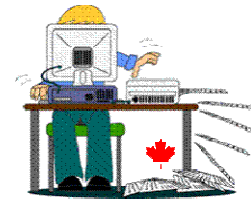


Media Watch...

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.

7 September Edition | Issue #113



Compilation of Media Watch 2008, 2009 ©

Compiled & Annotated by Barry R. Ashpole

New thinking, new data and new arguments about issues surrounding the end of life:
Scroll down to [Specialist Publications](#) and 'New perspectives on the end of life.'

Canada

Funding freeze lift gives hope for hospice

B.C. | *Westerly News* – 3 September 2009 – The local hospice society says it's hopeful it will receive the money it needs to operate after the provincial government lifted a funding freeze on millions of dollars in voluntary sector funding last week. The Pacific Rim Hospice Society gets two-thirds of its annual budget (about \$44,000) from the province's community gaming grants. The society's director has said the hospice faces closure if it doesn't receive the grant. <http://www.canada.com/Funding+freeze+lift+gives+hope+hospice/1957849/story.html>

Legal euthanasia supported in Britain, Canada [and the U.S.]

ANGUS REID GLOBAL MONITOR | Online report – 4 September 2009 – Many Britons and Canadians support legalizing euthanasia in their countries, according to a poll by Angus Reid Strategies. 75% of respondents in Britain, and 71% in Canada, generally agree with this notion. In the U.S., 45% of respondents support legalizing euthanasia, 32% are opposed, and 23% are undecided. http://www.angus-reid.com/polls/view/34149/legal_euthanasia_supported_in_britain_canada/

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- ALBERTA | *Ottawa Sun* – 5 September 2009 – '**Archbishop rallies against assisted suicide legislation.**' Local Catholics are inundating their MPs with e-mails and letters opposing a proposal to legalize assisted suicide and euthanasia. The campaign was launched by Archbishop Richard Smith, who warned parishioners that Bill C-384 is "morally unacceptable and unworthy of our country." <http://www.ottawasun.com/news/canada/2009/09/05/10759641-sun.html>

U.S.A.

Funeral home uses special dog to help grieving cope with loss

OHIO (CLEVELAND) | *Sun News* – 6 September 2009 – Bringing trained dogs to comfort people to nursing homes and hospitals is a well-accepted practice. So, Ross DeJohn, Jr., reasoned, why not bring such a dog to a funeral home? About a year ago, DeJohn, owner of the DeJohn, Flynn-Mylott Funeral Home ... did just that, and the results have been soothing to many a bereaved client. http://blog.cleveland.com/sunmessenger/2009/09/south_euclid_funeral_home_uses.html

Continuity of care

In medicine, the perils of the 'handoff'

NEW YORK TIMES | Online article – 3 September 2009 – In a track and field relay, the fastest athletes in the world will still lose if they fumble the handoff of the baton. The same is true in medicine. The best medical care in the world won't help you if doctors and nurses don't get the "handoff" right. The handoff is the time health care workers change shifts and the care of a patient is handed to a new set of doctors and nurses. The handoff is said to be among the most risky and error-prone times for a patient, a time when information isn't communicated or heard, when medication allergies aren't reported and when vital insights into patient care aren't shared. <http://well.blogs.nytimes.com/2009/09/03/in-medicine-the-perils-of-the-handoff/>

Oregon's leadership in end-of-life care offers lessons for the rest of the country

OREGON | *The Oregonian* – 2 September 2009 – An OHSU [Oregon Health & Science University] study, based on interviews with caregivers of people who died of natural causes, found that 78% of Oregonians have a written document known as an advance directive specifying what sort of medical care they want – or do not want – at the end of life. The document may be a living will or a medical power of attorney or a newer POLST (Physician Orders for Life-Sustaining Treatment) form. Oregon ranks fourth – behind Arizona, Florida and Iowa – on rate of hospice use by Medicare patients, people over age 65. Nearly half – 46% – get hospice care when they die. http://www.oregonlive.com/politics/index.ssf/2009/09/oregons_leadership_in_endoflif.html

