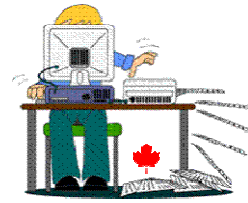


## Media Watch...

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.

## 26 October Edition | Issue #120



Compilation of Media Watch 2008, 2009 ©

Compiled & Annotated by Barry R. Ashpole

**Physician-patient communication: Scroll down to [Specialist Publications](#) and 'The truth is patients often aren't understanding as much of what we tell them as we'd hope.' (p.8)**

## Canada

### **Alberta's spiritual care services reviewed**

ALBERTA | *Calgary Herald* – 20 October 2009 – One day after Alberta's medical superboard confirmed it's reviewing the future of a Calgary grief support program, the cash-strapped organization said it's also examining hospital-based spiritual care services. Alberta Health Services said spiritual care and other programs are under review to see if they can be delivered more efficiently as the superboard attempts to tackle a deficit of more than \$1 billion. <http://www.calgaryherald.com/health/Alberta+spiritual+care+services+reviewed/2121548/story.html>

### **Winnipeg lacking in hospice care**

MANITOBA | CJOB Radio – 20 October 2009 – Manitoba needs more places for people facing terminal illness to be able to die with dignity. That's the word from Mary Williams who is the Executive Director of Hospice & Palliative Care in Manitoba. She tells CJOB [that] besides Winnipeg, there is a huge lack of hospice care in our province for people who are facing their final days. <http://www.cjob.com/News/Local/Story.aspx?ID=1153095>

### **Unique website answers a thousand questions about life's most difficult journey**

MANITOBA | Canadian Virtual Hospice press release – 19 October 2009 – Questions about end of life are as old as humanity, yet they can be new and overwhelming when someone we care about is dying. The palliative care professionals at Canadian Virtual Hospice provide answers to these age-old questions using modern information technology.<sup>1</sup> This fall, the website answered the one-thousandth question through its Ask a Professional feature, which invites patients, families and health care providers to submit personal queries about terminal illness. Each question is handled by an inter-disciplinary team of palliative care experts, who provide detailed, personalized, confidential responses addressing the medical and emotional concerns that arise during terminal illness. <http://www.newswire.ca/en/releases/archive/October2009/19/c7915.html>

1. Canadian Virtual Hospice website: [www.virtualhospice.ca](http://www.virtualhospice.ca)

## Assisted (or facilitated) death

Representative sample of recent news media coverage:

- CANWEST NEWSPAPERS | *Ottawa Citizen* – 25 October 2009 – '**Vancouver church hosts right-to-die doctor.**' A Vancouver church is stepping in to host a workshop by an Australian right-to-die doctor [Philip Nitschke] after the city's public library cancelled the event over legal concerns. <http://www.ottawacitizen.com/news/Vancouver+church+hosts+right+doctor/2142389/story.html>
- QUEBEC | *Montreal Gazette* – 24 October 2009 – '**Euthanasia never.**' The gravely ill don't want to die; they want to live without pain. More energy should be directed toward other end-of-life issues, such as stopping futile treatments in advanced disease, inappropriate use of intensive-care units and ventilators for patients with no hope of recovery, and improving communication and psycho-social support. <http://www.montrealgazette.com/health/Euthanasia+never/2140927/story.html>
- ONTARIO | *Ottawa Citizen* (OpEd) – 23 October 2009 – '**Why we're debating euthanasia now.**' Why is Canada's Parliament now considering a bill to legalize euthanasia ... when we have prohibited it for millennia? Not one of the bottom-line conditions usually linked with calls for legalizing euthanasia – that a person is terminally ill, wants to die and we can kill them – is new. These factors have been part of the human condition for as long as humans have existed. And our capacity to relieve pain and suffering has improved remarkably. So, is some other cause the main one? <http://www.ottawacitizen.com/debating+euthanasia/2134980/story.html>

