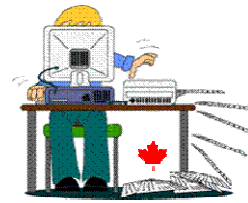


Media Watch...

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.

5 October Edition | Issue #117



Compilation of Media Watch 2008, 2009 ©

Compiled & Annotated by Barry R. Ashpole

Issues in end of life care: Scroll down to [Specialist Publications](#) and 'Undertreating pain violates ethical principles.' (p.7)

Canada

Construction complete on Alberta's first hospice for children

ALBERTA CHILDREN'S HOSPITAL FOUNDATION | Press release – 2 October 2009 – Alberta Health Services and the ... Foundation opened the province's first hospice for children. The facility is only the sixth of its kind in North America for children with progressive and life-threatening illnesses and is expected to serve more than 400 families in southern Alberta. Flames Rotary House is named after two of the main benefactors, The Calgary Flames Foundation for Life and the Rotary Club of Calgary. <http://www.newswire.ca/en/releases/archive/September2009/30/c2723.html>

Dying with dignity

Cost of end of life care

ONTARIO | *Welland Tribune* – 2 October 2009 – Statistics released by Hospice Niagara show that Niagara has the oldest age demographic in Ontario and by 2010 it is expected that 50,000 residents will be over the age of 75 years. This is expected to cause an increased pressure amongst health care institutions. The complete cost, including service and operational supports, for an acute care hospital bed is an estimated \$830/day compared to \$437 for a residential hospice bed. <http://www.wellandtribune.ca/ArticleDisplay.aspx?e=1788673>

Specialist Publications

Of particular interest:

'Best interests at end of life: A review of decisions made by the Consent & Capacity Board of Ontario.' Scroll down to p.6 and a recent article in *Journal of Critical Care*.

'The desire to hastened death...' Scroll down to p.8 for the findings of a Toronto, Ontario, study published in *Social Science & Medicine*.

'Attitudes of Quebec doctors toward sedation at the end of life.' Scroll down to p.9 and a recent article in *Palliative & Supportive Care*.

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- CBC NEWS | Online report – 1 October 2009 – **'Doctors decry euthanasia bill.'** The legalization of euthanasia and assisted suicide ... could reduce the level of care available to those with terminal illnesses. "We need to improve care, not terminate it," Dr. Jose Pereira [chief of palliative medicine at the long-term-care hospital Bruyère Continuing Care in Ottawa] told reporters at a news conference. <http://www.cbc.ca/canada/ottawa/story/2009/10/01/ottawa-euthanasia-bill-doctors-pereira.html>
- CTV NEWS | Online report – 30 September 2009 – **'Right-to-die movement wants new Canadian laws.'** There are two private member's bills before Canada's House of Commons, one that advocates decriminalizing assisted suicide and euthanasia, and one that seeks to ban them. http://www.ctv.ca/servlet/ArticleNews/story/CTVNews/20090930/euthanasia_debate_090930/20090930?hub=Health

U.S.A.

Bishops may revise end-of-life directive on nutrition, hydration

CATHOLIC CULTURE | Online report – 2 October 2009 – The Conference of Catholic Bishops ... [is to] consider revising a paragraph on end-of-life care in their *Ethical & Religious Directives for Catholic Health Care Services*. The 2001 directive reads: "There should be a presumption in favor of providing nutrition and hydration to all patients, including patients who require medically assisted nutrition and hydration, as long as this is of sufficient benefit to outweigh the burdens involved to the patient." The potentially ambiguous language of "benefits" outweighing "burdens" will likely be revised in light of the Congregation for the Doctrine of the Faith's

2007 *Responses to Certain Questions of the U.S. Conference of Catholic Bishops Concerning Artificial Nutrition and Hydration*. <http://www.catholicculture.org/news/headlines/index.cfm?storyid=4211>

Specialist Publications

Of particular interest:

'Physicians' beliefs about conscience in medicine.' Scroll down to p.5 and the findings of a national study published in *Academic Medicine*.

