

## NEW HAMPSHIRE HOSPICE and PALLIATIVE CARE ORGANIZATION

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### From The Board

Dear Friends:

It is with regret that we have accepted the resignation of Board President, Sue DiBona.

Sue is taking time out from nursing and hospice, and for personal reasons felt she could not continue in this role.

The Board would like to thank Sue for all her hard work and support and wish her luck in her future endeavors.

*NHHPCO BOARD*

### Greetings From Ira Byock, MD, Director of Palliative Medicine at Dartmouth beginning in December

I'm honored to have been offered this position and am thrilled by the opportunities that the new post offers. I am well aware of many remarkable people and the depth of experience and expertise within the region. I discover more all the time. I am delighted by the prospect of working collaboratively with colleagues from a range of disciplines and walks of life. I have a lot to learn about the local history, perspectives, politics, challenges and opportunities. I plan on listening a lot. Of course, my primary focus will be on patient care, staff support and development, and understanding the health systems and social support networks that currently exist. I want to learn how we can best support one another in the work we do.

During my interviews, the Dartmouth leadership expressed a firm commitment to integrate palliative care and hospice within a continuum of mainstream care at DHMC and its affiliates. I believe we have an opportunity - even a mandate - to deliver "the best care possible" for patients who are seriously ill or injured and their families served by Dartmouth in a manner that raises the bar locally and nationally.

I know well that real change is always local. I also recognize that comprehensive, competent health care is necessary to provide "the best care possible," but that it is not sufficient. "The best care possible" requires active involvement of people's communities. I'll work hard, ask questions and try to pay careful attention. I'll need your patience and lots of help I am truly, deeply excited to think of all we might accomplish together.

The position itself entails directing an interdisciplinary clinical team, teaching students, residents and fellows and building new models for integrating palliative care within a large, mainstream healthcare system. Dartmouth's dominance of healthcare in the region offers myriad opportunities to work in communities. The accomplished community coalitions of Vermont and New Hampshire (and Maine) offer unbounded opportunities to work within faith communities, schools, etc.

### Why Dartmouth?

In addition to being a top-notch academic medical center which encompasses a Level I Trauma Center and an NCI-designated Comprehensive Cancer Center, Dartmouth is an institution with heart. It has a serious commitment to practicing truly patient-centered, family focused care.

I came out to Dartmouth twice this summer. In addition to being interviewed, I asked pointed questions and probed the powers that be (the Dean, hospital President, clinic President, head of the cancer center) about their own vision and willingness to support palliative care. Each one affirmed their desire to make Dartmouth Hitchcock Medical Center and the Norris-Cotton Cancer Center living examples of "the best care possible." My assessment is that, system-wide, the institution is ripe to do just that.

Personally, since it became clear that relocating for work was unavoidable, Yvonne and I are delighted to be moving to such a beautiful environment and welcomed within such a vibrant community. We will arrive in December. As a bonus, we'll be within 3.5 hours from Montreal and Yvonne's mother, two hours from Boston and 5 hours from NYC.

I will continue as Director for the Robert Wood Johnson Promoting Excellence program and return to Missoula at intervals for meetings. I will also continue to be involved in Life's End Institute and will be looking for ways for LEI to involve the communities of the northern tier of New Hampshire and Vermont in a collaboration in the areas of research and program development.

### NHHPCO Annual Meeting

The annual business meeting will be held during the lunch break at the October 2, 2003 Pain and Beyond: 2003 conference at Geneva Point.

Everyone is welcome to attend but only active members can vote.

**All articles in this newsletter except the piece from Ira Byock have been taken from the Hospice Network News with permission.**

### NHHPCO Newsletter via E-Mail

If you would like to receive this newsletter by e-mail, notify Ann Blair at [hosp@nhho.org](mailto:hosp@nhho.org). Please specify what word processing program you use. For those with adobe acrobat reader, the newsletter is available as an adobe file.

