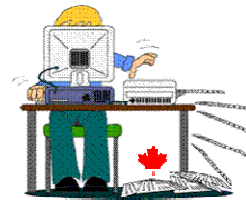


Media Watch...

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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Compilation of Media Watch 2008, 2009, 2010 ©

Compiled & Annotated by Barry R. Ashpole

Issue of access to end of life care universal: Publication of a Canadian Cancer Society report (below) coincided with the release of findings of an audit by the Irish Hospice Foundation and the latter's national action plan. Scroll down to [International](#) and 'Audit on end-of-life care in hospitals' and 'Website of the Forum on End of Life in Ireland' (p.5).

[Canada](#)

End of life care 'inadequate': Cancer Society report

CANWEST NEWS SERVICE | Syndicated report – 19 May 2010 – A new report by the Canadian Cancer Society shows that end of life care in Canada is a patchwork of services.¹ The study, based on data from three provinces – B.C., Ontario and Nova Scotia – shows that services to allow people to die at home are inadequate, and that where palliative care services exist, they're often not used, or used too late, because of delays in referring patients. Patients are dying on hurried, acute-care hospital wards – and even in emergency rooms – waiting to be admitted to a palliative care unit.

<http://www.vancouversun.com/health/life+care+inadequate+Cancer+Society+report/3046832/story.html>

Canadian Cancer Society recommendations:

To help ensure uniform, high quality support is available for people dying of cancer, it is recommended that:

- Surveillance about end-of-life care be improved to help define the needs of people dying from cancer and to allow better planning
- Definitions and methods of reporting end-of-life care be standardized so that surveillance data are more comparable across jurisdictions – this would allow researchers, policy makers and healthcare planners to more easily identify gaps in care

1. CANADIAN CANCER SOCIETY | Press release – 19 May 2010 – **'Dying cancer patients need more support.'** The type and quality of care and services to ensure a cancer patient dies with dignity in the setting of their choice depends on where the person lives in Canada, according to a special report about end-of-life care in Canadian Cancer Statistics 2010, released by the Canadian Cancer Society. http://www.cancer.ca/Canada-wide/About%20us/Media%20centre/CW-Media%20releases/CW-2010/Canadian%20Cancer%20Statistics%202010.aspx?sc_lang=en

Cont.

Representative sample of press coverage of the Canadian Cancer Society report:

- MANITOBA | *Winnipeg Free Press* – 20 May 2010 – **'Where to turn to help dying loved ones?'** The Cancer Society is calling on Ottawa to implement a national caregiver strategy that would extend compassionate-care benefits to 26 weeks from the current six weeks and establish a tax benefit to help families with the financial hit.
<http://www.winnipegfreepress.com/local/where-to-turn-to-help-dying-loved-ones-94403684.html>
- NEW BRUNSWICK | CBC News – 20 May 2010 – **'New Brunswick needs more palliative care: Doctor.'** There are not enough services in New Brunswick for terminally ill people who want to die in dignity, says a Moncton doctor. "We keep focusing on cure, cure, and then when it comes to a point where you can no longer cure, it's almost like the patient is forgotten about," said Dr. Pam Mansfield, clinical director, palliative medicine, at Moncton Hospital.
<http://www.cbc.ca/canada/new-brunswick/story/2010/05/20/nb-cancer-stats-2010.html>
- MANITOBA | CTV News (Winnipeg) – 19 May 2010 – **'End-of-life care needs fixing: Cancer Society.'** With so many patients, families, and even doctors not wanting to broach the subject of death and palliative care, misunderstandings can result. The [Canadian Cancer Society] report found that oftentimes, patients and their families delay accessing palliative care services for their loved ones.
<http://winnipeg.ctv.ca/servlet/an/local/CTVNews/20100519/palliative-care-Cancer-100519/20100519/?hub=WinnipegHome>

Of related interest:

- ONTARIO HEALTH COALITION | Press release – 17 May 2010 – **'Cross-province report appealing for equity and better access.'** *Toward Access & Equality: Realigning Ontario's Approach to Small & Rural Hospitals to Serve Public Value* appeals for equity and improved access to hospital services in rural Ontario. The coalition organized its own public hearings after the government's own rural and northern health panel – created after hospital closures in small and rural communities – refused to hold any public consultations. Recommendations include creating a basket of services, available in every hospital, including the smallest and amalgamated hospitals. Services must include ... palliative care close to home, etc.
<http://www.newswire.ca/en/releases/archive/May2010/17/c4340.html>

Extract of a letter to the editor of AVISO¹

Informing discussion on end of life issues

Much emphasis is rightly placed by the palliative care community on the quality of life for those living with a terminal illness. Implicit is the concept of informed decision making. Many ethical issues, however, have muddied public discussion on euthanasia and assisted suicide, for example:

- Principle of double effect
- Medical futility; Resuscitation
- Artificial hydration and nutrition
- Treatments that may hasten death
- Withholding or withdrawal of treatment
- Palliative or terminal sedation
- Persistent vegetative and minimally conscious states

For the most part, the general public (in particular those living with a terminal illness) is more often than not ill-informed or misinformed on these issues. Its primary sources of information – the Internet and the news media – have consistently demonstrated over the years a lack of understanding or ability to articulate clearly on end of life issues. As a consequence, much posted or published news and views are often inaccurate, contradictory, emotionally charged and, at the very least, distorted or one-sided.
http://www.chpca.net/aviso/AVISO_62_EN.pdf

N.B. Scroll down to p.6 of AVISO and "Letter to the Editor."

1. Published by the Canadian Hospice Palliative Care Association.

The persistent vegetative state

Canada's \$200-million lure pulls in 19 big-name researchers

GLOBE & MAIL | Online report – 17 May 2010 – A \$200-million international recruitment drive is bringing 19 leading researchers to Canadian campuses with multimillion-dollar grants that are setting off alarm bells over a potential brain drain in other countries. At the University of Western Ontario [for example] the appointment of Cambridge neuroscientist Adrian Owen is creating an international stir. Prof. Owen ... has gained prominence for his ability to communicate with subjects in a vegetative state. <http://www.theglobeandmail.com/news/politics/canadas-200-million-lure-pulls-in-19-big-name-researchers/article1572362/>

From Media Watch dated 2 February 2010:

- NEW YORK DAILY NEWS | Online report – 4 February 2010 – **'Patients in a vegetative state have the ability to think and communicate, new research shows.'** Using hi-tech MRIs that measure brain activity ... researchers found that patients who ... are in a persistent vegetative state seem to be able to understand what people are saying to them and can also respond to easy "yes" or "no" questions.¹ <http://www.nydailynews.com/lifestyle/health/2010/02/04/2010-02-04-patients-in-a-vegetative-state-have-the-ability-to-think-and-communicate-new-res.html>
- 1. NEW ENGLAND JOURNAL OF MEDICINE | Online article – 3 February 2010 – **'Wilful modulation of brain activity in disorders of consciousness.'** [The results of this study] ... show that a small proportion of patients in a vegetative or minimally conscious state have brain activation reflecting some awareness and cognition. Careful clinical examination will result in reclassification of the state of consciousness in some of these patients. This technique may be useful in establishing basic communication with patients who appear to be unresponsive. <http://content.nejm.org/cgi/reprint/NEJMoa0905370v1.pdf>

U.S.A.