'Patient-centered care: What is the best measuring stick?' Scroll down to p.5 and a recent commentary on proposals to reform of health care in *Archives of Internal Medicine*.

From Media Watch dated 3 August 2009:

- *NATIONAL CATHOLIC BIOETHICS QUARTERLY*, 2009;9(2):293-304. **'The clinical reality of artificial nutrition and hydration for patients at the end of life.'** Data presented indicate artificial nutrition and hydration can cause significant harm and may shorten life administered inappropriately. <http://ncbcenter.metapress.com/app/home/contribution.asp?referrer=parent&backto=issue,7,9;journal,1,34;linkingpublicationresults,1:119988,1>



10 October 2009 <http://www.worldday.org/>

Key messages: <http://www.worldday.org/pr-press/>
[Scroll down to 'Download the Key Messages' for 2009 (PDF)]

The high cost of dying

AMERICAN ASSOCIATION OF RETIRED PERSONS BULLETIN | Online article – 1 October 2009 – Home funerals are ... on the rise. These eliminate chemical embalming and fancy metal caskets. Instead, usually with the assistance of "death midwives," family members bathe, dress and lay out the body – preserved with dry ice – for up to three days in their homes, enough time for fond farewells. In some cases, states allow families to conduct burials on private property in rural areas after obtaining the necessary permits. Such funerals can cost as little as \$250.
http://bulletin.aarp.org/yourmoney/personalfinance/articles/the_high_costdyng.3.html

The death of nursing homes

KAISER HEALTH NEWS | Online article – 29 September 2009 – As hospitals discharge patients "quicker and sicker," many need a level of assistance they cannot receive at home. As medical technology keeps people with horrific injuries and severe illness alive for years, they will need careful monitoring and drug treatments that are beyond the abilities of most family caregivers or part-time paid aides. So where will they get this care? The trend away from nursing homes is already clear. The number of facilities has fallen by nearly 1,000 to about 15,700 since 2000. More than 80,000 beds have been shuttered over those nine years. And the number of Medicaid-only beds – those certified for long-term care stays – has plunged by half since 1995, to about 114,000. All this is happening even as the population of those 75 and older – those most likely to need long-term services – has grown from 16.6 million ... to almost 19 million. Why the change?
<http://www.kaiserhealthnews.org/Columns/2009/September/092809Gleckman.aspx>

Questions and answers about moment of death

NBC (Today) | Online article – 28 September 2009 – The Awareness During Resuscitation [Multi-Center] Study seeks to discover whether "out-of-body experiences" really happen and, if so, how resuscitation practices can be improved so that more people can be revived after being clinically dead. http://today.msnbc.msn.com/id/33054659/ns/today-today_health/

After a death, the pain that doesn't go away

NEW YORK TIMES | Online article – 28 September 2009 – Each of the 2.5 million annual deaths in the U.S. directly affects four other people, on average. For most of these people, the suffering is finite – painful and lasting, of course, but not so disabling that 2 or 20 years later the person can barely get out of bed in the morning. For some people, however – an estimated 15% of the bereaved population, or more than a million people a year – grieving becomes what Dr. M. Katherine Shear, a professor of psychiatry at Columbia, calls "a loop of suffering." And these people, Dr. Shear added, can barely function. This extreme form of grieving, called complicated grief or prolonged grief disorder, has attracted so much attention in recent years that it is one of only a handful of disorders under consideration for being added to the *DSM-V* [*Diagnostic & Statistical Manual of Mental Disorders-V*], the American Psychiatric Association's handbook for diagnosing mental disorders, due out in 2012. Some experts argue that complicated grief should not be considered a separate condition, merely an aspect of existing disorders, like depression or post-traumatic stress. http://www.nytimes.com/2009/09/29/health/29grief.html?_r=1

N.B. Scroll down to [Specialist Publications](#) and 'Prolonged grief disorder: Psychometric validation of criteria proposed for DSM-V and ICD-11' (p.10), a recent online article in PLoS Medicine.

