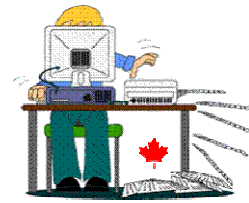


Media Watch...

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

The "process of dying" and quantum mechanics?
Scroll down to [Specialist Publications](#) and 'Non-local effects in the process of dying: Can quantum mechanics help?' (p.10) published in *NeuroQuantology*

Canada

Raising the Bar: A Roadmap for the Future of Palliative Care in Canada

SENATE OF CANADA | Online posting – 8 June 2010 – Manitoba Liberal Senator Sharon Carstairs called upon federal, provincial and territorial governments, and community organizations and professional associations, to improve palliative care services for Canadians. In a report tabled in the Senate, Carstairs set out a vision and goals for improved palliative care services, making 17 recommendations to serve as a roadmap to governments and the community for realizing that vision.¹ "Canadians are still needlessly dying in pain and discomfort," said Senator Carstairs. "We can and must do better. In the last 15 years we have made strides. Yet, we need to raise the bar. We will not have achieved success until we recognize that the passing of life is as important as the birth of that life. To realize a society where all Canadians have access to quality palliative care services we need five things: a culture of care, sufficient capacity, support for caregivers, integrated services, and leadership. The evolution of palliative care is being profoundly affected by the increase in chronic diseases. Combined with an aging population, the system is being stretched and tested as never before.

The report to the Senate states that Canada needs to:

1. Develop a culture of care that overcomes the limitations imposed by a death-denying society.
2. Undertake a serious capacity-building exercise, comprising the full spectrum, from significantly increased research activities and knowledge translation, to improved and consistent education and training, to modernizing our health human resources plans to meet emerging needs.
3. Adapt systems and programs to facilitate support for caregivers.
4. Integrate services so that patients and caregivers can transition from one care setting to another.
5. Improve leadership at the federal government level, provincial and territorial government level and community level.

1. *Raising the Bar: A Roadmap for the Future of Palliative Care in Canada*
http://sen.parl.gc.ca/scarstairs/PalliativeCare/PalliativeCare_e.asp

N.B. See sidebar (p.2), 'Landmark reports on end-of-life care in Canada.'

Cont.

Representative sample of news media coverage of the Senate report:

- CANWEST NEWS SERVICE | Newswire report – 10 June 2010 – **'Palliative care report calls for funding.'** A new report on palliative care in Canada calls for more money for research, a national strategy and better benefits for people who take time off work to care for ailing loved ones. The report, tabled by Manitoba Liberal Senator Sharon Carstairs, says about 70% of Canadians do not have access to even minimal levels of palliative care. Her report is based on a survey distributed to members of the Canadian Hospice Palliative Care Association and roundtables with experts in the field. <http://www.ottawacitizen.com/health/National+Palliative+care+report+calls+funding/3134019/story.html>
- MANITOBA | *Winnipeg Free Press* – 10 June 2010 – **'Senator flays lack of progress on provision of palliative care.'** Dying is as much a part of life as living but Canada still isn't giving death the respect it deserves, a Manitoba senator said in a report released this week. Liberal Senator Sharon Carstairs tabled her third report on palliative care in Canada since 2000 (see sidebar). This report calls for more money for research, a national strategy and better benefits for people who take time off work to care for ailing loved ones. <http://www.winnipegfreepress.com/local/senator-flays-lack-of-progress-on-provision-of-palliative-care-96034594.html>

Landmark reports on end-of-life care in Canada

2010

Raising the Bar: A Roadmap for the Future of Palliative Care in Canada (Author: Sen. Sharon Carstairs)

http://sen.parl.gc.ca/scarstairs/PalliativeCare/PalliativeCare_e.asp

2009

10 Years Later: A Progress Report on the Blueprint for Action – 2000, Quality End-of-Life Care Coalition of Canada

http://www.chpca.net/qelccc/information_and_resources/QELCCC_2010_Progress_Report_on_the_2000_Blueprint_for_Action.pdf

2005

Still Not There: Quality End of Life Care (Author: Sen. Sharon Carstairs)

<http://sen.parl.gc.ca/scarstairs/PalliativeCare/Still%20Not%20There%20June%202005.pdf>

2000

Quality End-of-Life Care: The Right of Every Canadian, Report of the Senate Subcommittee to Update *Of Life & Death* (see below)

<http://www.parl.gc.ca/36/2/parlbus/commbus/senate/Com-e/upda-e/rep-e/repfinjun00-e.htm>

1995

Of Life and Death – Final Report, Special Senate Committee on Euthanasia & Assisted Suicide

<http://www.parl.gc.ca/35/1/parlbus/commbus/senate/com-e/euth-e/rep-e/lad-tc-e.htm>



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.

