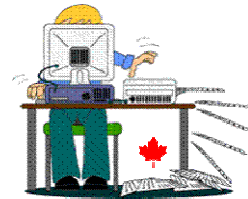


Media Watch...

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.

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Compiled & Annotated by Barry R. Ashpole

Care planning: Scroll down to [Specialist Publications](#) and 'End-of-life care pathways as tools to promote and support a good death: A critical commentary' (p.10), published in the *European Journal of Cancer Care*.

Canada

Parliamentary Committee on Palliative & Compassionate Care

MPs call for national palliative-care, suicide-prevention strategies

POSTMEDIA NEWS | Online report – 17 November 2011 – A patchwork system of end-of-life care must be replaced with a national palliative-care strategy to ensure those whose lives are coming to an end can spend it in comfort, says a report from a cross-party parliamentary committee.¹ The report ... recommends the federal government create a palliative-care secretariat that could ensure end-of-life care is available to anyone across the country. Currently, palliative care is only available for up to one-third of Canadians, the report found, and sometimes care isn't provided evenly in the same city. Some parts of Canada have no access to palliative care, the report said. Other nations, such as Georgia and Poland, have national strategies for end-of-life care, but not so in Canada, the report said. "Despite efforts made by palliative-care providers, Canadians have a long way to go to meet our goal of quality end-of-life care. Canadians in all parts of our country should

be able to get effective palliation of their pain and symptoms," the report said. "Palliative care requires the mobilization of persons and communities from coast to coast. Compassion has long been the hallmark of what it is to be Canadian." The report ... provides ... 14 recommendations that also address ways to prevent suicide and elder abuse. <http://www.montrealgazette.com/news/call+national+palliative+care+suicide+prevention+strategies/5726803/story.html>

Of related interest:

Report of the Royal Society of Canada expert panel on end of life decision making

Scroll down to '**Experts panel urges decriminalization of euthanasia and assisted suicide**' (p.3).

1. *Not to be Forgotten: Care of Vulnerable Canadians*, Ad Hoc (All Party) Parliamentary Committee on Palliative & Compassionate Care, 17 November 2011. <http://pcpcc-cpspsc.com/wp-content/uploads/2011/11/ReportEN.pdf>

Hassan Rasouli case

End of life decisions – do doctors have the right to decide?

ONTARIO | *Jewish Tribune* – 14 November 2011 – Mr. [Hassan] Rasouli was in a permanent vegetative state. Fed through a tube inserted into his stomach, he was only being kept alive by a mechanical ventilator. Believing there was no realistic hope of recovery the doctors wanted to remove his life support. His family said no. Who has the right to make these decisions? The doctors suggested that they do. The family disagreed. As Shia Muslims, Mr. Rasouli's family believed that as long as a person was alive everything should be done to prevent death. Accordingly, they opposed the doctors' plan to withdraw the mechanical ventilation. This case was first heard by Madam Justice Himel of the Ontario Superior Court of Justice. It was appealed to the Ontario Court of Appeal. Now leave is being sought to have the matter heard by the Supreme Court of Canada. This case depends on the definition of 'treatment' in the Ontario Health Care Consent Act and the steps set out by the act to resolve disagreements between doctors and substitute decision makers about treatment plans. The act provides that medical treatment shall not be administered without the consent of the patient. If the patient is not capable of giving consent, the treatment must be approved by the person appointed as the patient's substitute decision-maker. Key to the court's review is the legal meaning of the word 'treatment.' Also fundamental to the decision-making process are the real wishes of the patient. The substitute decision-maker's wishes were unimportant – it's what the patient wanted to do that is key. http://www.jewishtribune.ca/TribuneV2/index.php?option=com_content&task=view&id=5062&Itemid=53

From Media Watch dated 26 September 2011:

