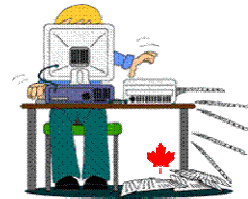


Media Watch...

is distributed weekly to my colleagues who are active or have a special interest in **hospice, palliative care** and **end-of-life issues** – to help keep them abreast of current, emerging and related issues, and to also inform discussion and to encourage further inquiry.

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Compilation of Media Watch 2008, 2009, 2010 ©

Compiled & Annotated by Barry R. Ashpole

Trends in best practice: Scroll down to [Specialist Publications](#) and 'Why health care is going home' (p.9) for an editorial published in the *New England Journal of Medicine*.

[Canada](#)

Family, doctors battle over 'do not resuscitate' order

ONTARIO | *Toronto Star* – 25 October 2010 – As Mann Kee Li lies in hospital fighting dire prospects, his family is engaged in a life-or-death struggle, not with the cancer spreading through his body, but with the doctors treating it. Li, a 46-year-old Toronto accountant ... wants doctors to use all medical measures possible to save him in the event of a life-threatening emergency. He made those intentions clear to his doctors at Sunnybrook Health Sciences Centre when he entered the hospital in August. He wrote it in a power of attorney document and confirmed it in a videotape statement, his lawyers say. While his doctor initially agreed to respect those wishes, physicians unilaterally reversed the decision a week ago without consultation and imposed a "do not resuscitate" order, his family alleges. <http://www.thestar.com/news/article/880422--family-doctors-battle-over-do-not-resuscitate-order>

From Media Watch dated 6 September 2010:

- ONTARIO | *Toronto Star* – 4 September 2010 – '**Lawsuit could set precedent about end-of-life decisions.**' While [Joy] Wawrzyniak and her father, Douglas (Dude) DeGuerre, had repeatedly requested he receive life-saving treatment in case of a medical emergency, doctors unilaterally overruled those wishes without consent or consultation ... [a \$1 million] lawsuit [against Sunnybrook Health Sciences Centre] claims. <http://www.thestar.com/news/gta/article/856741--lawsuit-could-set-precedent-about-end-of-life-decisions?bn=1>

Home-care agency tightens belt

ONTARIO | *St. Catharines Standard* – 18 October 2010 – New high-needs elderly patients admitted to hospital who require more than 60 hours of personal support upon returning home will be put on indefinite waiting lists. The cost-cutting move by Community Care Access Centre [CCAC] is required, officials say, because funding for at-home care isn't keeping up with increasing demands <http://www.stcatharinesstandard.ca/ArticleDisplay.aspx?e=2804836>

Cont.

From Media Watch dated 6 September 2010:

- ONTARIO | *Ottawa Citizen* – 1 September 2010 – '**Cash no cure for nursing home gridlock.**' Funding in Eastern Ontario aimed at keeping seniors in their homes ... has increased nearly four-fold over the past three years. However, the region continues to have Ontario's longest waits for nursing-home beds, leading critics to question whether the money is being spent in the right place. <http://www.ottawacitizen.com/health/Cash+cure+nursing+home+gridlock/3466880/story.html>
- ONTARIO | *Kitchener Record* – 31 August 2010 – '**New program transitions seniors from hospital to home or long-term care.**' The new transition program is among 21 programs being funded locally, most continuing from the first two years of the province-wide strategy that's intended to relieve pressure on emergency rooms and hospitals by reducing the number of unnecessary hospital visits and stays by seniors. <http://news.therecord.com/News/Local/article/771199>

U.S.A.

CMS attempts to improve coordination between hospice, long-term care providers

MCKNIGHT'S LONG TERM CARE NEWS & ASSISTED LIVING | Online report – 25 October 2010 – The Centers for Medicare & Medicaid Services [CMS] has proposed a change in guidelines as to how skilled nursing facilities qualify for Medicare and how nursing facilities qualify for Medicaid [which] would make it easier for long-term care facilities to arrange hospice care provisions with one or more Medicare-certified hospice providers. <http://www.mcknights.com/cms-attempts-to-improve-coordination-between-hospice-long-term-care-providers/article/181537/>