Majority Policy Committee hears from experts about palliative care

PENNSYLVANIA | Online posting – 13 May 2010 – The [State] House Majority Policy Committee held a public hearing ... to learn more about palliative care and its status in Pennsylvania, according to Chairman Mike Sturla, D[emocratic]-Lancaster. Rep. Dan Frankel, D[emocratic]-Allegheny, requested the hearing and served as co-chairman. "Often when trying to cure a disease, the painful symptoms that result from the illness or the treatment itself can be overlooked, and palliative care can be a useful pain management tool for alleviating suffering," Sturla said. <http://www.pahouse.com/PR/096051310.asp>

Laughing at death is healthy, studies find

BRITISH COLUMBIA | Vancouver Sun – 20 May 2010 – Laughing in the face of death makes good psychological sense – in fact, it may be the best way to make any sense of our own mortality. That conclusion emerged from a series of Simon Fraser University studies on human expectations, affirmations and the need to impose order upon absurd or incomprehensible situations. Travis Proulx, a psychology professor and the lead researcher on the project, conducted three separate studies exploring: the need for personal affirmation in absurd or threatening scenarios; why some people find absurd humour threatening; and the desire to impose order when confronted with one's own death or an equally incomprehensible situation. The studies will be published next month in *Personality & Social Psychological Bulletin*. <http://www.vancouversun.com/entertainment/Laughing+death+healthy+studies+find/3050755/story.html>

International

Dying patients refused pain-relief because nurses fear prosecution for assisted suicide

U.K. | *Daily Mail* – 20 May 2010 – Dying patients are being refused pain-relief because nurses fear they will be prosecuted for assisted suicide, a poll has found.¹ More than one in ten nurses say they have held back treatment such as morphine on terminally-ill cancer sufferers in case they are implicated with hastening their death. Many admit they are leaving their patients in agony but fear they they will be charged with giving an overdose if medical records are later scrutinized. <http://www.dailymail.co.uk/news/article-1279743/Dying-patients-refused-pain-relief-nurses-fear-prosecution-assisted-suicide.html>

1. Scroll down to [Specialist Publications](#) (p.9) and '**Dying patients denied pain relief because of legal fears**' for a detail report of the study published in *Nursing Times*.

General Medical Council guidelines

Doctors must respect wishes of terminal patients 'to refuse treatment and die'

U.K. | *Daily Telegraph* – 20 May 2010 – Mandatory new rules drawn up by the General Medical Council warn medics that they must not ignore the wishes of dying patients who do not want their lives prolonged. Doctors must not start or continue any life-extending treatment, including artificially providing patients with food and water, it warns. They must also follow "advance directives," or "living wills," in which a patient decides ahead of time what care, such as resuscitation, they would refuse. Doctors must not let their own personal or religious objections interfere, although they can withdraw from treating an individual patient. The guidance was welcomed by doctors' leaders who said it offered more clarity over how they should act in difficult situations. But it is likely to concern those who feel that doctors should do everything they can to help keep their patients alive. The rules also state that if a patient requests that a treatment – such as

artificial hydration and nutrition – continues until their death a doctor can overrule these wishes if they feel it would offer no benefit and cause the patient discomfort or harm. <http://www.telegraph.co.uk/health/healthnews/7741046/Doctors-must-respect-wishes-of-terminal-patients-to-refuse-treatment-and-die.html>

The General Medical Council guidelines state:

Following established ethical and legal (including human rights) principles, decisions covering potentially life-prolonging treatments must not be motivated by a desire to bring about a patient's death and must start with a presumption in favour of prolonging life. This presumption will normally require you to take all reasonable steps to prolong a patient's life. However, there is no absolute obligation to prolong life irrespective of the consequences for the patient, and irrespective of the patient's views, if they are known or can be found out.

- N.B.** Scroll down to [Specialist Publications](#) and '**Doctors should avoid making assumptions about patients' choices at the end of life**' (p.6) for a report published in the *British Medical Journal*.



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.

