

Quality^{of} Life Matters[®]

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

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'Excellent Record of Hospice' Offers Hope Amidst Grim Findings in Nationwide Report

State-by-State Report Rates Health Care System for Dying Patients as 'No Better Than Mediocre'

While findings from a major report about care of the dying point to many weaknesses nationwide, hospice care is cited as a "gold standard" for quality end-of-life care.

"Means to a Better End: A Report on Dying in America Today" was released in November 2002 by Last Acts, a coalition working for better care and caring near the end of life.

Intended as a statistical portrait to raise awareness and "spur both the expectation and demand for good end-of-life care," the report evaluates the most recent data on the availability and use of eight key aspects of quality care for the dying. The findings are presented as a "report card" grading system of the 50 states and the District of Columbia. Even when graded on a curve, most states

earned no better than a C or D in the majority of categories.

Overall, care for dying patients is "no better than mediocre," the authors state. "This is true, despite years of research, improved professional education and training, the excellent record of hospice, innovation among hospitals and some nursing homes, grassroots advocacy, and millions of dollars of private philanthropy."

URGENT NEED FOR EARLIER HOSPICE REFERRALS

The authors emphasize that "many end-of-life care experts, as well as patients and families, consider hospice to be the 'gold standard' in end-of-life care — in terms of both quality and cost-effectiveness. Family members consistently report the quality of hospice care to be excellent."

Yet, although "experts agree that patients need to be enrolled for at least 60 days to maximize its benefits," **the average length of stay in hospice has dropped from 70 days in 1983 to 36 days more recently**, the report notes. In addition, **28% of hospice patients are enrolled for one week or less** before death. Other findings include:

- In the last year of life, only 21.5% (range among states: 4.9% to 42%) of people over 65 years of age use hospice, although it is a benefit covered by Medicare.
- The median length of stay in hos-

pice is 25.3 days (range of state medians: 13.7 days to 42.9 days).

- A national mean of 24.9% (range: 14.7% to 35.8%) of Americans die at home, although recent polls have shown that between 71% and 86% of those surveyed say that dying at home would be their wish.
- About 50% of persons aged 65 and older die in hospitals. The percentage of hospitals reporting hospice programs is 23.5% (range: 5% to 57.5%); the percentage reporting palliative care programs is 13.8% (range: 0 to 54.5%).

"The issue is one of urgency, which is why our study does not mince words," says Judith Peres, Last Acts deputy director and leader of the report's research team. "Our elderly population is expected to nearly double over the next thirty years. We need to build a better system of care for the dying now."

RECOMMENDATIONS AFFECTING PHYSICIANS

Among the report's recommendations:

- Supporting physicians in practice who seek training in palliative care
- Including hospice service rotations in the training of medical professionals
- Changing the Medicare eligibility criteria to allow patients to qualify for hospice benefits by diagnosis, not prognosis

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Hospice Offers Hope *(from Page 1)*

- Working with clinicians to improve key communication skills for breaking bad news and setting realistic treatment goals
- Setting state targets for the numbers of physicians and nurses with palliative care training needed to care for critically ill and dying patients
- Developing evidence-based palliative care clinical protocols
- Conveying the expectation of good pain and symptom management to clinical staff
- Promulgating policies that encourage advance care planning and do-not-resuscitate programs
- Encouraging hospitals and nursing homes to contract with hospice
- Supporting the provision of hospice services in government-operated institutions
- Coordinating health service programs to provide continuity of care for terminally ill patients of all ages
- Advocating for the comfort and support of dying patients and their families; insisting on quality end-of-life care for patients, loved ones, co-workers, neighbors

Last Acts is funded by the Robert Wood Johnson Foundation, headquartered in Princeton, New Jersey. An interactive presentation of the report is available on the foundation's website.

For more information, visit www.rwjf.org/special/betterend.

93% of Americans Want Improvements to End-of-Life Health Care System

A recent survey has found that 93% of American adults think improving the health care system to deliver better care to dying people is important, with 72% of participants naming it "very important." Only 1% of those polled consider the issue "not at all important."