Provincial Framework on End of Life Care Care

We cannot let this issue die

BRITISH COLUMBIA | *The Source* (Castlegar) – 8 June 2010 – The stand of Interior Health in this rural area of the West Kootenays is falling far short of the B.C. Ministry of Health Services Provincial Framework on End of Life Care.¹ That framework ... mandates well-planned and well-coordinated interprofessional care delivered by competent and well-trained providers, with expert back-up support from specialists, and psychosocial support for the staff who spend time providing palliative care. With the loss of the palliative care social worker and the previous clinical palliative care and bereavement nurses, as well as the underutilization of a community doctor trained in palliative complications, staff in hospital, residential and community venues are left without on-site specialist help and care coordination in our community. <http://castlegarsource.com/node/5985>

1. B.C. Provincial Framework on End of Life Care Care: <http://www.health.gov.bc.ca/hcc/endoflife.html>

From Media Watch dated 31 May 2010:

- BRITISH COLUMBIA | *Trail Roseland News* (Letter) – 24 May 2010 – **'Interior Health Authority's social worker cut hurts area care.'** I was stunned to learn last week that the Interior Health Authority has decided to eliminate the Social Worker position with the Trail Hospice Palliative Care Program. http://www.bclocalnews.com/kootenay_rookies/trail_rosslandnews/opinion/94786009.html

Of related interest:

- ALBERTA | CBC News (Edmonton) – 7 June 2010 – **'Chemo denied to some at Edmonton clinic.'** A shortage of oncologists is forcing doctors at the Cross Cancer Institute in Edmonton to limit chemotherapy for gastrointestinal patients to those who would have a chance at full recovery if they received the treatment. <http://www.cbc.ca/canada/edmonton/story/2010/06/07/edmonton-oncologist-shortage-cross-cancer-chemotherapy.html>

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- BRITISH COLUMBIA | *Vancouver Sun* – 9 June 2010 – **'Belgian euthanasia nurses fail to get consent.'** Almost half of deaths by euthanasia in Belgium have involved patients who have not explicitly requested their lives to be ended by a doctor, a study has suggested.¹ <http://www.vancouversun.com/health/Belgian+euthanasia+nurses+fail+consent/3132473/story.html>

1. *Canadian Medical Association Journal* | Online article – 17 May 2010 – **'Physician-assisted deaths under the euthanasia law in Belgium: A population-based survey.'** <http://www.cmaj.ca/cgi/rapidpdf/cmaj.091876v1?ijkey=7e8aeb7d487df3b7630863f09968fab81968bfdd>

N.B. The journal article was noted in Media Watch dated 24 May 2010.

Hospice signs seven-year deal

BRITISH COLUMBIA | *Times-Colonist* – 12 June 2010 – Victoria Hospice Society has signed a long-term agreement with the Vancouver Island Health Authority that allows it to meet increased demand for medical care for the terminally ill. The seven-year, \$20-million agreement is the longest the two have ever signed. In recent years, the two organizations have worked primarily with one-year agreements. They say the longer-term agreement will allow Victoria Hospice to expand its range of medical care to reflect the changing profile of palliative patients as Victoria's population ages. <http://www.timescolonist.com/health/Victoria+Hospice+signs+seven+year+deal/3146792/story.html>

U.S.A.

Expansion of hospice blocked by moratorium

ALABAMA | *Tuscaloosa News* – 12 June 2010 – Hospice of West Alabama ... has plans to expand its in-patient beds by almost 50% and has received a gift of \$250,000 for that expansion. But it may be a long wait before the hospice can start on the project. The state has a moratorium, dating back to 2005, that prevents the expansion of in-patient hospice beds; the reasoning ... was the state's concern about Medicaid costs associated with expanding the number of hospices. <http://www.tuscaloosaneews.com/article/20100613/NEWS/100619882/1291/datetime11?Title=Expansion-of-hospice-blocked-by-moratorium>

What happens when medical, religious ethics clash?

