

Quality of Life Matters®

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

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Cardiovascular Disease, Dementia, Stroke: Hospice Diagnoses Extend Beyond Cancer

Almost Half of the 885,000 Patients Served by Hospice in 2002 Had Non-Cancer Diagnoses

A report released by the National Hospice and Palliative Care Organization (NHPCO) in July 2003 shows that not only is the use of hospice care rising significantly in the U.S., but the percentage of hospice patients with non-cancer diagnoses is also steadily increasing.

In 2002, more than 885,000 Americans received hospice care, a jump of almost 15% above the estimated 775,000 patients served in 2001, according to statistics reported in the 2002 NHPCO National Data Set Summary Report.

Noting that there is a misconception that hospice serves only aging cancer patients, the NHPCO points out that “hospice services can benefit patients

at any age and with any life-limiting condition.”

The report’s findings on diagnoses at admission include:

- **Cardiovascular disease** represented 10.7% of patient diagnoses in 2002, up from 9.8% in 2001.
- **Dementia** was the diagnosis of 8.3% of patients in 2002, vs. 7% in 2001 and 5.5% in 2000.
- **Lung, kidney, and liver disease** represented a respective 6.7%, 2.9%, and 1.6% of patient diagnoses in 2002.
- **Other diagnoses** included stroke and/or coma (4.1% of patients) and motorneuron disorders (2.4%).

Of all patients served by hospice in 2002, 49.5% had non-cancer diagnoses at admission, compared with 46.7% in 2001 and 38.7% in 2000.

“Hospice care providers are becoming more accomplished at serving persons facing a wide range of serious illnesses,” the NHPCO says.

“Research has consistently shown that almost 80% of Americans — if facing a life-limiting illness — would prefer to remain in their homes, free of pain, surrounded by loved ones,” adds J. Donald Schumacher, Psy.D., president and CEO of NHPCO. “Hospice makes this happen. It’s important that people understand that hospice focuses on living fully up until the end of life.”

For information: www.nhpco.org

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Tube Feeding Offers No Survival Benefit in Patients with Advanced Dementia

Second Study Finds 34% of Such Patients in Nursing Homes Have Feeding Tubes

Despite its increasing use, there is no survival benefit to support artificial feeding by percutaneous endoscopic gastrostomy (PEG) tube placement in patients with severe dementia.

That is the finding of a study conducted by a team of clinician-researchers from the Veterans Affairs Medical Center, Washington, D.C. Further, artificial nutrition in this patient population has been associated with increased health risks and discomfort, state the authors in their report published in the June 9, 2003, issue of the *Archives of Internal Medicine*.

In a second recent study on tube feeding [see box, Page 2], New England researchers have found that 34% of U.S. nursing home residents with advanced

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Tube Feeding Offers No Survival Benefit *(from Page 1)*

dementia have feeding tubes.

The Washington, D.C., investigators compared survival in two groups of equivalent patients referred to them for PEG consultation over a two-year period. All 41 patients had advanced dementia, and all met the facility's medical criteria for PEG tube placement. PEG was performed in 23 patients; the procedure was refused by surrogates or was precluded by advance directives in the other 18 patients.

The study found that among those patients who underwent PEG tube placement, median survival was 59 days (range, 2 to 365 days). Median survival for those patients who did not receive tube placement was 60 days (range, 2 to 229 days). In survival curve analysis, no statistically significant difference in survival between the two groups was found.

“Hospice literature suggests that avoiding artificial nutrition and allowing the patient to consume food ad lib may enhance comfort.”

“In patients with advanced dementia and dysphagia, placement of a PEG tube neither enhances survival nor prevents death by starvation,” write the authors.

“We need to separate the need for the nurturing aspect of food from the provision of artificial nutrition.”

Previous research has established little health benefit from PEG tube feeding in patients with dementia in any variable studied, note the authors, and “the evidence against PEG tube placement for artificial feeding in patients with dementia is substantial.”

No demonstrable health benefit from artificial feeding in dementia patients has been found for: aspiration pneumonia, nutrition status, pressure sores, functional status, patient comfort, or survival. Further, state the authors, **the provision of artificial nutrition has been associated with an increased risk for pressure sores, due to possible increase in incontinence and/or the use of restraint to prevent extubation.**

“Surrogate decision-makers are often presented with a bleak choice — agree to PEG or ‘let your loved one starve to death,’” write the authors. But not only is tube feeding not the lesser of two evils (i.e., tube feeding or no feeding) it is not the only alternative to no feeding, they note. “Hospice literature suggests that avoiding artificial nutrition and allowing the patient to consume food ad lib may enhance comfort.”

