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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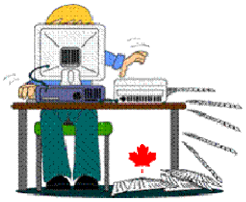


Compiled & Annotated by Barry R. Ashpole

Truth-telling: Scroll down to Specialist Publications and 'Lay people's and health professionals' views about breaking bad news to children' (p.4), published in *Child: Care, Health & Development.*

Canada

It costs a lot to die in Nova Scotia, survey says

NOVA SCOTIA | *Chronicle-Herald* (Halifax) – 5 September 2012 – Nova Scotia may not be the most expensive place to live in this country. According to a new national survey, it's dying here that will kill your pocketbook. The average cost of a traditional funeral in Nova Scotia is $10,495, according to a survey conducted in April by Everest... that makes this province the steepest place for a traditional funeral in the country. What's more, of the nine Canadian centres surveyed by Everest, Haligonians [residents of Halifax] lay out the most dough in the land – an average of $11,152. Adam Tipert, of the Funeral Service Association of Nova Scotia, said he thinks the figures are "not truly accurate" and possibly "inflated." http://thechronicleherald.ca/business/133001-it-costs-a-lot-to-die-in-nova-scotia-survey-says

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- *CANADIAN LAWYER* | Online OpEd – September 2012 – **'Times have changed.'** Assisted suicide – the issue that rips everyone's heart out – is headed back to the Supreme Court of Canada. What will the court do this time? http://www.canadianlawyermag.com/4309/times-have-changed.html

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

U.S.A.

Health-care, hospice fraud costs us all

FLORIDA | *Orlando Sentinel* (OpEd) – 8 September 2012 – Last year, I penned a column about allegations of overbilling Medicare at Hospice of the Comforter. I wrote that I have long supported Hospice's mission, but that the claims – and some undisputed facts – were so troubling that I hoped the feds turned the place inside out. Now it looks as if they are. Late last week, the U.S. Department of Justice announced that it is investigating. That's good – and not just because of the disturbing details in this case, including allegations of massive amounts of misspent public money, as well as CEO bonuses of $200,000 for keeping patient counts high. But also because the issue of fraud is so much bigger. You see, you've been duped when it comes to waste, fraud and abuse in America's health-care system. Politicians love to rant about it. They often do so when explaining why they're about to cut your benefits. They're right that fraud happens. But the individual scammers they portray as the problem are nothing compared to the systemic white-collar fraud perpetrated by corporations – and, yes, faith-based nonprofits. This is America's dirty little health-care secret. http://articles.orlandosentinel.com/2012-09-08/news/os-scott-maxwell-hospice-adventist-medicare-fraud--20120908_1_medicare-fraud-settlement-adventist-hospitals-health-care-fraud

Specialist Publications

Of related interest:

'Out-of-pocket spending in the last five years of life' (p.6), published in the *Journal of General Internal Medicine.*

Court: You can appeal Medicare decisions about hospice services

CALIFORNIA | *New York Times* – 7 September 2012 – When Emily Back lay dying and in excruciating pain, her hospice made a decision that her husband couldn't accept. Ignoring a doctor's order, the organization said it wouldn't supply Ms. Back, who was 81, with Actiq [fentanyl citrate], a fast-acting, powerful narcotic that a patient sucks on, like a lollipop. That outraged Howard Back, who then bought the medication on his own dime and filed a lawsuit after his wife died. Now a California court decision has resulted in an important clarification, determining that Medicare beneficiaries and their survivors have a right to appeal the denial of services by a hospice provider. http://newoldage.blogs.nytimes.com/2012/09/07/court-affirms-right-to-appeal-medicare-decisions-about-hospice-services/

A world apart, the challenges of long-distance caregiving

CALIFORNIA | *Washington Times* (Washington, DC) – 3 September 2012 – Taking care of a family member's safety and health can be difficult when you live in another city, state or country. In today's mobile society, many families are geographically spread apart, and that can create a constant sense of concern and generate tremendous guilt. The National Institute of Health estimates that seven million Americans are long-distance caregivers, defined as providing caregiving for someone who lives an hour's drive or more away. This can include providing respite care to a spouse or another relative who is the primary in-home caregiver; providing remote financial or medical management support; arranging and supervising in-home care; or being available in case of emergency. The typical long-distance caregiver is a middle-aged working mother with many family responsibilities at home. But happily this is changing as more men become engaged. Some surveys now show men are up to 40% of all caregivers. But whatever your gender, income, age, social circumstances or employment, long-distance caregiving is an enormous challenge. http://communities.washingtontimes.com/neighborhood/lifecycles/2012/sep/3/world-apart-challenges-long-distance-caregiving/

