

Quality of Life Matters®

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

Vol. 6, Issue 1 May/June/July 2004

Home Hospice Care Receives Highest Family Rating Among End-of-Life Care Sites

Families Report High Levels of Unmet Needs in Other Care Settings

A national study of family perspectives on end-of-life care has found overall high rates of unmet needs for symptom management, emotional support, physician communication, and respectful treatment among adults who are dying — especially among the 67% of Americans who die in institutional settings.

“Only bereaved family members whose loved one received home hospice services reported higher satisfaction and fewer unmet needs,” write the authors of a report published in the January 7, 2004, issue of the *Journal of the American Medical Association*.

Hospice care at home received the highest level of overall satisfaction rating, with 71% of respondents grading its care quality as “excellent.” Less than 50% gave that grade to nursing homes,

hospitals, or home health services.

Researchers interviewed family members of 1578 adults from 22 states who died of chronic illness in 2000. Respondents were asked to rate the quality of their loved one’s dying experience at the last place of care in which the patient spent more than 48 hours prior to death.

LAST PLACE OF CARE

- **INSTITUTION.** For 67% of patients, the last place of care was an institution, with 38.4% dying in a hospital and 30.5% in a nursing home.
- **HOME.** Of the 33% of patients dying at home, 49.3% had home hospice care, 38.2% received no formal services, and 12.5% had home health care nursing services, with no hospice participation.

QUALITY OF CARE

- **PAIN, DYSPNEA.** About 25% of all patients with pain or dyspnea did not receive “any” or “enough” treatment, respondents reported. **Inadequate pain management was 1.6 times more likely in a nursing home setting or with home health services and 1.2 times more likely in a hospital than with home hospice care.**
- **PHYSICIAN CONTACT.** Almost one-third of respondents wished for but did not have physician contact. This was 3.0 times more likely in a nursing home, 1.8 times more likely in a hospital, and 1.6 times more likely with home health services than with home hospice.

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\$1.2 Million Grant Boosts Establishment of Palliative Care as Recognized Specialty

The American Academy of Hospice and Palliative Medicine (AAHPM) will be advancing the establishment of palliative care as a recognized specialty in multiple disciplines, thanks to a \$1.2 million grant provided by the Project on Death in America (PDIA). The grant will also enable the AAHPM to establish a College of Palliative Care to promote research and education.

The PDIA, a ten-year initiative of the Open Society Institute of New York City, has distributed \$45 million in grant awards as it fulfilled its mission to transform the culture and experience of dying and bereavement in America.

As part of its exit strategy on December 31, 2003, the PDIA announced a number of final grants, with the largest awarded to the AAHPM in the belief that the academy will play a crucial role in advancing the development of palliative medicine and serve as the focal point for ongoing initiatives in interdisciplinary palliative care research, education, and practice.

For further information, visit www.aahpm.org.

Palliative Medicine Becomes 'Mainstream,' Creating Career Opportunities for Physicians

Palliative medicine is beginning to emerge more and more into the mainstream, as highlighted in an article in the January 26, 2004, issue of *American Medical News*, a publication of the American Medical Association.

"Today, growing awareness of the field, expanded fellowship opportunities, and full-time positions are mainstreaming the specialty as a more viable career choice for young doctors," states the article. "The field's growth has been driven by new knowledge and an increase in medicine's ability to relieve pain and suffering."

FELLOWSHIP OPPORTUNITIES

Nationwide Participation. The American

Academy of Hospice and Palliative Medicine (AAHPM) maintains a list of fellowship programs on its website (www.aahpm.org). The programs currently number about 45 and are sponsored by medical colleges, universities, medical centers, hospitals, hospices, and the Department of Veterans Affairs. As well, the National Hospice and Palliative Care Organization (NHPCO) has announced a jointly-funded program to support new fellowships in palliative care, to be coordinated by the AAHPM.

A GROWING SPECIALTY

Physicians Certified. More than 1530 physicians have been certified as specialists in palliative care by the American

Board of Hospice and Palliative Medicine (ABHPM) since its formation in 1995.

Hospital-Based Programs. There are more than 800 hospital-based palliative care programs today, compared with virtually none just five years ago, says the Center to Advance Palliative Care, based at Mount Sinai School of Medicine.

15% Increase in Hospice Patients Served. The NHPCO reports that 885,000 dying Americans were served by 3200 hospice providers in 2002, an increase of nearly 15% over those cared for in 2001. Such numbers are expected to grow as the U.S. faces a demographic shift in the number of older patients requiring care.

