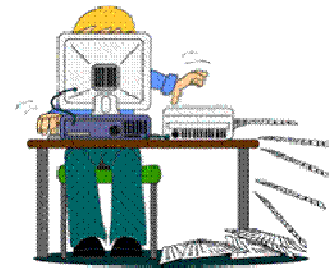


## Media Watch

...is distributed weekly to colleagues active or with 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 inform discussion and encourage further inquiry. Following is an annotated listing of recent articles, reports, etc., with links to the original source.

15 September 2008 Edition | Issue #62



Compilation of Media Watch 2008 ©

Compiled & Annotated by Barry R. Ashpole

The economics of hospice palliative care: Scroll down to [U.S.A.](#) and 'Better care of sickest patients can actually save hospitals money, says biggest study of its kind.'

## Canada: National

### Federal election

#### **Canadian Cancer Society calls on parties to support a National Caregivers Strategy**

CANADIAN CANCER SOCIETY | Press release – 11 September 2008 – More than 50% of Canadians are concerned about the financial impact of caring for a sick family member, says a national public opinion poll. Poll results also show that more than 60% of Canadians believe it is likely that they, or their spouse or partner, will be a caregiver to a sick family member in the future. "A federal election is a good time to ask candidates about our citizens' future needs," says Dan Demers, Director, Public Issues, Canadian Cancer Society. "The Canadian population is aging and increasingly Canadians will be caring for loved ones who have cancer and other serious illnesses that could lead to death. While some financial support currently exists for caregivers, much more needs to be done to assist these people who are the invisible backbone of our healthcare system. We are calling on all the political parties to implement a national caregivers strategy to prevent this growing challenge from become a future crisis." The poll results show Canadians support improved caregiver benefits: almost three in five or 59% of Canadians said they would be more likely to vote for a party that promises a longer period of support for Canadians who have to be absent from work to care for a gravely ill family member at risk of dying. 50% say that a fair government program would provide up to six months of paid leave if a person had to leave work temporarily to be a caregiver to a gravely ill family member at risk of dying. <http://www.newswire.ca/en/releases/archive/September2008/11/c3288.html>

- Canadian Cancer Society (Press release): '**Canadians fear financial impact of caring for sick family member.**' <http://www.cnw.ca/fr/releases/archive/September2008/11/c3288.html>

From Media Watch dated 09.01.08.

- BMC Palliative Care (7:14): '**An evaluation of Compassionate Care Benefit from a family caregiver's perspective at end of life.**' <http://www.biomedcentral.com/1472-684X/7/14>

## Federal election

### **Canadian Hospice Palliative Care Association (CHPCA) federal election kit**

CHPCA – 8 September 2008 – Canadians, especially those in ... hospice palliative care ... must speak with one voice to ensure that politicians understand the importance of improving access to hospice palliative care throughout Canada. The louder the voice, the greater the chance that positive policy changes will be made. With the federal election, CHPCA and its supporters must deliver a clear and unified message: all Canadians must be able to die with dignity, free of pain, surrounded by loved ones, in a setting of their choice. Hospice palliative care ... is becoming an increasingly urgent issue, due to Canada's changing demographics. However, in the past few years, federal political will seems to be showing signs of diminishing, just when it should be increasing. As a major example, Health Canada cut funding to the National Strategy on Hospice & Palliative Care (established in 2001), before ultimately discontinuing its working groups in March 2007 – before their work was finished. An election provides excellent opportunities to raise issues with politicians and raise awareness of issues with fellow Canadians and gain their support. Download a copy of the kit at: [http://www.chpca.net/public\\_policy\\_advocacy/CHPCA-Election-Kit\\_EN.pdf](http://www.chpca.net/public_policy_advocacy/CHPCA-Election-Kit_EN.pdf)

## Canada: The Provinces

### Hospice & Palliative Care Manitoba Conference

#### **Grieving gays often face discrimination**

MANITOBA | *Winnipeg Free Press* – 11 September 2008 – Two Winnipeg men, in their 70s, had been together for more than half their lives. However, when one died ... his relatives descended upon the couple's residence and started taking their belongings. The surviving man lost almost everything, said Chad Smith, a Men's Resource Centre social worker who counselled the devastated man following his partner's death. Smith said the situation is all too familiar. The discrimination many gay men and women face while grieving their partner (was) the subject of the keynote address at the annual Hospice and Palliative Care Manitoba Conference. "Lots of older men come from a generation where they were used to hiding their relationship and who they are, and when they were younger it was against the law to be gay or perceived as mentally ill or sick, so there's these long-term partnerships that people are used to hiding," said Smith. He added problems around palliative care can be particularly acute for older gay, lesbian, bisexual, transgendered, and two-spirited people in their 60s to 80s, who may not have disclosed their relationship to family or friends. <http://www.winnipegfreepress.com/life/story/4224766p-4862352c.html>