Medical challenge

Finding more balance in decision making at the end of life

PENNSYLVANIA | *Philadelphia Inquirer* – 17 October 2010 – About 2.4 million Americans die every year, an estimated 400,000 in an intensive care unit. Most Americans don't want an ICU death, but many start down a path of aggressive medicine that takes them there. Some doctors say they themselves are partly to blame. They need to do a better job early on telling patients with chronic illnesses the risks and grim realities that likely lie ahead. But doctors get paid to treat, to do procedures. And they don't get reimbursed to have difficult and time-consuming conversations, to deal with family members who want explanations or have objections. It's easier for doctors to say, "Go for it." Increasingly, patients who start down that aggressive road are deciding – when hope is gone – to surrender, to focus on comfort at the very end, doctors say. Palliative care teams, meeting with families, have helped that happen. For those who choose – or whose loved ones choose – not to surrender, they can live longer than ever these days because of care advances in the last 10 years. These therapies won't restore the brain, lungs, or liver, but they can prevent or delay the blood infection that might have killed the patient earlier. Virtually all physicians agree with the right of patients or their loved ones to make decisions regarding care at the end of life. But virtually all physicians also agree they have an obligation to use ... resources wisely. http://www.philly.com/inquirer/front_page/20101017_Medical_challenge_Finding_more_balance_in_decision_making_at_the_end_of_life.html

Quotable Quotes

Dying is never fun and it is rarely easy. Most people experience a time of discomfort and personal struggle in the process of dying. But the arduous nature of the experience should not obscure its potential value. Many, many people have told me that the last part of their life has been among the most wonderful times of their life. This phenomenon of human experience is largely ignored in public discussions despite its relative frequency. **Ira Byock**

International

It's your funeral

IRISH TIMES | Online report – 19 October 2010 – Irish people are increasingly looking for a 'death-style,' which matches their lifestyle. Inscribed on the gravestone of [comedian] Spike Milligan, this final quip ["I told you I was sick"] shows the ex-Goon's desire to be as much himself in death as he was in life. But when it comes to our own funeral arrangements, are we quite as sanguine and prepared? The Irish are said to "do death" well, with attendance at funerals by work colleagues, neighbours and politicians a societal norm. But our traditional format of a two-day funeral can sometimes feel formulaic. While the ritual of an evening removal with a religious service and burial the next day can be a familiar frame in which to process grief, we're increasingly asking for our personality, or that of a loved one, to be reflected in the process. <http://www.irishtimes.com/newspaper/health/2010/1019/1224281433251.html>

Of related interest:

- NATIONAL COUNCIL OF THE FORUM ON END OF LIFE IN IRELAND | Irish Hospice Foundation press release – 20 October 2010 – The condition of many mortuaries, the lack of regulation for the funeral industry and crematoria, and the ban on anyone but a doctor to pronounce death, are among the issues to be tackled by the National Council of the Forum on End of Life chaired by Justice Catherine McGuinness. <http://www.endoflife.ie/news/updates.aspx?article=84669445-0012-47d2-8748-255a04c6ce34>

People should be able to die at home: Ministers

U.K. | *Daily Telegraph* – 19 October 2010 – Eventually everyone should be able to die at home if they wish to and in the meantime community services should be improved to help that become a reality for more people [states *Equity & Excellence: Liberating the National Health Service*].¹ The National Health Service must provide more 24-hour nursing care in the community along with other services to allow more people to die where they choose to. A review will be held in 2013 to decide when the offer of dying at home can be offered as a universal choice. Ministers launched the consultation ... with the aim to extend the patient choice agenda

to allow people to have greater control over their own healthcare.

<http://www.telegraph.co.uk/health/healthnews/8070777/People-should-be-able-to-die-at-home-ministers.html>

Extract from report:

In end-of-life care, we will move towards a national choice offer to support people's preferences about how to have a good death, and we will work with providers, including hospices, to ensure that people have the support they need.

1. *Equity & Excellence: Liberating the National Health Service*, Department of Health, October 2010. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalassets/dh_117794.pdf

Of related interest:

- U.K. | National End of Life Care Intelligence Network report¹ – 19 October 2010 – '**Ageing population requires new approaches to end of life care...**' Providers and commissioners of end of life care must address the implications of a predicted large increase in the numbers of people dying at a very old age. In England the number of people aged 75 and over is projected to increase over the next 25 years, from 4.0 million in 2008 to 7.2 million in 2033. In 2008 there were 214 women aged 85 and over per 100 men. The report ... also looks at where and from what conditions older people die. <http://www.endoflifecare-intelligence.org.uk/news/default.aspx>

N.B. Scroll down to 'Read the report' for a link to *Deaths in Older Adults in England*, National End of Life Care Intelligence Network, October 2010.