Quotable Quotes

What lies behind us and what lies before us are small matters compared to what lies within us.
Ralph Waldo Emerson (1803-1882) American Essayist & Poet

International

Improving Tasmanian palliative care

AUSTRALIA | Tasmanian State Government press release – 30 September 2009 – Health Minister Lara Giddings ... formally launched the new [Clinical] Palliative Care Clinical Network. The Network ... is primarily intended to connect up those working in palliative care ... both in the public and private sectors, in hospitals, the community and aged care facilities. The Network aims to support and improve palliative care services, as well as promote public awareness of what can be done for those who face a terminal illness, and those who look after them. The Network will consult widely, provide advice to the Department of Health & Human Services, and undertake projects that promote palliative care. <http://www.media.tas.gov.au/release.php?id=27940>

Include palliative care in our national healthcare strategy

UGANDA | New Vision (OpEd) – 30 September 2009 – Tragically, millions of people in Africa who need palliative care do not get it. In 2007 alone, 22.5 million people in sub-Saharan Africa lived with AIDS and there were 7.6 million new cancer cases and 6 million deaths from cancer. Few of these patients will have died a pain-free, dignified death. But there are two pieces of good news. The first is that Uganda is among the countries spearheading palliative care development in sub-Saharan Africa. That is why the African Palliative Care Association (APCA) is based in Kampala. APCA works to promote palliative care across the continent by supporting local and national palliative care associations and programmes, promoting palliative care education for doctors, nurses, social workers and other therapists, and advocating with governments to include palliative care in their national health plans. The organisation has its work cut out. Palliative care remains neglected despite the challenges of AIDS and cancer, and does not feature in the national health strategies of many African countries. Instead, it is limited to a few islands of good practice in a sea of neglect. Barriers include lack of trained palliative care professionals; extremely basic health and social care infrastructures, and drug laws that restrict the availability of essential pain-beating medication, such as morphine. It all sounds rather grim – but the second piece of good news is that everyone of us in Uganda can play our part in strengthening palliative care provision in and beyond the country. The question is how. <http://www.newvision.co.ug/D/8/459/696289>

Public awareness

Help living with terminal illness

U.K. | BBC News (Birmingham) – 28 September 2009 – *Night and Day* documents the highs and lows of six patients and their families from the Birmingham area as they come to terms with impending death. The documentary explores how illness affects relationships when spouses become the primary caregiver. Patients, families and friends talk candidly about the impact on them from both a practical and psychological perspective, as well as the support they need from palliative care teams in the community. http://news.bbc.co.uk/2/hi/uk_news/england/8279429.stm

Of related interest:

- U.K. | *Mirror* – 29 September 2009 – **'Two Feet in the Grave.'** It's a subject many of us prefer to shove to the back of our minds, so Richard Wilson faces a tough job examining why death is such a taboo subject. He finds absolutely the right tone – dignified, sensitive and curious – as he visits funeral directors, crematoriums, coffin-makers and a school of embalming to find out what happens beyond the final curtain. <http://www.mirror.co.uk/tv-entertainment/tv/todays-tv/2009/09/29/richard-wilson-two-feet-in-the-grave-bbc1-10-45pm-115875-21707976/>

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- U.K. | *Daily Telegraph* – 1 October 2009 – **'Doctors who ignore directives 'can be charged with assault.'** They also face [the prospect] being struck off from practising by the General Medical Council. <http://www.telegraph.co.uk/health/healthnews/6248195/Doctors-who-ignore-directives-can-be-charged-with-assault.html>
- U.K. | *Guardian* – 1 October 2009 – **'Doctors acted legally in 'living will' suicide case.'** Doctors who allowed a young woman to kill herself acted within the law, a coroner has ruled. Kerrie Woollorton is believed to be the first person to have used a living will to kill herself. She was admitted to hospital after poisoning herself but doctors said they had no alternative but to allow her to die. The will said that if she called for an ambulance it was not because she wanted life-saving treatment but because she did not want to die in her flat alone or in pain. Woollorton died the next day in hospital. <http://www.guardian.co.uk/society/2009/oct/01/living-will-suicide-legal>
- IRELAND | *Irish Times* – 29 September 2009 – **'Improving care for end of life.'** There is "no appetite" for discussing the controversial issue (of assisted suicide) here (in Ireland), according to representative groups. However, there is a hunger to debate end of life issues, the need for death with dignity, and the removal of regional imbalances in providing palliative care, they say. <http://www.irishtimes.com/newspaper/health/2009/0929/1224255431650.html>