## U.S.A.

### Honesty, education break down barriers to hospice care

COLORADO | Delaware Online (OpEd) – 25 October 2009 – When we talk honestly with patients and families about dying, we allow them to consider what's most important to accomplish in the time they have left. The results are often decisions like: "If my husband has just a few weeks to live, I want to take a leave from work and stay home with him," or "If my sister is dying soon, I'll be on a plane right away to come visit with her." When we avoid talking about dying, we rob people of their right to make those choices. Every patient deserves to receive expert care and support during the last stages of life. This means breaking down barriers to hospice by educating people ... and encouraging patients, families, and health care providers to talk honestly about dying. <http://www.delawareonline.com/article/20091025/OPINION08/910250320/1004/OPINION>

### Home care

### Getting paid to take care of Mom or Dad

WALL STREET JOURNAL | Online article – 25 October 2009 – A small but growing number of families are taking an unusual step to acknowledge family caregivers. Rather than leave uneven bequests for their heirs, they are entering into formal "caregiver contracts," in which adult children or other relatives are hired, for modest salaries, to take care of elderly or disabled family members. These arrangements, also called personal-service or personal-care agreements, help reward family members for the significant amounts of time, effort and money they often spend taking care of an elderly relative. <http://online.wsj.com/article/SB125641980720606125.html>

From Media Watch dated 22 December 2008:

- CANADIAN JOURNAL OF ELDER CARE | Online article – 15 December 2008 – '**Formalizing the informal: Family care agreements in Canada and the U.S.**' In both Canada and the U.S., family caregiving agreements are increasingly being used to formalize the responsibilities that family caregivers undertake when providing in-home assistance for their (typically) older relatives. <http://www.bcli.org/cjel/projects/formalizing-informal-family-care-agreements-canada-and-unitedstates>

## Maybe grief isn't so bad after all

NEW YORK TIMES | Online book review – 23 October 2009 – George A. Bonanno, a clinical psychologist who is chairman of the counseling and clinical psychology department at Teachers College at Columbia University – has published *The Other Side of Sadness: What the New Science of Bereavement Tells Us About Life After Loss*. Bonanno does not minimize the acute sorrow people feel when someone they love dies. He acknowledges that a small proportion of mourners ... have long-lasting depression and distress, and may benefit from medical intervention. But most people are, to use the term he does, resilient: they fluctuate between pain and happier emotions, seek comfort, maintain their equilibrium and, before long, find renewed meaning and pleasure in life. <http://newoldage.blogs.nytimes.com/2009/10/22/grief-maybe-not-so-bad-after-all/?hp>

- FLORIDA | *Daily Commercial* – 20 October 2009 – **'Life's final journey.'** For the patient, their family and even the caregivers, dealing with the loss and moving away from the grief can be the hardest and possibly most healing stage of life's final journey. "I think it's just up to the individual and how they want to perceive what death really is," hospice social worker Kristine Carlson said. <http://www.dailycommercial.com/localnews/story/102009finaljourney3>

## Health care reform

### Americans dying while we debate

IOWA | *Des Moines Register* (OpEd) – 21 October 2009 – Each day of delay [in the debate on health care reform] is another day hundreds of lowans must choose between life savings and life-saving treatment. Nearly 45,000 uninsured Americans die annually as a consequence of not having insurance. That's one needless death every 12 minutes. The proposed legislation has the potential to lower medical costs and expand coverage to those people struggling to get health insurance. Reform would save lives by providing full coverage for prevention and early detection of life-threatening disease, as well as assuring quality of life until the end of life. <http://www.desmoinesregister.com/article/20091021/OPINION04/910210338/1038/Opinion>

### End-of-life medical directives directory to go statewide

OREGON | *The Oregonian* – 20 October 2009 – Oregon's POLST [Physician Orders for Life-Sustaining Treatment] program, which has become a national model for ensuring that doctors follow people's end-of-life medical wishes, is starting a computerized statewide registry. The electronic registry is designed to make sure paramedics and others can obtain accurate information about a patient's health care wishes immediately during a medical emergency. Emergency medical personnel treating an incapacitated person will be able to check a hotline at Oregon Health & Science University for such information even if the patient's bright pink POLST form is not readily available. POLST ... is a medical order designed specifically for patients with advanced illness or frailty. [http://www.oregonlive.com/health/index.ssf/2009/10/post\\_21.html](http://www.oregonlive.com/health/index.ssf/2009/10/post_21.html)