Recommended reading:

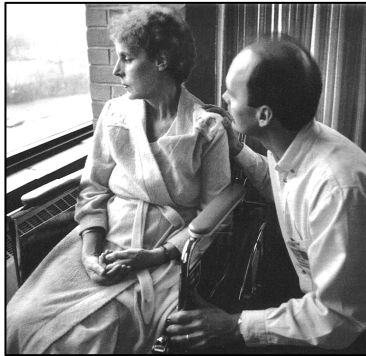
- *Sexualities*, 2008;11(3):275-300. 'Gagged grief and beleaguered bereavements?' <http://sexualities.sagepub.com/cgi/content/abstract/11/3/275>
- GayWired.com: 'Till death do us part.' <http://www.gaywired.com/article.cfm?id=20290&section=67>

Additional press coverage of the Manitoba conference:

- CJOB Radio (Winnipeg): 'End of life decisions.' <http://www.cjob.com/News/Local/Story.aspx?ID=1026066>

## Can't compete with McDonald's for home-care workers, employers say

NEWFOUNDLAND & LABRADOR | CBC News – 9 September 2008 – Home care workers paid by the provincial government earn only \$9.66/hour – without benefits, and despite years of



experience. An informal review by CBC News found that the salaries for the workers, some of whom are responsible for keeping their clients alive by tending to daily needs, pale compared to unskilled jobs. For instance, some workers at St. John's-area McDonald's restaurants – which have been recruiting heavily and have been promoting a roster of benefits to lure people to fill staffing shortages – earn more than \$10/hour. Entry-level security guards make \$9.50/hour, while call-centre employees start at \$9.25.

<http://www.cbc.ca/health/story/2008/09/09/home-care.html>

Photograph: Johnnie Eisen | *The Palliative Patient*

## Alberta must take steps to head off crisis in seniors' care

ALBERTA | *Edmonton Journal* – 8 September 2008 – The demographics of an aging population have been known for decades. In 2011, the first of the baby boomers will turn 65. The number of seniors in Alberta is expected to increase by 40% in the next 10 years and will double today's number in less than 20 years. This knowledge has in fact been the basis of government action for many years – action to divest itself of responsibility for seniors' care. Using the spectre of supposed unsustainability, the government has been systematically transferring that responsibility to the private sector and ultimately onto seniors and their families, as the paying consumers of these services. Premier Ed Stelmach published (in 2006) the priorities that each of his ministers was to address. Among other things, the Minister of Seniors & Community Supports was to "establish a Demographic Planning Commission to provide analysis and proposals to prepare for the needs of an aging population and ensure facilities and supports are available for seniors."

<http://www.canada.com/edmontonjournal/news/opinion/story.html?id=d4a8dab3-9591-407b-84f6-83d7c27172c6>

## Impact of Ontario's End-of-life Care Strategy on end-of-life care in the community

ONTARIO | *Healthcare Quarterly*, 2008;11(1):56-62 –8 September 2008 (Date accessed) – This article describes the impacts of the Ministry of Health & Long-Term Care's End-of-Life Care Strategy on the quality of end-of-life (EOL) care services delivered by home care providers across the province of Ontario. The authors compared key home care services one year before the strategy's implementation with those one year after. In addition, we conducted a qualitative survey of all community care access centres, the main providers of home care, and nearly all EOL Care Network directors to assess improvements to EOL care at the system and client level. Results showed that the number of clients of EOL care served increased by 3,537 over the baseline year. Moreover, the total number of nursing visits, shift nursing hours and personal support hours increased by 26%, 31% and 47%, respectively, compared with the baseline year. The qualitative analysis indicated that increased collaborations and communication have enhanced integration, coordination and consistency of EOL care. Anecdotally, clients and families feel more supported navigating the healthcare system, and more of their wishes are being met. The strategy appeared to improve EOL care on multiple levels. However, several barriers and challenges remain. Further investments and research are needed to achieve reliable quality EOL care for all Ontarians. <http://www.longwoods.com/product.php?productid=19498&cat=522>

