ANZSPM
Australia and NZ Society of Palliative Medicine

Volume 15 Issue 3 December 2006
Newsletter

Editorial

The ANZSPM conference at Newcastle in October this year was a great success. Thanks must go to Phillip Good and the other members of the organising committee. This edition contains highlights of the meeting as viewed by the NZ contingent. The trainee program, coordinated by Rohan Vora was particularly impressive with sessions from the international speakers plus national experts in the field. Many members, who have not been trainees for years were seen sneaking in at the back. My abiding memory of the conference will be that of Sebastiano Mercadante strumming away on a guitar at the conference dinner, crooning Italian love songs, somewhat out of tune (see page 4). Diane Meier is a truly inspirational speaker. Recently, when flicking through a pile of airport magazines (as one does), I was delighted to see her work featured in a Newsweek article of best world hospital services. The next ANZSPM conference in 2008, will be in Darwin and will be co-ordinated by Mark Boughey and his team. Start planning those abstracts now.

At the AGM, Odette Spruyt was elected as president of ANZSPM following Paul Glare's last term. Many thanks to Paul for all his hard work and best wishes to Odette for moving ANZSPM forward in line with our new and dynamic times. Congratulations also to Joy Percy who has been elected to the position of chair of the NZ branch of ANZSPM following Willie Landman's term.

Several members of ANZSPM, most notably our new president, have contributed significantly to palliative care in the third world. Last month, I had the opportunity of visiting both China and India to gain an insight into traditional medicines and palliative care services within both these vast and rapidly developing countries. The time lines, hassles and work pressures within my ivory tower seem somewhat less important now, but I will endeavour to get this edition out by Christmas. I do hope you have a merry one.

Janet Hardy, Brisbane
Newsletter Editor

President's Report

"At Christmas I no more desire a rose
Than wish a snow in May's new-fangled mirth
But like of each thing that in season grow "
W.Shakespeare Love's Labour Lost (1595)

act 1, sc 1, l. 105

First, thanks to Phillip Good and the organising committee in Newcastle for the excellent conference in October 06.

A key development of this conference was the involvement of the trainees and the very positive response to this from the trainees. We have established a trainee position on the Council to ensure ongoing interaction and representation of trainees' issues. We now look ahead to Darwin where Mark Boughey and his organising committee are planning balmy August nights and tropical experiences for us all in 2008.

Medical workforce issues in palliative care are at crisis levels. One palliative care doctor rated his concern for workforce shortages as higher than for water shortages! For example, it is becoming difficult in Victoria to offer training positions given the lack of specialist consultant FTEs in many centres and the fragmented nature of specialist palliative care positions in all sectors of care. A major teaching hospital in Melbourne provides only 0.2 FTEs specialist palliative care for over 500 patients.

One proposal is to establish state-wide trainee coordination both to develop and coordinate the trainee posts and also to promote palliative care as a specialty area of practice, liaise with other key specialties (med onc, rad onc, pain medicine). Please let us know if you have any novel approaches to workforce issues. We thought it might be interesting to start a service profile section in the newsletter for the next few editions of the newsletter, with snapshots of services to illustrate the range of models and the creativity employed in attempting to overcome workforce shortages.

However, much of this action needs to occur centrally at the College of Physicians. For example, the RACP specialties board on which ANZSPM is represented, has recently reviewed the flexibility of training in various specialties aimed at facilitating the training of general physicians. One principle aim was to improve ability of trainees to gain experience in varied subspecialties of interest. This is of relevance to our trainees

ANZSPM, PO BOX 2918, Chelthenham, Vic, 3192
Ph: 613 9585 1419, Fax: 613 9585 3785
Email: secretariat@anzspm.org.au

Dr Odette Spruyt	President	Email: president@anzspm.org.au Assistant: Mrs Kathie M Thomas
Prof Janet Hardy	Newsletter Editor	Email: editor@anzspm.org.au
Website		www.anzspm.org.au

given the ongoing struggle to obtain oncology positions, which is deterring potential candidates from palliative care training. ANZSPM will seek to lobby hard on these and other fundamental workforce issues.

