ANZSPM Newsletter

Volume 19 Issue 2 August 2008

President's Report

In the middle of a Victorian winter, the promise of balmy nights in Darwin in September is enticing. Mark Boughey and the ANZSPM conference organising committee are heading for the home strait and we wish them smooth sailing. Registrants so far number more than 150, so we can look forward to an interactive and social conference.

In July, ANZSPM Council once again met with the facilitator of our strategic plan, Michael Goldsworthy, to take stock of progress over the last 18 months and increase our understanding of governance. Did you know there are over 700,000 "Not for Profit" organisations registered in Australia? We are one of many! Expectations for competent governance of all such groups have increased. Budget allowing, we would like to provide this kind of education on governance for all council members in the future. We were pleased to see the progress we have made in our governance structures and processes and recognise the great work of Karen in achieving many of our aims. We have developed a work plan which includes creating an induction manual to help newcomers to Council learn the ropes as quickly and painlessly as possible.

Recent developments:

We have been having discussions with the Chapter and RACP about representation on the Adult Medicine Division Council (AMDC). As a result of the new governance structures within the College, both the Chapter and ANZSPM are represented by respective presidents on the AMDC. The College has advised us that only one palliative medicine representative can attend. At this stage, both ANZSPM and Chapter feel the need to be there and this issue is not easily resolved. We have suggested to the College that there be one vote from Palliative Medicine as with other specialty areas, but that both the Chapter and ANZSPM presidents continue to attend the meetings in order to keep their members well informed of College and training matters.

In Victoria, the Medical Treatment Act (Physician Assisted Dying) Bill, proposed by MP Colleen Hartland, is being debated in the Upper House. A vote will take place in the second week of August, the outcome of which is uncertain at the time of writing. ANZSPM wrote to all politicians in Victoria personally, outlining our stance on this Bill. Our letter is posted on our website. We have been asked by the College to develop a position paper for the College on euthanasia and this is in progress. To date, the College has no such position.

The clinical indicators working group is underway under the leadership of Rohan Vora and there is a detailed update from Rohan in this newsletter.

The Constitution review committee has also been convened and will undertake a full revision of the Constitution to present to members at the AGM in 2009.

The third trainee day was held in Adelaide in May and thanks go to Toula and Scott King for coordinating the day. Also thanks to the Chapter for their assistance with sponsorship of the day. The next trainee day will be in Darwin. It provides a good opportunity for trainees to clarify training concerns with representatives from the Palliative Medicine Education Committee.

Workforce issues continue to plague us. Many consultant and advanced training positions are unfilled. In Victoria, the DHS in consultation with palliative medicine specialists, has developed a communication strategy designed to attract trainees into palliative medicine. Other specialty societies have well developed trainee websites to keep applicants well informed about jobs available, the nature, conditions and strengths of those jobs. We would like to develop something similar for our trainees, again, budget allowing.

Finally, thanks to members for responding so generously to the option to pay the higher fee this year. It has made a great difference and in large part, enabled us to continue to employ our Executive Director for at least a further 12 months. We are still seeking sponsorship for specific educational activities.

Odette Spruyt, Melbourne

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ANZSPM membership renewal

ANZSPM membership renewals are now due. If you have not received your renewal notice or have misplaced it, please email Karen at karen@anzspm.org.au

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New Zealand Branch Report

Our annual conference in NZ is over and judging by the feedback, it was enjoyed by all. We combined our education day with HPCNZ (Hospital Palliative Care NZ) which includes nurses and allied health professionals working in hospital teams. The total attendance was 70 of which 39 were doctors all of whom were ANZSPM members. This amounts to over 2/3rds of the NZ ANZSPM membership.

The education day comprised 4 sessions covering topics such as heart failure, relationships with ambulance services and comparisons of different opioids in the management of nerve pain. This latter topic was based on presentations of literature searches and produced lively debate amongst the audience. We ended the day with some interesting topics not least of which was an item showcasing spirituality and rhythm and blues!!! You had to be there to enjoy it and what a good way to end the educational part of the day. This lead nicely into the evening festivities which involved wining and dining and a testing quiz. There emerged some clear winners and they were rewarded by being elected the organisers of the evening entertainment for next year!!

