

# Quality of Life Matters™

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

Vol. 2, Issue 2 Aug/Sept/Oct 2000

## Practical Tool Helps Physicians Conduct End-of-Life Care Discussions

A Harvard researcher has developed a four-step guide to help physicians discuss fundamental end-of-life issues with patients and their families entitled, "A Physician's Guide to Talking About End-of-Life Care."

Richard B. Balaban, MD, of Harvard Medical School, Boston, notes that it can be difficult and uncomfortable for today's physicians to initiate discussions on end-of-life care. Yet it is the physician's responsibility to ensure the development of a treatment plan that is both medically sound and in agreement with the dying patient's wishes, he adds.

Balaban believes the key to developing such a treatment plan is communication. "Good communication can help allay fears, minimize pain and suffering, and enable patients and their families to experience a 'peaceful death,'" he says.

Included in Balaban's practical guide, which was published in the March 2000 issue of the *Journal of General Internal Medicine*, are **actual wordings that physicians can incorporate into their dialogues with patients and families.**

### STEP 1: INITIATING DISCUSSION

■ **Establishing a supportive physician-patient relationship.** Showing empathy by acknowledging the stresses and fears that accompany terminal illness and letting the patient know it is safe to talk openly can help to remove some of the taboos surrounding the subject of death.

This will make later conversations easier and may encourage the patient and family to continue discussions on their own. "I know this is a very difficult time for you and your family. You have never been this sick before, and I know that it must be frightening to you...While I can't cure you, there are still many things I can do for you. No matter what happens, I can be here for you—you are not alone."

■ **Designating a surrogate decision-maker** is not only important to continuing care, but it also can help direct

*Continued on Page 2*

### Inside:

#### NewsLine ..... 2-3

- ✓ Center Will Promote Palliative Care in Hospitals & Health Systems
- ✓ Leading Medical Organizations Adopt End-of-Life Care Principles

#### Research Monitor ..... 4-6

- ✓ What Is a 'Good Death?' Six Important Themes Identified
- ✓ Nurses Identify Barriers to Effective End-of-Life Care
- ✓ Oregon Families Report Pain in Dying Hospitalized Patients
- ✓ Advanced Dementia Patients at Risk for Undertreatment of Pain
- ✓ Treating Patients with Severe COPD May Require a New Model of Care

#### Physician Resources ..... 7

## New AMA Guide Views Dementia As a Terminal Illness

A new physicians guide published by the American Medical Association (AMA) recommends treating progressive dementia as a life-altering terminal illness from which people die over the span of years rather than months.

"**Diagnosis, Management and Treatment of Dementia: A Practical Guide for Primary Care Physicians**" is a 48-page booklet designed to aid physicians in caring for their dementia patients from the initial diagnosis through the end of life.

Although the proximate cause of death may be complications of immobility, notes the guide, progressive dementia is an eventually fatal condition for which no curative therapy is available. Thus, physicians would do well to **decide on an aggressive palliative care plan early**, before the disease inevitably progresses.

The guide's section on end-of-life issues covers such topics as:

- Advanced care planning
- Hospice referral

*Continued on Page 2*

## Practical Tool for End-of-Life Discussions

From Page 1

the conversation. *"If you ever became so ill that you were unable to speak for yourself, who would you want to make decisions regarding your medical care?"*

■ **Identifying the patient's general preferences** includes probing beyond any stock phrases. *"You said that you don't want to be a burden to your family—what do you mean by that?"* Maintaining the open communication established in this initial discussion **will facilitate important treatment decisions to be made later**, in the face of changing medical and psychosocial needs.

### **STEP 2: CLARIFYING PROGNOSIS**

■ **Keeping the message clear.** Because anxiety impairs comprehension, the message should be kept simple, with repeated explanations. When no therapeutic options exist, there must be **no chance for misunderstanding**, as patients base their treatment decisions on this information. *"This cancer is getting the better of you. The treatments that have helped you in the past are no longer working. I understand your desire to get better, but it is not realistic."*

■ **Acknowledging prognostic limitations** can build trust. Many patients appreciate knowing the uncertainties of their prognosis as well as the average prediction.

