

Quality of Life Matters®

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

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AMA Urges Physicians to Help Patients with End-of-Life Planning, Decision Making

Caring Connections Website Offers State-Specific Advance Directives for Free Downloading

In the wake of recent national debate on end-of-life decision making for incapacitated patients following the Terri Schiavo case, the American Medical Association (AMA) voted during its June 2006 annual meeting to increase its efforts to educate patients on the importance of discussing and completing advance directives.

“Physicians can help patients with these important decisions as they grapple with this difficult topic,” says AMA board member Robert M. Wah, MD. “We encourage patients to talk to their physicians and use the health care community as a resource to help make educated decisions for the future.”

Among the several end-of-life care planning resources cited in the AMA board of trustees report on the topic is Caring Connections, the national consumer initiative of the National Hospice and Palliative Care

NHPCO Publications Include:

- Questions and Answers: Advance Directive and End-of-Life Decisions
- Conversations Before the Crisis
- Artificial Nutrition and Hydration at the End of Life
- End-of-Life Caregiving
- Questions and Answers: Dying at Home

Available free of charge at www.caringinfo.org or by calling 800-658-8898

Organization (NHPCO), one of the groups the report refers to as having “significantly more expertise than the AMA in the general area of end-of-life care, including advance care planning.”

The Caring Connections website (www.caringinfo.org) offers easily acces-

sible information on such topics as advance care planning, pain, caregiving, financial planning, and hospice/palliative care, as well as free access to state-specific advance directive documents for all 50 states and the District of Columbia.

Resources on the site include direct links to professional, government, and advocacy organizations, listed by topic. Educational publications range from two-page brochures to twenty-page booklets, and are available free for individual download. Multiple copies can be purchased online or by calling 800-658-8898.

“Physicians and their staff play an important role in encouraging conversations about the importance of planning before someone experiences a health care crisis,” adds J. Donald Schumacher, PsyD, NHPCO president and CEO.

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More Aggressive Care Isn’t Better Care

Dartmouth Medical School Analyzes Data from 4.7 Million Chronically Ill Elderly Medicare Beneficiaries

Medicare per capita spending for care delivered to chronically ill elderly patients during the last two years of life varies greatly among states, regions, and facilities. Yet higher spending and greater utilization of resources cannot be shown to extend survival, improve quality of life, or increase patient satisfaction, according to a report issued by Dartmouth Medical School.

“There is growing concern about the way chronic illness is managed in the United States, and about the possibility that some chronically ill and dying Americans might be receiving too much care — more than they and their families actually want or benefit from,” write the authors. The report’s lead investigator is John E. Wennberg, MD, MPH, director of the Center for the

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Applying Guidelines for Delivering ‘Bad News’

The ‘Universal Precaution’ of All Physician Communication with Seriously Ill Patients

Because patient appraisal of information as “bad and new” is subjective and cannot always be predicted, and because physician-patient interactions often include family members with their own individual perceptions and questions, **physicians should be ready to deal with the communication of bad news in all interactions.**

This is according to a team of experts in medical communication skills, whose report was published in the *Journal of Clinical Oncology*. “We suggest that physicians prepare for all interactions in which they will disclose any information — from the most momentous to the most trivial — by engaging in communication behaviors appropriate for delivering potentially stressful information,” write the authors.

The team observed and analyzed 25 randomly selected videotaped interactions between oncologists, patients, and their companions at the outpatient clinics of two comprehensive cancer research centers. 92% of patients (mean age, 60.7 years) had at least one companion (mean age, 48.6 years) present during the interaction. Findings include:

- **All interactions but one were found to include multiple bad news topics** — defined for this study as information perceived by patients and/or companions as sad and new — with a mean of 3.2 bad news topics per interaction. In the sole interaction containing just one such topic, the patient was informed that further tests were required before diagnosis could be determined.
- **Companions asked significantly more questions** than did patients. 62% of the 647 questions asked (mean, 10.04 questions per interaction) came from companions, with a difference that remained significant even for those interactions including only one companion.

