

# Quality of Life Matters™

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

Vol. 3, Issue 4 Feb/Mar/Apr 2002

## National Physician Group Offers Tools to Help Seriously Ill Patients 'Live Well'

**Educational Materials Include Take-Home Patient Brochures and Physician 'Tip Sheet'**

A set of educational materials on end-of-life topics is available from the American College of Physicians-American Society of Internal Medicine (ACP-ASIM) as part of its recently developed End-of-Life Care Patient Education Project.

**Physicians are encouraged to offer these materials to patients during clinical visits and as take-home brochures.**

The End-of-Life Care Patient Education project was designed to provide physicians, patients, and their loved ones with **tools to help seriously ill persons "live well" near the end of life.** The tools are meant to serve as

companion pieces to the ongoing series of papers being published by the ACP-ASIM End-of-Life Care Consensus Panel.

### FOR PHYSICIANS

Also available as part of the project is a **physician "tip sheet,"** which suggests that physicians consider which patients might benefit from the educational brochures by asking themselves the following questions:

- *Would I be surprised if this patient died this year? (If not, the patient might benefit.)*
- *Has this patient been in the ICU lately? (If so, the patient might benefit.)*

The tip sheet, entitled "Improving Your End-of-Life Care Practice," provides a list of 12 suggestions for talking to seriously ill patients and their families.

These tips include:

- **It is often easier to talk to patients** with serious chronic illness (eventually terminal) than to those patients who are closer to death.
- **You don't need to discuss** all issues in one visit.
- **Learn about the patient's concerns,** so they can be used in developing a care plan.
- **Don't feel that you have to do everything yourself.** Nurses, so-

cial workers, clergy, and organizations such as hospice can help.

- **Include family and friends** in your discussions, if the patient agrees.
- **Know your resources** (hospices, home care services, nursing homes).
- **Tell the patient and family what symptom control** is possible near death, and make plans together.
- Except in hospice care, few families hear from their physicians after a death. **Make a follow-up call or visit** to offer support or answer questions, and send a condolence card.

### FOR PATIENTS

The take-home patient brochures, called the Patient Education and Care: End-of-Life (PEACE) series, can be used by physicians to:

- Serve as "**icebreakers**" for difficult conversations with patients and families.
- Help to **focus conversation** in the examination room.
- Give the patient **time to reflect upon and discuss matters** with family members.

The brochures offer patients definitions of such terms as "palliative care" and "living wills;" suggest questions to

### Inside:

#### NewsLine ..... 2-3

- ✓ DEA Joins Physician Groups in Call for Balanced Pain Medication Policy
- ✓ Physicians Urged to Take Active Role in Bereavement 'Aftercare'

#### Research Monitor ..... 4-5

- ✓ Fewer than 53% of Medical Students Feel Prepared for End-of-Life Care
- ✓ Prognosis Discussions May Improve Patient Care
- ✓ 85% of Seriously Ill Patients Say They Would Prefer to Die at Home

#### Physician Resources ..... 6-7

- ✓ Managing Non-Pain Symptoms at the End of Life

Continued on Page 2

## DEA Joins National Physician Groups in Call for Balanced Policy on Pain Medications

In an unprecedented move, the federal Drug Enforcement Administration (DEA) has joined with 21 professional medical and patient advocacy groups in issuing a **consensus statement on the importance of promoting pain relief while preventing the diversion and abuse of opioid analgesics** and other pain medications.

The joint statement was released at a press conference held in October 2001, in the wake of increasing concern over the illicit use of OxyContin (oxycodone hydrochloride). Although not mentioned by name in the statement, OxyContin was a major topic of discussion among the panelists at the press briefing.

