

Quality of Life Matters™

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

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Hospice Care Linked to Superior Pain Management in Dying Nursing Home Patients

Hospice Patients Twice as Likely to Receive Regular Pain Management as Nonhospice Residents

A study of pharmacological pain management for dying residents in more than 800 nursing homes across five states has found that hospice care delivered to these patients is associated with superior analgesic management of daily pain.

Residents enrolled in hospice were twice as likely as their nonhospice counterparts to receive regular treatment for daily pain. As well, the analgesic prescribing patterns for hospice residents were more consistent with recommended guidelines for the management of chronic pain in long-term care settings.

Although the Medicare hospice benefit was extended to nursing home residents in 1985, only 6% of residents dy-

ing in nursing homes in the U.S. are estimated to use hospice care, according to lead author Susan C. Miller, PhD, and colleagues at the Center for Gerontology and Health Care Research, Brown University, Providence, RI.

“Hospice care in nursing homes offers a collaborative opportunity for nursing homes and hospices to provide intensive palliative services to dying residents, including high-quality pain management,” write the authors in their report in the March 2002 issue of the *Journal of the American Geriatrics Society*.

From a matched cohort of 10,573 hospice and nonhospice nursing home

residents who were assessed between 1992 and 1996 and who died before April 1997, Miller and colleagues analyzed data on a subset of 2035 residents with daily pain near the end of life (709 hospice; 1326 nonhospice). The states included were Kansas, Maine, Mississippi, New York, and South Dakota.

SUPERIOR PAIN CONTROL

In multivariate analysis, the factors associated with a greater likelihood of receiving regular treatment for daily pain included:

- **Hospice enrollment** (odds ratio, 2.08; 95% confidence interval, 1.68-2.56)

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U.S. Surgeons Emphasize Importance of Hospice and Palliative Care

National Journal Offers 15-Article Series About End-of-Life Issues

The *Journal of the American College of Surgeons* is featuring a monthly series of articles focusing on issues in end-of-life care encountered in the surgical setting. **Many surgeons have become actively involved in hospice care, “the preeminent model of palliative care,”** writes series editor Geoffrey P. Dunn, MD.

Nevertheless, he says, the recent expansion of information and education on palliative care seen in the nonsurgical fields of medicine has been late in reaching the surgical disciplines.

“Palliative care identifies total pain — not disease — as ‘the enemy,’” Dunn says. Good palliative care is based on strong communication skills and the aggressive relief of physical, psychological, social, and spiritual pain, or “total pain.”

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Hospice Care in Nursing Homes *(from Page 1)*

- Diagnosis of cancer with no dementia (OR, 1.51; 95% CI, 1.14-2.00)
- Documentation of a do-not-resuscitate order (OR, 1.25; 95% CI, 1.00-1.57)

Variables associated with a reduced probability of receiving adequate daily pain treatment included being aged 75 years or older and a diagnosis of congestive heart failure.

The analgesics used most frequently for hospice residents were morphine derivatives (30%); acetaminophen (18%); codeine derivatives (13%); and fentanyl, transdermal (12%).

In contrast, the analgesic used most frequently (not in com-

bination) in the nonhospice cohort was acetaminophen (25%), followed by propoxyphene-containing drugs (19%), which are not recommended by the American Medical Directors Association for use in this population. Morphine derivatives (15%) and codeine derivatives (14%) were received in almost equal proportion by nonhospice residents.

The authors note that a strengthening of the hospice effect in nursing homes is needed. **“The provision of Medicare hospice care in nursing homes appears to be a viable means of improving analgesic prescribing practices and thus improving the quality of end-of-life care for nursing home residents,”** they conclude.

Surgeons Emphasize End-of-Life Care *(from Page 1)*

Entitled “Palliative Care by the Surgeon,” the 15-article series is written by North American surgeons from a variety of specialty backgrounds. The series is the collaborative work of the *Journal of the American College of Surgeons* and the Surgeons Palliative Care Workgroup of Promoting Excellence in End-of-Life Care, a national program office funded by the Robert Wood Johnson Foundation of Princeton, NJ.

Meant to be practical and informative, the articles are presented in a case-based format, “to remind us what has been learned in countless clinical encounters — the closer to the bedside, the better,” writes Dunn, who is medical director of Great Lakes Hospice, Erie, PA.

