

# Quality of Life Matters®

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

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## Crisis in U.S. Cancer Care Demands Shift to Patient-Centered Care

*End-of-life care must match patients' wishes, says Institute of Medicine*

Urgent changes are needed in the way health care is delivered to cancer patients, warns a new report from the Institute of Medicine. In order to reform a system that is "in crisis," the priority must be to engage patients in their treatment, with close attention paid to the needs of the growing number of elderly and advanced-disease patients.

According to the report, entitled "Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis," an aging population, increasing complexity and cost of cancer care, and a shrinking oncology workforce are all contributing to the growing crisis. A committee of experts released the report in September 2013.

"Care often is not patient-centered, many

### Strategies for Improving Delivery of Cancer Care

- Provide patients and their families with understandable information about cancer prognosis, treatment benefits and harms, palliative care, psychosocial support, and costs.
- Provide patients with end-of-life care that meets their needs, values, and preferences.
- Ensure coordinated and comprehensive patient-centered care, and that all individuals caring for cancer patients have appropriate core competencies.
- Expand the breadth of data collected in cancer research for older adults and patients with multiple comorbid conditions.

— Institute of Medicine, 2013

patients do not receive palliative care to manage their symptoms and side effects from treatment, and decisions about care often are not based on the latest scientific evidence," the committee found.

The report outlines six components needed for the delivery of cancer care that is accessible, affordable, and evidence-based. Recommendations include strengthening clinicians' core competencies in cancer care, shifting to team-based models of care, and communicating more effectively with patients. The report also recommends that clinicians be provided with tools and initiatives for incorporating new medical knowledge into routine clinical care.

Components of high-quality cancer care, in order of priority are:

- Engaged patients
- An adequately staffed, trained, and coordinated workforce
- Evidence-based care
- An information technology system
- Systematic translation of evidence into

clinical practice, with quality measurement and performance improvement

- Accessible, affordable care for all patients

### END-OF-LIFE CARE

To more fully engage patients in their care, the committee recommends that patients and their families receive understandable information on prognosis, the benefits and harms of treatment in light of their treatment goals, the costs of care, and palliative and end-of-life care.

"Patients with advanced cancer should receive end-of-life care consistent with their needs, values, and preferences," the report states. "This will require cancer care teams to revisit and implement patients' advance care plans — which detail the type of care patients would want to receive if they become unable to speak for themselves — and to place a primary emphasis on palliative care, psychosocial support, and timely referral to hospice for end-of-life care."

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## End-of-Life Discussions Initiated Too Late for Many Ovarian Cancer Patients

Among women with advanced ovarian cancer, more than half of end-of-life care planning discussions take place within 30 days of death, too late in the disease course for avoidance of overly aggressive treatment and the timely enrollment in hospice, according to a report published in *Gynecologic Oncology*, the official journal of the Society of Gynecologic Oncology.

“Our findings support prior data indicating that end-of-life discussions are occurring too late in the ovarian cancer disease process and occur too often in the hospital,” write the authors. “We found that women who had earlier end-of-life discussions also had care that more highly conformed with end-of-life quality measures.”

Quality performance measures for end-of-life cancer care were published by the National Quality Forum in 2009, and have been endorsed by organizations such as the American Society of Clinical Oncology, the National Cancer Institute, and the Center for Medicaid and Medicare Services, the authors note.

“Conformance with end-of-life quality measures, better utilization of hospice, and reduction in various measures of health resource utilization — such as end-of-life hospitalizations and invasive procedures — may be achieved by addressing end-of-life discussion in a timely and proactive fashion,” they suggest.

Ovarian cancer is the most lethal gynecologic cancer and the fifth leading cause of cancer deaths in the U.S., the authors point out. Patients with ovarian cancer may have more than one recurrence of the disease, and unlike patients with other types of cancer, often receive all treatment — including surgery, chemotherapy, and surveillance — from one specialist, the gynecologic oncologist.

*“To provide optimal end-of-life quality care, greater effort is needed to help physicians identify ways to initiate end-of-life discussions during a timeframe in which meaningful improvement in end-of-life quality can be made.”*

— Lopez-Acevedo et al,  
*Gynecologic Oncology*

“Given the lethal nature of ovarian cancer, the disease course, and the centralized approach to care in gynecologic oncology, there is a critical need to identify and ameliorate deficiencies in end-of-life care for women diagnosed with this disease,” write the authors.

