

Quality of Life Matters®

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

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Number of Veterans Receiving VA-Supported Home Hospice Care Triples

Continuing improvement in end-of-life care delivery remains high priority

As part of its comprehensive initiative to transform the care delivered to dying veterans — and to honor their end-of-life wishes — the U.S. Department of Veterans Affairs (VA) began several years ago to build a network of partnerships with community hospice providers. By 2006, these partnerships were active in 33 states, and the number of veterans receiving home hospice care had tripled, according to a report published in the *Journal of the American Geriatrics Society*.

“The pursuit of a ‘good death’ remains out of reach for many, despite numerous piecemeal solutions to address the growing need for access to quality care at the end of life,” the authors state. **“Although advances have been made in end-of-life care . . . patients’ goals of care are often ignored, referrals for hospice care are commonly within days of death, and our culture marvels at a ‘good death’ as an exception rather than an expectation.”**

The number of Americans aged 85 years and older is projected to increase by 71% from 2000 to 2020. Meanwhile, the

Three-Year Improvements in VA End-of-Life Care Include:

- Triple the number of veterans receiving VA-paid home hospice care
- The presence of palliative care teams in all VA hospitals, with 42% of dying inpatients receiving palliative care consultations in 2006 (up from less than 20% in 2002)
- An increase in access to VA non-acute inpatient hospice care, with nearly triple the number of veterans using hospice beds, accounting for 22% of all VA inpatient deaths in 2006

— Edes, et al,
Journal of the American Geriatrics Society

number of American veterans aged 85 years and older doubled from just 2000 to 2005, and is projected to triple by 2010. Thus, note the authors, the VA was faced with the imperative to improve its end-of-life care delivery sooner than were other national health care systems.

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Hospice Care Often Chosen for Diseases with High Caregiving Burden

Diseases with a high burden of caregiving for families, or with a predictable time frame leading to death, account for the majority of enrollments in hospice programs among all Medicare patients, a team of researchers from Harvard and the National Hospice and Palliative Care Organization (NHPCO) has found.

Their study is the first to enumerate the pattern of hospice use by comparing data from both the complete national mortality and hospice utilization data sets, point out the authors of a report

published in the *Journal of Pain and Symptom Management*.

The team examined the records of the entire population of those aged 65 years or older who died in 2002 (n = 1,811,720; 2002 being the most recent year for which comprehensive data were available), together with data on all those served by Medicare and Medicaid hospice during that same year.

Key findings include:

- The overall hospice rate of use for older Americans was 28.6%.

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Inaugural 'National Healthcare Decisions Day' Set for Spring

Nationwide publicity can provide opening for end-of-life care discussions

Leading organizations committed to increasing Americans' awareness of the importance of advance care planning have announced April 16, 2008, as the launch date for the first National Healthcare Decisions Day (NHDD).

The nationwide public awareness campaign aims to provide people with the information and tools needed to consider and complete a written medical advance directive (AD), such as a health care power of attorney and/or living will. Participants in the campaign will include groups, professionals, and volunteers at the national, state, and local levels.

"Only a small minority of Americans have executed an advance directive," says Nathan A. Kottkamp, chair of the NHDD initiative and member of the American Health Lawyers Association. "The goal for the national campaign is for millions more Americans to have conversations about their health care decisions and execute thoughtful and reliable advance directives to make their wishes known."

The anticipated national attention focused on ADs can provide physicians with the opportunity to introduce the topic with patients before a crisis, before exacerbation of or incapacitation from serious illness occurs.

The NHDD initiative notes that according to a report published by the U.S. Agency for Healthcare Research and Quality (AHRQ) in 2003:

- Less than 50% of seriously or terminally ill patients studied had an AD in their medical record.
- Only 12% of those patients with an AD had received input from their physicians.
- 65% to 76% of physicians whose patients had an AD were not aware of its existence.

"Because physicians are in the best position to know when to bring up the subject of end-of-life care, they are the ones who need to initiate and guide advance care planning discussions," comment the authors of the report, which is entitled *Advance Care Planning: Preferences for Care at the End of Life*.

"As a result of National Healthcare Decisions Day," says Kottkamp, "fewer families and health care providers will have to struggle with making difficult health care decisions in the absence of guidance from the patient; and health care providers and facilities will be better equipped to address advance health care planning issues before a crisis and be better able to honor patient wishes when the time comes to do so."

