

# Quality of Life Matters<sup>®</sup>

End-of-life care news & clinical findings for physicians

Vol. 5, Issue 2 Aug/Sept/Oct 2003

## Opioid Tolerance Has Positive Clinical Aspects with Long-Term Use: Surgeons Journal

*Patients Develop Tolerance to Side Effects, Too, Experts Say*

Although tolerance to the analgesic effects of opioids can be a challenge to providing relief of chronic pain, “the same tolerance to other opioid effects, such as sedation and respiratory depression, make the phenomenon of tolerance generally advantageous in the clinical setting,” write the authors of an article published in the February 2003 issue of the *Journal of the American College of Surgeons*.

Pain is often undertreated because physicians, while aware of the dangers of opioid use, may lack complete understanding of the safety of opioids, particularly with long-term use, according to A. Reed Thompson, MD, of the Palliative Care Service, University of Arkansas for Medical Sciences, Little

Rock, and James B. Ray, Pharm D, of Hamot Medical Center, Erie, Pennsylvania.

As an analgesic drug group, opioids have two unique pharmacologic properties not fully appreciated by physicians, note the authors. Yet, “these two properties are at the core of their safety as analgesics.”

### **OPIOIDS DO NOT CAUSE VISCERAL ORGAN DAMAGE**

Unlike acetaminophen, or salicylates and other nonsteroidal anti-inflammatory drugs, opioids do not damage organs. The dose-limiting factor in opioid use, say the authors, is not the risk of organ damage, but the development of intractable side effects. These include

### **Opioid Safety Overview**

Despite the development of tolerance to their analgesic effect, opioids provide safe therapy for chronic pain because:

- Opioids do not damage organs.
- Opioids do not have a ceiling dose.
- The development of tolerance to opioid side effects also occurs with chronic use.

nausea, vomiting, somnolence, myoclonus, and cognitive failure, “all of which are reversible with dose reductions or

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## Medicare Urges Referral to Hospice, Cites ‘No Risk’ to Physicians

*Prognostication of Life Expectancy ‘Not an Exact Science’*

Emphasizing the benefits of hospice care for terminally ill patients □ as well as the recognized value of hospice care among members of the medical community □ the federal agency responsible for Medicare has released a national education article targeted at physicians.

In the article, entitled “Hospice Care Enhances Dignity and Peace As Life Nears Its End,” the Centers for Medicare & Medicaid Services (CMS) reminds physicians that Medicare’s hospice benefit is

not limited in terms of time, because the agency understands that terminal illness does not always have a predictable course.

“CMS recognizes that making medical prognostication of life expectancy is not always an exact science. **Thus, physicians need not be concerned. There is no risk to a physician about certifying an individual for hospice care that he or she believes to be terminally ill,**” states the article, which was released in March 2003.

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## Opioid Tolerance Has Positive Clinical Aspects

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rotation to alternative opioids or use of adjuvant medications.”

### **OPIOIDS DO NOT HAVE A CEILING DOSE**

There is no plateau on the opioid dose-response curve (known as the pharmacologic “ceiling”) beyond which dose increases cause only more side effects or toxicities without increasing analgesia. “Increases in an opioid dose most often advance drug efficacy, and increased analgesia is produced with each dose escalation,” the authors point out.

“These two properties — the lack of organ toxicities and lack of a ceiling — mean the development of tolerance to the analgesic effect of opioids is clinically irrelevant...The appropriate dose of an opioid is that which is required to control the pain.”

### **OPIOID TOLERANCE AS A ‘GOOD THING’**

With regard to opioids, tolerance, or “loss of drug effect

with chronic dosing,” is widely understood to refer only to the development of tolerance to their analgesic effect. What is less well known, note the authors, is that tolerance to opioid side effects also occurs with chronic use. **“Development of tolerance to opioid side effects is the other aspect of opioid pharmacology that contributes to opioid safety.”**

Tolerance usually begins after a few weeks of around-the-clock opioid dosing. As tolerance to the analgesic effect develops, so too does tolerance to the respiratory depression effect and to other side effects (except constipation), which usually resolve, say the authors.

“Concern about causing a dangerous respiratory depression with chronic opioid use is generally unwarranted and can prevent adequate pain relief,” the authors warn. “Tolerant patients can receive steadily higher opioid doses without risk of respiratory depression as long as the dose increases are appropriate (25% - 50% increase with each dose escalation).”

