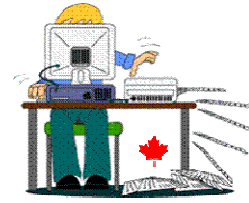


Media Watch...

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

Learning about dying: Scroll down to [Specialist Publications](#) and 'How the mass media report social statistics: A case study concerning research on end-of-life decisions' (p.9) for the findings of a study published in *Social Sciences & Medicine*

U.S.A.

California program helps people record wishes at end of life

CALIFORNIA | *Los Angeles Times* – 2 July 2010 – A program used in California to help nursing home and terminally ill patients express their wishes regarding treatment at the end of life results in the type of care patients want and expect, according to a new study. The program is called Physician Orders for Life-Sustaining Treatment and has been adopted in many nursing homes, hospitals and long-term care facilities in California beginning in January, 2009. The form was designed 20 years ago in Oregon because of concerns that traditional Do Not Resuscitate orders and advanced directives do not fully communicate patients' wishes for many situations and types of treatments. http://latimesblogs.latimes.com/booster_shots/2010/07/endoflife-care-orders-treatment.html

1. Scroll down to [Specialist Publications](#) and '**Comparison of methods to communicate treatment preferences in nursing facilities**' (p.8) published in the *Journal of the American Geriatrics Society*

Of related interest:

- UNIVERSITY OF TEXAS | Southwestern Medical Center online posting – 28 June 2010 – '**Including families in hospital-care discussions improves communication, benefits medical trainees.**' It has long been routine for individual medical professionals to go room-to-room on "rounds" to evaluate hospitalized patients. This often causes the day to seem like a parade of caregivers, with senior physicians, residents, bedside nurses, pharmacists, care coordinators and social workers dropping by to administer medication, discuss treatment options or just check in. A new study ... suggests that having such team discussions in a pediatric patient's room with family present ... is becoming more widespread nationwide, particularly in hospitals that have many trainees on staff.¹ <http://www.utsouthwestern.edu/utsw/cda/dept353744/files/595220.html>
1. *PEDIATRICS* | Online article – 29 June 2010 – '**Family-centered rounds on pediatric wards: A PRIS [Pediatric Research in Inpatient Settings] Network survey of U.S. and Canadian hospitalists.**' <http://pediatrics.aappublications.org/cgi/content/abstract/peds.2009-2364v1>

Into the great green beyond

NEW YORK TIMES | Online article – 1 July 2010 – At the end of an eco-conscious life, there is a final choice a person can make to limit his or her impact on the planet: a green funeral. "Consumers might live green, but they don't think about dying green," said Darren Crouch, president of Passages International, which supplies funeral homes with environmentally friendly caskets and urns. "They don't know that they can green their funeral." Of the more than 2.4 million deaths per year in the U.S., roughly 70% of the newly departed are interred in traditional caskets – that is, wood, steel or even copper caskets, many of which are then encased in slabs of reinforced concrete to prevent the weight of the earth from causing them to collapse. For those who go the casket route, embalming with toxic chemicals like formaldehyde remains common. As a result, the environmental footprint of the dead is a heavy one. Every year, cemeteries across the nation bury approximately 30 million board feet of hardwood, 104,000 tons of steel, 2,700 tons of copper and bronze and 1.6 million tons of reinforced concrete, according to statistics gathered by environmental groups and advocates for green burial. For those inclined toward a green funeral for themselves or a loved one, there are several options.
<http://green.blogs.nytimes.com/2010/06/30/into-the-big-green-beyond/>

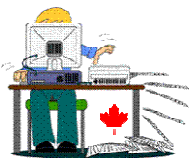
End-of-life care has 'room for improvement'

IOWA | *Business Week* – 29 June 2010 – U.S. hospitals need to do more to improve care for dying patients, researchers say.¹ Tending to patients in their last year of life accounts for 10-12% of the U.S. health care budget and 27% of Medicare costs. "Despite this intensive resource use, studies suggest that when lifesaving treatments are unsuccessful, hospitalized patients often die with distressing symptoms. Studies of patients who died in hospital find that pain, dyspnea (trouble breathing) and restlessness or agitation are prevalent before death. Furthermore, persons dying in the hospital often receive burdensome care immediately before death that may not match patient preferences," [says researcher] Dr. Anne M. Walling, of the University of California, Los Angeles. <http://www.businessweek.com/lifestyle/content/healthday/640540.html>

1. Scroll down to [Specialist Publications](#) and **'The quality of care provided to hospitalized patients at the end of life'** (p.5) published in *Archives of Internal Medicine*.