## U.S.A.

### **Study: State not reviewing 'natural' deaths in waiver program for disabled**

TEXAS | *Daily News* 14 September 2008 – Linda Rava learned her disabled son was dying in an early-morning phone call from his Houston care facility. He had pneumonia, doctors told her. His lungs had filled with fluid. Within hours of her arrival at the hospital, he was dead. Ms. Rava was grief-stricken. A week earlier, she had returned with her healthy 29-year-old from a family vacation. And she'd heard from her son and his care providers two days before his death, with no indication that Carlos was sick or suffering. But doctors never performed an autopsy. And when an in-house review determined there was no wrongdoing in Carlos' death, Ms. Rava said, that's as far as it went. "I was shocked, broken hearted," Ms. Rava said. "I kept saying, 'Is there something else I should've done? Or something they should've done? I don't understand how this could've happened so fast.'" Ms. Rava's experience wasn't unusual. This summer, a 14-state report released by the U.S. Government Accountability Office found Texas was the only state that didn't review the deaths of people who succumb to "natural causes" in home or community-based care. [http://www.dallasnews.com/sharedcontent/dws/news/nation/stories/DN-noautopsies\\_14tex.ART.Central.Edition1.26e2012.html](http://www.dallasnews.com/sharedcontent/dws/news/nation/stories/DN-noautopsies_14tex.ART.Central.Edition1.26e2012.html)

### **California study finds sharp increase in hospital palliative care programs**

CALIFORNIA | *Sacramento Business Journal* – 12 September 2008 – Hospital-based palliative care programs are quickly growing in popularity, according to a report released by the Oakland-based California Health Foundation. More than 90% of California's 111 programs surveyed by the foundation were started since 2000, with 64% started since 2004. Teaching hospitals are also moving toward palliative care in their training programs for doctors. The majority of programs (51%) catered to white patients and more patients in these programs suffered from cancers than any other condition. <http://www.bizjournals.com/sacramento/stories/2008/09/08/daily68.html>

- Illinois (*Chicago Tribune*): **'Inpatient hospice facilities become more common.'** <http://www.chicagotribune.com/news/local/chi-hospice-inpatient-15-sep15.0.7024131.story>

### **Seven years after 9/11 attacks, television grapples with grief**

NEW YORK | *Daily News* – 12 September 2008 – We can debate how much coverage of the annual 9/11 victims' ceremony is appropriate, or even if it should air on every channel. It's a fair discussion, just not now because once the coverage starts, it is incredibly hard to look away. Anyone with a heart watching Thursday would have been hard-pressed not to feel something. "With each passing year, September 11 seems to take on more meaning," said Jay Dow on WCBS/Channel 2 Thursday morning. It seems that way, for sure. After seven years, the scene has become familiar, but the emotions are still fresh. And, TV – local TV specifically – does a good job of delivering them. TV is there to capture the crowds of family members and others walking down to Ground Zero, and the reading of the names. Silent shots of tortured faces. [http://www.nydailynews.com/entertainment/tv/2008/09/12/2008-09-12\\_seven\\_years\\_after\\_911\\_attacks\\_television.html](http://www.nydailynews.com/entertainment/tv/2008/09/12/2008-09-12_seven_years_after_911_attacks_television.html)

From Media Watch dated 08.11.08.

- *Journal of Death & Dying*, 2008;57(3):261-278. **'The reporting of grief by one newspaper of record for the U.S. – *The New York Times*.'** N.B. Link unavailable.
- U.S. (*Mental Health*): **'How long (according to the media) should grief last?'** <http://www.mentalhealth.com/mental-health-blog/how-long-according-to-the-media-should-grief-last/>
- U.S. (*San Francisco Chronicle*, CA): **'A reporter and the journalism of grief.'** <http://www.sfgate.com/cgi-bin/article.cgi?f=c/a/2008/08/02/INEG12011B.DTL>

## Euthanasia and assisted suicide: Washington's Initiative 1000

### **Assisted suicide: Both sides**

WASHINGTON | *Olympian* – 11 September 2008 – Activists on both sides of the debate on ... Initiative 1000 made their case before the Thurston County Chamber of Commerce. "A desire for suicide reflects despair, desperation, hopelessness," Patricia O'Halloran said. "The advocates ... have not made the case why physicians and society ... should recast suicide thoughts by the terminally ill as somehow a good that should be facilitated, rather than a tragedy that should be averted." She spoke during a public session of the *Olympian's* editorial board. Allowing those with six months or less to live to use lethal drugs is not suicide as most people think of it, said Rob Miller, executive director of Compassion & Choices Washington. "A decision to end one's life at this stage is not that much different than a decision to forgo further treatment," he said. The proposed law is based on Oregon's Death With Dignity Act. In a 4-1 vote, the editorial board said Dr. O'Halloran (*et al*) had not shown that Oregon's law – the nation's only law allowing assisted suicide – led to serious problems. <http://www.theolympian.com/elections/story/581221.html>

