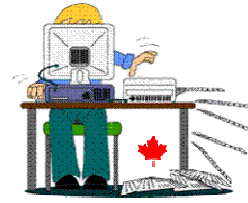


Media Watch...

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

End of life issues: Scroll down to [U.S.A.](#) and 'Lifesaving devices can cause havoc at life's end' (p.2) for a report published in the *New York Times*.

Canada

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- ONTARIO | *Chronicle-Journal* – 14 May 2010 – '**Man gets probation in assisted suicide.**' Peter Fonteece has been sentenced to 12 months probation for his role in his wife Yanisa's February 2009 suicide at a Thunder Bay hotel. http://www.chroniclejournal.com/stories_local.php?id=264578

Specialist Publications

Of particular interest:

'**A proposed systems approach to the evaluation of integrated palliative care.**' Scroll to p.6 for a Canadian conceptual framework discussed in an online article at *BMC Palliative Care*.

U.S.A.

Well-being in body, mind and spirit

Hospitals rethink spiritual spaces, create meditation rooms

CALIFORNIA | *Sacramento Bee* – 13 May 2010 – They have space for prayer rugs and windows facing east – but no pews or religious symbols. They are called meditation rooms, sanctuaries where families can pray for patients, and doctors can pause for spiritual refreshing. At least three area hospitals have plans to open meditation rooms – or expand and revise what were once known as chapels – for non-denominational observance. Reasons range from the changing needs of hospital staff, with more Muslims seeking a place to follow daily rituals, to the evolving view of medicine that the body and soul can heal together. "When people are facing the ultimate spiritual and existential crisis such as illness, they need a quiet place to go," said Chaplain Connie Johnston, manager of spiritual care for Kaiser North Valley hospitals. Some hospitals don't call the rooms chapels because that label invokes the Judeo-Christian tradition, she said. <http://www.sacbee.com/2010/05/13/2747097/meditation-room.html>

Lifesaving devices can cause havoc at life's end

NEW YORK TIMES | Online article – 13 May 2010 – Defibrillators are a modern medical miracle, small implants that save lives by sending an electrical jolt to interrupt a potentially fatal heart rhythm and restore normal beating. But with a rapidly growing number of patients in this country getting the devices, they are increasingly posing a bionic challenge near life's end, for both patients and their families. Specialist say that a failing heart often begins to beat in the same type of wildly erratic rhythm that a defibrillator is programmed to recognize and intercept with a jolt. And though doctors and patients routinely discuss end-of-life issues like withdrawing medications and resuscitation attempts, studies suggest that what to do about a defibrillator rarely comes up. <http://www.nytimes.com/2010/05/14/health/14device.html>

From Media Watch dated 8 March 2010:

- *ANNALS OF INTERNAL MEDICINE*, 2010;152(5):296-299. **'Management of implantable cardioverter-defibrillators in hospice.'** Ensuring that hospices have policies in place to address deactivation may improve the care for patients with these devices. The authors provide a sample deactivation policy. <http://www.annals.org/content/152/5/296.abstract>

Specialist Publications

Of particular interest:

'Cardiac device deactivation not euthanasia, Heart Rhythm Society says.' Scroll down to p.8 for a report published in *MedPage Today*.

New Jersey needs independent panel to resolve disputes over end-of-life care

NEW JERSEY | *Star-Ledger* (Editorial) – 12 May 2010 – Ruben Betancourt, 73, lay in a persistent vegetative state for nearly a year at Trinitas Medical Center in Elizabeth. He was hooked up to a ventilator, dialysis machine and feeding tube. Doctors concluded there was no hope of recovery and further treatment would be futile, but Betancourt's daughter did not agree. Against her wishes, the hospital placed a "do not resuscitate" sign on his bed and halted dialysis. The daughter went to court, and a judge ordered treatment resumed. Betancourt later died, but the legal dispute continues – exposing a gap in New Jersey law when it comes to end-of life care. http://blog.nj.com/njv_editorial_page/2010/05/new_jersey_needs_independent_p.html

Of related interest:

- *MINNESOTA* | *Pioneer Press* – 12 May 2010 – **'House passes bill that gives gay couples the right to make end-of-life decisions.'** The Minnesota House has passed a bill that grants surviving same-sex partners rights when their partner dies. http://www.twincities.com/politics/ci_15065396
- *WISCONSIN LAWYER* | Online article – Accessed 10 May 2010 – **'Withholding a feeding tube from a nonvegetative dementia patient.'** The average person might wrongly think that feeding tube decisions only come into play when a patient is a "vegetable" or in a coma. http://www.wisbar.org/AM/Template.cfm?Section=Wisconsin_Lawyer&template=/CM/ContentDisplay.cfm&contentid=92738



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.