Source: “Percutaneous Endoscopic Gastrostomy Does Not Prolong Survival in Patients With Dementia,” Archives of Internal Medicine; June 9, 2003; 163:1351-1353. Murphy LM, Lipman TO; Veterans Affairs Medical Center, Washington, DC.

34% of Nursing Home Residents with Advanced Dementia Have Feeding Tubes

A nationwide study has found that not only is feeding tube placement prevalent among nursing home residents with advanced dementia, but also that institutional factors influence the use of this intervention.

“The aggressiveness of care provided at the end of life is increasingly recognized to be determined by more than the preferences and needs of individual patients,” write the authors of a report published in the July 2, 2003, issue of the *Journal of the American Medical Association*. “This study confirms that feeding tube use among older persons with advanced cognitive impairment varies depending on the characteristics of the nursing home in which they reside.”

The researchers assessed data on patients with advanced dementia (n=186,835) and the licensed nursing homes (n=15,135) in which they lived during the first part of 1999.

More than a third (33.8%) of severely cognitively impaired residents had feeding tubes, although the data did not specify which type of tube was used. Both patient and facility profile characteristics were found to be independently associated with a greater likelihood of feeding tube use.

Advanced dementia patients who were more likely to have feeding tubes were nonwhite, younger, male, without an advance directive, and diagnosed with stroke.

Patients were more likely to have feeding tubes if they resided in nursing homes within an urban location, with no special dementia unit, more than 100 beds, a smaller proportion of residents with do-not-resuscitate orders, a higher prevalence of nonwhite residents, and no nurse practitioner or physician assistant on staff.

“Empiric data and expert opinion suggest that use of feeding tubes is not beneficial for older persons with advanced dementia,” write the authors. **“We identified several potentially modifiable factors at the facility level that may reduce feeding tube use, including greater use of advance directives, having a nurse practitioner or physician assistant on staff, and having a special dementia care unit.”**

Source: “Clinical and Organizational Factors Associated With Feeding Tube Use Among Nursing Home Residents With Advanced Cognitive Impairment; Journal of the American Medical Association; July 2, 2003; 290:73-80. Mitchell SL, Teno JM, et al; Harvard Medical School, Boston; Brown Medical School, Providence, RI.

Physicians Offered Practical Tool for Prognostic Disclosure

Experts Address the 'Science of Prognosis' and the 'Art of Prognostic Disclosure'

Among the most difficult tasks faced by physicians are the prediction of survival and the disclosure of that prediction to patients with terminal illness, says a team of experts in oncology and palliative care.

Helping patients to understand the life-limiting nature of their illness and the likely duration of their remaining time is critically important for quality end-of-life experiences, emphasize the authors of an article published in the *Journal of the American Medical Association*.

"Such efforts should be regarded as at least as important as the fundamental therapeutic tasks of pain and symptom management and may well be as professionally rewarding," the authors say. "Patients use this information... as a way to make informed decisions about which medical therapies to pursue and when to put their personal affairs in order."

The article includes suggestions for estimating survival accurately, discussion of an algorithm for delivering a prognosis, and a list of sources of information on end-of-life care.

"Patients with terminal illness want their physicians to be honest about the severity of their illness, but also want physicians to be optimistic," they add.

The disclosure algorithm the authors present [*see box, right*] is a summary of tasks they and other clinicians believe are important, based on what patients have said they want and need in order to make informed decisions about how to spend their remaining time.

Source: "Complexities in Prognostication in Advanced Cancer: To Help Them Live Their Lives the Way They Want to," Journal of the American Medical Association; July 2, 2003; 290(1):98-104. Lamont EB, Christakis NA; Department of Medicine and the Cancer Research Center, University of Chicago; Harvard Medical School and Massachusetts General Hospital, Boston.

Helpful Approach to Delivering a Prognosis

1. PREPARATION

Research the patient's condition to determine therapeutic considerations (both life-prolonging and palliative) and expected survival (both with and without therapy).

