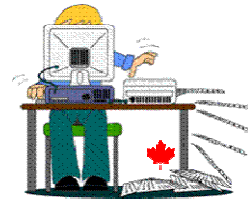


## Media Watch...

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

Setting of standards and the provision of dignity at the end of life: 'Death is more than just a set of measures.' Scroll down to [Specialist Publications](#) for a letter published in the *Irish Medical Times* (p.9).

## Canada

### How and when we die

#### No good deed

CBC RADIO ONE | The Current – 10 March 2010 – This segment of the program started with a clip featuring Craig Ewert. At the time of the recording, he was 59 years old. He was dying from ALS and he was arguing for the right to end his own life. Four years ago, Craig Ewert traveled to Switzerland, drank a concoction of medicines and died. His decision to die became a [PBS] 'Frontline' documentary, *The Suicide Tourist*.<sup>1</sup> Today, his ruminations about playing God remain at the heart of a debate over how and when we die. In the U.S. and Canada, thousands of patients die every day and in a lot of those cases, they die because doctors and nurses are doing – what many say is – a standard part of their duties: withdrawing life support systems. According to Lewis Cohen, those decisions can have devastating consequences for the doctors and nurses who make them. Dr. Cohen is a clinical researcher at the Baystate Medical Centre, Springfield, Massachusetts. He is also the author of *No Good Deed: A Story of Medicine, Murder Accusations and the Debate Over How We Die* (New York: Harper Collins, 2010).

#### When is euthanasia justified?

*GLOBE & MAIL* | Online OpEd – 15 March 2010 – Legalizing euthanasia causes death and dying to lose the moral context within which they must be viewed. Maintaining that moral context is crucial in light of an aging population and scarce and increasingly expensive health-care resources, which will present us with increasingly difficult ethical decisions. <http://www.theglobeandmail.com/news/opinions/when-is-euthanasia-justified/article1499212/>

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The debate over the ethics of how and when we die is back on the agenda in Canada, too. Next Monday, a private member's bill put forward by the Bloc Quebecois' Francine Lalonde, will have its first [sic] hour of debate in the House of Commons.<sup>2</sup> The Bill calls for the decriminalization of euthanasia and doctor-assisted suicide. George Webster, clinical ethicist at St. Boniface General Hospital in Winnipeg, talks about how the debate is playing out in Canada. The Current web page (scroll down to 'Listen to Part Three'): <http://www.cbc.ca/thecurrent/2010/201003/20100310.html>

1. PBS | Frontline – 2 March 2010 – '**The Suicide Tourist.**' Five months after being diagnosed with ALS, Craig Ewert arrived in Switzerland for his scheduled suicide. A story about struggling to live ... and deciding when to die. <http://www.pbs.org/wgbh/pages/frontline/suicidetourist/view/>
2. The first hour of debate of Bill C-384 actually took place 2 October 2009. A private member's bill receives two hours of debate in parliament before it is voted-on at a second reading. Suspension of the parliament delayed the second reading until 16 March 2010.

### **Why aren't we teaching doctors how to communicate better?**

CBC NEWS | Online OpEd – 8 March 2010 – If all 10 recommendations in a recent report are fully implemented, the process of training Canadian doctors will get its first major overhaul in a century. *The Future of Medical Education in Canada* was commissioned by the Canadian association of faculties of medicine and has been unanimously endorsed by the country's 17 medical schools.<sup>1</sup> It promises to make other multi-tasking professionals feel like slackers. Each school will enact curriculum changes in its own way but the overall goal is to graduate doctors who are fully equipped to practise medicine in the 21st century. If achieved, that means they will all have to be medical experts, superb clinicians, collaborative managers, technological whizzes, health advocates and lifelong scholars who are up to speed on every new medical breakthrough ...they will have to deliver more compassionate care to a diverse population, be more sensitive to patient and family needs, and work more productively with other health professionals as well as the public. Almost as an aside, the report also proposes that doctors should become excellent communicators.

