

# Quality of Life Matters™

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

Vol. 4, Issue 3 Nov/Dec/Jan 2002-2003

## Late Referral to Hospice: More Than a Prognostication Problem?

Noting that late referral to hospice is a persistent problem, particularly for cancer patients, a Chicago research team has compiled a report that offers insights and suggestions for oncologists and other physicians. The report appears in the June 1, 2002, issue of the *Journal of Clinical Oncology*.

Although oncologists can frequently identify their patients with a life expectancy of 6 months or less, the median survival of cancer patients after hospice enrollment is just 2 to 3 weeks. **This is “barely enough time for many patients and families to understand the hospice program’s system, let alone receive the full range of benefits offered,”** the report points out.

“Dying of cancer without the help of a hospice program has been compared

to undergoing surgery without anesthesia,” comments lead author Christopher K. Daugherty, MD, of the Department of Medicine, University of Chicago. “Why, then, does the promise of hospice care so frequently go unfulfilled?”

Daugherty’s answer to this question is not that oncologists systematically overestimate their patients’ survival time, as some researchers have found, or that they tend to continue aggressive anticancer therapy even when death is clearly imminent, as others believe.

Rather, Daugherty and colleagues suggest that oncologists’ aversion to hospice referral may be due to “ethical dilemmas” caused by apprehensions about communicating terminal diagnoses and by concerns about how hospice enrollment may change patient care.

### MAINTAINING HOPE

Some clinicians worry that conveying a terminal diagnosis may destroy a patient’s hope, says Daugherty. If patients do not seem ready to redirect hope toward attainable goals or mistakenly equate hospice enrollment with “giving up,” rather than with choosing professional supportive care, Daugherty suggests that physicians speak in terms of possibility and likelihood rather than certainty.

**Under the Medicare hospice rules, “only a reasonable possibility of dying in the next 6 months is required for hospice eligibility, not an absolute certainty of death,”** Daugherty

### AT A GLANCE

- “Hospice-based palliative care is widely acknowledged as an invaluable intervention for patients approaching the end of life.”
- “Only a reasonable *possibility* of dying in the next 6 months is required for hospice eligibility, not an absolute *certainty* of death.”
- “...there are no consequences for an inaccurate hospice referral made in good faith.”
- “...hospice benefits allow oncologists to continue to play an important role... physicians can continue to bill as they normally would...”
- “... it is best not to make assumptions (about coverage for interventions)... but rather to communicate directly with hospice programs on a case-by-case basis.”

states. Patients who need to believe that their case will be the exception may still enroll in hospice. “There are no penalties for pessimism, and there are no consequences for an inaccurate hospice referral made in good faith.”

### ABANDONMENT AND SEPARATION ANXIETY

Physicians as well as their patients may have apprehensions concerning

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## Late Referral to Hospice *(from Page 1)*

separation and abandonment, particularly if the relationship has been a longstanding one, notes Daugherty. Oncologists may hesitate to recommend hospice, fearing to cut their patients off from familiar settings.

**“The good news is that hospice benefits allow oncologists to continue to play an important role in their patients’ care.” Hospice patients can continue to make visits to outpatient clinics, and physicians can continue to bill as they normally would for these services.** Although cancer patients who are referred to hospice very late will most likely be too ill to travel to outpatient settings, says Daugherty, those patients who are enrolled at an earlier point in the course of their disease may continue to visit their clinicians until the final stages of illness.

### REIMBURSEMENT AND RESOURCES

The bulk of hospice revenue in this country is provided by Medicare on a per diem basis that ranges from \$100 to \$120, an amount that does not begin to cover costly, aggressive palliative interventions, explains Daugherty. Delays in referral exacerbate this problem, as hospices will have fewer days of per diem benefit over which to spread the expenses. Medicaid and insurance benefits are similarly meager.

Oncologists who believe strongly in the benefits of expensive and aggressive therapies for patients nearing the end of

life may choose not to refer certain patients to hospice care. In fact, says Daugherty, they may develop the habit of not referring *any* patients to hospice.

