

# Quality of Life Matters®

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

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## New Heart Failure Guidelines Urge Use of Hospice and Palliative Care Services

***‘Cardiologists aren’t used to talking about hospice. They are more used to doing interventions.’***

New, updated guidelines for heart failure management recommend that physicians address end-of-life care options early in the course of the disease and educate patients and families about the benefits of palliative and hospice care programs.

The guidelines were recently released by the American College of Cardiology (ACC) and the American Heart Association (AHA) and were published in the September 20, 2005, issue of the AHA journal *Circulation*.

“Cardiologists aren’t used to talking about hospice. They are more used to doing interventions. So, it is a big shift,” says co-author Mariell Jessup, MD, medical director of the Heart Failure and Cardiac Transplantation Program, University of

**“I think using hospice is a way of improving the remaining days that these patients have. Hospice can be a very positive experience for patients and their families.”**

—Mariell Jessup, MD  
*Circulation*

Pennsylvania Medical Center, Philadelphia.

As the incidence of heart failure in the nation continues to rise, so, too, does the annual number of hospitalizations for the disease. From 1990 to 1999, the number of hospitalizations for heart failure as a primary diagnosis rose from 810,000 to more than one million, the authors note.

In 2001, nearly 53,000 patients died of heart failure as a primary cause.

“There is a failure to recognize that end-stage heart failure patients frequently come in and out of the hospital over and over again and suffer a lot, with really no impact on their ultimate survival,” comments Jessup. “I think using hospice is a way of improving the remaining days that these patients have. Hospice can be a very positive experience for patients and their families.”

The ACC/AHA guidelines encourage physicians to discuss treatment plans for a variety of likely contingencies with their patients, being careful to distinguish short-term interventions with expected rapid

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## 98% of Bereaved Families Would Recommend Hospice to Others

*New survey tool launched to further quality of care improvement*

A post-death survey of 29,292 family members of patients cared for by 352 hospices nationwide has found that 98% of respondents report they would recommend hospice services to others caring for a dying loved one.

The Family Evaluation of Hospice Care (FEHC) survey, a 61-item questionnaire, is a new tool designed to reflect the quality of the hospice experience from the perspective of family caregivers. The preliminary

results of the survey from the first two quarters of 2004 were published in a report in a recent issue of the *Journal of Pain and Symptom Management*.

“Ongoing quality monitoring through medical record review or administrative audit is fundamental to maintaining quality of care,” write the report authors. “However, care for dying patients must also be centered on what patients and their families

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## New Heart Failure Guidelines Urge Use of Hospice and Palliative Care Services

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recovery from prolonged life support with no reasonable expectation of a return to good functional capacity.

Other recommendations for heart failure patients at the end of life include:

- Ongoing patient and family education about prognosis for functional capacity and survival
- Patient and family education regarding the role of hospice and palliative care programs, with re-evaluation as clinical status changes
- Discussion of inactivation of implantable cardioverter defibrillators
- Ensuring continuity of care between inpatient and outpatient settings
- Use of hospice components appropri-

### THE ACC/AHA GUIDELINES RECOMMEND:

*“...all those involved with heart failure care make it a priority to improve recognition of end-stage disease and provide care to patients and families approaching this stage.”*

ate for the relief of suffering — including opiates, and not precluding inotropes and intravenous diuretics for palliation of symptoms

- Examination of current end-of-life processes, with a commitment to improving approaches to palliation and end-of-life care

“As we become more familiar with the steps in progression to end-stage heart failure in this era, the current abrupt transition from aggressive intervention to comfort and bereavement care will be softened by a gradual and progressive emphasis on palliation, until it dominates the final days of care,” the authors conclude.

*Source: “ACC/AHA 2005 Guideline Update for the Diagnosis and Management of Chronic Heart Failure in the Adult: a Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Writing Committee to Update the 2001 Guidelines for the Evaluation and Management of Heart Failure): Developed in Collaboration with the American College of Chest Physicians and the International Society for Heart and Lung Transplantation; Endorsed by the Heart Rhythm Society,” Circulation; September 20, 2005. Hunt SA, Abraham WT, Chin MH, Feldman AM, Francis GS, Ganiats TG, Jessup M, et al.*

## 98% of Bereaved Families Would Recommend Hospice to Others

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need and want.”