For more information, visit www.nationalhealthcaredecisionsday.org.

Downloadable Resources

AMERICAN BAR ASSOCIATION

"Consumer's Tool Kit for Health Care Advance Planning" includes 10 tools, such as "The Proxy Quiz for Family & Physician," "Are Some Conditions Worse Than Death?" and "Conversation Scripts: Getting Past the Resistance." — www.abanet.org/aging/toolkit

CENTER FOR PRACTICAL BIOETHICS

"Caring Conversations: Making Your Wishes Known for End-of-Life Care" is a workbook in questionnaire format to guide personal reflection and conversations with loved ones. Includes a health care directive and/or health care power of attorney document to complete. — www.caringinfo.org

AMERICAN HOSPITAL ASSOCIATION

"Put It in Writing" is a brochure explaining the basic facts about advance directives. It includes a glossary of terms and a question-and-answer section.

"Advance Directive Notification" is a wallet ID card with contact information to alert health care professionals that the patient has completed an advance directive or has discussed preferences with family and physician. — www.putitinwriting.org

NATIONAL HOSPICE AND PALLIATIVE CARE ORGANIZATION

State-Specific Advance Directive Documents — with instructions — for all 50 states and the District of Columbia can be found on this site maintained by the NHPKO. Also available are dozens of educational documents for patients, families, and physicians. — www.caringinfo.org

Links to these and other resources are also available at www.nationalhealthcaredecisionsday.org.

Number of Veterans Receiving VA-Supported Home Hospice Care Triples

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Under a VA mandate, all enrolled veterans are now eligible to receive needed hospice and palliative care. But because it does not operate home hospice services itself, the VA offers to purchase care from local hospice programs.

VA initiative success factors that may be relevant to other health care systems include:

- Identification of major barriers to access and quality
- A coordinated and synchronous approach to resolving these barriers

“Coordinated, synchronous changes are critical, because omission of change in even one category may preclude system change,”

“The VA’s experience serves as a powerful example of the magnitude of change possible in a complex health system and a model for improving access and quality of palliative care services in other health systems.”

— Edes, et al,
Journal of the American Geriatrics Society

warn the authors.

“To ensure quality care at the end of life, the VA must continue to build the palliative care expertise needed in all venues,” the authors state, adding that the VA will continue to leverage its strengths in all key categories in order to build a model system of care. **“Honoring veterans’ preferences for care at the end of life**

has been and will be at the core of this model.”

Source: “Increasing Access and Quality in Department of Veterans Affairs Care at the End of Life: A Lesson in Change,” Journal of the American Geriatrics Society; October 7, 2007; 55(10):1645-1649. Edes T, Shreve S, Casarett D; Department of Veterans Affairs, Veterans Health Administration, Office of Geriatrics and Extended Care, Washington, DC; Philadelphia Veterans Affairs Center for Health Equity Research and Promotion, Philadelphia.

Hospice Care Often Chosen for Diseases with High Caregiving Burden

From Page 1

- More women than men used hospice services in the last year of life (30% vs 27%).
- White patients were more likely than black patients to enroll in hospice (29% vs 22%). [Data for other ethnic groups were not available.]

Hospice use by cause of death varied significantly, and was highest among those patients enrolled with a diagnosis of:

- Cancer (65%)
- Kidney disease and nephritis (55%)
- Alzheimer’s disease (41%)
- Chronic obstructive pulmonary disease (30%)

“The three causes of death with the highest hospice utilization rates (i.e., malignancies, nephritis/kidney disease, and Alzheimer’s disease) correspond to diseases that commonly impose high burdens of

caregiving on family caregivers and/or that make it easier for decision makers to predict the time frame of death,” comment the authors.

They note that the rate of hospice use in this country has been steadily increasing, as has the percentage of those with noncancer diagnoses being served by hospice. The NHPCO report for 2005 estimated that nearly one-third of all decedents of all ages were under hospice care, with 54% of those enrolled having a primary diagnosis other than cancer.

“In the early days of hospice care, the population was predominantly cancer patients, while now the hospice population is becoming more consistent with the major causes of death from chronic illness diagnoses,” the authors write.

Geographically, the rate of hospice use was generally higher in the South and Southwest areas of the country, and lower

in the Midwest and Northeast. The states with the highest rates of usage included Arizona (49%), Colorado (45%), and Florida (42%). The lowest use of hospice services was found in Alaska (8%), Maine (14%), South Dakota (16%), and Wyoming (16%).

