

Quality of Life Matters®

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

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Physicians Offered Clinical Strategies for Treating a Dying Colleague

The Physician-Patient Is Both Like and Unlike Other Patients

Physicians caring for a terminally ill colleague face the same challenges encountered in the care of other dying patients, as well as problems unique to caring for a fellow physician: issues such as professional identity, perfectionism and control, confidentiality, and self-doctoring, according to a team of Boston palliative care physicians.

“Caring for dying doctors can teach us a great deal about all patients and about ourselves,” write Erik Fromme, MD, and J. Andrew Billings, MD, in an article published in the Oct. 15, 2003, issue of the *Journal of the American Medical Association*.

Because the virtues of a good phy-

sician can pose both strengths and liabilities in the doctor adapting to the new role of patient, the treating physician is encouraged to draw attention to the physician-patient relationship at the outset, and to establish and revisit ground rules. The authors provide strategies for negotiating the physician-patient relationship when both parties are physicians. [See box, Page 3.]

Like all terminally ill patients, physician-patients must be able to rely on their physicians for support and guidance — for themselves and their families — through the unfamiliar territory of severe illness and dying. Thus, note the authors, the challenge for the treating physician

“Physician-patients and their families are no less likely than others to experience difficulties or have dysfunctional coping strategies...”

— Fromme and Billings
Journal of the American Medical Association

is to maintain “equanimity.”

While treating physicians may find themselves identifying with the physician-patient, they must guard against overinvolvement, warn the authors. On the other hand, some physicians may try to protect themselves from suffer-

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AMA Urges Improved Pain Management, Better Understanding of Hospice Care

The *Journal of the American Medical Association* (JAMA) has devoted an entire recent issue to the theme of pain management. The published articles “point out the necessity for greater awareness of pain as a symptom by clinicians,” as well as the need for further research in the field, comments JAMA editor Catherine D. DeAngelis, MD, MPH.

According to DeAngelis, the major existing clinical and research challenges regarding pain management include:

- The removal of obstacles preventing clinicians from using known effective means of relieving pain

in the very young, the elderly, and at the end of life

- Educating patients in the effective use of pain-relieving therapies
- Advancing knowledge about the mechanisms of pain
- The development of better analgesic medications and improved methods of delivery

Along with articles on a variety of pain management methods, JAMA's Nov. 12, 2003, issue contains a brief history of pain management. Among the men-

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Later Referrals Do Not Allow Time for Hospices to Meet Patients' Goals

While the number of hospice admissions was rising, the lengths of stay in hospice decreased steadily between 1995 and 1999, making provision of the full range of hospice services less likely, according to a team of researchers from Brown University Medical School, Providence, RI.

“Increases in short stays raise concerns because in addition to being inefficient, short stays may provide less opportunity for hospices to provide high-quality pain and symptom management,” the authors write in their report published in the October 2003 issue of *Journal of Palliative Medicine*.

The team examined hospice stays for 127,162 nursing home and non-nursing home patients admitted from October 1994 to September 1999 to more than 20 hospices owned by one provider across seven states. Probability of a short hospice stay

The research team encourages earlier referrals so hospices can better meet the following goals for each patient/family:

- Self-determined life closure
- Safe and comfortable dying
- Effective grieving

— a stay of 7 days or less — during that time rose from 26% to 33% for nursing home patients and from 32% to 36% for non-nursing home patients.

Median length of stay dropped from 26 days in 1996 to 15 days in 1999 for nursing home patients and from 15 days to 12 days for non-nursing home patients during the same time period.

Factors significantly associated with greater likelihood of short length of stay included: diagnosis of renal failure, stroke, or heart failure; male gender; private insurance status; and being referred from a hospital.

A changing patient case mix, as more noncancer patients are referred to hospice, may account for an increase in short hospice stays, note the authors. As well, technological advances may have encouraged physicians to suggest more and new treatment possibilities before referring patients to hospice.

Nevertheless, the major influence on the timing of hospice referrals may have been government monitoring of admission patterns during this period, when imposed criteria — rather than the treating physician's judgment — were employed to determine who was terminally ill, the authors suggest.

Because short hospice stays probably make full provision of care for dying patients and their families less likely, “it is important to reverse this trend, and to the extent that government oversight has contributed to increases in short stays, reversal is possible to some extent.”

