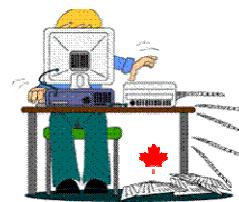


Media Watch...

is intended as an advocacy and research tool. The weekly report is international in scope and distribution – to colleagues who are active or have a special interest in **hospice** and **palliative care**, and in the quality of **end-of-life care** in general – to help keep them abreast of current, emerging and related issues – and, to inform discussion and encourage further inquiry.

4 March 2013 Edition | Issue #295



Compilation of Media Watch 2008, 2009, 2010, 2011, 2012, 2013 ©

Compiled & Annotated by Barry R. Ashpole

Caring during birth and death: Scroll down to [Specialist Publications](#) and 'Working in a medicalised world: The experiences of palliative care nurse specialists and midwives' (p.8), in *International Journal of Palliative Nursing*.

Canada

Bruyère Continuing Care plans big cuts to support staff

ONTARIO | *Ottawa Citizen* – 28 February 2013 – As it grapples with a \$4.2-million deficit, Bruyère Continuing Care is looking at eliminating 120 to 150 positions, mainly personal care attendants, over the next two years. Other positions at risk include managers, directors, supervisors, administrative support staff, physiotherapists, housekeepers, ward clerks, porters, and rehabilitation assistants. "Like all the other hospitals in Ontario we are facing some financial challenges and also we're doing some redesign of some of our programs," president and chief executive Bernie Blais said. "In that process, there will be a number of people impacted by that," he said. "This is a work in

progress. No final decision has been made." <http://www.ottawacitizen.com/Bruy%C3%A8re+Continuing+Care+plans+cuts+support+staff/8032057/story.html>

Extract from *Ottawa Citizen* report

Other changes under consideration include closing about 25 to 30 of the 536 beds at Elisabeth Bruyère Hospital and Saint-Vincent Hospital, among them 10 geriatric rehabilitation beds, 10 stroke rehabilitation beds, and five to 10 palliative care beds.

Canadians close their eyes to the staggering cost of elder care

ONTARIO | *The Toronto Star* (OpEd) – 27 February 2013 – No one has to clue how to pay for elder care as the population ages and families stagger under the load. It is critical to get Canadians thinking and talking about this issue. The existing elder care system is breaking under the strain – the waiting list for a spot in a nursing home is approximately 20,000 in Ontario alone – and the baby boom hasn't even hit its heavy-need years. Home care is severely underfunded. And hospitals, the most expensive option, can't accommodate an influx of frail, elderly patients. http://www.thestar.com/opinion/editorialopinion/2013/02/27/canadians_close_their_eyes_to_the_staggering_cost_of_elder_care_goar.html

Cont.

Noted in Media Watch, 14 January 2013:

- ONTARIO | CBC News – 8 January 2013 – '**Ontario eyes changing health needs of aging population.**' The 1.9 million seniors living in Ontario make up about 14.6% of the province's population. But, they account for nearly half of all health-care spending. The number of Ontario seniors may double within 20 years. <http://www.cbc.ca/news/health/story/2013/01/08/ontario-seniors-health-care-needs.html>

U.S.A.

Elder care

Medicare paid \$5.1 billion for poor nursing home care

WASHINGTON DC | Associated Press – 28 February 2013 – Medicare paid billions in taxpayer dollars to nursing homes nationwide that were not meeting basic requirements to look after their residents, government investigators have found.¹ The report by the Department of Health & Human Services said Medicare paid about \$5.1 billion for patients to stay in skilled nursing facilities that failed to meet federal quality of care rules in 2009, in some cases resulting in dangerous and neglectful conditions. One out of every three times patients wound up in nursing homes that year ... in facilities that failed to follow basic care requirements laid out by the federal agency that administers Medicare, investigators estimated. Not only are residents often going without the crucial help they need, but the government could be spending taxpayer money on facilities that

could endanger people's health. The findings come as concerns about health care quality and cost garner heightened attention as the Obama administration implements the nation's sweeping health care overhaul. <http://abcnews.go.com/US/wireStory/medicare-paid-51b-poor-nursing-home-care-18614818>

Extract from Associated Press report

By law, nursing homes need to write up care plans specially tailored for each resident, so doctors, nurses, therapists and all other caregivers are on the same page about how to help residents reach the highest possible levels of physical, mental and psychological well-being.