Among the articles published to date (with excerpts):

- **Patient Assessment in Palliative Care: How to See the “Big Picture” and What to Do When “There Is No More We Can Do.”** “The end of life and dying, itself, are not merely medical events... Surgeons are not alone in yielding to the temptation of viewing the end of life as a stage of a disease that must be controlled.”
- **Chronic Pain Management and the Surgeon: Barriers and Opportunities.** “Studies on undertreatment of pain show that clinicians’ concern about addiction is among the most frequently cited reasons... The apparent high prevalence of [perceived] addiction may be from the confusion about the terms *tolerance*, *physical dependence*, and *addiction* (or substance abuse).”
- **Palliative Care in the Surgical Intensive Care Unit.** “Regardless of prognosis or likelihood of dying, a focus on the goals of care will facilitate this transition [from

curative therapy to palliative care], so that palliative care can be provided alongside other therapy, not in an either/or fashion.”

- **The Role of Tube Feeding and Total Parenteral Nutrition in Advanced Illness.** “An important part of... discussion[s] with the terminally ill and their families is to help them understand the normal physiologic changes that precede death. Knowledge of what to expect and the realization that a gradual loss of interest in food is a normal part of the dying process can help to alleviate much anxiety and restore a crucial sense of control.”
- **Management of Dyspnea at the End of Life: Relief for Patients and Surgeons.** “Dyspnea is treatable, as are other symptoms at the end of life, and physician expertise in its management can go a long way to provide comfort and allay patient and family fears. Surgeons must recognize that withdrawal of life support is the beginning of heightened, intensive palliative care, when symptoms of dyspnea should be treated aggressively.”
- **Palliative Care Symposium. Who Should Manage the Dying Patient?: Rescue, Shame, and the Surgical ICU Dilemma.** “The covenant between the surgeon and the patient as social and — at the end of life — spiritual beings demands comfort and dignity. Repeated fruitless attempts at physiologic rescue delay and even deny these covenantal obligations.”

To view the articles in their entirety, go to www.promotingexcellence.org/content/workgroups.html and click on “Surgeons Palliative Care Workgroup.”

Experts Urge Broad Availability of Pediatric Palliative Care

Adult Care Standards Deemed Inappropriate for Children with Life-Threatening Conditions

Specialized palliative care services for children and their families should begin at the time of diagnosis of a life-threatening condition, according to a recent report from a multidisciplinary group of pediatric care experts. Because the impact of a child's illness and death on loved ones and friends is so profound, palliative care and family-centered support must run concurrently with life-prolonging care, says the report.

“Death is inherently a social/community event, not a medical event. At the present time, it is placed in the hands of a medical community ill-prepared to meet these unique needs, particularly for children, who frequently die in the hospital,” notes Houston-based pediatric palliative care consultant Marcia Levetown, MD. Levetown is lead author of the report, which was produced for the National Hospice and Palliative Care Organization (NHPCO) of Alexandria, VA.

Levetown calculates that 75% to 85% of deaths among children aged 1 to 19 years occur in the hospital, with 75% of these occurring in tertiary care facilities, which are seldom close to home. Thirty-six percent of children in this age group die of congenital and chronic conditions. Further, the proportion of infants dying of chronic conditions has risen from 31% in 1980 to 41% in 1997.

“These children need longer-term palliative care with home-based options,” Levetown writes.

Of the approximately 53,000 children who die annually, only about 5,000 receive hospice services, “generally for a brief duration,” notes Levetown. “Delayed implementation of palliative care interferes with the all-important focus on pre-

vention of unnecessary pain and other symptoms, effective communication, preparation for death, and orchestration of care to achieve the child's and family's goals.”

BARRIERS TO EFFECTIVE CARE OF CHILDREN

According to the report, barriers to effective palliative care for children include:

- **Widespread misperception** that palliative care is useful only when all curative efforts have been attempted
- **Reimbursement patterns** that place little value on the comprehensive care provided by an interdisciplinary team-based approach
- **Difficulty in determining** what is in the best interests of a child whose current and future value system is unknown
- **Lack of research and training** in pediatric palliative care: “Continued extrapolation from adult data is unethical; over and over it has been shown that children are not small adults, physically, psychologically, emotionally, or otherwise.”
- **Poor professional communication**, as well as personal and societal pressures, which “often force children to endure therapies that adults, given the choice, reject for themselves.”
- **Uncertainty of determining prognosis** or estimated time of death, when survival time is a criterion for eligibility

“The sole admission criterion for pediatric palliative care services must be that the child is not predicted to survive to adulthood,” insists the report. “Prognosis for short-term survival should *not* be required, as it is very difficult to predict, interfering with access to palliative care needed to provide appropriate family-centered support from the time of diagnosis of a potentially life-threatening condition.”