### **STEP 3:**

### **IDENTIFYING END-OF-LIFE GOALS**

■ **Determining if preferences have changed.** Once the approach of death is acknowledged, open the discussion to desired medical care and remaining life goals. *"A few months ago we spoke about what kind of care you would want if you were to become very ill. We're now facing that situation. I want to know if your thoughts are the same, or if they have changed in any way."*

■ **Learning about individual priorities.** Many terminally ill patients share similar goals: maximizing time with family and friends, avoiding hospitalization, and minimizing pain. *"I need to know what things are most important to you, given your illness. How do you want to spend your remaining time?"*

### **STEP 4:**

### **DEVELOPING A TREATMENT PLAN**

■ **Providing guidance in understanding treatment options and making recommendations.** *"From what you have said, let me suggest the following plan. Please tell me if I am correctly representing your views."* Comprehensive treatment plans can include site of care, the use of resuscitation and other aggressive treatments, and the implementation of palliative care.

■ **Discussing resuscitation.** Many patients and families do not know that its success rate has been overrepresented and that it rarely prolongs meaningful life in the terminally ill. Similarly, patients can be unaware that they will not be able to speak while on a ventilator.

■ **Initiating palliative care** is best achieved by supportive, unpressured discussions. Patients need to be certain they are making the best choices, and families need to know that their decisions represent acts of love, not abandonment.

Balaban developed the guide by drawing upon interviews with experienced end-of-life care clinicians at a major university hospital. He reminds physicians that their skill and comfort level with end-of-life discussions will increase through feedback, repetition, and practice. **Providing quality care for a dying patient is not just a challenging responsibility**, says Balaban, **but can be a gratifying and meaningful experience.** *"To help someone die in comfort, in peace, and with dignity is to give [that person] one final gift of life."*

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## New AMA Guide for Dementia

From Page 1

- Aggressive symptom control
- Family support
- Ethical issues concerning artificial feeding and hydration

The course of dementia can run from 2 to 20 years, and its prevalence rises exponentially, doubling every 10 years after the age of 65, according to the

AMA. It is estimated that 35% to 45% of people over age 85 suffer from some form of dementia, with the majority of patients cared for in the community by family members.

The guide includes community resource information to assist physicians in addressing the burden of care felt by

families and loved ones.

Intended to provide physicians with practical and clinical advice on keeping patients as independent as possible, the guide also includes sections on cognitive problems, safety, and elder abuse.

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For information, call 312-464-5563.

## Center Established to Promote Palliative Care in Hospitals and Health Systems

Headquartered at Mount Sinai School of Medicine in New York, a new **Center to Advance Palliative Care** has been established to assist hospitals and health networks nationwide in the planning, development, and implementation of high-quality palliative care services.

“The Center is intended to help hospitals learn **how to provide good palliative care**,” says co-director Christine Cassel, MD, who chairs Mount Sinai’s Department of Geriatrics and Adult Development. “Some degree of palliative care is needed in almost every illness episode, but it is particularly important for patients with serious chronic illnesses and patients nearing the end of life.”

With a 4-year grant from the Robert Wood Johnson Foundation, Princeton, NJ, the Center will:

- Facilitate collaboration among **hospice**, hospital, and nursing home providers
- Collect and disseminate a wide range of information on how to establish and sustain a palliative care program
- Monitor national palliative care practice and delivery trends
- Promote consensus on appropriate standards of care
- Encourage new ways to finance palliative care services

- Promote educational opportunities for physicians, nurses, hospital executives, and other team members
- Publish a manual on how to establish a hospital-based palliative care program
- Create a national directory of palliative care programs
- Establish a comprehensive website at [www.capcmssm.org](http://www.capcmssm.org)
- Organize a speakers’ bureau
- Coordinate a national educational conference

Partnering with Mount Sinai will be such national organizations as **EPEC** (Education for Physicians on End-of-Life Care) and the **American Hospital Association** (AHA).