The results of the poll were released in November by Last Acts, the national coalition of groups working to improve end-of-life care, at the same time the organization released its state-by-state report on care of the dying, entitled "Means to a Better End." (*See story, Page 1.*)

The 1,002 adults surveyed were asked to rate the quality of end-of-life care delivered by the current system, both in general and by specific aspects.

The findings include:

- ✓ **Only 11% of Americans overall think the current system does an excellent or very good job in caring for dying people.** While 24% rate the system as good, the majority (59%) rate it as only fair or below, including 26% who give it a rating of poor.
- ✓ Among those adults who have recently experienced the loss of a loved one, however, 42% rate that person's care as excellent or very good; 26% rate it as good; and 28% rate the treatment as only fair or below.
- ✓ About half of participants think the system is doing a good or better job in respecting dying people's spiritual beliefs (54%), providing comfort and pain control (52%), and involving patients and families in care decisions (50%). Nevertheless, only about one in five respondents rated the system as excellent (6% or less) or very good (16% or less) in any one of these areas.
- ✓ The lowest ratings were for the financial and emotional aspects of end-of-life care. Fully 73% rated the system as only fair or poor in assuring that families' savings are not depleted by end-of-life care. **Only 16% of participants thought the system was doing an excellent or very good job in providing emotional support to patients and families or in ensuring that pa-**

tients' wishes concerning their medical care were followed.

"We need to change, radically, our approach to death and dying," writes Eric Anderson, MD, in his commentary on the survey in the Dec. 9, 2002, issue of the *American Medical News*, a publication of the American Medical Association. **"We need to get beyond the doctor's belief that death is the enemy...And we really do need to keep our terminally ill patients out of hospitals."**

As to the care patients expect near the end of life from their physicians, Anderson, a San Diego family physician with 40 years of experience in primary care, has this to say: "I believe they would often prefer the place to be the home. They would want us to be generous with comfort items, especially analgesics, but also generous with our time. And they would like some continuity of care during this process, the longitudinal care famously given by good family physicians."

For more information, visit www.lastacts.org.

End-Stage Alzheimer Disease: Physicians Can Help Ensure ‘A Good Ending’

Physicians can ease the way for patients and their families through the terminal phase of Alzheimer disease (AD) by opening discussions of care preferences early, and by educating and supporting them along each decision-making step associated with the disease, says a team of Boston experts.

AD currently affects about 4 million people in this country, and the number of cases is expected to more than double by the year 2050. That is according to Ann C. Hurley, RN, DNSc, of Brigham and Women’s Hospital and Northeastern University, and Ladislav Volicer, MD, PhD, of Boston University Medical School, whose report appears in the Nov. 13, 2002, issue of the *Journal of the American Medical Association*.

Because patients can live from 2 to 20 years after diagnosis, and because the most frequent immediate cause of death is life-threatening infection, care decisions can be burdensome, the authors note. For instance, decisions regarding the initiation or cessation of treatments, transfer of the patient to a long-term care

setting, and enrollment in a hospice program can be very difficult for family members, Hurley and Volicer say.

The authors suggest that physicians can assist AD patients and their loved ones “by preparing them for the relentless progression of the disease and by supporting them through the intellectual and emotional conflicts accompanying the end of life.” Physicians can:

Encourage patient discussion early in the disease progression — soon after diagnosis — to elicit treatment preferences and to establish a health care proxy.

Maintain educated decision-making by explaining both the patient’s current problems and what family/caregivers can expect to occur as the disease progresses.

Suggest community support for home caregivers, such as family counseling or support groups.

Assist the family in selecting a nursing home facility, if appropriate, by providing a list of safety, health, and qual-

ity-of-life issues to be considered (the authors provide a sample list).

Ease caregiver guilt and grief over decisions to relinquish care by offering positive reassurance and reiteration of the ultimately terminal outcome of the disease.

Help the family to understand the unpredictability of death, and to focus on the goal of maximizing patient comfort rather than prolonging life.

Hurley and Volicer also offer suggestions for the management of common consequences of advanced dementia. [See sidebar below.]