Legislation regarding the Medicare hospice benefit was modified in 2000 to make clear that certification of terminal illness is based on clinical judgment (of the attending physician and the hospice medical director). Since then, **the federal agency responsible for Medicare has issued statements emphasizing its understanding that prognostication is not an exact science and assuring physicians and providers that no penalty attaches to certifying a patient believed to be terminally ill.**

The government must continue its initiatives “to assure providers that there is no restriction to Medicare hospice coverage when beneficiaries have the required physician-certified 6-month terminal prognosis,” state the authors. “By such continued assurances, providers may increase their comfort with the ambiguity inherent in terminal prognoses.”

AMA Urges Improved Pain Management

Continued from Page 1

tioned historical highlights is the medical initiative of the United Kingdom physician Cicely Saunders — founder of the first modern day hospice — who formulated pain as a complex multidisciplinary problem.

“Saunders’ concept of ‘total pain,’ a clinical phenomenon that compounded physical and mental distress with social, spiritual, and emotional concerns,” transcended earlier formulations, “demanding a holistic concept of management focused on the individual patient,” writes author Marcia L. Meldrum, PhD.

In a review of a palliative care self-study program for physicians offered by the American Academy of Hospice and Palliative Medicine (AAHPM), V.S. Periyakoil, MD, writes: “Good palliative care requires an intricate combination of expert symptom management and understanding of the many categories of human response to terminal illness.”

Periyakoil adds: **“To facilitate a good quality of life in terminally ill populations, it is imperative that all primary care practitioners gain a better understanding of the basic tenets of hospice and palliative care.”**

For information on the AAHPM series, “Hospice/Palliative Care Training for Physicians: A Self-Study Program,” visit www.aahtm.org.

Physicians Offered Clinical Strategies for Treating a Dying Colleague

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ing with the dying colleague by becoming cold and distant.

“If we become neither overinvolved and overwhelmed nor underinvolved and distant, we may appreciate more clearly how we want ourselves and our families to be treated in the crisis of terminal illness — in effect, practicing for our own dying — and can become better clinicians and stronger advocates for improved end-of-life care,” note the authors.

“Physician-patients and their families are no less likely than

others to experience difficulties or have dysfunctional coping strategies and are no less likely than others to benefit from the expertise, guidance, detachment, and equanimity of a team of professional caregivers,” the authors write.

Source: “Care of the Dying Doctor: On the Other End of the Stethoscope,” Journal of the American Medical Association; Oct. 15, 2003; 290(15):2048-2055. Fromme E, Billings JA; Massachusetts General Hospital Palliative Care Service and the Harvard Medical School, Boston; Department of Medicine and Center for Ethics in Healthcare, Oregon Health and Science University, Portland.

When the Patient Is Also a Physician: Strategies for Negotiating the Patient-Physician Relationship

- **Acknowledge the situation:** “This is a new relationship for both of us. I want us to work well together, so it’s important that I understand how you want to be treated as a patient.”
- **Start with the basics:** “How would you like me to address you, as Dr. X or something else? How would you like the staff to address you?”
- **Establish confidentiality:** “I want to make it clear that I’ll be treating you with absolute confidentiality, and not gossiping about your care with the staff or fellow physicians. I will remind my staff about the importance of confidentiality around your care. Since medical records can be accessed by many people, I’ll be especially careful about what I include in my notes. I want you to tell me directly if there is any matter you want discussed totally off the record.” Add: “Folks here in the facility care about you and are going to be wondering how you are and asking questions. I will be extremely circumspect, but you may want to guide me about what information to share.”
- **Explain information handling:** “I will make a special effort to explain what I’m doing and not assume that you understand everything. I’d rather seem condescending than take for granted that you’re familiar with what we are discussing. And I want you to feel free to ask questions and not feel you’re expected to understand and remember everything.”
- **Explore sharing information with family:** “How would you like me to involve your family? I need your guidance on when you would like them present for information sharing and decision-making. Is there anything about your care you would rather I did not discuss with your family?”
- **Provide comprehensive care:** “I consider being your physician as taking an interest not only in the details of your medical care, but also in how you and your family are coping with this illness. These are important aspects of good care, and I want to make sure we talk about these sorts of things. I’m going to make an effort to ask you the same questions I would with any patient.”
- **Structure consultations:** “I know you may be tempted to grab me or your colleagues in the hall for questions and informal consults. That’s understandable, but I don’t think it can substitute for a formal patient-physician relationship. I would prefer that we set aside some time on a regular basis to review your concerns, so I can give you my full attention and we can decide which consultants to involve in your care.”
- **Supervise self-doctoring:** “Many physicians, when they become patients, take a very active role in their medical care and make a lot of decisions and plans for themselves. Others look for and expect more guidance and assistance from their doctor. How do you see this?” Add: “If you are thinking of making plans and decisions on your own, my request is that you keep me in the loop, so I can have a clear view of your care and can offer my expertise.” Consider saying: “I know that you are quite capable of arranging tests, getting appointments with specialists, and so on, and that you might prefer to do that. But I don’t want to dump responsibilities on you just because you’re a physician. We should at least discuss or negotiate situations when you are assuming responsibilities that might normally be mine.”

