

Quality of Life Matters™

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

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Medicare Hospice Use Soars As Length of Stay Declines

While a major government report shows that the use of hospice under the Medicare benefit more than doubled between 1992 and 1998, the report also reveals that the median length of hospice stay declined 27%.

These and other hard-hitting statistics were presented to the Senate Special Committee on Aging by the General Accounting Office (GAO), an investigative arm of Congress. More specifically:

■ **The number of Medicare beneficiaries receiving hospice care increased 151%**, from 143,100 in 1992 to 358,949 in 1998.

■ **The percentage of Medicare hospice users with noncancer diagnoses rose substantially**, from 24% in 1992 to 43% in 1998. (Such diagnoses include congestive heart failure, chronic obstructive

pulmonary disease, stroke, and Alzheimer's disease.)

■ **Half of Medicare's hospice users in 1998 were enrolled for 19 or fewer days, a 27% decline** in the median length of stay from 26 days in 1992.

■ **The average length of stay declined by 20%** (from 74 to 59 days) for the same period.

■ **The decline in the average length of stay was more dramatic among noncancer patients**, dropping by 38%, while the average length of stay among cancer patients fell 14%.

The statistics were presented by William J. Scanlon, PhD, Director of Health Financing and Public Health Issues at the GAO, who noted that the GAO has released an accompanying report entitled, *Medicare: More Beneficiaries Use Hospice; Many Factors Contribute to Shorter Periods of Use*.

Scanlon said the "chilling effect" of recent federal investigations into compliance with the six-month eligibility rule has been cited as a cause of late enrollment—particularly among noncancer patients, in whom prognosis may be more difficult. He noted, however, that the trend toward fewer average days of hospice use began prior to the time of increased federal scrutiny.

The U.S. Health Care Financing Administration, which handles Medicare, was concerned by this "disturbing misperception" and issued a letter to all Medicare hospices assuring them that **no penalties will result if patients outlive their prognosis of six months**. [See article below.]

Other GAO statistics include:

■ **Only 7%** of Medicare hospice patients received hospice services for more

Continued on Page 2

Inside:

NewsLine 2-3

- ✓ Med Students Focus on EOL Care
- ✓ AAP States Children Should Receive Palliative Care at Diagnosis
- ✓ American Bar Association Adopts New Pain Management Policy

Research Monitor 4-6

- ✓ 83% of Older Patients with Specific Preferences Choose to Die at Home
- ✓ Physicians Can Foster Hope in Terminally Ill Patients
- ✓ Nutritional Support May Increase Mortality Risk in Certain Patients
- ✓ Social/Market Factors Linked to Timing of Hospice Referral

Physician Resources 7

Hospice Benefit Under Medicare Not Restricted to Six Months

In a direct statement to the nation's Medicare hospice providers, the Health Care Financing Administration (HCFA) has addressed the confusion surrounding Medicare's six-month eligibility rule, emphasizing that **no penalties will result if patients outlive their physician-certified prognosis of six months**.

Nancy-Ann DeParle, then Administrator of HCFA, the federal agency that runs

Medicare, sent letters in September to all 2,200 hospices participating in Medicare. **She expressed concern that patients who want and could benefit from hospice care may be receiving it too late—or not at all—due to the difficulty in making accurate prognoses.**

"There also is a disturbing misperception that hospices and beneficiaries will

Continued on Page 2

Medicare Hospice Use Soars

(From Page 1 — Medicare Hospice Use)

than six months in 1998, while **28% of hospice beneficiaries were in hospice care for one week or less** that same year, compared with 21% in 1992.

The report identified key factors contributing to the shorter use of Medicare hospice benefits. These include:

PHYSICIAN PRACTICES:

- Physician discomfort with discussing end-of-life care
- Lack of professional training in care of the dying
- Physicians' lack of awareness that they can continue to provide services after a patient has entered a hospice program

PATIENT PREFERENCES & CIRCUMSTANCES:

- Patients' refusal to confront and accept the terminal na-

ture of their illness (influenced by a general American unwillingness to accept limits, such as aging and death)

- Improvements in cancer care and new treatment options for other chronic conditions, which may prompt some patients to opt for curative treatment until they are closer to death

GENERAL AWARENESS:

- Lack of public awareness of hospice care and its range of services
- Lack of public and professional knowledge of the Medicare hospice benefit
- Mistaken fear of penalties if patients live longer than six months

For a copy of the GAO report (GAO/T-HEHS-00-201), log on to www.gao.gov.