International

Paediatric palliative care

'We're doing medicine in a really inefficient way,' says Royal College of Paediatrics & Child Health leader

U.K. | *The Guardian* – 4 September 2012 – "It is unusually emotionally demanding work," says Dr. Hilary Cass of her role as a consultant in paediatric disability at St. Thomas' hospital in central London. Some of the children she works with have profound disability. Her caseload includes dealing with the patients' and their families' hopes and hunger for information about their child's treatment and chances. Palliative care is also part of Cass's workload. "Sometimes it's about parents making decisions about when they want to carry on pulling out all the stops, by having maximum intervention, and when they want to be less interventionist and say 'quality [of life] is now more important than quantity' for their kid," she explains. Advising parents who are exploring what they hope will be a miracle cure for their child is not easy either. "It may be that parents are searching and searching and searching for a cure. You have to manage their expectations and try to help them understand the limits of what's possible and what's not possible." Fulfilment comes from the positive feedback that even bereaved parents can give. "Actually, if a family can walk out of the hospital having lost their child and say that they couldn't have been better supported, then I can go home and feel O.K. about that," says Cass. http://www.guardian.co.uk/society/2012/sep/04/medicine-inefficient-way-rcpch-leader?newsfeed=true

Specialist Publications

Of related interest:

'Lay people's and health professionals' views about breaking bad news to children' (p.4), published in *Child: Care, Health & Development*

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- INDIA | *The Times of India* (Kaipur) – 10 September 2012 – **'Euthanasia case: Government offers financial, medical help.'** Responding to the application of the couple who sought euthanasia for their two children who have been paralysed for years, the district administration and non government organizations have come forward to help the couple get proper medication and financial aid for the kids. http://timesofindia.indiatimes.com/city/jaipur/Euthanasia-case-Government-offers-financial-medical-help/articleshow/16328929.cms

- U.K. (ENGLAND & WALES) | *Daily Telegraph* – 8 September 2012 – **'Terminal illness sufferers 'should be allowed help to die' says new minister.'** Terminal illness sufferers who want to obtain help to end their lives should be allowed to do so in Britain, one of David Cameron's new health ministers has said. Anna Soubry said current laws on voluntary euthanasia were dishonest and needed to "evolve" to allow people to die at home. But Ms. Soubry, in her first interview as Under-Secretary of State for Health, maintained her opposition to allowing doctors to end patients' lives. http://www.telegraph.co.uk/health/healthnews/9529790/Terminal-illness-sufferers-should-be-allowed-help-to-die-says-new-minister.html

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

Air medical repatriation: Compassionate and palliative care consideration during transport

AIR MEDICAL JOURNAL, 2012;31(5):238-241. The number of elderly and very elderly international travelers continues to increase. Many of these travelers are afflicted with multiple, often severe, medical conditions; in fact, a significant portion of these elderly travelers are considered end stage with respect to their disease state. While traveling, they are exposed to travel hazards and deterioration of their already compromised health. Once acute illness or injury occurs, medically appropriate, compassionate repatriation of these elderly patients is associated with a range of complex challenges. http://www.sciencedirect.com/science/article/pii/S1067991X11002483

The relief of existential suffering

ARCHIVES OF INTERNAL MEDICINE | Published online – 3 September 2012 – Advanced and progressive illnesses bring existential suffering to patients as an inevitable consequence of the disease and its treatment. Physicians need a typology of existential distress to aid its recognition and improved management. The major forms of existential challenge include 1) death anxiety; 2) loss and change; 3) freedom with choice or loss of control; 4) dignity of the self; 5) fundamental aloneness; 6) altered quality of relationships; 7) our search for meaning; and, 8) mystery about what seems unknowable. http://archinte.jamanetwork.com/article.aspx?articleid=1356535

