

# Quality *of* Life Matters®

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

Vol. 5, Issue 1 May/June/July 2003

## Physicians May Be Unaware of Hospice Benefit Opportunities, Says Last Acts Report

*Improved communication may encourage earlier referral to hospice*

Although the use of Medicare's hospice program tripled in the last decade, only 23% of beneficiaries who died in 2000 took advantage of the "physical, psychological, social, and spiritual care for dying persons, their families and other loved ones," offered by the Medicare hospice benefit.

This is one of the findings in a new report from Last Acts, the national coalition of groups working to improve care at the end of life.

Entitled "Medicare and End-of-Life Care," the report suggests a number of changes Medicare might make to improve both the access and quality of care provided to beneficiaries facing death.

For example, Medicare could clarify and better publicize new or little-known

regulations to physicians.

Under current Medicare policy:

- **Physicians are permitted to bill for advance care planning sessions**, consultations in which end-of-life planning constitutes more than 50% of a physician visit.
- **Physicians can recertify hospice patients whose terminal illness runs a more gradual course than originally expected.** Upon enrollment, beneficiaries receive two 90-day "periods of care," followed by an unlimited number of 60-day periods, provided their prognosis continues to fit the eligibility requirement.
- **Pain management is recognized as a physician specialty.** Geriatricians and internists specializing in

pain management can bill Medicare for consultations requested by a patient's primary care physician.

The report points out that improved communication regarding these existing Medicare regulations may encourage physicians to:

- ✓ Discuss end-of-life care with their patients;
- ✓ Provide access to better pain relief; and
- ✓ Refer eligible patients earlier to hospice without fear of reprisal.

Last Acts says The Centers for Medicare & Medicaid Services reported in 2001 that its denial rate for hospice benefit certification (including recertifications) was less than 1%.

For more information: [www.lastacts.org](http://www.lastacts.org)

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## VA Directive Urges Use of Hospice

As part of an ongoing program to improve end-of-life care for the nation's veterans, the Veterans Health Administration of the U.S. Department of Veterans Affairs (VA) has issued a directive requiring each of its facilities to establish a multidisciplinary consult team within its palliative care program.

According to the directive, one-fourth of all Americans who died in 2001 were veterans, with only 4% of those dying in VA inpatient care. Thus, there is a substantial and growing need within VHA to provide for hospice and palliative care

services in other settings.

According to the new directive, the VA is required by federal regulation to "provide or purchase" needed hospice care — including inpatient and home hospice care — for enrolled veterans, whether or not they are covered by or choose to use a non-VA payment source (such as Medicare).

"This project is about honoring veterans' preferences for care at the end of life," said Thomas Holohan, MD, chief officer for VHA Patient Care Services.

For information: [www.va.gov/oa/flp](http://www.va.gov/oa/flp)

## Institute of Medicine Targets End-of-Life Care As Priority Area

In a recent report aimed at “transforming” the quality of health care delivered to Americans, the Institute of Medicine (IOM) has identified 20 priority areas for improvement. These target areas range across the spectrum of care, from preventing disease to **“providing dignified care at the end of life that is respectful of the values and preferences of individuals and their families.”**

Current inadequacies in the delivery of health care nationwide are due to systems failure rather than to lack of knowledge or capacity, states the report committee, noting that “although the health care workforce is trying hard to deliver the best care, those efforts are doomed to failure with today’s outmoded and poorly designed systems.”

The report, entitled “Priority Areas for National Action: Transforming Health Care Quality,” lists the areas the committee selected as presenting the greatest challenges and opportunities for narrowing the gap between the health care

that is routinely delivered and that which is recognized as best medical practice. Among these priority areas are “Pain Control in Advanced Cancer” and “End of Life with Advanced Organ System Failure.”

### Pain Control in Advanced Cancer

The report points out that many cancer patients experience pain throughout the course of their illness, and pain at the end of life is widely dreaded.

**“Hospice programs have earned a good reputation with regard to pain management,”** says the report. But despite the existence of proven guidelines for pain relief and programs showing that cancer pain can almost always be controlled, major health organizations have stated that “the major cause of serious pain in cancer is failure to use methods already proven effective.”

