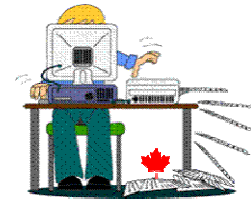


Media Watch...

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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Compiled & Annotated by Barry R. Ashpole

Prognosis: Scroll down to [Specialist Publications](#) and 'Explaining marginal benefits to patients, when "marginal" means additional but not necessarily small' (p.6), published in *Clinical Cancer Research*.

Canada

Lives in nursing homes improving: Minister

ONTARIO | *Toronto Star* – 22 December 2010 – Nursing homes that care for Ontario's 77,000 vulnerable seniors are slowly but surely getting better, says Ontario's Minister of Health & Long Term Care. Minister Deb Matthews said systemic problems were first identified by the *Star* in a 2003 series on nursing home care and now, seven years later, regulations hammered out in the new Long Term Care Homes Act are finally starting to make change. "You can connect the dots to the *Star* stories, to (former health minister) George Smitherman's reaction to (his parliamentary assistant) Monique Smith's report, to the new legislation," Matthews said in an interview... Smitherman wept in December 2003, when the *Star* showed him pictures of a gangrenous bedsore that killed an elderly nursing home resident. After reading the *Star's* 11-day investigative series on nursing home care – which included a detailed analysis of three databases that showed a deep crisis in the system – Smitherman promised to lead a "revolution" in long term care. Matthews was responding ... to a ...

(Cont. in next column)

provincial Ombudsman's report on nursing homes.¹ <http://www.thestar.com/news/article/910576--lives-in-nursing-homes-improving-minister>

1. Ministry of Health & Long Term Care's Monitoring of Long-Term Care Homes, Ombudsman, Ontario, December 2010. <http://www.ombudsman.on.ca/media/161447/ltc%20for%20web-en.pdf>

Ontario long-term care lacks oversight: Watchdog

ONTARIO | CBC News – 21 December 2010 – Ontario's inspection of long-term care homes, where 75,000 people live, is afflicted with "serious, systemic problems," ombudsman Andre Marin reported. Marin began an investigation of the 616 long-term care homes after The Canadian Press reported three-quarters of them consistently failed to meet the province's 450 standards of care. The investigation found the Ministry of Health & Long-Term Care "routinely" tells people to take complaints to the home operators. <http://www.cbc.ca/health/story/2010/12/21/ont-long-term-care-report.html>

(Cont. in next page)

Of related interest:

- **CANADIAN MEDICAL ASSOCIATION JOURNAL** | Online report – 23 December 2010 – **'National home care standards urged.'** Home care has become one of the fastest-growing areas in Canadian health care over the past decade, though, as is often the case in Canada's fractured health care landscape, some provinces are performing better than others. It is difficult, however, to compare the state of home care in different jurisdictions because the very notion of home care differs from province to province. This is why, according to Marg McAlister, a project manager for the Canadian Home Care Association, Canada needs a set of national standards for home care. <http://www.cmaj.ca/earlyreleases/23dec10-national-home-care-standards-urged.dtl>
- ONTARIO | *St. Catharines Standard* – 22 December 2010 – **'Funding will help people waiting for home care.'** The organization responsible for at-home care in Niagara says its waiting list of 365 people will be cleared early in the new year, thanks to a funding boost... The Hamilton Niagara Haldimand Brant Community Care Access Centre received \$3.8 million from the provincial government through the Local Health Integration Network, the body that funds health care in the region. <http://www.stcatharinesstandard.ca/ArticleDisplay.aspx?e=2900181>

Canada's real health costs hidden, unsustainable

CTV NEWS | Online report – 22 December 2010 – Governments at the provincial and federal level have not been honest with Canadians about rising health care costs that will someday swamp budgets, the [Washington-based] International Monetary Fund [IMF] warns. With escalating medicare costs and an aging population, Canada's health-care system is unsustainable. Accordingly, provinces need to be more upfront with Canadians about the true nature of the costs and the best practices for ensuring service can be maintained in the future. <http://toronto.ctv.ca/servlet/an/local/CTVNews/20101222/imf-health-costs-101222/20101222/?hub=TorontoNewHome>