### **Considerations of palliative sedation therapy**

HEMONC TODAY | Online article – 10 September 2008 – Symptom control is a major aspect of palliative care. Although most patients have symptom control and are able to maintain personally satisfying lives, for a subset of patients symptomatic control remains elusive. For these patients, palliative sedation therapy, a treatment of last resort, may prove beneficial. Its controversial nature exists secondary to an absent standardized definition, ill defined indications for use and implementation, and misinterpretation as euthanasia. The intention behind euthanasia is death of the patient, while the intention behind palliative sedation therapy is relief of intractable suffering. <http://www.hemonctoday.com/article.aspx?rid=31171>

Recommended reading:

- *JOURNAL OF PAIN & SYMPTOM MANAGEMENT*, 2008;36(3):310-333. '**Palliative sedation: A review of the research literature.**' N.B. Link unavailable.

### **Grant to help raise awareness of long-term care alternative**

MISSOURI | *News-Leader* – 9 September 2008 – Missouri is one of seven states that will receive a share of more than \$8 million in federal grants through Centers for Medicare & Medicaid Services. The grants are part of the Real Choice Systems Change grant program. The program tries to help states and territories re-balance their long-term support programs to help people with chronic illness or disabilities live in their homes and participate in community life. Missouri will use its grant money to develop new Aging & Disability Resource Centers. <http://www.news-leader.com/apps/pbcs.dll/article?AID=/20080909/BREAKING01/80909069>

- Philadelphia (*Inquirer*): '**Aging U.S. lacks plan for long-term care.**' [http://www.philly.com/inquirer/opinion/20080912\\_Aging\\_U\\_S\\_lacks\\_plan\\_for\\_long-term\\_care.html](http://www.philly.com/inquirer/opinion/20080912_Aging_U_S_lacks_plan_for_long-term_care.html)

Of related interest:

- Florida (*The Ledger*): '**Medicare launching caregiving initiative with 18 September webcast.**' <http://blogs.theledger.com/default.asp?item=2260991>
- Texas (*Houston Chronicle*): '**Employers: Don't assume (employees who are) caregivers can't.**' <http://www.chron.com/disp/story.mpl/business/sixel/5994876.html>

## The economics of hospice palliative care

### **Better care of sickest patients can actually save hospitals money, says biggest study of its kind**

CENTER TO ADVANCE PALLIATIVE CARE | Press release – 8 September 2008 – A new study by the Center to Advance Palliative Care (CAPC) and National Palliative Care Research Center (NPCRC) finds hospitals can save more than \$300/day per seriously ill patient while giving them even better care. With the aging of the population, especially the baby boomers, hospitals are caring for an increasing number of patients with advanced illnesses, such as cancer, heart disease and kidney failure. Palliative care programs provide a way for hospitals to meet the needs of these patients while staying financially viable. "Americans are aging with serious, chronic illnesses," said Sean Morrison, director of the NPCRC and the study's lead author. "But despite enormous expenditures, they still get uncoordinated care, extreme burdens on their families and poorly managed pain." Adds Diane Meier, director of the CAPC, a national organization based at Mount Sinai School of Medicine: "The potential to reduce the suffering of millions of Americans is enormous. This study proves that better care can go hand in hand with a better bottom line." <http://www.marketwatch.com/news/story/better-care-sickest-patients-can/story.aspx?guid=%7BAC158A52-4EF4-4E5B-B185-DD33C95E000E%7D&dist=hppr>

**N.B.** The CAPC/NPCRC study was published in the 8 September 2008 issue of the *Archives of Internal Medicine* [168(16):1783-1790]. '**Cost savings associated with U.S. hospital palliative care consultation programs.**' <http://archinte.ama-assn.org/cgi/content/short/168/16/1783>

Representative sample of news coverage of the CAPC/NPCRC study:

- MedPageToday.com: '**Palliative care programs lead to cost savings.**' <http://www.medpagetoday.com/PublicHealthPolicy/PublicHealth/tb/10831>
- Reuters (Newswire service): '**Special care teams help U.S. patients, hospitals.**' <http://www.reuters.com/article/healthNews/idUSN0848270820080908>

### **Eco-afterlife: Green burial options**

*SCIENTIFIC AMERICAN* | Online article – 5 September 2008 – Modern western-world burial practices are arguably absurd, all things considered: We pack our dearly departed with synthetic preservatives and encase them in impenetrable coffins meant to defy the natural forces of decomposition that have been turning ashes to ashes and dust to dust for eons. And in the process we give over thousands of acres of land every year to new cemetery grounds from coast to coast. According to *National Geographic*, American funerals are responsible each year for the felling of 30 million board feet of casket wood (some of which comes from tropical hardwoods), 90,000 tons of steel, 1.6 million tons of concrete for burial vaults, and 800,000 gallons of embalming fluid. Even cremation is an environmental horror story, with the incineration process emitting many a noxious substance, including dioxin, hydrochloric acid, sulphur dioxide, and climate-changing carbon dioxide. But increasing demand for more natural burial practices has spawned changes in the industry, and dozens of funeral homes and cemeteries across the country have started to adopt greener ways of operating. Many are members of the non-profit Green Burial Council, which works "to make burial sustainable for the planet, meaningful for the families, and economically viable for the provider." <http://www.sciam.com/article.cfm?id=eco-afterlife-green-burial>