Med Students Focus on End-of-Life Care Curricula

The American Medical Student Association (AMSA) has announced **plans to evaluate end-of-life and palliative care curricula in the nation's medical schools** and to honor the most innovative with its 2001 Paul R. Wright Award for Excellence in Medical Education.

Concerned about recent studies detailing the number of Americans who die in pain or in hospitals rather than at home, as well as the lack of medical textbook information on care of the dying, the AMSA seeks to spark improvement in end-of-life care training.

The award will be presented at the organization's annual meeting in March 2001. Nominations will be accepted through December 15. For more information, call **703-620-6600** or visit the AMSA website at www.amsa.org.

Hospice Benefit Not Restricted to Six Months

(From Page 1 — Hospice Benefit)

be penalized if a patient lives longer than six months," wrote DeParle. "Nothing could be further from the truth."

Under federal law, DeParle noted, a Medicare patient is eligible for hospice benefits when the person chooses palliative or other care from a hospice, and when a physician and the hospice medical director certify a medical prognosis of six or fewer months to live if the illness runs its normal course.

There have been "a handful of cases," said DeParle, in which beneficiaries were not diagnosed carefully and were then enrolled inappropriately in hospice. "Nev-

ertheless, that is very different from situations in which a terminally ill patient has had the good fortune to live longer than predicted by a well-intentioned physician," she stressed.

DeParle explained that physicians can re-certify these longer-lived patients. In addition, **the Balanced Budget Act of 1997** made changes in the law to **ensure that Medicare beneficiaries whose prognoses improve can transfer out of hospice and return at a later date.**

Americans need to be informed about hospice care, DeParle said, and

can obtain the publication, *Medicare's Hospice Benefits*, from medicare.gov or by calling **1-800-MEDICARE**.

Excerpts from HCFA Letter to Hospices

"Let me be clear:

- In no way are hospice beneficiaries restricted to six months of coverage.
- There is no limit on how long an individual beneficiary can receive hospice services, as long as they meet the eligibility criteria.
- As long as a physician continues to properly and conscientiously re-certify the six-month prognosis, a beneficiary can continue to receive the hospice benefit."

American Academy of Pediatrics States Children Should Receive Palliative Care 'at Diagnosis'

In its first formal policy statement on palliative care for children, the American Academy of Pediatrics (AAP) urges that an interdisciplinary program of palliative care for children with life-threatening or terminal conditions should be **“offered at diagnosis and continued throughout the course of illness, whether the outcome ends in cure or death.”**

Physicians and family members often delay implementing a palliative care program for children until all curative options have been exhausted, notes the AAP, allowing those children to suffer—and some to suffer and die—without the benefits that individualized family-centered palliative care can provide.

Medical professionals are **“obligated” to ensure that suffering in children with life-threatening or terminal conditions is minimized** and that “medical technology is used only when the benefits for the child outweigh the burdens,” the academy says in the statement, which appeared in the August 2000 issue of its journal, *Pediat-*

The goal of palliative care is to optimize the quality of the child's experience rather than to hasten death.

rics.

Further, physicians are encouraged to provide palliative care therapies that go beyond the narrow definition of “medically indicated,” yet may **improve the child's quality of life.** Such therapies may include education, peer support, music therapy, or counseling. **“The goal is to add life to the child's years, not simply years to the child's life,”** the AAP declares.

Since children's needs—and causes of death—are often significantly different from those of adults, the academy recommends **regulatory and policy changes** to remove current obstacles to effective palliative care for children. Their recommendations include:

- The development of widely-available **pediatric palliative care services**, and the implementation of an **integrated plan of care at diagnosis**
- Equitable **reimbursement of hospice and palliative care services** to allow for simultaneous curative and comfort care for children, therapies

likely to improve their quality of life, and respite care for families

- **Broader eligibility criteria** concerning the length of expected survival
- **Physician education programs** in communication skills, grief counseling, and the spiritual dimensions of life and illness
- An effort by generalists, pediatricians, pain specialists, and pediatric surgeons to **familiarize themselves with pediatric palliative care**
- Provision by pharmaceutical companies of **labeling information** for symptom-relief medications suitable for children