Alert the patient ahead of time. *"The next time we meet, we'll be discussing significant test results about your illness. I think it's essential to bring along someone who is important to you."*

Set the scene. Arrange for a private meeting place with no interruptions, and allow plenty of time for questions.

Establish how the patient is feeling. Identify symptoms that can be focused on later in a discussion of palliative therapies. Establish current performance status. *"First, I'd like to know how you are feeling right now." "Do you have any pain or other symptoms?" "How are you spending your days?" "How much of the day do you spend in bed or on the couch?"*

Establish the patient's understanding of the illness and expectations of you. *"I wonder what your current understanding of your illness is and what you hope we can do for you."*

Determine what the patient wishes to know about the illness. *"Some people want to know everything possible about their illness and others prefer to know very little. How much about your illness do you want to know from me today?"*

2. CONTENT

Tell the patient you have bad news. *"I'm sorry to say I have bad news to share."*

State the news clearly, simply, and sensitively. *"It appears that the cancer has spread to your bones, which means that it is no longer curable."*

Make optimistic statements that are truthful. *"I am very hopeful that with medicine we can control your bone pain."*

Anchor the survival estimate in published data for similar patients, disclosing the median survival and interquartile range. *"On average, patients with stage IV gastric cancer live 4 months. One quarter of patients will live 1.5 months or less and one quarter live 8 months or more. While I do not know for sure where you are in that group, the fact that you are feeling so poorly right now and in bed most of the time makes me concerned that you may not live longer than the average 4 months."*

3. PATIENT'S RESPONSE

Acknowledge the patient's response and express empathy. *"I can tell how very difficult it is for you to hear this bad news."*

Assure the patient you will remain involved in their medical care. Emphasize that forgoing chemotherapy does not create a therapeutic void. *"Although we can't cure or shrink your cancer with chemotherapy, we can certainly continue to take care of you and treat you for any symptoms the cancer may cause. There is always something we can do to help you."*

4. CLOSING

Summarize the new information sensitively. **Make a short-term plan** to assuage any fears that "nothing more can be done." *"What we have discussed is..." "What I recommend we do next is..."*

Arrange for a follow-up visit as a concrete example of your commitment, even if the patient is being referred to hospice.

Offer to discuss the news with anyone important to the patient who is not present.

Provide a means for the patient to contact you or your team in an emergency.

— Lamont and Christakis
Journal of the American Medical Association

RESEARCH MONITOR

Unique Concerns of ALS Patients Influence Quality of Life

Researchers Recommend Timely Referral to Hospice

As their disease progresses, patients diagnosed with amyotrophic lateral sclerosis (ALS) experience increasing deterioration in physical function, which inevitably affects the quality of their lives. These functional impairments influence patients' quality of life in psychosocial areas, say researchers, creating concerns that health care professionals need to address.

"[ALS] patients face increasing limb weakness, breathing difficulties, and bulbar (speech, swallowing) impairment that frequently lead to dependence on others, changes in lifestyle, and alterations in the nature of relationships with family and friends," comment the authors in their report in the *Journal of Palliative Medicine*.

The team analyzed the questionnaire responses of 100 consecutive patients (mean age, 58.2 years) enrolled in the ALS clinic at Baylor College of Medicine, Houston. All patients had a diagnosis of definite or probable ALS (mean disease duration, 1.9 years); none was ventilator dependent.

Although more than three-quarters of patients reported that supportive relationships with family and friends helped them to

Nonmedical factors influencing quality of life "need to be identified and discussed with patients and families throughout the illness."

cope with their disease, patients also experienced deterioration in those close relationships as their disease progressed.

As changes in their speech increasingly caused communication difficulties, patients experienced declines in relationship quality. Increasing loss of mobility and physical dependence on others compounded relationship stress. These factors often led to misunderstandings, role reversals, and mutual avoidance in social interactions.

Patients also reported mood changes, anger, sadness, and frustration.

ALS patients and their families would benefit from supportive help before their stresses become overwhelming, note the authors. **"Timely referrals are recommended to community agencies, to members of the clergy, to appropriate mental health professionals, and to hospice organizations."**

Source: "Quality of Life in Patients with Amyotrophic Lateral Sclerosis: Perceptions, Coping Resources, and Illness Characteristics;" Journal of Palliative Medicine; June 2003; 6(3):417-424. Nelson ND, Trail M, et al; Department of Neurology, Baylor College of Medicine and Neurology Care Line, VA Medical Center, Houston.

