

# Quality of Life Matters™

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

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## Persistent Legal Myths Pose Barriers to Good End-of-Life Care

Misconceptions about current laws can undermine ethical medical practice and prevent the quality care of dying patients, according to a statement developed by the Consensus Panel on End-of-Life Care, convened by the American College of Physicians-American Society of Internal Medicine (ACP-ASIM).

Because of the persistence of some legal myths, says the statement, **physicians tend to overestimate the legal risks of certain practices**, such as the use of high doses of medication intended to treat pain. Such myths may also keep patients and surrogates from knowing, for example, that they have the right to refuse artificial fluids and nutrition.

**“Physicians need to be able to separate fact from fiction in determining how to care for patients and respect patient rights,”** says Bernard Lo, MD,

chairman of the consensus panel. [See *Practical Guidance below.*]

With the expanding national focus on care of the dying, much ethical and legal consensus has been established, the statement notes. However, some confusion and differences still do exist, and physi-

cians are urged to stay abreast of changes in the laws of the state in which they practice.

For more information, call the ACP-ASIM Center for Ethics and Professionalism at **215-351-2839** or log on to [www.acponline.org/ethics/papers.htm](http://www.acponline.org/ethics/papers.htm).

## Practical Guidance for Physicians Who Are Not Palliative Care Specialists

**NOTE: The following is not intended to be an up-to-the-minute reflection of laws within each jurisdiction. Physicians are urged to stay abreast of changes in the laws of the state in which they practice. Adapted from ACP-ASIM End-of-Life Care Consensus Panel paper, “Seven Legal Barriers to End-of-Life Care: Myths, Realities, and Grains of Truth,” published in the Journal of the American Medical Association, November 15, 2000 (284:2495-2501).**

### Withholding and Withdrawing Treatment

- **Evidence of Patient's Wish.** Most states do not require evidence of an incapacitated patient's actual wish for life-sustaining treatment to be foregone.
- **Surrogate's Role.** If the surrogate declares that this was the patient's actual wish, or, in most states, that it was the patient's probable wish, any medical treatment—including the administration of artificial fluids and nutrition—may be withheld or withdrawn.
- **Risk Manager?** There is no legal requirement that a risk manager must be consulted before end-of-life decisions are made.

### Advance Directives

- **All states** have health care power of attorney statutes. Court decisions have upheld the validity of living wills in the 3 states without living will statutes. Even if they do not comply with specific forms, advance directives can provide the best guidance in end-of-life decision-making for the incapacitated patient.
- **Oral advance directives** are legally valid and should be entered into the patient's medical record.

### Pain Management

- **Criminal Prosecution?** Physicians who prescribe or administer high doses of medication with the intention of relieving pain in the terminally ill have not committed murder or assisted suicide if the patient inadvertently dies.

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## Physicians Urged to Use Hospice Principles to Relieve Suffering in Other Care Settings

Until the beginning of the 20th Century, most people died at home, surrounded by loved ones. Yet, despite the growth and success of the hospice movement, an estimated **85% of Americans currently die in hospitals (60%) and other health care facilities (25%),** often suffering unnecessarily in a depersonalized and medically prolonged process of dying. **All physicians who care for imminently dying patients can do more to relieve their suffering by adopting the hospice principles of care.**

That is the position outlined in a special paper prepared for the Mayo Clinic Cancer Center Quality of Life Working Group by Teresa A. Rummans, MD, Department of Psychiatry and Psychology, Mayo Clinic, Rochester, Minn., and colleagues. The paper, entitled **“Maintaining Quality of Life at the End of Life,”** appeared in the December 2000 issue of the *Mayo Clinic Proceedings*.

**Physicians have an ever-expanding role in the manner in which people die,** the authors say. Physicians may unintentionally increase end-of-life suffering by not changing their primary focus of care from postponing death to eliminating the obstacles that interfere with quality of life at the end of life.