Developed jointly by the National Hospice and Palliative Care Organization (NHPCO) and researchers at Brown University, the FEHC survey is part of a quality improvement process allowing individual hospices to identify both high performance areas and opportunities for improvement in care. Hospices submitting their data to the NHPCO will receive quarterly benchmarks, and aggregated results of the surveys will be reported periodically.

In order to reduce the leniency bias often encountered in traditional satisfaction surveys, FEHC asks respondents to narrowly and clearly define the quality and quantity of their hospice experience, with a focus on areas in need of improvement. Most questions are designed to have only one “most desirable answer;” all other answers are considered “negative” or as opportunities for improvement.

Nevertheless, in one of the few questions requiring a rating, respondents rated their overall satisfaction with their hospice experience at 47.1 on a 0-to-50-point scale (0 = worst possible care; 50 = best possible care).

Other findings include:

- 33% of patients received hospice services for 7 days or fewer; for

60% of patients, length of hospice stay was less than one month

- Unmet needs in areas of physical comfort and emotional support were reported by just 5.8% and 9.8% respondents, respectively
- On an aggregate scale of 3 to 12, family confidence in the provision of care for the dying person was rated at 10.4
- Areas targeted by respondents for quality improvement included educating families about what to expect as the patient is dying and what they should do at the time of death

“Patients who are confronting death often have goals that are different from patients in whom death is not imminent, as dying patients may be forced to choose between length of life and quality of life,” write the authors. “Therefore, understanding patient and family perspectives is critical in designing a treatment plan that provides quality life experiences for dying patients.”

The complete FEHC survey questionnaire is available at [www.nhpc.org](http://www.nhpc.org). Follow the links to “Inside NHPCO” and “Quality Care.”

*Source: “Family Evaluation of Hospice Care: Results from Voluntary Submission of Data via Website,” Journal of Pain and Symptom Management; July 2005; 30(1):9-17. Connor SR, Teno J, Spence C, Smith N; National Hospice and Palliative Care Organization, Alexandria, Virginia; Center for Gerontology and Health Care Research, Brown University School of Medicine, Providence, Rhode Island; and Deyta, Inc., Louisville, Kentucky.*

## Will Artificial Nutrition Help Accomplish the Goals of the Patient?

*Tips for guiding families through this challenging decision-making process*

For patients with advanced cancer and their families, dealing with issues surrounding consideration of artificial nutrition in the setting of cachexia and anorexia at the end of life can be confusing and emotionally distressing. Using a broad approach, physicians can help in this decision making, suggest the authors of a recent case report.

“The physician must ensure that the patient and the family are basing nutrition-related decisions on a realistic grasp of what artificial nutrition can and cannot accomplish and not on myths and emotions,” write the authors, in the September 1, 2005, issue of the *Journal of Clinical Oncology*.

### **PHYSICIANS CAN:**

- Help patients and families understand cachexia in the context of advanced disease, explaining why nutritional support is usually not helpful.
- Review the overall prognosis and treatment options for the cancer itself.
- Focus the discussion on interventions aimed at improving the patient’s comfort and quality of life and at maintaining dignity.
- Guide the family in selecting alternative supportive and nurturing activities — such as touching, massage, bathing, dressing, and mouth care — as a substitute for feeding.
- If needed, provide the patient and family with data regarding the potential risks and benefits of artificial nutrition.

**“Overall, physicians should feel comfortable informing the patient and family that there is no evidence to suggest**

**that, in patients with cancer anorexia and cachexia, increased caloric intake will improve patient survival or quality of life,”** write the authors.

“Despite the lack of proven benefit, artificial nutrition at the end of life will remain a sensitive topic for some patients and families,” the authors continue. Physicians are urged to “acknowledge that nurturing is an essential part of human existence and that feeding is a central part of human nurturing.... Substituting other nurturing activities for feeding can help keep the family members involved in their loved one’s care.”

**“The most important question to ask in this situation is: will artificial nutrition help accomplish the goals of the patient?”** When, in the physician’s judgment, the patient’s goals would not be achieved by the implementation of artificial nutrition, the physician should state this explicitly and recommend against it. Not to do so would be unfair to the patient and family, the authors assert.

