

# Quality of Life Matters®

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

Vol. 8, Issue 4 Feb/Mar/Apr 2007

## Use of Opiates to Relieve Pain and Suffering in Dying Patients Hampered by Clinicians' Lack of Knowledge

Most current literature on opiate administration for refractory pain and suffering at the end of life comes from hospice care. Yet it is hospitalized patients who too often die with their symptoms uncontrolled, due in part to attitudinal concerns and lack of knowledge among clinicians, according to a recent study.

“Our study shows that there exists a chasm between the support clinicians express for the use of unrestricted opiate administration and the experience and knowledge they have regarding this critical component of symptom management,” write the authors of a report published in the *Journal of Palliative Medicine*.

Investigators surveyed 381 hospital-based clinicians at an academic medical center with a long-standing policy permitting use of unrestricted opiates for uncontrolled symptoms at the end of life [see sidebar]. Euthanasia is not permitted by this institution.

Although most (77%) clinicians agreed that management of pain and suffering is the principal goal of unrestricted opiate use for patients at the end of life, 16% identified either initiating discussion of end-of-life care or providing comfort for families as the primary goal of this modality. Just slightly more than half of respondents indicated that they themselves would feel comfortable administering this treatment.

### Medical Center Policy for Unrestricted Opiates Use Directs That:

- Opiate dosage reflects patient need; the goal is to relieve patient suffering to the fullest extent possible.
- The patient has a terminal illness; death is not unexpected.
- The patient is experiencing pain, discomfort, or distress for which opiate medications are an accepted treatment.
- The care plan is discussed with the patient or proxy, and a do-not-resuscitate order is in place.
- Health care professionals unable to apply this policy to patient care must arrange for alternative care.

— Fineberg, et al, *Journal of Palliative Medicine*

Other findings from the study include:

- 67% of respondents agreed that the unrestricted opiate policy is used too seldom.
- 45% felt that the policy is often used too late.
- 58% of respondents reported feeling comfortable caring for

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## Record 1.2 Million Patients Received Hospice Care in 2005

### Noncancer Patients Accounted for 54% of Admissions

The use of hospice services by Americans facing terminal illness continues to increase yearly; and so, also, does the percentage of patients admitted to hospice with noncancer diagnoses, according to an annual report issued in November 2006 by the National Hospice and Palliative Care Organization (NHPCO).

About one-third of the 2.4 million deaths in the United States in 2005 occurred under the care of a hospice program, notes the report. When those pa-

tients discharged alive or still receiving care at year's end are included, the number of patients served by hospice in 2005 reached 1.2 million.

The most common noncancer hospice admissions in 2005 include:

- Heart disease (12%)
- Dementia (9.8%)
- Debility (9.2%)
- Lung disease (7.5%)

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## Patient Abandonment: Experts Urge Increased Involvement of Primary Physicians in End-of-Life Care

In a fragmented health care system, patients can feel abandoned by their primary or attending physicians. A sense of abandonment may occur when a patient is transferred to other care sites, referred to specialists, or, most particularly, when “handed off” to palliative and end-of-life care specialists without further physician contact.

That is according to the authors of a case study and analysis of physicians’ responsibilities in end-of-life care whose article appeared in the *Journal of Palliative Medicine*.

**“Physicians’ withdrawal from further care of their dying patients should be planned and communicated clearly among clinicians, consultants, patients, and families,”** write the authors.

In the two illustrative cases, the primary or attending physicians did not abandon their patients in the narrow, culpable sense, note the authors. That is, they did not leave the patients without care. But they did “sign off” the cases without discussing this with the patients and families. Thus,

### ***Palliative Care Specialists Can:***

- Attempt to communicate directly, frequently, and consistently with clinicians who request their services
- Help requesting physicians plan an effective transfer of care responsibilities and communicate this jointly to patients and families
- Seek ways to partner proactively with physicians in greatest need of assistance — not only intellectually but also emotionally (i.e., coping with death and dying)

— Han and Arnold, *Journal of Palliative Medicine*

despite their satisfaction with the care delivered by the palliative care team, the patients and families *felt* they had been abandoned by these physicians.