Levetown provides patient cost studies to demonstrate that a restructuring of the nation's health care expenditure could enable children with serious illness to receive quality care at home. The report also offers specific recommendations for improvement in pediatric palliative care in the areas of clinical care, education, research, federal and state regulations, and ethics.

The report is entitled “A Call for Change: Recommendations to Improve the Care of Children Living with Life-Threatening Conditions,” and is available at www.nhpc.org.

AT A GLANCE

- An estimated 53,000 U.S. children die annually
- Of these, only about 5,000 receive hospice services, and for a short duration
- 75% to 85% of deaths among children aged 1 to 19 years occur in the hospital
- 75% of such hospital deaths occur in tertiary care facilities, which are seldom close to home
- 36% of deaths in children aged 1 to 19 are a result of congenital and chronic conditions
- The proportion of infants dying of chronic conditions has risen from 31% in 1980 to 41% in 1997

Patients with Untreated Pain Six Times More Likely to Develop Delirium

'Opioids Should Not Be Withheld from Older Patients,' Researchers Conclude

Noting that physicians are often reluctant to prescribe opioid analgesics in older patients for fear of precipitating or exacerbating delirium, a research team set out to identify risk factors for delirium.

Investigators conducted a prospective cohort study of 541 patients admitted to four New York City hospitals with hip fracture and without delirium.

Delirium was determined prospectively through patient interviews using the Confusion Assessment Method supplemented by reviews of medical records.

Using multiple logistic regression, researchers identified risk factors for delirium in the first 362 subjects. This

data was used to develop a prediction rule, which was validated in the next 179 patients.

In the first cohort, 65 of 362 patients became delirious. Risk factors included:

- ✓ cognitive impairment absent diagnosed dementia
- ✓ dementia
- ✓ heart failure on admission
- ✓ restraint use
- ✓ underprescribing of analgesics

Each of the 179 patients in the validation cohort was successfully stratified using these five risk factors. Patients were stratified into three risk groups: low (2% of subjects), medium (8%), and high (28%).

Investigators found a significant association between severe pain at rest and the development of delirium in patients who were cognitively intact. Such patients with untreated pain were six times more likely to develop delirium than subjects receiving adequate pain control.

“Opioids should not be withheld from older adults for fear of precipitating or worsening delirium,” the study authors conclude.

Source: "The Impact of Pain and Opioid Analgesics on the Development of Delirium," 14th Annual Assembly of the American Academy of Hospice and Palliative Medicine; Jan. 30-Feb. 3, 2002, Palm Springs, CA. Morrison, RS, et al, Hertzberg Palliative Care Institute, Mount Sinai School of Medicine, New York, NY.

Conventional Oncology Treatment Plus Hospice Results in Multiple Benefits

Michigan researchers collected data on 167 patients enrolled in a clinical trial to evaluate the bridging of active treatment and hospice care.

Patients were identified as terminally ill with advanced, metastatic cancers of the lung, breast, prostate, pancreas, and colon. Subjects were randomized between conventional oncology management alone (control group) vs. conventional oncology management plus hospice enrollment and support (intervention group).

Because the conventional oncology protocol included aggressive interventions deemed to be palliative and life expectancy was six months or less, hospice enrollment was appropriate.

Oncologists participating in the study practiced in a comprehensive cancer

center, community-based cancer centers, or private practice.

Ongoing treatments and hospice care were coordinated by a nurse specializing in palliative care.

Investigators measured symptom control, quality of life, caregiver burden index, health care outcomes, and cost of care in service units.

No differences between the two groups were found in symptom control or survival, with median survival rates at 5.5 months for both cohorts.