Visit: www.aahpm.org, www.nhpco.org, www.abhpm.org, and www.capcmssm.org.

Home Hospice Care Receives Highest Rating (from Page 1)

Public Policy Recommendations

✓ Increased Access to Hospice Services, Both in Home and Institutional Settings

- Statewide efforts to encourage timely referrals to hospice
- Federal review of financial barriers to hospice referrals in nursing homes

✓ Continued Growth in Field of Palliative Medicine

- Palliative specialists on the faculty of every medical school
- Curricula addressing pain management and end-of-life care

✓ Improved End-of-Life Care in Nursing Homes

- Congressional attention to the nursing home challenges of caring for sicker residents while managing staffing shortages and a high rate of staff turnover in wake of federal funding cuts

✓ Annual Reports to Congress and the President

- Ongoing national mortality surveys on the quality of care of the dying to be conducted by the National Center for Health Statistics

— Teno, Clarridge, Casey, et al
Journal of the American Medical Association

- **EMOTIONAL SUPPORT.** Half of patients did not receive any or enough emotional support. This was 2.7 times more likely with home health care and 1.3 times more likely in an institutional setting. About 35% of respondents said the family did not receive enough emotional support. This was about 1.5 times more likely to be the case in all other settings than in home hospice.
- **LACK OF RESPECT.** 21% reported that the dying person was not always treated with respect. Compared with hospice, this was 3.0 times higher in a hospital, 2.9 times higher with home nursing services, and 2.6 times higher in a nursing home.

"Blaming the nursing home industry is not the answer," cautions lead author Joan Teno, MD, of Brown Medical School, Brown University. "Nursing homes have been faced with substantial cuts in federal funding and increased care management challenges."

Teno and colleagues recommend a number of public policy initiatives [See sidebar, left], including **statewide efforts to encourage more timely referrals to hospice care.**

[Note: Hospice care provided in institutions was not measured within the methodology of this study.]

Source: "Family Perspectives on End-of-Life Care at the Last Place of Care," Journal of the American Medical Association; January 7, 2004; 291(1):88-93. Teno JM, Clarridge BR, Casey V, et al; Brown Medical School and Department of Community Health, Brown University, Providence, RI; Center for Survey Research, University of Massachusetts at Boston.

Physicians 'Have Much to Offer and Much to Gain' by Supporting Caregivers at the End of Life

By providing support to both members of the interdependent patient-caregiver unit, physicians have opportunities to benefit all parties concerned, experts say. "In caring well for family caregivers at the end of life, physicians may not only improve the experiences of patients and family, but also find greater sustenance and meaning in their own work," write the authors of an article published in the January 28, 2004, issue of the *Journal of the American Medical Association*.

The article alerts physicians to the burdens experienced by family caregivers at the end of life and identifies ways in which physicians can approach the goal of providing comprehensive patient care by giving "important and perhaps even life-sustaining support to family caregivers."

Among the authors' suggestions are:

RECOGNIZING BURDENS OF FAMILY CAREGIVING

"Family caregiving is typically at the core of what sustains patients at the end of life."

In addition to being at risk of physical injury from moving or lifting seriously ill adults, caregivers often neglect their own health, curtail their usual activities, and place themselves at significant risk of illness and mental health morbidity. Physicians can:

- Assess family caregivers with a simple screening question. "How is the caregiving going for you?" Or, "How is everything with the family?"
- Evaluate vulnerable caregivers for their ability to continue care without risking their own health.
- Refer caregivers who are overwhelmed to their own physicians and to community support services.

COMMUNICATING WELL

"Families want to know that their loved one's physician is comfortable talking about death and dying."

Timely and clear medical information is a necessity for family caregivers. Physicians can:

- Explain the role and benefits of hospice care.
- Provide data on the efficacy of clinical interventions, the process of initiating or withdrawing life support, and the meaning of a do-not-resuscitate order.

ASSISTING WITH DECISION MAKING

"Advance care planning is...an ongoing process and an opportunity to engage with patients and families."

As an essential component of end-of-life care, advance care planning includes not only the preparation of legal documents

or appointment of a health care proxy, but also the opportunity to explore and identify patient values, preferences of care, and wishes regarding after-death issues. Discussions with patients, appointed surrogates, and/or family members should be initiated early in the patient's illness.

'...hospice was associated with a significant reduction in the risk of death of the hospice patient's bereaved spouse, even when hospice was used only for 3 to 4 weeks.'