“To merely present patients with options from which to choose is insensitive to the fact that illness limits the patient’s ability to appraise complex information and that a patient seeking the guidance of an authority is now forced to ascertain what the physician really thinks is best.”

If the physician does believe that artificial feeding might have potential benefit, or if the family insists that tube feeding be implemented despite the physician’s recommendation against it, a time-limited therapeutic trial can be initiated, the authors note.

The goals of this therapeutic trial should be clearly delineated, a firm date set for

### **SUGGESTIONS FOR PHYSICIANS INCLUDE:**

- Explain why nutritional support usually is not helpful in advanced cancer patients with anorexia and cachexia.
- Review overall prognosis and treatment options.
- Focus on interventions aimed at improving the patient’s comfort, quality of life, and dignity.
- Suggest alternative supportive and nurturing activities.

—Moynihan, Kelly, and Fisch  
*Journal of Clinical Oncology*

re-evaluation of those goals, and the criteria for discontinuing therapy agreed upon in advance. This will make the transition more acceptable to the family and patient, according to the authors.

“Ongoing communication between the patient, family members, and the health care team throughout the entire course of the illness, with an effort to prepare the patient and family for future complications, can help provide the best possible relief and prevention of suffering,” the authors conclude.

*Source: “To Feed or Not to Feed: Is That the Right Question?” Journal of Clinical Oncology; September 1, 2005; 23(25):6256-6259. Moynihan T, Kelly DG, Fisch MJ; Mayo Clinic, Rochester, Minnesota; and University of Texas MD Anderson Cancer Center, Houston.*

## Attending Physicians Can Use ‘Teachable Moments’ to Improve Care of Dying Patients

Because internists and oncologists are rarely trained to deal with the powerful emotions that can be evoked by caring for a dying patient, resulting stress can cause physician burnout or cynicism and suboptimal patient care, according to a recent research report. By initiating discussion of the medical and emotional aspects of patient death with physicians-in-training, attending physicians can contribute to the improvement of both patient care and physician well being, notes the report, which appeared in a recent issue of *Academic Medicine*.

“Physicians’ emotional reactions to patient death can affect patient care and the personal lives of physicians,” write the authors. “Supervising physicians have an opportunity to improve both the care of dying patients and housestaff coping with these deaths by using the ‘teachable moments’ that are present for trainees as they care for the dying.”

Researchers analyzed the results of interviews with 135 physicians at two qua-

ternary care medical centers in the northeastern United States between 1999 and 2001. Participants were asked to describe their most emotionally powerful reactions to patient death, their methods of coping, and any subsequent changes in their clinical behavior.

### THE FINDINGS INCLUDE:

- Physicians experienced powerful reactions to patient death at all stages of their careers.
- Most patient deaths could be categorized as “shocking/unexpected” (44%), “good” (28%), or “overtreated” (17%).
- Physicians-in-training were more likely than more experienced physicians to be shocked at patient death and to attribute the death to personal lack of competence.
- Housestaff often reported coping in isolation, with only 2 of 135 participants reporting that a discussion of patient death took place between attending physician and trainee.

- Resultant changes in clinical behavior ranged from increasing physical contact with patients to closing off emotionally to avoid further hurt.

“[T]hese experiences can provide an opportunity for housestaff and attending physicians to reflect on the often intimate relationship between physicians and the dying, and the power of the human spirit as they bear witness to the suffering and death of another,” write the authors.

### FROM EXPERIENCED PHYSICIANS, TRAINEES CAN LEARN:

- The principles of pain and symptom management
- How to communicate about terminal illness with patients and families
- Personal coping strategies

In a related study reported in the same issue, researchers found no evidence of discussion of either the medical or social aspects of patient death in 63% of cases in which patients had been cared for by third-year medical students’ teams.

“Students viewed the medical system as ignoring their emotions and avoiding discussions of death, thus acculturating them to view emotions and death as negative aspects of medicine,” comment the authors.

