

Quality of Life Matters®

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

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Self-Awareness Approach Offered to Protect Physicians from Burnout and Compassion Fatigue

JAMA article offers practical suggestions for self-care in the workplace

Caring for terminally ill patients can expose clinicians to a number of institutional and personal stressors, leading to the mental and emotional distress of burnout and/or compassion fatigue. To help clinicians enhance both their own well-being and that of their patients, a team of experts has proposed an approach to physician self-care based on self-awareness.

“Physicians working with patients at the end of life frequently have to respond to overwhelming human suffering in the absence of adequate institutional support or resources,” write the authors of an article published in the *Journal of the American Medical Association*. “In this context, the idea of ‘self-care’ may seem a selfish irrelevance and an unjustifiable

luxury. In fact, self-care is an essential part of the therapeutic mandate.”

While there has been more research on burnout than on compassion fatigue, the authors note, a review of the literature suggests that promoting their opposites (i.e., job engagement and compassion satisfaction) can improve both the physician’s professional satisfaction and the quality of patient care.

Burnout

Burnout can result from stresses encountered by the clinician within the work environment. “[B]urnout is a result of frustration, powerlessness, and inability to achieve work goals,” the authors write. Key dimensions of burnout include:

- **Emotional exhaustion:** feelings of overextension and depletion of physical and emotional reserves
- **Depersonalization:** negative or callous responses, excessive detachment from or cynicism about the job
- **Low personal accomplishment:** feelings of incompetence and underachievement

Compassion Fatigue

Compassion fatigue arises from unresolved emotional pain experienced in the relationship between the clinician and the patient. Some researchers have likened compassion fatigue to posttraumatic stress disorder (PTSD), experienced vicariously.

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Advanced Dementia Patients 2.5 Times More Likely to Have Feeding Tube Placement in Areas with High Rates of End-of-Life Health Care Transitions

Recent reviews and studies have shown a lack of health benefit from artificial feeding in patients with advanced dementia, yet the use of feeding tubes in this population not only continues, it varies widely in prevalence — as much as tenfold — across the nation.

Now, researchers have found that U.S. regions with higher rates of transitions in health care settings among elderly nursing home residents in the last six months of life are also much more likely to have higher rates of feeding tube placement in those with severe cognitive impairment.

“While this observation does not necessarily imply a causal relationship, it raises serious concerns about the quality and efficiency of end-of-life care in the United States,” write the authors of a report published in the *Journal of Palliative Medicine*.

“Future research is needed to understand whether a poorly executed transition played a role in the insertion of a feeding tube or [whether] this strong association is a reflection of a medical culture toward overall aggressive medical care.”

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Self-Awareness Approach Offered to Protect Physicians from Burnout and Compassion Fatigue

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Often called “secondary traumatization,” compassion fatigue mirrors PTSD in certain domains. Symptoms of compassion fatigue include:

- **Hyperarousal:** disturbed sleep, irritability, and hypervigilance
- **Avoidance:** “not wanting to go there again,” avoiding discussing, thinking, and feeling about the patient’s pain and suffering
- **Re-experiencing:** intrusive dreams or thoughts, psychological or physiological distress triggered by reminders of caring for dying patients

Self-Care with Self-Awareness

There is empirical data to support the use of practices such as mindful meditation and reflective writing to prevent burnout.

Other suggested measures include: training in communication skills, promoting fairness and feelings of choice and control in the workplace, providing a supportive work community, and developing self-awareness skills.

“Physicians with burnout who use self-care without self-awareness may feel as though they are drowning and barely able to come

“Self-care enables physicians to care for their patients in a sustainable way with greater compassion, sensitivity, effectiveness, and empathy.”