Investigators analyzed data on 220 women (mean age, 61.2 years) who died of advanced ovarian, fallopian tube, or primary peritoneal cancer. All of the subjects were diagnosed between 1999 and 2008, and treated by gynecologic oncologists at Duke University Medical Center, Durham, NC, during the period before the facility had initiated a palliative care service.

Although most patients had documented end-of-life discussions (defined for purposes of the study as the earliest such discussion documented in the patient’s medical record) more than half of these initial discussions had taken place less than one month before death. Further, more than one-quarter (29%) of patients had care that failed to meet at least one end-of-life quality performance indicator.

### OVERALL FINDINGS

- 80% of patients had documented end-of-life discussions.

- 51% of initial discussions occurred < 30 days prior to death.
- 56% of discussions took place during hospitalization, rather than in an out-patient setting.
- Median interval from first end-of-life discussion to death was 29 days.
- 52% of patients were hospitalized in the last month of life, with a median length of hospital stay of 9 days.
- 62% received chemotherapy in the last three months of life.
- 29% received care that failed to meet at least one end-of-life care quality measure.
- Median length of hospice enrollment was 21 days.

“Length of enrollment in hospice is a critical determinant of both caregivers’ satisfaction and cost reduction,” note the authors. Research shows that caregivers are more satisfied with hospice services when patients are enrolled in hospice for more than 30 days. Further, “in the gynecologic oncology literature, hospice is associated with a reduction in the number of procedures and hospitalizations near the end of life.”

### BENEFITS OF EARLY DISCUSSION

Having an end-of-life discussion at least 30 days before death was associated with:

- Less likelihood of being admitted to hospice  $\leq 3$  days before death (2% vs 11%;  $p = 0.02$ )
- Fewer invasive procedures in the last month of life (13% vs 59%;  $p = 0.001$ )
- A lower likelihood of being hospitalized in the last month of life (18% vs 89%;  $p = 0.001$ )
- Less likelihood of  $> 1$  hospitalization in the last 30 days of life (3% vs 27%;  $p = 0.001$ )

*Continued on Page 3*

## Crisis in U.S. Cancer Care Demands Shift to Patient-Centered Care (from Page 1)

Cancer incidence in the U.S. is expected to rise 45% by the year 2030, from more than 1.6 million new cases diagnosed per year to 2.3 million new cases, according to the report. Currently, approximately 14 million people in this country have had cancer.

“Most clinicians caring for cancer patients are trying to provide optimal care, but they’re finding it increasingly difficult because of a range of barriers,” says Patricia Ganz, MD, chair of the committee authoring the report and professor at the School

of Medicine and School of Public Health, University of California, Los Angeles.

“As a nation, we need to chart a new course for cancer care. Changes are needed across the board, from how we communicate with patients, to how we translate research into practice, to how we coordinate care and measure its quality.”

Sponsors of the report include the National Cancer Institute, the Centers for Disease Control and Prevention, the American Society of Clinical Oncology, the American

College of Surgeons, the American Society of Hematology, and the American Society for Radiation Oncology.

The report is available at [www.iom.edu/Reports/2013/Delivering-High-Quality-Cancer-Care-Charting-a-New-Course-for-a-System-in-Crisis.aspx](http://www.iom.edu/Reports/2013/Delivering-High-Quality-Cancer-Care-Charting-a-New-Course-for-a-System-in-Crisis.aspx). The committee also presents its findings and demonstrates some of its recommendations for the clinical setting in a 22-minute video, online at [www.cancer.ucla.edu/Index.aspx?page=1389](http://www.cancer.ucla.edu/Index.aspx?page=1389).

