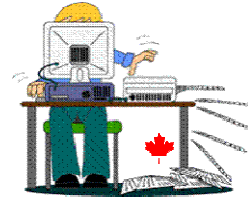


Media Watch...

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.

14 September Edition | Issue #114



Compilation of Media Watch 2008, 2009 ©

Compiled & Annotated by Barry R. Ashpole

**Sense and sensibility ...and, public debate about end of life care:
Scroll down to [U.S.A.](#) and 'The truth about death panels' & 'I was a teenage death panelist.'**

Canada

We do have to put a price on life

GLOBE & MAIL | Online OpEd – 10 September 2009 – How much is a life worth? What price can we put on extending a life for a few years, a few months or a few days? Increasingly, those are questions that, however unsettling, need to be asked, particularly in the cancer field. There are a growing number of cancer therapies. They are increasingly expensive. And many produce only a short extension of survival. That combination can pose some serious dilemmas, clinical as well as ethical. The issue is underscored by a recent article in the *Journal of the National Cancer Institute*.¹ <http://www.theglobeandmail.com/life/health/we-do-have-to-put-a-price-on-life/article1281655/>

1. *Journal of the National Cancer Institute*, 2009;101(15):1044-1048. **'How much is life worth: Cetuximab, non-small cell lung cancer, and the \$440 billion question'** Although health-care professionals avoid putting a value on a life, our limited resources require that society address what counts as a benefit, the extent to which cost should factor in deliberations, and who should be involved in these decisions. <http://jnci.oxfordjournals.org/cgi/content/short/djp177v1>

N.B. Scroll down to [Specialist Publications](#) (p.7) and HEMONCTODAY | Online article – 10 September 2009 – **'[U.S.] Experts debate if the cost of end-of-life cancer care is too high.'**

If you gotta go, why not go green?

B.C. | CTV News – 7 September 2009 – Within the environmentally-conscious set, many are ... choosing to make their funeral arrangements more eco-friendly, from using recycled paper announcements to choosing non-toxic embalming fluid to using a green casket made without harmful materials. But now the green death care movement is taking the environmentally-friendly end one step further: The greening of the final resting place. While many consider cemeteries quite natural already, advocates argue manicured lawns and concrete grave liners are anything but. http://www.ctvbc.ctv.ca/servlet/an/local/CTVNews/20090906/bc_green_burials_090906/200907/?hub=BritishColumbiaHome

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- ALBERTA | *Western Catholic Reporter* – 14 September 2009 – '**Archbishop squares off on euthanasia on talk show.**' Legalizing euthanasia would weaken the trust between patients and doctors, Archbishop Richard Smith told a local open-line radio show. "There needs to be that fundamental confidence on the part of the patient that the doctor will always do what the traditional Hippocratic Oath has said the doctor will always do – do no harm and uphold one's life."
<http://www.wcr.ab.ca/news/2009/0914/smith091409.shtml>
- ONTARIO | *Windsor Star* – 8 September 2009 – '**Taking away choice.**' In reality, legalized assisted suicide is all about giving doctors control, even making choices for patients, without any repercussion. <http://www2.canada.com/windsorstar/news/editorial/story.html?id=bb9ab7d6-7ac0-4075-b7d9-760299ce7739>

N.B. Scroll down to [Specialist Publications](#) (p.10) and *CANADIAN MEDICAL ASSOCIATION JOURNAL* | Online report – 11 September 2009 – '**Euthanasia debate reignited.**'
http://www.cmaj.ca/earlyreleases/11sept09_euthanasia.shtml

[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.

U.S.A.