Of related interest:

- WISCONSIN PUBLIC RADIO | Online posting – 30 June 2010 – **'[Ira] Byock discusses end-of-life care...'** People are actually now sicker as they die, and some find that treatments become a greater burden than the illness was. Ira Byock, Director of Palliative Medicine at Dartmouth-Hitchcock Norris Cotton Cancer Center, and Professor of Anesthesiology and Community & Family Medicine at Dartmouth Medical School, discusses the trend of people being "overtreated to death." Listen (Length 51:04): http://www.cancer.dartmouth.edu/media/release/070110_byock_wpr.shtml
- NATIONAL HOSPICE & PALLIATIVE CARE ORGANIZATION | Press release – 29 June 2010 – **'Attention on medical overtreatment raises awareness on advance care planning, hospice and palliative care.'** Recent media coverage on the challenges patients and families face with overtreatment of a life-limiting illness brings the issues of hospice and palliative care and advance care planning to public attention. <http://www.nhpco.org/i4a/pages/Index.cfm?pageid=4649>



[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.

International

Classical music moves the heart in vegetative patients

ITALY | *New Scientist* – 2 July 2010 – Classical music pulls at the heartstrings of people in a vegetative state as well as those of healthy listeners. If you play music to vegetative patients, their heart rate changes in the same way as that of healthy controls, suggesting that music can affect the neural systems of emotion even when conscious thought is impossible. Francesco Riganello at the Santa Anna Institute in Crotona, Italy, and colleagues played four pieces of classical music to 16 healthy volunteers while measuring their heartbeats.¹ The team then repeated the experiment with nine people who were in a vegetative state. In addition, they asked the healthy volunteers to describe the emotions they had felt while listening. The pieces, each three minutes long and by different composers, were chosen because they have different tempos and rhythms – factors previously shown to elicit positive and negative emotions. Riganello found that the music affected the heart rates of both groups in the same way. Pieces rated as "positive" by healthy

volunteers, such as the minuet from Boccherini's string quintet in E, slowed heart rate; "negative" pieces, like Tchaikovsky's sixth symphony, increased heart rate. <http://www.newscientist.com/article/dn19123-classical-music-moves-the-heart-in-vegetative-patients.html>

The creative arts therapies: Making health care whole

U.S. | *MINNESOTA MEDICINE* – July 2010 –The creative arts therapies are six fields that combine artistic expression with psychotherapy to promote healing, wellness, and personal change. Although they are well-established fields, they are garnering renewed attention with the recent focus on health care and the arts. This article ... provides information about the training and professional standards of creative arts therapists and examples of how these therapies are being used in health care settings.

<http://www.minnesotamedicine.com/CurrentIssue/ClinicalGoodwillJuly2010/tabid/3497/Default.aspx>

1. *CLINICAL NEUROPHYSIOLOGY* | Online article – 20 June 2010 – **'Heart rate variability: An index of brain processing in vegetative state?'** Brain processing at varying levels of functional complexity has been documented in vegetative state. In this study, data mining procedures are applied to identify significant changes in heart rate variability (an emerging objective descriptor of autonomic correlates of brain activation) in response to complex auditory stimuli with emotional value (music). http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6VNP-50BRK07-2&_user=10&_coverDate=06%2F20%2F2010&_rdoc=1&_fmt=high&_orig=search&_sort=d&_docanchor=&view=c&_acct=C000050221&_version=1&_urlVersion=0&_userid=10&md5=f57659fda324da8522192bce7bd8d93d

