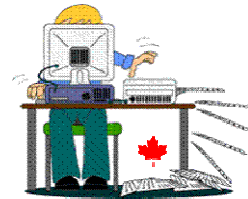


Media Watch...

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.

28 February 2011 Edition | Issue #190



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

Compiled & Annotated by Barry R. Ashpole

Out of hours palliative care services: Scroll down to [Specialist Publications](#) and 'Is there a need for weekend face-to-face inpatient assessments by hospital specialist palliative care services?' (p.8), published in *Palliative Medicine*.

Canada

Medical, legal and ethical issues of 'Baby Joseph' case

London Health Sciences Centre launches public information campaign

ONTARIO | London Health Sciences Centre (LHSC) press release – 27 February 2011 – LHSC ... is launching a public information campaign to correct the enormous amount of false and misleading information about the condition and ongoing treatment of a critically ill infant in its care. While medical, legal and ethical support for the best interests of "Baby Joseph" is widespread, the hospital believes that since this has become a public issue, the public has a "right to know" the truth so they can form their opinions based on fact, not innuendo, speculation or untruths. <http://www.newswire.ca/en/releases/archive/February2011/27/c6400.html>

N.B. The Ontario Consent & Capacity Board ruling and report regarding "Baby Joseph" can be found at: <http://www.canlii.org/en/on/oncccb/doc/2011/2011canlii7955/2011canlii7955.html>

- ONTARIO | *Toronto Star* – 26 February 2011 – '**Hospital caring for 'Baby Joseph' on alert after threats.**' The hospital caring for Joseph Maraachli, a terminally ill 13-month-old from Windsor, has increased its security measures and notified police after receiving threats over its plan to remove the baby from life support. <http://www.thestar.com/news/article/945533--hospital-caring-for-baby-joseph-on-alert-after-threats?bn=1>

From Media Watch dated 21 February 2011:

- ONTARIO | *Toronto Sun* – 18 February 2011 – '**Judge orders baby off life-support.**' Joseph Maraachli ... will die after his breathing tube is removed from his tiny body at a London hospital, ending an ethical and legal dilemma that tried to balance unwanted suffering with the needs of a child and his family. <http://www.torontosun.com/news/canada/2011/02/18/17322476.html>

Specialist Publications

Of particular interest:

'Hospital policy on medical futility – does it help in conflict resolution and ensuring good end-of-life care?' (p.5), published in the *Annals of Academy of Medicine*.

It's time we focused on quality of death

MANITOBA | *Winnipeg Free Press* (OpEd) – 26 February 2011 –The debate over euthanasia is always simmering just below the surface of Canadian society and occasionally it bubbles over, as it is doing today with the release on full parole of Robert Latimer, convicted of the 1993 so-called mercy killing of his 12-year-old daughter.¹ That debate is not likely to be settled any time soon, no matter how much public attention it receives. There is, however, another compelling issue associated with both mercy and death that passes largely ignored by the Canadian people and their politicians, even though it touches directly on the lives of many of us. Ultimately, the question of how to make dying an easier, less terrifying prospect affects us all. Dying is a scary business for most people, and one of its most frightening aspects is the pain that might be associated with it. The most effective way of managing severe pain in the terminally ill is heroin, but it is virtually impossible to obtain in a hospital or hospice setting. One can buy it on almost any street corner in almost any city in Canada, but doctors cannot obtain it legally and safely for a cancer patient living out her last few days or hours in excruciating agony that can't really be touched by any other painkiller. *Free Press* medical columnist W. Gifford-Jones recently pointed out that Britain, the only Western nation where the medical use of heroin is allowed to treat the terminally ill, is also ranked as the best place on Earth to die, largely because of that – Canada is ninth.^{2,3} <http://www.winnipegfreepress.com/opinion/fyi/its-time-we-focused-on-quality-of-death-116972413.html>

1. Scroll down to **Assisted (or Facilitated) Death and 'Latimer's lawyer urges update of euthanasia law.'**
2. W. Gifford-Jones's nationally syndicated column appears on a weekly basis in many Canadian newspapers (see sidebar). Gifford-Jones is the pseudonym for Toronto-based physician Ken Walker.