### **[Back Issues of Media Watch](#)**

Back issues of Media Watch are held on file for a limited time and available on request.

## International

### **Medical students don't have enough 'death' experience, says consultant**

U.K. | *Birmingham Post* – 15 September 2008 – A Birmingham medic has criticised the clinical community for not placing enough importance on palliative care, despite the recent introduction of the Government's End of Life Strategy. Dr. Steve Plenderleith believes medical students are not encouraged to spend time with patients suffering from terminal or long-term conditions, and as a result "have little or no experience of patient death." Seriously ill patients are "falling through the cracks" as a result because GPs either do not know how to access hospice services, what care they provide and where it is provided. <http://www.birminghampost.net/news/2008/09/15/medical-students-don-t-have-enough-death-experience-says-consultant-65233-21819916/>

### **Survey reveals dearth of care for terminal patients in Japan**

JAPAN | *Mainichi Daily News* – 13 September 2008 – Only about 20% of doctors in Japan are skilled in pain relief for terminally-ill patients, according to a Japan Medical Association survey. The survey quizzed 267,523 doctors between January and February about their knowledge and skills for palliative care, with 97,961 responding. 58.3% said they wanted to be involved in palliative care in some form. However, 33.5% complained of anxiety in explaining the conditions of diseases to patients, while 37.1% said it's difficult to talk about death with their patients. When asked why they're reluctant to provide palliative care, 47.8% said they have no extra time to spare because they're occupied with other duties, while 30.6% said palliative care simply "doesn't pay." <http://mdn.mainichi.jp/mdnnews/national/news/20080913p2a00m0na009000c.html>

## Prognosis

### **When death comes knocking, make him knock twice**

U.K. (Scotland) | *LimaOhio.com* – 11 September 2008 – Andy Lees couldn't say he was surprised by the news (i.e., prognosis). He'd been a miner most of his life and had seen both parents and two brothers die from cancer. Being as stiff-lipped as the next Scot, Lees set about preparing to die. He split up his life savings, doling it out among his children and grandchildren and a few close friends. Being a dependable sort, he set back enough to cover his own funeral, even ordered his own tombstone. Then he went home and waited to die. And waited, and waited. After a month or so, Lees began to think he was either particularly hearty or particularly lucky. After a few months, he began to suspect something may be up, but his doctors assured him he was a man on limited time. Finally, after almost a year, they looked around a bit more and realized the original diagnosis had been off. Lees actually had pulmonary disease, not cancer. He was sick, but not dying. [http://www.limaohio.com/articles/lees\\_28029\\_article.html/story\\_most.html](http://www.limaohio.com/articles/lees_28029_article.html/story_most.html)

From Media Watch dated 09.01.08.

- U.S. (*Norwich Bulletin*, Connecticut): **'Many factors may skew final prognosis.'** <http://www.norwichbulletin.com/lifestyles/health/x560277875/Dr-Jeff-Hersh-Many-factors-may-skew-final-prognosis>

Of related interest:

- U.S. (*Washington Post*): **'I'll keep my aging to myself, thank you.'** <http://www2.tbo.com/content/2008/sep/12/na-ill-keep-my-aging-to-myself-thank-you/>

## World's largest-ever study of near-death experiences

U.K. | *Science Daily* – 10 September 2008 – The AWARE (awareness during resuscitation) study is to be launched by the Human Consciousness Project of the University of Southampton, an international collaboration of scientists and physicians who have joined forces to study the human brain, consciousness and clinical death. The study is led by Dr Sam Parnia, an expert in the field. Following a successful pilot phase at selected hospitals in the U.K., the study is now being expanded to include other centres within the U.K., Europe and North America. "Contrary to popular perception," Dr Parnia explains, "death is not a specific moment. It is a process that begins when the heart stops beating, the lungs stop working and the brain ceases functioning – a medical condition termed cardiac arrest, which from a biological viewpoint is synonymous with clinical death." <http://www.sciencedaily.com/releases/2008/09/080910090829.htm>