There have been a number of requests lately from members and others to utilise the ANZSPM membership list to contact palliative care providers for the purpose of conducting research or surveys. One such survey is included with this newsletter. Council has taken the line of reviewing each of these as they arrive. However, we are interested in members' views on this as we do not wish to add to your load if you are basically opposed to such approaches.

Council meets for the first time after the AGM, on 8th December. At this meeting, we will include discussion about donating to our neighbours in the Asian Pacific region and will communicate any decision to membership in our next edition.

Finally in brief, Paul Glare is seeking members who are interested in establishing an ANZSPM clinical indicators working group. Please let him know of your wish to participate in this. Also, are you aware of the work underway to develop an item number which relates to case conferencing on inpatients (not related to discharge) or for a community patient.

Wishing you all the best of the festive season

Odette Spruyt, Melbourne

New Zealand News

This is my first report as chairperson of the new executive that was elected at our annual NZ branch meeting in August. I would like to thank Willie Landman, our outgoing Chairperson of 2 years and executive member of 4 years, for all his hard work and excellent leadership during that time. I would also like to thank Warrick Jones, who resigned from the executive and as treasurer earlier this year, for all his contributions. His role as treasurer has been filled by Andrew Wilson who has made a concerted effort to increase membership subscriptions and update our membership database. Jonathan Adler continues on the executive providing us with much information from the various committees and groups that he is involved in at a national level. We also welcome two new members Cathy Miller and Mike Harris. Cathy will take over the secretarial role in February 2007 from a grateful Jonathan who has kindly offered to fill this role meantime. Mike is a trainee registrar on the Chapter program and has been co-opted to the executive to allow representation for the NZ trainees.

We held our annual meeting in August 4th to 6th at the delightful Formosa Resort in Auckland. Due to popular demand, we repeated the format of last year with a combined education day with the HPCNZ (Hospital Palliative Care Group) comprising senior nurses as well as doctors. Unfortunately fog closed Auckland Airport well into the afternoon on the Friday, which meant some serious re-organising of the hospital team program. The education day was very successful with over 40 attendees. There was a good variety of presentations from members and an excellent visiting speaker, Sinead Donnelly, a Palliative Care Specialist from Ireland. As usual the networking and collegial support was a highlight.

Our New Zealand membership has increased to 63 at last count. This is a definite upward trend which is encouraging. However there seems to be a decrease in our GP membership which we have identified as an area for improvement. The executive will be looking at ways to increase this and improve the support to our GP colleagues in providing Palliative Care. It is hoped that the GP diploma in Palliative Care which is being piloted in Australia will be transferable to NZ soon and that funding will be made available for this. There are other creative GP/PC partnership initiatives that hopefully will grow in other areas to further support our GP colleagues.

At present in NZ we have seven Chapter trainees and at least one in the RACP program. Eight sites (Hospitals and Hospices) have been accredited for training to date. It is hoped that having a co-opted trainee on the executive will enhance the support of this small but vitally important group – the future workforce in Palliative Care.

The Hospital Palliative Care New Zealand group has continued to provide a valuable forum for those working in or trying to set up hospital palliative care teams. The group provides a mechanism in which resources can be shared between small teams - for example teaching material and clinical resources. This group has considerable cross representation with ANZSPM in NZ and has representation on all the key national initiatives in palliative care.

Following on from this is the exciting progression of the development of a national organisation for Palliative Care in NZ. The Palliative Care Advisory Committee chaired by Kate Grundy with involvement of all parties involved in Palliative Care, has worked hard towards this with the guidance of a project manager Jud Fretter from the Royal NZ College of General Practitioners. Happily the final scoping document is now complete and has been submitted to the Ministry of Health for consideration. Watch this Space!