**“As physicians, we are obligated to focus equally on the quality of our patients’ dying as on fending off death at the expense of the quality of life,”** Rummans’ group writes. “With modern medicine emphasizing genetic manipulations, high technology, and cure at all costs, **we often neglect what was once the most sacred aspect of being a physician: alleviating suffering.**”

The paper outlines the basic principles

### **While visiting a patient, physicians can:**

- **Take time to sit rather than stand** – even if only briefly – and resist the urge to check the time
- **Listen to patients** talk about their illness without immediately offering interventions; **the best intervention can sometimes be a physician’s undivided attention**
- **Accept where each patient is** in the dying process, rather than offering superficial comments or judgmental opinions about where the patient ‘should’ be
- **Be aware of personal limitations,** so as not to impose private biases on patients who are dying

of multidimensional quality care for dying patients, and recommends ways for physicians to make the transition from active treatment and crisis management to palliation. Addressing pain and other somatic symptoms is a priority in palliative care, say the authors. But physicians must not neglect treatment of the **psychological, social, and spiritual dimensions of suffering.**

For example, a critical aspect of a dying patient’s quality of life is **social connectedness,** which physicians can offer by **maintaining the physician-patient relationship.** “Physicians must recall and focus on the impact that ‘caring’ has on a patient’s quality of life,” the authors write.

**No one physician can be all things to one patient,** or meet all of a dying patient’s needs, the authors warn. Spiritual care, for instance, is an important part of palliative care, and maintains hope. If a patient requests more spiritual support than the physician can provide, or has other unmet needs, Rummans’ group urges referrals to other health care professionals, or to psychologists, social workers, and chaplains.

For a copy of “Maintaining Quality of Life at the End of Life,” log on to [www.mayo.edu/proceedings](http://www.mayo.edu/proceedings).

## Patient Satisfaction Increases Following AD Discussion with Physician

Elderly and chronically ill patients said they were more satisfied with their primary care physicians and outpatient visits after advance directives (ADs) had been discussed, a new study has found.

**Physicians often hesitate to initiate such discussions for fear of upsetting patients,** the researchers note. **But the percentage of study patients who rated their visits as “excellent” rose from 34% for visits prior to AD discussion to 51% for visits after ADs had been discussed.**

“The improvement in visit satisfaction was substantial and

persistent,” says study leader William M. Tierney, MD, of the Department of Medicine at the Indiana University School of Medicine, Indianapolis. The report appeared in the January 2001 issue of the *Journal of General Internal Medicine*.

**“It is particularly important that physicians hold such discussions in the primary care environment during routine visits,”** says Tierney. “Patients are less likely to be acutely ill during these routine visits and can carefully explore end-of-life care issues with a physician they know and likely trust.”

## Physicians' Misunderstanding of Hospice Eligibility Rules May Limit Patient Referrals

**Although most physicians report being satisfied with their experiences with hospice care for terminally ill patients, nearly half of their eligible patients are not referred,** according to a team of Yale researchers. Among the factors limiting hospice use, the team found, is physician misperception of the fundamental facts about hospice eligibility and benefit rules.

**“Many patients are missing out on the benefits of hospice care, which has been shown to improve the quality of life for terminally ill patients,”** says study leader Elizabeth H. Bradley, PhD, Assistant Professor in the Department of Epidemiology and Public Health, Yale University School of Medicine, New Haven. **“The study indicates that physicians refer only 55% of their eligible, terminally ill patients for hospice care, and that many physicians lack knowledge about basic facts concerning hospice.”** The study report was published in the December 22, 2000, issue of the *Journal of Palliative Care*.

To determine the proportion of eligible patients referred to hospice care and to evaluate physician factors related to referral, Bradley and colleagues analyzed data from self-administered questionnaires completed by 231 Connecticut physicians in 1999 and 2000. Respondents included internists, family physicians, oncologists, pulmonologists, and cardiologists who had admitted patients to community hospitals in the previous year.

**Overall, 74% of physicians said they were “very satisfied” with their experiences with hospice;** only 1.8% reported any dissatisfaction.

Nonetheless, an average of only 54.8% referred their eligible terminally ill patients to hospice; 26.7% referred less than one-quarter of eligible patients, and 12% re-

ferred none. Nearly 25% of physicians referred all of their terminally ill patients to hospice care. Terminally ill was defined as “expected to die within six months.”

Physician factors independently associated with hospice referral included:

- **MEDICAL SPECIALTY.** Oncologists referred the largest proportion (68%) of patients, while cardiologists referred the smallest (40%).