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- SPAIN | *Leader* – 23 October 2010 – **'Euthanasia supported by more than half of Spaniards.'** A new report by the Centre for Sociological Investigation show that 60% of Spaniards are in favour of euthanasia being legalised. <http://www.theleader.info/article/25607/euthanasia-supported-by-more-than-half-of-spaniards/>
- NEW ZEALAND HERALD | Online OpEd – 19 October 2010 – **'There's much more to death than dying.'** The debate over euthanasia is difficult ground. The arguments on both sides have been well-rehearsed. There is no ideal scenario. I do not pretend to know clearly where lines about life and death should be drawn, although I do think there are lines and where they rest matters. http://www.nzherald.co.nz/opinion/news/article.cfm?c_id=466&objectid=10681473
- U.K. | *Daily Mail* – 19 October 2010 – **'Let the distraught partners of terminally ill who commit suicide die too says Dignitas boss.'** Ludwig Minelli wants the deadly drug that is prescribed to his clients to be made available to the partners of those suffering from dementia. <http://www.dailymail.co.uk/news/article-1321547/Dignitass-Ludwig-Minelli-Let-partners-terminally-ill-commit-suicide-die-too.html>

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

"You let them do what?!!!"

Decision-making capacity and the exercise of patient autonomy in long term care

ANNALS OF LONG TERM CARE, 2010;18(10):25-30. In long-term care (LTC) ... residents commonly exhibit conditions that negatively impact their ability to engage in a rational decision-making process. At the same time, patient rights statutes tend to assume that persons in our care are capable of making their own decisions, and are heavily weighted toward preserving patient autonomy. When a patient's decisions are in accordance with the family, healthcare providers, or societal norms, then the issue of decision-making capacity may be less of a challenge; the risks of the decisions made are likely to be low, and conflict is minimal. Greater challenges arise when there is a juxtaposition of patient incompetence or impaired capacity and a conflict between the patient's "wishes" and societal norms, medical advice, or family opinions. In these circumstances, clinicians are called upon to answer the question "Can the patient make his or her own decisions?" <http://www.annalsoflongtermcare.com/content/you-let-them-do-what-decision-making-capacity-and-exercise-patient-autonomy-ltc>

Of related interest:

- *CURRENT OPINION IN SUPPORTIVE & PALLIATIVE CARE* | Online article – 20 October 2010 – **'Decision making among older people with advanced heart failure as they transition to dependency and death.'** This review indicates a need to think carefully about how policy recommendations and guidance relating to patient participation in decision making at the end-of-life can be effectively implemented in practice. The need for continuity of involvement from key health workers is identified as very important in this regard. http://journals.lww.com/co-supportiveandpalliativecare/Abstract/publishahead/Decision_making_among_older_people_with_a_dvanced.99915.aspx

Palliative care (supportive and end of life care): A framework for clinical practice in perinatal medicine

BRITISH ASSOCIATION FOR PERINATAL MEDICINE | Online report – August 2010 – In 2008 the association acknowledged that perinatal palliative care must be recognised as its own speciality, and commissioned a working party to develop a framework for clinical practice. <http://www.bapm.org/media/documents/P%20alliative%20Care%20Report%20final%20Aug10.pdf>

Good death for all remains distant goal

BRITISH MEDICAL JOURNAL | Online letter – 19 October 2010 – Ellershaw and colleagues again defend their Liverpool Care Pathway.¹ The pathway has obvious appeal, but it has proved controversial, and reports of misuse remain disturbingly frequent. Despite decades of research in the care of patients with cancer, the accurate prediction of dying ... remains difficult. <http://www.bmj.com/content/341/bmj.c5815.extract>

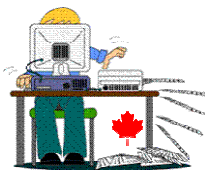
1. *BRITISH MEDICAL JOURNAL* | Online article – 16 September 2010 – **'Achieving a good death for all.'** A good death for all is now recognised as a priority at societal and political levels. <http://www.bmj.com/content/341/bmj.c4861.extract>

Of related interest:

- *BRITISH MEDICAL JOURNAL* | Online letter – 19 October 2010 – **'Spirituality is a weasel word.'** Grant and colleagues correctly assert that the emotional, psychological, existential, and sometimes religious needs of dying (and indeed all) patients are often neglected.¹ They have no doubt that more "spirituality" is needed. <http://www.bmj.com/content/341/bmj.c5801.extract>

1. *BRITISH MEDICAL JOURNAL* | Online article – 16 September 2010 – **'Spiritual dimensions of dying in pluralist societies.'** The authors explore how the spiritual needs of dying patients can be understood and met in pluralist and secular societies. <http://www.bmj.com/content/341/bmj.c4859.extract>

N.B. The two articles were part of a series on palliative care, detailed in Media Watch dated 20 September 2010. Journal contents page: <http://www.bmj.com/content/341/bmj.c5028>



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.

