



San Diego Hospice

San Diego Hospice Corporation is a not-for-profit, community-owned health care provider. Our specially trained staff provides compassionate, specialized care for patients with terminal or chronic illnesses, and emotional and spiritual support for them and their loved ones. The San Diego Hospice professional staff also offers ongoing education and support services for other health care professionals managing seriously ill patients throughout San Diego County.

Practical Palliative Care Today is published quarterly each year by the Center for Palliative Studies at San Diego Hospice to update physicians and medical professionals about trends and advances in modern palliative care.

The San Diego Hospice administrative offices are located at 4311 Third Avenue, San Diego, California 92103. Our website address is www.sdhospice.com.

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PRACTICAL Palliative Care Today

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Redefining hospice: The future of end-of-life care

Views from the desk of SDH President/CEO Jan Cetti

As the year 2000 approaches, many are wondering what changes the new millennium will bring. As I ponder the future, relativity also comes to mind. Time can be simultaneously both long and short. Sometimes I wonder if that's more true if you or someone you love is terminally ill.

In my role at San Diego Hospice, I am most concerned about what we can do tomorrow, next year and into the new decade to improve end-of-life care. Unfortunately, research shows that only 20 per cent of those who could benefit from hospice care nationally receive such care today. As a specialty in health care, hospice has accomplished much since end-of-life care became a recognized entity in the mid-1970s. And yet, we're still not reaching enough of those who need hospice care. In our self examination, we are discovering that it is we who must change the ways we deliver care.

Achieving universal access

While hospice care is meant to help those with any terminal diagnosis, demographic data suggests that hospice is still primarily serving white adults with advanced stages of cancer. The most common causes of death are still unrelated to cancer. Individuals with heart disease, lung disease, nervous system disease and dementia are not being reached by current hospice programs.

At least two barriers exist in trying to reach more of those who are dying. To break through those barriers requires creativity and flexibility in the way we design our programs and services.

First is the issue of expectations and standards. Our challenge is to set strong, clear standards for quality end-of-life care and to create methods to ensure that health plans, institutions and clinicians adhere to them. Rather than "There's nothing more we can do for you," at the appropriate time, terminally ill patients should be told, "Now's the time to refer you to a palliative care specialist who can do a lot for you."

The second issue is admission criteria. There are misconceptions about who is "appropriate for hospice care." Admission criteria and services offered are increasingly determined by profit margins and stop-loss strategies, and are further complicated by reimbursement requirements imposed by Medicare and other government-subsidized programs.

San Diego Hospice already has begun to work collaboratively with the National Hospice Work Group to change attitudes and policy about end-of-life care on a national level. In the short run, we believe it is our mission, not the margin, that matters most. We feel ethically bound to "do the right thing" by serving all patients who seek our services, and in our view, it would be immoral to withhold treatment because of an individual's inability to pay.

In addition, this year we developed and enhanced several specialized teams. Our Cultural Diversity Task Force continues to seek ways to tailor hospice care to meet the needs of culturally diverse populations. A bilingual patient care team now exists to meet the needs of the Spanish-speaking population. Our Children's Program now works collaboratively with other health care systems to serve dying children and their families. It has also designed and implemented a specialized program to fill an especially difficult void, one for parents with knowledge that an unborn child will likely die soon after childbirth.

Integrating into mainstream health care

Care for the dying must improve in all environments, particularly in hospitals and long-term care facilities. Studies documenting deficiencies in care, the movement to legalize physician-assisted suicide, and the aging of the baby boomers all contribute to a growing concern about how we die in America. Efforts to improve care for the incurably ill and dying have received the attention of health care and public policy leaders.