USA TODAY | Online article – 8 June 2010 – The case of an abortion at a Catholic hospital in Phoenix prompted an angry bishop to rebuke the Sister of Mercy who allowed the surgery to save the mother's life. But you don't have to be a pregnant woman with a rare heart condition to be affected by the questions raised at St. Joseph's Hospital & Medical Center. You don't even have to be Catholic. If you are in a Catholic facility (where one-sixth of U.S. hospital beds are located), the Phoenix case could make you question who has final say in life-and-death decisions: You, or the local bishop? What happens if your care choices, or your doctor's, clash with the ethical dictates Catholic hospitals must heed? The Catholic bishops' *Ethical & Religious Directives for*

Catholic Health Care Services spells out a vision of life and the morality of care from conception to "natural death." http://www.usatoday.com/news/religion/2010-06-08-ethics08_ST_N.htm

Specialist Publications

Of particular interest:

'Therapeutic privilege: Between the ethics of lying and the practice of truth' and 'Medical decision-making and communication of risks: An ethical perspective.' Scroll down to p.7 for articles published in the *Journal of Medical Ethics*.

From Media Watch dated 4 January 2010:

- CALIFORNIA | *San Francisco Chronicle* – 3 January 2010 – **'New Catholic mandate on comatose patients.'** The nation's Catholic hospitals ... face a new religious mandate in the new year: to provide life-sustaining food, water and medicine to comatose patients who have no hope of recovery. <http://www.sfgate.com/cgi-bin/article.cgi?f=/c/a/2010/01/03/BA321BC2R1.DTL>

Experts revise guidelines for determining brain death

U.S. NEWS & WORLD REPORT | Online report – 7 June 2010 – The American Academy of Neurology has issued new guidelines – an update of guidelines first written 15 years ago – that call on doctors to conduct a lengthy examination, including following a step-by-step checklist of some 25 tests and criteria that must be met before a person can be considered brain dead. The goal of the guidelines is to remove some of the guess work and variability among doctors in their procedure for declaring brain death, which previous research has found to be a problem. According to the U.S. Uniform Determination of Death Act, brain death occurs when a person permanently stops breathing, the heart stops beating and "all functions of the entire brain, including the brain stem" cease. <http://health.usnews.com/health-news/family-health/brain-and-behavior/articles/2010/06/07/experts-revise-guidelines-for-determining-brain-death.html>

N.B. Scroll down to [Specialist Publications](#) (p.11) and **'Determining brain death in adults'** published in *Neurology*.

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- CONNECTICUT | NBC News – 8 June 2010 – '**Judge dismisses end of life case.**' A judge has dismissed a lawsuit filed by two Fairfield County doctors and end-of-life advocates who want a clarification of the state's ban on assisted suicide. The judge said the matter is something that must be decided by the General Assembly and not the court. <http://www.nbcconnecticut.com/news/local-beat/Judge-Dismisses-End-of-Life-Case-95868034.html>

International

Issues in pain management

European patient survey add weight to expert call for greater clinical consensus on breakthrough cancer pain

U.K. (SCOTLAND) | Research Congress of the European Association for Palliative – 10 June 2010 – The European Survey of Breakthrough Cancer Pain ... show[s] that up to 45% of cancer patients experiencing breakthrough pain do not adhere to medication despite suffering from devastating episodes. "The low adherence to drug therapy is a remarkable discovery and demonstrates that current treatments aren't adequately meeting patients' needs during these incapacitating episodes of pain," explained Dr. Andrew Davies, Department of Palliative Medicine, Royal Marsden Hospital, U.K. The survey, moreover, found that up to 50% of patients seek additional help from non-pharmacological methods such as heat, positional changes and rest demonstrating the need for improved pain relief. <http://www.webnewswire.com/node/543088>

Of related interest:

- *NURSING TIMES* (U.K.) | Online report – 13 June 2010 – '**Dignity and end-of-life care guide updated.**' Guidance on pain management and end-of-life care have been added to the *Dignity in Care* guide.¹ <http://www.nursingtimes.net/whats-new-in-nursing/acute-care/dignity-and-end-of-life-care-guide-updated/5015816.article>

1. *Dignity in Care*, Social Care Institute for Excellence: <http://www.scie.org.uk/publications/guides/guide15/index.asp>

NHS denies dying mother chance to live long enough to see her son, 4, start school...