Of related interest:

- TEXAS | *Washington Times* – 6 September 2009 – '**A model for end-of-life care?**' The national debate on health care reform has brought long overdue attention to the controversial, emotional topic of end-of-life care. It is unfortunate that the current conversation has at times produced half-truths. <http://washingtontimes.com/news/2009/sep/06/a-model-for-end-of-life-care/>

The informed patient

Patients get power of fast response

MASSACHUSETTS | *Wall Street Journal* – 1 September 2009 – A recent change to Massachusetts law requires all hospitals to set up "rapid response" programs that allow patients and family members to contact someone to come to the patient's bedside if the patient appears to need prompt help. Children's hospitals in states including Ohio and North Carolina have established family-alert programs allowing parents to quickly summon help if they fear their child is in danger. While staffers initially feared families would over-use the ... program or call for non-emergency issues, hospitals say that hasn't been the case. The ... not-for-profit Institute for Healthcare Improvement is working with hospitals around the country to establish such programs, offering sample brochures and educational materials for family-activated rapid-response teams. <http://online.wsj.com/article/SB20001424052970204047504574384591232799668.html>

End-of-life care is not the end of treatment

TENNESSEE | *Tennessean* (OpEd) – 1 September 2009 – If we distill the discussion about health-care reform down to its basis, most of us are looking for quality health care that we can afford available generally to citizens of the U.S. What we fear from health-care reform is health-care rationing, particularly the idea that effective treatment may be withheld from some among us because of an arbitrarily applied standard, such as age. Nowhere has this fear been more clearly stated than with regard to the issue of end-of-life care, whose opponents have described "death panels" making decisions about what treatments a patient may have. We have had government-sponsored end-of-life care in the U.S. since the enactment of the Medicare Hospice Benefit in 1983, which gives us a 26-year experience with end-of-life care and ... good research into that experience. <http://www.tennessean.com/article/20090901/OPINION01/909010314/1008>

Hospitals expanding duties of chaplains

MASSACHUSETTS | *Boston Globe* – 31 August 2009 – A man was dying. The chaplain should come immediately. [Rev. George] Winchester found the patient and his son lightly crying. "I hear you've made a big decision," he said. The conversation marked the start of a ... recent workday for the Catholic priest [at Brigham & Women's Hospital], a day that included the traditional jobs of a hospital chaplain, such as anointing of the sick, but that also involved duties once reserved for doctors and nurses: attending medical rounds and helping run a difficult family meeting. http://www.boston.com/news/health/articles/2009/08/31/more_patients_seeking_spiritual_guidance_from_chaplains/

End-of-life issue gets new teeth

MISSOURI | *Columbia Tribune* – 31 August 2009 – Until today, there was no standard, universally accepted form to instruct Missouri EMTs [Emergency Medical Technicians] and paramedics not to resuscitate a patient. Most ambulance districts in the state had their own policies on how to handle "do not resuscitate" orders, and doctors exacerbated the confusion by drawing up hundreds of different forms. Sometimes these forms were honored, sometimes not. <http://www.columbiatribune.com/news/2009/aug/31/end-of-life-issue-gets-new-teeth/>

Do you have compassion fatigue?

OPRAH MAGAZINE | Online article – 31 August 2009 – As any of the more than 50 million Americans caring for an elderly, disabled, or chronically ill loved one knows, the task requires superhuman strength and patience – and loads of compassion. Given the constant demands on your time and energy – for months or years on end – as well as the stress and frustration involved, having large reserves of empathy is crucial. Yet as strange as it sounds, all that empathy can backfire, flooding you with the other person's pain, and leaving you exhausted, angry, even unable to care anymore. No one likes to talk about these feelings; they seem selfish, shameful, indecent. They take a toll, however – on both you and the patient. And they're a growing concern among physicians, who have a name for what's happening: compassion fatigue. <http://www.oprah.com/article/omagazine/200909-omag-compassion-fatigue>