<http://www.cbc.ca/canada/story/2010/03/08/f-conlon-doctors.html>

1. *The Future of Medical Education in Canada*, Association of Faculties of Medicine of Canada, 2010. [http://www.afmc.ca/fmec/pdf/collective\\_vision.pdf](http://www.afmc.ca/fmec/pdf/collective_vision.pdf)

### **Evaluating Canada's Compassionate Care Benefit: The Perspective of Family Caregivers**

ONTARIO | McMaster University (School of Geography & Earth Sciences) – March 2010 – This study has aimed to provide policymakers with the information required on how to improve the Compassionate Care Benefit (CCB) program and better meet the needs of family caregivers in Canada. The authors identify five common suggestions for improving the CCB:

1. Implement a CCB awareness campaign that targets all stakeholder groups and the Canadian public simultaneously through a range of formats;
2. Improve the application process to be quicker, simpler, and more sensitive to the stressful and emotional realities of CCB applicants;
3. Eliminate the required two-week unpaid waiting period;
4. Lengthen the period of support to allow for: flexibility because of the challenges in prognosticating death, a more reflective and not rushed palliative process, and caregivers to extend the paid leave after death to include time for bereavement; and
5. Increase the financial assistance to more adequately reflect the 'real' costs endured by family caregivers when taking time off work to provide end-of-life care.

English language edition of the report: <http://www.coag.uvic.ca/eolcare/documents/CCB%20evaluation%20final%20report%20-%20English.pdf>

French language edition of the report: <http://www.coag.uvic.ca/eolcare/documents/CCB%20evaluation%20final%20report%20-%20French.pdf>

Of related interest:

- *PEDIATRICS*, 2010;125(3):491-496. **'Interns overestimate the effectiveness of their hand-off communication.'** Theories ... suggest that miscommunication is caused by egocentric thought processes and a tendency for the speaker to overestimate the receiver's understanding. <http://pediatrics.aappublications.org/cgi/content/abstract/125/3/491>

## U.S.A.

### **Managing pain doesn't mean hastening death**

SOUTH CAROLINA | *Island Packet* (Letter) – 15 March 2010 – I want to point out that it is a myth that morphine accelerates death under the intention of alleviating pain. This myth about heavy doses of morphine accelerating death, commonly called "double effect," has been a misunderstanding around the world for many years. This misunderstanding is due to a lack of education among the general public, as well as inexperience among many doctors in the treatment of dying patients. The myth leads to a fear of hastening death and often the undertreatment of physical suffering at the end of life. Medical research is clear that morphine does not speed death. When administered correctly, morphine is well-tolerated by patients. <http://www.islandpacket.com/2010/03/15/1170819/managing-pain-doesnt-mean-hastening.html>

### **Clarity needed on end-of-life issues**

CALIFORNIA | *Sacramento Bee* (OpEd) – 14 March 2010 – When the nurse came back to the bedroom to take Daniel's pulse, he was lying still, his breathing irregular. Each deep breath was accompanied by a moaning sound. This breathing had lasted for well over an hour, and everyone in the room was incredibly uncomfortable hearing Daniel's moan. In medicine, we call these last noisy breaths of life "agonal respirations," and that's appropriate: They sound exactly like a person in agony. Daniel's eldest daughter could listen to them no more. She asked that he be given something to stop his suffering and gasping for air. The nurse assured her that this type of breathing was normal at the end of life; her father was not in any pain. Experts believe these breathing noises are some sort of reflex. The daughter was skeptical. "How do you really know that," she asked the nurse? <http://www.sacbee.com/2010/03/14/2600814/inside-medicine-clarity-needed.html>

### **Death and the in-between**

COLORADO | *Denver Post* (OpEd) – 14 March 2010 – The popular notion that elderly people will die when they're ready, when they've done all they need to do, or talked to everyone they need to talk to, or when they've decided they really want to go, is, I'm learning, untrue. I think such a notion simply makes us all feel better. It allows us to placate ourselves and imagine we have control, or will have control someday, over our own death. But, we don't. And that's uncomfortable. [http://www.denverpost.com/headlines/ci\\_14658185](http://www.denverpost.com/headlines/ci_14658185)

### **Idaho House committee says "conscience" trumps patient's rights**

AMERICAN ASSOCIATION OF RETIRED PERSONS (AARP) | News release – 11 March 2010 – The Health Freedom of Conscience Bill enables any health care professional to object to and refuse to perform any end of life health service that violates his or her conscience. The bill's vague language will mean any end of life service could be denied, irregardless of the patient's living will and advance directives, which provide instructions for ... how to address end of life care issues. [http://www.aarp.org/community/AARPID/journals/IDAHO\\_HOUSE\\_COMMITTEE\\_SAY/2590472](http://www.aarp.org/community/AARPID/journals/IDAHO_HOUSE_COMMITTEE_SAY/2590472)