Philosophers are helping doctors with dilemmas over life-and-death decisions

U.K. | *Guardian* – 29 June 2010 – Consider the A&E doctor's dilemma. Someone suffering from severe depression is brought to hospital, having made a serious suicide attempt. Without treatment, they will die. But they insist they want only palliative care and will regard any attempt to prevent their death as assault. There's not much time to make a decision. And, there are two conflicting pieces of legislation to confuse the issue. The Mental Health Act says intervention is required where a mentally-ill individual is a danger to themselves (or to the public). But the Mental Capacity Act (2007) is organised around a very different legal principle: it says that if someone passes a legal test of their capacity to make a decision, then they cannot be treated without their consent – even if they suffer from a major mental disorder. This is not a theoretical scenario – it happens. So do various others involving mental-health conditions – anorexia is one, schizophrenia another – that potentially have life or death consequences. Philosophers are now being asked to help medical and social care professionals to think through the collisions between these different approaches. <http://www.guardian.co.uk/education/2010/jun/29/mental-health-patients-decisions>

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- U.K. (SCOTLAND) | *Press & Journal* (Aberdeen) – 3 July 2010 – **'Warning over controversial proposals to assist suicide.'** Controversial proposals to legalise assisted suicide could lead to health-care workers being criminalised, it has been claimed. The Royal College of Nursing in Scotland fears that staff, who may feel pressurised to help a terminally-ill patient they have developed a relationship with, could be prosecuted. <http://www.pressandjournal.co.uk/Article.aspx/1810415?UserKey=>
- SWITZERLAND | BBC News (U.K.) – 2 July 2010 – **'Switzerland plans new controls on assisted suicide.'** Swiss assisted suicide organisation Dignitas is under growing pressure as questions about its finances and urns of ashes found in Lake Zurich coincide with plans for a law that would make it harder for foreigners to end their life in Switzerland. <http://news.bbc.co.uk/2/hi/europe/10461894.stm>
- U.K. | *Daily Telegraph* – 1 July 2010 – **'Legal assisted suicide creates 'slippery slope' to doctors killing without consent, expert claims.'** Prof. David Jones said that if society agrees that it is in some people's interests for them to end their own lives, it is difficult to resist the logical conclusion that others should be helped to die even if they have not made such a request. <http://www.telegraph.co.uk/news/uknews/law-and-order/7865305/Legal-assisted-suicide-creates-slippery-slope-to-doctors-killing-without-consent-expert-claims.html>
- U.K. | *Economist* – 1 July 2010 – **'Debating death.'** The argument over the ethics of assisting the terminally ill to die is sharpening, as two recent cases concentrate minds. On 25 June Keir Starmer, the Director of Public Prosecutions, said that Michael Irwin

and Alan Cutkelvin Rees would not be prosecuted for helping Raymond Cutkelvin, who had pancreatic cancer, die at a Swiss clinic in 2007. Prosecuting would not be in the public interest, he held: Mr Rees was motivated by compassion; Mr Irwin, a former doctor, was an elderly man; and neither had profited from the death. In another, very different, case, the General Medical Council struck Howard Martin off the medical register on 18 June. Mr Martin admitted to hastening the death of a number of patients and said that he had not always sought consent from sufferers or their families before doing so. In 2005 he was acquitted of murdering three patients through overdoses of morphine. The police may reopen that investigation. At issue is whether it should be legal to help a sufferer who wants to take his own life, or whether this might put pressure on the sick, the disabled and the elderly to call it quits early. http://www.economist.com/node/16485582?story_id=16485582&fsrc=rss

Association Press correction

Germany right-to-die story

GERMANY | Associated Press – 3 July 2010 – In a story [dated] 25 June about a right-to-die case, The Associated Press reported erroneously that Germany's top criminal court legalized assisted suicide. The court didn't rule on the issue of assisted suicide. The case involved a woman in a vegetative coma who was being kept alive through an intravenous feeding tube, though not terminally ill. The court overturned the attempted manslaughter conviction of a lawyer who had told the woman's daughter she could remove the tube from her mother. The woman had previously said she did not want to be kept alive under such circumstances. <http://www.google.com/hostednews/ap/article/ALeqM5jdo0vCHstOuVPeqVb08e4nbHWHEAD9GN2QK81>

N.B. Scroll down to p.9 and **'How the mass media report social statistics: A case study concerning research on end-of-life decisions'** for a case study of related interest published in *Social Sciences & Medicine*