1. 'Skilled Nursing Facilities Often Fail to Meet Care Planning and Discharge Planning Requirements,' Office of the Inspector General, Department of Health & Human Services, February 2013. <https://oig.hhs.gov/oei/reports/oei-02-09-00201.pdf>

'Cost of Dying' series wins national health care journalism award

CALIFORNIA | *San Jose Mercury-News* – 26 February 2013 – Two Bay Area News Group journalists have won a first-place national award for their yearlong series 'Cost of Dying.' Lisa Krieger and Dai Sugano won the top prize in the consumer/feature category of the Association of Health Care Journalists contest for newspapers with circulations above 100,000. Their work detailing how harsh the end-of-life experience can be and gentler ways to die also received honorable mention in the health policy category. http://www.mercurynews.com/health/ci_22671926/cost-dying-series-wins-national-health-care-journalism

N.B. 'Cost of Dying' series: www.mercurynews.com/cost-of-dying. [Noted in Media Watch, 31 December 2013]

Of related interest:

- NATIONAL PUBLIC RADIO | Online – 1 March 2013 – '**A mother's death tested reporter's thinking about end-of-life care.**' <http://www.npr.org/blogs/health/2013/03/01/173224862/a-mothers-death-tested-reporters-thinking-about-end-of-life-care>

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- MONTANA | *The Missoulian* – 27 February 2013 – **'House backs physician-assisted suicide ban.'** The House [of Representatives] is backing a plan to ban physician-assisted suicide in. Supporters say it is needed to protect elderly people from potential abuse of heirs seeking money. The Legislature has struggled with physician-assisted suicide since a 2009 state Supreme Court ruling that said nothing in state law prohibits it. http://missoulian.com/news/state-and-regional/montana-legislature/house-backs-physician-assisted-suicide-ban/article_c2d2d55a-812a-11e2-9dac-001a4bcf887a.html

International

Respite Services for Children with Life-Limiting Conditions and their Families in Ireland. A Needs Assessment

IRELAND | Irish Hospice Foundation – 5 March 2013 – This report provides a national overview of the current provision and future need for respite care for children with life-limiting conditions. An estimated 1,400 children are living with life-limiting conditions in Ireland and about 350 children die from a life-limiting condition each year – the majority in the first year of life. This needs assessment was completed to assist in the implementation of a national policy.¹ This policy recognises respite is an essential element of comprehensive palliative care. <http://hospicefoundation.ie/wp-content/uploads/2012/05/Respite-Services-for-children-with-life-limiting-conditions-and-their-families.pdf>

1. 'Palliative Care for Children with Life-limiting Conditions in Ireland – A National Policy,' Department of Health & Children, December 2009. <http://hospicefoundation.ie/wp-content/uploads/2012/05/DoHC-Childrens-policy-March-20101.pdf>

Extracts from the Irish Hospice Foundation report

This needs assessment has identified a requirement for a range of respite care programmes to ... meet the needs of 411 children currently and up to 478 children by 2021.

It is estimated that the development and operation of the six forms of respite care outlined in this assessment will require a budget in excess of €10m per annum, rising to over €12m by 2021.

A well-structured respite service can reduce hospital admissions both because it provides the additional community supports that may prevent a child's condition from deteriorating to a point where hospitalisation becomes necessary; and because many tests and procedures may be completed as part of a respite programme.

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>

Liverpool Care Pathway: Fifth of doctors query about always telling relatives

U.K. | *The Daily Telegraph* – 1 March 2013 – Last November, Norman Lamb, the Care [& Support] Minister, said it was "simply unacceptable" that patients were being put on the controversial pathway "without a proper explanation or their families being involved." But an online survey of some 563 doctors involved in end-of-life care^{1,2} ... revealed a substantial minority disagree with that view. The survey, to which doctors responded anonymously, found strong support for the pathway. Nine in 10 who used it thought it represented "best practice" for the dying patient, while the same proportion of senior palliative care doctors would choose it for themselves. The survey discovered widespread concern that criticism of the Liverpool Care Pathway in the media had led to less use of the pathway, with half saying patients

and relatives had asked them not to use it. <http://www.telegraph.co.uk/health/healthnews/9900976/Liverpool-Care-Pathway-fifth-of-doctors-query-about-always-telling-relatives.html>

Specialist Publications

Of related interest:

'Inquiry launched into newspaper story about babies on "death pathway"' (p.7), in *British Medical Journal*.

'Doctors aren't like others at the end of life' (p.11), in *The Medical Post*.