Statement and commentary on palliative sedation therapy to promote greater understanding

NATIONAL HOSPICE & PALLIATIVE CARE ORGANIZATION (NHPCO) | Online posting – 11 May 2010 – For the limited number of imminently dying patients whose pain is intolerable and unresponsive to other palliative interventions, the NHPCO acknowledges palliative sedation can be a treatment option that should be considered by healthcare providers, patients, and families. Palliative sedation refers to ... using medications for the purpose of limiting patient awareness of suffering that is intractable and intolerable. NHPCO's has published *Use of Palliative Sedation in Imminently Dying Terminally Ill Patients*, prepared by the organization's Palliative Sedation Task Force. <http://www.nhpc.org/i4a/pages/index.cfm?pageid=5847>

N.B. NHPCO's position statement and commentary is also posted on the *Journal of Pain & Symptom Management* website: http://jpsmjournal.com/webfiles/images/journals/JPS/JPS7612_p roof.pdf

[Specialist Publications](#)

Of particular interest:

'Rethinking guidelines for the use of palliative sedation.' Scroll down to p.7 for an article published in *The Hastings Report*.

In-home palliative care a vital link for patients managing illness

OHIO | *Plain Dealer* (Cleveland) – 11 May 2010 – Nurse Eric Baum has a different examination room for every one of his patients. As a member of Hospice of the Western Reserve's palliative care team, Baum doesn't see his charges in a sterile atmosphere of a hospital or clinic. Instead, he sees them in their living rooms, bedrooms and kitchens, surrounded by the stuff of life: framed family photos, lace curtains, green houseplants. That, he says, gives him a good deal of insight into his patients, who are dealing with serious illness and having trouble managing daily life. http://www.cleveland.com/healthfit/index.ssf/2010/05/in-home_palliative_care_a_vita.html

New health-care law raises concerns about respecting providers' consciences

WASHINGTON DC | *Washington Post* – 11 May 2010 – Deep within the massive health-care overhaul legislation, a few little-noticed provisions have quietly reignited one of the bitterest debates in medicine: how to balance the right of doctors, nurses and other workers to refuse to provide services on moral or religious grounds with the right of patients to get care. Advocates for protecting health workers argue the new law leaves vulnerable those with qualms about abortion, morning-after pills, stem cell research and therapies, assisted suicide and a host of other services. Proponents of patients' rights, meanwhile, contend that, if anything, the legislation favors those who oppose some end-of-life therapies and the termination of pregnancies and creates new obstacles for dying patients and women seeking abortions. Both sides acknowledge that the scope of any new conflicts that might arise under the legislation will become clear only as the implications of the overhaul unfold. But both agree that clashes are probably inevitable. <http://www.washingtonpost.com/wp-dyn/content/article/2010/05/10/AR2010051003235.html>

[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/>

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- CONNECTICUT | *Hartford Courant* – 16 May 2010 – **'Doctors' 'right-to-die' efforts for terminally ill patients worry advocates for people with disabilities.'** Cathy Ludlum [who lives with a neuromuscular disease that took away her ability to move] says she has a great life, but since childhood she's been aware not everyone thinks so. <http://www.courant.com/health/hc-hc-right-to-die-disability-0.artmay16,0,7088546.story>
- CONNECTICUT | CBS – 12 May 2010 – **'Murder-suicide puts spotlight on state law, lawsuit.'** The issue of assisted suicide is back in public debate after a couple who was married for 38 years died in what police are calling a murder-suicide. <http://www.nbcconnecticut.com/news/local-beat/Was-the-Murder-Suicide-in-West-Haven-a-Mercy-Killing-93569189.html>

From Media Watch dated 15 March 2010:

- 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 ... 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