The authors suggest that a “steady-state” in hospice usage may eventually be achieved, when all patients in the nation who can reasonably receive end-of-life palliative care — perhaps a percentage as high as 67% — are served. Until that time, the authors note, “there is valuable room for increased and beneficial use of hospice care at the end of life.”

Source: “Geographic Variation in Hospice Use in the United States in 2002,” Journal of Pain and Symptom Management; September, 2007; 34(3):277-285. Connor SR, Elwert F, Spence C, Christakis NA; National Hospice and Palliative Care Organization, Alexandria, Virginia; Department of Health Care Policy, Harvard Medical School, Boston.

Diagnosing Death: 'Communication in the Face of Uncertainty'

Waiting for certainty about prognosis may leave little opportunity for physicians to help dying hospitalized patients and their families prepare for death, conclude the authors of a report on physician communication, which was published in the *Journal of Palliative Medicine*.

Investigators from several major centers analyzed data collected from 1999 to 2001 on 196 attending physicians, residents, and interns caring for 70 patients (mean age, 65.7 years; range, 21 to 94 years) who died on the general medicine or intensive care unit at two hospitals.

Key Findings:

- 42.8% of physicians said they felt certain upon admission or first meeting that the patient would die during this hospitalization, with 38.3% reporting they were uncertain.
- 86.4% of physicians had become certain over the course of hospitalization that the patient's death was imminent.
- Only 11% of physicians reported having personally spoken with patients about the possibility of dying, while 33.3% reported believing that someone on the medical team had done so.

No relationship was found between physician or patient variables and whether or when physicians recognized that death was imminent. However, **patients whose physicians were certain of imminent death were three times more likely to have been told of this possibility than were patients whose physicians were not certain.**

"Because certainty came only within days of death, however, and because more than two-thirds of patients were, by that point,

Importance to Patients and Families

Clinician recognition and communication of approaching death is important, note the authors, so that patients and families can:

- Clarify or change goals of care
- Make informed medical decisions
- Avoid nonbeneficial and burdensome treatments
- Have the opportunity for transfer to hospice care

— Sullivan, et al,
Journal of Palliative Medicine

unconscious or in and out of lucidity, waiting for certainty appeared to preclude meaningful communication with the majority of patients," write the authors. **"Given the inherent uncertainty in predicting death, these findings point to a need for enhancing communication about end-of-life issues in the face of this prognostic uncertainty."**

Other Findings:

- The length of time physicians cared for patients ranged from less than one day to 30 days, with majority caring for patients for a period of either 4-7 days (34%) or 8-30 days (26.9%).
- Formal education in end-of-life care was limited for all physicians, with the number of courses or educational experiences related to care of the dying averaging 1.5.
- Those physicians who did speak to patients about dying were more likely to report feeling closer to the patient

and more satisfied with the care provided.

"The discrepancy between the proportion of physicians who reported that *someone* on the team had spoken with the patient about the possibility of dying compared with those who actually described (in interview transcripts) talking with patients themselves about this issue (33% vs 11%) raises the possibility respondents may have thought someone had spoken with patients when, in fact, they had not done so," the authors comment.

The authors believe their findings point to areas for fruitful research in the care of hospitalized patients nearing the end of life. **"In particular, communication in the face of uncertainty emerges as a key direction,"** they suggest.

"Skillful communication holds potential not only for enhancing care at an intensely vulnerable time, but also for deepening physicians' sense of connection and satisfaction in providing that care for patients at the end of life and their families," the authors point out. "In addition to potential benefits to patients and families, these findings suggest that enhancing communication practices may also benefit physicians through increased satisfaction with care and closer connection with those for whom they provide care."

Source: "Diagnosing and Discussing Imminent Death in the Hospital: a Secondary Analysis of Physician Interviews," Journal of Palliative Medicine; 10(4):882-893. Sullivan AM, Lakoma MD, Matsuyama RK, Rosenblatt L, Arnold RM, Block SD; Division of Psychosocial Oncology and Palliative Care, Dana-Farber Cancer Institute, Boston; Department of Social Medicine, Harvard Medical School, Boston; Department of Social and Behavioral Health, Virginia Commonwealth University, Richmond; Department of Psychiatry, Brigham and Women's Hospital, Harvard Medical School, Boston; Department of Medicine, University of Pittsburgh, Pittsburgh.