— Rabow, Hauser, Adams
Journal of the American Medical Association,
citing a large population-based
sample of elderly persons

ACKNOWLEDGING BEREAVEMENT

"Research suggests that the caregiving experiences of family members influence their adjustment to the patient's eventual death."

Physicians are urged to continue their support of family members into the bereavement period. Physicians can:

- Send a letter of condolence, make a condolence phone call or visit, or attend the funeral. These actions are highly valued by families.
- Normalize the family member's feeling of grief, working in conjunction with an interdisciplinary team; recommend behavioral interventions.
- Alert the bereaved person to potential outbreaks of intense grief around dates of personal significance. Monitor or refer for clinical depression.

Physicians may discover that they also benefit from the experience of supporting family caregivers, add the authors. "The appreciation and well-being of family caregivers may help sustain physicians," they write.

"If dying is, at least in some measure, 'what the family remembers,' then physicians have a fundamental opportunity to support the profound experiences of family caregivers," conclude the authors. "In being of service to this legacy, physicians may foster healing and dignity at the close of life."

Source: "Supporting Family Caregivers at the End of Life: 'They Don't Know What They Don't Know,'" Journal of the American Medical Association; January 28, 2004; 291(4):483-491. Rabow MW, Hauser JM, Adams J; Department of Medicine, University of California, San Francisco, and Center for Caregiver Training, San Francisco; Buehler Center on Aging, Palliative Care and Home Hospice Program, Department of Medicine, Feinberg School of Medicine, Northwestern University, Chicago.

Aggressiveness of End-Stage Cancer Treatments Increasing; Palliative Care Encouraged

Lower Rate of Aggressive Care Found Related to Hospice Availability

A growing proportion of cancer patients are receiving aggressive treatment near the end of life, and these interventions are occurring increasingly closer to death, a team of Boston researchers has found.

“Whether such [aggressive] care has positive effects on survival or quality of life is questionable and deserves additional investigation,” write the authors of a study published in the January 15, 2004, issue of the *Journal of Clinical Oncology*.

The team found that terminally ill cancer patients who live in areas of higher hospice density are less likely than others to experience aggressive care near the end of life.

“Interestingly, the findings suggest that the availability of hospice services and related medical resources may reduce the chance that a patient will receive aggressive treatment at the end of life,” comments lead author Craig Earle, MD, of the Dana-Farber Cancer Institute. **“Increasing the availability of hospice may improve the quality of care for many terminally ill patients.”**

The researchers analyzed data on 28,777 Medicare patients (aged 65 years and older) who died within one year of diagnosis of lung, breast, colorectal, or other gastrointestinal cancer between 1993 and 1996. All subjects had resided in one of 11

regions monitored by the National Cancer Institute’s Surveillance, Epidemiology, and End Results program.

KEY STUDY FINDINGS INCLUDE:

- The use of chemotherapy among these patients increased from 27.9% to 29.5% during the 4-year period.
- Among patients being treated with chemotherapy, the proportion of those receiving chemotherapy within 2 weeks of death increased from 13.8% in 1993 to 18.5% in 1996.
- Increasing proportions of patients in their last month of life were treated more than once in an emergency department (from 7.2% in 1993 to 9.2% in 1996), hospitalized (7.8% to 9.1%), or admitted to an intensive care unit (7.1% to 9.4%).

“This study is the first to indicate that the treatment of advanced cancer patients is becoming increasingly aggressive and that aggressive treatment is continuing later in life,” the authors write. “Although the absolute changes observed from year to year were small, the relative changes were remarkable and the trends were consistent.”

OPPOSING TRENDS OBSERVED INCLUDE:

- More patients used hospice services (from 28.3% in 1993 to 38.8% in 1996).
- Fewer patients died in acute-care hospitals (from 32.9% down to 29.5%).

However, the proportion of patients admitted to hospice within 3 days of death increased during the same period from 14.3% to 17%. **“This suggests that hospice is being used in these cases to manage death itself, rather than palliating the disease.”**

FINDINGS UNCHANGED OVER TIME INCLUDE:

- Patients treated with chemotherapy were more likely to die in the hospital than those not receiving chemotherapy (34.9% vs. 29%).
- Chemotherapy patients eventually admitted to hospice were enrolled closer to death than other cancer patients (26.6 days vs. 35.2 days).