Terminally ill get new rights to refuse life-prolonging treatment

U.K. (SCOTLAND) | *Scotsman* – 16 May 2010 – Dying patients are being given new rights to refuse treatment that will prolong their lives under official government guidelines. The new guidelines, which will come into force in Scotland later this year, mean that paramedics, GPs and hospital doctors will be forbidden from reviving terminally ill patients whose hearts stop if they do not wish to be resuscitated. All terminally ill patients will be offered the option for the first time and the guidelines will make clear that once a patient has made the decision, it cannot be overruled by doctors or relatives. <http://www.scotsman.com/news/Terminally-ill-get-new-rights.6297725.jp>

Forum on End of Life in Ireland

Dealing with death

IRISH TIMES | Online report – 12 May 2010 – The report of the Forum on End of Life [an initiative of the Irish Hospice Foundation] has brought a sharp focus to how we treat death, dying and bereavement ... with draft proposals for making Ireland a better place in which to die. One pivotal view is the need for a national end-of-life strategy to permeate every aspect of Irish life. As is clear ... death issues are not just the business of doctors and nurses. Equitable distribution of palliative care services is ... required. Indeed the new national council of the forum, which will work on the issues highlighted in the report and the draft action plan, could tackle the recurring issue of where and in what circumstances people die. With imaginative planning many more people could die at home rather than in overcrowded hospital wards. Some nursing homes too could desist from inappropriately sending elderly dying patients to emergency departments. Behind all of these and other forum themes there is a human rights and legal underlay. <http://www.irishtimes.com/newspaper/opinion/2010/0512/1224270207787.html>

1. Irish Hospice Foundation news release: http://www.hospice-foundation.ie/index.php?option=com_content&task=view&id=540&Itemid=11

N.B. Copies of the report on the 2009 'Forum on End of Life in Ireland: Perspectives on End of Life' and a draft of the Irish Hospice Foundation Action Plan are expected to be available online the w/o 17 May at: <http://www.endoflife.ie/>

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- IRELAND | *The Sunday Business Post* – 16 May 2010 – **'Euthanasia body to set up Irish group.'** Exit International, the controversial pro-euthanasia organisation, is setting up a group in Ireland. <http://www.sbpost.ie/news/ireland/euthanasia-body-to-set-up-irish-group-49289.html>
- AUSTRALIA | ABC News – 11 May 2010 – **'MP makes fresh bid to legalise euthanasia.'** Independent MP Bob Such says his legislation would only allow euthanasia when a dying patient cannot get adequate pain relief. <http://www.abc.net.au/news/stories/2010/05/11/2895758.htm>
- U.K. | *Daily Telegraph* – 11 May 2010 – **'Anti-ageing drugs 'will fuel euthanasia.'** People will simply choose to end their own lives in the future, when anti-ageing drugs that could extend lifespan by many years become commonplace, according to an expert on longevity. <http://www.telegraph.co.uk/science/science-news/7711264/Anti-ageing-drugs-will-fuel-euthanasia.html>

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

Beneficent persuasion: Techniques and ethical guidelines to improve patients' decisions

ANNALS OF FAMILY MEDICINE, 2010;8:260-264. Physicians frequently encounter patients who make decisions that contravene their long-term goals. Behavioral economists have shown that irrationalities and self-thwarting tendencies pervade human decision making, and they have identified a number of specific heuristics (rules of thumb) and biases that help explain why patients sometimes make such counter-productive decisions. The authors ... describe the many ways in which these heuristics and biases influence patients' decisions. They argue that physicians should develop their understanding of these potentially counterproductive decisional biases and, in many cases, use this knowledge to rebias their patients in ways that promote patients' health or other values. <http://www.annfammed.org/cgi/content/abstract/8/3/260>

Of related interest:

- *JOURNAL OF ONCOLOGY PRACTICE*, 2010;6(2):94-96. **'When the family requests withholding the diagnosis: Who owns the truth?'** In the U.S., patient autonomy is a strongly held ethical principle. Although this right to self-determination has not always been the norm in health care, it has become the foundation for all our patient interactions, such as the standard practice of providing sufficient, understandable information to a patient before obtaining consent for treatment. <http://jop.ascopubs.org/cgi/content/extract/6/2/94>

