

Quality of Life Matters™

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

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92% of Americans Favor Access to Hospice Care

Emotional Support Ranked As Most Important End-of-Life Service

A national survey measuring the public's attitudes toward end-of-life issues found that most American adults (92%) believe that hospice should be available to anyone facing the end of life, with a large majority (73%) identifying emotional support for dying patients and their families as an important aspect of end-of-life care.

In a regionally representative sample, 1006 adults (aged 18 years and older) were interviewed by telephone in February 2000 concerning their end-of-life care knowledge and preferences. While 54% said they had never sought advice or information on end-of-

life issues, the majority (61%) said they would turn to family members if faced with end-of-life decisions for a relative or friend.

Almost half (49%) of the respondents said they would seek advice from their primary care physician, and 41% said they would ask a member of the clergy. In practice, 28% of those interviewed had sought end-of-life care advice from relatives, 14% from clergy members, and 10% from physicians.

The aspects of end-of-life care given

the highest priority by the respondents were:

- **Emotional support** for patients and families (73%)
- **Control of pain and other symptoms** according to the patient's wishes (71%)
- **Spiritual support** for patients and families (69%)
- **The option to die at home** (68%)
- **Bereavement counseling** for family members (56%)

The study was conducted by the

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Physicians Are Systematically Overoptimistic in Predicting Survival

Doctors Miss the Chance to Devote More Time to 'Improving the Quality of the Patient's Remaining Life'

Physicians' predictions of survival in their terminally ill patients are often inaccurate (80%) and usually optimistic (63%); and the incidence of prognostic error is not restricted to certain kinds of physicians or particular types of patients, according to a recent physician survey conducted by Chicago researchers.

The findings, published in the February 19, 2000, issue of the *British Medical Journal*, were compiled by Nicholas A. Christakis, MD, PhD, and Elizabeth B. Lamont, MD, University of Chicago Medical Center.

"Although some error is unavoidable in prognostication, the type of systematic bias towards optimism that we have found in doctors' objective prognostic assessments may be adversely affecting patient care," the authors write. "Doctors who do not realize how little time is left may miss the chance to devote more of it to improving the quality of the patient's remaining life."

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92% Favor Access to Hospice Care

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Foundation for End of Life Care based in Miami and Yankelovich Partners of Norwalk, Connecticut.

J. Richard Williams, MD, president of the foundation, says the findings confirm the need for end-of-life care to go beyond the treatment of a terminal disease.

"Dying is a very personal process; it is not just a medical and nursing process," Williams told *Quality of Life Matters*. "There is a lot of emotion involved, and a clear need for psychosocial and emotional support of the dying and their families. The interdisciplinary services offered by the hospice team are very important in meeting those needs, by focusing on the patient and family as the center of the dying process."

The survey findings were presented at a symposium entitled, "Opening Doors: Access to Care at the End of Life," held in March at Duke University, Durham, North Carolina, to coincide with the opening of the Duke Institute on Care at the End of Life. [See Sidebar.]

Duke Opens \$13.5 Million End-Of-Life Care Research Center

Duke University has opened the Duke Institute for Care at the End of Life, a research center devoted to finding ways to improve care of terminally ill patients and their families.

Based in Duke's divinity school, the institute is an international, interdisciplinary research center, with links to its medical school and hospital, to other universities in the state, and to a major pioneer in hospice care, St. Christopher's Hospice, London.

L. Gregory Jones, Dean of Duke's School of Divinity, notes that the institute was born from the recognition that dying patients and their families have needs beyond the medical. "Surveys show that at the end of life, people want reconciliation, to be at peace spiritually and with their families, and that they regard that as the most important aspect of dying, second only to a pain-free death."

The institute is funded by an initial gift of \$13.5 million arranged by hospice pioneer Hugh A. Westbrook, a graduate of Duke Divinity School and an ordained minister. Westbrook is co-founder and chief executive officer of VITAS Healthcare Corp. of Miami.

Overoptimistic Survival Predictions

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The prospective cohort study followed 468 patients (mean age, 69 years; cancer diagnosis, 65%) admitted to 5 outpatient hospice programs in Chicago during 1996. At the time of admission, the 343 referring physicians (median duration of medical practice, 16 years) were asked in a telephone survey to objectively communicate their prognoses to the investigators. Patient and physician characteristics were evaluated, and predicted survival was compared with actual survival.