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

U.S. National Survey

Physicians' beliefs about conscience in medicine

ACADEMIC MEDICINE, 2009;84(9):1276-1282. The surveyed explored physicians' beliefs about whether physicians sometimes have a professional obligation to provide medical services even if doing so goes against their conscience, and to examine associations between physicians' opinions and their religious and ethical commitments. A substantial minority of physicians do not believe there is ever a professional obligation to do something they personally believe is wrong. http://journals.lww.com/academicmedicine/Abstract/2009/09000/Physicians__Beliefs_About_Conscience_in_Medicine_.28.aspx

Health care reform

Patient-centered care: What is the best measuring stick?

ARCHIVES OF INTERNAL MEDICINE, 2009;169(17):1551-1553. The concept of patient-centered care – that medical care providers should respect patients' preferences, wants, and needs; solicit patients' input into decisions; and customize treatment recommendations – is not new. However, advances in medical science and the increasing complexity of treatment options have made achieving patient-centered care both more difficult and more important. For a growing number of decisions, the best choice of treatment depends on patient preference, with patients needing to consider the potential benefits and harms of treatment within the context of their lives. This type of decision making demands integrating the best medical knowledge into patient care, supporting more active patient participation in care, and promoting systems of care that are responsive to patients' needs. <http://archinte.ama-assn.org/cgi/content/short/169/17/1551?home>

Linkage, coordination and integration: Evidence from rural palliative care

AUSTRALIAN JOURNAL OF RURAL HEALTH, 2009;17(5):263-267. The authors evaluated fifteen projects across all six states of Australia that focused on integration between general practitioners and other community-based health providers. The terms 'integration' and 'coordination' were used frequently but without clear definitions. Coordination required someone specifically designated to do the coordinating, usually a nurse. Formal arrangements to improve linkage and coordination were difficult to maintain. The main mechanism to achieve full integration was the development of common clinical information systems. The authors observe that it is important to be clear on what level of integration is required. Improving links might be sufficient (and realistic), rather than striving for full integration.

<http://www3.interscience.wiley.com/journal/122609030/abstract>

Of related interest:

- *PALLIATIVE & SUPPORTIVE CARE*, 2009;7(9):357-364. **'Reflections of nurse-specialists in palliative home care.'** Nurse-specialists can work collaboratively with home care nurses to improve patients' quality of care and their quality of life. Moreover, patients and their families would benefit from the more widespread establishment of palliative care teams within community health organizations. <http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=6238524&fulltextType=RV&fileId=S1478951509990290>

Sickest patients to get free social care in their homes...

BRITISH MEDICAL JOURNAL | Online report – 2 October 2009 – Prime minister Gordon Brown announced a plan to provide free social care for adults with the most serious needs ... to help the elderly get the amenities to do what they most want: to receive care and to stay in their homes as long as possible." http://www.bmj.com/cgi/content/extract/339/oct02_1/b4041

Survey of (U.S.) Midwestern states

Death and dying course offerings in psychology

DEATH STUDIES, 2009;33(8):762-770. The certainty of facing death and bereavement and the complex personal and societal issues involved argue for the importance of death education. The current study addresses a gap in knowledge by beginning to assess the extent of dying, death, and bereavement course offerings by U.S. psychology departments. This article reports on data collected from an initial survey of psychology departments in nine Midwestern states.

