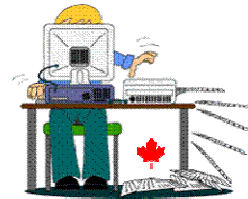


Media Watch...

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.

31 January 2011 Edition | Issue #186



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

Compiled & Annotated by Barry R. Ashpole

Understanding and completely absorbing the true risks and benefits of treatment: Scroll down to [U.S.A.](#) and 'Too much optimism may be bad for cancer patients' (p.3), broadcast on MSNBC News.

Canada

Promoting a culture of compassion

Hospice care encompasses a dying patient's physical, emotional, social and spiritual needs

BRITISH COLUMBIA | *Vancouver Sun* (OpEd) – 31 January 2011 – There has been a lot of recent press coverage – and public outcry – about the current hospice controversy at University of British Columbia. Specifically, a group of condominium owners has voiced concern over a proposed 15-bed hospice being located near their properties. In the words of one protester, "We cannot have dying people in our backyard." While the issue and resulting public backlash have, unfortunately, been hurtful to many individuals and communities, there is a silver lining to this cloud – one that will benefit our city and province in the years to come. A spotlight has been shone on critical issues that have remained in darkness for too long: That is, the acute shortage of hospices and related palliative care supports for the dying and their families in Vancouver. The controversy has also provided a rare sighting of one of our culture's greatest taboos in action: death. Our society remains reluctant to openly face, discuss and plan for the inevitability of death. <http://www.vancouversun.com/health/Promoting+culture+compassion/4194600/story.html>

N.B. The hospice controversy at the University of British Columbia was reported in the issues of Media Watch dated 17 and 24 January 2011.

Alberta personal health directives not recognized in the U.S.

ALBERTA | *Edmonton Journal* – 29 January 2011 – The Eccles had been spending the winter in Phoenix [Arizona] in their mobile home, but it wasn't until they bought a house there in 2008 they learned their Alberta personal directives were not valid in the U.S. Some jurisdictions call them living wills, but in Alberta, the legal term is personal directives, a signed, dated and witnessed document that appoints a representative to make decisions of a health nature (non-financial) if you are incapacitated or unable to speak for yourself. Another person, even your spouse, cannot make health decisions on your behalf without first being named an agent in a personal directive. <http://www.edmontonjournal.com/health/Arizona+living+wills+give+snowbirds+peace+mind/4189834/story.html>

Local Health Integrated Network approves more hospice beds

ONTARIO | *Ottawa Citizen* – 27 January 2011 – Eastern Ontario's health authority has approved a plan to more than quadruple the number of palliative care beds in the Champlain region by 2014. The plan, created by a committee of medical professionals and local hospice volunteers, calls for a single hospice agency to oversee 39 care beds at four sites, including the existing nine-bed program at the Hospice at May Court and another small but innovative hospice program for homeless men at the Ottawa Mission. Ottawa needs at least 66 to 80 hospice palliative care beds overall, according to a report. The lack of palliative care beds means many people die in hospital in acute-care hospital beds that cost the province \$1,000/day. Hospice beds cost \$400/day and provide patients and their families with a more supportive, homelike environment, says Dr. Jose Pereira, chief of palliative medicine at Bruyere Continuing Care, one of the authors of the report. <http://www.ottawacitizen.com/health/LHIN+approves+more+hospice+beds/4174955/story.html>

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- QUEBEC | *McGill (University) Reporter* – 26 January 2011 – '**Just dying: A discussion of euthanasia, assisted suicide and the law.**' Despite a 1993 Supreme Court of Canada decision – the case of Sue Rodriguez – making it clear assisted suicide and euthanasia are illegal in Canada, both are occurring, but prosecutors by and large are not charging anyone. "It's clearly prohibited, but it's clearly happening," said Jocelyn Downie, Canada Research Chair in Health Law & Policy at Dalhousie University [Halifax]. <http://publications.mcgill.ca/reporter/2011/01/just-dying-a-discussion-of-euthanasia-assisted-suicide-and-the-law/>

U.S.A.

