oregonian* – 3 January 2012 – **'An Oregon study points to better end-of-life care planning.'** Report on a study published in the *Journal of the American Medical Association*. http://www.oregonlive.com/health/index.ssf/2012/01/an_oregon_study_points_to_bett.html

Spirituality and end of life issues: A review

JOURNAL OF RELIGION, SPIRITUALITY & AGING, 2012;24(1-2):120-130. This article explores theories related to the development of spirituality and its relationship to end of life circumstances. It also considers the source of spiritual well-being, and its place in the context of the third (older, but still living independently) and fourth (frail elderly, needing care support) stages of life; plus how a sense of spirituality affects and hopefully enhances the end of life experience, increasing resilience to adverse events that might otherwise hasten death. It concludes that spiritual as well as religious issues are important for people facing terminal illness and death. http://www.tandfonline.com/doi/abs/10.1080/15528030.2012.633054

Cont.

Of related interest:

- *JOURNAL OF PALLIATIVE MEDICINE* | Online article – 13 January 2012 – **'Discussing religion and spirituality is an advanced communication skill: An exploratory structural equation model of physician trainee self-ratings.'** This study suggests that discussion of religious and spiritual issues is a communication skill that trainees consider more advanced than other commonly taught communication skills... http://www.liebertonline.com/doi/abs/10.1089/jpm.2011.0168

Advice from National Institute for Health & Clinical Excellence aims to improve commissioning for end of life care

[U.K.] NATIONAL INSTITUTE FOR HEALTH & CLINICAL EXCELLENCE (NICE) | Online posting – 11 January 2012 – The guide aims to support local implementation of the Department of Health End of Life Care Strategy and the NICE Quality Standard for end of life care for adults. The guide includes an end of life care commissioning and benchmarking tool to help users determine the level of service that might be needed locally and to help cost and identify potential savings associated with commissioning end of life care services. The ... tool demonstrates that in England a 10% reduction in the number of hospital admissions ending in death could potentially result in a saving of £52million. These savings can be invested in alternative, community-based end of life care services. http://www.nice.org.uk/newsroom/pressreleases/EndOfLifeCareCommissioning.jsp

The landscape of blogging in palliative care

PALLIATIVE MEDICINE | Online report – 4 January 2012 – The authors present the case of a 30-year-old patient with pontine glioblastoma multiforme ... [and] ... the patient's use of social media as a medium of expression. This popular form of communication raises important clinical, ethical and social issues relating to confidentiality and the nature of the physician–patient relationship in a unique context. http://pmj.sagepub.com/content/early/2012/01/03/0269216311432900.abstract

Assisted (or facilitated) death

Representative sample of recent articles, etc:

- *JOURNAL OF MEDICAL ETHICS* | Online article – 12 January 2012 – **'Older peoples' attitudes towards euthanasia and an end-of-life pill in The Netherlands: 2001–2009.'** An increasing proportion of older people reported that they could imagine desiring euthanasia or an end-of-life pill. This may imply an increased interest in deciding about your own life and stresses the importance to take older peoples' wishes seriously. http://jme.bmj.com/content/early/2012/01/12/medethics-2011-100066.abstract

- *JOURNAL OF MEDICAL ETHICS* | Online article – 10 January 2012 – **'Are general practitioners prepared to end life on request in a country where euthanasia is legalised?'** In 2002, Belgium set a legal framework for euthanasia, whereby granting and performing euthanasia is entrusted entirely to physicians, and ... in the context of a trusted patient-physician relationship. Euthanasia is, however, rarely practiced, so the average physician will not attain routine in this matter. Although GPs [i.e., study participants] can understand a patient's request for euthanasia, their own willingness to perform it is limited, based on their assumption that legal euthanasia equates to an injection that ends life abruptly. http://jme.bmj.com/content/early/2012/01/10/medethics-2011-100048.abstract

- *THE PERMANENTE JOURNAL*, 2011;14(4):79-84. **'Physician-assisted suicide and euthanasia: Can you even imagine teaching medical students how to end their patients' lives?'** The peer-reviewed literature includes numerous well-informed opinions on the topics of euthanasia and physician-assisted suicide. However, there is a paucity of commentary on the interface of these issues with medical education. This is surprising, given the universal assumption that in the event of the legalization of euthanasia, the individuals on whom society expects to confer the primary responsibility for carrying out these acts are members of the medical profession. Medical students and residents would inevitably and necessarily be implicated. http://www.thepermanentejournal.org/files/Fall2011/Suicide.pdf

Worth Repeating

The economics of dying

The illusion of cost savings at the end of life

NEW ENGLAND JOURNAL OF MEDICINE, 1994;330(8):540-544. None of the individual studies of cost savings at the end of life associated with advance directives, hospice care, or the elimination of futile care are definitive. Yet they all point in the same direction: cost savings due to changes in practice at the end of life are not likely to be substantial. The amount that might be saved by reducing the use of aggressive life-sustaining interventions for dying patients is at most 3.3% of total national health care expenditures. In 1993, with $900 billion going to health care, this savings would amount to $29.7 billion. It is important to note that achieving such savings would not restrain the rate of growth in health care spending over time. Instead, this amount represents a fraction of the increase due to inflation in health care costs and less than the $50 billion to $90 billion needed to cover the uninsured population. The unlikeliness of substantial savings in health care costs does not mean, however, that there are no good reasons to use advance directives, fund hospice care, and employ less aggressive life-sustaining treatments for dying patients. Respecting patients' wishes, reducing pain and suffering, and providing compassionate and dignified care at the end of life have overwhelming merit. But the hope of cutting the amount of money spent on life-sustaining interventions for the dying in order to reduce overall health care costs is probably vain. Our alternatives for achieving substantial savings seem limited to major changes in the financing and delivery of health care, difficult choices in the allocation of services, or both. Whatever we choose, we must stop deluding ourselves that advance directives and less aggressive care at the end of life will solve the financial problems of our health care system. http://www.nejm.org/doi/full/10.1056/NEJM199402243300806

Media Watch: Editorial Practice

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

Distribution

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

Links to Sources

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.

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