“Many hospitals want to provide palliative care, but don’t know just where to start,” says AHA President Dick Davidson. “The Center will provide tangible tools hospitals can use to make this kind of care a reality.”

In a recent AHA survey of 6,200 hospitals, **27%** of respondents said they **had pain management programs**; only **15%** offered **end-of-life services**.

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For information, call the Center at **212-241-7885**.

## Leading Medical Organizations Adopt End-of-Life Care Principles

Fourteen US medical specialty societies, along with the Joint Commission on Accreditation of Healthcare Organizations, have formally adopted or endorsed a consistent set of basic principles for end-of-life care, according to a report published by the Milbank Memorial Fund, New York.

Entitled “**Principles for Care of Patients at the End of Life: An Emerging Consensus Among the Specialties of Medicine**,” the report explains that some medical societies have adapted the principles or modified them for a stronger impact. Supporters include:

- American Medical Association
- American Society of Clinical Oncology
- American Academy of Neurology
- American College of Physicians - American Society of Internal Medicine
- American Academy of Pediatrics.

### ***Core Principles for End-of-Life Care***

1. Respect the **dignity** of both patient and caregivers
2. Be sensitive to and respectful of the patient’s and family’s **wishes**
3. Use the most appropriate measures consistent with **patient choices**
4. Encompass **alleviation of pain** and other physical symptoms
5. Assess & manage **psychological, social, & spiritual/religious** problems
6. Offer **continuity** (the patient should be able to continue to be cared for, if so desired, by his/her primary care and specialist providers)
7. Provide access to any therapy which may realistically be expected to improve the patient’s **quality of life**, including alternative or nontraditional treatments
8. **Provide access to palliative care and hospice care**
9. Respect the **right to refuse treatment**
10. Respect the physician’s professional responsibility to **discontinue some treatments** when appropriate, with consideration for both patient and family preferences
11. Promote clinical and evidence-based research on **providing care at the end of life**

## What Is a 'Good Death?' Six Important Themes Identified

There is no “right” way to die, but a recent study has identified **6 key attributes of a good death**, which researchers say might provide clinicians with a framework for addressing end-of-life topics of value to patients and families.

Researchers from Durham, N.C., convened focus groups from 2 medical centers and a community hospice, then conducted in-depth interviews to confirm the findings. Stratified by role, the groups consisted of physicians, nurses, social workers, chaplains, hospice volunteers, patients, and recently bereaved family members. The 75 participants were asked to discuss their experiences with the deaths of patients or loved ones, and to consider what made those deaths good or bad.

The study confirmed the importance of 4 themes found in previous end-of-life care literature [see sidebar, items 1 through 4], as well as identifying 2 new components [5 and 6].

“Although death is a rite of passage in which we will all participate—as family member, provider, or eventually, patient—we understand little of what is valued at the end of life,” the authors write. Providers often avoid end-of-life discussions for fear of removing hope. “However, **patients and families feared bad dying more than death**,” they observe. “For dying patients and their families, preparation does not preclude hope; it merely frames it.”

**During the past century** as the location of death changed from home to hospital, **death became viewed more and more from the biomedical perspective**, defined primarily as a physiologic event, explain the authors. But for those in all focus groups except physicians, the study found that “death is infused with broader meaning and is considered a natural part of life, not a failure of technology.” While biomedical care is crucial, they say, it is “merely a point of departure toward a good death.”

**The authors remind physicians that they are not alone in the care of the dying**; many other providers are available for comprehensive care. Asking the patient a question concerning issues of value can help the physician direct the patient or family to the appropriate nurse, social worker, or chaplain.

Patients and families want professional care that affirms the larger view of the death experience, they conclude. “**When physical symptoms are properly palliated**, patients and families may **have the opportunity to address the critical psychosocial and spiritual issues** they face at the end of life.”