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.

Barry R. Ashpole

Assisted suicide: How the chattering classes have got it wrong

CENTRE FOR POLICY STUDIES [U.K.] | Online report – 18 October 2010 – A painless and speedy death, resulting from a hygienic medical procedure that leaves no mess: assisted suicide is the final consumer fantasy. Although illegal in Britain, it is already available to the determined and comfortably-off, who can buy (at £10,000 a shot) an appointment with death at the Dignitas clinic in Switzerland [see sidebar]. Here, completely legally, a physician will inject them with a fatal poison. Why can't, argue the distinguished and articulate advocates of assisted suicide and voluntary euthanasia, this choice be available to all? The simple answer is that, if we legalise assisted suicide, we risk having a strident *élite* condemning the less fortunate to a premature death. For it is the marginalised, the disabled, the less articulate and the poor who are most likely to be under pressure to accelerate their death. The National Health Service hospital or care home, engulfed by a rising tide of elderly people, and starved of funds, will feel the burden of the "bed-blocker" – and fill the insecure and vulnerable patient with guilt for taxing a system that is already under severe strain. http://www.cps.org.uk/cps_catalog/assisted%20suicide.pdf

From Media Watch dated 18 October 2010:

- U.K. | PRESS ASSOCIATION – 17 October 2010 – '**Attack over 'legal euthanasia' call.**' A writer from a leading think-tank has attacked the "chattering classes" who she said were calling for the legalisation of assisted dying. Cristina Odone, from the Centre for Policy Studies, warned legalising euthanasia could lead to the elderly, frail and vulnerable being viewed as an expendable burden. <http://www.google.com/hostednews/ukpress/article/ALeqM5j4k0MaQdr9LJjJN98NslFubvcMPQ?docId=N0315161287311355841A>

Of related interest:

- *AMERICAN JOURNAL OF HOSPICE & PALLIATIVE MEDICINE*, 2010;27(7):441-443. '**Physician-assisted dying.**' Editorial comment on two articles published in the *Canadian Medical Association Journal (CMAJ)*.^{1,2} <http://ajh.sagepub.com/content/27/7/441.full.pdf+html>
 1. '**Physician-assisted deaths under the euthanasia law in Belgium: A population-based survey.**' *CMAJ*, 2010;182(9):895-901. <http://www.cmaj.ca/cgi/content/abstract/182/9/895>
 2. '**The role of the nurses in physician-assisted deaths in Belgium.**' *CMAJ*, 2010;182(9):905-910. <http://www.cmaj.ca/cgi/content/abstract/182/9/905>

N.B. The *CMAJ* articles were noted in Media Watch dated 24 May 2010.

- *JOURNAL OF CLINICAL NURSING* | Online report – 19 October 2010 – '**Communication in nursing care for patients requesting euthanasia: A qualitative study.**' This article adds to the growing body of literature on nursing care for patients requesting euthanasia. The findings suggest that for nurses, communication is a key instrument for realising good-quality euthanasia care. <http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2702.2010.03367.x/abstract>
- *LEGAL STUDIES* | Online article – 13 October 2010 – '**Informal legal change on assisted suicide: The policy for prosecutors.**' Following the House of Lords' decision in *Purdy*, the Director of Public Prosecutions issued an interim policy for prosecutors setting out the factors to be considered when deciding whether a prosecution in an assisted suicide case is in the public interest. This paper considers the interim policy, the subsequent public consultation and the resulting final policy. <http://onlinelibrary.wiley.com/doi/10.1111/j.1748-121X.2010.00184.x/full>

N.B. The interim policy for England & Wales come after a legal battle won by Debbie Purdy. The Law Lords accepted that Purdy had a right to know whether her husband would be prosecuted if he helped her to travel abroad to commit suicide.