Source: “It Was Haunting... Physicians’ Descriptions of Emotionally Powerful Patient Deaths,” *Academic Medicine*; July 2005; 80(7):648-656. Jackson VA, Sullivan AM, et al; Massachusetts General Hospital, Dana-Farber Cancer Institute, Brigham and Women’s Hospital, and Harvard Medical School, Boston. “This Is Just Too Awful; I Just Can’t Believe I Experienced That... Medical Students’ Reactions to Their ‘Most Memorable’ Patient Death,” *Academic Medicine*; July 2005; 80(7):648-656. Rhodes-Kropf, Carmody SS, Seltzer D, et al; Albert Einstein College of Medicine, Bronx, New York; Hennepin Hospital, Minneapolis; Center for Research on Health Care, University of Pittsburgh, Pittsburgh.

### An Approach to Discussing Patient Death with Physician Trainees

- **Understand the trainee’s perspective.** “What was your experience with Mr. Jones’ death? What did you find to be the most difficult aspects?”
- **Review the medical details.** “What do you think was the cause of Mr. Jones’ death? What are your questions or concerns regarding the care we gave this patient? Is there anything you wish we had done differently?”
- **Explore the trainee’s feelings and express your own.** “What was it like caring for Mr. Jones? What feelings did it elicit? In what ways did you find yourself identifying with the patient or family? What aspects of the care were disturbing? Satisfying? How did you manage these feelings? Did you get the support you needed?”
- **Explore the impact on future care.** “What lessons did you learn from caring for Mr. Jones?”

—Jackson, et al, *Academic Medicine*

## Palliative Sedation: Option of Last Resort

*Expert discusses ethical and practical aspects of its use*

Ethical issues surrounding palliative sedation, clinical indications for its use, and the practical aspects of administering high doses of opioids and sedatives to relieve refractory symptoms in dying patients are the subjects of an article published in a recent issue of the *Journal of the American Medical Association*.

“The doctrine of double effect, the traditional justification for palliative sedation, permits physicians to provide high doses of opioids and sedatives to relieve suffering, provided that the intention is not to cause the patient’s death and that certain other conditions are met,” writes lead author Bernard Lo, MD, professor of medicine and director of the Program in Medical Ethics, University of California, San Francisco.

According to Lo, palliative sedation may be justified when:

- **Alternate means to relieve symptoms are not effective or cause intolerable side effects.** Before characterizing symptoms as refractory, physicians should consult with a palliative care or pain specialist.
- **The goal of sedation is to relieve symp-**

### PATIENT INFORMATION AND CME

Patient information on palliative sedation is available online for download and distribution. Visit <http://jama.ama-assn.org>.

The American Medical Association (AMA) offers one CME credit for the completion of an online quiz on Lo’s article. This educational activity is available to AMA members and to physicians subscribing to the AMA’s journals. Go to <http://cmejama-archives.ama-assn.org>.

**toms, not to hasten death.** This goal, or intention, is what distinguishes palliative sedation from active euthanasia, which is illegal and widely unacceptable ethically in this country.

- **The patient is “at the point of death, in a dying state, or close to death;”** thus, it is unlikely that survival will be significantly shortened.

After obtaining consent for palliative sedation from the patient and family, phy-

sicians are encouraged to continue to elicit their wishes and concerns, and to include other measures for providing comfort, closure, and dignity as part of the care plan.

As practical aids, the article offers a tool for discussing palliative sedation with the patient, family, and health care team, an examination of agents and dosages of medication, and a list of important practical points to consider when initiating palliative sedation.

“Because palliative sedation should be considered a last resort, it usually occurs in complicated cases, under stressful conditions, and with time constraints,” Lo concludes. “Although palliative sedation should never be easy for caregivers, it is immensely rewarding to relieve a dying patient’s suffering, without crossing the line into ethically controversial ground.”

*Source: “Palliative Sedation in Dying Patients: We Turn to It When Everything Else Hasn’t Worked,” Journal of the American Medical Association; October 12, 2005; 294(14):1810-1816. Lo B, Rubinfeld G; Program in Medical Ethics and Division of General Internal Medicine, Department of Medicine, University of California San Francisco, and Division of Pulmonary and Critical Care Medicine, Department of Medicine, Harborview Medical Center, University of Washington, Seattle.*

## Academic Hospice Programs: Leaders of Innovation

Contemporary medicine and hospice have their historical roots in the same philosophy of care; and, just as academic medical centers provided leadership for the unprecedented advancements in health care in the 20th century, academic hospice programs are currently needed to respond to the demographic and economic challenges of today.