Audit on end-of-life care in hospitals

IRELAND | RTE News – 19 May 2010 – Some one in five acute hospital patients could have died at home if there were enough supports, according to a national audit of end-of-life care in hospitals. The report published ... by the Irish Hospice Foundation says that admissions through emergency departments have a negative impact on patients who die in hospital and it should be possible to arrange more planned admissions. The audit found significant weaknesses in how the hospital system responds at each stage of a patient's journey, from admission through to death, with variations not only between hospitals, specialties and wards but within them also.
<http://www.rte.ie/news/2010/0519/health.html>

- IRELAND | *Independent* – 20 May 2010 – '**Care for dying patients varies depending on type of disease.**' Patients with dementia get the worst care when dying in hospital – while standards are highest for cancer sufferers, a new report revealed yesterday. <http://www.independent.ie/national-news/care-for-dying-patients-varies-depend-on-type-of-disease-2186641.html>
- IRELAND | *Irish Times* – 20 May 2010 – '**Extra supports would allow more to die at home.**' The report [on the national audit of end-of-life care in hospitals] ... found significant differences in how doctors, nurses and relatives assess the care and quality of death of patients, with doctors tending to underestimate the negative aspects of care and relatives tending to overestimate them. <http://www.irishtimes.com/newspaper/ireland/2010/0520/1224270711345.html>

Website of the Forum on End of Life in Ireland

IRELAND | Forum on End of Life posting – 18 May 2010 – The period of public consultation on a Draft Action Plan, arising out of the work of the Forum during 2009, has begun.^{1,2} It will continue until 18 June 2010. Views and comments on this document will guide the work of the National Council of the Forum on End of Life in Ireland. Website: <http://www.endoflife.ie/>

1. Draft Action Plan: <http://www.endoflife.ie/alist/draft-action-plan.aspx>
2. Perspectives on End of Life, Report of the Forum, 2009: <http://www.endoflife.ie/alist/forum-report.aspx>

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- U.K. (SCOTLAND) | *Scotsman* – 24 May 2010 – '**Capital minister challenges Kirk's opposition to assisted dying bill.**' An Edinburgh minister today challenged the Church of Scotland's blanket opposition to assisted dying and said he believed there were occasions when it could be right to help someone end their life. <http://news.scotsman.com/politics/Capital-minister-challenges-Kirk39s-opposition.6314561.jp>
- AUSTRALIA | *Sydney Morning Herald* – 20 May 2010 – '**MP's euthanasia bill angers Christians.**' A West Australian Greens MP has introduced a bill that will pave the way for legalised euthanasia in the state, angering Christian groups. Robin Chapple introduced the Voluntary Euthanasia Bill into parliament ... which would allow any terminally ill West Australian over the age of 21 and of "sound mind" to elect to be euthanised. <http://news.smh.com.au/breaking-news-national/mps-euthanasia-bill-angers-christians-20100520-vnnd.html>

Freeze-dry, eco-friendly burials set for global launch

CHINA (HONG KONG) | Reuters – 20 May 2010 – Amid the potato starch coffins and bio-degradable urns at an Asian funeral expo, a freeze dry burial technique similar to cremation, but without the pyres, stood out as the ultimate green alternative. Liquid nitrogen is used to super-freeze a corpse, which is then shaken until it disintegrates into a pile of dust. <http://economictimes.indiatimes.com/news/news-by-industry/et-cetera/Freeze-dry-eco-friendly-burials-set-for-global-launch/articleshow/5953106.cms>

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

Medicare to test allowing more than palliative care in hospice

AMERICAN MEDICAL NEWS | Online report – 24 May 2010 – New changes to Medicare and Medicaid payment could address the emotionally wrenching dilemma faced by physicians and terminally ill patients forced to choose between continuing curative treatments and taking advantage of hospice care programs' in-home palliative, psychological and spiritual services. The health reform law enacted in March directs state Children's Health Insurance Programs and Medicaid plans to immediately cover "concurrent care" – a combination of curative efforts and hospice care – for children with terminal illnesses. The Congressional Budget Office estimates that the expanded coverage will cost \$200 million over 10 years. The law also calls on the Health & Human Services secretary to conduct a three-year, budget-neutral demonstration project of concurrent care for Medicare patients at 15 hospice-care sites. <http://www.ama-assn.org/amednews/2010/05/24/prsb0524.htm>

Doctors should avoid making assumptions about patients' choices at the end of life