— Kearney et al, *Journal of the American Medical Association*

up for air;” assert the authors, **“whereas self-care with self-awareness is like learning to breathe underwater.”**

The self-awareness approach may help physicians to experience greater job engagement with less stress, thus remaining emotionally available to their patients, even in the most difficult clinical situations. Further, physicians can experience vicarious posttraumatic growth by witnessing the patient’s or family’s own posttraumatic growth, especially as aided by the clinician’s deepened empathy.

This enhanced or “exquisite” empathy is facilitated by physician self-awareness and can be experienced as a mutually healing connection with the patient. “This approach enhances the potential of the work itself to be regenerative and fulfilling for the clinician,” write the authors. “When patients experience mean-

Practical Suggestions for Self-Awareness and Self-Care in the Workplace

- As you walk toward your workplace or through its halls, pay careful attention to the sensation of your feet contacting the ground.
- Before entering the next patient’s room, pause and pay attention to your breathing for two to five breaths.
- Don’t be afraid to ask, “Is it time for a break?” Call a “time out” to deal with emotional flooding after a traumatic event. Call a colleague to say, “I need a walk [or break].”
- Set your watch or other alarm for the same time each day as a prompt for centering. Recite a line from a favorite poem or prayer. Think of a loved one. Take four deep, slow breaths. Picture weights around your waist and the words “ground, down.”
- Use the 20 seconds of suggested hand-washing time creatively. Pay full attention to the sensation of the water on your skin. Recite a poem or prayer. Tell yourself, “I am worthy of my own time.” Sing “Happy Birthday!” to yourself.
- Stop by a window and look at something in nature, giving it your full attention for several moments.
- Deliberately make connections with colleagues and with patients. Use humor. Notice something unusual in the patient’s room. Comment on a patient’s date of birth.
- Keep a notebook for writing “field notes” on traumatic or meaningful encounters or events. Share these occasionally at interdisciplinary team meetings.
- Develop a deliberate “role-shedding ritual” for the end of the day, which you can use as you hang up your white coat or put away your stethoscope. Use the drive home to listen attentively to the news, music, or an audio book.

— Adapted from Kearney et al, *Journal of the American Medical Association*

ing and peacefulness in relation to their approaching death, this enriches the lives of the clinicians involved.”

Source: “Self-Care of Physicians Caring for Patients at the End of Life: ‘Being Connected...A Key to My Survival,’” *Journal of the American Medical Association*; March 18, 2009; 301(11):1155-1164. Kearney MK, Weininger RB, Vachon MLS, Harrison RL, Mount BM; Palliative Care Service, Santa Barbara Cottage Hospital and Visiting Nurse and Hospice Care of Santa Barbara, and La Casa de Maria Retreat and Conference Center, Santa Barbara, California; Department of Psychiatry and Dalla Lana School of Public Health, University of Toronto, Toronto; Counseling Psychology Program, University of British Columbia, Vancouver; Department of Medicine, McGill University, Montreal.

New Pediatric Standards Aim to Improve Palliative and Hospice Care for Children

The National Hospice and Palliative Care Organization (NHPCO), along with the Children's Project on Palliative/Hospice Services, has released the first "Standards of Practice for Pediatric Palliative Care and Hospice." Intended to be used by hospices as a supplement to the NHPCO standards for adults, the document addresses the special needs of pediatric patients and their families. Care is provided to patients in the perinatal period, infancy, childhood, adolescence, and young adulthood. Key features include:

- **Life affirming care** by supporting the child's and family's goals for the future. **Services can be provided along with concurrent life-prolonging or curative care** or as the main focus of care.
- **A combination of active and compassionate therapies** intended to comfort and support the child, as well as family members and other significant people in the child's life.
- **Holistic care**, assisting in fulfilling children's physical, social, developmental, educational, psychological, and spiritual goals while remaining sensitive to personal, cultural, and religious values, beliefs, and practices.

"All children with life-threatening conditions deserve excellent pediatric palliative care, either as the primary treatment or concurrent with disease modifying or curative therapies," the authors state.