*The full text is available at [www.promotingexcellence.org/downloads/jacs\\_0203.pdf](http://www.promotingexcellence.org/downloads/jacs_0203.pdf)*

## Medicare Urges Referral to Hospice, Cites ‘No Risk’

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Medicare beneficiaries are enrolled in hospice programs for specified amounts of time, known as “election periods,” the CMS explains. Following two initial 90-day election periods, patients may be enrolled for an unlimited number of 60-day periods, so long as the physician certifies terminal illness at the beginning of each coverage period.

**“The value of hospice is recognized and advanced by many physicians and other health professionals,”** states the article. It cites as an example the American Academy of Hospice and Palliative Medicine, a professional organization focusing on palliative therapy, education, and counseling.

“Among the Academy’s objectives are to **‘bring the hospice approach into mainstream medicine and eliminate the dichotomy whereby patients receive either curative or palliative care,’**” says the CMS. This distinction between curative and palliative care is important, notes the article, because a reticence to contemplate the end of life is one of the perceived barriers to a broader understanding and acceptance of the hospice philosophy of relief of suffering.

Another barrier is a lack of knowledge about hospice care among both patients and practitioners. The article urges phy-

sicians, skilled nursing facilities, and hospitals to raise their patients’ awareness of the benefits of hospice care, and its ready availability through Medicare coverage. It further urges physicians and other providers to recommend hospice care to beneficiaries they feel may benefit from it.

**“Hospice is not about death,”** the article concludes, **“but rather about the quality of life as it nears its end,”** for all concerned — the patient, family and friends, and the health professional community.”

*The full text is available at [www.cms.hhs.gov/manuals/pm\\_trans/AB03040.pdf](http://www.cms.hhs.gov/manuals/pm_trans/AB03040.pdf)*

### **THE MEDICARE HOSPICE BENEFIT COVERS:**

- Physician services and nursing care
- Pharmaceutical therapy for pain relief, symptom control
- Home health aide and homemaker services
- Physical, occupational, and speech therapy
- Medical equipment and supplies
- Case management
- Dietary counseling
- Social work services
- Respite care
- Bereavement counseling

## Major Report Calls for Greater Use of Hospice

*America's Existing Hospices Hailed as a 'National Resource'*

A national study on the existing barriers to hospice access has found that, in the face of an aging population, our present health care system is providing too few Americans in need with the benefits of hospice care, or is providing it too late; yet, **“preventing suffering at the end of life requires more hospice care, not less.”**

“Access to Hospice Care: Expanding Boundaries, Overcoming Barriers,” is the result of a three-year research project conducted by a task force of experts in both hospice and nonhospice professions. It was published as a freestanding supplement to the March/April 2003 issue of the bioethics journal, *Hastings Center Report*.

The study examines the current state of end-of-life care in the nation — with specific attention to the human values involved in hospice policy and practice — and offers a new vision of hospice as a coordinating center of care, “seamlessly” serving patients from diagnosis to death.

### **NEED FOR INCREASED ACCESS TO HOSPICE**

Currently in the U.S., “too many Americans die unnecessarily bad deaths — deaths with inadequate palliative support, inadequate compassion, and inadequate human presence and witness,” state the authors. At a glance:

**Many dying patients would benefit from its care, but are never referred to hospice.** Although hospice now serves more than 700,000 dying persons, an estimated one million more die each year without receiving any kind of hospice or coordinated palliative care.

**Other patients are referred to hospice only in the final days of their lives.** More than one-third of patients spend fewer than seven days enrolled in hospice care. Patients who are referred to hospice too late are rarely able to experience the benefits of its supportive services.

**Some patients and families need hospice-type care management much earlier than in the last six months of life.**

There are aspects of hospice care that would benefit persons whose lives are turned upside-down from the time of diagnosis of a life-threatening illness.

### **The Physician's Role**

- **NON-CANCER PATIENTS.** “Failure to refer patients to hospice, delay of referrals until shortly before death... Lack of physician knowledge about the availability of hospice, especially for non-cancer patients...” are cited as major barriers impeding hospice access.
- **PHYSICIAN-PATIENT RELATIONSHIP.** “...Neither palliative care nor hospice care should signal the end of the physician-patient relationship, but simply a new stage in that relationship, with new goals and new collaborating caregivers.”
- **WHO WILL BROACH THE SUBJECT?** “Patients wait for physicians to bring it up, physicians wait for patients; someone must break this vicious cycle.”