Hospice cuts don't add up for state

SOUTH CAROLINA | *Sun News* (Myrtle Beach) – 31 January 2011 – In its attempt to address the fiscal behemoth that is Medicaid, state agencies have three options: 1) reduce payments to doctors (certain to reduce the number of doctors willing to accept Medicaid patients); 2) reducing the rolls of eligible recipients; or 3) reducing services. The recent decision by the Department of Health & Human Services [DHHS] to disallow Medicaid recipients older than 21 from receiving hospice care is an example of No. 3. The anticipated state budget shortfall for the next fiscal year is about \$228 million. Cuts will have to be made in many areas. But will elimination of this program actually reduce the state's overall Medicaid costs? There are some 825,000 Medicaid recipients in the state. DHHS says 957 Medicaid patients received hospice care in 2009 (more accurate data from the state's hospice organization cite closer to 1,450). Estimates of savings to the

state from elimination of this benefit range from \$4 million to \$9 million. However, in doing so, the state loses \$24 million in federal matching funds. Furthermore, hospice patients are the sickest of the sick and their social support systems are among the most fragile. The majority will end up in emergency departments and admitted to hospitals receiving much less appropriate, compassionate and cost-effective care than that for which hospice is especially skilled and equipped to provide. A small hospice study in this state in the 1990s concluded that for every dollar spent for hospice care, the overall costs of health care were reduced \$1.68. National studies have consistently demonstrated that hospice saves millions in Medicare and Medicaid dollars. <http://www.thesunnews.com/2011/01/31/1952794/hospice-cuts-dont-add-up-for-state.html>

Cont.

Of related interest:

- NATIONAL PUBLIC RADIO | Online OpEd – 28 January 2011 – **'The weekly standard: Let the rationing begin.'** When Sarah Palin warned that Obamacare could lead to medical rationing and "death panels," supporters were outraged. Alarmism! they roared. A lie! Right-wing propaganda! Alas for supporters of the Patient Protection & Affordable Care Act, Palin's provocative sound bite was at least partly grounded in reality — which is why the term entered the political lexicon. Now, however, some are seeking to wield the term against conservatives. The Arizona legislature recently cut its Medicaid budget because the state is in dire financial straits – a move approved by the Obama administration. When the cuts led to canceling Medicaid coverage for organ transplant surgeries, and a potential organ recipient died, death panel claims suddenly became all the fashion. <http://www.npr.org/2011/01/28/133297747/the-weekly-standard-let-the-rationing-begin>

Even in death, budget cuts take a toll

WALL STREET JOURNAL | Online article – 24 January 2011 – Government budget cuts have reached the potter's field. Communities have long provided simple burials for the indigent or unidentified, but cash-strapped jurisdictions from North Dakota to Arizona are trimming subsidies, raising fees or switching to cremation. Deliberations over such changes underscore that in an era of austerity, governments have to face issues that touch on both the economic and the moral. <http://online.wsj.com/article/SB10001424052748704678004576090203156194200.html>

Specialist Publications

Of particular interest:

'Maximizing palliative care provision in economic downturns' (p.8), published in the *International Journal of Palliative Nursing*.

Too much optimism may be bad for cancer patients

MSNBC NEWS | Online report – 28 January 2011 – An optimistic outlook is often believed to have a positive impact on cancer. But researchers now say that optimism, like anything else, can be overdone.¹ And "unrealistic optimism," which a new study has found to be common among patients enrolling in early phase drug trials, may have a serious downside. The problem, some experts say, is that unrealistic optimism may lead patients to sign up for very early stage trials when the patients might make other choices if they really understood and completely absorbed the true risks and benefits. <http://www.msnbc.msn.com/id/41299984/ns/health-cancer/>

1. *IRB: ETHICS & HUMAN RESEARCH*, 2011;33(1):1-8. **'Unrealistic optimism in early-phase oncology trials.'** <http://www.thehastingscenter.org/Publications/IRB/Detail.aspx?id=5097>