While predicting 6-month survival in patients with advanced dementia is difficult, the authors remind physicians that **“once enrolled in a Medicare-certified hospice program, the patient may remain beyond the 6 months as long as continued decline is documented.”**

“Although caring for patients with AD can be challenging and involves many difficult decisions, good endings are possible,” the authors conclude.

ALZHEIMER DISEASE: CLINICAL MANAGEMENT SUGGESTIONS

- **NUTRITION.** “Permanent tube feeding is not recommended for persons with advanced dementia.” Natural feeding offers the benefit of caring, interpersonal contact. Later, during the dying process, the body functions start shutting down and food is no longer necessary.
- **BEHAVIORAL SYMPTOMS.** Whenever possible, treatment should target the origin of the symptom. Begin with nonpharmacologic strategies. Medications should be used only to provide comfort.
- **INFECTIONS.** Oral antibiotic treatment is preferred over parenteral antibiotics, which may require restraints. In patients with poor oral intake, intramuscular administration of cephalosporins can be considered. Hospitalization for pneumonia is not recommended; it has been shown to result in more frequent death and functional deterioration. The comfort of dying patients can be maintained by administration of analgesics and antipyretics, rather than antibiotics.
- **PAIN.** Use a protocol for discomfort assessment and arrange for scheduled analgesics and nonpharmacologic comfort interventions. Early administration of acetaminophen may also help with behavioral problems by addressing unrecognized pain.
- **COMORBID CONDITIONS.** Treatment should be conservative, aimed at reducing short-term complications and preventing consequences of overtreatment.
- **COGNITIVE IMPAIRMENT.** “Treatment of cognitive impairment is an unrealistic goal in severe dementia.”

— Hurley and Volicer in the *Journal of the American Medical Association*

Study of ALS Patients Indicates Multiple Benefits of Hospice Care

In their final month of life, patients with amyotrophic lateral sclerosis (ALS) are **significantly more likely to receive morphine and to die outside the hospital and in their place of choice if they are enrolled in a hospice program**, a recent study has found.

Further, caregivers of ALS patients in hospice have a **better understanding of the illness and of the goals of care** than do caregivers of nonhospice patients, according to Linda Ganzini, MD, director of the Palliative Care Fellowship at the Portland VA Medical Center, Oregon, and lead author of the report appearing in the Aug. 13, 2002, issue of *Neurology*, the journal of the American Academy of Neurology.

To determine the health care experiences and palliative care needs of ALS patients in the last month of life, Ganzini's team surveyed 50 bereaved caregivers whose loved ones had died between 1995 and 1999. Of these caregivers, 38 had participated in a previous study of ALS patient and caregiver attitudes toward end-of-life care and patient experiences of pain and suffering.

Caregivers reported that patient goals of care were honored by 88% of the health care practitioners. For 76% of patients, the major goal of care in the last month of life was relief of pain and discomfort as far as possible, even at the risk of shortening life. For 22% of patients, however, the goal was extending life, even if this meant more pain and discomfort.

Pain frequency in the last month of life was rated by 34% of caregivers as being 5 or 6 on a 6-point scale. Pain severity was rated as 5 or 6 on a 6-point scale by 30% of caregivers. One-third (34%) reported being dissatisfied with some aspect of their loved one's symptom management.

The most commonly reported symptoms — those said to occur either frequently, almost all the time, or constantly — included:

- ✓ Difficulty communicating (62%)
- ✓ Dyspnea (56%)
- ✓ Discomfort other than pain (48%)

- ✓ Insomnia (42%)
- ✓ Choking episodes (34%)

Two-thirds (66%) of the patients were enrolled in hospice by the last month of life. Hospice patients were significantly more likely than nonhospice patients to:

- ✓ Die outside the hospital (88% of hospice patients vs. 53% of nonhospice patients)
- ✓ Die in the location of their preference (85% vs. 59%)
- ✓ Receive morphine (94% vs. 56%)

In addition, caregivers of hospice patients were more likely than caregivers of nonhospice patients to report that the medical team talked with them in such a way that they understood the illness and the goals of care (58% vs. 29%).