## [Specialist Publications](#)

Of particular interest:

**'Predicting social support for grieving person.'** Scroll down to p.6 for a recent article in *Death Studies*.

## [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/>

## **Pet therapy**

### **Tribute to Baxter the world's oldest hospice therapy dog**

CALIFORNIA | *Examiner* – 16 October 2009 – Baxter, the world's best, most devoted, and [at 19½ years] the oldest therapy dog, eased peacefully from his life. Baxter began volunteering seven years ago at San Diego Hospice. In a place created for making goodbyes gentler, Baxter comforted everyone who crossed his path. <http://www.examiner.com/x-14956-San-Diego-Dog-Training-Examiner~y2009m10d19-Tribute-to-Baxter-the-worlds-oldest-hospice-therapy-dog>

Of related interest:

- ALABAMA | *Sound Mountain Reporter* – 22 October 2009 – **'Hospice cat captures hearts of many.'** Described as stubborn, spoiled, lazy, nosey, and even humorously as worthless, a portly multi-colored feline ball of fur named Squirt has captured hearts at Hospice of Marshall County's Shepherd's Cove. <http://www.sandmountainreporter.com/story.lasso?ewcd=ad5ddb6949f4e71>

**N.B.** Profile of Baxter: <http://www.peoplepets.com/news/heart-warming/baxter-the-dog-brings-calm-and-joy-to-final-moments-of-very-ill/1>

## **International**

### **Doctor calls for change in attitude towards the last great taboo**

U.K. | *Dorset Echo* – 24 October 2009 – A doctor is calling for a change in society's attitude towards dying. Karen Steadman believes death has replaced sex as "the last taboo." She and her colleagues are working on ... education and training programmes for nursing homes, community hospitals and other health care professionals to highlight the need to help people die with dignity. [http://www.dorsetecho.co.uk/news/4700580.Doctor\\_calls\\_for\\_change\\_in\\_attitude\\_towards\\_the\\_last\\_great\\_taboo/](http://www.dorsetecho.co.uk/news/4700580.Doctor_calls_for_change_in_attitude_towards_the_last_great_taboo/)

### **Care for dying needs improvement**

SWISSINFO.CH | Online report – 23 October 2009 – Switzerland's health care system is not properly prepared to ease the suffering of those with terminal illnesses. The country's health minister, Pascal Couchepin, who steps down at the end of October, joined Pierre-Yves Maillard, president of the Swiss Conference of the Cantonal Ministers of Public Health, to present a concept on palliative care in Bern. Switzerland is grappling with a shortage of nurses while modern medicine has helped prolong the lives of those of all ages entering the last phase of life. [http://www.swissinfo.ch/eng/news\\_digest/Care\\_for\\_dying\\_needs\\_improvement.html?siteSect=104&sid=11393103&ty=nd](http://www.swissinfo.ch/eng/news_digest/Care_for_dying_needs_improvement.html?siteSect=104&sid=11393103&ty=nd)

### **Thousands back plans for Marie Curie Cancer Care hospice...**

U.K. | *Birmingham Post* – 20 October 2009 – Marie Curie Cancer Care has revealed 11,214 people signed a petition backing its plans to build a "hospice for the 21st century" on greenbelt land in Solihull. However, nearly 400 residents initially signed a petition opposing the plans on grounds including protecting the Green Belt and the location's suitability for the development. If approved, the new hospice will include more beds and treatment rooms and an education and training space within the six-acre site. <http://www.birminghampost.net/news/west-midlands-news/2009/10/20/thousands-back-plans-for-marie-curie-cancer-care-hospice-in-solihull-65233-24967960/>

