

Quality of Life Matters™

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

Vol. 1, Issue 4 Feb/Mar/Apr 2000

JAMA Plans End-of-Life Care Theme Issue

"Little research has focused on the process of defining the shift from prevention to palliation and the necessary components of such care," JAMA's editors report.

The *Journal of the American Medical Association* (JAMA) has announced plans to devote a theme issue in November 2000 to the care of patients at the end of life.

JAMA's editors note that while modern medical science has provided physicians and nurses with effective treatments for promoting health and preventing disease in an increasingly older group of patients, it has at the same time distanced health care professionals from the traditional role of caring for their patients who are dying.

"Little research has focused on the process of defining the shift from prevention to palliation and the necessary components of such care," state Deputy Editor Margaret A. Winker, MD, and Managing Senior Editor Annette Flanagin, RN, MA.

"Few textbooks provide answers to these questions, and physicians and other caregivers have difficulty predicting when patients' lives will end," they add.

The November 2000 end-of-life care theme issue will examine the time in a

patient's life when the focus of care changes from preventive medicine to palliative medicine. Emphasis will be placed on both the patient's role in determining when such a shift occurs and the role of the health care professional in assisting the patient's journey through the end of life, Winker and Flanagin note.

SUBMISSIONS INVITED

JAMA invites health care professionals to submit studies and reports on

Continued on Page 2

Inside:

NewsLine 2-3

- ✓ 95% of Adults Don't Want Life-Sustaining Procedures if Demented
- ✓ More Statewide Partnerships Funded for Care of Dying Programs

Research Monitor 4-6

- ✓ Prognostic Criteria for Hospice Eligibility of Non-Cancer Patients Found Ineffective
- ✓ Study Examines Use of ICU Technologies in Dying Process
- ✓ Lack of Relationship to Patients Prevents the Writing of DNA Orders
- ✓ Pain Assessment Scale Developed for Young Children with Cancer
- ✓ Tube Feeding May Harm Rather Than Benefit Demented Patients
- ✓ Opioid-Induced Constipation Relieved Without Reversal of Analgesia

Physician Resources 7

Hospice Symptom Management Tips Found Valuable for All Practitioners

A recent article in the *Journal of the American Medical Association* (JAMA) summarizes information presented by hospice experts attending a clinical meeting in Chicago last summer entitled Home, Hospice, and Long-Term Care '99.

The author of the JAMA article, M.J. Friedrich, notes that such optimal symptom management techniques can be valuable to all practitioners, not just hospice clinicians.

"Because achieving the best possible symptom management for all patients is an integral goal of medical care, the information gleaned by hospice professionals can be of value to everyone who cares for severely ill patients, including physicians and nurses in whose practices hospices seldom figure," Friedrich states.

WHY HOSPICE WORKS SO WELL

Joni Berry, MS Pharm, of the Hospice of Wake County, NC, a speaker at the Chicago conference, said there are many reasons why hospice care is so effective.

Continued on Page 3

95% of Adults Would Not Want Life-Sustaining Procedures if Demented

An investigation of the attitudes of a group of cognitively normal adults 65 years and older revealed that 95% would not want life-sustaining procedures in the face of severe dementia, and 75% would not want these procedures with even the milder forms of dementia.

In addition, the study found that 60% of the participants did not want to be hospitalized or given antibiotics if they could not recognize their loved ones or care for themselves.

“These preferences stand in stark contrast to existing end-of-life medical practices in so many communities in our country,” notes lead author Dwenda K. Gjerdingen, MD, Department of Family Practice, University of Minnesota, St. Paul. The report was published in the Sept./Oct. 1999 issue of *Archives of Family Medicine*.

Gjerdingen and associates conducted interviews with 84 cog-

nitively normal adults (mean age, 80.5 years) from a variety of urban and suburban sites. The participants were asked to consider their preferences for five procedures in the setting of four levels of hypothetical dementia. The procedures included:

- Cardiopulmonary resuscitation
- Ventilatory support
- Parenteral/enteral tube feedings
- Hospitalization
- Administration of antibiotics

Even if they became ill in their present mental state, only 50% of the subjects would want ventilatory support or tube feedings for life support, and just 6% would want these procedures unconditionally.