BRITISH MEDICAL JOURNAL | Online report – 20 May 2010 – The General Medical Council [GMC] has issued comprehensive new guidance for doctors on end of life care, including advice on how to decide whether to attempt cardiopulmonary resuscitation (CPR), and when to withhold or withdraw artificial nutrition and hydration. The guidance, which comes into force on 1 July, covers the whole of the U.K. and replaces the GMC's 2002 guide on withholding or withdrawing life prolonging treatments. It follows extensive consultation and takes into account recent court cases, the Mental Capacity Act 2005, GMC guidance on consent in 2007, and government strategies on end of life care in England and Scotland. The GMC said it also wanted to use the guidance to deal with requests from doctors for clarification about CPR, and "ongoing public concerns about the standard of end of life care provided to some patients such as people with disabilities or dementia." http://www.bmj.com/cgi/content/extract/340/may20_1/c2609

Of related interest:

- *AMERICAN MEDICAL NEWS* | Online report – 17 May 2010 – **'Can doctors be compelled to provide futile care?'** A New Jersey appeals court heard arguments in April on a case that is expected to clarify physicians' part in determining treatment in medically futile cases. Judges will decide whether family members could compel Trinitas Regional Medical Center [Elizabeth, NJ] to continue life-sustaining care for their comatose father when hospital doctors believed further treatment was medically inappropriate. Legal experts said the case has the potential to set a precedent in New Jersey and beyond for decisions on end-of-life care. <http://www.ama-assn.org/amednews/2010/05/17/prsc0517.htm>

Rehabilitation in end-of-life management

CURRENT OPINION IN PALLIATIVE & CANCER CARE | Online article – 18 May 2010 – Palliative patients have rehabilitation needs including difficulties with activities of daily living, disruption to usual routines and roles, and anxieties about being a burden to others. These needs are not adequately identified, leading to patients receiving less than optimal help in living with disability. Research shows that rehabilitation interventions such as exercise programmes have beneficial effects on fatigue and quality of life. http://journals.lww.com/co-supportiveandpalliativecare/Abstract/publishahead/Rehabilitation_in_end_of_life_management.99940.aspx

It's about time: Aging prisoners, increasing costs, and geriatric release

INSTITUTE OF JUSTICE | Online report – April 2010 – Correctional facilities throughout the U.S. are home to a growing number of older adults with extensive, costly medical needs. This report examines statutes related to the early release of geriatric inmates in 15 states and the District of Columbia and concludes that these provisions are rarely used, despite the potential of reduced costs at minimal risk to public safety. <http://www.vera.org/download?file=2973/lts-about-time-aging-prisoners-increasing-costs-and-geriatric-release.pdf>

N.B. Articles and reports focused on the provision and delivery of end of life care for prison inmates have been highlighted in Media Watch on a fairly regular basis. For those interested in prison hospice, a compilation of these articles and reports in a single document is available on request. Media Watch is posted on the *Prison Terminal* website: <http://www.prisonterminal.com/news%20media%20watch.html>

Psychological well-being and quality of care: A factor-analytic examination of the Palliative Care Outcome Scale

JOURNAL OF PAIN & SYMPTOM MANAGEMENT | Online article 17 May 2010 – The Palliative Care Outcome Scale (POS) is a widely used outcome measure in palliative care research, and has good psychometric properties. It has been used for clinical or research purposes in specialist cancer centers, nursing homes, day hospice units, and hospice settings in a growing number of countries. The POS appears to capture two factors, psychological status and quality of care, and to have three items that function independently (family anxiety, symptoms, and pain control). Findings suggest that future evaluations of palliative care services should include assessment not only of symptoms and well-being or quality of life, but also of quality of care, and that unidimensional measures will not capture all relevant aspects in palliative care. [http://www.jpmsjournal.com/article/S0885-3924\(10\)00277-0/abstract](http://www.jpmsjournal.com/article/S0885-3924(10)00277-0/abstract)

Of related interest:

- *CURRENT OPINION IN PALLIATIVE & CANCER CARE* | Online article – 19 May 2010 – **'Quality indicators in end-of-life care.'** The definitions of end-of-life and palliative care differ widely. However, comprehensive domains of end-of-life care have been developed and translated into indicators to monitor quality in end-of-life care, mostly on national levels. A substantial number of indicators exist derived using an inhomogeneous methodological quality. Gaps are described mainly for the spiritual, religious, existential and cultural aspects of care. http://journals.lww.com/co-supportiveandpalliativecare/Abstract/publishahead/Quality_indicators_in_end_of_life_care.99939.aspx

From the Institute's report

In 2008 at least 13 states had dedicated units for older inmates, six had dedicated prisons, nine had dedicated secure medical facilities, five had dedicated secure nursing-home facilities, and eight had dedicated hospice facilities.

Nearly 45% of seniors in residential care live with depression or symptoms of depression

CANADIAN INSTITUTE FOR HEALTH INFORMATION | Online press release – 20 May 2010 – More than 44% of Canadian seniors living in residential care homes are diagnosed with or have symptoms of depression, according to a new study. *Depression Among Seniors in Residential Care* is one of the largest of its kind in Canada to examine the prevalence of depression and the impact it has on persons living in residential care facilities, such as long-term care, nursing or personal care homes. http://www.cihi.ca/cihiweb/disPage.jsp?cw_page=media_20100520_e

Directly observed patient–physician discussions in palliative and end-of-life care: A systematic review of the literature

JOURNAL OF PALLIATIVE MEDICINE, 2010;13(5):595-603. This study demonstrates that direct observation methods can be feasibly used when studying physician-patient/physician-family communication in palliative/end-of-life care, but few investigations have utilized this approach. This article highlights areas that need improvement, including physicians' ability to address patient/family emotional issues and provide what patients and families find most satisfying (participation and support). A particular focus on older patients and patients with end-stage or late-stage chronic (non-cancer) illness, the adaptation/application of existing communication measurement tools to capture palliative care communication issues, and development of corresponding outcome measures to assess impact is now needed.
<http://www.liebertonline.com/doi/abs/10.1089/jpm.2009.0388>

Reflection

When death is certain

JOURNAL OF PALLIATIVE MEDICINE, 2010;13(5):609-610. On my way out of the hospital, I walk through the Medical ICU and am greeted by the intensivist who says "I have six names for you guys to see on Monday". As I drive home this rainy Friday night to prepare a rather pathetic Sabbath dinner for my family, I am plagued by cases like these from a typical week on the palliative care consult service. I have known the physicians caring for these patients for nearly two decades and would refer my own family members to them. They are good doctors. How is it, that care rendered when cure is no longer possible, is so bad? Why is non beneficial treatment offered? Why do six subspecialty consultant notes immediately precede my death note? Does one really need their Lipitor_ on the day of death? I cannot submit bills for the countless hours of conversations I had this week with families about goals of care because these conversations were not "face-to-face" with the patient as is required for payment by Medicare (99356 billing code for prolonged face-to-face discussion with patient). My patients are generally obtunded or dying and cannot participate in these lengthy discussions regarding their care. If physicians actually got paid to have these difficult and time consuming goals of care discussions with family members and surrogates, would they? Instead, physicians are financially incentivized to perform more tests and write more notes. If payment was bundled for each hospitalization, thereby eliminating financial incentives for piecemeal work, would care of hospitalized terminally ill patients improve? Might we then provide appropriate palliative care to patients—when death is certain?
<http://www.liebertonline.com/doi/pdfplus/10.1089/jpm.2009.0367>

[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>

Dying patients denied pain relief because of legal fears

NURSING TIMES (U.K.) | Online report – 18 May 2010 – Dying patients are being denied adequate medication to control symptoms and relieve pain because nurses fear prosecution for assisting suicide, a *Nursing Times* survey has found. More than one in 10 of the 2,311 respondents to the online survey of nurses said they had restricted a patient's medication despite that exacerbating symptoms as they were concerned about being prosecuted. The respondents acknowledged restricting medication left patients in more pain than necessary and prolonged their lives against their wishes. <http://www.nursingtimes.net/whats-new-in-nursing/news-topics/ethics-and-law-in-nursing/dying-patients-denied-pain-relief-because-of-legal-fears/5014721.article>