From Media Watch dated 21 February 2011:

ONTARIO | *Toronto Sun* – 19 February 2011 – **'Helping ease terminal patients' No. 1 fear.'** As a physician, I've always known that pain is the overwhelming fear, particularly for cancer patients. <http://www.torontosun.com/life/healthandfitness/2011/02/17/17312936.html>

3. Canada rated 9th 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

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- NOVA SCOTIA | *Chronicle Herald* [Halifax] – 25 February 2011 – **'Latimer's lawyer urges update of euthanasia law.'** Jason Gratl said that Canada's criminal laws do not reflect the opinions of Canadians on issues of euthanasia or assisted suicide. The Vancouver lawyer represented Robert Latimer, a Saskatchewan farmer who received a life sentence for second-degree murder in the death of his daughter Tracy. <http://thechronicleherald.ca/NovaScotia/1230078.html>
N.B. Robert Latimer was granted full parole in November 2010 after serving a ten-year prison term.
- NOVA SCOTIA | CBC News – 24 February 2011 – **'Man claims mercy killing of terminally ill wife.'** A Nova Scotia man admits to giving his terminally ill wife a deadly dose of drugs, according to a report that also says he turned himself in to police. He said he came forward because he wanted to spur a public debate about euthanasia. <http://www.cbc.ca/news/canada/nova-scotia/story/2011/02/24/ns-liverpool-euthanasia-claim.html>
- BRITISH COLUMBIA | *Vancouver Sun* – 23 February 2011 – **'Assisted suicide group applies to become legal corporation.'** The Farewell Foundation for the Right to Die ... argues that the section of the Criminal Code that prohibits assisted suicide is unconstitutional and therefore it should be allowed to help people who are capable of informed decision commit suicide if they choose. <http://www.vancouversun.com/news/Assisted+suicide+group+applies+become+legal+corporation/4330714/story.html>

U.S.A.

Professor with terminal cancer uses illness to teach

MINNESOTA PUBLIC RADIO | Online article – 23 February 2011 – College professors know using personal experiences in their lectures can be an effective way to drive a point home. With that in mind, a sociology professor at Metropolitan State University ... is sharing one of the toughest struggles imaginable with his students. "I've had the most extraordinary life. I have experienced so much. I have no regrets. No, I didn't miss anything on this trip," Monte Bute says. He has terminal cancer. Bute has been using his personal perspective to

enlighten students on the process of death and dying in a class called 'Life of the Mind.' <http://minnesota.publicradio.org/display/web/2011/02/23/dying-professor-death/>

Something just clicked with me being a teacher. This is a teachable moment. Americans are so into denial about death and dying that I can use this, and along with sharing my own quest, for some understanding and wisdom out of this process. Monte Bute

Palliative care prolongs life, reduces suffering

USA TODAY | Online article – 22 February 2011 – There are no secret passwords in medicine, no mysterious handshakes or signals to use when seeking the best care for a serious illness. But experts say two words come close: palliative care. Many people have never heard of palliative care, a comprehensive service that aims to relieve suffering in people with serious illnesses, such as cancer, lung disease or kidney failure. Some patients – and even many doctors – confuse palliative medicine with hospice, a form of palliative care for people in the last six months of life. Other patients mistakenly worry that doctors won't work as hard to cure them if they ask for palliative care, says Gail Cooney, former president of the American Academy of Hospice & Palliative Medicine. Those notions could change in light of recent research. <http://yourlife.usatoday.com/health/medical/treatments/story/2011/02/Palliative-care-prolongs-life-reduces-suffering/44046292/1>

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- WASHINGTON EXAMINER | Online report – 21 February 2011 – **'Montana lawmakers punt on physician-assisted suicide.'** Montana legislators had been asked to choose between two proposed bills in creating a physician-assisted suicide law: Ban the practice altogether or create regulations for doctors and terminally ill patients to follow. Now it appears they'll do neither, leaving the state in the same legal limbo that has existed since a Montana Supreme Court ruling effectively legalized the practice more than a year ago. <http://washingtongaminer.com/news/2011/02/mont-lawmakers-punt-physician-assisted-suicide-0>



