ANZSPM
Australia and NZ Society of Palliative Medicine

Volume 15 Issue 2 August 2006
Newsletter

Editorial

$62.8 million was allocated to Palliative Care in the Community in the 2006 Federal Budget. This will support the ongoing work of the National Palliative Care Program. One of the priorities of this program is to enable improved access to palliative care medicines in the community. A communication network has been established to help the Palliative Care Medicines Working Group in addressing this priority. The aim is to disseminate information about the palliative care medicines that are available through the PBS and to promote quality use of palliative care medicines in the community. Members of the network are taking every opportunity to deliver the information to as many people as possible. Since February, nearly 500 people have attended information sessions where material on palliative care medicines has been delivered. I intend to use this newsletter to list all new PBS approved items as they come through and to "spread the word" as much as possible. We have published a number of articles on the PBS process in previous editions and Phillip Good's paper about the "Essential Palliative Care Medicines" survey is reviewed here. A number of concerns have been raised, especially by GPs and I hope to focus on these in the next edition. As always, I encourage readers to send in their thoughts/concerns/criticisms on this issue. In the meantime, please use and encourage others to use the mauve pages and the palliative care authority scripting. In line with the rugby terminology that so often infiltrates this newsletter- "use it or loose it"!

.....and don't forget to register for the ANZSPM conference in October (see back page advert).

Janet Hardy, Brisbane
Newsletter Editor

President's Report

The ANZSPM Council met in Cairns during the RACP Annual Scientific Meeting in May 2006, and there was an extensive agenda. An on-going issue is the clarification of the role of ANZSPM in the environment of several other dynamic organisations with related aims, viz the Chapter and PCA. I believe that there is a clear role for ANZSPM as a professional home of all doctors with an interest in the practice of palliative medicine irrespective of their training or qualifications. We can address many of the professional developmental needs of that diverse group, particularly with regard to education (e.g. through our biennial conference, the Maddocks Club, subsidised journal subscriptions) and statements on standards of practice (e.g. through our ethics position statements). The RACP regards us as the special society for palliative medicine.

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We need to work closely with the other two organisations to ensure that palliative care generally and palliative medicine in particular, continues to progress and that this country retains its international reputation as a leader in our discipline. There has been some discussion about the signing of an MOU between the three parties to formulate the communication and decision making progress although nothing formal had been arranged at the time of writing. Like all such organisations, ANZSPM is only as strong as the effort put in by its members and with the AGM coming up next month, it's a great opportunity to get involved particularly for younger members.

In the last newsletter, we sent out a survey on private practice and got a good response rate. Because the newsletter gets posted on the website in the public domain, I would prefer not to give specific details, even though the results were de-identified, but will do so at the AGM. Suffice it to say, few respondents who are not already billing plan to start doing so, and just as many of those who aren't billing now have no plans to start doing so. Not all who are/will bill intend to use the new item numbers, which are not finalised yet. A number of respondents wrote comments indicating a fair degree of confusion surrounding the whole issue of private practice and billing. The Society can play an educational role in this regard. Like all non-procedural specialities, making a go of purely private practice in palliative medicine is likely to be challenging.

Paul Glare, Sydney
President, ANZSPM

Advance Notice: ANZSPM AGM is on Wednesday October 4th at Newcastle during the ANZSPM Conference. Please plan to be there!

ANZSPM Newsletter
Volume 15 Issue 2 August 2006

New Zealand News

The chill of winter is upon us, but at least we have the warmth of the rugby season and the All Blacks to cheer us up (not to mention the performances of the Tall Blacks and the Silver Ferns in recent sorties against Australia).

ANZSPM NZ has had a healthy increase in membership, partly due to a positive inflow of physicians from abroad, as well as a concerted effort from our treasurer, Andrew Wilson, to sign up local members. There also seems to be some progress in the development of registrar training positions in the main centres. The GP diploma in Palliative Care is still in the melting pot and we are looking at the pilot program in Australia to give some further direction in this regard.

The main event on the future calendar is the annual meeting of ANZSPM New Zealand, due to be held at the Formosa Country Lodge on the 4th to the 6th August. This meeting will again be accommodating the Hospital Palliative Care (HPCNZ) group, following positive feedback from our last meeting in Wellington in 2005. The program has the hospital group meeting on Friday and the ANZSPM business meeting on Sunday, with a shared education day on the Saturday. There will also be ample time for socialising and networking outside of the formal agenda. Registration numbers have been very positive, and this meeting seems to be gaining in strength.