## Health care reform

### 'Life panels' invaluable for Americans

MSNBC-TV | Countdown – 11 March 2010 – Keith Olbermann shares some of the details of his personal experience dealing with difficult medical decisions for his ill father and the importance of talking with loved ones about end-of-life care and the value to Americans of including "life panels" in any health reform solution. Olbermann speaks about the necessity of loved ones talking about the care they would want and completing a living will and appointing a health care proxy. <http://www.msnbc.msn.com/id/3036677/vp/35654411#35654411>

From Media Watch dated 1 March 2010:

- MSNBC-TV | Countdown – 24 February 2010 – '**An American cry for help.**' Keith Olbermann shares his personal experience with a real life 'death panel' situation and scorns the unfairness of health insurance in America. [http://www.msnbc.msn.com/id/35566903/ns/msnbc\\_tv-countdown\\_with\\_keith\\_olbermann](http://www.msnbc.msn.com/id/35566903/ns/msnbc_tv-countdown_with_keith_olbermann)

Of related interest:

- MINNESOTA | *Star Tribune* (Minneapolis) – 9 March 2010 – '**New tool lets patients call the shots at end of their lives.**' [Doug] State was one of the first people in Minnesota to obtain a new kind of medical document that told his family and doctors exactly what kind of care he wanted at the end of his life. The document – Provider Orders for Life Sustaining Treatment – seems to work. <http://www.startribune.com/lifestyle/health/87173072.html?elr=KArks7PYDiaK7DUHPYDiaK7DUiD3aPc: Yyc:aUU>

From Media Watch dated 16 February 2009:

- *JOURNAL OF PALLIATIVE MEDICINE*, 2009;12(2):133-141. '**Use of the Physician Orders for Life-Sustaining Treatment Paradigm Program in the hospice setting.**' The POLST Paradigm Program was designed to ensure the full range of patient treatment preferences are honored throughout the health care system. <http://www.liebertonline.com/doi/abs/10.1089/jpm.2008.0196>

N.B. POLST website: <http://www.ohsu.edu/polst/>

### 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.hpcconnection.ca/newsletter/inthenews.html>

#### **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/>

U.K. | Omega, the National Association for End of Life Care: <http://www.omega.uk.net/media-watch-provides-global-roundup-of-end-of-life-issues-n-96.htm>

### Quotable Quotes

*As a well-spent day brings happy sleep, so a life well spent brings happy death.*  
**Leonardo da Vinci (1452-1519)**

## What price for medical miracles? High costs at end of life still part of national health debate

*KAISER HEALTH NEWS* | Online article – 9 March 2010 – Bioethicist Arthur Caplan ... recently posed a question: "What would you do if your mother needed an expensive, painful operation that had only a one in a million chance of saving her?" Without pausing, he opined, "Most Americans would say 'do it.' In this country, we are all about hope. We like miracles, and we don't like to leave people behind. These are strong cultural trends." Aiming for miracles, however, can lead to debilitating therapies that continue after there is no hope; to dying patients being hooked up to feeding tubes and to ventilators; and to agonizing surgeries that cannot save them. "This is no way to die, with every technology imaginable being deployed, and a patient in pain in their final days or weeks," says Laurie Jacobs, a gerontologist at Montefiore Medical Center in New York. <http://www.kaiserhealthnews.org/Stories/2010/March/09/fiscal-times-end-of-life.aspx>

Of related interest:

- *THE FISCAL TIMES* | Online article – 9 March 2010 – '**Life at all costs: Part three, the politics.**' The political hyperbole surrounding the health care debate has shut off a frank discussion of how to approach end-of-life care. <http://www.thefiscaltimes.com/Issues/Health-Care/2010/03/09/Life-At-All-Costs-Part-Three.aspx>
- *THE FISCAL TIMES* | Online article – 8 March 2010 – '**Life at all costs: Part two, the mid-death crises.**' Science and technology could make medical miracles a common occurrence, but at what price? <http://www.thefiscaltimes.com/Issues/Health-Care/2010/03/07/In-Defense-of-Dying-Part2.aspx>
- *THE FISCAL TIMES* | Online article – 3 March 2010 – '**Life at all costs: Part one, the choices.**' As the first wave of the 78 million baby boomers nears 65, The Fiscal Times offers a special report about the end of life. <http://www.thefiscaltimes.com/Issues/Health-Care/2010/03/03/In-Defense-of-Dying-Part-1.aspx>
- *WASHINGTON POST* | Online OpEd – 9 March 2010 – '**A patient's death prompts a doctor to assess 'Do Not Resuscitate' orders.**' It's so easy to let someone die, but it takes effort, determination and stamina to help someone stay and feel alive. Only after you made every effort to let me be happy and human, ask me again if my life is worth living. Then, listen and comply. At that point, if I wish to die, let me die. But until that happens, none of us realizes what I can accomplish with another day, another week, another month. So do it all for me. Then ask someone to do it all for you. <http://www.washingtonpost.com/wp-dyn/content/article/2010/03/08/AR2010030802432.html>

## Voluntary end-of-life measures banned at Catholic hospitals

*NEW YORK TIMES* | Online article – 8 March 2010 – In ... Zoe FitzGerald Carter's *Imperfect Endings*, a woman growing increasingly incapacitated from Parkinson's disease deliberately stops eating and drinking so she can die in her home with her children and grandchildren nearby. It's a controversial decision, both within her own family and in the society at large, but it's a legal one – and a personal one that doesn't require any bureaucracy's blessing. Where the picture grows murkier is in institutions like hospitals and nursing homes, which have their own formal policies and informal routines about treatment at the end of life and how much weight a patient's expressed desires carry. In the 600 Catholic hospitals and hundreds of Catholic nursing homes around the country, such issues may grow more contentious in the wake of a new directive. <http://newoldage.blogs.nytimes.com/2010/03/08/voluntary-end-of-life-measures-banned-at-catholic-hospitals/>

From Media Watch dated 1 March 2010:

- *KAISER HEALTH NEWS* | Online report – 24 February 2010 – '**Bishops cite 'obligation' for using feeding tubes at religious facilities.**' If a patient – or family – didn't want a feeding tube "and the reason they don't want it is they basically want to die, then the Catholic institution would explain to them they can't cooperate with that and they would have to go to another institution." <http://www.kaiserhealthnews.org/Stories/2010/February/24/Catholic-directive-may-thwart-end-of-life-wishes.aspx>

## Assisted (or facilitated) death

Representative sample of recent news media coverage:

- OREGON LIVE | Online OpEd – 10 March 2010 – **'Cornering the market on physician-assisted suicide.'** Oregon Health Department officials expressed concern in 2009 regarding the "worrisome trend" over the years in the decline in requests for formal psychiatric evaluation. Researchers reported in 2008 that 25% of patients requesting assisted suicide are depressed. Why, in spite of these concerns and information, are only 1% of patients being referred for psychiatric evaluation? [http://www.oregonlive.com/opinion/index.ssf/2010/03/cornering\\_the\\_market\\_on\\_physic.html](http://www.oregonlive.com/opinion/index.ssf/2010/03/cornering_the_market_on_physic.html)
- CONNECTICUT | *The Day* – 9 March 2010 – **'State argues ban on assisted suicide is a matter for legislature, not courts.'** During the first court hearing in a lawsuit challenging Connecticut's ban on assisted suicide, the state Monday sought to persuade a judge that the legislature, not a courthouse, is the proper venue to decide whether doctors should be prosecuted for helping patients end their lives. <http://www.theday.com/article/20100309/NWS12/303099910/1019&town>

## International

### Scandal of cancer drugs kept from dying victims

U.K. | *The Independent* – 15 March 2010 – Thousands of cancer patients are being denied access to costly drugs by the National Institute for Clinical Excellence (NICE) ... a year after ministers ordered the institute to relax its spending criteria for patients close to the end of their lives, campaigners claim. NICE is failing to follow the "spirit" of new guidance which was supposed to raise the threshold for costly drugs that could extend life, the Rarer Cancers Forum said. There are hundreds of rare cancers, each affecting a small number of patients, but which together account for between a third and a half of all cancer cases. Because of their low numbers, it is more difficult for drug companies to research and produce drugs for them cost-effectively. Last year, the Government ordered NICE to increase its cost limits for new drugs for end-of-life conditions, from an estimated £30,000 per quality-adjusted life year (Qaly) to £40,000-£45,000 per Qaly, following the "top-ups" review of funding for cancer drugs by Professor Mike Richards, published in 2008. <http://www.independent.co.uk/life-style/health-and-families/health-news/scandal-of-cancer-drugs-kept-from-dying-victims-1921426.html>