Prediction Findings Include:

- Only 20% of predictions were accurate (within 33% of actual survival).
- Most (63%) predictions were overoptimistic, with physicians predicting, on average, that their patients would live 5.3 times longer than they actually did. Me-

dian survival was 24 days.

Although few physician or patient characteristics were associated with prognostic accuracy, physicians in the upper quartile of practice experience were found to be the most accurate. In contrast, those physicians reporting the longest physician-patient relationship and the most recent patient contacts were least likely to be accurate.

Implications:

- "Unduly optimistic" ideas about patient survival may explain the pattern of **late referral for hospice care**, and deny physicians the opportunity of enhancing patients' remaining life
- Optimistic physician communication may influence patients to make **counter-**

productive choices, such as requesting futile, aggressive care rather than more beneficial palliative care.

- Corrective techniques might include **"second opinions"** from other physicians who have more experience and less personal contact with the patient.
- It may be helpful to consider the uniform distribution of prognostic error when planning **physician training and self-assessment**.

"Obtaining prognostic information is often the highest priority for seriously ill patients, eclipsing their interest in treatment options or diagnostic details," the authors conclude. "And reliable prognostic information is a key determinant of both doctors' and patients' decision-making."

Experts Suggest 'Diagnosis' and Management of Physician-Family Conflicts about End-of-Life Care

Many factors may contribute to what can be difficult and disturbing conflicts between physicians and families over end-of-life care decisions. Identifying the underlying basis for disagreements—in a “differential diagnosis”—may help to defuse or prevent them, according to an article published in the February 16, 2000, issue of the *Journal of the American Medical Association*.

By applying a scientific model to a psychosocial aspect of medical care, the study authors (from university research centers in Ann Arbor, Michigan, and Pittsburgh) hope to promote physicians’ understanding of the causes of disagreements and to stimulate a creative problem-solving approach.

A brief summary of the study authors' suggestions and recommendations appears below.

FAMILY FACTORS

There can be a number of reasons why a family member may not understand the medical facts. Ask families to put the patient’s history in their own words, e.g., “Can you tell me what others have told you is going on with your father?” Reasons that a family member may not understand the medical situation:

1. DENIAL. The family may be psychologically unprepared to recognize/accept the facts, due to grief, guilt, or anger. Try:

- √ Open-ended listening.
- √ Nondefensive, neutral responses, or silence.
- √ Frequent, regular opportunities for the family member to communicate with a consistent health care provider.
- √ Validating family members’ emotions, e.g., “It must be very hard for you to see your father so ill.”

2. "BAD NEWS" is often poorly processed and imperfectly remembered. Try:

- √ Repeating key concepts.
- √ Giving written as well as verbal information.
- √ Encouraging questions.

3. COMMUNICATION STYLE. A physician’s use of jargon, hedges, and differences in semantics may confuse families. Try:

- √ Using language appropriate to the family’s educational level.

- √ Frequently assessing their understanding, e.g., “To make sure we are all on the same page, can you tell me your understanding of the situation?”

4. INFORMATION FROM MULTIPLE SOURCES. Families obtain information from the media, friends, and the numerous clinicians who may have been involved in the patient’s case. Try:

- √ Choosing one health care professional to serve as the primary communicator.
- √ Holding regularly scheduled family meetings.

5. FAMILY CONFLICT. Families have their own histories and sometimes compete to be the “most caring.” Try:

- √ Focusing discussions on what the patient’s goals would be.
- √ Obtaining information from several family members or from other professionals familiar with the family dynamics.

Take the Time to Ask!

Study co-author Robert M. Arnold, MD, of the Division of General Internal Medicine, Center for Bioethics and Health Law, University of Pittsburgh, presented the study findings at a clinical conference held in April entitled, "End of Life Issues in the 21st Century: Exploring Controversies in Palliative Care."

Arnold emphasized to the Tampa conference attendees the importance of asking questions. "How do you find out what's happening? Simply take the time to ask."

PHYSICIAN FACTORS

1. ATTITUDES & BELIEFS. Physicians may be uncomfortable with prognostic uncertainty, or with discussing death. Some may view death as a medical “failure.” There may also be different value systems, religious or philosophical beliefs from those of the family. Try:

- √ Insights into one’s own limitations and beliefs regarding death.
- √ Opening a discussion of areas of disagreement with mem-

bers of the patient's family.

