

Quality of Life Matters™

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

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Physician Board to Establish Hospice and Palliative Medicine as Subspecialty

The American Board of Hospice and Palliative Medicine (ABHPM) has announced plans to expand its development of standards for physician training and practice in hospice and palliative medicine, with the **aim of establishing this emerging discipline as a recognized subspecialty.**

Formed in 1995, the ABHPM maintains a registry of all physicians who have met specific eligibility requirements and passed its certification examination in hospice and palliative medicine. Currently, **nearly 800 physicians** in 48 states, the District of Columbia, and Canada **have achieved ABHPM certification.**

With recent grants from both the Robert Wood Johnson Foundation and

the Project on Death in America, the ABHPM plans to:

- **Standardize requirements for fellowship programs** in hospice and palliative medicine, leading to accreditation
- **Improve its certification examination** and create a re-certification process
- **Develop physician consensus** on the appropriate approach for formalizing hospice and palliative medicine as a subspecialty

The ABHPM, which is based in Silver Spring, Maryland, defines hospice and palliative medicine as **“an interdisciplinary approach to the study and care of patients with active, pro-**

gressive, far advanced disease for whom the prognosis is limited and the focus of care is quality of life.”

The organization developed its certification program as a first step in its **mission to promote and improve standards of excellence in the delivery of hospice and palliative medicine**, a field that “recognizes the multidimensional nature of suffering, responds with care that addresses all of these dimensions, and communicates in a language that conveys mutuality, respect, and interdependence,” says the ABHPM.

The certification examination is offered semi-annually. For more information, call the ABHPM at **301-439-8001**, or log on to **www.abhpm.org**.

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JAMA Offers Patient Pages on End-of-Life Care

Goal is to help increase physician-patient communication

The *Journal of the American Medical Association (JAMA)* now includes several topics related to hospice and end-of-life care in its archive of Patient Pages, **a health information service offered weekly in single-page format, which physicians are invited to reproduce and share with patients.**

The most recent of these theme pages, entitled “Hospice Care,” appeared in the Feb. 21, 2001, issue of the journal.

“The goal of the page is to help increase doctor-patient communication,” according to the American Medical Association. Each page is devoted to a single public health topic, and provides definitions of terms, along with resources patients can contact for further information. Each topic is also tied into a related

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'Loss of Autonomy' Biggest Concern Among Patients Choosing Physician-Assisted Suicide

Among the 27 terminally ill patients in Oregon who used the legal option of physician-assisted suicide (PAS) in 2000, **losing autonomy was the most frequently reported end-of-life concern**, and was cited 3 times more often than was concern about pain relief.

The findings are included in a recent report released by the Oregon Health Division (OHD) and published in the Feb. 22, 2001, issue of the *New England Journal of Medicine*.

Oregon health officials also found that **being a burden to others rose significantly as a cited concern** among patients who died by PAS, jumping from 12% and 26% in 1998 and 1999, respectively, to 63% in 2000.

"Physicians who were interviewed reported that, as in past years, patients had several reasons for requesting le-

thal medication," says Katrina Hedberg, MD, deputy state epidemiologist with OHD. **"This year, physicians reported increasing patient concerns about being a burden on friends, family, and caregivers."**

Compared with the 6,981 Oregon residents who died in 1999 from similar underlying illnesses, reports Hedberg, those choosing PAS in 2000 differed little in demographic characteristics. The one exception was in the level of education: **31% of PAS patients had post-baccalaureate degrees**, and only 8% had less than a high school education.

PATIENT CONCERNS INCLUDED:

- √ Losing autonomy (93%)
- √ Losing control of bodily functions (78%)
- √ Decreasing ability to take part in

activities that make life enjoyable (78%)

- √ Becoming a burden (63%)
- √ A combination of some of the above concerns (96%)
- √ Inadequate pain control (30%)

An editorial about the Oregon report appearing in the March 19, 2001, edition of *American Medical News* (published by the American Medical Association) stated, **"Oregon's experience is a reminder to the medical community—which in both its past and present has not done nearly enough to provide the best end-of-life care—that dying patients need help in coping with a constellation of deeply felt concerns."**

The full OHD report is available online at www.ohd.hr.state.or.us.