The truth about death panels

NATIONAL PUBLIC RADIO (Foreign Policy) | Online report – 10 September 2009 – As the U.S. debates how to overhaul its health-care system, arguments have become increasingly outlandish – perhaps none more so than former vice-presidential nominee Sarah Palin's assertion that the Obama administration plans to implement state-sponsored "death panels" to determine whether the elderly and infirm deserve life-saving medical treatment. Writing in [the] *Wall Street Journal*, Palin doubled down on her claims, saying that though "establishment voices" dismissed them, they nonetheless "rang true for many Americans."¹ Of course, the U.S. government has no plans to "pull the plug on grandma"; the claims were false and the provision that sparked the rumors – a measure providing for free advice on how individuals can create living wills to inform their doctors and families what kind of end-of-life care they want – was removed from prospective legislation, just in case. But Foreign Policy took a ... look around the world in places where something akin to death panels is alive and well.

<http://www.npr.org/templates/story/story.php?storyId=112705969>

1. *WALL STREET JOURNAL* | OpEd – 8 September 2009 – '**Obama and the bureaucratization of health care.**' The president's proposals would give unelected officials life-and-death rationing powers. <http://online.wsj.com/article/SB10001424052970203440104574400581157986024.html>

Of related interest:

- MINNESOTA | *Star Tribune* (Minneapolis-St. Paul) – 11 September 2009 – '**Consider these two end-of-life scenarios.**' One family faced death with no idea of treatment wishes. The other had a plan. <http://www.startribune.com/opinion/commentary/58662962.html?elr=KArksc8P:Pc:U0ckkD:aEyKUiD3aPc: Yyc:aULPQL7PQLanchO7DiUr>
- *NEW YORK TIMES* | OpEd – 9 September 2009 – '**Prolonging death at the end of life.**' Medicine today achieves great things, but too often when patients have no hope of surviving we use technology and drugs simply to keep people alive. Those racked bodies give us the peace of mind that when our time comes "everything will be done," and we will get our own chance at a miracle. This patient's suffering was one way, for the doctors at least, to keep the dream alive. <http://well.blogs.nytimes.com/2009/09/09/prolonging-death-at-the-end-of-life/>

I was a teenage death panelist

NEWSWEEK | Online OpEd – 12 September 2009 – Though I did not realize it on either occasion, I have twice served on death panels. The first was more than two decades ago, when my grandmother was ill and there was little hope of recovery. My grandfather asked me (in passing, to be sure; I was 16) whether we ought to prolong her life by artificial means or let her die what I clearly remember his calling "a noble death." Then, last year at this time, my father was diagnosed with a fatal case of lung cancer (three packs of cigarettes a day for 40 years will do that to you) and quickly ended up on a respirator for several days, with, the doctors advised, no hope of ever waking up. His wife and I consulted over a painful weekend and made what was to us a clear decision. A priest was summoned, prayers said, and the machines turned off. He died within moments. Such situations are not what the right-wing opponents of President Obama's health-care reform were thinking of when they coined the term "death panels," a lie crafted to foment opposition to the president's push for reform. In fact, the origins of what became the dreaded death panels show the idea to be sensible and humane: the proposal was to encourage families to consult with their doctors about end-of-life care. The phrase is at once politically brilliant and horribly misleading. <http://www.newsweek.com/id/215289>

Doctors seeing elderly patients at home saves money, improves care

MAINE | *Kennebec Journal & Morning Sentinel* (OpEd) – 8 September 2009 – While Congress is debating health reform and struggling to accomplish the apparently competing goals of reducing costs while improving quality, I am one of a growing number of doctors who reduce costs and improve care by seeing frail, elderly patients in their homes. Such patients consume a highly disproportionate amount of Medicare dollars, as they are most likely to require admission to a hospital or nursing home. Seeing these patients in their homes gives me a wealth of information that I can't get in the office: how reliably they take their medications, how well they eat and other aspects of their home life. Having this kind of information enables me to work better with their other caregivers to anticipate problems before they occur. Unfortunately, this proven approach that reduces unnecessary spending is being largely overlooked in the current reform debate. <http://kennebecjournal.maintoday.com/view/columns/6802745.html>