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- MONTANA | News Channel 5 – 2 September 2009 – **'Montana Supreme Court hears arguments on physician-assisted death.'** Montana Supreme Court heard arguments on whether or not Montanans have a constitutionally protected right to a physician-assisted death. The court is now faced with the decision of whether or not to uphold a lower-court ruling. The decision could take weeks or months. <http://www.kfbb.com/news/local/56750387.html>

International

Fears Bristol hospice closure will cause suffering

U.K. | *Evening Post* (Bristol) – 5 September 2009 – Campaigners fighting the closure of St Peter's Hospice at Knowle believe it will lead to cancer patients dying in pain. St Peter's announced in July that the Agnes Avenue site will close for good by the end of the year after helping people with terminal illnesses for 29 years. Managers of the charity said they were closing the 112-year-old Knowle building because it will cost about £300,000 to patch it up. And the charity has also faced a drop in its income because of the recession. But the Save Our Hospice group do not believe the charity gave the people of Bristol the chance to raise funds for the hospice and are urging the trustees to re-think their plans. <http://www.thisisbristol.co.uk/homepage/Fears-Bristol-hospice-closure-cause-suffering/article-1313428-detail/article.html>

'Crisis' over terminally-ill care

U.K. | BBC News – 3 September 2009 – Official guidelines are causing a crisis in care of the terminally ill and growing anger among patients' families, medical experts say. The advice allows food and fluids to be withdrawn from patients, who are then continuously sedated, if they are judged to be close to death. In a letter to the *Daily Telegraph* the six doctors and campaigners criticise a "tick-box approach" to care.¹ The government says the guidance helps deliver high quality care for people. <http://news.bbc.co.uk/2/hi/health/8235106.stm>

1. *Daily Telegraph* (Letter) – 3 September 2009 – **'Dying patients.'** The Government is rolling out a new treatment pattern of palliative care into hospitals, nursing and residential homes. It is based on experience in a Liverpool hospice. If you tick all the right boxes in the Liverpool Care Pathway, the inevitable outcome of the consequent treatment is death.¹ As a result, a nationwide wave of discontent is building up, as family and friends witness the denial of fluids and food to patients. Syringe drivers are being used to give continuous terminal sedation, without regard to the fact that the diagnosis could be wrong. <http://www.telegraph.co.uk/comment/letters/6127443/Lack-of-strategic-planning-for-energy-policy-means-Britain-is-over-reliant-on-imported-gas.html> [Scroll down to 'Dying Patients.']

1. Liverpool Care Pathway for the Dying Patient: <http://www.mcpcil.org.uk/liverpool-care-pathway/>

Nurse makes major hospice bequest

U.K. (Scotland) | BBC News – 3 September – A retired nurse has left more than £500,000 in her will for the creation of the first hospice in the Borders. Margaret Kerr, 83, from West Linton, died in March and wanted the bulk of her estate to pass to a charitable trust for hospices in Scotland. She stipulated that any project must have the support of the medical and nursing community in the Borders. http://news.bbc.co.uk/2/hi/uk_news/scotland/south_of_scotland/8235862.stm

It's time for an honest debate about health care

Daily Telegraph (Editorial) – 3 September 2009 – NHS (National Health Service) patients with terminal illnesses are dying prematurely thanks to a system of palliative care which puts them into heavy (and fatal) sedation that shortens their lives, according to a group of leading doctors who wrote to this newspaper yesterday. The letter, signed by palliative care specialists, raised the possibility of patients – many of them elderly – being wrongly assessed as close to death. The sedative drugs they are given ease suffering but make recovery impossible; if patients are not quite as ill as they seem, signs of improvement are hidden and they are effectively subjected to euthanasia. <http://www.telegraph.co.uk/comment/telegraph-view/6134739/Its-time-for-an-honest-debate-about-health-care.html>

Assisted (or facilitated) death

Representative sample of recent news media coverage:

- U.K. | *Guardian* – 4 September 2009 – **'The debate about assisted dying needs to move on.'** So far discussion about end of life care and assisted dying has tended to be polarised. Supporters of end of life care fear that it will lose what little priority it has if euthanasia is on the menu. Advocates of assisted dying don't see end of life care as offering many people a viable alternative to the right to die. But the debate so far has been unhelpfully narrow. Little attention has so far been paid to what now looks increasingly likely. What are the implications for end of life care likely to be if and when assisted dying is legalised? <http://www.guardian.co.uk/society/joepublic/2009/sep/04/assisted-suicide-end-life-care>
- U.K. | BBC News – 2 September 2009 – **'A matter of life and death.'** It is not just friends and family who want clarity about potential criminal prosecutions for helping someone travel abroad for an assisted suicide – doctors too may face criminal proceedings for offering advice or assistance under the current law. Medical Defence Union's Dr James Armstrong warns that doctors may be putting their livelihood and liberty on the line by becoming involved. <http://news.bbc.co.uk/2/hi/health/8207085.stm>

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.



10 October 2009 <http://www.worldday.org/>

Key messages: <http://www.worldday.org/pr-press/>
[Scroll down to 'Download the Key Messages' for 2009 (PDF)]

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

Discussing treatment preferences with patients who want "everything"

ANNALS OF INTERNAL MEDICINE, 2009;151(5):345-349. When asked about setting limits on medical treatment in the face of severe illness, patients and their families often respond that they want "everything." Clinicians should not take this request at face value, but should instead use it as the basis for a broader discussion about what "doing everything" means to the patient. The discussion might include questions about what balances of treatment burden and benefit the patient can tolerate and about emotional, cognitive, spiritual, and family factors that underlie the request. After this initial exploration, the clinician can propose a philosophy of treatment and make recommendations that capture the patient's values and preferences in light of the medical condition. Clinicians should respond to emotional reactions, directly negotiate disagreements, and use harm-reduction strategies for the relatively infrequent instances in which patients continue to request burdensome therapy that is unlikely to help. By using this approach, patients, families, and clinicians will be better able to understand each other and join together to develop a treatment approach that best respects patient and family values in light of what is medically achievable.

<http://www.annals.org/cgi/content/abstract/151/5/345>

Issues in pain & symptom management

Regulatory colleges to set painkiller guidelines

CANADIAN MEDICAL ASSOCIATION JOURNAL | Online news report – 31 August 2009 – Faced with staggering increases in opioid prescribing, rising rates of addiction and criminal activity, as well as an apparent vacuum in national leadership, provincial colleges of physicians and surgeons are banding together to craft opioid use guidelines. Draft guidelines have been circulated to a national advisory group of experts in a bid to achieve consensus and are expected to be finalized by October as part of the provincial colleges' unprecedented move to create national clinical practice guidelines. While that likely means better pain control for select groups – such as cancer and palliative care patients – the colleges are concerned that physicians are inappropriately prescribing opioids for all manner of ailments.

http://www.cmaj.ca/earlyreleases/31aug09_painkiller.shtml

Print symposium

New perspectives on the end of life

JOURNAL OF BIOETHICAL INQUIRY, 2009; 6(3):269-270 (Overview of print symposium). End of life concerns are a key area for ethics, law and health care. Much has been written about death and dying and there are many well-known and well established positions about a range of issues, including: the understanding of death; the management of terminal illness, pain and suffering; the "value" of life; "killing and letting die," euthanasia and physician assisted suicide; cultural and spiritual dimensions of death and dying; and the impact of "medical" considerations on death, such as organ donation and resource utilisation. So is there anything new that can be said about the subject? Are there new positions that can be developed and new arguments that can be adduced? Are there old issues and controversies that need to be revisited? Are there new issues that need to be opened up? And are there new conceptual tools that can be brought to bear on old problems? In this symposium we seek to provide new thinking, new data and new arguments about issues surrounding the end of life that continue to be of significant public and professional concern.