Source: "Standards of Practice for Pediatric Palliative Care and Hospice," April 2009; National Hospice and Palliative Care Organization and the Children's Project on Palliative/Hospice Services, Alexandria, Virginia.

Statistics at a Glance

- According to the 2005 Annual Summary of Vital Statistics [most recent data available], 28,534 infants died, with 4% of deaths estimated to be preventable or sudden.
- Of infants who died with complex chronic conditions, 32% of deaths were cardiovascular, 26% congenital, 17% respiratory, and 14% neuromuscular.
- Beyond infancy, 25,018 children ages 1-19 years died, with 53.3% estimated to be preventable or sudden deaths.
- Of children ages 1-19 who died with complex chronic conditions, 43% of deaths resulted from malignancy, 23% neuromuscular, and 17% cardiovascular.
- Historic data indicate that 70% of families state they would prefer for their child to die at home, if adequate support were available. However, statistics show that 82% of children dying of complex chronic conditions die in the hospital, with only 15% at home.

— NHPCO April 2009 Facts and Figures:
Pediatric Palliative and Hospice
Care in America

Advanced Dementia Patients and Feeding Tube Placement

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Transitions were defined as transfers to or from a hospital, inpatient rehabilitation, nursing home, inpatient hospice, or home.

Researchers utilized two national databases from 2000 to create their study samples: nursing home residents aged 65 years and older with advanced cognitive impairment but no feeding tube placement at baseline (n = 97,239), and all Medicare patients who died that year with at least one nursing home stay in the last six months of life (n = 348,276).

Key findings include:

- Nationwide, the Medicare decedents with a nursing home stay in 2000 experienced an average of 3.2 transitions in the last six months of life. This varied

threefold across the 306 hospital referral regions, ranging from 1.9 transitions (Salem, Oregon) to 5.1 transitions (Monroe, Louisiana).

- Patients residing in regions (grouped into quintiles) with the highest rate of transitions were 2.5 times more likely to have a feeding tube inserted compared with those living in the lowest quintile.
- One-year incidence per 1000 residents of feeding tube placement among advanced dementia nursing home patients ranged from 0-12 in the lowest quintile to 86-247 in the highest quintile.

The authors call for future research into possible mechanisms that would explain the strong association of health care transitions with feeding tube insertion in "a

population in whom benefit is unlikely."

"It is possible that persons are hospitalized without information about their wishes regarding artificial hydration and nutrition [being known]," suggest the authors. "An alternate potential explanation is that both of these findings are markers of local medical culture that tends toward aggressive interventions such as feeding tubes and hospitalizations among dying persons."

Source: "Churning: The Association between Health Care Transitions and Feeding Tube Insertion for Nursing Home Residents with Advanced Cognitive Impairment," Journal of Palliative Medicine; April 9, 2009; 12(4):359-362. Teno JM, Mitchell SL, et al; The Warren Alpert Medical School, Brown University, Providence, Rhode Island; Beth Israel Deaconess Medical Center, Boston; Dartmouth Medical School, Hanover, New Hampshire.

Physician Aid in Dying: Requests Often Based on Worries about Future Symptoms, Circumstances

Patients who completed a survey regarding their reasons for requesting physician aid in dying (PAD) using the Oregon Death with Dignity Act routinely cite concerns for the future, rather than for current symptoms, as the reason for their request. That is according to a study published in the *Archives of Internal Medicine*, in which 56 patients were surveyed.

Within 2 to 3 months of participating in the study, 41 patients (73%) had died, 18 (44%) had received a prescription for a lethal dose of medication, and 9 (22%) died after ingesting the medication.

The most common terminal diagnoses among respondents were cancer and amyotrophic lateral sclerosis. Most patients were white, and more than half were well educated, single, and lived on their own. About one-third were enrolled in hospice.

