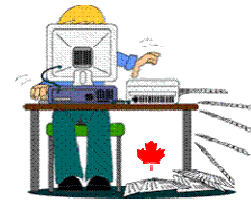


Media Watch...

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

Physician-patient communication: Scroll down to [U.S.A.](#) and 'Facing end-of-life talks, doctors choose to wait' published in the *New York Times* (p.2).

Canada

Hospice operating costs high

ONTARIO | *Observer* (Sarnia) – 12 January 2010 – The \$6-million capital campaign for the newly opened St. Joseph's Hospice residence was a success, but the fundraising isn't finished. Executive director Monica Robson told the Rotary Club of Sarnia ... the 10-bed hospital needs to raise \$750,000 to \$1 million each year to pay operating expenses not covered by the provincial government. Ontario is giving the hospice \$58,000 per bed annually toward nursing and personal support care, but the St. Joseph's board will have to go out to the community to come up with the rest. Board member Bob Murray said those additional costs work out to about \$3,000 a day so the hospice will soon be asking local businesses and groups to pledge that amount annually. Robson said tapping 300 of those donors will allow the hospice to raise what it needs. But, hospices across the province are also lobbying the province to increase its funding to 80% of operating costs. <http://www.theobserver.ca/ArticleDisplay.aspx?e=2256855>

Of related interest:

- BRITISH COLUMBIA | Canwest News Service – 12 January 2010 – **'Difficult choices have to be made to rein in health care costs.'** Fraser Health Authority's decision to cut funding to some "non-core" services, such as social work and psychological counseling, is a case in point. Among those cuts, perhaps the most dramatic is the decision to terminate 12 spiritual care directors (chaplains). <http://www.kelowna.com/2010/01/12/difficult-choices-have-to-be-made-to-rein-in-health-care-costs/>
- NEW BRUNSWICK | *Daily Gleaner* (OpEd) – 12 January 2010 – **'Long-term care: myths and realities.'** It is unrealistic to think that because the number of people in New Brunswick over the age of 65 is going to double over the next 20 years the response should be a massive increase in nursing home beds. <http://dailygleaner.canadaeast.com/opinion/article/917301>

Specialist Publications

Of particular interest:

'End of life care falls short for kidney disease patients.' Scroll down to p.5 for the findings of a University of Alberta study published in the *Clinical Journal of the American Society of Nephrology*.

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- *GLOBE & MAIL* | Online OpEd (Margaret Somerville) – 12 January 2010 – **'Finding meaning in dying.'** We have medicalized, depersonalized, dehumanized and technologized death – and, as a result, dying people suffer intense pre-mortem loneliness. We need to recognize and address that loneliness. Euthanasia is a medical technological response to suffering and death. But in a caring, ethical society, the answer to loneliness and abandonment is not a lethal injection. <http://www.theglobeandmail.com/news/opinions/finding-meaning-in-dying/article1428766/>

Corrections & Clarifications

In the supplement to the 11 January 2010 edition of Media Watch, 'Assisted (or Facilitated) Death: The Debate in Canada,' under the sub-head 'Advocacy Groups (representative sample)' on p.8, the link to the Right to Die Society of Canada should have read www.righttodie.ca.

U.S.A.

Hospice objects to MedPAC margin projections and reductions

NATIONAL HOSPICE & PALLIATIVE CARE ORGANIZATION | Press release – 14 January 2010 – The organisation urged the Medicare Payment Advisory Commission to adjust the community's 2010 projected profit margins from 4.6% to 2.6% in order to more accurately reflect hospice's unique, mandatory program costs of volunteer and bereavement services. The ... hospice benefit includes all care related to the terminal illness, as well as requires programs to provide up to 13 months of bereavement services to the families and loved ones of the beneficiary after he or she dies. In addition, the Medicare hospice benefit requires that trained volunteers provide at least 5% of the patient care hours. <http://www.nhpco.org/i4a/pages/index.cfm?pageid=6187>