Why should care at the end *Continued on page 8*

Michael Frederich, M.D., is the newest member of the San Diego Hospice medical staff. Born, raised and educated in St. Louis, Missouri, he has been a family practitioner in both private practice and academia in the past. Dr. Frederich became a full-time hospice physician in 1990 and spent most of the intervening time as medical director of Hospice of Southern Illinois, followed by three years as medical director of St. Vincent Hospice in Indianapolis. Dr. Frederich is active in the American Academy of Hospice and Palliative Medicine and currently serves as treasurer in that organization.

From the desk of the editor ...

I would like to take this opportunity to introduce you to this first edition of *Practical Palliative Care Today*, the professional newsletter of San Diego Hospice and Palliative Home Healthcare. This quarterly publication is intended to help keep you apprised of new developments with our program and to provide educational material that will be useful to you in managing your chronically ill as well as terminally ill patients. We have broadened this publication from a physician newsletter to that of a professional newsletter, so that our entire interdisciplinary team of physicians, nurses, social workers, chaplains, pharmacists and therapists may contribute to it and gain from it.

The articles included in this first issue fall into several categories. A vision beyond cure is provided by Jan Cetti, president and CEO of San Diego Hospice. Pearls of Palliation focuses on the management of nausea and vomiting. Integrative Palliative Care discusses aromatherapy, and Administrative Issues provides

information on the hospice Medicare benefit. An article on the importance of flexibility completes the didactic text.

Some lighter material is also included in this issue. In Meet the San Diego Hospice Medical Staff, brief biographies are provided for your information about two of our six full-time certified staff physicians. And finally, from *A Little Book of Doctor's Rules*, Clifton Meador, M.D., offers a view of the physician as a drug.

As editor of this newsletter, I am always looking for others who wish to contribute material. I'm interested in your articles, comments, questions and suggestions. Please don't be shy.

I look forward to sharing ideas and to working with you and your patients served by San Diego Hospice. I hope you enjoy this newsletter.

Michael E. Frederich, M.D., Editor

Meet the Staff

In this column, we will introduce some San Diego Hospice professional staff members.

Rebecca Ferrini, M.D.

The youngest physician on staff, Rebecca Ferrini, M.D., MPH, completed medical school and her residency at UCSD. She has worked at San Diego Hospice for four years and is certified by the American Board of Hospice and Palliative Medicine. Rebecca is awaiting results from her board examination in General Preventive Medicine.

At San Diego Hospice, Rebecca is primarily involved in acute care management of terminally ill patients being cared for in the Inpatient Care Center. In addition, she is actively involved in medical education, training medical students and resident physicians in the areas of pain management, communication skills and palliative medicine. She has been instrumental in adapting the Comprehensive Plan of Care (CPOC) to San Diego Hospice's computerized medical record system.

Rebecca has wide-ranging interests and achievements in many areas of health care. She has authored policy statements for the American College of Preventive Medicine on topics ranging from screening for can-

cers of the skin, breast, and prostate to needle exchange programs and folate supplementation. She received a national award as outstanding resident in 1997.

Additionally, she has published primary research findings on the interaction between hormone levels and cancer risk factors through a three-year fellowship from the American Cancer Society. Rebecca is currently completing the third edition of a textbook on health and aging entitled, *Health in the Later Years*.

Rebecca was initially attracted to hospice care through an interest in improving quality of life. She maintains the highest professional standards of caring for her patients and is a great asset to San Diego Hospice. She and Jeff Klein, her partner, are kept busy by a bustling household with three energetic young children who range in ages between two months and six years old.

Frances Philley, M.D.

The most experienced teacher among the physicians at San Diego Hospice, Frances Philley, M.D., taught elementary school and special education for 18 years before pursuing a career in medicine. During her teaching career she returned to obtain a Masters degree in

education and to study computer programming extensively. She also taught in Calexico for four years and became fluent in Spanish.

After all these years of teaching, Frances went to medical school at Michigan State University. In a way this was returning to her roots because after obtaining her undergraduate degree in psychology, Frances had been a social worker in nursing homes. After medical school, she completed an internal medicine residency and a fellowship in geriatrics. Frances is certified by the American Board of Hospice and Palliative Medicine.

