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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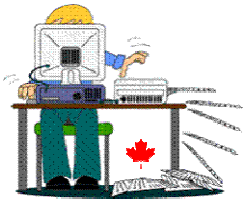


Compiled & Annotated by Barry R. Ashpole

Prison hospice: Scroll down to Specialist Publications and 'Educating prison staff in the principles of end-of-life care' (p.6), published in the *International Journal of Palliative Nursing.*

Canada

'Legally dead' may still be alive: Warning over new organ-donor guidelines

THE NATIONAL POST | Online report – 28 August 2012 – Months into the latest national campaign to recruit ... organ donors, a legal scholar is arguing that new guidelines for declaring people brain dead and eligible for organ harvesting likely violate the Charter of Rights & Freedoms. The non-binding rules developed by a government-appointed expert panel in 2004 – designed to expand the pool of transplant donors – make it more likely that people are being declared dead when they are still alive, and were drafted with no public input, complains Jacqueline Shaw in the *McGill Journal of Law & Health*.[1] Given that the panel's "inappropriately one-sided" guidelines emerged from a government transplant initiative, they are subject to the Charter, and appear to violate the right to life, liberty and security of the person, she argues. http://news.nationalpost.com/2012/08/28/canadas-new-organ-donor-rules-likely-violate-the-charter-legal-expert/

1. 'A death-defying leap: Section 7 Charter implications of the Canadian Council for Donation & Transplantation's guidelines for the neurological determination of death,' *McGill Journal of Law & Health*, 2012:6(1):41-136. http://mjlh.mcgill.ca/pdfs/vol6-1/MJLH%20Vol.%206,%20No.%201%20-%20Shaw.pdf

Noted in Media Watch, 27 August 2012:

- *CLINICAL ETHICS*, 2012;7(3):128-132. **'Brain death: Justifications and critiques.'** The authors review the historical development of brain death, and then evaluate the various attempts to justify the claim that patients who are diagnosed as brain dead can be considered dead for all legal and social purposes, and especially with regard to procuring their vital organs for transplantation. http://ce.rsmjournals.com/content/7/3/128.abstract

Specialist Publications

Of particular interest:

'Canadian provincial, territorial, and federal government aging policies: A systematic review' (p.5), published in *Advances in Aging Research*.

'Why withdrawing life-sustaining treatment should not require "Rasouli consent."' (p.7), published in the *McGill Journal of Law & Health*.

Funding issues in end-of-life care

Hospices merge in struggle to survive

ONTARIO | CBC News (Ottawa) – 27 August 2012 – Two Ottawa hospice services will merge in the hope of being able to get more stable funding, and expand to serve the growing number of aging people who need help. For years, Friends of Hospice in the city's west end, and the May Court hospice in Ottawa south, have struggled to survive. They are joining forces to become Ottawa Hospice Services. "You can imagine, with 35% of your funding coming from the government, and … having to raise the lion's share of the funding, you're living month to month. It's very precarious," said Peggy Taillon ... director for Ottawa Hospice Services. http://www.cbc.ca/news/canada/ottawa/story/2012/08/27/ottawa-hospices-merge.html

Noted in Media Watch, 2 July 2012:

- *Ottawa Citizen* – 29 June 2012 – **'Residential hospice avoids shutdown.'** http://ca.news.yahoo.com/residential-hospice-avoids-shutdown-102520677.html

Corrections & Clarifications

Justice Minister & Attorney General Rob Nicholson confirmed 17 August 2012 that the Federal government will appeal the 15 June British Columbia Supreme Court Carter decision that struck down Canada's laws against euthanasia and assisted suicide. In the recent *Lee Carter and Hollis Johnson* et al. *v. Attorney General of Canada* decision, B.C. Supreme Court Justice Lynn Smith said the laws against assisted suicide and euthanasia violated the equality rights of those who could not commit suicide without help, since suicide is legal. She also argued the Criminal Code provisions violated disabled peoples' Section 7 rights of life, liberty and security of the person. http://www.justice.gc.ca/eng/news-nouv/nr-cp/2012/doc_32783.html

Noted in Media Watch, 16 July 2011:

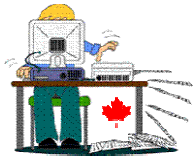
THE CATHOLIC REGISTER | Online report – 13 July 2012 – **'Federal government appeals B.C. decision striking down euthanasia laws.'** http://www.catholicregister.org/news/canada/item/14880-federal-government-appeals-bc-decision-striking-down-euthanasia-laws

U.S.A.