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

Cancer patient felt guilty over funding

AUSTRALIA (NEW SOUTH WALES) | *North Shore Times* (North Sydney) – 25 February 2011 – Walter Penzias, 86, who has pancreatic cancer, was taken off the [palliative care] service after a nurse said during a home visit that he looked "very well" and that funding was limited. Retired palliative care specialist Yvonne McMaster said Mr. Penzias was one of many who had suffered following State Government funding cuts to charity Hammond Care. Mr. Penzias was referred to Wahroonga's Neringah Supportive & Palliative Care Community Service late last year after deciding not to seek cancer treatment. The service provides around-the-clock advice and symptom control to help terminally-ill patients stay at home. After the nurse's comment he felt bad he was depriving someone else of the service. "I did agree at that moment, I felt okay and didn't want to waste resources," he said. Weeks later Mr. Penzias developed a high temperature and his wife Carolyn, who is a nurse, said she had no support. "I didn't know whether to take him to the hospital," she said. "It's the uncertainty, the horrible feeling in my stomach all night, that I couldn't do the right thing by him." Dr. McMaster, who co-leads a cancer support service at Wahroonga's Sydney Adventist Hospital, said such cases were becoming common. <http://north-shore-times.whereilive.com.au/news/story/cancer-patient-felt-guilty-over-funding/>

Crisis for U.K. cemeteries?

U.K. | BBC Radio 4 – 19 February 2011 – The U.K.'s death rate is projected to rise over the next 20 years as the baby boomers begin to leave us. With around 30% of people choosing to be buried it has led to concerns about where they are going to go. Burial space in London has been at critical point for some time. It is also a problem in most cities, towns and villages across the country. http://news.bbc.co.uk/today/hi/today/newsid_9402000/9402415.stm

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- AUSTRALIA (SOUTH AUSTRALIA) | *Adelaide Now* – 24 February 2011 – **'New push for euthanasia law.'** A renewed attempt to reform voluntary euthanasia laws ... will be made in Parliament next month. Supporters say the Bill has a stronger chance of being passed than previous proposals. <http://www.adelaidenow.com.au/news/south-australia/new-push-for-euthanasia/story-e6frea83-1226011010075>
 - U.K. | *Daily Mail* – 24 February 2011 – **'We're happy and don't want euthanasia say patients locked in their bodies.'** Most patients 'trapped' in their own bodies are happy and do not want euthanasia, according to the biggest survey yet of people with locked-in syndrome. Contrary to the conventional image of those with the condition, many are able to adapt to the 'devastating' change in their lives, researchers say. And the longer somebody has had the syndrome, the more likely they are to report happiness. The survey, published by the *British Medical Journal*,¹ looks set to ignite the debate about whether people whose lives appear hopeless should be given the chance to die. <http://www.dailymail.co.uk/health/article-1360051/Euthanasia-Patients-locked-bodies-happy-want-die.html>
1. *BRITISH MEDICAL JOURNAL* | Online article – 23 February 2011 – **'A survey on self-assessed well-being in a cohort of chronic locked-in syndrome patients: Happy majority, miserable minority.'** Recently affected LIS [locked-in syndrome] patients who wish to die should be assured that there is a high chance they will regain a happy meaningful life. End-of-life decisions, including euthanasia, should not be avoided, but a moratorium to allow a steady state to be reached should be proposed. http://bmjopen.bmj.com/content/early/2011/02/16/bmjopen-2010-000039.short?q=w_open_current_tab

Cont.

- U.K. | *Telegraph* – 24 February 2011 – '**National Health Service chiefs back calls to reform assisted suicide law.**' The current law, under which helping someone commit suicide is illegal, is not fit for the 21st century, according to the West Midlands NHS [National Health Service] Strategic Health Authority. [Pauline Smith's] comments will be seen as a boost for the right to die campaign, as West Midlands has become the first health authority to back calls for a change in the law to date. <http://www.telegraph.co.uk/news/uknews/8343851/NHS-chiefs-back-calls-to-reform-assisted-suicide-law.html>
- UNITED ARAB EMIRATES (UAE) | Emirates 24/7 – 21 February 2011 – '**UAE people accepting mercy killing: Study.**' People in the UAE have started to accept the idea of helping terminally ill people to die, an act known medically as euthanasia. Nearly half the 226 people surveyed by Twam Hospital in the oasis town of Al-Ain said they approve of the controversial euthanasia for terminally ill patients. <http://www.emirates247.com/news/emirates/uae-people-accepting-mercy-killing-study-2011-02-21-1.358948>