Noted in Media Watch, 9 April 2012:

- *CURRENT OPINION IN SUPPORTIVE & PALLIATIVE CARE* | Published online – 6 April 2012 – **'An existential approach to oncology: Meeting the needs of our patients.'** http://journals.lww.com/co-supportiveandpalliativecare/toc/publishahead

Of related interest:

- *CANADIAN ASSOCIATION OF NURSES IN ONCOLOGY JOURNAL*, 2012;22(3):195-199. **'Palliative sedation to alleviate existential suffering at end-of-life: Insight into a controversial practice.'** http://www.cano-acio.ca/~ASSETS/DOCUMENT/CONJ/conj-22-3-2012-195-199.pdf

Lay people's and health professionals' views about breaking bad news to children

CHILD: CARE, HEALTH & DEVELOPMENT | Published online – 29 August 2012 – Bad health news is difficult to communicate, especially when parents must give bad news to their children. The authors had 170 lay persons, 33 nurses and six physicians in Toulouse, France, judge the appropriateness of the parents' behaviour in 64 scenarios of parents dealing with this problem. The scenarios were composed according to a four within-subject orthogonal design: child's age (4, 6, 8 or 10), severity of disease (lethal or worrisome but curable), child's concern or not about his illness and parents' decision about communicating the news (tell nothing, minimize, tell the truth or ask the physician to tell the truth). Cluster analysis revealed four clusters, labelled 'always tell the truth' (33%, including a majority of doctors and nurses), 'tell nothing or minimize' (16%, with an older average age), 'tell the truth except in cases of incurable illness' (22%) and 'depends on child's characteristics' (29%). http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2214.2012.01420.x/abstract?deniedAccessCustomisedMessage=&userIsAuthenticated=false

Of related interest:

- *OMEGA – JOURNAL OF DEATH & DYING*, 2012;65(4):335-346. **'Parental interest in a bereavement support visit when a child dies from cancer.'** Analysis of parental comments revealed common themes ... processing grief, practical suggestions for visit, recognition of individual differences, perceived risks/benefits of visit, connections with medical staff ... unmet needs for support.http://baywood.metapress.com/app/home/contribution.asp?referrer=parent&backto=issue,7,8;journal,1,259;linkingpublicationresults,1:300329,1

From persistence to palliation: Limiting active treatment in the ICU

CURRENT OPINION IN CRITICAL CARE | Published online – 29 August 2012 – End-of-life care and communication deficits are important sources of conflicts within ICU teams and with patients or families. This narrative review describes recent studies on how to improve palliative care and surrogate decision-making in ICUs and compares the results with previously published literature on this topic. Awareness and use of end-of-life recommendations is still low. Education about end-of-life is beneficial for end-of-life decisions. Residency and nurses training programmes start to integrate palliative care education in critical care. Integration of palliative care consults is recommended and probably cost-effective. Projects that promote direct contact of care team members with patients/families may be more likely to improve care than educational interventions for caregivers only. The family's response to critical illness includes adverse psychological outcome ('post-intensive care syndrome-family'). Information brochures and structured communication protocols are likely to improve engagement of family members in surrogate decision-making; however, validation of outcome effects of their use is needed. http://journals.lww.com/co-critical-care/Abstract/publishahead/From_persistence_to_palliation___limiting_active.99672.aspx

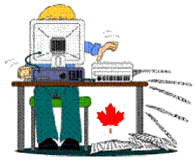
Decision-making in ICU

Time for change in culture

INTENSIVE CARE MEDICINE | Online editorial – 1 September 2012 – At the core of shared decision-making is communication that utilizes a set of strategies that attempts to understand the patient and/or family understanding of their condition, their hopes and goals, educates them about their prognoses and treatment options, and arrives at a treatment plan that honors realistic patient goals. This is a complex intervention. Note that I explicitly stated a set of communication strategies. It is very important that each physician adjusts his communication strategy based on the background and needs of the patient and family with whom they are speaking, and the disease trajectory of the patient. In some cases, we should be paternalistic (e.g., in the case of an 89-year-old with advanced cancer in septic shock with the husband of 60 years unable to let go, I believe it is permissible to say that the final act of love is "letting go"), while in other circumstances our goal is to be educator and provide the best available evidence (e.g., a dean of a college who at the age of 49 years knew more about the treatment of colon cancer than many oncologists). Can we achieve such change? http://www.springerlink.com/content/n1040n476g455743/fulltext.pdf