- *THE MEDICAL POST* | Online article – 21 September 2011 – **'Vegetative patient dispute forces rethink of term "treatment."** Words are what law is made of. So it comes as no surprise that judges often interpret words and decide what they mean. A good example is a recent case from the Ontario Court of Appeal involving the word "treatment." The case ... deals with the perennial and difficult question of how a doctor can legally pull the plug on someone who has entered a permanent vegetative state. <http://www.canadianhealthcarenetwork.ca/physicians/magazines/the-medical-post/september-20-2011/vegetative-patient-dispute-forces-rethink-of-term-treatment-18209>

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?mediawatch=1>

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/pg/file/owner/MediaWatch>

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

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

Assisted (or facilitated) death

Expert panel urges decriminalization of euthanasia and assisted suicide

CANADIAN PRESS | Online report – 15 November 2011 – A long-awaited experts' report on how Canada and Canadian families handle the end of life calls on the federal government to decriminalize euthanasia and assisted suicide.¹ And if Ottawa won't co-operate, the panel says provinces should go it alone, by making clear they won't prosecute health-care professionals involved in assisted dying. "Assisted suicide and voluntary euthanasia should be legally permitted for competent individuals who make a free and informed decision that their life is no longer worth living," says the report by the Royal Society of Canada's expert panel on end-of-life decision-making. The report was two years in the making. It brought together a panel of experts on medicine, philosophy, ethics and health to look at what is being done in other countries, examine Canadian practices and sentiments and formulate recommendations. The panel was meant to be neutral, to inform rational debate and lead to solid policy in an area that is always emotional and controversial. But the Euthanasia Prevention Coalition of Ontario dismissed the report before it was even public, saying at least one of the panel members is a noted euthanasia advocate. But the panel says that Canadians are overwhelmingly in favour

of finding an even-handed way to allow voluntary assisted suicide but would not permit anything involuntary. "We carefully considered Canadian values, international experience in permissive regimes, and legal and ethical aspects of these practices and came to the unanimous conclusion that Canada should have a permissive yet carefully regulated and monitored system with respect to assisted death," the report says. <http://www.winnipegfreepress.com/arts-and-life/life/health/expert-panel-urges-decriminalization-of-euthanasia-and-assisted-suicide-133873143.html>

Extract from Canadian Press report:

Controversy surrounding euthanasia aside, the main thrust of the Royal Society of Canada report was to stress that Canadian governments, institutions and families alike are doing a rotten job in preparing for death and dying. The panel urged far more attention to palliative care, living wills and public education about how to prepare advance directives for a patient's own health care. The panel also dismissed the use of the word 'dignity' in discussions about the end of life. The word is abused by both sides of the euthanasia debate, and is too vague to do anyone any good, the report says.

1. *Royal Society of Canada Expert Panel: End of Life Decision Making*, November 2011:

In brief: http://www.rsc-src.ca/documents/RSC_EOL_1_3_25_Twenty-five_EN_FINAL.pdf

In full: http://www.rscsrc.ca/documents/RSCEndofLifeReport2011_EN_Formatted_FINAL.pdf

N.B. The report is also published online in the journal *Bioethics*:
<http://onlinelibrary.wiley.com/doi/10.1111/j.1467-8519.2011.01939.x/abstract>

Representative sample of news media commentary on the Royal Society report:

- ONTARIO | *Toronto Star* (OpEd) – 16 November 2011 – **'MPs can't run from right-to-die debate forever.'** Parliamentarians can run from the resurging right-to-die debate all they want but the past suggests that they will not be able to hide forever. Once in every political generation, a societal issue creeps up onto MPs' radar despite the strenuous efforts by a majority of the country's legislators to look the other way. <http://www.thestar.com/news/canada/politics/article/1087934--hebert-mps-can-t-run-from-right-to-die-debate-forever>

Cont.