## Euthanasia and assisted suicide: Victoria Medical Treatment (Physician Assisted Dying) Bill

### Right to die Bill defeated

AUSTRALIA | News.com.au – 10 September 2008 – A bid to legalise euthanasia in Victoria has been defeated in parliament. Greens MP Colleen Hartland introduced a private members Bill to legislate right-to-die laws in the upper house in June. The Bill was defeated by a vote of 25-13. "I'm very disappointed. The disappointing part is all the people ringing my office urging me to do this and for them this is a terrible disappointment," Ms Hartland said. The Medical Treatment (Physician-Assisted Dying) Bill would have enabled Victorians suffering "intolerably from a terminal or advanced incurable illness" to end their lives. It also would have provided protection for doctors who help patients die. <http://www.news.com.au/heraldsun/story/0,21985,24324655-5005961,00.html>

Representative sample of media coverage of defeat of Medical Treatment (Physician Assisted Dying) Bill:

- Australia (ABC Radio News): '**Group calls for further study of euthanasia bill.**' <http://www.abc.net.au/news/stories/2008/09/11/2361448.htm>
- Australia (ABC Radio News): '**Liberal Member ... accusing Labour MPs of sending mixed messages on the issue of legalising euthanasia.**' <http://www.abc.net.au/news/stories/2008/09/11/2361921.htm?site=gippsland>
- Australia (*Christian Today*): '**Victorian Government urged to step up palliative care support following welcome defeat of euthanasia bill.**' <http://au.christiantoday.com/article/victorian-government-urged-to-step-up-palliative-care-support-following-welcome-defeat-of-euthanasia-bill/4277.htm>
- Australia (*Geelong Advertiser*): '**Agonising over euthanasia.**' [http://www.geelongadvertiser.com.au/article/2008/09/13/18248\\_opinion.html](http://www.geelongadvertiser.com.au/article/2008/09/13/18248_opinion.html)

Of related interest:

- Australia (News.com.au): '**Euthanasia Bill to go before (Northern Territory) Senate.**' <http://www.news.com.au/story/0,23599,24340763-29277,00.html>
- Holland (*The Guardian*, U.K.): '**Death in a Dutch family: 'I'm going to die on Monday at 6.15 p.m.'**' <http://www.guardian.co.uk/lifeandstyle/2008/aug/23/euthanasia.cancer>
- Rome (Associated Press): '**Pope states anti-euthanasia message.**' <http://ukpress.google.com/article/ALeqM5iUn1LhAbsP5OjPGZUbeHt9xckigQ>
- U.K. (*The Independent*): '**Don't jail my husband if he helps me to die, pleads MS sufferer.**' <http://www.independent.co.uk/home-news/dont-jail-my-husband-if-he-helps-me-to-die-pleads-ms-sufferer-927090.html>

## 1,000 journalists in fight against HIV/AIDS

U.S. | Internews Network press release – 10 September 2008 – Against a backdrop of misinformation and stigma, how can developing countries fight a virus that has already killed tens of millions of people? Part of the answer is to enlist the power of the local news media. Internews Network is an international non-profit organization that has provided in-depth training and mentoring to more than 1,000 journalists. "We estimate that these journalists reach a combined audience of 150 million people. So you can make the case that one journalist trained in HIV/AIDS reporting can single-handedly, on average, reach 150,000 people. That's a tremendously effective use of resources," says Dr. Laurie Zivetz, director of Internews' HIV/AIDS media training and mentoring project. <http://www.marketwatch.com/news/story/internews-enlists-more-1000-journalists/story.aspx?quid=%7B343E344D-B598-4BD5-8904-73AD24163E7B%7D&dist=hppr>

## Journal Articles

### **An exploratory study of spiritual care at the end of life**

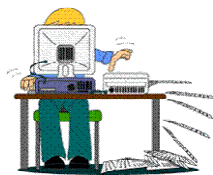
*ANNALS OF FAMILY MEDICINE*, 2008;6:406-411. Although spiritual care is an important element of end-of-life care, it is unclear how this care is viewed and delivered at the end of life. This study explores how health caregivers understand and view spiritual care for dying patients and their family members. Clinicians consider spiritual care at the end of life as a series of interpersonal processes, rather than a set of defined roles. These processes include being present with the patient, awareness by patient and clinician of one another's humanity and perspectives, and co-creation by patients, family members, and clinicians of a holistic care plan that maintains the patient's humanity and dignity in the face of death. These findings provide a conceptual framework for spiritual care at the end of life. Future research should focus on the appropriateness of this framework for enhancing spiritual care and the overall care of patients at the end of life. <http://www.annfammed.org/cgi/content/full/6/5/406>