The authors make the argument that, while primary care physicians cannot be expected to provide all manner of care to dying patients, it is “a moral duty of all physicians — regardless of specialty — to

provide a basic level of palliative care” to their patients.

“We might be willing to say that not all physicians need to have the ability and interest to perform craniotomies,” write the authors. “But are we equally willing to say that not all physicians need to have the desire and skill to care for and communicate with patients who are suffering and dying?”

The article suggests ways palliative care specialists can ensure that primary physicians are kept “in the loop” concerning patient care. [See sidebar, left.] In this way, note the authors, primary physicians may become empowered to increase their involvement with their patients in the future.

*Source: “Palliative Care Services, Patient Abandonment, and the Scope of Physicians’ Responsibilities in End-of-Life Care,” Journal of Palliative Medicine; December 2005; 8(6):1238-1245. Han PKJ, Arnold RM; Cancer Prevention Fellowship Program, Division of Cancer Prevention, National Cancer Institute, National Institutes of Health, Rockville, Maryland; Section of Palliative Care and Medical Ethics, Division of General Internal Medicine, University of Pittsburgh, Pittsburgh.*

## Designation of Hospice and Palliative Care as a Medical Subspecialty: More Medical Schools to Develop Education Programs

In the wake of the accreditation of hospice and palliative care medicine as a subspecialty, six U.S. medical schools will be awarded funding for development of a comprehensive palliative care curriculum, to include both didactic and experiential training in the field.

A call for proposals for the 18-month curriculum enhancement project was issued November 2006 by the Medical College of Wisconsin’s End of Life/Pal-

liative Education Resource Center (EPERC), with awards to be announced in February 2007.

“The recent American Board of Medical Specialties’ designation of hospice and palliative care as a medical subspecialty in eleven medical practice areas adds further impetus for medical schools to develop strong clinical palliative care training for medical students,” states EPERC.

“The growing number of hospital-

based palliative care consultation programs and/or community-based hospice programs have made it possible for several successful models of experiential training to be implemented,” EPERC points out.

Funding for the project was provided by the Robert Wood Johnson Foundation, Princeton, NJ.

For more information, visit [www.eperc.mcw.edu](http://www.eperc.mcw.edu).

## Use of Opiates to Relieve Pain and Suffering in Dying Patients

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someone who is imminently dying.

- 55% felt comfortable administering unrestricted opiates for refractory symptoms in such patients.
- 21% of physicians and nurses who had administered unrestricted opiates reported feeling pressured to do so.

“Clearer guidelines for unrestricted opiate administration when there are disagreements over perceived need might reduce clinician discomfort with these situations, which in turn might contribute to use of this modality in a more timely fashion,” note the authors.

Findings regarding clinician knowledge of protocols for administration of unrestricted opiates [see sidebar] “suggest the need to educate clinical staff about the use

### Findings Regarding Clinician Knowledge of Protocols

- 50% of respondents incorrectly believed that the patient must have a written advance directive before the protocol could be implemented.
- 30% did not realize that dose and interval for opiate titration should be specified in the orders.
- 27% mistakenly felt that eligible patients should have an expected survival of three days or less.

— Fineberg et al, *Journal of Palliative Medicine*

of unrestricted opiate administration,” the authors comment. “Clinician education and clarification of the appropriate use of this modality when there are differences in clinician and family perception of dis-

comfort are [also] needed.

**“Unrestricted opiate administration in response to refractory pain and other symptoms at the end of life is a critical component of sound palliative care,”** state the authors. “While sufficient opiate dosing should be provided to manage all patients’ pain, the concept of ‘unrestricted’ opiate dosing is intended for patients at the end of life for whom the potential attendant risks of adverse events (such as aspiration) or hastened death may be reasonable.”