U.K. | *Daily Mail* – 9 June 2010 – A distraught mother has been refused life-prolonging drugs that could let her live to see her son start school. Mikki Blunden, 37, who has breast cancer, has been given just weeks to live. Her only hope of surviving to see her son Thomas, four, start school in September is a "wonder drug" called Lapatinib. But, NHS [National Health Service] bosses say the treatment, which costs \$25,000 for a one-year course, is too expensive and may not work. <http://www.dailymail.co.uk/news/article-1285185/Mother-given-just-weeks-live-denied-wonder-drug-NHS.html>

From Media Watch dated 15 March 2010:

- U.K. | *The Independent* – 15 March 2010 – '**Scandal of cancer drugs kept from dying victims.**' Thousands of cancer patients are being denied access to costly drugs by the National Institute for Clinical Excellence ... a year after ministers ordered the institute to relax its spending criteria for patients close to the end of their lives, campaigners claim. <http://www.independent.co.uk/life-style/health-and-families/health-news/scandal-of-cancer-drugs-kept-from-dying-victims-1921426.html>

Patient died in agony after doctors ignored 'Do Not Resuscitate' request

U.K. | *Staffordshire Sentinel* – 9 June 2010 – Terminally-ill Arthur Johnson had signed forms instructing medics not to revive him if his heart stopped. But relatives say they arrived at hospital to see a full crash team fighting to keep the grandfather alive. They say Mr. Johnson ... spent the final three hours of his life in pain at the University Hospital of North Staffordshire before he died earlier this year. <http://www.thisisstaffordshire.co.uk/news/DOCTORS-IGNORED-DAD-S-DYING-WISH/article-2282996-detail/article.html>

From Media Watch dated 7 June 2010:

- U.K. | *Yorkshire Post* – 31 May 2010 – '**Anger after doctors put 'Do Not Resuscitate' note on records.**' A daughter has told of her "outrage" after discovering doctors treating her late mother did not plan to resuscitate her if she collapsed. <http://www.yorkshirepost.co.uk/news/Anger-after-doctors-put-39Do.6331334.jp>

From Media Watch dated 24 May 2010:

- U.K. | *Daily Telegraph* – 20 May 2010 – '**Doctors must respect wishes of terminal patients 'to refuse treatment and die.'**' 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. <http://www.telegraph.co.uk/health/healthnews/7741046/Doctors-must-respect-wishes-of-terminal-patients-to-refuse-treatment-and-die.html>

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

Compassion fatigue: What is it? Why does it matter? Recognizing the symptoms, acknowledging the impact, developing the tools to prevent compassion fatigue, and strengthen the professional already suffering from the effects

AMERICAN JOURNAL OF HOSPICE & PALLIATIVE MEDICINE, 2010;27(4):239-242.

Compassion fatigue is recognizable. It erodes the professional's ability to function at an optimum level. Depression, caregiver stress, secondary trauma, and post traumatic stress syndrome are very much a part of the daily landscape for today's professional. The costs are many: staff turnover, loss of self-worth, diminished productivity, poor morale, and more. We in the helping professions must acknowledge the syndrome and validate its impact on professional staff.

<http://ajh.sagepub.com/cgi/content/abstract/27/4/239>

A paediatric palliative care programme in development: Trends in referral and location of death

ARCHIVES OF DISEASE IN CHILDHOOD | Online article – 3 June 2010 – This article describes the formation of a paediatric palliative care programme providing care in hospital, at home or in hospice, ensuring continuity of care where the child and family desire. Referral to the palliative care team has increased over time in all diagnostic categories and from all sources. Most children died in hospital; however, a significant number of families chose end-of-life care at home or in a hospice. <http://adc.bmj.com/content/early/2010/06/02/adc.2008.153494.abstract?sid=f889f156-1d94-42b5-820b-b711eab31275>

Of related interest:

- *ARCHIVES OF PEDIATRIC & ADOLESCENT MEDICINE*, 2010;164(6):547-553. '**Medical end-of-life decisions in children in Flanders, Belgium.**' Medical end-of-life decisions are frequent in minors in Flanders, Belgium. Whereas parents were involved in most end-of-life decisions, the patients themselves were involved much less frequently, even when the ending of their lives was intended. <http://archpedi.ama-assn.org/cgi/content/abstract/164/6/547>

