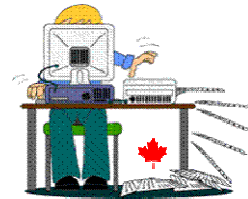


Media Watch...

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, 2011 ©

Compiled & Annotated by Barry R. Ashpole

Ethics of end-of-life care: Scroll down to [Specialist Publications](#) and 'The need for improved communication among physicians, patients, and families' (p.7), published in *Ethics in Biology Engineering & Medicine*

Canada

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- **TORONTO STAR** | Online article – 5 August 2011 – **'In right-to-die case, new issues drive an old debate.'** Margaret Somerville, a medical ethics and law professor at McGill University, said the pro-euthanasia side has always rallied behind people who like [Sue] Rodriguez are in obvious distress and can articulately emphasize that individuals should have the right to choose how they die. "When you use that scenario, the case for euthanasia is at its most persuasive, some poor person knows exactly what they want and you think, 'I never want to be in a situation where I can't make my own choice.' But I tell people to think about not how you will die, but in 50 years time, how will your grandchildren die if we legalize this?" said Somerville. "What we have seen in places that have a history of euthanasia is the parameters have expanded and it becomes an easy way to dispose of medically expensive people." <http://www.thestar.com/news/canada/article/1035283--in-right-to-die-case-new-issues-drive-an-old-debate>
- **GLOBE & MAIL** | Online report – 4 August 2011 – **'Euthanasia issue won't be reopened, Justice Minister Rob Nicholson says.'** Canada's Justice Minister says the Conservative government won't be revisiting the question of assisted suicide despite a B.C. Supreme Court ruling to expedite a case on the matter. But following an unrelated roundtable meeting with community leaders, Mr. Nicholson told reporters that Parliament has passed judgment on the issue of euthanasia, and won't soon return to the matter. He was referring to the defeat of a bill on euthanasia and assisted suicide introduced by veteran *Bloc Québécois* MP Francine Lalonde, but defeated 228 to 59 in May 2010. <http://www.theglobeandmail.com/news/national/british-columbia/bc-politics/euthanasia-issue-wont-be-reopened-justice-minister-rob-nicholson-says/article2120252/>
- **BRITISH COLUMBIA** | *Vancouver Sun* – 2 August 2011 – **'Right-to-die group begins court challenge of law prohibiting assisted suicide.'** The Farewell Foundation for the Right to Die has filed a constitutional challenge to Canada's law, which was first introduced in the 1800s. Section 241(b) of Canada's Criminal Code makes it an offence to help in a suicide, punishable by a term of up to 14 years in prison. But first, the New Westminster-based group has to convince a judge that it has the jurisdiction to launch the legal challenge. The Attorney General of B.C. and the Attorney General of Canada are opposing the court challenge, arguing the group is not legally constituted so there is no appropriate plaintiff. <http://www.vancouversun.com/news/Right+group+begins+court+challenge+prohibiting+assisted+suicide/5194112/story.html>

U.S.A.

Nurse midwives moving into hospice care

COLORADO | *Daily Camera* – 7 August 2011 – Death and birth: They seem like opposites. Yet [Teresa] Robertson ... says it was seamless to leave her lifelong career as a midwife to become a hospice nurse. Many consider themselves bridges between life and death, whichever way you are walking across the bridge. Because when it comes down to it, as they explain, the transitions of birth and death bring up the same concerns and needs: education, misconceptions, fears, changes in family dynamics, uncertainties, hope, faith, planning, rituals and the loss of control. And, while the popularity of home births continues to grow, so is the choice of home deaths – and even home funerals and burials, although this latter movement remains relatively rare. Both home-based options have battled legal hurdles, societal stigmas and safety concerns. http://www.dailycamera.com/health-fitness/ci_18623805

Hospice voted as having biggest impact on health care in 35 years

VIRGINIA | *Richmond Register* – 7 August 2011 – A little more than 30 years ago, small groups of nurses and other volunteers across the country began a grassroots movement of taking their care to the homes of the terminally ill, focusing on the patients' comfort and happiness. Now that system of care, known as hospice, has been named as the innovation having the biggest impact on health care in the last 35 years.¹ <http://richmondregister.com/localnews/x850292422/Hospice-voted-as-having-biggest-impact-on-health-care-in-35-years>