Requirements for improved control of

pain in advanced cancer include:

- ✓ Skillful use of medications
- ✓ Cooperation in protocols across settings
- ✓ Advance planning for increases in pain and changes in settings
- ✓ Public education regarding the merits of opioid medications for pain

### End of Life with Advanced Organ System Failure:

#### *Focus on CHF and COPD*

Heart, lung, and liver failures account for about one-fifth of fatal illness in this country, notes the report. Because better treatments are now available for slowing the progression of these illnesses, **people with CHF and COPD are living longer than ever in “perilous circumstances.”**

Requirements for good care for this population include:

- ✓ Self-care education
- ✓ Reliable availability of medications
- ✓ Early intervention at any sign of trouble
- ✓ Mobilizing of services — both urgent and end-of-life — to the home setting
- ✓ Continuity of care

The report committee calls upon Congress and the Administration to provide the necessary funding. It also recommends that the Agency for Healthcare Research and Quality, a division of the U.S. Department of Health and Human Services, work with other organizations to monitor progress, oversee data collection, and update the list every three to five years, as circumstances change.

For information, visit  
[www.iom.edu](http://www.iom.edu)

## HEALTH CARE QUALITY IMPROVEMENT AIMS

### PAIN CONTROL IN ADVANCED CANCER

- To ensure that patients facing incurable and progressive cancer can count on living without serious pain through to the end of life.

### END OF LIFE WITH ADVANCED ORGAN SYSTEM FAILURE

To arrange care so that people facing the end of life with heart, lung, or liver failure will have:

- As few frightening exacerbations as possible
- As few symptoms as possible
- As many opportunities for life closure and control of the circumstances of death as possible

—“Priority Areas for National Action: Transforming Health Care Quality,” Institute of Medicine, January 2003.

## Physicians Can Help Meet Diverse Needs of Dying Patients

Health care systems designed primarily for curing acute illness or managing chronic conditions are now also required to address the diverse needs of dying patients. And, although system changes are needed to improve the quality of end-of-life care, physicians can help — not only by improving their skills in care of the dying — but also by being aware of how their interactions with the health care system affect patient care in this population.

That is according to Jan D. Carline, PhD, J. Randall Curtis, MD, and colleagues from the University of Washington, Seattle, whose report appeared in the January 2003 issue of the *Journal of Pain and Symptom Management*.

The team analyzed data collected from 20 focus groups held with 137 participants between October 1997 and July 1998 to identify domains of physician skills important to those receiving or providing end-of-life care.

Participants included:

- **Patients** diagnosed with: C3 acquired immunodeficiency syndrome; oxygen-dependent chronic obstructive pulmonary disease; or metastatic cancer or non-operable lung cancer
- **Family members** who had closely observed and participated in the care of a dying patient
- **Nurses and/or social workers** working with dying patients in either a hospital or hospice setting
- **Physicians** considered by participating nurses to be experts in end-of-life care

The study authors note that physicians need to be aware of impediments to good care in the structure of health care delivery and work around them to increase coordination of care. In addition, "Individual physicians must improve their skills in focusing on patients' and families' needs during clinical encounters," the authors point out.

**"Effective interventions to improve quality of care at the end-of-life will need to consider both improvements that physicians can make in their day-to-day practice and improvements that require larger-scale structural change,"** the researchers conclude.

*Source: "Physicians' Interactions with Health Care Teams and Systems in the Care of Dying Patients: Perspectives of Dying Patients, Family Members, and Health Care Professionals," Journal of Pain and Symptom Management; January 2003; 25(1):19-28. Carline JD, Curtis R, Wenrich MD, et al; Department of Medical Education and Biomedical Informatics, Division of Pulmonary and Critical Care Medicine, Department of Medicine, and School of Medicine, University of Washington, Seattle.*

### FAMILIES APPRECIATE PHYSICIANS WHO:

#### Take as much time as needed with the patient

This is especially important when explaining the details of the illness and proposed treatment plans. "It takes more than ten minutes to talk about end of life," said a family member.

#### Reassure patients they won't be abandoned

"There's that sense of abandonment that comes when there are fewer interventions being offered, fewer reasons to go see the doctor," said a nurse. "Those little things like phone calls become the line they still have to somebody, a physician who cares."

#### Help them get consistent information

Conflicting information regarding care can confuse or frustrate patients and families. The researchers note that the designation of one person as patient care coordinator has been shown to improve the dying experience.

#### Let them know who to call for problems

Patients with multiple physical complaints wanted assurance that the physician they contacted would not tell them, "That's not my area." The researchers suggest that one physician be identified as responsible for patient care.

#### Guide them to hospice in a timely manner

"Our oncologist encouraged us to join a hospice. It helped my father die with dignity at home, and we were there with him. I wouldn't have chosen anything any other way," said a family member. Health care workers appreciated physicians who helped patients and families through the initial process of transition to hospice, rather than simply saying, "Here's the number to call."