### Tackling the taboo of where children die

U.K. (WALES) | *Western Mail* – 15 March 2010 – Children with life-limiting illnesses should be given more choice about their end-of-life care and where they want to die, a charity today said. Despite moves to improve palliative and end-of-life care for adults, many children in the U.K. are not given the same choices. Figures released by ACT [Association for Children's Palliative Care], the leading U.K. children's palliative care charity, to mark Dying Well Matters week show almost three-quarters of children and young people with palliative care needs die in hospital – only 23% die at home or in a hospice. And the charity said more than 98% of neonates – babies under 28 days old – with palliative care needs die in hospital. <http://www.walesonline.co.uk/news/health-news/2010/03/15/tackling-the-taboo-of-where-children-die-91466-26031214/>

### Bed crunch at hospices

SINGAPORE | *Straits Times* – 10 March 2010 – Hospices are so short of beds that terminally ill patients sometimes have to be put on a waiting list for a place, with some dying before they can be admitted. <http://news.asiaone.com/News/the%2BStraits%2BTimes/Story/A1Story20100310-203612.html>

## Elderly and terminally-ill win legal right to die at home

U.K. | *Daily Mail* – 8 March 2010 – Elderly and terminally-ill patients will have the legal right to die at home if Labour wins the next [national] election, health secretary Andy Burnham pledged today. At present more than 80% of people express a wish to die in the comfort of their own home surrounded by their family and friends. But 60% end up dying in hospital. Mr. Burnham said that in the future he wants to see families given the right to sue their National Health Service trust if they failed to respect their loved one's last wishes. <http://www.dailymail.co.uk/news/article-1256368/Elderly-terminally-ill-win-legal-right-die-home.html>

Of related interest:

- U.K. | Associated Press – 14 March 2010 – **'Most adults 'lack death plans.'** Nearly two-thirds of adults, including a quarter of over-65s, have not written a will, while more than three-quarters have not written down preferences about the end of their lives, according to research by the Dying Matters Coalition. <http://www.google.com/hostednews/ukpress/article/ALeqM5heFGOscie18dbL-Omu9LVeIF-Flw>

## Assisted (or facilitated) death

Representative sample of recent news media coverage:

- U.K. | *Guardian* (OpEd) – 10 March 2010 – **'The right to a 'good' death.'** An assisted dying law wouldn't just benefit the terminally ill, but bring peace of mind to those terrified of a 'bad' death too. <http://www.guardian.co.uk/commentisfree/2010/mar/10/right-to-good-death>
- U.K. | *Leicester Mercury* – 10 March 2010 – **'Leicester MP in call to investigate assisted suicide law.'** Leicester West MP Patricia Hewitt ... [is to call for] ... a Royal Commission to investigate how the U.K. might allow assisted suicides. <http://www.thisisleicestershire.co.uk/news/Leicester-MP-investigate-assisted-suicide-law/article-1899502-detail/article.html>
- THE NETHERLANDS | CTV News (Canada) – 8 March 2010 – **'Dutch assisted suicide proposal gains support.'** A campaign to give elderly people ... the right to assisted suicide ... has gathered more than 100,000 signatures, hoping to push the boundaries another notch in the country that first legalized euthanasia. The signatures are enough to force a debate in parliament, where it [will] face resistance. [http://www.ctv.ca/servlet/ArticleNews/story/CTVNews/20100308/netherlands\\_suicide\\_10\\_0308/20100308?hub=Health](http://www.ctv.ca/servlet/ArticleNews/story/CTVNews/20100308/netherlands_suicide_10_0308/20100308?hub=Health)
- U.K. (SCOTLAND) | Journal OnLine (Law Society of Scotland) – 5 March 2010 – **'Lawyers called upon to help shape End of Life Bill.'** A Scottish Parliament committee is calling for written evidence from lawyers and others to help shape its examination of the issue of "assisted death." <http://www.journalonline.co.uk/News/1007726.aspx>