2. LACK OF KNOWLEDGE or skills in treatment options, symptom management, interpersonal communication, or legal or hospital policies can lead to inappropriate care. Try:

- √ Programs designed to enhance physicians’ knowledge and skills in end-of-life care, such as the American Board of Internal Medicine’s End-of-Life Patient Care Project and the American Medical Association’s Education for Physicians on End-of-Life Care Project.

Use of Opioid Analgesics Increases, While Abuse Rate Remains Low

The medical use of opioid analgesics in the treatment of severe pain increased during the years 1990 through 1996, while opioid abuse during that time remained low and stable, according to a study of the most recent data available from two federally-sponsored drug databases.

“Although there are many ways to treat pain, the increased medical use of opioids is a strong indicator that we are making progress to improve pain management,” said lead author David E. Joranson, MSSW, Director of the Pain and Policy Studies Group at the University of Wisconsin, Madison. **“At a time when abuse of illicit drugs continues to increase, it is reassuring that abuse of opioid pain medications is a small part of the US drug problem.”**

The study evaluated medical use data from the US Drug Enforcement Administration’s Automation of Reports and Consolidated Orders System (ARCOS), which collects information on the lawful distribution of opioids and other controlled substances to retailers such as hospitals, pharmacies, and licensed practitioners.

To determine abuse trends, the researchers examined data from the Substance Abuse and Mental Health Services Administration’s Drug Abuse Warning Network (DAWN), a nationally representative sample of hospital emergency department visits for drug-related problems.

Because of their effectiveness in treating severe pain, 5 specific Schedule II opioids were chosen for review. Medical use increased 59% for morphine, 23% for oxycodone, 19% for hydromorphone, and a dramatic 1168% for fentanyl. In contrast, the use of meperidine decreased by 35%. “This decrease may reflect increasing awareness of the shortcomings of the use of meperidine for chronic pain, which include short duration of action,” comment the authors.

As a proportion of total drug abuse, opioid analgesic abuse was low, and declined by 25% (from 5.1% to 3.8%) during the 7-year period. Each of the 5 study drugs accounted for less than 1% of the total DAWN abuse mentions. Further, while the overall number of drug abuse mentions increased by 42.8%, the total number for opioid abuse during the same period increased by only 6.6%.

Since some abuse of opioid analgesics does exist, the authors caution that care must be maintained to minimize their

nonmedical use. **“If the abuse of opioid analgesics should increase, the sources of diversion should be addressed directly, without interfering with medical availability of opioid analgesics, legitimate medical practices, or patient care.”**

Source: “Trends in Medical Use and Abuse of Opioid Analgesics,” Journal of the American Medical Association; Apr. 5, 2000; 283(13):1710-1714. Joranson DE, Ryan KM, Gilson AM, Dahl JL; Department of Pharmacology and the Pain and Policy Studies Group, Comprehensive Cancer Center, University of Wisconsin Medical School, Madison.

Parents Report Substantial Suffering in Children Dying of Cancer

A survey of 103 parents whose children died of cancer between 1990 and 1997 has found that 89% of the children suffered “a lot” or “a great deal” from at least one symptom in the last month of life, most commonly pain, fatigue, or dyspnea. According to the parents, more than 50% of the children suffered from 3 or more symptoms.

“The multidisciplinary approach to care [such as hospice care] may be best.”

Elaine R. Morgan, MD, and Sharon B. Murphy, MD

Researchers from the Dana-Farber Cancer Institute and Children’s Hospital, both in Boston, interviewed the parents approximately 3 years after the death of the child and conducted a review of each child’s medical records. Nearly half (49%) of the children died in the hospital, with half of those deaths occurring in the intensive care unit. Almost 80% of the children died of progressive disease; the rest died of treatment-related complications.

Parents reported that when children were treated for specific symptoms, treatment was successful in 27% of those with pain and 16% of those with dyspnea. **However, children whose primary oncologist remained actively involved in end-of-life care were less likely to suffer from pain, the study found.** Parents were significantly more likely than physicians to report that their child experienced fatigue, poor appetite, constipation, and diarrhea.

“Children who die of cancer receive aggressive treatment at the end of life,” the authors conclude. “Many have substantial suffering in the last month of life, and attempts to control their symptoms are often unsuccessful. **Greater attention must be paid to palliative care for children who**

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are dying of cancer.”