HOSPICE BENEFITS REPORTED

Data show that patients and families randomized to hospice care benefited significantly in three major areas:

- ✓ **Quality of life**, which was positively impacted by hospice interdisciplinary care
- ✓ **Caregiver burden**, reported to be significantly lower, especially in the first month of care
- ✓ **27% reduction in costs of care** (preliminary analysis only), representing an extrapolated Medicare savings of \$2,540 per patient

Researchers note that findings from this three-year phase III trial may assist in the development of future demonstration projects.

Source: "Palliative Care Project: Bridging Active Treatment and Hospice for Terminal Cancer," 38th Annual Meeting of the American Society of Clinical Oncology; May 2002, Orlando. Finn, JW, Pienta, KJ, Parzuchowski, J, and Worden, F, Hospice of Michigan, Detroit, and University of Michigan Comprehensive Cancer Center, Ann Arbor, MI.

Physicians Demonstrate More Positive Attitudes About Hospice Care Than Generally Assumed

Noting that underutilization of hospice care continues to be a public health issue and that physician knowledge and attitudes are suggested barriers to hospice referral, Michigan researchers set out to identify issues for physicians that might be posing such barriers.

Investigators conducted a mail survey of all physicians in the metropolitan area of a small midwestern city who practiced in any specialty area that referred patients to hospice care. Questionnaires were returned by 190, or 72%, of physicians. Of those, 56% were family physicians. The single largest group of respondents was in the 41- to 50-year-old age group, and 28% percent of respondents had been in practice for more than 20 years.

POSITIVE ATTITUDES ABOUT HOSPICE

Investigators found that physicians are more positive about hospice care than is generally assumed. For example:

- 99% of respondents said they are **comfortable discussing a hospice referral** with patients and families.
- 99% agreed that **hospice is a valuable alternative** for provision of terminal care as compared to hospital, nursing home, or home health services.
- 96% agreed that when there is no longer a realistic hope for cure and a patient's life expectancy is limited to months rather than years, **hospice should always be included in discussions** regarding treatment options.
- 94% said hospice is effective because of its **interdisciplinary approach**.
- 88% agreed that when patient care goals change from rehabilitation to palliation and support, **transfer from home health services to hospice** should be facilitated.

KNOWLEDGE ABOUT HOSPICE SERVICES AND POLICIES

Researchers note that overall, physicians seemed knowledgeable about the services offered by hospices and policies governing hospice care. At a glance:

- 96% of physicians knew that **all adults and children who are terminally ill are candidates for hospice services, not just those with cancer**.
- 77% were aware that **patients may drop hospice benefits and resume them at a later date** if desired.

- 66% knew that **patients may reside in a nursing home** and receive hospice services.

Areas of incorrect or uncertain knowledge included:

- Only 10% of physicians knew that **a patient need not have a 24-hour caregiver available** in order to be eligible for hospice, and 68% of respondents were uncertain.
- Only 7% were aware that **palliative radiation and chemotherapy use did not exclude patients** from hospice care, and 88% were unsure.
- Only 6% were certain that **patients do not need to have health insurance** to receive hospice services, and 64% were unsure.
- Only 3% knew that a terminally ill **patient who lives beyond the 6-month prognosis can continue to receive hospice care**, and 90% were uncertain.

HOSPICE REFERRALS: BENEFITS AND BARRIERS

Overall, physicians rated the following aspects of hospice care "very beneficial:"

- **Enhanced quality of life** for patient and family
- Allows patients to **die at home**
- **Skilled care** for terminally ill
- **Expert pain and symptom management**
- **Interdisciplinary team**
- **Hospice volunteers** available
- **Bereavement services**

Researchers found that only two barriers to hospice referral were rated by a majority of physicians as moderate to strong barriers. In summary:

- 69% of physicians said they find that **patients or families are unwilling or unready to elect hospice services**.
- 51% noted that patients or families are **reluctant to have strangers in their homes**.

The study authors conclude that "further study is needed to elucidate the difficulties in the physician-patient-family interaction that lead both sides to wish for earlier hospice referrals and to attribute delays in that process to the other."

Source: "Physicians and Hospice Care: Attitudes, Knowledge, and Referrals," *Journal of Palliative Medicine*; February 2002; 5(1):85-92. Ogle, KS, et al; Program in Palliative Care Education and Research, Michigan State University, East Lansing, MI.