JAMA Patient Pages Help Physician-Patient Communication

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article appearing in that week's issue of *JAMA*. To date, the *JAMA* Patient Pages related to end-of-life and palliative care topics include:

Hospice Care (Feb. 21, 2001)

Outlines the goals of hospice care and the multidisciplinary services provided. Patients learn that, "If you choose hospice care, in addition to your personal doctor, you will be working with a team of health care professionals and volunteers: doctors, nurses, social workers, physical therapists, and volunteer workers."

Decisions about End-of-Life Care (Nov. 15, 2000)

Explains the need for special care that patients and families may experience as they face the challenges of terminal illness. Terms such as "palliative care," and "hospice care" are defined, and patients are directed to seek more information.

Managing Pain (April 5, 2000)

Common types of pain are outlined, as are drugs used to treat pain. Other therapies, such as psychological therapy and relaxation techniques, are explained.

Advance Directives for End-of-Life Medical Decisions (March 15, 2000)

Patients are encouraged to discuss with their physician their wishes and concerns about this important subject. Types of advance directive documents are explained, including a living will, durable power of attorney for health care decisions, and combination documents. Patients also learn about do-not-resuscitate orders.

The pages are offered free of charge for downloading from the *JAMA* website at <http://jama.ama-assn.org>, or they can be ordered in bulk by calling 718-946-7424.

Physicians Offered Practical Approach to Grief and Bereavement

Physicians will encounter grief in both their clinical practice and personal lives. Recognizing its presentation and intervening to relieve its distress can provide physicians with the opportunity “to make an important difference” in the healing process, according to a recent paper from the **End-of-Life Care Consensus Panel of the American College of Physicians-American Society of Internal Medicine (ACP-ASIM)**.

Grief may be responsible for many physical symptoms that physicians will be asked to assess, and has been associated with increased risk for health problems, as well as for suicide and death from other causes, the panel notes. **“Physicians should therefore include recognition of grief among their clinical skills,”** according to David Casarett, MD, MA, Institute on Aging, University of Pennsylvania, Philadelphia, and colleagues.

The paper identifies and describes 4 aspects of the grieving process, offers practical techniques for assessing grief in patients, and suggests recommendations for interventions and referrals. **“Intervention by the physician need not take a considerable amount of time,”** the authors note.

ANTICIPATORY GRIEF

This is the process by which those close to terminally ill patients—and the patients themselves—come to terms with impending loss. Physicians can:

- √ **Encourage open acknowledgment of feelings and concerns**
- √ **Support frank discussion** of the dying patient’s condition and prognosis
- √ **Facilitate life review activities** provided by loved ones, clergy, and psychosocial professionals

ACUTE GRIEF

Grief reactions in a family member at the time of death may be distressing to other relatives and to providers. Physicians are advised to curb their own feelings of awkwardness and resist the urge to prescribe a quick “fix.” Attending physicians can:

- √ **Be present:** remain in the room with the family, witnessing their grief and sharing in their loss
- √ **Allow time for the expression of grief, and reassure** other relatives and the staff that acute reactions are not abnormal
- √ **Facilitate practical planning** for the immediate future, such as transportation home and companionship
- √ **Arrange a follow-up appointment** with the bereaved person’s primary care physician
- √ **Plan to write or telephone a message of condolence**

NORMAL GRIEF

Primary care physicians can assist bereaved patients through the processes of normal grief by identifying symptoms and experiences with a few open-ended questions during a visit following the death, and by reassuring patients that their reactions are normal. Physicians can:

- √ **Review recent events** (“You’ve faced a lot over the past several weeks. How has that been?”)
- √ **Determine whether the experienced symptoms are interfering with the patient’s life and recovery process** (“Has anything been especially troubling for you?”)
- √ **Review available social support** (“Has anyone been particularly helpful to you in the past month?”)
- √ **Identify resources for support and comfort** (“Are there any activities that have made this less difficult for you?”)
- √ **Determine whether any practical difficulties have arisen, particularly with elderly patients** (“How are things around the house? With your finances?”)

Patients’ progress through the processes of mourning can be assessed in a follow-up visit several months after the loss.

Casarett and colleagues remind physicians, “the result of these processes is accommodation, not ‘acceptance’ or ‘recovery.’ **Grief changes people, and failure to return to one’s baseline is therefore not a sign of abnormal grief.** Instead, a more realistic aim is an altered life in which the person has adapted to the loss.”