1. 'Nine out of 10 palliative care experts would choose Liverpool Care Pathway for themselves,' *British Medical Journal (BMJ)*, 1 March 2013. Findings of the *BMJ*-BBC's 'Channel 4 Dispatches' survey. <http://www.bmj.com/content/346/bmj.f1303>
2. 'The Liverpool Care Pathway: What do specialists think?' *British Medical Journal*, 1 March 2013. <http://www.bmj.com/content/346/bmj.f1184>

Of related interest:

- U.K. | Department of Health – 28 February, 2013 – **'Liverpool Care Pathway independent review: Sessions with families and...'** <http://www.dh.gov.uk/health/2013/02/lcp-sessions/>

Survey

'End-of-life care should be priority'

U.K. (SCOTLAND) | *The Evening Times* (Glasgow) – 1 March 2013 – More than 80% of Scots believe that National Health Service (NHS) end-of-life care should be a higher priority. Research carried out by Marie Curie Cancer Care also found that 50% of people would be unsure where to turn for support if a relative was terminally ill. However, most of those polled, 57%, said they were confident in the quality of NHS end-of-life care. <http://www.eveningtimes.co.uk/news/end-of-life-care-should-be-priority-117176n.20382616>

Elder care in the U.K.

Dementia 'affects 80% of care home residents'

U.K. (ENGLAND, WALES & NORTHERN IRELAND) | BBC News – 25 February 2013 – More than 320,000 of the 400,000 people living in care homes ... now have dementia or severe memory problems, the Alzheimer's Society estimates.¹ It said the figure was almost 30% higher than previous estimates because of the rise in the ageing population and improvements in data collection. Around one in three people over the age of 65 will develop dementia in their lifetime. It is estimated that there are around 800,000 people in the U.K. who have dementia, but many have not yet been diagnosed. <http://www.bbc.co.uk/news/health-21579394>

Cont.

1. 'Low expectations: Report on attitudes on choice, care and community for people with dementia in care homes,' Alzheimer's Society, February 2012. The report summarises evidence from surveys of family members, care home staff, and people with dementia about their views on care in care homes. http://www.alzheimers.org.uk/site/scripts/download_info.php?fileID=1628

Noted in Media Watch, 14 January 2013:

- *END OF LIFE JOURNAL*, 2013;3(1). **'Talking about death in dementia.'** Although dementia may strip away memories and coherent verbal communication, it does not take away feelings, such as shame, embarrassment, pride, happiness, empathy, fear, anxiety, or the sense of... <http://endoflifejournal.stchristophers.org.uk/clinical-skills/communication-vignettes-talking-about-death-in-dementia>

N.B. Several articles on end-of-life care for people with dementia are noted in this issue of Media Watch (p.9).

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- IRELAND | RTÉ News (Dublin) – 27 February 2013 – **'Supreme Court told legislation to allow assisted suicide for terminally ill need not pose risk to others.'** The Supreme Court has been told it would be possible to design legislation to allow the terminally ill to end their lives with assistance without a risk to others. The submission was made by lawyers for Marie Fleming, a 59-year-old Wicklow woman with multiple sclerosis, who needs help to end her life. Ms. Fleming is appealing a decision of the High Court which ruled against her landmark challenge to the ban on assisted suicide. Last month the High Court ruled any relaxation of the absolute ban could put other vulnerable people at risk. <http://www.rte.ie/news/2013/0227/369841-marie-fleming/>

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

International recommendations for outpatient palliative care and pre-hospital palliative emergencies: A prospective questionnaire-based investigation

BMC PALLIATIVE CARE | Online – 21 February 2013 – Survey responses were obtained from 35 different countries. The following ... were recommended: 1) early integration of "palliative care teams" and basic outpatient palliative care systems; 2) end-of-life discussions; 3) defined emergency medical documents, drug boxes, and "do not attempt resuscitation" orders; and, 4) emergency medical training (physicians and paramedics). This study detected structurally and nationally differences in outpatient palliative care regarding the treatment of palliative emergencies. Accordingly, these differences should be discussed and adapted to the respective specifications of individual single countries. <http://www.biomedcentral.com/content/pdf/1472-684X-12-10.pdf>

Noted in Media Watch, 24 December 2012:

- *ONCOLOGY TIMES*, 2012;34(24):24-27. **'Palliative care pushing into outpatient settings.'** The [U.S.] Center to Advance Palliative Care has launched a new initiative to improve palliative care in cancer care clinics and other outpatient settings. http://journals.lww.com/oncology-times/Fulltext/2012/12250/Palliative_Care_Pushing_into_Outpatient_Settings.6.aspx

Media Watch posted on Palliative Care Network-e Website

Palliative Care Network-e (PCN-e) promotes education amongst health care providers in places around the world where the knowledge gap may be wider than the technology gap ... to foster teaching and interaction, and the exchange of ideas, information and materials. <http://www.pcn-e.com/community/pg/file/owner/MediaWatch>

Encouraging and discouraging talk about illness progression, dying and death: A systematic review of communication literature