As reported in previous newsletters, Palliative Care has been featuring fairly prominently on the health agenda in New Zealand, largely due to the considerable efforts of a relatively small number of committed individuals. The increasing participation in our annual meeting bodes well for involving a greater number of the membership in national initiatives. The development of a peak body for Palliative Care in New Zealand (P.C.N.Z.) has advanced rapidly, with full engagement of all parties involved in PC and has now reached the final consultation stage, before being submitted to the ministry of Health. This project has been managed by the College of General Practitioners through a project officer, Jud Fretter, working with The Palliative Care Advisory Group, chaired by Kate Grundy. The success of this project is in no small way due to the efforts of the above mentioned Jud and Kate.

The Cancer Control strategy has also enabled the Palliative Care subgroup to address National Service Specifications and Workforce development, both of which are high priorities to secure equitable, high quality Palliative Care provision to all New Zealanders.

As this will be my swansong as chairperson for ANZSPM NZ. I would like to extend my great appreciation to the NZ executive, for all their efforts on our behalf- Joy Percy, as the secretary (and housekeeper "par excellence"), Warrick Jones followed by Andrew Wilson as treasurer and Jonathan Adler (as plenipotentiary, involved in all aspects of Palliative Care in New Zealand).

AND NOW- I can sit back and watch the rest of the rugby season unfold as it will, not unlike palliative care!

Willie Landman, Auckland

Highlights of SIPM

The annual Sydney Institute of Palliative Medicine Symposium – Royal Prince Alfred Hospital Sydney, June 2006.

As in previous years, the first half-day focused on research, with A/Prof Stockler telling us how to turn good ideas into successful palliative care studies. This was followed by free paper presentations: "Consultative Palliative Medicine Services in Tertiary Hospitals", "A Qualitative Study of End-of-Life Decision-Making in Palliative Care", "Home Deaths project", "A Pilot Study of Haloperidol for the Control of Nausea and Vomiting" and "Survival of Palliative Care Patients in a Nursing Home".

Friday's session this year was modelled on the successful "Controversies in Cancer Pain", a satellite meeting of the International Congress of Pain Conference that was held in Cairns last year. This meeting was abbreviated to one day and was titled "Controversies in Cancer Pain Management". There were 13 invited speakers covering a broad range of pain-related topics including:

A/Prof Geoff Goulay, "What is the best drug?" This focused on opioid pharmacology (particularly pharmacokinetic considerations) and the evidence-based medicine approach to assess the analgesic efficacy of drugs and other interventions.

Dr Steven Gibson, "What is the best route?" Dr Gibson discussed considerations for using the spinal route of administration in palliative medicine. Most importantly, Dr Gibson discussed the need to review systematically the role of neuro-axial administration of analgesia to improve our patient selection, the mix of analgesics in infusions and the method of administration of infusions.

Professor Janet Hardy. The practice of opioid rotation is becoming an increasingly common practice in palliative care. The theories as to why it is useful are numerous and include incomplete cross-tolerance, genetic variability and inter-individual variation in drug handling. It remains difficult to explain how one opioid should be better than another when all of the commonly used opioids are predominantly mu agonists acting at the same receptor. Whilst the scientific explanations are becoming more numerous, the art remains is to find the opioid best suited to the individual patient.

Prof Andrew Somogyi discussed the burgeoning field of pharmacogenomics. This area of study acknowledges how genetic factors may contribute to the large interindividual variability in pain sensitivity and response to opioids.

Prof Michael Ashby, "Wind-up". Previous guidelines for analgesic management have not taken into account the phenomena of central sensitisation. There is increasing interest and knowledge of the behaviours of receptors that are upgraded in pathological pain states and how to modify their behaviours. The most studied and understood is the NMDA receptor.

Dr Katherine Clark. A study was undertaken on the cancer ward of RPAH to test the validity of nurse-collected pain scores and to investigate whether this practise was acceptable to patients and nursing staff. As a result of this study, routine collection of pain scores is now undertaken.