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

### Racial and ethnic differences in hospice use among patients with heart failure

*ARCHIVES OF INTERNAL MEDICINE*, 2010;170(5):427-432. Heart failure is the leading non-cancer diagnosis for patients in hospice care and the leading cause of hospitalization among Medicare beneficiaries. Racial and ethnic differences in hospice patients are well documented for patients with cancer but poorly described for those with heart failure. In a national sample of Medicare beneficiaries with heart failure, blacks and Hispanics used hospice care for heart failure less than whites after adjustment for individual and market factors. To understand the mechanisms underlying these findings, further examination of patient preferences and physician referral behavior is needed. <http://archinte.ama-assn.org/cgi/content/abstract/170/5/427>

## Continuous deep sedation until death in Belgium: A nationwide survey

*ARCHIVES OF INTERNAL MEDICINE*, 2010;170(5):490-493. In recent years much debate has focused on the practice of continuous deep sedation until death and its acceptability on an ethical level. While many view its performance as part of normal medical practice ... it is also believed to be a covert form of euthanasia in some cases and thus morally equivalent to euthanasia. As a result, several guidelines have been issued worldwide relating to the conditions and modalities of its use. First, sedation should not be aimed at hastening death. The patient should be expected to die "imminently" (i.e., within no more than two weeks) and have refractory symptoms.  
<http://archinte.ama-assn.org/cgi/content/extract/170/5/490>

- *ARCHIVES OF INTERNAL MEDICINE*, 2010;170(5):494-495. **'Palliative sedation: Need for consensus guidelines and standards.'** There has been very little study of palliative sedation, and there are no well-accepted guidelines that rigorously outline the best methods and standards of effective palliative sedation. There is wide variation on how the practice of palliative sedation is performed. <http://archinte.ama-assn.org/cgi/content/extract/170/5/494>

Of related interest:

- *CURRENT OPINION IN ANAESTHESIOLOGY*, 2010;23(2):173-176. **'Palliative care and involvement of anaesthesiology: current discussions.'** Anaesthesiologists have a significant role in palliative care due to their unique complex expertise mainly in pain therapy and including transient sedation of patients. [http://journals.lww.com/co-anesthesiology/Abstract/2010/04000/Palliative\\_care\\_and\\_involvement\\_of.10.aspx](http://journals.lww.com/co-anesthesiology/Abstract/2010/04000/Palliative_care_and_involvement_of.10.aspx)

### Assisted (or facilitated) death

#### Dying with dignity

*THE HASTINGS REPORT*, 2010;40(2). On the last day of 2009, a divided Montana Supreme Court ruled that physicians in the Big Sky state can legally prescribe medications for terminally ill patients to use in ending their lives. Right-to-die activists would have preferred that the court find a constitutional right to assisted suicide. Still, they applauded the narrow decision, which merely exempted physicians from prosecution, as advancing death with dignity. In a separate opinion, Justice James C. Nelson wrote, "This right to physician aid in dying quintessentially involves the inviolable right to human dignity – our most fragile right."  
<http://www.thehastingscenter.org/Publications/HCR/Detail.aspx?id=4538>

- *BRITISH MEDICAL JOURNAL* | Online editorial – 10 March 2010 – **'Doctors and assisted suicide.'** What may have come as a surprise [with regard the Director of Public Prosecution's policy guidelines] is the apparently heightened risk of prosecution that doctors now face under the Suicide Act. [http://www.bmj.com/cgi/content/extract/340/mar10\\_2/c1394](http://www.bmj.com/cgi/content/extract/340/mar10_2/c1394)
- *MODERN LAW REVIEW*, 2010;73(2):295-304. **'Disobedience to law – Debbie Purdy's case.'** This case note examines the implications of the House of Lords decision to order the Director of Public Prosecutions to issue offence specific guidelines allowing those contemplating assisting terminally ill persons to commit suicide to know the risk they face of prosecution under section 2(1) of the Suicide Act 1961. <http://www3.interscience.wiley.com/journal/123305500/abstract>