Workplace discriminates against elder caregivers

MASSACHUSETTS | *Enterprise News* (Brockton) – 30 August 2012 – A new report from the American Association for Retired Persons [AARP] says that caregivers of older adults are facing increasing discrimination in the workplace.[1] The report ... also highlights the limited legal protections for working caregivers. http://www.enterprisenews.com/blogs/goodage/x282947166/AARP-Workplace-discriminates-against-elder-caregivers

1. 'Protecting Family Caregivers from Employment Discrimination,' AARP, Public Policy Institute, August 2012. http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/protecting-caregivers-employment-discrimination-insight-AARP-ppi-ltc.pdf



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

Palliative care in hospitals continues rapid growth trend

CENTER TO ADVANCE PALLIATIVE CARE | Online report – 27 August 2012 – Palliative care in U.S. hospitals has increased for the 11th consecutive year, according to a new analysis [see sidebar right]. The number of hospitals with a palliative care team increased from 658 (24.5%) to 1,635 (65.7%) – a steady 148.5% increase from 2000-2010. The steady growth of palliative care has been primarily in response to the increasing number and needs of Americans living with serious and chronic illness. Also contributing to the rise of palliative care are the overwhelming caregiving burdens faced by patients' families. "Palliative care teams are transforming the care of serious illness in this country because they address a fragmented healthcare system and put control and choice back in the hands of the patient and family," said Diane E. Meier, MD, director of the Center to Advance Palliative Care. "Hospitals today recognize that palliative care is the key to delivering better quality and better coordinated care to our sickest and most vulnerable patients." http://www.capc.org/news-and-events/releases/08-27-12

Key Findings

87.9% of hospitals with 300 or more beds have a team compared to 56.5% of hospitals with 50-299 beds

The Northeast has the greatest growth and the highest prevalence (75.8% of hospitals in 2012 compared to 73% in 2011)

The South shows some growth, but still has the lowest prevalence (52.7% of hospitals in 2012 compared to 51% in 2011)

N.B. 'A State-by-State Report Card on Access to Palliative Care in Our Nation's Hospitals,' Center to Advance Palliative Care, 2011. http://www.capc.org/reportcard/

World hospice & palliative care day

October 13 2012

International

Palliative care in India

Relief for terminally ill at doorstep

INDIAN (TAMIL NADU) | *The Hindu Times* – 3 September 2012 – A first time initiative by National Rural Health Mission and Tamil Nadu State Health Society with support from non-government organiozations envisages alleviating pain of persons suffering from incurable or life-threatening illness in rural areas, by providing relief and support at their doorstep. The first leg of the project that provides palliative home care has been initiated in Andanallur block in Tiruchi district. The community based rural relief and palliative care is being taken up as a pilot project in four districts in Tamil Nadu – Tiruchi, Nagapattinam, Tiruvallur and Kanchipuram. The project in Andanallur block covers close to one lakh people spread over 19 villages through three primary health care centres (PHC) in Kulumani, Perugamani and Andanallur. The project in Tiruchi is executed by the Sudharsana pain relief and palliative care services.
http://www.thehindu.com/news/cities/Tiruchirapalli/article3853985.ece

Of related interest:

- INDIA | *Business Standard* – 24 August 2012 – **'Supreme Court ultimatum to states on pain killer for cancer patients.'** The Supreme Court warned the states that their Chief Secretaries would have to appear before it if they failed to comply with its directives to ensure easily availability of "morphine" preparations, a pain killer for terminally ill cancer patients. Because of its possible misuse by drug addicts, the availability of morphine preparations is greatly restricted in India and the sale is governed by the Narcotics Drugs & Psychotropic Substances Act, 1985. http://www.business-standard.com/generalnews/news/sc-ultimatum-to-statespain-killer-for-cancer-patients/47812/

Cont.