MORE KEY FINDINGS:

Predictors of the likelihood of receiving aggressive care near death included care in a teaching hospital (among nonblack patients only; black patients were more likely to receive ag-

Excerpts from the

STATEMENT on PALLIATIVE CARE

Issued in 1998 by the

American Society of Clinical Oncology

“ASCO believes that it is the oncologist’s responsibility to care for their patients in a continuum that extends from the moment of diagnosis throughout the course of the illness. In addition to appropriate anticancer treatment, this includes **symptom control and psychosocial support during all phases of care, including those during the last phase of life.**”

So that all patients and families have access to optimal end-of-life care, the society states: “ASCO firmly believes it is essential to emphasize a humane system of cancer care,” based on several principles, including:

- “Cancer care optimizes quality of life throughout the course of an illness through meticulous attention to the myriad physical, spiritual, and psychosocial needs of the patient and family.”

— Source: www.asco.org

Continued on Page 5

Interns Look to Attending Physicians As Role Models in End-of-Life Care

Interns believe that the most effective format for learning end-of-life care skills is the observation of attending physicians' discussions with dying patients and their families, a recent study has found. However, 34% of interns rate the performance of attending physicians as role models in these skills as "poor" to "mediocre."

"The results of this study make education of attending physicians about end-of-life care a high priority for effective house staff education," comment the authors of a report published in the December 2003 issue of the *Journal of Palliative Medicine*.

Further, although more than half (58%) of interns rated their comfort level in discussing end-of-life issues with patients and/or families as good or very good, only 16% reported talking to patients about psychological issues surrounding dying, and 60% evaluated the emotional support they provided to ease the dying experience as "none" or "minimal."

Researchers interviewed 38 internal medicine interns at two major New York City teaching hospitals. Participants were the primary house officers of 50 patients who died between January and April of 2000. All interns had cared for the dying

Interns consider attending physicians to be good role models in end-of-life care when they:

- Show compassion toward the patient and family
- Take a proactive role in dealing with patient and family concerns
- Teach aspects of palliative medicine to the house staff.

— Rhodes-Kropf, Meier, et al
Journal of Palliative Medicine

patients a mean of 4 to 7 days.

Direct observation of attending physicians' interactions with patients and families was rated highest (4.45 on a 5-point scale) as an effective way to improve intern skills in caring for dying patients, followed by talking with a palliative medicine consult team (3.86) and discussion of specific cases during attending teaching rounds (3.76).

FINDINGS INCLUDE:

- 36% of attending physicians did not discuss pain management or symptom control with primary care interns.
- 46% never discussed do-not-resuscitate orders with interns.

- 60% did not discuss discharge planning, such as home hospice or inpatient hospice care.
- 60% of attending physicians never shared personal thoughts about the death and dying of an intern's patient.
- 70% never addressed the patient's psychological, spiritual, or cultural concerns in discussions with interns.
- 10% discussed no aspects of patient care at all with interns.

The authors note that interns often mentioned the difficulty they experienced in the lack of "closure" following the death of a patient. "Housestaff would benefit from the implementation of a formal support system and encouragement of attending physicians to facilitate debriefing sessions after patient deaths," they write.

Because the study showed that interns place high value on observing the interactions of attending physicians with dying patients and their families, "attending physicians should make an effort to include interns in these important discussions," the authors recommend.

Source: "Interns Learning to Care for Dying Patients," *Journal of Palliative Medicine*; December 2003; 6(6):865-872. Rhodes-Kropf J, Meier D, et al; Albert Einstein College of Medicine, Bronx, NY; Mount Sinai School of Medicine and Cornell University Medical Center, New York City.

Aggressive Treatment (from Page 4)

aggressive treatment in nonteaching hospitals); comorbidity; and higher density of teaching hospitals.

FACTORS LINKED TO LESS AGGRESSIVE TREATMENT:

- Female sex
- Greater local availability of hospice services
- Older age

The authors note that, since the end of their study, such professional organizations as the American Society of Clinical Oncology have issued policy statements emphasizing the impor-

tance of palliative and end-of-life care. [See sidebar, Page 4.] Hence, further monitoring of trends in aggressiveness of cancer care near the end of life is warranted.

"There is a growing need for policymakers to reframe the Medicare hospice benefit to make combined cancer treatment and hospice care financially feasible, to allow patients to have access to potentially beneficial treatments for their cancer without sacrificing excellent end-of-life care," the authors conclude.