Facing end-of-life talks, doctors choose to wait

NEW YORK TIMES | Online report – 11 January 2010 – It's a conversation that most people dread, doctors and patients alike. The cancer is terminal, time is short, and tough decisions loom – about accepting treatment or rejecting it, and choosing where and how to die. When is the right time ... to bring up these painful issues with someone who is terminally ill? Guidelines for doctors say the discussion should begin when a patient has a year or less to live. That way, patients and their families can plan whether they want to do everything possible to stay alive, or to avoid respirators, resuscitation, additional chemotherapy and the web of tubes, needles, pumps and other machines that often accompany death in the hospital. But many doctors, especially older ones and specialists, say they would postpone those conversations, according to a study published in the journal *Cancer*.¹ <http://www.nytimes.com/2010/01/12/health/12seco.html>

1. Scroll down to [Specialist Publications](#) for an abstract of **'Physician factors associated with discussions about end-of-life care'** (p.5) published online in *Cancer*.

Confusing what the public understands about coma recovery

Rude awaking

NEWSWEEK | Online report – 7 January 2010 – Late last year, the world was captivated by the story of Rom Houben, a Belgian man who suffered a traumatic brain injury and was misdiagnosed for 23 years as being in a vegetative state. In fact, media outlets reported breathlessly, Houben had been conscious the whole time, trapped inside his motionless body, until a heroic doctor used cutting-edge scans to find normal brain activity. It was a fantastic story that ruled the headlines for a few days, but unfortunately, it was only partly true, and the resulting media circus distorted the work of Houben's doctor, Steven Laureys. <http://www.newsweek.com/id/229784/page/1>

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- NEW HAMPSHIRE | Associated Press – 14 January 2010 – **'House defeats assisted suicide bill.'** New Hampshire's House defeated a bill that would have allowed the legalization of assisted suicide for terminally ill patients. <http://www.wcax.com/Global/story.asp?S=11821032>
- CONNECTICUT LAW TRIBUNE | Online report – 11 January 2010 – **'Aid in dying.'** Two doctors are asking a Connecticut court to rule that ... [the current law] does not necessarily prohibit "aid in dying ... a recognized term of medical art." <http://www.ctlawtribune.com/getarticle.aspx?ID=36017>
- MONTANA | *Billings Gazette* – 10 January 2010 – **'Doctors won't rush into assisted suicide.'** The [recent] court decision made Montana the third state where ... [physician-assisted suicide] is legal, but the state has no specific laws outlining guidelines for doctors like they do in Oregon and Washington. That will leave Montana doctors on their own to determine how to proceed if they choose to help a dying patient commit suicide. http://billingsgazette.com/news/state-and-regional/montana/article_950bf20a-fe1a-11de-8841-001cc4c002e0.html

International

Dying children suffer unnecessarily

AUSTRALIA | *The Age* – 18 January 2010 – Victorian children dying of cancer are suffering more than they should be and need better access to palliative care. After surveying parents of 94 children who died from cancer, John Heath and colleagues from the Royal Children's Hospital found that despite no realistic chance of a cure, 47% of children received therapies directed at their cancer during their last month. One-third of parents thought this treatment would relieve their child's suffering as much as possible, but many concluded it was not effective. Of the 47% who received this treatment, about a third experienced significant side effects. In an article published in the *Medical Journal of Australia*, Heath said although many children received treatment for their symptoms, in many cases it was inadequate ... he hoped new guidelines for pediatric palliative care ... would improve the care given to children. <http://www.theage.com.au/national/dying-children-suffer-unnecessarily-20100117-medg.html>

1. Scroll down to [Specialist Publications](#) for an abstract of **'Symptoms and suffering at the end of life in children with cancer'** (p.8), and a link to the journal article.

Natural burials increase in popularity as eco-conscious Baby Boomers grow old

U.K. | *Daily Telegraph* – 11 January 2010 – A Ministry of Justice document says more than 220 woodland cemeteries have been established around Britain in just 16 years. It claims they are increasingly seen as an alternative to cremation or burial in a churchyard because they are more environmentally friendly. The guide puts this down to the fact that the postwar Baby Boomer generation, who pioneered the "green" movement in the 1960s and 1970s, are now pensioners and having to decide on funeral plans for their parents or themselves. The government document observes: "Environmentally-friendly funeral provision is not only a logical extension of an environmentally-aware lifestyle, but also has broad appeal as an alternative to a conventional cemetery." <http://www.telegraph.co.uk/news/newstoppers/politics/6873997/Natural-burials-increase-in-popularity-as-eco-conscious-Baby-Boomers-grow-old.html>