In their accompanying editorial, Elaine R. Morgan, MD, and Sharon B. Murphy, MD, of Children’s Memorial Hospital, Chicago, point out that a major barrier to the improvement of palliative care for children is the perception of adults that discontinuing aggressive care means accepting failure. “The shift in the goal from achieving a cure to making the patient comfortable usually occurs only when all other options have been exhausted, perpetuating the myth that palliative care is second best,” they comment.

“To achieve the goals of optimal care for all children with cancer, care at the end of life should be a priority,” Morgan and Murphy urge, suggesting that the multidisciplinary approach may be best. “This should be flexible enough to provide support for both the children whose disease can be cured and those for whom a cure is not yet possible.”

Sources: “Symptoms and Suffering at the End of Life in Children with Cancer,” *New England Journal of Medicine*; Feb. 3, 2000; 342(5):326-333. Wolfe J, Grier HE, Klar N, et al; Departments of Pediatric Oncology and Biostatistical Science and Center for Outcomes and Policy Research, Dana-Farber Cancer Institute, Boston; Department of Medicine, Children’s Hospital, Boston. “Care of Children Who Are Dying of Cancer,” *New England Journal of Medicine*; Feb. 3, 2000; 342(5):347-348. Morgan ER, Murphy SB; Children’s Memorial Hospital, Chicago.

By Listening Well, Physicians Can Ease Caregivers’ Burdens

Many caregivers experience psychosocial hardship while caring for terminally ill patients with substantial needs, according to a new study. Yet the findings indicate that physicians have an opportunity for reducing caregivers’ depression and easing some burdens, simply by listening to their needs and concerns.

Interviews with 988 terminally ill patients (mean age, 66.5 years; cancer diagnosis, 51.8%) and 893 caregivers from March 1996 to March 1997 revealed that 34.7% of patients had substantial care needs (for transportation, nursing care, homemaking, and personal care).

Among the caregivers of patients with substantial needs, 31.4% had depressive symptoms and 35.6% reported that their caregiving responsibilities interfered with their personal lives. However, caregivers of patients with substantial needs who reported that the physicians they dealt with listened to their “needs and opinions about the patient’s illness or medi-

cal treatment” were significantly less likely to be depressed than caregivers whose physicians did not listen (27.6% vs. 42%) and less likely to report that caring for the patient interfered with their lives (31.5% vs. 47.7%).

“It seems that physicians can reduce caregivers’ depression simply by listening well,” the authors write, suggesting that training in empathy and listening skills might be structured into physician educational settings. **Additional hospice or home care services, as well as unskilled caregiving assistance, may be helpful to burdened patients and families, note the authors.**

“These families need help, and doctors can do a lot to provide it.”

Ezekiel J. Emanuel,
MD, PhD

“These families need help, and doctors can do a lot to provide it,” says lead investigator Ezekiel J. Emanuel, MD, PhD, chair of the Department of Clinical Bioethics, Warren G. Magnuson Clinical Center, National Institutes of Health, Bethesda, Maryland. “This study indicates that doctors have a pivotal role to play by listening better to caregivers and providing them with support at a stressful time in their lives.”

Source: “Understanding Economic and Other Burdens of Terminal Illness: The Experience of Patients and Their Caregivers,” *Annals of Internal Medicine*; March 21, 2000; 132(6):451-459. Emanuel EJ, Fairclough DL, Slutsman J, Emanuel LL; Department of Clinical Bioethics, Warren G. Magnuson Clinical Center, National Institutes of Health, Bethesda, Maryland; Center for Research Methodology and Biometrics, AMC Cancer Research Center, Denver; Department of Health Policy and Management, School of Hygiene and Public Health, Johns Hopkins University, Baltimore; Institute of Ethics, American Medical Association, Chicago.

Depression in Dying Patients Can Be Assessed and Treated

Psychological distress can add to the suffering of dying patients and their families, and requires treatment even when it does not constitute a psychiatric diagnosis, says Susan D. Block, MD, of the Dana-Farber Cancer Institute, Boston.

In a recently published paper, Block reviews the clinical characteristics of normal distress and grieving, clinical depression, and suicidal ideation in the terminally ill patient, and provides strategies – often in the form of accompanying tables — for diagnosis and treatment.

“The first step in assessing and treating depression is controlling pain,” states Block. Although little is known

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about depression in patients with end-stage pulmonary, cardiac, renal, and neurologic disease, uncontrolled pain is a major risk factor for depression and suicide among patients with cancer, she notes.