This is according to the authors of an article published in a recent issue of *Annals of Internal Medicine*.

Compelling reasons for the academic hospice to become an important part of academic medicine include:

- **Medical advances occur when research is grounded within the medical care of the population of interest.** Pioneering research in the use of oral morphine for pain control, for example, was conducted at the first modern academic hospice, St. Christopher’s Hospice, London.
- **Physicians and other health care**

**professionals learn best at the bedside, under the tutelage of experts.**

“There is now copious evidence that the care of patients who are dying is better in hospice programs and that good care requires physicians to play a critical role,” the authors write.

- **Curricula for palliative medicine trainees address the core competencies for physicians** as now required by

*Continued on Page 6*

# PHYSICIAN RESOURCES

## How Physicians Can Communicate Beyond ADs

*A practical approach to clear decision making at the end of life*

Although advance directives can be useful in facilitating discussions of goals of care with patients and families, they cannot cover all contingencies. Medical decision making for patients nearing the end of life must be responsive to changing scenarios, and physicians conducting advance care planning discussions need to take into account factors that can affect clear decision making. This is according to an article published in the *Journal of the American Medical Association*.

“Misunderstandings remain about the role and applicability of advance directive documents, and interpretation of preferences may be difficult when overshadowed by questions of uncertainty, trust, affect, and hope,” writes James A. Tulsky, MD, director of the Center for Palliative Care at Duke University Medical Center, Durham, NC.

Tulsky’s article offers practical suggestions for addressing key factors influencing how messages in a medical encounter are perceived and understood by patients and families confronting the possibility of the approach of the end of life.

“Clinicians, at their best, can provide an empathic, reflective presence that will help patients marshal and draw strength from their existing resources,” Tulsky writes. “Helping the patient and family manage their hope and their resources in a realistic way may leave the family in the best possible shape after their loss.”

Source: “Beyond Advance Directives: Importance of Communication Skills at the End of Life,” *Journal of the American Medical Association*; July 20, 2005; 294(3):359-365. Tulsky JA; Center for Palliative Care and the Department of Medicine, Veterans Affairs Medical Center and Duke University, Durham, North Carolina.

### ADDRESSING UNCERTAINTY

All medical decision making involves uncertainty, notes Tulsky, and it is the physician’s role to help patients manage it. Most patients wish to receive as much information as possible and to participate in decision making, guided by the physician’s advice about recommended options. Physicians tend to find it easier to express uncertainty than to offer recommendations, out of concern that they will seem paternalistic. But clear recommendations are often welcomed by patients nearing the end of life, especially when based on the patient’s goals and values.

### ESTABLISHING TRUST

Tulsky suggests that physicians can:

- **Encourage the patient/family to talk:** “Tell me what you understand about your illness. How are you coping with this?”
- **Demonstrate respect:** “I’m very impressed by how involved you’ve been throughout your father’s illness. I can see how much you must love him.”

### SUPPORTING HOPE

Discussing end-of-life treatment choices does not necessarily rob patients of hope, says Tulsky. “Redirecting the patient’s goal toward realistic hopes and being present with compassion can serve as powerful acts in helping patients make decisions while maintaining a hopeful outlook.” Physicians can:

- **Help the patient hope for the best but prepare for the worst:** “Have you thought about what might happen if things don’t go as you wish? Sometimes having a plan that prepares you for the worst makes it easier to focus on what you hope for most.”
- **Reframe hope:** “I know you are hoping that your disease will stay in remission. I hope that, too. But if we cannot make that happen, what other shorter-term goals could we work toward?”
- **Focus on the positive:** “We’ve talked about some treatments that are really not going to be effective and that we don’t recommend. But there are a lot of things we can still do to help you. Let’s focus on those.” Or, “What sorts of things are left undone for you? Let’s talk about how we might be able to make these happen.”

—James A. Tulsky, MD, *Journal of the American Medical Association*

## Academic Hospice (continued from page 5)

the Accreditation Council for Graduate Medical Education.

Contemporary hospice programs that view patient care, concern for public health, education, and research as essential and inextricable elements of their mission can rightly be called academic, assert the authors, who consider this country to have fewer than six of such programs.