*Source: “In Search of a Good Death: Observations of Patients, Families, and Providers,” Annals of Internal Medicine; May 16, 2000; 132(10):825-832. Steinhilber KE, Clipp EC, McNeilly M, Christakis NA, McIntyre LM, Tulskey JA; Durham Veterans Affairs Medical Center, Duke University, and the Institute for Multiculturalism, Durham, N.C.; University of Chicago, Chicago.*

### SIX COMPONENTS OF A 'GOOD DEATH'

#### 1. PAIN AND SYMPTOM MANAGEMENT

Many participants **feared dying in pain or undergoing aggressive therapy with insufficient analgesia**. There was concern about both current and future control of such symptoms as **breakthrough pain** and **extreme air hunger**. Reassurance from providers that these future symptoms would be managed was important to patients and families.

#### 2. CLEAR DECISION-MAKING

Providers and families expressed the need for improved communication to avoid entering into a crisis situation without clear knowledge of the patient’s values and preferences. **Patients felt empowered by being included in treatment decisions concerning their own illnesses**.

#### 3. PREPARATION FOR DEATH

Patients wanted to know what to expect during their illness so they could plan ahead, arrange personal affairs, or say goodbye. Both families and providers expressed the need for families to **understand the physical and psychosocial changes** that accompany the approach of death.

#### 4. COMPLETION

All nonphysician groups emphasized the **deep importance of spiritual and emotional meaningfulness** at the end of life. Issues of belief, individual life review, conflict resolution, and time shared with loved ones were considered crucial aspects of the dying process.

#### 5. CONTRIBUTING TO OTHERS

Dying patients wanted to **feel included in human interactions and be allowed to reciprocate care**. Ways of contributing to the well-being of others included sharing gifts, time, knowledge, or newly acquired understanding.

#### 6. AFFIRMATION OF THE WHOLE PERSON

Participants stressed the importance of **approaching the terminally ill patient as a whole, unique person, rather than as just a case or “disease.”** Providers appreciated their personal relationships with the dying, and patients expressed a desire to “simply be known.”

## Nurses Identify Barriers to Effective End-of-Life Care

Despite their central role in the care of terminally ill patients, many nurses feel that their training has inadequately prepared them for end-of-life (EOL) care, and they identify various barriers—system, professional, and patient—to the effective care of the dying.

That's according to a recent study conducted by researchers from the City of Hope Cancer Center, Duarte, CA. Nevertheless, the study found that 66% of nurses believe care of the dying has improved during the past 5 years.

The researchers surveyed 2,333 nurses (mean age, 46 years) by mail in 1998 to determine their views of the dilemmas, barriers, educational needs, and effectiveness of EOL care. The most common clinical areas of the respondents were oncology (70%) and medical/surgical (13%); the predominant setting of practice was hospital (52%), followed by ambulatory care/outpatient clinic (28%).

Although less than 13% of respondents rated their basic nursing education as "very adequate" in preparing them for aspects of EOL care, **more than 99% considered training in EOL care to be an important component of nursing education.** Aspects of education most often rated inadequate were pain management (71%), overall EOL care content (62%), and the roles/needs of family caregivers (61%).

Barriers to effective care cited most often as "severe" included: the influence of managed care on EOL care (25%); lack of continuity of care across settings (23%); and family members' avoidance of death (19%). Family members' avoidance of death was also rated frequently (73%) as "somewhat of a barrier," followed in that category by patients' avoidance of death (70%), lack of knowledge by health care providers (57%), and health care professionals' personal discomfort with death (56%).

A section for open-ended responses was included in the survey, and here the researchers discovered some confusion in terms, despite their efforts at clarity in phrasing the questions. **Some nurses believed that giving scheduled pain medications to imminently dying patients constituted assisted suicide** and worried that they had hastened death because they

did not want a patient to die in pain.

**"It is vastly important to hear from nurses, as they make up the largest professional group at the bedside,"** says lead author Betty Ferrell, PhD, RN, of City of Hope. "It is apparent to us that improved end-of-life care is contingent on better education of nurses and health care professionals."