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- CALIFORNIA | *Mercury News* (San Jose) – 9 September 2009 – **'It's time for California legislature to act on assisted suicide.'** It's been two years since the failure of California's most recent attempt to legalize doctor-assisted suicide. A report this week from Washington ... should provide new impetus for lawmakers to act. http://www.mercurynews.com/opinion/ci_13301058
- WASHINGTON | *Seattlepi.co* – 8 September 2009 – **'28 have asked to end lives under 'Death with Dignity Act.'** At least 28 Washington residents have received life-ending medication from their physicians and of those 11 have taken the pills, according to data tracking the Death with Dignity Act, which ... took effect in March. http://www.seattlepi.com/local/409929_death08.html

International

Communications surrounding death

At the end of life

IRELAND | *Irish Times* – 14 September 2009 – A consultation process linked to the Forum on End of Life in Ireland has received significant public attention. One piquant reason is that dying and death affect us all. About 30,000 people die in Ireland annually, many of them in unhappy circumstances, away from their homes, or in crowded, grubby or noisy wards. What to do about this and related issues is one task of the forum, a project of the Irish Hospice Foundation. Already in its workshops, public meetings and submissions, considerable material has been gathered on what people believe are the main issues at end of life. The process has been considerably enhanced by the perspectives of illness groups, statutory agencies, gays and lesbians, nursing and medical agencies, children's groups, as well as bereavement and suicide experts. The views of older people, religious and spiritual groups, carers, architects and marginalised groups, and the pending presentations from nursing home interests, emergency services, educationalists, patients and family groups, as well as legal and human rights experts will also ensure rich material for public debate. Arising from the forum, it is intended that action be taken on the substantial issues early next year. One of these is expected to be communications surrounding death. There is a failure on the part of many people, as well as Government and organisations, to engage with death issues. There is a gathering, though incomplete, view of what is meant by a "good death". There is a general reluctance to plan for death and insufficient discussion on advanced care directives. <http://www.irishtimes.com/newspaper/opinion/2009/0914/1224254474633.html>

Families 'kept in the dark' as doctors make life-or-death decisions

U.K. | *Times* – 14 September 2009 – One in four families are not informed when doctors decide that a patient in hospital is dying under a widely used NHS [National Health Service] scheme for palliative care, a national audit has found. Less than half of terminally ill patients and their relatives are offered religious or spiritual support in their final days and hours, while a quarter of doctors are not being trained within hospitals to deal with dying patients. The audit, seen by *The Times*, comes after the NHS was accused of having a "tick-box culture" of care that defines patients as dying without questioning whether they might recover. The criticism relates to the Liverpool Care Pathway (LCP), which is endorsed by the Government and many healthcare professionals as the best way to improve treatment for dying patients with cancer or other illnesses. About 20,000 people are estimated to die each year while being cared for under the guidelines. http://www.timesonline.co.uk/tol/life_and_style/health/article6833149.ece

From Media Watch dated 7 September 2009:

- *Daily Telegraph* (Letter) – 3 September 2009 – '**Dying patients.**' The Government is rolling out a new treatment pattern ... based on experience in a Liverpool hospice. If you tick all the right boxes in the Liverpool Care Pathway, the inevitable outcome of the consequent treatment is death.¹ <http://www.telegraph.co.uk/comment/letters/6127443/Lack-of-strategic-planning-for-energy-policy-means-Britain-is-over-reliant-on-imported-gas.html>

1. Liverpool Care Pathway for the Dying Patient: <http://www.mcpcil.org.uk/liverpool-care-pathway/>

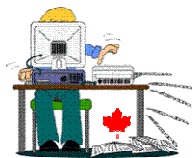
Developing palliative care in Singapore gets a boost

SINGAPORE | Channel NewsAsia – 13 September 2009 – More details will be available soon on the Health Ministry's decision to liberalise the use of Medisave for home palliative care. A new movement is gaining appeal among the elderly ... described ... as the "slow medicine movement," where the elderly value the quality over quantity of life spent. Palliative care is a key aspect of slow medicine and ... home care will help bring down medical costs for the patient and family. <http://www.channelnewsasia.com/stories/singaporelocalnews/view/1004709/1/.html>