#### "Shock me, tube me, line me"

*HEALTH MATTERS*, 2010;29(2):324-326. In my role as a doctor, I've met countless disabled, disfigured, machine supported people who enjoy living and wish to continue doing so as long as possible. Among my fair share of unsuccessful resuscitations, I've also been fortunate to save some patients whom I should have lost. There were those who were asking to die when they were in agony and delirium, and thanked me when they were fixed and well. I've met intensive care survivors who lead full, productive lives, often with few or no memories of their ordeals and heroic procedures because their sedation was done correctly.  
<http://content.healthaffairs.org/cgi/reprint/29/2/324>

## U.K. perspective

### **Exploring the needs of hospice staff supporting people with an intellectual disability**

*INTERNATIONAL JOURNAL OF PALLIATIVE NURSING*, 2010;16(2):93-98. This article introduces a qualitative research study ... [that explored a] ... hospice staff's perceptions of their own professional needs while caring for a person with intellectual disability (ID) who required palliative or terminal care within the hospice setting. This article defines the population involved, explores the literature which provides a contextual backdrop against which the research sits, introduces the methods and procedures used, and describes and discusses these findings in relation to the palliative care provision for people with an ID from a hospice perspective. It concludes by recognizing that appropriate education and training remain essential preparation for hospice workers when caring for someone with an ID. [http://www.ijpn.co.uk/cgi-bin/go.pl/library/article.html?uid=46755;article=IJPN\\_16\\_2\\_93\\_98](http://www.ijpn.co.uk/cgi-bin/go.pl/library/article.html?uid=46755;article=IJPN_16_2_93_98)

### **Death is more than just a set of measures**

*IRISH MEDICAL TIMES* | Online letter – 11 March 2010 – I read with interest the ... preliminary findings of the national audit for end-of-life care conducted by the Irish Hospice Foundation.<sup>1</sup> Though I keenly support the setting of standards and the provision of dignity at the end of life, the oversimplification of how we care for the dying to a set of measured figures is worrying. I have worked in many hospitals and community settings in Ireland where comprehensive palliative care services are unavailable. Despite this, the dedication, commitment and compassion of many staff who work under less than ideal situations can never be quantified. Many of these units will undoubtedly fall below the "standards" set. They lack single rooms, have poor community resources and staff may potentially lack the skills to ensure that all the components of what constitutes a "good death" is met. However, death is an individual experience. It can never and should never be standardised. It is an event that will remain unique to every family and individual. [http://www.imt.ie/opinion/2010/03/death\\_is\\_more\\_than\\_just\\_a\\_set.html](http://www.imt.ie/opinion/2010/03/death_is_more_than_just_a_set.html)

1. *IRISH MEDICAL TIMES* | Online article – 27 January 2010 – '**Enabling dignity at patient's end of life.**' [http://www.imt.ie/opinion/2010/01/enabling\\_dignity\\_at\\_patients\\_e.html](http://www.imt.ie/opinion/2010/01/enabling_dignity_at_patients_e.html)

Of related interest

- *IRISH MEDICAL TIMES* | Online report – 12 March 2010 – '**Three causes of death...**' While encouraging palliative care specialists to develop services for those with organ failure or frailty and dementia, Prof. Scott Murray, a palliative care specialist at Edinburgh University, encouraged them to get involved from diagnosis, as patients often had psychological and spiritual questions at diagnosis of cancer and not just in the terminal stage. <http://www.imn.ie/index.php/current-issue/news/3199-three-causes-of-death-conference-told->



### **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.

Lessons learned from  
surveying parents' experiences

**Addressing end of life care  
issues in a tertiary treatment centre**

*JOURNAL OF CHILD HEALTH CARE*, 2010;14(1):52-66. A survey of the care received by parents whose child had died in a children's tertiary treatment centre led to a greater understanding of the parents' experiences and the ways in which care could be enhanced. Parents talked of the way in which the geography of the hospital could be disruptive and dislocating and yet they often had no place to be alone or in private. Communication was identified as a core issue with many parents being positive about the quality and timing of communication. However, other parents expressed a preference for more preparation about the possibility that their child might die. Some parents had positive experiences of follow-up visits after their child's death, whilst others remained frustrated and some felt this visit had made them re-live the experiences. The importance of kind, supportive and consistent care was clearly evidenced by the parents when they spoke about their feelings and emotions. The findings helped to develop and implement an End of Life Care Pathway and a pathway tool which aimed to enhance parents' experiences and to improve care. A further survey was triggered by the concern that the pathway was not being fully utilized and it became apparent that ... staff were still reluctant to provide anticipatory guidance, even though many practical aspects of care scored well. The need for good communication that prepares parents for the eventuality that their child might or will die is one of the clearest lessons from the second survey. <http://chc.sagepub.com/cgi/content/abstract/14/1/52>

**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.

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**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.