Developments within two other national groups are worth mentioning. A joint process between the MOH and DHBNZ is currently under way drawing up proposals for new national service specifications for specialist palliative care. A consultation process will be undertaken shortly with service providers on the draft proposals. Thanks to Jonathan Adler for his hard work in chairing this Service Specification Group. Also work is proceeding and almost completed to develop national definitions for palliative care. Thanks to Anne McLennan who has been working hard on this in her role as chairperson of the

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Palliative Care Subcommittee of the Cancer Treatment Working Party.

Finally I'd like to say a big thank you to the organisers of the ANZSPM 2006 Conference in Newcastle, in October. It was an excellent and extremely well organised conference and the venue on the waterfront was beautiful and therapeutic. Thank you also to the ANZSPM council for their friendliness in welcoming me as the NZ representative. I look forward to working with you all in the challenges ahead.

Joy Percy – NZ Branch Chairperson

Letter to the Editor

Re Quality use of medicines in Palliative Care

In a recent presentation to GPs, pharmacists and nurses in Mildura, Victoria, there was a rather sceptical response from several GPs regarding:

1. the definition of a palliative patient

2. the length of authority (4 rather than 6 months as for opioids)

3. the perceived bureaucracy now introduced

4. the likely success of the efforts to obtain acceptable evidence to achieve licensing of other medications identified as essential.

It was suggested that given the complexities of that process, that a specific fund be given to hospitals to supply medications which are seen as essential by the palliative care community and acknowledged as recognised therapies in publications such as the Therapeutic Guidelines.

We had vigorous discussion in which we promoted the ideals of this process but I am not sure if they were convinced. Ideas from other network members on how to best follow-up such discussion, materials to address such questions etc would be welcome.

Odette Spruyt, Melbourne

A response to this letter will be published in the next newsletter.

ANZSPM Conference

Newcastle, October 2006

This was a stimulating and challenging conference with 170 participants. The location, venue and accommodation were all of the highest standard. The guest speakers were very well chosen as their fields provided a wide range of topics spanning basic science, clinical pharmacology, psychosocial and communication issues and psychiatry. There was something for everyone. Thank you to the organisers for a very well planned and highly professional conference. How restoring to the psyche it was to have the soothing walk morning and evening along the water-front to and from the conference venue.

Bowel obstruction and complex pain-Sebastiano Mercadante

Sebastiano Mercadante is remarkable. He fails to contain his enthusiasm and knowledge. He can deliver an hour long presentation, supported by 70 PowerPoint slides, in 45 minutes, leaving 15 minutes for questions! - all in understandable Italian-accented English. Some attendees would have preferred to read his power-point slides and felt they would have been sufficiently informed. This wasn't for me. Receiving the power-point presentations on CD after we had returned whence we came, was both a privilege and an excellent service. My handwritten hieroglyphics a week after the conference were of no use to me. The CD resource is wonderful – references to satisfy the insatiable. There was much to take from both of Sebastiano's main presentations. I have focused only on a single aspect from each.

a) Management of bowel obstruction in palliative care

This was a well argued and supported outline of the rationale behind aggressive early management of bowel obstruction with DOMG (a combination of dexamethasone 12mg/day IV, octreotide 0.3mg/day IV, metoclopramide 60mg/day IV and a single dose of amidotrizoato (Gastrograffin) as an osmotic laxative; with NSAIDs (ketorolac) and opioids for pain relief).