In view of the strong opinions concerning life support evidenced in their study, the authors recommend that the topic of dementia be included in advance directive planning.

More Statewide Partnerships Funded for End-of-Life Care Programs

The Community-State Partnership to Improve End-of-Life Care (CSP) has announced the addition of four states to its funding program.

The Minnesota partnership will receive \$445,000; the Florida and New Hampshire partnerships, \$450,000 each; and the Oklahoma partnership, \$375,000.

These four states are among 23 statewide partnerships to receive funding for their programs through CSP,

which is supported by the Robert Wood Johnson Foundation (RWJF) of Princeton, NJ. A total of \$11.25 million will be awarded by RWJF over three years to support broad-based, multidisciplinary state coalitions in their efforts to improve end-of-life care.

The coalitions identify problems, make recommendations, and build public support for practical policies, regulations, and guidelines for the care of the dying.

JAMA (from Page 1)

caregiving for patients of all ages who are dying from:

1. Well-studied diseases such as:

- Metastatic cancer
- AIDS

2. Other diseases such as:

- Dementia
- Congestive heart failure
- Chronic liver failure
- End-stage chronic lung disease

According to the editors, JAMA is looking for studies that:

- Analyze data and tools to measure quality of life and outcomes of care for terminally ill patients

- Explore ways to assess, treat, and support the physical, psychological, social, and spiritual dimensions of dying

- Examine treatments and interventions to prevent and alleviate pain and other symptoms

- Identify and recommend ways to remove social, system, and financial barriers to end-of-life care

Topics of interest include:

- Ways to reconcile medical training that focuses on ‘cure and save’ with the emotional and spiritual challenges of clinical care of dying patients

- Ways clinicians can make the mental and emotional shift necessary to accept and embrace end-of-life care, so they can then optimally care for patients at the end of life.

See “Caring for Patients at the End of Life: Call for Papers,” *JAMA*; 1999; 282:1638-1645, or access the website at <http://jama.ama-assn.org>. For information on submitting papers for publication, see “Instructions for Authors,” *JAMA*; 1999; 282:84-92, or visit the web page at <http://jama.ama-assn.org/info/auinst.html>. Manuscripts received by March 30, 2000, will have the best chance for acceptance.

Symptom Management *(from Page 1)*

tive. She said that hospice practitioners:

- Focus on each symptom as an active problem.
- Accept that pain is what the patient says it is.
- Consider the interaction between physical symptoms and psychosocial events.
- Monitor symptoms constantly and adjust treatment accordingly.

PHARMACOLOGICAL CONSIDERATIONS

Berry offered pharmacological insights, such as:

- When assessing a patient, examine all medications. Look for duplications or unnecessary drugs. When patients enter a hospice program, pain very often is not under control.

Patients might be taking medications for insomnia, anxiety, depression, or other adverse effects of chronic pain. Once the pain is controlled, certain other drugs may become superfluous.

- Monitor symptoms continually so drugs can be titrated accordingly. This is important because pharmacokinetics and pharmacodynamics are affected by a patient's declining condition.

- Remember that: 1) Drug absorption may be affected by reduced stomach acid; 2) Poor blood flow can affect drug distribution in patients with cardiac disease or low body fat; and 3) Hepatic dysfunction may cause a reduced ability to metabolize drugs.