In the last month of life, most patients (90% to 92%) were reported to be at least "somewhat" aware of and accepting death's imminence; 80% were said to be "very" aware that death was imminent; 62% were "very" accepting of death; and 60% were seen as "very much" at peace before death.

Physicians were found to be respectful of and sensitive to religious and spiritual issues by 82% of caregivers. Further, 60% of caregivers reported that a physician or member of the health care team wrote to them after their loved one's death, and 36% said that a physician or member of the team attended a memorial service for the patient.

The authors note that many ALS patients still experience distressing symptoms in the last month of life and recommend further patient-based studies of symptom prevalence, treatment, and barriers to symptom relief in this population.

Source: "The Final Month of Life in Patients with ALS," Neurology; August 13, 2002; 59(3):428-431. Ganzini L, Johnston WS, Silveira MJ; Behavior Health and Clinical Neurosciences Division, Portland VA Medical Center and Department of Psychiatry, Oregon Health and Science University, Portland, Oregon; Division of Neurology, University of Alberta, Edmonton; VA Ann Arbor Healthcare System and General Medicine, Bioethics Program, University of Michigan School of Medicine, Ann Arbor, Michigan.

SIGNIFICANT BENEFITS OF HOSPICE INCLUDED:

- **DYING OUTSIDE THE HOSPITAL.** 88% of hospice patients vs. 53% of nonhospice patients.
- **DYING IN LOCATION OF PREFERENCE.** 85% of hospice patients vs. 59% of nonhospice patients.
- **RECEIVING MORPHINE.** 94% of hospice patients vs. 56% of nonhospice patients.

UK Researchers Urge Earlier Discussion of Palliative Care for Heart Failure Patients

The median survival for chronic heart failure is worse than that for many cancers; yet patients with advanced heart failure experience many unmet needs, and physicians are uncertain when or how to initiate palliative care, according to two recent studies in the *British Medical Journal*.

A focus group study of general practitioners and specialists in four areas found that physicians are concerned about the impact of giving bad news to heart failure patients too soon, and often find that they themselves have accepted the poor outlook only late in the illness. “Unlike with cancer, the diagnosis of heart failure does not begin with bad news,” the authors write. Despite the uncertainty of prognostication in

“These patients could benefit from the continuity, multidisciplinary care, and focus on symptom control and family support that are the hallmarks of the palliative care approach.”

— Study in the *British Medical Journal*

heart failure, they recommend that physicians discuss prognosis early in the course of the disease and elicit the patients’ views.

A second study interviewed patients with either inoperable lung cancer or advanced cardiac failure and their caregivers. While facing death was the prime concern of cancer pa-

tients (“How long have I got?”), the lives of heart failure patients were dominated by the concerns of increasing social isolation, comorbidity, progressive losses, and the stress of monitoring complex and frequently changing medication regimens (“I know I won’t get better, but I hope it won’t get any worse.”)

Continued on Page 6

Choice Between Hospice and Phase I Oncology Trial May Be a ‘False Dilemma’

Patients with advanced cancer who choose to enroll in Phase I clinical trials do not currently have access to the range of supportive services offered by hospice care. But a recent study has found that **most Phase I investigators and hospices believe that simultaneous enrollment is possible.**

“Phase I trials are designed to determine a therapy’s safety, not to test its efficacy,” write lead author David J. Casarett, MD, Philadelphia Veterans Affairs Medical Center, and colleagues. “Therefore, patients with advanced cancer who desire palliative care without aggressive treatment might still logically enroll in a Phase I trial.” Agents and interventions tested in Phase I trials, they add, “offer no meaningful chance of direct medical benefit.”

The team analyzed the results of surveys completed by two groups: the intake coordinators of 89 operating hospices; and 45 principal investigators in Phase I oncology trials that accepted patients with a prognosis of less than 6 months. Both groups were asked whether an eligible patient with advanced cancer who was enrolled in hospice could enroll in a Phase I trial. Most investigators (91%) and hospices

(67%) were in favor of dual enrollment in hospice and Phase I trials.