“The repeated accounts of misuse have skewed people’s perceptions about drugs like OxyContin,” said Russell K. Portenoy, MD, chairman of pain medicine and palliative care at Beth Israel Medical Center, New York City. **“The reality is that the vast majority of people who are given these medications by doctors will not become addicted.”**

### *Physician groups participating in the development and release of the joint statement include:*

- The American Academy of Family Physicians
- The American Medical Association
- The American Academy of Pain Medicine
- The American Society of Anesthesiologists

**“Undertreatment of pain is a serious problem in the United States, including pain among patients with chronic conditions and those who are critically ill or near death.”**

*Excerpt from the joint statement*

“Unfortunately,” Portenoy continued, **“some doctors may now be frightened to prescribe these medications**, pharmacists may be reluctant to stock them, and patients may refuse to take them, because of fear of addiction and the new social stigma.”

DEA administrator Asa Hutchinson stressed the need for **balance in educating members of society and the medical community** about the serious-

ness of their responsibility for minimizing opportunity for drug diversion and abuse, while not preventing them from seeking or providing needed pain treatment.

Portenoy agreed that more education about addictive medicine was needed, so that clinicians can select patients appropriately and prescribe appropriately. At the same time, he stressed, the clinical community needs to be “very forceful” in addressing any extreme effort on the part of law enforcement “to restrict access to these drugs without clearly understanding the clinical implications.”

For that, he said, “we have to engage in ongoing dialogue, so that every action taken by law enforcement has an understanding of its consequences for patients.”

Last Acts, the coalition working to improve end-of-life care, sponsored the briefing and was also a participant. A copy of the consensus statement is available on their website, as is a form that can be used by organizations interested in endorsing the statement. Log on to: [www.lastacts.org](http://www.lastacts.org).

### Tools to Help Patients 'Live Well' (from Page 1)

ask the physician; describe hospice access and benefits; provide explanations of pain medications; and include lists of resources for further information. The titles include:

- “Living Well with a Serious Illness: Talking with Your Doctor When the Future is Uncertain”
- “When You Have Pain at the End of Life”
- “Making Medical Decisions for a Loved One at the End of Life”

Each of the four available tools can be downloaded from the ACP-ASIM website, then printed on both sides of one sheet of paper and folded to form a brochure. Access them at [www.acponline.org/ethics/patient\\_education.htm](http://www.acponline.org/ethics/patient_education.htm). Free printed copies are available from the ACP-ASIM Center for Ethics and Professionalism. Call 800-523-1546, ext. 2835.

## Physicians Urged to Take Active Role in Bereavement 'Aftercare'

In a report published in the *Journal of the American Medical Association*, Yale researchers remind physicians that bereavement has been associated with increased risk for adverse health behaviors, morbidity, and mortality, and can most often occur in later life, when a person's health and adaptive capacities may already be compromised.

**Whether physicians recognize it or not, they are already caring for many distressed or ailing bereaved patients**, the researchers note. And with the aging of the US population, the number of grieving patients seen in clinical settings is likely to increase. Further, **medical training offers little guidance in bereavement "aftercare."**

In their report, "Caring for Bereaved Patients: 'All the Doctors Just Suddenly Go,'" the authors offer communication strategies and intervention guidelines for bereavement aftercare.

**"There are several compelling reasons for physicians to actively engage in bereavement care,"** write Holly G. Prigerson, PhD, and Selby C. Jacobs, MD, of the Department of Psychiatry, Yale University School of Medicine, New Haven, Conn. "Most importantly... physicians who aid grief-stricken patients are afforded the rewarding, quintessentially human opportunity of transforming a personal sorrow they inevitably will experience into sympathetic and supportive 'aftercare.'"

### *Normal Grief*

While the authors recommend that physicians remain alert to symptoms of major depressive disorder and complicated grief, they caution against viewing the normal progression of a patient's grief as a series of neatly arranged and easily identifiable "stages," as this rarely occurs. **Most patients experiencing normal, or uncomplicated, grief reactions will progress at their own pace** toward an acceptance of the loss and the ability to carry on with their changed lives.

### *Complicated Grief*

The authors maintain that complicated grief should be identified and treated as distinct from major depressive disorder. Participation in a consensus panel evaluation of the literature on complicated or "traumatic" grief led the team to refine a set of diagnostic criteria into a tool physicians can use for the diagnosis of complicated grief.