<http://www.informaworld.com/smpp/content~db=all~content=a913912781>

Best interests at end of life: A review of decisions made by the Consent & Capacity Board of Ontario (Canada)

JOURNAL OF CRITICAL CARE | Online article – 24 September 2009 – Although each jurisdiction has its own rules or legislation governing how surrogates are to make health care decisions, many rely on the notion of "best interests" when no prior expressed wishes are known. The authors ... sampled written decisions of the Ontario Consent & Capacity Board that focused on the best interests of patients at the end of life. Many substitute decision makers rely on an appeal to religion or God in their interpretation of best interests, whereas physicians focused narrowly on the clinical condition of the patient in their interpretations. Several lessons are drawn for the benefit of health care teams engaged in end-of-life conflicts with substitute decision makers. [http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B7590-4X9D5B2-H&_user=10&_coverDate=09%2F24%2F2009&_rdoc=2&_fmt=high&_orig=browse&_srch=doc-info\(%23toc%2312940%239999%23999999999%23999999%23FLA%23display%23Articles\)&_cdi=12940&_sort=d&_docanchor=&_ct=87&_acct=C000050221&_version=1&_urlVersion=0&_userid=10&md5=6429be78cf4adeb39d875cc079eb944b](http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B7590-4X9D5B2-H&_user=10&_coverDate=09%2F24%2F2009&_rdoc=2&_fmt=high&_orig=browse&_srch=doc-info(%23toc%2312940%239999%23999999999%23999999%23FLA%23display%23Articles)&_cdi=12940&_sort=d&_docanchor=&_ct=87&_acct=C000050221&_version=1&_urlVersion=0&_userid=10&md5=6429be78cf4adeb39d875cc079eb944b)

Undertreating pain violates ethical principles

JOURNAL OF MEDICAL ETHICS, 2009;35(10):603-606. Doctors outside pain and palliative specialties are often unfamiliar with pain guidelines and sceptical about patient reports of unrelieved pain. They are therefore likely to undertreat it. Undertreating pain, however, violates respect for persons and beneficence. This paper reviews literature supporting these claims and ... argues that physicians in most specialties are not, but should be, familiar with palliative evidence and guidelines so that they are equipped to relieve pain and symptoms quickly and effectively. <http://jme.bmj.com/cgi/content/abstract/35/10/603>

Of related interest:

- *THE LANCET*, 2009;374(9693):872-873 (Perspectives). '**The Death of Ivan Ilyich and pain relief at the end of life.**' A son admonished us for the inpatient hospice care of his mother, a 78-year-old woman with cancer and neuropathic pain. "It says so on your wall." He held up a poster taken from our wall, with the title 'The Rights of the Dying.' He pointed ... to 'The RIGHT to be free of physical pain.' <http://www.thelancet.com/journals/lancet/article/PIIS0140673609616160/fulltext?rss=yes>

Evaluation of patient-physician communication style during telemedicine consultations

JOURNAL OF MEDICAL INTERNET RESEARCH, 2009;11(3):e36. Results suggest that when comparing TM [telemedicine] and IP [in person] consultations in terms of physician-patient communication TM visits are more physician centered, with the physician controlling the dialogue and the patient taking a relatively passive role. <http://www.jmir.org/2009/3/e36>

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.

Assisted (or facilitated) death

Limits on legitimacy: Moral and religious convictions as constraints on deference to authority

JOURNAL OF PERSONALITY & SOCIAL PSYCHOLOGY, 2009;97(4):567-578. Various versions of legitimacy theory predict that a duty and obligation to obey legitimate authorities generally trumps people's personal moral and religious values. However, most research has assumed rather than measured the degree to which people have a moral or religious stake in the situations studied. This study tested compliance with and reactions to legitimate authorities in the context of a natural experiment that tracked public opinion before and after the U.S. Supreme Court ruled in a case that challenged states' rights to legalize physician-assisted suicide. Results indicated that citizens' degree of moral conviction about the issue of physician-assisted suicide predicted post-ruling perceptions of outcome fairness, decision acceptance, and changes in perceptions of the Court's legitimacy from pre- to post-ruling. <http://psycnet.apa.org/journals/psp/97/4/567/>