- CANADA (ALBERTA) | *Calgary Sun* – 11 January 2010 – **'Calgary ponders eco gravesites.'** In a 10-year plan to be presented to a council committee ... the city suggests incorporating environmentally friendly interment areas at new cemeteries as the burial option is becoming more popular. <http://www.calgarysun.com/news/alberta/2010/01/11/12415836-sun.html>

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- AUSTRALIA | ABC News – 14 January 2010 – **'Test detects suicides...'** Euthanasia group Exit says a new autopsy test will see many euthanasia cases being recorded as suicides rather than natural deaths. <http://www.abc.net.au/news/stories/2010/01/14/2792176.htm?section=australia>
- SWITZERLAND | RT – 12 January 2010 – **'Swiss politicians ponder ban on assisted suicide.'** Recent proposals to restrict or even ban the practice of euthanasia have emerged in Switzerland, where doctors have been permitted to offer the option not only to Swiss residents but also foreigners. http://rt.com/Top_News/2010-01-12/euthanasia-switzerland-suicide-contraversy.html
- SWITZERLAND | World Radio Switzerland – 11 January 2010 – **'New twist in 'suicide tourism' debate.'** Right-wing politicians have found support in parliament for their argument that people from outside Zurich shouldn't be allowed to come to the canton to use the services of assisted suicide groups. <http://worldradio.ch/wrs/news/wrsnews/new-twist-in-suicide-tourism-debate.shtml?17440>

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

Compassion fatigue

What is it? Why does it matter? Recognizing the symptoms, acknowledging the impact, developing the tools to prevent compassion fatigue, and strengthen the professional already suffering from the effects

AMERICAN JOURNAL OF HOSPICE & PALLIATIVE MEDICINE | Online article – 14 January 2010 – Compassion fatigue (CF) is recognizable. It erodes the professional's ability to function at an optimum level. Depression, caregiver stress, secondary trauma, and post traumatic stress syndrome are very much a part of the daily landscape for today's professional. The costs are many: staff turnover, loss of self-worth, diminished productivity, poor morale, and more. We in the helping professions must acknowledge the syndrome and validate its impact on professional staff. Giving lip service to "staff support" is not enough. We must fully understand how CF comes about and how we can effectively support those suffering its debilitating consequences. <http://ajh.sagepub.com/cgi/content/abstract/1049909109354096v1>

Facilitating needs based cancer care for people with a chronic disease

BMC PALLIATIVE CARE | Online article – 11 January 2010 – Palliative care should be provided according to the individual needs of the patient, caregiver and family, so that the type and level of care provided, as well as the setting in which it is delivered, are dependent on the complexity and severity of individual needs, rather than prognosis or diagnosis. This paper presents a study designed to assess the feasibility and efficacy of an intervention to assist in the allocation of palliative care resources according to need, within the context a population of people with advanced cancer. <http://www.biomedcentral.com/content/pdf/1472-684x-9-2.pdf>

Of related interest:

- *AGE & AGEING*, 2010;39(1):86-91. **'Experiences of older adults in the community dying from cancer and non-cancer causes.'** Less than half of the decedents [in this study] were reported to have received treatment which completely relieved their symptoms some or all of the time. There were significant variations in the receipt of district nursing, general practitioner care and other health and social care, and the reported quality of this care, for decedents dying of cancer and non-cancer causes. <http://ageing.oxfordjournals.org/cgi/content/abstract/39/1/86>

Physician factors associated with discussions about end-of-life care

CANCER | Online article – 11 January 2010 – Most [respondents in this national survey of physicians ... about timing of discussions regarding prognosis] reported they would not discuss end-of-life options with terminally ill patients who are feeling well, instead waiting for symptoms or until there are no more treatments to offer. More research is needed to understand physicians' reasons for timing of discussions and how their propensity to aggressively treat metastatic disease influences timing, as well as how the timing of discussions influences patient and family experiences at the end of life. <http://www3.interscience.wiley.com/journal/123237834/abstract>

From Media Watch dated 30 November 2009:

- **JOURNAL OF CLINICAL ONCOLOGY** | Online article – 23 November 2009 – '**Paradoxes in advance care planning: The complex relationship of oncology patients, their physicians, and advance medical directives.**' Many seriously ill patients with cancer do not discuss prognosis or advance directives, which may lead to inappropriate and/or unwanted aggressive care at the end of life. <http://jco.ascopubs.org/cgi/content/abstract/JCO.2009.24.6397v1>

End-of-life care preferences and needs: Perceptions of patients with chronic kidney disease

CLINICAL JOURNAL OF THE AMERICAN SOCIETY NEPHROLOGY | Online article – 14 January 2010 – Despite high mortality rates, surprisingly little research has been done to study chronic kidney disease (CKD) patients' preferences for end-of-life care. The study evaluated end-of-life care preferences of patients to help identify gaps between current end-of-life care practice and patients' preferences and to help prioritize and guide future innovation in end-of-life care policy. Participants reported relying on the nephrology staff for extensive end-of-life care needs not currently systematically integrated into their renal care, e.g., pain and symptom management, advance care planning, and psychosocial and spiritual support. Participants also had poor self-reported knowledge of palliative care options and of their illness trajectory. A total of 61% of patients regretted their decision to start dialysis. More patients wanted to die at home (36.1%) or in an inpatient hospice (28.8%) compared with in a hospital (27.4%). Less than 10% of patients ... had a discussion about end-of-life care issues with their nephrologist in the past 12 months. <http://cjasn.asnjournals.org/cgi/content/abstract/CJN.05960809v1?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=1&title=End-of-life+care+preferences+and+needs&andorexactitle=and&andorexactitleabs=and&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&sortspec=relevance&resourcetype=HWCIT>

Quotable Quotes

I wanted a perfect ending. Now I've learned, the hard way, that some poems don't rhyme, and some stories don't have a clear beginning, middle, and end. Life is about not knowing, having to change, taking the moment and making the best of it, without knowing what's going to happen next. Delicious ambiguity.
Gilda Radner (1946-1989)

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/>

"It's not necessarily the distance on the map..."

Using place as an analytic tool to elucidate geographic issues central to rural palliative care

HEALTH & PLACE, 2010;16(2):284-290. Palliative care is intimately connected with place, yet little research has explored these relationships in depth, especially with respect to rural and remote settings. This paper uses multiple dimensions of the concept 'place' as an analytic tool to understand the nature of palliative care provision in a rural region of B.C., Canada. The authors draw upon primary data from formal and informal providers (n=31) to explore the social and physical place of rural palliative care. We unpack four highly geographic issues raised by participants, namely: 1) distance; 2) location; 3) aesthetics; and, 4) sites of care. This analysis reveals a rich and complex experience of rural care-giving long overlooked in palliative care research and policy. [http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6VH5-4XJP43C-1&_user=10&_coverDate=03%2F31%2F2010&_rdoc=14&_fmt=high&_orig=browse&_srch=doc-info\(%23toc%236057%232010%23999839997%231578601%23FLA%23display%23Volume\)&_cdi=6057&_sort=d&_docanchor=&_ct=32&_acct=C000050221&_version=1&_urlVersion=0&_userid=10&md5=5233042d64792e23a7eaba7215a9a7c2](http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6VH5-4XJP43C-1&_user=10&_coverDate=03%2F31%2F2010&_rdoc=14&_fmt=high&_orig=browse&_srch=doc-info(%23toc%236057%232010%23999839997%231578601%23FLA%23display%23Volume)&_cdi=6057&_sort=d&_docanchor=&_ct=32&_acct=C000050221&_version=1&_urlVersion=0&_userid=10&md5=5233042d64792e23a7eaba7215a9a7c2)

N.B. Several articles on the provision and delivery of palliative care in rural areas were listed in the 11 January 2010 edition of Media Watch (p.9).