*Source: "Beyond the Supreme Court Decision: Nursing Perspectives on End-of-Life Care," Oncology Nursing Forum; April 2000; Vol. 27, No. 3: 445-455. Ferrell B, Virani R, Grant M, Coyne P, Uman G; City of Hope National Medical Center, Duarte, California; Medical College of Virginia Hospitals, Richmond; Vital Research, Los Angeles.*

## Oregon Families Report High Levels of Pain in Dying Hospitalized Patients

The number of family members reporting that their hospitalized loved ones experienced moderate to severe pain in the last week of life increased sharply at the end of 1997 and remained high in late 1998, Oregon researchers have found.

In an earlier interview study, Susan W. Tolle, MD, and associates from Oregon Health Sciences University had asked 475 recently bereaved family members to rate their loved one's level of pain during the last week of life on a 4-point scale (none, mild, moderate, and severe). They found that **rates of moderate to severe pain were higher for in-hospital deaths only**, and that this jump occurred during the last 3 months of 1997, when **reports of moderate to severe pain increased from 33% to 57%.**

To determine whether reports of pain had returned to baseline by the end of the following year, the team interviewed family members of 103 patients (mean age, 74 years) who had died in a hospital setting in the last 3 months of 1998. The top 3 causes of death were: cancer (17%), heart disease (16%), and cerebrovascular disease (16%).

**Fifty-six family members (54%) reported that their loved ones experienced moderate to severe pain in the last week of life.**

Possible explanations for their findings include the fact that Oregon in late 1997 was in the midst of political and regulatory volatility regarding physician-assisted suicide. "We must not pretend that patient care happens in a vacuum," the authors point out. "The influence of environmental factors on pain management may have implications for practice and policy nationwide."

*Source: "Family Reports of Pain in Dying Hospitalized Patients: A Structured Telephone Survey," Western Journal of Medicine; June 2000; 172:374-377. Tolle SW, Tilden VP, Hickman SE, Rosenfeld AG; Center for Ethics in Health Care, Division of General Medicine, School of Medicine, Oregon Health Sciences University, Portland.*

**"The barriers reported as common and the diversity of these barriers illustrate the complexity of effective EOL care," the authors point out.**

## Advanced Dementia Patients at Risk for Undertreatment of Pain

Patients with advanced dementia may be at substantial risk for undetected or undertreated pain, according to a prospective cohort study that examined the treatment of pain in elderly patients following hip fracture.

Researchers at a large teaching hospital in New York conducted daily assessments of 97 patients aged 70 years or older who were hospitalized with hip fracture. The cognitively intact patients (n = 59) were asked to rate their pain on a 4-point scale from “none” to “very severe.” The investigators then recorded the analgesics prescribed to these patients and compared them to those administered to advanced dementia patients (n = 38) with hip fracture.

***“This study and others suggest that directed interventions to improve pain detection and alter physician prescribing practices in the cognitively impaired are needed,” researchers conclude.***

More than 40% of the cognitively intact patients reported severe to very severe pain both preoperatively and postoperatively, and over half of those with moderate to very severe pain were prescribed inadequate analgesia, researchers found.

The advanced dementia patients received one-third the amount of morphine sulfate equivalents as the cognitively intact patients. Further, only 24% of dementia patients and 17% of cognitively intact patients were found to have received standing orders for an analgesic agent.

**“These data reveal that a majority of elderly hip fracture patients experienced undertreated pain,”** the study authors comment. The fact that such a large percentage of cognitively intact patients reported severe postoperative pain combined with the much smaller amounts of opioid analgesics prescribed to the patients with advanced dementia “suggests that **the majority of dementia patients were in severe pain postoperatively,**” the researchers add.

“This study and others suggest that directed interventions to improve pain detection and alter physician prescribing practices in the cognitively impaired are needed,” they conclude.