- **Interactions lasted a mean of 37 minutes**, with 63% of that time used for discussing diagnosis and treatment. Most interactions were highly complex and contained numerous pieces of related and unrelated information.

“Our observations of these 25 interactions within the framework of current guidelines for giving bad news lead us to challenge some of the basic assumptions underlying the guidelines,” the authors state. They identify three assumptions that oversimplify the potentially complex nature of actual oncologist-patient/companion interactions.

ASSUMPTIONS TO AVOID

ASSUMPTION 1: A bad news interaction can be predicted or planned

Almost any news has the potential to be perceived negatively and does not become bad news until it is disclosed and then appraised as such. This appraisal occurs within the context of each individual hearer’s expectations and values. Thus, physicians cannot plan a bad news interaction before it occurs, note the authors, and “actual interactions do not follow scripts.”

ASSUMPTION 2: The focus of bad news interactions is one single piece of information

The researchers found that patients and their companions in the observed interactions were given numerous pieces in a range of information, from details concerning diagnosis and staging to logistical complexities and adverse effects of treatment to prognostic probabilities. “Information was disclosed and discussed in the context of other information and questions or comments by patients and companions,” they write. “Responses to any single portion of the information were not predictable.”

Communication Guidelines for Physician-Patient/Companion Interactions

- **Take the universal precaution** of applying strategies for discussing bad news to *all* interactions in which information is discussed, because any information has the potential to be perceived as bad news.
- **Discuss multiple pieces of related and unrelated information** in a way that allows patients and their companions to absorb and respond to each piece of information, independently and in context.
- **Address the varying needs** of all participants in the interaction, including patients and each of their companions.

— Eggly, et al, *Journal of Clinical Oncology*

ASSUMPTION 3: Bad news interactions consist of two participants, the physician and the patient

Companions were active participants in the observed interactions, introducing complexities and even controversy, the authors note. Since it is rare for patients to be unaccompanied, the questions, comprehension, reactions, and needs of companions must also be addressed and respected.

“Existing guidelines for giving [potentially stressful] information should apply to all interactions in which information is delivered and discussed,” state the authors. “This step should be the universal precaution of patient-physician communication.”

Source: “Discussing Bad News in the Outpatient Oncology Clinic: Rethinking Current Communication Guidelines,” Journal of Clinical Oncology; February 1, 2006; 24(4):716-719. Eggly S, Penner L, et al; Communication and Behavioral Oncology Program, Karmanos Cancer Institute, Wayne State University, Detroit.

More Aggressive Care Isn't Better Care (from Page 1)

Evaluative Clinical Sciences at Dartmouth, Hanover, NH.

The research team analyzed health care spending and resource utilization during the last two years of life among 4.7 million Medicare beneficiaries (aged 67 to 99 years) who died between 2000 and 2003 and had at least one of 12 chronic illnesses.

Extensive variation in the utilization of acute care hospitals, intensive care units, medical specialists, and diagnostic testing was found among states, among regions within states, and among individual facilities within regions.

According to the authors, three major issues drive the differences in spending and utilization in the management of patients with severe, life-threatening chronic illness. These are:

- **Overuse of Resources:** “The majority of acute care hospitals are applying their standard forms of ‘rescue medicine’ to people who are in advanced stages of diseases that can’t be cured,” says Wennberg. “Patients don’t benefit — they can’t be rescued — and the costs of such care are very high, both in dollars spent and in providing care that the majority of chronically ill patients might not want, such as admissions to intensive care and being sent to specialist after specialist.”
- **Lack of Evidence-Based Guidelines:** “Scientifically validated, detailed evidence defining efficient clinical pathways — for example, whom to hospitalize, when to schedule a revisit, or when to refer to a medical specialist, home health agency, or hospice — does not exist,” write the authors.
- **Assumption That More Aggressive Treatment Is Better:** “The extra spending...doesn’t buy longer life or better quality of life,” states the report. “In fact, those with chronic illnesses who live in high rate regions have slightly shorter life expectancies and less satisfaction with their care than those in regions with lower rates of spending...the problem is waste.”