Reasons for Requesting PAD

The most important reasons for requesting PAD include:

- Desire to control the time, location, and manner of death and die at home
 - Fear of worsening pain or quality of life
 - Fear of becoming unable to take care of themselves
 - Having witnessed intolerable deaths
 - Perception of self as a burden
- Factors that had little influence on the decision to request PAD include:
- Current pain or other physical symptoms
 - Perception of being a financial drain
 - Depression
 - Existential reasons, such as feeling that life is pointless
 - Current level of support from others

The authors note that as of the time of their study, Oregon was the only jurisdiction in the U.S. where patients legally could receive a lethal dose of medication from a physician. For a PAD request to be approved, 2 physicians must conclude that the patient has less than 6 months to live and is mentally capable of requesting PAD.

How Clinicians Can Help

Clinicians can improve patients' sense of control and lessen their fears, and therefore the desire for PAD, by:

- Providing education about quality end-of-life care
- Reassuring a sense of control, especially in those patients who witnessed intolerable deaths
- Reassuring patients that all efforts will be made to control pain and other symptoms and to ensure they will be able to die where they wish

— Ganzini et al, *Archives of Internal Medicine*

Source: "Oregonians' Reasons for Requesting Physician Aid in Dying," *Archives of Internal Medicine*; March 9, 2009; 169(5):489-571. Ganzini L, Goy ER, Dobscha SK; Portland Center for the Study of Chronic, Comorbid Mental and Physical Disorders, Health Services Research and Development Service, Portland Veterans' Affairs Medical Center; Department of Psychiatry, Oregon Health and Science University, Portland.

Chronic Critical Illness: Advance Directives, Appointment of Health Care Proxies Could Ease Burdens for Patients, Families

As care for acute critical illnesses improves, more patients survive these illnesses. However, many of the patients who survive become chronically critically ill, requiring that decisions be made regarding life-sustaining therapies.

According to a study published in *Critical Care Medicine*, "Most chronically critically ill patients fail to designate a surrogate decision-maker or express preferences regarding life-sustaining treatments." Consequently, in many cases, no one is authorized to make decisions regarding limiting or withdraw-

ing treatments, even when extended use of these treatments has not provided meaningful benefits to the patient.

Researchers interviewed caregivers for 203 chronically critically ill patients in the respiratory care unit (RCU) at a large university-affiliated hospital in New York. All patients had tracheotomies after failed attempts to wean them from mechanical ventilation in an intensive care unit, and none of the patients previously had been in the care of an RCU.

Investigators found that:

- 43 of the 203 patients (21.2%) had ap-

pointed a health care proxy (37 before entering the RCU and 6 during treatment in the RCU).

- 33 (16.2%) completed an advance directive (31 before admission and 2 during RCU treatment).
- 71 (35%) had do-not-resuscitate orders (27 before RCU admission).
- Treatment was limited for 39 patients (19.2%), most often for vasopressors.

In some states, including New York where this study was conducted, only a

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Perception of Physician Abandonment at End of Life Affects Patients' Sense of Continuity, Closure

When patients transition from care by a primary physician to end-of-life care, patients and their families sometimes feel as if they have been abandoned by their physicians.

In a study published in the *Archives of Internal Medicine*, researchers note that before a patient's death, perceived abandonment can lead patients and families to feel a "loss of continuity," both because they have lost access to their physician's medical expertise and because they have lost the patient-physician relationship.

At the time of death and afterward, the feelings of abandonment can result from "lack of closure."

Investigators conducted interviews at three time periods with patients, family caregivers, physicians, and nurses: at the time they enrolled in the study, after 4-6 months, and again after 12 months. In the interviews, participants (including patients, family caregivers, physicians, and nurses) frequently brought up abandonment as a concern, even though the interviewers did not use the word "abandonment."

Patients and caregivers consistently noted the need for continuity and closure

Facilitating Continuity and Closure

BEFORE DEATH:

- Assure the patient that the physician and the nurse will still be available after transition to hospice.
- Continue to call and/or see the patient and family.
- Initiate a discussion during the probable final visit with the patient to say goodbye.