Clinicians Offered Step-Wise Approach to Managing Intractable Nausea and Vomiting

A team of Chicago palliative care experts recommends a step-wise, mechanism-based approach to the evaluation and treatment of the highly distressing symptom complex of intractable nausea and vomiting in patients nearing the end of life.

“Using this step-wise approach, nausea and vomiting can be successfully managed in most patients at the end of life,” write the authors of an article published in the *Journal of the American Medical Association*.

“We advocate and practice a mechanism-based management paradigm because it facilitates a systematic approach to caring for the patient, identifies all potential symptomatic contributors, directs therapy, and minimizes the risk of overmedicating a vulnerable population,” the authors write.

Common pitfalls in the management of nausea and vomiting include prescribing

first-line antiemetics on an as-needed basis and the coadministration of multiple antiemetics that antagonize the same receptor, the authors state.

An illustration of the four neural pathways that mediate nausea and vomiting and their interrelationships is provided. Tables include: a mechanistic listing of some of the most common clinical scenarios associated with this symptom complex at the end of life along with typical first-line antiemetics; a list of frequently used antiemetics, their mechanistic action, dosage, major adverse effects, and cost; and the results from a selection of studies supporting the use of antiemetics in patients at the end of life.

Source: “Management of Intractable Nausea and Vomiting in Patients at the End of Life,” *Journal of the American Medical Association*; September 12, 2007; 298(10):1196-1207. Wood GJ, Shega JW, Lynch B, Von Roenn JH; Department of Medicine,

THE STEP-WISE APPROACH INVOLVES:

- Careful evaluation to determine the etiology of the presenting symptoms
- Using pathophysiology to determine the mechanism, specific transmitters, and receptors underlying the nausea and vomiting
- Prescribing the most appropriate antagonist to the implicated receptor

— Wood, et al,
Journal of the American Medical Association

Division of Hematology/Oncology, Feinberg School of Medicine, Northwestern University, Chicago. [Gordon J. Wood, corresponding author, is now at the Section of Palliative Care and Medical Ethics, Institute to Enhance Palliative Care, University of Pittsburgh School of Medicine, Pittsburgh.]

Palliative Care Yields Lower Costs, Greater Patient Satisfaction

Results of a trial delivering in-home palliative care services modeled after hospice programs — without the 6-month prognosis restriction — to patients with end-stage chronic obstructive pulmonary disease, congestive heart failure, or cancer, provide strong evidence for the reform of the Medicare hospice benefit, researchers report.

“[P]roviding an interdisciplinary palliative care team within the home of terminally ill homebound patients earlier in the disease trajectory has a positive effect on patient satisfaction with the medical care, in addition to influencing costs of care at the end of life,” write the investigators in a recent issue of the *Journal of the American Geriatrics Society*.

The team analyzed the interview re-

sponses of 297 homebound patients with a prognosis of one year or less who were receiving health care services from health maintenance organizations in Colorado and Hawaii. Participants were randomized into groups receiving usual care (n = 152) or usual plus palliative care (n = 145).

Findings include:

- 93% of those receiving palliative care were very satisfied with their care, compared with 81% of those in the usual care group.
- 36% of patients in the palliative care group were hospitalized during the 90-day follow-up period, compared with 59% of those with usual care.
- Overall costs of care for those in the palliative care program were 33% less than for those receiving standard care.

“Hospice patients with a short length of stay often require intensive care to initiate the care plan, resulting in higher per diem costs of care than for patients who receive longer periods of stabilized, low-cost palliative care,” write the authors. They suggest that end-of-life care programs no longer be limited to the last six months of survival.

Source: “Increased Satisfaction with Care and Lower Costs: Results of a Randomized Trial of In-Home Palliative Care,” *Journal of the American Geriatrics Society*; July 2007; 55(7):993-1000. Brumley R, Enguidanos S, Jamison P, Seitz R, Morgenstern N, Saito S, McIlwane J, Hillary K, Gonzalez J; Kaiser Permanente Southern California Medical Group, Downey, California; Partners in Care Foundation, San Fernando, California; Kaiser Permanente Hawaii Medical Group, Honolulu; Kaiser Permanente Colorado Medical Group, Aurora, Colorado.

CLINICIAN RESOURCES

Handling Requests for Nondisclosure: Experts Offer a Clinical Approach

A family's request that a clinician not reveal bad news to a patient raises legitimate ethical issues, and may cause considerable distress when the situation is viewed as an I win/you lose dilemma. Either the patient is told despite the family's wishes, or the patient is not told in violation of the physician's medical values.