Source: “Unrestricted Opiate Administration for Pain and Suffering at the End of Life: Knowledge and Attitudes as Barriers to Care,” *Journal of Palliative Medicine*; August 2006; 9(4):873-883. Fineberg IC, Wenger NS, Brown-Saltzman K; Division of General Internal Medicine and Health Services Research, David Geffen School of Medicine at UCLA, and UCLA Healthcare Ethics Center, Los Angeles.

## Record 1.2 Million Patients Received Hospice Care in 2005

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Since 2003 — the first year the number of patients admitted with noncancer diagnoses exceeded that of cancer patients — the percentage of patients with life-limiting illness other than cancer being cared for by hospice multidisciplinary teams has been steadily increasing. In 2005, 54% of patients were enrolled in hospice with a diagnosis other than cancer.

The NHPCO report is based on data from 2,700 providers participating in the organization’s annual online surveys. Overall, the number of hospice programs in the U.S. increased to 4,160 in 2005, up from 3,650 in 2004.

Other findings include:

- 76% of hospice patients died at home or in a residential facility in 2005. In contrast, 50% of all deaths nationally occur in acute care settings.
- Although the median length of service in 2005 rose to 26 days — up from 22

days in the previous two years — **approximately one-third of all hospice patients in 2005 received care for seven days or less.**

- The percentage of minority patients served by hospice grew from 16.5% in 2004 to 17.8% in 2005.
- 18% of hospice programs are actively providing pediatric palliative care, while another 2% are developing such a program.

“Hospice care enables many of our citizens to spend their final days in comfort and dignity, surrounded by loved ones,” states a presidential proclamation designating November as National Hospice Month.

“This palliative care plays a vital role in our nation’s health care system,” the presidential proclamation continues. “Hospice caregivers also reach out to families and friends to provide guidance and counseling after the loss of a loved one.”

The commitment to service by area hospice programs is often community-based, notes NHPCO, and can extend from educational information offered prior to enrollment to support provided following a loved one’s death. For example:

- Most hospice agencies (94.6%) provide bereavement support not only to family members of patients, but also to anyone in the community at large who has lost a loved one.
- Hospice programs can serve as important sources of information for medical professionals, patients, and families on care options at the end of life.

“End of life is not a topic that many people are comfortable thinking about,” says J. Donald Schumacher, PsyD, NHPCO president and CEO. “But there are many dedicated care providers within our communities to help us learn about this important subject.”

For information, visit [www.nhpc.org](http://www.nhpc.org).

## Clinical Approaches to Recognition and Management of Frailty in Older Patients

Timely recognition of frailty — a “diminished capacity to withstand stress that places individuals at risk for adverse health outcomes” — may be helpful for early identification of potentially treatable underlying conditions in older adults. Further, identifying frailty is important for the timely introduction of needed geriatric and palliative care services.

That is according to an article published by two New York geriatricians in a recent issue of the *Journal of the American Medical Association*.

“Frailty is associated with symptomatic long-term disease, decline in function, and abbreviated survival,” write the authors. “Therefore, when frailty is severe, delivery of palliative care focused on relief of discomfort and enhancement of quality of life is highly appropriate.”

The article provides both a full discussion and a table outline of the assessment and management of the common symptoms of frailty. This approach is designed to be incorporated into regular clinical practice.

“Frailty in older adults is increasingly a recognized syndrome of decline, sometimes subtle, in function and health that may be amenable to available approaches to care,” they note.

Core clinical features of frailty include:

- Loss of strength
- Weight loss
- Low levels of activity
- Poor endurance or fatigue
- Slowed performance

Frailty is “progressive, is associated with chronic disease, worsens with advancing age, and is often marked by a transition from independence in activi-

ties of daily living to dependence on caregivers.”

The authors divide frailty into three stages, offering an outline of appropriate palliative care support services as frailty progresses. “Treating these patients’ complex social, psychological, and medical needs requires state-of-the-art geriatrics knowledge and is best accomplished via a multidisciplinary, team-based approach,” they state.