Of related interest:

ONTARIO | *Toronto Star* – 25 December 2010 – **'Dying man's access to life-saving drug soon ends.'** Ontario's health ministry has yet to decide if it will pick up the cost of a \$500,000-a-year drug that is keeping a dying Guelph-area man alive. Lucas Macieszka has a deadly, extremely rare blood disorder. The disease causes the body to attack oxygen-rich red blood cells and leaves patients prone to internal bleeding. The American-made drug Soliris has been hailed as a near cure for the disorder but the costs are prohibitive – \$500,000-a-year – and patients are on it for life. <http://www.thestar.com/news/canada/article/912307--dying-man-s-access-to-life-saving-drug-soon-ends?bn=1>

Palliative & Therapeutic Harmonization Clinic

A place to find comfort

NOVA SCOTIA | *Chronicle-Herald* (Halifax) – 21 December 2010 – Making life – usually the end of life – as pleasant, peaceful and pain-free as possible are among the goals ... [of the PATH (Palliative & Therapeutic Harmonization) Clinic] ..., founded by [Dr. Laurie] Mallery and Dr. Paige Moorhouse at the Queen Elizabeth II Health Sciences Centre. Mallery, a geriatric specialist, says she saw the need for the clinic when watching so many patients with dementia and multiple physical ailments suffer and decline further after hospitalization and surgeries or other treatments. The clinic isn't about limiting treatments, she says, but rather taking a comprehensive look at the multiple conditions of these "frail" elderly patients and how treating one illness might actually hurt another. Clinic staff try to help patients with this "illness burden" weigh all the risks before they make a decision. If they're too cognitively impaired, the responsibility falls to family members, who often face an emotional burden as well. "Basically, we're on a fast track toward decision-making in health care where we just very quickly decide on treatments that have a lot of risks. So really what we want to do is just slow that process down a bit, to give people a chance to really fully understand where they are in their health and then to make decisions based on that." <http://thechronicleherald.ca/ArtsLife/1218300.html>

Confronting the issue of death can lead to a better life

BRITISH COLUMBIA | *Vancouver Sun* (OpEd) – 21 December 2010 – Think of the clichés you might use to cheer up a friend who's going through a difficult time: "One day, you'll look back on this and laugh," you might say. Or in an effort to put things in perspective, you might tell your friend, "At least you have your health," or better yet, "It's not like you're dying!" The abundance of such clichés, which always assume that life goes on, and the lack of clichés that deal with the reality of death confirm that in many ways, Western society is a death-denying culture. So afraid are we of death that we prefer not even to think of it, except when we compare it with our present situation in an effort to make that situation appear rosier. This death-denying aspect of our culture has even infiltrated medicine, as medical education places intense emphasis on the curative and preventive aspects of medical practice, while paying little attention to palliative care. <http://www.vancouversun.com/health/Confronting+issue+death+lead+better+life/4007368/story.html>

N.B. The OpEd discusses the article '**Impact of death and dying on the personal lives and practices of palliative and hospice care professionals,**' published in the *Canadian Medical Association Journal* 6 December 2010 (and noted in Media Watch dated 13 December 2010).

<http://www.cmaj.ca/cgi/rapidpdf/cmaj.100511v1?maxtoshow=&hits=10&RESULTFORMAT=&fulltext=Shane+Sinclair&searchid=1&FIRSTINDEX=0&sortspec=date&resourceype=HWCIT>

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- QUEBEC | Post Media News – 22 December 2010 – '**Court confirms acquittal of Quebec man charged with assisted suicide.**' The Quebec Court of Appeal confirmed ... the acquittal of a Quebec man charged with helping his disabled uncle commit suicide. The ruling could have an impact on another pending case of assisted suicide in Quebec. Leger Ayotte, of Trois-Rivieres, will face a trial before judge and jury in 2011 for allegedly "aiding or encouraging" his partner to take her life. <http://www.vancouversun.com/news/ASSISTED+SUICIDE/4014873/story.html>

U.S.A.