Decision making and end-of-life care

When concretized emotion-belief complexes derail decision making capacity

BIOETHICS | Online article – 17 May 2010 – There is an important gap in philosophical, clinical and bioethical conceptions of decision-making capacity. These fields recognize that when traumatic life circumstances occur, people not only feel afraid and demoralized, but may develop catastrophic thinking and other beliefs that can lead to poor judgment. Yet there has been no articulation of the ways in which such beliefs may actually derail decision-making capacity. In particular, certain emotionally grounded beliefs are systematically unresponsive to evidence, and this can block the ability to deliberate about alternatives. People who meet medico-legal criteria for decision-making capacity can react to health and personal crises with such capacity-derailing reactions. One aspect of this is that a person who is otherwise cognitively intact may be unable to appreciate her own future quality of life while in this complex state of mind. This raises troubling ethical challenges. <http://www3.interscience.wiley.com/journal/123442690/abstract>

Of related interest:

- *JOURNAL OF MEDICAL ETHICS*, 2010;36(6):353-357. **'Therapeutic privilege: Between the ethics of lying and the practice of truth.'** The 'right to the truth' involves disclosing all the pertinent facts to a patient so that an informed decision can be made. This concept of a 'right to the truth' entails certain ambiguities, especially since it is difficult to apply the concept in medical practice based mainly on current evidence-based data that are probabilistic in nature. <http://jme.bmj.com/content/36/6/353.abstract>
- *JOURNAL OF MEDICAL ETHICS*, 2010;36(6):349-352. **'Medical decision-making and communication of risks: An ethical perspective.'** This article examines the question of whether ... the ideal of informed decision-making is only an illusion or whether concrete steps can be taken towards its realisation. <http://jme.bmj.com/content/36/6/349.abstract>
- *MEDICAL DECISION MAKING* | Online article – 8 June 2010 – **'A nationwide survey of U.S. adults regarding 9 common medical decisions.'** Patients are a vital link between physicians' assessments of patients' needs and actual implementation of appropriate care. Yet no study has specifically examined how and when a representative sample of patients considered, discussed, and made medical decisions. <http://mdm.sagepub.com/cgi/content/abstract/0272989X09353792v2>
- *NURSING PHILOSOPHY*, 2010;11(3):170-177. **'Is the doctrine of double effect irrelevant in end-of-life decision making?'** The authors consider three arguments for the irrelevance of the doctrine of double effect in end-of-life decision making; a third argument is their own. <http://www3.interscience.wiley.com/journal/123501418/abstract?CRETRY=1&SRETRY=0>
- *PATIENT EDUCATION & COUNSELING* | Online article – 10 June 2010 – **'Identifying transparency in physician communication.'** The primacy of information exchange over process-oriented, relational communication was demonstrated. Proactive transparency appears promising to increase understanding and collaboration. [http://www.pec-journal.com/article/S0738-3991\(10\)00285-5/abstract](http://www.pec-journal.com/article/S0738-3991(10)00285-5/abstract)

[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>

National [Italian] Tumor Association Foundation

A 30 year old model of home palliative care

BMC PALLIATIVE CARE | Online article – 8 June 2010 – Models of palliative care delivery develop within a social, cultural, and political context. This paper describes the 30-year history of the National Tumor Association (ANT), a palliative care organization founded in the Italian province of Bologna, focusing on this model of home care for palliative cancer patients and on its evaluation. The ANT home care model of palliative care delivery has been well-received, with progressively growing numbers of patients served. It has resulted in a greater proportion of home deaths and in patients' accessing palliative care at an earlier point in the disease trajectory. <http://www.biomedcentral.com/content/pdf/1472-684x-9-12.pdf>

Of related interest:

- *JOURNAL OF PAIN & SYMPTOM MANAGEMENT*, 2010;39(6):1003-1015. **'End-of-life care in Italian hospitals: Quality of and satisfaction with care from the caregivers' point of view – results from the Italian survey of the dying of cancer.'** This study revealed poor quality of EOL [end-of-life care] care in Italian hospitals, with almost one-third of the caregivers expressing their clear dissatisfaction. A national policy is, therefore, urgently called for to improve the quality of EOL care in Italian hospitals. [http://www.jpmsjournal.com/article/S0885-3924\(10\)00244-7/abstract](http://www.jpmsjournal.com/article/S0885-3924(10)00244-7/abstract)