1. 'The big impact tournament: Hospice wins,' 25 July 2011, *Modern Healthcare Magazine*. <http://www.modernhealthcare.com/article/20110725/SUPPLEMENT/110729979>

Rural communities enhanced palliative care services

MINNESOTA | *StratisHealth* – 3 August 2011 – Ten rural communities in Minnesota have made advances toward establishing or strengthening palliative care services, through the Minnesota Rural Palliative Care Initiative, an 18-month learning collaborative. The initiative required interdisciplinary community-based teams that spanned multiple health care settings. This experience should strengthen the communities' ability to work together in the future to further transform care delivery. <http://www.stratishealth.org/news/20110803.html>

Hospice of Holland introduces 'Still Me' dementia program

MICHIGAN | *Holland Sentinel* – 2 August 2011 – Hospice of Holland [has] launched a new specialized end-of-life care program ... called 'Still Me' for patients with advanced dementia. Through the program staff will assess pain, provide positive stimulation for the senses and customized care for patients with dementia. The program also offers educational opportunities to the clinical community on solutions they can use to help ease the mind, address behaviors and treat patient symptoms. <http://www.hollandsentinel.com/newsnow/x643161849/Hospice-of-Holland-introduces-Still-Me-dementia-program>

[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/pg/file/world/world/>

Hospices in Florida: From cause to commerce

FLORIDA TREND | Online article – 1 August 2011 – In the 1970s, hospices began to grow in the U.S. as a grassroots effort by those who believed that terminally ill people should be able to die with dignity. Advocates set up non-profit organizations called hospices on shoestring budgets to care for the emotional, social and spiritual needs of dying people and their families. The programs relied almost entirely on charitable contributions and volunteers. Florida became the first state to set standards for care, enacting a hospice licensure law in 1978. In 1983, the federal government validated the approach when Congress approved Medicare reimbursement for hospice services aimed at cancer patients, then expanded coverage to other terminal illnesses. Medicare reimbursement also began transforming hospice from righteous cause to a multibillion-dollar industry. Once Medicare began paying, demand for hospice services surged. In 2008 alone, Florida hospices provided care to nearly 100,000 Medicare recipients with terminal illnesses at an estimated cost of \$1.2 billion, far more than any other state in the nation. Providers of hospice services grew to meet the demand. Many non-profits got bigger, but the Medicare reimbursement system was generous enough to attract for-profit providers, too. Recent growth has been noticeably uneven. Between 2000 and 2007, the number of non-profit hospices nationally has remained at around 1,200, while the number of for-profit hospices more than doubled, from 725 to 1,660. Just as it spurred the expansion of the industry, the Medicare reimbursement system continues to shape its evolution and the tension that has emerged between the for-profits and

non-profits. Non-profit executives, for example, rejoice at the overall acceptance of hospice while lamenting what they see as the loss of a sense of mission implicit in the emergence of so many for-profit providers. <http://www.floridatrend.com/article.asp?aID=55369&mostread=true>

N.B. Several articles on trends in for-profit hospices in the U.S. are noted in Media Watch dated 1 August 2011 (p.5).

End of life: End the taboo on cost of death

FLORIDA TIMES-UNION | Online OpEd – 30 July 2011 – You have terminal cancer. Your doctor says a new drug can extend your life by four months. It costs \$120,000. Who pays for it? You? Your children? Luckily for you, that's a question you don't have to answer. The taxpayers pay for it, no questions asked. Like much in America's cockeyed health care system, price is not a factor once the federal government approves a drug. The particular drug is not the issue, though several drugs have been approved that fit this description. As a spokesman for Medicare wrote in an email, "We are not legally prohibited from considering cost in making a coverage decision; we just by policy never had and don't intend to." Should they? Retired physician Glenn Pohlman wrote in an email about a new drug for treating melanoma that is expected to cost \$1 billion to Medicare per year. "When will we come to our senses, spend our health care dollars where they do the most good and accept the reality of futile therapies?" Pohlman wrote. "I doubt that any individual presented with the cost, assuming no insurance or federal funds are available, plus facing the side effects, would choose treatment." <http://jacksonville.com/opinion/editorials/2011-07-30/story/end-life-end-taboo-cost-death>