A "good death": Perspectives of Muslim patients and health care providers

ANNALS OF SAUDI MEDICINE, 2010;30(3):215-221. This study aimed to review *The Future of Health & Care of Older People* good death perception to determine its validity for Muslim patients and health care providers, and to identify and describe other components of the Muslim "good death perspective." On average, each participant [in this study] agreed on eight principles of the questionnaire. Dignity, privacy, spiritual and emotional support, access to hospice care, ability to issue advance directives, and to have time to say goodbye were the top priorities. Participants identified three main domains: the first was related to faith and belief; the second included some principles related to self-esteem and person's image to friends and family and, the third was related to satisfaction about family security after the death of the patient. Professional role distinctions were more pronounced than were gender or nationality differences. Several aspects of "good death," as perceived by Western communities, are not recognized as being important by many Muslim patients and health care providers. The study introduced three novel components of good death in Muslim society. <http://www.saudiannals.net/text.asp?2010/30/3/215/62836>

Cont.

- *JOURNAL OF HOSPICE & PALLIATIVE NURSING*, 2010;12(3):156-163. **'Considering faith within culture when caring for the terminally ill Muslim patient and family.'** This article presents an overview of the Islamic faith within the cultural context and highlights considerations that may empower nurses to deal with challenges of caring for the dying Muslim patients and their families. http://journals.lww.com/jhpn/Abstract/2010/05000/Considering_Faith_Within_Culture_When_Caring_for.5.aspx

From Media Watch dated 4 January 2010:

- *JOURNAL OF THE ISLAMIC MEDICAL ASSOCIATION OF NORTH AMERICA*, 2009;41(3):109-113. **'Do not resuscitate: A case study from the Islamic viewpoint.'** It is encouraged for Muslim patients to have a living will, but they are discouraged from putting in a DNR order that covers all situations. In other words, they should be full code if there is a reasonable chance of recovery. http://jima.imana.org/article/view/4477/41_3-109

From Media Watch dated 6 April 2009:

- U.K. | *New Statesman* – 3 April 2009 – **'Death and Islam.'** [In the Islamic faith] death is divinely willed and when it arrives it should be readily accepted. There should, therefore, be no reasoning by the bereaved as to why they have lost their loved one. <http://www.newstatesman.com/blogs/the-faith-column/0000/00/holy-qur-muslims-life-death>
- THE NETHERLANDS | *Islam in Europe* – 31 March 2009 – **'Muslims refusing pain management treatment.'** Palliative care for Muslims is often hindered by cultural barriers and prejudices. Muslims are often afraid of pain management since it makes one drowsy, and in the Koran it says one must be alert before Allah. <http://islamineurope.blogspot.com/2009/03/netherlands-muslims-refusing-pain.html>

Death of a partner: Financial implications and experience of loss

BEREAVEMENT CARE, 2010;29(1):23-28. This article discusses key findings from a study conducted in the U.K. of the financial implications of the death of a partner. Many participants experienced considerable change in their financial situation following the death of their partner, and many perceived themselves to be worse off. Dealing with financial issues occupied a considerable amount of time and could take an immense emotional toll, adding to the distress of the bereavement. An important conclusion is that practical and emotional responses to economic changes following a death are closely intertwined, and that palliative care and bereavement services are well-placed to understand and address this, and offer appropriate help and support. <http://www.informaworld.com/smpp/content~db=all~content=a921440726~frm=abslink>

A proposed systems approach to the evaluation of integrated palliative care

BMC PALLIATIVE CARE | Online article – 10 May 2010 – There is increasing global interest in regional palliative care networks to integrate care, creating systems that are more cost-effective and responsive in multi-agency settings. Networks are particularly relevant where different professional skill sets are required to serve the broad spectrum of end-of-life needs. The authors propose a comprehensive framework for evaluating palliative care networks, focusing on the nature and extent of inter-professional collaboration, community readiness, and client-centred care. <http://www.biomedcentral.com/content/pdf/1472-684x-9-8.pdf>

From Media Watch dated 8 February 2010:

- U.K. | *Government Monitor* (Department of Health) – 2 February 2010 – **'U.K. highlights integrated care network for increased quality of care.'** A new self-assessment tool will give local health and social care services the opportunity to join ... [an] extended integrated care community. http://thegovmonitor.com/civil_society_and_democratic_renewal/governance/uk-highlights-integrated-care-network-for-increased-quality-of-care-22856.html