Of related interest:

- CNN (Cable News Network) | Online report – 24 January 2011 – **'Terminally ill patients need frank conversation about prognosis, cancer group says.'** In an effort to improve the communications between doctors and patients, the American Society of Clinical Oncologists [have] released a new policy statement and a patient guide for conversations about the time when treatment options run out.¹ <http://pagingdrqupta.blogs.cnn.com/2011/01/24/terminally-ill-patients-need-frank-conversation-about-prognosis-cancer-group-says/>
- 1. *JOURNAL OF CLINICAL ONCOLOGY* | Online article – 24 January 2011 – **'American Society of Clinical Oncology statement: Toward individualized care for patients with advanced cancer.'** <http://jco.ascopubs.org/content/early/2011/01/24/JCO.2010.33.1744.abstract>

N.B. Scroll down to [Specialist Publications](#) and **'End-of-life talks difficult but shouldn't be avoided'** (p.7), published in *American Medical News*.

Materials for end-of-life care have reading levels too high to be effective

WISCONSIN | *Badger Herald* (University of Wisconsin-Madison) – 26 January 2011 – When families are coping with the emotional stress and uncertainty associated with caring for those in hospice, a University of Wisconsin study found the hospice literature meant to be informative is written at a reading level that is too advanced to be effective. Associate professor of nursing Karen Kehl said caretakers, on average, receive 2.5 documents about hospice care and how to cope with sickness in the family. Some receive as many as seven. Kehl said this method of educating families on important warning signs and coping strategies is impractical and confusing. http://badgerherald.com/news/2011/01/26/uw_professor_release.php

From Media Watch dated 24 January 2011:

- REUTERS | Online report – 18 January 2011 – **'U.S. laws a barrier for advance directives: Study.'** In a study of advance directive laws across all U.S. states, researchers found that the documents used in end-of-life planning were written in legalese that the average American would be hard-pressed to understand. <http://in.reuters.com/article/idINTRE70G65K20110117>

Assisted (or facilitated) death

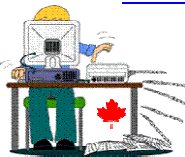
Representative sample of recent news media coverage:

- OREGON PUBLIC HEALTH DIVISION | Online report – Accessed 27 January 2011 – **'Dying with Dignity 2010 Annual Report.'** As of 7 January 2011, 96 prescriptions for lethal medications had been written under the provisions of the Dying with Dignity Act (DWDA) during 2010, compared to 95 during 2009. Of the 96 patients for whom prescriptions were written during 2010, 59 died from ingesting the medications. In addition, six patients with prescriptions written during previous years ingested the medications and died during 2010 for a total of 65 known 2010 DWDA deaths at the time of this report. <http://oregon.gov/DHS/ph/pas/docs/year13.pdf>

Sundance film puts spotlight on euthanasia

UTAH | Agence France-Presse – 28 January 2011 – They are terminally ill, and they have decided to die – a heartbreakingly honest film at the Sundance Film Festival casts a sober light on the reality of euthanasia, in one U.S. state. 'How to Die in Oregon' ... is in competition at the independent movie fest. http://www.google.com/hostednews/afp/article/ALeqM5gMw0XrViPHnL-VJM10O5q8yiA_4Q?docId=CNG.03bfe254c1c9fec859eaff112841844.2a1

- HARRIS/BBC WORLD NEWS AMERICA | Online report – 25 January 2011 – **'Large majorities support doctor assisted suicide for terminally ill patients in great pain.'** A new ... poll finds that large majorities of Americans now favor physician assisted suicide and euthanasia for terminally ill patients in great pain who wish to end their lives. This new poll confirms that substantial majorities of the public now favor physician-assisted suicide, and the right of some terminally ill patients to commit suicide. In reviewing these measurements of public opinion it is worth noting that that the real world is often more nuanced and complicated than these blanket hypothetical scenarios. <http://www.harrisinteractive.com/NewsRoom/HarrisPolls/tabid/447/ctl/ReadCustom%20Default/mid/1508/ArticleId/677/Default.aspx>



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.