## Funeral customs and rituals

### **Funerals that blare out Tina Turner make me feel a lemon says vicar**

U.K. | *Daily Express* – 20 October 2009 – An angry vicar launched an extraordinary tirade against his flock, accusing them of making him feel like "a lemon" at funerals where they blast out Tina Turner songs and read bad poetry. Father Ed Tomlinson said his presence at services was "pointless" and he had "a hundred better ways" of spending his time. The vicar of St Barnabas' Church in Tunbridge Wells, Kent, wrote on his blog: "In the last few years it has become painfully obvious that many families I have conducted funerals for have absolutely no desire for any Christian content whatsoever. <http://www.express.co.uk/posts/view/135033/Funerals-that-blare-out-Tina-Turner-make-me-feel-a-lemon-says-vicar>

### **Assisted (or facilitated) death**

Representative sample of recent news media coverage:

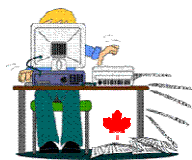
- *THE AUSTRALIAN* | Online report – 26 October 2009 – **'85 per cent support voluntary euthanasia – poll.'** Support for voluntary euthanasia is on the increase in Australia, with a new survey showing 85% of the country is in favour of it [a five point increase from the results of a survey conducted in 2007]. <http://www.theaustralian.news.com.au/story/0,25197,26262019-12377,00.html>
- POLAND.COM | Online report – 21 October 2009 – **'Poles support euthanasia.'** According to 48% of Polish society, the doctors should fulfil the will of suffering, incurable patients who want to end their life. <http://news-poland.com/result/news/id/3432>

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

### **Use of intensive care services during terminal hospitalizations in England and the U.S.**

*AMERICAN JOURNAL OF RESPIRATORY & CRITICAL CARE MEDICINE*, 2009;180(9):875-880. Despite broad concern regarding the provision and cost of health care at the end of life, country-specific patterns of care have rarely been compared. The authors assessed the use of hospital and intensive care services during terminal hospitalizations in England and the U.S., two populations with similar socioeconomic backgrounds and life expectancies. Of all deaths, 50.3% occurred in hospital in England and 36.6% in the U.S., yet only 5.1% of all deaths in England involved intensive care, versus 17.2% in the U.S., representing 10.1% of hospital deaths in England versus 47.1% in the U.S.. Greater intensive care use in the U.S. was most notable with older age; among decedents 85+ years, intensive care was used for 31.5% of medical deaths and 61.0% of surgical deaths in the U.S. versus 1.9 and 8.5% of deaths in England. Despite similar overall hospitalization rates in England and the U.S., there were marked differences in terminal hospitalizations, with far greater use of intensive care services in the U.S., especially among medical patients and the elderly. <http://ajrccm.atsjournals.org/cgi/content/abstract/180/9/875>

### **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.

## **Mandating cultural competency: Should physicians be required to take courses?**

*AMERICAN MEDICAL NEWS* | Online article – 19 October 2009 – Study after study has shown that racial and ethnic disparities exist in health care delivery. How do health care professionals and others eliminate them? One approach appears to be gaining momentum: Mandate cultural competency training for physicians. In 2005, New Jersey began requiring physicians to take continuing medical education courses that provide a grounding in culturally competent patient care, in addition to CME [continuing medical education] courses needed to maintain their licenses. California also mandates cultural competency training for physicians, while Maryland "strongly recommends" it. And debates about requiring such training are taking place in Arizona, Colorado, Florida, Georgia, Kentucky, New Mexico, New York, Ohio and Washington, according to the [U.S.] Department of Health & Human Services' Office of Minority Health. Some physicians bristle at the training mandates. <http://www.ama-assn.org/amednews/2009/10/19/prsa1019.htm>

Of related interest:

- *EDUCATIONAL GERONTOLOGY*, 2009;35(11):1008-1025. **'Educating gerontologists for cultural proficiency in end-of-life care practice.'** An educational program was developed to train practitioners to provide care for patients and families that are responsive to cultural concerns. <http://www.informaworld.com/smpp/content~db=all~content=a915821939>