SYMPTOM MANAGEMENT TIPS

Joni Berry, MS Pharm, of the Hospice of Wake County, NC, presented the following tips at the Home, Hospice, and Long-Term Care '99 Conference in Chicago:

- **PAIN.** Determine the **source of the pain** and whether it is responsive to opioids. Muscle pain is not, so consider a nonpharmacological therapy such as massage to provide relief. **Nerve pain** is only partially responsive to opioids. Start with nonpharmacological means and adjuvants of pain control, then add opioids if needed. With **damaged nerves**, use antidepressants and anticonvulsants to help normalize conduction within the nerve, thus decreasing pain. **When opioids are appropriate**, morphine is Berry's drug of choice. Interest is growing in oxycodone and the lozenge form of fentanyl, she notes. She recommends the latter for breakthrough pain in patients who still work and need to self-titrate. **Non-pharmacological means** of pain management, such as massage, guided imagery, and biofeedback, are sometimes more effective than medications. "Clearly we need to mesh the two."

- **WEAKNESS & FATIGUE.** Berry recommends dexamethasone and methylphenidate, which increase energy levels and improve appetite.

- **DYSPNEA.** Consider long-acting bronchodilators and opioids, as morphine is believed to reset the respiratory center in the medulla.

- **ANXIETY.** Berry avoids alprazolam, as it can cause rebound anxiety in three to four hours. She uses oxazepam for elderly patients because it is metabolized in one step, and clonazepam, which can work for up to 24 hours.

- **STRESS & GRIEF.** Be aware that these are

normal reactions upon learning of a life-limiting illness. Often patients go through a period of grieving and then adjust.

- **DEPRESSION.** Diagnosing depression can be difficult, because the symptoms can also be caused by pain, illness, or medications. Focus on the way patients describe how they feel, and listen for indications of clinical depression, such as feelings of worthlessness, loss of self esteem, and suicidal thoughts.

Stephen Arter, RPh, BS Pharm, a consultant with Parkview Home Health Hospice in Fort Wayne, IN, also presented symptom management tips, such as:

- **NAUSEA & VOMITING.** Identify which of four potential vomiting sites is being stimulated, select the group of antiemetics specific to that site, then choose the most potent drug with fewest side effects. If symptoms do not subside, increase dosage. If this fails, reassess the patient.

- **CONSTIPATION.** Initiate a bowel regimen for patients taking opioids, since opioids stop peristalsis of the round muscles in the gut. One option is a petroleum jelly ball. Use a quarter teaspoon of petroleum jelly, frozen, and rolled in powdered sugar. Arter says a few doses can help any type of impaction.

The above was adapted from an article published in the Oct. 6, 1999, issue of JAMA. Author Friedrich notes, "A myriad of other symptoms plague hospice patients. While it is not always possible to avoid all factors that can interfere with a peaceful death, alleviating as many of the patient's symptoms as possible is a primary goal of hospice care."

Prognostic Criteria for Hospice Eligibility of Non-Cancer Patients Found Ineffective

In a study of 2607 seriously ill adult patients hospitalized with chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), or end-stage liver disease (ESLD), researchers found that prognostic models based on currently available criteria for identifying those patients likely to live 6 months or less were ineffective when the results were compared with actual survival at 6-month follow-up.

According to the study authors, this prognostic failure may not necessarily imply serious flaws in the clinical guidelines. "The more likely implication of this study is that the goal of determining in advance—with a high degree of accuracy—which individual patients with COPD, CHF, or ESLD will die within 6 months is unrealistic."

Predicting 6-month survival in this patient group may be an unrealistic goal, say researchers.

The validation study used data from the Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT) to follow a consecutive

sample of 2607 patients with one of three commonly fatal chronic diseases (COPD, CHF, or ESLD) who survived to hospital discharge, with a follow-up at 6 months.

"The combination criteria we analyzed all succeeded in excluding most patients who lived longer than 6 months, but in doing so they also excluded the vast majority of the target group they were supposed to identify—patients who were dead in 6 months or less," state the authors.

The prognostic criteria evaluated in this study, therefore, "were largely ineffective in predicting which seriously ill hospitalized patients with COPD, CHF, or ESLD have a prognosis of 6 months or less," they conclude.