International

Experts in palliative care welcome call for end-of-life changes

THE AUSTRALIAN | Online report – 29 January 2011 – Experts in palliative and end-of-life care have welcomed a proposal from the Productivity Commission for improved funding for such services. *Caring for older Australians* highlights an area often overlooked. "Palliative and end-of-life care needs of older Australians are not being adequately met under the current arrangements," the report states. <http://www.theaustralian.com.au/news/health-science/experts-in-palliative-care-welcome-call-for-end-of-life-changes/story-e6frg8y6-1225995762013>

N.B. Palliative Care Australia's Submission to the Treasurer on Priorities for the 2011 Federal Budget. <http://www.palliativecare.org.au/Portals/46/PCA%20Budget%20Submission%20January%202011.pdf>

What price do we put on the dignified exit of a loved one?

IRELAND | *Independent* (Dublin) – 24 January 2011 – We Irish pride ourselves in giving the ultimate send-off to those who have died. We may no longer keen at the graveside but the tradition of the wake and walking after the hearse still survive in many areas. So how would we react to a tax on death? We may yet be asked to directly or indirectly pay a levy for each funeral. It may be necessary because not all funeral undertakers are qualified to care for someone's passing. And there are growing calls to ensure that funeral directors, in whom we put so much trust in our most vulnerable state of bereavement, are properly controlled and monitored. But this will not be cheap, and a levy may be the only way to fund a national watchdog to oversee these undertakers. The Irish

Hospice Foundation is leading the way in trying to clean up standards in the funeral industry. <http://www.independent.ie/health/latest-news/what-price-do-we-put-on-the-dignified-exit-of-a-loved-one-2507985.html>

Mourners for hire

TANZANIA | *The Citizen* (Dar es Salaam) – 29 January 2011 – While death has always been a source of income for funeral homes in the urban centres, coffin makers, transporters, grave diggers, and providers of other services, including catering, to give the dead a grand send-off, the idea of "professional mourners" is a brand new one. <http://thecitizen.co.tz/component/content/article/37-tanzania-top-news-story/7720-mourners-for-hire.html>

Hospice and palliative care in Ukraine

Не мучити людей просять державу онкохворі українці

UKRAINE | TSN.UA – 24 January 2011 – The following English language summary of this television newscast is generously provided by Sergej Psyrnik, a palliative care physician in Russia:

There are great problems in Ukraine concerning hospice and palliative care that are only just beginning to be solved. First of all there is the absence of proper quality hospice care. In the hospitals the situation is a little better, but at the homes of patients it is much worse. Daily amounts of pain medication are limited to 4-6 ampoules of analgesics. Sometimes these are given to the patient only at the fixed time of the day; of course, it can be understood without saying, at what level the psychological and social assistance to the patients is provided. Thanks to the support of the international Renaissance Fund, hospice care in Ukraine is gradually beginning to improve.

Link: http://tsn.ua/video/video-novini/?page=2&media_id=383379732&items=28066&type=0

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- FRANCE | *Le Figaro* – 26 January 2011 – **'Le Sénat refuse de légaliser l'euthanasie.'** Après un débat intense, les sénateurs ont voté dans la nuit de mardi à mercredi contre l'instauration d'«une assistance médicalisée pour mourir». La proposition de loi sur la légalisation de l'euthanasie a été définitivement balayée. Les sénateurs ont voté contre l'instauration d'«une assistance médicalisée pour mourir» dans la nuit de mardi à mercredi, après un débat intense et «pas comme les autres». Une majorité de sénateurs (170 sur 142, nldr) a supprimé l'ensemble des articles du texte trans-partisan présenté par leur collègue Jean-Pierre Godefroy (Parti socialiste), Alain Fouché (L'Union pour un mouvement populaire) et Guy Fischer (Parti communiste français). <http://www.lefigaro.fr/actualite->

[france/2011/01/25/01016-20110125ARTFIG00478-le-texte-sur-l-euthanasie-vidé-de-sa-substance.php](http://www.lefigaro.fr/actualite-france/2011/01/25/01016-20110125ARTFIG00478-le-texte-sur-l-euthanasie-vidé-de-sa-substance.php)

N.B. The Senate in France defeated a bill to legalize euthanasia by a vote of 170 to 142. The bill would have allowed euthanasia for people with disabilities, those with chronic conditions and people who are defined as terminal.