“At a minimum, it would seem obvious that every academic medical center will want to develop clinical, teaching, and research relationships with a hospice program,” the authors conclude. “At an optimum, a few academic hospices will develop to inform the health care system in the way that a few academic hospitals have done.”

Source: “The Academic Hospice,” *Annals of Internal Medicine*; November 1, 2005; 143(9):655-658. von Gunten CF, Ryndes T; San Diego Hospice & Palliative Care, San Diego, California.

# PHYSICIAN RESOURCES

## Online Clinician Resource: The Chronic Pain Network

— [www.chronicpainnetwork.com](http://www.chronicpainnetwork.com) —

Launched in August 2005, the Chronic Pain Network (CPN) is a national pain management education program for health care professionals that offers resources to aid in appropriate pain assessment, treatment, and balanced risk management of chronic pain.

One of the key components of the network is a pain management resource system, consisting of two complementary resource kits. The Clinical Resource Kit features assessment tools, patient education materials, and practice guidelines designed to assist clinicians in providing customized patient care.

Patient education materials include:

- A pain diary
- Frequently asked questions about sustained-release opioids
- Information on managing insomnia and other side effects

The Regulatory Resource Kit, which is CME-accredited, includes materials concerning the prescription of opioids, such as: regulatory documents, policy statements, a pharmacist's manual, a clinician's handbook, and position statements from leading medical professional organizations.

Membership in the CPN is for health care professionals only; there is no cost to join. For more information, visit [www.chronicpainnetwork.com](http://www.chronicpainnetwork.com).

## Medical Algorithms Available Online

— [www.medal.org](http://www.medal.org) —

More than 7,000 medical algorithms, organized into 45 chapters, are available for access or download from the Medical Algorithms Project at [www.medal.org](http://www.medal.org). Intended for use by health care professionals and students, all algorithms include documentation and references. Registration is free.

The website is designed to provide quick access to accurate and reliable equations and algorithms, and includes a search engine. Many of the algorithms are available also as web-based spreadsheets.

Chapter headings include: Performance Measures and Quality of Life, Clinical Pharmacology and Toxicology, Neurology, Nutrition, Oncology: Nonhematologic, and Oncology: Hematologic.

The chapter on performance measures and quality of life includes categories related to more than a dozen specific disorders. Additional topics include:

- End-of-Life Issues in Seriously Ill Patients • Symptom Burden
- Impact of Comorbidities • Measure of Social Support
- Quality of Life and Performance Measure in the Elderly
- Quality of Life Measures in Chronic Fatigue

The website is a project of the Institute for Algorithmic Medicine, a Texas-based nonprofit corporation.

## 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 (EPEC)

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

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

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

National Hospice & Palliative Care Organization

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

Palliative Care Policy Center

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

Americans for Better Care of the Dying

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

Medical College of Wisconsin Palliative Care Center

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

University of Wisconsin Pain and Policy Studies Group

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

Center to Advance Palliative Care

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

Pain Medicine & Palliative Care, Beth Israel Medical Center

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

An online community for end-of-life care

# HOSPICE OF THE PIEDMONT

~ Serving Central Virginia Since 1980 ~

## Hospice House Meeting Variety of Needs

The City of Charlottesville's Board of Architectural Review has presented a Preservation Award to Hospice House for Historic Building Rehabilitation. While this is gratifying, the deeper beauty of Hospice House is to be found in the loving and compassionate care given its patients and the warm and sensitive support provided for their loved ones. One family member wrote, "Everything that you and the Hospice House have done for our family has been incredible. You have touched our lives and enriched each and every one of us."

Since opening last November, 76 patients have been cared for at Hospice House. In these patients and their families, we have marveled at the variety of needs that Hospice House is meeting. Beyond its primary function as a haven for patients who cannot remain at home, Hospice House is proving to be an ideal setting for entire families to deal with end-of-life issues for their loved one – a quiet and dignified surrounding where family devotion can be affirmed, where forgiveness for past failures can be sought, where estrangements can be healed, where peace and acceptance can be found, and where final good-byes can be spoken.

Information on vacancies and admission criteria can be obtained from Jean Bradley, RN, Director of Clinical Services, at 434-817-6904.



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Intake Office: 434-817-6900 or 800-975-5501

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