

Editorial

Welcome to the "new look" ANZSPM newsletter. John Cavenagh, a previous editor, has told me the history behind the previous design and logo. In 1995, the ANZSPM executive asked all members to submit suggestions for the design and colour layout for a society logo that was to be used on all official ANZSPM correspondence. A prize was offered for the winning design. The winning logo, from an anonymous member, was a picture of a hand-held Australian wattle and New Zealand silver fern. Unfortunately, another group, TROG (the Trans Tasman Radiation Oncology Group), had independently produced a very similar logo that was already on their letterheads. ANZSPM therefore had to withdraw the wattle and have used the gold and bold black ANZSPM format ever since.

The snake symbol represents the Aesculapian snake, a harmless snake that symbolizes the Greek God of Medicine, Aesclepius. It was included to indicate that ANZSPM is a medical society. Aesculapian snakes were kept in the combination hospital-temples built by the ancient Greeks and later by the Romans in honour of God. Aesclepius is often pictured with his staff, around which is entwined one of these snakes. Escaped snakes have survived and flourished in various places in Germany and Austria where Roman temples were established. If I had been aware of the richness of this history, I would have been less likely to delegate said reptile to the cutting room floor. If any of you feel strongly that it should remain, please let me know. Perhaps it would be preferable to re-think a symbol with an Australasian flavour? Alternatively, we could use the stylised snake symbol in the logo advertising the next ANZSPM conference (see page 8). This could also be seen to represent the water separating the two countries. All suggestions welcome.

You will note also that the yellow colour has been toned down a few shades. This does seem appropriate, as the yellow and black are meant to represent Australia and New Zealand respectively, and the yellow did seem to dominate somewhat in previous editions. I will resist the obvious sporting analogy here, but Willie has been true to form (see NZ report, page 6). In line with the "toned down yellow", I would encourage our New Zealand readership to contribute articles for the next edition.

As reflected in this edition, several groups have asked to use the newsletter as a means of communicating new developments, updates and ideas. I like to think that this is a sign of a successful newsletter.

Best wishes for the festive season,

Janet Hardy
Editor

President's Report

In the era of accountability that we now work, it seems to be no longer a matter of 'just' providing palliative care to the patients referred to us, but we must now strive to provide "quality palliative care for all Australians". Palliative Care Australia (PCA) has been working on standards for palliative care for more than a decade and the 3rd iteration of their work, "Standards for Providing Quality Palliative Care for all Australians" was released earlier this year (see

page 5). The stated aim of the standards is "to improve the quality of practice and outcomes". The objective of this President's report is not so much to comment on the standards – an excellent commentary can be obtained in the issue of the CPCRE's newsletter "Centre Line" (www.cpcrc.com and follow links in Publications) and the complete Standards document can be viewed at the PCA website (www.pallcare.org.au) – but rather to raise the associated issue of measuring quality and in particular, clinical indicators (CIs) for palliative medicine. I alluded to this matter briefly in the last President's Report.

The Australian Council for HealthCare Standards (ACHS) has been working on CIs since the early 1990's and they form a key part of the EQUiP process. Everyone knows the common hospital-wide CIs for post-op pulmonary embolus, readmission to hospital within 7 days, etc and how they aren't very applicable to palliative medicine. What is less well known is that the ACHS also has specific CIs for more than 20 different areas of health care, apart from the original hospital-wide ones. There are none for palliative care but some other areas may be more or less relevant to the development of palliative care CIs. These include CIs for hospital in the home, rehabilitation, mental health/ mental health-community based and geriatrics. There are also CIs for Internal Medicine by speciality (e.g. Endocrinology: "the number of insulin dependent diabetics having major surgery who get BSIs done at least 4 times on the first post-op day" or Oncology: "the rate of women with stage II breast cancer receiving adjuvant therapy"). The ACHS publication on CIs "Determining the potential to improve the quality of care" (5th ed) can be found at their website and is worth reading (www.achs.org.au).

The reason for presenting all of this is that ANZSPM is represented on the Specialities Board of the RACP. In April this year, all specialist societies were asked to look at their CIs and to report back with three new or revised ones that they would start collecting in 2006. Your ANZSPM Council has had some discussion of this topic at its meetings in May and November, but progress has been understandably slow. If you attended the PCA Conference in Sydney in September, you would have heard about a new national academic initiative, the Palliative Care Outcomes Collaboration (PCOC), that has CI development as part of its remit. However, the PCOC CIs will still be some years off and we need to report back to the RACP in the new year. [More information about PCOC can be found at the University of Wollongong's website <http://www.uow.edu.au/commerce/pcoc/>].