Hospice Patients More Realistic About Their Disease Course

While more than half of hospice patients with advanced cancer feel that death is the most likely outcome — with only 16% believing in improvement or cure — fully 36% of their nonhospice counterparts with a comparable prognosis believe that their disease can be cured or improved, according to a team of researchers in Tampa, Florida.

The percentage of patients comprehending that the course of their illness would result in progression or death was found to be highest among hospice patients who had been informed of their poor prognosis, and lowest among those nonhospice patients who said they were not told of their poor prognosis.

More than 90% of study patients who said they had been informed of their limited life expectancy rated their dealing with this information as either "well" or "fair," researchers note. "What may be surprising to some is that, contrary to common concerns, patients' reactions to their poor prognosis were generally managed well in this study," write the authors in the *Journal of the American Geriatrics Society*.

"Patients' perceptions regarding their disease course should be determined and corrected if needed, for patients and families to make informed and appropriate decisions."

The team analyzed data from interviews conducted with 234 patients diagnosed with advanced lung, breast, prostate, or colon cancer. All participants had a life expectancy of less than 1 year, and most of the 213 study participants for whom survival data was available died within 1 year.

More than half (58%) of patients reported being first told about hospice by a health care professional, most often by a physician (40%). Only 30% of nonhospice patients reported that hospice care had ever been considered for them.

"Hospice care has the potential of offering quality end-of-life care while reducing medical costs," the authors note. Through the communication of accurate prognoses, better understanding of patient preferences, and the identification of those patients in need (for example, those with limited caregiver support), the medical community can increase access to available hospice services.

Source: "Decisions for Hospice Care in Patients with Advanced Cancer," Journal of the American Geriatrics Society; June 2003; 51(6):789-797. Chen H, Haley WE, Robinson BE, Schonwetter RS; Department of Gerontology and Division of Geriatric Medicine, Department of Internal Medicine, University of South Florida College of Medicine, and LifePath Hospice and Palliative Care, Inc., Tampa, Florida.

RESEARCH MONITOR

Physicians Urged to 'Bridge the Gap' Between Patient and Medical Points of View

Providing quality medical care for patients with life-limiting illness requires a care plan addressing the needs of patients and their caregivers. But uniting patient and physician points of view is not always easy, acknowledge the authors

of a recent study.

To "bridge the gap" between patient/caregiver and clinician concerns, physicians can develop patient-centered relationships with seriously ill patients and their families, suggest the authors, in their

report published in the *Journal of Palliative Medicine*.

The researchers conducted interviews with family practice physicians and the patients and caregivers from the physicians' clinical practice who were facing the end of life. Issues and expectations of importance to participants in each group were identified.

Patients and caregivers focused on:

- The awareness of mortality
- Managing demands of illness and the ongoing needs of daily living
- Maintaining and adapting relationships
- Physical discomfort, personal suffering, and loss
- Personal and spiritual growth

Physicians stressed the importance of:

- Developing a common understanding of diagnosis and prognosis
- Treating the disease; developing specific goals and a treatment plan
- Delivering technically competent medical care
- Respecting patient autonomy

Based on their findings, the authors have compiled a list of questions family practitioners and other clinicians can use to explore areas of concern to patients and families. [See sidebar.]

"Using such questions may help bridge the cultural gaps and develop the therapeutic relationships that patients, caregivers, and clinicians can use to integrate patient/caregiver perspectives into goal setting and decision-making," they write.

More than just 'treating the disease'

Physicians with more than 10 years of practice experience also emphasized the importance of doing more than just "treat-

QUESTIONS PHYSICIANS CAN USE TO EXPLORE PATIENT/CAREGIVER CONCERNS

[Note: Suggested phrasing for a caregiver, rather than a patient, appears in italics]

AWARENESS

- Many patients with this condition (*families caring for a person with this condition*) tell me they think about the possibility of (*their loved one*) dying. They have questions about this. Do you?
- How does your cultural tradition approach a serious illness like this? Are there any traditions, beliefs, or rituals we should be aware of?
- When you think about (*your loved one*) getting very sick, what worries you the most?