*Source: “A Comparison of Pain and Its Treatment in Advanced Dementia and Cognitively Intact Patients with Hip Fracture,” Journal of Pain and Symptom Management; April 2000; 19(4):240-248. Morrison RS, Siu AL; Hertzberg Palliative Care Institute, Department of Geriatrics and Adult Development, Mount Sinai School of Medicine, New York.*

## Treating Patients with Severe COPD May Require a New Model of Care

The dominant paradigm of care for patients with advanced chronic obstructive pulmonary disease (COPD)—a dichotomy often manifest as an abrupt change from “doing everything” to “there’s nothing more we can do”—is insufficient, a new study suggests. **Patients with severe COPD may benefit from an approach to care that combines good symptom management and discussion of death with attempts to treat potentially reversible illness if the patient wishes.**

In a new analysis of findings from the Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment (SUPPORT), researchers compared the course of illness and patterns of care for 2 groups of seriously ill, hospitalized adults: 939 patients with non-small cell lung cancer and 1008 patients with acute exacerbation of severe COPD. Although less well studied, **COPD deaths nevertheless account for two-thirds as many deaths as are caused by cancer of the lung and bronchus,** note the study authors.

The study found that pain and dyspnea were pervasive problems in both diseases, as determined by patient reports or in surrogate interviews. Treatment preferences in the 2 groups were about the same, with 58% preferring relief of pain and discomfort to life extension; 37% wanting Do Not Resuscitate orders, and about 80% strongly opposed to indefinite ventilator dependence. However, the authors caution, these preferences reflect the dichotomous model of care. The COPD patient was not given the option of a trial of life-sustaining therapy combined with attention to relief of pain and suffering.

Patients with COPD had much worse baseline functional capacity and cardiopulmonary reserve, yet markedly longer median survival (23.9 months vs 3.3 months). During the index hospitalization, 34% of COPD patients and 4% of lung cancer patients received ventilator support; of these, 76% of patients with COPD and 38% of patients with lung cancer survived to leave the hospital.

**“Physicians caring for patients with severe COPD should be cognizant of patients’ desires for comfort-focused care and more aggressively implement palliative treatments,** even while remaining open to provision of life-sustaining interventions,” the authors conclude.

*Source: “Dying with Lung Cancer or Chronic Obstructive Pulmonary Disease: Insights from SUPPORT,” Journal of the American Geriatrics Society; May 2000; 48 (suppl):S146-153. Claessens MT, Lynn J, Zhong Z, et al; Palliative Care Program, Marshfield Clinic and St. Joseph’s Hospital, Marshfield, Wisconsin; The Center to Improve Care of the Dying, The George Washington University, Washington, DC.*

# PHYSICIAN RESOURCES

## National Initiative Aims to Improve End-of-Life Nursing Care

The American Association of Colleges of Nursing (AACN) has announced the launch of a national education program to improve end-of-life care by nurses. In partnership with researchers from the City of Hope Cancer Center, Los Angeles, the AACN will develop a core of expert faculty, coordinate national efforts, and evaluate the impact of the education. The project is called **The End-of-Life Nursing Education Consortium (ELNEC)**.

The project will be **similar in activity to EPEC (Education for Physicians on End-of-Life Care)**, a program founded by the American Medical Association to enhance end-of-life care by practicing physicians. A core training curriculum for the ELNEC project will be developed to improve the end-of-life care expertise of nursing faculty in bachelor, associate, and continuing education programs.

ELNEC project training will take place in **five conferences at different educational sites around the nation**, with the first conference slated for January 2001. The project is supported by a grant from the Robert Wood Johnson Foundation of Princeton, N.J. For information, call **202-463-6930** or visit **www.aacn.nche.edu**.

## Books on Care for the Dying

### **Death Foretold: Prophecy and Prognosis in Medical Care**

By **Nicholas A. Christakis, MD, PhD, MPH**, this analysis of prognosis in medical practice reviews information on the subject from a number of sources: physician interviews and clinical encounters, surveys, and medical and sociological literature. Attitudes of physicians and the medical community toward prognostication are discussed. The author offers recommendations for clinical education and practice to aid physicians in providing this important service.

Chapter headings include:

- Making Use of Prognosis
- Error and Accountability in Prognostication
- The Ritualization of Optimism & Pessimism
- Telling Patients Their Prognosis

*Published by University of Chicago Press, 2000; ISBN: 0226104702 (hardcover); 307 pp.*

### **Topics in Palliative Care (3 Volumes)**

By **Russell K. Portenoy, MD, (Editor) and Eduardo Bruera, MD, (Editor)**, this series of medical reference texts covers specialized aspects of palliative care for the terminally ill patient. Volume to volume, each chapter is devoted to a different topic, within which are sections on various aspects of that topic. Volume 1, for example, begins with a chapter on delirium in cancer patients, which contains sections covering the epidemiology and clinical features of delirium, and counseling of the confused patient and the family.