However, certain hospice programs may be willing to accept patients whose physicians prescribe costly interventions, in order to encourage the enrollment of more patients who need their services. “Therefore, it is best not to make assumptions,” writes Daugherty, “but rather to communicate directly with hospice programs on a case-by-case basis.”

In conclusion, Daugherty recommends use of the continuing medical education programs aimed at improving physicians’ understanding of end-of-life care. He suggests that research focus on clarifying the behaviors, habits, and beliefs underlying the communication and decision-making practices of oncologists and their patients.

“Until education improves knowledge and research provides clarification, the ethical dilemmas faced by cancer physicians will continue to promote misunderstandings and will prevent patients with advanced cancer from receiving the best possible palliative care — and inertia and inaction will hold the day.”

*Source: “Overcoming Obstacles to Hospice Care: An Ethical Examination of Inertia and Inaction,” Journal of Clinical Oncology; June 1, 2002; 20(11):2752-2755. Daugherty, CK, Steensma, DP; Department of Medicine, MacLean Center for Clinical Medical Ethics, the Cancer Research Center at the University of Chicago.*

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## Residency Program Uses Hospice Expertise in Curriculum

In order to promote awareness of the “therapeutic potential” of integrating medicine and spirituality in patient care, the University of Massachusetts School of Medicine, Pittsfield, has implemented a new curriculum in its internal medicine residency program, reports assistant professor Mark C. Pettus, MD, in the July 2002 issue of *Academic Medicine*.

“Traditionally, graduate medical education has not emphasized the importance of spirituality as a ‘target’ for routine inquiry, understanding, and sharing in the context of patient care,” Pettus says.

**Included in the medicine-spiritual-**

**ity curriculum are lectures given by local hospice professionals on the ethical implications of end-of-life care, as well as on advance directives, pain management, and palliation. As well, residents spend one or two days per year with a hospice team.**

Monthly ward rounds are led by a faculty member who emphasizes the spiritual dimensions of a particular case and describes resources available for spiritual care in the hospital and the community at large. “Because the curriculum is seamlessly integrated into a preexisting infrastructure, it has been relatively easy

to implement,” Pettus notes.

Residents are provided with a syllabus of evidence-based medical literature on the relationship of spirituality to health, and they attend monthly lectures on various religious and spiritual practices and their implications on health and science.

“By remaining sensitive and respectful of all views, we strive to diminish the obstacles and enable a more provocative, enlightening residency experience... we are forced to reconsider what it is to be a ‘healer’ and what it is to be ‘healed,’” Pettus concludes. “I expect this to be a permanent aspect of our residents’ training.”

## Attorneys General Group Targets End-of-Life Issues

The new president of the National Association of Attorneys General (NAAG) has targeted end-of-life health care as a top priority of his term in office. Oklahoma Attorney General W.A. Drew Edmondson announced his presidential initiative on end-of-life care at his recent election.

“As baby boomers and many aging Americans struggle with the issue of caring for or becoming an individual with advanced, progressive, irreversible condi-

tions... the legal issues that have emerged have become quite complex and the public discourse has become quite emotional,” he said.

Although attorneys general in many states already work to assist citizens with advanced illness and to encourage health care professionals to provide the best possible care for these patients, said Edmondson, more focus is needed.

**“Attorneys general can work with consumers and lawmakers to make**

**sure current laws are adequate in meeting the needs of patients and families facing these difficult situations. Our role may be more educational than enforcement,”** Edmondson told his fellow attorneys general at their June meeting.

To this end, Edmondson has planned for a series of “listening conferences” to be held around the country.

For more information, call the NAAG at 202-326-6000, or visit [www.naag.org](http://www.naag.org).

## Expert Offers 'Therapeutic Map' for Conserving Patient Dignity at End of Life

Despite the politicization of the term “death with dignity” by movements favoring assisted death, the clear goal of palliation is the preservation of dignity; indeed, “the basic tenets of palliative care, including symptom management, psychological and spiritual well-being, and care of the family, may all be summarized under the goal of helping patients to die with dignity,” states Harvey Max Chochinov, MD, PhD, professor at the University of Manitoba, Winnipeg, Canada.