— Fromme and Billings
Journal of the American Medical Association

More Hospice and Palliative Care Urged for Late-Stage HIV/AIDS Patients

Although recent advances in medical therapy have largely transformed AIDS (Acquired Immunodeficiency Syndrome) in the developed world from a rapidly fatal disease into a manageable chronic illness, for many patients AIDS remains a life-threatening illness. Thus, clinicians are faced with the challenge of integrating palliative care into what has become a narrowly-focused, “curative” approach, say the authors of a recent journal article.

“As patients survive longer in the later stages of progressive HIV [human immunodeficiency virus] disease, they may in fact have increasing need for comprehensive symptom management, as well as wide-ranging need for psychosocial, family, and care planning support,” write the authors.

AIDS remains a leading cause of death among young adults in this country, the authors note. And while AIDS-related mortality rates have plateaued at about 15,000 deaths per year since 1997, there has been no decrease in HIV incidence. Thus, the prevalence of HIV/AIDS has actually increased, “including the subgroup of patients requiring chronic disease management and palliative care interventions.”

Integration of Disease and Symptom Management

The emergence of highly active antiretroviral therapy (HAART) as the preferred treatment for HIV has led to a “de facto separation” between disease-specific and symptom-specific treatment approaches for these patients.

“In the HAART era, the false dichotomy of curative vs. palliative care for patients with HIV/AIDS must be supplanted by a more integrated model to provide comprehensive care for patients with advanced HIV disease and their families,” the researchers point out.

Within the article, the authors pro-

vide a table listing more than a dozen common AIDS symptoms and their possible causes. Listed alongside are suggestions for clinically-based interventions — both disease-specific and symptom-specific. The authors comment: **“Careful and thorough attention to pain and symptom management are critical throughout the disease’s progression.”**

For optimal care of their patients, physicians need to be both knowledgeable concerning palliative treatments and aware

Hospice Can Help

“Physicians should proactively address these [psychosocial] issues with family and other caregivers. Recommending support groups and respite benefits that hospice services may provide can help caregivers who may be ambivalent about accepting help from others.”

of potential drug interactions between palliative and HIV medications, the authors caution. Included in the paper is a table listing palliative medications that may require careful monitoring for potential drug interactions with certain HIV medications.

Prognostication and Treatment Discontinuation

Another challenge for physicians caring for patients in the HAART era is the unreliability of prognostic markers in the late stage of the disease. Previously used short-term mortality predictors — such as cell counts, viral loads, and certain opportunistic infections — may be overridden by the impact of HAART on patients.

A recent study has found that functional deficits and/or the presence of other life-threatening illness may predict short-term mortality in patients

with late-stage HIV better than the traditional markers. More research is needed to develop prognostic variables for this disease, the authors urge.

A further challenge for clinicians is the lack of guidelines for the discontinuation of HAART after treatment failure. Physicians must repeatedly assess whether or when to discontinue therapy in late-stage disease. The authors provide a listing of potential risks and benefits of HAART commonly considered in clinical decision-making.

Advance Directives and Supportive Services

Since research has shown that patients with AIDS are less likely to discuss advance directives with their physicians than are other patient populations, physicians need to identify and address possible barriers to such discussions — particularly the fear that palliative care is substandard care. “This underscores the key role of the physician as someone who can accompany the patient and family through a complex process that goes far beyond medical treatment regimens.”