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

Barriers to providing palliative care for older people in acute hospitals

AGE & AGEING, 2011;40(2):233-238. Participants [in this study] identified various barriers to palliative care provision for older people, including attitudinal differences to the care of older people, a focus on curative treatments within hospitals, and a lack of resources. Participants also reported differing understandings of whose responsibility it was to provide palliative care for older people, and uncertainty over the roles of specialist and generalist palliative care providers in acute hospitals. <http://ageing.oxfordjournals.org/content/40/2/233.abstract>

Of related interest:

- *PUBLIC HEALTH ETHICS* | Online article – 17 February 2011 – '**The meaning, limitations and possibilities of making palliative care a public health priority by declaring it a human right.**' There is a growing movement to increase access to palliative care by declaring it a human right. Calls for such a right rarely define crucial concepts involved in such a declaration, in particular 'palliative care' and 'human right.' This paper explores ... the difficulties in using a human rights approach to promote palliative care, and the relevance of such an enterprise to public health ethics. <http://phe.oxfordjournals.org/content/early/2011/02/17/phe.phr002.abstract>

From Media Watch dated 28 September 2009:

- *JOURNAL OF PAIN & SYMPTOM MANAGEMENT* | Online article – 25 September 2009 – '**Advancing palliative care as a human right.**' This article describes recent advocacy activities and explores practical strategies for the palliative care community to use within a human rights framework to advance palliative care development worldwide. [http://www.jpmsjournal.com/article/S0885-3924\(09\)00647-2/abstract](http://www.jpmsjournal.com/article/S0885-3924(09)00647-2/abstract)

Hospital policy on medical futility – does it help in conflict resolution and ensuring good end-of-life care?

ANNALS ACADEMY OF MEDICINE (Singapore), 2011;40(1):19-25. There is a widespread use of policies and guidelines based on the concept of medical futility. Conflicts are rare and appear to arise primarily from the manner in which policies are implemented. End-of-life care appears to be improving as evidenced by a significant number of deaths occurring following: 1) discussions involving patient, family, healthcare team members; 2) cessation of intensive care; and, 3) cessation of institution of palliative care. Deaths are increasingly taking place in the presence of family and outside the intensive care wards. Finally, post mortem audit of processes and practices indicate: 1) compliance, but in a limited manner with policies and recommended guidelines; 2) family satisfaction; and, 3) identify areas where improvement in end-of-life care can be effected. <http://www.annals.edu.sg/pdf/40VolNo1Jan2011/V40N1p19.pdf>

Cont.

N.B. Several articles, reports, etc., on the topic medical futility are noted in Media Watch dated 22 November 2010 (p.2).

Of related interest:

- JAPAN | *Mainichi Daily News* – 25 February 2011 – **'7% of institutions cut life support for children beyond treatment.'** Seven percent of Japanese medical institutions stopped life-sustaining treatment for child emergency patients while 34% withheld active therapies for them, such as an increase in medications, when they were judged unlikely to recover, a survey by a medical research institute showed. The survey by the National Center for Child Health & Development also indicated more than 60% of doctors may present such options to families of such patients, apparently from the point of view of preserving the children's dignity.
<http://mdn.mainichi.jp/mdnnews/news/20110226p2g00m0dm002000c.html>

Patient and healthcare professional factors influencing end-of-life decision-making during critical illness: A systematic review

CRITICAL CARE MEDICINE | Online article – 17 February 2011 – The need for better understanding of end-of-life care has never been greater. Debate about recent U.S. healthcare system reforms has highlighted that end-of-life decision-making is contentious. Providing compassionate end-of-life care that is appropriate and in accordance with patient wishes is an essential component of critical care. Because discord can undermine optimal end-of-life care, knowledge of factors that influence decision-making is important. The authors performed a systematic review to determine which factors are known to influence end-of-life decision-making among patients and healthcare providers. Patients and clinicians may approach end-of-life discussions with different expectations and preferences, influenced by religion, race, culture, and geography. Appreciation of those factors associated with more and less technologically intense care may raise awareness, aid communication, and guide clinicians in end-of-life discussions.
http://journals.lww.com/ccmjournal/Abstract/publishahead/Patient_and_healthcare_professional_actors.98437.aspx

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.