Archetypal trajectories of social, psychological, and spiritual wellbeing and distress in family care givers of patients with lung cancer

BRITISH MEDICAL JOURNAL | Online article – 10 June 2010 – In this study, carers followed clear patterns of social, psychological, and spiritual wellbeing and distress that mirrored the experiences of those for whom they were caring, with some carers also experiencing deterioration in physical health that impacted on their ability to care. Psychological and spiritual distress were particularly dynamic and commonly experienced. In addition to the "Why us?" response, witnessing suffering triggered personal reflections in carers on the meaning and purpose of life. Certain key time points in the illness tended to be particularly problematic for both carers and patients: at diagnosis, at home after initial treatment, at recurrence, and during the terminal stage. http://www.bmj.com/cgi/content/abstract/340/jun09_4/c2581

Of related interest:

- *JOURNAL OF PAIN & SYMPTOM MANAGEMENT* | Online article – 7 June 2010 – **'Informal care and home-based palliative care: The health-related quality of life of carers.'** Clinicians caring for palliative care patients should be alert to the potential health impairments of informal carers and ensure that they are adequately supported in their caregiving role and have access to appropriate treatment and preventive health care. [http://www.jpmsjournal.com/article/S0885-3924\(10\)00259-9/abstract](http://www.jpmsjournal.com/article/S0885-3924(10)00259-9/abstract)

Withholding, discontinuing and withdrawing medications in dementia patients at the end of life: A neglected problem in the disadvantaged dying?

DRUGS & AGING, 2010;27(6):435-449. Recent years have seen a growing recognition that dementia is a terminal illness and that patients with advanced dementia nearing the end of life do not currently receive adequate palliative care. However, research into palliative care for these patients has thus far been limited. Furthermore, there has been little discussion in the literature regarding medication use in patients with advanced dementia who are nearing the end of life, and discontinuation of medication has not been well studied despite its potential to reduce the burden on the patient and to improve quality of life. There is limited, and sometimes contradictory, evidence available in the literature to guide evidence-based discontinuation of drugs... <http://www.ingentaconnect.com/content/adis/dag/2010/00000027/00000006/art00001>

Letter

Palliative Care at U.S. cancer centers

JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, 2010;303(22):2251. The observations of Dr. Hui and colleagues on palliative care at U.S. cancer centers are timely.¹ Hospice and palliative care is a rapidly emerging discipline encompassing the care of many patients with terminal illness in addition to those with cancer. For many reasons, including the limited ability until recent years to cure most malignancies, the foundations of palliative care were laid by programs focused on cancer patients. Although cancer is the second leading cause of death in the U.S., accounting for 23% of deaths in 2007, 44% of deaths occurred from other categories of chronic conditions, including heart disease, cerebrovascular disease, chronic lung disease, dementia, diabetes, and renal disease. <http://jama.ama-assn.org/cgi/content/extract/303/22/2251>

Authors' response:

JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, 2010;303(22):2251. Given that more patients die of non-malignant diseases than of cancer, we agree with Dr. Weems that it is important to further develop the discipline of palliative care for other life-threatening diseases. Cancer has traditionally been the main disease model for palliative care because of its high prevalence, the relatively predictable disease trajectory, and the significant physical and psychosocial symptom burden among oncology patients. <http://jama.ama-assn.org/current.dtl>

1. *JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION*, 2010;303(11):1054-1061. **'Availability and integration of palliative care at U.S. cancer centers.'** Most cancer centers reported a palliative care program, although the scope of services and the degree of integration varied widely. <http://jama.ama-assn.org/cgi/content/abstract/303/11/1054>

N.B. The journal article was noted in Media Watch dated 12 April 2010.

The difficulties assessing spiritual distress in palliative care patients

MENTAL HEALTH, RELIGION & CULTURE | Online article – 2 June 2010 – This paper reports on a focus group study aimed at exploring the difficulties that palliative care healthcare professionals encounter while assessing the spiritual distress of their patients. Emergent themes included: lack of vocabulary around spiritual issues, personal issues surrounding death and dying, training issues, fear of being unable to resolve spiritual problems, time constraints and difficulty separating spiritual and religious needs.