In addition, clinicians caring for patients with late-stage AIDS need to be aware of the serious emotional burdens carried by caregivers. **“Helping the caregiver understand that the need for support during difficult times is normal can be a clinician’s most powerful intervention for a family in distress over the burden of caring for someone with advanced HIV disease.”**

Source: “Overcoming the False Dichotomy of Curative vs. Palliative Care for Late-Stage HIV/AIDS: Let Me Live the Way I Want to Live, Until I Can’t,” Journal of the American Medical Association; Aug. 13, 2003; 290(6):806-814. Selwyn PA, Forstein M; Department of Family Medicine, Montefiore Medical Center, Albert Einstein College of Medicine, Bronx, NY; Department of Psychiatry, Cambridge Hospital, Harvard Medical School, Boston.

Rate of Hospitalization Among Hospice Cancer Patients Found Very Low, and Steadily Declining

A recent study of Medicare patients with lung or colorectal cancer who were enrolled in hospice during the last six months of life has found a 6% rate of hospitalization in this population over the past decade.

Further, the rate of hospitalization after hospice entry declined each year by about 7%. **“This may be evidence that a better understanding of patients’ needs at the end of life has led to improved provision of palliative care and thus a decrease in the need for hospital management of patients enrolled in hospice services,”** comment the study authors.

The researchers from Harvard Medical School and Beth Israel Deaconess Medical Center in Boston analyzed data on 23,608 Medicare hospice patients with lung or colorectal cancer who died between 1988 and 1998. Although all patients were enrolled in hospice at some point during the last six months of life, not all patients were enrolled continuously during this time period.

Of the study sample, 6% (n=1423) were hospitalized at least once after hospice entry. Median length of hospital stay was 4 days; median survival after hospital admission was 21 days. 36% of those hospitalized died in the hospital. Of those

who survived, 65% returned to hospice care after hospital discharge.

Factors associated with higher rates of hospitalization were: younger age, black race, male gender, local cancer stage at diagnosis, and hospice enrollment within 4 months of diagnosis. The most common admission diagnoses were lung cancer, metastatic disease, bone fracture, and pneumonia. 13% of hospital admissions were considered elective.

Patients receiving hospice care are significantly more likely than nonhospice patients to die at home, the authors point out. Data from the National Hospice and Palliative Care Organization, they note, reveal that 52% of patients enrolled in hospice care died at home in 2001, while 22% died in a nursing facility, and just 10% died in the hospital. In contrast, overall during the same year, 25% of Americans died at home, 25% in a nursing facility, and 50% died in the hospital.

Source: “Hospitalization of Hospice Patients with Cancer,” Journal of Palliative Medicine; October 2003; 6(5):757-768. Cintron A, Hamel MB, Davis RB, Burns RB, Phillips RS, McCarthy EP; Division of General Medicine and Primary Care, Department of Medicine, Harvard Medical School, and Beth Israel Deaconess Medical Center, Boston.

Caregivers of Dementia Patients Need Bereavement Support *Before* Death

How does the death of a dementia patient affect the life of the family caregiver who often spends up to 24 hours a day tending to the needs of the patient in the year before death?

That was the question a group of Pittsburgh researchers set out to answer. Their conclusions, published in the November 13, 2003, issue of *The New England Journal of Medicine*, suggest that when death is preceded by a protracted and stressful period of caregiving, caregivers accept the death with considerable relief and resiliency.

The crucial period — in which intervention and support services for caregivers are needed most — comes *before* the patient’s death, not after, the team found. **“It is possible that when caregivers know that their relatives are on a trajectory toward death and when caregivers are aware of the patient’s disability and suffering, they grieve for the loss of the patient before the death,”** the authors write.

Noting there are more than 2 million dementia patients in

this country, most of them cared for at home, the researchers analyzed four years of data on 217 family caregivers of patients with Alzheimer’s disease. All participants had experienced the death of their loved one during the course of a larger, multisite study. The mean age of the caregivers was 65 years; 84% were women. Approximately half were spouses, and the other half were primarily children of the patients. Of the patients with dementia, 54% were men (median age, 81 years).

The impact of end-of-life care on the family caregivers was striking. According to the authors, more than half of the caregivers (59%) reported feeling “on duty” 24 hours a day. 18% had stopped working in order to care for their loved ones. Of the 56 who remained employed outside the home, 48% reported having to reduce their working hours in order to meet the demands of care.