- **BOARD CERTIFICATION.** Physicians with board certification were more likely to refer eligible patients than were those without board certification.

- **KNOWLEDGE OF HOSPICE.** Greater knowledge about hospice policies was associated with greater propensity for hospice referral of eligible patients.

Although most (74.5%) of the respondents indicated that they were knowledgeable “enough” to discuss hospice care with patients and families, an analysis of their objective knowledge of hospice revealed important gaps. For instance, says Bradley, many physicians (42%) reported that a patient must be expected to die within two months to be eligible for inpatient hospice care, whereas the law states one must be expected to die within six months.

Nearly 40% of physicians did not know the consequence for referring a patient to hospice who then did not die within six months, and one-third were unaware that patients may revoke their hospice benefits and return to their standard or managed care benefits under Medicare Part A.

### MEDICARE HOSPICE BENEFITS

According to federal law, Medicare Part A beneficiaries are eligible for hospice care when they:

- Sign a statement choosing hospice care rather than curative treatment
- Are certified by a physician and the hospice medical director as having a life expectancy of six months or less if the illness runs its normal course
- Enroll in a Medicare-approved hospice program. Medicare will continue to provide care for any covered health problems that are not related to the terminal illness. Patients who cannot live at home may receive hospice care in a hospice facility, hospital, or nursing home

Hospice care is provided in “periods of care.” Patients may receive hospice care for two 90-day periods followed by an unlimited number of 60-day periods, provided the physicians continue to recertify the terminal illness for each period of care.

A hospice patient has the right to stop receiving hospice care at any time, for any reason. Medicare coverage then reverts to the patient’s original standard or managed care plan. If eligible, a patient may resume hospice care at any time.

Source: *Medicare Hospice Benefits*. U.S. Department of Health and Human Services; Publication No. HCFA 02154.

## Hospice Use Varies Widely Across U.S.

A national analysis of hospice use by Medicare beneficiaries in 1996 has found wide geographic variation, with rates of death in hospice care **varying more than 11-fold among the largest metropolitan statistical areas**, researchers report.

Portland, Maine, for example, had the lowest rate of hospice use per 100 deaths at 3.5, while Fort Lauderdale had the highest rate, 39.7. Low rates for New York City (7.5) and Albuquerque (7.5) contrast with higher rates for Phoenix (30.3) and Chicago (20.2). **Nationwide, 15.5 of every 100 Medicare patients (aged 65 and older) who die use hospice care**, the study found.

Several demographic characteristics were found to be strongly associated with hospice use. Persons in the **younger** age group (65-74 years), **non-black** persons, and those who lived in **wealthier or urban areas** were much more likely to use hospice care. **Women** were slightly more likely to use hospice, as were persons who paid their own **Medicare premiums** (vs. those with state buy-ins.)

Factors of local markets (Hospital Service Areas) were also related to hospice use, as were local health care resources. A larger proportion of hospice users with non-cancer diagnoses within a market was strongly related to overall increased hospice use. Areas with fewer hospital beds per capita, and areas with lower in-hospital death rates showed higher hospice use. Further, markets with greater managed care penetration also had higher rates of deaths in hospice.

**The study is limited by lack of information on patient preferences**, upon which the individual choice to use hospice services should be based, the authors note. Although there is a possibility that cultural or social factors may be causing patients to refuse their physicians' recommendations to enter hospice, **the large variability found across even culturally similar areas indicates that patient preferences alone are not an influence**, they comment.

"These findings suggest that use of hospice services is a complex decision that is influenced by both patient and community characteristics... **Attempts to change patterns of hospice use must consider this variety of factors.**"

*Source: "Geographic Variation in Hospice Use Prior to Death," Journal of the American Geriatrics Society; September 2000; 48(9):1117-1125. Virnig BA, Kind S, McBean M, Fisher E; University of Minnesota School of Public Health, Minneapolis; Dartmouth Medical School, Hanover, New Hampshire; White River Junction Veterans Affairs Medical Center, White River Junction, Vermont.*

## Eight Measurable Areas of Concern Identified Among Dying Patients

An analysis of survey information from a national cohort of nearly a thousand terminally ill patients validates a conceptual framework for quality end-of-life care based on patients' perspectives, researchers have found. Eight measurable dimensions of concern to dying patients were identified.