Frances remains an incredibly talented teacher and is responsible for developing the use of simulated patients as part of the third-year medical student rotation in palliative medicine at San Diego Hospice, a mandatory requirement of all students enrolled in the School of Medicine at UCSD. She is currently assistant director of education at San Diego Hospice.

Frances has many interests and hobbies outside of work including travel (especially by train), hiking and communing with nature, meditation and eastern religions, reading, gardening, cooking and working out.

Flexibility: A Key Hospice Component

Flex • i • bility (flex'ibil'i•ty) *n.*

1. Capable of or responsive to change; adaptable.
2. Capable of withstanding stress without injury.

In a hospice program, flexibility is a key characteristic. Flexibility applies to all staff: physicians, nurses, social workers, chaplains, and volunteers. At times, some hospice programs deny service to needy individuals for any variety of reasons: rigid interpretations of what is or is not palliative, the comfortable limits of providing care, and most often reimbursement issues including the Hospice Medicare Benefit.

Indeed, barriers exist for some. One example could be denying admission to an individual requesting full resuscitation status or refusing Do Not Resuscitate status. This is not only inflexible, it is against National Hospice Organization policy. Even though CPR may be futile for an individual, it is the right of the individual to request it. In fact, San Diego Hospice does not provide CPR, nor do we encourage it for our terminally ill patients. Given time to work with the patient and family, our staff often helps them see the futility and invasiveness of this infrequently successful procedure. If the patient or family continues to desire and request this service, s/he must access the 911 system. All patients admitted to our Inpatient Care Center must be DNR.

San Diego Hospice is committed to remaining flexible in our admission criteria in order to better serve the needs of terminally ill patients and their families. Sometimes rules need to be bent. For years we had no guidelines for hospice admission other than physicians agreeing the patient was terminally ill with a life expectancy of six months or less if the disease were to run its normal course. In the past few years, however, an expert panel of physicians was organized by the National Hospice Organization to produce a set of guidelines—not criteria—for non-cancer diagnoses. Its four-page introduction confirms

that the physician's clinical judgment is the best determination for appropriate admission into a hospice program.

There really is only one way to prognosticate with complete accuracy when someone has exactly six months to live: simply take the date of death and subtract six months. Clearly, due to individual and disease variation, no one can accurately predict death. We can only exercise our expert opinion based on disease models and experience. Ironically, guidelines developed earlier as an aid to refer patients to hospice have back-fired. Now the median length of stay nationally is fifteen days, not the forty-five it was a few years ago.

Your judgment as a physician is critical in the certification process. Who knows the patient better? For this reason and for documentation purposes, we need help in securing patient records as soon as possible from your office. Any patient you feel is dying is usually appropriate for hospice care. Let us worry about the regulations.

What about seemingly futile interventions at the end of life? Certainly, the individual has the right to discuss options and to be informed of treatment choices at this time of life as at any other time. Giving them truthful information is not an option, it is an ethical imperative and necessity. The individual can only make informed decisions if given accurate information. Of course every case must be individualized in an attempt to meet the goals of the patient and family, and the standard of care may vary widely from case to case.

For some individuals, the only goal is a comfortable death. There is no other goal or agenda, or needs to be met. The patient and family are ready for the end of life. In these cases, no life-extending measures will be offered or applied. When the individual

becomes non-verbal and incapable of taking oral hydration or nutrition, none will be offered nor provided by extraordinary means.

Other individuals who remain functional except for a few problems may be managed very aggressively. For example, in an individual who functions well but is dependent on occasional blood transfusions, those transfusions will be provided as part of the hospice comprehensive plan of care (CPOC). Perhaps the goal is to live for a special event one month away. In this case, measures will be taken to help assure survival for the next thirty days, or to move the event up if possible.