Of related interest:

- BRITISH COLUMBIA | *Globe & Mail* – 17 November 2011 – **'Desire to control future spurs assisted suicide requests, court hears.'** A desire to control their future, not depression or fear of pain, is the main reason people seek physician-assisted suicide or euthanasia, the Supreme Court of British Columbia has heard in a right-to-die case. Helene Starks, an associate professor at the University of Washington School of Medicine, told court that a groundbreaking study she was involved in showed that terminally ill patients sought the right to die only after long periods of reflection – and that they were primarily driven by a desire for control over the place, process and timing of death. http://www.theglobeandmail.com/life/health/end-of-life/desire-to-control-future-spurs-assisted-suicide-requests-court-hears/article2240575/?utm_medium=Feeds%3A%20RSS%2FAtom&utm_source=Home&utm_content=2240575
- BRITISH COLUMBIA | *Globe & Mail* – 15 November 2011 – **'Right-to-die case explores legal, ethical and moral issues.'** The moral, legal and ethical issues doctors face as they care for patients in the final weeks of their lives are being highlighted in a right-to-die case before the Supreme Court of British Columbia. During cross-examination, Douglas McGregor, regional medical director of palliative care for the Vancouver Coastal Health Authority, was asked about having to make the troubling life-or-death decisions concerning terminally ill patients. Joseph Arvay, a lawyer trying to strike down a section of the Criminal Code that makes it illegal for physicians to assist in suicide, outlined a hypothetical case for Dr. McGregor in which a terminally ill patient begs to be heavily sedated, knowing it will be fatal. <http://m.theglobeandmail.com/life/health/end-of-life/right-to-die-case-explores-legal-ethical-and-moral-issues/article2237574/?service=mobile>
- ONTARIO | *Ottawa Citizen* (OpEd) – 17 November 2011 – **'The Dutch are on the euthanasia slippery slope, right? Wrong.'** With the release of an important new report, and the launch of another Charter challenge, the debate about euthanasia is flaring up again. It will be passionate. You will hear emotional claims from both sides. Many people will listen to nothing else. But for those who want to be rational, those who want to learn as much as they can and draw a conclusion based on evidence, there is one essential fact to bear in mind. The Dutch are more honest than we are. <http://www.ottawacitizen.com/opinion/Dutch+euthanasia+slippery+slope+right+Wrong/5726698/story.html>
- NATIONAL POST | Online OpEd – 14 November 2011 – **'Anti-euthanasia victory could prove to be a defeat.'** Euthanasia and end-of-life care are controversial enough when the patient is demonstrably eager for death. It's even more complex when it involves patients who have been left unable to make their own decisions due to severe brain injury. A new study¹ ... offers hope of making the choice between life and death easier, and would seem to favour the pro-life camp of the right-to-die debate. <http://fullcomment.nationalpost.com/2011/11/14/matt-gurney-anti-euthanasia-victory-could-prove-to-be-a-defeat/>
 1. 'Bedside detection of awareness in the vegetative state: A cohort study,' *The Lancet*, published online 10 November 2011 (noted in Media Watch dated 14 November 2011). [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(11\)61224-5/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(11)61224-5/fulltext)

[U.S.A.](#)

Death midwife also assists at the end of life

ILLINOIS | *Chicago Tribune* – 21 November 2011 – When we think of a midwife or a doula, typically we imagine a person who helps a mother during her pregnancy, labor and delivery. While Ana Blechschmidt is a certified birth doula who works in this regard, she also specializes in the end of life, helping people pass on. That makes her a death doula, or death midwife. What makes a death doula different from a hospice nurse is that a death doula doesn't administer medicine or perform medical procedures, and is not certified or licensed by the state, according to the Illinois Department of Financial & Professional Regulation. Also, the death doula will remain – if the family wants – after the client dies to help with the funeral, which often is carried out in a place other than a funeral home. <http://www.chicagotribune.com/news/columnists/ct-met-trice-death-doula-1114-20111121.0.6947868.column>

Prison hospice

Amid ill and dying inmates, a search for redemption

CALIFORNIA | *Los Angeles Times* – 20 November 2011 – They passed a row of rooms filled with men in their 50s, 60s and 70s. Most had committed horrendous crimes and would spend their final days in this small wing of the California Medical Facility, a high-security prison at the base of rolling hills near Sacramento. The facility housed roughly 3,000 criminals: some in good health, some ill, some dying. In the hospice, the oldest inside a California prison and one of the nation's first, some of the dying men looked robust, as if defying their illnesses. Some were hunched and gaunt. <http://www.latimes.com/news/local/la-me-1120-prison-hospice-html,0,6904576.htmlstory>