#### Continue to be involved after hospice referral

Some physicians may be uncomfortable with or uncertain of their role in palliative care, note the researchers, but patients appreciated physicians who let them know they were not "cut off" from their concern.

#### Contact the family after the patient's death

"It would mean a lot to me to get a call from a physician, asking if I had any more questions," said a family member.

— Carline, Curtis, Wenrich, et al,  
University of Washington,  
Seattle, January 2003

## Nephrologists in Special Position to Prompt Palliative Care Evaluation

Because of the unique nature of dialysis, the nephrologist can play a crucial role in initiating or prompting a broader discussion of palliative care for terminally ill patients for whom dialysis may no longer offer any benefit, according to a team of New York City investigators.

However, like many physicians, the nephrologists in this study were found to be unprepared for confronting end-of-life issues. "If no one is present to do the prompting, the patient's death may be needlessly prolonged," writes lead author Eugenia Siegler, MD, associate professor of clinical medicine at the Weill Medical College of Cornell University.

Siegler's team conducted a chart review of 21 hospitalized patients with renal failure for whom dialysis was maintained, offered, or considered in the context of end-of-life care. "[W]e found evidence that the nephrologist initiated end-of-life discussions with only one of the seven patients on dialysis (or their families) who wished to stop dialysis," notes Siegler.

Yet, the nephrologist can play a crucial role in determining the quality and nature of care for terminally ill patients, Siegler says. Rather than serving simply as a subspecialist, "overseeing dialysis and focusing on fluid and electrolyte balance," **the nephrologist can take a leading role, initiating end-of-life dis-**

**cussions with patients, families, or the medical team, or prompting the attending physician to do so.**

The study's chart review showed few instances in which clinicians discussed withdrawal of dialysis as part of a global plan of care — that is, along with consideration of do-not-resuscitate orders or cessation of other treatments. Discussion of dialysis termination tended not only to occur independently, but also just days or even hours before the patient's death. "This sequence of events, a sort of 'just-in-time' approach to end-of-life care, seems unnecessarily prolonged and burdensome," writes Siegler.

**"End-of-life discussions should not focus exclusively on whether the patient wants to be resuscitated, but instead on broader priorities and choices, such as symptom relief, location of death, emotional support, and spiritual needs."** Siegler's team believes that the nephrologist is in a special position to implement this type of discussion.

*Source: "What Role Should the Nephrologist Play in the Provision of Palliative Care?" Journal of Palliative Medicine; October 2002; 5(5):759-762. Siegler EL, Del Monte ML, Rosati RJ, von Gunten CF (ed.); Division of Geriatrics and Gerontology, Weill Medical College of Cornell University, New York; Section of Nephrology, Brooklyn Hospital Center.*

## Patient-Focused Consensus Urged in ICU Discussion on Limiting Life Support

Authors of a report published in the Dec. 4, 2002, issue of the *Journal of the American Medical Association* urge intensive care clinicians to share actively in the decision-making process to withdraw life support by encouraging patient-focused consensus.

"Shifting the perspective to the patient's wishes is crucial to effective decision-making at the end of life," the authors note. Otherwise, the decision can be perceived by surrogates as their individual responsibility, compromising patient care and leading to family feelings of guilt and dissatisfaction with care.

By working together with families, clinicians can ensure that the best decision for the patient is made and help to alleviate family guilt. **"This shift from individual responsibility to patient-focused consensus often permits the family to understand, perhaps reluctantly and with great sadness, that intensive caring may involve letting go of life-sustaining interventions,"** write the authors.

In this way, "intensive care may become aggressive symp-

tom control allied with attention to family needs during the dying process."

Throughout the decision-making process, clinicians can:

- Provide timely and understandable clinical and prognostic information
- Ensure aggressive symptom control for the patient
- Encourage family discussions, maintaining focus on what the patient would have wanted
- Reassure the family that limiting life support does not mean limiting care
- Arrange for a comfortable patient environment and continuous psychosocial support for the family

*Source: "Withdrawal of Life Support: Intensive Caring at the End of Life," Journal of the American Medical Association; December 4, 2002; 288(21):2732-2740. Prendergast TJ, Puntillo KA; Departments of Medicine and Anesthesiology, Dartmouth-Hitchcock Medical Center, Lebanon, New Hampshire; Department of Physiological Nursing, School of Nursing, University of California, San Francisco.*

## Medical Students Completing Hospice Rotations Gain Valuable Insights

Including home hospice visits among the community venues of a required family medicine rotation enabled students not only to develop a fuller understanding of hospice care, but also to gain new insights into death, medicine, and the role of the physician.