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- MASSACHUSETTS | *Boston Globe* – 4 August 2011 – '**Drive begins to put assisted suicide law on ballot next year.**' Voters may be asked to determine the fate of a proposal permitting dying patients to take life-ending drugs, a wrenching issue that backers say is a matter of dignity for the terminally ill, but that opponents have warned is fraught with the potential for error. Backers of assisted suicide for certain terminally ill patients filed paperwork ... with Attorney General Martha Coakley to begin the process of bringing their plan, dubbed the Death With Dignity Act, to the 2012 ballot. http://www.boston.com/news/local/massachusetts/articles/2011/08/04/assisted_suicide_issue_may_go_to_voters/

International

Improving Taiwan's end-of-life care

TAIWAN TODAY | Online article – 7 August 2011 – A Taiwanese anesthetist [and] a terminal cancer patient, had a party to bid farewell to her family and friends. News on this "living funeral" and the participants' openness to death amazed readers in a society where talk of death is customarily avoided. The tendency to shun such communication has also hampered the advancement of end-of-life measures including palliative care, life support withdrawal and do-not-resuscitate orders. In the face of this cultural taboo, hospice care began to develop in Taiwan thanks to the efforts of a group of medical professionals dedicated to ensuring that terminally ill patients get the best care possible, without overtreatment. <http://www.taiwantoday.tw/ct.asp?xItem=173667&ctNode=1767>



This documentary project, presented by the Singapore-based Lien Foundation, includes a series of short films themed around pain control and end of life issues. The production team filmed in 11 countries including India, Uganda, Singapore, Canada, China, the U.S., South Africa, Australia, Georgia, Ireland and Hong Kong, exploring a diverse range of cultural perspectives on pain, death and dying. <http://www.lifebeforedeath.com/movie/short-films.shtml>

N.B. The Lien Foundation commissioned *The Quality of Death: Ranking End-of-life-Care Across the World*, published by the Economist Intelligence Unit in July 2010. http://graphics.eiu.com/upload/QOD_main_final_edition_Jul12_toprint.pdf

Children and the law

Medical consent

IRELAND | *Irish Times* – 3 August 2011 – The balance between protecting children and allowing them a voice in their own affairs is a difficult one. There are few areas where this tension is more acute than in relation to medical treatment and information, including contraceptive advice and highly invasive but potentially life-saving treatments. In a recent report on these issues,¹ the Law Reform Commission [of Ireland] reiterated that those aged 16 and 17 should be allowed to consent to or decline healthcare and treatment, and be entitled to medical confidentiality on the same basis as those over 18. Children under 16 should have their views taken into account when obtaining medical treatment but, in general, they would not be considered capable of giving or withholding consent. However, the commission did envisage exceptional circumstances where children under the age of 16 may have the maturity to give such consent and be guaranteed confidentiality. <http://www.irishtimes.com/newspaper/opinion/2011/0803/1224301767204.html>

1. 'Law Reform Commission publishes report on children and the law: Medical treatment,' Law Reform Commission, July 2011. <http://www.lawreform.ie/news/law-reform-commission-publishes-report-on-children-and-the-law-medical-treatment.348.html>

From Media Watch dated 10 November 2008:

- CANADIAN PAEDIATRIC SOCIETY | Press release – 5 November 2008 – **'Provinces should recognize the wishes of children and youth with life-threatening illnesses, advise paediatricians.'** Most jurisdictions in Canada do not have legislation that recognizes the formal wishes for care made by parents and minors who are very sick or dying. There are no laws requiring third parties, such schools and emergency services, to respect them. The Canadian Paediatric Society is calling on the provinces and territories to legally recognize advance care directives.¹ <http://www.cps.ca/english/Media/NewsReleases/2008/LifeThreateningIllnesses.htm>

1. 'Advance care planning for paediatric patients,' Canadian Paediatric Society, November 2008. <http://www.cps.ca/english/statements/B/B08-02.pdf>

New report compares people's preferences for where they die with actual place of death