Prof Michael Ashby, 'Is cancer pain relief a form of Euthanasia?' Professor Ashby summarised his MD thesis, which explored medical, legislative, legal and parliamentary scrutiny of end of life issues in Australia 1983-1998, and in four comparable OECD countries: the United Kingdom, Canada, USA and New Zealand. This work collated and analysed the arguments about death causation in palliative medicine. Contrary to the palliative care view above, of causal neutrality, all the reports, judgements and parliamentary committee proceedings studied assume that palliative care interventions and treatment abatement decisions may indeed constitute a cause of death. However, this is allowed in law due to the public policy imperative to relieve pain and suffering and to avoid prolongation of the dying process.

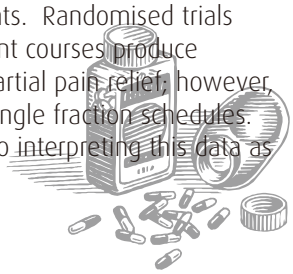
Prof David Currow, 'Evidence Based Pain Relief: the Palliative Care Trial'. How do you integrate recent changes in evidence into clinical practise? One method that has attracted attention is the practise of academic detailing. Academic detailing includes the provision of evidence-based information with a number of key messages for a brief encounter between a health professional as the detailer and the clinician. This process is resource intensive and potentially time consuming. It requires high levels of training, expert input into distilling the key messages on the available evidence, piloting and often the involvement of focus groups.

Dr Dilip Kapur considered the role of cannabinoids for cancer pain considering the major increase in research that has focused on this class of medications. Advocacy groups whose main aim is to legalise recreational cannabis have hampered the progress.

A/Prof Paul Haber spoke on the topic of tolerance and addition. He defined pharmacological tolerance as the need for increasing doses to achieve the same effect and accompanies continuing use of opioid analgesics. This compares with tolerance, which is one of a number of features required to establish the presence of addiction. These processes may be difficult to define and recognise in palliative care.

Dr Frank Brennan has interests in education and the interface of Palliative Medicine and the law, literature and humanities. As both a lawyer and doctor, Dr Brennan spoke about this interface and the basic rights of all patients to receive adequate analgesia.

A/Prof Chris Milross covered the role for radiotherapy as an established useful and effective palliative treatment for pain caused by bone metastases. There have been multiple discussions to consider whether single or multiple fractions provide the best outcomes for patients. Randomised trials have concluded that shorter treatment courses produce comparable rates of complete and partial pain relief; however, re-treatment rates are higher after single fraction schedules. Caution is encouraged with respect to interpreting this data as "one size fits all".



Katy Clark, Sydney

4th Research Forum of EAPC

The European Association for Palliative Care. "Collaborate of Catalyse Research" May 2006, Venice, Italy.

I had the privilege of attending this meeting in late May in the beautiful city of Venice. The organisers put together an excellent program and the opening address was attended by over 1000 delegates. It was clear as the conference went on that this number dwindled somewhat, perhaps as delegates were tempted by gondola rides down the Grand Canal, or tours of St Marks Basilica or the adjacent Doge's Palace. The conference was truly international with over 50 countries represented.

There was an obvious emphasis on looking at collaboration in research in palliative care, as one way of overcoming well documented barriers. The first session I attended was a pre-conference educational session on "The Art of Preparing Grants". This was run by Mari Lloyd-Williams and Jose Pereira. Jose in particularly ran a worthwhile exercise on preparing a grant based on the use of olanzapine for nausea in palliative care patients. He had already received funding from the NIH for this study and so was able to give us tips on how to be successful in preparing such applications. This was well complemented by Amy Abernethy giving great pointers on the structure of applications and the use of 'key phrases' to get your message across.

The plenary session on the second day was given by speakers whose abstracts were judged as the most outstanding in terms of new research. The first of these was given by David

Currow, presenting "Improving palliative function – results from a prospective randomised controlled trial". This was a very large, cluster randomised trial from South Australia looking at the effect of academic detailing with general practitioners, case conferencing and patient education on the outcomes of new patients referred to a specialist palliative care service. The message I took away was that the latter two made a substantial difference, but the former less so. This was followed by "A Phase III Double-Blind Placebo-Controlled Trial of Subcutaneous Methylnaltrexone for Opioid-Induced Constipation in Advanced Medical Illness" by Jay Thomas from San Diego in the USA. It was exciting to see the almost completed trial data for a totally new class of drugs in palliative care practice. The median time to 'laxation' was 45 minutes and 50% of patients get a response within an hour of subcutaneous injection. Trials are ongoing in regards to an oral formulation of the preparation. The only disappointment for me was that none of the trial team could tell me who made up the word 'laxation', as I was unconvinced that it was a real word. This had been the subject of great mirth at one journal club at my institution. Jay was a very interesting man, who was initially a molecular biologist before moving into the world of palliative care. He also produced a greater poster on the use of ""Hylenex" (recombinant hyaluronidase human injection), for subcutaneous infusions. When this drug is given before subcutaneous hydration, a maximum flow rate of 800ml/hr can be achieved in some cases. This to me was an extraordinary figure (rivalling intravenous administration).