BMJ SUPPORTIVE & PALLIATIVE CARE, 2013;3(1):130. Communicating with patients about their feelings and preferences for the future is a challenging element of palliative care. Useful evidence exists, but most is embedded in social-scientific rather than clinical research. 2,203 publications were initially identified. Of the 18 meeting the inclusion criteria, five were social science, five clinical and eight linguistics publications. Strong evidence (11/18) indicates *hypothetical questions* are effective in encouraging people to address feelings and plans for uncertain and difficult futures. Moderate evidence (5/18) indicates that another way to create such opportunities entails using *cautious, euphemistic language*; and that this provides distinctive opportunities for people to deflect or avoid the topic. Moderate evidence (3/18) indicates that people often *steer such conversations towards more optimistic statements*, which tends to stop further talk about difficult events. Social-science, linguistic and clinical evidence is available to inform this skilled, often problematic element of care. There are different ways to provide opportunities to discuss

feelings and plans in relation to end of life. <http://spcare.bmj.com/content/3/1/130.2.abstract>

Dialoguer avec l'enfant sur la mort en rapport au présent, au passé et à l'histoire familial

('Dialogue with children about death, in relation with the present, past and the family history')

MÉDECINE PALLIATIVE: SOINS DE SUPPORT – ACCOMPAGNEMENT – ÉTHIQUE | Online – 1 March 2013 – The way a child copes with his/her possible death, the way his/her parents support him/her, is linked with their present: his/her medical situation and its causes, his/her place in the family, the family situation, which includes its social and economic aspects. But it is also linked with the family history, which is often marked by past traumatic events, met by the parents or the grandparents. These events were severe illness, unending grief, immigration, dictatorship, wars, massacres or long lasting economic difficulty. <http://www.sciencedirect.com/science/article/pii/S1636652212001511>

Of related interest:

- *BMC PALLIATIVE CARE* | Online – 26 February 2013 – '**Symptom burden, palliative care need and predictors of physical and psychological discomfort in two U.K. hospitals.**' This study explores the extent of burden in two large U.K. hospitals, focusing upon those patients who meet palliative care criteria. Furthermore, the paper explores the use of palliative services and identifies the most significant clinical diagnostic and demographic factors which determine physical and psychological burden. <http://www.biomedcentral.com/content/pdf/1472-684X-12-11.pdf>
- *JOURNAL OF HOSPITAL MEDICINE* | Online – 25 February 2013 – '**Where do you want to spend your last days of life? Low concordance between preferred and actual site of death among hospitalized adults.**' The overwhelming majority of persons state they would prefer to die at home. But, recent findings suggest most people will die in an institutional setting. <http://onlinelibrary.wiley.com/doi/10.1002/jhm.2018/abstract?deniedAccessCustomisedMessage=&userIsAuthenticated=false>
- *JOURNAL OF PALLIATIVE MEDICINE* | Online – 26 February 2013 – '**Patient values and preferences for end-of-life treatments: Are values better predictors than a living will?**' Providing better guidance than a living will ... are 1) knowledge about a patient's religiosity; 2) patient's wishes for longevity; and, 3) patient's wishes for following family preferences. Wishes for dignity and pain management and reluctance to burden others do not offer better guidance than a living will. <http://online.liebertpub.com/doi/abs/10.1089/jpm.2012.0303>

Does referral to specialist paediatric palliative care services reduce hospital admissions in oncology patients at the end of life?

BRITISH JOURNAL OF CANCER | Online – 28 February 2013 – [In this study of data on patients to aged 19] referral to specialist paediatric palliative care services [SPPCS] significantly reduced the number of planned hospital admissions for children and young people with cancer before their death, which are often integral to paediatric oncology treatment regimens. Overall, the authors' findings show that SPPCS have a role in reducing hospital admissions during end of life care of paediatric cancer patients with potential personal, social and economic benefits. <http://www.nature.com/bjc/journal/vaop/ncurrent/abs/bjc201389a.html>

Liverpool Care Pathway

Inquiry launched into newspaper story about babies on "death pathway"

BRITISH MEDICAL JOURNAL | Online – 1 March 2013 – In November 2012, amid a long campaign to expose misuse of the Liverpool Care Pathway, the *Daily Mail* newspaper ran a front page story entitled "Now sick babies go on death pathway."¹ The story claimed that National Health Service hospitals were discharging sick children and babies to hospices or their homes, where food and fluid were withdrawn until they died. Several complaints over major inaccuracies were made at the time, including by the *British Medical Journal (BMJ)*.² The Press Complaints Commission has since received 10 more complaints and recently launched an inquiry into the story. The centre piece was a doctor's anonymous testimony – billed as "doctor admits starving and dehydrating ten babies to death in neonatal unit." But that testimony – which was first published in the *BMJ*³ – came from a physician practising in another country, although the location was not disclosed to protect the families involved. <http://www.bmj.com/content/346/bmj.f1273>