Of related interest:

- *OMEGA – JOURNAL OF DEATH & DYING*, 2012;65(4):257-280. **'Honoring patient care preferences: Surrogates speak.'** Findings of this study suggest engaging surrogates at the time of patient admission may be essential ... to clarify patient preferences and strengthen communication between surrogates and the interdisciplinary healthcare team.http://baywood.metapress.com/app/home/contribution.asp?referrer=parent&backto=issue,3,8;journal,1,259;linkingpublicationresults,1:300329,1



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 Ireland

Huge gaps in hospital palliative care training

IRISH MEDICAL TIMES [*IMT*] | Online report – 4 September 2012 – New research has shown that the vast majority of healthcare staff in a range of healthcare facilities are severely lacking in training to cope with patients with life-limiting diseases. Figures obtained by *IMT* ahead of a major palliative care conference in the Royal College of Physicians Ireland show that in the case of dementia patients, 70% of staff had not had any palliative care training in the past two years and 66% of healthcare assistants and 42% of nurses did not feel that they were competent to address death and dying with patients. In cases of severely-ill heart disease patients – with the research being conducted by the Cardiology Departments at the Mater and Connolly Hospitals and St Francis Hospice and Fairview Family Practice – 98% had not received any palliative care training in the past two years. Furthermore, 69% were 'not familiar' with the principles of palliative care. In advanced respiratory disease patients with life-limiting disease, only 7% had received education in palliative care, while 76% were not familiar with the principles of palliative healthcare. http://www.imt.ie/news/latest-news/2012/09/huge-gaps-in-hospital-palliative-care-training.html

Out-of-pocket spending in the last five years of life

JOURNAL OF GENERAL INTERNAL MEDICINE | Published online – 5 September 2012 – Despite Medicare coverage, elderly households face considerable financial risk from out-of-pocket healthcare expenses at the end of life. Disease-related differences in this risk complicate efforts to anticipate or plan for health-related expenditures in the last 5 years of life. http://www.springerlink.com/content/427m88565153p76k/

The social stratification of older adults' preparations for end-of-life health care

JOURNAL OF HEALTH & SOCIAL BEHAVIOR, 2012;53(3): 297-312. The author uses data from the Wisconsin Longitudinal Study[1] to evaluate the extent to which socio-economic status affects three health-related (living will, durable power of attorney for health care, and discussions) and one financial (will) component of end-of-life planning. Net worth is positively associated with all four types of planning, after demographic, health, and psychological characteristics are controlled. Low rates of health-related planning among persons with low or negative assets are largely accounted for by the fact that they are less likely to execute a will, an action that triggers health-related preparations. Rates of health-related planning alone are higher among recently hospitalized persons, whereas financial planning only is more commonly done by homeowners and those with richer assets. Economically advantaged persons engage in end-of-life planning as a two-pronged strategy entailing financial and health-related preparations. http://hsb.sagepub.com/content/53/3/297.abstract

1. Wisconsin Longitudinal Study
   http://www.ssc.wisc.edu/wlsresearch/

"A good death" – Sequence (not stigma), to an enigma called life: Case report on end-of-life decision making and care

AMERICAN JOURNAL OF HOSPICE & PALLIATIVE MEDICINE | Published online – 4 September 2012 – Fear of death and the stigma associated with the terminal events of illness prevents us from dying well. Lack of recognition of palliative care as a specialty, in many countries, leads us to die a pathetic death in ICU rather than dying at home with near and dear ones around. It's time to break the taboo of death and to start talking about this terminal sequence (good death) of good living. http://ajh.sagepub.com/content/early/2012/09/06/1049909112458962.abstract

Palliative care in Japan

Specialized palliative care services in Japan: A nationwide survey of resources and utilization by patients with cancer