Another session I particularly enjoyed looked at Pain and Translation Research. Sophy Gretton, from the Royal Marsden in London, presented a paper entitled "Morphine and Metabolite Levels Predict Response to Morphine". This was really about the pharmocol-genomics of analgesia. I was interested to hear of a huge European collaborative research project looking at opioids, their metabolites and the effect that differing genetic make ups have in influencing all this. I guess this is research in its infancy, whereby one day, by doing simple blood tests, we may be able to target the best opioid, or combinations of opioids for each individual.

The final day enabled me to become more educated on the emerging problem of opioid hyperalagesia. Sebastiano Mercadante gave a talk on this very difficult subject and some practical pointers on how to determine whether it is happening and how to manage it. Hopefully he will expand further on this at the ANZSPM conference in Newcastle later this year. This was followed by an excellent session on "Studies that never landed or never got off the ground". The most impressive of the speakers was Eduardo Bruera who gave a warts and all account of his experience of studies he had tried to perform but failed to enrol any patients, or just a couple of patients. He emphasised how important it was to have a whole team on board and how often the work falls to one or two people, who will need to recruit patients themselves.

In addition to these sessions, there were two different displays of posters. We were given ample opportunity to peruse these as often breaks didn't seem to coincide with the catering. In all there were over 500 posters.

The conference was held on Venice Lido, an island separated from Venice by a thin stretch of water. It is famous as the venue for the Venice International film festival held each year. There was a beautiful beach on the eastern side of the island, but you had to make a payment in order to be allowed onto it, or to swim in the sea. Unfortunately it also happened to be the only place in Venice where cars are allowed. Finally, I am sure a great city always adds to the ambience of a conference and Venice itself was very much enjoyed by many participants.

Phillip Good, Newcastle

PCOC

Palliative Care Outcomes Collaboration – can it contribute to improve standards and quality in palliative care?

The enormity of the PCOC goal is unfolding as the PCOC partners headed by the Centre for Health Service Development, University of Wollongong, begin collecting data. With funding from the Australian Government for three years to 2008, PCOC aims to develop and support a national benchmarking system that will contribute to improved palliative care outcomes. PCOC is working with palliative care service providers to:

- develop consistency in data collection
- provide evidence through the collection and analysis of data
- assist with quality and standards reporting
- provide a benchmarking service
- promote and support palliative care research

As a voluntary, quality initiative, the challenge is to accommodate the varying models of care and practices amongst palliative care service providers throughout Australia. The difference in current data collection practices is vast– from sophisticated data collection to none. Considerable work is required with some services before they can start to collect data.

It has taken several months to develop and trial the first version of the PCOC data that includes demographic, episode and phase data. It is an iterative process and in time will lead to a second version. Lead service providers in each state have begun to collect data and as practices become established, additional services will be encouraged to join. When a service agrees to join PCOC, Zone Coordinators meet with senior

administration staff of each service, followed by meetings with clinical staff. Discussions with service providers include an assessment of current data collection methods and how extraction and mapping issues can be resolved.

Feedback from services providers has led the PCOC team to conclude that the Version 1 data set requires improved definitions and guidelines as well as the introduction of systematic training programs for those responsible for collecting PCOC data. If PCOC is to collect valid data that can be benchmarked, it must ensure consistency in understanding and interpreting PCOC data items. PCOC staff are now working on the development of training modules in clinical data items. Training programs will be conducted for trainers nominated by service providers who will in turn train staff with responsibility for collecting clinical data items for PCOC. This approach has been strongly endorsed by lead services.

Participating service providers will receive their first report later this year with the expectation that this will become a half-yearly publication. The extent to which these reports can be used by services and assist with their standards reporting will be a big determinant of the value of PCOC to palliative care service providers.

Meetings of the PCOC Scientific and Clinical Advisory Committee (SCAC) which considers issues relating to quality and standards, education and training, research and benchmarking highlight the challenges ahead for PCOC and the benefits to services if we can get it right. This will unfold over the next two years.