“Dignity provides an overarching framework that may guide the physician, patient, and family in defining the objectives and therapeutic considerations fundamental to care at the end of life,” writes Chochinov in the May 1, 2002, issue of the *Journal of the American Medical Association*.

To assist clinicians in conserving or bolstering the dignity of dying patients, Chochinov offers a model, or “therapeutic map,” of dignity and dignity-conserving care. Because individuals will have their own unique definitions of a dignified death, Chochinov identifies three main areas of influence on a patient’s perception of dignity.

### DIGNITY-RELATED AREAS OF INFLUENCE

- **Illness-Related Concerns**, which can include practical matters, such as comfort and independence
- **The Dignity-Conserving Repertoire**, which derives from the patient’s internal resources, such as past experience, psychological traits, and spiritual life
- **The Social Dignity Inventory**, which encompasses environmental influences, such as privacy, social support, and the tone of care

Chochinov offers a number of practical ways that physicians can foster dignity (see sidebar). “Dignity-conserving care comprises not only what one does to patients, but how one sees patients,” concludes Chochinov. By treating the patient as a whole person rather than a disease or a collection of symptoms, professional caregivers are themselves “imbued with the dignity rendered by their actions, better enabling them to provide care and comfort to those nearing death.”

### PHYSICIANS CAN FOSTER DIGNITY BY:

- ✓ **Seeing the patient as worthy of honor, respect, and esteem**, and assuming a stance that conveys this. “*What about yourself or your life makes you most proud?*”
- ✓ **Providing accurate information** upon request and sharing strategies for dealing with possible future crises. “*Are you getting all the information that you need? Is there anything about the later stages of your illness that you would like to know?*”
- ✓ **Encouraging the patient to participate in meaningful activities and normal routines**. “*What things that you did before your illness were most important to you? Are there things you still enjoy doing on a regular basis?*”
- ✓ **Safeguarding and respecting privacy**. Ask for permission to examine the patient. “*Is there anything in the way you are treated that is undermining your sense of dignity?*”

## Patients' End-of-Life Care Expectations May Vary According to Diagnosis

### *COPD Patients Express Strong Desire to Have Physicians Educate Them Each Step of the Way*

A study of terminally ill patients' perspectives on the quality of end-of-life care delivered by their physicians has found that, while there are areas of strong agreement among patients with different diseases, each diagnosis group may have its own unique needs and expectations.

The research findings of J. Randall Curtis, MD, associate professor of medicine, Department of Medicine, University of Washington, Seattle, and colleagues were published in the July 2002 issue of *Chest*, the journal of the American College of Chest Physicians.

In their qualitative study, Curtis' team analyzed data collected from 11 focus groups of 79 terminally ill outpatients from multiple medical settings in the Seattle area.

### **DIAGNOSIS GROUPS**

Participants were separated by diagnosis into one of three disease groups:

- Oxygen-dependent chronic obstructive pulmonary disease (**COPD**);
- C3 acquired immunodeficiency syndrome (**AIDS**); and
- Metastatic cancer or nonoperable lung **cancer**

### **PHYSICIAN SKILL DOMAINS**

Among patients in all three disease groups, four of the 12 domains of physician skills necessary for quality end-of-life care were identified most frequently.

- **Emotional support** was the single most commonly identified domain, regardless of diagnosis.
- **Communication with patients** consistently ranked second or third in frequency of identification.

- **Accessibility and continuity** ranked second to fourth.
- **Competence** ranked from third to fifth in importance among the three groups.

### **EDUCATING PATIENTS WITH COPD**

Each of the disease groups identified an area of care within these domains that was uniquely important to them. Patients with COPD were the only group, however, to identify an entire domain — that of **patient education** — as being of great importance to their care.

While a physician's ability to provide patient education was ranked seventh among cancer patients and 11th among patients with AIDS, for COPD patients it

was the fourth most important aspect of quality end-of-life care.

Patients with COPD desired education from their physicians in the following areas:

- Diagnosis and disease process
- Treatment options and their mechanism of action
- Prognosis, both short-term and long-term
- What the experience of dying might be like
- Advance care planning

Previous studies indicate that patients with COPD receive lower-quality end-of-life care compared with cancer patients, comment the authors. COPD patients are more likely to die in an intensive care unit and on a respirator, with a feeding tube in place, and with inadequate control of pain and other symptoms.