### THE ROLE OF HOSPICE

For patients with severe frailty, physicians can reassess the goals of care and implement support services, recommending and explaining the benefits of hospice care. This would include addressing any patient misconceptions about what agreeing to enter hospice means.

Misconceptions patients may have concerning hospice care include:

#### *Misconception: Entering Hospice Means Forgoing All Treatments*

While agreeing to forgo insurance coverage for life-sustaining treatments, patients would be expected to continue any medications for long-term illness, because such treatments play an important role in symptom control.

#### *Misconception: Patients Enter Hospice to Die*

Most enrolled patients do die in hospice. Each year, however, a significant number of hospice patients improve and are discharged. These patients may enroll again at any time, provided they meet the hospice criteria.

**“The advantage of hospice under Medicare is that it provides a level of**

### Hospice Guideline Criteria Include:

- Multiple hospitalizations or emergency department visits during the past six months
- Recent decline in functional status
- Progressive, unintentional weight loss of more than 10% over the past six months

**services, medication, equipment, around-the-clock home coverage, and bereavement support for families that is greater than that provided by any other payment mechanism — beyond what a geriatric or palliative care interdisciplinary team is reimbursed for,”** the authors state.

Physicians are encouraged to become familiar with their local hospices and their enrollment guidelines for frail patients, as Medicare intermediaries’ medical review policies modify these guidelines in various regions of the country. The National Hospice and Palliative Care Organization guidelines for determining prognosis in noncancer patients would apply to frail older adults. [See sidebar, above.]

“Providing high-quality geriatric and palliative care for frail older adults requires time, effort, and regular communication, but, in our experience, is rewarded by rich professional and personal relationships and satisfaction on par with success in curing disease,” the authors conclude.

*Source: “Palliative Care for Frail Older Adults,” Journal of the American Medical Association; November 8, 2006; 296(18):2245-2253. Boockvar KS, Meier DE; James J. Peters Veterans Affairs Medical Center, Bronx, New York; Mount Sinai School of Medicine, and The Jewish Home and Hospital, New York City.*

## Addressing Spirituality: The Physician's Role

*Two recently published articles suggest ways clinicians can improve care by recognizing and responding to patients' spiritual needs at the end of life.*

Whether or not patients consider themselves to be religious or identify with a particular religious community, spiritual issues — questions of human value, meaning, and relationship — will arise among almost all those approaching the end of life. Addressing these issues is integral to the physician's job of providing quality care, say the authors of two recent articles, and can be approached practically by the busy clinician.

### SCREENING TOOL: 'ARE YOU AT PEACE?'

According to the authors of a study published in the *Archives of Internal Medicine*, the complex spiritual concerns of dying patients are important to themselves and to their families. They are important also to the quality of their care, because these concerns can influence:

- ✓ Disease course
- ✓ Treatment choices
- ✓ Relationships with loved ones
- ✓ Overall quality of life

Investigators tested the validity of a one-item screening tool — the question “Are you at peace?” — for use in the clinical assessment of spiritual distress at the end of life by analyzing the responses of a cross-sectional sample of 248 patients with advanced serious illness.

Feeling at peace was strongly associated with emotional and spiritual well-being, as well as with the religious and meaning-making components of spirituality, thus indicating that it can be applied to both traditional and nontraditional definitions of spirituality, note the authors.

The tool is not intended to reduce all spiritual, religious, or emotional concerns to the construct of peace, nor to replace the taking of a full spiritual history, point out the authors. Rather, much like the question “Are you depressed?” it can be a gateway to larger discussions or to referrals.

### A PRACTICAL APPROACH TO ASSESSING SPIRITUAL NEEDS

In a case study report published in the *Journal of the American Medical Association*, Daniel P. Sulmasy, MD, PhD, writes, “**If physicians are committed to treating patients as whole persons in the 21st century, spirituality and religion cannot be ignored.**” Sulmasy, who is chair of the Department of Ethics, St. Vincent's Hospital-Manhattan, New York City, adds, “Spiritual and existential well-being are major components of health-related quality of life, especially at life's end.”