Obama returns to end-of-life plan that caused stir

NEW YORK TIMES | Online report – 25 December 2010 – Under the new policy, outlined in a Medicare regulation, the government will pay doctors who advise patients on options for end-of-life care, which may include advance directives to forgo aggressive life-sustaining treatment. Congressional supporters of the new policy, though pleased, have kept quiet. They fear provoking another furor like the one in 2009 when Republicans seized on the idea of end-of-life counseling to argue that the Democrats' bill would allow the government to cut off care for the critically ill. The final version of the health care legislation, signed into law by President Obama in March, authorized Medicare coverage of yearly physical examinations, or wellness visits. The new rule says Medicare will cover "voluntary advance care planning," to discuss end-of-life treatment, as part of the annual visit. Under the rule, doctors can provide information to patients on how to prepare an "advance directive," stating how aggressively they wish to be treated if they are so sick that they cannot make health care decisions for themselves. While the new law does not mention advance care planning, the Obama administration has been able to achieve its policy goal through the regulation-writing process, a strategy that could become more prevalent in the next two years as the president deals with a strengthened Republican opposition in Congress. http://www.nytimes.com/2010/12/26/us/politics/26death.html?_r=1

(Cont. in next page)

Of related interest:

- NORTH CAROLINA | *News & Observer* (Raleigh) – 26 December 2010 – **'New rules coming on long stays at hospice.'** People who have been through two rounds of hospice care must meet face-to-face with a hospice doctor or nurse practitioner under new Medicare rules ... designed to ensure that longer-term patients are actually in need of the end-of-life care and that proper help is being given. In North Carolina, about 9% of the 33,000 people who sought hospice care in 2008 would have been affected by the new rule, which is aimed at patients who have been enrolled in two 90-day care periods. <http://www.newsobserver.com/2010/12/26/881885/new-rules-coming-on-long-stays.html>

Hospice among South Carolina Medicaid cuts

SOUTH CAROLINA | WYFF4 News (Greenville) – 21 December 2010 – Officials with the South Carolina Department of Health & Human Services say an increase in the number of people who have lost their jobs or insurance benefits has led to more Medicaid patients in the state. The department recently released a list of cuts and reductions to Medicaid, after projecting a \$228 million dollar budget shortfall during the current fiscal year. Starting in February 2011... Hospice care services will also be eliminated. <http://www.wyff4.com/news/26210971/detail.html>

Physician orders for life sustaining treatment (POLST)

Economics of end-of-life care plans are touchy

WALL STREET JOURNAL | Online article – 21 December 2010 – As more states allow patients to outline specific end-of-life care plans with their doctors, the economics of such programs are still a touchy subject. The programs outlined in today's article,¹ known as physician orders for life sustaining treatment (POLST), allow frail patients to choose as much or as little care as they prefer near the end of their lives. Susan Tolle, of the Center for Ethics in Health Care at Oregon Health & Science University ... is wary about discussing the economic impact of such programs, though. "Obviously there can be some cost calculations, which we have not made. We were worried that the focus would fairly quickly come on the potential financial cost savings," Dr. Tolle said. "We have always wanted the focus to remain on the wishes and values of the individual patient." <http://blogs.wsj.com/economics/2010/12/21/economics-of-end-of-life-care-plans-are-touchy/>

1. WALL STREET JOURNAL | Online article – 21 December 2010 – **'Digital lists clarify end-of-life choices.'** Oregon is making it easier for the seriously ill to voluntarily make their wishes known about end-of-life care by creating an electronic database that first responders can quickly check during a medical emergency. At least two other states – West Virginia and New York – are developing similar systems, which are an outgrowth of signed paper forms. <http://online.wsj.com/article/SB10001424052748704610904576031740528446836.html>

From Media Watch dated 6 December 2010:

- OREGON | *Portland Tribune* – 1 December 2010 – **'New state registry helps clear up 'do not resuscitate' confusion.'** The 40,000 registrants [to date] far exceeds ... expectations. During the past 11 months, the registry has received 322 calls from paramedics, emergency departments and hospital intensive care units wanting immediate access to patient forms. http://portlandtribune.com/news/story.php?story_id=129114965203992200