MANAGEMENT/COPING

- How do you cope with the physical challenges/financial demands resulting from this illness? (*How do you maintain the energy to care for your loved one while renewing your own strengths?*)
- As you think about this illness, what are the hardest issues for you?
- (*Do you have all the resources you need to care for your loved one? If not, where do you need help?*)

RELATIONSHIPS

- What roles and responsibilities do you want (*your loved one*) to maintain? What roles and responsibilities have you had to give up (*take on*)?
- How are you dealing with changes in the way you relate to your caregiver (*loved one*) caused by this illness?
- Has this illness (*caring for your loved one*) increased your appreciation of your abilities or potentials?

PERSONAL EXPERIENCE

- As you think about your (*loved one's*) current condition, what is hardest for you? What do you fear most?
- What are the hardest losses you have experienced with this illness (*while caring for your loved one*)?
- From what sources do you draw your strength? What role does spirituality play in your life?
- If you (*your loved one*) died tonight, is there anything that would be left unsaid or undone that you would regret?
- Are you suffering physically in any way? Are you afraid of anything? (*Are there symptoms your loved one is experiencing that cause you to suffer?*)

— Farber, Egnaw, Herman-Bertsch, et al,
Journal of Palliative Medicine

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Physicians' Survival Predictions, Though Inaccurate, Found Reliable and Clinically Useful

International researchers: 'Physicians are able to distinguish which patients are dying'

A recently published review of the literature on clinical prognostication has confirmed previous findings that physicians tend to overestimate survival in terminally ill cancer patients. However, say investigators, clinician predictions of up to six months are reliable and useful, because they are highly correlated with actual survival.

"That doctors cannot predict the timing of death in terminal cancer with much accuracy is not surprising, but the fact that their predictions are highly correlated with survival indicates that they are able to sense when things are starting to go wrong," write the authors in their report in the *British Medical Journal*. **"These results reaffirm the importance of physicians' judgment in an era of expanding technology and dependence on test results."**

The multinational team of researchers conducted a systematic review of eight published studies comparing clinical predictions of survival (CPS) with actual survival in 1563 patients with end-stage cancer. The studies covered physicians from three countries (the United Kingdom, Italy, and the United States) and spanned a 30-year time period.

Clinical prediction of survival was generally overoptimistic. In a population very close to death (median actual survival, 29 days), the median CPS was 42 days. CPS was correct to within one week in 25% of cases and overestimated by more than four weeks in 27% of cases.

The longer the clinical prediction of survival, the greater the variability in actual survival. "When CPS exceeds six

"Doctors face two challenges in prognosticating near the end of life: formulating accurate predictions and communicating them... both are necessary for patients to achieve a good death."

months, it has no predictive value," they note. However, for predictions of up to six months, analysis revealed that CPS and actual survival were highly significantly associated, even though agreement between them was poor.

"The results of this review indicate that doctors' predictions of survival have discriminatory ability even if they are poorly calibrated," the authors say. In other words, "physicians are able to distinguish which patients are dying."

Further research is not needed merely to document physician inaccuracy in prediction of survival in cancer patients, note the authors, because CPS seems to be related to actual survival. Instead, they recommend research on factors influencing clinical predictions and on ways to enhance the CPS. "On the basis of our findings, CPS could now be used as the reference standard for evaluating other methods for predicting survival, and it has been used for this purpose."

However, physicians need to be aware of their tendency to overestimate survival in cancer patients who are approaching death, warn the authors. **"This optimism may have serious implications for the patient in terms of inappropriate application of disease-controlling treatment and delays in referral to hospice or palliative care."**

Source: "A Systematic Review of Physicians' Survival Predictions in Terminally Ill Cancer Patients," British Medical Journal; July 26, 2003; 327(7408):195. Glare P, Virik K, et al; Royal Prince Alfred Hospital, Camperdown, Australia; University of Sydney and MacQuarie University, Sydney, Australia; Kantonsspital, St. Gallen, Switzerland; Harvard Medical School, Boston.

Physicians Urged to 'Bridge the Gap' (from Page 5)

ing the disease." These physicians identified the following as important to successful end-of-life care:

- Emphasizing that care for the patient and family will continue through and beyond death
- Creating a relationship that allows patients and families to discuss any topic of importance to them — medical or otherwise

Patients/caregivers also valued this relationship. Along with expecting the provision of high quality medical care, patients wanted their physicians to listen to their personal concerns and

treat them as persons, not as a "disease." Caregivers expressed similar desires, along with a need for being treated as an important part of the care team.