Recognizing that acute care hospitals — the only locus of organized care throughout the country — are financially dependent upon utilization, the authors call for reform of the Medicare reimbursement policy to reward better organized, higher quality, and more efficient care in the management of chronic illness. Toward this end, the Dartmouth Atlas Project has released Medicare claims data rating utilization for more than 4,300 hospitals in 306 regions in a new interactive database, which is freely accessible online.

The report, entitled “The Care of Patients with Severe Chronic Illness: A Report on the Medicare Program by the Dartmouth Atlas Project,” was released in May 2006, and is also available online.

For more information, visit www.dartmouthatlas.org.

Variations by State in the Care of Chronically Ill Patients During the Last Six Months of Life

HOSPICE CARE

- The proportion of elderly, chronically ill patients enrolled in hospice during their last six months of life ranged from 6.7% to 44.7%; the national average rate was 27.2%.
- Western states such as Arizona (44.7%), Colorado (39.3%), and Utah (36.6%), along with Florida (37.9%), Michigan (34.3%), and Ohio (32.7%) had a substantially higher proportion of hospice enrollees than did Alaska (6.7%), Maine (12.6%), South Dakota (14.6%), Wyoming (16.3%), and Vermont (17.9%).

ICU DAYS

- The national average number of days spent in intensive care units (ICUs) per decedent during the last six months of life — which is “a measure of the aggressiveness of end-of-life care,” according to the report — was 3.2 days (range, 1.5 to 4.7 days).
- Florida (4.7 days), California (4.6), New Jersey (4.6), South Carolina (3.9), Delaware (3.9), and the District of Columbia (3.8) had substantially higher rates than such states as North Dakota (1.5), Vermont (1.7), New Hampshire (1.8), and Maine (1.9).

HOSPITALIZATION

- The average number of hospital days per decedent during the last six months of life ranged from 7.3 to 16.4, while the U.S. average was 11.7 days.
- Rates of hospitalization for residents of Hawaii (16.4 days), New York (16.3), the District of Columbia (15.8), and New Jersey (15.2) were about twice as high as for those in Utah (7.3), Oregon (7.8), and Idaho (8.2).

MULTIPLE PHYSICIANS

- The proportion of patients seeing 10 or more physicians during the last six months of life ranged from 10.8% to 38.7%. “**So many different physicians being involved in the patient’s management could indicate problems with continuity of care,**” comment the authors.
- Rates were high in Wyoming (38.7%), the five Mid-Atlantic states (average, 35.7%; range, 38.7% to 34.1%), Florida (34.6%), and Massachusetts (34.2%), but substantially lower in Wyoming (10.8%), Montana (12.0%), Idaho (13.3%), Oregon (14.5%), and Utah (15.0%).

Innovative Program Instructs Emergency Physicians on Hospice Referral of CHF Patients

A Washington, D.C., hospital has incorporated into its physician resources a teaching module on an element of the health care network often underutilized in the emergency care of patients with advanced chronic disease: hospice referral.

“Late in a disease process such as end-stage CHF [congestive heart failure], the complex terminal care needs of patients and families facing the end of life are best met by comprehensive hospice care, not by calls to 911 for transportation to the emergency department,” write Michelle Grant Ervin, MD, of the Washington Hos-

pital Center, and colleagues.

An interactive, computer-based tutorial offers instruction designed for both attending and resident emergency physicians. Components include: National Hospice and Palliative Care Organization guidelines for identifying CHF patients eligible for hospice referral; key talking points for discussion of hospice referral with patients and family members; available resources and appropriate forms.

A daily update of disease-specific visit counts alerts emergency physicians that hospice referral may be appropriate.