<http://www.springerlink.com/content/a75m07wkh5483m30/fulltext.pdf>

Contents page with links to individual articles:

<http://www.springerlink.com/content/ku130r8366q3/?p=27e47edfe05a48c286ffe5b7e3bf51e7&pi=0>

Literature review

Dementia and life expectancy: What do we know?

JOURNAL OF THE AMERICAN MEDICAL DIRECTORS ASSOCIATION, 2009;10(7):466-471. Dementia is a common geriatric syndrome. It is unclear how best to predict survival among dementia patients, which leaves clinicians, patients, and families uncertain as to how to proceed with medical decisions and reassessing goals. Increased age, male gender, decreased functional status, and medical co-morbidities such as diabetes, cardiovascular disease, and malignancy were associated with a higher mortality rate in dementia patients. Patients' baseline education level showed no influence on survival. There was no consensus regarding the association among dementia type, baseline cognitive function, and neuropsychiatric symptoms with dementia prognosis. Despite much data, we lack a unifying guideline for dementia prognostication. Moving forward, the creation of a risk score for dementia could be helpful for patients and families in reassessing goals of care and possible enrollment in services such as hospice or palliative care. [http://www.jamda.com/article/S1525-8610\(09\)00105-4/abstract](http://www.jamda.com/article/S1525-8610(09)00105-4/abstract)

Euthanasia and eudaimonia

JOURNAL OF MEDICAL ETHICS, 2009;35(9):530-533. This paper re-evaluates euthanasia and assisted suicide from the perspective of eudaimonia, the ancient Greek conception of happiness across one's whole life. It is argued that one cannot be said to have fully flourished or had a truly happy life if one's death is preceded by a period of unbearable pain or suffering that one cannot avoid without assistance in ending one's life. While death is to be accepted as part of life, it should not be left to nature to dictate the way we die, and it is fundamentally unjust to grant people liberal latitude in how they live their lives while granting them little control over the conclusion of their life narratives. Three objections to this position are considered and rejected; the paper also offers an explanation of why we think killing can be a benefit. Ultimately, euthanasia may be necessary in some cases in order to achieve eudaimonia. <http://jme.bmj.com/cgi/content/abstract/35/9/530>

Of related interest:

- *CAMBRIDGE QUARTERLY OF HEALTHCARE ETHICS*, 2009;18(4):420-428. **'How to deal with euthanasia requests: A palliative filter procedure.'** On 23 September 2002, the Belgian law on euthanasia came into force. This makes Belgium the second country in the world ... to have an act on euthanasia. Even though there is currently a legal regulation of euthanasia in Belgium, very little is known about how this ... could be translated into care for patients who request euthanasia. <http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=6114784&fulltextType=RA&fileId=S0963180109090616>
- *PSYCHOLOGICAL SCIENCE*, 2009;20(9):1092-1099. **'Right or wrong? The brain's fast response to morally objectionable statements.'** How does the brain respond to statements that clash with a person's value system? The authors recorded event-related brain potentials while respondents from contrasting political-ethical backgrounds completed an attitude survey on drugs, medical ethics, social conduct, and other issues. Results show that value-based disagreement is unlocked by language extremely rapidly, within 200 to 250 ms [milliseconds] after the first word that indicates a clash with the reader's value system (e.g., "I think euthanasia is an acceptable/unacceptable..."). <http://www3.interscience.wiley.com/journal/122525253/abstract>

[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. PCN-e link (click on 'Projects'): <http://www.pcn-e.com/>

The place where they have to take you in or the place where you prefer to be?