Environment is another area where flexibility is crucial. By having services available in all environments (home, nursing home, hospital, hospice inpatient care center) we are able to follow the patient and provide continuity of care regardless of where they may be physically at the moment. Having the only free-standing hospice inpatient care center in San Diego gives us a great deal of flexibility. Consistency in following the patient's desires is assured.

In order for hospice care, or end-of-life care to be effective, it must be individualized. Communication is essential to the process. Know that our San Diego Hospice physicians do not want to supplant or replace your role as primary attending physician. We wish to collaborate as consultants in palliative care, when needed. We presently have seven certified physicians to interact and work with you and your patients.

Please invite us to participate in this special care. By understanding the needs of your terminally ill patient, we can apply standards of care in the most appropriate, supportive and flexible manner possible. We're here simply to help.

Administrative Issues

In this column, we will discuss and address administrative issues in hospice and palliative medicine. In this first issue, we'll start with a discussion of the Hospice Medicare and Medi-Cal Benefits and focus on physician reimbursement issues.

The Hospice Medicare/ Medi-cal Benefit

Originally established by legislation in 1982, the Hospice Medicare Benefit (HMB) provides for the care of terminally ill patients. After certification by both the primary attending physician and the hospice physician that the patient is terminally ill with a life expectancy of six months or less, the patient relinquishes Medicare Part A benefits for the care of the terminal illness, substituting it with the Hospice Medicare Benefit.

In return for accepting the patient, the hospice receives a per diem amount, but is responsible for all the expenses generated by the patient for the care of the terminal illness. This is best explained by an example. If a patient with cancer also has diabetes mellitus, the hospice care for the cancer is reimbursed by the Hospice Medicare Benefit, while the diabetes management is covered by traditional Medicare. Hospice is also expected to provide continuity of care regardless of environment, and thus must be able to work in acute hospitals or hospice inpatient units, skilled nursing facilities, and the homes of patients.

The HMB requires that the patient be re-certified at 90 and 180 days of service for continued appropriateness for hospice care. Following 180 days of benefit, the patient must be re-certified every 60 days. This is usually done by the hospice interdisciplinary patient care team with the assistance of the primary attending physician and the hospice physician.

Reimbursement of physician services varies depending on the physician's role. When a patient signs up for the HMB, he or she designates

one primary attending physician. Attending physicians who are not employees of the hospice program may bill for professional services under Medicare Part B, as usual. They will receive 80 percent of the usual and customary fee from Medicare with the other 20 percent coming either from secondary insurance or from the patient.

Consulting physicians and hospice-employed physicians who provide direct clinical services for hospice patients for conditions related to the terminal illness must be reimbursed directly by the hospice.

Primary physicians who care for enrollees of Medicare HMOs may also be reimbursed for their care. Under special HMO rules, the HMO may bill Medicare on behalf of the physician on a fee-for-service basis for physician services provided to Hospice Medicare Benefit patients. Note that the care provided must be related to the terminal disease. This alleviates the potential loss of revenue these physicians experience when their PMPM rate is decreased after the patients' election of the Hospice Medicare Benefit.

Under current regulations, attending physicians may also bill for care plan oversight with reimbursement