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

Palliative care isn't just for the dying

AMERICAN JOURNAL OF NURSING, 2010;110(7):11. In palliative care, death is a possibility but not a certainty. The goal is to make the patient's life as meaningful as possible, regardless of the prognosis, and to provide some relief from the pain, symptoms and stress associated with a life-threatening illness or injury. An important part of palliative care is offering patients someone with whom they can have difficult conversations who can help them deal with the everyday challenges of living with a life-threatening illness or injury. Whether the patient ultimately lives or dies from the illness or injury, palliative care plays a crucial role in helping patients and their families endure. http://journals.lww.com/ajnonline/Fulltext/2010/07000/Palliative_Care_Isn_t_Just_for_the_Dying.2.aspx

The quality of care provided to hospitalized patients at the end of life

ARCHIVES OF INTERNAL MEDICINE, 2010;170(12):1057-1063. Patients in American hospitals receive intensive medical treatments. However, when lifesaving treatments are unsuccessful, patients often die in the hospital with distressing symptoms while receiving burdensome care. Systematic measurement of the quality of care planning and symptom palliation is needed. Over half of the patients [whose medical records were analyzed in this study] were admitted to the hospital with end-stage disease, and 28% were 75 years or older. One-third of the patients required extubation from mechanical ventilation prior to death, and 15% died while receiving cardiopulmonary resuscitation. Overall, patients received recommended care for 70% of applicable indicators. Goals of care were addressed in a timely fashion for patients admitted to the intensive care unit approximately half of the time, whereas pain assessments and treatments for pain and dyspnea were performed with fidelity. A practical, medical chart-based assessment identified discrete deficiencies in care planning and symptom palliation that can be targeted to improve care for patients dying in the hospital. <http://archinte.ama-assn.org/cgi/content/abstract/170/12/1057>

From Media Watch dated 12 April 2010:

- CENTER TO ADVANCE PALLIATIVE CARE | Online report – 5 April 2010 – **'Palliative care programs continue rapid growth in U.S. hospitals becoming standard practice**

throughout the country.' Researchers report that the number of programs in U.S. hospitals with 50 or more beds increased from 658 (24.5%) to 1,486 (58.5%) – a 125.8% increase from 2000-2008. <http://www.capc.org/news-and-events/releases/04-05-10>

Palliative treatment: Redefining interventions to treat suffering near the end of life

JOURNAL OF PALLIATIVE MEDICINE, 2010; 13(6):643-646. The treatment of suffering is now recognized as an essential component of medical care. By referring to this treatment as "palliative care," however, we diminish its importance. In this essay, the authors propose a shift in our conception of the treatment of suffering and advocate for the use of a new term: "palliative treatment." They argue that the word "treatment" is more appropriate than "care" because the interventions we employ are evidence-based, goal-directed, and effective in diminishing suffering. They articulate that this alteration in terminology is necessary because it facilitates patient and physician understanding of the importance and efficacy of palliative treatment interventions. The authors enumerate four distinct forms of suffering that each requires treatment: physical, psychological, existential, and spiritual. Finally, they argue that in rare cases when aggressive palliative treatment has been unsuccessful in diminishing suffering to a degree that is bearable, allowing death to occur unimpeded may be viewed as therapeutic because in death the patient's suffering is finally ended. <http://www.liebertonline.com/doi/abs/10.1089/jpm.2009.0410>

Cont.

Of related interest:

- *JOURNAL OF PAIN & SYMPTOM MANAGEMENT* | Online article – 25 June 2010 – **'The costs of treating terminal patients.'** Different approaches to deliver palliative care are not substitutes of each other and, thus, have different costs. From a cost perspective, hospitals need to pay attention to admitting patients to the palliative care unit at the right time. [http://www.jpmsjournal.com/article/S0885-3924\(10\)00363-5/abstract](http://www.jpmsjournal.com/article/S0885-3924(10)00363-5/abstract)
- *NURSING TIMES* (U.K.) | Online article – 28 June 2010 – **'Why do patients with complex palliative needs experience delayed hospital discharge?'** Patients with complex palliative care needs often experience delays in being discharged from hospital. The planning of complex discharges was often found to be uncoordinated and the evidence demonstrated a lack of cohesiveness between the services relevant for a safe and timely discharge. <http://www.nursingtimes.net/nursing-practice-clinical-research/acute-care/why-do-patients-with-complex-palliative-needs-experience-delayed-hospital-discharge/5016488.article>