Aggressive end-of-life care

End-of-life care for older cancer patients in the Veterans Health Administration versus the private sector

CANCER | Online article – 5 May 2010 – Treatment of older cancer patients at the end of life has become increasingly aggressive, despite the absence of evidence for better outcomes. The authors compared aggressiveness of end-of-life care of older metastatic cancer patients treated in the Veterans Health Administration (VHA) and those under fee-for-service Medicare arrangements. Older men with metastatic lung or colorectal cancer treated in the VHA healthcare system received less aggressive end-of-life care than similar men in fee-for-service Medicare. This may result from the absence of financial incentives for more intensive care in the VHA or because this integrated delivery system is better structured to limit potentially overly aggressive care. <http://www3.interscience.wiley.com/journal/123418398/abstract?CRETRY=1&SRETRY=0>

Of related interest:

- *INTENSIVE CARE MEDICINE*, 2010;36(5):732-734. **'The worst is yet to come. Many elderly patients with chronic terminal illnesses will eventually die in the emergency department.'** This editorial presents the author's opinion regarding unwanted life-sustaining medical treatment provided for patients at the end of their life in intensive care units. The author tells that studies suggest that death is unnecessarily prolonged by technical and pharmacological interventions. <http://springerlink.com/content/65147543464731k3/?p=66febb33ba33462a99d5dd97036966f5&pi=1>

Rethinking guidelines for the use of palliative sedation

THE HASTINGS REPORT, 2010;40(3):32-38. The use of continuous palliative sedation to unconsciousness rests on a consensus that leads quickly to controversy. Although there is consensus that it should be used only for terminally ill patients and even then reserved for cases in which severe symptoms persist despite efforts to find an alternative palliative treatment, authorities disagree about whether PSU [palliative sedation use] is appropriate for existential suffering and about how close to death the patient should be before PSU is introduced. Some authorities stipulate that PSU should be withheld until the patient is within hours to days from death, while others specify no particular time frame. A patient sedated to unconsciousness generally die from dehydration in two weeks or less unless – as in fact typically happens – they die first from the underlying disease. There is also a consensus within medicine that PSU is a medical treatment and is therefore not tantamount to active euthanasia. However, the consensus also holds that PSU should be subject to restrictions that do not otherwise apply to medical treatments. In short, PSU is both a medical treatment and subject to restrictions that are extraordinary in medicine. Medical authorities have not articulated a cogent medical and ethical rationale for this seeming contradiction. This article delves into this problem, along with some others associated with PSU, and offers revised guidelines for its use. <http://www.thehastingscenter.org/Publications/HCR/Detail.aspx?id=4661>

Finding the language to talk about death

JOURNAL OF ONCOLOGY PRACTICE, 2010;6(2):112. The summer of 2009 brought a surge [in the U.S.] in media coverage of and public interest in the medical care of dying patients. News articles addressed the role of palliative care, and television shows analyzed the human and monetary costs associated with expensive and intensive treatment during the final weeks of life. What started as a reasonable discussion about fair compensation for physicians who counsel patients about resuscitation and take the time to discuss preferences for care at the end of life evolved into a shrill debate over "pulling the plug on Grandma" and imaginary death panels. <http://jop.ascopubs.org/cgi/content/extract/6/2/112>

Cont.

Of related interest:

- *ANNALS OF ONCOLOGY*, 2010;21(5):914-915. **'End of life in cancer patients: Drugs or words?'** Each and every stage of the illness is critical for patients due to the extremely negative impact the communication of a diagnosis or a relapse or progression of the illness can have on their lives in both physical and psychological terms. It is, however, also a critical situation for the doctor particularly if he or she understands fully the importance and delicacy of the moment when communicating bad news. <http://annonc.oxfordjournals.org/content/21/5/914.extract>
- *JOURNAL OF APPLIED GERONTOLOGY* | Online article – 22 April 2010 – **'Conversations about death: Talking to residents in independent, assisted, and long-term care settings.'** Respondents [i.e., participants in this study] talked of acceptance and little fear, mixed notions of the afterlife, the importance of place of residence, and the salience of suicide as an issue. <http://jag.sagepub.com/cgi/content/abstract/0733464810367637v1>
- *NEW YORK TIMES* | Online OpEd – 12 May 2010 – **'Telling patients the whole truth.'** It may be just as important to tell someone they are dying as to tell them that they aren't. So much harder, but needed, and in the end, perhaps even more wanted and more kind. <http://well.blogs.nytimes.com/2010/05/12/telling-patients-the-whole-truth/>