## End-of-Life Discussions for Ovarian Cancer Patients (from Page 2)

- Lower incidence of chemotherapy in the last 14 days of life (1% vs 12%;  $p = 0.003$ )
- Lower probability of intensive care unit (ICU) admission in the last 30 days (3% vs 16%;  $p = 0.005$ )
- Lower likelihood of dying in the hospital (5% vs 30%;  $p = 0.001$ )
- Longer enrollment in hospice (median, 53 days [range, 34 to 81 days] vs 11 days [range, 5 to 15 days];  $p = 0.001$ )
- A lower incidence of non-conformance with any quality-of-life measure (10% vs 54%;  $p = 0.001$ )

The median interval from initial end-of-life discussion to death among patients who failed to meet at least one end-of-life quality performance measure was 10.5 days.

### OUTPATIENT DISCUSSIONS

Having end-of-life discussions as an outpatient vs in the hospital was linked to:

- Lower probability of > 1 hospitalization in the last 30 days of life (5% vs 23%;  $p = 0.001$ )
- Less likelihood of any hospitalization in the last 30 days (36% vs 69%;  $p = 0.001$ )
- Less risk for dying in the hospital (10% vs 23%;  $p = 0.03$ )

- Lower probability of invasive care in the last month of life (23% vs 46%;  $p = 0.002$ )

There are many factors that may influence physicians’ decisions about when — and whether — to introduce end-of-life care planning in an ambulatory setting, suggest the authors. Studies indicate that many physicians are hesitant to broach the topic with terminally ill patients who are feeling well.

### REASONS FOR LATE DISCUSSIONS

- Postponement of such discussions until the onset of end-of-life symptoms
- Reluctance to initiate end-of-life discussions while administering chemotherapy
- Difficulties experienced in the accurate estimation of life expectancy
- The perception among physicians that the death of a patient is a professional failure

For some gynecologic oncologists, the preferred time for initiating an end-of-life discussion is at the first recurrence of the disease, note the authors. “The first recurrence is a benchmark, in that disease cure thereafter is extremely unlikely,” they write. “While a subset of women will attain a second and sometimes lengthy remission, the first recurrence is a reasonable target for initiating the end-of-life conversation.

Our data indicate that we are nowhere near that goal.”

The health care paradigm is currently changing from an emphasis on rewarding providers for the number of procedures utilized (“fee for service”) to the quality of the outcomes (“pay for performance”), note the authors. “In the near future, the care we provide will be evaluated based on conformance with performance measures as opposed to how much treatment we provide,” they observe.

“Our analysis confirms that addressing end-of-life care at least 30 days before death may reduce overutilization of health care resources near the end of life by avoiding hospitalizations, ICU admissions, and invasive procedures in the last month of life,” conclude the authors. “We also demonstrated that earlier end-of-life discussions may improve the utilization of hospice services, as evidenced by a longer length of hospice enrollment.”

*Source: “Timing of End-of-Life Care Discussion with Performance on End-of-Life Quality Indicators in Ovarian Cancer,” Gynecologic Oncology; July 2013; 130(1):156-161. Lopez-Acevedo M, et al; Division of Gynecologic Oncology, Division of Hematology-Oncology, and Department of Medicine, Duke University Medical Center; Duke Cancer Institute; and Duke Palliative Care, all in Durham, North Carolina.*



## Two-Thirds of Medical Professionals Oppose Physician-Assisted Suicide, Journal Poll Finds

Votes cast by more than 2300 readers of *The New England Journal of Medicine* (NEJM) show that although the majority believe that physician-assisted suicide (PAS) should not be permitted, the issue continues to be widely debated. However, many readers consider palliative and hospice care valuable, regardless of their stance on PAS.

“A large number of commentators on both sides of the divide agreed on the importance of palliative care, including hospice, for helping terminally ill patients manage their symptoms, both physical and psychological,” NEJM reports.

The poll was conducted as part of NEJM’s interactive feature Clinical Decisions, in which a case vignette is presented with commentaries representing clinically acceptable management options. In April 2013, the case presented was of a 72-year-old man with metastatic pancreatic cancer who was contemplating PAS. Readers were then asked to vote and comment on whether PAS should or should not be permitted.

### POLL RESULTS

- 2356 unique votes were cast from 74 countries, including 1712 from the U.S.

- Overall, 65% of NEJM voters opposed allowing physicians to assist in suicide.
- 67% of U.S. readers voted against PAS.