1. 'Now sick babies go on death pathway: Doctor's haunting testimony reveals how children are put on end-of-life plan,' *Daily Mail*, 28 November 2012, <http://www.dailymail.co.uk/news/article-2240075/Now-sick-babies-death-pathway-Doctors-haunting-testimony-reveals-children-end-life-plan.html>
2. 'Daily Mail story on care of sick babies was "highly misleading," says BMJ editor,' *British Medical Journal*, 4 December 2012 – <http://www.bmj.com/content/345/bmj.e8240>
3. 'How it feels to withdraw feeding from newborn babies,' *British Medical Journal*, 1 November 2012. <http://www.bmj.com/content/345/bmj.e7319>

N.B. The *Daily Mail* and *BMJ* articles were noted in Media Watch, 10 December 2012.

European Association for Palliative Care

Core competencies in palliative care: White Paper on palliative care education – Part 1

EUROPEAN JOURNAL OF PALLIATIVE CARE, 2013;20(2):86-91. It is widely recognised that palliative care is applicable across a range of healthcare settings. All healthcare professionals and workers should be able to provide appropriate palliative care and thus need to be trained to provide the highest possible standards of care in order to meet the challenging needs of patients and families, irrespective of diagnosis. Certain aspects of education and training are, by necessity, discipline-specific. However, there are clearly elements of palliative care training and core competencies for practice that are relevant to all professional groups involved in palliative care. The EAPC White Paper presents expert opinion on global core competencies for professional practice, irrespective of discipline, intended as a resource for practitioners and educators alike. http://www.haywardpublishing.co.uk/year_search_review.aspx?JID=4&Year=2013&Edition=472

Focus groups highlight that many patients object to clinicians' focusing on costs

HEALTH AFFAIRS, 2013;32(2):338-346. Having patients weigh costs when making medical decisions has been proposed as a way to rein in health care spending. The authors ... identified the four barriers to patients' taking cost into account: a preference for what they perceive as the best care, regardless of expense; inexperience with making trade-offs between health and money; a lack of interest in costs borne by insurers and society as a whole; and, non-cooperative behavior characteristic of a "commons dilemma," in which people act in their own self-interest although they recognize that by doing so, they are depleting limited resources. Surmounting these barriers will require new research in patient education, comprehensive efforts to shift public attitudes about health care costs, and training to prepare clinicians to discuss costs with their patients. <http://content.healthaffairs.org/content/32/2/338.abstract>

Caring during birth and death

Working in a medicalised world: The experiences of palliative care nurse specialists and midwives

INTERNATIONAL JOURNAL OF PALLIATIVE NURSING, 2013;19(2):85-91. This study explored birth and death care experiences from the perspectives of midwives and palliative care clinical nurse specialists. A grounded theory approach illuminated the social processes associated with caring during birth and death. Four categories were identified through thematic analysis: memories, one act, advocate, and medical event. These integrated to create a core category: working to counter the pathologisation of birth and death. Study participants illustrated the impact of medicalisation on the experience of birth and death and struggle with the negative effects of this. Health professionals should work toward practice that emphasises the importance of holistic care. http://www.ijpn.co.uk/cgi-bin/go.pl/library/article.html?uid=97019;article=IJP_N_19_2_85_91

Cont. next page

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 and research tool.

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.

Noted in Media Watch, 8 August 2011:

- U.S. | *The Daily Camera* (Boulder, Colorado) – 7 August 2011 – **'Nurse midwives moving into hospice care.'** The transitions of birth and death bring up the same concerns and needs: education, misconceptions, fears, changes in family dynamics, uncertainties, hope, faith, planning, rituals and the loss of control. And, while the popularity of home births continues to grow, so is the choice of home deaths... http://www.dailycamera.com/health-fitness/ci_18623805

Noted in Media Watch, 14 March 2011:

- U.K. | *Eulogy* – 8 March 2011 – **'Soul midwives: Rethinking a good death.'** In a utopian world, perhaps disease and old age would be non-existent, but such is currently not the case; there comes a point at which medicines and machinery can no longer provide a chance of recovery from illness. <http://www.eulogymagazine.co.uk/article/features/detail/id/110>

Loss and separation

DSM-5 – the future arrived

JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION | Online – 25 February 2013 – *Diagnostic & Statistical Manual of Mental Disorders (DSM-5)* will be published in May 2013 and is the first revision of this psychiatric nomenclature in almost two decades. *DSM-5* involved an international, multidisciplinary team of more than 400 individuals who volunteered vast amounts of their time throughout this six-year official process, as well as many contributions from numerous international conferences that were held during the last decade. Readers will recognize a few notable differences from *DSM-5*. One distinction is *DSM-5's* emphasis on numerous issues important to diagnosis and clinical care, including the influence of development, gender, and culture on the presentation of disorders. This is present in select diagnostic criteria, in text, or in both, which include variations of symptom presentations, risk factors, course, co-morbidities, or other clinically useful information that might vary depending on a patient's gender, age, or cultural background. A distinct feature is ensuring greater harmony between this North American classification system and the In-

ternational Classification of Diseases system. <http://jama.jamanetwork.com/article.aspx?articleid=1656312>