“Therefore, COPD represents an important disease for patient education and for discussing patient preferences regarding end-of-life care,” write the authors. “Perhaps the most important content area for physicians caring for end-stage COPD patients is education about the progressive and irreversible nature of severe COPD.”

### **FEARS OF AIDS PATIENTS**

Patients with AIDS were unique in expressing fears that their physicians would not provide sufficient pain relief near the end of life, due to professional bias about drug addiction.

Pain is a common symptom among these patients, note the authors, with as

### **SUGGESTIONS FOR PHYSICIANS**

- **COPD.** Discuss each patient's preferences regarding end-of-life care and educate them about the progressive and irreversible nature of end-stage COPD.
- **AIDS.** Reassure each patient that the goals of palliative care include adequate pain relief.
- **CANCER.** Consider redirecting a patient's desire to maintain hope toward maximizing quality of life and planning for a positive and comfortable dying experience.

*Continued on Page 5*

## Physicians May Alleviate Suffering by Exploring Reasons for PAS Requests

Although only 0.1% of dying patients in this country will die by physician-assisted suicide (PAS), and just 1% will specifically request it, about 50% would like to have the option available to them and 10% will seriously consider it. If physicians are willing to explore the motivations of patient requests for PAS, they may alleviate suffering and, in most cases, meet the patient's wishes without PAS.

That is according to Paul B. Bascom, MD, and Susan W. Tolle, MD, of the Oregon Health & Science University, Portland, in their discussion of a case study of a patient with amyotrophic lateral sclerosis who attempted to raise his consideration of PAS with his attending physician.

"Patients who initially consider PAS are, in part, exploring their options at the end of life. Their most pressing question may have changed from 'Why me?' to 'What next?'" write the authors. Physicians should interpret an initial request for PAS as a call for information and for a commitment to alleviating future suffering.

While remaining mindful of moral and legal concerns, physicians should be willing to explore the individual values, concerns, and fears motivating a PAS request, say Bascom and Tolle.

Areas of exploration might include:

- ✓ **Expectations and fears.** "How do you expect your death to go? What's the worst that could happen as you die?"
- ✓ **Knowledge of end-of-life care.** "What do you understand about your options for end-of-life care? How specifically would you like me to help you?"

- ✓ **Patient goals.** "What is the most important thing for you right now? If you were to die now, what would be left undone?"
- ✓ **Family.** "How is your family affected by your illness? What do they think about PAS?"
- ✓ **Relief of suffering.** "Are you suffering now? What kind of suffering concerns you most?"
- ✓ **Meaning and quality of life.** "What is your quality of life right now? What gives your life meaning right now? How bad would your quality of life have to become for your life to have no meaning?"
- ✓ **Depression.** "Are you depressed? What things in life still give you pleasure? Have you had a good life?"

"Almost all patients do not persist in their request when their concerns are addressed effectively," write the authors. In their case study, the patient abandoned his pursuit of PAS when his fears of a prolonged, agonizing death were explored by his new physician (a hospice medical director), and he was assured that his suffering would be controlled.

**"When physicians commit themselves to remain present with patients and to respond to their suffering, in almost all cases, the patient's wishes can be met without PAS,"** the authors conclude.

*Source: "Responding to Requests for Physician-Assisted Suicide: 'These Are Uncharted Waters for Both of Us...'" Journal of the American Medical Association; July 3, 2002; 288(1):91-98. Division of General Internal Medicine and Geriatrics, and Center for Ethics in Health Care, Oregon Health & Science University, Portland.*

From Page 4

many as two-thirds of patients with advanced AIDS reporting moderate-to-severe and constant pain. In this study, pain control was one of the components of physician competence.

"Physicians caring for patients with advanced AIDS should clarify with their patients that the goals of palliative care include adequate pain relief," write the authors. "If physicians address these fears prior to the terminal phase of AIDS

care, patients may have a much better palliative care experience."