Source: "Trends in the Aggressiveness of Cancer Care Near the End of Life," *Journal of Clinical Oncology*; January 15, 2004; 22(2):315-321. Earle CC, Neville BA, Landrum MB, Ayanian JZ, Block SD, Weeks JC; Department of Medical Oncology, Dana-Farber Cancer Institute; Department of Health Care Policy, Harvard Medical School; and Division of General Medicine and Department of Psychiatry, Brigham & Women's Hospital, Boston.

PHYSICIAN RESOURCES

Physicians Urged to Begin Process of Advance Care Planning *Before* Onset of Crisis

Advance directives are considered the cornerstone of advance care planning. But for a patient struggling with acute illness, discussing care preferences for a living will or the designation of a surrogate “is easier if it takes place within a previous discussion of the goals of treatment.”

That is according to a paper published in the January 1, 2004, issue of *The New England Journal of Medicine*. Advance care planning “is a process that begins with physicians helping their patients to articulate and prioritize their goals of care,” writes Muriel R. Gillick, MD, associate professor of medicine, Harvard Medical School, Boston.

“If physicians take seriously their obligation to engage patients in decisions about their health care, they will initiate discussions of goals and preferences before a crisis develops,” she states.

The U.S. Supreme Court, in the 1990 decision in *Cruzan v. Director, Missouri Department of Health*, upheld the right of patients to self-determination. But in order to exercise this right, patients must be informed of the implications of their choices to accept or reject medical treatment, Gillick notes.

“Only if patients know the benefits and burdens of treatment alternatives can they effectively exercise their autonomy, and only if patients engage in advance care planning can they hope to maintain their autonomy, should they become incapable of making decisions,” writes Gillick.

However, only 15% to 20% of American adults have a written directive, notes Gillick. Further, the *Cruzan* decision also upheld the right of individual states to determine the standards of evidence required for treatment limitation. Thus, although all 50 states and the District of Columbia have passed legislation on advance directives, the majority of states place restrictions on surrogate decision making.

“Like other types of preventive medicine, advance directives are underutilized — even though they are cheap, low-tech, and potentially highly effective,” asserts Gillick, who is also associate director of the Geriatrics Fellowship Program at Harvard Medical School.

“Once [physicians] begin the conversation, advising the patients to appoint a health care proxy and determining the scope of that person’s authority will follow naturally,” says Gillick. “And that is all that physicians need to do — the idiosyncrasies of state law notwithstanding — to enable their patients to be treated in accordance with their wishes.”

[See sidebar, right, for online advance directive documents.]

STATE-SPECIFIC ADVANCE DIRECTIVES, INSTRUCTIONS AVAILABLE ONLINE

Go to www.partnershipforcaring.org

Downloadable living will and medical power of attorney documents for all 50 states and the District of Columbia are available at the website of Partnership for Caring: America’s Voices for the Dying, a national nonprofit organization dedicated to improving how our society cares for dying people and their loved ones.

Each state-specific document packet is offered together with pertinent instructions and recommendations for completing the advance directives (ADs), to insure that patients indicate clearly the end-of-life medical care they desire within current state regulations.

DOWNLOADABLE INSTRUCTIONS INCLUDE:

- When and under what circumstances each AD becomes effective
- How to make it legal
- Whether one may or should add additional instructions
- How to change an AD

TOLL-FREE HOTLINE: 800-989-9455

Partnership for Caring also maintains a national toll-free hotline (800-989-9455) to answer questions about ADs and to counsel patients and families struggling to deal with end-of-life issues. The hotline is staffed for emergency calls on a 24-hour basis. Issues commonly addressed include:

- How to discuss death with one’s family
- How to ensure that one’s physician provides adequate pain management
- What care questions to ask a loved one’s physician

ADDITIONAL RESOURCES

Additional resources that can be downloaded or printed for the use of patients and families include fact sheets on end-of-life care and a booklet entitled, “Talking About Your Choices.” Topics covered in the booklet include: talking with your doctor or your health care agent; acting as a health care agent; understanding life-support measures; and learning about pain management. The booklet also contains a glossary of terms and a list of resources for patients and families.

— Source: www.partnershipforcaring.org

PHYSICIAN RESOURCES

BOOKS FOR CLINICIANS

Pocket Guide to Hospice/Palliative Medicine

Developed by the American Academy of Hospice and Palliative Medicine, this practical guide is designed for residents and practicing physicians who are not experts in end-of-life care. Measuring 5 by 7 inches, the book can also serve as a quick reference for experienced palliative care clinicians.