Since its initiation, the program has successfully identified for referral 82 CHF patients with a history of more than four emergency department visits within a 12-month period. Although these patients represented only 4% of total heart failure patients, they accounted for 13% of CHF emergency visits, notes Ervin.

Source: “Teaching Emergency Physicians Hospice Referral Criteria to Decrease ED Recidivism in End-Stage CHF,” Academic Emergency Medicine; May 2006; 13(5 Supplement 1):S211-S212. Abstract presented at the Annual Meeting of the Society for Academic Emergency Medicine, May 2006. Ervin MG, Davis G, Milzman D; Washington Hospital Center, Washington, DC.

Physician Discussion of End-of-Life Care Found Important, But Often Too Little, Too Late

Family members often play a major role in decision making at the end of life, relying primarily on the patient’s physician for information regarding terminal illness, life expectancy, and hospice. But physician communication on these issues is frequently limited in scope and delayed in timing, and can sometimes be poorly absorbed, a recent study has found.

“We find that the family caregivers’ own understanding of the patient’s condition and the possible treatment alternatives is strongly influenced by discussions they report having with the physician,” write the authors of a report published in the *Journal of Palliative Medicine*. “We additionally find that those who are told that the patient’s illness is not curable are often told very late in the course of the patient’s illness.”

The team analyzed data from interviews with 206 primary family caregivers at or near the time their loved ones were enrolled in hospice with advanced cancer, between October 1999 and September 2001.

Findings Include:

- 20.8% said they were never told by a physician that the disease was incurable.
- Of those informed that there was no cure, 40.7% were never provided with an estimate of life expectancy.
- Hospice length of stay was significantly shorter for the group not told the illness was incurable compared with those who were so informed (17.8 days vs 34.6 days).
- Of those with whom hospice was discussed, 41.1% reported that the physician introduced the topic less than one month prior to the patient’s death; 27.4% said they were first told about hospice less than 2 weeks before death.

“Patients whose family caregiver reported discussions of the patient’s incurable illness had significantly longer hospice length of stays prior to death,” write the authors. **“Recent research has shown significant benefits of earlier hospice enrollment for both patients and family caregivers, and earlier communication about hospice as an option might promote its more timely consideration and use.”**

The authors add, “In the vast majority of cases, family caregivers report that they

did not know the patient’s illness was incurable [75.9%] or that hospice might be appropriate [84.7%] until a physician raised it with them.”

Source: “Communication between Physicians and Family Caregivers about Care at the End of Life: When Do Discussions Occur and What Is Said?” Journal of Palliative Medicine; December 2005; 8(6):1176-1185. Cherlin E, Fried T, et al; Department of Epidemiology and Public Health and Department of Internal Medicine, Yale School of Medicine, New Haven, Connecticut; Center for Psychoncology and Palliative Care Research, Dana-Farber Cancer Institute, and Department of Psychiatry, Brigham and Women’s Hospital, Harvard Medical School, Boston.

What Parents of Dying Children Require from Clinicians

Honesty, Coordinated Communication, and Emotional Support Top the List

Dying children have unique palliative care needs, and so do their families. Along with honest and coordinated sharing of information, parents most value respect for their crucial role in the child's care and a genuine expression of compassion from medical professionals. This is according to a recent report published in *Pediatrics*.

"In many ways, staff members can be most helpful to parents when they honor the rightful place and privilege of parents, and support them in their efforts to be the best parents they can be," write the authors. **"Indeed, clinicians need not fear displaying their empathy and own emotions, for this is the very substance that can convey one's humanity and matters deeply to parents."**

The investigators analyzed the questionnaire responses of 56 parents whose children (range of age, newborn to 18 years) had died after life support was withdrawn between 12 and 45 months earlier. Most pediatric end-of-life care currently takes place in acute care hospitals, where two-thirds of children's deaths in critical care units occur following the forgoing of life-sustaining treatment, note the authors.