That's according to researchers at the Department of Family Medicine, Thomas Jefferson University, Philadelphia. **"The students experienced a lesson about being a physician that their lectures, small group discussions, even their interactions with patients, nurses, and physicians in the hospital had not provided,"** report the study authors in the October 2002 issue of the *Journal of Palliative Medicine*.

The researchers analyzed 49 reflection papers written by third-year medical students following a week of community activities included in their six-week rotation. Students were free to choose the venue on which to write. Although hospice visitation was just one of five venues, one-half of the reflection papers from July 2000 to present have been on the topic of hospice, note the authors.

The number of hospice descriptions and the level of engagement they displayed prompted an independent review of the papers to identify themes in the student experience. Seven significant themes emerged.

### 1. *The value of hospice and the supportive role of the hospice nurse/team*

Many students were apprehensive before the visit, thinking that hospice was a "place" filled with uncomfortable, dying people, the authors note. Students expressed surprise at finding themselves in the homes of patients who seemed content and even happy. **A new realization of the value of dying at home was continually mentioned.**

As one student wrote, "When we left, I had a whole new appreciation of dying. It made sense that this man...chose to die in his own home, surrounded by his loved ones, in a familiar atmosphere, while being made comfortable by the hospice doctors and nurses. The other alternative is to stay in the hospital and be traumatized in attempts to avoid the unavoidable."

Students were particularly impressed by the hospice nurse, whom they had previously viewed as primarily an expert in pain and symptom management. **"The students initially assumed hospice nursing was a depressing profession,** but by the end of their visit, it was viewed as an inspiring and rewarding occupation," the authors note.

### 2. *The value of empathy*

Students struggling for detachment in the professional doctor-patient relationship realized that professionalism can depend on being present and emotionally available, especially when patients are dying. **"Students recognized that showing emotion may be a way of providing care** and that listening to patients' stories and sitting with them itself was therapeutic," note the authors.

### 3. *The distinction between acceptance and resignation*

When a student visited a patient who had refused a life-prolonging invasive procedure, he came to realize the difference between giving up and accepting. As the hospice nurse explained, **the quality of dying was more important to the patient than the length of time left to live.** "How could I expect the family members of all of these patients to accept the situation if I couldn't?" the medical student wrote.

### 4. *The changing face of hope*

Seeing hospice patients who had accepted the inevitability of death interacting with their families at home, students realized that the object of hope can change. As one student noted, **"You could also say that they [the family] had a look of hope on their faces.** Not hope that he was somehow going to get better, but hope that they were going to get through this."

### 5. *An understanding of death as a natural event*

Students found themselves recognizing the dying patients as people very like themselves or their loved ones — still actively involved in living. One student who was present at a patient's death realized the value for both the patient and the medical team of accepting death as a natural process. **"I learned that it [death] really can be a process, a part of life, if we can learn to embrace it as such, and not just continue to push it away like an enemy breaking down our door of life."**

### 6. *The quality of family caregiving*

The difference between family dynamics they had seen in a hospital setting and the family dynamics in patients' homes was

*Continued on Page 6*

## 'Whole Pain' Approach of Hospice Care Addresses Complexity of Suffering

Although suffering was found in a recent study to be a distinct clinical symptom, a patient's subjective experience of suffering is a complex symptom representing an "amalgam of factors," including depression, subjective quality of life, and perceived social support.

"Despite the centrality of 'the relief of suffering' to the practice of medicine, almost no research has addressed the concept of suffering as a distinct, measurable, and clinically significant symptom," write researchers from the Institute of Living at Hartford Hospital, Connecticut.

To determine the factors contributing to the experience of suffering, the team analyzed data gathered from interviews with and assessments of 157 hospitalized medical patients aged 64 years and over.

**Suffering was most significantly correlated with depression and subjective quality of life.** Other significant correlations included total disease loading and perceived social support. Suffering was *not* statistically correlated with severity of

disease, activities of daily living requiring assistance, or spiritual/religious coping style or activities.

The absence of correlation between suffering and the severity of physical disease suggests that subjective suffering is derived from patients' relationships to their particular stress factors, note the researchers. In addition, although no "protectant effect" was found to be derived from a patient's spiritual or religious coping style, "the quality of a person's social supports have a powerful impact upon their subjective suffering."