**Help Save NHHPCO some money.**

## Notes

Patients being treated for bone metastases prefer zoledronic acid over pamidronate. A new study, presented at the recent meeting of the American Society of Clinical Oncology, revealed that 89% of the patients commented favorably on the 15-minute administration time for zoledronic acid, compared to two hours for pamidronate. The study did not assess the efficacy of the treatments and pamidronate has not been shown to be useful in the treatment of metastases of prostate and other solid tumor cancers. (Clinical Oncology Week, 6/23)

The California Coalition for Compassionate Care (CCCC) has completed an end-of-life needs assessment of the Chinese-American community. The key findings include that focus group participants were interested in learning how to talk about death and dying more directly, in spite of possible taboos in their culture. The lack of information on end-of-life palliative care leads many Chinese to see their choices as aggressive care or no care at all. Some Chinese families are uncomfortable with caregivers who are strangers to them, particularly if they do not speak Chinese. Many Chinese Americans consider it unlucky if a family member dies at home. (Rallying Points E-Newsletter)

Buffalo's St. John Baptist Church and the Center for Hospice and Palliative Care are partnering to bring wider access to hospice care to the community. This is the first time that the hospice has partnered with a local church. Karla Holloway, dean of humanities and social science at Duke University, recently participated in a program sponsored by the partnership to introduce minorities to palliative care. "They're forming the kind of partnership that will bring this method of care to African-Americans so that they can come to an awareness of what hospice provides," says Holloway. (Buffalo News, 7/20)

The Robert Wood Johnson Foundation has awarded \$4.5 million to fund increased palliative care availability in the US. Six institutions with exemplary palliative care programs, called Palliative Care Leadership Centers, will be funded over three years. Each will host a program for visiting professionals from other institutions that wish to start palliative care programs. The PCLCs will also offer training on the financial and operational aspects of such programs. The Center to Advance Palliative Care's website, [www.capc.org](http://www.capc.org), has more information. (Center to Advance Palliative Care Press Release, 8/5)

The Oregon House of Representatives has passed legislation allowing psychologists who complete an approved pain management education program to forego paying their license renewal fees. The Senate has also passed the legislation, SB 155. See a summary and full text at [landru.leg.state.or.us/billsset.htm](http://landru.leg.state.or.us/billsset.htm). (Oregon State Legislature Website)

Saint Barnabas Hospice and Palliative Care Center in Millburn, New Jersey, is offering a limited number of copies of a special video and training materials. "Changing Tides: A Child-Parent Bereavement Program" has been used at the hospice since the early 1990s. A training manual and companion video were added, and the program won an award from the National Hospice and Palliative Care Organization in 1996. To receive a copy, send a donation acknowledgment from your agency and a check for \$5.00 (made out to SBHPCC for postage) to Spiro Ballas, Saint Barnabas Hospice and Palliative Care Center, 187 Millburn Avenue, Suite 102, Millburn, New Jersey, 07041. (Last Acts E-Newsletter, 9/12)

Doctor visits are a social activity in Boca Raton, says a recent New York Times article. Some patients have 8-12 specialists, and see one or more of them most days of the week. It's a case study, the article says, of "what happens when people are given free rein to have all the medical care they could imagine. It's also a cautionary tale ... for it demonstrates what [Medicare] covers and does not cover, and how much or how little it pays, determines what goes on in a doctor's office and why it is so hard to control costs." The article is online at [www.nytimes.com/2003/09/13/business/13BOCA.html](http://www.nytimes.com/2003/09/13/business/13BOCA.html). (New York Times, 9/13)

An unpublished letter from David Abrams of the Hospice Foundation of America to USA Today responded to the recent article by Dr. Diane Meier. Speaking of her assessment of palliative care in hospitals, Abrams says that Meier's analysis of the extent of suffering in hospitals is correct, but "her solution is misconceived." Abrams says, "Every single solution Dr. Meier proposes in her piece is already available" in hospice. (Letter from David Abrams, President of HFA, to USA Today, 9/9)

## Pain Information

Two letters to the editor of JAMA question a Clinical Crossroads article by Jess H. Lonner, MD, in which he said, "COX-2 selective inhibitors are as effective as... NSAIDs," but may be less toxic than NSAIDs though 15-20 times more expensive. Thomas E. Finucane, MD, writes to say that a later analysis of celecoxib was no safer than other NSAIDs and that the FDA disagreed with the manufacturer that celecoxib was safer. Dr. Barry Egner wrote to say that opioids might be a better choice for elderly patients with severe osteoarthritis, though both their use and that of NSAIDs may be contraindicated in those patients. Lonner responds that physicians should consider "drugs' equivalent therapeutic benefits and cost differential when choosing a specific NSAID," and that he has rarely found that osteoarthritis pain is severe enough to require opioids. (JAMA, 2003; 290)