"We think, however, there is a third way that often allows satisfaction of the patient, the family, and the physician's concerns," write two experts in physician-patient com-

munication in the *Journal of Clinical Oncology*. The authors propose a strategy using negotiation skills and an understanding of the cultural factors underlying each party's point of view, based on related communication techniques and their own experience. [See sidebar, below.]

Until relatively recently, nondisclosure of medical bad news such as diagnosis of terminal illness or poor prognosis was the norm in this country, and is still traditional in most other countries, the authors point

out. Thus, it is not uncommon to encounter families believing it their duty to protect a loved one from the burden of making difficult medical decisions.

The article includes a table with examples of skilled and less skilled ways to express clinician values about nondisclosure. Sample questions show how to elicit a family member's "explanatory model" of illness: what the person thinks has happened, what will happen, how the illness should be managed, and by whom.

Responding to a Request for Nondisclosure

- **DO NOT OVERREACT.** Take a deep breath and acknowledge to yourself that this will be a difficult conversation. Arrange for an appropriate place and enough time to address the request.
 - **STEP BACK AND TRY TO UNDERSTAND** the reason for the family's request before sharing your own concerns. "Tell me more about your loved one." Explore their explanatory model of the illness, and identify the normal roles of the patient and relative(s) within the family. "Who do you believe should be the decision maker, if not the patient, and why?"
 - **BE FLEXIBLE** enough to reconsider the significance of patient autonomy if the patient had explicitly expressed the desire not to be told of a terminal illness. Offer to think through the implications with the family. "I wonder if you have thought about some of the practical issues associated with not telling your mother about her diagnosis. May I mention some of my concerns?"
 - **RESPOND EMPATHICALLY** to emotional distress. Fostering a connection can lower the emotional temperature and build a foundation for subsequent negotiation. "I appreciate and share your concern. None of us wants her to lose hope. We all want what is best for her."
 - **TALK TO THE FAMILY** about what the patient would want. Even in cultures with a tradition of family decision making, an individual may want to decide for herself. If the family appears merely to assume patient agreement with nondisclosure, open the possibility that she might feel otherwise. "I wonder how we would know if your mother did want to know more about her illness."
 - **STATE YOUR VIEWS AS YOUR VIEWS.** Speak in the first person ("I think..."), avoiding confrontational universalities
- (*"The patient has a right..."*). Stress the common ground shared with the family in wanting what is best for the patient. "Just as you have an obligation to your mother as a family member, I have an obligation as her physician. My obligation is to make sure she gets the best possible care, and is involved in decision making to the degree she wishes."
- **NEGOTIATE YOUR APPROACH** to talking with the patient. Make it clear that, although you could not lie if asked a direct question, your goal is not to talk the patient into anything. "I'm fine with your being the decision maker, if that is what your mother wants. I just want to confirm that, so we know we are doing what she wants." Set up certain ground rules beforehand and discuss possible outcomes. For instance, if the patient does wish to be told, should he or she be offered the choice of hearing bad news from the physician or a family member? Would the family be comfortable doing this?
 - **BEGIN YOUR TALK WITH THE PATIENT** with an open-ended question. "What is your understanding of your medical condition?" Depending upon physician preference, the question about disclosure may be presented neutrally ("Some patients want to be told directly about their illnesses, and others would prefer for the family to be in charge. What do you want in this regard?") or slanted in favor of nondisclosure ("Your daughters told me that in your family, details and decisions regarding your illness and care should be handled by them. This is fine with me, if this is what you wish."). If the patient declares the desire to be told, this must be pursued.
- Source: "A Request for Nondisclosure: Don't Tell Mother," *Journal of Clinical Oncology*; November 1, 2007; 25(31):5030-5034. Hallenbeck J, Arnold R; Division of General Medicine, Stanford University, Stanford, California; Veterans Affairs Palo Alto Health Care System, Palo Alto, California; and University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania.

CLINICIAN RESOURCES

END-OF-LIFE CARE BOOKS FOR PHYSICIANS

A Practical Guide to Palliative Care

By Jerry L. Old and Daniel L. Swagerty, this manual for health care professionals offers a multidimensional approach to the assessment and management of the end-of-life care needs of patients and their families.