### Conducting the Explicitly Spiritual Conversation

**Open with:** “It must be hard to find yourself so sick. How are you holding up?”

**Explore meaning:** “Have you thought about what all this means? Would there be anything for which you might hope even if you are not cured? Do you attach any spiritual significance to the word ‘hope’?”

**Explore value:** “Are you able to hold onto a sense of your own dignity and purpose? Are there any spiritual or religious resources upon which you can draw to help see you through this?”

**Explore relationship:** “How are things with your family and friends? Is there anyone with whom you need to ‘make up?’ If you're a religious person, how are things between you and God?”

**Have an exit strategy:** “I can't do everything — that's why we work as a team. If it's all right with you, I'd like to send Reverend R. to see you. First, I'll tell her some of what you've shared with me. Would that be okay?”

— Sulmasy, *Journal of the American Medical Association*

Sulmasy's article explains the distinction between spirituality and religion, offers the clinician helpful acronyms for taking a spiritual history, provides a list of religion-specific needs of dying patients, and presents a practical approach to conducting an assessment of spiritual needs. [See sidebar, above].

Hospice care can provide needed support to patients of all faiths: “the hospice movement generally embraces patients regardless of their religious beliefs and works with them from their own perspectives,” writes Sulmasy. “Enrollment in hospice often provides patients with resources that would not otherwise be available to them.”

Because the patient in Sulmasy's case study believed God would miraculously extend his life, his care team erroneously concluded — despite their belief that he had less than six months to live — that he was not a candidate for hospice care.

**“Nothing in the federal regulations says that patients who believe in miracles are ineligible for the hospice benefit,”** points out Sulmasy. **“The physician, not the patient, needs to believe the patient will not live longer than six months.”**

Source: “Are You at Peace?” *Archives of Internal Medicine*; November 11, 2006; 166(11):101-105. Steinhauser KE, et al; Centers for Palliative Care, Health Services Research in Primary Care, Veterans Affairs Medical Center, Durham, North Carolina. “Spiritual Issues in the Care of Dying Patients: It's Okay between Me and God.” *Journal of the American Medical Association*; September 20, 2006; 296(11):1385-1392. Sulmasy DP; St. Vincent's Hospital-Manhattan and New York Medical College, New York City.

# CLINICIAN RESOURCES

## Tailoring Prognosis Discussions to What Patients Want to Know

### Experts Propose Patient-Centered Approaches to Prognosis Disclosure

As an alternative to common approaches used by physicians for disclosing prognosis to their patients, two experts in end-of-life care communication have proposed a set of discussions and negotiation tools based on the question: "How much do you want to know?"

"Asking patients how much they want to know can facilitate an explicit discussion that meets individual patient needs," comment the authors in their article published in the *Journal of Clinical Oncology*. "This approach provides a framework that oncologists can use to align themselves with their patients and guide patients toward sound medical decisions in the midst of difficult circumstances."

The authors describe strategies commonly used by physicians for discussing prognosis, along with their useful features and some unintended consequences. These include the following:

- **REALISM** can help patients and physicians make sound medical decisions; but discussions may appear blunt, even brutal, and physicians may be perceived as uncaring.
- **OPTIMISM** can support a patient's hopes; but physicians may eventually lose the patient's trust, and patients may be led to choose life-sustaining procedures in the face of impending death.
- **AVOIDANCE** tacitly sidesteps the problems of inaccurate predictions, possible loss of hope, and patient distress. However, physicians may seem evasive and untrustworthy, especially to patients who want to know their prognosis.

The article outlines conversations and commentaries useful for a step-wise approach to discussing prognosis, based on negotiation techniques and patient-centered communication. [See sidebar.]

### Physicians Can Use a Step-Wise Approach

**Negotiate the content of the discussion:** "Would you like me to talk about the prognosis for this kind of cancer? What kind of information do you want me to cover?"