According to the authors' algorithm, if the bereaved patient's "separation distress" symptoms (such as intrusive thoughts about or searching for the deceased) and "traumatic distress" symptoms (futility, numbness, disbelief, etc.) endure for 6 months or longer and are linked to substantial functional impairment, that patient satisfies the criteria for complicated grief.

### ***BEREAVEMENT AFTERCARE: WAYS PHYSICIANS CAN HELP***

- **Ease psychological stress** by demonstrating respect for the deceased and concern for the survivors. ("I'm so sorry [name of deceased] is gone. I just can't imagine what you're going through.")
- **Improve satisfaction with care by reducing the family's sense of "abandonment"** by the health care system. If the bereaved is not the physician's patient, a condolence call, letter, or visit shortly after the death is appropriate. Physicians whose patients are recently bereaved should telephone to express their condolences, then recommend an office visit to evaluate and monitor the survivor's health care needs.
- **Provide "closure" for both the family and themselves** by offering to clarify medical decisions and care related to the deceased. ("Do you have any questions about the final illness and treatment?")
- **Identify and treat bereavement-related psychiatric complications.** ("How are you feeling since [name of deceased's] death? How has his/her death affected you?")

### ***COMMUNICATION TIPS***

*To facilitate support of their bereaved patients, physicians can:*

- **Establish a system for being informed of deaths** in patients' families: encourage notification from colleagues; ask about recent loss on patients' waiting room forms.
- **Contact the patient after notification of bereavement:** offer condolences, suggest a scheduled visit.
- **Supply a list of resources for bereaved patients:** community groups, professionals, organizations, and/or information in print or on websites that can help.

## Fewer than 53% of Medical Students Feel 'Prepared' for End-of-Life Care

**"Many students are graduating from medical school without being prepared in basic end-of-life competencies," researchers note.**

A recent survey of fourth-year medical students has found that, depending upon the topic of competency, **only 22% to 53% felt they had been sufficiently trained by their education to handle end-of-life issues.** Students attending medical schools with a formal end-of-life curriculum, however, were

more likely to report feeling their training was adequate than were students from schools with no formal curriculum.

Researchers analyzed data from mail and email questionnaires completed by 262 senior students (male, 49.2%) at 6 medical schools in as many states. Using a list of core competencies developed by a national consensus conference on medical education for care near the end of life, researchers asked the students to rate the adequacy of their training.

Overall, 53% of students said they felt "prepared" to be able to determine the impact of illness on a patient's life; 49% felt prepared to understand the physiology and management of common end-of-life symptoms; 34%, to discuss end-of-life issues with patients; and 22%, to understand cultural and spiritual aspects of death and dying.

Students attending medical schools with "formal" curriculum (required training consisting of at least 12 contact hours

with a specific focus on palliative care issues) were 34% more likely than those from schools with no such curriculum to feel prepared to treat common end-of-life symptoms, 21% more likely to feel prepared to address psychosocial and cultural/spiritual issues, and 18% more likely to feel prepared to discuss technical aspects of end-of-life care with patients.

**The most frequently cited educational contribution to end-of-life learning was clinical experience (or "rotations"), followed by resident mentoring and personal experience.** The least identified educational contributions were basic science courses, problem-based learning seminars, and courses in patient interviews.

While more than 80% of students reported being present for a pronouncement of death, only 52% were present during a patient's death in a do-not-resuscitate (DNR) situation, and just 16% had witnessed a hospice death. "A majority of students have never even been present during a patient's death in a hospice or DNR situation," comment the authors. **"Students cannot be expected to exhibit competency in end-of-life and palliative care issues without exposure to terminally ill patients in a palliative care scenario,"** they conclude.