Recently, Kathie Thomas, the ANZSPM secretariat, emailed you a short survey on any CI you are currently collecting. In particular CIs are to be distinguished from Key Performance Indicators that measure activity and efficiency but not quality. If you haven't already completed the survey please do so, so that we can at least provide the Specialities Board with a statement on the current status of CIs in palliative medicine. For those who did not receive the email, the survey is included within this newsletter. You can fax it back to Kathie on 03 9585 3785 or ask for an e-version via secretariat@anzspm.org.au. We will present the results of the survey in the next issue of the newsletter.

Don't forget to put the dates for the ANZSPM Conference, in Newcastle, October 4-6, 2006 in your diaries. International keynote speakers include Diane Meier (USA) and Sebastiano Mercadante.

For now, Merry Christmas and Happy New Year.

Paul Glare
Sydney

Conference reports

"Controversies in Cancer Pain"

Highlights of the Cancer Pain 2005 Satellite Symposium Cairns, Queensland, August 2005

This conference featured several high profile overseas speakers en route to the International Pain Conference in Sydney. Unfortunately, Kathy Foley from the Memorial Sloan Kettering Cancer Centre in New York had to withdraw the week before the conference. Her place was taken by Dr Jim Cleary from Winsconsin who gave an excellent presentation on current controversies in cancer pain management. Many of the subsequent talks addressed the issues raised in this presentation. Plans are underway to hold a similar conference next year at the Sydney Institute of Palliative Medicine's 15th Annual Symposium.

Is the WHO ladder obsolete?

Paul Glare's view was that it is still probably appropriate in countries where access to opioids is limited but that it is inadequate for comprehensive cancer pain management because, it assumes all pain in cancer patients is due to progressive disease, it over emphasises pharmacological treatments, its construct implies inevitable escalation of opioid potency over time. He recommends consideration of other models e.g. the "pyramid and ribbon" approach advocated by the US Agency for Health Care Policy and Research.

What is the risk to society of addiction and substance abuse?

Opioids are very effective for the treatment of pain when the duration of treatment is short, such as in the terminal phase. With the recent explosion of new anticancer therapies, cancer survival is improving. In the next few years, many more patients will be living for prolonged periods with their cancer, as is the case for many patients with HIV disease. This raises questions about sustaining efficacy and about the risk of addiction when using opioids. Tolerance to opioids can develop over time and interfere with analgesic efficacy. Similarly, although addiction implies drug seeking behaviour and a psychological need for drugs, there is no doubt that patients become physically dependent to opioids over time such that abstinence symptoms will develop when the drug is withdrawn. Jane Ballantyne from the Massachusetts General Hospital in Boston explored these potential problems and discussed ways to avoid or minimise them.

Is pain relief a form of euthanasia?

In an MD thesis, Michael Ashby examined the medical, legislative, legal and parliamentary scrutiny of end of life issues. Of some concern was his finding that all the reports, judgments and parliamentary committee proceedings studied, assume that palliative care interventions and treatment abatement decisions may indeed constitute a cause of death. Of equal concern, is that the so called doctrine of "double effect" is widely supported (i.e. opioid-related deaths are acceptable if the opioid was given with the intention of providing pain relief). There was general agreement in the discussion following this lecture that the doctrine of double effect is seen to be unhelpful and unnecessary in the determination of what is permissible in palliative care and that the goals and intentions of drug prescribing in palliative care can and should be made clear.

Why is there such a large inter-country difference in the prescription of opioids?

The use of morphine globally has increased significantly since 1972,

especially in a limited number of "top countries where there is relatively high use e.g. Australia, Canada, Denmark, Iceland, Ireland, New Zealand, Norway, Sweden, the United Kingdom, and the United States. In other countries, such as South Africa, Botswana and Uganda, morphine use is comparatively very low. These disparities are concerning and highlight the socioeconomic factors driving treatment choice.

For a bit of light relief, and the highlight for many of us was the talk by a local marine biologist on the Irukandji syndrome. He explained with great enthusiasm what it is like to be stung by a stinger and the pain that develops thereafter. It is not often that one gets such a graphic description of pain from a patient. This was followed by a discussion on how best to manage this syndrome, with suggestions ranging from magnesium infusions to ketamine.

**Janet Hardy
Brisbane**

11th IASP World Congress on Pain Sydney, August 2005

The 11th World Congress of Pain in association with the International Association for the Study of Pain was held at Darling Harbour, Sydney, from August 21 - 26, 2005. More than 5000 delegates were presented with a plethora of choice of topic through addresses, workshops, refresher courses and poster sessions. An impressive trade display competed for the delegate's interest. The following few insights gleaned over the week are chosen for their potential relevance at the bed-side. The historically misunderstood (glue) or glial cells of the CNS featured widely in research presentations.