Of related interest:

- *CANADIAN MEDICAL ASSOCIATION JOURNAL* | Online article – 17 May 2010 – **'Physician-assisted deaths under the euthanasia law in Belgium: A population-based survey.'** Physician-assisted deaths with an explicit patient request ... and without an explicit request occurred in different patient groups and under different circumstances. Cases without an explicit request often involved patients whose diseases had unpredictable end-of-life trajectories. Although opioids were used in most of these cases, misconceptions seem to persist about their actual life-shortening effects. <http://www.cmaj.ca/cgi/rapidpdf/cmaj.091876v1?ijkey=7e8aeb7d487df3b7630863f09968fab81968bfdd>
- *EVALUATION & THE HEALTH PROFESSIONS* | Online article – 18 May 2010 – **'Consulting a trained physician when considering a request for euthanasia: An evaluation of the process in Flanders and The Netherlands.'** In Belgium and The Netherlands, consultation of a second independent physician by the attending physician is mandatory in euthanasia cases. In both countries, specialized consultation services have been established to provide physicians trained for that purpose. This retrospective study describes and compares the quality of consultation of both services based on surveys of attending physicians and those providing the consultation (consultants). <http://ehp.sagepub.com/cgi/content/abstract/0163278710370605v1>

A fast track path improves access to palliative care for people with learning disabilities

NURSING TIMES (U.K.) | Online article – 17 May 2010 – People with learning disabilities often experience inequalities in accessing general health services. This group, their families and carers need access to effective palliative care when facing a life limiting illness. This article describes the development and implementation of a fast track referral pathway for people with learning disabilities at St Francis Hospice in Essex. <http://www.nursingtimes.net/nursing-practice-clinical-research/clinical-subjects/learning-disabilities/a-fast-track-path-improves-access-to-palliative-care-for-people-with-learning-disabilities-/5014791.article>

Of related interest:

- *JOURNAL OF INTELLECTUAL DISABILITY RESEARCH*, 2010;54(6):538-546. **'Placement, relocation and end of life issues in aging adults with and without Down's syndrome.'** The present results suggest that aging adults with Down's syndrome (DS) encounter more relocations, and are more likely to have their final placement for end of life care in a nursing home. In contrast, the adults without DS were subjected to less relocation and remained in the same group home setting. <http://www.ingentaconnect.com/content/bsc/jidr/2010/00000054/00000006/art00006>

Worth Repeating

Folklore associated with dying in the west of Ireland

PALLIATIVE MEDICINE, 1999;13(1):57-62. The warm welcome for modern advances in the care of the dying should not exclude the past in which there is much to be learned from the skills of our ancestors. A bilingual two-year qualitative research project into traditions associated with dying and death was undertaken. Research began in the archives available in the internationally recognized university folklore departments of Ireland and Scotland. This was augmented by in-depth personal interviews with Gaelic- and English-speaking residents in rural communities of both countries, recalling local customs and practices in the care of the dying. This paper reports the Irish experience; the collection of data in Scotland continues. From this study, several main themes emerged. Death was seen and accepted as a natural continuation of life, simply a step into the spirit world. In view of people's oneness with nature and the spiritual world, death was not to be feared. Traditions were unique to each area even down to the precise number of candles used at the sickbed. People understood the signs and symptoms of dying and were skilled in alleviating the distress of both relatives and the dying; and, in this, language was important in capturing and expressing the philosophy of these people. The acceptance of death as the one truism of life was facilitated by the strong faith and prayer of people for whom, in the celebration of death, humour was never far away. In their grief, the community was supported by the loose formality of the wake (torramh), funeral procession, keening (caoineadh [lament]) and music. In all these, the men and women of the community and its leaders had distinct and respected roles to play.

<http://pmj.sagepub.com/cgi/content/abstract/13/1/57>

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.

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