Participants were asked to evaluate the aspects of their child's end-of-life care that were most and least helpful, and to offer suggestions for improving care. "Parents valued being listened to, respected, not judged, and included in the decision-making process," write the authors. Their article includes many of the parents' comments in their own words.

Parents' recommendations for quality end-of-life care for children included:

- **Honest and Complete Information:** Parents said: "Listen. Answer all questions. Give all information — parents can handle it. What we cannot handle is not knowing what is going on."

- **Ready Access to Staff:** Many parents emphasized the importance of easy access to the staff, not only for needed information, but also to increase their confidence and trust, and for emotional reassurance. "The biggest problem was that it was too late before anyone really spoke to us, despite our asking," one parent said. "Just keep us updated with regular meetings. Set a regular time for 'office hours at the bedside.'"

"Our findings are consistent with mounting evidence that most parents prefer full disclosure of information ... For example, parents of children with cancer who were better informed were more likely to have care that met the goals for palliative care, including earlier hospice referrals, greater satisfaction with home care, and greater focus on relief of suffering."

— Meyer, et al
Pediatrics

- **Communication and Care Coordination:** Some parents desired that trusted and familiar spokespersons filter all information to them. "There were too many doctors explaining things; there really should be just a few. It is too confusing." Others preferred there be a coordinated meeting between themselves and all clinicians and an airing of various and conflicting viewpoints. "Share with us the dilemmas the medical staff may be facing, what bias the doctors and nurses may have to stop or keep going."
- **Emotional Expression and Support by Staff:** "Be compassionate and ask

how parents are. Don't fall into that detached type of working. Parents need to feel that people really care, not that it's just a job," one parent commented. "That personal touch becomes so important to people who are functioning at a low level. The staff becomes the only link between you and the unknown."

- **Preservation of the Integrity of the Parent-Child Relationship:** Parents emphasized the importance of respect for their unique relationship and responsibilities. "Listen to what the parents have to say. In the long run, the parents do know what is best for their child." Many also described the importance of privacy and "quiet time" with their child, of being able to provide traditional parental love, protection, and physical tenderness throughout the dying process. As one parent said, "They let us take as much time as we needed to say goodbye."

The authors write, "End-of-life discussions that focus on organ systems or offer information only on a need-to-know basis may not hit the mark and can leave some families feeling overwhelmed, underinformed, or wondering what the information means relative to their child's quality of life and survival." They add, "Preserving the integrity and sanctity of the parent-child relationship can help parents begin to cope with feelings of helplessness associated with the heartbreaking realization that they will no longer be able to parent their child in the future."

Source: "Improving the Quality of End-of-Life Care in the Pediatric Intensive Care Unit: Parents' Priorities and Recommendations," Pediatrics; March 2006; 117(3):649-657. Meyer EC, Ritholz MD, Burns JP, Truog RD; Medical Surgical Intensive Care Unit, Children's Hospital, Boston; Department of Psychiatry and Department of Anesthesia (Pediatrics), Harvard Medical School, Boston.

CLINICIAN RESOURCES

End-of-Life Care 'Fast Facts' Online Now Number 156

The Fast Facts Index has continued to expand its list of one-page, peer-reviewed outlines of key clinical information on end-of-life care for practicing physicians, physicians-in-training, medical educators, nurses, social workers, and other health care professionals.

The most recent titles include:

- “Teaching the Family What to Expect When the Patient Is Dying”
- “Prognostication in Dementia”
- “Use of Interpreters in Palliative Care” (see summary below)
- “The Military History as a Vehicle for Exploring End-of-Life Care with Veterans” (see summary below)

All information on the EPERC (End-of-Life Care/Palliative Education Resource Center) website is available free of charge. Fast Facts can be downloaded as text or PDF files, or to a personal digital assistant (PDA).

Access the complete collection of Fast Facts at www.eperc.mcw.edu.