## **Predicting social support for grieving persons**

*DEATH STUDIES*, 2009;33(10):869-889. Research has consistently reported that social support from family, friends, and colleagues is an important factor in the bereaved person's ability to cope after the loss of a loved one. The authors of this study ... [concluded] behavioral beliefs, followed by control beliefs and past behavior, were the most important predictors of intention to support a grieving person. <http://www.informaworld.com/smpp/content~db=all~content=a915994664>

## **Recent developments in the reform of English law on assisted suicide**

*EUROPEAN JOURNAL OF HEALTH LAW*, 2009;16(4):333-349. Three assisted dying for the terminally ill bills were introduced in a three year period, all of which failed. Despite the provision of clear and precise safeguards, at each reading the House of Lords fixed largely on the traditional slippery slope and sanctity of life positions. This article assesses recent developments in English law and considers implications for a more inclusive and reasoned debate in the future. <http://brill.publisher.ingentaconnect.com/content/mnp/ejhl/2009/00000016/00000004/art00003>

- *BRITISH JOURNAL OF GENERAL PRACTICE*, 2009;59(568):809-810. **'Our debt to those who are dying: the U.K. medical establishment should reconsider its stance on assisted suicide.'** <http://rcgp.publisher.ingentaconnect.com/content/rcgp/bjgp/2009/00000059/00000568/art00007>
- *COMMUNITY CARE (U.K.)* | Online article – 23 October 2009 – **'Care Not Killing Alliance and Dignity in Dying debate assisted suicide.'** The law on assisted suicide has been clarified but it still splits opinion. Here, representatives of the Care Not Killing Alliance and Dignity in Dying go head to head. <http://www.communitycare.co.uk/Articles/2009/10/23/112959/assisted-suicide-the-cases-for-and-against.html>

Of related interest:

- *AMERICAN MEDICAL NEWS* | Online report – 19 October 2009 – **'Assisted-suicide statute challenged by two Connecticut doctors.'** The lawsuit argues that "aid in dying" is not assisted suicide and physicians who hasten terminally ill patients' deaths should not have to fear punishment. <http://www.ama-assn.org/amednews/2009/10/19/prsd1019.htm>

## **Palliative access through care at home: Experiences with an urban, geriatric home palliative care program**

*JOURNAL OF THE AMERICAN GERIATRICS SOCIETY*, 2009;57(10):1925-1931. The aging of the U.S. population has resulted in a large number of persons with multiple, chronic illnesses and gradual functional decline. Many older adults with these conditions are homebound and have great difficulty accessing medical care. They are also more likely to suffer from unaddressed symptoms and end-of-life care needs. Although the informal caregivers attending to such persons may become overwhelmed without adequate support, palliative care, which covers a broad population, is an optimal way to address many of these needs. This article describes a unique, urban, home-based geriatrics palliative care program, Palliative Access Through Care at Home. <http://www3.interscience.wiley.com/journal/122573550/abstract>

## **Palliative and end-of-life care in correctional settings**

*JOURNAL OF SOCIAL WORK IN END-OF-LIFE & PALLIATIVE CARE*, 2009;5(1):7-33. The prison population in the U.S. has grown fivefold in the last 27 years. Like the general population, the inmate population is aging. With age comes infirmity, disability, and chronic conditions that may, over the course of years or decades, lead to death. Inmates enter the prison system in poorer health than their age-matched free counterparts. A growing number of inmates will die in prison. A few will receive medical or compassionate release in order to die "outside the walls." Whether inside or outside, these dying men and women are entitled to receive high quality health care, including palliative care. Dying inmates face many of the same issues as the terminally ill in free society. However, death behind bars also poses some unique challenges to the dying, their prison family, their biological family, their caregivers and health care providers, custody staff, prison administration, and society as a whole. This article provides important background for understanding the unique and the ubiquitous aspects of dying inmates and offers direction to social work professionals in serving these inmates, their loved ones, their custodians, and the larger society. <http://www.informaworld.com/smpp/content~db=all~content=a915086728>

Of related interest:

- U.S. | KYW News Radio (Pennsylvania) – 21 October 2009 – These [end of life care] issues are nothing new to area prison officials. New Jersey Department of Corrections' ... hospice program was initiated in 2002 and 30 inmates have enrolled in a volunteer program to help others in their last days. Pennsylvania Department of Corrections has a similar program, which they began 10 years ago. <http://www.kyw1060.com/End-of-Life-Programs-Remain-Active-at-Area-Prisons/5488424>

**N.B.** Articles and reports focused on the provision and delivery of end of life care for prison inmates have been highlighted in Media Watch on a fairly regular basis. For those interested in prison hospice, a compilation of these articles and reports in a single document is available on request.