On a more serious note, we had our annual NZ branch meeting the next day and were grateful to have Odette Spruyt and Karen Cooper attend to do a presentation on ANZSPM and its emerging role. Both Odette and Karen have done an enormous amount of work over the last 6 months in developing and professionalising ANZSPM in line with the strategic plan developed last year. There was much discussion around the implications for NZ and I believe an improved understanding of how the Society is working towards being truly representative of the two countries. An update on national developments in Palliative Care in NZ is covered in the following article by Anne MacLennan.

I will end this report by advertising two coming events in Palliative Care in NZ. The first is the 2008 Hospice New Zealand Conference, "Widening the Circle" to be held in Palmerston North on the 29th – 31st October (www.hospice.org.nz/conference-08)

The second is an early alert for the RACP (NZ Branch) annual conference, tentatively planned for November 4th – 6th 2009. The ANZSPM (NZ Branch) have been invited to join this conference and this will be a great opportunity for us to promote Palliative Care alongside general medicine and hopefully learn from each other. Further details of this will follow.

The ANZSPM Conference in Darwin is not far away now and I look forward to catching up with many Australian and New Zealand members there.

Joy Percy (NZ Branch Chair)

The NZ Palliative Care Working Party (PCWP)

The PCWP is an advisory group affiliated to the Ministry of Health and District Health Boards (DHBs). Members represent a range of specialist and generalist palliative care interests. Willem Landman represents ANZSPM. Current working groups include those addressing palliative care and cancer nursing education, palliative medicine workforce development, and medications in palliative care.

New Service Specifications for specialist palliative care are now being implemented around the country after much hard work by that group. The Ministry of Health has allocated extra funding for the new components: 24/7 specialist advice for generalists, 'last days of life' care, and education for generalists. It will be important to monitor how the implementation works in practice.

A Syringe Driver Advisory group links clinicians with Hospice NZ, DHB management and Medsafe (regulatory agency). This group meets monthly to coordinate and disseminate information about the transition from Graseby MS syringe drivers to newer devices. Currently, DHBNZ is going through a formal process to identify the preferred device for DHBs (the public health service) to purchase. We hope to have an outcome by the end of August. This has to be seen to be done correctly as there are considerable commercial implications. It is hoped that district collaboration will assist hospices and other charitable or private providers to adopt new devices.

A new group, chaired by Warrick Jones, will work on data and information systems. This group should be active by next month. Warrick is already part of the larger National Cancer and Palliative Care Information Systems Project, so this ensures a strong link.

Discussions continue between the Palliative Care Advisory Committee and Ministry of Health about the formation of a NZ umbrella body for palliative care. This is likely to impact on the form and function of the PCWP. Watch this space!

Anne MacLennan, Chair PCWP

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Trainee Report

The first registrar training day this year was in May, in Adelaide at the Lion Hotel. I would like to extend my thanks to Toula Christou, advanced trainee in Adelaide, for organising the venue and speakers. Without her help the day would not have been possible. It was an excellent day with interesting speakers and great food. It also allowed the opportunity for many of the trainees to meet colleagues from other states (and one from New Zealand). Many thanks also go to the presenters who gave up their time to speak to the trainees, especially when many of them are not palliative care specialists but work closely within palliative care. Thanks as well to Greg Crawford and Michael Briffa for attending to field questions from the trainees regarding the training program.

The website has been updated and things are progressing with the trainee page. Information regarding the next trainee day in Darwin can be found there and a few trainees have agreed to have their details available for those who are new to the training program and have questions they may want to ask. There are a few glitches that will be sorted out in the next couple of months. There are plans to expand what is available on the trainee page, but any suggestions from trainees will be greatly appreciated by ANZSPM. Email me at saking70@yahoo.com.au if you have any thoughts on what could be included on the site.