JOURNAL OF HOSPICE & PALLIATIVE MEDICINE | Published online – 3 September 2012 – Responses were received from 751 institutions (response rate, 91%); 541 had specialized palliative care services. The total estimated number of institutions with specialized palliative care services was 659. Of all the patients with cancer who died in the period from April 2009 to May 2010 in Japan, the estimated proportion who utilized specialized palliative care services was 24%. http://ajh.sagepub.com/content/early/2012/08/23/1049909112457874.abstract

Noted in Media Watch, 9 July 2012:

- *PALLIATIVE & SUPPORTIVE CARE* | Published online – 6 July 2012 – **'Living with pleasure in daily life at the end of life: Recommended care strategy for cancer patients from the perspective of physicians and nurses.'** One of the most important goals of palliative care is achieving a good death. Most Japanese believe "having some pleasure in daily life" is necessary at the end of life. http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=8632866&fulltextType=RA&fileId=S1478951512000442

Noted in Media Watch, 19 March 2012:

- *JAPANESE JOURNAL OF CLINICAL ONCOLOGY* | Published online – 6 March 2012 – **'The current status and issues regarding hospital-based specialized palliative care service in Japanese regional cancer centers...'** Responses indicated 99% had palliative care consultation teams. For the process of palliative care consultation service, 90% defined the palliative care consultation request methods, 92% implemented seminars about palliative care for health-care workers in the hospital and 31% had joint meetings with the clinics and home nursing station in the community. http://jjco.oxfordjournals.org/content/early/2012/03/06/jjco.hys022.abstract

N.B. Japan was rated 23rd (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

Would you go broke to stay alive in Singapore? Further analysis of a survey on how costs may affect choice of therapy

JOURNAL OF HOSPICE & PALLIATIVE MEDICINE | Published online – 3 September 2012 – This study explores how high treatment costs can result in people foregoing necessary treatment. The majority would choose the cheapest treatment option if treatment costs mirrored that in real life. But, the majority would opt for the treatment that gave the greatest median survival, if cost was not an issue. http://ajh.sagepub.com/content/early/2012/08/23/1049909112458031.abstract

"Whatever my mother wants"

Barriers to adequate pain management

JOURNAL OF PALLIATIVE MEDICINE | Published online – 4 September 2012 – Opioids are the preferred medications to treat cancer pain; however, several barriers to cancer pain management exist, including those related to the patient, health care provider, and family caregiver. The authors describe one such situation in which a family member prevents the patient from receiving adequate pain management at the end of life despite interdepartmental and interdisciplinary efforts. http://online.liebertpub.com/doi/abs/10.1089/jpm.2012.0189

Public hospital palliative social work: Addressing patient cultural diversity and psychosocial needs

JOURNAL OF SOCIAL WORK IN END-OF-LIFE & PALLIATIVE CARE | Published online – 4 September 2012 – As the field continues to grow and evolve, new opportunities are emerging to profile palliative social work in diverse health care settings. A statewide initiative to spread palliative care in California's public hospitals provided just such an opportunity. Palliative social workers from ... hospitals participating in the initiative formed a group to discuss palliative social work in this unique hospital setting. This article highlights the group's insights and experiences as they address significant cultural diversity and psychosocial needs of public hospital patients receiving palliative care. http://www.tandfonline.com/doi/abs/10.1080/15524256.2012.708113

Some things change, some things stay the same: A longitudinal analysis of cancer caregivers' unmet supportive care needs

PSYCHO-ONCOLOGY | Published online – 3 September 2012 – Although prevalence of unmet needs significantly decreased over time, almost a third of caregivers still reported unmet needs at 24 months. Unmet needs were more prevalent among caregivers of lung cancer survivors, at 6 and 24 months. Top ranking unmet needs across time included 'managing concerns about cancer coming back,' 'reducing stress in the person with cancer's life,' 'understanding the experience of the person with cancer,' and 'accessible hospital parking.' At 24 months, some of the top ranking unmet needs were related to caregivers' well-being and relationships. Increased interference in activities due to caregiving, anxiety, depression, avoidant and active coping, and out-of-pocket expenses was associated with reporting more unmet needs. Less involvement in caregiving roles and increased physical well-being and social support were associated with reporting less unmet needs. For some variables (e.g., anxiety and depression), association with unmet needs strengthened over time. http://onlinelibrary.wiley.com/doi/10.1002/pon.3166/abstract

Cont.