The indexed work addresses the major aspects of palliative care, providing specific information on interventions aimed at improving the patient's quality of life, especially at the end of life. It offers symptom and psychological assessment tools, tables providing key clinical information, and an index to analgesic drugs.

Sections include:

- The Palliative Medicine Approach to End-of-Life Care
- Alleviation of Psychological and Spiritual Pain
- Assessment and Management of Pain
- Management of Nonpain Symptoms
- Communication and the Physician's Role on an Interdisciplinary Team
- Ethical and Legal Decision Making
- The Hospice/Palliative Medicine Approach to Caring for Patients with HIV/AIDS
- The Hospice/Palliative Medicine Approach to Caring for Pediatric Patients

Visit www.aahpm.org/bookstore

Cancer Pain: Assessment and Management

By Eduardo D. Bruera, MD (Editor), and Russell K. Portenoy, MD (Editor), this comprehensive book provides the physician with both clinically-oriented and scholarly information on all aspects of cancer pain — its pathophysiology, prevalence, clinical assessment, and pharmacological and nonpharmacological treatment approaches.

Contributors include experts in pain management across a wide range of disciplines. Obstacles to pain management among special populations (children, the elderly, and chemically-dependent patients) are addressed, as are the concerns that may prevent physicians from providing appropriate interventions.

Chapter titles include:

- Cancer Pain: Prevalence and Undertreatment
- Multidimensional Assessment: Pain and Palliative Care
- Opioid Side Effects and Management
- Cancer Pain and Depression
- Breakthrough Pain
- Understanding Clinical Trials in Pain Research
- Legal and Regulatory Aspects of Opioid Treatment: the U.S. Experience
- Role of Family Caregivers in Cancer Pain Management

Published by Cambridge University Press, 2003; ISBN: 0521773326 (hardcover); 500 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.epeconline.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

Accessing Pain Management: Effective Policy, Practice And Action — 15th Annual Meeting of the American Alliance of Cancer Pain Initiatives. June 17-19, 2004, Hyatt Regency, New Brunswick, NJ. Contact: Lorre Kolb; Phone: 608-265-4013; Email: ljkolb@wisc.edu; Website: www.aacpi.wisc.edu/mtg15.htm

15th International Congress on Care of the Terminally Ill. September 19-23, 2004, Palais des Congrès de Montréal, Montréal, Québec, Canada. Sponsor: McGill University; Phone: 514-286-0855; Email: pal2004@eventsintl.com; Website: www.eventsintl.com/pal2004

Pain: Advances in Research and Clinical Practice — 3rd World Congress of the World Institute of Pain. September 21-25, 2004, Barcelona, Spain. Contact: Meet2 Ltd., Organizing Secretariat, P.O. Box 14264, Barcelona 08080, Spain; Phone: +34 93 212-6520; Fax: +34 93 417-2279; Email: wipcongress@meet2.net; Website: www.wipain.org

Children's Hospice International 16th World Congress: Completing the Circle of Care. September 26-29, 2004, Carlton Hotel, Edinburgh, Scotland. Contact: CHI, 901 North Pitt St., Suite 230, Alexandria, VA 22314; Phone: 800-2-4-CHILD; Email: info@chionline.org; Website: http://www.chionline.org/events/world_congress_16th.phtml

Annual Assembly of the American Academy of Hospice and Palliative Medicine and the Hospice and Palliative Nurses Association. January 19-23, 2005, New Orleans. Phone: 847-375-4712; Fax: 877-734-8671; Email: info@aahpm.org; Website: www.aahpm.org

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Like you, we're passionate about hospice care!

Quality of Life Publishing Co. specializes in clinical and grief support publications for hospices and other end-of-life care organizations. Members of the National Hospice & Palliative Care Organization since 1999, we work closely with the American Academy of Hospice and Palliative Medicine and the Hospice and Palliative Nurses Association.

QUALITY OF LIFE MATTERS®

Now in its sixth year of publication, Quality of Life Matters is a periodical dedicated solely to end-of-life care news and clinical findings. It is researched and written by professional medical journalists who specialize in covering palliative care issues. Quality of Life Matters is an independent publication; it is not affiliated with any health care organization or company. The quarterly newsletter is published by Quality of Life Publishing Co., a firm dedicated to easing the way for patients with life-limiting illnesses and their families.

We customize copies of the newsletter for hospices and other organizations to provide as an educational service for their local clinicians. For information and rates:

TOLL FREE in U.S. and CANADA:

1-877-513-0099

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www.QoLpublishing.com

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