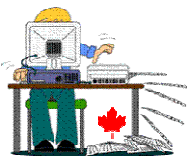
From Media Watch dated 21 September 2009:

- *PSYCHOLOGICAL SCIENCE*, 2009;20(9):1059-1063. **'Gut reactions: Moral conviction, religiosity, and trust in authority.'** The authors ... assessed the degree to which people trusted the U.S. Supreme Court to rule on the legal status of physician-assisted suicide. <http://www3.interscience.wiley.com/journal/122521480/abstract>

Of related interest:

- *JOURNAL OF BIOETHICAL INQUIRY*, 2009;6(3):271-283. **'Two decades of research on euthanasia from the Netherlands. What have we learnt and what questions remain?'** Two decades of research on euthanasia in the Netherlands have resulted into clear insights in the frequency and characteristics of euthanasia and other medical end-of-life decisions in the Netherlands. <http://www.springerlink.com/content/r8j54p674n4lw860/?p=477a0f1d11a54644b3914d03bec72f7f&pi=3>
- *SOCIAL SCIENCE & MEDICINE*, 2009;69(2):165-171. **'The desire for hastened death...'** The goal of this study [at a cancer centre in Toronto, Canada] was to understand the experience of the desire for hastened death as expressed by individuals ... and to understand how it evolves over time. [http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6VBF-4WDD1C9-1&_user=10&_coverDate=07%2F31%2F2009&_rdoc=5&_fmt=high&_orig=browse&_srch=doc-info\(%23toc%235925%232009%23999309997%231264059%23FLA%23display%23Volume\)&_cdi=5925&_sort=d&_docanchor=&_ct=22&_acct=C000050221&_version=1&_urlVersion=0&_userid=10&md5=f6efe39e8fc0887b5b521a0c7797353c](http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6VBF-4WDD1C9-1&_user=10&_coverDate=07%2F31%2F2009&_rdoc=5&_fmt=high&_orig=browse&_srch=doc-info(%23toc%235925%232009%23999309997%231264059%23FLA%23display%23Volume)&_cdi=5925&_sort=d&_docanchor=&_ct=22&_acct=C000050221&_version=1&_urlVersion=0&_userid=10&md5=f6efe39e8fc0887b5b521a0c7797353c)

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.

Intensive care units poorly equipped to care for the dying

JURAFORUM | Online article – 5 October 2009 – Almost half of the patients who die in intensive care units die within 24 hours, but the environment is not equipped to provide good end-of-life care shows a thesis from the Sahlgrenska Academy at the University of Gothenburg, Sweden. An intensive care unit (ICU) is designed primarily to save lives rather than provide end-of-life care. When a patient dies on an ICU, this often follows a sudden illness or trauma, and neither the patient nor relatives are prepared for death. Most units do not have a care programme for end-of-life care, and many also have no procedures in place for supporting relatives after a death, which is standard practice at hospices. <http://www.juraforum.de/jura/news/news/p/1/id/297654/f/196/>

From Media Watch dated 6 July 2009:

- *AMERICAN JOURNAL OF HOSPICE & PALLIATIVE CARE* | Online article – 1 July 2009 – '**End-of-Life decision making and emotional burden: Placing family meetings in context.**' Helping families make end-of-life care decisions can be challenging for health care providers in an intensive care unit. <http://ajh.sagepub.com/cgi/content/abstract/1049909109338515v1>

From Media Watch dated 9 March 2009:

- *ONCOLOGY NURSING NEWS* | Online article – 2 March 2009 – '**"Unnatural Environment" provides good care and challenges.**' The ICU has benefited little from the growth of programs in palliative care, psychosocial programs, and supportive care services for patients and hospitals. <http://www.oncologynursingnews.com/Unnatural-Environment-Provides-Good-Care-and-Challenges/article/128119/>

From Media Watch dated 26 January 2009:

- *CHEST*, 2009;135(1):26-32. '**Implementation of ICU palliative care guidelines and procedures.**' Ethical conflicts are commonly encountered in the course of delivering end-of-life care in ICU. <http://www.chestjournal.org/content/135/1/26.abstract>

From Media Watch dated 19 January 2009:

- *ARCHIVES OF INTERNAL MEDICINE*, 2009;169(1):81-86. '**Continuity of care and intensive care unit use at the end of life.**' There is increasing concern about discontinuity of care across transitions (e.g., from home to the hospital) and how it might affect appropriate medical management. <http://archinte.amaassn.org/cgi/content/short/169/1/81>

Attitudes of Quebec doctors toward sedation at the end of life

PALLIATIVE & SUPPORTIVE CARE, 2009;7(9):331-337. The goal of this study was to explore the practice [of sedation at the end of life] from both a clinical and ethical point of view. Doctors' first priority was their patients, not patients' families. Clinically, the therapeutic aim of sedation was strictly to relieve suffering on the part of the patient. Ethically, getting the patient's consent was imperative. The family's consent was only required in cases of incapacity. Generally, sedation and euthanasia were seen as two distinct practices. There are still very few guidelines regarding end-of-life sedation in Québec, and its normative framework is more implicit than explicit. <http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=6238488&fullTextType=RA&fileId=S1478951509990265>

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

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

Hope in palliative care

PALLIATIVE & SUPPORTIVE CARE, 2009;7(93):365-377. There are at least two overarching themes [that emerge in the authors' review of the literature] of patients' hope in the palliative context: "living with hope" and "hoping for something." The main concern for caregivers was "hanging on to hope" in spite of eroding effects on hope caused by different factors. The majority of ... research ... focuses on patient hope and factors influencing patient hope. Research ... in significant others and nurses in palliative care is scant. More ... is needed about the factors threatening patient hope, hope in significant others, and interventions to engender hope...
<http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=6238536&fulltextType=RV&fileId=S1478951509990307>

Prolonged grief disorder: Psychometric validation of criteria proposed for DSM-V and ICD-11

PLOS MEDICINE | Online article – 4 August 2009 – Grief becomes a serious health concern for a relative few. For such individuals, intense grief persists, is distressing and disabling, and may meet criteria as a distinct mental disorder. At present, grief is not recognized as a mental disorder in the *DSM-IV* [*Diagnostic & Statistical Manual of Mental Disorders-V*] or the *ICD-10* [*International Statistical Classification of Diseases & Related Health Problems-10*]. The goal of this study was to determine the psychometric validity of criteria for prolonged grief disorder to enhance the detection and potential treatment of bereaved individuals at heightened risk of persistent distress and dysfunction.
<http://www.pubmedcentral.nih.gov/articlerender.fcgi?tool=pubmed&pubmedid=19652695>

Worth Repeating

A young woman sits alone, dying

A young physician learns that the failure to care can be worse than the failure to cure

MEDICAL ECONOMICS | Online article – 5 June 2005 – More than a million dollars has been spent on the battle against Julia's cancer, yet, in the end, a young woman sits alone, pondering not the elusive cure, but the unbearable sorrow of a lonely journey. In my moments of honesty, I see that we are both searching for truths. At the threshold of my career, I seek the truth of academia that will liberate me from a constant feeling of inadequacy. At the conclusion of her life, Julia seeks the truth of humanity that will ease the blow of devastation. Whose truth is more compelling? Next year I will be an oncologist. I can already hear in my mind the clamor of questions. Whom to test, and how? Whom to treat, whom to palliate? What do the scans really mean? What drug to choose? The pressures of the day will be manifold and the demand for my attention unrelenting. The excuse to cut corners on humane interactions will be ever present. But I have learned that compassion in medicine will never grow old fashioned. As I say goodbye to Julia, never knowing when it will be the final time, I hope that her voice always rises above the fray: "Why don't they just ask me what is best?"
<http://medicaleconomics.modernmedicine.com/memag/article/articleDetail.jsp?id=163099>

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