Specialist Publications

Of particular interest:

'Content of health status reports of people seeking assisted suicide: A [Swiss] qualitative analysis' (p.9), published in *Medicine, Health Care & Philosophy*

- INDIA | BBC News (South Asia) – 24 January 2011 – **'India doctors to examine 'euthanasia' woman.'** India's Supreme Court has directed three doctors to examine the medical condition of a woman who has been in a vegetative state since 1973. The court is hearing a plea to end the life of Aruna Shanbaug ... who has been paralysed and considered "brain-dead" since she was attacked by a rapist in November 1973. <http://www.bbc.co.uk/news/world-south-asia-12272915>

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.

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

End-of-life talks difficult but shouldn't be avoided

AMERICAN MEDICAL NEWS | Online OpEd – 24 January 2011 – Discussions about end-of-life care are on the front burner again, as they should be, given health system reform, our critical updating of medical education requirements and our aging population. But they are on the front burner for the wrong reason. After being left out of the health reform legislation, new regulations suggested that physicians offer – and be paid for doing so – annual discussions with Medicare patients about end-of-life care. The discussions were to be voluntary, not mandated. Then, just five days into the New Year, that provision of the regulation was rescinded. The people in Washington have done a great disservice to America's seniors. Despite many Americans' general unwillingness to recognize the inevitability of death, every physician should be prepared to talk with patients about what sort of care they expect during their final days, and to update that conversation periodically. This is called "practicing good medicine." It is not a mechanism to inappropriately limit care or access to care. As these discussions take preparation, thought and time on the part of physicians, they are also something for which doctors should be paid. We all recognize that conversations about and

planning for the end of life can be difficult to initiate. Patients often wait for physicians to broach the subject. Physicians, on the other hand, can be leery of raising the issue, afraid that it might frighten patients or their families. <http://www.ama-assn.org/amednews/2011/01/24/edca0124.htm>

Words matter: How "EOL" rhetoric undermines good palliative care

BIOETHICS FORUM | Online article – 21 January 2011 – Key words can be powerful in shaping cultural norms, including the norms of sub-cultures that flourish in hospitals and training programs. At the beginning of a large-scale social change, such as the new public prominence of debates over Medicare policy and palliative care, a telling phrase that emerges early can influence how the change becomes manifest, for better and ill, and often in ways their originators did not intend. Individuals and groups, their imaginations imprinted with a poignant rhetorical turn – e.g., "EOL" and "ethics at EOL" – may go down one set of pathways, not considering others. <http://www.thehastingscenter.org/Bioethicsforum/Post.aspx?id=5109&blogid=140>

Of related interest:

- *BMC PALLIATIVE CARE* | Online article – 27 January 2011 – '**Mapping hospice patients' perception and verbal communication of end-of-life needs: An exploratory mixed methods inquiry.**' Patients' perceptions of end-of-life needs are multidimensional, often ambiguous and uncertain. Mixed methodology appears to hold considerable promise for unpacking both the occurrence and prevalence of cognitive structures represented by verbal encoding that constitute patients' narratives. Communication is a key currency for delivering optimal palliative care. Therefore understanding the domains of needs that emerge from patient-based vocabularies indicate potential for: (1) developing more comprehensive clinical-patient needs assessment tools; (2) improved patient-clinician communication; and (3) moving toward a theoretical model of human needs that can emerge at the end of life. <http://www.biomedcentral.com/1472-684X/10/1/abstract>