Law to care for dying 'supported'

U.K. (SCOTLAND) | BBC News – 13 September 2009 – Proposed legislation requiring health boards to provide specialist care for the terminally ill has won a high level of public support, it has been claimed. A backbench bill being spearheaded by SNP [Scottish National Party] MSP [Member of the Scottish Parliament] Gil Paterson aims to secure high-quality palliative care on the NHS [National Health Service] for anyone who needs it. The plans have already attracted cross-party support. They were brought forward amid concern over varying levels of palliative care across Scotland. http://news.bbc.co.uk/2/hi/uk_news/scotland/8251600.stm

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.

Families being 'wrongly burdened' with life or death questions over loved ones

U.K. | *Daily Telegraph* – 12 September 2009 – Relatives are being left with the impression that they have made the choice, said Prof Claud Regnard, a consultant in palliative care medicine, despite clear rules which state that they must not. He warned that unnecessary distress was being caused because not enough doctors were following official guidelines. Guidance makes clear that relatives' wishes are "irrelevant." The wishes of the patient themselves are paramount in deciding whether to issue a Do Not Resuscitate order. If they cannot indicate their view then medical staff are under an obligation to act "in their best interests." However, the guidelines state that doctors should consult families or partners to discover if a patient had previously expressed a view on being resuscitated. Prof Regnard called for the rules to become part of doctor's mandatory training and to be taught in medical schools. He said: "Doctors have sometimes the habit of asking the family or partners. Doctors should ask the family what the patient's previous views were, but they are not asking the family what their views are, that is irrelevant." <http://www.telegraph.co.uk/health/healthnews/6174296/Families-being-wrongly-burdened-with-life-or-death-questions-over-loved-ones.html>

Cost of dying soars to £7,000 on average, survey finds

U.K. | *Guardian* – 9 September 2009 – The average cost of dying has soared to £7,098 this year and is expected to rise by another third over the next five years, according to a survey which warns that many bereaved families will struggle to cover all the expenses. The cost of a "standard" funeral in the U.K. has risen by 7.2% to £2,733, but additional and often "hidden" costs such as venue hire, catering and flowers can push the overall average cost much higher, the research suggests. <http://www.guardian.co.uk/money/2009/sep/09/rising-funeral-costs>

Hospice study aims to improve care for youngsters

U.K. (SCOTLAND) | *Scotsman* – 9 September 2009 – The Children's Hospice Association Scotland [CHAS] will launch a major research project into how youngsters with very rare, life-limiting conditions, feel and investigate further their symptoms. The family's perspective will also be considered as part of this study as CHAS, which operates two hospices in the country, attempts to improve palliative care for youngsters. <http://news.scotsman.com/health/Hospice-study-aims-to-improve.5630032.jp>

Patient-physician communication

Internet complica la relación médico-paciente

SPAIN | Plataformasinc.es – 31 August 2009 – Que los pacientes pregunten a su médico por alguna información leída en Internet o por las web donde informarse mejor sobre su diagnóstico ha dejado de ser una anécdota. Un estudio realizado por investigadores españoles muestra las ventajas e inconvenientes de las consultas médicas on line. Un 31% de los médicos cree que la 'red de redes' complica su relación con los pacientes y que mina su credibilidad. <http://www.plataformasinc.es/index.php/esl/Noticias/Internet-complica-la-relacion-medico-paciente>

N.B. A new study confirms that Spanish physicians have concerns regarding the Internet.¹ Two negatives, for example, are that 31% think that the internet diminishes the physician's image and complicates the relationship; only 20% think that the Internet favors patient independence.

1. *ATENCIÓN PRIMARIA*, 2009;41(6):308–314. 'Uso de Internet por médicos de primaria y hospitales y percepción de cómo influye en su relación con los pacientes.'