Noted in Media Watch, 23 July 2012:

- INDIA | Press Trust of India (New Delhi) – 20 July 2012 – **'Supreme Court directs governments to respond on palliative care policy.'** http://www.business-standard.com/generalnews/news/sc-directs-govts-to-respondpalliative-care-policy/34709/

N.B. India was rated 40th (of forty countries surveyed) 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

Palliative care in Africa

A palliative care meeting commits to conquer pain

ALLAFRICA.COM | Online report – 25 August 2012 – A two-day progress review meeting with a focus on improving pain management in public hospitals in Africa, organized through partnership between the African Palliative Care Association and the [Rwanda] Ministry of Health, came to a close in Kigali. Access to pain medication is difficult for many people. This is what the project 'Improving Pain Management' seeks to address in the countries it operates from – Kenya, Malawi, Rwanda, Swaziland, Uganda,[1] Gambia and Zambia – by increasing health professional capacity in pain management. http://allafrica.com/stories/201208260352.html

1. Uganda was rated 39th (of forty countries surveyed) 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. South Africa, the only other African country included in the survey, was rated 30th. http://graphics.eiu.com/upload/QOD_main_final_edition_Jul12_toprint.pdf

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- AUSTRALIA (AUSTRALIAN CAPITAL TERRITORY) | *Canberra Times* – 3 September 2012 – **'Corbell rejects assisted death move.'** The ACT government has knocked back a bid for an inquiry into whether legal prohibitions on assisted suicide contradict the Territory's Human Rights Act. http://www.canberratimes.com.au/act-news/corbell-rejects-assisted-death-move-20120902-258ry.html

- NEW ZEALAND | *Bay of Plenty Times* (Tauranga) – 29 August 2012 – **'Skill levels better in palliative care.'** Legalising euthanasia could cut short people's lives who may be unaware of advances in palliative care, a Tauranga doctor warns. Waipuna Hospice chief executive Dr. Richard Thurlow told the *Bay of Plenty Times* patients sometimes wished they had the option of physician-assisted suicide. But that was before they realised the options available with palliative care. http://www.bayofplentytimes.co.nz/news/skill-levels-better-in-palliative-care/1523201/

- THE NETHERLANDS | *Dutch News* – 28 August 2012 – **'Doctors and chemists agree joint euthanasia guidelines.'** Doctors and dispensing chemists have agreed a joint guideline on euthanasia. The KNMG [Royal Dutch Medical Association] and the KNMP [Royal Dutch Society of Pharmacists] guidelines replace those drawn up five years ago by dispensing chemists and underline the cooperation between the two sets of medical professionals on the subject. The guidelines not only contain technical information but also explain for the first time why a certain method has been chosen. http://www.dutchnews.nl/news/archives/2012/08/doctors_and_chemists_agree_joi.php

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

Systematic review

Canadian provincial, territorial, and federal government aging policies:

ADVANCES IN AGING RESEARCH, 2012; 1(2):38-46. In most countries, population aging is becoming more evident now that the first members of the large baby boom cohort have reached 65 years of age. As an accelerating increase in the number of older persons and the proportion of the public aged 65 and older will now occur, planning for population aging has become ever more crucially important. A systematic review of Canadian provincial, territorial, and federal government documents was undertaken to search for the existence of population aging policies, and to determine the aims and other content of the most current policy documents. Documents were identified in all but two jurisdictions of Canada (two northern territories). Document developers, and the aims and content of the 14 reviewed documents varied considerably. Some similarities were identified, however, including some common stated purposes for these documents... http://www.scirp.org/journal/aar/

In amenable mortality … progress in the U.S. lags that of three European countries

HEALTH AFFAIRS, 2012;31(8):2114-2122. The authors examined trends and patterns of amenable mortality – deaths that should not occur in the presence of timely and effective health care – in the U.S. compared to those in France, Germany, and the U.K. between 1999 and 2007. Americans under age sixty-five during this period had elevated rates of amenable mortality compared to their peers in Europe. For Americans over age sixty-five, declines in amenable mortality slowed relative to their peers in Europe. Overall, amenable mortality rates among men from 1999 to 2007 fell by only 18.5% in the U.S. compared to 36.9& in the U.K. Among women, rates fell by 17.5% and 31.9%, respectively. Although U.S. men and women had the lowest mortality from treatable cancers among the four countries, deaths from circulatory conditions … were the main reason amenable death rates remained relatively high in the U.S. These findings strengthen the case for reforms that will enable all Americans to receive timely and effective health care. http://content.healthaffairs.org/content/early/2012/08/20/hlthaff.2011.0851.full.pdf+html