COMPLICATED GRIEF

Nevertheless, some patients will experience complicated grief, a **delayed or incomplete adaptation to loss**. Physicians may find it difficult to distinguish complicated grief from depression, the authors note, but both conditions are indications for additional counseling or psychotherapy. In general, symptoms of depression tend to start later, remain constant, and persist for several months. **Risk factors for complicated grief include younger age, female sex, limited social support, and a death that was sudden or traumatic.** Physicians can:

- √ **Refer the patient** for individualized professional counseling
- √ **Recommend the patient join a peer-led support group**
- √ **Suggest contact with clergy members or social workers**
- √ **Consider prescribing anti-depressant therapy** with known benign side effects

“Attention to bereavement offers a valuable opportunity to participate in healing in its purest form,” the authors conclude. “It is an opportunity to leave technology behind and to heal with listening, words, and gestures.” Further, **grief affects health care professionals as well as families**, they note, and **“physicians who can recognize grief in themselves or their colleagues will be able to seek support and to offer it to those in need.”**

The paper, entitled “Life after Death: A Practical Approach to Grief and Bereavement,” was published in the Feb. 6, 2001, issue of *Annals of Internal Medicine*.

'Good Death' Survey Finds Both Consensus and Diversity

A national survey of patients, families, physicians, and other care providers has found that, while many factors related to quality care at the end of life are considered very important by all participants in the experience of dying, significant variations in values and preferences occur both within and across the different groups.

These variations "serve as a reminder that **there is no one definition of a good death**," write the authors of a report on the survey results, which appeared in the November 15, 2000, issue of the *Journal of the American Medical Association*.

"Quality end-of-life care is a dynamic process that is negotiated and renegotiated among patients, families, and health care professionals, a process moderated by individual values, knowledge, and preferences for care," they add.

Respondents to the survey, which was conducted March-August 1999, included: seriously ill Veterans Affairs patients (n = 340); recently bereaved family members (n = 332); physicians (n = 361); and other providers (nurses, social workers, chaplains, and hospice volunteers; n = 429) involved in end-of-life care.

Participants were asked to rate the importance of 44 attributes generated from a previous study conducted on the end-of-life experience. Items rated as important by more than 70% of respondents in each group were considered to possess substantial agreement of importance. [See Box]

The importance of mental clarity to patients highlights "one of the challenges of comprehensive end-of-life care: attending to aspects of care that are not intuitively important to clinicians but are critical to patients and their families," note the authors. The findings suggest that **"physicians may be more willing than patients to sacrifice lucidity for analgesia,"** the investigators add.

Similarly, while the group of other care providers stressed the importance of the care patients need to receive, patients themselves indicated that **giving help to others and not being a burden are important components of quality of life at the end of life.**

Although spirituality was clearly important to patients, the authors note, patients as a group were the least likely to rate talking about personal fears and discussing the meaning of death as important. "These findings suggest that for some patients, issues of faith that are resolved with oneself are more important than social or interpersonal expressions of spirituality."

Other significant findings included:

- Non-white participants were significantly more likely than whites to want all available treatments, regardless of chance of recovery.
- Persons to whom spirituality was not at all important were more likely to wish to maintain control over the timing and place of death than those to whom spirituality was very important.

"The results of this survey suggest that for patients and families, physical care is expectedly crucial, but is only one component of total care," write the authors. "While physicians' biomedical focus is a natural outgrowth of medical care that emphasizes the physical self, **physicians should recognize patients' other needs and facilitate means for them to be addressed.**"

Source: "Factors Considered Important at the End of Life by Patients, Family, Physicians, and Other Care Providers," *Journal of the American Medical Association*; November 15, 2000; 284(19):2476-2482. Steinhauser KE, Christakis NA, Clipp EC, McNeilly M, McIntyre L, Tulskey JA; Program on the Medical Encounter and Palliative Care, Durham Veteran Affairs Medical Center, Department of Medicine, Duke University, and Institute for Multiculturalism, Durham, NC; Departments of Medicine and Sociology, University of Chicago, Chicago.