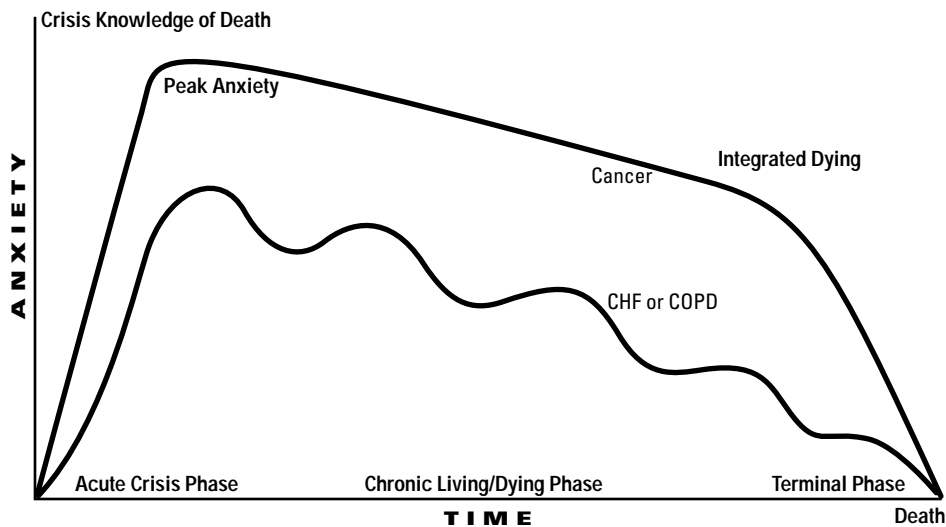
dependent on documentation of their activities and time spent during the month of service billed. Other services provided by attending physicians for hospice patients such as laboratory studies, x-rays, and medications, are not independently reimbursable under Medicare Part B, unless they are for evaluation and treatment of other non-terminal conditions and diseases. If such services are part of the hospice patient's plan of care, the hospice is responsible for paying for the services.

Consulting physicians and hospice-employed physicians who provide direct clinical services for hospice patients for conditions related to the terminal illness must be reimbursed directly by the hospice. The HMB allows the hospice to bill Medicare Part A on a fee-for-service basis for direct patient care services provided by a consultant or employed physician. The services, of course, must be included in the patient's plan of care. The hospice bills Medicare Part A, which reimburses the program for consultant and employed physician services at 100% of the usual and customary charge. The hospice in turn then pays the consultant physician.

The hospice physician is not allowed to bill for routine administrative activities or for care plan oversight because these activities are covered under the per diem reimbursement that the hospice receives from the HMB. Although the HMB is not perfect by any means, it was the first system of managed health care in this country and has been responsible for the expansion of hospice from voluntary agencies to full service health care providers. Understanding the HMB will facilitate your working relationship with San Diego Hospice.

The Living-Dying Trajectory

The living-dying trajectory is a useful model to better understand end-of-life care. Each specific disease has a typical trajectory, but every patient reacts to the disease as an individual with a lot of variation. For instance, end stage cardiac or pulmonary disease waxes and wanes while typically cancer has a sharp delineation that defines end of life. From the diagram you can see these variations:



This model is useful in looking at the usual phases of a chronic illness that results in death. As can be seen from the diagram, four phases are present on the x-axis time line: the acute crisis phase, the chronic living-dying phase, the terminal phase, and the point of death.

The acute crisis phase is the most stressful. This is the time when the individual patient and family are informed that a disease state exists that will affect longevity. Often, this is the first inkling that some individuals have that immortality in this life is not possible. Freudian annihilation anxiety may result. Feelings of helplessness, inadequacy, and confusion may follow and when the crisis of the knowledge of death occurs, peak anxiety may result.

The indicated treatment in this phase is crisis intervention. Unfortunately in most settings, this is when medical care is often poorly organized. It is usual for the physician to be breaking the bad news alone to the patient, in a hurried manner, and in a public place (hospital setting)—all of which are known to be less than

optimal for communicating unfavorable news. Bringing in ancillary staff such as nurses, social workers and chaplains for support is time-consuming and typically less than satisfactory for the patient. Indeed, special communication skills are required to break bad news effectively.

As a result, the patient quickly enters the stages of denial, anger, and bargaining, again with little or poorly organized support. The traditional hospice interdisciplinary team is not contacted because the patient is not yet terminally ill, however, an integrated palliative care disease management team would be very helpful and appropriate at this time.

After surviving the initial shock of the diagnosis and weathering the acute crisis phase, most individuals enter the chronic living-dying phase. This phase consists of more living than dying as modern medicine brings its life-sustaining and life-prolonging interventions to bear. Often this phase is lengthened by the excellent medical treatments provided, but this often places more burden on the family. The patient and the illness become the focus of life for the

entire family for years.