AFTER DEATH:

- Call the family to express condolences.
- Send a condolence letter.
- Attend the patient's funeral.

— Back et al, *Archives of Internal Medicine*

in their relationships with primary physicians. Physicians, however, were less consistent. Some physicians reported feeling guilt over the frequent lack of closure. Some also described the emotional difficulty of saying goodbye to a patient.

Other physicians stated that they had overflowing schedules and did not have time to see patients who did not need medical care from them. But as one physician said, "...if you drop them that means you're only interested in treatment and you're not interested in them."

As the authors point out, "Expert guidelines on caring for patients at the end of life emphasize the importance of not allowing a patient to feel abandoned, especially when the care plan includes withdrawal of disease-modifying treatment."

According to an editorial commenting on the study published March 2009 in the *Journal of Palliative Medicine*, "The value of end-of-life care derives from both the continued expertise of the physician and the importance of the ongoing physician-patient relationship." The need for continuity and the need for closure occur at different times, and physicians need to address this in different ways, experts note.

Source: "Abandonment at the End of Life from Patient, Caregiver, Nurse, and Physician Perspectives," *Archives of Internal Medicine*; March 9, 2009; 169(5):474-479. Back AL, Young JP, McCown E, Engelberg RA, et al; Fred Hutchinson Cancer Research Center, and University of Washington, Seattle.

Chronic Critical Illness (from Page 4)

legally designated proxy can make decisions to withhold or withdraw treatments that can keep patients alive. The lack of a proxy or advance directive can make it impossible to limit critical care treatment, even if "professional and family caregivers believe that the burdens of this treatment outweigh potential benefits."

Limits on life-sustaining treatments are more likely if the patient has:

- Designated a health care proxy before admission

- Been involved with a palliative care service
- Indicated a preference for limitation to the physician

In a *Critical Care Medicine* editorial referencing this study, Howard B. Degenhotz, PhD, states that families need more information and counseling about the outcomes their chronically critically ill relatives face. He also suggests that advance directives often are not enough. "Perhaps, a more promising route would be to pursue orga-

nizational changes that would involve palliative care specialists on a more consistent basis."

Source: "Deciding in the Dark: Advance Directives and Continuation of Treatment in Chronic Critical Illness," *Critical Care Medicine*; April 2009; 37(3):919-925. Camhi SL, Mercado AF, et al; VA Pittsburgh Health Care System, Pittsburgh; Mount Sinai School of Medicine, New York; and Bronx VA Medical Center, Bronx, New York. "Two and a Half Weeks: Time Enough for End-of-Life Care Planning?" *ibid.*, pp. 1145. Degenholtz HB; Graduate School of Public Health, University of Pittsburgh, Pittsburgh.

RESEARCH MONITOR

Latino Patients: Improving Their End-of-Life Experience Through Clear Communication and Cultural Understanding

Clinicians can improve end-of-life care for Latino patients and families by clearly communicating health information and by understanding and respecting cultural influences. This is according to recommendations published in the *Journal of the American Medical Association*.

Communication Issues

Language barriers and/or limited health literacy can impede understanding of health status and treatment options for some Latino patients. To address language barriers, clinicians should use professional interpreters whenever possible.

Regardless of the patient's ethnicity and health literacy, clinicians are advised to:

- Use the "ask-tell-ask" model. Ask what patients understand about their condition, provide needed information, and confirm that they comprehend the information. "What have you already been told about your illness?"
- Use simple terms, not jargon.
- Limit new information to only 2 items per conversation.
- Assume that there are questions. "What questions do you have?"
- Ask the patient or family to restate information. "I've just said a lot of things. To make sure I did a good job and explained things clearly, can you describe to me what we've talked about in your own words?"