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- U.K. | Press Association – 11 September 2009 – '**Assisted suicide debate rolls on.**' Campaigners for a change in the law ... have called for the House of Commons to debate the issue. <http://www.google.com/hostednews/ukpress/article/ALeqM5jHyxZ30nnjO7H9ndt1PpDegg2oLg>
- U.K. | *This is London* – 11 September 2009 – '**Chief judge: It will be hard to change law on assisted suicide.**' Lord Phillips of Worth Matravers said that he understood why those suffering "horrible diseases" would want to spare their relatives pain and distress... But in a blow to those who are campaigning for assisted suicide to become legal, he warned that any change in the law was unlikely to produce any "more satisfactory answer" than existing legislation which outlaws the practice. <http://www.thisislondon.co.uk/standard/article-23742946-details/Chief+judge:+lt+will+be+hard+to+change+law+on+assisted+suicide/article.do>

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

Research in pediatric palliative care: Closing the gap between what is and is not known

AMERICAN JOURNAL OF HOSPICE AND PALLIATIVE MEDICINE | Online article – 10 September 2009 – Pediatric palliative care provides physical and psychosocial care to children with life-limiting illnesses and their families. Services are provided by physicians, nurses, volunteers, and other providers in a myriad of settings. Over the past 30 years, a portfolio of research has amassed on palliative care. Yet, much remains unknown, particularly about pediatric palliative care. This article is the first in a series and it provides a general overview of what is known and unknown about the provision and need for pediatric palliative care. Subsequent articles will focus on specific topics such as decision making and support care. The purpose of this series is to inform and promote discussion about research in pediatric palliative care. <http://ajh.sagepub.com/cgi/content/abstract/1049909109345147v1>

Of related interest:

- *PEDIATRIC BLOOD CANCER*, 2009;53:647-651. '**An assessment of the current state of palliative care education in pediatric hematology/oncology fellowship training.**' Pediatric oncology fellowship directors believe it is very important for fellows to learn about palliative care during training; however, currently the majority of fellowship programs [in the U.S.] do not have a palliative care curriculum and lack significant formal education in end-of-life care. <http://www3.interscience.wiley.com/journal/122386571/abstract>

[U.S.] Experts debate if the cost of end-of-life cancer care is too high

HEMONCTODAY | Part 1 of a two-part online article – 10 September 2009 – According to a national survey of patients with cancer and their families, 25% exhausted or nearly exhausted their savings in treating the disease. Even among families with health insurance, 33% of respondents to the survey conducted by the Kaiser Family Foundation and the Harvard School of Public Health said they struggled to pay medical bills. Among those who had ever been uninsured, 27% delayed or skipped treatment because of financial concerns. The NIH [National Institute of Health] has estimated that Americans spent \$89 billion on direct costs for cancer care in 2007, with that expense expected to increase as the baby boom generation ages. The cost of cancer care is even higher in the last weeks of life. Medicare spends one-third of the cost of treating cancer in the final year, and 78% of that spending occurs in the final month. The experts interviewed ... about the cost of cancer care at the end of life were unanimous in saying the expense is untenable. <http://www.hemonctoday.com/article.aspx?rid=43593>

Palliative respite services using nursing staff reduces hospitalization of patients and improves acceptance among carers

INTERNATIONAL JOURNAL OF PALLIATIVE NURSING, 2009;15(8):389-395. People caring for palliative patients at home identify respite care as a key need. However, caregiver concern over the skill level of respite care providers has been cited as a common barrier to uptake and satisfaction with respite services. This study implemented and evaluated an at-home palliative care respite service delivered by enrolled nurses. The program reduced hospitalizations of palliative patients by 80% and potentially increased the likelihood that they would die at home. http://www.ijpn.co.uk/cgi-bin/go.pl/library/article.html?uid=43798;article=IJPN_15_8_389_395