The Congress coincided with the 40th anniversary of the publication of Melzack and Wall's "gate control model". This was fittingly recognised by a former post-doctoral fellow of Pat Wall's, who drew on Wall's earlier work demonstrating the powerful role of inhibitory neurones. The death of inhibitory neurones in the dorsal horn (DH), by apoptosis has been shown to be facilitated by activation of microglia and subsequent release of TNF- α , resulting in release of activated caspase-3 (CAPS-3). Inhibition of CAPS-3 was shown to decrease loss of inhibitory neurones and reduce allodynia and pin prick hyperalgesia. It was postulated that an inhibitor such as CAPS-3 may confer neuro-protection and thus pre-empt the development of neuropathic pain.

Glial cells are not activated in normal pain states but switch on with activation of excitatory neurones to produce pro-inflammatory cytokines (TNF and Interleukin-1) in the DH. Another group's research demonstrated that this mechanism could be blocked with IL-10. It was further postulated that patients might be treated with a monthly intra-thecal injection of a long acting IL-10 molecule to inhibit microglial activity in the DH in abnormal pain states.

The cannabinoid workshop highlighted research on peripheral cannabinoid (CB)-2 receptors. An anti-nociceptive effect (release of endogenous endorphin) was demonstrated in keratinocytes using a CB-2 agonist. Potentially dangerous side effects are known to be mediated via CB1 receptors in the CNS. It is postulated that developing CB-2 agonists for clinical use may be safer but this may reduce efficacy. Further concerns surrounded potential cardiovascular side-effects and fertility issues.

One of the more fascinating presentations related to the use of functional MRI to demonstrate the different images between brain responses evoked by a noxious stimulus from the responses activated with the actual perception of the evoked pain. In one application, the abnormal activations were demonstrated in patients with irritable bowel syndrome. A further study demonstrated the integration of cognitive tasks into pain studies to examine the interaction and interference effects between pain and cognition/attention-related activities. It was suggested that attenuation of pain evoked responses during cognitive performance may relate to different coping strategies and or shifts of attention related processing.

Visceral pain mechanisms were addressed in particular identifying the growing evidence that vagal afferent input is important and contributes to the affective dimensions and unpleasantness associated with visceral pain. It was shown that 5-HT is likely to stimulate the vanilloid receptors in gut increasing mechanosensitivity of afferents. This has important clinical applications in hypersensitive conditions such as irritable bowel syndrome and may provide an explanation for non-cardiac chest pain due to oesophageal spasm.

New analgesic formulations were show-cased in the trade display. Perfalgan, the first ready to use infusible paracetamol is non-PBS marketed for mild to moderate pain in the acute pain setting e.g. post-orthopaedic surgery. It is claimed that the analgesic efficacy of paracetamol is improved by the use of the intravenous route. Burprenorphine (a partial mu agonist) transdermal system had its Australian launch as Norspan, a 7 day patch. Available in three doses (5,10 or 20microgms/hr) with the highest dose limited to 40microgms/hr (equivalent to 30mg Oxycontin twice daily). Due to dose limitations it would have only limited application in the palliative setting. The scientific and therapeutic approach to the 'sodium channel in neuropathic and inflammatory pain' was explored with promotion of the use of transdermal lidocaine in post herpetic neuralgia and other non-malignant pain states.

The gap between the laboratory bench and the bedside was 'bridged' and one's appreciation of the sheer complexity of pain mechanisms and the potential for analgesic approaches was once more enhanced after such a meeting.

Carol Douglas
Brisbane

"New Horizons"
The 8th Australian Palliative Care Conference 2005;
Sydney Convention and Exhibition Centre
30 August – 2 September 2005

I was fortunate to be amongst the almost 900 delegates at the 8th Australian National Palliative Care Conference in Sydney in early September 2005. Sydney produced its most beautiful weather and the venue at Darling Harbor rivals anywhere in the world for beauty and the excitement of an international city. Despite living and loving the peaceful tranquillity of sedate Adelaide, we all need to "break-out" occasionally.

The conference organisers, i.e. the committee from Palliative Care New South Wales in conjunction with the Palliative Care Australia Executive and Secretariat are to be commended for producing another exciting and informative conference in a climate of diminishing corporate sponsorship and in a city where costs and venues are challenging.

The key note speakers were an appropriate mix of local and overseas experts. All in their own way provoked significant reflection and challenges. Therese Rando from Rhode Island, USA spoke on "New Thinking about Grief and Bereavement" and the links between stress, trauma, grief, anxiety, sadness, guilt and depression. Cynthia Goh from Singapore discussed "New Populations and Partnerships", in particular those with South-East Asia. She certainly challenged the notion of delivering a Westernised product, rather than standing along-side our colleagues and assisting them to clarify their own issues and solutions. The plenary session on Indigenous Palliative Care presented by Mark Boughey and Beverley Derschow from Northern Territory Palliative Care built on the strong indigenous focus of the previous National Conference held in Adelaide in 2003. This was a well-constructed, considered and most interesting session.