National Quality Forum draws on American Medical Association toolkit to gauge patient-friendly communication

AMERICAN MEDICAL NEWS | Online report – 28 August 2012 – The National Quality Forum endorsed a dozen measures of physician group and hospital performance in improving communication with patients who have poor health literacy or limited English proficiency. Seven of the metrics were developed by the American Medical Association's Ethical Force Program and are used as part of its Communication Climate Assessment Toolkit. The toolkit ... features surveys to be used with patients, executive leaders, physicians, nurses and non-clinical staff. Patients grade their experiences in understanding elements such as signage, forms, receptions and their communications with doctors and other health professionals. The survey of staff asks for their assessment of how well the health system or clinic does in providing interpreter services and training. http://www.ama-assn.org/amednews/2012/08/27/prsc0828.htm

Early identification of palliative care patients in general practice: Development of RADboud indicators for PAlliative Care Needs (RADPAC)

BRITISH JOURNAL OF GENERAL PRACTICE, 2012;62(602):e625-e631.The RADboud indicators for PAlliative Care Needs (RADPAC) is the first tool developed from a combination of scientific evidence and practice experience that can help GPs in the identification of patients with congestive heart failure, chronic obstructive pulmonary disease], or cancer, in need of palliative care. http://www.ingentaconnect.com/content/rcgp/bjgp/2012/00000062/00000602/art00033

How care home staff can gain the end-of-life care skills they need

COMMUNITY CARE (U.K.) | Online report – 29 August 2012 – As a survey shows, families rate end-of-life care in hospices as superior to that in care homes. The first national survey of bereaved people for the Office of National Statistics found that care homes provide better end-of-life care than hospitals, but hospices still came out best.[1] Nearly half the people surveyed said end-of-life care in care homes was excellent. Encouraging, but there is still much room for improvement, not least in training. http://www.communitycare.co.uk/Articles/29/08/2012/118469/how-care-home-staff-can-gain-the-end-of-life-care-skills-they-need.htm

1. 'National Bereavement Survey, 2011,' Office for National Statistics, July 2012 (noted in Media Watch, 9 July 2012). Key Findings & Summary: http://www.ons.gov.uk/ons/dcp171778_269914.pdf

Educating prison staff in the principles of end-of-life care

INTERNATIONAL JOURNAL OF PALLIATIVE NURSING, 2012;18(8):391-395. This paper reports a project that aimed to provide an education programme to both prison nurses and officers to support their understanding of EoL [end-of-life] care and how it may be provided within the confines of the prison environment. On offer was a mixed-methodology education programme incorporating a pre-existing university module not specifically tailored to the prison setting. The mentorship of a clinical nurse specialist already known to the prison staff proved crucial to its successful implementation. Both the nurses and the prison officers reported having a deeper understanding of the issues and more confidence in providing EoL care to prisoners who are patients. Further delivery of the programme to a wider group is planned, and similar initiatives nationally may provide a flexible, affordable approach to EoL care for those ending their days in prison. http://www.ijpn.co.uk/cgi-bin/go.pl/library/article.html?uid=93648;article=IJPN_18_8_391_395

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.9.

Community palliative care

One community's experience providing outpatient palliative care

JOURNAL OF HOSPICE & PALLIATIVE NURSING | Published online – 28 August 2012 – This article explores the innovative approach that one community devised to provide palliative care services to patients and their families outside an acute facility. Referrals, staffing, care setting, and care processes that were developed when the patient and family are placed at the center of the care plan are discussed. The article describes this non-hospital-funded, interdisciplinary, predominantly home care model of delivery of palliative care services. http://journals.lww.com/jhpn/Abstract/publishahead/Community_Palliative_Care__One_Community_s.99987.aspx

Hospital palliative care

Nurse executives' perceptions of end-of-life care provided in hospitals

JOURNAL OF PAIN & SYMPTOM MANAGEMENT | Published online – 27 August 2012 – The findings of this study highlight the need for interventions that focus on improving communication at the bedside and in transitions of care, enhancing educational interventions, and developing patient-centered care systems, which translate into a higher quality end-of-life experience for patients and their family members. Nurse executives are currently an underused resource in end-of-life care but are poised to be able to champion innovative models and a culture of change that integrates high-value care for patients with serious and chronic illnesses. http://www.jpsmjournal.com/article/S0885-3924(12)00267-9/abstract

Cont.