**Provide the information:** "Most people with [your disease] live for months to years. I am hopeful you will do better than most."

**Acknowledge patient reactions explicitly:** "Is that what you were expecting? I know that talking about prognosis can be difficult."

**Check for understanding:** "Could you tell me what you are taking away from our conversation today?"

#### For those patients who say they do not want to know their prognosis, physicians can:

- ✓ Try to elicit and understand the patient's reasoning and coping mechanisms
- ✓ Acknowledge patient concerns explicitly
- ✓ Privately assess whether the patient needs the information now

#### When patients are ambivalent about knowing prognosis, physicians can:

- ✓ Acknowledge the ambivalence
- ✓ Ask patients to describe the pros and cons of knowing/not knowing
- ✓ Demonstrate their perception of the difficulty of the patient's situation
- ✓ Outline options for discussion, such as different levels of disclosure and their consequences to the patient

— Back and Arnold, *Journal of Clinical Oncology*

"Real success in discussing prognosis means engaging the patient in a process of growing understanding about their situation, understanding the patient's evolving information needs, and providing the information in a way that the patient can understand it," write the authors.

"The strength of this approach is that it allows the physician to give each patient what he needs, rather than guess, or assume that what is appropriate for one patient will work for another patient," the authors conclude. "Physicians

using this approach should feel more authentic, more attuned to individual patient needs, and more deeply involved with their medical decisions."

Source: "Discussing Prognosis: 'How Much Do You Want to Know?' Talking to Patients Who Are Prepared for Explicit Information," *Journal of Clinical Oncology*; September 1, 2006; 24(25):4209-4213. Back AL, Arnold RM; University of Washington, Fred Hutchinson Cancer Research Center, Seattle; Institute for Doctor-Patient Communication, University of Pittsburgh, Pittsburgh. "Discussing Prognosis: 'How Much Do You Want to Know?' Talking to Patients Who Do Not Want Information or Who Are Ambivalent," *ibid*, pp. 4214-4217.

# CLINICIAN RESOURCES

## Online AMA Journal Offers Theme Issue on End-of-Life Care

The September 2006 issue of *Virtual Mentor*, the online ethics journal of the American Medical Association (AMA), addresses as its theme “Humanist Approaches to Care at the End of Life.”

A monthly publication launched in 1999, the journal explores specific ethical challenges encountered by medical students, residents, and other physicians in their daily practice or training. It can thus serve as a teaching resource for both physicians and physicians-in-training. The theme editors are competitively selected from among students and residents, who then solicit original articles and case commentaries from experienced physicians and other experts.

**The end-of-life care issue “directly addresses a number of common but rarely discussed difficulties faced in the care of dying patients,”** writes issue editor Tom LeBlanc, MD, MA, resident physician at Duke University, Durham, NC. “Despite countless advances in treating disease, we often seem to falter when addressing ‘illness,’ the lived experience of disease within the context of an individual’s life and personhood.”

In his article entitled “**Dying Well in America: What Is Required of Physicians?**” Richard Payne, MD, director, Institute on Care at the End of Life, Duke University Divinity School, suggests that physicians adopt the holistic philosophy of palliative medicine in caring for seriously ill patients. This combines:

- Strict attention to pain and symptom management
- Excellent communication skills
- The ability to solicit and comprehend each patient’s narrative

“We must effectively manage pain and other unpleasant symptoms such as nausea so that patients have the physical and mental strength to attend to their spiritual and existential concerns,” Payne states.

Other article titles in the September 2006 *Virtual Mentor* include:

- When Doctors Disagree
- Taking Your Communication Skills to the Next Level
- Why Physicians Avoid Straight Talk about CPR
- Myths and Misconceptions about Palliative Sedation
- Racial Disparities in Hospice: Moving from Analysis to Intervention
- The Evolution of Surrogates’ Right to Terminate Life-Sustaining Treatment

All current and past issues of *Virtual Mentor* are freely available online and are searchable via a listing of issue month and year, as well as through indices by author, clinical case, and topic. Contents can be read or downloaded as individual articles (in PDF or HTML format) or by entire issue (PDF only).