The conference dinner, as is the tradition at Palliative Care Australia National Conferences was a great success. The dance floor was crowded beyond its capacity and the gender balance was predictably skewed. There were the inevitable extraverts with insignificant space on the dance floor, who joined the band on-stage and the concurrent sessions on the following morning were predictably subdued but nonetheless well attended. One does not attend these dinners for a culinary experience of any significance.

The concurrent sessions were jam-packed with interesting sessions showing the continuing breadth and level of endeavour within the palliative care community, to further understand what it is that we do and why. I found resonance with a presentation by Bob Brown from Ulster on the "Lived Experience of Loneliness Among People with life-limiting illnesses". There were Paediatric streams, workshops building on the Plenary sessions and opportunities for Special Interest Groups to meet. The AGM of Palliative Care Australia was held during this meeting and the new President-Elect of PCA is Professor Margaret O'Connors.

This was a most successful conference, culminating on the last day with the introduction of the Andrew Taylor Memorial Debate. Andrew Taylor was the Executive Officer of the Palliative Care Council of South Australia and my fellow delegate from South Australia to the PCA Board. His untimely death earlier this year was a great shock to us all and as is so often the case we only really understand the full breadth and support of such people when they are no longer in our midst. This debate was "That Palliative Care is more science than art" and the decision of the conference delegates was that the affirmative failed to prove this assertion. This was a lively debate with much hilarity and humour, and a very quick moving rhetoric. The next National Australian Palliative Care Conference is in Melbourne in 2007. But of course before that we have the ANZSPM Scientific Meeting in Newcastle in early October 2006. See you there if not before.

Greg Crawford
Adelaide

Inaugural Palliative Medicine Trainee Day

The inaugural Palliative Medicine Trainee day was held at the Sacred Heart Hospice, Sydney NSW on the 28th August 2005, and was attended by 23 trainees from throughout Australia and New Zealand along with A/Prof Paul Glare (representing ANZSPM), Prof. Peter Ravenscroft (representing the SAC of Palliative Medicine) and A/Prof Richard Chye (representing the Australasian Chapter Education



Committee). The day was organised by the trainee representatives on the Chapter and SAC committees in response to the requests of trainees to have access to educational sessions and to develop links with trainees in other regions. It is hoped that this can become an annual event, with support from ANZSPM, the Chapter and SAC of Palliative Medicine. The development of trainee involvement in ANZSPM is also to be fostered under the auspices of the "Maddock's Club."

Dr Frank Brennan, Staff specialist at Calvary, St George and Sutherland Hospitals Sydney discussed some of the issues surrounding the transition from registrar to consultant. He emphasised advocacy, education, and the teaching of juniors as key roles to fulfil. Dr Meg Sands, staff specialist, Westmead Hospital used an analogy from a childhood story "Put me in the Zoo" to describe the skills of a consultant - an ability to listen and to quarantine time for reading, research and writing, learning to say no, understanding that culture change takes years and that there are always colleagues and mentors at the end of a phone. Her advice - "walk slowly, speak quietly... and carry a big stick."

In a session entitled "Interventional Pain Update," Dr Paul Murphy, Clinical Pain Fellow, Royal North Shore Hospital, discussed intrathecal drug delivery systems and the evidence base for the drug choices. There was also had an update on neurolytic blocks pertinent to cancer pain management.

An expert in the field of Doctors' Health, Dr Simon Willcock, who works with the Doctors Health Advisory Board, provided us with an insight into "self care for palliative care clinicians" and the evidence that relates to doctors health and how to maintain it. He discussed research that has identified a model for predicting psychological distress and methods that allow us to take better care of ourselves.

A/Prof Richard Chye was given the task of deciphering the mysteries that are project reports and job interviews. He gave a clear outline of how to interpret a job advertisement, how to make a CV clear and concise, what to expect in an interview for a senior job and how to get projects to publication standard.

Michael Parle (clinical psychologist) and Mark Ryan (psychiatrist) who have many years of communication training expertise between them, ran a dynamic communication workshop using role play. This was linked with small group discussions aimed at provoking us to determine our reactions and influence in a communication setting.

The inaugural trainee day saw the launch of the "Hitchhikers Guide to Palliative Medicine". This document, based on an introduction handbook sent to medical oncology trainees, is designed for first year trainees and outlines what to expect, key contacts, key dates and helpful websites. The aim is to smooth the transition into advanced training and to address topics such as on-call, communication skills, burnout and college issues.

The next trainee day will be at the time of the next ANZSPM conference in Newcastle, October 2006.