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.

Of related interest:

- *AMERICAN JOURNAL OF HOSPICE & PALLIATIVE MEDICINE* | Published online – 4 September 2012 – **'Spirituality, religiosity, and spiritual pain among caregivers of patients with advanced cancer.'** The majority of caregivers of patients [i.e., study participants] ... considered themselves spiritual and religious. Despite this, there is high prevalence of spiritual pain in this population. http://ajh.sagepub.com/content/early/2012/09/04/1049909112458030.abstract

- *JOURNAL NEUROLOGY, NEUROSURGERY & PSYCHIATRY*, 2012;83(Suppl):A51-A52. **'Huntington's disease: difficulties of family caregivers.'** Because of the characteristics of Huntington's disease, such as the unknown possibility of cure, the progressive loss of autonomy and life expectancy resulting from an accelerated progression of the symptoms leading to death. The informal caregivers, including family members, face different problems capable of causing serious changes in their quality of life. http://jnnp.bmj.com/content/83/Suppl_1/A51.4.abstract

- *SUPPORTIVE CARE IN CANCER* | Published online – 4 September 2012 – **'Economic and social changes among distressed family caregivers of lung cancer patients.'** Findings suggest that distressed caregivers of lung cancer patients experience high rates of adverse economic and social changes that warrant clinical and research attention. http://www.springerlink.com/content/m381q8gl7007mw8r/

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

Do you need to be certified in palliative care?

TODAY'S HOSPITALIST | Published online – Accessed 9 September 2012 – When Satya Chelamkuri MD finished her residency two years ago she knew the clock was ticking. If she could take the certification exam in palliative care by this October, she wouldn't need any additional training. If Dr. Chelamkuri misses next month's test, however, she'll have to complete a one-year fellowship in palliative care before she can sit for the exam in the future. Dr. Chelamkuri, a hospitalist with the Cogent HMG program at Allegiance Hospital in Jackson, Michigan, is studying hard and working more with patients who need palliative care, all of which is required to be eligible for next month's exam. Her goal is not only to be certified, but to be certified now. What are her plans if she doesn't pass the test? Although it would be disruptive, Dr. Chelamkuri says she wants certification badly enough to consider leaving her job to do a fellowship. "If you want to take a year out of your life," she notes, "you must be passionate about it." But leaving current careers or spending another year on training is not an option for many hospitalists. As a result, the new fellowship requirement is raising questions about how many palliative care physicians will actually become certified. http://todayshospitalist.com/index.php?b=articles_read&cnt=1524

Assisted (or facilitated) death

Representative sample of recent articles, etc:

- *GLOBAL JOURNAL OF HEALTH SCIENCE* | Published online – Accessed 4 September 2012 – **'Assisted or hastened death: The healthcare practitioner's dilemma.'** This paper explores salient practical and ethical considerations for healthcare practitioners associated with assisted death, with a focus on examining the concepts of autonomy for patients and healthcare practitioners. The role of the healthcare practitioner has clearly and undoubtedly changed over time with advances in healthcare practices but the duty of care has not changed. The dilemmas for healthcare practitioners thus who have competent patients requesting hastened death extends far beyond acting within a country's laws as they go to the very heart of the relationship between the practitioner and patient. http://ccsenet.org/journal/index.php/gjhs/article/view/19405

- *JOURNAL OF AGING STUDIES*, 2012;26(4):377-385. **'Alzheimer's disease and euthanasia.'** This paper discusses the ethical debate surrounding assisted suicide for persons suffering end-stage Alzheimer's. It first presents a classification of the dissociative situations between "human individual" and "human person." It then moves on to discuss challenges to diagnosed persons and their caregivers in relation to the cardinal virtues of Spinozistic ethics — strength of character, firmness and generosity. Finally, a number of ideas attached to the debate – "right of choice," "death with dignity," "quality of life" and "compassion in dying" – are discussed in order to clarify their foundations. http://www.sciencedirect.com/science/article/pii/S089040651200028X