*Excerpts from “Access to Hospice Care: Expanding Boundaries, Overcoming Barriers,” a Special Supplement to The Hastings Center Report. March 2003.*

### **‘TRUSTWORTHINESS’ OF HOSPICE**

According to the report, the characteristics of care that have demonstrated hospice’s “trustworthiness” to patients and families are:

**Condition management.** Hospice is an active process of providing expert assistance to patients and families in “managing” the total human condition of terminal illness, with respect for the integrity and participation of all involved.

**Response to changing community needs.** Hospice has adapted its vision and practice to meet the needs of people with diseases other than cancer, as well as those in all age groups and from a variety of ethnic backgrounds.

**Continuity of care.** Hospice maintains its coherent vision of desired and effective care across a broad continuum of settings and services.

### **THE FUTURE OF HOSPICE**

“The main reason we devote this report primarily to the question of increasing access to hospice care is because **the existing infrastructure of hospice programs is a national resource of continuing value and viability,**” state the authors.

Because of the flexibility and responsiveness of its infrastructure, hospice is ideally positioned to become the “potential new paradigm of social health care for an aging society,” the authors note.

To view or download the report, visit [www.thehastingscenter.org](http://www.thehastingscenter.org)

## Lung-Disease Patients Receptive to End-of-Life Discussions Regardless of Disease Severity

While 85% of patients with chronic lung disease indicate an interest in end-of-life discussions with their physicians, only 21% of these report having had such discussions, according to a recent study.

Further, no association has been found between patient willingness to discuss end-of-life care and such clinical clues as objective disease severity or recent clinical events or findings, report the study authors in the March 10, 2003, issue of the *Archives of Internal Medicine*, a journal of the American Medical Association.

“Our study suggests that patients are no more or less interested in discussing end-of-life care at advanced disease severity than at earlier disease stages,” write investigators from the Department of Medicine, University of Louisville, Kentucky.

The team evaluated patient desire for end-of-life discussion in 100 consecutive adults (mean age, 49 years) with chronic lung disease who were completing scheduled outpatient pulmonary function testing. Respiratory impairment among participants ranged in severity from normal (17%) to severe (28%).

The findings include:

- The mean percentage of the predicted forced expiratory

volume in 1 second — a common estimate of lung impairment — was similar in patients wanting and not wanting discussions.

- 84% of patients requiring oral corticosteroids desired discussions; 86% of those not receiving corticosteroids desired discussions.
- Of patients hospitalized in the past year, 81% wanted discussions, while 90% of those not hospitalized wanted discussions.
- Desire for end-of-life discussions was also not associated with either functional status score or previous mechanical ventilation.

**“Aware of the failures of advance directives and the inaccuracies and difficulties of surrogate decision making, physicians cannot use objective disease progression to predict which patients are most receptive to end-of-life discussions,”** note the authors.

Most patients and physicians agree that such discussions should be initiated by physicians; and, despite uncertainty about individual patient responsiveness, **“physicians must still proceed with discussions,”** say the authors.

The authors recommend that end-of-life plans be discussed “routinely” as part of patient intake histories, as well as during preoperative or posthospitalization follow-up visits. Health communication strategies can assist physicians in balancing “candor, hope, and individual patient characteristics.”

Suggested communication strategies for difficult discussions include:

- Asking open-ended questions
- Introducing neutral topics
- Using prompts and specific phrasing
- Focused listening
- Soliciting patient values and goals
- Minimizing discussion of treatment details

**“Focusing on physician skill in using specific communication strategies for patients at all stages of illness may be the most promising approach to increasing end-of-life discussions,”** the authors conclude.

Source: “The Value of Disease Severity in Predicting Patient Readiness to Address End-of-Life Issues,” *Archives of Internal Medicine*; March 10, 2003; 163(5):609-612. Pfeifer MP, Mitchell CK, Chamberlain L; Department of Medicine, University of Louisville, Louisville, Kentucky.

### At a Glance

- 100,000 patients with chronic lung disease die each year in the U.S.
- Direct patient-physician discussion is considered the most important tool for end-of-life care planning.
- Although the vast majority of patients desire such discussions, less than 30% of even seriously ill patients have their wishes met.
- Physicians cannot use disease severity to predict when patients will be most receptive to such communication.
- Physicians are urged to initiate end-of-life care discussions routinely as part of patient intake histories or during preoperative/postoperative visits.