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Introducing the Adverse Medicine Events (AME) Line.



ADVERSE MEDICINE EVENTS LINE
1300 134 237

Everyone knows that new adverse reactions and drug interactions may be discovered when a drug is first marketed, and used by large numbers of patients under conditions straying from those of pre-marketing clinical trials. In these post-Vioxx times, however, health professionals and consumers alike are increasingly concerned that the systems for monitoring medication safety post-marketing are somehow not working.

Spontaneous adverse drug reaction (ADR) reporting is currently the cornerstone of post-marketing pharmacovigilance worldwide. In Australia, health professionals (HPs) are responsible for submitting reports of ADRs to the Adverse Drug Reaction Advisory Committee (ADRAC) of the Therapeutic Goods Administration, and these reports are shared with other HPs as well as 70 other countries who contribute to the World Health Organisation's International Drug Monitoring Programme.

But how representative is the data they receive? When was the last time you reported an ADR? It has been suggested that a major limitation of the system is its reliance on HPs, who are notoriously time-poor and few have any training in pharmacovigilance. No wonder less than 10% of serious ADRs and less than 1% of all ADRs get reported to ADRAC.

One solution to this problem is to allow consumers to report their own ADRs. Indeed, evidence from pilot studies of consumer ADR reporting shows that, in general, consumers report ADRs more quickly, with more detail, to a broader range of medicines than health professionals. For these reasons, pharmacovigilance services around the world are opening up adverse drug event (ADE) reporting to accept reports from consumers.

Here in Australia, the Adverse Medicine Events (AME) Line has been established to assist consumers to report and enquire about ADE's. Operated by the Mater Pharmacy Services in Brisbane, the AME Line is an initiative of the Australian Council of Safety and Quality in Health Care and works in conjunction with the Adverse Drug Reactions Advisory Committee (ADRAC) in Canberra.

Objectives of the AME Line are to:

- create a system for consumers to report adverse experiences with medicines, via an expert intermediary (pharmacist).
- promote open and accurate discussion regarding adverse medicine events;
- identify trends in adverse medicine events to know when, where and how things go wrong, in order to ultimately;
- integrate such information into health systems, to improve the safety and quality of medication use.

As well as ensuring that ADRs for ADRAC satisfy appropriate criteria, AME Line pharmacists also provide evidence-based information and answers to questions from consumers regarding medication-related adverse events. Medication errors and so-called 'near misses' may also be reported, and these are submitted (in a de-identified manner) to the Australian Council for Safety and Quality in Health Care.

AME Line cards, posters, fridge magnets and brochures are available, which can be requested by phone or via the website. Please spread the word that the AME Line exists and feel free to refer clients who wish to report adverse events relating to medicines. Our service is accessible from anywhere in Australia, for the cost of a local call or through our website at www.mater.org.au/ame/

Geraldine Moses

**AME Line Project Officer and Senior Pharmacist
Brisbane**

Additions to the Schedule of Pharmaceutical Benefits

The following items, have been added to the mauve Palliative Care section in the Schedule of Pharmaceutical Benefits for patients receiving palliative care.

Diazepam, tablet 2 mg (Antenex 2; Valpam 2; Ducene; Valium)

Diazepam, tablet 5 mg (Antenex 5; Diazepam-DP; Valpam 5; Ducene; Valium)

Diclofenac Sodium, tablet 25 mg (enteric coated) (Chem mart Diclofenac; Clonac 25; Diclofenac-BC; Diclohexal; Dinac; GenRx Diclofenac; Terry White Chemists Diclofenac; Fenac 25; Voltaren 25)

Diclofenac Sodium, tablet 50 mg (enteric coated) (Chem mart Diclofenac; Clonac 50; Diclohexal; Dinac; Fenac; GenRx Diclofenac; Terry White Chemists Diclofenac; Voltaren 50)

Diclofenac Sodium, suppository 100 mg (Voltaren 100)

Ibuprofen, tablet 200 mg (Rafen 200)

Ibuprofen, tablet 400 mg (Brufen)

Indomethacin, capsule 25 mg (Arthrexin; Indocid)

Indomethacin, suppository 100 mg (Indocid)

Naproxen, tablet 250 mg (Inza 250; Naprosyn)

Naproxen, tablet 500 mg (Inza 500; Naprosyn)

Naproxen, tablet 750 mg (sustained release) (Proxen SR 750; Naprosyn SR750)

Naproxen, tablet 1 g (sustained release) (Proxen SR 1000; Naprosyn SR1000)

Naproxen Sodium, tablet 550 mg (Anaprox 550; Crysanal)

Nitrazepam, tablet 5 mg (Alodorm; Mogadon)

Oxazepam, tablet 15 mg (Alepan 15; Serepax)