The authors conclude: **"This data supports the 'whole pain' philosophy of hospice care, which seeks to relieve patients' suffering by addressing their complex subjective relationship to the physical, social, psychological, and spiritual aspects of their experience."**

*Source: "A Study of the Determinants of Subjective Suffering in Elderly Hospitalized Patients," 15<sup>th</sup> Annual Assembly of the American Academy of Hospice and Palliative Medicine; February 2003, Orlando. Duffy J, Robison J, Blank K; Hartford Hospital and Institute of Living/University of Connecticut, Hartford.*

## Medical Students

*Continued from Page 5*

very striking to the students. **"The frustration and anger that I was accustomed to seeing in the hospital were not present in the family members or the spouses,"** one student noted.

Many students were struck by the integral role families played in the care of people dying at home, and the burden these families endured. A student said, "Physicians need to remember that when they are taking care of a dying patient, they are actually taking care of everyone else in the household."

### 7. **The role of the physician in caring for the dying**

Some students came away from their hospice experience with a new perception of physician responsibility. "You can only fail a patient if you fail to understand and respond to their needs. We may not be able to cure all of our patients, but if we can make them comfortable in the last moments of their lives, we will not have failed them," one student noted.

Other students expressed a realization of the expanded role physicians can play in end-of-life care. "... I wondered if patients wanted something more out of the doctor-patient rela-

tionship. It seems that patients need a person to guide them and their families through the various stages of death and to make them comfortable, both physically and spiritually," a student wrote.

The students' training to date had focused on aggressive treatment to cure disease; some had even expressed doubts beforehand about the value of palliative care. Their hospice experience allowed them to balance the philosophy of aggressive intervention with the philosophy of palliative attention to patients' comfort, needs, and values.

As one student wrote, "And I came to understand that this was medicine...that the true practice of medicine is not the miraculous cure of a disease, but the total care of a person."

The study authors conclude, **"Perhaps the most striking insight for most of the students was a new understanding of the potentially limitless value of empathy and human dignity in fulfilling the role of healer."** They suggest that reflection upon actual hospice experience — which could easily be coordinated with hospice programs — may be crucial for medical training related to death and dying.

*Source: "Experience with Hospice: Reflections from Third-Year Medical Students," Journal of Palliative Care, October, 2002; 5(5):721-727. Maxwell TL, Passow ES, Plumb J, Sifri RD; Center for Palliative Care, Department of Family Medicine, Thomas Jefferson University, Philadelphia.*

# PHYSICIAN RESOURCES

## Online, Peer-Reviewed 'Fast Facts' Now Number 85

Fast Facts and Concepts, the list of peer-reviewed, one-page summaries of important clinical topics in end-of-life care, has recently been expanded on the website of the End of Life/Palliative Education Resource Center (EPERC) to include 85 items. The most recent topics in the Fast Facts index include:

- Medicare Hospice Benefit, Part 1
- Telephone Notification of Death, Parts 1 & 2
- Epidural Analgesia • Oxycontin • Hiccups
- Swallow Studies, Tube Feeding and the Death Spiral
- Why Patients Do Not Take Their Opioids [see summary below]

EPERC is an education project of the Palliative Medicine Program of the Medical College of Wisconsin, Milwaukee, with additional support from the Robert Wood Johnson Foundation of Princeton, New Jersey. A one-time registration is required for searching the database of peer-reviewed educational materials.

The complete listing of Fast Facts is available at [www.eperc.mcw.edu](http://www.eperc.mcw.edu).

### *Why Patients Do Not Take Their Opioids*

[ADAPTED FROM EPERC FAST FACT # 83]

There are a number of reasons why patients may refuse or neglect to take their prescribed pain medications — from commonly held misconceptions regarding opioids to the desire to be a “good” patient — often resulting in unnecessary pain and suffering. Physicians can:

- **Ask open-ended, nonjudgmental questions:** “Tell me exactly how you take your pain medicine.” Or: “I know how difficult it can be with all these pills; how many times in the past week would you say you skipped one or two?” Simply asking, “Are you taking your pain medicine?” is likely to elicit a quick, doctor-pleasing affirmative.
- **Normalize patient concerns:** “Some patients worry that they may become addicted to their pain medications. Do you have worries like that?” Patients may also worry about physical tolerance, believing that they need to save the “best” medicine for possible severe pain during the dying process.
- **Ask patients explicitly about their health beliefs** regarding opioids, their understanding of morphine, and for any observations they may have of loved ones who have taken morphine.
- **Inquire about side effects at every visit** just as you would inquire about pain. Ask if the patient notices any other changes and believes them to be opioid related. Patients are especially concerned about such side effects as mental impairment, nausea, and constipation.