Eleven of the 74 countries cast the majority of their votes in favor of PAS, but the total number of votes from these countries was small. Of the 49 U.S. states with readers who voted, 18 had a majority of votes supporting PAS. However, Oregon and Washington, where PAS has been legalized, were not among these.

### COMMENTS ON PAS

“Physician-assisted suicide is fundamentally inconsistent with the physician’s professional role,” states the American Medical Association (AMA) report on PAS, adopted by the organization in 1993 and updated in 1996. “Physicians must not abandon or neglect the needs of their terminally ill patients.

“Indeed,” continues the AMA report, “the desire for suicide is a signal to the physician that more intensive efforts to comfort and care for the patient are needed. The use of more aggressive comfort care measures, including greater reliance on hospice care, can alleviate the physical and emotional

suffering that dying patients experience.”

In a resolution issued in 2005, the National Hospice and Palliative Care Organization (NHPCO) stated unequivocally that it does not support the legalization of PAS. “NHPCO values life. The philosophical constructs and evolving practices of hospice/palliative care are concerned foremost with the dignity of persons throughout the trajectory of life-limiting illness,” states the resolution.

“When symptoms or circumstances become intolerable to a patient, effective therapies are now available to assure relief from almost all forms of distress during the terminal phase of an illness without purposefully hastening death as the means to that end,” the NHPCO further asserts. “These modalities and the means to safely administer them must be within the expertise of and available from all hospice/palliative care providers as an alternative to PAS.”

*Source: “Clinical Decisions: Physician-Assisted Suicide — Polling Results,” The New England Journal of Medicine; Epub, September 12, 2013; DOI: 10.1056/NEJMcide1310667. Colbert JA, et al. “Clinical Decisions: Physician-Assisted Suicide,” ibid.; April 11, 2013; 368(15):1450-1452.*

## 90% of Americans Think End-of-Life Conversations Are Important, Yet Don’t Hold Them

Although Americans overwhelmingly agree that discussing how they and their loved ones would prefer to be cared for at the end of life is important, fewer than 30% report having ever had such a discussion. This is according to a national survey commissioned for The Conversation Project, a public engagement campaign launched in 2012 to spur Americans to begin talking about their values and wishes before the onset of a serious illness or health crisis.

“This is no longer a taboo subject,”

says Maureen Bisognano, MSN, president and CEO of the Institute for Healthcare Improvement (IHI), which collaborated in the development of the project. “Everyone, including health providers, has a role to play to close the current gap.”

The survey was conducted by Kelton, a strategic consultancy firm, during the summer of 2013 among two sets of nationally representative Americans aged 18 years or older (n = 2073). Margin of error was three percentage points.

### KEY FINDINGS

- 90% of Americans think talking about their own and their loved ones’ wishes for care at the end of life is important.
- Fewer than 30% have actually had such a discussion.
- Among those who did have such a conversation before a loved one’s death, 63% said they felt better knowing they had honored that person’s wishes; 39%

*Continued on Page 5*

## Dialysis Patients' Survival Expectations Found Unrealistic and Uninformed

Seriously ill hemodialysis patients are mistakenly more optimistic than their nephrologists about their chances of long-term survival, and nephrologists rarely disclose prognostic estimates to their patients, a team of Boston researchers has found.

"In our sample, patients' expectations about one-year survival were more accurate than those of their nephrologists, but their longer-term survival expectations dramatically overestimated even their two-year survival rates," write the authors of a report published in *JAMA Internal Medicine*.

"Patients' prognostic expectations are associated with their treatment preferences. Our findings suggest the need for interventions to help providers communicate effectively with patients about prognosis." An accurate prognosis estimate lets patients and families plan for the future and make informed decisions about care, they note. "We therefore believe that physicians should offer to discuss prognosis with patients, particularly those who are seriously ill."

Investigators analyzed data from medical records and interview responses of 62 seriously ill patients (mean age, 70.2 years) who underwent dialysis from November 2010 to September 2011 at one of two dialysis units in Boston. "Seriously ill" was defined as having a predicted one-year mortality of at least 20%. Interviews were also conducted with each patient's nephrologist.

### OVERALL FINDINGS

- No patients reported having had a discussion about life expectancy with their nephrologist.
- Nephrologists reported discussing prognosis with 3% of their seriously ill patients.
- Nephrologists said they would not provide any estimate of prognosis for 60% of their patients, even if the patient insisted.