Critical care nurses' perceptions of obstacles, supports, and knowledge needed in providing quality end-of-life care

DIMENSIONS OF CRITICAL CARE NURSING, 2010;29(6):297-306. In response to critical care nurses' perceptions of increasing stress and conflict in difficult end-of-life (EOL) situations, the researchers conducted a study to identify perceived obstacles, supports, and knowledge needed to provide quality EOL care. The conclusions: 1) families and patients need clear, direct, and consistent information to make EOL decisions; 2) physician-related issues affect nurses' ability to provide quality EOL care; 3) critical care nurses need more knowledge, skill, and a sense of cultural competency to provide quality care; and, 4) having properly completed advance directives can reduce confusion about the goals of care. Recommendations ... were made as a result of the study.
http://journals.lww.com/dccnjournal/Abstract/2010/11000/Critical_Care_Nurses_Perceptions_of_Obstacles_12.aspx

Comfort care packs: A little bit of hospice in hospital?

INTERNATIONAL JOURNAL OF PALLIATIVE NURSING, 2010;16(10):511-515. The Comfort Care Pack initiative is ... designed to enhance the inpatient experience of end-of-life patients and their carers. The response to the packs was overwhelmingly positive and they were much valued by the carers. This was the case despite the fact that relatively few of the items were actually used by the recipients. It is suggested that the value of the packs to recipients lies in the gesture of being thought about during what is a difficult time for them. http://www.ijpn.co.uk/cgi-bin/go.pl/library/article.html?uid=79217;article=IJPN_16_10_511_515

Palliative care gains ground in developing countries

JOURNAL OF THE NATIONAL CANCER INSTITUTE | Online article – 21 October 2010 – Palliative care has gained ground in developed countries over the last few decades, with the loosening of laws on morphine use and the introduction of palliative care programs in many large hospitals. In the U.S., recent attention has focused on how it saves on expensive life-sustaining treatments of questionable benefit; improves the quality of life for patients and their families; and, according to a recent study, may even prolong survival. But also in the past two decades, non-profit groups and international organizations have begun introducing palliative care to the developing world.
<http://jnci.oxfordjournals.org/content/early/2010/10/21/jnci.djq445.extract>

[Media Watch Online](#)

The weekly report can be accessed at several websites, among them:

Canada

Ontario | Hamilton Niagara Haldimand Brant Hospice Palliative Care Network:
<http://www.hnhbhpc.net/Resources/UsefulLinks/MediaWatch/tabid/97/Default.aspx>

Ontario | HPC Consultation Services:
<http://www.hpcconnection.ca/newsletter/inthenews.html>

Ontario | Mississauga Halton Palliative Care Network
<http://www.mhpcn.ca/Physicians/resources.htm>
(Scroll down to 'Newsletters/Media Updates')

U.S.A.

Prison Terminal:
<http://www.prisonterminal.com/news%20media%20watch.html>

International

Global | Palliative Care Network Community:
<http://www.pcn-e.com/community/search/?tag=Media+Watch>

U.K. | Omega, the National Association for End of Life Care: <http://www.omega.uk.net/news.htm>

Regional variations in palliative care: Do cardiologists follow guidelines?

JOURNAL OF PALLIATIVE MEDICINE | Online article – 18 October 2010 – Despite professional guidelines suggesting that cardiologists discuss palliative care with patients with late stage heart failure, less than half of [the] cardiologists [who responded to a mail survey] would discuss palliative care in two elderly patients with late-stage heart failure [i.e., hypothetical patient scenarios] and this guideline discordance was worse in the regions with more health care use in the last six months of life. <http://www.liebertonline.com/doi/abs/10.1089/jpm.2010.0163>

From Media Watch dated 5 April 2010:

- *CANADIAN JOURNAL OF CARDIOLOGY*, 2010;26(3):135-141. **'End-of-life planning in heart failure: It should be the end of the beginning.'** End-of-life care was made a theme of the ... Canadian Heart Health Strategy & Action Plan. From this, several recommendations are made, central to which is the need to reframe CVD [cardiovascular disease] as a condition ideally suited to a chronic disease management approach. Replacement of the term 'palliative care' with the term 'end-of-life planning and care' is proposed to foster earlier and more integrated comprehensive care. <http://www.pulsus.com/journals/abstract.jsp?sCurrPg=abstract&jnlKy=1&atlKy=9419&isuKy=907&isArt=t&fromfold=Current Issue>

1. Canadian Heart Health Strategy & Action Plan website: <http://www.chhs-scsc.ca/>

Coping with terminal illness: The experience of attending specialist palliative day care

JOURNAL OF PALLIATIVE MEDICINE, 2010;13(10):1211-1218. The current research has provided a piece of the puzzle attempting to explore processes in attendance at Specialist Palliative Day Care [SPDC] from a patient's perspective. It suggests that through staff and other patients SPDC provides an environment in which patients receive help in coping with stressors such as loss of identity and feeling like a burden. In such an under researched area this study provides an exploration of SPDC attendance which can be built upon or challenged by future research. <http://www.liebertonline.com/doi/pdfplus/10.1089/jpm.2010.0131>