Leading a discussion on ethical and legal issues in pain management at the recent meeting of the American College of Physicians, Dr. David Fleming of the University of Missouri said that physicians may be able to keep patients alive longer with new technologies and drugs, "but we're also able to keep patients in their suffering mode a lot longer." Dr. Jay Jacobson, of the University of Utah, agrees, and says there are two forms of abuse - "abuse of drugs through over-treatment and abuse of patients through under-use of medication." (Medical Post, 6/17)

J. Donald Schumacher, President and CEO of NHPCO, responded to last week's USA Today op-ed article entitled "Many doctors lack training to ease patients' severe pain." Schumacher's response, which was printed in full in USA Today, says that the original article "does justice to the problems surrounding hospital-based end-of-life care. It does a gross injustice, however, by ignoring the role of hospice in providing patient-centered care focused on aggressive management of pain and other symptoms." Schumacher called attention to the leadership, history and importance of hospice. "Should palliative care be available in hospitals? Absolutely. Palliative care is good medical care. It is also critical, however, that we respond to the wishes and needs of those we are trained to serve. In most cases, this involves moving the dying process out of the hospital and to less-forbidding environments where dignity, comfort and compassion can be provided. It's called hospice." (USA Today, 9/12)

## States' Pain Policies Graded by Report

The University of Wisconsin Pain and Policy Studies Group (PPSG) has released *Achieving Balance in State Pain Policy: A Progress Report Card*. The report grades each state on "the quality of current statutes, regulations and guidelines that govern the use of medications needed for the relief of moderate to severe pain," especially opioid analgesics. A companion document, *Achieving Balance in Federal and State Pain Policy: A Guide to Evaluation, Second Edition*, evaluates each state's regulatory policy environment. The reports contain a state-by-state policy analysis.

In addition to the two publications, PPSG also published an accompanying cover letter and FAQ. All of these materials are available at PPSG's website at [www.medsch.wisc.edu/painpolicy/2003\\_balance/](http://www.medsch.wisc.edu/painpolicy/2003_balance/). The evaluation of states' policies was guided by a central principle called balance. Balance, PPSG explains, "represents a dual obligation of governments to establish a system of controls to prevent abuse, trafficking, and diversion of narcotic drugs while, at the same time, ensuring their medical availability." Seventeen criteria were developed from this principle. Eight of the criteria are positive indicators and nine are negative. Higher grades were given for meeting more of the positive criteria and fewer of the negative ones.

The executive summary notes that 35% of states received a grade of C, with 39% above a C and 25% below. No grade of A or F was earned. Compared to the study released by PPSG three years ago, 14 states had positive policy changes. Much of the change that occurred since the last study is owed to three factors: 1) regulatory boards adopted policies which encourage pain management, palliative care or end-of-life care; 2) single- or multiple-copy prescription programs were repealed; and 3) ambiguous or restrictive policy language was rescinded.

Some regional differences were noted. The central midwestern states of Kansas, Iowa, Nebraska and South Dakota received grades in the B range. The western states of California, Colorado, Idaho, Montana, Nevada, Oregon, Utah and Wyoming were in the C range. The three states with the largest population, California, Texas and New York, all earned Cs. These three states' policies had many positive provisions but also had many negative ones.

The report notes that, while public policies are "intended only to prevent drug abuse and substandard practice related to prescribing," some state policies either fail to conform to, or actually conflict with, current standards of professional practice. The following areas are cited:

- ❖ The amount of medication that can be prescribed and dispensed is limited.
- ❖ Special government-issued prescription forms are required.
- ❖ Access to medication is restricted if patients have a history of substance abuse or addiction, even if they also have pain.
- ❖ Outdated language confuses pain patients with persons with addiction problems.
- ❖ Opioids are considered to be a treatment of last resort.
- ❖ Policies suggest that the therapeutic use of opioids may hasten death.

The report contains a number of suggestions on how states can improve their grades for the next report.

- ❖ Evaluate and modify state pain policies. States that already have many positive provisions should repeal negative ones. Ambiguous language, which was cited in the policies of 33 states, needs to be removed.
- ❖ Implement new policies and disseminate them widely. Communicate with all those who have responsibility, including administrators, government officials, investigators, attorneys and the public.
- ❖ Seek cooperation, which is essential for further progress, between healthcare professionals, regulators and policymakers. (*Achieving Balance in State Pain Policy: A Progress Report Card, Achieving Balance in Federal and State Pain Policy: A Guide to Evaluation, Second Edition, 9/2003*)

## EOL Social Workers Formalizing Professional Expertise

In "EOL Social Work: A Coming of Age," Larry Beresford writes that social workers, more than ever, are key players on healthcare teams providing end-of-life care. Just as other end-of-life (EOL) specialties have done, social workers are working together to formalize their area of expertise in EOL. Social workers are now engaged in more research and refining end-of-life practices in social work. Additionally, they are working to include EOL care in basic training programs for social workers. They are also, Beresford says, creating a national organization for EOL social workers.