Autonomy and end-of-life advance directives in Italy: The courts' struggle against the political majority's attacks on constitutional rights

CLINICAL ETHICS, 2010;5(2):67-72. This paper explores the significance of a landmark Italian judgement regarding end-of-life advance directives, emphasizing the legal and political context in which the decision was made. The analysis particularly focuses on the political majority's attempt to overturn the outcome of the courts' proceedings – challenging the country's institutional order and jeopardizing constitutional rights. <http://ce.rsmjournals.com/cgi/content/abstract/5/2/67>

From Media Watch dated 14 June 2010:

- *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>

Patients' needs and satisfiers: Applying human scale development theory on end-of-life care

CURRENT OPINION IN SUPPORTIVE & PALLIATIVE CARE | Online article – 28 June 2010 – Patients, families and healthcare professionals become part of a process that aims to embrace a unique 'world': the patients' subjectivity, his or her own needs and resources capable of meeting those needs. Reported 'gaps' between desired and current practice in the provision of care reflected the complexity of human needs, specifically at the end of life. http://journals.lww.com/co-supportiveandpalliativecare/Abstract/publishahead/Patients_needs_and_satisfiers_applying_human.99933.aspx

Of related interest:

- *JOURNAL OF PALLIATIVE MEDICINE*, 2010;13(6):719-726. **'The influence of age on the likelihood of receiving end-of-life care consistent with patient treatment preferences.'** Older patients preferring life-prolonging therapies are less likely to receive them than younger patients; middle-aged patients who want to avoid life-prolonging care are more likely to do so than younger patients. <http://www.liebertonline.com/doi/abs/10.1089/jpm.2009.0337>

Quotable Quotes

Most dying today is not well managed. Instead, we are witnessing a rise in shameful forms of dying. It is not cancer, heart disease or medical science that present modern dying with its greatest moral tests, but rather poverty, ageing and social exclusion.

Allan Kellehear, Professor of Sociology, University of Bath

**Perspectives from the frontlines:
Palliative care providers' expectations
of Canada's compassionate care
benefit programme**

*HEALTH & SOCIAL CARE IN THE
COMMUNITY* | Online article – 23 June
2010 – This study examines the
perspectives of front-line palliative care
providers regarding a social benefit
programme in Canada designed to support
family caregivers at end-of-life. Findings
demonstrate that participants expect the
Compassionate Care Benefit ... to provide:
1) an adequate length of leave time from
work, which is reflective of the uncertain
nature of caregiving at end-of-life; 2)
adequate financial support; 3) information on
the programme to be disseminated to
FLPCPs so that they may share it with
others; and, 4) a simple, clear, and quick
application process.
<http://www3.interscience.wiley.com/journal/123559157/abstract?CRETRY=1&SRETRY=0>

Of related interest:

- BRITISH COLUMBIA LAW INSTITUTE
& THE CANADIAN CENTRE FOR
ELDER LAW | Online posting – 14 April
2010 – **'Care/work: Law reform to
support family caregivers to balance
paid work and unpaid caregiving.'**
This paper considers whether the law
recognizes the value of unpaid family
caregiving labour and examines to what
extent the law assists British
Columbians who are managing the
double role of worker/caregiver.
<http://www.bcli.org/ccel/publications/study-paper-family-caregiving>

N.B. Three recent studies of the
Compassionate Care Benefit have been
noted in Media Watch. These are
summarized in the weekly report dated 19
April 2010 (p.2) with links to the authors'
reports.

The ethical balancing act of hospice care

HOME HEALTH CARE NURSE, 2010;28(7):
407-413. Hospice clinicians are confronted
with numerous challenges ... in the provision
of care to their patients. At the heart ... are
ethical considerations ... triggered by
questions such as: Do patient's wishes

always take precedence over others'? How
do I deal with family's wishes that appear to
contradict what the patient told us when able
to speak for themselves? What do I do if the
patient's behavior demonstrates that he is
not interested in receiving hospice care?
The focus of this article is to identify ethical
challenges that cause hospice clinicians to
question whether they are doing the right
thing.http://journals.lww.com/homehealthcareonline/Fulltext/2010/07000/The_Ethical_Balancing_Act_of_Hospice_Care.5.aspx

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.