PHYSICIAN RESOURCES

Responding to Patients' Spiritual Concerns at the End of Life

A National Team of Physicians Offers Practical Guidelines for Helping Patients in Distress

Spiritual or religious concerns can be a source of distress or even the basis of medical decision-making for patients nearing the end of life, says a national team of physicians who developed a practical guide for discussing such issues with terminally ill patients.

Physicians need to know how to approach spiritual concerns when chaplains or clergy are not available or if a patient prefers not to talk to such advisors, the authors note. Their report appears in the Feb. 13, 2002, issue of the *Journal of the American Medical Association*.

“Some patients may explicitly base decisions about life-sustaining interventions on their spiritual or religious beliefs,” write Bernard Lo, MD, Division of General Internal Medicine, University of California, San Francisco, and colleagues. “Physicians need to explore those beliefs to help patients think through their preferences.”

SPECIFIC INTERVENTIONS

In a discussion of life-sustaining interventions, such as cardiopulmonary resuscitation (CPR), patients may make a direct statement

by acknowledging patient and family beliefs and working toward shared goals. “**Patients and families who feel that the physician understands them and cares about them may be more willing to consider the physician’s views on prognosis and treatment,**” he writes. Physicians might say:

- ✓ *I see that your faith is very important to you.*
- ✓ *I would hope, too, that your mother might be able to go home.*
- ✓ *As you think about her illness, what else do you hope for?*

In this discussion, physicians need to listen respectfully and make a connection with the patient and family, with the objective of reaching agreement on clinical goals of care and then mobilizing the necessary support, notes Lo.

POSSIBLE SPIRITUAL DISTRESS

During a clinical discussion, terminally ill patients may make a general statement, such as, “I don’t understand why this is happening to me.” Physicians alert to possible spiritual distress can initiate a dialogue to elicit patient concerns and express their own caring.

“This dialogue is not a digression, but an integral part of clinical care because it builds empathy and helps relieve distress,” writes Lo. “**Patients who believe that the physician has really understood them may no longer feel alone with their distress.**” Physicians can:

- ✓ Ask open-ended questions. *What do you mean...?*
- ✓ Normalize concerns. *Many patients...*
- ✓ Express empathy. *That sounds like a painful situation.*

LIMITS

“**Spiritual suffering cannot be ‘fixed’ in the same way that pain may be alleviated with analgesics,**” warns Lo. Physicians cannot answer the ultimate questions of faith that patients may have at the end of life. Nor should they expound their own beliefs or offer quick or superficial reassurance. “Yet, paradoxically, patients may feel comforted when another person is simply present or ‘walks with’ them.”

Thus, “by responding to patients’ spiritual and religious concerns and needs, **physicians may help them find comfort and closure near the end of life,**” he concludes.

For more information, go to <http://jama.ama-assn.org>.

TIPS FOR PHYSICIANS

- Follow the patient's lead
- Clarify and acknowledge the patient's concerns
- Identify shared goals of care
- Mobilize support

of belief, such as, “I trust God to decide when it’s my time.” Rather than pressing for an immediate decision, physicians can help patients clarify their preferences based on what is important to them. Physicians might say:

- ✓ *What are you thinking when you say...?*
- ✓ *Many patients say they feel puzzled about...*
- ✓ *Would it help if I explained how successful CPR might be in various situations?*

REJECTION OF PHYSICIAN RECOMMENDATIONS

Religious beliefs can sometimes cause patients and families to insist on life-sustaining interventions that their physicians consider futile. Rather than arguing medical facts, says Lo, physicians would do well to defuse potential disagreements

PHYSICIAN RESOURCES

'Five Wishes,' Popular Advance Directive, Now Legal in Most States

An estimated 1.5 million copies of the popular advance directive, "Five Wishes," have been provided nationwide, according to Aging With Dignity, a Florida-based nonprofit organization dedicated to improving end-of-life care.

Five Wishes is legally valid under the advance directive statutes in 35 states. In states where another specific form is mandatory, Five Wishes can be a valuable adjunct document.

"It is unique among all other living will and health agent forms because it looks to all of a person's needs: medical, personal, emotional, and spiritual," Aging With Dignity points out. Five Wishes also encourages individuals to discuss their preferences with family and physicians.