Don't forget to register for the ANZSPM conference in Darwin, September 24-26. If you are a member of ANZSPM you pay a special discounted trainee rate. There is a trainee day on the Tuesday 23rd at which the invited plenary speakers (Prof Declan Walsh, Dr Michael Wright, Dr Christine Connors, Mr Tony Egan) will give presentations to the trainees. It's a great opportunity to catch up and meet other trainees as well as network with other doctors who work in palliative care from across the country.

I look forward to seeing many of you in Darwin.

Scott King, Melbourne

Note: if any trainees are finding it difficult to find positions that offer experience in oncology, please contact Prof J Hardy in Brisbane janet.hardy@mater.org.au

Physician Assisted Dying Bill

In May this year Greens MLC Colleen Hartland introduced the Medical Treatment (Physician Assisted Dying) Bill 2008 into the Legislative Council in the Victorian Parliament. The purpose of the Bill is stated as: 'A Bill for an Act to enable a mentally competent adult person suffering intolerably from a terminal or advanced incurable illness to exercise their right to end their life by requesting medical assistance from their doctors, to protect doctors who so assist, to prevent misuse of their ability to assist, and for other purposes.' The debate for this Bill was resumed in the Legislative Council and adjourned on 30 July 2008 until second week in August. ANZSPM sent a letter to all MPs in the Victorian Parliament indicating that we do not support the Bill and why.

To view ANZSPM's response, go to www.anzspm.org.au under Resources

To view the proposed Bill:

http://www.legislation.vic.gov.au/domino/Web_Notes/LDMS/PubPDocs.nsf/ee665e366dcb6cb0ca256da400837f6b/97A3D62C55E9C6ACCA2574560026DC28/$FILE/561PM12bi1.pdf

Formation of a "Clinical Indicator Working Group"

The pressure to develop performance indicators (PIs), continuous quality improvement processes and evidence of translational research activities to facilitate rapid implementation of 'best practice' are inevitable consequences of expectations of greater accountability by both fund holders and patients and their carers. ANZSPM will engage these processes and has formed a working group to develop some cohesion in our response to the many quality assurance initiatives that will affect our practice. We hope to play a constructive role in the development of both quality frameworks and relevant clinical indicators (CIs) by which we can measure the quality of our care, benchmark our services and identify service and resource gaps.

There are many organisations looking at what is happening in our sector of healthcare:

The National Health & Hospitals Reform Commission (NHHRC) has increased the pressure on clinicians to demonstrate our engagement in quality and safety processes and has identified 44 PIs by which to benchmark and hold relevant parties responsible for meeting targets.

The Palliative Care Outcomes Collaborative (PCOC) is a national initiative funded by the Australian Government Department of Health & Ageing to introduce routine assessment of palliative outcomes across Australia. The aim is to develop relevant and robust benchmarking processes based on outcomes data being collected across many specialist palliative care settings. The hope is that standardised assessments and a common language can be developed across our diverse care sector.

The National Standards Assessment Program (NSAP), coordinated by Palliative Care Australia and funded by the Australian Government Department of Health & Ageing, is recruiting pilot sites for patient and carer self assessment tools. Site documentation audits that are being developed as quality assurance tools based on the National Palliative Care Standards. The aim is to develop standardised audit tools to provide nationally relevant quality indicators based around the standards. This process may in the long run become part of a standardised accreditation process for specialist palliative care services.

The RACGP has a national committee on quality care that has developed a quality framework within which it is proposed to develop CIs for various special interest areas by which GPs can gain quality assurance and continuing education points. A special interest group has been formed to develop some of these indicators in aged care and palliative care.