U.K. | National End of Life Care Intelligence Network – 2 August 2011 – A new report compares people's preferences for place of death with actual place of death as recorded by Office for National Statistics mortality data. A population based telephone survey was used to explore people's preferences. <http://www.endoflifecare-intelligence.org.uk/news/default.aspx>

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- ITALY | News 24 (Southern Africa) – 4 August 2011 – **'Dying Italian stirs euthanasia debate.'** A dying Jehovah's Witness in Italy has won the legal right not to receive treatment, sparking a heated debate on Thursday between supporters and opponents of euthanasia in this predominantly Catholic country. "I don't want my life to be prolonged if doctors are reasonably convinced that my case is hopeless," Clarice Di Tullio, 48, had told the court. Judges respected her wish in a ruling earlier this week. Prime Minister Silvio Berlusconi's centre-right government, which is attempting to pass a bill in parliament that would outlaw these types of end-of-life decisions, reacted angrily to the Di Tullio ruling. <http://www.news24.com/World/News/Dying-Italian-stirs-euthanasia-debate-20110804>
- U.K. | *Daily Mail* – 4 August 2011 – **'GP 'gave overdose of diamorphine to speed up death of terminally-ill cancer patient.'** A 'tired and stressed' family doctor deliberately hastened the death of a terminally ill man by giving him an overdose of painkillers, a tribunal heard. William Bassett gave a lethal injection of diamorphine after his 65-year-old patient, who had lung cancer, became distressed. The hearing was told that in his notes the GP said the drugs were a 'large dose but he is dying and I would like him to die in peace.' <http://www.dailymail.co.uk/news/article-2022026/GP-gave-overdose-diamorphine-speed-death-terminally-ill-cancer-patient.html?ito=feeds-newsxml>
- U.K. | *Guardian* – 3 August 2011 – **'Assisted dying poll shows support for change in law.'** A survey [of more than 2,000 people] shows three in four people think terminally ill adults should have access to medical help to die, but only one in three think people with physical disabilities should have same right. <http://www.guardian.co.uk/society/2011/aug/02/assisted-dying-support-law-change>

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?mediawatch=1>

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/pg/file/world/world/>

International Palliative Care Resource Center: <http://www.ipcrc.net/archive-global-palliative-care-news.php>

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

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

Lung cancer physicians' referral practices for palliative care consultation

ANNALS OF ONCOLOGY | Online article – 29 July 2011 – The authors surveyed physicians to identify factors influencing their decisions for referral to palliative care. Although palliative care consultation is increasingly available and recommended throughout the trajectory of lung cancer, their data indicate it is underutilized. Understanding factors influencing decisions to refer can be used to improve integration of palliative care as part of lung cancer management.

<http://annonc.oxfordjournals.org/content/early/2011/07/29/annonc.mdr345.abstract>

Palliative care in Africa since 2005: Good progress, but much further to go

BMJ SUPPORTIVE & PALLIATIVE CARE | Online article – 6 July 2011 – There has been rapid progress in palliative care in Africa since the World Health Assembly in 2005, which identified palliative care as an urgent humanitarian need. Palliative care is now recognised as a basic human right, and momentum has gathered to translate this into action. From being significantly present in only five countries in 2004, palliative care is now delivered in nearly 50% of African countries. Even so, still less than 5% of people in need currently receive it, and with an estimated 300% increase in the need for palliative care for people with non-communicable diseases over the next 20 years, and with those living with HIV needing more prolonged support, the demand for palliative care will continue to outpace supply. African countries adopting a public health approach and networking together through palliative care associations are beginning to embed and integrate palliative care into health systems and communities. Current challenges are to increase coverage while maintaining quality, to develop dynamic and flexible responses to the changing illness patterns in Africa, and to counter false beliefs. Resourcefulness and harnessing new technologies such as mobile phones while respecting cultural traditions, may be the way forward. <http://spcare.bmj.com/content/early/2011/08/06/bmjspcare-2011-000057.abstract>