Turnover of direct care workers in home care and hospice agencies

JOURNAL OF AGING & HEALTH | Online article – 28 June 2010 – High turnover and staff shortages among home care and hospice workers may compromise the quality and availability of in-home care. Differences in turnover between hospice and home health agencies suggest that organizational characteristics of hospice care contribute to lower turnover rates. <http://jah.sagepub.com/cgi/content/abstract/0898264310373390v1>

Comparison of methods to communicate treatment preferences in nursing facilities

JOURNAL OF THE AMERICAN GERIATRICS SOCIETY, 2010;58(7):1241-1248. Residents [i.e., participants in this retrospective observational cohort study] with POLST [Physician Orders for Life-Sustaining Treatment Program] forms were more likely to have treatment preferences documented as medical orders than those who did not, but there were no differences in symptom management or assessment. <http://www3.interscience.wiley.com/journal/123572530/abstract>

From Media Watch dated 16 February 2009:

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

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

A self-assessment by physicians at all levels of training of ability and comfort to deliver bad news

JOURNAL OF PALLIATIVE MEDICINE, 2010;13(6):677-683. Independent of level of training, this study reveals a lack of self-

assessed preparedness from many responsible for delivering bad news to patients and families. A significant barrier to improvement is the disproportionate level of self-assessed comfort versus knowledge level. Educational models should include both didactics to learn the skills and practice-based learning to refine the techniques. <http://www.liebertonline.com/doi/abs/10.1089/jpm.2009.0338>

Of related interest:

- *EUROPEAN JOURNAL OF CANCER CARE* | Online article – 29 June 2010 – 'Doctor, how long?' This study aimed to quantify the average survival time of cancer patients once terminal sedation was started until death and identify potential variables that may influence their survival time on sedation. Sedated, terminal cancer patients usually live about one day. The authors identified risk factors for a shorter sedation period. <http://www3.interscience.wiley.com/journal/123567659/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>

A palliative prognostic score for terminally ill children and adolescents with cancer

PEDIATRIC BLOOD & CANCER | Online article – 29 June 2010 – The loss of a child is considered the hardest moment in a parent's life. Studies addressing length of survival under pediatric palliative care are rare. The aim of this study was to improve a survival prediction model for children in palliative care, as accurate information positively impacts parent and child preparation for palliative care. Factors that increase accuracy of life expectancy prediction enable adequate information to be given to patients and families, contributing to therapeutic decision-making issues. <http://www3.interscience.wiley.com/journal/123567996/abstract>

Of related interest:

- *PEDIATRIC CRITICAL CARE MEDICINE* | Online article – 24 June 2010 – '**Physicians' experiences and perspectives regarding follow-up meetings with parents after a child's death in the pediatric intensive care unit.**' Parents of children who die in the pediatric intensive care unit often desire a follow-up meeting with the physicians who cared for their child. Critical care physicians have a wide range of experience conducting follow-up meetings with bereaved parents. http://journals.lww.com/pccmjournals/Abstract/publishahead/Physicians_experiences_and_perspectives_regarding.99554.aspx

How the mass media report social statistics: A case study concerning research on end-of-life decisions

SOCIAL SCIENCES & MEDICINE | Online article – 19 June 2010 – This case study contributes to existing knowledge about the ways in which mass media establish, exaggerate and otherwise distort the meaning of statistical findings. Journalists ignored findings that did not fit into existing media interest in the 'assisted dying' story and were subject to pressure from interest groups concerned to promote their own interpretations and viewpoints. Rogue statistics mutated as they were set loose from their original research report context and were 'laundered' as they passed from one media report to another. Yet media accounts of the research, fuelling an already heated public debate about ethical issues in end-of-life care, arguably acted as a conduit for introducing new considerations into this debate, such as the role played by sedation at the end of life, the extent to which euthanasia is practiced outside the law, and the extent of medical opposition to the legalisation of assisted dying. The expectation that accuracy and comprehensiveness should be the sole criteria for judging journalists' reports is, finally, considered to be unrealistic and it is argued that social scientists need to understand and adapt to the conditions under which mass media reporting operates if they are to succeed in introducing the findings of social research into public debates.