— Pfeifer, Mitchell, and Chamberlain  
*Archives of Internal Medicine*

# RESEARCH MONITOR

## Physicians Offered Guidelines for Discussing Both ‘Hope’ and ‘Preparation’ with Seriously Ill Patients

In the face of life-threatening illness, physicians and patients often consider that hoping for disease remission and preparing for potential death are mutually exclusive. Yet, focusing on hope for cure alone may leave patients unaware of their limited life expectancy, denying them opportunities for improved symptom management, examination of underlying fears and concerns, and exploration of life closure.

That is according to an article entitled “Hope for the Best, and Prepare for the Worst,” which was published in the March 4, 2003, issue of the *Annals of Internal Medicine*, a journal of the American College of Physicians-American Society of Internal Medicine.

**“Although it may seem contradictory, hoping for the best while at the same time preparing for the worst is a useful strategy for approaching patients with potentially life-limiting illness,”** write the authors, led by Anthony L. Back, MD, of the Veterans Administration Puget Sound Health Care System, Seattle.

“The difficulty for physicians is acknowledging and supporting the patient’s hopes while recognizing the severity of the patient’s disease, thus offering an opportunity to discuss end-of-life concerns.”

To assist physicians in implementing discussions that include both living and dying, the authors offer a number of guidelines. [See sidebar.]

“Embracing a dual approach of hoping for the best and preparing for the worst helps physicians join with patients and families, yet plan medical care that is responsive to a range of potential outcomes for the patient,” conclude the authors. “These conversations can enrich the patient-physician relationship and provide a fresh source of meaning for the work of medicine.”

*Source: “Hope for the Best, and Prepare for the Worst,” Annals of Internal Medicine; March 4, 2003; 138(5):439-444. Back AL, Arnold RM, Quill TE; Veterans Administration Puget Sound Health Care System and University of Washington School of Medicine, Seattle; Section of Palliative Care and Medical Ethics, University of Pittsburgh; Palliative Care Program, University of Rochester School of Medicine, Rochester, New York.*

### **Introduce the dual topics of hope and preparation, allowing equal time for both**

*Physicians might say, “I will do everything I can to optimize your chances. I am hoping for the best. If the treatment works, what would be most important for you to do? At the same time, I wonder if you would be willing to talk about what would be important to you and what we should do in case the treatment doesn’t work.”*

This gives patients permission to consider a wide range of issues and to discuss the topics that are most important to them or with which they feel most comfortable. The authors recommend following the lead of patients who wish to discuss their hopes first, then placing those hopes in the context of the patients’ disease process. On the other hand, note the authors, some patients may prefer to discuss and confront their potential death before considering active treatment.

### **Align patient and physician hopes**

*“Could you tell me more about what you are hoping for? It would help me to do a better job for you.”*

Both patients and physicians want to hope for positive outcomes; indeed, hope is considered a critical element of coping with illness, the authors note. Sharing hopes for such things as improved health status, quality of life, or relationships with loved ones offers physicians the opportunity to align with their patients and to deepen the patient-physician relationship.

### **Encourage the dual agenda of hope and preparation without imposing it**

*“I talk about hoping for the best and preparing for the worst with all my patients who are seriously ill. Discussing these topics helps me to know you better and to arrange the best medical care for you, no matter what happens.”*

By encouraging patients to make such practical arrangements as naming a health care proxy, preparing financial matters, or settling family affairs, physicians can help patients to address their fears, clarify their priorities, and strengthen bonds with family and friends — “all components of a good death identified in empirical studies of patients with life-threatening illnesses.” Physicians can also benefit from these discussions. When conducted in the context of a supportive relationship, discussing the worst allows physicians to be honest with their patients. It can also prepare patients and families for a range of outcomes, making it less likely they will believe the physician is to blame for the consequences of disease progression.

— Back, Arnold, and Quill  
*Annals of Internal Medicine*

# PHYSICIAN RESOURCES

## Medical Textbooks Lauded for End-of-Life Care Content

*'It is so important to reach young physicians... early in their training about caring for seriously ill people and their families.'*

Last Acts, the national coalition to improve care near the end of life, has presented awards for excellence in end-of-life care content to authors and editors of medical textbooks who have responded to the previous dearth of such information with new material or revisions, providing "exemplary end-of-life content."