[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/>

Traditions make way as death goes green

MINNEAPOLIS | *Pioneer Press* (Minnesota) – 19 December 2010 – How many houses could you heat from burning dead bodies? That's a question Americans could be asking themselves in the future, according to John Troyer, a self-described professor of death. Troyer, a Minneapolis native whose doctorate dissertation at the University of Minnesota was titled 'Technologies of the Human Corpse,' is the deputy director of Centre for Death & Society at the University of Bath in England. But the academic is back in the Twin Cities for the holidays, where he'll give a couple of talks, one sponsored by the university's Bell Museum about green options for body disposal and another for the Minnesota Historical Society based on his research on memorial tattoos – tattoos in remembrance of a dead person or pet. http://www.twincities.com/ci_16899487?nclick_check=1

International

No increase in funding for St Asaph hospice

U.K. (WALES) | *Denbigh Visitor* – 22 December 2010 – A plea for Welsh Assembly Government support for a hospice in a funding crisis has fallen on deaf ears. Assembly Member for Clwyd West, Darren Millar, has told of his disappointment after Health Minister Edwina Hart refused to support his calls for short-term funding arrangements for St. Kentigern's hospice in St. Asaph. The funding [for] similar projects in England receive is much higher than their Welsh counterparts. <http://www.denbighshirevisitor.com/news/denbighshire-news/2010/12/22/no-increase-in-funding-for-st-asaph-hospice-105722-27863181/>

Palliative care beds threatened

Outrage at Canossa plan

AUSTRALIA (QUEENSLAND) | *Springfield News* – 21 December 2010 – The State Government has disclosed plans to preserve some publicly backed palliative care services at Canossa Private Hospital. Less than a week after the *News* reported Queensland Health was withdrawing funding for 10 beds at the Oxley hospital, the Government has agreed to maintain the status quo until late next year when new beds at QEII Hospital come on line. But the reprieve was met with scepticism by protesters... Palliative Care Queensland president, associate professor Rohan Vora, said Queensland Health needed to invest more time and money developing policies which ensured quality, dignity and comfort for people in the final stage of their life. "Closing palliative care beds does not save money. It results in dying patients clogging up already busy emergency departments and acute medical wards where staff are inadequately trained to provide the care these people deserve," he said. <http://springfield-news.whereilive.com.au/news/story/outrage-at-canossa-plan/>

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- SOUTH AFRICA | Eye Witness News (Cape Town) – 22 December 2010 – **'Mercy killing accused calls for legalised euthanasia in South Africa.'** A Cape Town based professor accused of the 2006 mercy killing of his mother in New Zealand wants voluntary euthanasia legalised in South Africa. In what is believed to be an unprecedented move, a court in Dunedin allowed the University of the Western Cape Professor Sean Davidson to return to South Africa before his trial in June 2011. <http://www.eyewitnessnews.co.za/articleprog.aspx?id=55558>

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

Access to palliative care varies widely across Canada

CANADIAN MEDICAL ASSOCIATION JOURNAL | Online report – 24 December 2010 – Access to high-quality palliative care in Canada should not depend on your area code, according to the Canadian Hospice Palliative Care Association (CHPCA), a non-profit organization that advocates for improved palliative care services for Canadians. And yet geography does dictate quality of care, the association states in a June report.¹ <http://www.cmaj.ca/earlyreleases/24dec10-access-to-palliative-care-varies-widely-across-Canada.dtl>

1. *Quality End-of-Life Care? It Depends on Where you Live...and Where You Die*, June 2010. http://www.chpca.net/resource_doc_library/HPC_Policy_Brief_Systems_Approach_June_2010.pdf

From Media Watch 26 July 2010:

GLOBE & MAIL | Online OpEd – 21 July 2010 – **'There are a lot better places to die than Canada.'** Canada didn't fare so well [9th on the Economist Intelligence Unit Quality of Death Index, which ranked countries according to their provision of end-of-life care]. There are four principal reasons for the mediocre showing: End-of-life care is poorly co-ordinated; it is expensive (many services and drugs needed at the end of life are not covered by medicare); patient-centred care is lacking (meaning the wishes of patients are not respected nearly enough) and there is a shortage of policy leadership. <http://www.theglobeandmail.com/life/health/there-are-a-lot-better-places-to-die-than-canada/article1647604/>