Our sector does not have a common language by which we can assess our patients' needs or talk meaningfully about how we practice our craft. Allowing for transparency in measurement of our practices, signing up to national standards, CIs and PIs by which we are happy to be measured is vital to our work but will be an enormous challenge for us all. A group of us in ANZSPM have formed a working group on CIs to sift through all the current initiatives and come up with a series of discussion papers for our members. We hope to engage with others sectors (eg oncology, geriatrics, paediatrics, renal medicine) and other colleges (eg RACS, RACGP) to develop relevant appropriate end of life CIs that can be used to gauge the quality of care we all provide. We will engage actively with other national organisations to develop a cohesive, succinct and clinically useful set of PIs. We aim to keep our society members fully informed about developments in this area and engage as many members as possible in these processes. We hope to have an introductory discussion paper that can be distributed at the ANZSPM Conference in Darwin in September.

If you are interested in joining this group, contact Karen Cooper: karen@anzspm.org.au. Rohan Vora is chairing this Working Group and members are from NZ and Australia: Odette Spruyt, Melanie Benson, Anthony Herbert, Scott King, Janet Turnbull and Brian MacDonald. Karl Lorenz will be providing advice to the Group.

A/Prof Rohan Vora

Chair Clinical Indicator Working Group

Membership Working Group

To ensure and viable and vibrant Society, ANZSPM has formed a Membership Working Group to develop a strategy to:

- provide additional services to existing members
- recruit new members to the Society

Mary McNulty will be Chairing the Group and members are from Australia and New Zealand: Joy Percy, Susan Hamilton, Brian Cole and Karen Cooper.

ANZSPM Constitution Working Group

ANZSPM has established a Constitution Working Group with members from Australia and New Zealand to undertake a review of its Constitution. The members of the working group are Frank Brennan, Cathy Miller and Odette Spruyt.

As the Constitution was last updated in 1998, it is anticipated this will be a major redraft. The redrafted Constitution will be presented to ANZSPM members for approval at the AGM in 2009.

You are welcome to either join the Working Group or provide input via email to karen@anzspm.org.au. In addition if you can help with obtaining pro bono or reduced rates for legal advice, we would be pleased to hear from you.

Palliative Care and Pain Treatment as Human Rights

Leading organisations from Africa, Latin America, Eastern Europe, Western Europe, Asia and North America have issued a Joint Declaration and Statement of Commitment calling for the recognition of palliative care and pain treatment as human rights.

According to data from the World Health Organization (WHO) and the International Narcotics Control Board (INCB), only a minority of the more than 1 million people who die each week receive palliative care to alleviate their suffering.

The seven goals in the Declaration are:

1. Identify, develop and implement strategies for the recognition of palliative care and pain treatment as fundamental human rights.

2. Work with governments and policy makers to adopt the necessary changes in legislation to ensure appropriate care of patients with life-limiting conditions.

3. Work with policy makers and regulators to identify and eliminate regulatory and legal barriers that interfere with the

rational use of controlled medications.

4. Advocate for improvements in access to and availability of opioids and other medications required for the effective treatment of pain and other symptoms common in palliative care, including special formulations and appropriate medications for children.

5. Advocate for adequate resources to be made available to support the implementation of palliative care and pain treatment services and providers where needed.

6. Advocate for academic institutions, teaching hospital and universities to adopt the necessary practices and changes needed to ensure that palliative care and pain positions, resources, personnel, infrastructures, review boards and systems are created and sustained.

7. Encourage and enlist other international and national palliative care, pain treatment, related organizations, associations, federations and interested parties to join this global campaign for the recognition of palliative care and pain treatment as human rights.

To read and sign the Declaration, visit

http://www.hospicecare.com/resources/pain_pallcare_hr/ before 11 October 2008.

Karen Cooper

ED, ANZSPM

Superannuation Payments

The Australian Government has announced the passage through Parliament of Tax Laws Amendment (2008 Measures No.2) Bill 2008 relating to changes in superannuation payments for those with a terminal illness.

The details of the Bill are:

• Superannuation lump sum payments will be tax free when paid to individuals suffering from terminal medical conditions.

• The tax free treatment will apply to payments made on or after 1 July 2007.