Assessing and treating pain in hospices: Current state of evidence-based practices

JOURNAL OF PAIN & SYMPTOM MANAGEMENT, 2010;39(5):803-819. The aim of this study was to report on current provider evidence-based assessment and treatment practices for older adults with cancer in community-based hospice settings. When examining individual practices, most of the patients had their pains assessed at admission using a valid pain scale (69.7%) and had primary components of a comprehensive assessment completed at admission (52.7%); most patients with admission reports of pain had an order for pain medication (83.5%). However, data revealed a number of practice gaps, including additional components of a comprehensive assessment completed within 48 hours of admission (0%); review of the pain treatment plan at each reassessment (35.7%); reassessment of moderate or greater pain (5.3%); consecutive pain reports of 5 or greater followed by increases in pain medication (15.8%); monitoring of analgesic-induced side effects (19.3%); initiation of a bowel regimen for patients with an opioid order (32.3%); and documentation of both non-pharmacological therapies (22.5%) and written pain management plans (0.6%). [http://www.jpmsjournal.com/article/S0885-3924\(10\)00215-0/abstract](http://www.jpmsjournal.com/article/S0885-3924(10)00215-0/abstract)

Cardiac device deactivation not euthanasia, Heart Rhythm Society says

MEDPAGE TODAY | Online report – 14 May 2010 – Deactivation of implantable cardioverter-defibrillators and pacemakers can be a thorny issue for clinicians and industry alike, but the Heart Rhythm Society (HRS) urged clinicians to respect the right of patients to request it. In a first-of-its-kind comprehensive consensus statement, the HRS in collaboration with the major cardiology, geriatrics, and palliative care societies emphasized that deactivation of this potentially life-sustaining therapy is neither euthanasia nor physician-assisted suicide.¹ The right to refuse or request the withdrawal of a treatment is a personal right of the patient and does not depend on the characteristics of the particular treatment involved. That means that patients can request deactivation even if death does not appear imminent from other causes. "Fifty years of bioethics, more than that in the law, have established a patient's right to request the withdrawal of a treatment they no longer want," Paul S. Mueller, MD, of the Mayo Clinic, said in an interview. <http://www.medpagetoday.com/MeetingCoverage/HRS/20119>

1. *Heart Rhythm Society Expert Consensus Statement on the Management of Cardiovascular Implantable Electronic Devices in Patients Nearing End of Life or Requesting Withdrawal of Therapy* developed by the Heart Rhythm Society in collaboration with the American College of Cardiology, the American Geriatrics Society, the American Academy of Hospice & Palliative Medicine; the American Heart Association, and the European Heart Rhythm Association. http://www.hrsonline.org/Policy/ClinicalGuidelines/upload/ceids_mgmt_eol.pdf

Relatives' experience of the moment of death in a tertiary referral hospital

MORTALITY, 2010;15(1):81-100. The moment of death carries a compelling image and dominant concept throughout history. However, the hospice says so little about this last moment of life, when cultural tradition has said so much. Historically, death was seen as a natural extension of life and the moment of death was held sacred. There was ritual and custom associated with this time for the person who was dying and the community. The authors wished to determine if this time still had significance in the acute hospital where a majority of deaths occur and to explore what added or detracted from this experience for relatives. In this article, they discuss the results of a qualitative enquiry into the moment of death in a hospital as experienced by relatives in Ireland. <http://www.informaworld.com/smpp/content~content=a919672698&db=all>

From the archives:

- *THE HOSPICE JOURNAL*, 1999;14(3-4):253-270. **'The moment of death: Is hospice making a difference?'** The vast experience acquired by hospice programs ... has not yet been translated into a vision of the moment of death and the deathbed scene for our times. Hospice programs could contribute much to our understanding of the final moments of life if this should ever become a priority. <http://www.informaworld.com/smpp/content~content=a904143202&db=all>