Dementia patients receive less palliative care

IRISH MEDICAL NEWS | Online report – 12 January 2010 – Patients dying with dementia do not get equal access to palliative care compared to other patients, a new study shows. Researchers from the Department of Psychiatry in Beaumont Hospital, Dublin, found that individuals with a formal diagnosis of dementia appear to receive a different pattern of end-of-life care compared to those without formally established dementia when admitted to hospital. "Of note is that patients dying with dementia in a general hospital setting may have a relatively restricted level of access to palliative care and their caregivers are consulted less often about treatment decisions than those of non-dementia patients," the researchers stated. Retrospectively reviewing patients aged over 65 years who had died on acute medical wards within a six-month period in a general hospital in Dublin, they examined the quality of palliative care as benchmarked with the Liverpool Care Pathway for the Dying Patient programme. <http://www.imn.ie/index.php/current-issue/news/2884-dementia-patients-receive-less-palliative-care->

Of related interest

- *BMC GERIATRICS* | Online article – 12 January 2010 – '**Patient preferences for future care: How can advance care planning become embedded into dementia care.**' This study was designed to explore ... how advance care planning (ACP) can best be carried out in routine practice. It affords the opportunity to develop both a theoretical and practical understanding of an area which both patients and professionals may find emotionally challenging. The study will develop practical tools. <http://www.biomedcentral.com/content/pdf/1471-2318-10-2.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.

Teaching end-of-life issues: Survey of U.S. dental schools and dentists

JOURNAL OF DENTAL EDUCATION, 2010;74(1):43-49. The aim of this research endeavor was to survey the teaching of end-of-life issues in the curriculum of U.S. dental schools and to ascertain changes in education compared to a 1989 study of dental schools. In addition, the aim was to survey practicing dentists in South Carolina regarding end-of-life issues. Findings indicated that dental schools today are placing more emphasis on end-of-life issues than twenty years ago. <http://www.jdentaled.org/cgi/content/abstract/74/1/43>

From Media Watch ('Worth Repeating') dated 7 December 2009:

- *SPECIAL CARE IN DENTISTRY*, 2008;28(2):58-60. **'Death, dying and bereavement: a survey of dental practitioners.'** This study determined the prevalence of death within a dental practice and investigated methods by which dentists supported grieving survivors and ... received bereavement education in dental school. <http://www3.interscience.wiley.com/journal/119401608/abstract>

American College of Physicians Position Paper

Family caregivers, patients and physicians: Ethical guidance to optimize relationships

JOURNAL OF GENERAL INTERNAL MEDICINE | Online article – 9 January 2010 – Family caregivers play a major role in maximizing the health and quality of life of more than 30 million individuals [in the U.S.] with acute and chronic illness. Patients depend on family caregivers for assistance with daily activities, managing complex care, navigating the health care system, and communicating with health care professionals. Physical, emotional and financial stress may increase caregiver vulnerability to injury and illness. Geographically distant family caregivers and health professionals in the role of family caregivers may suffer additional burdens. Physician recognition of the value of the caregiver role may contribute to a positive caregiving experience and decrease rates of patient hospitalization and institutionalization. However, physicians may face ethical challenges in partnering with patients and family caregivers while preserving the primacy of the patient-physician relationship. The American College of Physicians ... offers ethical guidance to physicians in developing mutually supportive patient-physician-caregiver relationships. <http://www.springerlink.com/content/d7427r3717110213/?p=8937acb9410647a28dfb717b29a9c815&pi=0>

Results from the [U.S.] National Hospice Volunteer Training Survey

JOURNAL OF PALLIATIVE MEDICINE | Online article 18 January 2010 – Although the role of volunteers is at the heart of hospice care, little is known about hospice volunteer training and volunteer activity. A survey was used to assess current training programs for hospice volunteers. Results revealed that the majority of volunteer work is in patient care, with most hospice agencies requiring a minimum 12-month volunteer commitment and an average 4-hour volunteer shift per week. Volunteer training is separate from staff training, is provided by paid agency staff. Communication and family support are considered important curriculum topics. Revisions to current volunteer training curriculum and format are suggested. <http://www.liebertonline.com/doi/abs/10.1089/jpm.2009.0240>

Is survival better at hospitals with higher "end-of-life" treatment intensity?