Cultural Considerations

Physicians in Latin America are less likely to disclose the truth to a patient with a poor prognosis and more likely to direct a patient's choices regarding life-extending treatments. In addition, palliative care is less available in Latin America than in the U.S. Consequently, Latino patients and families often are uncomfortable making

Ways Clinicians Can Help

- Be sensitive to external challenges faced by many Latino immigrants, such as geographical distance from family members, fears of deportation if the immigrants are undocumented, and perception of discrimination.
- Avoid asking questions about immigration status unless it affects treatment.
- Ask questions to help with cultural understanding:
 - "What language do you speak at home?"
 - "Were you born in the United States?"
 - "How long have you lived in the United States?"
 - "Tell me what I need to know about your culture."
 - "What do you think is the cause of this illness?"
 - "How would this illness be treated in your culture?"
 - "How do doctors in your culture talk with people about illness?"

— Smith, Sudore, and Perez-Stable
Journal of the American Medical Association

end-of-life care decisions.

Other cultural factors can affect patient decisions:

- *Familismo*: Clinicians should be prepared to have extended families present and involved in health care decisions.
- *Machismo*: The traditional need to provide for and protect the family may lead Latino males to make the majority of the medical decisions for a female family member. Clinicians should try to speak to the female patient in private, to determine her true wishes and concerns. In addition, when a male Latino is too sick to fulfill what he sees as his family duties, he may feel shame. Clinicians should be respectful, ask about his concerns, and try to use creative ways to help him contribute to his family despite his illness.

Religious Considerations

Very religious patients sometimes insist on using all measures to extend life, stating that they expect a miracle even when clinicians have exhausted all available treatments. If the patient agrees, clinicians can

bring in the patient's faith ministers, who often can help clinicians understand religious beliefs that are different from their own, while providing the patient and family with additional spiritual support.

Issue of Discrimination

Many Latinos report that they have experienced discrimination in health care situations. Because of these experiences, patients sometimes feel distrust toward clinicians and the health care system in general and may assume that they are not being offered curative treatments because of discrimination.

To gain the trust of their Latino patients, clinicians can "state outright that they do not tolerate discrimination in their practices and that they strive to treat all patients equally," the authors write.

Source: "Palliative Care for Latino Patients and Their Families: Whenever We Prayed, She Wept," *Journal of the American Medical Association*, March 11, 2009; 301(10):1047-1057. Smith AK, Sudore RL, Perez-Stable EJ; Division of Geriatrics, Department of Medicine and Division of General Internal Medicine, University of California, San Francisco; Veterans Affairs Medical Center, San Francisco.

CLINICIAN RESOURCES

Consensus Guidelines Offered for Identifying SICU Patients in Need of Palliative Care

The first set of clinically relevant criteria, or “triggers,” for identifying patients in the surgical intensive care unit (SICU) who would benefit from the end-of-life care services of palliative medicine specialists has been formulated by a team of surgeons from the Medical College of Wisconsin, Milwaukee.

“Because many patients who encounter difficult end-of-life issues in the SICU do not receive palliative care services, there is a need to educate surgeons on how to better identify those patients,” write the authors of a report published in *Critical Care Medicine*.

The team refined the three-round survey responses of 25 national and local experts in surgical intensive care and palliative care, until consensus among participants was achieved for the ten most important criteria. [See sidebar, below.]

“The first three criteria all address the importance of family negotiation and goal setting,” the authors note. While using their expertise in communication and mediation techniques to help resolve disagreement, continue the authors, palliative care specialists can also offer medical recommendations and continued palliative care, thus complementing the surgeon’s dedication to caring for the entire patient.

“The underlying message of this article may be the importance of open communication among intensivists, surgeons, and palliative care consultants,” write two palliative care experts in an editorial accompanying the report.

The commentators urge palliative care consultants to observe “consult etiquette” — carefully defining the reason for the consult with the primary team before addressing any issues with the patient/family; discussing care concerns privately with the surgical intensivist; and making clear that the consultant will only manage goals of care when directed.