Use of Interpreters in Palliative Care

[ADAPTED FROM EPERC FAST FACT #154]

The need for an interpreter in a clinical encounter implies that cultural, as well as language, differences exist between the physician and patient. Using a trained medical interpreter will help ensure that the communication is effective, reassuring, and culturally sensitive.

“During times of emotional stress and conversations that touch the inner soul, it is most comforting and safe for patients and families to describe feelings and thoughts in their primary language,” comments the author.

Physicians are advised to:

- Brief the interpreter ahead of time regarding the purpose of the encounter and the need for accuracy. Alert the interpreter if the topics of end-of-life care or dying will be addressed.
- Face the patient at eye level, positioned next to the interpreter, so the patient will not need to keep turning his/her head.
- Speak to the patient directly, and in the first person. “I am here today to talk to you about...” Avoid requesting the interpreter to “tell him” or “ask her.”
- Be clear and concise. Pause at the end of each statement to allow the interpreter time to translate.
- Watch for nonverbal cues indicating confusion or misunderstanding. Stop, and clarify with the interpreter that everyone has understood the information.
- Debrief the interpreter following the interaction, inviting questions or comments, particularly if the discussion was emotionally charged. “How are you doing?” “Was that distressing for you?”

Source: “Fast Facts and Concepts #154: Use of Interpreters in Palliative Care,” April 2006; Howard S; End-of-Life/Palliative Education Resource Center; www.eperc.mcw.edu.

The Military History as a Vehicle for Exploring End-of-Life Care with Veterans

[ADAPTED FROM EPERC FAST FACT #152]

Veterans account for more than 25% of national deaths yearly, with an estimated 54,000 dying each month. Polite, respectful inquiries into the military background of a patient can bridge the silence surrounding what is often a defining experience and act as a catalyst for discussions about end-of-life care.

“Establishing an environment of trust is critical when speaking with war veterans about end-of-life care,” note the authors.

To introduce the topic, physicians might ask:

- “Are you a veteran? What branch of the military were you in?”
- “Where and when did you serve? What did you do?”
- “Would you like to tell me about your military experience? How do you think it has affected you?”

If the patient is responsive, ask for details:

- “Did you see combat, or were you in a combat area?”
- “Were you ever wounded or hospitalized?”
- “Do you have a service-connected condition?”
- “Are you enrolled for VA medical benefits?”

When appropriate, deepen the discussion:

- “Do you think being in the military changed you. How so?”
- “Are your experiences in the military affecting you today? Do you think they are influencing the way you are coping with your illness?”

If the patient experiences significant anxiety, or needs psychological assistance, contact the local VA Medical Center.

Source: “Fast Facts and Concepts #152: The Military History as a Vehicle for Exploring End-of-Life Care with Veterans,” March 2006; Hallarman L, Kearns C; End-of-Life/Palliative Education Resource Center; www.eperc.mcw.edu.

CLINICIAN RESOURCES

BOOK FOR CLINICIANS

A Palliative Ethic of Care: Clinical Wisdom at Life's End

This volume by Joseph J. Fins, MD, offers clinicians a practical guide to goal setting for patients nearing the end of life, presented within the context of ethical, legal, and historical considerations of palliative care. Although addressed to physicians in training, the book has been found to be a valuable resource for experienced clinicians and all those addressing the transition from curative to palliative care near the end of life.

Patients “have not been acculturated to think about palliative care as a goal of care,” writes Fins. Often overlooked, goal setting is key to effective palliative care in that it “overcomes the routinization of care decisions that often lead to an escalation of care, when this was neither desired nor likely to influence the outcome.”