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/>

As death approaches: A retrospective survey of the care of adults dying in Alice Springs Hospital

AUSTRALIAN JOURNAL OF RURAL HEALTH, 2011;19(1):4-8. Hospital care is largely based on episodically reversing acute-on-chronic pathology, with death regarded as a 'failure of the treating team,' and continued aggressive treatment in the last year of life is often the case although the benefit for patients is often marginal. Diagnosing dying is an important clinical skill especially for initiating appropriate care pathways. The needs of patients and their families (physical, psychological, practical, social) must be addressed in a way consistent with an individual's cultural and spiritual background. Fear of dying 'badly' might be considered worse than being dead for many people and physicians need to deal expectantly with these fears. The care provided during the final stages of life can affect the family as the person dies and subsequently. This survey aimed to document demographic, process and outcomes data on end-of-life care in a regional hospital with large aboriginal populations and to compare these three domains for aboriginal and non-aboriginal decedents. <http://onlinelibrary.wiley.com/doi/10.1111/j.1440-1584.2010.01169.x/pdf>

Longing for ground in a ground(less) world: A qualitative inquiry of existential suffering

BMC NURSING | Online article – 27 January 2011 – Findings of this study suggest the process of existential suffering begins with an experience of groundlessness that results in an overarching process of longing for ground in a ground(less) world, a wish to minimize the uncomfortable or anxiety-provoking instability of groundlessness. Longing for ground is enacted in three overlapping ways: by turning toward one's discomfort and learning to let go (engaging groundlessness), turning away from the discomfort, attempting to keep it out of consciousness by clinging to familiar thoughts and ideas (taking refuge in the habitual), and learning to live within the flux of instability and unknowing (living in-between). <http://www.biomedcentral.com/1472-6955/10/2/abstract>

Palliative care in people with chronic obstructive pulmonary disease

BRITISH MEDICAL JOURNAL | Online article – 24 January 2011 – The fact that chronic obstructive pulmonary disease (COPD) is a terminal illness comes as no surprise to clinicians on acute medical wards, especially as the winter takes hold. Why then are patients surprised when end of life issues are raised or referrals made to hospice services? Pinnock and colleagues postulate that patients passively accept their lot and see the increasing disability as part of normal ageing. The researchers found that, unlike patients with other diseases (such as cancer and heart failure) – who can tell the story of how the illness occurred, events that have unfolded, and their current disease status – patients with COPD seem to lack this narrative story. The realisation of illness ... is not a conscious thought for these patients. There is no clear point of diagnosis, especially one with a poor prognosis. <http://www.bmj.com/content/342/bmj.d106.extract>

Maximizing palliative care provision in economic downturns

INTERNATIONAL JOURNAL OF PALLIATIVE NURSING, 2011;17(1):4-6. The current recession and crisis in public finances has resulted in most health systems being starved of new investment and facing significant cutbacks in many areas. Ireland's case provides a typical example... In this climate, a strong case exists for reallocating some of current health spending away from acute services towards community-based palliative care services. http://www.ijpn.co.uk/cgi-bin/go.pl/library/article.html?uid=81601;article=IJPN_17_1_4_6

Exploring the dynamics of interdisciplinary palliative care teams in providing psychosocial care: "Everybody thinks that everybody can do it and they can't"

JOURNAL OF PALLIATIVE MEDICINE | Online article – 25 January 2011 – Two major themes emerged from the authors' research: "Lack of clear role boundaries" and "Strategies for maintenance of role boundaries," which included: "Claiming access to specialist expertise and knowledge" and "Minimizing the knowledge of other professions and professionals." It is argued that effective team functioning can be enhanced through the development of interdisciplinary team training programs and policies, resources and structures that provide support for the interdisciplinary team model. <http://www.liebertonline.com/doi/abs/10.1089/jpm.2010.0229>