The research team says their study suggests that:

- Patients in Phase I trials may be able to gain access to the interdisciplinary services of hospice, such as aggressive pain and symptom management, social work support, and counseling.
- Phase I investigators might be willing to consider ways they could facilitate hospice enrollment for those patients most likely to benefit.
- Academic medical centers and community hospice programs could develop collaborative relationships to provide hospice care more efficiently.

“These results suggest that the choice between hospice and a Phase I trial is a false dilemma and that greater collaboration in this area is needed,” they conclude.

Source: “Must Patients with Advanced Cancer Choose Between a Phase I Trial and Hospice?” Cancer; October 1, 2002; 95(7):1601-1604. Casarett DJ, Karlawish JHT, Henry MI, Hirschman KB; Philadelphia Veterans Affairs Medical Center, and Center for Bioethics and Department of Medicine, University of Pennsylvania, Philadelphia.

PHYSICIAN RESOURCES

Online Publisher Adds *Palliative Care* to List of Peer-Reviewed Journals

Symptom Management Summary Available from Physician's Project on End-of-Life Care

BioMed Central, the independent online publisher of peer-reviewed biomedical research, has recently added *BMC Palliative Care* to its list of nearly 60 medical journals whose articles are available online — immediately and free of charge.

To access the articles in *BMC Palliative Care*, go to www.biomedcentral.com/bmcpalliatcare.

To maintain open user access, BioMed Central charges authors a processing fee per article, with the option of a yearly flat fee for institutions. Current institutional members include the Dana-Farber Cancer Institute, Harvard University, the National Institutes of Health, Princeton University, and the World Health Organization. Each member has its own page listing articles published with BioMed Central.

With a board of editorial advisors composed of leading U.S. palliative care experts, the new journal has published five end-of-life care articles to date. Titles include:

- ✓ Ensuring Competency in End-of-Life Care: Controlling Symptoms
- ✓ Quality End-of-Life Care: A Global Perspective
- ✓ The Family's Evaluation on Management, Care, and Disclosure for Terminal Stage Cancer Patients
- ✓ Factors Associated with Home Death for Individuals Who Receive Home Support Services
- ✓ Accuracy of Prognosis Estimates by Four Palliative Care Teams: A Prospective Cohort Study

Links are provided to each article's citation in PubMed, the search service of the U.S. National Library of Medicine's archive MEDLINE, as well as to relevant articles from other BioMed Central publications.

PHYSICIAN PROJECT FEATURED

The most recent article to appear in *BMC Palliative Care* is a distillation of the approaches to symptom management offered by the Education for Physicians in End-of-Life Care (EPEC) Project. The article "aims to summarize the core competencies in symptom control needed by any physician, no matter his or her specialty," writes lead author and EPEC Project Co-Principal Frank D. Ferris, MD, of the Center for Palliative Studies, San Diego Hospice, San Diego.

"While some physicians will have specialist palliative care services upon which to call, most in the world will need to provide the initial approaches to symptom control at the end of life," notes Ferris. **"This is not a fringe activity, but a core competency for physicians...Many of the approaches will apply much earlier in the course of the illness, not just at the end of life."**

Entitled "Ensuring Competency in End-of-Life Care: Controlling Symptoms," the article addresses management of those symptoms found commonly among patients nearing the end of life, such as: depression, nausea and vomiting, dyspnea, and fatigue. **A section on pain includes graphics of analgesic dosing recommendations, and explains the differences between opioid addiction, pharmacological tolerance, and physical dependence.**

Strategies to relieve suffering near the end of life must begin with the process of whole-patient assessment, which in itself can be a therapeutic tool, note the authors. Physicians caring for these patients will need competency in communication, decision-making, and relation-building skills, as well as familiarity with the concept of end-of-life care and the legal issues that support it.

Visit the BMC Palliative Care site at www.biomedcentral.com/bmcpalliatcare.

U.K. Heart Failure Studies (from Page 5)

The authors recommend a "dual approach" to the care of patients with end-stage cardiac and other chronic illnesses, with the continuation of active management of the disease while the possibility of death is acknowledged and discussed. "Care for people with advanced progressive illnesses is currently prioritized by diagnosis rather than need... Care should be proactive and designed to meet their specific needs," the researchers conclude.