- *JOURNAL OF HEALTH PSYCHOLOGY* | Published online – 29 August 2012 – **'To end life or not to prolong life: The effect of message framing on attitudes toward euthanasia.'** People ascribe "euthanasia" different values and view it differently. This study hypothesized that a different framing of objectively the same euthanasia situations would affect people's attitudes toward it. Indeed, "positive" framing of euthanasia as not prolonging life resulted in more support for both passive and active euthanasia relative to "negative" framing of the objectively same situations as ending life. http://hpq.sagepub.com/content/early/2012/08/29/1359105312455078.abstract

- *JOURNAL OF SOCIAL WORK IN END-OF-LIFE & PALLIATIVE CARE* | Published online – 4 September 2012 – **'What their terms of living and dying might be: Hospice social workers discuss Oregon's Death with Dignity Act.'** Three themes emerged from the analysis: a) values regarding physician-assisted death; b) agency policies about the option; and, c) the role of hospice social workers with physician-assisted death. Hospice social work practitioners work with patients and families as they consider this option and their voices reflect the complexities and nuances of these interactions. http://www.tandfonline.com/doi/abs/10.1080/15524256.2012.708295

Cont.

- *THE LANCET*, 2012;380(9845):869-870. **'Euthanasia in The Netherlands: what lessons for elsewhere?'** http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)61128-3/fulltext

- *MAYO CLINIC PROCEEDINGS*, 2012;87(9):814-816. **'Murder and euthanasia accusations against physicians.'** Conflicts are ubiquitous in medicine, but it is difficult to imagine a physician facing a more calamitous accusation than that of murder or euthanasia. In 2005, the author of this commentary and his colleagues published an article describing such accusations following the care of dying patients. While it is important for law enforcement to identify and prosecute the rare medical personnel who are *bona fide* criminals, they were more interested in learning about unjustly charged practitioners. Their review found that doctors from any specialty providing terminal care could become the object of allegations, although many of these physicians worked under the rubric of palliative care. As a result, they subsequently developed an online research survey to be administered to members of a national palliative medicine professional society because these practitioners are most likely to be involved in the management of end-of-life cases. The overall survey findings have just been published,[1] and 25 of 633 respondents (4%) reported having been formally investigated for hastening a patient's death when that was not their intention –13 while using opiates for symptom relief and 6 for using various medications while discontinuing mechanical ventilation. In one-third of these cases, a fellow member of the health care team initiated the charges against the physician. In this commentary, the author intend to explore the implications of another question from the survey – one about humor and its double-edged qualities in the end-of-life setting. I will then speculate as to why accusations of hastening death are occurring and specifically why medical colleagues are charging physicians on their team with engaging in this practice. http://www.mayoclinicproceedings.org/article/S0025-6196(12)00669-6/fulltext

    1. 'Prevalence of formal accusations of murder and euthanasia against physicians,' *Journal of Palliative Medicine*, published online 8 March 2012 (noted in Media Watch, 12 March 2012). http://online.liebertpub.com/doi/abs/10.1089/jpm.2011.0234

Worth Repeating

'The worst thing about hospice is that they talk about death': Contrasting hospice decisions and experience among immigrant Central and South American Latinos with U.S.-born White, non-Latino cancer caregivers

PALLIATIVE MEDICINE, 2010;24(4):427-434. Hospice care is promoted as a model for improving end of life care and decreasing burden on caregivers. However, hospice use is low in Latinos and little is known about how Latinos make hospice decisions and experience hospice once enrolled. Qualitative methods were used in this study to conduct in-depth interviews and focus groups with Latino bereaved hospice family caregivers and White non-Latino bereaved hospice family caregivers to describe hospice experiences and evaluate whether cultural factors affected the experience. Differences in decision-making and caregiving experience were identified that were influenced by culture. For example, cultural values of denial, secrecy about prognosis and a collective, family-centered system influenced hospice decisions and experience in Latinos but not non-Latinos. This study identifies a significant dilemma: that is, how to discuss hospice with a patient and family who prefer not to discuss a terminal prognosis. Future research is needed to extend these preliminary results; such results may be useful for designing interventions to improve end of life care and caregiving in Latinos. http://pmj.sagepub.com/content/24/4/427.short

> **N.B.** The U.S. Census Bureau reported in 2011 that the Hispanic population surpassed 50 million and accounted for more than half of the 27.3-million population increase in the last decade.

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