The advance directive is sold for a nominal price: \$5 for one copy; \$2 each for orders of 10-24; and \$1 each for bulk orders of 25 or more. For ordering details or to view a list of states in which the document is legal, go to www.agingwithdignity.org.

Physicians Offer Mnemonic Learning Tools for End-of-Life Care

Using mnemonics as a central theme, physicians from the Bronx VA Medical Center and Mount Sinai School of Medicine in New York have created a set of teaching tools for clinicians who care for patients at the end of life.

The tools are designed to help physicians, nurses, and other clinicians memorize a list of items related to the assessment, care, and treatment of palliative care patients. For example:

G.O.O.D.

Adapted from The Stanford Faculty Development Program on End-of-Life Care, this mnemonic offers steps to follow when helping patients and families make difficult decisions. It stands for: **G**oals of care, **O**ptions, **O**pinions of those involved, and **D**ocumentation of the discussion and decision.

N.O.P.Q.R.S.T.

This tool helps clinicians assess pain and other symptoms. It stands for: **N**umber of pains, **O**origin, **P**alliating factors, **Q**uality, **R**adiation, **S**everity, and **T**iming.

M.&M.s

Entitled the "M&Ms of Nausea & Vomiting," this teaching tool contains a list of etiologies all starting with the letter M, such as **M**etastasis, **M**edication, and **M**icrobes.

Source: "Mnemonics in Palliative Care: Fun Teaching Tool for a Tough Audience," 14th Annual Assembly of the American Academy of Hospice and Palliative Medicine; Jan. 30-Feb. 3, 2002, Palm Springs, CA. Cohen, SE, Bronx VA Medical Center; Pan, CX, Hertzberg Palliative Care Institute, Mount Sinai School of Medicine, New York, NY.

End-of-Life Care Websites

www.eperc.mcw.edu

End of Life Physician Education Center (EPERC)

www.aahpm.org

American Academy of Hospice & Palliative Medicine

www.epec.net

The EPEC Project (Education for Physicians on End-of-Life Care)

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.medicaring.org

Center to Improve Care of the Dying

www.abcd-caring.org

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.medsch.wisc.edu/painpolicy

University of Wisconsin Pain and Policy Studies Group

www.capcmssm.org

Center to Advance Palliative Care

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

End-of-Life Care Meetings for Clinicians

4th Biennial International Forum on Pediatric Pain, The Context of Pediatric Pain: Biology, Family, Society, Culture. Sept. 19-22, 2002, White Point Beach Resort, Nova Scotia, Canada. Sponsors: Pediatric Pain Research Lab, Dalhousie University and the IWK Health Centre. Phone: 902-453-4664; Fax: 902-423-5232; Email: info@conventionalwisdom.ca; Website: www.pediatric-pain.ca/ifpp

14th International Congress on Care of the Terminally Ill and 2nd International Symposium on Research Methods in Palliative Care. Oct. 5-10, 2002, Montreal, Quebec, Canada. Sponsor: Palliative Care Division, Department of Oncology, McGill University. Phone: 514-286-0855; Fax: 514-286-6066; Email: info@eventsintl.com; Website: www.eventsintl.com/pal02

9th Annual Conference, The Science & Art of Pain and Symptom Management. Nov. 15-16, 2002, The Old Mill, 21 Old Mill Road, Toronto, Ontario, Canada. Sponsor: Division of Palliative Medicine, Department of Family and Community Medicine; Oncology Continuing Education; and Department of Radiation Oncology, University of Toronto. Phone: 416-978-2719; Fax: 416-971-2200; Email: ce.med@utoronto.ca; Website: www.cme.utoronto.ca

22nd Annual Scientific Meeting of the American Pain Society. March 20-23, 2003, Chicago, Illinois. Phone: 847-375-4715; Fax: 877-734-8758 (United States) or 732-460-7318 (international); Email: info@ampainsoc.org; Website: www.ampainsoc.org

8th Congress of the European Association for Palliative Care. April 2-5, 2003, Netherlands Congress Centre, The Hague, The Netherlands. Contact: Kenes International, 17 Rue du Cendrier, P.O. Box 1726, CH-1211 Geneva 1, Switzerland. Phone: +41 22 908-0488; Fax: +41 22 732-2850; Email: eapc03@kenes.com

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