DSM-5: Removal of bereavement exclusion

Individuals meeting criteria for a major depressive episode were excluded from a diagnosis of major depressive disorder if symptoms occurred within two months of the death of a loved one. However, the implication that bereavement ends in only two months or that major depression and bereavement cannot co-occur appears false. Depression related to bereavement can share many of the same symptoms as non-bereavement-related depression and can accordingly respond to treatment. Similarly, major depression can share features with other forms of significant loss or stress, including job loss and natural disasters, and may be in need of intervention. To prevent the denial of diagnosis (and care) of individuals who meet full criteria for a major depressive disorder, even during bereavement or other significant loss, *DSM-5* now permits such a diagnosis and includes two notes, within the major depressive episode criteria set, to guide clinicians in making the diagnosis in this context.

Of related interest:

- *DEATH STUDIES* | Online – 27 February 2013 – **'Economic components of grief.'** A challenge for service providers and professionals is how to bring understanding of economic components within emotional and practical support for people preparing for death and those who are bereaved. <http://www.tandfonline.com/doi/abs/10.1080/07481187.2012.692456>

Is providing elective ventilation in the best interests of potential donors?

JOURNAL OF MEDICAL ETHICS, 2013; 39(3):135-138. The authors examine the lawfulness of a proposal to provide elective ventilation to incompetent patients who are potential organ donors. Under the current legal framework, this depends on whether the best interests test could be satisfied. It might be argued that because the Mental Capacity Act 2005 (U.K.) – and the common law – makes it clear that the best interests test is not confined to the patient's clinical interests, but extends to include the individual's own values, wishes and beliefs, the proposal will be in the patient's best interests. The authors reject this claim. They argue that, as things currently stand, the proposal could not lawfully be justified as a blanket proposition by reference to the best interests test. Accordingly, a modification of the law would be necessary to render the proposal lawful. They conclude with a suggestion about how that could be achieved. <http://jme.bmj.com/content/39/3/135>

Noted in Media Watch, 4 February 2013:

- *JOURNAL OF MEDICAL ETHICS* | Online – 26 January 2013 – '**Honouring the donor: In death and ...**' <http://jme.bmj.com/content/early/2013/01/25/medethics-2012-101159.abstract>

Noted in Media Watch, 14 January 2013:

- *JOURNAL OF MEDICAL ETHICS* | Online – 8 January 2013 – '**Dignifying death and the morality of ...**' <http://jme.bmj.com/content/early/2013/01/08/medethics-2012-100995.abstract>

Editorial

Ventilating the debate: Elective ventilation revisited

JOURNAL OF MEDICAL ETHICS, 2013;39(3): 127-128. Elective ventilation (EV) – also known as "non-therapeutic ventilation" – was originally described in the 1990s by doctors working in Exeter in the U.K. At that time there was concern about the large shortfall in organs for transplantation. Patients could become organ donors if they were diagnosed as being brain dead, but this only ever occurred in patients on breathing machines in intensive care who developed signs of brain-stem failure. Doctors wondered if there were patients dying outside intensive care who, if they were ventilated, could become brain dead and hence eligible to donate their organs. They embarked on a process of identifying patients who were dying who would not normally be taken to intensive care because their prognosis was judged to be too poor, and then "electing" to insert breathing tubes when they stopped breathing. With the consent of family members the patients were supported in intensive care until they were diagnosed as having signs of brain death, or until the family and doctors together judged that this was unlikely to occur. The Exeter team saw a 50% increase in their numbers of organs for transplantation. EV was a controversial practice at the time. There were a number of papers written from points of view defending and criticising it. A Department of Health guideline in 1994 concluded that EV was not in the best interests of patients and was therefore unlawful; subsequently, the practice effectively ceased. However...http://jme.bmj.com/content/39/3/127.short?g=w_jme_current_tab

Predictors of health service use over the palliative care trajectory

JOURNAL OF PALLIATIVE MEDICINE | Online – 25 February 2013 – Health system restructuring coupled with the preference of patients to be cared for at home has altered the setting for the provision of palliative care. Accordingly, there has been emphasis on the provision of home-based palliative care by multidisciplinary teams of health care providers. Evidence suggests that these teams are better able to identify and deal with the needs of patients and their family members. Currently there is a lack of literature examining the predictors of palliative care service use for various professional service categories. The results of this study indicate that each service category emerged with a different set of predictor variables. They suggest that a consistent set of predictors across service categories does not exist, and thus the determinants of access to each service category are unique. <http://online.liebertpub.com/doi/abs/10.1089/jpm.2012.0199>

Cont.