**The findings confirm the importance of both quality clinician communication and an interdisciplinary team approach to end-of-life care**, note the authors, led by Linda L. Emanuel, MD, PhD, Director of the Interdisciplinary Program on Professionalism and Human Rights at Northwestern University Medical School, Chicago.

The researchers analyzed data from in-person interviews conducted among 988 terminally ill patients (mean age, 66.5 years; cancer diagnosis, 51.8%) between March 1996 and July 1997. A follow-up interview with 650 of the 682 surviving patients was completed 4-6 months after the baseline interview. Factor analysis was used to identify discrete dimensions, and regression analysis was used to examine associations both among the dimensions, and between dimensions and sociodemographic characteristics.

Analysis revealed **8 measurable factors that were personally meaningful to terminally ill patients across sociodemographic groups and over time**. These are:

- √ Patient-clinician relationship
- √ Social connectedness
- √ Caregiving needs
- √ Psychological distress
- √ Spirituality/religiousness
- √ Personal acceptance
- √ Sense of purpose
- √ Clinician communication

Although 4 factors (unmet needs, access to care, financial burden, and pain and other symptoms) did not meet the study criteria, these may be found to represent measurable dimensions in future studies and deserve attention, the authors note.

*Source: What Terminally Ill Patients Care About: Toward a Validated Construct of Patients' Perspectives," Journal of Palliative Medicine; Winter 2000; Vol. 3, No. 4:419-431. Emanuel LL, Alpert HR, Baldwin DC, Jr., Emanuel EJ; Department of Medicine, Northwestern University Medical School, Chicago; Vital Science & Health, Newtonville, Massachusetts; Institute for Ethics, American Medical Association, Chicago; Department of Clinical Bioethics, National Institutes of Health, Bethesda, Maryland.*

## Earlier Recognition of Prognosis Linked to Treatment of Suffering in Children Dying of Cancer

Not until more than 3 months after a prognosis is documented by physicians do parents of children with advanced cancer understand that there is no realistic hope of cure, a new study has found. **Yet when both the parents and physicians recognize the prognosis at least 50 days prior to death, there is greater integration of palliative care into the child's treatment and more emphasis on relief of suffering.**

A team from the Dana-Farber Cancer Institute and Children's Hospital, both in Boston, interviewed 103 parents of children who died of cancer. They surveyed the children's primary oncologists and reviewed their medical records. In an earlier study, parents had reported substantial suffering in their children who were dying of cancer. The current study aimed to assess parental understanding of prognosis and evaluate its relationship to treatment goals and outcomes.

**Parents reported first understanding that their child had no chance for cure (onset of the end-of-life care period) a mean of 106 days prior to death. In contrast, medical charts indicated a mean of 206 days from first documentation that the child had entered the end-of-life care period to the child's death.**

Although nearly all parents (95%) reported having a discussion with a medical caregiver about the absence of any realistic chance for cure, only 49% of parents said their understanding that their child was terminally ill came from this discussion; 30% said this understanding resulted from a perceived change in the child's appearance or behavior; and 9% said the understanding came from a feeling or dream.

Most parents (79%) currently believed that the goal of treating symptoms during the end-of-life care period was to lessen suffering, and 34% said the primary goal of cancer-directed therapy was relief of suffering, rather than the prolongation of life. However, more than half of parents (59%) believed in treating symptoms for relief of suffering during the end-of-life care period, while at the same time wanting cancer-directed therapy for the purpose of extending their child's life.

**"There is a growing consensus that in patients with life-threatening illness, palliative care should be integrated early and concurrent with treatment of the underlying disease,"** the authors note. "Parents may be comfortable with such an approach, and our findings suggest a framework in

which caregivers could broach the topic of integrating palliative care earlier, while not eroding hope."

Outcomes of earlier combined recognition included: earlier discussion of hospice; higher ratings by parents of the care delivered by the home care team; earlier institution of a do-not-resuscitate order; less use of cancer-directed treatment in the last month of life; and more likelihood that both parents and physicians would identify the primary goal of cancer-directed therapy as the relief of suffering.