JOURNAL OF PALLIATIVE MEDICINE, 2009;12(9):763-764. In contrast to the U.S., the U.K. model of "hospice" and palliative care began with inpatient hospices, and now includes inpatient hospices as well as multi-professional home care and hospital teams. Although there are 500,000 deaths each year in the U.K., there are only some 3200 inpatient hospice beds across 240 hospices, 80% managed by the voluntary sector. This gives us only 6.4 hospice beds per 1000 yearly deaths. Nevertheless, approximately 18% of the 130,000 cancer deaths are in inpatient hospice or palliative care units, although only approximately 4% of all deaths. Of course, many more people are cared for by home care and hospital palliative care teams.

<http://www.liebertonline.com/doi/pdfplus/10.1089/jpm.2009.9570>

Evaluation of a children's palliative care service in Africa

JOURNAL OF PALLIATIVE MEDICINE | Online article – 28 August 2009 – This study suggests affordable, nurse-led, volunteer-supported children's palliative care services are both achievable and effective in sub-Saharan African ... that palliative care units should provide a specialized service focused on children. Such a service would clearly identify children in need of children's palliative care and should provide medication for symptom control; food and basic needs support; play and learning facilities; child protection; and systems for patient education, communication and follow up. Staff lack confidence and/or competence and this is a significant barrier to children's palliative care that should be addressed in Africa.

<http://www.liebertonline.com/doi/abs/10.1089/jpm.2009.0125>

A comprehensive case management program to improve palliative care

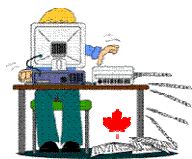
JOURNAL OF PALLIATIVE MEDICINE, 2009;12(9):827-832. The objective of this study was to evaluate the impact of comprehensive case management (CM) and expanded insurance benefits on use of hospice and acute health care services among enrollees in a national health plan. Hospice use increased for all groups receiving CM compared to the respective control groups: from 30.8% to 71.7% for commercial members with CM, and from 27.9% to 69.8% for commercial members with CM and enhanced hospice benefits. Mean hospice days increased from 15.9 to 28.6 days and from 21.4 to 36.7 days for these groups, respectively.

<http://www.liebertonline.com/doi/pdfplus/10.1089/jpm.2009.0089>

Final questions – Final plans

JOURNAL OF PALLIATIVE MEDICINE, 2009;12(9):837-838 (Personal Reflection). What stops us from asking our patients about end-of-life care? Doctors know the end will come – it comes for all of us. We can even predict with some certainty when the end is beginning. Think of a patient. Would you be surprised if death came within the year? If the answer is no, the probability is that the end has begun. For patients who are terminally ill, have advanced chronic illness, or are in multisystem failure, probability turns to certainty. We have our reasons for avoiding these uncomfortable discussions. <http://www.liebertonline.com/doi/pdfplus/10.1089/jpm.2009.0091>

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.

Worth Repeating

Armfuls of time: The psychological experience of the child with a life-threatening illness

MEDICAL PRINCIPLES & PRACTICE, 2007;16:37–41 (Extract). The endpoint of the terminal phase [for the child living with a life-threatening illness] is often marked by a turning inward on the part of the child. Their cognitive and emotional horizons may narrow as they conserve all their energy simply for physical survival. A generalized irritability is not uncommon. The child may talk very little, and may even retreat from physical contact. Although such withdrawal is not universal, a certain degree of quietness is almost always evident. The child is pulling into him or herself, not away from others. If the parents understand this behavior as a normal and expectable precursor to death, they do not interpret it as rejection. They must be reassured that their contribution to the child's care and comfort – most of all, simply their presence – are now the essence of the child's world. <http://content.karger.com/ProdukteDB/produkte.asp?Aktion=ShowPDF&ArtikelNr=104546&Ausgabe=233304&ProduktNr=224259&filename=104546.pdf>

Quotable Quotes

I have a closer relationship with my family than most other kids because I've needed them more these last years. Armfuls of Time: The Psychological Experience of the Child with a Life-Threatening Illness. [Pittsburgh: University of Pittsburgh Press, 1995 (p.87)]

Barry R. Ashpole
Beamsville, Ontario CANADA

'phone: 905.563.0044
e-mail: barryashpole@bellnet.ca