More dead than dead: Perceptions of persons in the persistent vegetative state

COGNITION | Online article – 27 July 2011 – Patients in persistent vegetative state (PVS) may be biologically alive, but these experiments indicate that people see PVS as a state curiously more dead than dead. Experiment 1 found that PVS patients were perceived to have less mental capacity than the dead. Experiment 2 explained this effect as an outgrowth of afterlife beliefs, and the tendency to focus on the bodies of PVS patients at the expense of their minds. Experiment 3 found that PVS is also perceived as "worse" than death: people deem early death better than being in PVS. These studies suggest that people perceive the minds of PVS patients as less valuable than those of the dead – ironically, this effect is especially robust for those high in religiosity. <http://www.sciencedirect.com/science/article/pii/S0010027711001752>

Imagining the future in complicated grief

DEPRESSION & ANXIETY, 2011;28(8):658-665. Complicated Grief (CG) is a chronic and debilitating consequence of bereavement. Although sharing features with depression and anxiety, CG is associated with independent negative health outcomes. Despite these significant health costs, relatively little is known about the cognitive mechanisms that contribute to the maintenance of CG. The ability to envisage the future is important for adaptive functioning. [Study] participants were less specific in their imagining of future positive events and were more likely to imagine future events relating to their loss. The extent to which individuals were able to imagine a specific future event was significantly correlated with recalling specific memories. The tendency to imagine loss-related events in the future was associated with holding grief-related goals.

<http://onlinelibrary.wiley.com/doi/10.1002/da.20866/abstract>

Ethics of end-of-life care

The need for improved communication among physicians, patients, and families

ETHICS IN BIOLOGY ENGINEERING & MEDICINE, 2011;2(1):45-69. Modern medicine and public health initiatives in the U.S. have produced positive widespread changes in the health and longevity of its citizens. However, for many patients, these advancements have resulted in a longer but decreased quality of life. Other important effects include increased emotional burden on the family and higher financial costs on the healthcare system. Important ethical questions of futility and of patient autonomy have been brought to the forefront of end-of-life care. These questions have sparked a widespread debate as to when life-support treatments should be performed. Previous research has shown that even with increasing demands of patient autonomy, informed consent, and communication among physician, patient, and family, communication was limited or sometimes occurred only in an emergency. The authors provide a background on the ethical principles of beneficence and non-maleficence, discuss death and dying, and present a concise history of cardiopulmonary resuscitation (CPR) and do-not-resuscitate (DNR) orders. Furthermore, they identify the key communication gaps between physicians and patients/surrogates with respect to end-of-life care and decision making, and they also provide suggestions

for ways in which these gaps can be reduced. The communication gaps among physicians, patients, and/or surrogates with respect to advanced directives (ADs), DNR orders, and end-of-life care need to be minimized with appropriate, realistic goals, detailed treatment planning, minimal medical paternalism, and communication that involves the least amount of vague or ambiguous language. By clarifying decisions on end-of-life care, resources can be better managed, resulting in decreased pain and suffering of the patient and family.

http://dl.begellhouse.com/journals/6ed509641f7324e6_4d295d873f8fa6d9_6d2372d124060ce5.html

Patient-oriented cancer information on the Internet: A comparison of Wikipedia and a professionally maintained database

JOURNAL OF ONCOLOGY PRACTICE | Online article – 4 August 2011 – Because of a lack of formal editorial control, the authors hypothesized that the content of Wikipedia [which can be freely edited] would be less complete and accurate than that of a peer-reviewed web site. Although the Wikipedia resource had similar accuracy and depth as the professionally edited database, it was significantly less readable.

<http://jop.ascopubs.org/site/er/JOP000209.pdf>

Of related interest:

- *CONGESTIVE HEART FAILURE* | Online article – 1 August 2011 – **'Ethics in the treatment of advanced heart failure: Palliative care and end-of-life issues.'** Planning for adverse events and the end of life, formulated as "preparedness planning," can be integrated into HF [heart failure] care early in illness. Discussions that acknowledge the uncertainty of HF course and length of life and incorporate patient and family goals and values facilitates this planning. Clear processes for weighing potential benefits and burdens of interventions and therapies should accompany decision-making. <http://onlinelibrary.wiley.com/doi/10.1111/j.1751-7133.2011.00245.x/abstract>
- *JOURNAL OF MEDICAL ETHICS* | Online article – 2 August 2011 – **'Death and legal fictions.'** The authors argue that the current approach to determining death consists of two different types of unacknowledged legal fictions ... developed for practices that are largely ethically legitimate but need to be reconciled with the law. The considerable debate over the determination of death in the medical and scientific literature has not informed the public that vital organs are being procured from still-living donors and it seems unlikely that this information can remain hidden for long. <http://jme.bmj.com/content/early/2011/08/02/jme.2011.045385.abstract>

Does palliative care have a future in the emergency department?