During this longer phase, the patient begins to cope with the disease and learns to handle fears. Fear of the unknown is probably only second to the fear of pain, loss of function or disfigurement for individuals at this stage. Societal isolation is also a high risk as friends and acquaintances may withdraw. This is particularly true if the disease is stigmatized or misunderstood.

Palliative care or hospice care should be initiated during this phase to lend support of an emotional, psychosocial, and spiritual nature in addition to relieving the distress of uncontrolled pain and symptoms. Although ideally, anticipatory grieving should also begin at this time, it often does not. Most often saying good-bye and “I love you,” is put off for the last phase before death: the terminal phase.

The terminal phase is where most of us “lump” hospice care, but by this phase it is often too late. Since most individuals put off hospice until the very end, the terminal phase is being defined as days or hours instead of weeks to months. With this trend, there is no opportunity for the simple tasks of closing one’s life, saying good-bye and creating a happy legacy. There is definitely a lost opportunity for growth and development at the end of life which can be profound and awe-inspiring.

Nothing helps grieving family members like a good death. Comfort, communication, and communing with a loved one are never forgotten, and help heal the grieving soul. As the diagram shows, a time for integrated dying, when allowed, should be a standard part of the model.

Of course, we cannot force individuals and families to bend perfectly to fit any model. But by knowing what is possible, we can encourage them to stretch themselves into an experience at the end of life that can be every bit as dramatic and positive as that at the beginning of life. A far-fetched unrealistic goal? You may not believe it’s possible if you’ve never seen it. I have seen it many times and know the joy and exhilaration of the experience and truly wish all could witness what we call good death.

Management of Nausea and Vomiting

The management of nausea and vomiting becomes relatively simple after making a diagnosis or defining the etiology of the symptom. Please use the attached chart to refresh your memory about the site of action and the appropriate anti-emetics most effective for treatment.

This system often works wonders when the problem is straight-forward and due to only one cause. Unfortunately, in many terminally ill individuals, it is not simple to solve and manage the nausea and vomiting because etiologies are not single nor clearly defined.

One strategy I suggest is to use the enclosed chart to list all the possible etiologies and then to make a plan for which anti-emetics to prescribe. The key here is the plural form of the word. Often, combinations of anti-emetics work best.

For example, you will notice from the chart that opioids cause nausea and vomiting through two distinct mechanisms. Initially, the opioid may stimulate the vestibular apparatus. Selecting either oral meclizine (Antivert) or scopolamine (TransdermScop) in the patch form makes sense as first agents to prescribe. At the same time, a second agent may be added to completely control any opioid stimulation of the chemoreceptor trigger zone. Adding either promethazine (Phenergan) or haloperidol (Haldol) may be more effective in controlling the nausea and vomiting than prescribing either the meclizine or scopolamine alone.

Partial bowel obstruction as the mechanism of nausea and vomiting requires entirely different management. In addition to attempting to keep the bowel open and functional with the prescription of docusate sodium in combination with senna (Senokot S) or casanthranol (Pericolace), the prescription of the somatostatin analog octreotide is often essential. Prescribing octreotide in a continuous subcutaneous infusion starting at 5-10mcg/hr and increasing it to 250-750mcg/day may completely relieve this problem without the use of nasogastric suctioning or an anti-emetic.

For very complex nausea and vomiting induced by incompletely relieved pain and opioids or other multifactorial etiologies, a triple medication may be necessary. A combination suppository of diphenhydramine (Benadryl), metoclopramide (Reglan), and dexamethasone has been shown to be effective. The usual dosages prescribed are one to two suppositories every four hours:

BRD Suppositories		
	Benadryl	25mg
	Reglan	10mg
	Dexamethasone	2mg

In addition to choosing an effective anti-emetic or anti-emetic combination, general treatment measures for nausea and vomiting can be beneficial. Encouraging caregivers to provide small frequent meals consisting of foods selected by

the patient, frequent liquids, and an atmosphere that is quiet, relaxing, and pleasant will be positive. Encouraging the patient to get enough rest, particularly before meals and to avoid disagreeable foods (particularly fatty and fried foods) and strong odors of cooking will be helpful. Often a mild appetite stimulant such as caffeine and alcohol containing beverages will be beneficial. Taking most medications after meals may reduce nausea.