*Source: "Senior Medical Students' Perceptions of the Adequacy of Education on End-of-Life Issues," Journal of Palliative Medicine; Fall 2001; 4(3):337-343. Fraser HC, Kutner JS, Pfeifer MP; School of Medicine, University of Colorado Health Sciences Center, Denver; School of Medicine, University of Louisville, Kentucky.*

## Prognosis Discussions May Improve Patient Care

Although documented discussions about prognosis with hospitalized, terminally ill patients are infrequent and limited in scope, such discussions are strongly associated with broader discussions of life-sustaining treatment and do-not-resuscitate (DNR) orders, Yale researchers have found.

**"Encouraging more explicit discussions about prognosis with patients and families may improve patients' abilities to express informed preferences and clinicians' likelihood of meeting those preferences for care at the end of life,"** the study authors write.

In a cross-sectional study, the research team reviewed the medical records of 232 cancer patients (age 65 years or older) admitted to 6 community hospitals in Connecticut during 1997. All subjects had a diagnosis associated with poor prognosis (brain, pancreas, liver, gall bladder, or inoperable lung cancer).

The team found that discussion of prognosis was docu-

mented for 89 patients (38%), with mention of a specific time frame recorded in only 8 (9%) of these. Of the 89 cases of documented discussion, physicians and patients were both present for 46 (52%). Among those patients who were not present for these discussions, only 2 were noted in the chart as being cognitively impaired.

In multivariate analysis, having discussions about prognosis was significantly associated with having documented discussions about life-sustaining treatment (odds ratio [OR], 5.8; 95% confidence interval [CI], 2.8 to 12.0) and with having discussed DNR orders (OR, 2.2; 95% CI, 1.1 to 4.2). For 46 (70%) of the 66 patients who had documented discussions of both prognosis and life-sustaining treatment choices, the latter discussion occurred on either the same day or the day following the prognosis discussion. Additionally, for 31 (54%) of the 57 patients with documentation of both prognosis and DNR

*Continued on Page 5*

## 85% of Seriously Ill Home Health Patients with Preferences Choose to Die at Home

A pilot study of a structured advanced care planning (ACP) process designed to be conducted in the patient's home has found that, of those seriously ill home health agency patients expressing a clear preference, most (85%) wanted to die at home.

The quality improvement project was conducted in Minnesota among 84 non-hospice patients (median age, 75 years; range, 37 to 94 years) cared for between September 1997 and January 1999 by a large, urban home health agency owned by a not-for-profit integrated health care system. All patients were identified by home care staff nurses as having a life expectancy of less than 2 years and offered social worker assistance with ACP; 83 patients (99%) of participants accepted.

The comprehensive ACP process took place during 1 to 3 social worker visits, each lasting 1 to 2 hours. The patient and family were asked to share their experiences with death, their understanding of the patient's illness, and their personal goals. Resources within the family and the community were identified, and communication patterns within the family and with physicians were assessed.

Participants were asked their preferences for end-of-life care location, provided with information on hospice services, and assisted with completing a health care directive, when desired. Completed information was forwarded to the appropriate home health nurse and the attending physician.

Nearly two-thirds (64%) of participants expressed a clear location preference for end-of-life care. Of these, 46 (85%) wanted to be at home, 5 (9%) preferred care in a nursing home, and 3 (6%) chose residential hospice care. **None of the participants who expressed a preference wanted to die in the hospital.**

At the end of follow-up in June 1999, 58 (69%) of the

patients had died. Of these, 40 (70%) died at home, 10 (18%) died in nursing homes, 4 (7%) died in hospitals, and 3 (6%) died in residential hospice care. **No patient who died at home had expressed a preference to die elsewhere.**

*The home-based advanced care planning process empowered patients and families to express a preference to die at home and to achieve their goal.*

The authors point out that the project's strategy to target seriously ill home health patients timed ACP appropriately for most patients: while 39 patients (47%) died within 90 days of ACP initiation, only 6 (7%) died within two weeks. For 2-year prognosis, they note, the project relied upon the judgment of nurses familiar with the patients' medical history, functional status, and home situation.