### **Quotable Quotes**

*For those who are terminally ill, the hard won expertise of the general hospital (to investigate, diagnose, cure and prolong life) is no longer relevant. For these patients, the appropriate goal is symptom control aimed at providing the optimum quality of life. The skills of the institution and the needs of these patients and their families are mismatched, resulting in isolation and compounding suffering. Ina Cummings & Balfour Mount, 1980*

**N.B.** Quote from the introductory pages of *The R.V.H. [Royal Victoria Hospital] Manual of Palliative/Hospice Care*, 1980. [http://books.google.ca/books?id=raTmhHmW\\_qYC&pg=PA201&lpg=PA201&dq=Balfour+Mount+quotes&source=bl&ots=mMkqJPSBVG&sig=z0R3P8uxvAqBAL8BMY7YWc1E97q&hl=en&ei=iKPcSrivB4yo8AbX3LC3BQ&sa=X&oi=book\\_result&ct=result&resnum=1&ved=0CAwQ6AEwAA#v=onepage&q=&f=false](http://books.google.ca/books?id=raTmhHmW_qYC&pg=PA201&lpg=PA201&dq=Balfour+Mount+quotes&source=bl&ots=mMkqJPSBVG&sig=z0R3P8uxvAqBAL8BMY7YWc1E97q&hl=en&ei=iKPcSrivB4yo8AbX3LC3BQ&sa=X&oi=book_result&ct=result&resnum=1&ved=0CAwQ6AEwAA#v=onepage&q=&f=false)

## Physician-patient communication

### **The truth is patients often aren't understanding as much of what we tell them as we'd hope**

*THE MEDICAL POST* (Canada) | Online article – 20 October 2009 – It's not surprising patients often don't understand. Medical culture compounds the problem for physicians when they try to communicate. Doctors are highly educated, navigate within a world of ongoing learning, use regulatory and abstract language, and put high importance on both printed material and technology, whereas less literate Canadians (their patients) have less education and learn through life experiences, prefer practical, simple, concrete language and verbal plus visual information. This mismatch causes breakdowns in communication and unmet expectations and needs. [http://www.medicalpost.com/life/article.jsp?content=20091020\\_133642\\_9708](http://www.medicalpost.com/life/article.jsp?content=20091020_133642_9708)

Of related interest:

- *SUPPORTIVE CARE IN CANCER* | Online article – 18 October 2009 – **'Do patient attributes predict oncologist empathic responses and patient perceptions of empathy?'** The authors of this study conclude oncologists ... did not respond empathically to patient's negative emotion, and did this equally for most patients. Oncologists responded more empathically to patients who were less economically advantaged. In turn, patients with lower economic security perceived more empathy. <http://www.springerlink.com/content/t1x0320h02vhjw47/?p=360d01a0d41a47af9d66c97c19142e14&pi=0>

### **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.

## Unmet palliative needs for patients with heart failure

*NURSING* (U.K.) | Online report – 21 October 2009 – The National Heart Failure Audit ... shows that sharp differences in the quality of care patients receive continue to exist, with access to the key therapies recommended by the National Institute for Health & Clinical Excellence frequently dependent on the type of ward to which patients are admitted. Overall mortality at one year is still poor at 30%. For end-of-life care, of patients who died only 6% were referred to palliative care and likely to reflect the national picture of unmet palliative needs for patients with heart failure. <http://www.nursinginpractice.com/default.asp?title=%22Careimproving%22forheartfailurepatients&page=article.display&article.id=19005>