<http://www.informaworld.com/smpp/content~content=a922721721&db=all>

Of related interest:

- *QUALITY HEALTH RESEARCH* | Online article – 7 June 2010 – **'Facing existential realities: Exploring barriers and challenges to spiritual nursing care.'** Although nurses ... recognize the importance of spiritual care to health and healing, in practice and education, spiritual care dwells on the periphery of the profession. <http://qhr.sagepub.com/cgi/content/abstract/1049732310372377v1>

From Media Watch dated 29 March 2010:

- *JOURNAL OF PASTORAL CARE & COUNSELING*, 2010;64(1):1-14. **'A Canadian ethnographic study on sources and definitions of spiritual reflection used by health care professionals who are not chaplains.'** This ... study presents a literature review, methodology, findings and discussion from a sample of twenty health care professionals around their experiences of sources and definitions of spiritual reflection. <http://journals.sfu.ca/jpcp/index.php/jpcp/article/view/213/160>

From Media Watch dated 8 March 2010:

- U.S. | *CHRISTIANITY TODAY* – 3 March 2010 – **'The medical hazards of spiritual care.'** New studies are finding that terminal cancer patients do better when doctors and medical staff are spiritually supportive. <http://www.christianitytoday.com/ct/2010/marchweb-only/19-31.0.html>

Non-local effects in the process of dying: Can quantum mechanics help?

NEUROQUANTOLOGY, 2010;8(2):155-163. Studies in hospices and nursing homes have shown that a number of different phenomena are associated with the mental states of the dying. In the days or weeks before death, the dying person may have premonitions, often unrecognised, of their impending death, or visions of dead relatives who they say have visited them. Relatives who may be spatially distant from but emotionally close to the dying person may experience an inexplicable awareness of them at the time of their death. Other phenomena reported at the time of death are clocks stopping, mechanical malfunctions, strange animal behaviour and shapes seen leaving the body or light seen surrounding it. Although these phenomena are well recognised by both carers and relatives, they are seldom discussed because they are difficult to explain in terms of any recognised medical model. A possible alternative hypothesis involves non-local effects, which would require a quantum mechanical explanation. This is supported by parapsychological findings, which are not always accepted by mainstream science. The hypothesis suggests that as death approaches consciousness becomes loosened from the brain-mind structure and this is the prime mover for the non-local effects that are noticed at this time.
<http://www.neuroquantology.com/journal/index.php/nq/article/viewFile/446/440>

From Media Watch dated 31 May 2010:

- U.K. | *Daily Mail* – 30 May 2010 – '**Near-death experiences 'explained': Scientists believe it's the last gasp of a dying brain.**' The mystery of why people 'bought back from the dead' report powerful spiritual experiences may have a biological explanation, according to experts.¹
<http://www.dailymail.co.uk/sciencetech/article-1282598/Near-death-experiences-explained-Scientists-believe-gasp-dying-brain.html?ito=feeds-newsxml>

1. *Journal of Palliative Medicine*, 2009;12(12):1095-1100. '**Surges of electroencephalogram activity at the time of death: A case series.**' The authors report a case series of ... patients who were neurologically intact before the decision to withdraw care due to extensive systemic critical illness.
<http://www.liebertonline.com/doi/abs/10.1089/jpm.2009.0159?prevSearch=allfield%253A%2528Chawla%2529&searchHistoryKey>

N.B. Noted in Media Watch dated 12 October 2009.

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

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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.

Evidence-based guideline update

Determining brain death in adults

NEUROLOGY, 2010;74(23):1911-1918. This is a report of the Quality Standards Subcommittee of the American Academy of Neurology. The authors provide an update of the 1995 American Academy of Neurology guideline with regard to the following questions: Are there patients who fulfill the clinical criteria of brain death who recover neurologic function? What is an adequate observation period to ensure that cessation of neurologic function is permanent? Are complex motor movements that falsely suggest retained brain function sometimes observed in brain death? What is the comparative safety of techniques for determining apnea? Are there new ancillary tests that accurately identify patients with brain death? In adults, there are no published reports of recovery of neurologic function after a diagnosis of brain death using the criteria reviewed in the 1995 American Academy of Neurology practice parameter. Complex-spontaneous motor movements and false-positive triggering of the ventilator may occur in patients who are brain dead. There is insufficient evidence to determine the minimally acceptable observation period to ensure that neurologic functions have ceased irreversibly. Apneic oxygenation diffusion to determine apnea is safe, but there is insufficient evidence to determine the comparative safety of techniques used for apnea testing. There is insufficient evidence to determine if newer ancillary tests accurately confirm the cessation of function of the entire brain. <http://www.neurology.org/cgi/content/abstract/74/23/1911>