More information about PCOC and contact details for the Zone Coordinators can be found on our website – http://uow.edu.au/commerce/pcoc

Prue Watters, PCOC Manager
Centre for Health Service Development
University of Wollongong

Research Study

A qualitative study of end-of-life decision-making in palliative care.

I am writing to ask whether you would be interested in being interviewed as part of a qualitative study of end-of-life decision-making being undertaken through the University of Sydney. Interviews are being sought from amongst palliative care physicians and nurses by inviting people to volunteer through their professional associations. A total of approximately 20 in-depth interviews are being sought from professionals with a range of demographics and different backgrounds. The purpose of the study is to try to understand more fully the moral issues in end-of-life decision-making, particularly with regard to the distinction between palliative care and active interventions to bring about death.

Participation in the study would involve your being interviewed for approximately one hour regarding your views on good care of the dying, and the way in which you make difficult end-of-life decisions. The interview will involve discussion of some hypothetical clinical scenarios as prompts, but will be open-ended, as we are interested in your descriptions of how you make decisions and how you understand what factors influence your decisions.

If you agree to participate in this study, Dr. Charles Douglas will contact you to arrange an interview. With your permission, the interview will be recorded. The recordings will be stored temporarily in a secure location; subsequently the recording will be transcribed, any identifying information removed, and the original recording destroyed. The transcriptions will be analysed, with a view to publication in a scientific journal and presentation at meetings. A copy of the resulting publication will be made available to you through your professional association.

All aspects of this study, including results, will be strictly confidential and only Dr. Douglas will temporarily be able to link your interview recording with your name. However even this link will be destroyed immediately after transcription of the interview.

If you would like to be involved in the study, or would like to know more about what is involved, please call me on my mobile, 0400 390 748, or contact me by e-mail at charles.douglas@newcastle.edu.au. Full details are available in the participant information statement available on request.

Dr. Charles Douglas, FRACS
Lecturer in Clinical Ethics and Health Law,
University of Newcastle PhD candidate,
Centre of Value Ethics and Law in Medicine,
University of Sydney

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Journal Club

What are the essential medications in palliative care?

A survey of Australian palliative care doctors.

Dr Phillip D Good, Dr John D Cavenagh, Professor David C Currow, Dr David A Woods, Dr Penny H Tuffin and Professor Peter J Ravenscroft.

Australian Family Physician, April, 2006, Vol 35(4), 261-264.

Whilst I admit there is a large element of bias in my choosing this article for review, I also thought it was important to make sure that all ANZSPM members are aware of its history and contents. The article itself was edited a lot (for brevity) by the journal editors and most of what is written here are sections of the article that were edited out. This is done to inform ANZSPM members more fully about the article and subsequent directions taken in regards to palliative care medications on the PBS.

Initially, the Therapeutics Committee of ANZSPM recognised the need to advocate for palliative care drugs for use by those people who wanted to be looked after in the community. As early as 1992, a list of commonly used medications was drawn up and the Pharmaceutical Benefits Committee (PBAC) was approached seeking their advice on a way forward. The PBAC informed the ANZSPM Committee that some of the drugs on the list required the Therapeutics Goods Administration (TGA) to clarify the quality, safety and efficacy for the palliative care indication sought. For others, the PBAC would require evidence of effectiveness, cost-effectiveness and clinical place in therapy. Importantly, they also clarified that all these drugs would require a sponsor to pay for and take on the medico-legal responsibility for the application and subsequent use, as required by Australian law. Unfortunately many of the drugs were out of patent and their usage in palliative care was so small that it was not financially viable for the pharmaceutical industry to sponsor these drugs. This still remains a significant problem.

As a way forward, a Joint Therapeutics Committee (JTC) of PCA, ANZSPM and the Clinical Oncological Society of Australia was formed to address the issue and to consider mechanisms by which a list of essential drugs could be compiled from practitioners in Palliative Medicine.

The article describes the process by which this committee surveyed members of ANZSPM on what they thought were the essential medications in their practice. This survey was done with four main aims. Firstly, to compile a list of medications that were considered essential by a broad range of palliative care practitioners in Australia. Secondly, to assess the level of evidence for these medications and compare it to the level of evidence perceived by prescribers. Thirdly, to assess which of these medications were not available to community patients via the PBS and finally to determine which non PBS listed medications had a strong level of evidence, so that efforts could be concentrated to have them considered for inclusion on the PBS.