"This is an important result," they write, "because **timing of care planning requires consideration of likely scenarios of future health crises, few of which can be predicted years in advance.** ACP, the intervention tested, must also be timed appropriately, to begin before such crises occur. **Efforts to improve communication between providers and their patients who are within days of death do not leave time for implementation of plans.**"

The authors believe that the study's greatest strength lies in its **ease of replication**: the target population is easily identified; the intervention requires minimal training; and most insurers, including Medicare, consider the intervention a benefit. Further, they note, approaching ACP as a process allowed a focus on open communication and mutual understanding within the context of family issues and preferences, rather than on patient autonomy and control.

*Source: "Death at Home Following a Targeted Advance-Care Planning Process at Home: The Kitchen Table Discussion," Journal of the American Geriatrics Society; June 2001; 49(6):778-781. Ratner E, Norlander L, McSteen K; Department of Family Practice, University of Minnesota, Minneapolis; Minnesota Partnership to Improve End of Life Care, Minneapolis; Allina Hospice and Palliative Care, St. Paul.*

*From Page 4*

orders discussion, the DNR discussions took place on the same day or the day after.

"It is apparent that discussion of prognosis and other advance care planning efforts are closely linked, and that discussions about prognosis may sometimes be a catalyst for explicit discussions of patient and family preferences about treatments and future care," comment the authors.

However, the authors point out that the documentation of

prognosis discussions was infrequent, vague, and rarely explicit as to estimated life expectancy. "These findings are notable, given that the study was conducted among terminally ill patients with poorly treatable cancers, for whom prognostic certainty is greatest, and for whom such discussions may be particularly useful."

*Source: "Documentation of Discussions about Prognosis with Terminally Ill Patients," The American Journal of Medicine; August 15, 2001; 11(3):218-223. Bradley EH, Hallemeier AG, Fried TR, et al; Yale School of Medicine, Connecticut VA Healthcare System, New Haven, Connecticut.*

## Managing Non-Pain Symptoms at the End of Life

Terminally ill patients suffer from physical symptoms other than pain, any of which can cause great distress and interfere with quality of life. This is according to a team of experts from the University of Maryland School of Medicine in Baltimore, whose two-part article was published in the journal, *American Family Physician*.

Douglas D. Ross, MD, PhD, and Carla S. Alexander, MD, remind physicians that: "Treatments often change as the patient approaches the end of life. **The continued presence of physicians and a steadfast commitment to ameliorating symptoms are particularly important** when it is impossible to cure or even slow the progression of an underlying disease process."

### **FATIGUE**

**Fatigue is often undiagnosed or ignored** in medical practice, note Ross and Alexander. Little is known about the pathogenesis of fatigue, although **it is a problem in up to 90% of patients with cancer or other terminal illnesses**. It can be directly caused by the disease process, or by treatment for cancer, hypertension, or heart disease. Psychologic causes can include depression or anxiety.

The authors urge physicians to determine the severity of a patient's fatigue, identify factors that worsen or relieve it, and assess the impact it has on the patient's daily activities. (One helpful tool is the "Brief Fatigue Inventory," included in their article.)

**FATIGUE:** *When no underlying cause is found, non-pharmacological treatments include:*

- **Educating the family that the patient's fatigue is real**, and giving the patient "permission" to be tired.
- **Helping the patient restructure** daily activities to conserve energy and include rest times.
- **For patients nearing death**, eliminating unnecessary medications and instituting appropriate dietary and hydration practices.

### **ANOREXIA AND CACHEXIA**

Wasting syndromes, characterized by lack of appetite (anorexia) and weight loss (cachexia), are seen in patients with systemic illnesses such as cancer, chronic organ failure, infections, or acquired immunodeficiency syndrome. Although little is known about their pathogenesis, wasting syn-

dromes are caused by the underlying disease process with cancer and hypermetabolic states, and are therefore **unlikely to be reversed by improved nutrition**, note the authors.

Anorexia and cachexia can have treatable causes, such as chronic pain, mouth conditions, gastrointestinal motility problems, or reflux esophagitis. In patients undergoing treatment for cancer, it is important to determine whether wasting is due to the effects of treatment rather than the progressive disease, the authors say.