Themes slated for upcoming issues include the illness-poverty relationship and ethical issues in cancer care. To access *Virtual Mentor*, click on its link under “Publications” on the AMA homepage at [www.ama-assn.org/](http://www.ama-assn.org/).

## End-of-Life Care Websites

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

American Academy of Hospice and Palliative Medicine

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

End of Life/Palliative Education Resource Center (EPEC)

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

The EPEC Project (Education in Palliative and End-of-Life Care)

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

National Hospice & Palliative Care Organization

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

National consumer engagement initiative to improve end-of-life care

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

Promoting Excellence in End-of-Life Care

[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)

Hospice and Palliative Nurses Association

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

Palliative Care Policy Center

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

Americans for Better Care of the Dying

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

Medical College of Wisconsin Palliative Care Center

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

University of Wisconsin Pain and Policy Studies Group

[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

# End-of-Life Care Meetings for Clinicians

**Annual Assembly of the American Academy of Hospice and Palliative Medicine and the Hospice and Palliative Nurses Association.** February 14-17, 2007, Salt Lake City, UT. Phone: 847-375-4712; Fax: 877-734-8671; Email: [info@aahpm.org](mailto:info@aahpm.org); Website: [www.aahpm.org](http://www.aahpm.org)

**11th Annual International Symposium: Palliative Medicine 2007.** March 15-17, 2007, Hyatt Regency Coconut Point Resort & Spa, Bonita Springs, FL. Sponsor: Cleveland Clinic Center for Continuing Education. Phone: 800-238-6750 or 216-297-7330; Website: [www.clevelandclinicmeded.com/pm2007](http://www.clevelandclinicmeded.com/pm2007)

**Pain Management.** April 21-28, 2007, Mexican Riviera Conference Cruise from San Diego, CA. Accredited by the Accreditation Council for Continuing Medical Education. Phone: 800-422-0711 (US) or 727-526-1571 (outside US); Fax: 727-527-3228; Website: [www.continuingeducation.net](http://www.continuingeducation.net)

**26th Annual Scientific Meeting of the American Pain Society.** May 2-5, 2007, Washington, DC. Phone: 847-375-4715; Fax: 877-734-8758; Email: [info@ampainsoc.org](mailto:info@ampainsoc.org); Website: [www.ampainsoc.org](http://www.ampainsoc.org)

**Current Concepts in Palliative Care Course.** May 10-12, 2007, Nashville, TN. Sponsor: American Academy of Hospice and Palliative Medicine. Accredited by the Accreditation Council for Continuing Medical Education. Phone: 847-375-4712; Fax: 877-734-8671; Email: [info@aahpm.org](mailto:info@aahpm.org); Website: [www.aahpm.org](http://www.aahpm.org)

## The American Academy of Hospice and Palliative Medicine states:

- The proper role of a physician is to help the sick, even when cure is not possible.
- Death is a natural and inevitable end to life, and helping patients achieve an easy passage to death is one of the most important and rewarding services that a physician can provide.
- The medical profession should attend to all of the needs of dying patients and their families.
- Physicians have an important responsibility in hospice and palliative care, and should take a leadership role in promoting and guiding the future direction of this care.
- Physicians have a major responsibility for bringing the hospice approach into mainstream medicine.

*For more information about hospice and palliative care, or to make a referral, please contact your local hospice and palliative care organization.*

Quality of Life Matters® is recommended as an educational resource by the American Academy of Hospice and Palliative Medicine and the Hospice and Palliative Nurses Association.

## QUALITY OF LIFE MATTERS®

Now entering its ninth year of publication, Quality of Life Matters *is recommended as an educational resource by the American Academy of Hospice and Palliative Medicine*. The periodical is dedicated solely to end-of-life care news and clinical findings and is researched and written by professional medical journalists who specialize in covering palliative care issues. It 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 patients with life-limiting illnesses and their families.

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