• The tax free treatment will apply to lump sums from both taxed and untaxed funds.

• There is a new condition of release to give persons with terminal medical conditions unrestricted access to their superannuation benefits.

This Bill will help to alleviate financial distress that people with a terminal illness and their families may experience. Currently, superannuation lump sum payments that are paid from taxed funds to individuals under the age of 55 are taxed at a maximum rate of 21.5 per cent (including the Medicare levy). Higher tax rates apply to lump sums paid from untaxed funds.

Journal Club

Differing management of people with advanced cancer and delirium by four sub-specialties. Agar M et al. Palliat Med 2008. 22(5): 633-640.

Study Objective: Compare the assessment and management practices for each specialist medical group (medical oncology, palliative care, psychogeriatrics and geriatric specialists) in the treatment of delirium.

Study Design: A questionnaire was sent by post.

Population: Specialists in medical oncology, palliative care, geriatrics and psychogeriatrics, with permission and distribution by their respective Learned Colleges. A reminder letter and second copy of survey was sent out at 6 weeks. Workforce demographic surveys for each speciality group were also obtained.

Intervention: The questionnaire was designed to identify demographic variables of age, gender, specialty area of practice, years of practice in this speciality field and frequency of patients with delirium in their practice. Two contrasting case vignettes of delirium were presented:

Case 1 - delirium in the setting of good functional status,

Case 2 - delirium superimposed on the last days of life. Respondents were asked the location in which they would provide care for this patient, usual assessment and investigations for reversible components of delirium, usefulness of non-pharmacological measures, symptomatology of delirium requiring treatment, pharmacological treatment of choice and dosing schedule used.

Main results: The overall response rate was 30% (270/918). Response rates for the four specialist groups were: medical oncology n = 62 (24%), palliative medicine n = 79 (38%), geriatrics n = 88 (33%) and psychogeriatrics n = 41 (26%). Significant differences between speciality disciplines were noted. Medical oncologists reported no community based practice compared with over 51% of other specialists ($p < 0.01$). Fewer palliative medicine specialists (67%) practiced in acute care inpatient settings compared with 90% of other specialists ($p < 0.01$). There was a significant difference in the number of patients seen with delirium per week with 51% of geriatricians seeing more than five patients with delirium versus only 18% of other specialists ($p < 0.01$).

Location of care

Case 1 - 35% of medical oncologists would consider care at home as an option for a patient with delirium in the setting of good functional status compared with 66% of other specialists ($p < 0.01$).

Case 2 - there were no significant differences between specialties.

Investigative approaches

Case 1 - significant differences between groups were seen in the median number of first line investigations ordered by palliative care specialists (median = 5) compared to other specialists (median = 7; $p < 0.001$). A CT head scan was ordered by 46% of medical oncologists compared with only 23% other specialists ($p < 0.01$). Only 13% of palliative care specialists would order a chest X-ray to investigate potentially reversible delirium compared with 60% of other specialists ($p < 0.01$).

Case 2 - no significant differences were seen between any speciality groups with a median of one investigation for all groups.

Management approaches

Case 1 - medical oncologists are significantly more likely to use pre-emptive antibiotics (16% vs 4%, $p < 0.05$), intravenous fluids (39% vs 16%, $p < 0.01$) and oxygen (39% vs 12%, $p < 0.01$) before the aetiology was defined. Symptomatic pharmacological measures were more likely to be used by palliative medicine specialists (77%), as initial management compared with only 33% of other specialists ($p < 0.01$). Twenty one percent of medical oncologists would use a benzodiazepine as agent of choice for Case 1 compared with 3% of other specialists ($p < 0.01$).

Case 2 - a benzodiazepine was given as agent of choice by 77% of medical oncologists compared with 34% of other specialists ($p < 0.01$). Overall, the usage of benzodiazepines by all specialty groups was higher for terminal delirium (43%) than for reversible delirium (7%). It was also interesting to note 9.4% of psychogeriatricians and 4.8% of geriatricians nominated they would use an opioid as agent of choice to manage 'terminal delirium' symptoms despite this not being provided as a choice in the questionnaire.