Source: "Doctors' Perceptions of Palliative Care for Heart Failure: Focus Group Study," British Medical Journal; September 14, 2002; 325:581-585. Hanratty B, et al; University of Liverpool, Liverpool, UK. "Dying of Lung Cancer or Cardiac Failure: Prospective Qualitative Interview Study of Patients and Their Carers in the Community," British Medical Journal; October 26, 2002; 325:929-933. Murray SA, et al; University of Edinburgh, Edinburgh, UK.

PHYSICIAN RESOURCES

AMA Journals to Offer Theme Issues on Pain

In November 2003, the *Journal of the American Medical Association (JAMA)* and several of the AMA's Archive journals, including the *Archives of Internal Medicine*, will publish theme issues on pain management, according to a "Call for Papers" in the November 6, 2002, issue of *JAMA*.

Whether it occurs as part of daily life or at the end of life, is due to trauma, surgery, or illness, pain is one of the most frequently encountered complaints in most clinical settings, notes JAMA Editor Catherine D. DeAngelis, MD. "Despite the development of new drugs and supportive therapies and documentation of their effectiveness, appropriate use to relieve pain remains poor," writes DeAngelis.

The journals invite original research, systematic reviews, observational research, scholarly commentaries, and special communications on such pain management topics as: direct therapeutic interventions, ancillary support for patients and families, and ethical issues.

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

BOOK FOR PHYSICIANS

The Medical Care of Terminally Ill Patients

By **Robert E. Enck, MD**, this second edition provides concise, updated reviews of clinical studies applicable to the management of patients nearing the end of life. Appropriate as an introduction to end-of-life care for internists, family physicians, and other nonspecialists in palliative care, the book can also serve as a quick reference for oncologists, nurses, and palliative care professionals.

The emphasis throughout is on the importance of enhancing quality of life when addressing the most common symptoms found among terminally ill patients. Additional information is provided in accompanying tables with drugs and dosages, a list of abbreviations, and more than 100 new references.

The opening chapter offers estimates of survival duration in patients with cancer, dementia, and motor neuron and other nonmalignant diseases. Chapter titles include:

- General Symptoms of Dying Patients
- Other Problems of Patients with Cancer
- Other Problems of Patients with Nonmalignant Diseases
- An Overview of Pain Management
- Complications of Pharmacologic Therapy
- The Final Moments
- Issues Concerning the Sustaining of Life

Enck is clinical associate professor of medicine, University of Pennsylvania School of Medicine, Philadelphia, and editor-in-chief of the *American Journal of Hospice and Palliative Care*.

Published by Johns Hopkins University Press, 2001; ISBN: 0801867665 (paperback); 226 pp.

End-of-Life Care Websites

www.eperc.mcw.edu

End of Life Physician Education Resource 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

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 for Palliative Care Studies

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

22nd Annual Scientific Meeting of the American Pain Society. March 20-23, 2002, Chicago. Contact: APS, 4700 W. Lake Avenue, Glenview, IL, 60025-1485. 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, 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; Website: www.kenes.com/eapc2003

4th Joint Clinical Conference. April 10-12, 2003, Adams Mark Hotel, Denver, CO. Sponsors: National Hospice and Palliative Care Organization, Hospice and Palliative Nurses Association and Partnership for Caring, Inc. Phone: 703-837-1500; Website: www.nhpco.org

Harvard Medical School Center for Palliative Care Program in Palliative Care Education and Practice. April 29 - May 6 and November 11-18, 2003, Massachusetts General Hospital, Boston, MA. (Attendance at the April session is a prerequisite for the November session). Contact by email: pallcare@partners.org; Website: www.hms.harvard.edu/cdi/pallcare

6th International Symposium on Pediatric Pain: The Big Questions. June 15-19, 2003, Sydney Convention Centre, Darling Harbour, Sydney, Australia. Sponsor: International Association for the Study of Pain. Contact: DC Conferences, P.O. Box 571, Crows Nest, NSW 1585, Australia. Phone: +61 2 9954-4600; Fax: +61 2 9954-0666; Email: ISPP2003@dcconferences.com.au; Website: www.dcconferences.com.au/ISPP2003

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