Beresford says that the Project on Death in America (PDIA), founded by the George Soros Foundation Open Society Institute, has pioneered much of the work that is helping to advance the role of social workers in EOL care. Since 1999, PDIA has recognized and provided scholarships to 42 social workers in academic and clinical settings. The program encouraged mentoring and networking among leaders in end-of-life care and the PDIA scholars. Mary Raymer, a leadership award recipient, says, "PDIA really did spin some exciting work. It pulled together a group of us who were already doing a lot of work on our own, and it helped to create a synergy from that work I now see social work finally beginning to take its rightful place in end-of-life care." PDIA has focused on education for social workers and Beresford highlights several examples of these efforts. While NHPCO, Association of Oncology Social Work, Association for Death Education and Counseling and the National Association of Social Workers have all provided some support for social workers in the end-of-life field, EOL social workers still lack a central voice in the political arena. In March of 2002, PDIA, Last Acts and Duke University co-sponsored the Social Work summit on End-of-Life and Palliative Care. A consortium gathered during that meeting and has plans now, perhaps as early as this fall, to offer a formally structured and incorporated membership organization for end-of-life and palliative care social workers. Grace Christ, assistant professor of social work at Columbia University, is the coordinator of this informal group, the Social Work Palliative Care Consortium.

The field's current challenge, says Christ, is "advancing the 'psychosocial technology' of end-of-life care social work." More research is needed on clinical practice, past research needs to be disseminated and new models and evaluation tools should be developed. The article is online at [www.lastacts.org](http://www.lastacts.org). (Last Acts, 6/24)

## Alternate Opioid Delivery Routes Explored

The current issue of Cancer Pain Release is devoted to optimizing analgesia when oral opioids fail to control pain. According to the publication, many patients, perhaps as many as 70%, experience improved pain management “from a change in route during the course of their disease.” The authors say that “the choice of an alternative route is influenced by a consideration of the benefits, risks, effectiveness and costs for each individual patient; the choice is also limited by what drugs and delivery options are available in the country or care setting.”

The publication includes an interview with Dr. Nathan Cherny, of the Shaare Zedek Medical Center of Jerusalem, and Dr. Sharon Weinstein, of the University of Utah Huntsman Cancer Institute. They review several reasons why oral opioids may not be appropriate. Some patients experience severe vomiting, bowel obstruction, inability to swallow pills (the most common reason), patient confusion or side effects such as drowsiness, cognitive impairment, hallucinations, etc. The doctors suggest trying a different opioid before changing the route of administration, since patients who have poor pain control with one, or cannot tolerate one, may have better results with another.

The physicians also recommend that clinicians evaluate the relative potency of opioids administered by different routes. They note, for example, that drugs introduced into the system intravenously and subcutaneously require smaller doses because they do not go through the liver and are absorbed faster than when given by mouth or rectally. The interview reveals that there is limited evidence to suggest that differences in side effects of opioids are related to specific routes of administration. Some patients experience less nausea and/or drowsiness from rectal and subcutaneous administration of morphine than oral, and some patients have less constipation with transdermal fentanyl than with oral morphine.

One article lists the alternative methods of administration - subcutaneous, rectal, intravenous, transdermal, intraspinal, transmucosal and sublingual, intranasal and topical - and for each method, details which opioids may be given by that method and information about the method, advantages, disadvantages, costs and references.

The site also lists a number of online sites about opioid delivery and provides links to research about opioid administration to address cancer pain and palliative care. The issue is available for online reading at [http://www.whocancerpain.wisc.edu/eng/16\\_1-2/16\\_1-2.html](http://www.whocancerpain.wisc.edu/eng/16_1-2/16_1-2.html). (Cancer Pain Release, 2003;16:Nos. 1-2; email from Sophie M. Colleau, Editor, Cancer Pain Release, 7/30)