While cancer patients often experience a period of steady decline before death, many patients with advanced lung, heart, or liver disease "never experience a time during which they are clearly dying of their disease," note the authors. Their analysis suggests that

"if a high degree of predictive accuracy is demanded by those who interpret the 6-month prognostic requirement for hospice enrollment, few patients who die of these types of chronic diseases will be eligible for hospice care."

Source: "Evaluation of Prognostic Criteria for Determining Hospice Eligibility in Patients with Advanced Lung, Heart, or Liver Disease," Journal of the American Medical Association; Nov. 3, 1999; 282:1638-1645. Fox E, Landrum-McNiff K, Zhong Z, et al, for the SUPPORT Investigators; National Ethics Center, Veterans Health Administration, Department of Veterans Affairs, Washington, DC; Center to Improve Care of the Dying, The George Washington University School of Medicine and Health Sciences, Washington, DC)

Canadian Team Examines Use of ICU Technologies to Ease the Dying Process

Canadian researchers report that although intensive care unit (ICU) life-support technologies are traditionally used to treat morbidity and delay mortality in patients, they may also be used to ease the way for dying patients.

"The orchestration of death involves process-oriented as well as outcome-oriented uses of technology," says lead author Deborah J. Cook, MD. "These uses should be considered in the assessment of life-support technologies and directives for their appropriate use in the ICU."

In the 15-bed ICU of a university-affiliated hospital, Cook and colleagues observed 25 rounds and 11 family meetings addressing the withdrawal or withholding of advanced life support. Interviews discussing patients and life-support practices in general were conducted with ICU and hospital staff. The objective of the study was to understand how advanced life support is used in the care of critically ill, dying patients who are unable to make their own decisions.

Investigators found that the therapeutic goals of ICU life support can shift from extending life to allowing life to end. "Decisions to withhold, provide, continue, or withdraw life support are socially negotiated to synchronize understanding and expectations among family members and clinicians," they note. "Withdrawal is not a de-

cisive event, but rather an unfolding process,” the authors conclude.

Source: "Life Support in the Intensive Care Unit: A Qualitative Investigation of Technological Purposes," Canadian Medical Association Journal; Nov. 2, 1999; 161(9): 1109-1113, Cook DJ, Giacomini M, et al, for the Canadian Critical Care Trials Group; Department of Medicine, St. Joseph's Hospital, Hamilton, Ont.

Lack of Relationship to Patients Prevents Attending Physicians from Writing DNR Orders

When an earlier study revealed that only 23% of patients in their intensive care unit were designated do-not-resuscitate (DNR), investigators at a tertiary care, university-affiliated hospital conducted a study to determine what impediments to writing DNR orders their physician staff might be experiencing. They concluded that **“limitations in the extent and depth of the physician-patient relationship” underlay the explanations given most often by the physicians.**

Over a 4-month period, all inpatient (n=613) medical records were evaluated for diagnoses indicating increased likelihood of mortality by use of a DNR screening tool. The resulting “DNR possibly warranted” charts were then given to a 5-member multidisciplinary panel, which identified 149 patients for whom DNR orders were indicated. Of these, 88 (59%) had no DNR orders written. Absence of a DNR order was not found to correlate with age, sex, or race.

Attending physicians were given the case summaries, asked in an interview to recall the reasons that a DNR order had not been written, and supplied with a list of 11 possible reasons, including “other.” When more than one reason was appropriate for the same case, physicians were asked to rank their answers by importance.

The most frequently cited impediment (56%) was the belief that the patient was not likely to die during that hospital stay. The second most often described impediment (49%)—and the most frequent first choice in this

group of physicians—was the perception that it was the primary physician’s responsibility to discuss DNR issues. Third (43%) was the feeling of not knowing the patient well enough and not having sufficient time to discuss end-of-life choices. **“Our study provides insights into why attending physicians opt not to discuss end-of-life issues: time pressure and deference to the patient’s main care provider,” the authors note.**

Source: “Impediments to Writing Do-Not-Resuscitate Orders,” Archives of Internal Medicine; Oct. 11, 1999; 159:2213-2218. Eliasson AH, Parker JM, Shorr AF, et al; Departments of Medicine and Clinical Investigation, Walter Reed Army Medical Center, Washington, DC; Department of Medicine, Uniformed Services University of the Health Sciences, Bethesda, Maryland.