Formatted for quick reference at the bedside, the book features an “In a Nutshell” summary of key points for each chapter, along with bullet points and quick-reference tables. The multiple appendices include tables of medical guidelines for specific diseases and an equianalgesic dosing chart for opioids.

Topics include:

1. Communicating with patients and families
2. Cultural diversity in end-of-life care
3. Predicting life expectancy
4. Non-pain symptom management
5. Pain control
6. Terminal care
7. Ethics at the end of life

The book outlines the palliative care services available through Medicare, reminding physicians that although eligibility for hospice care requires a prognosis of six months or less, there is no penalty if a patient lives longer.

The authors stress the importance of discussions about advance care planning for seriously ill patients, and urge the writing of a condolence letter following a patient’s death. Practical suggestions for writing such letters are offered, as well as guidelines for clinicians wishing to address their own emotions during various stages of a patient’s care.

Published by Lippincott Williams & Wilkins, 2007; ISBN: 9780781763431 (hardcover); 240 pp.

Principles and Practice of Palliative Care and Supportive Oncology, Third Edition

Edited by Ann M. Berger, John L. Schuster, Jr., and Jamie H. Von Roenn, this revised and updated interdisciplinary textbook serves as a practical guide to managing the wide range of symptoms and quality-of-life issues found among patients with cancer — from the newly diagnosed to those nearing the end of life.

Contributions from experts in such fields as hospice and palliative care medicine, oncology, neurology, nursing, psychiatry, anesthesiology, and pharmacology provide a blend of current scientific knowledge with detailed descriptions of related therapeutic options.

The section on pain has been widely remodeled, with summarized tables accompanying the text in the chapter on opioid therapy, and the inclusion of visceral pain and neuropathic pain (along with bone pain) in the chapter on difficult pain syndromes.

New chapters cover such topics as: Hot flashes, hepatic failure, pulmonary failure, caregiver stress, research issues in palliative care, and beginning a palliative care program.

The content has been designed to correspond to the needs of the recently accredited palliative care fellowship training programs, and includes new figures and protocols, tables on therapeutic management of various conditions, and guidelines for decision making.

Published by Lippincott Williams & Wilkins, 2007; ISBN: 9780781795951 (hardcover); 944 pp.

End-of-Life Care Websites

www.aahpm.org

American Academy of Hospice and Palliative Medicine

www.eperc.mcw.edu

End of Life/Palliative Education Resource Center (EPERC)

www.epec.net

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

www.nhpco.org

National Hospice & Palliative Care Organization

www.caringinfo.org

National consumer engagement initiative to improve end-of-life care

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

Palliative Care Policy Center

www.abcd-caring.org

Americans for Better Care of the Dying

www.mcw.edu/pallmed/

Medical College of Wisconsin Palliative Care Center

www.painpolicy.wisc.edu/

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

End-of-Life Care Meetings for Clinicians

12th Annual International Symposium: Palliative Medicine 2008. March 13-15, 2008, The Westin — Kierland Resort & Spa, Scottsdale, AZ. Sponsor: Cleveland Clinic Center for Continuing Education. Phone: 800-238-6750 or 216-297-7330; Website: www.clevelandclinicmeded.com/PM2008

The Program in Palliative Care Education and Practice. April 29-May 6, 2008, and November 11-18, 2008, Royal Sonesta Hotel, Boston. An intensive course for medical and nursing educators, given in two sessions (both spring and fall). Sponsor: Harvard Medical School Center for Palliative Care. Phone: 617-582-7859; Email: pallcare@partners.org; Website: www.hms.harvard.edu/cdi/pallcare

27th Annual Scientific Meeting of the American Pain Society. May 7-10, 2008, Tampa Convention Center and Marriott Tampa Waterside Hotel & Marina, Tampa, FL. Phone: 847-375-4715; Email: info@ampainsoc.org; Website: www.ampainsoc.org

17th International Congress on Care of the Terminally Ill. September 23-26, 2008, Montreal, Canada. Sponsor: Palliative Care Division, Departments of Medicine and Oncology, McGill University. Phone: 514-481-7408; Fax: 514-481-7379; Website: www.pal2008.com

9th Clinical Team Conference of the National Hospice and Palliative Care Organization. October 23-25, 2008, Hyatt Regency Dallas at Reunion, Dallas, TX. Mail: NHPCO-CTC 2008, P.O. Box 34929, Alexandria, VA 22334-0929; Fax: 877-779-6472; Website: www.nhpco.org



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