*Source: "Understanding of Prognosis among Parents of Children Who Died of Cancer," Journal of the American Medical Association; Nov. 15, 2000; 284:2469-2475. Wolfe J, Klar N, Grier HE, et al; Departments of Pediatric Oncology and Biostatistical Science, Dana-Farber Cancer Institute, Boston.*

## Brief Test Screens for Confusional State in Palliative Care Patients

A 2-minute, bedside screening test may offer clinicians a simple, portable tool for identifying confusion in terminally ill patients, say researchers. A pilot study of the Bedside Confusion Scale (BCS) found it to be valid, highly sensitive, and easily used in daily clinical practice.

**"The lack of a commonly used bedside diagnostic test for confusion or delirium further highlights concerns that delirium remains unrecognized, misidentified, and inadequately measured in modern medical practice,"** writes the team, led by Mark J. Stillman, MD, Department of Neurology, the Cleveland Clinic Foundation, Cleveland.

The brief BCS test consists of 2 parts: observation of the patient's level of alertness (normal, hyperactive, or hypoactive); and a timed operational task of attention (recitation of the months of the year in reverse order). The test is scored with a 5-point diagnostic algorithm and the patient is then classified as normal, borderline, or confused.

For this prospective comparison study, Stillman administered the BCS to 31 consecutive patients (mean age, 68) admitted to the palliative care ward at the Cleveland Clinic. Results were compared to the Confusion Assessment Method, which was used as the reference standard.

**The BCS exhibited a sensitivity of 100%, with a specificity of 84.6%.** A comparison of patient characteristics among the 3 BCS categories showed worsening Karnofsky functional performance and more abnormalities on neurological examination across the groups. The BCS was also found to be eas-

*(Continued on Page 6)*

(From Page 5)

ily incorporated into routine ward medicine practice, and easily understood by an English-speaking adult population.

Source: "The Bedside Confusion Scale: Development of a Portable Bedside Test for Confusion and Its Application to the Palliative Medicine Population," *Journal of Palliative Medicine*; Winter 2000; Vol. 3, No. 4:449-456. Stillman MJ, Rybicki LA; Departments of Neurology, Hematology/Medical Oncology, and Biostatistics and Epidemiology, Cleveland Clinic Foundation, Cleveland.

## Physicians May Foster 'False Optimism' About Recovery in Cancer Patients

Many patients with advanced cancer develop unrealistic hopes for recovery during cancer-directed therapy, say investigators. This "false optimism," which prevents patients from acknowledging their approaching death, is the result of ineffective communication between physicians and patients, a study in the Netherlands has found.

From 1992 to 1997, researchers observed 35 patients (male, 80%; age, 45-70 years) with small cell lung cancer in the outpatient clinic and lung disease ward of an Amsterdam university hospital. Patients were followed from initial diagnosis to death.

In consultations after diagnosis of terminal illness, **both physicians and patients concentrated on the short-term treatment schedule, avoiding discussion of prognosis or the likely trajectory of the disease, the study found.**

False optimism in patients began with the first chemotherapy session, continuing throughout further therapy sessions even after tumor recurrence. Patients came eventually to realize their prognosis by observing their own physical deterioration, and by talking to fellow patients whose disease was more advanced, the study found. This phase was followed by a "final crisis" when patients were told no further therapy was available.

In retrospect, most patients expressed regret for missed opportunities to make arrangements and "say farewell," say the researchers.

The study authors suggest breaking the cycle of false optimism with an active patient-oriented approach, such as the involvement of "treatment brokers" to clarify communication and expectations.

Source: "Collusion in Doctor-Patient Communication about Imminent Death: An Ethnographic Study," *British Medical Journal*; December 2, 2000; 321:1376-1381. The AM, Hak T, Koeter G, van der Wal G; Institute for Research in Extramural Medicine/Department of Social Medicine, Vrije Universiteit, Amsterdam, Netherlands.

## Lack of Training, Resources Linked to Oncologists' Attitudes Toward Hastened Death

Oncologists' attitudes regarding euthanasia and physician-assisted suicide (PAS) are influenced by their access to necessary palliative care services for their patients, the adequacy of their training in end-of-life care, and the amount of time available to spend with dying patients, say researchers.