Pain Assessment Scale Developed for Young Children

French researchers have developed and tested a scale for grading prolonged pain in children with progressive cancer. The Gustave Roussy Child Pain Scale (Douleur Enfant Gustave Roussy, or DEGR scale) bases its scorings on the usual activity of children aged 2 to 6 years.

Designed to be completed during the children’s playtime, the DEGR takes about 5 to 10 minutes to complete. The 15 scale items, which are rated from 0 to 4, consist of 6 behaviors specific to pain, 5 psychomotor inertia items, and 4 anxiety items, with a total score ranging from 0 to 60.

In the first part of the study, 152 children (aged 2 to 6 years) with progressive cancer were rated according to the DEGR scale by 2 nurses in a pediatric cancer ward. Next, 53 of these children were videotaped; their pain was assessed by a panel of specialists using a 0 to 7 Likert scale, as well as by a nurse using the DEGR scale. A DEGR score of more than 12 indicated pain.

The DEGR scale was found to correlate strongly with the pain specialists’ ratings.

Source: “The Development of the DEGR: A Scale to Assess Pain in Young Children with Cancer,” European Journal of Pain; June 1999; Vol. 3, No. 2: 165-176. Gauvain-Piquard A, Rodary C, Rezvani A, Serbouti S; Psychiatry and Psycho-Oncology Unit, Institut Gustave Roussy, Villejuif, France.

Impediments to writing DNR orders included time pressures and deference to the patient’s primary physician.

Tube Feeding May Harm Rather Than Benefit Severely Demented Patients

Following a review of more than 30 years of medical literature on the subject, researchers have concluded that enteral tube feeding offers no clinical benefit to patients with advanced dementia, yet the risks of this therapy may be substantial.

Tube feeding is often used for severely demented patients who develop difficulties with eating. In addition to providing nourishment, the therapy is believed to prevent aspiration pneumonia, forestall the consequences of malnutrition, prolong survival, prevent pressure ulcers and other infections, and provide patient comfort.

To determine whether any type of tube feeding can accomplish these goals in this group of patients, a team from the Johns Hopkins Geriatrics Center, Baltimore, searched MEDLINE from 1966 through March 1999 for clinical evidence of benefits and risks of this therapy. **“We found no data to suggest that tube feeding improves any of these clinically important outcomes and some data to suggest that it does not,” they report. “Further, risks are substantial.”**

The available data on the benefits and risks of this therapy suggest that:

- Tube feeding may increase rather than prevent the risk of aspiration pneumonia.
- Wasting may not be a cause of death, but rather a component of the dying process.
- Patients who are tube fed do not necessarily survive longer than other patients, and feeding tube placement can itself cause death.
- There is no link between nutrient intake and the prevention or improvement of pressure sores or other infections, yet feeding tubes may cause infection.
- Feeding tubes diminish human contact and are often uncomfortable.

The authors offer “conservative alternatives” to tube feeding, including conscientious hand feeding, the discontinuation of nonessential medications, the use of ad-lib diets and assistive devices, modifications in the patient’s environment, and an evaluation for other illnesses, particularly depression. “The widespread practice of tube feeding should be carefully reconsidered,”

they conclude, “and we believe that for severely demented patients the practice should be discouraged on clinical grounds.”

Source: “Tube Feeding in Patients with Advanced Dementia: A Review of the Evidence,” Journal of the American Medical Association; Oct. 13, 1999; 282:1365-1370. Finucane TE, Christmas C, Travis K; Division of Geriatric Medicine and Gerontology, Johns Hopkins Bayview Medical Center, Baltimore.