1. *The Quality of Death: Ranking End of-life-care Across the World*, Economist Intelligence Unit, July 2010 http://graphics.eiu.com/upload/QOD_main_final_edition_Jul12_toprint.pdf

From Media Watch dated 24 May 2010:

- CANADIAN CANCER SOCIETY | Press release – 19 May 2010 – **'Dying cancer patients need more support.'** The type and quality of care and services to ensure a cancer patient dies with dignity in the setting of their choice depends on where the person lives in Canada, according to a special report.¹ http://www.cancer.ca/Canada-wide/About%20us/Media%20centre/CW-Media%20releases/CW-2010/Canadian%20Cancer%20Statistics%202010.aspx?sc_lang=en
1. Canadian Cancer Statistics 2010, Canadian Cancer Society. <http://www.cancer.ca/canada-wide/about%20cancer/cancer%20statistics/~media/CCS/Canada%20wide/Files%20List/English%20files%20heading/pdf%20not%20in%20publications%20section/Canadian20Cancer20Statistics2020102020English.ashx>

Discussing outcomes

Explaining marginal benefits to patients, when "marginal" means additional but not necessarily small

CLINICAL CANCER RESEARCH, 2010;16(24):5981-5986. Most oncologists will tell a patient if he is not curable, but not give specific survival information unless prompted. As an example, chemotherapy for pancreas cancer improves survival and does not worsen quality of life, but the impact on lifespan is small. Patients with advanced pancreas cancer have options that increase their average survival by about 16/100 at 1 year, and by about 9 weeks compared with best supportive care, but almost all patients are dead by 24 months. Telling patients that they have incurable disease and that treatment is ineffective is hard. Partly as a result, only about a third of cancer patients are told they are going to die, and those who are not told live no longer but have worse medical outcomes, such as dying on a ventilator and less time with hospice. These difficult conversations can be done if the oncologist has the right medical information, the right script, and some decision aids. <http://clincancerres.aacrjournals.org/content/16/24/5981.abstract>

Something's ironic in Denmark: An otherwise progressive welfare state lags well behind in care of patients at the end of life

HEALTH POLICY | Online article – 22 December 2010 – The objective of this study is to describe, in a comparative context, the current status of end-of-life palliative care in Denmark using quantitative research published in the past five years. This study's conclusions, based on a synthesis of the research, suggest that despite its well earned reputation as a generally progressive welfare state, Denmark tends to trail well behind its European neighbors when it comes to end-of-life care. Understanding the cultural forces that underlie this reality may help Danish health care professionals and policy makers overcome the barriers that stand in the way of providing state-of-the-art medical care to patients who suffer at the end of life.

[http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6V8X-51S6FND-1&_user=10&_coverDate=12%2F22%2F2010&_rdoc=3&_fmt=high&_orig=browse&_origin=browse&_zone=rslt_list_item&_srch=doc-info\(%23toc%235882%239999%2399999999%2399999%23FLA%23display%23Articles\)&_cdi=5882&_sort=d&_docanchor=&_ct=89&_acct=C000050221&_version=1&_urlVersion=0&_userid=10&md5=5342c7727e883562668b2c9ec1439b9e&searchtype=a](http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6V8X-51S6FND-1&_user=10&_coverDate=12%2F22%2F2010&_rdoc=3&_fmt=high&_orig=browse&_origin=browse&_zone=rslt_list_item&_srch=doc-info(%23toc%235882%239999%2399999999%2399999%23FLA%23display%23Articles)&_cdi=5882&_sort=d&_docanchor=&_ct=89&_acct=C000050221&_version=1&_urlVersion=0&_userid=10&md5=5342c7727e883562668b2c9ec1439b9e&searchtype=a)

N.B. Singapore is ranked 18th among countries worldwide when it comes to the quality of death, according to *The Quality of Death: Ranking End-of-life-care Across the World*, Economist Intelligence Unit, July 2010. http://graphics.eiu.com/upload/QOD_main_final_edition_Jul12_toprint.pdf

Developing a policy for do not resuscitate orders within a framework of goals of care