All 4 groups agreed upon the importance of:

- √ Pain and symptom management
- √ Preparation for the end of life
- √ Opportunity to achieve a sense of completion
- √ Making treatment preferences known
- √ Being treated as a whole person
- √ A strong patient-physician relationship

Attributes of substantial importance to patients, but not to physicians, included:

- √ Maintaining mental awareness
- √ The ability to help others
- √ Not being a burden
- √ Spirituality

Distressing Symptoms Often Severe for Critically Ill Patients in ICUs

Cancer patients at high risk for hospital death report multiple distressing symptoms—often at significantly severe levels—during treatment in intensive care units (ICUs), say researchers at Mount Sinai School of Medicine. Although the aim of ICUs is to save lives, the study authors note, **it is not yet widely recognized that many ICU patients are actively dying**, often with an avoidable burden of symptoms.

“For these patients, **optimization of symptom management warrants the same priority and attention as for patients in hospices or other settings in which the proximity of death is similar but more readily acknowledged,**” state Judith E. Nelson, MD, JD, and colleagues.

Nelson’s team analyzed 100 consecutive patients with a present or past diagnosis of cancer who were admitted during an 8-month period to the ICU of Mount Sinai Medical Center in New York City. All of the 50 patients capable of self-reporting symptoms provided daily responses. More than 60% of the responders were mechanically ventilated, and 36% died during hospitalization. Hospital mortality for the entire cohort was 56%.

- √ A majority of responding patients (55% to 75%) reported moderate to severe levels of pain, discomfort, anxiety, sleep disturbance, or unsatisfied hunger or thirst.
- √ Similar levels of depression and dyspnea were reported by 40% and 33% of patients, respectively.
- √ Among conditions specific to the ICU setting, the inability to communicate, sleep disruption, and visiting limitations were identified by patients as the most distressing.

Interventions were also a source of distressing symptoms, despite Mount Sinai’s “liberal” policy of premedication with analgesic and sedative drugs, note the authors. Further, because the study was conducted in an ICU in which the staff is trained to be highly sensitive to patient comfort, and in which palliative care experts are in regular attendance, the authors believe that their findings may underestimate the actual degree of suffering to be found across ICU settings.

“**Existing evidence suggests that the ICU can be a difficult and painful place to die,**” the authors comment. “**There is no evidence to suggest that prevention or palliation of distressing symptoms would compromise aggressive efforts to save or prolong lives.**”

Source: “Self-Reported Symptom Experience of Critically Ill Cancer Patients Receiving Intensive Care,” *Critical Care Medicine*; February 2001; 29(2):277-282. Nelson JE, Meier DE, Oei EJ, Nierman DM, Senzel RS, Manfredi PL, Davis SM, Morrison RS; Division of Pulmonary and Critical Care Medicine, Departments of Medicine and Geriatrics and Adult Development, Mount Sinai School of Medicine, New York, NY.

No Survival Benefit Found in Tube Feeding of Hospitalized Patients with Advanced Dementia

Patients with advanced dementia who are hospitalized for acute comorbid illness are at high risk for feeding tube placement, a recent study has found. Nevertheless, the intervention was found to have no measurable association with survival in these patients.

“**With or without tube feeding, these patients have a 50% 6-month median mortality, similar to that observed in a wide range of reports from other clinical settings,**” report Diane E. Meier, MD, and colleagues from the Mount Sinai School of Medicine, New York City.

The team investigated 99 patients (median age, 84 years) with advanced cognitive impairment admitted to Mount Sinai

Hospital from August 1994 to June 1997. The most common (62%) admitting diagnosis was infection: pneumonia or urosepsis. All patients had available surrogate decision makers, with whom contact was maintained through June 1999 or the subject’s death.

Of the 82 patients without a feeding tube on admission, 51 (62%) received placement of a percutaneous endoscopic gastrostomy tube during hospitalization. Median survival following hospitalization for subjects

receiving a feeding tube was 195 days, compared with 189 days among the 31 patients who left the hospital with no feeding tube.

Factors strongly associated with new feeding tube placement included African American ethnicity (odds ratio [OR], 9.43; 95% confidence interval [CI], 2.1-43.2) and residence in a nursing home (OR 4.9; 95% CI, 1.02-2.5), the researchers found, while an admitting diagnosis of infection was associated with mortality (OR, 1.9; 95% CI, 1.01-3.6).