Source: *Fast Facts and Concepts #83: “Why Patients Do Not Take Their Opioids,” End-of-Life/Palliative Education Resource Center; February 2003; www.eperc.mcw.edu. Arnold R; Division of General Internal Medicine, Department of Medicine, Section of Palliative Care and Medical Ethics, University of Pittsburgh, Pittsburgh.*

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

[www.eperc.mcw.edu](http://www.eperc.mcw.edu)  
End of Life/Palliative Education  
Resource Center (EPERC)

[www.aahpm.org](http://www.aahpm.org)  
American Academy of Hospice & Palliative  
Medicine

[www.epec.net](http://www.epec.net)  
The EPEC Project (Education for  
Physicians on End-of-Life Care)

[www.nhpco.org](http://www.nhpco.org)  
National Hospice & Palliative Care  
Organization

[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)  
The Hospice and Palliative Care Nurses  
Association

[www.medicaring.org](http://www.medicaring.org)  
Center to Improve Care of the Dying

[www.abcd-caring.org](http://www.abcd-caring.org)  
Americans for Better Care of the Dying

[www.lastacts.org](http://www.lastacts.org)  
Last Acts Coalition

[www.mcw.edu/pallmed/](http://www.mcw.edu/pallmed/)  
Palliative Medicine Program at the Medical  
College of Wisconsin

[www.medsch.wisc.edu/painpolicy](http://www.medsch.wisc.edu/painpolicy)  
University of Wisconsin Pain and Policy  
Studies Group

[www.capcmssm.org](http://www.capcmssm.org)  
Center to Advance Palliative Care

[www.stoppain.org](http://www.stoppain.org)  
Pain Medicine & Palliative Care, Beth  
Israel Medical Center

[www.growthhouse.org](http://www.growthhouse.org)  
Online community for end-of-life care

[www.partnershipforcaring.org](http://www.partnershipforcaring.org)  
America's Voices for the Dying

# End-of-Life Care Meetings for Clinicians

**6th International Symposium on Pediatric Pain: The Big Questions.** June 15 - 19, 2003, Sydney, Australia. Sponsor: International Assn. for the Study of Pain. Phone: +61 2 9954-4600; Fax: +61 2 9954-0666; Email: ISPP2003@dcconferences.com.au; Website: www.dcconferences.com.au/ISPP2003

**Principles and Practices of Pain Medicine.** June 25 - 29, 2003, Fairmont Copley Plaza Hotel, Boston, MA. Sponsor: Harvard Medical School Dept. of Continuing Education. Phone: 617-384-8600; Fax: 617-384-8686; Email: hms-cme@hms.harvard.edu; Website: http://cme.med.harvard.edu

**Interventional Pain Management Cadaver Course and Advanced Pain Management.** July 14 - 20, 2003, Cambridge, MA. Sponsor: The Society for Pain Practice Management. Phone: 913-387-3155; Fax: 913-387-3156; Website: www.sppm.org

**ASCO/AACR 2003 Workshop.** July 26 - Aug. 1, 2003, Vail Cascade Resort, Vail, CO. Sponsors: American Society of Clinical Oncology and American Assn. for Cancer Research. Phone: 215-440-9300; Fax: 215-351-9165; Email: meetings@aacr.org; Website: www.vailworkshop.org

**Geriatric Oncology Consortium, Annual Multi-Disciplinary Conference: Advances in Elderly Cancer Care.** Sept. 18 - 20, 2003, Washington, DC. Sponsor: Geriatric Oncology Consortium. Phone: 202-333-8845; Email: goc@iasia.org; Website: www.thegoc.org

**Practical Aspects in Palliative Medicine: Integrating Palliative Care into Clinical Practice.** Oct. 17 - 19, 2003, Sheraton Boston Hotel, Boston, MA. Phone: 617-724-9509; Email: pallcare@partners.org; Website: www.hms.harvard.edu/cdi/pallcare

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**Tel:** 239-513-9907

**Toll Free:** 1-877-513-0099 (US & Canada)

**Fax:** 239-513-0088

**Email:** info@QoLpublishing.com

**Quality of Life Publishing Co.**  
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