The goal of palliative care is to optimize the quality of the child's experience rather than to hasten death, says the academy, reiterating its opposition to the practice of physician-assisted suicide or euthanasia in children. Although forgoing burdensome interventions or providing adequate analgesia or sedation to relieve progressive symptoms may shorten a child's life, **“dying with dignity and without pain or distress is the primary goal.”**

American Bar Association Adopts New Pain Management Policy

The American Bar Association (ABA) has adopted a policy resolution **urging all of the nation's governments**—state, federal, and territorial—**to remove barriers to quality pain and symptom management**, and to support the right of the individual to effective evaluation and management, “even if such pain and symptom management may result in analgesic tolerance, physical dependence or, as an unintended consequence, shorten the individual's life.”

The resolution addresses the impediments to effective medical care caused by the **imbalance in the nation's drug policies, some of which pursue abuse goals at the expense of the suffering.** “Such policies interfere with decisions about

the care of individual patients that require medical expertise rather than government dictum,” states the ABA in an accompanying report.

Noting that perception of the law can be a more powerful factor than its substance, the report calls for the support of the legal community in efforts **“to overcome the deeply embedded cultural, social, legal, and medical misunderstanding of pain and symptom management practices.”**

The policy report was prepared by the ABA's Commission on Legal Problems of the Elderly, and the resolution was adopted in July. Full texts are available on the ABA website at www.abanet.org/elderly.

83% of Older Patients with Specific Preferences Choose to Die at Home

In a retrospective study of homebound patients in a single community, researchers found that making clearly documented plans to die in a particular place was common, implemented successfully in 91% of the cases, and that 83% of those who planned their site of death wanted to die at home.

Bruce Leff, MD, of Johns Hopkins University, Baltimore, and colleagues reviewed the medical records of 125 older persons who had been actively managed for approximately two years by a physician-led house call program. The patients, who died between July 1995 and November 1998, had suffered from a variety of chronic illnesses.

Of the 80 patients who made a plan to die in a specific place:

- 66 (83%) wanted to die at home, and 61 (92%) of those patients did so
- 13 (16%) wanted to die in the hospital, and 11 (85%) of those patients did so

Of the remaining 45 patients who did not formulate a plan to die in a particular place:

- 71% died in the hospital
- 29% died at home

In logistic regression analysis, **planning the place of death was positively associated with having a Do Not Resuscitate (DNR) advance directive** and negatively associated with the lack of an identifiable medical problem other than being homebound.

The researchers believe the association of DNR status with having a plan may relate to the fact that **“making decisions about end-of-life care is a process.”** Patients’ documented place of death had changed during the course of their care from one location to another in 79% of cases; and in all but one case, the plan evolved from wanting to die in the hospital to wanting to die at home.

“Whether dying at home is a ‘better’ death is unclear. However, it is probably true that dying where one wants to does represent a better death,” write Leff and colleagues. **“Understanding where patients prefer to die is important to delivering quality end-of-life care.”**

Source: “Prevalence, Effectiveness, and Predictors of Planning the Place of Death Among Older Persons Followed in Community-Based Long-Term Care,” Journal of the American Geriatrics Society; August 2000; 48(8):943-948. Leff B, Kaffenbarger KP, Remsburg R; Johns Hopkins Bayview Medical Center and Johns Hopkins University Schools of Medicine, Hygiene and Public Health, and Nursing, Baltimore.

Physicians Can Foster Hope in Terminally Ill Patients

Physicians—often the modulators of hope in patients who are facing terminal and life-threatening disease—can employ specific strategies to **improve their patients’ quality of life** by fostering humane and appropriate hope in those who know their life is ending.

That is the recommendation of Paul Rousseau, MD, Phoenix Veterans Affairs Medical Center, in an article that reviews recent literature on the topic. Hope is frequently defined as the **expectancy of good in the future**, notes Rousseau, so when a patient’s future is defined in months or even hours, those physicians who equate hope with cure **“must acknowledge the dynamic and complex nature of hope and how it changes during the dying process.”**

Initially, patients receiving the diagnosis of terminal illness may also relate hope to cure or unrealistic therapeutic procedures, says Rousseau. He urges physicians to provide **“compassionate disclosure”** of the diagnosis of a terminal illness and to **“face the challenge of balancing honest communication with maintaining hope.”**

According to Rousseau, research has identified the following **three obstacles to hope** in terminally ill people:

- **Abandonment and isolation**
- **Uncontrolled pain**
- **Devaluation of personhood**

As their disease advances and they confront their own mortality, many patients experience the **anguish of vulnerability and isolation**. Rousseau notes that people who are terminally ill often become marginalized from mainstream society as their familiar social and occupational roles disappear.