Rehabilitation and palliative care

Allied health professional's views on palliative care for people with advanced Parkinson's disease

INTERNATIONAL JOURNAL OF THERAPY & REHABILITATION, 2011;18(1):49-58. Participants [in this study] viewed palliative care as holistic care ... however, the rehabilitation care they provided was impeded by a number of personal and organisational barriers, and negative perceptions. Misconceptions as to the value of rehabilitation in the palliative stage and a lack of training resulted in uncertainty as to when and how it could be introduced. While the importance of early referral to AHP [allied health professionals] rehabilitation services was highlighted, organisational and administrative barriers prevented many people from accessing such care. http://eprints.ulster.ac.uk/17068/1/Allied_Health_Professionals'_Views_on_Palliative_Care_for_People_with_Advanced_Parkinson's_Disease.pdf

From Media Watch dated 21 February 2011:

- *GERIATRIC REHABILITATION*, 2011;27(1):229-235. '**Geriatric rehabilitation and palliative care: Opportunity for collaboration or oxymoron?**' Over the past decade, there has been much collaboration among clinicians in the area of palliative care and several medical specialties, including physical medicine and rehabilitation. There is a natural compatibility between these two fields. http://journals.lww.com/topicsingeriatricrehabilitation/Abstract/2011/01000/Geriatric_Rehabilitation_and_Palliative_Care_.5.aspx

Palliative care nursing: Defining the discipline?

JOURNAL OF HOSPICE & PALLIATIVE NURSING, 2011;13(2):106-111. For nurses, human response is a complex phenomenon that encompasses the physical, social, emotional, and spiritual aspects of being. Through the art of being present and the science of evidence-based interventions, palliative nurses assess, diagnose, and intervene to support or modify these responses in patients with acute or chronic, potentially life-limiting illnesses and their families to achieve positive patient outcomes that maximize quality of life and alleviate suffering. As the palliative nurse comes to know the patient and family in the nurse-patient relationship, the values, beliefs, past experiences, and goals of all parties emerge and shape future care from symptom management, to advanced directives, treatment choices, and care at the time of death. http://journals.lww.com/jhpn/Abstract/2011/03000/Palliative_Care_Nursing_Defining_the_Discipline_.9.aspx

- *JOURNAL OF HOSPICE & PALLIATIVE NURSING*, 2011;13(2):89-94. '**Integrating palliative care in the ICU: The nurse in a leading role.**' Palliative care is increasingly recognized as an integral component of comprehensive intensive care for all critically ill patients, regardless of prognosis, and for their families. Here we discuss the key role that nurses can and must continue to play in making this evidence-based paradigm a clinical reality across a broad range of intensive care units. http://journals.lww.com/jhpn/Abstract/2011/03000/Integrating_Palliative_Care_in_the_ICU_The_Nurse.6.aspx

Pain relief and end of life care needs focus in India

MED INDIA | Online report – 22 February 2011 – Although most often associated with non-profit institutions diligently serving the poor and the needy... recently, even private healthcare institutions have started incorporating ... [pain management and palliative care] ... at their hospitals, and are trying to expand the reach of palliative care. At present only a very small fraction of patients and families who can benefit from palliative care are able to get access to these services but gradual progress is being made by individuals and organizations working towards a common goal. <http://www.medindia.net/news/Interviews/Pain-Relief-and-End-of-Life-Care-Needs-Focus-in-India-81238-1.htm>

Cont.