"Patients and caregivers do not see themselves as a case of end-stage heart disease or terminal cancer. Instead, they live as meaningful a life as possible, living each moment in a way that makes sense," comment the authors.

Source: "Issues in End-of-Life Care: Patient, Caregiver, and Clinician Perceptions," Journal of Palliative Medicine; February 2003; 6(1):19-31. Farber SJ, Egniew TR, Herman-Bertsch JL, et al; Department of Family Medicine, University of Washington, School of Medicine, Seattle.

PHYSICIAN RESOURCES

A Clinician's Guide to Palliative Care

By George J. Taylor, MD (Editor), and Jerome E. Kurent, MD (Editor), this medical text focuses on the clinical and practical management of advanced disease. It was designed to aid practicing physicians in their clinical decisions and can also be used by residents and medical students as an introduction to care of the dying patient.

Chapters are arranged by disease systems, and the text includes discussion of appropriate and inappropriate therapies for advanced disease. Also reviewed are such topics as: assessment of prognosis; communicating and facing tough decisions; the uses and limitations of advance directives; and the criteria for hospice admission and the role of hospice care.

Chapter headings include:

- Palliation for Chronic Illness
- The Pharmacology of Symptom Control
- Heart Disease
- Chronic Lung Disease
- Renal Disease
- Neurological Diseases
- AIDS
- Cancer
- Liver Disease
- The Pediatric Patient
- Dying of Old Age: The Frail Nursing Home Resident

Published by Blackwell Publishing, 2003; ISBN: 0632046422 (paperback); 224 pp.

Online Pain Management Site Expands Resources

The National Pain Education Council (NPEC) is marking the completion of its first year online by adding to its multimedia educational programs for physicians and other health care professionals interested in improving their clinical pain management skills. (Go to www.npecweb.org.)

In addition to the existing continuing medical education (CME) programs, NPEC will be offering a new CME case study focusing on the multidisciplinary team approach to improving functionality in patients with chronic pain, as well as a slide set entitled "Cases to Go," compiled from its other interactive case studies.

All CME activities are archived on the site for access by clinicians who wish to read them without formally participating in the program. A one-time user registration is required for free-of-charge access to all information on the site.

Other CME monographs on pain management include:

- Optimizing Treatment of Chronic Pain with Opioid Therapy
- Assessment and Management of Aberrant Drug-Related Behavior
- Management of Pain in Patients with Progressive Medical Diseases

Visit www.npecweb.org

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 for Physicians on End-of-Life Care)

www.nhpco.org

National Hospice & Palliative Care Organization

www.promotingexcellence.org

Promoting Excellence in End-of-Life Care

www.hospicfoundation.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

Annual Assembly of the American Academy of Hospice and Palliative Medicine and Hospice and Palliative Nurses Association. January 22-25, 2004. Pointe Hilton Tapatio Cliffs Resort, Phoenix, AZ. Contact the AAHPM; Phone: 847-375-4712; Email: info@aahpm.org

Palliative Medicine 2004. March 11-13, 2004. The Sonesta Beach Resort and Spa, Bermuda. Sponsor: Cleveland Clinic Foundation. Phone: 216-444-5695 or 800-223-2273, Ext. 45695

14th Annual Provincial Conference on Palliative and End-of-Life Care. April 25-27, 2004. Westin Harbour Castle Hotel, Toronto. Sponsors: Humber College and the Ontario Palliative Care Association. Phone: 416-675-6622, Ext. 4559; Fax: 416-675-0135; Email: teresa.sottile@humber.ca

23rd American Pain Society (APS) Annual Scientific Meeting, Joint APS and Canadian Pain Society Annual Meeting. May 6-9, 2004. Vancouver, BC, Canada. Contact APS: 847-375-4715; Fax: 877-734-8758; Email: info@ampainsoc.org

Principles and Practice of Pain Medicine. June 23-27, 2004. Boston. Sponsor: Harvard Medical School, Department of Continuing Education. Phone: 617-384-8600; Fax: 617-384-8686; Email: hms-cme@hms.harvard.edu

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

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