JOINT COMMISSION JOURNAL ON QUALITY & PATIENT SAFETY, 2010;37(1):11. Discussions about DNR ... orders or code status are common but can be difficult and may not lead to accurate understanding between clinicians and patients. These discussions are often isolated from the larger context of a patient's plan of care. Addressing patients' goals of care, which provide a basic orientation for clinical and ethical decision making, may improve clinicians' understanding about patients' code-status preferences. The DNR order policy represents an effort to translate conceptual analysis, empirical research, and clinical experience into hospital policy so that clinicians are encouraged to place code-status discussions within a larger, goal-oriented context. <http://www.ingentaconnect.com/content/jcaho/jcqs/2011/00000037/00000001/art00002>

Correlation between caregivers' burnout and elderly psychological abuse

JOURNAL OF AMERICAN SCIENCE, 2011;7(1):206-214. There are strong positive associations between levels of caregivers' burnout and levels of elders' psychological abuse. Media coverage of abuse in elders homes has made the public knowledgeable about-and outraged against-abusive treatment in those settings, providing education, appropriate training and counselling for the caregivers to find solutions for their problems and the problems of the elderly and about the risk factors for abuse. http://www.jofamericanscience.org/journals/am-sci/am0701/30_4379am0701_206_214.pdf



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.

The de-medicalisation of assisted dying: Is a less medicalised model the way forward?

MEDICAL LAW REVIEW, 2010;18(4):497-540. Although assisted dying has been most commonly presented within a medicalised framework, the notion of de-medicalisation is employed in this paper to suggest that there are emerging models of assisted dying in which some medical aspects assumed to be an integral part of the phenomenon are both challenged and diminished. The paper considers cases where relatives have facilitated a loved one's assisted suicide abroad, cases of assisted death in which the assistor in the actual suicide act is a non-medical, and the growing debate surrounding non-medical grounds for desiring death. In evaluating the potential impact of partial de-medicalisation on the assisted dying debate, the argument presented is that whilst a de-medicalised model could well contribute to a richer understanding of assisted dying and a better death for the person who is assisted, there are cogent reasons to retain some aspects of the medicalised model and that a completely de-medicalised model of assisted dying is unrealistic. <http://medlaw.oxfordjournals.org/content/18/4/497.abstract>

- *MEDICAL LAW REVIEW*, 2010;18(4):541-563. **'Assisted dying and the context of debate: "Medical law" versus "End-of-life law."** This paper provides a reflective analysis of the nature of normative critiques of law generally, and within medical law specifically. It first seeks to establish the context within which critical analysis of law and legal measures takes place, and develops an argument that critiques should focus on political norms. Entailed in this claim is the contention that positions that seek to address controversial social problems can not resort simply to moral philosophy. <http://medlaw.oxfordjournals.org/content/18/4/541.abstract>

New bid to improve end-of-life care for U.K.'s growing diabetes community

MEDICAL NEWS TODAY | Online report – 23 December 2010 – A new initiative has been launched to improve end-of-life care for up to 45,000 people dying in the U.K. each year who also suffer from diabetes. The Association of British Clinical Diabetologists has issued new guidance on how clinicians can best complement diabetes care and palliative care in a hospital, hospice or community setting. The organisation ... has taking its action as the number of people in the U.K. with diabetes continues to grow. <http://www.medicalnewstoday.com/articles/212332.php>

[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.hpconnection.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>

Worth Repeating

Communication difficulties and intellectual disability in end-of-life care

INTERNATIONAL JOURNAL OF PALLIATIVE NURSING, 2008;14(4):189-194. Around 1-3% of the world's population has intellectual disabilities. Communication difficulties are a major obstacle in providing effective palliative care to this group. Problems may arise due to a lack of comprehension and a lack of verbal skills, affecting assessment and the provision of psychosocial support. This paper maps the communication difficulties experienced by people with intellectual disabilities within a palliative care setting, drawing on several research studies carried out by the authors. These include the time-consuming nature of effective communication, and difficulties around breaking bad news. The paper explores the ways in which people with intellectual disabilities may (mis)understand verbal information. Strategies for managing communication difficulties are outlined, including ways to use clear, unambiguous language. The authors conclude that the ability to communicate effectively with people with intellectual disabilities is a useful skill that will benefit all patients. <http://www.dhospicepalliativecare.org/comdif.pdf>

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.

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