Broad management approaches

Twenty-three percent of medical oncologists use benzodiazepines or a combination of benzodiazepine and neuroleptic to manage hallucinations versus 5% of other specialists ($p < 0.01$). Medical oncologists are more likely to use a benzodiazepine alone to manage agitation (30% vs 10% of other specialists) ($p < 0.05$) and disruptive behaviour (18% vs 3%, $p < 0.01$). Significantly more palliative care specialists compared to other specialists use a neuroleptic to manage disorientation (56% vs 16.7%, $p < 0.01$), decreased activity (36% vs 3%, $p < 0.01$), impaired concentration (31% vs 9%, $p < 0.01$) and cognitive impairment (46% vs 7%, $p < 0.01$).

Dosing schedules

Haloperidol – initial oral or subcutaneous doses ranged between 0.25 and 25 mg (in a 24-h period), with maximum doses ranging from 0.5 to 120 mg per 24 hours.

Midazolam – initial doses ranged between 0.5 and 30 mg per 24 hours, maximum doses of 10–150 mg per 24 hours.

Limitations: Relatively low response rate, although standard for this type of survey and representative of respective specialities. Case vignettes present a very small snapshot of information. The biggest limitation is the lack of high quality studies in the management of dementia in advanced cancer patients.

Conclusions: More research is needed to explore efficacy of pharmacological management of delirium in advanced cancer. An evidence-based strategy is needed to allow clinicians to balance burdens of excessive investigation against investigations that may define potential reversibility or improve symptoms in the population with advanced cancer. This study also raises significant implications for the approach to training of medical specialists with the need to obtain a core body of knowledge in delirium management to drive management decisions irrespective of type of medical specialty.

Commentary: It is interesting to see how different clinicians perform in clinical practice. As delirium occurs across almost every area of medicine, it is a good topic to compare management by different subspecialties. As alluded to in this study, the management of delirium in advanced cancer patients is essentially an "evidence free zone", and as such it is hard to justify (or criticize) one particular practice from another. One of the factors highlighted in this study is that those with a predominantly hospital-based practise (medical oncologists), are more comfortable managing patients in hospital than in the community. The other findings may reflect access to investigations, as well as familiarity with different patient populations. An interesting implication for training and education between specialities is the finding that some geriatricians and psychogeriatricians think it is reasonable to use morphine for 'terminal delirium', despite little clinical justification.

Dr Phillip Good, Newcastle

Note : A PaCCSC study of delirium in palliative care patients, developed by the lead author of this paper, comparing haloperidol, risperidone and placebo is about start in 6 sites across Australia. The aim is to answer many of the uncertainties in the management of delirium as described above.

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Notices

The Carers Virtual 2020

Carers Australia has opened an online forum asking Australians for their big ideas about what will help provide sustainable support for Australian carers. The question being asked is: What should this country have achieved for its carers by the year 2020?

The Carers Virtual 2020 kicked off at 10am Friday 1 August.

To register your big idea, go to www.carers2020.com.au

Cancer Learning is live

Cancer Learning is a new site that aims to consolidate the rapidly growing variety of evidence-based learning activities, resources and information available from both within Australia and from overseas.

There are three new online learning modules on the site in multidisciplinary care, principles of psychosocial support and frontline psychosocial management which are relevant to all health professionals and easily accessed in small sections.

To access Cancer Learning: www.cancerlearning.gov.au

Interim report on Motor Neuron Disease and palliative care

The interim report for the Motor Neuron Disease and palliative care project is available. In July 2007, the MND Pathway Project was established to develop a framework to assist people living with Motor Neurone Disease (MND) to access palliative care services, and to assist palliative care services manage and support people living with MND. The project was commissioned by the Cancer and Palliative Care Unit of the Department of Human Services. The project was undertaken by MND Victoria.