Chapter headings in Volume 3 include:

- Pediatric Palliative Care
- Psychopathology in Patients with Cancer
- Skin Disorders and Their Management
- Management of Bone Pain

*Published by Oxford University Press. Volume 1, 1997; ISBN: 0195102444. Volume 2, 1998; ISBN: 0195102452. Volume 3, 1998; ISBN: 0195102460.*

## **End-of-Life Care Websites**

**www.aahpm.org**

American Academy of Hospice & Palliative Medicine

**www.nhpco.org**

National Hospice & Palliative Care Organization (formerly the NHO)

**www.hospicefoundation.org**

Hospice Foundation of America

**www.americanhospice.org**

American Hospice Foundation

**www.hpna.org**

The Hospice and Palliative Care Nurses Association

**www.gwu.edu/~cicd**

Center to Improve Care of the Dying, The George Washington University

**www.abcd-caring.com**

Americans for Better Care of the Dying

**www.lastacts.org**

Last Acts Coalition

**www.mcw.edu/pallmed/**

Palliative Medicine Program at the Medical College of Wisconsin

**www.chcr.brown.edu**

Center for Gerontology and Health Care Research

**www.halcyon.com/iasp/**

International Association for the Study of Pain

**www.medsch.wisc.edu/**

**painpolicy**

University of Wisconsin Pain and Policy Studies Group

**www.soros.org/death**

Project on Death in America of the Open Society Institute

**www.stoppain.org**

Pain Medicine & Palliative Care, Beth Israel Medical Center

**www.growthhouse.org**

Online community for end-of-life care

**www.partnershipforcaring.org**

America's Voices for the Dying

## Upcoming Meetings for Clinicians Interested in End-of-Life Care Education

**First International Geriatric Palliative Care Congress.** October 11-14, 2000, New York. Sponsors: Beth Israel Medical Center and Continuum Health Partners, Inc. Contact: Events International Meeting Planners, Inc. Phone: 514-286-0855; Fax: 514-286-6066; e-mail: [info@eventsintl.com](mailto:info@eventsintl.com)

**Improving End-of-Life Care for the Hospitalized Patient.** October 25, 2000, Grand Hyatt Hotel, San Francisco. Contact: Cliff Brock, Department of Medicine, CME UCSF Box 0656, San Francisco, CA 94143-0656. Phone: 415-476-5208; Fax: 415-476-3542; e-mail: [cme@medicine.ucsf.edu](mailto:cme@medicine.ucsf.edu)

**Update in Pain, Palliative Care, and Infectious Disease.** November 11-18, 2000, Southern Caribbean Cruise. Sponsor: University of Wisconsin. Contact: Ann Bailey. Phone: 608-263-2854; Fax: 608-262-8421; e-mail: [rkdux@facstaff.wisc.edu](mailto:rkdux@facstaff.wisc.edu)

**The Science & Art of Pain and Symptom Management.** November 17-18, 2000, The Old Mill, Toronto. Contact: Continuing Education, Faculty of Medicine, University of Toronto, Room 121, 150 College St., Toronto, Ont., Canada M5S 3E2; Phone: 416-978-2719; Fax: 416-971-2200; e-mail: [kristin.parsonson@utoronto.ca](mailto:kristin.parsonson@utoronto.ca)

**First Congress of the Research Network of the European Association for Palliative Care: Research and Development in Palliative Care.** December 7-9, 2000, Hotel Inter-Continental, Berlin, Germany. Contact: EAPC, P.O. Box 1726, CH-1211 Geneva, Switzerland; Phone: +41 22 732 11 88; Fax: +41 22 732 28 50; e-mail: [eapcresearch@kenes.com](mailto:eapcresearch@kenes.com)

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