- *International Journal of Palliative Nursing*, 2008;14(8):396-400. **"'Catching' the concept of spiritual care: Implementation of an education programme."** [http://www.internurse.com/cgi-bin/go.pl/library/article.cgi?uid=30777;article=IJPN\\_14\\_8%20\\_396\\_400](http://www.internurse.com/cgi-bin/go.pl/library/article.cgi?uid=30777;article=IJPN_14_8%20_396_400)

Recommended reading:

- *Palliat Support Care*, 2006;4(1):13-24. **'Collective soul: the spirituality of an interdisciplinary palliative care team.'** <http://www.ncbi.nlm.nih.gov/pubmed/16889320?dopt=Abstract>

### 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 workshops for frontline care providers.

### Was Something Missed or Overlooked?

If you come across a media report, journal article, etc., relevant to hospice palliative care or end-of-life issues not mentioned in this edition of Media Watch, please alert this office so that it can be included in a future issue of the weekly report. Thank you.

## **A model to guide physicians in assisting patients and family members who are facing complex decisions**

*ARCHIVES OF INTERNAL MEDICINE*, 2008;168(16):1733-1739. Over the last century, developments in new medical treatments have led to an exponential increase in longevity, but, as a consequence, patients may be left with chronic illness associated with long-term severe functional and cognitive disability. Patients and their families are often forced to make a difficult and complex choice between death and long-term debility, neither of which is an acceptable outcome. Traditional models of medical decision making, however, do not fully address how clinicians should best assist with these decisions. The authors present a new paradigm that demonstrates how the role of the physician changes over time in response to the curved relationship between the predictability of a patient's outcome and the chance of returning to an acceptable quality of life. To translate this model into clinical practice, we propose a 5-step model for physicians with which they can: (1) determine at which point the patient is on our model; (2) identify the cognitive factors and preferences for outcomes that affect the decision-making process of the patient and his or her family; (3) reflect on their own reaction to the decision at hand; (4) acknowledge how these factors can be addressed in conversation; and (5) guide the patient and his or her family in creating a plan of care. This model can help improve patient-physician communication and decision making so that complex and difficult decisions can be turned into ones that yield to medical expertise, good communication, and personal caring.  
<http://archinte.ama-assn.org/cgi/content/short/168/16/1733>

Of related interest:

- Medical Futility: 'Linda Emanuel on futility.' <http://medicalfutility.blogspot.com/2008/09/linda-emanuel-on-futility.html>

## **Using the experiences of bereaved caregivers to inform patient- and caregiver-centered advance care planning**

*JOURNAL OF GENERAL INTERNAL MEDICINE*, 2008;23(10):1602-1607. Traditional approaches to advance care planning (ACP) have many limitations. New approaches are being developed with the goal of improving end-of-life care, to understand how the end-of-life care experiences of older patients and their caregivers can inform the development of new approaches to ACP. In-depth interviews were conducted 6 months after the patient's death with 64 caregivers. Interviews began with open-ended questions to encourage the caregiver to tell the story of the patient's experiences at the end of life. Additional questions asked about how decisions were made: patient-caregiver, patient-clinician, and caregiver-clinician communication. Although the experiences recounted by caregivers were highly individual, several common themes emerged from the interviews. These included the following: 1) the lack of availability of treatment options for certain patients, prompting patients and caregivers to consider broader end-of-life issues; 2) changes in preferences at the very end of an illness; 3) variability in patient and caregiver desire for and readiness to hear information about the patient's illness; and, 4) difficulties with patient-caregiver communication. The experiences of older patients at the end of life and their caregivers support a form of ACP that includes a broader set of issues than treatment decision-making alone, recognizes the dynamic nature of preferences, and focuses on addressing barriers to patient-caregiver communication. **N.B.** Link unavailable.

### [Links](#)

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**Editorial by Charles F. Von Gunten**

## **Oncologists and end-of-life care**

*JOURNAL OF PALLIATIVE MEDICINE*, 2008;11(6):813. As I travel in United States and elsewhere in the world, a unifying refrain is that oncologists, as a group, are the most difficult to deal with in the provision of palliative care near the end of life. Yet, in a second breath, one hears about oncologists that are “fabulous” in this regard. It would appear there are two types of oncologists. Research reported in this month’s issue sheds light on why there might be two different “kinds” of oncologists as they relate to end-of-life care. Eighteen academic oncologists were asked to describe the most recent inpatient death on the medical oncology service in which they were involved. Qualitative analysis demonstrated they fell into two categories. Type I: Oncologists who viewed their role as encompassing both biomedical and psychosocial aspects of cancer care reported a clear method of communication about end-of-life care and an ability to positively influence patient and family coping with death. These physicians described communication as a process, made recommendations to the patient using an individualized approach, and viewed the provision of effective end-of-life care as professionally satisfying. In contrast, type II oncologists described primarily a biomedical role. They reported a more distant relationship with the patient, a sense of failure at not being able to alter the course of the disease, and an absence of collegial support. In their descriptions of communication encounters with patients and families, these Type II oncologists did not seem to feel they could influence patients’ coping and acceptance of death and made few recommendations about end-of-life treatment options. <http://www.liebertonline.com/doi/pdfplus/10.1089/jpm.2008.9888>