MEDICAL CARE | Online article – 6 January 2010 – Concern regarding wide variations in spending and intensive care unit use for patients at the end of life hinges on the assumption that such treatment offers little or no survival benefit. The authors explored the relationship between hospital "end-of-life" (EOL) treatment intensity and post-admission survival. Results of their research indicate that admission to higher EOL treatment intensity hospitals is associated with small gains in post-admission survival. http://journals.lww.com/lww-medicalcare/Abstract/publishahead/Is_Survival_Better_at_Hospitals_With_Higher.99834.aspx

Australian perspective

Symptoms and suffering at the end of life in children with cancer

MEDICAL JOURNAL OF AUSTRALIA, 2010;192(2):71-75. The authors examined the symptoms, level of suffering and care of Australian children with cancer at the end of life. Eighty-four per cent of parents [i.e., survey participants] reported their child had suffered "a lot" or "a great deal" from at least one symptom in their last month of life – most commonly pain (46%), fatigue (43%) and poor appetite (30%). Children who received cancer-directed therapy during the end-of-life period (47%) suffered from a greater number of symptoms than those who did not receive treatment, but the severity of symptoms did not differ between these groups. Of the children treated for specific symptoms, treatment was successful in 47% of those with pain, 18% of those with fatigue and 17% of those with poor appetite. Of the 61 families who felt they had time to plan where their child would die, 89% preferred to have their child die at home. The majority of children (61%) died at home. Of those who died in hospital, less than a quarter died in the intensive care unit. Relatively high rates of death at home and low rates of unsuccessful medical interventions suggest a realistic approach at the end of life for Australian children dying of cancer. However, many suffer from unresolved symptoms, and greater attention should be paid to palliative care for these children. http://www.mja.com.au/public/issues/192_02_180110/hea10080_fm.html

Intractable end-of-life suffering and the ethics of palliative sedation

PAIN MEDICINE | Online article – 15 January 2010 – Palliative sedation ... as an option of last resort for intractable end-of-life distress has been the subject of ongoing discussion and debate as well as policy formulation. A particularly contentious issue has been whether some dying patients experience a form of intractable suffering not marked by physical symptoms that can reasonably be characterized as "existential" in nature and therefore not an acceptable indication for palliative sedation. Such is the position recently taken by the American Medical Association.¹ In this essay the authors argue that such a stance reflects a fundamental misunderstanding of the nature of human suffering, particularly at the end of life, and may deprive some dying patients of an effective means of relieving their intractable terminal distress. <http://www3.interscience.wiley.com/journal/123243207/abstract>

1. *AMEDNEWS* | Online report – 7 July 2008 – '**American Medical Association OKs palliative sedation for terminally ill.**' The seldom-used technique is deemed ethical because the aim is to relieve intractable symptoms, not hasten death. <http://www.ama-assn.org/amednews/2008/07/07/prsi0707.htm>

From Media Watch dated 11 January 2010:

- *JOURNAL OF MEDICINE & PHILOSOPHY* | Online article – 6 January 2010 – '**Disambiguating clinical intentions: The ethics of palliative sedation.**' It is often claimed that the intentions of physicians are multiple, ambiguous, and uncertain – at least with respect to end-of-life care. This claim provides support for the conclusion that the principle of double effect is of little or no value as a guide to end-of-life pain management. This paper argues proponents of the claim fail to distinguish two different senses of "intention" and, as a result, they are led to exaggerate the extent to which clinical intentions in end-of-life contexts are ambiguous and uncertain. <http://jmp.oxfordjournals.org/cgi/content/abstract/jhp056v1?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=1&andorexacttitle=and&titleabstract=Disambiguating+Clinical+Intentions%3A+The+Ethics+of+Palliative+Sedation.&andorexacttitleabs=and&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&sortspec=relevance&resourceType=HWCIT>
- CENTER TO ADVANCE PALLIATIVE CARE | Online press release – 6 January 2010 – '**Palliative sedation: Myth vs. fact.**' The belief that symptom management hastens death in the dying is a classic example of confusing an association with causation. <http://www.capc.org/news-and-events/releases/01-06-10>

Worth Repeating

Hospice social workers' perspectives

Redefining hope for the terminally ill

AMERICAN JOURNAL OF HOSPICE & PALLIATIVE MEDICINE, 2002;19(2):115-120. Hospice social workers assist patients and families in finding new hope and meaning in their lives as care goals turn from cure to comfort. Assessment factors important to the redefinition process and intervention strategies are explored. Hope is defined as the positive expectation for meaning attached to life events with the emphasis on meaning instead of life events. The author seeks to demonstrate the importance of meaning to the feeling of hope and the possibility of socially constructing meaning to alleviate the traditional medical perspective that hope revolves around the outcome of disease. <http://ajh.sagepub.com/cgi/content/abstract/19/2/115>

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.

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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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