Trial Shows Relief of Opioid-Induced Constipation Without Reversal of Analgesia

Constipation is the most common long-term adverse effect of opioid pain medications in patients with advanced cancer, and many hospice patients choose to endure their pain rather than experience the often incapacitating constipation that opioids can cause, researchers say.

In a double-blind, randomized, placebo-controlled trial, investigators found methylnaltrexone (N-methylnaltrexone bromide) to be effective in treating chronic methadone-induced constipation, with no evidence of opioid withdrawal.

Subjects who had been enrolled in a methadone maintenance program for 1 month or longer were admitted to the research center of a university hospital for 2 days. All 22 patients had methadone-induced constipation (no or 1 bowel movement in the previous 3 days, or 2 or fewer bowel movements in the previous week), and all continued to receive their usual dosage of methadone.

Participants were randomly assigned to receive intravenous placebo or methylnaltrexone. While those in the placebo group showed no laxation response, all 11 subjects in the intervention group had laxation response with methylnaltrexone administration.

No opioid withdrawal symptoms were observed in any patients, the researchers report, suggesting that methylnaltrexone is a novel peripheral opioid receptor antagonist. Since it does not penetrate into the brain, it does not cause reversal of analgesia.

Source: “Methylnaltrexone for Reversal of Constipation Due to Chronic Methadone Use,” Journal of the American Medical Association; Jan. 19, 2000; 283:367-372. Yuan CS, Foss JF, O’Connor M, et al; Committee on Clinical Pharmacology and Departments of Anesthesia and Critical Care, Pritzker School of Medicine, University of Chicago, Chicago.

PHYSICIAN RESOURCES

Medical Schools to Improve Curricula in Geriatrics and End-of-Life Care

The Association of American Medical Colleges has announced the receipt of a four-year, \$2.6 million grant from the John A. Hartford Foundation, New York, NY, to improve the teaching of geriatrics and gerontology in US medical schools.

Scheduled to begin in the fall of 2000, the program will support selected medical schools in their efforts to provide students with the necessary skills to deliver high quality, compassionate care to the nation's growing elderly population and to handle the complex issues associated with end-of-life care.

Despite the presence of geriatrics in the curricula of most medical schools

(122 of 125), nearly one-third of recent graduates perceived their instruction in the care of the elderly to be inadequate, according to the association.

Medical school graduates noted that instruction in specific topics related to geriatrics—such as death and dying—was lacking.

“As our population ages, the new generation of physicians must be particularly skilled in caring for the elderly,” says association president Jordan J. Cohen, MD. “To meet this demand, the topic of geriatrics must be represented in a more coherent and comprehensive manner in the curricula of all US medical schools.”

Books on Care of the Dying

Symptom Management Algorithms: A Handbook for Palliative Care, 2nd Edition

By Linda Wrede-Seaman, MD, this pocket-sized handbook presents decision algorithms for the assessment and management of pain and common symptoms in terminal illness. Each section integrates assessment procedures with a range of pharmacologic and non-pharmacologic treatment algorithms. Topics covered include:

- Pain and symptom management
- Use of the Karnofsky and ECOG scales
- Appetite problems and palliative nutrition
- Cultural sensitivity guidelines
- Tables of adjuvant medications

Published by Intellicard, 1999; ISBN: 1888411007-4 (paperback); 109 pp.

Forgoing Life-Sustaining Therapy: How to Care for the Patient Who Is Near Death

By Margaret L. Campbell, RN, MSN, CS, this is a handbook for clinical care providers, offering practical guidance and clinical case examples on such issues as how to stop a ventilator, the use of artificial nutrition and hydration, and forgoing dialysis in the final days of life. Chapter headings include:

- Ethical and Legal Considerations
- Communicating a Poor Prognosis
- Usual Care Requirements for the Patient Who Is Near Death
- Responding to a Patient's Fear, Anxiety, and Delirium
- Grief: Family Needs

Published by the American Association of Critical-Care Nurses, 1998; ISBN: 0945812779 (paperback); 140 pp.