For a copy of the report:

http://www.health.vic.gov.au/palliativecare/mnd-report.pdf

PCA releases new glossary of terms

PCA has released 'Palliative and End of Life Care Glossary of Terms'. This document is the first step in the process of developing an agreed, commonly understood language to describe end of life and palliative care.

Available at: www.palliativecare.org.au

Conference Update

Hospice New Zealand Conference
"Widening the Circle"
29 – 31 October 2008 Palmerston North, NZ
www.hospice.org.nz/conference-08

RACP (NZ Branch) Annual Conference
4 – 6 November 2009

World Congress of Internal Medicine
20-25 March 2010 Melbourne, Australia
www.wcim2010.com.au

ANTEA Worldwide Palliative Care Conference
12-14 November 2008 Rome, Italy
www.anteaconference2008.com

COSA_ IACR 2008 Joint meeting
18-20 November 2008 at Sydney, Australia
www.cosa-iacr.org

Together! 2009
International Conference on Cultural Connections for Quality Care at the End of Life
24 - 28 September 2009 Perth, Western Australia
www.palliativecare.org.au

19th International Symposium on ALS/MND
3-5 November 2008 Birmingham, UK
www.mndresearch.asn.au

2008 National Conference for Rural & Remote Allied Health Professionals
27-30 August 2008 Yeppon, Australia
http://www.sarrah.org.au/site/index.cfm?display=87530

Children's Hospice International 19th World Congress
16-19 November 2008 San Francisco, USA
http://www.chionline.org/events/world_congress_19th.php

Palliative Care : A Sea Change 2008 NSW State Palliative Care Conference
12-14 November 2008 Coffs Harbour, Australia

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Advertisement

AUSTRALIAN AND NEW ZEALAND SOCIETY OF PALLIATIVE MEDICINE CONFERENCE

23 – 26 SEPTEMBER 2008

DARWIN, NORTHERN TERRITORY, AUSTRALIA

REGISTRATION

Register before the 5th September to save up to $100 on your registration fees!

You can register online or by downloading a registration brochure from the home page of the Conference website and sending the form back to the Conference Secretariat. The Conference website address is: www.willorganise.com.au/anzspm08

INVITATION TO ATTEND

Welcome to Darwin and the lands of the Larrakeyah people.

On behalf of the organising committee, it gives me great pleasure to invite you, your colleagues and family to the 8th biennial conference of the Australian and New Zealand Society of Palliative Medicine. I hope you enjoy your stay and catch a glimpse of the appeal and charm of Australia's tropical Top End.

"Inspirations and innovations" has been taken as a theme for the conference and we are keen to capture, share and tell our stories. The stories of medical practitioners working in palliative care. The stories that keep us working, educating, researching and developing the field. From the clinical coal face to the planners and organisers of our area of medical practice, we all have stories to tell.

The mix of overseas, national and local speakers I hope will reflect our diversity of practice and the diversity of participation across the spectrum of practice.

The *Clinical Interface, Learning and Wellbeing, Society and Culture* are the themes for each day and being within the Northern Territory indigenous health and wellbeing, boarder social and health impacts on the palliative phase of care, as well as the provision of care to remote and lesser populated areas will be highlighted local considerations.

A pre-conference Trainees Day hopes to highlight the crucial role that trainees bring to our future workforce and I encourage their participation and presence across the conference.

In September the air is filled with the scents of freshly blooming frangipani, the sunsets and seasonal lightening storms are spectacular and the barometer indicates that the built up to the Wet Season is on its way. Changes to the previous conference structure hope to give you time to relax and socialise in the cooler parts of the day, so we hope that you will take time to relax and take in the best of our social program, the conference dinner and what Darwin and the Top End has to offer.

We look forward to being your hosts and we look forward to seeing you here.

Maybe you'll go home with your own crocodile story!

Mark Boughey,

Conference Chair

FOR MORE INFORMATION

Contact the Conference Secretariat on:

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