## **Patients' and families' misperceptions about hospice and palliative care**

*JOURNAL OF HOSPICE & PALLIATIVE NURSING*, 2010;12(2):107-115. The primary purpose of this study was to examine barriers to timely referral to palliative care ... [and] the impact of late referral on quality of life for palliative care patients and their families. Lack of knowledge about palliative care services and its benefits was an overarching theme among the three groups studied (healthcare providers patients, and families). This study finds that additional burden is placed on patients and families when referral to palliative care is late in the disease trajectory. [http://journals.lww.com/jhpn/Abstract/2010/03000/Patients\\_and\\_Families\\_Misperceptions\\_About.9.aspx](http://journals.lww.com/jhpn/Abstract/2010/03000/Patients_and_Families_Misperceptions_About.9.aspx)

## **People continue to trust physicians, despite increasing health information online**

*NCI CANCER BULLETIN* | Online report – 9 March 2010 – According to a recent National Cancer Institute survey, the public's trust in their physicians has continued to rise in spite of the fact that people report turning to the Internet first for their health information needs. In contrast, trust in the Internet and other more traditional sources such as television has been on the decline. <http://www.cancer.gov/ncicancerbulletin/030910/page3#e>

## **Do green graves change the way we mourn?**

*SCIENCE & RELIGION* | Online article – 12 March 2010 – Do green graves change the way we mourn? That question assumes that mourning takes the same form for everyone. Yet, we now know that there is no single way to mourn. Some funerals are deeply sad events that focus on the loss; others are joyous celebrations of the life of the departed. Research provides little support for the notion that there is a "right" or "wrong" way to respond to significant losses. There are only different ways. <http://www.scienceandreligiontoday.com/2010/03/12/do-green-graves-change-the-way-we-mourn-roxane-cohen-silver-answers/>

## **Worth Repeating**

### **Reframing remoteness in providing palliative care in remote Australia**

*COLLEGIAN: JOURNAL OF THE ROYAL COLLEGE OF NURSING, AUSTRALIA*, 2004;11(3): 29-33. People living in remote areas often experience problems accessing palliative care services, and yet there is a dearth of research examining these problems. A review of the limited literature on this topic highlights the assumption that poor access to services is chiefly a product of remoteness, or geography. This paper will argue, however, that previous studies have reacted to remoteness by focusing on a discourse of "needs and deficits," which draws attention away from developing a body of remote area palliative care knowledge. The suggestion will be made that overemphasis of remoteness as the limiting factor has created a mind-set that extrapolates geographical limitations to people and, that such extrapolations are oppressive. Moreover, an over reliance on a simplistic and binary view of remote cultures, has shifted attention away from an examination of the real capacity of remote communities to aid in developing their own palliative care service. In exposing this as a distraction, this paper highlights the importance of understanding remote communities as heterogeneous entities separate from urban communities, and able to develop and use palliative care services based on the principle of community capacity. [http://www.sciencedirect.com/science?\\_ob=ArticleURL&\\_udi=B8JGC-4T0VRR-8&\\_user=10&\\_coverDate=12%2F31%2F2004&\\_alid=1238975585&\\_rdoc=1&\\_fmt=high&\\_orig=se-arch&\\_cdi=43667&\\_docanchor=&\\_view=c&\\_ct=30879&\\_acct=C000050221&\\_version=1&\\_urlVersion=0&\\_userid=10&md5=08133f7817bcaac9a4c7f6648ec9375b](http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B8JGC-4T0VRR-8&_user=10&_coverDate=12%2F31%2F2004&_alid=1238975585&_rdoc=1&_fmt=high&_orig=se-arch&_cdi=43667&_docanchor=&_view=c&_ct=30879&_acct=C000050221&_version=1&_urlVersion=0&_userid=10&md5=08133f7817bcaac9a4c7f6648ec9375b)

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