End-of-Life Care Websites

www.aahpm.org

American Academy of Hospice & Palliative Medicine.

www.nho.org

National Hospice Organization.

www.hospicefoundation.org

Hospice Foundation of America.

www.americanhospice.org

American Hospice Foundation.

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, care and caring at the end of life.

www.mcw.edu/pallmed/

Palliative Medicine Program at the Medical College of Wisconsin. Includes “Improving End-of-Life Care: a Resource for Physician Education.”

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.

Upcoming Palliative Care Meetings for Physicians

End-of-Life Issues in the 21st Century. April 14-15, 2000, Tampa Convention Center and Tampa Marriott, Tampa. Sponsors: LifePath Hospice and the University of South Florida College of Medicine. Contact: Lara Gelsing. e-mail: lwgelsing@yahoo.com

Palliative Care Into the 21st Century. June 7-9, 2000, Dublin Castle, Ireland. Contact: Ms. Olwyn Ryan, 5 Northumberland Road, Dublin 4, Ireland. Phone: 353 (1) 668-1855; Fax: 353 (1) 668-7599; e-mail: oryan@irishcancer.ie

The 11th National Meeting for State Cancer Pain Initiatives. June 15-17, 2000, Westin Crown Center, Kansas City, Mo. Sponsor: The American Alliance of Cancer Pain Initiatives. Contact: Mary Bennet. Phone: 608-265-4013; e-mail: aacpi@aacpi.org

Palliative Medicine Goes Mainstream: 12th Annual Assembly. June 26-July 1, 2000, Hilton Hotel, Atlanta. Sponsor: American Academy of Hospice and Palliative Medicine. Phone: 847-375-4712; Website: www.aahpm.org

Worldwide Pain Conference. July 15-21, San Francisco Marriott Hotel, San Francisco. Contact: Meetings Plus, 242 Lafayette Circle, Lafayette, Calif. 94549. Phone: 925-284-4040; e-mail: painconference2000@meetingsplus.com

Palliative Care 2000. September 22-23, 2000, Newport Regatta Club, Newport, R.I. Sponsor: Care New England, endorsed by the American Academy of Hospice and Palliative Medicine. Contact: Palliative Care 2000. Phone: 401-737-7010, ext. 1435.

This Is Your *FREE* Space Each Issue!

Each issue we will design and typeset your custom copy for this box. You might choose to use this space to:

- List your ongoing services,
- Emphasize your mission statement,
- Introduce key personnel, or
- Announce upcoming events.

By customizing this box, the newsletter lands on the referring clinician's desk as an educational service from YOUR organization. Let's work together to educate physicians and other clinicians about the importance of hospice and palliative care.

Like you, we're passionate about hospice care!

Quality of Life Publishing Co. specializes in clinical and grief support publications for hospices and other end-of-life care organizations. Members of the National Hospice & Palliative Care Organization since 1999.

QUALITY OF LIFE MATTERS™

is a physician newsletter dedicated solely to end-of-life care news and clinical findings. It is researched and written by professional medical journalists who have been covering palliative and hospice care issues for a decade.

QUALITY OF LIFE MATTERS is an independent publication. It is not affiliated with any health care organization or company.

The quarterly newsletter is published by Quality of Life Publishing Co., a firm dedicated to easing the way for dying patients and their families.

Hospices provide copies of QUALITY OF LIFE MATTERS as an educational service to their area physicians. Call Quality of Life Publishing Co. for information and rates:

TOLL FREE

1-877-513-0099

Joyceanna J. Rautio
Publisher

Karla M. Wheeler
Editor

Jan Carlton Doetsch
Clinical Editor

© 2000 by Quality of Life Publishing Co. All rights reserved. No part of this newsletter may be reproduced without prior permission of the publisher. For reprint requests or information:

Tel: 941-513-9907

Toll Free: 1-877-513-0099

Fax: 941-513-0088

Email: info@QoLpublishing.com

Quality of Life Publishing Co.
10641 Airport Rd. N., Ste. 31
Naples, FL 34109