Interventions That Engender Hope

- Controlling symptoms
- Providing assistance with practical goals
- Fostering interpersonal connectedness
- Affirming individual worth
- Identifying personal attributes
- Supporting spiritual beliefs
- Encouraging humor and lightheartedness, when appropriate
- Facilitating uplifting memories with life review

—Adapted from an article by Paul Rousseau, MD

RESEARCH MONITOR

At this time, their relationships with family, friends, health care professionals, and a higher spiritual being can provide dying patients with **sources of a more global hope**, says Rousseau. The future becomes defined by positive outcomes for others and the **meaning attached to life, rather than to the amount of time remaining**. Then, with the approach of death, the focus of many patients turns to themselves and their desire for inner peace and serenity.

“In the context of terminal illness, hope can exist even when time is limited,” he concludes. “Such hope is bolstered by appreciating our patients’ value, strengthening and reconciling their relationships with family and friends, helping them to explore spiritual matters, and controlling their symptoms. Although physicians may find it hard to comprehend, when everything seems to be lost, that hope may actually be stronger than ever before.”

Source: “Hope in the Terminally Ill,” Western Journal of Medicine; August 2000; 173(2):117-118. Rousseau P; Geriatrics and Extended Care, Veterans Affairs Medical Center, and RTA Hospice, Phoenix, Arizona.

Nutritional Support May Increase Mortality Risk in Certain Patients

Nutritional supplementation appears to worsen the likelihood of survival in patients with cirrhosis, chronic obstructive pulmonary disease (COPD), acute respiratory failure (ARF), or multiorgan system failure (MOSF) with sepsis.

Led by Marie L. Borum, MD, MPH, of the Department of Medicine, The George Washington University Medical Center, Washington, DC, the team conducted a new analysis of data from SUPPORT (Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment), a study of seriously ill adults (median age, 65 years) who were hospitalized between 1989 and 1994.

The team examined the effect of enteral tube and parenteral hyperalimentation on 6-month survival among 6,298 patients with ARF, COPD, cirrhosis, coma, or MOSF with sepsis, comparing those who did not receive artificial nutrition with those patients (n = 2,149) who had nutritional supplementation on days 1 or 3, and with those (n = 1,206) who were still receiving the treatment on day 7.

COPD patients receiving enteral feeding on days 1 or 3 had a 57% higher risk of 6-month mortality, and cirrhosis patients had a 48% higher risk, when com-

pared with those who did not receive the treatment. In those patients still being treated on day 7, the increase in mortality risk associated with tube feeding was: 21% in patients with ARF or MOSF with sepsis; 115% in patients with cirrhosis; and 37% in patients with COPD, compared with patients who were not treated. Further, ARF/MOSF with sepsis patients treated with parenteral hyperalimentation on day 7 had a 34% increased mortality risk compared to those not treated.

“The results of our investigation suggest that **further study should be conducted that addresses the apparent lack of benefit of nutritional supplementation in seriously ill, hospitalized patients** and the possibility of a strongly negative effect in patients with COPD and cirrhosis,” the authors write.

The researchers suggest that patients with COPD, ARF/MOSF with sepsis, or cirrhosis may be **less tolerant of complications that can result from nutritional support**, adding that “perhaps even the increased metabolic work of nutrition was overwhelming to the marginal oxygen-carrying capacity of patients with advanced COPD.”

“This study cannot directly illuminate the causal pathway,” they conclude, “but it does raise a caution that patients with COPD, ARF/MOSF with sepsis, and cirrhosis who receive nutritional support may be at increased risk.”

Source: “The Effect of Nutritional Supplementation on Survival in Seriously Ill Hospitalized Adults: An Evaluation of the SUPPORT Data,” Journal of the American Geriatrics Society; May 2000; 48(suppl):S33-S38. Borum ML, Lynn J, Zhong Z, et al; Department of Medicine and The Center to Improve Care of the Dying, The George Washington University Medical Center, Washington, D.C.