Core attitudes of professionals in palliative care

INTERNATIONAL JOURNAL OF PALLIATIVE NURSING, 2009;15(8):405-411. The aim of this study was to explore what core attitude means for palliative care professionals and whether there is a specific core attitude in palliative care. Core attitude in palliative care can be best described with the following three domains: 1) personal characteristics; 2) experience of care; and, 3) competence in care. Authenticity is the most important characteristic of professionals, along with honesty and mindfulness. In the field of palliative care, core attitude consists predominately of authenticity, manifests itself in relationships, and requires a high degree of perceptiveness. http://www.ijpn.co.uk/cgi-bin/go.pl/library/article.html?uid=43800;article=IJPN_15_8_405_411

Physicians' experience with surrogate decision making for hospitalized adults

JOURNAL OF GENERAL INTERNAL MEDICINE, 2009;24(9):1023-1028. Hospitalized patients frequently lack decision-making ability, yet little is known about physicians' approaches to surrogate decision making. Nearly three fourths of physicians [responding to a survey] had made a major decision with a surrogate during the past month. Although nearly all patients (90%) had a surrogate, physicians reported trouble contacting the surrogate in 21% of cases. Conflict was rare (5%), and a majority of physicians agreed with surrogates about the medical facts (77%), prognosis (72%) and best course of action (65%). Physician-surrogate decision making may be enhanced if patients discuss their preferences in advance and if physician contact with surrogate decision makers is facilitated. <http://www.springerlink.com/content/v628585625816573/>

N.B. Scroll down to [Worth Repeating](#) and **'Family surrogate decision making at the end of life: Seeing them through with care and respect.'**

Of related interest:

- *JOURNAL OF PAIN & SYMPTOM MANAGEMENT*, 2009;38(3):473-476. **'The defined trial period in ethical decision making.'** In the face of acute life-threatening illness, especially when superimposed upon chronic illness, patients and their families often face great difficulty in establishing treatment preferences and goals of care. This is especially true early in treatment when prognostication is difficult. [http://www.jpmsjournal.com/article/S0885-3924\(09\)00645-9/abstract](http://www.jpmsjournal.com/article/S0885-3924(09)00645-9/abstract)

[Media Watch posted on Palliative Care Network-e Website](#)

Palliative Care Network-e (PCN-e) promotes education amongst health care providers in places around the world where the knowledge gap may be wider than the technology gap ... to foster teaching and interaction, and the exchange of ideas, information and materials. PCN-e link (click on 'Projects'): <http://www.pcn-e.com/>

Literature review

Hospice care in the nursing home setting

JOURNAL OF PAIN & SYMPTOM MANAGEMENT, 2009;24(9):440-451. The U.S. Medicare hospice benefit has expanded considerably into the nursing home (NH) setting in recent years. This literature review focuses on the provision of NH hospice, exploring its growth and the impact of such care on NH residents, cost and efficiency implications for NHs and government, and policy challenges and important areas for future research. Although hospice utilization is relatively modest among NH residents, its increased availability holds great promise. As an alternative to traditional NH care, hospice has been shown to provide high-quality end-of-life care and offer benefits, such as reduced hospitalizations and improved pain management. The provision of NH hospice also has been shown to have positive effects on non-hospice residents, suggesting indirect benefits on NH clinical practices. Importantly, the expansion of hospice in NHs brings challenges, on both clinical and policy dimensions. Research has shown that NH-hospice collaborations require effective communication around residents' changing care needs and that a range of barriers can impede the integration of hospice and NH care. Moreover, the changing case mix of hospice patients, including increased hospice use by individuals with conditions such as dementia, presents challenges to Medicare's hospice payment and eligibility policies. To date, there has been little research comparing hospice costs, service intensity, and quality of care across settings, reflecting the fact that few comparative data have been available to researchers. The Centers for Medicare & Medicaid Services have taken steps toward collecting these data, and further research is needed to shed light on what refinements, if any, are necessary for the Medicare hospice program. [http://www.jpmsjournal.com/article/S0885-3924\(09\)00598-3/abstract](http://www.jpmsjournal.com/article/S0885-3924(09)00598-3/abstract)

Of related interest:

- *MCKNIGHT'S LONG TERM CARE NEWS & ASSISTED LIVING* | Online report – 11 September 2009 – **'Most hospice services in nursing homes fail to meet Medicare requirements.'** A growing number of Medicare beneficiaries are receiving hospice care in nursing facilities. But most of these services do not meet Medicare requirements ... according to two [recent] reports.^{1,2} <http://www.mcknights.com/Most-hospice-services-in-nursing-homes-fail-to-meet-Medicare-requirements-OIG-finds/article/148606/>
 1. *Medicare Hospice Care: Services Provided to Beneficiaries Residing in Nursing Facilities*, Office of the Inspector General of the Department of Health and Human Services, September 2009. <http://oig.hhs.gov/oei/reports/oei-02-06-00223.pdf>
 2. *Medicare Hospice Care for Beneficiaries in Nursing Facilities: Compliance with Medicare Coverage Requirements*, Office of the Inspector General of the Department of Health and Human Services, September 2009. <http://oig.hhs.gov/oei/reports/oei-02-06-00221.pdf>

Defining spirituality at the end of life

JOURNAL OF PALLIATIVE MEDICINE, 2009;12(8):677 (Letter). Vachon *et al* performed a conceptual analysis of spirituality at the end of life by reviewing the empirical literature for definitional elements of the concept.¹ Eleven themes were identified ... for example, "meaning and purpose" and "developmental nature." Based on this work, a definition of spirituality at the end of life was provided as "a developmental and conscious process, characterized by two movements of transcendence; either deep within the self or beyond the self." Spirituality is an ill-defined concept leading to similar problems in research and practice as with a concept such as quality of life, and promoting consensus on an inclusive definition may help to advance research and practice. We ... appreciate the contribution of a literature review and comprehensive thematic analysis ... [and] add some suggestions and comments to their approach and resulting themes, and to the provided definition. <http://www.liebertonline.com/doi/pdf/10.1089/jpm.2009.0103>

1. *JOURNAL OF PALLIATIVE MEDICINE*, 2009;12(1):53-59. **'A conceptual analysis of spirituality at the end of life.'** <http://www.liebertonline.com/doi/abs/10.1089/jpm.2008.0189>

Emotional dimensions of end-of-life care

Growing pains: Palliative care making gains

NCI CANCER BULLETIN (National Cancer Institute | Online article – 8 September 2009 – At Virginia Commonwealth University Medical Center, some third-year residents and nurses are taking part in something new: mindfulness training. Incorporating aspects of meditation, the 3-month pilot training program is meant to help them better deal with patients approaching the end of life. "We are teaching these practices to increase clinicians' awareness of the emotional dimensions of end-of-life care," explained the program's leader, Dr. Amy Sullivan. "Our aim is to enhance clinicians' ability to respond to patient and family psychosocial needs at a very vulnerable time." On average, doctors give patients about 17 seconds before they interrupt them. <http://www.cancer.gov/ncicancerbulletin/090809/page7>

Of related interest:

- *CA: CANCER JOURNAL FOR CLINICIANS*, 2009;59(5):327-335. **'Current status of palliative care – clinical implementation, education, and research.'** Palliative and end-of-life care is changing in the U.S. This dynamic field is improving care for patients with serious and life-threatening cancer through creation of national guidelines for quality care, multidisciplinary educational offerings, research endeavors, and resources made available to clinicians. <http://caonline.amcancersoc.org/cgi/content/abstract/59/5/327>

Medical end-of-life practices under the euthanasia law in Belgium

NEW ENGLAND JOURNAL OF MEDICINE, 2009;361(11):1119-1121 (Letter). We found that the enactment of the Belgian euthanasia law was followed by an increase in all types of medical end-of-life practices, with the exception of the use of lethal drugs without the patient's explicit request. No shift toward the use of life-ending drugs in vulnerable patient groups was observed. However, the substantial increase in the frequency of deep sedation demands more in-depth research. Different findings in a similar study in the Netherlands show that the influence of similar euthanasia laws on medical end-of-life practices seems to vary substantially according to country-specific factors. <http://content.nejm.org/cgi/content/full/361/11/1119>