### CANCER PATIENTS & HOPE

The investigators found that cancer patients were unique among the three groups in their emphasis on the importance of maintaining hope, which was one of the components of the domain of emotional support. This is a challenging area for physicians, note the authors. Some experts have suggested redirect-

ing patients' hope toward maximizing quality of life and planning for a positive and comfortable dying experience.

But more research is needed to determine what cancer patients find helpful in maintaining hope, say the authors, and "further research is needed to find ways to help physicians caring for patients with advanced cancer to maintain patients' hope while simultaneously helping them confront the terminal nature of their disease."

## Physician Factors Linked to Patient Survival in Hospice

Certain attributes of referring physicians — such as accuracy of estimated patient survival, practice specialty, and hospice referral patterns — are associated with the survival of terminally ill cancer patients after referral to hospice care, researchers have found.

“Although physicians state that patients ideally should receive hospice care for three months before death, the majority of patients survive less than one month in hospice care,” comment investigators from the Department of Medicine and the Cancer Research Center, University of Chicago.

The team conducted a prospective cohort study of 313 terminally ill cancer patients referred to outpatient hospice programs in Chicago. The median survival among the participants was 26 days after hospice referral. In multivariate analysis, several physician factors were associated with the length of patient survival in hospice. Key findings include:

- ✓ **Patients whose physicians estimated their survival accurately lived 20 days longer** in hospice

care than those patients whose physicians made inaccurate survival estimates.

- ✓ **Patients referred by general internists and geriatricians lived 18 days longer** in hospice compared with patients referred by oncologists.
- ✓ **Patients whose physicians had referred 2 or more patients to hospice care in the previous three months survived 17 days longer** than patients whose physicians had referred fewer patients.

“Physician prognostic accuracy, specialty, and previous experience with hospice patients each are associated with longer patient survival in hospice, and thus most likely earlier referral,” the authors conclude.

*Source: “Physician Factors in the Timing of Cancer Patient Referral to Hospice Palliative Care,” Cancer; May 15, 2002; 94(10):2733-2737. Lamont EB, Christakis NA; Sections of General Medicine and Hematology-Oncology, Department of Medicine and Cancer Research Center, University of Chicago, Chicago.*

## Aggressive Treatment Found Prevalent Among Patients with Advanced Dementia

*Greater Use of Hospice Care Recommended by Mount Sinai Researchers*

The use of systemic antibiotics — an aggressive treatment measure — among elderly patients with severe dementia is prevalent during the last six months of life, “despite the limited utility and discomfort associated with these measures,” according to researchers from the Mount Sinai School of Medicine, New York City.

The team reviewed data on 279 patients with dementia and 24 control patients living in chronic care facilities at the time of death who were brought for clinical autopsy between 1985 and 2000. Patients were divided into time cohorts based on date of death. Charts were reviewed for use of systemic antibiotics and for palliative measures such as narcotic pain medication.

Investigators found a high prevalence of systemic antibiotic use (53%) among all patients with dementia, with little variation by severity of the disease, and no significant change in use over the past 15 years. Although antibiotic treatment may reduce mortality among patients with mild or moderate dementia, note the authors, “**aggressive treatment of infection does not improve survival rates among persons**

**with severe dementia and has been associated with accelerated progression of the severity of dementia.”**

Narcotic medication was given to 38% of patients without dementia but to only 14% of dementia patients. This difference remained significant after adjustment for potentially painful conditions. While the proportion of dementia patients receiving narcotic medication had risen from none to 18% during the 15 years, this is “still significantly below that observed among patients who do not have dementia,” write the authors.

“The futility and discomfort of aggressive treatments, combined with the underrecognition and undertreatment of pain among patients with severe dementia, support the use of palliative care for advanced dementia,” the authors state. “**Greater use of hospices by patients with dementia may constitute good patient care and good public policy.”**

*Source: “Palliative and Aggressive End-of-life Care for Patients with Dementia,” Psychiatric Services; May 2002; 53(5):609-613. Evers MM, Purohit D, Perl D, Khan K, Marin DB; Mount Sinai School of Medicine, New York City.*

# PHYSICIAN RESOURCES

## Online Pain Management Site Offers Assessment Tools, Education Programs

Visit [www.npecweb.org](http://www.npecweb.org)

A new web-based physician resource offers clinical tools and multimedia educational programs for all practitioners interested in advancing their knowledge and skills in the clinical management of pain. The content on the National Pain Education Council (NPEC) site was developed by a contributing faculty of leading pain management experts.