The September issue of Pain Medicine includes several studies that address pain issues. “The Unequal Burden of Pain: Confronting Racial and Ethnic Disparities in Pain” addresses the disparities in the experiences of and treatment for pain for racial and ethnic minorities. “Methadone and the Hospice Patient: Prescribing Trends in the Home Care Setting” concludes that methadone, in spite of its economical and clinical benefits, is not commonly prescribed for hospice patients’ pain. “Reality and Viability of an Interactive Computer Method for Rating Quality of Life” concludes that interactive computer methods for assessing quality of life are both valid and reliable for patients in chronic pain as well as for healthy patients. Go to [www.blackwell-synergy.com](http://www.blackwell-synergy.com) and choose Pain Medicine (volume 4, issue 3) from the Quicklink list. (Pain Medicine, 2003;4(3); 277,269,257)

## Public Policy Notes

A new Illinois law, House Bill 96, expands hospice eligibility to persons with a life expectancy of up to one year. The legislation text is at [www.legis.state.il.us](http://www.legis.state.il.us). Click on “Bills and Resolutions” and then find the house bill. (Illinois General Assembly Website)

The Medicare reform bills in both houses of Congress contain provisions for preserving the Medicare hospice benefit, contracting with other Medicare-certified hospices for core services, and allowing nurse practitioners not employed by a hospice to follow patients if they elect to receive hospice care. The Senate bill would include physician assistants and clinical nurse specialists as well. The House bill includes a one-time “hospice educational consult” and a rural hospice demonstration project. Senate majority leader Bill Frist (R-Tennessee) expects that reconciling the two bill versions will be difficult and may take months to accomplish. (NHPCO NewsBriefs, 7/3)

Congressman Mike Rogers (R-Michigan) has introduced a comprehensive pain care bill, HR 1863. The bill reflects many of the positions of the American Pain Foundation and the Pain Care Coalition, as well as incorporating suggestions from many other organizations dealing with pain. Enter “HR 1863” without the quotes at [thomas.loc.gov](http://thomas.loc.gov) for full information on the bill. (Purdue Pharma E-Newsletter for Healthcare Professionals, 7/2003)

## Education

Roshi Joan Halifax’s workshop on the Buddhist approach to end-of-life, “**Being with Dying**,” is being presented at Dartmouth October 20th. Unfortunately the one-day workshop is completely filled and a wait list of 50 is growing. Those who are signed up for the workshop should know that this year’s **Bear Creek Retreat, “Stilling the Waters,”** will serve as an extension of the workshop, with Dr. Halifax leading two more days examining these issues, with “more heart and less head.” Facilitators from the Retreat are discussing opening up the Dartmouth workshop, perhaps via video, with Dr. Halifax and the Dartmouth group.

To participate in the 5th Bear Creek Retreat you must:

- ❖ Already be registered with DHMC for the Joan Halifax Conference Oct. 20.
- ❖ Register with Lake Morey Resort for Monday Oct. 20-Thursday noon Oct. 23 - call 800-423-1211. Rates are \$106 for double, \$126 for single per night and include breakfast and dinner. Swimming, golf, boating, etc. are available.
- ❖ Register with Virginia Fry at HPCCV at 802-229-0579 for a \$35 commitment fee only. Commuters are welcome and will be charged for meals only.

Email [plclary@aol.com](mailto:plclary@aol.com) for further information.

**November 4 & 5, 2003- End of Life: A Map for Uncharted Terrain** Presented by The Hospice & Palliative Care Federation of Massachusetts. For more information phone: 781-255-7077 or e-mail [hospicefed@aol.com](mailto:hospicefed@aol.com).

**November 16-18, 2003 The Rallying Points 2003 National Conference** will be held in Boston, Tom Wolff, PhD, consultant on coalition building and community development, will speak at the second plenary session. The conference is free. See [www.rallyingpoints.org](http://www.rallyingpoints.org) for registration and program information. (Rallying Points)

## Difficulties and Importance of Prognostication Explored

Predicting patient survival rates and sharing these predictions with patients are among the most difficult tasks physicians face, according to author-physicians Elizabeth B. Lamont, University of Chicago, and Nicholas Christakis, Harvard Medical School. "Complexities in Prognostication in Advanced Cancer" appears in the July 2, 2003, issue of JAMA. The article uses the story of Mrs. M, an 83-year-old woman who greatly outlived her doctor's predicted survival rate, to explore "clinical issues related to the science of prognosis in advanced cancer and the art of its disclosure."