JOURNAL OF PAIN & SYMPTOM MANAGEMENT | Online article – 30 July 2011 – Providers [i.e., study participants] acknowledged many benefits of palliative care presence in the ED [emergency department], including provision of a specialized skill set, time to discuss goals of care, and an opportunity to intervene for seriously ill or injured patients. Providers believed that concerns about medico-legal issues impaired their ability to forgo treatments where risks outweigh benefits. Additionally, the culture of emergency medicine ... was sometimes at odds with the culture of palliative care, which balances quality of life with the burdens of invasive treatments. Some providers also felt it was the primary physician's responsibility, and not their own, to address goals of care. Finally, some providers expressed concern that palliative care consultation was only available on weekdays during daytime hours. Automatic consultation based on predetermined criteria was suggested as a way to avoid conflicts with patients and family. <http://www.sciencedirect.com/science/article/pii/S0885392411002727>

From Media Watch dated 25 July 2011:

- *JOURNAL OF PALLIATIVE MEDICINE* | Online article – 18 July 2011 – '**The palliative care model for emergency department patients with advanced illness.**' Although some data on pilot programs are available, optimal models of delivery of emergency department-based palliative care have not been rigorously studied. <http://www.liebertonline.com/doi/abs/10.1089/jpm.2011.0011>

A brief guided self-help intervention for psychological distress in palliative care patients

PALLIATIVE MEDICINE | Online article – 1 August 2011 – Previous findings implicated rumination (recurrent dwelling on abstract concerns) in elevated psychological distress in palliative patients. The findings [of this randomized controlled trial] suggest that a brief guided self-help intervention based on concreteness training can be effective in addressing anxiety in palliative care. <http://pmj.sagepub.com/content/early/2011/07/31/0269216311414757.abstract>

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.

Assisted (or facilitated) death

Representative sample of recent articles, etc:

- *NURSING TIMES* (U.K.) | Online report – 27 July 2011 – '**Life support woman allowed to die.**' The High Court has given a health trust permission to lawfully withdraw life-sustaining treatment from a woman in a permanent vegetative state. Mr. Justice Charles, sitting at the Court of Protection in London [England], ruled that stopping artificial nutrition and hydration would be in the best interests of the 54-year-old mother of four.
<http://www.nursingtimes.net/nursing-practice/clinical-specialisms/critical-care/life-support-woman-allowed-to-die/5033123.article>

Worth Repeating

Lesson in life and death: Pupils build dying teacher's coffin

AUSTRALIA | TheAge.com.au – 14 February 2007 – A Dutch primary school teacher dying of cancer is overseeing one last class project: her pupils are making her coffin. Eri van den Biggelaar has just a few weeks to live after being diagnosed last year with an aggressive form of cervical cancer. She asked the woodwork teacher, a friend, to build a coffin for her. "Why don't you let the children make it?" replied Erik van Dijk. Now pupils of the school in Someren ... have been helping with the finishing touches. They have already sawed more than 100 narrow boards and glued them together. Only the lid needs to be completed. The coffin now stands in the middle of one of the classrooms. Although Miss van den Biggelaar can no longer teach, she has looked at sketches of the coffin and is being kept up to date about it by pupils, aged between four and 11, who visit her at home. "Life and death belong together," she said. "The children realised that when I explained it to them. I didn't want to be morbid about it; I wanted them to help me. I told them: 'Where I will go is much nicer than this world.' "None of the children considered it creepy or was afraid and nobody felt traumatised, she said. Parents of the children involved all gave their consent. <http://www.theage.com.au/news/world/lesson-in-life-and-death-pupils-build-dying-teachers-coffin/2007/02/13/1171128974213.html>



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. Biosketch on the International Palliative Care Resource Center website at: <http://www.ipcrc.net/barry-r-ashpole.php>

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