Last offices neglected in over half of hospital deaths

NURSING TIMES (U.K.) | Online report – 11 May 2010 – A dearth of training and guidance means nurses are failing to follow "last offices," the simple procedures for treating dead patients with dignity and respect, a *Nursing Times* investigation has found. In more than half of hospital deaths, nurses neglect to follow procedures such as straightening patients' limbs or closing their eyes and mouth before rigour mortis sets in (see sidebar). Such failures can mean patients have tubes and lines wrongly removed or are left with loose dressings, resulting in fluid leaks which can be distressing for relatives. On occasions patients are not cleaned properly or are left with marks on their bodies. <http://www.nursingtimes.net/whats-new-in-nursing/acute-care/last-offices-neglected-in-over-half-of-hospital-deaths/5014365.article>

What should last offices involve?

- If the patient is not catheterised, apply gentle pressure over the bladder to allow it to drain
- Remove and record jewellery and any personal items, unless requested or advised otherwise
- Attend to hygiene needs, particularly hair, nail and mouth care
- Replace dentures
- Attempt to close the eyes, using a small piece of clinical tape if required
- Attach identification labels
- Dress the patient in a gown/shroud or own clothes, as required
- Place an incontinence pad under the buttocks to contain any soiling

Giving honest information to patients with advanced cancer maintains hope

ONCOLOGY | Online article – 13 May 2010 – Oncologists often do not give honest prognostic and treatment-effect information to patients with advanced disease. One of the primary reasons stated for withholding this information is to "not take away hope." The authors could find no study that tested if hope was influenced by honest clinical information. They tested decision-aids in 27 patients with advanced cancer. The scores on the Herth Hope Index did not change and the patients remained uniformly hopeful about their future. The authors conclude hope is maintained when patients with advanced cancer are given truthful prognostic and treatment information, even when the news is bad. <http://www.cancernetwork.com/cme/article/10165/1568753>

Acute care practices relevant to quality end-of-life care: A survey of Pennsylvania hospitals

QUALITY & SAFETY IN HEALTH CARE | Online article – 27 April 2010 – There is low penetration of hospital practices relevant to quality end-of-life care in Pennsylvania acute care hospitals. The results of this cross-sectional mixed-mode survey may serve to inform the development of future benchmark goals. It is critical to establish a strong evidence base for the practices most associated with improved end-of-life care outcomes and to develop quality measures for end-of-life care to complement existing hospital quality measures that primarily focus on life extension.

<http://qshc.bmj.com/content/early/2010/04/27/qshc.2008.030056.abstract>

Assisted (or facilitated) death

Representative sample of recent articles, etc:

- *THE HASTINGS REPORT*, 2010;40(3):IBC. **'Assisted suicide in the U.K.: From crime to right?'** Unfortunately, judicial alchemy in the last year has radically altered the law's social and moral significance, transforming what had unequivocally been a crime subject to condemnation into a right worthy of respect. <http://www.thehastingscenter.org/Publications/HCR/Detail.aspx?id=4658>
- *PUBLIC OPINION QUARTERLY*, 2010;74(1):109-139. **'A comparative study on permissiveness toward euthanasia.'** This study explores explanations for the approval of euthanasia by assessing differences among individuals and countries, using four main arguments used by opponents and proponents. <http://poq.oxfordjournals.org/cgi/content/abstract/74/1/109>

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.

Worth Repeating

Living with a life-threatening illnesses

Children's wishes

JOURNAL OF HOLISTIC NURSING, 2008;26(2):147-154. Expressions of children who have life-threatening illnesses are revealed in their art that provides a way for adults to know how they are experiencing their world. The language of children is unsophisticated; however, they speak meaningfully through their drawings. Children use symbols and images to represent elements in circumstances they are trying to understand. This article demonstrates how the drawings of children with life-threatening illnesses who had special wishes fulfilled reveal meaning that

translates into holistic practices.

<http://jhn.sagepub.com/cgi/content/abstract/26/2/147>

Quotable Quotes

The process of art therapy is based on the recognition that man's most fundamental thoughts and feelings, derived from the unconscious, reach expression in images rather than words. (Margaret Naumberg 1890-1983)

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>

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>

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