Other key points from Block include:

DIAGNOSIS. During the clinical interview, ask, "Are you depressed?" Remember that the diagnostic features of depression do not directly apply to the terminally ill, so put a patient's responses in context.

SUPPORTIVE THERAPY alone sometimes is sufficient treatment. Combine listening, emotional support, exploring concerns, flexibility, appreciation of the patient's coping strengths, dialogue with family members, and elements of life review.

MEDICAL THERAPY. Have a low threshold for treating depression in dying patients, Block recommends. Consider a therapeutic trial of antidepressant medication when a diagnosis is in question. Treatment with psychostimulants can provide a fairly quick test of whether antidepressants are likely to be effective.

MAINSTAY AGENTS include psychostimulants, selective serotonin reuptake inhibitors (SSRIs), and tricyclic antidepressants. For patients who require urgent treatment but are expected to survive several months or more, begin with a psychostimulant, then gradually add an SSRI to a therapeutic dosage level while decreasing the psychostimulant. When immediate onset of action is not essential, the SSRIs paroxetine and sertraline would be Block's agents of choice.

INTERDISCIPLINARY TEAM. Throughout the assessment and management of depression in these patients, rely on the expertise of the interdisciplinary team. Psychiatrists, social workers, and chaplains can provide important assessments, information, and insights.

OVERALL. "Skillful management of depression relieves suffering and is a core element of the provision of comprehensive end-of-life care. Although treatment of pain and other symptoms at the end of life has improved, depression and other psychological symptoms and disorders remain troublesome for terminally ill patients. Many of these conditions can be easily controlled with state-of-the-art psychosocial treatments. Physicians who care for dying patients must be competent in this critical area of clinical practice."

Source: "Assessing and Managing Depression in the Terminally Ill Patient," *Annals of Internal Medicine*; Feb. 1, 2000; 132(3):209-218. Block SD, for the American College of Physicians – American Society of Internal Medicine End-of-Life Care Consensus Panel; Dana-Farber Cancer Institute, Boston.

50% of Delirium Episodes in Terminal Patients May Be Reversible

A Canadian prospective cohort study has found that although delirium is present in most cancer patients before death, nearly 50% of delirium episodes may be reversible by treating the underlying causes with low-burden interventions.

"Causes that are highly associated with reversibility, such as psychoactive medications and dehydration, are potentially correctible with minimally invasive measures, such as change of opioid, dose reduction, or discontinuation of unnecessary psychoactive medication, and hydration," say the authors, based in Edmonton, Alberta.

"Delirium impedes communication and contributes to symptom distress in patients with advanced cancer," they add, which hinders the patient's participation in family interaction, symptom assessment, and therapeutic counseling. Even though **delirium imposes an additional burden on the terminally ill patient,** it has been underrecognized and underresearched in general medical patients as well as in patients with cancer, the researchers point out.

In what they note as the first study of its kind, the team evaluated delirium occurrence and reversal rates, duration, and patient survival in advanced cancer patients admitted to the acute palliative care unit of a teaching hospital. Researchers followed 104 patients referred to the facility in 1997 with advanced cancer and a high level of symptom distress.

Opioids and other psychoactive medications were found to be independently associated with delirium reversibility. Dehydration, while not independent, was significantly associated with reversibility in univariate analysis. Since the study found a median number of 3 precipitating factors per episode of delirium, the authors suggest that dehydration may act in association with other reversible factors, such as opioid toxicity.

"For the physician in clinical practice, our study findings highlight the need to diagnose delirium and to recognize both its multifactorial nature and its reversibility," the researchers conclude.

Source: "Occurrence, Causes, and Outcome of Delirium in Patients with Advanced Cancer: A Prospective Study," *Archives of Internal Medicine*; Mar. 27, 2000; 160(6):786-794. Lawlor PG, Gagnon B, Mancini IL, et al; Edmonton Palliative Care Program, Grey Nun's Hospital, and Division of Palliative Medicine, Department of Oncology, University of Alberta, Edmonton, Alberta.

PHYSICIAN RESOURCES

AMDA Offers Physician Information Kit on End-of-Life Decision-Making

The American Medical Directors Association (AMDA) has released “**Care at the End of Life**,” an information kit designed for the use of physicians and other practitioners, as well as administrators and staff, in helping patients and families manage end-of-life decision-making in the long-term care setting. The kit is the most recent entry in the **AMDA’s Long-Term Care Physician Information Series**.