Oxazepam, tablet 30 mg (Alepan 30; Murelax; Serepax)

Sulindac, tablet 100 mg (Acclin)

Sulindac, tablet 200 mg (Acclin 200)

Temazepam, tablet 10 mg (Temaze; Temtabs; Normison)

Source: the proposed additions to the Schedule of Pharmaceutical Benefits – to be operative from December 2005 – from AusPharmacist.net.au

Standards for Palliative Care

It must be said that the modern hospice and palliative care movement was founded on the idea that providers should focus upon consumer needs not upon their own (provider) needs and provide appropriate and sensitive care at the end of life. It also must be considered that consumers may bring differing perspectives to a conversation about health care service delivery and what constitutes quality palliative care.

It was with this in mind that in March 2004 Palliative Care Australia (PCA) undertook a national review process to revise the existing 3rd Edition of Standards for palliative Care Provision (1999). This revision of the standards was undertaken to ensure the continuing relevance of the standards to current community needs. The revised Standards aim to assist those services that provide care to people with life limiting illness to plan for and manage quality. The 4th edition of the Standards have been developed following a robust sector and consumer consultation process. The consultation process and the development of a resource and training to support the implementation of the Standards were funded by the Commonwealth Department of Health & Ageing.

The revised Standards, launched in May 2005 by the Minister for Health and Aging, the Hon. Mr Tony Abbott with widespread cross sectoral endorsement, for the first time, sets out the relationship between primary care providers and specialist palliative care services. Perhaps more importantly, they provide guidance as to the specific requirements for services that provide care to people at the end of their life.

Traditionally, palliative care has focused on the needs of patients with cancer. The 4th edition of the PCA Standards moves beyond a simplistic diagnosis basis for determining need and focuses on establishing networks of care that allow patients to access appropriate and timely care consistent with their level of need. The Standards also recognise and reflect the considerable effort and success that some services/sectors have had in developing and implementing co-ordinated network based approaches to service development and delivery.

The vision for palliative care set out in the Standards includes and is relevant to consumers (patients, families) general practitioners, community nurses, staff of residential care facilities, acute care staff, as well as specialist palliative care staff. As such they represent a whole-of-sector approach to ensuring high quality needs- based care at the end of life.

The Standards are available on the PCA website (www.pallcare.org.au) under publications.

Brenda Cattle

**National Project Manager, Standards and Quality Project
Palliative Care Australia**

Palliative Care in our Aging Society

The demographics of the Australian population are changing. The "baby boomers" from the post WWII era are now joining the ranks of the elderly in our society. There are proportionately less young people (especially 'potential taxpayers'), more families are now 'dual worker' families and there are going to be even less carers in the future, at a time when the demand for care is going to increase dramatically.

Governments are still relying on an increase in provision of services by informal carers as a solution to the problem. Community based care is being recognised as vital and new initiatives such as "extended aged care in the home" (EACH) packages are a welcome addition as any extensions to the "community aged care packages programmes" (CACPS). However, the strain placed on families and carers is increasing. New research into the future availability of carers to look after Australia's frail aged has projected that by 2031, more than 573,000 frail older Australians will be living in the community without a primary unpaid carer. Added to this, better cancer detection programmes and treatments are extending the life of many cancer patients, who are living longer with a 'potentially terminal chronic illness'. This provides new challenges for us in the way we practice our 'craft' as palliative care physicians. Our more traditional hospice based models of "end-stage, terminal care of the dying" may be inappropriate for many patients who require 'early interventional, integrated palliative care' in this changing environment. We need to develop new models for palliative care service provision to include the population who are "living actively" with 'frailty' in our communities and who, along with their relatives/carers, are likely to have many unmet palliative care needs.

Similarly, new terms of reference need to be developed for palliative care services to allow us to work in a collaborative and integrated manner with our medical colleagues in geriatrics, rehabilitation, psychogeriatrics, oncology and general practice. We need to advocate for the development of more integrated and broadly based hospital and community allied health interdisciplinary teams that we can all share. Physiotherapy, occupational therapy, clinical pharmacy, nutrition, speech therapy and diversional therapy should be used to a greater extent along with counseling and pastoral care services within interdisciplinary palliative care teams. Whilst our focus in palliative care is more appropriately placed on "care" rather than "cure", our revised models of service delivery in the new demographic environment will need to focus more on "active living until the end" rather than "supported dying". If we do not do this, we face the danger of inadvertently making our patients prematurely functionally impaired, both physically and cognitively (WHO-ICF 2001 & Report for AHMAC Nov 2004).

We also need to join GPs and carer groups in advocating for increased support for families and carers via better family/carers education and information services, financial and employment support, integrated respite services, counselling and bereavement services as well as increased community recognition and valuing of families/carers fulfilling this vital community role.