Of related interest:

- *JOURNAL OF PALLIATIVE MEDICINE* | Published online – 27 August 2012 – **'Conceptual models for integrating palliative care at cancer centers.'** Despite the growing evidence to support early palliative care involvement, referral to palliative care remains heterogeneous and delayed. To address this issue, we will discuss various conceptual models and practical recommendations to optimize palliative care access. http://online.liebertpub.com/doi/abs/10.1089/jpm.2012.0147

- *SUPPORTIVE CARE IN CANCER* | Published online – 31 August 2012 – **'Concepts and definitions for "supportive care," "best supportive care," "palliative care," and "hospice care" in the published literature, dictionaries, and textbooks.'** Commonly used terms such as "supportive care," "best supportive care," "palliative care," and "hospice care" were rarely and inconsistently defined in the palliative oncology literature. http://www.ncbi.nlm.nih.gov/pubmed/22936493

Why withdrawing life-sustaining treatment should not require "Rasouli consent"

MCGILL JOURNAL OF LAW & HEALTH, 2012;6(2):54-104. Technology allows us to keep patients alive despite very poor prognoses and quality of life. We must therefore confront questions of when medical intervention should cease, and who should be allowed to make that decision. Until recently it was unclear whether doctors or patients have the ultimate say in whether to withhold or withdraw life-sustaining treatment. In *Rasouli v Sunnybrook Health Sciences Centre*, the Ontario Court of Appeal held that doctors may only withdraw certain life-sustaining treatment with the consent of patients or their substitute decision makers. It reasoned that withdrawing certain treatment is "treatment" for which consent is required under Ontario's Health Care Consent Act. This effectively gives the patient an entitlement to continued life support. The author argues that the law of informed consent should not dictate who may decide whether treatment is withheld. http://mjlh.mcgill.ca/pdfs/vol6-2/MJLH%20Vol.%206%20No.%202%20-%20Young.pdf

Noted in Media Watch 11 April 2011:

- *CANADIAN MEDICAL ASSOCIATION JOURNAL* | Online article – 8 April 2011 – **'Court rules that withdrawal of life support is a plan of treatment requiring consent.'** Ontario doctors cannot withdraw life-sustaining treatment from patients without their consent or that of their substitute decision-makers... http://www.cmaj.ca/earlyreleases/8april11_court-rules-that-withdrawal-of-life-support-is-a-plan-of-treatment-requiring-consent.dtl

Paediatric palliative care

Lessons for adult practice

PALLIATIVE MEDICINE, 2012;26(6):777-779. Although adult and paediatric palliative care share the same fundamental principles ... there are significant differences in needs and practice. Whereas adult palliative care has traditionally focused on patients with cancer, paediatric services look after children with a diverse range of life-limiting conditions, most commonly genetic/congenital diseases (41%) and neuromuscular conditions (39%). Disease trajectories tend to be long and particularly unpredictable. Emergencies, often respiratory crises, occur relatively frequently and usually respond to active intervention. Prescribing for children is influenced by many factors, including body weight and low acceptability of the subcutaneous route of drug administration. Families carry a particularly heavy burden, as long-term primary care givers. Related psychosocial morbidity, such as depression, divorce and unemployment, is prevalent. Children, unlike adults, tend to continue to develop physically and cognitively throughout their illness, and families expect flexible, responsive support at the location of the child, whether at home, school or hospital. Paediatric hospice admission usually occurs for planned respite care or for symptom management, at any time from diagnosis to death. The dual approach, combining palliation with disease modification, cuts across the conventional transition from active treatment to palliative care. http://pmj.sagepub.com/content/26/6/777.full.pdf+html

Cont.