From Media Watch dated 8 March 2010:

- *JOURNAL OF PAIN & SYMPTOM MANAGEMENT* | Online article – 29 January 2010 – '**Factors associated with congruence between preferred and actual place of death.**' Congruence between preferred and actual place of death may be an essential component in terminal care. Most patients prefer a home death, but many patients do not die in their preferred location. Specialized (physician, hospice, and palliative) home care visits may increase home deaths, but factors associated with congruence have not been systematically reviewed. This study sought to review the extent of congruence reported in the literature and examine factors that may influence congruence. [http://www.jpmsjournal.com/article/S0885-3924\(09\)01137-3/abstract](http://www.jpmsjournal.com/article/S0885-3924(09)01137-3/abstract)

Nurses need national guidance to standardise last offices care

NURSING TIMES (U.K.) | Online OpEd – 11 June 2010 – The care of deceased patients presents nurses with a unique challenge. They are the only profession to care for people both in the period leading up to death and immediately afterwards. Last offices mark the care transition between life and death. The processes that are integral to this make it explicit that patients are now dead; something that transforms an apparently simple procedure into a complex social and professional act, which is potentially emotionally difficult. <http://www.nursingtimes.net/nursing-practice-clinical-research/acute-care/nurses-need-national-guidance-to-standardise-last-offices-care-/5015832.article>

From Media Watch dated 17 May 2010:

- *NURSING TIMES* (U.K.) | Online report – 11 May 2010 – '**Last offices neglected in over half of hospital deaths.**' 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. <http://www.nursingtimes.net/whats-new-in-nursing/acute-care/last-offices-neglected-in-over-half-of-hospital-deaths/5014365.article>

Quotable Quotes

As we struggle to make sense of things, life looks on in repose. **Anon**

Masculinity, moralities and being cared for: An exploration of experiences of living and dying in a hospice

SOCIAL SCIENCES & MEDICINE | Online article – 4 June 2010 – This paper explores some important facets of the contemporary hospice experience. The authors explore ... conceptions of death and dying [among male and female hospice patients] and ... experiences of being cared for. The results illustrate a range of important themes including: tensions around what constitutes 'the good death'; dying and caring as moral practice; and, the centrality of gender identity and relations in shaping experiences of dying and caring. They argue for a sociological approach to death and dying that better elucidates the interplay of identity, morality and relationality at the end of life. http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6VBF-507BHVC-9&_user=10&_coverDate=06%2F04%2F2010&_rdoc=1&_fmt=high&_orig=search&_sort=d&_doc_anchor=&view=c&_searchStrId=1368174641&_rerunOrigin=scholar.google&_acct=C000050221&_version=1&_urlVersion=0&_userid=10&md5=68260e55305f6975972da62f11ebccb0

Assisted (or facilitated) death

Representative sample of recent articles, etc:

- *JOURNAL OF MEDICAL ETHICS*, 2010;36(6):333-335. **'Eluana Englaro, chronicle of a death foretold: Ethical considerations on the recent right-to-die case in Italy.'** This paper ... gives a chronicle of Eluana's last months until her death on 9 February 2009, and discusses the right-to-die controversy in Italy. <http://jme.bmj.com/content/36/6/333.abstract>

Worth Repeating

Legitimizing the shameful: End-of-life ethics and the political economy of death

BIOETHICS, 2007;21(1):23-31. The author explores one of the most politically sensitive and intellectually neglected issues in bioethics – the interface between the history of contemporary end-of-life ethics and the economics of life and death. He suggests that contrary to general belief, economic impulses have increasingly become part of the conditions in which contemporary end-of-life ethics continues to evolve. Although this conclusion does not refute the philosophical justifications provided by the ethics for itself, it may cast new light upon its social role. This paper does not deal with ethics, but with the history of ethics; it takes its point of departure to be the observation that economic justifications for hastening the death of some people are gradually becoming morally acceptable. The author attempts to find out why and how. Specifically, he focuses on the contribution of contemporary end-of-life ethics to this process. <http://trucha.ens.uabc.mx/bioetica/parte2/Bioetica%20Bibliografia%20y%20Literatura/0520.pdf>

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