The current de-emphasis on prognosis in medical literature in favor of diagnosis and treatment, the authors say at the outset, may mean that clinicians have difficulty finding the information they need in order to make accurate survival estimates. Doctors usually err on the side of overestimating length of life for cancer patients in palliative care, underestimating less than 20% of the time. One suggested reason for this is that terminally ill patients have been shown to want both honesty and optimism from their physicians. According to the article, "it may be that the difficulty of meeting both these seemingly disparate needs that leads some physicians to communicate overly optimistic survival estimates to patients..."

The article highly recommends consultation with subspecialists as a means of improving survival estimates. The authors say, "Aggressive evaluations by subspecialists may be of value for some patients: (1) to enhance prognostic certainty through more refined characterization of the disease, and (2) to inform supportive care." Research also suggests that consulting physicians may be better at prognostication because they have less emotional attachment to the patient than the primary physician, and may provide more realistic estimates of survival. The same research suggests that prognoses from several physicians, averaged together, are more accurate than the prognosis of one physician.

The authors provide several sources of prognostic information and offer suggestions for using each. These include the above-mentioned prognostic consultation, published survival curves, performance status, patient signs and symptoms, physicians' clinical predictions, and integrated models using all of these factors.

Giving a patient a poor prognosis is one of a physician's most difficult tasks, the article acknowledges, but "physicians must understand how critically important it is for patients to obtain information about the expected course of their illness... Patients use this information in a variety of ways, including as a way to inform decisions about which medical therapies to pursue and when to put their affairs in order."

Communicating bad news to patients is made easier by using algorithms that include the elements that patients have said they need to make decisions about the time they have left. The components of one such algorithm, detailed in the article, are:

- ❖ **Preparation.** Research the patient's disease and provide prognoses both with "life-prolonging" and palliative care. Alert the patient, before a visit, that important health issues will be discussed and suggest that he or she bring someone to the meeting. Establish how the patient is feeling, and explore symptoms and functioning that can be used as a focus of later discussion about prognosis.

Find out what the patient understands about the illness and what he or she expects of the physician. Determine what the patient wants to know about the illness.

- ❖ **Content.** Tell the patient that you have bad news. Be sensitive, but tell the news simply and clearly. Give information in small amounts. Make truthful optimistic statements. Tie your survival estimate to previously published data and relate it to the patient's clinical status.
- ❖ **Patient's Response.** Acknowledge the patient's response and be empathetic. Reassure the patient that you will continue to be involved in care. Emphasize that foregoing chemotherapy doesn't mean the same as "doing nothing."
- ❖ **Close.** Summarize the information and make a short-term plan of care. Arrange a follow-up visit, even if the patient is being referred to hospice. Offer to discuss the news with the patient's friends and family. Give the patient a way of contacting you or the team.

In conclusion, the authors say, the efforts of patients to accomplish certain things before dying should be regarded "as at least as important as the fundamental therapeutic tasks of pain and symptom management," and may be as professionally rewarding for the physician. "Thus, prognosis deserves prominence in the care of patients with life-threatening diseases like advanced cancer, and continual research on the science of prognosis and the art of disclosure is needed." (JAMA, 2003; 290:98-104)

## Med Students to Get Web-Based Pain Education

The American Academy of Pain Medicine has announced the development of a web-based textbook for medical students. The initiative is named TOP MED, which stands for Topics on Pain Medicine. Physician Daniel Carr is director of the project and is a professor of pain research at the New England Medical Center in Boston. Also sharing in the announcement of the program was Dr. Louis Sullivan, former Health and Human Services secretary and former Surgeon General, Dr. David Satcher, currently with Morehouse School of Medicine. The American Medical Association is also participating in the development of the project. Dr. Jordan Cohen, president of the Association of American Medical Colleges, speaking at the announcement of the program, said, "If we are to effectively treat a future generation of pain patients, we first must educate the next generation of doctors who will care for them." Even though 50 million Americans live with persistent pain, the article notes, most medical students fail to take a single course that truly is focused on pain treatment and management. A 2000-2001 survey of 125 medical schools conducted by the Association of American Medical Colleges found that only three percent of medical schools have a separate required course in pain management, and only four percent require an end-of-life care course. Fewer than one-third offer elective courses in pain management, and only 25% in end-of-life care. TOP MED includes the topics of neurobiology, costs of pain, patient evaluation, analgesics, acute pain, cancer pain and palliative care, chronic pain, pediatric pain and culture, race and ethnicity. Students will be able to work on their own self-directed schedule and self-test their comprehension. (US Newswire, 9/8; AP, 9/8)