The material is aimed at enabling physicians to clarify their role in helping patients, surrogates, and families to understand their end-of-life choices and document their wishes. The kit outlines general principles applicable to patients of all ages and offers specific information and materials, sample forms, guidance, commentary, and references.

Key legal and ethical issues addressed include:

- The Patient Self-Determination Act of 1990
- Advance directives
- Life-sustaining treatments
- Do-not-resuscitate orders

Long-Term Care Guidelines for Pain and Wound Management Also Available

The AMDA has also announced the release of two new clinical practice guidelines. “**Chronic Pain Management in the Long-Term Care Setting**” is directed toward the interdisciplinary team, patients, and their families. It includes a step-by-step approach to effective pain management, a treatment algorithm, tables and charts, and references. The guideline also outlines ways of overcoming barriers to the recognition of chronic pain in the long-term care patient.

These barriers include:

- Blunted response
- Cognitive and communication barriers
- Cultural and social barriers
- Co-existing illnesses and multiple medication use
- Lack of staff training or access to appropriate tools
- System barriers, such as high caregiver turnover

“No barrier should be accepted as an excuse to ignore pain in long-term care patients,” says Paul Katz, MD, CMD, member of the AMDA work group that developed the guidelines. “Practitioners and caregivers need to listen carefully to what patients have to say.”

The new “**Pressure Ulcer Therapy Companion**” is an update of the 1996 practice guideline. Updates include information on managing and monitoring wounds. Similar in structure to the pain guideline, the therapy companion can be used in conjunction with existing programs and treatment tools.

For more information, call **410-740-9743**, or visit **www.amda.com**.

End-of-Life Care Websites

www.aahpm.org

American Academy of Hospice & Palliative Medicine.

www.nhpco.org

National Hospice & Palliative Care Organization (formerly the NHO).

www.hospicefoundation.org

Hospice Foundation of America.

www.americanhospice.org

American Hospice Foundation.

www.gwu.edu/~cicd

Center to Improve Care of the Dying, The George Washington University.

www.abcd-caring.com

Americans for Better Care of the Dying.

www.lastacts.org

Last Acts Coalition.

www.mcw.edu/pallmed/

Palliative Medicine Program at the Medical College of Wisconsin.

www.chcr.brown.edu

Center for Gerontology and Health Care Research.

www.halcyon.com/iasp/

International Association for the Study of Pain.

www.medsch.wisc.edu/painpolicy

University of Wisconsin Pain and Policy Studies Group.

www.soros.org/death

Project on Death in America of the Open Society Institute.

www.stoppain.org

Pain Medicine & Palliative Care, Beth Israel Medical Center.

www.growthhouse.org

Online community for end-of-life care.

www.partnershipforcaring.org

Partnership for Caring: America's Voices for the Dying.

www.missoulademonstration.org

Missoula Demonstration Project: The Quality of Life's End.

Upcoming Meetings for Physicians Interested in End-of-Life Care Education

Worldwide Pain Conference. July 15-21, 2000, San Francisco Marriott Hotel, San Francisco. Contact: Meetings Plus, 242 Lafayette Circle, Lafayette, CA 94549. Phone: 925-284-4040; e-mail: painconference2000@meetingsplus.com

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

First World Conference on Geriatric and Palliative Care. October 11-14, 2000, New York. Sponsors: Beth Israel Medical Center and Continuum Health Partners, Inc. Contact: Events International Meeting Planners, Inc. Phone: 514-286-0855; Fax: 514-286-6066; e-mail: info@eventsintl.com

Improving End-of-Life Care for the Hospitalized Patient. October 25, 2000, Grand Hyatt Hotel, San Francisco. Contact: Cliff Brock, Department of Medicine, CME UCSF Box 0656, San Francisco, CA 94143-0656. Phone: 414-476-5208; Fax: 415-476-3542; e-mail: cme@medicine.ucsf.edu

Update in Pain, Palliative Care, and Infectious Disease. November 11-18, 2000, Southern Caribbean Cruise. Sponsor: University of Wisconsin. Contact: Ann Bailey. Phone: 608-263-2854; Fax: 608-262-8421; e-mail: rkdx@facstaff.wisc.edu

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