Of related interest:

- *BMJ SUPPORTIVE & PALLIATIVE CARE* | Online – 22 February 2013 – '**Public health approaches to end-of-life care in the U.K.: An online survey of palliative care services.**' Of those providers [i.e., respondents] 60% indicated that public health approaches to death, dying and loss were a current priority for their organisation. The findings demonstrate the relevance of a public health approach for palliative care services and how they are currently engaging with the communities they serve. <http://spcare.bmj.com/content/early/2013/02/22/bmjspcare-2012-000334.short>
- *INTERNATIONAL JOURNAL OF OLDER PEOPLE NURSING* | Online – 25 February 2013 – '**Diagnosis, prognosis and awareness of dying in nursing homes: Towards the Gold Standard?**' <http://onlinelibrary.wiley.com/doi/10.1111/opn.12024/abstract>

Doctors aren't like others at the end of life

THE MEDICAL POST (Canada) | Online – 26 February 2013 – "Doctors are people, too." It's a refrain that's often bandied about. But when it comes to questions of what to do at the end of life, according to evidence out of Johns Hopkins University in Baltimore, doctors aren't like the rest of the population. Take the work of Dr. Joseph Gallo, a professor at Johns Hopkins who runs the Precursors Study, which is a longitudinal survey of 1,337 Hopkins medical students from the classes of 1948 to 1964. As participants aged, Dr. Gallo and fellow investigators started to probe end-of-life questions, too. What they found was startling: Physicians said they would decline most life-sustaining interventions. In particular, they found that when doctors were asked about their treatment preferences in the hypothetical event of an irreversible brain injury, 90% said they would decline CPR, more than 85% reported they would say no to ventilation and dialysis, and around 80% would opt out of surgery and a feeding tube. The only treatment most wanted: pain medication. <http://www.canadianhealthcarenetwork.ca/physicians/news/doctors-arent-like-others-at-the-end-of-life-26828>

Noted in Media Watch, 12 March 2012:

- *FORBES* | Online – 7 March 2012 – '**How to die like a doctor.**' When doctors choose how to treat their terminal illness, they take prognosis into account. If prognosis is not good, most opt for comfort care and conservative treatment. Ideally, a death well prepared for is a more comfortable death, and this is what doctors choose. So what can you do to die like a doctor? <http://www.forbes.com/sites/carolynmclanahan/2012/03/07/how-to-die-like-a-doctor/>

N.B. Several articles on doctor's personal preferences in the context of their own end-of-life care are noted in this issue of Media Watch (p.3).

Of related interest:

- *AMERICAN JOURNAL OF HOSPICE & PALLIATIVE MEDICINE* | Online – 1 March 2013 – '**End-of-life care attitudes, values, and practices among health care workers.**' This international study concluded that to avoid cumbersome though well-meant interventions, it is important that the caregiving team is aware of the patient's own wishes with respect to end of life care issues. <http://ajh.sagepub.com/content/early/2013/02/28/1049909113479440.abstract>
- *INTENSIVE CARE MEDICINE* | Online – Accessed 3 March 2013 – '**The luck of the draw: Physician-related variability in end-of-life decision-making in intensive care.**' Although physician-related variability in end-of-life care can never be eliminated entirely, it is potentially ethically problematic. The authors outline four potential strategies for reducing the "roster lottery." http://icmjournal.esicm.org/journals/abstract.html?v=0&j=134&i=0&a=2871_10.1007_s00134-013-2871-6&doi=

The 'dis-ease' of dying: Challenges in nursing care of the dying in the acute hospital setting

PALLIATIVE MEDICINE | Online – 26 February 2013 – Nurses [i.e., participants in this qualitative observational study] took a passive role in recognising dying, providing active care until a medical officer's declaration of dying. Ward design, nurse allocation and nurses' attitude to death impacts patient care. End-of-life care in a single room can have negative consequences for the dying. Nurses demonstrated varying degrees of discomfort, indicating that they were underprepared for this role. When patients are terminally ill, acknowledgement of dying is essential in providing appropriate care. It should not be assumed that all nurses are adequately prepared to provide dying care. <http://pmj.sagepub.com/content/early/2013/02/22/0269216313477176.abstract>

Distinguish patients in a vegetative state from the minimally conscious state: Moral and legal dilemmas