**“The major objective of the NPEC initiative is to relieve the burden of human suffering by educating physicians about the latest aspects of pain assessment and management...with particular emphasis on the use of opioid medications,”** states NPEC co-chair Richard Payne, MD, chief of the Pain and Palliative Care Service at Memorial Sloan-Kettering Cancer Center, New York City.

Access to the site is free, requiring only a one-time user registration. Resources include a clinical toolbox, with fully downloadable forms that physicians are encouraged to print and use in their clinical practice.

A reference section on the NPEC site provides links to key abstracts from the National Library of Medicine database on pain management, opioids, and the pathophysiology of pain; recommended journals; and pertinent professional and regulatory websites.

The online learning section offers multimedia, interactive CME/CE programs, with all materials necessary for credit hour allocations. These activities, which include case-based learning systems, are also archived for access by any clinicians who wish to read them without formally participating in the program.

The NPEC initiative is funded through an unrestricted educational grant from

Janssen Pharmaceutica Products, LP, Titusville, New Jersey; all content was developed independently. NPEC is headquartered in Parsippany, New Jersey.

The NPEC website address is [www.npecweb.org](http://www.npecweb.org)

For more information on pain management, visit:

American Academy of Pain Medicine: [www.painmed.org](http://www.painmed.org)

American Academy of Pain Management: [www.aapainmanage.org](http://www.aapainmanage.org)

## End-of-Life Care Websites

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

End of Life Physician Education 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 (formerly the NHO)

[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

### Printable Clinical FORMS AND GUIDELINES

Include:

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- An equianalgesic chart
- Pain management and regulatory guidelines

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Include:

- The Code of Ethics and Opioid Consent Form developed by the American Academy of Pain Medicine
- The Patient Bill of Rights developed by the American Academy of Pain Management

# End-of-Life Care Meetings for Clinicians

**7th Multidisciplinary Approach to Palliative Care, Pain and Symptom Management Conference.** January 31-February 1, 2003, Houston. Sponsor: University of Texas MD Anderson Cancer Center. Phone: 713-792-2222; Fax: 713-794-1724; Email: meetings@mdaisdl.mdacc.tmc.edu; Website: www.mdanderson.org/conferences

**Palliative Medicine 2003.** March 6-8, 2003, Marriott Harbor Beach Resort, Ft. Lauderdale. Sponsor: Cleveland Clinic Foundation. Contact: Lisa Clough. Phone: 216-444-7793; Email: clough@ccf.org

**22nd Annual Scientific Meeting of the American Pain Society.** March 20-23, 2002, Chicago. Contact: APS, 4700 W. Lake Avenue, Glenview, IL, 60025-1485. Phone: 847-375-4715; Fax: 877-734-8758 (United States) or 732-460-7318 (international); Email: info@ampainsoc.org; Website: www.ampainsoc.org

**8th Congress of the European Association for Palliative Care.** April 2-5, 2003, Netherlands Congress Centre, The Hague, Netherlands. Contact: Kenes International, 17 Rue du Cendrier, P.O. Box 1726, CH-1211 Geneva 1, Switzerland. Phone: +41 22 908-0488; Fax: +41 22 732-2850; Email: eapc03@kenes.com; Website: www.kenes.com/eapc2003

**6th International Symposium on Pediatric Pain: The Big Questions.** June 15-19, 2003, Sydney Convention Centre, Darling Harbour, Sydney, Australia. Sponsor: International Association for the Study of Pain. Contact: DC Conferences, P.O. Box 571, Crows Nest, NSW 1585, Australia. Phone: +61 2 9954 4600; Fax: +61 2 9954 0666; email: ISPP2003@dcconferences.com.au; Website: www.dcconferences.com.au/ISPP2003

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**L. Addison Smelko, Jr.**  
*Hospice Support Specialist*

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