The tables in the article show which were considered the top medications and which ones were already on the PBS.

The authors concluded that in palliative care, there are good levels of evidence for many of the indications for which medications are used. There are many widely used medications where the best level of evidence is not sufficient to broaden the registration criteria or to seek further subsidy. Not only is there a need to generate robust level 2 data of efficacy (ie. therapeutic benefit in a highly selected sub-population), but adequate comparative studies (eg. laxative A vs laxative B for opioid induced constipation) are also required. For optimising benefit and minimising burden in prescribing, effectiveness studies are needed (ie what actually happens in day-to-day practice in a population for whom this medication would reasonably be prescribed). Finally, safety studies need to be considered (i.e. large studies powered to detect significant harm to inform practice fully). These are difficult studies unless clinicians work closely together to recruit to such studies.

From the initial results of this study, an attempt was made to streamline a process to increase the listing of such medications. With assistance from PCA, executive members of the JTC and PCA met with politicians and bureaucrats from the Department of Health and Community Services (as it was called then), TGA and PBAC to explain the problems members of the community were having accessing subsidised drugs on the PBS. The Rural Health and Palliative Care Branch of the Department of Health and Ageing in association with the Cancer Strategies Group established the Palliative Care Medications Working Group. This group has included representation of the TGA, PBAC and the Health Insurance Commission, and has been working on the evidence base for selected drugs as well as liaising with industry to provide applications for listing of medications. This has lead to a section in the Schedule of Pharmaceutical Benefits specifically for palliative care and an initial group of drugs approved in this section with work being done on others. The same criteria apply for palliative care drugs as for other drugs, but a definition of a palliative care patient is now given in the palliative care section of the PBS. For these patients, increased quantities are approved for 4 months treatment in the initial authority prescription. This mechanism is now potentially available for the inclusion of new or old drugs used in palliative care. This is the first section created in the PBS for a specific patient population.

One of the commonest questions members ask is why certain medications have been taken forward towards PBS listing and others haven't. The process of prioritising medications for subsidy was an issue where there was a choice of more than one medication in the class or more than one priority medication for the symptom experienced. There are criteria agreed "a priori" (see below). For example, there were 4 benzodiazepines selected in the top 20 medications, all of which in the past have enjoyed broader listings than they now have. The disappointment of many clinicians is that 'their' benzodiazepine is not listed, but there were clinical, administrative and commercial factors that influenced the final list. No medication can be listed specifying a route of administration or an indication that is not supported specifically by the documentation registered with the TGA and supplied by the company to the PBS. Some of this may have been through lack of data or concerns around specific medicolegal responsibility. There were several medications in the "essential list" for which either the indication, route of administration or formulation was not approved by the TGA. In almost all cases, data to help assess comparative cost effectiveness was difficult to source for any subsequent PBS listing. Medications successful in the first round of applications were all medications where the clinical indication, formulation and route of administration were already registered with the TGA and generally where the medication was already subsidised for another indication or route of administration. Moreover, at least two medications were previously provided over the counter and placing them within the PBAC again is recognition of the financial burden to families of providing medications at the end of life.

Criteria for the choice of medications:

- No equivalent available drug on the PBS, nor on the rest of the priority list for palliative medications
- The most community friendly form of administration/ transport/storage of medications if there is an equivalent efficacy between two choices
- A range of medication to address frequently encountered symptoms with preference given to covering the widest possible range of symptoms from the priority list
- Medications where hospitalisation would otherwise be likely to occur
- Medications where there may be a number of palliative indications for the same medication
- Medications where there is likely to be wide consensus within palliative medicine and more broadly within the profession for the indications proposed and the seriousness of the problem being addressed
- Medications where there are data for the indications, formulations and/or routes of administration proposed

This survey is now six years old, and it is important to thank many members of various committees that worked on the issues that arose from the survey and continue to do so today.

Phillip Good, Newcastle

PaCCSC

The Palliative Care Clinical Studies Collaborative.

The Department of Health and Ageing have awarded a contract to Flinders University Department of Palliative & Supportive Services for a national multi-site clinical research collaborative. The work of the collaborative will build on the last 8 years work by the Joint Therapeutics Committee (ANZSPM, COSA , PCA and the Palliative Care Medications Working Group) to improve the affordable access to key medications for symptom control in the community.