Ezekiel J. Emanuel, MD, PhD, of the National Institutes of Health, Bethesda, Maryland, and colleagues analyzed the combined results of 2 questionnaire surveys of 3299 members of the American Society of Clinical Oncology (ASCO) who were actively caring for imminently dying patients in 1997.

**Euthanasia performance rates, although low, were found to be four times higher among oncologists reporting administrative, fiscal, and structural barriers to providing necessary care for their dying patients (6.2%) than among oncologists who felt they could obtain all the care their patients needed (1.5%).**

"Some have worried that inadequate access to palliative care might make euthanasia and physician-assisted suicide attractive alternatives," the authors write. "Our data lend some support to this concern."

The authors warn that a **reluctance to prescribe opioids for fear of performing euthanasia or physician-assisted suicide can lead to inadequate pain management.** "The ASCO and others must educate physicians on the ethical and legal acceptability of increasing narcotics for pain control, even at the risk of respiratory depression and death," they urge.

**The study results point to a substantial decline in support for euthanasia and PAS among US oncologists between 1994 and 1998.** During that period, oncologists' support for PAS declined by half, while support for euthanasia dropped by almost three-quarters. "This decline may reflect expanding knowledge about how to facilitate a 'good death,'" the researchers suggest.

**"Overall, our results emphasize the need to educate physicians about optimal pain and palliative care practices throughout their formal training and as part of their continuing medical education,"** the team concludes. "Physicians who are better informed about end-of-life issues feel less need to use euthanasia and physician-assisted suicide."

Source: "Attitudes and Practices of U.S. Oncologists Regarding Euthanasia and Physician-Assisted Suicide," *Annals of Internal Medicine*; October 3, 2000; 133: 527-532. Emanuel EJ, et al; National Institutes of Health; Bethesda, Maryland.

# PHYSICIAN RESOURCES

## **IMPROVING CARE FOR THE END OF LIFE: A SOURCEBOOK FOR HEALTH CARE MANAGERS AND CLINICIANS**

By **Joanne Lynn, MD, Janice Lynch Schuster, and Andrea Kabcenell, RN**, this is a practical and comprehensive guide to delivering improved quality end-of-life care within a variety of health care systems. Intended for use by managers and clinicians, the book suggests strategies for immediate improvement in clinical care, as well as methods for reforming systems and policies. An appendix offers instruments for measuring the quality of care and assessing the quality of life in dying patients and their families.

Major sections include:

- Improved Patient Care through Improved Practice and Systems
- Arrangements to Promote Reform
- Opportunities in Specific Diseases

Full-text extracts can be viewed by following the links on the Americans for Better Care of the Dying website at [www.abcd-caring.org](http://www.abcd-caring.org). Selections include "How to Avoid Common Problems," and "Preventing, Assessing, and Treating Pain."

Published by Oxford University Press, 2000; ISBN: 0195116615 (hardcover); 288 pp.

## **HOSPICE CARE FOR PATIENTS WITH ADVANCED PROGRESSIVE DEMENTIA**

By **Ladislav Volicer, MD, PhD, and Ann Hurley, RN, DSNc, (Editors)**, this is a comprehensive technical reference for physicians, nurses, social workers, and other professionals who care for patients with severe dementia. With contributions from 27 specialists, the book addresses a variety of the clinical, ethical, and practical issues related to developing and implementing an appropriate care plan for these patients.

Chapter headings include:

- Overcoming Eating Difficulties in the Severely Demented
- Palliative Care for Alzheimer Patients: Implications for Institutions, Caregivers and Families
- Nursing Staff as Moral Agents

Published by Springer Publishing Company, 1998; ISBN: 0826111629 (hardcover); 305 pp.

## **HANDBOOK OF PSYCHIATRY IN PALLIATIVE MEDICINE**

By **Harvey M. Chochinov, MD, PhD, (Editor) and William Breitbart, MD (Editor)**, this text presents contributions from experts in the relatively new field of psychiatric intervention for the dying patient. Practitioners in fields other than palliative care may also find the concepts and insights helpful. Topics include: the role of psychiatry in terminal care; diagnosis and management of depression; suicide in the terminally ill; and the nature of suffering in terminal illness.