Homecare and hospice seeks veterans to volunteer for new type of service to nation

MINNESOTA | *Chisago County Press* – 17 November 2011 – Fairview Homecaring & Hospice ... is putting out a call for some special volunteers ... As the daughter of a career Navy chief bosun's mate, [Community Liaison Susan Taylor] has been especially struck by the number of aging and ill veterans who are clients. Taylor is looking for volunteers ... who are veterans themselves, who can relate to and support veterans and their families in a way that non-military people can't. <http://www.chisagocountypress.com/main.asp?SectionID=1&SubSectionID=1&ArticleID=15223>

Of related interest:

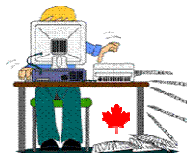
- FLORIDA | *Times* (Tampa Bay) – 18 November 2011 – **'HPH Hospice accepting worn U.S. flags.'** HPH Hospice has introduced a new component to its We Honor Veterans pinning ceremonies. In addition to a certificate and pin, hospice patients who are veterans receive a star from a worn American flag, with a message that reads "I am part of our American flag that has flown over a home in Florida. I can no longer fly. The sun and wind have caused me to become tattered and torn. Please carry me as a reminder that you are not forgotten." <http://www.tampabay.com/news/briefs/hph-hospice-accepting-worn-us-flags/1202234>
- NEW YORK | *Daily News* (Albion) – 14 November 2011 – **'Orleans Hospice offers transitions program.'** Anyone may take advantage of the program who has a serious illness with a life-limiting prognosis; needs assistance in assessing community and medical resources to manage their disease and the challenges it brings; may be undergoing curative treatment for their disease; or is not yet ready to make a decision about entering a hospice program. http://thedailynewsonline.com/news/article_d0aaec60-0e87-11e1-8dc8-001cc4c03286.html

End-of-life documents not a huge concern for many boomers

ASSOCIATED PRESS | Online report – 16 November 2011 – Most people don't want to think about death, much less plan for it – especially when they feel healthy and young in their middle-age years. And that, some baby boomers say, is one of the big reasons so few of them have end-of-life legal documents such as a living will. An Associated Press-LifeGoesStrong.com poll found that 64% of boomers – those born between 1946 and 1964 – say they don't have a health care proxy or living will. http://www.washingtonpost.com/politics/end-of-life-documents-not-a-huge-concern-for-many-boomers/2011/11/16/gIQA0HFMQN_story.html

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>



Physicians push for more palliative care despite barriers

KAISER HEALTH NEWS | Online report – 15 November 2011 – A poll ... found that an overwhelming majority of doctors support palliative care, with 96% responding that they believe enhancing the quality of life for seriously ill patients is more important than extending life as long as possible.¹ Despite these sentiments, many physicians responded that they have some hesitations about palliative care and that there are barriers to its full adoption. Notably, the poll ... also found a dramatic "generation gap" in physicians' education and training on palliative care. Seventy-three percent of physicians age 39 or younger report "a great deal" or "some" exposure to palliative care during medical school compared to 36% of those age 40-49, 23% of those age 50-59, and only 6% of those age 60 or older. The poll found that 79% of physicians think the health care system spends too much trying to extend life while 21% believes the system should do whatever it takes. Many physicians also reported that they received little training on operational and financial aspects of palliative care and that they would like more on those topics. <http://capsules.kaiserhealthnews.org/index.php/2011/11/physicians-push-for-more-palliative-care-despite-barriers/>

1. 'Living well at the end of life poll: Topline results,' *The National* & Regence Foundation, November 2011. <http://syndication.nationaljournal.com/communications/NationalJournalRegenceDoctorsToplines.pdf>