"This percentage of nondisclosure is higher than the percentage documented in the cancer literature, and suggests that nephrologists may be even more reluctant to discuss prognosis with their hemodialysis patients than physicians caring for patients with cancer," comment the authors. The one-year mortality rate for patients undergoing long-term hemodialysis is comparable to that of many types of cancer, ranging from 20% to 25%, they point out.

### SURVIVAL ESTIMATES

- 6% of patients thought their chance of survival in five years was less than 50%.
- Actual survival at two years was 56%.
- 54% of patients said they would prefer focus on comfort care vs life-extending care if they were seriously ill.
- 73% of those who thought their chance of being alive in one year was less than 90% indicated a preference for comfort-

focused care; 49% of these patients said they would prefer comfort care if they learned they were seriously ill.

In 2010, the Renal Physicians Association and the American Society of Nephrology issued an update of their 2000 joint clinical practice guideline, which cites validated prognostic tools and recommends that physicians communicate the likelihood of survival to all patients undergoing dialysis. "A number of prognostic indices with good predictive properties exist for end-stage renal disease," note the authors.

The ability to accurately estimate prognosis in patients with noncancer diagnoses is increasingly being recognized as critical to patient-centered decision making, note the authors. "As our ability to accurately prognosticate for seriously ill patients continues to advance, developing interventions to help providers communicate effectively with patients about prognosis will become increasingly important."

*Source: "Relationship between the Prognostic Expectations of Seriously Ill Patients Undergoing Hemodialysis and Their Nephrologists," JAMA Internal Medicine; July 8, 2013; 173(13):1206-1214. Wachterman MW, et al; Division of General Medicine; Division of Nephrology, Beth Israel Deaconess Medical Center; Section of General Internal Medicine, Veterans Affairs Boston Healthcare System; Division of Renal Medicine, Brigham and Women's Hospital, all in Boston; and School of Nursing, University of Pennsylvania, Philadelphia.*

## End-of-Life Conversations Are Important (from Page 4)

said they knew their loved one was able to die "just the way they wanted to."

Respondents' reasons for not discussing their own wishes:

- It's not something they need to worry about at this point (29%).
- They aren't sick yet (23%).
- The subject is uncomfortable (21%).
- They don't want to upset others (19%).

Reasons given for not discussing a loved ones' wishes:

- It never seems like the right time (25%).
- It's not something their loved one needs to worry about right now (21%).
- They don't know how to start such a conversation (17%).

"Everybody is waiting for someone else to start," states the IHI. One-fifth of

respondents reported they were waiting for a loved one to broach the topic; 48% said they would welcome the conversation and would feel relieved if a loved one asked them about their wishes for end-of-life care. And while 41% believed that the conversation would be difficult, they would still be willing to participate.

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

## Futile Treatment Deemed Common in Intensive Care

Nearly 20% of intensive care unit (ICU) patients are considered by their critical care specialists to be receiving treatment that is futile or probably futile, according to a report published in *JAMA Internal Medicine*. Futile treatments are those that intensive care physicians perceive as “interventions that prolong life without achieving an effect that the patient can appreciate as a benefit.”

Investigators analyzed daily assessments (n = 6916) made by 36 critical care specialists of 1136 patients (mean age, 62 years) cared for from December 2011 through March 2012 in one of five ICUs in an academic health care system.

### KEY FINDINGS

- 11% of patients were perceived to be receiving futile care.
- 8.6% were perceived as “probably” receiving futile care.
- Among those who received futile care, 68% died while hospitalized and 85% died within six months.

“[B]ecause critical care physicians defined futile treatment, the findings raise the question of why they provided such care,” comment the authors. They suggest that possible reasons may include lack of agreement from the family, lack of agreement within the clinical team, and failure of the clinician to address end-of-life issues.