As reported in the news media:

- ASSOCIATED PRESS | Newswire report – 9 September 2009 – **'Assisted suicide rate continues to climb in region of Belgium.'** Cases of euthanasia in Belgium's Flanders region soared to nearly 2% of all deaths in 2007 after the country legalized the practice a few years earlier, a medical study has shown. The survey, conducted by an end-of-life research group at the Brussels-based Free University, said the rise was mainly due to Belgium's 2002 euthanasia. http://www.oregonlive.com/health/index.ssf/2009/09/assisted_suicide_rate_continue.html

Of related interest:

- *CANADIAN MEDICAL ASSOCIATION JOURNAL* | Online report – 11 September 2009 – **'Euthanasia debate reignited.'** Few health care topics stir debate like euthanasia and assisted suicide, and some right-to-die advocates believe that debate is slowly, but inexorably, shifting in their favour. http://www.cmaj.ca/earlyreleases/11sept09_euthanasia.shtml

Quotable Quotes

Dying is more than a set of problems to be solved. The nature of dying is not medical, it is experiential. Dying is fundamentally a personal experience, not a set of medical problems to be solved. Ira Byock

"We will remember them"

A mixed-method study to explore which post-funeral remembrance activities are most significant and important to bereaved people living with loss...

PALLIATIVE MEDICINE, 2009;23(6):537-544. In an increasingly secular age in which society no longer offers a code of behaviour for those who are bereaved as in Victorian times, the majority of people do not seek support from church-based rituals of remembrance. Most hospices provide religious Services of Remembrance and Thanksgiving or non-faith remembrance gatherings for families and friends, and although these are usually well attended, the average number of families represented is usually less than 20% raising the question of whether alternative support should be offered to the remaining majority of families. Results [of this study] indicated although formal remembrance events are valued, informal rituals created by the bereaved are more important and significant to them. <http://pmj.sagepub.com/cgi/content/abstract/23/6/537?etoc>

QUM [quality use of medicines] forgotten in palliative care

PHARMACY NEWS (Australia) | Online report – 11 September 2009 – The quality use of medicines (QUM) is falling by the wayside during the end stages of life, according to the National Prescribing Service (NPS). The medicines advisory body made the pronouncement to highlight a comprehensive new report into palliative care that it will present in a fortnight at the tenth Australian Palliative Care Conference in Perth. The report will identify key issues affecting appropriate, safe and effective medicines use in palliative care and areas where further work is needed. "The principles of quality use of medicines are often forgotten during the end stages of life, when really this is the most critical time for best practice," NPS chief executive Dr Lynn Weekes said. "Patients at the end of life are often taking a large number of medicines to manage pain and other symptoms, and the medicine regimen may change frequently within a short period of time." Palliative Care Australia chief executive Donna Daniell said palliative care required a unique medicine use approach. <http://www.pharmacynews.com.au/article/qum-forgotten-in-palliative-care/497998.aspx>

Worth Repeating

Family surrogate decision making at the end of life: Seeing them through with care and respect

QUALITATIVE HEALTH RESEARCH, 2004;14(2):204-225. Family surrogate decision makers are pivotal in end-of-life decision-making processes. The author investigated decision-making experiences of twenty surrogates who assisted terminally ill family members for this grounded theory study. Findings describe a basic social process of seeing them through with care and respect, during which surrogates continuously synthesized the core values of caring for their family member, and respecting their family member's autonomy. Surrogate narratives began with learning the diagnosis. The major categories of surrogate decision makers' activities during the process were standing with and acting for the ill family member. Events reported in two gating categories, brokering information and working with family, facilitated or impeded decision making. A final category, outcomes, reports consequences for the surrogate of having been a decision maker. <http://qhr.sagepub.com/cgi/content/abstract/14/2/204>

Barry R. Ashpole
Beamsville, Ontario CANADA

'phone: 905.563.0044
e-mail: barryashpole@bellnet.ca