The book's first part, “Death and Dying in Context,” examines the challenges of caring for dying patients in the light of bioethics, the law, and the emergence of controversial palliative care issues. Chapter subtitles include:

- The Challenge of Caring for the Dying
- Toward an Ethic of Patient's Rights
- Quinlan and the Right to Die
- Back to the Future: The Schiavo Case
- Death in the Modern Hospital

The second part, “Goal Setting: A Strategy for Effective Palliative Care,” offers a comprehensive guide to the practical application of setting goals of care. It includes, for example, a list of clinical cues that should “trigger” a reassessment of care, and ends with a discussion of working with a multidisciplinary team. Chapter subtitles include:

- Goal Setting as Differential Diagnosis
- Triggering the Process
- Hospice or Palliative Care Referral
- The Ethics of Opioid Use
- The Elusive Advance Directive

The author's empirically-based Goals of Care Assessment Tool (GCAT) is presented in the book's appendix. “GCAT is specifically designed to ensure that the patient's goals drive their therapy instead of the therapy driving the goals,” says Fins. **“The goal is to help people have a better quality of life and — when the time comes — quality of death.”**

Fins is chief of the Division of Medical Ethics, Weill Medical College of Cornell University, where he is also a professor. In addition, he serves as director of medical ethics at New York-Presbyterian Hospital/Weill Cornell Medical Center, New York City.

*Published by Jones and Bartlett Publishers, 2005; ISBN: 0763732923
(paperback); 281 pp.*

“The average length of stay in a hospice is only a few weeks. This is often too little, too late. In fact, many patients deserving of a comfortable and dignified death aren't even given the option.”

—Joseph J. Fins, MD

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.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

End-of-Life Care Meetings for Clinicians

17th Annual Clinical Meeting of the American Academy of Pain Management. "Beyond Boundaries: Forging New Alliances in Pain Management." September 7-10, 2006, Walt Disney World Swan and Dolphin, Lake Buena Vista, FL. Phone: 209-533-9744; Fax: 209-533-9750; Website: www.aapainmanage.org

7th International Symposium on Pediatric Pain. September 26-29, 2006, The Fairmont Hotel, Vancouver, BC, Canada. Sponsor: Canadian Pain in Child Health Society for the Special Interest Group on Pain in Childhood of the International Association for the Study of Pain. Phone: 604-681-2153; Fax: 604-681-1049; Email: ispp2006@meet-ics.com; Website: www.ispp2006.com

16th International Congress on Care of the Terminally Ill. September 26-29, 2006, Palais des Congres, Montreal. Sponsor: Palliative Care Division, Departments of Medicine and Oncology, McGill University. Phone: 514-481-7408, ext. 227; Fax: 514-481-7379; Email: info@pal2006.com; Website: www.pal2006.com

The Science & Art of Pain and Symptom Management. November 17-18, 2006, The Old Mill Inn, Toronto. Sponsor: Oncology Continuing Education, University of Toronto. Phone: 416-978-2719, or 888-512-8173 (North America only); Fax: 416-946-7028; Email: ce.med@utoronto.ca; Website: www.cme.utoronto.ca

Annual Assembly of the American Academy of Hospice and Palliative Medicine and the Hospice and Palliative Nurses Association. February 14-17, 2007, Salt Lake City, UT. Phone: 847-375-4712; Fax: 877-734-8671; Email: info@aahpm.org; Website: www.aahpm.org

The American Academy of Hospice and Palliative Medicine states:

- The proper role of a physician is to help the sick, even when cure is not possible.
- Death is a natural and inevitable end to life, and helping patients achieve an easy passage to death is one of the most important and rewarding services that a physician can provide.
- The medical profession should attend to all of the needs of dying patients and their families.
- Physicians have an important responsibility in hospice and palliative care, and should take a leadership role in promoting and guiding the future direction of this care.
- Physicians have a major responsibility for bringing the hospice approach into mainstream medicine.

For more information about hospice and palliative care, or to make a referral, please contact your local hospice and palliative care organization.

Quality of Life Matters® is recommended as an educational resource by the American Academy of Hospice and Palliative Medicine and the Hospice and Palliative Nurses Association.

QUALITY OF LIFE MATTERS®

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

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

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