U.K. National End of Life Care Programme

Call for nurse training in end-of-life care

NURSING IN PRACTICE | Online report – 27 January 2011 – Many more nurses should be helped to improve their communication with dying people and their families, according to a new report ... [which] ... calls for greater use of free or lower-cost training options such as e-learning – as well as access to advanced communication skills training where appropriate. *Talking about end of life care: right conversations, right people, right time* brings together the lessons of 12 pilot sites.¹ It concludes that wider access to high quality training would lay the groundwork for the "cultural change" that is required if people approaching the end of life are to help shape and plan their care. http://www.nursinginpractice.com/article/24206/Call_for_nurse_training_in_end-of-life_care

1. *Talking about end of life care: right conversations, right people, right time*. National End of Life Care Programme. <http://www.endoflifecareforadults.nhs.uk/assets/downloads/TalkingAboutEndOfLifeCare20110124.pdf>

Assisted (or facilitated) death

Representative sample of recent articles, etc:

- *JOURNAL OF MEDICAL ETHICS* | Online article – 27 January 2011 – **'Prevalence of depression in granted and refused requests for euthanasia and assisted suicide: A systematic review.'** It is unclear whether depression increases the probability of making a request for euthanasia/physician assisted suicide (PAS), but in The Netherlands most requests in depressed patients are rejected, leaving a depression rate in cases that is similar to the surrounding population. Less evidence is available elsewhere, but some level of depression has been identified in patients undergoing euthanasia/PAS in all the countries studied. Whether the presence of depression is ever compatible with an ethical decision on euthanasia/PAS is discussed. <http://jme.bmj.com/content/early/2011/01/27/jme.2010.039057.abstract>
- *MEDICINE, HEALTH CARE & PHILOSOPHY* | Online article – 19 January 2011 – **'Content of health status reports of people seeking assisted suicide: A qualitative analysis.'** Two right-to-die organisations offer assisted suicide in Switzerland. Both organisations require a report of the person's health status before considering assistance. This qualitative study explored these reports filed to legal authorities after the deaths of individuals in the area of Zurich. Many cases contained diagnosis lists only. Other reports had more elaborate reports revealing that some physicians were aware about the patient's death wish and the intention to solicit assisted suicide. Physicians' attitudes ranged from neutral to rather depreciative. Few physicians openly referred the patient to the organisations and supported the patient's request by highlighting a history of suffering as well as reporting understanding and agreement with the patient's wish to hasten death. In the health status reports five categories could be identified. Some files revealed that physicians were aware of the death wish. The knowledge and recognition of the patient's death wish varied from no apparent awareness to strongly supportive. This variety might be due to difficulties to discuss the death wish with patients, but might also reflect the challenge to avoid legal prosecution in the country of origin. To require comparable health status reports as requirements for the right-to-die organisations might be difficult to pursue. <http://www.springerlink.com/content/nm10212j1138113k/>

Worth Repeating

The challenge of patients' unmet palliative care needs in the final stages of chronic illness

PALLIATIVE MEDICINE, 2007;21(4):313-322. There is consensus in the literature that the end of life care for patients with chronic illness is sub-optimal, but research on the specific needs of this population is limited. Deteriorating health status was the central theme derived from the authors' analysis. It led to decreased independence, social isolation and family burden. These problems were mitigated by the limited resources at the individual's disposal and the availability of support from hospital and community services. Generally resources and support were perceived as lacking. All participants in this study expressed concerns regarding the patients' future and some patients described feelings of depression or acceptance of the inevitability of imminent death. Patients dying from chronic illness in this study had many concerns and unmet clinical needs. Care teams were frustrated by the lack of resources available to them and admitted they were ill-equipped to provide for the individual's holistic needs. Some clinicians described difficulty in talking openly with the patient and family regarding the palliative nature of their treatment. An earlier and more effective implementation of the palliative care approach is necessary if the needs of patients in the final stages of chronic illness are to be adequately addressed.

<http://pmj.sagepub.com/content/21/4/313.short?rss=1&ssource=mfc>

Media Watch Online

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

Canada

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

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

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

U.S.A.

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

International

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

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

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