The awards ceremony capped the efforts of separate research projects on the inclusion of such subject areas as pain and symptom management, psychosocial issues, and spiritual issues in textbooks for the health care professions.

**"We congratulate these editors, authors, and publishers for responding so quickly to a near void in content,"** said Steven Schroeder, MD, Last Acts immediate past president. "It is so important to reach young physicians... early in their training about caring for seriously ill people and their families."

The original research study on end-of-life care content in medical textbooks was led by Michael W. Rabow, MD, of the University of California, San Francisco. Rabow's 1998 review of 50 top-selling textbooks from multiple specialties appeared in the February 9, 2000, issue of the *Journal of the American Medical Association*.

"Initially, we found amazingly few references or, in some cases, no mention of any kind of palliative or end-of-life care content," said Rabow. "This, in spite of advances in palliative

and end-of-life care over the last decade." On average, textbooks evaluated in the 1998 study listed less than 2% of their total content as related to end-of-life care.

Winners of 2003 Last Acts awards for excellence include:

### **Primary Care Medicine, 4th Edition**

Editor: Allan H. Goroll, MD. Chapter 90: "Management of Chronic Cancer Pain and Palliative Care," by Linda A. King, MD, et al

### **Clinical Gynecologic Oncology, 6th Edition**

Chapter 21: "Palliative Care and Quality of Life," by Philips J. DiSaia, MD, et al

### **Rudolph's Pediatrics, 21st Edition**

Editors: Colin D. Rudolph, MD, PhD, et al. Chapter 7: "Complex Decisions in Pediatric Law, Ethics, and Care Near the End of Life," by Angela Roddey Holder, JD, LLM, et al

### **Neurology and General Medicine, 3rd Edition**

Chapter 61: "Care at the End of Life," by Michael J. Aminoff, MD, DSc.

### **Textbook of Cardiovascular Medicine, 2nd Edition**

Editor: Eric J. Topol, MD. Chapter 34: "End-of-Life Care," by Gary S. Francis, MD

### **Principles of Ambulatory Medicine, 6th Edition**

Editor: L. Randol Barker, MD. Chapter 13: "Care at the End of Life," by Thomas E. Finucane, MD, et al

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## Clinical Guide to Palliative Care for AIDS Patients Available

The Health Resources and Services Administration (HRSA) of the federal Department of Health and Human Services has released a publication to assist health care professionals in providing palliative and other supportive care for their patients living with HIV/AIDS.

The 602-page publication, entitled "Clinical Guide on Supportive and Palliative Care for People with HIV/AIDS," presents information and guidelines on the many aspects of palliative care that are key to quality care of these patients, both throughout their illness and at the end of life.

**"Palliative care is complementary care, not alternative care, and therefore should not be provided only when disease-directed therapy fails or is unavailable,"** states the guide. "One need only reflect on the pain associated with receiving a first HIV diagnosis... to realize the importance of using palliative care principles at all points along the course of this illness."

The manual is organized into the following major sections:

management of advanced HIV disease; psychosocial, cultural, and ethical issues; and care at the end of life. A reference section includes a comprehensive annotated list of publications, organizations, and websites arranged both by topic and alphabetically, and a chapter on pharmacologic interactions, including one list of "red-flag" medications for physicians and one that can be printed as a handout for patients.

Chapters on end-of-life care include:

- Patient-Clinician Communication
- Facilitating the Transition to Home-Based and Hospice Care
- Medical Care at the End of Life

A copy of the publication can be ordered free of charge either on the website (<http://hab.hrsa.gov/tools/palliative>), or by calling the HRSA Information Center at **888-ASK-HRSA (888-275-4772)**.

# PHYSICIAN RESOURCES

## College of Surgeons Offers Palliative Care Resources Online

The American College of Surgeons (ACS) has recently added a section devoted to palliative and end-of-life care to its website. The collected information is presented by the ACS's Surgical Palliative Care Task Force, which aims to gather data and develop tools to assist surgeons in becoming more effective in the "art and science" of palliative care. This goal is consistent with the statement of "Principles Guiding Care at the End of Life" issued in 1998 by the ACS. [See sidebar below.]