I was interested to consider the contribution of the inflammatory process and the hypertensive intraluminal state as part of the pathophysiological process. The following model was provided to support the rationale for the DOMG regime:

i) Impaired propulsion leading to distension, fluid and gaseous accumulation, increased distension and propulsive action and impaired propulsion (all this compounded by faecal impaction)

ii) A hypertensive intraluminal state ie mucosal damage resulting in an inflammatory response with prostaglandin (PG) and vasoactive intestinal polypeptide (VIP) release

This regime doesn't cater for our patients with established colic and in New Zealand, octreotide used outside the hospital setting is prohibitively expensive.

b) Complex pain problems

Sebastiano integrated basic scientific concepts into pain management. He described endocytosis of opioid receptors which was fascinating and clinically relevant to the development of hyperalgesia. For me it explains lack of effect sometimes seen with rapidly increasing opioid doses. At the end of Sebastiano's lecture, I was feeling as if I knew very little but was able to

grasp 4 clinically relevant points :

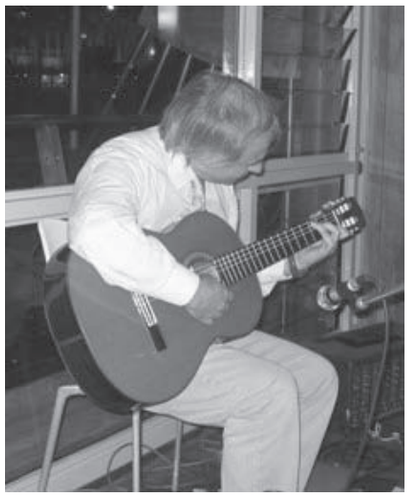
i) Sebastiano's practice is to "clean" the patient with complex and confused therapy by administering 24 hours of parenteral midazolam 15mg + ketamine 100mg/day.

ii) may have a role in modifying opioid-induced hyperalgesia, by reducing opioid tolerance, rather than via its analgesic effect

iii) Opioid induced hyperalgesia (apparent by rapid dose escalation) is common

iv) Combining opioids may reduce tolerance, rather than necessarily enhance analgesic effect.

Sebastiano with relaxed admirers



Sebastiano with $4000 guitar

Emotional pain - James Carstens

James presented a true gem for us. His work on emotional pain was delivered simply and stunningly. His own professional and personal experience has forged his comprehensive understanding of emotional pain. It is practical. It is real. It makes the seemingly nebulous nature of emotional pain more tangible. James has crafted a book which he has called Emotional Pain. It covers all, and includes 252 references! Those who attended were privileged to receive a copy.

Carol McAllum, Auckland

Interface Between Geriatrics and Palliative Care- Diane E. Meier

Geriatric patients often have multiple chronic pathologies, that pose complex clinical problems in their care. This presentation highlighted the benefits of Palliative Medicine in this setting - not only for the patient, but for their caregivers as well. It also discussed the increasing prominence of non-cancer patients in palliative care. As a result, there has been a blurring of the roles of Geriatric Medicine and Palliative Medicine. Dr Meier's presentation was ideally timetabled for the Advanced Trainees Session, as the overlapping services could challenge the future provision of care for elderly patients. It was demonstrated that both specialities face growing demands on services, amid health economic concerns, but they have a lot to learn from each other. Palliative Care could be involved earlier in disease progression, aiming to support the patient and their whanau into the terminal stages of disease. In order to optimize quality of life, palliative care should also be more aware of functional assessment and rehabilitation; frailty and loss of function; community geriatric care; and the illnesses which may benefit from joint care, e.g. Dementia and Parkinson's Disease. The final discussions raised the hope of cross-speciality training to move towards a more integrated approach to care for the elderly.

Spiritual Distress - Doug Bridge and Peter Ravenscroft

This Workshop Session explored the definitions of spiritual distress and spirituality. It also introduced the working term of psycho-spiritual distress, which links the secular and the spiritual contributors to distress. A case presentation demonstrated the benefits of addressing psycho-spiritual distress. The support provided allowed the patient to open their "painful memories of past wounds" and regain meaning in their life. We had the opportunity to then share our own models of spirituality, and stories of patients with severe spiritual distress, in small groups. It is always a challenge to broach such issues with patients and sometimes we may question if we should. They should feel comfortable to explore these conversations, as well as stop them if they so desire. This session certainly provided me with a means of opening these discussions and allowing the patient to remain in control. Psycho-spiritual care was best defined as "helping people whose sense of meaning, purpose and worth is challenged by illness". We may not always succeed, or be allowed to succeed, but we should try to assess the feasibility of helping. Finally, Prof Ravenscroft returned at the end of the session to feedback on the findings of teaching spirituality to medical students. The programme obviously worked well to connect the students to their patients – and families - at a deeper level. They produced revealing reflective diaries and no doubt learned a lot about palliative care in the process.