Bringing palliative care to neurology

NEUROLOGY TODAY, 2010;10(19):16-17. In 2006, palliative care was accepted as a subspecialty by more than half a dozen medical specialty programs, including primary care, family medicine, anesthesiology, radiation oncology – and neurology. Many neurologists still do not integrate the principles of palliative care into their practice. In 2008, 31 neurologists sat for the subspecialty exam; in 2010, the number remains about the same: 30 signed up to take the exam. http://journals.lww.com/neurotodayonline/Citation/2010/10070/Special_Report_Bringing_Palliative_Care_to.5.aspx

N.B. Click on 'Article as PDF' under 'Article Tools' for the complete article.

From Media Watch dated 16 November 2009:

- *ARCHIVES OF NEUROLOGY*, 2009;66(11):1427-1428. **'Are neurology residents prepared to deal with dying patients?'** With daily frequency, neurologists diagnose and treat patients with life-threatening, life-limiting, or significantly life-altering disease. It is, therefore, surprising that such a pervasive theme is inadequately addressed during neurology residency training. <http://archneur.ama-assn.org/cgi/content/extract/66/11/1427>

Of related interest:

- *INTERNATIONAL JOURNAL OF PALLIATIVE NURSING*, 2010;16(10):472-474. **'Management of multiple sclerosis and the role of respite and palliative care.'** Do people with multiple sclerosis [MS] need palliative care and respite provision? This question has been thrown into sharp focus by the recent decision taken by the MS Society to close their four respite homes in the U.K. http://www.ijpn.co.uk/cgi-bin/go.pl/library/article.html?uid=79210;article=IJPN_16_10_472_474

Trends in best practice

Why health care is going home

NEW ENGLAND JOURNAL OF MEDICINE | Online editorial – 20 October 2010 – In the past century, health care became highly concentrated in hospitals, clinics, and other facilities. But I believe that the venue of care for the future is the patient's home, where clinicians can combine old-fashioned sensibilities and caring with the application of new technologies to respond to major demographic, epidemiologic, and health care trends. Five major forces are driving health care into the home: the aging of the U.S. population, epidemics of chronic diseases, technological advances, health care consumerism, and rapidly escalating health care costs.

<http://www.nejm.org/doi/full/10.1056/NEJMp1000401>

From Media Watch dated 11 October 2010:

- *ACP INTERNIST* (American College of Physicians) | Online article – 8 October 2010 – **'House calls becoming a viable model.'** The reform bill passed earlier this year includes a pilot of house call care for chronically ill Medicare beneficiaries. Called Independence at Home, the program would involve interdisciplinary teams of physicians, nurses and other clinicians caring for patients who have multiple chronic conditions, difficulties with activities of daily living, and a history of hospital utilization. <http://www.acpinternist.org/archives/2010/10/house.htm>

Worth Repeating

Dame Cicely Saunders remembered

Spiritual care as a fundamental component of quality palliative care gets a major boost

ANNALS OF LONG TERM CARE, 2010;18(10):15-16. In honoring the memory of Dame Cicely Saunders (who would have been 92 years old this year), the founder of the modern hospice movement, it is fitting to focus on a core concept of palliative care, that of total pain, particularly spiritual pain. Although the biopsychosocial approach in medicine traces back to the 1950s, when George Engel, MD, who was later on the faculty of the University of Rochester School of Medicine, began to develop and refine that concept, it was Saunders who, in 1948, had added the spiritual domain of suffering to this mix, which she referred to as total pain. As Saunders recounted, "My story in this field goes right back to 1948 when I was a social worker... meeting a young Polish Jew who had an inoperable cancer...I became very fond of him." (David Tasma had escaped the Warsaw ghetto and was dying in a London hospital. Tasma's pain, loneliness, and anguish had a profound affect on Saunders. She visited Tasma frequently in the last 2 months of his life. As Saunders and Tasma spoke of his looming death, Saunders had a revelation.) "I realized that we needed not only better pain control but better overall care. People needed the space to be themselves. I coined the term total pain, from my understanding that dying people have physical, spiritual, psychological, and social pain that must be treated. I have been working on that ever since." <http://www.annalsoflongtermcare.com/content/spiritual-care-fundamental-component-quality-palliative-care-gets-major-boost>

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