Featured in this issue of the *Journal of Palliative Care*:

- **'A qualitative study of oncologists' approaches to end-of-life care.'**  
<http://www.liebertonline.com/doi/pdfplus/10.1089/jpm.2007.2480>
- **'End-of-Life care in U.S. nursing homes: Nursing homes with special programs and trained staff for hospice or palliative/end-of-life care.'**  
<http://www.liebertonline.com/doi/pdfplus/10.1089/jpm.2007.0278>

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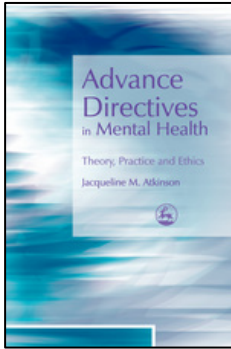
## **Books & Resources**

### **New tool helps pain advocacy community address growing public health crisis**

U.S. | PharmaLive.com – 9 September 2008 – Healthcare professionals and patient advocates working to alleviate suffering and improve the care of millions of Americans with undertreated pain now have a new resource to help them achieve greater awareness and understanding of this serious national health problem. In the Face of Pain® is a free interactive toolkit to create individualized action plans, educational materials, and presentations tailored to a specific area of focus. <http://www.pharmalive.com/News/index.cfm?articleid=569580&categoryid=22>

### **Quotable Quotes**

*If we do not care for families as they go through this difficult time (the dying and death of a loved one), then they may well become our patients later.* **Linda Kristjanson.** 'Comfort my father and you comfort me.' *Pain Management Newsletter*, 1997;10(5):1-3.



### **Advance Directives in Mental Health: Theory, Practice and Ethics**

U.K. | CommunityCare.co.uk – 8 September 2008 – This book examines the background and implementation of advance directives. Like living wills in healthcare, they allow service users to plan for the future. They enable people to decide what mental health treatments they would wish to receive, or not wish to receive, in the event of them becoming unwell and incapable of making those decisions. Atkinson, a professor of mental health policy at the University of Glasgow, has written an accessible guide that considers the legal, ethical and medical issues surrounding treatment in the event of future episodes of mental illness. Her book is intended as a comprehensive reference and differentiates between the different types of directives in use

in other countries, including advance statements and advance agreements. Readers in the U.K. may find too much emphasis on the different legal frameworks adopted in Australia, Canada and the U.S. <http://www.communitycare.co.uk/Articles/2008/09/08/109347/book-review-advance-directives-in-mental-health.html>

## **Worth Repeating**

### **Editorial**

#### **Patient centred death**



**Cover artwork for the BMJ  
'good death' issue**

*BRITISH MEDICAL JOURNAL*, 2003;327:174-175. We need better, more innovative research on patients' views on dying. A good death has always been important in all cultures. To achieve your chosen afterlife you died either well (*euthanatos*) or nobly (*kalosthanein*). But what is a good death in a world that for many is post-religious and medicalised? We know something from research on patients and their families – but not nearly enough. We need much better research that uses innovative and different methods. We don't have good data on how people die (as opposed to what they die of), but there is a strong impression that many die badly. People do not die in the places they wish or with the peace they desire. Probably too many die alone, in pain, terrified, mentally unaware, without dignity, or feeling alienated. People who are poor, from ethnic minorities, or marginalised may have even worse deaths. Modern dying involves a struggle for control. Some doctors fear failure when they cannot keep their patients living. Families, filled with grief and sometimes guilt, often have their own strong views on how and where patients should die. This can lead to struggles with doctors, who may see such assertions as an affront to their authority. The "needs" of the dying patient are defined and thus filtered through the views of family and healthcare professionals. So while debates about a good death are hardly new, what has largely been a professional and expert driven exercise now needs to incorporate patients' views. The authority over dying must now be invested in patients. Patients' concepts of a good death should guide our efforts to make deaths better. <http://www.bmj.com/cgi/content/full/327/7408/174>

**N.B.** The theme of the July 2003 issue of the *British Medical Journal* is "a good death." Contents page with links to articles and editorials: <http://www.bmj.com/content/vol327/issue7408/?etoc#PAPERS>

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