Advanced dementia generally is not seen by family and health care providers as a terminal illness, per-

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Inadequate intake of food and water is often thought by family and physicians to lead to distressing symptoms, “despite data suggesting that among cognitively intact patients refusal of food and water in the context of terminal illness is not painful.”

-Study Authors

RESEARCH MONITOR

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haps because of the variability in individual life expectancy, note the authors. Further, **inadequate intake of food and water is often thought by family and physicians to lead to distressing symptoms, “despite data suggesting that among cognitively intact patients refusal of food and water in the context of terminal illness is not painful,”** they write.

The authors note that hospitalization, with its high risk of feeding tube placement, may not be the best choice for achieving goals of care—either prolongation of life or relief of symptom distress—in patients with acute illness superimposed on late-stage dementia. They recommend further trials to determine the benefit of hospitalization vs. nursing home or home care in this growing population of patients.

Source: “High Short-Term Mortality in Hospitalized Patients with Advanced Dementia,” *Archives of Internal Medicine*; February 26, 2001; 161(4):594-599. Meier DE, Ahronheim JC, Morris J, Baskin-Lyons S, Morrison RS; Department of Geriatrics and Adult Development, and Lilian and Benjamin Hertzberg Palliative Care Institute, Mount Sinai School of Medicine; Eileen E. Anderson Section of Geriatrics, St. Vincent’s Hospital and Medical Center; and New York Medical College, New York, NY.

Bereaved Caregivers Identify Barriers to Earlier Hospice Access

In a series of focus group sessions to discuss their hospice experience, caregivers who had recently lost a loved one identified barriers that had delayed their use of hospice services, and provided researchers with recommendations addressing these access concerns.

“Participants openly acknowledged that they were the lucky ones who had utilized hospice; they only wished they could have accessed the services sooner,” write investigators from Michigan State University, East Lansing.

The team analyzed the perceptions of 12 caregivers who had made the decision to enter a family member or friend into hospice care, and whose loved one had died recently (an average of 9.9 months earlier). In each case, **the length of hospice care was short, ranging from less than 1 week to 2 months.**

Although the researchers found that caring for the terminally ill was an engulfing experience for these participants, and that both subjective and objective comments were integrated “into the overall richness of their hospice experience,” two access-related themes emerged.

The first theme identified **societal and health care system issues** that delay access to hospice. These included:

- Misconceptions about the coordination and payment** of hospice services
- Physicians’ legal concerns** regarding incorrect prognostication
- A “youth-oriented” society** that is reluctant to confront death
- Lack of personal support** for a caregiver’s decision to shift to comfort care

The caregivers stressed that **“it would help for there to be more clarity that participation in hospice is not equivalent to giving up hope,”** the authors write. A repeated recommendation was for a health care system that would provide palliative care while allowing for the patient’s possible recovery.

“This type of continuum of care might make physicians more willing to prognosticate the potential need for hospice, which would provide the patient and family with a system of care that did not require a deterioration of physical health,” the authors note.

The second theme included **education and practice needs of health professionals** that affect hospice access. These included:

- Lack of experience with declining health status**
- Focus on curative care**
- Lack of comfort discussing death and dying**
- Failure to recognize the burden of care at home**

Aside from recommending more formal, academic training in the care of dying patients, the participants suggested that health care professionals could: provide clinical rotations through hospice; attend hospice staff meetings; and **offer information on hospice in offices and waiting rooms.**

The authors acknowledge that the findings from their qualitative research cannot be generalized to a larger population, but suggest that the themes and recommendations they captured be used for further research to develop “models of care that offer transition services to seriously ill patients whose health may or may not improve,” and to **design and test “more effective interventions for both the family and the patient, prior to and during the dying process.”**

Source: “Access to Hospice: A Perspective from the Bereaved,” *Journal of Palliative Medicine*; Winter 2000; Vol. 3, No. 4:433-440. Wyatt GK, Ogle KS, Given BA; College of Nursing, Department of Family Practice, College of Human Medicine, Palliative Care Education and Research Program, Cancer Center, and Institute for Managed Care, Michigan State University, East Lansing.