[http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6VBF-50BJNTN-4&_user=10&_coverDate=06%2F19%2F2010&_rdoc=15&_fmt=high&_orig=browse&_srch=doc-info\(%23toc%235925%239999%2399999999%23999999%23FLA%23display%23Articles\)&_cdi=5925&_sort=d&_docanchor=&_ct=80&_acct=C000050221&_version=1&_urlVersion=0&_userid=10&md5=95301b430070bdd56940c92bc3759c88](http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6VBF-50BJNTN-4&_user=10&_coverDate=06%2F19%2F2010&_rdoc=15&_fmt=high&_orig=browse&_srch=doc-info(%23toc%235925%239999%2399999999%23999999%23FLA%23display%23Articles)&_cdi=5925&_sort=d&_docanchor=&_ct=80&_acct=C000050221&_version=1&_urlVersion=0&_userid=10&md5=95301b430070bdd56940c92bc3759c88)

From Media Watch
dated 24 May 2010:

Informing discussion on end of life issues

CANADIAN HOSPICE
PALLIATIVE CARE
ASSOCIATION | AVISO
(Letter) – May 2010 – 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 [for example] euthanasia and assisted suicide. For the most part, the general public ... 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 ... distorted or one-sided.

http://www.chpca.net/aviso/AVISO_62_EN.pdf

Assisted (or facilitated) death

Representative sample of recent articles, etc:

- *ARCHIVES OF DISEASE IN CHILDHOOD* | Online article – 23 June 2010 – '**Attitudes and practices of physicians regarding physician-assisted dying in minors.**' A majority of surveyed Flemish physicians appear to accept physician-assisted dying in children under certain circumstances and favour an amendment to the euthanasia law to include minors. The approach favoured is one of assessing decision-making capacity rather than setting arbitrary age limits. <http://adc.bmj.com/content/early/2010/06/23/adc.2009.182139.abstract>
- *CRITICAL PUBLIC HEALTH*, 2010;20(2):169-199. '**Communities of interpretation: Euthanasia and assisted suicide debate.**' Informed by the theories of social construction of reality and social movement, this study examined how medical journals, the publications of social movement organizations, and newspapers portrayed Jack Kevorkian in the physician-assisted suicide (PAS) and euthanasia debate. <http://www.informaworld.com/smpp/content-db=all-content=a923340791>
- *JOURNAL OF INVESTIGATIVE SURGERY*, 2010;23(3):125-128. '**Good life good death according to Christiaan Barnard.**' Christiaan Barnard (1922–2002), pioneering heart transplant surgeon, introduced his ideas on euthanasia in a well-written and researched book, *Good Life Good Death. A Doctor's Case for Euthanasia and Suicide* (1980). The authors discuss Barnard's beliefs and attempt to clarify some misunderstandings regarding this particular controversial area of medicine. <http://informahealthcare.com/doi/abs/10.3109/08941939.2010.492026>

Worth Repeating

The "moment of death"

OMEGA – JOURNAL OF DEATH & DYING, 2007;55(3):219-236. The "moment of death," once a dominant concept in preparing for a "good death," has been eclipsed by a focus on the wider concept of the "dying trajectory." However, findings from interviews with ... bereaved individuals suggest that dying loved ones' final moments may still be experienced as highly significant in their own right. In some accounts the dying individual's final moments did not feature or made little impression, either because the survivor was not present, or there was no obviously definable moment, or because other, usually medical factors, such as whether to resuscitate the person, took precedence. However, in six cases such moments were constructed as profound, special, and memorable occasions. These constructions are explored in relation to achieving a good death, the dying trajectory as a whole, and making sense of the bereavement experience. Their implications for sociological theories of identity and embodiment are also considered. <http://baywood.metapress.com/app/home/contribution.asp?referrer=parent&backto=issue,4,5;journal,24,241;linkingpublicationresults,1:300329,1>

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