Leeroy William, Auckland

Hope in Palliative Care - Simon Wein

This was one of the most enlightening presentations on hope I have had the privilege to attend. After overcoming my initial surprise, as the original title in the program was Psychiatric aspects in Palliative care, I was thoroughly mesmerised by the tour into the philosophical realm of hope, with quotes from the classical and modern philosophers. The essential points for me revolved around the concept of hope always being in the future, potentially attainable and good, but also linked with fear. The research evidence that hopelessness is a keener predictor of desire for early death than depression emphasised how important it is to explore issues of hope as an integral part of existence.

Willie Landman, Auckland

Update on opioid receptors - Maree Smith

There are only four opioid receptor genes, all of which have been cloned: mu, kappa1, kappa 3 and delta. Large variability is generated by splice variants of these receptor genes (ie. RNA transcripts of these genes are spliced in different ways to generate many different receptor proteins from one gene). There are many more mu receptor splice variants than kappa or delta. Splice variants tend to differ in the intracellular signalling portion of these cell membrane proteins. There is little difference in their ability to bind ligands on the extracellular portion. Morphine and other mu opoiod agonists have different effects on different splice variants. Acute binding of opioid agonists results in inhibition of intracellular signalling and therefore inhibition of nociception, but chronic exposure results in superactivation of intracellular signalling, responsible for analgesic tolerance.

Variability is also generated by dimerization of opioid receptors. Delta and kappa opioid receptors can form novel heterodimers with functional properties (in vitro) distinct from parent receptors. Mu-delta heterodimers have also been studied. In 'knock out' mice in which selective opioid receptor genes have been deleted, the mu-delta heterodimer has been shown to be involved in opioid-induced respiratory depression. The implication is that further understanding of heterodimers may allow for separation of desired opioid effects from undesirable side effects.

Combining opioids; preclinical and clinical studies - Maree Smith

In this talk, Marie reviewed work being done on combining opioids - not only as separate drugs given simultaneously, but as bivalent opioids, i.e. two ligands bound with variable length spacers. These experimental drugs have been built which combine an opioid agonist and antagonist, or two opioid agonists. One such molecule is a mu-agonist tethered to a mu-antagonist. When the spacer length is greater than 22A, the bivalent ligand generated no opioid tolerance in animal studies.

Buprenorphine patches -David Woods

These have been available in Australia since April 2005. He felt that the bad reputation of Buprenorphine was due to over-interpretation of pre-clinical data. He argued that the partial mu -agonist, kappa-antagonist action was the reason it was so effective in reducing the phenomenon of hyperalgesia, and therefore an advantage rather than a problem. He thought this would also be useful in neuropathic pain.

He noted the patch has a 7 day dosing interval, was less constipating and lacked the immunosuppression of morphine. Its main use currently is in opioid addiction. It is available in Australia in 5, 10 and 20 mcg/hr strengths.

Ian Gwynne-Robson, Wellington

The Fatal Shore-Reflection on Palliative care in a Multicultural Society - Jan Maree Davis.

Australia is the second most multicultural society in the world. Many of the minority groups in Australia do not access specialist palliative care services. One of these groups is that of patients and families from culturally and linguistically diverse (CALD) backgrounds. In this group culture and language bring another dimension to dying. Health professionals need to ask questions to understand what these patients are experiencing. How else can we hope to understand the experience of 'total pain' for example? The pain of grief and loss is universal and ultimately we share the same language heart to heart. In bicultural consultations we need to be aware that our similarities are greater than our differences. But also that if we provide culturally insensitive care then members of minority groups may not access palliative care services. Within the diversity of culture there are many nuances of interpretation of spoken language, body language and approaches, such as, to truth telling.