Providing indicated interventions for specific etiologies will also be productive. Changing the NSAID intolerant patient to choline magnesium trisalicylate (Trilisate) may ease gastrointestinal distress. Providing specific antibiotics for candidiasis or clostridia should help greatly. A trial of diuretics for ascites may reduce the fluid overload.

By following these guidelines, nausea and vomiting may be effectively managed in many patients which helps ensure their end-of-life experience will be as free of suffering from physical problems as possible.

Etiology	Site of Action	Anti-emetic
Increased intracranial pressure Anxiety Memories	Cerebral Cortex	Dexamethasone Lorazepam
Motion sickness Vestibular disease Initial opioid effect	Vestibular Apparatus	Meclizine Scopolamine
Pain Visceral Stimuli	Vomiting Center	Diphenhydramine Scopolamine Ondansetron
Uremia Hypercalcemia Multiple drugs • Digoxin • Theophylline • Chemotherapy • Opioids • Antibiotics	Chemoreceptor Trigger Zone	Promethazine Haloperidol Droperidol Discontinue medications
Gastrointestinal irritants • NSAIDS iron • Alcohol, antibiotics	Gastric Distention	Trilisate
Tumor infiltration Radiation injury		Dexamethasone
Infection • Candida esophagitis • Clostridium colitis		Fluconazole Metronidazole
Obstruction • Poor motility • Ascites • Constipation	Gastric stasis	Metoclopramide Cisapride Diuretic Stimulant/Bulk Enema

Integrative Palliative Care

At San Diego Hospice a new entity is coming to life. Called the Integrative Palliative Care Team, this group is organizing and drawing together individuals within San Diego Hospice and in the community to further learn about and apply complementary or alternative medicine techniques to the care of our terminally ill patients. Constantly growing in popularity, alternative medicine techniques were recently presented as an entire issue of the Journal of the American Medical Association (JAMA).

The word integrative was specifically chosen because these therapies are integrated into a plan of care to complement traditional modern American palliative medicine. They do not stand alone, nor should they.

In order to briefly introduce these techniques to the general medical community, we will discuss one technique from the Integrative Palliative Care Team in each issue of Practical Palliative Care Today.

Aromatherapy

Over the past year, the bouquet of our Inpatient Care Center at San Diego Hospice has taken on a new array of interesting aromas thanks in large part to the generous and innovative spirit of one of our volunteers, Rodney Schwann. Rodney, a certified aromatherapist, is founder of the Southern California Institute of Aromatherapy and the first Aroma-Genera Diploma Graduate in the United States.

What is aromatherapy? It is a natural treatment that uses essential oils derived from plants that are inhaled, placed in whirlpool baths, used in massage and in compresses. In our experience at San Diego Hospice we have found that essential oils appear to raise spirits, relieve stress, clear the mind and provide comfort to the body by softening and easing some of the distressing effects of illness. If chosen by the patient, aromatherapy is used in conjunction with traditional Western medicine to help manage pain and symptoms.

Recently, Aroma-Genera founder Valerie Ann Worwood presented a two-day workshop at San Diego Hospice based on her book, *The Fragrant Mind*. This included material on the physiology of olfaction, using

essential oils for emotional and physical well-being, and cultural dynamics related to aromatherapy.

The Aroma-Genera system uses personality types and essential oils that relate specifically by class to those types to access physiological or psychological events which may impede physical healing, emotional well-being and life in general. It draws upon such personality typing as suggested by C.G. Jung, G.I. Gurdjiff, Oscar Ichazo, the enneagram, and present day psychology personality indicators such as the Myers-Briggs test.