Features of the website accessible to all visitors include:

✓ **Complete listing of articles** on palliative care published in the *Journal of the American College of Surgeons* (JACS), with links to their full texts. Articles include:

- "Is This a Bad Day, or One of the Last Days?: How to Recognize and Respond to Approaching Demise"
- "The Spiritual Needs of the Dying Patient"
- "When the Sun Can Set on an Unoperated Bowel Obstruction: Management of Malignant Bowel Obstruction"
- "The Paradox of Hydration in Advanced Terminal Illness"
- "The Importance of Opioid Tolerance: A Therapeutic Paradox"  
[See article, p. 1.]

✓ **Annotated bibliography** of books, articles and chapters, and more.

✓ **Transcripts** of sessions on palliative care held at the ACS annual congress.

✓ **Links** to other professional end-of-life and palliative care websites.

Visit [www.facs.org/palliativecare](http://www.facs.org/palliativecare)

### Principles Guiding Care at the End of Life

- Respect the dignity of both patient and caregivers.
- Be sensitive to and respectful of the patient's and family's wishes.
- Use the most appropriate measures that are consistent with the choices of the patient or the patient's legal surrogate.
- Ensure alleviation of pain and management of other physical symptoms.
- Recognize, assess, and address psychological, social, and spiritual problems.
- Ensure appropriate continuity of care by the patient's primary and/or specialist physician.
- Provide access to therapies that may realistically be expected to improve the patient's quality of life.
- **Provide access to appropriate palliative care and hospice care.**
- Respect the patient's right to refuse treatment.
- Recognize the physician's responsibility to forego treatments that are futile.

— Adopted by the American College of Surgeons in 1998

### End-of-Life Care Websites

[www.eperc.mcw.edu](http://www.eperc.mcw.edu)  
End of Life/Palliative Education Resource Center (EPERC)

[www.aahpm.org](http://www.aahpm.org)  
American Academy of Hospice and Palliative Medicine

[www.epec.net](http://www.epec.net)  
The EPEC Project (Education for Physicians on End-of-Life Care)

[www.nhpco.org](http://www.nhpco.org)  
National Hospice & Palliative Care Organization

[www.promotingexcellence.org](http://www.promotingexcellence.org)  
Promoting Excellence in End-of-Life Care

[www.hospicefoundation.org](http://www.hospicefoundation.org)  
Hospice Foundation of America

[www.americanhospice.org](http://www.americanhospice.org)  
American Hospice Foundation

[www.hpna.org](http://www.hpna.org)  
The Hospice and Palliative Nurses Association

[www.medicaring.org](http://www.medicaring.org)  
Center to Improve Care of the Dying

[www.abcd-caring.org](http://www.abcd-caring.org)  
Americans for Better Care of the Dying

[www.lastacts.org](http://www.lastacts.org)  
Last Acts Coalition

[www.mcw.edu/pallmed/](http://www.mcw.edu/pallmed/)  
Palliative Medicine Program at the Medical College of Wisconsin

[www.medsch.wisc.edu/painpolicy](http://www.medsch.wisc.edu/painpolicy)  
University of Wisconsin Pain and Policy Studies Group

[www.capcmssm.org](http://www.capcmssm.org)  
Center to Advance Palliative Care

[www.stoppain.org](http://www.stoppain.org)  
Pain Medicine & Palliative Care, Beth Israel Medical Center

[www.growthhouse.org](http://www.growthhouse.org)  
Online community for end-of-life care

[www.partnershipforcaring.org](http://www.partnershipforcaring.org)  
America's Voices for the Dying

# Newsletter Member Benefit Helps Hospices Get Earlier Referrals!

The American Academy of Hospice and Palliative Medicine is pleased to provide you with this issue of *Quality of Life Matters*, the physician outreach newsletter used by hospices nationwide to educate area physicians about end-of-life care.

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Each quarter, you will receive the latest issue of *Quality of Life Matters* via email before the newsletter is even off the printing press. This way, you and your colleagues will have immediate access to the timely clinical summaries and news articles published each issue.

## MEMBER DISCOUNT

Should your hospice choose to use *Quality of Life Matters* as a customized educational tool for your area physicians, you will receive an **additional 5% AAHPM discount** for newsletter costs. (*This is in addition to the 10% in existing newsletter discounts already available to hospices*). Any hospice or other palliative care organization with an AAHPM member on staff — or on its clinical team in any official capacity — will receive this AAHPM member discount.

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