To deal with potential misunderstandings, lack of trust and provision of culturally appropriate services some hospitals have multicultural officers for strategic planning. There is also regular community consultation. One of the fundamental problems is that of language and explanations of what a palliative care service and a hospice means. Bereavement is another area where services need to be provided in their own language.

A case study was used to highlight the promotion of Cultural Safety – which encourages the distinction between cultures and nurtures an appreciation of the differences. Also highlighted was the need to explore the bias of your own culture as health

provider and to reflect on your own practice and beliefs. In conclusion it was hoped that a balance could be achieved between what is realistic and what is emotionally needed.

Mike Harris, Palmerston North

Trainee Report

Having only joined the training program in August, the ANZPM conference provided a great opportunity for me to meet doctors and trainees from across Australia and New Zealand, as well as hear from international speakers as well as our home-grown leaders in the field of palliative care. I had never attended a national conference like this so I was a little unsure of what to expect.

The first trainee session was with Dr Sebastiano Mercadante presenting on hyperalgesia and Diane Meier presenting on the interface between geriatrics and palliative care. The meeting room was packed, with standing room only at the back and I was left guessing how many trainees there were in Australia and New Zealand. As it turned out less than half the room were trainees. With the quality of the international speakers organized for this session many of our more senior colleagues were unable to pass up the temptation of attending.

The program for the next 2 days was packed with presentations and workshops, always with something of interest. Not only did I learn much about the latest scientific theories and practices in palliative care, but I also saw what research and practices others were doing/had done. Breaks in the conference program allowed time to catch up with familiar faces and meet many new ones, including other trainees. This provided the opportunity to discuss the topics of the previous session, the training program and how other trainees were going with their training. I learnt more about the training program talking face to face with others those 3 days of the conference.

There was a lunch time set aside for all the trainees to meet with representatives from the chapter to discuss the training program and associated problems and issues. This meeting was kept informal and allowed anyone to speak up about issues that they saw was important and allowed an open discussion. Of course not all the problems were solved then and there but it provided a valuable opportunity for the trainees to speak about their concerns.

The final training session at the end of the 3rd day concentrated on research and writing research papers, presented by Dr John Cavenagh, Prof Janet Hardy, Prof David Currow and A/Prof Paul Glare. For me this was a valuable session as I look towards planning and designing my own research project, something that we all need to do to complete our training.

For my first conference it was a great experience. I learnt a lot about palliative care practice, new directions and developments, how others tackle problems and issues in palliative care as well as the training program. I was able to meet many trainees and discuss the training program, valuable for me as I had not had the opportunity to do so face to face before. I encourage all trainees not to miss the next conference in Darwin in 2008. See you there.

Scott King, Melbourne

Some Thoughts on the Role of Clergy in Palliative Care

First of all, we're all in this together. Let's say we are talking about Pat, who is lying there in the bed, or sitting up in a comfortable chair. Pat might be a Patrick or a Patricia. When we talk among ourselves, we might describe Pat as one of our patients, or clients, or residents, or parishioners. But that's not how Pat will be experiencing life, looking from the inside out, as it were. Pat sees himself or herself as husband or wife, or otherwise partnered, or divorced or single. Pat remembers his or her childhood – golden days of innocence and promise, or hard times of pain and suffering, or each person's unique mixture of the two. Pat will be conscious of his or her children and grandchildren, and will remember years of employment and/or child-rearing. Again, a multi-coloured autobiography of joy and sadness.

Pat has also had an inner life, and continues to live it. Perhaps now, in terminal illness, Pat goes into that personal sanctuary of the inner life more frequently and more deeply. What is life about? What is the point of life, if any? What has my life been about? Has it been of any value?