**WASTING:** *Once treatable causes have been ruled out, non-pharmacological treatments include:*

- **Patient and family education.** "The physician can be of particular assistance in helping the patient and family understand that cachexia is an expected consequence of the underlying disease process," the authors state. Family caregivers can be taught to replace their "need to feed" with other caring activities.
- **Eliminating dietary restrictions**, and allowing the patient to choose what, when, and how much is desired.
- **Exploring related emotional and spiritual issues.**

### **NAUSEA AND VOMITING**

**Effective control of the debilitating symptoms of nausea and vomiting can be achieved in most patients at the end of life**, according to the authors. For pharmacological intervention, identification of the pathophysiologic origin is helpful, they suggest, noting that the key organs involved are the brain and the gastrointestinal tract.

The article provides a table summarizing the common causes ("the 11 M's") of nausea and vomiting, along with the pathophysiology and treatments of these symptoms. An accompanying table lists commonly used medications and their dosage schedules.

### **CONSTIPATION**

Management of constipation, which can be a frequent cause of nausea and vomiting in terminally ill patients, depends upon the **assessment and manipulation of the 4 major factors affecting bowel movements:** intestinal solids, stool water content, gastrointestinal motility, and gastrointestinal lubrication, according to the authors. A table of treatment suggestions and comments, factor by factor, is

*Continued on Page 7*

# PHYSICIAN RESOURCES

From Page 6

provided in the article.

Alexander and Ross remind physicians that patients do not develop tolerance to constipation as an opioid-induced side effect; it is dose-related, and much easier to prevent than to treat. **They recommend that all patients with opioid prescriptions be given both a prophylactic gastrointestinal motility stimulant laxative and a stool softener** (unless their use is contraindicated).

## DELIRIUM

**Delirium occurs in 25% to 85% of terminally ill patients**, often heralding the end of life, and can be extremely distressing to the family, who observe agitation or the appearance of fear or uncontrolled pain, say Alexander and Ross. "Because the period before death can be a last chance for the patient and family members to mend relationships, share dreams, and say goodbye, it is imperative that measures be instituted to control delirium," they write.

**Causes of delirium near the end of life include** hypoxia, infections (including simple urinary tract infection), dehydration, and a combination of medications. As death approaches, patients become more vulnerable to delirium, particularly as caused by medications. Risk factors for delirium in patients aged 80 years or older can include: impaired vision, severe illness, cognitive impairment, and dehydration.

**Pharmacological therapies include** neuroleptics (e.g., halperidol, thioridazine) and benzodiazepines (lorazepam, midazolam), with halperidol being Ross and Alexander's agent of choice for managing delirium associated with hyperactivity at the end of life.

The authors suggest that when delirium occurs close to the time of death, this "**terminal restlessness**" may simply be observed — with full attention paid to physical safety — unless sedation is required for the comfort of the family or professional caregivers. Additionally, patients near death may describe "visits" from deceased loved ones, but "these encounters usually appear to be comforting to dying patients and consequently may not require medical treatment."

**"An interdisciplinary approach, such as that provided by hospice, can be very helpful," the researchers note.**

**"A visit from the physician to offer care and reassurance is invaluable to the patient and family," they conclude.**

## DYSPNEA

As "a subjective experience of difficult or distressed breathing," dyspnea is a **common symptom in patients with terminal illness** (cancer patients, 70%; AIDS patients, 11% to 62%), and objective findings may not fully convey the distress experienced, the authors note.

Opioid therapy is considered the mainstay of dyspnea treatment when the cause is not reversible, with benzodiazepines — titrated until dyspnea is relieved — commonly added to alleviate the anxiety component.

Source: "Management of Common Symptoms in Terminally Ill Patients: Part I. Fatigue, Anorexia, Cachexia, Nausea, and Vomiting," American Family Physician; Sept. 1, 2001; 64(5):807-814. "Management of Common Symptoms in Terminally Ill Patients: Part II. Constipation, Delirium, and Dyspnea," American Family Physician; Sept. 15, 2001; 64(6):1019-1026. Ross DD, Alexander CS; University of Maryland School of Medicine, Baltimore.