Terminally Ill Cancer Patients Who Desire Hastened Death Exhibit Psychological Suffering

Most patients with advanced cancer who participated in a recent Canadian study said they favored the legalization of euthanasia and physician-assisted suicide (PAS). Those participants who said they would opt for immediate physician-hastened death—if access were available at the time of the interview—differed significantly from the other patients in their symptoms and concerns, researchers found.

The team surveyed 70 cancer patients (mean age, 65 years; range, 43 to 88 years) who were nearing death to evaluate their attitudes toward euthanasia and PAS and to determine the factors related to a personal interest in these

(Continued on Page 6)

RESEARCH MONITOR

(From Page 5)

practices. The median survival of participants was 44.5 days.

Most patients (73%) said that **euthanasia or PAS should be legal**. The reasons cited most frequently were: the **individual's right to choose, pain, diminished quality of life, suffering, and hopelessness**.

Compared with all other participants, patients who wished for immediate hastened death (12%) rated significantly higher in reports of:

- Loss of interest or pleasure in activities
- Hopelessness
- Desire to die
- Drowsiness
- Weakness
- Loss of control

There were no differences found among any of the groups in the ratings of pain severity. The study authors suggest that, for patients who would request physician-hastened death, **psychological considerations may be as important as physical symptoms**.

“Our results indicate that it is not necessarily extreme physical distress that motivates this desire,” they conclude. “Rather, the psychological and existential dimensions of suffering – which are, perhaps, no less central in determining quality of life – also emerge as important reasons behind patient requests for physician-hastened death.”

Source: “Attitudes of Terminally Ill Patients Toward Euthanasia and Physician-Assisted Suicide,” Archives of Internal Medicine; September 11, 2000; 160:2454-2460. Wilson KG, Scott JF, Graham ID, et al; Institute for Rehabilitation Research and Development, The Rehabilitation Centre, Ottawa; Institute of Palliative Care, Department of Medicine, and School of Psychology, University of Ottawa, Ottawa, Ontario.

Social and Market Factors Linked to Timing of Hospice Referral

Some terminally ill patients — women, nonwhites, those with dementia, and those with psychiatric disease — appear to be enrolled in hospice care earlier than do other groups, according to a recent study. In addition, those patients residing in areas with greater hospice capacity or a higher proportion of generalist physicians tend to be admitted sooner than others to hospice programs.

“The apparent role of certain social and market factors in the timing of hospice enrollment suggests that it is not merely the patient's clinical status, but other factors as well, that influences this important end-of-

life transition in care,” write lead investigator Nicholas A. Christakis, MD, PhD, MPH, et al, from the University of Chicago Medical Center. **“This in turn suggests that it may be possible to change the way hospice is used.”**

The researchers measured the duration of survival after hospice enrollment in a national cohort of 151,410 Medicare patients who entered 1,366 terminal care programs in 1993.

Principal diagnosis, burden of illness, and previous hospital use were associated with shorter survival. After adjustment for these and other factors, the study found that, compared with complementary groups, women were enrolled in hospice 5 days (17%) earlier before death; nonwhites, 4 days (13%) earlier; and older persons (aged 84 vs 73 years), 1 day (3%) earlier. Patients with a history of dementia as a comorbid condition, psychiatric disease, or substance abuse were each enrolled in hospice 3 days (10%) earlier.

Further, a greater number of both newly admitted hospice patients and area hospital beds per 1,000 people aged 65 years and older was associated with earlier enrollment, as was a higher percentage of area physicians in general practice.

Possible explanations for the **earlier enrollment** of certain groups include: **prognostic uncertainty**, with the tendency of **physicians to underestimate the nearness of death** in those patients who resemble themselves; the **need for earlier outside support** in caring for problematic patients, or for those who were themselves caregivers in the family (e.g., women); and the tendency for **socially disadvantaged persons to be offered hospice care** rather than the more costly aggressive care, the authors note.

The finding that a higher proportion of generalists was associated with earlier hospice referral is supported by previous research, which suggests that **generalists are more willing than specialists to forgo aggressively curative efforts**, the authors note.