I suspect that a woman's way of asking these questions is different from a man's, but I believe we all ask them. Likewise with the spiritual or religious questions: Is there anything up there, or out there, or in here – a God, a something, an anything? And if so, does this God truly know or care about me – and about those I love and whom I will be leaving behind? Do I believe that I will somehow live beyond my death, that I will somehow meet this God? Do I believe in any sort of heaven – or hell too, for that matter? Can I live the rest of my life, and then die, in peace?

Now each Patrick and Patricia will have his and her own answers to all these questions, just as each of us will have our different ways of viewing all this stuff. You would hope that, if clergy had any role in palliative care, it would be precisely in helping Pat address and perhaps find some answers to such questions.

Not to provide answers – only Pat can work out Pat's own answers. I imagine it takes great skill, courage and confidence to be a surgeon, to wield a scalpel and a saw onto and into another person's body. I believe it takes a similar skill, courage and confidence to seek to enter a person's inner life, and, if invited, to enter it in a life-giving way. What we bring to our role (or at least, what we should bring to it) is an array of skills, knowledge, wisdom and life experience.

Our skills should include all those things that are included in the word "professional" – competence, confidentiality, courtesy, accountability, and so on.

Our knowledge should include a solid grasp of our theological tradition, such as would allow us to say to someone of our own faith "no, our God is not like that" or, to use a specifically Christian formula, "your sins are forgiven". We should be familiar with the rituals of our own traditions – in my case, things such as the prayers for the sick, anointing with oil, and prayers for the dying. It should also include an understanding of when we are out of our depth – if Pat is seeing demons, do we call an exorcist or ask the medical staff to adjust the hallucinogens.

Our wisdom and life experience will include all the love, joy, pain, insight etc. that we have enjoyed or endured on our own journey. I believe strongly in the truth of a saying that can sound rather trite, that suffering makes you either bitter or better. We don't burden Pat with our sorrows ("Yes, Pat, my brother/sister suffered with the same cancer that you have"). But the suffering that we have experienced is, I am convinced, our passport into the life of another who is in pain. There is no short-cut to wisdom. And the person who has acquired the greatest compassion through suffering is the one who can use most surely the particular scalpel that is needed to open up the inner life of another.

I've talked only of Pat, but of course in palliative care all of us deal, as well, with Pat's family and closest friends. As with their medical questions, so also with their spiritual and religious questions, about Pat and about themselves – they must be told no lies, and they have a right to straight answers, but they need not be given more truth or information than they want or are looking for. One of the reasons I decided to sit down and put these thoughts on paper was that it would make me get some thoughts into order. Now, looking back over what I've written, perhaps the key sentence is: "can I live the rest of my life, and then die, in peace?"

Clergy are supposed to have some competence and wisdom, in answering this question for their own lives, and in helping others to answer it. Perhaps this is, fundamentally, their life's mission. It would be good to think that clergy are working with people all the time on this question, "in good times and in bad, in sickness and in health", to borrow a phrase from the Marriage Rite. It should be a natural, privileged part of our lives to help people ask all this in the context of palliative care – the Pats of this world, their families and loved ones, and perhaps their colleagues, too, in the palliative care environment.

Can I live the rest of my life, and then die, in peace?

(Rev) Peter Brock, Bulahdelah, NSW

Medical Director

Hospice Southland seeks a suitably qualified medical practitioner specialising in Palliative Care, to join our team and have overall clinical responsibility for the approximately 234 patients refereed per annum within the inpatient and community settings.

This role is supported by a second medical specialist qualified in Palliative Medicine, highly experienced part-time medical officers, and a team of extremely capable and skilled nursing and allied health professionals.

If you are interested, please contact me for a confidential no obligation discussion on this position, Nicki Kitson, Chief Executive Officer, Hospice Southland, Ph 0064-3-2140464 nicki.kitson@hospicesouthland.org.nz.