### HOW CLINICIANS CAN RESPOND

Current recommendations call for futility assessments to be “based on an inclusive process that incorporates the perspectives of all stakeholders,” according to the authors of a commentary accompanying the report. “We offer four suggestions for how clinicians in critical care units should conceptualize and respond to requests for treatment that they judge to be futile or wrong,” write Robert D. Truog, MD, professor of Medical Ethics and Anaesthesia (Pediatrics) at Harvard Medical School, Boston, and Douglas B. White, MD, MAS, director of

### Addressing Requests for Futile ICU Treatment

- Provide emotional support to the family and/or surrogate.
- Discuss the patient's prognosis.
- Elicit the patient's values and preferences.
- Explain the principles of surrogate decision making.
- Discuss which treatment options fit with the patient's goals, including the option of a focus on palliation.
- Try to understand the surrogate's perspective and agree upon a treatment plan.
- Consider the early involvement of expert consultants, such as palliative care clinicians.

— Truog and White, *JAMA Internal Medicine*

the Program on Ethics and Decision Making in Critical Illness at the University of Pittsburgh Medical Center, Pittsburgh.

**1. Avoid using the word “futile.”** Instead, use the term “potentially inappropriate” to describe treatment that the clinician deems to be contrary to both professional values and the patient's best interests.

**2. Remember that disputes concerning futility are often more complicated than they seem.** The debate about the boundaries of acceptable practice near the end of life is ongoing, and even among medical professionals there is substantial variation in opinions and practices regarding appropriate treatment at the end of life.

“There are no criteria or rules to which clinicians can appeal to justify decisions to refuse life support, at least when those treatments hold even a small chance of achieving the patient's goals,” observe Truog and White.

**3. Respond to requests for treatment believed to be wrong by increasing communication with the patient or surrogate.** Rather than simply refusing the request or acquiescing despite the judgment that the treatment would be inappropriate, clinicians can take steps to reach a mutual resolution with the patient's surrogate. [See sidebar.]

“An important goal is to intervene early, before conflicts become entrenched and intractable,” urge Truog and White.

“Empirical research suggests that the vast majority of disagreements can be resolved collaboratively through ongoing dialogue, or with the help of expert consultants, such as ethics or palliative care clinicians.”

**4. If communication with the patient/surrogate becomes stalemated, pursue a fair process of dispute resolution.** Seek a second opinion from a qualified physician, request a case review by the hospital ethics committee, or advise surrogates of their rights to seek judicial intervention.

“Making assessments about potentially inappropriate care is complex and requires multiple perspectives,” observe Truog and White. “When disputes arise despite sustained efforts to prevent them, a step-wise procedural approach to resolving conflicts is essential.”

Source: “The Frequency and Cost of Treatment Perceived to Be Futile in Critical Care,” *JAMA Internal Medicine*; Epub ahead of print, September 9, 2013; DOI: 10.1001/jamainternmed.2013.10261. Huynh TN, et al; Division of Pulmonary and Critical Care Medicine and Division of General Internal Medicine and Health Services Research, Department of Medicine, David Geffen School of Medicine; and Department of Psychology, University of California Los Angeles, Los Angeles; and RAND Health, Santa Monica, California. “Futile Treatments in Intensive Care Units,” *ibid.*; DOI: 10.1001/jamainternmed.2013.7098. Truog RD, White DB; Department of Global Health and Social Medicine and Department of Anaesthesia, Harvard Medical School, Boston; Program on Ethics and Decision Making in Critical Illness, Department of Critical Care Medicine, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania.



# CLINICIAN RESOURCES

## **Free Online Resources and Information on Hospice and Palliative Care**

**[www.ehospice.com/usa](http://www.ehospice.com/usa)**

The National Hospice and Palliative Care Organization (NHPCO) recently debuted ehospice-USA, an online resource for physicians, hospital discharge planners, and other health care professionals caring for patients and families facing serious and life-limiting illness. In addition to resources, news, commentary, and analysis, the site offers information on hospice and advance care planning that can be shared with patients and family caregivers.

“One of the most frequent comments we hear from the families we care for is that they wish they had known about hospice earlier,” says J. Donald Schumacher, PsyD, NHPCO president and CEO. “Any professional caring for or supporting patients and families who may be appropriate for hospice will find useful information on ehospice-USA.”

In addition to the U.S. edition of ehospice, the site maintains an international edition, as well as editions delivered by organizations in half a dozen other regions, such as Canada, the U.K., Australia, India, and countries in Africa.