REVISTA DE BIOÉTICA Y DERECHO, 2013;27(1):13-27. Research done using current neuroimaging techniques – specifically, positron emission tomography (PET) and functional magnetic resonance imaging (functional MRI) – have provided evidence that vegetative patients may have fragments of consciousness. These findings make all the more urgent the familiar moral and legal dilemmas arising in connection with persons in these "reduced" states, because in debating whether these persons have a will, we have to take into account the possibility that they may have "glimpses of consciousness." In other words, we have to revisit that principle in light of scientific advances enabling us to more accurately detect signs that a patient is expressing a will to be taken off life support. English language article: http://www.ub.edu/fildt/revista/pdf/rbyd27_art_zullo.pdf

Noted in Media Watch, 18 February 2013:

- *AMERICAN JOURNAL OF BIOETHICS: NEUROSCIENCE*, 2013;4(1):46-51. **'Communicating with the minimally conscious: Ethical implications in end-of-life care.'** The author discusses whether we are capable of formulating the right questions to communicate with an minimally conscious state patient, whether we are capable of understanding the patient's response...<http://www.tandfonline.com/doi/abs/10.1080/21507740.2012.740142>

Assisted (or facilitated) death

Representative sample of recent articles, etc:

- *AMERICAN JOURNAL OF BIOETHICS*, 2013;13(3):13-14. **'Suicide in the context of terminal illness.'** An individual's right to refuse life-sustaining treatment is a fundamental expression of patient autonomy; however, supporting this right poses ethical dilemmas for health care providers when the patient has attempted suicide. The authors of the target article (Brown *et al* 2013)¹ astutely suggests that reasonable requests for withdrawal of life support ought to be honored, even in the aftermath of suicide, provided certain criteria are satisfied. <http://www.tandfonline.com/doi/abs/10.1080/15265161.2012.760680?journalCode=uajb20>

1. 'Withdrawal of non-futile life support after attempted suicide,' *American Journal of Bioethics*, 2013;13(3):3-12. <http://www.tandfonline.com/doi/abs/10.1080/15265161.2012.760673>

Of related interest:

- *AMERICAN JOURNAL OF BIOETHICS*, 2013;13(3):22-24. **'Is the principle of proportionality sufficient to guide physicians' decisions regarding withholding/withdrawing life-sustaining treatment after suicide attempts?'** Commentary on Brown *et al* article. <http://www.tandfonline.com/doi/abs/10.1080/15265161.2013.760967?journalCode=uajb20>

Cont.

- *ANNALS OF ONCOLOGY* | Online – 27 February 2013 – '**Families' experiences with patients who died after assisted suicide: A retrospective interview study in southern Switzerland.**' Pain and symptom burden were not regarded by patients [i.e., study participants] as key reasons to seek assisted suicide: existential distress and fear of loss of control were the determinants. Most had made pre-illness decisions to use assisted suicide. A general need for perceived control and fear of dependency were reported as a common characteristic. Patients held misunderstandings about the nature and purpose of palliative care, and ... indicated that patients did not regard provision of palliative care services as influential in preventing their decision. <http://annonc.oxfordjournals.org/content/early/2013/02/27/annonc.mdt033.abstract>
- *JOURNAL OF MEDICINE & PHILOSOPHY* | Online – 28 February 2013 – '**Continuous sedation until death as physician-assisted suicide/euthanasia: A conceptual analysis.**' The author argues that continuous sedation until death is equivalent to physician-assisted suicide/euthanasia in that both involve killing. This is established by first defining and clarifying palliative sedation therapies in general and continuous sedation until death in particular. A case study analysis and a look at current practices are provided. This is followed by a defense of arguments in favor of definitions of death centering on higher brain (neocortical) functioning rather than on whole brain or cardiopulmonary functioning. It is then shown that continuous sedation until death simulates higher brain definitions of death by eliminating consciousness. <http://jmp.oxfordjournals.org/content/early/2013/02/27/jmp.jht005.abstract>

Media Watch Online

Asia

SINGAPORE | Centre for Biomedical Ethics (CENTRES): <http://centres.sg/> (Scroll down to 'Palliative Care Network: Media Watch')

Australia

AUSTRALASIAN PALLIATIVE INTERNATIONAL LINK: <http://www.palliativecarewa.asn.au/news.php> (Scroll down to 'International palliative care news and journal articles')

Canada

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

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

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

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

Europe

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

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

International

INTERNATIONAL PALLIATIVE CARE RESOURCE CENTER: <http://www.ipcrc.net/archive-global-palliative-care-news.php>

PALLIATIVE CARE NETWORK COMMUNITY: <http://www.pcn-e.com/community/pg/file/owner/MediaWatch>

Barry R. Ashpole
Beamsville, Ontario CANADA

'phone: 905.563.0044
e-mail: barryashpole@bellnet.ca