“If these lines of communication remain open ... and a mutual trust is built, perhaps the next set of triggers will include all of the domains of palliative care, including symptom management early in the course of a serious illness,” the commentators conclude.

Source: “Developing Guidelines That Identify Patients Who Would Benefit from Palliative Care Services in the Surgical Intensive Care Unit,” *Critical Care Medicine*; April 2009; 37(3):946-950. Bradley CT, Brasel KJ; Division of Trauma/Critical Care Surgery, Medical College of Wisconsin, Milwaukee. “How Can We Be Helpful? Triggers for Palliative Care Consultation in the Surgical Intensive Care Unit,” *ibid.*, pp. 1147-1148. Wood GJ, Arnold RM; Section of Palliative Care and Medical Ethics, University of Pittsburgh, Pittsburgh.

Criteria Triggering SICU Palliative Care Consultations Ranked in Order of Importance

1. Family request
2. Futility considered or declared by the medical team
3. Family disagreement (with the team, with the advance directive, or with one another) lasting >7 days
4. Death expected during this SICU stay
5. SICU stay of >1 month
6. A diagnosis with median survival of <6 months
7. More than 3 SICU admissions during the same hospitalization
8. Glasgow Coma Scale score <8 for >1 week in a patient older than 75 years
9. Glasgow Outcome score <3 (i.e., persistent vegetative state)
10. Multisystem organ failure of >3 systems

— Bradley and Brasel,
Critical Care Medicine

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 (EPEC)

www.epec.net

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

www.nhpc.org

National Hospice & Palliative Care Organization

www.caringinfo.org

Caring Connections: 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/palliativecare.htm

Medical College of Wisconsin Palliative Care Center

www.painpolicy.wisc.edu

University of Wisconsin Pain and Policy Studies Group

www.capc.org

Center to Advance Palliative Care

www.stoppain.org

Pain Medicine & Palliative Care, Beth Israel Medical Center

End-of-Life Care Meetings for Clinicians

10th Clinical Team Conference of the National Hospice and Palliative Care Organization. September 24-26, 2009, Hyatt Regency Denver at the Convention Center, Denver, CO. Mail: NHPCO, CTC 2009 Conference Registration, P.O. Box 34929, Alexandria, VA 22334-0929; Fax: 877-779-6472; Website: www.nhpco.org/ctc2009

20th Annual Clinical Meeting of the American Academy of Pain Management. October 8-11, 2009, Sheraton Phoenix Downtown Hotel, Phoenix, AZ. Website: www.aapainmanage.org/conference/Conference.php

Practical Aspects of Palliative Care: Integrating Palliative Care into Clinical Practice. October 9-11, 2009, Royal Sonesta Hotel, Cambridge, MA. Sponsor: Harvard Medical School Center for Palliative Care. Phone: 617-582-7859; Fax: 617-632-6180; Email: pallcare@partners.org; Website: www.hms.harvard.edu/cdi/pallcare

Pain Management. December 5-12, 2009, Hawaiian Islands cruise from Honolulu. Sponsor: Continuing Education, Inc. Accredited by the Accreditation Council for Continuing Medical Education. Mail: 5700 4th St. N., St. Petersburg, FL, 33703; Phone: 800-422-0711; Email: contactus@continuingeducation.net; Website: www.continuingeducation.net

Annual Assembly of the American Academy of Hospice and Palliative Medicine and the Hospice and Palliative Nurses Association. March 3-6, 2010, Boston, MA. Phone: 847-375-4712; Fax: 847-375-6475; Email: info@aahpm.org; Website: www.aahpm.org

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Mail: P.O. Box 112050
Naples, FL 34108-1929

Phone: 239-513-9907

Toll Free: 1-877-513-0099 (U.S. and Canada)

Fax: 239-513-0088

Email: info@QoLpublishing.com



Karla Wheeler
Editor & Founder

Jan Carlton Doetsch
Clinical Editor

L. Addison Smelko, Jr.
Vice President
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