More than 90% of caregivers felt that the death came as a

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PHYSICIAN RESOURCES

Palliative Care Manual Available on VA Website

Comprehensive Book Features Hundreds of Practical Suggestions for Physicians

Tips for Physicians: Sharing the Bad News

Excerpts from "The Palliative Response"

PHYSICIAN'S ROLE:

Patients/families both need and want to know the truth of their situation. The authors stress: "Do not delegate sharing the bad news!" Patients often accept bad news only from a physician. An MD is best prepared to interpret news and to offer advice.

STARTING THE CONVERSATION:

Ask: What do you (the patient/family) understand about what is happening? What have others told you?

Wait: 15-30 seconds to give opportunity for response.

Listen: Responses may vary from "I think I am dying" to "I don't understand what is happening." Ask patient how much he/she wants to know, including prognosis.

SHARING BAD NEWS:

Recommended statement for terminal illness: "This is an illness that man cannot cure." This is a humble statement, the au-

thors state, which leaves open the possibility of the miraculous. It helps change the focus from "cure" to palliation and support.

SUGGEST A BRIEF PLAN:

Medical Plan: Control symptoms such as dyspnea; recommend home assistance to help patients deal with weakness.

Ancillary Support: Suggest social worker and pastoral care visits.

Introduce Advance Care Planning: "Sometimes when people die, doctors try to bring them back to life. Have you considered whether you would want this or not?"

OFFER FOLLOW-UP MEETING:

When? Usually within 24 hours.

Who? Current/additional family members.

Why? To repeat portions of the news.

How? Offer to contact absent family members. Get permission to share news, if necessary.

The full text of a comprehensive yet concise manual on palliative care is available for reading or downloading on the website of the Department of Veterans Affairs (VA) hospice and palliative care network (www.hospice.va.gov).

"Palliative Response," written by palliative care expert F. Amos Bailey, MD, with a complete teaching guide by Carol Padgett, PhD, presents key points for managing physical symptoms of terminally ill patients and for addressing the emotional, spiritual, and social suffering commonly encountered in end-of-life care.

Both the manual and teaching guide are appropriate for instructing medical students or for residents and fellows in palliative medicine rotations. Also available are provider pocket cards with detailed information on such topics as: Equianalgesic Dosing for Pain Control, When to Consider Palliative Care, Sharing the Bad News, Comfort Care in the Last Hours of Life, and Making the Death Pronouncement.

Visit www.hospice.va.gov/Amosbaileybook/index.htm

Caregivers Need Bereavement Support *Before* Death

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relief to the patients, and 72% reported that it was a relief to themselves. Close to two-thirds of caregivers (62%) believed the patients were in pain often or all of the time before death.

Although the caregivers exhibited high levels of depressive symptoms during the time of caregiving, those symptoms declined significantly within 3 months of the patient's death. By the end of 1 year following the death, the levels of depressive symptoms were below those exhibited during the active caregiving period.

"One of the greatest frustrations physicians face in caring for patients with Alzheimer's disease is their own sense of helplessness," writes the author of an accompanying article in the same journal issue.

"Providing for the mental health care needs of the second victim of Alzheimer's disease — the family caregiver — may prove a tangible and cost-effective way to ensure that both patients and caregivers have the best quality of life possible," this author points out.

Source: "End-of-Life Care and the Effects of Bereavement on Family Caregivers of Persons with Dementia," The New England Journal of Medicine; Nov. 13, 2003; 349(20):1936-42. Schulz R, Mendelsohn AB, et al, for the Resources for Enhancing Alzheimer's Caregiver Health (REACH) Investigators. Departments of Psychiatry and Epidemiology, the Institute on Aging, and the University Center for Social and Urban Research, University of Pittsburgh. "Costs to Society of Family Caregiving for Patients with End-Stage Alzheimer's Disease," The New England Journal of Medicine; Nov. 13, 2003; 349(20):1891-1892. Prigerson HG; Yale University, New Haven, CT.

PHYSICIAN RESOURCES

AMA Offers Tool to Assess Health Risks of Caregiving

Physicians who treat the terminally ill may find themselves increasingly involved with two patients in the future: the one who is dying and the caregiver at risk of becoming ill. According to the American Medical Association (AMA), the problem of distress-related illness is expected to increase as changes in health care delivery place ever greater reliance on family caregivers.