The collaborative includes key people whose background is in palliative care clinical trials complimented by a number of experts in areas such as clinical pharmacology, medication assays, pharmacoeconomics , biostatistics and clinical study methodology. The collaborative will work with Government, the clinical sector and industry in order to deliver the best outcomes from this ambitious project.

At the same time, it is going to allow palliative care clinical researchers from across the country to work closely together on rigorous, adequately powered randomised studies. This infrastructure will allow the collaborative to build expertise for future studies that are broader than the registration of these medications. It will allow palliative care to explore efficacy, effectiveness and safety of key mediations more formally.

The National Management Advisory board will be chaired by Prof Felix Bochner. This group will oversee the conduct of the collaborative. A scientific committee made up of a wide range of experts will be the engine room of the group. Sites from Queensland, New South Wales, Victoria, South Australia and Western Australia have been identified as foundation sites and these sites have expertise in a range of clinical studies. It is hoped to add at least one more site per year for the life of the initiative.

At the upcoming ANZSPM scientific meeting, there will be an opportunity to learn more about the collaborative and for a meeting with sites who are interested in being part of a funded pharmaco-vigilance network for post-marketing clinical studies in Australia. It will be a wonderful opportunity for interested clinicians from around the country to flag their interest in the next step in this exciting program.

David Currow, Adelaide

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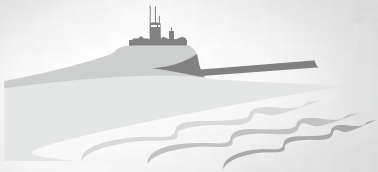
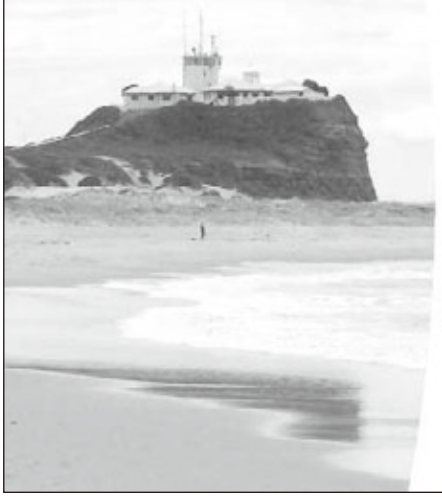


Australian and New Zealand
Society of Palliative Medicine
Newcastle, NSW
4-6 October 2006

ANZSPM

AUSTRALIAN AND NEW ZEALAND SOCIETY OF PALLIATIVE MEDICINE CONFERENCE 4 – 6 October 2006 NEWCASTLE NSW



DESTINATION

Newcastle is Australia's 6th largest city, and one of its oldest. It has a fast growing reputation as a conference destination as it offers a unique blend of big city facilities and country town friendliness. It is the capital of the Hunter Region and the most popular tourist destination outside of Sydney in NSW.

INVITED SPEAKERS

Diane E. Meier, MD
Director, Lilian and Benjamin Hertzberg Palliative Care Institute Director, Center to Advance Palliative Care Catherine Gaisman Professor of Medical Ethics Professor Departments of Geriatrics and Medicine Mount Sinai School of Medicine

Sebastiano Mercadante MD
Chief of Anaesthesia & Intensive Care Unit, Pain Relief & Palliative Care Unit, La Maddalena Clinic for Cancer, Palermo, Italy

Maree Smith
Professor and Head of the Pain Research Group, School of Pharmacy, University of Queensland

Linda Kristjanson
RN, BN, MN, PhD. Professor of Palliative Care Nursing at Edith Cowan University

These will join local speakers to give talks on diverse and stimulating topics. The first major topic area that will be covered relates to pain (specifically complex pain situations, opioid poorly responsive pain, neuropathic pain, palliative treatment of bowel obstructions, opioid receptor updates, combining opioids, new opioid preparations). Another major topic will be looking at practical ways of dealing with spiritual distress. As well we hope to look at palliative care in non-malignant illnesses – where the boundaries lie.

THE MEETING

The Australia and New Zealand Society of Palliative Medicine holds a major conference every two years. The meeting is the major conference for medical practitioners working in Palliative Medicine in Australia and New Zealand and also for parts of South-East Asia. As well the conference has an emphasis on General Practitioner education, and as such expects a large local contingent of general practitioners to attend.

If you would like to be kept up to date with the progress of this conference, please either contact the secretariat on the below details, or register your details online at www.willorganise.com.au/anzspm.

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