From Media Watch dated 14 February 2011:

- INDIA | *Indian Express* – 14 February 2011 – '**Palliative care body to draw national policy.**' The Indian Association of Palliative Care has named a committee to formulate a national policy for it. <http://www.indianexpress.com/news/palliative-care-body-to-draw-national-policy/749747/>

N.B. India rated 40th 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

Is there a need for weekend face-to-face inpatient assessments by hospital specialist palliative care services? Evaluation of an out-of-hours service

PALLIATIVE MEDICINE | Online article – 24 February 2011 – There is an increasing demand for hospital specialist palliative care services to be made more accessible outside of normal working hours. A 'routine' Saturday face-to-face visiting service was introduced into a hospital palliative care team and the service was evaluated to determine whether it was being utilised appropriately. Most of the Saturday assessments resulted in a significant change in management or were undertaken on patients close to death. The authors found clear evidence of the need for a specialist out-of-hours face-to-face inpatient visiting service for hospital palliative care. <http://pmj.sagepub.com/content/early/2011/02/20/0269216310397568.abstract>

From Media Watch dated 16 August 2010:

- *BMC PALLIATIVE CARE* | Online article – 12 August 2010 – '**Out-of-hours GPs and palliative care: A qualitative study exploring information exchange and communication issues.**' Out-of-hours GPs felt left alone on occasion, unable to access daytime services and not knowing who to call for advice. <http://www.biomedcentral.com/content/pdf/1472-684x-9-18.pdf>

From Media Watch dated 31 May 2010:

- *PALLIATIVE MEDICINE* | Online article – 25 May 2010 – '**"Oh God, not a palliative": Out-of-hours general practitioners within the domain of palliative care.**' This project explored factors influencing confidence in dealing with symptom control and palliative care provision outside regular working hours. <http://pmj.sagepub.com/cgi/content/abstract/0269216310368580v1>

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>

Refractory suffering: The impact of team dynamics on the interdisciplinary palliative care team

PALLIATIVE & SUPPORTIVE CARE | Online article – 25 February 2011 – In the face of refractory suffering, team cohesion was identified as a key requirement to support the interdisciplinary team. However, team cohesion was found to be undermined by philosophical differences between team members, a paradigm shift concerning cure versus care and individual opinions regarding the chosen approach and levels of respect between the individual disciplines involved in the care of a person with a life limiting illness. The findings of this study highlight the precarious nature of the interdisciplinary team when significant challenges are faced. As a result of witnessing refractory suffering the division and fracturing of teams can easily occur; often team members are completely unaware of its cause. The findings of this study contribute to the limited literature on the nature of refractory suffering from the perspective of the interdisciplinary team. <http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=8146858&fulltextType=RA&fileId=S1478951510000544>

Assisted (or facilitated) death

Representative sample of recent articles, etc:

- *THORAX* (International Journal of Respiratory Medicine) | Online article – 18 February 2011 – '**The law looks at assisted dying.**' This paper, loosely based on an invited lecture to the 2010 summer meeting of the British Thoracic Society, seeks to explore the dilemma by tracing the attitude of English law to medical involvement in death and dying over the last 75 years. <http://thorax.bmj.com/content/early/2011/02/18/thx.2011.159574.extract>

Worth Repeating

"Be nice – until it is time not to be nice"

JOURNAL OF PALLIATIVE MEDICINE, 2007;10(2):308. The organizational culture of palliative care can be stratified into three value levels: the "surface level values," which can be easily discerned but hard to understand; beneath the surface level are the "espoused values," which are conscious strategies, goals and philosophies; and finally, the inner "core values," which are the basic underlying assumptions and premises of palliative care. In a field focused on improving care for patients with serious illnesses, clinicians are often caught between vulnerable patients and families who need compassion, gentleness, and sufficient time to make decisions and a health care system that is often fast paced, unrelenting, and less than optimally responsive to the human needs of dying patients and their families. While a gentle compassionate approach is congruent with the core palliative care value of providing quality care, it is true that this soft approach is ineffective when interfacing with main stream medicine and in effecting changes at a health care system level. Thus, palliative care clinicians may often experience the cognitive dissonance created by the need to switch from being the gentle clinician (core value) providing patient-centered care to the unrelenting activist (espoused value) grappling with the system in an effort to foster social change aimed at advancing care at the end of life. <http://www.liebertonline.com/doi/abs/10.1089/jpm.2006.9982?prevSearch=allfield%253A%2528compassion%2529&searchHistoryKey=>

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