Of related interest:

- *JOURNAL OF PAIN & SYMPTOM MANAGEMENT* | Published online – 27 August 2012 – **'Putting on a happy face: Emotional expression in parents of children with serious illness.'** The inverse relationship between parents' positive emotional expression and their self-reported positive affect should remind both researchers and clinicians to be cognizant of the possibilities for emotional miscues, and consequent miscommunication, in the pediatric care setting. http://www.jpsmjournal.com/article/S0885-3924(12)00294-1/abstract

- *JOURNAL OF PALLIATIVE MEDICINE* | Published online – 28 August 2012 – **'The wrap-up: A unique forum to support pediatric residents when faced with the death of a child.'** The Wrap-up, a unique forum for debriefing after a pediatric death, was well-received by residents and assisted them with processing, understanding, and resolving their experience regarding the pediatric death. http://online.liebertpub.com/doi/abs/10.1089/jpm.2012.0253

- UCLA CENTRE FOR HEALTH POLICY RESEARCH | Online report - Accessed 31 August 2012 – **'Better outcomes, lower costs: Palliative care program reduces stress, costs of care for children with life-threatening conditions.'** This policy brief examines the Partners for Children program – California's public pediatric community-based palliative care benefit to children living with life-threatening conditions and their families. Preliminary analysis of administrative and survey data indicates that participation in the program improves quality of life for the child and family. In addition, participation resulted in a one-third reduction in the average number of days spent in the hospital. Shifting care from a hospital setting to in-home community-based care resulted in cost savings of $1,677 per child per month on average – an 11% decrease in spending on a traditionally high-cost population.http://www.healthpolicy.ucla.edu/pubs/Publication.aspx?pubID=569#download

Media Watch Online

Canada

ONTARIO | Hamilton Niagara Haldimand Brant Hospice Palliative Care Network: http://www.hnhbhpc.net/CurrentNewsandEvents/tabid/88/Default.aspx (Click on 'Current Issue' under 'Media Watch')

ONTARIO | HPC Consultation Services (Waterloo Region/Wellington County): http://www.hpcconnection.ca/newsletter/inthenews.html

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

ONTARIO | Palliative Care Consultation Program (Oakville): http://www.palliativecareconsultation.ca/?q=mediawatch

U.S.A.

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

Europe

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

U.K. | Omega, the National Association for End of Life Care: http://www.omega.uk.net/media-watch-hospice-palliative-care-and-end-of-life-news-n-470.htm?PHPSESSID=b623758904ba11300ff6522fd7fb9f0c

Asia

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

International

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

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

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

Assisted (or facilitated) death

Representative sample of recent articles, etc:

- *ANNALES FRANÇAISES D'ANESTHÉSIE ET DE RÉANIMATION* | French language article published online – 20 August 2012 – **'Euthanasia, assisted suicide and palliative care: A review by the Ethics Committee of the French Society of Anaesthesia & Intensive Care.'** French law addresses most of the end of life issues an intensive care physician might encounter. It is credited for imposing palliative care when therapies have become senseless and are withdrawn. There is a great need for more education and stronger incentives for early action in this area. On the rare occasions when euthanasia/assisted suicide is requested, either by the patient or their loved-ones, it often results from a failure to consider that treatments have become senseless and conflict with patient's best interest. http://www.sciencedirect.com/science/article/pii/S0750765812003139

Worth Repeating

Understandings of death and dying for people of Chinese origin

DEATH STUDIES, 2009;33(2):153-174. This article introduces the primary beliefs about ancestor worship, Taoism, Confucianism, Buddhism and traditional Chinese medicine that have influenced Chinese people for thousands of years, particularly in relation to death and dying. These cultures and traditions remain important for Chinese people wherever they live. Chinese people have integrated these philosophies and religions to form the basis of their culture and traditions. Although they agree that death is a natural part of the life span, a unique belief about death and dying has emerged among the Chinese from this integration. From this, the people find a significant definition of death and dying. http://www.tandfonline.com/doi/abs/10.1080/07481180802440431

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.

Barry R. Ashpole **'phone: 905.563.0044**
Beamsville, Ontario CANADA **e-mail: barryashpole@bellnet.ca**