### **PRACTICAL TIPS FOR PHYSICIANS AND PATIENTS**

Under the category Care and Practice, clinicians can find such articles as:

- “Delivering Bad News: Helpful Guidance That Also Helps the Patient”
- “Hospice Admission Criteria”
- “Talking about Treatment Options and Palliative Care: A Guide for Clinicians”
- “Advice for Physicians Caring for Dying Patients”

In one of the most-read articles, “Delivering Bad News,” the authors remind clinicians that bad news can be “any information which is considered by the patient and/or family to be something other than information they desire.” Examples can include news that the patient’s medications are not effective or that a procedure is necessary. They recommend structured communication over impromptu discussions, and suggest that clinicians use a six-step protocol, which is provided in the article.

A section entitled “Pain at the End of Life” links readers to the NHPCO’s patient support website, Caring Connections, where patients will find free, downloadable tip sheets on topics such as caring for a loved one in pain, understanding pain for improved quality of life, and commonly asked questions about pain at the end of life.

### **SPECIAL RESOURCES FOR VETERANS**

For clinicians caring for veterans, the site includes links to such resources as:

- A military history checklist, for evaluating the impact of a patient’s military experience
- The Military Health History Pocket Card for Clinicians, available from the U.S. Department of Veterans Affairs
- A facilitator’s guide for grief and bereavement work with veterans’ families
- Information on health care, burial, and survivor and dependent benefits

## **End-of-Life Care Websites**

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

American Academy of Hospice and Palliative Medicine

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

End-of-Life/Palliative Education Resource Center (EPERC)

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

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

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

National Hospice & Palliative Care Organization

**[www.caringinfo.org](http://www.caringinfo.org)**

Caring Connections: National Consumer Engagement Initiative to Improve End-of-Life Care

**[www.promotingexcellence.org](http://www.promotingexcellence.org)**

Promoting Excellence in End-of-Life Care

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

Hospice Foundation of America

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

American Hospice Foundation

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

Hospice and Palliative Nurses Association

**[www.hospicenet.org](http://www.hospicenet.org)**

Resources for Patients and Families

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

Americans for Better Care of the Dying

**[www.mcw.edu/palliativecare.htm](http://www.mcw.edu/palliativecare.htm)**

Medical College of Wisconsin Palliative Care Center

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

University of Wisconsin Pain and Policy Studies Group

**[www.capc.org](http://www.capc.org)**

Center to Advance Palliative Care

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

Pain Medicine & Palliative Care, Beth Israel Medical Center

# End-of-Life Care Meetings for Clinicians

**Primary Care Geriatrics Review.** February 22–March 1, 2014, 7-night Hawaiian Islands cruise conference from Honolulu, HI. Topics include Hospice and Palliative Care — Prognostication and Communication and Transitions in Care. Sponsor: Continuing Education, Inc. Accredited by the Accreditation Council for Continuing Medical Education. Phone: 800-422-0711; Email: 022214Geriatrics@continuingeducation.net; Website: continuingeducation.net

**2014 Annual Assembly of the American Academy of Hospice and Palliative Medicine (AAHPM) and the Hospice and Palliative Nurses Association (HPNA).** March 12–15, 2014, San Diego, CA. Website: [www.aahpm.org/learn/default/meetings.html](http://www.aahpm.org/learn/default/meetings.html)

**33rd Annual Scientific Meeting of the American Pain Society.** April 30–May 3, 2014, Tampa Convention Center, Tampa, FL. Website: [www.americanpainsociety.org/meeting/content/conferencehome.html](http://www.americanpainsociety.org/meeting/content/conferencehome.html)

**2014 Annual Scientific Meeting of the American Geriatrics Society.** May 15–17, 2014, Walt Disney World Swan and Dolphin, Orlando, FL. Website: [www.americangeriatrics.org](http://www.americangeriatrics.org)

**NHPCO 29th Management & Leadership Conference.** March 25–26, 2014, Gaylord National Resort and Convention Center, National Harbor, MD. Website: [www.nhpc.org](http://www.nhpc.org)

## We Are Dayton's Hospice.



Celebrating the lives of  
the patients we are  
privileged to serve and  
providing extraordinary  
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