## End-of-Life Care Websites

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

End of Life Physician Education Center (EPERC)

[www.aahpm.org](http://www.aahpm.org)

American Academy of Hospice & Palliative Medicine

[www.epec.net](http://www.epec.net)

The EPEC Project (Education for Physicians on End-of-Life Care)

[www.nhpc.org](http://www.nhpc.org)

National Hospice & Palliative Care Organization (formerly the NHO)

[www.hospicefoundation.org](http://www.hospicefoundation.org)

Hospice Foundation of America

[www.americanhospice.org](http://www.americanhospice.org)

American Hospice Foundation

[www.hpna.org](http://www.hpna.org)

The Hospice and Palliative Care Nurses Association

[www.medicaring.org](http://www.medicaring.org)

Center to Improve Care of the Dying

[www.abcd-caring.org](http://www.abcd-caring.org)

Americans for Better Care of the Dying

[www.lastacts.org](http://www.lastacts.org)

Last Acts Coalition

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

Palliative Medicine Program at the Medical College of Wisconsin

[www.medsch.wisc.edu/painpolicy](http://www.medsch.wisc.edu/painpolicy)

University of Wisconsin Pain and Policy Studies Group

[www.capcmssm.org](http://www.capcmssm.org)

Center to Advance Palliative Care

[www.stoppain.org](http://www.stoppain.org)

Pain Medicine & Palliative Care, Beth Israel Medical Center

[www.growthhouse.org](http://www.growthhouse.org)

Online community for end-of-life care

[www.partnershipforcaring.org](http://www.partnershipforcaring.org)

America's Voices for the Dying

# End-of-Life Care Meetings for Clinicians

**Palliative Medicine 2002.** March 7-9, 2002, Sheraton Bal Harbour Beach Resort, Miami Beach, FL. Sponsor: the Cleveland Clinic Foundation. Phone: 800-762-8173; Fax: 216-445-9406; Email: [marksl@ccf.org](mailto:marksl@ccf.org)

**21st Annual Scientific Meeting of the American Pain Society.** March 14-17, 2002, Baltimore Convention Center, Baltimore MD. Sponsor: American Pain Society. Phone: 847-375-4715; Fax: 877-734-8758; Website: [www.ampainsoc.org/meeting](http://www.ampainsoc.org/meeting)

**3rd Annual Joint Clinical Conference and Exposition on Hospice and Palliative Care.** March 21-23, 2002, Hyatt Regency New Orleans, New Orleans, LA. Sponsors: the National Hospice and Palliative Care Organization, the American Academy of Hospice and Palliative Medicine, and the Hospice and Palliative Nurses Association. Phone: 703-533-8468; Website: [www.nhpco.org](http://www.nhpco.org)

**Harvard Medical School Program in Palliative Care Education & Practice.** April 23-30, 2002, and November 12-19, 2002, Boston, MA. (Attendance at the April session is a prerequisite for the November session). Contact: Wendy Katz; Phone: 617-724-9509; Email: [pallcare@partners.org](mailto:pallcare@partners.org); Website: [www.hms.harvard.edu/cdi/pallcare](http://www.hms.harvard.edu/cdi/pallcare)

**38th Annual Meeting of the American Society of Clinical Oncology.** May 18-21, 2002, Orlando, FL. The meeting will feature an integrated Session on End-of-Life/Palliative Care. Contact: Michael Levy; Email: [mh\\_levy@fccc.edu](mailto:mh_levy@fccc.edu); Website: [www.asco.org/prof/ai/html/2002am.htm](http://www.asco.org/prof/ai/html/2002am.htm)

**10th World Congress on Pain.** August 17-22, 2002, San Diego, CA. Sponsor: the International Association for the Study of Pain. Phone: 206-547-6409; Fax: 206-547-1703; Email: [iasp@locke.hs.washington.edu](mailto:iasp@locke.hs.washington.edu)

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