The authors remind practicing physicians that conventional patterns of practice can influence their decisions on the timing of hospice referral for certain patients. Understanding the factors that have shaped that practice can aid physicians in optimizing care. **“Because hospice care is cost-effective and preferred by most patients, modification in practice might help to rationalize care at the end of life from both patient and societal perspectives.”**

Source: “Impact of Individual and Market Factors on the Timing of Initiation of Hospice Terminal Care,” Medical Care; May 2000; 38(5):528-541. Christakis NA, Iwashyna TJ; Departments of Medicine and Sociology, and the Center on Aging and Population Research Center, University of Chicago, Chicago.

PHYSICIAN RESOURCES

JAMA Theme Issue on End-of-Life Care Available November 15

The *Journal of the American Medical Association* (JAMA) has devoted its November 15, 2000, issue to the topic of end-of-life care. JAMA editors indicated in their call for papers that the journal intended to examine “the time in a patient’s life when the appropriate focus of care shifts from prevention to palliation.” Emphasis would be placed, they said, on “the patient’s role in helping determine when that shift occurs” and **the role of health care professionals in assisting the patient’s journey through the end of life.**

EPEC Project Expands Plans to Train Physicians on End-of-Life Care

The Education for Physicians on End-of-Life Care (EPEC) Project, which offers **a training program to provide physicians with the basic knowledge and skills needed for the appropriate care of dying patients**, has begun a phase of multi-lateral partnerships from its new location at Northwestern University Medical School, Chicago.

With renewed funding from the Robert Wood Johnson Foundation of Princeton, NJ, EPEC will work with various groups as partners in establishing and perpetuating quality end-of-life care in the medical profession.

EPEC was begun four years ago in partnership with the Institute for Ethics of the American Medical Association. The AMA will continue its founding partnership by providing EPEC materials at cost, and by maintaining an extensive information resource on the AMA website at www.ama-assn.org/ethic/epec.

The project's curriculum presents core materials in end-of-life care and offers guidance on teaching these palliative care skills to colleagues. Materials include a trainer's guide, a participant's handbook, trigger tapes, and slide sets.

For information on EPEC's upcoming training sessions and other conferences, call the EPEC Project at 312-695-4353, or visit www.epec.net.

Advance Directives Now Accepted in MedicAlert Repository

Advance directives of all types can now be stored in the national repository of MedicAlert Foundation, the nonprofit organization has announced. This extension of its emergency medical information service is designed to provide medical personnel with rapid access to a patient’s directives, regardless of the health care setting.

The service will collect, store, and transmit end-of-life care documents and directives concerning life support, resuscitation, living wills, durable power of health care attorney, organ/tissue donations, and autopsy instructions. Once the initial forms have been completed and registered, MedicAlert will notify the designated health care providers and proxies that the information is on file.

For information, call 800-432-5378 or go to www.medicalert.org.

End-of-Life Care Websites

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.chcr.brown.edu

Center for Gerontology and Health Care Research

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

First Annual Palliative Care Forum of the Center to Advance Palliative Care: Fall Forum 2000. December 3-5, 2000, Washington Monarch Hotel, Washington, DC. Contact: Kathleen McClear, Center to Advance Palliative Care, Mount Sinai School of Medicine. Phone: 212-241-7885; e-mail: kathleen.mcclear@mssm.edu

Second Clinical Conference & Exposition on Hospice and Palliative Care. March 23-26, 2001, Radisson Hotel Universal Orlando, Orlando, FL. Sponsors: the National Hospice and Palliative Care Organization, the American Academy of Hospice and Palliative Medicine, and the Hospice and Palliative Nurses Association. Phone: 703-533-8468.

7th Congress of the European Association for Palliative Care. April 1-5, 2001, Palermo, Sicily, Italy. Contact: K & K Congress, 17 Rue de Cendrier, CH-1211, Geneva 1, Switzerland. Phone: +41 22 908 1888; Fax: +41 22 908 1851; e-mail: eapc@kenes.com

Humber College 11th Annual Palliative Care Conference. April 22, 2001, Royal York Hotel, Toronto. Sponsors include the Canadian Palliative Care Association, the Ontario Medical Association, and the Ontario Palliative Care Association. Contact: Teresa Sottile, Continuing Education, Humber College. Fax: 416-675-0135; e-mail: sottile@admin.humberc.on.ca

Program in Palliative Care Education and Practice. April 24-May 1, 2001, Boston. Contact: Harvard MED-CME. Phone 617-432-1525; Fax: 617-432-1562; e-mail: hms-cme@hms.harvard.edu

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