Other initiatives such as day care centres, more community based hospices with 24 hour outreach home visiting services and provision of residential aged care beds that are adequately staffed with appropriately trained personnel will need to be considered. There will also need to be provision for more non-acute care beds that

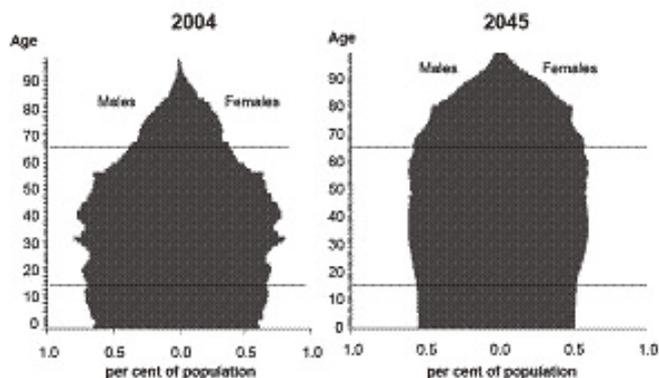
are appropriately staffed in our hospitals to service the needs of the 'older population'.

To be able to advocate for all these changes, we are going to have to work collaboratively with our medical colleagues, our allied health colleagues, industry employer and employee groups and consumer groups. This was realized by the AMA and other key lobby groups in the Aged Care sector in 2000 and resulted in the formation of the **National Aged Care Alliance (NACA)**. Five years on, the Alliance includes 24 key bodies including the Australian Society for Geriatric Medicine, the Australian Association of Gerontology, Australian Divisions of General Practice, Royal Australian College of General Practitioners (RACGP), Royal Australian College of Nursing, Australian Associations of Physiotherapy and Occupational Therapy, the Pharmacy Guild of Australia and many other important groups.

Representatives attending the inaugural meeting resolved to recommend to their organisations that a united policy agenda be developed to achieve better outcomes for the care of older Australians. Four broad issues were identified: consumer rights, quality of care, workforce planning and financing of aged care. The Alliance's vision for aged care in Australia is that all Australians have access to planned and properly resourced integrated quality aged care services that are flexible, equitable, that recognise diversity and promote choice and respect for users and workers.

In order to broaden both the Aged Care and Palliative Care debates in this country it is vital that both ANZSPM and PCA join the alliance. The initiative has the approval of the ANZSPM council and members are to be approached regarding their willingness to represent ANZSPM at NACA. Further information can be found on the NACA website (<http://www.naca.asn.au/about.html>) or from Dr Rohan Vora (r.vora@bigpond.net.au) who represents the RACGP on the alliance.

"From Pyramid to Coffin"



New Zealand Report

ANZSPM New Zealand has been relatively quiet since the Pain and PCA conferences in August in Sydney. The main area of activity has been related to the further development of a national peak body, similar to Palliative Care Australia. The challenges faced have been identification and engagement of all role players in palliative care in a collaborative group and setting up an effective process framework. The College of General Practitioners have become involved as project facilitators.

ANZSPM NZ is still concerned about workforce planning, both in regards to reference frameworks regarding numbers of personnel, as well as specialist training and succession planning issues. A factor that complicates this further is the relative absence of service specifications within the hospice setting with widely differing levels of service provision. Of concern, Palliative Medicine specialists and generalists do not have service planning input in all hospices.

Fortunately, on the positive side, we seem to still be home to many winning teams down here: netball, Grand Slam rugby and now the tri-nations in NRL. Would it be too much to expect us to give you a scare at cricket?

We wish all our colleagues a great festive season and a fun-filled summer break.

Willem Landman
Auckland, NZ

Book Review

Therapeutic guidelines – Palliative Care Version 2, 2005, Therapeutic Guidelines Ltd, Melbourne

This is a pocket sized resource book that follows the same format as version 1.

It is designed mainly for doctors and nurses who work with patients with life-limiting illness as part of their practice and as such, is likely to be a very helpful resource for both generalist and specialist palliative care practitioners.

The book is easy to read and I like the sequencing with the issues around communication and ethics early in the book. The “practical points - frequently asked questions” will be helpful to generalist health care practitioners. The highlighted examples throughout the book provide practical/applied examples to assist understanding. Furthermore, I would expect that the examples of communication strategies would be helpful for practitioners with less experience, helping them to open difficult conversations.