Many oncologists not on top of managing pain: Study

REUTERS | Online report – 14 November 2011 – In new survey of cancer doctors in the U.S., many oncologists said they were good at managing their patients' pain¹ – but most failed to choose the right treatment option in a test, and said that figuring out how much pain patients have is still a major barrier to providing appropriate care. The study is a follow-up to a similar survey that found a lack of good pain management practices in U.S. oncologists in 1990 – and it shows that more work needs to be done to educate doctors about pain, researchers said. Experts agreed that the findings mean it's extra important for patients to be vocal about their symptoms. "When patients come to see their oncologists, they're wondering often, 'Am I going to die from this? What is the size of the tumor the doctor's going to palpate?'" said Dr. Neil Hagen, the head of palliative medicine at Alberta Health Services Cancer Care in Calgary, Canada, who didn't participate in the new research. "In that scenario it's so easy for pain and symptoms to take second place to the cancer treatment." <http://www.reuters.com/article/2011/11/14/us-oncologists-pain-idUSTRE7AD2B620111114>

1. 'Medical oncologists' attitudes and practice in cancer pain management: A national survey,' *Journal of Clinical Oncology*, published online 14 November 2011. Data suggest that, for more than 20 years, a focus on cancer pain has not adequately addressed the perception of treatment barriers or limitations in pain-related knowledge and practice within the oncology community. <http://jco.ascopubs.org/content/early/2011/11/13/JCO.2011.35.0561.abstract>

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- WASHINGTON | *The Olympian* (Olympia) – 16 November 2011 – **'Perhaps it's time to expand Washington's Death with Dignity Act.'** ...the Death with Dignity Act was written to apply only to the choices of the terminally ill who are competent at the time of their death. This raises the question whether, if the act continues to work as intended, we should extend the choice of voluntary euthanasia to: persons who are not terminally ill but suffering a severely debilitating medical condition they judge to be unbearable; [and] persons who are not competent at the time of their death but who previously made a competent choice of euthanasia as evidenced through a special type of advance directive. <http://www.theolympian.com/2011/11/16/1878667/perhaps-its-time-to-expand-washingtons.html>

International

Eldercare

Thousands of vulnerable elderly lose help they need to stay at home because of town hall cuts

U.K. | *Daily Mail* – 21 November 2011 – Thousands of vulnerable pensioners are being stripped of care services which are vital to help them stay in their own homes because of town hall cuts. More than four in five councils are now denying free care – such as home helps, meals on wheels and the installation of stairlifts – to all but those with the most serious health needs. This means that elderly people with crippling disabilities are being left to fend for themselves, even though they need help to wash, dress and go to the lavatory. The findings come just days before the release of a damning report from the Equalities & Human Rights Commission which will castigate councils for ignoring the human rights of the elderly by providing shockingly poor levels of home care. <http://www.dailymail.co.uk/news/article-2064066/Thousands-vulnerable-elderly-lose-help-need-stay-home.html>

Hospices claim victory in Health & Social Care Bill amendment

U.K. | Civil Society (Finance) – 16 November 2011 – The House of Lords has voted for an amendment to the Health & Social Care Bill requiring government to report to Parliament on the VAT [Value Added Tax] treatment of supplies used by charities providing healthcare services on behalf of the NHS [National Health Service]. The amendment ... requires the government to provide a report within one year of the Health and Social Care Bill passing. Hospices in particular claim the current VAT system puts them at a financial disadvantage to NHS providers. http://www.civilsociety.co.uk/finance/news/content/10971/sue_ryder_care_wins_amendment_to_health_and_social_care_bill

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.