PHYSICIAN RESOURCES

'Fast Facts' Provide Key End-of-Life Care Information Online

The End of Life Physician Education Resource Center (EPERC) has recently included more listings in its collection of one-page, **peer-reviewed summaries of important clinical topics in end-of-life care**. Fast Facts and Concepts, now numbering 39, are designed as single-page outlines to facilitate printing or downloading.

The most recent additions are:

- √ Discussing Hospice
- √ Using Naloxone

Established as an online community to support medical educators in the dissemination of information on all aspects of end-of-life education, EPERC also maintains end-of-life care resources for clinicians on its website. Visitors to the site can find links to recent journal articles and recommended books, meetings, and training opportunities.

Additional topics in the Fast Facts index include:

- √ Delivering Bad News
- √ Myths about Advance Directives
- √ Patient-Centered Interviewing: Understanding the Illness
- √ Writing a Condolence Letter
- √ Opioids and Nausea
- √ Prognostication
- √ Calculating Opioid Dose Conversions

Funded by a grant from the Robert Wood Johnson Foundation of Princeton, New Jersey, EPERC maintains its website as part of the Palliative Medicine Program at the Medical College of Wisconsin. A one-time registration is requested. The complete listing of Fast Facts is available by selecting "Educational Materials" at www.eperc.mcw.edu.

A PHYSICIAN'S GUIDE TO PAIN AND SYMPTOM MANAGEMENT IN CANCER PATIENTS

By **Janet L. Abrahm, MD**, this guidebook for primary care physicians, internists, oncologists, and other health professionals stresses the importance of reducing suffering at all stages of cancer care: at diagnosis, during curative therapy, in the event of recurrence, and at the end of life. The first part, entitled "Hidden Concerns, Unasked Questions," addresses unstated assumptions and fears of patients and families and offers suggestions for improving physician-patient communication on these issues. The second part, "Pain Control and Symptom Management," contains therapeutic protocols, opioid conversion charts, pain assessment tools, and clinical scenarios. Two separate bibliographies are included for the use of physicians and patients/families.

Chapter headings include:

- √ Helping Patients Accept Opioid Pain Medication
- √ Approaching the End
- √ Assessing the Patient in Pain
- √ Managing Other Distressing Problems
- √ The Last Days...and the Bereaved

Published by Johns Hopkins University Press, 2000; ISBN: 0801862469 (paperback); 410 pp.

End-of-Life Care Websites

www.eperc.mcw.edu

End of Life Physician Education 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 (formerly the NHO)

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 to Improve Care of the Dying

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

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

13th Annual Assembly of the American Academy of Hospice and Palliative Medicine. June 21-24, 2001, Pointe Hilton Squaw Peak Resort, Phoenix, AZ. Website: www.aahpm.org

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

Ethics and End-of-Life Issues. July 9-16, 2001, Alaskan cruise. Sponsor: Postgraduate Institute for Medicine. Contact: Continuing Education, Inc., 5700 4th St. N., St. Petersburg, FL 33703; Phone: 800-422-0711; Fax: 727-527-3228; Website: www.continuingeducation.net/070901ethicsci.htm

Ethics & Action in End-of-Life Care. July 15-18, 2001, Missoula, MT. Sponsors include: Practical Ethics Center, University of Montana; National Program Office for Promoting Excellence in End-of-Life Care, Robert Wood Johnson Foundation; Missoula Demonstration Project; and Institute of Medicine and Humanities, St. Patrick's Hospital, Missoula. Contact: Colleen Hunter. Phone: 406-243-6605; E-mail: huntercs@mso.umt.edu

Canadian Palliative Care Conference 2001: An Odyssey—Personal and Professional Journeys in Hospice Palliative Care. Oct. 21-24, 2001, Victoria Conference Centre, Victoria, BC. Sponsor: Victoria Hospice Society. Contact: Focus Conferences; Fax: 250-598-4863

Program in Palliative Care Education and Practice. Nov. 14 and 21, 2001, Boston, MA. Sponsor: Harvard Medical School. Contact: Eve Panzera; Fax: 617-726-2691; E-mail: epanzera@partners.org; Website: www.hms.harvard.edu/cdi/pallcare

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

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Hospices provide copies of **QUALITY OF LIFE MATTERS** as an educational service to their area physicians. Call **Quality of Life Publishing Co.** for information and rates, or to learn about **upcoming publications** designed to bring much-needed support to hospice patients and families. Call:

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