Caregiver stress heightens the risk of morbidity and mortality in this population, a situation the AMA says that both physicians and caregivers often ignore. To assist physicians in assessing the risk to caregivers, the AMA has developed a short Caregiver Self-Assessment Questionnaire, available online in both English and Spanish.

Designed to facilitate caregiver-physician discussions of the need for supportive services, the tool can be printed out for caregivers to complete during an office visit when accompanying a patient. Instructions are included on how to score and interpret the answers.

The tool consists of such “yes/no” statements as:

- Felt strained between work and family responsibilities
- Had sleep disturbed because of caring for my relative
- Felt a loss of privacy and/or personal time
- Felt ill (headaches, stomach problems, or common cold)
- Had back pain

Also included on the questionnaire is a list of resources for caregivers, including a national directory of local community services, as well as space for physicians to enter local resources and contacts.

To download: Go to www.ama-assn.org and search for “caregiver self-assessment.”

BOOK FOR CLINICIANS

Hospice and Palliative Care: Concepts and Practice, Second Edition

By Walter B. Forman, MD (editor), et al, this second edition provides both practical information and theoretical perspectives for health care professionals considering hospice as an appropriate care option for seriously ill patients.

Beginning with a historical overview of hospice and an explanation of how the hospice interdisciplinary team functions, the text covers common challenges and issues encountered by professionals providing hospice and palliative care.

Topics include:

- Eligibility and reimbursement
- Symptom management
- Death education
- Cultural concerns
- Ethical issues
- Support groups

Published by Jones & Bartlett, 2003; ISBN: 0763715662; 288 pp.

End-of-Life Care Websites

www.aahpm.org

American Academy of Hospice and Palliative Medicine

www.eperc.mcw.edu

End of Life/Palliative Education Resource Center (EPERC)

www.epec.net

The EPEC Project (Education on Palliative and End-of-Life Care)

www.nhpco.org

National Hospice & Palliative Care Organization

www.promotingexcellence.org

Promoting Excellence in End-of-Life Care

www.hospicefoundation.org

Hospice Foundation of America

www.americanhospice.org

American Hospice Foundation

www.hpna.org

Hospice and Palliative Nurses Association

www.medicaring.org

Center for Palliative Care Studies

www.abcd-caring.org

Americans for Better Care of the Dying

www.lastacts.org

Last Acts Coalition

www.mcw.edu/pallmed/

Palliative Medicine Program at the Medical College of Wisconsin

www.medsch.wisc.edu/painpolicy/

University of Wisconsin Pain and Policy Studies Group

www.capcmssm.org

Center to Advance Palliative Care

www.stoppain.org

Pain Medicine & Palliative Care, Beth Israel Medical Center

www.growthhouse.org

An online community for end-of-life care

www.partnershipforcaring.org

America's Voices for the Dying

End-of-Life Care Meetings for Clinicians

National Hospice and Palliative Care Organization 5th Clinical Team Conference. March 22-25, 2004, The Riviera Hotel, Las Vegas. Phone: 800-646-6460; Website: www.nhpco.org

Harvard Medical School Program in Palliative Care Education and Practice. April 27-May 4, 2004 and Nov. 10-16, 2004, Boston. Phone: 617-724-9509; Email: pallcare@partners.org; Website: www.hms.harvard.edu/cdi/pallcare/

23rd Annual Scientific Meeting of the American Pain Society and 4th Annual Pediatric Pain Forum. May 6-9, 2004, Vancouver, BC, Canada. Held jointly with the Canadian Pain Society. Phone: 847-375-4715; Fax: 877-734-8758; Email: info@ampainsoc.org; Website: www.ampainsoc.org

Third Research Forum of the European Association for Palliative Care. June 3-6, 2004, Stresa, Lago Maggiore, Italy. Phone: 39-02-3343281; Fax: 39-02-38006761; Email: mariagrazia.tacconi@effetti.it; Website: www.eapcnet.org/research2004/

15th International Congress on Care of the Terminally Ill. Sept. 18-22, 2004, Montreal, PQ, Canada. Sponsor: McGill University. Contact: Events International; Phone: 514-286-0855; Email: info@eventsintl.com

9th Congress of the European Association for Palliative Care. April 6-10, 2005, Aachen, Germany. Website: www.eapcnet.org/Aachen2005/index.html; Email: info@aahpm.org

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