I think this text could have been strengthened by including: A short piece about the service delivery of palliative care from the Palliative Care Australia document “Palliative Care Service Development: a population based approach” further highlighting the fact that palliative care provision is provided across all sectors and by many health care practitioners. A section on referrals/consultation between non-medical staff. For example generalist nurses with specialist palliative care nurses (eg wound care specialists) and primary care allied health professionals and specialist allied health professionals (eg for complex family issues or lymphoedema management). Specialised palliative care staff have many opportunities to improve patient and family outcomes and are often consulted by generalist providers about complex patient issues. An example of the use of the multidisciplinary team approach to care could have been included in “Domiciliary Care” and in the “Principles of Symptom Control”. The multidisciplinary approach has not been highlighted well in this book it is still very medical / nursing orientated. Considering that palliative care advocates for a multidisciplinary team approach to the care of people with life limiting illness, it may have prudent to include some allied health practitioners on the expert panel. Some explanation as to how to use each tool in the appendix on assessment tools.

Despite these suggestions, I believe this is a great resource for clinicians working with people with a life limiting illness.

Linda Barrett, RN
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Therapeutic Guidelines Limited (TGL) is a not-for-profit independent organisation responsible for the production and publication of Therapeutic Guidelines. It is independent of government and licensing authorities and any form of commercial sponsorship, including the pharmaceutical industry. The text of Therapeutic Guidelines, Palliative Care was prepared by a multi-professional expert group of experienced clinicians. It represents “independent consensus distillation and interpretation of the best available evidence and opinion at the time of publication”.

The aim of TGL is to provide clear, practical, authoritative and succinct therapeutic information for health practitioners. The guidelines are not meant primarily to instruct, but rather to assist prescribers in ensuring patients receive optimum treatment. “Unlike reviews or summaries of the literature where the evidence found determines the basis and scope of the text, the starting point for the development of TGs is a clinical problem”. Decision-making in medical practice is inherently complex and multifaceted and, in addition to the evidence, other factors (eg the availability and affordability of treatment, risk factors and patient characteristics) need to be considered to ensure the advice is relevant and useful.

Because factors additional to scientific evidence are taken into account in the development of TGs, it is not possible to use the tools developed by other agencies to assign graded evidence hierarchies to the evidence. The approach taken in all TGs is to indicate whether a recommendation is based on strong evidence or otherwise by including “explicit statements in the surrounding text”. This is true to a large extent in the palliative care text eg “oxycodone *is* 1-2 times as potent as morphine...*and* may have fewer CNS effects*and may* be useful if delirium or cognitive impairment limits the analgesia obtainable with morphine”. I looked hard for definitive statements to disagree with and found a few (eg psychostimulants *are* of use for opioid-induced sedation) but on the whole, the expert committee must be congratulated for their use of language considering that so much of the teaching in palliative care is based on anecdote alone. References are given in the electronic version but not the printed version of the text.

For me, some of the strengths of the text include the excellent tables eg those on NSAIDs, steroids, breaking bad news and the depth of coverage. This is not just a symptom control cook book but covers ethical issues, care of the provider, loss, grief and bereavement etc. Similarly, the inclusion of many pertinent practical points is a plus eg how to administer naloxone, advice for locums called to see a deceased patient, a child's concept of death related to age.

Sections done less well include the management of the dying patient. This section is very brief, although the management of specific symptoms are covered elsewhere. There is some repetition, as in “know your drugs” followed by “treatment of specific symptoms”. As a minor quibble, hypercalcaemia and hyponatremia are included under paraneoplastic syndromes and not under metabolic complications of malignant disease or oncological emergencies.

Janet Hardy, MD
Brisbane

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Cardiff University, College of Medicine

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Please visit our website to obtain further information and an application pack. www.palliumwales.co.uk

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Postgraduate Certificate & Diploma in Palliative Medicine for Medical Practitioners

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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

Chapter of Palliative Medicine, Royal Australasian College of Physicians

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Palliative Medicine journal

As an ANZSPM members, you are entitled to a privileged rate for this journal. To take advantage of this offer, or to request a sample copy, visit www.palliativemedjournal.com

The Conference Update

"Making a Difference". The 17th Hospice New Zealand Palliative Care and Pain Society Conference will be held in Dunedin, October 26-28, 2006. For more details contact event project manager Barry Woodland at Conference Innovators, phone +64 3 379 0390 or email barry@conference.co.nz.

"Oncology Update for Palliative Care"

Friday 10th March 2006, Education Centre, Royal Brisbane and Women's Hospital, Brisbane.

Centre for Palliative Care Research and Education, Queensland

Aim: To update health professionals in palliative care on the latest developments in the treatment and management of malignant disease. Contact cpcrc@health.qld.gov.au or janet.hardy@mater.org.au

"Schizophrenia and Related Psychoses: A Clinical Update"

The 7th International Mental Health Conference, Holiday Inn, Gold Coast Friday 4th & Saturday 5th August 2006

Conference web site: <http://www.gcimh.com.au/conference>



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, Lillian 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

Marec 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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