Ashes to beads: South Koreans try new way to mourn

SOUTH KOREA | Associated Press – 14 November 2011 – The intense grief that Kim Il-nam has felt every day since his father died 27 years ago led to a startling decision: He dug up his father's grave, cremated his bones and paid \$870 to have the ashes transformed into gem-like beads. Kim is not alone in his desire to keep a loved one close – even in death. Changes in traditional South Korean beliefs about cherishing ancestors and a huge increase in cremation have led to a handful of niche businesses that cater to those who see honoring an urn filled with ashes as an imperfect way of mourning. "Whenever I look at these beads, I consider them to be my father and I remember the good old days with him," a gray-haired Kim, 69, told The Associated Press in an interview. <http://www.google.com/hostednews/ap/article/ALeqM5gT0OwyQFgT51TghLEBo8-t9yOHWQ?docId=98c742f31df842fa94a1b76bc894685e>

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

Family dynamics

When the office visit is a family matter

AMERICAN MEDICAL NEWS | Online article – 14 November 2011 – As a geriatrician who treats many patients with cognitive problems, Lee A. Lindquist, MD, MPH, is accustomed to seeing family members accompany patients on visits to her Chicago clinic. The relatives often serve as caregivers and help make critical medical decisions. Yet Dr. Lindquist was taken aback when she walked into an exam room recently to find her patient waiting – along with seven family members. "It was like being in a crowded elevator," says Dr. Lindquist, assistant professor of medicine at Northwestern University Feinberg School of Medicine in Illinois. "We had a wheelchair in there, too, that the patient was sitting in. They all wanted to be in there, so we did it." With relatives in the room, it proves difficult to keep the office visit focused, Dr. Lindquist says. "It becomes more about managing family affairs than about what's best for the patient," she says. "I have to say, 'Stop! We're here for your mom.' It's kind of like how I treat my toddlers." <http://www.ama-assn.org/amednews/2011/11/14/prsa1114.htm>

When doctors and daughters disagree: Twenty-two days and two blinks of an eye

JOURNAL OF THE AMERICAN GERIATRICS SOCIETY | Online article – 8 November 2011 – A cornerstone of American medical ethics is the right to say, "Keep your hands off of me," to decline medical treatment. A central problem is how to decide about individuals who have become incapacitated and can no longer request or refuse potentially life-sustaining treatment. An advance directive is a formal attempt to protect people's right to autonomy when they are no longer autonomous. As such, it assumes that previously expressed wishes are precise and immutable, but many families make decisions together, and individuals may negotiate, compromise, and modify their genuine preferences, especially when novel threats arise, and the stakes are high. The current article describes a case in which two daughters overruled a patient's explicit preference to refuse life-sustaining treatment, leading to burdensome illness before death. <http://onlinelibrary.wiley.com/doi/10.1111/j.1532-5415.2011.03700.x/abstract>

From Media Watch dated 17 January 2011:

- *JOURNAL OF PAIN & SYMPTOM MANAGEMENT* | Online article – 14 January 2011 – **'Is the patient's voice under-heard in family conferences in palliative care? A question from Sydney, Australia.'** Effective, humane, and trustworthy communication among patient, family, and professional carers is an essential element of good palliative care. Family conferences are thought to facilitate such communication. [http://www.jpmsjournal.com/article/S0885-3924\(10\)00983-8/fulltext](http://www.jpmsjournal.com/article/S0885-3924(10)00983-8/fulltext)

Technology in palliative care

Palliative medicine and smartphones: An opportunity for innovation?

BMJ PALLIATIVE & SUPPORTIVE CARE | Online article – 15 November 2011 – Six apps specific to palliative medicine were identified [in this study] across all five operating systems. These consisted of blog orientated apps (Pallimed and Geripal), an app containing guidelines from eight cancer networks (PalliApp), an educational app (Palliative Care) and opioid dose converter apps (eOpioid and PalliCalc). There is a lack of palliative medicine specific resources for smartphones and no studies have been published which examine the potential benefits of mobile technology for learning, clinical practice and professional development. Academic institutions could work with technological developers to improve access to, and dissemination of, key information for practice. <http://spcare.bmj.com/content/early/2011/11/15/bmjspcare-2011-000151.abstract>

Of related interest:

- *TELEMEDICINE AND E-HEALTH* | Online article – 15 November 2011 – '**A systematic review of the evidence base for telehospice.**' The use of telehealth technologies to overcome the geographic distances in the delivery of hospice care has been termed telehospice. Although telehospice research has been conducted over the last 10 years, little is known about the comprehensive findings within the field. A small evidence base for telehospice has emerged over the last 10 years. Although the evidence is of medium strength, its pertinence is strong. <http://www.liebertonline.com/doi/abs/10.1089/tmj.2011.0061>

Integrating palliative care in the surgical and trauma intensive care unit: A report from the Improving Palliative Care in the Intensive Care Unit (IPAL-ICU) Project Advisory Board and the Center to Advance Palliative Care

CRITICAL CARE MEDICINE | Online article – 10 November 2011 – Characteristics of patients with surgical disease and practices, attitudes, and interactions of different disciplines on the surgical critical care team present distinctive issues for intensive care unit palliative care integration and improvement. Physicians, nurses, and other team members in surgery, critical care and palliative care (if available) should be engaged collaboratively to identify challenges and develop strategies. Important components of an improvement effort include attention to efficient work systems and practical tools and to attitudinal factors and "culture" in the unit and institution. Approaches that emphasize delivery of palliative care together with surgical critical care hold promise to better integrate palliative care into the surgical intensive care unit. http://journals.lww.com/ccmjournal/Abstract/publishahead/Integrating_palliative_care_in_the_surgical_and.98189.aspx

Extract from *Critical Care Medicine* article

"Consultative," "integrative," and combined models can be used to improve intensive care unit palliative care, although optimal use of trigger criteria for palliative care consultation has not yet been demonstrated.

From Media Watch dated 14 November 2011:

- CENTER TO ADVANCE PALLIATIVE CARE | Press release – 10 October 2011 – '**IPAL-EM launches to improve palliative care in emergency medicine.**' A new national initiative ... will integrate and increase the use of palliative care when seriously ill patients are admitted to the emergency department. http://www.eurekaalert.org/pub_releases/2011-11/tmsh-ilt110411.php

N.B. IPAL-EM website: www.capc.org/ipal

Cont.

Of related interest:

- *INTERNATIONAL JOURNAL OF NURSING STUDIES* | Online article – 10 November 2011 – **'Challenges in transition from intervention to end of life care in intensive care: A qualitative study.'** Patients who died in intensive care appeared to follow a three-stage end of life trajectory: admission with hope of recovery; transition from intervention to end of life care; a controlled death. The transition ... was reported as being the most problematic and ambiguous stage in the end of life trajectory, with potential for conflict between medical teams, as well as between doctors and nurses. <http://www.sciencedirect.com/science/article/pii/S0020748911004160>

End-of-life care pathways as tools to promote and support a good death: A critical commentary

EUROPEAN JOURNAL OF CANCER CARE | Online article – 10 November 2011 – This paper calls into question whether and how end-of-life care pathways facilitate the accomplishment of a 'good death.' Achieving a 'good death' is a prominent social and political priority and an ideal which underpins the philosophy of hospice and palliative care. End-of-life care pathways have been devised to enhance the care of imminently dying patients and their families across care settings and thereby facilitate the accomplishment of a 'good death.' These pathways have been enthusiastically adopted and are now recommended by governments in the U.K. as 'best practice' templates for end-of-life care. However, the literature reveals that the 'good death' is a nebulous, fluid concept. Moreover, concerns have been articulated regarding the efficacy of care pathways in terms of their impact on patient care and close analysis of two prominent end-of-life pathways reveals how biomedical aspects of care are privileged. Nonetheless drawing on a diverse range of evidence the literature indicates that end-of-life care pathways may facilitate a certain type of 'good death' and one which is associated with the dying process and framed within biomedicine. <http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2354.2011.01301.x/full>