To quote from another book by Valerie Ann Worwood, *The Complete Book of Essential Oils & Aromatherapy*:

“Essential oils are one of the great untapped resources of the world. The concentrated essences of various flowers, fruits, herbs, and plants have been used for centuries all over the world, but in modern times we have forgotten the power of these ancient medicines of the earth, preferring instead to use the products of perfume and chemical properties of essential oils. Because the essential oils are so sweet smelling, many people suppose their value is essentially one of charm and fragrance-but this is a mistake.

Modern scientific research has proven that essential oils are potent, with remarkable medicinal properties. These substances are very complex in their molecular structure, and very powerful. The essential oil of oregano, for example, is twenty-six times more powerful as an antiseptic than phenol...

“Unlike chemical drugs, essential oils do not remain in the body. They leave no toxins behind. And essential oils make much more sense as air fresheners than commercial products, as they cleanse the air by altering the structure of the molecules creating the smells, rather than masking the unwanted smells...”

Thanks to the support of Rodney Schwann and interested others at San Diego Hospice, as well as a \$4000.00 grant for medical research from the Heller Foundation of San Diego, we now have the opportunity to study the efficacy of aromatherapy through a controlled study. Hopefully, the knowledge gained from the study will further the discipline and allow us to validate this effective treatment for our terminally ill patients.

Each physician is a drug

With each encounter a physician's actions can...

- Produce side effects
- Exhibit a duration of action
- Induce toxicity
- Be indicated
- Be contraindicated
- Be given in an overdose
- Be given in an underdose
- Be given at the right interval
- Be given at the wrong interval
- Most of all...produce a placebo effect.

Learn the pharmacology of being a physician.

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Clifton K. Meador, M.D.
Hanley and Belfus Publishing

of an illness be so separate from all that has gone before? As palliative care specialists, we have the necessary knowledge and skills to provide what is needed by those who are dying.

We can and need to integrate our skills and services into mainstream medicine. Providing small amounts of palliative care at the time of diagnosis with a gradual increase as death approaches concomitantly with an equally gradual decrease in active curative measures as they become futile and inappropriate is a better system. In the presence of dying, we can train physicians to work toward health (that balance of body, mind and spirit) that is so much more than simply freedom from disease. There is no abrupt shift or perceived

abandonment at the end of life. There is simply a gradual transition within an integrated system.

At San Diego Hospice we are developing satellite palliative care programs for non-hospice patients at some local hospitals. As these programs grow, we will be able to play a broader role in improving care for those who are dying in settings other than hospice.

Advancing the science of palliative care

As part of her vision when she funded our Inpatient Care Center, Mrs. Kroc wanted to create a world-class center of excellence in end-of-life care, and through the years we have continuously involved ourselves in advancing hospice care through education and

research in our Center for Palliative Studies (CPS). One of our most notable accomplishments in this arena is that San Diego Hospice and UCSD School of Medicine developed one of the nation's few programs in which palliative care is a mandatory part of the medical student's training, now a growing trend in our nation.

In addition, we train physicians participating in residency programs and fellowships in San Diego and have hosted students from across the United States and foreign countries who visit us to learn about palliative care. We are committed to seeking grants and other funding, and envision playing a larger role in transforming end-of-life care through professional educational and research in the future.

A promising future

Standing at the brink of the new millennium, there's is an expectation of change. This is a pivotal time for end-of-life care. There is much to be done. By improving access, integrating palliative care into the broader health care system, and advancing the art and science of palliative care through education and research, San Diego Hospice is working to fulfill its mission and improve the way people die in our community. As long as we have *stakeholders* rather than *stockholders*, and our community's significant financial support for which we are most thankful, we will continue to meet our mission without threatening the survival of our many valuable hospice programs.



San Diego Hospice

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