## Hastening death in end-of-life care: A survey of [U.K.] doctors

*SOCIAL SCIENCE & MEDICINE* | Online article – 17 October 2009 – Results [of a national survey] show that there was no time to make an "end-of-life decision" (deciding to provide, withdraw or withhold treatment) for 8.5% of those reporting deaths. A further 55.2% reported decisions which they estimated would not hasten death and 28.9% reported decisions they had expected to hasten death. A further 7.4% reported deaths where they had to some degree intended to hasten death. Where patients or someone else had made a request for a hastened death, doctors were more likely to report expecting or at least partly intending to hasten death. Doctors usually made these decisions in consultation with colleagues, relatives and, where feasible, with patients. Palliative medicine specialists were the least likely to report decisions they expected or at least partly intended to end life, in spite of reporting a high incidence of requests from their patients for a hastened death. Doctors with strong religious beliefs or who opposed the legalisation of assisted dying were unlikely to report such decisions. The survey suggests that concerns about the sanctity of life, as well as estimates of the quality of life, enter clinical decision-making. [http://www.sciencedirect.com/science?\\_ob=ArticleURL&\\_udi=B6VBF-4XGCHM0-1&\\_user=10&\\_coverDate=10%2F17%2F2009&\\_rdoc=2&\\_fmt=high&\\_orig=browse&\\_srch=doc-info\(%23toc%235925%239999%2399999999%23999999%23FLA%23display%23Articles\)&\\_cdi=5925&\\_sort=d&\\_docanchor=&\\_ct=58&\\_acct=C000050221&\\_version=1&\\_urlVersion=0&\\_userid=10&md5=58eabee0e4df078298834d83cf9da7fe](http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6VBF-4XGCHM0-1&_user=10&_coverDate=10%2F17%2F2009&_rdoc=2&_fmt=high&_orig=browse&_srch=doc-info(%23toc%235925%239999%2399999999%23999999%23FLA%23display%23Articles)&_cdi=5925&_sort=d&_docanchor=&_ct=58&_acct=C000050221&_version=1&_urlVersion=0&_userid=10&md5=58eabee0e4df078298834d83cf9da7fe)

Representative sample of recent media coverage:

- U.K. | *Guardian* – 23 October 2009 – **'Third of doctors act to shorten lives of dying.'** Around a third of doctors say they have given drugs to terminally ill patients or withdrawn treatment, knowing or intending that it would shorten their life, research reveals. A study of doctors in charge of the last hours of almost 3,000 people finds decisions almost always have to be made on whether to give drugs to relieve pain that could shorten life and whether to continue resuscitation and artificial feeding. <http://www.guardian.co.uk/society/2009/oct/23/assisted-suicide-doctors-terminally-ill>

## End-of-life treatment preferences among older adults: An assessment of psychosocial influences

*SOCIOLOGICAL FORUM*, 2009;24(4):754-778. The authors explore the content and correlates of older adults' end-of-life treatment preferences in two hypothetical terminal illness scenarios. For each scenario, they assess whether participants would reject life-prolonging treatment, accept treatment, or do not know their preferences. They observe that persons who have made formal end-of-life preparations, persons with no religious affiliation, mainline Protestants, and persons who are pessimistic about their own life expectancy are more likely to reject treatment in both scenarios. <http://www3.interscience.wiley.com/journal/122649419/abstract>

## Worth Repeating

### **Working with families in palliative care: One size does not fit all**

*JOURNAL OF PALLIATIVE MEDICINE*, 2006;9(3):704-715. Comprehensive palliative care requires that family concerns are understood and addressed. Yet medical professionals frequently lack formal training in family systems concepts and, therefore, may be unprepared to engage in family-inclusive approaches to treatment. In order to address this problem, the authors selectively review the literature on working with families in end-of-life settings and offer specific recommendations for involving families as collaborators in the care process. Based on existing theory regarding the development of family communication styles and problem-solving abilities, they propose a tentative framework for understanding and responding to a range of common family dynamics encountered in palliative care and hospice settings. In light of the lack of empirical studies in this area, the authors conclude with recommendations for future research.  
<http://www.liebertonline.com/doi/abs/10.1089/jpm.2006.9.704>

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