Clinical Diploma in Palliative Medicine

The 2nd Clinical Diploma in Palliative Medicine is now available after the successful completion of the pilot stage. New trainees can enrol now for programs commencing in January, 2007. For entry and course requirements, see www.racp.edu.au/public/pallmed

Survey

Janet Hardy would be very grateful if you could complete the questionnaire included with this newsletter. Consent is implicit on your response. Thanking you in anticipation.

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Conference update

Palliative Care Victoria in conjunction with Palliative Care Australia is hosting the 9th Australian Palliative Care Conference. "Partners across the Lifespan". It will take place at the Melbourne Convention Centre, Victoria Australia from Tuesday 28 to Friday 31 August 2007. **Note abstract deadline has been extended to 23 January.**

- Annual Assembly of the American Academy of Hospice and Palliative Medicine and Hospice and Palliative Nurses Association. To be held February 14-17, 2007 in Salt Lake City, UT. Physicians, nurses, social workers, pharmacists and others who practice hospice and palliative care are invited to attend.
- Improving the Delivery of Palliative Care for Older People. This seminar will be held on 15-16 March 2007 at Sydney Masonic Centre, NSW.
- 3rd International Forum on Pain medicine Montréal, Canada, June 28-July1, 2007
- Improving Aboriginal and Torres Islander Health, moving forward together. Carlton Crest Hotel, Sydney, Feb 28-March 2, 2007
- 4th World Congress, World Institute of Pain, Budapest, Hungary. Sept 25-28, 2007

27th ASM of the Australian Pain Society

The Torture of Pain

1-4 April 2007 Adelaide Convention Centre, Adelaide

CONTACT

Conference Secretariat
DC Conferences
T: 612 9954 4400
F: 612 9954 0666
www.apsoc.org.au
aps@dcconferences.com.au

Graduate Certificate and Diploma of Psycho-Oncology

The Centre for Palliative Care, University of Melbourne, offers Graduate Certificate (1 year) and Graduate Diploma (2 year) multi-disciplinary courses for nurses, doctors, psychologists, social workers, allied health and pastoral care practitioners who are interested in the area of oncology and palliative care. Both courses are part time and are available in face-to-face learning and distance learning formats. These courses aim to provide students with a sound understanding of the range of psychosocial issues that occur in oncology and palliative care and equip them with enhanced counselling skills which can be applied to the management of patients in the palliative care setting.

Applications for 2007 for the Graduate Diploma of Psycho-oncology close on 28th February 2007. Late applications will be considered. For a course handbook and application form or for further information please contact: Sue Donnelly, Academic Programs Officer, Centre for Palliative Care, C/- Box 65, St Vincent's Hospital, PO Box 2900, Fitzroy, Vic 3065 Tel: +61 3 9416 0000
Email: sued@medstv.unimelb.edu.au

The Australian Pain Society meeting is in Adelaide in 2007. Keynote speakers include Cynthia Goh and Mary Cardosa. Dr Cynthia Goh is Head of the Department of Palliative Care at the National Cancer Centre, Singapore and Dr Cardosa is a Consultant Anaesthetist and Pain Management Specialist in Hospital Selayang, Malaysia. Professor Lars Arendt-Nielsen from Denmark is the basic scientist plenary speaker. He is widely published and has a special interest in the assessment of pain from skin, muscles and viscera.

Other topics to be covered including Pain following violence, Indigenous pain issues and Persisting Pain in the Middle Eastern community in Australia. There is a session on the Vulnerable Child with invited topics of Child Abuse and Persisting Pain and Self-harm in Children. Other plenary sessions include Persisting Pain across Cultures, Persisting Pain in the Palliative Care Patient, Vulnerable Health Workers and the Challenging Patient.

There are also concurrent topical workshops covering intrathecal analgesia in cancer pain, Taking the torture out of compensable injury, Opioids and Driving, The nursing process and pain, and The role of interventional techniques in relieving persisting Cancer pain. And a great social program. Don't miss it!

Greg Crawford, Adelaide, December 2006