Breaking bad news – an interdisciplinary curricular teaching-concept

GESELLSCHAFT FÜR MEDIZINISCHE AUSBILDUNG | Online article – 15 November 2011 – The concerns of patients suffering from life-threatening disease and end-of-life care aspects have gained increasing attention in public perception. The increasing focus on palliative medicine questions can be considered to be paradigmatic for this development. Palliative medicine became a compulsory subject of the undergraduate curriculum in Germany to be implemented until 2013. The pre-existing conditions and qualifications at the medical faculties vary, though. The authors describe the conceptual process, didactic background, and first experiences with the new interdisciplinary course "Delivering bad news" as a compulsory part of the palliative medicine curriculum. <http://www.egms.de/static/en/journals/zma/2011-28/zma000764.shtml>

Having to focus on doing rather than being – Nurse assistants' experience of palliative care in municipal residential care settings

INTERNATIONAL JOURNAL OF NURSING STUDIES | Online article – 12 November 2011 – The nurse assistants described palliative care as a contrast to the everyday care they performed in that they had a legitimate possibility to provide the care needed and a clear assignment in relation to relatives. Palliative care also meant having to face death and dying while feeling simultaneous that it was unnatural to talk about death and having to deal with their own emotions. They emphasised that they were in need of support and experienced leadership as invisible and opaque, but gained strength from being recognized. In order to support nurse assistants in providing high quality end-of-life care, more focus is needed on the trajectory of older peoples' dying, on the importance of involving relatives throughout the period of care provision, and on support when encountering death and dying. There is also a need for engaged care leaders, both registered nurses and managers, to recognize the work of nurse assistants and to support care provision for older people within the framework of palliative care philosophy. <http://www.sciencedirect.com/science/article/pii/S0020748911004135>

Building on individual, state, and federal initiatives for advance care planning, an integral component of palliative and end-of-life cancer care

JOURNAL OF ONCOLOGY PRACTICE, 2011;7(6):355-359. Historically, advance care planning interventions ... have been unable to consistently demonstrate positive outcomes for patients with life-threatening illnesses. However, more recent literature, including that on patients with cancer, illustrates that both patients and caregivers report improved quality of life and less distress after discussions with their health care teams about end-of-life care. The authors discuss recent federal and state public policy that focuses on advance care planning, suggesting the promise for care delivery improvements and the means by which existing barriers might be surmounted. These care delivery issues apply to several disease states but are particularly pertinent to the adult oncology setting. <http://jop.ascopubs.org/content/7/6/355.abstract>

N.B. This issue of the *Journal of Oncology Practice* includes several articles on different aspects of palliative care: Contents page: <http://jop.ascopubs.org/content/current>

A narrative literature review of the evidence regarding the economic impact of avoidable hospitalizations amongst palliative care patients in the U.K.

PROGRESS IN PALLIATIVE CARE, 2011;19(6):291-298. The evidence base from the U.K. relating to the economic impact of avoidable admissions in palliative care is limited. Although two recent retrospective studies suggest that there are currently high levels of avoidable admissions, the feasibility of avoiding such admissions and the full economic consequences of such changes have not been clearly demonstrated. Further evidence is needed to provide a more robust estimate of the extent to which the additional costs of providing high-quality community support are offset by reduced inpatient usage by palliative care patients. Prospective studies are needed which seek to demonstrate the scale of admissions which can actually be avoided in clinical practice, when issues such as capacity constraints come into play. <http://www.ingentaconnect.com/content/maney/ppc/2011/00000019/00000006/art00001>

Worth Repeating

The dying, those who care for them, and how they cope with loneliness

AMERICAN JOURNAL OF HOSPICE & PALLIATIVE MEDICINE, 2007;24(5):399-407. This study compares the manner in which the dying, their caregivers, and the general population cope with loneliness. The patients were recruited in an oncological hospice in Israel and, despite being on their deathbed, agreed to participate. The participants anonymously answered a 34-item questionnaire and were asked to endorse those items that described their strategies of successfully coping with loneliness. Dying patients scored significantly lower than the general population on the social support network and increased activity sub-scales, with a reversed trend for religion and faith. <http://ajh.sagepub.com/content/24/5/399.short>

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