Major sections include:

- Psychiatric Complications of Terminal Illness
- Symptom Management
- Psychotherapeutic Intervention and Palliative Care
- Pediatric Palliative Care
- Ethical and Spiritual Issues

Published by Oxford University Press, 2000; ISBN: 0195092996 (hardcover); 435 pp.

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

[www.aahpm.org](http://www.aahpm.org)

American Academy of Hospice & Palliative Medicine

[www.epec.net](http://www.epec.net)

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

[www.nhpc.org](http://www.nhpc.org)

National Hospice & Palliative Care Organization (formerly the NHO)

[www.hospicefoundation.org](http://www.hospicefoundation.org)

Hospice Foundation of America

[www.americanhospice.org](http://www.americanhospice.org)

American Hospice Foundation

[www.hpna.org](http://www.hpna.org)

The Hospice and Palliative Care Nurses Association

[www.medicaring.org](http://www.medicaring.org)

Center to Improve Care of the Dying

[www.abcd-caring.org](http://www.abcd-caring.org)

Americans for Better Care of the Dying

[www.lastacts.org](http://www.lastacts.org)

Last Acts Coalition

[www.mcw.edu/pallmed/](http://www.mcw.edu/pallmed/)

Palliative Medicine Program at the Medical College of Wisconsin

[www.medsch.wisc.edu/painpolicy](http://www.medsch.wisc.edu/painpolicy)

University of Wisconsin Pain and Policy Studies Group

[www.chcr.brown.edu](http://www.chcr.brown.edu)

Center for Gerontology and Health Care Research at Brown University

[www.capcmssm.org](http://www.capcmssm.org)

Center to Advance Palliative Care

[www.stoppain.org](http://www.stoppain.org)

Pain Medicine & Palliative Care, Beth Israel Medical Center

[www.growthhouse.org](http://www.growthhouse.org)

Online community for end-of-life care

[www.partnershipforcaring.org](http://www.partnershipforcaring.org)

America's Voices for the Dying

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

**2nd Clinical Conference & Exposition on Hospice and Palliative Care.** March 23-26, 2001, Radisson Hotel Universal Orlando, Orlando, FL. Sponsors: National Hospice and Palliative Care Organization, American Academy of Hospice and Palliative Medicine, and Hospice and Palliative Nurses Association. Phone: 703-533-8468; Website: [www.nhpco.org](http://www.nhpco.org); select "Professional Education."

**7th Congress of the European Association for Palliative Care.** April 1-5, 2001, Palermo, Sicily, Italy. Contact: 7th EAPC Congress, P.O. Box 50006, Tel Aviv 61500, Israel. Phone: +972 3 514-0018; Fax: +972 3 517-2484; e-mail: [eapc@kenes.com](mailto:eapc@kenes.com); Website: [www.kenes.com/eapc](http://www.kenes.com/eapc).

**Humber College 11th Annual Palliative Care Conference.** April 22-24, 2001, Royal York Hotel, Toronto. Sponsors: Canadian Association of Nurses in Oncology, Canadian Palliative Care Association, Ontario Medical Association, and Ontario Palliative Care Association. Contact: Teresa Sottile, Conference Manager, Humber College. Phone: 416-675-6622, Ext. 4559; Fax: 416-675-0135; e-mail: [sottile@admin.humberc.on.ca](mailto:sottile@admin.humberc.on.ca); Website: [www.palliativecare.humberc.on.ca](http://www.palliativecare.humberc.on.ca).

**Pain Management in the 21st Century: 2nd World Congress of World Institute of Pain.** June 27-30, 2001, Istanbul Convention and Exhibition Center, Istanbul, Turkey. Contact: Organizing Secretariat, Dilan Tur Congress International; Phone: +90 212 257-8667; Fax: +90 212 265-5474; e-mail: [info@dilan.com.tr](mailto:info@dilan.com.tr); Website: [www.dilan.com.tr/wip2001](http://www.dilan.com.tr/wip2001).

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*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 specialize in covering palliative and hospice care issues.

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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, or to learn about a **series of books** to be published this year. The books, available for purchase in **bulk quantities at reduced rates**, are designed to bring much-needed support to hospice patients and families. Call:

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